SALT Brief on Continuing Care 2008

February 20, 2008

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The Seniors Action Liaison Team (SALT)
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Introduction

The two reports included in this Brief have a lot of detail to support the themes: Alberta's elders have reason to be worried, and our Government has not kept its promises for continuing care.

Even to someone who's been concerned about Alberta's continuing care system for a dozen years, the Alberta's Elders Are Worried! Report and a closer look at the explicit promises in the Broda-inspired policies of our Government are startling.

The reality is that our continuing care system has been fragmented, deskilled and downgraded. Both responsibility and costs have been off-loaded to those in need of care and their families.

In the context of an increasing and an increasingly aging population, we're confronted with a failed social experiment in rationing and privatizing health care for Alberta's vulnerable elders.

These folks don't complain. They can't. Their families are overwhelmed with responsibilities they don't have the special skills to deal with, with increasing demands on their time and financial resources, and with fear that complaining will only result in more stress with very little if any improvement. They are boggled by the complicated system and by the confusion of terms which can mean whatever someone wants them to mean.

Many long term care recipients and their families will say they are satisfied with the 'hospitality services' and the care they receive – although almost all will say there aren't enough staff. Operator satisfaction surveys do not address issues around the quality or appropriateness of care. We know that many residents do not get the care they need, and some are caused actual harm by failures in care. It isn't good enough to say that most are OK.

Most of us know very little about the complex of illness and disabilities that aging can bring. But we know, from our own experiences and the research in the first report, that most of us will experience this situation either as a person in need of care or as an informal caregiver – or both.

The second report, with its 'By the Numbers' appendix, describes the changing context of the continuing care system from 1988 to 2007.

Alberta's population has increased by more than 43% at the same time as number of continuing care spaces has decreased by 3.5%.

The resident fees charged for public care facilities have increased from 30% of an individual's federal pension income, to a rate fixed by the government to recover the market cost of 'hospitality' or 'hotel' services – and which is higher than their total income for more than half the residents. Public funding now pays only for an increasingly narrow range of nursing care services.

The age and the severity of illness and impairment of the residents have increased, and the care provided no longer includes much except basic personal care. Private care, to supplement or replace facility care, is both very expensive and increasingly difficult to find.

The staffing shortages, which affect both the quality and the availability of care, are largely explained by the low wages of the care aides – the person who hands you your morning coffee at Tim Horton's probably makes more money – and by the 'efficiencies' the facilities create by reliance on part-time and casual staff. Government and Health authority funding formulas have meant a steady decline in the level of skilled nursing staff providing direct care to residents.

The relentless shift to supportive living care for all but the most seriously ill seniors is worrying on several counts.

- The most obvious is that we simply don't have enough supportive and affordable housing in our communities; we're years behind the predicted need.
- A great deal of the recent 'special funding' to increase supportive housing has gone to compensate for a dozen years of failure to provide for repair, maintenance and renovation in our public lodges.
- We don't have the social supports (income security, transportation, household supports, and social involvement) that make supportive housing successful.
- We don't have adequate home care: it's rationed, it's intermittent, and it covers a very narrow range of services.
- Too many folks are being placed in 'assisted living' settings where the skilled monitoring and care they need is not provided.
- The shift to assisted living and Enhanced Designated settings comes with a shift of the costs of care to the individual and their families. Shifting the costs of care to the 'consumer' doesn't save money; it just puts the burden on a few individuals – much like the auto insurance injury caps.
- The role of informal caregivers is increasingly to replace, rather than to supplement, basic care.

Alberta's policy for long term care reform have been very systematically developed and implemented over the last two decades. Elders and their families who suffer from delays in access to care, inadequate care, and the increased personal cost of even basic care, are experiencing the consequences of deliberate policy goals to spend less public money for continuing care.

What does SALT want?

We want every Albertan to have access to publicly funded, comprehensive, quality care at the end of life.

We want the Government to accept and fulfill our responsibility to provide care that respects each person's dignity and quality of life.

That responsibility includes adequate funding; effective planning; provision for the necessary resources; regulation and oversight with monitoring and compliance authority – and real accountability. This is not a responsibility that should be delegated to individuals, their families, or the private market.

We want those initial promises fulfilled without the hidden agenda, without excuses, without continued delays - and without more unfilled promises.

We know it's possible; let's just do it!

Carol Wodak, for SALT; February 20, 2008
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Alberta's Elders Are Worried!

A long-term care system is comprised of a comprehensive range of services, some based in the home, others based in the community, in health care institutions, and elsewhere. In an optimal and rational model, all of the services and structures that form a system will be designed to allow individuals to lead lives of dignity and, where possible, independence, without placing intolerable burdens on their families.[1]

Continuing care is an integrated mix of health, social and support services offered on a prolonged basis, either intermittently or continuously, to individuals whose functional capacities are at risk of impairment, temporarily impaired or chronically impaired. The objective of continuing care is to maintain, and when possible, improve the functional independence and quality of life of these individuals.[2]

The 1960 Canadian Bill of Rights is founded upon the dignity and worth of the human person, which compels the provision of excellent end-of-life care at a time when each person is at his or her most vulnerable. Each person is entitled to live their final years as free as possible from physical, emotional, psychosocial, and spiritual distress. Each Canadian is entitled to access skilled, compassionate, and respectful care at the end of life. Quality end-of-life care must become an entrenched core value of Canada's health care system. [3]

We're the first generation of Canadians who have contributed for all of our working lives to the development and the funding of the Canadian health care system, as well as other important social security programs such as public pensions. We have a greater life expectancy than ever, in part because of those programs.

There are 354,000[4] Albertans over the age of 65 – about 11% of the population. (For comparison, there are 277,000 more Albertans under the age of 14.) About 40,000[5] Alberta seniors are over the age of 85. Most seniors (81%) live in urban areas, and 60% live in Calgary or Edmonton.[6] About 80% of Alberta's seniors report their health as good, [7] and about 4% live in long term care facilities.

More than 90% of Canadian seniors live in a private home, and nearly a third of that number live alone. Women are especially likely to live alone – more than half of women aged 85 and over live on their own.[8] Many of us run the risk of becoming increasingly isolated, as our own mobility is challenged and the health of our friends limits their ability to help –especially when our families are far away. A 1995 Eldercare and the Workplace Report by the Conference Board of Canada found that 16% of children live more 1000 kilometers from their parents, 14% live 400-1000 kilometers away and 14.5% live 100-400 kilometers away.

Our median income[9] is much less than that of average Albertans; if all we have is federal government pensions, we'll be eligible for the Alberta Seniors Benefits for some things – but those benefits were slashed in 1993 and, despite promises, have not been fully restored.

37% of seniors provide household or personal assistance to others, including our children, and 7% of us spend at least 5 hours a week helping other seniors. Many of us are trying to cope with inadequate or even unavailable care services for another elder, either a family member or a friend. [10] We find ourselves trying to be nurse, counselor, advocate, care manager, crisis worker, personal care provider, housekeeper, chauffeur and friend, in the midst of our other responsibilities.

In 2002, almost 20% of Canadians over the age of 45 were providing care to one or more family members over the age of 65, and most of this care had been provided for 5 to 10 years. A 1996 estimate of the value of informal caregiving for that year was that it would have taken 276,509 full-time employees, at a cost of $5 - $6 billion, to replace all the unpaid eldercare providers.[11] Informal caregiving comes with great satisfaction, and often with significant costs. There are

expenses – an American study estimates that out-of-pocket expenses to informal caregivers averages $19,525 over the caregiving period. Changes in work or work patterns to accommodate caregiving responsibilities can have implications for current and future income and benefits of caregivers, and there are often physical, emotional and social costs.[12]

Most seniors are already living with a chronic health problem or two.[13] Some of us are surviving with illnesses that used to be fatal. But 5% of us will, in the next decade, develop 4 more serious chronic health problems, and need continuous skilled nursing care, for an average of ±3 years. (Length of stay data is hard to find – but reports indicate that average length of stay is declining quite rapidly, because the entry bar is continually being raised.)[14] We have an 8% chance of a dementia illness (mild, moderate or severe) until we reach age 85, when it increases to 35%.[15]

At age 65, we can expect to live another 20 years, but we can also expect to live from 3 to 6 of those years with disabilities.[16] 10% of us will need long term home care by the time we're 65, and that increases to 42% by age 85.[17] Half of us will have to rely on informal caregivers to provide that care. We will have to pay privately for half of the formal care we need; some of us won't get the care we need[18] – and may suffer from a newly-defined illness called 'self-neglect'.[19]

Even in a care facility, we'll get almost as much care from family members as we do from nursing home staff.[20] If we're placed in an assisted living setting, families and friends will have even more responsibility for organizing or providing – and often paying for – complex care services.[21] Whatever care we need, planning ahead is difficult, since we can't even get on wait lists until care needs have reached a crisis point, and the wait lists and times are increasing.[22]

Consider the care needs of continuing care centre residents. 75% have serious dementia illness[23]; more than 90% need assistance with mobility, eating, toileting, dressing[24]; they average 5 serious chronic medical diagnoses[25]. Most of the care is provided by untrained staff, according to a facility schedule.[26] 'Care plans' are required – but even where care needs are documented, there's no guarantee that appropriate interventions are provided.[27] The Capital Health Region's continuing care operation has been 'working short' for several months. That means care plans are 'modified' to the minimum essential services; getting residents out of bed for the day is not an essential service for many; and beds are left empty when residents die.[28]

A 2001 Ontario study[29] showed that 68% of long term care residents received no nursing rehabilitation. Only 10% of those who could benefit received even 1 physiotherapy intervention, and only 27% got daily range of motion exercises – usually for 20 minutes a week. The most common response to distress indicated by behaviour 'problems' is sedation. In Alberta, facility staff 'hours of care' is defined as paid hours of work for all unit staff, regardless of what job they're doing.[30] As the illness and disability acuity level of residents has risen, staffing levels and competencies have been reduced. And so have the therapy services that might help to slow the physical deterioration of residents; a1993 study funded by Alberta Health[31] showed that daily physical activity supervised by professional staff not only slowed decline in several health and functional status areas, but reduced care costs by significantly more than the program cost.

The Health Quality Council of Alberta, created in 2002, is the agency responsible for monitoring quality of health care.[32] In the last health care 'customer satisfaction' surveys it did, the ratings for complaint handling and long term care ranked lowest – and were headed down.[33] As a result, the Council identified long term care facilities as a high priority concern, and is just now completing a detailed survey of family and resident satisfaction in facilities. This is the first survey undertaken in Alberta to assess long term care from a family/ resident view; and, like the very critical Auditor General's report in 2005[34], does <u>not</u> address clinical care quality. There are other issues of patient safety in care centres not yet addressed – such as the frequency and consequences of superbug infections, and the adverse effects from the use of antipsychotic medications used off-label.

We're all at risk of the serious illnesses that can come with increased age, and of aging with existing chronic illness. We're also at risk of health care funding and policies that limit the health care and related support services that we might need, because of our age. The public discourse too often is based on the premise that our health care is too expensive, and that if it's not controlled, there won't be enough for others.

Indeed, if one looks at health care spending by age category, seniors and infants are the most expensive. Of course, one can argue that health care costs are related to illness (heart disease or cancer, for instance); but we don't see health care spending restricted for those expenditures.

In Alberta, we've seen public spending on continuing care decrease from 10.5% of health spending in 1998, to 6.3% in 2006.[35] In Toronto, during the SARS epidemic, the exclusion of

the elderly from intensive care units resulted in a 95% death rate, while only 3% of the younger persons who did have access to ICUs died.[36]

The frequent media stories about wait times, bed shortages and closures, superbug infections, and health system performance ratings focus on acute care hospital services. We know those problems are just as severe and significant in continuing care centres, and affect many people – mostly old people – but they don't get noticed on the radar. If anything, we hear talk of 'bed-blockers' –just getting in the way of others - when in fact those are ill or injured folks who are not getting the extended care they need.

We're concerned that our health care is being rationed, not only in the overall spending, but in spending to ensure we have health care staff trained in geriatric care, to provide the programs and supports to slow our decline into dependency, and to adequately care for those of us who live long enough to become physically and cognitively disabled.

Between 1988 and 2007, the population in the province by 2007 has increased by more than 43%, but the number of residents in long term care facilities had decreased by 3.5%.[37] Last year, the Minister of Health spent $1.3 billion on facility-based, community care and home care. But, as the Auditor General confirmed, we have no idea where that money went.[38]

Private spending on health care has increased in Canada; individuals pay about 30% of health care costs overall – and that doesn't include the cost of health care or other insurance premiums (such as auto insurance, that pays for accident-related health care costs), or many other 'goods and services'.[39] For continuing care, the costs to the individual are much higher; and in Alberta, they've been increasing as government shifts facility costs to the residents, adds co-payments to home care, and limits publicly-funded care and services. [40]

It's discouraging that the only measures of success for our continuing care system used by Alberta Health and Wellness are the decrease in the number of long term care beds and the rate of shift to community care settings – both fiscal measures.[41] Nobody seems to care about the care, or the expense and burden this puts on elderly spouses and others.[42]

Indeed, we can look even further back, to the Government's redefinition of its responsibility to health care itself: *"The Alberta government has redefined its role from direct service provider to setting strategic direction for the health system through policy, legislation and standards".*[43]

This might have worked, if the legislation, standards, and oversight responsibility had been competent and with adequate funding and accountability measures. In the area of eldercare (and seniors benefits), the priority has been to delegate, save money, and ignore the signs of problems.

By transferring most elder care responsibility away from the Ministry of Health, and promoting the shift to assisted living and the reduction of continuing care centre beds as the goal of our continuing care system, the Government is saying quite clearly that health care for seniors is a nice-to-have extra, not the fundamental basis for comprehensive, coordinated health care program.[44]

In 2005, following the Auditor General's report on Seniors Care and Services, then-Health Minister Iris Evans estimated that it could cost as much as $250 million to implement his recommendations, with $150 million for staffing alone. What was provided was a total of $78 million, including $38.2 million for staffing. [45] It made no noticeable difference in the daily care of the residents.[46] Neither have the repeated Health Workforce Strategies, or the sophisticated recruitment initiatives, or the implementation of the health care aide curriculum and competencies.

This is not a housing or homelessness issue; it's a healthcare issue. The shift from 'institutionalization' to 'community care' for frail elderly persons got its start in Denmark 30 years ago. In the following 10 years, Denmark established a plan for appropriate community housing with publicly funded, carefully planned comprehensive health, personal, and social care services, including medications, supplies and equipment, physical therapies and activities. Instead of shifting the costs to the individual, as most American and Alberta imitators did, they provided the same level and range of care that previously was available in nursing homes, 24 hours a day. This 'ambient'[47] care includes community services like transportation and income support. The initial costs were high; but in 10 years, the costs had stabilized, the health of elders had improved, only the most seriously ill required nursing home care, and the total health care costs had stabilized at a lower level than previously.[48]

We're concerned that the new 'continuing care' settings have been systematically privatized. Public capital funding is given to private developers and operators; since they then own the land and the building, it's an instant boost to their fixed assets. (The remaining capital costs will be recovered from 'resident fees', which is good news for their investors – and so are the private-

pay service fees.) One of the growing industries is home-care franchises - one of the "great business opportunities of all time", "tapping unprecedented wealth"[49] with "years of sharply accelerating revenues" [50]

A recent Industry Overview of nursing homes and assisted living by Hoovers[51] reports that the US industry has about 30,000 companies, operating 60,000 nursing facilities, with combined annual revenue of $100 billion. It notes that profitability depends on efficient operations; most revenue comes from government sources; adequate staffing is a problem because of low pay and difficult work. The report notes that annual revenue per worker is less than $50,000.[52]

Measuring success in this way explains both the correlation between wage increases for nurses and subsequent substitution of less skilled employees in care facilities, and reliance on time-motion scheduling of personal care services.[53]

Our children have often been part of our struggles to care for our aged parents. They are just as concerned as we are that they'll be dealing with that same trauma on our behalf during the next 20 years.

Our health care system is based on the principles that health care is a public concern, and that we are willing share the costs to support the needs of vulnerable others based on need rather than ability to pay. (In the same way, we all contribute to the costs of public education, even though the costs for that are much greater for children.)

We've got good reason to be worried – for all Albertans.

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Endnotes

Note: unless otherwise indicated, data in this report is Canadian.

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[1] Ethical choices in long-term care: What does justice require? World Health Organization, 2002

[2] Canadian Healthcare Association. Guide to Canadian Healthcare Facilities, Volume 7

[3] Rephrased from Quality End-of-Life Care: the Right of Every Canadian 2002, the Report of the Standing Senate Committee on Social Affairs Science and Technology, Sharon Carstairs, Chair

[4] Alberta Facts 2007 http://www.finance.gov.ab.ca/aboutalberta/alberta_facts_brochure.pdf

[5] Annual Demographic Statistics 2005 Statistics Canada, http://www.statcan.ca/english/freepub/91-213-XIB/0000591-213-XIB.pdf

[6] A Profile of Alberta Seniors May 2007, Alberta Seniors and Community Supports

[7] alberta facts brochure 2007.pdf http://www.finance.gov.ab.ca/aboutalberta/alberta_facts_brochure.pdf

[8] Rage Against the Darkness http://www.cbc.ca/documentaries/rageagainstthedarkness/ Statistics Canada (1996 data)

[9] The Daily Statistics Canada May 3, 2007

[10] Rage Against the Darkness http://www.cbc.ca/documentaries/rageagainstthedarkness/ Statistics Canada (1996 data) Statistics Canada (1996 data)

[11] Informal Caregivers in Canada: A Snapshot 2001 Janet E. Fast, Norah C. Keating http://www.hecol.ualberta.ca/RAPP/documents/Snapshot%20on%20Caregiving%20Final%20Report.pdf

[12] Caregiving: A Fact of Life Janet Fast

[13] Seniors in Canada 2006 National Advisory Council on Aging: *In 2005, 91% of seniors reported one or more chronic health conditions as diagnosed by a health professional, compared to 87% in 2000-01*.

[14] Assisted Living Today – Coming Out of the Woods http://www.crd.bc.ca/hfp/documents/AssistedLivingToday.pdf

[15] http://www.bcma.org/public/patient_advocacy/DementiaFacts.pdf BC Medical Association

[16] Research on Aging: Providing evidence for rescuing the Canadian Health Care System Dr. Réjean Hébert, Scientific Director of the CIHR Institute of Aging 2002

[17] Statistics Canada Supplement to Health Reports, Volume 16, 2003

[18] Aging and Social Support 2002 Statistics Canada General Social Survey (GSS); Health Council of Canada Fixing the Foundation 2008

[19] Senior citizens who self-neglect http://seniorjournal.com/NEWS/Eldercare/2007/7-08-01-StudyOffers.htm; Self-Neglect: A Proposed New NANDA Diagnosis International Journal of Nursing Terminologies and Classifications Volume 17 Issue 1 Page 10-18, January 2006
SELF-NEGLECT IN OLDER ADULTS IS A GERIATRIC SYNDROME Journal of the American Geriatrics Society, Volume 54, Number 11, November 2006 , pp. 1796-1797(2)

[20] Dr. Norah Keating, Caregiver Symposium VAC Gerontological Advisory Council 1998

[21] Missing Pieces of the Shift to Home and Community Care: A Case Study of the Conversion of an Alberta Nursing Home to a Designated Assisted Living Program Wendy Armstrong, Raisa Deber, PhD. March 2006 www.continuingcarewatch.com
Starting Points: Recommendations for Creating a More Accountable and Affordable Health System Alberta Health Planning Secretariat, 1993. . . *'defining basic health services will restrict the number of publicly funded services offered, and that the "consumer first" approach demands that consumers have access to an optimum number of nonessential services. . . the consumer's right to a maximum choice of nonessential services will include the consumer responsibility of paying for those services'*

[22] Alberta Health and Wellness Annual Reports

[23] Alberta Continuing Care Association Response to MLA Task Force Seniors Report, 2005 On file with author.

[24] Ontario Ministry of Health and Long-Term Care, 2005 Levels of Care Classification On file with author. Both the Alberta and Ontario governments use the Alberta resident information system, but the Alberta government does not report similar information from the data collected (Email, response to request for information, from Alberta Health and Wellness, February 2007)

[25] Health Services Utilization in the Population Aged 65 and Older: Review of the Literature 1999 http://www.health.gov.ab.ca/key/01_report.pdf

[26] Bethany Care Society Milestones 2002, author's file. The note to this "basic care" time allocation: *"The 3 hours of funded care are also 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. Other – vacations, sick time, holidays and other staff leave."
Alberta Continuing Care Association Newsletter June 2007
http://www.longtermcare.ab.ca/publication.htm

[27] Report of the Auditor General on Seniors Care and Programs 2005 http://www.oag.ab.ca/
Report of a Study to Review Levels of Service and Response to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators 2001,
http://www.health.gov.on.ca/english/public/pub/ministry_reports/ltc_rep/ltc_rep_mn.html
Indicators of the Quality of Nursing Home Residential Care, Saliba D and Schnelle JF, Journal of the American Geriatrics Society, 2002

[28] Continuing Care Crisis Worsens C. Wodak 2007
http://www.continuingcarewatch.com/perspectives.php

[29] Report of a Study to Review Levels of Service and Response to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators *(see endnote 24)*

[30] Concerns regarding "Hours of care" in Continuing Care Facilities C. Wodak, 2007
http://www.continuingcarewatch.com/pdf/Hours%20of%20Care.pdf

[31] A study of the outcomes of Enhanced Physical Therapy and Occupational Therapy Hours of Service Long Term Care Residents in a Nursing Home Setting, a Project conducted at Salem Manor Nursing Home, Leduc, Alberta and funded through LTC, Alberta Health, Sept 1993, B. Purzyblyski, B.Sc.R, et al, Arch Phys Med Rehabil. 1996 Jun; 77(6):554-61: "*Mean score differences favored the enhanced group for the tests over the 2 years. Significance was observed on FIM Total at 6 and 12 months, FIM Self Care at 6 months, FIM Communication at 24 months, and FIM Psychosocial at 6, 12, 18, and 24 months; FAM Total at 6, 12, 18, and 24 months, FAM Self Care at 6 months, FAM Mobility at 12 months, FAM Communication at 6 and 24 months, FAM Psychosocial at 6, 12, 18, and 24 months, and FAM Cognition at 6 and 12 months; and COVS at 6, 12, 18, and 24 months. A cost analysis demonstrated that PT/OT offered at the 1:50 ratio would result in a cost savings in terms of nursing staff dollars for 30 long-term-care beds of $16,973 over the 2 years of the study compared to the 1:200 ratio. This equates to an annual cost savings of $283 per bed* [1993/94 funded hourly rates]*."*

[32] The Hon. Iris Evans, May 4, 2006 Hansard: *"in the last few months the Health Quality Council has been given the status and the authority to assess through its matrix of quality the quality of care delivery in any kind of facility that exists in Alberta that is publicly funded as a health care facility."* (section 7(2) of the *Regional Health Authorities Act)*

[33] Health Quality Council of Alberta, 2003 and 2004, Satisfaction with Health Care Services *A survey of Albertans. Long Term Care Resident and Family Experience Survey* expected to be released in June or July 2008.

[34] http://www.hqca.ca/

[35] Alberta Finance published budget documents (file AB Financial data 1985_2006)
National Health Expenditure Trends 1975.2007 Canadian Institute for Health Information: Acute care hospitals account for 30%, drugs for 17%, and physician fees 13% of health care spending.
In 2005, the latest year available for age-specific data, per capita health care spending by provincial and territorial governments was highest for infants under the age of 1 ($7,437) and people 65 years of age and older ($9,502). In contrast, health care spending on Canadians between the ages of 1 and 64 averaged an estimated $1,735 per person.

[36] Dr. Janice E. Lessard, Specialist in Geriatric Medicine, Toronto; Toronto Star Nov. 23, 2005

[37]

	1988	2000	2007
Alberta Population	2,400,000	2,900,000	3,436,000
Ratio LTC beds/1,000 population >75	105/1,000	(1998) 86/1,000	(2006) 67.3/1,000
LTC Residents	~ 13,000	~13,000	12,551

Sources: Hollander, 2000 Technical Report 2: The Public-Private Split in Continuing Care Case Studies of Nova Scotia and Alberta; Alberta Ministry of Health and Wellness Annual Report 2005/2006; Correspondence, AHW August 15, 2007

[38] Alberta Health and Wellness Annual Report 2006-2007

[39] Canadian Institute for Health Information, Health Care in Canada 2006

[40] The Identification and Analysis of Incentives and Disincentives and Cost-Effectiveness of Various Funding Approaches for Continuing Care; Technical Report 2: The Public-Private Split in Continuing Care Case Studies of Nova Scotia and Alberta Hollander, May 2000

Missing Pieces of the Shift to Home and Community Care: A Case Study of the Conversion of an Alberta Nursing Home to a Designated Assisted Living Program Wendy Armstrong, Raisa Deber, PhD. March 2006 www.continuingcarewatch.com

[41] Alberta Health and Wellness Annual Reports, RHA Funding and Accountability documents.

[42] Population Aging, Health Care Spending and Sustainability: Do We Really Have a Crisis? Joe Ruggeri, 2002 http://www.caledoninst.org/Publications/PDF/297ENG.pdf "Currently, health care policy is being shaped by fiscal considerations, and proposals for reforming the delivery of health care are largely directed at their potential for reducing government spending. Although fiscal considerations do impose some constraints on the feasibility of certain reform proposals, the main objective of health policy should be the provision of uniform quality health care to all Canadians, independent of their place of residence or their economic status . . . we should not let the focus on fiscal sustainability obscure the fact that ultimately the debate about health care reform is not about dollars and cents but about fundamental values."

[43] Health Care 99

[44] Hansard May 8, 2007: Mr. Hancock ". . .*Long-term care. I've had some preliminary discussions with the Minister of Seniors and Community Supports. I think it's very important that we identify a way of dealing with both the housing component and the health component that go into the continuum of care. . . we need to have a discussion about where long-term care should be. . .That's a discussion we need to have. It comes right out of the Broda report. It's something that we've struggled with but that I think we need to grasp."*

May 15, 2007 Mr. Melchin ". . .we have implemented a number of standards for ongoing care, and this fits into both facilities and for the care itself. . . if it has been transferred from health to the department of seniors, this still remains a shared responsibility. It is work that I'd suggest we'll forever have to work on, whether long-term care becomes fully in one or the other. . . I know from our own department that while you have many of the issues of housing and seniors, one of the greater challenges, really, is the care component if it's really a health delivery portion of it. . . There needs to be a tremendous amount of facilitation and ongoing co-operation so that we don't miss who's ultimately responsible for the various tasks".

[45] Annual $250M increase to overhaul system still has to get past caucus conservatives Edmonton Journal September 8, 2005

Estimates, Continuing Care, Hansard April 27/05

Alberta Continuing Care Association April 2006 Information update for Alberta MLAs; "*On February 23, the government announced $15.2 million to fund care hours to 3.4 hours per day. This was followed by the March 22, 2006 provincial spring budget announcement of $42 million in additional funding – of which approximately $23 million in available for increased care hours funding – to reach 3.6 hours per day.*"

Hansard March 1, 2006: (Supplemental for LTC $36 million + Budget for LTC $42 million = $78 million)

[46] See Long Term Care Staffing Background and Continuing Care Crisis Worsens C. Wodak 2007 http://www.continuingcarewatch.com/perspectives.php

[47] "Ambient": completely surrounding; encompassing *(Dictionary.com Unabridged (v 1.1) Based on the Random House Unabridged Dictionary, © Random House, Inc. 2006)*

[48] Balance of Care Conference, Canadian research network for care in the community, Toronto October 2007; Presentations by Dr. David Challis, Dr. Eigil Hansen http://www.crncc.ca/knowledge/events/SupportiveHousingSymposium.html

Prescription for Excellence Dr. Michael Rachlis 2005 http://www.coaottawa.ca/health_forum/PrescriptionforExcellence.pdf;

Home- and Community-Based Long-Term Care Lessons From Denmark The Gerontologist 41:474-480 (2001) http://gerontologist.gerontologyjournals.org/cgi/content/abstract/41/4/474

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http://www.carp.ca/display.cfm?CabinetID=263&LibraryID=70&cityID=7&documentID=1904
Summary of Consultations with Experts Long Term Care Review (Broda) 1999
Housing and Care for Older People in Denmark and Some Other European Countries Georg Gottschalk M. Sc.;
Assisted Living as a Model of Care Delivery Assisted Living as a Model of Care Delivery Karen Brown Wilson Ph.D (Gamroth, Semredek, Tornquist, Eds. 1994, Enhancing Autonomy in Long-Term Care: Concepts and Strategies Benedictine Institute for Long-term Care);
Designing Continuing Care Services in Alberta for the Next Millennium: Some Policy Options Phil Gaudet MSW (President and CEO, Good Samaritan Society)
Assisted Living: Needs, Practices, and Policies in Residential Care for the Elderly S Zimmerman, PD Sloane, and JK Eckert, eds 2001, JHU Press http://books.google.com/books?id=AmbxephnarQC
Long Term Care in Developed Nations http://assets.aarp.org/rgcenter/health/2003_13_ltc_dv.pdf
The Shift From Nursing Home to Assisted Living Is It Defensible? Phil Gaudet, Stride Magazine 2002 http://www.stridemagazine.com/articles/2002/q2/assisted.living/

[49] Franchise.com http://www.franchise.com/franchise/senior-elderly-healthcare/senior-care/Home-Care-Assistance/company-information.cfm

[50] http://www.bison.com/Home_Care_Assistance_senior_care_franchise

[51] http://www.hoovers.com/nursing-homes-and-assisted-living/--ID__48--/free-ind-fr-profile-basic.xhtml

[52] Street Authority Investment Guidance http://www.streetauthority.com/terms/r/revenue-per-employee.asp "*Revenue per employee is a measure of how efficiently a particular company is utilizing its employees. In general, rising revenue per employee is a positive sign that suggests the company is finding ways to squeeze more sales/revenues out of each of its workers.*"
http://www.marketingprinciples.com/startingsmallbusiness/default.asp?cat=115
"As a rule of thumb, small manufacturing and service companies need to produce a minimum of $80,000 revenue per employee to cover operational cost and to produce an after tax profit."

[53] See Hours of Care, Bethany Care Society basic care schedule for 3.4 hours/resident/day, C. Wodak 2007 http://www.continuingcarewatch.com/pdf/Hours%20of%20Care.pdf

The Promises (2000)[1] and The Reality (2008)

Promise 1: Publicly funded health care services will be delivered as needed, whether the person was in their own home, supportive housing, or in a facility, through a process called 'unbundling'; services will be coordinated to match the care to the needs of the person in any setting, so people will have choices.	This a great idea – and it works well, in Denmark. There, the community care is comprehensive, coordinated, available, and publicly funded. (We bought into the American version of the Danish system.) But the fine print in the Broda reports was really focused on a different goal: Albertans will be healthy, and will be responsible for their own health – and health care, if they're foolish enough to be chronically ill – so continuing care will be 'sustainable' (that means, not publicly funded). Systematic underfunding, promises instead of service delivery, delegating responsibility to individuals and the private market-place, deskilling the workforce, and cutting funding for slew of "unbundled" care services and products haven't worked for us. What we have is not comprehensive, coordinated, available, and publicly funded health care. 'Choice' and 'Aging in Place' mean you find and you pay. It's rather like Lego – if you buy the right pieces, and have the capacity and skills to put it together, you may end up with what you need. It's Do It Yourself healthcare. It doesn't work for most folks.
Promise 2: Care services and housing will be affordable and accessible in a timely manner.	Anyone who has needed either care or affordable housing knows that it's not there when you need it and it's not affordable. If you need both, as many seniors do, you know about desperation. Facility fees have nearly doubled, to recover the cost of everything except specified nursing care – and it is being 'unbundled' in bits and pieces and reclassified as non-nursing care. With private housing-and-care, it's a smorgasbord, for which you can arrange for and pay separately for every service. This is, indeed, a growth industry for developers and operators, with public funding for capital costs, public rent subsidies, and operating contracts helping their bottom line. They like the unregulated rents and no specified care standards, too.
Promise 3: Home care services will be expanded, and supports will be provided for family and other informal caregivers.	Actually, public home care services have been reduced, and increasingly rationed. We're told the government is spending more than before on home care, probably because so many folks need post-acute home care and because the population has increased – and possibly because of private service providers, who need to make a profit. Home care staff is poorly paid, so there staffing shortages and high turnover rates. Integrated care programs, day programs and respite are in short supply. Most elder care is provided by informal caregivers, who have few emotional or financial supports, which helps to make the system 'sustainable' (you pay).

[1] from Healthy Aging: New Directions for Care (1999) http://www.health.alberta.ca/key/lt_aging.pdf and Strategic Directions and Future Actions(2000), Alberta Health and Wellness http://www.health.alberta.ca/key/lt_stratreport.pdf

Promise 4: Supportive housing settings with expanded care services will provide an alternative to institutionalization for folks who just need some assistance.	There is a need for care between independent living and a nursing home; this is another good idea from Denmark. The reality is that these 'settings' are being used to replace nursing home care with much lower levels of care (and in fact, many are 'institutional' in nature even if they look nicer). Folks who just need a little assistance to live independently get 'choice', with a bill at the end of the month.
Promise 5: Care centres will be regenerated to provide care for persons with high and complex care needs – and particularly for persons with dementia illnesses or mental health illnesses.	There are fewer care centre beds than in 2001 – and with our increasing population, even more seriously ill and impaired people who need skilled nursing care. Most care services are now provided by untrained staff, without adequate monitoring and assessment skills. Increasingly, this care is provided according to a pre-determined schedule, rather than need. Restorative and rehabilitation therapies are seldom available. As many as 80% of care facility residents have a diagnosis of dementia, but few facilities have staff with the expertise or the time to provide appropriate care, so there is significant reliance on sedation to reduce care needs. Most 4-bed wards have been renovated to private rooms – but it does further reduce the number of beds. New care centres which replace older ones usually have fewer beds – or are built as assisted living facilities, offering less care.
Promise 6: The supply of both professional and other health care workers, with appropriate skills and knowledge, will be increased.	Care centre beds are being closed because of staffing shortages. The job posting lists grow by the day, while the work force heads for better paying, easier jobs elsewhere. The promise that Care Aides would have formal training or a demonstrated equivalency by March, 2008 has simply evaporated; the regional college training spaces are empty. The $13 an hour wage isn't worth a huge investment in training - especially for a part-time or casual job. Nurses are being used as administrators, and the new information and assessment systems take even more of their time from the residents. Maybe that's why the 'hours of care' are defined as paid time, rather than time when care is actually delivered to people. Alberta is remarkably slow to recognize that nurse practitioners have an important role in the complex care of seniors, and also fails to provide an appropriate role and adequate compensation for facility medical directors and attending or on-call physicians for time-intensive geriatric care. There are few geriatricians, and physician training pays little attention to the special care needs of seniors.

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1. 20 years of reform for Alberta Long Term Care

	1988	2000	2007
Alberta Population	2,400,000	2,900,000	3,436,000[2]
Ratio LTC beds/1,000 population 75+	105/1,000[3]	(1998) 86/1,000[4]	(2006) 67.3/1,000[5]
LTC Residents	~ 13,000[6]	~13,000 [7]	12,551[8]
Calgary Herald Dec 17 2006: The government estimates 910 adults under age 65 - live in long-term care Residential Care bed change, 2001 - 2004, -12.5%; change in population 75+, 2001–2004, 11.7%			
Urgent placement wait list, average for year /as of March 31	522[9]	713[10]	666[11]
Residents over 85 years	(1990) 48%[12]		(2003) 49%[13]
Residents in 3 (of 7) highest care needs categories	10%[14]	68%[15]	n/a (2004) 70%[16]
Residents with dementia diagnosis	33.9%[17]		(2003) 75%[18]
Resident fees ($ per day; SP = semi-private, P = private room)	(1990 SP $16.50 P $20.25)[19]	(1994) SP $26.25 P $28.60[20]	SP $44 P $50.75[21]
Before 1988: Resident fees fixed @30% of federal old age pension; co-pay to offset rent			
Facility ownership[22]		(2001 14,486 beds*)	(2006 14,468 beds*[23])
Public	n/a	46%	38%
Voluntary	n/a	25%	27%
For-profit	n/a	29%	35%
Supportive Living Units[24]	n/a	(2002) 8,005 (Public Lodges)	23,545 (incl. Lodges)

[2] http://www.schneidergroup.ca/files/2007-03-30_AB_Weekly_Economic_Highlights.pdf as of January 1, 2007
[3] Hollander, 2000 Technical Report 2: The Public-Private Split in Continuing Care Case Studies of Nova Scotia and Alberta
[4] See above
[5] Alberta Ministry of Health and Wellness Annual Report 2005/2006
[6] A New Vision for Long Term Care 1988
[7] Regional Health Authority Global Funding Manualshttp://www.health.gov.ab.ca/resources/Pub_RHAs.html
[8] Correspondence, AHW August 15, 2007
Continuing care clients, facility-based: 2003, 12,940; 2006, 12,551.
LTC beds, in separate and acute care facilities: 2003, 14,125; 2006, 14,468.
[9] How long do people wait? A Framework for Reform Appendices, Premier's Advisory Council on Health 2001
[10] How long do people wait? A Framework for Reform Appendices, Premier's Advisory Council on Health 2001
[11] Alberta Health and Wellness Annual Report 2006/07
[12] Table 24, Trends in the Utilization of Health Services by Seniors in Alberta June 1999
[13] http://www.health.gov.ab.ca/regions/RHA_reglist.htm
[14] Eldercare On the Auction Block
[15] http://www.health.gov.ab.ca/regions/e2-00.htm
[16] File LTC Residents by age.doc; http://www.health.gov.ab.ca/regions/RHA_reglist.htm
2003 http://www.health.gov.ab.ca/regions/e1-03.htm Table E-1, 2002/03 7,157/14,559 = 49%
Over 75: 11,829/14,559 = 81%
[17] Health Services Utilization in the Population Aged 65 and Older: Review of the Literature 1999
[18] Alberta Long Term Care Association Response to MLA Task Force Seniors Report, 2005 On file with author.
[19] Edmonton Journal Mar 27, 1990.
[20] Alberta Government News Release, June 17, 2003
[21] Alberta Government News Release, July 25, 2007
[22] AHW Response to Written Question #9, submitted May 7,2007
[23] Bed count includes long term and short stay sub-acute (palliative, sub-acute, rehab, transition, etc.)
[24] Alberta Seniors, response to Written Question #10 on April 3, 2007

2. What 3.4 hours per resident per day looks like:

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
In a 2000 newsletter, the Bethany Care Society published a **24 hour care schedule** for a dependent resident (total, 205 minutes, 3.42 hours). The chart was part of an article explaining that the Calgary Health Region had reduced care staff funding from 3.09 hours to 3 hours.. 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. (Source: author's files)		

3. Private Nursing and Home Support Care is Expensive.

Private Nursing and Home Support: A variety of services can be contracted from private home support agencies in order to help individuals and families in their home. These services would be paid for by the individual and/or family and may include professional nursing or home support services such as personal care, companion or respite care, homemaking (meal preparation, cleaning, etc.) and child care.
Approximate Cost:

Registered Nurse: $50 per hour
Licensed Practical Nurse: $35 per hour
Community Support Worker: $20 per hour

Insurance Extended Health Benefits Insurance may pay some private nursing benefits.
(from Calgary Health Region Community and Supported Living Options: Information for Clients and Families, 2007)

Typical Resident Care Staff Wages (Feb 2008)

Registered Nurse: $29.33 - $38.50/hr (9 step grid)
Licensed Practical Nurse: $17.55 - $19.94/hr (5 step scale)
Care Guide $13.48 - $23.45/hr (5 step grid)
http://www.capitalcare.net/careers/nursing.html Feb 16, 2008
Community Home Support Worker: $11.82 – 16.73/hr (5 step grid)
Resident Companion $11.98 - $13.70/hr (5 step grid)
http://www.capitalcare.net/careers/resident_care.html

CEO, Capital Health: $880,000 (Calgary Herald June 27, 2007); with a 17% pay hike, $538,000 (Edm Sun March 18, 2006); $475,000 (2002,UNA news, Sept 2003)

4. The shift from facility care to assisted living settings in East Central Alberta

East Central Health Annual Report 2005/06

Vegreville: converting 90 long term care (LTC) spaces to 60 heavy complex care units.
Construction is underway and will be complete July 2007.
Vermilion: converting 65 LTC spaces to 48 heavy complex care units and are reviewing tender and will award the contract by July 2006.
Wainwright: converting 69 LTC spaces to 44 heavy complex care units and 40 DSH units
Lloydminster (Dr. Cooke Extended Care Centre): replacing 55 LTC spaces with 60 heavy complex care units.

East Central Annual Report 2004-05

Camrose: The Bethany Group replaced 188 LTC beds with 100 Facility care beds (long term care), 30 Flex beds (facility/supportive housing), 78 Supportive housing spaces.
Vermilion: Planning is underway for the replacement of the aging, 65-bed Alice Keith Nursing Home with a new, 48-bed long term care facility on the same site.
Vegreville: Replacing 90 long term care beds with 60 long term care beds and 40 supportive housing spaces.
Wainwright: will develop 40 supportive housing spaces and reduce 25 of the 67 long term care beds.

5. The care cost difference between facility care and Designated Assisted Living

Summary Chart, Hinton Mountain View Centre Conversion from Care Centre to DAL Jan 2008

	Continuing Care Centre (nursing homes)	**Designated Assisted Living** ('Designated" means spaces under contract to Regional Health Authority)
Resident Fees	Regulated by province	Controlled by contract between operator and RHA
Accommodation Subsidy	Available through Alberta Seniors Benefits; income tested, must apply. (Changed in 2006 re grandfather arrangements)	
Nursing Care	24/7 on-site RN and LPN RNA supervision of LPN and Care Aide staff. Rehab Assistant on-site	24/7 available (off-site, on call; may be provided by home care, operator or contracted agency) LPN on-site during daytime hours Rehab assistant only on-site
Personal Care	24/7 on-site RNA supervision	May be provided by Home Care on a scheduled basis. Controlled by contract with RHA; may be available on a fee-for-service basis
Call system	Call system provided.	Call system (Telecare) Mixed; some must pay for phone to access.
Prescriptions	Supplied by Centre as needed.	Resident responsible for providing, and for costs not covered by Alberta Seniors Drug Plan. Costs often higher than RHA bulk purchasing, special packaging increases costs.
Medical supplies and equipment	Supplied by Centre; specialty items resident responsibility (AADL may be available)	Resident responsible; some items may be eligible for subsidy through Alberta Aids to Daily Living (AADL)
Medically required Transportation	Supplied by Care Centre.	Resident responsibility
Personal Care Supplies	Supplied by Centre	Resident responsible
Personal Grooming Supplies Resident responsible**; dentures, eyeglasses:** Resident responsible; Seniors benefits may apply		
Room Furnishings, bedding, towels	Supplied by Centre; resident may replace with own furnishings.	Resident must provide.
Food Services	24-hour; tray service in room if required; snacks and fluids.	Uncertain. Additional charge for tray service to room.
Sources: Missing Pieces of the Shift to Home and Community Care: A Case Study of the Conversion of an Alberta Nursing Home to a Designated Assisted Living Program; Wendy Armstrong, Raisa Deber, PhD. 2006 ; 2008 updates from Ron and Lynda Jonson.		

6. Examples of Private Assisted Living Optional Care Service Fees

Assisted Living Optional Care Service fees/month (subject to GST)	Holy Cross	Columbia
Medication assistance	$300	$50.00
Medication reminder	$175	-------
Resident night Checks	$175	-------
Meal Escort (3 meals/day)	$300	$270
Meal Escort (2 or less/day)	$175	-------
Daily Tray Service	$300	-------
Meal Time reminder	$175	-------
Meal assistance	-------	$360
Daily light housekeeping	$300	-------
Weekly personal laundry	$50	$35
Support stocking assistance	$250	-------
Dressing, am **or** pm, 15 minutes per	-------	$270
Incontinence management	$300	-------
Toileting, 10 minutes	-------	$90
Bath assist (one/week)	$100	$9.00 per bath
Bath assist (two/week)	$175	-------
Extra assistance	$350	-------
Holy Cross Manor, Calgary; data from website (service rates no longer posted on site) Studio Apartment from $1945.00, One Bed room Apartment from $2445.00 per month (2008) Additional resident $750.00 per month. Seniors feel rent squeeze at Holy Cross Manor (Calgary Herald, Mar 1, 2007). . . rents are being boosted by up to 40 per cent June 1. . . The cost for a one-bedroom apartment is expected to jump about a third, from around $1,800 to roughly $2,400 a month.		
Columbia Assisted Living, Lethbridge; (data from website) Studio Suite (380 sq. ft.) $1585, One Bedroom Suite (550 sq. ft.) $1895 per month Additional resident in suite $600 per month; resident parking $20 per month		

7. Funding announced for new long term care beds (resident & bed data from various AHW documents)

1998	LTC residents: 12,880 LTC beds: 14,396	Capital Health reopened 24 extra long-term care beds at the Edmonton General in late January, trying to take pressure off the system.[25] **The province has announced 600 new long term care beds over the next three years because of the shortages identified**.[26]
2000	Residents: ~13,000 LTC beds 14,226 beds	
2002		
2004	LTC residents 12,732 LTC beds ~14,300	
2008	LTC residents 12,551 LTC bed count 14,468	**Stelmach is promising to spend $300 million to open 600 new, long-term-care beds.**[27]

7 (a)

2000	Bethany Group plans 200 new continuing care spaces (130 continuing care, 70 supportive living spaces).[28]	The new facilities will replace 188 spaces in the Bethany Long Term Care Centre and the Hawthorne wing of the Rosehaven Care Centre.[28]
2005	New Kipnes Centre for Veterans' (120 beds) opens.[29]	Mewburn Centre (140 beds[30]) closes.

[25] Edmonton Journal, Feb 3 1998
[26] November 15, 1999, CBC News
[27] 9 Jan 2008 Alberta Government news release: Government announces $300 million for 7 new Facilities, hundreds of LTC beds http://www.alberta.ca/home/NewsFrame.cfm?ReleaseID=/acn/200801/22978C72B6D2F-DAEA-51AC-503664572F8BF41B.html
[28] Edmonton Journal, Nov 4 2000
[29] Capital Health News Release Nov 10, 2005
[30] Edmonton Journal, Nov 9, 2001,

7 (b)

$300 million for 7 new Facilities, hundreds of LTC beds (29 Jan 2008 Government news release[31])		
Project from Backgrounder	History	
Calgary Garrison Green Care Centre (supplementary funding) 200-bed long-term care facility $125 million	Jan 2005, Intercare will build 191 beds at Garrison Green; Feb 2005 CHR buys GG land for $4m from Intercare. Nov 2005, project shelved. Aug 2007: total cost was $62m, escalated to $70m; 191 beds for disabled young and frail elderly. ***CHR LTC beds 2001: 4,583; 2006: 4,550***	+100?
Didsbury, (supplementary funding) 60-bedLTC facility to replace the older 50-bed wing	Planned in 2005, 2006	+10?
Strathmore, new 100-bed LTC facility (supplementary funding) to replace the older existing 23-bed wing	Planned 2005, 2006; completion by 2007 P3 planning for 'community of care" includes the relocation of (23) long term care units out of the hospital. Dec 05 –Feb 06, RASL $1.35 million to Brenda Stafford Foundation Ltd; Supportive Living Beds Strathmore $1.35m (45 beds)	+22?
Capital Health will add 300 new transition and support beds at Alexandra/Glenrose/Norwood	2006: Announced Transfer of Chronic Ventilator Unit to a specialty Continuing Care Centre (Norwood) to open 2010. Of the 1400 residents in 11 CapitalCare LTC centres, 168 are specialty beds (2007) **Capital Health LTC beds: 2001, 4,644; 2006, 4,686**	0
Capital Health/Good Samaritan Society; replace 70-bed LTC facility in Stony Plain.	Replace 1968 care centre, should begin by 2005 (GSS Annual Report 2004). GSS website 1/30/08: Currently in the design phase	+10?
Lloydminster, Dr. Cooke Extended Care Centre , new 60-bed LTC facility to replace the 55-bed nursing home wing	Proposed 2007. East Central Health Annual Report 2005/06: Lloydminster (Dr. Cooke Extended Care Centre): replacing 55 LTC spaces with 60 heavy complex care units; $4,335,762 RASL funding, Jan 2006). ECH has converted 279 LTC spaces to 212 Designated Supportive Housing units.	+5?
Lacombe Continuing Care Centre; 2 4-bed rooms replaced with 12-bed dementia cottage	$10 million; no dates	+ 4?
Alberta Seniors Business Plan 2007-10: To support the shift to supportive living from long-term care settings, the Ministry encourages the development of affordable supportive living projects for seniors and persons with disabilities through approved capital funding. continuing-care waiting lists, including people who are not in acute-care wards, have risen to 481 names from 426 a year earlier and 270 two years earlier		151

[31] 29 Jan 2008 news release: Government announces $300 million for 7 new Facilities, hundreds of LTC beds http://www.alberta.ca/home/NewsFrame.cfm?ReleaseID=/acn/200801/22978C72B6D2F-DAEA-51AC-503664572F8BF41B.html