ASCENT
STRATEGY GROUP

Final Summary 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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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 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.

1.0 Project Background

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 baby boomers age, Prince Edward Island will experience a large demographic shift leading to an increase in the senior population. It is estimated 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. In this context, an analysis of trends, projections and recommended approaches to the delivery of residential long-term care (LTC) is appropriate and essential.

This summary report is intended to give a high-level overview of the key findings, conclusions and recommendations. The full report for *Trends, Projections and Recommended Approaches to Delivery of Residential LTC in Prince Edward Island* contains the detailed analysis, facility review, population projections and rational for conclusions and recommendations.

2.0 Situational Analysis

The overarching purpose of this report is to **focus on the LTC component of residential care**. This includes assessing the current situation, conducting research, identifying trends and developing options and recommendations for the future. Information was gathered through key informant interviews, from existing available data, from the Department of Health database, and from various research studies conducted within the past eight years.

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. In order 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 in the final report: the under 60 population, placement committees and the admission process, professional services, and funding / subsidization policies.

For the purpose of this summary report, an overview of the current situation for the delivery of programs and services in LTC in PEI will be provided. In order to paint the overall picture of what services will be required in the future, it is important to analyze how the current system operates, this includes assessing: trends in admission patterns, utilization of services, length of stay and wait times for admittance.

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

2.1 Long-term Care – Public and Private

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.

2.1.1 Number of LTC Beds 2000 - 2006

The following table shows the breakdown of LTC beds in the public and 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 1*). 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. In total, there are 29 temporary beds in the LTC system.

Table 1: 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[5]	53	238	53	238
Queens County	388	186	324[2]	256[3]	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	**472[4]**	**518[1]**	**411[4]**	**586[1]**	**395[4]**	**594[1]**	**398[4]**	**595[1]**	**400[4]**	**597[1]**	**400[4]**	**596[1]**	**400[4]**	**594[1]**
	990		**997**		**989**		**993**		**997**		**996**		**994**	

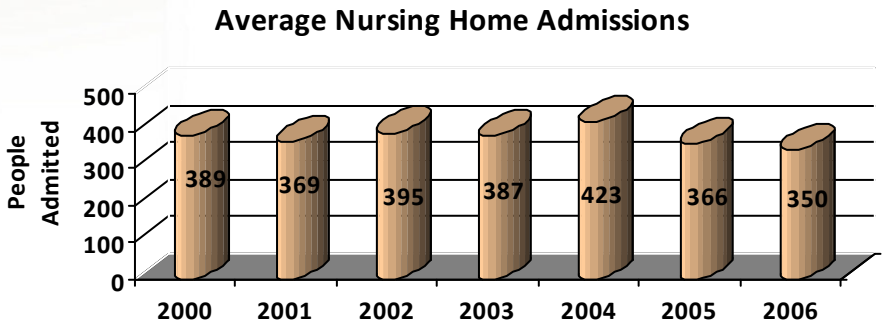
1 Does not include respite beds in public manors/facilities; does include palliative care and convalescent care beds at the PE Home. 2 Decrease in numbers due to a private NH closure. 3 Increase in beds due to a private NH closure. 4 Includes temporary beds that were reported annually. 5 Expansion at Community Hospital.

2.1.2 Admissions to LTC 2000 - 2006

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 2.88

years. On average, 383 new patients are being admitted to LTC annually, indicating that 39% of the LTC population changes every year.

Graph 1: Average Annual LTC Admissions 2000 -2006



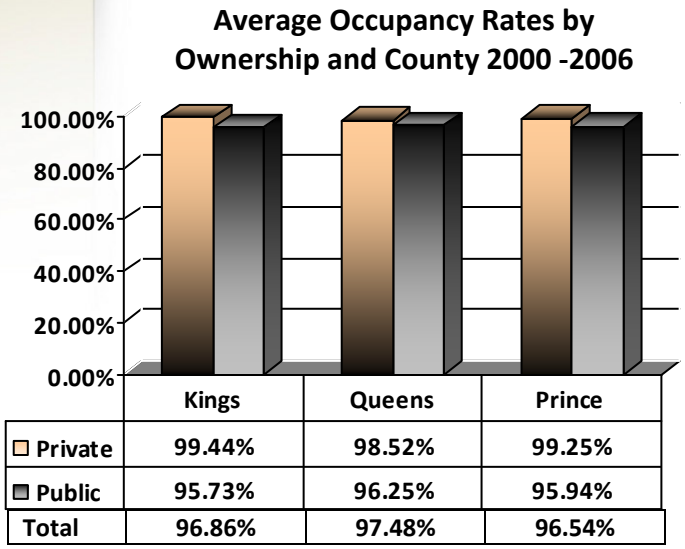
About 70% of people admitted to LTC are over the age of 80. Admissions to LTC facilities over the past seven years have also shown that on average 35% of the clients are male and 65% of the clients are female. The complexity of care has increased and the majority of nursing home residents have dual diagnoses, 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.[2] This is within the norms of data reported nationally. National data indicates that 60% of all nursing home residents have Alzheimer's disease.[3]

2.1.3 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.[4]

[2] Key Informant Interview. (2007).Dr. Gloria MacInnis Perry. 2007
[3] Dr. Gloria MacInnis Perry. (2006). Dementia Care Program for Provincial LTC Centres, October 2006
[4] Department of Health, LTC database, December 2007.

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



As evidenced by *Table 2,* 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. The timeframe to refurbish a room 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 may lengthen the admission process.[5] As evidenced by *Table 2*, 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.

Table 2: LTC Beds, Admissions and Occupancy Rates for Private and Public Facilities

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%

[5] Key Informant Interview, PEI Private Nursing Home Association, 2008

The gap between utilization of beds in the public and private sector indicates there is an opportunity for the publically operated facilities to improve efficiencies. *Table 3* 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 3* improvements in occupancy to 98% or 99% could lead to further gains in bed efficiencies that may improve wait time for residents awaiting placement and decrease the overall number of additional beds required.

Table 3: 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 Wait List and Wait Times

The LTC system in Prince Edward Island has a wait list for admittance into a nursing home. *Table 4* below 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 peaked in 2007 in Queens County at 78 days, a 97% increase over the average wait time of 40 days from 2000 to 2006. The number of people awaiting placement also peaked in 2007 at 138 people.

Table 4: 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.

2.1.5 Length of Stay

Utilization of the LTC system is affected by how long residents live in a LTC facility. 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 5* 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 East Prince could be the higher utilization of home care in that region. It is possible that length of stay could be reduced if policy changes aimed at increasing HCS services are implemented.

Table 5: 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**
Province Average[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 actual days spent in LTC facilities.

2.2 Funding and Subsidization Policies

Beginning in January 1st, 2007 major changes were made to the funding arrangements for LTC. 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 required to pay the accommodation portion of LTC, which covers room and board, including meal service, housekeeping, laundry and social/recreational activities. The accommodation rate is $67 per day for all public LTC facilities. Although private LTC facilities establish their own respective accommodation rates, 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 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 because government will

cover the health care component of the cost of care. While admission to LTC is subject to an assessment requiring a minimum Level 4 care, any qualitative assessment tool can be subject to certain bias and assessor subjectivity. The subsidization policy should be re-evaluated in the context of the entire continuum of care. It has been noted that a potential "carrot" is now dangling over the most expensive care in the continuum. This factor makes it important to re-evaluate the Seniors Assessment Screening Tool (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.

3.0 Research

3.1. Canadian Provinces - Review and Trends

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 aimed 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, non-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.

According to a Statistics Canada report in November 2007, one in 30 Canadians aged over 65 were living in a residential home in 2005/06.[6] These homes are not covered by the Canada Health Act, therefore, they 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. **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; however, 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.

The availability of residential care beds for seniors varies from province to province. The Canadian average 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 to residential care; almost double the national average, with 9.2% of the population over 65 having access to either long-term care or community care beds.**

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

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.

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.[7] 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 care costs were significantly less for home care.[8]

Prince Edward 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 of $1,901 per capita over the age of 75. **Spending in PEI on HCS is the lowest per capita among all Canadian provinces.**

3.2 Internal Scan – Key Informant Interview Findings

To accurately reflect and report on the current state of affairs in LTC in the province, a broad cross section of key informant interviews were undertaken. Respondents were drawn from; administrators and front-line medical and nursing staff of public LTC facilities and acute care hospitals, private nursing home operators and CCF operators. The following themes emerged during the interviews:

- bed shortages, especially for safety beds;
- limitation of facility design and some structural deficiencies;
- staffing shortages and issues related to scope of practice;
- certain unmet needs of subpopulations; and
- issues relating to governance.

Input received from these key groups was evaluated and analyzed in the development of the recommendations for this report.

[7] *Stitching the Patchwork Quilt Together. (2004).* Facility-Based Long-Term Care within Continuing Care – Realities and Recommendations.
[8] Hollander. (1999). Sub-Study 1*"Comparative Cost Analysis of Home Care and Residential Care Services.*

4.0 Population Trend Projections

The methodology for projecting future need for LTC beds involved 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 for 2007 to 2027, by gender and county for the over 75 year old cohort.

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.

4.1 Population Trend Projections for PEI to 2027

In the coming years, the **province's overall population is projected to grow marginally reaching a peak in the next five years and then declining slowly.** By contrast, the P**rovince's senior population will grow markedly, with the over 75 year old cohort increasing from their present level of 9,340 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 numbers of people over 80 year of age after 2027. That population is currently between the ages 44 and 59 years.

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 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.[9]

Table 6: 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	9,340	10,042	10,902	12,830	15,784

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

[99] PEI Department of the Provincial Treasury, Population Projection Model, based on Statistics Canada data

4.2 Impact of Population Trends on LTC

Table 7 presents a breakdown of the average number of males and females admitted annually to public and private 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 clients are, on average, over 80 years of age.**

Table 7: 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 *Table 6*, was used to project the likely demand for admissions in future years. This projection assumes that the proportion of the population being admitted annually to LTC facilities over that past seven years provides an indication of demand for LTC. Since this projection is based on past utilization of LTC services, it also assumes there will be no changes that will impact that rate of institutionalization in the future. The percentages of each age group being admitted to LTC are summarized in *Table 8*.

Table 8: 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. The likely future demand for annual admissions can be projected by applying these admissions percentages to the population by age for each county. 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 growth for each age and gender category in each county. The projected trend in demand for admissions is shown in *Table 9* and in *Graph 3*.[10]

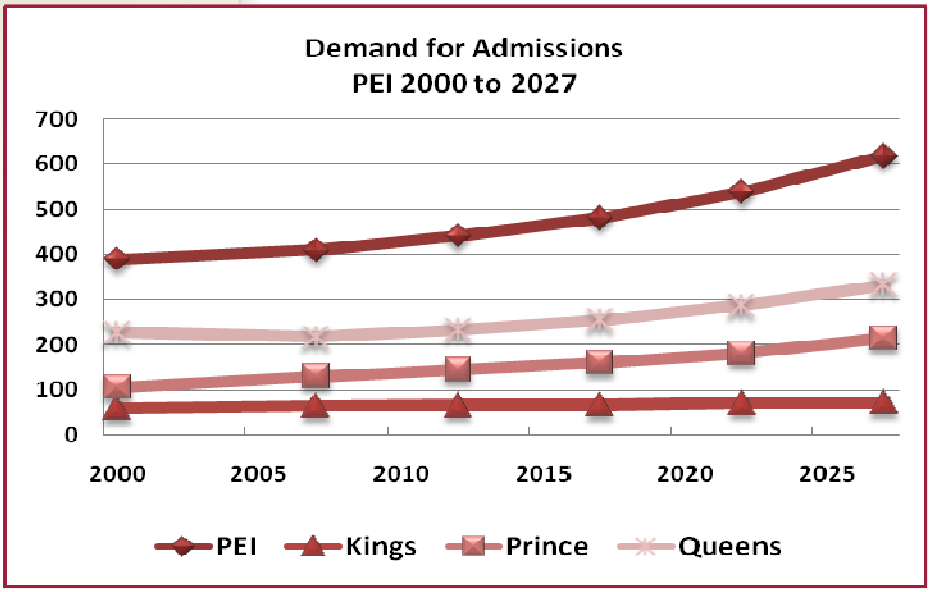
Table 9: Projected Demand for Admissions in Five-Year Intervals

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
Province	**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.

[10] Projections completed by JP Consulting.

Graph 3: Demand for Long-term Care Admissions 2000 to 2027



It is evident from *Graph 3* that the demand for admissions for the Kings County population is projected to experience little change over the forecast period. 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 evident in *Table 9*.[11]

The number of beds in the public and private sector averaged 994 over the past seven years and totaled 1012 in 2007. 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. The following table indicates the bed projections by County in five-year intervals.

Table 10: 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.

[11] Projections completed by JP Consulting.

5.0 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 following recommendations are research driven, based on the statistics gathered both provincially and nationally. The recommendations also take into account the information gathered during the extensive consultative process. The recommendations for LTC bed projections are derived by linking important data together: the projected population of the Province by age and gender; past admissions into public and private nursing homes and manors; and the number of beds available. **The 14 recommendations are overarching, meaning they are recommended for the continuum of care to operate most effectively. The subsequent four priorities integrate and prioritize the recommendations for LTC bed projections and facility replacements into time intervals of five-years.**

Conclusions and detailed rational for all recommendations can be found in *Section 8.0 and 9.0* of the final report for *Trends, Projections and Recommended Approaches to Delivery of Residential Long-term care in PEI*.

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 re-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.

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 11* below.

Table 11: 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. [12]

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

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. A Specialty Care Centre near or adjacent to Beach Grove Home should be constructed to service residents requiring complex care and dementia care.

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 12: 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**