Legislative Assembly of Ontario

Assemblée législative de l'Ontario

STANDING COMMITTEE ON PUBLIC ACCOUNTS

LONG-TERM CARE FACILITIES ACTIVITY

(Section 4.04, 2004 Annual Report of the Provincial Auditor)

2nd Session, 38th Parliament
54 Elizabeth II

Legislative Assembly of Ontario

Assemblée législative de l'Ontario

The Honourable Michael A. Brown, MPP,
Speaker of the Legislative Assembly.

Sir,

Your Standing Committee on Public Accounts has the honour to present its Report and commends it to the House.

Norman Sterling, MPP,
Chair.

Queen's Park
November 2005

STANDING COMMITTEE ON PUBLIC ACCOUNTS

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PREAMBLE

The Auditor General (the Auditor)* reported on a follow-up to a 2002 audit of the Long-Term Care Facilities Activity in Section 4.04 of his *2004 Annual Report*. The Standing Committee on Public Accounts held hearings on this follow-up on May 5, 2005, with representation from the Ministry of Health and Long-Term Care.

This report contains the Committee's findings and recommendations as they relate to those areas of particular interest to Committee members. *Hansard*, the official record of the hearings, should be consulted for the complete proceedings.

The Committee extends its appreciation to officials from the Ministry for their attendance at the hearings. The Committee also acknowledges the assistance provided during the hearings by the Office of the Auditor General, the Clerk of the Committee, and staff of the Legislative Library's Research and Information Services Branch.

The Committee held hearings in February 2003 and issued a report in July 2003 on the audit report on the Long-Term Care Facilities Activity that appeared in Section 3.04 of the Auditor's *2002 Annual Report*.

The words 'facilities' and 'homes' both appear throughout this report. The former was the term most commonly used by the Ministry of Health and Long-Term Care prior to late 2003. The latter has been employed by the Ministry in the time since.

Ministry Response to Committee Report

The Committee requests that the Ministry of Health and Long-Term Care provide the Committee Clerk with a written response within 120 calendar days of the tabling of this report with the Speaker of the Legislative Assembly, unless otherwise specified in a recommendation.

1. OVERVIEW[1]

Long-term care homes provide care and services to those who are unable to live independently and require round-the-clock nursing services. They operate under the authority of the *Nursing Homes Act*, the *Homes for the Aged and Rest Homes Act*, and the *Charitable Institutions Act*, which, along with their regulations, specify admission and resident care requirements, residents' rights, home responsibilities, and Ministry obligations. Rest and retirement homes do not receive Ministry funding and are not covered by these Acts.

Admissions are arranged by designated placement co-ordinators through local community care access centres (CCACs). Eligibility for admission is determined

* Formerly the Provincial Auditor.

by an assessment of impairment or capacity, and an assessment of information related to requirements for medical treatment, health care or other personal care.

The Ministry's key responsibility is to ensure that homes deliver services in accordance with their service agreements with the Ministry, and in compliance with applicable legislation and policies.

In 1998, the government announced an eight-year plan to provide 20,000 new long-term care beds and to renovate non-compliant homes containing 13,583 beds. In March 1999, it announced that the new beds would be completed by 2004. The number of beds to be renovated by 2006 was later revised to 15,835. In early 2000, a Long-Term Care Redevelopment Project office was established to take over responsibility for the plan. (In 1998, the province had 57,000 long-term care beds. At the time of the hearings, there were 74,000.[2])

Funding is provided through three per diem/funding envelopes: nursing and personal care; program and support services; and other accommodation costs, including raw food.[3] The daily rate for each is set by regulation. Per diems are the same for all homes, except for the nursing and personal care rate, which is based on an assessed level of care for each resident. A co-payment for accommodation and food is made by each resident, with assistance being provided if necessary.

The 2004 provincial budget made an overall investment of about $2.5 billion for the care of residents in long-term care homes. (Spending increased by $1 billion between 2001 and 2004.) After the budget, an additional $191 million was invested over a two-year period (2004/05 and 2005/06) in enhanced care funding and improved services.[4]

2. MONITORING QUALITY OF CARE[5]

The primary tool for monitoring quality of care is the Compliance Management Program (CMP). Under the terms of the CMP, the Ministry is to conduct annual inspections of all facilities, conduct other inspections as required by specialists, and investigate complaints.

Regional offices are responsible for the CMP. Each is staffed by a long-term care manager and compliance advisors (Registered Nurses - RNs). Some also have an advisor(s) to handle more specialized reviews. Compliance advisors inspect facilities to ensure compliance with the Ministry's *Long-Term Care Facility Program Manual*. Facilities that fail to meet these requirements must take appropriate and timely corrective action. A facility can be put under enforcement if standards continue to be unmet.[6]

2.1 Annual Inspections

Committee's 2003 Report[7]

The three long-term care facilities statutes give the Ministry the right to inspect facilities to ensure compliance with legislation and regulations, service

agreements and/or licences. Ministry policy says reviews will be conducted at least once a year. The annual inspection monitors and evaluates the quality of resident care and services, the quality of programs, and the overall operation of each facility. Its results are to be posted in each facility.

Fewer than half of the facilities were inspected annually between 1997 and 1999. In 2000, it was announced that all facilities would be inspected on a yearly basis. All were inspected in 2001. Audit staff reviewed the inspection process and noted that senior management did not routinely review inspection findings.

Audit staff also noted that the Ministry lacked a formalized risk-assessment approach for prioritizing inspection procedures or focusing on facilities with a history of failing to meet provincial quality standards. The two associations representing facility operators told audit staff that their members reported that compliance standards were not applied consistently.

Facilities may be notified up to a week in advance of an upcoming annual inspection. Some may use the time to prepare for the inspection, leading to results that may not reflect the ongoing care provided.

The Auditor recommended that the Ministry ensure senior management assesses the results of annual facility inspections, implement a formalized risk-assessment approach for its annual inspections, ensure consistency in the application of standards, establish acceptable notification periods and conduct surprise inspections of high-risk facilities, and evaluate the experience and skills required to inspect facility operations and ensure the appropriate mix of specialists is available.

Committee Hearings

The Ministry is being more thorough and consistent in how it monitors the progress of individual homes in meeting standards through the CMP. A full-time professional staff of 65 delivers the CMP at the regional level. This number has grown from 23 in 1998. (A corporate enforcement unit was created in February 2003.[8]) Senior management in regional offices assess inspection results for corrective and preventive actions where required.

The Ministry now conducts unannounced annual inspections of every home and follows up on all reported complaints or unusual occurrences. Since January 2004, over 4,000 inspections have been conducted, including annual inspections. (All annual inspections have been unannounced since this date.)

Seniors and families now have access to information about individual homes and their records of care through a link on the Ministry's web site.

The Ministry has initiated a redrafting process for care program and service standards to ensure consistent application in the inspection process. In the fall of 2004, all compliance and enforcement staff received training based on the proposed standards. New legislation governing all long-term care homes is to be

introduced later in 2005. The intention is to have the legislation incorporate these standards.

To reinforce a consistent approach to inspections and to strengthen the tools available to compliance teams, the Ministry organizes annual compliance education sessions.[9]

Risk Management Framework

Much work has been undertaken on a risk management framework that will be finalized in the near future. The goal of the framework is to use the information received and recorded to focus and expedite inspections. The framework will identify risk indicators and use that information to correct problems and look at more systematic policies or standards to reduce risk.[10] Committee members were told that the framework is used in other sectors of health care to ensure that standards in quality of care are maintained at the highest level possible.[11]

Supplementary Information

In its development of the risk management framework, the Ministry has conducted surveys of practices in other provinces to identify which risk indicators are being used, how they are used in inspection and data collection processes, and whether risk adjustment or weighting factors are being applied.

The Ministry is also examining a common assessment and quality indicator tracking methodology known as the Minimum Data Set (MDS). The MDS is in use in over 20 jurisdictions and has a strong basis in clinical research and evidence-based practice. In addition, the Ministry has consulted with the American federal government's Veteran's Administration, a leader in applying key quality of care indicators.[12]

Committee Recommendation

During the Committee's hearings on Section 3.04, the Long-Term Care Facilities Activity, of the Auditor's *2002 Annual Report*, Ministry of Health and Long-Term Care staff reported that the Ministry was considering moving to the Minimum Data Set (MDS). The MDS was described as a more modern instrument that would provide "some data that the Ministry does not have at present."[13] Two years later, the Ministry continues to examine the MDS.

The Committee therefore recommends that:

1. The Ministry of Health and Long-Term Care provide the Committee with the status of its examination of the Minimum Data Set (MDS) as a consistent assessment and quality indicator, and when it expects to make a decision about the possible implementation of the MDS.

The Committee requests that the Ministry provide the Committee Clerk with a written response to this recommendation within 30 days of the tabling of this report in the Legislature.

3. PER DIEM FUNDING

3.1 Level of Care Classifications

Auditor's 2002 Annual Report[14]

Level-of-care classifications are determined through an annual classification assessment of residents at each facility. Assessors review resident charts and plans of care. Residents are classified into one of seven nursing and personal care categories. Each category is assigned an established weight based on assessed resident needs. The percentage of residents in each category is multiplied by weighting factors to determine a facility's case-mix measure (CMM). The ratio of the facility's CMM to the provincial average produces a case-mix index (CMI), which is multiplied by a set per diem rate to determine the funding a facility will receive per resident.

A decrease in a facility's CMM affects its nursing and personal care per diem. A facility can appeal its classification if its measure decreases by more than 7% from the previous year. Annual audits were introduced in 1997. They verify the level-of-care classification at a sample of facilities. The audits initially involve the reassessment of a minimum of 20 residents and are based on documented care and direct observation. If the measure for those residents exceeds their annual classification by more than 10%, a full audit is conducted on all individuals resident in the facility when the annual classification was completed.

According to Ministry policy, if the full audit verifies that the documented and observed care have changed by more than 10% from the annual classification, the Ministry will consider increasing or decreasing funding. A December 2000 Ministry memorandum to all regional offices noted that since the audit and appeals process began, the policy to decrease funding had not been applied where warranted.

Seminars are offered by the Ministry to help facilities improve their documentation of resident care needs. Those facilities that, based on the audits, the Ministry knows or strongly suspects are misrepresenting resident needs are not penalized.

The Auditor recommended that the Ministry adjust funding where warranted as a result of any level-of-care classification audit in accordance with its policy.

Committee Hearings

The Ministry has a process dedicated to appealing the results of level-of-care classification audits. A policy has been in place whereby funding is adjusted upward or downward, where warranted, as a result of the audits, since April 2003.[15]

Classification Process

The classification instrument used by the Ministry, the Alberta Residential Classification system, was introduced in the early 1990s. It is employed by about 150 trained nurses who conduct assessments each fall.

Assessors look at key indicators (e.g., the ability to cope, the ability to deal with activities of daily living) and then derive a level-of-need index. Based on the index, they determine the category in which a resident belongs (A through G). A home's resident population is then averaged and compared with provincial measures.

The previously mentioned MDS will provide a better grounding in the clinical information presented by residents. More information is needed to refine this level-of-care approach and include aspects of resident care which the current tool does not adequately reflect.[16]

Supplementary Information

The classification of residents is not based on their diagnosis, but rather on their care needs in three areas: activities of daily living; behaviours of daily living; and continuing care levels (continence levels).

Depending on their care needs, a resident can be placed in any category from A to G, 'A' being light care and 'G' being heavy care. The nursing and personal care per diem for a home is determined by the proportionate total of residents in each classification category, multiplied by category weights and divided by the number of residents classified in the home. Weights vary from 30.92 for category A to 160.21 for category G. The greater the proportion of residents in a heavier care classification, the greater the home's proportionate funding for the nursing and personal care per diem.

Over 64,000 residents were classified in the fall 2004 classification. This number represents almost the entire LTC population in homes. The only exceptions were newly admitted residents or those in homes opened between classifications.

The coding of resident care needs is performed by RNs and Registered Practical Nurses retained by the Ministry from the LTC sector for the three month classification period. They review a variety of materials to determine residents' nursing and personal care needs. A range of documented behaviours are included in this review (e.g., language barriers, memory and orientation, paranoia, wandering).

The classification establishes case-mix measures (CMMs) for both documented and observed care. The CMM for a home reflects the care levels of all its residents. Since the case-mix index (CMI) is a relative number, a home with average care levels will have a CMI of 100.[17]

Funding Levels

The Committee asked for the range of funding available for a level A resident as opposed to that for a level G resident. According to Ministry staff, the CMI is based on a home's population and its situation relative to other homes; they were unable to connect it to an individual resident.[18]

Supplementary Information

Following the hearings, the Committee learned that as per the 2004 classification results, the current per diem range for the nursing and personal care envelope is $22.71 to $117.68. Aggregated, the average for the nursing and personal care envelope is $67.27, as of April 1, 2005.[19]

Specialized Populations

When asked if there are homes that tend to specialize in specific levels of care, Ministry staff replied that there is no purposeful segregation of residents. Some may have speciality areas (e.g., mental health). Others have separate units to deal with patients of like type. Similarly, patients who are bedridden and require a certain type of nursing care may be grouped in different parts of the home to provide more consistent nursing care. While there are no situations where 50% or 100% of a home's population is one kind of care versus another, the Ministry is looking at how homes are dealing with specialized population needs so that it can guide others in the future.[20]

3.2 Reasonableness of Per Diem Funding

Committee's 2003 Report[21]

In 1995, the Auditor recommended that the Ministry use information on the cost of providing care and accommodation to verify the accuracy of the standard rates paid in each envelope. Periodic adjustments have been made, but the Ministry has not done a detailed analysis to determine an appropriate amount of funding.

In June 2000, the Ministry established a committee to review how funding was determined, allocated and distributed, and to recommend improvements to the per-diem-based methodology. The committee recommended increases in each envelope, but did not discuss funding adequacy.

For the two years previous to the audit, the Ministry produced reports that listed the actual amount spent per resident per day for each type of expense and for each funding envelope for each facility. Cost data is accumulated by sector within each region. Audit staff reviewed the 1999 reports for the three regions visited and noted large variances among the sectors and among facilities in expenditures for nursing and personal care, and in accommodation expenses.

In 1995 the Auditor recommended the development of standards to measure the efficiency of facilities in providing quality care, and the development of models for staff mixes for providing nursing and personal care to arrive at appropriate funding levels. Prior to 1996, the Ministry required each facility to have an RN on

duty and on site at all times. It guaranteed, as a minimum, sufficient funding to ensure that each nursing home resident received, on average, a minimum of 2.25 hours of nursing and personal care per day. This funding was to be provided regardless of the overall care needs of residents in each nursing home.

In 2001 the Ministry provided funding for PricewaterhouseCoopers to compare and review the level of services provided to residents of Ontario's facilities and those provided in other jurisdictions in Canada, the U.S., Europe, and Ontario's chronic care facilities. The report considered only the amount of care provided. Data for many of the comparative jurisdictions predated the Ontario data by three to five years. Several of those jurisdictions were required to submit the data for funding purposes, which the consultants thought might influence data quality. Even with these caveats, the report stated that the study results indicated that residents of Ontario facilities received fewer nursing and therapy services than similar jurisdictions with similar populations. Ontario residents also had some significant differences in terms of their levels of depression, cognitive levels and behavioural problems.

The audit found no evidence that the Ministry had addressed the study's results. It also noted that 36 U.S. states had established staffing requirements or standards. At the time of the audit, the Ministry did not have any staffing requirements and did not track facility staff-to-resident ratios, the number of RN-hours per resident or the mix of registered and non-registered nursing staff.

The Auditor recommended verifying the reasonableness of current standard rates for each funding category, developing standards to measure the efficiency of facilities providing services and developing appropriate facility staffing standards.

Committee Hearings

The development of staffing information began in 2004. The Ministry is in the process of strengthening the reporting requirements in service agreements. The 2004 service agreement introduced a provision that enables the Ministry to request that operators provide information regarding levels of service, staffing and any other matter relating to the operation of a home. In addition, during annual reviews and other inspections, compliance staff monitor and evaluate staffing patterns.

In 2005, the Ministry will be moving toward quarterly reporting on staffing for all operators.[22] This process was described as the principal way to monitor compliance with service agreements. In April 2005, the Ministry received the results of its first survey requiring all homes to report actual nursing hours by category and expenditures over a period of time. The survey's results will lead to a baseline amount of nursing staff and hours provided. It covered the period from January 1, 2004 to June 30, 2004 and preceded funding that flowed to homes in October 2004.

A second survey had gone out for the following time period and was due by the end of May 2005. The results of the first survey were being analyzed at the time

of the hearings. About 40 homes were outstanding on the second survey. After that, the Ministry hopes to analyze the data and report, probably by mid-year. This process will become a routine reporting requirement.[23]

Since 2003, the government has brought in regulations ensuring 24-hour, seven-day-a-week coverage by RNs in all homes and a minimum of two baths per week per resident.[24]

A review of accountability requirements for the current program funding system is planned to resolve many of the complex issues faced by the sector. To enhance the Ministry's ability to assess resident care and staffing needs, and identify resource allocation requirements, it has initiated a project to explore the implementation of the MDS in long-term care homes.[25]

Staffing and Legislation

When asked if they were examining such items as ratios of nurses or personal care workers to residents, and the efficacy of permanent as opposed to contract staff in terms of the new legislation, Ministry staff replied that those issues were under consideration. Reference was made to policy review processes on funding and care standards. Current work on staffing hours will establish a floor. Within a flexible range, the Ministry is moving toward being more definitive about staffing expectations.[26]

Staffing Levels

In response to questioning, Ministry staff told the Committee that three factors have the potential to lead to the perception that staff numbers have been reduced in homes: a change in capacity; the funding formula (i.e., adjustments year to year); and occupancy. In the case of occupancy, the Ministry can freeze admissions as part of its enforcement function. This means both the number of residents and staff levels will fall.[27]

Special Funding

The focus of the funding formula is the care needs of residents. It is not sensitive to the variety of differences that affect the cost structures of homes (e.g., age, size, unionized versus non-unionized staff). Increases year over year are meant to adjust for that.

Homes do receive pockets of special funding. One deals with labour legislation. In homes where pay equity has been a factor, the Ministry provides additional funding to recognize those pressures. Special amounts are also allowed for municipal taxes, recognizing some of the variability across the province.

Other pockets of funding deal with historical discrepancies, those instances where homes had a different cost structure (e.g., originally built as a chronic care facility). There were special transitional arrangements for some homes at the time of the hearings.[28]

Allocations have also been made this year for level of care adjustments. Additional revenues to offset the costs of increased wages were partially accounted for in a separate allocation. The Ministry expects to see a substantial change in the number of nursing and personal care hours as a result of this allocation.[29]

Nutrition

In response to questions about nutrition and the amount of funding available for raw food in the accommodation envelope, Ministry staff reported that the minimum amount to be spent on raw food is $5.24 per day per resident. Over the past year, Ministry staff have been working on a draft regulation dealing with nutrition and hydration. (Other jurisdictions were examined in the course of this work.) This area was considered a priority as nutritional status underpins overall health status. The new regulation will appear in the fall as part of the Ministry's proposed regulatory and legislative package.[30]

Supplementary Information

Following the hearings, the Ministry provided the Committee with a table showing average actual raw food per diems by type of home from 2001 to 2003. (The provincial average is weighted by the number of beds in each sector.[31]) Figures for 2004 were unavailable as the reconciliation for that year had not been completed. Those for 2003 are preliminary as the reconciliation for that year was still in progress.[32]

TYPE OF FACILITY	2001	2002	2003
Charitable institution	$5.58	$5.55	$5.90
Municipal home for the aged	$5.40	$5.53	$5.74
Nursing home	$4.69	$4.81	$5.15
PROVINCIAL	**$5.04**	**$5.12**	**$5.40**

Committee Recommendation

The Committee recommends that:

> **2. The Ministry of Health and Long-Term Care report to the Committee on the results of its first and second surveys of long-term care homes' actual nursing hours and what actions related to staffing, if any, it plans to take in response to those results.**
>
> **The Committee requests that the Ministry provide the Committee Clerk with a written response to this recommendation within 30 days of the tabling of this report in the Legislature.**

4. THE LONG-TERM CARE REDEVELOPMENT PROJECT

4.1 Supply of Long-Term Care Beds

Committee's 2003 Report[33]

The 1995 audit report noted that the Ministry did not have a strategy for dealing with the anticipated increase in demand for long-term care beds and no systemic plan to determine where beds were most needed.

In the fall of 1996, the Ministry established the Long-Term Care Bed Distribution and Needs Study Steering Committee to review ways to equitably distribute beds and to suggest policy or legislative changes to facilitate this distribution.

That committee's 1997 report noted that provincially funded and regulated beds had been inequitably distributed and that distribution had occurred more by accident than as a result of needs-based planning. It recommended further study and research to define a bed-planning target, and urged that its recommendations be considered in conjunction with long-term care recommendations from the Health Services Restructuring Commission (HSRC). The HSRC released a discussion paper in 1997 which reported that Ontario would need an additional 15,404 long-term care beds by 2003. This would result in an average bed ratio of 96.4 beds for every 1,000 individuals aged 75 and over.

In April 1998, Management Board of Cabinet approved in principle a Ministry plan requesting a total of 20,000 new beds to be built by the end of 2005/06 and the renovation of facilities with 13,583 existing beds that did not meet current structural requirements. Ministry staff told audit staff that although there was no Ministry standard for determining the need for beds, they were attempting to reach a target of 100 beds for every 1,000 individuals aged 75 and over. While the Ministry was unable to provide information on how it arrived at this target, it was consistent with the target recommended by the HSRC. The Auditor noted that future need was affected by many factors, including the availability of home care, chronic care and other services.

Based on the allocation of new beds, by 2006 the projected ratios across service areas are expected to range from 88 to 138 beds for every 1,000 individuals aged 75 and older. Without the new beds, projected ratios would have ranged from 38 to 138 beds for every 1,000 individuals aged 75 and over. Those areas most likely to exceed the target were generally above it before the allocation and were generally not awarded new beds.

The Auditor recommended that the Ministry conduct research to determine whether its target is appropriate and develop a strategy to address the results of the research.

Committee Hearings

The Ministry, particularly its Long-Term Care Planning and Renewal Branch, is conducting policy work on a long-term strategy for the long-term care sector. It is

looking into the full range of services available to seniors, including the potential use of alternative measures of need. This will include a review of community and home-based services as alternatives to long-term care home placement. This ongoing work will inform recommendations made for long-term care homes this fall.

The Ministry continues to implement key improvements. A significant component is the proposed new legislative framework: revitalized standards, public reporting, the risk framework, and the introduction of the MDS on care needs. Currently in the pilot phase for introduction, these key areas of reform will help improve the overall quality of life of residents.[34]

Needs of Younger Clients

Some concern was expressed for the long-term care needs of younger clients, those under the age of 65. When asked if consideration was being given to homes for this demographic group, Ministry staff said the issue was not on their policy agenda at present but would probably arise in the future. Finding specialized accommodations in the form of LTC homes was considered a final option. As part of its review of the 100 beds per 1,000 population over the age of 75, the Ministry will probably examine the matter in order to develop a broader contextual understanding of the issues involved.[35]

Committee Recommendation

The Committee recommends that:

> **3. The Ministry of Health and Long-Term Care provide the Committee with the current status of its review of the bed allocation ratio of 100 beds per 1,000 population over the age of 75**.
>
> **The Committee requests that the Ministry provide the Committee Clerk with a written response to this recommendation within 120 days of the tabling of this report in the Legislature.**

Alternative Levels of Care Strategy

A portion of the earlier mentioned $191 million invested over two years is for the Alternative Levels of Care (ALC) strategy (over $46 million in 2005/06). A limited number of specialized beds are being developed in some homes for patients from hospitals who do not require acute intensive medical care, but need a longer period of convalescent care. (Moving patients to ALC beds, frees up in-patient beds in hospitals and improves access through emergency departments.) The Ministry was in the midst of an RFP process to solicit proposals at the time of the hearings.

Funds from 2004/05 had been allocated to a number of homes in underbedded regions with severe needs, many of them in northern areas. A pilot project in Ottawa had seen 25 beds allotted to that municipality.[36]

Supplementary Information

The Minister of Health and Long-Term Care announced the government's $29.2 million investment in the ALC strategy on February 10, 2005. The strategy has three components: 1) the Interim Beds Program - $10 million for up to 500 interim LTC beds for those waiting in hospital for a permanent LTC bed; 2) the New Convalescent Care Program - $5.75 million for up to 340 convalescent care beds in LTC homes; and 3) the High Intensity Needs Fund - $13.45 million for the purchase of equipment and supplies for the care of patients requiring the highest level of care in LTC homes.[37]

During the hearings, Ministry staff were asked for data from the past five years on the number of hospital beds blocked by people awaiting admission to an LTC home.[38] A response was received following the hearings.

The Ministry did not collect or monitor placement data prior to 2003/04. In 2003/04, 8,267 people were placed in LTC from acute care hospitals. In 2004/05, the number was 8,324. The numbers represent clients placed during the year, rather than the number of placements. (Some clients were placed more than once, but are only counted once.) Only clients placed from acute care hospitals were counted. Additional clients were placed from complex continuing care and rehabilitation hospitals.

The Ministry also collects data from hospitals related to the ALC strategy. This data covers all patients waiting for placement in other settings of care including LTC. Between 2000 and 2003, while the number of ALC cases increased, the lengths of stay associated with these patients decreased by 8.5%. Typically, the majority of patients listed as ALC are waiting for placement in LTC homes.[39]

Committee Recommendation

The Committee recommends that:

> **4. The Ministry of Health and Long-Term Care report to the Committee on the results of the RFP process for its Alternative Levels of Care strategy, including the number of beds being planned.**
>
> **The Committee requests that the Ministry provide the Committee Clerk with a written response to this recommendation within 120 days of the tabling of this report in the Legislature.**

5. COMMITTEE RECOMMENDATIONS

The Committee requests that the Ministry provide the Committee Clerk with a written response to these recommendations within 120 days of the tabling of this report in the Legislature, unless otherwise specified in a recommendation.

> **1. The Ministry of Health and Long-Term Care provide the Committee with the status of its examination of the Minimum Data**

Set (MDS) as a consistent assessment and quality indicator, and when it expects to make a decision about the possible implementation of the MDS. The Committee requests that the Ministry provide the Committee Clerk with a written response within 30 days of the tabling of this report.

2. The Ministry of Health and Long-Term Care report to the Committee on the results of its first and second surveys of long-term care homes' actual nursing hours and what actions related to staffing, if any, it plans to take in response to those results. The Committee requests that the Ministry provide the Committee Clerk with a written response within 30 days of the tabling of this report.

3. The Ministry of Health and Long-Term Care provide the Committee with the current status of its review of the bed allocation ratio of 100 beds per 1,000 population over the age of 75.

4. The Ministry of Health and Long-Term Care report to the Committee on the results of the RFP process for its Alternative Levels of Care strategy, including the number of beds being planned.

NOTES

[1] The overview is a revised and updated version of Ontario, Legislative Assembly, Standing Committee on Public Accounts, *Long-Term Care Facilities Activity* (Toronto: The Committee, July 2003), pp. 1-2, which was based on Ontario, Office of the Provincial Auditor, *2002 Annual Report* (Toronto: The Office, 2002), pp. 114-115.
[2] Ontario, Legislative Assembly, Standing Committee on Public Accounts, *Official Report of Debates (Hansard)* (5 May 2005): P379.
[3] The 2002 audit reported that there were four funding envelopes: nursing and personal care; program and support services; raw food; and other accommodation costs. Updated information provided by Issues Media and Communications Planning, Communications and Information Branch, Ministry of Health and Long-Term Care, Toronto.
[4] The source for the information in this paragraph is Standing Committee on Public Accounts, *Official Report of Debates*, p. P379.
[5] The information in the following two paragraphs was taken verbatim from Standing Committee on Public Accounts, *Long-Term Care Facilities Activity*, p. 3, which was based on Office of the Provincial Auditor, *2002 Annual Report*, p. 118.
[6] 'Under enforcement' means that a home has had infractions reported and is being monitored to ensure compliance with standards and regulations.
[7] The following is a revised version of information appearing in Standing Committee on Public Accounts, *Long-Term Care Facilities Activity*, p. 4, which was based on Office of the Provincial Auditor, *2002 Annual Report*, pp. 119-121.
[8] Ontario, Office of the Provincial Auditor, *2004 Annual Report* (Toronto: The Office, 2004), p. 383.
[9] Standing Committee on Public Accounts, *Official Report of Debates*, pp. P379-P380 and P387.
[10] Ibid., pp. P380 and P384.
[11] Ibid., pp. P384-P385.
[12] Letter from Deputy Minister, Ontario Ministry of Health and Long-Term Care to Clerk, Standing Committee on Public Accounts, 13 June 2005.
[13] Standing Committee on Public Accounts, *Long-Term Care Facilities Activity*, p. 21.
[14] Office of the Provincial Auditor, *2002 Annual Report*, pp. 125-126.
[15] Standing Committee on Public Accounts, *Official Report of Debates*, p. P381.
[16] Ibid., pp. P383-P384.
[17] Letter from Deputy Minister to Clerk.
[18] Standing Committee on Public Accounts, *Official Report of Debates*, pp. P383-P384.
[19] Letter from Deputy Minister to Clerk.
[20] Standing Committee on Public Accounts, *Official Report of Debates*, p. P385.
[21] The information in this section was taken verbatim from Standing Committee on Public Accounts, *Long-Term Care Facilities Activity*, pp. 11-12, which was based on Office of the Provincial Auditor, *2002 Annual Report*, pp. 126-128.
[22] Standing Committee on Public Accounts, *Official Report of Debates*, pp. P381-P382.
[23] Ibid., pp. P385-P386; and e-mail from Issues Media and Communications Planning, Communications and Information Branch, Ontario Ministry of Health and Long-Term Care to Researcher, Standing Committee on Public Accounts, 7 October 2005.
[24] Standing Committee on Public Accounts, *Official Report of Debates*, p. P379.
[25] Ibid., pp. P381-P382.
[26] Ibid., pp. P386-P387.
[27] Ibid., p. P385.
[28] Ibid., pp. P382-P383.
[29] Ibid., pp. P387-P388.
[30] Ibid., p. P388.
[31] E-mail from Issues Media and Communications Planning, Communications and Information Branch, Ontario Ministry of Health and Long-Term Care to Researcher, Standing Committee on Public Accounts, 23 June 2005.
[32] Letter from Deputy Minister to Clerk.

[33] The information in this section was taken verbatim from Standing Committee on Public Accounts, *Long-Term Facilities Activity*, pp. 17-18, which was based on Office of the Provincial Auditor, *2002 Annual Report*, pp. 130-131.
[34] Standing Committee on Public Accounts, *Official Report of Debates*, pp. P382 and P389.
[35] Ibid., p. P387.
[36] Ibid., pp. P387 and P390.
[37] Ontario, Ministry of Health and Long-Term Care, "McGuinty Government Speeds Access to Long-Term Care, Relieves Pressure on Hospitals," *Canada NewsWire*, 10 February 2005. Internet site at http://ogov.newswire.ca/ontario/GPOE/2005/02/10/c2729.html?lmatch=&lang=_e.html accessed 6 September 2005.
[38] Standing Committee on Public Accounts, *Official Report of Debates*, p. P384.
[39] Letter from Deputy Minister to Clerk.