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Manitoba Association of Residential & Community Care Homes for the Elderly
Resident Centered • Community Owned • Not for Profit
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Enhancing Partnerships in Seniors Care: The Future is Now

Introduction

The Manitoba Association of Residential Care Homes for the Elderly (MARCHE) represents twenty-three (23) community based private not for profit organizations who own and operate 29 long term care homes in three Health Regions, various elderly persons housing and supportive housing facilities across the province. Our organizations have a long history of providing health and social services prior to, and in collaboration with, government and government agencies. We have strong volunteer bases that contribute thousands of hours of unpaid time to the work we do with Manitoba's seniors, and that assist in fund raising efforts. MARCHE also collaborates with the Long-Term Care Association of MB (LTCAM), the Interfaith Healthcare Association of MB (IHCAM), and the Catholic Health Association of MB (CHAM) on various issues, such as this, that are of common concern to their members.

As the Health System is undergoing significant transformation, we want to be active partners in a collaboration to improve the care of seniors in the province. As key contributors in quality senior's care we seek to be part of the discussions, that will shape the future of systematic and societal changes around health care and aging.

Background

Not for Profit (NFP) and faith-based community organizations have provided care to the frailest members of society for well over 100 years prior to their inclusion of long-term care in publicly funded health care in the province in the early 1970's.

Over the last forty plus years, the relationships of the NFP organizations have shifted with the changes in the system. Relationships were developed between individual organizations and the Department of Health, then individual organizations and the various District Health Associations, and over the last 20 years, between groups of homes and various Regional Health Authorities.

MARCHE was formed out of the former Manitoba Non Profit Long Term Care Association to reflect the fact that many of its members are actively involved in senior's housing and Supportive Housing, as well as long term care. Its members include organizations from the Baptist, Catholic, Jewish, Lutheran, Mennonite, Pentecostal, Salvation Army, Seventh Day

Adventist and United Church faith traditions, as well as community organizations such as the Convalescent Home of Winnipeg, Lions Club and the Independent Order of Odd Fellows.

The goals of our Association are to:

- Support and help define the relationship between our members and the government, regional health authorities, allied health agencies and the community.
- Advocate for sufficient resources for quality care and respectful and safe work environments.
- Influence the formulation of public policy related to trends, changes in the environment and evolving needs of our residents.
- Nurture a learning environment and network to: share knowledge, expertise and results among members; share resources to meet and/or exceed national and provincial standards; and, coordinate efforts for the benefit of all, based on our collective needs.

Current and Emerging Challenges

Our joint focus needs to be improving services for seniors and ensuring that the funding models are sustainable to do this. There are many challenges in providing personal care for seniors.

These include, but are certainly not limited to:

- An aging population, with more chronic health concerns and disabilities
- Societal change that decreases available family support for seniors
- Predicting and assessing the need for additional long-term care, and other services
- Decreasing available paid work force to meet the needs
- The need for solutions that allow couples to be together, despite different needs for care.
- The increasing need for higher levels of care and specialized care, especially for those with mental health and behavioral issues.
- Understanding and cooperation between all the various government departments, public and community agencies and organizations involved to eliminate duplication and fill gaps
- Funding models that maximize the value for taxpayer dollars while providing care options that are affordable for seniors.
- Regulations that ensure quality care and do not divert care resources from the bedside.
- Value added processes to monitor regulatory compliance, and allow independent corporations to be supported in meeting care standards
- Cooperative discussions around the financial and system implications of policy and practice change so that necessary changes can be implemented without decreasing care.
- Collaborative working relationships that are supported by documented, easily understood principles that allow the private NFP sector to be a strong partner with government and government agencies.

- Clarification on the intent of the government decisions over past years to declare the private non-profit long-term care facilities as Government Reporting Entities for financial purposes. Discussion has been ongoing intermittently since 2008.

A Roadmap for Sustainability in Seniors Care

MARCHE believes that sustainability of the health and social systems for Manitoba's seniors, and all Manitobans, requires that we find new ways to work together between governmental, regional and community organizations. We have identified two major issues where we would like to share our thoughts: the roles of multiple organizations in the system and funding and accountability models.

1) The Roles of Multiple Organizations in the System

We believe that in healthcare, as in all other undertakings, the greatest good is accomplished through mutually beneficial partnerships. No single organization exercising a monopoly can accomplish as much for the common good as can be achieved through the purposeful collaboration of many organizations.

We continue to promote the importance of governance autonomy for healthcare organizations because we believe that too much will be lost if a single organization has complete control over both the funding and the provision of healthcare. Manitoba Health, Seniors and Active Living (MHSAL), the various Regional Health Authorities, and the Boards of the community sponsored organizations each bring a unique perspective and skill set to the challenge of providing the best possible healthcare to the people of Manitoba. If these groups work together, we will find more creative, more patient-centered, more faith, culturally and linguistically appropriate, and more sustainable solutions to healthcare challenges than any one or two of them could find alone.

Some of the significant contributions which autonomous governing boards can bring to their partnership with the MHSAL and the RHAs include:

- Increased community ownership of, and investment in, and commitment to healthcare and health promotion;
- An ability to be reflective of and responsive to local culture and unique population needs;
- The ability to create partnerships across political lines and between diverse community organizations;
- An increased accountability to the local community as well as to residents and their families and to staff;
- The proven capacity to manage scarce resources effectively and address funding deficits creatively;
- The ability to provide objective oversight while remaining close enough to be resident centered.
- An ability to maintain stability in an ever-changing political environment;

- An ability to draw upon diverse resources to address unforeseen needs and unique needs;
- The ability to engage distinct linguistic, cultural and faith communities to inspire a communal commitment to caring for those in need.

MHSAL and the RHAs have the task of creating an overall vision for healthcare and identifying and prioritizing the healthcare needs of the population. Independent governing boards are uniquely positioned to actualize this vision and these priorities in the context of a particular community and culture. To do this, they must have the power to truly govern their organizations and to establish real partnerships.

When independent boards are engaged as true partners, they eminently add value to the healthcare system and enhance the effectiveness of the RHA in achieving its long-term goals and objectives. If they are merely "cultural translators" for the RHA with no real capacity to shape and mold their organizations in response to the community and culture(s) they serve, they will rapidly lose their credibility, and with it, their ability to engage their supporting community. To truly work in collaboration with MHSAL, Shared Health and the RHAs it would be beneficial that NFP LTC facilities have representation on key provincial and regional tables where policy directives, including funding schedules, are first formed.

Faith-based service providers should also be regarded as a valued and irreplaceable part of the Manitoba health care system. Their distinctive contributions to the overall system must be recognized. These include engaging the care and support of various communities, offering residents options that fulfill their cultural and spiritual needs, and carrying on traditions and embracing innovations from which other providers can learn.

We expect that all service delivery organizations will collaborate in a meaningful fashion and that regular discussions will occur at various levels, from day to day operations to governance, respecting the mandate of the various parties as defined in the faith-based and service purchase agreements.

We do recognize that collaboration does not mean consensus.

<u>Service Purchase and Operation Agreements</u>

The responsibility and accountability for negotiating and renegotiating these agreements needs to be defined. In some Regions, the negotiations have proceeded smoothly, while in others, they have been extended. For example, the Winnipeg members of MARCHE invested heavily in the last five years negotiating new Service Purchase Agreements with the Winnipeg Regional Health Authority. We understand that this work will all be put aside and replaced with a mandated standard "business" provincial SPA document, and another SPA like it with the additional proviso of "faith based" organizations.

Within the new SPA, there needs to be a clause that ensures transparency and shared ownership of resident admissions to the NFP healthcare organizations / Affiliated Health

Corporations (AHC), and it is suggested that there should be a more focused reporting process for the larger RHAs, in comparison to some of the rural ones.

Existing faith-based agreements must be honoured, and their core principles, faith, culture and linguistic distinctive values respected when renegotiation of the operating/service purchase agreements are undertaken. It would be important to include the following clauses:

- An AHC is able to allocate a reasonable portion of its funding to enable the organization to provide for organized spiritual care programming as required by LTC standards;
- A distinct appeal process be established should policies or directive by any authority impinge on religious rights;
- Ensure the AHCs do not have to deliver services inconsistent with its faith distinctive;
- That AHCs will not be penalized for non-participation when policy or directive by government or the RHA or Shared Health are inconsistent with the AHCs fundamental faith distinctive.
- The latter should be incorporated into the main body of any new Service Purchase Agreement, and not as part of an appendix.

We believe that the new Agreement for all independent NFP healthcare organizations should be consistent with the RHA Act and its provisions, and ensure that the corporate ownership, autonomy, and governance are assured for these entities providing deliverables are met, care is delivered at the expected level of quality, and we work in a cooperative environment with MHSAL, Shared Health and the RHAs. It would also be important to clearly articulate primary (RHA), and secondary relationships (Shared Health) to the AHCs.

Our organizations must be free to set their own Mission and Vision and Strategic Plans and to engage in other services that do not conflict with the SPA. NFP healthcare organizations should not have to request approval for setting budgets, recruitment and wages of non-union related management and administrative staff or other regular operational activities.

Attached to this document as Appendix I, are the principles under which the MARCHE group negotiated for the past five years.

2) Funding and Accountability Models

We recognize that difficult decisions need to be made by the government about which parts of the health and social system for seniors will be funded by tax payer dollars.
We also acknowledge that long term care is not necessarily part of the Canada Health Accord, and that funding varies across provincial jurisdictions.

We know that there are limited, if any, new tax dollars to be added to the health and social system over the next few years, and things need to be done differently.

A sustainable, equitable funding model for services needs to be developed and implemented in Manitoba that levels the playing field between the three types of ownership of long term care facilities (RHA, NFP and For Profit). In Winnipeg, a "Median Rate" funding model was instituted over 10 years ago as a temporary solution to recognize historical funding inequities. Other Regions use different funding models which may have some merit but any funding model for Manitoba should reflect the needs of Manitobans and their various and unique healthcare service providers.

Allocation of funding among providers should be fair, equitable and without bias. Allocations must consider factors such as the actual cost of delivering care, the quality of care delivered and the extent to which providers are efficient and productive in their use of allocations;

Funding allocations should reflect mandates imposed by the RHAs. RHAs should not seek to require providers to offer goods or services directed by the RHA without adjusting funding levels to reflect cost increases for those services;

Funding should also be provided to permit providers to compensate their employees on the same basis as comparable providers, and thereby enable them to recruit and retain quality staff. There should be no funding bias for or against providers whose employees are unionized.

Winnipeg facilities collect data using the Minimum Data Set (MDS) for reporting through WRHA to Manitoba Health and nationally to CIHI. Rural regions do not. We do not have a common, validated tool to measure resident care needs across the province, and to know whether residents with similar care needs are supported by similar funding across the province.

The funding models should take in to account both operating and capital expenditures. For many years, NFP long term care facilities have participated in "Safety and Security" programs within Regions. Over the last few years, this process has experienced delays (and sometimes cancellations) of three or more years between submitting proposals, and approval of tenders. Often project costs have gone up by the time the work is tendered, and the home is required to cover the increases. Concomitantly, because of the low total amount of funding, many critical infrastructure needs cannot be supported.

Standards, deliverables, and outcome measures need to be determined that make sense in the sector. We support the need to measure the effectiveness of expenditures, and the quality of care delivered for the money spent. We hope to work toward a reporting system that minimizes duplication of data collection and focuses on value added measures.
This data, once reported, should be publicly available and comparable.

Although we support consistent outcome measures and reporting, MARCHE members do not believe that reporting measures introduced under Bill 6 in 2012 enhance transparency or

provide any value to the healthcare system, while adding unnecessary administrative work at all levels.

In conclusion, the members of MARCHE are ready and willing to forge a new and stronger partnership with MHSAL, Shared Health and the RHAs. We believe our long experience and [illegible]sonal care and seniors housing will be critical to reach the goals [illegible]d to seniors' care. We look forward to meeting with you to

Appendix 1

STATEMENT OF BASIC PRINCIPLES AND SHARED UNDERSTANDING
WRHA and MARCHE Members 2015

A. Shared understanding of fundamental principles for collaboration under the Service Purchase Agreement.

The parties seek collaborative processes that are:

- expeditious, amicable and constructive;
- aimed at addressing the needs of both parties;
- based on a shared understanding of the fundamental principles reflected in the existing Service Purchase Agreements and the Agreement on Faith Related Issues; and
- reflective of a desire by both parties to build upon those fundamental principles, rather than to abandon them.

Agreements that preserve the "corporate ownership, autonomy, governance and mission" of health corporations are contemplated by *The Regional Health Authorities Act* (the "**Act**"), and collaborative processes and regional policies should respect those basic principles.

There is in place a Service Purchase Agreement and Agreement on Faith Related Issues between MARCHE members and the WRHA and the Province of Manitoba, respectively which have, on the whole, worked in practice:

- various faith sponsored facilities and supporting communities have retained their sense of ownership and responsibility for not-for-profit proprietary personal care homes ("**PCHs**" or a "**PCH**");
- the people of Manitoba have been given reasonable choice to find residential environments rooted in a particular faith, cultural or other supporting community in which they are treated with dignity by collegial staff who understand their distinctive needs;
- medical care needs have been met in accordance with provincial standards and social, cultural and spiritual needs in the wider living environment at a PCH are consistent with the distinctive values and sensitivities of various communities; and

- MARCHE members have been able to operate in a fiscally responsible manner, with accountability to the WRHA for public funding and to their other stakeholders, including their owners and supporting communities.

Collaborative processes should be clearly understood as a matter of preserving the basic principles contained in the Service Purchases Agreements, which continue to affirm the status of PCHs as autonomous partners with the WRHA in achieving quality care for residents. Collaborative processes must respect the distinctive nature and function of PCHs as people's homes; they must respect that PCHs provide long-term and comprehensive living environments for residents, rather than serving only as the sites for medical care. Regional policies must do the same.

B. The basic principles embodied in the Service Purchase Agreement should guide collaborative processes and regional policies arising therefrom.

The fundamentals include these principles:

- The WRHA and MARCHE members, as autonomous parties, should be partners in meeting shared objectives;
- MARCHE members must be guaranteed the continuation of certain rights that are associated with their independence and autonomy. These rights of "corporate ownership, autonomy, governance and mission" (to use the language of the Act) include:
  - the ownership of their property;
  - the ability to define their mission, including the right of faith-based institutions to maintain and act upon their distinctive characters;
  - the ability to exercise leadership in the carrying out of that mission;
  - the ability to raise money and use it to enrich communities, institutions and programs in ways that supplement, rather than substitute, for governmental support;
  - the authority to select boards and senior executives and to appoint staff, including medical staff;
  - an explicit acknowledgement that PCHs are accountable to all their stakeholders, including the communities which they serve;
- The WRHA should provide funding to support MARCHE members in fulfilling their mission of providing quality health care to their residents and both sides should co-operate on developing a relationship in which limited government resources can be distributed among different facilities in a manner that is timely, equitable and adequate, that ensures high quality care;
- Both sides should recognize that regional health authorities can and should play a vital role in establishing priorities for public funding, in ensuring its equitable and efficient distribution, and in helping to define resident care standards.

C. MARCHE owners and operators have unique Service Purchase Agreements with the WRHA based on the distinctive nature of long-term care facilities, and collaborative processes and regional policies must respect that uniqueness, as summarized below:

- PCHs are primarily people's homes that provide total living facilities to which medical care is also provided;
- The homes that PCHs provide are an even more pervasive aspect of residents' lives than are the homes of ordinary Manitobans. The latter tend to be mobile and have jobs and social lives outside of the home. Residents of PCHs often live their day-to-day lives almost entirely within the physical and social environment provided by the PCHs;
- The staff (including the ED/CEO) is, for many long-term residents, a second kind of family. Warmth and people skills assume a unique importance in this context, as does the stability of staffing. Turn-around in the staff can cause grave upset and emotional injury to the residents of long-term care homes;
- The success of a PCH is largely a matter of whether residents feel they are living meaningful and dignified lives in a supportive social environment. These are matters that are not easily measured or quantified;
- Institutional diversity permits choice for patients, residents, clients and care providers. It allows for innovation and creativity and for everyone in the system to learn from successful innovations.
- The success of a PCH also depends largely on the special understanding that owner/operators have of the needs and wishes of their residents and of the supporting communities from which they come;
- The boards, chief executive officers and senior level staff of PCHs must have substantial authority to make decisions that reflect those distinctive needs and missions, while at the same time meeting provincial standards;
- Without a substantial measure of autonomy and independence, the operators of PCHs will be severely limited in their ability to recognize distinctive needs and missions in the homes, which distinctiveness encourages private investment of time and money necessary to supplement limited government resources.

D. Manitobans benefit from the contribution of time and money by members of the communities which MARCHE members serve. The continuation of this support depends in large part on the continuing independence and autonomy of PCHs.

The erosion of the independence and autonomy of PCHs is liable to seriously impair their ability to raise funds and secure the support of volunteers in order to supplement resources provided by government. Contributors want leaders and key staff of PCHs to be individuals who understand the distinctive needs of residents and their supporting communities. Contributors want the leaders and administrators of PCHs to be able to exercise independent and creative judgment in the best interest of their residents.

MARCHE members believe that contributions of time and money would drop substantially if their PCHs were seen as government agencies, rather than autonomous entities that can make independent judgments and act upon them.

With a greying population, the government, as represented by the WRHA and Manitoba Health, will be harder pressed than ever to meet all the demands that will be placed on the public health and social welfare systems. MARCHE members help significantly in the long-term

care environment by encouraging various communities to share the burden of maintaining high quality PCHs, but essential to any strategy of maintaining and promoting community support must be the maintenance of the independence and autonomy for the PCHs.

The Service Purchase Agreements allow MARCHE members the ability to provide homes rooted in a particular faith, cultural or other supporting community and to express their traditions, beliefs and identity through the provision of services, including health care services. Collaborative processes must also respect these principles, as must any regional policies implemented by the WRHA.