Ontario Health Coalition

HEALTH FACTS - CHRONIC CARE

Chronic Care Policy Issues

Patients requiring Chronic Care are facing some of the worst effects of Harris government and Health Service Restructuring Commission changes. This area of patient care has been gutted by new guidelines of only 8.23 beds/1000 population 75 years and over[1], compared to the 1996 rate of 14.1 beds/1000 for 75+.

3506 Chronic Care beds are to be closed by the government[2]. This represents a huge loss for the most vulnerable and high-needs patients, including those living with AIDS, Multiple Sclerosis and Huntington's.

The government believes there are two categories of Chronic Care patients: those who are dependant and require technological interventions, and those who do not. As Chronic Care beds are closed, the government is in the process of creating and substituting less specialized Long Term Care beds and services.

Chronic care beds have much higher levels of medical, therapeutic and nursing care and are funded at a rate of $200+/day. Long Term Care beds are funded at approximately $90/day, with only limited care. The difference in the per diem rates results in less programs and services for chronic care patients.

That is why the Ontario Health Coalition has condemned the plan to move Chronic Care patients into long term care beds as "warehousing".

THE DOWNWARD SPIRAL - Cheaper and Cheaper Care

In looking at the overall picture of long-term care, the HSRC committed itself to **"downward substitution"** throughout a spectrum which includes chronic care hospitals, nursing homes, homes for the aged, supportive housing, long-term in-home care and community support services like adult days programs. They define their effort as aiming to provide care in the "least intrusive" environment that will meet the patient's need**. For "least intrusive" we need only substitute the word "cheapest" to get their meaning.** This downward spiral of care means not only dumping chronic patients into less expensive nursing home care, but also means moving persons in nursing homes into supportive housing or long-term home care, and bumping people on long-term home care onto the backs of their families, with the possible aid of adult day care programs.

DOWNWARD SUBSTITUTION - A Faulty Premise

Downward substitution clearly starts from the assumption that persons receiving long term care are now getting too high a level of care. **For patients in chronic care hospitals, the assumption is that more than half of them could get along with less**. Nothing could be farther from the truth. Marian Walsh, CEO of the Toronto's Riverdale Hospital notes that "Non-clinically complex patients at The Riverdale Hospital still have very complex and often co-existing medical problems and disabilities. They require intensive nursing care, therapy and medical interventions, as well as high levels of personal care. In the case of Riverdale's patients, personal and nursing care needs range from one to ten hours per day with almost all needing greater than three hours of personal care per

day, plus extensive therapy. These include people living with Multiple Sclerosis, Parkinson's Disease, ALS, HIV/AIDS, severe dementias, multi-system failures, organ transplant failures, etc."

NOWHERE TO GO

Chronic Care bed closings are to be completed this year. Plans call for many of these patients to be downloaded to Nursing Homes and Homes for the Aged. But waiting lists for these long-term care facilities are currently stand at 18,000+!

Meanwhile, the government has recently awarded 6,700 new nursing home beds. (Overall, 20,000 Nursing Home beds are supposed to be awarded but only by the year 2006!) The problem is very few of the 6,700 will be ready by the end of this year when the chronic bed closings are to be completed. Even if all the 6700 new beds were ready this year, they would accommodate less than a third of those who will need them. Of the 18,000 on waiting lists, 4000 are already in facilities but waiting to be moved to a more appropriate place. That makes 14,000, plus 3500 chronic beds to be cut, **a total of 17,500 prospective occupants for the 6700 new beds.** For this reason, Toronto's Riverdale Hospital is pressing the government for an extension to March 2003 ". . . The Board has concluded that the capacity will not exist in the health care system to serve the needs of the Riverdale Hospital's current patients (and future chronic care patients) as of March 31, 2000." Riverdale CEO has said the Board therefore believes that it will not be possible, nor responsible, for it to attempt to close the Riverdale Hospital by the directed HSRC date.

The other problem is, as explained earlier, these are much cheaper beds with much less care attached to them and will not provide appropriate care for thousands of people. Without the appropriate level of care, the government will be placing patients' lives at risk.

DOWNLOADING TO LONG TERM CARE FACILITIES (Nursing Homes & Homes for the Aged)

Even before this next round of downloading to Nursing Homes and Homes for the Aged begins, an already disastrous situation exists in this sector. Since about 1992 (the year of the Chronic Care Role Study), chronic care hospitals and units have been admitting only patients with medically complex needs. Patients who, before 1992, would have been accepted into chronic care hospitals, have been sent to nursing homes. These are patients who experience mobility problems, swallowing difficulties, incontinence, as well as a wide variety of psychological impairments.

Such heavy care patients now make up approximately 60% of nursing home residents, placing an impossible burden on the workers in these facilities. Staffing has not increased and required staffing ratios have been eliminated. Where previously facilities were required to have enough staff to provide 2.25 hours of care per day per resident, there are now no requirements at all, and it is estimated that the heavy care patients need at least 3.5 hours of care per day.

The 3,500 chronic care beds to be closed mean 3,500 heavy-care patients are to be absorbed into an already overburdened long-term care facility system.

These patients will not only be subjected to the traumatic experience of being moved from what, in some cases, has been their home for a decade or longer, but they will also find themselves in an environment that offers much less care and support. "The patients we care for at Runnymede do not necessarily fit the government's new view of chronic care patients. The problem stems from the Minimum Data Set and RUGS III³ patient classification systems which are not capable of capturing the true and intense care requirements of many of our patients. As a result, there will be a large number of chronic care patients, both young and old, who will find themselves moved inappropriately into long term care facilities where they will not receive the 24-hour specialty care they require. Even those that meet the new chronic care view will be affected in a similar manner as they will be forced

into another chronic care facility or a long term care facility that may not have the specialty programs and services to meet their complex care needs," says Normand Allaire, President and CEO of Runnymede.

DOWNWARD SUBSTITUTION A BONANZA FOR PRIVATE SECTOR: Winners and losers

In addition to **downward substitution,** the government has revealed its other agenda **that of massive privatization** in the awarding of the contacts for the 6700 new, cheaper long term care beds. The big winners were major corporate players and in particular Extendicare (965 beds, or 14.4% and Versa-Care/Central Care Corp (1385 beds or 20.7%). Leisureworld Inc was awarded 512 beds, or 7.5%. Other private, for-profit operators also received awards.

Privatization also takes place when patients are moved out of public hospitals and no longer have the protection of the Public Hospitals Act and the Medical Insurance Act. As a result, chronic care patients will be hit with new charges, such as drugs, therapy, dental care, foot care, etc., that they will have to pay out of their own pockets.

FOOTNOTES:

1. HSRC "Change in Transition April 1998: Planning Guidleines and Implementation Strategiew for Home Care, Long Term Care, Mental Health, Rehabilitation and Sub Acute Care"
2. ibid
3. A MOH planning tool that is supposed to identify care needs.

Produced January 1999