

New Directions for Facility-Based Long Term Care

Nouvelle direction pour les soins de longue durée en établissement



Canadian Healthcare Association
Association canadienne des soins de santé

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*Whatever you can do, or dream you can do, begin
it. Boldness has genius, power, and magic in it.
Begin it now*

— Johann Wolfgang von Goethe

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Executive Summary

Facility-based long term care is not an insured service under the *Canada Health Act*. Unlike services currently defined as medically necessary (hospital and physician services) that receive public funding (termed “first-dollar coverage”), long term care is an “extended” service, and hence there is no obligation on the part of governments to provide a standard range of services.

Consequently, differences exist not only *among* provinces and territories but also *within* them. There is variability in access to and provision of long term care services and differences in the application of co-payments and user fees. The delivery of appropriate facility-based long term care services will continue to be a challenge until policy-makers realize its importance to the changing health system and focus on making services more equitable across the country.

The Canadian Healthcare Association (CHA) believes that all health services must be adequately funded, effectively organized and appropriately interconnected in order to function optimally, thus providing the appropriate care in the appropriate setting at the appropriate time. Facility-based long term care must be included in the pan-Canadian health planning agenda in order to ensure the principle of access to quality health care for Canadians now and in the future.

This *Policy Brief* highlights the need to achieve the appropriate balance of health services through a variety of means, including:

- matching the health service setting to the health condition;



- enhancing ongoing health services to the chronically ill, disabled and mentally ill;
- offering health services in the setting that is most cost-efficient and care-effective for each individual situation; and
- averting the premature admission to facility-based long term care of individuals who could move to supportive/assisted living arrangements (or remain in their own home) with the support of quality-driven home and community services. This should be achieved while recognizing that facility-based long term care is a desirable option for many people and not a dreaded “institution of last resort”.

The current health system must prepare for the future by planning for an increase in the absolute number of seniors who will be healthier than previous generations. The next cohort of seniors will live longer, are predicted to experience a compressed period of morbidity at the end of life and will have definite ideas on the types of services they require and the methods of delivery.

We must respond to the changing health needs of Canadians by ensuring enlightened leadership, progressive management practices, an engaged workforce and by taking advantage of the opportunities provided by new technologies, innovative therapies and contemporary ways of delivering health care services.

The realities of 21st century Canada in which significant numbers of citizens will migrate across provincial/territorial boundaries, relocate from rural to urban centres and work away from home must be addressed by:

- facilitating the movement of chronically ill Canadians across geographic boundaries to be near relatives and caregivers; and

- not overestimating, but considering carefully, the amount of caregiving that can be reasonably assumed by informal (unpaid) caregivers.

The goal of this paper is to put facility-based long term care on the Canadian health care policy agenda. CHA’s advocacy efforts have called for government leadership, adequate funding and health system change to strengthen the entire health continuum. Facility-based long term care is an essential part of the health system. But ways and means of strengthening it have long been ignored. The federal government has not recognized the essential value of long term care and its legitimate position as a vital and equal partner in the continuum of health care services. Even the high-profile health commissions, committee reports and intergovernmental agreements such as *The Royal Commission on the Future of Health Care in Canada (Romanow Report)*, *The Kirby Commission on Mental Health Report (Kirby Report)* and *A 10-year Plan to Strengthen Health Care (Ten Year Plan 2004)* did not address this sector.

This paper therefore, will:

- reinforce CHA’s ongoing commitment to enhance appropriate facility-based long term care, which should form part of a broad continuum of publicly-funded health services across Canada;
- describe the facility-based long term care sector across Canada by providing a national definition of facility-based long term care, and by highlighting broad equivalencies between the provinces and territories;
- identify the disconnected nature of facility-based long term care throughout the country, the inequities in resident charges, the inconsistencies in admission

requirements and the wide variations in the public/private mix of funding and delivery;

- describe the residents served by the facility-based long term care sector;
- demonstrate that facility-based long term care is a vital component of our publicly-funded health care system;
- highlight the need for governments, health system leaders and trustees to devote more attention to this important segment of the health continuum; and
- provide recommendations to address key challenges so that Canadians with similar needs can be assured access to quality facility-based long term care services no matter where they live in Canada.

This paper is a call to action on multiple fronts: in addition to raising our thinking about the important role of long term care homes in the lives of many Canadians, we must also expand our view about what truly constitutes *quality*. Excellence in clinical care is of great import, but it is not the only relevant performance measure of quality in long term care.

Quality of care in the eyes of most residents is determined by three main elements: the outcome of an intervention and the manner in which it was carried out; the technique and frequency of staff to resident interaction; and whether residents are consistently treated with respect. Some homes would rate highly if measured on these criteria. Others would not, especially those who subscribe to the institutional model of care that focuses first and foremost on the completion of tasks – feeding, dressing, medicating and documenting.

Bureaucratic traditions must give way to cultural transformation. For this to happen we would be well advised to devote less energy into creating more regulations and direct more attention to processes that will help transform long term care homes into desirable places to live and work. Structural aspects of quality (size of rooms, environment and staff ratios) and process elements (care planning, nutrition and quality improvement) must be complementary to outcome dimensions (prevalence of pressure sores, pain management, social engagement and privacy protection). Many in the field believe that an outcome-based approach which places priority on resident satisfaction is the key to system improvement. But all three elements are relevant and must be given due consideration in a transformed system.

If facility-based long term care is to meet future expectations we must fund it properly and hold homes accountable for excellence. Neither can exist without the other. Resource allocation and accountability are inseparable. Interestingly, there are pockets of innovation in every corner of the country despite the provision of inadequate resources. Many examples of excellence give testimony to the commitment and resourcefulness of those managing and working in facility-based long term care across Canada. But the challenges within the sector will not vanish. Instead, weaknesses will intensify and become more pronounced with the emergence of a demanding baby boomer cohort.

Finally, this paper offers recommendations to all governments and stakeholders to address the challenges Canada faces.

1. Ensure adequate and sustainable funding for facility-based long term care tied to pan-Canadian principles.

- 1.1 The federal government must show leadership and establish a facility-based long term care fund.
 - 1.2 Rectify the current underfunding of facility-based long term care and prepare a predictable and sustainable funding base for future generations of seniors.
 - 1.3 Stop shifting health costs to residents.
 - 1.4 Explore a social insurance model of long term care insurance.
2. Focus on quality and accountability to Canadians.
 - 2.1 Establish mandatory requirements for all long term care homes to conduct annual resident, family, and staff satisfaction surveys that address quality of life issues.
 - 2.2 Use existing data more effectively and develop comparable classification systems to facilitate the collection of data, so that it can be compared between and within jurisdictions.
 - 2.3 Promote research and invest in staff education and leadership training.
 - 2.4 Enhance the teaching capacity of long term care homes.
 - 2.5 Establish mandatory accreditation in facility-based long term care.
 3. Invest in health human resources.
 - 3.1 Optimize full scope of practice.
 - 3.2 Develop pan-Canadian minimum staffing models.
 - 3.3 Develop a national personal support worker curriculum.
 - 3.4 Develop a strategy to attract people to work in facility-based long term care.
 4. Reflect a shared approach to risk.
 - 4.1 Ensure access to comparable services no matter where one lives in Canada and regardless of the illness or the care setting.
 - 4.2 Respect regional realities.
5. Guarantee reciprocity between the provinces and territories.
 - 5.1 Develop reciprocal agreements among the provinces and territories, so that movement among provinces and territories is seamless.
 - 5.2 Allow funding to follow the resident in an interprovincial transfer, so that provinces with massive in-migration do not experience excessive costs.
 6. Develop cultures of caring.
 - 6.1 Require long term care homes to be reflective of home life rather than institution life.
 - 6.2 Address the needs of non-seniors.
 - 6.3 Address end-of-life care.
 - 6.4 Address mental health care.
 7. Respect volunteers and families.
 - 7.1 Determine the optimal use of volunteers within long term care homes.
 - 7.2 Welcome family members as participants in the daily lives of residents.
- The opportunity to transform facility-based long term care is before us. Collaboration and commitment will be required among multiple groups including governments, residents, employers, employees, associations, unions and other key stakeholders. Only then will we create a long term care environment that is prepared to accelerate the uptake of leading practices across the system, recognize and reward excellence and enhance the quality of care for residents by improving the quality of work life for staff. In order to advance with confidence and vigor we must be heedful of the cautionary notice that procrastination is the grave in which great opportunities are buried.

Sommaire

Sommaire

Les soins de longue durée en établissement ne sont pas un service assuré en vertu de la Loi canadienne sur la santé. À la différence des services actuellement définis comme étant nécessaires (les services hospitaliers et les services des médecins) qui reçoivent des fonds publics (appelés « couverture à partir du premier dollar »), les soins de longue durée sont considérés comme un service « complémentaire » et les gouvernements n'ont donc aucune obligation d'offrir une gamme de services standards.

En conséquence, on observe des différences non seulement entre les provinces et territoires, mais également au sein de ceux-ci. L'accès aux soins de longue durée et la prestation des services varient d'une autorité à l'autre, tout comme les règles relatives à la participation au coût et aux tickets modérateurs. La prestation de services appropriés de soins de longue durée en établissement continuera de poser problème tant que les décideurs n'auront pas réalisé son importance par rapport à l'évolution du système de santé et n'accorderont pas une plus grande attention à la prestation de services plus équitables à la grandeur du pays.

L'Association canadienne des soins de santé (ACS) croit que tous les services de santé doivent être subventionnés adéquatement, organisés efficacement et interreliés comme il se doit pour fonctionner de manière optimale, assurant ainsi la prestation des soins appropriés dans l'environnement qui convient et en temps opportun. Les soins de longue durée en établissement doivent être inclus au programme de planification de la santé à l'échelle pancanadienne pour respecter le principe de l'accès des Canadiens à des soins de santé de qualité, maintenant et dans le futur.



Le présent Mémoire souligne la nécessité d'atteindre l'équilibre approprié des services de santé à l'aide de diverses mesures, parmi lesquelles :

- l'adéquation entre le milieu de prestation des services de santé et l'état de santé;
- l'amélioration des services de santé continus pour les personnes atteintes d'une maladie chronique, d'un handicap et d'une maladie mentale;
- la prestation de services de santé dans le milieu le plus économique et le plus efficace, selon chaque cas individuel;
- l'adoption de mesures pour éviter l'admission prématurée en établissement de soins de longue durée des personnes qui pourraient emménager dans des logements assistés ou dans des résidences-services (ou même demeurer dans leur propre logement) avec le soutien de services à domicile et communautaires de qualité. Ces mesures pourraient être mises en place tout en ayant conscience que les établissements offrant des soins de longue durée représentent une option souhaitable pour bien des personnes et qu'ils ne sont pas d'affreux « établissements de dernier recours ».

Le système de santé actuel doit se préparer pour l'avenir en tenant compte d'une hausse du nombre absolu de personnes âgées qui seront plus en santé que les générations précédentes. La prochaine cohorte de personnes âgées vivra plus longtemps, connaîtra probablement une courte période de morbidité en fin de vie et aura des idées bien claires sur les types de services dont elle a besoin et les façons de les prodiguer.

Nous devons prendre des mesures à l'égard des besoins de santé évolutifs

des Canadiens en assurant un leadership éclairé, en adoptant des pratiques de gestion progressives, en s'assurant de la collaboration des effectifs et en profitant des possibilités offertes par les nouvelles technologies, les thérapies novatrices et les façons contemporaines de prodiguer les services de soins de santé.

Le Canada du 21^e siècle verra de nombreux citoyens migrer entre les provinces et les territoires, quitter les zones rurales pour les centres urbains et travailler loin de leur domicile. Il faudra relever ces défis, notamment :

- en facilitant le déplacement entre les provinces et territoires des Canadiens atteints de maladie chronique qui désirent se rapprocher de leurs proches et de leurs aidants naturels;
- en ne surestimant pas, mais en examinant attentivement, l'ampleur des soins qui peuvent raisonnablement être prodigués par des aidants naturels (non rémunérés).

Le présent document a pour but d'inscrire les soins de longue durée en établissement au programme politique du Canada en matière de soins de santé. Par son action de sensibilisation, l'ACS a lancé un appel en faveur du leadership gouvernemental, du financement adéquat et de l'évolution du système de santé pour renforcer tout le continuum de la santé. Les soins de longue durée en établissement sont un volet essentiel du système de santé. Toutefois, on se soucie peu de les consolider. Le gouvernement fédéral n'est pas conscient de la valeur primordiale des soins de longue durée, et il ne réalise pas qu'il a un statut légitime à titre de partenaire essentiel et égal dans le continuum des services de soins de santé. Même les commissions prestigieuses sur la santé, les rapports de comités et les ententes intergouvernementales, comme la Commission

royale sur l'avenir des soins de santé au Canada (rapport Romanow), le rapport Kirby de la Commission de la santé mentale et Un plan décennal pour consolider les soins de santé (Plan décennal 2004) ne se sont pas penchés sur le secteur des soins de longue durée en établissement.

C'est pourquoi le présent mémoire entend :

- renforcer l'engagement soutenu de l'ACS visant à valoriser la prestation appropriée des soins de longue durée en établissement, qui devrait faire partie d'un vaste continuum de services de santé subventionnés par le secteur public au Canada;
- décrire le secteur des soins de longue durée en établissement à la grandeur du Canada en fournissant une définition nationale de ce type de soins et en faisant ressortir les équivalences générales entre les provinces et les territoires;
- cerner les différences relatives aux soins de santé de longue durée en établissement à la grandeur du pays, en qui a trait aux frais inévitables facturés aux résidents, aux exigences d'admission disparates et à la grande diversité de combinaison de financement public/privé et de modes de prestation;
- établir le profil des résidents desservis par le secteur des soins de longue durée en établissement;
- démontrer que les soins de longue durée en établissement sont un volet essentiel de notre système de soins de santé public;
- souligner la nécessité pour les gouvernements, les dirigeants et les administrateurs du système de santé

d'accorder une plus grande attention à cet important segment du continuum de la santé;

- formuler des recommandations visant à relever les principaux défis pour que les Canadiens ayant des besoins semblables soient assurés de l'accès à des services de soins de santé de longue durée en établissement, peu importe où ils vivent au Canada.

Le présent mémoire se veut une invitation à l'action sur plusieurs fronts : en plus de nous sensibiliser au rôle important des maisons de soins de longue durée dans la vie de nombreux Canadiens, nous devons également élargir notre vision de ce qui constitue réellement de la qualité. L'excellence en matière de soins cliniques revêt une grande importance, mais ce n'est pas la seule mesure de performance pertinente de la qualité des soins de longue durée.

La qualité des soins, aux yeux de la plupart des résidents, est déterminée par les trois principaux éléments suivants : le résultat d'une intervention et la façon dont elle a été effectuée; la technique et la fréquence de l'interaction entre le personnel et le résident; et la constance du respect avec lequel les résidents sont traités. Certaines maisons obtiendraient des notes élevées si elles étaient évaluées selon ces critères. D'autres pas, surtout celles qui souscrivent au modèle institutionnel de soins qui insiste d'abord et avant tout sur les tâches de nourrir, habiller, administrer les médicaments et tenir les dossiers.

Les traditions bureaucratiques doivent laisser place à la transformation culturelle. Pour cela, il serait avisé de consacrer moins d'énergie à l'établissement de règles et plus d'attention aux processus qui contribueront à la transformation des maisons de soins

de longue durée en lieux de vie et de travail agréables. Les aspects structuraux de la qualité (dimension des chambres, environnement et ratio en personnel) et les éléments du processus (planification des soins, nutrition et amélioration de la qualité) doivent être complémentaires aux dimensions liées aux résultats (prévalence des plaies de décubitus, gestion de la douleur, engagement social et protection de la vie privée). Bien des intervenants du milieu croient qu'une approche fondée sur les résultats, qui accorde la priorité à la satisfaction des résidents, est l'élément clé de l'amélioration du système. Toutefois, ces trois éléments sont pertinents et doivent être dûment pris en considération dans un système transformé.

Si les soins de longue durée en établissement doivent répondre aux attentes futures, nous devons les financer adéquatement et tenir les établissements responsables de l'excellence. L'un ne va pas sans l'autre. L'allocation des ressources et la responsabilisation sont inséparables. Il est intéressant de noter que l'innovation se manifeste dans tous les coins du pays, malgré l'insuffisance de fonds. De nombreux exemples d'excellence témoignent de l'engagement et de l'esprit d'initiative des gestionnaires et des employés des établissements de soins de longue durée au Canada. Toutefois, les défis à relever dans le secteur ne s'évaporeront pas. On verra plutôt les faiblesses s'intensifier et prendre plus d'importance avec l'émergence d'une cohorte de baby-boomers plus exigeants.

Finalement, le présent mémoire présente des recommandations à tous les gouvernements et intervenants dans le but de relever les défis auxquels le Canada fait face.

1. Assurer un financement adéquat et durable au secteur des soins de longue durée en établissement, lié aux principes pancanadiens.

- 1.1 Le gouvernement fédéral doit faire preuve de leadership et créer un Fonds des soins de longue durée en établissement.
 - 1.2 Remédier au sous-financement actuel des soins de longue durée en établissement et préparer une base de financement prévisible et durable pour les futures générations de personnes âgées.
 - 1.3 Cesser de transférer des coûts de santé aux résidents.
 - 1.4 Examiner un modèle d'assurance sociale pour l'assurance de soins de longue durée.
2. Mettre l'accent sur la qualité et la responsabilisation envers les Canadiens.
 - 2.1 Établir des exigences obligatoires imposant à toutes les maisons de soins de longue durée de procéder à des sondages annuels sur la satisfaction auprès des résidents, de leurs familles et du personnel, et d'y aborder des questions relatives à la qualité de vie.
 - 2.2 Utiliser plus efficacement les données existantes et élaborer des systèmes de classification comparables pour faciliter la collecte de données susceptibles d'être comparées entre les diverses autorités et à l'intérieur de celles-ci.
 - 2.3 Promouvoir la recherche et investir dans la formation du personnel et la formation en leadership.
 - 2.4 Améliorer la capacité d'enseignement des maisons de soins de longue durée.
 - 2.5 Établir un programme d'agrément obligatoire en matière de soins de longue durée en établissement.
3. Investir dans les ressources humaines en santé.
 - 3.1 Optimiser le plein champ d'activité.
 - 3.2 Développer des modèles de dotation pancanadiens minimaux.
 - 3.3 Créer un programme national de formation des préposés aux services de soutien à la personne.

- 3.4 Élaborer une stratégie visant à attirer les travailleurs dans le domaine des soins de santé de longue durée en établissement.
- 4. Refléter une approche commune face au risque.
 - 4.1 Assurer l'accès à des services comparables, peu importe le lieu de résidence au Canada et peu importe la maladie ou le milieu de soins.
 - 4.2 Respecter les réalités régionales.
- 5. Garantir la réciprocité entre les provinces et les territoires.
 - 5.1 Conclure des ententes de réciprocité entre les provinces et les territoires pour favoriser la migration.
 - 5.2 Autoriser le transfert interprovincial du financement du résident qui se déplace dans une autre province, de sorte que les provinces qui accueillent un grand nombre de nouveaux patients interprovinciaux n'aient pas à assumer des coûts excessifs.
- 6. Créer une culture de compassion.
 - 6.1 Exiger que les maisons de soins de longue durée se rapprochent de la vie à la maison plutôt que de la vie en institution.
 - 6.2 Tenir compte des besoins de personnes qui n'appartiennent pas au groupe des aînés.
 - 6.3 Tenir compte des soins en fin de vie.
 - 6.4 Tenir compte des soins en santé mentale.
- 7. Respecter les bénévoles et les familles.
 - 7.1 Déterminer l'utilisation optimale des bénévoles dans les maisons de soins de longue durée.
 - 7.2 Accueillir les membres de la famille comme des participants à la vie quotidienne des résidents.

Nous avons la possibilité de transformer le secteur des soins de longue durée en établissement. Il faudra pour ce faire compter sur la collaboration et la participation de nombreux groupes, dont les gouvernements, les résidents, les employeurs, les employés, les associations, les syndicats et d'autres intervenants clés. Ainsi, nous saurons créer un environnement de soins de longue durée propice à accélérer l'adhésion à des pratiques exemplaires à la grandeur du système, à récompenser l'excellence et à améliorer la qualité des soins aux résidents tout en améliorant la qualité du milieu de travail du personnel. Pour progresser avec confiance et énergie dans cette voie, nous devons toutefois éviter de tomber dans le piège de la procrastination qui sonne souvent le glas de projets pourtant prometteurs.

Facility-Based

The Realities of Facility-Based Long Term Care in Canada

The following points are intended to highlight some of the current realities:

- Baby boomers (people born between 1946 and 1964) will have a dramatic impact on the Canadian health system in the next five decades. Seniors made up just seven percent of the population when hospitalization was introduced in the 1950s. Today they comprise 13.7 percent of the population, and by 2035 will approach 25 percent (Turcotte and Schellenberg, 2007). Therefore, planning is vital.
- Life expectancy at age 65 is now projected to be 84.9 years of age overall – 83.2 years for men and 86.4 years for women (Statistics Canada, 2009). Women make up 70 percent of the 85 and older age cohort. Differences in life expectancy between men and women are expected to narrow in the future. With the steady increase in the number of elderly men, programs and services sensitive to their interests will need to be developed. Still, facility-based long term care remains a women's issue, as the vast majority of residents and staff are female (Armstrong et al., 2008).
- Seniors are experiencing more disability-free life expectancy, but there are still a number of years lived with disability near the end-of-life.
- The most common chronic conditions reported by seniors living at home are arthritis, high blood pressure and allergies. But dementia and incontinence are the more likely conditions to necessitate admission to a long-term care home. Dementia affects eight percent of seniors over age 65. Its prevalence increases with age, as 35 percent of people aged 85 years and older meet the diagnostic criteria for dementia.



Recent estimates indicate that nearly ten percent of the Canadian population experience some form of incontinence. As with degenerative brain diseases such as Alzheimer's and Parkinson's disease, the prevalence of incontinence increases rapidly with age.

- In general, the non-senior disabled community and parents of children with disabilities do not favour placement in long term care homes. Still, there are younger disabled persons residing there, often inappropriately located in environments with confused elderly residents.
- Facility-based long term care encompasses different services in each province and territory of Canada. It is not a publicly-insured service under the *Canada Health Act* but is partially insured as extended health care services. Facility-based long term care is not a fully insured health service in any jurisdiction.
- Although all provinces and territories have legislation pertaining to facility-based long term care, there is a broad mix of public and private funding, ownership and administration of homes across Canada. The sector includes not-for-profit lay and faith-based homes, government operated homes, and proprietary for-profit operations. Consolidation of private sector ownership is a recent trend likely to gain momentum in the future as small local homes are being purchased by large, for-profit corporations. Facility-based long term care is known by various names across Canada.
- In some provinces, residents are paying for more than their accommodation; they are also incurring personal care expenses. If "health services" encompasses both medical care and personal care, then long term care residents in some provinces are paying out-of-pocket for portions of their health care services. It is believed that governments are looking for ways to pass on future funding obligations.
- Both accommodation rates and comfort allowances vary across Canada. The charges for *non-preferred* accommodation (i.e., basic ward room) in facility-based long term care are three or more times greater in some jurisdictions than in others. The resident comfort allowance for personal expenditures such as clothing, toiletries, transportation (including ambulance fees and wheelchairs) ranges from \$103 per month to \$265 per month across jurisdictions.
- The level of resident acuity and complexity of health services required in long term care homes has increased dramatically since the start of the new millennium. In the recent past, length of resident stay has dropped in many provinces largely due to the expansion of home care services, the enhancement of community support services and advances in technology. As a result, admission to facility-based long term care is delayed until individuals are nearing the end of their lives.
- Supportive/assisted living arrangements are the newest modality of continuing care being introduced as a middle option along the continuum between home care and facility-based long term care. In some quarters it is being advanced as a more appropriate and less costly alternative to facility-based long-term care. It is still in its infant stage of development and there is no consistent

approach to its philosophy, organization or terminology in jurisdictions across Canada. Some retirement homes use the term *assisted living* primarily for marketing purposes.

- Home care is appropriate for many individuals with functional deficits, but not all. The most appropriate environment for the care of individuals with advanced dementia is often in a long term care home with a fitting staff complement, supportive programming and adequate space for safe wandering.
- The needs of informal (family or unpaid) caregivers and the preferences of the individual are both worthy considerations when determining if home care, supportive/assisted living arrangements or facility-based long-term care is the best option.
- Provincial residency requirements for admission to facility-based long term care can present obstacles in placing frail seniors near their relatives, which causes unnecessary stress on families. Canadian citizens often migrate across provincial borders to seek employment opportunities and may not be able to remain close to loved ones in long term care homes.
- Inadequate staffing numbers and inappropriate staff mix continue to be a problem in facility-based long term care.
- Despite advancements in staff training, organizational culture and leading practices, respect for dignity of the individual and the provision of quality service in long term care homes remains under scrutiny across Canada.

Introduction

When Canadians become ill – regardless of who they are, the nature of their illness or where they live in the country – they expect that comparable, publicly-funded health services will be available. But this is not the case if they require facility-based long term care.

An individual's illness, whether dementia, cardiovascular disease or an acquired brain injury, will determine the location for care and treatment, and the portion of their expenses that will be assumed by the public purse. The person experiencing a heart attack will be cared for at a publicly-insured hospital, complete with its fully insured physician services and a multiplicity of treatment options that include surgery and pharmaceuticals. The person diagnosed with advanced dementia is likely to be admitted to a long term care home where the care is not fully publicly-funded and where the resident is also responsible for additional out-of-pocket fees, user charges or co-payments.

There are broad inequities within facility-based long term care across Canada but it is often not until the later years of life that Canadians discover that the health services they believe are available to them are not provided outside hospitals in an all-encompassing, publicly-funded system.

The focus of this brief is facility-based long term care, which has been selected for review because of:

- the absence of its examination in recent national health care reports;
- the inequities and inconsistencies within this sector across Canada; and



- the critical place occupied by facility-based long term care along the health care continuum.

It is not the intent of this brief to recommend the transfer of funds from one part of the

No sector along the Canadian health care continuum is more misunderstood than facility-based long term care.

continuum to another. Strengthening one element of the system at the expense of another would be counter-

productive. Instead, CHA is advocating for pan-Canadian objectives that will address inequities and firmly position a resident-centered facility-based long term care system in its rightful place along the health care continuum.

Today, no sector along the Canadian health care continuum is more misunderstood than facility-based long term care. The cultural stigma of long term care is derived largely from historical accounts that described environments for seniors as little more than warehouses of death. It is little wonder the industry has been pilloried in the press and mired in a vortex of negative media. The tarnished image of facility-based long term care is sustained by periodic accounts that reveal and even dramatize cases of neglect and abuse. The information contained in incident reports, required by provincial regulatory agencies, can be readily accessed by inquisitive journalists through freedom of information legislation. Thus, the industry is more vulnerable than publicly-funded acute-care hospitals which are not typically subjected to the same reporting requirements.

The conventional government response to one series of critical media reports after another has been a combination of increased regulation and heightened scrutiny by provincial field staff, yet these developments do not necessarily lead to a better experience for residents and their families. Residents and families rarely equate quality

of life with the absence of unmet regulatory standards. Instead, the actual consumers of facility-based long term care services place the highest value on the quality of their relationships.

Despite unfavourable media coverage, most facility-based long term care organizations in Canada quietly provide good care and routinely score high grades in annual satisfaction surveys and accreditation reviews. Still, public anxiety about quality of care continues to beleaguer the industry despite the fact that actual users of the system generally have a high regard for the services provided in long term care homes.

Excellence in clinical care is of great importance, but it is not the only relevant performance measure of quality in long term care. Quality of care in the eyes of most residents is determined by three main elements: the outcome of an intervention and the manner in which it was carried out, the technique and frequency of staff to resident interaction, and whether residents are consistently treated with respect. Some homes would rate highly if measured on these criteria. Others would not, especially those who subscribe to the institutional model of care.

Facility-based long term care has traditionally been committed to the institutional model of care by focusing first and foremost on the completion of tasks: feeding, dressing, medicating and documenting. Unfortunately, the institutional model is still evident today though few homes will admit it. Mission, vision and values statements speak about individualized approaches to care and empowering stakeholders, but when you strip away the language and move past the colourful drapes, pets, and carefully-placed personal belongings, little has changed in some long term care environments.

Creating a dignified living environment for residents and a quality working environment for staff goes well beyond finishings and rhetoric. Cultures of caring will never materialize in homes that cling to the institutional model of care. Many organizations have made lasting improvements in the culture of their homes through their own ingenuity and sense of purpose. Others have been inspired by methodologies such as the *Eden Alternative*, the *Wellspring Nursing Home Learning Collaborative* model and *Gentlecare*. While each of these concepts has merit, none of them have a monopoly on compassion. There is no preferred methodology for all homes (Samuelson, 2003).

Each methodology should collectively lead us to one simple, yet profound, realization: it is how we shape the long term care home environment that will have the greatest influence on the quality of life for residents, and the quality of work life for staff. An organization that superimposes one of those models into their home may be missing the whole point of culture change. Each home has its own culture. Therefore, each home should develop its own pathway toward a social model, and away from the institutional model.

Creating a “home” is a journey, not a destination. To prescribe ways to create a home could strip away one of the greatest benefits of the quest: to stimulate curiosity and transform the home into a learning organization. Fortunately, the literature is replete with guiding principles for establishing a nurturing long-term care home environment for all stakeholders (Samuelson, 2003).

Many practitioners in the field desire change because they know that the institutional model stifles innovation and is associated

with poor outcomes for residents, frustration for family members and an unsatisfying work environment for staff (Grant, 2008). Some bemoan the preoccupation with physical care and the lack of priority given to the psychological, social, and spiritual elements of resident life. Yet, holistic care requires that the long-term care team effectively provide care in all four domains. Every home can claim to provide psychological, social and spiritual care, but do they provide it well?

Equally perplexing is the inadequate support given to family members, many of whom provided years of informal care to their loved ones prior to admission. Caregiving does not disappear for some Canadians when their loved one moves out of their private home. This is amply evidenced by the fact that in 2007, approximately one in five caregivers provided care to a senior living in a formal care environment such as a long-term care home. Their reasons for doing so typically include maintaining continuity of family care; reducing costs for additional services; and increasing the amount of care provided (Statistics Canada, 2008b).

Furthermore, no meaningful progress will be made in creating dignified long-term care environments across Canada until we recognize the urgent necessity to address the needs of employees, many of whom do not receive adequate training, reasonable compensation or respect in the workplace (Armstrong, 2009; Samuelson, 2002).

Bureaucratic traditions must give way to cultural transformation. For this to happen we would be well advised to devote less energy into creating more regulations or devising new ways to enforce strict compliance and direct more attention to processes that will

It is how we shape the long term care home environment that will have the greatest influence on the quality of life for residents and the quality of work life for staff.

help transform facility-based long term care into desirable places to live and work. Structural aspects of quality (size of rooms, environment and staff ratios) and process elements (care planning, documentation, diet and quality improvement) must be complementary to outcome dimensions

The federal government must fulfill its stewardship role in helping to ensure, along with the provinces, that the facility-based long term care system has the capacity to meet the needs of our aging population.

(prevalence of pressure sores, pain management, social engagement and privacy protection).

Many professionals in the field believe that an outcome-based approach which places

priority on resident satisfaction is the key to system improvement (Attias, 2009; Samuelson, 2003). But all three elements are relevant and must be given due consideration in a transformed long term care system.

Provincial ministries responsible for compliance should be at the forefront of culture change. Governments need to create traction, not just action. Bureaucratic edicts will result in action but will not secure commitment. Sanctions will always be warranted for those homes that defy critically important standards. In some cases, sanctions might be too lax or enacted too late. Many homes are deluded into thinking, “we are in full compliance, so everything is fine.” Under such tragic thinking, the practice of diverting human resources from rendering care to accommodating paperwork is legitimized when full compliance becomes the key benchmark of quality. Those who work in long term care must seek a higher goal than simply meeting regulatory compliance.

Employers endure intense pressure to consistently provide a high-quality long term care program. There are pockets of innovation in every corner of the country

despite the provision of inadequate resources. Many examples of excellence give testimony to the commitment and resourcefulness of those managing and working in facility-based long term care across Canada. But the challenges within the sector will not vanish. Instead, weaknesses will intensify and become more pronounced with the emergence of a demanding baby boomer cohort.

If facility-based long term care is to meet future expectations, we must fund it properly and hold homes accountable for excellence. Neither can exist without the other; resource allocation and accountability are inseparable. Collaboration and commitment will be required among multiple stakeholders including government, employers, residents, employees, unions and other key players. Only then will we create a long term care environment that is prepared to accelerate the uptake of leading practices across the system, recognize and reward excellence, and enhance the quality of care for residents by improving the quality of worklife for staff.

The vast majority of long term care homes in Canada will embrace the opportunity to engage in a cultural transformation of the sector. Organizations and individuals might step up and offer to lead it, but they can’t do it alone; leadership must come from government itself. Good leadership is not just manifested in holding long term care providers and their staff accountable, but also in understanding the need for and dedication to a range of resources appropriate for the provision of quality facility-based long term care services.

A transformation needs to take place, but it cannot happen at the regional, provincial and territorial levels alone. The federal government must fulfill its stewardship role in helping to ensure, along with the provinces

and territories, that the facility-based long term care system has the capacity to meet the needs of our aging population.

It is the responsibility of the federal government to exercise leadership, create a national vision and provide the funding needed to enhance access to all continuing care services for Canadians. CHA believes that facility-based long term care can be flexible enough to meet regional realities, while delivering comparable high-quality services across Canada. Ensuring that Canadians have access to quality, resident-centered long term care when they need it must become a national priority.

Continuing Care

Defining Continuing Care

Not all provinces and territories use the term *continuing care*. The Canadian Healthcare Association has chosen to use this term and has delineated four pillars or components within continuing care. CHA has done so in order to discuss national-level health policy in an area of health care which is both diverse and inconsistent across Canada. In fact, the continuing care sector has often been described as a patchwork quilt, which is loosely sewn together and configured differently in each province and territory. CHA recognizes that continuing care services are classified and delivered differently across Canada.

In order to undertake a national dialogue, we must use common terminology. For purposes of this brief, continuing care will be defined as:

... 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.

The continuing care network is composed of a continuum of services available for individuals and their families according to needs (CHA, 1993).



The Pillars

The Pillars of Continuing Care

The continuing care system consists of four key components or pillars. These include home care, community support services, supportive/assisted living arrangements and facility-based long term care. The relationships between these components are so interconnected that it is difficult to examine one pillar without considering another. However, it is important to provide context for each of these components.

Home Care

Home care is not new in Canada. Rather, we have come full circle, as health care was primarily home-based before the introduction of medicare and the consequent emphasis on acute care.

Home care services today encompass an array of health services delivered to individuals in their homes. These services include assessment and case management, professional health services, personal care, homemaking and other services.¹ The Canadian Healthcare Association's definition of the three main functions of home care originally appeared in a background document released in 1993 and was reiterated in its 2009 policy brief, *Home Care in Canada: From the Margins to the Mainstream*:

- “The *maintenance (/preventive/restorative function)*...serves people with health and/or functional deficits in the home setting, both maintaining their ability to live independently, and, in many cases preventing health and functional breakdowns and eventual hospitalization.” In addition, individuals may improve or restore their functional status rather than simply maintain their current health status or avoid further deterioration. This prevents admission to hospital because independence is restored



or illness is avoided. The restorative/maintenance/preventive function also averts admission to a long term care home because adequate functional health status is maintained or deterioration is prevented.

- “The *long term substitution (function)*... meets the (ongoing) needs of people who would otherwise require institutionalization” if home care were not available.
- “The *acute care substitution (and replacement function)*... meets the needs of people who would otherwise have to enter or remain in acute care facilities.” Acute care substitution is more than follow-up hospital care, since technology now allows for many health treatments to be performed in the home during an episode of illness without the client first requiring hospital admission (Costs, 1993, p. 1–2).

Home care is delivered as a discrete service in individual dwellings, retirement homes, supportive/assisted living units or group homes for persons with disabilities. Care at home provides many benefits.

Individuals often function better, remain more

Acute care substitution home care has increased because it provides an opportunity to free up needed beds and enables patients to recover in their own homes.

independent, experience a sense of normalcy and enjoy social integration within a home environment. There is less family conflict while an

elderly parent is receiving care at home, but the issue of long-term care placement can create a crisis within families.

The amount of home care provided as long term substitution and as maintenance/prevention has implications for the facility-based long term care sector, because robust home care services can reduce the requirement for space in long term care homes. These particular aspects of home care

are in jeopardy because hospitals release patients earlier and acute care substitution/replacement services have increased and consume larger portions of home care resources (Sheppard et al., 2002/2003).

Although the *Ten Year Plan 2004* provided funding for post-acute home care, there has been some reallocation of home care dollars to acute care substitution/replacement. This has reduced resources for long term substitution and maintenance/prevention home care. Acute care substitution home care has increased because it provides an opportunity to free up needed beds, and enables patients to recover in their own homes. As Réjean Hébert (2003), Dean of the Faculty of Medicine at the University of Sherbrooke, noted:

With the shift towards ambulatory care in recent years, some convalescent care has been transferred from short term hospitals to home care services. Without an increase in the budget for home care, this has had the perverse effect of reducing the coverage of home care services for the frail older individual (Hebert, 2003, p. 9).

The frail elderly and the chronically disabled may not receive the sustained, ongoing home care they need, or they may have to wait too long to be allocated services due to the shift in home care priorities. The deterioration in their health status, which can occur rapidly without adequate home care services, may result in admissions to hospital and/or earlier placement in long-term care homes, actions which could have been prevented or delayed with appropriate home care support.

Community Support Services

Although the term is not standardized across Canada, *community support services* identifies an array of health services and programs

across jurisdictions. Community support services are health services that are delivered in a variety of settings other than the home, the long-term care facility or the hospital. These services include respite programs, adult day programs and personal care services. Home care services are closely linked to community support services. Some provinces also consider transportation services and meal programs such as *Meals on Wheels* or *Wheels for Meals* as community support services while other jurisdictions consider them to be part of the home care sector.

Though not acute care services or public health programs, they may be associated with hospitals. Community support services are not home care programs because they are not provided within the individual's residence.

Like home care, community support services have been developed to better meet client health needs and to delay or avoid facility admission, resulting in better use of resources along the continuum of care. Programs such as day respite can provide relief for family caregivers by providing recreational programming and meal service. Community care programs can offer an array of services which may not be met by home care alone. Although an individual's health status may improve under these programs, they are not strictly curative but focus on aging in place.

Supportive/Assisted Living

Assisted living is collective housing to which support services such as meals and basic housekeeping, personal care services and health services are added. Assisted living is sometimes called *supportive living*. It is different from *supportive housing*, a term often used to identify a range of housing configurations. Supportive housing projects for seniors exist in a number of provinces, provide a range of services and are known

under different names depending on the jurisdiction, the program and the amount of assistance provided to residents. Supportive housing does not generally include personal care or health services.

The British Columbia Ministry of Health Services defines supportive housing as "a residence in which the operator provides hospitality services only. No personal assistance services are provided by or through the operator" (Government of British Columbia, 2009). Ontario employs a broader definition, in that supportive housing

is designed for people who need "minimal to moderate care – such as homemaking or personal care and support"

Increasing numbers of people will have health and mobility restrictions that require support with day-to-day routines.

(Government of Ontario, 2009). In Ontario, *supportive housing services* (a term used for public sector services) include personal care services available 24 hours a day in addition to support services. This is rental housing with possible government support in the form of a geared-to-income subsidy.

In the future, increasing numbers of people will have health and mobility restrictions that require support with day-to-day routines. For elderly Canadians of modest income, *subsidized supportive housing* may be the most viable option to "age in place" as independently as possible (Canadian Policy Research Networks, 2007). Currently, supportive housing in Canada is suitable for the vast majority of healthy seniors and for many disabled individuals, but it is largely unregulated and provides limited access to health care.

Public supportive housing and public supportive/assisted living should not be confused with private *retirement homes and residences*. These are private pay accommodations which provide a private room and hotel services such as group meals,

laundry and housekeeping primarily for seniors who are functionally independent. They are available to those who choose to pay a fee for the management of their day-to-day

Any pan-Canadian discussion of supportive / assisted living arrangements will uncover the ambiguity around nomenclature, definitions and health service design.

living arrangements. Minimal nursing care may be available as part of the company's package and, sometimes, additional support can

be purchased from the operator according to a menu of services. If the resident qualifies, publicly-funded home care services may be provided just as they would be for an individual living in a single family dwelling.

Private retirement residences are viewed as an attractive option for seniors who can afford them. Canada is witnessing an explosion of elaborately-appointed retirement residences. The residence fees vary, and most are well out of range for low and middle-income seniors. In Ontario, for instance, some residences have not been able to fill their rooms with the healthy and wealthy, so they have cast a wider net and offer a menu of assisted living services to attract a larger cohort of seniors. The operation of retirement residences is not regulated in some provinces. For example, in Ontario, it falls to members of private associations such as the Ontario Retirement Communities Association (ORCA) to set independent province-wide standards.

Assisted living arrangements are the newest model of continuing care that fits best as a middle option along the continuum between home care and facility-based long term care. There are many definitions of assisted living. Indeed, any pan-Canadian discussion of supportive/assisted living arrangements will uncover the ambiguity around nomenclature, definitions and health service design, as these services have evolved uniquely and rapidly within some provinces.

Some assisted living costs to residents may be subsidized by government programs.

Assisted living is still in its infancy and there is no consistency in its philosophy, organization or terminology. The term has not been granted "title protection" in any jurisdiction in Canada. Theoretically, a person can operate any type of residential home or community care facility and simply call it "assisted living".

Designated assisted living provides a bridge between home care and facility-based long term care along the continuum in Alberta. The term *designated* refers to specific spaces within a facility where there is a contract between the health authority and a private assisted living operator. These contracts outline the health and support services that the operator must provide under the terms of the agreement, such as assistance with medication and activities of daily living. The target group for designated assisted living includes those who require personal care and can no longer manage in their own home, even with the support of home care. In British Columbia this configuration is termed *subsidized assisted living*.

The provision of assisted living arrangements has had an impact upon the development of facility-based long term care, especially in Alberta where it is being advanced as a more appropriate and less costly alternative. The main policy of the Alberta government since the release and implementation of the *Healthy Aging: New Directions for Care* (Broda report) in 1999 has been to aggressively expand assisted living options while limiting the number of long term care homes (Parkland Institute, 2008).

Alberta's passion for assisted living is reflected in the rapid growth of assisted living units in the province, and is articulated in its continuing care strategy *Aging in the*

Right Place released in December 2008. While the province has committed to an additional 1,225 approved assisted living spaces by 2011, the strategy also contains a declaration that the number of long term care beds will be frozen at the current level of 14,500 for several years. Health care observers have expressed concern, as not only does this contradict election pledges to provide 600 new long term care beds, it is not prudent in light of claims that Alberta has approximately 1,500 seniors assessed as urgently requiring long term care placement, half of which are waiting in acute care hospital beds (Somerville, 2009).

British Columbia has undertaken extensive expansion of assisted living and was the first province to introduce assisted living legislation covering both private and publicly-funded services. Health authorities in BC may contract with the operators of rental units for a basket of care services and for control over entry to designated rental units, which must be available at market rates. Proprietary or nonprofit operators use their own capital and/or public housing money to build or open rental units, then set the rental price. To qualify for admission, assisted living applicants must require support and personal care services, be able to direct their own care and be at significant risk in their current living environment. The rent and care costs are split, with the health authority paying for the personal care supports required by the tenant. BC Housing may provide a subsidy to the operator to assist with rent.

According to the Fraser Health Authority, three components must be available in an assisted living environment:

- on site health support;
- health supports (but not direct supervision) 24 hours a day, 7 days a week; and

- health supports must meet scheduled and unscheduled needs. Case management and nursing services are provided as part of the supportive/assisted living package, but professional nurses are not continuously on site. Additional home care, such as therapies, is provided through existing home care programs under the same policies as provided to clients living in their own dwelling (Fraser Health Authority, 2002).

The vigorous development of subsidized and for-profit assisted living facilities is also reflective of BC's policy of deinstitutionalization. From 2001 to 2004, the provincial government closed down 2,529 long term care beds across the province. The government's original commitment to replace 5,000 long term care beds that were housed in outdated, unsustainable facilities was amended to include assisted living and supportive housing units in the count (Canadian Policy Research Networks (CPRN), 2007). The loss of long term care beds in BC and beyond has placed significant pressure on other sectors along the health care continuum, most notably acute care beds in hospitals (Cohen, 2005).

A distinct difference between facility-based long term care and assisted living is that continuous professional health delivery supervision is not provided in the latter. The combination of accommodation, hotel services and personal care provided in assisted living arrangements attempts to maximize the independence of frail seniors and meet the ongoing needs of individuals, some of whom might otherwise be prematurely admitted to facility-based long-term care. But the complex care needs of seniors cannot be met in assisted living environments. Facility-based long term care provides an infrastructure of support for people with complex care requirements. Assisted living cannot match this level of care and is characterized by

a comparably low level of supervision and assistance (CPRN, 2007).

The Special Senate Committee on Aging called for vigilance to ensure that assisted living does not evolve into unregulated long term care homes with à la carte care (Special Senate Committee on Aging, 2009).

Facility-based long term care is both a home for residents and a workplace for health providers.

Assisted living units cannot be viewed as a replacement for long term care beds. Instead,

government should make decisions that reflect the essential nature of all services along the health care continuum. Assisted living and facility-based long term care should be complementary to one another.

Facility-Based Long Term Care

Facility-based long term care is both a home for residents and a workplace for health providers. Care is provided for people with complex health needs who are unable to remain at home or in a supportive living environment. Health service is typically delivered over an extended period of time to individuals with moderate to extensive functional deficits and/or chronic conditions.

Components of Facility-Based Long Term Care

Facility-based long term care is composed of three broad components: accommodation, hospitality services and health services.

Accommodation encompasses lodging and hotel services or room and board on a permanent basis. These services include the provision of meals and snacks, environmental services such as laundry, housekeeping, interior and exterior maintenance and overall administration. The provision of personal clothing, toiletries, personal items and special off-site transportation is not usually considered part of accommodation.

Hospitality services include general recreational or activation programs and social programming. These are critical elements of facility-based long term care because opportunities for socialization and stimulation are universally regarded as being of crucial importance for residents. The long term care environment should maximize the personalization of living space by replicating a regular home environment and permitting personalized touches. The home's structure should accommodate both physical incapacity and wandering residents, and provide for the safety of frail individuals. A common element in recent construction is the grouping of residents in neighbourhoods of no more than 32 people. Some operators have exceeded the standard and provide for even more generous living space in their units or neighbourhoods.

Health services provided in long term care homes generally comprise the following:

- on-site *professional nursing services* available 24 hours a day, 7 days a week. Clinical nursing services include nursing treatments such as skin and wound care, medication administration, artificial feeding, ostomy care and ventilation assistance. It is the uniform provision of these professional nursing services by registered nurses or licensed/registered practical nurses that differentiates facility-based long term care from other types of accommodations where professional nurses may not be continuously on staff;
- on-site *personal care* involves assistance with activities of daily living (ADLs), including help with eating, personal hygiene, dressing, ambulating, toileting and the provision of basic safety. Personal care is an essential element of health services. Most personal care is provided in long-term care homes by

unregulated health care workers under the supervision of registered or licensed/registered practical nurses. These health support workers are identified by titles that vary from province to province, including personal support workers, residential care aides, and health care aides. They comprise the largest group of employees within the long term care environment;

- *facility-based case management* includes assessment, care planning, reporting, communication with families, scheduling, care conferences and charting;
- *intermittent health professionals' services* may include therapies (nutrition, recreation, occupational health, physiotherapy, psychotherapy, speech language pathology and respiratory therapy), social work and pharmacy. Drugs, medical supplies, specialized equipment and mobility aides may or may not be supplied as part of the professional health service. Equipment such as wheelchairs, geriatric chairs, walkers and toilet aids for the common use of all residents should be provided; and
- *physician services*: Regulations require each resident to have an attending physician which could be the resident's personal family physician or a physician on staff at the long term care home.

Facility-based long term care does not include group homes, retirement residences, assisted living or supportive housing, because these do not provide daily, around-the-clock professional nursing services. Instead, each provides care to individuals at a different point along the health care continuum.

In recent years, *convalescent care* has become a mainstream service within long term care

homes. Convalescent care programs assist individuals with recuperation and recovery after surgery or serious illness. Designated beds in selected long term care homes are set aside for convalescing individuals with a length of stay (usually) no greater than three months. Discharge from care may occur sooner depending on an individual's health status. While the age and medical condition of convalescent care residents vary widely, they all have one common goal – eventual discharge from the program and a return to the community.

Few could argue against the short term placement of recovering individuals in long term care, but concerns are widespread with regard to inappropriate placement in long term care. For example, while individuals with acquired immunodeficiency syndrome (AIDS) sometimes reside in long term care homes, program design and staffing patterns do not usually facilitate such care. Studies dealing with the care of AIDS patients identify home care as the program of choice, provided that access to acute care or professional services in the home is made available when required. However, where such services do not exist or are overextended, individuals with AIDS may reside in long term care homes by default.

Concerns are common over the placement of psychiatric clients in long term care homes. While the industry has proven capable to care for elderly residents with a history of some psychiatric problems, it can be argued that long term care homes are poorly-equipped to care for those with recent or acute behavioural conditions, given current staffing levels and a system of oversight that is outdated and punitive.

If a resident's health status deteriorates, *end-of-life* care may be offered as a natural extension or adaptation of the health services already being provided to

the individual. A long term care home is not a hospice, though residents often prefer to spend their remaining days and weeks there, surrounded by family and friends, rather than going through the trauma of being uprooted to a different environment. This is not to imply that facility-based long term care couldn't develop more of a hospice role.

Facility-based long term care services are not subject to the provisions of the Canada Health Act.

With adequate funding and appropriately trained staff, long term care organizations could be well positioned to provide hospice.

Location of Facility-Based Long Term Care

The location of facility-based long term care varies across Canada. These services may be delivered in a facility designated specifically for long term care or in other health care settings. The only location in sparsely populated areas may be an acute care (hospital) environment or a health centre in which beds or units are specifically designated for long term care. This option enables individuals to remain close to their family or their lifelong community within Canada; an option which is more common in Saskatchewan, Alberta, Prince Edward Island, the Yukon and the Northwest Territories.

Depending on the jurisdiction, long term care is also delivered in chronic care or extended care hospitals, or in specifically designated units within acute care hospitals. When facility-based long term care services coexist with acute care services in the same building, the two services may be regulated under different provincial health legislation. However, facility-based long term care services are not subject to the provisions of the *Canada Health Act*.

Designated hospital-based long term care should be distinguished from beds being occupied by *medically discharged* acute hospital patients (patients who have been

officially discharged from hospital by a physician with the discharge date duly noted on the patient's chart). The patient may remain in hospital awaiting appropriate placement within the continuing care system. In most jurisdictions, the term *alternative level of care* (ALC) is used to describe these medically discharged patients preparing for discharge or awaiting long term care placement. ALC is not a recent phenomenon. The issue was raised in the 1950s as a problem in Alberta, and while we might change the acronym, the message back then was the same as it is now.

A recent Canadian Institute for Health Information (CIHI) report *Alternate Level of Care in Canada* revealed that in 2007-2008, ALC patients accounted for 5 percent of hospitalizations and 14 percent of hospital days in Canadian acute care facilities. This translates into approximately 5,200 beds in acute care hospitals being occupied by ALC patients on any given day. Saskatchewan and Prince Edward Island had the lowest ALC rate, at 2 percent of hospitalizations, while 7 percent of hospitalizations in Ontario and Newfoundland and Labrador were ALC. The sources of this variation are not well understood. Differences in funding and available spaces for ALC patients within the system may account for much of the variation. Another factor may be associated with differences in documentation and data collection (CIHI, 2009).

Dementia is a key diagnosis related to ALC. Overall, dementia accounted for almost one quarter of ALC hospitalizations and more than one third of ALC days. Hospitalizations with a main dementia diagnosis had a longer median ALC length of stay (23 days) than typical ALC patients (10 days). Among ALC hospitalizations, the predominant discharge destination was facility-based long-term care at 43 percent. Twenty-seven percent of ALC patients were discharged home and 12

percent died. Many of those who died were in hospital to receive palliative care (42 percent), but almost half (45 percent) were awaiting admission to another facility (CIHI, 2009).

In Ontario, medically-complex residents with multiple health problems and long term functional impairments may reside in hospitals and continuing care nursing units designated as *complex continuing care*² (CCC) by the Ministry of Health and Long-Term Care (MOHLTC). The term has been used interchangeably with *chronic care*. Many CCC residents have been affected by conditions such as multiple sclerosis (MS), amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's disease) and chronic obstructive pulmonary disease (COPD). Typically, these individuals have care needs that exceed those available through community services or facility-based long term care. CCC provides specialized care to residents whose condition is medically unstable and may require ongoing technology-based care including dialysis, treatment for stage four ulcers, suctioning, transfusions, lung aspiration, tube feeding, tracheotomy care and ventilator care.

In some other provinces these individuals may be concentrated in hospital settings equipped to deal with this level of care. In most jurisdictions, however, these higher-needs residents have been moved into the facility-based long term care program. Recently, the distinction between those receiving care in CCC and LTC has become blurred as complex care residents are now routinely admitted to and often managed effectively in long term care homes across Canada.

Nomenclature for Facilities across Canada

Every province and territory has adopted its own official nomenclature for facility-based long term care. While there is similarity in

the nomenclature across provinces, some terms may connote a different type of service. For example, *nursing home* is a generic term used by the public across provinces and territories, but is an official designation for a type of long term care home only in Nova Scotia, New Brunswick, and Newfoundland and Labrador.

Care Equivalencies across Canada

Equivalencies of care have been identified by Statistics Canada in the *Residential Care Facilities Study* (RCFS) in order to cross-reference similar levels of facility-based services in different jurisdictions. The level or type of care is identified and measured differently in each jurisdiction. The RCFS equivalencies of care are based on the number of hours of care provided per resident in a facility in which continuous onsite nursing is available. Type II, Type III and higher-type care defined by the RCFS is roughly equivalent to what CHA has defined as facility-based long-term care. Please refer to Appendix A for a detailed description of types of residential care and their equivalencies.

Notes:

- 1 For a detailed description of home care, readers should refer to CHA's 2009 Policy Brief, *Home Care in Canada: From the Margins to the Mainstream*, available at www.cha.ca.
- 2 CHA recognizes that Complex Continuing Care in Ontario is not part of its long term care sector. Complex Continuing Care is governed by the Ontario Public Hospitals Act and is part of the hospital sector. For the purposes of this Policy Brief, CHA has included Complex Continuing Care because the type and level of extended health care provided within complex continuing care in Ontario is delivered primarily within the long term care sector in other jurisdictions. However, the purpose of this brief is to call for increased federal support for long term care wherever and however it is administered or delivered.

Table 1: Nomenclature for Facility-Based Long Term Care

Province-Territory	Current Nomenclature	Former Nomenclature
BC	Residential care facility Assisted living residence Family care home Group homes	Extended care hospital (heavier care) Private hospital (heavier care) Intermediate care facility Multilevel care facility
AB	Nursing home Auxiliary hospital	Auxiliary hospital Nursing home Continuing care centre
SK	Special care home (higher-level care provided, publicly-subsidized care) Personal care home (tends to provide lower level of care, not publicly-subsidized, is not considered a special care home)	
MB	Personal care home	
ON	Nursing home Municipal homes for the aged Charitable homes for the aged	Proprietary nursing home Municipal or charitable home for the aged (not-for-profit) Long-term care facility (administered within MOHLTC Community Health Division) Complex continuing care hospital (administered within MOHLTC Acute Services Division)
QC	Centre d'hébergement et de soins de longue durée (CHSLD) (publicly-funded) Includes: Public (publicly-owned, funded and administered facility) Private (privately-owned under agreement, receives funds from government) (privé conventionné) CHSLD privés non conventionnés (privately-owned and administered, not under agreement, receives no funds from government) Centre de réadaptation	
NB	Nursing home Special care home (lower-level personal support, not publicly-funded, is not considered facility-based long-term care) Community residences	
PE	Government manor home (government-owned, higher-level care) Private nursing home (privately-owned, higher-level care) Community care facility (privately-owned, lower-level support)	Private manor homes
NS	Nursing home/home for the aged Residential care facility Group home/developmental residence Adult residential centre Regional rehabilitation centre	
NL	Nursing home Personal care home	
YK	Continuing care facility	Residential continuing care facility
NT	Adult group homes and supportive living homes	Personal care facility Residential long term care facility (lower-level of nursing support, is not considered facility-based long term care)
NU	Residential and specialized treatment facilities for mentally or physically challenged adults, seniors and children	Group living environment for dependent elderly (run by a not-for-profit community agency through contribution agreement with territorial government)

Source: Canadian Healthcare Association. (2007). *Guide to Canadian Healthcare Facilities, Volume 15, 2007–2008*. pp. 16–22; CHA's provincial/territorial member organizations and contacts, 2007–2008. Ottawa: CHA Press.

Continuing Care

Classifying Continuing Care

Gateway to Continuing Care

The admission of an individual to facility-based long term care differs from admission to a publicly-funded hospital where the physician is the gatekeeper. Every province and territory in Canada, on the other hand, has established or is establishing a coordinated placement process for admission to long term care. Depending on the region, the gatekeeper may be a committee or a case manager who seeks input and assessment from a number of members of the health team, including the physician.

This coordinated placement process or *single point of entry* is known by a variety of names, for example: screening, paneling, referring, case-managing and placement. Effective entry systems are critically important, as they reduce costs for the entire health system, while optimizing the suitability and ease of placement for the individual. All these systems try to ensure that appropriate non-facility options have been exhausted before admission into a long-term care home is approved. Some wait lists have been reduced in recent times because inappropriate placements on these lists have been avoided and redundant applications eliminated.

Decisions about the placement of an individual are often made during a health crisis when the individual and family have little time to make a decision and a limited number of options are available to them. Consequently, the admission process is often fraught with tension and conflicting emotions despite the development of efficient coordinated entry systems.



The Role of Classification Systems in Continuing Care

Disease diagnoses or medical specialties such as cardiac care, psychiatry, orthopedics and obstetrics determine the organization of acute care services. In long term care, generalized classification systems, rather

Decisions about placement are often made during a health crisis when the individual and family have little time to make a decision and a limited number of options are available to them.

than specialty groupings, provide a structure for services. Here, the focus is on the level of care needs and not on the specific disability

or disease diagnosis. In each province or territory, data derived from a variety of assessment tools is used to stratify applicants into alphabetical or numerical levels, categories or types, generally referred to as *resident classification systems*. These provincial, hierarchical classification systems are based on health service requirements, usually measured in the number of hours of professional nursing required and the functional status of the individual. Eligibility for admission to a home is determined based on this stratification.

The use of different classification systems, various admission policies and diverse government funding has led to inconsistent entry criteria for long term care homes. The same person assessed as eligible for admission to a long term care home in one province could be referred to a different service in another. A study conducted in St. John's, Newfoundland and Labrador, identified a number of residents with minimal needs living in long term care homes who could have been residing elsewhere (McDonald and Parfrey, 2001). Thus, the same people who would be admitted into facility-based long term care in some provinces could be placed in supportive/assisted living arrangements or offered community-based services if they were available.

The use of a common database would be instrumental in the future for determining equitable, federal public funding for Canadians receiving facility-based long term care. Inconsistencies in how facility admission is determined in some provinces lead to variations about who receives long-term care. This disparity provides a challenge in calling for equitable funding for facility-based long term care across Canada.

Standardized assessment tools are available to collect information and inform decision making on functional ability, health status, service requirements, funding allocation and resident outcomes. The compatibility of assessment systems between multiple settings such as long-term care, home care, assisted living and mental health is essential. A seamless health assessment system will improve continuity of care and promote a person-centered approach to care (interRAI website). But no single comparable assessment tool is currently being used throughout Canada.

The Functional Autonomy Measurement System (SMAF) is a 29-item scale used in Quebec to measure functional ability in five different areas: activities of daily living, mobility, communication, mental functions and instrumental activities of daily living. It is based on the World Health Organization (WHO) classification of disabilities, and contains a built-in classification system. It may have application as a system-wide assessment tool for people in all healthcare settings (Boissy et al., 2007).

The single data collection instrument gaining the most attention in Canada is the Resident Assessment Instrument Minimum Data Set 2.0 (RAI-MDS 2.0). The instrument is used in several countries for one or more of the following purposes: care planning, policy development, quality improvement and

benchmarking, reimbursement, research, resident needs assessment or service eligibility.

In Canada, RAI-MDS 2.0 is currently being implemented in seven provinces and one territory. The MDS suite of programs is a powerful tool that can be used to identify issues and trends and to enhance the quality of care. It encompasses

- Resident Assessment Protocols (RAPs): 18 protocols of care used to flag areas where further review is needed and to guide changes and improvements in care (ie., falls, pressure ulcers, psychosocial well-being and nutritional status).
- Quality Indicators (QIs): 24 indicators that provide information on the effectiveness, efficiency and appropriateness of resident care (ie., weight loss, decline in range of motion, urinary tract infection and anti-psychotic use in the absence of psychotic or related conditions).
- Resource Utilization Groups (RUGs): The software automatically classifies residents into groups. There are 7 major groups, further divided into 44 distinct sub-groups. These groups classify residents according to their clinical and diagnostic characteristics and resource utilization and can be used to determine funding allocations.

All assessments are submitted electronically to the Canadian Institute for Health Information where home-specific, provincial and pan-Canadian reports can be produced on facility-based long term care.

RAI-MDS 2.0 is generally regarded in the field as vastly superior to any previous resident assessment methodology for several

reasons, including the ability to accurately compare one home with similar ones across a jurisdiction, and the focus on maximizing resident independence rather than dependence. The transition to a new and more robust assessment process brings its share of challenges. Challenges can become problems when implementation responsibility is assigned to a person who also has to manage a department or a home. The timelines and workloads associated with the implementation of RAI-MDS 2.0 must be realistic.

Governments have a vested interest in making sure that implementation is effective. One means to enable this is through the development of knowledge centers staffed by specially-trained individuals who can coach and support homes in its efforts. An example used in Ontario is the Data Accuracy Review Team (DART). DART consists of gold standard assessors who visit homes upon invitation and perform parallel assessments to assist homes determine the level of accuracy. DART is not a punitive process but rather an education vehicle that will either compliment the home for its work or provide support and direction to help improve the quality and accuracy of the home's assessments. The DART model should be given consideration by all jurisdictions.

The same person assessed as eligible for admission to a long term care home in one province could be referred to a different service in another.

RAI-MDS 2.0 is not without its critics. The chief complaints among actual users in facility-based long term care revolve around two areas of concern. First, direct resident interviews are often absent from the assessment process, and secondly, the time requirements necessary to collect and input data is burdensome for front-line caregivers. Both problems have the potential

to disenfranchise the two most important groups in facility-based long term care – the residents and staff.

A joint team of experts from the RAND Corporation and Harvard University developed and tested a revised version, the Resident Assessment Instrument Minimum Data Set 3.0 (MDS 3.0) in 2008. Preliminary results show promise for an improved system. The goals of the MDS 3.0 revision were to “introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, and increase the resident’s voice by introducing more resident interview items” (RAND, 2008).

Experts in long term care requested that MDS 3.0 revisions focus on shortening the tool while improving its clinical utility and maintaining the ability to use MDS data for quality indicators, quality measures and funding allocation (RUGS). In addition to improving the content and structure of MDS, the RAND/Harvard team also aimed to improve user satisfaction. This is a key consideration as staff attitudes are key determinants of quality improvement implementation. Negative user attitudes toward the process are often cited as a reason that long term care homes have not fully implemented MDS data in targeted care planning (RAND, 2008).

After a national trial in the United States, MDS 3.0 demonstrated that it is possible to provide long term care residents a voice by gathering MDS information directly from them. Moreover, it showed that MDS 3.0 improved the accuracy of the assessment items and increased the tool’s efficiency (RAND, 2008). Conducting a trial of MDS 3.0 in Canada is worthy of consideration.

Long Term Care

Facility-Based Long Term Care Research

The Need for More Pan-Canadian Data

The development of pan-Canadian policies to provide comparable access to facility-based long term care must be evidence-informed. The data on facility-based long term care come from a variety of sources, including but not limited to:

- **Statistics Canada, Residential Care Facilities Survey:** This annual survey collects administrative data and serves as a generalized resource for countrywide information about facilities, including estimates of bed capacity, facility expenditures, revenues and ownership of facilities. The survey does not contain detailed information about residents such as level of acuity, admission rates or length of stay. Completion of the survey is a legal requirement under the *Statistics Act*. The survey's response rate was 72 percent of all residential care facilities between 1984/1985 and 1993/1994, 77 percent between 1996/1997 and 1999/2000 and 80 percent and higher since 2000/2001 (Statistics Canada online). The survey is hampered in its collection of comparable data because care classifications differ across jurisdictions.
- **Statistics Canada, National Population Health Survey:** This longitudinal survey collects information from a sample of people who lived in Canada when the survey was launched in 1995. Its goal is to collect information on the health status of Canadians and factors that can have an influence on their health. A number of respondents now reside in long-term care homes. With the agreement of these residents, the information can be provided by employees or by a family member.



- **Canadian Institute for Health Information, *National Health Expenditure Trends*:** This is published annually and provides information about current and past expenditures, by province and type of health service, using various data sources. The information includes data on lower-level custodial institutions, and therefore encompasses more than facility-based long term care.

Because CIHI's category of "other institutions" (which includes long term care homes and retirement facilities) differs from that of the Statistics Canada survey, data from these two sources cannot be easily amalgamated into a more comprehensive picture of facility-based long term care across Canada.

Facility-Based Continuing Care in Canada: This information reveals differences in the populations served and the services delivered between hospital and residential care settings, illustrating a continuum of care within the facility-based continuing care sector. The goal of the report is to enhance understanding of the continuing care sector and the individuals served.

- **Provincial/territorial studies and reports on facility-based long term care:** Readers should refer to Appendix B and the bibliography of this brief for an extensive list of reports from the provinces and territories.
- **Canadian Healthcare Association, *Guide to Canadian Healthcare Facilities*:** This guide is updated and published annually and lists organizations by province and territory, their designation and the number and types of beds.
- **Health Canada, *Participation and Activity Limitation Survey 2006 (PALS)*:** This post-

census survey was most recently conducted shortly after the 2006 Census. PALS collected information about disability in Canada but did not include data on residents in long term care homes.

- **Federal/Provincial/Territorial Advisory Committee on Health Services, *Working Group on Continuing Care, The Identification and Analysis of Incentives and Disincentives and Cost-Effectiveness of Various Funding Approaches for Continuing Care*** [Hollander et al.]: This onetime study, published in 2000, contains detailed comparative information about the organization of continuing care in each province and territory. This type of information needs continuous updating because provinces and territories frequently change their programs, legislation and service organization.

Recent provincial/territorial studies have dealt with a range of continuing care issues in their jurisdictions. Some provincial/territorial documents have considered facility-based long term care within overall health system publications. The information in these provincial reports cannot necessarily be generalized to the national level, but they do provide a snapshot about the status of care in different parts of Canada. These documents are listed in the bibliography at the end of this brief.

Individual homes are required to report some administrative information to their respective provincial/territorial governments. The information collected and sent varies by province and territory. Data are therefore not readily comparable across jurisdictions, thus making pan-Canadian analysis and benchmarking difficult. While regional data is helpful, a broader range of comparable pan-Canadian data is needed to better inform decision-makers.

Information about facility-based long-term care should include provincial/territorial resource allocations and reimbursement models, expenditures, health human resources, staffing ratios and mixes, physician visitation, the health status of residents, outcome measures, family/resident/staff satisfaction, waiting times, admission rates, discharge rates, services delivered and information about trends.

Unfortunately, the resources of most long term care homes are stretched to collect and report information about even basic resource utilization. They have neither the human resources nor technical capacity to collect the extensive data needed to help fuel research in this neglected part of the continuum. Data are not readily available because homes have been slow to computerize due to a chronic lack of resources. The introduction of new classification systems in some jurisdictions has stimulated the simultaneous introduction of information technology but while more long-term care homes have become computer-savvy, the industry still lags behind its acute care counterpart in the wide scale implementation of information systems.

Research on Facility-Based Long Term Care

Though Canada is behind other countries in per capita expenditures for research on aging (Rockwood, 2001), funding from various sources such as Health Canada (HC), Canadian Patient Safety Institute (CPSI), and the Canadian Health Services Research Foundation (CHSRF) has stimulated some research relevant to facility-based long term care.

The Canadian Institutes of Health Research (CIHR) integrates research through an interdisciplinary structure made up of 13

“virtual” institutes which consist of research networks brought together to collaborate across sectors, disciplines and regions. The Institutes of Health Services and Policy; Neurosciences; Mental Health and Addiction; and Aging hold the most relevance for facility-based long-term care research.

The Institute of Aging’s goal is to become the champion of health research on aging in Canada (CIHR, 2007). It made a step toward realizing that vision by establishing itself as the driving force behind the *Canadian Longitudinal Study on Aging (CLSA)*, a pan-Canadian, long-term study designed to examine health trends and identify ways to reduce disability and suffering among aging Canadians.

The CLSA operates on the premise that improvements in overall physical, social and emotional health may have the added benefit of reducing the demand for health care services in the future. Approximately 50,000 Canadians between the ages of 45 and 85 will be followed for a period of at least 20 years to collect information on the changing biological, medical, psychological, social and economic aspects of their lives. By studying the same adults over a prolonged time period, researchers will be better able to understand the factors that come into play both in maintaining health and during the progression of disease and disability. Following several years of preparation, the CLSA was officially launched in 2008 and holds promise as one of the most complete studies of its kind.

Various provincial health quality councils have been created since the start of the new millennium and each hold great research potential. Early results of provincial initiatives are impressive. The Health Quality Council (HQC) in Saskatchewan has provided quality improvement (QI) training

to over 1,400 individuals since its inception in November 2002. Furthermore, the HQC has researched and enacted province-wide QI initiatives that have yielding concrete results, including a greater than 50 percent reduction in pressure ulcers in selected long term care homes and hundreds of residents being taken off unnecessary medication (*Health Quality Council Strategic Plan, 2007*).

The Ontario Health Quality Council was established in September 2005 and has published reports on Ontario's health system under the banner *QMonitor*. Since 2008, the Council has been involved in a framework for long term care homes that includes measuring and publicly reporting on the quality of long term care and resident satisfaction (Ontario Health Quality Council, 2009). The Council works with the long term care sector to promote a culture of quality improvement, and in 2009 began piloting Lean methodology and Kaizen (continuous improvement) events with early adopter homes in Ontario. Lean is an improvement approach perfected by the Toyota Motor Company and inspired by the writings of Henry Ford and the practices of the Ford Motor Company in the 1930s. It is highly regarded for its ability to improve process

Research capacity needs to be expanded across the healthcare continuum.

flow, eliminate waste and improve service. The Council is working with a number of organizations

to determine the applicability of these continuous improvement processes to long term care.

University faculties, institutes on aging and public policy organizations conduct research projects that have policy implications for facility-based long term care. Most research on facility-based long term care uses region-specific data. Data is region-specific because the researcher is often only interested in a particular region, is funded by regional

interests or data relevant to the project is only available from a specific location. The research which is produced may provide insight into regional trends, leading practices and service gaps but policy implications from regional research cannot necessarily be generalized to all of Canada.

Research capacity needs to be expanded across the healthcare continuum. Capacity includes adequate funding, trained human resources, accurate and timely data, an appropriate infrastructure for analysis and research sites located both in academia and in the field. The limitations in long term care are particularly evident as there are not enough independent researchers or research staff in-house to analyze, design and collect relevant data or to assess a project's ethical acceptability. Few long term care homes are affiliated with research centres.

A background paper released in 2008 by the Canadian Patient Safety Institute called for a stronger research effort to identify leading practices that optimize the safety of residents in long-term care homes. Pressure ulcers, medication issues, falls, resident aggression and infections are all too common occurrences in long term care. The study suggested that staff skills were simply not meeting the increasing clinical complexity of residents. Communication was identified as another critical area with the potential to significantly affect resident safety, especially in the areas of inter-disciplinary communication, family engagement, care planning and disclosure of incidents and adverse events. The study highlighted training and leadership development for management as a key recommendation for the continued creation of a culture of safety in long term care environments (CNW, February, 2008). While patient safety has ascended the research agenda, comparatively little of the increased

attention has been devoted to facility-based long term care and other areas outside of the acute care setting (Rust, 2008).

Although not yet embedded in the DNA of long term care homes, research is essential to support the evolution of facility-based long term care and to help provide knowledge for evidence-informed practice. This goal is being advanced in various jurisdictions. As a result, innovation is being achieved across the map of long term care, especially in areas such as dementia care, responsive behaviours, pain management and skin care.

The Seniors Health Research Transfer Network (SHRTN) is an Ontario-wide knowledge exchange network that links long term caregivers with researchers and policy makers. Through a comprehensive library service, the support of knowledge brokers, and the nurturing of local implementation teams, SHRTN is emerging as a driving force in assisting homes to become acquainted with innovative practices and to put them into action. A key feature of the program is the social learning tool known as *communities of practice* (COPs). SHRTN has developed 19 COPs throughout Ontario on topics of high importance to facility-based long-term care, including Alzheimer and related dementias, continence care, end-of-life care, and elder abuse prevention. The SHRTN is a model that could be modified and applied across Canada.

Pan-Canadian research in facility-based long term care is urgently needed in order to forecast service needs, identify health human resource challenges and solutions, evaluate quality, test alternative modes of care and encourage innovative practices. The establishment of *teaching long term care homes* should be given immediate priority as they can serve as natural laboratories for research activities.

Teaching Long Term Care Homes

Many Canadians, health professionals included, are poorly informed about facility-based long term care. This is largely due to insufficient exposure or erroneous views about what constitutes the practice of long term care. This knowledge deficit should serve as additional motivation to pursue the development of teaching long term care

homes across Canada.

Knowledge shared is knowledge gained.

Every post-secondary health education

program should have an

affiliation with a long term care home in their community. Without exception, every medical school, nursing school and program in social work, nutrition, pharmacy, occupational therapy, physiotherapy, speech-language pathology and health services management should have a formal relationship with a long term care organization. Such alliances would promote the cultural transformation that is vital if we are to effectively serve the long term care residents of tomorrow.

Partnerships would have multiple objectives including, but not limited to, the development of practices that emphasize improving outcomes rather than endless documentation of care. We should:

- recognize that success is better measured by resident satisfaction and preservation of ability, rather than cure;
- affirm the facility-based long term care setting as a learning environment;
- reinforce the view that in a culture of caring, all stakeholders (residents, family, students, volunteers and employees) are valued members of a dynamic, interdisciplinary team (Samuelson, 2004).

The establishment of teaching long term care homes should be given immediate priority as they can serve as natural laboratories for research activities.

Collaborative partnerships between and among educational institutions and long term care homes should become commonplace. Long term care can serve as a valuable setting for researchers and provide unique learning opportunities for all levels of staff, from physician to nurse and dietician to front line worker. The home can provide extensive experience in cognitive and functional assessment, offer contact with challenging family dynamics and interdisciplinary teamwork, provide a forum for the discussion of ethical issues and advance directives and

Governments can play a pivotal role in legitimizing the creation and nurturing of teaching long term care homes.

help all stakeholders gain a thorough appreciation for the importance of quality, not just quantity of life (Samuelson, 2004).

and innovation that would eventually pervade and guide facility-based long-term care in Canada. Pilot projects in the United States have successfully promoted a more positive image of facility-based long term care and generated clinical improvements in areas as disparate as pressure ulcers, range of motion, dehydration and depression (Mezey et al., 2008). Research and innovation developed under the model of teaching long term care homes would be more actively disseminated and readily implemented because the field would have ownership in its creation and a stake in its ongoing success.

A sustainable and replicable pan-Canadian model of teaching long term care homes would infuse intellectual vigor and could better support the current and prepare the future workforce in this field. Relationships would be more robust than those which currently exist via short term student clinical placements in host-site long-term care homes. These homes would actively support inquiry and research, promote innovation and work with educational institutions to address the need to move long-term care from a traditional medical model to a social model. Ultimately, a framework will need to be developed to address one of the most pressing issues facing facility-based long term care – balancing residents’ safety needs with their right to self-determination.

Governments can play a pivotal role in legitimizing the creation and nurturing of teaching long term care homes. Adequate resources will be required to build the necessary infrastructure, but the investment will yield a bountiful harvest. Many benefits will accrue including a culture of learning

Profile of Residents

Profile of Residents Living in Facility-Based Long Term Care

The vast majority of Canadian seniors reside in private dwellings (93 percent). The rest live in group settings, primarily hospitals and long term care homes. The rate of institutionalization of seniors has decreased since the early 1980s. The most marked decline occurred among seniors aged 85 years and over, where 32 percent were institutionalized in 2001 versus 38 percent in 1981. While recent figures from Statistics Canada indicate that Canada's 4,291 long term care homes look after a growing number of residents (235,916), from the elderly to the mentally-ill, it is generally the elderly who become long term care residents (Statistics Canada, 2007).

Younger Adults

Historically, facility-based long term care has been the main option for the provision of lodging and health services to younger adults with disabilities. Today, the prevailing sentiment is that facility-based long term care is not the preferred option for this population. The decision to seek placement for a family member with acquired brain injury (ABI), for example, is usually taken after families have endured personal, social and economic duress (O'Reilly and Pryor, 2003). Unfortunately, detailed information about this population group is even less readily available than for the elderly population in facility-based long term care

In 2005–2006, just over one in six persons (17%) who received treatment in Ontario complex continuing care (CCC) was between 19 and 64 years old (CIHI, 2007). The number of CCC patients under the age of 65 years will likely grow and experience an increased life expectancy largely through advances in medical technology.



Table 2: Number of Canadians Living in a Health Care Facility, 2006

	General Hospitals ¹	Other hospitals and related institutions ²	Special care facilities ³	Facilities for persons with a disability ⁴	Total
Under 15 years, male	5	35	210	435	685
Under 15 years, female	5	25	240	285	555
Under 15 years, total	10	60	450	720	1,240
Age 15 to 24 years, male	125	225	470	2,315	3,135
Age 15 to 24 years, female	25	75	495	1,205	1,800
Age 15 to 24 years, total	150	300	965	3,520	4,935
Age 25 to 34 years, male	275	275	585	4,080	5,215
Age 25 to 34 years, female	90	90	595	2,230	3,005
Age 25 to 34 years, total	365	365	1,180	6,310	8,220
Age 35 to 54 years, male	500	1,020	4,305	15,440	21,265
Age 35 to 54 years, female	285	570	4,215	9,110	14,180
Age 35 to 54 years, total	785	1,590	8,520	24,550	35,445
Age 55 to 64 years, male	265	605	6,835	5,470	13,175
Age 55 to 64 years, female	235	375	7,045	3,965	11,620
Age 55 to 64 years, total	500	980	13,880	9,435	24,795
Age 65 to 74 years, male	400	660	13,245	2,470	16,775
Age 65 to 74 years, female	405	695	17,720	2,265	21,085
Age 65 to 74 years, total	805	1,355	30,965	4,735	37,860
Age 75 years and over, male	1,885	2,085	62,985	2,545	69,500
Age 75 years and over, female	3,160	4,935	180,445	5,470	194,010
Age 75 years and over, total	5,045	7,020	243,430	8,015	263,510
Canada total all ages	7,660	11,670	299,390	57,285	376,005

Source: Statistics Canada, 2006 Census of Population
Statistics Canada, 2008 Selected Collective Dwelling and Population Characteristics and Type of Collective Dwelling

1. Institutions providing medical or surgical diagnosis and treatment to the ill or injured.
2. Institutions providing diagnosis and treatment of a limited number of diseases or injuries, or providing a wide range of services to persons within a specific age group. Included are psychiatric hospitals, chronic care hospitals, children's hospitals, hospitals for the elderly, cancer treatment.
3. Refers to nursing homes, residences for senior citizens, and chronic and long-term care and related facilities.
4. Institutions providing care and treatment to the physically handicapped.

As with seniors, disabled persons must live with additional functional limitations as they grow older. Parents of disabled children often care for them well into their adult lives. But, as the parents age, they may face the double challenge of caring for their own parents as well as aging dependent children (often termed the *sandwich generation*), both

of whom may eventually require placement in a long-term care home.

Children and adults with disabilities are part of a small-volume but high-needs population. Advocates for this community point out younger residents are often inappropriately placed in long-term care homes with very old

residents. They may effectively communicate with elderly residents but often do not relate to them as peers or share common interests. As a result, some of these younger residents experience debilitating social isolation, although the physical care that they receive in long term care homes may be excellent.

While some homes have taken the initiative to develop unique mosaics, wings and modules, little is known about the specific support needs and preferences of younger residents living in facility-based long term care (Winkler et al., 2007). Research is needed to inform the development of clear policies regarding the placement and care of younger adults with disabilities.

The disabled community has long been vocal about the need for consumer choice that emphasizes privacy, autonomy, dignity and the right to manage their own risk. Advocates justifiably call for more home care funding, more appropriate housing options, and they view facility-based long term care as an inappropriate lifetime home for this population. Young adults with disabilities continue to emphasize that they would rather live as citizens, not as patients or residents.

Advocates for the disabled community suggest that if adequate community supports were in place, cost-savings could be realized in moving children and young adults from hospitals and long term care homes into the community. They have stressed the need for integrated community services and are not interested in facility-based long term care as the main solution (Valentine, 2001).

People with disabilities, regardless of age, do not want their disability equated with dependence since they have much to contribute to society in terms of productivity, reciprocal relationships and accumulated wisdom and experience (Stone, 2003). Yet, younger people with disabilities continue

to be admitted to facility-based long term care because of lack of alternative options, overwhelming caregiver burden, financial constraints and aging caregivers (MacLellan et al., 2002).

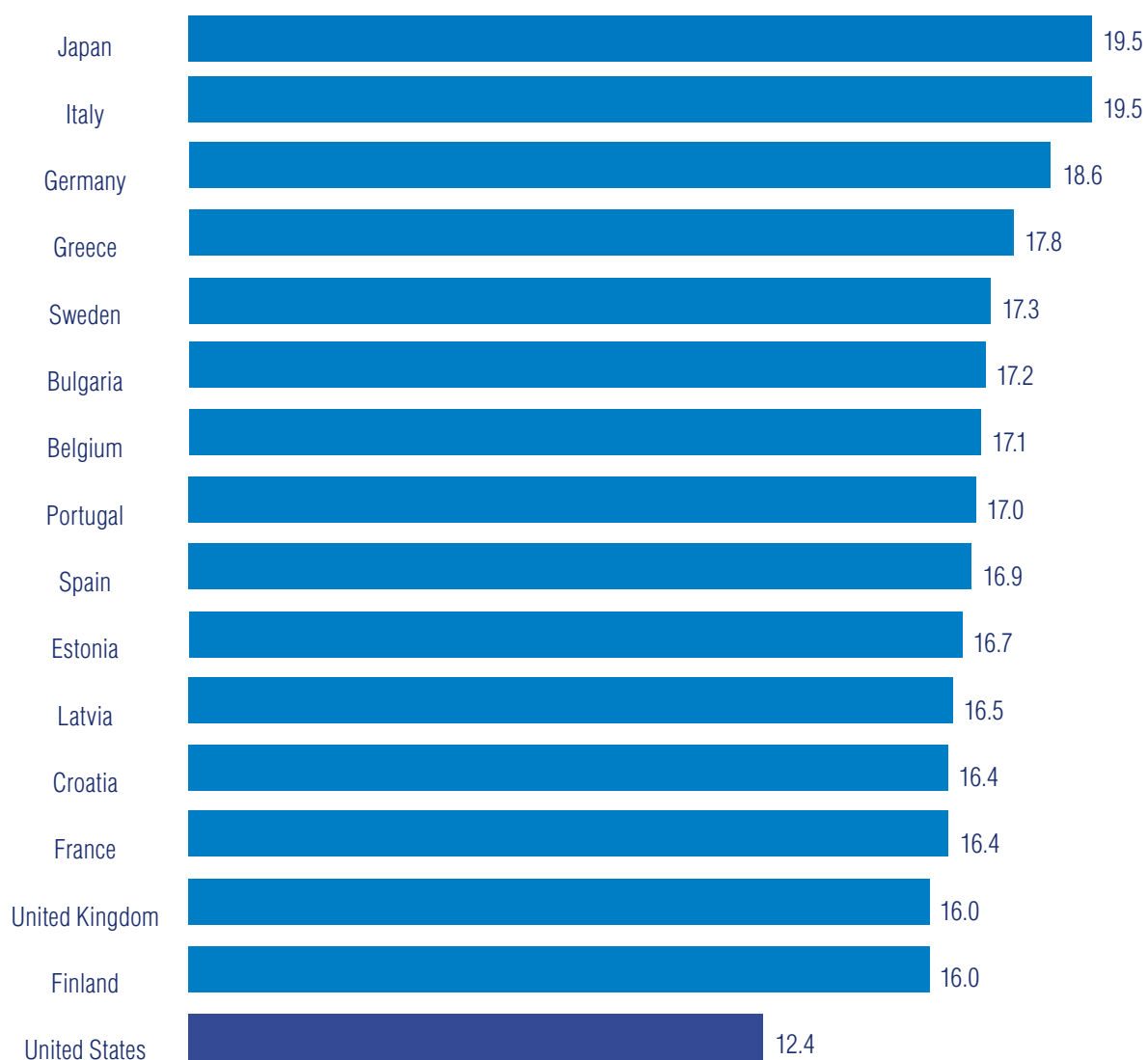
A potential solution to support the needs of the disabled community of all ages is the development of more alternative living arrangements. Without these alternatives, long term care placement of some individuals within the disabled population may be the only option. Further research will fuel a review of effective and efficient health services for young adults with disabilities. A balance must be struck between reasonable public expenditures and appropriate location of care for this neglected population.

Seniors

Although most elderly Canadians would prefer to live at home, many seniors will require care in a long term care home. When the time for placement arrives, seniors and their families prefer and often actively seek long term care settings that are clean, modern and have a reputation for providing quality care.

Defining the Terminology

Various labels or terms are used today to identify the aging and older Canadian population. According to Health Canada, the terms *senior* and *older Canadian* refer to adults 65 years of age and older. Some gerontologists distinguish between the *young-old* (aged 65 to 74 years), the *middle-old* (aged 75 to 84 years) and the *oldest-old* (aged 85 years and over) (Havens and Finlayson, 1999). Yet another concept is that of a *third* and a *fourth* age (National Advisory Council on Aging [NACA], 1999). The third age is described as a time when younger seniors, who are primarily healthy and independent, may pursue interests

Figure 1: The World's 15 'Oldest Countries' and the U.S. — Percent Age 65 or Older

Source: Carl Haub, *2006 World Population Data Sheet*.

that they have put off until retirement. The fourth age is the last stage of life and may be associated with illness and dependency (NACA, 1999).

Functional status has also been used to classify seniors. The terms *well*, *frail* and *dependent senior* were used by the Canadian Working Group on Seniors Health Issues to identify cohorts of seniors by health needs.

Both the concepts of 'oldest-old' and 'fourth age' refer to a narrow time span

that is of most relevance when discussing facility-based long term care. Within this group, however, there are many healthy, independent seniors who require minimal health services.

Canadian Seniors Are Increasing in Number

Canada's population is predicted to grow to 35 million people by 2041 (Lazurko and Hearn, 2000) and the proportion of seniors in the population is projected to increase even more dramatically over the next 50 years.¹

Population aging is the term used to describe the progressive aging of an entire body of people (Lilley and Campbell, 1999). Today, the segment of Canada's population over the age of 85 is the fastest growing cohort of seniors, with approximately 500,000 Canadians. The number of Canadians aged 85 and older will nearly double to some 900,000 in 2026.

Canada stands out among the industrialized countries. The upward swing in the proportion of seniors is happening later than in Europe, but will progress more rapidly this century because of the impact of the aging baby boomer generation (those born between 1946 and 1964). However, demographers (Rosenberg, 2000) note that countries that have already begun to experience the aging of their population are coping with the social and economic dimensions of aging.

The percentage of First Nation, Inuit and Métis seniors, although lower than the Canadian average, is also growing. In 2001, an estimated 39,900 First Nation, Inuit and Métis seniors represented four percent of their total population. By 2017, this is expected to increase to 6.5 percent (Health Canada, 2006).

The proportion of seniors in Canada's population (male and female) in relation to the younger cohort is illustrated in Figure 2 in a population pyramid.

Population aging is also determined by changes in fertility, mortality and immigration rates. Fertility rates have been cyclical during the 20th century. The most important groups that will affect planning are the individuals in the postwar *baby boom* (from 1946 to 1964) and the *echo* (children of the baby boom generation) (Foot, 1996). Thus, the proportion of seniors over 85 years of age is expected to increase over the next four decades. The peak of the baby boom

generation will pass through the 75 years of age and over between 2025 and 2045. The pressure exerted by baby boomers will reverse and policymakers must consider eventual attrition and not create an over-supply of long term care homes or construct static systems.

While the rise of baby boom seniors is yet to come, there has been a significant increase in the number of seniors over the past twenty years because of increased longevity. Life expectancy at age 65 is now 84 years of age overall (82.1 years of age for men and 85.6 years of age for women). The spread between the genders is more pronounced with advancing age. Women make up 70 percent of the age 85 and over cohort (Figure 3). While today, it is most often women 85 years of age and older who require facility-based long term care to support them in their final years, the differences in life expectancy between men and women are expected to narrow in the future. An increase in the number of elderly men will necessitate the development of programs and services sensitive to their needs and interests.

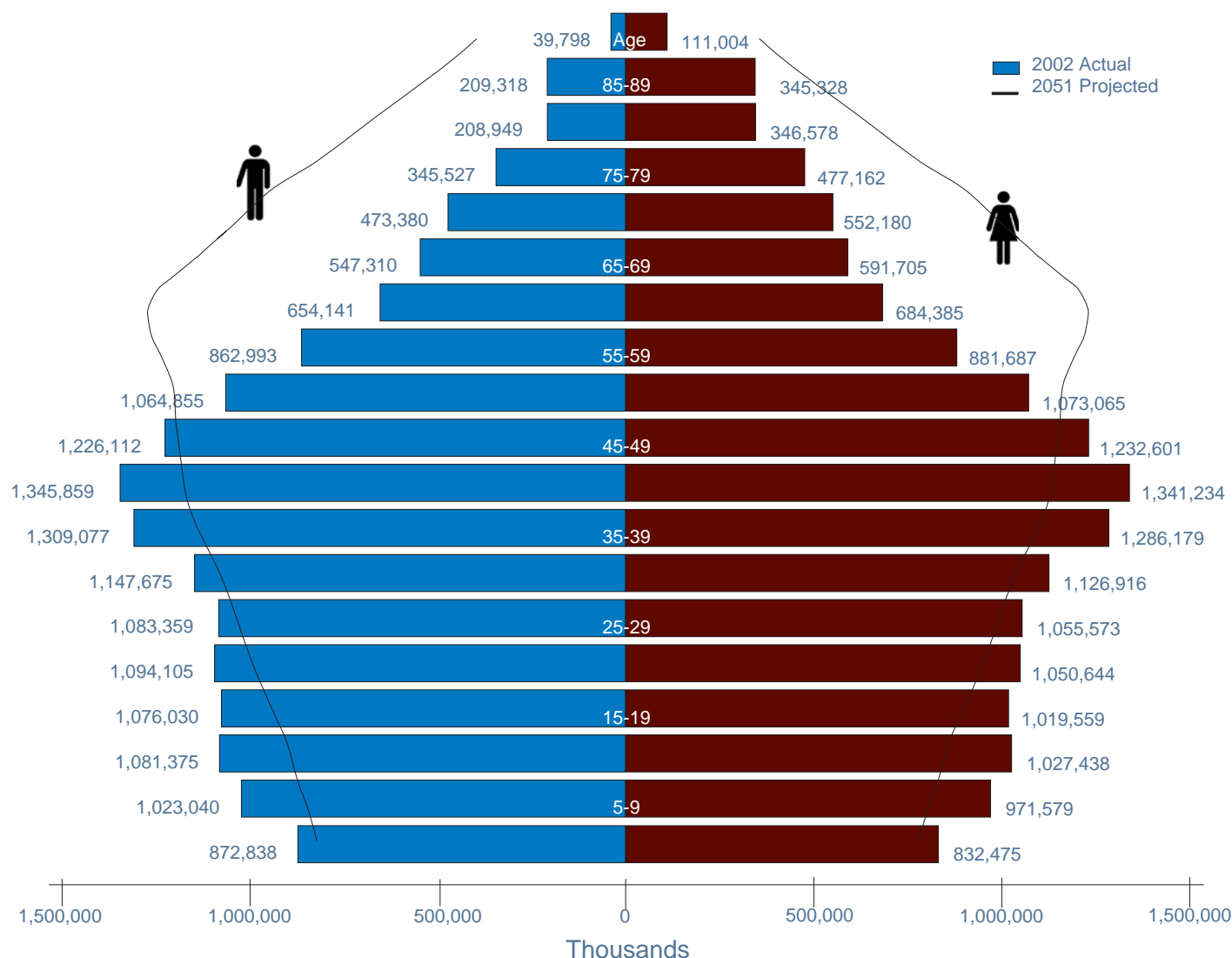
The Distribution of Seniors in Canada

With the exception of British Columbia, Canada's population is older from east to west and from south to north. Atlantic Canada, the northern regions and the rural areas have experienced a net population outmigration, especially among the working age population. The proportion of the population living in urban areas in Canada today is 78 percent versus 22 percent in rural regions. The Northwest Territories and Nunavut still have a high proportion of rural residents.

There is a large concentration of younger working families in Alberta and Ontario,

While the rise of baby boom seniors is yet to come, there has been a significant increase in the number of seniors over the past twenty years because of increased longevity.

Figure 2: Population by Age and Sex, Canada, 2002 Actual and 2051 Projected



Source: Statistics Canada, Demography Division (Ottawa: Statistics Canada). Statistics Canada information is used with the permission of Statistics Canada. Users are forbidden to copy the data and disseminate them, in an original or modified form, for commercial purposes, without permission from Statistics Canada. Information on the availability of the wide range of data from Statistics Canada can be obtained from Statistics Canada's Regional Offices, its World Wide Web site at www.statcan.gc.ca, and its toll-free access number 1-800-263-1136

and a higher-than-average senior population in Saskatchewan and Manitoba. But, the overall proportion of seniors in the total population in Saskatchewan and Manitoba is offset by a high birth rate. A breakdown of the population by age and by province and territory is shown in Table 3.

A Social and Economic Profile of Seniors

As people live longer and the senior years cover a wider time period, distinct

differences in the health and social characteristics of the oldest and youngest seniors become more pronounced.

Social characteristics have been assigned to cohorts of seniors based on the social environment that each experienced as younger adults. As a result, future generations of seniors may have little in common with preceding generations. They will be better educated, have higher incomes and will be more demanding of their rights.

Table 3: Population by Sex and Age Group, by Province and Territory (Number, Both Sexes)

2008				
	All ages	0 to 14	15 to 64	65 and older
Both sexes (thousands)				
Canada	33,311.4	5,597.7	23,150.6	4,563.1
Newfoundland and Labrador	507.9	76.3	358.3	73.3
Prince Edward Island	139.8	23.4	95.3	21.1
Nova Scotia	938.3	142.7	651.1	144.4
New Brunswick	747.3	115.8	517.9	113.6
Quebec	7,750.5	1,232.2	5,385.7	1,132.7
Ontario	12,929.0	2,218.8	8,966.3	1,743.9
Manitoba	1,208.0	229.2	812.3	166.5
Saskatchewan	1,016.0	193.0	671.5	151.6
Alberta	3,585.1	654.5	2,556.4	374.2
British Columbia	4,381.6	686.2	3,059.1	636.4
Yukon	33.1	5.8	24.9	2.5
Northwest Territories	43.3	9.6	31.5	2.1
Nunavut	31.4	10.3	20.2	0.9
Note: Population on July 1. Source: Statistics Canada, CANSIM, table (for fee) 051-0001. Last modified: 2009-01-15.				
Find information related to this table (CANSIM table(s); Definitions, data sources and methods; <i>The Daily</i> ; publications; and related Summary tables).				

Source: Statistics Canada, Demography Division (Ottawa: Statistics Canada). Statistics Canada information is used with the permission of Statistics Canada. Users are forbidden to copy the data and disseminate them, in an original or modified form, for commercial purposes, without permission from Statistics Canada. Information on the availability of the wide range of data from Statistics Canada can be obtained from Statistics Canada's Regional Offices, its World Wide Web site at www.statcan.gc.ca, and its toll-free access number 1-800-263-1136

The upcoming cohorts of seniors will have different expectations of facility-based long term care (Brooks, 2002). In comparison with the World War I cohort (born 1914-1919) and the Depression cohort (born 1930-1939), the baby boom cohort (born 1946-1964) define themselves as social leaders and will likely continue to redefine social practices as they move through the subsequent decades. They will have clear

perceptions about retirement, healthy aging and death. The baby boom generation may not have as much money in retirement as the previous seniors' cohort despite having contributed hugely to Canada's safety net during their entire working lives, but they are more likely to have high expectations of the publicly-funded healthcare system.

Various income sources are available to seniors in their retirement years including pensions, retirement plans, special assistance and investments.

There are three major streams or levels of income available to seniors, which are obtained from public and private sources:

- the first level is the cornerstone of Canada's retirement income system and comprises universal Old Age Security (OAS), the Guaranteed Income Supplement (GIS) and the Allowance/ Allowance for the Survivor. Some provinces also provide universal or income-tested seniors' top-ups.
- the second level includes the earnings-based Canada/Quebec Pension Plans (CPP and QPP), which provide retirement pensions to persons who have contributed to one of these plans during their years of employment. The federal government also provides tax assistance on savings in Registered Pension Plans (RPPs) and Registered Retirement Savings Plans (RRSPs) up to specified limits.
- the third income level for seniors is derived from private retirement pensions, investment income, personal savings, assets and ongoing employment.

The following provides a brief description of the government-funded and tax-assisted plans:

1. First level of income:

- *Old Age Security* pays a maximum of \$516.96 per month to individuals aged 65 years or older. Those who have lived in Canada for 40 years are entitled to a full pension; a partial pension is paid to those who have lived here for at

least 10 years. OAS rates are adjusted quarterly for inflation based on cost-of-living estimates. Individuals need not be retired to receive OAS. Benefits are reduced for those whose annual income is above \$64,718 but no OAS payments are made to individuals with an annual income above \$105,266. A person who cannot meet the requirements for the full OAS pension may qualify for a partial pension which is earned at the rate of 1/40th of the full monthly pension for each full year lived in Canada after his or her 18th birthday.

- *Guaranteed Income Supplement* is a non-taxable, income-tested payment for low income seniors. Recipients must re-apply annually for the GIS by filing an income statement or by completing an income tax return. The amount of monthly payments may increase or decrease according to reported changes in yearly income. For seniors with no income other than OAS, the GIS will provide an additional income of \$652.51 per month for a single senior. The OAS and GIS are significant because fewer than half of Canadian workers are covered by employer pension plans (Human Resources Development Canada [HRDC] web site, 2009).
- The *Allowance* and *Allowance for the Survivor* provides support when the combined yearly income of the couple, or the annual income of the survivor, does not exceed a certain income. The OAS and GIS are not included in their combined yearly income. An applicant must be between the ages of 60 and 64 and must have lived in Canada for at least 10 years after turning 18 years old.
- *Provincial/Territorial Seniors' Top-ups*: A number of provinces and territories

have established income-tested plans to provide income to seniors in addition to the federal pensions and supplements. Some jurisdictions also have social insurance programs to meet specific health and housing needs. But these programs are not targeted specifically to the senior population.

2. The second level of income is derived from government-funded and tax-assisted plans:

- *Canada Pension Plan and Quebec Pension Plan* were established in 1966 to provide a pension to retired workers. Employees must pay into this plan during their working years, and in return they receive a commensurate pension in retirement. The employer and the employee pay matching premiums based on the employee's income; the self-employed are responsible for the payment of the entire premium. On retirement, the amount of CPP paid is dependent on how much and for how long contributions were made prior to retirement, to a maximum of \$884.58 per month. Seniors receiving the maximum will receive the full OAS per month but no GIS. CPP is adjusted for inflation annually, and the pension and benefits are taxable. Retirees may opt to receive CPP at a reduced rate between 60 and 65 years, the full rate at 65 years or an increased rate between 66 and 70 years of age.
- *Tax-assisted retirement plans:* The federal government provides tax assistance on savings in retirement savings plans and RRSPs up to specified limits. Tax owing on the contributions and investment income in these plans is deferred until the savings are withdrawn or received as pension income. The tax-assisted private pension system accounts for an increasingly large

share of retirement income payments to seniors.

Canadian seniors have an average income of more than \$21,000 per year, which is lower than adults in other age groups. Couples over 65 years of age have the highest median net worth in Canada. But the wealth of the elderly is not evenly distributed. In 2006, about 5 percent of those aged 65 or older lived on a low income, compared with a low-income rate of 9 percent a decade earlier. Still, low-income rates among senior women remain more than double those of senior men (3 percent for men and 8 percent for women). Low-income rates for unattached, senior women remain much higher. In 2006, 17 percent of unattached women aged 65 years or older had low incomes, compared to 12 percent of unattached men (Statistics Canada, 2008).

While OAS is the largest source of income for senior women, private employment-related retirement plans and RRSPs contribute the most income to senior men. Though seniors' average incomes are lower, so are their daily living expenses. Most seniors have no dependents, and in households headed by a senior, approximately 68 percent own their own home. Of these homeowners, 90 percent have paid off their mortgages.

Seniors' Contribution to the Economy and the Tax Base

Seniors provide in-kind assistance and financial help to their children and their families. Although seniors do not comprise 18 percent of the population, they do comprise 18 percent of the Canadian volunteer pool, thus donating almost five hours of unpaid time per week to various organizations that would otherwise have to pay for staff. Seniors are strong supports of charity. For example, in 2004, 83 percent of Alberta

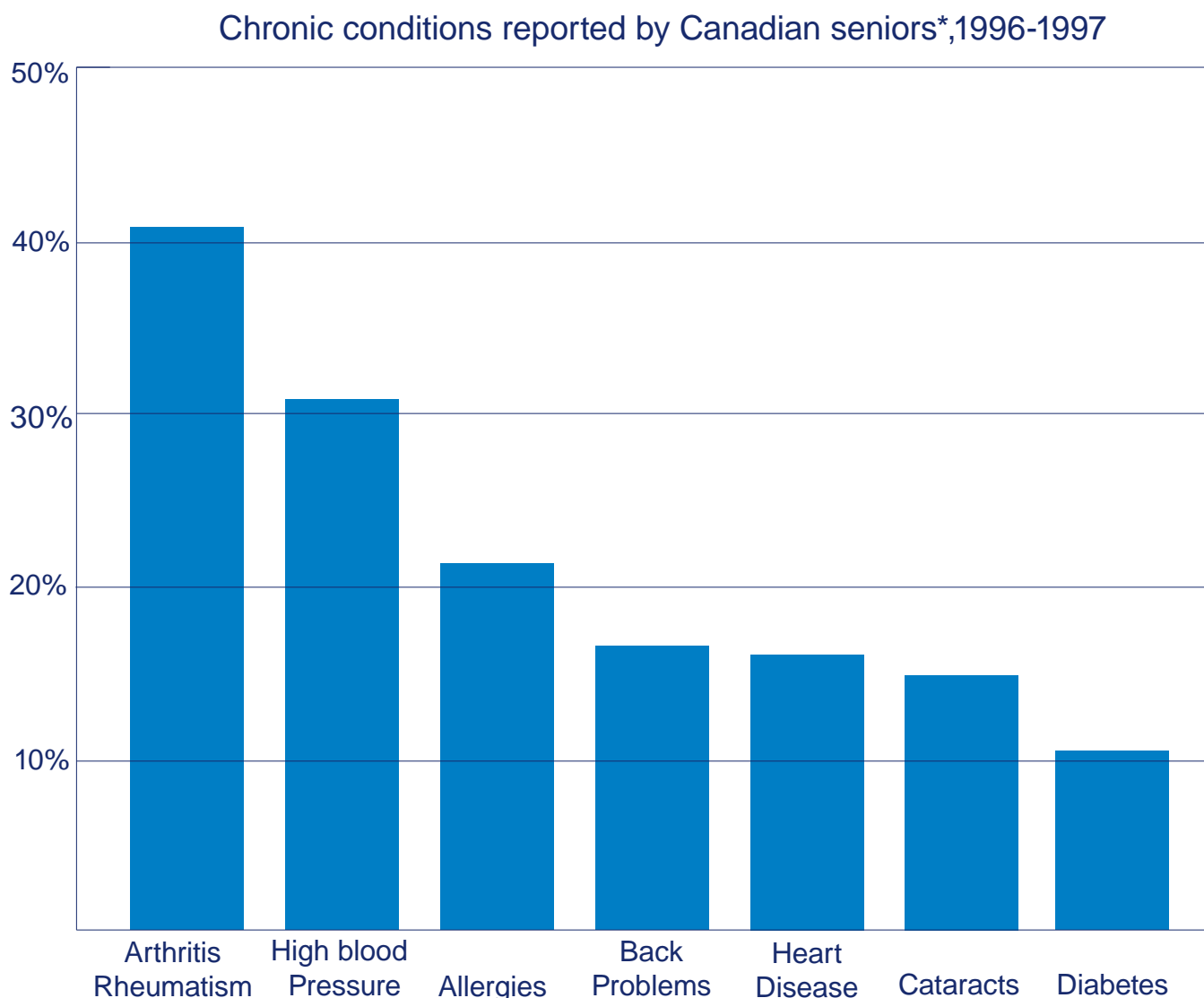
seniors made financial donations to charities (Government of Alberta, 2007).

extra government support to pay for their increased health care delivery.

Registered pension plans are costing the government tax revenues today. But the same schemes will create increased tax revenues for the federal government when the baby boomers retire and turn their pension assets into taxable retirement income (Brown, 2002). This tax revenue will come at the exact time when baby boomers will need

Current Health Expenditures Attributed to Seniors
According to the Health Council of Canada, the “persistent belief that our aging population will overwhelm the health care system is a myth”. A relatively small number of medically frail older Canadians with multiple chronic health problems use a large share of health care services (Health

Figure 3: Chronic Conditions Reported by Seniors Living at Home



*Seniors living in private households only.

Source: Canada's Aging Population, Cat. No. H39-608/2002E, Public Health Agency of Canada (Ottawa: 2002), p. 11, chart 8. Reproduced with the permission of the Minister of Public Works and Government Services Canada, 2009.

Council of Canada, 2009). Furthermore, it is the factor of nearness to death — not old age per se — that increases the use of health services. The largest health care expenditures occur in the year of death regardless of age. In the American Medicare plan, 6 percent of seniors who die in any one year account for approximately 30 percent of the annual expenditures in that plan (CHSRF, 2003). Similar reports from other industrialized countries suggest that one third of health expenditures occur in the last year of life (Pollack, 2001). The medical costs of seniors who die relatively young are higher near the end of life than the costs of people who die at 85 years of age and older.

Seniors' Health Status

The majority of seniors report good health, although they cope with chronic illnesses. Of seniors living at home, 21 percent of those between 65 and 74 years of age have reported a disability, 28 percent of those between 75 and 85 years reported a disability and over 45 percent of those 85 years of age and over reported a disability. The most common chronic health problems of those living at home are summarized in Figure 3 (Health Canada, 2002).

Variations in Life Expectancy

While Canadians have one of the highest life expectancies in the world, a number of countries have a higher life expectancy than Canada (OECD, 2007). The average Canadian born in 2006 can be expected to live an estimated 80.6 years. Six countries have higher life expectancies than Canada—82.4 years in Japan, 81.7 years in Switzerland, 81.5 years in Italy, 81.1 years in Australia, 80.9 years in France, and 80.8 years in Sweden (OECD, 2008).

Life expectancy varies across the country. British Columbia residents are expected to live 81.2 years, while people in

Canada's three northern territories have a life expectancy of 76.3 years of age (Conference Board of Canada, 2008). There are also gaps within regions of a province; for example, life expectancy in the Laval region of Quebec is 79 years versus 76 years of age in the Nunavik region.

Why are Canadians living longer?

According to The Conference Board of Canada (CBoC), economics plays a critical role in life expectancy as people in high-income countries live 21 years longer than people in low-income countries. The same applies within a country, where the wealthy generally have a longer lifespan than the poor. Life expectancy is affected by a number of factors in addition to economic wealth, including access to quality health care, advances in medicine, better lifestyle choices and availability of clean water (CBoC, 2008).

Living Longer in Better Health: A Decline in Disability

There is a trend toward a decrease in the number of years in which a senior will live with a disability. While life expectancy is increasing, the period between the onset of illness and the end of life has decreased, resulting in more years of better health. This is referred to as *disability-free life expectancy* (DFLE) or the *compression of morbidity* (Fries, 1980). At 85 years of age and beyond, the proportion of life spent disability free compared with overall life expectancy narrows. Men 85 years of age and over will spend approximately 1.5 years of their remaining 3.7 years dependence-free. Women 85 years of age and over can expect to spend 2.5 of their remaining years dependence-free; however, 1.5 years will be spent in a health care facility (Martel and Bélanger, 2000).

The prevalence of dementia has a huge impact on facility-based services now and will continue to loom large in the future.

Some of the reasons cited for the decline in disability include: better nutrition, medical care improvements such as joint replacement surgery, improvement in health behaviour, the

increased use of aids which allow people to cope with impairments, improved educational levels, less hazardous

work environments, better pharmaceuticals and the decline in infectious diseases.

Rural and remote communities throughout Canada have not made these disability-free gains. As with life expectancy in general, disability-free life expectancy is highest in Richmond, British Columbia, and lowest in the Nunavik Health Region in Quebec.

The Need for Admission to a Long Term Care Facility

Seniors suffer from a range of disabilities, some of which are more likely to lead to admission to facility-based long-term care than others. Cognitive impairment, incontinence, and the aftermath of stroke increase the odds of living in a long term care home. Although incontinence is not reported as a prevalent chronic condition for seniors at home, it is closely associated with overall functional decline, and is often the critical factor that determines relocation to a long-term care home (Cartier, 2003). Falls resulting in fractures are another cause of admission to facility-based long term care (Ulysse, 1997), as are the after-effects of stroke.

The loss of autonomy caused by severe cognitive impairment often necessitates admission to a long term care home. While dementia is not ranked as one of the seven major chronic illnesses reported by Canadian seniors, this is the predominant disorder within long term care. The prevalence of dementia (the most common cause of cognitive impairment) has a huge impact on

facility-based services now and will continue to loom large in the future.

The *Canadian Study of Health and Aging* has been tracking health care statistics since 1991 and reports that dementia affects eight percent of all Canadians. An estimated 364,000 Canadians currently have Alzheimer's disease or a related dementia, and this number is expected to increase to 750,000 by 2031. This means a two-fold increase in only 30 years, or 386,000 more Canadians requiring care.

The incidence of dementia increases with age. While dementia affects one percent of persons under age 65, it affects 35 percent of persons over 85 years of age. At age 85, the rates increase to 371 cases per 1,000 women and 287 cases per 1,000 men. Because women tend to outlive men, the majority of seniors with dementia are women (85 percent). But, even when age-standardized, women's rates remain higher. On average, women live more years with dementia and, therefore, more women than men are likely to be living in long term care homes. Of the years senior women live with dementia, 1.4 years on average are spent in facility-based long term care, compared with 0.6 years for men. This disproportion is due to the overall increased incidence, and to the fact that women outlive men and are available as caregivers, so that their afflicted spouses can remain at home rather than requiring the support of long term care.

There is no cure for dementia, although drugs may improve functioning and certain life style modifications may slow the progress of the illness. People with dementia eventually require ongoing nursing care, assistance with activities of daily living and provision of a safe living environment on an around-the clock basis.

Long term care homes often employ psychosocial treatments to modify behaviour or to assist the individual to maximize his/her functioning. These strategies include:

- graded assistance: a method that involves providing verbal prompts, physical demonstrations, skill practice and positive reinforcement to help the resident with dementia carry out simple activities of daily living such as eating and dressing;
- reality orientation: a technique where the resident is provided the correct time, place and other information unique to the person's experience to help them reorient themselves; and
- reminiscence therapy: a popular activity that works with residents either individually or among a group of peers to recall events in a person's life (Tierney et al., 2002).

Modifications in long term care living environments can be helpful to residents with dementia. Design features that can minimize confusion and torment include small, home-inspired living spaces with increased lighting, camouflaged exits and access to therapeutic gardens (Tierney et al., 2002).

Today, the most appropriate setting and environment for care of people with later stages of dementia is often a long-term care home. Major progress in the treatment of dementias could significantly influence the size and nature of the facility-based long term care population in the future.

Note:

- ¹ Based on the May 2006 census, Canada's population is 31.6 million people of which 15.5 million are men and 16.1 million are women.

Care Landscape

The Canadian Facility-Based Long Term Care Landscape

Determinants for Admission

Individuals are admitted to long term care homes because of four interrelated factors:

- the complexity of ongoing health service requirements;
- the level and type of service required;
- the amount of support available in the home; and
- the availability and affordability of health service alternatives.

Complexity of Ongoing Health Service Requirements

Broadly speaking, the people who require facility-based long term care encompass:

- adults or seniors who are technology-dependent;
- adults or seniors with complex disability and functional deficits as a result of an injury or progressive neurological degeneration; and
- frail elderly with functional deficits as a result of physical degeneration or cognitive impairment.



These individuals have a wide range of disabilities and are admitted to homes with functional deficits and heavy care requirements related to cognitive impairment, organic brain injury, incontinence, frailty, degenerative neurological deficits, the aftermath of strokes, acquired brain injury and other disorders. Most need assistance with more than one activity of daily living and many require around-the-clock monitoring to ensure their safety. The most common disability present in long term care homes is dementia.

Level and Type of Service Required

Not all individuals in the broad categories previously listed, however, require facility-based long-term care. The environment may best meet an individual's ongoing health service needs when:

- the individual's health treatments are stabilized and the individual no longer requires the intensive medical interventions provided in acute care hospitals or rehabilitation centres;
- home care, community services or supportive/assisted living arrangements for an individual are not deemed to provide the necessary services that facility-based care can provide; and/or
- the individual requires daily around-the-clock support and assistance, which is beyond the means of family members and home care services.

The amount of support available in the home is pivotal in the lives of seniors. Individuals with significant care requirements may be able to remain at home if sufficient formal and/or informal home support is available. Conversely, the lack of a support network might necessitate admission to facility-

based long term care of an individual with less complex service requirements. The implementation of rigid entrance requirements for facility-based care has resulted in a steady decline of lighter care admissions. However, there are still cases where admission is equally predicated on the individual's personal situation as the complexity of care.

In some jurisdictions, individuals are directed to facility-based long term care because it is available, although it may not be the ideal or the most appropriate option. These situations are often influenced by public policy or personal income level. Situations where this may occur include:

- insufficient publicly-funded home care available to augment family caregiving;
- supportive/assisted living arrangements are not available or have not been developed;
- there is an oversupply of long term care spaces;
- an individual has insufficient out-of-pocket money to pay for private home support services such as cleaning, meal deliveries and private personal care; or
- an individual has insufficient out-of-pocket money to pay for private retirement living.

Organizational Variations Across Canada

Number of Beds (Spaces) in Canada

Comparable data about the number of facility-based long term care spaces in Canada are not available from a single

source. For example, Statistics Canada provides roughly comparable data on long term care beds based on equivalency ratings. The survey data do not include Ontario's complex continuing care beds, any Quebec data or data on designated long term care beds in community hospitals or hospital chronic care units.

The Canadian Healthcare Association publishes an annual guide which lists acute care and long term care organizations based on information provided by provincial ministries, regional health authorities and health care organizations. The numbers of long term care homes (but not chronic care hospitals) and total beds are shown in Table 4. Clearly, there are variations in the estimates of long term care homes currently operating in Canada.

The call to build more long term care homes is being sounded in urban and rural Canada alike. On April 7, 2009, two newspaper articles addressing the issue appeared in disparate communities: the Nation's Capital, Ottawa, and Strathmore, Alberta, a rural agricultural community.

- George Lattery, Mayor of Strathmore, expressed concern in the *Calgary Herald* that couples have been separated and are living in facilities in different communities because of the local shortage of long term care beds (Lang, 2009).
- Dr. Jack Kitts, CEO of The Ottawa Hospital told the *Ottawa Citizen* that the shortage of long term care homes in eastern Ontario has created chronic gridlock within the region's hospitals, resulting in overcrowding, cancelled surgeries and some of Ontario's longest emergency-room waits. During nine months ending in December 2008,

more than 70 elective surgeries were cancelled at The Ottawa Hospital due to bed shortages caused by frail elderly patients who languished in acute care for months while waiting for long term care placement (Tam, 2009).

A regional initiative to strengthen home care and housing supports for the elderly, which is part of a \$700 million province-wide plan, "hasn't had the impact that we would have liked to see," said Kitts, "...and giving (hospitals) more money won't solve this problem. We need more long-term care capacity" (Tam, 2009).

Politicians and health care professionals are not the only ones speaking to the need for additional long term care beds. Grass roots movements are forming to champion the expansion of facility-based long-term care in an effort to improve the quality of life for local seniors.

The South Eastern Ontario Long-Term Care Facility Committee, formed by a group of concerned citizens in 2007, is lobbying the Ontario government for an expansion of long term care beds in the counties of Stormont, Dundas, Glengarry, Prescott and Russell (population approximately 96,000). The group was inspired to act by the difficulty that some individuals experienced in finding a long term care home to accept their family members. They convinced the five local councils to provide moral support and contribute financial grants of \$5,000 each. The latter was used as "seed" money to help organize the group into a formal entity and to fund a feasibility study to assess the need for local long term care beds in the area over a 20-year period (2010-2030). In the summer of 2007, a report by G-KAM Consulting advised the Committee that the main argument against

additional long term care beds was a statistical one – according to Provincial guidelines the region had an over-supply of long term care beds.

The formula in Ontario for determining facility-based long term care allocations is based on a benchmark of 99.1 beds per thousand persons over the age of 75, but the formula does not consider the reality that, across Ontario, many long term care homes are at full occupancy with long-waiting lists.

Further weakness in the formula is evident by the fact that the age of eligibility for admission to a long term care home in Ontario is 18, not 75. There are many current long term care residents under the age of 75, and while some of them could have their needs met through a blend of community-based services, such assistance is not always available in rural communities.

The consultant assured the South Eastern Ontario Long-Term Care Facility Committee that they had a strong argument for additional beds in the region. A number of points helped build the case including:

- an uneven distribution of existing beds;
- lengthy waiting lists;
- lack of transportation services within a large geographical region;
- few supportive housing options; and
- a growing population of seniors who wish to live close to their home communities where many have family roots dating back several generations (South-Eastern Ontario Long-Term Care Facility Committee, 2007).

Table 4: Estimated Number of Long Term Care Facilities (Private and Public) in Canada, 2007
Annual CHA Survey

Province or Territory	Total Number of Facilities	Total Number of Beds	Total Response Rate
British Columbia	373	28030	96%
Alberta	205	15750	91%
Saskatchewan	162	9134	91%
Manitoba	152	10736	97%
Ontario	862	96699	95%
Quebec ¹	435	38178	83%
New Brunswick	118	5421	99%
Nova Scotia	144	8151	99%
Newfoundland and Labrador	66	3708	100%
Prince Edward Island	47	1959	100%
Northwest Territories	8	86	100%
Yukon	3	94	100%
Nunavut	2	23	
Total	2577	217969 ²	
Note: 1. It is not entirely clear if all the facilities reporting from Quebec are private, not under agreement facilities (CHSLD privés non conventionnés). 2. Any facilities not opened at the time of the CHA data collection do not appear in these figures.			
Source: Canadian Healthcare Association. (2007). <i>Guide to Canadian Healthcare Facilities, 2007-2008</i> . Vol. 15. Ottawa: CHA Press.			

The Ontario government has yet to approve the additional beds, but the grass roots initiative has not lost its thrust. Committee spokesperson Steven Byvelds expressed in a letter to the *Ottawa Citizen* that “we appreciate that (the aging at home) strategy will help keep seniors and others at home longer but the future needs of an aging population will still need to be addressed with more long term care facilities” (Byvelds, 2009).

Perhaps the most dire need for long term care beds are in the 633 First Nations communities across Canada, where only 30 have a long term care home. This represents less than 900 beds for all First Nations people living in their own communities. Currently, many First Nations residents must leave their family and friends to be placed in a long term care home located outside their community. In the case of northern and remote areas, this usually means that the individual must move to a facility that is located hundreds of miles away, often in an urban setting, where they feel socially isolated and lonely (Assembly of First Nations, 2007).

Ethnic, Religious and Geographical Variations

There are several not-for-profit homes that provide an environment specifically for a designated ethnic or religious group (e.g., Italian-, Ukrainian-, Jewish- Chinese- Canadian and First Nations, Inuit and Métis). They do admit clients of other ethnic origins but the majority of residents belong to a dedicated ethno-cultural group. Language, dietary preferences, special holidays and religion are important considerations in these facilities. These not-for-profit homes have usually been constructed through volunteer initiatives within their cultural community.

In addition to criteria based on ethnicity or religious affiliation, several provinces

and territories have established minimal periods of residency within their jurisdiction. Applicants may have to wait from three months to two years before admission to facility-based long term care is considered.

These residency requirements represent a significant challenge to portability and accessibility and are shown in Table 5.

Residency requirements represent a significant challenge to portability and accessibility.

Table 5: Residency Requirements by Province or Territory

Province or Territory	Residency Requirements
British Columbia	19 years of age; Canadian citizen or landed immigrant; BC resident for 1 year for clients assessed at the intermediate care level; or 3 months for clients assessed at the extended care level.
Alberta	Lived in Canada for 10 years and in Alberta for 12 months or have been a resident for 3 consecutive years during their lifetime; individual may be admitted to a long-term care facility at any time if assessed as requiring permanent long-term care services; but the individual will be responsible for paying the health care costs, plus accommodation charges, until he/she is eligible for AHCIP coverage on the first day of the third month following the date of arrival.
Saskatchewan	No residency requirements; individual has to be assessed as requiring the care. Three month waiting period to receive provincial health card.
Manitoba	If newcomer, eligible after living in the province for 24 consecutive months; or if formerly lived in Manitoba for 30 years and has returned after absence of less than 10 years. Waiting period requirement does not apply to a person who has been a resident of a province or territory of Canada for 5 consecutive years and establishes residency in Manitoba immediately.
Ontario	18 years of age; must be an insured person under the Health Insurance Act with a valid Ontario Health Insurance Plan (OHIP) number. To be eligible for Ontario health coverage an individual must be a Canadian citizen or have immigration status as set out in Ontario's Health Insurance Act; make a permanent and principal home in Ontario, and be physically present in Ontario 153 days in any 12-month period. OHIP coverage normally becomes effective three months after the date of establishing residency in Ontario.
Quebec	Can be admitted, but will not be subsidized for first 3 months until receipt of Quebec health card.
New Brunswick	Individuals who are Canadian citizens are eligible for facility-based long-term care immediately upon entering the province. The individual will be responsible for medical/prescription costs for three months, after which time he/she will be granted provincial coverage.
Nova Scotia	Over 18 years of age and a resident of NS. Exceptions may be considered by the Director, Continuing Care, Department of Health. An individual can apply for a Nova Scotia Medical Service Insurance (MSI) health card on arrival in the province, but eligible services will be paid by the home province for the month of arrival and the following two months.
Prince Edward Island	An application for admission may be made by a resident of PEI who holds Canadian citizenship or is a landed immigrant (a non-Canadian who has established residence in Canada and who holds a visa entitling permanent residence in Canada); is ordinarily present for six months or more in Prince Edward Island; and holds a valid PEI health card. An individual who does not meet the eligibility criteria as outlined above may make application for admission to a nursing home and request consideration for admission on an exceptional status basis by the Director of Long Term Care.
Newfoundland & Labrador	A person moving to Newfoundland and applying for coverage under the "Medical Care Plan" (MCP) is required to confirm that he/she will be living in the province for at least 12 months. If approved, coverage begins the 1 st day of the 3 rd month following the move. Eligible services will be paid by the home province during the three-month interim.
Yukon	One-year residency requirement. Individual must live in Yukon one year prior to applying for continuing care, otherwise he/she will be responsible for the full per diem. The exception being an individual who has lived in the Yukon for ten consecutive years and have not been away from the Yukon for more than ten years.
Northwest Territories	3-month residency requirement.
Nunavut	No specific requirement.
Sources: 1. <i>Technical Report 5: An Overview of Continuing Care Services in Canada, The Identification and Analysis of Incentives and Disincentives and Cost-Effectiveness of Various Funding Approaches for Continuing Care</i> by Hollander et al., May 2000. 2. The Canadian Seniors Policies and Programs Database. http://www.sppd.gc.ca/ (2009). < http://www.sppd.gc.ca > (July 31, 2009) 3. Personal communication.	

Funding, Governance and Ownership

The variations in how facility-based long term care is funded, governed and owned in Canada is based on historical developments and federal and provincial legislation.

Publicly-funded health insurance in Canada (medicare) is a relatively recent development in our growth as a nation. Historically, government involvement in health matters in Canada related to public health, which was modeled after Great Britain's initiatives. Early public health measures in Canada included prevention and control of epidemics (including immunization), and maternal and child health programs. Otherwise, services related to health were predominantly supplied by families, charities, religious groups, and voluntary organizations such as the Victorian Order of Nurses and the Canadian Red Cross. While private health insurance gradually became available in Canada in the early 20th century, it was inaccessible to the poor.

Social programming has been a municipal responsibility dating back to the beginning of the last century. Municipal governments, religious organizations and philanthropic associations were the first to provide institutional care, home care and social services. But, during the depression of the 1930s, many municipal governments went bankrupt as they attempted to provide social services to an increasing number of indigent citizens. As a result, provincial governments became involved and began to provide financial assistance to municipalities. The depression also had an impact on provincial budgets and the provinces were soon forced to look to the federal government, which had the capability to raise money through its taxation powers.



Evolution of Canadian Health System Funding

The murkiness in delivering non-acute health services is a product of legislative history. Canada's medicare system originally defined two broad categories of services.

- *Insured Health Services*, which were hospital services introduced in 1957 and physician services introduced in 1966; and
- *Extended Health Care Services*, what are now usually called continuing care or long-term care in the provinces and territories (facility-based long term care, adult residential care, home care and ambulatory health services).

These two broad categories of health services remain in the *Canada Health Act* of 1984.

A number of factors influenced the development of publicly-funded health insurance in Canada. The concept of the welfare state took root during and immediately after the "Great Depression". It was believed that by helping individuals in need, government would contribute to the common good of society. This new spirit of social conscience culminated in Great Britain with the post-war creation of the National Health Service (NHS). This concept of publicly-funded health services gained momentum in Canada, most notably in Saskatchewan which pioneered hospital insurance and ultimately paved the way to a national hospital insurance plan.

The introduction of two federal statutes (the *Hospital and Diagnostic Services Act* in 1957 and the *Medical Care Act* in 1966) provided Canadians with publicly-funded universal hospital and medical insurance coverage.

The *Hospital and Diagnostic Services Act* of 1957 established a detailed set of standards and required that service be delivered on equal terms and conditions. The costs were split 50:50 between federal and provincial governments but only programs provided in the hospital setting were eligible for cost-sharing. The result was the establishment of a thriving hospital-based system with no incentive for provinces to create less-expensive healthcare alternatives.

The *Medical Care Act*, introduced in 1966, affirmed the federal responsibility to provide fifty percent cash funding of provincial medical care services rendered by physicians. The two Acts together helped form the bedrock of the Canadian health care system and placed an open-ended obligation on the federal government, as they had no control over provincial expenditures, and the provinces had little motivation to contain costs.

The original 50:50 cost-sharing arrangement ended in 1977 with the passing of the federal *Established Programs Financing Act* (EPF). The previous 50:50 deal was replaced with block funding for health services from the federal government, and a transfer of tax points to the provinces and territories. Under EPF, separate, but virtually unconditional per capita funding for certain types of long term residential care services, home care and adult day care services were provided. It should be noted that this per capita funding was low.

Though transfer amounts were no longer strictly tied to provincial spending on hospital and physician services, and limits were set on federal spending, provinces and territories were now afforded the flexibility to invest in other areas of health care that had long been neglected. As a result, the amount of money invested in facility-based long term

care and home care gradually increased, resulting in the building of long term care homes and the development of provincial home care programs.

Each jurisdiction selected different health priorities, resulting in an array of homegrown services which were diverse in scope and unique to each province. There were no conditions or principles attached to these programs, so the services were labeled differently, designed differently and met different healthcare needs. Although territorial funding for health care is calculated somewhat differently through a territorial formula, the outcome is ultimately the same. Each territory has developed and is continuing to develop facility-based long term care in its own unique way to satisfy local realities.

Canada does not have one system of health insurance, but rather 13 interlocking provincial and territorial health insurance plans, all of which share certain common features and basic standards of coverage. These plans adhere to five unifying principles (public administration, comprehensiveness, universality, portability and accessibility) and two conditions (no user fees and no extra-billing) that were affirmed in the *Canada Health Act*.

The *Canada Health Act* (*The Act*) amalgamated the provisions of the *Hospital Insurance and Diagnostic Services Act* and the *Medical Care Act*. *The Act* also included the extended health care services provisions, which had previously been included under the *EPF*. However in 1995, the federal government replaced *EPF* and *Canada Assistance Program* (*CAP*) with *Canada Health and Social Transfer* (*CHST*) block fund. Section 6 of *The Act* (amount payable for extended health care services) was deleted in 1995 to reflect the new fiscal

arrangements adopted by the government (i.e. *CHST*) that required one payment to provinces and territories rather than multiple payments. This change did not reduce the scope of insured health services (hospital and medical) under *The Act*. Extended health care services, while in the legislation, were not included within the medicare basket of insured services.

The *CHST* was referred to as an unconditional transfer. The *CHST* goes into the consolidated revenue funds of each province and can be spent on acute care services, social services, post-secondary education and extended health services as each province sees fit. It can be spent on roads and other provincial priorities, as long as people receive insured hospital and physician services in compliance with the *Canada Health Act*. In 2004 the *CHST* was split into the Canadian Health Transfer (*CHT*) and the *Canada Social Transfer* (*CST*). Both the *CHT* and *CST* go directly into the consolidation revenue funds of each province as the *CHST* did, dating back to the mid-1990s.

Evolution of Facility-Based Long Term Care

Long term care in Canada has developed over time on a patchwork basis. Even after publicly-funded health insurance was firmly established in Canada, the family and local community groups and municipalities were still seen as having significant responsibility for long term care. The involvement of charitable groups and religious orders in providing long term care dates back to colonial times, while municipalities became active in the early part of the last century. There is a scarcity of research related to the elderly, who constitute the majority of facility-based long term care users.

The subsequent dearth of demographic information and poor understanding of aging has hampered planning and funding of long term care in Canada.

What has evolved across Canada is a kaleidoscope of extended health care services, the result of emphasis on insured services, and the lack of attention accorded

What has evolved across Canada is a kaleidoscope of extended health care services.

to extended health care services. The views in the kaleidoscope change from one province and

territory to the next as different aspects of extended health services delivery are considered. These evolutionary processes have resulted in the development of different operational definitions, numerous classification systems and an assortment of legislative standards. The most remarkable differences are evident in facility-based long term care.

As provincial governments became more involved in the delivery of health services, responsibility for long term care facilities fell to various provincial departments: social services, housing or health. Each jurisdiction developed its own funding formula for beds/spaces and its own methods of collecting data to quantify the amount of provincial funding a home should receive. Each province also sets the rates for user charges or co-payments.

In most of Canada (except Alberta), the responsibility for facility-based long term care has been devolved to regional health authorities. On one hand, this arrangement enhances the adaptation of services to regional realities and facilitates coordination of services across the health service continuum. On the other hand, facility-based long term care may not be evenly distributed within a region or province, and portability of services across health region boundaries may be restricted.

The federal government maintains a presence in the delivery of long term care through Veterans Affairs Canada (VA), which provides long term care to the majority of qualifying veterans through purchase-of-service agreements with the provinces. These agreements have replaced the federal government's former ownership of all but one veterans' facilities (St. Anne's Hospital, Sainte-Anne-de-Bellevue, Quebec). VA has the authority to fund 10,000 long term care beds across Canada, but fewer are being used because of better home care options and the diminishing clientele. The *Winnipeg Free Press* reported on March 20, 2009, that the average age of Second World War veterans is 86 years, and their numbers are decreasing by approximately 500 per week. Surviving spouses of war veterans form the majority of clients accessing VA benefits.

Regardless of the contribution and involvement of each level of government, ultimately the money for long term care comes from Canadians who contribute to facility-based long term care through their taxes at the federal, provincial and municipal levels. Yet, because of various funding and jurisdictional arrangements, when these same taxpayers require residency in a long term care home, they may pay again for health services, because some of the elements of the care that they require are not publicly-funded.

The Public/Private Mix in Ownership and Delivery

When examining the public/private mix within facility-based long term care, there are three things to consider: ownership of facilities, financing of services and the administration and management of the system.

The kaleidoscope of ownership of long term care homes and the delivery of services falls into three broad categories:

- Public not-for-profit government-owned and/or operated: may include provincial/ territorial government ownership, regional health authority or municipal ownership;
- Private not-for-profit religious, ethnic, lay/charitable organization ownership; and
- Private for-profit (proprietary) ownership: may include multinational chains and smaller family operations of more than four beds operating as a private for-profit business. A recent trend is that these smaller homes are being purchased by large multinational or local chains and private equity firms. Consolidation of ownership is likely to gain momentum in the future.

Ownership patterns vary widely across the country. For instance, in Nova Scotia there were 76 licensed long term care homes in 2007. For-profit operators owned 20 while the remaining 56 were owned by non-profit organizations and municipalities (Auditor General Nova Scotia, 2007). There was a 50/50 split between public and private homes in Prince Edward Island, until the fall of 2007 when one private home closed its doors. Of the 17 long term care homes currently in PEI, nine are classified as public and eight are classified as private (Ascent, 2009).

All homes in Ontario are now referred to under the umbrella term, *long term care facilities*, and residents pay the same basic co-payment or user fee. However, all homes do not have access to identical revenue streams. Not-for-profit homes operated by municipalities have a unique revenue source

– the municipal taxpayer. Municipalities in Ontario are required to operate a public home for the aged, but it is not mandatory for any municipality to subsidize its ongoing operation. Yet most do. Compared to for-profit and charitable homes, municipal homes for the aged generally pay higher wages, provide superior benefit plans to their employees and have greater collective agreement obligations. Consequently, the financial contributions of municipal taxpayers are substantial. Some municipal homes would be in crisis without the extra revenue stream.

Quebec has both publicly-owned and privately-owned long term care homes. Some have agreements with the provincial government and others do not. The government sets a similar schedule of charges or user fees for publicly-owned and private facilities with agreements. But those private facilities without provincial agreements set their own admission criteria and rate of charges, which the resident will pay 100 percent out of pocket. The complexity of care required in the private facilities without agreements may be just as high as that in the public facilities, except that they are entirely private-pay.

Few comparative studies of the long-term care proprietary and not-for-profit sector have been done in Canada. Michael Rachlis, policy analyst, examined international studies which compared the performance of for-profit and not-for-profit facility-based long term care and home care. The impact of for-profit health care delivery was assessed with respect to costs, quality of care and societal benefits such as volunteer involvement and community development. Rachlis' conclusion about private ownership included the following observations:

- health care costs to government for continuing care were reduced initially but overall costs were likely to increase;

- the quality of care as measured by patients outcomes worsened; and
- staff turnover increased. He also predicted that volunteer involvement likely decreased in for-profit facilities (Canadian Centre for Policy Alternatives, 2000).

Representatives of private operators suggest that there are economies of scale in bulk purchasing and coordinated administration. They identify an additional source of funds for private operators as the higher accommodation fees charged for room upgrades, that is, private rooms with more expansive and elaborate individual spaces. Private operators are well established in some provinces and provide a significant proportion of facility-based care. More data is needed to determine whether there are differences in quality of services, health outcomes, cost to governments and to individuals in public and private long term care homes in Canada.

The Cost of Facilities

It is difficult to pinpoint the actual costs of facility-based care, because there are differences in the regional costs of living and variations in how costs and overhead are calculated. Estimates encompass different cost factors and may or may not include all services. The inclusion of laundry charges, building maintenance, drug charges and incontinence supplies can change the estimates of facility costs. Estimates for facility expenses are lower if revenue from residents' out-of-pocket payments and income from fundraising is considered. Acuity levels and level of care requirements may be considered in calculating costs. There may also be differences in each province and territory in resident classification, staff

complements and the complexity of care deemed appropriate within facility-based long term care.

The annual cost of operating a long term care bed in Saskatchewan based on the province's 2007-08 *Annual Report* (audited numbers), and on 2007-08 utilization numbers, is estimated to be \$65,587, or approximately \$179.57 per day. It is generally held that the average cost in Ontario is \$130 per day, while in 2002 the St. John's Nursing Home Board stated that average resident care costs in its six not-for-profit nursing homes was \$5,000 per month or \$167 per day before revenue from other sources was considered. The province estimated the provincial government's contribution to be \$4,000 per month or \$133 per day. Government authorities in Newfoundland and Labrador noted that the ratio of professional nursing staff to unregulated workers is high compared to staff ratios in other provinces. It is not clear if these are real differences or if the wide variations in costs reflect differences in what is factored into the calculations.

Government Spending on Facility-Based Long Term Care

The Canadian Institute for Health Information reported in 2008 that private and public health expenditures in the category "Other Institutions" was 10.3 percent of total Canadian health expenditures, or \$15.5 billion dollars. Other institutions are identified by CIHI as including nursing homes and residential care facilities, which encompasses a broader category of lower-level institutional services than what CHA considers to be facility-based long term care. Total health expenditures for all categories of health services in 2006 are shown in Figure 4.

Besides the vagueness of the definition, “other institution”, it is not known if figures include expenditures that individuals make to unsubsidized private-pay residences that provide accommodation and varying amounts of health and personal services, but which are not categorized as health facilities. It would be helpful if CIHI could report data on long term care homes separately and not aggregate expenditures with other facilities.

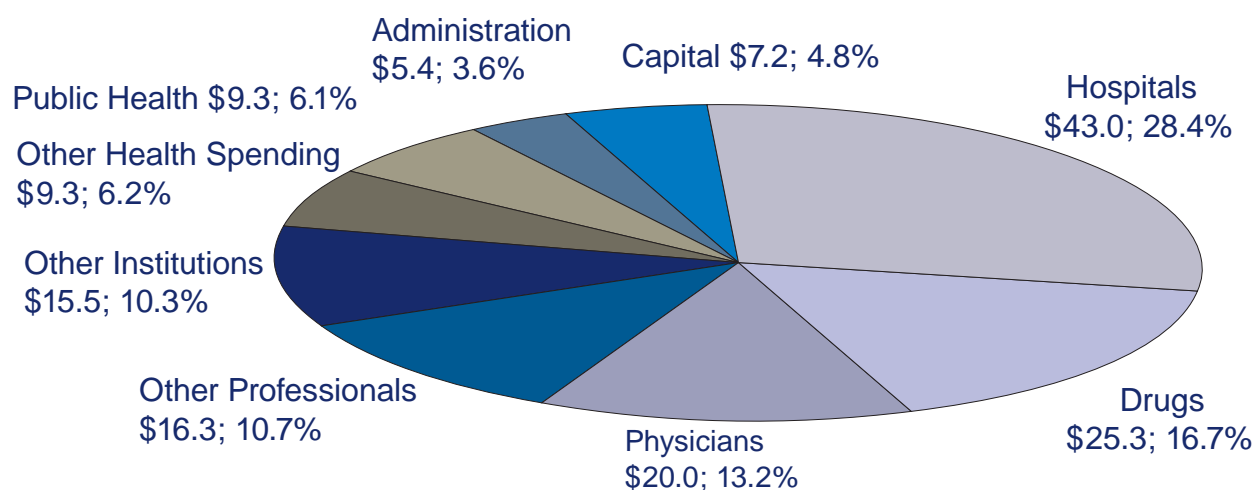
Funding the Facility-Based Long Term Care System

The funding of facility-based long term care is a major issue in every province. Front-page news stories have appeared across the country about government attempts to solve the cost pressures on facility-based care. One of the main solutions has been for governments to set higher charges, co-payments and accommodation fees. However, rising costs are not simply due to increases in expenditures related to room and board. Seniors stay in their homes longer with support programs, and when they enter the long term care system they do

so as high-acuity residents who require more complex care and additional staff time. The cost pressures are related to the increased proportion of these residents. Greater personal care and more professional services are needed in long term care homes, and relevant recreational services should be in place to provide good quality of life for residents. As a result, homes need enhanced staffing but as budgets become tighter, staffing cuts are made or support services are contracted out to the lowest bidder.

All provinces and territories determine the charges and set guidelines on how much residents will pay out-of-pocket for long term care. Unlike acute hospital care, which is one hundred percent publicly-funded service, long term care residents are subject to charges (called facility charges, user fees, accommodation fees or co-payments). Residents depend on various sources to cover these charges: income from OAS and GIS, CPP and other pensions, income from assets, third-party insurance (health insurance policy benefits) and social assistance.

Figure 4: Total Health Expenditure by Use of Funds in Canada, 2006 (\$' Billions)



Source: Reprinted with permission from the Canadian Institute for Health Information (CIHI), *National Health Expenditure Trends, 1975–2008* (Ottawa, Ont: CIHI, 2008), p. 15, figure 10.

The 2008 report of the Auditor General in British Columbia was critical of the provincial government's level of funding for care provided to some of that province's most vulnerable citizens: "The Ministry of Health Services is not adequately fulfilling its stewardship role in helping to ensure that the home and community care system has the capacity to meet the needs of the population" (CBC, 2008).

In early 2009, the British Columbia Care Providers Association (BCCPA) expressed that the quality of senior's care varies dramatically depending on where one resides. Despite the fact that all long term care homes in B.C. are required to provide the same standard of care, the Association estimated that funding ranges from \$110-\$240/resident/day. In its recently published *Health and Safety Guidelines*, the BCCPA reminded all 125 member organizations of their legal and ethical responsibilities and cited BC's *Adult Care Regulations* that require a home to provide accommodation only to those persons for whom safe and adequate care can be provided. But due to the lack of provincial funding for staff, BCCPA members felt compelled to make a choice between providing substandard care and refusing new admissions in order to protect employees and current residents (BCCPA, 2009).

To reflect their caution that licensed long term care operators must meet their legislative and regulatory obligations, the BCCPA developed a *Resident Care Safety Grid* to provide long term care managers with a pre-admission tool to ensure that safe care can be delivered to a prospective resident. The assessment tool is based on established workload management models. In addition to helping homes ensure that adequate staff is in place to achieve acceptable standards of care, the guidelines allow care providers to evaluate the increased workload of new referrals and determine whether or not they

are able to accept complex cases. BCCPA President Christine Nidd explained the necessity of the guidelines:

Adopting residential care health and safety guidelines in our facilities across BC will allow more informed decision-making and make client assessment easier. The fact is many of our members are being forced to refuse some new admissions now. These guidelines will be another tool they can use to help them make these difficult admission decisions that put the safety of patients and staff first (BCCPA, 2009).

Lack of funding has a direct link to resident and staff safety

Causes of safety problems can generally be distinguished as either individual actions or latent conditions. The first involves front-line actions that have a direct negative impact on safety, for example momentary oversight, distraction, lack of knowledge or fatigue. However, it is now recognized that behind these individual factors exists latent conditions that actually render the work environment unsafe. The factors include lack of staff, insufficient training, heavy workloads, inadequate equipment and supplies and/or complicated or poorly presented instructions. It is believed that the vast majority of safety errors are due to latent failures at the system level rather than incompetence or individual responsibility (Blais, 2008).

The guidelines developed by the BCCPA have been welcomed in the field. The BC experience should be reviewed and the guidelines updated and widely disseminated across Canada as a leading practice.

Long Term Care Insurance

The purchase of private long term care insurance is an option being promoted by

the insurance industry in Canada. Following the model pioneered during the 1980s in the United States, insurers typically employ advertising strategies that emphasize the potential risks of not being covered by one of their policies. Some have accentuated the dire consequences of paying out-of-pocket for the ongoing expenses of facility-based long term care, such as liquidating family assets, surrendering a comfortable lifestyle and losing control over making personal decisions. But private long term care insurance has not gained popularity in Canada. The premiums are high and the language is complex; even subtle differences in wording can mean substantial variance in the services covered. Incentives to purchase this type of insurance are not as apparent to purchasers as they are for life insurance given that the likelihood of death is much higher than the probability of placement in long term care.

Long term care insurance premiums become more expensive as people develop co-morbidities and move into higher risk categories. Age can also dramatically affect the cost of a policy. Information from the United States suggests that only about 10 to 20 percent of elderly Americans can afford long term care insurance. The premiums for two adequate policies, bought at 65 years of age, would cost 13 percent of the median annual income of an elderly, married American couple. Private insurance is also problematic because the people who need it the most may be rejected because of coverage and benefit restrictions (Hollander et al., 2000a).

Private long term care insurance in Canada has emerged as a niche market for prosperous young seniors. A typical policy would cost a couple \$3,376 a year at age 50, or \$7,551 from age 65, for a benefit that would pay the equivalent of \$1,500 a month for care in the home or \$3,000

for care in a facility, up to a maximum of \$300,000 per person. The benefit amounts would be adjusted by 2 percent a year to address inflation but premiums would be payable to age 100, and could be adjusted upward at the discretion of the insurance company. One research firm estimated that only 60,000 private long term care insurance policies had been sold to Canadians by the end of 2007 (Daw, 2007).

The lack of uptake may be due to:

- high premiums;
- the prevailing sentiment that long term care is a largely a public responsibility in Canada. Such cultural attitudes become fixed as people age; and
- the younger population often doesn't have a long term horizon.

The Council on Aging of Ottawa offered the following advice to individuals contemplating the purchase of long term care insurance:

Individuals most likely should *not* buy long term care insurance if

- they can't afford the premiums;
- they have limited assets;
- their only source of income is Old Age Security and Guaranteed Income Supplement benefits; and
- they often have trouble paying for utilities, food, medicine or other important needs.

Individuals should, however *consider* buying long term care insurance if:

- they have significant assets and income;

- they want to protect some of their assets and income;
- they want to personally pay for any care they may need; and
- they want to stay independent of the support of others.

Other issues that should be considered:

- current health and family history as indicators of future concerns;
- supports (spouse and children etc.) present and future; and
- trade-offs when considering the limits placed on disposable income by hefty premiums (Council on Aging of Ottawa, 2008).

An attorney specializing in elder law underscored the importance of clarity in what an insurance policy is actually going to cover. She described a recent U.S. Court of Appeals case (*Milburn v. Life Investors Insurance Co. of America*, 511 F.3d 1285 C.A.10 (Okla.), 2008) in which the insurance policy in question did not cover care in an assisted living facility, only in a long term care home. This case reflects the fact that many individuals are confused by both the language of insurance and the nomenclature of care facilities. Long term care insurance policies often distinguish between long term care homes, retirement homes and assisted living centres. One policy might specifically exclude a retirement home from its coverage while another might include it, depending upon how care is provided. The irony surrounding long term care insurance in Canada is that the type of client who can afford the premiums is the type of person most likely to opt for care at a villa in Tuscany (Goddard, 2008).

In view of the lack of interest in private long term care insurance, it has been suggested that Canada might consider the adoption of a social insurance model for long term care insurance similar to the *Canada Pension Plan*. Some of the features of this model could include the following:

- be sponsored by government and nationally or provincially administered;
- be defined by statute in terms of benefits, eligibility requirements and other aspects;
- be funded by taxes or premiums paid by or on behalf of participants
- be earnings related;
- serve a defined population (with specifically defined eligibility criteria) for receipt of benefits; and
- have compulsory participation.

As a social insurance program, long term care insurance would pool the risks, and in this way, resemble private insurance. Unlike private insurance, a government plan, though having eligibility requirements to receive benefits, would not deny benefits on the basis of pre-existing medical conditions. In a publicly-administered long term care plan, there would be an equitable distribution of premium costs. Care would not be provided on the basis of ability to pay but rather on the basis of need. Unlike private insurance which is voluntary, this form of long term care insurance would be mandatory. Like *CPP*, all employed (and self-employed) individuals over 18 years of age would contribute a defined portion of their income to a national/provincial plan.

How Much Do Facility Residents Currently Pay?

User fees are permitted because facility-based long term care is not an insured service under the *Canada Health Act*. A co-payment has traditionally been deemed acceptable since the environment is considered both the resident's home, as well as the location for the delivery of care.

In our society it is generally accepted that people should be proactive and save to pay for some dependency needs as they age. But how much of a burden should an individual bear? Once admitted to a long term care home, the individual is in need of health care, not just hotel services.

Provincial and territorial policy decisions vary in determining what individuals are capable of paying. Rates may involve income and/or asset testing. As the majority of residents in long term care homes are seniors, monthly or per diem charges set by provinces and territories are linked to the minimum income of the most indigent of Canadian seniors. This minimum income is usually the combined total of the Old Age Security and Guaranteed Income Supplement.

In general, charges increase as one travels south and east across Canada:

- Yukon residents pay between \$540 and \$630 per month for facility-based long term care, regardless of their income;
- charges in the Northwest Territories are \$712 per month;
- residents of Nunavut have their costs covered entirely by the territorial government;
- the maximum fee for accommodation in a standard room in Alberta is \$1,335 per month;
- in British Columbia, Saskatchewan and Manitoba, an income-based sliding fee schedule is set with the minimum charge tied to the OAS/GIS payment, and a maximum ceiling for those with higher income;
- the charge for standard accommodation in Ontario is \$1,558 per month, but this rate is reduced for those with less monthly income than the monthly charge;
- standard accommodation in Quebec is considered to be a room with three or more beds and the maximum monthly rate of \$1,013 can be reduced following an assessment of the resident's income and assets; and
- each of the Atlantic Provinces conducts an income test with maximum monthly rates ranging from a low of \$1,950 in Prince Edward Island to a high of \$2,800 in Newfoundland and Labrador.

Accommodation charges or user fees are deemed acceptable in Canada because the home is the resident's permanent residence. But the charges currently in place extend beyond housing or room and board.

Accommodation charges are not the only cost to residents. Some provinces pay for prescription drugs in long term care homes while other provinces have an income-tested drug plan. In provinces where drugs are not wholly covered, drug expenses can add considerably to the resident's out-of-pocket expenses for facility-based long term care.

Payments for equipment and supplies constitute another hidden cost for residents. There is wide divergence of coverage

among the provinces in the provision of supplies such as incontinence products, therapeutic devices such as specialized wheelchairs, prosthetics, therapeutic mattresses, and services such as the laundering of personal clothing.

A minimum comfort or personal allowance is set by each jurisdiction to provide residents with pocket money for personal incidentals. These allowances range from \$103 per month in Prince Edward Island to \$265 per month in Alberta. Little will be left over for simple pleasures if residents have to pay for a therapeutic seating device or the washing and drying of clothing. This undermines the resident's dignity and treats them like small children with monthly allowances rather than adults who have contributed to society.

What is the true cost of long term care for residents and their family? Accommodation charges or user fees are deemed acceptable in Canada because the home is the resident's permanent residence. But the charges currently in place extend beyond housing or room and board. Residents are also paying for needed health services such as drugs and equipment.

Societal Attitudes and Government Positions on Facility-Based Long Term Care

Various consumer polls indicate that Canadians are concerned that affordability, availability and access to facility-based long term care may be in jeopardy. Although some individuals may not wish to be admitted to a long term care home, there is comfort in knowing that the service is available if it is needed.

An Ipsos-Reid poll conducted on behalf of the Canadian Medical Association (CMA) in June 2007 measured what services were most important to Canadians, their level of worry over being able to afford services in

the future, and which services should be a priority for governments.

The poll found:

- 55 percent were confident they would be able to cover long term care expenses but 43 percent were not;
- Most (37 percent) thought long term care should be the top priority if medicare were to be expanded, followed by home care (26 percent), prescription drugs (18 percent), dental care (11 percent), and vision care (2 percent) (CMA, 2007).

Bias by Disease and Ability to Pay

Numerous reports, studies and commissions have commented on the nature of the publicly-funded health care system in Canada, which favours acute care over continuing care. The current health system was designed on the 1950s premise that sick people belonged in hospital (Deber, 2000). As a result, Canada has a health system in which acute episodes of illness are treated through hospital and physician services that are fully insured. Beyond that, there are no guarantees.

Canadians with chronic illnesses and disabilities such as dementia often require little hospitalization but may eventually need facility-based long term care. However, they are experiencing personal financial burdens due to the nature of their illnesses. Individuals with heart disease and cancer have access to fully-insured services for both diagnosis and treatment. But Canadians with dementias or debilitating diseases such as Parkinson's disease are treated differently. Bias by disease type has evolved in public policy development.

Another unfair practice relates to ability to pay. Low-income Canadians who need long term care will be required to pay most of their OAS and GIS income for accommodation fees, leaving little funds left for personal comforts. There is also bias in the system of charges or co-payments that penalize middle-income Canadians who have saved money throughout their lives. Thus, sliding scale co-payment systems and high fees also impact those middle-income Canadians.

Canada's health system is based on the principle of access to health services based on health need rather than on ability to pay. While there's room for a means-tested accommodation co-payment, it is clear that charges well above any reasonable room and board mean that people are paying for their health services in addition to their accommodation charges.

Table 6: British Columbia Long Term Care Accommodation Rates Effective January 1, 2009

Residential care clients pay a daily fee depending on their after-tax income. Rates are adjusted annually based on the consumer price index.		
Remaining Annual Income	Rate Code	Rate
\$0.00 - \$7,000.00	A	\$30.90
\$7,000.01 - \$9,000.00	B	\$33.50
\$9,000.01 - \$11,000.00	F	\$37.20
\$11,000.01 - \$13,000.00	G	\$40.40
\$13,000.01 - \$15,000.00	E	\$44.90
\$15,000.01 - \$18,000.00	C	\$49.70
\$18,000.01 - \$21,000.00	P	\$54.30
\$21,000.01 - \$24,000.00	Q	\$59.10
\$24,000.01 - \$27,000.00	R	\$63.90
\$27,000.01 - \$30,000.00	S	\$69.00
\$30,000.01 or more	T	\$74.30
Couples in receipt of GIS at married rate & sharing a room	M	\$24.20
Source: British Columbia Ministry of Health Services (http://www.health.gov.bc.ca/hcc/fees.html#residentialfees)		

Trends and Issues

Trends and Issues in Facility-Based Long Term Care

Quality

There is a belief among Canadians that placement in a long term care facility should be avoided at all costs. The mainstream sentiment is that no one would ever want to be admitted to a long term care home due the supposed loss of dignity, lack of privacy, limited autonomy and the ongoing regimentation which are sometimes associated with life in such settings. Thus, admission to facility-based long term care is often associated with failure to cope by both the resident and family. Robert and Rosalie Kane (2001) cited research in the United States that revealed in “. . . a large sample of seriously ill persons over seventy, 29 percent indicated that they would rather die than enter a nursing home” (Kane and Kane, 2001, p.114).

Public discomfort and lack of interest in long term care does not mean that services are of poor quality. Facility-based long term care has been subjected to public misconceptions that accord little recognition to the quality care and services available in many homes across Canada.

Both accreditation and anecdotal reports of satisfied residents and families add to the evidence of quality long term care services across the country. But other information sources – both published and anecdotal – indicate that quality in long term care remains a concern.

Broad areas of concern include:

- the system-level issue of institutional drift when residential enterprises offer health care for which they are not licensed;



- the need for more outcome-oriented standards;
- an appropriate range of quality indicators that consider both quality of care and quality of life;
- inadequate operating budgets that result in benign neglect, physical injury, insufficient social programming, questionable food services and inadequate human resources; and
- lack of educational opportunities for staff. This is especially relevant as appropriately educated and trained human resources help form the foundation on which quality is established and maintained.

Provincial/Territorial Licensure

Each province and territory has licensing requirements and detailed regulations relating to facility standards, which must be maintained in order to retain an operating license. Licensure is a means of establishing minimal standards of performance to guarantee safety and the appropriate use of resources, including the number of beds in a home. Licensure is mandatory and is subject to reporting and/or reviews (MacRae et al., 2003). The rigor with which standards are monitored varies among jurisdictions.

An emerging issue is the growth of retirement homes and some assisted living centres that are not intended to provide health services, are not licensed, or may be subject to less rigorous standards. This institutional drift occurs, however, and components of health services gradually appear in some of these unlicensed establishments. In a crisis, individuals desperately seeking care will sometimes accept whatever is available to them regardless of what the organization is equipped to provide.

Another issue concerns whether licensed homes are being adequately and/or appropriately monitored for compliance with established standards for licensure. For example, Manitoba passed *The Protection for Persons in Care Act* to help protect adults from abuse while receiving care in personal care homes, hospitals or any other designated health facilities and established an office to deal with residents' complaints. Alberta passed *Protection of Persons in Care* legislation and set up a health facilities review committee. Other provinces are following suit.

Ontario long term care homes are expected to meet over 400 standards relating to everything from the documentation of food temperatures to providing a clean, safe and respectful environment. Each home is inspected annually to determine the degree to which they meet these standards. Many long term care professionals in the field have been critical of the invasiveness of compliance inspectors in the lives of their homes and the focused attention on trivia that has resulted in homes being cited for infractions that have little or no effect on resident care. Some long term care professionals have been especially concerned that the compliance process is adversarial rather than consultative.

In 2008, Donna Rubin, CEO of the Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS), which represents many of the province's not-for-profit homes, expressed her members' concerns to *The Canadian Press* (CP). She noted that "when you are living in a quasi-police state, you're just focusing on keeping your nose clean and documenting rather than doing what's important. We've got a culture that is... focused on fear and making sure you check boxes" (Puxley, 2008).

Inspections should focus on both resident care and quality of life. All reports should be transparent and posted within the home. While homes must be held to account for their actions, so too should the overseers. Therefore, inspection practices and results should be rigorously reviewed to ensure a high level of consistency, reasonableness, and fairness among inspectors.

The importance of relevant review and the need for risk management activities has been sounded for several years.

The 2001–2002 report of the Quebec Auditor General identified that:

- the public residential system for the elderly was seriously disorganized;
- measurable objectives and outcome indicators were lacking;
- there were no standard number of beds per region or standards of minimum services to be offered to residents;
- there were wide variations in waiting periods;
- there was a lack of standardized information about accessibility to accommodation;
- there was irregular availability of facility services; and
- there were delayed response times for needs assessment.

A 1999 Quebec study reported that licensing does not necessarily guarantee quality of care. These researchers indicated that, overall, 25 percent of the facilities in the study (both licensed and unlicensed facilities) did not offer adequate care to at least one

resident. Both licensed and unlicensed homes were weak in the psychosocial aspects of care. The researchers also identified that regulatory standards focused on the capability of facilities to deliver good care, rather than on the quality of care that they actually provided. They highlighted the need to develop adequate quality indicators and tools to pinpoint the underlying causes of inadequate care (Bravo et al., 1999).

A citizens' advocacy group, Concerned Friends of Ontario Citizens in Care Facilities (Concerned Friends), periodically reports on various aspects of facility-based long term care in Ontario. In March 2009, they advised their members that they were optimistic about changes being planned for a new compliance system in Ontario that will focus more attention on risk indicators such as the prevalence of pressure ulcers, weight loss, urinary tract infections, falls and restraint use (Concerned Friends, 2009).

It is not clear what provinces such as Ontario will do with risk data collected or how it will be disseminated to the public. Comparison among homes based solely on raw data can be misleading. The principle of risk adjustment will need to be considered, because a home with a high number of bed-bound residents may legitimately have a higher pressure ulcer rate than a home occupied primarily by active residents. Indicators that measure physical status do not tell the whole story. For residents, quality of life may represent something quite different to quality of care.

Most quality indicators focus on clinical markers of poor health care, such as dehydration, urinary tract infections and weight loss. Media stories occasionally report that long term care homes score badly on these measures. As a result, it may strike some people that quality of life

issues are inconsequential in comparison to the more traditional test of quality of care. But the matter of quality of life must be elevated, not trivialized (Kane, 2003).

The Ontario Association of Residents' Councils organized a wide consultation with residents throughout the province in 2008. The following reveals residents' perceptions about quality in facility-based long term care:

- homes should be peaceful and quiet;
- there is a need for more staff, especially nursing staff;
- residents would like to see more male staff in the homes;
- there is a wish for more affordable transportation choices;
- there is a wish for improved meals with more attractive presentation;
- older homes (should) receive funding to make upgrades comparable to new buildings;
- elements that contribute to quality of life in a home include flowers, family, birds, (pocket) money, shopping, sharing life stories, church, humour and a good night's sleep
- quality of life is being able to talk about (our) problems and having people (available) to listen (eHealth Ontario, 2008).

A research team at the University of Laval in Quebec City integrated the opinions of actual users of long term care into the process of developing valid outcome measures for the quality of life in long term

care homes. The three most important quality of life indicators identified by residents and their family were: being treated with respect, a sense of community (sympathetic involvement in relationships), and perceived competency of staff through gestures, attitudes and methods of work (Robichaud, 2006; Rehab and Community Care Medicine, 2008).

Upcoming cohorts of seniors will expect to experience quality of life as defined by them and that it will be available in long term care across the country.

Accreditation: The pan-Canadian Measure of Quality

Accreditation is different from licensure, in that it is a voluntary "process undertaken to raise the level of care and services," with the goal of achieving continuous quality improvement (MacRae et al., 2003, p. 14). The accreditation process developed by Accreditation Canada is used across all provinces and territories. It is a rigorous examination of major elements of long term care service over a three-year cycle. Accreditation standards are developed with the input of experts in the field and are fully tested before being applied. Most importantly, the accreditation process does not suffer from inertia. When stakeholders pushed for refinements to keep the accreditation process relevant to long term care, but more manageable within a demanding work environment, Accreditation Canada responded in February 2008 with *Qmentum*. Three years in development, this latest accreditation program is highly regarded in the field for being rational, sustainable, interactive and resident focused.

The accreditation program is identical for all homes. First, the organization

collects information, completes the self-assessment process and prepares for the on-site accreditation survey. A team of peer surveyors visit the home to assess compliance with national standards, and to evaluate strengths and identify areas for improvement. While on site, the surveyors seek to achieve knowledge transfer by sharing and exchanging expertise with the organization's staff and leadership. The surveyor's report and recommendations are sent to the home after which the team reviews the submission and implements the recommendations prior to the next survey. Accreditation Canada maintains liaison with the home between surveys and assists them along their course of quality improvement.

In 2008, 1,077 organizations participated in Accreditation Canada's programs, encompassing more than 4,400 sites and programs administered by those health service organizations. 124 long term care homes were surveyed by Accreditation Canada in 2008 (Accreditation Canada, 2009).

As quality initiatives in long term care gain momentum, new players will arrive on the scene to promote their products or services. The most recent accreditation body on the Canadian landscape is the Arizona-headquartered Commission on Accreditation of Rehabilitation Facilities (CARF). 42 long term care homes in Ontario and Alberta have been accredited by CARF since 2006. Early assessments by homes which have completed the CARF accreditation process regard it as being a "positive, collaborative and non-inspective experience" (CARF Canada, 2009).

Accreditation systems both in Canada and abroad can serve a catalytic function in improving the care of residents and the worklife for staff. It is an inter-disciplinary

undertaking, and lasting examples of quality improvement through accreditation are inevitably stories about people learning together (Wilcock, 2002). The experience can provide an excellent vehicle for which long term care homes can engage in team building. Staff engagement is cited as one of the key benefits of *Qmentum* as front-line employees are encouraged to be active participants (Tepfers et al., 2009).

Multi-disciplinary group dynamics enable the home to build stronger relationships between people geared more towards harmonizing talent and less towards hierarchical relationships. As homes work through the accreditation cycle, a higher sense of purpose and belonging can be achieved by giving front-line staff opportunity to provide input and to have their work receive due recognition. Accreditation can provide a forum for all stakeholders to discuss and debate ideas and to create and nurture a culture of learning, and for management, staff and others to work toward a common goal – the provision of quality resident care (Pomey et al, 2005). While it is standard procedure for acute care facilities to seek accreditation in Canada, there remain many long term care homes outside of the process.

There is more consistency in hospital legislation and licensure among provinces than for long term care homes. Without federal legislation related to facility-based long term care, there is little uniformity among provinces and territories in nomenclature, levels of care, governance and ownership. The relationship of long term care homes to their regional health authorities also varies by jurisdiction: some homes retain their own governance structure but are affiliates within a health authority,

Without federal legislation related to facility-based long term care, there is little uniformity among provinces and territories in nomenclature, levels of care, governance and ownership.

others are governed and administered by their local health authority, and some do not have a formal relationship with the authority at all. Long term care homes are not as homogenous as hospitals, and this can

It is not only the amount of government funding, but also the funding mechanisms that influence quality.

present a challenge to accreditation surveyors when they visit a province or territory other than their own.

The federal government, through Health Canada, supports First Nations, Inuit and Métis services in seeking accreditation. Saskatchewan pays for a portion of the survey fees while long-term care homes in Ontario receive a supplement of \$.33 per resident per day for the period of time that the home is accredited. Quebec and Alberta both have a mandatory accreditation requirement. Accreditation is not mandatory for long term care homes in British Columbia, though all health authorities assert that they have adopted standards from Accreditation Canada to help form their regional standards.

The literature indicates several benefits of accreditation, including:

- enhancing (resident) safety by effectively managing and mitigating clinical and safety-related risks;
- ensuring an acceptable level of quality among health care providers;
- stimulating sustainable quality improvement and continuously raising the bar with regard to QI initiatives;
- enhancing organizations' understanding of the continuum of care;
- increasing reputation among end-users and enhancing their awareness and perception of quality care;

- promoting capacity-building and organizational learning; and
- providing a framework that assists in the creation and implementation of systems and processes which improve operational effectiveness and enhance positive health outcomes (Nicklin, 2008).

The cultural transformation of facility-based long term care will have implications for all accreditation bodies, as surveyors will need to possess the requisite competencies to assess cultural change, and in some cases actually help guide homes toward its achievement.

Funding and Quality of Care

Inadequate funding affects the delivery of services in many ways, from the basics such as food services, to the provision of appropriate therapeutic programs and the safety and adequacy of health services.

Families often supplement basic personal care and may feel obligated to purchase extra services which should ideally be provided by the home, e.g., assistance with feeding, grooming and ambulation. Staff working in under-resourced homes have little time to reminisce with residents or generally interact with them (FAIRE, 2003; Health Canada, 2000).

One report has documented that in one Ontario long term care home, on a unit of 50 residents, 14 families had arranged for extra help to supplement care on a daily basis (Concerned Friends, 2001). Facility spokespeople in Alberta have reported that funding in that province does not allow for incidentals such as taking a resident outside on a sunny day or helping to apply makeup (Milestones, 2002).

It is not only the amount of government funding, but also the funding mechanisms that influence quality. Some provincial funding formulas have proven to be a disincentive to providing quality care. Long term care leadership has been critical of case mix formulas that result in reduced funding if a resident's level of functioning improves after a course of rehabilitation.

The lack of funding in long term care affects more than the numbers of direct care staff to attend to residents. It also has a dramatic effect on the numbers and mix of management and service staff. Middle management and service staff in areas such as Housekeeping, Laundry, Maintenance and Dietary were the first to bear the brunt of budgetary cutbacks and staff layoffs when health care restructuring was implemented in the early 1990s. These areas have yet to recover. As in the clinical areas, high turnover, workplace injury and unsustainable workloads are commonplace within the service departments of facility-based long-term care homes.

Insufficient funding also prevents homes from delivering appropriate services and programs that will enhance the quality of residents' lives. Some organizations have opted to contract out the service components of their operations to private vendors in an effort to save money, but results are mixed. While dollars may be saved, what is the real cost if the health care team is fragmented? The value and consequences of contracting out such services in a resident-centered long-term care home might be dramatically different than doing the same at a chain of motels or department stores. Resident-centered long term care homes require staff to actively support the inter-disciplinary team approach to care and service. Those homes that opt to contract out their services must be extra vigilant to build a culture in which teamwork can thrive.

Lack of funds can prevent homes from creating environments where residents live a fulfilling, quality lifestyle closer to the ones enjoyed in their own homes. A clean and safe environment joins respectful treatment as the most frequently cited criteria in the quality of life for residents. Cleanliness often serves as a proxy for overall quality in the minds of residents and their families. There is little potential for maintaining a consistently clean and safe environment with staff numbers that are too few.

Human Resources: The Key to Quality

Most staff employed by long term care homes includes nurses and personal support workers who work along with administrators and service employees. In lesser numbers, but vital to the success of facility-based long term care, are physicians and other health care professionals who provide essential services. A consideration of human resources in these homes should include the employment of sufficient professional and support staff to provide adequate care and service, the right staff mix, staff morale, continuing education of an array of health providers and an overall plan for an adequate long-range supply of health human resources to meet changing future demands.

Long term care is human resource intensive because approximately 80 percent of operating budgets are allocated to salaries and benefits. Adequate staffing is the key to delivering quality care in long term care homes (numbers, mix and knowledge). As more technology is introduced, this will add to the required competencies of staff. Families, long term care associations, employers,

Lack of funds can prevent homes from creating environments where residents live a fulfilling, quality lifestyle closer to the ones enjoyed in their own homes.

professional associations, unions, the media and policy makers have identified that public funding in most provinces does not provide for adequate staff numbers or appropriate staff mix.

There are numerous reports of high-quality service provided by committed caring staff in long term care homes (Adleman, 2003).

The most successful long term care organizations develop workplaces that empower their staff.

The report of the House of Commons Standing Committee on National Defense and Veterans

Affairs (2003) succinctly stated, “The most common trait that we found amid all the variations in terms of problems and resource levels, was the dedication of the staff and their desire to provide the best possible care” (p. 24).

Yet it is becoming increasingly more difficult to retain and recruit staff.

The most successful long term care organizations develop workplaces that empower their staff. One of the key methods to keep professional staff engaged is to enable nurse practitioners, registered nurses, registered practical nurses, therapists and others to work to their full scope of practice. The motivation of progressive employers is not to displace one health care professional with another, but rather to recognize the unique skills that each player brings to the team, and to facilitate informed decision-making within an interdisciplinary team environment. Some employers recognize and develop internal talent and therefore build upon the knowledge and skills of their employees, mentoring them to higher positions within the organization.

Enlightened human resource practices bode well for the future, but this is not yet common practice in facility-based long term care. Despite some leading practices in human resources, staff members in long-term care

homes face major challenges. According to the 2005 *National Survey of the Work and Health of Nurses*, half (50 percent) of nurses working in long term care homes reported that they had been physically assaulted by a resident during the previous year. Emotional abuse from a resident was reported by almost half (48 percent) of long term care nurses (Statistics Canada, 2006). The results are similar among unregulated front-line staff such as personal support workers (PSWs) and housekeeping aides who spend most of their time in close proximity with residents.

A study led by York University researchers resulted in a disturbing comparison between the long term care work environments in Canada and Scandinavia. Workers at 71 unionized long term care homes in Manitoba, Ontario and Nova Scotia were surveyed about their experiences of physical violence, unwanted sexual attention and racial comments. The study found that 43 percent of PSWs in Canada endured daily physical violence in the workplace, while another quarter had to contend with aggression every week. They were nearly seven times more likely to experience such daily violence than European workers in Denmark, Norway, Finland and Sweden. The study also established a correlation between levels of violence and heavy workloads placed on staff (Banerjee et al., 2008).

Many long term care staff members gain intrinsic satisfaction from their work. They particularly enjoy engaging in the affective dimensions of care such as listening and reminiscing with residents. But these same health care workers continue to believe that those who work in other health care settings do not value the skills required in long term care. Nurses, for example, have expressed that their skills, expertise and services are not as valued as those of nurses in acute care (College of Nurses of Ontario, 2007).

A May 2007 report, *Supporting Quality Nursing Care in the Long-Term Care Sector*, by the College of Nurses of Ontario (CNO) contained a statement by a long term care nurse that there is “a strong sense of LTC being a second class sector managed by second rate nurses...” (College of Nurses of Ontario, 2007, p. 6).

The CNO research provided further testimony from nurses in the field that pointed to the need for greater attention to resource and workplace factors:

Compared to even 10 years ago, the complexity of residents has increased - G tube feeds, catheters, oxygen, and the concept of palliative care and pain control are added dimensions to an increasing and more incapacitated population...

Most of our residents have complex medical problems and approximately 80 % of these residents have dementia. This directly impacts (the) number of meds per resident. We have worked with (the) physician and family to review, change, or reduce meds but it remains difficult to give meds in timely manner...

Lack of recognition and sense of isolation could be attributed to poor funding for (the) LTC setting...

The sentiments expressed above are consistent with those of other categories of long term care staff. Some health care providers remain working in long term care for decades, but high turnover rates are undeniable and result largely from heavy workload, physical exhaustion and low morale. Turnover rates have such significance that the Quality Worklife-Quality Healthcare Collaborative (QWQHC) deemed it one of seven critical indicators in the management of healthy healthcare workplaces (QWQHC, 2007).

Many employees enjoy working in facility-based long term care and cite numerous rewards in working there. They express satisfaction with their vocation and speak warmly of the residents entrusted to their care (Adleman, 2003; Lage, 2003). Some consider a career in facility-based long term care as a “calling”, similar to individuals engaged in the spiritual professions.

Health human resources (HHR) are a priority across Canada. But single policy changes such as increasing enrollment in health care education programs on its own will not close the gap between supply and demand. A 2009 report by the Canadian Nurses Association (CNA), *Tested Solutions for Eliminating Canada’s Registered Nurse Shortage*, tested six scenarios to measure their potential impact on the registered nurse (RN) shortage. These six scenarios included:

- increasing RN productivity;
- reducing RN annual absenteeism;
- increasing enrollment in RN education programs;
- improving retention;
- reducing attrition rates in RN education programs; and
- reducing international in-migration (CNA, 2009).

The CNA formula postulated that the combined effects of the six policy scenarios would eliminate Canada’s RN shortage within 15 years and reduce Canada’s reliance on international recruitment. A multi-faceted approach to HHR as espoused by the CNA may also apply to other categories of health care workers, as most of their policy recommendations have universal relevance.

Still, even under ideal staffing compliments in the most progressive organizations in the country, work in the caring professions is not for everyone. In a 2006 report to the Ontario Minister of Health and Long-Term Care on regulatory issues respecting personal support workers, *Report to the Minister of Health and Long-Term Care on Regulatory Issues and Matters respecting Personal Support Workers*, the Health

Long term care health human resources should be guaranteed a prominent position on the health policy agenda.

Professions Regulatory Advisory Council (HPRAC) identified numerous instances of abuse committed by

staff both in long term care and home care.

HPRAC did not document the frequency of abuse, but it did identify the types of abuse reported by residents, clients and employers as being psychological, such as the social and/or physical isolation of the client, verbal and emotional abuse including insults and threats of harm or abandonment, withholding services and/or the essentials of life including medications and access to health care, physical and/or sexual abuse including inappropriate remarks, and fraud in financial matters or coercing changes to the client's will or powers of attorney.

The employer is responsible for the actions of its employees and must have a zero tolerance for abuse, not just in policy but also in practice. HPRAC also noted the importance of in-service training for staff to ensure that they understand how to deal appropriately with residents (HPRAC, 2006). As prevention is better than cure, long term care homes should have hiring practices that give them a higher degree of certainty about the suitability of new applicants. The importance of employee screening cannot be overemphasized.

Despite what may be assumed by those removed from facility-based long term

care, a unique body of knowledge and skill is actually required to master the many challenges embedded in the work. Every role in long term care is noble. Staff who thrive, rather than simply survive, have common characteristics: empathy, patience, a desire to learn and apply new approaches to care, and a need to live beyond themselves and make a difference in the lives of others. This conflicts with the traditional point of view that relates working in the long term care field akin to a ghetto in which caregivers with diminished skill and ability spend their time performing perfunctory tasks. Care of residents is neither undesirable nor demeaning. Rather, inadequate conditions detract from the integrity of the work.

Working in facility-based long term care can be both personally and professionally exhilarating. But for each person who experiences such fulfillment, there is likely another who becomes dispirited and leaves the industry. This is a sobering thought considering the challenges posed by dementia and its burgeoning incidence in Canadian society. Consequently, long term care health human resources should be guaranteed a prominent position on the health policy agenda for years to come (Samuelson, 2004).

Staffing Ratios

Long term care staff are faced with intense pressure to care for increasingly more complex residents (Adleman; Lage, 2003). Staff members are often overwhelmed by the amount of time required to provide care, which results in burnout and impacts the quality and safety of care delivered. Media reports suggest that staff members are rushed, cut corners and regiment residents as a way of coping with the increased workload. A former president of the Canadian Nurses Association said: "It's not

unusual to hear stories of one RN for every 50 patients in a long term care facility... This whole situation needs to be corrected” (Muggeridge, 2003, p. 44).

Inadequate staffing has major implications for the preservation of dignity and quality of life, as well as the guarantee of adequate basic physical care for residents. An expert panel in the United States has recommended that 4.55 hours per resident day of total nursing time (which includes administrative nursing, direct and indirect care) is required (Kovner et al., 2002). Most Canadian long term care homes would fall far short of this standard.

Ontario doesn’t have minimum staffing ratios, having abandoned them in 1995. New Brunswick has a model of funding for care staff based on 3.1 hours of care per resident. But New Brunswick doesn’t simply assign a number. It is committed to a strong professional nursing presence in their homes by establishing that 2.5 of the assigned hours are based on a ratio of 20 percent RN, 40 percent licensed practical nurse (LPN) and 40 percent PSW. The balance is assigned to LPN Rehabilitation (0.08 hours per resident); clerical support for nursing (0.13 hours per resident) and PSW peak workload hours (0.39 hours per resident).

New Brunswick also established support department staffing standards based on the number of residents and square footage of the home. A laundry staff complement, for example, is based on the standard number of pounds of material in the home.

Having prescribed staffing standards doesn’t necessarily mean that homes can always meet them. This is particularly challenging when the numbers of staff available are in short supply, as is the case with registered nurses. Some provinces require homes to report on hours paid by category. Others

require homes to report on actual hours worked, a measure that is more reflective of what the resident actually experiences.

Low staffing correlates with inadequate operating budgets. Provincial long term care associations have repeatedly called for increased levels of government funding to improve staffing. Many long term care homes have identified that current levels of funding are insufficient to provide the actual amount of care and level of health service required by residents. It is no secret that in facility-based long term care there are not enough resources “on the floor.”

The 2001 landmark study, *Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long-Term Care Facilities and Selected Comparators*, by PricewaterhouseCoopers confirmed the anecdotal reports of inadequate staffing. In addition to wide discrepancies in nursing hours and total staffing hours between homes identified in Manitoba, Ontario and Saskatchewan (Figure 5) there were differences in staffing ratios. There is also an insufficient quota of professional staff (therapists, dieticians, social workers and psychologists) to meet the needs of residents due to inadequate funding for these positions (PricewaterhouseCoopers, 2001). A plethora of research legitimizes the value of establishing minimum staffing standards.

“Research shows that the level of staffing in a care facility has a direct correlation with positive outcome measures and quality care,” expressed Ed Helfrich, CEO of the British Columbia Care Providers Association. “We know a facility with six care aides per shift cannot provide comparable care to a similar site with 10 care aides per shift” (BCCPA, 2009).

Establishing minimum staffing ratios is not a panacea. There are numerous factors that

contribute to quality of life for long term care residents, but the entire infrastructure of care and service is built upon the foundation of an adequate staff complement. Every home should be required to maintain a basic minimum number of staff in all major categories. The acuity of the resident population, the behavioural challenges facing the staff, the special dietary requirements, and the square footage of the

The development of pan-Canadian minimum staffing standards for long term care homes in Canada should become a priority of policy makers at the federal level.

home all impact what might be considered a reasonable, if not optimal, staff complement in areas such as nursing, activation, dietary and

housekeeping. It is clear that in the absence of adequate numbers and appropriate staff mix, many programs cannot be offered, and leading practices will not be implemented or sustained in long term care homes.

The development of pan-Canadian minimum staffing standards for long term care homes in Canada should become a priority of policy makers at the federal level. Health delivery is a provincial/territorial responsibility but since long term care affects all Canadians at some point in their lives, it is appropriate for the federal government to spearhead the development of broad pan-Canadian objectives and principles. This is especially true if the federal government is to take on additional funding responsibility in long term care. The precedent exists for the federal government to dedicate separate funds for common priorities. One only has to consider past initiatives such as early childhood development and primary health care as evidence of federal leadership for programs that positively impact Canadians in every jurisdiction.

All stakeholders – residents, families, employers, staff, associations, unions and researchers – should be asked to provide

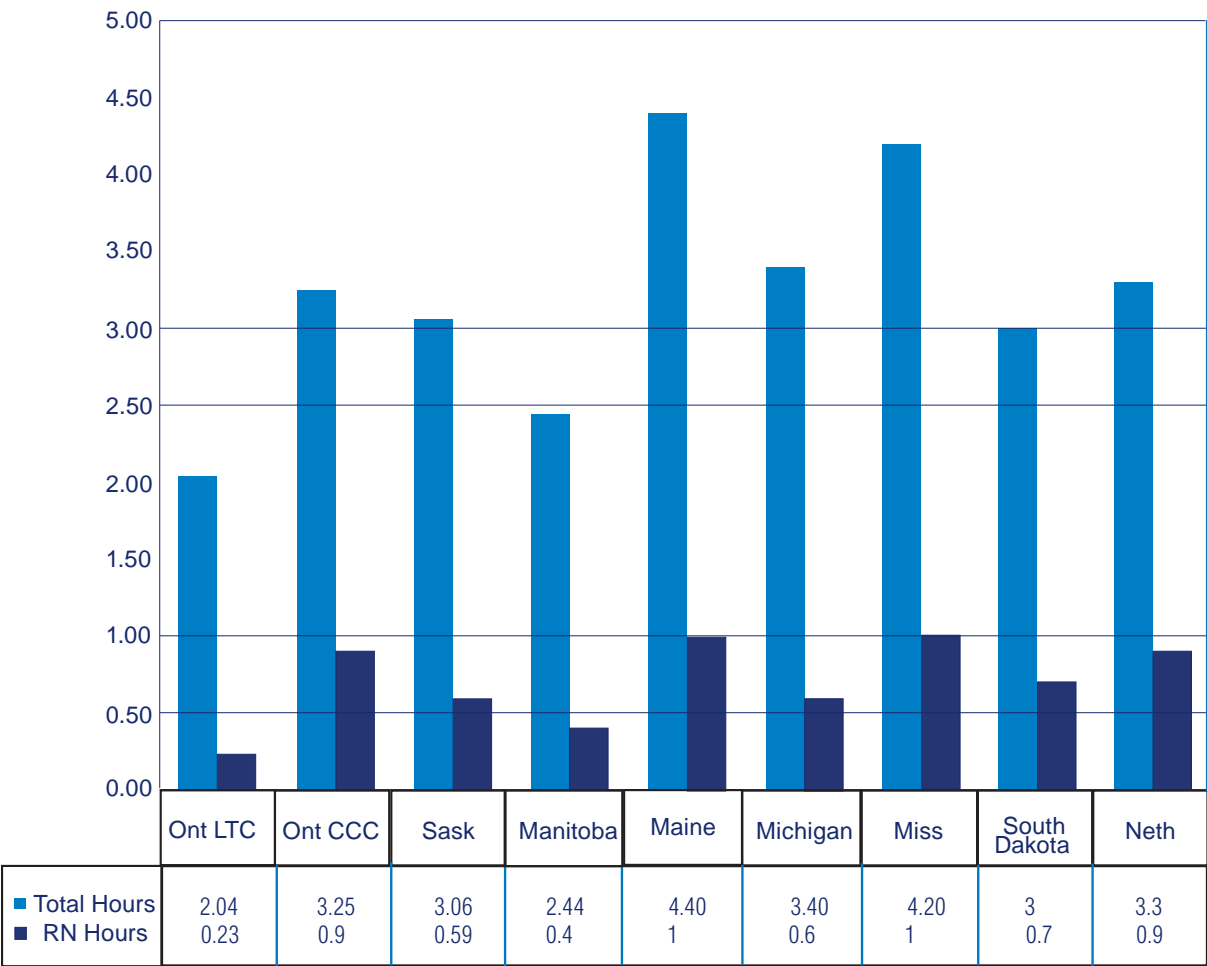
input into a national deliberation on the subject to help ascertain the appropriate benchmarks. This would allow each long term care home to determine its own levels of adequacy. Staffing numbers and mix should also be publicly reported and explained in clear language to ensure understanding, transparency, and to enable a higher level of informed consumer choice.

Staff Education

The culture of facility-based long-term care has historically placed little emphasis or value on staff education. Few incentives have been offered to encourage or motivate staff to improve their knowledge and skills by engaging in continuing education (Kortes-Miller et al., 2007). Yet, the changing realities of long-term care have intensified the need for accessible, relevant education. The pleasant, mildly confused senior citizen with one or two easily managed chronic conditions is atypical of long-term care residents. The resident profile today is dominated by persons with complex health conditions, including advanced dementia, who require assistance and direction with feeding, toileting, social interaction and mobility.

Homes must provide their management and staff with a continuum of educational opportunities if they seek to achieve a culture of learning. The learning format might include formal off-site training, home study, distance learning, webinars, and the most commonly employed methodology – in-service education sessions at the workplace. The latter is best maximized for front-line employees through the provision of replacement coverage so that those in attendance can concentrate on the learning experience and not be disrupted by external stimuli, such as vibrating electronic devices triggered by activated call bells. Multi-tasking might be appropriate in some venues,

Figure 5: Total Hours per Resident per Day, RN, RPN and Health Care Aide, Combined and RN only



Source: Reprinted with permission from OANHSS and OLTCA from PricewaterhouseCoopers, *Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators* (Toronto: OANHSS and OLTCA, 2001), p. 100.

but not in the classroom or similar learning environment. But poor staff coverage, heavy workloads and complex clinical issues often preclude staff from attending even brief in-service education sessions (Stolee, 2006).

Interestingly, 19 of the 85 recommendations from the 2005 coroner’s inquest into the homicides of two residents by another resident at Casa Verde Health Centre in Toronto contained reference to training needs. Education programs such as PIECES, and U-First do much to augment the

knowledge of staff but result in little benefit to residents if the learning is not consistently integrated into practice. Given the high staff turnover in long-term care, it is critical that training in resident rights, cultural competency, resident-centered care and behaviour management is provided routinely.

It can also be argued that there is not adequate educational support for long term care managers. Empathy is paramount among the arsenal of skills necessary to be an effective manager in long term care. It is

absolutely critical for the front-line manager to show attentiveness to team building and honestly express empathy toward another individual's thoughts and workplace realities. After all, there is much truth to the adage that individuals don't leave employers, they leave managers. Managers in a transformed long term care system must understand the factors that motivate and retain front-line staff, and work to reduce or eliminate those that make them leave.

The challenge of staff education is not only to reach a large audience, but also to capture and codify leading practices.

The challenge of staff education is not only to reach a large audience, but also to capture and codify leading care practices. The provision of dignified care must become part of the DNA in every long term care home. Such a transformation will require an investment in staff education. This will serve notice to all stakeholders that leaders in long term care intend to move beyond knowledge transfer and to move toward knowledge integration in the workplace.

While all health care providers should receive sufficient basic preparation and ongoing education, there will also be a need for more health professionals with advanced studies in the care of the elderly. In Canada, the level of geriatric education or practice currently included in undergraduate nursing courses is unknown (Tassone et al., 2003). Health care professionals are still educated for last century's battle against acute illness rather than mastering new skills to meet the 21st century's expansion of chronic conditions (Dawson et al., 2007).

Nursing certification in gerontology was introduced by the Canadian Nurses Association in 1999. As of 2007, just over 13.6 percent of all certified RNs in Canada achieved specialty certification in gerontology (1,989 out of 14,526 RNs). The

University of Alberta offers a Masters of Nursing degree with a certificate in aging studies. Continuing education courses in gerontology, dementia and aging are also offered across Canada, but research is problematic because the term "continuing education" is defined differently in different provinces. The provision of these programs is dependent on demand as expressed in enrollment numbers each year.

Courses are available in different provinces to prepare unregulated health care staff to work in long-term care homes. But there are inconsistencies in the level of basic training required for personal support workers which has recently given rise to a call for a pan-Canadian PSW curriculum. The need to address the development of a standard curriculum that reflects the real nature of the work is urgent. For those presently in the health system, the costs of the courses and opportunities for time away from work are restrictive. All workers need ongoing in-service education and access to other educational opportunities to stay current and become comfortable with innovative approaches to care and service. Placing a premium on knowledge will go a long way in encouraging worker retention. Employers must receive adequate funding so they can provide appropriate educational opportunities and budgets for staff development.

Long term care is multidisciplinary, and positioning appropriate health professionals within the team is essential. Adequate education in the care of the elderly at the undergraduate, postgraduate and specialty levels is critical for therapists, social workers, pharmacists, psychologists, and dieticians (Samuelson, 2004).

Concerned Friends of Ontario Citizens in Care Facilities has long recommended

mandatory interdisciplinary education in gerontology for all care providers in Canadian long term care homes (Concerned Friends, 2001). Yet, Canada is found lacking on indicators of continuing education and training. Less than 30 percent of adult workers in Canada participate in job-related education and training, compared to almost 35 percent in the United Kingdom and nearly 45 percent in the United States. Access to learning opportunities for less-educated adults, whether by returning to the formal education system through government-funded programs in the community or through employer-sponsored training, is generally poor in Canada. This problem is compounded by the fact that over 40 percent of adult Canadians lack the literacy and numeracy skills they need to effectively work in today's society. Sadly, this figure has remained virtually constant for the last decade (Saunders, 2007).

When compared with other industry sectors in Canada, health care falls near the bottom of the list with an investment of \$567 per employee in 2004 compared to an average of \$914 in other industries. Furthermore, the figure above is undoubtedly inflated as it is derived mainly from data submitted by large acute care organizations (CBC, 2007). The amount of investment in training in the long term care sector has not been determined, because of a dearth of information, but if it were known it would likely pale in comparison to its richer acute care cousin.

Physicians

The physicians most involved with facility-based long term care are family practitioners, geriatricians (physicians with a sub-specialty in geriatric medicine) and specialists in geriatric psychiatry. An attending physician is assigned to each

resident admitted to a long-term care home. This may be their long-time family physician or a physician from a roster who cares for a certain number of residents. According to the 2007 *National Physician Survey* conducted by The College of Family Physicians of Canada, 22.1 percent of Canadian family physicians indicated a long term care home as a practice site, while only 1.2 percent reported this as their main care setting.

Family physicians need adequate knowledge about the care of the elderly given that they provide the preponderance of medical care to long term care residents, participate on multidisciplinary teams, contribute to program design and provide education. Thirteen Canadian universities offer Care of the Elderly training accredited by The College of Family Physicians of Canada. But little research or information is available about the undergraduate preparation of Canadian medical students to work with the elderly. According to Dr. William Dalziel, "I would estimate two weeks on average. To put two weeks or eighty hours into perspective, it is one percent of a total four-year curriculum. Yet students graduating as [medical doctors] MDs today may spend up to 70 percent of their career time with elderly patients." Rotations in geriatric medicine are still not mandatory for Canadian internal medicine training programs (Hogan, 2007). Some medical students may never enter a long-term care home during the course of their studies. This contrasts sharply with the Dutch model, where a two-year training program for long-term care physicians has been available and well utilized for twenty years (Tutton, 2009).

Long term care homes desperately need the services of geriatricians. Although geriatrics has been a certified medical subspecialty of internal medicine since 1981 (Gordon, 2001), the numbers of geriatricians

in Canada is still woefully inadequate (Rockwood et al., 2001). Canada currently has fewer geriatricians than other developed countries (Hogan et al., 2002).

The National Advisory Council on Aging expressed its concern with the inadequate number of geriatricians in Canada by way of its 2003 *Interim Report Card*. In 2000, there were 144 geriatricians in Canada, although

Today's inadequate supply of specially-qualified physicians will be compounded in the near future as the number of seniors increases.

an estimated 481 were needed at the time. By 2007, the number grew to 211 geriatricians.

This is a noteworthy improvement, but the number of geriatricians is nowhere near the estimated 538 needed in Canada.

There is also an urgent requirement for physicians specializing in geriatric psychiatry, to treat psychiatric problems associated with dementia, depression, behavioral and affective disorders. Many geriatric psychiatrists serve long-term care homes, but their availability is limited. Additional funding would positively affect the amount of contact time in long-term care, and geriatric psychiatrists could not only provide resident consultations, but also participate on multidisciplinary teams, assist in therapeutic program design and provide staff education. For under-resourced communities and regions, the use of telepsychiatry could be employed to link geriatric psychiatrists and other mental health clinicians to a long-term care home.

Sadly, of the 12,453 medical residents engaged in postgraduate studies in 2009, only 38 were enrolled in care-of-the-elderly programs and geriatric internal medicine (Busing and Gold, 2009). Today's inadequate supply of specially-qualified physicians will be compounded in the near future as the number of seniors increases. The best time to have prepared for change to ensure adequate physician services in

order to serve the needs of long term care residents was ten years ago. The second best time is now.

Volunteers

Volunteering is the willing offer of financial donations, material resources or in-kind services and should be distinguished from *unpaid caregiving* (discussed in the next section). Volunteerism has historically been associated with fundraising for capital construction and financing the daily operations of some long-term care homes through contributions from the community, religious organizations or philanthropists. There is a strong spirit of individual volunteerism in long-term care, particularly in the not-for-profit homes.

According to the Canadian Association of Healthcare Auxiliaries (CAHA), 70,000 members contributed 7.9 million volunteer hours inside health care facilities and in the community between the years 2001 and 2002, while Auxiliary fundraising generated over \$59 M dollars for the health care system. Recent statistics show that in British Columbia alone, health care auxiliaries volunteered over 1.3 million hours of service and donated over \$8M to health care organizations in that province.

Twelve million Canadians contributed almost two billion volunteer hours to all organizations across Canada in 2004 – the equivalent of one million full-time jobs. Yet a small percentage of Canadians provide most of the service, and many of them are now in their seventies (Volunteer Canada, 2009). While there will be an increase in the absolute number of seniors as the baby boomers age, this will not necessarily translate into a huge influx of senior volunteers to lend a hand in long-term care homes. The upcoming cohort of baby boom retirees has different social

characteristics than current seniors, and their volunteering patterns may be quite different from previous cohorts. Long-term care organizations would be wise to gain an understanding of this diverse cohort, especially in light of the fact that there is a soft decline of 1 to 2 percent per year in volunteering in Canada. Indeed, three out of 10 baby boomers who volunteer do not return for a second year. Twenty percent of these lost volunteers are never replaced (Volunteer Canada, 2009).

What factors cause a person to stop volunteering even when they are committed to the goals of the organization? Interestingly, the reasons are similar to those that send employees in another direction – interpersonal conflict, boredom, tasks with no direct relationship to goals of the organization, unreasonable expectations, burnout, unreasonable deadlines, absence of feedback and appreciation and frustration with management caused by lack of direction, ineffective work processes and poor leadership (HRCAP, 2009).

In order to effectively engage baby boomers as volunteers, long term care homes must shift their thinking about volunteer roles and responsibilities. When baby boomers volunteer, they prefer mission-linked, productive, satisfying work that allows them to use their skills and experience. They enjoy short term work, flexible schedules at convenient locations, including opportunities to volunteer online (Volunteer Canada, 2009). Long term care homes must avoid the temptation of using volunteers to supplement an inadequate labour force.

The special contribution of young volunteers should not be overlooked. There is a reciprocal value in involving youth volunteers in long term care. Young volunteers can offer practical help and social enrichment through the interaction of the generations, and gain

an appreciation for the career opportunities in long term care homes.

Residents and Family/Informal Caregivers

Admission to a long term care home sometimes hinges on the lack of availability of an informal support system in the home. Individuals with lesser needs and no family support may be admitted to a home, while individuals with more complex deficits may remain in their own private residence because they have access to home care services or the support of family members and friends who provide care and reassurance. This latter type of support or care is referred to as *informal caregiving*. Informal caregivers usually provide support and/or hands-on care because of a close relationship or connection with the individual. Their contributions in home care are well documented. Their efforts in facility-based long term care are also significant.

The Canadian Caregiver Coalition considers “family” to include both biological members and family of choice in which the informal caregiver is considered part of the family circle whether legally related or not (Torjman and Makhoul, 2008). Yet, the current continuing care system was designed to work with the “traditional” family structure of the 1960s and 1970s, when many families included one adult male working outside the home and one adult female working in the home to raise the children. The family structure has changed dramatically and the next cohort of seniors and their family members have a different experience of family and worklife. Today, there is a wider range of relationships considered to be a legal family, including more single-parent, same-sex, and blended families.

The special contribution of young volunteers should not be overlooked.

Current residents in long term care homes have usually been married only once and have parented an average of 3.5 children. The birthrate of today's parents, and tomorrow's seniors, is closer to 1.6 births per couple. This means that there will be fewer children to provide caregiving support to their parents in long term care. Another phenomenon in caregiver support is that frailty is occurring at a later age, which

Family members sometimes become informal caregivers through default rather than choice.

means that the children of frail elders are also older. It is not uncommon now for the children of

frail residents to be seniors themselves. This is evidenced by the fact that in 2007, one in four caregivers were of senior age and one-third of these senior caregivers were over the age of 75 (Statistics Canada, 2008b).

Many of today's elderly women were often not employed outside the home; these women assumed the predominant caregiving role as homemakers. But the upcoming baby boomers and their children will have had part-time or full-time careers throughout a lifetime of employment outside the home. Most have not experienced a tradition of housebound caregiving and may not naturally fall into the caregiving role for a parent or partner.

The automatic assumption that family members will be willing and available caregivers for a future generation of elderly could prove false. The level of informal caregiving in the future could be less than it is today. The recent behaviour patterns of the baby boom generation indicate that they may employ professional caregivers more extensively to care for their aging parents or seek other ways to secure care. A Quebec study exploring family values and long term care in that province found:

... little empirical evidence that the first choice of most frail elderly is to depend on family for hands-on caregiving, nor

that most family members would freely and willingly choose to do so. On the contrary, it points to increased openness to delegating responsibility to formal services (Guberman et al., 2006).

This study raised legitimate questions about the family's capacity to maintain the current level of involvement in care to the elderly in the coming decades.

In addition to changing family structures, today's families and income earners tend to be more mobile, often out of necessity rather than choice. While extended family connections are still reported to be strong in Canada, these ties are often maintained over long distances. Therefore, the proximity of adult children to their parents is a significant factor in determining the amount of support that they can reasonably provide to elderly kin. Studies published by Statistics Canada in 2001 show that the rate of interprovincial migration has been 11.3 per 1,000 people. Atlantic Canada, the northern regions and the remote rural areas have experienced a net out-migration, especially among the adult working population.

Retired seniors, on the other hand, often do not move very far from their original home. If they do move, it is usually to be closer to amenities or to their children. Of those who relocate to retirement resorts, some will return to their original home locations with the onset of a disability (Stone, 2000).

There are day-to-day challenges, as well as personal rewards, in providing care for family members in the home. Family caregivers may sense filial satisfaction and fulfillment in caregiving. They may also experience impacts on their physical and emotional health, their financial situation, their social relationships and their work lives (Fast and Keating, 2001; Hawranik and Strain, 2000).

Family members sometimes become informal caregivers through default rather than choice. They may assume a role which they find restrictive and with which they are uncomfortable or feel compelled to undertake because it is the accepted norm. The unrelenting demands of family/informal caregiving can lead to disability and even to early death for some caregivers who are themselves frail or weak. Governments, policymakers, trustees, health system managers and the public must avoid the temptation to reduce health care spending by offloading health services onto informal caregivers. We also need to take into account the true cost of informal caregiving in terms of time spent, employment income relinquished and resources dedicated. Increased public funding should be undertaken to enhance health care across the continuum and to offer the flexibility needed by clients and families.

The experience of placing someone in a long term care home can leave family members feeling guilt, loss, and a lack of control (Dawson et al., 2007). Research shows that family members often maintain close relationships with their loved ones following admission to a long-term care home (Gladstone et al., 2007). Many provided years of informal caregiving which enabled their loved one to remain at home. Family members can help the staff understand the resident and emerge as true partners in care while others may complicate the relationship. Some of them feel a responsibility to continue with caregiving duties despite the change in venue. Providing companionship, emotional support, and advocacy are the predominant activities of most family members, but others assist their relatives and other residents with personal care because staff appear to be hurried and unable to take the required time.

Family members of residents develop relationships with staff. Their involvement in the long term care home can have an impact on the caregiving experience as conflicting expectations around caregiving roles and methods may create unnecessary tension. Since different family members desire varying levels of involvement in the care and support of their relatives, it is critical for the home's leadership to establish a culture in which people can openly discuss what is practical and acceptable to both parties (Gladstone et al., 2007). Such an investment in positive engagement can strengthen ties with a secure and supportive family, and defuse or prevent problems with families that suffer from dysfunction.

Long term care is a social environment and the vast majority of residents want to be accepted, and not become branded as "trouble-makers". Consequently, many residents in long term care homes are silent about the quality of care they receive. This may not indicate satisfaction, but rather an inability to state their concerns. Many residents have lost the intellectual capacity to speak for themselves, or they may feel at the mercy of those in charge of their care. They and their families may hesitate to voice their concerns for fear of losing some elements of service if they complain. The reticence to express themselves is a real concern in facility-based long term care. Several provinces have mandated residents' and family councils to provide a voice for people that have traditionally been silent. Family councils work in partnership with residents' councils and staff to provide a structured forum for families to constructively participate in the life of the home.

Governments, policymakers, trustees, health system managers and the public must avoid the temptation to reduce health care spending by offloading health services onto informal caregivers.

When a home accepts a resident, it is also accepting the family. While each family unit is unique, there is one common denominator in all families – they will judge the home largely by the attitudes of staff. A family's trust and level of support will diminish if they feel that the staff doesn't care enough to treat their loved one as a unique individual. High levels of resident and family satisfaction

A national long term care strategy should also consider a review of retirement homes and assisted living arrangements.

lead to a good reputation, engaged stakeholders and a more positive bottom line. Providing quality care

within a dignified living environment simply makes good business sense.

Utilization

The Utilization of Facility-based Long Term Care

In 1986, almost 16 percent of Canadians aged 75 of age or older resided in long term care homes. By 1996, the rate had dropped to about 14 percent, although the total number of residents rose from 203,000 to 240,000 in that same period (Statistics Canada, 1999; NACA 1999). The projected number of future residents by 2031 varies from 560,000 to 740,000.

The drop in institutional utilization rates is attributed to improved overall health, better community support services and shifting clients with lower levels of care to private, less regulated services. While enhanced home care has allowed some people to remain at home, social policies have allowed others to be directed to alternative types of accommodation.

Today, long term care homes admit clients with heavier care needs than ever before. Individuals with lower-level care needs, who would have been admitted to long term care in the past, are now paying privately

for the full costs of accommodation and care in retirement homes which are often not licensed or regulated. In Saskatchewan, personal care homes are intended for individuals with light care needs, and are regulated differently than special care homes (long term care homes). There is a thriving retirement home industry in many provinces with more residences springing up all the time.

While it is not appropriate for individuals to be placed into long term care homes if they do not need this level of care, some retirement homes are able to retain their residents by providing increasing levels of health service as a resident's health deteriorates. Often, the resident continues to pay entirely out-of-pocket for health services, which have been gradually added to the room and board charges. Consequently, individuals in these situations are paying not only for health services but also for services that may not be appropriately regulated. A national long term care strategy should also consider a review of retirement homes and assisted living programs.

Research has shown that seniors in the lowest or lower-middle income groups were twice as likely to be institutionalized, compared with those in the middle or highest income groups. More financially secure seniors are less likely to be in long term care for several reasons: higher-income seniors are generally in better health; they have the means to pay out of pocket for the home support they need and they can afford to live in a retirement facility.

Based on the 2002-03 National Population Health Survey, 54 percent of residents surveyed had lived in a long term care home for two years or less and 22 percent had been there less than one year. The length

of stay is declining for seniors because individuals are admitted at a later stage of declining health.

Numerous efforts have been made to predict the number of long term care beds needed. Forecasts have considered variables such as the increased number of seniors, the compression of morbidity and a shift to more home and community care. Figure 6, based on weighted information from seven provinces on bed ratios for citizens 75 years of age and over, shows anticipated facility bed capacity using four scenarios. The four scenarios are described as:

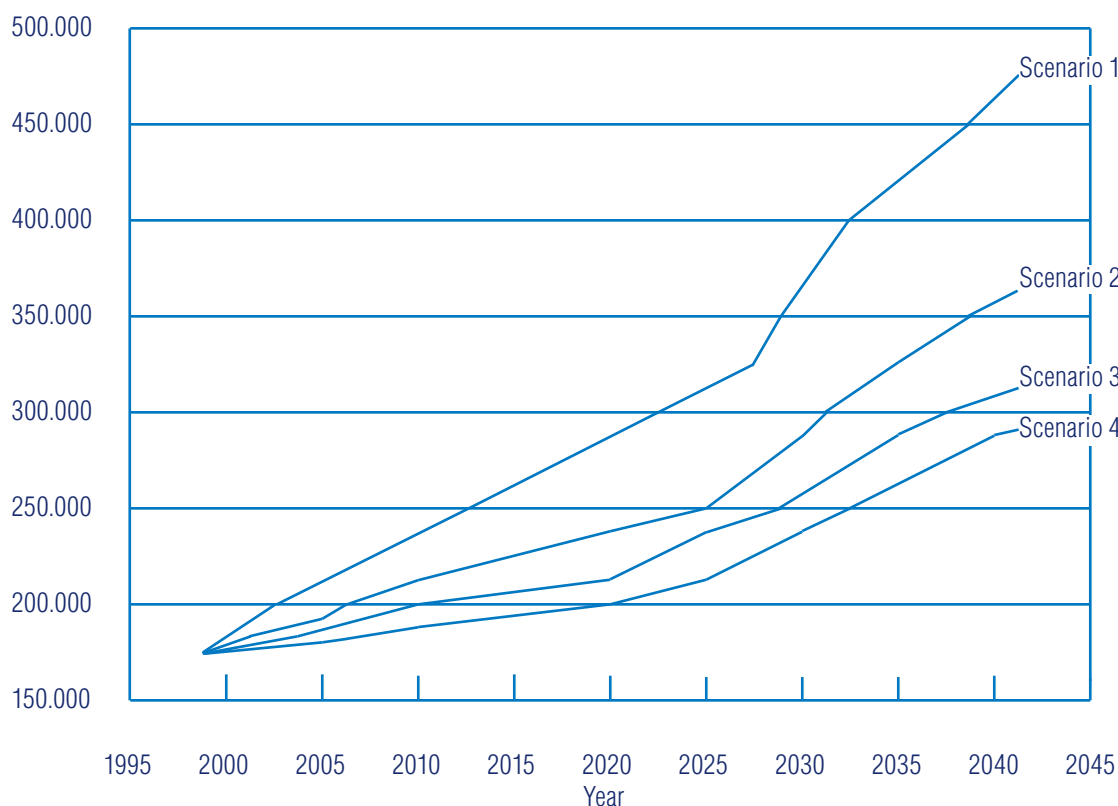
Scenario 1 – maintain current bed ratio;

Scenario 2 – low shift to community services, including expanded home care and supportive housing, combined with supportive/assisted living options, which would decrease bed ratio by 0.59 percent per year;

Scenario 3 – medium shift to community services, including expanded home care and supportive housing, combined with supportive/assisted living options which would decrease bed ratio years by 1.06 percent per year; and

Scenario 4 – high shift to community services with facility care offered only to those with high needs, which would decrease bed ratio by 1.47 percent per year.

Figure 6: Projected Number of Residents in Canadian Facilities 1999–2041



Source: Lazurko, M. & Hearn, B. 2000, *Canadian Continuing Care Scenarios 1999-2041*, KPMG Final Project Report to FPT Advisory Committee on Health Services, Ottawa. Reproduced with permission of the Minister of Public Works and Government Services Canada, 2009.

This research noted that increasing community capacity through expansion of supportive housing and assisted living services, as described in scenarios 3 and 4, is unrealistic for rural and remote areas. The Manitoba Centre for Health Policy has produced a number of studies about bed ratios for seniors, and suggests that a ratio of 110 beds per 1,000 persons, 75 years of age and older, should be sufficient to meet future needs until 2020; but it is difficult to estimate the appropriate number of beds over the longer term. The problem is compounded by the fact that Canada is a large country with scattered populations. Health care planners face the unenviable task of reconciling the needs and desires of local constituents with large scale projections on future need.

Projected Health Expenditures

Apocalyptic demographers predict that increasing number of seniors and disabled individuals will use a disproportionate share of health services and overburden the publicly-funded health system. Other analysts suggest that health costs do not swell at the moment seniorhood is reached, but rather occur gradually and will be cushioned by the economy (CHSRF, 2001).

Some American researchers believe that the additional numbers of seniors, not their longer life span, will increase American Medicare costs. Still others suggest that while

the total spending for all seniors may rise, each senior on average will cost the health system less because seniors 65 to 74 years of age will be healthier overall than this same cohort from past decades.

The Organisation for Economic Co-operation and Development has stated that a decline in disability and the trend to delayed institutionalization will moderate costs even though there are more seniors. A Caledon Institute report (2002) predicts that increases in health spending in 2016 will be only 10 percent of total government spending and 10.8 percent in 2026. International evidence suggests that modest economic growth should enable most developed countries to manage the higher numbers of elderly in their populations and the need for increased health care spending in the future (Rosenberg, 2000). Even if increases in the gross domestic product (GDP) do not offset rising health care costs, the reduction in illness will mitigate proportionate increases in health spending. What is not clear in these discussions is what costs are being considered: mainly medicare (ie. hospital and physician) costs or projected costs along the entire continuum of care? A large proportion of the health care for future seniors may be provided in the continuing care sector and outside of acute care. In general, the growth of public and private health expenditures may not be as dramatic as some fear.

Table 7: Projected Government Spending on Health Care as a Percentage of Total Government Spending

Fiscal Year	Without Population Aging(%)	With Population Aging(%)
2000-01	9.1	9.1
2006-07	8.9	9.4
2011-12	8.7	9.6
2016-17	8.6	10.0
2021-22	8.5	10.3
2026-27	8.4	10.8

Source: Reprinted with permission of the Caledon Institute of Social Policy from Joe Ruggeri, *Population Aging, Health Care Spending and Sustainability: Do We Really Have a Crisis?* (Ottawa: Caledon Institute of Social Policy, 2002), table 6, p. 9.

System Issues

Technology

People are living longer and experiencing better quality of life because of technology, pharmaceuticals, complex surgeries and prosthetics. But these scientific advances have resulted in waiting lists for these new treatments that did not exist previously, thereby exerting more pressure on the acute care system. While technology has improved outcomes, it has also increased demand.

Technology has had both positive and negative effects on facility-based long term care. On the one hand, technology has decreased the demand for long term care (PricewaterhouseCoopers, 2001). Relatively simple technologies like microwave ovens, large-number keys on phones and emergency alert systems have boosted the autonomy of frail seniors allowing them to remain at home longer. More complex technologies like telemonitoring and telehealth also keep individuals out of health care facilities, while medical advances like surgery for joint replacement and corrective vision have decreased facility admissions.

However, advanced technology and the greater use of complex treatments such as tube feedings, ostomies, ventilators, nutritional systems and dialysis have increased the time required and the skills necessary to deliver services in long term care homes. More residents require special treatments such as catheter care, oxygen therapy, physiotherapy, psychotherapy and speech therapy. As a result, the level of resident acuity and complexity of health services have continued to rise. The complexity of care of long term care residents is largely due to a number of factors including:



- technological advances have been introduced that are more complex, require more staff time and demand more complex skills;
- increased acuity levels have been fuelled by the placement in homes of heavier care residents that would formerly have remained in hospital;
- a decrease in the rate of admission of residents with less serious problems because of the policy shift to funding community services and home care; and
- a gradual shift of seniors' mental health services into facility-based long term care.

Mental Health

Historically, Canadians with mental illness have not fared well. Most were confined to institutions where conditions were crowded, discharge was rare and care was custodial rather than restorative. Mistreatment was common, some examples of which have only recently come to light. By the 1950s, there were around 75 mental institutions in Canada. Patients included many people who did not have mental illness, such as mildly confused elderly individuals without family support who were designated as *mentally disordered*.

Deinstitutionalization began in the 1960s, which resulted in two thirds of the psychiatric beds in Canada being closed within twenty years. Factors influencing this transformation included growing awareness of inappropriate placement, new methodologies in caring for the mentally ill, the development of effective psychotropic medications and progress in establishing mental health programs in the community.

The process of deinstitutionalization in Canada was further encouraged in the 1980s by the inclusion of a *Canadian Charter of Rights and Freedoms (Charter)* in the *Canadian Constitution*. The introduction of the *Charter* resulted in a review of legislation relating to compulsory care, with the result that community support, rather than institutional control, was the preferred option for treating those with mental illness.

The idea that Canadians with mental illnesses would increasingly be cared for at the community level was also consistent with regionalization of health services which represents a devolution of authority from the provincial to the regional levels. Several provinces have created regional/district health boards to oversee the provision of mental health services. Today, most people with mental illness are treated in the community rather than in hospitals.

A report by the Canadian Institute for Health Information in 2005 indicated that inpatient hospital care for individuals living with mental illness is continuing to evolve in Canada. The report revealed that fewer people are being admitted to hospital and for shorter periods of time as a result of more refined medications and the availability of care through outpatient and community-based services. Between 1994–1995 and 2002–2003, the number of Canadians accessing inpatient mental health services declined from 715 per 100,000 people to 607 per 100,000 of our population. The average length of stay also dropped from 66 days to 41 days, over the same period (CIHI, 2005).

Yet, Phil Upshall, Executive Director of the Mood Disorders Society of Canada, believes that the report's interpretation of data on hospital stays is overly optimistic.

I believe a more realistic interpretation for why hospitalization rates are down has to do with political and economic decision-making rather than measures of clinical necessity and treatment efficacy. These reductions coincide with the fourth wave of deinstitutionalization. We saw provincial governments across the country in the 1990s trim their budgets by closing psychiatric facilities and cutting psychiatric beds in general hospitals. We lost tens of thousands of treatment beds. While the money saved by these closures was to be shifted to community-focused mental illness care, in actual fact the money was shifted to other portfolios with a 'higher priority' than mental illness and mental health programs. This deliberate decision by provincial governments across Canada has meant that community care programs were non-existent for years and only now have begun to materialize. I don't think it is a coincidence that as the rates and duration of hospitalizations goes down, the levels of incarceration; suicide and homelessness of the mentally ill are going up (CNW, 2005).

The prevalence of mental illness is such that the demand for services is greater than the supply. As a result, many who are mentally ill lack care, or receive inadequate care (Canadian Mental Health Association [CMHA], 2006). This reality is not limited to those suffering in the community. It also applies to residents in long term care homes.

Facility-based long term care has been described as the mental institution of the 21st century. Dr. David Conn, Past President of the Canadian Academy of Geriatric Psychiatry, has expressed on a number of occasions that long term care homes are the modern mental institutions for the elderly. The characterization has been supported by other professionals including Judy Armstrong, the Program Coordinator of the Seniors Mental Health Team in Saint John, New Brunswick (Fellows, 2008).

Dementia affects approximately 60 percent of all residents, while depression affects 30 to 60 percent of those residing in long term care (PricewaterhouseCoopers; Barnes, 2001). Yet the staffing mix, physical structure, supportive programs and behavioural therapies to address the emotional and cognitive needs of these residents are sadly lacking in many long term care homes.

This deficiency in proper mental health services does not imply that a long term care home is the wrong setting for residents with mental illness. Quite the contrary, some homes are capable of providing the most appropriate care for persons suffering from certain types of maladies. Dr. Ken LeClair, Co-Chair of the Canadian Coalition for Seniors Mental Health, expressed in a 2009 interview that his mother “was the happiest person when she went to a nursing home because they were able to take care of her needs.” Other seniors who enter long-term care “when they have a high level of need, actually come out of their depressions” (Gerstel, 2009).

Homes must be adequately resourced to provide the right programs, establish the right environment and attract and retain the right mix of qualified staff to provide for those with cognitive and mental disorders. Government funding for long term care health services typically provide for the residents' basic needs: safety, meals and physical care. But funding is woefully inadequate to provide comprehensive mental health services in the facility-based long term care environment.

In some regions, adults with complex mental health problems have found it difficult to obtain placement in facility-based long term care because they are viewed as difficult to serve and not a good fit in an environment that focuses on care of the frail elderly.

However, opposition by long term care homes has been overcome by the emergence of single entry systems. Homes are often obligated to admit young adults with serious mental illness despite legitimate concerns over the safety of residents and staff, as well as anxieties over their ability to address the complex needs of this type of resident.

To reduce agitation, protect other residents and reduce demands on overworked

Funding is urgently needed for social programs to replace pharmaceuticals, and to provide staff training as well as better therapeutic physical environments.

staff, homes may use pharmaceuticals as an approach for managing behaviours. Inevitably, some homes will overuse them. Long term care associations, employers,

unions and other stakeholders have lobbied for increased funding to meet the increased service requirements of more challenging residents with mental disorders. Funding is urgently needed for social programs to replace pharmaceuticals, and to provide staff training as well as better therapeutic physical environments. In order to meet the challenge of providing more complex services, long term care homes should augment their staff numbers and realign their staff mix. Instead, many have been forced to reduce staff ratios and to replace professional staff with less qualified workers in order to cope with reduced budgets.

A CIHI report in 2008 revealed that 45 percent of residents living in a sample of Nova Scotia long term care homes displayed behavioural symptoms including resistance to care, verbal abuse, socially inappropriate behaviour and physical abuse. Delirium, insomnia and depression were the three most critical factors associated with aggressive behaviours in the homes studied. The report also suggested that having more than one condition increased a resident's risk of striking out. For example, residents who suffered from both delirium and depression

were more likely to display aggression than residents suffering from just one condition. These findings have relevance for long term care, not only in Nova Scotia, but across the country. The most effective method to decrease the incidence of aggression in long term care is to address underlying mental health conditions. This will only occur if the sector is properly resourced.

Angela Greatley, CEO of the Sainsbury Centre for Mental Health in England, stated that mental illness is not just a costly burden on those who live with it. It is also a major, though underestimated, contributor to poor physical health. Mental health problems worsen the prognosis of many physical conditions. For example, stroke patients with depression are four times as likely to die within six months as those who are not depressed (Greatley, 2009). It is time to assign mental health the priority status it deserves because there is no health in long term care without mental health.

Perhaps the most pressing problem is the inappropriate transfer of mentally ill patients from other facilities into long term care homes because there is no other place for them to go. So great is the challenge that some are calling for a system-wide, comprehensive strategy to deal with it. In an open letter to the Ontario Minister of Health and Long-Term Care in December, 2007, the CEO of OANHSS expressed that:

...there are few alternate care locations where potentially violent residents can be transferred. We need specialized units that can care for those with aggressive behaviours so that other residents and staff in our homes can live and work in a safe environment. In addition, work needs to begin to address other special populations such as those with developmental disabilities and those with acquired brain injury (ABI), Huntington's disease and substance abuse issues (OANHSS, 2007).

The challenges associated with caring for residents with mental health problems are not unique to Canada. The need to support and strengthen mental health services in long term care is felt worldwide. The unmet mental health needs of long term care residents moved the International Psychiatric Association (IPA) to form the Mental Health Service Provision in Nursing Homes and Residential Care Facilities Task Force in 2005. Task force members have found similar issues to be evident across the globe and include:

- inadequate staffing levels;
- lack of staff training in mental health;
- poorly designed long term care homes;
- failure to assess residents in a timely manner;
- inappropriate use of psychotropic medications; and
- limited availability of mental health professionals. (Conn, et al, 2008).

Cultural competence

The cultural diversity of Canadian society has and will continue to have a significant impact on facility-based long term care. Culture in its simplest form describes the ways in which members of a group communicate and understand each other. Sometimes the nuances of meaning are generated by behaviour rather than words, and much of the interaction between members is determined by shared values operating at an unconscious level. Many groups have their own distinctive culture and in Canada the most commonly recognized cultures include but are not limited to:

- First Nations, Inuit and Métis
- Asian (Chinese, Japanese, Korean)
- East Indian
- German
- Jewish
- Lutheran
- Italian
- Gay, Lesbian, Bisexual, Transgender, Two-Spirited, Queer, Questioning (GLBTTQQ)

Each of these cultures can have different expectations of long term care, and some residents may belong to multiple cultures simultaneously. The key is to ascertain those cultural affiliations through a detailed social history (Royal New Zealand College of Family Practitioners, 2007) and adapt service delivery to reflect an understanding of cultural diversity practice. Sensitivity and responsiveness to cultural realities can have a positive impact on the quality of care, quality of life, and resident, family and staff satisfaction. Achieving staff satisfaction in diverse long term care communities will necessitate education in diversity to achieve the ultimate in positive team dynamics.

The cultural diversity of Canadian society has and will continue to have a significant impact on facility-based long term care.

Culturally sensitive long term care services for seniors have traditionally been established by organizations associated with large ethno-cultural communities. Some of the standard-bearers for supporting the unique cultural values of their resident population include the Simon K.Y. Lee Seniors Care Home in Vancouver and the Apotex Jewish Home for the Aged in Toronto. Other

homes have effectively partnered with local communities to establish a cultural-specific unit as a *neighbourhood* within the larger home. Many homes are seeking to provide culturally relevant services for their residents, and while it may not be possible to meet all of the needs of every resident from Canada's vast number of unique cultural communities, facility-based long term care is likely ahead of other health providers in the area of cultural competence.

Cultural competency is a double-sided coin. It constitutes self-awareness and knowledge of one's own belief system on the one side, and understanding of another person and his/her cultural values on the other. Cultural competency seeks to eliminate stereotyping and to build positive and supportive relationships. It requires long term care stakeholders to:

- value diversity;
- conduct an internal assessment;
- manage the dynamics of difference;
- acquire and employ cultural knowledge; and
- adapt to diversity and the cultural contexts of individuals and communities served (AHRQ, 2009).

Concerned Friends of Ontario Citizens in Care Facilities produced a 2007 model toolkit on creating welcoming communities in long term care. Among its many insightful recommendations, the guide encourages homes to reach out to ethno-cultural and religious communities to engage trainers who understand the cultural background of residents, and to train staff in the ways and means of demonstrating respect. Community partnerships are essential to bridging the

gap between cultural groups and long term care homes, especially when the group is not familiar with long term care, or the home needs to better understand the culturally influenced behaviors and traditions of the specific group.

Perhaps the most marginalized culture is the GLBTTQQ community. Most GLBTTQQ seniors aged prior to gay liberation so they have lived much of their lives surrounded by overt discrimination and hostility. Older GLBTTQQ seniors even feel slighted within their own community. While literature suggests that GLBTTQQ people make up between 5 and 10 percent of urban populations, the gay community's focus on youth has led to numerous unmet needs of gay seniors in areas such as social outlets, recreation and housing (Hainsworth, 2006). The aging of the GLBTTQQ community needs to be addressed as many individuals will fear entering a long term care home if they have to deny their identity and suppress their own human emotions.

Culturally-competent organizations view diversity as an asset rather than a problem. Fortunately, leading cultural practices are quickly emerging along the long term care landscape. The City of Toronto Long-Term Care Homes and Services partnered with the GLBTTQQ community to develop a toolkit to guide long term care homes in the creation of gay-positive long term care. Homes need to share their successes and actively support networks of evolving knowledge to meet the challenges of diversity.

Spirituality and Palliative Care

Spirituality is about finding meaning, purpose and connection in life. Many believe that loss of connection can lead to pathology and illness. This belief is admirably captured

in some of Canada's aboriginal cultures where all persons are interconnected in a 'web of creation'. So, when one person loses that sense of connection and becomes ill, a disturbance is created among others in the community (Lusk, 2008).

Facility-based long term care is a community of its own with strong bonds between residents and staff. In some homes a community of care has become so entrenched that when a resident, staff or volunteer passes away it is akin to losing a member of one's own immediate family. This need not be construed as a bad thing. It is a positive cultural signal but the resulting despair must be acknowledged, understood, and managed with sensitivity.

The major mistake in long term care is equating spiritual care solely with religion. Religious care at its best should have spiritual dimensions, but not all spiritual care is religion based. Spiritual care is person-centered and makes no judgments about the individual's beliefs or lifestyle orientation.

A study which examined the impact of spirituality and religion on depressive symptom severity in a sample of the terminally-ill found that the beneficial aspects of religion were primarily those that related to spiritual well-being rather than religious practices alone. Spirituality emerged as a source to strengthen faith, hope, and courage (Gill, 2005). Accordingly, a multi-dimensional approach to spiritual care necessitates training in cultural competence and sensitive practice within an environment of respect for all.

Palliative care (end-of-life care) was developed to address the unmet needs of dying individuals and their loved ones. Its purpose is to neither hasten nor postpone death but to provide relief from pain and

suffering during the end of a person's life. Palliative care integrates the medical, psychological and spiritual aspects of care for the resident and offers a valuable support system to help relatives and friends cope during the bereavement period. All activities must be done in a culturally appropriate and sensitive manner. Ideally, palliative care protects the resident's spirit. This requires an understanding on the part of all long term care staff that while there is erosion of the human body, the spirit remains.

How critical is the connection between spirituality and palliative care?

Researchers in the United States studying a random sample of cancer survivors found that spiritual care was more important to the individual's quality of life than support groups, counseling sessions or even spousal support (Gill, 2005).

A cross-sectional survey of 426 directors of care (known in some other jurisdictions as directors of nursing) assessed the current practice of end-of-life care in Ontario long term care homes. Staffing levels were viewed by a majority of the respondents as being inadequate to provide quality end-of-life care (Brazil et al., 2006b). A similar survey was completed by 275 medical directors representing 302 long term care homes in Ontario with identical results. Most medical directors (67.1%) reported insufficient staffing levels as an impediment to the provision of palliative care. Further barriers to effective end-of-life care included the heavy time commitment required and a lack of needed equipment (Brazil et al., 2006a).

Facility-based long term care is a community on its own with strong bonds between residents and staff.

Health care professionals have historically recognized the need for increased education in palliative care and have expressed a lack of competence in the delivery of end-of-life care. In spite of the emergence of palliative care leading practices and advances in pain and symptom management, front line staff concur that there is still a need for more training in palliative care (Kortes-Miller et al., 2007). A strong palliative care approach can be realized through committed leadership, complete staff and management involvement in decision-making, and implementing changes in manageable segments (Peacock, 2008).

Long term care homes should become palliative care centers of excellence given that 39% of all deaths occur in facility-based long term care in Canada and there is a growing preference among residents to remain there among family and friends during their last days rather than being

Residency requirements for admission to facility-based long term care cause unnecessary stress on Canadian families.

transferred to a hospital. There is a dearth of information about the quality of palliative care in Canada but if major studies were conducted they would likely reveal extreme variances across the country. Notwithstanding the fact that some homes provide exceptional end-of-life care, there is an urgent need to raise the knowledge quotient of all long term care staff in the areas of spirituality and end-of-life care. This investment in people will promote a culture of care that benefits not only the dying resident but all residents in facility-based long term care (Brazil, 2006a).

Jurisdictional Boundaries

The lack of federal funding and related criteria have resulted in each province

and territory offering a different range of services, different degrees of coverage and the levying of different out-of-pocket user fees for facility-based long term care. This variation in the provision of extended health services presents both opportunities and challenges. It enables each province and territory to adapt extended health programs to meet the specific needs of its population and adapt to regional realities. But dissimilarities can also create broad inequities and barriers. Canadians are not free to move to their location of choice for long term care services, should they choose, because provincial or territorial residency requirements and waiting periods vary considerably. This becomes an issue of the portability of services.

A province cannot be expected to open its doors indiscriminately to individuals seeking facility-based long term care. But there should be reasonable and humane provisions for the transfer of citizens across jurisdictional boundaries when care is needed. If federal funding of facility-based long term care was linked to compliance with pan-Canadian objectives or principles such as reciprocity, residents could move to a long term care home in another province, pay the local accommodation fee, and be reunited with family. Currently, residency requirements for admission to facility-based long term care cause unnecessary stress on Canadian families.

The Potential of the Social Union Framework for Canadians

The *Social Union Framework for Canadians* was introduced in 1999 to improve social programs. This agreement provides for the introduction of new social initiatives with the consent of the majority of the provincial and territorial governments. It provided for

cost-sharing arrangements with the federal government which allows provinces and territories to meet agreed on objectives and principles while using the detailed program design and mix best suited to their own needs. A provincial or territorial government which, because of its existing programs, does not require the total transfer to fulfill the agreed upon objectives would be able to invest funds in the same or related areas.

If legislation encompassing all jurisdictions is not possible, it may be acceptable to obtain some degree of consensus on federal funding of continuing care services, including facility-based long term care, by using a process similar to the Social Union Framework. A modified model of universal coverage, which would allow for reasonable co-payments, might be feasible. As well, some sort of reciprocity or portability might be possible to avoid stringent residency requirements and waiting periods for Canadians who would better be served in a different province than where they currently live. The transfer of clients might be possible, without penalty to existing provincial budgets, through federal legislation (Hollander and Chappell, 2002).

Inappropriate Hospitalization

Inappropriate hospitalization occurs when hospitalized patients cannot be moved to facility-based long term care or discharged home with appropriate support. All provinces and territories have effectively streamlined the assessment process through central placement and have tightened up the requirements for applicants to take an available long term care bed whether this is the person's first choice or not. Most provinces have policies where hospitalized patients are responsible for a co-payment once they are medically discharged even though they

remain in hospital. Despite the incentives available in provinces and territories for medically discharged patients to leave hospital promptly, there are many hospital patients waiting for weeks and months for a long-term care bed to become available to them.

Another aspect of inappropriate hospitalization occurs when long term care residents are transferred back and forth between the home and the hospital whenever there is a decline in their health status. Inappropriate hospitalization of residents is costly and devours scarce health service funding which could be directed to enhance facility-based long term care services. A study from New Brunswick indicates that diagnostic assessments and treatments such as intravenous therapy could occur in long term care homes if there were adequate numbers of skilled professional staff to deal with minor fluctuations in health status (McCloskey, 2002). Studies in the United States have shown that staffing models may impact the number of hospital transfers. Long term care residents were less likely to be sent to hospital from homes that had access to registered nurses, nurse practitioners and physicians (Konetzka et al., 2008; CIHI, 2009).

Inappropriate hospitalization may also occur near the time of death, a period which generates higher health costs as a result of substituting hospital medical treatments for palliative care. In some instances, appropriate palliative care can be provided in long term care homes and costly transfers to hospitals avoided. One study showed that residents who had completed advanced directives had half as many hospital admissions, but the same mortality rate, as those who did not have advanced directives (McCloskey, 2002). Avoidable hospitalizations lead not only to higher

health care costs but also to stress and strain on the physical and mental health of the frail elderly (Doty et al., 2008).

Many seniors are more concerned with dignity and quality of life than extended life. Dr. Michael Gordon (2001) identified a number of challenges related to end of life care, including tube feeding during end-stage dementia, inappropriate cardiopulmonary resuscitation, and the

The challenge is to find the right balance between home care, community services, supportive/assisted services and long term care.

provision of expensive drugs or other therapeutic interventions for older individuals with a short life expectancy.

In addition to the ethical debate about quality of life, there is also an ethical debate about the use of finite resources. Ethicists question the provision of invasive medical interventions over comfort and pain control. In many cases, the most appropriate service is palliative care rather than attempts at cure. Advance directives offer one response to these ethical dilemmas.

Balancing the Delivery of Continuing Care

In the 2003 Health Accord the federal government identified its intention to provide first-dollar coverage for acute home care substitution services, as well as for some mental health and palliative services outside of hospitals. The 2004 Accord provided the funding for post acute home care, palliative care as well as post acute mental health home care. Many believe that this pan-Canadian home care package has not gone far enough and there are calls for the federal government to also augment publicly funded long term home care services (Hollander, 2003).

The Canadian Healthcare Association has consistently advocated for a broader basket of publicly funded continuing care services. No one service—be it home, community or facility-based long term care—is automatically the best option for every person. The challenge is to find the right balance between home care, community services, supportive/assisted living services and facility-based long term care. This balance must weigh the individual's preferences, the ability of informal caregivers to assist with care needs and the capacity of governments to sustain public funding.

In a number of studies, Hollander and colleagues have used available data from various jurisdictions to identify the cost-savings of various modes of care. One study provided evidence that maintenance/preventive home care services reduce health expenditures throughout the entire health service continuum and such cost savings extended over a period of years. In fact, a client's health status is often stabilized by preventing deterioration in functional status over time (Hollander and Chappell, 2002). In addition, when caregiver time was factored in at minimum wage, home care costs were markedly lower. When caregiver time was calculated at a replacement wage, costs were still lower but not significantly so. However, the costs of care at home increased as the care requirements of the clients increased.

The SIPA (Services integer personnes âgées) project in Québec employed a community-based coordinating multidisciplinary approach involving community services, long term care homes and hospitals. The 2000 evaluation found that there were reductions in the numbers of patients in acute care hospitals awaiting placements and higher numbers of emergency room users returned

home after emergency room visits. There was a shift in costs from hospitals and long term care homes to the community. Savings to hospitals and long term care homes were offset by increased spending on home/community services. The recipients perceived that they received better quality of care and were more satisfied with the outcomes.

The dilemma in publicly funding a basket of preventive/maintenance services is for the funders to decide what constitutes bona fide medical services and what constitutes basic household functioning, and which household services should be financed out of pocket and which should receive publicly funded assistance. How do public funders decide when cleaning services are a frill, a social service or health necessity? The unrestricted provision of home support services could become a public financial drain, diverting scarce public funds from actual health services to supportive social services (Gray, 2000). Conversely, there is strong evidence that it is supportive social services which maintain many frail elderly in their homes, delaying or preventing admission to more expensive facility-based long term care (Hollander and Tessaro, 2001).

There is an important role for hospital and facility-based long term care services, when individuals have high care needs or are very ill. If the care intensity – as expressed in the number of hours of care, the number of service providers, or the necessary equipment requirements – becomes extensive, home care expenditures may become more costly than facility-based long term care. Thus, the costs of home care can exceed the costs of similar health services in long term care homes. This again raises the question of what can be reasonably and equitably funded across Canada.

According to an article in *The Medical Post* (September 16, 2003), long term care homes may offer other cost-savings. Elderly clients receiving home care, and even healthy seniors, were more likely to require costly acute care than residents in facility-based long term care. These findings reveal that residents benefit from ongoing daily care, on-site nursing supervision and regular attention from physicians, all of which are standard services in long term care homes. Problems and complications are typically addressed quickly and effectively in the facility-based environment. So, problems are often caught early and addressed promptly, thus avoiding a transfer to acute care.

The quality of life for informal caregivers is another aspect to be factored into the equation. The shift to home care as an alternative to hospital and facility-based long term care raises questions about the capacity of informal caregivers to cope. There are hidden expenses incurred by informal caregivers in terms of out-of-pocket expenses, in-kind donations of time, and lost employment time and wages. Emotional stress and increased health risks are also critical issues, especially when the informal caregivers are themselves elderly persons.

The most appropriate place for individuals with dementia is not always in the home, even when preferred by families and the individuals themselves. Setting unrealistic expectations to maintain relatives with dementia at home exposes family members to feelings of failure and abandonment should placement in long term care become necessary.

The merits of facility-based care versus home care are not a subject of debate. The matter is not an either-or proposition.

An adequate environment for an individual living with dementia should include exit control, outdoor freedom, wandering space, sensory stimulation and appropriate privacy. Programs sensitive to the realities of dementia and the support of specially trained health care professionals and staff can enhance functioning and add quality of life. Such a customized environment is not always available in the home on a daily around-the-clock basis.

The merits of facility-based care versus home care are not a subject of debate. The matter is not an either-or proposition. Facility-based care and home care each occupy a critical place along the healthcare continuum. We need both to be well managed, well staffed, well funded and well functioning.

Recommendations

Recommendations for Facility-Based Long Term Care within the Continuing Care Sector

The Canadian Healthcare Association and its provincial and territorial members have strongly supported and will continue to support access to a broad continuum of comparable health services, based on health need and not the ability to pay, no matter where one lives in Canada.

Over the last decade, several studies and reports have been commissioned to evaluate the state of continuing care in Canada. Action at all levels is required to ensure that Canadians who need continuing care receive the right care, at the right time, and in the right setting.

Common approaches and definitions need to be in place to reflect the values held by Canadians regarding the care of individuals who require facility-based long term care. The following recommendations are designed to help contribute to the transformation of facility-based long term care and the provision of appropriate services across Canada.

1.0 Ensure Adequate and Sustainable Funding for Facility-based Long Term Care Tied to Pan-Canadian Principles.

- 1.1 The federal government must show leadership and establish a Facility-based Long Term Care Fund. The precedent has been established with the federal government directing funding to the provinces to address common priorities through the Infoway Fund in 2001, the Primary Health Care Transition Fund in 2000 and the Health Resources Fund in 1966. Additional federal funding must be linked to pan-Canadian principles to ensure Canadians have access to comparable facility-based long term care.



The principles must be developed collaboratively by the federal, provincial and territorial governments.

Accessibility and comparability for facility-based long term care is achievable without providing first-dollar coverage for accommodation costs and without standardizing every feature of facility-based long term care among jurisdictions.

- 1.2 Rectify the current underfunding of facility-based long term care and prepare a predictable and sustainable funding base for future generations of seniors.
 - If facility-based long term care is expected to meet future expectations for quality, safety, and appropriateness, we must fund it properly and hold homes accountable for excellence. Neither can exist without the other. Resource allocation and accountability is a package. Collaboration and commitment will be required among multiple stakeholders including government, employers, residents, employees, unions and other key stakeholders.
 - Lack of funds can prevent homes from creating environments where residents live a fulfilling, quality of life closer to the lives enjoyed in their own homes. A clean and safe environment joins respectful treatment as the most frequently cited criteria in the quality of life for residents.
 - Prepare now for flexible and appropriate continuing care services for future generations of seniors. While people are expected to age in a healthier manner, and medical spending should not increase as rapidly as the increase in the number of seniors, growth in the proportion of seniors in Canada will require health planners and policymakers to consider the preferences and needs of the next generation of seniors. Preferred options will include respite care, community programs, supportive/assisted living and facility-based long term care. Gradually, the pressure exerted by baby boomers will ease and health planners must consider eventual attrition and not create static systems.
- 1.3. Stop shifting health costs to residents.
 - CHA believes that medical *and* personal care = health services. Vulnerable individuals are being required to pay out-of-pocket for facility-based long term care which should be publicly funded and available.
 - Pan-Canadian guidelines need to be established to make the distinction between accommodation costs and health service costs. While CHA is not opposed to a co-payment for reasonable room and board (i.e., meals, accommodation, laundry, building maintenance, basic administration expenditures), the charges should not rise above what a healthy independent individual would pay for comparable, modest room and board. The resident who is charged more than the cost of basic living expenses is paying the cost of health services out of pocket.
 - All health care (medical *and* personal care) should be funded. In facility-based long term care, this would include incontinent supplies, pressure mattresses and basic therapeutic seating.

- Explore a social insurance model of long term care insurance. Long term care insurance would:
 - be sponsored by government and nationally or provincially administered
 - be defined by statute in terms of benefits, eligibility requirements and other aspects
 - be funded by taxes or premiums paid by or on behalf of participants
 - be earnings related
 - serve a defined population (with specifically defined eligibility criteria) for receipt of benefits
 - have compulsory participation.

As a social insurance program, long term care insurance would pool the risks. A government plan, though having eligibility requirements to receive benefits, would not deny benefits on the basis of pre-existing medical conditions. In a publicly administered long term care plan, there would be an equitable distribution of premium costs and care would not be provided on the basis of ability to pay but rather on the basis of need. This form of long term care insurance would be mandatory. Like CPP, all employed (and self-employed) individuals over 18 years old would contribute a defined portion of their income to a national/provincial plan.

2.0 Focus on Quality and Accountability to Canadians.

Elevate quality of life considerations to the same level of importance as quality of care. External review by accreditation and compliance and internal quality review processes should focus attention both on quality of care risk indicators such as the prevalence of pressure ulcers, weight loss, urinary tract infections, falls and restraint use and also quality of life information gleaned through annual resident and family surveys. Long term care ownership and governance must be accountable, proactive, and responsive to ensure the safety, quality of care and quality of life of Canadians who require facility-based long term care.

- 2.1 Establish mandatory requirements for all long term care homes to conduct annual resident, family, and staff satisfaction surveys that address quality of life issues.
- 2.2 Use existing data more effectively and develop comparable classification systems to facilitate the collection of data that can be compared between and within jurisdictions.
 - CIHI needs to receive adequate funding so that it can collect and report comparable pan-Canadian indicators specific to facility-based long term care, including but not limited to staffing ratios, staff qualifications, levels of care, waiting lists, admissions, discharges, and deaths in long term care homes.

- The long term care sector must have adequate resources to supply CIHI with accurate and comparable data to populate the indicators that have been developed.
- Preliminary results of a RAI-MDS 3.0 national trial in the United States show promise for an improved system in the future. Test the suitability and effectiveness of RAI-MDS 3.0 in a sampling of Canadian long term care homes.

2.3 Promote research and invest in staff education and leadership training.

The provision of dignified care and service must become part of the DNA in every long term care home. Such a transformation will require an investment in research, staff development and leadership training. Simply augmenting the knowledge of management and staff will result in little benefit to residents if the learning is not consistently integrated into practice. Given the wide range in educational preparation and the high turnover in staff, it is critical that training in dementia care, behaviour management, and dignity in long term care is provided routinely. The challenge in long term care is not only to reach a large audience but also to codify leading practices. Facility-based long term care must move beyond knowledge transfer and toward knowledge integration in the workplace.

- Research capacity needs to be expanded across the healthcare continuum. Capacity includes adequate funding, trained human resources, accurate and timely data, an appropriate infrastructure for analysis, and research sites located both in academia and the field.
- Target research areas on the elderly and on disabilities at all ages (e.g., clinical, health service and population health and especially research on every aspect of the dementias.)
- Codify leading practices that have the potential to delay the onset of disability, maintain residents at the optimal level of functional ability, and deinstitutionalize the long term care home environment.
- Funding for individual long term care homes should include allocations for ongoing in-service education and training for all levels of staff in order to provide a learning environment and ensure the effective implementation of leading practices.

2.4 Enhance the teaching capacity of long term care homes.

- The establishment of teaching long term care homes should be given immediate priority as they can serve as natural laboratories for research activities.
- Every post-secondary health education program should have an affiliation with a long term care home in their community. Such alliances would promote the cultural transformation that is vital if we are to effectively serve the long term care residents of tomorrow.
- A sustainable and replicable pan-Canadian model of teaching long term care homes

would infuse intellectual vigor and better support the current and prepare the future workforce in this field.

2.5 Establish mandatory accreditation in facility-based long term care.

- Accreditation should become the norm for long term care homes. Transitional funding should be made available so that homes are adequately resourced to be fully engaged in this quality-driven process.

3.0 Invest in health human resources.

Appropriately educated and trained human resources help form the foundation on which quality of care and quality of life is established and maintained in facility-based long term care. In order to meet the challenge of providing for the complex needs of residents, long term care homes may have to augment their staff numbers and realign their staff mix. A higher acuity in long term care homes requires sufficient funding to ensure appropriate staffing complements. In most jurisdictions, increased funding is needed immediately as staffing levels and ratios are generally inadequate. Quality of life and death are affected because of reduced staffing as a way to stay within budget.

3.1 Optimize the full scope of practice.

The motivation should not be to displace one health care professional with another, but rather to recognize the unique skills that each player brings to the team and facilitate informed decision-making within an interdisciplinary team environment.

3.2 Develop pan-Canadian minimum staffing models.

Health delivery is a provincial/territorial responsibility but since long term care affects all Canadians at some point in their lives, it is appropriate for the federal government to spearhead the development of broad pan-Canadian objectives and principles. This is especially true if the federal government were to take on additional funding responsibility in long term care. All stakeholders – residents, families, employers, staff, unions, researchers – should be asked to provide input into a national deliberation on the subject to help ascertain the appropriate staffing benchmarks. Staffing numbers and mix should be publicly reported to ensure transparency and enable a higher level of informed consumer choice.

3.3 Develop a national personal support worker (PSW) curriculum.

There are inconsistencies in the level of basic training required for personal support workers (also called special care aides or personal care aides) across Canada. Personal support worker educational programs in community colleges, career colleges, not-for-profit organizations and boards of education should adhere to a mandatory pan-Canadian curriculum and standardized educational outcomes.

3.4 Develop a strategy to attract people to work in facility-based long term care.

- There is a well-documented shortage of registered nurses and geriatricians.
- Long term care must attract individuals from all health care professions and vocations who have a genuine desire to work in this field and make a difference in their lives of residents. An apprenticeship framework should be considered to engage young adults in vocational learning and show them the possibilities for a rewarding career in long term care.

4.0 Reflect a Shared Approach to Risk.

- 4.1 Ensure access to comparable services no matter where one lives in Canada and regardless of the illness or the care setting.

We have not yet had the debate in this country that heart disease and cancer were illnesses for which there should be insured services, but dementias or debilitating conditions like Parkinson's disease were to be treated differently. This is essential to achieving a continuum of care approach.

- 4.2 Respect regional realities.

Regional realities must be considered in planning health services and developing pan-Canadian principles for facility-based long term care. A publicly funded long term care policy should be flexible and take into consideration the variation in the population distribution of seniors throughout the jurisdictions.

5.0 Guarantee Reciprocity between the Provinces and Territories.

At a minimum, portability of long term care services across Canada will cover individuals until they meet their residency requirements, and thus prevent them from losing benefits and services as they move from one part of the country to another to be closer to family. This recommendation would give facility-based long term services the same measure of portability as those types of health care services listed in the *Canada Health Act*.

- 5.1 Develop reciprocal agreements between the provinces and territories, so that movement among provinces and territories is seamless. Residents should be able to live in long term care homes reasonably close to home or close to family/next of kin.
- 5.2 Allow funding to follow the resident in an interprovincial transfer, so that provinces with massive in-migration do not experience excessive costs.

6.0 Develop Cultures of Caring.

Cultures of caring will never materialize in homes or systems that cling to the institutional model of care. The institutional model focuses on tasks, schedules and processes related to illness. It stifles innovation and is associated with poor outcomes for residents, frustration for family members, and an unsatisfying work environment for staff. Cultures of caring will assign greater priority to the psychological, social, and spiritual elements of life.

Bureaucratic traditions must succumb to cultural transformation. For this to happen we must devote less energy into creating additional regulations and more attention to processes that will help transform facility-based long term care into desirable places to live and work.

6.1 Require long term care homes to be reflective of home life rather than institution life.

Dignity and respect should be two fundamental values on which a pan-Canadian facility-based long term care system is built and maintained. The consumers and baby boomers of today will be the residents and families of tomorrow. They will not accept institutional settings, structured schedules, rigid dining hours and waiting for care. Privacy, respect, flexibility and the right to manage one's own risk should be the cornerstones of facility-based long term care services.

6.2 Address the needs of non-seniors.

A revised and clear policy needs to be in place in each jurisdiction regarding the placement of younger adults, the physically and mentally disabled and other populations. This will ensure that, if facility-based long term care is considered the best option, age-appropriate environments or age-specific wings or modules are available to meet their needs.

6.3 Address end-of-life care.

- Long term care homes should become palliative care centers of excellence given that 39% of all deaths occur in facility-based long term care in Canada and there is a growing preference among residents to remain there during their last days rather than being transferred to a hospital. There is a need to raise the knowledge quotient of all long term care staff in end-of-life care. This investment in people will promote a culture of caring that benefit not only the dying resident but all residents in facility-based long term care.
- Adequate public funding for appropriate end-of-life care must be available.
- Identify appropriate health services in the year of death: palliative care rather than aggressive medical treatment, the promotion of advance directives, the continuation of care in facility-based long term care rather than costly transfers to hospitals near the time of death, and culturally-sensitive and humane practices throughout the health care system.

6.4 Address mental health care.

Long term care homes can provide appropriate care for persons suffering from Alzheimer Disease and related dementias. But if the recent trend of admitting former psychiatric patients is to continue, homes must be adequately resourced to provide the right programs, establish the right environment and attract and retain the right mix of qualified staff to provide care and support for those with mental disorders. Government funding for long term care health services typically provide for the residents' basic needs – safety, meals and physical care. Funding in every jurisdiction is woefully inadequate to provide comprehensive mental health services in facility-based long term care.

7.0 Respect Volunteers and Families.

7.1 Determine the optimal use of volunteers within long term care homes.

As the baby-boom generation retires, there will be an influx of healthy senior volunteers to contribute talents, skills and time to the facility-based long term care sector. Creative ways to engage adult and youth volunteers need to be devised.

7.2 Welcome family members as participants in the daily lives of residents

Families should be recognized as a component of the multidisciplinary team. This can be accomplished both through formal processes such as attendance at care conferences and membership on quality improvement committees and through informal engagement activities. Positive engagement can strengthen ties with a secure and supportive family and defuse or prevent problems with families that suffer from dysfunction.

Families and volunteers are not a substitute workforce. Assistance rendered by family and volunteers must be to augment basic care by staff, not to replace it. Family members should be encouraged to participate in the daily life of their family in their appropriate roles as companions and relatives.

Families and volunteers should be able to avail themselves of all appropriate educational activities in the home to heighten their knowledge and enhance their comfort level with common resident conditions such as Alzheimer's disease and related dementias.

Recommendations

Recommandations concernant la prestation des soins de longue durée en établissement au sein du secteur des soins continus

L'Association canadienne des soins de santé et ses membres provinciaux et territoriaux ont toujours fermement appuyé l'accès à un vaste continuum de services de santé comparables, fondés sur les besoins en santé et non sur la capacité de payer, peu importe où l'on vit au Canada. Ils entendent continuer dans la même veine.

Au cours de la dernière décennie, plusieurs études et rapports ont été commandés pour évaluer l'état des soins continus au Canada. Il faut maintenant prendre des mesures à tous les niveaux pour assurer aux Canadiens qui ont besoin de soins de santé continus l'accès à des soins appropriés, au bon moment et dans le milieu adéquat.

Il importe de déterminer des approches et des définitions communes qui tiennent compte des valeurs des Canadiens concernant les soins aux personnes ayant besoin de soins de longue durée en établissement. Les recommandations qui suivent ont pour but de contribuer à la transformation des soins de longue durée en établissement et à la prestation des services appropriés à la grandeur du Canada.

1.0 Assurer un financement adéquat et durable au secteur des soins de longue durée en établissement, lié aux principes pancanadiens.

- 1.1 Le gouvernement fédéral doit faire preuve de leadership et créer un Fonds des soins de longue durée en établissement. Il existe des précédents, car le gouvernement fédéral a déjà versé du financement aux provinces pour faire face à des priorités communes, par le biais du Fonds Inforoute en 2001, du Fonds pour l'adaptation des soins de santé primaires en 2000 et



de la Caisse d'aide à la santé en 1966. Les fonds fédéraux additionnels doivent être liés aux principes pancanadiens pour assurer à tous les Canadiens l'accès à des soins de longue durée en établissement comparables. Les principes doivent être déterminés en collaboration par les gouvernements fédéral, provinciaux et territoriaux.

Il est possible d'assurer l'accès à des soins de longue durée en établissement comparables sans offrir une couverture à partir du premier dollar pour les frais d'hébergement et sans normaliser toutes les caractéristiques inhérentes à ces soins dans l'ensemble des provinces et territoires.

- 1.2 Remédier au sous-financement actuel des soins de longue durée en établissement et préparer une base de financement prévisible et durable pour les futures générations de personnes âgées.
 - Si les soins de longue durée en établissement doivent répondre aux attentes futures, nous devons les financer adéquatement et tenir les maisons responsables de l'excellence. L'un ne va pas sans l'autre. L'allocation des ressources et la responsabilisation sont inséparables. La collaboration et la participation de multiples intervenants, dont le gouvernement, les employeurs, les résidents, les employés, les syndicats et autres acteurs clés, seront essentielles.
 - Le manque de fonds peut empêcher les établissements de créer des environnements qui offrent aux résidents une vie pleinement satisfaisante et une qualité de vie qui se rapproche davantage de ce qu'ils appréciaient dans leurs propres logements. D'ailleurs, le critère le plus souvent mentionné par les résidents concernant leur qualité de vie a trait à un environnement propre et sécuritaire allié à des soins respectueux.
 - Se préparer maintenant à assurer des services de soins continus adéquats aux futures générations de personnes âgées. Même si l'on prévoit que les gens vieilliront plus en santé et que la dépense médicale n'augmentera pas aussi rapidement que la hausse du nombre de personnes âgées, la croissance de la proportion de personnes âgées au Canada exigera que les planificateurs et les responsables des orientations politiques en santé tiennent compte des préférences et des besoins de la prochaine génération de personnes âgées. Parmi les options préférées, mentionnons les soins de relève, les programmes communautaires, le logement en milieu de soutien ou le logement-services, et les soins de longue durée en établissement. Graduellement, la pression exercée par les baby-boomers s'atténuera. Les planificateurs en santé doivent donc tenir compte d'une attrition éventuelle et ne pas créer de systèmes statiques.
- 1.3. Cesser de transférer des coûts de santé aux résidents.
 - L'ACS croit que soins médicaux et soins personnels = services de santé. Des personnes vulnérables doivent payer des frais pour des soins de longue durée en établissement qui devraient être financés à même les fonds publics et disponibles.
 - Il faut établir des directives pancanadiennes qui font la distinction entre les coûts d'hébergement et les coûts des services de santé. L'ACS ne s'oppose pas à une participation des résidents à des coûts raisonnables pour le gîte et le couvert (repas,

hébergement, lavage, entretien du bâtiment, dépenses administratives de base), mais elle croit que ces frais ne devraient pas s'élever à plus que ce qu'une personne autonome en santé paierait pour des conditions de gîte et de couvert comparables. Le résident à qui l'on facture plus que le coût des frais de subsistance de base paie en fait pour des services de santé.

- Tous les soins de santé (médicaux et personnels) devraient être subventionnés. En matière de soins de longue durée en établissement, ces soins devraient comprendre les fournitures pour incontinents, les matelas à pression variée et les sièges thérapeutiques de base.
- Examiner un modèle d'assurance sociale pour l'assurance de soins de longue durée. Un tel type d'assurance :
 - serait parrainé par le gouvernement et administré à l'échelle nationale ou provinciale;
 - comporterait des avantages, exigences d'admissibilité et divers autres aspects définis par une législation;
 - serait financé par des impôts ou des primes versées par les participants ou versées en leur nom;
 - serait lié aux revenus;
 - s'adresserait à une population définie (avec des critères d'admissibilité spécifiquement définis) en ce qui a trait à l'octroi des avantages;
 - serait à participation obligatoire.

En tant que programme d'assurance sociale, l'assurance des soins de longue durée permettrait de partager les risques. Un régime gouvernemental, même s'il comportait des exigences d'admissibilité, ne refuserait pas la couverture sur la base de troubles médicaux préexistants. Dans un régime public d'assurance de soins de longue durée, le coût des primes serait distribué de manière équitable et les soins ne seraient pas prodigués sur la base de la capacité de payer, mais plutôt sur la base des besoins. Cette forme d'assurance de soins de longue durée serait obligatoire. Tout comme pour le RPC, tous les travailleurs (y compris les travailleurs autonomes) de plus de 18 ans seraient tenus de verser un montant prédéterminé de leur revenu à un régime national/provincial.

2.0 Mettre l'accent sur la qualité et la responsabilisation envers les Canadiens.

Accorder à la qualité de vie la même importance qu'à la qualité des soins. L'examen externe en vue de l'agrément et de la vérification de la conformité et les processus d'examen interne de la qualité devraient porter attention aux indicateurs de risque à la qualité des soins – comme la prévalence de plaies de pression, la perte de poids, l'infection des voies urinaires, les chutes et l'utilisation des appareils de contention – ainsi qu'aux renseignements sur la qualité de vie obtenus dans le cadre des sondages annuels auprès des résidents et de leurs

familles. Les propriétaires et les dirigeants d'établissements de soins de longue durée doivent être tenus de rendre compte, proactifs et attentifs aux besoins pour assurer la sécurité, la qualité de soins et la qualité de vie des Canadiens qui requièrent des soins de longue durée en établissement.

- 2.1 Établir des exigences obligatoires imposant à toutes les maisons de soins de longue durée de procéder à des sondages annuels sur la satisfaction auprès des résidents, de leurs familles et du personnel, et d'y aborder des questions relatives à la qualité de vie.
- 2.2 Utiliser plus efficacement les données existantes et élaborer des systèmes de classification comparables pour faciliter la collecte de données susceptibles d'être comparées entre les diverses autorités et à l'intérieur de celles-ci.
 - L'ICIS doit recevoir un financement adéquat pour la collecte des données et la réalisation de rapports sur les indicateurs pancanadiens comparables en matière de soins de longue durée en établissement, y compris, sans s'y limiter, sur les ratios d'effectifs, les qualifications du personnel, les niveaux de soins, les listes d'attente, les admissions, les permis de sortie et les décès dans les maisons de soins de longue durée.
 - Le secteur des soins de longue durée doit disposer des ressources adéquates pour fournir à l'ICIS des données précises et comparables qui alimenteront les indicateurs ainsi déterminés.
 - Les résultats préliminaires d'un RAI-MDS 3.0 national aux États-Unis sont prometteurs concernant une amélioration du système dans le futur. Tester l'adaptabilité et l'efficacité du RAI-MDS 3.0 auprès d'un échantillonnage d'établissements de soins de longue durée au Canada.
- 2.3 Promouvoir la recherche et investir dans la formation du personnel et la formation en leadership.

Le respect de la dignité doit faire partie intrinsèque de la prestation de soins et de services de toute maison de soins de longue durée. Pour effectuer un tel virage, il faudra investir en recherche, en perfectionnement du personnel et en formation en leadership. Toutefois, le renforcement des connaissances des dirigeants et des employés n'apportera que peu d'avantages aux résidents si ces connaissances ne sont pas intégrées à la pratique de façon constante. Étant donné la vaste gamme de programmes de formation et le taux élevé de roulement des employés, il est crucial que la formation en soins aux personnes atteintes de démence, en gestion comportementale et en dignité dans les prestations des soins de longue durée soit offerte systématiquement. Le défi des soins de longue durée ne consiste pas seulement à atteindre un grand nombre d'intervenants, mais il consiste aussi à codifier les pratiques exemplaires. Les soins de longue durée en établissement doivent aller au-delà du transfert des connaissances et viser l'intégration des connaissances dans les lieux de travail.

- La capacité en recherche doit être élargie à la grandeur du continuum des soins de santé. La capacité fait référence au financement adéquat, à des ressources humaines bien formées, à des données précises et opportunes, à une infrastructure appropriée pour l'analyse et à des sites de recherche établis dans le milieu universitaire et sur le terrain.
- Cibler la recherche sur les personnes âgées et sur les incapacités à tous les âges (p. ex., volet clinique, service en santé et santé de la population en accordant une attention spéciale à la recherche sur tous les aspects de la démence).
- Codifier les pratiques exemplaires susceptibles de retarder l'apparition de l'incapacité, de maintenir les résidents au niveau optimal de capacité fonctionnelle et de désinstitutionnaliser l'environnement des maisons de soins de longue durée.
- Inclure au financement des différentes maisons de soins de longue durée des allocations pour la formation continue en milieu de travail et la formation des employés de tous les niveaux afin d'offrir un milieu d'apprentissage et d'assurer la mise en œuvre efficace des pratiques exemplaires.

2.4 Améliorer la capacité d'enseignement des maisons de soins de longue durée.

- Il faudrait accorder une priorité immédiate à la création de maisons de soins de longue durée à vocation d'enseignement, car elles peuvent servir de laboratoires naturels aux activités de recherche.
- Tous les programmes de formation postsecondaire en santé devraient être affiliés à une maison de soins de longue durée de leur collectivité. De telles alliances favoriseraient la transformation culturelle qui est vitale si nous voulons offrir des services efficaces aux résidents des établissements de soins de longue durée de demain.
- Un modèle d'enseignement pancanadien durable et reproductible dans les maisons de soins de longue durée injecterait une vigueur intellectuelle et soutiendrait mieux la main-d'œuvre actuelle dans ce domaine tout en offrant une meilleure préparation à la main-d'œuvre future.

2.5 Établir un programme d'agrément obligatoire en matière de soins de longue durée en établissement.

- L'agrément devrait devenir la norme pour les maisons de soins de longue durée. Les maisons devraient avoir accès à un financement transitoire qui leur assurerait les ressources adéquates pour s'engager pleinement dans ce processus axé sur la qualité.

3.0 Investir dans les ressources humaines en santé.

Les ressources humaines ayant reçu une éducation et une formation adéquates contribuent à bâtir les fondements sur lesquels sont établies et maintenues la qualité des soins et la qualité de la vie dans le domaine des soins de longue durée en établissement. Pour relever le défi de

pourvoir aux besoins complexes des résidants, les maisons de soins de longue durée devront peut-être augmenter leur nombre d'employés et en modifier la répartition. Elles auront aussi besoin de financement suffisant pour s'assurer de la complémentarité des effectifs. Dans la plupart des provinces et territoires, les niveaux et les ratios de dotation en personnel sont généralement inadéquats et il faut dès maintenant injecter des fonds additionnels à ce chapitre. La réduction des effectifs comme mesure de contrôle budgétaire a des répercussions négatives sur la qualité de la vie et de la mort.

3.1 Optimiser le plein champ d'activité.

Le but ne devrait pas être de supplanter un professionnel des soins de santé par un autre, mais plutôt de reconnaître les compétences particulières de chacun et de faciliter la prise de décisions éclairées dans un environnement multidisciplinaire.

3.2 Développer des modèles de dotation pancanadiens minimaux.

La prestation des soins de santé est de responsabilité provinciale et territoriale, mais comme les soins de longue durée touchent tous les Canadiens à un moment de leur vie, il convient que le gouvernement fédéral ouvre la voie au développement d'objectifs et de principes pancanadiens, surtout s'il doit assumer une responsabilité additionnelle en matière de financement des soins de longue durée. Il faudrait tenir une réflexion nationale sur la question de la dotation en personnel en vue d'établir des points de référence appropriés et solliciter le point de vue de toutes les parties intéressées – résidants, familles, employeurs, employés, syndicats, chercheurs. Le nombre et la combinaison d'employés de chaque établissement devraient être diffusés publiquement pour assurer la transparence et permettre aux consommateurs de faire des choix plus éclairés.

3.3 Créer un programme national de formation des préposés aux services de soutien à la personne.

On constate des incohérences dans le niveau de la formation de base requise des préposés aux services de soutien à la personne (aussi appelés aides aux soins spéciaux ou aides au service de soins personnels) dans les diverses autorités du Canada. Les programmes de formation de ces préposés offerts par les collèges communautaires, les collèges carrières, les organismes sans but lucratif et les conseils scolaires devraient adhérer à un programme pancanadien obligatoire et viser des résultats normalisés.

3.4 Élaborer une stratégie visant à attirer les travailleurs dans le domaine des soins de santé de longue durée en établissement.

- Il y a une pénurie attestée d'infirmières autorisées et de gériatres.
- Le domaine des soins de longue durée en établissement doit attirer des personnes de toutes les professions et vocations des soins de santé qui ont un désir profond de travailler dans ce domaine et d'exercer une influence positive sur la vie des résidants de ces établissements.

4.0 Refléter une approche commune face au risque.

- 4.1 Assurer l'accès à des services comparables, peu importe le lieu de résidence au Canada et peu importe la maladie ou le milieu de soins.

Nous n'avons pas encore tenu le débat dans ce pays sur le fait que les maladies du cœur et le cancer sont des maladies pour lesquelles les services doivent être assurés, mais que la démence ou les conditions débilitantes, comme la maladie de Parkinson, doivent être traitées différemment. Cela est pourtant essentiel pour assurer le continuum des soins.

- 4.2 Respecter les réalités régionales.

Les réalités régionales doivent être prises en compte lors de la planification des services de santé et de l'élaboration des principes pancanadiens relatifs aux soins de longue durée en établissement. Une politique de soins de longue durée subventionnée par des fonds publics doit être souple et tenir compte des différences sur le plan de la répartition des personnes âgées dans les provinces et territoires.

5.0 Garantir la réciprocité entre les provinces et les territoires.

La transférabilité des services de soins de longue durée à la grandeur du Canada doit à tout le moins couvrir les personnes jusqu'à ce qu'elles satisfassent aux exigences de résidence, de sorte qu'elles ne perdent pas leur droit à des avantages et à des services lorsqu'elles se déplacent d'une partie du pays à une autre pour se rapprocher de leur famille. Cette recommandation assurerait aux services de soins de longue durée en établissement la même mesure de transférabilité que les types de soins de santé énumérés dans la *Loi canadienne sur la santé*.

- 5.1 Conclure des ententes de réciprocité entre les provinces et les territoires pour favoriser la migration. Les résidents devraient pouvoir vivre dans des établissements de soins de longue durée à proximité raisonnable de leur maison ou de leur famille/de leurs proches parents.
- 5.2 Autoriser le transfert interprovincial du financement du résident qui se déplace dans une autre province, de sorte que les provinces qui accueillent un grand nombre de nouveaux patients interprovinciaux n'aient pas à assumer des coûts excessifs.

6.0 Créer une culture de compassion.

Nous ne pourrions jamais créer une culture de compassion dans les maisons ou les systèmes qui adhèrent au modèle institutionnel de soins. Ce modèle met l'accent sur des tâches, des échéanciers et des processus reliés à la maladie. Il réprime l'innovation et va de pair avec de piètres résultats pour les résidents, de la frustration pour les membres de leurs familles et une insatisfaction des employés par rapport à leur environnement de travail. La culture de compassion accordera une plus grande priorité aux volets psychologiques, sociaux et spirituels de la vie.

Les traditions bureaucratiques ne doivent pas survivre à la transformation culturelle. Pour cela, nous devons consacrer moins d'énergie à l'ajout de nouveaux règlements et porter une plus grande attention aux processus qui favoriseront la transformation des établissements de soins de longue durée en endroits où il fait bon vivre et travailler.

- 6.1 Exiger que les maisons de soins de longue durée se rapprochent de la vie à la maison plutôt que de la vie en institution.

La dignité et le respect doivent être deux valeurs fondamentales sur lesquelles on bâtit et on maintient un système pancanadien de soins de santé de longue durée en établissement. Les consommateurs et les baby-boomers d'aujourd'hui seront les résidents et les familles de demain. Ils n'accepteront pas les milieux institutionnels, les horaires structurés, les heures de repas fixes et l'attente pour des soins. Le respect de la vie privée, la souplesse et le droit de gérer ses propres risques devraient être les pierres angulaires des services de soins de longue durée en établissement.

- 6.2 Tenir compte des besoins de personnes qui n'appartiennent pas au groupe des aînés.

Il faut réviser et clarifier la politique de chaque autorité concernant l'hébergement d'adultes plus jeunes, de personnes handicapées physiquement et mentalement et d'autres groupes de patients. Une telle mesure assurera à ces derniers d'être hébergés dans un environnement approprié à leur âge ou dans des ailes ou modules de bâtiments particuliers pour leur âge, s'il est déterminé que les soins de longue durée en établissement sont la meilleure option pour satisfaire à leurs besoins.

- 6.3 Tenir compte des soins en fin de vie.

- Les maisons de soins de longue durée devraient devenir des centres d'excellence en soins palliatifs étant donné que 39 % de tous les décès surviennent dans de tels établissements au Canada et que les résidents préfèrent de plus en plus y demeurer en fin de vie plutôt que d'être transférés dans un hôpital. Il faut améliorer les connaissances de tous les employés d'établissements de soins de longue durée en matière de soins en fin de vie.
- Il faut allouer des fonds publics adéquats à la prestation de soins de fin de vie appropriés.
- Déterminer les services de santé qui conviennent dans l'année du décès : les soins palliatifs plutôt que le traitement médical agressif; la promotion des directives préalables; le maintien des soins en établissement de soins de longue durée plutôt que les coûteux transferts dans les hôpitaux à l'approche du décès; et les pratiques humaines et adaptées à la réalité culturelle dans tout le système de soins de santé.

- 6.4 Tenir compte des soins en santé mentale.

Les maisons de soins de longue durée peuvent offrir des soins appropriés aux personnes atteintes de la maladie d'Alzheimer et de démences connexes. Toutefois, si la tendance récente d'admettre d'anciens patients psychiatriques s'affirme, les maisons devront avoir les ressources

adéquates pour offrir les bons programmes, établir le bon environnement et attirer et maintenir en poste la bonne combinaison de personnel qualifié pour offrir les soins et soutenir les personnes atteintes de troubles mentaux. Le financement gouvernemental des services de soins de longue durée pourvoit généralement aux besoins de base des résidents – sécurité, repas et soins physiques. Le financement dans les diverses autorités est tout à fait inadéquat pour offrir des services en santé mentale exhaustifs dans les établissements de soins de longue durée.

7.0 Respecter les bénévoles et les familles.

7.1 Déterminer l'utilisation optimale des bénévoles dans les maisons de soins de longue durée.

Au fur et à mesure que les baby-boomers prendront leur retraite, on verra arriver de nombreux bénévoles plus âgés et en santé qui apporteront leurs talents, leurs compétences et leur temps au secteur des soins de longue durée en établissement. Il faut concevoir de nouvelles façons créatives pour recruter des bénévoles, jeunes et adultes.

7.2 Accueillir les membres de la famille comme des participants à la vie quotidienne des résidents.

Les familles devraient être reconnues comme une composante de l'équipe multidisciplinaire, que ce soit par des processus formels, comme la participation à des conférences en soins de santé et l'adhésion à des comités d'amélioration de la qualité, ou par diverses activités informelles. L'engagement réel peut renforcer les liens avec une famille désireuse de rendre service sur qui on peut compter, et désamorcer ou prévenir des problèmes avec les familles dysfonctionnelles.

Toutefois, les familles et les bénévoles ne constituent pas une main-d'œuvre de remplacement. L'aide qu'ils apportent doit servir à augmenter les soins de base prodigués par le personnel de l'établissement et non pas à les remplacer. Les membres des familles devraient être encouragés à participer à la vie quotidienne de leurs proches au titre qui leur revient, soit celui de compagnons et de parents.

Les familles et les bénévoles devraient avoir accès à toutes les activités éducatives pertinentes dans l'établissement pour renforcer leurs connaissances et se sentir plus à l'aise avec certaines conditions courantes parmi les résidents, comme la maladie d'Alzheimer et les démences connexes.

Conclusion

Although provincial governments have considered facility-based long term care in various reports and planning documents, the 2003 and 2004 Health Accords did not include provisions for this vital sector. Nor did the Romanow Commission on the Future of Health Care in Canada make recommendations. The Kirby Report examined a broad range of health issues but was silent on facility-based long term care. While these health reports made reference to the aging population, the federal government has not subsequently taken action to make meaningful long-range changes. The National Advisory Council on Aging produced some far-sighted recommendations related to all aspects of continuing care. The House of Commons Standing Committee on National Defense and Veteran's Affairs also produced a report and recommendations in 2003, while the Special Senate Committee on Aging issued its final report in 2009. But there have been no federal government statements or actions on facility-based long term care in this decade.

Perhaps the reason for federal silence may be the assumption that the introduction of comparable funding, attached to pan-Canadian principles for long term care, is neither affordable nor sustainable. Ironically, the appropriate balancing of integrated services across the entire continuum could actually save money and ensure suitable options for Canadians at the same time.

Canadians cannot ignore nor avoid the reality that the baby-boom generation is aging. Plans must be made now to meet future needs. We need to engage in a national dialogue about how we can build and maintain an enlightened and far-sighted pan-Canadian system of continuing care which includes sufficiently resourced facility-based long term care.



While long term care homes are attempting to meet the needs of an increasingly complex resident population, they are simultaneously faced with major fiscal and human resource challenges. Fortunately, there are long term care organizations that serve as incubators for innovative approaches to care and service. But chance should not determine whether a resident receives appropriate long term care in a dignified setting. Baby boomers will expect comparable quality continuing care services wherever they live in Canada. And they will expect it to be available in an environment that helps them feel at home.

There is a window of opportunity to meet future needs and improve the current system of facility-based long term care for the benefit of our most vulnerable members of society – frail seniors and non-senior citizens with disabilities. If we are going to get serious about quality of life for residents and staff, then we must invite all key stakeholders to share their knowledge and aspirations. In doing so, we would do well to remember the story of the Spanish prisoner who was confined in a dungeon for many years. One day it occurred to him to push the door of his cell. It opened, as it had never been locked. The opportunity to transform facility-based long term care is before us. All we have to do is act.

Glossary

Glossary

Organizations

BCCPA	British Columbia Care Providers Association
CAHA	Canadian Association of Healthcare Auxiliaries
CARF	Commission on Accreditation of Rehabilitation Facilities
CBoC	Conference Board of Canada
CHA	Canadian Healthcare Association
CIHI	Canadian Institute for Health Information
CIHR	Canadian Institutes of Health Research
CMA	Canadian Medical Association
CMHA	Canadian Mental Health Association
CNA	Canadian Nurses Association
CNO	College of Nurses of Ontario
CNW	Canada Newswire
CP	The Canadian Press
CPRN	Canadian Policy Research Networks
CPSI	Canadian Patient Safety Institute
CHSRF	Canadian Health Services Research Foundation
Concerned Friends	Concerned Friends of Ontario Citizens in Care Facilities
FAIRE	Families Allied to Influence Responsible Eldercare
HC	Health Canada
HQC	Health Quality Council (Saskatchewan)
HRDC	Human Resources Development Canada
HPRAC	Health Professions Regulatory Advisory Council
IPA	International Psychiatric Association
MOHLTC	Ministry of Health and Long-Term Care (Ontario)



NACA	National Advisory Council on Aging
NHS	National Health Service (Great Britain)
OANHSS	Ontario Association of Non-Profit Homes and Services for Seniors
OECD	Organisation for Economic Cooperation and Development
ORCA	Ontario Retirement Communities Association
QWQHC	Quality Worklife-Quality Healthcare Collaborative
SHRTN	Seniors Health Research Transfer Network
WHO	World Health Organization
VA	Veterans Affairs Canada

Key Terms

ALC	Alternative Level of Care
CCC	Complex Continuing Care (Ontario)
CHST	Canada Health and Social Transfer
CHT	Canada Health Transfer
CLSA	Canadian Longitudinal Study on Aging (published by CIHR Institute on Aging)
COP	Communities of Practice
CPP	Canada Pension Plan
CST	Canada Social Transfer
DART	Data Accuracy Review Team
GIS	Guaranteed Income Supplement
GLBTQQ	Gay, Lesbian, Bisexual, Transgender, Two-spirited, Queer, Questioning
Guide	Guide to Canadian Healthcare Facilities (published by the Canadian Healthcare Association)
HHR	Health Human Resources
LPN	Licensed Practical Nurse
LTC	Long Term Care
OAS	Old Age Security
PSW	Personal Support Worker
QI	Quality Improvement
QPP	Quebec Pension Plan
RCFS	Residential Care Facilities Study (Statistics Canada)
RN	Registered Nurse
RPP	Registered Pension Plans
RRSP	Registered Retirement Savings Plans
RAI-MDS 2.0	Resident Assessment Minimum Data Set 2.0
SMAF	Functional Autonomy Measurement System (Quebec)
The Act	Canada Health Act

Appendix A

Types of Residential Care and Their Equivalencies

Every province and territory in Canada has adopted its own official nomenclature for facility-based long term care. Different jurisdictions also have similar levels of facility-based long term care. This table provides a detailed description of residential care and their equivalencies across Canada. Please see page 39 of the brief for more information.

Province/Territory	Provincial level / Type of care	Type of care equivalencies for the survey
All	Most children's and alcohol and drug facilities	Room and board with guidance /counselling with respect to social, employment, addiction problems, or parental guidance with skilled counselling
Newfoundland and Labrador	<i>Personal Functions</i>	
	Room and board with custodial care	Room and board with custodial care
	Level 1	Type I (i.e., supervision and/or assistance with daily living and meeting psychosocial needs)
	Level 2	Type II (i.e., medical and professional nursing supervision, etc.)
	Level 3	Type III (i.e., medical management, skilled nursing care, etc.)
	Level 4	Type III (i.e., medical management, skilled nursing care, etc.) or Higher Type
	<i>Mental/Sensory/Perceptual</i>	
	Room and board with custodial care	Room and board with custodial care
	Level 1	Type I (i.e., supervision and/or assistance with daily living and meeting psychosocial needs)
	Level 2	Type II (i.e., medical and professional nursing supervision, etc.)
	Level 3	Type III (i.e., medical management, skilled nursing care, etc.)
	Level 4	Higher Type
Prince Edward Island	Level I	Room and board with custodial care
	Level II	Room and board with custodial care or Type I (i.e., supervision and/or assistance with daily living and meeting psychosocial needs)
	Level III	Type I (i.e., supervision and/or assistance with daily living and meeting psychosocial needs)

For more detailed information, please refer to the *Guide to Canadian Healthcare Facilities, Types of Care, Volume 15, 2007-2008* (Canadian Healthcare Association).

Types of Residential Care and Their Equivalencies

Province/Territory	Provincial level / Type of care	Type of care equivalencies for the survey
Prince Edward Island	Level IV	Type II (i.e., medical and professional nursing supervision, etc.)
	Level V	Type III (i.e., medical management, skilled nursing care, etc.) or Higher Type
Nova Scotia	Room and board with custodial care	Room and board with custodial care
	Level 1	Type I (i.e., supervision and/or assistance with daily living and meeting psychosocial needs)
	Level 2	Type II (i.e., medical and professional nursing supervision, etc.) or Type III (i.e., medical management, skilled nursing care, etc.) or Higher Type
	Care in Residential Care Facilities	Room and board with custodial care or Type I (i.e., supervision and/or assistance with daily living and meeting psychosocial needs)
	Care in Adult Residential Centres	Room and board with custodial care or Type I (i.e., supervision and/or assistance with daily living and meeting psychosocial needs)
	Care in Group Homes and Room and board with custodial care Developmental Residences	Room and board with custodial care Developmental Residences or Type I (i.e., supervision and/or assistance with daily living and meeting
	Care in Regional Rehabilitation Centres	Type I (i.e., supervision and/or assistance with daily living and meeting psychosocial needs) or Type II (i.e., medical and professional nursing supervision, etc.)
New Brunswick	Level I	Room and board with custodial care
	Level II	Type I (i.e., supervision and/or assistance with daily living and meeting psycho-social needs)
	Level III	Type II (i.e., medical and professional nursing supervision, etc.)

Types of Residential Care and Their Equivalencies

Province/Territory	Provincial level / Type of care	Type of care equivalencies for the survey
New Brunswick	Level IV	Type III (i.e., medical management, skilled nursing care, etc.)
	Care in a Nursing home	Type III (i.e., medical management, skilled nursing care, etc.)
	Care in a Hospital extended care	Type III (i.e., medical management, skilled nursing care, etc.) or Higher Type
Ontario	Care in a Retirement home	Room and board with custodial care or Type I (i.e., supervision and/or assistance with daily living and meeting psychosocial needs)
	Care in a Long-term care home	Type II (i.e., medical and professional nursing supervision, etc.) or Type III (i.e., medical management, skilled nursing care, etc.) or Higher Type
Manitoba	Personal Care Level 1	
	Personal Care Level 2	Room and board with custodial care
	Personal Care Level 3	Room and board with custodial care Type I (i.e., supervision and/or assistance with daily living and meeting psychosocial needs)
	Personal Care Level 4	Type II (i.e., medical and professional nursing supervision, etc.)
	Hospital Acute Care Level Equivalent	Type III (i.e., medical management, skilled nursing care, etc.) or Higher Type
	Hospital/Extended Care Facility Equivalent	Type III (i.e., medical management, skilled nursing care, etc.) or Higher Type
Saskatchewan	Supervisory care	Room and board with custodial care
	Limited personal care	Type I (i.e., supervision and/or assistance with daily living and meeting psychosocial needs)
	Intensive personal or nursing care	Type II (i.e., medical and professional nursing supervision, etc.)
	Long-term restorative or palliative care	Type III (i.e., medical management, skilled nursing care, etc.) or Higher Type

Types of Residential Care and Their Equivalencies

Province/Territory	Provincial level / Type of care	Type of care equivalencies for the survey
Alberta	Assisted Living – Level 3	Type I (i.e., supervision and/or assistance with daily living and meeting psychosocial needs)
	Assisted Living – Level 4	Type II (i.e., medical and professional nursing supervision, etc.)
	Facility Living	Type II (i.e., medical and professional nursing supervision, etc.) or Type III (i.e., medical management, skilled nursing care, etc.) or Higher Type
British Columbia	Personal care	Room and board with custodial care or Type I (i.e., supervision and/or assistance with daily living and meeting psychosocial needs)
	Intermediate care 1	Type I (i.e., supervision and/or assistance with daily living and meeting psychosocial needs)
	Intermediate care 2	Type I (i.e., supervision and/or assistance with daily living and meeting psychosocial needs)
	Intermediate care 3	Type II (i.e., medical and professional nursing supervision, etc.)
	Extended care	Type III (i.e., medical management, skilled nursing care, etc.) or Higher Type
Yukon Territory	Level 1	Room and board with custodial care
	Level 2	Type I (i.e., supervision and/or assistance with daily living and meeting psychosocial needs)
	Level 3	Type II (i.e., medical and professional nursing supervision, etc.)
	Level 4	Type III (i.e., medical management, skilled nursing care, etc.)
	Level 5	Type III (i.e., medical management, skilled nursing care, etc.) or Higher Type
Northwest Territories	Level 1	Room and board with custodial care
	Level II	Type I (i.e., supervision and/or assistance with daily living and meeting psychosocial needs)

Types of Residential Care and Their Equivalencies

Province/Territory	Provincial level / Type of care	Type of care equivalencies for the survey
Northwest Territories	Level III	Type II (i.e., medical and professional nursing supervision, etc.)
	Level IV	Type III (i.e., medical management, skilled nursing care, etc.)
	Level V	Type III (i.e., medical management, skilled nursing care, etc.) or Higher Type
Nunavut	Level 1	Room and board with custodial care
	Level II	Type I (i.e., supervision and/or assistance with daily living and meeting psychosocial needs)
	Level III	Type II (i.e., medical and professional nursing supervision, etc.)
	Level IV	Type III (i.e., medical management, skilled nursing care, etc.)
	Level V	Type III (i.e., medical management, skilled nursing care, etc.) or Higher Type

Source: Statistics Canada, *Residential Care Facilities Survey: Instructions & Definitions, 2007-2008* (Ottawa: Statistics Canada, 2007), Appendix 1. Statistics Canada information is used with the permission of Statistics Canada. Users are forbidden to copy the data and disseminate them, in an original or modified form, for commercial purposes, without permission from Statistics Canada. Information on the availability of the wide range of data from Statistics Canada can be obtained from Statistics Canada's Regional Offices, its World Wide Web site at www.statcan.gc.ca, and its toll-free access number 1-800-263-1136.

Appendix B

Reports and Publications from the Provinces

Alberta

- Alberta Community Development. (2000). *Alberta for all ages: Directions for the future*. Report and Recommendations of the Steering Committee for the Government-wide Study on the Impact of the Aging Population. (ISBN: 0-7785-1231-2). Edmonton, Author.
- Alberta Health and Wellness. (2008). *Vision 2020: The future of health care in Alberta. Phase one*. (ISBN: 978-0-7785-6699-1). Edmonton: Author.
- Alberta Health and Wellness. (2008). *Continuing care strategy: Aging in the right place*. (ISBN 978-0-7785-7422-4). Edmonton: Author.
- Alberta Health and Wellness. (2002). *Tracking progress: A progress report on continuing care in Alberta*. (ISBN: 0-7785-2833-7). Edmonton: Author.
- Alberta Health and Wellness. (2000). *Alzheimer disease & other dementias. Strategic directions in healthy aging and continuing care in Alberta*. Edmonton: Author.
- Alberta Health and Wellness. (2000). *Strategic directions and future actions: Healthy aging and continuing care in Alberta*. Edmonton: Author.
- Alberta Health and Wellness, Long Term Care Review. (1999). *Final report of the Policy Advisory Committee. Healthy aging: New directions for care. Part three: Implementing new directions*. Edmonton: Author.
- Alberta Health and Wellness, Long Term Care Review. (1999). *Final report of the Policy Advisory Committee. Healthy aging: New direction for care. Part two: Listening and learning*. Edmonton: Author.
- Alberta Health and Wellness, Long Term Care Review. (1999). *Final report of the Policy Advisory Committee. Healthy aging: New directions for care. Part one: Overview*. (ISBN 0-7785-0218-X). Edmonton: Author.
- Alberta Health and Wellness, Long Term Care Review. (1999). *Summary of consultations with public, November 1998 to March 1999*. Edmonton: Author.
- Alberta Seniors and Community Supports. (2007). *A profile of Alberta seniors*. Edmonton: Government of Alberta.
- Alberta Seniors and Community Supports. (2007). *Supportive living framework*. Edmonton: Government of Alberta.
- Auditor General Alberta. (2005). *Report of the Auditor General on seniors care and programs*. (ISBN 0-7785-3717-X). Edmonton: Author.

British Columbia

- British Columbia Ministry of Health Planning. (2002). *The picture of health: How we are modernizing British Columbia's health care system*. (ISBN 0-7726-4884-0). Victoria: Author.
- British Columbia Ministry of Health Planning. (2004). *Prevention of falls and injuries among the elderly: A special report from the Office of the Provincial Health Officer*. Victoria: Government of British Columbia.
- British Columbia Ministry of Health. (2007). *Care aide competency project: Framework of practice for community health workers and resident care attendants*. Victoria: Government of British Columbia.
- British Columbia Ministry of Health Services. (2009). *Glossary of terms*. Retrieved April 16, 2009, from <http://www.health.gov.bc.ca/assisted/glossary.html#s>.
- British Columbia Ministry of Health Services. (2002). *Home and community care policy manual*.
- British Columbia Ministry of Health and Ministry Responsible for Seniors. Ministry of Social Development and Economic Security. (1999).

Reports and Publications from the Provinces

Supportive housing in supportive communities. (ISBN 0-7726-4005-X). Victoria: Government of British Columbia.

Fraser Health Authority. *Supportive living...Creating choices for life!* BC Housing. New Westminster, BC, 2002.

Herman, M., Gallagher, E. & Scott, V. (2006). *The evolution of seniors' falls prevention in BC: Working strategically and collectively to reduce the burden and impact of falls and fall-related injury among seniors.* (ISBN 0-7726-5491-3). Victoria: British Columbia Ministry of Health.

Office of the Assisted Living Registrar of British Columbia. (2009). *Complaint investigation for residents of assisted living for seniors.* [Brochure]. Vancouver: Author.

Manitoba

Government of Manitoba. (2002). *A strategy for alzheimer disease and related dementias in Manitoba.* Winnipeg: Author.

Newfoundland & Labrador

Government of Newfoundland and Labrador. (2008). *Long term care and community support program adult needs assessment.* [Reference Manual]. St. John's: Author.

Government of Newfoundland and Labrador Department of Health and Community Services. (2007). *Provincial healthy aging policy framework.* St. John's: Author.

Government of Newfoundland and Labrador Department of Health and Community Services. (2002). *Healthier together: A strategic health plan for Newfoundland and Labrador.* St. John's: Author.

Government of Newfoundland and Labrador Department of Health and Community Services. (2008). *Strategic Plan 2008-2011.* St. John's: Author.

St. John's Nursing Home Board. (2002). *Final report – Role and feasibility study for St. John's Nursing Home Board.* St. John's: Author.

New Brunswick

Province of New Brunswick. (2002). *Health renewal: Report from the Premier's Health Quality Council.* Fredericton: Author.

Province of New Brunswick. (2008). *Be independent. Longer. New Brunswick's Long-term care strategy.* (ISBN 978-1-55471-076-8). Fredericton: Author.

Nova Scotia

Advisory Committee on Capital Investment in Long Term Care. (2000). *Advice and recommendations of the Advisory Committee on Capital Investment in Long Term Care.* Halifax: Nova Scotia Department of Health. Retrieved from www.gov.ns.ca/health/reports/pubs/macleod_report_ltc.pdf.

Auditor General Nova Scotia. (2007). *Report of the Auditor General to the Nova Scotia House of Assembly.* Halifax: Author.

Government of Nova Scotia. (2007). *Long-term care bed contracts awarded.* [Press release, December 7]. Retrieved from <http://www.gov.ns.ca/news/details.asp?id=20071207003>.

Reports and Publications from the Provinces

Government of Nova Scotia. *Continuing care programs. Long-term care*. Retrieved from <http://www.gov.ns.ca/health/ccs/ltc.asp>
Nova Scotia Office of Health Promotion. (2003). *Your health matters. Working together for better care*. Halifax: Government of Nova Scotia.

Ontario

- Health Services Restructuring Commission. (2007). *Rebuilding Ontario's health system: Interim planning guidelines and implementation strategies. A Discussion Paper*. Toronto: Author.
- Ontario Hospital Association. (2007). *Changing Trends in Co-Payment Collection in Complex Continuing Care*. Toronto: Author.
- Ontario Ministry of Health and Long-Term Care. (2009). *Seniors care: Supportive housing*. Retrieved April 16, 2009, from http://www.health.gov.on.ca/english/public/program/ltc/13_housing.html
- Ontario Ministry of Health and Long-Term Care. (2009). *Every Door is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy. A Discussion Paper*. (Catalogue No. 013924 ISBN No. 978-1-4435-0805-6). Toronto: Queen's Printer for Ontario.
- Ontario Ministry of Health and Long-Term Care. (2008). *People caring for people: Impacting the quality of life and care of residents of long-term care homes*. Toronto: Author.
- Ontario Ministry of Health and Long-Term Care. (2008). *What we heard: Long-term care quality consultation 2008. A common vision of quality in Ontario long-term care homes*. (Catalogue No. CIB-2254100 100). Toronto: Queen's Printer for Ontario.
- Ontario Ministry of Health and Long-Term Care. (2007). *LTC-Mental health framework – Toronto region: How-to guide*. Retrieved May 11, 2009, from http://www.toronto.ca/ltc/pdf/how-to-guide_mental-health.pdf.
- Ontario Ministry of Health and Long-Term Care. (2000). *2001-2002 Planning, funding & accountability policies & procedures manual for long-term care community services* (8th ed.). Toronto: Author.
- PricewaterhouseCoopers. (2001). *Report of a study to review levels of service and responses to need in a sample of Ontario long term care facilities and selected comparators*. Toronto: Author.
- PricewaterhouseCoopers. (2000). *A review of Community Care Access Centres in Ontario. Final Report*. Toronto: Author.
- The Ontario Health Services Restructuring Commission. (2000). *Looking back, Looking forward. The Ontario Health Services Restructuring Commission (1996 – 2000) A legacy report*. (ISBN 0-7778-9353-3). Toronto: Author.
- Toronto District Health Council. (2002) *Admission and eligibility issues in complex continuing care in the greater Toronto area*. Toronto: Author.
- Toronto District Health Council. (2002). *Building on a framework of support and supportive housing in Toronto supportive housing services for seniors*. Toronto: Author.

Prince Edward Island

- Ascent Strategy Group. *Trends, projections and recommended approaches to delivery of long-term care in the province of Prince Edward Island 2007-2017*. Charlottetown: PEI Department of Health.
- Corpus Sanchez International Consultancy. (2008). *An integrated health system review in PEI. A call to action: A plan for change*. Retrieved June 22, 2009, from http://www.gov.pe.ca/photos/original/doh_csi_report.pdf.

Reports and Publications from the Provinces

East Prince Health Region. (2002). *Proposal for long term nursing beds*. Charlottetown: Author.

Prince Edward Island Department of Health. (2009). *Prince Edward Island's healthy aging strategy*. Charlottetown: Government of Prince Edward Island.

Québec

Gouvernement du Québec. (2008). *Getting our money's worth: Accessible patient services, sustainable funding, a productive system, shared responsibility. Report of the Task Force on the funding of the health system*. [ISBN 978-2-550-52157-0 (PDF)] Québec: 2008.

Le Vérificateur Général du Québec. *Report to the National Assembly for 2001-2002*. Québec : Publications Québec.

Ministère de la Santé et des Services sociaux, Québec. (2003). *Document Explicatif. Pour un nouveau partenariat au service des aînés. Projets novateurs*. Québec : Service des personnes âgées, Direction générale des services à la population, Ministère de la Santé et des Services sociaux.

Ministère de la Santé et des Services sociaux. (2002). *Making the right choices*. Québec: Government of Quebec.

Québec Commission d'étude sur les services de santé et les services sociaux. (2001). *Emerging solutions – Report and recommendations*. Québec : Author.

Québec Famille et Enfance. (2001). *Québec and its seniors: Together in action*. Commitments and Perspectives: 2001-2004. Québec : Author.

Saskatchewan

Government of Saskatchewan. (2009). *Government of Saskatchewan to replace 13 long-term care facilities*. [Press release, February 3]. Regina: Author.

Health Services Utilization and Research Commission. (1994). *Long term care in Saskatchewan. Final report*. Saskatoon: Author.

Saskatchewan Health. (2003). *It's for your benefit. A guide to health coverage in Saskatchewan*. (ISBN 1551570114). Regina: Author.

Bibliography



- Accreditation Canada. (2009). *2008 Canadian Health Accreditation Report*.
- Accreditation Canada. (2008). *Leadership in the Journey to Quality Health Care*.
- Adleman, S. (2003). Working in a Personal Care Home. *Canadian Nurse*, 99(4), 14-15.
- Advocacy Centre for the Elderly. (2007, January 17). *Written Submission to the Standing Committee on Social Policy On Bill 140, An Act respecting long-term care homes*.
- Agency for Healthcare Research and Quality (AHRQ). (n.d.). *What is Cultural and Linguistic Competence?* Retrieved May 12, 2009, from <http://www.ahrq.gov/about/cods/cultcompdef.htm>
- Alberta Community Development. (2000). *Alberta for All Ages: Directions for the Future. Report and Recommendations of the Steering Committee for the Government-wide Study on the Impact of the Aging Population*. Edmonton, AB.
- Alberta Health and Wellness. (1999). *Healthy Aging: New Directions for Care. Part Three: Implementing New Directions. Long Term Care Review: Final Report of the Policy Advisory Committee*. Edmonton, AB.
- Alberta Health and Wellness. (1999). *Healthy Aging: New Direction for Care. Part Two: Listening and Learning. Long Term Care Review: Final Report of the Policy Advisory Committee*. Edmonton, AB.
- Alberta Health and Wellness. (1999). *Healthy Aging: New Directions for Care. Part One: Overview. Long Term Care Review: Final Report of the Policy Advisory Committee*. Edmonton, AB.
- Alberta Health and Wellness. (1999). *Summary of Consultations with Public, November 1998 to March 1999. Long Term Care Review*. Edmonton, AB.
- Alberta Health and Wellness. (2000). *Alzheimer Disease & Other Dementias. Strategic Directions in Healthy Aging and Continuing Care in Alberta*. Edmonton, AB.
- Alberta Health and Wellness. (2000). *Strategic Directions and Future Actions: Healthy Aging and Continuing Care in Alberta*. Edmonton, AB.
- Alberta Health and Wellness. (2002). *Tracking Progress. A Progress Report on Continuing Care in Alberta*. Edmonton, AB.
- Alberta Health and Wellness. (2008). *Continuing care strategy: Aging in the right place*. (ISBN 978-0-7785-7422-4). Edmonton: Author.
- Alberta Long Term Care Association. (2007, June). *Caring* [Newsletter].
- Alberta Medical Association. (2003, December). *Status Report on Alberta's Community-based Continuing Care System*. Health Issues Council of Alberta Medical Association, AB.
- Alberta Seniors and Community Supports. (2007, March). *Supportive Living Framework*. AB.
- Alberta Seniors and Community Supports. (2007, May). *A Profile of Alberta Seniors*. AB.
- Alexander, T. (2002). The History and Evolution of Long-Term Care in Canada. In M. Stephenson & E. Sawyer (Eds.), *Continuing the Care* (Rev. ed., pp. 1-55). Ottawa, ON: CHA Press.
- Alzheimer Knowledge Exchange Ontario. (n.d.). *Dementia Education Needs Assessment (DENA)*. Retrieved May 11, 2009, from <https://akeontario.editime.com/DENA>

- Alzheimer Society of Canada. (n.d.). *Put your mind to it*. Retrieved July 17, 2009, from <http://www.alzheimer.ca/english/media/putyourmind09-adfacts.htm>
- Alzheimer Society of Ontario. (2007, January 17). *Written Submission to Standing Committee on Social Legislature of Ontario On Bill 140 – An Act Respecting Long-Term Care Homes*. Toronto: Author.
- Anderson, K. (2003, March). *New Developments in Continuing Care. Housing and Community-Based Services*. Presentation at the CHA Continuing the Care Conference, St. John's, NL.
- Angelelli, J. (2006). Promising Models for Transforming Long Term Care. *The Gerontologist*, 46(4), 428-430.
- Arling, G., Kane, R.L., Mueller, C., et al. (2007). Nursing effort and quality of care for nursing home residents. *The Gerontologist*, 47(5), 672-682.
- Armstrong, P. (2009, May 1). Long-term Care Problems. *The CCPA Monitor*.
- Armstrong, P., Armstrong, H., & Scott-Dixon, K. (2008). *Critical to Care: The Invisible Women in Health Services*. Toronto, ON: University of Toronto Press.
- Armstrong, P., Banerjee, A., Szebehely, M., Armstrong, H., Daly, T., & Lafrance, S. (2009). *They Deserve Better: The long-term care experience in Canada and Scandinavia*. Ottawa, ON: CCPA.
- Armstrong, W.L. (2002). *Eldercare – On the Auction Block*. Edmonton, AB: Consumers' Association of Canada.
- Armstrong, W.L. (2002). *Jumping on the Alberta bandwagon: Does B.C. need this kind of assisted living?* Burnaby, BC: Hospital Employees' Union.
- Ascent Strategy Group. (2009). *Trends, Projections and Recommended Approaches to Delivery of Long-Term Care in the Province of Prince Edward Island 2007-2017*. Charlottetown, PE: PEI Department of Health.
- Assembly of First Nations. (2007, May). *Sustaining the Caregiving Cycle: First Nations People and Aging. A Report from the Assembly of First Nations to the Special Senate Committee on Aging*. Retrieved May 21, 2009, from <http://www.afn.ca/misc/SCC.pdf>
- Association of Canadian Medical Colleges. (2003). *CAPER. Annual Census of Post-MD. Trainees Recensement annuel des stagiaires post-MD. 2002-2003*. Ottawa, ON.
- Astrom, S. et al. (2004). Staff's experience of and the management of violent incidents in elderly care. *Scandinavian Journal of Caring Science*, 19(60), 361-368.
- Attias, M. (2009, June 19). Nursing Home Surveys to Focus on Residents' Needs, Right. *The Commonwealth Fund* [Press release].
- Aud, M.A. (2004). Dangerous wandering: elopements of older adults with dementia from long-term care facilities. *American Journal of Alzheimer's Disease and Other Dementias*, 19(6), 361-368.
- Audette, T. (2009, January 28). Seniors' homes short-staffed, Alberta NDP charges. *The Edmonton Journal*.
- Auditor General Alberta. (2005, May). *Report of the Auditor General on Seniors Care and Programs*. AB.
- Auditor General Nova Scotia. (2007, June). *Report of the Auditor General*.
- B.C.ukonm (BCCPA). (2009, Spring). *Residential Care Health and Safety Guidelines*.
- B.C. Ministry of Health Planning. (2004). *Prevention of falls and injuries among the elderly: A special report from the Office of the Provincial Health Officer*. Victoria, BC.
- Baillon, S., et al. (2004). A comparison of the effects of Snoezelen and reminiscence therapy on the agitated behaviour of patients with dementia. *International Journal of Geriatric Psychiatry*, 19(11), 1047-52.
- Ballantyne, P., & Marshall, V.W. (2001). Subjective Income Security of (Middle) Aging and Elderly Canadians. *Canadian Journal on Aging*, 20(2), 151-173.
- Banerjee, A., Daly, T., Armstrong, H., Armstrong, P., Lafrance, S., & Szebehely, M. (2008). *Out of control: violence against personal support workers in long term care*. Toronto, ON: York University.
- Banks, P. (2004). *Policy Framework for Integrating Care for Older People*. London, ON: Kings University College Fund
- Barnes, I. (2001). Depression. *Canadian Nursing Home*, 12(1), 4-15.
- Barnett, S. (2009, May). *Workforce issues: a global context. Presentation to the International Hospital Federation Leadership Summit*.
- BC Housing. (2001, October). *Speaker's Notes*. From Canada Forum, Developing Affordable Supportive Housing for Seniors. Montreal, QC.
- Béland, F., & Bergman, H. (2002, October). Integrated Services Delivery Networks for the Frail Elderly: A Canadian Overview. Panel Members, Pre-Conference Workshop, Canadian Association of Gerontology Scientific & Educational Meeting. Montreal, QC.
- Béland, F., Bergman, H., & Lebel, P. (2001). *A System of Integrated Services for the Frail Elderly Evaluation of Phase1, June 1999-May 2000*. Ottawa, ON: Health Canada, Health Transition Fund.
- Blais, R. (2008). Patient Safety: Scope of the problem and possible solutions. *Qmentum Quarterly*, 1(1), 8-11.
- Block, S. (2004, May 16). Gay couples enter golden years with more risk. *USA Today*.
- Boissy, P., Briere, S., Tousignant, M., & Rousseau, E. (2007). The eSMAF: a software for the assessment and follow-up of functional autonomy in geriatrics. *BioMed Central Geriatrics*, 7(2).
- Boodt, C. (2008, September). *Introducing CARF Accreditation into the Long Term Sector in Ontario*. Paper presented to the Ontario Ministry of Health and Long Term Care & CARF Canada. Toronto, ON.
- Bournes, D. A., & Ferguson-Pare, M. (2007). Human Becoming and 80/20: An Innovative Professional Development Model for Nurses. *Nursing Science Quarterly*, 20(3), 237-253.
- Branswell, H. (2007, October 18). Seniors wait longer in ER for hospital beds: Study. *Canadian Press*.
- Bravo, G., Charpentier, M., Dubois, M., De Wals, P., & Émond, A. (1998). Profile of residents in unlicensed homes for the aged in the Eastern Townships of Quebec. *Canadian Medical Association Journal*, 159(2), 143-148.
- Bravo, G., Dubois, M., Charpentier, M., De Wals, P., & Émond, A. (1999). Quality of Care in Unlicensed Homes for the Aged in the Eastern Townships of Quebec. *Canadian Medical Association Journal*, 160(10), 1441-1445.

- Brazil, K., Bedard, M., Drugeger, P., Taniguchi, A., Kelley, M. L., McAiney, C., & Justice, C. (2006). Barriers to providing palliative care in long-term care facilities. *Canadian Family Physician*, 52, 472-73.
- Brazil, K., Krueger, P., Bedard, M., Kelley, M. L., McCaig, C., Justice, C., & Taniguchi, A. (2006). Quality of care for residents dying in Ontario long-term care facilities: Findings from a survey of directors of care. *Journal of Palliative Care*, 22(1), 18-25.
- British Columbia Ministry of Health Planning. (2002). *The Picture of Health*. BC: Author.
- British Columbia Ministry of Health Services. (2002). *Home and Community Care Policy Manual*. BC: Author.
- British Columbia Ministry of Health Services. (n.d.). *Glossary of Terms*. Retrieved April 16, 2009, from <http://www.health.gov.bc.ca/assisted/glossary.html#s>
- British Columbia Ministry of Health, Ministry Responsible for Seniors & Ministry of Social Development and Economic Security. (1999). *Supportive Housing in Supportive Communities*. Victoria, BC: Ministry of Social Development and Economic Security.
- British Columbia Ministry of Health. (2006). *The Evolution of Seniors' Falls Prevention in BC: Working strategically and collectively to reduce the burden and impact of falls and fall-related injury among seniors*. Victoria, BC.
- British Columbia Ministry of Health. (2007). *Care Aide Competency Project: Framework of Practice for Community Health Workers and Resident Care Attendants*. Victoria, BC.
- Brooks, S. (2002). *The New Retirees 21st Century Seniors*. Presentation to the Ontario Long Term Care Association and Ontario Residential Care Association Conference. Toronto, ON.
- Brown, R. (2002). *Paying for Canada's Aging Population: How Big is the Problem?* Toronto, ON: Canadian Institute of Actuaries.
- Bruhm, G., & Nardecchia, M.A. (2009). Family caregiving and the workplace: Striking a balance. *Rehab and Community Care Medicine*, 18(1), 30-31.
- Burgio, L.D., et al. (2002). Teaching and maintaining behavior management skills in the nursing home. *The Gerontologist*, 42(4), 487-496.
- Burgio, L.D., Fisher, S.E., Fairchild, J.K., Scille, K., & Hardin, J.M. (2004). Quality of care in the nursing home: effects of staff assignment and work shift. *The Gerontologist*, 44(3), 368-77.
- Burke, K. (2003). Long term care will "implode" unless personal care comes free. *British Medical Journal*, 327(7418), 770.
- Busing, N., & Gold, I. (2009). Faculties of Medicine: Important Contributors to Health Human Resources Planning in Canada. *HealthcarePapers*, 9(2), 25-29.
- Byvelds, S. (2009, April 13). Action needed now on long-term care. *Ottawa Citizen*.
- Cameron, C., Pirozzo, S., & Tooth, L. (2001). Long-term care of people below age 65 with severe acquired brain injury: appropriateness of aged care facilities. *Australian and New Zealand Journal of PublicHealth*, 25(3), 261- 264.
- Canada Mortgage and Housing Corporation. (2000). *Research Report. Supportive Housing for Seniors*. Ottawa, ON: Author.
- Canada's Ageing Population Could Run Short on Docs. (2007, July 19). *Canadian Press*.
- Canadian Academy of Geriatric Psychiatry and Canadian Coalition for Seniors Mental Health. (2003). *Mental Health and Mental Illness Seniors Roundtable*. Submission to Standing Committee on Social Affairs, Science and Technology.
- Canadian Association for Community Care and Health Canada. (1997). *Services for Children with Special Needs in Canada*. V. Hayes, M. Hollander, E. Tan & J. Cloutier (Eds.). Victoria, BC: Health Network, Canadian Policy Research Networks.
- Canadian Association for Community Care. (1998). *National Respite Care Project, Canadian Association of Community Care*. P. Bowen, N. Chappell, B. LaPerrière & N. Thornton (Eds.). Author.
- Canadian Association for Social Workers. (2009). *Fact Sheet National Social Work Month 2009*. Available at http://www.casw-acts.ca/celebrating/nswm09/factsheet09_e.html
- Canadian Association of Gerontology. (2000, September). *Report: National Forum on Closing the Care Gap*. Canadian Association of Gerontology. Ottawa, ON.
- Canadian Association of Healthcare Auxiliaries. (2002). *CAHA Quick Facts 2001/2001*.
- Canadian Auto Workers Union. (2007, January 17). *Submission of the National Automobile, Aerospace, Transportation and General Workers Union of Canada (CAW-Canada) to the Standing Committee on Social Policy Regarding Bill 140: The Long-Term Care Homes Act, 2006*.
- Canadian Caregiver Coalition. (2008, December 1). *A Framework for a Canadian Caregiver Strategy*.
- Canadian Centre for Elder Law. (2008, October). *Discussion paper on Assisted Living: Past, Present and Future Legal Trends in Canada*.
- Canadian Centre for Policy Alternatives – BC Office. (2000). *Without Foundation. How Medicare is Undermined by Gaps and Privatization in Community and Continuing Care*. Vancouver, BC: Author.
- Canadian Centre for Policy Alternatives. (2000). *Without Foundation*. British Columbia: British Columbia Government and Service Employees Union & British Columbia Nurses' Union & Hospital Employees' Union.
- Canadian Continence Foundation. (2007, May). *Incontinence: A Canadian Perspective*.
- Canadian Health Services Research Foundation. (2001). *Myth: The aging population will overwhelm the healthcare system. Mythbusters*. Ottawa, ON.
- Canadian Health Services Research Foundation. (2003). *Myth: The cost of dying is an increasing strain on the healthcare system. Mythbusters*. Ottawa, ON.

- Canadian Healthcare Association. (1999). *Funding Canada's Healthcare System*. CHA Policy Brief. Ottawa, ON: CHA Press.
- Canadian Healthcare Association. (2001). *The Private-Public Mix in the Funding and Delivery of Health Services in Canada: Challenges and Opportunities*. CHA Policy Brief. Ottawa, ON: CHA Press.
- Canadian Healthcare Association. (2006) *Guide to Canadian Healthcare Facilities. Volume 14. 2006-2007*. Ottawa, ON: CHA Press.
- Canadian Heritage, Health Canada, Human Resources Development Canada, Statistics Canada, Public Health Agency of Canada, & Volunteer Canada. (2006). *Caring Canadians, Involved Canadians*. Statistics Canada.
- Canadian Hospice Palliative Care Association. (2001). *Fact Sheet. Hospice Palliative Care in Canada*. Ottawa, ON.
- Canadian Hospice Palliative Care Association. (2007, June 18). *Hospice Palliative Care in Canada: A Brief to the Special Senate Committee on Aging*. Retrieved May 5, 2009, from <http://www.chpca.net>
- Canadian Institute for Health Information (CIHI). (2006). *National Health Expenditure Trends, 1975-2006*. Ottawa, ON.
- Canadian Institute for Health Information. (2000). *Development of National Indicators and a Reporting System for Continuing Care (Long Term Care Facilities)*. Ottawa, ON: Retrieved February 5, 2009, from http://secure.cihi.ca/cihiweb/en/downloads/indicators_contcare_e_CCIndctr.pdf
- Canadian Institute for Health Information. (2002). *Health Care in Canada*. Ottawa, ON.
- Canadian Institute for Health Information. (2005, October 12). *One in Seven Hospitalizations in Canada involve patients diagnosed with Mental Illness*. [Press release]. Available at http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_12oct2005_e
- Canadian Institute for Health Information. (2006). *Facility-Based Continuing Care Services in Canada, 2004/2005. An Emerging Portrait of the Continuum*. Ottawa, ON.
- Canadian Institute for Health Information. (2007). *Canada's Health Care Providers 2007*. Ottawa, ON.
- Canadian Institute for Health Information. (2007). *The "Younger" Generation in Ontario Complex Continuing Care*. Ottawa, ON.
- Canadian Institute for Health Information. (2008). *Canada's Health Care Providers, 1997-2006, A Reference Guide*. Ottawa, ON.
- Canadian Institute for Health Information. (2008). *Caring for Nursing Home Residents with Behavioural Symptoms: Information to Support a Quality Response*. Ottawa, ON.
- Canadian Institute for Health Information. (2008). *Health Indicators, 2008*. Ottawa, ON.
- Canadian Institute for Health Information. (2008). *Nearly half of residents in Nova Scotia nursing homes display behavioural problems*. Ottawa, ON.
- Canadian Institute for Health Information. (2009). *Alternate Level of Care in Canada*. Ottawa, ON.
- Canadian Institute for Health Information. (2009). *Patient Pathways: Transfers from Continuing Care to Acute Care*. Ottawa, ON.
- Canadian Institute of Actuaries Submission to the Standing Senate Committee on Social Affairs, Science and Technology. (2001). *Health Care in Canada: The Impact of Population Aging*. Ottawa, ON.
- Canadian Institutes of Health Research. (2007). *The future is aging: The CIHR Institute of Aging Strategic Plan 2007-2012*. Retrieved (n.d.) from <http://www.cihr-irsc.gc.ca/e/34013.html>.
- Canadian Intergovernmental Conference Secretariat. (2007, February 4). *A Framework to Improve the Social Union of Canadians*. First Ministers Meeting. Retrieved from http://www.scics.gc.ca/cinfo99/80003701_e.html
- Canadian Journal of Aging. (2002). Editorial: Canadian Association on Gerontology Policy Statement on Issues in the Delivery of Mental Health Services to Older Adults. *Canadian Journal on Aging*, 21(2), 165-174.
- Canadian Life and Health Insurance Association Inc. (2009, June 3). *CLHIA Report on Health Care Policy: Towards a Sustainable, Accessible, Quality Public Health Care System*. Toronto, ON.
- Canadian Medical Association. (2007, August 20). *Canadians Concerned Over Costs of Long-Term Care*. [News release].
- Canadian Mental Health Association. (2006). *Fact sheet – having a mental illness is not a crime*. Available: <http://www.ontario.cmha.ca/>
- Canadian Mental Health Association. (2007, January). *Submission on Bill 140, An Act Respecting Long-Term Care Homes*.
- Canadian Nurses Association. (2008, January). *The Long-Term Care Environment: Improving Outcomes through Staffing Decisions*. Ottawa, ON.
- Canadian Nurses Association. (2009). Evaluating nursing staff mix decisions in long-term care. *Canadian Nurse*, 105(2), 26-27.
- Canadian Nurses Association. (2009, May). *Tested Solutions for Eliminating Canada's Registered Nurse Shortage*. Ottawa, ON.
- Canadian Nurses Association. (2005). *Evaluation framework to determine the impact of nursing staff mix decisions*. Retrieved November 29, 2007, from <http://www.cna-aiic.ca/cna/>
- Canadian Patient Safety Institute. (2008). *Safety in Long-Term Care Settings: Broadening the Patient Safety Agenda to Include Long-Term Care Services*. Edmonton, AB.
- Canadian Patient Safety Institute. (2009). *Half of the seniors living in long-term care facilities fall and injure themselves every year*. Edmonton, AB.
- Canadian Policy Research Networks. (2007, June). *The Frontline Health Dialogues*. Ottawa, ON: Author.
- Canadian Policy Research Networks. (2007, September). *Building on the Common Ground: Report from the Saskatchewan HHR Consultation Conference*. Ottawa, ON: Author.
- Canadian Policy Research Networks. (2007, September). *Taking the Next Step: Options and Support for a Pan-Canadian, Multi-Professional HHR Planning Mechanism*. Ottawa, ON: Author.

- Canadian Policy Research Networks. (2008, April). *Frameworks of Integrated Care for the Elderly: A Systematic Review*. Ottawa, ON: Author.
- Canadian Union of Public Employees. (2007, January 17). *Submission to the Standing Committee on Social Policy Re: An Act Respecting Long-term Care Homes; Bill 140*.
- Canadian Union of Public Employees. (2009, January). *Healthcare associated infections: a backgrounder*. Ottawa, ON.
- Canadian Youth and Home Care Network. (2001, October). *Addressing the Challenges of Making Home Care for Children and Youth Evidence-Based. Forum Proceedings*. Toronto, ON.
- Canadian Youth and Home Care Network. (2002). *Submission to the Commission on the Future of Health Care in Canada by the Children and Youth Homecare Network*. Author.
- Cartier, C. (2003). From home to hospital and back again: economic restructuring, end of life, and the gendered problems of place-switching health services. *Social Science & Medicine*, 56, 2289-2301.
- Casa Verde Coroner Recommendation. (2005). *Recommendations of deaths of El Roubi, Ezzeldine and Lopez, Pedro at Casa Verde Nursing Home*. Retrieved January 6, 2008, from <http://www.mcscs.ius.gov.on.ca>
- CBC. (2007, October 16). *The many forms of dementia*. Retrieved October 20, 2008, from <http://www.cbc.ca/news/background/mental-health/dementia.html>
- CBC. (2008, January 14). *Life expectancy hits 80.4: Statistics Canada*. Retrieved April 23, 2009, from <http://www.cbc.ca/canada/story/2008/01/14/death-stats.html>
- CBC. (2008, October 17). *2 new care homes for N.L.* Retrieved May 6, 2009, from <http://www.cbc.ca/canada/newfoundland-labrador/story/2008/10/17/new-homes.html>
- CBC. (2008, October 30). *B.C.'s home-care system needs improvement: auditor general*. Retrieved November 2, 2008, from <http://www.cbc.ca/canada/british-columbia/story/2008/10/30/bc-seniors-care-report-auditor-general.html?ref=rss>
- CBC. (2009, February 15). *15 percent of people with dementia under 65: Alzheimer society*. Retrieved February 15, 2009, from <http://www.cbc.ca/health/story/2009/01/05/alzheimer.html>
- CBC. (2009, February 27). *Bed crunch causes cancelled surgeries at Gander hospital*. Retrieved March 12, 2009, from <http://www.cbc.ca/canada/newfoundland-labrador/story/2009/02/27/bed-crunch.html>
- CBC. (n.d.). *Canada's nursing homes*. Retrieved July 17, 2009, from <http://www.cbc.ca/news/interactives/map-nursing-homes/>
- Cohen, M., et al. (2005). *Continuing Care Renewal or Retreat? BC Residential and Home Health Care Restructuring 2001-2004*. Vancouver, BC: Canadian Centre for Policy Alternatives.
- College of Nurses of Ontario. (2007, May). *Supporting Quality Nursing Care in the Long-Term Care Sector*. Results of the 2005-2006 Long-Term Care Teleconference Series. Author.
- Concerned Friends of Ontario Citizens in Long Term Care Facilities. (2001). *Report Card for Ontario's Provincially Regulated Long-Term Care Facilities. June 2000 to May 2001*. Toronto, ON.
- Concerned Friends of Ontario Citizens in Care Facilities. (2007, February). *Creating Welcoming Communities in Long-term care homes: Support for Ethno-cultural and Spiritual Diversity*. Retrieved April 26, 2009, from <http://www.concernedfriends.ca/Welcoming%20Communities.pdf>
- Concerned Friends of Ontario Citizens in Care Facilities. (2009, March). *Changes Affecting how your LTC is Monitored*. Retrieved April 26, 2009, from <http://www.concernedfriends.ca/monitoring.htm>
- Concerned Friends of Ontario Citizens in Long Term Care Facilities. (2001). *Recommendations for the Future of Long-Term Care in Canada. Submission to the Commission on the Future of Health Care in Canada*.
- Conference Board of Canada. (2007). *The U.K. Way, Spending and Measuring in the National Health Service – Lessons for Canada*. Ottawa, ON.
- Conklin, A., Hallsworth, M., Hatzianandreu, E., & Grant, J. (2008). *Facilitating Diffusion of Innovation in Health Services*. Cambridge, UK: The RAND Corporation.
- Conn, D. (2002). Mental Health Services and Long-Term Care. In M. Stephenson & E. Sawyer (Eds.), *Continuing the Care* (Rev. ed., pp. 143-161). Ottawa, ON: CHA Press.
- Conn, D. (2002). Mental Health Services for Seniors in Long Term Care Facilities: A Call for Action! A presentation to the Canadian Invitational Symposium. Toronto, ON.
- Conn, D., & Silver, I. (1998). The Psychiatrist's Role in Long-Term Care. *Canadian Nursing Home*, 9(4), 22-24.
- Conn, D., et al. (2008). Guidelines for the assessment and treatment of mental health issues in LTC. *Canadian Nursing Home*, 19(1), 24-31.
- Corpus Sanchez International Consulting. (2008). *An Integrated Health System Review in PEI A Call to Action: A Plan for Change*. Retrieved June 22, 2009, from http://www.gov.pe.ca/photos/original/doh_csi_report.pdf
- Cott, C.A. (2001). Health and Happiness for Elderly Institutionalized Canadians. *Canadian Journal on Aging*, 20(4), 517-535.
- Coutts, P., Goodman, L., & Norton, L. (2009). Practical Pressure Ulcer Strategies. *Rehab and Community Care Medicine*, 18(1), 14-18.
- Coyte, P. (2000). *Home Care in Canada: Passing the Buck*. Toronto, ON: Department of Health Policy, Management and Evaluation, University of Toronto.
- Coyte, P., Laporte, A., Baranek, P., & Croson, W. (2002). *Forecasting Facility and In-home Long Term Care for the Elderly in Ontario: The Impact of Improving Health and Changing Preferences*. Toronto, ON: Department of Health Policy, Management and Evaluation, University of Toronto.

- Crang, C., & Muncey, T. (2008). Quality of life in palliative care: being at ease in the here and now. *International Journal of Palliative Nursing*, 14(2), 92-97.
- Cranswick, K. (1997, Winter). Canada's Caregivers. *Canadian Social Trends*, Statistics Canada, 2-6.
- Cranswick, K., & Dosman, D. (2008, October 21). Eldercare: What we know today. *Canadian Social Trends*, Statistics Canada, 44-56.
- CTV. (2004, May 4). *Antipsychotics given to nursing home residents*. Retrieved January 14, 2009, from http://www.ctv.ca/servlet/ArticleNews/print/CTVNews/1083607155249_79016355?hub=CTVNewsAt11&subhub=PrintStory
- Cullen, B., Coen, R.F., Lynch, C.A., et al. (2005). Repetitive behaviour in Alzheimer's Disease: description, correlates and functions. *International Journal of Geriatric Psychiatry*, 20(7), 686-693.
- Cutler, D. (2001). Declining Disability among the Elderly. *Health Affairs*, 20(6), 7-26.
- Dalziel, W. (2002, February). Future of Health Care for the Elderly in Canada. *Geriatrics Today*, 5, 3-4.
- Darra, I. (2000, January 27). Caring for gay oldsters. *Xtra*.
- Davidson, C., and Hall, B. (2009, April 7). CARF Canada. Accreditation: It's all about choice. Presentation to OLTCA/ORCA Convention and Trade Show. Toronto, ON.
- Daw, J. (2007, November 17). Long-term-care insurance a flop. *Toronto Star*.
- Dawson, S., Morris, Z., Erickson, W., Lister, G., Altringer, B., Garside, P., & Craig, M. (2007). *Engaging with Care*. London, UK: The Nuffield Trust.
- Deber, R.B. (2000). *Getting What We Pay For: Myths and Realities about Financing Canada's Health Care System*. Toronto, ON: Department of Health Administration, University of Toronto.
- DeCoster, C., & Kozyrskyj, A. (2000). *Long-Stay Patients in Winnipeg Acute Care Hospitals*. MB: Manitoba Centre for Health Policy and Evaluation, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba.
- Dellefield, M.E. (2006). Using the Resource Utilization Groups (RUG-III) system as a staffing tool in nursing homes. *Geriatric Nursing*, 27(3), 160-5.
- Denton, F., & Spencer, B. (2002). Some Demographic Consequences of Revising the Definition of 'Old Age' to Reflect Future Changes in Life Table Probabilities. *Canadian Journal on Aging*, 21(2), 346-356.
- Denton, F.T., Gafni, A., & Spencer, B. (2003). Requirements for physicians in 2030: Why population aging matters less than you may think. *Canadian Medical Association Journal*, 168(12), 1545-1547.
- Deutschman, M. (2001, November/2002, January). How to Attract and Keep the Best and Brightest Workers in Nursing Homes. *Stride: Excellence in Long Term Care*, 20-24.
- Diachun, L.L., Hillier, L.M., & Stolee, P. (2006). Interest in geriatric medicine in Canada: How can we secure a next generation of geriatricians? *Journal of the American Geriatrics Society*, 54, 512-519.
- Dijkstra, A. (2007). Family Participation in Care Plan Meetings: Promoting a Collaborative Organizational Culture in Nursing Homes. *Journal of Gerontological Nursing*, 33(4), 22-29.
- Doty, M., Koren, M.J., & Davis, K. (2008). Health Care Opinion Leaders' Views on the Future of Long-Term Care. *The Commonwealth Fund*, 1157(10), 1-12.
- Doty, M., Koren, M.J., & Elizabeth, L.S. (2008, May 9). Culture Change in Nursing Homes: How Far Have We Come? Findings from The Commonwealth Fund 2007 National Survey of Nursing Homes. *The Commonwealth Fund*, 91.
- Drugs may increase health problems in seniors. (2008, May 27). *The Calgary Herald*.
- Dubois, M., Bravo, G., & Charpentier, M. (2001). Which Residential Care Facilities Are Delivering Inadequate Care? A Simple Case-Finding Questionnaire. *Canadian Journal on Aging*, 20(3), 339-355.
- Dupuis, S., & Smale, B. (2004). Probing the major concerns and issues encountered by dementia caregivers. *Canadian Nursing Home*, 15(1), 36-40.
- Duxbury, L., Higgins, C., & Schroeder, B. (2009). *Balancing Paid Work and Caregiving Responsibilities: A Closer Look at Family Caregivers in Canada*. Ottawa, ON: Canadian Policy Research Networks (CPRN).
- Dying Patients and their Families are Suffering in Silence According to Canadian Survey on Palliative Care. (2008, September 25). *Canada NewsWire*.
- East Prince Health Region. (2002). *Proposal for Long Term Nursing Beds*. PE.
- e-Health Ontario. (2009). *Quality in Long-Term Care*. Retrieved April 2, 2009, from <https://www.ehealthontario.ca/portal/server.pt?open=512&objID=1070&PageID=0&cached=true&mode=2&userID=11862>
- Eisenhower, N.D., & Raphael, C. (2008, July 21). Revamping Long-Term Care in Pennsylvania. *The Commonwealth Fund* [Commentary].
- Elderly residents lack tender care. (2001, February). *The Gazette*. Montreal, QC.
- Ellis, A., Priest, M., MacPhee, M., & Sanchez McCutcheon, A. (2006). *Staffing for safety: A synthesis of the evidence on nurse staffing and patient safety*. Retrieved December 14, 2007, from www.chsrf.ca
- Evans, R., McGrail, K., Morgan, S., Barer, M., & Hertzman, C. (2001). Apocalypse No: Population Aging and the Future of Health Care Systems. *Canadian Journal of Aging*, 20(Supplement 1), 160-191.
- Families Allied to Influence Responsible Eldercare. (2003). *Creating Protections for Better Lives of Vulnerable Seniors in Care Today and in the Future*. Presentation to the Standing Policy Committee on Health and Community Living.

- Families Allied to Influence Responsible Eldercare. (2001). *The Shame of Canada's Nursing Homes: A Testimony of the Experiences of Older Persons in Care Facilities in Canada*. Cochrane, AB: Author.
- Fast, J., Eales, J., & Keating, N. (2001). *Economic Impact of Health, Income Security and Labour Policies on Informal Caregivers of Frail Seniors*. Edmonton, AB: Department of Human Ecology, University of Alberta. Available: <http://www.hecol.ualberta.ca>
- Faux Fido eases loneliness in nursing homes. (2008, February 26). *Medical News Today*.
- Feldman, P.H., & Kane, R.L. (2003). Strengthening Research to Improve the Practice and Management of Long-Term Care. *The Milbank Quarterly*, 81(2).
- Fellows, J. (2008, November 18). Poor mental health often goes untreated in the elderly. *Fredericton Daily Gleaner*.
- Fillingham, D. (2008, May 21). *Undertaking the Journey of Lean in the NHS*. HSJ Conference, London, UK.
- Fitzgerald, J. (2007, July 11). Have a Gay Old Time: Nursing Home to Set Up Specialized Unit. *Boston Herald*.
- Fitzpatrick, M. (2009, January 6). Greying population presents solid job opportunities. *Canwest News Service*.
- Fitzpatrick, M. (2009, January 6). Study of aging expanding in university programs. *Vancouver Sun*.
- Foot, D.K., & Stoffman, D. (1996). *Boom, Bust and Echo: How to Profit from the Coming Demographic Shift*. Toronto, ON: Macfarlane Walter and Ross.
- For-Profit Nursing Homes Cost Province More. (2003, September 3). *Toronto Star*.
- Fraser Health Authority. (2002). *Supportive Living...Creating Choices for Life!* New Westminster, BC: BC Housing.
- French, J. (2008, September 18). Long-term care backlog clogs system. *The StarPhoenix*.
- Fries, J. (1980). Aging, Natural Death, and the Compression of Morbidity. *The New England Journal of Medicine*, 303(3), 130-35.
- Frohlich, N., DeCoster, C., & Dick, N. (2002). *Estimating Personal Care Home Bed Requirements*. MB: Manitoba Centre for Health Policy and Evaluation, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba.
- Gates D.M., Fitzwater E., & Succop, P. (2005). Reducing assaults against nursing home caregivers. *Nursing Research*, 54(2), 119-127.
- Gerstel, J. (2009, May 2). Depression late in life can be well disguised. *Toronto Star*.
- Gibbs, L.M., & Young, L. (2007, March). The Medical Director's Role: Neglect in Long-Term Care. *Journal of the American Medical Director's Association*, 194-196.
- Gill, S. (2005, February). Spirituality and religion in multiethnic palliative care. *Cancer Nursing Practice*, 4(1), 17-21.
- Gillespie, K. (2008, July 17). Nursing homes face back-door investigation. *Toronto Star*.
- Gladstone, J., & Wexler, E. (2002). Exploring the relationships between families and staff caring for residents in Long-Term Care Facilities: Family members' perspectives. *Canadian Journal on Aging*, 21(1), 39-45.
- Gladstone, J., Dupuis, S.L., & Wexler, E. (2007). Ways that families engage with staff in Long-term care facilities. *Canadian Journal on Aging*, 26(4), 391-402.
- Gnaedinger, N. & Cohen, M. (2000). *Changes in Long Term Care for Elderly People with Dementia. A Report from the Front Lines*. BC: CUPE Hospital Employees' Union.
- Goatcher, R. (2003). *Glossary of Housing Terms*. CMHC unpublished reports. Edmonton, AB: Canadian Mortgage and Housing.
- Goddard, J. (2008, April 4). Disability planning: A look at long-term care insurance. *The Lawyers Weekly*.
- Goldenberg, M. (2006). *Employer Investment in Workplace Learning in Canada*. Canadian Policy Research Networks (CPRN).
- Good homes are hard to find. (2009, March 27). *Globe and Mail*.
- Gordon, M. (2001). Challenges of an Aging Population. *Annals Royal College of Physicians and Surgeons*, 34(5), 306-308.
- Gouvernement du Québec. (2008). *Getting our Money's Worth: Report of the Task Force on the funding of the Health System*. QC.
- Gouvernement du Québec. Ministère de la Santé et des Services sociaux (MSSS). (2002). *Making the Right Choices*. QC.
- Government of Canada. (n.d.). *Seniors benefits*. Retrieved May 11, 2009, from <http://www.sppd.gc.ca>
- Government of Manitoba. (2002). *Alzheimer Disease and Related Dementias*. Winnipeg, MB.
- Government of New Brunswick. (2008, February). *Be independent. Longer. New Brunswick's Long-Term Care Strategy*.
- Government of New Brunswick. Family and Community Services. (2001). *Going to a Nursing Home*. NB: Public Legal Education and Information Service of New Brunswick.
- Government of New Brunswick. (2002). *Health Renewal. Report from the Premier's Health Quality Council*. NB.
- Government of Newfoundland and Labrador Department of Health and Community Services. (2007). *Provincial healthy aging policy framework*. St. John's: Author.
- Government of Newfoundland and Labrador Department of Health and Community Services. (2008). *Strategic Plan 2008-2011*. St. John's: Author.
- Government of Newfoundland and Labrador Department of Health and Community Services. (2002). *Healthier Together. A Strategic Health Plan for Newfoundland and Labrador*. NL.
- Government of Nova Scotia. (2007, December 7). *Long-Term Care Bed Contracts Awarded*. Available: <http://www.gov.ns.ca/news/details.asp?id=20071207003>

- Government of Nova Scotia. (2009). *Continuing Care Programs: Long Term Care*. Available: <http://www.gov.ns.ca/health/ccs/ltc.asp>
- Government of Nova Scotia. Department of Health. (2000). *Advice and Recommendations of the Advisory Committee on Capital Investment in Long Term Care*. Halifax, NS: Available at www.gov.ns.ca/health/reports/pubs/macleod_report_ltc.pdf
- Government of Nova Scotia. Office of Health Promotion. (2003). *Your Health Matters. Working Together for Better Care*.
- Government of Ontario. Ministry of Health and Long-Term Care. (2000). *2001-2002 Planning, Funding & Accountability Policies & Procedures Manual for Long-Term Care Community Services*. 8th Edition. ON.
- Government of Ontario. Ministry of Health and Long-Term Care. (2007). *LTC-Mental Health Framework – Toronto Region: How-to Guide*. Toronto, ON: Retrieved May 11, 2009, from http://www.toronto.ca/ltc/pdf/how-to-guide_mental-health.pdf
- Government of Ontario. Ministry of Health and Long-Term Care. (2008, July). *What We Heard: Long-Term Care Quality Consultation 2008. A Common Vision of Quality in Ontario Long-Term Care Homes*. ON.
- Government of Ontario. Ministry of Health and Long-Term Care. (2008, May). *People Caring for People: Impacting the quality of life and care of residents of long-term care homes*. Toronto, ON.
- Government of Ontario. Ministry of Health and Long-Term Care. (2009). *Every Door is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy* [Discussion paper]. Toronto, ON.
- Government of Ontario. Ministry of Health and Long-Term Care. (n.d.). *Seniors Care: Supportive Housing*. Retrieved April 16, 2009, from http://www.health.gov.on.ca/english/public/program/ltc/13_housing.html.
- Government of Prince Edward Island. Department of Health. (2009). *Prince Edward Island's Healthy Aging Strategy*. Charlottetown, PE: Author.
- Government of Saskatchewan. Executive Council. (2009, February 3). *Government to replace 13 long-term care facilities*. Retrieved February 18, 2009, from <http://www.gov.sk.ca/news?newsId=6b11ca08-e708-4463-ad52-633cff74da2e>
- Government of Saskatchewan. (2009, February 4). *Government of Saskatchewan to replace 13 long-term care facilities*. Regina, SK.
- Grant, L.A. (2008, February). *Culture change in a for-profit-nursing home chain: an evaluation*. The Commonwealth Fund.
- Gray, J. (2000). Home Care in Ontario; the Case for Copayments. *Health Law Journal*, 8.
- Gray, K. (2002, February 20). Long-term care 'falling apart'. *Ottawa Citizen*.
- Greatley, A., (2009, March 13). Angela Greatley on focusing on mental health. *Health Services Journal*, Available: <http://www.hsj.co.uk/>
- Gross, J. (2005, January 30). Under One Roof, Aging Together Yet Alone. *The New York Times*.
- Gross, J. (2007, October 9). Aging and Gay, and Facing Prejudice in Twilight. *The New York Times*.
- Gruss, V., et al. (2004). Job Stress Among Nursing Home Certified Nursing Assistants: Comparisons of Empowered and Nonempowered Work Environments. *Alzheimer's Care Quarterly*, 5(3), 207-216.
- Guberman, N., et al. (2006). Families' Values and Attitudes Regarding Responsibility for the Frail Elderly: Implications for Aging Policy. *Journal of Aging and Social Policy*, 18(3/4), 59-78.
- Hainsworth, J. (2006, October 12). Gay senior threatened with eviction. *Xtra West*.
- Half of the seniors living in long-term care facilities fall and injure themselves every year. (2009, May 26). *Canada NewsWire*, [CPSI news release].
- Halifax Regional Community Access Programming Association. (2004). *Volunteer Manual: Position Design*. Retrieved, June 15, 2009, from <http://www.hrca.ns.ca/volunteer/manual/section1/position.htm>
- Haran, C. (2006, April). *Transforming Long-Term Care: Giving Residents a Place to Call 'Home.'* The Commonwealth Fund.
- Harrington, C., et al. (2000). Experts Recommend Minimum Nurse Staffing Standards for Nursing Facilities in the United States. *The Gerontologist*, 40(1), 5-16.
- Hawranik, P., & Strain, L. (2000). *Health of Informal Caregivers: Effects of Gender, Employment, and Use of Home Care Services*. Prairie Women's Health Centre of Excellence. Winnipeg, MB.
- Health Canada. (2000). *Abuse and Neglect of Older Adults: A Discussion Paper*. Ottawa, ON: Government of Canada.
- Health Canada. (2001). *Abuse and Neglect of Older Adults: Community Awareness and Response*. Ottawa, ON: Government of Canada.
- Health Canada. (2001). *Health Expenditures in Canada by Age and Sex, 1980-81 to 2000-01*. Ottawa, ON: Health Policy and Communications Branch.
- Health Canada. (2002). *Canada's Aging Population, 2002*. Ottawa, ON: Government of Canada.
- Health Canada. (2003). *Proceedings from the Invitational Symposium. Continuing Care/Long Term Care*. Ottawa, ON: Policy and Public Health Branch.
- Health Canada. (2004). *Informal/Family Caregivers in Canada Caring for Someone with a Mental Illness*. Prepared by Decima Research Inc. Ottawa, ON.
- Health Canada. (2005). *The Cost Effectiveness of Respite: A Literature Review*. Prepared by J. M. Keefe & M. Manning for Health Canada Home and Continuing Care Policy Unit, Health Care Policy Directorate.
- Health Canada. (2007). *Canadian Strategy on Palliative and End-of-Life Care - Final Report of the Coordinating Committee*. Ottawa, ON: Author.
- Health Canada. (2007). *Pan-Canadian Health Human Resources Strategy 2006-07 Report*. Ottawa, ON: Author.

- Health Canada. (2007). *The working conditions of nurses: Confronting the challenges. Strengthening the Policy-Research Connection*, 13, 1-46. Retrieved September 19, 2008, from http://www.hc-sc.gc.ca/sr-sr/alt_formats/hpb-dgps/pdf/pubs/hpr-rps/bull/2007-nurses-infirmieres/2007-nurses-infirmieres-eng.pdf
- Health Council of Canada. (2009). *Value for Money: Making Canadian Health Care Stronger*. Toronto, ON.
- Health Professions Regulatory Advisory Council. (2006, September). *Report to the Minister of Health and Long-Term Care on Regulatory Issues and Matters respecting Personal Support Workers, September, 2006*. Retrieved May 1, 2009, from <http://www.hprac.org/en/reports/pswreportsept06.asp>
- Health Quality Council of Saskatchewan. (2007, May). *Providing Saskatchewan residents the highest quality of health care: Aligning priorities, accelerating improvement. Strategic Plan 2007-2010*. Saskatoon, SK.
- Health Quality Council of Saskatchewan. (2009). *Workshop builds enthusiasm for Releasing Time to Care in Saskatchewan*. Retrieved April 11, 2009, from <http://www.hqc.sk.ca/download.jsp?1ZjAooO7o23hFCWtTnLfDTBlzBf0QfLQkUwK4QBZaJtbm7Yt+EJYBw>
- Health Services Restructuring Commission. (1997). *Rebuilding Ontario's Health System: Interim Planning Guidelines and Implementation Strategies. A Discussion Paper*. Toronto, ON: Author.
- Health Services Utilization and Research Commission. (1994). *Long-Term Care in Saskatchewan. Final Report*. SK: Health Services Saskatoon.
- Hébert, R. (2002). *Research on Aging: Providing Evidence for Rescuing the Canadian Health Care System*. Ottawa, ON: Submission to the Romanow Commission.
- Hébert, R. (2003). Yes to Home Care, but Don't Forget Older Canadians. *Canadian Journal of Aging*, 22(1), 9-10.
- Henry, B.F. (2001, October 22). Decent care for the elderly. *Western Catholic Reporter*. Retrieved September 26, 2008, from <http://www.wcr.ab.ca/bishops/henry/2001/henry102201.shtml>
- Henton, D. (2008, April 25). Too many seniors can't stay home, can't afford to leave. *The Edmonton Journal*.
- Hertzberg, A., & Ekman, S.L. (2003). We, not them and us?: Views on the relationships between staff and relatives of older people permanently living in nursing homes. *Journal of Advanced Nursing*, 31(3), 614-622.
- Hogan, D. (2001, February). Human Resources, Training and Geriatrics. *Geriatrics Today*.
- Hogan, D. (2007). Proceedings and Recommendations of the 2007 Banff Conference on the Future of Geriatrics in Canada. *Canadian Journal of Geriatrics*, 10(4).
- Hogan, D., Beattie, L., Bergman, H., Dalziel, W., Goldlist, B., MacKnight, C., et al. (2002, February). Submission of the Canadian Geriatrics Society to the Commission on the Future of Health Care in Canada. *Geriatrics Today*, 5, 7 -12.
- Hogan, S. (2001). Aging and Financial Pressures on the Health Care System. *Health Policy Research Bulletin*, 1(1), 5-9.
- Hollander Analytical Services. (2000a). *Federal-Provincial-Territorial Advisory Committee on Health Services (ACHS) Working Group on Continuing Care. The Identification and Analysis of the Incentives and Disincentives and Cost-Effectiveness of Various Funding Approaches for Continuing Care. Technical Report 1: Incentives and Disincentives in Funding Continuing Care Services – Key Concepts, Literature and Findings for Canada*. Victoria, BC: Author.
- Hollander Analytical Services. (2000b). *Federal-Provincial-Territorial Advisory Committee on Health Services (ACHS) Working Group on Continuing Care. The Identification and Analysis of the Incentives and Disincentives and Cost-Effectiveness of Various Funding Approaches for Continuing Care. Technical Report 5: An Overview of Continuing Care Services in Canada*. Victoria, BC: Author.
- Hollander Analytical Services. (2000c). *Federal-Provincial-Territorial Advisory Committee on Health Services (ACHS) Working Group on Continuing Care. The Identification and Analysis of the Incentives and Disincentives and Cost-Effectiveness of Various Funding Approaches for Continuing Care. Final Report: The Identification and Analysis of Incentives and Disincentives and Cost-Effectiveness of Various Funding Approaches for Continuing Care*. Victoria, BC: Author.
- Hollander Analytical Services. (2001). *Final Report. Evaluation of the Maintenance and Preventive Function of Home Care*. Ottawa, ON: Home Care/Pharmaceuticals Division, Policy and Communication Branch, Health Canada.
- Hollander, F.P., & Kane, R. (2003). Strengthening Research to Improve the Practice and Management of Long-Term Care. *The Millbank Quarterly*, 81(2). Available: www.millbank.org/quarterly/8102feat.html
- Hollander, M. (2001). *National Evaluation of Cost-Effectiveness of Home Care and Residential Services. Substudy 1. Final Report of the Study of Comparative Cost Analysis of Home Care and Residential Care Services*. Ottawa, ON: Health Transition Fund, Health Canada.
- Hollander, M. (2003). *Unfinished Business: The Case for Chronic Home Care Service. A Policy Paper*. Victoria, BC: Hollander Analytical Services Ltd.
- Hollander, M., & Chappell, N. (2002). *National Evaluation of Cost-Effectiveness of Home Care. Synthesis Report. Final Report of the National Evaluation of the Cost-Effectiveness of Home Care*. Ottawa, ON: Health Transition Fund, Health Canada.
- Hollander, M., & Chappell, N. (2007). A Comparative Analysis of Costs to Government for Home Care and Long-term Residential Care Services, Standardized for Client Care Needs. *Canadian Journal on Aging*, 26(1), 149-161.
- Hollander, M., & Prince, M. (2002, February). *Final Report: "The Third Way": A Framework for Organizing Health Related Services for Individuals with Ongoing Care Needs and Their Families*. Ottawa, ON: Home Care and Pharmaceuticals Division, Health Policy and Communications Branch, Health Canada.
- Hollander, M., Chappell, N., Havens, B., McWilliam, C., & Miller, J. (2002). *National Evaluation of Cost-Effectiveness of Home Care. Substudy 5. Study of the Costs and Outcomes of Home Care and Residential Long Term Care Services*. Ottawa, ON: Health Transition Fund, Health Canada.

- Hollander, M.J., et al. (2007). Providing Care and Support for an Aging Population: Briefing Notes on Key Policy Issues. *Healthcare Quarterly*, 10(3), 34-45.
- Hollings, J., & Brandt, P. (2003). Carewest Sarcee's C3 Program: A New Direction in Community Care. *Stride*, 5(1), 20-23.
- Home Care Sector Study Corporation. (2002, February). *Canadian Home Care Human Resources Study. Phase I Report: Setting the Stage: What Shapes the Home Care Labour Market?* Ottawa, ON.
- Home Care Sector Study Corporation. (2003, December). *Canadian Home Care Human Resources Study. Technical Report*. Ottawa, ON.
- Home Care Sector Study Corporation. (2003, October). *Canadian Home Care Human Resources Study. Synthesis Report*. Ottawa, ON.
- House of Commons. (2003). *Honouring the Pledge: Ensuring Quality Long-Term Care for Veterans*. Report of the Standing Committee on National Defence and Veterans Affairs. Report of Sub-Committee on Veterans Affairs. Ottawa, ON.
- Hughes, R., (2008). Electronic surveillance and tagging people with dementia. *International Journal of Palliative Nursing*, 14(2), 74-76.
- Hylton, J. (2008, July/August). The seal of approval. *Canadian Healthcare Manager*, pp. 46.
- interRAI. (2006). *The Integrated Suite of Instruments*. Retrieved June 24, 2009, from <http://www.interrai.org/section/view/>
- Jensen, C. (2008, February 2). *MDS funding model unknown*. OLTCA Morning Report. Retrieved March 3, 2008, from <http://www.oltca.com/axiom/DailyNews/2008/February/February22.html>
- Joffres, C. (2001). Barriers to Residential Planning: Perspectives from Selected Caring for Adult Offspring with Lifelong Disabilities. *Canadian Journal on Aging*, 21(2), 303-311.
- Kagis, M., Menec, V., & Blandford, A. (2006, January). *Manitoba's Seniors A Companion to the 'Manitoba Fact Book on Aging'*. MB: Centre on Aging, University of Manitoba.
- Kamimura, A., et al. (2007). Do corporate chains affect quality of care in nursing homes? The role of corporate standardization. *Health Care Management Review*, 32(2), 168-178.
- Kane, R., Lum, T., Cutler, L., Degenholtz, H., & Tzy-Chyi, Y. (2007). Resident Outcomes in Small-House Nursing Homes. *Journal of the American Geriatric Society*, 55(6), 832-839.
- Kane, R.A. (2003). Definition, measurement, and correlates of quality of life in nursing homes: Toward a reasonable practice, research, and policy agenda [Special edition II]. *The Gerontologist*, 4328-36.
- Kane, R.L., & Kane, R.A. (2001). What Older People Want From Long-Term Care, And How They Can Get It. *Health Affairs*, 20(6), 114-127.
- Kane, R.L., Kane, R.A., & Degenholtz, H. (2005). Assessing the Quality of Life among nursing home residents: Implications for Alzheimer's Disease. *Research and Practice in Alzheimer's Disease*, 12, 167-171.
- Kapp, M.B. (2003). 'At least Mom will be safe there': the role of resident safety in nursing home quality. *Quality and Safety in Health Care*, 18(3), 201-204.
- Keating, N., Fast, J., Frederick, J., Cranswick, K., & Perrier, C. (1999, November). *Eldercare in Canada: Context, Content and Consequences*. Statistics Canada.
- Kennedy, S. (2003, July 8). Nurses shun elderly care. *Ottawa Citizen*.
- Kerrison, S.H., & Pollock, A.M. (2001) Caring for older people in the private sector in England. *British Medical Journal*, 323(7312), 566-9.
- King, M. (2007, July 17). Elder co-housing project is aimed at gay women. *The Seattle Times*.
- King, P., & Jackson, H. (2000). *Public Finance Implications of Population Ageing*. Ottawa, ON: Department of Finance Canada.
- Kleinman, A. (2009, July 11). Health care's missing care. *Globe and Mail*.
- Knight, V., & Vautier, R. (2001, August/October). Quality of Service Approach in the Nursing Homes of New Brunswick. *Stride*, 16-18, 20.
- Konetzka, R.T., Spector, W., & Limcangco, M.R. (2008). Reducing Hospitalizations From Long-Term Care Settings. *Medical Care Research and Review*, 65(1), 40-66.
- Koren, M. J. (2008, May 25). *In the Hands of Strangers: Are Nursing Homes Safeguards Working?* Moving to a Higher Level: How Collaboration and Cooperation Can Improve Nursing Home Quality, Invited Testimony. U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Oversight and Investigations.
- Kortes-Miller, K., Habjan, S., & Kelley, M.L. (2007). Development of the palliative care education program in rural long-term care facilities. *Journal of Palliative Care*, 23(3), 154-162.
- Kosak, J. (2000, September). *National Forum on Closing the Care Gap Report*. Ottawa, ON: Canadian Association on Gerontology.
- Kovner, C.T., Mezey, M., & Harrington, C. (2003). Who Cares For Older Adults? Workforce Implications Of An Aging Society. *Canadian Health Care Management*, 103(8), 84-88.
- Kozyrskyj, A., Black, C., Dunn, E., Steinbach, C., & Chateau, D. (2003). *Discharge Outcomes for Long-Stay Patients in Winnipeg Acute Care Hospitals*. MB: Manitoba Centre for Health Policy and Evaluation, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba.
- KPMG. (2001). *Tax Planning for You and Your Family*. Toronto, ON: Carswell Thompson Professional Publishing.
- Kucharska, D. (2004, May). *Seniors' Health and Housing Crossroads: Exploring Alternatives to Long-term Care Facilities*. Ontario Coalition of Senior Citizens' Organizations.
- Lage, L. (2003). Letter to the Editor. Rewards of Long-Term Care. *Canadian Nurse*, 99(7), 7.
- Lang, M. (2009, April 7). Strathmore calls for long-term beds. *Calgary Herald*.

- Lazurko, M., & Hearn, B. (2000). *Canadian Continuing Care Scenarios 1999-2041*. Ottawa, ON: KPMG, Federal-Provincial-Territorial Advisory Committee on Health Services.
- Le Vérificateur Général du Québec. (n.d.). *Report to the National Assembly for 2001-2002*. QC: Publications Québec.
- Lightman, E. (2008, July 22). Nursing home sector needs basic reform not more money. *Toronto Star*.
- Lilley, S., & Campbell, J.M. (1999). *Shifting Sands: The Changing Shape of Atlantic Canada*. Halifax, NS: Atlantic Regional Office, Health Canada.
- Lloyd-Williams, M., & Filbet, M. (2004). Can palliative care improve the symptoms during the terminal phase of dementia? *European Journal of Palliative Care*, 11(3), 99-101.
- Lorinc, J. (2008, August 9). The Medicare Myth that Refuses to Die. *Globe and Mail*.
- Low, L.F. (2004). The relationship between self-destructive behaviour and nursing home environment. *Aging and Mental Health*, 8(1), 29-33.
- Lusk, C. (2008). Establishing palliative care support programs in LTC. *Canadian Nursing Home*, 19(2), 11-17.
- Mabell, D. (2008, December 22). Province lowering boom on seniors. *Lethbridge Herald*.
- Maclean, M., & Greenwood Klein, J. (2002). Access to Long-Term Care: The Myth versus the Reality. In M. Stephenson and E. Sawyer (Eds.), *Continuing the Care* (Rev. ed., pp. 71-86). Ottawa, ON: CHA Press.
- MacLellan, M., Norris, D., Flowerdew, G., MacPherson, K., Bird, L., & Langille Ingram, E. (2002). *Age Related Transitions: Older Parents Caring for Adult Sons/Daughters with Lifelong Disabilities*. Final Report. Mount Saint Vincent University – Halifax.
- MacRae, A., Menger, C., & Prada, G. (2003). Accreditation in Long Term Care Organizations. *Stride*, 5(3), 14-17.
- Manitoba Nurses Union. (2006, December). *Long-term care in Manitoba*.
- Manulife. (2008, October). *Long Term Care in Quebec*. Retrieved January 14, 2009, from [https://hermes.manulife.com/canada/repsrcfm-dir.nsf/Public/ThecostoflongtermcareinQuebec/\\$File/QUEBEC_LTC_CostReport.pdf](https://hermes.manulife.com/canada/repsrcfm-dir.nsf/Public/ThecostoflongtermcareinQuebec/$File/QUEBEC_LTC_CostReport.pdf)
- Marketing key to solving nursing shortage. (2003, July 9). *Ottawa Citizen*.
- Markle-Reid, M., Browne, G., Weir, R., Gafini, A., Roberts, J., & Henderson, S. (2008). Seniors at Risk: The Association Between the Six-Month Use of Publicly Funded Home Support Services and Quality of Life and Use of Health Services for Older People. *Canadian Journal on Aging*, 27(2), 207-224.
- Maxwell, J. (2003). *The Great Social Transformation: Implications for the Social Role of Government in Ontario. A Paper Prepared for the Panel on the Role of Government*. Ottawa, ON: Canadian Policy Research Networks.
- Maxwell, J. (2008, March 24). Out of the ER: Finding the 'right' setting for elderly patients. *The Globe and Mail*.
- McAiney, C., Haughton, D., Jennings, J., Farr, D., Hillier, L., and P. Morden. (2008). A unique practice model for Nurse Practitioners in long-term care homes. *Journal of Advanced Nursing*, 62(5), 562-571.
- McCloskey, R. (2002). Nursing Homes as Acute Care Providers. *Nursing Home*, 12(4), 9-14.
- McCloskey, R. (2003). *Impact of Long Term Care Policy on Health of Older Adults*. RAO 2nd International Conference on Elder Care. Toronto, ON.
- McCrimmon, C. (2008, July). *Manitoba Seniors 2006 Census Update*. Centre on Aging, University of Manitoba.
- McDonald, J., & Parfrey, P. (2001). *The Needs for Long-Term Institutional Care Within the St. John's Region in 2001*. Clinical Epidemiology Unit, Memorial University, NL.
- McGrail, K.M., McGregor, M.J., Cohen, M., Tate, R.T., & Ronald, L.A. (2007). For-profit versus not-for-profit delivery of long-term care. *Canadian Medical Association Journal*, 176(1), 57-58.
- McGregor, M.J., et al. (2005). Staffing levels in not-for-profit and for-profit long-term care facilities: does type of ownership matter? *Canadian Medical Association Journal*, 172(5), 645-9.
- Meade, C.M., Bursell, A.L., & Ketelsen, L. (2006). Effects of Nursing Rounds on Patients' Call Light Use, Satisfaction, and Safety. *American Journal of Nursing*, 106(9), 58-70.
- Medical-Net. (2005, May 20). *Physiotherapy is effective in treating stress incontinence*. Retrieved September 2, 2008, from <http://www.news-medical.net/?id=10257>
- Menec, V. H., MacWilliam, L., Soodeen, R.A., & Mitchell, L. (2002). *The Health and Health Care Use of Manitoba's Seniors: Have They Changed Over Time?* MB: Manitoba Centre for Health Policy and Evaluation, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba.
- Mental Health Commission of Canada. (2009). *Out of the Shadows – Forever: 2008-2009 Annual Report*. Calgary: Mental Health Commission of Canada.
- Mérette, M. (2002). The Bright Side: A Positive View on the Economics of Aging. *Choices*, 8(1). Retrieved August 12, 2009, from <http://www.irpp.org/fastrak/index.htm>.
- Mezey, M.D., Mitty, E.L., & Green Burger, S. (2008). Rethinking Teaching Nursing Homes: Potential for Improving Long-Term Care. *The Gerontologist*, 48(1), 8-15.
- Michaud, C. (2002). Palliative Care or Openness to the Spiritual Dimension in the Face of Death. *Review*, 30(1), 10-4.
- Middleton, J. (2002). *Community Mosaics*. RAO 1st International Conference on Elder Care. Toronto, ON.

- Milner, B., & Scofield, H. (2009, July 9). The demographic challenge facing developed nations is expected to dwarf the cost of recent financial stimulus. *Globe and Mail*.
- Minister's Commitment to Address Long Term Care Issues Welcomed. (2003, December 8). *Canada NewsWire*.
- Monaghan, B., Malek, A., & Simson, H. (2001). Public-Private Partnerships in Healthcare: Criteria for Success. *Healthcare Management Forum*, 14(4), 44-49.
- Moreau, V. (2009, May 12). Kiwanis-run care facility gets a reprieve. *Oak Bay News*.
- Morgan, D.G., et al. (2005). Work stress and physical assault of nursing aides in rural nursing homes with and without dementia special care units. *Journal of psychiatric and mental health nursing*, 12(3), 347-358.
- Muggeridge, P. (2004, February). Inside Canada's Nursing Homes 50Plus, 15-34.
- Muirhead G., & Sachs, C. (2003). A multidisciplinary approach to LTC patients with behavioral problems. *Journal of Clinical Nursing*, 12(6) 888-898.
- Multiple Sclerosis Society of Canada. (2006). *Finding My Place: Age-appropriate housing for younger adults with multiple sclerosis*. Toronto: ON.
- Murphy, J. M. (2006, November). *Residential care quality: A review of the literature on nurse and personal care staffing and quality of care*. Prepared for the Nursing Directorate, British Columbia Ministry of Health.
- Myers, K., & de Broucker, P. (2006). *Too Many Left Behind: Canada's Adult Education and Training System*. Canadian Policy Research Networks.
- National Advisory Council on Aging. (2000). *The NACA Position on Enhancing the Canadian Health Care System*. Ottawa, ON: Minister of Public Works and Government Services Canada.
- National Advisory Council on Aging. (2002). *The NACA Position on Supportive Housing for Seniors*. No. 22. Ottawa, ON: Minister of Public Works and Government Services Canada.
- National Advisory Council on Aging. (2002). *Writings in Gerontology: Mental Health and Aging*. Ottawa, ON: Minister of Public Works and Government Services Canada.
- National Advisory Council on Aging. (2005). *Aging in poverty in Canada*. Ottawa, ON. Retrieved February 18, 2009, from <http://dsp-psd.pwgsc.gc.ca/Collection/H88-5-3-2005E.pdf>
- National Advisory Council on Aging. (2005, October 19). *NACA Demands Improvements to Canada's Long-Term Care Institutions*. Marketwire. Retrieved October 22, 2007, from <http://www.ccnmatthews.com/news/releasesfr/show.jsp?action=showRelease&actionF=563363>
- National Advisory Council on Aging. (2006). *Seniors in Canada: 2006 Report Card*. Ottawa, ON. Retrieved December 16, 2008, from <http://dsp-psd.pwgsc.gc.ca/Collection/HP30-1-2006E.pdf>
- National Commission for Quality Long-Term Care. (2007, December 3). *From Isolation to Integration*. National Commission for Quality Long-Term Care. Washington, DC.
- National Institute for Clinical Excellence. (2005). *Violence: The short-term management of disturbed/violent behavior on psychiatric in-patient setting and emergency departments: NICE guideline*. Retrieved January 17, 2009, from <http://www.nice.org.uk/Guidance/CG25>
- National Patient Safety Agency. (n.d.). *Seven steps to patient safety - your guide to safer patient care*. Retrieved April 4, 2009, from <http://www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/7steps/>
- National Report Confirms Priorities for Addressing Alberta RN Shortage. (2009, May 11). *Canada NewsWire* [CARNA press release].
- National Steering Committee on Patient Safety. (2002). *Building a Safer System :A National Integrated Strategy for Improving Patient Safety in Canadian Health Care*. Ottawa, ON. Retrieved January 25, 2009, from http://rcpsc.medical.org/publications/building_a_safer_system_e.pdf
- National Union of Public and General Employees. (2007, February). *Dignity Denied: Long-Term Care and Canada's Elderly*. Ottawa, ON.
- Nelson, W.A. (2009). Ethical Uncertainty and Staff Stress. *Healthcare Executive*, 24(4), 38-39.
- Newson, B. (2002). *Principles to Guide a Unified Funding Model for Non-Medicare (Non-Insured) Health and Social Services*. Halifax, NS: Atlantic Institute for Market Studies.
- Nursing Homes are the Modern Mental Institutions for Seniors. (2002, April 29). *Canadian Coalition for Seniors Mental Health* [Press release].
- O'Brien-Pallas, L., Hiroz, J., Cook, A., et al. (2005). *Nurse-Physician Relationships: Solutions & Recommendations for Change*. Retrieved February 22, 2008, from www.nhsru.com
- O'Brien-Pallas, L., Mildon, B., Tomblin Murphy, G., et al. (2007). *Promoting awareness and uptake of best practice guidelines in long term care: an impact evaluation*. Retrieved February 22, 2008, from www.nhsru.com
- O'Bryan, W. (2006, April 6). The GLBT community looks ahead to its golden years. *Metro Weekly*.
- O'Reilly, K., & Pryor, J. (2003). Young People With Brain Injury In Nursing Homes: Not The Best Option! *Canadian Health Care Management*, 103(3), 38-40.
- O'Rourke, N., Cappeliez, P., & Neufeld, E. (2007). Recurrent Depressive Symptomatology and Physical Health: A 10-Year Study of Informal Caregivers of Persons with Dementia. *The Canadian Journal of Psychiatry*, 52(7), 434-439.

- Office of the Assisted Living Registrar of British Columbia. (2009). *Complaint Investigation for Residents of Assisted Living for Seniors*. Vancouver, BC.
- Oliver, K. (2007, July 3). No place like home: Long over due long term health care facility underway. *The Labradorian*.
- One in nine nursing homes 'high risk'. (2008, June 20). *Vancouver Sun*. Retrieved January 20, 2009, from <http://www.canada.com/vancouver/features/care/story.html?id=b080334f-677e-493c-b096-b92bba6071f2>
- Ontario Association of Non-Profit Homes and Services for Seniors. (2008, June). *Submission to the Provincial-Municipal Fiscal and Service Delivery Review*. Woodbridge, ON: Author.
- Ontario Association of Non-Profit Homes and Services for Seniors. (2007, January). *Submission to the Standing Committee on Social Policy re: Bill 140*. Woodbridge, ON: Author.
- Ontario Federation of Labour. (2005, October). *Understaffed and Under Pressure: A reality check by Ontario health care workers*. Toronto, ON.
- Ontario Health Coalition. (2007, January, 16). *Submission to the Standing Committee on Social Policy Regarding Bill 140: An Act Respecting Long-term Care Homes*. Toronto, ON: Author.
- Ontario Health Coalition. (2008, May). *Violence, Insufficient Care, and Downloading of Heavy Care Patients: An evaluation of increasing need and inadequate standards in Ontario's nursing homes*. Toronto, ON.
- Ontario Health Quality Council. (2008, December). *Strategic Plan 2008*. Toronto, ON: Author. Retrieved May 1, 2009, from http://www.ohqc.ca/pdfs/final_strategic_plan_december_2008.pdf
- Ontario Health Quality Council. (2008, July 31). *Accountability Agreements in Ontario's Health System: How can they accelerate quality improvement and enhance public reporting?* Ontario Health Quality Council & Ontario Joint Policy and Planning Committee White Paper. Retrieved May 1, 2009, from http://www.ohqc.ca/pdfs/accountability_agreements_in_ontario-july_31_2008.pdf
- Ontario Health Quality Council. (2009). *Long-Term Care in Ontario: A Report on Quality*. Toronto, ON: Author.
- Ontario Health Quality Council. (2009). *Mandate*. Retrieved May 11, 2009, from <http://www.ohqc.ca/en/mandate.php>
- Ontario Hospital Association. (2007, June). *Changing Trends in Co-Payment Collection in Complex Continuing Care*.
- Ontario Human Rights Commission. (n.d.). *Time for Action: Advancing Human Rights for Older Ontarians*. Retrieved December 10, 2008, from http://www.ohrc.on.ca/en/resources/discussion_consultation/TimeForActionsENGL?page=TimeForActionsENGL-Elder-2.html
- Ontario Long Term Care Association. (2009, June 9). *Report Supports Continued Capacity Building Efforts in Long Term Care*, [OLTCA press release].
- Ontario Long Term Care Association. (2007, October 18). *Another Wakeup Call for Government to Fund Long-Term Care Appropriately* [Press release].
- Ontario Long Term Care Association. (2008, August). *Submission to the Health Professions Regulatory Advisory Committee Respecting the Review of the Scope of Practice of: Registered Dietitians, Pharmacists, Physiotherapists in Ontario*. Markham, ON.
- Ontario Long Term Care Association. (2009). *A Unique Practice Model for Nurse Practitioners in Long-Term Care Homes*. Markham, ON: Retrieved May 23, 2009, from <http://www.oltca.com/en/research/newsandviews.html>
- Ontario Nurses Association. (2007, January 17). *Submission on Bill 140 – Long-Term Care Homes Act, 2006*. Toronto, ON: Author.
- Ontario Public Service Employees Union. (2007, January 17). *Submission to the Standing Committee on Social Policy Re: Bill 140 – Long Term Care Homes Act*. Toronto, ON: Author.
- Ontario Residential Care Association. (n.d.). *What's the Difference Between a Retirement Residence and a Nursing Home?* Retrieved October 14, 2007, from http://www.orca-homes.com/orca_faq.html#2
- Ontario Society of Occupational Therapists. (2007, January 19). *Submission to the Standing Committee on Social Policy on Bill 140*. Toronto, ON: Author.
- Orchard, M., Green, E., Sullivan, T., Greenberg, A., & Mai, V. (2008). Chronic Disease Prevention and Management: Implications for Health Human Resources in 2020. *Healthcare Quarterly*, 11(1), 38–43.
- Organisation for Economic Co-operation and Development. (2000). *Reforms for an Ageing Society*. Paris, France: OECD.
- Organisation for Economic Co-operation and Development. (2005). *Long-Term care for Older People*. Paris, France: OECD.
- Orsted, H.L. (2009). The future of wound care: The focus must be on prevention. *Rehab and Community Care Medicine*, 18(1), 20-23.
- Otani, K., et al. (2009). Patient Satisfaction: Focusing on "Excellent". *Journal of Healthcare Management*, 54(2), 93-103.
- Paddock, K., & Hirdes, J.P. (2003). Acute Health Care Service Use Among Elderly Home Care Clients. *Home Health Care Services Quarterly*, 22(1), 75-85.
- Pain Education in Canada: Vets get over 3 times more training than other Health Sciences grads, including doctors and nurses. (2007, November 4). *Canada NewsWire*.
- Parkland Institute. (2008, September). *Sustainable Healthcare for Seniors: Keeping It Public*. Edmonton, AB.
- Patient safety in long-term care under the microscope - Canadian Patient Safety Institute releases background paper. (2008, February 25). *Canada NewsWire* [CPSI press release].
- Patrick, D.L., Curtis, R., Engelberg, R.A., Nielsen, E., & McCown, E. (2003). Measuring and Improving the Quality of Dying and Death. *American College of Physicians*, 139(5), 410-415.

- Peacock, S. (2008). The moral challenges involved in palliative end-of-life dementia care. *Canadian Nursing Home* 19(3), 11-17.
- Philip, M. (2009, April 3). Nursing homes that need EMS: Senior care still in troubled state. *Globe and Mail*.
- Pickering Institute. (2007, September). *Is the NHS becoming more patient-centered?* Retrieved July 18, 2008, from http://www.pickereurope.org/Filestore/Publications/Trends_2007_final.pdf
- Picard, A. (2008, April 3). Quality, not just quantity, of care matters. *Globe and Mail*.
- Pitters, S. (2002) Long-Term Care Facilities. In M. Stephenson and E. Sawyer (Eds.), *Continuing the Care* (Rev. ed., pp. 163-201). Ottawa, ON: CHA Press.
- Pollack, A. (2001). Aging as a Health Care Cost Driver. *Health Policy Research Bulletin*, 1(1) 10-12.
- Pollack, A. (n.d.). Compression of Health Expenditures. *Health Policy Research Bulletin*, 1(1), 13-15.
- PricewaterhouseCoopers. (2000). *A Review of Community Care Access Centres in Ontario. Final Report*. ON: Ontario Ministry of Health and Long Term Care.
- PricewaterhouseCoopers. (2001, January). *Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long-Term Care Facilities and Selected Comparators*. Prepared for the Ontario Long Term Care Association and the Ontario Association of Non-Profit Homes and Services for Seniors. ON.
- Province releases consultant's report on the Island's health care. (2008, November 18). *The Guardian*.
- Psychiatric Patient Advocate Office. (2007, January 16). *Long-Term Care Rights Protection: Submission Regarding Bill 140 – An Act Respecting Long-Term Care Homes*. Toronto, ON: Author.
- Public Health Agency of Canada, Division of Aging and Seniors. (n.d.). Retrieved September 3, 2008, from http://www.phac-aspc.gc.ca/seniors-aines/pubs/info_exchange/incontinence/exch_toc_e.htm
- Puxley, C. (2008, July 2). Three-quarters of nursing homes cited for not meeting some provincial standards. *Canadian Press*.
- Puxley, C. (2008, July 4). Ontario nursing homes poorly staffed, more likely to restrain residents: experts. *Prince Albert Daily Herald*.
- Quality End-of-Life Care Coalition of Canada. (2008, May 13). *New QELCCC Report: Provinces and Territories Making Progress in Providing Palliative Home Care but Inequalities in Access Still Exist* [Press release].
- Quality End-of-Life Care Coalition of Canada. (2008, May). *Hospice Palliative Home Care in Canada: A Progress Report*. Ottawa, ON: Author.
- Quality Worklife-Quality Healthcare Collaborative. (2007). *Within Our Grasp: A Healthy Workplace Action Strategy for Success and Sustainability in Canada's Healthcare System*. Ottawa, ON.
- Québec Commission d'étude sur les services de santé et les services sociaux. (2001). *Emerging Solutions – Report and Recommendations*. QC.
- Québec Famille et Enfance. (2001). *Québec and its Seniors: Together in Action. Commitments and Perspectives: 2001-2004*. QC.
- RAND Corporation. (2008, April). *Development and validation of a revised nursing home assessment tool MDS 3.0*. Retrieved April 18, 2009, from <http://www.cms.hhs.gov/NursingHomeQuality/Inits/Downloads/MDS30FinalReport.pdf>
- Rantz, M.J., Hicks, L., Grando, V., Petroski, G.F., Madsen, R.W., Mehr, D.R., et al. (2004). Nursing home quality, cost, staffing, and staff mix. *The Gerontologist*, 44(1), 24-38.
- Raphael, C. (2008, July 21). Long-Term Care: Preparing for the Next Generation. *The Commonwealth Fund* [Commentary].
- Rauscher, M. (2009, April 30). Exercise calms agitation associated with dementia. *The Calgary Herald*.
- Reference Manual Long Term Care and Community Support Program Adult Needs Assessment. (2008, August). NL.
- Registered Nurses Association of Northwest Territories and Nunavut. (n.d.). *Restraint: Who, when and what process*. Retrieved January 14, 2009, from <http://www.rnantnu.ca/Portals/0/Documents/News/restraint.pdf>
- Registered Nurses' Association of Ontario. (2007, January 16). *Dignity, Security, Safety and Comfort for All: Long-Term Care Homes Act, 2006 Submission to the Standing Committee on Social Policy*.
- Rehab and Community Medicine. (2008). What makes you feel at home? 17(3), 3.
- Ritter, J. (2006, July 5). Gay seniors settle into a niche. *USA Today*.
- Riudavets, M.A., Colegial, C., Rubio, A., Fowler, D., Pardo, C., & Troncoso, J.C. (2005). Causes of unexpected death in patients with multiple sclerosis: a forensic study of 50 cases. *American Journal of Forensic Medicine & Pathology*, 26(3), 244-249.
- Roberts, R. (2007, December 10). Long-term beds coming, but not to Pictou County. *The Pictou County News*.
- Robichaud, L., Durand, P.J., Bédard, R., & Ouellet, J. (2006). Quality of life indicators in long term care: Opinions of elderly residents and their families. *Canadian Journal of Occupational Therapy*, 73(4), 245-251.
- Robson, W. (2001). Will the Baby Boomers Bust the Health Budget? *C.D. Howe Institute Commentary*, 148, 1-29.
- Rocker, G., & Heyland, D. (2003). New Research Initiatives in Canada for End-of-Life and Palliative Care. *Canadian Medical Association Journal*, 169(4), 300-301.
- Rockwood, K. (2001, November 6). *Future of Health Care for Frail Older Adults*. Presentation to the Standing Senate Committee on Social Affairs, Science and Technology. Ottawa, ON.
- Rockwood, K. (2002, February). *Future of Health Care for Frail Older Adults*. *Geriatrics Today*.

- Rockwood, K., MacKnight, C., & Powell, C. (2001). Clinical Research on Older Adults in Canada: Summary of Recent Progress. *Canadian Journal on Aging*, 21(Supplement 1), 1-16.
- Rogers, J. (2002, April 2). Poor care for elderly is shameful. *Ottawa Citizen*.
- Rosenberg, M. (2000). Social and Economic Dimensions of an Aging Population. *SEDAP Research Paper No. 14*. Hamilton, ON: McMaster University Program for Research on Social and Economic Dimensions of an Aging Population.
- Royal Bolton Hospital. (2007). *Bolton Improving Care System (BICS) - Using Lean Methodology*. Retrieved July 16, 2009, from <http://www.boltonhospitals.nhs.uk/bics/default.html>
- Ruggeri, J. (2002). *Population Aging, Health Care Spending and Sustainability: Do We Really Have a Crisis?* Ottawa, ON: Caledon Institute of Social Policy.
- Rupert, J. (2009, July 4). Housing initiative to begin in the fall. *Ottawa Citizen*.
- Rust, T.B., et al. (2008). Broadening the Patient Safety Agenda to Include Safety in Long-Term Care [Special issue]. *Healthcare Quarterly*, 11, 31-34.
- Samuelson, K. (2002). Effective leadership. *Canadian Nursing Home*, 13(2), 11-15.
- Samuelson, K. (2003). Home-like – It just isn't enough! *Canadian Nursing Home*, 14(5), 27-30.
- Samuelson, K. (2004). Raising the Profile of Long-Term Care. *Canadian Nursing Home*, 15(1), 62-63.
- Samuelson, K. (2006). Who cares for the care-giver? *Canadian Nursing Home*, 17(1), 62-63.
- Sanders, C. (2009, March 20). Veterans share stories of war. *Winnipeg Free Press*.
- Sask. dentist calls for oral health program for long-term care residents. (2008, May 2). *Regina Leader Post*.
- Saskatchewan Association of Health Organizations. (2000). *A Response to the Commission on Medicare's 'Caring for Medicare: the Challenges Ahead'*. Regina, SK.
- Saskatchewan government promises to build 13 new long-term care facilities. (2009, February 9). *Daily Commercial News and Construction Record*.
- Saskatchewan Health. (2003). *It's for Your Benefit. A Guide to Health Coverage in Saskatchewan*. Regina, SK: Saskatchewan Health.
- Sass, B. (2009, January 28). Foundation offers capped rents for seniors. *The Edmonton Journal*.
- Saunders, D. (2001). Trends in Utilization of Health Services by Seniors in Alberta. *Canadian Journal on Aging*, 20(4), 493-516.
- Saunders, R. (2007). *Moving Forward on Workplace Learning*. Canadian Policy Research Networks (CPRN).
- Schaffer, A. (2008, February 19). Fighting Bedsores With a Team Approach. *The New York Times*.
- Schindel-Martin, L. (2003). Teaching staff to respond effectively to cognitively impaired residents who display self-protective behaviors. *American Journal of Alzheimer's Disease and Other Dementias*, 18(5), 273-281.
- Schnelle, J., Simmons, S., Harrington, C., Cadogan, M., Garcia, E., & Bates-Jenson, B. (2004). Relationship of nursing home staffing to quality of care. *Health Services Research*, 39(2), 225-249.
- Seguin, R. (2009, May 21). Quebec to send in the clowns to nursing homes. *The Globe and Mail*.
- Seniors advocates find strong voice in FAIRE comment. (2001, February 22). *Calgary Herald*.
- Seniors getting 'assembly-line care' at facilities: CUPE. (2007, September 25). *The Windsor Star*.
- Seniors Need More Care, Not Less. (2002, Fall/Winter). *Milestones*, 7(3).
- Service des personnes âgées, Direction générale des services à la population, Ministère de la Santé et des Services sociaux. (2003). *Document Explicatif. Pour un nouveau partenariat au service des aînés. Projets novateurs*. QC: Ministère de la Santé et des Services sociaux.
- Shain, M. (2008). *Stress at Work, Mental Injury and the Law in Canada: A Discussion Paper for the Mental Health Commission of Canada*. Calgary, AB: Mental Health Commission of Canada.
- Shapiro, E. (1998). Market Forces and Vulnerable Elderly People: Who Cares? *Canadian Medical Association Journal*, 159(2), 151-152.
- Shapiro, E. (2002). *What Works, What Doesn't: Federal and Provincial Imperatives for Elder Health*. RAO 1st International Conference on RAO Eldercare. Toronto, ON.
- Shaw, M.M. (2004). Aggression toward staff by nursing home residents: findings from a grounded theory study. *Journal of Gerontological Nursing*, 30(10), 43-54.
- Sheppard, S.M., Rathgeber, M.R., Franko, J.M., Treppel, D.M., Card, S.E., & Neudorf, C.O. (2002/2003). Are Longer Hospital Stays Beneficial for the Elderly? *Hospital Quarterly*, 6(2), 52-55.
- Shinoda-Tagawa T., Leonard R., Pontikas, J., et al. (2004). Resident-to-resident violent incidents in nursing homes. *Journal of the American Medical Association*, 291(5), 591-598.
- Sholzberg-Gray, S. (2008, June 2). *The Patchwork Quilt of Care Outside of Hospitals: Regional or Pan-Canadian Solutions?* Presentation at the National Healthcare Leadership Conference, Saskatoon, SK.
- Sinnema, J. (2009, June 30). Health care privatizing in stealth mode--UNA boss. *The Edmonton Journal*.
- Smallbrugge, M., Pot, A.M., Jongenelis, K., Beekman, A.T., & Eefsting, J.A. (2005). Prevalence and correlates of anxiety among nursing home patients. *Journal of Affective Disorders*, 88(2), 145-153.

- Somerville, N. (2009, March 23). Liepert's strategic attack on Alberta seniors. *Edmonton Journal*.
- Souder, E. (2003). Disruptive behaviors of older adults in an institutional setting. *Journal of Gerontological Nursing*, 29(8), 31-36.
- South-Eastern Ontario Long-Term Care Facility Committee. (2007, July). *Stormont, Dundas and Glengarry Long-Term Care Beds Needs Analysis*. G-KAM Consulting.
- Spencer, C. (1994). *Abuse and Neglect of Older Adults in Institutional Settings. A Discussion Paper Building from English Language Resources*. Ottawa, ON: Mental Health Division, Health Services Directorate, Health Canada.
- St. John's Nursing Home Board. (2002). *Final report – Role and feasibility study for St. John's Nursing Home Board*. St. John's: Author.
- St. John's Nursing Home Board. (2002). *Submission to the Commission on the Future of Health Care*. NL.
- Stadnyk, R. (2002). *The Status of Canadian Nursing Home Care: Universality, Accessibility, and Comprehensiveness*. Halifax, NS: Atlantic Centre of Excellence for Women's Health.
- Standing Senate Committee on Social Affairs, Science and Technology. (2002). Ottawa, ON: Unrevised Evidence, Social 38774.
- Statistics Canada. (1999). *Health among older adults*. In J. Chen & M. Shields (Eds.). *Health Reports*. 11(3), (Catalogue 82-003). Ottawa, ON: Author.
- Statistics Canada. (2000). Disability-free life expectancy by health region. In F. Mayer, N. Ross, J.-M. Berthelot & R. Wilkins (Eds.). *Health Reports*, 11(4), (Catalogue 82-003). Ottawa, ON: Author.
- Statistics Canada. (2000, Summer). Dependence-Free Life Expectancy in Canada. In L. Martel & A. Bélanger (Eds.). *Canadian Social Trends* (Catalogue No. 11-008), 26-29.
- Statistics Canada. (2002). *A Profile of Disability in Canada, 2001*. Ottawa, ON: Housing, Family and Social Statistics Division.
- Statistics Canada. (2002). *Profile of the Canadian Population by Age and Sex: Canada Ages*. (Catalogue 96F0030XIE2001002). Ottawa, ON.
- Statistics Canada. (2006). *Findings From the 2005 National Survey of the Work and Health of Nurses*. Ottawa, ON: Author.
- Statistics Canada. (2007). M. Turcotte and G. Schellenberg. (Eds.). *A Portrait of Seniors in Canada* (Catalogue 89-519-XPE). Ottawa, ON.
- Statistics Canada. (2007, November 22). *Residential Care Facilities Survey: Survey Description*. Retrieved December 2, 2008, from <http://www.statcan.gc.ca/pub/83-237-x/2008001/4097306-eng.htm>
- Statistics Canada. (2008). *Income in Canada 200*. (Catalogue 75-202-XWE, Table 11.1). Ottawa, ON.
- Statistics Canada. (2008, January 14). Deaths. *The Daily*.
- Statistics Canada. (n.d.). *Life expectancy at birth and at age 65 - abridged life table by sex and geography*. Retrieved July 16, 2009, from <http://www.statcan.gc.ca/pub/84f0211x/2006000/t032-eng.pdf>
- Statistics Canada. (n.d.). *National Population Health Survey. 1998-99*.
- Statistics Canada. (n.d.). *National Population Health Survey. 2002-03*.
- Statistics Canada. (n.d.). *National Population Health Survey. 2000-01*.
- Stevenson, D.G., & Studdert, D.M. (2003). The Rise Of Nursing Home Litigation: Findings From A National Survey Of Attorneys. *Health Affairs*, 22(2), 219-229.
- Stewart, D., Finlayson, G., MacWilliam, L., & Roos, N. (2002). *Projecting Hospital Bed Needs for 2020*. MB: Manitoba Centre for Health Policy and Evaluation, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba.
- Stodel, E.J., & Chambers, L.W. (2006). Assessing satisfaction with care in long-term care homes: current and best practices. *Health Management Forum*, 19(3), 45-52.
- Stolee, P., Hillier, L.M., Esbaugh, J., Griffiths, N., & Borrie, M.J. (2006). Examining the nurse practitioner role in long-term care: Evaluation of a pilot project in Canada. *Journal of Gerontological Nursing*, 32(10), 28-36.
- Stone, D. (2002). Disability, Dependence, and Old Age: Problematic Constructions. *Canadian Journal of Aging*, 22(1), 59-67.
- Stone, R. I. (2000). *Long-Term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-First Century*. USA: Milbank Memorial Fund.
- Strasser, S.M., & Fulmer, T. (2007). The Clinical Presentation of Elder Neglect: What We Know and What We Can Do. *Journal of the American Psychiatric Nurses Association*, 12(6), 340-349.
- Suther, M. (2002, April). *Volunteers in Home Care*. Presentation to From Knowledge to Wisdom. A Living International Exchange on Home and Community Care, Toronto, ON.
- Tam, P. (2009, April 7). Ontario needs more nursing homes: Kitts. *Ottawa Citizen*.
- Tamaru, A., McColl, M.A., & Setsuko, Y. (2007). Understanding 'Independence': Perspectives of occupational therapists. *Disability and Rehabilitation*, 29(13), 1021-1033.
- Tell, S. (2002, October). *Integrated Services Delivery Networks for the Frail Elderly: A Canadian Overview*. Panel Member, Pre-Conference Workshop, Canadian Association of Gerontology Scientific and Educational Meeting.
- Tell, S. (2003, March). *Strengthening Community-Based Services in the Continuum of Care*. Presentation to CHA Continuing the Care Conference. St. John's, NL.
- Tepfers, A., Hruska, C., Stone, J., & Moser, J. (2009). New Accreditation Program: University Health Network's Experience with Qmentum. *Healthcare Quarterly*, 12(3), 90-95.

- Teresi, J., Abrams, R., Holmes, D., Ramirez, M., & Eimicke, J. (2001). Prevalence of depression and depression recognition in nursing homes. *Social Psychiatry and Psychiatric Epidemiology*, 36(12), 613-620.
- The College of Family Physicians of Canada. (2007, June). *Priorities for the Health Care of the Elderly: The Role of the Family Physician*. Toronto, ON: CFPC's Health Care of the Elderly Committee.
- The College of Family Physicians of Canada. (n.d.). Retrieved April 2, 2009, from <http://www.cfpc.ca/English/cfpc/programs/patient%20care/elderly/Training/default.asp?s=1>
- The Conference Board of Canada. (2009). Retrieved April 23, 2009, from http://www.conferenceboard.ca/HCP/Details/Health/life-expectancy.aspx#_ftn1
- The Council on Aging of Ottawa. (2008, August). *Housing Seniors: Choices, Challenges and Solutions*. Ottawa, ON.
- The Council on Aging of Ottawa. (2008, October). *Long-term care insurance in Canada: What is it and do I need it?* Retrieved April 25, 2009, from http://www.coaottawa.ca/library/publications/LTC-Insurance_Oct2008.pdf
- The Joint Commission. (2007, April). *Exploring Cultural and Linguistic Services in the Nation's Hospitals: A Report of Findings*. Retrieved May 12, 2009, from <http://www.schanew.org/images/stories/pdf/diversity/Hospitals,%20Language,%20and%20Culture--A%20Snapshot%20of%20the%20Nation.pdf>
- The Ontario Association of Residents' Councils. (2002). *Stride* [Editorial], 13(3), 22-24.
- The Ontario Health Services Restructuring Commission. (2000). *Looking Back, Looking Forward - A Legacy Report 1996-2000*. ON.
- The Royal New Zealand College of General Practitioners. (2007). *Cultural Competence*. Retrieved May 12, 2009, from <http://www.rnzccgp.org.nz/assets/Documents/qualityprac/culturalcompetence.pdf>
- The Special Senate Committee on Aging. (2009, April). *Canada's Aging Population: Seizing the Opportunity*. Ottawa, ON: The Senate.
- Thomson, A. (1999). *Federal Support for Health Care. A Background Paper*. Ottawa, ON: The Health Action Lobby (HEAL).
- Tierney, M.C., & Charles, J. (2002). Care and treatment of people with dementia and cognitive impairments: An update. *Writings in Gerontology - National Advisory Council on Aging*. Retrieved: www.naca-ccnta.ca
- Torjman, S., & Makhoul A. (2008, June). *Caregivers and Dementia*. Ottawa, ON: Caledon Institute of Social Policy.
- Toronto District Health Council. (2002). *Admission and Eligibility Issues in Complex Continuing Care in the Greater Toronto Area*. Toronto, ON: Survey Report.
- Toronto District Health Council. (2002). *Building on a Framework of Support and Supportive Housing in Toronto Supportive Housing Services for Seniors*. Toronto, ON.
- Toronto District Health Council. (2003). *Complex Continuing Care in Toronto*. Toronto, ON.
- Treasury Board of Canada. (2007). *Canada's Performance Report 2006-07 – Annexes*.
- Trisat Resources. (1999). *The Income Testing of Seniors' Social, Health and Income Supports*. Ottawa, ON: Division of Aging and Seniors, Health Canada.
- Turner, S. (2005). Behavioural symptoms of dementia in residential settings: a selective review of non-pharmacological interventions. *Aging and Mental Health*, 9(2), 93-104.
- Tutton, M. (2009, July 11). In N.S., doctors seek to reform nursing home care with dedicated visits. *Winnipeg Free Press*.
- Ubelacker, S. (2007, February 23). Artificial intelligence to help dementia sufferers. *Canadian Press*.
- Ulysse, P.J. (1997). *Population Aging: An Overview of the Past Thirty Years*. Ottawa, ON: Division of Aging and Seniors, Health Canada.
- Valentine, F. (2001). *Enabling Citizenship: Full Inclusion of Children with Disabilities and Their Parents*. Ottawa, ON: Canadian Policy Research Networks.
- Varey, M.T. (2008, March/April). Social Work in Long-Term Care. *Long Term Care*, 7-8.
- Veterans Affairs Canada. (2001, June 6). *Our Clinical Programs*. Retrieved November 27, 2008, from <http://www.vac-acc.gc.ca/clients/sub.cfm?source=steannes/stannecli#dem>
- Victorian Order of Nurses. (2007, January 16). *VON Ontario's submission to the Standing Committee on Social Policy regarding Bill 140 An Act respecting Long-Term Care Homes*.
- Vision 2020: *The Future of Health Care in Alberta*. (2008, December). AB.
- Vogel, D. Rachlis, M. and Pollack, N. (2000). *Without foundation. How medicare is undermined by gaps and privatization in community and continuing care*. Vancouver: Canadian Centre for Policy Alternatives – BC Office.
- Volunteer Canada. (2009). *Baby Boomers – Your New Volunteers*. Ottawa, ON: Author.
- Wanless, D. (2004, February). *Securing Good Care for Older People*. London, England: King's Fund. Retrieved November 29, 2007, from http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4074426
- Welsh, M. (2003, December 3). Natalie's story. *Toronto Star*.
- Welsh, M. (2007, July 30). Elderly care: 'We're still waiting'. *Toronto Star*.
- Welsh, M., & Benzie, R. (2008, June 18). No minimum standard for senior care. *Toronto Star*.
- White, D., Suter, E., Parboosingh, J., & Taylor, E. (2008). Communities of Practice: Creating Opportunities to Enhance Quality of Care and Safe Practices [Special issue]. *Healthcare Quarterly*, 11, 80-84.

- Williams, A., Challis, P., Deber, D., Watkins, R., Kulski, J., Lum, K., et al. (2009). Balancing Institutional and Community-Based Care: Why Some Older Persons Can Age Successfully at Home While Others Require Residential Long-Term Care. *Healthcare Quarterly*, 12(2), 95-105.
- Wilson, D. (2002, September). *The Health of Canadian Seniors and the trend Toward Hospitalization of Death*. Canadian Association of Gerontology National Forum on Closing the Care Gap Report.
- Winkler, D., Farnworth, L., & Sloan, S. (2006). People under 60 living in aged care facilities in Victoria. *Australian Health Review*, 30(1), 100-108.
- Winkler, D., Sloan, S., & Callaway, L. (2007). *Younger people in residential aged care: Support needs, preferences and future directions*. Melbourne: Summer Foundation Ltd.
- WorkSafe BC. (2003, February). *Reducing Injuries in Intermediate Care Risk factors for musculoskeletal and violence-related injuries among care aides and licensed practical nurses in Intermediate Care facilities*. Vancouver, BC.
- World Health Organization. (2000). *Towards an International Consensus on Policy for Long-Term Care of the Ageing*. Ageing and Health Programme, World Health Organization & Millbank Memorial Fund.
- World Health Organization. (2007). *WHO global report on falls prevention in older age*. Geneva: Author.
- Yukon Health and Social Services. (2001). *Information Please...A Handbook for Yukon Seniors & Elders*. 2001-2002. YT.
- Zairi, M., & Jarrar, Y.F. (2001). Measuring organizational effectiveness in the NHS: Management style and structure best practices. *Total Quality Management*, 12(7 & 8), 882-889.
- Zeisel, J. (2003). Environmental correlates to behavioral health outcomes in Alzheimer's special care units. *The Gerontologist*, 43(5), 697-711.
- Zentner, C. (2008, October 24). Chinook Health looks to keep seniors independent through DAL. *Lethbridge Herald*.

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