Brief
to the

Government MLA Task Force on Continuing Care Health Service and Accommodation Standards

ALBERTA
MEDICAL
ASSOCIATION

July 2005

EXECUTIVE SUMMARY

The Alberta Medical Association (AMA) is the professional association representing Alberta's 7,700 physicians/physicians in training and a spokesperson for the medical profession on quality of care issues. The AMA supports a comprehensive framework of provincial standards for continuing care. The *Draft Alberta Continuing Care Health Service and Accommodation Standards* covers many of the areas we have, in the past, identified for care standards and medical input. We also see a need, however, to bring the proposals into alignment with important patient care principles and to strengthen the standards in noted areas.

The AMA's input is focused on the medical perspective of delivering quality care. It is not intended to be exhaustive, but instead to highlight certain issues that stand out regarding appropriate standards. We would be pleased to continue to provide medical input and would welcome an integral role in future discussions.

For physicians, the key issues are:

- **Standards** – must be fixed benchmarks, consistently applied and measurable, including financial/resource accountability
- **Staffing** – resources must be available and then managed to provide adequate staffing levels with skills to match the complexity of patient care responsibilities
- **Provider education** – more training is needed to enhance the geriatric skill sets of current and future providers, enhancing the system's ability to mentor

GENERAL PRINCIPLES

Standards

- Standards define basic requirements that must be met, universally applied and measured. The draft document, however, often treats standards as moving targets. If allowed, the erratic nature of such discretionary targets will promote uneven, substandard care across the province.

Timeliness

- The draft standards should more explicitly set out expectations and accountabilities regarding timeliness of access and delivery of services.

Scope/Applicability

- Health service standards for continuing care should apply equally in public and private delivery settings. Individuals who receive home care for less than three months should not be excluded from the standards.

Monitoring compliance

- An improved and authoritative process for monitoring compliance with provincial standards is needed, conducted by one body, without variation from region to region.

MEDICAL CARE ISSUES IN THE STANDARDS

Standard 1.13 Medical Services

- The patient-physician relationship is central to quality patient care. The patient has the right to receive care from the physician of his/her choice.
- It may be appropriate to apply the same standards to supportive living settings that are proposed for nursing homes and auxiliary hospitals.
- There is no one-size-fits-all solution to delivering on standard 1.13 for nine regional health authorities (RHAs) and the mix of public/private/voluntary sector facility operators. The focus for standards must be on the ends to be achieved vs. the method of delivery.
- The AMA favors a provincially or regionally mandated process to develop (i) standardized service agreement templates and (ii) standardized processes for appointment of medical advisors that can take local factors into account.
- Standards to support education and enhancement of geriatric skill sets for medical advisors should be implemented.

Regular medical review

- It is a more relevant standard to require an annual clinical review than an annual physical exam.

Wellness promotion

- Health promotion and illness prevention should be based on assessment of whether the preventive service will provide a significant benefit.

PATIENT SAFETY ISSUES

Medication administration/management

- Staffing levels must be sufficient to administer drugs at exactly the right time, in the right way.
- Staff monitoring medications, especially antipsychotics, need the appropriate skill set to recognize therapeutic impacts.
- There should be a level playing field for coverage of drug-related costs in supportive living settings and care centres.
- Standards should clearly address issues of staff responsibility, including ensuring physicians' orders are followed, use of chemical restraints, etc.

Staffing

- The need for higher staffing levels and skills for managing the increasing and complex needs of the frail elderly will continue and must be addressed.
- The determination of appropriate staffing mix must be linked to specific, evidence-based criteria.
    - Planning must also consider the potential impact of standards and new administrative systems (e.g., MDS) on available nursing time for direct patient care.
    - Standards should set the maximum case load for case managers as well as ensure their education and skills match the complexity of patient care needs.

Comprehensiveness of care

- Standards should clearly articulate expectations for access to a comprehensive range of care for those with multiple, complex health problems.

IMPLEMENTATION OF MDS

- While adoption of this well-recognized set of quality indicators and performance measures is to be applauded, implementation will raise a number of issues:
    - Communication with physicians regarding the impact on their practice and care delivery with opportunity to provide medical input.
    - Implementation will impact on time available for patient care over a lengthy period; appropriate coverage is required.

OTHER DRAFT STANDARDS

- Standard 1.5[d]: Code status/do-not-resuscitate orders should indicate the role of the case manager and ensure appropriate physician-patient discussion and documentation.
- Standard 1.3: Family liaison function in facilities and supportive living should address the need to designate someone from staff to work with families.
- Standards 1.8 and 1.9 regarding the legislative framework: Raise the issue that the existing legislative framework is a barrier to innovation and required changes.

PHYSICIAN EDUCATION/TRAINING ISSUES

- There is a serious shortage of physicians trained in geriatrics. Need continues to outpace ability of medical schools and programs to respond, and more capacity must be built into the system both to train new providers and to give current providers access to short- or long-term geriatric education.

BRIEF TO THE
GOVERNMENT MLA TASK FORCE ON CONTINUING CARE
HEALTH SERVICE AND ACCOMMODATION STANDARDS

FROM THE
ALBERTA MEDICAL ASSOCIATION

Medical/Professional Issues in the Auditor General's Report and *Draft Alberta Continuing Care Health Service and Accommodation Standards*

July 2005

The Alberta Medical Association (AMA) is the voluntary professional association representing Alberta's 7,700 physicians/physicians in training and a spokesperson for the medical profession on quality of care issues. Through past and present work done under the auspices of our Health Issues Council, physicians have taken on an active role in responding to proposals for changes affecting patient care in Continuing Care delivery. The importance of the issue for the medical profession is reflected in past briefs to the Long Term Care Policy Advisory Committee, the status report we submitted to ministries and regional health authorities (RHAs) on care quality issues arising from deinstitutionalization, and our meeting with the Auditor General.

With respect to the 2005 consultation for continuing care health service and accommodation standards, the AMA input is focused on the medical perspective of providing and maintaining quality care. The AMA recognizes that the task force will hear from many interested parties during this consultation process and that other groups will provide you with a comprehensive understanding of issues in other areas. Accordingly, our input is not intended to be exhaustive or all-encompassing but instead to highlight certain issues that stand out regarding appropriate standards for care delivered to older Albertans with more complex care needs. We would be pleased to continue this process of providing medical input in the months to come and would welcome an integral role in discussions around changes to this sector.

INTRODUCTION

In relation to medical and patient care issues, our previous correspondence identified five main areas of interest for the profession: (1) revisions to existing standards; (2) risks to patient safety; (3) quality of care monitoring and its implications for medical practice; (4) the need for care standards in the supportive living sector; and (5) physician education/training for Continuing Care.

All except the fifth item are encompassed to some degree within the scope of the proposed draft standards. Therefore, we will address our concerns in the format provided by the draft document, commenting on the five issues as they apply for each content area.

DRAFT CONTINUING CARE HEALTH SERVICE STANDARDS

The medical profession has been a strong proponent for a comprehensive framework of provincial standards to govern care delivered in an evolving range of care settings. For physicians, the need to establish system-wide benchmark standards has been a high priority. We, therefore, welcomed the Auditor General's recommendations for standards governing care centres and supportive living and the joint ministries' action in releasing *Draft Alberta Continuing Care Health Service and Accommodation Standards* on June 27.

We are reassured by the fact that the draft document covers many of the areas that we identified for care standards and medical input. At the same time, we see a number of issues of general principle or other concerns where proposals must be strengthened to fully address the findings in the Auditor General's review.

A. General Principles

(1) Standards – fixed measures of quality and accountability

Standards define basic requirements that must be met. By definition, they are fixed benchmarks, universally applied and measurable, designed to assure even quality and clear accountability.

The "Draft Continuing Care Health Service Standards" is not always consistent in applying this concept of "standard" as a fixed benchmark. Because provision of appropriate care for assessed needs is the standards' intended outcome, standards are the factors that must determine resource allocation – and not vice versa. Ministries and regional health authorities are ultimately responsible and accountable for delivering a system that functions appropriately, and this entails appropriate allocation of resources to support intended outcomes.

Sections of the standards document that highlight this concern include Standards 1.11 (regarding mix of providers) and 1.17 ("Therapeutic Services"). We feel that it is essential to have fixed standards for these issues rather than the suggested moving targets. If variable, discretionary factors of budgets and programming are not removed, the erratic nature of these requirements will promote uneven care across the province, confusion among Albertans about what to expect in terms of publicly funded care, and unfairness in that some Albertans will have their needs met through Continuing Care while others will not.

(2) Timeliness of service

There is no explicit reference in the health service standards to timeliness in access to, or delivery of, services. Since timeliness is intrinsic to quality care, it is important for the standards to be more specific in terms of these expectations and accountabilities.

(3) Scope/Applicability

- Standards are meant to provide assurance of basic care that Albertans should expect. There is no valid reason to discriminate between Albertans who receive publicly funded services and those who receive privately delivered ones. The health service standards should apply to Continuing Care services wherever they occur.

- We do not understand why the "Draft Continuing Care Health Service Standards" exclude individuals who receive Home Care for less than three months. In keeping with the previously noted principle, anyone receiving Continuing Care should benefit from the assurances and protections of basic standards from the time they enter Continuing Care. We are unaware of any current standards governing Home Care when delivered for less than three months and question the rationale for including any such criterion now. There could be conflicts in interpreting and applying different standards to two subgroups of the same population.

(4) Monitoring compliance

The recent audit has demonstrated the need for a process with more responsibility and authority for monitoring compliance with standards. This process should encompass both health services and accommodation standards. The monitoring mechanism should be a uniform provincial process, not one that varies region by region. It must also recognize that factors are often interdependent and difficult to attribute solely to care service or environment. One body with responsibility for monitoring levels of compliance with both sets of standards can deal with these issues more effectively, meeting the needs of individual patients and applying any lessons learned to the care sector overall.

B. **Medical Care Issues in the Standards**

(1) Standard 1.13 - Medical Services

We welcome this opportunity to provide further physician input on these proposals.

- The AMA supports the patient-physician relationship as central to quality patient care and supports the patient's right to receive care from the physician of his/her choice. If facilities do not abide by this principle, their decision to do otherwise should be evidence-based.

- Standard 1.13 applies only to formal structures for medical input and supervision (privileging, bylaws) in nursing homes or auxiliary hospitals. This begs the question of whether the standards should provide for any medical oversight in supportive living settings, which have taken over part of the traditional role of facilities by providing moderate or higher levels of care in group care environments.

- Despite the assumptions underlying 1.13, in reality there is no one-size-fits-all solution to delivering on this standard. Among the diverse administrative structures of nine regional

health authorities and the mix of public/private/voluntary sector facility operators, different mechanisms will or will not be appropriate. As an example, the Calgary Health Region has a regional process to privilege physicians for all of its care centres, and a requirement for individual facility agreements is unnecessarily onerous. Also, the current evolution of Primary Care Networks, with its potential for facilities to enter into agreements with a designated group of physicians within a network, rather than with individual physicians, only adds further complexity to this issue.

The focus is on the outcomes desired; the standards in this area, therefore, must acknowledge that there will be different avenues for achieving the same ends concerning privileging or contracting for physician services.

- Regarding service agreements, the AMA would favor a provincially or regionally mandated process to develop standardized service agreement templates. There are successful precedents for taking this type of approach – for example, the provincial development of the regional medical staff bylaws template or the provincial development of the Primary Care Network framework – which are designed to support adaptability to local needs but within an overarching structure that responds to the Auditor General's general concern about the lack of consistency across the system.

- With respect to appointment of medical advisors, the same comments apply. The principle is that appointment of a medical advisor is a requirement. How this is achieved may be different and be dictated by local factors in any given area of the province.

- In general, educational matters related to physicians have not been addressed in the standards. However, medical advisors have an integral role in providing medical oversight in facilities which care for the most complex patients, and some formal mechanism in the standards to support these physicians in enhancing their geriatric skill set should be considered.

(2) ***Regular medical review***

The "Draft Continuing Care Health Service Standards" are silent on the question of periodic medical review. This is one area where the Auditor General raised the need to re-evaluate and update this standard.

It is our recommendation that a more relevant standard would be to have an annual clinical review rather than an annual physical examination.

(3) Wellness promotion

The continuum of medical care includes health promotion and prevention, and physicians strongly support the intent of Standard 1.21. At the same time, this standard should be consistent with the principle of "assessed need" and reflect whether the preventive service will provide significant benefit.

Some preventive measures provide more immediate benefit than others; this is part of the thought process that goes into decision-making around prevention. For example, calcium supplementation to potentially reduce fractures, or calcium with vitamin D supplementation to reduce falls, is eminently reasonable whereas new management with a cholesterol lowering agent may not be as reasonable, given an individual's other needs and anticipated life span. This is the same decision-making process that occurs in the setting of the physician's office.

C. Patient Safety Issues

(1) Medication administration/management

- The proposed standards do not go far enough in addressing medication issues.

- One of the important findings by the Auditor General was that staffing levels are causing delays in the administration of medications (i.e., staff cannot free themselves from their other duties). This situation poses obvious patient safety risks, especially with medications that are on a tighter or more critical timeline. Certain medications have to be given at strictly controlled timed intervals (i.e, every "X" hours), and this need to administer medications as directed must be addressed. The standards should stipulate the timely administration of medications in all of these aspects.

- Monitoring medications, especially medications such as antipsychotics, must be specifically targeted to a response and must be the responsibility of staff who have an appropriate skill set to recognize therapeutic impacts.

- In supportive living settings, there needs to be a more level playing field for coverage of medications. For example, costs charged to residents for compliance packaging (e.g., blister pack) requirements in these settings can create significant hardship. The Auditor General alluded to this in a broader statement noting that "[benefit programs] may not be sufficient to meet needs of seniors in supportive living facilities."

- The standards only peripherally address issues related to staff responsibility to ensure physicians' orders are followed and chemical restraints are used only when there is a specific order.

(2) *Staffing*

- From the perspective of patient safety, we foresee problems with Standard 1.11 in that the determination of appropriate staffing mix to meet assessed needs has not been linked to specific criteria, particularly evidence-based criteria. In other words, who is the arbiter of what is "appropriate" and how will Alberta Health and Wellness measure the appropriateness of the provider mix? This ambiguity creates a potential source for ongoing concern for patients, families, and care providers.

- Safety of care is intrinsically linked to the skill set of providers. Issues such as timeliness of medication administration, appropriate medication management, and compliance with medical care orders depend on appropriate skill sets and staffing levels. Despite the guiding vision for the future, Continuing Care has not mobilized in this critical area of staffing to meet the needs of the most complex, frail elderly in both facility and other settings. The need for higher staffing levels and skills for managing care needs will only increase as the demographic shift continues into the future.

- While Standard 1.11(d) makes provision for professional nursing services in care centres, we foresee the potential for impacts on available nursing time for direct patient care due to increasing administrative demands as a result of MDS-related duties or case management responsibilities.

- For case managers, there should be a standard that sets a maximum caseload. The standards should also specify that the education and skill set of case managers should be commensurate with the complexity of the patient population the individual serves.

(3) *Comprehensiveness of care*

- The provision of comprehensive care was set out as a fundamental principle in the 1999 recommendations from the Long Term Care Policy Advisory Committee and in the government's response confirming key policy directions. We would like to see this principle more clearly articulated in the draft standards so as to reflect the expectations around access to a comprehensive range of care to serve the needs of those with multiple, complex health problems.

D. Implementation of MDS

The implementation of MDS, a well-recognized and more widely used set of quality indicators and performance measures, responds to the need for standardized processes and tools that assess medical as well as functional needs. This is to be applauded. Proposed implementation, however, raises a number of issues:

- **Physician awareness/training** – To date, there has been almost no communication with physicians about the proposed implementation of MDS and how it may impact on physicians and the care they deliver. This is an important issue, given that MDS is a more

clinically oriented process. Physicians should have input into determining quality indicators around medical care that will be medically appropriate.

- **Impact on staffing/patient care** – We are concerned that the implementation phase for MDS will impact on time available for patient care. Although regions are receiving some support to cover staff absences due to MDS training, we understand that the funding falls short of full coverage and will inevitably impact on patient care. We also understand, based on experience in other jurisdictions, that the learning curve for MDS is time-intensive for a lengthy period of time, which also affects time available for patient care.

E. Other Draft Standards

(1) Code status/do-not-resuscitate orders (Standard 1.5[d])

The issue of resuscitation is an important one for the patient and physician to discuss. The proposed standard is not clear on specific responsibilities. It is our view that the standards should indicate that the role of the case manager is to ensure that this discussion between patient and physician occurs and to document both the patient's expressed wishes and the fact that the discussion has taken place.

(2) Family liaison function in facilities and supportive living (Standard 1.3)

The standards refer to staff competencies but not to the issue of staff interactions with families. Although the case manager carries out part of this function, it often falls to staff to explain care-related issues to families (an understanding of the resident's medications, an understanding of behavior management decisions, etc.). The standards should address the need to designate someone from staff to work with families.

(3) Legislative framework (Standards 1.8 and 1.9)

We had understood that current legislation was under review and would be consolidated under a new act. There is an ongoing concern that maintaining the existing legislative framework makes it more difficult to achieve the required changes and innovation in this sector.

PHYSICIAN EDUCATION/TRAINING ISSUES

The Long Term Care Policy Advisory Committee, in its final report, commented on this issue:

> *"Combined with the need to expand education and training, steps also need to be taken to ensure that there is an adequate supply of health professionals – physicians and registered nurses in particular. While the number of physicians practicing in Alberta increased in 1998-99, there continues to be a serious shortage of physicians trained in geriatrics. Programs are also needed to expand the ability of family physicians to get additional training in geriatric medicine."*

This statement is as valid today as it was then, even though steps have occurred to increase enrollment in medical schools and enhance geriatric skills of family physicians through the northern and southern Alberta geriatric programs. However, in both cases need outpaces the ability of these programs to respond.

The Continuing Care work environment has also become much more interdisciplinary, and policies are needed to support physicians in transitioning to this different care environment.

CONCLUSION

As front-line care providers, physicians echo the immediacy of the need for changes to ensure quality patient care in Continuing Care. The issues summarized in this brief reflect the first-hand experience of physicians delivering care to Albertans with chronic or complex medical conditions.

The Alberta Medical Association wishes to reaffirm the medical profession's interest in contributing to planning and policy development affecting patient care and looks forward to providing continuing input.

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