Approaches to Accountability in City of Toronto Long-Term Care Homes

by

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Examining Committee:

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Research Supervisor	Dr. Brenda Gamble
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The above committee determined that the thesis is acceptable in form and content and that a satisfactory knowledge of the field covered by the thesis was demonstrated by the candidate during an oral examination. A signed copy of the Certificate of Approval is available from the School of Graduate and Postdoctoral Studies

Abstract

Approaches to Accountability in City of Toronto Long-Term Care Homes

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Faculty of Health Sciences

Within the context of healthcare accountability are concepts such as quality and safety of care, resource allocation and the notion of value for money. When understanding accountability, questions such as who is accountable for what and how is accountability demonstrated arise. As the number of stakeholders and funders increase, and in a highly regulated long-term care sector, the answers to these questions increase in complexity. The goal of this study is to examine the approaches to accountability within ten homes that are publicly funded and publicly delivered by the City of Toronto, within a framework of accountability mechanisms including financial oversight, regulations and information, and professionalism. A case study research design, with both document review and semi-structured interviews, was utilized to understand the implications of key variables on the framework to evaluate accountability. The results are based on seven informants from publicly funded and delivered homes in the province of Ontario both from senior management and long-term care home administrators. The dominant mechanisms of accountability found in this research are financial oversight, regulations, and information, while professionalism played a marginal role. Key informants identified the challenges of being accountable to multiple funders, including five LHINs and to the City of Toronto. The increased need to be compliant with legislation requirements, LHIN performance indicators, and ensure high-quality resident care is not consistent with the

finite and decreasing resources required to successfully demonstrate accountability to multiple stakeholders.

Key words: Accountability, Long-Term Care Homes, City of Toronto, Regulations

Statement of Originality

I hereby declare that this thesis is, to the best of my knowledge, original, except as acknowledged in the text, and that the material has not been previously submitted either in whole or in part, for a degree at this or any other University.

Acknowledgement

I cannot express in words the gratitude that I have for my thesis supervisor, Dr. Brenda Gamble. There were times when I did not think that I would be able to finish, but your encouraging words, patience, and support have truly been more than I could ever imagine and expect from a supervisor. I am incredibly grateful to have been blessed to work with such an amazing woman. Thank you to my committee members, Dr. Wendy Stanyon and Dr. Toba Bryant, for your thoroughness and suggestions in reviewing my written work.

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Finally, to my team of cheerleaders, I am forever grateful, and I cannot thank you enough for your on-going support and encouragement. My mentor, coach and friend, Nancy, who has provided me with reinforcement and inspiration and has helped shape me to be the person that I have become. My mom, dad, Heather, and Jason, whose praise and uplifting words make all the difference in the world.

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List of Abbreviations

CCAC	Community Care Access Centre
CHC	Community Health Centre
CIHR	Canadian Institutes of Health Research
CIHI	Canadian Institute for Health Information
CMI	Case Mix Index
ECFAA	Excellent Care for All Act
ELDCAP	Elderly Capital Assistance Program
FMB	Financial Management Branch
H-SAA	Hospital Service Accountability Agreement
HQO	Health Quality Ontario
LAPS	Long-Term Care Home Accountability Planning Submission
LHIN	Local Health Integration Networks
L-SAA	Long-Term Care Home Service Accountability Agreement
LTCH	Long-Term Care Home
LTCHA	Long-Term Care Home Act
MFIPPA	Municipal Freedom of Information and Protection of Privacy Act
MIS	Management Information System
MLPA	Ministry LHIN Performance Agreement
MOHLTC	Ministry of Health and Long-Term Care (Ontario)
M-SAA	Multi-Sector Service Accountability Agreement
NPC	Nursing and Personal Care
OA	Other Accommodations

OHIP	Ontario Health Insurance Plan
P4P	Pay for Performance
PHIPA	Personal Health Information Protection Act
PSS	Program and Support Services
QIP	Quality Improvement Plan
RAI	Resident Assessment Instrument
RNAO	Registered Nursing Association of Ontario
RPNAO	Registered Practical Nursing Association of Ontario
RF	Raw Food
RNAO	Registered Nurses Association of Ontario
RPNAO	Registered Practical Nurses Association of Ontario
UOIT	University of Ontario Institute of Technology

Glossary of Terms

Approved Beds

The number of beds that a facility has been approved to operate by the ministry. These cannot be sold to another licensee and are different than licensed beds due to the nature or location of the beds.

Community Care Access Centres (CCACs)

Community Care Access Centres (CCACs) are organizations established by MOHLTC that provide services to the community including admission into LTC homes. They have Case Managers/Placement Coordinators who authorize admissions into LTC homes for both short stay, convalescent care, and long stay admissions.

Home Administrator

The Administrator has overall responsibility for the day-to-day operations of a home.

Home Type

There are various types of operators of LTC homes: charitable organizations, municipalities, corporations, partnerships, and sole proprietors. The Ministry of Health and Long-Term Care funds LTC homes to provide care and services to their residents. Long-term care homes may be either for-profit or non-profit. Charitable and municipal homes are non-profit. Some hospitals in northern communities may also operate LTC beds under the Elderly Capital Assistance program.

Licensee

Is the holder of a licence issued by the Ministry of Health and Long-Term Care, and includes an individual or corporation, the municipality or municipalities, or board of

management that maintains a municipal home, joint home, or First Nations home approved by the ministry.

Licensed Beds

Beds that have been licensed by the ministry to an LTC home to a licensee (includes an individual or corporation, the municipality or municipalities or board of management) and can be sold to another licensee.

Nursing Home

The term nursing home was historically used as a term for a home that provided care to elderly residents. More recently, the term long-term care home has been adopted by the healthcare sector as it was deemed to be more encompassing of the services that were provided.

Section 1 Introduction

Overview of Thesis

The thesis format is based on the criteria of a published article as part of the fulfillment of the master's degree. The article was published in 2014, titled *Accountability in the City of Toronto's 10 Long-Term Care Homes*. This article was published in the peer-reviewed journal of *Healthcare Policy, volume 10, special edition* and has been used with permission of the publisher as part of this thesis. The thesis is divided into six sections:

- Section 1: An introduction that outlines the context of the researcher within the broader-funded study and an overview of the research questions.
- Section 2: A literature review, with emphasis on:
    - Healthcare model, long-term care sector
    - Theoretical framework
    - Policy instruments
    - Independent variables
- Section 3: A discussion section that further details the methodology and research design and study limitations. It will further expand on the findings presented in the published article in Section 4, as well as some additional considerations and how they connect to the theoretical framework.
- Section 4: The manuscript for the completed study in the format for submission to *Healthcare Policy*. The article is titled *Accountability in the .City of Toronto's 10 Long-Term Care Homes,* published 2014 Sep; 10(SP): 99–109.

- Section 5: Summary of the thesis that includes a conclusion, recommendations, and areas for future research.
- Section 6: Appendices which includes informed consent forms and related questionnaires.

Overview of Accountability

The first known use of the word accountability dates to 1770, while the concept of accountability, known as the act of being accountable to someone for something, dates to the 14th century (Business Dictionary, 2017). The transition from personal accountability, responsibility for one's own actions, to organizational accountability is a more difficult concept to define. When organizations are required to show that they are accountable, questions arise as to who are these organizations' accountable to, for what and how do they demonstrate accountability (Deber, 2014).

Currently, Canada faces significant aging of its population as the proportion of seniors increases more rapidly than all other age groups (Government of Canada, 2012). In 2001, one-in-eight Canadians was aged 65 years or over; by 2026, one-in-five Canadians will have reached age 65 (see Figure 1). The necessary supports needed for this aging population will require efforts in improving health; strengthening supportive environments within communities; and sustainability of government programs, such as long-term care homes and programs (Government of Canada, 2012).

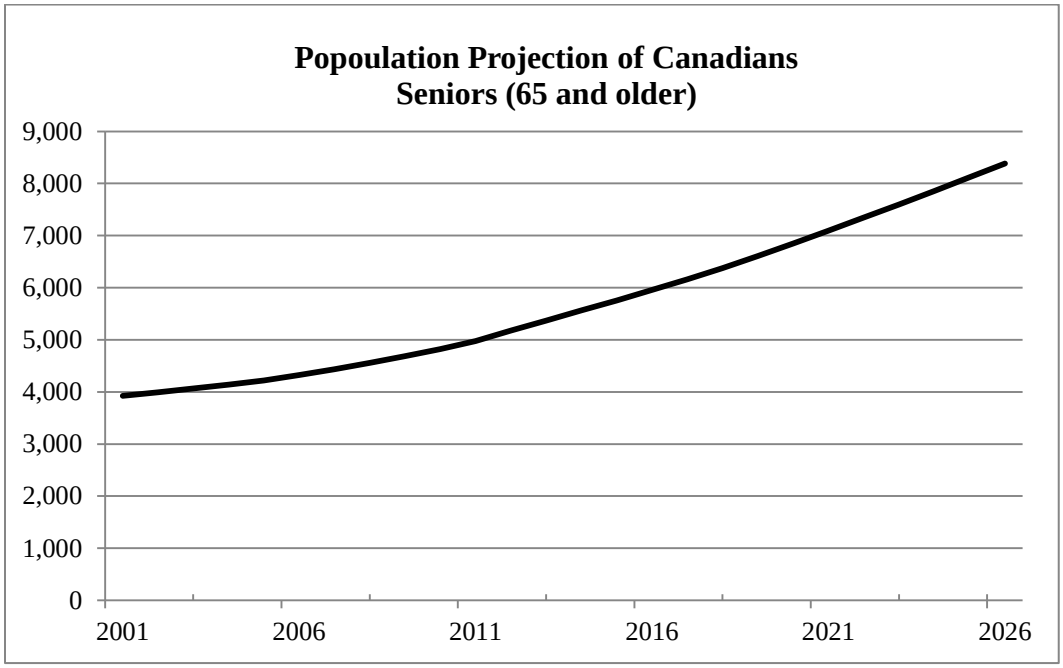


Figure 1. Canadian Senior Population Project (Stats Can, 2016).

The complexity of accountability continues to increase when multiple stakeholders are involved in a complex funding model. Ontario's LTC homes can be categorized into three sub-sectors, based on their ownership structure: private not-for-profit (e.g., religious or lay groups), private for-profit (e.g., individual, private organizations or corporations) and public (e.g., municipal homes) (Berta et al., 2006). This research specifically addresses the publicly funded, publicly delivered long-term care homes (LTCHs) in the City of Toronto.

The literature indicates that while there has been research on the subject of accountability (Fooks & Maslove, 2004; Abelson & Gauvin, 2004; Minkler, 2004), the majority of this work has not been focused on healthcare and especially not on long-term care homes. There are many stakeholders involved in the delivery, regulation, and funding of long-term care homes in Ontario. A layer of complexity is added within the City of Toronto homes, as the City is an additional source of supplemental funding and

accountability. This thesis will examine the role of accountability and address the research questions; (1) What are the approaches to accountability used in LTCHs? and (2) to whom and for what are homes accountable?

This thesis is part of a larger project funded by the Canadian Institute for Health Research (CIHR). The project was Partnership for Health System Improvement on Approaches to Accountability. Within the project, an analytical framework was created and developed to include policy instruments of financial incentives, regulations, information and reliance on professionalism and stewardship. There are various accountability structures that may be competing, crossing many stakeholders and utilizing many different instruments such as regulations, quality of care and financial incentives. Research in this area is essential to understand how accountability is defined and managed, who is responsible for accountability and whether there are any unintended consequences to these multiple layers of accountability. The purpose of the larger study was to determine if in fact there were multiple ways to achieve accountability across the healthcare continuum and whether there were any similarities or differences in these approaches. By utilizing a standard framework it would allow for these comparisons. In addition, this research could help to begin and inform the conversation about best practices in accountability.

Research Questions

This thesis is part of the research completed for the larger study of Partnership for Health System Improvement (PHSI) funded by the Canadian Institute for Health Research (CIHR).). The purpose of this study was to use a standard framework to examine and compare the variety of approaches to accountability across the continuum of

the healthcare system. Eleven sectors were included in this study, such as hospitals, community care access centres, long-term care facilities, the Ministry of Health & Long-Term Care, medical laboratories, etc. (Deber, 2014). The research presented in this thesis is a contributing section within the long-term care sector published in the special edition of *Healthcare Policy* (2014).

This research project included collaborative participation with a larger provincial study, including representatives from key stakeholder groups, other researchers, and research assistants; establishment of the partnerships with key stakeholders; development of the research questions and research design; collection of data; data entry; data analysis; and the authoring of a published paper.

As one of the larger sectors in the continuum of care within the funded project, long-term care was broken into two separate studies: for-profit delivery homes and publically delivered homes. The focus of this thesis is the City of Toronto homes, as they are the largest group of LTCHs that includes both those that are publicly funded and those that are publicly delivered. Another study was completed on those homes that are publicly funded but have a private, for-profit delivery system (Berta, Laporte & Wodchis, 2014).

The City of Toronto currently operates 10 LTCHs that fall within five different LHINs, some of which also encompass areas outside city boundaries. The responsibility for both the operation and management of these 10 homes resides with the City of Toronto's Long-Term Care Homes and Services Division ('the Division') (City of Toronto, 2016).

The goal of this thesis was to

1. Identify and describe the current accountability structures used within long-term care homes;
2. Determine the relationships between structures and organizations and identify the advantages and disadvantages of these; and
3. Examine the contractual agreements and compensation used to formally or informally measure and demonstrate accountability.

Section 2 Literature Review

Overview

This study used multiple sources of information including scholarly, peer reviewed literature, as well as grey literature. Grey literature is defined as documents that are not controlled by commercial publishers, or peer review process. This can include documents produced for academics, government, or business, and are of sufficient quality to be collected and preserved (University of New Mexico Health Sciences Library and Informatics Center, 2018). The grey literature that was used in this thesis includes accountability agreements, manuals, and legislation relating to the long-term care sector. Document review can be useful in studies where data beneficial to the study has already been collected and access to a data set may be more extensive than what they would have independently been able to collect (World Bank Institute Evaluation Group, 2007). The literature review was to identify research and articles related to accountability in the healthcare as well as long-term care sector.

There were three strategies in the literature search. The first strategy was to review the sources identified in the larger CIHR study that have been previously utilized. The second strategy was to use information the researcher was aware of due to previous experience in the long-term care field. The third strategy was using search engines such as Pub Med, Ovid, Medline, and Google Scholar. This search strategy looked at key words such as accountability, regulations, funding, long-term care, nursing homes, and performance standards, alone and in combination. The abstracts were reviewed and screened for relevance and included in a computerized bibliographic database.

The data collection of documents was completed using electronic index searching and articles maintained in an electronic database. The documents were saved on the researcher's computer and identified by a reference system that identified the key areas to support the research questions and theoretical framework of the study. The majority of the literature utilized was from 2006 to the present, with the exception of a number of historical articles that provided context and supported the theoretical framework. The year 2006 has significance as this was the year LHISA, or the Local Health Integration System Act, was created. This legislation created the local healthcare integration networks, or the LHINs, in Ontario. This is noteworthy as this changed the funding source and accountability body for various healthcare sectors in Ontario, such as hospitals, community services, and long-term care homes.

All documents were available via PDF format and readily obtainable. All articles were in the English language as this was the native tongue of the researcher. Articles from Canada, England, New Zealand, Australia, and USA were mostly chosen because these countries have a publicly funded healthcare system or had similar economic status as Canada, thus making it easier to make comparisons (Deber, 2010; Marchildon, 2013).

The grey literature search completed was mostly due to the researcher's previous knowledge of the long-term care home sector and searching various websites. The grey literature or unpublished articles are important as they provide contextual information that may not otherwise be published. There are few scholarly articles on approaches to accountability within the healthcare sectors, and even fewer written for long-term care homes, making the grey literature instrumental in this research. Grey literature and articles were important for this research as the LHINs were in their infancy. The grey

literature provided context within the field of long-term care, relationships (both formal and informal), and also highlighted processes and requirements.

Data collected from documents for analysis included both written documentation and documentation provided by Toronto Long-Term Care Homes and Services Division. The documentation retrieved from websites includes

- Legislation & regulations (e.g., LHISA 2007, Long-Term Care Home Act);
- Historical documents and reports from organizations (e.g., strategic directions, report cards, efficiency review, annual reports), and associations (e.g., OLTCA); and
- Long-Term Care Home Service Accountability Agreements (L-SAA) and supporting documentation (e.g., Long-Term Care Home Accountability Planning Submission, Target Definitions).

Each document was reviewed and analyzed for its contributions in informing the research questions for this study. The literature review was to identify research and articles related to accountability in the healthcare as well as long-term care sector.

Overview of Healthcare Model

Accountability has been a key driver for influencing change in healthcare both in a Canadian and an international context (Canadian Healthcare Association, 2001; Leo and Canadian Healthcare Association, 2006; Marchildon, 2013). But what does this mean? Literature supports ideas around accountability in other sectors, but little research has been completed for the healthcare sector, even though this has been identified as a priority by governments, health service providers, and users of the healthcare system (Deber, 2014; Romanow Inquiry, 2002).

The literature defines accountability in many different ways. In essence, accountability is the notion of having to be answerable to someone for meeting defined objectives (Emanuel and Emanuel 1996). The literature indicates that accountability has financial, performance, and political/democratic implications, (Binkerhoff, 2004) and can be ex ante or ex post (Klein, 1993). Within healthcare, this may translate into fiscal accountability to payers, clinical accountability for quality of care, (Binkerhoff, 2004) and accountability to the public. Those who participate in accountability may include various combinations of providers, patients, payers, and regulators who may have formal or informal relationships (Fooks & Maslove, 2004; Binkerhoff, 2004; Klein, 1993).

In Ontario, long-term care homes are regulated, inspected and have accommodation fees set by the Ministry of Health and Long-Term Care (MOHLTC). To ensure that long-term care homes provide "residents safe, consistent, high-quality, and resident-centred care", there are provincial standards defined in the Long-Term Care Homes Act, 2007, and Ontario Regulation 79/10 ("Find a long-term care home", 2016, p.1). Long-term care provides more support than what can be provided through home and community care, and is less expensive than care provided at an acute hospital level ("This is Long-Term Care", 2015).

Residents of Ontario with valid Ontario healthcare insurance (OHIP) who require 24-hour nursing or personal care and need assistance with all or some activities of daily living are eligible for this residential service. The cost for a resident is standardized based on the type of accommodation requested (basic, semi-private or private room). There is an opportunity to have a rate reduction from the standard cost if a person can demonstrate a lower level of income. The services that are provided to all residents include meals,

housekeeping, social, spiritual, and recreational programs, bed linens and laundry service, and access to medical services and health professionals. Services for additional fees are available and vary depending on the home; such as hair dressing, cable, telephone, massage therapy, etc. ("Find a long-term care home", 2016).

There are 625 licensed homes in Ontario and 77,541 beds available for seniors ("This is Long-Term Care", 2016). LTCHs also provide other services such as convalescent care beds, which provide short-term care to support the transition between a hospitalization and a patient's home. LTCHs also provide respite beds, which support residents for a period of time to allow caregivers and families respite from providing many hours of care for their loved one. The Convalescent Care and Short Stay-Respite programs make up only 1% of all beds available in the province ("Find a long-term care home", 2016).

A unique feature in the LTC sector is the mix of private for-profit homes and not-for-profit homes. As of June 2017, 58% of LTCHs are for-profit, with a mix of sole proprietors and board oversight among publicly traded corporations such as Extendicare, Chartwell Master Care Inc., and Revera Long-Term Care Inc. Another 23% are not-for-profit homes with varying governance structures, principally charities (e.g., The Central Canadian District of The Christian And Missionary Alliance in Canada). The remaining 16% were municipally owned homes (e.g., City of Toronto) and 2% were classified as Other, such as hospitals in northern communities operating under the Elderly Capital Assistance program (ELDCAP) ("This is Long-Term Care", 2016).

Beds in a LTCH are either licensed beds or approved beds. This means that the MOHLTC approves and has a licence for every one of the 77,541 beds available in

Ontario. Any modifications (change in bed type, change of ownership) to a bed require multiple levels of approval ("This is Long-Term Care", 2015).

Overview of Accountability

The accountability phenomenon is a concept that is not easily defined and is very fluid, dependant on the situation, stakeholders and desired outcomes (Mulgan, 2000). To study accountability, a focus on distinction, clarity, and which approaches are most successful is required. Accountability has been defined multiple ways (Mulgan 2000); most simply, it means being answerable to someone for meeting defined objectives (Emanuel and Emanuel 1996).

Accountability in healthcare is considered one of the major issues in the sector (Emanuel & Emanuel,1996) and is a key element of many current healthcare reform efforts, both in Canada and internationally (Canadian Healthcare Association, 2001; Leo and Canadian Healthcare Association, 2006; Ontario Health Coalition, 2012; Marchildon, 2013). The Ministry of Health defines accountability as meeting performance or planning obligations (MOHLTC, 2017). As Brown et al., have identified, "strengthening accountability is central to the recommendations made in all recent studies on the future of healthcare" (2006, p.72.) Yet there is insufficient research about the best practices and a perception that "poorly applied approaches may have unintended negative consequences and severe effects on the health system" (Deber, 2014, p.12). It has been stated "no single model of accountability is appropriate to healthcare," (Emanuel & Emanuel, 1996, p.229), and there is no one-size-fits-all model (Deber, 2014, Marchildon, 2005; Forest, Marchildon & McIntosh, 2004; Flood & Archibald, 2005.)

Accountability in healthcare is stressed by all levels of government and the public with respect to the health outputs produced (e.g., patient outcomes, decreased wait times, cost containment, and quality of care) and from the inputs used (public funds derived from tax revenue, medical services). For accountability to be demonstrated, it requires that all parties know their roles, responsibilities, and performance expectations. Currently some avenues of accountability exist from a governance perspective, such as professional accreditation and monitoring by an appropriate professional association. Another method is the establishment of provincial performance targets that health regions are responsible to meet and are monitored by a public body (the government) (Fooks, Maslove, & Rhetoric, 2004.). This information is disseminated through annual reports produced by health regions to the governing body and the general public, albeit not in a timely manner.

To evaluate the effectiveness of accountability and the impact that is has on the healthcare sector, a standard framework is required. This includes not only the policy that informs accountability, but in a practical sense of how to achieve and demonstrate accountability. Clarification and understanding around the best way to achieve accountability has been identified as a priority by governments, providers, and recipients of healthcare services, both in Canada and internationally (Deber, 2014). The lack of research in this area suggests that demonstrating accountability may have unintended consequences, and the long-term care home sector is no different from other healthcare sectors. In other words, this supports the need for future research into accountability and the role it plays within LTC homes.

In 2010, further legislation supported increased accountability with the Excellent Care for All Act (ECFAA, 2010). This Act outlines the steps the Ontario Government will make to reform healthcare, "[by putting] Ontario patients first by strengthening the healthcare sector's organizational focus and accountability to deliver high quality patient care." ("Excellent Care for All," 2016). This additional legislation requires that health service providers have a legislative requirement to provide and demonstrate quality service to the users of the healthcare system.

In 2006, the Ontario government implemented the regionalization of healthcare services with the introduction of 14 Local Health Integration Networks (LHINs). Each LHIN is responsible for the planning, integration, and funding of health services in its region, including hospitals, community care providers, and long-term care homes ("Ontario LHINS", 2014). As part of this legislation, accountability agreements were put in place to support the funding structure from the Ministry to LHINs and, cascading down, from LHIN to health service providers ("Ontario LHINS", 2014). This structure supports publicly funded hospitals and long-term care homes.

The Long-Term Care Home Service Accountability Agreement (L-SAA) is a legal agreement between the LTCH and the LHIN, required under the Local Health System Integration Act (LHSIA, 2006). The initial L-SAA was executed April 1, 2010, with a term of three years. The second L-SAA was executed April 1, 2013 until March 31, 2016. The current agreement from April 1, 2016 is set to expire March 31, 2019. The body of the agreement is a standard contract common to all LHINs and agreed to by MOHLTC, LHIN Legal Counsel, LTCH Legal Counsel(s), and an L-SAA Steering Committee and Working Group, with representation from LTCH Associations, OHA, LHINS, and

LTCHs. Within the current Long-Term Care Accountability agreement, the initial verbiage outlines:

"The service accountability agreement supports a collaborative relationship between the LHIN and the HSP [long-term care home]: to improve the health of Ontarians through better access to high quality health services; to co-ordinate health care in local health systems, by such actions as supporting the implementation of Health Links to facilitate regional integrated health care service delivery; to manage the health care system at the local level effectively and efficiently; and, to create a health care system that is person-centered, accountable, transparent, and evidence-based " (L-SAA, 2016). Schedules within the agreement serve as appendices that enable customization for individual LHINS and LTCHs. (LAPS Guidelines, 2016).

Although highly relevant to the research questions, much literature has existed within silos, and has not necessarily been applied to issues of accountability and governance/ownership within healthcare. This framework is a common platform created by Raisa Deber (2014), to understand the accountability phenomenon in healthcare and allows for a fluid approach for analysis to address the strengths and weakness of accountability and the effect on performance and/or policy development.

Theoretical Framework

This framework by which this thesis evaluates accountability in publicly funded, publicly delivered long-term care homes is a pre-existing framework designed by the research of a larger study of the Partnership for Health System Improvement (PHSI), funded by the Canadian Institutes of Health Research (CIHR), on approaches to accountability. This framework does not identify specific models of accountability such

as political accountability, economic accountability, or professional accountability, as described by Emanuel and Emanuel (1996), but rather focuses on dimensions of accountability. These dimensions allow for a fluid approach for analysis to address the strengths and weaknesses of accountability and the effect on performance and/or policy development. Much theoretical literature, which, although highly relevant to the research questions, have existed within silos, and have not necessarily been applied to issues of accountability and governance/ownership within healthcare (Howlett &Ramesh, 2003; Brinkerhoff, 2004; Doern & Phidd, 1992; Eliadis, 2007). Deber, the principle investigator with the ground-breaking research, describes this approach as "…several literatures that have not previously, to our knowledge, been used to analyze… various approaches to accountability" (2014, p.13)

This framework (see Figure 2) draws from the political science concept of "policy instruments" or "governing instruments" (Deber, 2014). There are four policy instruments that will be utilized in the evaluation of accountability: regulations, financial incentives, information directed towards patients/payers, and professionalism/stewardship. Within this framework, there were three independent variables examined that were identified based on the research questions. While this is a qualitative study, standard quantitative terminology (such as variable) has been used to identify key concepts and is consistent with previously published articles. The independent variables examined were chosen based on broader research questions. These variables directly or indirectly influence the approaches to accountability and highlight successes and weak points of the policy instruments.

The central hypothesis of this thesis is that these four approaches/instruments will have varying outcomes based on the three variables;

(1) policy goals being pursued, framed as a question of, "What are you accountable for?";

(2) the governance/ownership relationships, framed as a question of "Who is accountable to whom?"; and

(3) the types and characteristics of services being delivered, framed as a question, "How are you demonstrating accountability and what are the impacts?"

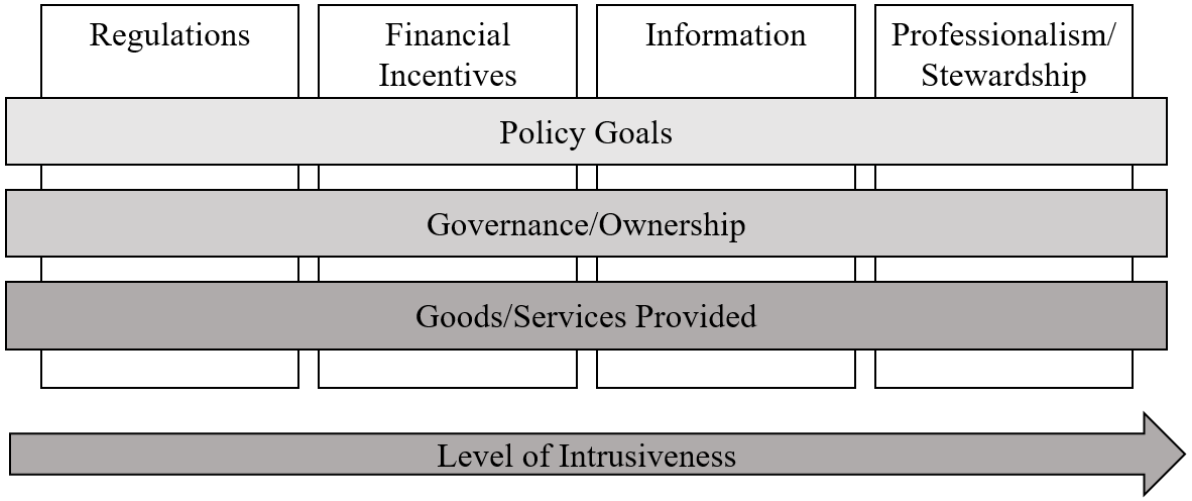


Figure 2. Theoretical Framework.

Policy Instruments

The research goal for this thesis is to identify which of these policy instruments, or approaches to accountability, have been used within the long-term care home sector that is publicly funded and publicly delivered. The policy instruments may be classified in many ways. Doern and Phidd (1992) used a scale based on their level of intrusiveness or extortion (see Figure 3). Beginning with the non-intrusive end of this scale, decision

makers may choose not to act or respond at all. The next step includes symbolic responses, education, or information to encourage people to act in a particular way. Doern and Phidd (1992) term this approach "exhortation." Very simply, this would relate to the concept of a “gold star” for a favorable behaviour/outcome. The next step on the scale is slightly more invasive, where decision-makers may choose to intervene indirectly by using incentives. This could range from voluntary compliance without threats or may include something more formal as ‘expenditures’ and/or ‘taxation’ policies. Still more intrusive are directives or ‘regulations’. This can be seen in many different formats, but the main goal is ‘Thou shalt act/do/behave’ as per the objectives set forth. This level of instrumentation often shifts the compliance costs from regulators to those being regulated (Deber, 2014). The literature also looks at ways of enforcing these steps, from information to licensure/accreditation, payment, and legal sanctions. This has been linked to literature on the new public management (Hood, 2000) and identifies interactions between public and private forces, as well as the implications of the type of policy network for selection of policy instrument (Bressers & O'Toole, 1998). Although these concepts have been applied to the field of environmental regulation, (Jordan et al., 2005; Zito et al., 2003) and in a limited way to healthcare (e.g., the governance of primary care in Switzerland (Braun & Etienne, 2004) and social services, such as child health policy in Australia (Leggat, 2004)) there has yet to be research conducted on applying this methodology to accountability in long-term care homes.

Based on the literature from Hood (2000), who identifies the difference in the public and private dynamics, additional and supplemental research by Berta, Laporte and Wodchis has been conducted on homes that are for-profit and privately delivered care

and services (2014). This suggests that there is a difference in the impact of accountability and what this means for those companies that are publically funded versus privately funded. The four policy instruments/approaches have been selected as they are currently being utilized in the health sector in Canada and internationally (Deber, 2014). The hypothesis is that these four approaches will have varying outcomes based on the three variables as outlined in the previous section.

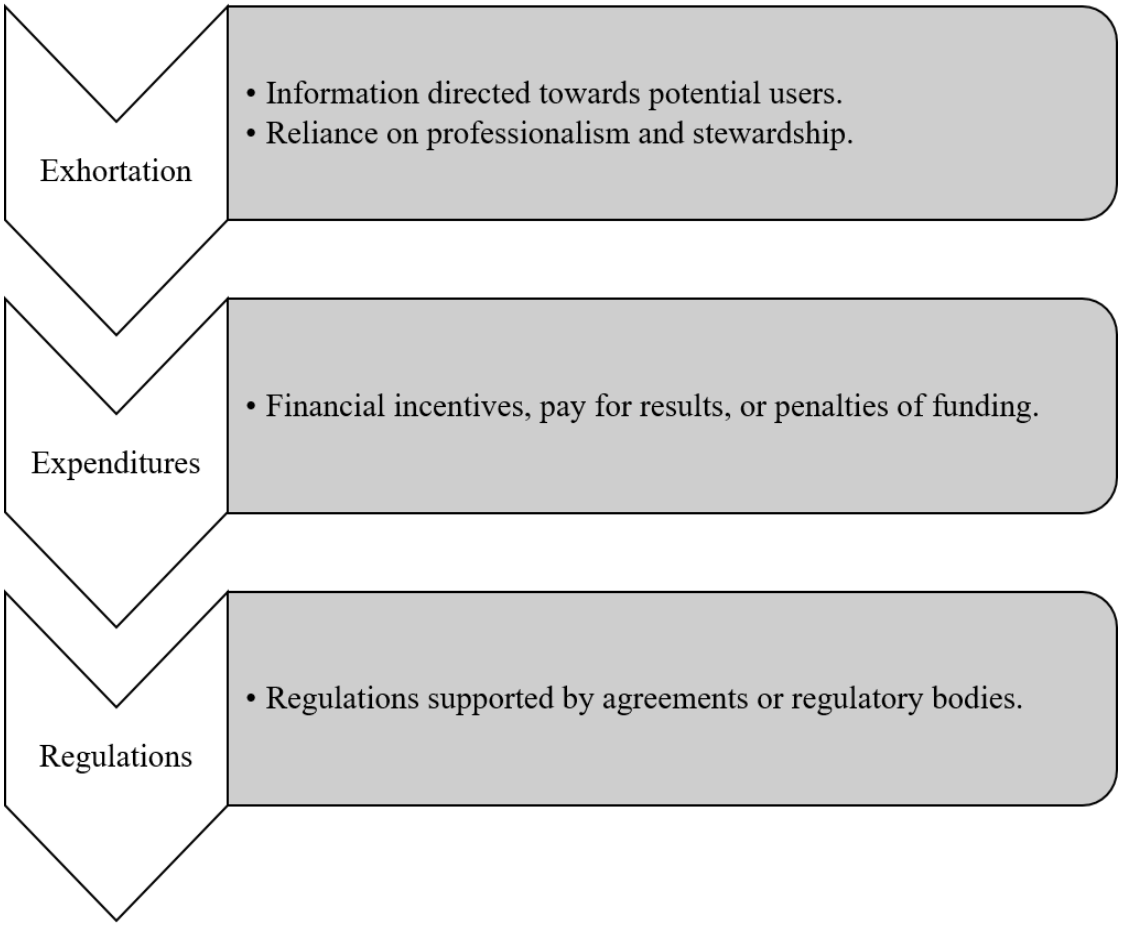


Figure 3. Governing Policy Instruments (Deber, 2014).

Information directed towards patients/payers.

One variation of the exhortation governing instrument is information, which may work both directly and indirectly by directing potential "end users" (residents, public/private payers) within a context of allowing market forces to work more effectively by encouraging rational choice of the 'best' care (Howells, 2005; Morris & Zelmer, 2005). An example of the use of this approach is the ongoing performance measurement and improvement of an organization that is shared or supplied to the end user (Barnsley et al., 2005; Hurst & Jee-Hughes, 2001; Shaw, 2003; Smith, 2002; Veillard et al., 2005). Issues in using this approach include who establishes these measures and which parties enforce them (Baker et al., 2004). This thesis will look at performance management and public reporting, both quality/adverse event indicators, and compliance inspection reports.

Professionalism and stewardship.

The other instrument that is a variant on the exhortation governing instrument directs information to providers rather than to payers or residents and their family (Lemieux-Charles & Champagne, 2004). It relies on high trust and the expectation that providers, as a group, have intentions to do the right thing but may need support in clarifying best practices as well as exposing poor practice. Documents such as best practices or clinical guidelines that inform evidence-based practice often fall within this category if compliance is voluntary. Depending on the indicator and how the information is disseminated, performance reports or scorecards may also fall into this type of approach. It is important to note that this approach is often supported by other regulatory approaches such as professional bodies. There is literature that supports best practice

guidelines for Registered Nurses and Registered Practical Nurses that is supported through their regulatory bodies (RNAO, RPNAO). The challenge with this instrument in long-term care is that almost three-quarters of the work force in long-term care are personal support workers (PSWs) who are unregulated healthcare professionals. PSWs perform the majority of the services and are not regulated by a governing body.

Financial incentives.

This instrument, also known as an expenditure governing instrument, alters payments to entice providers to behave in a certain manner (Donaldson et al., 2005; Evans, 1984; Robinson, 2001). One example of this concept which has been reviewed in detail is the conception of pay for performance which has occurred in the UK, US, Australia and Canada (Epstein, 2007; Pink et al., 2006; Doran et al., 2006; Donaldson et al., 2005). An Ontario example of this is the Pay for Results Program that is used to incentivise hospitals to improve emergency department performance. The premise is based on a ranking system, where the better the hospital performs relative to their peers, the more funding they receive. This is also being used an incentive in the hospital service accountability agreement and has been identified in Ontario's funding formulas for specialized wait times funding and quality-based procedure methodology (Sutherland, 2011; Sutherland et al., 2011).

Regulations.

This governing instrument that employs the regulation concept also plays a major role in healthcare (Walshe, 2003). This requires providers to act or behave in a certain way, or not. These regulations can be supported by agreements or legislation; they may also rely on agency theory and enforcement through a regulatory body, for example, the

Registered Nursing Association of Ontario (RNAO). The literature notes the ongoing challenges of balancing market forces and regulation (Chinitz et al., 1998; Saltman et al., 2002). As 72.6% of the workforce in long-term care is personal support workers (PSWs) and are, to date, are currently unregulated healthcare professionals. PSWs are therefore not registered or licensed to a regulatory body or college ("This is Long-Term care," 2016, Baumann et al., 2014), outlining the challenges with using regulations to support accountability.

Blended approach.

There is also the opportunity to use a blended model of policy instruments. This is apparent when there are additional policy instruments used for reinforcement. An example of this is using a combination of information both designed to be communicated to the consumers as well as to the providers. A publicly reported balanced scorecard that includes best practice indicators, financial performance as identified in a service accountability agreement, and quality indicators is an example of a blended approach. The enforcement of desired policy instruments at the strongest level is backed by government legislation. An example is Norway, which has a 'Patient's Bills of Rights' as a part of its formal appeal mechanism for patients. A relevant example that will be described throughout this thesis is the enforcement of the Long-Term Care Home Act (LTCHA). An example of government policy aimed at enforcing a piece of legislation may include various combinations of exhortation (e.g., efforts to evaluate and improve the quality of information, public reporting), expenditure (e.g., financial penalties, service accountability agreement), and regulation (e.g., audits, compliance process, accreditation, professional self-regulation) (Deber, 2011).

Independent Variables

The second component to the framework for this thesis focuses on three variables:

- Policy goals that are being pursued, such as access, quality, effectiveness, satisfaction;
- Governance/ownership structure, importantly, the variation between public and privately funded structures;
- Goods/services that are being delivered, which can affect the success of the various accountability approaches.

This framework was also designed to adapt to other researchers working across different sub-sectors of the healthcare continuum in a larger study. These sub studies represent different combinations of services and governance/ownership, including hospitals, primary care, long-term care homes and medical laboratories (Deber, 2014). By using a consistent framework across each subsector, it allows for the comparison across subsectors and across jurisdictions to understand the advantages and disadvantages of various approaches to accountability (Deber, 2014). Based on the use of these variables, the larger study was able to examine and evaluate the impact, the similarities and differences in the policy goals, governance/ownership, and the production characteristics of the services they deliver—see special issue *Healthcare Policy, Vol. 10 Special Issue, Approaches to Accountability, 2014.*

Policy goals.

A policy goal may contain both processes and outcomes. Policy goals for healthcare typically include a combination of access, quality, safety, better value for money (cost effectiveness), and satisfaction (Deber, 2012). The Institute for Healthcare Improvement

(IHI) focuses on quality, cost, and value. They work with healthcare organizations to move "from 'volume to value' to ensure that cost reduction or optimization is driven by improvements in clinical and operational quality" ("Quality, Cost, and Value", 2015). More often than not, these policy goals are in conflict. For example, hospitals that are increasing efficiencies and are able to provide service to more patients, or provide more procedures more effectively are also faced with funding caps, or increasing market share while being measured against quality indicators such as wait times and readmission rates. Ideally, there should be congruence between the policy goals being sought and what the organization is being held accountable for, but often there are perverse and opposing incentives (Deber, 2012).

Governance and ownership.

The governance and ownership structures in place also vary across jurisdictions and across subsectors; they affect who is accountable for what and to whom (Denis, 2004; Jordan et al., 2005; Van Kersbergen & Van Waarden, 2004). For-profit organizations are required to return the maximum amount of profits to shareholders, while non-profit organizations are required to spend allocated resources, and demonstrate their fiduciary responsibility, typically to the tax-paying public. The challenge for most Ontario healthcare organizations is that allocations from the LHINs that are not spent within a fiscal year (with the exceptions of hospitals and occasionally by exception CCACs) are required to be returned. This incentive may affect the services they choose to provide and the populations they choose to serve. For those organizations that are responsible to more than one funder, this can add a layer of complexity (Rhodes, 1997). There is literature that suggests a relationship between governance/ownership and the ability to achieve and

monitor goals such as quality improvement can exist (Baker et al., 2006; Thomas, 2006). A helpful resource is the framework developed by Denis and colleagues (2005) for Accreditation Canada, which identifies three governance models: agency, stakeholder, and stewardship.

Characteristics of goods and services.

The final variable is the characteristics of the goods and services being delivered. According to the literature, it is important to examine the characteristics of goods and services as they relate to contestability, measurability and complexity (Vining & Globerman, 1999; Preker et al., 2000; Deber, 2004; Rico & Puig-Junoy, 2002, Debra, 2014). Preker and Harding (2000) define contestability as goods/services with low barriers to enter or exit the market, versus non-contestable goods/services that have high barriers and asset specificity. This describes the goods or services and whether or not the transactions within the market have higher value than if these goods or services were stand alone or used for another purpose. The measurability of goods/services relates to how well a service can be measured based on the process, inputs, outputs, and outcomes (Deber, 2014). Monitoring performance is easy when measurability is considered high. For example, the measurability of a clinician's performance is low, as it is difficult to determine precise outcomes when there are many factors involved. The final component is complexity, which does not rely on the difficulty or intricacy of a good or service. Rather, the question to ask is, does this good or service require coordination with other providers or is it a stand-alone service (Deber, 2004, 2014). The coordination of providers further blurs the lines of accountability and increases complexities when multiple providers are required to provide the services. Another term used to describe this

same concept is “embeddedness”. Many of the services provided in healthcare gain their value by being embedded within a larger system, an example being contracted out services within a healthcare setting, which appears seamless to the end user.

Section 3 Discussion

Overview

This section of the thesis aims to supplement and provide more detail that supports the published article in Section 4. An overview of the qualitative research design and subsequent design limitations are discussed, followed by the study limitations and a brief summary of the totality of the findings as it relates to the theoretical framework identified in Section 2.

Research Design Overview

Within in the qualitative paradigm, the research design for this thesis was a case study methodology. This approach allows an empirical inquiry that investigates a contemporary phenomenon with real-life context, especially when the boundaries of this phenomenon and context are not clear (Yin, 2009). This approach allows the researcher to achieve a greater understanding for complex concepts, such as accountability, for which little information exists in healthcare, and even less for the long-term care sector (Debra, 2012, 2014; Wyers et al., 2014).

A benefit of a case study approach is it relies on multiple sources of evidence, and benefits from prior development of theoretical approaches to guide data collection and analysis (Yin, 2009, 2016). This study is based on the theoretical framework as identified and designed by the larger CIHR study of Approaches to Accountability (Deber, 2014). The current research uses this framework to identify the advantages and disadvantages of the mechanisms used for accountability in long-term care, and why and how certain approaches to accountability are utilized, while others are not.

A case study design is the ability to incorporate data from a variety of sources including observations, documents, artefacts, and interviews, (Merriam, 1998, Yin, 2016). The design of this study includes semi-structured interviews as well as document review of both the peer-reviewed and grey literatures. This approach is helpful due to the limited research and information available on accountability mechanisms used within the long-term care sector.

In addition, a case study approach is also useful in obtaining specific information about the human side of an issue, including behaviours and beliefs (Mack et al., 2005). Utilizing semi-structured interviews with stakeholders enables the researcher to develop a comprehensive understanding of accountability structures and relationships among those structures. In-depth interviews are optimal for collecting data on individuals' personal perspectives, histories and experiences (Mack et al., 2005). The premise of a semi-structured interview is for the researcher to guide the informant while keeping it open enough to allow the researcher to probe areas of interest and allow the informant to come to their own conclusions (Esterberg, 2002). This design allows for an introduction to each topic area, specific and open-ended questions, and summary questions, through a staged approach (Bowling & Ebrahim, 2007). The benefit is that the researcher can probe and ask additional questions and uncover their framework of meaning (Britten, 1995). This is of value in this particular study as it enables the researcher to explore concepts that may have not been known at the time of the designing of the research questions based on the limited research available in this area of study.

Ethical Considerations

An ethics proposal was submitted to the UOIT Research Ethics Board in December of 2010 and the study received ethics approval from UOIT on April 13, 2011 (see Appendix C). Ethical approval was also required from the City of Toronto Long-Term Care Homes and Services prior to the collection of data. The ethics proposal was submitted March 2012 and approved by the Ethics and Research Committee on July 19, 2012 (see Appendix D).

In this research, confidentiality was an important aspect of the research design to ensure participation and to reduce possible risk to the informants. Anonymity of participants was established within the terms of the Consent Form signed by both the investigator and each participant, and by reporting the results (other than those in the public domain) in a manner that does not identify any informant.

Sampling Methodology

The sample method used in this research was snowball, or chain referral sampling. With this method, participants that the researcher has contacted use their social networks to refer the researcher to other people who could contribute to the study (Mack, Woodsong, Macqueen, Guest, & Namey, 2005).

In this study, the initial contact was made with the General Manager, City of Toronto Long-Term Care Homes and Services. The sample included Directors and Administrators within the City of Toronto, Long-Term Care Homes and Services. A list of Long-Term Care Home Administrators was provided by the General Manager, which was then utilized to recruit additional informants. After receipt of the mailing list from the Manager, an email was sent as an introduction and for the purpose of requesting an

interview (see Appendix E) with an attached consent form (see Appendix F). There were 14 individuals contacted. One individual retired while the interview process was underway, and was not replaced, and another individual was on sick leave. Of the 12 available informants, seven individuals consented to be interviewed, three from senior leadership and four LTC home Administrators,

Data Collection

Data was collected though semi-structured interviews and document review. Semi-structured interviews were conducted with key informants within the City of Toronto Long-Term Care Homes and Services division.

Data collection occurred in two different formats, in-person interviews and telephone interviews. The different format was chosen based on geographic location and time constraints of the researcher and informants. Telephone interviews have equal accuracy rates as face-to-face interviews (Bowling & Ebrahim, 2007). The interviews ranged from one to two hours. There was no incentive offered to informants participating in this study. The data obtained during the interviews were collected by a digital recording device, as well as hand-written notes by the researcher. It was imperative to the researcher that there were no consequences intended or otherwise in order for informants to speak freely and to ensure the anonymity of their responses, as this could potential impact funding or employment.

The interview guide was created in collaboration with other members of the research team as part of the larger study and was provided to the researcher (see Appendix G). The guide was established by and the researcher was able to provide some clarification and

wordsmithing of the questions prior to being finalized for the two research projects on long-term care as part of the larger study. The guide was based on themes and questions that were identified based on the literature review conducted as part of the larger research grant and utilized by the research partners who were completing the similar study with privately delivered long-term care homes (Berta, Laporte & Woodchis, 2014). The rationale for having a consistent interview guide was to allow for the various sub-studies to be able to compare and contrast commonalities and differences across sub-sectors across the healthcare continuum with the application of the same conceptual framework- see special issue *Healthcare Policy, Vol. 10 Special Issue, Approaches to Accountability, 2014.* The intention of this thesis and research was not to compare and contrast across subsectors, but rather to identify what approaches to accountability are used in publically funded publically delivered long-term care homes.

Data Analysis

In a case study design, data analysis requires key phases to be completed, such as organization of data, coding, creating themes, and patterns, and then synthesizing the data and utilizing literature to explain findings. The interviews were transcribed using voice audio device and reviewed to ensure that nothing was missed. A coding system used was then created for each interview and used throughout the transcription when individuals were mentioned; for example, M1 for a specific manager.

The transcriptions were coded using themes of the policy instruments and independent variables as outlined in the theoretical framework. Additional themes also emerged while coding, and the researcher combined like themes and categories together

such as unintended consequences of accountability, resourcing, contracted-out services, and the impact of LHINs.

Design Limitations

In qualitative research, one must demonstrate that a level of rigour has been completed in order to defend the quality of the qualitative research process. Polit & Beck (2011) outline five key areas that support rigour for the research paradigm. This next section will review each of the areas and then describe how the research design addresses these areas. Figure 4 provides an overview.

Figure 4: Qualitative Approach to Rigour (Polit & Beck, 2011).

Table 1

Qualitative Approach to Rigour (Polit & Beck, 2011).

Qualitative Area	How is This Demonstrated?
Credibility	• Triangulation • Peer Debriefing
Dependability & Confirmability	• Utilized anonymity to reduce reflexivity • Peer review • Triangulation
Transferability & Authenticity	• Stakeholder engagement • Peer review • Triangulation

The first area in the research paradigm is credibility, which is defined as the value and believability of the findings (Polit & Beck, 2011). Dependability is often compared to the concept of reliability in quantitative research. It refers to how stable the data are

(Rolfe, 2006). Confirmability is the neutrality and accuracy of the data and is closely linked with dependability as the processes for establishing both are similar.

Transferability "refers to whether particular findings can be transferred to another similar context or situation, while still preserving the meanings and inferences from the completed study" (Leininger, 1994). Authenticity "that both the conduct and evaluation of research are genuine and credible not only in terms of participants' lived experiences but also with respect to the wider political and social implications of research" (Polit and Beck, 2011). The methods utilized to provide rigour in this qualitative research include triangulation, reflexivity, peer review, and debriefing and stakeholder engagement. Triangulation was a method utilized in this study to ensure accuracy of the data collected and to validate interpretations and meanings. Triangulation is defined as using multiple data collection methods in order to provide sureness in the interpretation of the results from the data analysis (Yin, 2003; 2016). In this study, document review (legislation, regulations, and agreements) and informant interviews were used to illustrate "converging lines in inquiry" (Yin, 2003, p.73).

In order to demonstrate reflexivity, anonymity was used. Due to the reporting relationships between the senior leadership at the City and the Administrators of the home, all identifying or potentially identifying data was removed prior to publishing. This was identified to reduce any reflexivity from the participants. Reflectivity is when the participant tells the researcher what they want to hear (Yin, 2009, 2016). This was important in this research because of the potential conflicts or perceived conflicts of discussing accountability structures with current funders and employment status. For example, negative conations against funders may impact future funding results.

To ensure reliability, one transcript in NVivo11 was coded by another person who was familiar with accountability and long-term care. The volunteer was given a briefing on the nature of the study and was provided the initial article on which the study was based and was asked to code one of the interviews with the pre-determined themes. The result from the coding comparison resulted in an 87% agreement with that of the researcher. This step reduced the chance of researcher bias and provided credibility of the coding process (Richards, 2005).

Peer review and debriefing occurred throughout the process of analysis; this included checking the findings and themes against various stakeholders within the study including other researchers and partners, meetings to discuss the findings, and sharing writing for comments and feedback.

The stakeholder engagement in the accountability process included collaborative participation (with a larger provincial study, including representatives from key stakeholder groups, other researchers, and research assistants), the establishment of partnerships with key stakeholders, development of the research questions and research design, collection of data, data entry, data analysis, and the authoring of a published paper.

Study Limitations

The research study used a case study design, with the collection of data through semi-structured interviews and document review. The following section describes limitations that were experienced by the researcher.

The researcher's bias was declared at the onset, as the researcher had previous work experience prior to conducting the research with a LHIN, and participated in the

administration of accountability agreements within the long term care homes. This helped with credibility of the research, but also emphasized the importance of rigour, and the control for rigour in the research design, in order to minimize investigator bias and to maximize the accuracy and validity of the interpretation (Yin, 2003, 2016). Control for researcher bias did not interfere with or alter their perception of the data and any insights offered (Creswell, 2014).

Access to key informants was initially obtained through one senior team member who was able to provide the contact details of the potential informants from City of Toronto's head office and all ten homes. The researcher made initial individual contact with each identified individual, during which very few participants (only one) volunteered for the study. A second request was made to all individuals, but this was done through senior leadership after they had participated in the study. While the senior leadership did not know who had volunteered for the study, there was the potential that respondents may have learned about the study prior to their official interview.

The sample size of the qualitative portion of this study was small (n = 7). This could affect the diversity and variability in responses. However, there was a fair split of those informants from the senior leadership team (n = 3) compared to those who were administrators (n = 4). Three attempts were made to increase the sample size; although there was only a 58% response rate, this may not have captured all the views of the administrators who are employed with the City of Toronto Long-Term Care Homes and Services. Data saturation was achieved as the researcher did not generate any new data after the 7^{th} interview (Guest, Bunce, & Johnson, 2006). In other words, data saturation

occurred when interviews were not revealing any new information, but instead, repeated what was already captured by previous respondents.

In semi-structured interviews, a guideline of interview questions was utilized (see Appendix G). This guideline was provided to the researcher and was not modified. One of the modifications to the questionnaire would have been to ask the informants what was their own definition of accountability and compare and contrast to those definitions provided in the literature.

In addition to study limitations, study delimitations can also been identified by the researcher. Study delimitations refer to those limitations that can be controlled by the researcher (Simon, 2011). The theoretical framework, policy instruments and the variables selected are just one approach in reviewing accountability. As well the sampling methodology and informant selection also has a boundary or limit on what findings that can be ascertained by the researcher.

Summary of Results

In addition to the results in the published article, the following section details some additional findings and identifies the linkages with the theoretical framework.

Ontario ranks among the lowest of the Canadian provinces as it relates to long-term care funding. Spending for this sector has increased 1% per year since 2011, while total healthcare spending has increase by 4.8% in the same time period ("2017 OLTCA Budget Submission", 2016). In 2016, 4.07 billion dollars was allocated to long-term care, 7.9% of the overall health budget ("About long-term care in Ontario, 2018). In multiple publications, the need for increased funding has been lobbied, as the care needs of residents are becoming more complex, requiring additional resources, training, and

equipment. Individuals pay a portion of these services, unlike other healthcare costs such as surgical procedures, which are covered 100%.

Regulations.

This policy instrument exercises the regulation concept which acts as a rule book for providers to act and behave in a certain way. All key informants in this study acknowledged that regulation was the main approach to achieving accountability in the long-term care sector.

The major underpinning and reform of long-term care homes was generated by the passing of the *Long-Term Care Home Act*, 2007 (LTCHA), commonly referred to as "the Act". The Act, that was effective July 2010, replaced three discreet acts that governed Ontario's different models of LTCH's; *The Nursing Home Act* (this was for-profit homes), the *Charitable Institution Act* (non-for-profit homes) and the *Homes for the Aged and Rest Homes Act* (municipal homes, including the 10 homes run by the City of Toronto) (Berta et al., 2014). MOHLTC's LTCH Compliance Management Program was redesigned to align with the LTCHA. The Long-Term Care Home Quality Inspection Program ensures that LTCHs are meeting the criteria and standards that are identified in the MOHLTC policy and licensing agreements, as well as conditions within the L-SAA (Berta et al., 2014).

Some informants stated it was difficult to meet all the requirements of the Act and its regulations. The Act and regulations have over 440 requirements for each home to meet. The Compliance Management Program was redesigned to support the enforcement of these requirements. If a home is found non-compliant with the requirements, the Ministry may complete the work in order to make a home compliant by withholding

funding or ordering the LHIN to withhold funding (LTCHA, s. 154(4)). The Ministry may also penalize homes for non-compliance with an amount not to exceed $50 per bed, per day (LTCHA, s. 155).

Another organization that key informants described as being involved in the regulation of the long-term care sector was Accreditation Canada. While all Ontario LTCHs must be licensed through MOHLTC, most voluntarily seek accreditation through Accreditation Canada, a non-governmental entity that evaluates nursing homes and assists them in meeting regulations and compliance (see also Mitchell et al. 2014). While accreditation is a voluntary process, one LHIN has made this a mandatory reporting performance requirement within the L-SAA,

Although the ECFAA regulation was not applicable to long-term care homes at the time of the interviews, the *Excellent Care for All Act, 2010 (ECFAA)* is also an important piece of legislation to ensure "high quality, integrated care for all patients, clients and residents [as the] the goal of everyone involved in delivering healthcare in Ontario" (Quality Improvement Plan (QIP) Guidance Document for Ontario's Healthcare Organizations., 2014, p.3). ECFAA requires healthcare facilities (hospitals, CCAC, CHCs, and LTCHs), to develop and post annual quality improvement plans (QIPs). In addition, hospitals are also required to implement patient and employee satisfaction surveys, link executive compensation to achievement of QIP indicators, and create a quality committee that reports to the Board of Directors (MOHLTC, 2015). At the time of this study, these requirements were not required for long-term care homes, but they could possibly be required in the future.

Financial incentives.

Financial incentives are defined in the literature as a concept that rewards performance, behaviours, or actions that would not otherwise occur with monetary rewards (Woodchis, 2004). Currently, there are no financial incentives or rewards within the long-term care sector, unlike the hospital sector emergency department Pay-for Results initiative, (MOHLTC, 2015). There is the requirement to maintain a balanced budget within LTCHs and there may in fact be financial ramifications if this requirement is not met. All informants agreed that they were required to create budgets and stay within the financial resources as allocated by the LHINs and any additional resources from the City of Toronto.

Some key informants from the interviews spoke to what they consider to be a deficiency in the complex funding formula; the funding allocation is not timely and unable to adapt to the changing needs of a home. To support the complex funding formula, full-scale implementation of the RAI-MDS in Ontario's LTCHs began in 2010. RAI-MDS provides a comprehensive functional and clinical assessment of residents and is intended for use in resident-care planning and evidence-based decision-making. Informants acknowledged the benefits of having additional funding through the City of Toronto and identified this helps reduce the financial burden placed on homes. The additional resources from the City of Toronto, as well as the ability to move funds among the 10 homes, supports financial pressures and emergencies such as repairs or capital purchases based on regulations or the LTCHA standards.

Information.

The literature review identified that in healthcare settings, information was best disseminated through reports such as balanced scorecards or report cards (Howells, 2005; Morris & Zelmer 2005). This study showed that information sharing is only a portion of how the long-term care sector achieves accountability. The challenge is that there are limited meaningful reports available. Key informants believed the challenges with public reporting are the indicator selection and how they directly support quality and accountability. For example there are many different ways to addressed quality of care for residents, but only one indicators has been selected (pressure ulcers). As stated by the informants, there may be other indicators that support quality of care and accountability.

Performance expectations are publicly available from the L-SAA, which is mandated to be publicly available online as well as visible in all homes. In order to report on some of the provincially mandated indicators, Health Quality Ontario's (HQO) public reporting portal is utilized. HQO maintains its own LTCH public reporting website which provides performance data for each LTCH in Ontario. These indicators are reported or each home as well as how homes are doing relative to provincial averages for falls, incontinence, pressure ulcers, and restraint use. A view that was seen by many informants was the additional requirements needed to be put in place and no additional resources to meet the demand for public reporting. Informants also indicated the need for standard definitions of these indicators and how they relate to overall patient care if they are truly to be used to assess quality in a comparative nature.

Professionalism and stewardship.

The role of professionalism is far less emphasized in long-term care as compared to other healthcare sectors. This study showed the role of professionalism and stewardship is not utilized in the long-term care sector to achieve accountability. This is largely due to the low involvement of professional staff, those who are considered a regulated health professional, accountable to an association (i.e. RNs), in the delivery of care for the residents. Most of the direct resident care (~80%) is delivered by unregulated workers: healthcare aides (HCAs) and personal support workers (PSWs) (Berta, 2013). There is minimal physician oversight, with managerial and clinical roles carried out predominantly by registered nurses (RNs) and registered practical nurses (RPNs) (Berta, Laporte & Woodchis, 2014). For these professionals, there are best practice documents and guidelines supported through their regulatory associations (RNAO, RPNAO). These associations allow for tracking, monitoring, and licencing of RNs and RPNs, and ensure nursing competencies as set out by their governing bodies.

While professionalism as traditionally constructed may play less of a role in LTC, there may be a future for unions to play a role in ensuring standards of care. Currently there are 90,000 PSWs that provide support to long-term care homes, hospitals, and community programs in Ontario (OLTCA, 2017). The Canadian Union of Public Employees represents 24,000 workers, and the Canadian Auto Workers Union represents 16,000 workers in Ontario's LTC sectors (Berta, Laporte & Wodchis, 2014).

Blended approach of regulation and information.

One of the findings outside of the framework was the concept of a blended approach of two policy instruments, a concept when one instrument is used to enforce another. This

approach combines the compliance program that enforces the regulations through the use of publicly reported findings and inspection reports. Informants expressed discomfort with the education surrounding public reporting in the compliance program, stating the general public will just see "non-compliant" and will have little context to what this means for a home.

One of the key features of the Compliance Management Program is transparency. This is achieved by having the inspection documentation and protocols available to homes, so they know what to expect and can incorporate these into their own education or quality improvement programs. In addition, copies of the public version of inspection reports detailing all findings of non-compliance must be publicly posted in LTC Homes, publicly posted on the Ministry's website and provided to Residents' and Family Councils (MOHLTC, 2015). When reviewing these reports online, there is a glossary of terms used for each report that is posted. There is not an overall rating for each home that identifies a severity scale or summary of the issues or orders without reviewing every report individually. The language for the general public who are not familiar with long-term care or the regulations and the Act may find this difficult to comprehend, supporting the informant's ideas around misinterpretation of results.

Independent variables.

This section will examine the views of the key informants on the independent variables and will strive to determine the relationships between structures and organizations and identify the advantages and disadvantages.

Policy goals.

The policy goals for long-term care are consistent with other sectors where there is a dichotomy between quality initiatives and regulations, and the limited funding to achieve these goals. There are minimal increases to funding allocations annually, yet the cost of doing business continues to increase and the pressure to provide value for money and a quality service continues to rise.

In the LTC sector, the balance of fulfilling the Act and associated regulations, with capped funding and increasing acuity and complexity of residents, is a daily struggle. Decisions are made to meet the needs of the residents, and provide high quality care while balancing financial indicators, such as a balanced budget, sick and overtime benchmarks and the increasing pressures of publicly reported quality and compliance indicators. For example, the indicator 'percent of residents who were physically restrained' is reported annually by Health Quality Ontario, as well as an indicator identified in the L-SAA. There are many facets in which a home will need to address to ensure this indicator is favourable. The education for staff on how and when to use a restraint needs to be in place, costing additional training dollars. The staffing ratios may also play a role into the use of restraints, as well as activities and programing for the residents. This is an example where additional resources are required, potentially making the financial indicators unfavorable while ensuring the publicly reported indicators are favorable.

Governance and ownership.

This section discusses the multiple governance/ownership structures and relationships that are in place within this sector. An important finding in this thesis is that ownership is

one variable in which different approaches to accountability were identified. The findings from the interview data demonstrated that key informants all identified the same three bodies to which they were accountable: The City of Toronto, the LHINs, and the residents of the homes. But, these varied based on what they were accountable for doing. There was also a varying degree of accountability identified as arms-length providers, e.g., the tax payer who provides funding to the City of Toronto or the Ministry of Health (whose funds originate from the tax payer) whom provides funding to the LHINs. All respondents stated that multiple lines of accountability made it difficult to be accountable. For example, one respondent stated, "we have many masters". This is another important finding because the literature suggests when evaluating accountability, one size does not fit all and there is a need to define accountability for what and to whom (Deber, 2012).

The LTC sector is accountable to many different bodies. The major funder is the Local Health Integration Network (LHINs) and, depending on the type of home, there is a Board of Directors or Head office to which the homes would also be accountable. Accountability to the Ministry of Health and Long-Term Care involves a few branches within the ministry: (Compliance, Financial Management Branch) -- and ultimately tax payers and communities in which the homes provide services to their residents.

The City of Toronto Long-Term Care Homes have a second layer of accountability, as their funding is supplemented by the City of Toronto and the tax payers who contribute to this additional funding allocation. The homes are required to comply with City of Toronto policies and procedures, in addition to the Act and regulations set out by the LHINs and MOHLTC.

Several key informants also identified other organizations and bodies to whom they were accountable. These include family members of residents, staff, Health Quality Ontario, regulatory bodies, students and volunteers, and Accreditation Canada.

It was identified in this study that there was no one body or organization that the long-term care sector was chiefly accountable to. When asked to respond to the question, "to whom are you chiefly accountable to?", the response varied across depending on what the homes were accountable for. All respondents identified they were accountable for the financial resources both from the LHINs and the City of Toronto. All respondents spoke to the importance of maintaining a balanced budget and to demonstrate fiscal responsibility of tax payers' dollars. Informants described that they were ultimately accountable to the resident with respect to quality of care and safety. This was identified by respondents in ensuring that all the regulations in the Act are met. One informant identified that the use of compliance reporting and quality performance indicators were used to gauge how well these policy goals were being achieved. Two examples of performance indicators that can speak to quality of resident care are rate of pressure ulcers and falls.

Characteristics of goods and services.

All informants described the process "very difficult to near impossible" to no longer be in the business of providing long-term care homes for residents of Toronto. The services that long-term care homes provide is residential 24-hour nursing and support services. Based on the regulations of approved or licensed beds, the MOHLTC must approve any changes to ownership of the beds. In addition, approval from the LHINS is also required as per the L-SAA. Based on these factors, and data analysis, an important

finding is that the services that the City of Toronto LTC homes provide are non-contestable., meaning removing themselves from the market is extremely difficult and requires multiple approvals.

The other characteristic to review within this is the measurability of the services provided. Key informants provided some important findings regarding the measurability of this sector. In addition to the public reporting, respondents commented on the informal reporting through resident and family councils, as well as corporate scorecards and data collection within the Division. All LTCHs are very measurable, as there are many ways to assess long-term care services, including resident and staff satisfaction, compliance orders and reports, financial reporting, quality indicators such as pressure ulcers and falls.

The final component is the assessment of complexity of the services, which relates to the coordination of services provided. The complexity lies with the process of applying, and selecting a long-term care home, that may have extensive wait lists for any one particular home. Once a resident has been placed in a home based on their choices and facilitated through the Community Care Access Centre, there is minimal coordination required as compared to other components of the healthcare system (i.e. hospital or community services). There are processes in place to provide the daily support to the residents which include nursing care, activation and meal services. This is standard practice in Ontario and is true for both private and publicly run homes.

All key informants were asked to comment on contracted out services. An important finding in this study is that all informants acknowledged that some services within long-term care should be contracted out. These services included difficult to recruit positions with specialized skills that could be leveraged across many different homes, such as

music therapy, art therapy and spiritual care coordinators. Some key informants identified the benefits of having third party service contracts for physiotherapy and occupational therapists. This suggests lower costs and reduced human resource efforts in recruitment and performance management. On more than one occasion, when asked if there were services you would never contract out, the response was "never, say never", but all respondents suggested that personal nursing care would not be beneficial to contract out.

An important finding in this study based on document review and qualitative analysis is that long-term care sector is non-contestable and has a high degree of measurability and complexity. While the complexity within a long-term care home can vary depending on the services contracted out, there is much more value in having the embeddedness within the continuum of care when residents are selecting and transitioning into a long-term care home from a variety of settings- home, retirement home, or hospital.

Summary

Accountability within healthcare has been identified as an area of interest by many sources as a platform to reform healthcare (Deber, 2011, 2014). In Canada specifically, consumers of the healthcare system are demanding greater vertical and horizontal accountability from government and healthcare providers (Schacter, 2000; Flood & Choudhry, 2001; Kirby, 2001; Maxwell, 2002). This thesis looks at one aspect of the healthcare continuum, of the ten publically funded, publically delivered City of Toronto's long-term care homes in Ontario.

The policy instruments that support the long-term care home sector and specifically the City of Toronto long-term care homes are regulations, financial incentives and information. There is minimal influence of professionalism/stewardship component, as

80% of the staff providing direct patients care are unregulated healthcare professionals. The independent variables that are examined in relation to the policy instruments are policy goals, governance/ownership, and services that are being delivered. For all variables, the level of complexity increases for those LTC homes within the City of Toronto based on the fact of an additional level of accountability to the Division.

The investigation of accountability has both positive and negative impacts on the publicly funded and publicly delivered long-term, care homes in the City of Toronto. Answering questions as who is accountable to whom, and for what, and how this accountability is demonstrated, and if there are any consequences or resource constraints are research questions that this thesis and the published article in the next section addresses.

References

Abelson, J., & Guavin, F.P. (2004). Engaging citizens: One route to healthcare accountability. Healthcare Accountability Papers, No. 2, Health Network, Ottawa, ON: Canadian Policy Research Networks. Retrieved from http://www.cprn.com/doc.cfm?doc=560.

Baker G.R., Norton P.G., Flintoft V., Blais R., Brown A.D., Cox J. et al. (2004). The Canadian Adverse Events Study: The Incidence of Adverse Events among Hospital Patients in Canada. *Canadian Medical Association Journal,* 170(11), 1678–86.

Barnsley J., Berta W., Cockerill R., MacPhail J., Vayda E. (2005). Identifying Performance Indicators for Family Practice: Assessing Levels of Consensus. *Canadian Family Physician,* 51(5), 700–01.

Baumann A., Norman P., Blythe J., Kratina S., Deber R.B. (2014). Accountability: The Challenge for Medical and Nursing Regulators. *Healthcare Policy,* 10(Special Issue), 121–31.

Berta, W., Laporte, A., Deber, R., Baumann A., Gamble, B. (2013). The evolving role of healthcare aides in the long-term care and home and community care sectors in Canada. *Human Resources for Health,* 11(25).

Berta W., Laporte A., Wodchis W.P. (2014). Approaches to Accountability in Long-Term Care. *Healthcare Policy*,10(Special Issue), 132–44.

Berta W., Laporte A., Zarnett D., Valdmanis V., Anderson G. (2006). "A Pan-Canadian Perspective on Institutional Long-Term Care." *Health Policy*, 79(2–3), 175–294.

Braun D., Etienne J. (2004). Policy Ideas and Health Policy Instruments: The Governance of Primary Care in Switzerland. Lausanne, Switzerland: Université de Lausanne. [Internet]. Retrieved from http://www.unil.ch/files/live//sites/iepi/files/users/epibiri1/public/HealthPolicyMix.pdf.

Brinkerhoff, D. (2004). Accountability and health systems: Toward conceptual clarity and policy relevance. *Health Policy and Planning*, 19(6), 371-379.

Britten N. (1995) Qualitative interviews in medical research. *British Medical Journal.* Jul 22;311(6999), 251–253.

Brown, A. D., Porcellato, C., & Barnsley, J. (2006). Accountability: Unpacking the suitcase. *Healthcare Quarterly,* 9(3), 72-75.

Business Dictionary. (2017). *Accountability.* [Internet] Retrieved from http://www.businessdictionary.com/definition/accountability.html.

Canadian Healthcare Association. (2001). Towards improved accountability in the health system: Getting from here to there, CHA Policy Brief: Canadian Healthcare Association. Retrieved from http://www.cha.ca/documents/accountability.pdf.

Canadian Healthcare Association. (2006). Achieving health system excellence in Canada - Working in partnerships to implement principles for governance, management, accountability, and shared responsibility: Summary report of the Canadian Healthcare Association's National Roundtable on Health System Effectiveness: Canadian Healthcare Association. [Internet]. Retrieved from http://www.cha.ca/documents/CHARoundtable%7BIHSE%7DSumaryReport%7BIEn glis h.pdf%7D.

Central LHIN. (2013). *LAPS Guidelines 2013-2016 Long-Term Care Home Accountability Planning Submission (LAPs)*. [Internet]. Retrieved from http://www.centrallhin.on.ca/forhsps/lapsandlsaa.aspx.

City of Toronto. (2017). *All Homes.* [Internet]. Retrieved from https://www.toronto.ca/community-people/housing-shelter/long-term-care-homes/all-homes/ .

City of Toronto. (2016). *Long-Term Care Homes.* [Internet]. Retrieved from http://www1.toronto.ca/wps/portal/contentonly?vgnextoid=83f761315d071410VgnV CM10000071d60f89RCRD.

Chinitz D., Preker A., Wasem J.R. (1998). "Balancing Competition and Solidarity in Healthcare Financing." In Saltman R.B., Figueras J., Sakellarides C., editors. , eds., Critical Challenges for Healthcare Reform in Europe (pp. 55–77). Buckingham: Open University Press.

Creswell, J. W. (2014). Educational Research Planning, Conducting and Evaluating Quantitative and Qualitative Research. Harlow Pearson.

Cutcliffe, J.R., Stevenson, C., Jackson, S., & Smith, P. (2006) A modified grounded theory study of how psychiatric nurses work with suicidal people. International *Journal of Nursing Studies,* 43,791-802.

Deber R.B. (2014). Thinking about Accountability. *Healthcare Policy,* 10(Special Issue), 12–24.

Deber R.B. (2014). What Have We Learned from the Substudies? *Healthcare Policy*, 10(Special Issue), 163–64.

Deber,R. (2010). Approaches to Accountability. [Internet] Retrieved from http://www.approachestoaccountability.ca/reports.php.

Deber, R. (2004). Delivering healthcare services: Public, not-for-profit, or private? In G. P. Marchildon, T. McIntosh & P.-G. Forest (Eds.), The fiscal sustainability of healthcare in Canada: Romanow papers, Volume 1 (pp. 233-296).

Deber, R. (2002). Delivering healthcare services: Public, not-for-profit, or private? Commission on the future of healthcare in Canada: Discussion papers No. 17 Toronto, ON: University of Toronto Press.

Denis J.-L. (2004). Governance and Management of Change in Canada's Health System. In Forest P.-G., Marchildon G.P., McIntosh T., editors. , eds., *Changing Healthcare in Canada* (Romanow Papers, vol. 2) (pp. 82–114). Toronto: University of Toronto Press.

Denis J-L., Champagne F., Pomey M.P., Préval J., Tré G. (2005). Towards a Framework for the Analysis of Governance in Healthcare Organizations. Preliminary Report Presented to the Canadian Council on Health Services Accreditation, October 2005, Université de Montréal.

Doern G.B., Phidd R.W. (1992). Canadian Public Policy: Ideas, Structure, Process (2nd ed.). Toronto: Nelson Canada.

Donaldson C., Gerard K., Jan S., Mitton C., Wiseman V. (2005). Economics of Healthcare Financing: The Visible Hand (2nd ed.). Basingstoke, UK: Palgrave/Macmillan.

Doran T., Fullwood C., Gravelle H., Reeves D., Kontopantelis E., Hiroeh U. et al. (2006). Pay-for-Performance Programs in Family Practices in the United Kingdom. *New England Journal of Medicine,* 355(4), 375–84.

Eliadis, P. (2007). Diversity and Equality: The Vital Connection. In Banting, K., Courchene T.J., and Seidle, F.L. (Eds.), Belonging? Diversity, Recognition and Shared Citizenship in Canada (pp.547-560). Montreal, QC: *Institute for Research and Public Policy.*

Emanuel E.J., Emanuel L.L. (1996). What Is Accountability in Healthcare? *Annals of Internal Medicine,* 124(2), 229–39.

Epstein A.M. (2006). Paying for Performance in the United States and Abroad. *New England Journal of Medicine,* 355(4), 406–8.

Esterberg, K. (2002) Qualitative methods in social research. McGraw Hill, Boston.

Evans R.G. (1984). Strained Mercy: The Economics of Canadian Healthcare. Toronto: Butterworths.

Excellent Care for All Act, 2010, S.O. 2010, c. 14. [Internet]. Retrieved from https://www.ontario.ca/laws/statute/10e14.

Flood, C., & Archibald, T. (2005). Hamstrung and hogtied: Cascading constraints on citizen governors in Medicare. Healthcare Accountability Papers, No.6, Health Network, Ottawa, ON: *Canadian Policy Research Networks.* [Internet]. Retrieved from http://www.cprn.com/doc.cfm?doc=1264&l=en.

Flood, C.M. & Choudhry, S. (2002). Strengthening the Foundations: Modernizing the Canada Health Act. Saskatoon: The Commission on the Future of Healthcare in Canada. Discussion. Paper No. 13.

Fooks C., Maslove L. (2004). Rhetoric, Fallacy or Dream? Examining the Accountability of Canadian Healthcare to Citizens. Ottawa: *Canadian Policy Research Networks.*

Forest, P.G., Marchildon, G.P., & McIntosh, T. (2004) Changing healthcare in Canada: Romanow papers. Toronto, ON: University of Toronto Press.

Hood C. (2000). Paradoxes of Public-Sector Managerialism, Old Public Management and Public Service Bargains. *International Public Management Journa*l, 3(1), 1–22.

Government of Ontario. (2016). *Find a long-term care home.* [Internet]. Retrieved from. Retrieved https://www.ontario.ca/page/find-long-term-care-home#section-0.

Government of Ontario. (2016) *Excellent Care for All* [Internet]. Retrieved from http://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. Field methods, 18(1), 59-82.

Howells G. (2005). The Potential and Limits of Consumer Empowerment by Information. *Journal of Law and Society*, 32(3), 349–70.

Howlett M., Ramesh M. (1993). Patterns of Policy Instrument Choice: Policy Styles, Policy Learning and the Privatization Experience. *Policy Studies Review,* 12(1–2): 3–24.

HPRAC. (2015.) *The Regulation of Personal Support Workers*. [Internet] http://www.hprac.org/en/reports/resources/psw-finalreportsept27-06.pdf.

HQO. (2017). *Health Indicator Library.* [Internet]. Retrieved from http://indicatorlibrary.hqontario.ca/Indicator/Search/EN?searchTerms=people+waited

+to+move+into+a+long-term+care+home+%28days%29&kwsGrid-sort=Rank-asc&kwsGrid-page=13&kwsGrid-pageSize=15&kwsGrid-group=&kwsGrid-filter.

Hsiu-Fang, H., Shannon, S. (2005). Three Approaches to Qualitative Content Analysis. Qualitative Healthcare Research, 15(9), 1277-1288.

Hurst J., Jee-Hughes M. (2001. Performance Measurement and Performance Management in OECD Health Systems. Paris: Organisation for Economic Co-operation and Development; Retrieved from http://www.oecd-ilibrary.org/social-issues-migration-health/performance-measurement-and-performance-management-in-oecd-health-systems_788224073713.

IHI. (2015). *Quality, Cost, and Value*. [Internet] Retrieved from http://www.ihi.org/Topics/QualityCostValue/Pages/Overview.aspx.

Jordan A., Wurzel R.K.W., Zito A. (2005). The Rise of 'New' Policy Instruments in Comparative Perspective: Has Governance Eclipsed Government? *Political Studies*, 53(3), 477–96.

Kirby, M.L. (2002). The Health of Canadians – The Federal Role. Volume Six. Recommendations for Reform. Ottawa: Standing Senate Committee on Social Affairs, Science and Technology Government of Canada.

Klein, R. (1993). An anatomy of accountability. Presentation, CHEPA's 6th Annual Health Policy Conference: 'The Buck Stops Where? Accountabilities in Health and Healthcare', Hamilton, ON: McMaster University, 20 May.

Leggat S.G. (2004). "Healthy Children, Healthy Country: The Use of Governing Instruments in Shifting the Policy Paradigm." *Australia and New Zealand Health Policy*, 1(4): 1–4.

Lemieux-Charles L., Champagne F., eds. (2004). Using Knowledge and Evidence in Healthcare: Multidisciplinary Perspectives. Toronto: University of Toronto Press.

Leo, A. and Canadian Healthcare Association. (2006). Achieving Health System Excellence in Canada — Working in Partnerships to Implement Principles for Governance, Management, Accountability and Shared Responsibility: Summary Report of the Canadian Healthcare Association's National Roundtable on Health System Effectiveness, December 15—16, 2005, Ottawa, ON. Ottawa: Canadian Healthcare Association.

Lincoln, Y. S., & Guba, E. G. (2000). *Paradigmatic controversies, contradictions, and emerging confluences*. In N. K. Denzin, & Y. S. Lincoln (Eds.), Handbook of qualitative research (2nd ed.) (pp. 163-188). Retrieved from https://sabinemendesmoura.files.wordpress.com/2014/11/gubaelincoln_novo.pdf

Local Health System Integration Act, 2006, S.O. 2006, c. 4. Retrieved from https://www.ontario.ca/laws/statute/06l04.

MOHLTC. (2017). *Long-Term Care Home Quality Inspection Program.* [Internet]. Retrieved from http://www.health.gov.on.ca/en/public/programs/ltc/31_pr_inspections.aspx.

MOHLTC. (2017). Terms and Definitions. [Internet]. Retrieved from http://publicreporting.ltchomes.net/en-ca/homeprofile.aspx?Home=2821.

MOHLTC. (2016) *Home, Community and Residential Care Services*. [Internet]. Retrieved from http://www.health.gov.on.ca/en/public/programs/ltc/lsaa_policies.aspx.

MOHLTC. (2015). Ontario Wait Times. [Internet]. Retrieved from http://www.health.gov.on.ca/en/pro/programs/waittimes/edrs/about_ts.aspx

MOHLTC. (2015). 2016 Ontario Budget, LTCH Level-of-Care Per Diem Funding Summary. [Internet]. Retrieved from http://www.health.gov.on.ca/en/public/programs/ltc/docs/loc_funding_summary_080716.pdf.

MOHLTC. (2014). *RAI-MDS 2.0 LTC Homes – Practice Requirements*. [Internet]. Retrieved from http://www.health.gov.on.ca/en/public/programs/ltc/docs/rai_mds_practice_requirements.pdf.

MOHLTC. (2014). *Quality Improvement Plan (QIP) Guidance Document for Ontario's Healthcare Organizations*. [Internet]. Retrieved from http://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/qualityimprove/qip_guide.pdf.

MOHLTC. (2013). *LTCH Level-of-Care Per Diem Funding Policy, 2011.* [Internet]. Retrieved from http://www.health.gov.on.ca/en/public/programs/ltc/docs/loc_per_diem_policy_20130118.pdf.

MOHLTC. (2012) *A Guide to the Long-Term Care Homes Act, 2007 and Regulation 79/10.* [Internet]. Retrieved from http://www.health.gov.on.ca/en/public/programs/ltc/docs/ltcha_guide_phase1.pdf.

MOHLTC. (2012). *A Guide to the Long-Term Care Homes Act, 2007 and Regulation 79/10.*[Internet]. Retrieved from https://www.oltca.com//OLTCA/Documents/Reports/2017OLTCABudgetSubmission.pdf.

Morris K., Zelmer J. (2005).*Ottawa: Canadian Policy Research Networks*. Public Reporting of Performance Measures in Healthcare. Report no. 4.[Internet]. Retrieved fromhttp://www.cprn.org/documents/34883_en.pdf>

Mulgan, R. (2000). 'Accountability': An Ever-Expanding Concept? Public Administration 78 (3).

OANHSS. (2013). *A Submission to the Ontario Standing Committee on Finance and Economic Affairs.* [Internet]. Retrieved from https://www.advantageontario.ca/oanhssdocs/MembersOnly/PositionPapers/March_2013_FinanceandEconomicSubmission.pdf.

OLTCA. (2016). *2017 OLTCA Budget Submission*. [Internet]. Retrieved from https://www.oltca.com/oltca/OLTCA/OLTCA/Public/ReportsPublications/AssociationPublications.aspx.

OLTCA. (2016). *About long-term care in Ontario: Facts and figures*. Retrieved from https://www.oltca.com/oltca/OLTCA/LongTermCare/OLTCA/Public/LongTermCare/FactsFigures.aspx.

OLTCA. (2016). *This is Long Term Care, 2015.*[Internet]. Retrieved from https://www.oltca.com/OLTCA/Documents/Reports/TILTC2016.pdf.

Ontario Health Coalition. (n.d.). [Internet]. Retrieved from http://www.web.net/ohc/.

Ontario LHINS. (2014). [Internet]. Retrieved from http://www.lhins.on.ca/.

Patton, M. Q. (2008). Evaluation criteria. In L. M. Given (Ed.), The SAGE encyclopedia of qualitative research methods (pp. 302-304).

Pink G.H., Brown A.D., Studer M.L., Reiter K.L., Leatt P. (2006). Pay-for-Performance in Publicly Financed Healthcare: Some International Experience and Considerations for Canada. *Healthcare Papers,* 6(4), 8–26.

Polit, D.E. and Beck, C.T. (2006) Essentials of Nursing Research. 6th Edition, Lippincott Williams & Wilkins, Philadelphia.

Preker A.S., Harding A., Eds. (2003*).* Innovations in Health Service Delivery: The Corporatization of Public Hospitals. Washington, DC: The World Bank.

Preker A.S., Harding A., Travis P. (2000). 'Make or Buy' Decisions in the Production of Healthcare Goods and Services: New Insights from Institutional Economics and Organizational Theory. *Bulletin of the World Health Organization*, 78(6), 779–89.

Rhodes R.A.W. (1997). Understanding Governance: Policy Networks, Governance, Reflexivity and Accountability. Buckingham, UK: Open University Press.

Richards, L (2005). Handling Qualitative Data: A Practical Guide. London: Sage Publications.

Rico A., Puig-Junoy J. (2002). *What Can We Learn from the Regulation of Public Utilities?* In Saltman R.B., Busse R., Mossialos E., editors. , eds., Regulating Entrepreneurial Behaviour in European Healthcare Systems (pp. 73–90). Buckingham, UK: Open University Press.

Robinson J.C. (2001). Theory and Practice in the Design of Physician Payment Incentives. *Milbank Quarterly*, 79(2), 149–77.

Rolfe, (2006). Validity, trustworthiness and rigour: quality and the idea of qualitative research. Journal of Advance Nursing, 53(3), 304-10.

Romanow Inquiry (2002). [Internet]. Retrieved from http://www.hc-sc.gc.ca/hcs-sss/hhrrhs/strateg/romanow-eng.php.

Romanow, R.J. (2002). Building on Values. The Future of Healthcare in Canada. Saskatoon: The Commission on the Future of Healthcare in Canada. Retrieved from http://www.publications.gc.ca/collections/Collection/CP32-85-2002E.pdf.

Saltman R.B., Busse R., Mossialos E., eds. (2002). *Regulating Entrepreneurial Behaviour in European Healthcare Systems.* Buckingham, UK: Open University Press.

Saumure, K, Given, L. (2008). *"Data saturation."* In The Sage Encyclopedia of Qualitative Research Methods, edited by Lisa M. Given, 195-196. Thousand Oaks, CA: Sage Publications.

Schacter, M. (2000). *When Accountability Fails: A Framework for Diagnosis and Action.* Ottawa Institute on Governance. Policy Brief No. 9.

Shaw C. (2003). *How Can Hospital Performance Be Measured and Monitored?* Copenhagen, WHO Regional Office for Europe. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0009/74718/E82975.pdf.

Simmons G. (2011). *Dissertation and scholarly research: Recipes for success*. Seattle, WA: Dissertation Success, LLC.

Smith P., ed. (2002). Measuring Up: Improving Health System Performance in OECD Countries. Paris: Organisation for Economic Co-operation and Development.

Stats Canada (2016). *An Aging Population*. [Internet] Retrieved from https://www150.statcan.gc.ca/n1/pub/11-402-x/2010000/chap/pop/pop02-eng.htm.

Sutherland J.M. (2011). Hospital Payment Mechanisms: An Overview and Options for Canada. CHSRF Series of Reports on Cost Drivers and Health System Efficiency: Paper 4. Ottawa: *Canadian Health Services Research Foundation*. Retrieved from http://www.cfhi-fcass.ca/Libraries/Hospital_Funding_docs/CHSRF-Sutherland-HospitalFundingENG.sflb.ashx.

Sutherland J.M., Barer M.L., Evans R.G., Crump R.T. (2011). Will Paying the Piper Change the Tune? *Healthcare Policy* 6(4), 14–21.

Thomas P.G. (2006). From Good Intentions to Successful Implementation: The Case of Patient Safety in Canada. *Canadian Public Administration* 49(4), 415–41.

University of New Mexico Health Sciences Library and Informatics Center (2018). *Gray literature 101*. [Internet]. Retrieved from https://libguides.health.unm.edu/graylit.

Van den Hoonaard, D. K. (2015). Qualitative research in action: A Canadian primer (2nd ed.). Don Mills, ON: Oxford University Press.

van Kersbergen K., van Waarden F. (2004). "'Governance' as a Bridge between Disciplines: Cross-Disciplinary Inspiration Regarding Shifts in Governance and Problems of Governability, Accountability and Legitimacy." *European Journal of Political Research* 43(2), 143–71.

Vennavally-Rao, J (2013*). 'It's despicable': son reacts after told no charges laid in mistreatment of mother*. CTV News. [Internet]. Retrieved from https://www.ctvnews.ca/canada/it-s-despicable-son-reacts-after-told-no-charges-laid-in-mistreatment-of-mother-1.1442579.

Veillard J., Champagne F., Klazinga N., Kazandjian V., Arah O.A., Guisset A. L. (2005). A Performance Assessment Framework for Hospitals: The WHO Regional Office for Europe Path Project. *International Journal for Quality in Healthcare.* 17(6), 487–96.

Vining A.R., Globerman S. (1999). Contracting Out Healthcare Services: A Conceptual Framework. *Health Policy,* 46(2), 77–96.

Walshe K. (2003). Regulating Healthcare: A Prescription for Improvement? Maidenhead, UK: Open University Press.

WBI Evaluation Group. (2007). *Nominal Group Technique*. [Internet] Retrieved from https://www.scribd.com/document/246095093/WBI-Evaluation-Group-2007-Nominal-Group-Technique.

Wyers L., Gamble B., Deber R.B. (2014). Accountability in the City of Toronto's 10 Long-Term Care Homes. *Healthcare Policy*, 10(Special Issue), 99–109.

Yin, R. K. (2016). Qualitative research from start to finish (2nd ed). New York, NY: The Guilford Press.

Zito A.R., Radaelli C.M., Jordan A. (2003). Introduction to the Symposium on 'New' Policy Instruments in the European Union. *Public Administration*, 81(3), 509.

Section 4 Manuscript

Accountability in the City of Toronto's 10 Long-Term Care Homes from Healthcare Policy, 10(Special Issue), 99–109.

Abstract

Long-term care (LTC) residential homes provide a supportive environment for residents requiring nursing care and assistance with daily living activities. The LTC sector is highly regulated. We examine the approaches taken to ensure the delivery of quality and safe care in 10 LTC homes owned and operated by the City of Toronto, Ontario, focusing on mandatory accountability agreements with the Local Health Integration Networks (LHINs). Results are based on document review and seven interviews with LTC managers responsible for the management and operation of the 10 LTC homes. One issue identified was the challenges associated with implementing new legislative and regulatory requirements to multiple bodies with differing requirements, particularly when boundaries do not coincide (e.g., the City of Toronto's Long-Term Care Homes and Services Division must establish 10 different accountability agreements with the five LHINs that span into the City of Toronto's geographic area).

Like other countries, Canada's population is aging. By 2026, it is estimated that one in five Canadians will have reached the age of 65 years (Health Canada and Interdepartmental Committee on Aging and Seniors Issues 2002). Supporting this aging population will require efforts directed at implementing strategies for healthy aging. This includes the provision of supportive environments within communities for seniors and sustainable government programs (Health Canada and Interdepartmental Committee on Aging and Seniors Issues 2002).

Residential long-term care (LTC) homes provide a supportive environment and 24-hour nursing care for the small but vulnerable proportion of seniors and other individuals who are unable to live on their own due to cognitive/physical impairment, challenges with daily living activities and/or the lack of informal support. Although the number of LTC beds across Canada per 1,000 seniors has remained stable, the level of care has become more intense due to more complex conditions and health needs. Overall, the majority of residents in LTC homes in Canada are female, single, over the age of 85 years old, and cognitively impaired (CIHI 2011).

The provision of safe, quality and efficient residential LTC for this vulnerable population is a high priority for residents, families, governments and providers. LTC homes are not required to be a publicly insured service under the terms of the *Canada Health Act* (Madore 2005). Nonetheless, most jurisdictions cover a proportion of the costs for certain populations (Berta et al. 2006). A number of different funding models exist that rely on a mix of public (e.g., provincial/territorial and municipal governments) and private (e.g., private insurance, co-payments paid by residents) sources. Variation also exists across Canada in terms of ownership status of the homes (Berta et al. 2006). Although there are many unregulated LTC homes (often called "retirement homes"), the formal LTC sector in Ontario is highly regulated and must respond to a variety of legislative/regulatory measures and policy decisions made by different levels of government.

Currently in Ontario, there are approximately 77,605 residents in 628 regulated LTC homes (Ontario Association of Non-Profit Homes and Services for Seniors 2013). Recent media reports have foregrounded the need to address abuse and neglect in Ontario's LTC

home sector. The Long-Term Care Task Force on Resident Care and Safety in Ontario was established in 2011 in response to these reports highlighting the need to recognize the rights of residents to receive quality care in a safe, respectful environment free of abuse; it has issued progress reports (Long-Term Care Task Force on Resident Care and Safety 2013). Providing quality and safe care for LTC residents is also a high priority for Ontario's Ministry of Health and Long-Term Care (MOHLTC). In a January 2013 press release, the Minister of the MOHLTC stated: "My ministry has been working closely with task force members, and I am proud of the actions and recent investments the ministry has made to further support long-term care homes, and staff to improve the care and safety of residents" (http://www.newswire.ca/en/story/1106837/working-together-to-provide-safe-care-to-residents-in-long-term-care).

Purpose

Ontario's LTC homes can be categorized into three sub-sectors, based on their public–private ownership status: private not-for-profit (e.g., religious or lay groups), private for-profit (e.g., individual, private organizations or corporations) and public (e.g., City of Toronto's LTC homes) (Berta et al. 2006). This study focuses on the 10 public LTC homes owned by the City of Toronto, Ontario; a companion paper in this volume deals with other private LTC homes in Ontario (Berta et al. 2014). Responsibility for both the operation and management of these 10 homes rests with the City of Toronto's Long-Term Care Homes and Services Division (the Division). The Division is responsible for providing a variety of long-term healthcare services in the City of Toronto. A number of different factors influence the quality and care delivered to residents, including management structure and process (Wodchis et al. 2014). The Division's mission

statement is to "…provide a continuum of high quality long-term care services to eligible adults in both long-term care homes and the community." The Division is guided by a set of core values: Compassion, Accountability, Respect and Excellence (CARE). The CARE values are intended to be shared by all stakeholders, drive culture and priorities and provide a framework in which all decisions are based. A general manager, three directors and 10 administrators, along with a number of other senior staff, provide overall leadership to the Division using a participatory style of management that involves shared decision-making and shared responsibility for the Division's performance.

City of Toronto's 10 LTC Homes

Each of the 10 LTC homes has an administrator whose primary focus is on the operations of that particular home. A variety of healthcare, social care and administrative staff provide "nursing and personal care, medical, recreational, rehabilitation, nutritional, spiritual, social work, housekeeping, laundry and administrative services." Volunteers also play an important role providing assistance, visitations, programs and activities for the residents.

The City's LTC homes have 2,641 approved beds (17.3% of the regulated LTC beds in Toronto) and provide permanent, convalescent and short-stay accommodations to a diverse population (mainly seniors) from more than 50 countries of origin and speaking 38 languages. The Division's decision-making framework for providing support and activities for the 10 LTC homes takes into account the cultural, religious and sexual diversity of their residents, as well as diverse abilities such as the level of cognitive ability. The majority of permanent residents have some form of cognitive impairment and require nursing care and assistance with daily living activities.

In 2006, the Ontario government implemented the regionalization of healthcare services with the introduction of 14 Local Health Integration Networks (LHINs). Each LHIN is responsible for the planning, integration and funding of specified health services in its region, including hospitals and community care, as well as LTC services. To ensure the responsible use of healthcare resources, accountability agreements between healthcare providers and LHINs and between LHINs and government have been established. The LHIN boundaries are not necessarily co-terminus with those of the local government. Toronto falls into five different LHINs, some of which also encompass areas outside the city boundaries. Accordingly, the 10 public LTC homes operated by the Division are situated in five different LHINs, and this has resulted in the establishment of 10 different accountability agreements with five different LHINs. We examine the approaches taken to ensure the delivery of quality and safe care in LTC homes owned by the City of Toronto by focusing on the challenges and/or benefits resulting from these accountability agreements.

Methodology

Data collection for this case study used data triangulation from more than one type of data source to give more insight into the sub-sector and to identify more easily any inconsistencies found between the data (Bickman and Rog 1998). We used a combination of document review and in-depth interviews with seven LTC managers from the City of Toronto's Long-Term Care Homes and Services Division who are responsible for implementing the accountability requirements within this sub-sector. Participants were each given a unique identifier, e.g., M1, M2, etc. Participants provided informed consent prior to data collection, and the Research Ethics Boards at University of Ontario Institute

of Technology and the City of Toronto Long-Term Care Homes and Services Division provided ethics approval. One-hour semi-structured interviews were conducted via telephone or in person.

Documents reviewed included peer-reviewed literature, grey literature (e.g., professional association websites) and provincial legislation and regulations. The City of Toronto Long-Term Care Homes and Services Division provided strategic directions documents, report cards, efficiency review documents; annual reports and long-term care home service accountability agreements (L-SAAs). Following identification of the relevant documents, each was summarized and reviewed by at least two members of the research team (which included at least one expert from the LTC sub-sector) to ensure consensus. Similar procedures were used for the coding of the key informant interviews to validate the themes identified.

Results

Approaches to accountability.

In terms of "to whom," our respondents noted multiple layers. They noted that providing quality and safe care to the residents was the first and most important priority and that they believed that the Division was accordingly primarily:

…accountable to the residents and their families, who in some cases provide a co-payment for their accommodations … and by extension we are accountable to the local citizens. (M1)

However, management is not only accountable to the residents and their families but also to other stakeholders. As articulated by one respondent:

The Division receives funding and therefore is financially accountable to the Province of Ontario, Central East LHIN, Toronto Central LHIN, Central LHIN, Central West LHIN and Mississauga/Halton LHIN and the City of Toronto Council. (M2)

While respondents agreed, "there are many layers" (M3) of accountability, they agreed that primary governance and oversight lies with Toronto's City Council: even though the majority of the funding is from the province, they [City Council] have governance over the operations. (M1)

In terms of how, accountability in this sub-sector uses a combination of all four mechanisms of accountability (financial incentives, regulation, information directed to potential users and reliance on professionalism) identified in the conceptual framework (Deber 2014). These do not entirely derive from the government. For example, the Long-Term Care Task Force on Resident Care and Safety in Ontario released an 18-item action plan in 2012 to improve safety in Ontario's LTC homes (Long-Term Care Task Force Ontario 2012). A subsequent report provided educational/training strategies for staff (i.e., professionalism) and support tools for staff and families (i.e., information directed to potential users), as well as earmarking resources (i.e., financial incentives) for the recruitment of qualified clinical, support and administrative staff (Long-Term Care Task Force on Resident Care and Safety 2013).

Role of regulation.

Regulation plays a significant role in ensuring accountability in the LTC home sector in Ontario. In the opinion of one respondent: "After nuclear power plants, long-term care homes are the most regulated sector. (M4)"

In respect to whether the Division or LTC homes have any influence over these regulations, one respondent commented:

We have an opportunity to influence policy … or influence the direction of various legislation or regulations, and certainly provide evidence to the direction in which change needs to be made. (M1)

All regulated LTC homes in Ontario are licensed and approved by the MOHLTC. Regardless of the ownership status (private not-for-profit, private for-profit and public), LTC homes are governed by the *Long-Term Care Homes Act* (LTCH) of 2007 and Ontario Regulation 79/10 (Legislative Assembly of Ontario 2007). In addition, a variety of other legislation and regulations apply to this sector, as noted by two respondents from the senior management team:

They [regulations] are all specified from the Ministry standpoint, long-term care home acts, including homemakers and nurses' services, health and safety, privacy (MFIPPA [the *Municipal Freedom of Information and Protection of Privacy Act*] and PHIPA [the *Personal Health Information Protection Act*]), and so many others … even the AODA … the fire code, lots [of others] as well. (M5)

The Act … public health requirements, Ministry of Labour, Health Quality Ontario … there are many, many layers. (M6)

The LTCH Act and Regulation 79/10 are considered the foundation of the Ontario government's commitment to reforming the accountability of LTC homes. LTC homes are accountable for providing safe, respectful, quality health and social care services, as well as safeguarding residents' rights. The Long-Term Care Homes' Quality Inspection Program was initiated to ensure that LTC homes comply with legislation and regulations.

Health Quality Ontario (HQO) makes the data available to the public on the Ontario MOHLTC website.

Accreditation processes are overseen by Accreditation Canada or the Commission on Accreditation of Rehabilitation Facilities and are encouraged by MOHLTC through financial incentives to accredited LTC homes. Two of the LHINs to which the Division must report (Central East and Central West LHINs where three LTC homes are located) go beyond this and require accreditation by a recognized Canadian accreditation program as a performance requirement. In 2012, the City of Toronto's Long-Term Care Homes and Services was awarded Accreditation with Exemplary Standing by Accreditation Canada, their highest level of performance recognition in meeting the requirements of the Qmentum accreditation program (Mitchell et al. 2014).

Long-term care home service accountability agreements.

With the enactment of the *Local Health System Integration Act* (LHSIA) in 2006, the LHINs began the negotiation of service accountability agreements (SAAs) between the LHINs and health service providers (HSPs) funded by the LHINs in accordance with the timetable set out in LHSIA, O.Reg. 279. LHINs were originally expected to enter into SAAs with LTC homes by March 31, 2010; however, the L-SAA was developed within the context of the LTCH Act. The L-SAAs are for a period of three years. Accordingly, LTC homes signed their first L-SAA on July 1, 2010, concomitant with the date of proclamation of the LTCH Act, and were effective until March 31, 2013.

The LHINs have an accountability framework that supports their legislative requirements with respect to the LTC sector, but this framework acts only as a guideline. The planning and accountability cycle within the LHIN and HSPs began in the fall of the

final year of the agreement. The beginning of this cycle is the Long-Term Care Home Accountability Planning Submission (LAPS). The LAPS informs discussion with the LHIN in regards to the L-SAA. It provides a tool for homes to describe their services, and is composed of two parts: (a) an overview of the LTC home that includes general identifying information, bed types and numbers offered within the home, structural classification and listing of additional services provided to residents; and (b) the Service Plan narrative, which will allow the LTC home to provide information that describes services that the home operates or plans to operate within each year of the agreement. There are strict instructions on how this is to be completed. The LAPS documents facilitate discussions with the LHIN and become appendices to the L-SAA.

Commenting on the accountability process and who had final say on the contents of the L-SAA, one respondent indicated:

We had input and some opportunity with respect to the development of service accountability agreements, but they are accountability agreements and not contracts, so you don't necessarily negotiate them, you discuss, you provide feedback but in the end they [LHIN] can prescribe, and in some respects it had been prescribed. (M3)

There was consensus from the respondents that there was oversight provided from the Division at the provincial L-SAA Steering Committee (in the formulation of the agreements).

While there is guidance from the provincial steering committee to align the processes and to provide guidance to the LHINs, each LHIN ultimately has flexibility on how it carries out the L-SAA process. One result is that timelines may vary for each LHIN, and not be consistent with the Division approval process. One requirement of the LAPS and

L-SAA is having the submission and agreement endorsed by the governing body and executed by two signing authorities that can bind the organizations. For the Division, this means having City Council approval, which requires time for management to review and obtain the necessary approvals, and often this process does not coincide with the LHINs' timelines.

Performance indicators.

Another portion of the L-SAA agreement that varies by LHIN is the performance indicators used to measure the HSPs' performance and tools used for demonstrating accountability. The L-SAA Indicators Working Group is responsible for developing recommendations for consideration by the L-SAA Steering Committee regarding L-SAA performance indicators. The Working Group is composed of LTC sector representatives, MOHLTC, HQO and LHIN staff, and is chaired by an LHIN Senior Director of the Health System Indicator Initiative Steering Committee. For the 2013–2016 L-SAA, the working group created the following sets of indicators to reflect the Pan-LHIN "Ontario" systems imperative: Enhancing Coordination and Transitions of Care; Maintaining Achievements in Access, Accountability and Safety; and Ensuring Sustainable Organizational Health. Within these categories, there were four indicators that were in every L-SAA. Each indicator has a performance target, performance corridor and a performance standard. Because the Division has LTC homes situated in five different LHINs, it must thus comply with five different processes. This has implications for the Division's financial and human resources. Even within one LHIN, there are differences for performance targets for the same indicator across different sub-sectors.

In addition to the four Pan-LHIN indicators, the Division reports on 17 separate performance indicators that were identified by the five different LHINs. Reporting on all the indicators requires resources and systems in place in order to meet the reporting requirements laid out in the L-SAA. One respondent commented that while reporting on the indicators is achievable, it was time-consuming:

It's not difficult for us to achieve them [indicators], it is difficult for us when we are reporting to the five LHINs … the five LHINs don't even use the same template, for their reporting systems … we find the workload really difficult. (M2)

Concern was also raised regarding the ability to get the work done in a timely manner:

…it is not that the work doesn't get done, it doesn't get done in a timely fashion because of the different reporting systems that we need to meet. (M3)

Resourcing accountability.

Whether an increase in regulation, accountability requirements or performance indicators, in most instances, respondents said that meeting their accountability requirements was getting increasingly challenging. The proportion of funding was decreasing, while the expectations and requirements were increasing. Our respondents believed that insufficient funding was provided to implement new legislative and regulatory requirements. For example, although the Division attempts to be sensitive to the cultural needs of their residents and their families, including incorporating ongoing review and revision of policies, prioritizing could be affected by legal requirements. One respondent expressed frustration with the lack of additional funds to meet the requirements of the *Accessibility for Ontarians with Disabilities Act*:

… one of the residents was demanding an interpreter; this is a very expensive proposition to have an interpreter available constantly for an individual resident, but there is an act that requires that you do so. (M2)

Quality is a major concern for the Division, especially when cuts are made to an already limited budget. One respondent commented on the struggles on being a municipal home:

… you are limited on how far back you can cut without having an adverse effect on your residents, while still providing quality of care. (M7)

As noted previously, the Toronto City Council provides funds to and oversight of the Division. Recognizing that the Division is one of the many responsibilities of the City Council, delivering care in an efficient matter is an important part of the Division's accountability to the City of Toronto: we [the Division] subject ourselves to higher levels of accountability, so there is the value for money. (M1)

Discussion and Conclusion

Our respondents stressed that delivering quality and safe care to the residents of the City of Toronto's 10 LTC homes is a top priority. Demonstrating accountability to funders is also required to ensure the 10 LTC homes have the resources needed to deliver care to this vulnerable population. The necessity of establishing 10 different accountability agreements with five different LHINs for its 10 LTC homes has brought to the foreground implementation challenges in terms of both time and human resources for the Division. Each LHIN is given some latitude to define performance indicators to better respond to the needs of the population that it serves. As a result, each home has autonomy and the potential to negotiate performance indicators that are meaningful to the home

(Ontario Local Health Integration Network 2012). As well, there are different funding opportunities for each home depending on what LHIN it resides in, including behavioural support units and process improvement initiatives (e.g., through the Health System Improvement Pre-Proposal). Although this can present difficulties in responding to the various requirements, the ability to respond to local health needs is seen as one of the benefits of regionalization. Considering the diversity between the 10 LTC homes, accountability agreements with the different LHINs strengthen each home's ability to meet the needs of its clients.

Funding for the 10 LTC homes is transferred from the LHINs to each individual LTC home, and funding may vary depending on LHIN-funded priorities; however, the Toronto City Council allocates funds to the Division based on a global budget. This adds another layer of complexity that can potentially lead to resource planning challenges. For example, Toronto's City Council implemented a 10% funding cut in 2011, which affected all Divisions, including the Long-Term Care Homes and Services Division.

Results of this study have brought to the foreground the challenges service providers face when implementing new legislative and regulatory requirements. This is increasingly challenging when negotiating accountability agreements with multiple organizations (in this case, LHINs) that can use funding tools to force compliance. This experience is not unique to Toronto's Long-Term Care Homes and Services Division (which deliver not only residential care but also community services and supportive housing services), but is also experienced by community agencies that receive public funding and provide services to specific populations located in different LHINs. Accountability through performance indicators can be highly measurable. However, the

implementation of measures to demonstrate quality and value for money must take into consideration the governance structure of service providers and the relationship between the funders and providers.

As in other healthcare sectors and within the LTC sector, providers are not only responsible to the recipients of care (in this case, residents and their families) but also to other stakeholders who provide funding and are responsible for ensuring regulatory requirements are met to demonstrate accountability. The creation and implementation of accountability agreements in the City of Toronto's 10 LTC homes requires flexibility to accommodate and respond to the needs of the residents and their families, as well as the budget requirements of the City of Toronto. This does not come without its challenges for the Division responsible for the operation of the LTC homes. However, the Division recognizes these challenges and endeavours to ensure the regulatory structures are adhered to while maintaining balanced budgets, but more importantly ensuring quality and safe care for their residents.

References

Berta, W., A. Laporte and W. P. Wodchis. 2014. "Approaches to Accountability in Long-Term Care." *Healthcare Policy* 10(Special Issue): 132–144.

Berta, W., A. Laporte, D. Zarnett, V. Valdmanis and G. Anderson. 2006. "A Pan-Canadian Perspective on Institutional Long-Term Care." *Health Policy* 79(2-3): 175–94.

Bickman, L. and D.J. Rog, eds. 1998. *Handbook of Applied Social Research Methods*. Thousand Oaks, CA: Sage Publications.

Canadian Institute for Health Information. 2011. *HealthCare in Canada 2011: A Focus on Seniors and Aging*. Ottawa, ON. Retrieved March 15, 2014. <https://secure.cihi.ca/estore/productFamily.htm?locale=en&pf=PFC1677>.

Deber, R.B. 2014. "Thinking about Accountability." *Healthcare Policy* 10(Special Issue): 12–24.

Health Canada and Interdepartmental Committee on Aging and Seniors Issues. 2002. *Canada's Aging Population*. Ottawa, ON: Health Canada. Retrieved March 15, 2014. <http://publications.gc.ca/collections/Collection/H39-608-2002E.pdf>.

Legislative Assembly of Ontario. 2007. Bill 140: *An Act Respecting Long-Term Care Homes*. Legislation. Retrieved March 15, 2014. <http://www.e-laws.gov.on.ca/html/source/statutes/english/2007/elaws_src_s07008_e.htm>.

Long-Term Care Task Force Ontario. 2012. *Long-Term Care Task Force on Resident Care and Safety*. Retrieved March 15, 2014. <http://longtermcaretaskforce.ca/>.

Long-Term Care Task Force on Resident Care and Safety. 2013. *Progress Report: Delivering on the Action Plan to Address Abuse and Neglect in Long-Term Care Homes*. Retrieved March 15, 2014.
<http://longtermcaretaskforce.ca/images/uploads/LTCFTReportEnglish.pdf>.

Madore, O. 2005. *The Canada Health Act: Overview and Options*. Ottawa, ON: Library of Parliament. Retrieved March 15, 2014.
<http://www.parl.gc.ca/Content/LOP/ResearchPublications/944-e.htm>.

Mitchell, J.I., W. Nicklin and B. MacDonald. 2014. "The Accreditation Canada Program: A Complementary Tool to Promote Accountability in Canadian Healthcare." *Healthcare Policy* 10(Special Issue): 150–53.

Ontario Association of Non-Profit Homes and Services for Seniors. 2013. *Long Term Care Provincial Snapshot*. Woodbridge, ON: OANHSS. Retrieved March 15, 2014. <http://ocsco.ca/uploads/Image/OANHSS_Provincial_Snapshot.pdf>.

Ontario Local Health Integration Network. 2012. *Long-Term Care Home Accountability Planning Submission (Laps)*. Toronto, ON: Ontario Local Health Integration Network. Retrieved March 15, 2014.
<http://www.torontocentrallhin.on.ca/page.aspx?id=2708"
http://www.torontocentrallhin.on.ca/page.aspx?id=2708>.

Wodchis, W.P., T. Burns, B. Chan, W. Berta, K. McGilton, K. Walker et al. 2014. *Determinants of Quality in Ontario Ltc Homes (2011–2014)*. Retrieved March 15, 2014. <http://www.ihpme.utoronto.ca/about/research/hsr/projects/ltc>.

Section 5 Summary

Thesis Summary

The purpose of this study was to gain a broader understanding of accountability structures of long-term care homes that are publicly funded and publicly delivered, utilizing a consistent framework by Deber (2010). The framework identified four major approaches to accountability that can be used in both Canadian and international healthcare settings. These four approaches are: a) regulations b) financial incentives c) information directed towards patients/payers d) professionalism and stewardship. This framework was used to guide the analysis and presentation of results and findings. This chapter concludes with a summary of research and opportunities for future exploration.

The long-term care home sector supports almost 80,000 residents per year with 24-hour nursing and personal care through a mix of for profit, not-for profit and municipally run homes. To protect this frail and vulnerable population, rigourous regulations and legislation must be in place. As stated previously, accountability in healthcare has not been well studied, and few studies have specifically examined these issues in the long-term care sector. The complexities of accountability are continually changing within this sector. There have been media reports around the need to address abuse and neglect in the Ontario's LTC sector. An incident in 2013, involving a hidden camera, caught this abuse on tape. In 2012, a *W5* investigation uncovered that more than 10,000 seniors suffered abuse in nursing homes across Canada (Vennavally-Rao, 2013). These issues continue to occur and need to be addressed by continuing to highlight the challenges in this sector, specifically around unregulated healthcare professionals.

A partnership between the LHINs and the MOHLTC allows for a comprehensive compliance program to ensure that all homes are compliant with the regulations, policies, and standards. A complex funding formula that reflects acuity of residents is used to support the resources required for residents. The administration of these funds is provided by the LHIN and is formalized through an agreement. Based on the LHISA, the LHINs and LTCHs are required to enter into an agreement to formalize the accountability relationship between the homes and the LHINs. Beyond the administration of the L-SAA, the LHINs are also responsible for the performance management of homes.

The policy instruments that support the long-term care home sector and, specifically, the City of Toronto long-term care homes, are regulations, financial incentives, and information. There is minimal influence of the professionalism/stewardship structure as 80% of the staff providing direct patients care are unregulated healthcare professionals. The independent variables that are examined in relation to the policy instruments are policy goals, governance/ownership, and services that are being delivered. For all variables, the level of complexity increases for those LTC homes within the City of Toronto based on the presence of an additional level of accountability to the Division. The Division recognizes these challenges and endeavours to ensure the regulatory structures are adhered to while maintaining balanced budgets and ensuring safety and quality for their residents.

The five LHINS to which the 10 homes are accountable based on the LHIN's geographic boundaries (see Appendix A), have the opportunity to streamline their approach to ensure accountability with respect to process, reporting, and performance obligations. The creation and implementation of the L-SAAs in the City of Toronto's 10

LTC homes requires the flexibility to respond and accommodate the needs of the residents and their families, while being able to meet the financial, compliance, and clinical requirements of the City of Toronto, MOHLTC, and LHINs.

Recommendations

This section speaks to where and how this research can support further research, policy change and impact resident care in the future.

Resourcing.

A key concern that was raised by all informants is the lack of resources to achieve the increasing accountability requirements, while continuing to emphasize the importance of providing value for money when receiving public funds. There was no additional funding provided to homes when the new regulations took effect, and changes that homes were required to make in order to be compliant were not funded through the MOHLTC. Other activities such as participation with Accreditation Canada is not funded, so homes where this is part of their L-SAA are required to participate and therefore must sacrifice some level of goods/services due to the homes' finite resources and required to reallocate resources from another funded area.

Another conflict with allocating resources is the balance between meeting the regulations, standards, and performance obligations and being able to provide a home-like environment, where there is time spent with the residents and their family members is key. Staff and Administrators are occupied with meeting the prescribed quality standards and completing the associated paperwork and reporting, rather than creating what is considered quality from the perspective of residents and their families

Public understanding.

The long-term care sector is incredibly complex. The legislative requirements and standards for a home for the vulnerable population are very prescriptive and, in some cases, require significant documentation. For the lay person, the healthcare system can be difficult to navigate and understand, and long-term care is no different. There are challenges with public perception around long-term care homes, the compliance process, and public reporting. There are unintended consequences of not having the background knowledge of the compliance program and the media influence of comparing homes with orders against another. LTC home selection based on minimal information for potential resident could be impacted resulting in lower occupancy rates, or decrease family satisfaction or participation. For example, one home has an order of a staff member who has caused physical harm to a resident which would be compared to an order where there is not physical impact to a resident, rather a regulation has not been followed (i.e. a change in menu has not been communicated with residents.). Without further knowledge of these order types, the public perception is to compare the homes equally. Further education to the public about the compliance program will have a huge impact on the reputation and approaches to accountability for the long-term care homes. This is an area where further public engagement and knowledge transfer would support accountability and transparency with consumers.

Streamline approach.

The City of Toronto Long-Term Care Homes and Services Division finds themselves in a very interesting situation. While all 10 homes receiving funding from the City of Toronto, based on the geographic location, these homes sit within five different LHIN

boundaries (see Appendix A). There is opportunity to support the Division, which has oversight on all ten homes, by encouraging senior leadership to streamline processes. There are differences that occur with respect to accountability among these five LHINs. Informants noted that each LHIN operates very different than another LHIN, making it more difficult to meet the reporting requirements and the execution of the L-SAA. This can vary from quarterly performance requirements and reporting to the LAPS and L-SAA process and timelines that are uniquely defined by each LHIN. One LHIN has no additional LHIN-specific performance obligations above the standard performance indicators in the agreement, while another LHIN has eight additional indicators, some with monthly reporting. Each LHIN has set out different performance expectations based on that LHIN's strategic priorities.

Recommendations for Future Research

The purpose of this research was to study approaches to accountability among the publicly funded and publicly delivered long-term care homes in Ontario. This study helped to increase the understanding of various approaches to accountability within a consistent framework that identified the perceived advantages and disadvantages to each approach. This study also identified gaps within the current accountability structure of the homes and the LHINs and the documents that support this relationship. There are a few areas of contextual comparison and further inquiry that have been identified.

Comparisons amongst **l**ong-**t**erm **c**are **h**omes**.**

While a similar study was conducted through the larger research project with homes that were privately delivered (Berta, Laporte ,& Woodchis, 2014), a comparison study of the two different home types could further enhance the knowledge of

accountability structures within the long-term care sector. Like the findings in this study, the research for homes from the for-profit sector also have the three dominant approaches to accountability which are identified as regulation, financial incentives, and the provision of performance information to payers and the public (Berta, Laporte, & Woodchis, 2014). Future research could help inform future policy, enhancement of the L-SAA, and performance requirements and quality of care for residents.

Comparisons cross Canada.

All the participants in this study were employees of the City of Toronto. Other provincial structures or governing bodies were not represented and may have different challenges or benefits not identified in this study. A second step would be to extend the study to other provinces within Canada. Conducting a study of this nature would be time consuming and potentially costly.

This study only collected qualitative data from key informants. A strategy for future studies may be to include a survey with open ended questions which may enable an examination of a wider cross-section of long-term care homes representation across Canada. This information would provide even more evidence to support accountability approaches to long-term care in Canada and perhaps leverage existing structures or policies to further enhance quality and value for money solutions for residents.

Cross-continuum collaboration.

Approaches to accountability are not just confined to the long-term care home sector but also has a wider implication across the healthcare continuum. This study is part of a larger study looking at “Approaches to Accountability” in the 11-other healthcare sub-sectors. Future research in this area will be able to provide foundational information that

may be used to create best practice or guidelines for accountability that may be used national and global healthcare sectors.

Key informants identified that each LHIN has their own process on how this agreement is executed. The experience of the LAPS and L-SAA process that the senior administration has is less than coordinated. There is opportunity for these LHINs to coordinate their approach to streamline the process for the ten homes.

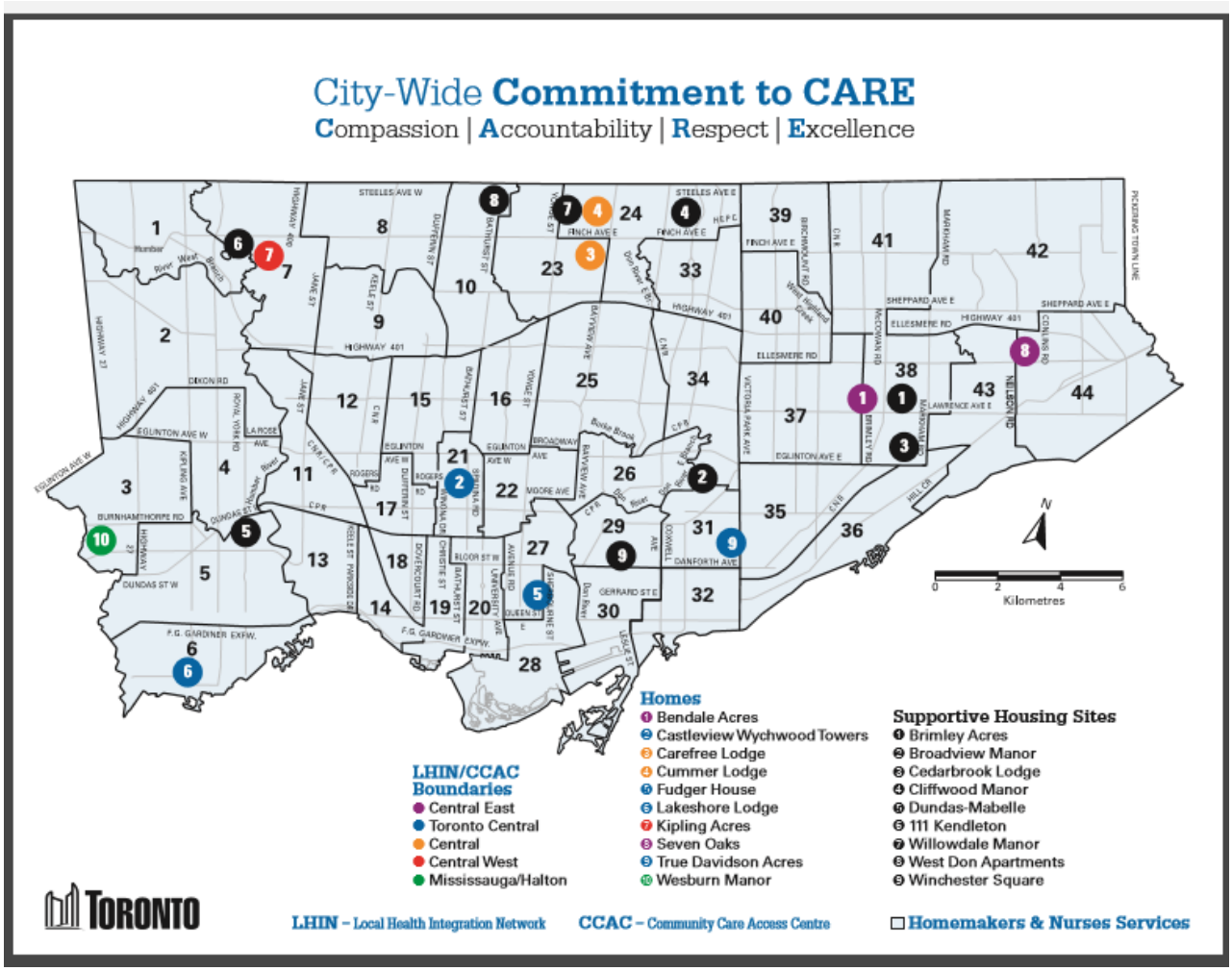
One informant expressed their concerns that even through there are performance obligations, when a home does not meet them; there is a lack of clarity about what the ramifications are. There is language in the L-SAA that supports performance management, including performance meetings and performance improvement process that may include a HSP-designed improvement plan, a review, or/and adjustment to funding (L-SAA, Section 7). The LHINs have discretion on how they will enact this section of the agreement, to what performance indicators, and when. This inconsistency further complicates the outcomes of not meeting accountability requirements.

The perspectives and shared knowledge of the key informants on approaches to accountability were insightful and crucial for a meaningful result in answering the key questions surrounding accountability. The participants came from the perspective of senior management as well as a cross-section of administrators responsible for long-term care homes. The results of the interviews support the belief that long-term care homes are highly regulated. LTCHs, and in particular those whom are publicly funded and publicly delivered have a very complex relationship both from a funding, compliance and quality of care perspective. There is room for improvement with a more coordinated

approach with respect to interactions across the five LHINs and the City of Toronto Long-Term Care Homes and Services Division.

Section 6 Appendices

Appendix A: City of Toronto Long-Term Care Homes & Services Map



Source: City of Toronto Long-Term Care Homes and Services, 2016

Appendix B: City of Toronto Long-Term Care Homes and Services

Long-Term Care Homes & Services

TORONTO

Long-Term Care Homes: All homes provide 24-hour nursing care, dementia care, Gentlecare™, physiotherapy, occupational therapy, dental care, optometry, complementary care, art/music therapy, lesbian, gay, bi and transgendered (LGBT) supports, community outreach including volunteer programs, and spiritual/religious care.

HOMES	BEDS	LANGUAGE/ CULTURAL SERVICES	BEHAVIOURAL SUPPORTS	SHORT-STAY RESPITE BEDS	YOUNG ADULT CARE	ADULT DAY PROGRAM	CONVALESCENT CARE
Bendale Acres 2920 Lawrence Ave. E. (Ward 38)	302	• French (Pavillion Omer Deslauriers) • Mandarin • Ismali	●	●	●	●	
Carefree Lodge 306 Finch Ave. E. (Ward 24)	127	• Cantonese • Jewish • Korean • Mandarin • Russian					
Castleview Wychwood Towers 351 Christie St. (Ward 21)	456	• Japanese • Korean • Portuguese	●	●	●		●
Cummer Lodge 205 Cummer Ave. (Ward 24)	391	• Jewish	●	●	●	●	
Fudger House 439 Sherbourne St. (Ward 28)	250	• Cantonese • Mandarin	●	●			●
Kipling Acres (under redevelopment) 2233 Kipling Ave. (Ward 2)	337		●	●	●	●	●
Lakeshore Lodge 3197 Lakeshore Blvd. W. (Ward 6)	150						
Seven Oaks 9 Neilson Rd. (Ward 43)	249	• Armenian • Tamil	●	●	●		●
True Davidson Acres 200 Dawes Rd. (Ward 31)	187	• Spanish		●			●
Wesburn Manor 400 The West Mall (Ward 3)	192		●	●		●	

Community-Based Programs: provide quality care and services to improve and/or maintain functional independence and quality of life to clients that may be isolated, vulnerable, or would otherwise not be able to live independently in their homes.

- Homemakers and Nurses Services offers light housekeeping and meal preparation, laundry, incidental grocery shopping, to approximately 2,600 individuals living in the city. Applicants are assessed for functional and financial eligibility.
- Supportive Housing Services offer homemaking, light meal preparation, personal care, medication reminders, and security checks to 465 seniors who live in their own apartments, in nine designated buildings across the city. Staff are available onsite 24/7.
- Adult Day Programs offer a variety of quality activities and services in a safe, supportive environment for people who are physically frail, have a cognitive impairment or who are socially isolated.
- Meals on Wheels is supported by preparing 2,400 meals per week distributed from five sites.

Source: City of Toronto Long-Term Care Homes and Services, 2016

Appendix C: UOIT Ethics Approval

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RESEARCH ETHICS BOARD
OFFICE OF RESEARCH SERVICES

Date: April 15th, 2011

To: Lindsay Wyers (PI), Brenda Gamble (Faculty Supervisor)

From: Amy Leach, REB Chair

REB File #: 10-089

Project Title: Accountable Approaches to Accountability

DECISION: APPROVED

START DATE: April 13th, 2011 **EXPIRY: April 13th, 2012**

The University Of Ontario Institute Of Technology Research Ethics Board has reviewed and approved the above research proposal. The application in support of the above research project has been reviewed by the Research Ethics Board to ensure compliance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS) and the UOIT Research Ethics Policy and Procedures.

Please note that the Research Ethics Board (REB) requires that you adhere to the protocol as last reviewed and approved by the REB.

Always quote your REB file number on all future correspondence.

Please familiarize yourself with the following forms as they may become of use to you.

- **Change Request Form:** any changes or modifications (i.e. adding a Co-PI or a change in methodology) must be approved by the REB through the completion of a change request form before implemented.
- **Adverse or unexpected Events Form:** events must be reported to the REB within 72 hours after the event occurred with an indication of how these events affect (in the view of the Principal Investigator) the safety of the participants and the continuation of the protocol. (I.e. un-anticipated or un-mitigated physical, social or psychological harm to a participant).
- **Research Project Completion Form:** must be completed when the research study has completed.
- **Renewal Request Form:** any project that exceeds the original approval period must receive approval by the REB through the completion of a Renewal Request Form before the expiry date has passed.

All Forms can be found at http://research.uoit.ca/EN/main/231307/Research_Forms.html.

REB Chair Dr. Amy Leach, SSH amy.leach@uoit.ca	Ethics and Compliance Officer Sascha Tuuha, (905) 721-8668 ext. 3693 compliance@uoit.ca

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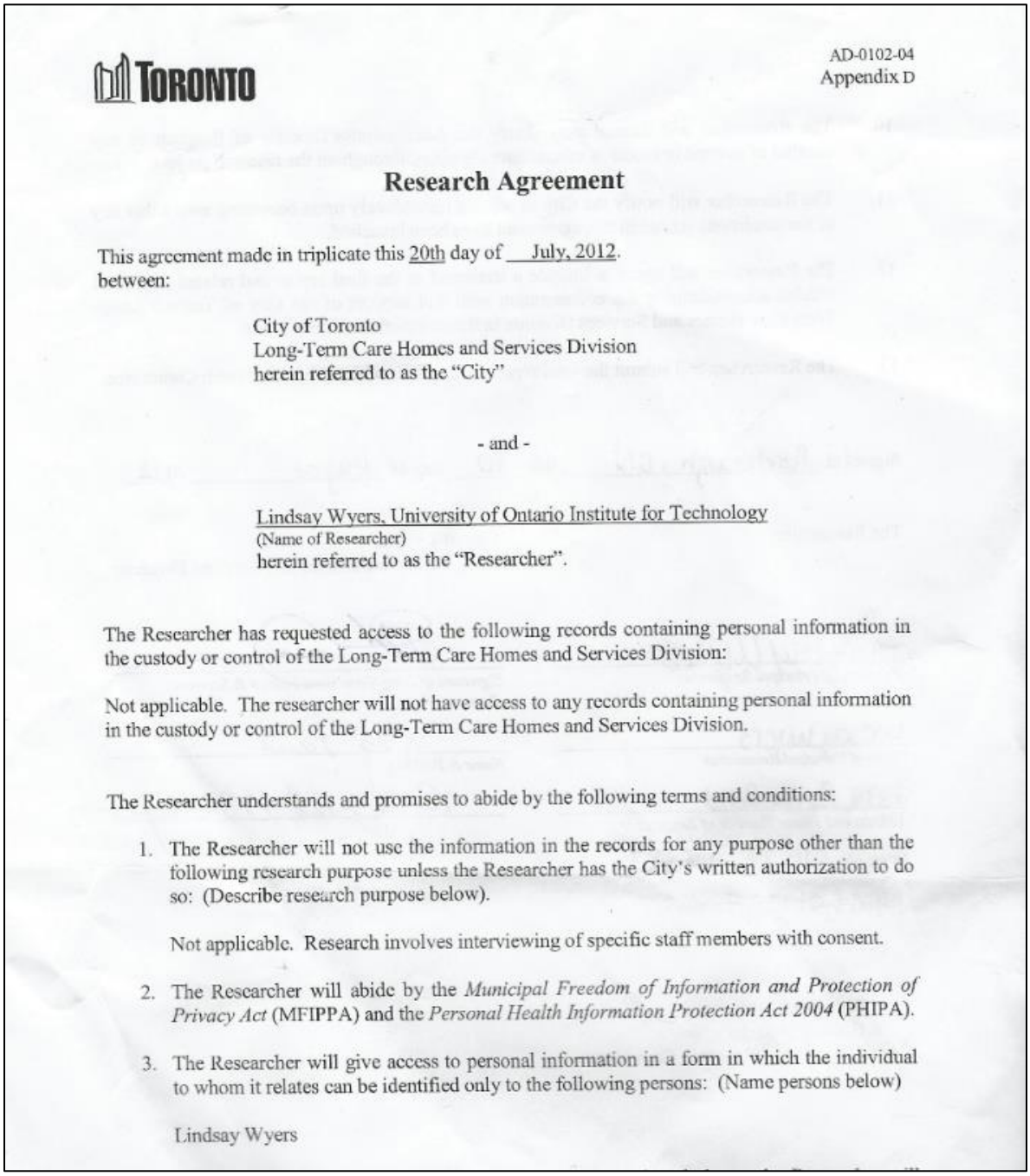
Appendix D: City of Toronto Ethics Approval



TORONTO

AD-0102-04
Appendix D

Research Agreement

This agreement made in triplicate this 20th day of July, 2012.
between:

City of Toronto
Long-Term Care Homes and Services Division
herein referred to as the "City"

- and -

Lindsay Wyers, University of Ontario Institute for Technology
(Name of Researcher)
herein referred to as the "Researcher".

The Researcher has requested access to the following records containing personal information in the custody or control of the Long-Term Care Homes and Services Division:

Not applicable. The researcher will not have access to any records containing personal information in the custody or control of the Long-Term Care Homes and Services Division.

The Researcher understands and promises to abide by the following terms and conditions:

1. The Researcher will not use the information in the records for any purpose other than the following research purpose unless the Researcher has the City's written authorization to do so: (Describe research purpose below).

   Not applicable. Research involves interviewing of specific staff members with consent.

2. The Researcher will abide by the *Municipal Freedom of Information and Protection of Privacy Act* (MFIPPA) and the *Personal Health Information Protection Act 2004* (PHIPA).

3. The Researcher will give access to personal information in a form in which the individual to whom it relates can be identified only to the following persons: (Name persons below)

   Lindsay Wyers

4. Before disclosing personal information to persons mentioned above, the Researcher will enter into an agreement with those persons to ensure that they will not disclose it to any other person.

5. The Researcher will keep the information in a physically secure location/environment to which access is given only to the Researcher and the persons mentioned above.

6. The Researcher will destroy all individual identifiers in the information by April 1, 2014.

7. The Researcher will not contact any individual to whom personal information relates, directly or indirectly, without the prior written authority of the institution.

8. The Researcher will ensure that no personal information will be used or disclosed in a form in which the individual to whom it relates can be identified without the written authority of the City.

9. The Researcher will maintain and submit scientific and ethical approval extensions to the Chair of the Ethics/Research Committee during the project.

10. The Researcher will immediately notify the Administrator/Director of Program of any conflict of interest or research misconduct identified throughout the research project.

11. The Researcher will notify the City in writing immediately upon becoming aware that any of the conditions set out in this agreement have been breached.

12. The Researcher will agree to include a statement in the final report and related published articles acknowledging the collaboration with and support of the City of Toronto Long-Term Care Homes and Services Division in the completion of the project.

13. The Researcher will submit the final report to the Chair of the Ethics/Research Committee.

Signed at Peterborough, ON, this 10 day of August 2012.

The Researcher:

Lindsay Lyers
Signature of Principal Researcher

Lindsay Lyers
Name of Principal Researcher

2392 Rundle Road
Address and Phone Number of Researcher

Bowmanville ON L1C3K7
905 621 1337

City of Toronto
Long-Term Care Homes and Services Division:

Signature of Long-Term ~~Care Homes~~ & Services Representative

Reg Paul
Name & Position

General Manager

cc: Principal Researcher
General Manager
Chair, Ethics/Research Committee

Revised: 01-06-2008

Appendix E: Letter to Administrators

Dear Administrators:

I am a student from the University of Ontario Institute of Technology (UOIT). I have been lucky enough to partner with the City of Toronto, Long-Term Care Homes and Services, to conduct my research for my Masters of Health Science, in community health.

I am requesting your participation in my research project in the form of a semi-structured interview. My research project is trying to understand your views on accountability in the long-term care sector and the strengths and weaknesses of the protocols that you follow.

What does the study involve?

You will be asked to answer a number of questions in the form of a semi-structured interview over the telephone. These questions will ask you about your opinion on a number of areas related to accountability in long-term care, as well as some general demographic questions. This interview should take 30-60 minutes to complete and will be digitally recorded.

All individual and facility information will be held in the strictest confidence and no information which enables identification of any facility or individual will be published or disclosed. Only summary information will be available in future reports or publications.

Next Steps

If you are willing to participate, I have attached the letter of consent, which I will need signed prior to conducting the interview**. Please forward me some times & dates that are convenient for you by September 26th, 2012**, if you are interested in participating in this study.

I sincerely hope that you will take the time to participate and I thank you in advance for your willingness to partake in my research study.

Sincerely,

Lindsay Wyers, H.B.Sc., MSc (c)

Appendix F: Consent Form

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FACULTY OF HEALTH SCIENCES

Appendix C

Consent Letter

Title: Accountable Approaches to Accountability in Long-Term Care
Investigator: Ms. Lindsay Wyers
Research Supervisor: Dr. Brenda Gamble

Background and Purpose of Research

Accountability in health care is stressed by all levels of government and the tax-paying public with respect to the health outputs produced (i.e. patient outcomes, decreased wait times, cost containment, and quality of care) from the inputs used (public funds derived from tax revenue, medical services utilized). Accountability requires that all parties know their roles, responsibilities, and performance expectations. In the past there has been considerable variation in how accountability is defined and measured in the Canadian health care landscape.

In this interview, we are trying to understand your views on accountability in your sector of health care and the strengths and weaknesses of the protocols that you follow.

This study is being conducted by researchers from the University of Ontario Institute for Technology. It has been approved by the Research Ethics Board at the University of Ontario Institute for Technology. The text below describes this study. Please read this information carefully before you decide if you are willing to participate in this study.

Who is participating?

Stakeholders from the Ministry of Health and Long-Term Care, Local Health Integration Networks, long-term care homes, and City of Toronto employees will be participating in this study. This means that many of your colleagues may also be interviewed.

What does the study involve?

You will be asked to answer a number of questions in the form of a semi-structured interview. These questions will ask you about your opinion on a number of areas related to accountability in health care as related to your sector, as well as some general demographic questions. This interview should take 30-60 minutes to complete and will be digitally recorded.

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FACULTY OF HEALTH SCIENCES

Contacts

This research is being conducted by Lindsay Wyers as part of the requirements for the Masters degree in Health Sciences at the University of Ontario Institute of Technology. This research is being supervised by Brenda Gamble, PhD (University of Ontario Institute of Technology). If you have any questions about the study, you may contact Lindsay Wyers at 905: 621-1337 or email at Lindsay.wyers@uoit.ca or Brenda Gamble at 905: 721- 8668 ext 2934 or email at brenda.gamble@uoit.ca.

You waive no legal rights by participating in this study. If you have any questions about your rights as a participant, you may contact the Ethics Review Office of the University of Ontario Institute of Technology at Tel: (905)-721 8668 x 2357 or email compliance@uoit.ca

Benefits / Risk of the Study

There are no personal benefits or risks to the study, but we anticipate that the results should be helpful to decision makers in improving how accountability is being implemented. The questions included in the interview are of low sensitivity. If you feel uncomfortable at any time you are free to discontinue participation, either temporarily or permanently.

What about confidentiality?

The information collected will not be used to identify a particular organization or individual unless express consent is received or the information is already in the public domain. You will have the opportunity to review your response to ensure that we have correctly captured your views. Your responses will only be used for the purposes of this research study and will not be accessed by anyone outside of the research team. All electronic and paper records will be kept in a secure location and will be maintained for 4 years after study completion and then destroyed.

Voluntary Participation / Withdrawal

Participation in this study is completely voluntary. If you choose to participate, you may exit the interview at any time without any consequence, and if requested, your responses to any questions will be destroyed.

Compensation

You will not receive any compensation for participating in the study.

Publication of Results

The results from this study will be published in academic journals and presented at conferences. It will also be shared with the participants in the study, including through workshops.

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FACULTY OF HEALTH SCIENCES

Funding of Research

This study is being funded through CIHR.

Consent

I have read the above information and by signing below I provide my consent to participate in this research study.

_____
Printed Name

_____ _____
Signature Date

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Appendix G: Interview Guide

Data Collection Guide – LTC

Updated-January 20, 2011

SCRIPT:

TO BE READ AT THE BEGINNING OF THE INTERVIEW AFTER CONSENT FORM HAS BEEN SIGNED

"CONFIDENTIALITY:

- Your participation in this interview is completely voluntary and you may choose to stop it at any time.
- No information identifying you or your organization will explicitly appear in any report or publication of this research unless you give consent or it is otherwise public knowledge.
- Your interview transcripts and recording will be safely stored on a password protected computer and only research staff will have access to this information."

"I would be happy to send you a transcript of the interview, for you to correct or amend as needed."

"There are no right answers to any of these questions, I just want to talk with you and learn from your experience."

"For some questions you may know of documents where I can find the information, please feel free to refer me to those documents."

Concept (addressed by Question)	**Question/Explanation**	**Prompt**
General/Introductory		
NB: types of services/key function areas and specialty services are knowable through publicly available reports	What are the main goals of your organization?	Mission, Vision, Values; Cost, Quality, Service Access
	Through public reports, we are aware that you offer the following types of services and specialty services (list to interviewee). Are these accurate? Do you provide any other services we have not mentioned?	L-SAA Agreement
Resource Dependence		
	What types of services does your organization contract out? Why have you chosen to sub-contract for these services? In your view, are there pros and cons to sub-contracting for these services and, if so, what are they?	
	What types of services would your organization NEVER contract out?	
Accountability		
General Introduction	Accountability means: being answerable to another person, or organization for a specified outcome. You might be accountable to individuals internal to your organization, or external to it. We are going to ask you about 3 specific areas of accountability, in turn: financial, compliance, and quality of care. Let's begin with financial accountability.	

Financial		
	With respect to this aspect of accountability: To whom (i.e., organization, entity) is your organization chiefly accountable?	
	For what is your organization accountable, i.e. what are the requirements?	
	Did your organization have input into setting the accountability requirements?	
	Do the accountability requirements align with or reflect your organization's mission, values and goals? If so, can or do you use the accountability measures to make decisions regarding performance improvement initiatives in your organization? What are the domains of performance in this area that your organization is concerned about – and how do these differ from what is measured through the accountability system that is currently in place (for this area of accountability)?	
	How is accountability achieved, or demonstrated?	How do they (see above answer) know you are accountable
	Is it difficult to achieve accountability/meet the requirements? Why or why not? Who, specifically, is held accountable in your organization, i.e.., who reports against requirements?	
	How clear, generally, are the roles in your organization around accountability?	
	Who supplies the resources needed to ensure that accountability requirements are met?	
	What is the motivation for demonstrating accountability? Why is it important to your organization?	
	Are there consequences of not meeting accountability requirements?	
	Is it difficult for you (your organization) to achieve accountability in this area? If so, why? Has your	

	ability to meet the requirements improved over time?	
	In your view, are there any unintended consequences that arise due to the need to be accountable in this area?	
Compliance (Overseer/Regulation)		
	With respect to this aspect of accountability: To whom (i.e., organization, entity) is your organization chiefly accountable?	
	For what is your organization accountable, i.e. what are the requirements?	
	Did your organization have input into setting the accountability requirements?	
	Do the accountability requirements align with or reflect your organization's mission, values and goals? If so, can or do you use the accountability measures to make decisions regarding performance improvement initiatives in your organization? What are the domains of performance in this area that your organization is concerned about – and how do these differ from what is measured through the accountability system that is currently in place (for this area of accountability)?	
	How is accountability achieved, or demonstrated?	
	Is it difficult to achieve accountability/meet the requirements? Why or why not? Who, specifically, is held accountable in your organization, i.e.., who reports against requirements?	
	How clear, generally, are the roles in your organization around accountability?	
	Who supplies the resources needed to ensure that accountability requirements are met?	
	What is the motivation for demonstrating accountability? Why is it important to your organization?	
	Are there consequences of not meeting accountability requirements?	

	Is it difficult for you (your organization) to achieve accountability in this area? If so, why? Has your ability to meet the requirements improved over time?	
	In your view, are there any unintended consequences that arise due to the need to be accountable in this area?	
Quality of Care (Clinical)		
	With respect to this aspect of accountability: To whom (i.e., organization, entity) is your organization chiefly accountable?	
	For what is your organization accountable, i.e. what are the requirements?	
	Did your organization have input into setting the accountability requirements?	
	Do the accountability requirements align with or reflect your organization's mission, values and goals? If so, can or do you use the accountability measures to make decisions regarding performance improvement initiatives in your organization? What are the domains of performance in this area that your organization is concerned about – and how do these differ from what is measured through the accountability system that is currently in place (for this area of accountability)?	
	How is accountability achieved, or demonstrated?	
	Is it difficult to achieve accountability/meet the requirements? Why or why not? Who, specifically, is held accountable in your organization, i.e.., who reports against requirements?	
	How clear, generally, are the roles in your organization around accountability?	
	Who supplies the resources needed to ensure that accountability requirements are met?	
	What is the motivation for demonstrating accountability? Why is it important to your organization?	

	Are there consequences of not meeting accountability requirements?	
	Is it difficult for you (your organization) to achieve accountability in this area? If so, why? Has your ability to meet the requirements improved over time?	
	In your view, are there any unintended consequences that arise due to the need to be accountable in this area?	
Other Areas	In addition to the areas of accountability we have covered so far, are there additional entities, organizations or individuals to which you/your organization are accountable?	An internal QI Committee If a member of a large multi-unit organization, like a nursing home chain, the may have additional accountabilities to chain HQ
Summary	Does being required to meet accountability requirements in all of these areas (of accountability), introduce any tensions or necessitate any trade-offs in your day-to-day operations and decision-making?	
Contestability		
Market Entry	How easy is it for an organization like yours to enter into the LTC sector and to provide the services, and specialty services, you provide?	
	Why is it difficult/easy?	
	Is it easy to move from one geographic area to another?	Whether through expansion in the case of multi-unit chain, or relocating a home to another area
Change in Services	How easy is it for an organization like yours to change the services, and/or specialty services, you provide once established in the market?	E.g.: Short stay bed, convalescent care, EPC

	What makes this difficult/easy?	
Market Exit	How easy is it for an organization like yours to stop operations and exit the market?	
	What makes this difficult/easy?	
Measures		
	Why do you think the performance measures used in the LSAA were chosen?	
	What activities do you think are important, but are not being measured currently in the LSAA – if any?	
	Can you speculate as to why they are not being measured?	

"Thank you for taking time for this interview, if you have any questions, or think of any additional answers or materials that are relevant, please feel free to contact me"