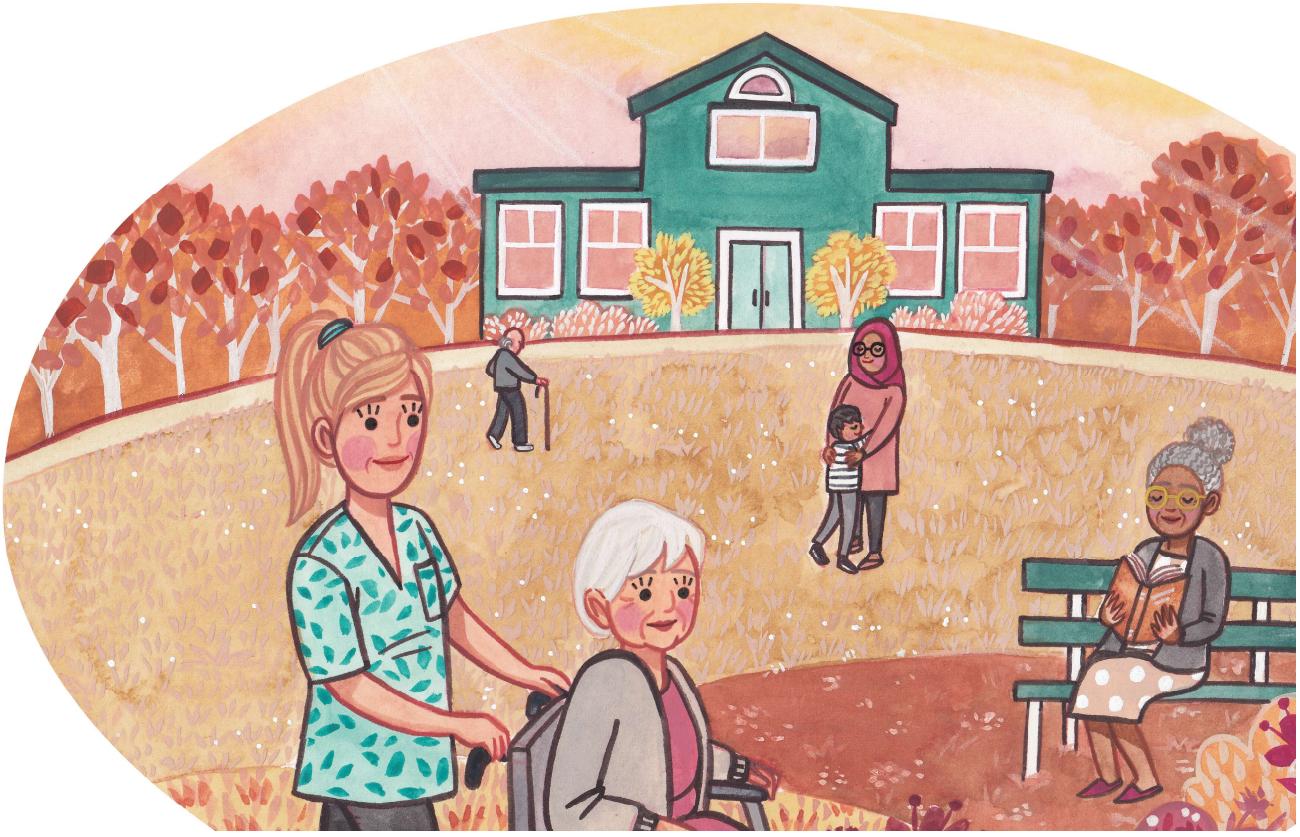
GETTING RESULTS FOR LONG-TERM CARE

In partnership with Saskatchewan's non-profit sector



Suggested citation:
Care Collaboratory (2023). Getting Results for Long-term care: Lessons from Leaders. Saskatoon, SK: Care Collaboratory.

About The Care Collaboratory

The Care Collaboratory is a research group located at St. Thomas More College at the University of Saskatchewan. We focus on the experiences of adults living with disabilities and their friends, family, and healthcare providers. We work through team-mentored, student-led research partnerships focused on achieving the quintuple aim of health equity, community wellbeing, better care outcomes, employee well-being, and good value across the continuing care spectrum. By using patient-oriented and participatory approaches, we aim to improve quality and relevance through collaboration.

Authors:

Jyllenna Landry
Research Associate
Care Collaboratory

Dr. Paulette V. Hunter
Associate Professor
Care Collaboratory

Contributors:

Kayley Lawrenz
Lived Experience Advisor
Care Collaboratory

Dr. Abigail Wickson-Griffiths
Associate Professor
Faculty of Nursing
University of Regina

Yash Tendulkar
Research Assistant
Care Collaboratory

Acknowledgements:
Representatives of Saskatchewan's non-profit long-term care sector generously provided their time, experience, and insights to support this project.

Original artwork by @lovelyworksbyheather is licensed by and used with the permission of Strengthening a Palliative Approach in Long-Term Care (www.spaltc.ca).

The following organizations provided research funding support:

Catholic Health Association of Saskatchewan was formed in 1943 to be a voice for Catholic hospitals and long-term care facilities, and to protect and promote Catholic health care in Saskatchewan. It provides leadership, education, and resources for all who serve in the healing ministry of Christ – in health care, parishes, and communities.

Mont St. Joseph Foundation is a registered, non-profit charity, directed by a volunteer Board of Trustees from Prince Albert, Saskatchewan. Through the generosity of community members, it supports furniture and equipment upgrades, spiritual care, staff training and development, and other special programs and initiatives for Mont St. Joseph Home.

St. Thomas More College is a Catholic undergraduate liberal arts college that is federated with the University of Saskatchewan.

Jyllenna Landry's work on this report was also supported through a Canada Graduate Scholarship from ***Social Sciences & Humanities Research Council (SSHRC)*.**

The views expressed herein do not necessarily represent the views of the organizations providing funding support.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

In 2022, the Catholic Health Association of Saskatchewan commissioned this research report, with Mont St. Joseph Foundation joining the project as a partner. The goal was to learn more about Saskatchewan's non-profit long-term care sector (including faith-based homes, homes operated by non-profit organizations, and homes owned by municipal governments), including the distinctive role of this sector, and the pressures it is currently facing.

Leaders from 37 long-term and integrated healthcare organizations across Saskatchewan were invited to participate, and approximately two thirds did so – a robust response demonstrating the sector's strong interest in the future of long-term care.

As the report further documents, the penultimate concern of leaders in the non-profit long-term care sector is to address the needs and uphold the priorities of Saskatchewan's communities. They seek to provide quality health and disability care, employment opportunities, and community partnerships, while achieving excellent value.

Yet, the sector has been heavily taxed by the pace of change over the last 30 years. These changes include population aging, a shift from hospital-based care to long-term care at the end of life, a pandemic, and the emergence of a province-wide health authority still in the early stages of its organizational development.

The number of long-term care homes within the sector has decreased steadily over the last 30 years, and today, still more homes continue to turn over their keys. These conditions beg questions about Saskatchewan's future plans for the sector (1).

The non-profit long-term care sector and Saskatchewan's health authority are interdependent. Just as the health authority depends on non-profit sector to provide service, so too do non-profit homes rely on the Saskatchewan health authority for concrete forms of support (2). This report illustrates some ways that these interdependencies can be more fully utilized to the benefit of Saskatchewan people. Toward this end, the following recommendations are made:

1. Recognize Saskatchewan's non-profit organizations as distinct organizational partners with their own histories, identities, and missions.
2. Identify the value the non-profit sector brings through its longstanding healthcare experience and relationships with Saskatchewan communities.
3. Initiate work on an equitable model of funding and service to support the non-profit sector, acknowledging the amalgamated health authority as a former organizational partner (by virtue of pre-existing relationships within amalgamated authorities) but also as a new partner (by virtue of new relationships and practices within the centralized health authority) (1,2).
4. Identify service portfolios or models of care that provide unique value to Saskatchewan communities, and/or uniquely complement the services of the provincial health authority. Provide commensurate support for these service portfolios.
5. Expand mechanisms to advance mutual understanding between the provincial health authority and non-profit healthcare organizations. Urgently begin work to identify critical communication gaps.

Long-term care matters to Saskatchewan people. And getting results for Saskatchewan's long-term care sector depends on the robust collaboration of Saskatchewan's healthcare organizations.

LONG-TERM CARE IN CANADA

Many people think of long-term care homes as an unwelcome last stop in a person's life journey. But to those who rely on long-term care or who work in the long-term care sector, a long-term care home is an interdependent community of residents, families and friends, volunteers, staff, and leaders. Within this community, there are many opportunities for expressions of mutual care.

THE CURRENT STATE OF LONG-TERM CARE

Despite the opportunity for rewarding experiences of care and community in LTC, there are many challenges. In Canada, the need for LTC will double as the large "baby boomer" cohort accesses LTC (3, 4). Despite this, the total number of living spaces in Canada has *decreased* over the last decades due to a lack of investment in physical and social infrastructure (5, 6). Long wait times for LTC are straining hospital care (7), and by the time people access long-term care they are, on average, 18 months away from death (8). One result of these changes is that the support needs of those who ultimately access long-term care are consistently much higher than in the past.

These dramatic changes have not been met with a robust change in the LTC service model. Recent media reports illustrated that the Canadian LTC system performed more poorly than that of any other OECD nation during the COVID-19 pandemic, with significantly more deaths arising from infectious outbreaks (9). These problems were attributed to poor policy choices, an erosion of infrastructure, and a

failure to invest in human resources at a pace that keeps up with need and inflation (9).

WHO PROVIDES LONG-TERM CARE?

Long-term care is both a home and a healthcare setting. Across Canada, residents pay for room and board, while provincial governments provide healthcare support, including support for activities of daily living (10). In Canada, overall, 46% of LTC homes are government owned and operated, 29% are owned and operated by private for-profit organizations, and 23% are owned and operated by private non-profit organizations (10). In Saskatchewan, government-owned facilities predominate (74%) with most of the remainder (21%) as non-profit organizations (10). The mix of government-owned, private non-profit, and private for-profit homes varies across Canada, with some provinces and territories relying heavily on government ownership and others, like Nova Scotia, relying heavily on the private for-profit and non-profit sectors (10).

THE NON-PROFIT LONG-TERM CARE SECTOR

Non-profit organizations build LTC homes to support their own community members. This might include people living in the same town or urban neighbourhood, or people who share a faith or cultural community.

The communities surrounding LTC provide important additional value to the sector. For example, in a rural community, citizens often continue to invest in upgrades to an LTC home, knowing that they are supporting their own friends and family members. In faith-based long-term care homes, the moral principles of staff and leaders can help them navigate healthcare dilemmas. The common experiences shared within a cultural community – even very simple things, like what is served for dinner – help to support residents' quality of life.

Thirty years ago, there were 169 non-profit long-term care providers in the province of Saskatchewan, yet, at the outset of this report, just

37 providers remained. As this work unfolded, three for-profit long-term care homes and one municipally-operated non-profit home were amalgamated by the provincial health authority. More changes were underway.

These statistics raise several questions. What forces are driving the amalgamations? What is gained? What is lost? Is Saskatchewan planning to strengthen and encourage the non-profit sector, or to amalgamate all or part of it into the provincial health authority? Which direction provides the best outcomes and value for Saskatchewan's people?

LEADERSHIP IN LONG-TERM CARE

To better understand the experiences of LTC leaders in Saskatchewan's non-profit sector, including how they approach their work, the challenges they face, and their achievements, 23 non-profit LTC leaders were interviewed about their experiences. Together, they represented over half of the non-profit organizations currently providing LTC services in Saskatchewan. Their organizations spanned rural communities, small urban centres, and two mid-size urban centres (Regina and Saskatoon). With an average of 7.8 years in their current leadership roles and 27.8 years in healthcare, non-profit LTC leaders' voices collectively represented over 600 years of healthcare experience. In the following pages, LTC leaders further articulate their leadership experience in the following themes:

- *Success is building community;*
- *Strong leaders are relationship-centred;*
- *Getting results for long-term care;*
- *The need for strong relationships at every level;*
- *Putting quality and equity in focus;*
- *It all goes back to community; and*
- *Collaboration is crucial.*

LEADERSHIP IN THE NON-PROFIT SECTOR

SUCCESS IS BUILDING COMMUNITY

Long-term care homes are tied to communities

Across the non-profit sector, leaders emphasized that LTC homes were built in partnership with communities and for communities. For some LTC homes, these are faith or cultural communities while for others, these are rural communities or urban neighbourhoods. Regardless of the communities they serve, for the leaders of Saskatchewan's non-profit LTC homes, their work is intrinsically linked to community.

LTC leaders strive to honour the histories of their organizations within their respective communities. They see it as part of their role to continue to foster reciprocal relationships with these communities by providing care for community members as they age; providing employment opportunities in their communities; being good stewards of healthcare and community resources; and developing a wider range of programs or space-sharing partnerships with reciprocal benefits to community, including daycare services, school programs, fundraisers, animal training programs, and more. Providing high quality care and support to community members is their penultimate goal.

Leaders were appreciative of the ways community members went out of their way to support LTC homes —from dropping off baking and leading activities to raising hundreds of thousands of dollars for

needed supplies. Community support motivated and supported leaders, reinforcing their vision of community-oriented work.

Leaders were uneasy about policies that deprioritized the match between the community identity of long-term care homes and the residents and families they support. For instance, Saskatchewan's LTC placement policy specifyies that residents can be asked to move up to 150 km away to access available long-term care support to address a shortage of available long-term care beds.

Although leaders were pleased to welcome and support people from outside their own cultural or local communities, they gave examples of limitations. One leader told the story of a resident who came to stay in their community. The resident did not speak English, and their primary support for communication was a spouse who did not drive. No one in the LTC or surrounding community spoke the resident's language. The move took a serious toll on the resident's mental health and quality of life, and the resident wept every day. Moral distress about the situation was so high that the family, multiple staff members, and the leader ultimately insisted the provincial health authority find a way to return the resident to their home community. They succeeded, but only after the resident experienced four months of grief.

Overall, leaders worried that eroding historical ties between LTC homes and communities ultimately compromises the quality of care.

"These are people that have served our community. They are our elders and the pillars of our community. They shouldn't be warehoused."

Long-term care is ideally about supporting community participation

LTC leaders emphasized that residents' wellbeing fundamentally depends not only on having basic needs met, but on being supported to participate in their communities.

To facilitate meaningful participation, leaders found it hopeful to focus most on residents' abilities, rather than on their health conditions and disabilities. For those living with progressive disabilities like dementia, they expanded their focus to include residents' past and present contributions to the community, including through work, community engagement, family roles, friendships, and the everyday life of the LTC home.

Leaders described recreation programs as a key way to support engagement in community life within and outside the long-term care home. But they also mentioned the importance of specific contributions to the wider community, such as when a group of residents raised thousands of dollars for the Terry Fox run.

"The residents believed in supporting their community. They contributed to their community, and that's powerful beyond description. It's not enough for us to bathe and feed people if we don't remember that they are *people* – aged people, most of them, who are young at heart. And all they want to do every day is do the best they can."

STRONG LEADERS ARE RELATIONSHIP-CENTRED

Leaders recognized that community participation requires strong relationships among residents, family members, volunteers, staff, and leaders. When LTC leaders were asked to reflect on their successes, they consistently spoke of cultivating a mutual sense of support among these members of the long-term care community. They sought to promote an environment where residents want to live and where staff want to work. To them, strong leadership was relationship-centred.

Relationship-centred leadership is principled

The following guiding principles were evident in the way leaders spoke about their work:

1. ***Work from a collective mission and vision rather than a personal one.*** LTC leaders recognized that the LTC community would outlast their own involvement and the involvement of current residents, families, and staff. To them, the key to a stable organizational identity and a thriving organization was to work from a collective mission and vision rooted in the community's shared values, rather than from a personal mission and vision.

   "You look at really successful healthcare organizations, and a longstanding core mission has driven everything they've done. Their mission drove how they worked, how they acted, and what they would prioritize. When you're changing your mission and your goals every three to five years, you have no core mission."

2. ***Everyone's personhood matters.*** Through LTC leaders' comments, it was evident that person-centred care requires *relationship-centred* leadership. In this approach, everyone in the community, including family, friends, volunteers, staff, and leaders, must know they are respected and they belong. This ultimately cultivates an environment where residents can be confident they matter to the community.

3. ***Keep relationships at the centre.*** People-centred leadership ultimately meant nurturing strong relationships at every level. Although LTC leaders had meetings to attend, policies to review, emails to respond to, and documents to file, they knew they could not effectively lead an organization as bureaucrats. Instead, they aspired to keep a balance between necessary organizational functions and maintaining quality connections with residents, families, and staff. Additionally, they dedicated some of their time to building relationships with the wider community, other LTC organizations, and with the provincial health authority.

4. ***Remember that trust must be earned.*** Leaders believed that when relationships among LTC community members are not thriving, then trust has not been earned. Even if another healthcare experience or another person had damaged trust, leaders believed the only way forward was to build quality relationships and *earn* trust.

5. ***Lead by example.*** LTC leaders followed the golden rule, "do unto others as you would have done to you". Their relationship-centred approach emphasized modeling the same skills they hoped to see their employees use. This included acknowledging mistakes and striving for improvement.

Relationship-centred leaders share power with others

LTC leaders believed their greatest influence over care quality was through the LTC staff who directly support the residents. By seeking to create strong, supportive relationships with their staff teams, leaders aimed to model how they hoped staff might relate to residents.

"If the staff are feeling disempowered, they're going to be looking for power, and the easiest place to find that is through the residents. But if leaders empower the staff – which means that the staff are well equipped and have everything they need to do what you're asking them to do, and they understand the values – then the staff can empower the residents."

Several leaders emphasized that in addition to providing staff with the necessary resources and guidance, it was important to create a climate that enabled staff to lead. They recognized that staff have a firsthand view of problems in care delivery. When staff feel heard and understood and are given the permission and resources to make the necessary changes (as consistent with the organization's mission and values) significant shifts in care quality can take place quickly.

"When staff can begin to share their successes and challenges and the reasons behind them, healthcare teams can begin to move mountains."

Relationship-centred leaders are sustained by a network of support

LTC leaders acknowledged that every day they face the dilemma that it is not possible to adequately meet residents' needs or families' expectations within available resources. However, seeing other staff and leaders working to support the wellbeing of LTC residents or communities bolstered their hope.

Hope eroded when support from healthcare partners weakened. In particular, for some leaders with long careers in the sector, witnessing the steady erosion of the non-profit LTC sector and the steadily increasing challenge of effectively addressing the support needs of residents within available resources, had resulted in demoralization.

To weather these challenges, leaders spoke of the importance of relying on a network of support, including relationships with their own family members, their home communities, their staff, and other LTC organizations.

They emphasized that effective leaders are mentored leaders. Their past and present mentors served as essential career guides, coaching them to maintain a focus on the wellbeing of residents, families, and communities. They continued to seek out mentorship to improve their leadership skills.

"We all make decisions that, in hindsight or with more information, we might have done differently. You pick yourself up, learn from it, and move forward. But I think it's really important for people to know they have support."

Relationship-centred leaders advocate

As direct witnesses to the needs of residents, families, and staff, non-profit LTC leaders felt compelled to respect these relationships by openly acknowledging the LTC sector's deficiencies and actively pursuing necessary changes.

During the COVID-19 pandemic, media reports regularly emphasized the sector's shortcomings, resulting in a strong public focus on LTC. On one hand, this felt like a deeply personal commentary on their work, but on the other, it was seen as a very important form of support. It felt like the public had finally heard what LTC leaders had been saying for years—decades even—and had joined the call for change. LTC leaders felt it was vital for members of the public to continue to become aware of the needs and challenges in LTC and join the effort to identify solutions.

"You know, everybody was shocked during COVID that these older people [were] living in these conditions. Well, that's how we [as a society] valued them. We need people to say, 'This is terrible. These people deserve so much more. This has to change!"

They believed LTC residents and their closest supporters, including family and friends, ought to have the strongest voice in quality improvement. Yet, they perceived significant barriers. For instance, the average stay in LTC is very short, and often stressful for family caregivers, limiting available time and energy for advocacy. When a resident dies, family and friends who were once motivated to advocate for change often need to shift their focus to other areas of life.

"A lot of things need to change, but until the families and the residents are comfortable and believe that they have a voice and they can share, I don't think we are going to see a whole lot of change. Once residents and families begin to expect and

demand change in the system, I think that's when we're going to see it."

Equipped with relevant experience and knowledge from their own organizations, many non-profit LTC leaders felt compelled to speak up for residents and families. They feared that without relief, intensifying pressures on the LTC sector could result in the provincial health authority amalgamating more non-profit LTC homes. They worried that as more of these homes disappear, the needs and interests of the acute care sector and the risk management interests of a large healthcare organization could overwhelm the interests of the long-term care sector.

GETTING RESULTS FOR LONG-TERM CARE

Neglecting long-term care wastes dollars and undermines value

Many LTC leaders expressed concern that Saskatchewan is not getting good value for money with the current approach to LTC service delivery, including the model of care, staffing mix, funding model, and number of homes. They described how the current approach builds in waste rather than quality by emphasizing high use of hospital services and contributing to staff absenteeism and turnover problems.

Number of homes. Leaders explained that there are currently not enough LTC homes to meet the need. This has several downstream consequences. For example, most people arrive in LTC after waiting as long as 2 years, with complex health conditions and requiring a high level of health functional support. During their wait for LTC service, they frequently access emergency departments and may have hospital stays several months long at a much higher dollar value than LTC.

Funding to meet the needs. A downstream effect of minimizing available LTC spaces is that the average LTC resident arrives with very complex care needs and dies within 18 months of admission. Although many leaders believed improving access to home-based services was consistent with the values of many Saskatchewan people, all leaders voiced that there must also be more attention to the influence of this policy choice on LTC residents' current support needs. Today's funding model has not kept up with resident needs *or* with inflation.

Model of care. Given the available funding, LTC organizations have simplified their staffing model to emphasize two things: (1) a minimal standard of functional support, such as with toileting and assisting at meals; (2) a minimum standard of group recreational programming to contribute to quality of life. This rebalancing has reduced access to professional staff, and most homes lack a robust interdisciplinary team (e.g., advanced practice nursing, physical therapy, pharmacy, occupational therapy, social work, psychology, spiritual care). Access to physician care is also very limited, though for other structural reasons. The net effect is that the skill mix is not well matched to the holistic care needs of residents. This situation leaves residents, families, and staff feeling under-supported.

Staffing. Staff turnover and absenteeism is very high in healthcare, and this is a particular problem for the long-term care sector. Several leaders expressed that having the right care model, staff mix, and staff ratio is part of the solution to the current staffing crisis. When staff become overburdened by healthcare work and are absent or quit, homes must either rely on contract staff (at a higher cost) or on overtime. Small LTC organizations find it very hard to bear these costs, yet many maintain significant staff overtime budgets (i.e., they budget for waste) because solutions are not readily available. In rural settings, this is a particular problem. For example, in some areas of the province, contract staff are not available, and it is not possible to attract enough casual staff to cover absences.

Improving value

Ultimately, most non-profit LTC leaders believed an increase in the number of LTC homes would be necessary to meet the needs of the aging population. In addition, they believed an increase in funding would be necessary to keep up with inflation, ensure buildings and equipment meet current standards, address the increasing level of resident support needs within the LTC sector, and enhance staff retention. Nevertheless, they advocated against 'throwing money at

the problem' and called for a strategic approach to improving healthcare quality, safety, and value.

"I'm very cautious about saying 'just throw more money at it.' It needs to be done correctly. It needs to be done with the residents in mind. They are the centre of what we're doing."

LTC leaders believed an effort to improve the quality, safety, and value of LTC begins with identifying a standard of care, which is then translated into practice through a corresponding model of care, and supported by an appropriate staffing model and building design – with each of these efforts guided by residents' support needs. Progress towards a standard of care for long-term care has been slow. Leaders commended the Ministry of Health's introduction of new LTC standards during the pandemic (11). However, they also expressed concern that these standards are not achievable without an associated staffing standard and an adequate funding base to support that standard.

THE NEED FOR STRONG RELATIONSHIPS AT EVERY LEVEL

Non-profit organizations value healthcare partnerships

Non-profit LTC leaders were proud to be experienced healthcare organizations delivering value for Saskatchewan residents. They believed they were providing quality care for good value because of their organizational experience and ability to leverage relationships with local communities. They maintained strong interest in partnering with the provincial health authority to provide long-term care service and associated knowledge and experience.

Non-profit LTC leaders also expressed strong appreciation for the support they received by partnering with the provincial health authority. The forms of support that were most valuable varied significantly from one organization to the next and included:

- *Direct funding to provide healthcare services to residents;*

- *Integrated support for long-term care access and system flow;*
- *Access to clinical guidance and consultation support; and*
- *Provision of infection prevention and control supplies during the first year of the COVID-19 pandemic.*

There was more diversity when it came to payroll, financial services, human resources management, and scheduling. Some were satisfied with the current level of support, while others wished they could access more support in one or more of these areas, and still others preferred to manage some or all of these functions within their own organizations.

Contributing to the variety of partnership preferences was the range of partnerships that had evolved prior to the formation of the provincial health authority. For instance, in some areas, arrangements for support with payroll, financial services, human resources management, and/or scheduling were longstanding, while in others they were non-existent.

Also contributing to the variety of preferences was each organization's own history and identity. It was important to non-profit organizations to engage their community members in decision-making or align their decisions with organizational missions and values determined priorities. Non-profit organizations were cautious about outsourcing functions if there was a risk these choices might be disadvantageous to the communities they served. They sought partnerships based on a specific knowledge of and investment in their respective communities.

Non-profit organizations feel like "second class" partners

All non-profit organizations were interested in fostering mutually beneficial collaborations with the provincial health authority through mutual exchanges and by maintaining an awareness of each other's roles and responsibilities. To them, the main sign of a fully engaged collaborative partnership was the capacity to work together to address challenges as they arose.

Yet, non-profit LTC leaders conveyed a sense that they were seen as 'second-class' partners that could easily be done without. They were perplexed by the sense that their organizational knowledge, experience, and skill did not seem to count. They stressed that in a context as strained as LTC is today, their longstanding experience negotiating the issues the LTC sector faces, such as staff recruitment and retention challenges, is relevant to supporting the sector's needs.

Non-profit LTC leaders readily acknowledged that the provincial health authority is relatively new – a young organization just faced with a global pandemic. Most attributed the indifference they perceived to a lack of knowledge on the part of provincial health authority employees; for example, some are likely not aware that LTC homes can be owned and operated by the health authority, by non-profit organizations, or by for-profit organizations, and others have not considered the implications.

They mentioned that a lack of awareness of the non-profit sector can lead to incorrect assumptions, such as taking for granted that LTC homes have access to health authority knowledge or resources. For example, non-profit leaders might be asked to navigate to a shared drive for important leader updates, but on requesting access, be denied because they are not owned and operated by the health authority. In addition, when non-profit LTC leaders ask the health authority for support with an issue, they have the sense that the employees themselves are uncertain how to navigate the organization to support a resolution. Restructuring and role turnover is sometimes a contributing factor.

"When I reach out to you and I ask you to have a conversation with me about a situation, I need to know that you're hearing me; that you understand the urgency of the situation. This isn't about me. This is about an individual that needs care. I'm calling you because I have a situation and I need your support.

When you call, I want you to trust that I'm here to listen and respond with my full attention."

Some non-profit LTC leaders noted that while their leadership roles are recognized and respected within their own organizations, they do not have the same sense from health authority leaders. They feel their organizations are treated as health authority subsidiaries rather than health authority partners, and they are tacitly demoted in rank.

One situation that activated this sense was the difficulty they had in accessing LTC decision-makers outside of heavily structured "cascading huddles" – daily large group meetings focused on translating and achieving specific SHA goals. They emphasized that their concerns often require time-sensitive decision-maker input; otherwise, they would manage within their organizations. Yet, urgency seems to be lost as messages are referred "up the chain of command". Some doubted their requests had ever reached senior personnel.

"I hear the word 'collaboration' a lot, but the feeling doesn't exist. That's probably what hurts the most – the use of the word collaboration with an absolute absence of *actual* collaboration."

Although each of these rebuffs could easily be contextualized, leaders worried that the overall pattern of interaction ultimately impeded problem-resolution for the residents and families who are relying on their organizations.

They contrasted their experience with provincial health authority's engagement framework, which emphasizes holistic, community-centred care. They emphasized that their organizations are deeply rooted in community and well-positioned to enact this engagement framework. They perceived that many of the actions needed to foster stronger mutually supportive partnerships with the provincial health authority are very straightforward and believed that everyone stands to gain by making these changes.

PUTTING QUALITY AND EQUITY IN FOCUS

A point of pride for non-profit LTC leaders is that their diverse organizations previously negotiated the *Principles and Services Agreement* – an agreement among multiple regional health authorities and several non-profit organizations about the principles of partnership supporting LTC delivery. This agreement formed the basis for a mutual understanding of respective roles and responsibilities. A key feature was a provision for collaborative consultation on the budget allocated to each non-profit LTC provider.

The problem is that the agreement has not been renewed since 2012 – more than a decade ago. Moreover, the health regions that originally partnered with the non-profit sector to reach this agreement have now been amalgamated as a provincial health authority, and no alternative agreement has been reached. Since the last renewal of the agreement, before the creation of the provincial health authority, there has been an increase in the level of care long-term care residents are needing, long-term care infrastructure has aged another full decade, and a global pandemic has resulted in additional work strain and cost inflation.

Adding to the concerns of non-profit providers, the provincial health authority has not collaboratively renegotiated each organization's budget the way the health regions had in the past, leaving non-profit LTC providers effectively stuck in previously negotiated contracts that do not properly recognize current needs.

Meanwhile, LTC providers have a growing awareness of each other's service and funding arrangements. One leader cited examples of some LTC organizations receiving twice the dollars per resident per day others did. The term most frequently used to describe these differences was "inequity". While non-profit LTC providers were prepared to support each other's work no matter the differences, they are concerned about equity for LTC residents.

One leader illustrated the problem using this simple example: Let's say two homes receive the same amount of funding. The first home manages its own human resources department while the other relies on the provincial health authority's department. The first home must dip into its budget to fund the human resources department while the second home has more funding to support LTC residents' care needs.

"Originally, affiliates did all of their negotiations with the Ministry of Health. Some homes had really good funding support, while other homes had pretty miniscule support. Then the health districts were introduced, followed by health regions, and then the health authority. Each time, the decision-making about budgets got more and more consolidated, but they never did that fundamental balancing. So, the homes that had really crappy funding to begin with continue to have really crappy funding, and we just keep floating everybody up – everybody gets an extra dollar. That's equality, but we need equity. A resident who moves into LTC today should be able to expect the same good quality care, regardless of what funding arrangement was negotiated 35 years ago."

It is not yet clear whether the provincial health authority will renegotiate the *Principles and Services Agreement* as a new partner. What is clear is that the provincial health authority and non-profit LTC providers need a working relationship to collaboratively get results for LTC. This relationship must be founded on the recognition that Saskatchewan's non-profit LTC providers are distinct organizations seeking to represent the interests of the communities they serve.

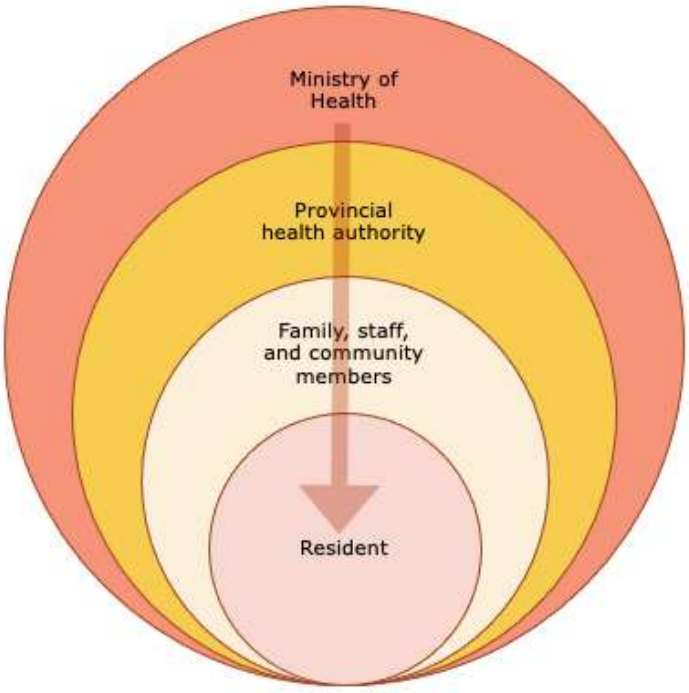
CONCLUSION

IT ALL GOES BACK TO COMMUNITY

A sense of neglect is the first step to perceiving that one does not truly matter; that one is being tolerated rather than celebrated (12). Many people believe LTC residents have been neglected – warehoused in institutions and excluded from the wider community. Non-profit LTC leaders actively work against this sentiment, seeing the potential for LTC homes to functions as small communities embedded within larger ones. When an LTC home feels like a community, and maintains a vibrant relationship with the surrounding community, a sense of abandonment fades, and people know they matter (12, 13).

The classic paradigm of resident-centred care

For decades, the LTC sector has advocated for a resident-centred philosophy of care – an approach where LTC residents' values guide care delivery (14, 15). This approach opposed the medical model that prioritized health providers' expertise and institutional efficiency (16).



Well-intentioned healthcare hierarchy

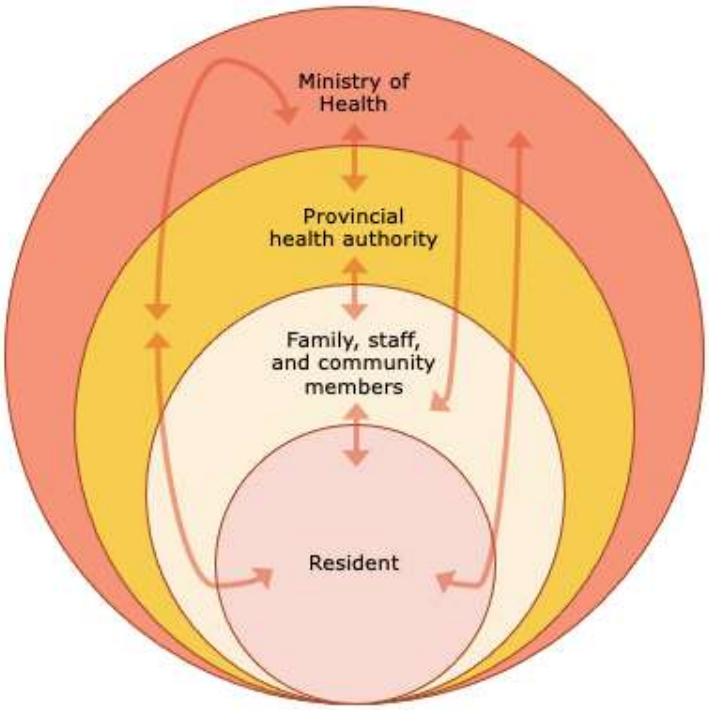
Although this approach had the potential to be a powerful paradigm shift, many people believe the concept of resident-centred care never fundamentally changed LTC. Ideologically, residents were

positioned at the centre of health providers' efforts, but in practice, the new goodwill continued to carry strong remnants of ageism, ableism, and paternalism. LTC residents continued to be on the receiving end of the decisions of a well-intentioned healthcare hierarchy rather than engaged in co-determining the forms of support they needed to participate in their communities.

A paradigm shift to relational care

Collectively, non-profit LTC leaders seem to have moved beyond resident-centred care, toward a relationship-centred approach to care. This approach works against paternalism in a seemingly paradoxical way – by recognizing the inherent worth of *everyone* in the LTC community, including residents, family members, staff, leaders, healthcare partners, and decision-makers (17).

One way of envisioning relationship-centred care is as circles of supportive relationships. When these relationships are fully engaged, they enable fuller participation in community. To achieve this, relationship-centred leaders cultivate supportive and interdependent relationships between residents, families, staff, and others (13, 18). When residents, families, volunteers, and staff feel they matter to each other and to the organization, they support each other, shaping the culture of care



Relationship-centred care

(13) and improving resident care and quality of life (19).

The concept of relationship-centred care extends offers a new opportunity for a paradigm shift. Many LTC leaders aspire to a future where people at all levels participate in co-determining the future of LTC.

COLLABORATION IS CRITICAL

The provincial health authority and the non-profit LTC sector each share a goal of achieving high quality care for Saskatchewan people. Each faces challenges achieving this goal given the current allocation of resources. Each has critical resources they can offer the other to address the problem. The non-profit sector offers direct service, decades of experience, and the potential to leverage community relationships. The health authority provides budget, policies, clinical guidance, and a range of essential supports to strengthen healthcare quality and equity.

The non-profit LTC sector and the provincial health authority have also arrived at largely the same vision for guiding improvements to healthcare. The provincial health authority's engagement framework emphasizes people-centred care – an approach that places Saskatchewan people and communities at the centre (20). Similarly, LTC leaders emphasize a relational, community-centred approach. These healthcare organizations are mutually positioned for stronger reciprocal engagement based on the principle that if Saskatchewan LTC residents are to know they matter, strong relationships must be present at every level.

REFERENCES

1. The Provincial Health Authority Administration Regulations (2017). Regina: Government of Saskatchewan.

2. The Provincial Health Authority Act (2017). Regina: Government of Saskatchewan.

3. Banerjee, A. (2007). An overview of long-term care in Canada and selected provinces and territories. Women and Health Care Reform.

4. Gibbard, R. (2017). Sizing up the challenge: Meeting the demand for long-term care in Canada. Ottawa: The Conference Board of Canada.

5. Béland, D., & Marier, P. (2020). COVID-19 and long-term care policy for older people in Canada. Journal of Aging & Social Policy, 32(4-5), 358-364.

6. Statistics Canada. Nursing and residential care facilities in 2020. *The Daily*, Nov 22, 2022. Accessed on March 15, 2023: https://www150.statcan.gc.ca/n1/en/daily-quotidien/221102/dq221102c-eng.pdf?st=t8QK_0O9.

7. MacKinnon, J. C. (2017, July). Wait times in Canada. In Healthcare Management Forum (Vol. 30, No. 4, pp. 190-192). Sage CA: Los Angeles, CA: SAGE Publications.

8. Hunter, P.V., McCleary, L., Akhtar-Danesh, N., Goodridge, D., Hadjistavropoulos, T., Kaasalainen, S., Sussman, T., Thompson, G., Venturato, L., & Wickson-Griffiths, A. (2019). Mind the gap: is the Canadian long-term care workforce ready for a palliative care mandate? *Ageing & Society, 40*(6),1223-1243.

9. Canadian Institute for Health Information. (2020) Pandemic Experience in the Long-Term Care Sector: How Does Canada Compare with Other Countries? Ottawa, ON: CIHI.

10. Canadian Institute for Health Information. Long-term care homes in Canada: How many and who owns them? [infographic]. Accessed December, 2022. https://www.cihi.ca/en/long-term-care-homes-in-canada-how-many-and-who-owns-them

11. Saskatchewan Ministry of Health (2021). Program Guidelines for Special Care Homes. Regina: Government of Saskatchewan.

12. Flett, G.L. & Heisel, M.J. (2021) Aging and feeling valued versus expendable during the COVID-19 pandemic and beyond: a review and commentary of why mattering is fundamental to the health and well-being of older adults. *International journal of mental health and addiction, 19*(6):2443-69.

13. Brown Wilson, C. (2009) Developing community in care homes through a relationship-centred approach. *Health & social care in the community,17*(2):177-86.

14. Eales, J, Keating, N, & Damsma, A. (2001). Seniors' experiences of client-centred residential care. *Ageing & society, 21*(3):279-96.

15. Clemens E, Wetle T, Feltes M, Crabtree B, Dubitzky D. (1994). Contradictions in case management: client-centered theory and directive practice with frail elderly. *Journal of aging and health. 6*(1):70-88.

16. Williams B, Grant G. (1988). Defining 'people-centredness': making the implicit explicit. *Health & social care in the community, 6*(2):84-94.

17. Rockwell J. (2012) From person-centered to relational care: Expanding the focus in residential care facilities. *Journal of gerontological social work, 55*(3):233-48.

18. Lloyd, L. (2004). Mortality and morality: ageing and the ethics of care. *Ageing & society, 24*(2):235-56.

19. Haunch, K., Thompson, C., Arthur, A., Edwards, P., Goodman, C., Hanratty, B., Meyer, J., Charlwood, A., Valizade, D., Backhaus, R., & Verbeek, H. (2021). Understanding the staff behaviours that promote quality for older people living in long term care facilities: a realist review. *International journal of nursing studies, 117*:103905.

20. Saskatchewan Health Authority. Engagement [infographic]. Accessed on July 17, 2022. https://www.saskhealthauthority.ca/our-organization/our-direction/engagement