Ontario Health Coalition
Briefing Note and Analysis of Shirlee Sharkey Report
June 23, 2008

> *"We are not recommending that there should be a regulation under the Long Term Care Homes Act 2007 that provides a provincial staffing ratio or a staffing standard."* (Shirlee Sharkey,pp. 9)

What We Advocated For	**Sharkey's Recommendation**
1. A care standard that would provide 3.5 hours average hands-on care per resident per day, contoured to acuity	1. The report recommends explicitly against a regulated care standard, opting instead for continued deregulation and annual reports on unspecified "outcomes". Sharkey does support increasing PSW and nursing hours *up to* 3.5 hours (not average).
2. A provincial funding formula and improved accountability for funding across Ontario	2. Most of the report rejects a strong provincial approach. Sharkey recommends each facility set up its own staffing plan. She rejects our recommended regulation, compliance and enforcement regimes – opting instead for a more lax approach to enforcement including unspecified provincial "guidelines" for further funding increases. (Note: there are already directives and other forms of "guidelines".)
3. Review downloading of heavier care patients, concern about violence, special care units	3. Not mentioned.
4. Urgently address staffing shortages	4. Recommends the province "develop strategies" to increase recruitment and retention of human resources. No actual recommendations.
5. More openness and transparency	5.Not mentioned.

Why we need accountability and a regulated link between measured need, funding increases and expectations for improved levels of care (all figures are from the MOHLTC in the latest release of information revealed through a Freedom of Information request):

TIME PERIOD	RESIDENT CARE NEED INCREASE (Measured Acuity)	FUNDING INCREASE (Nursing and Personal Care Envelope)	LEVEL OF CARE INCREASE (Nursing And Personal Care)
March 2006 to June 2007	3.5% (from average CMM of 93.39 to 96.66)	8.1% (from $68.19 to $73.69)	0.04% or 0.001 hours (from 2.850 to 2.851 hours)

General

The general approach taken in the report, the evaluation of the evidence, and the recommendations run counter to the core proposals made by the Ontario Health Coalition and many other groups that participated in Shirlee Sharkey's consultation. Some of the recommendations may actually be less than what currently exists or are certainly less than regulatory requirements that have existed in the past. The approach – a total rejection of provincial standards, compliance and enforcement regimes – is based on the assumption that homes will work in partnership with stakeholders to increase care levels on their own without actual requirement to do so. On an individual home level the absence of regulations leaves no enforcement mechanism whatsoever. The recommendations do not increase provincial government accountability for improving care. The numbers used in the report confuse the issues by changing the classifications of staff included in care measurements without any justification from the literature or in "best practices" used in other jurisdictions. Many of the recommendations are extremely vague. The one positive is the recognition that care levels are inadequate and that staffing levels for PSWs and RNs be increased *up to* 3.5 hours (not average, no requirement, no enforcement). Overall, it is difficult to find much to support in the approach nor in the recommendations.

Rejection of a Regulated Minimum Care Standard

The report posits dismissal of a regulated care standard against what Sharkey recommends as a "broader" approach that embraces funding increases but actually recommends against a regulated care standard (pp. 9). There are a number of internal inconsistencies in the report, and some inaccuracies.

- The groups representing residents, families, care workers and the public interest called for staffing standards *and* specific initiatives that improve the quality of life and work environments in their submissions.
- In fact, the report does not propose a "broader" approach (which implies the adoption of a regulated care standard and concrete increases in daily care levels plus additional improvements). Rather, it proposes a lesser approach – increased funding with less accountability, less enforcement, less clarity, no provincial human resources plan to reduce shortages, no recommendations regarding the downloading of heavy care patients into the homes.
- The general approach presumes that more funding increases with "guidelines" will achieve increased care levels though they have not done so to date.
- The report does recognize a need to increase care levels and recommends up to 3.5 hours of nursing and personal support – unregulated, not an average, not tied to acuity, unenforceable and without a timeline nor health human resource strategy to get there.
- The few recommendations that the report does make are vague frameworks with little or no substance provided.
- A strong provincial approach with accountability and enforcement are entirely eschewed.

Sharkey asserts that studies provided limited evidence on staffing standards and links to quality of care (pp. 9). This is untrue:

- The major "best practice" research, conducted by the U.S. Health Care Financing Administration used a decade of concrete evidence-based research including multivariate analysis and time motion studies to correlate exact levels of care (to the hour and minute) by each of the daily hands-on care classifications to specific health outcomes to recommend specific hours of care that reduce harm and improve quality outcomes.
- We provided Shirlee Sharkey with five additional studies plus the Coroner's Jury Recommendations that link hours of care to outcomes, including specific hours of care that

lead to measurable decreases in injury rates for nurses and aides and the evidence-based relationship between staffing levels and quality of care as measured by a number of outcome indicators.

Sharkey suggests that if "available resources" are used to increase staffing and care levels, other areas such as staff education, leadership development and team building would be affected (pp. 9).

- This implies that "available resources" are not already allocated to increase staffing and care levels every year based on measured acuity (measured resident need). Yet, according to a formula arranged between the MOHLTC and the facility operators, funding is increased every year based on the measured increase in acuity, ostensibly to improve care levels to meet higher need. However, though the money goes up every year the care levels are not increasing. There is no requirement for increasing care levels as a pre-condition for the increased funding. Available resources are already being flowed to the sector – more than $1 billion (according to Health Minister George Smitherman) since the McGuinty government took office. But they have not resulted in any measured increase in care levels since 1995, and in fact care levels dropped in 1996, recovering to 1995 levels in 1997 according to the government's figures.
- In the end, unless the funding formula is changed (and so far, neither Sharkey nor the Ministry have recommended this) we will be paying for an average 3.5 hour care level but will not be receiving that level of care.

Sharkey uses complaints of paperwork to recommend against standards and compliance, but then applauds the new RAI-MDS 2.0 assessment tool (which, though we support it with the caveat that it requires consultation on the evaluation of the pilot projects, requires much more charting and paperwork). She makes no recommendations to reduce less important paperwork or to priorize administrative reporting. She simply uses this to support her rejection of daily care standards.

- Staff are complaining that they are "charting for dollars" since the weighty charting requirements are used to measure increases in acuity to get more funding for the homes but are not tied to increases in actual care. Thus, charting has resulted in annual funding increases, but actual daily care levels remain stagnant.
- Since staff already chart for acuity and homes already have to report actual staffing levels (and there is no proposal to change these requirements) it is hard to see how a standard would place prohibitive additional paperwork requirements on homes

Recommendations in the Report

Sharkey suggests a number of initiatives that have sketchy details and no clear plans – including:

1. Provincial "guidelines" (unspecified) to support funding increases over the next four years
   - The MOHLTC already issued a directive to facilities to increase their staffing levels. It is hard to imagine how a "guideline" approach with no teeth – no compliance and enforcement – would achieve what this directive has not.
   - The MOHLTC through the LHINs already has Accountability Agreements (formerly Service Agreements) with each LTC home. It is not clear if this "guideline" approach might be less than what is already in place.
   - This approach to enforcement is lax, given the experience in Ontario's LTC homes and in the for-profit chains in other jurisdictions. To date, the nurses are reporting a failure to enforce the regulated requirement for an RN 24/7, and 98 of the 603 homes have failed to report their actual staffing levels, according to the government in the latest response to a Freedom of Information request on care levels. In the U.S. this information is available on a home by home basis on the web. In Ontario, this information is not being provided openly by the Ministry, successive Freedom of Information requests have been required to obtain it.

2. Development of annual staffing plans at each LTC home – including an unspecified process for input from staff, residents, families and LHINs
   - The MOHLTC used to require homes in their Service Agreements to report on staffing levels, to adhere to planned or budgeted levels of staffing (eliminated by the Harris government) and to increase the average staffing per resident as a condition for eligibility for new funding (eliminated by the McGuinty government). Thus, Sharkey's report recommends less accountability than was previously in place.
   - Sharkey does not provide any information on what these "staffing plans" might achieve since the homes will simply claim they don't have enough money to increase staffing and potentially use these meetings to campaign for more funding with no accountability as they have been doing for years.

3. Annual evaluations to "validate" that funding is addressing resident care needs and to inform decisions about staff enhancements.
   - This is substantively less than our recommendation for inspections to ensure that homes are compliant with required staffing and care levels. Inspection compliance reports have an escalating process to ensure enforcement. This unspecified evaluation process – based on an RNAO framework that would have to be re-written to fit the context of LTC homes – does not.

4. Provincial guidelines designed to achieve up to 4 hours of care per resident/day over the next four years.
   - This 4 hours is very deceptive. It includes allied health professionals plus PSWs/RNs/RPNs. There appears to be no justification in the literature for changing the regular measure of care/resident day to include these classifications. Perhaps this is actually a deliberate attempt to confuse since no jurisdiction measures allied health professional hours/day in a daily-care staffing standard (need for social workers, therapists etc. is highly variable).
     - Though we support improving access to these important health professionals, they do not belong in a daily care measure. This inclusion will not improve access to daily care nor to allied health professionals' care, in fact it is more likely to achieve the opposite. The report includes no clear proposals to improve access to allied health professionals.

- According to StatsCan, Ontario was at 3.8 hours/resident/day for total ltc staff in 05/06; the second lowest level in the country. Though many different staffing categories are important, daily hands-on care is provided by only a portion of those staff – the RN/RPN/PSW. The staffing standard we called for is an average – tied to acuity - of 3.5 hours of RN/RPN/PSW specifically because these are the hands-on daily care staff that provide turning, feeding, bathing and other care functions for daily living, these staff are covered by the nursing and personal care funding envelope, and these are the staff covered by daily care regulations in all other jurisdictions and the literature. The reporting that the MOHLTC has been using for several years includes the same range of staff, plus a minute amount of time for Nurse Practitioners. There are already staffing standards for the following classifications in Ontario: Administrator; Director of Nursing; Food Services Supervisor; Therapy Services Coordinator; Registered Dietician; Recreation and Leisure Services.
- Sharkey also asserts that with the new staff announced (but not yet flowed) the number of hours will increase to 3.5 hours. Again, this number inappropriately includes allied health professionals. It also appears to be based on the existing number of beds divided by the total number of staff (including announced new staffing that have yet to materialize) but fails to take into account the bed increase which totals, according to the Health Minister today, another 2,500 beds that are announced but not yet on stream. Thus, this number is likely incorrect.
- Linking resources to resident outcomes by developing quality measurement tools and satisfaction surveys.
- It should be noted that, by the figures used in Sharkey's report 73% of residents have some form of cognitive impairment, including Alzheimer disease or dementia, and the utility of resident surveys is constrained by this reality.
- There are no concrete proposals for what "quality measurement tools" might be developed, but it is clear that actual standards with enforcement and compliance regimes as we have repeatedly recommended are specifically rejected in Sharkey's recommendations.
- It is not clear what "linking resources to resident outcomes" might mean.

What is Missing

- There are no concrete proposals to deal with epidemic shortages across several staff categories including PSWs, nurses, health professionals and doctors. These shortages exist in all areas of the province and leave homes working "short staffed" regularly. They are a serious impediment to improving quality of care. This is a provincial policy responsibility and requires a clear provincial health human resource plan. The report calls for strategies to be developed to improve recruitment and retention without giving any actual proposals (we thought that was what Shirley Sharkey was supposed to do) and leaves individual homes and regions to strategize about how to deal with the shortages which amounts to the status quo.
- There are no concrete proposals to improve reporting about actual care levels, nor to ensure concrete accountability for increased funding. The MOHLTC press release states that the Health Quality Council will be "tasked" with reporting on quality of care and resident satisfaction. It is the government, not the Health Council, that is accountable for reporting on care levels and compliance and for ensuring that funding reaches its intended goals. This provision should not be used as a means to reduce government reporting and accountability for actual daily hands-on care levels in the homes.
- To date, the Ministry itself is not keeping its undertaking to report publicly on staffing levels. A very critical Provincial Auditor General's report was required to force the government to require homes to start reporting on actual care levels after the Harris government removed this regulatory requirement. Under the McGuinty government two "Freedom of Information" requests have had to be filed to obtain information that the government collects on actual care levels. The June 2007 report indicates that 98 of 603 homes failed to report their staffing levels. For the 22,000 of 75,000 residents now covered by the new resident assessment system (calls RAI/RUGSIII), data on their measured care needs is not being released. The Sharkey report and announcement provide no assurance of any improvements to transparency to provide greater accountability.
- Though the report recognizes the increasing acuity of residents, it neglects to propose any clear recommendations to prevent downloading of patients with care needs too great for homes to meet. It does not propose any concrete steps to reduce violence, illness, accidents and injury in the homes. It rejects the recommendations of the Coroner's Inquest in the Casa Verde homicides.

Clarifying the numbers

The Minister reported that the government has introduced 6,100 new front-line staff including 2,300 nurses to long term care since the government was elected in 2004. He announced that the government is committing to increasing the number of PSWs by 2,500 over the next four years.

- The problem with using these numbers is that they fail to take into account the dramatic and ongoing increase in the number of beds and residents. From 2004 to May 2007 the McGuinty government increased the number of long term care beds by 4,912. In the press conference to release Shirley Sharkey's report, the Minister stated that the government is creating another 2,500 long term care beds.
- The government is relying on overall increases in funding to improve levels of care for residents. Provincially, the last Freedom of Information release showed that care hours increased by only 0.001 hours per resident per day from March 2006 to June 2007. During the same period, resident care need increased by 3.15% -- from an average "Case Mix Measure" of 93.39 to 96.66. During the same period, funding increased by 8.1%-- from $68.19 to $73.69. Clearly just transferring increased funding to the homes does not translate into increased care levels.
- Since 2005, according to government figures, the amount of care per resident per day has not increased, despite increased funding and increased acuity. In the previous several years, increased numbers of staff have likely gone to the increasing number of beds, not to improving care in existing beds.
- Since the reinstitution of reporting actual care levels, the for-profit homes have had the least increase in actual hours of care/day and the public homes have had the greatest increase in hours of care/day. This points to a requirement for more accountability in the use of public funds, not less.
- The previous announcement of increased PSWs has not occurred yet.

Ontario Health Coalition
15 Gervais Drive, Suite 305,
Toronto, Ontario
M3C 1Y8
Tel: 416-441-2502
Fax: 416-441-4073
Email: ohc@sympatico.ca
www.ontariohealthcoalition.ca