OMSA
Ontario Medical
Students Association

POSITION PAPER

Improving Long-term Care Access for Seniors

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Background

Long-term care in Ontario

Long-term care homes provide adults with 24-hour nursing and personal care for those who require constant supervision and frequent assistance with activities of daily living, and are a key component of seniors' health care. Those who use long-term care services are required to pay for accommodation costs (room and board), but all nursing and personal care is covered by the government. Maximum accommodation rates are set by the MOHLTC, while subsidies are available for those who cannot afford long-term care. Current standards for Ontario's long-term care homes are specified in the *Long-Term Care Homes Act, 2007* [1].

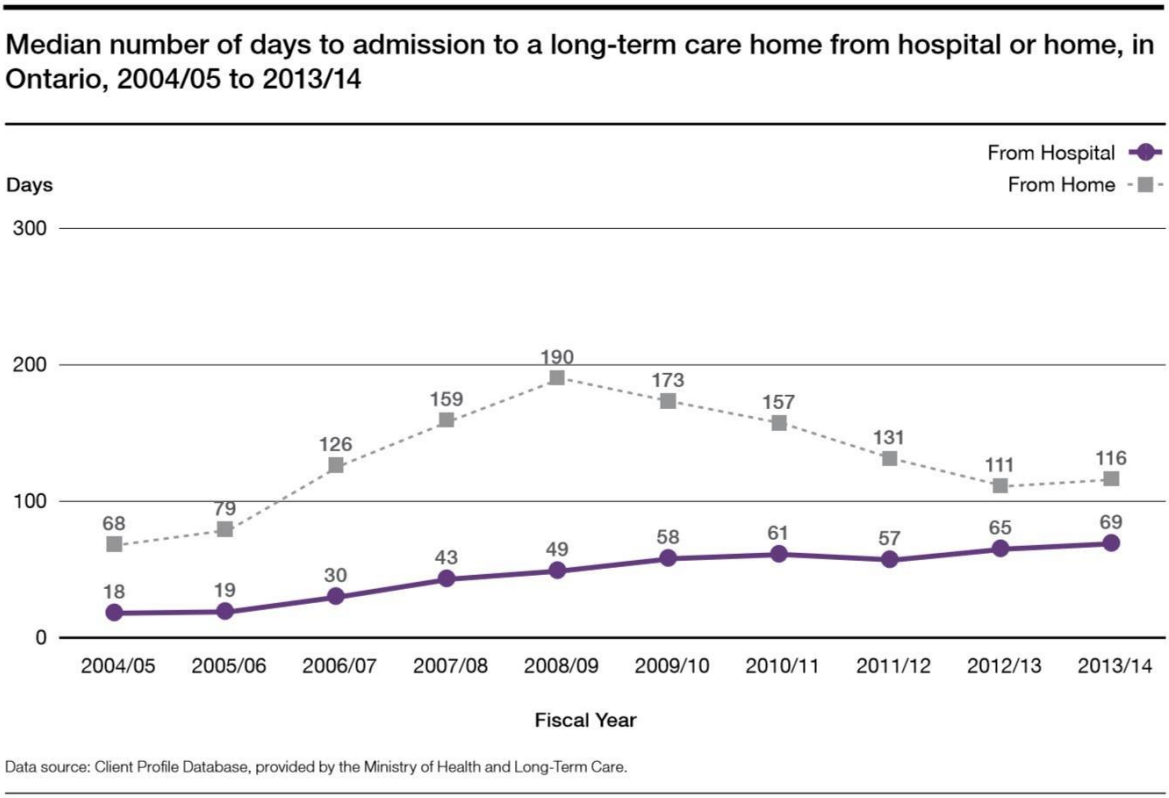
As of 2015, Ontario has 626 long-term care homes, with 76 569 long-stay beds [2]. Nearly all residents have two or more chronic diseases such as arthritis, about two thirds have dementia, and a third have severe cognitive impairment. The MOHLTC is responsible for the regulation of long-term care homes, which can be for-profit or not-for-profit; each long-term care home is responsible by law for delivering quality and consistent care. Admission to long-term care homes is currently managed by case managers through the local community care access centres (CCACs).

To access long-term care, clients must meet eligibility requirements, which include being 18 years or older, being part of the Ontario Health Insurance Program (OHIP), and requiring health care needs such as 24-hour nursing care and on-site supervision that cannot be met by community-based services and can be met in a long-term care home. These applications are currently assessed by the CCACs. Then, individuals may apply for a maximum of five long-term homes. The CCACs forward applications to the long-term care homes, which can reject clients or choose to place the client on their waitlist. When a bed becomes available, the client's application is re-evaluated by the long-term care home, taking into account any significant changes in the patient's eligibility since the initial submission. If accepted, the client may then choose to either accept or reject the offer, effectively closing

their application to wait for their other long-term care home choices. These steps, from start to finish, make up the wait time for long-term care homes.

The long-term care waitlist

Ontario's waitlist for long-term care beds in May 2015 had 23 443 individuals, which includes clients in hospitals and at home[3]. The time spent waiting for a long-term care bed results in stress for seniors and their caregivers, and may lead to the development of health complications. A report from Health Quality Ontario shows the trend of average wait times from 2004 to 2014, where the most recent median wait times are 69 days for hospital patients and 116 days for patients at home [3]. However, these numbers can dramatically vary by LHIN region, including a 197 day median wait time for hospital patients in Mississauga Halton. In Toronto Central, there is a 57 day median wait time for hospital patients, but for home clients, the median wait time is 243 days [3].



Reproduced with permission from Health Quality Ontario's annual report, *Measuring Up 2015* [3].

While progress has been made in reducing wait times among clients from home since 2008, there is an ongoing trend in increased wait times for hospital patients (increasing from 18 to 69 days over the last decade). Despite recent decreases, the admission time among clients from home over the last decade (from 68 to 116 days) has also increased overall.

Many factors contribute to longer wait times, including clients' right of choice, accommodation of crisis applicants (such as spousal reunification), and out-of-date waitlists, which may include clients who no longer desire or qualify for long-term care. The number of seniors seeking long-term care beds is expected to increase, and the Ontario Association of

Non-profit Homes and Services for Seniors (OANHSS) estimates that left unchecked, the number of individuals on the waitlist will double to 48 000 in six years [4].

Long-term care homes renovation

In July 2007, the MOHLTC announced the *Long-Term Care Home Renewal Strategy*, aimed at the redevelopment of 35 000 long-term care beds in Ontario. By 2014 however, only 5000 of the 35 000 beds were renovated [5,6]. In response, the MOHLTC introduced the *Enhanced Long-Term Care Home Renewal Strategy* (ELTCHRS) in the fall of 2014. The ELTCHRS aimed to provide updated incentives for the renovation of the remaining 30 000 long-term care beds to improve resident privacy, security, and comfort [7].

These updated standards, set by the *Long-Term Care Homes Act, 2007* and reinforced by the *Long-Term Care Home Design Manual 2015*, include substantial updates, such as resident bedrooms that "must have one or two beds but not more than two beds per bedroom" [7]. Many older long-term care homes still have three or four-bed wards, which not only limit residents' privacy but places them at risk. Particularly, people with dementia are more likely to become upset and aggressive if they perceive invasion into their personal space [8]. Safety measures including infection control standards and fire sprinkler systems also need to be updated [9].

In a 2013 report, the Canadian Medical Association indicated that limited municipal and provincial funding restricted the ability of long-term care homes to bring their building standards up to code, particularly affecting disabled and obese residents [10]. The Ontario Association of Community Care Access Centres stated that the lack of appropriate facilities for potential clients was the primary reason for long-term care homes to decline an application [11].

Redeveloping these 30 000 beds represents 40% of Ontario's long-term care beds, and is central to the province's future long-term care home strategy, especially as "new LTC beds are not being authorized at this time" [7]. However, the Ontario Long-term Care Association (OLTCA) describes several challenges including high cost and lengthy licensing processes that are limiting redevelopment of these beds. In a report released January 27, 2016, the OLTCA noted that since the ELTCHRS was introduced, only 22 applications were submitted by long-term care homes, and only six projects have been approved [8].

At a press release on April 4, 2016, the MOHLTC highlighted Ontario's commitment to long-term care, noting that more than 300 long-term care homes would be able to access construction funding subsidies to facilitate upgrades over the next nine years [12]. Yet, the statement lacked specific funding objectives. In addition, the nine-year timeline, which stretches over two provincial elections, does not address the urgent need for long-term care home renovation.

A changing landscape

In December of 2015, the Ministry of Health and Long-term Care (MOHLTC) published "Patients First: A proposal to strengthen patient-centred health care in Ontario" [13]. The proposal formed the basis for *Bill 41: An Act to amend various Acts in the interests of patient-centred care*. The Bill, which was passed December 8, 2016, serves to update a number of laws including the *Local Health System Integration Act, 2006* and the *Community Care Access Corporations Act, 2001*, as the government seeks to expand the role of Local

Health Integration Networks (LHINs) to improve healthcare access and consistent care.

It is not clear what changes this new healthcare legislation will bring, particularly pertaining to the role of case managers. Case managers currently help to provide home care and manage long-term care home placement. Their responsibilities also include informing clients of available services, from ambulance transport to the Ontario Drug Benefit, and determine and assess their eligibility and need for each service [14]. It is uncertain how patient access to case managers will be impacted by the new legislation, which is concerning given case managers have served as a key contributor to coordinating multidisciplinary care and improving patient outcomes.

Interprovincial comparison

Tables 1 and 2 below compare Ontario's long-term care performance with that of other provinces. Alternate level of care (ALC) refers to patients who remain in an acute care bed despite having completed the acute care phase of their treatment, or whom due to the lack of a more appropriate care setting are admitted instead into an acute hospital bed. Most of these patients would be better suited to live in their own home with appropriate supports or in a long-term care facility [10].

Compared to other provinces, 7% of Ontario's hospitalizations are ALC related -- the highest in the country. In terms of percentage of acute care beds used for ALC, Ontario also ranks fourth highest at 11.4%, with 2,590 acute care beds used for ALC patients who are waiting to be transferred to more suitable settings. These statistics demonstrate a need for patients to be transferred to long-term care in a more timely fashion, allowing acute care beds currently occupied for ALC patients to be freed up and allocated more appropriately to acutely ill patients.

Table 1: Hospitalizations related to ALC by province [15]. Manitoba and Quebec are not included due to lack of data.

	% of hospitalizations that were ALC related
Ontario	7
Newfoundland and Labrador	7
New Brunswick	5
British Columbia	5
Nova Scotia	3
Alberta	3
Prince Edward Island	2
Saskatchewan	2

Table 2: Acute care beds used for ALC by province [15]. Manitoba and Quebec are not included due to lack of data.

	Number of acute care beds	Number of hospital beds used for ALC	% of acute care beds used for ALC
Nova Scotia	2703	460	17.0

New Brunswick	2425	340	14.0
Newfoundland and Labrador	1589	180	11.3
Ontario	23251	2590	11.1
British Columbia	8188	910	11.1
Prince Edward Island	459	30	6.5
Alberta	8471	520	6.1
Saskatchewan	2913	150	5.1

Principles

The Ontario Medical Students Association (OMSA), puts forward three principles to guide its recommendations for improving long-term care access for seniors:

1. Ontario's seniors should have timely access to quality long-term care.
2. Ontario's long-term care homes should be equipped for complex health care needs, especially for clients living with dementia.
3. Ontario's seniors and their family and caregivers should be able to navigate health services easily and quickly.

Recommendations

1. **That the MOHLTC develop a comprehensive wait times strategy to address system challenges for long-term care placement.**

The current lengthy wait-time for a long-term care home placement and the expected increase in the number of seniors seeking long-term care, necessitate an urgent need to decrease the waitlist. Given that many factors contribute to longer wait-times, a comprehensive wait times strategy is required to ensure the many facets of this issue are taken into consideration. This wait times strategy may include elements such as active waitlist management, incentives to balance the disparity between waitlists among regions and client groups, and a needs-based assessment of current long-term care homes to better allocate future infrastructure spending and staff resources. This wait times strategy should also be made in consultation with appropriate stakeholders, including the LHINs, sub-LHINs, and Ontario's long-term care home associations.

2. **That the MOHLTC improve the ELTCHRS to provide timely, regular and predictable funding for the renovation of long-term care homes that do not meet current regulatory standards, and set a timeline of five (5) years for completing these renovations.**

The *Long-Term Care Homes Act, 2007* set newer standards to help to ensure the safety, comfort, and privacy of residents. From 2007 to 2014, only 5000 of the 35 000 targeted beds were renovated. From 2014 to January 2016, out of 300 long-term care homes that still require renovation, only 22 applications were submitted and just 6 long-term care home projects were approved. As of March 2016, 40% of long-term care beds in Ontario not meeting current standards. To improve long-term care services, especially in the context of an aging population with complex needs, the MOHLTC should improve the ELTCHRS to

provide timely, regular and predictable funding for the renovation of long-term care homes that do not meet current regulatory standards. In particular, a clear source of funding should be set aside explicitly for long-term care home renovations; federal and provincial infrastructure investments can be reviewed as a potential source of funding.

The MOHLTC should also set a timeline of five (5) years for completing these renovations. Maintaining long-term care facilities is an urgent problem actively affecting 40% of current long-term care residents as well as future users of these services. The disparity between these older beds and newer long-term care facilities also complicates the long-term care home selection process that has many implications for wait times. Therefore, efforts to improve the ELTCHRS should be discussed and implemented as soon as possible.

Furthermore, the ELTCHRS should be able to adapt to the needs of different long-term care homes, from urban centres that face high land costs to small, rural homes that have construction and operational challenges. In addition, the lack of new long-term care beds may prevent long-term care homes from renovating at optimal efficiencies of scale, as practical construction and expansion may not be cost-effective if no new long-term care beds are licensed [9]. Ongoing consultations with the ELTCHRS Stakeholder Advisory Committee will ensure that various perspectives and systemic challenges are identified.

3. **That the MOHLTC maintain the role of case managers to coordinate services in both home care and long-term care settings, especially through the transition period of implementing Bill 41.**

Case managers have served as a key contributor to improving patient care and outcomes. Their role in coordinating multidisciplinary care helps to integrate the healthcare continuum. As the transition period begins for implementing the new healthcare legislation outlined by Bill 41, the MOHLTC should maintain the role of case managers to coordinate services in both home care and long-term care settings.

In addition, clients should have timely access to case managers, including through any transitions in service delivery. Case managers should also be able to continue accommodating culturally diverse populations, including indigenous peoples, Francophones, immigrants, and refugees.

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