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# 10TH ASSEMBLY, 1ST SESSION

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Department of Health
Government of the Northwest Territories

# LONG TERM CARE FOR THE ELDERLY AND DISABLED IN YELLOWKNIFE AND THE TERRITORIES

## A REVIEW FOR THE DEPARTMENT OF HEALTH GOVERNMENT OF THE NORTHWEST TERRITORIES

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## INTRODUCTION

The purpose of this report is to provide advice to the Department of Health as to the services which may be necessary to improve care to elderly and disabled residents of the Territories for both the short term and into the future. The primary focus is the city of Yellowknife and the perceived need for nursing home beds there. However, a broader approach is being taken by the author in the belief that it is advisable for government to consider a comprehensive program of community services which will be less costly both in economic and social terms. While institutional beds must be part of any continuum of care, a continuum of care really means being able to provide appropriate care in the appropriate place, whether it is homecare in the person's home, homecare in another residence, or institutional care. Therefore, the development of beds should be undertaken only in conjunction with the development of these other services. Communities are developing an awareness of the fact that all individuals, but particularly the elderly and disabled are more likely to progress towards or remain in a state of wellness in their own homes and communities;* however, communities planning services to meet health care needs of the elderly and disabled still tend to have a traditional institutional focus. While a minority of individuals can have their needs best met in this way because of the type of care they require or because of a variety of factors in the community, such as lack of support services, family and housing, the emphasis must be on developing the total continuum of care so that options are available.

* A Study of Home Care Effectiveness. Manitoba, 1975.

The Departments of Health and Social Services have recognized that the issue is broader than a need for beds. However, traditionally departments of health have had an institutional focus as this is where health services have been provided. Their mandate has been to administer funds and monitor standards for these institutional programs. The roles and responsibilities of the Department of Health in the Northwest Territories have developed in the same manner and programs and services have tended to develop on this basis with an institutional focus.

Federal and provincial health funding systems have also traditionally favoured the more expensive forms of care. Hospitals have had "free" access in most places, long term care facilities and finally homecare have only recently begun to be included in universal health insurance programs. This, in my view, has increased communities' expectations that institutional care, including nursing homes, is the desirable choice for care of the elderly and disabled.

It is suggested in this report that there has been limited development and coordination of non-institutional services to and for the elderly and it is therefore recommended:

That there be a shift away from the institutional focus until such time as a comprehensive community based long term care program is in place.

Experiences in the provinces have shown that where there are community programs in place conjointly with institutional beds, premature and inappropriate placement can be avoided although there must be a parallel educational process for both communities and health professionals because of the traditional expectations described earlier. Once individuals are in an

institutional system they remain there for long periods and there will still be beds needed for those who follow.

In any case, there is little likelihood of having nursing home or other additional long term facilities available for four or five years because of the time frames of the process of construction. This, therefore does not provide a ready solution to care needs in the short term. The identified care needs do require an immediate (short term) response. It necessitates looking at other alternatives or permits the opportunity to look at alternatives before getting locked into an institutionally oriented system.

## OVERVIEW OF CURRENT SERVICES AND RESOURCES IN YELLOWKNIFE

Some basic community service care components are in place. There is an institutionally based homecare program out of Stanton Yellowknife Hospital; nursing services, homemakers, meals-on-wheels are all available, the hospital has the mandate for service delivery and funding is provided by the Departments of Health and Social Services. There are four chronic beds available at Stanton Yellowknife and twenty Extended Treatment beds will be available in the next few years. There is one newly designated personal care facility available through the Department of Social Services and one senior citizens residence, Mary Murphy Home.

There is good cooperation at the staff level of both the Departments of Health and of Social Services in delivering services to the elderly; the hospital has been responsive to meeting the needs of individuals for care when they arise.

An "Information Package on Services for the Aged and Disabled in the Northwest Territories" has been developed by the Departments of Health and

Social Services and Medical Services and contains good information for the operation of the long term care program.

While there are a number of positive points on which to build there are also a number of problems to instituting a continuum of care (see glossary) in the present circumstances.

1. There is a lack of overall coordination between the Departments of Health and Social Services for this purpose. Health is responsible for institutional programs and Social Services is responsible for community programs including personal care facilities. Although staff work well together at the level of providing service delivery, there is no mechanism to allow formal integration of these services, development of additional services, and budget planning in terms of a "program". Therefore it is difficult to develop a singular policy direction for a continuum of care. There is the additional difficulty of having to integrate the services provided by Medical Services. Fragmented planning can lead to a fragmented delivery of services. (While we are talking about a small system in the Territories and the informal network does work for the most part, it doesn't negate the need for a program and formal coordination.)

2. Housing is a major problem that perhaps has not been addressed to its fullest extent. A lack of appropriate residential accommodation can often be translated into a perceived need for institutional beds. No public housing starts in Yellowknife could be identified in recent years. As far as could be established, the only low cost housing available to the elderly is Mary Murphy Home. While various individuals have expressed recognition of this need, there has been no one group, voluntary or otherwise, lobbying

for this development. There is no one government program or department which has responsibility for evaluating housing needs for the elderly or instituting action on this matter. It is easier for the Department of Social Services to look at personal care facilities or for the Department of Health to look at nursing home or chronic beds. That is not meant as a criticism of either department but is rather a reflection of the difficulty in developing programs and services when there is no comprehensive coordinating program agency or coordination of health planning between existing agencies.

3. The population age and geographic distribution of that population also present problems to developing programs for the elderly and disabled. The population is basically young, and scattered ir small communities over a large territory. The largest proportion of the population of Yellowknife is between 25 and 29 years of age and each subsequent age grouping decreases until there are a total of only 235 individuals 65 years and over (See Table II). This represents 1.5% of the total population which is a very small percentage when looking at around 10% across the rest of the country. These 235 people will represent the largest single group of elderly in the Territories given the total number of people in any other one community in the Territories. Using census figures it would appear that about 20% of the 235 individuals are (treaty?) Indian (47 individuals) and the rest are Metis/Other. In my Manitoba experience I would not consider those 65-69 years in calculations for nursing home beds (the average age of Personal Care Home residents in Manitoba is 84 years and calculations for beds is done based on individuals 70 + years). However, even looking at the total

population 65+ years there is a need for a total of only 11.75 institutional beds* for all institutional long term care at this time. Projected increases for the next four years suggest that those over 65 are increasing at an average of 15.5 individuals per year, (See Table I) which means an anticipated population of 390 individuals 65+ years in Yellowknife in 1993. Using the same calculation as above** this translates into a potential need for 19.5 institutional beds; that 19.5 represents the need for all types of long term institutional beds for the elderly and disabled in Yellowknife at that time. Detah and Snowdrift are considered part of the catchment area for health services in Yellowknife. There are a total of 400 people in the two communities.

However, these 400 people do not represent a homogenous cultural grouping together, or in relation to the Yellowknife population. Because of this and factors discussed below I don't feel there will be an significant impact on any nursing home beds build in Yellowknife.

In calculating a need for long term beds for these communities a figure of 10% elderly has been used based on the ratio of elderly in the general population. This was done because they are established home communities. However, my experience with native communities suggests that the number of native elderly do not represent this high a percentage of the population; there are though, a higher percentage of younger adults needing chronic care because of poor public health and lifestyle.

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*A noted Canadian Gerontologist Cope Schwenger suggests in his report to the Geriatric Nurses in Victoria (and experts agree) that Canada has a high rate of institutionalization for the elderly compared to other countries. He says that we are at over 7% compared to the U.S. at 5.3% and Britain at 5%. I have used the British figure for calculation.

**I have used the population figures of T.H.I.S. with trends indicated by the Bureau of Statistics.

Using 10% of the 400 population figure and looking at a 5% institutional rate (10% x 400 = 40 x 5% = 2) there is a need for two beds to serve long term care needs in both communities. Very few individuals in these communities would be prepared to leave on a permanent basis unless there were absolutely no options as it means breaking social and cultural ties. It is recognized that there are inherent physical and mental risks (relocation stress) for everyone, but particularly the elderly and disabled, who are required to leave their familiar environment for care. While this same concept also applies to the more frail or sicker elderly individuals, it is only practical that a certain number of these individuals will have to leave for long term care at some point given that care options will become limited as their care needs increase. It is suggested that the impact on beds in Yellowknife will be at the chronic care level because it is when individuals reach this care level, that services won't be able to support them in their communities.

While the impact on total long term care beds in Yellowknife by people in Detah and Snowdrift will be limited, access to beds by people from neighbouring communities will have to be available as it is inappropriate to consider any local institutional facitities given the numbers of people involved. The direction of planning for service should be to provide co-ordinated community services to meet as many care needs as possible in the community, and to promote the formal linkage to institutional planning as well.

4. Homecare in the Territories is a hospital based program following a medical/custodial model. A low percentage of elderly will have needs most appropriately met by institutionalization, either extended treatment or nursing home. A high percentage of needs can alternately be more appropriately met by housing, homecare and community service programs, suggesting that the present program needs coordination at the community level.*

Manitoba statistics show frequency of use of Homecare services increases with age. However, the services to the elderly are often psycho-socially and maintenance oriented--companionship, security, meals, housekeeping, shopping etc. A review of statistics from the Yellowknife Homecare program indicates a high ratio of nursing vs. Homemaker visits to "chronic care clients" which suggests that the types and frequency of services to the elderly (both care and care giver) should be reviewed and assessed. Perhaps individuals on the program are sicker; perhaps there is a need for more housekeepers and volunteers; perhaps the focus of the program has to be changed to a social support model; if nursing is an insured service and homemaking is not, funding may be having an impact on staff utilization, availability of staffing may also make an impact.

A cost limit on the amount and type of Homecare Service an individual could receive prior to institutionalization would also be valuable; it would help identify individuals in need of alternative institutional accommodation.

5. The leveling system for elderly and disabled needing care is institutionally oriented e.g. Level III/Nursing Home Care, Level IV/Chronic.

* A Ten Point Model for Home Care Delivery - Manitoba.

It infers that an individual with a level III care need has a need for institutional care. The focus at initial assessment for care should be on the need for support or care at home. The levelling tool should be used only when it has been decided that institutionalization is necessary and a decision must be made as to the appropriate placement. Levels of Care are basically an institutional tool used for funding, staffing and statistics.

Personal Care Facilities are not an insured health service in the Northwest Territories. They are residential accommodation and provide support for household functions, meals and supervision. Nursing care is not part of this program. It is community based and meets care needs through Homecare as these needs would be met in a person's home. The assessment for need should not be confused with a label, i.e. level of care. Reference to Levels I and II/Supervisory and Limited Personal Care in the Health Brochure--Levels of Care, ties these types of care to institutional care. A Social/Development Model would not require a "Leveling" structure as need would be the criteria for entry, not care level, i.e. the same care level can be met in a variety of fashions dependent upon existing resources (this is where cost effectiveness comes in). Maintaining care levels as an indicator for program services, then, does not allow for assessment of the individual's unique situation.

TABLE 1

YELLOWKNIFE POPULATION 65+ YEARS
PROJECTED FROM 1981 CENSUS - BUREAU OF STATISTICS

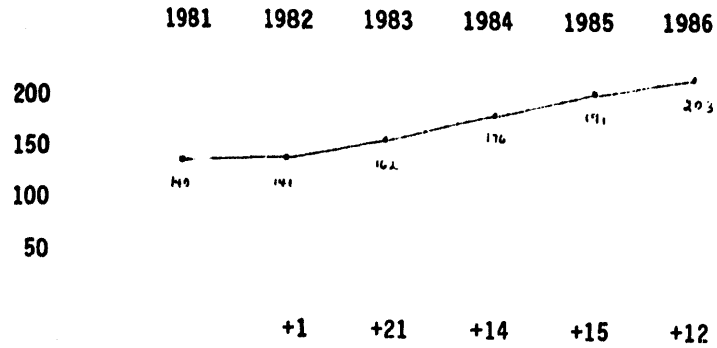
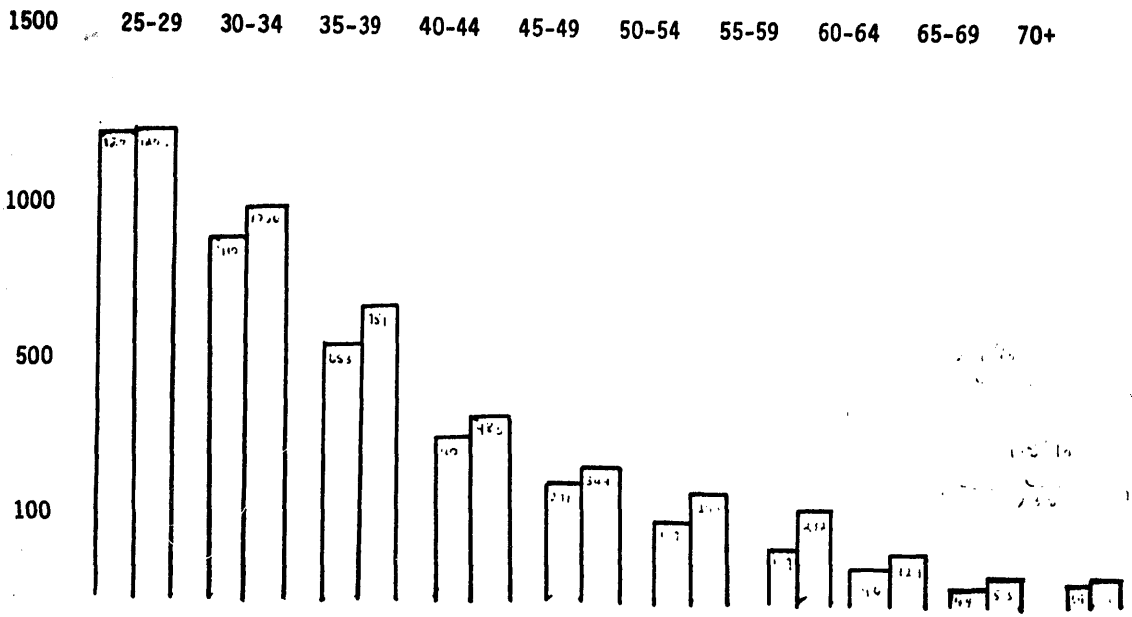



TABLE 2

YELLOWKNIFE POPULATION BREAKDOWN
BY AGE AND SEX FROM T.H.I.S. REGISTRATION
SEPTEMBER 1983




TOTAL POPULATION 15,561

RECOMMENDATIONS #1

That no nursing home beds be built in Yellowknife at this time. There is no possibility of constructing a facility in less than three years so immediate problems will not be resolved in this direction. The new hospital, which will include twenty Extended Treatment Unit beds will be operational in three years. Twenty beds will meet all long term care institutional needs until 1993 using present population projections.

It is suggested that for practical purposes the chronic care facilities currently in place are multi-level facilities for all levels of care requiring institutional placement. Government policy should formally recognize these institutions as nursing home/chronic care facilities. Generalizing from Yellowknife statistics it is doubtful that any one community could support a one level or a freestanding long term care facility.

Juxtaposition in the sense of a separate but attached building offers little benefit to the residents of these units until you have a unit of at least 30 beds. The identity of the unit (as long term care) is always fragile; long term care programs are difficult to maintain; a medical/custodial model develops and the unit easily becomes an extension of the acute facility. A specific administrative separation and separate program identity are really the deciding factors on how successful the unit is, not the type of physical separation--unless the unit is freestanding which is a program ideal.

Rather than looking at more beds for Yellowknife, the focus should be to develop program for the existing and proposed beds so that they are not a "dumping ground" for the elderly and disabled. Also "program" will promote flow through the beds and make for better, broader utilization.

**SUGGESTED PROGRAM GUIDES FOR PROPOSED E.T.U. BEDS**

1. Admission criteria should be established. There should be a clinical director of the unit who sits on the Admissions-Discharge Committee along with at least one Community Services/Homecare representative, some appointed representative of hospital administration and someone from the staff of the Unit itself.
2. There should be some separation between this unit and the rest of the hospital at an expedient level of authority to ensure that the Unit can achieve its independent objectives and standards of care without competing with the active treatment unit for staff and resources on a daily basis.
3. Clinical Director - It is recommended that a Clinical director be appointed from the medical staff to act as the coordinator of the program to promote the objectives of the unit with medical staff.
4. Consultative Services - It is recommended that the services of a specialist in geriatrics, internal medicine or physical medicine be retained to act in a consulting capacity to staff of the unit, the admissions committee and the client's physician.
5. Utilization Review Committee - It is recommended that the extended treatment unit have a utilization review committee. This could be a program function of the Admission-Discharge Committee.
6. Day Care - It is recommended that consideration be given to offering such a program through this unit. The need should be defined by the Homecare Program.
7. Beds should be designated for certain programs, i.e. rehabilitation, chronic care, nursing home, assessment and respite/social.

## SUGGESTED PROTOCOL FOR PROPOSED PROGRAMS MODIFIED FROM "EXTENDED TREATMENT SERVICES - RURAL FACILITIES" MANITOBA 1978

### Rehabilitation

Objective: To improve the functioning status to the extent that patients can return home with or without support or be appropriately placed in alternate accommodation.

Protocol

Each patient admitted to this program should receive the benefit of:

1. 24 hour nursing supervision.
2. Continuing medical (clinical) management.
3. Access to an adequate range of rehabilitative services e.g. - occupational, physiotherapist, speech therapy, etc.
4. Access to diagnostic services.
5. Access to social services as required.
6. Access to a medical specialist appropriate to the program at least once per month and preferably every 2 weeks.
7. A team approach to care planning, treatment, and discharge.

### Chronic Care

Objective: To provide a program of care to those persons who have attained their maximum level of functional ability but who require more nursing care or specialized treatments than can be provided elsewhere. There will be no limit to the length of stay.

Protocol:

Each patient admitted to this program should receive the benefits of:

1. 24 hour nursing supervision.
2. Medical supervision as necessary.
3. Diversional therapy as deemed necessary to ensure as good a quality of life as possible.

## Nursing Home

Objective: To provide a program of care to those persons who have been assessed as needing nursing home care.

Protocol:

Each patient admitted to this program should receive the benefits of:

1. 24 hour nursing supervision.
2. Medical supervision as necessary.
3. Diversional therapy as deemed necessary to ensure as good a quality of life as possible.

## Assessment

Objective: To provide a total assessment of the patient's needs within 10 days to 1 month so that the most appropriate treatment regime may employed or that the most appropriate accommodation be selected.

Protocol:

Each patient admitted to this program should receive the benefits of:

1. A team approach to the assessment process including nursing, medicine, range of services, dietitian, pharmacist, diagnostic, social service, medical consultant and public health.
2. A care plan for treatment and discharge as deemed necessary following the completion of the assessment.

## Respite/Social

Objective: To provide holiday relief for patients' families (usually not exceeding 2 - 3 weeks) and/or intermittent adjustments to the patients care regime as an essential part of their continuing care plan.

Protocol:

Each patient admitted to this program should receive the benefits of:

1. Nursing and medical supervision as required.
2. Health and social services referrals as necessary to maintain them on the program as required.
3. Admissions pre-arranged as much as possible to meet the needs of families or primary care givers in the community.

This is by no means a comprehensive set of guidelines for the establishment of an E.T.U. but is intended to provide some direction.

Consideration should be given to developing similar guidelines and programs in the Chronic Care Facilities in Hay River and Fort Smith.

In relation to Yellowknife there is one more consideration. As construction has not yet proceeded and there is extra room over programmed space, some thought should be given to increasing the single room ratio because of long term stay and the difficulty many elderly have with communal living.

Considerations should also be given to programming for the present four "chronic" beds at Stanton Yellow Knife. They could probably be used more effectively if there was some program of intermittent admission for patient stabilization and social relief. It would also be beneficial to the hospital to be able to do some planning for use of these beds and not have to deal only with crisis intervention.

**RECOMMENDATION #2**

That the development of housing for the elderly be a priority program as part of improved Community Services to the elderly. It is one of the alternatives necessary if institutional care is not to be the focus of long term care and if long term beds are to be used appropriately only for heavier care. The following summarized quotation restates this point.

"While Canada as a whole experiences a higher rate of institutionalizion of the elderly than European countries or the United States, the highest rates are in those areas with a significant rural population spread over large areas. Factors which contribute to this are physical hardship of rural existence, risks of remaining in an isolated home as one becomes less mobile, related transportation difficulties and harsh climate, mobile extended families, limited availability of home help services, lack of rental accommodation and the relative abundance of long term care beds in larger rural communities."**

The recommendation supports the concept of an enriched multi-level residential facility for the frail well elderly and those requiring personal care as defined by the Departments of Social Services and of Health so that the Territories will not find itself in the situation of having to institutionalize the elderly because there are no alternatives.

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* Enriched Elderly Persons Housing & Generalized Functional Program Manitoba 1976.

** Multi Label Care Facilities: Evaluation of Models for Alberta, Alberta Department of Hospitals and Medical Care and Alberta Housing Corporation, Sept. 1981 Woods Gorden Management Consultants.

Both types of accommodation are residential in nature. The residents of an elderly persons housing unit or a personal care facility can have their care needs which are primarily social supports met through community resources (Homecare). Enrichment of a housing unit for the elderly, an E.E.P.H., can provide for the care needs of personal care type individuals. The nature of problems in Yellowknife and the rest of the Territories demands 24-hour supervision of any residential accommodation of this sort; supervision is also a program component of personal care. All these factors support the compatibility of the two services.

This type of facility would enable the elderly and disabled to maintain their independence for a longer period of time; it would provide options to both the elderly and professionals working with them and reduce pressure for institutional services.

Sponsors should be approached to build and operate such a facility within the spectrum of overall community services.

SUGGESTED GUIDELINES

1. The building should be designed to serve as a centre for well elderly programs and perhaps other community groups to help maintain integration with the community.
2. It should be designed to facilitate Homecare Services.
3. It should be situated centrally for social services and to assist residents in maintaining their community contacts.

**RECOMMENDATION #3**

That government develop a more comprehensive, coordinated and community based approach to services for the elderly and disabled. One component of this would be a central government office. It would be responsible for program funding, planning and development of Homecare with other parts of the system, including social services and housing, the establishment of linkages with institutional programs, as well as discharge planning and the integration of assessment for placement in institutions. The office should itself be formally linked with the Department of Social Services for purposes of assessment, of coordinating homemaking services and overall planning for programs for the well elderly and with the Department of Health for linkages with institutional programs.

This central office would be the program centre for the Territories. The delivery of services would continue with the existing Homecare Coordinators who would now be responsible to this Central office for program direction.

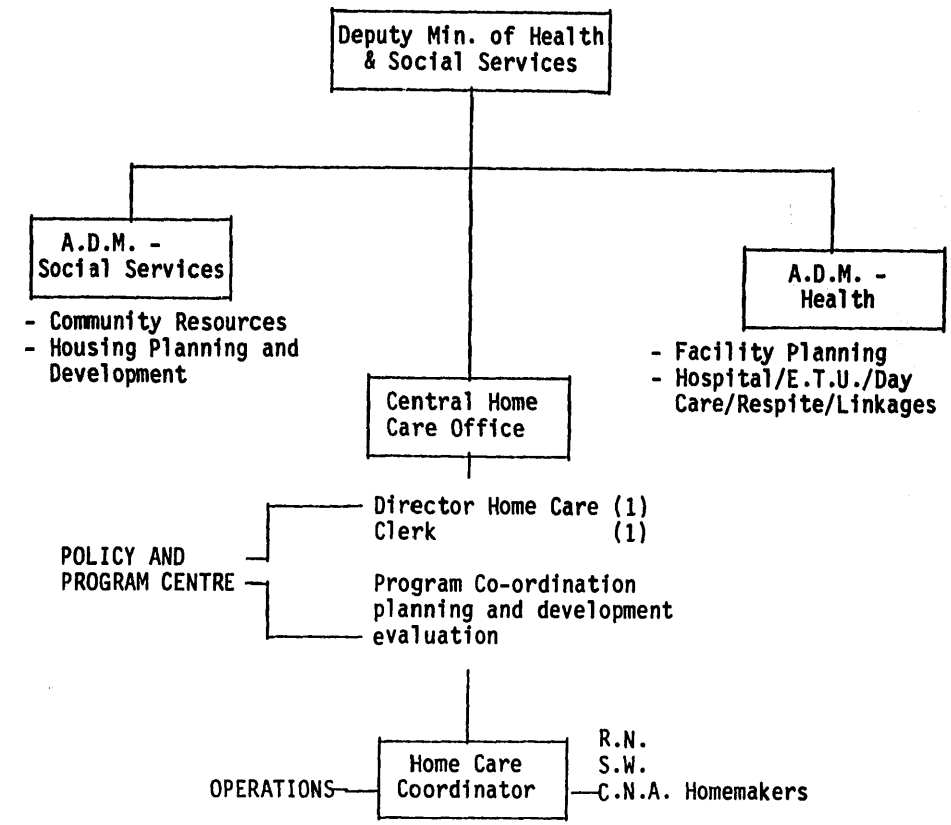
Realizing that we are not discussing a large client population at this time a massive hierarchy is not being suggested.

Positions

- One director with a community base and a knowledge of gerontology and community health
- One clerk/typist
- One community oriented social worker as a resource to Homecare Coordinators for assessment etc.
- Homemakers as needed
- Payroll clerk if there is a fee for service situation

It may be possible to transfer staff man years already in existence. I understand that there is a vacant position related to aging in the Department of Social Services.

Following is the proposed organizational structure.




| R.N./S.W. | C.N.A. Homemakers | Home Care Coordinator |
|---|---|---|
| Assessment<br>Care planning<br>Arranging for appropriate care<br>Placement and withdrawal of services<br>Counselling<br>Teaching<br>Working with Families | Care Provision | Service and Resources<br>Co-ordination and Development<br>Homemakers<br>Volunteers<br>Hospital liason<br>Respite<br>Day Care<br>Early Discharge Program |

This recommendation is designed to institute a Territorial Program for long term care on a community based model. With the exception of the Central office the pieces are in place. While the current Homecare system has some coordination as far as actual service delivery, an overall coordinated approach does not exist at the program level.

# GLOSSARY

INSTITUTIONAL BEDS - for purposes of this report are those beds in facilities with a medical or health component built into the facility. There is full-time nursing supervision and no resources for individuals to provide for their own meals, laundry etc. if they are able. There are routines established which must be followed by patients/residents to allow for ongoing operation of the facility.

A CONTINUUM OF CARE - is a system of linkages established between hospitals, long term care facilities and home care services to ensure continuity of care without interruption for those moving within the health care system in the Territories. It involves providing the most appropriate care in the most appropriate setting whether it be providing care in the person's home, an alternative residence or an institution.

LONG TERM CARE - for purposes of this report is all non-acute care provided to the elderly and the disabled whether or not it is institutional or community care. It goes beyond dealing with the individual's health needs to consideration of their psychosocial needs and functional abilities.

**GLOSSARY (cont.)**

DAY CARE - is a social program which allows individuals to be care for during selected hours on specified days throughout the week. It allows the primary care giver to be relieved for periods and provides the client with socialization with peers, a meal out, and a change of environment. It is usually in a long term care institutional environment but has been provided in hospitals or non-institutional settings.

MEDICAL/CUSTODIAL MODEL - describes an illness oriented, acute care system with emphasis on treatment for disease and cure. Access to the system is controlled by the physician.

SOCIAL DEVELOPMENT MODEL - describes long term care as a network that cares for the total needs of a person with an emphasis on maintaining his/her functional level. Access to the system is more open and can be obtained through department of health and social services workers.

## REFERENCES AND RESOURCES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