Mandate to Assess the Performance of Care and Services for Older Adults – COVID-19

The Duty to Do Things Differently

Executive Summary

January 2022

Québec

CSBE
Commissaire à la santé et au bien-être

Background

In August 2020, the government of Québec entrusted the Health and Welfare Commissioner (CSBE) with a mandate to assess the performance of the health and social services system in managing the first wave of the COVID-19 pandemic, from February 25 to July 10, 2020. This mandate focuses on the provision of care and services to older adults, and on the public health response. It does not assess measures taken to manage subsequent waves of the pandemic.

The final report, entitled *Le devoir de faire autrement* (The Duty to Do Things Differently), is published in two parts:

- Part 1: *Renforcer le rôle stratégique de la santé publique* (Strengthening the Strategic Role of Public Health), deals with the government's overall management of the pandemic;
- Part 2: *Réorienter la gouvernance vers des résultats qui comptent pour les gens* (Realigning Governance to Achieve Outcomes That Matter to People), deals with the system's performance in providing care and services to older adults in residential facilities during the first wave.

This two-part report follows a preliminary CSBE report published in September 2021, entitled *Mandat sur la performance des soins et services aux ainés – COVID-19* (Mandate to Assess the Performance of Care and Services to older adults – COVID-19), which provided a preliminary assessment of the governance of care and services to older adults in residential facilities.

These three publications assemble the observations and recommendations resulting from the CSBE's work on the special mandate. The publications are accompanied by a series of additional studies (some of which are forthcoming) conducted by CSBE staff and by academic teams enlisted by the Commissioner.

The findings and recommendations presented in these publications do not seek to assign blame to any particular organization or person for the consequences of the crisis. The CSBE considers we all share responsibility for its outcomes.

In closing, we wish to acknowledge the healthcare workers whose devotion and courage was evident throughout the first wave of the pandemic and persists today.

WHAT HAPPENED?

5,718 deaths in Québec
during the first wave of the pandemic
(February 25 to July 11, 2020)

4,836 in residential facilities for older adults
(CHSLDs, RPAs with/without care units, RI-RTFs)

- **3,675** in long-term care facilities (CHSLDs)
- **944** in private seniors' homes (RPAs)
- **217** in intermediary and family-type resources (RI-RTFs)

In the first wave, 64% of deaths occurred in CHSLDs, even though older adults in these residential facilities[1] **represent less than 0.5% of the population.**

Excess mortality:

- Québec-wide: **15 %**
- In CHSLDs: **34 %**

Fatality rate of infected persons:

- **In CHSLDs: 40 %**
- **In RPAs: 25 %**
- **In RI-RTFs: 23 %**
- **In the general population: 2 %**

The excess mortality in Québec during the first wave was greater than in other provinces.

Data collected in Québec reveals four risk factors that contributed to the occurrence of a first death in a CHSLD or RPA:

- Population density;
- Community transmission rate;
- Total number of beds in the facility;
- Private facility not under contract with a public establishment.

International studies point to factors that lead to increased risk and higher mortality rates in residential facilities:

- Community transmission;
- Reduced staffing levels;

1. **Living facility:** Includes all residential and long-term care centre (CHSLDs), private seniors' homes (RPAs), with or without care units, and intermediary and family-type resources (RI-RTFs).

   Residential facility: Includes all CHSLDs, RPAs with care units and RI-RTFs.

- High staff turnover;
- Staff assigned to several sites;
- Nurse-to-resident ratios below recommended thresholds;
- Underfunding, lack of supervision and lack of oversight in private long-term care homes not under public contract.

Healthcare workers in residential facilities were infected earlier and had higher rates of infection, which increased the vulnerability of these facilities.

- **14,090 healthcare workers infected in the first wave**
- **47% were CHSLD workers**

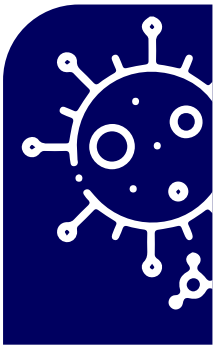
WHY DID IT HAPPEN?

Despite

- Exemplary population compliance with public health guidelines;
- Exceptional devotion of the vast majority of health teams and people working with older adults.

It was not possible to control the situation and effectively protect vulnerable populations. **The pandemic revealed and exacerbated four areas of vulnerability in the ecosystem of care and services for older adults.**

1. Management of the healthcare system in times of crisis, revealing that Québec was ill-prepared to face a pandemic.
2. The state of care and services for older adults at the start of the pandemic (labour shortage, lack of staff supervision, lack of expertise in infection prevention and control).
3. Deficiencies in the governance of care and services for older adults.
4. Deficiencies in the overall governance of the health and social services system.



1. Management of the healthcare system during a public health crisis

a. Lack of an up-to-date and tested pandemic plan adapted to all types of facility.

b. Lack of agility in organizations that did not have an emergency decision-making process.

c. Lack of knowledge and clarity about the roles and responsibilities of public health actors, which could even lead to mistrust.

d. Under-representation on decision-making committees of experts versed in the realities and needs of residential facilities for older adults.
e. Paternalistic attitude towards older adults.
f. Perceived lack of independence of the National Director of Public Health.
g. Lack of transparency in the development of guidelines and lack of a process to ensure accountability during a prolonged public health emergency.
h. Poor integration of digital tools and lack of access to high-quality data.
i. Lack of human, financial and information resources for public health.
j. Lack of infection prevention and control capacities.
k. Deficient planning of personal protective equipment (PPE) reserves.
l. Limited use of the «precautionary principle.»

2. Organization of care and services for older adults in residential facilities at the start of the pandemic

a. Shortcomings were evident at the start of the pandemic, including: financial resources, labour, staff supervision, expertise in infection prevention and control, the organization of medical care in residential facilities, monitoring and quality assurance systems, information, etc.
b. Human resources were organized based on mobility rather than team stability with staff assigned to a single institution; this created instability and structural weaknesses.
c. The shortage of nurses in residential facilities impacted on the quality of care and services, team motivation, and staff performance and retention.
d. Residential facilities did not all provide safe conditions.

3. Governance of care and services for older adults

a. Services for older adults are not recognized as a priority in the governance of the health and social services system.
b. There is insufficient leadership to apply a «seniors' lens» in government decision-making.
c. The integration of services with other components of the healthcare system, including medical services, is incomplete, especially in urban areas.
d. Quality control and accountability systems do not have enough impact on decisions.
e. Resource allocation is not based on reliable data and does not consider the service needs of residents.
f. Private residential facilities are increasingly used, with insufficient supervision.

4. Overall governance of the health and social services system

a. Centralization and focus on production volumes, access and cost control. Not enough consideration of outcomes in terms of care quality and individual health.
b. Budgeting based on historical data and lack of flexibility for institutions.
c. Professional practices defined and restricted by regulation.
d. Economic incentives not aligned with improving the value of health care.
e. Priority given to cost control.
f. Lack of available data for planning, decision-making, adjusting strategies and assessing results.

The root cause of our collective failure during the first wave

For many years now, the Ministry has failed to fulfill its crucial governance role:

- Attention placed on system operations (activities, resources, care/service volumes, access) **and not on outcomes**.
- The Ministry does not use all the governance levers at its disposal to improve system performance.
- **Governance shortcomings are an obstacle to developing a care and service model that optimizes healthcare resources to improve population health.**

Most of these issues were known before the pandemic. Recommendations were made. But decisions were not taken to act on them. A change in direction is needed to focus on outcomes and on the value of care and services.

THE DUTY TO DO THINGS DIFFERENTLY

Recommendations to make sure this never happens again

In the short term, to address management issues raised during the first wave:

1. Develop and adopt an integrated national strategy to ensure health crisis preparedness

a. Oversight mechanism for continued health risks analysis.
b. Health crisis management plan developed in collaboration with all concerned stakeholders.

c. Annual testing of the health crisis management plan.
d. Development of guidelines for supliers' preparedness.
e. Adoption of guiding principles for decision-making that integrate the precautionary principle.
f. Periodic independent assessment of results of the national health risk preparedness strategy.

2. Develop a culture of transparency with regard to population health policies and decisions

a. Ensure transparency of public health advices and recommendations (at both national and regional level).
b. Grant the National Director of Public Health the authority to inform the public in an independent manner.

3. Adopt an outcome assessment system based on recognized international standards to support decision making (clinical, organizational, governance)

a. Deploy this assessment system across the network of services that support the autonomy of older adults, starting with residential facilities.
b. Assure the assessment system is implemented by each CISSS/CIUSSS in all facilities and residential resources on their territory.
c. Implement the assessment system in all residential facilities and schedule periodic assessments of all residents.

4. Plan and regulate the provision of residential services based on expected outcomes and a fair funding model

a. Clarification from government of specific requirements/rules for collaboration between the public system and the private sector.

5. Call for joint solutions

a. To improve the delivery of health and social services in residential facilities and strengthen their coordination with support services in these facilities.

In the long term, to optimize resource usage, value creation and the sustainability of the public health and social services system:

6. Strengthen the strategic role of public health

a. Undertake a reflexive exercise to place public health at the heart of the Ministry's strategic priorities and define the desired evolution of the public health mission.
b. Build the capacities of the public health system (human, informational and financial resources) based on needs and targeted outcomes, to achieve levels comparable to those seen elsewhere in Canada and around the world.

c. Develop an infection prevention and control improvement plan.

7. National plan for a value-based healthcare system

a. National plan to equip Québec with a value-based healthcare system.
b. Plan to implement a value-based health and social services network.
c. Approval of the transformation plan.
d. Annual reporting to the National Assembly on progress in the plan's implementation and outcomes.

To guide us in making real profound changes that will ensure the sustainability of our healthcare system