



July 25, 2008

John Doyle, MBA, CA
Auditor General of British Columbia
8 Bastion Square
Victoria, BC V8V 1X4

Dear Mr. Doyle:

Request for Risk Management and Performance Audits

We are writing to you as the Auditor General to request a risk management audit regarding the funding practices of the Ministry of Health and Health Authorities with respect to independent residential care facilities that they contract with to provide complex care services to elderly clients. We are also writing to request a performance audit or a value for money audit with respect to the funding practices of Health Authorities regarding their self-operated residential care facilities.

Mandate of the Auditor General

The aforementioned requests fall well within the mandate of the Auditor General. More specifically, we understand the mission of the Office of the Auditor General is to serve the people of British Columbia and their elected representatives by conducting independent audits and by advising on how well government is managing its responsibilities and resources.

We further understand that the goals of your office are to have in place, *inter alia*:

- Sound financial administration and reporting across government
- Well-managed provincial programs, services and resources
- Comprehensive public sector accountability reporting
- Effective public sector governance

We understand that when selecting audits, all of government, including government organizations such as health authorities is included in your consideration. When selecting the audit subject, we understand that you base your decision on the significance and interest of an area or topic to your primary clients, the Members of the Legislative Assembly and the public. We understand that your office aims to provide fair, independent assessments of the quality of government administration and to identify opportunities to improve the performance of government. We believe our request for a review will be of great assistance to the government, health authorities as well as stakeholders such as contracted service providers and seniors that they serve.

Home and Community Care

Home and Community Care provides a range of health care and support services for eligible residents who have acute, chronic, palliative or rehabilitative health care needs. Residential care facilities provide 24 hr professional nursing care and supervision in a protective, supportive environment for people who have complex care needs and can no longer be cared for in their own homes.

Home and community care services are provided through the five regional Health Authorities. There are currently approximately 26,000 funded residential care beds of which 8000 are owned and operated by health authorities and the balance provided by private and non profit contracted service providers. Yearly

expenditures on residential care services exceed \$1.4 billion across the province. The emphasis of the residential program over the last 3 years has been to meet the 5000 new bed target by Dec. 2008.

BC Care Providers Association

The BC Care Providers Association represents independently-owned organizations that provide quality care services to seniors across the province. Its members represent more than 10,000 beds and one-third of all long term care beds in the province. BC Care members have more than \$1.4 billion in capital investment in the province and employ more than 7,000 workers.

Requirement to Provide Complex Care

As a result of the new policy direction given by the British Columbia Ministry of Health, the eligibility criteria for residential care changed significantly in late 2002. Effective April 15th 2002, policy 6.B.4 of the Home and Community Care Policy Manual (see Appendix 1) was changed to recognize *complex care* and the increasing levels of resources needed to meet the specialized care requirements of clients requiring residential care. At this time five categories of complex care were introduced replacing the intermediate and extended care assessment levels that had previously been in use.

With the inception of substitution models like assisted living, residential care is now reserved for the most physically frail and/or cognitively impaired seniors who cannot direct their own care and require 24 hour professional nursing care.

Complex care clients have some similarities by way of demographic, sensory, behavioural, physical, ambulation and cognitive attributes. The complex care categories attempt to group clients according to like needs. The five groupings have differing care, space and equipment needs and their requirements are summarized in the table below:

**Residential Care
 Complex Care Groupings**

GROUP	CARE REQUIREMENTS SUMMARY
A	Residents with severe behavioural problems, destructive, aggressive, violent. May or may not be independently mobile.
B	Cognitively impaired, socially appropriate. Unable to communicate needs, requires directional assistance and/ or requires total care with ADLs. Requires a secure environment for safety. May or may not be independently mobile.
C	Cognitive impaired, socially inappropriate, anti-social behaviours. Unable to communicate needs, requires total care with ADLs. Requires a secure environment for self protection.
D	Physically dependent and cognitively intact with medical needs requiring professional nursing for monitoring or medical intervention. Requires a planned care program. Unable to use wheelchair independently. Requires paraprofessional interventions.
E	Clinically complex requiring professional nursing, monitoring and skilled intervention. May need re-ambulation, hospice/ palliative, medical sub acute (high needs).

Since 2002, all independent operators of residential care facilities in health authorities have fully transitioned to provide complex care services.

Risk Management Issues

Quality of care and the health and safety of seniors in residential care is at considerable risk due to inequities and limitations in funding. Increasingly contracted service providers are refusing heavier care clients because

they are at a breaking point and cannot safely accept these referrals without additional staffing.

The shift to complex care has resulted in a significant increase in the acuity level of seniors in residential care. The funding lifts however have not recognized this acuity shift and have often been less than collective agreement increases and less than cost of living increases.

Contracted service providers are now in the untenable position of caring for seniors with insufficient resources to ensure the health and safety of their residents.

Each service provider currently has a signed contractual agreement with their respective Health Authority, although these contracts vary between and among health authorities. However, discussions have been ongoing for some time to try and finalize a standardized contractual agreement that all parties can support and adopt.

Contracts do not specify how facilities will be funded and the Authorities retain the ability to modify the services that are to be provided. These policy changes (eg client care levels, types of clients) can have significant impact on facility operations and there is no contractual obligation on health authorities to make funding adjustments to reflect these changes.

Many health authorities have established direct care staffing targets varying from 2.8 worked hrs/resident/day to 3.24 hrs. There is no consistency however in what facilities are funded and staffed at, with actual staffing varying from 2.1 hrs - 3.2 hours per resident per day. A staffing difference of up to 52% seriously impacts the quality of care provided and potential risks to residents. Service requirements and outcome measures are however the same regardless of funding or staffing shortfalls.

It is recognized that there is a direct relationship between the level of staffing and the quality of care that can be provided. The disparity particularly for the lower staffed facilities puts their resident's health and safety at risk and also threatens the facility's operational sustainability.

Although health authorities have established staffing targets the level of funding does not allow the majority of providers to staff at these levels. For new facilities that participated in the most recent tender calls, a staffing ratio of 2.8 hrs was required and funded. However all other facilities including those that tendered in 2004-2007 operate at a much lower staffing ratio and are required to care for the same complex care clients. As the acuity levels have increased some facilities have been forced to increase staffing levels just to ensure that basic health and safety of residents is protected.

To achieve equity, minimize risk and ensure adequate and appropriate care to residents additional investments in residential care staffing are urgently required.

Under funding independently operated facilities inequitably and in highly varying ranges is troubling because:

1. All residential care facilities are mandated to provide similar levels of complex care. Similar levels of responsibility should receive similar levels of funding.
2. The inequitably high and varying range of under funding indicates that Health Authorities do not have a properly structured and transparent funding system and processes for residential care facilities.
3. The inequitable and varying range of under funding indicates that Health Authorities do not have properly structured risk parameters for residential care facilities. Further, there is no evidence of appropriate risk management policies to govern potential negative impacts that may flow from under funding.

Transparency Results in Improved Outcomes for Seniors

Contracted service providers are funded through a system of "global funding" which is completely at the discretion of each health authority to define and administer. The result has been unexplained differences for operators for similar services and results. Specifically there are unexplained variations in funding and in staffing levels.

For facilities owned and operated by the health authorities, no disclosure is available. There is no mechanism to compare costs/funding of contracted providers with comparable costs and services provided directly by the health authorities. Evidence suggests however that health authority sites receive preferential consideration and higher levels of funding in comparison with contracted service providers. Some health authorities have admitted having higher staffing in their own operations, but simply state they don't have the resources to provide comparable funding to contracted sites even though the same service is to be provided to all clients.

Formal requests for comparative funding and operational information have been made, but health authorities have been unwilling to disclose this information. This information should be openly shared by all stakeholders under a collective goal to deliver the best health care possible to seniors. There appears to be a double standard in the staffing and funding of health authority operated sites versus contracted service providers.

Funding Rates for Complex Care Services

Health authorities have treated funding information as strictly confidential and been unwilling to voluntarily share this information. The rationale for non disclosure appears to be the disparity and unexplained difference in actual per diem and funding rates. The "Fraser Health Residential Contracts and Services Per Diem Rates 2007" document was formally released on August 16, 2007 by legal counsel for Fraser Health in response to a Freedom of Information and Protection of Privacy Request dated July 30, 2007. See Appendix 2.

According to the above-noted document, per diem funding rates for independent residential care facilities providing complex care services ranges from \$115.50 to \$167.28 per resident per day. The only mechanism to access facilities' funding and staffing levels is to file a formal FOI request.

Example of Standardized Model for Funding and Service Delivery

Most health authorities continue to utilize the global funding model for contracted facilities. However Vancouver Island Health Authority has taken steps to create and implement a standard funding and delivery model that applies to their own sites as well as contracted providers. The model is premised on a standardized staffing ratio for direct care services (3.24 hrs/resident/day) together with allocations for support services and accommodation costs. While the model still significantly under funds the housing and support service costs, we support the approach to establish a standardized and consistent approach in staffing for all service providers.

Historically the funding model for residential care facilities was clear. Providers were funded on a model based on acuity mix, wage and benefit costs, capital costs and administrative and supply costs. Differences in funding were then understandable, reflecting differences either in acuity, capital costs, or collective agreement costs.

Establishing a standardized and consistent funding model based on defined policy and operational principles ensures that all facilities are treated fairly and equitably, and similarly that all residents receive appropriate, effective and quality health services.

Examples of Funding Disparities and Preferential Consideration

Opening of Czorny Alzheimer Centre Owned by Fraser Health

On February 2, 2007, Fraser Health opened Czorny Alzheimer Centre, a residential care facility which it owned. The opening of the facility immediately generated significant controversy amongst Residential Care Administrators who attended the opening event.

The Residential Care Administrators were very concerned by the appearance of a double standard in the funding, facility size, admission criteria, and licensing of complex care beds at the facility. The specific concerns that the Residential Care Administrators had were as follows:

1. Per Diem Funding

Fraser Health officials at Czorny indicated at the opening event that the facility was being funded by Fraser Health at approximately \$225 per resident per day. Newspaper reports covering the opening indicated that Fraser Health would provide approximately \$3,000,000 annual operating funding, which would equate to a per diem of \$228 per resident per day.

Needless to say, Residential Care Administrators were shocked and astounded on receiving this information. A per diem rate of \$225 per resident per day for Fraser Health's self-owned facility was highly inconsistent with the per diem rate of \$174 per resident per day that Fraser Health had earlier offered independent operators to build and operate new complex care facilities.

2. Number of Beds

Another major concern that the Residential Care Administrators had with respect to Czorny Alzheimer Centre is the uneconomical and non-optimal size of the facility. Czorny is a 36 bed stand-alone residential care facility.

Fraser Health, in its own policies, has made it very clear that smaller facilities are not economically feasible. In the document titled "Residential Complex Care Building Requirements: Existing Building" issued in December 2007, Fraser Health policy is specified as follows:

"For viability, existing facilities should be a minimum of 75 beds in total (funded &/or private pay). New builds are required to be at least 100 beds." See Appendix 3.

Recently, Requests for Proposals were issued inviting independent operators to bid on building and operating new complex care beds towards the government's New Era Commitment to build 5,000 new beds for seniors care. At the time the RFP was issued, Fraser Health officials were adamant in their direction to potential bidders that it would only accept a minimum size of a 70 bed facility. Attached in Appendix 4 is an excerpt of Request for Proposal #01-2005-06-003, issued by Fraser Health on April 15, 2005, which specifies minimal facility size as 70 complex care beds.

Given its stated policy on a minimum bed size of 70 complex care beds, it was unclear to the Residential Care Administrator Group why Fraser Health had chosen to ignore its own guidelines and build a small 36 bed stand alone facility.

3. Abuse of Process

In 2002, new policy direction was given by the Ministry of Health to recognize complex care as well as assisted living. Considerable effort and resources were expended by the Ministries of Health, Housing, the five regional Health Authorities, as well as BC Housing to develop a public policy framework that supported the provision of funded complex care and assisted living services to fragile residents in BC Effective April 15, 2002, policy 6.B.4 of the Home and Community Care Policy Manual was changed to recognize complex care. See Appendix 1.

The development of public policy was further supported by the promulgation of the *Community Care and Assisted Living Act*, SBC 2002, c.75, as well as the *Community Care and Assisted Living Regulation*, BC Reg. 218/04, as amended by Reg. 6/06.

Given the significant pronouncement of public policy, Residential Care Administrators were very surprised and puzzled to find out that Czorny Alzheimer Centre was not licensed under the *Community Care and Assisted Living Act*. This was especially so since other cottage-style facilities similar in design to that of Czorny Alzheimer Centre, such as Village by the Station and Hillside Village, both of which are operated by the Good Samaritan Society in Penticton and Salmon Arm respectively, have been registered under the *Community Care and Assisted Living Act*.

The Resume of Orders in Council, (Vol.33, No. 25) shows that Ministerial Order 230 designated Czorny Alzheimer Centre as a hospital. A copy of the relevant Ministerial Order is attached in Appendix 5. Residential Care Administrators in Fraser Health were puzzled why Fraser Health had requested the Minister to designate Czorny Alzheimer Centre as a hospital. In the absence of a satisfactory explanation from Fraser Health the implied conclusion is that Czorny Alzheimer Centre was designated as a hospital so that it would not be subject to Fraser Health's own Licensing Department's requirements. The avoidance of the requirement to meet licensing requirements under the *Community Care and Assisted Living Act* by having Czorny Alzheimer Centre designated as a hospital is an egregious abuse of process that warrants further review.

Expression of Concerns by South Fraser [Residential Care] Owners and Administrators Group

Residential Care Administrators were perturbed by the information presented to them at the February 2, 2007 opening of Czorny Alzheimer Centre, and their concerns were tabled at the monthly meeting of the South Fraser Owners & Administrators Group which was held on February 7, 2007. After extensive discussion and review, a letter was issued on February 8, 2007 addressed to the Interim C.E.O. of Fraser Health outlining their concerns. A copy of the letter is attached as Appendix 6.

The Interim CEO responded within a day and by email on February 9, 2007, asked Fraser Health's Executive Director for Geriatric and Residential/Supported Living Services to respond. See Appendix 7. The Executive Director, in turn responded by correspondence dated February 15, 2007. See Appendix 8. The February 15, 2007 correspondence was reviewed by the South Fraser Owners & Administrators Group at its monthly meeting on March 7, 2007. The February 15, 2007 correspondence was unsatisfactory and the Administrators wrote back on March 12, 2007 expressing concern. See Appendix 9. No further explanation has been provided by Fraser Health.

Opening of CareLife Fleetwood Operated by Fraser Health

On March 26, 2008, Fraser Health opened the CareLife Fleetwood residential care facility. See Appendix 11. The facility is operated by Fraser Health under a leaseback arrangement. As per the press release announcing the opening Fraser Health provides annual funding of \$13.3 million or \$232 per resident per day. CareLife Fleetwood has a total of 191 beds of which 157 are funded by Fraser Health. The unoccupied beds will remain closed until they are needed by Fraser Health.

Again the facility opening generated significant controversy amongst Residential Care Administrators in Fraser Health. In response to these concerns, the C.E.O. of BC Care Providers Association wrote on April 21, 2008, to the new C.E.O. of Fraser Health seeking clarification of issues with respect to CareLife Fleetwood. See Appendix 12. BC Care was especially concerned about the inequity in funding where Fraser Health funded its own facilities at \$232 per resident per day when independent operators received funding in the range of \$115.50 to \$167.28 per resident per day. See Appendix 2.

The new CEO of Fraser Health delegated the query to the Interim Vice President, Geriatrics and Community Programs for response. On May 14, 2008, the C.E.O. of BC Care Providers emailed the Interim Vice President to seek a response to his original queries. On May 20, 2008, the Interim Vice President responded as follows:

"The operating budget is not that easy as it is not reflective of total costs. We do not allocate all costs to the residential cost centres or to a residential program. So, for example – social work, food, overhead, security, human resources etc are not easily gathered as they are within an individual department budget not residential. So, residential budgets are not inclusive. I have copied ... regarding your request, as he will be able to validate how difficult it is to get a complete budget for residential."

The response was evasive and it also indicated an unacceptable standard of fiscal probity that exists if actual operational costs cannot be identified. The response further heightened the concerns of Residential Care

Administrators. A copy of the email correspondence between the CEO of BC Care Providers and the Interim Vice President, Geriatrics and Community Programs, Fraser Health, is attached in Appendix 13.

Under funding independently operated facilities in comparison to health authority owned and operated facilities is highly troubling because all residential care facilities are mandated to provide similar levels of complex care. Similar levels of responsibility should be matched by similar levels of funding.

The “Building Capacity for Complex Care Report” Issued by Fraser Health

The inequity in funding between Fraser Health owned facilities and independently operated facilities was formally recognized by Fraser Health in its “Building Capacity for Complex Care Report” issued in March 2005. The report was subtitled “Marking Progress: Moving Forward” and was prepared for the Residential Complex Care Capacity Team and Residential Stakeholders.

On page 3, under the heading “Challenges to Linkage and Communication among and between FH Owned Facilities and Contracted Health Service Providers”, the report states as follows:

“[t]he convergence of mandates between FH and contracted [health service providers] with all expected to provide complex care, and the gradual decrease in resource differences have helped to mitigate the divisions between FH owned facilities and contracted service providers. The [Residential Complex Care Capacity] Team is recognized as a mechanism for formal linkage and collaboration.” See Appendix 14.

Three years after the March 2005 report, independent operators now provide complex care, however instead of a “gradual decrease in resource differences”, we still have funding and staffing inequities in the range of 50%. In the Fraser Health 2007/08 Service Plan it was recognized that the Authority “has been unable to increase our per diem payment to these providers to reflect the increased demand for complex care....The estimated cost to fully bring all Fraser Health Service Providers up to this standard is upwards of \$35 million.” The inequity has exacerbated risk in the residential care sector and a risk management audit is now both essential and necessary.

Expression of Concern by BC Care Providers Association to the Auditor General

On March 6, 2007, the BC Care Providers Association became so concerned about inequitable funding practices among health authorities that a letter was sent to the Auditor General asking for a review of the home and community care sector. A copy of the correspondence is attached in Appendix 10. Amongst other issues, BC Care asked that the Auditor General “re-examine the residential long term care service delivery to explore the issues of accountability, transparency and value for money.

We have recently become aware that one of the projects underway by the Auditor General’s office is “to assess whether the Ministry of Health is effectively carrying out its stewardship role to help ensure the Home and Community Care System has the capacity to meet the needs of British Columbia residents now and in the future.” This report is expected to be completed in July but it is uncertain whether it will address the issues we have identified above.

Maintaining Arms Length Relationships and Avoiding Conflicts of Interest: Lessons from Other Regions

There are some important lessons that can be learnt from other regions. In Alberta, a “long term care facility infrastructure partnership” is defined as:

“a contractual relationship between a Health Authority and private, voluntary, or public sector partner to develop and operate long-term care infrastructure. Under this arrangement the partner will contract with the Health Authority to perform all of the following functions – design, build, finance, own, operate and maintain the long-term care facilities.” (Source: “Health Capital Planning Manual – 3rd Edition, Revised April 2005”, Alberta Health and Wellness.

Hence to ensure fairness in funding across all sites, health authorities in Alberta have created an "internal" arms length relationship between the health authority as a funding agent and the same health authority as the legal owner and operator of its residential care facilities. For example, Capital Health Authority has set up "Capital Care" as a separate legal entity with the mandate to operate all of the health authority owned facilities. The establishment of an internal arms length relationship has closed the funding gap between private, non-profit and publicly owned residential care facilities.

Further review of the Alberta model should be undertaken to determine if it can be used in British Columbia to close the gap here as well. For a discussion of the current funding and operating model in Alberta, see the March 12, 2008 "Long Term Care Industry Review" prepared for the Alberta Continuing Care Association by Deloitte & Touche LLP in Appendix 15.

Performance Audit

In addition to a risk management audit, BC Care Providers is also requesting that a performance audit be carried out.

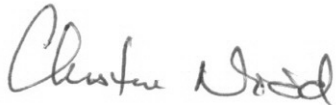
Performance audits, also known as value-for-money audits, examine whether money is being spent wisely by government. Specifically, such audits look at the organizational and program elements of public sector performance and whether the public sector authority is achieving a service that needs doing at a reasonable cost. A performance audit considers whether public sector managers are making the best use of public funds; and are adequately accounting for the prudent and effective management of the resources entrusted to them.

The aim of performance audits is to provide the Legislature with independent assessments about whether government programs are implemented and administered economically, efficiently and effectively. In the case at hand, BC Care Providers is requesting a performance audit because it makes no financial sense for Authorities to own and operate its own facilities at significantly higher cost when there is clear evidence that independent operators provide more efficient service. The public and the objectives of public policy in British Columbia are poorly served by the current practices

Conclusion and Request for Action

For the very extensive reasons canvassed above, BC Care Providers Association formally requests that the Auditor General carry out both risk management and performance audits with respect to health authorities service delivery and funding practices of residential care facilities and explore accountability, transparency and value for money.

Sincerely,



Christine Nidd, MSW, RSW
Board President



Ed Helfrich
Chief Executive Officer

cc All MLAs
Health Authority Board Chairs
Health Authority CEO's
BC Care Providers Association Members
Health Minister George Abbott
Deputy Minister Gordon Macatee
Deputy Auditor General Errol Price