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Dear Ken,

There are several issues to be addressed in our discussion regarding implementing a minimum care standard in Ontario. The first is a recognition that a care standard should be adopted in principle. The second is the model for such a standard. The third is the reporting and evidence needed to get it right for the long term. Finally, we have looked at how the former 2.25 hour minimum standard worked. I have included information regarding each of the key issues below.

The additional question of who is included in the standard is not included in any detail here as all jurisdictions looking at this question are including the direct care provision by RNs, RPNs and PSWs or equivalent, as we are proposing.

1. The adoption in principle of a minimum care standard.

The for-profit long term care industry is multinational and many of the chains operating in Ontario also operate in the U.S.

The United States has had a robust public discussion about reform in long term care over the last decade and a half. Scandals, lawsuits, and horrific tales of neglect have captured the attention of politicians and have resulted in major research and reform to improve standards. Most states moved to minimum care standards in this period. Efforts to achieve a federal minimum staffing standard were especially pronounced in the final years of the Clinton Administration. This debate and discussion is starting to become a significant piece in long term care reform in Canada also.

Even a perfunctory search of the U.S. experience yields a litany of abuses (not unlike the bankruptcies, stories of neglect etc. we have seen in Ontario in the last decade and a half). The US Congress, pressed for ever more funding from the industry, has mandated very intensive research into funding levels and care standards.

A very sound and credible analysis , and culmination of the research, is in the report that Congress mandated the U.S. Health Care Financing Administration do. In Phase I all prior studies on the correlation between staffing standards and quality of care were reviewed and minimum thresholds were identified that reduced poor quality of care outcomes. The methods were rigorous, including time motion studies and multivariate analysis. The conclusions of Phase I found:

> "1. We were able to demonstrate staffing levels (or thresholds) below which facilities were at substantially greater risk for quality problems.
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> 2. These levels were approximately 2 hours per resident day for nurses' aides, .75 to 1.0 hours per resident day for RNs and LPNs combined, of which RNs were required between .20 and .45 hours per resident day....

3. The minimum staffing levels appeared to be sensitive to case mix, requiring a system to classify all facilities into different categories."

The Institute on Medicine also recommends, based on the evidence, the adoption of minimum staffing standards weighted to case mix.

The minimum standard is recommended as one of the major tool to promote quality of care and accountability. It is used with other tools to create a regime of improved accountability and enforceable improvements in care.

It is based on findings of these reports, and the smaller studies correlating quality, outcomes and care standards of the staff mix in question, that we have made our recommendation to adopt a minimum care standard again in Ontario. We suggested putting it into the regulations since the standard will need to be assessed and changed as acuity changes. The political importance of ensuring that a future government would have to remove the regulation as the Conservatives did provides a degree of accountability for future governments. We believe that our recommendation for an amendment to the legislation to require a regulation that sets the actual threshold would therefore achieve the right and proper balance of flexibility and accountability.

2) The level of care required.

The Congressional report found that the absolute minimum is as listed in number 2 above (amounting to approx. 3 hours). The report found the *preferred* minimum standard, at which care improved across the board. It was 3.45 hours mixed between (the equivalent to) RNs, RPNs and PSWs. Thus, the claim I overheard from one of the Liberal Social Policy Committee members make outside the hearings, that the 3.5 does not withstand scrutiny, is untrue. There is no published rebuttal of the Report to Congress recommendation on this point.

Whether or not Monique Smith accepts the PriceWaterhouse Cooper's 2001 report comparisons across jurisdictions, the report's assessment of acuity in Ontario is not in question. Indeed, there is total consensus that the acuity in Ontario's homes is high and increasing. It is from this understanding, and the Congressional report findings that we are recommending 3.5 hours as an average.

U.S. states and other Canadian provinces are at a range of levels. We provided you in the meeting this week with a chart from the University of California San Francisco that gives the actual standards across the U.S. states as of 2000- 2001. Several states have increased their standards since then, including the jursidictions where, for example, Extendicare and Diversicare were found negligent in civil suits regarding deaths of residents in their facilities.

You will see that the states adopt a variety of mechanisms to deal with the size of the facilities and the case mix questions. There are obviously many ways to do this, and we are happy to discuss these options in more detail with you.

3) The reporting and research required to get it right.

Without the update of the 2001 PriceWaterhouse Coopers' comparative work, it is difficult to assess how Ontario is doing compared to other jurisdictions. However, since the recommendations to update that work have not happened, even after two auditor's reports and many years, we do not believe it is in the public interest to wait for an update at this point. (It should be noted that the Ministry has ignored for a decade the call for a standard and evidence to support it, and for a review of the funding levels.)

An interim care standard should be implemented now, based on the research and evidence that we have provided.

The Ministry should immediately commission and independent update of the comparative jurisdictional analysis and create a report that at minimum includes the current levels of acuity and the current actual levels of care.

The review must also include an assessment of an evidence-based appropriate minimum staffing standard, to be weighted to assessed need.

The funding, to the nursing and personal care envelope, should then be tied by formula to this assessment.

We should note that we have suggested a care standard to be tied to the average CMI, so that a 100 CMI home would be given resources and be expected to provide an average of 3.5 hours. The flaw in this approach is that if the average acuity goes up across the province, the staffing standard does not reflect this. There are a variety of ways of dealing with this including tying an increase in the standard to the increase in CMM and periodic reviews of the standard to ensure that it reflects variation in acuity.

4) The former 2.25 hour minimum.

Initially the minimum standard was 1.75. The funding and the minimum standard went hand in hand. Then there were program enhancements that moved the standard up ultimately to 2.25 (in the early 1990s). The regulation in this period that proceeded the levels of care classification tied extra funding to extra care.

In 1992, the first CMM results were publicized. The regulation was removed in 1993 (est. in the spring) with the introduction of levels of care funding. (In 1993 the Ministry provided funding for the introduction of the Alberta Classification System.) Later in 1993 (around October) the regulation was reinstated with the 2.25 hours of minimum staffing.

This regulation for 2.25 hours continued until it was removed by the Conservative government in 1996. It was an absolute minimum, not weighted to case mix. Each nursing home was obliged to provide the 2.25 on average. If levels of funding were insufficient to provide this level then they received supplementary levels of funding.

We hope this is helpful.

Regards,

Natalie Mehra
Director