ACA News

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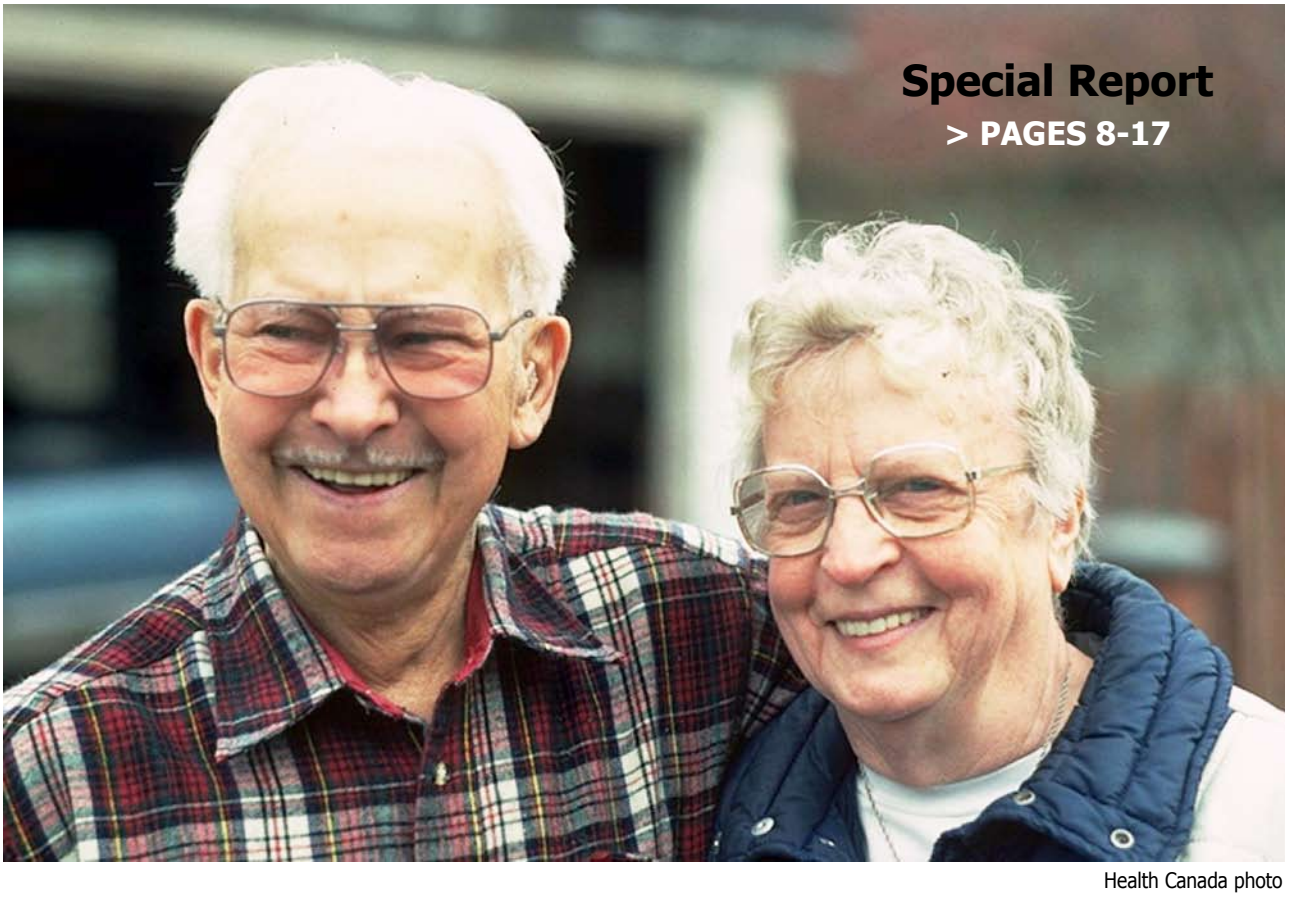
WORKING TOGETHER



Health Canada photo

Conference explores future for Seniors in Alberta

DON'T FORGET TO RENEW YOUR MEMBERSHIP: P.23

ACA News

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ACA News

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Working together for Seniors

Gary Pool
ACA President

The Mission Statement of the Alberta Council on Aging is "To empower and educate Seniors and government to support the quality of life for Seniors and encourage their full participation in all aspects of society." In support of this mission we are presently carrying out a number of activities.

On Jan. 13, we helped co-ordinate an information session with other groups dealing with Seniors' issues. This session (covered in detail starting on page 8) provided participants with information on Hospital Use in the Province of Alberta, Pharmaceutical Information, Seniors' Housing Issues (provided by the Strategic Area Liaison Team S.A.L.T.), a discussion paper by another group (Creating Synergy-Health Coalition of Alberta), and an item on Political Issues (presented by Public Interest Alberta). Several other groups participated in the session.

One of the purposes of the session was to focus on specific Seniors' issues. We think that a co-ordinated approach on a few issues will do a better job of getting the government's attention. A second purpose was to provide everyone present with consistent background information. Some "Health Care myths" were debunked." For instance, there have been a number of statements by both politicians and health-care officials that overloading is caused by an aging population and insufficient capacity to care for elderly people in the community.

We do agree that there remains an issue with capacity to care for elderly in the community. In 2008, 76.4 per cent of hospital admissions were under 65 years of age (Donna Wilson's special report December/January issue of the *ACA News*). This means that over 75 per cent of the overloading is caused by patients younger than 65.

In the last two issues there have been Health Committee reports. These have been reviewed and supported by the Board of Directors. The ACA submission to the Minister's Advisory on Health was developed and reviewed very quickly. The request for a submission was received in mid-October 2009 with a required submission date in early November. We believe the Health Committee did an excellent job in putting this together.

In addition to these activities, the ACA has been actively working a Senior Friendly™ Program and has developed an Elder Abuse program under a grant from New Horizons. We have started to disseminate information on Elder Abuse and expect to be reviewing the program with many groups over the course of this year.

Gary Pool, ACA President

AGM NOTICE

Alberta Council on Aging's 43rd
Annual General Meeting
will be held on May 26, 2010,
at the Morinville Seniors RendezVous Centre.
Mark your Calendars!
Watch for more information in the
April/May issue of the *ACA News*.
Or check out our website www.acaging.ca

NEWS FOR SENIORS

Patients waiting longer in emergency rooms

Karen Kleiss
Edmonton Journal
Reprinted with permission

Albertans are waiting longer for emergency health care today than they were two years ago, a new report from the independent Health Quality Council of Alberta says.

The median waiting time for admission to hospital was 14.4 hours in 2009, up 30 per cent from 11.1 hours in 2007. That means half of the patients admitted to hospital after emergency treatment waited more than 14.4 hours to get a bed.

As for patients treated by emergency staff and sent home the same day, the median stay was 3.6 hours, which means half of all emergency room patients waited more than three and a half hours to be treated and released.

In 2007, the median stay was 3.4 hours, or six per cent shorter.

The numbers fall far short of the guidelines set by the Canadian Association of Emergency Physicians, which recommends even patients with the least urgent problems — sprained ankles and upset stomachs — be treated and released in under an hour and a half.

"If you are waiting a long time to be admitted, it becomes a patient-safety issue," council CEO Dr. John Cowell said Monday.

"Your health could be deteriorating while you're waiting on a stretcher. Once a decision has been made to admit, the system needs to act as quickly as possible."

Cowell said the numbers reflect the first nine months under Alberta Health Services, a single provincial health governance board that replaced 12 separate health boards in May 2008.

"We are surprised," he said. "We had hoped that with the new architecture we would see improvement."

He said the statistics in the council's report come from AHS data, and the findings are validated by the results of the council's own survey of nearly 5,000 emergency room patients.

Nearly half said they stayed longer than 12 hours in the emergency ward and 42 per cent said they waited more than two hours to see a doctor, an increase of 23 and 10 per cent, respectively, since 2007.

Health Minister Gene Zwozdesky said the province is taking steps to address the problems.

"For example, halting the plan to close acute-care beds and ensuring that we keep as many of those open is one," he said. "And of course we've got the budget coming ... Hopefully, there will be some way of addressing some of these issues."

Provincial Emergency Department Clinical Network co-chair Dr. Grant Innes said the findings are no surprise to front-line workers.

"We knew we had problems, we know we are not achieving the targets we've set."

Innes said hospitals are testing new systems that will make emergency rooms more efficient.

For example, a trial clinical decision unit holds patients who need more than the standard four to eight hours of emergency care and less than the typical 48 to 72 hours of hospital care.

Emergency staff aggressively treat these patients in hopes of reducing the number of admissions, Innes said.

Dr. Chris Eagle, AHS vice-president of quality and service improvement, said rising wait times are caused by an aging population and insufficient capacity to care for elderly people in the community.

"Keeping up with that has been a problem, and we've gotten behind on building that community capacity," he said, adding the province is building 775 community care beds over the next three years.

"This is going to take some time to fix," he said.

"Doing a number of small things won't be enough. We have to address the fundamentals of the way care is delivered across the continuum of care to really fix this problem.

"The emergency department is really just the canary in the mine shaft."

ACA President Gary Pool Replies

Rising [hospital] wait times are caused by an aging population and insufficient capacity to care for elderly people in the community says Dr. Chris Eagle, Alberta Health Services VP for Quality and Service Improvement

(See related story on page 4)

Facts on Hospital Usage

To fall into 'ageism' to off-load the rising wait times is dead wrong.

Dr. Donna Wilson's 2006-2008 analysis 'Who Uses Hospitals in Alberta[1]' clearly refutes. To blame the elderly is a tragic myth. The facts are quoted below.

- 76.4% of all people admitted to hospital were under 65 years of age;
- 67.5% of all people admitted to critical care units (ICU) were under age 65; and
- 2.15% of all people admitted (6,060/year) waited in hospital for a nursing home or rehab bed had no procedures performed in-hospital.

Regarding Hospital Ambulatory Care Admissions[2] (Emergency Room, Out Patient Department, and/or Day Surgery), and using the latest (2008) data, we see:

- 3,290,350 individuals lived in Alberta;
- 1,466,499 visits were made to Ambulatory Care;
- 43.7 % of Albertans used Ambulatory Care;
- 8.4% of Albertans used a hospital bed;
- 84.3% of all people who used Ambulatory Care were under 65 years of age; and
- Children under 1 year were the most common Ambulatory Care patients, by age group.

Dr. Eagle's analysis that there is insufficient capacity to care for elderly people in the community is true. But added President Pool, it was Alberta Health and Wellness policy that froze the number of long-term-care beds at 14,500!

As the President of Alberta Council on Aging I am shocked that this high-ranking Alberta Health Services official is so poorly informed and is so willing to prejudicially dump on the elderly.

Please visit the facts, Doctor.

[1] See ACA News Dec 2009-Jan 2010 "A Special Report" for the text of this research.

[2] This is Donna Wilson's second paper which was released at the January 13 ACA Conference. (See page 8) It is available from the ACA office.

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SPECIAL REPORT: WORKING TOGETHER

Professionals, Senior-serving groups
explore a better life for Alberta's elders

Conference seeks a new way forward for Alberta's Seniors

On Jan. 13, ACA helped to present a conference at the University of Alberta. Its purpose was to bring together Seniors organizations to produce at a priority list of Seniors' issues.

The following pages contain a summary of the some of the day's key presentations.

Floyd Sweet
Policy Advisory Committee

Dr. Donna Wilson

Our mini-conference opened with Dr. Donna Wilson presenting her 2006-08 population-based study for Health Services Planning and Policy titled *Who Uses Hospitals in Alberta?*

Wilson is a registered nurse with a full-time tenured position as Professor in the Faculty of Nursing at the University of Alberta. Besides her RN, Wilson sports a Baccalaureate in Nursing degree (1981), and a Master of Science in Nursing degree majoring in Gerontology and Health Care Management (Austin, Texas 1985). With her Doctor of Philosophy degree in Educational Administration (U of A, 1993), Wilson focuses her research program

SPECIAL REPORT: WORKING TOGETHER

BY THE NUMBERS: HOSPITAL CARE IN ALBERTA

Some key findings by University of Alberta nursing professor Donna Wilson:

50 per cent of 13,000 hospital beds were closed (1993-95) with 6,800 beds now and population growth from 2,670,726 in 1993 to 3,632,483 in 2009.

57.6 per cent of all 731,110 admissions to hospital were to 10 Edmonton and Calgary city hospitals.

76.4 per cent of all people admitted to hospital were under 65 years of age; the average age was 39.5; one half were under age 36.

Children under one year were the most often hospitalized, responsible for **17.4 per cent** of all hospital admissions.

67.5 per cent of all people admitted to critical care units were younger (under age 65); younger people also had longer critical care unit stays than older people (6.5 days versus 4.7 days on average).

52.8 per cent of total in-patient hospital days in 2 years were used by persons under the age of 65.

25.1 per cent of high users by repeat admissions and also days of care were rural people — 20 per cent of Albertans are 'rural'.

2.15 per cent of all people admitted (6,060/year) waited in hospital for a nursing home or rehabilitation bed.

(Source: Who Uses Hospitals in Alberta?)

on health services utilization and health policies, although primarily in relation to aging, ageism and end-of-life care.

Her recent studies from Who Uses Hospitals in Alberta? has shown that:

a) Many common beliefs are only myths.

b) Many changes to the health system are made without research evidence to support them.

c) Health care has changed. It is possible now for someone to become ill, see many doctors and nursing practitioners, have many tests, undergo a series of treatments and pass away — without spending a single night admitted to hospital.

Her research shatters the myth that Seniors are "clogging up hospital beds" in Alberta.

For every one older person admitted to hospital, four or more younger people are admitted. The great majority, 84.3 per cent, of all people who went to hospital for emergency care were under 65 years of age.

The facts support that myths exist around ageism, particularly involving Seniors 65 and over.

To Alberta Council on Aging, this is welcome confirmation that Senior Albertans are NOT the largest users of Alberta hospitals, emergency rooms (ER), out-patient departments (OPD), or day surgery.

Wilson's study is based on two years of population-based evidence — not a small sample, but every individual who was served in an Alberta hospital, ER, OPD or day-surgery between 2006 and 2008.

Dr. Wilson integrates the extensive data that she discovered from the health records of the Alberta population — over 3 million people.

She summarized for the audience her findings:

1. Hospital utilization data revealed that younger persons are the most common patients to be admitted to hospitals in Alberta for one or more days of in-patient care, as well as the most typical patient admitted to Alberta hospital ERs, day surgery clinics, and outpatient clinics.

For each older person admitted to a hospital bed for in-patient care, 3.25 younger persons were admitted. For every older person admitted to a hospital for ambulatory care, 5.4 younger persons were admitted. Although it could be said that older people are more at risk of being admitted to hospital as compared to younger people and that older people are more at risk of admitted for ambulatory care than younger people, as reported by other researchers (Blackwell et al., 2009), the fact remains that hospital patients of all kinds basically reflect the popula-

SPECIAL REPORT: WORKING TOGETHER

tion distribution of Alberta — a province that is comprised of 89.3 per cent younger people.

This study clearly shows that older people are not the only Albertans who have health problems, and who seek to have these health problems diagnosed and treated. Instead, this study shows that younger people are the primary users of hospitals in Alberta. This use of both in-patient beds and ambulatory care services in hospitals by younger people is surprising and concerning. These finding indicate attention to the health and health-care needs of younger persons is warranted.

Dr. Donna Wilson

2. Some past research has suggested that with the hospital downsizing that occurred across Canada in the 1990s, including the 50 per cent hospital bed reduction in Alberta (from 13,000 to 6,500 hospital beds in 1993-95), only old people are admitted to hospital beds now, as younger people have been shifted to ambulatory care for outpatient tests and treatments (Sheps et al., 2000).

This Alberta study shows instead that younger people are the most common in-patient as measured by admissions and also by their share of total bed days. This study also found both older people and younger people receive ambulatory care. For each person of all ages who is admitted to a hospital bed for in-patient care, 20 more are admitted to hospital for ambulatory care.

3. It is also important to emphasize that only slightly more than 8 per cent of Albertans are admitted to an in-patient hospital bed each year now, while over 40 per cent of all Albertans are admitted each year to an ambulatory care area in these same hospitals.

Although much concern about health-care technology advances leading to additional expensive and perhaps futile treatment in hospital beds has been raised in the past, health care technological and knowledge advances have clearly made it possible for the vast majority of health care to be delivered on an ambulatory or outpatient basis.

Ambulatory care is much less expensive to provide than in-patient hospital care. Ambulatory care is also easier to plan and deliver as compared to in-patient hospital care that is provided 24 hours a day and 7 days a week, and to people who have much more serious health issues than those who can receive ambulatory care.

4. The concern, however, with this well-established and ongoing shift to ambulatory care is that the burden of pre- and post-ambulatory care is shifted to the patient and also often their family or friends. Although some tax credits exist for working people who claim medical expenses; there are few other ways that the time, effort, and expense of this ambulatory shift are addressed now. Older people and rural people are the most at risk of being burdened with this shift to ambulatory care.

Older people and rural people are also more affected by another shift, this being the consolidation of major tests and treatments at a few large urban hospitals. The cumulative effect of travel can be extremely burdensome; as it is now possible for a person to become ill, have many different diagnostic tests and many procedures performed, and pass away – without ever having spent a single night as a hospital in-patient.

Dr. Wilson concluded that research is important for correcting myths about aging and for preventing ageism, the intended or unintended prejudice against older people. This study of recent, complete, and population-level hospital data, which sought to clarify the use of hospitals by older and younger persons, clearly demonstrates that people of all ages can have health problems and a need for health care. Many more points could be made and concerns raised over the findings of this study, but the most important concern is that younger people are responsible for a large share of hospital in-patient and ambulatory care services provided across the province. In short, the people who currently use hospitals across the province basically reflect the population of Alberta — a province that is 89.3 per cent comprised of younger people.

Following Dr. Wilson's address, four specialists shared their perspectives on Seniors issues.

Dr. Kathy Kovacs Burns

Our panel discussion was led off by Dr. Kathy Kovacs Burns, MSc, MHSA, PhD. As the Associate Director of the Health Sciences Council at the University of Alberta, Kovacs Burns co-ordinates interdisciplinary and interprofessional research,

SPECIAL REPORT: WORKING TOGETHER

education and practice for the Health and Medical Faculties (U of A).

Her research, teaching, conference presentations and publications include analysis of local, national and international health and social policies and related decision-making processes, policy influencers and the impact of policies. This includes working with researchers and community members on aging, Seniors' issues with health care and policy impacts.

Dr. Kovacs Burns is the Chair of Creating Synergy: Health Coalition of Alberta. She is the Past Chair and on the Executive of the national patient/consumer organization called Best Medicines Coalition of Canada.

The Health Coalition of Alberta will advocate for people-centred health care in Alberta. As of September 2009, Kovacs Burns was named to the Minister's Advisory Committee on Health, giving many of us hope that a research-based, citizen-centred approach to health policy development will be more likely.

Mission: Creating Synergy: Health Coalition of Alberta is a coalition of voluntary groups advocating with a united voice for better access to optimal health care for all Albertans. Its principles are: commitment to the public good, integrity and honesty, respect for stakeholders, commitment to accountability and good governance. Alberta Council on Aging is delighted to be a liaison to Creating Synergy.

In 2008-09 its activities included strategic planning and fund raising, meetings with Alberta Health and Wellness on the Pharmaceutical Strategy, as well as the Alberta Drug Program and Therapeutic Substitution (of drugs0.

What Creating Synergy can offer to the Alberta Council on Aging is to support and address relevant issues:

a) Health and drug programs.

b) Continuing and long-term care.

c) Mental health considerations.

d) Background evidence/information for position papers.

e) Participation in meetings with government and others.

f) Workshops.

g) The-soon-to-be-released Patient and Stakeholder Engagement Framework.

Creating Synergy: Health Coalition of Alberta, and Chair, Dr. Kovacs Burns would welcome your inquiries, support (emotional/financial/volunteering) and interest through their e-mail: creatingsynergy@telus.net

It is critical that this kind of initiative be supported by all organizations who claim to represent the interests of Seniors, especially, but all Albertans for an equitable and patient-centered health system.

Carol Wodak

Carol Wodak of www.continuingcarewatch.com presented Mainly Seniors Housing. From the personal perspective of her mother's elder care and end-of-life, Carol wove a tapestry of Government of Alberta promises toward Seniors' housing over two decades and outcomes of reporting measures wait lists, home care and basic care for Seniors. Clear definitions of distinctions of care settings do not exist; appropriate housing and care are clearly related to income. Her presentation was titled Mainly Seniors' Housing. Her presentation opened with some basic questions.

"Who, what, why, when, where, and how? These are good questions to ask when one is investigating an issue. For the purposes of this discussion, I'm talking as a citizen about publicly funded housing with concomitant support and care for persons over the age of 65.

1. "Whose concerns? Which Seniors? What housing?"

We all filter information and see or come to a position on an issue through our personal experience and beliefs — but we seldom disclose those filters when we talk to others. And even worse, we usually reach our conclusions on an issue without regard or respect for the experience of others. We sometimes think differently when we're making a personal decision or choice.

For instance, when I'm buying a car, I consider my personal preferences and priority needs, and how much I can afford to pay. But I also look at consumer reports, safety and efficiency experience, resale value, future maintenance cost and resources, and the reliability of the vendor. I can't avoid the insidious effect of skilled marketing promotions, but I do consciously try to balance that with the best evidence I can find.

We don't have the same opportunity with health and elder care decisions. Our choices are limited by our access to information and knowledge, urgency and trauma, what services are available, and by barriers (includ-

SPECIAL REPORT: WORKING TOGETHER

ing financial and transportation) to accessing services.

2. My experience and concerns

My mother thought she had resolved her concern, as a Senior with a limited pension, about housing when she moved to a subsidized Seniors' independent living apartment after her retirement. She was in good health and active; and it worked, with gradually increasing family support, for 10 years. If things had continued in this best possible scenario, I wouldn't be here today.

The problems started with her first disabling stroke in 1995. Within a few months, the medical conclusion was that she was incapable of living alone, and the cognitive disability was progressive. But because she could still feed, dress and toilet herself, she was not eligible for publicly funded residential or personal care until 2001, when a stroke partially paralyzed her left arm and leg.

In the course of the decade from 1996 on, we encountered almost every aspect of elder care: primary medical care and diagnostics; assessment of care needs; rehabilitation and maintenance therapies; support for informal caregivers; home care; "community resources"; supportive housing; and finally the continuing-care centre (a.k.a nursing home). None of these elements of elder care is separable from the others, and they are a continuum of increasing need for most Seniors at the end of their lives.

But we provide and fund selected services separately and we have got to the point where we think about health care and elder care, pensions and taxes, social housing and transportation, each in their own silo. We even divide each issue into silos — so we talk about wait lists separately from home care and facility staffing; tenancy protections are not considered in supportive housing; prescription drugs are not part of health care; dental care, hearing and vision are not "medically necessary" services.

3. So – whose concerns?

Yours, as a Senior or a family member (or friend) of a Senior? Or the concerns of an investor? A care service provider? An insurance or pharmaceutical industry representative, looking for a market or increased profits? An MLA, anxious to comply with the government's budget edict?

What do you know about the housing and care that is or will be needed? Some of the premises of Alberta governments for the last two decades on these issues have been:

Dr. Kathy Kovacs Burns

- The free market provides the best services.
- Minimal regulation of that market is safe and effective.
- Health care is an economic driver and a business (like General Motors).
- Health care is limited to medical services provided by doctors and in hospitals.
- People should be responsible only for their own well-being.
- Illness and disability are consequences of bad individual choices.
- Health prevention will replace the need for health care services.
- The increasing elderly population is the major cost driver of increasing health care costs.
- Decisions about health care and related public policy be made by "experts."
- Albertans are independent, and willing to pay pri-

SPECIAL REPORT: WORKING TOGETHER

BY THE NUMBERS: SENIORS' HOUSING IN ALBERTA

Carol Wodak has analyzed Seniors' housing in Alberta. She wonders which Seniors the policy makers are concerned about:

The **60 per cent** of Seniors with incomes under $24,000 who may have difficulty paying market housing costs?

The **nearly 100 per cent** of Senior homeowners who are facing increasing costs of maintaining a house?

The **40 per cent** of Seniors who will need accommodation with increasing long-term personal care and support because of gradual impairments to living independently, even with "good health"?

The 7 per cent of Seniors who will need continuous nursing care and total personal care for several years?

The increasing costs, in financial, social and personal measures, of shifting responsibility to families?

What about those in between these statistics, or where the statistics overlap?

What about regulation and monitoring? Public reporting, consumer protections, safety and quality of both goods and services? How do we measure outcomes?

Who should pay?

Finding out what needs exist, and where?

(Source: www.continuingcarewatch.com)

vately in order to have choices.

• Only basic medically necessary services should be funded by public health care insurance.

Do these match your values and expectations?

What will we measure, and who will assess, the success of a policy?

In 1999, the University of Calgary Health Utilization Research Centre, in a background study commissioned by the Broda Long Term Care Review Committee, advised that utilization is not a measure of need, and recommended that "the extent and appropriateness of substitution of community care for institutional care, the quality of that care, and questions of whether health outcomes are better, worse, or unchanged, are important subjects for further study."

This was a clue: no one had been asked to survey needs, and there was no evaluation of the outcomes of existing services.

That has not happened. In fact, public reporting of measures has steadily been declining, terms of reference for evaluations have changed to "customer satisfaction surveys," and ministry targets have become a self-serving promotion. For instance, the measure of success of the Alberta Senior Benefits program is an estimate of how many Seniors are aware of the program. Wait list reporting for long-term care has been discontinued, and we have never seen wait list reports for other care settings or housing.

We know that the Aging in Place strategy has resulted in backlogs and wait lists for an appropriate level of care throughout the system, from the home care, independent living apartments and lodges through assisted living, supportive living, coordinated care programs such as Edmonton CHOICE (comprehensive home options for integrated care of the elderly) to acute care hospitals to long term care centres. And we know that many Seniors do not get the care they need.

4. Which Seniors?

In 2008, SALT published *Alberta's Elders Are Worried!* describing the context of our concerns about the continuing-care system. It is still a good basis for describing Seniors' care issues, but does need updating; circumstances have gone from bad to even more worrisome at an increasing pace in the last two years.

The process of aging, the opportunity for preventive and maintenance care to ward off increasing dependency, the odds of debilitating frailty and illness, the impact of unexpected medical trauma, are a continuum with a million possible variations — and there's no guarantee for anyone.

SPECIAL REPORT: WORKING TOGETHER

BY THE NUMBERS: WHERE DO SENIORS LIVE?

In 2006, about **70 per cent** of Alberta Seniors live in homes they own (**61 per cent** in single family detached homes).

Seven per cent live in provincial housing settings; **3 per cent** in long-term care facilities and **19 per cent** in rental accommodation.

Average monthly cost for Senior homeowners was **$590**, while gross rent was **$749**.

Most (**90 per cent**) Senior households consisted of one or two persons; **12%** had children living in their home. **One per cent** of Alberta children live with grandparents, without the presence of parents.

Four of every 5 women aged 75 and over lived alone. **82 per cent** of Alberta Seniors live in urban areas, and **61 per cent** live in Edmonton and Calgary.

The proportion of Seniors with a mortgage has been rising since 1996.

(Source: Carol Wodak and Alberta Seniors)

Forty-seven per cent of Alberta's Seniors reported a health-related disability that limited daily activity (a rate four times that of persons aged 15 to 64). Of those Seniors, 36 per cent reported a severe disability. The most common disabilities were mobility (34.4 per cent), agility (32.3 per cent), pain (29.2 per cent) and hearing (20.5 per cent).

5. What housing?

Government-funded Seniors' housing, like other Seniors' programs, is a financial assistance program — although in this case the "financial assistance" goes directly to the developer in the form of grants, which over the past decade have increased from 11 per cent to 50 per cent of the capital costs.

In return for these grants, the developer provides "affordable" supportive housing for Seniors. This means a housing charge (which includes meals) of not more than the cost of a private room in a continuing care centre — currently $1,650 a month, or $19,801 a year. (Perhaps coincidentally, or not, the combined OAS, GIS and average CPP pension now is $1,641.83 per month – but the average CPP for women is less than for men.

Other social housing (without additional "hospitality services") is available to Seniors. In 2009, maximum qualifying income in Edmonton was $29,500 for a bachelor unit, $35,300 for a one-bedroom unit. Rent, which includes heat, water and sewer expenses, is based on 30 percent of a household's adjusted income. Financial support is also available through several programs form the provincial and federal governments for specific purposes related to housing cost and adaptation.

The latest fads in Seniors' housing are life-lease and condominiums; both offset the developer's challenge of capital investment by collecting recovery cost up-front from the buyer. One of the attractions is that a couple can live together. In some cases, however, tenancy depends on one partner in need of the facility's care services, and if that partner dies, the survivor may have to vacate. As in all supportive housing, the tenancy conditions (including additional charges and care fees) depend on the individual contract.

A headline in the *Edmonton Journal* on June 23, 2009, read: "Edmonton has Alberta's most affordable seniors housing, CMHC says." I was intrigued, because what I was hearing from friends in, and looking for, Seniors' housing was a different story. The *Journal's* story focused on the Calgary ($2,679) and Edmonton ($2,091) average rents for all unit types where the resident does not require care. The CMHC surveyed 82 private or non-profit residences (7,073 spaces with 9,068 residents) where the majority of residents are 65 years of age or older and have access to additional services, such as meals and housekeeping, and available care services that not offered in traditional rental structures.

The rents ranged from less than $1,500 (10 per cent of the spaces) to more than $3,000 (18 per cent), with an average of $2,334 per month ($28,008 per year). The rent may or may not include meals.

The vacancy rate in Alberta for a standard retirement

SPECIAL REPORT: WORKING TOGETHER

home space averaged 5.9 per cent (1.6 per cent for spaces renting for less than $1,500 per month, and 10.4 per cent for spaces renting at $3,000 or more).

While most facilities have "on-site medical services," neither the services nor the charges are defined. The average monthly rent for a "heavy care" space (more than 1.5 hours a day) rents for an average of $3,169 in Calgary and $3,980 in Edmonton; 371 of the total 7,073 spaces are heavy care.

The care needs that Seniors' housing must meet are varied, but the varieties and cost of housing and care are infinite. The Alberta government has tried on several occasions to develop categories and definitions, but so far has not succeeded with any clear definitions or distinctions of care settings.

6. The ability to find appropriate housing and care is clearly related to income.

In 2008, the Alberta Demographic Planning Commission reported that the average pre-tax income of Senior families in 2005 was $56,000. Meanwhile, Statistics Canada reported that the 2006 median after-tax income of Alberta Senior families was $46,100; for women, $21,300, and for men, $20,700.

Alberta Seniors and Community Supports reports that income support for Seniors is working because Alberta Seniors' average total before-tax income is higher than that of Seniors in other provinces. That is true; but this measure ignores several factors: the cost of living in Alberta compared with other provinces; the difference between Seniors and non-Seniors income in each province; and the reality that after-tax dollars buy goods and services. The gap between the median after-tax income of Seniors and non-Seniors is significantly greater in Alberta than any other province — and Alberta personal income tax for the lowest tax bracket is the third highest in Canada.

Given that the private market is the keystone of Alberta seniors housing and care policies, this measure of success is dubious. The same report indicates that nearly 40 per cent of Alberta's seniors had total incomes under $22,000 for a single senior or $35,900 for a senior couple and thus qualified for cash benefits under the Alberta Seniors Benefit program.

7. Are there alternatives to the Alberta way?

The idea of "aging in place" did not originate here. What we have is a Danish model badly translated via the United States. Before the shift to community care was a gleam in the eyes of Alberta politicians, the Danes had carefully planned a transition of elder care services to community settings, including community housing settings. Instead of fragmenting services and shifting responsibility to individuals and investor providers in a private market, Denmark took responsibility for providing an integrated care system. This model is followed throughout northern Europe, with variations.

It is part of the inclusive health and social care systems, rather than a replacement or competition. It is publicly funded; it includes private providers who meet the contract requirements of quality and cost; it eliminates the "Alberta Seniors' shuffle" by simply providing more care — whether personal, medical or social — where and when it is needed. There was an initial public cost; the net result is stable operating public expense, healthier and happier Seniors, and less cost to other components of the health care system.

Dr. John Bachynsky

Dr. John Bachynsky shared an analytic report, *Pharmaceutical Strategy Falsities*, about pharmaceuticals in Seniors' lives in Alberta, with a close analysis of the Seniors Pharmaceutical Strategy. With a background in pharmacy administration (PhD, 1967) and as Director General in charge of long-range planning in the Federal Health Services Directorate (1970), Dr. Bachynsky's credentials are impeccable to analyze and comment on this Alberta dilemma due to become law on July 1.

Firstly, the new drug program for seniors as outlined in the Pharmaceutical Strategy document contains arguments that are false and misleading.

The plan is voluntary based on Seniors' income with on insurance premium and a co-payment for benefit drugs. If a Senior does not enrol but becomes ill, he or she must pay premiums for three months before being eligible for benefits. This is not integrated care; this is not patient-focused care.

In the policy document it is stated that pharmaceutical expenditures are due to the high price on new drugs. The Seniors Drug Benefit Program has few new drugs.

A number of factors begin on July 1: a revised reimbursement of pharmacists will begin; initiation of the revised Seniors Drug Benefit begins the same day —

SPECIAL REPORT: WORKING TOGETHER

thousands of drugs, beneficiaries, pharmacies functioning through a third party (Government of Alberta Program); without delays?

Vision 20/20 listed integrated care and patient-focused care, but the Pharmaceutical Strategy was developed after a consultation process that included fifteen pharmaceutical companies and two persons representing senior's organizations! Instead of universal coverage, a means test was proposed — no public consultation.

The impression is gained that health planning is proceeding independently for each budget area without a mechanism to set priorities based on health outcomes.

Noel Somerville

Noel Somerville

Political Chicanery was the title of the presentation by Noel Somerville, Chairman of the Public Interest Alberta Seniors' Task Force. During his 33-year career in education, Somerville developed a sharp wit and keen observation skills. He spoke about the trickery the current Alberta government has used to strip Alberta Seniors of so many of the benefits that they have traditionally enjoyed.

"Chicanery" is not a word I use very often, but the title was assigned to me by Floyd Sweet, whose vocabulary is a little more colourful than mine.

Nonetheless, I understood perfectly when he suggested the title. He wanted me to 'bell the cat' and talk about the trickery the current Alberta government has used to strip Alberta Seniors of so many of the benefits that they have traditionally enjoyed.

Initially, we were lulled by one of the first statements "Steady Eddie" made when he became Premier: "The Third Way is D.O.A." That followed a leadership campaign that produced only comforting platitudes about Seniors, and an election campaign in which Premier Stelmach promised 600 new long-term care beds.

Accordingly, we were all a little surprised when Ron Liepert was appointed to replace Dave Hancock as Minister of Health. He came into his new office like a horde of the Sorcerer's Apprentice's new brooms. He swept away nine Regional Health Authorities and replaced them with a centralized Alberta Health Services Board, made up of high-profile business types who, he said, could run our health care system like a business.

When asked what the purpose of all this change was, he played coy. He said he wasn't about to follow in the footsteps of Ralph Klein, who made the mistake of actually explaining what the Third Way meant.

Nine months into office, Liepert unveiled his first and hopelessly flawed Pharmaceutical Strategy. Billing it as a way of providing free prescription drugs to low-income Alberta Seniors, he never did acknowledge that it was a giant bonanza for the insurance industry and the death knell for the universal prescription drug program that Alberta Seniors had enjoyed for many years and on which they had planned their retirements.

A week later, as we were all readying for Christmas, he announced his Continuing Care Strategy. Couched in terms of "aging in the right place" and "choice," along with promises of vastly increased home care (none of which materialized), it also froze the number of LTC beds at 14,500, a number that existed for some time and had proven to be totally inadequate to meet the need.

Instead, frail Seniors were expected to settle for assisted living, where the cost of not only accommodation, but also medications, medical supplies and much of the care they require is off-loaded onto them.

The story goes on:

- The revised Pharmaceutical Strategy was introduced with premiums based on income and the requirement that Alberta Blue Cross triple its non-group insurance rates.
- While other jurisdictions were countering the global economic crisis by trying to stimulate their economies, Alberta used it as an excuse for further cuts.
- Steven Duckett was brought in from Australia to make those "tough decisions."

The rationale underlying all of this is the supposed need to preserve the sustainability of our health care system and the imminent threat of being overwhelmed by the aging baby-boom generation. The threat to the sustainability of our health care system is a myth.

Over the past 20 years, Alberta has been spending about five per cent of GDP on public health care and about six per cent of GDP on all health care. Even now, with depleted resource revenue, we are slightly over seven per cent of GDP.

By contrast, Canada spends over 10 per cent of GDP

SPECIAL REPORT: WORKING TOGETHER

on health care and the private health-care system in the U.S.A. costs about 16.3 per cent of GDP, with another three per cent of GDP on health and insurance-related litigation which doesn't exist in our single-payer system.

What is unsustainable is a taxation system overly reliant on volatile revenue from natural resources. Our government prides itself on the Alberta Advantage, by which they mean low levels of taxation, at least for corporations and the wealthy. They seem oblivious to the facts that:

- Alberta is the only debt-free province.
- The sustainability and capital funds have assets close to $15 billion.
- If the Heritage Savings Fund and other reserves are included, Alberta's assets are about $44 billion.
- Our 10 per cent flat tax introduced in 2001 alone robs us of $5.5 billion a year in tax breaks to wealthy Albertans.
- If Alberta taxed as other provinces do, we would generate between $10 and $18 billion more a year.
- Unlike other provinces, Alberta has no sales tax, no capital taxes and the lowest general business taxes of any province.

As for the baby-boom generation, we have known about that phenomenon for the past 50 years and we still use terms like tsunami to describe it as if it were coming at us out of the blue. As Greg Flanagan's 2008 study shows, the increase in the Senior population and their need for increased health care can be accommodated by increasing our health-care budgets by 1.23 per cent a year for the next 20 years.

Alberta, in fact, has the least problem of any province in accommodating its aging baby-boom generation. In 2006, we had the lowest median age (35.8 compared with the national average of 38.8). We also had the smallest (4.93 per cent) population age 75 and older compared to the national average of 6.27 per cent.

Premier Stelmach continues to assure us that he will "protect the most vulnerable citizens," while closing Alberta Hospital beds and cutting funding. Fewer and fewer Alberta Seniors who are frail, infirm or mentally incapacitated will be able to access the publicly funded care they need, and all of this will be rationalized as "providing choice".

Thinking back to the early days of this administration, I would suggest that the ultimate form of political chicanery is a government that is elected on one platform and governs on another.

Setting priorities for Seniors

The Alberta Council on Aging is thankful to these professionals for their expertise and credible educational values for ACA to take forward to Seniors and to Alberta government departments to complete their education.

With lunch over, the afternoon task was to focus on the various first priorities of the Seniors organizations present, and to seek the possibility of discovering a first priority for the group for the immediate future. The participating groups included:

- Alberta Council on Aging.
- Alberta Retired Teacher's Association.
- Canadian Association of Retired Persons, Edmonton.
- Crooked Lake Seniors.
- Public Interest Alberta, Seniors Action Committee.
- Seniors Advisory Council of Alberta.
- Seniors Advisory Liaison Team.
- Seniors Community Health Council.
- U of A Faculty of Nursing.
- U of A Faculty of Pharmaceutical Sciences.

HEALTH was clearly on everyone's mind with two priorities named, one short-term and one longer- term.

1. The short-term topic is a universal drug benefit program for Seniors incorporating many of the 20/20 principles and setting aside the current knee-jerk proposal of the Pharmaceutical Strategy.

A strategy to achieve the goal is a plan to replicate the educational program we experienced today, but with a much larger audience — research roll-out:

i) Who uses Alberta Hospitals (2006-2008)

ii) Who uses Emergency Rooms (ibid)

2) The longer-term goal is to gather research to support the principle that medical services must be provided on a free, universal basis regardless of age.

Lots of work lies ahead, but there are many Seniors organizations to help. The group was excited about our educational strategy — people in their 40s, 50s 60s and older need to learn what's in their health future! And we will guarantee to educate with FACTS. If you are interested in participating in future meetings, please contact the ACA office at 1-888-423-9666.

Floyd Sweet on behalf of ACA Policy Advisory Committee, and ACA Health Committee (Doug Janssen, Chair)

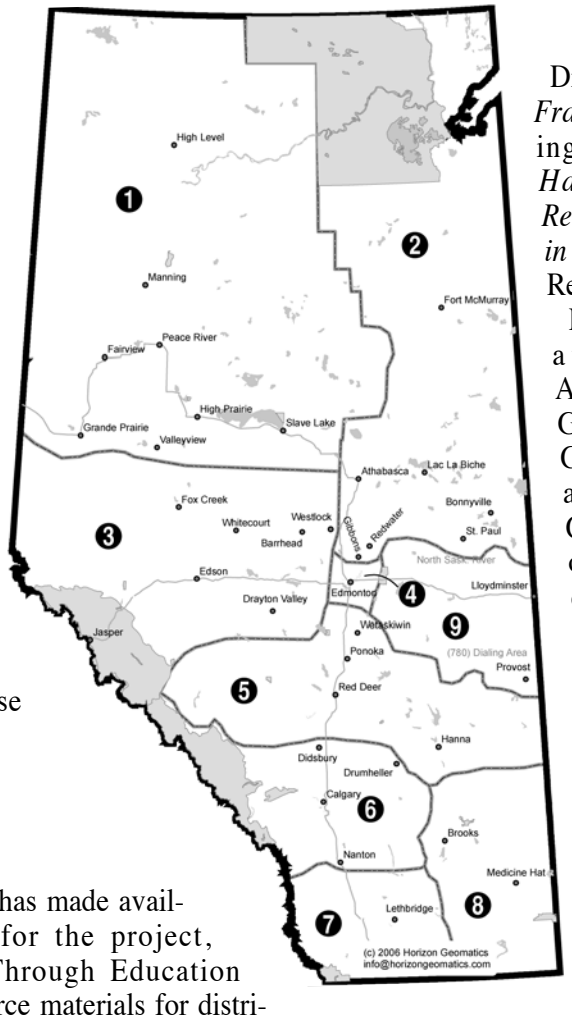
REGIONAL REPORTS

Region 2

We now have a supply of the DVD and booklets, *A Senior's Guide to Fraud Prevention*, which I will have at our upcoming district meeting.

We recently had our first executive meeting of this year. With the change in government ministers, we revisited some topics. Our first general meeting will be on Feb. 25 at 1 p.m. at the Heritage Society at 10122 102 Ave in Lac La Biche. Topics for discussion will include the pharmaceutical plan, training for health-care aides and more discussion on the continuing-care strategy. We are looking forward to good attendance. Please come and voice your concerns.

Diane Walker



Region 3

The Alberta Council on Aging has made available the resource materials for the project, Prevention of Elder Abuse Through Education (PEATE). I have received resource materials for distribution throughout Region 3. These include:

- *Helping Hands, A Service Provider's Resources Manual for Elder Abuse in Alberta*.
- *A Senior's Guide to Fraud Prevention*.
- The DVD *Stop Financial Fraud: Protect You & Your Finances* is an informative presentation by Brian Trainer, a retired police fraud detective The DVD presents emotional testimonials on power of attorney fraud, telemarketing scam, home improvement fraud, identity theft and internet fraud.

Next, I will be working on arrangements for dissemination of the above-noted elder abuse information at various Senior Centres in Region 3, as well as other community support organizations.

As noted in the December 2009-January 2010 issue of *ACA News*, the *Financial Fraud Handbook* will be forwarded with membership renewals.

Audrey Zilli, Director, Region 3

Region 5

Distribution of *A Senior's Guide to Fraud Prevention* with accompanying DVDs as well as *Helping Hands: A Service Provider's Resource Manual for Elder Abuse in Alberta* has begun to roll out in Region 5.

Public Interest Alberta presented a town hall meeting "Join Together Alberta.ca" which was held at the Golden Circle Seniors Resource Centre with over 150 people attending. The Central Alberta Council on Aging joined many organizations that are deeply concerned and want to take action on the government's plan to cut $2 billion from the upcoming budget. The CACA supported this campaign and some members acted as facilitators during the presentation.

Guest speakers were: Diana Gibson, Research Director, Parkland Institute; Bill Moore-Kilgannon, Executive Director, Public Interest Alberta; David Eggen, Friends of Medicare; Steven Kwasny, President of the Student's Association, Red Deer College; and Sam Denhaan, President of the CACA. Each table presented methods to develop a community action plan to challenge the cuts. As well, each table had pieces of fabric on which to write messages to the government. On Feb. 9 (Budget Day), there will be an rally in downtown Red Deer and the fabric chains will be taken to the offices of Red Deer MLA's Mary Ann Jablonski and Cal Dallas. All participants were given a tartan scarf (Alberta's tartan colours) and asked to wear the scarf to promote the campaign.

The CACA February General Meeting featured four speakers:

- Linda Healing, Communicator Facilitator, Social Planning and Franklin Kutuadu, Community Researcher from the City of Red Deer presented "Understanding Seniors Mobility and Suitable Transportation in Red Deer." This presentation reported the results of a

research project that took a comprehensive approach to study Seniors' transportation needs and options — a necessary first step to discover what constitutes suitable transportation for Seniors. Several areas of responsibility were established from recommendations of the study and as a direct result transportation innovations have started and will be ongoing.

Caroline Gee, Program Co-ordinator, Advocacy and Community Services of the Alberta Motor Association (AMA) gave an overview on Seniors Transportation Initiatives. One of the critical issues is: transportation involves government and the medical community struggling with fitness and testing standards; the emphasis has shifted from the age of the driver to the medically at-risk driver. Individuals who drive or have access to alternate transportation have a better quality of life. The AMA offers several types of Driver Education Courses. The Driving Angel Program recognizes drivers who provide transportation to Seniors in the community. This is a new program and the goal is to offer this program to all communities in Alberta.

Dr. Scott Oddie, Rural Health Research Chair, Red Deer College, presented an overview of the research project that is underway: "Medication Review to Enhance Independence and Health for Seniors in our Community." A partnership of the Health Research Collaborative (an applied research program of the Building Healthy Communities Through Learning and Collaboration Charter between RDC and Alberta Health Services-Central Zone) and the Central Council on Aging is developing a project to reduce adverse medication effects. Dr. Oddie indicated that more than 50 per cent of emergency room visits and 70 per cent of Seniors admitted to hospital for hip fractures were directly related to adverse medications. This important research aims to provide evidence to support a change in health practice that will hopefully reduce costs to the health-care system and improve the health and independence of seniors in our community.

Tatiana Poliakevitch, Outreach Librarian, Red Deer Public Library, outlined the services available for seniors, including a Homebound Readers' Service, Large Print Books, Audiobooks as well as One-on-One Computer Instruction.

Region 8

Working on distributing and promoting PEATE (Prevention Elder Abuse Through Education) resources has been going well in our district. In this process, I have encountered individuals and groups committed to decreasing elder abuse. One such group in our district is CRANE (Community Response to Abuse and Neglect of Elders). This is a council of 47 service providers and stakeholders addressing the problem of elder abuse through a collaborative, community-based approach. The CRANE Council was initiated in 2004 with the Veiner Centre in Medicine Hat as the focal point of contact. The members have been very enthusiastic about the resources available through PEATE. I attended my first Council meeting on Jan. 27 to introduce the program and enjoyed meeting some of the members. We all found the presentation on the revamped Adult Guardianship and Trustee Act to be very informative. The new act seems more flexible and responsive to the needs of individuals than the old. We were all encouraged to have a Personal Directive in place to avoid the necessity of becoming personally involved with the Act. Stay safe and well.

Beth Turner

Deadline near to apply for student subsidy

Not-for-profit organizations in Alberta have until Feb. 28 to apply for the Summer Temporary Employment Program (STEP). STEP is only available this year to secondary, post-secondary students and recent graduates.

Each summer, the provincial government program creates summer employment opportunities for students, while subsidizing wages paid by employers to encourage higher salaries. The program offers employers a wage subsidy of $7 an hour.

More than 2,000 STEP positions will be available this summer.

Employers must provide continuous, full-time employment between 30 and 40 hours per week, up to a maximum of 16 weeks. Priority will be given to employers offering full-time employment related to students' education and training between April 26 and Aug. 27.

Eligible employers include registered not-for-profit community organizations, First Nations bands, Métis settlements, municipalities, regional school divisions and post-secondary institutions.

Eligible employers must complete applications which are available online at www.employment.alberta.ca/step.

LETTER TO THE EDITOR

There's more than one way to create a budget

One way to make a budget is to decide what services need to be provided — for health care, Seniors' care, education, infrastructure etc. — then calculate how much it will cost to provide those services, and then figure out how to raise the necessary funds.

Another approach would be to decide arbitrarily how much you are willing to spend on a program or set of services, and then see how much you can get for that amount and somehow make do with it. If it's not enough to provide what's needed, tough luck. You'll have to cut some services, no matter how important they are.

The provincial government is following the second approach regarding health care. First, they gathered all the decision-making power unto themselves by dissolving all the regional health authorities.

Then they appointed a board of 15 people and instructed them to run the health-care system within the allocated amount set by the province. The government even promised the health board's CEO a whopping bonus if he was able to stay within this amount. (*The Edmonton Journal* reported on Oct. 27, 2009: "Duckett is paid $575,000, plus a potential $144,000 bonus if he can increase patient access and service quality while cutting $1 billion from the health budget.")

The new board is an odd collection of seven senior business executives, two lawyers, two engineers, a chartered accountant, two academics (one of them a physician and director of research from Toronto) and for some reason an advertising and public relations executive and consultant from New Jersey.

Although several have served on boards of directors related to health care, not one is actively involved in the provision of health care. The board members are appointed by the provincial government, not elected, and thus are not accountable in any meaningful way to the people they are supposed to serve.

Are Health Care Costs out of Control?

Why would the government choose this approach to budgeting? They say that they have to contain health-care costs, that we can't afford to continue offering the services that have been available. But for the past 10 years or more we have been told the same story: That health care is too expensive, that health costs are spiralling out of control, that if we don't stop this trend we will soon be overwhelmed by health-care costs. Is that true?

Of course health care costs are going up. Inflation drives up the costs -f everything. Besides that, the population of the province is increasing, the percentage of Seniors is increasing, new treatments and technologies are being introduced, and the cost of prescription drugs continues to climb, especially for newly developed treatments.

But in spite of all that, health-care costs in Canada are NOT spiralling out of control, and are NOT out of line with other countries. Provincial and territorial health-care expenditures account for about two-thirds of total health-care expenditures in Canada. (The rest are paid privately, either out-of-pocket or by company and private insurance plans.) The average government expenditure for all of Canada in 2008 was $3,330 per person. This put Canada in the top fifth of the OECD countries, similar to France, Germany, the Netherlands and Austria but considerably lower than the United States at $6,714 and also behind Norway, Switzerland and Luxembourg, according to the Canadian Institute of Health Information.

Within Canada, Alberta spent $3,318 per person in 2008, less than in Newfoundland and Labrador, the Northwest Territories, Yukon Territory and Nunavut. Expressed as a proportion of gross domestic product (GDP), Alberta spent the least amount of money on health care of all the provinces. (Expenditures ranged from a low of 6.9 per cent of GDP in Alberta and 8.8 per cent in Newfoundland and Labrador to a high of 14.6 per cent of GDP in Nova Scotia and 15.3 per cent in Prince Edward Island.)

In the Parkland Institute's report *Breaking the Myth*, published in October 2009, author Melville McMillan, an economist, examines spending in other provinces and

LETTER TO THE EDITOR

concludes: "Despite the substantial growth of provincial revenues since 2000, total provincial spending per capita has been and is quite average or typical. When comparing major expenditure categories, we find that only in outlays on education is Alberta even at the top in per capita spending and even there, Alberta follows behind Saskatchewan. Most striking, given current cuts to health care, is the fact that per capita health expenditures have been remarkably low in Alberta."

Where would the money come from?

What if the government wanted to raise more revenue so that it could maintain a broad range of services? Where would the money come from? There are several possibilities.

Perhaps the government should look at getting a larger benefit from the sale of our oil and natural gas resources. The Auditor General reported in the fall of 2007 that Albertans had been short-changed BILLIONS in oil and gas revenues over the preceding three years, and there's no reason to think that things have improved since then. In the Parkland Institute's 1999 report, *Giving Away the Alberta Advantage*, the authors studied the energy "rent" collection performance of Alberta, Alaska and Norway between 1992 and 1997. "The study found that Alaska collected roughly 1.6 times more than Alberta in royalties and taxes for every unit of oil, natural gas and by-products produced. Norway collected roughly 2.7 times more than Alberta … ."

Even in Alberta during the Peter Lougheed years, oil and gas revenue rates were more than double the rates under former premiers Don Getty and Ralph Klein. Surely, there is an opportunity here for putting more money into health care.

But oil revenues are an uncertain source of revenue because the price of gas and oil can fluctuate so widely. Perhaps, instead, the government should look at tax sources. Perhaps it could implement the increase in the tax on liquor that was proposed by the premier, but then abandoned. According to an article by Jason Fekete in *Inside Alberta Politics*, (July 9) that tax would have raised $180 million, but Premier Stelmach chose to give that up. Instead, he discontinued coverage for chiropractic care, saving a mere $53 million a year, causing the interim leader of the Wildrose Alliance to ask, "If his excuse for cutting chiropractic care is due to budgetary reasons, why is he cutting taxes on alcohol?"

The province also gave up a sizeable amount when it discontinued health-care premiums — over $900 million a year. Reinstatement of this flat tax would not be popular, but might be acceptable if the proceeds were guaranteed to go to support health-care services and not into general revenues as in the past.

There is also the possibility of a modest addition to the GST, as is done in other provinces. A report in the *Financial Post* (Oct. 17, 2009) cited a study by tax expert Jack Mintz, head of the School of Public Policy at the University of Calgary, in which Mintz says the province, "which is wrestling with a severe shortfall of energy revenue and a resulting escalating deficit, needs to adopt a 'growth-oriented tax structure.' " Mintz suggests "an even braver strategy" would be to adopt a provincial value-added tax, similar to the GST.

Fools or knaves?

Think about it. Well over a decade of confusion. Health regions created and dissolved and then created and dissolved again. Massive layoffs of nurses. Insufficient training opportunities. Legislation to allow private hospitals. Privatizing long-term care. Closing or selling off or even blowing up hospitals. Introducing two different pharmaceutical strategies within a year. Abandoning the principle of universality.

Is it just incompetence and muddle-headedness that allows such chaos? Or is there the hope — maybe even the plan — that by bringing the health-care system to its knees they will be opening the door to privatized, American-style health care?

You have to wonder.

Don Hepburn
Red Deer, AB

Send your comments and letters to: ACA News, 210-14964 121A Ave., Edmonton, AB, T5V 1A3. Fax: 780-425-9246. e-mail: info@acaging.ca

EXECUTIVE DIRECTOR'S REPORT

Hundreds of renewals have gone out with more to be processed. About half of our membership has renewed to date. Don't forget to renew your ACA membership!

Senior Friendly™

Bridgewater, N.S., has developed a Community Action Plan to assist them in meeting their targets. Their committee of volunteers plans to target 51 businesses and organizations. To meet the 60 per cent goal, 31 would need to participate and achieve Senior Friendly™ designation. Beth has added falls-prevention information to the program to help raise awareness.

Marcie Hoffman
ACA Executive Director

Additionally, FCSS from the Town of Hinton and the Program Co-ordinator for the Access Nanaimo Initiative (a program dedicated to making Nanaimo more accessible and inclusive for all) have requested Senior Friendly™ information.

I am working with Edith Parsens from the Edmonton Public Library to do a review of the Check Up and training and will work towards the library signing another license agreement to continue with their designation.

ACA News Committee

ACA wishes to form an *ACA News* Committee. Volunteers for this committee must have access to the Internet and e-mail. The committee will meet five times a year either in person or by conference call to plan articles and edit content and layout for final proofing. If you are interested in being a part of this committee, please contact Marcie Hoffman at the office: 1-888-423-9666.

PLEASE RENEW YOUR MEMBERSHIP

See form on opposite page, or
Phone: 1-888-423-9666
info@acaging.ca

PEATE

Preventing Elder Abuse Through Education has begun gathering information for the Multicultural Sensitivity Guide and to seek direction for the next phase of our Elder Abuse project.

Dissemination of the resource materials has begun. Directors will ensure the materials are as widely distributed as possible. If you are interested in receiving the Financial Fraud Handbook, Financial Fraud DVD or the Service Provider's Guide please contact us at the office.

Respectfully,
Marcie Hoffman

Thank you donors

ACA would like to thank the following people for their generous donations:

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