



THIS

IS LONG-TERM CARE 2014



Long-term care is not what you think



In recent years, the Ontario government has invested significant funds in “aging at home” strategies such as home care to help seniors to stay in their homes as long as possible. As part of this shift, the government also changed the admission criteria for long-term care in 2010, requiring new residents to have “high” or “very high” physical and cognitive challenges in order to qualify for placement (see *Who is eligible for long-term care?*, page 4.)

Long-term care homes in the province began to report rapid and dramatic changes to new residents admitted to their homes. As residents are now coming to long-term care at a later stage of their conditions, they have more complex health issues and are more physically frail. A larger proportion have Alzheimer’s disease or other dementias. A small but increasing number have mental health conditions such as bipolar disorder and schizophrenia. In some regions of the province, residential mental health facilities have closed and their patients have moved to long-term care homes.

As a result, the population in long-term care homes is changing. A larger percentage of residents need significantly more assistance with daily activities such as eating and toileting, often because their loss of cognitive function means they no longer know how to do these activities. Long-term care homes have also reported that incidents of aggressive behaviour are increasing, which is causing significant concerns about safety and increased stress

among staff and residents. In addition, more residents have unstable physical health, requiring close monitoring in the home and more trips to the hospital for care.

It is fair to say that the extent, speed, and impact of these changes to the resident population took long-term care homes—and the government—by surprise.

The system for long-term care was established and funded to provide the elderly with a safe, comfortable place to live that provided a light degree of care. Today, with a significantly more frail and ill population, most homes are evolving into complex, clinically oriented facilities that care for people at the end of their lives. But long-term care funding and staffing are still geared to what homes were like in the past.

Homes and their staff report they are working harder and faster, but many lack the clinical skills or the right mix of staff to manage some of the more complex health conditions and behavioural issues. And homes don’t have the medical technology, such as laboratory testing or X-rays, to support more complex care on-site.

To respond to these concerns, the Ontario Long Term Care Association (OLTCA) commissioned independent research in 2013 to investigate the changes that homes were reporting. The data confirmed that by the time seniors need long-term care, they are typically more frail and have more complex conditions than five years ago. **LTC**

Rapid change, dramatic impact



▶ **62%** of residents live with Alzheimer's disease or other dementias; nearly one third have severe cognitive impairment.¹ People with Alzheimer's and other dementias have always been part of the long-term care population, but since 2008, the proportion of residents with dementia has increased by 6%, and mild or moderate cognitive impairment has risen by 8%.^{1,2}

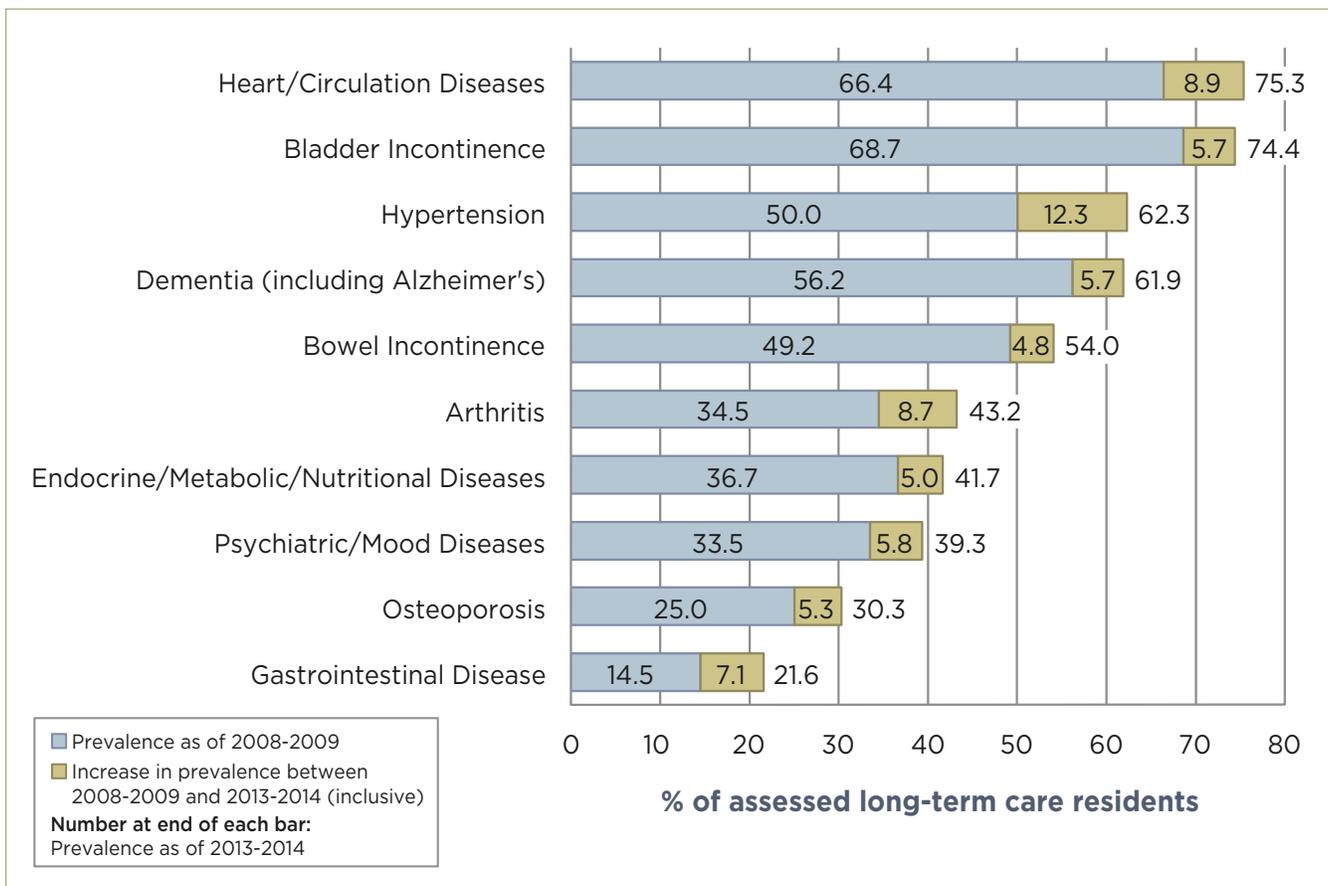
▶ **46%** of residents exhibit some level of aggressive behaviour,¹ and the incidence has been increasing. Between 2010 and 2012 alone, there was a 14% increase in moderately aggressive behaviour.³ (For a more detailed discussion of aggression, see *A balancing act*, page 6.)

▶ **1 in 3** residents has a psychiatric diagnosis such as anxiety, depression, bipolar disorder, or schizophrenia. Dual diagnosis, such as dementia coupled with a psychiatric diagnosis, is increasing at 11% per year.¹

▶ **93%** of residents have two or more chronic diseases, with notable increases in the proportion of residents with common conditions such as arthritis and heart disease.^{1,2} (See Figure 1, page 4.)

▶ **22%-24%** increase in the number of residents who need help with activities of daily living such as toileting (22% increase), personal hygiene (23% increase), and dressing (24% increase).⁴ (See Figure 2, page 5.)

Figure 1.
Significant increases in chronic conditions over five years



SOURCE: Canadian Institute for Health Information, *Continuing Care Reporting System (CCRS 2008-09)*; total number of residents assessed n = 40,248. Canadian Institute for Health Information, *Continuing Care Reporting System (CCRS 2013-14)*; total number of residents assessed n = 102,285.

About Figure 1. The prevalence of many chronic conditions among long-term care residents increased significantly—between 5% and 12%—in a five-year period. When more than 90% of long-term care residents have two or more chronic conditions, significant increases across multiple conditions add up to a rapid and dramatic change in the

profile of residents who live in long-term care and the level of health care and support they need. New residents are also coming to long-term care at a later stage in the progression of their diseases, when their health is more likely to be unstable and their overall needs are higher. **LTC**

Who is eligible for long-term care?

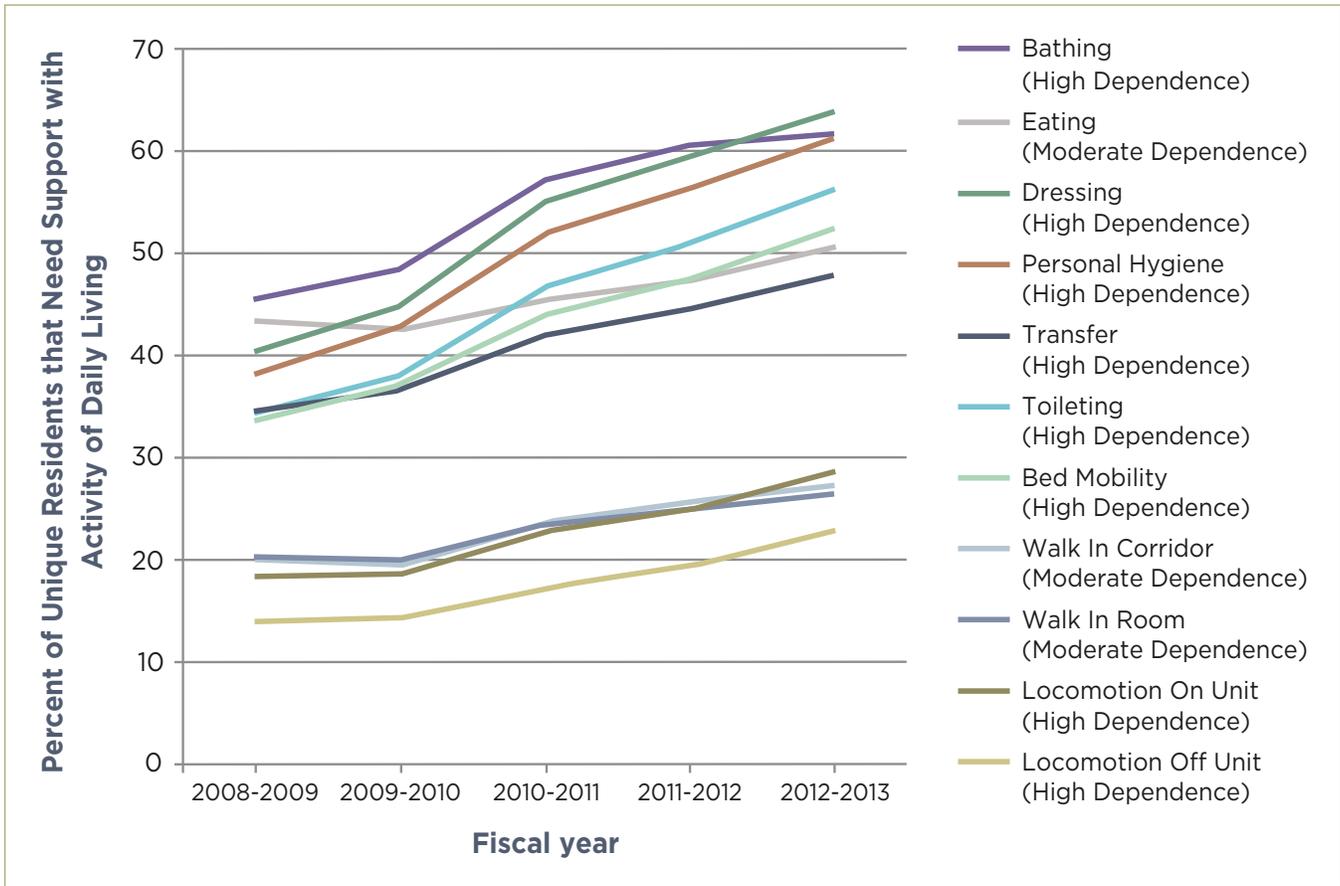
The Method for Assigning Priority Levels (MAPLe) is a tool used by health care professionals to prioritize clients' needs and to appropriately allocate home care resources and placement in long-term care facilities. Since 2010, only people with "high" or "very high" scores are eligible for long-term care in Ontario.

► **Low** clients are generally independent, without physical disabilities, and with only minor cognitive loss. There are no problems with behaviour, the home environment, medication, or skin ulcers. Some limited home care support may be needed because of early losses of function in limited areas.

- **Mild** clients need only a light level of care due to some problems with instrumental activities of daily living (e.g., housework, transportation) or loss of physical stamina.
- **Moderate** clients are beginning to show impairments in individual functioning that may be a threat to their independence, such as problems in the home environment, difficulty managing medications, or physical disability combined with mild cognitive impairment.
- **High** clients are experiencing more complex problems, including challenging behaviour or physical disability combined with cognitive impairment. These people

Figure 2.

Increased need for support among long-term care residents over four years



SOURCE: 15 Ways to Improve Ontario's Long-Term Care Funding Model.⁴

About Figure 2. The sharp rise in the need for support in daily activities is related to both frail physical health and

cognitive decline. As dementia progresses, people can lose the ability to care for themselves. **LTC**

have elevated risks of nursing home placement and caregiver distress.

- **Very high** clients have impairments in multiple areas of function that have a pronounced impact on their ability to remain independent in the community. These include factors such as physical disability, cognitive impairment, falls, challenging behaviour, and wandering. Rates of nursing home placement and caregiver distress are highest in this group.

Reprinted from *Seniors in need, caregivers in distress: What are the home care priorities for seniors in Canada?* Health Council of Canada, April 2012. **LTC**

**LONG-TERM CARE:
THE RIGHT PLACE AT THE RIGHT TIME**

“As Dad’s dementia got worse, he had difficulty communicating and taking care of himself, and sometimes he’d get irritated when Mom tried to help. He started to have health problems and was hospitalized for a few days. The change in his routine was upsetting and when he came back, the dementia symptoms seemed worse and he was physically aggressive a few times. We called the family doctor and the CCAC, and they put intensive home care in place. Things got better, but eventually home care just wasn’t enough. We were relieved when a spot came up in long-term care. I thought Dad might be upset about the move, or that it would be hard to see him there, but to be honest, he seems much better now.”

A balancing act: Understanding and managing aggression

Nearly half (46%) of long-term care residents exhibit some form of aggressive behaviour related to their dementia or mental health condition.¹ With more than 77,000 residents in long-term care at any given time, this means that approximately 35,000 people are currently affected.⁵

As a society, we need to have frank and compassionate discussions about what is happening to the people who are behaving this way, and also speak openly about the challenges of meeting their needs—without resorting to medication—while protecting those around them from violence.

As their disease progresses, people with Alzheimer’s and other dementias lose the ability to interpret their environment or control their behaviour. Aggressive behaviours related to dementia or mental health conditions often result from a chain of events that are difficult to attribute to a single trigger. Residents may be upset by intrusions into personal space, by verbal and physical interactions throughout the home, or by triggers that are hard to identify. They may react reflexively by hitting, or using angry and accusatory responses.

Aggression is defined as verbal abuse, physical abuse, socially disruptive behaviour, and “resistance to care,” meaning that a resident reacts negatively when staff try to help with activities such as toileting, bathing, cleaning teeth, or trimming fingernails. This is the most frequent type of aggressive behaviour, and is often challenging to manage. It is very difficult to provide care to someone who does not want to receive it. This type of aggression is also increasingly significantly. (See Figure 3, page 8.)

Staff in homes understand that the aggression is a function of the disease, and have a great deal of compassion for their residents, but there is no question that aggressive behaviour can lead to staff frustration, injury, and burnout.³

Use of the word “aggression” is very sensitive. There are concerns that discussing aggression, and the prevalence of it, will cause stigma for residents of long-term care, or people with dementia.

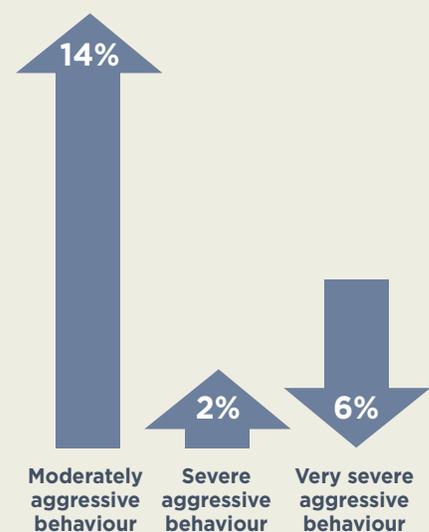
A diagnosis of dementia does not mean someone will have an aggressive episode. Neither does a mental health diagnosis. But the increasing incidence of aggression in long-term care needs to be openly discussed in order to find solutions. A safe environment for residents and staff is the number one priority. **LTC**

Data tells the story

OLTCA commissioned independent research into the prevalence of aggressive behaviours in long-term care, based on the internationally recognized Resident Assessment Instrument (RAI) Aggressive Behaviour Scale. This scale measures the occurrence of verbal abuse, physical abuse, socially disruptive behaviour, and resistance to care.³

Between July 2010 and April 2012 alone, there was an overall increase in the number of residents with aggressive behaviour. There was a 14% increase in moderately aggressive behaviour; a 2% increase in severe aggressive behaviour; and a 6% decrease in very severe aggressive behaviour scores.³

Homes report that aggression is still not accurately captured in the data. In early 2013, OLTCA did a survey of member homes that showed that nearly all (91%) of participating homes experienced one or more critical incidents related to serious aggression. While some homes have a higher proportion of residents with aggression, it was clear that all homes are struggling to manage aggressive behaviour. **LTC**



The use of antipsychotic medications



The use of medication to prevent aggressive or challenging behaviour is very controversial. In the spring of 2014, the *Toronto Star* published a critical series on the use of antipsychotic medications in long-term care homes.

Antipsychotic medications are potentially risky when used to treat older people. The decision to use them is not made lightly, and long-term care homes are concerned about current rates of use. Homes are working to reduce the use of these medications, which requires a range of strategies from medication reviews to specialized education in behaviour management strategies, and the staff to do it.

The Ontario government has already made some investments in a program called Behavioural Supports Ontario (BSO), which is showing very good results. New, specially trained teams work with a home's bedside staff to look at what triggers challenging behaviour in each individual resident, and then make personalized adjustments. The program rolled out in a limited number of homes in 2012. The Ontario Long Term Care Association has asked the government to fund a BSO team in every home.

With in-house behavioural education programs and support, the care teams in homes have a much better chance of dealing effectively with challenging behaviours. In the absence of this type of support, everyone involved—the care team, residents, and families—are caught in a very difficult situation.

The good news is that the prescribing rates for antipsychotic medication use in long-term care have been decreasing steadily since 2010. Many OLTC member homes have started programs to review and reduce their use of antipsychotic medications. In 2015, the Ontario Long Term Care Association will be supporting their efforts with a new antipsychotic management program that identifies and promotes best practices. **LTC**

Success stories: Behavioural Supports Ontario

► In one home, a Behavioural Supports Ontario (BSO) team taught frontline staff to track residents' challenging behaviour and to document what was happening at the time (such as the time of day, activity, and staff present). They also tracked whether anything positive happened during activities that were usually a trigger. In one case, a woman who typically lashed out during her bath was calm during bath time with a particular personal support worker (PSW). The team identified that the PSW reminded the resident of her daughter, whom she loved dearly. The home was able to change shifts so that as much as possible, that particular PSW bathed the resident.

► A new resident became agitated and aggressive every night before bedtime. The BSO Team worked with him to map the behaviour and asked his family for more information. They said their father had been accustomed to bathing his feet every night before bed, since that had been a ritual when he was growing up on a farm. The care team incorporated this foot bath into his plan of care, and his agitation was eliminated. He was able to sleep better, as did his roommate who had been affected by the agitation.

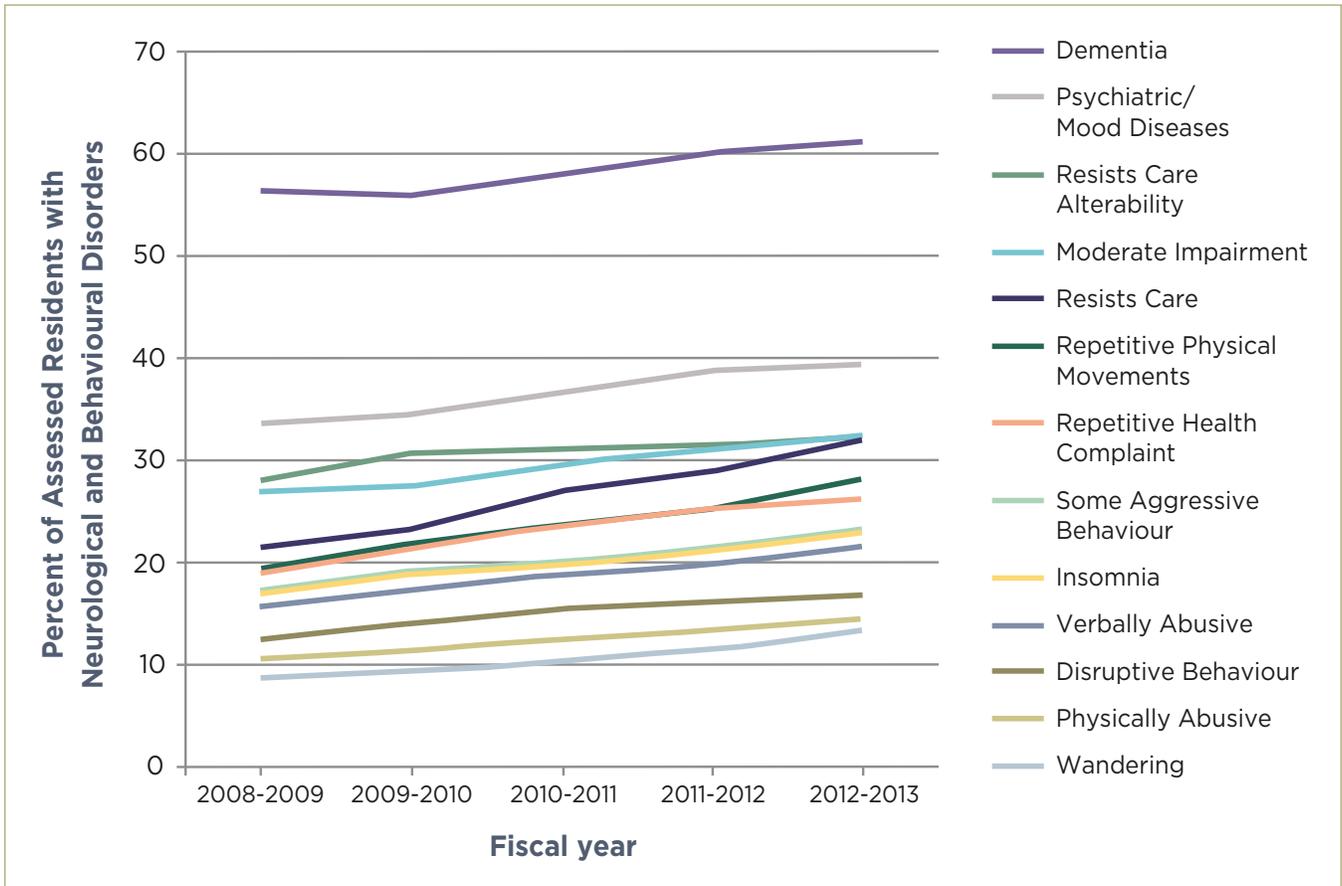
► A female resident became violent when staff tried to change her continence products. The BSO team identified through behaviour mapping that she was getting very cold during the process. The team kept her warm and comfortable while changing her continence products, and the outbursts stopped. **LTC**



“What all of us have acknowledged is the impending loom of the dementia issue and crisis coming down the pipeline for health-care systems...”

Rona Ambrose, federal Minister of Health, announcing the intention to develop a national dementia strategy, *The Globe and Mail*, October 1, 2014.

Figure 3.
Increases in neurological and behavioural disorders over four years



SOURCE: 15 Ways to Improve Ontario's Long-Term Care Funding Model.⁴

About Figure 3. Since 2008/09, there has been a steady increase in dementia, mental health conditions, and related behaviour. It's clear that the incidence of dementia in long-term care began to rise rapidly in 2010, the year that admission criteria changed to require more significant

physical and/or cognitive impairment. Resistance to care—the most frequent type of aggressive behaviour, and particularly challenging to manage—has increased in just four years from 21% to 32%. **LTC**



The Long-Term Care Task Force on Resident Care and Safety

In 2012, the LTC Task Force on Resident Care and Safety released a report in response to incidents of violence and abuse in long-term care homes. Task force members—a coalition of long-term care home operators, government, associations, residents, and families—identified 18 action items to put in place across long-term care. Regular Task Force updates are showing good progress. The Task Force's final report is due in 2015. **LTC**

What is a home?

Long-term care 101

Long-term care homes, and the process through which people are admitted, are rarely on people's minds until they need long-term care for a family member. As a result, there is little public understanding of how the process works.

In Ontario, Community Care Access Centres (CCACs) are the gatekeepers of long-term care. A family doctor, family member, or home care worker may tell the CCAC that it is no longer possible to keep the person in his or her home, but the CCAC conducts the assessment and makes the decision.

Long-term care homes report that new families are often unsure about the purpose of long-term care, and often confuse them with retirement homes. Long-term care homes are funded by the government to provide primary

health care and nursing care; rehabilitation, physiotherapy, and other restorative therapies; recreational activities; help with the activities of daily living; and special diets. They also provide a caring community, focused on helping residents live comfortably and with dignity in a safe environment at the end of their lives.

Long-term care homes are run by privately owned and publicly owned companies, non-profit/charitable organizations, and municipalities. These organizations own the buildings and are granted term licences and funding by the government to operate long-term care homes.

From the government's perspective, long-term care provides more support and services than can be provided through home care, and less expensively than in hospital. [LTC](#)

Ontario's long-term care homes, 2014

➔ **627** homes licensed and approved to operate in Ontario

➔ **76,535** long-stay beds provide care, accommodation and services to frail seniors who require permanent placement

➔ **719** convalescent care beds provide short-term care as a bridge between hospitalization and a patient's home

➔ **367** beds provide respite to families who need a break from caring 24/7 for their loved one

➔ Wait list for long-stay beds as of May 2014: **20,731**

➔ Average time to placement: **89** days

➔ **57%** privately owned, **24%** non-profit/charitable, **16%** municipal, **2%** other

➔ More than **40%** of long-term care homes are small, with **96** or fewer beds

➔ Of these small homes, about **44%** are located in rural communities that often have limited home care or retirement home options

SOURCE: LTCH System Report, May 2014, Health Data Branch, Ministry of Health and Long-Term Care. [LTC](#)

Residents pay a portion of long-term care



The government does not pay the full cost of long-term care and expects residents to pay a portion of their “room and board” to the long-term care home. The government sets the amount residents must pay the home, with an opportunity to qualify for a subsidy. Someone paying a basic accommodation rate (currently \$56.93 per day) without a subsidy would pay roughly \$1,700 per month. Research shows there is a significant lack of awareness of these out-of-pocket costs among the Canadian public.⁶ Residents also pay out of pocket for any medications or other services not covered by their private insurance plans or the provincial drug benefit program.

This “room and board” payment is what long-term care homes use to make a return on their investment. Funding allocated by the Ministry of Health and Long-Term Care for nursing and personal care, programs, support services, or raw food (used to make meals) is separate and must be reconciled at the end of the year. Unspent funds are returned to the government.

Provincial funding for long-term care, 2014

- \$3.9 billion (7.8% of overall health budget)
- \$137 per person, per day (\$50,032 per year)
- Approximately \$90.71 per day for nursing and personal care such as assistance with personal hygiene, bathing, eating, and toileting
- \$11 per day for specialized therapies, recreational programs, and support services
- \$7.87 per day for raw food (ingredients used to prepare meals)

SOURCES: 2014 Ontario Budget, LTCH Level-of-Care Per Diem Funding Summary (July 1, 2014).

Daily rate that residents pay the home for “room and board” (accommodation and food)

- Basic: \$56.93
- Semi-Private: \$64.93-\$67.93
- Private: \$74.93-\$80.18

SOURCE: Ministry of Health and Long-Term Care, Senior’s Care: Long-Term Care Homes. [LTC](#)

Should long-term care homes do more?

All homes provide meals and medication management, help with activities of daily living, and a community with recreational activities. But the availability of other types of services varies widely across the province. Some homes are able to offer medical treatment previously done in hospitals such as dialysis and IV therapy. This means residents in those homes do not need to go to hospital for this type of specialized care. Other homes have specialized in areas such as behavioural management or wound care.

Many leaders in seniors’ care believe there is a growing role for long-term care homes in the broader health care system and as part of the overall care of seniors. Some

homes are providing short-term convalescent care (called short-stay) to bridge the recovery period between hospitalization and home, which is much less expensive to the health system than keeping someone in a hospital while they recover. This focus on short-stay was recommended in several key reports on seniors’ care and long-term care,⁷ but there are currently only 719 beds available to offer this service. Other homes offer respite care, which eases the burden on family caregivers.

These are all options that could be expanded and are currently being discussed with long-term care homes, stakeholders, and government. [LTC](#)

Homes need upgrading

Approximately 44% of Ontario's older LTC homes—many of them small or in rural locations—do not meet the most recent (2009) design standards and need significant renovations or to be rebuilt. Older homes have four-bed wards and cramped living spaces, which don't meet the needs of residents living with dementia and Alzheimer's. Having individual rooms and other "home-like" amenities can help to create a safe and secure living environment for both residents and staff while respecting residents' privacy and dignity. Individual rooms also help with infection control. In addition, older homes may not be fully equipped with fire sprinkler systems and other important safety mechanisms that are needed to provide safe and supportive care.

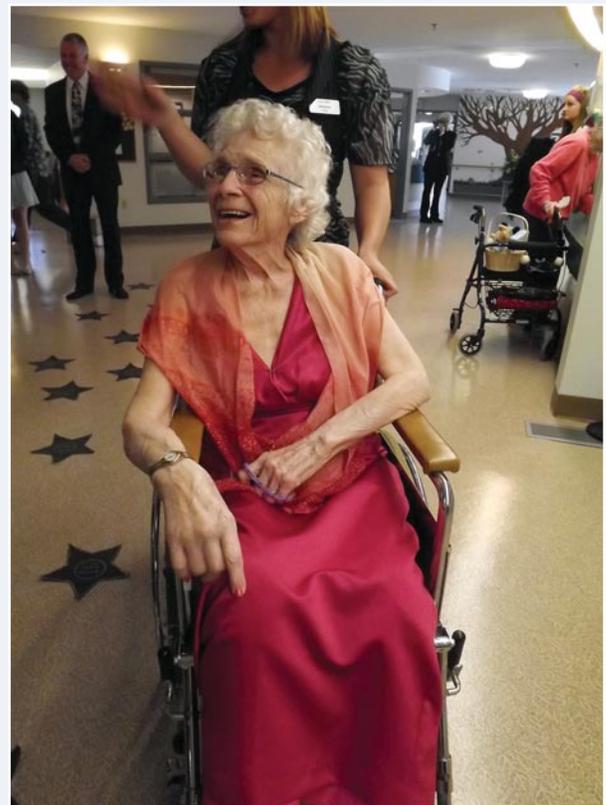
44%
of homes need redevelopment



In July 2014, the Ontario government announced a renewed capital redevelopment plan for long-term care in the provincial 2014 budget. As this report goes to press, the details of that plan are still in development. [LTC](#)

Relationships make all the difference

Residents are so pleased with a culture-change initiative by staff at Grey Gables in Markdale that they nominated the home for the Ontario Long Term Care Association's 2014 Culture Change Home of the Year award. The award recognizes efforts to create a home-like environment, enhancing quality of life and honouring residents' choice and voice. The home produced a video to "celebrate the way the community lives, works, and plays together" and launched it in the style of a movie premiere, complete with formal wear, photo ops on a walk of fame, and interviews on the red carpet. [LTC](#)



A resident participates in the Grey Gables celebration.

Staffing in long-term care

Ontario long-term care homes currently have the lowest levels of staffing in any of the Canadian provinces, and lower than many international jurisdictions. This is a particular concern because as residents' needs have become more complex, requiring more care and time, the health care system is also becoming more complex and data-driven, requiring more information and reporting. Unlike hospitals, long-term care homes don't have administrative departments to help gather this information; almost all staff work with residents. Time spent on additional reporting in long-term care takes time away from residents when they need it more than ever. Only a relatively small proportion of paid staff time is spent directly on frontline care.

The care team in each home includes a medical director, director of care, registered nurses, registered practical nurses, and personal support workers. Other health care professionals—such as a nutritionist or pharmacist—may be part of the care team, but typically these resources are not on staff and come to the home when needed.

The majority of staff members in long-term care homes are personal support workers. These integral members of the care team work under the leadership of the nursing staff to help residents with their daily activities, report to nursing staff about their changing needs, provide comfort, and liaise with families.

Some homes have access to a nurse practitioner who can offer primary health care. In 2014, the Ontario government announced funding for an additional 75 nurse practitioners for long-term care homes. [LTC](#)

Frontline care staff in long-term care



SOURCE: LTCH Staffing Data, Ministry Funded Portion, 2012. [LTC](#)

In the spotlight: Quality of care

“We all believe we’re providing high-quality care. In this new era of transparency and accountability, we need to show it with data.”

Candace Chartier, CEO, Ontario Long Term Care Association, in a newsletter to member homes

Long-term care homes gather data on the health and health care of their residents through an internationally recognized computerized tool called the Resident Assessment Instrument—Minimum Data Set (RAI-MDS 2.0). RAI-MDS was first rolled out in a limited number of homes in 2008, and was fully implemented across all homes by 2012. Now that this data is available, there is a great deal of interest in interpreting and reporting what it says about quality of care.

In 2014, the Canadian Institute for Health Information (CIHI) used RAI-MDS data for an analysis on the use of antipsychotics in long-term care. Through 2014/2015, CIHI will begin reporting on 10 other indicators in long-term care, including the use of restraints and falls.

In addition, as of April 2015, homes will be required to submit Quality Improvement Plans (QIPs) to Health Quality Ontario (HQP), demonstrating how they intend to improve health outcomes and care in specific areas. In 2014, more than 90 homes submitted quality improvement plans on a voluntary basis in order to have a “dry run” and receive feedback from HQO.

Quality improvement is not new to long-term care. Homes have been gathering data and reporting on four quality indicators (falls, incontinence, pressure ulcers, and restraints) since 2012/2013. Between 2009 and 2013, the use of restraints dropped from an average of 17% to 11%.⁸ Homes were also significantly involved in a quality improvement program run in partnership with Health Quality Ontario called Residents First, which introduced the methods of quality improvement to long-term care homes.

The increasing spotlight on quality of care and accountability is important, and supported by homes, but there is no question that it also places new time pressures on homes and their staff when the resident population also needs more time and a more intensive level of care. **LTC**

Quality inspections

The Ministry of Health and Long-Term Care conducts unannounced inspections to review how well homes are meeting all of the 600+ regulations in the *Long-Term Care Homes Act*. The Ministry has publicly committed to complete a Resident Quality Inspection in every home by the end of 2014. **LTC**

Quality awards 2014: Improving diabetes care

In 2009, the Ontario Long Term Care Association began an annual Quality Awards program to highlight successful efforts in providing quality of care.

One of the 2014 award winners is Riverview Manor in Peterborough, operated by OMNI Health Care. The home developed a diabetes protocol for use in long-term care, as no such guideline existed in Canada. At the centre of the program is a group of evidence-based order sets that provide clear instructions on several aspects of diabetes care, including nursing assessment, dietary and foot care, and resident sick-day management.

Diabetes is a serious issue in long-term care. Fluctuating blood sugar brought on by diabetes can cause falls, and the disease also poses challenges for wound care. In addition, diabetes can lead to cardiovascular disease and stroke. Improving the focus on diabetes management reduces the risk of other health complications that can happen with the disease, and helps to keep residents out of hospital. This in turn improves their quality of life, while helping to reduce the burden on the health care system.

OMNI is rolling out the diabetes protocol in its other homes, and has made it available to other long-term care homes as well. **LTC**

The challenge of change

In the past five years, the long-term care sector has undergone arguably the most significant transformation in its history. The province has an “aging-in-place” policy direction with more funding for home care, and new stricter admission criteria for long-term care. The result is that new residents in long-term care have significantly more complex health needs than five years ago, requiring long-term care to provide a different level of care and fulfill a different role in the health care system than it once did.

At the same time, long-term care homes have faced a new *Long-Term Care Homes Act* that came into effect in 2010, more intensive inspections, new public reporting

and quality improvement requirements, and increased public attention.

Homes are struggling with the fact that they are still funded for a less complex population and also more heavily regulated than any other sector in health care, which limits their ability to implement creative solutions. OLTC has been advocating to the government to increase funding, revise regulations, and expand specialty programs such as Behavioural Supports Ontario to help homes provide the level of care their residents need.

For details of OLTC's proposals to government, please visit betterseniorscare.ca. [LTC](#)

References

1. Canadian Institute for Health Information. (2013). *CCRS Continuing Care Reporting System: Profile of Residents in Continuing Care Facilities 2012-2013*. Ottawa: CIHI. Retrieved from: http://www.cihi.ca/CIHI-ext-portal/internet/EN/Quick_Stats/quick+stats/quick_stats_main?pageNumber=1&resultCount=10
2. Canadian Institute for Health Information. (2009). *CCRS Continuing Care Reporting System: Profile of Residents in Continuing Care Facilities 2008-2009*. Ottawa: CIHI. Retrieved from: http://www.cihi.ca/CIHI-ext-portal/internet/EN/Quick_Stats/quick+stats/quick_stats_main?pageNumber=1&resultCount=10
3. Preyra Solutions Group. (2014). *15 Ways to Improve Long-Term Care Planning*. An unpublished report for the Ontario Long Term Care Association.
4. Preyra Solutions Group. (2013). *15 Ways to Improve Ontario's Long-Term Care Funding Model*. An unpublished report for the Ontario Long Term Care Association.
5. Ontario Ministry of Health and Long-Term Care. (2014). *Long-Term Care Home System Report, May 2014*. Toronto: Health Data Branch, Ministry of Health and Long-Term Care.
6. Blomqvist, A. & Busby, C. (2014). *Paying for the Boomers: Long-Term Care and Intergenerational Equity*. Commentary No. 145. Toronto: C.D. Howe Institute.
7. Sinha, S.K. *Living Longer, Living Well*. (2012). Retrieved from http://www.health.gov.on.ca/en/common/ministry/publications/reports/seniors_strategy/docs/seniors_strategy.pdf
8. Health Quality Ontario. Long Term Care Public Reporting, Health Quality Ontario. Retrieved from <http://www.hqontario.ca/public-reporting/long-term-care>



Ontario Long Term Care Association

345 Renfrew Dr.,
Markham, ON L3R 9S9
Tel: (905) 470-8995
Fax: (905) 470-9595
www.oltca.com

This is Long-Term Care 2014
October 2014

With the exception of those portions of this document for which a specific prohibition or limitation against copying appears, the balance of this document may be produced, reproduced and published in its entirety, in any form, including in electronic form, for educational or non-commercial purposes, without requiring the consent or permission of the Ontario Long Term Care Association, provided that an appropriate credit or citation appears in the copied work as follows: Ontario Long Term Care Association. (2014). *This is Long-Term Care 2014*. Markham, Ontario: Ontario Long Term Care Association.

© 2014 Ontario Long Term Care Association

OLTCA is Canada's largest long term care association, representing a full spectrum of charitable, not-for-profit, private, and municipal long term care operators. The Association's member homes are funded and regulated by the Ontario Ministry of Health and Long-Term Care. OLTCA members provide care, accommodation, and services to almost 70,000 seniors annually.

