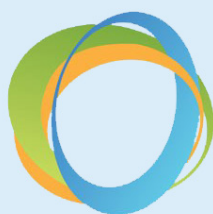




## **Report on the Financial Sustainability of the Non-Profit Personal Care Home Sector**



**marche**

Manitoba Association of Residential & Community  
Care Homes for the Elderly

**Resident Centered • Community Owned • Not for Profit**



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**N5067 - 431 Taché Avenue, Winnipeg MB R2H 2A6**

**[www.marchemb.ca](http://www.marchemb.ca)**

**204-235-3136**

**[jtmaynard@cham.mb.ca](mailto:jtmaynard@cham.mb.ca)**

# EXECUTIVE SUMMARY

## MARCHE REPORT ON THE FINANCIAL SUSTAINABILITY OF THE NON-PROFIT PERSONAL CARE HOME SECTOR

### ISSUE

The non-profit Personal Care Home (PCH) sector in Manitoba is well positioned to address existing and future demand for long-term seniors' care. However, past funding deficits and increased budget pressures threaten to undermine the sector's financial sustainability.

### BACKGROUND

- The Manitoba Association of Residential and Community Care Homes for the Elderly (MARCHE) represents twenty-three community based, private, non-profit organizations across three health regions who own and operate PCHs, elderly persons housing, and supporting housing in Manitoba.
- Facility-based Long-Term Care is a key pillar of the continuing care spectrum for seniors.
- With approximately 15% of the population over the age of 65, seniors' care is one of the most essential issues facing the Manitoba healthcare system today.

### DISCUSSION/ KEY MESSAGES

- MARCHE members face serious financial challenges in the areas of operating expenses, capital needs, and staffing guidelines.

#### i) OPERATING COSTS

- Non-salary operating costs in dietary expenses, nursing and recreational supplies, laundry and housekeeping, office and administration, utilities, taxes, and insurance increased in the last ten years (2008-2018) with minimal or no funding increases allotted for these items.

- Salary benefit expenses increased significantly as well as salaries for allied health and spiritual care.

#### ii) INFRASTRUCTURE AND CAPITAL COSTS

- Facilities have significant capital needs due to past funding deficits, the aging nature of infrastructure, and deferred spending on maintenance and small repairs in the face of increased operating costs.
- On average, funding covers only 22% of ten-year plan expenditures for a MARCHE facility.
- The funding levels of the two major pools available to facilities for infrastructure and repairs—the Major Repairs Reserve and Basic Capital Equipment funding—have not kept pace with inflation and have thus seen little to no increase in the last twenty-five years.

#### iii) STAFFING GUIDELINES

- MARCHE facilities require increased funding to ensure adequate levels of care are provided by nursing staff.
- Provincial guidelines call for 3.6 paid hours of care per resident per day (HPRD) for nursing staff. Paid HPRD includes indirect time on training,


administrative tasks, and time paid but not worked through breaks and sick leave. 3.6 paid HPRD translates to 3.2 **worked** HPRD.

- This falls short of the expert-recommended benchmark of 4.1 worked HPRD required to avoid jeopardizing the health and safety of PCH residents.
- Inadequate nurse staffing levels contribute to adverse health outcomes for PCH residents, increased caregiver violence, and mental and physical exhaustion among PCH staff (Banerjee et al., 2008; Konetzka et al., 2008).

### RECOMMENDATIONS

1. The information provided in this report should directly inform the future Service Purchase Agreement negotiations, especially including all future discussions on the SPA Schedule on new sustainable funding formulas.
2. MARCHE fully supports increasing the benchmark for nursing care from 3.60 paid HPRD to 4.1 worked HPRD in the provincial Personal Care Home Staffing Guidelines. The new funding model should also provide for other levels of staffing, supplies and equipment to meet current and ever-increasing resident care needs and community expectations.
3. Operating and Capital funding should be adjusted regularly to meet the cost of inflation.





**SENIORS'  
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SYSTEM  
TODAY.**



# INTRODUCTION

**Seniors' care is one of the most essential issues facing the Manitoba healthcare system today. Between 2011 and 2016, the proportion of seniors to the Canadian population grew more than it had in over 100 years, with people aged 65 and over accounting for nearly 17% of the overall national population (Canadian Health Coalition, 2018). In Manitoba, approximately 15% of the population is over the age of 65, and within the next 15 years, 10,000 Manitobans will reach an age where they will likely require long-term care services (Government of Manitoba, 2016). The steady growth of an aging population is a trend across Canada that all provincial governments and healthcare systems are finding ways to respond to in preparation for the current and future needs of seniors in Canada (Manitoba Nurses Union, 2018).**

Alongside Home Care, Community Support Services, Supportive Living, and Assisted Living, facility-based Long-Term Care is a key pillar of the continuing care spectrum for seniors. Personal care homes (PCHs) are important institutions as they deliver both health care and social services to seniors through income-supported housing, living assistance, and recreational, social, and spiritual programs (Banerjee, 2007).

The role of non-profit organizations in seniors' care is long-standing in Manitoba. Non-profit faith-based and other community supported organizations have been providing care to Manitoba's seniors and the most vulnerable in society for well over 100 years before their institutional inclusion into publicly funded healthcare in the early 1970s. Manitoba's Home Care Program was established in 1974 as the first province-wide co-ordinated continuing care program in Canada, and by 1997, regional health authorities assumed control over many functions including PCH admissions.

Manitoba has established a reputation as a provincial leader in Canada on addressing the needs of the personal care home (PCH) sector (Manitoba

Nurses Union, 2018). The recent decrease in PCH wait times in the city of Winnipeg and the government promise of 1,200 new PCH beds in the province are positive developments. However, increased and sustained funding for PCHs will be required to maintain our leadership in Canada.

This report on the financial sustainability of personal care homes in Manitoba highlights how past funding deficits and increasing budget pressures have become a significant challenge to the non-profit PCH sector, affecting everyday operations and resident care. The report begins by providing context on MARCHE, highlighting the role of our association in the seniors' care environment in Manitoba. The report then identifies the three pillars where our PCH facilities have been most impacted by financial strain: operating costs, infrastructure costs, and staffing guidelines. The report then discusses future challenges and opportunities facing the non-profit PCH sector in securing increased and sustainable funding. We conclude with three specific recommendations for future Service Purchase Agreement negotiations.



## CONCERNING MARCHE

**The Manitoba Association of Residential and Community Care Homes for the Elderly (MARCHE) represents twenty-three community based, private, non-profit organizations across three health regions who own and operate long-term care homes (or PCHs), various elderly persons housing, and supportive housing facilities in the province. MARCHE was formed out of the former Manitoba Non-Profit Long-Term Care Association, changing the name of the Association to better reflect our changing membership.**

MARCHE members maintain strong connections to the communities in which they are located, providing community-centred care that focuses on the dignity of its residents. Our members comprise many diverse, community-supported, faith-based and secular organizations. A full list of our membership is provided in Appendix 1 of this report.

MARCHE's mandate is to support the relationships between our member organizations, the provincial government and the regional health authorities, and coordinate efforts based on the collective needs of our members through public policy advocacy, networking opportunities, and knowledge sharing. MARCHE members also have a strong and dedicated volunteer base who provide

support to Manitoba's seniors and assist with fundraising efforts.

In our capacity as advocates, MARCHE has a long and successful history of working in collaboration with the provincial government and government agencies. We have been, and hope to continue to be, active partners in the health and social services transformation processes and system changes being undertaken. MARCHE members are keenly aware of the current and emerging challenges Manitoba's senior care system faces, including an aging population with more acute health concerns, decreasing family supports for seniors, a decreasing paid workforce to provide supports, duplication and gaps in the healthcare system, and finding the right funding models which balance value for taxpayer money





## MARCHE HAS A LONG AND SUCCESSFUL HISTORY OF WORKING IN COLLABORATION WITH THE PROVINCIAL GOVERNMENT & GOVERNMENT AGENCIES

while ensuring affordable care options are available for seniors. MARCHE, Manitoba Health, Seniors, and Active Living (MHSAL), and the regional health authorities share common goals centered on improving services to Manitoba's seniors and ensuring that robust and efficient funding models are in place to meet this goal.

Non-profit personal care homes are uniquely positioned to address these current and emerging challenges and contribute to the sustainability of Manitoba's health and social systems. Adequately funded community-based, independent, non-profit PCHs bring significant social and economic benefits not just for the seniors in their care, but for the communities in which they are located and for Manitoba's healthcare system.

Further, non-profit personal care homes and their autonomous governing boards bring an important perspective and set of skills to the healthcare system. Non-profit PCHs promote community ownership over healthcare and are responsive to local population needs by working across political lines and between diverse community groups.

MARCHE members take seriously the adage that the measure of greatness in a society is how it treats its most vulnerable members. Residents in PCHs are highly vulnerable, and the quality of their care is understandably a major focal point for public concern (Ronald et al., 2016). For this reason, we encourage that the principles of careful study, evidence-based

planning, and precaution be adopted when making changes and enacting policy for Manitoba's seniors.

MARCHE's values lend themselves to ensuring any spending and decisions made by administrators follow these principles and fit with our vision of providing resident-centred care which pays attention to the entire health continuum. Our facilities make a conscious effort to exercise love in the care we provide for a population of people who have extended love and care to their families and communities for years. Underpinning MARCHE are the shared values of companionship and compassion, trust, stewardship for the present and the future, and partnerships which serve the common good.

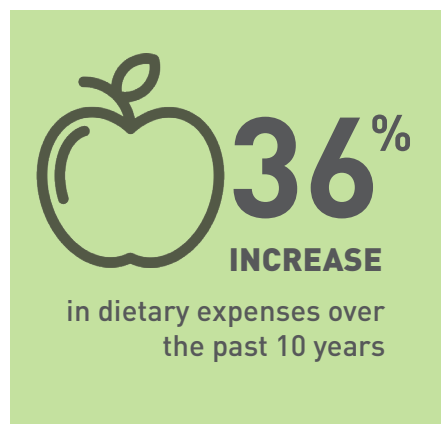
# REVIEW OF BUDGET DEFICITS AND FINANCIAL PRESSURES

## 1. OPERATING COSTS

**The information provided in this section is based on data collected on the operating costs of eleven MARCHE PCHs in the last 10 years (2008-2018). A full breakdown of expenses has been attached to this report as Appendix 2. Although not all PCHs submitted data, the information obtained from these 11 PCHs offer common examples of the financial strains our facilities are facing. The operating expenses are broken down into supply and staffing costs below.**

### A) SUPPLY COSTS

Over the last 10 years, non-salary operating costs have been increasing at MARCHE PCHs with minimal or no funding increases allotted for these items. Certain expenses increased as expected and are largely outside the control of PCH facilities. Dietary expenses increased by 36% (3.3% a year) because of an increase in food quantity, quality, and price. There has been a significant increase in food thickeners and supplements due to the advanced care needs of current residents, which has contributed to increasing overall dietary expenses. The quality and quantity of food provided in our facilities cannot be decreased because of its importance to residents' quality of life.



Additionally, nursing and recreation supplies increased by 50% (4.6% a year). This is in large part because medical supply prices have risen higher than inflation, and incontinent supply usage and nursing supplies have increased significantly in recent years due to the advanced care needs of current residents. Increased acuity has resulted in requiring more costly nursing supplies such as complex dressings and wound care treatments, as well as cytotoxic medication supplies to protect workers. Some cost control has been achieved by utilizing cheaper products and taking advantage of regional purchasing contracts. However, cheaper products often resulted in higher volume of usage due to inferior quality, reducing financial savings and compromising residents' comfort.

Other categories of supply-based operating expenses showed increases that were lower than expected due to the prudent financial management of PCHs. Laundry and housekeeping expenses increased by only 4% over ten years (0.4% per year) as several facilities moved to in-house laundry. This is despite the regional health authorities urging PCHs to keep the central laundering service and the increased protocols necessitated by Winnipeg Regional Health Authority (WRHA) standards around infection prevention and control.





**utilities, taxes, & insurance  
over the past 10 years**

Office and administration expenses only increased by 1.7% (0.2% a year) as new technologies in photocopies and printers became cheaper to purchase and operate, and bulk contracts kept expenses down. However, some contracts are projected to increase in the next few years, in part due to new carbon taxes, including a 4-5% increase for paper.

Utilities, taxes, and insurance increased by 12.2% (1.1% a year) as facilities invested in efficiency projects such as installing LED lighting, low flow plumbing, new roofing, and new windows which led to energy and water savings. Property tax freezes over several years helped keep taxes down. Some facilities utilized Property Tax specialists to appeal increases and keep their tax levies the same or at a lower rate of increase.

However, these levies are expected to increase again which could have a large impact on facilities. Utility rates as set by the provincial government have been increasing significantly, and will continue to increase, especially with the implementation of a carbon tax and given that most cost-saving efficiencies have already been realized.

Insurance rates have increased significantly over the last decade, though some facilities secured cheaper rates through active tendering. A further added cost in the past several years relates to increased professional fees for auditors and accountants.

It is important to note that although some regional health authorities have supported these increased supply costs, the WRHA has not. This disparity needs to be addressed if the future direction of Manitoba's healthcare system is to be equitable throughout all its regional health authorities.

## **B) STAFFING COSTS**

Spiritual care expenses, a high level of importance for our faith-based facilities, increased by 67.3% over the last 10 years (6.1% a year) due to the professionalization of the discipline. Spiritual care staff require higher theology education, membership in a professional organization, and a minimum number of Clinical Pastoral Education program credits. This has led to higher salaries with no direct funding for these expenses. Facilities have also seen an increase in residents experiencing serious health challenges and approaching the end of their lives. These residents often have higher spiritual support needs, contributing to the increased cost of spiritual care. Most MARCHE PCHs currently rely on donations to cover all these costs, which is not sustainable as donations decrease over time.

Benefit expenses increased by 78% (7.1% a year), though some of the expense is directly funded through the COLA pension increase and the Health

Care Spending accounts. However, facilities have been consistently underfunded over the last ten years in providing salary benefits. In 2007, the cost of benefits as a percentage of salaries averaged 19% for sites, with only 15% funded by the WRHA. This meant that facilities were operating at a deficit of 4% of all salaries. The increase in WRHA funding for benefits to 18% is offset by the fact that benefits cost 22% of salaries as of March 31, 2018. This has led to a situation where facilities in Winnipeg have been consistently underfunded for benefits by over 4% per year for at least ten years. Furthermore, the 18% funding benefits increase only applies to new salary dollars provided to the organization, excluding pre-existing salaries which have also seen an increase in benefit expenses.

As a result of increased operating costs, MARCHE members have been required to make other adjustments in staffing and expenses in order to maintain a balanced budget. MARCHE facilities have not received any increase in health funding to cover these costs. Furthermore, PCH standards have increased their reach in many areas of service delivery, including necessitating increased documentation to the point that audits of audits are required. This has the direct impact of requiring increased staff resources. With no added funding, this results in a decrease of staff time spent at the bedside.

## 2. INFRASTRUCTURE AND CAPITAL COSTS

**The financial information collected on eleven MARCHE PCHs (Appendix 2) shows that repairs and maintenance costs have generally been controlled by facilities over the last 10 years, increasing by 11.9% (1.1% a year). As a discretionary expense, repairs and infrastructure maintenance for less urgent projects have been postponed by all facilities facing tight budgets. However, this has been a short-term solution, and facilities are concerned about their growing infrastructure deficit exacerbated by deferring maintenance and smaller repairs. Short and long-term capital plans are therefore growing significantly in our facilities. Increased and sustained operating and capital funding for our facilities is necessary to meet immediate and future operating and capital needs.**

The capital needs of our PCH facilities are significant. Based on data from a sample of facilities, future capital repairs and maintenance needs for our members averages \$6.1 million per PCH over the next seven years (2020-2027). This data is presented in Appendix 3. Total future capital needs are high for our facilities in large part because of deferred spending to maintain operating funds in the last ten years, compounded by the aging nature of infrastructure and the need for building additions such as sprinklers and security systems to address resident expectations.

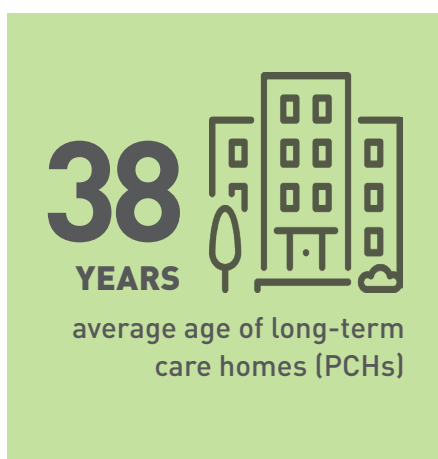
The average age of the PCHs presented in Appendix 3 is 38 years; province-wide, the majority of current personal care home infrastructure is over 40 years old (Long Term & Continuing Care Association of Manitoba). Some MARCHE PCHs have not had any expansions or additions to their buildings since the 1960s. Aside from obvious safety issues that arise

as buildings age, the older physical layouts of some facilities can negatively affect the treatment of people with dementia and pose resident and staff risks. Conversely, renovations which minimize crowded areas and noise are demonstrated to have a positive impact on reducing anxiety among residents in PCHs, lessening the risk of possible violent situations (Long Term & Continuing Care Association of Manitoba).

The lack of existing funding for spending on aging infrastructure and repairs has put a major strain on our members' budgets. On average, the percentage of funding that covers ten-year plan expenditures for these facilities sits at only 22%, and regular funding sources for PCH capital spending are limited to two sources:

- **The Major Repairs Reserve and;**
- **Basic Capital Equipment funding.**

For many facilities, funding levels to pay for basic PCH equipment was last adjusted at least 16 years ago. Levels at many of the PCHs equate to about \$175 per bed year (or \$1,750 over ten years), which is expected to cover the cost of new furniture for resident rooms as well as costly equipment needed for the facility at large such as unit dining furniture, nursing stations, kitchen equipment, nurse call systems, computers, and laundry equipment. Many facilities have not seen an increase in either funding pool for years; in some facilities, the Major Repairs Reserve and Basic







Capital Equipment funding levels have not been increased for over 25 years. For comparison, Ontario, Alberta, and British Columbia have had increased investment in operational and capital funding for their PCH sector, with an average base funding increase of 1.6–2% per year (Long Term & Continuing Care Association of Manitoba).

Both funding reserves have not kept pace with inflation, and compounded inflation has taken a dramatic toll on the funds available for major infrastructure projects and repairs. Given a national inflation rate of 57% since 1994, the equivalent of a facility receiving \$50,000 in 1994 is \$78,500 in 2019. It cannot be overstated how much natural inflation has contributed to eroding funding levels over the last 25 years.

Although our long-term care facilities also receive funding from the Safety & Security programs within their regions, this funding is not guaranteed and is dependent on need which is determined by Shared Health and approved by Manitoba Health. This

## THE LACK OF EXISTING FUNDING FOR SPENDING ON AGING INFRASTRUCTURE AND REPAIRS HAS PUT A MAJOR STRAIN ON OUR MEMBERS' BUDGETS.

process has experienced delays on the part of Manitoba Health. Over three years can pass between when PCHs submit proposals and when tenders are approved. Invariably, project costs have increased by the time work is tendered, and the facilities are forced to cover the increases per Manitoba Health policy. The funding has sometimes even been cancelled. Annual Safety & Security funding for the province has also not been increased over time, resulting in most critical infrastructure projects remaining financially unsupported.

External financial challenges further exacerbate the issue of insufficient funding reserves. The current SPA requires any surplus generated by a facility of over 2% of total funding to be returned to the regional health authority, preventing PCHs from raising enough equity to cover major capital projects and ensure the safety of their residents and staff. Additionally, with no new funds, increasing demands related to Manitoba PCH Standards, Workplace Health and Safety and building code requirements have significantly added to the cost of repairing aged infrastructure.

The available funding pools detailed above do not take into consideration any initiatives to enhance or upgrade facilities and equipment, only to maintain buildings at a safe, acceptable level. This has created an environment in the non-profit PCH sector where new builds of facilities are near to non-existent and repairs, such as safely mitigating potential hazards such as asbestos, bring significant costs and financial strain. At these levels, the safety and comfort of our residents and staff is compromised. To fill this gap, facilities have been resorting to applying for external grants (e.g. Winnipeg Foundation) and donations, and using accrued equity. These sources of funding, however, are unpredictable and often unattainable for large, long-term projects. Furthermore, a failure to fund desperately needed repairs and improvements now will lead to much larger investments in the future.

## MARCHE MEMBERS REQUIRE INCREASED AND SUSTAINED FUNDING TO ENSURE ADEQUATE LEVELS OF CARE HOURS ARE PROVIDED BY NURSES AND HEALTHCARE AIDES...

### 3. STAFFING GUIDELINES

**In tandem with future capital needs, MARCHE members require increased and sustained funding to ensure adequate levels of care hours are provided by nurses and healthcare aides to residents. According to data provided to CIHI through the RUGS-III Resident Reports of ten members' facilities in Winnipeg, the care needs of residents increased in a three-year time period (2015 to 2018) from requiring 3.56 to 3.6 *worked* hours of care per resident per day (HPRD), while facilities provided only 3.6 *paid* HPRD over this time period.**

The difference between these two measures is that paid hours of care does not reflect direct care hours that residents receive, as it includes indirect time on training, administrative tasks, and time paid but not worked through breaks and sick leave (Manitoba Nurses Union, 2018). This has translated to each resident, on average, receiving only 90% of the care they need from nursing staff.

Manitoba's Personal Care Home Staffing Guidelines calls for 3.6 paid HPRD for nursing staff, with 70% of this care being provided by healthcare aides. Many homes have adjusted their staff complement in other areas to maintain the nursing staffing guidelines and purchase supplies and food. However, expert-recommended guidelines are not measured in paid HPRD, but worked HPRD. Worked care hours measures time spent directly with residents and excludes time paid but not worked through vacation, sick time, statutory holidays, or education leaves. With the difference between paid and worked HPRD at 10%, the province's guideline of 3.6 paid hours of care per resident per day translates to approximately 3.2 *worked hours* of care per resident per day.

This sits well below the expert-recommended benchmark of 4.1 worked HPRD required to avoid jeopardizing the health and safety of PCH residents (Manitoba Nurses Union, 2018). Other studies have found that between 4.55 and 4.8 worked HPRD is required to see an *improvement* in care outcomes (CUPE Manitoba, 2015). Changing Manitoba's guidelines from 3.60 paid HPRD to 4.1 *worked HPRD* would help ensure nurse staffing at PCHs across the province are maintained at an adequate and safe level.









# THE IMPORTANCE OF ADEQUATE LEVELS OF STAFFING

**Funding for the salaries of registered nurses, healthcare aides, and other staff in PCHs to increase the hours of care provided is especially necessary given the rise of highly acute residents at PCHs with complex care needs such as dementia, which is growing in Manitoba at “alarming rates” (Alzheimer Society of Manitoba). Seniors with complex and chronic care needs often do not qualify for home care or Aging in Place strategies and thus depend on the care services provided in PCHs. Manitoba’s PCHs are comprised of seniors with particularly acute needs, as the average age of PCH residents in Manitoba is 85 years (Manitoba Nurses Union, 2018).**

This makes the province second in oldest PCH residents after British Columbia (Manitoba Nurses Union, 2018). Approximately 10% of PCH residents in Manitoba require clinically complex care, approximately 37% require extensive assistance completing daily living activities, and over half have reduced physical functionality (Manitoba Nurses Union, 2018). With care becoming more complex but staffing levels and guidelines remaining the same, existing staff have taken on a higher burden with limited resources to alleviate these pressures.

Research studies indicate that inadequate nurse staffing levels contribute to adverse health outcomes for PCH residents such as mortality, medication errors, and pressure ulcers (Konetzka, Sterns & Park, 2008; Needleman et al, 2006). Low staffing levels and increased workloads can also lead to resident falls, unprocessed or delayed processing of

medication orders, a lack of social and psychological support to residents, failing to turn/reposition residents in appropriate timelines, delayed or missed monitoring of vital signs, a lack of communication about resident care, and delayed, missed, or rushed interventions and meals for residents (Manitoba Nurses Union, 2018).

Conversely, empirical evidence demonstrates that adequate nurse staffing capacity is a key indicator of quality care outcomes in PCHs (Anderson, Hsieh & Su, 1998; Ronald, McGregor, Harrington, Pollock & Lexchin, 2016; Spilsbury, Hewitt, Stirk, & Bowman, 2011). Higher levels of nursing contribute to a decreased risk of pressure ulcers, sepsis, cardiac arrest, and pneumonia (Twigg, Duffield, Bremner, Rapley, & Finn, 2011). Higher staffing levels also contribute to a lower turnover rate and better relational care, contributing to an improved quality of life for residents (Ronald et al., 2016).



## RESEARCH STUDIES INDICATE THAT INADEQUATE NURSE STAFFING LEVELS CONTRIBUTE TO ADVERSE HEALTH OUTCOMES FOR PCH RESIDENTS...

Furthermore, inadequate funding for hiring and retaining more staff is dangerous for existing staff members and residents. Staff shortages have been linked with caregiver violence in PCH environments (Banerjee, Daly, H. Armstrong, P. Armstrong, Lafrance, & Szebehely, 2008). Violence in PCHs is a major concern for MARCHE members and a relevant issue of public concern; according to reporting from 2018, violence in Winnipeg PCHs alone led to more than 500 injuries in two years (Nicholson & Kubinec, 2018). Banerjee et al.'s (2008) pivotal study found that Canadian personal support workers in long-term care facilities were almost seven times more likely to experience daily violence than workers in Nordic countries because of a higher workload, fewer resources, and more shifts alone. These conditions put workers in dangerous situations and also lead to increased health problems for staff members such as musculoskeletal injuries and mental and physical exhaustion (Banerjee et al., 2008).

Several MARCHE facilities have been participating in Translating Research in Elder Care, a research project operating out of the University of Alberta. A 2018 publication of this research found that levels of burnout, emotional exhaustion and cynicism among healthcare aides are higher in Winnipeg than in other parts of the country (Chamberlain, Hoben, Squires, Cummings, Norton, & Estabrooks, 2018). The results of the study further indicate that overall, there has been worsening or little improvement in the health and quality of work life of healthcare aides in Western Canadian PCHs (Chamberlain et al., 2018).

The implications of these findings are significant as aide exhaustion and burnout contribute to rushed and missed care in PCH facilities (Knopp-Sihota, J. A., Niehaus, L., Squires, J. E., Norton, P. G., & Estabrooks, C. A., 2015). Among the care items most frequently missed by healthcare

aides facing burnout are talking with residents, taking residents for walks, preparing residents for sleep, and providing hair, nail and mouth care for residents (Knopp-Sihota et al., 2015). All of these care items are significant contributors to the quality of resident life in PCHs.

Finally, it is important to note that increased funding for staffing would allow for more staff hours spent with residents to address not only medical needs, but resident boredom, loneliness, and sadness as well. Increased funding for staff would allow facilities to retain a diversity of staff other than nurses and healthcare aides who can work to provide this care, such as physiotherapists, social workers, and recreational staff (Long Term & Continuing Care Association of Manitoba).





**IN THE  
LONG-TERM, A  
PREDICTABLE  
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# PLANNING FOR THE FUTURE

**The ability of MARCHE members to provide quality care in a cost-effective and self-sustaining manner is dependent on a stable, well-planned and predictable funding environment for seniors' care going forward. Currently, financial pressures facing non-profit PCHs in operating costs, infrastructure costs, and providing adequate levels of care hinder the ability for PCHs to deliver quality seniors care.**

The information gathered on our PCHs in this report has been Winnipeg-based due to a higher degree of reporting and data available. Non-profit PCHs in rural Manitoba have their own unique needs which differ from PCHs in the urban seniors' care environment. Rural PCH facilities also have different relationships with their regional health authorities, which must be considered. Though the challenges discussed in this report apply to rural PCHs as well, any future discussions ought to also consider the specific rural context of these PCHs and the unique challenges and opportunities present in rural seniors' care.

Looking ahead, MARCHE facilities require a funding model that is sustainable and predictable. The "business" of operating a PCH cannot be based on unsustainable funding sources such as Foundation and donation dollars. As discussed above, donations have been used to address various gaps in funding from spiritual care expenses to infrastructure and repairs. However, a business model based on the reliance of volunteers, donations, grants, and accrued equity will be weak, especially if basic inflationary expectations are not addressed. Though donations are a necessary and valued stream of revenue, a facility should not, nor cannot, rely on this kind of unsustainable and unpredictable funding.

In the long-term, a predictable and equitable funding model for personal

care services needs to be developed and implemented in Manitoba to ensure a level playing field, where allocations to providers are based on the cost of delivering care, the quality of care delivered, and the extent to which providers use their funding efficiently and productively. The existing SPA governing principles provide a collective understanding moving forward with MHSAL towards this kind of funding model. The governing principles are attached to this report as Appendix 4.

Section F of the Principles specifically provides a framework for consistent and equitable funding which has been collectively agreed to by MARCHE and MHSAL. This framework includes the "Establishment of a provincial approach to funding models within each sector that is transparent and strives to achieve fairness and equity between like services," "A commitment to reliable and predictable funding over time", and "Clear mutually agreed upon principles for funding distribution and explanations for justifiable variances due to such things as different types of providers, facilities, and different types of operations."

Additionally, while MARCHE recognizes that collaboration is a reality of the relationship between PCHs and their regional health authorities, the 2% surplus claw-back discussed earlier in this report hampers a facility's ability to accumulate a large enough surplus to fund necessary maintenance, repairs, and infrastructure upgrades. Given that

funds for repairs and equipment have been inadequate, a future SPA funding model which allows MARCHE facilities to retain any generated surplus would provide facility budgets with necessary breathing room. Any new model ought to also consider both operating and capital expenditures of the facilities when determining funding to address the multi-year chronic underfunding MARCHE facilities have faced for aging infrastructure and necessary repairs.

A new SPA should also include clauses in the main body allowing MARCHE members to allocate a reasonable portion of its funding to provide for organized spiritual care programming, as well as assurance that facilities will not have to deliver services inconsistent with its faith distinctive so long as the facilities meet their deliverables, care is provided at an expected level of quality, and facilities work cooperatively with MHSAL, Shared Health, and the regional health authorities. Though these recommendations are not directly related to funding, they set a precedent for governmental autonomy in the non-profit PCHs sector. With more governmental autonomy, MARCHE

members can set their own budgets, recruit and set wages for non-union management and administration staff, and engage in other regular operational activities without requesting approval.

Autonomy is particularly critical for the non-profit PCH sector, as the erosion of independence could seriously threaten the ability for independently owned private non-profit PCHs to raise funds and secure the support of volunteers. Community members expect the administrators of their PCHs to be able to address the distinctive needs of residents and their families, and exercise independent judgement on matters of spending based on the best interests of the community. Dependence on the regional health authorities and MHSAL to carry out everyday operations could jeopardize this relationship. Writing facility autonomy into the new SPA will allow MARCHE facilities to direct their own spending efficiently.

A final note on the future role of non-profit PCHs is to point out that PCHs figure into the overall transformation strategies recommended by leading

reports on Manitoba's healthcare system. Dr. David Peachey's report recommends creating a framework to align new investment in major building renovation and new construction for PCHs within a provincial clinical service plan (Peachey, 2017). PCHs also figure into KPMG's strategic system realignment models, playing a key role in the commissioning and delivery management of healthcare services (KPMG LLP, 2017a). A recommendation of the KPMG Phase 2 report is to increase access to PCHs in tandem with reinvesting in primary, community, sub-acute and home-based services (KPMG LLP, 2017b). The benefits of such a strategy include improved integration of healthcare services across the care continuum, the repurposing of community services, improving patient flow, redistributing services to the most appropriate setting, and reducing costs (KPMG LLP, 2017b). MARCHE members are excited to be active partners in province-level system changes to the coordination and planning of healthcare.

## RECOMMENDATIONS

### 1

If funded properly, the non-profit PCH sector is well positioned to take on the existing and future demand for long-term seniors' care. It is our **overall recommendation** that the information provided in this report directly inform the future Service Purchase Agreement negotiations, especially including all future discussions on the SPA Schedule on new sustainable funding formulas.

### 2

MARCHE fully supports increasing the benchmark for nursing care from 3.60 paid HPRD to 4.1 worked HPRD. This would increase staffing levels at PCHs across the province to an adequate and safe level. The new funding model should also provide for other levels of staffing, supplies and equipment to meet current and ever-increasing resident care needs and community expectations.

### 3

Operating and Capital funding should be adjusted regularly to meet the cost of inflation.



# CONCLUSION

The financial pressures affecting MARCHE facilities in the areas of operating costs, capital and infrastructure, and staffing guidelines demonstrate that non-profit PCHs in Manitoba face a growing and unsustainable structural deficit between the resources they require and the resources they are allocated. This is despite the fact that PCH operations have not changed significantly in the last twenty years in terms of mandate, scope, and staffing. Over the same period, regional health authorities have expanded dramatically and additional health care services have been implemented to improve health outcomes for acute care and diseases such as cancer. Long term care has therefore not been responsible for the significant increase in costs of the overall health care system, yet PCH funding has effectively been reduced every year while more resources are directed into the wider health care system.

Several positive steps have been undertaken by this government to strengthen seniors' care in Manitoba, such as new policies focussed on expanding at-home care and adding personal care home beds in the province. However, further investment into PCHs will be necessary for those who require intensive care and support. We recognize that difficult decisions must be made by the government on which parts of the health and social system for seniors will be funded by the taxpayers of Manitoba, that there is limited new revenue that can be added to these systems as the government balances spending with exercising fiscal responsibility, and that existing funding models and processes in the health and social services systems need to be transformed.

Our facilities have demonstrated creativity and innovation in the face of tight budgets to ensure that quality of care is not greatly impacted by funding shortfalls, and even finding savings in certain areas of expense. We are also active, collaborative, and accountable partners with MHSAL, Shared Health, and the regional health authorities. The resilience of the non-profit PCH sector is why increased government funding will be mutually beneficial to both parties, and in turn, to the communities and seniors we serve.

**OUR FACILITIES HAVE  
DEMONSTRATED  
CREATIVITY AND  
INNOVATION IN  
THE FACE OF TIGHT  
BUDGETS...**





## Appendix 1: MARCHE Members

### A \_\_\_\_\_

Actionmarguerite

### B \_\_\_\_\_

Bethania Mennonite  
Personal Care Home

### C \_\_\_\_\_

Calvary Place Personal  
Care Home

Convalescent Home of  
Winnipeg

### D \_\_\_\_\_

Dinsdale Personal  
Care Home

Donwood Manor  
Personal Care Home

### F \_\_\_\_\_

Fred Douglas Lodge  
Personal Care Home

### G \_\_\_\_\_

Golden Links Lodge

### H \_\_\_\_\_

Haven Group  
Holy Family Home

### L \_\_\_\_\_

Lindenwood Manor &  
Lindenwood Terrace

Lions Personal Care  
Centre

Luther Home

### M \_\_\_\_\_

Meadowood Manor

### P \_\_\_\_\_

Park Manor Care

Pembina Place  
Mennonite Personal  
Care Home

### S \_\_\_\_\_

Salem Home

Saul and Claribel  
Simkin Centre

Ste. Rose Hospital and  
Personal Care Home

The Salvation  
Army Golden West  
Centennial Lodge

### T \_\_\_\_\_

Tabor Home

### V \_\_\_\_\_

Villa Youville

### W \_\_\_\_\_

West Park Manor  
Personal Care Home

Winnipegosis &  
District Health Centre



## Appendix 2: Operating Expenses

| MARCHE - PCH Summarized Expense Analysis Survey |        |        |        |        |        |        |        |        |        |        |        |          |
|-------------------------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|----------|
| Major Cost Areas Over 11 Year History ('000's)  |        |        |        |        |        |        |        |        |        |        |        |          |
| Summary                                         | Year   | Year   | Year   | Year   | Year   | Year   | Year   | Year   | Year   | Year   | 11 Yr  | Avg %    |
| Expense                                         | 2008   | 2009   | 2010   | 2011   | 2012   | 2013   | 2014   | 2015   | 2016   | 2017   | 2018   | Change   |
| Account                                         | 2008   | 2009   | 2010   | 2011   | 2012   | 2013   | 2014   | 2015   | 2016   | 2017   | 2018   | Per Year |
| Nursing/Rec Exp (Non-Salary)                    | 1,130  | 1,435  | 1,527  | 1,584  | 1,667  | 1,609  | 1,587  | 1,653  | 1,697  | 1,741  | 1,698  | 50.3%    |
| Pre-Retirement Expenses                         | 362    | 311    | 371    | 444    | 385    | 675    | 442    | 808    | 602    | 866    | 593    | 63.8%    |
| Employee Benefits (all)                         | 6,935  | 8,432  | 9,709  | 10,237 | 10,809 | 11,254 | 11,463 | 12,066 | 12,436 | 12,536 | 12,358 | 78.2%    |
| Total Salaries (Excl.Prch Svc)                  | 37,415 | 45,009 | 48,270 | 48,997 | 49,590 | 51,495 | 52,601 | 54,810 | 55,860 | 56,579 | 56,339 | 50.6%    |
| Benefits as % of Salary                         | 19%    | 19%    | 20%    | 21%    | 22%    | 22%    | 22%    | 22%    | 22%    | 22%    | 22%    | 18.4%    |
| Purchased Svcs (All staffing)                   | 2,472  | 2,392  | 2,269  | 1,950  | 2,685  | 2,886  | 3,058  | 3,490  | 3,069  | 3,534  | 3,165  | 28.0%    |
| Spiritual Care (ALL Costs)                      | 275    | 331    | 471    | 442    | 459    | 470    | 490    | 487    | 474    | 475    | 461    | 67.3%    |
| Tot Office/Admin Exp                            | 1,288  | 1,420  | 1,211  | 1,596  | 1,405  | 1,436  | 1,307  | 1,331  | 1,372  | 1,460  | 1,309  | 1.7%     |
| Tot Dietary Exp                                 | 2,819  | 3,110  | 2,980  | 3,264  | 3,369  | 3,487  | 3,518  | 3,704  | 3,794  | 3,960  | 3,840  | 36.2%    |
| Tot Laundry/Hskpg Exp                           | 930    | 1,066  | 1,193  | 1,157  | 1,201  | 983    | 973    | 1,012  | 963    | 982    | 967    | 4.0%     |
| Tot Utilities/Taxes/Insce                       | 2,271  | 2,636  | 2,449  | 2,195  | 2,022  | 2,029  | 2,178  | 2,254  | 2,439  | 2,510  | 2,548  | 12.2%    |
| Tot repairs & Maint Exp                         |        |        |        |        |        |        |        |        |        |        |        | 0.0%     |
| (EXCL. Cap.Rsrvs.)                              | 1,425  | 1,340  | 1,270  | 1,340  | 1,356  | 1,410  | 1,508  | 1,410  | 1,449  | 1,400  | 1,595  | 11.9%    |
| OTHER COSTS                                     |        |        |        |        |        |        |        |        |        |        |        | 1.1%     |
| TOTALS                                          | 57,321 | 67,483 | 71,720 | 73,206 | 74,947 | 77,733 | 79,124 | 83,026 | 84,155 | 86,044 | 84,873 | 48.1%    |

## Appendix 3: Future Capital Needs

| Future Capital Needs      |                  |                  |                  |                  |                   |                  |                  |                  |                      |                     |
|---------------------------|------------------|------------------|------------------|------------------|-------------------|------------------|------------------|------------------|----------------------|---------------------|
|                           | 2019-20          | 2020-21          | 2021-22          | 2022-23          | 2023-24           | 2024-25          | 2025-26          | 2026-27          | Total                | Annual Average      |
| <b>Total Future Needs</b> | <b>1,744,800</b> | <b>6,845,682</b> | <b>6,674,108</b> | <b>7,797,850</b> | <b>14,529,779</b> | <b>2,754,132</b> | <b>2,124,809</b> | <b>1,824,129</b> | <b>\$ 44,295,289</b> | <b>\$ 6,078,641</b> |
| Funding as a % of Need    | 0%               | 0%               | 0%               | 0%               | 0%                | 0%               | 0%               | 0%               | 0%                   | 0%                  |

|                                                                    | Facility 1               | Facility 2 | Facility 3 | Facility 4 | Facility 6 | Facility 7 | Facility 8 | Total                     |
|--------------------------------------------------------------------|--------------------------|------------|------------|------------|------------|------------|------------|---------------------------|
| Avg Building Age (Year Built)                                      | 1976                     | 1989       | 1986       | 1979       | 1967       | 1983       | 1976       | -                         |
| Avg Age in Years (Original Build Year with Additions & Expansions) | 44                       | 30         | 33         | 41         | 52         | 37         | 44         | -                         |
| Last Increase in Major Repairs Reserve Funding                     | 1993-26 yrs              | 18+ years  | unknown    | 25+ years  | 25+ years  | unknown    | unknown    | unknown                   |
| Last Increase in Basic Equipment Funding                           | \$2,000 decrease in 2002 | 18+ years  | unknown    | 25+ years  | 25+ years  | unknown    | unknown    | unknown                   |
| % of funding that covers 10 year plan expenditures                 | 9%                       | 6%         | 15%        | 19%        | 83%        | 20%        | 4%         | 22% Average<br>15% Median |
| Total Bed Count: 1012                                              |                          |            |            |            |            |            |            |                           |
| Weighted Avg Age of total beds: 38                                 |                          |            |            |            |            |            |            |                           |



## Appendix 4: SPA Governing Principles

### A. Quality Care for All Manitobans

1. Clear focus on delivery of excellent services and outcomes with a focus on patient safety and responsiveness
2. Facilitate responsive access through integrated pathways to service
3. Reasonable accommodation for unique requirements of individuals and communities
4. Consideration of human rights, social determinants of health and health equity
5. Co-ordination of care between and within organizations in the health care system to support patients accessing timely care in the appropriate setting, at the appropriate level of service
6. Support the needs and roles of other service providers (SP) within the health care system
7. Responsive access through integrated pathways

### B. Community

1. Respect and recognize the unique needs of each service provider's stakeholders and those being served
2. Respect for the role that the service provider (SP) plays within the local community and within the health system
3. Respect for language, spiritual, cultural, and other requirements of the population being served
4. Respect the capability, capacity and history of service providers (SP) to deliver services

### C. Strategic Role

1. Role of service provider has strategic value and contributes to health care delivery system

2. Align service provider (SP) services and delivery within the needs of the overall health care system in support of provincial plans and delivery models and specifically structured in accordance with provincial policies, guidelines, and standards
3. Shared responsibility to support and encourage innovation in the healthcare system
4. Responsible stewardship of public investments in operations and capital
5. Simplified and straightforward approach to continuously improve the manner in which services are managed and delivered

### D. Collaboration

1. Early and ongoing engagement and collaboration is essential
2. Clear and consistent communication with stakeholders through established governance structures and mechanisms
3. Communication that is flexible, timely, honest and respectful

### E. Transparency

1. Transparency around health system expenditures and revenues at all levels
2. Purposeful and open conversations about why and how decisions are made to avoid the perception of bias or undisclosed intentions
3. Establishment of mechanisms to build capacity, share knowledge, collectively solve problems and discuss successes and challenges

### F. Consistent and Equitable Funding

1. Establishment of a provincial approach to funding models within each sector
2. A commitment to reliable and predictable funding over time
3. Consistency between different types of organizations in a given sector
4. Consistency between health authority operated facilities and those operated by service providers
5. Clear rules and principles for funding distribution and explanations for justifiable variances

### G. Accountability

1. Management decisions and planning will be based on objective criteria and performance measures
2. Shared accountability between the SP and the Health Authority (HA) for system performance
3. Clear expectations and metrics to measure success for the services being provided
4. Clear and consistent reporting processes and reporting relationships for the SP and the HA
5. Responsiveness to address performance gaps
6. Timely escalation and resolution of concerns
7. Strong governance and management practices for both the SP and the HA
8. Compliance with all legislation and regulations for both the SP and the HA
9. SPs may have other areas of businesses that are separate and shall not be included and impacted by this agreement

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