## Commentary on the Auditor General Reports on Seniors Care and Services April 2008

### I. This is the third report from the Auditor General on Seniors Care and Programs since 2005.

Much of the success Mr. Dunn has reported has to do with establishing or improving administrative procedures. The first report, in 2005, was pretty scathing about the management systems, even 10 years after the Province delegated responsibility to the Regional Health Authorities. On many of those issues, Mr. Dunn is reporting that progress has been made.

Mr. Dunn's current report indicates that the major success seems to be that both Alberta Health and Alberta Seniors now have Standards in place. Alberta Health has a bit further to go to satisfy Mr. Dunn. I was pleased to see his comments that Alberta Health has to do better at defining and monitoring 'critical incidents', developing a template for RHA compliance reporting, streamlining the facility inspection processes, and his gentle concerns that much of the data collected by the RHAs and reported to Alberta Health are not consistent, making trend analysis and cross-RHA comparisons difficult.

He repeats his recommendation that both Departments establish data and processes to make accommodation service cost decisions. He hasn't followed up on the astonishing revelation in his first report that supporting documentation on which Alberta Health has based its funding decisions for care services was lost several years earlier.

### II. Scope and purpose of the audits[1]

Mr. Dunn has been careful throughout his audits of long term care to stay within the boundaries of the management systems. This has been a huge disappointment to those of us who, as early as 2003[2], were making submissions to him based on concerns about accessibility, appropriateness, continuity, and quality of the care for the persons already receiving and those needing both community and facility care and support services, and the lack of transparency and accountability for the public money in the system. Our major concern, then and now, is that the system is failing to serve the real-life needs of the people who depend on the care and services.

Back in 1996, the Annual Report of the Auditor General suggested that evaluation of the health care system must include clinical and financial information, expectations and evaluation of results. The 1998 Auditor General's Report repeated that "*Greater emphasis should be given to accounting for the quality of health services, in particular the measurement of service outputs and patient outcomes.*"

The Ministers' Statement in response to his 2005 Report on Seniors asserted that "[we] *have a common goal: to ensure that Albertans receive quality programs and services for public expenditures. Quality services and programs for seniors are respectful, safe, preserve their dignity and, to the extent possible, support their independence*."

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[1] From the website of the Auditor General: *The mission of the Auditor General of Alberta is to identify opportunities and propose solutions for the improved use of public resources, and to improve and add credibility to performance reporting, including financial reporting, to Albertans.* *http://www.oag.ab.ca/?V_DOC_ID=843*

[2] Citizen Watch, http://www.continuingcarewatch.com/2003_audit_request.php

Mr. Dunn defines 'outcomes' as "the results an organization tries to achieve based on its goals"[3] In health terms, 'outcomes' includes concepts like maintaining and improving health and functioning; absence of illness and pain and adverse events, and patient satisfaction.

Mr. Dunn assumes that the new interRAI MDS assessment systems will ensure quality care[4]; but the evidence[5] is that having the systems in place does not guarantee appropriate or quality care. Quality care is dependent on adequate skilled nursing, therapy and physician resources, and highly regulated standards and monitoring.

Purpose and goals are political policy decisions, just as adequate public funding – especially here in Alberta – is a political choice. The 1995 Basic Service standards said "*the fundamental goal of continuing care services is to assist each individual who resides in a continuing care centre in maintaining or improving his or her quality of life and current abilities, and when necessary, in managing declining health and declining ability to do things for him/herself.*" I've been unable to find a recent clear articulation of the Government's goals and objectives for long term care, apart from statements about a "system of service delivery."[6]

But we haven't ever had any assessment of how well folks are maintaining their health and coping with chronic illness and impairments, how much of the responsibility has been shifted to informal caregivers, cost comparisons, or how much folks are paying from their own and their families' pockets.[7]

The 2005 audit and the subsequent implementation of recommendations haven't made any noticeable improvement in the experience of these folks or their families. Access to care services has not improved; the wait lists are increasing and the level of need has to be critical to get on the wait list; home care services for senior care and support are decreasing; facility care has not improved. We still hear reports of folks being placed in a facility far away from family and friends, on whom they rely for much-needed informal care and social support. We assume medication administration practices are better controlled in facilities,

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[3] April Report of the Auditor General of Alberta 2008, Glossary.

[4] Auditor General 2005 Report on Seniors pages 35 and 64.

[5] Report of a Study to Review Levels of Service and Response to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators PriceWaterhouseCoopers 2001. PWC also noted that the distinction between care available and care needs also tended to lower the recorded care needs ratings. http://www.health.gov.on.ca/english/public/pub/ministry_reports/ltc_rep/ltc_rep.pdf

Indicators of the Quality of Nursing Home Residential Care, Saliba D and Schnelle JF, Journal of the American Geriatrics Society, 2002 August 50(8):1421-30; "*MDS does not measure the manner in which, or the extent to which, need is met on a day-to-day basis*."

U.S. General Accounting Office, NURSING HOMES Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety http://www.gao.gov/new.items/d06117.pdf

[6] A 3 year study was funded to address some of these issues in 2004: Alberta Heritage Foundation for Medical Research http://www.ahfmr.ab.ca/press/2005-07-26.php *"Some older adults require the type of care provided only in nursing homes; however, many seniors who were in the past cared for in nursing homes are now residing in supportive or assisted living facilities. Yet, little is known about the health needs or outcomes of residents in these new care settings."*

[7] Trends in the Utilization of Health Services by Seniors in Alberta The Alberta Centre for Health Services Utilization Research 1999
The reports contained the warning that there was no data in care quality or outcomes in different settings, no evidence on the potential cost-effectiveness of the shift from institutional to community-based care for seniors, and concluded that the extent and appropriateness of substitution of community for institutional care, the quality of that care, and related outcomes are important subjects for further study

Supportive Living Definitions, 2007, http://www.seniors.gov.ab.ca/housing/asli/Definitions.pdf

but no one's monitoring the administration of inappropriate and potentially dangerous pharmaceuticals, particularly those used for sedation. Antibiotic-resistant infections seem to be occurring more frequently. Daily oral hygiene and toileting are still significant issues.

### III. Standards [8]

Both the Health Service Standards and the Supportive Living Accommodation Standards include provision for 'risk management' policies; if the care or the accommodation is not suitable to address the 'client's' needs, the client must accept responsibility for the risks. We've seen these 'Admission Waivers' in care centre Resident Admission Agreements.[9]

Mr. Dunn gives a good report on the progress that Alberta Seniors is making with the Accommodation Standards and the draft Supportive Living Licensing Act, and confirms that we can expect to see public reporting of facility compliance with the Standards. We still haven't seen a draft of the Supportive Living Licensing Act, but we do know that in other jurisdictions, similar initiatives have not addressed problems resulting from lack of tenancy protections and effective dispute resolution.[10]

**The Health Service Standards** deserve a closer look. When the draft Standards were introduced in 2005, the MLA Task Force referred to them as "health care standards". They are not care standards, an issue several submissions to the Task Force (including the Alberta Medical Association and the nurses' associations) specifically addressed. The Standards are process requirements for Health Regions to develop policies about health services, with no measureable or specific requirements for appropriate levels, quality or range of necessary care, or patient safety. Some Health Regions will provide a copy of their policies, and some require a Freedom of Information Application (and fees). The system entirely avoids the issues of appropriate and quality care, and of consistency of services or mobility of people between health regions. And most significantly, given the increasing shift to private-pay services, **the Health Service Standards only apply to publicly funded care services**. We do know that an increasing proportion of care in all care settings (including private homes and publicly funded facilities) is being paid for privately – and the agencies providing these services are neither licensed nor regulated.

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[8] Available at http://www.health.alberta.ca/resources/pub_continuing-care.html

[9] A Study of Negotiated Risk Agreements in Assisted Living 2006, U.S. Department of Health and Human Services, http://aspe.hhs.gov/daltcp/reports/2006/negrisk.htm

[10] Advocacy Centre for the Elderly, Retirement Homes Consultation Submission to the Ontario Seniors' Secretariat, 2007 http://www.advocacycentreelderly.org/ ; Assisted Living Consultation Response: Health and Safety By Charmaine Spencer, Gerontology Research Centre, Simon Fraser University, Vancouver, B.C. November, 2003; http://www.canadianelderlaw.ca/myweb/Assisted%20Living%20Consultation%20Response.pdf Seniors' Housing Update 2006 Vol 15 No 1, Gerontology Research Centre, Simon Fraser University at Harbour Center A First Step in Consumer Protection for Seniors http://www.sfu.ca/grc/shup_pdfs/SHUPv15n1.pdf

## IV. Concerns about the audit conclusions

I have some other concerns about the conclusions in the Auditor General's report, which illustrates a very disturbing problem. It's what I call the Humpty Dumpty syndrome: a word means what the speaker chooses it to mean – but it can mean so many different things[11].

For instance, a continuing care bed can mean a long-term resident's bed, or a short-stay bed designated for 'sub-acute' care to supplement acute care hospital recovery, or a palliative care bed (but only for a maximum stay of 3 months), or a respite bed, or . . . So the bed counts vary; the Auditor General reports 14,205 beds, while Alberta Health says there were 12,551 long term residents, in 2007. The urgent wait list for continuing care facilities was 540 in 2005, 516 in 2006, and 666 in 2007[12] – despite the increase of nearly 3,000 supportive living spaces.

We have facilities described as assisted living, designated assisted living, enhanced designated assisted living, supportive living, designated supportive living, seniors' lodges, enhanced seniors' lodges, and heavy complex care. Each has its own limited scope of services, and there is no consistency, no predictable level of services or care. What we don't have is the care that is needed provided to folks who 'age in place' with the services they need as their needs change; there's always another move, another wait list.

A similar illusion exists with the increased 'hours of care' per resident day reported in the 2006 review. Yes, the Alberta Health and Wellness Annual Report reports that they have increased (from 1.9, to 3.4 in 2006, and subsequently to 3.6 in 2007).

> The first difficulty is twofold: the definition of an 'hour of care' is based on payroll records, with no consideration for paid time not worked (holidays, sick days, etc.) and for benefit costs; or for distinguishing between direct hands-on resident care and for indirect work – housekeeping duties, administrative duties, training and meeting time, etc.
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> The second is the starting point of 1.9 hours; it apparently came from the 1985 Nursing Home Act Regulations, and not on the 2005 actual hours funded by Alberta Health; an article in the Calgary Herald in 1994 reported, from Alberta Health sources, that the provincial average was 2.81 hours per resident per day, and in 2000, Bethany Care reported a work schedule showing 3.42 hours of care per resident.
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> The third is that in 2007, with care centres 'working short', to the extent of modifying care plans and temporarily closing beds because of a reported 2,000 Care Aide vacancies, it's hard to believe that the staffing increases have resulted in more resident care. Mr. Dunn has reported a 14% increase in the care staff full-time equivalent positions (RNs, LPNs, and Health Care Aides) in long term care facilities (2005 to 2007), with the highest increase in the Health Care Aide numbers (16.2%).

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[11] *"When I use a word," Humpty Dumpty said, in rather a scornful tone, "it means just what I choose it to mean—neither more nor less." "The question is," said Alice, "whether you can make words mean so many different things." "The question is," said Humpty Dumpty, "which is to be master—that's all." "It's very good jam," said the Queen.*
*"Well, I don't want any to-day, at any rate."*
*"You couldn't have it if you did want it," the Queen said. "The rule is, jam to-morrow and jam yesterday—but never jam to-day."*
Through The Looking Glass ,Lewis Carroll (The word iam or jam in classical Latin means "now", but only in the future and the past.)

[12] Alberta Health and Wellness Annual Report 2006/2007

One would expect that increase to be noticeable on the units; families have reported steadily decreasing care time and increasing short-staffing over the past 3 years. The real-world experience is that families very often either provide care themselves, or hire private caregivers, to supplement inadequate staffing in the facilities.

## V. Other issues

**Public Funding:** In 2005, Mr. Dunn commented that the funding estimates for care needs was 29% less than actual costs, and that he was unable to account for differences in funding to facilities ( up to $10,000 per year per bed)[13] or to discern any relation between the level of funding and the quality of the services. These are serious indications of a system out of control, but have not been mentioned in his 2006 or 2008 reviews. This is bad optics, particularly given the secrecy surrounding the service contracts and the lack of detail in the financial reporting systems.

> **Alberta Health has been reporting the resident fees** as revenue (in 2005, $169,000,000[14]) and then again as facility-based continuing care expenses. This amounts to about 1/3 of the facility funding, reported as a Department (and, of course, then as RHA) funding for continuing care, when in fact it is paid by residents – or, in the case of the accommodation subsidies[15], transferred from Alberta Seniors.

**When the cost of health care is considered,** government has a knack of ignoring the costs paid directly to service providers by individuals. In the continuing care context, few if any of those goods and services are 'discretionary'. Many of the costs to residents are for services which have been delisted, or are no longer provided in long term care centres, or are now payable by residents arbitrarily placed in an assisted living facility. When the costs of health care are added up, the costs the health system has transferred to individuals should be included.

**Capital and operating funding decisions not coordinated:** In his 2005/06 Annual Report, Mr. Dunn commented that the Global Funding and the RHAs' capital plan were not coordinated to consider operating funds. One recent example is a local care facility which had 162 beds. With P3 funding from the Health Authority, a new building with 124 beds was added, and the older part was renovated to private rooms, resulting in a decrease to 96 beds in that part of the facility. It now has a total bed capacity of 220, an increase of 56 beds. But a year later, 66 of those 'new' beds remain closed because of staffing shortages - a net loss of 8 beds.

The same situation appears to exist with respect to capital funding for facility expansion and assisted living facilities, even where the proposals appear to rely on RHA home care services for the residents.

**Access** to the continuing care services, both at point of entry and to higher levels of care within the system, continues to be managed on the basis of triage decisions about urgency of existing needs – and now considers first the care that might be available from family and other informal caregivers. Several years ago, after years of raising the eligibility levels for access to care, the wait lists were reduced further by restricting them to "urgent need of

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[13] A review done by Citizen Watch in 2007[13] indicated a much wider range in funding to facilities, which did not appear to correlate to the Case Mix Indices ratings of facilities.

[14] Correspondence from Alberta Health and Wellness, 2006

[15] MEASURING UP 2005-06 Alberta Finance: As of January 2006, approximately 8,900 seniors in long-term care and designated assisted living facilities received an average of $354 per month to assist with their accommodation fees (nearly $38 million).

care". This defeats the whole spectrum of preventative and maintenance care to delay or avoid admission to settings where a high level of care is needed; folks are often diverted to 'assisted living' accommodation, where they can pay privately for unregulated support and intermittent care if it's available. Or, they do without, and end up being in the purgatory of waiting for urgently needed care.

**Home Care** is a significant and essential part of the Government's continuing care framework, absolutely essential to the goal of allowing folks to age safely in their own homes. While Mr. Dunn acknowledges that home care is the responsibility of the Regional Health Authorities within continuing care services, he seems to assume that if the administrative systems are in place, it's working fine. That isn't the experience of many folks, who are experiencing waits and rationing – and often having to rely on the private care for which they pay. A recent study[16] confirms anecdotal evidence that home care services, and in particular, the services provided to seniors, have been declining. Other studies document a steady increase of informal and private-pay caregiving[17] - replacing, rather than supplementing, formal public services. Estimates are that at least half the care folks receive is either informal or privately-paid.

**Mr. Dunn reports an increase in assisted and supportive living facilities**, to a total of 23,486 spaces from 20,500 in 2005. It would be useful if there was some information about the actual diversion of seniors into assisted living, how well these facilities are serving both their assessed and real needs, the public and private costs of the accommodation, health and support services, the wait lists, and a comparison of needs, services and health outcomes between Designated Assisted Living and continuing care centres.

**In regards to oversight**, I think Mr. Dunn is very optimistic. Most of the oversight he's reported is really self-monitoring, either customer-satisfaction surveys (which do not address, and would not be reliable assessment of, care quality issues).

Both the Protections for Persons in Care and the Health Facilities Review Committee have long demonstrated their ineffectiveness in dealing with abuse and neglect concerns. Audit and monitoring reports, and the investigation of complaints, are just as secret as most other information about the system.

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[16] **S**eeking Information on Linkages Between Chronic Illness and Home Care Through an Analysis of Alberta's Home Care Data, Donna Wilson 2008, Faculty of Nursing, University of Alberta

[17] Fixing the Foundation: Health Council of Canada 2005
http://www.healthcouncilcanada.ca/en/index.php?option=com_content&task=view&id=215&Itemid=10
Statistics Canada: Government-subsidized home care 2006 http://www.statcan.ca/english/studies/82-003/archive/2006/17-4-a.pdf; Seniors' use of home care 2006, http://www.statcan.ca/english/studies/82-003/archive/2006/17-4-c.pdf; Dependent seniors at home–formal and informal help 2003
http://www.statcan.ca/english/studies/82-003/archive/2003/14-4-b.pdf
Exploring the Balance Between Informal and Formal Care; Colleen Maxwell, 2001
http://www.stridemagazine.com/articles/2001/q4/exploring.the.balance/
Supporting Caregivers of Dependent Adults in the 21st Century 2005, Rajnovich, Keefe & Fast
http://www.cewh-cesf.ca/PDF/acewh/SupportingCaregivers.pdf
Informal Caregivers in Canada: A Snapshot 2001 Janet E. Fast, Norah C. Keating
http://www.hecol.ualberta.ca/RAPP/documents/Snapshot%20on%20Caregiving%20Final%20Report.pdf
The Differential Impact of Health Care Privatization on Women in Alberta 2000 Scott et al, the Prairie Women's Health Centre of Excellence http://www.uwinnipeg.ca/admin/vh_external/pwhce/pdf/alta.pdf
Canadian Coalition for Seniors' Mental Health http://www.ccsmh.ca/en/caregivers.cfm

The Health Quality Council is about to release a Satisfaction Survey of Long Term Care; it evolved from their 2003 survey of satisfaction with health care services, which indicated a remarkably low satisfaction with long term care services. Regardless of its findings, it is a customer satisfaction survey, and doesn't address appropriateness, quality, safety, health outcomes, or private cost issues.

**VI. There is one very worrying bit of new information in Mr. Dunn's current report.** Mr. Dunn reports that Alberta Seniors has been given the mandate for a plan "to expand long term care and improve standards of care. Ministry staff are working with stakeholders, Alberta Health and RHAs to develop this plan."

Lately, the responsibility for long term care has been shared, somewhat arbitrarily, between Alberta Health and Alberta Seniors. Last year, the Ministers mused in the Legislature about discussing whether that arrangement should or would change.

Once again, I wonder when or if the public and especially the users of the system will be consulted about what they want and need; or if, yet again, we'll only have a chance to comment once the basics have already been decided. This was certainly true with the MLA Task Force "consultation" about the Standards, and even truer of the development of the Supportive Living Licensing Act. The public interest surely should involve the public, who so far have been marginalized in the public policy making process.

**VII. My conclusion is** that Mr. Dunn's work, regardless of how well he has done what he's done and how important good administrative practices are, doesn't have much relevance to life on the front lines of continuing care. And in my opinion, that relevance is the bottom line of accountability and effectiveness of governance, and the credibility of the Auditor General.

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**Resources:**

Citizen Watch 2003 Submission to the Auditor General (available at www.continuingcarewatch.com)
Citizen Watch 2003 Submission available at www.continuingcarewatch.com
Ontario Auditor General reports available from http://www.auditor.on.ca/en/reports_health_en.htm
PriceWaterhouseCoopers 2001 Report of a Study to Review Levels of Service and Response to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators PWC also noted that the distinction between care available and care needs also tended to lower the recorded care needs ratings. http://www.AlbertaHealth.gov.on.ca/english/public/pub/ministry_reports/ltc_rep/ltc_rep.pdf
SALT Brief on Continuing Care 2008 www.continuingcarewatch.com)