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Jeudi 5 mai 2005

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and Long-Term Care

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Chair: Norman W. Sterling
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Thursday 5 May 2005

Jeudi 5 mai 2005

The committee met at 0947 in committee room 1, following a closed session.

2004 ANNUAL REPORT, PROVINCIAL AUDITOR

MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 4.04, long-term-care facilities activity.

The Chair (Mr Norman W. Sterling): Welcome. My name is Norm Sterling. Thank you for coming to the public accounts committee. Mr. Sapsford, would you like to introduce the people who are sitting with you, and if you require the help of any of the people who are behind you, maybe you could introduce those as well if they are called to the table. I see you've given us some notes

Mr. Ron Sapsford: I'll speak and introduce my officials as I go through my remarks.

The Chair: OK. That's fine. I was looking at 22 pages, but fortunately it's large print.

Mr. Sapsford: And I speak very quickly.

The Chair: Welcome. If you'd like, please take us through your opening remarks.

Mr. Sapsford: It's an honour for me to be here this morning for what will no doubt be the first of many appearances that I will make before this committee in my role as Deputy Minister of Health and Long-Term Care. My colleagues and I are happy to be here to answer any inquiries you may have about our programs, operations and expenses made on behalf of residents of Ontario in long-term-care homes.

It's with that in mind that I've brought answers today regarding our programs and actions on long-term-care homes in the Ministry of Health. Following my remarks, we'll be glad to answer any and all of your questions. To help me in this regard, I have some ministry officials here today: Mr. George Zegarac, assistant deputy minister for the community health division, is on my immediate left; Mr. Tim Burns, who is the director of the long-term-care homes branch, is next to him; and on my right is Mr. David Clarke, director of the long-term-care planning and renewal branch.

In a few moments, I'll talk to the specifics of the auditor's recommendations and how we are dealing with those important comments that the auditor has made to the ministry. But first, before I get into the details, I'd like to make a few more general comments about long-term-care homes and the importance the ministry attaches to these homes.

This sector has undergone tremendous changes in recent years: changes in types of patients, changes in demography in the population. I'd like to give you a few examples. In 1998, the province had 57,000 beds in this sector, and this year, in 2005, we have 74,000. Not only do we have more beds, but the ministry has more staff. Ministry compliance staff to monitor care in these homes has gone from 23 to 65 full-time staff since 1998.

The 2004 provincial budget made an overall investment of about $2.5 billion for the care of residents in long-term-care homes. This spending has increased, between 2001 and 2004, by $1 billion over that period of time. These figures give you a sense of how large this particular program is in the Ministry of Health.

I want to assure the members of the committee that since the auditor's report was released, the ministry has been moving forward with a determined plan. The plan has been responding directly to the recommendations and concerns that were raised by the auditor. We have been quietly and calmly going about making major improvements to this sector, and the ministry continues to implement substantial improvements to the long-term-care sector.

Some of the key accomplishments that have been made in long-term care over the year include an additional $191 million, which is being invested over a two-year period in enhanced care funding and improved services to long-term-care homes.

Regulations have been introduced to ensure 24-hour-a-day, seven-day-a-week coverage by registered nurses in all long-term-care homes and to provide a minimum of two baths per week for each resident.

Over $80 million has been distributed for medical equipment in long-term-care homes, including bed lifts, specialized mattresses and fall prevention equipment.

As of January of last year, all annual inspections are unannounced.

Through the ministry's long-term-care compliance management program, the ministry is being more thorough and more consistent in how we monitor the progress of individual homes in meeting our standards.

A public Web site has been launched that provides seniors and families with information on individual homes and their record of care.

A toll-free action line has been introduced for the public to use in registering complaints to the ministry about care in homes.

Placement regulations have been changed to enable couples who want to live together in long-term-care homes to be able to do so.

Increased funding for resident and family councils has been established to improve community engagement and to provide residents and their families with a greater voice in the day-to-day life of long-term-care homes.

The comfort allowance which is allowed to residents has been increased by more than 3%.

The resident co-payment rates have remained frozen.

We have begun work in the ministry on revitalizing standards for long-term-care homes. The ministry and its partners are taking a number of steps to clarify and strengthen the standards so that they are more resident-focused and will achieve better resident care outcomes.

As well, the government intends to introduce a bill which, with the consent of the Legislature, would create a new long-term-care homes act to govern all 600 long-term-care homes in the province.

I know the members of this committee are very aware of how active the ministry has been in this field, but I wanted to list out some of these recent accomplishments in light of the subject of this morning's discussion.

There are improvements taking place in this sector since the auditor's reports by way of sector-wide reform. Specifically, I want to respond to the auditor's report from 2004. As I mentioned, I'll cover the key recommendations and give you the implementation status of each.

The auditor has recommended that to help ensure that long-term-care homes meet the assessed needs of each of their residents, the ministry should: (1) ensure senior management assesses the results of annual home inspections for possible corrective and preventive action; (2) implement a formalized risk-assessment approach for its annual inspections that concentrates on homes with a history of non-compliance and prioritizes inspection procedures; (3) ensure consistency in the application of standards; (4) establish acceptable notification periods and conduct surprise inspections of high-risk homes to reduce the risk that homes will prepare for an inspection; and, finally, (5) evaluate the experience and skills that are required to inspect home operations and ensure that the appropriate mix of specialists is available to the ministry.

With respect to the ministry's compliance program, it's carried out by staff who are fully committed to ensuring the health and quality of life of residents. This program is supported by senior management in the regions and, more recently, with the creation of a multidisciplinary team in the ministry called the corporate enforcement unit.

In the case of early warning flags, otherwise known as the risk management framework, the goal of that framework is for the ministry to best use the information it receives and records so that we can focus and expedite inspections so that residents are safe and adequately cared for. There's been a great deal of work on this framework, and it is to be finalized in the near future.

The ministry conducts an unannounced annual inspection of every single long-term-care home in Ontario, and we follow up on every complaint or unusual occurrence reported. Since January 2004, the ministry has conducted well over 4,000 inspections, which includes annual inspections as well as other types.

A total of 65 professional staff deliver the compliance management program at the regional level, and this number has more than doubled since 1998. The overarching goal is to bring homes into compliance so that residents are safe and receive adequate care and services. Senior management in the ministry's regional offices assess each of the inspection results for corrective and preventive actions where required.

The ministry has also initiated a redrafting process for the care program and service standards to ensure they are consistently applied in the inspection process. In the fall of 2004, all ministry compliance and enforcement staff received training based on these proposed new standards. The ministry is working toward the introduction of new legislation in 2005 that would intend to incorporate these standards.

To reinforce a consistent approach to inspections themselves and to strengthen the tools available to compliance teams, the ministry organizes annual compliance education sessions. This year marks the third annual education session.

The auditor also recommended to the ministry that to better protect the health and safety of residents of long-term-care homes, the ministry should ensure that all (1) complaints are investigated and responded to in a timely manner, (2) unusual occurrences and outbreaks of contagious conditions are reported to the ministry and recorded in our facility monitoring information system on a timely basis, and (3) complaints, unusual occurrences and outbreaks of contagious diseases are assessed in relationship to annual home inspection results to identify and resolve systemic problems.

The ministry has a good track record of responding to complaints.

Let me say that we, as a ministry, have improved upon our own benchmarks of investigating and responding to complaints. The ministry now initiates follow-up action in two business days instead of the 20 days, as was noted previously.

The growth of our compliance teams in the regions and, more recently, in the corporate office of the ministry means the ministry is more aware of the record of care in homes and more responsive to homes not meeting ministry requirements of quality care and services.

In addition to improving the response times, the ministry has also made it easier for residents and families to register complaints. A toll-free action line was created in January 2004, and since its inception we have received over 5,000 calls.

With respect to the disease outbreaks, the ministry works in conjunction with local public health units for

reporting and procedures. Once a local public health unit determines a facility outbreak is in place, the ministry has set out strict protocols and procedures supporting the requirements of public health, which include mandatory reporting by homes and requirements for quarantines and specific hygiene measures, to ensure resident safety in outbreak situations. More strict and consistent reporting requirements have also been established for unusual occurrences, such as falls and medication errors.

Again, with stricter and more consistent reporting, the ministry has better information and can respond more swiftly to care and safety concerns in homes.

A few examples:

By June 2003, ministry staff had begun recording on a monthly basis all unusual occurrences, such as falls and medication errors, reported by homes in the facility monitoring information system.

Since March 2004, all ministry regional offices record outbreaks of contagious diseases in the long-term-care system. This is in addition to the requirement for homes to report outbreaks of contagious diseases directly to their local public health units.

The ministry also released a set of respiratory guidelines to long-term-care homes in October 2004.

The ministry is now working to ensure that public health information is accessed quickly and efficiently by appropriate ministry staff to verify home status regarding outbreaks of contagious disease.

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The ministry has also issued directives to long-term-care homes and standards for comprehensive infection control programs for certain respiratory illnesses in non-acute-care institutions such as long-term-care homes. As well, the ministry is analyzing the information stored in this facility monitoring information system to better identify and resolve any systemic problems that are found.

In another recommendation, the auditor suggested:

"To help ensure that ministry policies and legislation regarding long-term-care" homes "are followed and that long-term-care service providers understand their responsibilities, the ministry should ensure that all long-term-care" homes "have valid service agreements and that each facility's compliance status is taken into account. The ministry should also ensure that all nursing homes have valid licences as required by legislation."

The ministry has a program in place to ensure that all licences are current, and by 2004, service agreements were updated and standardized.

This recommendation has been implemented.

The auditor also recommended:

"To help ensure fairness in the levels of funding provided to long-term-care" homes, "the ministry should adjust funding where warranted as a result of any level-of-care classification audit in accordance with its policy."

That recommendation has been implemented.

Let me briefly say that the ministry has a process dedicated to appealing the result of the level-of-care classification audit. I would also like to add that since April 2003, a policy has been in place whereby funding is adjusted upward or downward, where warranted, as a result of level-of-care classification audits.

The next recommendation of the auditor I'd like to speak to calls for the ministry:

"To help ensure that the funding provided to long-term-care" homes "is sufficient to provide the level of care required by residents and that the assessed needs of the residents are being met, the ministry should verify the reasonableness of the current standard rates for each funding category and develop standards to measure the efficiency of" homes "providing services; track staff-to-resident ratios, the number of registered nursing hours per resident, and the mix of registered to non-registered nursing staff and determine whether the levels of care provided are meeting the assessed needs of residents; and develop appropriate staffing standards for long-term-care" homes.

This work is currently in progress.

Long-term-care homes fall under three categories, and all three are funded and regulated by the ministry: municipal homes for the aged, nursing homes, and charitable homes for the aged. The per diem funding arrangements, care standards and eligibility requirements for admission are the same for all three types of homes.

Every year, home operators are required to enter into a service agreement with the province as a condition of funding. The service agreement requires the home operator to provide care and services for residents according to ministry standards, policies, criteria, legislation and regulations.

As for the development of the staffing information the auditor has recommended, this commenced in 2004, and we're 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 home 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 of homes.

In 2005, the ministry will be moving toward a quarterly reporting cycle on staffing for all long-term-care home operators. A review of our accountability requirements for the current long-term-care homes program funding system is planned to resolve many of the complex issues faced by this sector.

The ministry funds homes using a resident-needs-based funding formula. Every fall, the ministry classifies all residents in long-term-care homes. The classification is a documentation-based system and involves coding resident care needs. The data from the classification represent almost the entire long-term-care population in homes in the province.

Each year, funding is adjusted according to changes in the resident population's care requirements and the appropriate staffing is then determined by the home. Long-term-care operators are required to ensure that staffing mixes and patterns are sufficient to meet the needs of the residents.

To enhance the ministry's ability to assess resident care and staffing needs and identify resource allocation requirements, the ministry has initiated a project to explore the implementation of a common assessment tool, known as the minimum data set, in long-term-care homes. This is a more comprehensive assessment tool which will better reflect the care needs of residents beyond the current tool that is used.

In another recommendation, the auditor says: "To help ensure surplus funding to long-term-care facilities is accurately identified and returned to the province on a timely basis, the ministry should ensure that: audited financial information provided by facilities meets ministry needs; and reconciliations are completed and surpluses recovered on a timely basis."

In the interests of time, I think I will just say, in this case, that the recommendation has been implemented. We now have a shorter period for completing reconciliations and we have moved to in-year recoveries to improve the financial management of this program.

Another recommendation says, "To help ensure that the need for long-term-care beds is met on a timely basis, the ministry should: conduct research to determine whether its target of 100 beds per 1,000 individuals aged 75 and over is appropriate; and develop a strategy to address the results of the research."

Work on this recommendation is in progress. The ministry is conducting policy work on a long-term strategy for the long-term-care sector. We are looking into the full range of services available to seniors, including the potential use of alternative measures of need for services. This would 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 in the fall of this year.

The ministry continues to implement key improvements to long-term-care homes. A significant component is the proposed new legislative framework: revitalized standards, public reporting, risk framework and the introduction of the minimum data set on care needs. Currently in the pilot phase for introduction into homes, these supporting key areas of the reform of long-term care will help improve the overall quality of life of residents in long-term-care homes.

I have given you some detailed information which illustrates how the ministry has responded to the Auditor General's important comments. We would be pleased to respond to your questions, either today or later in written form. Thank you for your attention.

The Chair: OK. I have Mr. Zimmer.

Mr. David Zimmer (Willowdale): My question has to do with the interaction between funding formulas and unionized and non-unionized workplaces in the LTC world and how that relates to the quality of care. I have a sense that some of the LTC facilities that are unionized have to compete with the ones that are non-union. How does your funding formula adjust for the different cost paradigms in the union and non-union LTC facilities?

Mr. Sapsford: The focus of the formula itself starts with the care needs of residents. The only variable funding in the formula itself is related to care needs. The structure of the funding is segregated so that there are separate parcels of funding for personal nursing and personal care, there's a separate amount for other activities such as recreation and other therapies, and then a third component, which covers the hotel costs of operating the home. The formula itself is not sensitive to differences between union and non-union homes, but increases year over year are meant to adjust for that.

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There are several other pockets of special funding that homes receive. One which deals specifically with labour legislation is pay equity. In homes where pay equity has been a factor in their cost structure, the ministry does provide additional funding to recognize those cost pressures. Similarly, there are other aspects of the operation that we recognize separately, such as municipal taxes. Special amounts are allowed for municipal taxes, which would recognize some of the variability across the province. But the specific issue of union or non-union—the formula is not sensitive to that.

Mr. Zimmer: So in your experience, what happens in a situation where—let's take two facilities in comparable geographical jurisdictions. They're drawing from the same client base, if you will, and they have the same number of residents. One is a unionized facility and one is non-union. Does each of those facilities get the same number of dollars, following the relevant formulas?

Mr. Sapsford: Yes, based on that factor. They may get a different amount of money depending upon the types of residents they have, but it's a standard amount of allocation per diem for the care that they're expected to provide.

Mr. Zimmer: On the assumption that the unionized facilities have a higher labour cost—how do you prevent that from reflecting back on patient care?

Mr. Sapsford: Well, I suppose you'd have to look at the funding levels themselves, in the sense that our current funding reflects the average in the province. To a degree, the current funding levels reflect differences in wage rates, because we do deal with average amounts. There are a variety of other differences among homes that affect the cost structure as well—new homes vs. old homes; the size of the home often affects the cost structure—but the formula is not directly sensitive to that. Maybe one of my colleagues has more information that would help.

Mr. George Zegarac: I'll ask Tim Burns to give some more detail, but there are some pockets of funding to deal with some historical discrepancies, where we had homes that had a different cost structure: were built as a chronic facility and now are running as a home. There is some transitional funding that we have provided over the history of the running of that home, but that's basically dealing with transition costs. Tim, I don't know if you have anything else to add.

Mr. Zimmer: Just for instance, what happens in a situation where there is a facility that's providing some

hospital-type services and they also have an LTC part in the facility—that may be a historical anomaly—but the facility itself, because of union contracts and so on, is paying hospital rates? We know that nursing home LTC rates are significantly lower, but the facility is locked into the higher wage because it's a hospital facility, it's unionized, and so forth and so on. Can you adjust for those sorts of anomalies?

Mr. Tim Burns: This won't be a definitive answer. George has mentioned that we have a few homes in the system that have some particular historical arrangements. There are some special transitional arrangements for, I believe, four homes at the moment that fall largely into the kinds of circumstances you're outlining.

But insofar as how we would look at the distribution of what we call the level-of-care funding, which is the funding that we tie to resident needs, we would look at the long-term-care residents in that situation in a joint hospital/long-term-care home quite distinct and apart from any of the hospital population. There would be a separate service agreement for that program that's on that site. So we would, if you will, put a perimeter around the long-term-care home residents and assess their needs and fund them according to our level-of-care classification system. So there's no different arrangement if you're on a hospital site as far as our general funding system is concerned.

Mr. Zimmer: Except if the union has organized the entire facility, that is, the hospital and the LTC part of it, how do you deal with those union contract obligations?

Mr. Sapsford: As I said, the current formula does not recognize that distinction. It becomes an operating challenge, obviously, for the home. Our position is that where licences are granted for long-term-care homes, and the signing of the service agreement, the home is prepared to provide the service to the standard.

Mr. Zimmer: Now you've hit the nail on the head. In those sorts of situations, the operating challenge, as you described it, rests with the home, does it?

Mr. Sapsford: That's correct.

The Chair: Mr. Brownell, we'll let you go ahead.

Mr. Jim Brownell (Stormont–Dundas–Charlottenburgh): I have a question with regard to the level-of-care classification audits. I come to these committees learning something new every day. I really didn't know that there were, I understand, six classifications, is it? Well, there are the classifications, anyway. Who administers these audits? I see that the recommendation is that there's ensured fairness in the level of funding and the ministry should adjust the funding where warranted, but who makes the determination at the nursing home level?

Mr. Sapsford: For the specific classification?

Mr. Brownell: Yes.

Mr. Sapsford: I'll ask Mr. Burns to respond to that.

Mr. Burns: I'll give you an overview of how the process works. We have a classification instrument that was implemented in the early 1990s and we've used it consistently every year. We have about 150 trained nurse assessors who go out in the fall each year. They apply this instrument to the documentation on hand for every resident in the system

It looks at eight key indicators and then derives a level-of-need index, A through G. I think perhaps that's where you got the six from. It's level A, level B, level C and so on. So they look at eight indicators that have to do with ability to cope, so potentially cognitive impairment, ability to deal with activities of daily living, such as can you eat independently and do you need assistance to get dressed, that kind of thing, and some other factors.

Based on that, they develop a determination as to which of the categories a resident falls into, A through G. Then the resident population of the home as a whole is averaged and that's compared with the provincial measures. So you know an individual resident's needs, the needs of the population of the home, and then how that population compares relative to other homes in the province. This is used to balance what we call the level-of-care funding system. That's how that system works.

Mr. Brownell: One of these 150 assessors would visit every patient at a nursing home or a facility in the province?

Mr. Burns: Yes, with some minor exceptions. I'm not going to recall them all, so I'm not going to venture it, but depending on whether you arrived at the home only within the last couple of weeks or were palliative—so it's not 100%—it's about 80% or 90% of the residents every year. So 64,000 were assessed this year. We do that year over year so we can track the evolution of care needs.

The Chair: Before you came into the room, the auditor gave us a spread between one and eight as being between $49 and $62.

Mr. Jim McCarter: What I indicated was that there are different funding levels, depending on the level-of-care classification, with respect to the nursing and personal care component. I was indicating to the committee—I think the numbers I had were three or four years old, but it was something like $48 to $62, and the committee was just wondering about what was the range, how big was the range between whether you were a very high-need person as opposed to someone who was very self-sufficient.

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Mr. Burns: I can give you a description of how the range would be established. I said that we go out and do individual residents, and then we get a home population and we can compare that home to other homes in the province. So what we would develop for your case-mix index as a home would be based on your home's population and how that is relative to other homes in the province. So I'm not going to be able to tie it back to an individual resident.

The Chair: That wasn't the concern. The concern was are they going to turn back the very critical patients, the hard-to-handle patients, because they're not getting enough, and are the very easy cases getting too much? There was some concern by some MPPs that if you had somebody who had Alzheimer's and it was hard to find beds there, was the range wide enough? Perhaps if you

would like to reply in writing, that would be just fine, in terms of what that range is.

Mr. Burns: Certainly, to provide more detail, at least as it pertains to the existing system, I'd be happy to provide that in writing. The broader question of what's recognized or not by the funding system is—

Mr. Sapsford: If I can add to that, I think it's important for you and the committee to understand that I made mention of the development of a new measurement tool. That really is to provide a better grounding in the clinical information presented by residents. We feel that we need more information to refine this level-of-care approach, so we have more accurate information and we include other aspects of care of the resident, such as mental health and behavioural needs, which the current tool does not really reflect very adequately.

So the principle of what we're trying to do with the funding is to provide sufficient resources for the requirements of the residents, and the question about the range is well taken. The objective, however, is to ensure that we are providing adequate resources for higher-level-need residents.

The criteria for admission to a nursing home, though, is quite clear. We've not yet had any evidence that homes are refusing admission to residents who do fit the general categorization for long-term care homes. The other indicator in the system that would help us measure that is, of course, the problem of hospital admission, so patients waiting in hospitals for admission to long-term care is another critical indicator that is monitored to ensure that there's appropriate movement of patients and residents through the health care system.

Mr. Zegarac: If I could just add briefly, the other tool that the deputy referenced in his opening remarks was the minimum data set that we'll be looking at to really try to relate this to outcome. That will be part of the research that'll help support, how relevant is that gap and how do we relate this really to the outcome of the residents?

The Chair: The deputy mentioned that part of the need is to not block beds in the hospital. Do you have numbers, going over the last five years, as to how that has improved? If you have 17,000 new beds, presumably you've unblocked a lot of hospital beds.

Mr. Sapsford: I believe we could provide some information on that, yes.

The Chair: Thank you. Mrs. Munro?

Mrs. Julia Munro (York North): Thank you very much for coming this morning. I just want to follow up on a couple of the ideas that have been presented at this point. Obviously, the question about the flow between hospital beds and long-term beds is certainly something that I think we're all conscious of, whether it's anecdotally, in terms of any kind of personal family experiences, as well as from a systemic perspective. Are the long-term care beds in the right place at the right time in terms of the opportunities for people to move from hospital beds? That's certainly something that I think is really important.

I wanted to ask a couple of questions in some of the other areas, particularly around the risk management framework that the auditor referred to. Perhaps displaying a naïveté on this issue, it would seem to me that given the kind of regulatory framework under which all long-term-care facilities operate, there would be few who would wish to put themselves at risk in terms of their management. While I certainly appreciate the need to have regular unannounced inspections and things like that, I wondered if you could comment on the benefit of the risk management framework from the sense of reducing the number of potentially at-risk facilities.

Mr. Sapsford: I guess one needs to be careful about the use of the word "risk." We refer to it from a systematic and generic use of the word. The purpose of this, of course, is to identify areas where there may be an indication of something more fundamental going on. So in identifying risk factors and identifying them during inspection or complaint investigations, we use them as indicators for something more fundamental going on. The development of the information system that the auditor talked about, where we're compiling this information and looking at it more systematically, will help us to see if there are fundamental things that need to be changed in the system. So it's not from the perspective of, "Oh, it's risky and we're going to handle the risk that exists," but identifying occurrences such as falls would be one; another one might be bedsores of patients. To identify these sorts of symptoms or characteristics allows us then to look more systematically at the care in the home.

The object of the risk framework is to identify outcomes of care or aspects of care that are not desirable and to use that as a way to, first of all, correct problems and, second of all, look at more systematic policies or standards that could be implemented to reduce risk in the future. So that's the purpose and function of the framework that we're talking about.

Mrs. Munro: I think it's important not only for us to understand that, but also for people generally. I think of a year ago, when there was a great deal of press attention drawn to specific situations which, obviously, all of us would find most objectionable. It naturally reflects then in a way on all providers, but also in terms of government and the oversight that people expect government to be taking. So I think it's really important for us and the general public to understand the kind of detail that you are working on and the benefit that it is going to provide to the system overall.

Are you able to look at other jurisdictions and the kinds of standards in this particular area of risk and to look at their success with a risk framework?

Mr. Sapsford: As far as the development of this, I'm not sure. But in general terms, certainly we're looking at a policy review in a number of these areas in the midst of it, and looking at other jurisdictions is certainly part of it. As we look at legislative reform as well, we will be looking at other jurisdictions, in this country as well as in others, to inform our discussion. Other sectors of health care also lend tools and measures that we will be looking at as well. In fact, the risk framework itself is used in

other sectors of health care to ensure that the standards in quality of care are maintained at as high a level as is possible.

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This ministry takes extremely seriously the responsibility of compliance with legislation and policy in this particular area. I hope you note from my remarks some of the things the ministry has done in the last year or two to strengthen that sense of responsibility in ensuring that care standards are maintained in the province. It's quite clear to me that we'll be doing more in the future. This is a very sensitive and very vulnerable population of Ontario residents. Certainly we're very engaged in ensuring that the framework around how care is given and the standards we would all expect are in fact achieved and maintained.

Mrs. Munro: I think we're all on the same page on that one.

I wanted to ask you about an issue that actually came to me from a constituent. His concern was that he believed there was a reduction in staff. I wondered whether or not, given my understanding of the regulatory framework upon which any facility would operate, it reflected more a change in the capacity of the facility as opposed to any other driver.

Mr. Sapsford: There are probably two or three factors that could lead to that perception, and one could be a change in capacity. The major one, though, would probably be the funding formula itself. As we've already explained this morning, the level-of-care system is adjusted annually based on the population of residents. One of the comments—or criticisms, frankly—from the auditor was that the ministry was adjusting the funding amounts where the care in the home actually fell over time. Because we're now doing these recoveries, if there is a substantial change in the care needs of a particular nursing home, the funding is reduced, because the requirements have gone down and that would lead to some adjustments in nursing home staffing levels.

The other was occupancy. Sometimes the occupancy in a home does fall, and consequently the staffing levels fall. Occasionally, as part of enforcement, the ministry will actually freeze admissions to a home, in which case the number of residents will fall, and consequently the staffing levels will fall.

There is usually a reason behind it, and those are typically the ones you would see.

Mrs. Munro: I wanted to ask you a question about the higher level-of-care component within a facility. Would they be characteristically similar, or would there be facilities that would tend to specialize in specific levels of care? In other words, are we going to see some where there aren't very many people who would require high levels of care and others where the decision would be to have the opposite kind of client?

Mr. Sapsford: The way the program is structured, there is no purposeful segregation in that manner. There is always, from home to home, a variation in the kind of residents. Over time, some homes tend to congregate a specific type of resident. So you may find that some homes have speciality areas in behavioural problems or mental health, and some have specialized units, or separate units, to deal with patients of like type. Similarly, patients who are bedridden and require a certain type of nursing care, a routine type of care, may congregate those residents in different parts of the home to provide more consistent nursing care.

As I said, I think you'd find some variation across homes, but not to the extent where 50% or 100% of their population is this particular kind of care versus another. I don't know whether my colleagues can add to that.

Mr. Zegarac: I'll just add that I think there definitely is a variance around the homes and how they themselves approach the issue. We're well aware of the issue of how we handle and invest most effectively and use our resources around those specialized needs. We are looking at examining the effectiveness of how different homes are dealing with that, so that we can look at how we can guide homes in the future around dealing with specialized population needs. So it's an issue we are looking at.

Mrs. Munro: If I could just bring an aspect of that to our discussion, one of the comments that has come, again from a constituent, is that you have people of a much younger age who may need the kind of care a long-term facility can provide. Of course, the tendency is that those people are with people who may be 30 or 40 years older than they are. There is perhaps an opportunity to be looking at the kind of special care needs of a much younger population.

The Chair: Andrea?

Ms. Andrea Horwath (Hamilton East): Good morning. I wanted to ask some questions around the service agreements. I know that in the documentation you indicated in your opening remarks that service agreements are now up to date and in place in all facilities. Looking at the kind of standard service agreement, they indicate requirements around where new envelopes, the additional funding, the extra money needs to be spent. I think the first section, up until December 31, 2004, is a little more flexible, recognizing, I guess, that there are transitional requirements. When we get into 2005, the requirements are a little bit more stringent in terms of ensuring that the nursing and personal care needs is where that money is going.

We're hearing some concerns around where the accountability is to ensure that funding is actually going to the provision of extra personal care and extra nursing, as is indicated and signed off on by ministry and long-term-care providers. Could you provide some information?

Mr. Sapsford: I can certainly start. The allocation of those funds was for specific purposes. Some of the flexibility really was to give the homes an opportunity to begin to hire staff and to put the requisite staff in place.

As far as the accountability portion of it is concerned, the agreement says the homes may only spend the additional funding for nursing and personal care. We've just received, actually last month, the results of our first

survey, where all long-term-care homes are required to report to the ministry actual nursing hours by category and expenditures over a period of time. That first period was prior to the introduction of the funding. We will be taking a baseline of the amount of nursing staff and hours that in fact were provided. Then the second survey has gone out for the next period of time. So we're in the midst of doing the analysis on the first piece of information, which would give us the baseline, and then from that point on, we intend to have quarterly reporting so that we can actually monitor the change in nursing hours and expenditures. That will be the principal way we'll monitor the compliance with the service agreements.

Mr. Zegarac: If I could just add to the deputy's comments, as he mentioned earlier, this funding is in specifically targeted envelopes, so if that funding isn't used for the intended purpose, we recover that funding. So the incentive is there for them to staff up and use the funding as intended. We also do reconciliation, and it's audited. I think those provisions will add to the accountability.

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Ms. Horwath: Just following up on that: So the baseline data is in; you're now in the process of the second leg of the survey to begin the comparison process. When would you expect to have your first piece of comparative data available?

Mr. Zegarac: There are about 40 homes still outstanding on that second survey. Those are due by the end of this month. So we're hoping, in the coming weeks, shortly after that, that we'll be able to analyze and report, probably in a month after that point in time.

Ms. Horwath: So mid-year, June?

Mr. Zegarac: Yes.

Ms. Horwath: Just to be clear, this will now become a routine reporting requirement that, every three months or so, an automatic survey goes out and comes back in, and there's, I guess, a system of technology that plugs the numbers in and spits out the information?

Mr. Zegarac: Absolutely.

Ms. Horwath: Then can I just ask, in the same vein around the extra funding provided for extra personal care and extra nursing staff: How are you making sure, or are you making sure or is there a way to ensure that, for example, the requirements for bathing don't cause other parts of people's personal care or needs to be reduced so that they can get the bathing in, because now that's a specified requirement? Do you know what I'm saying? How are we making sure that, where specified requirements are implemented like the bathing requirement, that doesn't reduce the quality of care in other areas of a person's needs?

Mr. Zegarac: I'll start on this one. First of all, we look at our compliance around the risk management framework that we've been speaking to. So the intent is that we're funding, obviously, those things that we think are most important in terms of the care and in the risk around the residents, but what we want to do is ensure that we can work with the homes to look at ensuring, in terms of our compliance reporting, that we're focused on the most important things, and that's where I referenced that relationship to the MDS system and the health outcomes. So that's what we're going to be evolving through and working through: ensuring that our compliance and enforcement activity and the homes are focusing on those things that are most important to securing the best health for the residents and the quality of life.

Ms. Horwath: The reason I raise it—and you may have heard—is that this is a concern that has come forward in terms of changing the requirements or reducing the number of times, for example, that adult diapers get changed, because they just don't have the time, so they're not going to bother. They let those garments fill up to their capacity, which means, then, that people are often sitting in their own waste for hours on end. Is that really appropriate in terms of a quality-of-life measurement?

Mr. Sapsford: Of course, we would say no, that isn't, but that becomes the ongoing challenge for our inspectors. So if they went into a home subsequent to this and found evidence that, from previous inspections, something else was giving way, then they would take note of that and require compliance.

The specific issue here is that additional resources have been provided to augment the care. So from the ministry's perspective, we wouldn't expect to see any diminution of service in other areas, because additional resources have been provided. So through the risk framework that we've talked about and, actually, the inspectors going in and monitoring the care, looking at charts to ensure that there's appropriate documentation of care, I would expect that we would identify additional problems through that mechanism or through complaints or other tools that we have.

Ms. Horwath: Just one last area: You talked a little bit, in your comments, about the future in regard to legislative change. I know that this is all specific to the 2002-04 Auditor General's reports, but there have been subsequent things that have occurred in this sector. I'm thinking particularly about the Casa Verde inquest. I know it's not part of this, but do you see things coming forward like ratios of nurses, for example, or personal care workers to residents, and things like dealing with the efficacy of permanent staff as opposed to contract staff? Are any of those kinds of issues on the radar? That might not be a fair question, but I think we need to take all information as we move forward, particularly toward legislation. Are these things in the hopper in terms of the way that you're thinking about change to the sector?

Mr. Sapsford: The short answer, I suppose, is yes; they're under active consideration. I referred to a couple of policy review processes, both on funding and on care standards. The work we're doing now, where we're actively surveying nursing homes for their staffing hours, will immediately establish at least a floor.

I guess our concern is that when people talk about standards of staffing, they're talking about a number. As we've tried to indicate to you, in long-term-care homes,

we're more interested in providing staff to the needs. Within a flexible range, I think it's quite clear the ministry is moving toward active consideration of being much more definitive about expectations around staffing. What the specifics of that are I can't tell you today. That's a matter of discussion, and ultimately the government will have to come to some decisions about that. But it's certainly very much part of our work agenda.

Ms. Horwath: In your comments you do mention the expectation that legislation will be forthcoming in 2005. Is that still the target?

Mr. Sapsford: That's the current intention.

Ms. Horwath: If I could ask one last indulgence, just following on the previous comments around young people: I come from Hamilton, and there are big issues right now in regard to a particular facility where some decisions have not been finalized. It seems to me that the issue is the extent to which a person's quality of life can be addressed when they are living with people who are 30 or 40 years older. It's not just a matter of physical care; it's a matter of social opportunities; it's a matter of peer groups and those kinds of things. I'm just wondering if purpose-built facilities for younger clients who need long-term care are something that's being considered.

Mr. Sapsford: At the present time, it's not on our policy agenda to look at specifically. I believe it will come up. The auditor suggested we look at 100 beds per 1,000 population over the age of 75. In examining that again, we're looking at a broader range of questions: Do we need 100 beds per 1,000, or are there other ways of providing care closer to the community, such as more supportive home care? Those sorts of options may shift the need for in-home residential care.

For the younger adult population, I would suggest that's an even more urgent question. Finding specialized facilities à la long-term-care facilities would be my last option. So as part of that review, we will probably be looking at that particular question in a broader context than simply that of, "Let's have purpose-built long-term-care homes for people under the age of"—and then pick an age. It becomes a difficult policy question. We're trying to address that issue from a broader perspective. Without projecting results, it may ultimately come on the agenda, but it does not currently.

Ms. Laurel C. Broten (Etobicoke-Lakeshore): I wanted to get some clarification on a statement made in your opening remarks with respect to the investment of $191 million over two years. It's my understanding that the projected funding for 2005-06 is $191 million for that fiscal year. The issue in 2004-05 was that the announcement was not made soon enough in the year to be able to fully flow the entire $191 million. I think we've had flow-out of $135 million of actual funding in 2004-05. If you could just clarify: The statement would seem that it was over two years, but I believe it is annualized funding at $191 million.

Mr. Sapsford: That's correct. It was a two-year implementation of the full amount. So the $191 million is the fully annualized amount. The additional funds began to flow effective, I think, October. As I've already mentioned, the uptake of additional staff takes some time. The full expenditure won't be realized until some time in this current fiscal year.

Ms. Broten: OK.

Mr. Sapsford: If I might add, some portions of the $191 million are also for what we call alternative level-of-care program, and on that particular part of the expenditure, we are developing a more specialized unit in some nursing homes for convalescent patients from hospitals, and we're in the midst of an RFP process to solicit proposals. So the balance of that $191 million in fact has not flowed yet because we're waiting to make decisions on which homes will receive that specialized funding.

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Ms. Broten: Can you give us a little bit more background on that alternative care strategy?

Mr. Sapsford: I will start. We start in hospitals where in-patient medical beds have patients who require not acute intensive medical care, but a longer period of convalescent care. This proposal really came up through the health care system to the ministry. It was to develop a limited number of more specialized beds in long-term-care facilities that could provide more convalescent care that typically had been provided in the hospital. By moving patients to those convalescent or alternative level-of-care beds, we could free in-patient medical beds in hospitals, and hence improve the access to in-patient hospitals through emergency departments. So that particular funding was allocated to implement those specialized units. As I've said, we're right at the decision-making process about which homes and where the allocations will go.

Ms. Broten: So by the end of fiscal 2005-06, just over $46 million will flow out, is my understanding.

Mr. Sapsford: Yes.

Ms. Broten: But in the current 2004-05 year, even though funds had been allocated, those funds were not able to flow because of the uptake issue you've mentioned?

Mr. Zegarac: If I can comment on that, there were 171 homes that we moved on immediately. Those are predominantly in the northern areas and, as we talked about, there are some areas that are underbedded and have severe needs. Those have been allocated and funded already out of last year's money. There are 25 convalescent beds that have been allocated. It was a pilot that we had run in Ottawa. So 25 of those beds have been allocated. It's the remaining portions that will be allocated this year.

Ms. Broten: Just to pick up on a question that Ms. Horwath was asking about, as we see the ministry really identify specific areas where money will flow to accomplish a certain goal, historically we've had citizens in the province who have said, "Government has flowed money for additional nurses, but in fact we're not seeing additional nurses in our long-term-care facility. We think it got used for raises or whatever it would be." I wonder if you could just go back to the issue of accountability and how, with each one of these specific line items that's

to accomplish a certain goal, we are going to be able to know at the end of fiscal 2005-06 that the money has been spent on those specific areas.

Mr. Sapsford: Principally on the question of nursing and personal care through the survey methods I've talked about already, other allocations have gone out to long-term-care homes this year for acuity adjustments. The question of additional revenues to homes to offset the costs of increased wages and so forth were at least partially accounted for in a separate allocation to long-term-care homes. Our expectation is that we should see a substantial change in the number of nursing and personal care hours as a result of this allocation. As has been said, the surveys that we're in the midst of conducting should provide the accountability back around that and, if it isn't there, then the ministry will be making recoveries in-year.

Mr. Richard Patten (Ottawa Centre): Thank you for your report this morning. I'm interested in the area of standards, and some comparative ones. I appreciate it's not just numbers. I fully appreciate that, because one of the hazards of government is flexibility in looking at each home as different, each community as different, yet the push is to always have a universal standard. You've always got that conflict, so I do appreciate that.

I want to say that—I'm from the Ottawa area—I get fewer complaints now than I did few years ago, when it was almost a daily occurrence, much of which was around the Perley-Rideau home. That is a very sad historical experience for the provincial government, in my opinion. It still has a way to go. I used to get complaints about family members having to complement the services of the staff, and that each year the home was required to drop staff on a six- or seven-year plan, when the deal with the old Perley hospital was that they would be a multi-service facility and then the government reneged on that. That is a very strong sore point, I want you to know, in our community.

Having said that, I know the inter-relationship of home care for certain homes has improved a little bit, because you have more resources now, and so does your portfolio. I'd like to look at an area that I haven't seen in the report, and that has do with nutrition and personal care support, such as dental checkups. These are for those who are somewhat confined to homes and it's very difficult for them in terms of mobility to get out to see a dentist or, for some reason, it's not identified. One of the areas that has been identified on a number of occasions is the visitations. There is a possible bill in the works that may address this, certainly with the dental hygienists, that I think would be a good thing.

I'm rambling a little bit, but when I heard $4.55—is that still what the food budget is per person in homes? If it is, tell me how you can do that. Three meals a day plus snacks for $4.55.

Mr. Burns: This is another area where some of the earlier discussions we've had—the operational implementation belongs with the home and there are challenges, but the raw food amount is now $5.24. I suggest to you it's important you consider that that is a protected amount, which means it's the minimum that can be spent, not the maximum, and there's some flexibility. We've mentioned the envelope system; it's a sub-envelope, if you will, within a bigger one, and it's a protected amount, not a maximum.

Mr. Patten: How would that compare to the actualities?

Mr. Burns: We would have, through our reconciliation process—I could get you some information on actual expenditures, but I couldn't hazard a guess right now.

Mr. Patten: You have dietitians or nutritionists in the system. Is that standard universal in all homes that receive government support, in terms of the quality of food, the nature of the preparation, the nutritional value?

Mr. Zegarac: If I can comment on that issue, over the past year we've been working on a draft regulation around nutrition and hydration, and this is one of the areas where we're looking to improve on our standards. That will be something that will be coming with a number of other regulations we're proposing as part of our regulatory and legislative package. I can just speak to the fact that I think there will be changes in that area in the future.

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Mr. Patten: I've been doing some reading on the area of hydration. In fact, there's a whole book on the area of, "You may not be sick, you may be dehydrated." It's a profound book because this doctor points out that as we age, we lose our capacity to identify when we're thirsty. If that's so, that has profound implications for personal care workers and their attention to make sure that individuals drink good, nutritional water each day.

When you look out, you must have some indications of how we are doing in relation to other jurisdictions. Which jurisdiction or province would be the finest in the land, as it were?

Mr. Burns: Ontario. I can tell you at this point, as has been suggested, that we've invested some staff effort and work with the sector on nutritional guidelines and standards as a priority. I can only agree with you that the nutritional status underpins your overall health status, so we identified that as one of our fast-track standards. I can assure you we did look at other jurisdictions in the course of doing that study.

Mr. Zegarac: If I can comment on this issue, I think it's always difficult when you're doing comparisons. We have, for example, significantly increased our compliance enforcement activity, so we'll find more issues. Many provinces have come—recently we've had provinces come because Ontario has been referenced as a benchmark. We share information. We look at that. At a point in time, we'll all be at different stages, but I think Ontario definitely is forward on many of those issues. We're looking to improve ourselves even further.

The Chair: I'd like to clarify that as I get older, I don't have any trouble at all identifying when I need a drink of Scotch.

Ms. Broten: I have one follow-up question to the questions I was asking earlier. In my own community, I

had the pleasure of connecting with my long-term-care homes to learn about the bed lifts and some of the equipment they were going to be purchasing this year. In your earlier statement, you made indication of an allocation of $80 million to equipment. I just wanted to confirm that what I would have been hearing in my own community would have come out of, I'm assuming, the $80 million in allocation, which is fully separate from the $191 million we were discussing earlier.

Mr. Zegarac: Yes.

The Chair: On page 3 of your opening remarks, Deputy, you talked about the spending in the long-term sector increasing by $1 billion from 2000-01. How would you characterize that huge increase in the health care area? Is this sector taking over some functions that the hospitals provided before or some other part of it, or was there just that huge need that wasn't being fulfilled in the past?

Mr. Sapsford: Maybe one of my staff can actually give you the proportions, but there were two basic reasons. One is simply the increased cost of operation and increases to the allocation year over year. An example would be this $191 million over two years for additional care. But remember, as well, that over this same period of time there have been thousands of new nursing home beds opened across the province, so a large part of that increase would also be related to an expansion from what was 57,000 to 74,000 beds. That is a large part of the growth.

It represents growth in the sector as a whole. However, it does, by and large, reflect the need for this kind of care as our population ages. Whether it's the exact right number, whether we need to do more, whether we need to modify it, whether we need to look at increasing the ability of homes to take care of heavier-care patients—these are all part of the adjustment process we now have to go through. There's been a huge capacity increase in long-term-care homes, and now we have the base on which we can begin to look at the program policies so as to best use these resources in the process.

Those would be the two major reasons where the $1-billion change over that period of time comes from.

The Chair: I guess I have a difficult time seeing a budget increase by—what would it be?—70% or 80%, from $1.5 billion, presumably, to $2.5 billion, without some kind of justification.

Mr. Patten: They're playing catch-up.

The Chair: Is it catch-up? That's what I'm asking. There was some catch-up, no question, but I know that in Ottawa, for instance, there was a waiting list of 1,400 people, but when the call came, only a third of those people would actually occupy a bed. The waiting list didn't match the need. I think we may have put 1,000 beds into Ottawa. Where did the other 500 people come from who are occupying those beds?

Mr. Zegarac: I'll start by commenting. Part of this is definitely an expansion of capacity. We expanded by 35%. That's a good portion of the attribution. Part of the problem, if we can look at wait lists, is that wait lists grow, and then when people get frustrated, they just don't bother to search for that capacity if they don't think it's there.

Our residents have historically been getting older in age, and while we are trying to provide additional home care services, we're going to have to adjust and continue to monitor. That's one of the efforts we're focusing on: How do we better assess the needs in those communities? We're looking not just at the supply but at the demand for those services. That's what David's group is focused on doing right now. They're looking at what we need to adjust in this, recognizing that there are other capacities in the community that we'll be investing in that may be more appropriate for the needs of the resident. What is it we want to have available in the more institutionalized, the hospitals, for those with the highest-level acuity, and then into long-term-care homes? We're trying to continue to monitor and adjust. I think that's one of the historical problems. We look at points in time, and then we react. Right now, we want to have ongoing assessments of those needs.

The Chair: I guess I'm still not getting the answer to my question. When you go up by $1 billion, we just can't afford to keep going up by those kinds of numbers and sustain our system. What I was looking for was whether there was part of those 17,000 beds that you could say would have been for people who would still have been in the hospital or in some other form of care that we might have provided. I'm also concerned that people may be in a higher-cost bed of $100 or $110, depending on whether you put capital in or not, approximately. Should some of these people be in less intense, less costly institutions on the continuum of care we provide for our elderly?

Mr. Sapsford: I follow. I can't quote systematic numbers to you today, Mr. Chair. We talked earlier about patients in hospitals. I can give you first-hand knowledge from my own experience, most recently in Hamilton. The hospital there at one point had 132 patients in the hospital waiting for placement in long-term-care homes. Subsequent to new nursing homes opening, that number fell. In one month, it was as low as 10 patients.

The overall strategy of expanding the capacity of the long-term-care system has in fact relieved to a degree the pressure on acute in-patient units. I've seen it first-hand. That allows more care in the hospital; it's a more appropriate use of resources.

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There are other examples where patients in chronic hospital often would only need extended levels of care. So I've also seen it where opening nursing homes has allowed freeing up of other, more intense resources for better use. There are limits to that, and I'm not aware that we have a systematic measure of that shift at the moment.

Mrs. Munro: Just a couple of questions.

When you gave your presentation, you referred to the facility monitoring information system. When I asked a question on the first round, I asked about the risk management framework. I'm assuming these two things are closely related, but perhaps you could confirm that for me or not. Would the benefit of the one, then, impact on the other?

Mr. Burns: The answer is yes. When the deputy framed his first response, he suggested—because you were concerned about how much risk was acceptable; not to put words in your mouth. The risk management framework operates, I think, in two important ways. One is to look forward to see how we can better reduce risk going forward. So that's where you get sort of system level indicators, if you will.

Operationally, the bulk of the data in that system derives from the compliance inspections. So they go out, do an inspection, come back, and there's information that comes from that. Then there's what you could call self-reported information, like unusual occurrences.

Then, in practical terms, how we operationalize the other side of a risk management framework, which I would call resident protection, is that we use it to see who's where on which indicator. So we look at things like medication issues or nutritional problems, that kind of thing, and we say, "What are our priorities, then, in terms of who we're going to visit, where the follow-ups need to be, who needs to get the next surprise annual inspection?" That's how we take it and apply it in practical terms, because you can't wait for the system to be perfect.

Mrs. Munro: I guess from my perspective as an MPP, obviously what I want is that you can't find anybody who falls into that category. Seriously, you want it so that anyone whose family member is a resident is guaranteed the kind of security and management that obviously reduces risk. That was why I asked about, first of all, the risk management side, but also, then, how the other would fold into establishing risk management.

Mr. Zegarac: The other thing I'd like to just bring to your attention is that we've also, in addition to our responsiveness on complaints and increased investigations, invested in resident and family councils in the homes so that they can participate and inform us of the issues in the homes. They can participate in the day-to-day decision-making in supporting the homes around the needs of their family members or their own needs in those homes. So we've layered different appropriate vehicles to share that information with us. That's just another one I wanted to bring to your attention.

Mrs. Munro: I appreciate that.

I wanted to ask you about the study that you're doing on the 100 beds per 1,000. I appreciate in your comments that you suggest it would be later this year that you would be able to provide some kind of information on the study.

One of the things I'm conscious of is that people who are under 75, if we're going to use that line, say, "Yes, my parents are there, but I don't want to go there," and the fact that I've heard that kind of comment among people who would be kind of the next generation to go to a long-term-care facility.

I also appreciate the fact that people are living longer. I just wondered if in your research you had run across this kind of attitude and whether it's significant enough to be of concern or not, and also the question of longevity. I understand that within a few years there are going to be so many more people who reach 100—things like that.

Mr. David Clarke: I think that's one of the reasons we're looking at the criteria that we had used previously. The 100 beds per 1,000 people over the age of 75 was the only tool the ministry had available at the time to figure out where the beds should go. But now, as we're building them and seeing that there are areas where we have too many beds and other areas where we don't have enough, we need to understand what's behind that and the demand side of the business, and to look at alternatives and other ways of serving the same population. The deputy mentioned more home care, supportive housing, looking at the alternatives. As you mentioned, long-term care isn't the answer for everyone. So we need to look at all those alternatives.

As for the increase in the number of senior citizens in Ontario, it will be booming over the next little while and we're also seeing higher instances of Alzheimer's and so on. We need to look at how we serve those populations. Those are some of the things we're looking at. It's just a broader perspective on what is the best way to serve the needs of the population, going forward.

Ms. Horwath: I just wanted to follow up on the alternative levels-of-care program and ask two specific questions; one is, how much of the $191 million is allocated to that alternative levels-of-care strategy?

Mr. Zegarac: It's $46 million.

Ms. Horwath: So is the alternative levels-of-care strategy a continuation of the sustainability program that ended at the end of last year, or is that different?

Mr. Zegarac: No, it's not. It's completely different, yes.

Ms. Horwath: That's it. I had those last two.

The Chair: We were discussing in the closed session some people who represent different areas. As MPPs, we receive complaints from people who have retirement homes. In the area that I represent, I've got some very, very good ones and one or two that I don't classify as that good. The very good ones are saying that when somebody goes to the CCAC they're never considered as an option in terms of reference of that particular person, who can no longer stay in their home.

Is there any policy that the Ministry of Health is developing to try to divert people into a less costly area of care than we have now? It's particularly pertinent when we have a large increase in our capacity in long-term care. There's actual competition for clients and residents. So, in the overall cost of providing this system, I think it's important for us to use a whole continuum of care in terms of what we're offering, especially if they can be taken care of in a less costly facility.

Mr. Sapsford: I would agree with that view. As my colleague has said, we are in the midst of looking at some of those issues now.

As to the specific question about CCACs and placement, they use a standard assessment tool to determine eligibility for a long-term-care home based on accommodation and physical home situation, care needs and so

forth. Where a person is at home and doesn't require the level of care of a nursing home, it would be my understanding that someone wouldn't be referred there. But the intermediate level of accommodation may, in fact, for that particular person, be the best choice.

You have to remember that we're dealing with insured services. Retirement homes are not insured services, so there is a difference in whether this would be a government-funded program. But there are criteria around access to each of these services and an assessment process to establish whether an individual person qualifies for placement.

The Chair: It just seems to me that, notwithstanding all of what you are saying, there is a tendency for the market to push them up to a level of service which may be excessive. I'm not saying that this is widespread, but even if it was 10%, that's a huge cost saving that we could allocate somewhere else in terms of our health care system.

Are there any further questions that we might have?

Thank you very much. You'll be responding to us in writing on some of those matters.

Mr. Sapsford: Yes, there are a couple of follow-ups that we'll provide for you.

The Chair: Thank you very much. I may forward to you some specific questions after the clerk and the auditor have gotten together in order to try to focus on those.

Members of the committee, we'll grab a sandwich next door and then reconvene after our guests leave and just talk about any recommendations we might want to make to our researcher in preparing the report.

The committee continued in closed session at 1121.

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