Discussion Paper

Transforming Seniors' Health and Wellness in Alberta

September 2019

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With longevity the new norm, and seniors thriving well beyond age 85 and even into their 100s, Alberta is grappling with how to cherish and care for a very different generation of seniors. Their numbers are unprecedented (quadrupled in the past five decades) due to shifting demographics. Social and family structures are significantly different than they were decades ago. And expectations are changing, with most seniors preferring to live independently in their own residence and community. Finally, there are the financial pressures that accompany 20-35 years of retirement.

Today's long-living seniors are more likely to suffer from social, emotional and physical isolation than from any other single disease or condition. Most will never see the inside of a long-term care facility. And many have a legitimate fear of outliving their financial resources.

Yet despite these significant changes, Alberta's continuing care system hasn't evolved much over the past 50 years. With seniors' care now accounting for 44% of Alberta's $21 billion health care budget, and the number of seniors continuing to grow, it's essential that we find the best way to deliver high quality care and protect seniors' quality of life in a compassionate yet sustainable manner.

A bold new vision

With our seniors' care system still reflective of a bygone era, it's time to revisit a decades-old system that can no longer meet the challenges of the future.

Some of the legislation and regulations governing seniors' care is more than 50 years old. And it's been 30 years since the province conducted a comprehensive consultation with Albertans on what they need and expect from their seniors' health and continuing care system. That 1980s vision – still unachieved in many respects – no longer reflects the new challenges we'll face over the next 30 years.

We're long overdue to modernize Alberta's seniors' care system yet again. But transformation will only materialize if Alberta communities, municipalities, families, seniors and all levels of government take bold action on creating and shepherding a new vision.

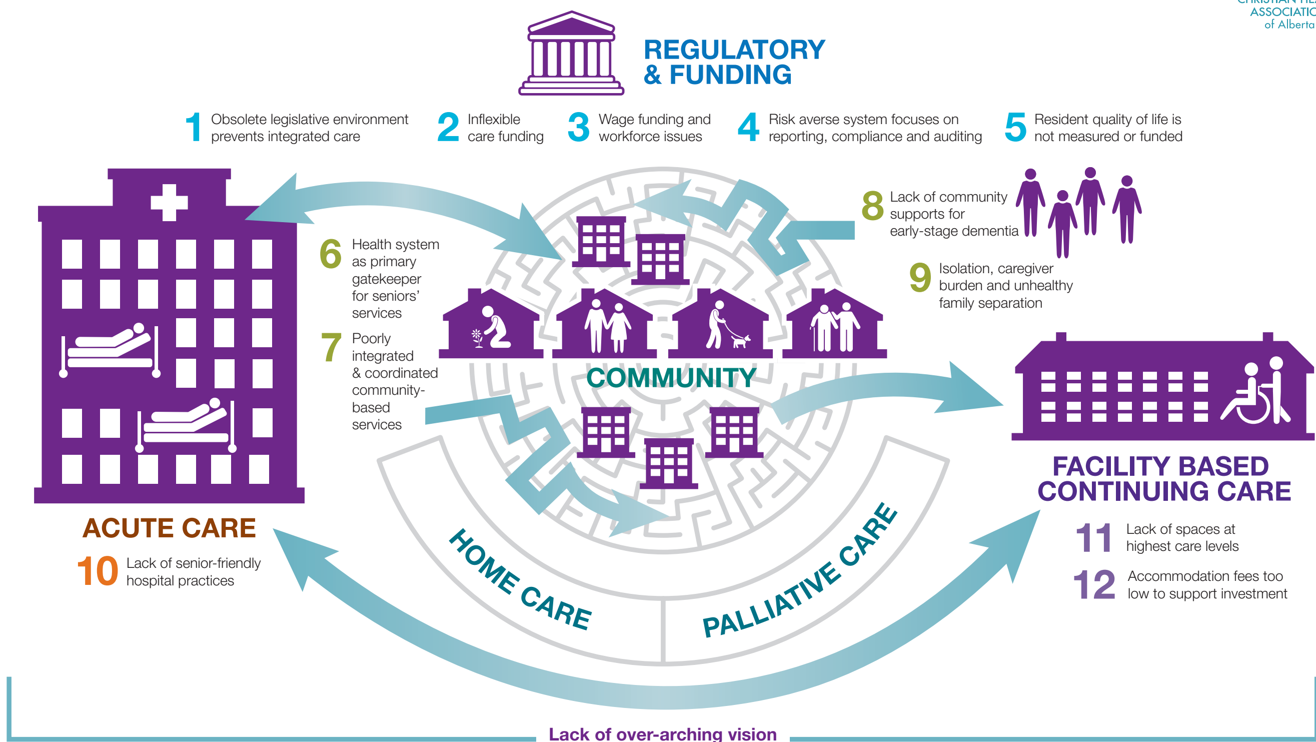
Why a discussion paper?

This discussion paper is a first step in starting the dialogue about a new vision for seniors' care. The vision must be owned and led by Albertans. It must be values-driven, serving as a source of unity and strength as we commit to a compassionate, caring and courageous approach to seniors' care. It must reflect new health professions, new models of care, and changing expectations about seniors' health and wellness. And it must be compelling as it articulates what it means to honour and care for those least able to look after themselves: seniors living with frailty, complex health conditions, social isolation, cognitive and mental health challenges, and limited financial means.

Let's begin the discussion

Christian Health Association of Alberta (CHAA) has identified 12 significant challenges to achieving a new vision for seniors' health and wellness, plus more than 60 opportunities to address those challenges through short-term and longer-term solutions. Each of the 12 challenge areas is depicted in the diagram below and then explored in greater detail in the pages that follow. We believe that none of the challenges can be addressed in isolation due to the interconnectedness and inter-dependencies across the entire seniors' care system.

We invite stakeholders across Alberta to join the dialogue by reviewing this discussion paper and then committing to work together toward solutions. Collectively, our efforts will lay the foundation for a bold and innovative path forward in seniors' care.



CHAA's role in leading the dialogue

CHAA has a 75-year history of providing values-based, holistic health and healing to vulnerable Albertans. Our legacy of caring for the province's most elderly, ill, marginalized and vulnerable citizens has remained one of the greatest privileges of our faith-based member organizations.

With roots dating back to a time before publicly funded health care services were available in Alberta, our mission-driven teams learned how to be resourceful, innovative, and frugal – yet holistic and patient-centered – in our approach to delivering services to those most in need. We have decades of experience operating between 25% and 40% of all care spaces for seniors, depending on the stream of care. This wealth of experience has yielded countless lessons learned about the effectiveness of current policies and the need for changes in the way our health care system works for seniors, their families, and unpaid caregivers.

Regulatory and Funding

1 Obsolete legislative environment prevents integrated care

Current seniors' care policies, acts, regulations, standards, operational directives, and regulatory bodies emerged piecemeal over decades – often in response to one-time incidents rather than trends. The resulting policy system is incredibly complex, lacks overarching coherence and alignment, and is cumbersome to implement and maintain.

There is considerable overlap and duplication across authorities, regulators and jurisdictions, making the system difficult to navigate for care providers, operators, and families alike. Current policies do not reflect evidence regarding best practices, and are not clearly linked to desired outcomes. Sometimes policy is risk-based and reactive in the aftermath of incidents – particularly in the areas of safety and security – rather than evidence-based. And in some cases, policies actually inhibit the implementation of best practice and innovation, and regularly create barriers to quality, person-centred care at the point of service.

A case in point: Continuing care options and sites are funded along rigid and prescriptive care levels, meaning residents can't move within a site if their health changes. As seniors become more ill/frail, they must be turned over to AHS for reassessment and reassignment to different care facilities in order to follow the funding.

Overlapping and outdated legislation means many frail seniors are forced to relocate when their health changes – because the funding is attached to the building or stream of care rather than the person

Short-term opportunities:

Conduct a legislative review, in consultation with stakeholders and contracted providers, to identify gaps and barriers in legislation and regulations.

Promote demonstration projects on age-in-place villages of care to better understand the regulatory changes needed to lay the foundation for the future of seniors' care.

Mid- and long-term solutions:

Implement significant regulatory and funding changes to promote intra-site assessment and placement, where the funding follows the resident rather than the facility.

2 Care funding methodology not sensitive to resident acuity, profile, facility size, or collective agreements

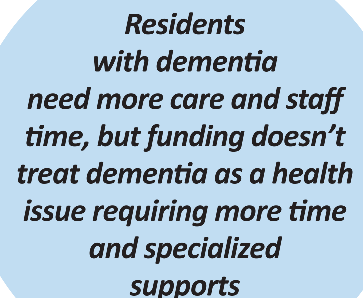
The current Patient Care Based Funding (PCBF) model poses serious challenges in providing appropriate continuing care services to seniors by prescribing the number of hours of care per resident, the type of provider authorized to deliver care, and the specific number of minutes permitted for specific tasks. This one-size-fits-all approach removes critical discretion from care managers in determining the most effective and efficient approach to delivering quality care, and frequently results in poor use of resources as well as inadequate interactions at the point of service.

PCBF focuses exclusively on tasks related to physical bodies with no regard for the value of and need for holistic care. The funding model underestimates the time needed to deliver quality care in a seniors' care context, in which tasks often require more time than similar tasks for other populations.

For example, under PCBF, cognitive and behavioural challenges – which affect 70-80% of residents in higher care settings -- are considered an inconvenience rather than an essential determinant of resident care needs. The time-intensive staffing levels that are required to provide responsive and compassionate care, while simultaneously managing resident behavioural issues, is not recognized or funded.

While the overall mix of seniors in a setting (the 'case mix index') can shift dramatically in a short period of time, funding does not catch up until one year later, often leaving the operator short for months due to the gap between prior versus current resident mix.

Finally, smaller facilities often struggle to achieve cost efficiencies due to poorer economies of scale. Ensuring the site is adequately staffed to care for local seniors at higher care levels – who naturally want to remain close to family and support networks – is a tremendous challenge for operators.



Short-term opportunities:

Immediately shift to a blend of block & variable funding to recognize different economies of scale based on facility size, facility age, and urban/rural/geographic area – particularly for smaller sites that have poor economies of scale.

Flex the funding formulae to guarantee adequate care staff regardless of facility size or geographic location. Provide top-ups or stipends for small volume facilities, especially in rural areas.

Broaden the CMI calibration period to ensure operators are funded for actual instead of planned resident acuity.

Remove rigid site-specific care level authorizations to allow funding to shift and adjust along with the resident's care needs.

Mid- and long-term solutions:

Re-weight assessment tools to appropriately account for the cognitive & behavioural needs of seniors with dementia.

3 Wage funding and workforce issues

Outdated legacy legislation and regulations (up to 70 years old) reflect a long-gone model of care based on a short duration of complex care and a workforce comprised predominantly of registered nurses. New provider groups (licensed practical nurses and health care aides) now provide the bulk of care but regulations remain unchanged based on a workforce composition from the 1950s.

As well, operators are funded for care hours based on the average wages across the sector, not the true wages incurred by the operator. This means organizations with collective agreements (in alignment with AHS agreements) are paid less than the true cost of nursing salaries/benefits and must make up the shortfall through staffing reductions, charitable donations, or cuts to non-health services (recreation, food services, housekeeping).

The funding gap also means organizations with long tenure employees have difficulty retaining their most seasoned and stable staff (important for resident quality of life and care quality) because senior employees generally earn more than the average wage in the sector.

Smaller sites without economies of scale are funded for less than 1.0 FTE of some positions (e.g., RNs) and thus have problems with recruitment and retention. Turnover among staff, especially HCAs, can be high in Alberta due to issues related to exhaustion/overwork and other challenges. Turnover exacerbates the challenges operators experience in recruiting and retaining HCAs – worsened by changes to Canada's foreign worker program – and the struggle to ensure provider competencies are current.

For example, a two-year early childhood education diploma is a prerequisite to caring for vulnerable children, yet the professionals that care for seniors with dementia generally are required to earn just a 17-week certificate. Operators must fill in the gaps with ongoing clinical education and support.

Not-for-profit operators with collective agreements must use staff reductions or donations to make up for wage funding shortfalls

Short-term opportunities:

Conduct a provincial review of actual wage rates within the continuing care sector to identify which operators or sectors are disadvantaged vs profit from the average wage funding policy.

Ensure operators are reimbursed at the true wage and benefits rates within their sector - including professional development and other non-work time -- rather than the average salaries and benefits across all sectors.

Flex the funding formulae to guarantee coverage of core staff regardless of volume or uncontrollable placement vacancies.

Mid- and long-term solutions:

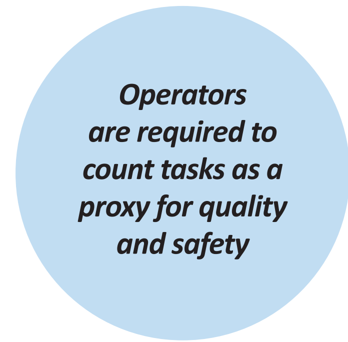
Implement a blended rate of fixed and variable funding, and consider core staffing levels as a fixed cost, thereby ensuring optimal care hours are funded.

Commit to a long-term review of workforce projections to develop a comprehensive workforce strategy to meet current and future demand.

4 Risk averse system focuses on reporting, compliance and auditing

There is considerable fragmentation regarding provincial monitoring at the resident, facility and system level. Jurisdictional overlap is a significant challenge with the accountabilities for safety, quality, compliance, inspections, accreditation, auditing, system performance, and funding spread across multiple national and provincial authorities and information/reporting systems. The burden on continuing care operators to track and report on indicators across multiple regulators means essential front-line staff resources must be diverted away from care activities to perform myriad reporting and auditing functions.

Furthermore, there is an over-reliance on micro-auditing for task-based care – such as toileting and dressing – and an emphasis on incident-based reporting of adverse events. Rather than assessing for overall quality of care and quality of life outcomes, system-wide monitoring has regressed from an oversight function to a micro-management system. This undermines the autonomy of operators and their staff, and impedes their ability to deliver resident-centered care and ensure residents receive timely, compassionate, flexible and responsive interactions at the point of care. For example, the system determines which tasks are to be performed for a resident based on the person's classification level – rather than encouraging front-line care staff to understand and meet the resident's most immediate and pressing needs while working within a global and holistic care plan.



Short-term opportunities:

Reduce audit duplication by allowing operators to skip provincial (AHS) reporting on audit criteria that have already been assessed as meeting the provincial standards of Accreditation Canada.

Involve seniors and families in determining the audit criteria that best evaluate resident quality of life.

Restore appropriate task-related decision-making (e.g., staffing assignments, care tasks) to the point of care.

Mid- and long-term solutions:

Untangle overlapping accountabilities by separating system performance oversight/reporting from compliance/standards auditing.

Delineate jurisdictional and oversight accountabilities on the basis of system-wide outcome measures rather than operator-level inputs.

5 Resident quality of life not measured or funded

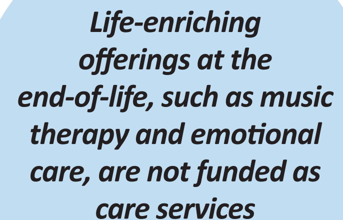
Across the continuing care system, resident care -- particularly at higher care levels -- is funded and audited as tasks and mechanical procedures rather than as human interactions. Aside from periodic benchmarking and tracking of site-specific resident and family experience, there is no systematic process in place to assess resident quality of life on an ongoing, system-wide basis.

Current evaluation measures make little distinction between the relative weighting of varying factors that contribute most to a seniors' quality of life. These determinants can change dramatically between age 65 and 100, particularly across different care settings and even more so as seniors approach the end of life.

Administrative preferences for the use of evidence-based, standardized tools and approaches mean residents — regardless of age or state of health — are more likely to be queried about food quality and call bell response times than on deeper determinants of quality of life, such as social relationships, personal interests, spiritual/emotional health, and autonomy.

Assessing quality of life in care settings with a high prevalence of cognitive impairment and frailty (e.g., long-term care) is even more challenging because evaluation data may be limited to the perspectives of family members and care staff. Finally, there is no process to assess care staff health and engagement, which is a significant determinant of providing a compassionate, holistic and responsive care environment.

To residents in care, the implications are significant. A long-term care resident (who is typically in the final 12-18 months of life) is more likely to be funded for physical therapy and mobility-related tasks (of limited value during end-of-life care) while operators must rely on donations and volunteers to deliver essential life-enriching services at the end of life, such as music therapy, companionship, and spiritual and emotional care.



Short-term opportunities:

Recognize quality of life as an essential measure of system performance.

Develop a richer and more relevant set of quality of life metrics for system performance and reporting purposes.

Recognize and incent quality of life outcomes system-wide, particularly for complex, frail, cognitively impaired and other residents in higher levels of supportive living and long-term care.

Provide global funding for the establishment of quality of life services within continuing care facilities, allowing local operators, care providers and informal caregivers to determine which services will enhance resident quality of life.

Mid- and long-term solutions:

Create flexibility in ancillary services to reflect determinants of quality of life across stages of aging.

Promote investment in lower-density spaces to reflect resident preferences and higher quality of life in home-like care settings, and to incent more diverse care environments (e.g., distinct social or cultural preferences).

Community Settings
(independent and supportive living)

6 Health system as primary gatekeeper for seniors' services

Rarely do seniors make a sudden 'leap' into getting older. Most often they experience gradual, cyclic changes in their daily function and health status – often spanning a 30+ year period. Given that most seniors prefer to remain in their own home and community for as long as possible, why is the health care system the primary entry point for services? Why aren't social and community supports the first formal and integrated point of entry for seniors needing help with yard work, snow shoveling, grocery shopping, meal preparation, housekeeping, transportation, companionship and the other unmet needs that can threaten independence?

Our health care system's focus on medical services means it is structured around serious and permanent health changes rather than on episodic/cyclical shifts and flexible supports. This introduces a system-wide bias toward the 'unwellness' of seniors in which individuals must demonstrate a significant, sustained or permanent change in function/health in order to meet health-defined criteria for services. This also creates stigma among seniors, who must admit and succumb to their declining health before qualifying for supports. With little focus on preventing and deferring age-related decline, our health system has proven ineffective at helping seniors adapt to their ever-changing 'new normals' by offering prevention and intervention services that preserve and protect the senior's social, community and daily living needs.

We have a system-wide bias toward the 'unwellness' of seniors

Short-term opportunities:

Broaden the scope of seniors' wellness to encompass community supports, including non-medical (daily living) support services as a necessary, first-line preventive measure to maintain independence and promote healthy longevity in community settings.

Consider a public awareness initiative to reduce the stigma experienced by seniors who reach out and request supports.

Improve navigation by implementing an 'any door is the right door' approach to accessing seniors' services. Create awareness and linkages across the full range of community health and social care.

Mid- and long-term solutions:

Formalize or strengthen linkages across government portfolios. Health, seniors' supports, housing and community services must be better aligned or fully integrated to prepare for the changing expectations of seniors in how care is provided.

Assessment approach: Re-orient Alberta's approach to assessing the health of seniors to incorporate a focus on preserving and protecting functional capacity and quality of life.

Whole-family approach: Focus on assessing the entire family and caregiver support network to identify preventive opportunities and early family education regarding age-related changes.

Families are often dismayed at how difficult it is to commission the support services that can stretch seniors' years of independence

7 Poorly integrated & coordinated community-based services

For at least the first decade of senior years (65+), the primary services and supports required to remain independent are social and daily living, not medical. Few health changes during this time are permanent, nor do they require a long-term entry into the health system. Rather, during this period seniors need easy and flexible navigation support to access various community supports and services, often on a short-term or periodic basis.

As family and caregivers witness their loved ones' support needs change and cycle over time, they are often dismayed at how difficult it is to commission the support services that can stretch seniors' years of independence by 5, 10 or even 20 years. The sheer number and diversity of community agencies, not-for-profit organizations, churches, municipalities and other provider groups operating in this space makes it exceptionally difficult for seniors and their family caregivers to navigate the maze of services and find the right bundle of services at the right price. Furthermore, the lack of integration means there is little cross-referral or information sharing between service-providing organizations.

Finally, seniors living alone or without family support may lack the capacity to reach out for community-based services; therefore, informal outreach services and volunteer networks are the critical 'eyes and ears' to identify and reach out to at-risk seniors.

Short-term opportunities:

User-driven: Shift from provider-driven to user-determined criteria for service access.

Instate lifelong in/out privileges to request, initiate, suspend, or terminate services at the user's discretion to reflect the cyclic nature of supports required by seniors.

Develop ways to formally mobilize today's healthy and active retirees to serve as ambassadors and navigators for older seniors needing social and community supports.

Promote navigation over directory services, as directories don't always meet the needs of lower-efficacy clients. Commission the development of a Seniors' Helpline or app-based navigation supports.

Ensure a mix of outreach and site-based services: Ensure all voluntary, community, and public sector staff are aware of their essential role in bringing at-risk seniors to the attention of support programs.

Stay community-driven: Continue to promote the nimble, cost-effective and innovative provision of social/community support services through the network of municipal, not-for-profit and charitable providers. However, incorporate resources and oversight for the essential functions of provider linkages/referral networks and user navigation services.

Allied health teams: Promote the establishment of nurse practitioner/ social worker teams in community settings to augment primary care services.

Mid- and long-term solutions:

Structured integration support: Provide provincial/municipal leadership to strengthen collaboration among diverse provider groups to facilitate better service planning, integration and cross-referral mechanisms.

Coordinate and align services along community hubs, led by users, community providers, municipalities and primary care, with formal linkages to next-stage care settings (supportive living, acute care).

Change ownership of records: Ensure records are owned by users to facilitate data integration and service alignment.

8 Lack of community supports for early-stage dementia

It can take families up to two years to confirm a loved one's dementia diagnosis. During this protracted diagnostic cycle, without a definitive diagnosis it is exceptionally difficult to qualify for early intervention dementia services. The result? Seniors may receive little or no coordinated system support until reaching more advanced stages of the disease.

Meanwhile, families and caregivers can struggle for years without the knowledge, insights or services they need to care for their loved one. Caregiver burden can quickly escalate, causing strain on families and declining health in the caregivers that are carrying the largest load.

Families living with dementia may receive little or no coordinated system support until reaching more advanced stages of the disease

For many caregivers, it is the social and daily living losses (e.g., inability to leave the home, social isolation, inability to perform normal household tasks, disruptive or abusive behaviour from the ill family member) that can trigger premature placement of their loved one into facility-based care.

Short-term opportunities:

Fast track implementation of the Alberta Dementia strategy, including the development of integrated, community-based and centralized access points for resources and navigation support regarding dementia.

Expand rapid pre-assessments and streamline diagnostic pathways: Expand the capacity for community-based rapid pre-assessment clinics that can assess suspected cases of dementia via a two-hour appointment and refer into specialty care for comprehensive testing.

Formalize respite care: Engage the community and continuing care sectors to expand offerings in a variety of respite care, caregiver support and day program services including overnight respite.

Mid- and long-term solutions:

Bridge primary care and dementia care linkages: Develop mechanisms to expand the linkages between primary care networks (PCNs), dementia care providers (e.g., SL4D, long-term care) and geriatric psychiatry to integrate a seamless diagnostic and care pathway.

9 Isolation, caregiver burden and unhealthy family separation

Unprecedented life expectancy means caring for a senior can fall to just one or two family members, friends or neighbours, and may require a 25+ year commitment to support a loved one from age 65 through to age 90. It should come as no surprise that distress among unpaid caregivers is at an all-time high, as today's seniors and their loved ones bear the costs – financial, social, and personal – of a system that fails to recognize, value and support their immense contributions. In fact, our social and health care systems would collapse without the largely uncelebrated work of the estimated 600,000 unpaid caregivers — mostly volunteers and family members – who care for our most vulnerable seniors.

Any caregiver will attest that system supports – such as education and respite care — can be difficult to access, schedule and rely on throughout a 25-year caregiving journey. And making frequent changes to the type and intensity of services for both the senior and their caregivers – as is often required – is even more challenging. Rigid admission requirements mean there is a lack of casual/part-time social care, respite care, and supportive living options for seniors during their decades-long transition from independence to dependence.

Caregivers that can no longer shoulder the tremendous weight of years of caregiving may be compelled to place their loved ones, often reluctantly, into institutional care. So many aspects of our seniors' care system – dementia care, complex medical care, palliative care – fail to offer families the right combination of supports for home-based care with flexible, on-demand access to respite services for caregivers.

Our system would collapse without Alberta's 600,000 unpaid caregivers. Are we looking after them?

Short-term opportunities:

Mandate assessment of the capacity, health and distress of the unpaid caregivers that are supporting the seniors accessing services. Ensure the psychosocial needs and capacity of both the senior and the caregivers/family are weighted equally in the care plan.

Change qualifying criteria to permit graduated entry into supportive living arrangements to ease the transition and shift the balance of independent/supportive living over time.

Promote and expand innovations in respite care and caregiver supports, including overnight respite care to sustain the sleep and health needs of caregivers while introducing the declining senior to supportive living.

Mid- and long-term solutions:

Offer and promote self-directed care to foster senior and family autonomy in selecting social and health care services.

Change legislation to offer tax credits and workforce leaves of absence to all Albertans in caregiving roles.

Acute Care Settings

10 Lack of restorative care to expedite hospital discharge and transitions into care

Hospitals have a number of structural challenges and processes that make it difficult for seniors to be well served. For example, integrated community-based rapid response teams can assess and treat seniors in their own homes, and link with primary care services, to prevent unnecessary transfers to a hospital emergency department.

Seniors requiring assessment in acute care will have a shorter and less debilitating experience in a senior-friendly hospital environment that integrates laboratory, diagnostic imaging and geriatric medicine to streamline care.

For seniors admitted to hospital, once they have recovered from their acute illness it is not uncommon to be stuck in hospital due to waitlists, inefficient placement processes, and a lack of system-wide capacity to transition discharged patients into more appropriate settings – called alternate level of care (ALC).

For senior inpatients needing placement in a new care setting, nearly 10% of their time in hospital is wasted while waiting for a space somewhere else in the system. That's because there are 'no vacancy' signs in the other parts of the senior's care system that could provide more appropriate levels of care. The cost to the Alberta health care system is an estimated one billion dollars per year.

Being stuck unnecessarily in a hospital bed is not only detrimental to the system overall: it puts seniors at considerable risk as they can lose 5% of their overall function each day they are in hospital unnecessarily. Nearly 50% of seniors needing continuing care can't be placed within 30 days of assessment, and during that month-long wait, some can be reduced to 20% of their pre-admission functional status, significantly reducing their chances of returning home to independent living. Up to one-third will end up being assessed for long-term care placement before they've even had an opportunity to try their best at rehabilitation services.

In contrast, restorative care provides seniors with intensive rehabilitation and support services for 30 to 90 days to return the individual as close as possible to their pre-hospital functional status. Adaptive strategies are put in place to help the senior and family cope with any permanent changes that constitute a 'new normal'. Family members and the home care team are involved throughout restorative care so they can fully participate in planning for an eventual return to home living.

If hospitalized seniors were transferred sooner into restorative or other care programs, we could trim up to $1 billion annually from hospital costs while increasing the likelihood of seniors returning to their own home.

Short-term opportunities:

Immediately increase the inventory of both outpatient and in-patient restorative care spaces (for inpatient spaces, repurpose and replace the system's oldest LTC care beds).

Mandate restorative care prior to assessment for LTC placement.

Engage the restorative care team upon the senior's arrival in ED to plan and prepare for transition to restorative care with or without hospital admission.

Mid- and long-term solutions:

Integrate restorative care within the community paramedic program to bridge transitions to/from home.

Whole care team approach: Involve the family, caregivers & home care team throughout the restorative care program to prepare for the eventual return home.

Facility-Based Continuing Care

11 Lack of spaces at highest care levels

A lack of restorative care spaces causes too many seniors to be prematurely and erroneously placed in long-term care rather than being rehabilitated for a return home. Restorative care should be the first option for most frail or recovering seniors, with LTC placement considered only as a secondary option.

Still, there remains an overall shortage of spaces at higher care levels, especially LTC, due to increasing life expectancy and a significant increase in the number of older seniors – especially those enjoying years of life beyond age 85. While there has been some investment in entry level supportive living spaces (SL1 and 2), it has not been matched by adequate capacity building at the highest supportive living (SL3, 4 and 4D) and long-term care (LTC) levels, where the most elderly and ill seniors require care.

Many seniors requiring LTC today are inappropriately placed in supportive living (SL) spaces, leaving SL operators with a more complex and frail resident population than they are equipped to safely manage. This scenario is risky and unsafe for both residents and professional care staff; financially unsustainable for operators; and a threat to achieving and maintaining audit and accreditation requirements regarding quality standards.

The issue is exacerbated in rural communities, where residents must often choose between the right care level in a far away community … or a local bed in a facility that is not funded to meet the resident's required level of care. Separating couples at such a crucial point in their lives is unconscionable.

With a surge in the population of Albertans aged 85 and over, it is no surprise that there is at least a 15% shortfall in spaces at higher care levels. It is estimated that between 3,000 and 4,000 more spaces are needed to reduce waitlists and create the system-wide capacity that would to allow couples and families to stay together in their own communities.

Lack of higher-level care spaces is the single largest driver of overcapacity in Alberta's hospitals. In fact, if the funds that are wasted by holding seniors unnecessarily in hospitals were redirected to the not-for-profit sector to build continuing care spaces (two-thirds financed by the operator and one-third supported by public funding) we could significantly increase capacity within three years by adding 500 new spaces annually.

The dollars spent holding seniors unnecessarily in hospital beds could be redirected to address the significant shortage of long-term care spaces

Short-term opportunities:

Use statistics and demand modelling to forecast and publicize the true, population-based estimate of required versus actual LTC and SL 3, 4 and 4D spaces so government and operators have an accurate picture of current and future capacity gaps.

Increase capacity: Redirect resources to immediately expand LTC and SL 3, 4 and 4D capacity by 15% to meet the true population-based calculations of current space needs at higher care levels.

Assess placement/acuity mismatches: Conduct a province-wide audit of resident case-mix index (CMI) to identify gaps between intended versus actual resident acuity and to shed light on system-wide risks that need to be urgently addressed.

Mid- and long-term solutions:

Develop a long-term demand modelling process to anticipate and mitigate against the current shortage of long-term care spaces.

Develop strategies to prepare for the capacity reversal (excess facility-based capacity) that is projected to follow beginning around 2032.

12 Accommodation fees too low to support investment

Alberta's regulated accommodation fees (the amount residents are charged) range from $1,705 to $2,074 per month and are now the second lowest in Canada. While the fees are barely affordable for the most vulnerable seniors (single seniors – mostly women – with a median income of $2,600 per month), these designated spaces still operate at a loss of 25% or more. Even AHS and its subsidiaries operate at a 30% loss.

With fees no longer covering operator costs related to food, housekeeping, utilities, maintenance and capital carrying costs, it should be no surprise that much of the growth in Alberta's spaces over the past two decades has been in private, market-rate spaces where residents pay between $3,500 to $7,500 per month – serving more affluent seniors/couples with an income of $100,000+ per year.

The result is a serious mismatch between demand and supply. For example, large, institutional-style facilities (150-bed capacity or larger) in urban areas are still economically viable despite resident preferences (especially among those with dementia) for smaller, home-like settings. This mismatch will reach a crisis as the current inventory of aging not-for-profit (NFP) infrastructure – with its excessive maintenance costs and an inability to repurpose or refurbish sites – will lead to closures and a net loss of affordable spaces in the next two decades.

While Alberta's NFP sector has historically been the largest net supplier of affordable, designated continuing care spaces – and remains committed to serving vulnerable populations – the sector can no longer finance new capacity unless there is a rebalancing between operating/capital construction costs and the level of accommodation fees. Although accommodation fee increases create the potential to cause hardship to the very population that needs the most protection, the risk can be mitigated through conscientious application of seniors' benefits programs and rebates.

Most LTC and SL spaces cost 25% more to operate than the operators receive in funding

Short-term opportunities:

Immediate accommodation fee increase: Raise the accommodation fee charged to residents to reflect the true cost of services, with a comparable adjustment to seniors' benefits to protect low-income residents.

NFP grant programs: Offer capital construction grants preferentially to not-for-profit operators, followed by for-profit operators that commit to allocating a majority proportion of their newly constructed/converted spaces to the public (designated) system.

Financing solutions: Allow not-for-profit operators to access the provincial capital financing programs that are currently available to municipalities – these offer guaranteed long-term financing for public infrastructure.

Adjust the capital funding formula to reflect the higher cost structures and higher quality of life in home-like care settings, and to incent the construction of lower density and more diverse care environments (e.g., distinct social or cultural preferences).

Mid- and long-term solutions:

Conduct geographic-specific supply and demand modelling to predict, at least 10 years in advance, which Alberta communities are projected to have a mismatch in demand versus supply of programming and facilities for seniors; earmark these communities for collaborative planning and funding.

CHAA welcomes your input and suggestions on transforming seniors' health and wellness in Alberta.

Please contact any of our member organizations with your ideas, or send your thoughts directly to CHAA at info@cha-ab.ca or visit www.cha-ab.ca

CHAA Members

South Country Village

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