



Transforming long-term care to keep residents healthy and safe

Do you support RNAO's call to transform funding models in long-term care (LTC) homes to improve resident care?

Will you commit to supporting minimum staffing levels in LTC homes so that residents can live safely and with dignity?

RNAO has long advocated that every senior in Ontario should have the opportunity to live with dignity in an environment that fully meets their needs.^{1 2 3 4 5} This evidence-based advocacy is in line with the fundamental principles of the *Long-Term Care Homes Act, 2007*,⁶ which asserts that an LTC home must provide its residents with a secure, safe, and comfortable setting.

About LTC in Ontario

- LTC homes provide accommodation and care for people – primarily seniors – with long-term health and/or cognitive disabilities. In LTC homes, residents have 24-hour access to nursing and personal care as well as assistance with activities of daily living.
- Ontario spends about \$4 billion – almost eight per cent of the overall health budget – each year on LTC.⁷ There are 627 LTC homes in the province with more than 78,000 beds in total, comprised of a mix of public, private for-profit, private not-for-profit, and other (e.g., religious) providers.⁸ Facilities receive most of their funding from government. Currently, Ontario's LTC homes operate at 99 per cent capacity.
- The *Long-Term Care Homes Act, 2007* (LTCHA) is the single legislative authority for safeguarding residents' rights, improving quality of care, and improving accountability in LTC homes.
- Of the total number of health-care providers in LTC, RNs account for nine per cent, RPNs for 17 per cent, and NPs for less than one per cent. Other regulated professionals include nutritionists, social workers, and physiotherapists, who together account for eight per cent of all health-care providers in LTC. The remaining 65 per cent of care is delivered by unregulated staff such as PSWs.⁹
- Under regulations in the LTCHA, homes are required to implement evidence-based practices to provide quality care for residents.^{10 11} RNAO has best practice guidelines (BPG) that address each of the mandatory programs that LTC homes are required to implement, including prevention of falls and fall injuries in the older adult; promoting continence using prompted voiding; prevention of



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constipation in the older adult population; assessment and management of pain; and various guidelines for skin and wound care. RNAO has numerous additional BPGs relevant to the sector, including alternative approaches to the use of restraints; preventing and addressing abuse and neglect of older adults; and delirium, dementia, and depression in older adults.

LTC has not adapted to meet the increased needs of today's resident population

Ontario's population is rapidly aging. Experts estimate the number of seniors aged 75 and older will double within the next 20 years.¹² Without dramatic system changes, there will be a shortfall of 48,000 LTC beds over the next five years.¹³

The needs of LTC residents are also changing. Compared to previous generations, residents in LTC homes today have increasingly complex care needs. For instance, nearly all residents have multiple chronic conditions (e.g., heart disease, diabetes, arthritis).¹⁴ This is due in part to changes to LTC admission criteria in 2010 that required new residents to have high or very high physical and cognitive challenges to qualify for admission.¹⁵

About 90 per cent of LTC residents have cognitive impairment, including dementia,¹⁶ and about 80 per cent of residents with dementia have behavioural symptoms, including aggressive or severely aggressive behaviour.¹⁷

The complexity of LTC residents has increased to rival that of patients in alternative level of care (ALC) beds in hospitals, or complex continuing care (CCC). But funding for LTC is significantly less. This needs to change.

Funding for LTC homes in Ontario

The Ministry of Health and Long-Term Care (MOHLTC) funds LTC homes on a level-of care (LOC) per diem basis within four spending envelopes, as follows:

Base LOC per diem funding (as of July 1, 2017):¹⁸

Funding envelope	LOC per diem
Nursing and personal care (includes direct care staff and care supplies)	\$96.26 (<i>variable</i>)
Program and support services	\$9.60
Raw food	\$9.00
Other accommodations	\$55.28



Total	\$170.14
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All LTC home beds receive the same base per diem funding for all funding envelopes, except nursing and personal care (NPC). Under the NPC envelope, per diem funding is adjusted based on resident complexity and care needs, identified by an indicator called the “case-mix index” (CMI) – a measure of relative patient acuity levels in a LTC home.¹⁹ Case-mix classification uses formulas to cluster residents into clinically similar groups that reflect the relative costs of services and supports that individual residents, with different needs, are likely to use. Funding is also dependent on the LTC home’s occupancy rate.

Funding and staffing must change to keep LTC residents safe

Despite the growing incidence of responsive behaviours (a term used to describe the behavioural and psychological symptoms of dementia)²⁰ and an increasingly complex LTC population, funding and staffing standards have not changed. It is not surprising that we are hearing increased reports of violence in LTC homes.^{21 22 23 24 25} Adequate funding and staffing must be put in place to safeguard vulnerable residents. Every LTC home in the province strives to provide the highest level of quality care to its residents. However, the reality is that finite resources and complex resident conditions are straining the current system.

It is shocking that the only legislated LTC staffing requirements in Ontario are a vague instruction for care “to meet the assessed needs of residents”²⁶ and a minimum requirement of one registered nurse (RN) on duty at all times.²⁷ Currently, there is no legislated minimum staffing ratio (the number of nursing home staff members compared to the number of residents), and no legislated requirements related to how much care residents receive on a daily basis (“paid hours of care per resident per day”, or PHPRD),²⁸ although a target staffing level of four hours of care per resident per day was recently promised by the Ontario government in its *Aging with Confidence: Ontario’s Action Plan for Seniors*. Why is it that child care in Ontario has strict, mandated care requirements under the *Child Care and Early Years Act, 2014*,²⁹ but care for vulnerable seniors is left up to LTC home operators?

Funding in LTC penalizes quality improvement practices

LTC funding models are severely flawed and must be transformed and modernized.

1. **Disincentive to improve patient outcomes:** Under the existing funding structure, there is a financial disincentive to improve patient outcomes. When evidence-based practices are implemented and resident problems are prevented or resolved, resident acuity decreases. While this is good for residents, the home’s CMI correspondingly falls and funding in future years is decreased. In other words, the unintended and negative consequence of improving resident outcomes is that LTC homes are financially penalized. This penalty acts as a disincentive to improve patient outcomes.



2. **Increased complexity and prevention not accurately funded:** Funding is not provided for activities or conditions that are not captured in the resident assessment tool,³⁰ including some preventative interventions. For example, if a resident is incontinent, funding is provided for incontinence care and supplies, but funding is not provided for the staff hours required to implement prompted toileting at regular intervals to reduce the frequency of incontinence. Similarly, the highest level of funding that can currently be provided for the responsive behaviours of residents with dementia is inadequate to cover the most costly and time-consuming interventions that are required for residents displaying severe or very severe aggressive behaviours.
3. **Retroactive data used to determine current funding:** LTC homes receive funding based on retroactive data. For example, funding for 2017-18 is based on the case-mix data that was submitted at the end of the four quarters in 2015-16. Consequently, funding is always outdated. It does not take into account the rapidly increasing complexity of residents, and is often insufficient to care for the immediate resident acuity.

LTC funding lessons from Alberta

Alberta uses an approach to LTC funding that can be adapted by Ontario to mitigate the current unintended disincentive. Alberta's Patient/Care-Based Funding (PCBF) matches funding to the needs of residents, similar to how funding adjustments are made under Ontario's nursing and personal care envelope.

In addition to the overall PCBF provided to Albertan LTC homes, there is also quality incentive funding (QIF). This is an annual allotment that is calculated separately from the overall PCBF amount to provide incentives for improving the quality of care.³¹ For instance, quality incentive submission criteria in past years have included achieving target immunization rates for staff and residents.

RNAO recommends that a resident outcomes improvement fund be put in place in Ontario's LTC system to offset any funding losses that are correlated with improvements in patient outcomes.

LTC needs the right mix and levels of staff to keep residents safe and healthy

In Ontario, LTC staff includes RNs, registered practical nurses (RPN), personal support workers (PSW), nurse practitioners (NP), allied health professionals (e.g., physical and occupational therapists, dietitians), and other employees (e.g., staff in housekeeping and food services). Each is trained to a different educational level and skill set.

Despite the best efforts of care providers, the needs of LTC residents are not being met due to inadequate staffing resources, inappropriate skill mix, and limited access to RNs and NPs.



Care delivered by the most appropriate provider

According to the College of Nurses of Ontario (CNO), the determination to use an RN or RPN should depend on three factors: the client, the nurse (or, in the case of LTC, other care providers such as PSWs), and the environment.³² More complex patients with less predictability and less stability should be cared for by RNs, whereas residents with less acuity and more predictability should be cared for by RPNs or PSWs, as appropriate.

The evidence is clear that RNs improve the quality of care in LTC homes. Research demonstrates that increasing RN staffing ratios in LTC homes reduces the probability of hospitalizations and associated health system costs, improves client outcomes (e.g., fewer pressure ulcers, fewer urinary tract infections, lower urinary catheter use, lower restraint use, fewer falls), and reduces mortality.^{33 34 35 36 37 38 39}

In recent years, there has been a marked increase in the share of nursing and personal care employment held by RPNs and PSWs in Ontario's LTC homes.⁴⁰ This is troubling when compared to the trend of increasing complexity of LTC home residents, for whom RNs are best suited to care. This may also place greater burden on other parts of the health system. For example, if one resident's care needs are beyond the scope of an RPN, and the home has inadequate RN staffing, this resident will be transferred to hospital, causing unnecessary disruption for the resident and increasing the burden of care and costs on the acute care sector.⁴¹

While RPNs and other care providers play important roles in LTC, it is critical to match skill mix to resident needs. RNAO's preferred model of care delivery in LTC homes would include NPs, RNs, and RPNs working to their full scope of practice with assistance from PSWs. Each resident would be assigned to one primary nurse provider, with RNs assigned total nursing care for complex and/or unstable residents with unpredictable outcomes. The assigned provider would take responsibility for all of the assigned resident's care needs on a continuous basis. This type of staffing model provides continuity of care and caregiver and would result in substantive improvements to resident outcomes and the broader health system.

Mandated staffing levels in LTC

Specific regulation in Ontario stipulates that one RN, who is both an employee of the LTC home and part of the home's nursing staff, must be on duty and present in the home at all times.⁴² This number is the same for all LTC homes despite varying sizes. The average number of residents in a nursing home in Ontario is 124. Thus the current staffing requirements translate to an average of just one RN for every 124 LTC residents. This is compounded for larger homes, which can legally employ one RN for upwards of 400 residents.



In Nov. 2017, through its *Aging with Confidence: Ontario's Action Plan for Seniors*, the government committed to increasing staffing levels in LTC to ensure a provincial average of four hours of direct nursing, personal, and therapeutic care in the target average number of hours.⁴³

RNAO welcomed this step, but we believe that funding should be provided for no less than an average of four hours of nursing (NP, RN, and RPN) and personal care (unregulated providers) per resident per day. Therapeutic care should be in addition to these four hours, with more hours for residents with greater acuity. This should be a home average, not a provincial average. RNAO calls for this minimum standard to be legislated.

Given the increasingly complex needs of Ontario's residents, RNAO continues to call for a legislated staffing mix in LTC that includes a minimum of one NP for every 120 residents, as well as at least 20 per cent RNs, 25 per cent RPNs, and no more than 55 per cent PSWs for every LTC home in Ontario.

Sufficient staffing numbers, and the right mix of staff, must be in place to deliver high quality care to LTC home residents and to safeguard their safety.

Untapped potential of attending NPs in LTC

All LTC homes must ensure that either a physician or an RN in the extended class (NP) “attend regularly at the home” to provide assessment and other clinical services, and be on-call.⁴⁴ NPs are RNs with advanced education and decision-making skills, and a broadened scope of practice.⁴⁵

RNAO successfully advocated for the creation of the attending NP role in LTC, with the goals of ensuring resident care needs were met on site in a timely manner, and providing continuity of care by allowing NPs and residents to develop long-term therapeutic relationships. Unlike attending physicians who typically visit LTC homes on a weekly or bi-weekly basis, attending NPs are meant to be based in their respective LTC homes full-time. The attending NP has the overall responsibility for managing and co-ordinating resident care in their respective LTC home. NPs can also play an important role in LTC through early detection and treatment of medical complications,^{46 47} treating chronic conditions, and dedicating time for health promotion, thereby reducing the need for hospitalization of LTC residents.⁴⁸

To date, the MOHLTC has announced funding for 75 attending NP in LTC positions, and filled the first 49 of these positions. As described in the MOHLTC's role description, 70 per cent of an attending NP's time is supposed to be spent on direct resident care, with the stipulation that funding should only to be used for NPs to carry out the role.^{49 50}



Unfortunately, the intended goals of attending NPs in LTC have not been realized. NPs are not being used to their full scope, as intended by the MOHLTC initiative. For instance, NPs have been used for administrative tasks instead of patient care. Many of the NPs were hired into these roles as independent contractors instead of employees and receive lower salaries than specified in the ministry's funding policy. This has resulted in difficulty attracting qualified candidates for the role.

RNAO's LTC ASKS

Funding

- Review and transform funding models in LTC to support improved resident care. In particular, consider putting resident improvement funding in place to encourage and enable – rather than penalize – improvements in resident outcomes
- Support the use of evidence-based practices in LTC homes to promote and sustain improvements in resident health and well-being
 - Incentivize LTC homes to proactively implement RNAO BPGs to meet legislative requirements⁵¹
 - Mandate the use of relevant RNAO BPGs when homes are found non-compliant after MOHLTC inspections. This would be similar to the approach Ontario has taken with the Quality Based Procedures in hospitals⁵²

Skill mix and staffing levels

- Legislate minimum hours of care as a home average of four hours of nursing and personal care per resident per day
- Legislate minimum nursing and personal care staffing and skill mix standards in LTC, accompanied by the necessary funding to support these changes
 - We urge no less than one attending NP for every 120 residents, and a nursing and personal care staff mix consisting of at least 20 per cent RNs, 25 per cent RPNs, and no more than 55 per cent PSWs. This ratio would guarantee all LTC residents receive care when they need it from the most appropriate provider

Attending NPs in LTC

- Increase the number of funded positions in LTC to a minimum of one attending NP per 120 residents



- These attending NPs must serve as primary care providers and practise to their full scope, as expressed in the role description provided in the MOHLTC Attending Nurse Practitioners in Long-Term Care Initiative Funding Policy
- Develop and implement an accountability framework to hold Local Health Integration Networks (LHIN) and LTC homes accountable for hiring attending NPs in the manner specified by the MOHLTC role description and funding policy



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- ⁴ RNAO. (2007). *Staffing and care standards for long-term care homes: Submission to the Ministry of Health and Long-Term Care*. Retrieved from http://rnao.ca/sites/rnao-ca/files/storage/related/3163_RNAO_submission_to_MOHLTC_-_Staffing_and_Care_Standards_in_LTC_-_Dec_21_20071.pdf.
- ⁵ Development and implementation of clinical practice guidelines in the area of elder care has been one of five top priorities of RNAO's Best Practice Guideline Program since its inception. RNAO has supported the uptake of clinical practice guidelines relevant to elder care, including: falls prevention, alternative approaches to the use of restraints, continence and constipation, prevention and management of elder abuse, pressure ulcer prevention and management, dementia, and chronic disease management. For more information, see <http://rnao.ca/bpg>.
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- ¹¹ O. Reg. 79/10, s. 48.
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¹⁸ Ontario Ministry of Health and Long-Term Care (MOHLTC). (2017). *Policy: LTCH level-of-care per diem funding policy*. Retrieved from http://www.health.gov.on.ca/en/public/programs/lc/docs/level_of_care_per_diem_funding.pdf.

¹⁹ Residents are assessed on admission, if there is a significant change in their status, and on a regular quarterly basis, using the Resident Assessment Instrument – Minimum Data Set (RAI-MDS). This assessment puts the resident into a clinically similar group. These groups are believed to consume a similar set of resources and, by extension, have similar costs. Each group is associated with a CMI, which is a relative measure of the expected resource consumption intensity of any group. Source: Costa, AP., Poss, JW. & McKillop, I. (2015). *Contemplating case mix: A primer on case mix classification and management. Healthcare Management Forum*, 28(1), 12.

More information about case-mix systems used to allocate resources is available from CIHI at <https://www.cihi.ca/en/submit-data-and-view-standards/methodologies-and-decision-support-tools/case-mix>.

²⁰ Responsive behaviours is a term to describe the behavioural and psychological symptoms of dementia, which includes, to varying levels of severity, changes in mood, delusions, apathy, agitation, wandering, calling out, repetitive questioning, and sexual disinhibition. Source: RNAO. (2016). *Delirium, dementia, and depression in older adults: Assessment and care (2nd ed.)*. Retrieved from http://rnao.ca/sites/rnao-ca/files/bpg/RNAO_Delirium_Dementia_Depression_Older_Adults_Assessment_and_Care.pdf.

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²² Helmer, A. (2017, July 27). *Union calls long-term care violence 'tragic symptom of a care system in crisis'*. *Ottawa Citizen*. Retrieved from <http://ottawacitizen.com/news/local-news/union-calls-long-term-care-violence-tragic-symptom-of-a-care-system-in-crisis>.

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²⁵ Geriatric and Long Term Care Review Committee. (2016). *2015 annual report*. Retrieved from <http://www.mcscs.jus.gov.on.ca/sites/default/files/content/mcscs/docs/GLTRC%202015%20annual%20report%20ENGLISH.pdf>.

²⁶ *Long-Term Care Homes Act*, 2007, S.O. 2007, c. 8, s. 8(1) Every licensee of a long-term care home shall ensure that there is, (a) an organized program of nursing services for the home to meet the assessed needs of the residents; and (b) an organized program of personal support services for the home to meet the assessed needs of the residents.

²⁷ *Long-Term Care Homes Act*, 2007, S.O. 2007, c. 8, s. 8 (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

²⁸ The previous standard of 2.25 hours of personal and nursing care per resident per day was repealed in 1996.

²⁹ The *Child Care and Early Years Act*, 2014, S.O. 2014, c. 11, Sched. 1, sets out the rules governing child care in Ontario. This includes, among other restrictions and standards, setting a ratio for the maximum number of children that a child care centre or home child care provider can care for (e.g., minimum ratio of three staff to ten children younger than 18 months for licensed child care centres; maximum six children under the age of thirteen for a licensed home child care provider).

³⁰ For RAI-MDS "... what counts is what is measured". This means that important data is often missing, namely contextual data that may provide more insight into the care required for a particular measurement. The tool also doesn't recognize the time that providers spend on more relational care. Source: Armstrong, H., Daly, T. & Choiniere, JA. (2016). The case of RAI-MDS in Canadian long-term care homes. *Journal of Canadian Studies*, 50(2), 348.

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- ⁴³ Government of Ontario. (2017). *Aging with Confidence: Ontario's action plan for seniors*. Retrieved from https://files.ontario.ca/ontarios_seniors_strategy_2017.pdf.
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- ⁵¹ The use of RNAO's BPGs is not mandatory; however it is an important resource for the LTC sector and enables improved resident outcomes.
- ⁵² Quality-based procedures clinical handbooks outline the evidence and clinical best practice recommendations for specific groups of patient services (e.g., hip fracture, tonsillectomy, chronic kidney disease). The goals of the program are to standardize care and ensure that patients get the right care at the right place and time. Providers (i.e., physicians) receive a standard funding amount on a 'price times volume' basis to implement quality-based procedures. Source: MOHLTC. (n.d.). Health system funding reform. Quality-based procedures. Retrieved from http://www.health.gov.on.ca/en/pro/programs/ecfa/funding/hs_funding_qbp.aspx.