Presentation to SALT, September 11 2007: Privatizing Continuing Care

The continuing care system is, theoretically, a continuum of services from home care through supportive living, and continuing care centres. There are variations in the care that's provided within each bit of the system, but generally speaking, each level provides a higher level of care. It's been an evolution over 50 years, from auxiliary hospital, nursing home, senior lodges, and home care, provided by a variety of operators with a high rate of public funding for the health care services and with housing cost subsidies.

At various times along the way, particularly in 1982 with the Alberta Nursing Home Review Panel (Hyde) Report , and the 1988 A New Vision for Long Term Care, recommendations were made to rationalize the system, including integrating the services under a proposed Long Term Care Act, and developing more "community based" options for providing housing and support services.

The auxiliary hospital and nursing home services were merged, reducing the skilled nursing care and rehabilitation services, and the "single point of entry" system was initiated. New services began to emerge: personal care services in private and group homes, specialized dementia care programs, assisted living, and day programs which coordinated a variety of care services. There were also "transition" programs, primarily to provide short-term care to reduce the pressure on acute care hospitals, often located in continuing care facilities. The underlying issues were both increasing demands for services, and a change in philosophy from institutional medical care to a community-based provision of services.

The subtext in these policy developments was that health care in general (and particularly for old folks, whose numbers were increasing) was costing a lot of public money. That became the primary message in the mid-90s. Both care facility and home care services were cut and downgraded, unbundling and delisting shifted costs to the users, and seniors' benefits were cut. Responsibility for providing services was shifted to the regional health authorities (under the direction of Alberta Health). The funding model changed from a program basis to a global population model, increasingly distanced from assessments of care needs. And we must not forget the famous Taft report from the early 1990s, which was shredded because its findings did not support government Policy that seniors care costs were escalating out of control. (Kevin Taft was also involved in the 1982 Hyde report, which identified a number of concerns about quality of care and funding.)

The Broda reports (1999 -2002) and related health care policy initiatives redefined the public role in continuing care services. Government responsibility for health care was redefined from direct service provider to setting strategic direction for the system through policy, legislation and standards; allocating resources; helping develop and support the health system; and administering provincial programs. Government would no longer be involved in building new housing facilities - from 1959 to 1993, government funded the construction of senior citizens' homes.

Beginning in 1994, in recognition that public subsidies were necessary to support private capital investment, capital funding was made available to non-profit organizations to develop new seniors' housing. By 2003, this funding was also available to private for-profit developers. Both for-profit and not-for-profit care centre operators have had access to pubic funding for construction costs, renovation and with the operating contracts; these subsidies are now being extended to supportive living facilities.

There has not been a consolidated report of the public funding for continuing care facilities. I did find, in the ASCHA newsletters, a list of 2005/07 recent Rural Affordable Supportive Living capital grants to 17 private for-profit care facility operators which totaled $16.5 million. RASL is only one of the capital funding programs available. When you see a press release announcing “Provincial surplus helps create more housing in rural Alberta”, you need to look at the “Backgrounder” to discover, for example, that we’re paying $2.4 million for half the construction costs of a Continuum Health Care Holdings Ltd. project under the Rural Capital Projects Initiative, which will be supported by a long term operating contract with the health region, and undoubtedly made more profitable by deals with land purchase and other perks.

The number of care spaces available is really hard to determine. Historical data reports 12,982 long term residents in 1990. From 1997 to 2003, Alberta Health published an annual census of long term care residents, including care needs classifications; these number show an increase from 12,836 in 1997 to14,449 in 2003. These numbers don’t coincide with other reported numbers (for instance, the RHA funding manual [2005/06] reports 12,732 residents in 2003). When Alberta Health was asked to reconcile the differing numbers, they said the resident count for 2003 was 12,940 – and for 2006, 12,551. But there can be no doubt that significant numbers of folks are being shifted to assisted and supportive living settings, which are increasingly privately owned and operated.

In 1990, Alberta’s population was 2.5 million; in 2000, 2.9 million, and by 2006, 3.4 million. Assuming the same proportion of the population (about 0.5%) need serious long term care, the care facility resident population should have increased at the same rate. But we know that seniors are now a somewhat larger proportion of the population, and that those with serious and complex health problems are living longer.

There is also no doubt that increasing numbers of people who apply for continuing care (including home care) are not being assessed for care which coincides with real life needs. The assessment criteria have traditionally been adjusted downward when the wait lists get out of control, assessed needs have more to do with services provided than with individual needs, and it’s all relative, anyway; the wait lists were cut in half when the “waiting in the community” category was dropped. If you’re not “urgent”, you can wait until you are. Or, you can buy private care, often in the same facilities that have contracts with the health regions for “designated” spaces.

At Columbia Assisted Living, in Lethbridge, personal care services may be provided by the RHA Homecare Program, and are also available from their staff. Rent, for one person is $1585 or $1895/month (plus telephone and cable). (Laundry is probably coin-operated.)

Laundry Service (once a week)	$35.00 per month
Bath - 30 minutes	$9.00 per bath, or
1 per week	$36.00 per month
Dressing (AM or PM) - 15 minutes per	$135.00 per month, or
Dressing (AM and PM) - 15 minutes per	$270.00 per month for both
Feeding - 20 minutes x 3 daily	$360.00 per month
Medication Management	$50.00 per month
Mobility (to dining room/return x 3 daily)	$270.00 per month
Toileting - 10 minutes	$90.00 per month

Full personal care services offered: $1111

At Holy Cross Manor in Calgary, even higher rents were raised earlier this year by 40%. The last posted “Available Optional” service charges (subject to GST) were:

ADDITIONAL OCCUPANT CARE SERVICES AND MEALS FEES:	$750.00
MEDICATION ASSISTANCE PROGRAM:	$300.00
MEDICATION REMINDER:	$175.00
RESIDENT NIGHT CHECKS:	$175.00
FT MEAL ESCORT: (3 meals/day 7 days/week)	$300.00
PT MEAL ESCORT: (2 or less/day 7 days/week)	$175.00
DAILY TRAY SERVICE:	$300.00
MEAL TIME REMINDER:	$175.00
DAILY LIGHT HOUSEKEEPING:	$300.00
WEEKLY PERSONAL LAUNDRY SERVICE:	$50.00
SUPPORT STOCKING ASSISTANCE:	$250.00
INCONTINENCE MANAGEMENT:	$300.00
EXTRA ASSISTANCE:	$350.00
BATH ASSIST X 1(ONE/WEEK):	$100.00
BATH ASSIST X 2(TWICE/WEEK):	$175.00
RESIDENT PARKING PER VEHICLE:	$100.00
SHAW BASIC CABLE PACKAGE/month	$20.00

Full personal care services offered: $2200

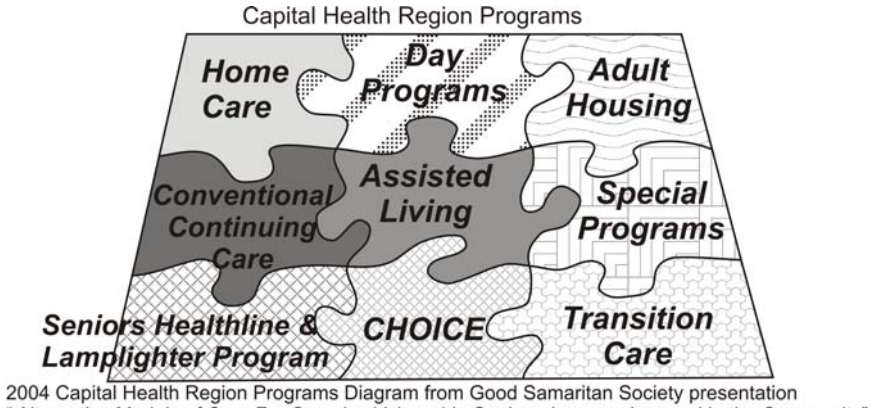
Current government care rates to operators for “designated” residents” are:

Assisted Living (2hrs. unscheduled care), $47.50
Enhanced Assisted Living (3 hrs unscheduled care), $72
Facility care, $148

The trend is to replace facility care with supportive living options. The distinctions are no longer clear; the initial justification was to delay or avoid “institutional care” as long as possible. But while the new assisted and supportive living facilities may be more attractive than a care centre built a decade or more ago, they are still a residential care facility. The difference is the level of care, and the competencies of the care staff – and the cost.

When Phil Gaudet (President and CEO of the Good Samaritan Society) said that assisted living might be seen as a “dumbed-down” care facility in 2002 , he was also in the process of selling the concept of assisted living facilities to replace care facilities. Good Sam has subsequently greatly expanded its assisted living operations in British Columbia and Alberta, with bundles of capital grant money. The Good Sam subsequently converted their publicly-funded Hinton care facility to a Designated Assisted Living facility, with financial help from the Aspen Health Region.

The shift to “community care” and the “unbundling” of care services has market opportunities for private providers (I’ve seen a number of advertisements for home care service provider franchises, some of which are operating in Alberta). The ownership of operators is difficult to trace; most appear to be Alberta or Canadian owned, but it is possible that some may be connected with American health care providers.



2004 Capital Health Region Programs Diagram from Good Samaritan Society presentation
" Alternative Models of Care For Complex Vulnerable Seniors: Lessons Learned in the Community".
(CHOICE = Comprehensive Home Option Integrated Care of Elderly)

> *One of the persistent problems with tracking what's happening, or identifying issues, is the absence of information; this is an issue of both accountability and of transparency – and even of competence. Quite simply, Alberta Health frequently responds to requests for information by saying "we don't track that" or "the health region reporting data in not consistent (or comparable)", or "the details aren't reported". Ask the health regions for information, and they refer you to a FOIP application and the fees.*

The extent of the private market opportunities is enormous. There's been a new interest in "Corporate Memberships" of both the Alberta Senior Citizens Housing Association (ASCHA) and the Alberta Continuing Care Association (ACCA, formerly the Alberta Long Term Care Association), lobby groups for the operators. (For $1500 a year, corporate members get to advertise products and services (including staffing agencies, home care services, long term care insurance, pharmaceuticals, energy, food services and management agencies) to the industry, attend meetings (but not vote), and also enjoy the benefits of "Government Liaison". Many of these suppliers are subsidiaries of facility operators already represented.

> *The Mission Statement of the ACCA, in 2005, was "To provide the best available information and services to our members and continue to work with the government of Alberta to improve legislation that affects long term care as a growing industry". It's been rewritten, to "Enhancing quality of life for individuals receiving continuing care by assisting members in networking, advocacy, education and pursuit of best practices".*

There is also a great deal of investment by international investment banks in the "retirement living" market. We're not just dealing with Summit Care Corporation, an Alberta company (which may or may not be affiliated with Summit Care Corporation US), or Columbia Health Care (with equally suggestive associations), or Extendicare, which operates infamously in the US. Central Park Lodges, a Canadian health care services company previously owned by the Reichmanns, became CPL REIT and then Retirement Residences Real Estate Investment Trust, which also operates in the US – and was chaired at one time by one William G. Davis, with Ernie Eves as a Board member.
(See attached extract from 1997 Prospectus).

The Macquarie Bank is another player: in addition to the Toronto 407 toll road, a share in AltaLink (chaired by David Tuer, also Chair of the Calgary Health Region), and Cardinal

Power, they also own Leisureworld (and retirement care operations in other countries). Leisureworld operates retirement communities, independent living facilities, assisted living facilities, and nursing homes; the purchase included Preferred Health Care Services, which provides staff for care facilities and for private care.

Aged Care a growth industry for Investors discussed why the resident fees have increased; the plan was first publicly outlined in the Broda report's final recommendations:

Recommendation 23 – Adopt a conceptual framework on responsibility for costs*:* The conceptual framework should be adopted as the basis for decisions about responsibility for the costs of different types of continuing care.

Who is responsible for the costs of continuing care?			
Cost components	**Home care**	**Supportive living**	**Long term care facility**
Professional care, e.g. health and medical treatments, visits, tests, etc.	Government – 100%	Government – 100%	Government – 100%
Activities of daily living, e.g. personal care and homemaking services	Government/individual share costs	Government/individual share costs	Government/individual share costs
Accommodation, e.g. food, cleaning, utilities, etc.	Individual – 100%	Individual – 100%	Individual – 100%
Capital, e.g. construction, renovations and upgrading	Individual – 100%	Individual, with income support where needed	Shared responsibility: Individual – 33% (through rental payments) Owner – 33% Government – 33%

What I didn't say in that paper was that, given occasional expressions of concern by private operators that they don't have a level playing field when they have to compete with public services[16], both the fee increase to reach "full cost recovery" and the capital subsidies to private operators were inevitable. There is already confusion about which "envelope" care staff is paid from; the "blended jobs" really confuse the line between health care, personal care, and housekeeping. That will probably be next. And then there was Recommendation 25: Additional revenues raised from increasing charges for residents of continuing care centres should be used in two ways:

§ Improving services in continuing care centres. . .

§ Establishing a capital pool to be used in each region to renovate and build new continuing care centres – The remaining portion should be used to upgrade facilities.

Is assisted living cheaper? We don't know. There's concern that the studies claiming to show it's less expensive don't count all the costs, or comparable costs; and there is the caveat that the costing doesn't include the out-of-pocket costs to the resident, which often include medications, supplies and equipment, and supplementary care staff. We don't have any idea what the cost of deferred capital funding from the grants will be. Administrative costs probably don't include the costs of the contracting processes, and certainly the profits (or, in the case of non-profit organizations, the "investment fund") aren't identified.

Is assisted living better? For some folks, it's the cat's pajamas. For many, it's too expensive. And for some – it's purgatory. But it is not public health care.

What's the government doing next?
The Health Service Standards have been incorporated into the Nursing Home Regulations, and Alberta Health is in the initial stages of developing a Compliance Unit. The Standards, of course, are simply process statements for required policy development, which the health regions will include in service contracts. They don't apply to services privately provided – which means, in a facility where some spaces are "designated" and some are private, or if you buy private home or nursing care, you're on your own.

The Supportive Living Accommodation Standards present a different problem. I wrote a short article (in the handouts) with my concerns about the current initiative to develop them into Supportive Living Accommodation Standards and Licensing (proposed for next spring). In the first place, the standards don't include ordinary consumer tenancy protection. Similar legislation in B.C. has clearly not worked for tenants. But at bottom, what it will do is write the separation of housing and health care for vulnerable seniors into law.

Premier Stelmach has proudly been talking about the Lobbyist Act – so we'll know who's trying to influence public policy and decision-makers. The Muttart Foundation and Volunteer Alberta have initiated a lobby to exclude non-profit organizations from this registry. We know that the care facility and seniors' housing operators, and their associations, have been heavily involved with lobbying for the changes we've seen to continuing care.

> We know that both the ACCA and ASCHA have been represented on Government committees: Broda had Carl Bond, owner of Summit Care Corporation and Travois Holdings and (then) President of the ALTCA; the legislative review committee for the Protection for Persons in Care Act had Carl Bond, Greer Black, president of Bethany Care Society and currently President of the ACCA; and Lyn Krutzfeldt, director of Central Park Lodge for Western Canada and also then a member of the Capital Health Authority Finance Committee and the Capital Health Peer Review Committee. We know that the Alberta Senior Citizens Housing Association and the Alberta Continuing Care Association were given funds to develop the Standards and are part of the ongoing Departmental review and implementation committees.

I've been trying to differentiate between the business of Extendicare and The Good Samaritan Society, to see how they differ so that the lobby efforts Good Sam should be excluded from even this public scrutiny. The only difference I can see is the professed religious beliefs of the Boards. I think this is worth public discussion, and perhaps even a presentation to the policy field committee.

What needs to be done? That's what I hope we can talk about. There aren't any easy answers, but there is urgency.

Carol Wodak, September 11, 2007

Response to Written Question WQ9, submitted May 7,2007: How many long-term care facilities and beds were operating in Alberta on March 31 for the years 2001 to 2006 inclusive, broken down by regional health authority and whether the facility and service providers are owned/operated publicly, privately, or on a voluntary basis?

From File: l***ong-term care beds by type of provider 2001-2006 as of2007.pdf***;
Title: Alberta Health and Wellness Long Term Care Facilities and Beds in Service by Health Region and Service Provider Types

Summary Chart:

AHW LONG TERM CARE FACILITIES AND BEDS, ALBERTA HEALTH AND WELLNESS; Provincial totals

Year	RHA		Private		Voluntary		Total	
	Facilities	Beds	Facilities	Beds	Facilities	Beds	Facilities	Beds
2006	113	5,524	49	5,100	37	3,844	199	14,468
2005	115	5,600	47	4,825	41	3,982	203	14,407
2004	115	5,808	43	4,502	39	3,954	197	14,264
2003	117	5,745	44	4,535	35	3,783	196	14,063
2002	117	5,982	44	4,411	33	3,791	194	14,184
2001	115	6,593	42	4,207	32	3,686	189	14,486

Notes:

1. The above summary of Long Term Care facilities and beds in service was reported by the regional health authorities as operating as of March 31,xxxx (point in time).
2. Long Term Care facilities include Auxiliary Hospitals and Nursing Homes. Combined Auxiliary Hospital and Nursing Homes are counted as two facilities.
3. Service Provider (RHA, Private and Voluntary) refers to the organization operating the facility. This may not be the same as the legal owner of the facility.

Comments, CW: Response provided in PDF document marked "Schedule 1"; document properties show "Created 6/13/2007" and "Prepared April 12, 2007". Wonder what the whole document was, what other information was in it?
These numbers don't distinguish care facility beds used for transition, respite, palliative, sub-acute, rehabilitation & convalescence, recovery, or other short-stay purposes.
Average beds per facility: 77

		2001		2006	
RHA	115	6,593	113	5,524	
Private	42	4,207	49	5,100	
Voluntary	32	3,686	37	3,844	
Total	189	14,486	199	14,468	

Our Forgotten Elders: The Hidden Failings of Seniors' Care in Alberta Edmonton Journal. Edmonton, Alta.: Dec 15, 2002.

There are 174 nursing homes and auxiliary hospitals in the province with a total of 14,715 long-term care beds. The facilities range in size from a six-bed unit in Fort Macleod to the 502-bed, multi-storey General, just west of downtown Edmonton. Of that total:

- 6,898 beds are run by regional health authorities;
- 4,072 beds are run by private, for-profit corporations such as Extendicare;
- 3,745 beds are run non-profit organizations such as the Good Samaritan Society.

Between 1988 and 2000, as the province closed some acute-care hospitals and reconfigured others, the number of active-treatment beds in Alberta dropped from 14,700 to about 6,400. In the past decade, more than 1,400 long-term care beds have been added and home- care programs have been expanded.

WQ10: How many supportive living facilities (including assisted living facilities, lodges, enhanced lodges, seniors complexes, and group homes) and related number of beds were operating in Alberta for each of the fiscal years 2001-02 to 2005-06, and for April 1, 2006 to March 19, 2007, broken down by regional health authority and by whether the facility is owned/operated publicly, privately, or on a voluntary basis?

The following information was taken from the Housing Information System and the Supportive Living Inventory that is maintained by the Supportive Living and Long-Term Care Branch. Please note that the term `unit' is used instead of 'beds'.

Fiscal Year	Number of Supportive Living Facilities	Number of Supportive Living Units
2001l02	139*	8,005
2002/03	140*	8,182
2003104	362	18,198
2004/05	380	19,903
2005/06	390	19,934
2006/07	682	23,545

*The department tracked only publicly funded seniors' lodges prior to 2003/2004

The following information is supportive living information broken down by Regional Health Authority and by type of owner/operator far the period of April1, 2006 - March 17, 2007.

Regional Health Authority	Private Supportive Living		Public Supportive Living		Voluntary Supportive Living		Unknown	
	Facilities	Units	Facilities	Units	Facilities	Units	Facilities	Units
Chinook	6	324	17	1,050	9	424	5	37
Palliser	6	446	6	509	4	562	6	34
Calgary	72	3,452	25	1,581	26	837	43	249
David Thompson	7	408	23	1,346	18	276	27	198
East Central	1	62	20	982	17	495	11	74
Capital	57	2,278	30	2,027	94	2,921	84	673
Aspen	0	0	20	996	4	101	9	78
Peace Country	2	157	14	747	0	0	15	94
Northern Lights	0	0	3	119	0	0	1	8
Total	151	7,I27	158	9,357	172	5,616	201	1,445

Comments:CW
Total facilities - 682; units – 23,575; average units per facility, 35.
The number of supportive living spaces receiving public funding was reported by the Auditor General in the 2005 Seniors Report (page 44):
Designated Assisted Living Facilities – 1,033 beds; other assisted living facilities – 552 beds; Enhanced Lodges – 307 beds; 143 lodges, with approximately 8,500 beds; and 10,000 other supportive living beds, some of which may not have contracts with the Departments or the Regional Health Authorities to provide service.
Source: letter from the Hon. Greg Melchin, Minister Alberta Seniors and Community Supports, dated May 9, 2007

Schedule 1

ALBERTA HEALTH AND WELLNESS
LONG TERM CARE FACILITIES AND BEDS IN SERVICE
BY HEALTH REGION AND SERVICE PROVIDER TYPE

			Service Provider							
			RHA		Private		Voluntary		Total	
Year	RHA	RHA Name	Facilities	Beds	Facilities	Beds	Facilities	Beds	Facilities	Beds
March 31, 2006	R1	Chinook Regional Health Authority	10	282	3	290	3	290	16	862
	R2	Palliser Health Region	5	133	5	329	1	80	11	542
	R3	Calgary Health Region	17	1,127	20	2,635	6	788	43	4,550
	R4	David Thompson Regional Health Authority	25	1,197	2	110	4	130	31	1,437
	R5	East Central Health	13	442	3	165	6	410	22	1,017
	R6	Capital Health	13	1,287	11	1,285	16	2,114	40	4,686
	R7	Aspen Regional Health Authority	16	579	4	226	1	32	21	837
	R8	Peace Country Health	10	402	1	60	0	0	11	462
	R9	Northern Lights Health Region	4	75	0	0	0	0	4	75
		PROVINCIAL TOTAL:	**113**	**5,524**	**49**	**5,100**	**37**	**3,844**	**199**	**14,468**
March 31, 2005	R1	Chinook Regional Health Authority	11	283	3	290	5	310	19	883
	R2	Palliser Health Region	5	133	5	329	1	80	11	542
	R3	Calgary Health Region	17	1,231	19	2,477	6	788	42	4,496
	R4	David Thompson Regional Health Authority	25	1,208	2	110	5	142	32	1,460
	R5	East Central Health	13	441	3	165	6	410	22	1,016
	R6	Capital Health	13	1,244	10	1,168	17	2,220	40	4,632
	R7	Aspen Regional Health Authority	16	581	4	226	1	32	21	839
	R8	Peace Country Health	11	405	1	60	0	0	12	465
	R9	Northern Lights Health Region	4	74	0	0	0	0	4	74
		PROVINCIAL TOTAL:	**115**	**5,600**	**47**	**4,825**	**41**	**3,982**	**203**	**14,407**
March 31, 2004	R1	Chinook Regional Health Authority	12	299	3	290	4	300	19	889
	R2	Palliser Health Region	6	163	4	309	1	80	11	552
	R3	Calgary Health Region	18	1,337	17	2,318	6	789	41	4,444
	R4	David Thompson Regional Health Authority	22	1,170	2	110	4	131	28	1,411
	R5	East Central Health	13	466	3	165	6	411	22	1,042
	R6	Capital Health	12	1,297	9	1,024	16	2,188	37	4,509
	R7	Aspen Regional Health Authority	17	596	4	226	2	55	23	877
	R8	Peace Country Health	11	412	1	60	0	0	12	472
	R9	Northern Lights Health Region	4	68	0	0	0	0	4	68
		PROVINCIAL TOTAL:	**115**	**5,808**	**43**	**4,502**	**39**	**3,954**	**197**	**14,264**
March 31, 2003	R1	Chinook Regional Health Authority	12	301	3	290	3	259	18	850
	R2	Palliser Health Region	6	163	4	304	1	80	11	547
	R3	Calgary Health Region	18	1,357	18	2,357	6	788	42	4,502
	R4	David Thompson Regional Health Authority	24	1,188	2	110	2	49	28	1,347
	R5	East Central Health	13	466	3	165	5	341	21	972
	R6	Capital Health	11	1,168	9	1,024	17	2,236	37	4,428
	R7	Aspen Regional Health Authority	18	624	4	225	1	30	23	879
	R8	Peace Country Health	11	413	1	60	0	0	12	473
	R9	Northern Lights Health Region	4	65	0	0	0	0	4	65
		PROVINCIAL TOTAL:	**117**	**5,745**	**44**	**4,535**	**35**	**3,783**	**196**	**14,063**
March 31, 2002	R1	Chinook Regional Health Authority	12	332	3	290	2	253	17	875
	R2	Palliser Health Region	8	211	5	324	1	80	14	615
	R3	Calgary Health Region	19	1,464	17	2,213	6	788	42	4,465
	R4	David Thompson Regional Health Authority	23	1,215	2	110	2	46	27	1,371
	R5	East Central Health	13	457	3	165	5	367	21	989
	R6	Capital Health	11	1,222	9	1,024	16	2,181	36	4,644
	R7	Aspen Regional Health Authority	17	594	4	225	1	30	22	849
	R8	Peace Country Health	10	422	1	60	0	0	11	482
	R9	Northern Lights Health Region	4	65	0	0	0	0	4	65
		PROVINCIAL TOTAL:	**117**	**5,982**	**44**	**4,411**	**33**	**3,791**	**194**	**14,184**

Prepared: April 12, 2007

Schedule 1

ALBERTA HEALTH AND WELLNESS
LONG TERM CARE FACILITIES AND BEDS IN SERVICE
BY HEALTH REGION AND SERVICE PROVIDER TYPE

			Service Provider							
			RHA		Private		Voluntary		Total	
Year	RHA	RHA Name	Facilities	Beds	Facilities	Beds	Facilities	Beds	Facilities	Beds
March 31, 2001	R1	Chinook Regional Health Authority	12	332	3	270	2	254	17	856
	R2	Palliser Health Region	8	344	4	306	0	0	12	650
	R3	Calgary Health Region	19	1,728	16	2,047	6	808	41	4,583
	R4	David Thompson Regional Health Authority	23	1,243	2	110	2	46	27	1,399
	R5	East Central Health	13	451	3	165	5	367	21	983
	R6	Capital Health	11	1,439	9	1,024	16	2,181	36	4,644
	R7	Aspen Regional Health Authority	17	590	4	225	1	30	22	845
	R8	Peace Country Health	8	400	1	60	0	0	9	460
	R9	Northern Lights Health Region	4	66	0	0	0	0	4	66
		PROVINCIAL TOTAL:	**115**	**6,593**	**42**	**4,207**	**32**	**3,686**	**189**	**14,486**

NOTICE TO READER

1 The above summary of Long Term Care facilities and beds in service was reported by the regional health authorities as operating as of March 31, xxxx (point in time).

2 Long Term Care facilities include Auxiliary Hospitals and Nursing Homes. Combined Auxiliary Hospital and Nursing Homes are counted as two facilities.

3 Service Provider (RHA, Private and Voluntary) refers to the organization operating the facility. This may not be the same as the legal owner of the facility.

Prepared: April 12, 2007

Legislative Assembly of Alberta

Title: **Thursday, June 14, 2007 1:00 p.m.**
Date: 07/06/14
[The Speaker in the chair]

Dr. Pannu: Thank you, Mr. Speaker. This government's enthusiasm for public health care privatization knows no bounds. Every time they have tried to openly privatize, they have met fierce resistance on the part of an overwhelming number of Albertans; they're proceeding nevertheless. Their latest target is long-term care. In fact, the government has been moving to privatize long-term care for some time. It's privatization by stealth. The Conservatives know it. They just don't want Albertans to. According to documents tabled yesterday by the Minister of Health and Wellness, there has been a steady decrease in the number of publicly operated long-term care beds in the province and at the same time a big increase in the privately owned . . .

The Speaker: Well, thank you, hon. member, now we'll proceed. No, no, no. I'm sorry, hon. member. Remember we've got a rule.

Mr. Melchin: Mr. Speaker, I've obviously anticipated the question that would have been asked. We want to thank him for the direction the government is taking to ensure that the seniors' care is there as they would desire, in the format that they wish. Yesterday I had the opportunity, for example, of being in the Speaker's constituency at Shepherd's Care. Certainly, this might have been a private care. This is assisted living, not necessarily long-term care, but they have a whole range of facilities here in Edmonton also that can serve the specific needs. It doesn't even mean that you have to transfer the place in which you live. It's a matter sometimes of providing the health to where you are rather than having to make them move from a building to another building.

The Speaker: The hon. member.

Dr. Pannu: Thank you, Mr. Speaker. Seniors' concerns are the last thing this minister wants to address. The fact is that from 2001 to 2006 we lost close to ~~11,000~~ (*note: should be 1,000? CW)* publicly run long-term care beds while the number of privately run beds increased by over 900. Why is this government quietly squeezing out quality public health care?

Mr. Melchin: On the contrary, we're actually working towards the direction of aging in place, allowing seniors to be able to live in their own facilities, in their own homes to the extent that they can. Many times those in long-term care actually even progress in health and can go back to assisted or designated assisted living. Their care and their standard of health do change. They're not perpetually having to be in a place where they might have to die.

In respect to whether it's private or public, it has always been a combination of private. The private sector has always participated in the provision of long-term care. That's why there's also a standard, provisions of continuing care that have been put in place to ensure that all facilities meet the requisite high standards of patient care.

The Speaker: The hon. member.

Dr. Pannu: Thank you, Mr. Speaker. The minister knows that there are almost three times as many private supportive living units in Calgary than there are publicly owned, and there are twice as many privately run long-term care beds in Calgary than there are public ones. Why are seniors' lives being put at risk for the sake of a Conservative ideological bias toward privatization at all costs?

Mr. Melchin: Well, we're certainly glad to hear the opposition put on the table that they feel that everything should be public at all costs and that the private sector has no role in our lives. It's quite contrary to the whole development of this great country in which we live, in which you and I can make private choices, can have private ownership and even the provision of services to an individual that are private. In this case it is the level of care that's important and even sustaining a person in their own place.

Summary of the Continuing Care Health Service Standards April 2007 Amendments

RHA responsibility under Continuing Care Health Service Standards May 2006, re: long term care facility residents	
Notes: RHAs operate facilities and contracts with private facility operators Issued pursuant to the authority of the Minister of Health and Wellness to issue directives and guidelines to Regional Health Authorities, pursuant to section 8 of the *Regional Health Authorities Act*; replace the 1995 consolidated Basic Service Standards for Long-Term Care Facilities. M = Mandatory requirement; P = Performance expectation. Professional Nursing Care is not defined although it is referenced in 1.10(b).	
A: Providing Quality Continuing Care Health Services	
1.1	Comply with mandatory; make reasonable attempts to comply with, and to ensure contract service providers comply with, performance expectations.
1.2	Provide general information on available services; provide relevant information to clients re: available services (P: inform clients of known options if a specific service is not available)
1.3	Manage waitlists to provide equal opportunity for services; levels and urgency of need as prime considerations.
1.4	Provide to clients information about services provided or offered, the importance of personal directives, guardianship, trusteeship (P), etc,; provide reasonable support for family councils (including establishing terms of reference), have a process for client feedback and biennial surveys.
1.5	Ensure each facility has a concerns resolution process, takes reasonable steps to ensure timely response; provide clients with information about the processes, including the HFRC, Provincial Ombudsman and PPIC.
1.6	Plan and provide health services to promote mental & physical health, independence, and the prevention of disease and injury (P).
1.7	Establish infection prevention and control guidelines and policies
1.8	Ensure that all potential clients are assessed for health service needs; if the required services or preferred setting are not available or ideal, inform client of the risks of available services and advise of available options; If client chooses the available services or preferred setting, work to mitigate the risks, obtain acknowledgement of the risks in writing from the client. ~~Assess all residents by Sept 30/07 with~~ phase in use of the MDS 2.0 according to the AHW timeline ; complete care plans, consult with appropriate professionals and consider the MDS protocols when preparing the care plan.
1.9	Establish policies and processes which permit client involvement in care planning.
1.10	Each client will have one care plan that includes the health service assessment; a description of the health service needs and goals within a time frame; the service interventions that will and will not be provided or funded; the responsibilities of each health care provider team member; how the goals will be monitored and the interventions evaluated; if expected results not achieved, a revision of the care plan. Care plans to be reviewed/updated at least every 3 months, case conference annually; care plans to include an evaluation of the effectiveness of the care plan; any changes to the plan or new health care service to be documented.
1.11	Establish health service coordination policies and processes, provide continuity of services, access to emergency services, identify a case manager/coordinator who will be responsible for information to the client, ensure the assessment and care planning. Document end-of-life wishes (P)
1.12	Ensure client health information is shared with appropriate **service providers** in accordance with legislation (P)
1.13	Ensure regulated health care workers work within their practice statement and competencies as defined by legislation and professional organizations; define by policy appropriate competencies and scope of work for unregulated health care providers, ensure they are appropriately trained and supervised to provide safe care; ensure all health care aides have graduated or demonstrated competency in the approved curriculum ~~by April 2008~~ by commencing a training program within 6 months of being employed and completing training within 2 years.
1.14	Establish policies re: nurse practitioner services.
1.15	Ensure all clients under the care of a physician; that physicians collaborate with the medical director (P); that all facility operators have a physician as medical director; that the medical director establish policies and procedures governing medical care of clients, including assessments, medication review at least every 3 months; reports adverse drug reactions, and annual case conference for each resident (P).
1.16	Establish policies and processes to ensure safe medication management, conduct an annual review of these policies, processes and procedures (with detailed requirements for medication management responsibilities).
1.17	Assess clients for nutrition and hydrations needs using interRAI or equivalent assessment; address these needs in the care planning process.
1.18	Where a client is assessed as requiring therapeutic services, address these needs in accordance with the care planning process; coordinate access or referral to therapeutic services (P).
1.19	Processes to support clients in accessing services such as oral health, dental, podiatry, hearing and vision, based on assessed health service needs (P).
1.20	Support clients in accessing medically necessary health service equipment and medical-surgical supplies where these are required but not provided; ensure the equipment provided is in safe condition and properly used.
1.21	Establish operational policies and procedures which reflect the changing characteristics of clients and current best practice, to guide care planning and service provision (15 areas of care services specified: e.g. care of clients with dementia, personal care of clients, use of restraints)
B. Quality Improvement and Quality Assurance, Standards of Practice	
1.22	Establish a quality improvement program to regularly evaluate and improve health care services (incorporating the HQCA Quality Matrix: acceptability, accessibility, appropriateness, effectiveness, efficiency and safety) for the four areas of need (being healthy, getting better, living with illness or disability and end of life. Strive to achieve accreditation status as determined by AHW by 2010, submit annual report on same.
1.23	Collect and submit data required by the *Alberta Continuing Care Information System Reporting Requirements*.
1.24	Establish policies and processes to ensure compliance with the standards and relevant legislation; submit an annual report summarizing compliance status.

Carol Wodak

What's in an hour of care?

In a 2000 newsletter, the Bethany Care Society published a basic care schedule:

24 hour care schedule for a dependent resident (total, 205 minutes, 3.42 hours)

30 minutes –morning: toilet, mouth care, wash, dressing	15 minutes – help with lunch (again, 3 - 4 people)	5 minutes – medication administration
5 minutes – medications, 10 minutes – 2-person transfer into chair	15 minutes – 2-person continence care or toilet, transfer /lift to bed for nap	15 minutes – lift onto bed, 2-person continence care or toilet
15 minutes –breakfast (each caregiver assisting at least 3 residents)	10 minutes – check on resident several times; provide fluids, snacks	15 minutes – bedtime mouth care, wash, make comfortable in bed
15 minutes – assist with toileting (2-person transfer)	10 minutes – 2-person transfer/lift to wheelchair	10 minutes – late evening check and care
10 minutes – help finish off getting ready for the day	15 minutes –assistance with dinner	10 minutes – nighttime care and comfort

The article noted that a great many every-day needs (portering to a church service, going outside for a while, talking about family) weren't included; and the 3 hours of funded care were expected to include: care management (physicians' medication orders, care conferences, care assessment and planning, calling family to update them on changes, charting, organizing appointments and transportation, etc.); clinical care and therapies (wound care, insulin, swallowing assessment, exercise/rehabilitation, recreation activity, social work support, pain; control, palliation and address unpredictable changes in clinical status); staff vacations, sick time, holidays and other leave.

This kind of routine care schedule is fairly common, based on "time-motion" studies of routine daily tasks for an "average" resident in actual time worked by a competent care-giver with no distractions or other responsibilities. The discussion of appropriate "hours of care" is simply an academic exercise without the context of the care needs of the residents. Caring for impaired and ill people is not comparable to a controlled assembly-line process, with discrete and predictable manual tasks.

Extract from ***What's in an hour of care.doc***

Prospectus re purchase of CPL Dated: April 25, 1997 (Extract)
http://www.cplreit.com/Investment/Documents/APR25ENG.PDF

The Industry

Nursing homes provide long term skilled nursing care and ancillary services to those seniors who may require more care than is readily available in their community setting or for whom government supported nursing home care is more feasible than the private cost of a retirement home. Nursing homes typically employ registered nurses, registered practical nurses and qualified health care aides to provide nursing and personal care and personal support services, as required. Nursing homes also employ recreational rehabilitators and social work professionals.

The nursing home industry in Canada is characterized by:

(i) *Increased demand for nursing home beds.* The demand for long term care for seniors in Canada is increasing due to a number of factors, including:

- *Favourable demand demographics.* The longevity of seniors is increasing. Statistics Canada projects the population aged 75 and older will grow over the next 20 years by 62% compared to 24% for the population overall.
- *Decreasing availability of informal care providers.* Because of the increase in the number of women in the workforce and two-income families and the added mobility of modern society, many families and neighbours that traditionally provided informal care are being replaced by alternative care providers.
- *Shift from hospital based services.* As a result of health care reforms initiated in each province and the impact of the federal government's debt reduction program, funding of more expensive hospital based services has been limited. The length of hospital stays have generally been reduced and seniors frequently are discharged while still requiring assistance and nursing care.

(ii) *Restricted supply of nursing home beds.* In Canada, nursing homes require provincial licences and/or contractual agreements and also have their services subsidized by provincial governments. Because of funding constraints, a very limited number of new nursing home beds are anticipated in the foreseeable future.

(iii) *Large number of single facility operators.* A large proportion of nursing homes in Canada are owned by single facility operators. Single facilities are not able to realize economies of scale achievable through group purchasing and standardized management practices and, accordingly, such operations are not necessarily cost efficient. Such facilities will be actively considered for acquisition by the REIT.

(iv) *Privatization of government operated homes.* Currently, government operated homes for the aged (which are similar to nursing homes) represent a significant percentage of all long term care facilities in Canada. In Ontario, the government is actively considering eliminating the legislative requirement for each municipality to support the operation of a home for the aged. In anticipation of this legislative change, three municipalities in Ontario have already advertised for expressions of interest in third party management and/or purchase of their homes for the aged. The REIT believes that if this legislative change comes to fruition, this will create additional opportunities for the REIT to acquire long term care facilities in Ontario.

It is anticipated that the above key attributes of the nursing home industry in Canada — increased demand, restricted supply, large number of single facility operators and privatization of government operated homes — will ensure stable and growing Distributable Cash for the REIT. In addition, with respect to new acquisitions, the opportunity exists for increasing returns to Unitholders by effectively managing operating costs and achieving economies of scale.

Although there are two national nursing home competitors and several midsize local and regional competitors, the REIT believes that as a result of the lack of availability of new nursing home licences, competition between nursing homes is low and it is unlikely to increase significantly in the near future.