

Ontario Long Term Care Association



# Caring for our future

Transforming Ontario's long-term care system



# About OLTC

For more than 60 years, the Ontario Long Term Care Association (OLTCA) has been committed to advancing the quality of long-term care services in Ontario.

With advocacy and leadership as a key focus, the Association works towards legislative, policy and regulatory change, supports sector expansion and redevelopment, and provides educational opportunities to ensure the increasing needs of residents are being met with safe, high-quality care.

Today, the Association is the largest association of long-term care providers in Canada and the only association that represents the full mix of long-term care operators – private, not-for-profit, municipal and First Nations. OLTCA represents 70% of Ontario's 626 long-term care homes located in communities across the province.



## Pandemic impacts

The issues were not new, but the pandemic amplified them: critical staffing shortages; outdated buildings with overcrowded rooms; a focus on compliance and checklists over residents and the quality of their care and living; and legislated staffing models that have not evolved with the increasing complexity of resident clinical care needs. When Ontario's most vulnerable seniors needed critical supports, homes did not have the resources, nor the relationships across the health system, to provide them.

The tragedy of the pandemic fostered a greater understanding of the need for an integrated system of seniors' living and care. We saw a health care system banding together to protect those in long-term care. Hospitals and homes forged new partnerships. Communities came together in support of long-term care homes, residents and their frontline heroes.

Long-term care home providers came together to source personal protective equipment from China for the benefit of seniors across Canada living in long-term care and retirement homes, regardless of ownership. The provincial government provided unprecedented supports and flexibility through emergency orders to protect residents, while working with long-term care homes and partners to define and implement longer-term solutions.



It is this spirit of collaboration and connection that will ensure that the devastating impact of COVID-19 on our residents, staff and families never happens again. It is time to build a new system – or ecosystem – of seniors' living and care that meets the changing and increasing needs of residents, their families, and their caregivers.

**The work ahead is not easy, but it is critical.**



## Ontario's population over 80 will double in the next 13 years.

The number of people waiting for long-term care continues to grow and is now close to 40,000, with an average wait time of 149 days for those coming into long-term care from a hospital. People in the community wait an average of 188 days. That's more than half a year where families need to support their frail family member with complex and growing care needs. That has never been more challenging than today, with home care devastated by the pandemic and reporting more than 6,000 home care appointments going unmet. Hospitals also have a long path to recovery post-pandemic. It will take an estimated three to five years to clear the surgical backlog. Long-term care homes will play a crucial role in helping the health system recover, including supporting more timely admissions from the community and supporting ALC admissions to ensure hospital capacity is available to support clearing the surgical backlog for Ontarians that have been waiting far too long.

At the same time, Ontario is in the midst of a health human resources crisis across the entire health care sector, happening both here, and around the world. The human resource crisis in long-term care predates the pandemic but is now more critical than ever before, and this workforce shortage is worsening just as Ontario has committed to increase the average hours of direct care for residents in long-term care homes and expand the number of spaces for residents across the province. We cannot meet the demands of today, and we will not be prepared for those of tomorrow unless we act quickly.

We know what we need to do. OLTC has developed a comprehensive plan for the future through broad consultation across the province with our board, committees, special task forces, long-term care homes, residents, families, long-term care clinicians, pharmacists, hospitals and other health system partners. In this document, we outline recommendations to build a seniors' care system for today and for the future that supports seniors in living as they choose and a system of care that can evolve with their living and care needs.

These recommendations are a starting point for collaboration and partnership, one that builds on what we know we need to address and on what we agree needs to be done: Ontario needs transformative change for our ageing population. This requires bold, visionary leadership and real partnership among all levels of governments with residents, families, caregivers, care team members, communities, long-term care homes, and health care partners. It will also take courage and a commitment to put the right foundation in place that will allow for a connected care ecosystem that prioritizes seniors and puts their choices at the centre. This requires action, constant attention and focus on moving forward with the changes we agree we need to address. Let's focus on where we agree, not on what divides us.

**The time to act is now. Together.**







# Care is more than a checklist

The rules and structures that govern long-term care in Ontario are embedded in legislation, are highly prescriptive and have unintentionally prevented homes and their care teams from adapting their models of care to the changing and diverse needs and preferences of their residents, including their cultural needs and practices.

These rules have also fostered a culture of compliance with a focus on checklists rather than on improving the quality of life and care by achieving defined outcomes. Indeed, as Ontario moves to provide four (4) hours of care to residents, care teams spend more than three (3) hours a day filling out checklists. This focus on administrative tasks diverts care teams' time and attention away from residents and their diverse needs. To build a better long-term care system for residents and a better seniors living and care ecosystem, we must allow homes to adapt their programs, services, staffing models, partnerships and buildings to the care and living needs of their specific residents and to assess the quality of those programs and services based on best practices, research and evidence.

For example, an urban home providing care to a younger population presenting with psychiatric conditions and related behaviours should be able to adapt its care and staffing model, its physical space, and its quality improvement plan and outcome measures to support the needs of its residents.

Similarly, a home specializing in the care of older Ontarians with late-stage dementia should be permitted to deliver an emotion-focused care program together with its quality programming in support of its residents and families.

**The system does not currently allow for these tailored approaches to care. However, a small number of homes have implemented these models with special approvals, exemptions, and sometimes additional funding from the Ministry of Long-Term Care and have been able to demonstrate their success.**

# Meeting the needs and preferences of residents

Meet three residents living in Ontario's long-term care homes. These stories, while composites created through consultations, highlight the range of individual needs and preferences - personal, clinical, emotion, social, spiritual and cultural - of those in long-term care.

Their stories also show how long-term care homes and their staff teams struggle against systemic challenges to focus on residents, their needs, and their preferences.







**Barry suffered a severe stroke at 73 and moved into a long-term care home after waiting in hospital for 18 months. His stroke was too severe for rehabilitation and after his prolonged hospital stay, Barry found he was living with further deconditioning.**

Barry was an educator in his rural community, and was one of the longest-serving principals at his local school board. He shared his love of the outdoors with his students, friends, and family and until his sudden stroke, spent his retirement hiking, fishing, and hunting. The stroke left him paralyzed on the right side, easy to tire, often confused, and increasingly depressed – which was devastating to him and his family.

Barry requires a lot of care from his long-term care team to help restore him to a more stable state. For example, to help support his mental health, the home's recreation therapist has set up virtual sessions to bring the outdoors in and to re-connect Barry to his love of nature.

Barry and his family say they appreciate not only the medical and nursing care that Barry receives to address his physical needs, but the emotional and social care he receives too. They share how grateful they are with the home's staff quickly recognizing his love of nature and finding ways he could still embrace the outdoors and experience joy. They say this personal connection has made the world of difference to Barry.

## Barry, 73

More people are coming to long-term care with higher acuity needs. While long-term care teams are experts in caring for people, they require multi-disciplinary staffing models – like the one that Barry is experiencing – to deliver high-quality, responsive care.



**Yu-Mei is 91 and has always believed she needs to remain as active as possible. Yet a recent fall in her family home sent her to hospital, causing her family to realize that her needs were beyond their abilities. Her fall and hospital stay also revealed that Yu-Mei's dementia was more progressed than they had realized.**

When Yu-Mei moved into a long-term care home in Scarborough, the family shared their concerns with the staff about her growing loss of vitality. They felt that Yu-Mei needed to regain her failing strength and mental abilities through activity and good nutrition.

A nutritional assessment by the home's registered dietitian confirmed that Yu-Mei needed to increase her daily calorie intake.

The home then worked to learn more about Yu-Mei's lived experience. Through discussions with her and her family, the care team learned about the family's immigrant experience – at a time when anti-Asian prejudice meant many employment opportunities were not available. Yu-Mei and her husband instead opened a restaurant to give them their start in their new country.

The care team learned that food preparation skills and activities were important to Yu-Mei, so they encouraged her to join the home's daily meal preparation. By helping her to focus on familiar skills and memories, Yu-Mei became interested in meals, resulting in her appetite improving and her vitality increasing, despite her frailty and advancing dementia.

## Yu-Mei, 91

Empowering long-term care homes to provide care that is responsive to individual preferences, needs, and values is what resident-focused care is all about – and what is generating positive outcomes for Yu-Mei.





Jocelyn is Franco-Ontarian and communicates best in French, her first language. Her diabetes has progressed to the point where she is dependent on dialysis, and she relied heavily on her eldest son and caregiver to help navigate her health care needs. When he passed away last year, Jocelyn began to feel isolated. She found it increasingly hard to travel three times a week to and from the hospital for dialysis, and she often could not find the support she needed.

Since moving into a long-term care home, which is part of the province's renal network, Jocelyn can receive dialysis at the home. The care team has helped Jocelyn manage her diabetes, but she still struggles with isolation as most staff at the home do not speak French.

Jocelyn has poor sight due to diabetes and can no longer read her beloved detective novels on her own. Her joy of "crime-solving" through books is only possible when someone can sit and read with her in French. But, it is a challenge for staff to find the time to read with Jocelyn.

Her long-term care home is in community near Windsor that has significant staffing vacancies for reasons that are systemic across the long-term care sector – including significant health human resource shortages across the health sector and long-term care staff finding more attractive pay in hospitals.

Jocelyn's home is working hard to recruit new staff – especially bilingual staff – and is trying avenues such as reaching out to local colleges to explore student placement opportunities. In the meantime, the home has found a local French community group who volunteer their time to read with Jocelyn and the other residents in the home who speak French.

## Jocelyn, 66

More comprehensive health human resource solutions in long-term care homes are vitally needed so that residents like Jocelyn not only get the care they need that meets their cultural needs, but also continue to experience the things that give them joy.

# Rebuilding long-term care to meet the needs of the people we serve

The needs of Ontario's seniors are changing. People who move into long-term care have increasingly complex living and clinical care needs. Our current legislation and regulations prescribe specific care team roles and responsibilities, but this rigid structure no longer works for the changing care needs and preferences. We must work together to reimagine long-term care as a continuum or network of services and supports that is part of a broader seniors' living and care framework, as well as part of the broader health, home and community care system. Let's allow for campuses of care, which will support seniors with more seamless care and services as they age.

We are advocating for a bold new framework for seniors' care that puts people at the centre of decisions about not just their care, but how they want to live. This new framework allows for more differentiated care models to serve more specialized resident populations, and outlines steps to adapt services to be more culturally sensitive, and to create better connections among care settings, and enhance workplaces for our care teams. Our recommendations define a path forward to creating a broader, connected seniors' care eco-system where Ontarians will live with dignity and choice as they age.

The number of long-term care residents who need extensive or complete support with daily activities such as grooming, getting dressed, and eating has risen from 79% to 86% over the last five years. This represents more than 9,000 additional people who need significant assistance.

## Increase in acuity of residents entering LTC:

**86%** of residents need extensive help with daily activities such as getting out of bed, eating, or getting dressed.

**1 in 3** residents are highly or entirely dependent on staff.



Long-term care is an integral part of this new model. Our homes are experts in caring for people with higher care needs as they age, and their teams also support residents' families and caregivers. Long-term care provides relief from pressures on other sector partners like hospitals and social housing.

But for decades, long-term care has not been seen as a partner in care and is often disconnected from the broader seniors' care system. In addition, the structures of regulation have made it difficult for the sector to share resources and knowledge. Despite these barriers, many long-term care homes across the province are already leading innovations in better care for our seniors, and we have seen communities of practice and innovation emerging from new relationships forged through the pandemic.

### This is a time of great opportunity and hope.

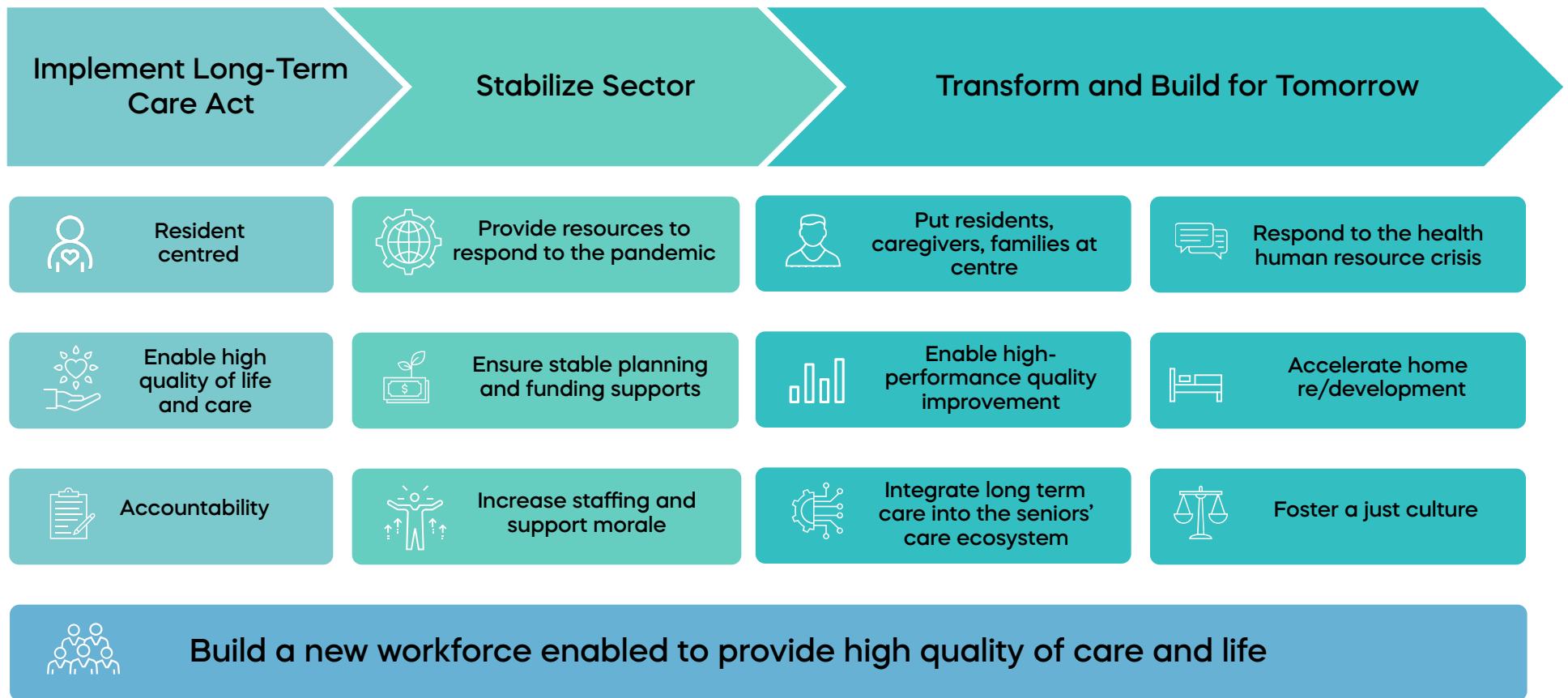
We believe change is possible with a shared vision, common principles, collaboration and the right tools. The tragic impact of COVID-19 on too many of our residents and team members demonstrated that Ontario needs a person-centred approach to implementing new legislation, as well as immediate action to stabilize our homes that are still recovering from devastating earlier waves of the pandemic.

New legislation can establish a firm foundation for the future of seniors' living and care on which we can begin transforming our long-term care sector.



# Our plan

Our recommendations focus on a range of mechanisms to enable change and transformation to build a better long-term care system for Ontario.





## STEP 1.

# Implement new legislation

The new legislation must be implemented in a way that puts residents at the centre.

Accountability, transparency, quality improvement and the legislation must allow homes to adapt as needed to the changing profile and evolving needs of their residents; support innovation and the adoption of best practices; provide a foundation for meaningful quality assurance and quality improvement programming and reporting; enable cross-sectoral health and social services collaboration and integration with homes; foster transparency and accountability; and support residents in accessing the range of services and supports they need to meet their living and care needs.

We recommend that the new legislation and regulations be person-centred in language and principles. By adopting person-centred language, we will begin to change the way society speaks about our ageing population and will support broader culture change across the sector.

The implementation of the new Act must be built on three pillars:

1. Resident-centredness
2. High quality of life and care
3. Accountability

### Take the pledge:

We recommend all sector partners including the Ministry of Long-Term Care to commit to the **“Person-Centred Care Language Pledge”**, developed by Behavioural Supports Ontario and the Ontario Centres for Learning, Research and Innovation in Long-Term Care.

We also recommend that all legislation, regulation, policies, procedures and all other communication within our sector be written with person-centred language.

Words matter. The right language grounds our work and discussions in the needs of the people we serve, respects residents' decisions and preferences, and promotes equity, diversity, and inclusion.

We further recommend that the new Act define long-term care within the context of the integrated health system as set out in the Connecting Care Act.

We also recommend that the legislation allow for a phased modernization of the sector and alignment with other health system legislation and integration efforts, similar to the approach taken with Ontario Health Teams.

# Enabling high quality of life and care

The new legislation needs to support quality of life, quality improvement, and connected care.

## Quality of life

Long-term care is different than other health care settings; it is someone's home, but the current measurement tools and compliance framework prioritize medical interventions, even when they undermine a resident's own preferences.

## Quality improvement

The legislative and policy focus on compliancy forces homes and their teams to focus on check-lists and standardizing care, rather than improving the care to meet resident needs. The current funding environment also does not give them adaptability they need to find the right tools to serve residents.

## Connected care

Long-term care is often unconnected from other health and social services partners; even the implementation of Ontario Health Teams has mostly excluded long-term care.

## Legislation should...

Focus on both quality of life and care outcomes

Allow for innovation and the adoption of best practices

Provide tools and resources need to meet diverse resident needs

Champion quality improvement

Enable collaboration and connection across sectors



# Resident centred

The prescriptive nature of the legislation and regulation produces major barriers to enabling resident-centred models of care.

## Resident choice and control

The day-to-day care for residents is overly regulated, limiting residents' abilities to make their own choices and live the way they want. Essential Caregivers do not have a well-defined role in supporting their loved one.

## Adaptable models of care

The current legal, policy, and funding framework encourages a “cookie cutter” approach to care that cannot adapt to our changing resident populations or adopt innovative models.

## Diversity, equity, and inclusion

The current system makes it hard for seniors to find care within their own communities, and does not address issues of equity or access well.

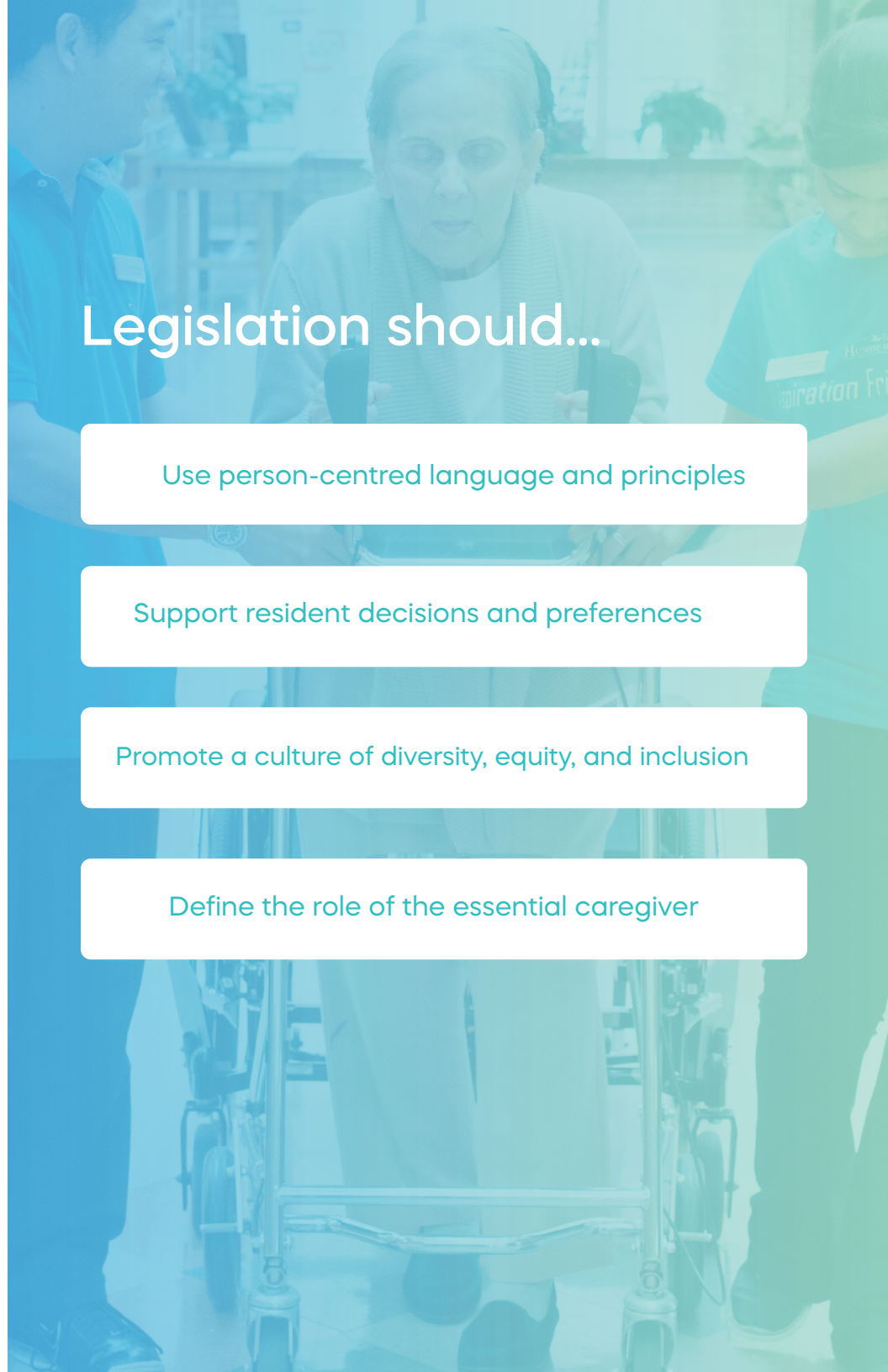
## Legislation should...

Use person-centred language and principles

Support resident decisions and preferences

Promote a culture of diversity, equity, and inclusion

Define the role of the essential caregiver



# Accountability

The current legislative and regulatory approach to accountability needs to change.

## Accountability for outcomes

The current framework is so rigid and prescribed in its approach to long-term care that homes have little control over outcomes; homes that are trying to innovate often do so knowing they will risk punishments from inspectors; and the framework is an impediment to creating a place where staff want to work because they are focused on checklists over caring for residents.

## Risk-based approaches to compliance

The regulatory, inspections, and complaints framework do not provide enough mechanism to address compliance violations based on severity; currently all homes are often punished for the bad actions of a few, which also stigmatizes the sector and affects morale.

## Dispute resolution

The current complaints process does not serve residents, caregivers, and families as there is no real mechanism for conflicts to be resolved between them and the home.

## Legislation should...

Enhance medical and clinical oversight

Create a new, tiered accountability framework with a transparent process for handling compliance issues and penalties for willful negligence

Enable new inspection program that supports homes in meeting defined quality of care and living outcomes

Streamline the complaint and conflict resolution process



## A new relationship

In implementing the new legislation, we have an opportunity to clarify the roles, responsibilities and accountabilities of the government, homes, residents and families.

Over time, we recommend moving away from the prescriptive approach in legislation and regulation to this framework:

- The Ministry sets expectations, quality standards and desired outcomes, and the Ministry holds homes accountable for meeting and reporting publicly against those measures.
- Homes are permitted to develop and introduce models of care and legislation based on evidence and best practices (e.g. emotion-focused care) to meet the diverse and increasingly complex care and quality of life needs of their residents; and
- Residents and their family, caregivers, and substitute decision makers are engaged, participate in and evaluate their living and care experiences and help to improve the system, including through a reported standardized third-party satisfaction survey.

To allow the system to adapt to evolving resident needs, current expectations, quality standards, and outcomes will need to be reviewed and revised to ensure they align with these roles and accountabilities, as well as with the principles of resident-centred care.



## STEP 2.

# Stabilize the sector

The long-term care sector has been destabilized after 2 years of a pandemic and after decades of neglect. Before transforming the sector, we need to focus on stabilizing it so that residents do not suffer the unintended consequences of policy changes that do not address current needs.

**Our recommendations focus on three areas:**

1. Provide long-term care homes with resources to respond to the pandemic
2. Ensure stable planning and funding supports
3. Increase staffing and morale



**Sector-government technical working group** to support stabilization and wind-down of pandemic policies



**Create a government insurance backstop** for pandemic exposure to support homes and family access to due process



**Stabilize Ministry funding and planning** so homes can plan for their communities' needs



**Change in tone and approach** to improve morale and support homes, staff, residents and family



**Ensure access to supports,** for outbreaks and pandemic-related emergencies



**Increase staffing supply and address inflation costs for staffing** (as well as food, constructions, PPE, energy)



## STEP 3.

# Transform and build for tomorrow

Once the sector is stabilized, with new enabling legislation we can build a person-centred long-term care system, led by a culture of innovation and quality improvement. At its core, this system will need strong leadership, transparency, accountability, and agility.

In order to build the long-term care system of the future, Ontario needs to:

1. Put residents, caregivers, and families at the centre of long-term care
2. Respond to the health human resources emergency
3. Enable high-performance and quality improvement
4. Accelerate home re/development
5. Integrate long-term care into the wider seniors' ecosystem
6. Foster a just culture that is accountable and transparent



**Increase equity, diversity, and inclusion training** and supports for long-term care homes.



**Improve reporting** to make accessible for residents, families, and caregivers, ensure reporting is focused on what matters to them



**Improve placement process**, to support cultural-specific communities and campuses of care



**Modernize funding and resourcing** to allow for adaptable care models, innovative approaches to care, and more complex care



**Recognize the importance of the full care team** in enhancing resident quality of life and care



**Continue work to expediate home re/development** including to addressing barriers to development



**Enhance long-term care pharmacy**, increasing medication safety and suspending further reductions in pharmacy capitation



**Increase opportunities for learning and career laddering**, to help address global health human resource shortages



**Quality framework** to support improved outcomes for quality of life and care, including standardized resident satisfaction survey



**Create a robust data strategy** to support quality improvement and reduce duplicative reporting requirements, with technological supports and infrastructure



**Allow staffing adaptability**, including working to full scope of practice to address resident needs and specialized care models



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**OLTCA**

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