ASCENT
STRATEGY GROUP

Final Report

Trends, Projections and Recommended Approaches to Delivery of Long-term Care in the Province of Prince Edward Island 2007 - 2017

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Table of Contents

Definitions and Acronyms

Level 1 Care – Minimum care and service needs. Level 1 Care residents are independent, but may require the use of assistive devices or special equipment.

Level 2 Care – Low care and service needs. Level 2 Care residents require some supervision (e.g., cueing, reminders) or the assistance of another person for initial preparation (e.g., positioning utensils, setting out bath equipment).

Level 3 Care – Medium care and service needs. Level 3 Care residents require limited and predictable supervision and/or the assistance of another person for personal care and daily living activities (e.g., A.M. and P.M. care – up to three times per day, etc.). May require medication monitoring or supervision.

Level 4 Care – High care and service needs. Level 4 Care residents require 24 hour availability of nursing level care and supervision. Residents require medication supervision/administration and the assistance of another person for many/most tasks.

Level 5 Care – Intensive care and service needs. Level 5 Care residents require 24 hour availability of nursing level care and supervision. Residents require medication supervision/administration and the assistance of two people for some tasks.

Community Care – In Prince Edward Island and for the purpose of this report, Community Care refers to licensed private facilities, homes, residences, etc. for the elderly that require Level 1, 2 or 3 care. Some community care facilities also service residents who are under 60 years of age and require a Level 1, 2 or 3 care.

Long-term Care – In Prince Edward Island and for the purpose of this report, Long-term Care refers to nursing homes and manors, both public and private, which offer 24 hour nursing care services and supervision for residents requiring Level 4 or Level 5 care.

Safety Unit – In Prince Edward Island, a Safety Unit refers to a secure place that prevents residents from wandering outside a closed unit. It is mainly used to serve the dementia population and psycho-geriatric patients.

Safety Bed – A Safety Bed is located within a safety unit with locked corridors.

Specialty Care Unit – In various jurisdictions across Canada and the US, this term is used to describe a unit that is used to service a segment of nursing home residents who require specialty care; namely, dementia care.

SCU – Specialty Care Unit
CCF – Community Care Facility
LTC – Long-term Care
SAST – Seniors Assessment Screening Tool
ASHRA – Atlantic Seniors Housing Research Alliance
HCS – Home Care Support
MS – Multiple Sclerosis
CCFNHB – Community Care Facilities and Nursing Homes Board
QEH – Queen Elizabeth Hospital
PCH – Prince County Hospital
RN – Registered Nurse
SUN – Senior's United Network
RCF – Residential Care Facility (Statistics Canada Acronym)

Report Disclaimer:

The information contained in this report, including data for projections are from sources believed to be reliable and accurate; however, data may be incorrect. Neither Ascent Strategy Group, nor the PEI Department of Health accepts responsibility for the accuracy or integrity of data supplied. Readers are cautioned that data is presented for information purposes only and to identify trends for high-level recommendations. Information and data should not be relied upon without personal verification.

Executive Summary

The Department of Health has requested a high level and rapid assessment of the need for long-term care (LTC) beds for the period of 2007 to 2027. In assessing the future needs, a number of factors were considered including; population demographics, trends in the delivery of LTC across Canada and the US and challenges and opportunities within the current LTC system.

The Department of Health Continuing Care system is complex and interconnected. In order to provide a clear picture, it was important that all aspects of the continuum of care be assessed. This review takes stock of the current situation and provides an analysis of these services including; seniors housing, home care, community care in addition to LTC.

There were some data inconsistencies with the Department of Health LTC database, therefore some trends were difficult to clearly identify. Caution should be exercised in reviewing the data and final projection outcomes should be considered estimates, not exact requirements.

Extensive consultations were conducted with key stakeholders, in both the public and the private sector, from across the Province. There is a general impression that there is a "looming" issue with the baby boom population aging. However, this baby boom population is now between the ages of 44 to 59 years of age and will not begin to impact the LTC system for another 15 years. Nevertheless, there will be a steady and significant growth in elderly over the age of 75 (67%), over the timeframe studied for this project 2007 to 2027. It is imperative that efficiencies in the continuing care system be maximized, in order to lessen the financial implications and requirements for LTC services in the future.

The detailed conclusions along with the foundation for the recommendations can be found in *Section 8.0 and 9.0* of this report. The 14 overarching recommendations are outlined below:

Recommendation No. 1 The Department of Health develop an "Aging at Home" strategy which would include expanded HCS services, Assisted Living housing options and community support services for the elderly.

Recommendation No. 2 The Department of Health set a standard of a three day turnaround time-period for new patient admissions into public LTC facilities.

Recommendation No. 3 The Department of Health stream-line the admission process. Ultimate control and decision making responsibility should be assigned to the management of the Division of Continuing Care and Community Hospitals.

Recommendation No. 4 The Department of Health should evaluate the SAST with a view to improving the effectiveness, consistency and the relevancy of the assessment tool for the varied population who are screened for admissions.

Recommendation No 5. The Department of Health should continue to maintain the same admission to bed to population ratio in the short-term until programs can be developed that could reduce the need for institutionalization. Maintaining this ratio will require adding an additional 134 LTC beds to the system by 2012.

Recommendation No. 6 The 29 temporary beds in the LTC system should be made permanent.

Recommendation No. 7 The following facilities are recommended for replacement and/or renovation in priority order:

Prince Edward Home -	replace the 1932 section and conduct a detailed engineering/architectural review of the 1960 section to determine what health programs and services could best be accommodated in this portion of the building. Depending upon the outcome of the review either renovate, vacate or use the 1960 section of the facility for another purpose.
Summerset Manor -	replace the facility
Colville Manor -	replace the facility
Maplewood Manor -	replace the facility
Riverview Manor -	replace the facility

Recommendation No. 8 Government continue to **operate** the same LTC facilities as they do currently and maintain approximately the same number of beds.

Recommendation No. 9 A request for proposals (RFP) be developed and thoroughly evaluated by the Department of Health for the ownership of the new public LTC facilities.

Recommendation No. 10 The private sector provide for the additional nursing home beds that are projected to be required.

Recommendation No. 11 A Specialized Care Centre be established in each of the two urban areas of the Province (Charlottetown and Summerside).

Recommendation No. 12 The population under 60 with complex care needs require specialized services and should be cared for in the Specialized Care Centres that are being proposed for Charlottetown and Summerside.

Recommendation No. 13 A philosophy of care must emerge based on the principle that the majority of residents in LTC facilities are those with cognitive impairments.

Recommendation No. 14 The Department of Health develop new design concepts/standards prior to the construction or conversion of any new LTC beds.

1.0 Project Background

Effective, efficient and sustainable delivery of health care services is fundamentally important to the well-being of society. This is especially true in Prince Edward Island, where statistics and demographic trends indicate a senior population that exceeds the national average. In this context, an analysis of trends, projections and recommended approaches to the delivery of residential long-term care (LTC) is appropriate and essential.

The publicly administered and funded health system in Prince Edward Island includes a wide range of integrated health and social services, such as long-term care, acute care, addictions, mental health, social assistance and housing services. As the population ages, Prince Edward Island will experience a large demographic shift leading to an increase in the senior population. It is expected that the proportion of the population aged 75 years and over in Prince Edward Island will increase by 67% over the next 20 years.[1] This shift will progressively affect the Island's health care system in a number of ways. Demand is expected to rise for acute care, long-term care, home care, mental health and other health and social services.

It is difficult to look at individual components of the health care system in isolation. All components in the system are inter-related. When one component of the system is under stress, other parts of the system are impacted to some degree. Throughout this report reference will be made to the entire continuing care system; however, the overarching purpose of this report is to focus on the LTC component of residential care, assess the current situation, conduct research, identify trends and develop options and recommendations for the future.

The objectives of this project are as follows:

- to identify and review the demographic and service delivery patterns and trends which will affect delivery of residential long-term care over the next twenty years;
- to determine the number and geographic distribution of long-term care beds required in the Province over the next five to ten years;
- to identify options and make recommendations concerning the most appropriate mix of private versus public responsibility in delivery of residential long-term care, with options considered to include Private Public Partnerships and how such an arrangement might work in the PEI context; and
- to identify capital building programs which can potentially support capital building or renovation of long-term care facilities.

This report will explain the current pressures on LTC services in the province and make recommendations for the future of long-term care in PEI.

[1] PEI Department of Treasury. (2007). Population Model, Statistics Canada Demographic Data.

2.0 Situational Analysis

The expected outcomes for this project call for the establishment of baseline data in the services offered in the continuum of care, namely: seniors housing, home care and support, community care and long-term care. To provide a more complete view of the current state of residential long-term care within the provincial continuing care system, observations from the following areas have also been included in the situational analysis: the under 60 population, placement committees and the admission process, professional services, and funding / subsidization policies.

Information was gathered through key informant interviews, from existing available data, from the Department of Health, and from various research studies conducted within the past eight years. It must be noted that there are considerable variations in the reliability of the data available for different components of the continuum of care.

2.1 The Continuum of Care

2.1.1 Seniors Housing

Information on the availability, use and future demand for senior's housing is quite comprehensive and current. The following assessment draws principally on two studies: 1) *Social Housing in PEI: Overview of Forecast of Supply and Demand, Draft,* February 23, 2007 (2007 Social Housing Study), Wendy MacDonald & Associates with Steve McQuaid of the Atlantic Evaluation Group; [2] and 2) *Projecting the Housing Needs of Aging Atlantic Canadians,* a five-year research project under the Atlantic Seniors Housing Research Alliance (ASHRA) based at Mount St. Vincent University.[3] ASHRA represents thirty-seven partners from universities, seniors' organizations, housing developers, service providers, and government departments. ASHRA's research project will look at the housing needs and choices, both existing and emerging, for Atlantic Canada's aging population, and develop policy recommendations on how best to meet those needs.

2.1.1.1 Overview

The Seniors Housing Program is directly administered by the Department of Social Services and Seniors. Seniors housing is contained in complexes or buildings that range in size from 4 to 96 units. Most units are apartments with a living room, kitchen, bathroom, one bedroom, and storage area, but some are bed-sitters, which offer a combined bedroom-living room. Some buildings have one or more units accessible to persons with a disability. The largest complexes (over 30 units) are located in Charlottetown.

[2] Wendy MacDonald and Steve McQuaid (2007). Social Housing in PEI, "*Overview of Forecast of Supply and Demand"* Draft Report February 23rd.
[3] Dr. Donald Shiner. (2007). "*Projecting the Housing Needs of Aging Atlantic Canadians"*, Atlantic Seniors Housing Research Alliance, Survey Overview Report.

The rent charged for a unit is geared to the tenant's income, and hence varies. While historically, the rental charge had been set at 30% of income, this rate was reduced to 25% in 2006.

Tenants must be over the age of 60 in order to be eligible, and are selected based on need, using a rating system which takes into account the person's income, assets, health, present accommodation, age, and length of time the application has been on file.

According to data collected in early 2007, the provincial seniors housing system consists of 1,137 active units, located in 37 communities across PEI. These can be broken down by county: 359 units (32%) in Prince County; 539 units (47%) in Queens County; and 239 units (21%) in Kings County. The breakdown in terms of type of community is: 628 units (55%) in the two cities, Summerside and Charlottetown; 270 units or 24% in towns (Souris, Montague, Cornwall, Kensington, O'Leary, and Alberton); and the remaining 239 units (21%) allocated in 29 smaller communities.

All of these senior's units were built between 1963 and 1992 in joint partnership with the federal government. Many of the units are showing signs of age. In fact, it is estimated that 62% require immediate structural repairs.

Among these units are six "Garden Suites." These are movable one-bedroom units, with the appearance of small single-story homes. Typically, they are constructed in place on a foundation of pilings in the yard of a host family member and designed to be relocated as needed. Once the suite is moved to its new location, the site is restored to its original condition. The cost of relocating each suite is approximately $15,000. These suites were added to the system in the 1990s. As of March 31, 2006, two units were located in Eastern Kings, one in Southern Kings, two in Queens, and one in East Prince.

2.1.1.2 Demand

Demand for seniors housing is influenced by demographic and income trends and inter-County migration patterns of seniors, changing needs related to the health and functioning of the pool of eligible tenants, and rising expectations regarding housing quality and amenities.

The number of new applications for seniors housing has declined slightly in the last 10 years. Findings from a 2007 Social Housing Study show that the annual rate of placements between 2002 and 2006 ranged from 173 to 176, and the rate of turnover was about 15.1% per year.[4] The demand varies between regions and within regions. For example, there is steady demand for seniors housing, with few vacancies, in urban centres, and a significantly lower demand for seniors housing in rural areas, where vacancies are not unusual.

When factoring in new applications with the number of placements, a gradual downward trend in demand emerged in both Kings and Prince Counties. In the Queens area there is a slight upward trend in demand. The data from waiting lists was unreliable and therefore not used for year over year comparisons.

[4] Wendy MacDonald and Steve McQuaid (2007). Social Housing in PEI, *"Overview of Forecast of Supply and Demand"* Draft Report February 23rd.

A survey of housing managers and officers as part of the 2007 Social Housing Study identified the following trends:

- In Charlottetown and Summerside, the only vacancies are in bed-sitters, which are very difficult to rent given that they offer a less desirable living unit for the same rent as a one-bedroom.
- In Queens region, apart from bed-sitters, the only long-term vacancies are found in rural communities such as Hunter River and Tracadie Cross.
- In West Prince, one long-term vacancy was reported, representing 2% of the total stock.
- East Prince reported 24 long-term vacancies, or 7.8% of the stock, plus five bedsitters and a vacant 6-unit building in Kinkora.
- In Southern Kings, five long-term vacancies, 4% of the total, were reported, plus a vacant 5-unit complex in Vernon River.
- Eastern Kings reported 24 long-term vacancies, representing 22.4% of units.

According to research by the Canada Mortgage and Housing Corporation, vacancies in rural seniors housing are a problem in all provinces. The dampening of demand can be caused by changing demographics and family structures, changing expectations, changing incomes, rural depopulation, competition from the private sector, and poor quality units.[5]

2.1.1.3 Length of Occupancy

The average length of occupancy in 2002 was six years. Just over half of the tenants had occupied their units for less than five years. A further one-quarter occupied their units for between 5 and 10 years, while the remaining one-quarter occupied their units for over 10 years.

2.1.1.4 Tenant Profile

This section draws on 2002 data presented in the 2007 Social Housing Study. This was the most recent data made available for that study and the authors were confident the data had not changed significantly in the interim five years. The same assumption is made for this report.

Household Structure

In 2002, women outnumbered men 3 to 1 in seniors housing: approximately 74% of tenants were single women and 24% were single males. The remaining 2% were two-person households.

Income and Rent Distribution

The average income of senior tenants was $1,073 a month in 2002. Overall, the average rent paid by tenants was $325 a month. Single tenants paid just over $300 a month, while couples and "other" households paid close to $500.

[5] Wendy MacDonald and Steve McQuaid. (2007). Social Housing in PEI, *"Overview of Forecast of Supply and Demand"* Draft Report February 23rd.

Age

The average age of tenants was 74 years. However, single males were significantly younger. While they accounted for 23% of tenants, they represented 38% of tenants under age 70 years. Single females were slightly older, with a particularly large number over the age of 80 years. Couples and "other" households were also significantly older than average.

2.1.1.5 Preferences

Location is the most important issue for seniors. For most, although their first preference is to remain in their own community, **they place even greater importance on housing that is close to health care services and facilities, and to shopping, church, and other key aspects of their daily living and independence.** Although primary research on the preferences of residents of Community Care Facilities (CCF) and Long-term Care (LTC) was not undertaken, one can infer that these findings apply to all seniors across the continuum of care, especially those who have maintained their mobility to access these services.

Seniors' advocacy groups in the province note that current seniors housing units are too small and that strong demand exists for two-bedroom units. They also identified a need for greater emphasis on and support for "aging in place;" in other words, seniors be given an opportunity to "grow older in the familiar and comfortable surroundings of their homes and communities while providing them with the assistance necessary to maintain a relatively independent lifestyle."

2.1.1.6 Looking Forward

The availability of home repair, home care, and other supports affects the capacity of seniors to stay in their own homes. Hence, the availability of these services also influences the level and timing of demand for seniors housing. The expansion of private sector rental and community care options offering high quality accommodation to those who can pay is also a factor, particularly among those tenants whose income level results in relatively high rents.

The authors of the 2007 Social Housing Study concluded that the reduction of the rental rate for seniors housing from 30% to 25% of income, in 2006, should continue to make seniors housing a desirable option for low and moderate income seniors, especially in the short to medium-term.[6] As well, forecasts to date from the ASHRA Study indicated that the population of seniors over 75 will experience steady growth to 2021 and will then increase dramatically. This accelerated growth rate will directly impact housing needs.[7]

[6] Wendy MacDonald and Steve McQuaid. (2007). Social Housing in PEI, *"Overview of Forecast of Supply and Demand"* Draft Report February 23rd.
[7] Dr. Donald Shiner. (2007). *"Projecting the Housing Needs of Aging Atlantic Canadians"*, Atlantic Seniors Housing Research Alliance, Survey Overview Report, 2007

2.1.2 Home Care and Support

Information on the PEI Home Care and Support (HCS) Program is drawn principally from key informant interviews, data available from the Department of Health and Social Services, and the Prince Edward Island chapter of *Portraits of Home Care – A Picture of Progress and Innovation,* Canadian Home Care Association, November 2003. The most recent comprehensive HCS data available is for fiscal year 2001-02.

2.1.2.1 Overview

Home care is recognized as a critical component of an efficient and effective health care system. Care at home provides many benefits: individuals often function better, remain more independent, experience a sense of normalcy and enjoy social integration within a home environment.

The overall goal of the PEI HCS Program is the prevention of unnecessary, premature or prolonged institutionalization. HCS services are provided to individuals based on assessed need and are intended to supplement the care and support available from family and friends. The HCS Program provides *health care* and *support services* including assessment, care coordination, nursing, personal care, respite, homemaking, occupational and physical therapies, adult protection, palliative care, community based dialysis, assessment for nursing home placement and community support services. The HCS Program is the single entry point for services at home and/or entry to a LTC facility.

The HCS Program is administered by the Department of Health and operates three county programs with sites in Souris, Montague, Charlottetown, Summerside and O'Leary. The services are provided by five multidisciplinary teams consisting of home support workers, who provide personal care and respite care; nurses; occupational therapists; physiotherapists; social workers, dietitians and in one case a pharmacist.

The demand for HCS services has been growing for the last decade. Factors increasing demand for HCS include an aging population, higher incidence of diabetes, increased need for dialysis, rising expectations of seniors for faster access to more services, shorter hospital stays, more outpatient and day surgeries, longer life expectancy, technological advancements that allow for the survival of persons with functional deficits, and an increased desire for end-of-life care at home.[8]

One mitigating factor that may affect utilization of HCS in PEI is the fact that unlike most other provinces and territories, HCS clients in PEI must cover the costs for supplies, equipment and medication.[9]

[8] Canadian Healthcare Association. (2004) "*Stitching the Patchwork Quilt Together: Facility-Based Long-Term Care within Continuing Care – Realities and Recommendations*".
[9] Canadian Home Care Association. (2003). "*Portraits of Home Care – A Picture of Progress and Innovation*", November . p. 122

An indicator of appropriate access to community-based care is the hospitalization rate for conditions which can be cared for in the community (ambulatory care sensitive conditions). It is noteworthy that in 2004 the hospitalization rate for ambulatory care sensitive conditions in PEI was 726 per 100,000 compared to a national rate of 406 per 100,000.[10]

2.1.2.2 Home Care Case Load

Data compiled in the Ministry of Health & Social Services Annual Report 2001-2002 is comprehensive. This same level of detail is not available for the data compiled in subsequent years.[11] *Table 1* below outlines the distribution of the HCS caseload by the type of services the client received. The majority of clients (57.5%) received care for a chronic illness or functional disability, followed by 22.3% receiving short-term care classified as acute care substitution.

Table 1: Distribution of Home Care Caseload by Client Type, 2001-2002

Distribution of Home Care Caseload by Client Type, 2001-2002	
Client Type	**Distribution**
Continuing Care (age 65 and over) (ie. Long Term Chronic illness or functional disability)	57.5%
Continuing Care (disabled under age 65)	9%
Acute Care Substitution and Short Term (ie. IV therapy, complex wound dressings, post surgery care, etc)	22.3%
Dialysis Support	2.2%
Palliative Care	3%
Pediatric	4%
Other (mental health, support/follow-up programs)	2%
Total Caseload	100%

The total number of admissions to home care increased by 9% from 1998-99 to 2001-02. In 2001-02, 61% of admissions were age 75 and over. This is consistent with previous years. There are approximately 160 admissions and 160 discharges per month; a turnover rate of approximately 10% of the caseload each month.

Table 2: Home Care Admissions by Fiscal Year 1998 - 2002

Home Care Admissions, 1998 – 2002				
Fiscal Year	**1998-99**	**1999-00**	**2000-01**	**2001-02**
Total Home Care Admissions	1,855	1,813	1,903	2,021
Total Admissions age 75 and over	1,119	1,070	1,122	1,127

[10] Prince Edward Island Health Indicators 2006, p. 17
[11] Prince Edward Island Ministry of Health & Social Services *Annual Report* 2001-2002 p. 81

As evident in *Table 3* below, in 2001-02 the average monthly caseload was 2,179. This included individuals who receive services from more than one discipline, which represented approximately 20% of clients. From 1999-00 to 2000-01, the average monthly caseload increased by 166 cases or 8.3%. From 2000-01 to 2001-02, there was no significant change in the monthly caseload. The highest proportions of the caseload are related to providing the following services: Nursing (45%), Home Support (30%) and Occupational Therapy (12%).[12]

Table 3: HCS Average Monthly Caseload by Service Type by Fiscal Year 1999 - 2002

HCS Average Monthly Caseload by Service Type			
Fiscal Year	**1999-00**	**2000-01**	**2001-02**
Nursing	903	982	963
Home Support	704	726	649
Occupational Therapy	159	220	268
Social Work	n/a	n/a	22
Community Support Worker	87	124	141
Adult Protection	48	49	51
Nutrition	45	22	23
Tele Home Care	0	0	14
Total Caseload	**1996**	**2162**	**2179**

In fiscal year 2006-07, respondents report the average monthly caseload was approximately 2000, a decline of 9% since 2001-02. The turnover rate remained consistent from previous years at approximately 10% of the monthly caseload.[13] **Data does indicate a large increase in the number of clients receiving multiple services. In 2007, 49% of patients were receiving one or more services compared to 20% of clients receiving multiple service in 2001-02.**

2.1.2.3 Patient Profile

HCS services are available to medically stable individuals and to defined groups with specialized needs. The HCS Program on Prince Edward Island services four main groups:

- individuals requiring end-of-life or palliative care
- individuals in post-acute discharge
- under 60 population (physically challenged, brain injuries, MS)
- elderly requiring Level 3 to 5 nursing care who reside at home

[12] Ministry of Health and Social Services Annual Report 2001-2002
[13] Key Informant Interview. 92007). HCS staff.

Age distribution information for HCS clients for fiscal year 2001-02 is outlined in *Table 4* below. In fiscal year 2001-2002, the senior population represented a significant proportion of the HCS caseload: 46.6% of clients were 80 years of age and older; 61% were 75 years of age and older. In comparison, fiscal year 2006-07 reports a slight decrease with approximately 57% of clients that are 75 years of age and older.

Table 4: Age Distribution of HCS Clients, 2001-2002

Age Distribution of HCS Clients, 2001-2002						
Age Category	0-18	19-39	40-64	65-74	75-79	80+
Distribution	5.2%	3.9%	14.6%	15.5%	14.3%	46.6%

According to respondents, the Department of Health has not yet adopted the Canadian Institute for Health Information (CIHI) service recipient codes, indicating the core program component the client has been assigned to, namely: Maintenance, Rehabilitation, Long-Term Supportive Care, Acute Care Substitution and End-of-Life Care.[14] Tracking this information in the future would be beneficial for analyzing the amount of home care services that are focused on providing care that provides a substitute for long-term care, where home care meets the needs of people who would otherwise require institutionalization.

2.1.2.4 Current Wait Times for HCS

No reliable data on current wait times, or on wait times for previous years was available. Respondents indicated that wait times vary by location and by service required. For example, in Kings County there is a wait list for occupational therapy; in Prince County there is a wait list for both occupational therapy and physiotherapy; and in Queens County there is a wait list for occupational therapy, physiotherapy and home support and nursing care.

2.1.3 Community Care

2.1.3.1 Overview

Community Care Facilities (CCFs) are private establishments, licensed under the *Community Care Facilities and Nursing Homes Act*. They offer services such as accommodation, housekeeping, supervision of the activities of daily living, meals and personal care assistance in grooming and hygiene. CCFs are available across the province and range from facilities which provide a basic service at a reasonable price to high-end facilities with many amenities and higher fees that reflect these amenities.

The 2007 Social Housing study provides a quantitative description of the size, makeup, distribution, and utilization of CCFs in the province. *Table 5* is based on data collected as recently as 2006 / early 2007.

[14] Key Informant Interview. (2007). HCS Staff.

While the number of beds occupied by residents fluctuates, possibly from month to month, it is assumed that the following data still provides an accurate reflection of current occupancy rates in CCFs.

Table 5: CCFs Provincial Baseline Data 2007

2007	CCFs	Beds	Facilities Full	Vacancies	Vacancy Rate
Province	38	1,132	14	211 beds	18.6%

Interviews of key individuals, conducted as part of the 2007 Social Housing Study, provided data on utilization as outlined below. Some facilities were struggling to maintain service quality and standards, and generally those were the ones with vacancies. It was noted that seniors expect facilities and services that will provide for independence, privacy, and high quality service.

Table 6: CCFs Utilization by Region 2007

Region	CCFs	Beds	Percent of Provincial Total	Vacancies	Vacancy Rate
Kings	6	172	15%	48 beds	27.9%
Queens	19	576	51%	89 beds	15.5%
East Prince	10	299	26%	70 beds	23.4%
West Prince	3	85	8%	4 beds	4.7%
Provincial Total	38	1,132	100%	211 beds	18.6%

2.1.3.2 Resident Profile

Data supplied by Statistics Canada, reveal that, for Fiscal Year 2005/06, almost 76% of CCF residents were over the age of 70 and close to 42% were over the age of 85.[15] About 20% of CCF residents are under the age of 65. According to a 2007 Social Housing Study, 37% of CCF beds were occupied by persons on social assistance, at a per diem rate of $55.[16] Some CCFs are dedicated to persons with intellectual disabilities, which may account for this sub-populations' significant share of the available CCF beds. In comparison to LTC facilities, CCF's house approximately 10% more of the under 65 age group and 10% less of the over 80 age group.

[15] Statistics Canada. "*Residential Care Facility Study*" Custom tabulation on PEI Community Care Facilities, 2005/2006 data. Includes data for the 28 Community Care Facilities who reported information.
[16] Wendy MacDonald and Steve McQuaid. (2007). Social Housing in PEI, *"Overview of Forecast of Supply and Demand"* Draft Report February 23rd.

Table7: CCFs Age of Residents Breakdown – 2005-06[17]

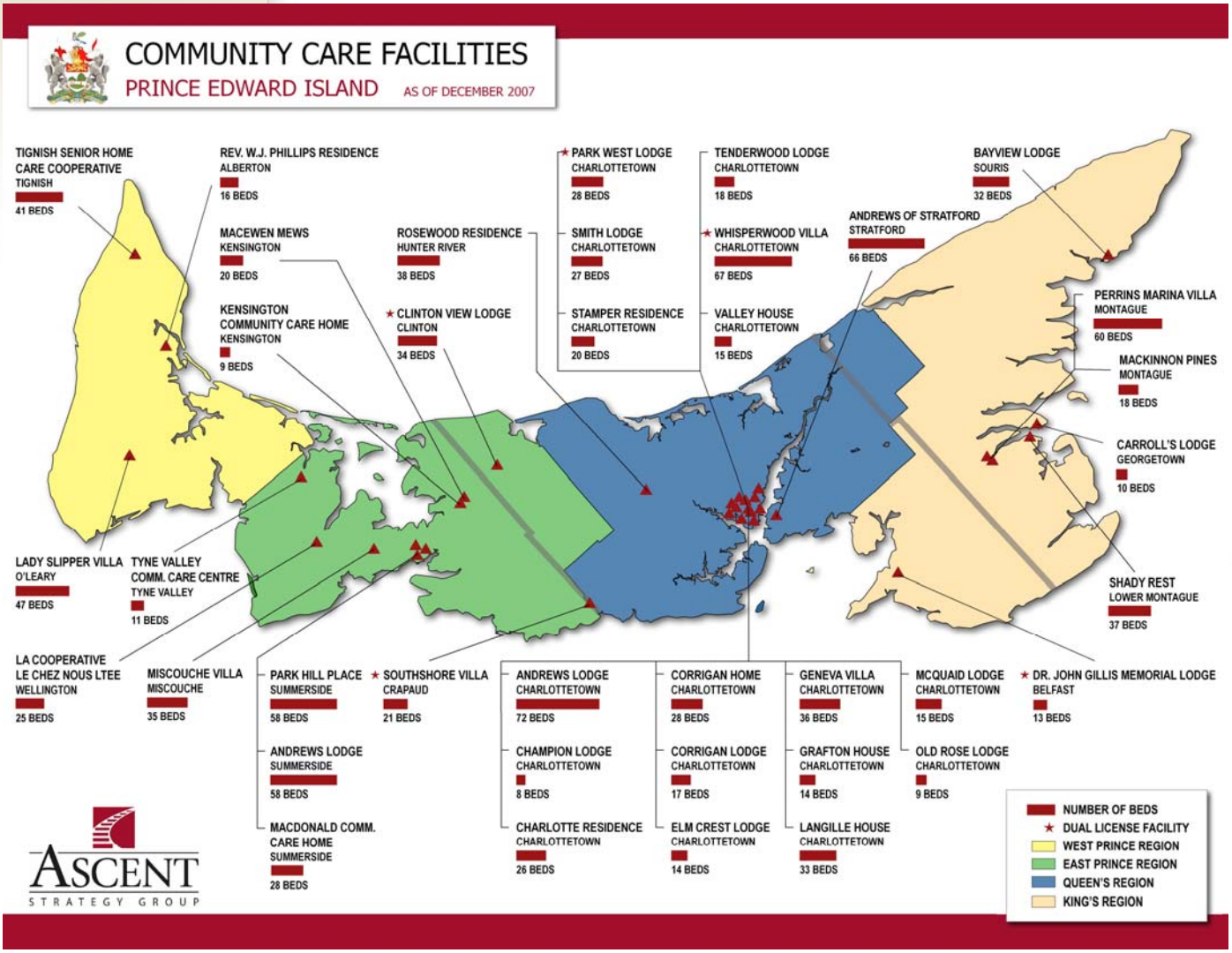
Number of Residents by Age Group and Gender, CCFs for the Aged, Prince Edward Island, 2005-06				
Age Group	**Male**	**Female**	**Total**	**Percent**
18-44	19	8	27	5%
45-64	57	30	87	15%
65-69	14	11	25	4%
70-74	8	19	27	5%
75-79	20	32	52	9%
80-84	20	96	116	20%
85+	42	195	237	42%
Total	180	391	571	100%

Upon admission to a CCF, individuals are assessed using the Seniors Assessment Screening Tool (SAST). Care levels of CCF residents range from Level 1 to 3. CCF operators are required to assess residents at the following times: upon admission, annually as part of licensing requirements, and as the patient's condition changes. Should a resident be assessed above Level 3, the CCF operator submits the resident's name to the local Placement Committee to be added to the priority list for placement in LTC.

2.1.3.3 Map of Community Care Facilities

The map below outlines the location of CCFs in the province, including the number of beds per facility as of December, 2007. Five CCFs are dual-licensed facilities which also offer LTC beds; Clinton View Lodge, Park West Lodge, Whisperwood Villa, Southshore Villa and Dr. John Gillis Memorial Lodge. See *Appendix I* for full page view of the CCF map.

[17] Statistics Canada. "*Residential Care Facility Study" Custom tabulation on PEI Community Care Facilities, 2005/2006 data – 28 out of 38 CCFs reporting.*


COMMUNITY CARE FACILITIES
PRINCE EDWARD ISLAND AS OF DECEMBER 2007
TIGNISH SENIOR HOME CARE COOPERATIVE
TIGNISH
41 BEDS
REV. W.J. PHILLIPS RESIDENCE
ALBERTON
16 BEDS
MACEWEN MEWS
KENSINGTON
20 BEDS
KENSINGTON COMMUNITY CARE HOME
KENSINGTON
9 BEDS
ROSEWOOD RESIDENCE
HUNTER RIVER
38 BEDS
CLINTON VIEW LODGE
CLINTON
34 BEDS
PARK WEST LODGE
CHARLOTTETOWN
28 BEDS
SMITH LODGE
CHARLOTTETOWN
27 BEDS
STAMPER RESIDENCE
CHARLOTTETOWN
20 BEDS
TENDERWOOD LODGE
CHARLOTTETOWN
18 BEDS
WHISPERWOOD VILLA
CHARLOTTETOWN
67 BEDS
VALLEY HOUSE
CHARLOTTETOWN
15 BEDS
BAYVIEW LODGE
SOURIS
32 BEDS
ANDREWS OF STRATFORD
STRATFORD
66 BEDS
PERRINS MARINA VILLA
MONTAGUE
60 BEDS
MACKINNON PINES
MONTAGUE
18 BEDS
CARROLL'S LODGE
GEORGETOWN
10 BEDS
SHADY REST
LOWER MONTAGUE
37 BEDS
LADY SLIPPER VILLA
O'LEARY
47 BEDS
TYNE VALLEY COMM. CARE CENTRE
TYNE VALLEY
11 BEDS
LA COOPERATIVE LE CHEZ NOUS LTEE
WELLINGTON
25 BEDS
MISCOUCHE VILLA
MISCOUCHE
35 BEDS
PARK HILL PLACE
SUMMERSIDE
58 BEDS
ANDREWS LODGE
SUMMERSIDE
58 BEDS
MACDONALD COMM. CARE HOME
SUMMERSIDE
28 BEDS
SOUTHSHORE VILLA
CRAPAUD
21 BEDS
ANDREWS LODGE
CHARLOTTETOWN
72 BEDS
CHAMPION LODGE
CHARLOTTETOWN
8 BEDS
CHARLOTTE RESIDENCE
CHARLOTTETOWN
26 BEDS
CORRIGAN HOME
CHARLOTTETOWN
28 BEDS
CORRIGAN LODGE
CHARLOTTETOWN
17 BEDS
ELM CREST LODGE
CHARLOTTETOWN
14 BEDS
GENEVA VILLA
CHARLOTTETOWN
36 BEDS
GRAFTON HOUSE
CHARLOTTETOWN
14 BEDS
LANGILLE HOUSE
CHARLOTTETOWN
33 BEDS
MCQUAID LODGE
CHARLOTTETOWN
15 BEDS
OLD ROSE LODGE
CHARLOTTETOWN
9 BEDS
DR. JOHN GILLIS MEMORIAL LODGE
BELFAST
13 BEDS
ASCENT
STRATEGY GROUP
NUMBER OF BEDS
DUAL LICENSE FACILITY
WEST PRINCE REGION
EAST PRINCE REGION
QUEEN'S REGION
KING'S REGION

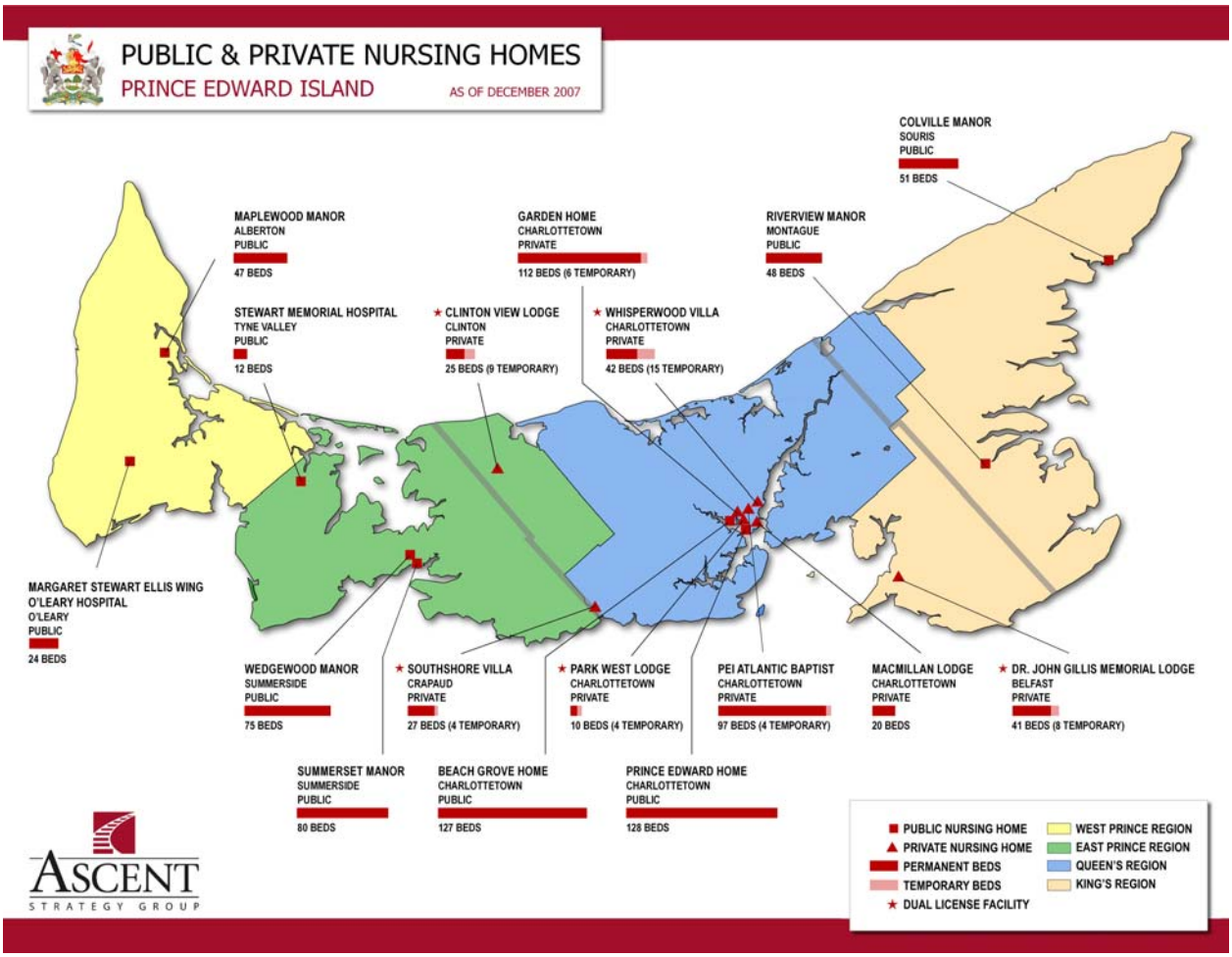
2.1.4 Long-term Care – Public and Private

2.1.4.1 Overview

As of December, 2007 there were 17 LTC facilities in the province of which, nine are classified as public facilities and eight are classified as private. A private LTC facility in Queens County closed in the fall of 2007 (Lennox Nursing Home, 21 beds). All of the residents from Lennox Nursing Home were accommodated in other facilities owned by the same operator. The split between public and private facilitates prior to this closure was nine public and nine private.

2.1.4.2 Map of LTC Facilities, December 2007

As noted in the map below, there are currently eight private LTC facilities. Five of these LTC facilities also have a dual license to operate as a CCF. All the private facilities are located within the Queens County boundaries; however, two fall close to the Prince Region and one close to the Kings Region. Private facilities include, Dr. John Gillis Memorial Lodge; Garden Home; MacMillan Lodge; PEI Atlantic Baptist Home; Park West Lodge; Whisperwood Villa; Clinton View Lodge and South Shore Villa. Lennox Nursing Home closed in 2007. There are 9 public facilities: Colville Manor; Riverview Manor; Prince Edward Home; Beach Grove Home: Summerset Manor; Wedgewood Manor; Stewart Memorial; Margaret Stewart Ellis Wing at O'Leary Community Hospital; and Maplewood Manor.



2.1.4.3 Number of LTC Beds 2000 - 2006

Data analysis and projections for this report were limited to the calendar years 2000 to 2006. At the time of writing complete 2007 data was not available. With multiple facilities reporting, caution should be noted on the reliability of the data. Respite beds were excluded from this exercise as they are separate from a LTC bed. It should be noted that comparisons to previously reported data from the Department of Health will not match directly to data in this report, as the department does not include temporary beds as part of its annual report. For this study, it was important to include all occupied beds in the province regardless of their status (e.g., permanent or temporary). Historical data shows that temporary beds eventually become classified as permanent beds though an official process. The private sector beds are all technically located in Queens County; however, for the purpose of this report, Dr. John Gillis Memorial was considered Kings County as it mainly serves the catchment area in the Kings Region. Also, the Clinton View Lodge and South Shore Villa were considered Prince County, as they were considered to be in or on the border of the Prince Region and mainly associated with that catchment area.

The following table shows the breakdown of LTC beds in the public versus private sector. On average, the private sector is responsible for 41% of the LTC beds and the public sector operates 59% of the LTC beds. However, this varies greatly by County. For example, in 2006 in Prince County the private sector accounted for only 18% of the beds, in Kings County the private sector accounted for 30% of the beds, while in Queens County the private sector operates 54% of the beds (See *Table 8*). Over the past seven years the total number of LTC beds has remained relatively stable; minor fluctuations were noted based on private facility closures.

The total number of LTC beds for 2007 is not reported below; however, 18 private sector temporary beds were added to the system in 2007, bringing the total number of beds to 1012. These temporary beds were added to ease pressure on the system. The map in *Appendix I* identifies the private LTC facilities that have been assigned temporary beds in 2007, along with the facilities that have temporary beds from previous years. In total, there are 29 temporary beds in the LTC system. In addition, 21 beds were moved within the private sector in Charlottetown to accommodate the closure of Lennox Nursing Home in late 2007.

Table 8: Number of Beds in Private and Public LTC Facilities

Private and Public LTC Beds by Region														
Region	**2000**		**2001**		**2002**		**2003**		**2004**		**2005**		**2006**	
	Priv	**Pub**	**Priv**	**Pub**	**Priv**	**Pub**	**Priv**	**Pub**	**Priv**	**Pub**	**Priv**	**Pub**	**Priv**	**Pub**
Prince County	46	231	46	230	52	230	53	231	53	238[3]	53	238	53	238
Queens County	320	254	324	256	300	264	300	263	300	258	300	258	300	257
Kings County	38	101	41	100	43	100	45	101	47	101	47	100	47	99
TOTAL	**404[2]**	**586[1]**	**411[2]**	**586**	**395[2]**	**594[1]**	**398[2]**	**595[1]**	**400[2]**	**597[1]**	**400[2]**	**596[1]**	**400[2]**	**594[1]**
	990		**997**		**989**		**993**		**997**		**996**		**994**	

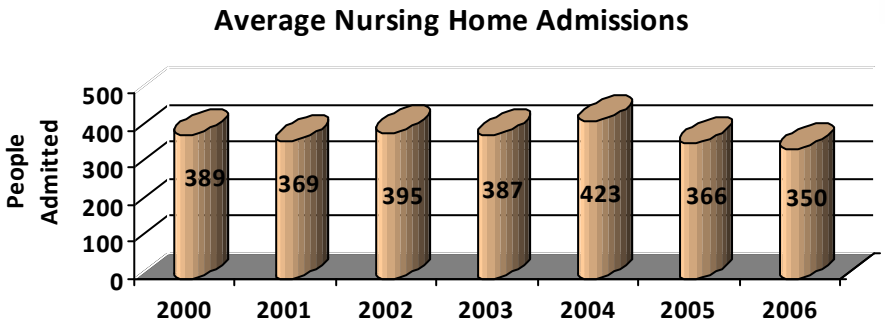
1 Does not include respite beds in public manors/facilities; does include palliative care and convalescent care beds at the PE Home 2. Includes temporary beds that were reported annually. 3 Expansion at Community Hospital.

2.1.4.4 Admissions to LTC 2000 - 2006

LTC is for individuals who require Level 4 or 5 nursing care. The SAST is used to determine service needs of individuals for all admissions to LTC facilities. Although a standardized tool is used for assessment, the assessor differs according to whether the patient is entering the LTC facility from home or community hospital (HCS assesses); a CCF (the operator is responsible for the assessment); or our largest acute care facility, QEH (Social Worker assesses).

Graph 1 below profiles the number of admissions to private and public LTC facilities since 2000. The number of admissions per year has ranged from 350 to 423. This is a relatively large range; however, because the data is available only for the seven year period, it is difficult to note any trends, norms or outliers. The spike in 2004 suggests there was a high number of deaths in that year, thus explaining the lower numbers in subsequent years as the average LTC resident length of stay was approximately 2.8 years. On average, 383 new patients are being admitted to LTC annually, an indication that 39% of the LTC population changes every year.

Graph 1: Average Annual LTC Admissions 2000 -2006



2.1.4.5 Resident Profile

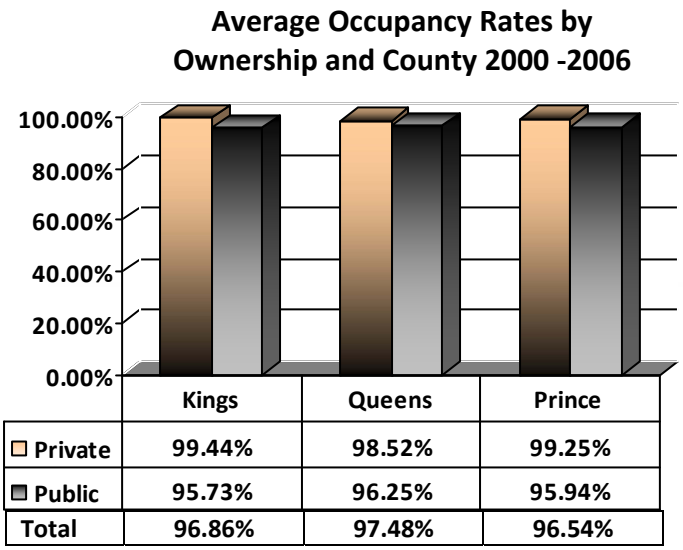
About 70% of people admitted to LTC are over the age of 80. Admissions to LTC facilities over the past seven years have also shown that on average 35% of the clients are male and 65% of the clients are female. The complexity of care has increased and the majority of nursing home residents have dual diagnoses, such as a chronic illness combined with a physical limitation, disability or cognitive impairment. It has been documented by Department of Health Professionals that approximately 80% of residents in public manors have some form of dementia.[18] This is within the norms of data reported nationally. National data indicates that 60% of all nursing home residents have Alzheimer's disease.[19]

[18] Key Informant Interview. (2007).Dr. Gloria MacInnis Perry. 2007
[19] Dr. Gloria MacInnis Perry. (2006). Dementia Care Program for Provincial LTC Centres, October 2006

2.1.4.6 Utilization of LTC Beds

Graph 2 below depicts the average occupancy rate for each County by ownership of facility. The occupancy rate is a measure of the days utilized in LTC beds. The following factors could affect the overall rate including; decreased or increased demand for services, over or under-supply of beds and the amount of time it takes the operator to re-furbish a room for the next resident. Queens County has experienced the highest occupancy rate at 97.48% on average. Prince County and Kings County have similar occupancy rates at 96.54% and 96.86% respectively. [20]

Graph 2: Average Occupancy Rates by Ownership and County 2000-2006



	Kings	Queens	Prince
Private	99.44%	98.52%	99.25%
Public	95.73%	96.25%	95.94%
Total	96.86%	97.48%	96.54%

As evident in *Table 9,* both public and private LTC facilities experience a proportional number of admissions to the number of beds they operate. The private sector operates 41% of the LTC beds and receives 44% of the LTC admissions. Likewise, the public sector operates 59% of the LTC beds and receives 56% of the total admissions. With almost 40% of the resident population changing each year it is not possible to operate a facility at 100% occupancy as downtime is expected and vacant days are required for the time delay between a discharge and when the bed is filled by a new resident. It is estimated that the time to refurbish a room and admit a new patient should be approximately three days. However, this timeframe may range from two days to seven days depending on the specific circumstances. For example, matching roommates for semi-private rooms and contacting family members can lengthen the process.[21] As evident in *Table 9*, when analyzing the breakdown between publicly operated facilities and privately operated facilities in PEI, it is apparent that there is a difference, 2.66 percentage points, in reported occupancy rates. A number of factors and policies could contribute to the variance of occupancy rates between the public and private sector. A significant factor affecting occupancy is bed turnaround time. A slower turnaround time for the admission process in the publicly operated facilities may account for a major portion of the reported difference in occupancy rate.

[20] Department of Health, LTC database, December 2007.
[21] Key Informant Interview, PEI Private Nursing Home Association, 2008

Table 9: LTC Beds, Admissions and Occupancy Rates for Private and Public Facilities - Annual Average (2000-2006)

LTC Beds, Admissions and Occupancy Rates for Private and Public Facilities Annual Average (2000-2006)					
	Number of Beds		Ave. Annual Admissions		Reported Occupancy Rate
Private	405	41%	168	44%	98.70%
Public	589	59%	214	56%	96.04%
Total	994	100%	382	100%	97.12%

Table 10 outlines what improvements in bed utilization may be achieved if occupancy rates could be maximized in the publicly operated LTC facilities. If operational policies and procedures were adjusted to allow for a 97% occupancy rate, the number of additional days that beds could be occupied is equivalent to an additional 5.6 beds being available on an annual basis. As outlined in *Table 10* improvements in occupancy to 98 or 99% could lead to further gains in bed efficiencies that may improve wait time for residents waiting placement and decrease the overall number of additional beds required.

Table 10: Options for Potential Improvements in LTC Bed Utilization

Options for Potential Improvements in LTC Bed Utilization				
	Reported Occupancy Rate	Projected Occupancy Rate	Percentage of Net Gain in Efficiency	Expect Gain in Bed Utilization
Private	98.70%	99%	0.3%	1.2 beds
Public	96.04%	97%	.96%	5.6 beds
Public	96.04%	98%	1.96%	11.5 beds
Public	96.04%	99%	2.96%	17.4 beds

2.1.4.7 Wait List and Wait Times

Table 11 shows the average number of days people waited for placement in LTC facilities for each of the last eight years. The average wait time was approximately 41 days; however, this fluctuates by year and by county. Wait times are affected by LTC facility closures. For example, a private LTC facility closure in 2001 reduced the total number of beds available in 2002 and as such wait times increased. Wait times peaked in 2007 in Queens County at 78 days, a 97% increase over the average wait time of 40 days from 2000 to 2006.

Table 11: Average Wait Time in Days for Placement in Long-term Care

County	2000	2001	2002	2003	2004	2005	2006	2007
	Days Waited For Placement in LTC							
Queens	19	35	45	44	32	42	60	78
Kings	55	39	50	38	24	12	34	51
Prince	49	34	44	34	34	42	30	59
Prov. Ave.[1]	41	36	46	39	30	32	41	63

1. Derived from average of total days waited for placement.

Table 12 below depicts the number of people awaiting placement in the month of November, 2007. A total of 138 people were waiting for admission into LTC. Queens County accounted for 54% of the total, which is consistent to Queens County's percentage of the total population at 50%. According to officials with the Department of Health, the number of people waiting for placement throughout the province in 2007 was higher than average. This may be partially attributed to the subsidization policy change in the Spring of 2007. Other provinces that have adopted the same subsidization policy noted an increase in demand for up to two years following the change.[22] It should also be noted that the numbers on the wait list may not be a true reflection of the number of "placement ready" seniors. For example, seniors indentify the nursing home where they would like to go to, but then may not accept an available bed if it is not in their preferred location.

Table 12: People Awaiting Placement in LTC

Snapshot of People Awaiting Placement – November 2007	
By County	**Number of People**
Queens County - Total	**75**
Southern Kings	12
Eastern Kings	10
Kings County – Total	**22**
East Prince	28
West Prince	13
Prince County – Total	**41**
Total Number of People	**138**

[22] Key Informant Interview. (2007). Policy Analyst, Nova Scotia Department of Health

2.1.4.8 Length of Stay

The average length of stay in LTC is approximately 2.88 years. This average has remained relatively stable since 2000, fluctuating from 2.6 to 3.0 years. *Table 13* shows the length of stay for residents in each County. East Prince has the lowest length of stay at 2.72 years on average. One factor that could have potentially impacted the shorter length of stay in Prince County could be the higher utilization of home care in that region.

In the future, the length of stay could be reduced if policy changes aimed at increasing HCS services are implemented, thus keeping residents at home longer and resulting in a corresponding decrease in length of stay in nursing homes.

Table 13: Average Length of Stay in LTC by County, between 2000 and 2007

Average Length of Stay by County (2000 – 2007)									
Year	2000	2001	2002	2003	2004	2005	2006	2007	**Ave. yrs**
Kings	4.09	2.94	2.72	2.26	2.90	2.87	3.03	3.10	**2.97**
Queens	3.16	2.75	2.98	2.89	2.72	2.79	2.91	3.26	**2.94**
East Prince	2.71	2.36	2.44	2.52	2.99	3.41	2.72	2.55	**2.72**
West Prince	6.68	2.54	2.13	2.28	2.43	4.06	2.17	1.94	**2.84**
Prov. Ave.[1]	3.42	2.66	2.76	2.64	2.78	3.02	2.81	2.98	**2.88**

1. Derived from average of total days spent in LTC facilities.

2.2 Funding and Subsidization Policies

LTC evolved over the past several decades as a self-pay service and a government subsidization service rather than an insured health service. Individuals who applied for admission to LTC were required to undergo a financial assessment. Individuals who required government subsidization in a private LTC facility also had to undergo a similar financial assessment. Prior to January 1st, 2007 clients entered the system either as self-pay, or with a partial subsidy from the Social Assistance Program. Eligibility for subsidy assistance would involve a financial assessment of the LTC resident's income and assets. Based on 2007 data, the province subsidized approximately 73 percent of residents in LTC. The federal government subsidized approximately 7 percent of LTC residents through the Department of Veterans Affairs, Canada. The remaining 20 percent financed their own care.

Beginning on January 1st, 2007 major changes were made to these funding arrangements. The costs for LTC were divided into two streams; health care and accommodation. As of 2008, the Department of Health covered health care costs including; nursing and personal care, incontinence and infection control measures, along with basic supplies for hygiene and grooming at a cost of $74.30 per day.

Residents are now required to pay the accommodation portion of their LTC cost, which covers room and board, including meal service, housekeeping, laundry and social/recreational activities.

In 2008, the accommodation rate was $67 per day for all public LTC facilities. Residents are still responsible for personal expenses which include, but are not limited to, eyeglasses, hearing aids, dental service, telephone service, hairdressing, dry cleaning, ambulance service and general transportation. Although private LTC facilities establish their own respective accommodation rates for self pay residents, the subsidized accommodation rate that government will pay for patients in private LTC (for those who qualify for Financial Assistance) is $67 a day.

Another major change coinciding with the separation of accommodation costs from health care costs was a change in the overall funding arrangements for LTC. Eligibility for subsidization is now solely based on income as opposed to income and assets. As a result, residents are no longer required to utilize their liquid and real assets to cover the costs of LTC. This change in subsidization policy brought PEI in line with the policies of other Canadian provinces.

The Department of Health is the payer of last resort for health care and accommodation costs for residents of LTC facilities. Residents who are eligible for cost of care funding from other sources are expected to seek assistance from those sources before seeking funding from the Department of Health. These sources include, but are not exclusive to:

- Veteran's Affairs Canada
- Workers Compensation Board
- Court awarded settlement
- Federal Government Acts
- Medical/Health Insurance

Individuals who are unable to pay the full accommodation cost can apply to the government for subsidization. If the applicant's assessed income is less than the accommodation cost of care, they are eligible for a subsidy. The cost of care for determining eligibility is the monthly cost of accommodation plus a provision for comfort allowance. A subsidized resident is required to contribute all of their income towards their accommodation costs.

The most recent change in subsidization policy that will exclude a person's assets from the financial assessment and payment plan for LTC will undoubtedly have a significant impact on the future costs to government to deliver LTC. During the key informant interviews it was noted that a number of patients who were fully self pay in 2006 became fully or partially subsidized when the new policy took effect in January 1st, 2007. *Table 14* shows the percent of residents who were classified as receiving a subsidy from 2000 to 2007.

Table 14: Percentage of Subsidized Residents in LTC, 2000 to 2007

Percentage of Subsidized Residents in LTC 2000 - 2007									
	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**Ave.**
Percent of subsidized residents in Private LTC	63%	64%	64%	63%	63%	67%	64%	70%	65%
Percent of subsidized residents in public LTC	80%	79%	79%	80%	79%	76%	76%	82%	79%
Percent of total residents subsidized	73%	72%	72%	73%	72%	72%	70%	76%	73%

As noted in *Table 14* above, on average approximately 65% of residents in private LTC facilities are subsidized. According to the Provincial Treasury Expenditure Estimates, the subsidy support to private LTC facilities in 2006/07 was estimated at approximately $8.9 million.[23] **The subsidy support to private LTC facilities in 2007/08 fiscal is forecasted to increase to $13.1 million, an increase of 47%.** This increase was projected and is a direct result of the subsidization policy change and the additional 18 LTC beds added to the system in 2007. *Table 12* indicates an increase of between five and six percentage points in subsidized residents in 2007 compared to 2006 for both public and private LTC facilities.

Respondents noted that the change in subsidization policy has had an effect on the CCFs. Private operators who charge a per diem rate over $67 a day, especially those who charge substantially more, have noted that some family members and individuals are investigating and seeking admission into LTC as government will cover the health care component of the cost of care. While admission to LTC is subject to an assessment of requiring a minimum Level 4 care, any qualitative assessment tool can be subject to certain bias and assessor subjectivity. The subsidization policy should be evaluated in the context of the entire continuum of care as it has been noted that a "carrot" is now dangling over the most expensive care in the continuum. This makes it important to evaluate the SAST and the admitting process as the objectivity and accuracy of the assessment process is essential to ensure that only those who require Level 4 and 5 care are being admitted into LTC facilities.

2.3 Placement Committees – Admission Process

Placement Committees have been established in West Prince, East Prince, Queens, Southern Kings and Eastern Kings. Placement Committees are responsible to assess applicants to determine their eligibility for LTC and to approve their admission.

Prior to regionalization a three member committee admitted all clients to the public LTC facilities and approved those clients who required subsidization in the private LTC facilities. The committee was made up of two placement officers and the Director of the Division of Aging. Following regionalization in 1993, placement committees were established in all five regions of the province.

[23] Government of Prince Edward Island, Estimates of Revenue and Expenditures 2006/2007 and 2007/2008

Currently, there are five placement committees throughout the province. Respondents indicated that in rural areas there is a high degree of satisfaction amongst the members of the Placement Committees. They reported that they are very familiar with the needs of the applicants and of the resources available and they were somewhat satisfied with their ability to access these regional resources. The placement committees in the rural areas reported that they were quick to respond when there was a vacancy and that there was adequate communications between the various service providers in the region. It was observed that rural placement committees were relatively small (3 to 4 members) and, as a result, there appeared to be a greater degree of satisfaction, more efficiencies and improved communications.

In urban areas of the province (East Prince and Queens) placement committees are somewhat larger. The placement committee in Queens County consists of up to nine members although not all members attend all admission meetings. Concerns were raised around the effectiveness of the Queens Placement Committee.

Given the relatively large number of people involved in the placement committee process across the province, there are concerns over the response time to changing situations and the consistency of decision making across the five regions.

The Placement Committees are responsible to the Department of Health; however, financial assessments of residents in LTC who have applied for an accommodation subsidy are completed by Department of Social Services staff. This separation of responsibility is confusing to some family members who are seeking services and creates additional barriers and hardships during the admission process; a time when applicants and their families are under considerable stress. In addition, this separation of functions, whereby one department completes the financial assessment and another department is responsible for the collection of resident revenue could lead to inconsistencies and discrepancies. This business office function may require further analysis.

A key component of the placement process is the SAST. This assessment tool is used to determine eligibility for LTC. The SAST came under considerable criticism throughout the course of this review. Many key informants reported that the tool was inappropriate for those applicants with psycho-geriatric needs, clients with dementia, and clients who are under 60 years of age, particularly those who are mentally challenged.

2.4 Professional Services

Respondents expressed concern that administration and nursing staff were unable to access professional support staff for LTC residents. Facility staff specifically referenced professional support services such as physiotherapy, occupational therapy, speech therapy (for assistance and training with swallowing), audiology, and dental care (oral hygiene). Staff indicated a need to have these services provided on-site. At a minimum, workshops and educational training should be developed to provide staff with the basic skills and understandings to support the delivery of professional therapeutic services, for example, workshops to develop basic skills on oral care and delivered by dental professionals and workshops on swallowing techniques delivered by Speech and Language Pathologists will enable nursing staff to improve the delivery of care within the LTC setting.

2.5 Population Under 60 Years of Age Requiring Complex Care

Persons under the age of sixty who require complex continuing care present a major challenge to the LTC system in PEI. In March 2007, Steve McQuaid of the Atlantic Evaluation Group prepared a report for the Director of Community Hospitals and Continuing Care. The population in question includes patients under the age of 60 currently living in LTC, and whose health and care needs are characterized by chronic physical, functional, cognitive and/or behavioural conditions, such as mental illness, addictions, and complex social issues/problems.

Placement of these patients in an LTC facility designed for geriatric clients is not appropriate, since many LTC facilities are not equipped in terms of the staffing, equipment and special rehabilitation programming that these residents require. This issue is a growing concern as the availability of modern medical intervention and care, will result in an increased demand for services among this population. [24]

The Environmental Scan identified that there are 63 residents that fit this category living in LTC facilities, with 27 of them residing in the Prince Edward Home. This LTC review echoed similar conclusions to the Environmental Scan, that the existing LTC options are not serving the under 60 population well. In addition, programming, staff training and professional services are all lacking in order to properly care for this sub-population. Mixing groups in the current LTC facilities is doing a disservice to both the elderly and the under 60 clientele.

[24] Steve McQuaid. (2006) *"An Environmental Scan and Needs Assessment of Patients Under Sixty Years of Age Requiring Complex Continuing Care"* Atlantic Evaluation Group.

3.0 Research

3.1 External Scan

In order to determine the context in which Prince Edward Island delivers services for long-term health care, a review of other Canadian jurisdictions was undertaken. This review aims to offer insight into challenges and best practices in other Canadian provinces. The external scan included reviewing provincial and national statistics and reports, more specifically examining changing demographic conditions, access to long-term care, service delivery patterns, the ratio of public to private facilities, levels of care, cost effective options to LTC and service amenities in other jurisdictions. Each province has a different set of guidelines to define long-term care. There are a number of models of delivery of care including private, public, not-for profit and private-public partnerships. Statistics Canada has established a set of guidelines in order to make comparisons, as accurately as possible, province by province.

3.1.1 Canadian Provinces - Review and Trends

According to a Statistics Canada report released in November 2007, one in 30 Canadians aged over 65 were living in one of Canada's homes for the aged in 2005/06.[25] These homes are not covered by the Canada Health Act and, therefore, fall under provincial or territorial legislation. Due to this, the homes are referred to by many different titles and contain various services and levels of care across the Country. To put a context around the information available for Prince Edward Island, **it is important to recognize that the following data includes both long-term care beds and community care beds**. This is the most accurate source of data for comparison purposes with other Canadian provinces. One caution in reviewing the comparison data is the Residential Care Facilities Survey does not collect data from facilities which are under the jurisdiction of a hospital. This will have only a minor effect on the Prince Edward Island data, but could have a greater impact in other jurisdictions.

As shown by *Table 15*, the availability of residential care beds for seniors varies from province to province. Based on the population of people over 65 and the number of beds available in the province an average value across Canada is that 4.9% of people over 65 have access to a bed in a residential or assisted living home. Quebec, Alberta and British Columbia fall under the national average while the rest of the provinces fall above the national average. **PEI has the highest access available, in fact almost double the national average, with 9.2% of the population over 65 having access to either long-term care or community care beds.**

[25] Statistics Canada, *Residential Care Survey, 2005/2006*, Issued November 2007.

Table 15: Access to Homes for the Aged in Canadian Provinces – 2005/06

Province	Population 65+	Number of Beds	Population 65+ with access to a bed
British Columbia	586,408	22,258	3.8%
Alberta	341,918	16,378	4.8%
Saskatchewan	147,160	8,166	5.5%
Manitoba	158,967	9,763	6.1%
Ontario	1,610,533	88,874	5.5%
Quebec	1,045,332	39,992	3.8%
New Brunswick	104,749	6,864	6.5%
Nova Scotia	133,918	6,733	5.0%
Newfoundland	67,709	4,987	7.4%
Prince Edward Island	19,565	1,802	9.2%
Territories (combined)	4,944	353	7.1%
Canada	4,221,203	206,170	4.9%

According to Statistics Canada, the cost of living in these homes also varied across the country, depending upon who owns the facility, what government involvement is present and what level of care the facility provides. In homes for the elderly, expenses per bed, on average, were lower in privately-owned facilities ($39,001) than in either non-profit ($52,845), or public facilities ($59,421).

The private sector owned 53.7% of the homes providing residential care to the elderly in 2005/06. The not-for-profit and governmental sectors constituted almost equal proportions of the rest. According to Statistics Canada some caution should be exercised in interpreting these numbers, as 32 of the 1,873 operating facilities were composites, which means they were comprised of several smaller facilities.[26] Although private operations made up over half of all facilities and beds, they had a disproportionately lower share of full-time employees (43.4%). This was also the case for part-time employees (37.2%), hours (38.7%) and wages (36.2%), showing that privately-owned facilities operated with lower employee-per-bed, hours-per-bed and wages-per-bed ratios in 2005/06. For example, privately-owned homes for the elderly had paid hours of just 1,154 per bed, compared with 1,598 and 1,892 for government-owned and not-for-profit facilities, respectively.

The above comparisons of expenses and staff ratio in public vs. private sector facilities can be partially explained by the higher levels of care (type III) required in public facilities compared to other facilities. The higher levels of care require more specialized staffing and more time spent with each resident therefore, the public sector facilities have a higher wage expenses per approved bed to meet these demands.

[26] Statistics Canada, *Residential Care Survey,* 2005/2006, Issued November 2007.

A provincial comparison of homes for the elderly also showed sizeable differences in the cost of care. On a per-capita basis for the population over 65, the Territories ($6,530), Prince Edward Island ($3,494), Saskatchewan ($3,348), Manitoba ($3,287) and Newfoundland and Labrador ($3,201) had the highest expenditures per capita. The per-capita costs are the lowest in Ontario ($2,475) and British Columbia ($1,874).

Each Canadian province has recognized that the changing demographics over the next 20-30 years will have a significant impact on the delivery of residential care for the elderly and many jurisdictions have undertaken studies and/or adopted diverse approaches and policy initiatives to address current issues and future anticipated requirements. One of the approaches adopted by a number of provinces has been to develop strategies termed "Aging in Place" or "Aging at Home", with the main component of the strategy being to expand home care and support and other community based services. A number of national research studies have confirmed that home care is a cost effective alternative to residential care.

In Canada, the function of home care is often divided into the following three models:

- The maintenance and preventive model, which 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 institutionalization;
- The long term care substitution model, where home care meets the needs of people who would otherwise require institutionalization; and
- The acute care substitution model, where home care meets the needs of people who would otherwise have to remain in, or enter, acute care facilities.[27]

The Canadian Healthcare Association policy brief reported that the amount of HCS services provided has major implications for the LTC system, as providing adequate HCS services can reduce the requirement for space in LTC facilities. [28] The 2002 *National Evaluation of the Cost-Effectiveness of Home Care*, an integrated program of 15 studies funded by Health Canada and conducted by the University of Victoria and Hollander Analytical, concluded that home care services can be a cost-effective alternative to residential long-term care. The first portion of the study compared costs incurred by home care clients to costs incurred by similar persons in skilled nursing facilities and found home care costs were significantly less. [29]

Under the Health Transition Fund, which was created to support evidenced based decision making, a total of 140 different studies and pilot projects were undertaken across Canada. [30] A number of these studies, 45 in total, investigated home care programs, in an effort to improve services and address the pressure points on the system. Like other similar studies, researchers found that home care is generally

[27] Federal/Provincial/Territorial Subcommittee on Long Term Care. (1990). Report on Home Care. Ottawa: Health and Welfare Canada, p. v.
[28] *Stitching the Patchwork Quilt Together. (2004).* Facility-Based Long-Term Care within Continuing Care – Realities and Recommendations.
[29] Hollander. (1999). Sub-Study 1*"Comparative Cost Analysis of Home Care and Residential Care Services.*
[30] Professor Evelyn Shapiro, University of Manitoba, "Sharing the Learning: Health Transition Fund: Synthesis Series: Home Care, Prepared for Health Canada

cheaper, at all levels of care, than is care in residential facilities. This key study highlights several significant findings:

- On average, the overall costs to the province for home care clients are about one half to three quarters of the costs of facility care.
- The costs differ by type of client – the lowest home care costs are for individuals whose type and level of care was stable over time.
- For persons who die, home care costs are higher than residential care costs.
- About one half of the health care costs for home care clients, especially when their type and level of care needs change, results from their use of hospitals.
- About 30 to 60 per cent of costs for home care clients is for hospital care, whereas traditional services, such as home care nurses and home support workers, account for about one third to one half of overall home care costs.

The study also found that, overall, **home care costs less than residential care and provides at least an equivalent quality of care.** Proportionally, savings are greater at the lower levels of care. However, the study suggests that residential care may be better in keeping clients stable and out of hospital.

A key learning resulting from these studies shows that home care is a very difficult environment in which to conduct original research. Comparisons are difficult as efficiencies in the hospital setting are being implemented quickly and savings are generally not transferred to the home care sector. This quick adoption of efficiencies inhibits research because changes are made before research can be conducted that compares costs and benefits before and after the implementation of a new initiative. [31]

Table 16 details Home Care Budgets for Canadian Provinces and Territories in 2004/2005.[32] Prince Edward Island falls well below the national average for home care expenditures for the senior population over the age of 75, with a budget of $935 per capita. This is half of the national average with a budget of $1,901 per capita over the age of 75. Spending in PEI on HCS is the lowest per capita among all Canadian provinces. Alberta ($2,908) has the highest per capita spending on HCS and New Brunswick ($2,609) and Manitoba ($2,502) have the second and third highest respectively.

[31] Professor Evelyn Shapiro, University of Manitoba, "Sharing the Learning: Health Transition Fund: Synthesis Series: Home Care, Prepared for Health Canada

[32] Data Provided by Government of PEI Department of Health, Dated December 2006

Table 16: Home Care Budgets in Canadian Provinces – 2004/2005

Province	Population 75+	Home Care Budget	Per Capita HC Budget - 75+
British Columbia	274,334	$467,244,653	$1,703
Alberta	156,689	$455,652,000	$2,908
Saskatchewan	77,651	$93,953,644	$1,209
Manitoba	80,800	$202,234,300	$2,502
Ontario	752,900	$1,307,841,100	$1,737
Quebec	461,033	$829,011,117	$1,798
New Brunswick	49,554	$129,302,032	$2,609
Nova Scotia	62,411	$126,794,000	$2,031
Newfoundland	29,795	$83,228,000	$2,793
Prince Edward Island	9,091	$8,507,100	$935
Territories (combined)	2,185	$17,252,746	$7,895
Canada	1,956,443	$3,720,990,692	$1,901

In summary, when comparing national information to PEI data on a per capita basis, the information points to two facts:

- The Island leads the Country in terms of access to residential care for elderly. The elderly population (over 65 years of age) has widespread access, almost double the national average, to community care beds and long-term care beds.
- The Island's Home Care & Support budget is less than 50% of the national average and the lowest in the country per capita for elderly over 75 years of age.

These facts point to the continuum of care being off balance. A number of research studies have proven that home care is a cost effective option to residential care and the continuum of care must be managed firstly in terms of quality care and services for seniors, but also taking into account cost effectiveness of services offered.

In addition to national benchmarks and standards, PEI can also learn from "best practices" evident in other provinces. The following describes the efforts in three Canadian provinces in more detail; highlighting challenges, solutions, best practices and policy initiatives for British Columbia, Ontario, and Nova Scotia.

3.1.1.1 British Columbia

British Columbia has a population 65 years and over of approximately 600,000 people. Seniors requiring long-term care have access to 268 residential homes for the elderly of which, 73 (27%) of these are operated publically, 111 (42%) privately and the remaining 84 (31%) not-for-profit.

Early in 2000, the province began implementing five new key continuing care policy directions for the future. These policies included: ensuring sustainability; embedding services in a caring community through the support of care givers and service providers; providing flexible housing options including supportive housing; delivering integrated and flexible services; and maintaining and improving quality.

These policy directions focused on providing continuing care for the aged population directly in the community. The current government has focused on a sustainability approach by providing sustainable housing options, encouraging community services provided by care givers or service providers as well as delivering integrated and flexible services. One of their leading edge housing and care initiatives has been developing *Campus of Care* locations. These locations provide sustainable housing options and include many levels of care for the elderly concentrated in one location. The reason *Campus of Care* locations are proving to be in high demand is that it eliminates a potential situation of moving from location to location. When patients require additional care moving outside of their current care centre can cause significant anxiety. Living in a *Campus of Care* can ease this stress. The campuses in B.C. usually include a combination of at least three of the following four options of care:

1. Apartment style complexes where the occupants do not require health care, but need assistance with winter snow removal, house renovations and lawn care, etc.
2. Apartment complexes where the occupants require home care assistance with laundry, meal preparation and house cleaning, with or without health-care. This is referred to as assisted living.
3. Locations where occupants require 24 hour medical assistance, referred to as a nursing home or residential care unit.
4. Some *Campus of Care* locations also have Special Care Units which also require 24 hour care along with special care and increased security and programming for patients living with dementia.

The fluidity of movement between the gradually increasing options can provide an increased level of comfort for the patient. *Campus of Care* locations have also proved to be beneficial financially as the increased demand for assisted living locations has placed a greater workload on home care, and there are lower costs associated with home care than with long-term institutional care. This leads to an increased quality of life for seniors. Research shows that home care is a cost friendly option when compared to 24 hour residential care. Increasing home care will help to keep seniors happy, productive and healthy in their homes and delay admission into residential care facilities. *Campus of Care* locations have proved to be beneficial for B.C. as they have increased the focus on aging in place, therefore keeping seniors happy and healthier in their own communities for a longer period of time. In addition to British Columbia, Alberta has also introduced *Campus of Care* locations as a widespread continuing care policy initiative.

3.1.1.2 Ontario

Ontario has 745 residential homes for the elderly; of these, 505 (68%) are owned and operated by the private sector, 5 (0.7%) are owned provincially, 106 (14%) municipally, and 129 (17%) are operated by not-for-profit groups.

Funding of long-term care beds in Ontario is based on separating room and board from health care costs, in line with the approach PEI has recently adopted. A trend observed in Ontario is the outsourcing of functions such as housekeeping and food preparation. They have also combined nursing home operations with other services for the elderly such as, private home care, pharmacies and retirement home services. Another trend has been the exploration of models of alternative housing as seniors are beginning to be concerned with long-term care institutional living. This attitude is expected to continue and even compound, as baby boomers become seniors. Baby boomers are a large segment of the population with a strong voice; they are well known for their high expectations and ability to have their concerns heard through government processes.

The most recent development for Ontario is the launch of a $700 million funding initiative in 2007 aimed at helping seniors "Age at Home". With this funding they launched a series of home care and appropriate support services for seniors across the Province. These services include enhanced home care and community support services like meals, transportation, shopping, snow shoveling, friendly home calling, adult day programs, homemaking services and caregiver support. These services are expected to reduce senior's use of hospitals, ERs and prevent early entrance to residential care facilities. Similar to B.C., Ontario is focusing on increasing home care options to help senior's age at home, which will lengthen the stay for seniors at home and prevent or decrease the stay at costly residential care facilities. This has proven to be a positive option on a number of fronts; helping to keep seniors happy and remain longer in their homes, communities and as near to their family and friends for as long as possible. At the same time, it is not as financially draining on the province's health care budget.

3.1.1.3 Nova Scotia

Nova Scotia is an interesting province to observe as it has gone through many changes in its continuing care system, specifically long-term care. Recently, it developed a new vision and strategy for the future and is beginning to implement an action plan based on this strategy.

There are three types of long-term care beds available in Nova Scotia: nursing homes which meet the needs of people who need a high level of nursing care; residential care facilities (RCF) which are homes for people who need supervisory or personal care; and community based-options (CBO) which provide a similar level of care to that of the RCF, but are housing units that serve a maximum of three people. According to data released by the Nova Scotia Department of Health in December 2007, there are 78 nursing homes and homes for the aged with 5,881 beds; 34 residential care facilities with 782 beds and 16 community based facilities with 84 beds. CBO's are mainly located in Halifax and Sydney. Typically, long-term care facilities are owned and operated by municipalities, District Health Authorities, private-for-profit owners, and not-profit organizations.[33]

[33] Nova Scotia Department of Health. (2005). Fact Sheet

The Department of Health has a *Single Entry Access (SEA)* system for all continuing care services. This single point of entry ensures that health care needs are identified through the use of a consistent assessment process. Care Coordinators conduct assessments and coordinate access to home care and LTC facilities. To provide services, the Department collaborates with approximately 160 provider organizations, including non-profit home support agencies, **V**ictorian **O**rder of **N**urses (VON), nursing homes, residential care facilities, and community based options.

Nursing Homes in Nova Scotia provide personal and skilled nursing care in a residential setting. These individuals require a registered nurse on-site at all times. A basic patient profile for Level I or Level II nursing care is:

- they are relatively stabilized (physical or mental);
- they have a chronic disease or functional disability, whose condition is not likely to change in the near future;
- they require the availability of personal care on a continuing 24 hours basis; and
- they require medical and professional nursing supervision and provision for meeting psycho-social needs.[34]

The differential between Level I and Level II care is the number of professional hours required to service the patient on a daily basis. Level I care requires no more than 1.5 hours of professional care per day. Level II care requires from 1.5 hours up to 3.5 hours of professional care per day.[35]

When home care is not appropriate and nursing care is not required, a residential care facility can provide people with personal care, supervision and accommodation in a safe and supportive environment. The patient profile of an RCF or CBO resident is as follows:

- usually suffer from chronic disease (eg. arthritis, hypertension);
- have decreased physical and/or mental abilities that reduce their independence;
- have care needs that cannot safely or consistently be provided at their home;
- require supervision and/or personal care of no more than 1.5 hours per day;
- does not require the services of an on-site registered nurse;
- can get around on their own (with or without assistance of canes, walkers or wheelchairs);
- usually does not require nighttime care; and/or
- have physical and mental ability to escape from building unassisted in case of emergency.

Prior to January 2004, Nova Scotia had a system of payment for nursing homes that involved two choices: either the patient paid for himself or herself to live and receive care in the facility, or where the patient couldn't afford to pay, the government would provide a subsidy. In January 2004, Nova Scotia decided to follow the lead of Ontario and New Brunswick and change the way that seniors paid for long term care. This involved dividing the cost into two main components, room and board fees called hotel services, and health care services. The province agreed to pay for the health care portion of long-term care and the room and board fees were to be paid by the resident. This had a significant effect on the long-term care sector. Within two years the number of people waiting to enter into a long term health care center increased by seventy percent (70%). An implication of this was a budget increase of 57%

[34] Nova Scotia Department of Health. (2001) Continuing Care Branch, Residential Care Facilities for Seniors.
[35] Nova Scotia Department of Health (2008). Key Informant Interview.

($145 million) over a five year period. In 2002, the health care budget devoted to long-term care was $197 million and by 2007 that budget had increased to $342.9 million. The largest component of the increase was due to the change in subsidization policy, but also by the consistent moderate increases in demand of the aging population.[36]

Each year, the Department of Health sets the standard accommodation charge for nursing homes. This rate is based on average operating costs. Residents are notified of their accommodation charge at least 30 days before the November 1 effective date. As of 2007, the current nursing home fee is $75.50/day, which includes accommodation and meals. This fee is collected directly by the nursing home. Residents must also pay for their personal expenses such as clothing, eyeglasses, hearing aids, dental services, transportation and other services not provided by the long-term care facility. Government pays for the health-care costs for resident care (nursing and personal care, social work services, recreation therapy and physical, occupational and other therapies).

To respond to the challenges and prepare for residential care in the future, Nova Scotia developed a 10 year strategy to enhance and expand continuing care in 2006 entitled *"Shaping the Future of Continuing Care".*[37] A main focus of the strategy is to provide programs and services, such as home care, respite and palliative care, in homes and communities. It is anticipated that nursing home costs can be reduced by keeping people healthier and in their homes longer through better home care and co-ordination of services. Nova Scotia envisions that this is the most economical approach and it also provides the greatest ability to be flexible to diverse needs, while offering individuals and families the highest level of independence and quality of life. Ensuring that Nova Scotians have access to long-term care when they need it is important and the strategy calls for 1,320 new long-term care spaces in the next 10 years, in response to the aging population and community needs. To deliver on this strategy the government will focus on five key action areas including:

- supporting individuals and families;
- supporting community solutions;
- investing in providers;
- strengthening the continuing care services; and
- investing in infrastructure.

Nova Scotia estimates that the cost to implement the strategy for the next four years will be $122 million. The remaining funding will be assessed thereafter. Announcements in 2007 included the replacement of nine manors across the province by the year 2010 and the addition of 832 beds to respond to current demand. The strategy calls for new long-term-care facilities that will reflect more home-like environments for smaller numbers of residents. Residents will have access to single rooms in small households of 12 to 15 people and no larger than 36 rooms, with a shared kitchen and living room, and have direct access to the outdoors. Facilities will include more social and recreation spaces, more personal space, private rooms, and rooms for couples. Facilities may also include different levels of care, allowing people to remain in the same location even as their health requirements change.[38]

[36] Web reference: http://www.gov.ns.ca/news/details.asp?id=20071102004
[37] Nova Scotia Department of Health. (2006). *"Shaping the Future of Continuing Care"*.
[38] Nova Scotia Department of Health. (2006).*"Shaping the Future of Continuing Care"*.

3.2 Internal Scan – Key Informant Interview Findings

To accurately reflect and report on the current state of affairs of LTC in the province, a broad cross section of key informant interviews were undertaken. Respondents were drawn from the following areas:

- administrators and front-line medical and nursing staff of public LTC facilities and acute care hospitals;
- operators of private LTC facilities; and,
- CCF operators.

A complete list of key informants is provided in Appendix II.

It should be noted that consultations took place during a particularly stressful period for the system (end of November/early December 2007), owing to a lower than usual turnover in LTC facilities (fewer discharges/deaths) and a higher than normal number of patients accessing the QEH Emergency Department. For a short period of time, the QEH was forced to divert ambulances to Montague and Summerside and cancel some elective surgeries. This also impacted the LTC system resulting in longer wait times and waiting lists for LTC beds.

In general, while respondents voiced concern about the current situation for various reasons, they also talked about a high level of compassion, dedication and commitment to high quality care and quality of life for residents in LTC and CCFs.

3.2.1 Administrators & Front-line Staff of LTC Facilities

The following themes emerged during the interviews:

- bed shortages, especially for safety beds;
- limitation of facility design and structural deficiencies;
- staffing issues; and
- unmet needs of subpopulations.

3.2.1.1 Bed Shortages

Administrators of LTC facilities indicated that waiting lists increased substantially in 2007, reaching a high of 140 people. In particular, both Queens and Prince County administrators indicated that the demand for safety beds had increased. In these regions, it could be up to eight months before a patient who required a safety bed would be admitted to LTC.

3.2.1.2 Limitations in Facility Design

All administrators and front-line staff at public LTC facilities, with the exception of the Margaret Stewart Ellis Wing of the Community Hospital in O'Leary, expressed concern about the limitations in the physical structure of the facilities. Respondents reported the following observations:

- a general lack of space;
- corridors are too narrow for wheel chairs and medication carts;
- residents' rooms are too small;
- the nine four-bed wards at Colville Manor are unacceptable to the residents in a LTC facility and their families;
- in many facilities there are not enough bathrooms and/or they are poorly located;
- for some facilities there is minimal room for storage so corridors get crowded and in some cases infection control could be compromised, for example, in one facility both the soiled and clean linens are kept in the same room;
- limited space for programming, social gatherings and family functions in some facilities;
- layout prevents proper programming for dementia patients and in fact may exacerbate their protective behaviours such as aggression and calling out;
- heating and ventilation systems are outdated in a number of facilities;
- not enough access to water, i.e. no sinks in resident rooms in a number of facilities.

3.2.1.3 Nursing Shortage

It was identified by respondents representing most facilities that bed closures in acute care facilities were attributed to nursing shortages. The "scope of practice" among the nursing care staff was raised frequently, but acknowledged as an almost intractable issue. While most of the representatives from nursing homes indicated more beds are required, they indicated that lack of human resources may be an issue in servicing the additional beds. Representatives of private LTC facilities pointed out that the competition with the public facilities for RNs is a challenge. Representatives of the Private Nursing Home Association indicated that their members had put in a lot of effort to bring their wages for RNs up to nearly the same level as those offered by the public institutions.

3.2.1.4 Needs of Dementia Patients

One of the most consistent findings from the consultations was the inability of facilities and the system in general to meet the needs of dementia patients and sub-populations, such as the mentally challenged, elderly addicts, the population under 60 requiring complex care and psycho-geriatric patients. Interviews were also conducted with dementia care experts. Dementia care is addressed in *Section 5.0* of this report.

3.2.1.5 Population Under 60 Years of Age Requiring Complex Care

Many respondents reported that the population under 60 requiring complex care is not being well served in LTC facilities. Residents under age 60 suffering from chronic conditions, such as MS, brain injury or Down Syndrome are living in close quarters with the frail elderly. Offering specific programming to these people becomes difficult, as most staff are trained to look after the elderly and don't have the skills or training to adequately respond to the varied needs of many patients under the age of 60. Several respondents expressed concern about the unmet needs of this sub-population.

3.2.2 CCF Operators

CCF operators raised a number of concerns during the consultation process. One of their primary concerns related to funding and subsidization. They reported that the subsidized rate of $55 per day is insufficient. Those operators whose fees are greater than the subsidized rate indicated they are considering not providing care to subsidized residents as this amount is not meeting the actual cost of care. It is their contention that the "self pay" resident is in fact subsidizing the "subsidized resident".

4.0 Population Trend Projections

The methodology for projecting future need for LTC beds involves an analysis of the following components:

- Inventory of past (2000 – 2006)LTC services to population ratios including;
  - LTC admission data including age and sex of resident population for public and private nursing homes and manors by county
  - Length of stay of residents in LTC by county
  - Inventory of LTC facilities (private and public) by county
  - Distribution of the Island's population by age, gender and county from 2000 to 2006
- Projected population over 75 years of age, by gender and county, from 2007 to 2027

Impacts of future population changes on the demand for LTC services are derived by linking data on the projected population of the province to data on past admissions into public and private nursing homes and manors. The potential impacts take into account the distribution of the Island's population by age, gender and county for the period 2007 to 2027.

Manitoba developed a method of estimating nursing home bed requirements using population based data. The research conducted by the Manitoba Centre for Health Policy determined a number of factors that are predictors of nursing home use. This research concluded that variables such as premature mortality rates, hip fracture, diabetes and stroke were not useful as predictors of nursing home use. Research findings also concluded that there is strong and consistent evidence that age, lack of spouse or other social supports, functional disability and cognitive impairment are strong predictors of the need for nursing home care. However, the projections completed for Manitoba were completed using the basic indicators of age, gender, region and population. The projections for Manitoba were found to be quite accurate, leading to the conclusion that **the basic indicators of age, gender, region and population are quite powerful in predicting nursing home bed demand**. [39]

The demographic projections for the Island are based on the population model produced by the Department of the Provincial Treasury, Statistical Office.[40] This model maps the population by age and sex for each year from 1986, using Statistics Canada demographic data on the components of population change. This includes data on births by age of mother, deaths by age and gender, immigration and emigration by age and gender, provincial population movement by age and gender, and other minor components of change. Data is complied by single year of age. This is the most detailed level of population modeling capable and provides reliable measures of population change.

Population projections for future years are calculated by aging the population one year at a time taking into account age/gender specific death rates and age/gender specific migration factors. Births are added in by estimating numbers from age specific fertility rates, which are applied to the projected numbers of females of child bearing age (15-44). The projections take into account assumptions about

[39] De Coster. C., Frohlich. N., Dik N. (2003). *"Estimating Nursing Home Bed Demand: 20-Year Projection From Administrative Data and Stakeholder Input"*, Manitoba Centre for Health Policy.
[40] PEI Department of the Provincial Treasury, Population Projection Model, based on Statistics Canada data

mortality, fertility and migration rates. The modeling of population projections is also available at the county level on the basis of trends in the proportions of persons in each county for each age and gender group. It should be noted that some caution should be used in interpreting results for each county, as this data is not as robust as the provincial level projections.

The focus of this study is the population of elderly on PEI and the provincial projections provided by the Department of Treasury are viewed as particularly reliable. Trends in mortality rates are very predictable and the older population group does not involve a great deal of interprovincial migration. Data on the number of elderly by age and gender are available from Statistics Canada, by year up to 2006. These data are based on Census information. In addition, in order to provide a picture of when the baby boomers will have the biggest impact on the LTC system, an estimate of the provincial population of 75 years and over was made to the year 2037. That estimate was made by projecting the Treasury model forecast from 2030 a further seven years by imposing the survival rates of the 2030 period on the population by age and gender of those 59 years and older.[41]

Data were obtained from the Department of Health on admissions and occupancy rates, by age and sex for all provincial and private sector nursing homes and manors for the years 2000 to 2006. Data for 1999 were not complete and data prior to this date were not available in the Department of Health's database on LTC services. The resident population of the manors ranges in age from approximately 55 years and up. However, the majority of residents in care are over 75 years with a concentration over 80 and so this trend analysis has focused on these older age groups.

[41] Projections completed by JP Consulting.

4.1 Population Trend Projections for PEI to 2027

In the coming years, the province's population is projected to grow marginally reaching a peak in the next five years and then declining slowly (see *Table 17*). This slowing of population growth is a common feature of Canadian provinces; however, it is more pronounced in the Atlantic Provinces. The Treasury population model anticipates that the Island's population will move into a long-term slow decline beginning at about 2012, after peaking at approximately 139,450 persons. The main factors at work to produce this result are the sharp decline in the birth rate that has been evident since the early 1960's, out migration of the younger population to other provinces and the lack of international immigration to the Atlantic region generally. Noteworthy, is the urbanization trend that has been documented over the past ten years. Based on the 2006 preliminary census data, among all the cities and towns in Prince Edward Island with over 1,000 people, only three areas in the Province exhibited growth: Stratford, Kensington and Cornwall; 12.2%, 7.2 % and 6.0% respectively. All other towns declined. Migration patterns are one of many factors included in the population projections.

Table 17: Population Projections to 2027 in Five-Year Intervals[1]

Year	1987	1992	1997	2002	2007	2012	2017	2022	2027
Total Pop	128,573	130,778	136,109	136,934	138,960	139,448	139,200	137,680	134,523
Males 75+	2,810	3,047	3,092	3,296	3,535	3,895	4,262	5,024	6,082
Females 75+	4,268	4,828	5,302	5,692	5,805	6,147	6,640	7,806	9,702
Both Sexes	7,078	7,875	8,394	8,988	9,430	10,042	10,902	12,830	15,784
75+ pop as %	5.5%	6.0%	6.2%	6.6%	6.7%	7.2%	7.8%	9.3%	11.7%

1. Data is taken to the 12th decimal point, variances for rounding may occur.

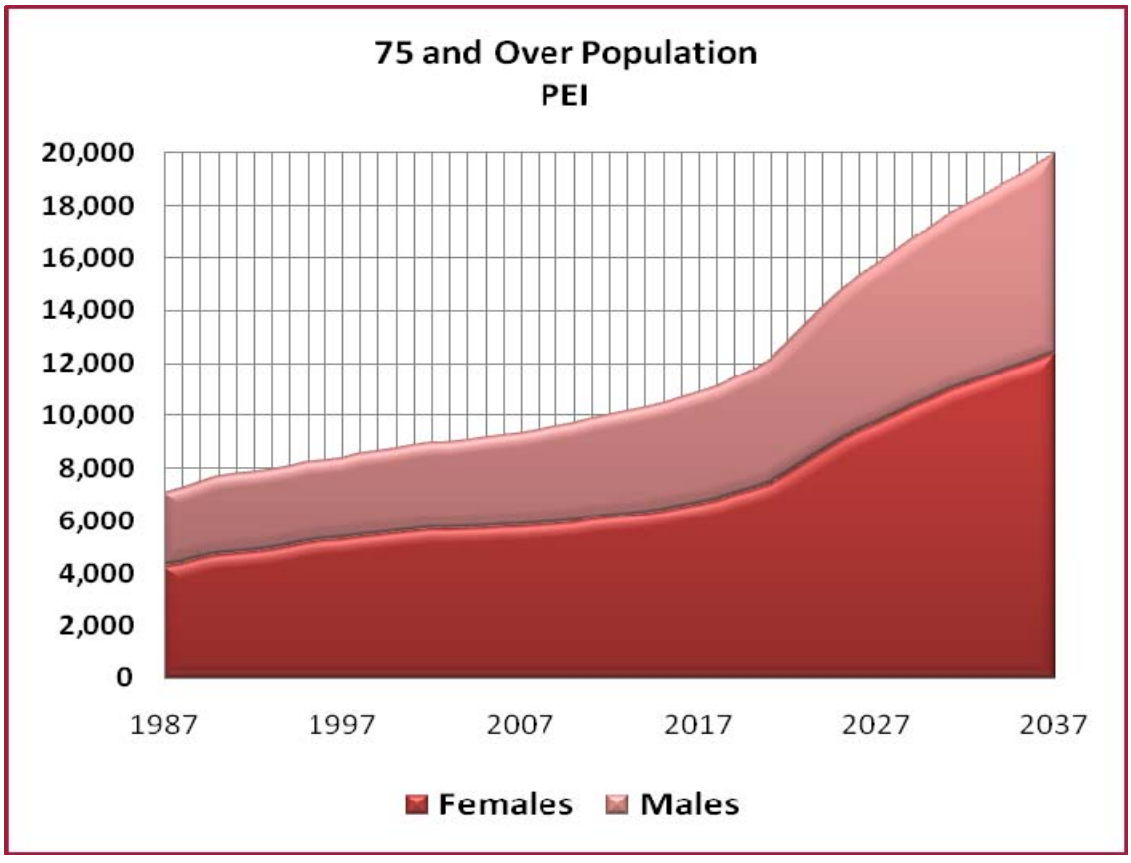
By contrast, as evidenced by *Table 17*, the province's older population will grow markedly, with the over 75 year olds increasing from their present level of 9,430 to 15,784 by 2027, an increase of 67%. The impact of this growth on admissions to LTC facilities is dampened until about 2022, by the fact that the admissions to these facilities are concentrated in persons over 80 years of age. The impact of the baby boomer population begins to have a noticeable impact on the number of people over 80 years of age after 2027. That population is currently between the ages 44 and 59 years.

Between 2007 and 2022, it is projected that there will be a steady increase in the population over 75 years of age, increasing from 9,430 in 2007 to 12,830 in 2022, an increase of 3,400 over 15 years. This change might be contrasted with growth of the population over 75 year olds of only 1,550 over the past 15 years (1992 – 2007). While the overall numbers may not seem substantive, this translates to an increase of 36%, in comparison to the 20% growth rate that has been experienced over the previous 15 years. The population over 75 years of age accelerates after 2022 as the baby boomers start moving into that age category, reaching 15,784 by 2027.

4.2 Population Trend Projections for PEI to 2037

With the baby boomer population only beginning to reach the age that will impact LTC in 2022, it was deemed important to look past 2027 to provide a snapshot of projected population growth of the population over the age of 75. *Graph 3* depicts the population growth projected from 1987 to 2037. The number of people over 75 years is projected to reach approximately 20,000 by the year 2037, which is more than twice the number today. It is clear from the projections that the impact of the baby boomer population on the number of elderly will become significant in the two decades following 2022. It might also be noted that the impact of the baby boomers will last about 20 years after which time (around 2045) the numbers of elderly start to shrink in line with the smaller numbers in the post baby boomer age groups.[42]

Graph 3: PEI Population Projection to 2037



[42] Projections completed by JP Consulting.

4.3 Population Trend Projections by County to 2027

Projections of the over 75+ population show that Prince and Queen's Counties have experienced growth of the elderly population in recent decades, whereas the 75+ population in Kings County has been shrinking since 1997. Projections indicate that the elderly population of Kings County is likely to experience little change in the coming 15 years and will have only moderate growth after 2022.

Table 18: Population Projections by County in Five-Year Intervals[1]

	Actual Population				Projected Population				
Year	**1987**	**1992**	**1997**	**2002**	**2007**	**2012**	**2017**	**2022**	**2027**
Prince 75+	2,380	2,600	2,756	2,999	3157	3,435	3,764	4,453	5,571
Queens 75+	3,584	4,097	4,359	4,774	4998	5,425	5,957	7,087	8,825
Kings 75+	1,114	1,178	1,279	1,215	1,185	1,183	1,181	1,289	1,388
Total 75+	7,078	7,875	8,394	8,988	9,430	10,042	10,902	12,830	15,784

1. Data is taken to the 12th decimal, rounding variances may occur

Table 19 below shows how the population of the elderly will continue to be dominated by females and the female dominance will increase with age. For example, over the past 20 years the percentage of the population that is female between 75-79 years old has been between 55% and 59%, while it has ranged from 70% to 73% for the population over 90 years old. This trend is projected to continue for the next 20 years.

Table 19: Female Population Projections [1]

% Female	1987	1992	1997	2002	2007	2012	2017	2022	2027
75-79	56.6%	58.1%	59.7%	57.8%	55.1%	56.3%	56.5%	57.0%	58.4%
80-84	60.3%	60.8%	63.0%	64.7%	62.4%	59.9%	61.2%	61.3%	61.7%
85-89	64.6%	65.0%	67.2%	68.3%	68.9%	67.4%	64.8%	66.0%	66.2%
90+	70.0%	72.8%	73.1%	73.6%	73.5%	73.3%	71.6%	69.4%	69.8%
Total	60.3%	61.3%	63.2%	63.3%	61.9%	61.2%	60.9%	60.8%	61.5%

1. Data is taken to the 12th decimal, rounding variances may occur

Given the predominance of over 80 year olds who are residents of the provincial homes, it is not surprising to see that female residents are in the majority. In addition, the percentage of females admitted to homes is slightly greater than for males, in specific age groups, which tends to further reinforce the numbers of females in manors.

4.4 Impact of Population Trends on LTC

Table 20 presents a breakdown of the average number of males and females admitted annually to LTC facilities by age group from the period 2000 to 2006. One can see the dominance of over 80 year olds being admitted to nursing homes. Admissions to the manors by age and gender indicates, that over **70 per cent of the incoming residents are, on average, over 80 years of age.**

Table 20: Average Number of Residents Admitted Annually by Age Group and Gender, 2000 to 2006[1]

Age	Males	Females	Total
Less than 60	4	4	8
60-64	5	4	9
65-69	8	8	16
70-74	11	16	27
75-79	22	31	53
80-84	31	56	87
85-89	29	65	94
90+	23	65	88
All Ages	**133**	**250**	**383**

1. Data is taken to the 12th decimal point, variances for rounding may occur.

The population projection by county, noted in section 4.3, was used to project the likely demand for admissions, by county, in future years. This projection assumes there will be no changes that will impact that rate of institutionalization. It is also assumed that the proportion of the population being admitted annually to LTC facilities, over the past seven years, provides an indication of the number of beds required for nursing care in PEI.[43] The percentages are summarized in *Table 21*.

Table 21: Average Percentage of Population By Age Group Being Admitted to LTC Facilities

Average Percent of Population By Age Group Being Admitted 2000-2006[1]			
	Males	**Females**	**Total**
55-64	0.1%	0.1%	0.1%
65-69	0.3%	0.3%	0.3%
70-74	0.5%	0.6%	0.6%
75-79	1.4%	1.5%	1.4%
80-84	3.1%	3.1%	3.1%
85-89	5.5%	5.8%	5.7%
90+	10.1%	9.7%	9.8%
Total	**1.5%**	**2.2%**	**1.9%**

1. Data is taken to the 12th decimal point, variances for rounding may occur.

It is evident that the proportion of the Island`s population being admitted in any year rises steeply after 80 years of age. Further, the percentages for males and females are very similar, though with a slight weight towards females, except in the over 90 year old category. In applying these admissions percentages to the population by age for each county, the likely future demand for annual admissions can be projected. Given the assumption that the demand will be a constant proportion of the population by age group for each county, the projection hinges on the future pattern of population

[43] Projections completed by JP Consulting.

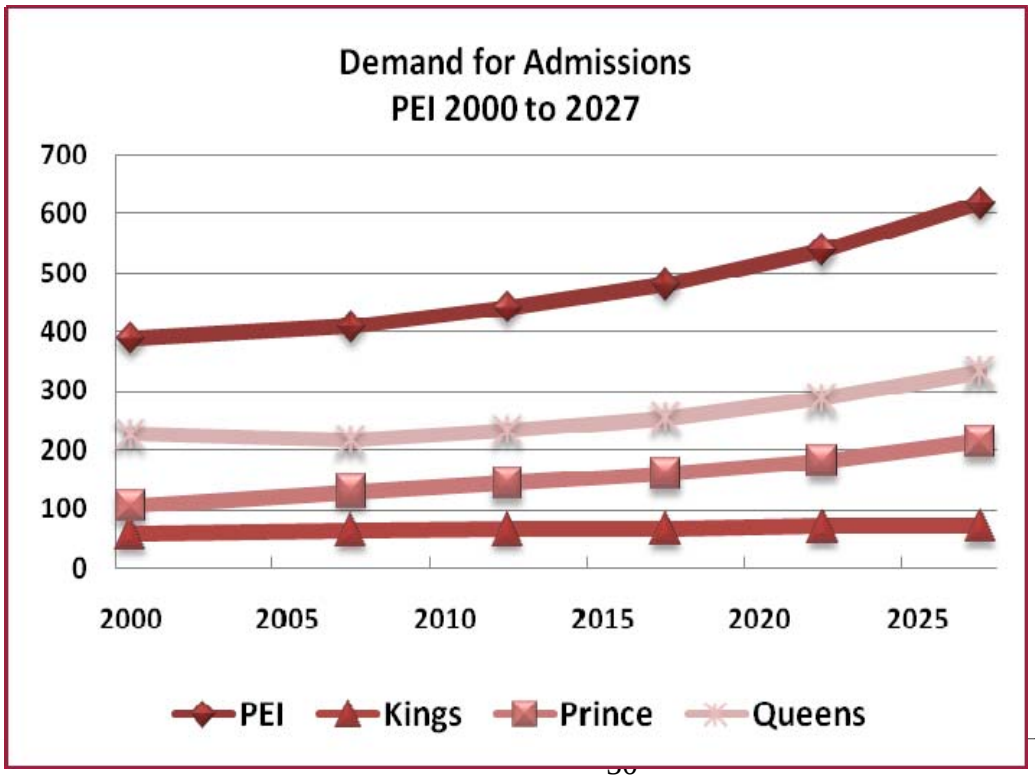
growth for each age and sex category in each county. The projected trend in demand for admissions is shown in *Table 22* and in *Graph 4*.

Table 22: Projected Demand for Admissions in Five-Year Intervals

Projected Demand for Admissions[1]					
County	**2007**	**2012**	**2017**	**2022**	**2027**
Prince	130	144	161	182	214
Queens	216	233	254	287	333
Kings	64	65	66	70	71
Total	**410**	**441**	**481**	**538**	**618**
Age					
Less than 65	21	24	25	25	22
65-69	17	22	28	29	30
70-74	30	32	41	51	52
75-79	53	61	66	85	107
80-84	91	90	104	114	148
85-89	102	109	107	123	134
90+	95	104	111	111	124
Total	**410**	**441**	**481**	**538**	**618**

1. Data is taken to the 12th decimal point, variances for rounding may occur.

Graph 4: Demand for Long-term Care Admissions 2000 to 2027



It is evident from *Graph 4* that the demand for admissions for the Kings County population is projected to experience little change over the forecast period. This could be attributed to the fact that the overall Kings population has been in decline for decades. [44] A number of factors could come into play including urbanization and employment trends and the fact that Kings County does not have a major urban centre to offset the declining rural population. Prince and Queens Counties will see a steady increase in demand, which slowly accelerates throughout the time period. The number of admissions has averaged 383 over the past seven years. Given present population trends the demand for admissions will rise to approximately 440 per year by 2012, 480 by 2017, 540 in 2022 and 620 by 2027. As previously noted, the elderly populations will be growing very quickly in the decade following 2027 and the pressures will increase substantially in those years. After about 2045 the numbers reaching the entry age into manors will begin to decline. [45]

The number of beds in the private and public sector manors totaled 1012 in 2007 and averaged 994 beds over the past seven years. The ratio of the number of admissions (383) into nursing home beds (994) per year over the past seven years averaged 2.6. This ratio varies by County and is 2.77 for Queens County, 2.45 for Kings County and 2.37 for Prince County. Assuming the length of stay remains constant in the future, the actual number of beds required to meet the demand for new admissions can be calculated by the above ratios for each County, multiplied by the estimated demand for admissions in that County. *Table 23* indicates the bed projections by County in five-year intervals. [46]

Table 23: LTC Bed Requirements in Five-Year Intervals By County

LTC Bed Requirements in Five-Year Intervals By County[1]							
County	**Actual Beds**		**Projected Beds Required**				
	2006 Actual	**2007 Actual**	**2007**	**2012**	**2017**	**2022**	**2027**
Queens	557[2]	561[2]	598	645	703	795	922
Prince	291	303	309	342	382	432	508
Kings	146	148	157	159	162	172	174
Province	**994**[2]	**1,012**[2]	**1,064**	**1,146**	**1,247**	**1,398**	**1,604**

1. Data is taken to the 12th decimal point, variances for rounding may occur. 2. Includes Palliative Care and Convalescent Care beds at the PE Home.

4.5 Factors Affecting Projections

There are a number of factors that impact the ratio of the number of admissions to beds, which is presently at 2.6. If the average length of stay in nursing homes shortens or increases for any reason, the ratio will change. There are a number of factors that could cause the length of stay to shorten or increase including: the incidence of disease and general health of the population, increased availability of alternative institutions to LTC facilities, improved health of the elderly, and improved non institutional care services. If the number of available beds does not keep pace with the growing numbers of elderly over a specific time period, the required number of beds will be even greater than the projections indicate for subsequent years.

[44] PEI Department of the Provincial Treasury, Population Projection Model, based on Statistics Canada data
[45] Projections completed by JP Consulting.
[46] Projections completed by JP Consulting.

According to a 2006 study on PEI Health Indicators, there are 37 health indicators that fall under four main categories; health status, non-medical determinants of health, health system performance, community and health system characteristics.[47] Health status can be measured in a variety of ways including well being, health conditions, disability and death. Overall, the findings illustrate that PEI has higher incidences of cancer and obesity than the national average. Islanders are also less active and consume more alcohol than the national average. Indicators where Prince Edward Island was above the national average were limited exposure to second hand smoke and birth weight.

The World Health Organization suggests that diabetes is rising in epidemic proportions worldwide. Prince Edward Island had 17 new cases of diabetes diagnosed each month in the mid 1970s, compared with 45 cases per month in the mid 1990s. When data for 2006 become available it is expected that this number will grow to 65 cases per month. If precautionary measures are not taken to control rising blood sugar levels, serious complications can result from diabetes, including heart disease, blindness and kidney disease. The prevalence of cancer and diabetes in PEI is expected to increase significantly as the population ages. If programs and services are not enhanced to help Islanders prevent, delay and manage these conditions, we will see the impact of these diseases through the continuum of care in future years.

According to new numbers released January 14th, 2007 by Statistics Canada the life expectancy of Canadians continues to rise and has now reached 80.4 years.[48] Life expectancy in Prince Edward Island falls in the middle among all Canadian Provinces at 79.8 years. In addition, the gap in survival rates between men and women across Canada is narrowing as life expectancy increases. Girls born in 2005 can expect to live 4.7 years longer than boys, with female life expectancy at 82.7 and male expectancy at 78 years. In 1990 the gap between males and females was 6.3 years.

It has been suggested in a number of medical journals that as life expectancy increases, the number of disability-free years will increase.[49] On the other hand, this could mean more pressure on the health system as these last few years may not be healthy ones. No one can predict what breakthroughs might occur in medical science or what epidemics may be faced over the next twenty years. Even if we are optimistic about future events, the sheer growth in the absolute number of elderly people, especially those 75 and over, will present significant challenges for health care providers.

[47] Prince Edward Island Health Indicators, 2006
[48] See CBC story at: http://www.cbc.ca/health/story/2008/01/14/death-stats.html?ref=rss
[49] Wilkins R, Adams O. Health expectancy in Canada, 1986. In Robine JM,Blanchet M, Dowd JE, editors. *Health expectancy: first workshop of the International Life Expectancy Network (REVES)*. London (UK): HMSO; 1992. p. 57-60.

5.0 Dementia – A Growing Concern

Dementia is a syndrome, a clustering of many different diseases. According to National Statistics, Alzheimer's is the most common form of dementias.[50] Alzheimer disease is a complex illness, characterized by a very slow and relentless course of brain function deterioration. People who suffer from the early stages of Alzheimer's may require reminders for simple tasks, find daily routines difficult and suffer from loss of concentration. In the middle stages of the disease they may need hands on care, get lost easily and suffer from personality changes. In the later stages of the disease the patient will be severely confused, need personal care and may not recognize themselves or family. Alzheimer`s disease not only affects the person who suffers from it, but also requires a great deal of understanding and patience from all those who provide care.

Dementia is a significant health problem and the Canadian Alzheimer's Society is calling on the Federal government to establish it as a *National Health Priority*. It is a national health priority in countries such as France, Australia and the United Kingdom.

Currently, an estimated 450,000 Canadians over 65 have dementia, with 260,000 of these patients having Alzheimer's disease. It is estimated by the Canadian Alzheimer's Society that by 2031, 750,000 Canadians will have dementia. Currently, 1 in 13 Canadians over the age of 65 are affected by this disease and Canada's baby boomers are now entering the age associated with the highest risk.[51]

It is more than a health concern; the Alzheimer's Society of Canada warns that the disease has the potential to overwhelm the health care system if required changes are not implemented. This organization states that dementia may prove to have the highest economic, social and health cost burden of all diseases in Canada.[52]

5.1 Planning for Dementia Care in Prince Edward Island

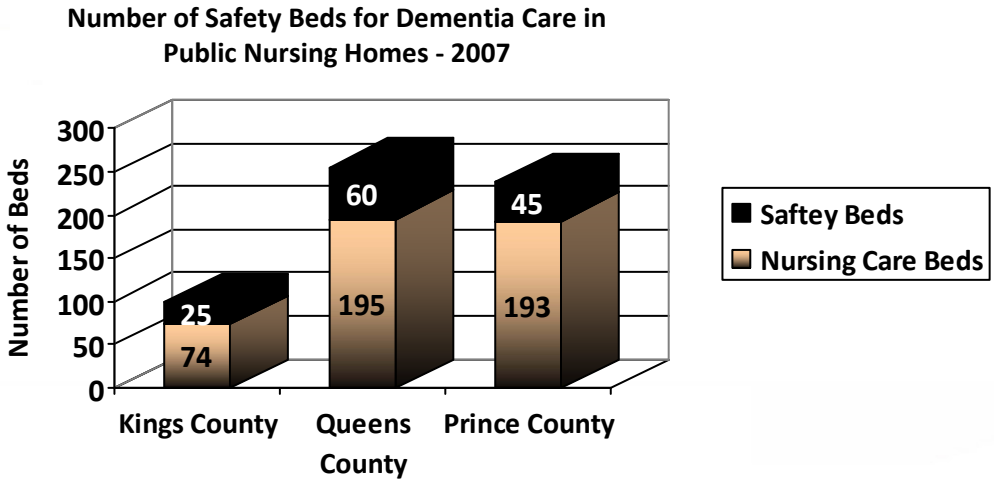
The Alzheimer Society of Canada reports that in 2007 approximately 1,830 people over 65 years of age were projected to have dementia, 1,170 of these were projected to be Alzheimer's cases.[53]

According to a basic review conducted by the Director of Seniors Mental Health Programs in 2006, it was estimated that 80% of all residents in public nursing homes had some form of dementia.[54] However, as noted in *Graph 5*, 22% of the approximately 590 public LTC facility beds are equipped, in a basic sense, to care for residents with advanced dementia. Six of the nine public facilities have what are known as, safety units, but it was recognized by each facilities management team that these units for dementia care are not properly designed, nor does programming exist to adequately serve the population. In the consultations as part of this study, it was noted that there is a growing need for specialized beds for

[50] Canada Alzheimer's Society. (2007). *Canadian Dementia Management Strategy*.
[51] Alzheimer Society of Canada (2008). Based on Canadian Study of Health an Aging Working Group: Canadian Study of Health and Aging: study methods and prevalence of dementia. Can Med Assoc J 1994; 150: 899-913.
[52] Alzheimer Society of Canada. (2007). *Canadian Dementia Management Strategy*.
[53] Alzheimer Society of Canada (2008). Based on prevalence estimates from the Canadian Study of Health and Aging and Statistics Canada population projections.
[54] Dr. Gloria MacInnis Perry (2007). Key Informant Interview.

dementia care located in specialized care units. In Queen's County, the LTC Placement Committee estimated that 40% of people waiting for a bed in LTC, in the fall of 2007, were people who required specialized care for dementia. These people are waiting longer than the average patient to be placed in LTC, as there are only a limited number of safety beds. It was noted that in West Prince the waiting time for a safety bed could be as high as eight months.[55]

Graph 5: Number of Safety Nursing Beds by County - 2007



The Alzheimer's Society of PEI believes that the present and future system must be person centered. The necessary supports will have to transcend the traditional boundaries of health, education, housing, and social services. They believe that leaders and personnel in all fields must become more involved in the implementation of services and programs that ensure dignity and respect are provided to someone living with this disease. The importance of bringing service to people instead of the traditional "placement" philosophy was stressed.[56]

Planning is underway for dementia care in PEI. A Dementia Care Steering Committee was established in 2006. The mandate of this Steering Committee is to develop a strategy, goals and tasks that will guide the implementation of an exemplar dementia care program for Prince Edward Island. The replacement of nursing homes in PEI needs to be considered in relation to dementia care needs, best practices and staffing solutions in order to build a broad-based strategy that will meet the demands of this large component of the elderly population.

[55] Key Informant Interviews. (2007). Queens Placement Committee and Manor Administrator in Summerside
[56] Key Informant Interview. (2007). PEI Alzheimer's Society and Provincial Strategy for Alzheimer's Disease, October 2001.

5.2 Caring For Dementia Patients in LTC

Research conducted on dementia behavioral patterns in relation to physical infrastructure shows that the physical environment of a dementia patient can help calm and stabilize a patient. It is suggested that properly designed facilities and adequately trained staff can decrease protective behaviors, specifically in Alzheimer's patients, and overall make the workload more manageable.[57]

In Prince Edward Island LTC facilities, limited programming has been undertaken to care for patients suffering from dementia. Safety units or special wings have been created to care for more aggressive dementia patients, in order to keep patients from wandering outside the area by providing secure corridors. For a variety of reasons, these safety units have been used for all patients that exhibit aggressive behaviors. Programming and staff training for the care of dementia patients is limited. PEI is not unique in this issue, as other jurisdictions have also encountered similar problems with inadequate solutions. Staff are often not qualified or trained to deal with the special needs of dementia patients. Situations like this, instead of fostering a nurturing atmosphere among staff and patients, can produce the opposite. Smaller residential homes and pods, with appropriately trained staff, have a much better chance of providing such an atmosphere. Dementia patients are generally more mobile and aware than other residents; therefore, having an atmosphere that is comfortable, home like and natural for the patients can make a notable positive difference in their health and behavior.

Specialty Care Unit's (SCU) are recommended by experts as a solution for servicing dementia patients within a LTC setting. It is important that a number of elements be considered in designing a SCU, including: the scale of the facility, the domestic environment, proximity to the community, wayfinding and orientation devices, familiarity of the environment, privacy and community, accessibility along with safety and security.[58] The scale of the facility is one of the most important factors to consider. An environment of appropriate scale helps a person have a sense of place and well being, a smaller scale reduces the number of decisions a person has to make and the number of people he or she interacts with. The scale of individual components of a facility can be just as important as the scale of the overall building.

The most effective SCU's are often smaller residential settings, where the patients can have quality healthcare along with a comfortable home like environment. However, many facilities can adequately and appropriately service dementia patients in larger scale buildings with smaller scale pods designed for 10 to 12 patients.

Dementia patients require more care and specialized care in comparison to other patients. They suffer from a tendency to wander, desire to rummage and incontinence. A special unit designed to keep them in a safe and monitored location will keep them safe and protected. The ideal layout for an SCU would

[57] Designing for Diversity in Dementia Care Conference, University of Waterloo. (2002) *"Alzheimer Behavioral Patterns Treated with Architectural Design"* LTC Facility Designed for Curing Dementia Ailments, Fourth Avenue, Sudbury.
[58] Kirsty Bennet, Uniting Care Victoria, *"Designing for Dementia: Australian Responses to Diversity"*, Designing for Diversity in Dementia Care Conference, University of Waterloo, 2002.

involve the fewest number of dead ends possible. Dementia patients wander excessively and reaching dead ends increases their level of anxiety; therefore a continuous loop with the staff desk located in the center allows for the patients to wander and the staff to monitor them continuously. If a continuous loop is not achievable, engineers and architects who specialize in dementia care recommend painting a calming scene on locked doors, like landscape imagery, to ease the tension. Wayfinding can be enhanced by including visual clues for the patients. Wayfinding signs can be placed on doors to help residents find their way on their own and thus they will require less assistance. Visual clues are also helpful to identify washrooms. Incontinence is a trait for many people in their later years and especially in dementia patients. Having a washroom opposite the bed and visible with a night light will mitigate this issue. Having washrooms beside dining and socializing areas is also important. Rummage boxes, gliding rockers, children's toys, display cases and fish tanks are all points of interest for dementia patients because these items feed their compulsive behavior needs, possibly mitigate forgetfulness and keep them occupied and happy.[59]

It is recommended for SCU's to have appropriate visiting rooms, and it has been noted that an increased number of smaller, more intimate visiting rooms are better than fewer, larger ones. Also it is recommended that SCU's have outdoor access, and that the outdoor facility should be divided into two separate parts: one for dining outside with tables and chairs; and another for gardening. However, the most important aspect of SCU's is keeping residents and staff safe. Giving them the opportunity to live in a safe location that is natural and comfortable is a notion to aspire towards.

[59] *"Alzheimer Behavioral Patterns Treated with Architectural Design"* LTC Facility Designed for Curing Dementia Ailments, Fourth Avenue, Sudbury. Designing for Diversity in Dementia Care Conference, University of Waterloo, 2002.

6.0 Facilities Review

The scope of work for this project involved conducting a high-level assessment and review of the current public LTC facilities. Through consultation with the Continuing Care Division of the Department of Health it was determined that this would involve conducting site visits in all nine publicly owned LTC facilities. The review included a high-level assessment and analysis of:

- condition and appearance of the facility;
- appropriateness of the facility's interior layout given future LTC care trends;
- appropriateness of facility's location in the future given demographic, population and behavioral trends; and
- current use of the facility, identifying any short-term modifications or updates required and a recommendation on what facilities requirements will need to be made to meet future demand.

6.1 Scope of Review

The review compiled information from key informants and has referenced this information within the report (e.g., size, age, construction and other details). The following process was undertaken for the review:

- assembly and review of selected real property assessment information on the facilities;
- assembly and review of risk management information on the facilities;
- review of report prepared by Transportation and Public Works in 2001, *"Assessment of Funding Requirements for Capital Repairs"* which identified major capital repair requirements for Health facilities;
- design and circulation of a questionnaire completed by LTC Administrators requesting information including; size, age, facility layout, programs, services, type of construction, maintenance information and general comments;
- conduct a walk through at each facility accompanied by various health care personnel including; administrators, directors of nursing, maintenance staff, etc.; and
- the inclusion of building descriptions, photographs and maps.

Information on each of the nine public LTC facilities is outlined in *Appendix III* and provides background information and analysis of the state of current facilities along with issues identified through the review process.

6.2 Summary of Review

The majority of the public LTC facilities were constructed when residents care requirements were substantially less than they are today. LTC facilities were constructed when the patient care requirements were Level 1 to Level 5. With Levels of Care now being only 4 and 5, several of the facilities are rendered to be functionally inadequate for the current patient population.

As identified in *Table 24*; 1 facility is less than 10 years old, 3 facilities are between 22 and 26 years old, 5 facilities are in between 37 and 48 years and one section of one facility is 76 years old. The four facilities that are 26 years old or less (Margaret Stewart Ellis Wing, Beach Grove Home, Wedgewood and Stewart Memorial) do require adequate budget allocation for regular maintenance and up-grades to meet the needs of the changing resident population.

Table 24: LTC Facilities By Age

Facility	Age of Construction
Community-Margaret Stewart Ellis Wing	2003
Beach Grove Home	1986
Wedgewood	1983
Stewart Memorial-Long Term Care Wing	1982
Colville	1971
Riverview	1967
Maplewood Manor	1966
Summerset	1965, 1970
Prince Edward Home	1932, 1960

The five facilities that are between 37 and 48 years old (Colville, Riverview, Maplewood, Summerset and Prince Edward Home) are structurally sound; meaning the actual physical infrastructure (bricks and mortar) is stable. However, these facilities are functionally inadequate and have several similar issues including:

- aging infrastructure, dated wiring, elevators, plumbing and boilers;
- washrooms located off hallways, shared washrooms and general lack of washrooms;
- inadequate storage space in each unit;
- ventilation is inadequate or non-existent;
- narrow hallways;
- infection control issues due to lack of space; and,
- inadequate design for the provision of care required.

7.0 Public Private Partnerships and Capital Building Programs

7.1 Public Private Partnerships

The Canadian Council for Private-Public Partnerships (CCPPP) provides the following definition for a private-public partnership:

> "A co-operative venture between the public and private sectors, built on the expertise of each partner, that best meets clearly defined public needs through the appropriate allocation of resources, risks and rewards".[60]

Governments in many countries have been experimenting with public-private partnerships (P3) arrangements. The primary objective of such arrangements is to enable tax payers to get better value for their tax dollars by shifting at least some of the operational and/or financial risk to the private sector.[61]

Researchers of P3 arrangements have distinguished among an array of arrangements, classifying them depending upon the nature of risk transferred between public and private sectors. On one end, the arrangements can be described as outsourcing or contracting out and, on the other, public assets are sold outright to the private organization ("privatization"). Between them is an array of options, such as BOO (Build Own Operate), BOT (Build Operate Transfer), BOOT (Built Own Operate Transfer), DBFO (Design Build Finance Operate).[62]

A successful P3 arrangement brings benefits to both the private sector partner and to government. The private sector partner participates to earn a return on its financial investment that is commensurate with the risks borne by the company. For government, the benefits of a P3 arrangement can include:

- it shares the project risks;
- it can gain access to new sources of capital;
- it can accelerate the development of infrastructure assets;
- it can maintain or improve service levels; and
- it can gain access to a wider range of skills (e.g., management, service delivery, planning, etc.).[63]

The P3 approach has been used to replace a few acute care facilities across Canada, such as the Royal Ottawa Hospital. Alberta has used the P3 option over the last five years to create more continuing care beds. Typically, these projects are based on a contractual arrangement between a health region and a private or not-for-profit (NFP) organization for the initial capital costs and for the operation and maintenance of the facility. Private or NFP organizations have designed, built, operated and financed the continuing care facilities under long term (e.g., 30-year) agreements with partial funding from the

[60] See the CCPPP website at: www.pppcouncil.ca/aboutPPP_definition.asp
[61] Nova Scotia Department of Finance. (1997). *Transferring risk in public/private partnerships: Discussion paper.*
[62] Jones, B. (2001). *Public-Private Partnerships for Ontario Hospital Capital Projects*. A background report prepared for the Ontario Hospital Association's Committee on Hospital Capital Development.
[63] KPMG. (2002). *Partnering for the future: Public-private partnerships in tourism development.* Prepared for the Ontario Ministry of Tourism, Culture & Recreation. Queen's Printer for Ontario.

local health authorities. In Prince Edward Island the P3 model was considered in the establishment of the Prince County Hospital; however, after an extensive and detailed analysis of the proposal, it was rejected in favour of a conventional public sector project.

The LTC system in Prince Edward Island includes both private and public sector participation. The private sector provides approximately forty (40%) per cent of the LTC beds, while the public sector provides the remaining sixty (60%) per cent. The private LTC facilities have operated under a Build Own Operate P3 arrangement for some time now. The Government's involvement in private facilities has been in regulating the activity and providing subsidy assistance for the cost of health care and subsidy assistance to eligible residents.

CCFs in the province are owned and operated exclusively by the private sector. Again, the government's involvement has been as regulator and in providing subsidies to residents whose income is insufficient to meet the basic daily rate. Respondents in this study revealed that private owners of LTC facilities, as well as, owners of CCFs did not reflect any concern or desire to change the manner by which private facilities are financed or operated.

The experiences of others with P3 arrangements in Canada and elsewhere in the world provide a number of lessons useful for those interested in pursuing P3 arrangements. Deber (2002) describes a number of conclusions reached from an assessment of P3 experiences. They include:

- comparisons are difficult (most attempts to compare costs and outcomes become bogged down because of different project types, services offered, cost structures, regulatory environments, etc);
- competition and cooperation must be balanced;
- when services are delivered privately, it is necessary to monitor performance;
- measuring and monitoring of performance is costly and difficult (The monitoring of performance is more likely to work for services whose outcomes are easy to measure; however, many health care services are too complex to be treated in this way);
- changing delivery structures also changes power structures;
- for-profit delivery requires predictable revenue streams.[64]

The challenges with P3 arrangements are to ensure that both the private and public sectors have a full and complete understanding of their individual and collective functions and that risks for both parties are fully understood and measured, so it is possible to determine whether projects are good value.

The City of Ottawa has used a P3 arrangement for the development of a LTC facility and adjacent seniors retirement complex. In June, 2005 the city of Ottawa opened a new 180 bed Long-term Care Home for $22.3 million in the centre of the city. This home was built through a P3 arrangement that was designed to provide Ottawa residents with a state-of-the-art LTC facility and new modern retirement residence for seniors. The Ontario Ministry of Health and Long-Term Care is a partner in this venture contributing $661,000 annually for 20 years ($13.2 million) to this project. The P3 arrangement worked as follows; a private sector company (PCL) was contracted through a public tender process to construct the LTC facility (Garry J. Armstrong Home) at a cost of $22.3 million, this will be paid for, owned and operated by

[64] Deber, R. (2002). *Delivering health care services: Public, not-for-profit, or private?* Commission on the Future of Health Care in Canada. Discussion Paper No. 17.

the City of Ottawa. The outdated senior's facility (Allan House) that was on site was demolished to make way for the construction of a new private sector built and operated seniors' residence. The multi-million ten-storey retirement residence, with 128 units for independent living for seniors was anticipated to be complete in the spring of 2007. The private sector will provide $2 million per year back to the City for a 50-year ground lease for ownership for the new seniors' residence on the former Allan House site. The site reverts back to the City at the end of the lease at no cost.

The City of Ottawa noted a number of benefits to using a Private Public Partnership to re-develop the Garry J. Armstrong Home and Allan House seniors' residence redevelopment:

- Residents get a new long-term care facilities available in a timely manner
- Builds long-term care at the best value to the City
- Increases programming and services for residents
- Offers more independent living capacity within the City for seniors
- Allows residents to benefit from the expertise of private-sector partners specialized in retirement living
- Ensures a high standard of quality in housing and support services for seniors

KPMG, in a study for the Ontario government, identified six criteria for facilitating decisions as to whether potential projects would be good candidates for P3.[65] Each project requires its own business case developed and should be considered on its own merits. The criteria for the business case include:

- Financial – Will a P3 be able to carry out the project under acceptable financial terms?
- Operational – Are there operational hurdles that prevent private sector involvement?
- Acceptability – Are there any public concerns that may result in rejection of the project, or private sector partner, by the public-at-large?
- Implementation – Are there implementation barriers that prevent the involvement of the private sector?
- Technical – Can a technical solution to the project be found through a P3?
- Timing – Are there time constraints that would pre-empt involvement of the private sector?

Any project which addresses the six criteria is a potential candidate for P3. On the other hand, if a project fails to meet one or several of the criteria, the consideration of alternate approaches may be an appropriate strategy.

By definition, a P3 arrangement for the delivery of LTC services in PEI already exists. There is a solid relationship between the public and private sector for delivery of LTC services in Prince Edward Island and the recent change, by which the government funds health care cost for all LTC residents, is a positive adjustment for all parties involved and this partnership should continue into the future. In terms of development of new public LTC facilities, there are a number of different options to establish a Public Private Partnership, each situation is complex and the merits of each facility would need to be evaluated and assessed on a case by case basis to determine if a mutually beneficial partnership exists.

[65] KPMG. (2002). *Partnering for the future*. P. 37-43.

7.2 Public vs. Private Delivery of Care

There are many sides to the debate, as to whether or not LTC should be provided by the public sector or private sector. It can be argued that health care is a public service and it is government's role to provide for and deliver that care. On the other hand, in many areas the private sector is willing and able to deliver LTC services.

The majority of key informants consulted for this review contend that both the public sector and the private sector have a role to play in the delivery of LTC services in Prince Edward Island. There is a healthy breakdown of public (60%) and private (40%) delivery of LTC in PEI and this balance is working. The privately operated LTC facilities in Prince Edward Island have a well established reputation with the public. With this in mind, however, there still remains a public assurance and confidence level attached to the publicly operated LTC facilities and the quality of care delivered.

With the increasing complexity of care and the need for more specialized services it is important that the public sector remain in the business of operating LTC facilities in PEI. It is equally important that the private sector continue their role in delivering LTC services to Islanders.

7.3 Capital Building Programs

The following process was undertaken to conduct a review of programs that could assist in funding capital buildings: web-based research, Federal Programs review and interviews with Federal Government Officials.

Web-based research into shared Capital Building Programs, or Infrastructure Programs, between the federal government and the provincial governments and/or a third partner, indicates that construction or renovation of LTC facilities do not meet the criteria of any of these funds. This finding was confirmed by interviews with federal government officials. The one possible fund that might be open to broad interpretation is the funding set aside in the Federal Budget 2007 to support Public Private Partnerships. To date, the parameters around the P3 funding from the federal government have not been set or communicated. Going forward, the Department of Health may wish to monitor developments in this policy and funding area.

8.0 Conclusions and Recommendations

The challenges facing the LTC sector in PEI include: steady growth of the elderly population, aging infrastructure, high utilization rates and increasing specialized care needs. These challenges can be ameliorated with a clearly articulated plan for the future. However, a single solution that can be universally applied across the province is not possible. The solution requires a broad-based approach – one in which the unique characteristics of each region; the different types of care; and the demands and preferences for various types of services are all recognized. Therefore, depending on the scope and nature of the solutions presented in this report, the recommendation will be provincial, regional or local in scope. In all cases, the recommendations will be based on current literature and related research and the feedback received from the stakeholders interviewed for this study.

The overarching recommendations are detailed in *Section 8*, followed by *Section 9.0*, which integrates and prioritizes the recommendations for LTC bed projections and facility replacements into implementation timelines of five-year intervals. The recommendations are research driven, based on the statistics gathered both provincially and nationally and also taking into account the information gathered during the extensive consultative process.

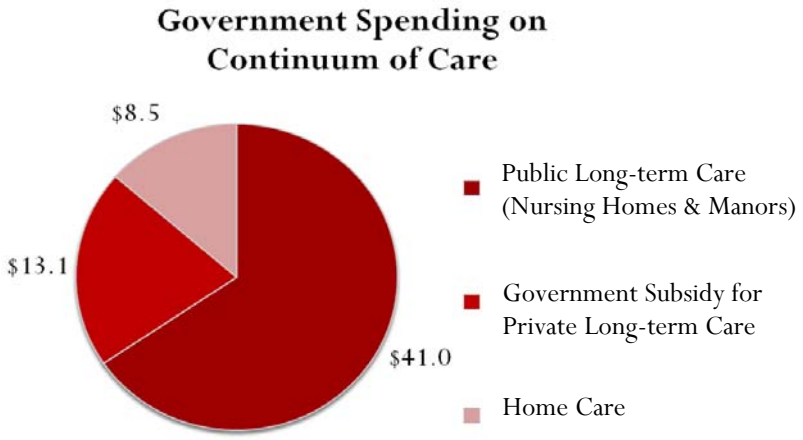
8.1 "Aging at Home"

Recommendation No. 1:	The Department of Health develop an "Aging at Home" strategy which would include expanded HCS services, assisted living housing options and community support services for the elderly.

Prince Edward Island is a leader in the country in access to residential care, with 9.2% of seniors over the age of 65 having access to a community care bed or long-term care bed. This results in reasonable wait times for long-term care and community care in comparison to other jurisdictions. However, as referenced in *Section 3.0* of this review, the provincial spending on HCS services is less than half the national average per capita for the population over the age of 75. The combination of these two factors creates an imbalance in the continuum of care towards caring for more patients in a residential setting as opposed to at home. With a growing elderly population, maintaining the ratio of admissions to LTC beds to the population over 75 years of age, presents a fiscal challenge, therefore solutions need to be implemented that will balance the scale.

The PEI Government budgeted $41 million in 2007/2008 for the provision of LTC in Provincial nursing homes and manors. In addition, $8.5 million is spent on home care services and $13.1 million for subsidies for residents requiring nursing care in private LTC facilities. The government subsidy for elderly in private LTC facilities increased by 47% over 2006/2007, due to the change in subsidization policy and an increase in the number of LTC beds. [66]

[66] PEI Estimates 2007/2008, Department of the Provincial Treasurer, Government of PEI



In order to address the fiscal challenges related to the demand for LTC services, it is recommended that the Department of Health develop an "Aging at Home" strategy which would include expanded HCS services, assisted living options and enhanced community support services for the elderly.

Elderly people want what most people want; control over their own lives to the greatest extent possible. When a number of elderly people at risk of institutionalization were asked what they would need for them to remain in their homes, they responded their most important needs were the ability to maintain control of their lives and adequate funding to enable them to do that. They felt that going to a nursing home or moving in with family would remove that control.[67]

As evidenced in this report, many Canadian jurisdictions are placing emphasis on "Aging in Place" or "Aging at Home" strategies. Nova Scotia, Ontario and British Columbia have focused attention on and invested resources in care that aims at keeping seniors healthier, happier and in their homes longer. This includes, investing in and expanding HCS services, community support and 'Assisted Living' options. More support for home care could not only be more beneficial for seniors who wish to remain in their communities and homes for as long as possible, but some research suggests that it could also mean cost savings to the public.[68]

It is important that the home care model of maintenance and prevention be enhanced in such a way that it better serves people with health and/or functional deficits in their homes, both maintaining their ability to live independently and, in many cases, preventing or delaying health and functional breakdowns and eventual institutionalization. Research concludes that maintenance of functional independence, good social support network, engagement in social activities, and good informal care

[67] Alcock, D., Gallagher, E., Diem, E., Angus, D. & Medves, J. (2000). *Decision Making: Home Care of Long-term Care Facility*. Report Prepared for the Health Transition Fund, Health Canada.
[68] Professor Evelyn Shapiro, University of Manitoba, *Sharing the Learning: Health Transition Fund*: Synthesis Series: Home Care. Prepared for Health Canada.

giver support may reduce or delay the demand for institutional care.[69] Investing in HCS services now could mean stemming the tide for the requirement of substantial increases in LTC services in the future.

'Assisted Living' options provide support services to seniors while allowing them to maintain their privacy and independence. 'Assisted Living' locations commonly provide 24-hour staff oversight, housekeeping, at least two meals a day, and personal assistance with two or more activities of daily living. They offer the elderly more privacy and autonomy and are often single, private rooms with a full bathroom or an apartment unit.[70]

The key characteristics that differentiate assisted living from other types of residential care are:

- an explicit focus on privacy, autonomy, and independence, including the ability to lock doors and use a separate bathroom;
- an emphasis on apartment settings in which residents may choose to share living space; and
- the direct provision of, or arrangement for, personal care and some nursing services, depending on degrees of disability.

Creating and implementing an "Aging at Home" strategy is critical to the effective delivery of the continuum of care. However, it will not be a quick fix, as there are many factors which impact the utilization of home care services. For example, Nova Scotia has been implementing an "Aging in Place" strategy since late 2006, which includes a substantial increase in the provinces HCS budget. However, a lack of human resources has prevented service delivery in many areas and wait lists for the services continue to expand.[71] Increases in home care spending and services should impact the continuum of care in Prince Edward Island, but the delay or reductions in residential care (LTC and CCF) are not likely to be experienced in the short-term. It is important the Department of Health monitor home care utilization over the next five to ten years to determine the impact on people requiring nursing care and identify any changes in the length of stay due to a delay of patient institutionalization. It is anticipated that with increases in the home care and community support budgets, along with increased utilization by seniors, a corresponding decrease in demand for LTC should evolve.

Data collection, reporting consistency and analysis of the Home Care and Support Program are currently lacking, therefore trends and utilization patterns are difficult to identify. More attention and resources are required to effectively manage the collection and reporting of data for this $8 million program.

[69] Woo, J., Ho, S.C., Yu, A.L. & Lau, J. (2000). An estimate of long-term care needs and identification of risk factors for institutionalization among Hong Kong Chinese aged 70 years and over. *Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, *55(2). M64-M69.*

[70] Stone. Robyn. I. "Long-Term Care for the Elderly with Disabilities" Current Policy, Emerging Trends, and Implications for the Twenty-First Century". August 2000 See. http://www.milbank.org/0008stone/#aging

[71] Key Informant Interview, Policy Analyst, Nova Scotia Department of Health, 2008

8.2 Efficiency of Admission and Placement Committee Process

Recommendation No. 2:	**The Department of Health set a standard of a three-day turnaround time-period for new patient admissions into public LTC facilities.**

Recommendation No. 3:	**The Department of Health stream-line the admission process. Ultimate control and decision making responsibility should be assigned to the management of the Division of Continuing Care and Community Hospitals.**

It was documented in *Section 2.1.4.6* of this report that publicly operated LTC facilities have lower occupancy rates in comparison to privately operated LTC facilities. It is recommended the Department of Health review all policies that could contribute to more downtime in the public sector. It is also recommended that the Department of Health set a standard of a three-day turnaround time-period to admit a new resident upon the availability of a bed.

In order to maximize financial efficiencies it is critical that a policy be implemented and appropriate steps put in place to ensure it is adhered to. This policy should also address the need for admitting residents whenever the vacancy arises; for example, weekend admittance should become a standard practice, not an exception to the rule. Training will be required in order to implement the policy effectively. It will take efficiencies in a number of areas including; maintenance services, placement committees, administrative staff and financial assessments.

If the publicly operated facilities are to improve the efficiency of the admission process, this would result in more LTC beds for the elderly and subsequently lessen the need for the construction of new LTC beds.

Currently, there are five Placement Committees that assess and approve applicants for admission to both the public and the private nursing homes. Committees range from three individuals in the rural regions of the Province to nine members in the Queens region. Membership on the committees consists of key stakeholders in the health region. Frequency of meetings is determined by the availability of a vacant nursing home bed in both the public and private sector or by a set time-frame for weekly meetings. All five committees operate differently as there are no set guidelines or standards to guide the consistency of the placement process. It is imperative that these committees are efficient and objective in their decision making.

Many critical factors must be taken into consideration when approving an applicant for admission to a LTC facility. While at the same time, decisions must be made quickly to ease pressures on individuals, families and often health care services. Delays create inefficiencies throughout the health care system.

The Department of Health should review the format, process and make-up of the regional placement committees to determine their effectiveness, efficiency and consistency of decision making across the Province. Since the Placement Committee is the gate keeper to entering the LTC system, the Department of Health should ensure that these committees are operating as efficiently as possible. It is

recommended that the Department of Health stream-line the admission process by having staff and stakeholders involved with ultimate control and decision making within the management of the Division of Continuing Care and Community Hospitals.

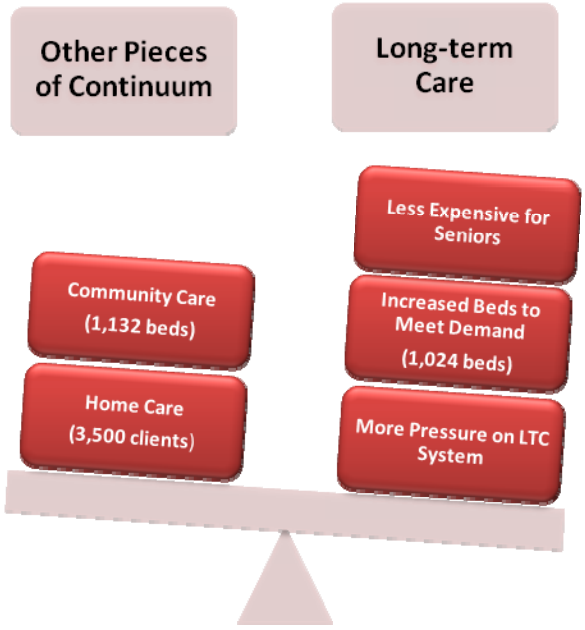
8.3 Seniors Assessment Screening Tool (SAST)

Recommendation No. 4:	The Department of Health should evaluate the SAST with a view to improving the effectiveness, consistency and the relevancy of the assessment tool for the varied population who are screened for admissions.

The SAST is used to determine if an individual is deemed eligible for placement in a nursing home. Assessment results are used to ensure that the applicant requires placement in a LTC facility rather than a CCF. The tool should ensure that only those who require nursing care are identified as eligible for admission to a LTC facility.

The imbalance in the continuum of care noted in *Section 8.1* has been further impacted by the changes to the LTC subsidization policy, whereby, government funds health care for all residents in a LTC facility. This subsidization policy change has placed increased pressure and demands on the most expensive type of residential care in the continuum (long-term care). Improving the effectiveness, consistency and decreasing the subjectivity of the SAST is one solution that would begin to balance the scale as it would ensure that only patients who are assessed properly at a level 4 or 5 care need would be admitted to a nursing home.

Effects of Subsidization Policy Change on PEI's Continuum of Care



Conducting assessments is a specialized skill and it is imperative that staff who administer the screening tool be thoroughly trained as an assessor. Consistency in the process throughout the Province is crucial to the overall effectiveness of the system and appropriate placements will be best achieved by well trained staff who consistently administer the assessment tool. The Department of Health must evaluate the SAST with a view to improving the effectiveness and the relevancy of the assessment tool for the varied population who are screened for admissions.

An appropriate assessment tool, properly and consistently administered will mitigate the concern of inappropriate placements from CCF and will ensure that the right applicant is in the right bed at the right time.

8.4 LTC Bed Requirements in Five-Year Intervals

Recommendation No. 5:	**The Department of Health should continue to maintain the same admission to bed to population ratio in the short-term until programs can be developed that could reduce the need for institutionalization. Maintaining this ratio will require adding an additional 134 LTC beds to the system by 2012.**

If the above noted "Aging at Home" strategy is developed and implemented, it will have a corresponding impact on future bed to population ratios, affecting the overall demand for LTC. Research in Canada to verify percentages by which home care services can delay or replace residential care has not been conducted. However, Canadian research does indicate that when appropriate substitutions of home care are made for residential care, overall continuing care costs can be reduced if all other factors remain constant, particularly for clients who are relatively stable.[72]

8.4.1 Temporary Beds & Transition Beds

Recommendation No. 6:	**The 29 temporary beds in the LTC system should be made permanent.**

In response to increased demand for LTC, 18 temporary beds were approved as additional beds in the LTC system in 2007. In addition, 11 temporary beds have been included in the system for a number of years for a total of 29 beds that are classified as temporary. These 29 temporary beds should be made permanent as they are located in geographic areas where indicators show there is a demand. Also, as the result of the closure of a private nursing home (Lennox Nursing Home) 21 previously licensed beds were moved to existing private facilities.

[72] Hollander Analytical, Sub-study 1: *Final Report of the Study on the Comparative Cost Analysis of Home Care and Residential Care Service.* Data obtained from British Columbia Continuing Care System.

8.4.2 Projection based on Status Quo Delivery of Care

The bed projections[73] are based on status quo bed to population ratios for LTC and past service delivery patterns. As noted in *Section 4.5* of this report, any significant program change in the delivery of services to the elderly in the future can impact demand for LTC and therefore adjust projections.

As presented in *Table 25*, if all other factors remain constant and the same admission to bed to population over 75 years of age ratio is to be maintained, the bed complement will have to be increased from the 1,012 beds available in 2007 – which includes temporary beds – to approximately 1,604 beds by 2027. This is an increase of approximately 590 beds over the next 20 years. The increase over the second ten year period (2017-2027) will be double the increase in beds required over the first ten year period (2007 -2017).

Table 25: LTC Bed Requirements in Five-Year Intervals By County

LTC Bed Requirements in Five-Year Intervals By County[1]							
County	**Actual Beds**		**Projected Beds Required**				
	2006 Actual	**2007 Actual**	**2007**	**2012**	**2017**	**2022**	**2027**
Queens	557[2]	561[2]	598	645	703	795	922
Prince	291	303	309	342	382	432	508
Kings	146	148	157	159	162	172	174
Province	**994**[2]	**1,012**[2]	**1,064**	**1,146**	**1,247**	**1,398**	**1,604**

1. Data is taken to the 12th decimal point, variances for rounding may occur. 2. Includes palliative care and convalescent care beds at the PE Home.

Table 26 shows the number of additional beds that are projected to be required by county in five-year intervals. In addition to the temporary LTC beds added to the system in 2007, it is evident from *Table 25* that the increase in beds was inadequate to meet the population demand in maintaining admission to bed to population ratio. An additional 52 beds were required in 2007.

Table 26: Additional Beds Required in Five-Year Intervals

Additional LTC Beds Required by County					
Year	**2007**	**2012**	**2017**	**2022**	**2027**
Queens	37	47	58	91	127
Prince	6	33	40	50	76
Kings	9	2	3	10	2
Province	**52**	**82**	**101**	**151**	**206**

[73] A projection is defined as a prediction made by extrapolating from past observations and present conditions. See, for example, Raymondo, J. (1992). *Population Estimation and Projections: Methods for Marketing, Demographic, and Planning Personnel.* New York, NY: Quorum Books.

It is recommended that the Department of Health continue to maintain the same admission to bed to population ratio in the short-term until policies can be developed that could reduce the need for institutionalization. Maintaining this admission to bed to population ratio will require adding an additional 134 LTC beds to the system by 2012. If these levels of LTC beds are not added to the system, the more costly response for acute care will likely be required.

8.5 Facility Replacement / Renovation

A high-level assessment and review was undertaken for all nine publicly owned and operated LTC facilities. The scope, analysis and results of this review are outlined in *Section 6.0* and *Appendix 3* of this report. Facility replacement and renovations have been recommended based on a number of factors including: building age, structure, function, and design as well as, projected demand.

8.5.1 Summary of Facility Review Findings

The majority of the LTC facilities were constructed when patient care requirements were substantially less than they are today. Several of the facilities are rendered to be functionally inadequate for the current patient population. One of the most frequent and significant issues identified by key informants had to do with the safety of facilities; in that the design was often deemed inadequate to service the needs of residents, particularly those with dementia. This was raised about most facilities regardless of their age. All facilities were deemed to have some functional limitations in the delivery of programs and services.

8.5.2 Replacement / Renovation

Recommendation No. 7:	**The following facilities are recommended for replacement and/or renovation in priority order.**	
	1. Prince Edward Home, (1932 Section)	**replace the 1932 section and conduct a detailed engineering/architectural review of the 1960 section to determine what health programs and services could best be accommodated in this portion of the building. Depending upon the outcome of the review either renovate, vacate or use the 1960 section of the facility for another purpose.**
	2. Summerset Manor	**replace facility**
	3. Colville Manor	**replace facility**
	4. Maplewood Manor	**replace facility**
	5. Riverview Manor	**replace facility**

It is further recommended that Beach Grove Home and Wedgewood Manor be re-configured to ensure that they are adequate to meet the needs of residents with dementia. For all LTC facilities, both existing and newly constructed, adequate budgets for maintenance and repair will be required.

8.6 Public and Private Delivery of Care

Recommendation No. 8:	**Government continue to operate the same LTC facilities as they do currently and maintain approximately the same number of beds.**

Recommendation No. 9:	**A request for proposals (RFP) be developed and thoroughly evaluated by the Department of Health for the ownership of the new public LTC facilities.**

Recommendation No. 10:	**The private sector provide for the additional nursing home beds that are projected to be required.**

This report is recommending either the renovation and/or replacement of several provincially owned LTC facilities. There is both an immediate need and a long-term need for additional capacity of LTC beds to address some of the findings identified in this report and there is a need for more emphasis on the provision of specialized care and more complex care.

In accordance with legislation, government regulates the private LTC sector by setting operational standards, licensing and monitoring all facilities annually. In addition to the role of regulator, government owns and operates LTC facilities. It is recommended that both government and the private sector continue to provide specialized nursing care along with caring for the frail elderly. A partnership currently exists between government and the private sector in the provision of LTC beds and this partnership, whereby the private sector builds, owns and operates LTC facilities and government provides subsidizes for health care, works well and should continue into the future.

It is recommended that government continue to operate the same number of LTC facilities as they do currently and that they maintain approximately the same number of beds. There is currently a healthy breakdown of beds between the public (60%)and private (40%) sector for the delivery of services in LTC facilities. Both the public sector and the private sector have a role to play in the delivery of LTC services. It is recommended that this breakdown maintain in the range of 50% public and 50% private into the future.

While it is recommended that the government continue to operate the same number of beds they currently do, there is potential opportunity to investigate the feasibility of a P3 arrangement for ownership of public LTC facilities that are deemed necessary for replacement. It is recommended that a request for proposals (RFP) be developed by the Department of Health seeking proposals from the

private sector for the ownership of public LTC beds based upon the needs identified within this report. Proposals for new facilities could be considered if they identify a mutually beneficial partnership that meets or exceeds the design concepts/standards to be developed by the Department of Health.

8.6.1 Specialized Care Centers

Recommendation No. 11:	A Specialized Care Centre be established in each of the two urban areas of the Province (Charlottetown and Summerside).

As part of the public manor replacement process, it is recommended that a Specialized Care Centre be established in both Charlottetown and Summerside that is equipped to care for patients with complex care needs including; residents with psycho-geriatric needs, the patient population under 60 years of age requiring nursing care and patients with cognitive impairment. It is important that these Specialized Care Centers would have sufficiently trained staff and the necessary facilities to provide the highly specialized care needed. In the event that the local LTC facility cannot provide the necessary care or meet the needs of a specific sub-population, the resident would be admitted to one of these urban centers. These Specialized Care Centers would also provide professional support services to HCS, as well as residents in other nursing homes and community care facilities. Specialized care is not recommended to be the exclusive responsibility of the public sector. Resident needs are increasingly becoming more complex and the private sector has the opportunity to provide for these services.

8.7 Delivery of Care to Sub-Groups of the Population

Sub-groups, in the terms of this review for LTC, can be defined as a segment of the overall population grouped by a specific demographic (i.e., age or specific care requirements).

8.7.1 Population Under 60 Years of Age Requiring Complex Care

Recommendation No 12:	Based on fiscal realities of the province, combined with the fact that this population requires complex nursing care and access to speciality professional services, the population under 60 requiring complex continuing care should be cared for in the Specialized Care Centres that are being proposed for Charlottetown and Summerside.

"An Environmental Scan and Needs Assessment of Patients Under Sixty Years of Age Requiring Complex Continuing Care" was conducted in March 2007 by Atlantic Evaluation Group. This study reported that there were 63 LTC residents under the age of 60, of whom 27 were residing in the Prince Edward Home.

The Environmental Scan concludes that the existing LTC facilities are not appropriate as they are designed to care for the elderly patient requiring chronic care. Programming, staff training and skill development are often not designed for the younger patient and facilities lack the access to professionals (physiotherapists, occupational therapists, etc.) who could adequately plan the complex

care required for the clientele under 60. In addition, there is no adequate plan or case management system to adequately address the needs of these patients, they are managed and cared for on a "case by case basis."[74]

Appropriate planning, staffing, programming and a case management process will need to be developed to adequately care for those who require complex nursing care. The Specialized Care Centres, for example, should be equipped to meet the needs of these patients through an appropriate design that will enable this population to have separate living quarters from elderly LTC residents, but also access to professional staff.

8.7.2 An Emerging Philosophy of Care

Recommendation No. 13:	A philosophy of care must emerge based on the principle that the majority of residents in LTC facilities are those with cognitive impairments.

Today's clientele in LTC require a more complex level of care. Many residents have dual diagnoses; that is, a chronic condition combined with a cognitive impairment. Department of Health staff has indicated that 80% of the clientele in the public LTC facilities have some form of dementia. [75] Based on this, it is imperative that a philosophy of care emerge that services the majority of the residents in LTC facilities, particularly those with cognitive impairments. This involves the planning, design and construction of new facilities, the establishment of staffing modules, the development of resident programming, and the design and delivery of professional development all of which are appropriate and relevant in an emerging philosophy of care for residents with complex needs. With such a high proportion of residents with some form of dementia, it is important that facilities be designed to service their needs.

[74] Steve MacQuaid *"An Environmental Scan and Needs Assessment of Patients Under Sixty Years of Age Requiring Complex Continuing Care"* Atlantic Evaluation Group, March 2007
[75] Gloria MacInnis Perry, Key Informant Interview, 2007

8.8 Design of Facilities

Recommendation No. 14:	The Department of Health develop new design concepts/standards prior to the construction or conversion of any new LTC beds.

New construction of LTC beds or conversion of existing beds, either provincially or privately operated, should incorporate design concepts/standards that are anticipated to better meet the future needs of all residents, with a strong focus on dementia care.

It is important that the philosophy of care be at the forefront when developing these standards. Planning for the care of residents with dementia should involve developing design standards based on current research and current design standards. Research shows that the physical environment can help considerably in calming and stabilizing dementia residents. It is suggested that properly designed facilities and adequately trained staff can decrease protective behaviors, specifically in Alzheimer's patients, and overall make the workload more manageable.[76]

In terms of design, a number of best practices are noted in *Section 5.0* of this study. In summary, Specialty Care Unit's (SCU) are recommended by experts as one solution for caring for dementia patients within a LTC setting. It is important that a number of elements be considered in designing a SCU, including: the scale of the facility, the domestic environment, proximity to the community, wayfinding and orientation devices, familiarity of the environment, privacy and community, accessibility along with safety and security.[77]

The scale of the facility is one of the most important factors to consider. An environment of appropriate scale helps a person have a sense of place and well-being, a smaller scale reduces the number of decisions a person has to make and the number of people he or she interacts with. The scale of individual components within facilities can be just as important as the scale of the overall building. The most effective SCU's are often smaller residential settings, where the patients can have quality healthcare along with a comfortable home-like environment. However, many facilities can adequately and appropriately service dementia patients in larger scale buildings with smaller scale pods designed for 10 to 12 patients.

[76] *"Alzheimer Behavioral Patterns Treated with Architectural Design"* LTC Facility Designed for Curing Dementia Ailments, Fourth Avenue, Sudbury. Designing for Diversity in Dementia Care Conference, Toronto, 2002.
[77] Kirsty Bennet, Uniting Care Victoria, *"Designing for Dementia: Australian Responses to Diversity"*, Designing for Diversity in Dementia Care Conference, Toronto, 2002.

9.0 Integrating and Prioritizing the Recommendations (2008 – 2012)

The methodology for evaluating and prioritizing the LTC needs in future years includes the assessment of a number of factors. These factors are identified as follows:

Methodology for Prioritizing Recommendations	

Population Demands by County and Region	• LTC bed projections by county
	• Historical occupancy rates by county
	• Stakeholder input for specialized care needs of current LTC residents and estimated current wait list for specialized services by county
	• Historical wait times by region
	• Current pressures from subsidization policy change (2007 data)
	  o Wait times by region
	  o Wait list by region
	  o Percentage increase in wait times and wait list

Functional Adequacy of Current Facilities	• Layout of facilities in terms of room size, openness of public spaces, storage space, hallways, washroom size, number and location, space for recreation, programming and visitors
Philosophy of Care	• Assessing facility design to meet the complex care needs of current residents and future resident populations • Taking into account dementia design standards, privacy for residents and programming requirements for person-centered care
Stakeholder Input	• Program staffing, capital and operational costs considerations, integration of services • Assessment of public and private sector delivery of care

Priority #1 Private Sector Provide Additional LTC Capacity (2008 – 2012)

Based on the LTC model projections, current wait time information and wait list data, it was determined that over the next four years there will be a need for increased LTC bed capacity in a number of regions throughout the Province. Recommendation No. 5 provides for an additional 134 LTC beds to be added over the next four years (2008-2012). Also recommended is that the provision of additional capacity be provided by the private sector. This could be accomplished in a number of ways including: construction of new facilities, conversion of CCF beds to LTC beds, or an addition to existing private LTC facilities. It is important that the Department of Health be prudent in ensuring that the new LTC beds meet current design requirements and standards and are equipped to service residents with dementia. Capacity needs for this time period by county are listed in *Table 27* below.

Table 27: Additional LTC Beds Required by County to 2012

Additional LTC Beds Required by County to 2012	
County	**Beds Required**
Prince	39
Queens	84
Kings	11
Total	**134 Beds**

In allocating LTC bed requirements to the private sector to meet regional requirements, consideration should be given to communities that have exhibited population growth. The 2006 PEI Census revealed that the greatest population growth (total population) has been in the municipalities of Stratford, Cornwall and Kensington. [78]

Priority #2 Public Sector Create New Specialized Care Centers (2008 – 2012)

Recommendation No. 7 states that a detailed engineering/architectural review of the1960 section of the Prince Edward Home be undertaken to determine what health programs and services could best be accommodated in the 1960 portion of the building. It also recommends that the 1932 section of the Prince Edward Home be closed. As part of the planning process to replace the Prince Edward Home, consideration should be given to constructing a Specialty Care Centre near or adjacent to Beach Grove Home.

[78] Source: Statistics Canada; data compiled by P.E.I. Provincial Treasury. *"A First Look at the 2006 Census of Populations"*

The new building(s) near or adjacent to Beach Grove Home would have between 75 - 80 beds for LTC and a separate or building(s) or unit(s) with approximately 30 – 35 beds for patients that are under 60 years of age requiring nursing care. Pending the review of Prince Edward Home, additional units may need to be created in a new location for convalescent and restorative care (13 beds) and palliative care (8 beds). The maximum number of beds that would be required would be 130 (the current number of beds at the Prince Edward Home).

As part of the plan to replace LTC beds at Summerset Manor consideration should be given to establishing a Specialty Care Centre for residents requiring complex care and dementia care. The new facility(s) should have the same number of LTC beds as the existing Summerset Manor (80 beds). Capacity growth for additional LTC beds in this region should be delivered by the private sector. This allows the public sector to have a specialized focus on more complex and specialized care services. The new Summerside Specialty Care Facility(s) would deliver specialized services to populations and sub-populations that require LTC including: psycho-geriatric patients, the population under 60 years of age that require 24 hour nursing care, and residents requiring dementia care. Consideration should be given to locate the manor near or adjacent to the new Prince County Hospital.

The new facilities in Summerside and Charlottetown should meet design standards as determined by the Department of Health. These design standards will address the requirements for dementia residents and other sub-populations that will require care in these specialized facility(s). Consideration should be given to creating smaller, home like units that can service 10 to 12 patients with separate common rooms, kitchens, visiting rooms and private and semi-private bedrooms. Separate buildings or units and programming can be created for residents who are under 60 years of age requiring nursing care.

Priority #3 Replace Maplewood Manor, Colville Manor & Riverview Manor (2012 – 2017)

Maplewood Manor, Colville Manor and Riverview Manor should be replaced in the five year cycle (2012 – 2017). However, in the short-term, Colville Manor has a number of issues that must be addressed, including: freezing pipes, drafts and elimination of four bed wards. Riverview Manor and Maplewood Manor were built in the same era with a similar design; although, Riverview Manor has weathered time better than the Maplewood facility. Adequate maintenance and repair budgets will need to be allocated to keep these three facilities in a good state of repair until new construction is complete.

Based on the methodology for prioritizing recommendations, each facility is located in an area that is not exhibiting a great increase in demand for services relative to the rest of the Province. Conversely, all three facilities are deemed to have functional inadequacies in a number of areas including: layout of the facility; the size of the rooms; the lack of storage space; hallways that are too narrow for wheelchairs; shared washrooms; a lack of space for recreation, inadequate programming and visiting areas. These facilities do not meet the current philosophy of care required for dementia care and other complex care needs.

The small increase in demand in the rural areas where each of these facilities is located can be provided by the private sector. Therefore, 50 beds per facility, provided by the public sector should service the population in each area well into the future. It is suggested that building new units in close proximity to local hospitals could create economies of scale for the operation and management of the facilities and better access to required professional services.

For each of the above mentioned areas it is recommended that design standards be created by the Department of Health to meet dementia care needs.

Priority #4 Private Sector Provide Additional LTC Capacity (2012 – 2017)

Prior to implementing the fourth priority, an evaluation of the "Aging at Home" strategy and its implications should be undertaken to determine if increased support for seniors at home and if other policy changes have had an effect on the demand for or length of stay in LTC.

Based on status quo projections, it is estimated an additional 101 LTC beds will be required for the five-year cycle 2012 -2017 for the geographical areas outlined below. The private sector should be given the opportunity to create the additional beds.

Table 28: Additional LTC Beds Required by County from 2012 to 2017

Additional LTC Beds Required by County from 2012 to 2017	
County	**Beds Required**
Prince County	40
Queens County	58
Kings County	3
Total	**101 Beds**

10.0 Observations and Considerations

During the consultative process many issues and shortcomings in the continuum of care were identified by key informants. The dedication and compassion of staff and their interest to improve the delivery of services to the elderly was most evident. Many of the following conclusions and observations fall outside the scope of this study; however, they were identified in the course of this study and are included in an effort to support improved delivery of services.

10.1 Community Care Facilities Nursing Homes Board (CCFNHB)

The Department of Health should review the staffing complement assigned to carry out the work and the mandate of the CCFNHB. This program continues to grow with an increasing number of facilities with a corresponding increase in the number of beds to monitor. The CCFNHB should take the necessary leadership role to ensuring that the standards of care continue to be upgraded to meet the changing needs of the population by taking a more proactive role in the licensing, monitoring, inspecting and upgrading of facilities.

10.2 Professional Support Services

The Department of Health should review how professional services are delivered to the residential LTC population. Specific emphasis should be directed towards reviewing the delivery of Physiotherapy, Occupational Therapy, Speech and Language Pathology, Dental Care, Medication Reviews and Psychogeratric treatment.

10.3 Act and Regulations

A comprehensive review of the Community Care Facilities and Nursing Home Act and Regulations should be undertaken. The current Act and Regulations is outdated and inadequate. Consideration should be given to include all public and private LTC facilities in the Act and Regulations. As well, the government subsidization rate of $55 a day for Community Care Facility residents (that meet subsidy eligibility requirements) should be assessed.

10.4 Governance

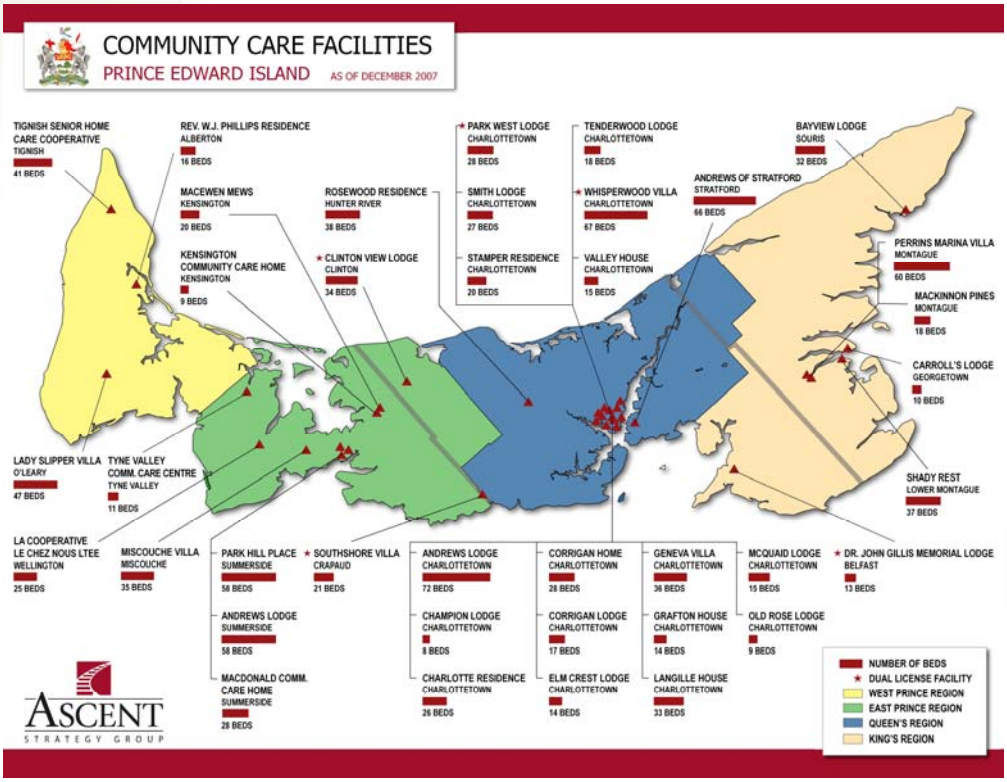
This study also noted a number of instances where the governance structures and policies were not in alignment to provide the most effective management of the program. During the consultative process there were several examples of how governance structures prevented the most effective management of programs and services. One example relates to maintenance of physical facilities, while another is staffing policies and the division of duties between staff in the Department of Health and the Department of Social Services and Seniors.

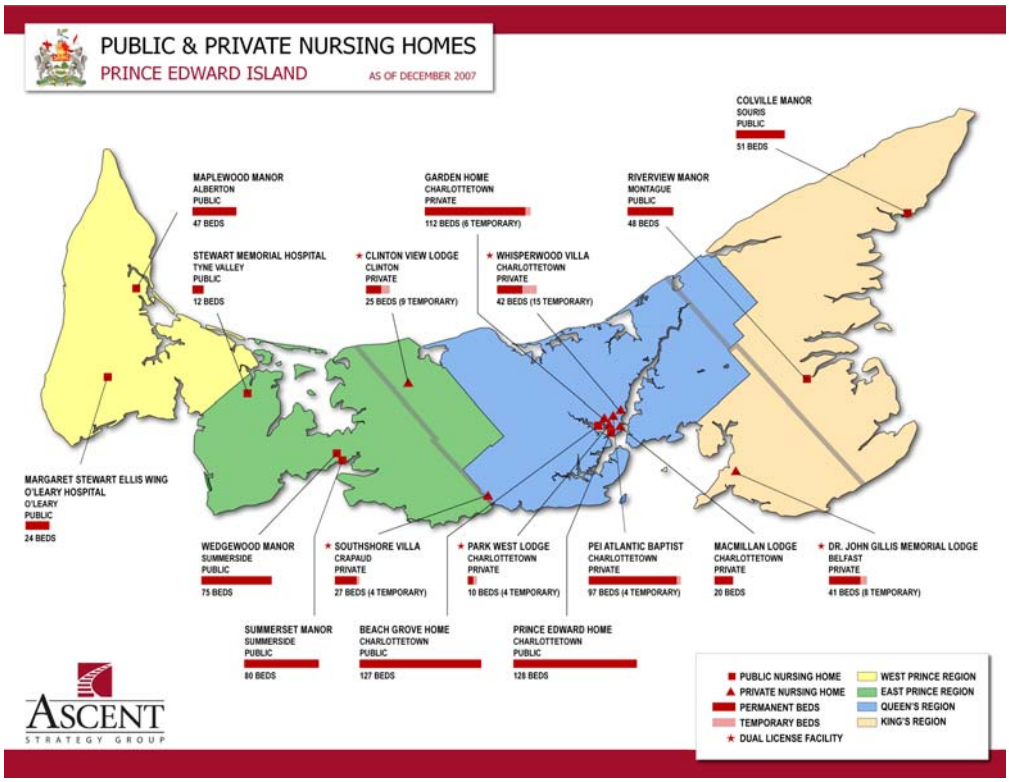
10.5 Statistics

That which gets measured, gets resourced and gets accomplished. It was observed that the collection, analysis and management of data on the continuum of care services is lacking. This is particularly true in the case of the Home Care and Support sector. It was suggested that the Department of Health review its current data sources and develop a plan to broaden the collection, retention, analysis and reporting of data.

Appendix I

Map of Community Care Facilities and LTC Facilities





Appendix II

List of Key Informants

Continuing Care and Community Hospital Senior Management Team
Administrator and Senior Front-line Staff for:

- Maplewood & Western Hospital (M. Bolger)
- Margaret Stewart Ellis Wing & Community Hospital O'Leary (J. Martin)
- Stewart Memorial Hospital, Summerset, Wedgewood (S. Chisholm)
- Beach Grove Home & Prince Edward Home (D. MacEachern)
- Riverview Manor & Kings County Memorial Hospital (J. Fallis)
- Colville Manor & Souris Hospital (T. Campbell)

Queen Elizabeth Hospital Management Team
Prince County Hospital Management Team
Private Nursing Home Association – Executive
Community Care Facility Association
Community Care Facilities and Nursing Homes Board
Souris Community Group
Tignish Initiatives Community Group
PEI French Language Health Services Network
Seniors United Network
Alzheimer's Society of PEI
Dr. Gloria McInnis Perry, Director, Seniors Mental Health Programs
Dr. Tim Stultz, Geriatrician
Steve McQuaid, Atlantic Evaluation Group
Tanya Kingyin, Community Care Facility Operator

Appendix III - Facility Review

Maplewood Manor	
Property Identification:	Maplewood Manor 397 Church Street Alberton Prince Edward Island
Date of Inspection:	December 20, 2007
Parcel Number:	31112-000
Land/Area Description:	5.0 Acres, assessed, 13.06 Acres Mapped
Present Use:	48 Bed Long Term Care Manor

Building Description: Maplewood Manor	
Building Use:	Long Term Care Manor
Storey Height:	1 Storey, Full Basement, Main Entrance Split Entrance
Year Built:	1966
Plumbing:	PVC, Copper, Galvanized
Heating:	Hot water heating, some electrical baseboard
Zoned Heating:	Yes, Significant limitations
Electrical:	400 Main, Several Splitter Panels
Emergency Power:	Yes
Ventilation:	Limited exhaust, no fresh air
Air Condition:	N/A
Sprinkler:	Yes, Wet
Elevator:	Yes
Building Size:	Basement: 18,500 Square Feet, 10,400 Square Feet Finished 1st Floor: Square Feet Total: 37,000 Square Feet
Basement:	Full basement, Land slopes from front to rear, semi basement at the rear
Foundation:	Concrete

Front Side View

Rear View (Long Term Care Entrance)

Exterior	
Walls:	Brick Veneer, panel
Frame:	Masonry
Roof:	Built up
Windows:	Mainly Vinyl, some wood

Interior

Interior

Interior	
Floors:	Vinyl tile, Vinyl, Concrete
Walls:	Gypsum/Plaster, Wood, Unlined
Ceilings:	Acoustical Tile, Gypsum/Plaster, Unlined
Doors:	Solid Core, Slab
Layout:	Basement: Mechanical, storage, day program, lockers, offices, laundry, other Main Floor: Patient rooms, lobby, offices, kitchen, dining, chapel, other
Units:	2 Nursing, 1 safety
Patient Rooms:	11-2 Bed Semi Private 25-1 Bed Private 1-1 Bed Palliative

Washrooms:	Resident washroom in halls, 2 per 11 rooms, semi-private 12 Shared between private rooms
Tub Room:	2 Tub Rooms
Some Issues Identified:	• Very narrow halls, narrow doors • Washrooms in halls • Special needs patients, limited ability to accommodate • Storage on nursing units • Inadequate heating controls • Deterioration of plumbing pipes • Infection control, inadequate separation • Institutional design, long narrow corridors • No central ventilation • Staining of ceiling tiles • Drug room, no cooling • Basement moisture/humidity issues • Nurse call system, not working properly • Parking lot, repairs required • Elevator, boilers, plumbing, are all old

Community Hospital – Margaret Stewart Ellis Wing	
Property Identification:	Community Hospital – Margaret Stewart Ellis Wing 14 MacKinnon Drive O'Leary Prince Edward Island
Date of Inspection:	December 20, 2007
Parcel Number:	793398-000
Land/Area Description:	11.93 Acres
Present Use:	24 Bed Long Term Care Manor Wing, Attached to Community Hospital

Building Description: Community Hospital – Margaret Stewart Ellis Wing	
Building Use:	Long Term Care Wing of Community hospital
Storey Height:	1 Storey, Slab on grade
Year Built:	2003 LTC Wing, hospital 1994
Plumbing:	PVC, Copper
Heating:	Heating, ventilation, air condition HVAC
Zoned Heating:	Yes, Adequate
Electrical:	800 Main, Several Splitter Panels
Emergency Power:	Yes
Ventilation:	Central system
Air Condition:	60% Cooling system
Sprinkler:	Yes, Wet
Elevator:	No
Building Size:	Basement: N/A 1st Floor: LTC Estimate 11,000 Square Feet, Total 1st floor 56,000 Square Feet, plus 5,000 Square Feet Mezzanine Total: 61,000 Square Feet
Basement:	No Basement, slab on grade
Foundation:	Concrete

Front Side View

Rear View (Long Term Care Entrance)

Exterior	
Walls:	Brick Veneer, panel
Frame:	Masonry
Roof:	Built up, modified
Windows:	Commercial grade metal

Interior

Interior

Interior	
Floors:	Sheet Vinyl
Walls:	Gypsum
Ceilings:	Acoustical Tile, Gypsum
Doors:	Solid Core, Slab
Layout:	Main Floor: Patient Rooms, Dining, Other, The long term care wing shares other services with the hospital
Units:	1 Nursing
Patient Rooms:	3-2 Bed Semi Private 18-1 Bed Private 1-1 Bed Respite
Washrooms:	Semi-private and private rooms all have washrooms, private rooms

Tub Room:	1 Tub Room
Some Issues Identified:	• No conference room • Limited air cooling in the 1994 section of the LTC wing • Limited storage

Stewart Memorial – Long Term Care Wing	
Property Identification:	Stewart Memorial – Long Term Care Wing 6926 Route #12 Tyne Valley Prince Edward Island
Date of Inspection:	December 17, 2007
Parcel Number:	20198-000
Land/Area Description:	1.0 Acres
Present Use:	12 Bed Long Term Care Manor Wing, Attached to Stewart Memorial Hospital (Services Integrated)

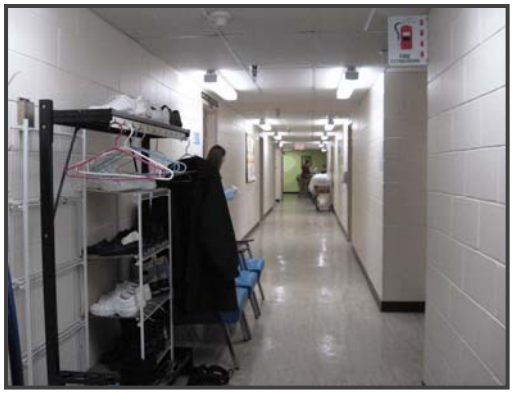
Building Description: Stewart Memorial – Long Term Care Wing	
Building Use:	Long term Care Manor of Stewart Memorial Hospital
Storey Height:	1 Storey, Full Basement, Front Entrance is to Hospital, Main Entrance, Split Entrance
Year Built:	1982 LTC Wing, Hospital 1952, 1963, 1982, 2000
Plumbing:	Cast, PVC, Copper
Heating:	Hot Water, some electrical
Zoned Heating:	Yes, adequate
Electrical:	400 Main, Several Splitter Panels
Emergency Power:	Yes
Ventilation:	Exhaust, some supply
Air Condition:	Central system, 3 units
Sprinkler:	Yes, Wet, Dry
Elevator:	Yes
Building Size:	Basement: 6,800 Square Feet, Mainly finished 1st Floor: LTC Estimate 2,700 Square Feet, Total 1st floor 7,200 Total: 14,600 Square Feet
Basement:	Full Basement
Foundation:	Concrete

Front Side View

Rear View (Long Term Care Section & Rear Entrance)

Exterior	
Walls:	Metal, Aluminum
Frame:	Wood
Roof:	Asphalt
Windows:	Vinyl, Some Wood

Interior



Interior

Interior	
Floors:	Sheet Vinyl
Walls:	Gypsum, Concrete Block
Ceilings:	Acoustical Tile, Gypsum
Doors:	Solid Core, Slab
Layout:	Basement: Acute care and support services for the entire facility Main Floor: Long term care patient rooms, LTC shares all other services with the hospital
Units:	1 Nursing
Patient Rooms:	4-2 Bed Semi Private

	4-1 Bed Private
Washrooms:	Semi-private 4 washrooms Private 4 washrooms
Tub Room:	1 Tub Room
Some Issues Identified:	• Limited storage • Some supply air • Elevator, boilers, plumbing, some windows are old

Wedgewood Manor	
Property Identification:	Wedgewood Manor 310 Brophy Street Summerside Prince Edward Island
Date of Inspection:	December 17, 2007
Parcel Number:	652198-000
Land/Area Description:	7.97 Acres
Present Use:	75 Bed Long term Care Manor

Building Description: Wedgewood Manor	
Building Use:	Long term Care Manor
Storey Height:	1 Storey, Full Basement, Part Basement Main Entrance Ground Level
Year Built:	1983
Plumbing:	PVC, Copper
Heating:	Hot Water Heating
Zoned Heating:	Yes
Electrical:	600 Main, Several Splitter Panels
Emergency Power:	Yes
Ventilation:	Small central ventilation system
Air Condition:	None
Sprinkler:	Yes, Wet, Dry
Elevator:	Yes-1 passenger, Dumb waiters
Building Size:	Basement: 17,600 Square Feet, 8,000 Square Feet Finished (Est.) 1st Floor: 35,000 Square Feet Total: 52,600 Square Feet
Basement:	Full Basement, crawl space, slab on grade
Foundation:	Concrete

Front Side View

Rear View

Exterior	
Walls:	Brick Veneer
Frame:	Masonry
Roof:	Asphalt
Windows:	Vinyl, Wood

Interior

Interior

Interior	
Floors:	Vinyl Tile, Vinyl, Carpet, Concrete
Walls:	Gypsum, Wood, Unlined
Ceilings:	Acoustical Tile, Gypsum, Unlined
Doors:	Solid Core, Slab
Layout:	Basement: Mechanical, Receiving, Storage, Home Care, Housing, Staff, Laundry, Other Main Floor: Patient Rooms, Lobby, Offices, Kitchen, Dining, Chapel, Other
Units:	2 Nursing
Patient Rooms:	16-2 Bed Semi Private 43-1 Bed Private 1-1 Bed Respite
Washrooms:	16 Washrooms in Semi Private Rooms

	44 Washrooms in Private Rooms
Tub Room:	2 Tub Rooms, 2 Not Used
Some Issues Identified:	• Central Ventilation, Some Air Quality Issues • Regarding Exterior, Some Water Problems • Windows Continue Replacement • Elevator, Boilers, Plumbing, Original • Parking lot, Limited Parking

Summerset Manor	
Property Identification:	Summerset Manor 205 Lefurgey Avenue Summerside Prince Edward Island
Date of Inspection:	December 17, 2007
Parcel Number:	322008-000
Land/Area Description:	2.33 Acres
Present Use:	80 Bed Long term Care Manor

Building Description: Summerset Manor	
Building Use:	Long term Care Manor
Storey Height:	1 Storey, Full Basement, Part Basement Main Entrance, Split Entrance
Year Built:	1965, 1992 Extensions to all three wings
Plumbing:	PVC, Copper, Galvanized
Heating:	Hot Water Heating
Zoned Heating:	Yes
Electrical:	400 Main, Several Splitter Panels
Emergency Power:	Yes
Ventilation:	Limited exhaust, No central ventilation
Air Condition:	Yes 2%, Window units
Sprinkler:	Yes, Dry
Elevator:	Yes-2 passenger, Freight, Dumb waiters
Building Size:	Basement: 23,800 Square Feet, 20,200 Square Feet Finished 1st Floor: 39,000 Square Feet Total: 62,800 Square Feet
Basement:	Full Basement, crawl space, slab on grade
Foundation:	Concrete

Front View

Front Side View

Exterior	
Walls:	Brick Veneer, Panel
Frame:	Masonry
Roof:	Asphalt
Windows:	Metal

Interior

Interior

Interior	
Floors:	Vinyl Tile, Vinyl, Carpet, Concrete
Walls:	Gypsum/Plaster, Wood, Unlined
Ceilings:	Acoustical Tile, Gypsum/Plaster, Unlined
Doors:	Solid Core, Slab
Layout:	Basement: Mechanical, Classroom, Storage, Meeting, Activity, old Laundry, Maintenance, Other Main Floor: Patient Rooms, Lobby, Offices, Kitchen, Dining, Chapel, Day Program, Other
Units:	3 Nursing
Patient Rooms:	33-2 Bed Semi Private

	20-1 Bed Private 1-1 Bed Respite
Washrooms:	Resident washrooms in halls, 7 Shared washrooms, Approximately 10-12 Private washrooms
Tub Room:	3 Tub Rooms
Some Issues Identified:	• Narrow halls, narrow doors • Washrooms in halls • Special needs patients, Limited ability to accommodate • Storage on nursing units • Plumbing pipes and plumbing very old • No central ventilation • Infection control, Inadequate separation • Institutional design, long corridors • Windows old • Some historical water problems in basement • Basement moisture/humidity issues • Parking lot, limited parking • Elevator, boilers, plumbing, windows are all old

Beach Grove Home	
Property Identification:	Beach Grove Home 200 Beach Grove Road Charlottetown Prince Edward Island
Date of Inspection:	January 14, 2007
Parcel Number:	694661-000
Land/Area Description:	8.05 Acres
Present Use:	129 Bed Long Term Care Manor

Building Description: Beach Grove Home	
Building Use:	Long term Care Manor
Storey Height:	1 Storey, Full Basement, Slab on Grade, Main Entrance Ground Level
Year Built:	1986
Plumbing:	PVC, Copper
Heating:	Hot Water Heating
Zoned Heating:	Yes
Electrical:	600 Amp Main, Several Splitter Panels
Emergency Power:	Yes
Ventilation:	Central ventilation system, Some supply and exhaust
Air Condition:	Yes 2%, Window units
Sprinkler:	Yes, Wet
Elevator:	Yes-1 passenger
Building Size:	Basement: 40,000 Square Feet, 10,000 Square Feet Finished (Est.) 1st Floor: 62,000 Square Feet Total: 102,000 Square Feet
Basement:	Full Basement, Part finished, Part unfinished, Crawl space
Foundation:	Concrete

Front View

Rear View

Exterior	
Walls:	Brick Veneer, Wood
Frame:	Masonry
Roof:	Asphalt, Some original, Some replaced
Windows:	Wood, Original

Interior

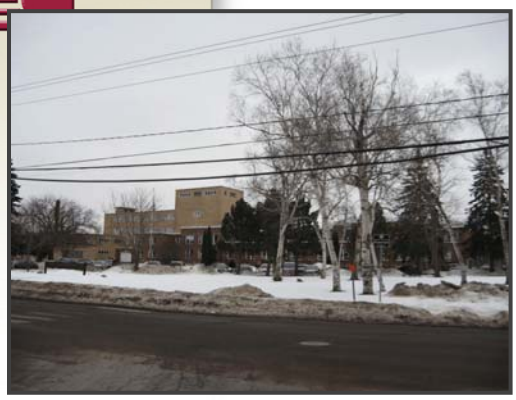
Interior

Interior	
Floors:	Sheet Vinyl, Concrete
Walls:	Gypsum, Unlined
Ceilings:	Acoustical Tile, Gypsum, Unlined
Doors:	Solid Core, Slab
Layout:	Basement: Mechanical, electrical, maintenance, payroll, lockers, laundry, housekeeping, offices, dialysis, storage 1st Floor: Reception admin, chapel, dining, auditorium
Units:	3 Nursing, 1 Safety
Patient Rooms:	33-2 Bed Semi Private 65-1 Bed Private

Washrooms:	Semi-private rooms 33 washrooms Private rooms 65 washrooms 3 Showers, 3 bath
Tub Room:	2 Tub Rooms
Some Issues Identified:	• No air conditioning, extremely hot in summer • Nursing units too large • Kitchen facilities much too small • Dementia/safety unit inadequate • Parking lot, repairs required • Remainder of the roof needs to be re-shingled

Prince Edward Home	
Property Identification:	Prince Edward Home 3 Brighton Road Charlottetown Prince Edward Island
Date of Inspection:	December 18, 2007
Parcel Number:	365957-000
Land/Area Description:	11.0 Acres
Present Use:	131 Bed Long Term Care Manor and Palliative Facility

Building Description: Prince Edward Home	
Building Use:	Long Term Care Manor and Palliative Care Facility
Storey Height:	4 Storey, 2 Storey, Full basement, Main entrance walk up outside stairs
Year Built:	1932, 1960, Renovated 1984, 1991
Plumbing:	Cast, Copper, Galvanized
Heating:	District Heat
Zoned Heating:	Yes
Electrical:	Main, Several Splitter Panels
Emergency Power:	Yes
Ventilation:	Central ventilation system, Some supply and exhaust
Air Condition:	Yes 2%, window units
Sprinkler:	Yes, Wet
Elevator:	Yes-3 passenger, 1 Freight, Dumb waiters
Building Size:	Basement: 27,000 Square Feet, 20,000 Square Feet Finished (Est.) 1st Floor: 30,700 Square Feet 2nd Floor: 24,500 Square Feet 3rd Floor: 8,000 Square Feet 4th Floor: 8,000 Square Feet 5th Floor: 1,600 Square Feet Total: 99,800 Square Feet
Basement:	Full Basement
Foundation:	Concrete



Front View

Rear Side View

Exterior	
Walls:	Brick Veneer
Frame:	Masonry
Roof:	Built up, tar & gravel
Windows:	Wood

Interior

Interior

Interior	
Floors:	Sheet Vinyl, Concrete
Walls:	Plaster, Unlined
Ceilings:	Acoustical Tile, Plaster, Unlined
Doors:	Solid Core, Slab
Layout:	Basement: Mechanical, electrical, maintenance, payroll, purchasing, offices 1st Floor: Reception admin, patient rooms, chapel, 15 rooms 21 beds, palliative care 8 private rooms 2nd Floor: 21 rooms-20 beds, 12 rooms-21 beds, 8 rooms-10 beds 3rd Floor: Patient rooms, 10 rooms-19beds, under 60 age 4th Floor: Patient Rooms, 11 rooms-21 beds, convalescent restorative
Units:	4 Nursing, 1 safety, palliative, convalescent, restorative, under 60

Patient Rooms:	33-2 Bed Semi Private 47-1 Bed Private 5-3 Bed Wards
Washrooms:	Washrooms in halls, shared washrooms and private washrooms, 3 baths
Tub Room:	3 Tub Rooms
Some Issues Identified:	• Multi storey building • Building security, public & private • Roof needs to be replaced • Plumbing pipes and plumbing very old, some leaking • Central ventilation inadequate in some areas • Infection control, inadequate separation in some areas • Institutional design, long corridors • Windows replacement program 1st & 2nd floors • Older elevator, replacement required • Parking lot, limited parking capacity, repairs required

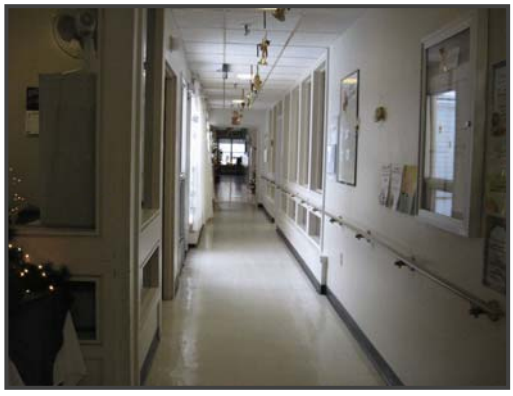
Riverview Manor	
Property Identification:	Riverview Manor 14 Rosedale Road Montague Prince Edward Island
Date of Inspection:	December 14, 2007
Parcel Number:	793398-000
Land/Area Description:	11.93 Acres
Present Use:	49 Bed Long term Care Manor, Seniors Housing buildings are on the same site

Building Description: Riverview Manor	
Building Use:	Long term Care Manor
Storey Height:	1 Storey, Full Basement, Main Entrance Ground Level
Year Built:	1967
Plumbing:	PVC, Copper, Galvanized
Heating:	Hot Water Heating, Boilers
Zoned Heating:	Yes, Significant Limitations
Electrical:	400 Main, Several Splitter Panels
Emergency Power:	Yes
Ventilation:	Limited Exhaust, No Fresh Air
Air Condition:	N/A
Sprinkler:	Yes, Wet
Elevator:	Yes Dumb Waiter
Building Size:	Basement: 18,500 Square Feet, 12,500 Square Feet Finished (Est.) 1st Floor: 18,500 Square Feet Total: 37,000 Square Feet
Basement:	Full Basement, Land Slopes from Front to Rear, Semi Basement at Rear
Foundation:	Concrete

Front Side View

Rear Side View

Exterior	
Walls:	Brick Veneer, Panel
Frame:	Masonry
Roof:	Built Up, Modified
Windows:	Vinyl



Interior

Interior

Interior	
Floors:	Vinyl Tile, Vinyl, Concrete
Walls:	Gypsum/Plaster, Wood, Unlined
Ceilings:	Acoustical Tile, Gypsum/Plaster, Unlined
Doors:	Solid Core, Slab
Layout:	Basement: Mechanical, Storage, Offices, Other Main Floor: Patient Rooms, Lobby, Offices, Kitchen, Dining, Chapel, Other
Units:	2 Nursing, 1 Safety
Patient Rooms:	12-2 Bed Semi Private 24-1 Bed Private 1-1 Bed Respite
Washrooms:	Resident Washroom in Halls, 2 per 12 Rooms Semi-private

	12 Shared between Private Rooms
Tub Room:	2 Tub Rooms
Some Issues Identified:	• Very narrow halls, Narrow doors • Washrooms in halls • Limited ability to accommodate Special Needs Patients • Storage on nursing units • Inadequate heating controls • Deterioration of plumbing pipes • Infection control, Inadequate separation • Institutional design, Long narrow corridors • No central ventilation • Some staining of ceiling tiles • Elevator, boilers, plumbing are all old

Colville Manor	
Property Identification:	Colville Manor 44 Chapel Avenue Souris Prince Edward Island
Date of Inspection:	December 14, 2007
Parcel Number:	100883-000
Land/Area Description:	2.7 Acres
Present Use:	51 Bed Long Term Care Manor

Building Description: Colville Manor	
Building Use:	Long Term Care Manor
Storey Height:	1 Storey, Partial Basement, Main Entrance Ground Level
Year Built:	1971, 1981, 1989
Plumbing:	PVC, Copper
Heating:	Hot Water Heating Boilers
Zoned Heating:	Yes, some limitations
Electrical:	400 Main, Several Splitter Panels
Emergency Power:	Yes
Ventilation:	Some fresh air, limited exhaust
Air Condition:	Yes 5%, kitchen, window units
Sprinkler:	Yes, Dry
Elevator:	No, Dumb waiters
Building Size:	Basement: 3,100 Square Feet, 2,000 Square Feet Finished (Est.) 1st Floor: 17,000 Square Feet Total: 20,100 Square Feet
Basement:	Part basement, slab on grade
Foundation:	Concrete, concrete block

Front Side View

Rear Side View

Exterior	
Walls:	Brick Veneer, panel
Frame:	Masonry
Roof:	Asphalt
Windows:	Vinyl, Wood

Interior

Interior

Interior	
Floors:	Vinyl Tile, Vinyl, Concrete
Walls:	Gypsum/plaster, Wood, Unlined
Ceilings:	Acoustical Tile, Gypsum/plaster, Unlined
Doors:	Solid Core, Slab
Layout:	Basement: Mechanical, Storage, Other Main Floor: Patient Rooms, Lobby, Offices, Kitchen, Dining, Chapel, Other
Units:	2 Nursing, 1 safety
Patient Rooms:	9-4 Bed Wards 8-2 Bed Semi-Private 2-1 Bed Private
Washrooms:	Each room has a 2 piece washroom

Tub Room:	1 Tub Rooms
Some Issues Identified:	• 4 Bed wards • Special needs patients, limited ability to accommodate • Pipes freezing • Storage very limited • 1 Tub room • Infection control, inadequate separation • Institutional design, long corridors • Blockage in piping waste • Limited central ventilation • Concrete floor uneven at staff room • Ceiling tile stained • Boilers, plumbing are old