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Jeudi 27 février 2003

Standing committee on public accounts

Comité permanent des comptes publics

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Rapport annuel 2002, Vérificateur provincial : Ministère de la Santé et des Soins de longue durée

Chair: John Gerretsen
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Thursday 27 February 2003

Jeudi 27 février 2003

The committee met at 1001 in room 151, following a closed session.

2002 ANNUAL REPORT, PROVINCIAL AUDITOR MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 3.04, long-term-care facilities activity.

The Vice-Chair (Mr Bruce Crozier): The standing committee on public accounts will come to order. We're meeting today to consider the 2002 Annual Report of the Provincial Auditor, and in particular to consider section 3.04, long-term-care facilities activity for the Ministry of Health and Long-Term Care. Welcome. I appreciate your appearing before the committee this morning.

One of the rules we operate under, Deputy Minister, is that we will allow up to approximately 20 minutes for you and your staff to address the committee. We'll then have rotation of the caucuses that will be 20 minutes in length for questions and comments. We will begin with the Liberal caucus.

I ask that any cellphones in the room be turned off or somehow muted so they don't interrupt the proceedings. We look forward to a productive meeting. One other thing: we would appreciate it if anyone who addresses the committee gave, as I have said, their name, rank and serial number, if you like. Thank you very much. You may begin, sir.

Mr Phil Hassen: Thank you very much, Mr Crozier and committee members. I appreciate having the chance to speak to you on these matters before you. My name is Phil Hassen. I am the Deputy Minister of Health and Long-Term Care. So that you have some context, I've been in the job for approximately six months. I'm running up to this very quickly, and I appreciate all the help from my staff who will be here as well to assist me today.

On behalf of the ministry in general, I'm pleased to meet with you and to have the opportunity to respond to the report of the Provincial Auditor as it applies to long-term-care facilities activity. Let me preface my remarks with an overview of long-term-care facilities services in the province. As many of you know, the government funds and regulates three types of facilities: nursing homes, municipal homes for the aged and charitable homes for the aged. These facilities are governed by the provisions of the Nursing Homes Act, the Homes for the Aged and Rest Homes Act and the Charitable Institutions Act. Per diem funding arrangements, care standards and eligibility requirements are the same for all three types of facilities.

As you probably know, long-term-care facilities take care of people who are no longer able to live independently in their homes or who require 24-hour nursing services. Nursing services are provided by registered nurses and registered practical nurses. As well, many people would say that personal support workers and health care aides are also providing a form of nursing support and personal care.

Long-term-care facilities are also funded specifically to provide other quality-of-life-related services, including some recreational activities, therapists, and other programs designed to assist residents in maintaining a good level of functioning and enable them to enjoy life.

Eligibility for admission is determined by a community care access centre, or CCAC. The CCAC also determines priority for admission and manages the waiting lists for facilities. As of January 6, 2003, the province funded 64,132 beds in 541 facilities. These include 376 nursing homes, with a total of 38,604 beds; 99 municipal homes, with a total of 16,558 beds; and 66 charitable homes, with a total of 8,970 beds.

Now let me turn to the 11 specific recommendations by the Provincial Auditor, recommendations that we very much appreciate the opportunity to respond to and take seriously. As well, we want to talk about some of the steps that we've taken to address these matters.

The first recommendation of the auditor was to ensure that long-term-care facilities meet the assessed needs of each of their residents. The government does ensure that. Certain standards for quality of care are provided to residents of long-term-care facilities through the ministry's long-term-care compliance management program. This program consists of annual inspections of the long-term-care facilities, and inspections as required by specialists such as dietary experts, environmental advisers and financial analysts. Investigations of complaints submitted by residents, their families or the general public are also attended to.

The ministry's compliance management program is carried out by registered nurses, registered dietitians and certified health inspectors with a background in long-

term-care. These are all dedicated professionals with an interest in long-term-care services who are fully committed to ensure the health and quality of life of long-term-care facility residents.

Currently, the ministry is undertaking a comprehensive review of its compliance management system in order to determine areas of improvement. The ministry continues to recruit for vacant positions to meet the needs of the compliance management program. The core of this review is the further development of a risk assessment approach. This may include additional risk factors that will act as triggers for action by compliance staff and senior management. These indicators and actions would be in addition to actions that are currently triggered by reports from the compliance management team. The ministry currently conducts annual reviews as well as unannounced compliance investigations and other types of review visits to long-term-care facilities, and we are considering unannounced annual review inspections in the future.

The second matter raised by the Provincial Auditor was that the ministry should better protect the health and safety of residents of long-term-care facilities. As you can appreciate, we are committed to protect the health and safety of all residents. We demonstrate this commitment through ministry reviews of resident care and services. This includes four key components: program and service reviews, indicator identification and analysis, in-depth review of residential care, and review of staffing. I must say that virtually all, but not all, go through an accreditation process as well through the Canadian Council on Health Services Accreditation.

For the program and service review, the compliance adviser examines the operation of each facility to assess compliance with the established standards and criteria.

For the indicator identification and analysis, the compliance adviser undertakes focused audits to review and evaluate resident care, programs and services from a risk-management perspective, concentrating on significant care concerns. Where possible, residents are interviewed from all resident care units. In addition to the residents selected for focused audits, a minimum of five residents are selected for the in-depth care review.

The review of staff deployment is completed to assess the allocation of staff in accordance with residents' needs as well as the staffing information submitted with the service agreement.

It is also our policy to investigate and respond to specific complaints within 20 days, and we are diligent about putting this policy into practice. While the ministry has a good track record of responding to complaints, it is continually striving to improve it. Ministry staff follow up on unusual occurrences, either at the time of the occurrence or during an annual review of a facility. In conjunction with local public health agencies, the ministry has strict protocols and procedures in place to ensure resident safety in outbreak situations. Local public health officials determine when to declare a facility in outbreak status and monitor the progression and resolution of that outbreak.

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The ministry is committed to improving its data entry systems and information management with respect to these issues and will use these data to identify and resolve any systemic problems.

Third, we are to ensure that all long-term-care facilities provide high-quality care to all residents in compliance with applicable legislation and government policies. We are very committed to providing high-quality care to all residents, and that's why the ministry's compliance advisors monitor facility compliance with the legislation, regulations, ministry policies, service agreements and the standards and criteria contained in the long-term-care facility program manual.

The ministry responds to all complaints, and I can assure you that it is conscientious in doing so. The enforcement function, formerly carried out by head office, was transferred to the regions in the late 1990s.

The Minister of Health and the director of long-term-care facilities have the authority to impose sanctions on long-term-care facilities. The ministry is reintroducing support for the enforcement function at head office and has hired an enforcement coordinator, whose function will be to coordinate the corporate compliance and enforcement unit. This unit will be responsible for monitoring high-risk facilities, the coordination of enforcement activities, improving data collection and analysis, the development of educational programs for compliance staff and, frankly, other operational support for the corporation and regional offices.

Also as part of this recommendation, we are to ensure that all long-term-care facilities have valid service agreements and that all nursing homes have valid licences as required by the legislation. The government is taking decisive steps to make the health care system more accountable to Ontarians. For example, each year facility operators must sign a service agreement with the ministry outlining what programs and services will be provided in exchange for funding. The ministry is undertaking a review of the management process supporting service agreements. The 2001 and 2002 service agreements have been distributed to facility operators. The ministry will distribute the 2003 service agreements to facility operators by April 30, 2003. I'm pleased to report all eligible nursing homes have had valid licences as of September 1, 2002.

The next issue is that the government ensure fairness in the levels of funding provided to long-term-care facilities. This government is committed to long-term-care facility services. To demonstrate that commitment, it will provide nearly $1.8 billion in long-term-care facility program funding in 2002-03. This funding represents an unparalleled $700-million increase since 1995. From 1998-99 to 2005-06, $602 million of the $1.2 billion is being invested in long-term-care facilities to bring the number of beds from approximately 57,000 to 77,000, to match the increased care requirements of all 77,000 residents.

Fifth, we should ensure that the funding provided to a long-term-care facility is sufficient to provide the level of care required by residents and that the assessed needs of residents are being met. I'm pleased to report that effective August 1, 2002, the government did increase nursing and personnel care funding by $100 million, which amounted to $6.33 per resident per day. The total per diem for a long-term-care facility with average care levels is $110.73. Currently, long-term-care facilities receive differential funding based on the care needs of their residents. We recognize that we need to move forward on the implementation of an improved assessment instrument in the long-term-care facility sector. This instrument will assist the ministry to develop staffing standards and outcome measures to improve resident care.

The ministry has been investigating the feasibility of a new resident classification instrument and funding methodology that will enhance its ability to better assess resident care and staffing needs.

Another recommendation is that surplus funding to long-term-care facilities be accurately identified and returned to the province on a timely basis. Let me assure the committee that the ministry will review the form and content of information currently collected from facilities to ensure that it is meeting ministry needs. In addition, the ministry's goal is to distribute the 2001 and 2002 reconciliation reports to long-term-care facilities by the end of this month. As well, the ministry has developed a consistent revenue-occupancy report. Beginning January 1, 2003, all seven regional offices have been monitoring and adjusting cash flows as required.

Ensuring that the need for long-term-care beds is met on a timely basis is the seventh recommendation. The government's plan has always been to provide the health services Ontarians need, not just for today but for the 21st century. More beds will mean less waiting. As announced in April 1998, the government is making room for Ontario's growing and aging population by building 20,000 new, additional long-term-care beds by the end of 2004 and by rebuilding approximately 16,000 so-called class D beds by the end of 2006. To accomplish this goal, the government is investing an unprecedented $1.2 billion in long-term care.

Until the new beds could be built, the government put in place 1,700 interim beds as a short-term solution to place patients awaiting transfer from hospital to a permanent long-term-care facility. The 1,700-bed target has been met and has assisted greatly.

The new bed expansion process is right on schedule, with all locations announced for the 20,000 new long-term-care beds to be developed. As of February 3, 2003, more than 8,400 new beds have been built and more than 7,800 additional beds are tendering or under construction.

In addition, we are currently conducting policy work on a long-term strategy for long-term care. This strategy will look at the full range of services available to seniors and make recommendations about program responses. The long-term-care planning and utilization methodology is a program that will enable the province to project needs into the future as well as monitor and adjust responses on a continuous basis.

We are pleased that the auditor noted that the ministry's target of 100 beds for every 1,000 individuals aged 75 and over was consistent with the target recommended by the Health Services Restructuring Commission.

The future of long-term-care facilities is affected by many factors, including the availability of home care, chronic care and other services that are available to these people. The policy work that the ministry is currently conducting on a long-term-care strategy will look at the full range of services available to seniors before making its recommendations about future programs and services.

Eighth, we are to ensure that the per diem paid to long-term-care facilities for capital construction are consistent with the actual construction costs incurred. The ministry's policy for funding long-term-care facility construction costs and development agreements requires operators to submit audited statements of final capital costs. The ministry is currently finalizing Final Statement of Disbursements forms and guidelines to ensure that long-term-care facility operators submit the required audit statements to the ministry within given timelines. The ministry is also developing an electronic tracking system that will allow for the monitoring of the status of long-term-care facility development projects which have been completed and are receiving the per diem construction funding to ensure their actual construction costs are reported to the ministry within the given deadlines.

To ensure that justification for all decisions in awarding new long-term-care beds is properly documented is the ninth matter raised by the auditor. We have taken note of this recommendation and will undertake to do our best to ensure proper documentation of all decisions.

Tenth, we are to ensure that funding for structural compliance is fair and that it encourages facilities to meet the new design standards. Again, the ministry is currently conducting policy work on asset management and facility renewal. This policy work will ensure that funding for structural compliance is fair and that long-term-care facility operators are encouraged to meet the new design standards.

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Finally, the 11th issue is to provide better accountability to the public. Comprehensive annual reports from the long-term-care facility compliance reviews are already posted at facilities for the public to see and are available to interested parties. It is the ministry's intention to move to a system that collects data and organizes the information to develop individualized residential care plans in order to ensure that we can reduce nursing time spent on documenting and to increase time spent on providing care and that uses the data to develop risk-weighted quality indicators. These quality indicators will enable us to set benchmarks that facilities must meet; and that compares facilities using the benchmark data. The ministry will take corrective action where necessary.

In closing, let me stress again that the government takes the Provincial Auditor's report as an important opportunity to improve what we do. In addition to the government's commitment to enhance the health system is the commitment to ensure that the health system is accountable to Ontario taxpayers.

Thank you, Mr Chair and committee members. Now my colleagues and I will be pleased to answer questions. I have at least three people here immediately to my right and left who are experts in these areas. They will be answering, probably, many of the questions you have.

The Vice-Chair: Thank you, Deputy Minister. We'll begin the questions and comments with the Liberal caucus, Mr Gerretsen.

Mr John Gerretsen (Kingston and the Islands): Good morning, everyone. Let me just say at the start that I think this is probably one of a number of different areas that the province is involved in where due diligence by the ministry and by all the people who are involved in dealing with residents in our long-term-care facilities—this is probably more important than any other from the point of view that many of these people have no one there to look after them, to protect their interests, to advocate for them. I think that's why it's all the more important that whatever procedures we have in place to ensure their dignity, their respect and their highest quality of life should be undertaken.

The way I look at it and as the auditor indicated earlier to us before this session opened, there are basically three areas that there are concerns about. One is the lack of staffing standards; another is the whole inspection area; and finally, is there enough assurance with respect to the adequacy of care from both a quality and a quantity viewpoint? During the day I want to develop some of these areas.

The first one I want to start on, which is probably the one that we could focus on the most directly, is the whole area of inspection. I realize you have been in the job for only six months and I'm sure that many of the people within your ministry are highly adequate and competent individuals etc. But I'd just like you to respond to what the auditor actually had to say when he did his audit.

I quote first of all from page 117. This is what he had to say about inspections: "Although the ministry inspected all long-term-care facilities in 2001"—that's only two years ago—"it did not have a risk-based approach for prioritizing its facility inspection procedures, such as conducting in-depth inspections of facilities with a history of failing to meet provincial quality-of-care standards." That's sort of a general statement that he makes.

He then goes into much greater detail on page 124. When I first read this last November when he came out with this report, I almost couldn't believe that this could be happening in as modern a province, with its highly regarded civil service, as we have here in Ontario. I'm quoting to you from the second paragraph on page 124:

"We reviewed the licence status of nursing homes and found that at the time of our audit, none"—not most, not some; none—"of the nursing homes operating in the province of Ontario had a valid operating licence." I don't know, out of the 538 facilities, how many would be nursing homes—maybe you can give me that information—but none of them had a valid licence. How is that possible?

He goes on to say, "While most of the licences had expired within the last year, at least 15% of licences had expired more than one and a half years ago. In fact, we noted one facility whose licence had expired in 1994," seven years before the audit was done, "another whose licence had expired in 1997, and two others whose licences had expired in 1998. As well, most nursing homes that opened after 1998"—so these are the newer ones—"had never been issued a licence to operate." How in goodness' name could that possibly happen?

I'll just finish off the quote. It says, "According to the Management Board of Cabinet directive on transfer payment accountability, a signed agreement" between the province and the operator "must be in place prior to advancing any provincial funds to transfer-payment recipients, which include long-term-care facility operators." But presumably none of those were in existence for any home that has opened since 1998.

Can you give us an explanation as to how that happened? Were there simply too many other things on the ministry's plate, and licensing was regarded as, "Well, we'll get to it when we get to it"? This is a stunning indictment against one of the fundamental principles in which your ministry is involved in inspecting the long-term-care facilities that 60,000 of our most vulnerable citizens in this province reside in. It's their home. How could you let that happen? Please provide me with an explanation.

Ms Mary Kardos Burton: Mary Kardos Burton, assistant deputy minister of community health. I'd like to take your three points in that order and attempt to respond to them.

In terms of the inspection and what we're doing with our inspection, the auditor said we needed a better risk-based approach, and we've taken the auditor's concerns to heart. We are doing a compliance management review right now, and I think the ministry is very proud to say that we have done 100% of the inspections, which is a good thing. But what it doesn't necessarily address is the giving of more time to the ones that have a trend or historically—

Mr Gerretsen: OK. But just a minute now. Excuse me for a moment. No inspections were done prior to the audit, which would be about a year ago now. You're saying to us that all of the facilities have now been inspected and licensed. Is that correct?

Ms Kardos Burton: I said they'd been inspected, they were 100% inspected. What the auditor said was that we needed a better risk-based management approach. We agree with the auditor, and we're doing that right now in terms of looking at compliance management.

Mr Gerretsen: So 100% of the nursing homes have not as yet been licensed?

Ms Kardos Burton: That's your second point. The licences have been in place since September. We understand the auditor's concerns around the licensing, and so we did in fact put the licences in. But just because they don't have a licence doesn't necessarily mean that they're carrying on—but we took the auditor's concerns to heart, and all licences have been in place since September.

Mr Gerretsen: But I assume that when you license a facility or when anything gets licensed, there is some sort of inspection mechanism taking place to see whether or not that facility meets the requirements of the legislation. For you now to say, "Well, just because a place isn't licensed doesn't mean it's not run properly," I totally agree. But if that's the answer, then why are we licensing any of them? Presumably we license so that we give people who live there and their caregivers some sort of guarantee that there are certain standards in place, certain things that we've looked at—perhaps only in a very rudimentary way, but that gives protection to the people who can't speak for themselves, namely the residents. You're not downplaying the licensing part, are you?

Ms Kardos Burton: We certainly agree in terms of the care we need to take with our residents, and we do devote attention to that. Paul Tuttle, our director of long-term-care facilities, will address the licensing issues in more detail.

Mr Paul Tuttle: As Mary said, it's Paul Tuttle, director of long-term-care facilities. Excuse my voice; I have a cold today.

Ms Kardos Burton: We all do.

Mr Tuttle: I know. I wasn't asking for sympathy.

We have the licences in place for nursing homes, not for charitable homes or municipal homes. They never have been licensed; there is an approval process. The reason we have the licence, as a matter of fact, is as a financial instrument for the—

Mr Gerretsen: It's a what? Sorry.

Mr Tuttle: It's a financial instrument for the owner to demonstrate equity. If you were to go and talk to the long-term-care association and say, "Why do you guys have licences?" they would say, "Well, we need something to demonstrate to the banks."

It's true that we were behind in the licensing process. We've made some administrative changes. We've been caught up since last September and will remain caught up with those licences, which, by the way, are deemed to continue from the point the operator applies. However, they aren't directly related to care. That's not why they're there, or else we'd license all the facilities; we wouldn't be just licensing nursing homes. They're a financial instrument. So the licences are up to date.

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As far as the compliance, I'd just add to what Mary said that we have, in fact before the audit, started a major compliance review to look at how we could do a better job of focusing our attention in those particular facilities where we're experiencing more problems. Right now we examine everybody every year and we spend four or five days on an annual review with all facilities, those with very good records and those with not-so-good records. We're taking what the auditor said to heart and this spring we'll have a report that's going to recommend substantial changes to the compliance program. But again, I want to stress that those licences are not to do with compliance; they're two separate issues.

Mr Gerretsen: Well, you may say that, but a lot of people take comfort in the fact that when they walk into one of the facilities it's kind of like, and I don't want to make the comparison, walking into an elevator and seeing a licence there; presumably, somebody has taken a look at it and it's still safe. It's the same thing here.

If you're now saying that the licence is just some sort of a financial situation that we're not really concerned about, I just don't buy that. We either have it in place for a good and proper reason, which is the protection of the individuals who live there, or we don't have it in place. I guess you were directly contrary to the Management Board of Cabinet directive that says a signed agreement must be in place prior to advancing any provincial funds. The auditor says, "We noted, however, that the ministry's normal practice is to finalize and sign service agreements after the funding year has passed."

Why aren't you adhering to these rules and regulations that at least give the people who live in these places some comfort that the rules of the game are being adhered to? I'm not even talking about the quality of care that is being delivered or the sufficiency of the number of people who work in these places. But these are some things that—just give me an explanation, because I find this very, very frustrating.

Mr Tuttle: I'd like to respond first to what you said about the idea of having the licence on the wall; you do make a good point. But again, what most people would look to for assurance in a long-term-care facility in Ontario isn't the licence on the wall, because about half the facilities wouldn't have those because they're charitable through the municipals. What they look to is the annual report, which must be posted each year and tells exactly what the results were at the annual inspection of that facility. That's the kind of thing people would look to for assurance.

As far as the service agreements, like the licences, many of our documents have evergreen clauses. However, we've taken what the auditor said very seriously and as far as service agreements go, the reconciliations associated with those agreements, we expect to be caught up in the current year. We have been behind. Nobody's questioning the point the auditor made that in some of our administrative and clerical procedures we could really stand some improvement. We are working very hard on that and taking it very seriously, and appreciate what the auditor has told us.

Mr Gerretsen: OK. You've just talked about the next area that I want to get into, and that's the inspections. Do you give notification to the nursing homes and to the homes for the aged and the charitable homes before an inspector goes in, or do you have surprise visits? If you

do have surprise visits, how often do you have the surprise visits?

Ms Kardos Burton: We normally have given notices; however, the auditor—

Mr Gerretsen: Why?

Ms Kardos Burton: —did request that we in fact do surprise visits and we are doing those.

Mr Gerretsen: How many have you done?

Mr Tuttle: Right now, all facilities are inspected annually. We have been notifying people. We have always had the right and have always conducted surprise inspections. Usually it has been in response to a complaint or a concern that's been expressed to us. As the deputy mentioned earlier, part of our compliance review—and I don't want to pre-empt the report, because it isn't out yet, but we are seriously considering, like many jurisdictions, having some or all of the annual reviews on a surprise basis. Our stakeholders have various views on that, but I think it's a fairly safe bet that we're going to move in that direction.

There are disadvantages. Most people would say that if you announce you're going, they're going to be all prepared, everything's going to be in place and all the paperwork is going to be done, whereas if you go on a surprise visit, you can get a better understanding of what's really going on at the place. We agree with the auditor in that respect.

Having said that, it's not uncommon for a compliance person to go in at 5 am in response to a complaint. It's the annual review process that we're—

Mr Gerretsen: I asked you a question, sir: how many surprise inspections have actually been done within the last month, within the last two months? You pick the time period and you give me the number.

Mr Tuttle: I'd have to endeavour to get back to you, because we're not doing annual reviews on a surprise basis yet. We've taken that recommendation and we're likely to introduce that in a coming year.

Mr Gerretsen: Can you give me a ballpark figure? Have there been any done at all, sir?

Mr Tuttle: Absolutely.

Mr Gerretsen: In every region?

Mr Tuttle: I won't endeavour to say in every region. I would speculate that in every region there have been surprise—we respond to complaints on a surprise basis. Our compliance advisers would be in to facilities—there are over 40 advisers, and it's safe to say that they're in there, very conservatively, 50 times a year in different facilities. So we're in several thousand times each year. Some of those visits are surprise; some aren't.

Mr Gerretsen: You called them compliance officials rather than inspectors, which assumes that obviously it's—ultimately I only talk about one thing, and that's the care and quality of care that the resident gets. All the other stuff is more dealing with governance and how things are done. But that's what I'm talking about. This isn't to try to trick any operators in there. Let me tell you, the vast majority of people I have met who work in these homes—I like to call them homes, not facilities—do an outstanding job. They're grossly underpaid and overworked, because the people who live there are older and need a lot more care than when I first got involved municipally 25 years ago. A lot of these places are chronic care hospitals now. They are no longer the traditional nursing homes or homes for the aged the way we knew them back then.

This is not at all intended to be a shot at those people who work in those facilities. I have the highest of respect for them. But the point is still that we as a government collectively have an obligation to make sure that these facilities are run properly and according to the law, for the best comfort of and attention to the people that live there. If you tell them that an inspector is coming or a compliance officer is coming, it's like a ministerial visit. They'll spruce up the place, paint it up, and this, that and the other thing.

Do inspections on a surprise basis. What's wrong with that? Why should anybody feel threatened by that? If they run a good operation, the operators would want to get the word out that they run one of the best homes in that area.

When did this whole notion of compliance officers start as opposed to inspectors?

Mr Tuttle: Let me just give a little bit of history. The inspection process for nursing homes started back in 1986. Up until around 1993-94 there were no inspections on a regular basis for any municipal or charitable home. They just weren't inspected. You might have a situation where the board of a municipal home would call the ministry and say, "You know what? We have a concern here," or we'd get a complaint, and we would go in. But there was no inspection process.

In long-term-care reform in 1993 through 1995 we gradually blended the funding, the inspection process and the standards so that everybody was treated uniformly. In other words, it was a level playing field.

Unlike the previous situation, if you lived in a municipal home or in a charitable home, you knew you were going to get the same kind of inspection you would have in a nursing home. That wasn't the case. Now it is.

Mr Gerretsen: You knew you were going to get inspections. From what you said earlier, the likelihood of an inspection taking place wasn't all that high anyway, so I don't know whether the standards weren't raised, necessarily. It sounds to me like they were lowered, very well due to the workloads that you people are involved in. I have no idea.

How do you prioritize the inspections in situations where you know a home has had problems in the past? How do you deal with that? What kind of an approach do you use?

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Mr Tuttle: Let me say that our starting assumption is the one you have, that the vast majority of operators are conscientious. They're in the business because they care about elderly people, they have parents themselves, they're good people, they're good operators. There are problems at times. Our assumption, from a compliance

adviser or inspection point of view, has to be that for all homes, whether they have no problems at all or a few problems or many problems, we have to do a detailed inspection process, a record-keeping process that assumes that at some point we might have to move up to a more serious level of enforcement or compliance.

As you may know, we have the ability to suspend admissions, if necessary, or apply other enforcement procedures, and we do so without hesitation when it is warranted.

Mr Gerretsen: How often have you done that in the last year?

Mr Tuttle: In the last year we've suspended admissions at four homes.

Mr Gerretsen: Out of 538?

Mr Tuttle: That's right, yes. In fact, it's all run through one lawyer, so you're kind of sure that the evidence, if you will, is consistent. It's an economic penalty, a serious penalty, and we don't take it lightly. There are very strict standards that have to be met before we would impose that, but we do keep detailed records. I know the auditor had mentioned senior management with respect to looking at these records. We do that because if we didn't do that—there's only one person who can sign a suspension order in the province and that's me. In order to do that, I have to have the lawyers advise me that all the standards have been met and have the program manager locally and the compliance adviser brief me on the situation so that we know exactly where we stand. So we do take that seriously and move where we have to.

Mr Gerretsen: How much time do I have left?

The Vice-Chair: Your timing in asking is impeccable. We're just slightly over 20 minutes. Ms Martel.

Ms Shelley Martel: Thank you for being here this morning. I want to begin in this way. Deputy, I looked through the comments that were in the notes regarding long-term-care beds and I don't see any mention of a scheme which the Ontario Long Term Care Association has been lobbying for, namely, the occupancy protection plan. That's a scheme that's going to see taxpayers pay for vacant beds in facilities—beds that are vacant primarily because there have been too many long-term-care beds opened, residents are leaving older facilities, they're not applying to older facilities, they're going into new ones, and the vacancies in the older homes are now increasing. So I'd like to know, is this scheme, the occupancy protection plan, now in effect?

Mr Hassen: Gail will probably be the best person to handle this. I think we can put some clarity on the question.

Ms Gail Paech: Gail Paech, assistant deputy minister, long-term-care redevelopment. When the 20,000 beds were announced, those beds had been coming into the system and there was a recognition that the beds were coming on and being built to meet the time frames. Right now, we have 10,000 beds built and within the next 18 or 20 months we will have the remaining 10,000 beds built. Recognizing the pace that the beds were coming on, we have put in place a system so that we can manage and monitor the occupancy of every single bed in this province.

The occupancy protection policy that you are talking about is now called the sustainability program. That program is being announced very shortly and we will be able to ensure that all beds are monitored. If there are occupancy problems with facilities, we will then look to see what programs we can put in place, such as short-term-stay programs or respite programs, so that we will ensure that those beds are filled and that there are spaces and programs for the clients who need them.

If you look at the occupancy for the past two years across this province, it has been 96.8%. If you look at the occupancy as we have been tracking it since we put in this program in the summertime, it is now at 98.4%. That is with 10,000 beds, and our waiting lists are decreasing. So we are not experiencing severe occupancy decreases in our long-term-care facilities at this time.

Ms Martel: So why is the Ontario Long Term Care Association lobbying you to establish a plan that will have the public pay for vacant beds and facilities? That's what they've been lobbying you for. We met with them as recently as three weeks ago, and they confirmed that. It appears that what the ministry is going to do is drop the vacancy rate in facilities—I think it's 97% now—to something lower. At that lower portion, facilities will still be able to retain the funding they get from the ministry for beds where there is no one in them. The problem that was outlined to us was that the government has built too many beds, and now facilities are seeing their beds vacated because residents are going to newer facilities. Now the public is going to pay for vacant beds, because the government built too many. I'd also like to know if it's true that the cost is going to be about $40 million, because that's the figure I was told. Taxpayers are going to pay for vacant beds. Does that make sense to you? That's the stupidest thing I've ever heard.

Mr Ted Chudleigh (Halton): I don't think that's going to happen.

Ms Martel: Maybe you should have a meeting with the long-term-care association.

The Vice-Chair: Excuse me. We'll give the respondent the opportunity to respond. You two, take it out in the hall if you want to talk about it. Sorry for the interruption.

Ms Paech: The sustainability program has been put in place to ensure that the beds that have been built, both the 57,000 old existing beds and the 10,000 new beds, will be there when the population needs them. It is the ministry's objective, and the programs are being put in place, that if there is decreased occupancy of the beds across the province, we have a series of programs and interventions we will put in place to fill those beds.

Presently, we know from pieces of research we have done that we have clients in hospitals who should more appropriately be placed in long-term-care facilities. Because we have had such high occupancy in our long-term-care facilities, they have waited in an acute-care facility. We will now try to expedite the moving of those

clients from our acute-care facilities to beds, when they become available. We are hoping that this program—

Ms Martel: But, Ms Paech, I'm trying to get at the issue of the taxpayers' paying for vacant beds in long-term-care facilities. I'm not talking about people in hospitals, right? The long-term-care association is lobbying you to give facilities money to pay for vacant beds. Is that correct?

Ms Paech: And I'm telling you that we are not paying for vacant beds.

Ms Martel: Well, here is a portion of the cabinet document. This is the Ministry of Health and Long-Term Care, long-term-care beds, B and C bed occupancy program: "The health and social services policy committee agreed to recommend to cabinet that the Ministry of Health and Long-Term Care implement a two-year long-term-care occupancy protection policy to help older facilities continue to operate during the temporary oversupply of long-term-care beds." It's going to apply to B and C facilities. It goes on to say that the recommended option was a time-limited two-year occupancy protection program that was supposed to start on January 1, 2000, with a sunset date of December 2003 and a six-month phase-out period. I am told that the estimated cost to do this is $40 million. Is that correct?

Mr Tuttle: I just want to say in starting out that I heard you mention the long-term-care association. I want to stress that not only the long-term-care association but OANHSS, the association representing not-for-profit facilities, also was looking for some temporary safety net for a period. The government obviously couldn't wait until the population exploded to start building these long-term-care facilities. In no jurisdiction is it an exact science. There is a feeling, but not much evidence to date, that there may be a temporary oversupply. So universally, all the stakeholders—municipal, charitable and for-profit—were looking for some assurance that there would be a bit of a safety net if they were at a competitive disadvantage for a short time.

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Ms Martel: Let me back up. The long-term-care association told me that they told your government not to proceed with round 3 in the competitive process for new beds because they felt there would be an oversupply and they would run into this very problem; that is, people making a decision to go into new beds and leaving beds in existing facilities vacant. Is that true? Did the long-term-care association tell you not to proceed with a third round of new long-term-care beds, give you that recommendation?

Ms Paech: I do not know that they made a formal recommendation to the government and the ministry. I can tell you that in the third round there were 6,000 beds that were available, and through a competitive process there were over 20,000 beds asked for, for those 6,000 beds. So if there was not an interest or if there was a sense that we had too many beds, there was certainly a desire for these organizations to have the 6,000 beds.

Ms Martel: If I might, Ms Paech, on February 5 I met with the Ontario Long Term Care Association: Karen Sullivan, executive director, and Fraser Wilson, who is the vice-president or chair of the board and runs some homes in Peterborough and other places. Mr Wilson said, and I'm quoting, "In the third round, the OLTCA recommended against these beds." All right? So you can check with him, because that's whom we met with.

Now we have a situation where we have too many beds on stream and we have facilities losing residents or potential residents because they are going to the newer facilities. The government now is going to put in place a plan where we, the taxpayers, pay for those beds. Now we're paying twice, because we have paid $75,000, or will pay $75,000, for the creation of new beds and for the redevelopment of the old beds, and now we're going to pay to keep beds in existing facilities vacant for a period of time until there are enough seniors available to go into the new beds. I am told that your plan covers a two-year period where we may end up doing that.

I want to know, is that true? Does this plan foresee a two-year period where we are going to pay for vacant beds? And how much are taxpayers going to pay for that?

Mr Hassen: Let me make a couple of comments and then I'll turn it to my staff again.

Gail Paech, who is the assistant deputy minister in this area, is working on a series of mitigating strategies to ensure that if there is a slight oversupply—and we can talk about what that means—those beds will be used effectively and efficiently within the system. That work is being done now; we're working on it now. We haven't made any recommendations to anyone yet on those, but we are working on that to ensure that we aren't in the position where we are inappropriately using the beds, which includes not having the beds open. The beds will open and be used appropriately, not necessarily in what you would call traditional long-term-care services. But that's our intent, to put forward something of that nature. The issue is that there are a lot of other people in hospitals right now who do need care of another sort. What we're intending to do is to use those beds for that purpose during that period.

Ms Martel: Deputy, the minute from the health and social services policy committee says they agreed to recommend to cabinet that the Ministry of Health and Long-Term Care would implement a two-year long-term-care occupancy policy: is it going to be a two-year policy?

Ms Kardos Burton: What's important is that, as I think Ms Paech said, we will be monitoring this policy.

A couple of points: first of all, the OLTCA and OANHSS both requested that we look at this. There was information from the financial sector.

To go to your point, Mr Gerretsen, this is a vulnerable group. All of us here are facing the kinds of parents who will need these facilities, and they need to be there. You cannot lose public confidence in a sector. So whether or not there is an oversupply—and as the deputy said, we can talk about that—we are monitoring the policy. We have mechanisms in place. A sustainability policy is not just something where the government has said, "Oh,

fine." We have to make sure that all the policies are in place to encourage appropriate use of beds, to make sure that the right people are in those beds, that if there are other uses of beds, if there is space available, we could do that, whether they be from hospitals or elsewhere, whether they're transitional uses etc. But I think the most important point here is that this policy will be monitored very, very, very closely.

Ms Martel: Let me just make a point about that. One of the things the auditor pointed out was—and I'm quoting from page 129—"We reviewed the financial information submitted by facilities to the ministry's regional offices and found that there was insufficient information to determine whether funds within each envelope were used for their intended purposes. Most of the ministry's regional financial analysts we surveyed agreed that the information was inadequate."

You don't have any kind of check and balance now to determine how money flows from the various envelopes; your own staff told the auditor's staff that during this review. I have no confidence that the money you're going to put in to protect these beds is going to be used for the intended purpose, which I'm told by the long-term-care facility is to maintain staff. That was their reasoning for pushing this policy.

I go back to my original questions, and I'm going to continue on this. These are not my documents; these are cabinet documents. They talk about a two-year policy. I want to know if that's what has finally been agreed to at cabinet and if that's what the ministry is working on. The second thing I want to know is the cost. You could not possibly have gone to cabinet to ask for this to be approved without some kind of estimate of how much it would cost taxpayers to implement.

Ms Paech: The program that was put forward to cabinet for their approval was for a two-year period of time, with a six-month phase-in. That program will be announced shortly. As we have indicated to you, the Ministry of Health will be monitoring this program. We have put the systems in place to monitor those programs. To date, we have seen a very small if not negligible decrease in the occupancy across this province. In fact, what has happened is that the waiting lists that have existed in this province for many years are now decreasing, so that people who have been waiting to get into long-term-care facilities are now having the access to these facilities and now will be provided the care they have been seeking for a long period of time.

In terms of the costs associated with this program, we do not anticipate that there will be any additional costs to the government for the provision of this program. Historically, if an organization did not have full occupancy at 97%, the funding in components of the funding formula then is remitted back to the Ministry of Health. Under this program, those remissions would not occur, but there is not an additional cost to the ministry at this point in time.

What I would reiterate is that it is our intention that if the beds are vacant and there is not a suitable long-term-care client available, we will then make those beds available to families who are looking after their parents in their homes and who need respite care, for which we presently do not have sufficient opportunity or beds available. Programs such as that would then be available for us to implement and to provide enhanced support and care to clients who require it.

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Ms Martel: Ms Paech, you keep trying to tell me there's not an over-supply problem. If that was the case, the sector wouldn't be lobbying you for some kind of protection policy. Please. Why did they come forward? Because they recognize they have a problem and the problem is they don't have people in their beds. Right? So they come to the ministry—and this came to the government a long time ago. The government was dealing with this last fall, so this is not a new, emerging problem. Right? They came forward telling you, "We've got a problem because we see people going to the new facilities." No kidding. The cabinet minute talks about "temporary over-supply of long-term-care beds." That's not my word, that's the cabinet document. All right? So there obviously is a problem and that's why they're lobbying you, and now you're going to respond.

While you tell me that this doesn't cost additional dollars, the fact of the matter is that if facilities now have less than a 97% vacancy rate, they would have to return the money back to the government. Now they're going to keep it. So of course there is a cost. They're going to keep the money and there's not even a person in the bed.

So the other question is, where is that money going to go for those empty beds? I'm quite worried that the for-profit sector is going to be able to divert some of that money into their profit line, because they've got no one in the bed, they don't have to pay for food costs, they don't have to pay for accommodation, for laundry, for nursing care etc, and they're still getting to keep that money. Can you guarantee this committee and the public that that money is just not going to go into straight profits in the for-profit institutions?

Mr Tuttle: I should explain that currently in a long-term-care facility we have an envelope system, as you've indicated.

Ms Martel: I know.

Mr Tuttle: I know you know that. It's much more intrusive and much more detailed than you would find in most social programs. The care funding since the mid-1990s has been separated so that the care funding is one side, segregated from the accommodation funding on the other side. We do recover in the nursing and personal care fund.

When your occupancy drops, you lose all the resident revenue. Right now, about $70 of revenue comes from government, about $40 from the resident. That drops. So it's not just a simple question of saying you don't have those costs. There are a number of fixed costs in an organization in the accommodation envelope; they might be, say, 50% at least or more. You're going to lose a

considerable amount of that when your occupancy drops. There will be an impact.

However, happily, to date the occupancy levels haven't been dropping. There's no doubt that people are worried about it. They are concerned that that's going to happen, but as Gail Paech said, the operators have subscribed. There was no difficulty issuing and getting the commitment to build the 20,000 beds. So although people are worried on the one hand, they're pretty confident on the other that we do need those beds and those beds will be filled. As Gail said, if there were vacant beds, they would be used for respite programs, other needs that will arise over the years.

Ms Martel: Mr Tuttle, if I might, it's true that the operators are going to lose the residents' portion but they're going to keep the government's portion. Earlier in our discussion, we figured it to be about $62 that a long-term-care facility would receive from the government per resident per day. Is that correct, about $62?

Mr Tuttle: On average; actually, right now the total per diem for an average facility is about $110, and it's about $70.

The Vice-Chair: One last question and then we'll move on.

Ms Martel: How much of that money are the facilities going to be able to keep? Of the $70 that they're getting from the ministry under your plan, how much will they keep?

Mr Tuttle: Our plan hasn't been finalized yet—

Ms Martel: I know.

Mr Tuttle: —and all those details haven't gone out to this point. At this stage, I guess I'd have to go back to what Gail said. First of all, we've always funded empty beds to some extent. We've always had a policy where if you don't fill 3% of your beds, we're going to fill them anyway. So the principle has always been there; it's not new. Right now, we're not experiencing an occupancy drop, although we recognize the anxiety of the operators about that possibility.

Mr Wayne Wettlaufer (Kitchener Centre): I find it passing strange that the NDP critic, Ms Martel, would be talking about a slight vacancy rate, whereas when their government was in power, and the Liberals as well, we had a waiting list a mile long for patients who couldn't get into long-term-care facilities because your governments never built one long-term-care bed in the combined 10 years you were in government.

Deputy, in Kitchener, which is my riding, we've had 811 beds that are either built or completed—I believe 600 are completed—and there still is a waiting list. These are new long-term-care beds. I'm a little bit concerned about the existing D beds. I'm not sure of the number in Kitchener, but certainly in all the province we're supposed to be rebuilding, even by your own statement, 16,000 existing D beds by the end of 2006. I was just wondering what our progress is on the rebuilding of those 16,000 existing D beds. I wonder if you could give us some information on that.

Mr Hassen: We certainly are focused on both the new beds and the rebuilding of the D beds, and I have to say that at least from my perspective we are targeting and are on target for the ones we've submitted for the period up to 2006. Gail Paech is responsible for that area and has been tracking that, and I'll let her speak to the specifics of that question.

Ms Paech: Thank you, Deputy. The D bed program was initiated in 1998, with the objective to rebuild 16,000 beds. The D bed facilities are facilities that did not meet the 1972 standards. These are facilities that are very small, that have bedrooms where four to six people are in them and that do not have dining rooms in the patient areas. So the ministry undertook to rebuild these facilities. By the end of March we will have rebuilt 3,400 beds, we will have approximately 3,500 under tendering or construction and we will have another 5,600 that are going through the municipal approval program. So the D bed program certainly is moving ahead, and we'll meet the objectives of that by 2006—these facilities where we did have 16,000 patients, citizens of Ontario, residing in facilities that were deemed not to provide an environment that was suitable to the provision of the quality of care that the Ministry of Health wanted to provide. So the program is moving along at this point in time.

Mr Wettlaufer: The long-term-care beds reconstruction as well as the new long-term-care beds were based on the needs assessment that was established by the Health Services Restructuring Commission, and the Provincial Auditor stated in his report that the ministry allocated funding to build and redevelop long-term-care beds in regions of the province where the need for beds was greatest. I wonder if you could perhaps expand on the needs allocation process a little bit.

Ms Paech: In the mid-1990s a commission was struck, the hospital commission, to look at the requirements for delivery of acute care services. Through that process and review, the hospital commission indicated and recommended to the government that, based upon the demographics and the growth of the aging population in the province, there would be a need for approximately 16,000 to 17,000 beds by 2008.

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When they looked at the number of beds that existed within the province and at the population that was over the age of 75 and at the bed ratio, they said that Ontario had one of the lowest bed ratios in this country. They recommended that for every 1,000 people over the age of 75 there should be 100 beds available. So with that recommendation that was received by the Ministry of Health, an analysis was done looking at the bed ratio across the province, and in areas where there was a lower ratio, a decision was made that a certain number of beds would be allocated to that area to bring the bed ratio up to the desired goal of 100 beds per 1,000 people over the age of 75. So that was the process that was used.

When the government announced that 20,000 beds would be built, those statistics were then used. The areas that were identified to be underbedded were the areas

with the recipients to be considered for the allocation in terms of the RFPs that were issued by the Ministry of Health. There were three RFP processes; two were formal RFP processes, the third was a process similar to an RFP, and the 20,000 beds were allocated to meet the goal of 100 beds per population of 1,000 people over the age of 75.

Mr Wettlaufer: There have been a number of books written, a number of reports issued, on the changing demographics in Canada—not just in Ontario, of course; in Canada and the United States—talking about the aging population explosion that is going to take place certainly in the next decade, certainly in the next 20 years even more so. I wonder if you would be willing to comment on the cost, financial and moral, if we had continued the same policies insofar as long-term care that had been in existence prior to 1995.

Mr Hassen: Perhaps I can just introduce it and then have Gail talk to some of the specifics that might have landed here. It's clear that it was an unsustainable system and that we would find ourselves with elderly people significantly compromised, and I don't think that's anything anyone would have wanted. In particular, we would find the hospital system backed up because that's simply what would happen. These people would often be found back in the hospital and cared for because many of them could not be attended to at home by their families or there would be an extraordinary strain on the family beyond what we would have seen.

So from our point of view, having a balance of a number of beds per 1,000, it's extremely critical that we now monitor that and look at the benefits of properly balancing home care and other forms of care with long-term care in the three forms of beds we have in long-term care and with hospitalization, the backup in the hospitalization.

I can say to you, having worked in hospitals most of my life and with long-term-care facilities, that there are still significant issues out there, and I think you alluded to that a little bit in your own area. We do not yet have a good balance.

Gail Paech, the assistant deputy minister responsible, has done a lot of analysis of all the areas and is keeping track of this to see how many beds we need in each area to ensure that we are continuing down the line to accommodate these people. I'll maybe turn it to Gail for some comments as well.

Ms Paech: Thank you, Deputy Minister. Certainly, within the province prior to the building of the 20,000, we had very long waiting lists. As the beds have been built and as those facilities have been opened across the province, we are seeing a drop in the waiting list. We still have, though, 16,000 people on the waiting list for beds in our long-term-care facilities. We are monitoring that, and we certainly are seeing that, as facilities open, those facilities are filled very quickly and care is then being provided in appropriate environments for people who require 24-hour nursing support. So the facilities are certainly meeting a need and a demand that exists in Ontario.

Mr Hassen: If I could just add another piece to this, I know that for some it is always difficult to understand the relationship of emergency with long-term care, but they're fundamentally linked as a system. Every time there is a person waiting in emergency, we can identify one or more people waiting in the hospital for a long-term-care bed. We know the emergency system will improve as we see this evolve over time. We're already seeing some indicators of that as we're bringing these beds up. I think the cost of trying to repair the system at emergency and pouring more money into emergency is extraordinarily frustrating, because it never is the right solution. We could pour endlessly into that, whereas as we build the beds and have them operational, it will begin to allow more beds to be available for emergency patients in the acute-care system, which is really what we want to do: get appropriate use of all our beds. So they're all tied together.

Mr Raminder Gill (Bramalea-Gore-Malton-Springdale): Thank you to the speakers for coming here this morning. I didn't think we'd see a day when we would say there are too many beds. I think that's great. Going back to the initial long-term-care beds announcement and the initial contracts being awarded, I know there were some hiccup problems. Can you perhaps explain what that was and how we are back on track?

Ms Paech: In 1998, the government announced that they would be taking the recommendations from the hospital restructuring commission and announced that 20,000 beds would be built across the province. Initially, the beds were to be built between 1998 and 2006. In 1999, there was an announcement that because of the need and the length of the waiting list, the completion of those beds being built would be by the end of 2004.

In 2000, the government asked for a report as to the progress of the beds. What we found was that with the first two RFPs that were initiated—and that was about 13,000 beds—we had not required that the individuals have land as part of their submission and response to the RFP. As we understood more about the complexities of the development of long-term-care facilities, it became evident to us that the time it takes an owner-operator, charitable group or municipal facility to find a suitable piece of land, have that land zoned for a long-term-care facility and have amendments to bylaws is anywhere from 12 to 18 months to two years. So we were experiencing a significant delay in these facilities coming on board because of not having asked for the requirement to have land.

In the third offering, which was the last offering, in 2000, it was a requirement to have land as part of the conditions in response to being eligible to be considered. What we have seen is that that has certainly expedited the whole development phase. Actually, we have some of the 2000 beds which were offered to the candidates who met the requirements and were successful. These facilities have been built faster than the facilities that were offered

in 1998 and 1999. But as I have indicated, as of March we will have over 10,000 beds, and we are tracking to have all the beds completed by the end of 2004.

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Mr Gill: In terms of quality assurance, how do you know what is the adequate quality of care in these, and how do you ensure that those facilities are meeting those quality standards?

Mr Tuttle: We have a comprehensive compliance management program. We have compliance advisors who are nurses. We have dietary inspectors, dieticians and environmental inspectors who are public health inspectors by background. Every single facility or home in the province gets a comprehensive annual investigation.

We also respond to complaints as quickly as possible, within 20 days. As the auditor noted, in most cases we are very good at getting back quickly. We certainly go back within the hour if we have a serious complaint. So we're in these places a lot: several thousand times a year.

We have a comprehensive book of standards. The most frequent knock we get from providers is that our standards manual is so big and there are so many criteria they have to meet—I think there are over 400—that it's pretty intrusive compared to a lot of jurisdictions. Again, we don't apologize for that. We want to be as thorough and comprehensive as possible.

In our annual reviews we look at all aspects of the home. We look at the whole universe. In other words, we're looking at everything: the physical structure, the care, how it's provided, the documentation. We look at each department. We do focused audits. A compliance adviser will go into a home and walk around and look at residents, and if there are certain risk indicators such as pressure ulcers or a person in restraints, they will then go and make sure that all the documentation is in place, that charting is done. They will look at the care for that person and then make an assessment of how the organization is doing overall, based on that sample. In addition, they will also do random audits of client charts while they are there.

So the focused audit is for a particular reason. The random audit is looking at a group of residents just as a sample to see how their care is, how their chart is. They will talk to residents, of course, and sometimes families if they're there.

Finally, after being there three to five days, all these types of inspectors produce a comprehensive report which must be posted by the home and be publicly available so that residents, families, the residents' council and advocacy groups can have access to that annual report. In fact, those annual reports are distributed to various groups such as Concerned Friends. So it's not just government that is looking at the organization; outside advocacy groups are doing pretty close scrutiny of the organization as well. It's publicly available.

I'm confident in saying that we have as good a long-term-care facility system as anywhere and that we have the means to ensure that is the case.

Mr Gill: Earlier today the auditor informed us, and I'm sure you're aware, of the risk assessment instrument that perhaps some of the facilities in the US are using. Where do we stand in terms of the implementation of that?

Mr Tuttle: The instrument that is being referred to is called the minimum data set. It's part of a resident assessment instrument which is really a suite of instruments that can be used with various groups of people. There's one for home care. There's one which in fact we're implementing as an assessment instrument. There's one for mental health. There is one for rehab. There is one for people in chronic care which is being used in our chronic care organizations. The instrument is the law in the United States. A skilled nursing facility in the United States has to use this instrument. They can't get Medicare and Medicaid funding if they don't use it.

We currently have an instrument that was developed in Canada called the Alberta classification system, which is a good instrument. It measures acuity. We look at the chart of every single resident each year. In other words, this year we will look at 64,000 charts and, on an individual basis, determine the care needs of all those residents using the Alberta system that we currently have.

We're actively considering moving to the minimum data set, not so much because there is anything terrible about the Alberta system but because the minimum data set is a more modern instrument and would provide us with some data that currently we don't have. So we're actively exploring that now. We have a staff person responsible for beginning to look at how we might implement the program.

The Vice-Chair: We'll move to the Liberal caucus, Mr Gerretsen.

Mr Gerretsen: I can now understand why, in one of the comments that was made, there were four times as many requests for these new beds than you could allocate. I guess it all has to do with the fact that if you're guaranteed $10.53 per day for the capital costs and now you're also being guaranteed that the bed is going to be filled somehow with this new plan that I guess the cabinet is coming up with, heck, I would be applying as well if I were in the private sector. I think the fact that so many people apply for basically guaranteed funding is a pretty good deal.

I always find it interesting: in any discussions we've had with the government members or the ministers on this, I have seen that there are two main issues in dealing with long-term care. We have the issue of whether the number of new beds that are being created is adequate or not, and I think there's overall agreement now by most of the organizations and the outside experts that we're building an oversupply. The two associations are saying that; Peter Coyte, I think, came up with the idea about six or seven months ago; and I guess the cabinet document sort of recognizes the fact. Yes, there may be some people who are now in these interim long-term-care beds in hospitals that are being moved, but let's not forget that a lot of these people were in beds for acute care that had

been closed in hospitals to start off with. So I don't know whether we're just paying Peter to rob Paul etc.

When we talk about the reasonableness of the per diem funding, the answer always has been that we're building 20,000 new beds. Well, that doesn't help the 57,000 to 60,000 people who are currently in the existing long-term-care homes. You're very familiar with the PricewaterhouseCoopers report that your ministry paid for that indicated that out of the 10 jurisdictions studied, here in Ontario our people receive the least amount of nursing care and personal care, on average. That's the bottom line as far as I'm concerned, and it has nothing to do with the new beds, other than the fact that if there's an oversupply of new beds, we're taking money out of the system, I suppose, that could have been used in this particular area. There's certainly a relevancy there. There are only so many dollars around, and if you're starting to create new beds now that aren't really needed, that money could have been used to deal with the per diem situation.

But the first question I have for you, Deputy, and I have it right out of your statement here earlier this morning: you're saying that the future of long-term care facilities is affected by many factors, including the availability of home care, chronic care and other services. The question that I have of you is, would you not agree that most people who need care, elderly people, if given the choice and if provided with the necessary resources, would much rather stay in their own home-like environment, whether it's an apartment or home, than go into a nursing home? Would you not agree with that, sir?

Mr Hassen: I think there is no question that people do stay in their home in so far as possible. But there is a point where they can't.

Mr Gerretsen: Absolutely.

Mr Hassen: And then there is the point of what the cost is to maintain them in their home versus somewhere else.

Mr Gerretsen: Exactly. That's precisely my point. I'm so glad that you led into that. I think that we have put artificial limits on the home care that somebody can get in their own home, and thereby we're pushing people into these long-term-care facilities. If we had a more open-ended home care program, these people could probably stay in their own homes, which they prefer by and large—not everybody, but by and large they prefer to stay in their own homes—rather than going into nursing homes.

1130

Do you think it's time that we started doing away with some of these artificial limits that we have placed on our home care programs? You and I know that with respect to the changes that have taken place with the community care access funding that, yes, there's money available for post-acute care recovery, home care etc, but it certainly is drying up rapidly for people whom I would regard as being more in a chronic care kind of situation. If we made more resources available in that area, wouldn't that be much preferable to saying to a person, "Well, I'm sorry, we can't give you home care. You'd better go into a nursing home"?

Mr Hassen: I understand your question. I believe there is more to it, in my view, not to say that there aren't some valid points you're making. I just would say to you, though, that there is, critically, a whole set of different issues here, and I'll let my colleagues speak, because I think they're just waiting to speak to this as well.

I've worked in other jurisdictions where the home care issue has been curtailed because it had become excessive as to what you can afford. Secondly, it is usually about people who don't belong in long-term-care facilities; it's for other reasons that this becomes the case. People have a view of entitlement, and I think you've got to decide what you're prepared to spend on entitlement. Long-term care is always a judgment of where there is a balance in cost and benefit to the individual who can no longer take care of themselves, but it's costing society significantly to keep them in their home because the people around them can't work or there are other issues related to that.

There are some future considerations coming on with the new reform agreement that has just occurred where we may be able to do some other things with employment insurance, where they're going to allow for some leave. We don't have the details on that. I think it's more for palliation. We certainly are going to encourage the development of those programs in concert on a province-wide basis.

Yet, I think we've got to really be sure that we understand that by just opening it, we'll suddenly not see those beds used. The standards we're using, this 100, are not far off what most provinces use. Some are different; I'm not saying they're all the same. But there's certainly a clarity that we do need these beds.

Finally, I just want to make a comment before I turn it over to Mary Kardos Burton. I'm not sure where you may have received this. There's a select situation where the odd nursing unit is being used in acute care for long-term-care beds, but it's an exception. In the kinds of situations we have out there, there are people in medical and surgical beds not able to be discharged to long-term-care facilities, which we must do. They're not closed, they are just—the word that gets used is "blocked," because you can't use them. So we really have to strengthen that. There are two areas here that I'm speaking of; one is that, and the second is the home care. It isn't simply that if we had more home care, the whole long-term-care situation would be—

Mr Gerretsen: Nobody suggested that, sir. But if there is more home care available—and I know of numerous situations—

Mr Wettlaufer: On a point of order, Chair.

The Vice-Chair: Just a moment. Let's stop the clock.

Mr Wettlaufer: I wonder if we could have some guidance from you on this. I thought we were dealing with the auditor's report. The auditor's report dealt only with the facilities, not necessarily with home care.

The Vice-Chair: Mr Wettlaufer, the questioner has the floor. The questioner has 20 minutes. The respondent

can either answer or not answer. I think it's more or less up to the questioner and the respondent, rather than you and I.

Mr Wettlaufer: I'm just asking for guidance.

The Vice-Chair: Yes.

Mr Gerretsen: Thank you very much, Mr Chair. I'm just taking a statement right out of the prepared statement that the deputy gave today. Personally and from talking to lots of knowledgeable people in this area, inside the ministry, in the field and CCACs and in hospitals and communities, I'm absolutely convinced that if we had a more flexible home care program, there would be a lot more people—not everybody—staying in home-like environments a lot longer, rather than pushing them into long-term-care facilities.

I've got a letter here that Minister Clement wrote to David Turnbull, the other minister. It doesn't have a date on it but I received it on October 9. I've quoted this before in the House. I find it absolutely amazing that he would say that the Ministry of Health "will undertake a communications campaign directed at ... highlighting the new home-like environment and improved comfort and amenities being offered by the new and redeveloped facilities."

We all know that the new facilities are much preferred to many of the older facilities. Why the ministry would be involved in that—is this just to help the people that have created the new beds etc? Aren't we much better off putting that kind of money and resources into the actual programs out there?

Anyway, I take great offence at that. If you give people the opportunity to stay in their own homes—not everybody—most of them will do that.

I'll just get away from that now and talk about, not the new beds, but I want to talk about the reasonableness of the per diem funding. Specifically, I will once again quote the auditor. This is right out of his report. He says on page 127, "The proportion of care provided by registered nurses in Ontario's long-term-care facilities to each resident per day was the lowest in comparison with other jurisdictions." This is from the Pricewaterhouse study. "Only one third of Ontario residents in long-term-care facilities who had restricted ranges of motion received any range-of-motion exercise." That's just to combat some of the earlier argument that people do get therapy and all that. At most it's one third.

This is the auditor's conclusion from doing his report: "Ontario residents in long-term-care facilities had the highest proportion of mental health disturbances and/or problems, of which 65% were handled either with restraints or anti-psychotic medication. Less than 6% had any intervention related to evaluation or 'talk therapies.'"

We've bled the existing facilities. We're not providing enough funding for them. You've seen that in your own funded study. What's the conclusion that the auditor came to? "We found no evidence to indicate that the ministry had addressed the results of this study." You've had the study. He found no evidence that you're dealing with that situation at all.

I know you're limited by your political masters as to what you can do. If they don't provide the funding for it, you can't do it. Again, I can accept that. But why we in Ontario should be dead last as far as providing per diem funding to the existing facilities—I don't want to talk about the 20,000 new beds; that's not the issue here. We're talking about the 50,000 to 60,000 people who live in those facilities right now.

If it weren't for the good care that many of them receive from the staff people, they'd be even worse off than they are. Why aren't you doing that? Is it as simple as that the government of the day is not ready to provide us with the necessary funding? If so, I dare you to say that.

Ms Kardos Burton: I think we are well aware of that study. Yes, the ministry did have a hand in terms of getting at those results. It pointed out a number of issues in terms of the nursing and personal care for the government. That's why the government did increase the funding by $100 million in August 2002.

What I can add to that: when that funding was increased, it was the nursing and personal care that the money in fact had to go to. I think one of things the long-term-care sector and many of the community sectors do sometimes require improvement in is the kind of information they need, and information systems, in terms of putting forward the case, in terms of why. That's why, as Mr Tuttle referred to earlier, we are looking at a new resident classification system that will be able to say, "What is it that each resident needs?" and have proof.

We have put the money into nursing and personal care. We have done a recent survey, and we're going to do a more comprehensive assessment as to that money: the uses it has been put toward, the increased hours that people have gotten and the quality of care that has been improved as a result of that money.

So I think there was a recognition that those study results were not positive to Ontario. I think we did actually make a conscious effort to increase our nursing and personal care.

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Mr Gerretsen: But you know as well as I do that even with the $100 million of new money, we're still last. That's why the association has taken up another campaign which they've started at every nursing home, addressed to every MPP. I'll just read it to you. They say, "Despite recent increases, Ontario still funds the lowest level of long-term care of any of the 11 other jurisdictions in the government-funded Level of Service Study.

"Ontario residents still get 45 minutes less"—and this is on average; I realize some people need more than others—"care daily than residents in Saskatchewan got in 1999"—four years ago. "This is simply not enough when: nine out of 10 require help to get dressed and eat; eight out of 10 require help to move around; and six out of 10 suffer from dementia and related disorders.

"Homes are unable to provide the programming recommended by the government's own compliance advisers.

"Government's long-term-care home construction and redevelopment programs will still leave 41,000 residents without access to new living and privacy standards." It's going to talk about the older homes here.

"A government commitment is needed now to increase operating funding by $260 million, or $10 per resident per day, in both 2003 and 2004....

"Government's only commitment is that residents will pay $2 more...." You may recall the 15% increase, which I'm sure, as individuals, shocked each and every one of you. That we would ask people in their upper 80s and lower 90s to all of a sudden come up with an extra $230 per month is absolutely deplorable by any government of any stripe to do that sort of thing. We're saying, "Yes, you've got to pay $2 more."

Let me ask you this: are you prepared to recommend to your political masters that this $260 million which is being asked for, and which undoubtedly cards will be coming in on, should be put into the next budget? You have input into the budgetary process. Are you prepared to make that kind of commitment or to give that kind of advice to the minister?

Mr Tuttle: I'd just like to go back to make a couple of points. In the last seven years, overall funding for long-term-care facilities has increased by 56%. That includes the expanding bed stock. If you take that out, the per diem has increased by 36% while resident acuity or complexity of care has only increased by 12.5%. So I think that's indicative of a willingness to address the funding issues.

The Mississippi study, as it's often called, was—

Mr Gerretsen: I prefer to call it the government study. They paid for it.

Mr Tuttle: —the government study—was a good study. It told us that we should take a look at the MDS system, which it's based on. Aside from the caveats the auditor pointed out about the study, I should say that many jurisdictions, unlike our own, don't separate out higher levels of care like the chronic care system. In our case, if you looked at our Alberta resident classification system, there are almost no residents in the highest category, G, and there's a very simple reason for that: we have a chronic care system which takes care of those folks. If we added the $300 million-plus for chronic care into our per diem as many other jurisdictions do, you'd get an entirely different picture.

Mr Gerretsen: So you're challenging the study, then? You're saying the study is invalid?

Mr Tuttle: Yes, I'd have methodological concerns about the study, absolutely.

I'd also like to make the point that our per diem doesn't reflect our total investment in long-term-care facilities. We just include the part that's directly flowed to the facilities for care and accommodation. There are many funds, millions of dollars, on top of that which aren't rolled into the per diem.

So I think that although that level-of-service study was instructive and told us some good things, it really is open to debate.

Mr Gerretsen: Do you disagree with the auditor's conclusion that "We found no evidence to indicate that the ministry had addressed the results of this study"?

Mr Tuttle: Yes, I do. I disagree—

Mr Gerretsen: What have you done?

Mr Tuttle: —in the sense that the government just finished investing $100 million in the nursing and personal care envelope.

In fact, another point to be made is that in 1993, for example, nursing and personal care represented about 48% of the total investment in the per diem. In 1995, it went to about 49% and now it's up to 54%. So the portion of funding devoted to care has been increased by the government as well as the total number of dollars.

Mr Gerretsen: Let's talk about the staffing requirements and the standards that you talked about earlier. He states in his report that "36 US states"—which I think is about three quarters of them—"have established staffing requirements or standards." As a matter of fact, I was interested in your comment earlier when you said you had this book with regulations. As I understand it, you've done away with many regulations with respect to bathing requirements and other things. We asked the minister about that during estimates here last September. The reason you've done away with them, that you no longer have those standards, was on the basis that the minimum standards become the maximum standards, so therefore we have no standards, and we basically leave it up to each operator and each facility to do that, which is very curious indeed.

The auditor states, "The ministry does not have any staffing requirements and does not track facility staff-to-resident ratios, the number of registered nursing hours per resident, or the mix of registered and non-registered nursing staff."

So you really have no idea as to what the staffing levels are in our different homes around the province. Why?

Mr Tuttle: We do in fact have an idea of the staffing. We do reconciliations on expenditures in nursing and personal care. However, aside from that, what has happened in Ontario is that we've moved to a system, as I said earlier, of looking at every single chart for all 64,000 residents, assessing their individual care needs and then providing funding on that basis.

Mr Gerretsen: How often do you do that?

Mr Tuttle: That's done annually.

Mr Gerretsen: Annually?

Mr Tuttle: Yes.

Mr Gerretsen: You look at the chart for every one of the 64,000 residents?

Mr Tuttle: Yes.

Mr Gerretsen: At the same time that you haven't got the inspectors there to inspect the facilities or to issue the licences etc, you want us to believe that your ministry goes in and looks at every one of the 64,000 personal charts on individuals?

Mr Tuttle: Yes. Let me explain how it's done and how it has been done since the system was introduced in

the early 1990s and came fully into play in 1996. Each year we contract with approximately 150 nurses. Those nurses go into every single facility and look at all the charts. Each year we produce a report based on that, which is publicly available.

For example, we know that over 80% of the people have incontinence problems. We learn that because we've gone in every year. We track the trends produced in the level-of-care report each year. That's how I can say with confidence that acuity has increased by 12.5% while funding has gone up that 36% I mentioned.

Mr Gerretsen: They look at the charts. Do they talk to the people?

The Vice-Chair: Thank you.

Mr Tuttle: It's not based on talking to residents. It's based on a review of charts that are prepared by the nurses and the facility staff.

Mr Gerretsen: Time goes so fast.

The Vice-Chair: It does go quickly, I know.

Ms Martel: I'd like to return to my previous line of questioning. Mr Tuttle, I heard you repeat again that we're not experiencing an occupancy drop right now. It begs the questions, then, of (a) why we are moving forward with such a plan and, more importantly, (b) why the ministry itself, in its proposal to cabinet, went forward with a document entitled Proposed Occupancy Protection Policy for Long-Term-Care Facilities that was retroactive to January 1, 2002. Your original proposal to fund vacancies was going to be retroactive to 2002. If there isn't a problem with vacancies, what was this document all about?

Ms Paech: A component of the program that has not yet been stated to you to explain why this program was brought into place was that you need to understand the financing of our long-term-care facilities.

Our facilities are financed through the financial community, and these organizations have mortgages that they must pay. The money that the organizations use usually comes from the accommodation envelope and also from the copay that clients pay.

The concern also was that if there were occupancy problems, these organization would not have the capacity to pay their mortgages, and what would happen within the province is that we could have a series of organizations not able to meet their pay requirements and we would then have facilities that go into bankruptcy and therefore not be available to provide care to clients and to the population of Ontario.

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The program you are referring to is not going to be retroactive to January 2002. The program will be announced and will come into being at that point in time. It is not a retroactive program.

The other point I would like to make is that the new facilities are not eligible for this program. That is a point that I believe may not have been clear. This program is only available to the B and C facilities and those D facilities that have a signed development agreement.

Ms Martel: I never suggested they were, because my understanding of the problem is that it's the existing facilities that are seeing vacancies as people move into the new beds. It goes back to my original problem of the government having built too many beds. If—part of the original document—organizations at that time were thinking they might not be able to pay their mortgages because they were going to have vacancies because their residents were leaving or didn't want to apply there because they wanted to go to the new beds, doesn't that tell us that the government was building and has built too many beds? You've got a problem of oversupply. If this many people are coming forward to you and you're actually considering something retroactive to 2002 so people don't lose their mortgages and go into bankruptcy, how did we get into a position of building so many beds that would result in this problem?

Ms Paech: The analysis has been done, looking at the demographics of the population of Ontario and looking at the requirement in bed ratios, that the number of beds we will require and will need to have is 57,000 plus 20,000 by 2006-07. As we know from our experience of developing and building these beds, it takes several years to build these beds. So there will be the requirement to have the number of beds, the 77,000, by 2006-07.

Ms Martel: Let me go back to the new vacancy rate. What will it be under this plan? It's 97% now, before you start getting your funding clawed back. What will it be under the new plan?

Mr Tuttle: The final details of the plan haven't been released to either association. We have been meeting with both associations, but one feature of the plan will be that there will be no replacement of copayment. I explained earlier the impact on that.

Ms Martel: I understand that.

Mr Tuttle: There will be no replacement of that. There will be retention of a certain portion of the per diem, and the lion's share of it, in fact virtually all of it, will go into the care envelopes as part of the program. Exact details—the application form is still being worked on; that isn't available yet. Again, I want to reiterate that it's not retroactive to 2002.

Ms Martel: I understand that. You told us before that the ministry gives about $70 daily as a per diem. Is the full $70 what the facility is going to be able to keep?

Mr Tuttle: The program doesn't contemplate its keeping the whole $70. I should let you know that what the associations—and again I stress it's both of them; this is uniform—have said to us is, "Look, vacancy rates drop. We might have to lay people off. We want to keep the workers employed—the nurses who are there, the personal health aides—and avoid layoffs where that's possible." So that's the purpose of the funding. You're keeping it, and you keep it in envelopes where you're paying for care.

Ms Martel: And that's where I was heading next. Let me repeat what I said earlier about my very serious concern with this proposal. The auditor made it clear that the ministry does not have the financial information

available to determine if money in the various envelopes is used for its intended purposes. Now, you're trying to tell this committee that most of this money will go into nursing and personal care because the associations are telling you that is where it will go to retain staff. But the auditor has already told us that you have no guarantee that that's where the money goes.

What I want to know today is, how are you going to guarantee that that money does not go into profits for for-profit facilities that access this plan? How are you going to guarantee that?

Mr Tuttle: Let me go back again, and I'm sorry for having to harp on the envelope system. I do think the auditor mentioned that some of our financial analysts would like to get even more information than we already have, and I think that's quite possible. I understand their wanting more information. However, we do recoveries, and we do audits where we think—and by the way, we wouldn't be able to do this if we didn't know where the money was going. If we think money, not necessarily maliciously in any way, has been used in a way we think is contrary to our manual, we recover it. That's what we do. We have a line-by-line system. We're criticized by stakeholders because it's too intrusive. It's line by line; it segregates by envelopes. A lot of people would like to move to a global budget. We think our system is better, and it does segregate not only profit but the surplus that a charitable or municipal—

Ms Martel: Let me just read into the record what the auditor said:

"We reviewed the financial information submitted by facilities to the ministry's regional offices and found that there was insufficient information to determine whether funds within each envelope were used for their intended purposes. Most of the ministry's regional financial analysts we surveyed agreed that the information was inadequate.

"The majority of expenditures in the nursing and personal care funding envelope are for staff salaries, yet facilities are not required to submit staffing data, such as the number of employees per type (registered nurses, practical nurses and health care aides) or their respective salaries. Also, facilities do not routinely provide regional offices with a list of equipment and supplies purchased during the year under each funding envelope. Analysts advised us that, in several instances, facilities charged accommodation equipment and supplies as medical items to the nursing and personal care ... envelope, thus minimizing the amount of funding they may be required to return to the ministry."

So you already have a problem. You have a problem that you have folks now who are diverting funding to other envelopes or are making purchases under other envelopes and you're not picking that up.

My concern with the policy you are going to bring forward is that facilities will not use that money to retain staff but will instead find a way to use it as profit. I want to know from you what you are going to do to ensure that the money that facilities are allowed to retain under this plan is not going to be used for profits but is going to be used for staff. What are you going to do to guarantee that?

Mr Tuttle: Again, at the risk of being redundant, and I'm sorry if I am, we segregate the envelopes, we do recoveries line by line on the nursing and personal care envelope. Every single expenditure in the nursing and personal care envelope relates to the quality of life and quality of care of the resident. You can't run a home with just equipment; you can't run a home with just staff. Every line in there has relevance to the quality of life of the residents, as does the accommodation envelope, because it is their home.

So we segregate those envelopes, we recover. If you ask me, "Could you get even more information?" then yes, absolutely. I think that may be the point our analysts were making, and they would always like to have more information so they can do their jobs as effectively as possible; I understand that.

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Ms Martel: If I listen to your answer, then I have to come to the conclusion that you cannot provide us that guarantee, and that makes my concern about this proposal even more serious. We are essentially having taxpayers pay twice. We are paying because we are contributing to the capital costs of not-for-profit and for-profit developers to build long-term-care beds, and the money for for-profit developers on the capital side is the first time ever in this province. Secondly, we are going to pay for vacant beds because we have an oversupply of new long-term-care beds. In essence, the taxpayers are paying twice because of the oversupply of beds.

Not only are we paying twice, but you can't guarantee to us or to residents and their families that the money that some of the existing facilities will keep because of their vacancies will actually be used to retain staff. That's my overwhelming concern. They are telling you that's what the money is going to be used for. You can't guarantee that's what is going to happen. What do you say to residents and their families about how this money is going to be used?

Mr Tuttle: I'm not sure I'm going to be able to give you an answer that will fully satisfy you. Again, we do reconciliations. I also want to stress that the operators, whether municipal, charitable or for-profit, all have the best interests of the resident at heart. They will use this money to retain employees, if necessary, to continue providing services to residents within our rules. The fact of the matter is that it is a safety net that we're contemplating. There is no evidence that occupancy has dropped so far. We don't necessarily even agree with the operators that we're going to see precipitous drops in occupancy. We think the funding may not in fact be fully used. We're just not seeing the evidence, and there are an awful lot of beds that have come on board.

Ms Martel: Let me back up, because I don't think I got this, and if I did, I apologize. What is the total estimated cost of this proposal over the two-year period?

Mr Tuttle: I don't think we know the final amount at this stage.

Ms Martel: OK. Give me your best estimate.

Ms Kardos Burton: It's very difficult to give an estimate, because the goal for this program would be that we wouldn't be spending any money and that we wouldn't come into this situation.

If I may come back to respond to your point, though, and I think we did say it, because of the issues that you have raised, this is why it is critical that we monitor this program. You can be assured that we will monitor this type of program. The final details, as both Paul and Gail have said, are being worked out, but one of the details in that is of course a monitoring mechanism, because we're very cognizant of what this could potentially raise.

Ms Martel: I want to go back to the cost again. You didn't go to cabinet without having some kind of cost attached to this. You just didn't. So what was the estimated cost you went to cabinet with to try to get approval for this policy?

Mr Hassan: Let me just say that we'll endeavour to see what we can find out for you. We do not have any numbers in front of us that would help you confirm that.

Ms Martel: The number that I was told was $40 million, so I'd like to get a confirmation of whether or not that's true.

Mr Hassan: I just don't know.

Ms Martel: All right. This leads into my questions now about the $100 million that was granted to facilities in 2002. My concern stems from what I've been harping on in terms of the ministry not knowing where some of this money is going.

The minister, when he announced this money on July 31, said very clearly that "the $100 million in nursing funding adds an additional"—that's key, additional—"2,400 nurses and personal care workers to the long-term-care sector, or approximately 3.9 full-time-equivalent nursing and personal care staff per 100-bed facility." That's the press release.

Here's the letter that was sent to residents. It says, "This investment will add an additional 2,400 nurses and personal care workers to the long-term-care sector, or approximately 3.9 nursing and personal care staff for each 100-bed facility."

What I would like to know is, how many new nurses and personal care aides have now been hired with this $100 million?

Mr Tuttle: We are about to do a comprehensive survey to determine exactly how the $100 million has been spent. The average facility would have received $6.33 on their per diem as a result of that $100-million investment, but we're really not in a position to comment until we complete that comprehensive survey, which is going to be field-tested this week and will probably go out in the next 10 days.

Ms Martel: When did this money go out? August?

Mr Tuttle: Yes, last August. However, it seemed reasonable to wait to do the survey until people had had a chance to actually invest the money.

Ms Martel: Wait a minute. Did all the money flow in August?

Mr Hassen: On or about that time.

Mr Tuttle: Yes, on or about that time.

Ms Martel: OK. That's August. August, September, October, November, December, January, February—we're hitting the start of eight months that this money's been out the door. So you're telling this committee that as we sit here today, almost eight months after this money went out the door, you can't tell us how many new nurses and personal care aides have been hired in these facilities—eight months later?

Mr Tuttle: Let me say that when we announced the $100 million, it does flow in monthly. We pay homes on or about the 22nd of each month. So it's not as if you're handing the whole amount at once. We know anecdotally, as do you and others, from people—for example, I know one chain has hired over 70 people, they tell me, to date. But right now it is anecdotal. We want to wait and get the facts through a comprehensive survey. I'd be only speculating right now. I know many organizations that have talked about the way they've spent the funds, but again it's anecdotal. I'd rather wait for the survey results.

Ms Martel: The homes would have known at the start of August the total amount of funding they were going to get, correct? Whether or not it was flowed on a monthly basis, they were advised at that time how much new money they were getting.

Mr Tuttle: Absolutely, and they would be advised what their specific amount would be.

Ms Martel: Right, OK. So let me give you some more anecdotal evidence then. This was actually a survey that was done by ONA to facilities where they obviously have nurses, which would be most of the facilities in the province. Here's how some of the money was spent, and these were in returns that came back from the facility operators to ONA. So I have to trust that they were correct.

County of Hastings—Hastings Centennial Manor: the new funding will be used to partially offset the current operating deficit for nursing and personal care.

Fairview Manor: the increased funding will be applied to the projected annual deficit of the nursing and personal care envelope in the amount of $471,000. A full-time ward clerk position has been created.

St Joseph's Heritage: used the increased funding to reduce the deficit. No plans to increase staff.

Finlandia Hoivakoti, which is in Sudbury: used the increased funding to reduce the deficit.

Rainycrest, up in northwestern Ontario: funding is being used to cover their budget shortfall.

Don Mills Home for the Aged: half of the funding is being used to cover the current deficit.

It goes on and on, and this is information that was provided to ONA by the facility operators.

Your minister—well, not yours; Mr Newman, sorry—said very clearly to residents, in the press release and again in the Legislature when I questioned him about

this, that the money was going to be used and only going to be used to hire new nurses and personal care aides. It's clear that's not what's happening. How do you respond to that?

Ms Kardos Burton: In responding to that—and Paul Tuttle said we were doing a comprehensive survey, but I don't want to leave you with the impression that we did not do any follow-up on where the nursing and personal care money was spent. Our information is based on a telephone survey. Some of the facilities which you've raised—we also have information that does suggest they used the money on nursing and personal care too in particular. I'm not sure that we want to dispute ONA's information versus the information we have. I think what's important is that we in fact do this comprehensive survey on exactly where the money was spent and then provide that wherever.

Ms Martel: If I might, the minister was really clear: 2,400 new nurses and personal care aides, right? We have facilities here that are over 100 beds that haven't seen four new staff hired, haven't seen any new staff hired. How is it that the minister goes out and makes this kind of announcement to blunt the opposition for the 15% fee increase, because that's what it was all about, and we find ourselves in a position today that the ministry has seemingly no idea how many people have been hired, and we also are in a position where people are clearly using the money not to hire new staff? How are we in this position?

Mr Tuttle: Again, I'm not willing to speculate. The survey is going out. From the beginning we said we were going to survey in January or February. We are doing so now. Admittedly, the survey is going to be out the first week of March, but we're pretty close to what we've always said: that we would do that comprehensive survey of every single home in the province and make our assessment based on the facts we find.

Ms Martel: Let me ask—

The Vice-Chair: Last question and then we'll break for lunch.

Ms Martel: What direction were Ministry of Health staff in the regional offices given with respect to how the money could be spent? Were the regional staff clearly told from the top that money could be spent on deficits instead of on staff?

Mr Tuttle: As always, whenever the government makes any new investment the funding is provided according to the rules that exist in the manuals. So they wouldn't really need to be told anything specific other than it was $100 million for nursing and personal care. Every single one of them knows exactly what that means and knows how it should be spent.

Ms Martel: And it doesn't mean new staff, does it?

The Vice-Chair: The clock usually catches up with us, and we are now going to break for lunch because I've determined that there are further questions and comments this afternoon.

I would ask that we return at 1 o'clock. That gives 45 minutes. I hope that's satisfactory. We're in recess until 1 o'clock.

The committee recessed from 1211 to 1302.

The Vice-Chair: We shall reconvene the standing committee on public accounts.

Mr Gill: Going back to quality assurance, again, adequacy of service—what is right, is it too much, is it too little—how do you establish that?

Mr Tuttle: Unlike some jurisdictions, we don't have a minimum standard that applies across the board to everybody. Quite frankly, in a lot of jurisdictions there is no one jurisdiction that arrives at the amount of funding the same way or the amount of services to be provided. As I said, in the last few years funding has certainly kept pace with acuity: 12.5% acuity, 36% funding increase. That's indicative of the level of services we might be providing.

However, we establish what's needed by going in and charting, and I know it amazes some people, every one of those 64,000 residents. We look at their charts, do a thorough assessment of their situation in every dimension—psychological, spiritual; we just pick up on the whole ball of wax. It's very thorough. We then look at the individual home's mix of residents, ascertain what level of funding would be required to take care of them, compare it to a provincial average and establish the funding. So it's really based on the individual, I would say.

If you were to ask me about standards, as I said, we have 30-odd standards and over 400 criteria that people are required to meet. So it's a pretty thorough system.

Mr Gill: Of these 64,000 charts that you look at, is there any kind of satisfaction factor as to how the consumers feel? Is there a feedback mechanism?

Mr Tuttle: Compliance advisers quite often will talk to residents or their families. That isn't an official part of the process, though, because you couldn't do that uniformly. You're not guaranteed of being able to talk to everybody and, quite frankly, and somewhat sadly, unlike a number of years ago, many of the residents now have some degree of dementia. Their needs are very complex. There are fewer people who are mobile in the homes than there used to be and you just couldn't converse with every resident to determine their level of satisfaction, as you might have at one time. Today's resident is much different from the 1990 resident.

Mr Gill: In terms of improving the D accommodation, or whatever the nomenclature is, how much does it cost to upgrade or renovate that accommodation?

Ms Paech: Within the province of Ontario, facilities are classified as A, B, C and D. A facilities are those facilities that meet the new 1998 design standards, B and C facilities are those that are above the 1972 standards and D facilities are those that did not meet the 1972 standards. When the D program was initially announced, it was only a development program, and the ministry informed all the operators who were responsible for operating a D facility that they would have to redevelop.

Upon further exploration, it became obvious that there needed to be a multi-component program for the D facilities, that many of the D facilities simply did not

have the funds to redevelop their facility fully. So long-term-care redevelopment developed a program that had a component of redevelopment. It had a component of retrofitting, which was a program that enabled a D facility to meet the majority of the 1998 standards, but along a sliding scale. An example would be that a room size in a 1998 facility, according to the new program standards, is 135 square feet. For the retrofit, recognizing that these facilities were in the main going to keep their exterior walls and the footprint of the facility, they had to adapt the space internal to the facility. So with the example of 135, we said that a D-facility bedroom would range from 130 to 135. We gave them an option for a range, but overall they had to meet the 1998 standards.

The third component of the D program was that organizations that were Ds and simply could not afford to do either the retrofit or the redevelopment would then have to commit a minimum of $3,500 to upgrade their facility so that it did reach the 1972 standards. The plan was that we would also look at these facilities, look at their operations and make recommendations as to how they could become more efficient in their operations so that when and if there was ever another program that was announced by the government to look at the B and C facilities, those facilities would be in a position then to redevelop. The organizations that either redevelop or retrofit are eligible for up to the $10.35.

Mr Gill: In terms of the newer accommodation, I think it came out this morning that perhaps the clients or the occupants are going toward the newer accommodation and some of the older accommodation is sitting vacant. Is that the case? Are we having difficulty filling them?

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Ms Paech: The ministry is tracking on a monthly basis the occupancy of all facilities. We are able to track the total number of people on waiting lists for facilities. We are able to track the movement of individuals who are presently in a facility who want to move to a new facility. We are able to identify how many people there are and where they are located. Overall, as I indicated this morning, we have seen very little fall or decrease in the level of occupancy of old facilities across the province. The occupancy as of December is 98.6%, and for the two previous years it was 98.8%, around that, so very little. As I indicated, the new facilities are filling up and are desirable to clients. Overall, there are some vacancies occurring in the Bs and Cs but, again, we have 16,000 people waiting to get into the facilities at this point in time.

Mr Gill: You said earlier that there are 64,000 charts that you are looking at or keep track of. Was that always the case or is this a later phenomenon?

Mr Tuttle: The level-of-care system, the Alberta classification system, was first introduced in a pilot in the early 1990s and came fully into use in 1996. Prior to the full introduction of the Alberta system, funding was not based at all on resident charts. It was a fixed amount in one system and on the municipal side it was almost unlimited in the government-funded deficits in municipal homes, whereas the nursing home had a fixed per diem system. But it wasn't based on resident care needs. So that's a new phenomenon introduced in the 1990s.

Mr Gill: Thank you. I think Mr Chudleigh has a question.

Mr Chudleigh: Recently a study came out that shows that Ontario was spending less money than Saskatchewan, we had fewer hours of care—I think Mississippi was used as one of the examples of fewer hours of care—and the raw food costs at I think $4.49 per day are significantly below other jurisdictions. Are you familiar with that study?

Mr Tuttle: Very familiar, yes.

Mr Chudleigh: Could you respond to it? The folks in some of the long-term-care units in my riding are very upset about that. Why should I not be upset about that?

Mr Tuttle: As I indicated this morning, one of the valuable pieces of the study for us was showing us that we might want to consider moving toward the classification system that's used in most other jurisdictions. From a methodological point of view, we still have the same kinds of arguments or caveats in addition to the ones provided by the auditor, in that many of those jurisdictions in Ontario integrate people who would be chronic care patients or complex continuing care patients into their general long-term-care population. We don't do that in Ontario, so the three-hundred-plus million dollars, I believe it is, that we spend for approximately 7,000 complex continuing care patients isn't considered part of our per diem. So it's a little bit of apples and oranges there.

In addition, we'll expect to spend about $1.8 billion this year and, of that, there are millions and millions of dollars that we supply in special pots, a high-intensity needs fund, for example, to supplement the care for really complex, difficult residents. We don't count that as part of the per diem, we don't take credit for that, yet there are millions of dollars in these pots. An accreditation pot for facilities that are accredited by a national accreditation program is not included in the per diem.

So it's a little bit misleading. I'm not trying to say that the study isn't suggestive or there's nothing to be learned, but I don't think people should be alarmed or take it entirely at face value.

Mr Chudleigh: Is that true of the raw food costs as well? There are also the other accommodation costs they talk about, which include dietary and laundry services. Are dietary services part of the food allowance? Are they measured somehow differently in different places?

Mr Tuttle: The dietary staffing is provided through the other accommodation envelope. Raw food is a separate envelope. You have to spend a certain amount on raw food. Certainly, if you ask me, and I know I've talked to the associations, they will say, "We could use more money and we'd like more money in accommodation, nursing and personal care," or whatever. The government has invested a considerable amount of money in nursing and personal care.

Not only is the total investment relevant here; there is a shift that I talked about earlier. The nursing and personal care portion of the envelope has gradually increased to a bigger proportion of the total per diem. That's where the emphasis has gone on the care.

Mr Chudleigh: I think you said 54%.

Mr Tuttle: Yes. We go back and forth, and there are varying opinions on how much you should have in raw food or accommodation, but additional funding has been put in those envelopes as well.

Mr Chudleigh: In the B, C and D types of nursing homes there are now 16,000 beds that are going to be renovated, I believe, and 15,000-and-some-hundred beds are under renovation. Whereabouts does that stand? How many of those beds have been renovated? How many of them are currently being renovated? I understand that program is to be completed by 2006. Is that correct?

Ms Paech: The D bed program numbers total 16,000. In terms of the three components of the program redevelopment, to date we have 3,000 beds, and by the end of March we will have 3,400 beds that have been totally redeveloped.

If you look at the status in terms of redevelopment, retrofit and upgrade, there are various numbers. In terms of the redevelopment, we have about 3,000. We have only one organization that is going to retrofit. Originally there were four organizations that made the determination. Since the time they made the announcement that they would retrofit, in looking at their costs associated with retrofitting they have decided to redevelop.

We have a total of 11 organizations that are going to upgrade. Those upgrades must be completed by December 2003. So the 11 facilities that are upgrading are in the process now of upgrading.

Mr Gerretsen: It's difficult to know where to start. Today is the first time I've heard that you're now trashing the study you paid for some year and a half ago; you're saying that we're not comparing apples to apples. Yet nowhere, when this question was raised in the House or earlier in estimates, did the minister or anyone ever suggest that we weren't comparing apples to apples.

What bothers me is that you're throwing terms around, sir, that you know as well as I do have totally different meanings. Complex care patients are different from chronic care patients, and we closed 5,000 chronic care beds in the hospital system. Where did those people go? We know where they went. They went into the long-term-care sector.

If what you're saying is correct, if this study wasn't comparing apples to apples, there is nothing in the Pricewaterhouse study itself that indicates anything to that effect. Why are you bringing this up now? Are you just trying to confuse the issue?

Mr Hassen: If I may just begin to comment on chronic care and nursing homes, I worked at St Joe's in London several years ago when we closed the chronic care hospital there. It was not a chronic care hospital as you are envisioning it.

Mr Gerretsen: You don't know how I'm envisioning it. So let's hear what you're saying.

Mr Hassen: Let me then try to describe it to you. We assessed—

Mr Gerretsen: Did we close 5,000 chronic care beds in this province or not?

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Mr Hassen: If I just can speak to the example of those beds, when we did the evaluation of the people living in the chronic care beds and the people in our long-term-care facility at Marion Villa, they were virtually identical. So it had nothing to do with them being chronic; it had to with where they were placed.

There are chronic patients, there's no question, and there are appropriate facilities for them, but they are different than nursing homes or homes for the aged, as has evolved over time.

Mr Gerretsen: Do you agree that the province closed 5,000 chronic care beds in the hospital system some time ago, within the last—

Mr Hassen: Let me turn to Paul—

Mr Gerretsen: Just answer the question. Did we close those beds or not?

Mr Hassen: Excuse me. I don't know the number, and I'm just trying to get the number verified.

Interjections.

Mr Hassen: I want to verify the number. I wasn't here during the period that you're alleging the closures, so I thought I would turn to my colleague and ask him the question. That was all I was doing.

Mr Tuttle: I'd have to get the exact number of beds that were closed. I don't have that at hand.

If I could clarify what I was saying, I wasn't in any way trying to trash the study. In fact, I said it was instructive and there is much to be learned in it. I have said before, talking about the authors of the study and with both associations, what kind of methodological quibbles I have with them, but in no way was I trying to trash the whole study. Really, to get down to that level of detail is something that was of interest to people in the associations and to myself.

Mr Gerretsen: There were conclusions reached in that study that state that we've spent less than anybody else in the other 11 jurisdictions on nursing and personal care. This is the first time that someone has suggested, that I'm aware of, in a public way, that basically the other jurisdictions weren't comparing the same things.

Could I just ask you another question? Two or three times I think the individual sitting beside you has mentioned that there are 16,000 people on the waiting list. Are those 16,000 individuals? As you well know, people can be on a waiting list for three different facilities. How many individuals are we talking about?

Ms Paech: When I refer to the number of 16,000 people waiting for admission to a long-term-care facility, I am referring to individuals. We have gone back and cleaned up the list. Previously what was counted was names for a facility, and so there was double counting.

We have since gone back and we now are only counting individuals.

Mr Gerretsen: OK. Thank you. That's a direct answer. I appreciate that. It's one of the few we've had here today.

Earlier this morning we talked about a comprehensive survey being done with respect to the extra $100 million that is expended, supposedly on personal care and nursing care and food costs. What do you mean by "a comprehensive survey"? Do you not do an internal audit? The perception is being left out there, by both the associations and by the ministry, that we, more than any other jurisdiction, are divvying money up into four different categories—so much for food, so much for nursing and personal care etc. We can't, apparently, follow that up with respect to the $100 million, even though the minister, in his announcement, made it quite clear that this was supposed to be for extra nursing care. What do you mean when you're talking about doing a comprehensive survey? What about an internal audit to see whether or not the individual organizations or homes are actually spending that money in the areas that it's being given for?

Ms Kardos Burton: As I think I referred to earlier this morning, we have done a telephone survey, but it doesn't include everyone. When we say "a comprehensive survey," we mean a paper survey where facilities will have to fill in information. It is much like an audit in terms of the kinds of information that we are requesting. We have some information. When the minister made his announcement, it was 2,400 nurses and personal care workers, and this morning we talked about the OANHSS survey, but it is also personal care workers in terms of the 2,400, or approximately 3.9 full-time-equivalent nursing. What we're looking for is exactly what those facilities spent their money on. So it will be a paper survey sent out to every facility and we will have the results tabulated, and it will be available for us so we will know exactly what the money is spent on.

Mr Gerretsen: But it's basically going to be that they're returned to you. You're not doing an internal audit as such, as to whether or not the money is actually being expended in the areas for which it was allocated.

Ms Kardos Burton: We probably wouldn't do an internal audit on all, but spot audits are not beyond the realm of possibility.

Mr Gerretsen: If you haven't done that with respect to the additional money, how can you give assurances to the people of Ontario that each individual facility or home in effect is spending the money in the areas that it's supposed to be allocated for? What kind of assurance can you give people? If you can't even do that for this minimal increase for a specific area, how can you do it province-wide for the entire system?

Ms Kardos Burton: I think we talked earlier about the kinds of information that we do get. This was a specific amount of money that was significant, and it was specifically stated for a certain purpose. There have been questions about whether in fact that amount of staff has been hired, and that's why we're actually going to get that information. But I think we can give the people of Ontario assurances that the money that is being spent in the facilities is being spent on what it's there for. Mr Tuttle referred to the envelope system we have and the recoveries we do if the money isn't spent where it should be.

Mr Gerretsen: But you heard this morning, and there were all sorts of examples given, where different homes—and perhaps they had no other alternative—had spent a lot of that money covering past deficits and things like that. Once you hear that kind of information—and that information has been out there since last October, if I remember correctly seeing the press release from the non-profit association initially. If the association itself is saying, "Here are the organizations that have not used it for nursing or personal care; this is the name, and that's what they've used it for," would that not twig a little bit of a light within the ministry to say, "Hey, the organizations, the homes themselves, are saying it's not being expended for what it was meant for. Maybe we should check with them"?

Ms Kardos Burton: I can assure you that accountability is very important to the ministry. We do have information that's reported to us. We have reporting mechanisms. We have service agreements. The money is to be spent on what it's intended for, and we will follow up with consequences if it is not. So we do have a system in place. Perhaps there could be improvement, but we certainly have a mechanism in place to ensure that money is being spent.

Mr Gerretsen: It just seems to me that since the money flowed out last August or September and you're only now doing what you call a "comprehensive survey," it doesn't give anybody any assurances that the money was actually spent in that area.

Talking about the new long-term-care beds, in the auditor's report on page 135 he makes a recommendation. He states, "To help demonstrate that awards for new long-term-care beds are based on a fair and open process that is consistently and objectively applied, the ministry should ensure that the justification for all decisions is properly documented." You responded to that as a ministry by saying, "The ministry will do its best to ensure proper documentation of all decisions." Is that documentation available to the public? If so, are you prepared to table it? What documentation exists?

Ms Paech: The documentation that was looked at was the material that was submitted for the response to the two RFPs and also to the allocation in process. In the year 2000, the ministry established the long-term-care redevelopment program. The project was responsible for the 2000 allocation process.

The process that was used prior to that with the two RFPs was a decentralized process where regional staff were involved in it and there were committees. We, as a redevelopment project, attempted to get all of that information, consolidate that information and store it within the archives of the redevelopment project. On review,

there were some files that were not complete files, and we have attempted to gain those materials. Certainly for the 2000 process, all of the documentation is there and is in the files for them.

I'm going to look to the deputy—

Mr Gerretsen: The question is, is it available to the public?

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Ms Paech: I'm going to look to the deputy, because I'm out of my league here in terms of the government's position on this one.

Mr Hassen: Obviously we don't have that information with us. We'll undertake to look at what is possible to be made available to you and to the public.

Mr Gerretsen: Well, I wasn't asking for any specific information. I was asking whether or not the information you have is available to the public.

Mr Hassen: I just have to look at the rules for making certain information available. I'll follow whatever is required according to the rules of privilege and confidentiality. If it's not confidential information, it's obviously available.

Mr Gerretsen: And you will make it available to the committee, then?

Mr Hassen: If it's appropriate, as I said, I will.

Mr Gerretsen: I'm hereby requesting that you make such information that you have available.

Mr Hassen: I'll undertake to see what I can provide you, based on that request.

Mr Gerretsen: We talked earlier this morning about licensing, and you indicated that only the nursing home sector has to be licensed. That's as a result of long-standing history. Has the ministry given any thought to licensing the municipal and charitable homes?

Mr Tuttle: Part of some of the policy work we're undertaking now with respect to our compliance review is to see if there's a way of establishing some kind of uniform approval process. That doesn't necessarily mean licensing; it may mean something else that applies to all organizations. But yes, it's under consideration right now.

Mr Gerretsen: We talked also about the complaints mechanism, and I think reference has been made to it a number of times, that all complaints are to be dealt with within 20 days, yet the auditor's report clearly indicates that this was not the situation in all cases. What have you done to ensure that all complaints in effect are being investigated within 20 days? What mechanism have you set in place? I think 20 days is a pretty long period of time, particularly if it's a serious complaint that affects the health and welfare of the residents or a resident, but be that as it may, what have you done to make sure that all complaints are actually dealt with within that 20-day period?

Mr Tuttle: The auditor, if I remember correctly, said that 83% were being responded to in 20 days. The way we evaluate the timeliness of our response is through a system called FMIS, financial management information system. With a complaint, sometimes the information goes into that system very promptly, and at other times—and a complaint isn't considered resolved until the last piece of data is entered in. Sometimes it happens that it takes more than 20 days to do that. So what we're looking at is being more timely in our reporting standards and reinforcing with staff the importance of getting their notes written up quickly because, quite frankly, some of the lag is due simply to getting in and responding to the complaint but then not having the time to write it up till perhaps 25 days rather than 20.

Mr Gerretsen: Well, 83% may sound like a good percentage, but it still basically means that more than one in seven complaints are not dealt with in the period of time. From your answer there, I take it that you have set up no specific new methodology as to how to deal with that so you can actually deal with 100% of the complaints within that period of time.

Mr Tuttle: I'm sorry. There are two ways that we are going at that. One is through the compliance review; we're looking at ways that we might improve our response time. We're always looking to improve—there's no question about that—and we're considering various methods for doing so. But one of the immediate things we're working on is just making sure we get credit where credit is due for our timely response by entering it and closing the file in time, because if you don't enter it until after 20 days, it appears that the complaint hasn't been resolved in that time. So we're working on the administrative processes now and we will have recommendations on the rest of it.

Mr Gerretsen: Are you understaffed?

Mr Tuttle: If you're asking me if long-term-care facilities branch, like most departments—if you said, "Could you use more staff?" everybody could, yes. We're not understaffed, though.

Mr Gerretsen: OK. You talked bout the FMIS, the facility monitoring information system, a little bit earlier. Have there been any plans by the ministry to include situations where a disease is spreading within a particular home for a certain period of time? From reading the auditor's report, that is not regarded as a FMIS matter at this time. Am I right in that? Are you going to include contagious diseases as part of that mechanism?

Ms Kardos Burton: I'd like to talk about the outbreak of diseases. The way that the report is written, they do certainly indicate that we could improve our documentation in terms of the outbreaks of diseases; there's no question about that. But one of the things I want to assure the committee: when there is an outbreak in a nursing home, we put all hands on deck. We have protocols in place in terms of the ministry; staff are there Friday night, Saturday, Sunday, whatever; the regional offices are available, because those are very serious. We're dealing with a population that is of course particularly vulnerable. We could improve our documentation, but in terms of the protocols that are in place for outbreaks of diseases, I can assure you that they're there.

Mr Gerretsen: OK. How much time do I have left?

The Vice-Chair: You have two minutes.

Mr Gerretsen: The other issue I'd like to get to is this new measurement issue that has been raised by the government members as well and that the auditor makes reference to: the resident assessment instrument. The auditor seems to be of the opinion that you—I'm just trying to find the exact location here, but I think it's at page 138—do not have a commitment to go to that kind of instrument assessment mechanism. I wonder why, when it seems to be so widely used elsewhere. Could you just give us some comments on that, please.

Ms Kardos Burton: I think Mr Tuttle referred earlier to the fact that we use the Alberta system. We are looking at this. In terms of not a commitment, like anything else, implementing something like this throughout the number of facilities that we have in Ontario does cost money. We are committed to reviewing it. We have a dedicated resource team looking at it. We are very well aware of the methods and how it is used, as Mr Tuttle mentioned, in mental health, in home care. We believe that it will help us identify the needs of all residents of Ontario but, like anything else, we need to look at the financing and make sure. Once you enter into it, you want to have it on a system-wide basis. So we are certainly looking into it, we are committed to that, but we just have to ensure that the financing is there to take us over the long haul.

Mr Gerretsen: OK, but the auditor states that in October 2000 a review committee was established by your ministry to determine whether or not a pilot should be done using this measurement, and your committee recommended that the ministry develop a funding methodology based on the MDS and explore a partnership with the home care sector to develop a common assessment tool. He concludes by saying, "However, at the time of our audit, no progress had been made in implementing a pilot project." Are we any closer now?

Ms Kardos Burton: I believe we are. We do have resources assigned to it and we certainly are looking at every way possible to make sure. We've also had some advancements in mental health and home care, so that other parts of the system are now using it. That advances our cause in terms of this, so I do believe we are making progress.

Ms Martel: Mr Tuttle, I just want to return to my previous line of questions. When we ended, you had just told the committee that the regional health employees would have been aware of what could be funded with $100 million. Let me ask this question: is it clear, then, that the $100 million could be used and can be used to reduce operating deficits?

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Mr Tuttle: The rules laid out in the financial manual are very specific about the kinds of expenditures that are eligible in nursing and personal care, other accommodation, programming and support services and raw food. Facilities not only have to spend according to those lines, but they have to spend the lines in the envelope where it is appropriate. That's what I meant by "they would be aware."

Ms Martel: I don't think you answered my question. Is it clear that a portion of the $100 million could be used by facilities to deal with their operating deficits—yes or no?

Mr Tuttle: If we understand deficits as I do, then the answer would be no. There isn't a line or an eligible expenditure for deficits in the manual, in other words. So the money that is transferred, the actual dollar that is transferred, in other words, is going to be spent according to the rules of our manual, and if it's not, there will be consequences.

Ms Martel: So you're telling me, then, that there are going to be consequences for the list I just read out to you, where those facilities indeed used money for operating deficits?

Mr Tuttle: I'm not in a position, respectfully, to determine what I'm going to do about a specific facility. As Ms Kardos Burton said, we are going to do a comprehensive survey. We will look at the facts and then base our decisions on those facts.

Ms Martel: Could facilities use this money to deal with WSIB premiums?

Mr Tuttle: Organizations have to pay WSIB premiums, yes.

Ms Martel: Could the new money, the $100 million, be used to pay WSIB premiums?

Mr Tuttle: If we're going to go down to that level of detail, I'm going to have to get back to you because I don't have the finance manual with me. But again, I'd say that organizations need to pay WSIB premiums and it would be a question of the allocation.

Ms Martel: I want to know specifically if the $100 million could have been used for that purpose. Then, when you're looking at that, I want to know if the $100 million of new funding that was promised for nurses and personal care aides could also have been used to fund long-term-care disability premiums. Do you know that?

Mr Tuttle: I'd want to look at our manual.

Ms Martel: All right. And what if other staff were hired, other than nurses and personal care workers? Was that allowed under the new $100 million?

Mr Tuttle: Yes. Certain supporting clerical positions are allowed in the nursing and personal care envelope, but they are directly related to the purposes outlined in the envelope.

Ms Martel: What kinds of clerical positions?

Mr Tuttle: A clerical position that would support nursing functions. But again, I'm reluctant to go much further into the details of the financing without the manual here. I'll have to get back to you on that.

Ms Martel: OK. I have another one. You and Ms Paech had a meeting October 30 with Barb Wahl of ONA and some other ONA representatives. ONA requested the meeting because they wanted to bring to your attention examples of where municipal homes for the aged were sending some of that new $100 million back to municipalities. I'm under the understanding that they provided you with concrete examples of where that was happening. You, in turn, as a result of that meeting, expressed

surprise. You had discovered that the long-term-care association, the not-for-profit association, was in fact supportive of that happening and that you were going to have a meeting with both that association and municipalities of Ontario to determine if indeed that was going on. Did you meet with those two organizations to determine if that was going on?

Mr Tuttle: I've met with those organizations, but only to say that we are going to do a comprehensive survey, and we gave them an opportunity to review the survey we were going to do. Again, we don't know the facts of the matter. We've heard anecdotes, we've had opinions, but we don't know the facts at this point.

Ms Martel: But you were given a list by ONA, correct? You were given examples.

Mr Tuttle: Yes, Ms Wahl gave examples.

Ms Martel: And if Ms Wahl, president of ONA, gave you some examples where she was clear that homes for the aged were sending money back to municipalities, this new $100 million, don't you think the ministry had an obligation to check into those examples to clarify whether or not that had happened?

Mr Tuttle: The best way for us to respond to those allegations is with a comprehensive survey.

Ms Martel: Oh, you're kidding. Come on, Mr Tuttle. The president of ONA gives you examples, and you don't think this is serious enough that you would go and find out immediately if that's what happened?

Mr Tuttle: The examples she gave me—again, I don't have my notes from that meeting with me, but at that meeting nothing was said to me that was startling enough for me to want to go out and do an immediate audit.

Ms Martel: OK, Mr Tuttle, tell me: do the rules in the financial manual allow for money like this to be used to reimburse municipalities? Is that an expenditure that would have been allowable with this money?

Mr Tuttle: There is no provision in our manual, no line that says, "Reimbursement for Municipalities." There is no such thing.

I really am at a disadvantage, because we need to know more facts before we respond.

Ms Martel: If there's no line in your manual, what's your normal policy with respect to this matter?

Mr Tuttle: Well, the matter hasn't come to my attention before, that we've ascertained. I can tell you that any time we establish that there have been inappropriate expenditures, we take action. We either recover immediately, send in auditors, we could call in our internal audit branch; we have a number of efforts we can use.

Ms Martel: So why didn't you do any of that in these cases?

Mr Tuttle: In these cases, based on what I was told in that particular meeting, I didn't believe it was warranted. In cases where it is warranted, we will do so.

Ms Martel: So when does it warrant further investigation, in your opinion?

Mr Tuttle: If we're still talking about the $100 million, again, I don't want to—I can't make a response to anecdotes. I can't make a response to opinions or assertions; I need to find out the facts.

Ms Martel: And I'm trying to get out why you didn't get at the facts. The president of the Ontario Nurses' Association—pretty significant, in my humble opinion—requests a meeting with you because they want to bring to your attention examples where homes for the aged have used some of this new $100 million to send money back to municipalities instead of hiring new staff like the minister promised. You didn't think that warranted some further investigation immediately?

Mr Tuttle: I don't recall the statement being made in exactly that way. And I have to tell you again, with all due respect, that when something comes to my attention regarding anything that impacts the finances or care of long-term-care residents, I do tend to act immediately.

Ms Martel: Do you meet regularly with Barb Wahl?

Mr Tuttle: No.

Ms Martel: So let me get back to this again, just to reinforce my point: you don't regularly meet with her, she requests a meeting with you to bring this to your attention, she gives you a list of examples and you don't follow up immediately? I'm astonished at that; I really am.

Ms Paech, can you help me?

Ms Paech: I also was at that meeting. That meeting was requested by the Ontario Nurses' Association, and Barbara Wahl, the president, was there. The purpose of that meeting was not solely focused on the $100 million. In fact, there was discussion—the reason I was there was because it was about the new facilities, about the project we have, Turning on the Lights, which is looking at the resourcing of the new facilities and some of the new initiatives we are undertaking to look at encouraging health care providers to work within those facilities, not only the new facilities but all facilities.

It was during the course of that meeting that Barbara Wahl indicated that they had done a small study, a small survey. She did not go into the details of how the study was conducted, nor did she indicate it was a comprehensive study. She gave us examples, and at that time we did express that we were surprised to hear this and that we would be following it up. As Mr Tuttle has indicated, the ministry's response to that is that we are, through negotiations and discussions then with the Ontario Long Term Care Association and OANHSS—and had discussions about how these monies were being spent, and upon further discussion, it was decided that the ministry would conduct a survey. That survey has been developed, it is being tested and it will be released shortly, so that we can understand comprehensively, using a methodology that the ministry believes will address those needs, and will be administered to the field.

Ms Martel: I'm sorry; I find that unacceptable. She gave you some examples. You should have followed up on that. You should have followed up immediately. We are here five months after this meeting, and you folks are telling us now that you're going to do some kind of

comprehensive study to figure out how this money was spent.

Do you think it's appropriate that money that was supposed to go to personal care aides and nurses could be sent back to municipalities? Do you think that's an appropriate use of this money, yes or no?

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Mr Tuttle: I had no evidence or indication at that meeting or otherwise that any of the money was used for any purpose other than what was intended. I can't talk to you about all the other possible sources of revenue they have.

Ms Martel: No, no—please, Mr Tuttle. Did Ms Wahl tell you that she was aware of homes for the aged that were sending some of that new money back to municipalities; yes or no?

Mr Tuttle: I don't remember her using those exact words, but I remember the point being made, and she did give us some examples of things she believed were happening. Again, this was a minor part of the meeting and not why she asked for the meeting in the first place.

Ms Martel: And you didn't think it was serious enough to follow up. So you can't tell us today whether you have any idea if a number of homes for the aged in the province actually did this? You are not in a position today to tell us that, eight months after this funding flowed?

Mr Tuttle: Again, the funding flowed on a monthly basis.

Ms Martel: They knew what their allocation was.

Mr Tuttle: They knew what their allocation was. They know how they're supposed to fund their allocation, and I can't imagine a municipality and would indeed be surprised that a municipality didn't use the money transferred to them from government for the purposes intended—the government money.

Ms Martel: But you didn't check to be sure, which is a serious problem. I'm astonished at that.

Let me ask: if you finally do this comprehensive survey and find that municipalities did that, is that an expense you're going to allow? Is that a transfer you're going to allow?

Mr Tuttle: I can only answer in the general sense that if we found an expenditure that was made that wasn't in accordance with the rules in our manual, then we would recover it. It would be quite clear.

Ms Martel: Is this an expense that is allowable under your manual for this money? Is this the intended purpose of this money? Does it comply with your rules?

Mr Tuttle: Our rules are quite clear. Again, I don't have any evidence—facts—that anybody has spent money in any way other than has been intended.

Ms Martel: I don't think you want the facts. If you really were interested in finding out about this, you would have made those calls immediately, it seems to me. Right? And you didn't.

Let me go back to this: if you do your study and find out that 2,400 new nurses and personal care aides were in fact not hired, then what happens?

Ms Kardos Burton: When we do our study, not if we do our study, and find that the intentions are not met, then we will certainly explore the reasons why—I think that's fair in any information that comes forward—and if the reasons are not acceptable or if they are in violation of policy, then we will take action.

Ms Martel: Can you tell me what the circumstances are for a facility if the intentions are not met? What's a ministry definition of that? What does that mean?

Ms Kardos Burton: It depends on what the circumstances are, whether it's recording or financial or care. There are lots of actions that are taken. We talked this morning about if concerns are expressed and a facility is not caring for the residents, then that can go from a letter to a meeting to increased staff to a takeover by another facility.

Ms Martel: I'm looking for the criteria. If you go out and find that people use this for operating deficits, is that going to conform to the intent of this money; yes or no?

Ms Kardos Burton: That's really difficult to answer. We need to be clear on the intentions, whether or not they met it. If it didn't, then I think there are a number of actions that could be taken. It depends on the circumstances. Like everything else, you look at whether they knew or ought to have known. It could result in a letter, or it could result in the money coming back, whatever. It's hard to say without specifics, but certainly some sort of graduated sanctions would be in place.

Ms Martel: Could you table for this committee the list of the ministry's intentions or expectations—however you want to define it—of what facilities should use this money for? Can you table that for this committee?

Ms Kardos Burton: I think we can do that.

Ms Martel: That would be great. And while you do that, I would like you to deal with the very specific issue of homes for the aged sending some of that new money back to municipalities. I want to know if the ministry would have intended that $100 million to be used for that kind of purpose.

Ms Kardos Burton: We will respond to that.

Ms Martel: Are you going to be tabling for the public the results of your comprehensive review?

Ms Kardos Burton: I don't have an answer for you at this point. We need to look at that and review that further.

Ms Martel: Would there be any reason under FOI that it shouldn't or couldn't be tabled publicly?

Ms Kardos Burton: We'd need to examine that information. We'd just need to examine it. We haven't made a decision on that. That's not a yes or a no; there is no decision on that.

Ms Martel: We've gone at this a number of ways. I remain extremely concerned that a minister on the one hand, frankly, to try to blunt public opposition to the rate increase, clearly promised residents and their families that this money was going to be used to hire more nurses and personal care aides: 2,400 new ones; four new ones for each 100-bed facility.

In a question that I raised with him on October 16, where I pointed out three for-profit facilities in the Durham region that used their money for different purposes other than hiring of staff, he said, "In fact, all those dollars are going toward more nursing and personal care in the province." I'm telling you, that's not what's happening. Someone misled someone, and it's a real shame, because residents and their families were essentially told that as a result of that rate increase they were going to get better-quality care. Here we are, eight months later, and you can't even tell us who was hired, so you certainly can't tell us that people are getting better care, and I think that's shameful.

This leads to my next set of questions that has to do with developing staffing standards. Mr Tuttle, I've heard you twice now, in questions about how we assure quality care or quality assurance—how can we guarantee that—refer to the case management index. The case management index certainly determines residents' needs, but the case management index doesn't mean that long-term-care facilities are actually meeting those needs. Those are two different things, and that's the issue I'm most concerned about. Are the facilities actually meeting the residents' needs? From what the auditor said, you've got no way of knowing that because you have no staffing standards in place to even determine what the level of care is and who is providing it.

I go back to the PricewaterhouseCoopers study because I believe it very clearly showed what happens when you get rid of minimum standards. Before 1996, you did have to have an RN on full-time in your facility, 24 hours a day; that's gone, courtesy of this government. Individual residents were guaranteed 2.25 hours of direct nursing care or personal care per resident per day; that's gone. We have a report in 2001 that shows that Ontario seniors are dead last, at the bottom of the heap in terms of all indicators of quality care.

The auditor made it very clear on page 128 in his recommendations that the ministry should "develop appropriate staffing standards for long-term-care facilities." When are you going to implement staffing standards for long-term-care facilities?

Mr Tuttle: It is quite true that at one time there was a requirement for 2.25 hours. It was eliminated when we moved to the Alberta level of care system that does look at individual needs.

What we take from the auditor's recommendation, again, is that we need to pursue better systems. We are taking a serious look at the minimum data set which would provide us much more information about what's actually going on in long-term-care facilities. We're moving forward on that. There is no plan at the present time to reintroduce a minimum number of staffing hours.

Ms Martel: Let me back up. You said, "We eliminated the minimum number of staffing hours when we moved to the Alberta model." But if I understand you correctly, you said it was in the early 1990s that the case management index was implemented. Did I misunderstand you?

Mr Tuttle: The case mix index is just the index that comes from the Alberta system. It wasn't fully implemented until 1996. I believe that was the first year it was fully in place.

Ms Martel: Why would a move to that model have resulted in a loss of minimum standards of care?

Mr Tuttle: Because prior to that there was nothing in place to assess the individual needs of residents' anticipated care needs and relate it to funding. Once we had a system in place that focused on the individual and groups of individuals rather than a standard that applied to everybody, we simply felt the standard was no longer required.

Ms Martel: But you now have no regulation at all that facilities have to respond to—none.

Mr Tuttle: There is no minimum staffing hours requirement now, that's correct.

Ms Martel: Right. So you've got no minimum standard, and what we've seen, if you look at Pricewaterhouse, is a decline in the quality of care for residents. I think that's what you take away from the PricewaterhouseCoopers study. That's the end result when you don't have minimum standards of care.

1400

Mr Tuttle: I'm not sure there's a direct connection between the results of that study and taking away the minimum hours of care; I'm not sure the connection is there. Again, I have some debates with that study, but it is suggestive, and we have learned from it. We certainly have learned that we can probably improve greatly in the way we assess needs.

Ms Martel: OK, but now the auditor has come forward—

The Vice-Chair: I'm afraid we're going to have to move on to the government caucus. Mr Gilchrist.

Mr Steve Gilchrist (Scarborough East): Let me just preface at the outset that I certainly don't disagree with the premise behind Ms Martel's line of questioning. It's a rare day that I agree with Shelley, but I will say that when it comes to accountability, it's tough not to be sympathetic.

Interjection.

Mr Gilchrist: No, I'm not going to go too far down that road. But it does raise a number of questions. I would say, not to counter Shelley, if that information is going to be provided, it would obviously be relevant to know, if in fact the money went back, whether it was a return of funds that had been advanced by a municipality over and above any normal commitment or in anticipation of the province flowing funds. So I hope that if, as and when you are able to come back to us with the results of your survey, it won't just be the quantum of what went where but, if in fact funds flowed outside of the envelope, an explanation, if one is available, of why they did what they did. Because there's a flip side to that, and Ms Martel didn't articulate it: if in fact municipalities have glommed on to a new income stream, that's obviously relevant to another ministry of the crown which continues to hear messages from them about how

underfunded they are in a variety of other programs. In the run-up to the municipal elections this fall, I think the good citizenry in those communities would love to know if in fact they've decided to make money on the backs of long-term-care clients in their institutions. But we'll all have to wait for that final answer.

Having joined you just for this afternoon, I have not heard what the time frame is for this survey that I've often heard mentioned. How quickly is that being prosecuted, and how quickly will you be turning around the results?

Mr Tuttle: We've just finished our consultations on the survey. We wanted to make sure it was as comprehensive as possible. It's going out for pilot either tomorrow or next week. We will try it in a few organizations to be sure that we're collecting the information and getting everything we want to know. I anticipate that it will take a couple of months before we have all the data back from all the organizations and are able to analyze it.

Mr Gilchrist: I'm afraid I'm also going to have to adopt a similar tone to Shelley here. We had a similar response when the Red Tape Commission tackled, along with other good folks in the civil service, the fewer forms, faster service project. The initial response we had was, "We can get back to you with a listing of all the forms in two years."

With the greatest respect, once you've done your survey preparation, your work is done. Why in blazes would we not be expecting these pilot facilities to give you a response in two weeks? There is nothing—nothing—that will not be immediately available from the production of a spreadsheet. They will either be able to immediately show you that the new source of revenue derived certain benefits or not. I would think it is preposterous to suggest that we should be sympathetic.

They have gotten the money on the basis of their appeal to us to get the money. Presumably it won't be very difficult to have them prove that, having heard yes to their appeals, they then went out and did what they promised they would do. Anyone who suggests that it will take an inordinate amount of time to assess the situation and come back to you with the data is probably hiding something. I don't have any sympathy for anyone who couldn't give an immediate turnaround. If you want to be really generous, give them 30 days. But we have to move. You need to get a response from those pilots.

By the way, the definition of "pilot": presumably you may find some design criteria that you want to tweak. Waiting to then get a response from the hundreds of homes that you will survey once it goes more broadly simply exacerbates the problem. So we need an answer to that, and we need it quickly.

If from your sample, which hopefully is geographically representative and crosses the charitable, municipal and nursing home sectors, your pilot and your sample size comes back and everything looks great, I guess it will calm a lot of the concerns you're hearing around this table. On the other hand, if all of the reports come back and they all have some problems—perhaps differing, but some problems—you're going to want to increase the horsepower that you're putting behind this project and we're going to want to increase the scrutiny that's being given to any subsequent requests for funding, such as the one they've just launched now.

I am, and allow me the editorial position while we have you here, quite fed up with those who come before us asking for more and more and more who can't prove—not to our satisfaction, to the taxpayers' satisfaction—that the last appeal did not derive the benefits they promised. So we are now being barraged—I'm sure even members of the opposition are going to be getting the postcards promised from the long-term-care folks—and I'm sure they'd like nothing better than to have that campaign over and done with before the results of your survey come back. You'll forgive me if I have a different perspective on timing.

I would challenge why, and I would appreciate your response, you think more than 30 days should be allowed and then why you should take more than about two weeks to very quickly assess against your criteria and see whether everyone did meet the test that was attached to the flow of those funds.

Mr Tuttle: Sorry. I may not have been clear. We're planning on giving them about a week to get back with the pilots.

Mr Gilchrist: Excellent.

Mr Tuttle: So that's going to be taken care of quickly, and a couple of days to make sure, as you say, that we don't want to tweak it. I won't guarantee we got it exactly right the first time. Then about 30 days, tops, for people to get back to us, and a couple of weeks on that. It will be quite a bit of data from 540 facilities. We'll have to enter it into a database, and I was just saying two months on the outside. We want it as quickly as possible, and if there's any way we can deliver it sooner than that and get it done right, we'll do it.

Mr Gilchrist: That's encouraging. Forgive me. I took from your response that the pilot was going to take those number of months.

Mr Tuttle: No, sorry.

Mr Gilchrist: That's good news. I would encourage you that even at the conclusion of your pilot project, though, if alarm bells are starting to go off, you share that information with the committee or at least with the Provincial Auditor—or the reverse. If it's a good-news story, then I think he deserves to see that as part of your response to his report as well.

There is another topic I wanted to deal with, and I don't know if any of my colleagues have questions. When I came in, Mr Gerretsen was talking about waiting lists. I had a visit from folks from one of the long-term-care facilities in my riding just over a week and a half ago. They have an interesting perspective on things. It happens to be one of the larger corporate nursing home operators, one of their facilities, and in my own riding that same company has just opened a beautiful new facility. Their complaint is that the customers all want to

go to the new facility. It is new. Their concern is that it will be increasingly difficult for the older facilities to attract any business, to the point that they are sitting on 10 empty beds today and have had them for a protracted period of time.

Ms Martel: Thank you. Read Hansard. You'll know why I'm doing this.

Interjection: You should have been here this morning.

Mr Gilchrist: But at the same time, when I talk to my local hospital, people are refusing to leave the hospital. So the bottom line is that, having built the new facilities, which is a good thing and addressed the concern of the Shelley Martels and others in this world that there were waiting lists, now we have a situation where the same folks who have benefited from that expansion are turning around and trying to lever more money for older facilities. And not just that; they are suggesting that somehow the onus is on the government to keep writing bigger and bigger cheques rather than promoting individual responsibility.

I would like to know from the ministry's perspective why, according to them—and I will admit this was anecdotal. They showed me their own but they indicated that there's another nursing home in Scarborough that has 50 empty beds. Why is the ministry sympathetic to any single person staying in a hospital, blocking a bed, when there is no waiting list in facilities that, up until the day we opened the new ones, were the top of the list in Scarborough?

1410

Ms Kardos Burton: Just a couple of comments and then my colleagues can add to it. I think the one thing that we do have to take into consideration: first of all, we did do placement regulations, and one of the goals of those regulations was to actually move people out of hospitals and into long-term-care facilities. So we understand the need to do that. Secondly, I guess, there are a number of communities who are trying different pilot projects in terms of persuading people to move from hospital. But the one thing I do think we need to factor in is the choice of the individual. Literally forcing them is not permissible.

Mr Gilchrist: Again, back in 1995, when we inherited a situation where every facility was at least 10 years old because nobody had built one new bed anywhere in the province in that time frame, and most facilities were much older, you had a certain circumstance, a certain relationship between any of the nursing homes in a particular catchment area. Today we have added the new facilities to that mix. Did not, in and of themselves, those additions change the nature of all the other nursing homes in the riding? It adds a level of competition; I accept that. We always envisioned that that would promote upgrades and investments by the existing nursing homes, or else they would ultimately have to turn in their licence because people just wouldn't be coming to their door.

But somewhere in the middle were the facilities that were the top of the list before. In 1995, it would have been your number one, number two or number three choice. Nothing has changed in those facilities. I question why we would now have the same tolerance for people sitting in that $300-, $500- or $600-a-day hospital bed, because they've seen that this government has made a commitment to building new facilities. But there's still a finite number of those. I really question why we have not gone back and, now that we have this very different equation out in the field, why we haven't reviewed the policy relating to discharges from hospitals.

Ms Kardos Burton: And we have. We've been working with the hospital association, we've been working with different communities, we've been working with the district health councils, and we've changed our placement regulations so that we have been actually working with it. Gail, would you like to add to that, please?

Ms Paech: We've recognized what's occurring in the hospitals, that even with the placement regs, individuals still are not moving. As we discussed this morning, we have built within the ministry a system now to give us a very thorough understanding of where empty beds are occurring and the numbers that are occurring. We also are developing now programs, such as a short-stay program, that we would recognize that the individual in a bed in the hospital probably is not in the right place. An acute care facility is not the appropriate place for an individual that does require long-term-care services.

So the programs that we're looking at—and we are looking at a variety of them. I said earlier this morning that we were looking at respite programs so that if there were beds that are empty in the long-term-care facilities, we would create these programs so that people who were in the community, being looked after by their family members who needed some relief—the patient could stay in long-term care for a period of time and then go back to their home.

Another program that we're looking at to implement to address the acute care problem is that for clients who want to go to a specific facility and there is not a bed available but we have empty beds, we will then create short-stay programs in these empty beds. Clients will be moved to those beds, and once there is a bed available in the home that the client wishes to go to, the client will go there.

Mr Gilchrist: OK. I guess my question to you then is, if the short-stay program, which is really not all that different from the status quo—people are waiting for a spot in the new facility. They think the hospital is their only option because they don't want to be forced into a longer-term commitment somewhere else. How is it different? Why should we not simply move to that as a policy immediately?

I can tell you that in the alternative, any delay will bring about situations such as one that is about to occur. At another hospital I spoke to the CEO, who indicated he's about to sign a contract to take over a certain number of beds in a nursing home facility. So he will

move the patients there, and theoretically they will not have been discharged from the hospital. So they're going to the very same facility they're saying no to at the CCAC, but it will nominally be under the control of the hospital, the 10, 20 or 30 beds he contracts for.

Again, it makes no sense to me. I am totally sympathetic that the patients' needs have to be recognized and the CCAC has to have a discharge plan. But if facility X can meet all those needs, even if it's in the context of a temporary stay—you can still specify three other facilities as your top three choices—you have no option, you're not staying in the acute care facility.

Why don't we move on that today and end the perception, first off, that we have a hospital bed shortage in the city of Toronto, because we don't, and secondly, that there are waiting lists, because it would largely, if not totally, eliminate—Shelley was right; I heard her comments this morning. We actually have too many beds. Let's make sure that's the banner headline and that people know there is quality care out there for every person who needs long-term care.

Ms Paech: I probably did not make myself clear. What you have described is the program I have described. What the CEO is proposing is what the ministry is proposing that we will do. So it will not have to be the hospital that does it and funds it. The ministry is moving in that direction. That is what we are going to do.

Mr Gilchrist: Good, and so it won't be a choice. The patient will not be allowed to stay in the hospital.

Ms Paech: The client will move to a long-term-care facility and wait in that facility in a short-stay program until the place where they want to go is available.

Mr Gilchrist: Great. Now tell me why we've added the bureaucracy and the red tape of the hospital having any involvement in the long-term-care facility. Why is the hospital contracting with that nursing home?

Ms Paech: The hospital will not be. The CEO of that hospital does not know of this new program. We are developing this program. It will be a standardized program across the province, so that we do not have every CEO in every hospital developing their own program. We are standardizing it. It will be rolled out across the province. It will be implemented locally.

Mr Gilchrist: And the time frame for this innovation?

Ms Paech: It will be in relation to the announcement of the sustainability program, and it is comprised of a variety of different programs in terms of respite care, short-stay programs—there is a variety, basically. We're developing a series of programs, which will be rolled out, that can fit whatever the local needs are.

Mr Gilchrist: Soon?

Ms Paech: Yes, absolutely. It will roll out with the sustainability program.

Mr Gilchrist: Let me, as a corollary to that—do I have a couple of minutes left? Very quickly then, what thought is being given, as the marketplace has evolved—not surprisingly, people see the extraordinary new facilities that have been built in the last couple of years, and not surprisingly as well, those facilities have made their way to the top of the list. Why was there no consideration before, and is there a possibility that we will consider in the future, a price differential that will still achieve the same average but will put a premium on the new facility and a reduction on the older facility to allow consumers the choice, so that if they perceive a difference, and it would appear they do, they will have the same mechanism as with every other product in the marketplace? It will be your choice. If you want the brand new facility, which probably has no different service, but it's perceptual—if you want to use that one, then there's a price differential over an identical-service facility down the road that may be 10 years old.

1420

Mr Hassen: Maybe I could just make one comment. I think you will find that providers of services are having difficulty filling even their private facilities now, even in the new facilities.

Mr Gilchrist: Exactly.

Mr Hassen: Increasing the price isn't going to improve that for the new facilities.

Mr Gilchrist: Are you saying they're having trouble filling the new facilities?

Mr Hassen: For private rooms generally they're having—

Mr Gilchrist: Not the ones in my riding.

Mr Hassen: It isn't as demanding in some of the privates as in others. All I can say to you is—

Mr Gilchrist: Sorry to interrupt you. My concern, and I should have said this, is at the ward level, not so much the private facility. Because of our new design for what we're calling ward space, which really are private rooms, it was to be expected that people would place a premium on the perception of improved privacy in those new facilities. Why do we pay the same to each facility in a four-person ward or two-people private rooms with a shared bathroom?

Mr Hassen: Let me turn it to my colleagues. I'm not aware that we've done that analysis but I'll let them speak to it.

Mr Tuttle: We often receive opinions on our charging policy and other ways it might be directed. The central principle of the policy right now is that ability to pay is not a barrier to care. Everyone pretty much agrees that that's a good principle.

Having said that, with the development of the new beds and the changes in the system that are occurring, not just in our side but hospitals and everywhere else, we're taking another look at our charging policy but can't say which direction it would be going right now. It's too premature for that.

The Vice-Chair: We'll move on.

Mr Gerretsen: I have some great concerns if we start charging differential rates. We're right into a two-tier system, where the people who can afford it get the better homes and the other people get the rest. It's something that I can assure you I would never support and I dare say my party wouldn't support.

I'd like to get back to this question of waiting lists, and only for this purpose. The metropolitan area here may be totally different than the less urbanized areas out there. I can only relate to my own situation in eastern Ontario, where the catchment area for being placed on a waiting list is rather large. There is a possibility in the Kingston area that if you get placed on a waiting list, and particularly under the new system that you have in effect now, you very well may end up in a home as much as 70 kilometres away from, let's say, the city of Kingston. This has happened to a number of people I know of, where they had to make those kinds of choices. Of course what that does immediately is, it severely limits the ability of family members to visit the elderly person in the home.

The point I'm simply trying to make is that whereas in an urban area you've got a whole group of homes and there are many more new units being built right now, the kind of choice we had a discussion about earlier simply does not exist in the less urbanized areas. I would dare say that the distances we're talking about in northern Ontario are probably even much more severe. The moment you start moving somebody X number of kilometres away from their own home and cut off their ability to connect with their own family members or other caregivers etc, that's going to severely affect them.

There's another issue that I simply want to raise with you, and I tried to raise it earlier. In one of the hospitals in my area, two floors which basically had been closed to beds have been turned into a long-term-care facility. I know what I'm speaking of, because one of my own relatives stayed on one of these floors for three months. There are people there for as long as two years. It's in effect a long-term-care facility within a hospital structure. That's so. I know what I'm talking about. I went there on a daily basis for a three-month period of time.

I can see that the hospital is doing it in order to get some additional revenue, because most of these people are immediately put on a copayment system. I'm not faulting the hospital for doing that. There may even be a certain comfort level that if somebody is in a long-term-care facility next to a hospital, if they need it right away at least it's right there, or it's part of a hospital system.

That's just to counter what somebody said this morning. That does exist, and these must be the interim long-term-care beds that we're talking about. If you're shaking your head no, I would suggest you check with the Kingston General Hospital. They've been doing this for quite some time.

On the accountability aspect, I totally agree with Mr Gilchrist and Ms Martel, and I never thought I'd ever agree with Mr Gilchrist on anything. But that's really what it's all about. I cannot understand: here is $100 million that the minister is saying will go for 2,400 nursing and personal care workers, which works out, on average, to about $200,000 a facility, maybe more in some of the larger ones, less in other ones. Why wouldn't the ministry have sent a letter out to each one of these organizations and said, "Here's the money. Write us back as to how you're going to spend it, or whom you've hired for it, or how many people you've hired for it"? To now come back, almost six or seven months later, and say, "Well, we're doing a comprehensive survey"—whatever that means, and—"We're only giving them a week to respond to that," I think is pretty lame.

What gives me real concern is the fact that this $100 million is only a very small part of the $1.6-billion total pie that both the associations and the ministry are saying, "We are better than anybody else around the world because we actually allocate the funding to four different categories, and nobody else does that." Well, if we have no handle on how the additional $100 million is going to be allocated, that sure doesn't give me much of a comfort level that the original $1.6 billion which is going out for the per diem care is being handled in an appropriate fashion.

That's what it's all about: accountability. So far, I have not been given any assurance by any of you that there really is any accountability and that the money is being expended the way it should be expended in those four categories of need.

That's all I'll say on that at this point in time. It's very discouraging, particularly when we're dealing with individuals who by and large, unless they have an advocate on their behalf, cannot speak for themselves. Thank goodness most of the operators, and certainly the vast majority of the staff people who work in these homes, do an outstanding job, as I mentioned earlier. But a lot of them are left to their own devices. For the government to say, either through the ministry or the minister, "Yes, we have all these safeguards in place. We're going to hire more people etc," and to be given the lame excuses or lame accountability mechanisms we've heard about today, gives me absolutely no assurance at all that it's being done.

I would only suggest to you that we actually do put some standards in place, not only to make sure the funding is going in the appropriate direction but also as far as staffing is concerned. I think that's probably the main area. I think there are only so many ways in which you can measure this; I realize that. All the standards that have now been done away with under some globalized regulation or what have you—I know there are a lot of complaints about the one bath a week and the various other things.

What I cannot understand is that inmates in provincial institutions are guaranteed one shower a day, and it's the same thing in federal institutions—I have seven of them in my riding—and here we aren't even willing to commit to one bath a week, because you've done away with that, for the people who live in our long-term-care homes, who have contributed so much to this province.

I think it tells you something about our society, about how government views the elderly in our society. I think we give them a very low priority in this province. Just so you know where I'm coming from, I don't think it's just the current government that started this; it probably

started way back when. When you look at some of the facilities elsewhere in the world in systems that are less well off than we are, it certainly seems to me that those societies value the contribution of their seniors a lot more than we do here. Unless we have a cultural change around that whole mechanism, this is just going to go on and on, and poor individuals like yourself basically are going to have to defend current government policy which really the politicians should be there to defend.

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I wish you well, and I still put that proposition to you that I did earlier today. I would like to hear somebody say to the minister, and you don't have to say it right now, "Look, if we really respect seniors and if we really make seniors our priority in this province, let's come up with that $260 million that's required to make sure that in that study we're talking about we're no longer at the bottom of the list as far as personal care and nursing care services are concerned. Let's at least strive to be somewhere in the middle." That's what's needed.

Thank you very much for all your answers.

The Vice-Chair: Thank you, Mr Gerretsen. We'll move on. Ms Martel.

Ms Martel: Thank you, Chair. Before I continue on with questioning on standards of care, I want to make one point with respect to the $100 million. I'm angry with facilities that didn't use that money to hire new staff. I'm more angry with the ministry for giving facilities approval to do the things they did with the money.

I'll give you the example of Rainycrest, because we talked to the director. The director at Rainycrest specifically asked the regional Ministry of Health office if he could use that additional funding from the $100 million to deal with his operating deficit at his home for the aged. He was told yes. He did that with the full approval of the Ministry of Health.

My question is, where's the ministry when it comes to ensuring that this money was used for the purpose that was intended, which was to hire new staff? That's what I'm truly concerned about. What guidelines did the ministry set up, and why weren't guidelines put in place that would have ensured money was used for the purposes that were intended?

Let me go back to the standards of care. Mr Tuttle, you've said a couple of times that the assessors go in and they determine the level of care that is required for each resident across the province, and that's well and good. The problem is that the ministry has no idea whether or not those needs are being met. Let me go back to what the auditor said, because not only do you not have any minimum standards, but you have no idea what the staffing requirements are in any of these facilities and how much staff is actually being provided.

I'm going to quote again, although this was done previously, from page 127: "Currently, the ministry does not have any staffing requirements and does not track facility staff-to-resident ratios, the number of registered-nursing hours per resident, or the mix of registered and non-registered nursing staff." In other words, you don't have a clue of whether or not the needs of residents are being met, because you don't have any of the information in place to determine that.

As a result of making that finding, the auditor's office has said to you in its recommendations, "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"—further—"develop appropriate staffing standards for long-term-care facilities."

I haven't heard you say you're going to do those two things, and I think that's critical if you're going to finally convince residents and their families that they are getting the care they need. When are you going to implement those two important recommendations?

Mr Tuttle: I'd go back to the point I made earlier, and I believe Mary Kardos Burton did as well, that one of the central recommendations from the Provincial Auditor that we take very seriously and have acted on was to introduce the minimum data set, which will help to—I can't exaggerate how much information this particular tool will produce. We're moving forward on that, and that's kind of the first step that we would need to go before any decisions that we make on other areas.

Ms Martel: Tell me, how long is it going to be before you have information from the minimum data set?

Mr Tuttle: At the present time, we have staff; we've assigned resources to begin to explore how we might implement this system. We have a very large system, as you well know. You know how big it is. We want to make sure that we're sure of all the consequences and that we have all the information technology and all the rest of the supports in place required to introduce the system properly.

Ms Martel: Just give me a ballpark figure: one month, two months, a year, what?

Mr Tuttle: I would think that, after a pilot, if government decided they wanted to proceed with this, in a system our size my estimate would be that it would probably take at least three years to fully introduce and train everybody. That would in fact be a little faster than it has been introduced in other jurisdictions.

Ms Martel: When is the pilot going to be over?

Mr Tuttle: The length of the pilot hasn't been determined yet. We're just looking at how big it needs to be.

Ms Martel: So the pilot hasn't started yet?

Mr Tuttle: The pilot hasn't started yet, no.

Ms Martel: How long do you think the pilot is going to take before you move to full implementation, which is an additional three years?

Mr Tuttle: I don't mean to prevaricate, but I'd be speculating on the outcome of the pilot. It depends on what we find: the state of readiness of the facilities, the technology we need and so on.

Ms Martel: When is the pilot going to start?

Mr Tuttle: I'm hopeful that we'll be able to start a pilot in the near future, but I can't commit to the exact timing.

Ms Martel: Oh, boy. I've got to tell you, you've got a situation where the Provincial Auditor does this work and comes forward with some recommendations that I think are pretty appropriate and, quite frankly, would probably for the first time since standards were cancelled give some idea to residents and their families that quality of care is being provided. At the minimum, as I look at this, it's going to be three years before you can implement it fully across the system, but we don't even know that date because you're not sure when the pilot will start and the three years happens some time after the pilot. So let's say we're talking four years before we even begin to effectively deal with recommendations they made; isn't that correct? That's how long you're talking.

Mr Tuttle: To fully implement the MDS system, yes, it will take some time. I would like to stress, though, with respect to some of the items the auditor has talked about—and I agree that we are talking about the protection of a very vulnerable, frail group here—that considerable improvements have been made. As I said earlier, it used to be that we didn't even have an annual review of everybody. We do have that now. We're in more often than we ever have been in the past, and there is more funding in total and in the percentage of the per diem devoted to nursing and personal care than there ever has been in the past.

Ms Martel: Wait a minute. The auditor said on many occasions—certainly on page 129, and this is the third time I'm going to repeat it—that you don't have enough information to determine if the money in those envelopes is being spent where it should be. I don't take any comfort whatsoever from your saying that.

Mr Tuttle: We do reconciliations each year. We recover and have recovered monies in nursing and personal care envelopes when it's not spent. The only way we could recover money is if we had the detection means to recover the money in the first place. We do it; it's just as simple as that.

Ms Martel: It's the patients who suffer when money that is supposed to go into nursing care and personal care doesn't go there. You're essentially telling us that some of the mechanisms you might use to really ensure the quality of care are going to take us another four years, maybe. Don't you think that's completely unreasonable?

Mr Tuttle: I'm giving you my best guess, based on what I know about how long it took to introduce in the United States and how long it's taken to introduce in other systems. I wouldn't want to mislead you by saying we can do this next year.

Ms Martel: I'm sure it won't be next year. I'll be surprised if it's even in four years. My concern is that you're going to have another report, another 2001 PricewaterhouseCoopers, with the same kind of results. If we don't start to get some standards in place, if we don't start to get some staffing ratios in place, if we don't start to get some conditions—strings attached to new money that goes in—we're going to be in the same boat with those kinds of abysmal results for residents who live in long-term-care facilities.

Mr Tuttle: I said earlier that I don't want to pre-empt our compliance review. It isn't completed yet; it's almost finished. It's pretty comprehensive, and I think the recommendations will go some way to addressing some of the concerns. But I repeat that full implementation of MDS, if the government decided on that direction, would take at least three years.

Ms Martel: How many compliance officers does the ministry have?

Mr Tuttle: Right now, I believe there are 41.

Ms Martel: How many vacancies do you have?

Mr Tuttle: I'd have to get back to you. I may have that data here; I'll try to get it for you. I think there's an environmental vacancy, a dietary vacancy and a compliance vacancy, but I want to stress that I want to get back to you with the exact vacancies.

Ms Martel: Is that for all seven regions? That's the total?

Mr Tuttle: Yes. When we do experience vacancies, like elsewhere in the civil service, we immediately advertise and recruit, and recruitment is going on right now.

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Ms Martel: The number of 41 compliance officers, is that up or down compared to previous years?

Mr Tuttle: Over the last four or five years it has remained pretty stable, if you take that amount compared to beds or facilities. However you divide it up, it's been pretty stable.

Ms Martel: Could you table for this committee the number of compliance officers? Can you give us the data back to about 1994?

Mr Tuttle: Absolutely.

Ms Martel: Great. Now let me ask you about service agreements, because the auditor pointed out that the ministry is signing service agreements with operators without ensuring that those facilities are in compliance. Why would you not refuse to sign a service agreement until a facility is in full compliance?

Mr Tuttle: I mentioned earlier that we have something like 30-odd standards and 400-plus criteria organizations are required to meet. The biggest criticism we have is—nobody tells us we have too few; they tell us we have too many. Those standards and criteria run from things like, for example, if a compliance adviser is walking through a long-term-care facility and the closet door is open to the cleaning area and there is a cap that's loose on a jar of cleaning fluid, they'll tell them to fix it right away, and they may even leave a finding. On the other hand, we go right up to the point where you have—and I want to stress that this information is reviewed by senior management—prevalent and recurring compliance violations that would lead to suspension. So there is a very wide range.

The object is always to bring the facility up to standard and they usually want to do that. They submit a compliance plan. We work with them and rectify the

situation. Immediately cancelling their service agreement wouldn't serve any purpose for the residents or the organization.

Ms Martel: Can you guarantee to this committee that where there are serious breaches, the service agreement is not signed and money does not flow? Can you guarantee that to us?

Mr Tuttle: In the case of a very serious breach, we can go right to the point of applying to take over the organization. We probably usually would have suspended admissions first—the economic penalty—then we can move to take over, and have done so.

Ms Martel: How many facilities are not in compliance?

Mr Tuttle: I'd have to get back to you. If you mean how many facilities have as little as even one compliance finding, then I'm going to have to get back to you on that.

Ms Martel: I would be interested in knowing how many are not in compliance. I don't have an idea of what you use for serious or not serious, so that's a bit problematic. Our definitions about what is serious and not might be different too—yours and mine.

It seems to me that if you want to get facilities into compliance, the best way to do that is to withhold their funding until they are. It wasn't just me that pointed that out. The auditor says very clearly, "The ministry did not take into consideration whether or not the facilities were in compliance with ministry standards at the time that service agreements were signed." He also said, in the recommendation, "The ministry should ensure that all long-term-care facilities have valid service agreements and that each facility's compliance status is taken into account."

Mr Tuttle: What I would say to that is—and this isn't just Ontario—any jurisdiction that has a compliance management program for vulnerable populations wants to make sure that their penalties don't have an unintended negative consequence for the residents. So the first instinct isn't to reduce funding, since all the funding is intended to provide for care of the residents, if we're talking about infractions of care. So if we go in and see charting that we don't feel is up to standard, then our immediate instinct isn't going to be to reduce the funding that's flowed in order to care for the residents. We will have other consequences.

Our first instinct is to rectify the situation. I think, from what I've heard everybody here say, we all agree that the workers, the staff, are there because they're absolutely dedicated to the care of their residents. We count on that. Sometimes problems happen and we usually find that we can work with those dedicated folks to fix things up.

Ms Martel: It's not the staff I'm usually worried about, to be honest with you; it's more the operators.

You told the auditor that the service agreements to operators were going to be distributed by December 31, 2002, and you told the committee this morning that's not going to happen now until April 30, 2003—2003 in 2003. Can you tell us why there has been a delay in that?

Ms Kardos Burton: The delay is because there were some information requirements. It was strictly information requirements that we needed. I think it had an adjustment for the copayment as well as the acuity level increase. So it was strictly information coming back to us that we needed to analyze.

Ms Martel: Let me ask you some questions about the new beds. One of the changes that the ministry made with respect to the new beds was to change the policy you had on the split of preferred accommodation revenue for long-term-care facilities. Previously it was a 50-50 split between the operator and the ministry. Can you tell me why that was changed so that facility operators now receive 100% of that revenue?

Ms Paech: In the year 2000, when the long-term-care redevelopment was created to assist facilities with the development process of the 20,000 beds, when we reflected back and looked back to when the program was first announced in 1998, and also when the $10.35 was determined—that was determined probably around 1996. When we looked at what was happening with the development process of the new beds and looked at the costs of construction and the inflation that was taking place, there was concern that the $10.35 was not sufficient or not covering the cost, and people were not able to get the trades to be involved in the construction. When we looked at whether we could rectify and change the $10.35, we were told that because we had used an RFP process, which is a competitive process which has very defined rules around it, we could not change the $10.35, that if we changed the $10.35, all of the parties that were involved and that were not successful and all individuals anywhere could come and say, "We did not make an application through the RFP process because we knew the $10.35 was insufficient."

So when we looked at it, we asked how we could adjust to recognize that there could be a problem that was impeding the development of these beds. The decision was made that one way we could assist is that the 50% from the preferred accommodation that the ministry was retrieving would be left with the facilities so that that money could then be used for the facilities to assist in the redevelopment of both the D facilities and the new facilities. It was clearly recognized that all of the facilities may not be redeveloping, such as the Bs and Cs, but it was hoped that monies that were retained would be used for upgrading their facilities and also enhancing their financial position so that when a new program came into place they would have increased equity.

That was why the decision was made. We were bound by the restrictiveness of the RFP process.

Ms Martel: Here's my concern: what guarantee do you have that that money that you hoped was going to be used for construction for the new facilities or construction for the upgrades actually went into construction?

Ms Paech: I do not have that guarantee. What I do know is that prior to that point in time we had 65 beds

built. At this point in time we have 10,000 beds built, and we will achieve the objective of 20,000 beds.

Ms Martel: You see, what I'm worried about is that money that used to come back to the government might be going into people's profits instead of any kind of construction. You've got facilities that weren't undergoing any kind of redevelopment or renovation that were entitled to get this revenue. Where did that money go if they weren't even doing any renovations or reconstruction?

Ms Paech: I do not know.

Ms Martel: OK. How much did the government lose as a result of this change? What was your loss in revenue—because you used to get 50% of this revenue, right?

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Ms Paech: Forty-three million dollars.

Ms Martel: Can you tell me, then, what did that $43 million, when you got it back—what was it used for previously, before this change in policy?

Ms Paech: It was returned to the Ministry of Health and it would go back to the treasury.

Ms Martel: So it wasn't used for any other kinds of supporting services in facilities?

Ms Paech: No. Those monies do not go back to the Ministry of Health. They go back to the treasury.

Ms Martel: That's on an annual basis, that loss of $43 million back to the treasury; is that correct?

Ms Paech: Yes, it is.

Ms Martel: Just in confirmation, because you guys lost 43 million bucks but you'd also, on the other hand, have no guarantee that that revenue went into construction and not into the pocket of the for-profit operators?

Ms Paech: That's right. I would reiterate my response that, prior to that point in time, we were not having any construction or development of the 20,000 beds. With the additional monies that were flowed, we then saw that the beds were being built.

Ms Martel: Well, yes, the beds could have been built because you were giving these folks $10.35 per diem as well that will give to each of them about $75,000 per bed, so that's a pretty significant incentive.

Ms Paech: We were giving the $10.35 prior to that point in time. As I've indicated, that amount was set several years earlier, that during the period of time from 1998 on, when we looked at the amount of construction that was occurring across the province and the costs of construction and inflation, the $10.35 was certainly a generous contribution, but owner-operators were experiencing difficulty in being able to construct facilities for that amount.

Also, if you look, it is up to $10.35 per bed per day for 20 years. If you understand the financing of that, up to $75,000 per bed, when you look at it over 20 years, is $45,000.

Ms Martel: Have you got some facilities that are building beds for less than that, less than $75,000?

Ms Paech: We have been tracking the costs of the beds that have been built. On average the beds are costing, and I believe this but I will certainly check, about $120,000 per bed.

Ms Martel: For the new beds.

Ms Paech: Yes.

Ms Martel: And for the redevelopment?

Ms Paech: Similarly, but I will certainly provide that information if you would like. We are tracking that.

Ms Martel: Further to that, the auditor made some comments about premiums for structural compliance. Those would be for the other facilities that have to be dealt with, on page 137. I'm going to ask these questions because I don't think the auditor got answers when he did his report.

The first point was, "Because the province had funded 50% of the original construction costs of charitable and municipal homes, per diem premiums for these facilities were apparently reduced by 50%; but premiums were not reduced for nursing homes that, prior to 1996, received provincial funding through debt servicing and compliance premiums to partially compensate them for the cost of construction."

Can you tell us why there is that discrepancy?

Ms Paech: My understanding of this policy was that prior to 1998, municipal homes and charitable homes, when construction of a new facility or an add-on to that facility occurred, it was done through a grant application. The grant application was that 50% of it was paid by the province—there was no cap on that—and 50% was paid by the owner-operator. The government did not give any financial commitment to the nursing home industry for the construction of these facilities. So when the structural premium program was brought in, because the government had paid 50% for the municipal and charitable homes, they believed that they had already made a contribution for the structural premium program. Therefore, they would give 50% of what they were giving to the long-term-care facilities, which were the private sector, because they had not in any way contributed to the costs of that. That was my understanding of the reason for the decisions that were made at that time.

Ms Martel: If I might, though, the auditor said, "Nursing homes ... prior to 1996 received provincial funding through debt servicing and compliance premiums to partially compensate them for ... construction." So they got some money too, correct? As I listened to you, the argument is that nursing homes didn't get any money for construction, so that's why their premiums are different. Non-profit homes did get some money for original construction, so their premium is being reduced by 50%, and I don't understand that. As I read the auditor's report, they both got money.

Ms Paech: I would have to provide you with further information. I do not know.

The Vice-Chair: Ms Martel, just for a moment, we've gone a bit over the normal time, and I would want to, then, give the government side an opportunity for another round.

Mr Chudleigh: A little clarification, Chair: would this be the last round? If the committee is ready to adjourn, I think we're probably ready to adjourn as well.

The Vice-Chair: There is no last round, I guess, until we realize that we've reached it. I'm just saying that the 20-minute segment—

Mr Gerretsen: That sounds like ministry-speak. What does that mean?

The Vice-Chair: The 20-minute segment is up. Actually, we've gone about 24 minutes on this one. I'm just saying I want to give the government side an opportunity. Ms Martel, do you have any idea—I guess that's what we're getting at—of what your length of time will be?

Ms Martel: Can you give me about 10 more minutes?

The Vice-Chair: Ten more minutes?

Mr Chudleigh: Sure, that's OK with me.

Ms Martel: I have another question on this section, and then on a different one.

Mr Chudleigh: Are you OK with that, John?

Mr Gerretsen: Sure.

The Vice-Chair: Thank you.

Ms Martel: I had questions about the next point as well, and Ms Paech may have to get information back to us: "Ministry staff could not explain the apparent inequity whereby class A charitable and municipal homes receive only 30% of the premiums received by nursing homes whereas class B and C facilities receive 50%."

Mr Tuttle: We'll have to come back with that answer.

Ms Martel: That would be great.

Let me ask some other questions that go back to the $100 million and the announcement that was also made at the same time. I raised this question in estimates, so some of you will remember this, but let me ask it again. I raised a particular concern that one of the changes the ministry made at the time of the $100-million announcement was a change with respect to the funding policy for incontinence supplies. Specifically, you said to operators that effective August 1, 2002, incontinence supplies will be eligible expenses to be reported and funded under the nursing and personal care envelope, rather than under the other-accommodation envelope. Secondly, there will be no corresponding decrease in funding for the other-accommodation envelope.

The argument I raised at the time of estimates was that it seemed to me that facilities were actually getting paid or were receiving money twice for incontinence supplies: first, under the nursing and personal care envelope, where it should be expensed; but, second, they were still receiving the same amount of money they had received previously for incontinence supplies under the other-accommodation envelope. So I asked the ministry what the value of that was, and we finally received information back to say it was about $26.7 million.

Here's my concern. If there's no corresponding decrease in the other accommodation envelope, ie, the facilities are receiving that money, where's that money going?

Mr Tuttle: Again, there are eligible expenditures in the accommodation envelope. I can't tell you exactly where that particular money was spent. I can tell you that the $1.20 moving into nursing and personal care seemed perfectly appropriate and helps us better to track expenditures on incontinence, which have become a huge issue in our homes; 86% of people, I believe it is, now have incontinence issues. So it's a major problem, and it was spread between some costs for laundry etc before. We are taking steps now to make sure that the incontinence costs are expensed to the nursing and personal care envelope. The $1.20 that was essentially freed up in accommodation could be used to help pay your utility bills; it could go to the salary of a dietary worker. I doubt there's one answer across the board for all facilities.

Ms Martel: Why would you essentially give facilities money twice for that? Because that's what you're doing. You're giving it to them in the personal care envelope and you're not removing the same amount of money under the other accommodation. Why?

Mr Tuttle: First of all, nobody wants to see funding for these organizations reduced. So in order to achieve our goals with the incontinence program, we moved that into the nursing and personal care envelope. That frees up some money for other pressures in the accommodation envelope, and they are legitimate pressures that relate to the operation of the home. But I can't tell you exactly how a particular facility would have used that extra $1.20. What they tell us so far is that it's things like utility bills, and again I mentioned the dietary workers, that sort of thing. But there are any number of expenses in accommodation that would be eligible.

Ms Martel: It's also the profit line for for-profit facilities.

Mr Tuttle: You're absolutely right. We have a segregated system, and the only place you can take a profit or a surplus is the accommodation envelope.

Ms Martel: It would be my concern that in fact that's what some of the money is being used for, and you would have been better to take the money out of that envelope and apply it to care, then, to be sure that's where it went.

Mr Tuttle: Again, I can't tell you exactly how it was spent, but it could be spent on dietary workers; it could be spent on any number of particular issues.

Ms Martel: It could be.

Mr Tuttle: There are private sector operators in the system. That is a fact of our system. It's approximately half the operators.

Ms Martel: OK, thank you.

The Vice-Chair: Is that it, Ms Martel? Thank you.

No more questions or comments?

I want to thank you, Deputy Minister, and your colleagues for appearing today. I think it's been a good day and a good session. Again, thank you for coming.

There being no further business, this committee is adjourned.

The committee adjourned at 1503.

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Mr John Gerretsen (Kingston and the Islands / Kingston et les îles L)
Mr Steve Gilchrist (Scarborough East / -Est PC)
Mr Raminder Gill (Bramalea-Gore-Malton-Springdale PC)
Mr John Hastings (Etobicoke North / -Nord PC)
Ms Shelley Martel (Nickel Belt ND)
Mr AL McDonald (Nipissing PC)
Mr Richard Patten (Ottawa Centre / -Centre L)

Substitutions / Membres remplaçants
Mr Ted Chudleigh (Halton PC)
Mr Wayne Wettlaufer (Kitchener Centre / -Centre PC)

Also taking part / Autres participants et participantes
Mr Jim McCarter, assistant provincial auditor
Mr Nick Mishchenko, director, health and long-term care and Management Board Secretariat portfolio
Ms Vanna Gotsis, audit manager, economic development portfolio

Clerk / Greffière
Ms Anne Stokes

Staff / Personnel
Ms Elaine Campbell, research officer,
Research and Information Services