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Seniors victims of long term care and home support cuts

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eniors, their families and the health care workers who provide elder care are becoming increasingly frustrated as the Campbell Liberals continue to make a bewildering number of changes and cuts to seniors care.

For most seniors, MSP no longer pays even a portion of the fee for physiotherapy or chiropractic care. Under the Liberals' changes to PharmaCare, many seniors are now paying increased fees, and many of the drugs they need aren't covered at all. Palliative care beds are being cut, leaving families struggling to provide adequate care for parents and grandparents during their final days.

The criteria to qualify for home care and home support have been made more stringent, so that fewer seniors trying to remain in their homes receive any assistance. Those who do qualify often have to wait longer to receive necessary home care like physiotherapy or home nursing. Others receive fewer hours per week of home support, and certain home support services they've relied on in the past, like assistance with cleaning, cooking or shopping, are no longer available.

Maureen Ashfield is a home health services care coordinator - often called a long term care manager - working in a community health centre in North Vancouver. [See profile below.] She fears increasing numbers of seniors are falling through the cracks.

"The criteria are more stringent, and we now have home support allocation guidelines. This gives the criteria for allocating home support hours and just recently, there has been an attempt to standardize care planning, so all the different service delivery areas in Vancouver Coastal Health are now working from the same document.

"The focus of the care is more towards direct, personal care, nutrition management, and therapy, for example, and cleaning or shopping services are no longer provided. Last year and the year before, we had to take people off the services.

"They received letters saying we were no longer providing that kind of care and they were taken off the service - and I have heard nothing to indicate that those people were followed afterward to determine the impact."

Ashfield explained that although low-level care like cleaning services might not seem as important as other forms of care, they are often a critical component of ongoing care.

"For some seniors, cleaning visits incorporated a monitoring effect. We might be able to identify early

dementia or we might find that the cleaning was no longer enough and they now really needed someone to help them with a bath.

"I haven't heard if any reserach is planned to see if these seniors have higher emergency room visits or if they come back on the program at a later date with increased health problems.

"I fear for these people. There are certainly studies around this issue. We read one from Ontario that said that taking seniors off these programs increases the risk of the person having a catastrophic event because nobody is monitoring them," she said.

"Cleaning services sound like a luxury, but some seniors are no longer able to do their own cleaning. They might have arthritis or osteoporosis, or cognitive loss. I work in an area of North Vancouver where most of the clients I have are on the Guaranteed Income Supplement, and they don't live in subsidized housing, so their rents are easily three-quarters of their income. They can't afford to pay for cleaning, and they can't do it themselves because it's physically painful for them to do it. This is the group that some of the cutbacks are hurting the most."

Ashfield said that previously many low-need clients might have remained on a "check-in" list, where a health worker would check up on them once every six months or a year, but increased workload and patient acuity makes this a difficult prospect. "The system is so driven by the people who are high-need, 'right now' or 'very soon'; the new intakes of people are generally extremely high-need, so trying to keep track of all the other people is hard."

Another area of concern is housing for seniors who are no longer well enough to remain in their own homes.

In their pre-election *New Era* document, the provincial Liberals promised to build 5,000 long-term care beds by 2006. Shortly after the May 2001 election, they reduced this commitment to 1,500 new long-term care beds and 3,500 assisted living units.

In April 2002, the BC government announced another change in plans. Instead of increasing the overall supply of long-term care beds, the Liberals had decided they would eliminate 3,111 long-term care beds by 2004-05 and replace them with 3,799 assisted living units. This plan would provide only 688 new spaces overall, and would mean an increasing number of seniors would end up in assisted living units - a relatively new and untested form of seniors housing in BC.

As of April 2003, very few new assisted living units had become available, and yet health authorities had closed or were in the process of closing 3,304 long-term care beds, and planned to open only 530 new long-term care beds, for an overall reduction of 2,774 long-term care beds. This reduction has left BC with the lowest number of residential care beds for people aged 75 years and over, of any province in Canada: 82.3 long-term care beds per 1,000 population aged 75 and over, in comparison to the Canadian average of 99.8 in 2001/02.

In January 2003, the provincial ministries of Health Services and Health Planning produced a discussion paper entitled *Meeting the ongoing care needs of seniors and people with disabilities*. This report proposes three possible scenarios for substituting assisted living and home support for residential care - a low, a moderate and a high "shift" scenario. The moderate and high shift scenarios would lead to even larger cuts to residential care beds, and an even greater substitution of assisted living for residential care beds. They are also the first scenarios to propose substituting home care and home support for residential care.

In the high shift scenarios, 5,654 residential care beds would be cut by 2006/07, but an additional 6,728 assisted living units would be built, and 5,305 clients would receive enhanced home care/support. These scenarios would leave BC with even fewer long-term care beds for people 75 and over (from 77.2 beds per 1,000 population 75 and over for the low shift scenario, to 67.5 in the high shift scenario).

No other province has initiated such a massive closure of long-term care beds. By comparison, Manitoba recently established a standard of 120 beds per 1,000 population 75 and over - close to 40 per cent more than what will be provided in BC by next year. Ontario, which had the lowest number of residential beds of any province in 2001/02 has committed to opening 20,000 new residential beds by 2006.

Alberta - the only other province that is planning a major substitution of assisted living for residential care beds - is moving much more cautiously than BC. There, the overall number of long-term care beds is being maintained while the supply of assisted living units is being increased.

There is growing concern that assisted living may not be affordable, or provide the right kind of care for the growing number of frail and vulnerable seniors in BC. Over the next 20 years, BC's population of people 75 years and older is expected to increase by approximately 68 per cent (more than three per cent per year). These older seniors are more likely to suffer from dementia or have other complex care needs that require long-term or extended care, rather than assisted living housing.

However, assisted living housing may be better than no housing at all - and that seems to be where the Liberals are headed. Although plans are underway to convert or build 3,334 affordable assisted living units in BC, the health ministries' planning model predicts that at least another 6,728 assisted living units will be required by 2006/07, to compensate for the reduction in long-term care spaces. This effectively leaves the government and health authorities with a shortfall of at least 3,400 assisted living units.

Louise McCormick, a social worker at Trillium Lodge - a long-term care facility in Parksville - has many concerns about the impact these changes are having on seniors.

"The assessment criteria have increased due to a change in provincial policy a year and a half ago. People now need to be assessed as 'complex care' for admission to a facility," she said.

"In long-term care, the assessment levels are called 'Intermediate Level II', 'Intermediate Level III', and 'Extended Care.' A year and a half ago, people assessed at any of those three levels could be admitted to facilities. But under today's guidelines, we're not seeing any Intermediate Care Level II's, who are the 'lighter care,' but people who still need care.

"A patient assessed at 'Level II' is usually somebody who doesn't need a lot of help getting out of bed in the morning or getting to bed at night, but they would have a very difficult time organizing their meals," she said. "They probably can't bathe alone, and there may be some forgetfulness going on - certainly in terms of safety around plugging in kettles or putting things on the stove, this is a serious concern.

"In addition, they'd be at a big risk for falling. They are just no longer able to live independently. Maybe having somebody come into their home three times a day for some Level II patients would be enough to keep them independent," she said. "But for some II's that's just not enough. II's are really on the cusp."

'Level III' patients require more care. "If you're 'Level III,' you're going to need people to help you get up in the morning and get dressed and get washed," she said. "You're going to need significantly more care. We're still admitting these patients. But those II's are getting put off. The II's are the ones that the government is saying, 'Great, we're going to put those people in the assisted living or supported living arrangement.'

"Our struggle here in Parksville/Qualicum is we don't have *any* of those assisted living facilities. There's not a one. Nothing. They tell me there'll be one in 2005. So current Level II patients now *have* no options."

McCormick agrees with Ashfield that patient acuity has risen dramatically. "People are coming in here much sicker. That causes other issues for us as care workers, because the increasing acuity means our workload is increased a hundred fold. The number of beds or the number of clients may not reflect the sheer increase in workload caused by this. When a patient is admitted who is very ill, there's a surge of activity around the patient.

"And we offer more palliative care services than we ever did before. Then, unfortunately, they die - and that opens a bed for another extremely ill patient who has been on the waiting list.

"We don't want to, but we are having to compromise a lot more - which means the people who are coming in might not be receiving the quality of life-care that would be ideal," she said.

Adding to the confusion and frustration around the issue of residential care for seniors is the question of what the government pays for when seniors enter long-term care.

A recent, widely distributed Ministry of Health Services brochure entitled *The Facts About Residential Care* adds to the confusion around this issue by stating: "The province covers all other costs, including full coverage for prescription drugs, routine medical supplies and equipment, as well as some over-the-counter drugs."

"This just isn't true," McCormick said. "In fact, this is one of the main discriminatory issues in residential care today. Any facility that is not licensed as a multi-level or extended care facility does not provide this type of coverage.

"Equipment - especially wheelchairs - is not provided by the health authority as comprehensively as it was a few years ago. With the new complex care guidelines, more residents need specialized equipment," she said. "Again, although the brochure indicates that all equipment is covered, residents are often required to purchase their own chairs.

"As another example, with anti-dementia drugs: people who have Alzheimer's are very likely to be in an intermediate-funded facility, and anti-dementia drugs can slow the progress of the illness. A therapeutic dose costs between $150-$200 a month. That amount will not be covered if you're living in a long-term care facility that's intermediate level.

"You can be paying your *per diem* cost to be living in the facility, which could be $1000 a month. You'll also be charged for your anti-dementia drug, and you're also paying for your Tylenol. Laxatives aren't covered, Gravol isn't covered," she said.

"For some people, this isn't affordable. I've had worried spouses tell me that they're having to decide between the medications and their groceries. This is very distressing to me," she said.

"No one should have to choose between keeping their spouse on an anti-dementia drug, and keeping themselves fed. Not in British Columbia."

For more information about the growing crisis in seniors care, see the BC Health Coalition web site at www.bchealthcoalition.ca

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