Health and Alberta Health Services—Seniors Care in Long-term Care Facilities Follow-up

SUMMARY

Thousands of Albertans live in long-term care facilities. They deserve to be as healthy and happy as possible in a setting that maintains their dignity and their connections with others. Achieving that goal is a complex and highly sensitive task, perhaps the most sensitive in the provincial healthcare system.

These persons are best served by a system designed around them, not around buildings or administrative bodies. It should be a system of patient centred care dedicated to meeting each individual's needs.

The province has 170 long-term care facilities containing more than 14,000 beds. They serve a constantly changing population with constantly changing needs. For many individuals, long-term care is actually transitional, end-of-life care. The numbers, the sensitivity of the task, and the many differences between individuals and the places where they are cared for combine to produce risk.

We reported in 2005 that the Alberta government and its health agencies lacked much of the information they needed to manage the risk.[1] Nor were all the right tools available to ensure that long-term care operated efficiently and with the best regard for people's health and dignity.

The Department of Health and Alberta Health Services have made strong improvements since then. They now have significantly more information on service quality and financial performance. This assists their planning for and management of Alberta's long-term care system.

AHS and the department have also established patient care based funding. This is an important mechanism that directs funding toward individuals' needs. It enables AHS to determine care needs and monitor outcomes for each resident, and it allows AHS to assess the performance of each facility. AHS recently reviewed its patient care based funding model and published its results in the fall of 2013.[2] The review concluded the model has a solid foundation,[3] although some improvement is needed.

We examined whether all these changes now provide for adequate oversight of long-term care in Alberta. We found strong movement in the right direction.

A further step is necessary. The improvements of the last decade have tended to concentrate in the areas of process and administration.

What is needed now is more attention to ensuring delivery of proper care every day to every individual in the 170 facilities. Health system managers need to know what really happens on a day-to-day basis in

[1] Under our 2005 publications, see the standalone Seniors Care report, the supplementary Frequently Asked Questions document, and the summary of our work on Seniors Care in the *Annual Report of the Auditor General of Alberta: 2004–2005*, pages 53-69.

[2] *The Alberta Health Services patient/care-based funding model for long-term care: A review and analysis.* September 2013, http://www.albertahealthservices.ca/Publications/ahs-pub-ltc-pcbf.pdf

[3] Ibid, pp. 41-42.

each home. Families deserve assurance that their loved ones are receiving proper care. The people living in the facilities deserve dignity and the best health possible.

For the families, long-term care is not an issue of organizing work and allocating resources. They have simple and direct questions. Will our parents be fed properly and at reasonable times? Will they be kept clean rather than left for long periods in their own wastes? Will they have people to talk to rather than being left alone for hours, drugged by sedatives? Will they receive prompt medical treatment whenever necessary?

For the residents, long-term care may come down to an even simpler test: Am I reasonably happy here?

The phrase “long-term care resident” has become somewhat misleading. Today, long-term care is largely short-term care for seniors who are too frail and too ill to be cared for in the community. Many die within two years of admission to a long-term care facility. The goal of care for most residents is to best manage their existing health conditions and prevent avoidable deterioration while maintaining their quality of life as well as possible.

The care needs of a typical resident have increased significantly over the last several decades. This happened partly because Alberta has emphasized development of home care and supportive living services. People with fewer care needs tend to use those services, leaving the more challenging cases to long-term care facilities.

Avoiding hospitalization is a key objective of long-term care. Among residents with complex care needs, even a brief hospitalization can result in a rapid deterioration of cognitive and physical condition. The acute care system is designed for treating acute or episodic conditions. It is not designed to best meet the unique and complex care needs of seniors. The strong push to move seniors quickly out of hospital beds and into long-term care beds is not just about saving money — it is about saving lives.

Although medical interventions and medications play an important role, the success of care depends largely on help with the seemingly simple activities of daily living. For example, proper bathing, management of continence, body rotation and foot care are critical for preventing sores and skin ulcers, which can often lead to severe health complications and death. Proper cognitive stimulation, daily interaction, social activities and communication are important for preventing and managing depression. Help with these basic activities of daily living prevents seemingly minor health issues that can easily snowball into rapid health deterioration and even untimely death.

Our 2005 audit identified absence of a consistent provincial system to inspect long-term care facilities, lack of standardized facility reporting requirements, lack of information to assess effectiveness of services provided by facilities, and inadequate financial information to make funding decisions around long-term care service delivery.[4]

Some of the entities we audited in 2005 no longer exist and their responsibilities have been transferred to other organizations. There were also important changes in how the government funds and monitors long-term care service delivery. Those important system changes have produced better management.

The risk underlying our 2005 recommendations is still relevant today, however.

Because the wording of our 2005 recommendations does not reflect the current situation in provincial long-term care service delivery, we replace the four outstanding recommendations to AHS and the

[4] Under our 2005 publications, see the stand-alone seniors care report, the supplementary frequently asked questions document, and the summary of our work on Seniors Care in the *Annual Report of the Auditor General of Alberta: 2004–2005*, pages 53-69.

department with three new recommendations.[5] This approach allows us to highlight significant improvements achieved by AHS and the department, and focus on the most important challenges still present in the long-term care system in Alberta in today's environment.

The long-term care system now has good mechanisms in place to say what should happen in each home and with each individual. It does not have good mechanisms to verify that daily care for each individual is carried out as planned.

Our audit found fragmented responsibility. It found unnecessary duplication of monitoring. It found that the Department of Health and AHS now have the information, but are not yet using it to assess performance and report on the results. Making this performance information public would go a long way toward enhancing trust in the system.

Our recommendations in this report aim at eliminating the visibility barrier that remains between plan and delivery, between intention and results.

It is important to note that we do not claim to have found specific shortcomings in care for specific individuals. We aim to help prevent shortcomings. This report recommends ways in which managers and agencies can be more aware of the daily experience of individuals in their care. Better knowledge can help assure delivery of proper care, and help achieve continuous improvement.

In short, while the long-term care system has been significantly improved since 2005, it can and should be improved further.

What we examined

Our overarching objective was to conclude whether improvements made by the department and AHS resulted in a system that provides adequate provincial oversight for health service delivery in long-term care facilities.

This follow-up audit focused on service delivery in long-term care facilities, and did not include home care or supportive living. Over the years, we followed up on individual recommendations. However, this was the first time our follow up looked at all outstanding recommendations, and did so in the context of the big picture of provincial long-term care system.

What we found

The department and AHS have gathered strong momentum and are moving in the right direction. They have:

- considerably improved the availability and consistency of facility cost data and resident care outcomes data
- introduced key provincial performance monitoring processes
- implemented a care funding model that takes Alberta a step closer to having a patient-centred model of long-term care service delivery

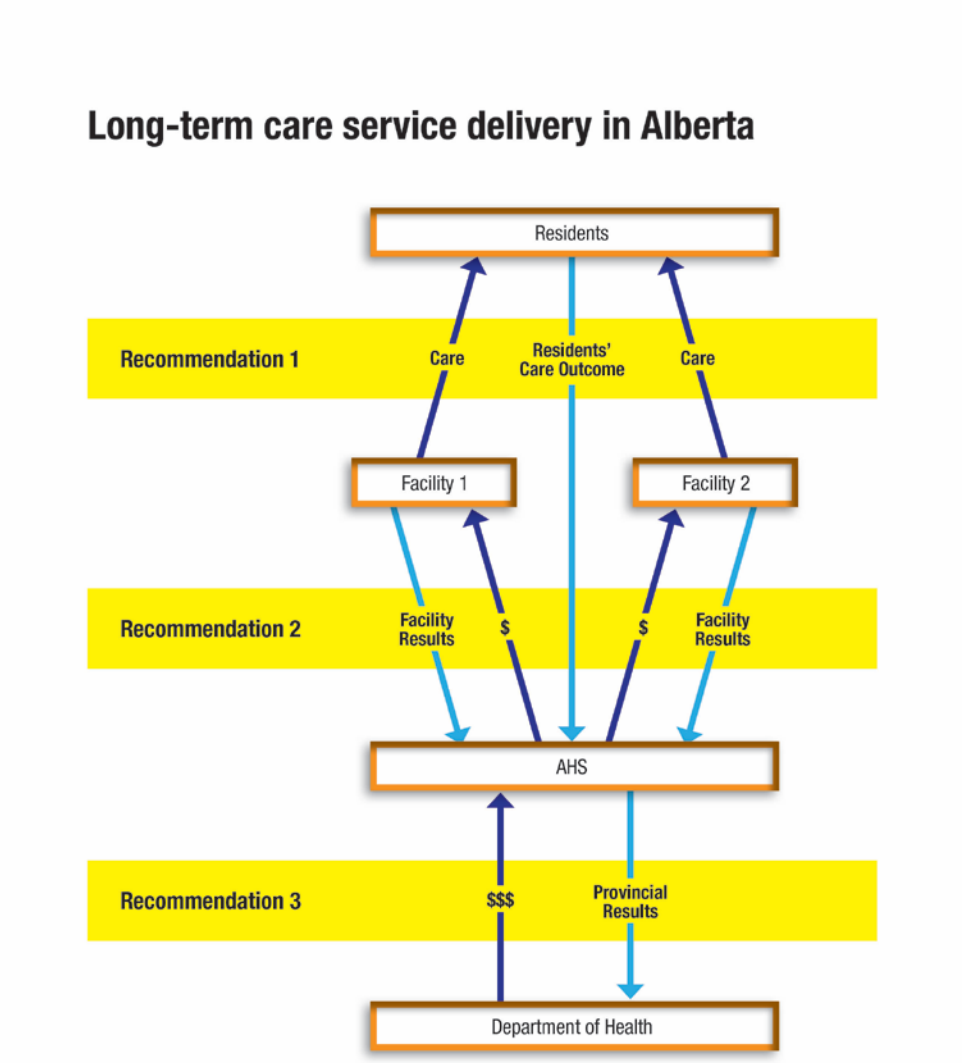
However, long-term care residents cannot yet obtain the full benefit of these improvements because a number of important deficiencies remain in the design and implementation of provincial systems to monitor and manage performance of long-term care in Alberta. We identified a number of areas where improvement is needed, but the following three are a priority:

1. AHS needs to improve its compliance monitoring by developing a process to periodically verify that long-term care facilities consistently implement care plans of individual residents.

[5] For the list of the four outstanding 2005 recommendations, see Appendix A.

2. AHS needs to clearly define which program area is responsible for managing the overall performance of facilities over time, develop a formal process to periodically assess performance of facilities and take standardized compliance action based on the level of risk to residents.
3. The Department of Health needs to clearly define and separate its monitoring role and responsibilities from those of AHS, and improve public reporting on the results achieved for the funds provided.

The diagram below shows how these three areas and the respective recommendations appear in the context of the provincial long-term care service delivery system.



AHS and the department now have comprehensive data on the unique care needs of every long-term care resident in the province. This data allows them to:

- fund long-term care facilities based on the unique care needs of individual Albertans who live there
- manage performance of individual facilities based on care results they achieve with the residents
- assess current and projected long-term care needs of the province and plan for the future
- report results of this work publicly

At the heart of these improvements is the new patient care based funding model. This model is designed to fund facilities based on the unique care needs of individual residents, and hold facilities accountable for results achieved in the care of these people. AHS has identified a number of technical areas where the model needs to improve and is working to fix them. However, the fundamental design of the patient care based funding model is consistent with the provincial government's move to results based budgeting and program delivery and is aligned with the principles outlined in the *Results-based Budgeting Act.*[6]

During our visits to a number of long-term care facilities we did not observe instances where there was an immediate and significant risk to safety of residents. However, we must note that these visits were arranged as part of the AHS's facility audits, which were announced to the facilities at least eight weeks in advance.

What needs to be done

We made two recommendations to Alberta Health Services and one to the Department of Health.

Recommendation 11: Monitoring care at the resident level

We recommend that AHS improve the design of its current monitoring activities. AHS should:

- develop a system to periodically verify that facilities provide residents with an adequate number and level of staff, every day of their operation
- develop a system to periodically verify that facilities deliver the right care every day by implementing individual resident care plans and meeting basic needs of residents

Recommendation 12: Managing performance of long-term care facilities

We recommend that AHS improve its system to monitor and manage performance of long-term care facilities. AHS should:

- clearly define which program area within AHS is responsible for managing the performance of individual facilities
- establish a formal mechanism to use all available compliance data to review periodically the overall performance of each facility, and initiate proactive compliance action with facilities based on the level of risk to health and safety of residents
- establish a formal mechanism to escalate compliance action for higher risk facilities

Recommendation 13: Oversight at the provincial level

We recommend that the Department of Health:

- clearly define and separate its role and responsibilities from those of AHS in monitoring and managing long-term care service delivery
- improve public reporting on what results the provincial long-term care system is expected to achieve and whether it is achieving them
- finish the review of the continuing care health service standards
- implement a mechanism for timely analysis and action on the accommodation cost data

[6] *Alberta Results-based Budgeting Act*, http://www.qp.alberta.ca/documents/Acts/R17P5.pdf

Why this is important to Albertans

The importance of long-term care goes beyond the $910 million that the province has spent on it last year alone. If long-term care delivery isn't done right, it can have significant negative impact on the cost and capacity of the rest of the healthcare system. More importantly, without good systems to support long-term care delivery, some Albertans may not have an opportunity to spend their final years in the best possible health.

AUDIT OBJECTIVE AND SCOPE

Our overarching objective was to conclude whether improvements made by the department and AHS resulted in a system that provides adequate provincial oversight of health service delivery in long-term care facilities.

The audit focused on services delivered at long-term care facilities. Services offered by AHS through homecare and supportive living settings were outside the scope of this audit. We will consider including homecare and supportive living services in our future audit work.

As part of our work we visited all five zones of AHS, reviewed relevant internal documentation of the department and AHS, and interviewed management and staff from various program areas at both entities. We accompanied AHS staff on their inspection visits to seven facilities and closely observed the inspection process. We participated in AHS's interviews with facility management and frontline staff, residents and their families.

We met with the Alberta Continuing Care Association and the Alberta Senior Citizens' Housing Association, and examined relevant documents published by other organizations, such as the Health Quality Council of Alberta.

The scope of our work did not include the mechanism AHS follows for placing residents in these facilities.

Although we relied on the data in department and AHS databases, and offer our conclusions on how both entities use that data, we did not directly verify the accuracy and completeness of individual records.

We conducted our field work between January and May of 2014. We substantially completed our audit on July 14, 2014. Our audit was conducted in accordance with the *Auditor General Act* and the standards for assurance engagements set by the Chartered Professional Accountants of Canada.

BACKGROUND

Following are the key concepts, processes and organizations involved in long-term care service delivery in Alberta. We start with those that matter the most.

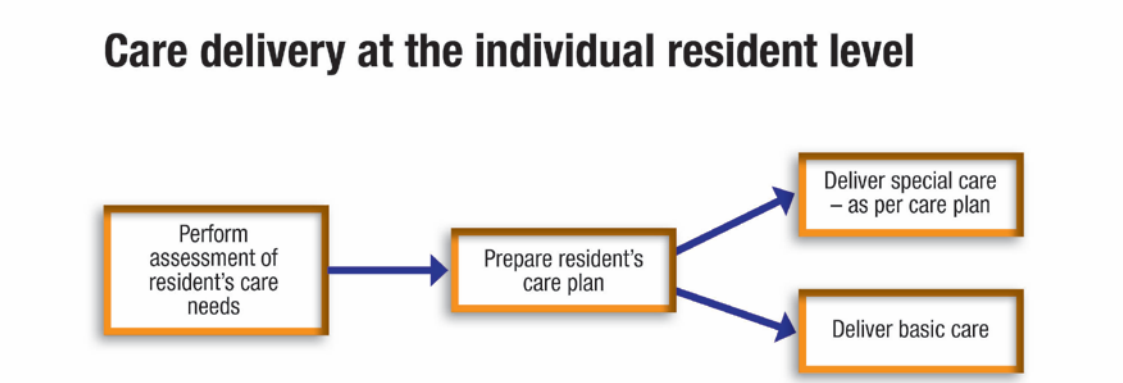
Care delivery at the individual resident level

Every program and process we discuss in this report serves a single function—to make sure that individual residents receive the daily care they need. All monitoring processes, funding models, contracting arrangements, staffing, education and training, performance measures and reporting, standards, legislation—everything—exists to make the following two things happen.

1. Unique care needs of every resident must be met. The current system requires that for every long-term care resident in the province:
   - a formal comprehensive assessment of care needs must be done and updated every three months
   - a care plan must be prepared based on the identified care needs, and updated every three months or with a significant change.
   - staff must follow the care plan as they provide daily care to each resident

2. Basic needs of every resident must be met. These basic needs are not explicitly defined in legislation and are not detailed in any standards of care. These basic human needs may be simple, yet are fundamental for maintaining residents' physical and mental health, and their human dignity. Help with basic personal grooming every morning, timely help with toileting to avoid incontinence, assistance with taking medications, timely clothing change when soiled, help with feeding, timely response to residents' bed calls, basic human interaction to avoid loneliness and depression, and physical stimulation to maintain mobility are all examples of such basic needs.

Following are the key elements of care delivery at the individual resident level.



Care delivery at the facility level

To deliver care to their residents, long-term care facilities bring together hardware (the building, supplies, equipment, etc.) and people (care providers and support staff). Of the two, people are far more important. Every information source we came into contact with echoed the view that staffing is the cornerstone of good resident care. The right people can deliver outstanding care even in a substandard facility, while residents in a state-of-the-art building will almost invariably suffer poor outcomes if staffing isn't done right. To get the staffing right, facilities need to ensure that the right staff are available at the right time, and deliver the right care to the residents.

While good staff scheduling alone does not guarantee good care outcomes, it is a necessary condition for successful care. During our work we considered whether the provincial systems, individually or jointly, can provide assurance that long-term care facilities have the right care providers, at the right place and time, and doing the right thing.

Provincial system to manage performance across individual facilities

Standardized quarterly assessments of residents' needs and the patient care based funding model are at the heart of AHS's ability to ensure that facilities achieve expected results as they provide care to individual residents. Although monitoring a facility's compliance with care standards and with general contracting arrangements is important, these activities primarily tell AHS whether the facility has the required processes in place. These activities tell much less about the care outcomes of individual residents. To provide a resident centred model of care, AHS needs to know the care needs of the people it places in long-term care facilities, fund facilities based on current needs of those residents, and know the subsequent care outcomes for individual residents.

Care standards and contracting arrangements are important in outlining the overall legal framework and responsibilities of the entities, and in setting certain universal minimum expectations for what services facilities are to provide. For example, it is important for AHS to know whether facilities have internal mechanisms to resolve resident complaints, systems to provide infection prevention and control training to their staff, and have business continuity plans in place. However, by their very nature, standards and contracts are too broad to set expectations for the unique and frequently changing care needs of individual residents. The patient care based funding mechanism and the reporting systems that support it allow AHS to set funding levels for each facility, and to monitor care outcomes at the resident level. All long-term care facilities in the province are now funded through this mechanism and electronically submit standardized clinical and financial data into central databases of AHS and the department.

In the past, a common approach to delivering care was for the funding entity to enter into contracts with facilities, fund them based on the reported cost of service, and expect the facilities to report on quality of the service provided. This approach has a number of weaknesses:

- Without knowing the exact care needs of individual residents, the department cannot make informed decisions on whether the total amount of funding for long-term care in Alberta is adequate.
- Resident centred care must be supported with resident centred funding. In other words, funding must follow the resident and change with his or her care needs. Without knowing the exact care needs of individual residents, AHS cannot ensure that facility funding is fair and adequate.
- Without a validated standardized resident assessment instrument, AHS cannot assess care results achieved by individual facilities and compare their performance to other facilities in the province.

AHS and the department have a number of mechanisms to monitor long-term care delivery in Alberta. These mechanisms, individually and jointly, need to provide AHS and the department with assurance that facilities achieve the desired resident care outcomes while meeting applicable legislation, standards and contract conditions. For a description of these monitoring mechanisms and our detailed findings, see Appendix B.

Roles and responsibilities in long-term care delivery

Facility operators

As at March 31, 2014, there were 170 long-term care facilities in Alberta, offering 14,370 beds. There are three types of facilities: for profit and not for profit facilities contracted by AHS, and facilities that AHS owns and operates. All three facility types are funded using the same formula and have to meet the same expectations. The table below summarizes these numbers by the three types of facility operator.[7]

Operator Type	Number of LTC Facilities	Percentage of LTC Facilities	Number of LTC Beds/Spaces	Percentage of LTC Residents
For Profit	45	26%	5,239	36%
Not for Profit	41	24%	4,540	32%
Operated by AHS	84	49%	4,591	32%
Total	**170**		**14,370**	

Public facilities owned and operated by AHS

AHS facilities tend to be smaller than for profit and not for profit sites, and are predominantly located in rural areas. These facilities are often either part of a regional hospital, or are a smaller local acute care facility converted for long-term care use. In some rural areas there are not enough long-term care residents to attract a contracted service provider and AHS uses its facilities to maintain an operational presence there. For these reasons, the per-resident cost of operating AHS's long-term care facilities tends to be higher than that of for profit and not for profit sites.

While AHS facilities are funded through the same formula as contracted sites, there is an important difference in their governance and oversight. As part of AHS's organizational structure, AHS facilities have direct lines of accountability from facility management to zone operations management and from there to AHS's provincial executive leadership. Their staff members are employees of AHS and they are connected into AHS's corporate and clinical information systems.

Not for profit service providers

These are typically philanthropic or faith based organizations that deliver long-term care services under contract with AHS. In addition to care funding provided by AHS and accommodation fees charged to their residents, these providers may also obtain some additional funding by engaging in charitable events and activities. Although some operators are quite successful in their fundraising efforts, this is usually not a major source of funding.

For profit providers

These privately operated and publicly funded facilities deliver long-term care services under contract with AHS. Most of these facilities are located in urban centres and tend to be larger sites with more residents.

[7] This information was provided by AHS and reflects the number of facilities and beds as of June 30, 2014. The numbers may be different if obtained at a different point in time.

AHS

AHS is responsible for the delivery of long-term care services in the province. It pays for the care provided to all long-term care residents in Alberta, and is accountable for their health outcomes. AHS delivers long-term care services at its own facilities, and through contracts with private and not for profit service providers. AHS places residents at facilities through its centralized placement mechanism.

Department of Health

The department is responsible to oversee and report on the overall performance of the continuing care system. It leads strategy development, develops and proposes changes to legislation, regulations and applicable standards. It sets maximum daily amounts that facility operators may charge their residents for accommodation services. It also regulates (through registration and inspections) the accommodation services the facilities provide, and gives financial support to qualifying low income residents.

The department is responsible to oversee the AHS budget, including the allocation of healthcare funding to be spent on long-term care in the province. With the exception of managing central information systems and some compliance monitoring activities, the department is not directly involved in long-term care service delivery.

Funding model for long-term care in Alberta

There are two separate sources of revenue for long-term care facilities: accommodation charges that facilities collect directly from residents and health service funding AHS provides to facilities. During this audit we heard strong views regarding problems with long-term care funding in Alberta. We also observed much controversy on this topic in the popular media. We observed that there was some confusion — even among some of the people who work in the long-term care system — in differentiating between accommodation services and healthcare services as a source of funding problems. In this section we will attempt to explain the two separate sources of funding for long-term care facilities.

Accommodation charges

The Department of Health sets the maximum daily amount that long-term care facilities are allowed to charge their residents for accommodation and related services. AHS is not involved in funding or monitoring compliance with the accommodation standards. Facilities charge accommodation fees directly to their residents. Low income residents may be eligible for subsidies under the Alberta Seniors Benefit program.[8] In 2013–2014, residents of long-term care facilities paid about $285 million for the cost of accommodation and related services.[9]

In May 2014 the department announced increases in current maximum accommodation charges in long-term care.[10]

	Daily Charges			
	2013	July 2014	July 2015	July 2016
Private room	$58.70	$60.45	$62.25	$64.10
Semi-private	$50.80	$52.30	$53.85	$55.45
Standard	$48.15	$49.60	$51.10	$52.65

[8] For more information on the Alberta Seniors Benefit program, see http://www.health.alberta.ca/seniors/seniors-benefit-program.html

[9] The estimate is based on the financial data provided by the Department of Health.

[10] http://alberta.ca/release.cfm?xID=36452DA76A3E5-C9B1-C301-7F7EB7156D19EB9F

The department expects accommodation charges to cover the cost of providing room and board, including housekeeping services, staff wages, utilities and routine building maintenance. In other words, accommodation charges are intended to cover the types of costs one would incur when running a hotel. These charges are not intended to cover healthcare costs, which are paid for by AHS.

Healthcare funding—AHS's patient care based funding model

Allocation of care funding to individual facilities and ongoing performance monitoring are the responsibility of the AHS. In 2013–2014, AHS provided over $910 million in healthcare funding to long-term care facilities, primarily through the patient care based funding model.

AHS uses the patient care based funding model to fund every facility based on the relative level of acuity and care needs of its residents. The model relies on data collected through the use of a standardized resident needs assessment instrument developed by interRAI—an international collaborative that has developed a number of continuing care assessment instruments broadly recognized and accepted around the world.[11] Over 30 countries have adopted standards of measurement for continuing care services developed by interRAI, including the United States, Australia, New Zealand, France and Germany.

Nursing staff at long-term care facilities assess each resident using interRAI upon admission and every three months thereafter. Facilities electronically submit each resident's assessment data to the department. AHS has full access to this data for the entire province and uses it to:

- determine the level of health service funding each facility will receive—AHS analyzes the data for all residents at each facility to determine each facility's relative acuity level (each facility's case mix index). For example, if a facility's case mix index is 10 per cent above the provincial average, the level of funding provided to that facility will be proportionately higher.
- monitor the care outcomes of residents over time and monitor certain aspects of service quality at each facility, by AHS zone and provincially

Patient care based funding is primarily an allocation mechanism. It simply allows AHS to allocate the existing pool of long-term care funding to facilities based on their relative acuity levels. The total funding available for long-term care in the province is set through AHS's budget, which is reviewed by the Department of Health and approved by the minister.

Healthcare funding—Hours of care provided

AHS's funding allocations to facilities come with specific expectations for the hours of care to be provided, and the level of care provider to be used.[12] The *Nursing Homes Operation Regulation* under the *Nursing Homes Act* sets the minimum level of care at 1.9 paid care hours per resident per day.[13] On average, AHS funds the facilities for 3.6 paid hours of care per resident per day.[14] In addition to the average of 3.6 hours of care, AHS also provides facilities with funding for about 0.4 paid hours per day for services of occupational, recreational and physiotherapists, social workers, psychologists and other specialized service providers. AHS expects the actual hours worked by care providers to be less than the hours funded. The difference is explained by administrative responsibilities, vacations and sick time. Nevertheless, AHS expects the actual hours worked to be no less than 75 per cent of the facilities' funded hours by each type of staff.

[11] For more information on interRAI, see http://www.interrai.org/

[12] When we discuss levels or types of care providers, we are referring to the following three categories: registered nurses, licensed practical nurses and health care aides.

[13] *Nursing Homes Operation Regulation*, Section 14(5) http://www.qp.alberta.ca/documents/Regs/1985_258.pdf

[14] According to the data provided by AHS and the department.

With each facility funding allocation, AHS sets specific expectations for the number of hours to be worked by the following four categories of care providers:

- Registered Nurses—Registered nurses typically hold a four-year Bachelor's degree from an approved program and are responsible for daily care delivery at the facility and for overseeing the work of licensed practical nurses and health care aides. The regulations require that every long-term care facility has at least one registered nurse on duty at all times, or at least on call if an on duty registered nurse is not available.[15] This requirement is the same for smaller 20-bed facilities as well as for large sites that may have 100 residents or more. At least 22 per cent of all paid care hours must be provided by registered nurses.[16]
- Licensed Practical Nurses—Licensed practical nurses typically hold a two-year diploma from an approved program. Their scope of work is narrower than that of registered nurses.
- Healthcare Aides—Healthcare aides must hold at least a high school diploma and complete an approved training program. Healthcare aides provide most of the routine daily care to residents, such as help with feeding, grooming, moving about and changing clothing. Healthcare aides provide the largest portion of the funded paid hours and they spend the most time in direct contact with residents. On several occasions during our facility visits, healthcare aides were referred to as a nurse's eyes and ears at the facility.
- Other specialized healthcare providers—Occupational therapists, recreational therapists, physiotherapists, social workers, psychologists and other specialists provide care to residents with specialized needs. In the past, services of these professionals were sometimes seen as a non-essential "nice to have" add-on at a long-term care facility. Today they are increasingly recognized as a critical component of care. Proper cognitive stimulation, physical exercise, proper personal medical equipment will all help residents maintain health, independence, dignity and the overall quality of life.

Key information systems

Jointly, Alberta Continuing Care Information System (ACCIS) and Financial Information Reporting Management System (FIRMS) are the pillars that support allocation of funding based on care needs of individual residents. AHS uses these IT systems to determine the level of care needs across the province. They truly enable consistent, results based performance management at the level of care outcomes for individual residents, and at the level of results achieved by each facility, within zones of AHS and at the provincial level.

Alberta Continuing Care Information System

ACCIS was developed by the Department of Health. It is a complex and sophisticated central information system that contains interRAI assessment data for long-term care residents in Alberta. ACCIS allows AHS to know the care needs of the residents at each facility in order to fund the facilities based on those needs. ACCIS also allows AHS to monitor health outcomes of residents at each facility over time, which is key to assessing the overall performance of each facility. The department and AHS also use the data in ACCIS to monitor overall trends in the level of care needs among long-term care residents in Alberta.

Each long-term care facility has to submit resident assessment results directly into ACCIS at least monthly. ACCIS functionality allows the department, AHS and facility staff to generate a number of standardized reports on activity levels at individual facilities, by facility operator and by AHS zone. Each facility has access to the data of its residents; access is restricted based on roles and responsibilities of individual staff.

[15] *Nursing Homes Operation Regulation*, Section 14(1) http://www.qp.alberta.ca/documents/Regs/1985_258.pdf
[16] Ibid, Section 14(6).

Financial Information Reporting Management System
FIRMS was developed by the Department of Health and is a central information system that contains operating cost data for individual long-term care facilities in Alberta. This database contains historical and current data on costs of operating for profit and not for profit long-term care facilities.

The data on the cost of operating AHS facilities is managed through AHS's internal financial systems, but AHS is expected to begin reporting into FIRMS later in 2014. Together, FIRMS and ACCIS provide the data necessary to operate AHS's patient care based funding model. This data is fundamental for enabling the department and AHS to determine and compare long-term care results achieved for the funds invested not only at the provincial level, but by AHS zone, and by individual facility. The data contained in FIRMS also allows the department to monitor the cost of accommodation and of healthcare service delivery in long-term care facilities, in order to ensure that provincial finding and maximum accommodation charges are sufficient to meet the long-term care needs of Albertans.

FINDINGS AND RECOMMENDATIONS

Background

Management at each long-term care facility is responsible for delivering day-to-day care. This applies equally to contracted facilities and to those operated directly by AHS. Each facility receives a funding allocation from AHS for provision of health services to residents based on their assessed needs and in accordance with their individual care plans.

As a funder, AHS needs to ensure that facilities distribute the funded care hours in a way that provides residents with the right number and the level of care providers at all times of the day and every day of the week. AHS also needs to obtain reasonable assurance that facilities properly assess the needs of residents and consistently deliver care in accordance with individual resident care plans. AHS needs to systematically verify that these things happen to determine whether resident care outcomes achieved by facilities are the best they can be with the resources invested. The data produced by such verification is also necessary for AHS to determine the root cause of the problem in cases when resident care outcomes fall below expectations.

AHS can obtain the assurance it needs through a number of direct and indirect monitoring techniques without becoming involved in daily management of individual facilities. For example, through unannounced inspection visits AHS inspectors could directly verify that an adequate number of staff are present on a given shift, and review a sample of shifts from the facility's staff schedule to ensure that the facility management properly distributes care provider hours between different times of day and on every day of the week. Through sampling of individual resident cases and in-depth analysis of their care histories, AHS inspectors could directly verify that facilities systematically implement individual care plans of residents.

RECOMMENDATION 11: MONITORING CARE AT THE RESIDENT LEVEL

We recommend that Alberta Health Services improve the design of its current monitoring activities. AHS should:

- develop a system to periodically verify that facilities provide residents with an adequate number and level of staff, every day of their operation
- develop a system to periodically verify that facilities deliver the right care every day by implementing individual resident care plans and meeting basic needs of residents

Criteria: the standards for our audit

AHS should have systems to ensure that for every long-term care resident in the province:

- a formal, comprehensive assessment of care needs must be done and updated every three months
- a care plan must be prepared based on the identified care needs, and updated every three months or with a significant change
- a care plan must be implemented and reflected in daily care a resident receives
- basic needs of every resident must be met, even if such needs are not explicitly mentioned in the care plan

AHS should have systems to ensure that facilities provide their residents with the right number and level of staff, at the right time of day and the week.

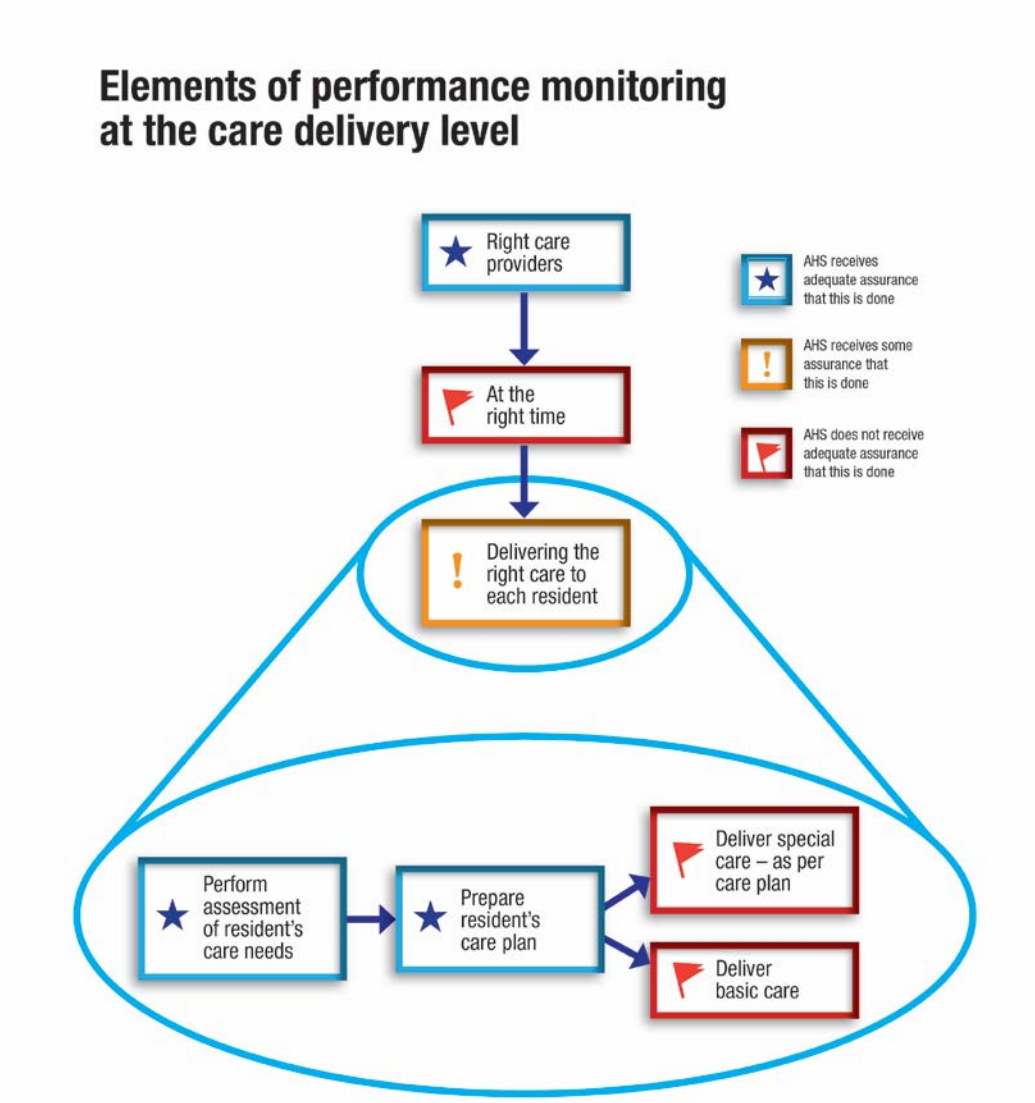
Our audit findings

KEY FINDINGS

- Overall, AHS has an adequate system to ensure that facilities hire the number and the mix of staff they were funded to provide.
- AHS does not have an adequate mechanism to periodically verify that daily scheduling of staff is adequate to meet the care needs of the residents on every shift.
- One important validation component is missing in the provincial monitoring system – AHS does not obtain sufficient assurance that facilities implement individual resident care plans, and meet basic and fundamental daily needs of residents.
- AHS has provincial monitoring processes to:
  - confirm that facilities formally assess care needs of individual residents
  - check to ensure that these resident assessments are accurate
  - check that facilities prepare individual care plans for their residents

Overall, AHS has an adequate system to ensure that facilities hire the number and the mix of staff they were funded to provide. However, AHS does not have an adequate mechanism to periodically verify that daily scheduling of staff across shifts is adequate to meet the daily care needs of the residents.

AHS has some systems to verify that facility staff assess the care needs of every resident and prepare customised personal care plans. However, AHS does not have an adequate system to verify that facilities daily implement personal care plans of individual residents. The diagram below shows the elements of performance monitoring at the care delivery level, and highlights the areas where we found weaknesses.



Providing the right staff

Rather than setting a single provincial minimum staffing ratio for all facilities, AHS's patient care based funding model allows it to set staffing level requirements for each individual facility based on the unique care needs of residents who live there. Because AHS knows the care needs of individual residents from interRAI assessment data submitted by each facility, the funding allocations are based on treatment needs of those residents. When AHS determines the level of funding a facility will receive, it also explicitly sets a minimum number of hours, by staff level, the facility must employ during the upcoming year.

AHS and the department have developed and are ready to implement a system to monitor whether facilities hire the number and the ratio of staff they are funded to provide. Starting in the fall of 2014 AHS plans to begin generating quarterly reports showing variance in funded versus worked hours by staff level for every facility.

In the past, there was no requirement to independently verify the worked hours data facilities submitted. In June 2014, the department and AHS introduced a new requirement that all worked hours and resident care management expenditures submitted by the facilities must be audited.

Scheduling the right staff at the right time

AHS does not have an adequate system to verify how facilities allocate the staff hours they are funded to provide. Availability of an adequate number and the right level of staff on each shift is critical for ensuring that basic daily care needs of residents are met and their individual care plans are implemented. The only way to directly verify that facilities properly distribute funded care hours is through periodic review of facility staffing schedules and through unannounced facility visits—neither of which is performed, as discussed further under this recommendation.

While the worked hours data reported by facilities allows AHS to calculate a facility's average number of worked hours by each three month period, it does not show how facilities distribute those hours between day and night shifts, and between different days of the week. This is important because staffing needs vary significantly with time of day and a simple three-month average does not reflect those differences. Some facilities and AHS staff we interviewed indicated that some facilities face challenges scheduling the right staffing mix on weekends and holidays, particularly with respect to ensuring availability of senior nursing staff.

We saw a good practice during our zone visits that AHS should consider adopting more broadly. In some instances, local financial support staff of AHS reviewed a facility's staffing schedule to check that it was consistent with the funding level. Of particular benefit, these checks were done on staffing schedules for the upcoming year, allowing management to fix the scheduling problem before the care was provided. Specifically, when some AHS financial support staff noted changes in a facility's funding level and expected hours of care to be provided in the upcoming year, they performed a basic check to see if the corresponding change in the facility's master schedule had been made. We saw this done only for facilities operated by AHS. If contracted facilities perform similar checks, AHS is not systematically informed of their results.

Delivering the right care

Overall, there are provincial monitoring processes that enable AHS to:

- confirm that facilities formally assess care needs of individual residents
- check that these resident assessments are accurate
- check that facilities prepare individual care plans for their residents

However, provincial monitoring activities are missing an important validation component—they do not provide AHS with sufficient assurance that facilities deliver care to their residents in accordance with individual resident care plans, and that facilities daily meet basic needs of their residents.

Facility inspectors of AHS and the department visit individual facilities and have access to detailed records of residents. However, the stated objective of these inspection programs and their very design do not focus on verifying either the implementation of individual resident care plans or adequate distribution of care provider hours in a facility's staffing schedule.

The objective of both entities' inspection processes is to verify that facilities have key policies and procedures in place, as required by the Alberta Continuing Care Health Service Standards. As a result, the inspections are designed largely as a desktop exercise; inspectors spend the majority of their time going over policy binders to check that facilities have the required processes and procedures in place, to verify compliance with the standards. The inspection process also includes resident chart reviews to verify that the required documents are on file. It is not designed to systematically conclude that the daily care provided to those residents matches their identified needs. For example, the process requires inspectors to check that each resident has a care plan on file, but the process is not designed to verify that facilities implement care plans of their residents. For detailed findings for these and other monitoring activities of AHS and the department, see Appendix B.

Throughout our work we noted a strong emphasis within AHS on building relationships with and supporting facilities—even among AHS inspectors. This philosophy is appropriate for daily management of operations, but might also reduce the effectiveness of a compliance assurance function. AHS needs to clearly separate the compliance assurance role from the work it does to support and educate facility staff.

Completion and accuracy of resident needs assessments

AHS has good assurance that every resident receives a needs assessment, because facility funding is based on their submitted resident assessments and operators have an incentive to ensure that assessments are timely. Through ACCIS, AHS and the department have access to assessment data on every resident in the province and continuously monitor to make sure that facilities prepare and submit resident assessments every three months.

To validate accuracy of resident assessments submitted by facilities, AHS has a risk focused and well-designed accuracy validation mechanism. However, the way this mechanism is funded does not ensure proper support and stability for such a critical monitoring task. AHS has a small team of highly experienced healthcare workers (about 3.9 full time equivalent) whose job is to sift through ACCIS data looking for red flags in resident assessments submitted by facilities, visit those facilities and do a deep dive into files and history of several residents to verify that the facility correctly assessed and recorded the level of acuity and care needs of those residents. However, the critical monitoring work performed by this team is funded by a temporary grant from the department, which ends in March 2015. This validation work is critical because AHS uses the data from resident needs assessments to determine the level of funding facilities receive, and to subsequently assess each facility's results. No other provincial function performs this validation, or penetrates care history of individual residents to such a great depth.

Implications and risks if recommendation not implemented

Without a system to monitor whether facilities implement care plans for individual residents, AHS cannot ensure that the unique care needs of each Albertan who lives in a long-term care facility are being met. Without a system to monitor that facilities provide adequate numbers and level of staff at different times of day and on different days of the week, AHS cannot ensure that residents it places at long-term care facilities are safe and have access to the right care at all times.

Background

There are a number of ways for AHS to monitor performance of long-term care facilities. Reactive episodic monitoring includes such approaches as critical incident response and follow up on complaints, which often focus on a specific negative event involving a particular resident. Ongoing proactive monitoring includes such approaches as periodic inspections and standardized reporting requirements. These approaches aim to collect performance information through direct observation and standardized reporting by the facilities. The purpose is to identify and eliminate problems before they lead to negative health outcomes or serious incidents.

In Alberta, multiple entities are involved in monitoring performance of long-term care facilities. Several provincial and municipal entities directly inspect long-term care facilities for compliance with various legislative requirements, standards and codes. Residents, their families and facility staff can voice their concerns to numerous entities and program areas. See Appendix B for the list of monitoring activities and entities with the most direct involvement with long-term care facilities. Individually, these programs and entities are able to monitor only certain individual areas of activity at the facilities. To obtain a complete picture of each facility's overall performance, the data generated by all these programs and entities needs to be brought together.

RECOMMENDATION 12: MANAGING PERFORMANCE OF LONG-TERM CARE FACILITIES

We recommend that Alberta Health Services improve its system to monitor and manage performance of long-term care facilities. AHS should:

- clearly define which program area within AHS is responsible for managing performance of individual facilities
- establish a formal mechanism to use all available compliance data to review periodically the overall performance of each facility, and initiate proactive compliance action with facilities based on the level of risk to health and safety of residents
- establish a formal mechanism to escalate compliance action for higher risk facilities

Criteria: the standards for our audit

AHS should have systems to:

- monitor facility compliance with applicable care standards and reporting requirements to determine whether facilities consistently meet care needs of individual residents
- bring together all long-term care data available from sources within and outside of AHS to formally assess the overall performance of each facility
- take formal proactive compliance action with facilities that do not meet AHS's service delivery expectations

Our audit findings

KEY FINDINGS

- The Department of Health and AHS have significantly improved the availability and consistency of data on performance of individual long-term care facilities across the province.
- The full benefit of these improvements has not yet been achieved because weaknesses exist in the design of AHS's system for monitoring and managing performance of individual facilities. In particular:
  - It is not clear which program area or function within AHS has the responsibility and the authority to manage the overall performance of individual facilities.
  - AHS does not have a formal process to review periodically all relevant facility data available from various functions within AHS and the department in order to assess each facility's overall performance and risk profile.
  - AHS does not have a standardized set of compliance tools to escalate its compliance response based on the level of risk involved.
- There are deficiencies in design and/or implementation of individual performance monitoring activities of AHS.

Significant improvements achieved since 2005

The department and AHS have achieved significant improvement in availability and consistency of critical performance data for long-term care services across the province. The two entities have accomplished this by developing and implementing a number of important provincial performance monitoring mechanisms. In 2005 we noted that the department and regional health authorities had little data on long-term care service quality, resident outcomes, and financial performance of individual facilities.

There was no provincial mechanism to inspect long-term care facilities. By contrast, in 2014 AHS and the department obtain detailed financial information for individual facilities, and comprehensive care needs data for every long-term care resident in the province. Both the department and AHS now have provincial inspection programs.

AHS systems to manage performance of individual facilities

The full benefit of improvements discussed above has not been obtained because AHS has the following weaknesses in the design of its systems to manage performance of individual long-term care facilities.

Roles and responsibilities for managing performance of individual facilities

No single function or program area within AHS has the responsibility and the authority to assess the overall performance of each long-term care facility. We reviewed program documentation and interviewed management and staff from various functions within AHS and the department, including areas responsible for facility inspections, review of reportable incidents, follow up on resident/family complaints, processing and analysis of financial and service quality data. The overall message we received from each of these areas was the same—each function operates within its individual area of responsibility and individually generates a significant volume of performance data for its specific areas of activity. However, management and staff within each of these functions expect someone else to compile all available data and take action to manage the overall performance of individual facilities.

We heard a similar view when we interviewed managers and staff from a number of facilities across the province—facilities must meet requirements of multiple program areas within AHS and the department, but it is not clear which area is in charge, and who is the facility's main contact to get decisions and action on critical matters.

It is up to AHS to determine which program area needs to have the responsibility and the authority to manage the overall performance of each long-term care facility. However, based on our analysis of the available performance data, this mechanism needs to be as close to the operational level as possible. Local AHS zone staff can become intimately familiar with a relatively small number of facilities in their respective geographic areas. A centralized team would not be able to accomplish this level of intimate familiarity for 170 facilities located in various communities across the province. However, these centralized functions have a key role in funneling key performance data for the local AHS staff, and ensuring consistency across the province.

System to assess performance and risk level of individual facilities

AHS does not have a system to compile all available data to monitor overall performance of individual facilities over time. There is also no process to proactively identify facilities with higher risk profile. In a way, what is missing is a periodic performance and risk review process, similar to multidisciplinary case conferencing for hospital patients, or the periodic performance appraisal process for employees in the workplace.

Although various AHS programs and functions are involved in long-term care, their involvement with individual facilities is often episodic and does not amount to a continuous performance management process. Much of this work is reactive in nature and is often centred on responding to specific negative events such as resident death or severe injury. The various functions may communicate with each other, but this is usually a point-in-time communication centred on resolution of specific situations rather than a continuous performance management process.

Analysis and distribution of performance information within AHS could improve. Some program areas within AHS produce separate high level summaries of their own data by zone and for the province, but do not analyze and trend information by individual facility and do not have a process to provide such facility level reports to local AHS operations staff or to facilities. Some program areas do not perform any formal analysis of their data.

Standard escalation process for higher risk sites

Even if AHS had a formal process to identify higher risk facilities, it does not have a set of formal compliance tools to deal with such facilities. AHS's current compliance response does not have formal compliance options between the extremes of "business as usual" and an emergency "all hands on deck" mode when extreme adverse events happen (for example, resident death). In extreme cases AHS could shut down the facility or take over its operation—relatively uncommon responses usually done in reaction to highly publicized adverse incidents. While a strong incident response is important, it is reactive in nature and is not a substitute for a proactive system to take formal action with higher risk facilities to prevent their residents from being hurt in the first place.

It isn't clear what standard consequences are available to AHS staff to deal with facilities with lax practices or how these consequences can be triggered. AHS could consider a variety of tools used by its own regulatory functions outside of continuing care and by various departments of provincial government. Fees and fines are clearly not a reasonable option in long-term care—the money can come only out of resident care or accommodation services. Alternatively, AHS could consider the following:

- Report facility inspection results publicly (as done by the Department of Health with results of accommodation inspections for long-term care and supportive living facilities, by Alberta government for its daycare inspections and AHS's own inspections of restaurants and food establishments).
- Categorize facilities by risk level and inspect them more frequently (as done for inspections of drinking water treatment facilities).
- Place higher risk facilities on a priority list to be monitored more closely and with more rigorous enforcement protocols. Clearly communicate to the facilities what results they need to achieve to be removed from the priority list.
- For facilities that persistently fail to improve, place an AHS worker on site (currently done only in one-off cases in response to highly publicized events).

Design and implementation of individual monitoring processes

We already mentioned that, since 2005, AHS and the department have introduced important improvements into their systems. However, during our work we identified a number of opportunities to improve design and implementation of some of these processes. For our detailed findings on these monitoring processes, please see Appendix B.

Implications and risks if recommendation not implemented

Without systems to monitor performance of individual facilities and take proactive compliance action based on risk, AHS cannot ensure that facilities achieve the expected care outcomes with the residents placed there by AHS.

Background

The Department of Health distributes healthcare funding in Alberta and has to report back to the Minister and Albertans on the system-wide results achieved. The department is not involved in direct healthcare delivery and funds other entities to provide healthcare services to Albertans. The department is responsible to provide system-wide oversight and ensure that AHS delivers the province-wide results expected for the annual investment of $910 million in the provincial long-term care system. As a funder of AHS, the department's oversight and monitoring activities should focus on the management systems and the system-wide results achieved by AHS, and not on the activities of individual service providers contracted by AHS.

It is the department's responsibility to ensure that the total amount of care funding in the province is sufficient to meet the needs of Albertans. After the Minister of Health approves AHS's budget, AHS's job is to distribute the existing funding pool among facilities using its patient care based funding model. In other words, if the funding level is insufficient to meet the needs of Albertans, the best AHS can do is to distribute the shortfall evenly among the facilities.

The department sets maximum daily amounts that facilities can charge residents for accommodation and related services. It also regulates (through registration and inspections) the accommodation services provided by the facilities.[17]

Other responsibilities of the Department of Health include identifying and implementing necessary updates to standards under applicable health legislation and coordinating with other government and non-government entities to ensure alignment of strategies and services in areas where activities of other organizations may have an impact on long-term care service delivery in the province.

For example, the Seniors Lodge Program, administered by the Department of Municipal affairs, provides accommodation services to about 9,700 mainly low-income seniors at 153 lodges across Alberta. The Department of Municipal Affairs has recently initiated a full review of the Seniors Lodge program, including a review of program objectives and performance expectations.[18] The Department of Health and AHS have a vested interest in the future of this program because changes to its objectives may have significant impact on demand and utilization of homecare, supportive living and long-term care services delivered by AHS. According to the analytical model operated by AHS's continuing care services, the complexity and the acuity of healthcare needs of older Alberta are expected to increase over the next 20 years. As many as 40 per cent of the residents at some lodges already receive AHS-funded homecare services. In some rural communities, a senior's lodge is the only continuing care setting available. Both the department and AHS have representatives on the Seniors Lodge program review committee to ensure any future changes to the program are aligned with the provincial vision for continuing care service delivery.

RECOMMENDATION 13: OVERSIGHT AT THE PROVINCIAL LEVEL

We recommend that the Department of Health:

- clearly define and separate its role and responsibilities from those of AHS in monitoring and managing long-term care service delivery
- improve public reporting on what results the provincial long-term care system is expected to achieve and whether it is achieving them
- finish the review of the continuing care health service standards
- implement a mechanism for timely analysis and action on the accommodation cost data

[17] For more information on regulatory activities of the Department of Health in the area of continuing care accommodation and related services, see http://www.health.alberta.ca/services/continuing-care-forms.html

[18] For results of our follow-up audit on the two Seniors Lodge recommendations please see page 183 of this report.

Criteria: the standards for our audit

The Department of Health should have systems to:

- Ensure that roles and responsibilities of entities involved in the long-term care system are aligned for effective service planning, delivery, monitoring and oversight.
- Take timely and appropriate action on available cost and service quality data.
- Publicly report relevant information about performance of the provincial long-term care system, including results achieved for the funds invested.

Our audit findings

KEY FINDINGS

- The department's current level of involvement in operational activities, particularly in facility inspections, goes beyond an oversight role. It overlaps with and erodes the authority of AHS, and creates confusion about who the facilities are accountable to for the care funding they receive from AHS.
- There is significant duplication of effort between the department and AHS in the area of inspection activities. The detailed facility review reports produced by Accreditation Canada are not used by either entity.
- The department has not acted in a timely manner in completing the review of the Continuing Care Health Service Standards.
- The department has not acted in a timely manner to respond to or report changes in the costs that facilities incur for providing accommodation and related services.
- A wealth of financial, service quality and compliance information is available now to the department and AHS, but the department does not ensure that this information is used to publicly report on the performance of the provincial long-term care system, including results achieved for the funds invested.

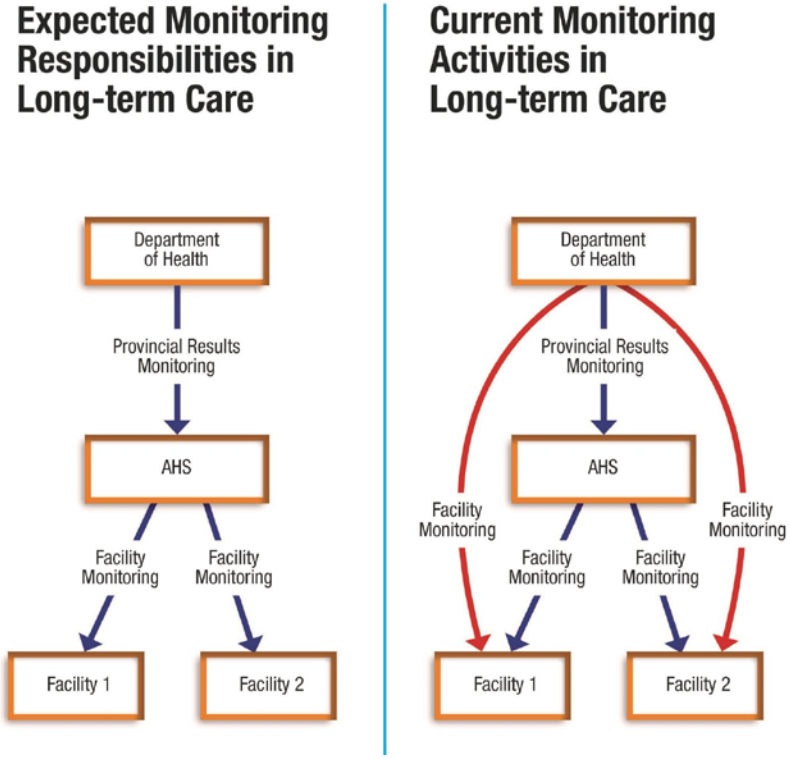
Unlike in 2005, when we noted complete lack of provincial systems to monitor and inspect individual facilities, in 2014 we saw the opposite—facilities are inspected by multiple entities against the same set of standards. While monitoring is much stronger than in 2005, lack of clear division of responsibilities and coordination results in a fragmented system, with lack of clear lines of accountability for the care outcomes of individual long-term care residents at each facility.

In addition to duplication of effort within the department and AHS, redundant monitoring activities are a significant resource drain for the facilities, which impacts the amount of care they can offer to the residents. During our visits to a sample of long-term care facilities across the province, we heard a strong and consistent view that there is significant duplication in inspection activities, and a lot of confusion about the respective roles of AHS and the department in monitoring and managing compliance. Management at every facility we visited stated that it takes a lot of their staff time to prepare for these inspections—time that could have been used to deliver care to the residents. Generally, facility staff we talked to recognized the importance of compliance monitoring. They were not necessarily asking for less monitoring, but for smarter and better coordinated monitoring. Several facility managers expressed frustration that various inspectors just look at the same set of policy binders over and over again, instead of observing the care of individual residents.

The department's involvement in operational monitoring of individual facilities

The extent of the department's current level of involvement in operational activities, particularly in the area of facility inspections, goes beyond an oversight role, overlaps with and erodes the authority of AHS, and creates confusion about who the facilities are accountable to for the care funding they receive from AHS.

The diagram below demonstrates our understanding of the department's provincial oversight role. The second diagram shows the monitoring activities as they presently happen.



Inspection programs at AHS and the department

AHS and the department run redundant inspection programs to monitor facility compliance with the provincial Continuing Care Health Service Standards.[19] AHS inspects each facility once every two years, and the department once every three years. Both organizations use virtually identical inspection criteria, aligned with sections of the provincial care standards. There is no coordination of inspection schedules. During our zone visits we were informed of multiple instances where AHS's inspection teams would arrive at a facility only to learn that the department's inspection team had either just finished their visit or was expected to arrive within a week.

Facility reviews by Accreditation Canada

The department and AHS require that every long-term care facility operator in Alberta must be accredited by one of the approved accreditation bodies.[20] However, neither AHS nor the department reviews the detailed facility accreditation reports provided by Accreditation Canada. Nor does either of them have a system to use this information in formally assessing facility performance. It is important to note that facilities can be accredited by Accreditation Canada even if they are missing a certain percentage of required organizational practices, with an expectation that the process gaps will be filled.

[19] Alberta Continuing Care Health Service Standards http://www.health.alberta.ca/documents/Continuing-Care-Standards-2008.pdf

[20] In Alberta, it is the requirement of AHS and the department that all long-term care facilities obtain accreditation with an approved accrediting body. Accreditation Canada accredits the vast majority of facilities in the province.

Expected results and public reporting on performance

The department does not provide sufficient public reporting on the results it expects the provincial long-term care system to achieve, and whether it meets those expectations.

The data now available to the department and AHS are not fully used to set specific results expectations for the long-term care system in Alberta. The department and AHS have the data on care needs of Albertans over time, facility inspection results, trends in reportable incidents and resident/family complaints, trends in cost of care and hours of care per resident, as well as trends in cost of accommodation over time. AHS runs a comprehensive analytical model to project demand and utilization of continuing care services in the province 20 years into the future. The model offers detailed estimates of demand at the level of individual communities, and allows the department and AHS to estimate future utilization and cost of services under different scenarios of services delivery. We could not obtain a clear understanding of what scenario of service delivery the department wishes to pursue and how it will monitor and report progress.

The information generated by the department and AHS can help Albertans better understand key strengths and weaknesses of their continuing care system, and the root causes of the challenges that remain, and avoid confusion by providing some key facts about the actual cost of health care and accommodation in long-term care.

Timely action on key initiatives

The department's action has not been timely in two important areas.

Update of the Continuing Care Health Service Standards

The department initiated an update to the Standards about three years ago and still has not completed it. This has caused serious delays in the implementation of the facility inspection program by the AHS and contributed to a sense of uncertainty at the front line level.

Action on accommodation costs data

The department's action on the available accommodation costs data hasn't been timely. In May of 2014 the department announced an increase in maximum accommodation charges to bring them up closer to the actual costs reported by operators. However, the department's analysis of the accommodation data shows that the maximum accommodation charges have been below the reported costs for about three years. The department does not have a mechanism to perform periodic cost gap analysis and formally report the results.

Extended periods of below cost accommodation charges, followed by sharp adjustments disrupt the ability of facilities to budget and plan service delivery. Such rapid adjustments, particularly without sufficient financial disclosure, may also negatively impact public confidence in the provincial long-term care system.

Implications and risks if recommendation not implemented

There is significant risk that if operational facility level monitoring remains divided between the department and AHS, the overall monitoring system will be fragmented and weak, with lack of clear lines of accountability for the care outcomes of individual long-term care residents at each facility.

Timely action on key initiatives and public reporting of information are important for maintaining the momentum behind improvement and for maintaining public confidence in the provincial long-term care system.

Appendix A

RECOMMENDATIONS OUTSTANDING FROM OUR 2005 REPORT

Recommendation 6, page 58 (No. 2, page 31 of the stand-alone report)

To AHS “Improve the system for monitoring compliance of long-term care facilities with basic services standard."

Recommendation Unnumbered, page 61 (page 37 of the stand-alone report)

To AHS "Identify the information required from long-term care facilities to enable the department and AHS to monitor compliance with legislations."

Recommendation 7, page 59 (No. 3, page 34, and No. 4, page 35 of the stand-alone report)

The Department of Health and AHS “Assess the effectiveness of the services in long-term care facilities.”

Recommendation 8, page 59 (No. 3, page 34, and No. 4, page 35 of the stand-alone report)

The Department of Health “Collect sufficient information about facility costs from AHS and long-term care facilities to make accommodation rate and funding decisions.”

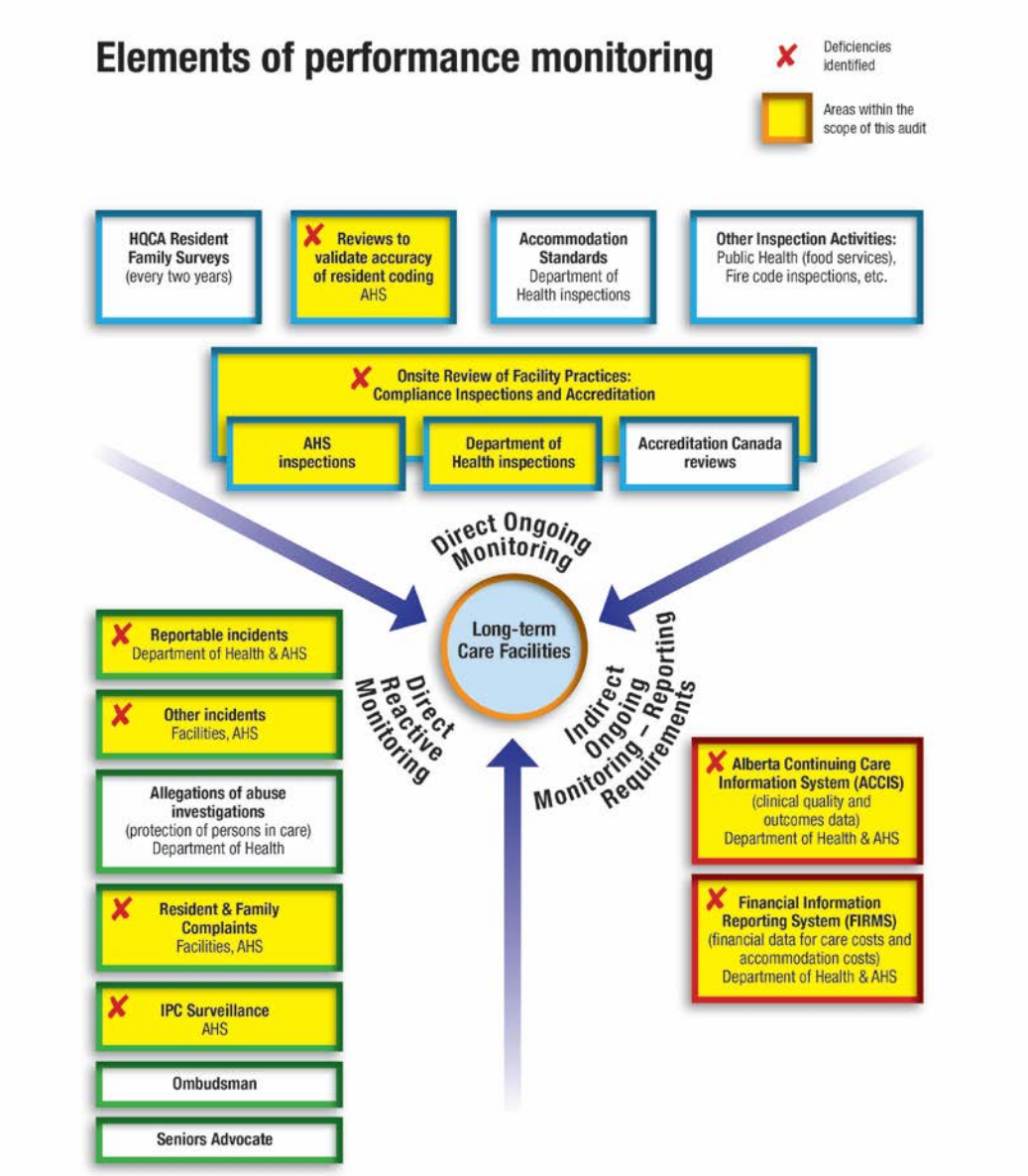
Appendix B

PROVINCIAL MONITORING PROCESSES

Provincial monitoring processes in long-term care broadly fall under three categories:

- direct ongoing monitoring through proactive inspections and observation of service delivery
- direct reactive monitoring through investigation of incidents, critical events and complaints
- indirect ongoing monitoring through reporting requirements

The diagram below shows key provincial monitoring processes for long-term care under each of the three categories and highlights the processes we examined during this follow-up audit, as well as those where we identified opportunities for improvement. Later in this appendix we provide a brief description of each monitoring process and our related findings.



Direct Ongoing Monitoring

Inspections by AHS and the department

Both AHS and the department have programs to inspect for facility compliance with the Continuing Care Health Service Standards, required policies and procedures. Facility inspectors of AHS and the department visit individual facilities and have access to detailed records of residents. However, the stated objective of these inspection programs and their very design do not allow AHS and the department to verify that facilities implement individual resident care plans and meet basic daily needs of their residents.

The objective of both inspection processes is to verify that facilities have key policies and procedures in place, as required by the Alberta Continuing Care Health Service Standards. As a result, the inspections are designed largely as a desktop exercise where inspectors spend majority of their time going over policy binders to check that facilities have the required processes and procedures in place. The inspection process includes resident chart reviews to verify that the required documents are on file, but is not well designed to systematically verify that what is written makes clinical sense or is being followed by staff daily. In other words, the process requires inspectors to check that each resident has a care plan on file, but the process is not designed to verify that facilities implement care plans of their residents.

For example:

- All inspections are announced at least eight weeks in advance. There are no systematic, unannounced facility visits to see care practices as they naturally occur. It is a common practice for facilities to prepare extensively for these inspections. Even with such preparation, the inspectors of AHS and the department identify a number of deficiencies.
- All site inspection visits are done Monday to Friday, during regular business hours. No inspections are done on evenings or weekends.
- AHS auditors in most zones rely on facility management to select resident charts to be reviewed. Methodologically, AHS auditors should control the sampling process. For example, ACCIS data can be used by AHS staff before the site visits to identify and sample higher risk resident charts. Inspectors typically review 10 per cent of resident charts during a facility visit.
- The chart reviews are designed to verify that the required documents are present on a resident's file, but we observed that the depth of these reviews does not allow inspectors to conclude on what actually happened to residents and why. For example, in the sample of charts AHS inspectors check that a care plan is present on a resident's file, but their review is not designed to perform sufficient level of work to conclude on whether the care plan is complete and detailed enough, and whether staff implement it daily.
- The design of inspection programs of AHS and the department specifically excludes the review of facility staffing schedules. Appropriate number and mix of staff are critical for facilities to meet basic needs of their residents, ensure their safety, and implement their individual care plans. There is no other monitoring process that allows AHS to verify adequacy of staffing mix and coverage on different days of the week and different times of day (for example, evening and night shifts, weekend shifts).

- During facility visits the inspectors spend a disproportionately large amount of their time in the boardroom going through policy binders. Site walkthrough inspections are relatively informal and brief. In some zones we observed that inspectors don't even go into the residents' rooms.
- The AHS's inspection checklist covers review of policy binders, resident charts and interviews. There are no checklists for a facility walkthrough, resident room inspection, medication room inspection, inspection of infection prevention equipment and activities throughout the facility, or a bathing room inspection.

Inspections data from AHS and the department are not analyzed to track and trend deficiencies identified during inspections. This would enable AHS to identify facilities with highest volumes of deficiencies, and facilities that repeatedly present with deficiencies in the same areas. AHS also does not analyze inspections data by zone or for the province, to identify overall trends in the nature of deficiencies and track the amount of time the facilities take to resolve their deficiencies. At some zones of AHS we observed a good practice where zone compliance staff do their own tracking, but these efforts are not coordinated across the organization and not centrally supported and monitored.

Facility reviews by Accreditation Canada

The department and AHS require that every long-term care facility operator in Alberta must be accredited by one of the approved accreditation bodies. However, neither AHS nor the department review the detailed facility accreditation reports provided by Accreditation Canada and they do not have a system to use this information in assessing facility performance. Accreditation Canada visits every non-AHS facility as part of its accreditation process, but only a sample of AHS facilities when it accredits AHS as an operator of multiple sites.

The accreditation reports are detailed 40 to 50 page documents that provide a comprehensive description of accreditation review findings, identify process gaps and highlight their relative importance. In many respects, Accreditation Canada reports are more detailed and comprehensive than inspection reports prepared by AHS and the department's inspection teams. Although the objective of the accreditation review process is ongoing quality improvement rather than compliance monitoring and enforcement, both the department and AHS miss an important opportunity to leverage the work done by Accreditation Canada while pursuing their own monitoring. Accreditation reviews are paid for by the facilities with care funding provided by AHS.

It is important to note that facilities can be accredited by Accreditation Canada even if they are missing a certain percentage of required organizational practices, with an expectation that the process gaps will be filled. To maintain their accreditation status with Accreditation Canada, facilities must undergo a detailed review of their practices, including a site visit, every four years.

Work done by Accreditation Canada at individual facilities serves a different purpose but is similar in nature to the work done by AHS and the department's inspection teams, which in many respects adds another layer of duplication. To meet criteria set by Accreditation Canada, facilities must have in place a set of required organizational practices for ongoing quality improvement. While the objective of accreditation activities is to facilitate continuous improvement and not monitor compliance with minimum standards, the accreditation requirements align closely with the expectations set out in the Alberta Continuing Care Standards, which are used as inspection criteria by AHS and the department.

AHS reviews to validate the accuracy of resident assessments
AHS has a system to validate the accuracy of resident assessments submitted by facilities. AHS has a small team of highly experienced healthcare workers whose job is to sift through ACCIS data looking for red flags in resident assessments submitted by facilities, visit those facilities and do a deep dive into files and history of several residents to verify that the facility correctly assessed the level of acuity and care needs of those residents.

There are about 3.9 of full-time equivalent staff doing this work for all long-term care facilities in the province. The work of this small team is funded by a grant from the department, which ends in March 2015. Such an arrangement does not ensure the support and stability needed to do this critical work. The data from resident needs assessments are used by AHS to determine the level of funding, and to assess care outcomes achieved by each facility. No other provincial function performs this validation, or penetrates care history of individual residents to such great depth.

HQCA Resident Family Surveys
Every two years the Health Quality Council of Alberta conducts a long-term care family experiences survey. The results of the 2011 survey are reported publicly on the HQCA website and include summary statistics at the provincial level. AHS received detailed results by facility. The HQCA indicated that the results of its 2013 survey will be made public in 2015.

Accommodation Standards
The Department of Health is responsible for approving individual facilities and monitoring their ongoing compliance with the accommodation standards. The department inspects facilities every year. These accommodation standards inspections are separate from the care standards inspections conducted by the department and AHS.

Other inspection activities
Facilities are also inspected by various other functions within and outside of AHS, such as inspections by public health officers of AHS and municipal fire code inspections.

Direct Reactive Monitoring

Review of incidents
The current model of long-term care service delivery identifies two types of incidents: reportable and non-reportable.

Reportable incidents
The facilities are required to report to the department and AHS any incidents that involve death or serious harm to a resident, or where a resident has gone missing for a period of time.[21] The Department of Health provides facilities with the definition of a reportable incident, incident reporting forms and guidance on the reporting process.[22] Once an incident report is received, AHS is responsible to perform appropriate follow up and resolution. The incident reports are received centrally by AHS and the department, and forwarded by AHS to its respective zone operations staff for follow up. There is no formal system within the zones or centrally to track incident follow up, how the issue was resolved or timeliness of the response.

[21] The requirement to report is outlined in the Alberta Continuing Care Health Service Standards http://www.health.alberta.ca/documents/Continuing-Care-Standards-2008.pdf
[22] As outlined in the Department of Health's Accommodation Standards and Licensing Information Guide http://www.health.alberta.ca/documents/CC-Accommodation-Guide4-2013.pdf

In March 2013 the department made changes to criteria for reporting resident falls. Incidents due to resident falls account for a major share of all incidents reported by facilities. In the past, facilities had to report all fall-related incidents. After March 2013, facilities only have to report fall-related incidents if the fall happened due to an error or omission in the provision of accommodation or health services. During our interviews with AHS zone staff, we heard concerns that in circumstances when a resident fall has not been witnessed, it may be difficult to determine if it was due to an error or omission in the delivery of care. As a result, it is less clear what fall-related incidents are reportable under the standards.

Non-reportable incidents
Under the standards, facilities are required to have an internal reporting mechanism for non-reportable incidents. AHS inspectors check that facilities have such a mechanism, but do not systematically analyze the results. Only one zone within AHS used to have a process to collect and analyze non-reportable incidents data from facilities. This process has now been discontinued.

Some non-reportable incident information is collected by AHS from its own facilities through the Risk Learning System—an internal reporting mechanism for identifying, tracking and resolving incidents and near misses. Contracted facilities do not presently report into RLS. AHS has informed us that in one of the zones it has started a pilot project where contracted facilities will begin submitting their non-reportable incident data into RLS.

Resident and family complaints
AHS has a centralized complaint resolution mechanism for the facilities it operates, but does not use it for contracted facilities.

Complaints regarding AHS facilities
Whenever a complaint is received for one of AHS's facilities, it is centrally logged by one of AHS's complaint resolution officers, who then contacts the AHS manager responsible for that facility. The complaint resolution officer follows up with the complainant to verify whether their concerns were resolved by the facility, and stays involved with the case until it is resolved to the satisfaction of the complainant, or AHS management decides that the concern cannot be resolved. The results are summarized by zone of AHS (but not by facility) and are reported internally within AHS. AHS operations staff indicated that such high level reporting shows the overall trends for the zones, but is not useful for assessing performance of individual facilities.

Complaints regarding contracted facilities
The AHS's centralized complaint resolution function does not process complaints from residents at contracted facilities. Whenever AHS's central complaint resolution function receives a complaint regarding residents at one of the contracted facilities, the complainants are systematically directed to raise their concerns directly with the facility. Only a small number of complaints from the contracted facilities are accepted and formally followed up by AHS on the exception basis.

Under the standards, all facilities are required to have an internal complaint resolution mechanism. AHS inspectors check that facilities have such a mechanism, but do not systematically analyze the results.

Infection prevention and control surveillance
For its own facilities, AHS records detailed information on individual cases of infection or colonization with antibiotic resistant organisms and influenza infections, analyzes and monitors trends, and manages

outbreaks using ProvSurv – a robust provincial infection prevention and control surveillance system.[23] This system, or equivalent, is not used for contracted facilities.

At one zone of AHS, local AHS staff created their own surveillance process to monitor individual instances of infection and colonization among residents of several contracted facilities located in that zone. We saw this as a good practice and an example of a good initiative taken by local AHS staff. However, to be fully effective, such initiatives need to be systematically identified, assessed and supported centrally by AHS.

Investigations of allegations of abuse

The *Protection for Persons in Care Act* (PPCA) requires all publicly funded health service providers to protect clients from abuse and prevent abuse from occurring.[24]

The department conducts formal investigations into allegations of abuse and provides AHS with copies of the investigation reports.

Seniors advocate

We met with the Office of the Seniors Advocate, who informed us that his role is primarily to educate residents and their families and help them navigate through the system. The seniors advocate does not have a mandate to compel facilities or AHS to take action or provide detailed information related to concerns raised by residents.

Ombudsman

We met with the Alberta Ombudsman, who informed us that the Ombudsman's role is to ensure fair treatment through independent investigations, recommendations and education. The Ombudsman has the authority to investigate complaints related to decisions, actions and recommendations made by an employee of the provincial government, its agencies, boards and commissions, listed professional colleges and the Patient Concerns Resolution Process of Alberta Health Services.

For long-term care, and continuing care overall, the Ombudsman indicated he does not have the mandate to directly investigate concerns raised for facility residents regarding health services or the delivery of services by non-government employees. The Ombudsman is limited to investigating complaints related to AHS's Patient Concerns Resolution process. For example, the Ombudsman can examine whether AHS's complaint resolution officer has properly informed the complainant of the decision made by AHS, but would not examine the decision itself. The Ombudsman also does not have the mandate to compel facilities to provide resident records.

Indirect ongoing monitoring through reporting requirements

Alberta Continuing Care Information System

ACCIS was developed by the Department of Health and is a central information system that contains interRAI assessment data of long-term care residents in Alberta. ACCIS is a complex and sophisticated system that allows AHS to know the care needs of the residents at each facility in order to fund the facilities based on those needs. ACCIS also allows AHS to monitor health outcomes of residents at each facility over time, which is key to assessing the overall performance of each facility. The department and AHS also use the data in ACCIS to monitor the overall trends in the level of care needs among long-term care residents in Alberta.

[23] For description of ProvSurv, see our October 2013 audit report (pp. 17-48) on Infection Prevention and Control in Alberta hospitals. http://www.oag.ab.ca/webfiles/reports/October2013Report.pdf

[24] For the Department of Health's summary of the *Protection of Persons in Care Act* see http://www.health.alberta.ca/services/PPC-Act-summary.html

Although ACCIS provides a wealth of service quality and resident outcomes data, it is currently not being used to its full potential by AHS staff in the zones. Some of the AHS zone operations managers and staff we interviewed either are not aware that they can directly access the ACCIS data for the facilities in their geographic area, or simply do not use this data. A lot of standardized reports for each facility are already available directly out of ACCIS, and others are being developed by AHS. For example, AHS and the department are developing standardized risk-adjusted quarterly quality indicator reports which will allow assessing a facility's performance in relation to other facilities in the zone and in the province. AHS expects to implement this mechanism later in 2014.

Financial Information Reporting System

FIRMS was developed by the Department of Health and is a central information system that contains operating cost data for individual long-term care facilities in Alberta. This database contains historical and current data on costs of operating for profit and not for profit long-term care facilities. Data on the cost of operating AHS facilities are managed through AHS's internal financial systems, but AHS is expected to begin reporting into FIRMS later in 2014.

Together, FIRMS and ACCIS provide the data necessary to operate the patient care based funding model of AHS. This information is fundamental for enabling the department and AHS to determine and compare long-term care results achieved for the funds invested not only at the provincial level, but by zone of AHS, and by individual facility. The data contained in FIRMS also allow the department to monitor the cost of accommodation and of healthcare service delivery in long-term care facilities in order to ensure that provincial finding and maximum accommodation charges are sufficient to meet the long-term care needs of Albertans.

Financial data available in FIRMS are not yet systematically analyzed and provided to AHS operations staff and to facilities. AHS and the department are developing standardized quarterly reports showing variances between each facility's care hours funded by AHS and worked hours reported by the facility operator. These reports will allow AHS to verify that facilities deliver the total hours of care they are funded to provide. AHS expects to implement this mechanism later in 2014.

Financial and service quality data are not analyzed together to determine whether the desired resident outcomes have been achieved at an acceptable cost. At the time of our audit AHS was not developing a mechanism to perform such analysis.