RESEARCH REPORT

LIFE LEASE SUPPORTIVE HOUSING: COMBINING THE BEST ASPECTS OF HOUSING AND COMPLEX CARE: VOLUME 1

EXTERNAL RESEARCH PROGRAM

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LIFE LEASE SUPPORTIVE HOUSING: COMBINING THE BEST ASPECTS OF HOUSING AND COMPLEX CARE

Final Report
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Abstract

The Laurier House model of care is an innovative approach that delivers, in a condominium-like setting, the level and type of healthcare and social services that are traditionally available only in long-term care institutions. The model offers a life lease arrangement, which provides:

- Seniors the advantage of "home ownership" and enables them to occupy a more spacious suite than long-term care institutions provide
- The developing agency, through the sale of life leases, the ability to quickly recapture its investment in the building
- The Alberta government a new publicly-owned facility equivalent to a long-term care institution, which was built without any government investment
- A new way of meeting the needs of frail elderly persons who do not want to move into an institutional setting

This study examined the attitudes toward life lease housing of Laurier House clients, their families, and the professionals whom seniors consult when they require long-term care. The results provided insights into the concerns and values that both seniors and their families hold regarding life-lease agreements and condominium-style living. The model appealed equally well to both the client group who were married and did not wish to be separated from a spouse, and the client group seeking more space and privacy.

Abrégé

Le modèle de soins de Laurier House est une démarche innovatrice qui offre, dans un milieu semblable à celui d'un immeuble en copropriété, le niveau et le type de services sociaux et de soins de santé qui ne sont habituellement offerts que dans les établissements de soins de longue durée. Voici ce que le modèle de location viagère offre :

- Il procure aux aînés l'avantage de la propriété et leur permet d'occuper un logement plus spacieux que dans les établissements de soins de longue durée.
- La vente des baux viagers permet à l'organisme promoteur de récupérer rapidement son investissement dans l'immeuble.
- Le gouvernement de l'Alberta bénéficie maintenant d'une nouvelle installation publique équivalant à un établissement de soins de longue durée dont la construction ne lui a rien coûté.
- Une nouvelle façon de répondre aux besoins des aînés à la santé fragile qui ne veulent pas aller vivre dans un milieu institutionnel.

La présente étude a examiné les attitudes envers la location viagère de logement des clients de Laurier House, de leurs familles et des professionnels que les aînés consultent lorsqu'ils ont besoin de soins de longue durée. Les résultats ont donné une idée des préoccupations et des valeurs des aînés et de leurs familles concernant la location viagère de logement dans un milieu semblable à celui d'un immeuble en copropriété. Le modèle a plu aussi bien au groupe de clients qui étaient mariés et qui ne voulaient pas être séparés qu'au groupe de clients qui voulaient plus d'espace et d'intimité.

Executive Summary

The demand for supportive housing in Canada has been linked to growth in the numbers of seniors over the age of 75 (Gnaedinger, 1999). By 2031, the population over age 75 is expected to grow by 277 percent to about four million persons and the 85-plus group is expected to triple (Statistics Canada, 1994, as cited in Canada Mortgage and Housing Corporation, 2000). This suggests that a wide range of housing solutions will be needed to provide these age groups with choices that reflect their individual circumstances and preferences (Gnaedinger, 1999).

Some new solutions are already being tested. In the past ten years, a few specially built assisted living settings have increased the level of service, adding some skilled nursing services. In Alberta, these assisted living settings have served as an alternative to long-term care facilities for persons who do not require complex care (Gardner, Finlayson, Schalm, & Milke, 1998).[1] Other provinces, such as British Columbia and Ontario, also are revising their service systems.

Laurier House is a new model of supportive housing, the only model currently available that fully substitutes for a traditional long-term care facility.[2] *The* CAPITAL CARE *Group* in Edmonton, Alberta, a provider of facility-based long-term care services, developed the model, which is wheelchair accessible and designed to facilitate the provision of healthcare, and built two examples; one, Laurier House Strathcona (LHS), is featured in this report.

The Laurier House model is an innovative approach that delivers, in a condominium-like setting, sufficient services to allow seniors to age in place even when their health seriously deteriorates. LHS appeals to elderly couples because it enables them to continue to reside together while receiving services equivalent to those offered in Alberta's long-term care facilities. The costs of healthcare at LHS are funded by the health region and clients must go through the same screening process as they would to be admitted to a long-term care facility.[3] Other supportive housing may accommodate couples, but other types do not provide 24-hour access to in-house skilled nursing when one or both of the couple require complex healthcare.[4] Traditional long-term care facilities cannot afford to allow a well spouse or companion to share a room.[5] Thus, when one member of a couple needs complex healthcare,

[1] Long term care or continuing care services vary from province to province. In Alberta, "continuing care centre" has replaced two older terms "nursing home" and "auxiliary hospital." The new term better reflects the diversity in physical layouts and the availability of specialized programs for on-going care (sub-acute, palliative, dementia-care, etc.).

[2] Long term care facilities are primarily engaged in providing inpatient nursing and rehabilitative services. The care is generally provided for an extended period to individuals requiring nursing care. These establishments have a permanent core staff of registered or licensed practical nurses who, along with other staff, provide nursing and continuous personal care services.

[3] The term client is used in this report for a person in need of support and healthcare services.

[4] A second person who may live in the client's suite might be a sibling, spouse, companion, or an adult child. This second person may require no, some, or even complex healthcare services.

[5] Building costs and building maintenance typically are subsidized by the healthcare system and government funding for staffing depends on the healthcare needs of clients.

the couple face a dilemma. Typically, one spouse moves to a long-term care facility. The other remains in the current home. This has been called "divorce by nursing home" (Gladstone, 1992).

One unique feature of the Laurier House model is that it utilizes life leases to untangle or "unbundle" the costs of various services that are provided, allocating them to either the client or the health system. Housing costs, a private expense, are separated from the costs of both the publicly-funded personal support services and the housing-related support services. The client traditionally pays the latter in long-term care facilities– these are sometimes referred to as the hospitality costs or "room and board". The unbundling of such costs is a concept advocated by advisors to both federal and provincial governments (Policy Advisory Committee on Long Term Care Review, 1999). By using life leases, LHS was built without government money. The operator was able to fully recover the cost of construction through the sale of life leases and do this relatively quickly. Although a bank loan was necessary to launch the project, the financial risk to the operator was minor because the operator is well known as the publicly owned provider of facility-based long-term care in the health region.[6]

In this life lease arrangement, the clients are considered owners of their suites. This enabled the operator to allocate more space for the client – a one- or two-bedroom suite (with respectively either 617 to 627 sq ft, or 806 sq ft). This is in contrast to the 120 sq ft of private space recommended by Canada Health and Welfare (1979) for a traditional long-term care facility. By offering suites, and other features more consistent with private for-profit housing,[7] the operators were able to market LHS competitively.

The Laurier House Model was previously tested in the Edmonton market. The construction of LHS in the suburban community of Sherwood Park, which has a population approximately 7% of the City of Edmonton, was another test of the model. Although there are very few private life lease projects in Canada (Scherlowski, 2000), both private and non-profit sectors could use this model to respond to the housing needs of seniors.

The physical setting and community acceptance

LHS was built on a healthcare campus that includes a traditional long-term care facility, built in 1994, and a centre for Alzheimer's disease built in 2001. LHS opened September 17, 2001. It is a wood frame two-story building with 42 suites (one and two-bedroom) and is physically linked to the other two centres. Outside, LHS has the appearance of a residential development and inside it looks like a small hotel. At the front entrance, a reception desk at

[6] The Edmonton Rural Auxiliary Hospital and Nursing Home District No. 24 was established in 1964 to provide public continuing care (long term care) in the greater Edmonton area. In 1991, the name was changed to *The* CAPITAL CARE *Group* (TCCG). When healthcare was regionalized in Alberta in 1995, the organization became a wholly owned subsidiary of the health region, the Capital Health authority, comprised of the capital city, Edmonton, and the surrounding area. TCCG operates all publicly owned continuing care centres (i.e., long term care centres) in the health region.

[7] Approximately 60% of floor space is devoted to suites and 40% to areas shared by residents, such as dining rooms.

the side lobby serves visitors to LHS and the Alzheimer care centre. The LHS dining room occupies a central location on the main floor and its kitchen operates like a restaurant with limited hours. The manager has an office near the dining room, but no "nursing office" is evident. The exterior of the building looks like a housing development. A natural aspen grove shades the back of the property. The grounds include a walking path, a large sheltered patio, and grassed areas around the individual patios of the main floor suites. All but three of the second floor suites have balconies.

Although life lease arrangements might have been expected to be less acceptable in the smaller community of Sherwood Park than they had been in Edmonton, the rate of suite sales was comparable. At the Edmonton location, 30 percent of the suites were pre-sold and more than two-thirds were sold within six months of opening. At LHS approximately one-third of the 42 suites were sold by the completion of construction and 90% of the suites were sold within six months of opening.

The study's objectives and methods

The type of life lease arrangement offered at LHS is not well known. Accordingly, a major objective of this study was to obtain information on the deliberations that led senior clients and their families to choose this type of arrangement over other options like traditional supportive housing and long-term care centres. This information would be useful to others who might wish to develop similar types of supportive housing elsewhere.

The following were the specific objectives of the study:

- To describe the clients' needs from the perspective of all parties (i.e., clients or potential clients, their spouses, and their families).
- To identify the clients' resources, both financial and social.
- To identify the parties' choice of residence and the reasons for their choice.
- To determine the priorities of the parties in regard to resolving the issue of choosing life lease accommodation (LHS).
- To determine how professionals involved in clients' transitions from home to residential long-term care make recommendations on those options.
- To determine whether the chosen residence meets the needs of the client, from the perspective of all parties.

The information needed to meet these objectives was gathered through structured interviews using both scaled and open-ended questions. Client, companion, and family member participants were selected through a cumulative process that began with those who expressed an interest in the LHS suites. The participants came from three sources: a list of people who had spoken to the manager of LHS and expressed interest, additional names provided by participants who were interviewed for the study, and temporary residents who moved into LHS.

Interviews were held at three times, Time 1 (T1) while the participants were considering the purchase of a life lease, Time 2 (T2) a month after the decision, and Time 3 (T3) approximately one year later. During interviews, clients, their spouses, and their family

members were asked what they liked and disliked about life leases, and other pertinent questions. The initial interview asked why the clients were considering a move and the level of their knowledge of life lease arrangements. In addition, they were asked about the extent of clients' needs, their health status, current living arrangements, dissatisfaction with the current environment, and priorities for a new location. The T2 interview focused on factors that had influenced the decision of the client with respect to the move, as well as the level of satisfaction with services at the new location. The focus for the final interview with clients and spouses was on current needs, level of satisfaction with current services and location, and their thoughts on the life lease concept.

Study results

A. Interviews with clients, spouses and family members

At the T1 interview, clients and their family members expressed some disagreement about whether the clients would move. Although 94 percent of family members believed clients were considering a move, only 72 percent of clients were in accord. In most cases, clients and their families said that the plan to have the client move was precipitated by either the client's or their caregiver's decline in health; the need for increased amounts of services was said to be at the root of the need to move. A large majority of spouses (75%) said it was important to them that the clients receive more support services (this included healthcare services). In contrast, only 37 percent of clients said receiving more assistance was important to them. The clients suggested that the amount of service was the issue, rather than the particular types of services.

Family members, in some instances, were making inquiries without the clients' knowledge. Families may have viewed a move as inevitable or may have been seeking respite because they were providing substantial support to clients. At the T1 interview, the majority of family members reported assisting clients with transportation (70%), grocery shopping (70%), cooking at the clients' location (76%), delivery of hot meals (73%), heavy cleaning (70%), and laundry (64%).

Participants were asked at the T1 interview if they would consider a life lease option for the client if the client decided to move. A substantial majority said yes (76% of families, 85% of spouses, and 75% of clients). Clients and spouses were less approving of life leases than family members were, but they also had less of a grasp of life lease contracts, lump sum payments, monthly payments, termination of lease, and resale.

Clients and their spouses were questioned at the initial interview about moving into LHS together. All married clients (50% of clients) expressed interest in moving with their spouse. Two unmarried clients (8%) were interested in having a companion (a sibling or friend) move with them. A substantial majority of spouses (86%) were interested in moving with their spouse (a client). All the family members of married clients said the client was interested in living with a spouse. Unmarried clients appeared to be interested in LHS because it offered a suite in contrast to the comparatively small space they would have in a long-term care facility (where bedrooms are typically shared). These clients said they did not wish to live with someone else (42%). Most family members of these unmarried clients

(82%) believed the clients would not want to live with a companion in a long-term care facility.

At the T2 interviews, approximately one month after the majority of clients had moved into LHS, a substantial majority of the clients, spouses, and family members said they were satisfied with the clients' physical accommodations.[8] Ninety-four percent of the family members said they would recommend a life lease to someone else. Clients were less certain (47%), but a large majority of spouses (78%) agreed.

At T2, just after a purchase, it was expected that participants would be knowledgeable about life lease arrangements; therefore, they were asked which features they considered to be best. Surprisingly, the majority of the clients (57%) and spouses (60%) said they did not feel they knew enough about the terms of the life lease to respond to questions about it. Only one family member felt this way. Participants who answered particularly liked the following: the ability to live with their spouse (20%), a guaranteed amount of money on termination of the lease (10%), the leasing organization handling resale (8%). Both the latter features were mentioned again at T3 by 40% of clients.

At T3 interviews, one year after clients had moved to LHS, the majority of clients and spouses remained satisfied with the accommodations in which the client had decided to live. Only one couple was a little dissatisfied. All of the family members interviewed at T3 remained well satisfied with LHS. When clients, spouses, and family members were asked what they would consider shortfalls of the life lease, at this time, they answered as follows: there is no investment profit (13%), the lump sum payment makes the building unaffordable to some (11%), the return of money at the end of the lease is confusing (7%), client's equity is all invested in the life lease (4%), and the spouse may have to move if the client dies (4%).

B. Interviews with professionals

The majority of professionals interviewed (60% of 15) said the type of tenure (i.e., property-holding) was not a consideration when they were advising clients who were looking at housing options. The rest of the professionals provided clients with information on all appropriate locations and allowed the client to determine which option was preferred. A substantial majority (80%) had heard of a life lease, although most said they did not feel overly confident in explaining the features to a client. A number seemed confused over the admission criteria for the life lease setting. Some recommended LHS inappropriately (e.g., to a client with an Alzheimer diagnosis).

Less than half (40%) of the professionals who had handouts on LHS said they regularly provided them to clients. Half of the professionals interviewed thought the life lease was a good idea, but 25 percent were impartial and the remaining 25 percent said it was not a good idea. Two (15%) of the professionals had never recommended the LHS to a client, and one who did not like the concept would not encourage any client to consider this option.

[8] Those associated with four clients who had not moved to LHS were also satisfied with their accommodations.

Conclusion

The results of the study provided insights into the concerns that both seniors and their families have with life-lease agreements and what they value in condominium-style living. This study illustrated a new way of meeting the needs of frail elderly persons who do not want institutional solutions. The Laurier House model successfully unbundled government-funded long-term care services from the costs of housing and support services in a way that persuaded elderly clients, their spouses, and families to invest in the housing component where their care is provided. Married clients said LHS appealed to them because it allowed them to continue living with their spouse. The setting appealed to unmarried clients primarily because it offered a private suite rather than a private or a shared room in a nursing home. Equal numbers of married and unmarried elderly clients moved into LHS, suggesting the life lease supportive housing concept appealed equally well to both the client group who wished to avoid leaving a spouse and the client group seeking more space and privacy.

Recommendations

Some specific recommendations emerged from this study.

- Developers of supportive housing who wish to appeal to family members might focus on including transportation services. Almost all family members helped their elderly relatives with transportation.
- Life leases could be improved, and in the view of some study participants made more affordable, if the lump sum payment could be divided into several instalments.
- The persistent concerns that a few holders of life lease agreements had with the terms of the life lease, suggest that operators could do more to help clients, companions, and family members understand specific terms of the lease.

Because the life-lease housing concept is not well understood, it is recommended that operators of life lease housing, in cooperation with other interested parties, hold provincial or regional workshops to discuss how life lease works, how it can be developed, marketed, and managed – while showing how workshop participants might play a role in life lease housing in their community. These workshops would target operators of assisted living residences, healthcare centres, seniors housing, and potential partners for public-private partnerships in seniors housing.

Résumé

La demande de logements en milieu de soutien au Canada a été liée à la croissance du nombre d'aînés âgés de plus de 75 ans (Gnaedinger, 1999). D'ici 2031, la population des aînés âgés de plus de 75 ans devrait augmenter de 277 % pour atteindre le nombre d'environ quatre millions de personnes et le groupe des plus de 85 ans devrait tripler (Statistique Canada, 1994, extrait de Société canadienne d'hypothèques et de logement, 2000). Cela laisse croire que nous aurons besoin d'une vaste gamme de solutions de logement pour offrir à ces groupes d'âge des choix qui reflètent leurs circonstances et leurs préférences particulières (Gnaedinger, 1999).

On est déjà en train de mettre à l'épreuve de nouvelles solutions. Depuis dix ans, quelques établissements aménagés spécialement pour la vie en milieu de soutien ont accru leur niveau de service en offrant aussi certains services de soins infirmiers spécialisés. En Alberta, ces établissements de vie en milieu de soutien ont servi de solution de rechange aux établissements de soins de longue durée pour les personnes qui n'ont pas besoin de soins complexes (Gardner, Finlayson, Schalm, & Milke, 1998).[9] D'autres provinces, comme la Colombie-Britannique et l'Ontario, sont également en train de réviser leurs systèmes de services.

Laurier House est un nouveau modèle de logement en milieu de soutien, le seul offert en ce moment qui remplace entièrement un établissement traditionnel de soins de longue durée.[10] Élaboré par *The* CAPITAL CARE *Group* à Edmonton, en Alberta, un fournisseur de services de soins de longue durée en établissement, il est accessible aux fauteuils roulants et conçu pour faciliter la prestation de soins de santé; l'un des deux exemples construits, Laurier House Strathcona (LHS), fait l'objet du présent rapport.

Le modèle de Laurier House est un concept innovateur qui offre, dans un milieu semblable à celui d'un immeuble en copropriété, suffisamment de services pour permettre aux personnes âgées d'y vieillir même lorsque leur santé se détériore sérieusement. LHS plaît aux couples âgés parce qu'il leur permet de continuer d'habiter ensemble en recevant des services équivalant à ceux offerts dans les établissements de soins de longue durée de l'Alberta. Les coûts des soins de santé à LHS sont subventionnés par le service régional de santé et les clients doivent se soumettre au même processus de triage que pour être admis dans un établissement de soins de longue durée.[11] D'autres types de logement en milieu de soutien

[9] Les services de soins de longue durée ou de soins prolongés varient d'une province à l'autre. En Alberta, le centre de soins prolongés désigne maintenant ce qu'on appelait avant les centres d'hébergement pour personnes âgées et les hôpitaux de soins prolongés. La nouvelle appellation reflète mieux la diversité des aménagements physiques et la disponibilité des programmes spécialisés pour les soins continus (soins pour affections subaiguës, soins palliatifs, soins aux personnes atteintes de démence, etc.).

[10] Les établissements de soins de longue durée offrent principalement des services de soins infirmiers internes et de réadaptation. Les soins sont généralement offerts pendant une longue période aux personnes qui ont besoin de soins infirmiers. Ces établissements ont un personnel permanent d'infirmiers et infirmières reconnus qui offrent, avec d'autres employés, des services de soins infirmiers et de soins personnels continus.

[11] Le présent rapport utilise le terme client pour désigner une personne qui a besoin de services de soutien et de soins de santé.

peuvent accueillir les couples, mais ils ne fournissent pas l'accès 24 heures par jour à des soins infirmiers spécialisés à l'interne quand l'un des deux membres du couple, ou les deux, ont besoin de soins de santé complexes.[12] Les établissements traditionnels de soins de longue durée ne peuvent pas permettre à un conjoint ou à un compagnon de partager une chambre.[13] Ainsi, lorsque l'un des deux membres du couple a besoin de soins de santé complexes, les deux font face à un dilemme. Généralement, l'une des deux personnes déménage dans un établissement de soins de longue durée. L'autre demeure où elle vivait. C'est le « divorce par centre d'hébergement pour personnes âgées » (*nursing home divorce*) dont a parlé Gladstone (1992).

Le modèle Laurier House a pour caractéristique particulière d'utiliser la location viagère pour démêler ou séparer les coûts des divers services offerts, en les chargeant au client ou au système de santé. Les coûts de logement, une dépense privée, sont séparés à la fois des coûts des services publics de soutien personnel et des services de soutien au logement. Le client paye en général les frais des services de soutien au logement dans les établissements de soins de longue durée; on dit parfois que ce sont les frais de séjour ou d'hébergement. La séparation de ces coûts est un concept favorisé par les conseillers des gouvernements fédéral et provinciaux (comité consultatif en matière de politiques sur l'examen des soins de longue durée, 1999). Le recours à la location viagère a permis de construire LHS sans qu'il en coûte un sou au gouvernement. L'exploitant a pu récupérer entièrement et assez rapidement le coût de la construction grâce à la vente des baux viagers. Il a fallu emprunter à la banque pour lancer le projet, mais le risque financier de l'exploitant était mineur parce qu'il est bien connu à titre de fournisseur public de soins de longue durée en établissement dans le service régional de santé.[14]

Ce bail viager fait en sorte que les clients sont considérés comme les propriétaires de leurs appartements. Cela a permis à l'exploitant de fournir plus d'espace au client, un appartement d'une ou de deux chambres (mesurant respectivement entre 617 et 627 pieds carrés, ou 806 pieds carrés). Cela fait contraste par rapport aux 120 pieds carrés d'espace privé recommandés par Santé et Bien-être social Canada en 1979 pour un établissement traditionnel de soins de longue durée. En offrant des appartements et d'autres caractéristiques

[12] Une deuxième personne peut partager l'appartement d'un client : un frère ou une sœur, un conjoint ou une conjointe, un compagnon ou une compagne ou encore un enfant adulte. La deuxième personne peut ne pas avoir besoin de services de soins de santé, elle peut en avoir besoin de quelques-uns ou elle peut même avoir besoin de soins complexes.

[13] Les coûts de construction et d'entretien sont généralement subventionnés par le système de santé et le financement du personnel par le gouvernement dépend des besoins en soins de santé des clients.

[14] Le Edmonton Rural Auxiliary Hospital and Nursing Home District 24 a été établi en 1964 pour offrir des soins publics continus (soins de longue durée) dans la grande agglomération d'Edmonton. Il est devenu en 1991 *The* CAPITAL CARE *Group* (TCCG). À la régionalisation des soins de santé en Alberta en 1995, l'organisme est devenu une filiale en propriété exclusive du service régional de santé, la Capital Health authority, formé de la ville capitale, Edmonton, et de la périphérie. TCCG exploite tous les centres publics de soins continus (c'est-à-dire les centres de soins de longue durée) dans le système régional de santé.

plus conformes au logement privé à but lucratif, [15] l'exploitant a pu commercialiser LHS de façon concurrentielle.

Le modèle Laurier House a d'abord été mis à l'essai dans le marché d'Edmonton. La construction de LHS dans la collectivité de banlieue de Sherwood Park, qui possède une population égale à environ 7 % de celle de la ville d'Edmonton, était un autre test du modèle. Même s'il existe très peu d'ensembles résidentiels privés en location viagère au Canada (Scherlowski, 2000), les secteurs privé et sans but lucratif pourraient utiliser tous les deux ce modèle pour répondre aux besoins en logement des aînés.

Aménagement des lieux et acceptation par la collectivité

LHS a été construit sur les terrains d'un complexe de soins de santé qui inclut un établissement traditionnel de soins de longue durée, construit en 1994, et un centre pour les personnes atteintes de la maladie d'Alzheimer, construit en 2001. LHS a ouvert ses portes le 17 septembre 2001. L'immeuble de deux étages à ossature de bois compte 42 appartements (de une et deux chambres) et il est relié physiquement aux deux autres centres. À l'extérieur, LHS a l'apparence d'un ensemble résidentiel; à l'intérieur, il ressemble à un petit hôtel. Le bureau de réception en retrait de l'entrée principale sert les visiteurs de LHS et du centre pour les personnes atteintes de la maladie d'Alzheimer. La salle à manger de LHS est au centre du rez-de-chaussée et sa cuisine fonctionne comme un restaurant dont les heures d'ouverture sont limitées. Le bureau du gérant est près de la salle à manger, mais on ne voit pas de « poste de soins infirmiers ». Un bosquet de trembles naturel crée un espace ombragé à l'arrière de la propriété. Le terrain comprend un sentier piétonnier, un grand patio couvert et des terrains herbagés autour des patios individuels des appartements du rez-de-chaussée. Tous les appartements du deuxième étage, sauf trois, possèdent un balcon.

Si on avait pu s'attendre à ce que la location viagère soit moins bien reçue dans la collectivité plus petite de Sherwood Park qu'elle l'avait été à Edmonton, le taux de vente des appartements s'est avéré comparable. À Edmonton, 30 % des appartements ont été prévendus et plus des deux tiers ont été vendus dans les six mois suivant l'ouverture. À LHS, environ le tiers des 42 appartements étaient déjà vendus à la fin de la construction et 90 % des appartements ont été vendus dans les six mois suivant l'ouverture.

Objectifs et méthodes de l'étude

Le type de bail viager offert à LHS n'est pas bien connu. Par conséquent, l'un des objectifs majeurs de la présente étude était d'obtenir de l'information sur les discussions qui ont amené les clients aînés et leurs familles à choisir ce mode d'occupation à la place d'autres options comme le logement traditionnel en milieu de soutien et les centres de soins de longue durée. Cette information serait utile aux autres qui voudraient élaborer ailleurs des logements en milieu de soutien semblables.

[15] Environ 60 % de la surface utile est consacrée aux appartements et 40 % aux espaces partagés par les résidents, comme les salles à manger.

Objectifs particuliers de l'étude :

- Décrire les besoins des clients du point de vue de toutes les parties (c'est-à-dire les clients ou les clients potentiels, leurs conjoints et leurs familles).
- Déterminer les ressources financières et sociales des clients.
- Déterminer le choix de résidence des parties et les raisons de leur choix.
- Déterminer les priorités des parties à l'égard de la résolution de la question du choix de la location viagère comme mode d'occupation (LHS).
- Déterminer comment les professionnels qui ont participé à la transition des clients entre la maison et l'établissement de soins de longue durée font des recommandations concernant ces options.
- Déterminer si le type de résidence choisi répond aux besoins du client, du point de vue de toutes les parties.

L'information requise pour atteindre ces objectifs a été réunie au moyen d'entrevues structurées avec des questions graduées et des questions ouvertes. Les clients, les compagnons et les membres de la famille qui ont participé ont été choisis au moyen d'un processus cumulatif entrepris auprès de ceux qui ont manifesté de l'intérêt envers les appartements de LHS. Les participants venaient de trois sources : une liste de personnes qui avaient parlé au gérant de LHS et manifesté de l'intérêt, des noms additionnels offerts par les participants interviewés pour l'étude et des résidents temporaires qui ont déménagé à LHS.

Les entrevues ont eu lieu à trois moments différents : Entrevue 1 (E1) au moment où les participants envisageaient l'achat d'un bail viager; Entrevue 2 (E2) un mois après la décision; Entrevue 3 (E3) environ un an plus tard. Lors des entrevues, on a demandé aux clients, à leurs conjoints et aux membres de leurs familles ce qu'ils aimaient et ce qu'ils n'aimaient pas de la location viagère et on a posé d'autres questions pertinentes. On a demandé à l'entrevue initiale pourquoi les clients envisageaient un déménagement et quel était leur niveau de connaissances de la location viagère. On leur a également posé des questions sur l'importance des besoins des clients, leur état de santé, leur mode de vie courant, leur insatisfaction à propos de l'environnement courant et les priorités pour un nouvel endroit. L'entrevue E2 était axée sur les facteurs qui ont influencé la décision du client à propos du déménagement et sur le niveau de satisfaction à l'égard des services au nouvel endroit. L'entrevue finale avec les clients et leurs conjoints était axée sur les besoins courants, sur le niveau de satisfaction à l'égard de l'endroit et des services courants et sur ce qu'ils pensaient du concept de la location viagère.

Résultats de l'étude

C. Entrevues avec les clients, les conjoints et les membres de la famille.

Lors de l'entrevue E1, les clients et les membres de leur famille ont manifesté un certain désaccord à propos du déménagement ou non des clients. Si 94 % des membres de la famille croyaient que les clients envisageaient de déménager, seulement 72 % des clients étaient d'accord. Dans la plupart des cas, les clients et leurs familles ont dit que l'exécution du plan de déménagement du client a été précipitée par le déclin de la santé du client ou de la santé de sa personne soignante; on a indiqué que la quantité additionnelle des services requis était à

la base du besoin de déménager. Une grande majorité des conjoints (75 %) ont dit qu'il était important pour eux que les clients reçoivent plus de services de soutien (cela incluait les services de soins de santé). En revanche, seulement 37 % des clients ont dit qu'il était important pour eux de recevoir plus d'aide. Les clients ont indiqué que le problème était la quantité de services plutôt que les types particuliers de services.

Les membres de la famille ont cherché dans certains cas à obtenir de l'information sans que le client le sache. Les familles ont pu considérer qu'un déménagement était inévitable ou ont pu chercher du répit parce qu'elles fournissaient un soutien important aux clients. À l'entrevue E1, la majorité des membres de la famille ont dit qu'ils aidaient les clients pour le transport (70 %), l'épicerie (70 %), faire la cuisine chez le client (76 %), livrer des plats chauds (73 %), faire le grand ménage (70 %) et la lessive (64 %).

On a demandé aux participants à l'entrevue E1 s'ils envisageraient l'option de la location viagère si le client décidait de déménager. Une majorité importante de participants ont dit oui (76 % des familles, 85 % des conjoints et 75 % des clients). Les clients et leurs conjoints étaient moins favorables à la location viagère que ne l'étaient les membres de la famille, mais ils comprenaient également moins de quoi il s'agissait, notamment en ce qui a trait aux paiements forfaitaires, aux paiements mensuels, à la cessation du bail et à la revente.

On a demandé aux clients et à leurs conjoints à l'entrevue initiale s'ils voulaient déménager à LHS ensemble. Tous les clients mariés (50 % de la clientèle) étaient intéressés à emménager avec leur conjoint. Deux clients non mariés (8 %) étaient intéressés à emménager avec un compagnon, une compagne, un frère ou une soeur. Une majorité importante des conjoints (86 %) étaient intéressés à emménager avec leur conjoint (un client). Tous les membres de la famille des clients mariés ont dit que le client était intéressé à vivre avec un conjoint. Les clients non mariés semblaient intéressés à LHS parce qu'on leur y offrait un appartement plutôt qu'un endroit relativement plus petit comme dans un établissement de soins de longue durée (où les chambres sont habituellement partagées). Ces clients ont dit qu'ils ne voulaient pas vivre avec quelqu'un d'autre (42 %). La plupart des membres de la famille de ces clients non mariés (82 %) croyaient que les clients ne voudraient pas vivre avec un compagnon dans un établissement de soins de longue durée.

Dans les entrevues E2, environ un mois après l'emménagement de la majorité des clients à LHS, une majorité considérable des clients, des conjoints et des membres de la famille se sont dits satisfaits des installations physiques des clients.[16] Et 94 % des membres de la famille ont déclaré qu'ils recommanderaient la location viagère à quelqu'un d'autre. Les clients étaient moins certains (47 %), mais une grande majorité des conjoints (78 %) étaient d'accord.

À l'entrevue E2, juste après un achat, on s'attendait à ce que les participants comprennent l'entente de location viagère; on leur a donc demandé quelles étaient les caractéristiques

[16] Ceux qui étaient associés à quatre clients qui n'ont pas déménagé à LHS étaient également satisfaits de leurs installations.

qu'ils considéraient les meilleures. Étonnamment, la majorité des clients (57 %) et des conjoints (60 %) ont affirmé qu'ils n'avaient pas l'impression d'en savoir assez sur les dispositions du bail viager pour répondre aux questions à ce sujet. Un seul membre de la famille avait la même impression. Les participants qui ont répondu aimaient particulièrement ce qui suit : la capacité de vivre avec leur conjoint (20 %), un montant d'argent garanti à la cessation du bail (10 %), le traitement de la revente par l'organisme (8 %). Les deux dernières caractéristiques ont été mentionnées encore à l'entrevue E3 par 40 % des clients.

Lors des entrevues E3, un an après l'emménagement des clients à LHS, la majorité des clients et des conjoints demeuraient satisfaits des installations où le client avait décidé de vivre. Un seul couple a manifesté une certaine insatisfaction. Tous les membres de la famille interrogés en E3 demeuraient bien satisfaits de LHS. On a demandé aux clients, aux conjoints et aux membres de la famille ce qu'ils considéreraient comme des lacunes de la location viagère à ce moment-là et ils ont répondu comme suit : l'investissement ne produit pas de profit (13 %), le paiement forfaitaire rend l'immeuble inabordable pour certains (11 %), la remise de l'argent à la fin du bail crée de la confusion (7 %), l'avoir propre du client est investi au complet dans le bail viager (4 %) et le conjoint peut être obligé de déménager si le client meurt (4 %).

D. Entrevues avec les professionnels

La majorité des professionnels interviewés (60 % sur 15) ont dit qu'ils ne tenaient pas compte du mode d'occupation (propriété) lorsqu'ils conseillaient les clients qui examinaient les options de logement. Les autres professionnels ont fourni de l'information aux clients sur tous les endroits convenables et ont permis au client de déterminer l'option la plus intéressante. Une majorité considérable de professionnels (80 %) avaient entendu parler de location viagère, mais la plupart ont dit qu'ils ne se sentaient pas très capables d'en expliquer les caractéristiques à un client. Un certain nombre de professionnels semblaient ne pas très bien connaître les critères d'admissibilité à la location viagère. Certains ont recommandé LHS à tort, par exemple dans le cas d'un client chez qui la maladie d'Alzheimer avait été diagnostiquée.

Moins de la moitié (40 %) des professionnels qui avaient de la documentation sur LHS ont déclaré qu'ils la fournissaient régulièrement aux clients. La moitié des professionnels interviewés pensaient que la location viagère était une bonne idée, mais 25 % étaient impartiaux et les 25 % restants prétendaient qu'il ne s'agissait pas d'une bonne idée. Deux des professionnels (15 %) n'avaient jamais recommandé LHS à un client et un autre qui n'aimait pas le concept n'encouragerait pas un client à envisager cette option.

Conclusion

Les résultats de l'étude ont mis en lumière les préoccupations des aînés et de leurs familles à l'égard de la location viagère et concernant ce qu'ils apprécient du style de vie qui s'apparente à celui d'un immeuble en copropriété. L'étude fait connaître une nouvelle façon de répondre aux besoins des aînés à la santé fragile qui ne veulent pas vivre en milieu institutionnel. Le modèle de Laurier House a séparé avec succès les services de soins publics de longue durée des coûts des services de logement et des services de soutien d'une façon qui

a persuadé les clients aînés, leurs conjoints et leurs familles d'investir dans le type de logement qui procure des soins. Les clients mariés ont dit que LHS leur plaisait parce que cela leur permettait de continuer de vivre avec leur conjoint. L'établissement plaisait aux clients non mariés principalement parce qu'il offrait un appartement privé plutôt qu'une chambre privée ou partagée dans un centre d'hébergement pour personnes âgées. Un nombre égal de clients aînés mariés et non mariés ont emménagé à LHS, ce qui porte à croire que le concept de la location viagère d'un logement en milieu de soutien plaisait tout aussi bien au groupe client qui voulait éviter de quitter un conjoint qu'au groupe client qui était à la recherche de plus d'espace et d'intimité.

Recommandations

Voici les recommandations particulières de l'étude.

- Les promoteurs du logement en milieu de soutien qui veulent convaincre les membres de la famille pourraient insister sur l'inclusion des services de transport. Presque tous les membres de la famille aidaient leurs parents âgés pour le transport.
- On pourrait améliorer la location viagère et la rendre plus abordable selon certains participants à l'étude, en permettant des versements échelonnés au lieu d'un paiement forfaitaire.
- Le malaise persistant de quelques détenteurs de baux viagers à propos des dispositions de la location viagère laisse croire que les exploitants pourraient faire plus pour aider les clients, les compagnons et les membres de la famille à comprendre les dispositions particulières du bail.

Parce que le concept des logements en location viagère n'est pas bien compris, il est recommandé que ses exploitants organisent, en coopération avec d'autres parties intéressées, des ateliers provinciaux ou régionaux pour examiner le fonctionnement de la location viagère afin d'établir comment l'élaborer, la commercialiser et la gérer – tout en montrant comment les participants à l'atelier pourraient jouer un rôle relativement à la location viagère dans leur collectivité. Ces ateliers viseraient les exploitants des résidences en milieu de soutien, ceux des centres de soins de santé et ceux du logement pour les aînés, et les partenaires susceptibles de participer à la création de partenariats publics-privés en habitation pour les aînés.

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Introduction

By 2031, the Canadian population over age 75 is expected to grow by 277 percent to about four million persons and the 85-plus group is expected to triple (Statistics Canada, 1994 as cited in Canada Mortgage and Housing Corporation, 2000). With this burgeoning senior population, the demand for supportive housing is expected to escalate (Gnaedinger, 1999). It is widely recognized that seniors are a very heterogeneous group with diverse interests, needs, and abilities that are best served by maximization of choice and alternative styles of housing (Gutman & Wister, 1994). Thus, a wide range of housing solutions will be needed to provide these age groups with choices that reflect their individual circumstances and preferences (Gnaedinger, 1999).

Seniors also vary considerably in their need for healthcare services. In the past, some of the pressure to provide different types of supportive housing has come from the healthcare system. Seniors have at times been considered "bed blockers" in acute care hospitals because of prolonged lengths of stay. Studies carried out in Alberta in 1958 found that approximately 18% of the patient days in acute care hospitals were incurred by those who required long-term care (Alberta Health, 1992)The need to reduce costs in acute care hospitals resulted in the rapid growth of auxiliary hospitals, nursing homes, and seniors' lodges, during the 1960s, all targeted toward supporting the over-65 age group.[17] In 1988, another study of the system found persons over age 65 represented 19% of acute care patients and accounted for 36% of total patient days (Committee on Long Term Care for Senior Citizens, 1988). At present, pressure continues from the healthcare system. A recent report said that patients 65 years and older accounted for 43% of all acute inpatient hospital days in Alberta (Alberta Centre for Health Services Utilization Research June 1999). This is a sizeable proportion, considering that seniors formed only 10% of Alberta's population (Alberta Community Development, 2000).[18] Such utilization reports suggest that organizations exploring new housing solutions for seniors, should consider the need for healthcare services. They should also plan for an older and frailer population (Mitniski, A., Song, X., & Rockwood, K., 2004; Schmit, 2002).

Some new seniors' housing solutions with enriched services are already being tested. In Alberta, several newer models of supportive housing have evolved to meet the needs of seniors with higher service needs. Assisted living, which typically provides both hotel and personal care services, was once considered to provide the highest level of service within the

[17] Seniors' lodges could be considered Alberta's first supportive housing program. Lodge construction began in 1958 under the Senior Citizens' Housing Act to provide a type of affordable housing for seniors. These settings provided supervision, meals, and housekeeping, but were not wheelchair accessible. Renovations to allow aging-in-place to occur did not begin until 1986 (Alberta Municipal Affairs, 2001). In 1959, the Auxiliary Hospital Program was introduced as an alternative type of care to that provided in acute care hospitals. In 1964 the Nursing Homes Act was passed and the Alberta Nursing Home Plan (1964) was seen as completing the continuum of care.

[18] Hospital inpatients were found to be older than they had been prior to 1991/92; they also were sicker (as measured by care intensity). Thus, while use of inpatient hospital services had shrunk (between 1991/92 to 1996/97), this was accompanied by a "greying" of the patients served (Alberta Centre for Health Services Utilization Research June 1999).

supportive housing spectrum.[19] However, in the past ten years, a few specially built assisted living settings in Alberta have increased the level of service, adding some skilled nursing services. These assisted living settings have provided an alternative to long-term care facilities (Gardner, Finlayson, Schalm & Milke, 1998).

Designated Assisted Living (DAL), a new higher service level of supportive housing, arose just after the turn of the century in several Alberta health regions. DAL is defined as the space and services contracted from an operator "intended to serve individuals who would otherwise be on a waitlist for admission to a continuing care centre" (Capital Health, 2004, p. 7). Clients must go through the same screening process as they would if they were being admitted to a long-term care facility. The contract services ensure that clients have 24-hour access to personal services. DAL may be located in housing operated by private for-profit, public, or charitable organizations. In this way, many retirement settings are serving not only large numbers of their usual renters, but also small numbers of the health regions' DAL clients.[20] The health regions fund most of the healthcare costs for DAL clients.[21] Although DAL provides some services found in long-term care facilities, if the clients' healthcare needs increase, they may need to move to facilities, which provide complex care.

Laurier House is yet another new form of supportive living developed in Alberta. In this model, seniors can age in place even if they have complex healthcare needs. This model of supportive housing fully substitutes for a traditional long-term care facility. The appearance is residential, although it is wheelchair accessible and designed to facilitate the provision of healthcare. *The* CAPITAL CARE *Group* in Edmonton, Alberta, a provider of facility-based long-term care services, developed the model and built two examples of it; one, Laurier House Strathcona (LHS) is featured in this report.

The Laurier House model is an innovative project that utilizes life leasing to disentangle or "unbundle" housing costs, the costs of hotel and personal care services, from the government-funded health services that are provided on site. Unbundling is a concept upheld

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[19] Hotel Services include housekeeping, laundry service, and congregate services. Some meals are usually provided. Transportation is sometimes available. Personal Care Services for "activities of daily living" (bathing, dressing, eating, using the toilet, etc.) are usually included, but often the administration of medications and preparation of special diets may not be available. Skilled Nursing Care, a "higher level" of care that must be provided by trained medical professionals is not usually available except through arrangements with home care staff.

[20] The term client in this report for persons who were perceived to need facility-based long term care services. At T1, the clients' need for such care was primarily from the perspective of the clients themselves, their spouses, and their family members because many "potential clients" had not been assessed by the health region's professional assessors. By T2, all professional assessments had been completed, and most of the client group had moved into LHS or had dropped out of the study because the found they did not qualify for facility-based long term care. However, participants related to 8 clients remained in the study through T2, and 6 clients through T3. At T3, only two spouses and four family members represented the client group who did not move to LHS.

[21] The health regions pay more client costs in long term care facilities than in DAL. For example, DAL clients pay the cost of their medications, whereas in long term care facilities the health regions pay for client medications.

by advisors to both federal and provincial governments (Policy Advisory Committee on Long Term Care Review, 1999; National Forum on Health, 1998).

The initiative allows clients, that is, the primary persons in need of support and healthcare services, to invest their home equity in the housing component, which is a purpose-built centre focused on providing healthcare services in a residential environment. Clients purchase suites in Laurier House Strathcona (LHS) through a life lease agreement and pay a monthly fee. Thus, the client pays the full costs of housing and support services and Alberta Health and Wellness pays the full cost of the health services the client requires. Moreover, the health services include the full range of those provided in traditional long-term care facilities.

The CAPITAL CARE *Group*[22] initiative, Laurier House Strathcona (LHS), represents a natural extension of supportive housing and introduces a unique and needed model for providing health services. In other forms of supportive housing clients and their companions can share a suite but may not be able to obtain services to meet their individual needs. On the other hand, traditional long-term care facilities, where the building costs and maintenance are subsidized by the healthcare system, do not provide suites and they can admit only persons who require facility-based services. When one member of a couple needs such services, they face a dilemma. This has been called "divorce by nursing home" (Gladstone, 1992). Care staff in traditional long-term care facilities tell of couples, married for 50 years and more, who live apart during the last years of their lives, one in a long-term care centre and one in a community home. Often they mark their time with nearly daily visits. Laurier House Strathcona (LHS) was developed to meet the needs of such couples, as well as individuals who need facility-based healthcare services and wish to have more space and more of their possessions around them than most health facilities allow. Admission criteria for LHS require that the primary client in each life lease suite be in need of facility-based health services, but a second person (a spouse, companion, or family member) may live in the client's suite. Thus, LHS enables couples to continue to reside together even though one requires the constant availability of nursing services.

The construction costs for LHS were financed through sale of life leases and a bank loan. No government money was required for capital costs. The life leases enabled the operator, TCCG, to recover the full cost of construction more quickly than is customary in supportive housing. The financial risk to the operator was minor. TCCG is the publicly owned provider of facility-based long-term care in the Capital Health Region and was recognized as a reputable owner-operator. This helped assure clients that their investments were secure. The financial success of this type of venture depends on the willingness of clients to invest in a suite.

This type of life lease has not been available previously for this type of client, so no studies exist on why clients might choose this type of arrangement. Accordingly, a major objective

[22] *The* CAPITAL CARE *Group* is a wholly owned subsidiary of the Capital Health Region in Alberta. The Region serves the capital city, Edmonton, and the surrounding area. TCCG operates all publicly owned continuing care centres (long term care centres) in the Region.

of this study was to obtain information on the deliberations that led senior clients and their families to choose life lease arrangements over other options like traditional supportive housing and long-term care facilities. The goal was to gain more insight into their decision-making. This information would be useful to others who might wish to develop similar types of supportive housing elsewhere.

The Study

The opening of LHS afforded investigators the opportunity to interview potential clients, their companions, and their families to ascertain why they were considering a life lease option. Some were also considering traditional care centres or housing with a few supportive services. Interviews were repeated at three points in time. The first two were at initial contact (T1) and shortly after the decision to move was made (T2). The objective was to discover the factors that influenced the decision. The T3 interview was held one year later to determine whether, in retrospect, LHS met their expectations.

It was expected that a number of influences would be evident as clients' and their families' made the decision about where the client would move. Factors were expected to include financial resources, the client's frailty, current needs and dissatisfactions, the views of professionals advising the family, and the concerns of the client's adult children. It was recognized that the novelty of the life lease itself might be a concern for the clients and their families. Financial resources were expected to be a factor, because a life lease purchase requires a lump sum expenditure that was higher than the average income for senior Albertans, but lower than the average value of a home in the region in 2001.[23] Statistics indicate that the majority of Canadian seniors are home-owners and most of their homes are mortgage free. This suggests that persons in the region with the average home value would find a LHS suite affordable. Client frailty in old age, and their current service needs, often precipitates a move to a long-term care facility as do concerns of adult children. (Subgroup on Nursing Homes, 2000)

The following were the specific objectives of the study:

- To describe the clients' needs from the perspective of all parties (i.e., clients or potential clients, their spouses or companions, and their families).
- To identify the client's resources, both financial and social.
- To identify the parties' choice of residence and the reasons for their choice.
- To determine the priorities of the parties in regard to resolving the issue of choosing life lease accommodation (LHS).
- To determine how professionals involved in clients' transitions from home to residential long-term care make recommendations on those options.

[23] The average value of a home in the region in 2001 was $146,411. In 2001, the average pre-tax income for Albertan senior families was $49,414. For single senior men the average was $32,681 and for single senior women it was $26,450 (Statistics Canada, 2001, cited by Alberta Government, 2002). In 1999, roughly 4,769,000 Canadian seniors owned their own home with 90% owning a mortgage free home (Statistics Canada, 2004).

- To determine whether the chosen residence meets the needs of the client, from the perspective of all parties.

The Setting for Laurier House Strathcona (LHS)

LHS was TCCG's second life lease centre. The life lease long-term care model was piloted in the City of Edmonton. The first centre, Laurier House Lynnwood (LHL), built in 1997 had 42 suites, which sold quickly (Milke et al., 1997). A post occupancy evaluation was completed in the first year of operation. An addition of 36 suites was then built for a total of 78 (*The* CAPITAL CARE *Group,* 1999, June). LHL was located on 3.8 acres in a quiet residential neighbourhood within walking distance of West Edmonton Mall.

LHS was built in the hamlet of Sherwood Park, in the County of Strathcona[24]. Sherwood Park is a bedroom community with a population approximately 7% of the City of Edmonton[25]. LHS is part of a healthcare campus that includes a long-term care centre, Strathcona Care Centre (SCC), which was built in 1994 as a traditional 75-bed centre that included a 25-bed unit designed for persons with dementia. LHS is connected by a corridor to SCC to facilitate sharing of services, such as the SCC rehabilitation clinic. The campus also has a new residential care centre for persons with dementia, modeled on *The* CAPITAL CARE *Group's* McConnell Place North and McConnell Place West (Zeisel, J., &Baldwin, P., 1999).

LHS construction began in June 2000. It was completed in August 2001. The centre opened on September 17, 2001. The two-story wood-frame building with 42 suites resembles the design of the first phase of LHL.

Although the Laurier House life lease model might have been expected to be more difficult to market in Sherwood Park, because it is much smaller than Edmonton, the rate of sales between LHL and LHS was reasonably comparable. At LHL 30% of the suites were pre-sold and in six months, more than two-thirds of the suites had been sold. At LHS approximately one-third of the suites were sold by the time construction was completed and over 90% of the suites had been sold within six months of opening.

The Physical Environment

The main LHS entrance has a small reception area and a view of the dining room, giving the appearance of a small hotel (Appendix A). The foyer and the hallways are carpeted on both floors of the building. Twenty one percent of the centre's 3,900 m^2 (41,900 sq. ft) is devoted to spaces shared by the clients. A personalized call system allows clients to communicate with care staff from any location within LHS, including its gardens. Staff can also

[24] The County of Strathcona has a population of 45,629 – Alberta Municipal Affairs, 2001, *Official Population List.*
[25] The City of Edmonton has a population of 648,284 as of June 25, 1999 – Alberta Municipal Affairs, 2001, *Official Population List*.

communicate with each other and receive external calls, such as those from physicians or families.

The main dining room occupies a central position on the main floor. Its kitchen operates like a restaurant with limited hours. There are daily hot meal specials, and clients can request sandwiches or other items routinely stocked. Coffee is available there throughout the day. A parlour and a family dining room allow clients to host small gatherings.

The LHS suites are designed to maximize independent living and privacy (Appendix B). They are furnished with window blinds and carpeting but the client provides furniture, dishes, and decorations, just as they would in a condominium or a rental apartment. This helps maintain clients' individuality and dignity, as well as support their ability to make choices. The suite also has a storage room, and a large, wheelchair-accessible three-piece bathroom. Each suite has a kitchenette with a microwave, a full size refrigerator, and a counter top stove to encourage independence. Clients or their companions who wish to prepare breakfasts and snacks in their suite are encouraged to do so. They are expected to have dinner in the dining room.

The majority of suites on the second floor have balconies large enough for several chairs and those on the main floor have doors onto small patios.[26] The abundance of doors facilitates clients' independence, allowing them to come and go freely. Doors from common areas on the main floor open onto garden areas and Sherwood Park streets.

LHS has a guest suite available that clients may reserve for overnight visitors. Individual mailboxes serviced by Canada Post further support independence and privacy. Shared spaced include an activity room, a kitchen area for client and family use, as well as a tub room for assisted bathing. An unobtrusive room serves the requirements of care staff and holds equipment and medical charts. .

The Service Model

Like traditional long-term care centres, LHS admits persons whose healthcare needs can no longer be met by community-based services.[27]

A qualified client interested in LHS is asked to purchase a life lease for a suite, giving him or her the right to occupy the suite and use LHS common spaces. A second person in the suite could, but need not, require health services. If that second person also requires health services, then LHS will arrange to provide them. Because LHS provides the full range of services provided in traditional long-term care facilities the client does not need to move again to obtain more intensive care services. Almost all clients choose to remain until their death. If a primary client vacates the suite, *The* CAPITAL CARE *Group* buys back the life

[26] Some suites share a cement patio with the neighbouring suite.
[27] This means that a range of available community services, such as home care with nursing, housekeeping, and personal care, as well as volunteer programs such as meals-on-wheels are no longer sufficient for their needs. Client needs are independently assessed by staff of the regional health authority.

lease and puts the suite back on the market. Should the client have a companion who does not need facility-based long-term care services, the lease agreement provides the companion with a grace period during which he or she may remain in the suite. This period is primarily for making other housing arrangements, but it also allows time to deal with grief.

The LHS clients are expected to play a role in developing their care plan, which will include services to meet assessed needs, as well as determine the frequency and type of various optional services that are available. LHS admission criteria exclude persons diagnosed with dementia, whereas traditional long-term care centres like SCC admit them.[28] LHS is not considered appropriate for persons with dementia, mainly for two reasons, one is the level of participation expected from clients in planning their care, and the second is the design of the building. Persons with dementia need specialized environmental features that are not available at LHS.

All centres operated by *The* CAPITAL CARE *Group* follow the same mission statement;[29] however, LHS espouses a model of care known as "care housing" which entails a merger of housing and long-term care services. The goals of care housing are to maintain clients' independence, choice, individuality, dignity, and privacy in a home-like environment (Peat, Marwick, Stevenson, & Kellogg Management Consultants, 1992). In LHS multi-skilled staff designated as care housing aides serve clients' needs. These staff are trained to provide many different services so they can replace the daily parade of different staff members, that is, housekeepers, personal care aides, and nursing staff.

The Life Lease

The suite is intended to replace the client's home in the community. The client purchases a life lease for the suite (one- or two-bedroom) and furnishes it. Like a condominium owner, the client makes a monthly payment and is responsible for any renovations desired in the suite (seeking prior approval for them).

The *Laurier House – The Care and Comfort of Home* manual (The Capital Care Group, 1999) describes the life lease to clients in this way:

> A life lease is a legal agreement that permits the purchaser to occupy a dwelling for life in exchange for a lump sum prepayment and monthly fees. These funds are used to finance the capital costs of the facility, thus relieving the public system of construction

[28] Over 76% of the clients of SCC have a dementia diagnosis.

[29] The mission is "Delivering quality continuing care in partnership with our community." And centres have six mandates: "Provide quality continuing care to our residents and clients; provide a care environment that respects the dignity of the individual and promotes independence and choice; provide specialized programs and services that are responsive to the needs of selected high risk target groups both in our centres and in the community; provide leadership in developing programs and services for the 'difficult to serve' continuing care population; educate families and communities about continuing care services and options; and provide leadership to the continuing care community in the areas of assessment, research, customer service, and innovative service delivery options." (The CAPTIAL CARE Group, 2003)

costs. Monthly fees cover maintenance and other operating costs similar to other Capital Care facilities.

At the beginning of the lease, you make a capital payment based on the size of your suite. Then you arrange for a monthly payment to cover operating costs and the domestic and food services you select. Alberta Health and Wellness funds the healthcare services you require and will return the capital payment to you, based on the terms of the life lease agreement.

At the end of the lease period, *The* CAPITAL CARE *Group* is responsible for arranging the sale of the residence. Under the terms of the life lease agreement, the lessee can expect that the purchase price of the lease will be refunded less 1-8%, with the rate depending on length of occupancy at the time of the life lease is terminated.

The Fee Structure

As in traditional long-term care centres, Alberta Health and Wellness funds, via the regional health authority, the LHS clients' healthcare services. All residents of Alberta long-term care centres, pay a government-set fee for their accommodation, which at the T1 interviews for this study was $28.60 per day for a private room or $870.03 per month. The health region approved a higher fee for the much larger private rooms at LHS. Thus, a resident's monthly fee was set at $1000 for a one-bedroom suite or $1060 for a two-bedroom suite. If two persons live in a suite, a client and a companion, a higher fee is assessed, but the fee is not doubled by the second person. In traditional long-term care centres, the fee has been referred to as "room and board" – using that analogy, two persons in a suite at LHS live in the same "room" but are apt to consume double the amount of food, thus the "board" could be expected to be higher.

The monthly payments at LHS cover support services like housekeeping and food services selected, as well utility and insurance costs, upkeep of common spaces and grounds-maintenance (see Appendix C). Supplemental services desired by clients, but not deemed necessary by the health region's assessors, can be purchased for a fee. The supplemental services could be personal services or even health services. Over the year, a proportion of clients' monthly payments are placed in two reserve funds, one is used for building maintenance with the balance going into a fund to replace the building in 60 years. Thus, the monthly payments at LHS are more than a rental fee; they are more akin to a condominium fee[30] that allows owners to lease space and contribute toward a fund that is used for the upkeep on commonly owned property (e.g., replacement of furnishings in common spaces). As indicated above, when clients terminate their lease a portion of their lease fee is withheld and retained in reserves for future capital replacement and capital maintenance requirements. The amount deposited into the reserve funds varies yearly depending on the number of terminated leases and the lengths of stay involved.

[30] Government agencies view LHS and LHL as supportive housing for seniors. Alberta's legislation on condominiums does not address life lease settings.

Method

Participants

Client, spouse, and family member participants came from three sources: a list of people who had spoken to the manager of LHS and expressed interest, contact names provided by the participants as they were being interviewed, [31] and temporary residents on the waitlist for traditional long-term care facilities. The health region sought space in LHS on a temporary basis because of bed shortages in the region.[32]

Family of potential clients comprised the majority of those who inquired about LHS. There were approximately 115 family inquiries directed to the LHS manager between April 25, 2001 and August 1, 2002. The term "family" here refers to one or more individuals, usually related to the client, who helped the person make the decision about whether or not to move into LHS, but were not living with them at the time of the interview, and were not planning to move into LHS with them. Most of the family members were children or children-in-law of the potential client. In a few instances, close friends of a client who had no family members or an estranged spouse were classified as family members. Not all of those contacted agreed to participate in the study, and not all those who did consent agreed to provide names of other contacts. There were 36 families for which at least one person in the family was contacted, but no one in the family was interviewed.[33]

The T1 interviews included 78 participants, the T2 56, and the T3 46. The number of clients, spouses, and family members involved were, respectively: 26, 14, and 38 at T1, 23, 10, and 23 at T2, and 15, 7, and 24 at T3 (see Appendix D for more information). Of the 36 clients, 16 companions, and 47 family members who were interviewed through the course of the evaluation, only four clients and five companions and 13 family members represented the group who did not choose to move into LHS. All companions were spouses of clients, therefore spouses is used in the remainder of the report rather than the term companions.

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[31] A client, a family member, or a friend of the client may have made the initial inquiry. They were contacted by phone and invited to participate in the study. If they agreed, a T1 interview was arranged for approximately one month after their initial inquiry at LHS. To include others involved in the deliberations being made about the client's possible move, those first contacted were asked at the T1 interview for the names of such individuals. The name of the client, the client's spouse (where applicable), and close family members were specifically requested.

[32] A total of six residents moved into LHS on a temporary basis, when, in October 2001 the health region had an increased demand for hospital beds which translated into a need for long term care spaces. The health region and *The* CAPITAL CARE *Group* agreed that for a maximum of five months the unsold suites at LHS would be made available to clients seeking admission to a traditional Sherwood Park long term care centre. Permanent spaces were expected to be found for these clients within that time. These persons who had been on the waitlist for traditional long term care facilities were asked to participate. Two of the temporary residents had been scheduled earlier to participate because they had shown prior interest in LHS. Two others agreed to participate when contacted and the other two declined.

[33] Reasons given for not consenting to an interview include such things as not seeing any purpose in participating because a decision had been made not to move into LHS; the death of the person for whom the family was inquiring; and telephone appointments not being kept, with further contact not being accomplished.

In addition, 15 professionals who often advised elderly persons on supportive housing and long-term care services were interviewed. Thirty professionals were invited to participate. Of the 15 professionals who did not participate, three declined; one who had agreed to participate could not be reached again, and contact was not possible with the remaining 11 within the period allocated for interviews.[34]

Questionnaires

The questionnaires for clients, spouses, and family members were developed specifically for the T1, T2, and T3 interviews. Both scaled and open-ended questions were used. Some items in the questionnaires were based on Seniors Survey S2 (Canada Mortgage and Housing Corporation, 1998).[35] Other items were new but were based on information from a post occupancy evaluation of LHL (Milke & Walsh, 1999)

On each occasion, one form of the questionnaire was utilized for the client, the person who required care, and that person's spouse, if they were planning to move with the client (for the T2 and T3 interview the spouse would have been living with the client in LHS). A second form of the questionnaire was utilized for relatives or friends of the client, termed family members for the purposes of this report.

The initial questionnaire used to interview clients and their spouses (Appendix E) asked about such things as future housing plans and needs, current housing and living arrangements, current dissatisfactions, priorities for a new location, knowledge about a life lease, personal care and daily living activities, and demographic information. The questionnaire utilized for the T1 interviews with family members (Appendix F) was very similar but it omitted items about current housing and living arrangements.

The T2 interview for clients and spouses (Appendix G) focused on factors that influenced the decision of the client with respect to the move, as well as expectations or satisfaction with services. The T2 family interviews utilized very similar questions (Appendix H). The focus for the T3 interview with clients and spouses (Appendix I) was on current needs, satisfaction with current services, thoughts on LHS design, and thoughts on the life lease concept. Again, the questionnaire for the third family interviews (Appendix J) was very similar to that utilized for the third client and spouse interviews.

[34] A snowball method also was used to involve professionals in the study. Initially, local hospitals and seniors' organizations that were named by clients were telephoned to obtain the contact information for their social workers or home care workers who regularly provided information on long term care options. The professionals who consented to be interviewed were asked to provide additional names of professionals who provided long term care information to persons whose healthcare needs could no longer be met through community-based services.

[35] The CEO of *The* CAPITAL CARE *Group* and Luis Rodriguez, Canada Mortgage and Housing Corporation, reviewed the questionnaires composed by the research team.

The questionnaire, for professionals' interviews (Appendix K), completed near the end of the study, examined their knowledge and thoughts about LHS and the life lease, as well as the number and types of clients to whom they recommended LHS.

Procedures

The information required to meet the study objectives was collected mainly through interviews. Three structured interviews were completed with each client, spouse, and family member who agreed to participate. A standard script was followed when participants were contacted initially over the phone. At the beginning of the conversation, person-to-person interviews were offered, but phone interviews were always offered if the individual did not want or have time to meet in person. If the person lived out of province, a phone interview was offered immediately. The study was described and the individual was asked if he or she would participate. If the person agreed, a T1 interview was arranged approximately one month after the initial inquiry at LHS. Interviews took place in the participant's home, or at an agreed upon public location.

The T2 interview was held approximately one month after the client made a choice about the move. The T3 interview was completed approximately one year after the housing decision. If the participant was living in LHS, and could not be reached by phone, a LHS staff member introduced the interviewer to the client. The interviewer then provided the information contained in the telephone script.

The same basic procedure was used for all client, spouse, and family interviews. The interviewer introduced himself/herself, described the study, and then went through the questionnaire with the participant. Interviews varied in length. Family interviews were typically completed in one hour, and client and spouse interviews lasted approximately 1 hour 30 minutes. In instances in which it was clear that the person did not understand some of the essential facts about the life lease arrangement or LHS, misconceptions were clarified at the end of the interview.

Although the interviewer requested that interviews be done individually, this was not always possible. Many wanted to complete the interviews with their spouse. Others indicated they would not participate in the interview unless there was another person present. When people were interviewed as a group, the interviewer noted which person provided which response, and responses from different family members were treated as separate data. Exceptions to this occurred when the other person present at the interview only listened and offered no responses. Such people were not considered participants.

Three interviewers were involved in the three sets of interviews. The Research Assistant (RA) who was involved throughout the study conducted T1, T2, and T3 interviews, completing the majority. A second RA completed three interviews at T1 and a third RA completed seven interviews at T3.

Professional Interviews

Professional interviews were conducted once, by phone, between June 23, 2003 and September 5, 2003. Their interviews lasted approximately 15 minutes. Fifteen participated; 14 were female. Professionals interviewed included social workers (7), Central Assessment and Placement Service case coordinators (3), a physician (1), a Community Care Coordinator (1), a nurse intake coordinator (1), a geriatric psychiatrist (1), and a senior health department advisor (1). Fourteen of the professionals indicated they regularly advised clients or client families on housing/long-term care options. One, who indicated she did not often advise such clients, had discussed LHL or LHS with approximately 5 clients, which was as often as other social workers.

Originally, the plan had been to interview only professionals who had been consulted about LHS, but most clients and families did not involve professionals in their deliberations, and those that did (33%) often were unable to name them or did not have contact information. When three of the professional interviews could not be completed because of practical and ethical reasons,[36] a new approach was developed; representatives were sought of the types of professionals whom clients said provided assistance as decisions were made. Initial contact information was made via phone at local hospitals and seniors organizations named by clients. A snowball method was used, and the professionals who participated when phoned were asked for additional names of persons who regularly advised clients on long-term care options. In this way, 30 professionals were identified for the professional interviews. Of the 15 professionals who did not participate, three declined; one who had agreed to participate could not be reached again. Contact with the remaining 11 was not possible throughout the two-month period over which other professional interviews took place.

[36] Questions focused only on housing and clients' needs for support, however, one declined because of client privacy, one did not return calls, and one had changed jobs. When the alternative method was adopted for professionals, data from the one physician interviewed was dropped from the study.

Results

Participants' Descriptive Information

Client Information

At T1, information was obtained for 42 clients. Their average age was 81.2 years (standard deviation (SD) =9.3 years, range 38-92 years). Only 26 of the clients were interviewed directly at T1 (23 at T2 and 15 at T3). The majority were female at all three interviews (T1=73%, T2=65% and T3=67%). Of the T1 clients (26), 50% were married or living common-law, 46% were widowed, and 4% were separated.

A number of clients had no formal education past elementary school (37%). Others had completed some high school (19%) or had graduated from high school (16%). Those who had formal education past grade 12 varied in the extent of their education. Some had completed college or university (16%); some technical school (6%), with the others having some college or university (6%). The type of work that clients did for most of their lives varied. A substantial number reported being homemakers (36%). All of those working in the primary sector[37] had farmed. Table 1 indicates the percent of clients who occupied various position classifications.

[37] Related to a natural resource industry such as forestry, mining, or agriculture, which collects and processes a natural resource (Microsoft Encarta World English Dictionary, 1999).

Table 1: Occupation Clients and Spouses and Family Members held for Most of Their Adult Life			
Occupation	**Client (n=36)***	**Spouse (n=14)**	**Family (n=40)**
Homemaker	36% (n=13)	43% (n=6)	18% (n=7)
Professional	6% (n=2)	7% (n=1)	38% (n=15)
Managerial	3% (n=1)	0% (n=0)	15% (n=6)
Clerical	3% (n=1)	0% (n=0)	8% (n=3)
Sales	6% (n=2)	0 (n=0)	5% (n=2)
Personal Services	3% (n=1)	0 (n=0)	3% (n=1)
Protective Services	6% (n=2)	7% (n=1)	3% (n=1)
Skilled – white collar	11% (n=4)	0 (n=0)	3% (n=1)
Skilled – Blue Collar	14% (n=5)	29% (n=4)	0 (n=0)
Semi-skilled or unskilled labour	3% (n=1)	7% (n=1)	3% (n=1)
Primary Sector	8% (n=3)	7% (n=1)	0 (n=0)
Entertainment	3% (n=1)	0 (n=0)	0 (n=0)
Miscellaneous	0 (n=0)	0 (n=0)	8% (n=3)

* In addition to responses shown here spouses answered this question for clients who did not respond. Two of these clients were said to be homemakers; one was in protective services and one was skilled blue collar.

Spouse Information

At the time of their T1 interview the average age of spouses was 79.1 years (n=22, SD=9.1 years, range 43-91 years). All were married or living common-law, with the majority living with the client (86%). One spouse lived with the client and an adult child and one spouse lived alone. At T1 the majority of spouses were male (57%), at T2 half were male (50%), and by T3 the majority of spouses interviewed were female (57%). The percentage of women spouses increased at T3 because the study retained more spouses associated with clients who moved into LHS and, among the married clients who moved into LHS, more clients were men.

One third of spouses ended their formal education with the completion of elementary school (33%) and one third had some high school (33%). The remaining had completed high school (20%) or held a college degree (13%); thus, education levels were much the same as clients. The largest percentage of spouses said homemaker was their occupation (43%). Spouses' occupations are listed in Table 1.

Family Information

At each of the three interviews the majority of family members were female (T1=68%, T2=83% and T3=63%). Age was not asked for. Interviews were primarily with daughters (T1=55%, T2=65%, T3=54%) and sons (T1=32%, T2=17%, T3=38%). Other family

members interviewed included daughter-in-laws (T1=11%, T2=14%, T3=4%), nieces (T1=3%, T2=0%, T3=0%) and close family friends (T1=0%, T2=0%, T3=4%).

More than half of the family members had completed a college or university degree (53%), therefore had substantially more formal education than either clients or spouses (16% and 13%, respectively, although an additional 6% of clients had completed technical school). A sizable proportion of the remaining family members had completed high school (38%), but some had incomplete high school grades (5%) or training from a college or university (5%). Family members' occupations varied, with the largest percent being professionals (38%). Table 1 lists family members' occupations.

Family Units

Group Composition: The types of individuals included in the family unit (i.e., the unit of people interviewed that were related to the same client) at T1, T2, and T3 varied. Table 2 provides the family unit composition for each of the three interviews. The table indicates, at the T1 interviews, there were 29 family units consisting of only one individual (i.e., 8 clients who named no supporting family members, 3 spouses who represented themselves as well as the clients with whom they were associated, and 18 family members who similarly represented themselves and their relatives who were clients). The remaining 18 family units were comprised of more than one individual, such as the client plus one or more family members (7), clients and spouses (3), clients and spouses plus one or more family members (6), and spouses plus family members (2).

Table 2:
Individuals Included in Family Units at T1, T2 and T3

Family Unit Members✦	**T1**	**T2**	**T3**
Client	8	7	1
Spouse	3	3	2
Family	18	11	10
Client and Family	7	8	9
Client and Spouse	3	4	2
Client, Spouse and Family	6	2	2
Spouse and Family	2	1	1
Total	**47**	**36**	**27**

✦Some units had more than one person interviewed who was in the same relationship to the client.

Family Unit Interviews

In situations where clients and spouses or a family unit composed of clients, spouses and family members were all asked the same question, the responses from the client interviews, spouse interviews and family interviews were combined, if all persons involved in the interview agreed. Thus, in questions answered yes or no, if all of the individuals agreed on either yes or no, then their mutual response was used. In questions that were scaled (from 1

not important to 10 important) the average of all the individual responses, if they were in general agreement, was coded as the "family unit" response. This provided an answer for the unit of people interviewed that were related to the same client, which facilitated general comparisons between clients (Table 2 above shows the number of clients, spouses, family members and family units included in the three interviews).

Results for Study Objective 1: To describe the clients' needs from the perspective of the parties (i.e., clients or potential clients, their spouses, and their families).

This section discusses why clients were considering a move, including participants' perception of the clients' needs and health status, and concerns about services.

Considering a Move

The T1 interviews revealed that clients and their family members were not in perfect agreement about whether the clients would move or not. The majority of clients intended to move (72%), but some were undecided about moving (12%), or said they were not planning to move (16%). Only 19% of clients had previously moved for reasons related to their health or mobility (but one couple disagreed on whether a move had been for that reason).

The majority of spouses were planning to move (64%), but for some a move was conditional on whether the client was able to move into LHS (21%). This was because the client required facility-based long-term care services and LHS (or alternately LHL) was the only location where a spouse could move into a centre that provided "nursing home level care." One spouse did not plan to move and one was undecided. The former lived near his employment outside Sherwood Park, and did not deem it feasible to move with the client.

Interestingly, an overwhelming majority of family members believed clients were considering a move (94%). Family members, clients, and spouses did not totally agree on the reasons for the clients' move, with one to five family units disputing whether factors such as decline in health or design barriers were relevant. Table 3 provides information for each question on whether the family units agreed on their answers related to why the potential client was considering a move.

Table 3: Reasons Clients Considered a Move According to Family Units			
Reason	Family Unit Agree Yes	Family Unit Disagree	Family Units with at least one yes
Decline in health of self or spouse	66% (n=31)	9% (n=4)	74% (n=35)
Physical difficulty maintaining home or garden	60% (n=28)	11% (n=5)	70% (n=33)
Problems with transportation	36% (n=17)	9% (n=4)	45% (n=21)
Isolated from family and friends currently	32% (n=15)	11% (n=5)	43% (n=20)
Home too large	28% (n=13)	2% (n=1)	30% (n=14)
Design barriers	23% (n=11)	6% (n=3)	30% (n=14)
Insufficient local healthcare services	19% (n=9)	11% (n=5)	30% (n=14)
Cost of living too high at current location	19% (n=9)	6% (n=3)	26% (n=12)
Insufficient leisure/recreational facilities and services at current location	11% (n=5)	4% (n=2)	15% (n=7)
Death of spouse	6% (n=3)	4% (n=2)	11% (n=5)

In most cases, clients and their families said that the plan for the client's move was precipitated by either the client's or the caregiver's decline in health. The most common reasons given were a decline in the client's health or the health of a spouse (75%), physical difficulties maintaining a home or garden (70%), problems with transportation (45%), and feeling isolated from family and friends (43%).

A large majority of spouses (75%) said it was important to them that the clients received more support services, although only 37% of clients said receiving more assistance with support services was important to them. When clients and spouses were asked which, if any, new services would improve the client's life, most said there was no particular service that would make the clients more comfortable or enable them to remain living in their current homes (85%). Their general conversation suggested that the issue was the amount of services rather than the particular type of services. However, individuals mentioned specific improvements that would help, such as assistance with: cooking, housekeeping, or general household tasks. One wanted a change in home care hours[38], and another suggested 24-hour in home nursing assistance would make a difference. When spouses were asked to answer the question from their own perspective, nearly all said there were no particular services that would improve their lives (86%). Two said they needed assistance with housekeeping (14%).

Participants' Health Status and Need for Health Services

At the T1 interview clients were asked whether they had been assessed for long-term care services (which is a requirement for admission into a long-term care facility) half (12/23 or 52%) who responded said yes. Some were in the process of being assessed, but others (44%)

[38] This spouse said the client woke early in the morning and often had to sit in bed for 3-4 hours before home care workers arrived to help her rise and dress. He believed this was one of the main factors contributing to the client's depression.

had not been assessed yet. Ten of the clients volunteered that they were receiving home care (this was not an interview question). One who had been assessed reported that no services were being received. Home care services clients included assistance at home with nursing care (5), bathing or showering (4), rising in the morning and dressing (4), and incontinence management (1).

The clients were asked to rate their overall health.[39] This had two purposes. One was to assess current needs for care; the other was to compare their self-rating with their rating after they moved. At T1 clients reported that their health was either fair (44%) or good (24%). However, 12% rated their health as excellent, 12% rated it poor, and 8% said it was very poor.[40] Most of the families rated clients' health in the poor (33%) to fair (29%) range, whereas clients who rated themselves tended to answer good (24%) or fair (44%).[41] Surprisingly, more that one-fifth of the clients rated their health to be good or excellent, considering that a professional assessment found them eligible for entry into a long-term care centre. Clients were also asked what they expected their health to be like in approximately one year. Of those who were willing to make this prediction, the majority said it would be much the same (48%), or would improve (43%). A small number predicted a decline (10%).

The clients and their family members were asked to rate the spouses' overall health because spouses living with clients were assumed to be the primary caregivers for the clients.[42] A failure of the spouse's health might precipitate the client's entry into a long-term care facility. Most spouses reported their health was either fair (31%) or good (46%), with 15 percent indicating their health was excellent and only 8 percent saying it was poor. At the T1 interview, all but one of the spouses reported that they had not been assessed for home care services or long-term care services (one was uncertain).

Objective 1 Summary

The central need of the potential client from the perspective of these clients, spouses, and their family members was for greater amounts of service. The need was related to their healthcare status. Spouses and family members were more concerned for the clients' health than the clients were, but results indicate that clients' health concerns were on all

[39] Self-report is considered a reliable measure of health status and a good predictor of risk of decline (Nikolaus, Bach, Oster, & Schlierf, 1996; Reuben, Siu, & Kimpau, 1996).

[40] If clients were not interviewed, or did not respond, their family members were asked to rate the clients' overall health (thus family rating were used for 21 clients at T1).

[41] In instances where the family unit did not agree the clients' self rating of health was accepted as most accurate, with the spouses' ratings being the next most accurate, and then the family members' ratings. Thus, the numbers here represent how the client rated his or her overall health, unless the client rating was not available, in that case spouses' rating was used. If neither the client nor spouse were interviewed then the family members' ratings of the clients' health were used. Self-ratings have been found to be more reliable than ratings from either their informal or formal caregivers (Dorevitch, Cossar, Bailey, Bisset, Lewis, Wise, & MacLennan, 1992).

[42] Even for the two married couples in which both persons were clients, the healthier of the two assisted the other with tasks, suggesting the one spouse played a caregiver role. Both spouses in these couples were always interviewed as clients, not companions on all of the questions.

participants' minds and were the main reason a move was being considered. Interestingly, families were actively seeking a new location for the client and sometimes this was without the knowledge of the client. Families were often appeared to be enmeshed in caring for the clients and in the clients' decisions about moving.

Results for Study Objective 2: To identify the clients' resources, both financial and social.
This section discusses client's resources, both social and financial, including where clients were living at T1 and their satisfaction with the accommodation.

Living Arrangement of Clients and Spouses

At the T1 interview, clients and spouses were asked about their current accommodation, its location, how many people lived in the household and the relationships between them. Table 4 depicts the living arrangements. Twenty-two clients (85%) were living in single-family detached houses or independent apartments. Approximately one-third of clients were living alone (36%). The remainder lived with one to six other people, including spouses, children, and grandchildren. Four clients considering a life lease at LHS were living in long-term care centres; half were in semi-private rooms, sharing their room with a roommate, and half had private rooms. One who was in a long-term care centre had a spouse living in their community home who was also interviewed. The other 13 who were interviewed were all living with their spouses in the community and in one instance the spouse and client were living with an adult child (i.e., 86% of spouses were living with one other person and 7% were living with two others).

If the client and/or spouse were living with someone at the time of the T1 interview they were asked where this person would be located if the client moved. Two clients indicated the people they were living with would remain in the current location (67%); these clients had moved in with children and grandchildren. The remaining client, who owned the house, was not sure where the other person would decide to move (33%). One spouse expected the other person currently living in the household to move to an apartment.

Table 4:
Client's and Their Spouse's Living Arrangements in the Community

People live with	Client	Spouse
With my spouse	55% (n=12)	93% (n=13)
No one, I live alone	36% (n=8)	7% (n=1)
With my child/children	14% (n=3)	7% (n=1)
With my grandchild/grandchildren	9% (n=2)	0% (n=0)

Most clients and spouses had lived in their current residence for many years. The average for clients was 15 years but the range was from less than one year to 50 years. Spouses had lived in their home for an average of 16 years with a range from less than one year to 51 years. A

number of clients (31%) and spouses (21%) had moved within the last year. Clients and spouses had been living in the same area for much longer than they had lived in their current home suggesting that most tended to stay in the same neighbourhood when they did move. The average for clients was 26 years (range <1- 93 years), whereas spouses' average was 22 years (range <1-51 years). However, 19 percent of clients and 14 percent of spouses had lived in their area for less than a year (this 19% was not congruent with the 19% mentioned above who had previously moved for health or mobility reasons).

Modifications to the Clients' Homes in the Community

At the T1 interview, many clients and spouses said the client had modified their homes to better accommodate the clients' needs (58%). Modifications included installing bathroom grab bars (39%), altering the bathtub or installing a shower (11%), ramp or stair lift at stairways (11%), hand railings on stairways (8%), and relocating a bedroom to the main floor (3%). None had modified kitchen cupboards or counters. Some of the family units (17%) had made additional modifications to the clients' homes. These included enlarging a bedroom, widening doorways, adding a hallway handrail, changing the type of doorknobs, changing light switches, lowering clients' beds, raising toilet seats, and adding grab bars either in the garage to assist entering and exiting vehicles or by the clients' beds. Other clients (8%) had considered but not made the following home modifications: stairway handrail, stair ramp or stair lift, widening a bathroom door, moving the kitchen sink forward in the counter, and lowering kitchen shelves. The clients considering modifications usually considered more than one.

Difficulties with their Homes in the Community

Clients and spouses were asked if clients had difficulties with a variety of things commonly found in a home. Table 5 depicts the responses of both clients and spouses in this regard. The most common areas causing difficulty for clients were stairs (37%), kitchen (37%), and the home entrances (31%). Although some spouses responded for clients or added to clients' responses, the couple disagreed only in two (7%) situations. In both situations, the spouse said clients had difficulties with stairs and the client disagreed.

Table 5:
Clients' Difficulty with Common Household Obstacles as Reported by Client and Spouse at the Initial Interview

	Client	Spouse*	Total Clients
Stairs	35% (n=7/20)	43% (n=3/7)	37% (n=10/27) ‡
Kitchen	35% (n=7/20)	43% (n=3/7)	37% (n=10/27)
Bathroom	17% (n=3/18)	50% (n=4/8)	27% (n=7/26)
Bedroom	0% (n=0/18)	11% (n=1/9)	4% (n=1/27)
Storage Space	0% (n=0/18)	29% (n=2/7)	8% (n=2/25)
Entrance	29% (n=4/18)	50% (n=4/8)	31% (n=8/26)
General Design	6% (n=1/18)	13% (n=1/8)	8% (n=2/26)

* Only spouse responses from spouses related to clients who did not respond are included.
‡ In two situations where both members of a couple responded, the client indicated no difficulties whereas the spouse disagreed. If this spouse's response were used instead of the client's this would be 44%.

Spouses had some difficulties with the environment that were similar to clients. The most common area of difficulty was stairs (50%), kitchens (29%), and home entrances (29%). Other problem areas for them were the bedroom (21%), storage areas (21%), bathroom (14%), and the general design (14%).

Satisfaction with Client Pre-move Accommodations

Most people interviewed were satisfied with the location where the client lived at the time of the T1 interview (prior to any decision to move). As indicated above, 26 clients, 14 spouses, and 38 family members were interviewed and most were either generally satisfied (clients 35%, spouses 50%, family 39%), or very satisfied (client 39%, spouse 0%, family 29%). The remainder were either a little dissatisfied (client 17%, spouse 25%, family 19%), or very dissatisfied (client 9%, spouse 25%, family 13%). When spouses rated their living accommodations from their own perspective, the majority were satisfied (36% very satisfied, 43% generally satisfied) and only three were dissatisfied (7% a little, 14% very).

Seventeen clients and nine spouses indicated how satisfied they believed their family was with the clients' accommodations. The majority of clients felt that the family was satisfied (53% generally satisfied, 18% very satisfied), whereas the majority of spouses felt that family members were dissatisfied (33% a little dissatisfied, 22% very dissatisfied). When compared with the families' own ratings, as reported here, it is evident that the clients overestimated their families' approval and the spouses overestimated their disapproval.

Ten clients had one or more specific dissatisfactions with the accommodation at the T1 interview. Design barriers, such as stairs or difficulty manoeuvring in the bathroom, were the most frequently mentioned dissatisfaction (50%). Other issues included the location being noisy (30%), physical safety hazards (10%), difficulty in maintaining the building (10%), heating problems (10%), lack of personal space (10%), not being allowed to use the kitchen

appliances (10%)[43], lack of privacy (10%), and the distance the client had to travel between the suite and the dining area (10%). Only two spouses listed specific dissatisfactions and like the clients the most common issue was design barriers (mentioned by both responding spouses). Other dissatisfactions mentioned by one spouse included a lack of space, noisy location, too large, too expensive, and the distance between client's suite and the dining area.

At the T1 interview, many family members (74%) listed specific dissatisfactions with the clients' accommodations. Most discontent was with either environmental factors or services. Environmental complaints included design barriers (16%), lack of privacy (13%), a building with difficult upkeep (10%), lack of space (10%), physical safety hazards (7%), and a confusing layout of the building (7%). Other complaints mentioned by individuals included the building being too isolated, concern the client would wander off, noisy neighbours, lack of visitor parking, and the location making family visits difficult. Dissatisfactions related to services included staff being unable to meet the needs of residents (10%), clients' dietary needs not being met (10%), the facility not offering the necessary service level (7%), care workers often being late (7%), and no medical care at the current facility. Two family members were dissatisfied because few people of the clients' age lived in the community. Individuals mentioned clients not being allowed to smoke on site, lack of staff training, communication problems among staff, communication problems between staff and family, the facility not providing meals, and lack of client control.

Expectations Prior to a Move and Clients' Social Resources

For clients saying LHS was their first choice for a new location, the single most frequently mentioned expectation was that the client would be happier (27%). However, expectations related to services were commonly expressed. For example, clients and spouses expected an improved quality of care compared to what they were currently receiving (20%) or assistance with common tasks such as cooking (13%) or cleaning (13%). Individual clients and spouses also mentioned features of the building that would facilitate care, such as being able to prepare a meal in their suite and having a call system in place. See Table 6 for other responses provided by clients and spouses.

[43] The family and staff of the current location turned off the power to the client's stove and microwave because they believed she was unable to use them safely.

Table 6: Clients and Spouses Expectations for Clients in LHS		
	Expectation	Percentage holding expectation (n=15)
Services	Improved quality of care will be provided	20% (n=3)
	Assistance with cooking	13% (n=2)
	Assistance with cleaning	13% (n=2)
	Assistance with nursing care	13% (n=2)
	Assistance with yard work	7% (n=1)
Miscellaneous	Will be happier	27% (n=4)
	Able to make friends	13% (n=2)
	Exactly the same as current residence	13% (n=2)
	Less stress	0% (n=0)
	Will have more free time	.7% (n=1)
Features	Freedom of space	.7% (n=1)
	Personal balcony off suite	.7% (n=1)
	Able to cook in suite	.7% (n=1)
	Will be more reliant on friends and family for outings	.7% (n=1)
	There will be a call bell system in place	.7% (n=1)
	Will be allowed to have a private telephone	.7% (n=1)

Family members were asked how things would change for themselves once the client and spouse move to a new location. Most of the 32 responding family members indicated that they expected that the move would give them peace of mind and (or) they would worry less (56%). Others indicated they would have increased quality time spent with the client (25%) and that they would have to do less for the client (22%). Some of the family members commented on the location of LHS and how it was closer to their home, so that visiting would be easier (28%) or more frequent (9%), and that they would be able to bring the client to their home more easily (6%). One family member expected to be more involved in assisting the client in the areas of healthcare, household tasks, and providing emotional support. Another expected to begin managing the clients' finances. The remaining family members said they would have more time with their own family, visiting friends, and to simply enjoy their own life. Responses provided some rationale for family members' involvement in clients' decisions to move.

Although two family members mentioned they would be more involved in assisting the client with specific tasks, most did expect this. Most indicated their workload would decrease when the client moved, based on a comparison of the personal assistance they provided for the client at present and what they expected to provide following a move (see Table 7). The majority of family members reported assisting with: transportation (70%), grocery shopping (70%), cooking at the clients' location (76%), delivery of hot meals (73%), heavy cleaning (70%), and laundry (64%).

Table 7: **Percent of Family Members Assisting with Different Tasks at the T1 Interview and Expectations for Assisting with these Tasks after the Client Moves**		
Tasks	Help provided at T1	Expect to provide help in future
Grocery Shopping	70% (n=23)	9% (n=3)
Cooking in the clients kitchen	76% (n=25)	0% (n=0)
Delivering hot meals	73% (n=24)	3% (n=1)
Heavy Cleaning	70% (n=23)	6% (n=2)
Laundry	64% (n=21)	6% (n=2)
Repairs	45% (n=15)	15% (n=5)
Snow removal	45% (n=15)	6% (n=2)
Errands	39% (n=13)	24% (n=8)
Yard work	33% (n=11)	21% (n=7)

The clients interviewed at T1 were asked what changes they expected upon moving to their new location. Overall, they listed more positive changes than negative changes, regardless of the new location selected as their first choice. A number of clients (38%), however, said they could not predict what changes they might experience with a move. Among those who listed LHS as their first choice, two said that they envisioned no change because they would still be living in their own home receiving care services. Both currently received home care and did not expect more assistance because of a move into LHS. Other clients expected both positive and negative changes. The positive change most commonly mentioned was the availability of receiving 24-hour professional support (30%), as well as, more frequent family visits (20%), less cooking (13%), less housework (10%), and having recreation programs on site (13%). A few clients had negative expectations such as being more isolated (7%), and single clients suggested they would be more wheelchair dependant, less satisfied with accommodations, need to travel to receive speech therapy, have less enjoyable recreation programs, no longer having a vehicle, and travel less in the community.

Financial Resources: Income and Home Ownership

Twenty of the 30 clients who moved to LHS owned their home prior to moving, according to information from family units at the T2 interviews.[44] For most of the clients (60%) selling their home was necessary to make the lump sum payment at LHS, according to at least one member of the family unit, although in one instance both the client and spouse maintained they could have afforded the initial payment without selling their home whereas their child indicated they would have to sell their home. The remaining 35% of clients did not have to sell their home to afford the lump sum payment.

All but two of the clients who owned a home sold it prior to or shortly after their purchase of a LHS suite. One client who did not sell a home had co-owned and the other owner had remained living in the house. The other client had kept the home, moving into LHS on what

[44] Either the 10 clients who were not homeowners rented, or they lived with family members.

he/she deemed a trial basis, planning to return to the community home if LHS did not satisfy. The client's family, however, said the home had been sold between the T2 and T3 interviews.

Proportion of Income Spent on Shelter Prior to Moving

At the T1 interview, some did not know what proportion of their monthly income was spent on total shelter costs including taxes and utilities (clients 15%, spouses 27%). Most indicated they spent more than 40% (clients 38%, spouses 18%), less than 30% (clients 27%, spouses 27%), or between 30 and 39% (clients 19%, spouses 27%). None of the clients indicated this proportion was financially difficult for them, but one spouse reported having difficulty finding money for housing related costs. In addition, most of those interviewed at this time indicated that they were not concerned (75% of clients, 83% of spouses and 87% of family members) that LHS charged higher monthly fees than traditional long-term care facilities.

Sources of Income

Clients and spouses were asked questions about their sources of income at T1. Most clients and spouses reported receiving money from OAS (Old Age Security) (68% of clients, 52% of spouses), CPP/QPP (Canada Pension Plan/Quebec Pension Plan) (68% of clients, 48% of spouses), or savings and investments (62% of clients, 48% of spouses). Table 8 is a compilation of sources reported by family members for the clients and spouses, as well as clients' and spouses' own reports.

Table 8:
Sources of Income of Clients and Spouses Reported by Family Units

Source	Clients (n=37)	Spouses (n=21)
Old Age Security	68% (n=25)	52% (n=11)
Fixed Government Income Supplement (FGIS)	24% (n=9)	14% (n=3)
Canada Pension Plan (CPP) or Quebec Pension Plan (QPP)	68% (n=25)	48% (n=10)
Other government related sources	14% (n=5)	5% (n=1)
Retirement pensions	32% (n=12)	38% (n=8)
Employment	3% (n=1)	5% (n=1)
Savings and investments	62% (n=23)	48% (n=10)

Objective 2 Summary

Potential clients had substantial social and financial resources at T1. They had social support at hand, because most of the 35 clients lived with other people. Thirteen of the clients were living with their spouses in the community and in one instance, the spouse and client were living with an adult child. Most clients had lived in their home for many years and home modifications had been made to accommodate the clients' needs. However, at the T1 interview most family members (74%) were dissatisfied with the clients' location. This dissatisfaction on the part of family members provides a reason for family members' to be involved in clients' decisions to move. When family members were asked how things would

change for themselves once the client moved, many echoed the person who said they expected "to have peace of mind." Family members may have been looking for respite for themselves, considering that a substantial majority reported that they assisted clients with: transportation, grocery shopping, cooking at the clients' location, delivery of hot meals, heavy cleaning, and laundry.

Twenty of the 30 clients who moved to LHS before T2 owned their home. The majority had sold their home to make the lump sum payment to purchase a life lease at LHS, but slightly more than one-third did not have to do that. Most participants indicated that they spent between 30% and 40% of monthly income on total shelter costs and this was not financially difficult for them. In addition, most indicated that they were not concerned that LHS charged higher monthly fees than traditional long-term care facilities. Nine clients, however, were receiving the Federal Government Income Supplement, which implies they had fewer resources than the average senior. They might be expected to have more financial concerns than other clients.

Results for Study Objective 3: To identify the parties' choice of residence and the reason for their choice

This section discusses the parties' choice of residence and possible reasons for their choice.

Spouse Interest in Being Able to Live with the Client in a Long-Term Care Setting

One of the main features of LHS is that it enables couples to continue to reside together even though one requires the constant availability of nursing services. T1 interviews were precipitated because someone in a client's family had inquired about LHS and left contact information. The inquiries may have prompted by the possibility of keeping a client and spouse together, if this were a central interest it would be expected to influence the decision to move to LHS. Therefore, at T1 the clients were asked if there would be someone with whom they would move if they had the opportunity to move to LHS.

All married clients (50% of clients) expressed interest in moving with their spouse at T1, and two unmarried clients (8%) were interested in having a companion (a sibling or a same sex friend) move with them. The other single clients said they did not wish to live with someone (42%). All family members of married clients (18% of all family members) said the client would be interested in living with a spouse, agreeing 100% with the married clients. Most family members of unmarried clients believed clients would not want to live with a spouse in a care housing facility (82%).

A substantial majority of spouses (86%) were interested in moving into a care housing centre with their spouse (a client), but one spouse was undecided and one said definitely not. The undecided spouse was still employed and a move would make it difficult for him, yet he said he would like to remain living with his spouse if possible. The spouse who said definitely not

was married to a client diagnosed with Alzheimer's disease who had recently been exhibiting difficult-to-manage behaviours according to the spouse and the couple's adult children.

The idea that the care housing model provides services equivalent to a long-term care facility was found to be one of the most difficult concepts for people to grasp during an evaluation of the first life-lease centre, LHL. To verify that participants were aware of the level of healthcare services LHS provided, clients and spouses were asked whether their friends understood that LHS' services were equivalent to a long-term care facility. The majority (57% of clients and 80% of spouses) said this was understood, suggesting that most participants and their families understood this too.

Comfort with Responsibilities Related to Owning a Home

Clients and spouses were asked to rate their own degree of comfort with the responsibilities normally associated with owning a home. In addition, spouses were asked to rate how comfortable they thought the clients were with these responsibilities. Most clients indicated that they were either generally comfortable (36%) or very comfortable (46%) with the responsibilities of owning a home; however, some were a little uncomfortable (5%), or very uncomfortable (14%). Most spouses were very comfortable (46%) with these home-owning responsibilities. Others were generally comfortable (31%) or a little uncomfortable (23%).

In most cases where both the clients and their spouses responded to this question, the spouses' answers were the same as the clients' answers. However, in one instance, a client indicated general comfort but the spouse said the client was a little uncomfortable. In two other cases the spouses responded for clients who did not reply. One said the client was very uncomfortable and the other said the client was very comfortable.

Objective 3 Summary

Spousal interest in being able to continue living with the client was expected to be an influence in the clients' decision to move to LHS. Spouses evidently approved of this concept behind the development of Laurie House model because a substantial majority of spouses (86%) said they were interested in moving into LHS with the clients. In fact, all married clients (50% of clients participating) were interested in moving with their spouse and two unmarried clients (8%) expressed interest in having a companion (a sibling or a same sex friend) move with them.

Results for Study Objective 4: To determine the priorities of the parties in regard to resolving the issue of choosing life lease accommodation (LHS).

This section discusses specifically why clients purchased a life lease, the participants' knowledge of particular features of the life lease, the importance they placed on various features, as well as their opinions on the security of the life lease investment.

Rationale at T2 for the Purchase of a Life Lease at LHS

The main reason the clients chose a life lease option, according to a majority of the family members participating at the T2 interview, was because the clients wanted to live in a LHS suite (50%). Some said they believed it was the only option available for the client in Sherwood Park (14%). Other reasons offered by a single family member in each case, included: not wanting to pay higher monthly fees, the immediate availability of LHS – no waitlist, LHS allowed the client and spouse to live together, the belief that there was no other option that would meet the needs and expectations of the client and family members, and because it gave the client "ownership" of their suite. Family members were asked to identify any features, from a list, that had prompted them to advise the client against purchasing a life lease. Their replies indicated the only features that prompted such advice were the lump sum (9%), the monthly fees (9%), and the lease termination (4%).

At T2, just after most clients had purchased a life lease at LHS, it was interesting to note, for the group that did not make the purchase, that none of the clients, companions or family members had been opposed to the life lease. The clients' particular circumstance, rather than family opposition appeared to account for their choice not to purchase a LHS suite. Only one of the clients who qualified for admission into LHS chose to move to another location. Family members indicated this client was familiar with the long-term care centre she chose because her husband had resided there and she knew many of the staff and residents. Ten other clients did not qualify for admission. Six of these clients remained in their community home, two moved from their house into another community location (i.e., a condominium), and two clients had diagnosis which required a different type of facility to provide adequate care.[45]

Family Involvement in the Decision

Family members appeared to play an important role in selecting the clients' accommodation. At the T1 interviews, an overwhelming majority of family members believed clients were considering a move (94%) and they viewed a move very positively. This was in spite of a number of clients being undecided (12%), or indicating they were not planning to move (16%). Family members may have viewed a move as an inevitable step because they were

[45] One client had a dementia diagnosis and required a secure facility, the other had a diagnosis of Amyotrophic Lateral Sclerosis which requires a high level of supervision.

providing so much support for the client. At the T1 interview, the majority of family members were providing substantial assistance to clients with everything from transportation to heavy cleaning. At the T2 interview, after the clients had moved 75% of family members were reported to be dealing with the details of the life lease for the clients. Family members knowledge of life lease arrangements and understanding of the key features may play an important role in the success of life lease developments such as LHS.

Attitudes toward Life Lease Arrangements and Knowledge of Life Lease Features

At the T1 interviews, all participants were asked if they would consider a life lease option for the client. The majority of spouses and family members, as well as potential clients, said yes, they would consider a life lease (76% of families, 85% of spouses, and 75% of clients). However, nearly one-quarter of the family members (24%), as well as some clients (17%) and a spouse said no, they would not consider a life lease. This left only a small percentage (8% of clients and one spouse) undecided about whether they would consider this option. They said this was because they did not know anything about a life lease.

Knowledge of life leases arrangements was investigated in several ways. All participants were asked at T1, T2, and T3 how comfortable, on a scale of 1 to 10, they would be in explaining the features of the life lease to another person. Most clients and spouses said they would be generally uncomfortable explaining life lease features. Each time, a number chose not to answer. At T2, for example, 13 of the clients, 6 spouses, and 1 family member said they did not feel they knew enough about the terms of the life lease to respond. For those that did provide answers, responses were not significantly different from those at T1. Family members seemed more willing to answer than clients and spouses. Many of the family members (75%) reported that they dealt with the details of the life lease for most of the clients. A few clients and family members dealt jointly with the details of the life lease (6%). Only two clients (13%) and one spouse said they dealt with the details of the life lease arrangements themselves.

Table 9 has the average comfort level at T1, T2, and T3 for clients, spouses, and family members. There were no significant differences in the responses of the three types of participants at T1, T2, or T3, although the trend was for clients' to reflect less comfort than spouses, and both to reflect less comfort in discussing features than family members did.

Table 9:
Average Client, Spouse and Family Member Comfort in Explaining the Life Lease

	Client Mean (SD)	Spouses Mean (SD)	Family Mean (SD)	Total Mean (SD)
T1	2.19 (2.67)	4.17 (4.15)	7.18 (3.19)	5.80 (3.83)
T2	2.18 (3.10)	3.39 (3.18)	6.32 (3.52)	4.43 (3.68)
T3	3.88 (2.77)	4.39 (3.26)	7.15 (2.47)	5.82 (3.07)

During theT3 interviews (approximately one year after the move) clients, spouses, and family members were asked whether they were familiar, yes or no, with the general concept of life lease. The majority of clients and spouses replied no. The majority of family members said yes (see Table 10). Participants were also asked to rate their familiarity with specific features of the life lease on a scale of 1-10. Responses suggested the majority of clients were most familiar with features that they would have dealt with or discussed a number of times, such as monthly fees, resident council, lease contract, lump sum payment, and purchase of household insurance (see Table 10). Few were familiar with features not dealt with such as the lease termination and resale of the suite. Spouses were more apt to be familiar with the resale of the suite than clients. Nearly all family members, however, reported being familiar with all features, with the exception of the resident council.

Table 10:
Familiarity with the Life Lease Concept (T3)

	Clients	Spouses	Family	Total
Not Familiar	53% (n=8)	50% (n=2)	6% (n=1)	30% (n=11)
A little Familiar	20% (n=3)	25% (n=1)	11% (n=2)	16% (n=6)
Generally Familiar	27% (n=4)	25% (n=1)	44% (n=8)	35% (n=13)
Very Familiar	0% (n=0)	0% (n=0)	39% (n=7)	19% (n=7)

Percent of Clients, Spouses and Family Members Familiar with Specific Features of the Life Lease Concept (T3)

	Clients	Spouses	Family	Total
Monthly Fees	73% (n=11)	75% (n=3)	94% (n=17)	84% (n=31)
Lease Contract	67% (n=10)	75% (n=3)	94% (n=17)	81% (n=30)
Lump sum payment	60% (n=9)	75% (n=3)	94% (n=17)	78% (n=29)
Insurance	53% (n=8)	50% (n=2)	94% (n=17)	73% (n=27)
Lease Termination	47% (n=7)	50% (n=2)	100% (n=18)	73% (n=27)
Resident Council	73% (n=11)	75% (n=3)	61% (n=11)	68% (n=25)
Resale	20% (n=3)	50% (n=2)	78% (n=14)	51% (n=19)

Importance of Specific Life Lease Features

Participants were asked directly what features of the life lease arrangements were important to them. The percent of clients, spouses, and family members who specified particular features as being important to them are provided in Table 11. No single feature was rated as being of equal importance to the three groups of participants. Nearly 50 percent of all participants, however, indicated that the resale of the suite was of key importance. Other features were rated as key by 30 percent to 40 percent of participants, with the exception of resident council, which no group viewed as a key element.

Table 11: Key Features of the Life Lease According to Clients, Spouses and Family members at T3				
	% Clients Yes (n=15)	% Spouses Yes (n=4)	%Family Yes (n=18)	Total Yes (n=37)
Resale	33% (n=5)	25% (n=1)	67% (n=12)	49% (n=18)
Lease Contract	20% (n=3)	0% (n=0)	67% (n=12)	41% (n=15)
Lease Termination	13% (n=2)	0% (n=0)	67% (n=12)	38% (n=14)
Monthly Fees	20% (n=3)	25% (n=1)	56% (n=10)	38% (n=14)
Lump sum payment	20% (n=3)	25% (n=1)	50% (n=9)	35% (n=13)
Insurance	27% (n=4)	25% (n=1)	39% (n=7)	32% (n=12)
Resident Council	13% (n=2)	0% (n=0)	28% (n=5)	19% (n=7)

Life Lease a Secure Investment

At the T2 interview, all participants were asked if they believed their investment in the life lease was secure. Three-quarters of the clients who responded (17) said they believed their investment was secure (76%). Others said they were unsure (24%) but none considered the investment insecure. When asked about this they elaborated in several ways. Two individuals mentioned government involvement, saying either that LHS is insured by the government or is operated by the government.[46] Two indicated trust in TCCG, saying, "I simply trust that it is (secure)" and several individual answers revealed that they trusted what they had been told by the LHS manager or their family members. Others indicted trust in legalities, for example, two trusted their lawyers and two other individuals trusted the lease contract. One client offered no reason but felt his investment was secure.

The majority of the spouses who replied in the T2 interview indicated they felt their investment in the life lease was secure (89%). Only one was uncertain. Like the clients, the rationale for this belief was that it was government-insured (60%), no one had suggested otherwise (20%), or they just trusted that it was (20%). Three spouses offered no reason, but believed the investment was secure.

At the T3 interview, all 18 family members said they believed the client's investment in the life lease was secure (100%). The chief reason provided was that they "trusted the government" (55%). Some listed other reasons such as they just trusted that it was (22%), the contract stated that it was (11%), a belief that TCCG is a solid institution (6%), and that healthcare is part of the Canadian economy and that the only way the healthcare industry will fail is if the Canadian economy fails (6%).

[46] The operator, TCCG, is a wholly owned subsidiary of the health region, but neither TCCG nor the health region is "government." TCCG does insure its long term care centres.

Expectations for Future Moves

At each of the three interviews, family units were asked if they expected the client to remain living for the remainder of their life in the place where they planned to move (the question was altered in the T2 and T3 interviews if the client had just moved). If the study participants understood the purpose of LHS, and were satisfied with the life lease arrangements, then their answers should indicate that they expected no further moves.

At the T1 interview, most of the members of the family units agreed that the client would remain in the location they were now selecting for the rest of his or her life (86%). Members of two family units (4%) did not agree on their answers. In one instance, the spouse expected the client to move again, whereas a family member expected no further moves. In the other family unit, the client expected to move again but the spouse expected no further moves. The family unit of a potential client who had not qualified for LHS and planned to move to an apartment did not believe the person would remain in that location (2%). The remaining family unit did not want to make a prediction, or they indicated they did not expect the potential client to move from their current location. Results suggested that the majority understood that LHS provided the services of a long-term care facility.

At the T2 interview, the majority of the family units agreed that the clients would remain living in their current location (LHS) for the remainder of their lives (76%). Again, some family units (8%) disagreed. All of the family units that indicated that clients were not expected to remain living at their current location (15%) either had not moved from their community home, or had moved into a location in the community rather than to LHS.

Indications that LHS was not viewed as a long-term care centre came from three of the family units that did not provide a yes/no answer to this question. Two of these expected the client would remain living at LHS for life but qualified this by saying the client might need to move because of concerns over unspecified health factors. One other family unit, associated with a potential client who did not qualify for admission to facility-based long-term care, indicated that the person should not stay at the current location in the community, but would do so unless they found a housing option that provided aging in place, to avoid moving again, and no discharge criteria. However, in the dream retirement environment described by this family unit, a couple would be able to move in before they required care and the arrangements would not require any further moves. If it had a lease agreement, then the lump sum would be returned at the current market value minus a small handling fee. This ideal setting was expected to meet all of their care requirements, have space for very large wheelchairs and lifting equipment, and have large green spaces with nice gardens and paved walking trails. It would also have a transportation system (bus) operated by the centre for scheduled trips, but also be available for private trips. In addition, the setting should be located in another city, they said.

At the T3 interviews, two family units were associated with clients who had not moved to LHS. They said that the clients would not remain living in their current location. In one instance, the potential client had remained living in the community and would need facility-based long-term care, and in the other the client had moved into a long-term care facility but

the spouse wanted the client to move again. The majority (78%) of family unit members associated with LHS were unanimous in their understanding that clients would remain living there for the remainder of their lives, although the question of needing to move if the client's health deteriorated was raised again by several people. In instances where these family units disagreed, it was because a single member believed that a move might be necessary. In one family unit, the family members understood that the LHS client would not move but the client and spouse thought it might be necessary if their health were to deteriorate. In another family unit, the LHS client did not think he would move again but the family member indicated he might if his dementia progressed to a point where he needed support for that condition (i.e., needed a secured site). This is a valid reason for discharge from LHS. Other than the valid reason for discharge just mentioned any changes in the LHS clients' health status would all be treated at LHS. There were no temporary transfers or discharges to acute care during the period of the study.

Objective 4 Summary

Family members appeared to play an important role in selecting the clients' accommodation. Thus it is important that family members understand that LHS provides the services of a long-term care facility and that clients can age in place there. They also need to understand the life lease. Family members' knowledge of life lease arrangements and understanding of the key features may play an important role in the success of life lease developments such as LHS. One-quarter of the family members and some clients said no, when participants were asked at T1 if they would consider a life lease option for the client. The majority said yes, however, with only a few being uncertain and saying this was because they lacked information.

Responses in this section suggest that the interest in LHS shown by potential clients', their spouses', and family members' did not stem from its life lease arrangements. Many participants seemed to be unfamiliar with the features of the life lease and generally uncomfortable in explaining them. When asked about the features with which they were most familiar, not surprisingly, the majority of clients indicated they were most familiar with features that they would have dealt with first hand or discussed with others. One of the strikes against life lease development may be its unfamiliarity. All of the participants, however, believed their life lease investment was secure. When asked directly which features of the life lease were most important to them, participants' answers focused on the resale of the suite.

It is important to note that most of the potential clients did in fact choose to move to LHS. Only one client who qualified for admission chose to move to another location. The proportion moving to LHS was high, no doubt, because those most interested in the centre were willing to be interviewed. The 4 clients, 5 spouses and 13 family members who represented the group not choosing LHS might have been expected to have more negative attitudes toward LHS, however, this was not the case.

Results for Study Objective 5: To determine how professionals involved in clients' transitions from home to residential long-term care make recommendations on those options.
This section discusses the advice professionals offer to clients regarding the life lease model during the clients' transition from home to long-term care facilities.

Professional Interviews

A number of professionals who advise elderly clients looking for supportive accommodations were interviewed by phone. In the interviews, questions were asked about Laurier House as a model of care, rather than LHS specifically. This meant that both LHS and LHL were discussed. The professionals were expected to be more familiar with LHL because of its longer operation. LHS and LHL are identical in terms of the life lease contract and the services offered, therefore knowledge and beliefs that professionals held for one site were believed to be representative of their beliefs of the other.

Professionals interviewed for this study included social workers (n=7), case coordinators with the health region's Central Assessment and Placement Service (n=3), a physician (n=1), a Community Care Coordinator (n=1), a Nurse Intake Coordinator (n=1), a geriatric psychiatrist (n=1), and a senior health department advisor (n=1). Although some clients, spouses, or family members indicated that lawyers assisted them in deciding on a location to move, none of the lawyers contacted were willing to participate in the study.

The professionals said they served four types of clients regularly (see Table 12). The majority served only seniors (73%), with the remainder serving the general population, which included children and younger adults as well as seniors (27%). The individuals they served were in either of two locations, that is, they were living in the community or moved directly from an acute care hospital (typically after an event that altered their health status), and they were of two frames of mind, either resolutely looking for housing options or not necessarily looking for housing options.

Table 12:
Professionals Report of the Type of Clients They Regularly Serve

	Looking for housing options	Not necessarily looking for housing options
Living in the Community	13% (n=2_)	47% (n=7)
In Acute Care Hospital	27% (n=4_)	20% (n=3)

_ One professional served clients in both the community and in hospital. She was included in both client groups.

Fourteen of the professionals indicated they advised clients or client families on housing options. One Social Worker did not view her role this way. She said her responsibility was to

arrange an appropriate discharge from hospital in the period available, not to provide advice or information on the places available to clients.

The majority of professionals said they did not take the type of tenure into consideration when advising clients who were looking at housing options (60%). When advising clients, most professionals provided the clients with information on all appropriate locations and allowed the client to determine which option was preferred (40%). Other professionals provided information on all locations available (27%), on the types of locations and the services that were typically offered (13%), or the names of all appropriate locations but no other information (7%). None of the professionals recommended specific locations to clients.

Professionals' Life Lease Knowledge

The majority (80%) of the professionals had heard of a life lease prior to their interview and all but two (of 12) remembered where they initially learned about the concept. A number had been exposed to the life lease model at a presentation by TCCG staff when LHL opened (30%), and an equal number during the orientation to their current job (30%). Others had heard the term from a client and had investigated further (10%), read about life leases in a magazine (10%), received information from a physician (10%), or attended a conference where information was provided (10%).

The majority of professionals said they did not feel overly confident in explaining the features of a life lease to a client. Most (50%) thought the life lease was a good idea, but 25 percent were impartial and the remaining 25 percent said it was a not good idea.

Professionals identified the following benefits of the life lease: the client living with a spouse (33%), a higher quality of life (25%), a guaranteed return of money at time of move out (25%), provides homeownership to clients (17%), offers all the care a client could need (17%), has a homelike atmosphere (17%), and one said the life lease model maintains the perception of independence. One professional stated there were no benefits for the client in the life lease setting.

Most professionals considered the major shortcoming of the life lease settings to be that they are not financially accessible to all (83%). Several, however, said that a lease that requires a spouse or companion (who does not qualify for facility-based long-term care services) to move after the client dies (25%) is a shortcoming. Three individuals mentioned the lack of regulations to govern rate increases and limitations such as the setting not being suitable for all medical conditions.[47]

[47] Clients who are in late stage dementia or have a diagnosis requiring a high level of supervision such as Amyotrophic Lateral Sclerosis (ALS also called Lou Gehrig's Disease would not be admitted to LHS or LHL. Approximately 3,000 people in Canada have a diagnosis of ALS (ALS Society of Canada, 1996).

Professionals Knowledge of LHS and LHL

Many made comments about the Laurier House model using their experience with the LHL site. Because most had a single source of information for both the model of care and the life lease arrangements, their responses were nearly identical to questions on both topics. The majority (87%) had heard of Laurier House prior to the interview and most heard while attending a TCCG presentation for the opening of LHL (33%), or through the orientation for their current job (13%). Other individuals had received information from various sources: a resident at LHL, a magazine article, a physician, a conference, or an in-service. Only one did not recall the origin of the information. Professionals were asked if they were aware of the specific services and features offered at LHS and LHL. The majority of those who had heard of the model of care indicated they were aware of the features (see Table 13).

Table 13:
Professional Awareness of Different Features and Services Available at LHS and LHL

Feature or Service	Professionals who knew this
Personal care equivalent to that in a long-term care facility	85% (n=11)
Nursing care equivalent to that in a long-term care facility	85% (n=11)
Clients can live with a spouse of their choice	85% (n=11)
Both residents of a suite can require nursing care	100% (n=13)
Clients have the option of having their own pet	69% (n=9)
Clients can decorate their suite as they wish	69% (n=9)
Clients have the option of making some of their own meals or taking them all in the main dining area	85% (n=11
Clients have the option of doing their own laundry or having LHS staff do their laundry for them	77% (n=10)
There is a party room and family dining room available for residents for residents wishing to entertain larger groups	77% (n=10)
There is a guest suite available for out of town visitors	54% (n=7)
There is a smoking room within the building	38% (n=5)

Recommending LHS (or LHL)

Twelve of the professionals provided reasons why they would recommend either of the Laurier Houses to a client, with the most common reasons focusing on specific features of the model of care. For example, LHS or LHL would be recommended if a couple wished to remain living together (64%), had the financial resources to purchase the suite (29%), in cases where a client was looking for more personal space (21%), wanted their own home (14%), or were looking for more control over the care they received (14%). Other criteria given by individual professionals included the client having either a pet that he or she wanted to keep, a strong desire not to go to a long-term care facility, or a spouse that seemed to need support and fellowship. One professional misunderstood the admission criteria saying LHS and LHL were for couples where both members required facility-based long-term care. The criteria two professionals were using were incorrect; one indicated the model of care was for

a client with an Alzheimer diagnosis, and the other said it was for a client with an Alzheimer diagnosis who had a spouse to care for the client.

The twelve professionals who had reasons for recommending the Laurier House model also felt there were one or more client characteristics that would dissuade them from recommending the Laurier House model. These included, the client being in a poor financial situation (42%), having a diagnosis needing a high level of supervision (33%, e.g., amyotrophic lateral sclerosis), a dementia diagnosis (25%), the spouse not wanting to move with the client (17%), the client having disruptive behaviours (17%), or behaviours that put the client at risk (17%). Individual professionals listed: client difficulties with socializing, a Mini Mental State Exam score of less than 26, a client not requiring facility-based long-term care, high levels of anxiety resulting from being separated from people, and a client not being able to use the call bell system. Again, two professionals were basing answers on a misunderstanding of LHS or LHL admission criteria. One would not consider the centres for clients who did not have a diagnosis of Alzheimer disease and the other would discount clients who did not have spouses who could assist in providing client care.

Two (15%) of the professionals who had heard of Laurier House had never recommended the location to a client. One of these professionals indicated she had not had the opportunity to do so stating that she never had a client that fit the entrance criteria for LHS (since she had learned of the centre) the other did not like the concept and would not encourage any client to consider this option. Eleven of the professionals had recommended either LHS or LHL to clients but only nine of them could estimate the number of clients to whom they had made the recommendation. For those willing to make an estimate, the number of clients varied from one to 54, with most estimating one to ten clients (78%). The remaining two had recommended LHS or LHL to more than 25 clients (22%).

Approximately half of professionals (54%) had the brochure, “Laurier House – The care and comfort of Home” and a third (36%) had a handout entitled “Laurier House Strathcona Campus,” and 14% had the handout on the Laurier House admission process. Other brochures or handouts professionals had that contained LHL or LHS information included, the Central Assessment and Placement Service listing (31%), the Seniors Housing Guide (23%), a Laurier House pamphlet (8%). Less than half (40%) of the professionals with handouts on LHL or LHS said they regularly provided them to clients. Two professionals who did not provide them to clients said the information was available on a shelf for people to take if they were interested. Three professionals only provided the brochure to clients they believed would consider a Laurier House, which meant people who met the entrance criteria (10%, i.e., the correct entrance criteria), were looking for assisted living (10%), or had shown an interest when it was mentioned (10%). The other professional stated that the most recent information would be obtained from one of the Laurier Houses if a client expressed interest.

Client Response to a Recommendation for Laurier House

According to the eleven professionals interviewed, clients usually viewed their recommendation of Laurier House positively (73%), although a few (9%) only expressed interest in the general concept. Two professionals mentioned clients who had expressed

concern about financial components of the life lease. One client was concerned about the lump sum payment. The other's concern was the monthly fee in addition to the lump sum payment.

Almost all the thirteen professionals (92%) who knew of LHS or LHL had a client who had heard about these centres prior to discussing the centre with the professional, although the professionals' estimates of the percentage with prior information varied widely (1-75%). The knowledge arose from clients' research, their physicians, knowing residents of LHL or LHS, home care Nurses, Family Support Groups, the LHS open house, word of mouth, and the Seniors' Housing Registry or the Society for the Retired and Semi retired (the Edmonton-based group that maintains the Seniors' Housing Registry).

Objective 5 Summary

Some of the professionals who often advise elderly persons making a transition from home to facility-based long-term care had inaccurate information about LHS and the life lease arrangements. It was surprising that even one of the 15 professionals who were interviewed thought that LHS was for persons with Alzheimer disease. Two others used incorrect admission criteria for LHS. Considering these errors, and the professionals' lack of confidence in explaining the features of a life lease to a client, it appears they need a better grounding in this new model of care. Two of the professionals who said they had heard of Laurier House had never recommended the location to a client. One of these stated, however, that she did not like the concept and would not encourage any client to consider it. Most (50%), thought the life lease option was a good idea, with 25 percent saying they were impartial and 25 percent indicating they did not think it was a good idea. At the time of the interviews, some professionals said they had passed on information about the Laurier House model to a number of clients, with the number ranging from one to 54, but most professionals estimating less than 10.

Results for Study Objective 6: To describe the parties' views as to whether the chosen residence met the needs of the client.

This section discusses the clients, spouses, and family members' satisfaction with the life lease setting and its services at T1 and T2, as well as their suggestions for the centre and the life lease arrangements. Comparisons are made in family involvement before and after the move and in ratings of the clients' health status before and after the move.

Were Initial Expectations Met by the Move?

The T2 interviews were arranged with all participants approximately one month after the client had moved, or made a choice not to move. For most, this was after they had moved into LHS. At T2, all 23 clients who were interviewed were in LHS, but 2 of 10 spouses and 6 of 23 family members were associated with clients who had not moved there.

All clients and spouses indicated that their expectations had been met by the location the clients' had chosen to live. Half said that their expectations had been totally met, with the remaining half indicating they had been met for the most part. Four, however, had no expectations and one client and one spouse chose not to answer.

The majority of the family members said their expectations had been totally met (56%), with the balance replying that expectations had been met for the most part (44%). Family members of clients in LHS said their expectations had been met through the care provided for the client and spouse (17%), exceptional staff (13%), the "beautiful" place (13%), and "everything being great" (9%). A few mentioned satisfactions or dissatisfactions that were specific to them. Satisfactions mentioned by a single person included: client privacy, staff encouragement of client independence, freedom experienced by the client and spouse, the centre being exactly how the manager described it, the spouse settling in better than expected, friendly staff, and good services (cleaning, meals and recreation). One person said the spouse had less freedom. [48] When family members were asked if they knew whether expectations of others in the family had been met, they said they had been met either totally (38%) or for the most part (63%), regardless of where the client moved.

Expectations for the Future

When clients were asked their expectations at T2, the majority of the clients and spouses who had moved to LHS indicated that things were currently good and were expected to stay that way (64%). One who had a diagnosis of dementia was concerned with the progression of the disease and the possibility of moving to a special setting. Two clients still living at home expected to have increased difficulty, but only one expected to move to obtain services. Clients and spouses' expectations are listed in Table 14.

[48] Some grievances were voiced, however. Individual family members expressed disapproval that family members were expected to sit with the client during a spouse's absence if family deemed oversight necessary; the suite being cleaned less well and less frequently than the client preferred (although clients who wished more than routine cleaning could arrange it for a fee); disapproval of medication handling in two instances (i.e., a specific medication arrived late once and was omitted once); concern that physical therapy might not be provided (although if assessed as necessary it would be), and with some staff members who needed to speak more clearly and learn to keep items in locations assigned by the client.

Table 14:

Clients' and Spouses' Combined Expectations for the Client Living at LHS at the T2 Interview

Expectations	Percentage holding belief (n=22)
It will be the same as it is now (good), nothing will change	64% (n=14)
Physical condition will deteriorate	9% (n=2)
Will continue to get good care	5% (n=1)
Will have more free time	5% (n=1)
Will continue not having to do housework	5% (n=1)
Client will develop a more positive attitude as she adjusts to routines	5% (n=1)
Will improve with meeting more people	5% (n=1)
Will make more friends	5% (n=1)
It will never be as good as home	5% (n=1)
Recreation activities will become better as more people become involved	5% (n=1)
Will improve when building is full and it is fully staffed	5% (n=1)
Dining room will be crowded once building is full	5% (n=1)
Will eventually have to move	5% (n=1)
Would not guess	14% (n=3)

Were Initial Expectations met for a Change in the Clients' Health Status?

At T1, clients had been asked their expectations for their health in approximately one year. The majority of those willing to make a prediction said it would be much the same (48%), or would improve (43%). A small number predicted a decline (10%).

At the T2 and T3 interviews when asked to rate their overall health, results were not significantly different from T1. At all three interviews, the majority said that it was fair (T1=44%, T2=50%, T3=50%) or good (T1=24%, T2=23%, T3=21%). Small changes suggested that they believed the move improved their health. For example, some reported very poor health at T1, but none chose that rating at T2 and T3 when all but four clients were in LHS. This seemed to reflect their optimism because in instances where ratings were available from both the client and their family, the interrater agreement was poor (T1=42%, T2=25%, T3=33%; agreement by chance would have been 50%). In most cases where they disagreed, the clients said their health was better than their family members rated it (T1=71%, T2=67%, T3=83%).

Family Members' Assistance – Were Initial Expectations Met?

Specific questions about family assistance were asked at the T2 and T3 interviews to assess whether the client's move had provided respite for families. Results suggested the type and quantity of assistance provided by family members was altered. For example, in the T2 interviews shortly after the move families provide a high level of assistance running errands (the percentage reporting this jumped from 39% at T1 to 91% at T2, see Table 15). This

continuation of caregiving after institutionalization is consistent with the results of other studies (Ross, Rosenthal, & Dawson, 1997). This could be explained by a settling in period and clients' needs for items for the new location. At the T3 interview, approximately a year after the move it would be expected that family assistance would be routine. At T3, more family members reported providing assistance with transportation (88% at T3, compared to 70% at T1 (see Table 15). Some family members reported providing assistance with tasks that had not been reported previously, such as finances (67%). One family member said new tasks included dealing with the client's "paper work" (cancelling a driver's license, writing letters, and dealing with legal matters). She also made and delivered special foods. Assistance with dressing the resident was the only task inquired about that dropped to a nil assistance level.

Table 15:
Percent of Family Members Assisting with Tasks at T1, T2 andT3

Household Tasks	**Helping at T1***	**Helping at T2**	**Helping at T3**
Grocery shopping	70% (n=23)	59% (n=13)	75% (n=18)
Cooking in the client's kitchen	76% (n=25)	5% (n=1)	17% (n=4)
Delivering hot meals	73% (n=24)	27% (n=6)	21% (n=5)
Heavy cleaning	70% (n=23)	18% (n=4)	17% (n=4)
Laundry	64% (n=21)	23% (n=5)	17% (n=4)
Errands	39% (n=13)	91% (n=20)	75% (n=18)
Repairs	45% (n=15)	23% (n=5)	33% (n=8)
Yard work$^{\mu}$	33% (n=11)	14% (n=3)	13% (n=3)
Snow removal$^{\mu}$	45% (n=15)	5% (n=1)	17% (n=4)
Nursing care	42% (n=14)	23% (n=5)	33% (n=8)
Assistance with dressing	3% (n=1)	0% (n=0)	0% (n=0)
Transportation	70% (n=23)	77% (n=17)	88% (n=21)

***** Helping at T1 is included in Table 6 but is included here to allow comparisons. Some of the variation across T1, T2, and T3 will be due to changes in the family members included in the three interviews as well as changes in client needs.

$^{\mu}$ At T2 and T3 family members assisted clients with snow removal and tending flower gardens on the patio or balcony off the clients' suites.

Some results suggest that family members did not receive as much respite as they may have anticipated after the clients moved (see Table 16). On most of the tasks discussed during the interview, however, more family members had stopped providing assistance than had began providing assistance to the client. For example 25 percent of family members who assisted the client with laundry before the move had stopped, but only 8 percent of family members began assisting with laundry after the move. At T3, grocery shopping (75%) and errands (75%) were the only two items where the majority of family members were assisting the clients.

Table 16: Percent of Family Members at T3 Assisting with Tasks for Clients who Moved				
Household Tasks	Assisting Client at T3		Not Assisting Client at T3	
	Began Assisting with After the move	Assisting before and after the move	Stopped assisting after the move	Never provided assistance
Grocery Shopping	25% (n=6)	50% (n=12)	4% (n=1)	21% (n=5)
Cooking in the clients kitchen	4% (n=1)	13% (n=3)	17% (n=4)	67% (n=16)
Delivering hot meals	4% (n=1)	17% (n=4)	8% (n=2)	71% (n=17)
Heavy Cleaning	13% (n=3)	4% (n=1)	13% (n=3)	71% (n=17)
Laundry	8% (n=2)	8% (n=2)	25% (n=6)	58% (n=14)
Errands	8% (n=2)	67% (n=16)	4% (n=1)	21% (n=5)
Repairs	21% (n=5)	13% (n=3)	17% (n=4)	50% (n=12)
Yard work	4% (n=1)	8% (n=2)	21% (n=5)	67% (n=16)
Snow removal	4% (n=1)	13% (n=3)	13% (n=3)	71% (n=17)
Nursing Care	13% (n=3)	21% (n=5)	17% (n=4)	50% (n=12)
Assistance with dressing	0% (n=0)	0% (n=0)	4% (n=1)	96% (n=23)
Transportation	13% (n=3)	75%(n=18)	4% (n=1)	8% (n=2)
Finances	21% (n=5)	46% (n=11)	8% (n=2)	25% (n=6)

Clients who decided not to move appeared to need more assistance according to their family members. One-quarter (6 of 23 family members were associated with clients who had not moved to LHS) listed types of assistance that they said would benefit the clients. These included checking by a health professional, counselling to help parents deal with relationships and health issues, provision of meals to meet dietary restrictions.

Early Satisfaction in the Physical Setting – Were Expectations Met?

The majority of those interviewed at T2 said they were satisfied with the clients' physical accommodations. Clients and spouses reported being very satisfied (clients 50%, spouses 60%) or generally satisfied (clients 46%, spouses 20%). One client and one spouse indicated that they were a little dissatisfied. All of the spouses who moved to LHS with clients said they were very satisfied with the setting from their own perspective and that family members were satisfied with LHS as a location for them. Two spouses who had not moved were satisfied. Approximately one-quarter mentioned specific satisfactions (26% of clients, 28% of spouses).[49] Clients and Companions mentioned the appearance of the building (12%), building location and its closeness to community amenities (6%), the privacy of the suite (6%), the view from the suite (6%), the location of light fixtures and windows in providing excellent lighting (6%), space to bring their own furniture (6%), and some were satisfied with

[49] One client complained that the suite did not have a view and minor issues that could have been remedied, were mentioned, such as the location of a toilet paper holder and the function of a bathroom latch.

everything (12%). Dissatisfactions with LHS included the lack of a second elevator and the ceiling heating system. [50]

The majority of family members said they were very satisfied (86%) with only a small percentage indicating they were generally satisfied (14%). The clients and spouses rated their family members approval of the clients' accommodations as much lower (52% as very satisfied and the rest generally satisfied).

Satisfaction with the Setting One Year after Clients Moved to LHS

The majority of clients and spouses interviewed at T3 remained satisfied with the accommodations in which the client had decided to live, indicating they were either generally satisfied (60% of clients, 40% of spouses) or very satisfied (33% of clients, 40% of spouses). One client and spouse were a little dissatisfied. Specific satisfactions included the homelike suite (21%), the suite's spaciousness (21%), the nurse call system (14%), the kitchenette having a fridge (14%), the appearance of the building (14%), the location of the building (i.e., closeness to family, 14%), and individual comments about suite privacy, the view, and the client and spouse being able to live together. Individual dissatisfactions included the suite being too big, a life lease not giving a legal title to the suite, a few clients not locking their suites, and staff having keys to access suites.

All of the family members remained well satisfied with LHS at T3 (80% were very satisfied and 20% generally satisfied). They said that LHS had met their expectations and they believed that their other relatives felt the same way. Two of the three family members of clients who had remained living in the community indicated that the clients' location also met their expectations (66%). However, one of those who were satisfied believed that other relatives' expectations had not been met.

Family members mentioned satisfactions with: the homelike suite (32%), building location (26%), spaciousness (of the building, 11%; the suite, 21%; and the suite's shower, 5%), building amenities (it being warm and friendly, 5%; nice, 5%; and the lighting throughout being great, 5%), as well as the privacy LHS offered (16%) and particular features that enhanced the clients and spouses' privacy (suite balconies or patios, 11%; and the fridge in the kitchenette, 11%). Two were dissatisfied with noise travelling into the suite, one with the bathroom floor of a suite, and one with the elevator being a long way from the clients' suite.[51]

[50] Spouses mentioned their satisfaction with the private balcony and the building's atmosphere, as well as dissatisfactions with the monthly fee, which was considered high, the layout of the bathroom, and, echoing a client, the heating system being at the ceiling instead of floor level.

[51] When asked specifically about dissatisfactions at T2, individual family members raised several environmental issues, including: the door to the suite being too heavy for the client and the call button system not being designed for a client who was very deaf (three call bells were in the suite, but the call-bell-speaker when staff could speak to the resident was only in the bedroom.

Satisfaction with Particular Features of LHS

LHS has a number of amenities, such as a guest suite that may be reserved for visitors and a small dining room that clients may book for family events. The developers believed these features would be important to life-lease holders. Some like the private balconies or patios, the kitchenettes, and the wheelchair accessible suite bathrooms, were mentioned during the interviews with clients, spouses, and family members; however, others like the guest room were not. Therefore, at the T3 interview, all participants were asked how often they used the features and, for some like the kitchenette, how they were used. In alphabetical order, usage of the seven features and comments on them were as follows:

Balcony or patio: Clients, spouses, and family members used the clients' balconies an average of 18 times per month (SD=14, range 0-30 times per month).

Kitchenette: The clients' kitchenettes were used, on average, 15 times a month (SD=18.7, range 0-60 times per month). Spouses were the most regular users (75%) but client and family member also used them (clients 27%, family members 21%). Clients said they prepared breakfasts (7%), lunches (27%), and snacks (13%). Spouses reported preparing breakfasts (50%) and lunches (25%), whereas family members reported preparing lunches (11%), snacks (5%), and dinners (5%).

Guest Suite: Only one-third of clients (33%) had used the guest suite, which is a second-floor fully furnished bedroom with its own entrance and an en-suite bathroom that clients may reserve for their overnight guests. Those using the suite had booked it once, on average, although a number had booked it twice. One family member and one spouse said they were pleased that there was no penalty for cancelling a booking and mentioned the room had always been available when requested.

Party Room: The party room, which consists of a large private dining room and an adjacent multi-purpose area, had been booked at least once by 67 percent of clients (mean=2, SD=3, range 0-10 times). Comments about the party room included it being: a good place to entertain (17%), spacious (11%), with seating for up to 60 people (5%), and easy to book (3%), as well as having a large dining table (5%), Individuals also mentioned liking the fire place, nice flatware, a supply of free coffee, lots of windows, and not having an air conditioning vent over the table[52]. They also liked that they could order in food and that they did not need to get a liquor licence because LHS was their home.

Smoking Room (ventilated): None of the clients and spouses interviewed regularly used the smoking room, but one client quit smoking after moving into LHS, and prior to quitting, had used it five to six times a day. Two family members reported using it between two and three times per month. When asked about their satisfaction with having a smoking room available within the building, the majority of clients, spouses, and family members were either very satisfied (13%) or generally satisfied (61%) that it existed. Some were pleased because it

[52] Tables in the main dining room have air conditioning vents over them.

meant that people were not allowed to smoke in their suites (24%). Others said they were satisfied that it was well ventilated and the smoke did not escape into the hall (22%), that it allowed smoking to be a social event for the smokers (3%), and that the room was small (3%).

Walkway: The walkway, an outdoor cement path that winds around the grassed area and the first floor patios, was regularly used by 67 percent of the clients. Clients reported using the walkway on an average of 10 times per month (SD=16, range 0-60 times per month).

As features were discussed, the majority of clients, spouses, and family members rated their satisfaction with each one (see Table 17). Specific likes and dislikes were discussed above.

Table 17:
Percentage of Client, Spouse, and Family Satisfaction with LHS Features at T3_

Feature	Very dissatisfied	A little dissatisfied	Generally satisfied	Very Satisfied	No Comment
Balcony	0 (n=0)	8 (n=3)	51 (n=19)	30 (n=11)	11 (n=4)
Bathroom	5 (n=2)	10 (n=4)	54 (n=21)	26 (n=10)	5 (n=2)
Bedroom	0 (n=0)	0 (n=0)	69 (n=27)	26 (n=10)	5 (n=2)
Dining Room	0 (n=0)	0 (n=0)	74 (n=28)	21 (n=8)	5 (n=2)
Kitchenette	3 (n=1)	5 (n=2)	71 (n=27)	16 (n=6)	5 (n=2)
Party room	0 (n=0)	0 (n=0)	40 (n=15)	30 (n=11)	30 (n=11)
Walkway	0 (n=0)	0 (n=0)	65 (n=24)	19 (n=7)	16 (n=6)
The client suite as a whole	0 (n=0)	3 (n=1)	43 (n=16)	54 (n=20)	0 (n=0)
The building as a whole	0 (n=0)	0 (n=0)	41 (n=15)	59 (n=22)	0 (n=0)

_ Row totals do not equal 100% because some of the clients, spouses, and family members had not used specific features of the building and therefore did not comment on the feature.

Was the Right Decision Made? – Personal Considerations

When participants were asked at the T3 interview if a life lease purchase really had been the right decision for them, they gave many of the same reasons heard during the T2 interviews. The satisfactions with the life lease stemmed from their comfort in knowing they would not have to move again (60%), the manner in which the lump sum would be returned (20%), and the fact that the lease is offered in combination with long-term care services (20%). The majority of spouses were generally satisfied (71%) or very satisfied with the life lease (14%). Only one spouse was a little dissatisfied. All of them said their satisfaction was a result of their being able to live with their spouse.

Family members also were asked if they felt buying a life lease was the right decision for their parent. All but two of the 16 family members (89%) who responded indicated that buying a life lease was the right decision for the client (the others said they did not know the life lease well enough to comment). Most were either generally satisfied 56 percent, or very satisfied 31percent, but one said it was not up to him or her to say, it was up to the client. The

one family member who indicated that buying a life lease was not the right decision for the client indicated that the client would have been happier in the community where she had friends and people she knew who could visit easier. This client had hearing and vision problems that limited her ability to socialize easily, and had expressed disappointment in not being able to make friends with the other residents living in LHS. Some family members indicated the lease was not a major factor in their belief that the move to LHS was the right decision for the client (38%). Their decision was based on the features of the building and the care and services provided. A rental or outright ownership situation, rather than a life lease, would have been just as satisfactory to them.

Was the Right Decision Made? – Financial Considerations

The satisfaction rates with LHS reported above, suggested that clients were happy with their decision to move. At the T2 interview, however, they and their spouses had been concerned with the lump sum payment and the requirement that their furnishings be insured. Family members were also concerned about the monthly fees and lease termination. All of these could reflect financial rather than conceptual concerns. At the T3 interview, clients and spouses were asked directly about their assessment of their financial situation. Clients' reports indicated that none were having a major problem managing the financial component of living at LHS. Some reported having a moderate problem (15%) and many said it was a small problem (77%). Only one client indicated there was no problem managing the financial component of living at LHS. Only one client indicated finances were not a problem at all. Of the spouses, only two indicated having a small problem managing the financial component of living at LHS (40%).

Twenty of the 30 clients who moved owned a home prior to moving, according to information from family units' at the T2 interviews. Most of these clients (60%) reported that it was necessary they sell their home to afford the down payment at LHS. The rest (40%) said they did not, although in one instance the family members disagreed with the client and the spouse who maintained it was not. All but two of the clients who owned a home sold the home prior to or shortly after their purchase of a LHS suite.

The lump sum payment for a suite at LHS ranged from $122,000 - $155,000[53] (2000-2005) depending on the size of suite and the number of bedrooms. The amount was believed to be within the price range of most persons who owned a home in the area. At the T1 interview, eight clients and six spouses had estimated the value of their homes and the largest percentage had valued their homes between $150,000 and $199, 999 (43%). Others' estimates were lower: $100,000 – $149,999 (36%) and $50,000 – $99,999 (21%). Thus, if these participants sold their house, which is the normal expectation when a person moves from one home to another, then approximately 80 percent would raise the amount for the lump sum payment through the sale. Initially, not all sold their houses, although all were able to pay the lump sum. One who did not had co-owned and the other owner had remained

[53] At the time this report was completed (2005), the lump sum amount had not changed from the time of opening (2000).

living in the house. The other client had kept the home, moving into LHS on what he or she deemed a trial basis. The client's family later said the home had been sold between the T2 and T3 interviews. Some of the 10 clients who had not owned a home at the time of the T1 interview volunteered the information that they had used personal savings, and one said family had assisted. One complained that their bank would not give them a loan or a mortgage for the lump sum.

At the time of the T1 interview clients and spouses were asked questions about their sources of income. Most clients and spouses received money from Old Age Security (OAS) (clients 68%, spouses 52%), the Canada or Quebec Pension Plan (CPP/QPP; clients 68%, spouses 48%), or savings and investments (clients 62%, spouses 48%). Table 18 is a compilation of sources reported by clients, spouses, and family members for the clients and spouses.

Table 18:
Sources of Income for Clients and Spouse reported by Family Units

Source	Clients (n=37)	Spouses (n=21)
OAS	68% (n=25)	52% (n=11)
FGIS	24% (n=9)	14% (n=3)
CPP or QPP	68% (n=25)	48% (n=10)
Other government related sources	14% (n=5)	5% (n=1)
Retirement pensions	32% (n=12)	38% (n=8)
Employment	3% (n=1)	5% (n=1)
Savings and investments	62% (n=23)	48% (n=10)

Was the Right Decision Made? – Life Lease Considerations

Best features of the life lease*:* At the T2 interviews, at a time when participants were anticipated to be most knowledgeable about life lease features, they were asked what they considered the best features. They answered: a guaranteed amount of money returned at the end of the lease (10%), the leasing organization worries about resale (8%), the client should never have to move again (6%), and the client does not have to pay rent (4%). Other features mentioned by single participants included monthly fees are lower than in non-lease buildings, it frees up capital so the health region can build similar sites in the future, in turn providing more people with the services, the cost of purchasing the life lease provides some exclusivity in the building, and it provides the client with an illusion of independence. At the T3 interviews, clients again indicated they liked how a guaranteed amount of money is returned to the estate when they die (40%) that TCCG resells the suite so they do not have to worry about it (40%), and that they can live with their spouse (20%). Two spouses who responded repeated the latter reason. Family members participating in the T3 interviews repeated a number of reasons provided earlier. These were: the fact that TCCG resells the suite (25%), a guaranteed amount of money is returned to the estate (18%), the client owns the space they live in (13%), the client does not have to move again (13%), the lease being cheaper than other options the client had considered (13%) and the client and spouse being able to live together (6%).

Shortfalls of the life lease: When asked what they would consider shortfalls of the life lease, clients, spouses and family members answered: there is no profit on the investment (13%), the lump sum payment makes the building unaffordable to some (11%), the return of money at the end of the lease is confusing (7%), client's equity is all invested in the life lease (4%), and the spouse may have to move if the client dies (4%). Individuals added these shortfalls: the client must seek permission to renovate the suite, the length of time for the spouse to move if the client dies,[54] high monthly fees, no ownership (title) for the property, no way to guarantee the security of the lease investment, possible liability if LHS staff are injured in the suite, and a lack of regulations specifying how much the monthly fees could be increased. Many of these were repeated when participants were asked about their concerns about the life lease at the T2 and T3 interviews (Table 19).

Lease Contract: Although there were no concerns regarding the lease contract at the T2 interview, at the T3 interviews concerns were raised. The major one was that the spouse would have to move if the client died. Some participants, however, were unclear about the conditions that precipitated an increase in the monthly fees. One disliked not owning the suite outright, one wanted the client's estate to benefit if the life lease was sold at a higher rate than the client had paid, and another was unclear who paid the cost of building repairs.

Monthly Fees: At the T2 interview, six individuals were concerned with the monthly fees at LHS. The concerns were that fees might increase (33%), fees were too high (17%), disliked the spouse fee (17%), the amount of the fee designated for food and heating were too high (17%), and disliked the amount of the fee designated for particular services although the total was thought to be fair (17%). The first two concerns were mentioned again at the T3 interview.

Lump Sum Payment: Four concerns were raised with the lump sum payment at the T2 interview, with most participants indicating it was too high (43%), that it was difficult to raise the money (29%), that the money might not be there when the client moved out (14%), and that the lump sum consumed all the client's capital (14%). At the T3 interview, the primary concern was that the lump sum would prevent some people having the option of receiving the type of services and care provided at LHS. Two participants mentioned clients having to borrow money to afford the lump sum, and another said a client had to get financing to afford the lump sum payment until the sale of a house was complete. One was uncertain how the money was returned when the suite was jointly purchased (which was a lease termination issue).

Lease Termination: The concerns raised over lease termination at the T2 interview included confusion about how the lump sum payment would be returned (50%), that the sum returned might not be sufficient for the spouse to repurchase because the money returned is less than the lump sum (25%), and resale not being clear enough in the lease contract[55] (25%). At the

[54] The lease indicates that a spouse who does not meet admission criteria is to move out within 45 days or such longer period that the operator may specify.

[55] Resale is the responsibility of *The* CAPITAL CARE *Group* and does not affect the sum returned when the lease is terminated. The lease is refurbished and resold. The resale rate is not intended to vary with the real

T3 interview, concerns over lease termination were the same as those raised regarding the lease contract.

Insurance: One spouse at the T2 interview was concerned that the insurance coverage was higher than necessary.[56] At the T3 interview, a person raised the same concern, and another wanted assurances that other LHS residents had actually purchased the insurance.

Resident Council: The concern with the resident council was that management did not listen to issues that the resident council raised.

estate market. Between 2000 and 2005 when this evaluation was completed the sale price of suites did not change, meaning having the sum returned based on the resale value would not change the amount returned. If the lease was co-owned by a couple, which was typical, a surviving spouse would not have to re-purchase, assuming the survivor required long term care and intended to continue living in the suite. Should the survivor choose to move from a two bedroom to a one-bedroom suite, the difference in initial purchase prices would be reimbursed. If a couple did not co-own the lease then the survivor would have to repurchase the lease.

[56] Residents of LHS are expected to have personal liability insurance of not less than one million dollars insuring against bodily injury, personal injury, and property damage, in addition to insurance on personal belongings located within their suite, as well as an all-risks insurance on all leasehold improvements incorporated into the suite by the tenant.

Table 19:
Clients, Spouses, and Family Members Concerns about Specific Life Lease Features (T2)

	Clients Yes (n=21)	Spouses Yes (n=10)	Family Yes (n=23)	Total Yes (n=54)
Lease Contract	0% (n=0)	0% (n=0)	0% (n=0)	0% (n=0)
Monthly Fees	5% (n=1)	0% (n=0)	26% (n=6)	13% (n=7)
Lump sum payment	10% (n=2)	30% (n=3)	17% (n=4)	17% (n=9)
Resident Council	0% (n=3)	0% (n=0)	0% (n=0)	0% (n=0)
Lease Termination	0% (n=0)	0% (n=0)	17% (n=4)	7% (n=4)
Insurance	0% (n=0)	10% (n=1)	0% (n=0)	2% (n=1)
Resale	0% (n=0)	0% (n=0)	0% (n=0)	0% (n=0)
T3 Interviews	Clients Yes (n=15)	Spouses Yes (n=4)	Family Yes (n=18)	Total Yes (n=37)
Lease Contract	7% (n=1)	50% (n=2)	28% (n=5)	22% (n=8)
Monthly Fees	7% (n=1)	50% (n=2)	22% (n=4)	19% (n=7)
Lump sum payment	7% (n=1)	50% (n=2)	22% (n=4)	19% (n=7)
Resident Council	20% (n=3)*	0% (n=0)	6% (n=1)	11% (n=4)
Lease Termination	7% (n=1)	0% (n=0)	6% (n=1)	5% (n=2)
Insurance	7% (n=1)	0% (n=0)	6% (n=1)	5% (n=2)
Resale	7% (n=1)	0% (n=0)	6% (n=1)	5% (n=2)

* The resident council was the only feature that caused concern for more than one client at T3.

The clients and spouses were seriously concerned about some of the things they raised, although a number were just misunderstandings, but the fact that some concerns persisted for a year, suggests that the operator could do more to help clients, spouses, and family members understand the terms of the life lease. To confront the misunderstandings about the terms of the life lease information might have to be repeated on a regular basis to allay concerns as new clients and spouses arrive.

Participants' Recommendations to purchase a life lease: At the T2 interviews when clients were asked whether they would recommend a life lease purchase to someone else, 17 (47%) said yes. Others indicated they would not (29%), or were unsure (24%). A large majority of spouses (78%) said yes and all family members but one replied that they would recommend a life lease to someone else (94%). Family members would recommend a life lease for these reasons: the family and the client never need to worry about moving again (15%), the client can still own the space they live in (15%). Reasons provided by individual family members included, less expense in the long run than other options, no reason to move because no problems have arisen, LHS offers all the services of a regular long-term care facility in a place that the client owns, the client can live with a spouse of their choice, it is better than a

traditional long-term care facility, and it provides the client with independence and privacy. Others indicated that it was a good option if you can afford the lump sum payment (23%).

Again, at the T3 interviews, the majority of clients (69%), spouses (50%), and family members (94%) indicated they would advise some one else to purchase a life lease. Those who indicated they would not advise it said they did not know enough about the lease to provide advice (22% of clients, 25% of spouses) or they did not feel it was their place to tell others where to live (11% of clients, 25% of spouses, and 6% of family members). Thus all of the clients, spouses and family members who were familiar with the life lease and believed they could provide advice to others, would recommend a life lease.

Only six (17%) of the participants at the T3 interviews had suggestions on improving the life lease. These were to split the lump sum payment into instalments to make it more affordable (suggested by 50%, i.e., three persons), build in some form of capital appreciation (17%), do not allow monthly fees to increase shortly after purchase (17%), allow spouses to remain living in the suite even if the client dies even if the spouse does not require care (17%), and lower the lump sum payment to make it more affordable to others in the community (17%). When family members were asked what, from a list of features, had prompted them earlier to advise the client against purchasing a life lease, they cited the lump sum (9%), the monthly fees (9%), and the lease termination (4%). This suggests that operators involved in life lease buildings need to find ways to make some of these features more palatable to their customers.

Objective 6 Summary

All clients and spouses indicated at T2 that their expectations were met by the location the clients' had chosen to live. Half said that their expectations had been totally met and half indicated they had been met for the most part. Half the clients were very satisfied with the physical accommodations and 60% of the spouses were very satisfied. At T3, the majority of clients and spouses interviewed remained well satisfied with the accommodations, indicating they were either generally satisfied (60% of clients, 40% of spouses) or very satisfied (33% of clients, 40% of spouses). In addition, the majority of the family members said at T2 that their expectations had been totally met by the decision regarding a move, with the balance replying that expectations had been met for the most part. The majority of family members said they were very satisfied (86%) by the physical accommodations, with the rest indicating they were generally satisfied. All of the family members remained well satisfied with LHS at T3 (80% were very satisfied and 20% generally satisfied), saying that LHS had met their expectations. At these interviews, the majority of clients (69%), spouses (50%), and family members (94%) indicated they would advise some one else to purchase a life lease. The remaining participants said they did not know enough about the lease to provide advice. Participants commented on the best and worst features of life lease, and a number had recommendations to improve life leases.

When asked directly at T3 whether buying a life lease was the right decision for the client, all but two of the 16 family members who answered said yes (89%). Some family members indicated the lease was not a major factor in their belief that the move to LHS was the right decision for the client. Much of their satisfaction stemmed from their comfort in knowing the

clients would not have to move again. Their decision was based on the features of the building and the care and services provided. A rental or outright ownership situation, rather than a life lease, would have been just as satisfactory to them.

Although clients' overall health at T2, after the move, was not significantly different than it had been at T1, some clients appeared optimistic and seemed to believe they were improved. At T1, a sizeable percentage of clients (43%) had expected their health to improve. Family members' expectation that they would be less involved with clients was not fulfilled in quite the way they expected. Results at T3 suggested the type and quantity of assistance provided by family members was altered. At T3, families shopped for groceries (75%), because LHS suites had kitchen areas, and ran errands (75%), because inexpensive transportation was not easy for clients to obtain. These were the only two tasks with which the majority of family members assisted.

At the T3 interview, clients and spouses were asked directly about their assessment of their financial situation. Clients' reports indicated that none were having a major problem managing the financial component of living at LHS. Some reported having a moderate problem (15%), with the majority considering it to be a small problem (77%). Of the spouses, two indicated having a small problem managing the financial component of living at LHS. Their answers and the fact that nine clients in the study received the Federal Government Income Supplement, suggested than the majority of clients and spouses who had purchased life leases were not rich. Many decided to invest the home equity in LHS because the centre enables couples to continue to reside together even though one requires the constant availability of nursing services.

Conclusion

The overall goal of this study was to investigate the attitudes of seniors toward life lease housing arrangements. The method was a series of three structured interviews with persons interested in purchasing a life lease for a new type of supportive housing that offers a way of meeting the needs of frail persons who do not want to move into an institutional setting. Laurier House Strathcona is an example of the Laurier House model, a housing initiative which utilizes life leasing to disentangle or "unbundle" housing costs, the costs of hotel and personal care services, and the government-funded health services that are provided on site. The model allows persons assessed by the health region as being in need of support and healthcare services to invest their home equity in the housing component of their care. Clients purchase a suite in Laurier House Strathcona (LHS) through a life lease agreement and pay a monthly fee to cover maintenance and other operating costs, including domestic and food services. Thus, the client pays the full costs of housing and support services but the provincial health system pays the full cost of the health services the client requires. The health services offered are the full range of those provided in traditional long-term care facilities in the province.

In the Laurier House model, the life lease is a legal agreement that permits the purchaser to occupy a dwelling for life in exchange for a lump sum prepayment and monthly fees. These funds can be used in Alberta to finance the capital costs of the facility, thus relieving the public system of construction costs. Upon termination of the life lease, the operator returns the capital payment, based on the terms of the life lease agreement.

To meet the overall goal, the study had a number of objectives. The first objective was to describe the needs of the client participants from the perspective of the clients, that is, persons who were perceived to need facility-based long-term care services, their spouses, and their family members. The interviews revealed that family members were more concerned about the clients' health status than the clients were. Many families were actively seeking a new location for the client, sometimes without the knowledge of the client. The main reason for families considering a move was their perceptions of the clients' health status. Many families were thoroughly involved in the clients' decisions about moving. In general, participants said the issue was not a gap in service, or a need for a particular type of service. Instead the issue was the amount of services being received.

Another objective was to identify the clients' resources, both social and financial. At the T1 interview, all clients appeared to have social support at hand because most of the clients lived with other people. Thirteen of the 26 clients interviewed at T1 were living with their spouses in the community. Very few of those interviewed were concerned about the availability of social support; however, the majority of family members were dissatisfied with the clients' housing accommodations. This could be another reason why family members' were seeking a new location for clients. In addition, family members may have been looking for respite from the many tasks they assisted with, such as, transportation, grocery shopping, heavy cleaning, and laundry. Most of the family members indicated that they expected that the move would give them peace of mind. Inquiries about home ownership were included in the

questions about the clients' financial resources. Twenty of the 30 clients who moved to LHS owned their home prior to moving, according to information from family units at the T2 interviews. These interviews occurred after the clients had made a decision about moving. The clients' health status had been assessed independently by this time by professionals of the health region, and almost all of clients had moved into LHS. Thirteen clients did not move to LHS. The majority of them did not qualify for facility-based long-term care and only one qualified to move into LHS. The majority of the homeowners had to sell their home to make the lump sum payment at LHS; however one-third said that selling their house was not necessary for that reason. Most clients estimated that they spent between 30% and 40% of monthly income on total shelter costs and this was not financially difficult for them. They were not concerned that LHS charged higher monthly fees than traditional long-term care facilities. Nine clients, however, were receiving the Federal Government Income Supplement, which implies they had less than resources than the average senior. These nine might be expected to have more financial concerns than other clients. The 10 clients who either rented or were living with family members, might also have more financial concerns. All 30 clients did manage to make the lump sum payment, however, and at the T2 and T3 interviews it was evident that the client group were managing the financial component of the life lease with little difficulty.

A third objective was to identify the clients', spouses', and family members' choice of residence and the reasons for their choice. All clients' preferred LHS, even those who did not qualify for admission. All of the clients, spouses, of family members had reacted positively to the life lease arrangements and LHS. Most had been prepared to move to LHS if possible. It became evident that clients', spouses', and family members' interest in LHS did not stem from the life lease arrangements when the interviewer tried to determine what participants understood about the features of the life-lease. The participants seemed open to the prospect of a life lease. Participants reported, however, that their choice of LHS was simply because the client wanted to live in a Laurier House suite and the purchase of a life lease was a requirement to do so. The opportunity for couples to continue to reside together at LHS, even though one of the partners required facility-based continuing care was important to married couples. The majority of spouse participants said they were interested in moving into LHS with the clients. This approval of the concept behind the Laurie House model appeared to influence clients' decision to move to LHS.

Another objective was to determine the priorities of the parties in LHS. Results discussed here indicate that the client's frailty, need for additional amounts of service, and their financial resources were important factors. The advice of professionals involved in clients' transitions from home to long-term care facilities did not appear to be an important factor in the choice of a location to move, even though one-third of the clients consulted professionals about the move. The interviews to determine how some of these professionals make their recommendations indicated that their knowledge of life lease arrangements and LHS was not extensive. It was sometimes incorrect. Some did not understand the basic criteria for admission into LHS. In addition, professionals, by their own reports, were selective about which clients received information on the life lease option. Less than half of them who had written information on LHS regularly provided the information to clients. Of more concern,

one-quarter of the professionals said that the life-lease setting was a not good idea, although 50 percent viewed it positively, and 25% were impartial.

The final objective was to determine, from the perspective of all parties, whether the chosen residence met the needs of the client. In general, clients, spouses, and family members were well satisfied with LHS. At the T2 interview, after clients had moved to LHS, a sizable majority of family members said they were satisfied with the life lease suites (86% very satisfied and 14% generally satisfied). All of the spouses who moved to LHS with clients said they were very satisfied with the setting from their own perspective. One year later the majority of clients and spouses remained satisfied with the LHS accommodations.

Considerations for Other Organizations

Overall, the results of this study suggest that those marketing life lease buildings for an elderly population need to be aware of the role that their family members play in their decisions. The driving force behind the clients' decision to move to new accommodation appeared to be the concerns of the adult children. The family members' influence first became evident when some family members said the clients could not be interviewed because their parents did not know that the children were looking for a long-term care facility for them. In addition, family members comprised the majority of those who investigated the suitability of LHS. Moreover, when clients were initially asked about moving approximately three-quarters said they were planning a move, although 94 percent of family members said that a move was in the future. Considering the influence that the family members appear to have, this is important to note that initially (T1), when participants were asked if they would consider a life lease option for the potential client, most participants said yes, but one-quarter of the family members and a few potential clients said no. Any organization marketing a life lease setting for seniors should be aware of this and that almost all of those saying no also said that their answer was based on their lack of knowledge about life lease arrangements. Family members' understanding of the key features may play an important role in the success of life lease developments such as LHS.

The study found that in some cases the family provided the client with even more personal support after the move. This was evident with transportation and finances. This continuation of caregiving after institutionalization is consistent with the results of other studies, but it may not have been what family members anticipated. Their stated expectations prior to the move suggested they anticipated being less involved. Therefore, developers of supportive housing may wish to focus on providing some of the services found in the list of families' tasks after the move. Provision of transportation services for clients, for example, could reduce family members' burden.

The persistent concerns that a few holders of life lease agreements had with the life lease arrangements in this study, suggests that operators could consider doing more to help clients, spouses, and family members understand the terms of the life lease. Misunderstandings of the life lease persisted, suggesting that life lease information might have to be repeated on a regular basis to allay concerns as new clients and spouses arrive. The same situation was evident with professionals in the community. A number of professionals who had the

opportunity to discuss various supportive housing options with elderly clients seemed confused over the admission criteria for the life lease setting in this study. Some professionals thought they should recommend it only to a client who had a spouse willing to move with the client, or because they thought the spouse was healthy enough to assist with the client's care. This shows that some professionals misunderstood the concept, because neither of these criteria were required for admission. Better ways of informing such professionals about life leases need to be developed.

The participants in the study suggested several improvements to the life lease agreement that might be tested. Of particular interest is the notion of splitting the lump sum payment into instalments to make it more widely affordable to elderly persons. This could be tested on a proportion of the suites in a new development.

The results provided insights into the concerns both seniors and their families have with life-lease agreements and with condominium-style settings, as well as information about what they value in such setting. In conclusion, this study illustrated a new way of meeting the needs of frail elderly persons who do not want institutional solutions. The Laurier House model successfully unbundled government-funded long-term care services from the costs of housing and support services in a way that persuaded elderly clients, their spouses, and families to invest in the housing component where their care was provided. Married clients said LHS appealed to them because it allowed them to continue living with their spouse. The setting appealed to unmarried clients primarily because it offered a private suite rather than a private or a shared room in a nursing home. Equal numbers of married and unmarried elderly clients moved into LHS, suggesting the life lease supportive housing concept appealed equally well to both the client group who wished to avoid leaving a spouse and the client group seeking more space and privacy.

Recommendations

Some specific recommendations emerged from this study.

- Developers of supportive housing who wish to appeal to family members might focus on including transportation services. Almost all family members helped their elderly relatives with transportation.
- Life leases could be improved, and in the view of some study participants made more affordable, if the lump sump payment could be divided into several instalments. A demonstration project could test this idea.
- The persistent concerns that a few holders of life lease agreements had with the terms of the life lease, suggest that operators could do more to help clients, companions, and family members understand specific terms of the lease.

Because the life-lease housing concept is not well understood, it is recommended that operators of life lease housing, in cooperation with other interested parties, hold provincial or regional workshops to discuss how life lease works, how it can be developed, marketed, and managed – while showing how workshop participants might play a role in life lease housing in their community. These workshops would target operators of assisted living residences, healthcare centres, seniors housing, and potential partners for public-private partnerships in seniors housing.

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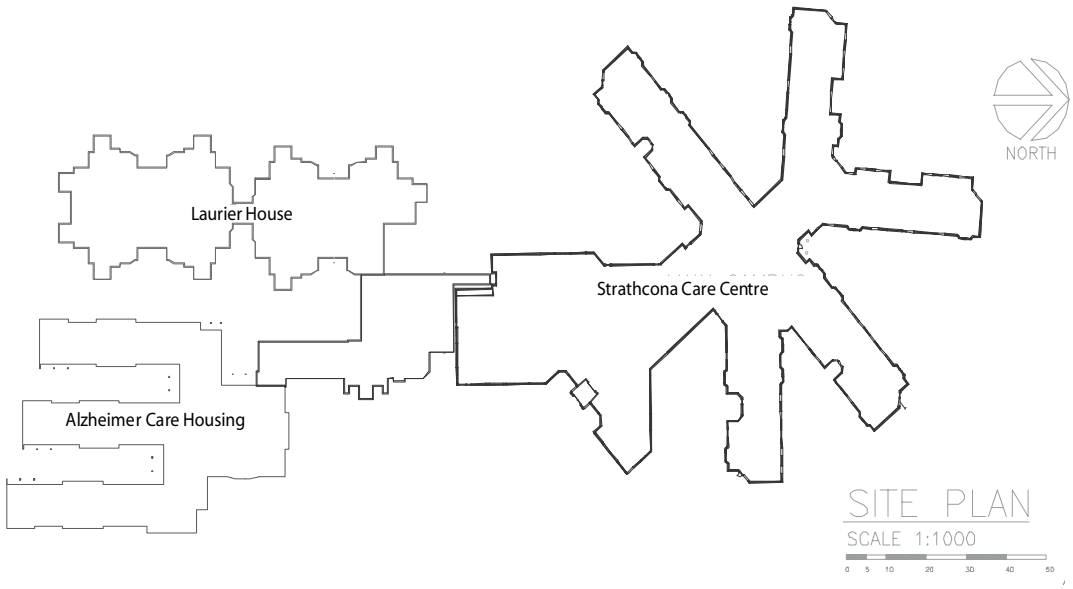
Appendix A:

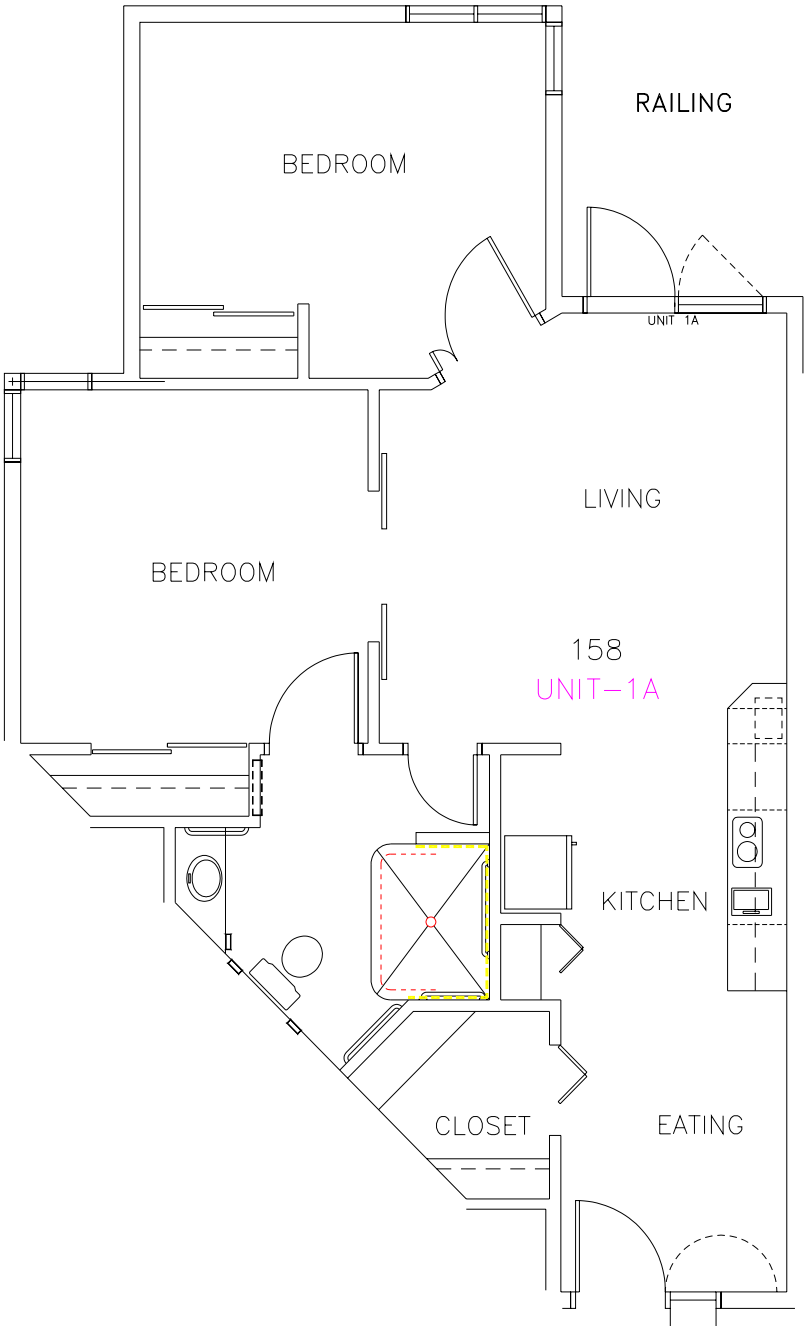
Maps of Strathcona Campus and Laurier House Strathcona

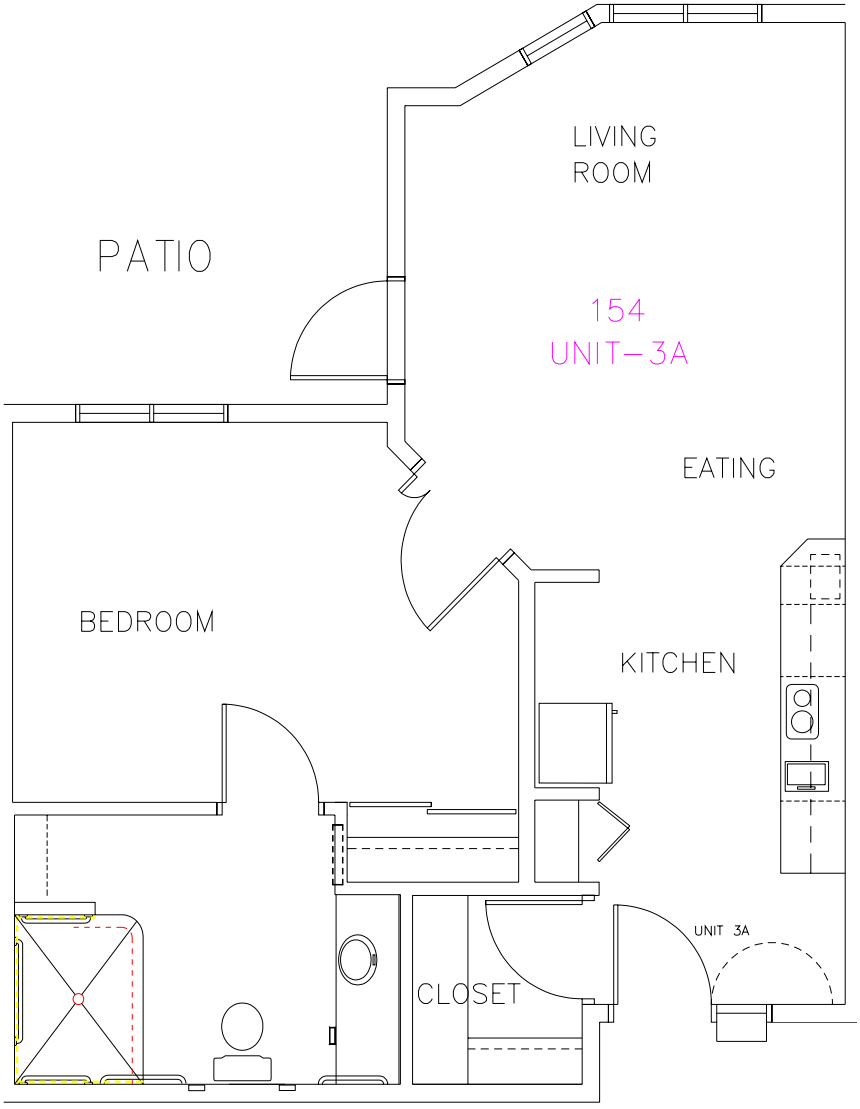
Figure A-1:
Strathcona Campus Footprint



Appendix B

Suite Floor Plans of One and Two Bedroom Suites at Laurier House Strathcona


RAILING
BEDROOM
UNIT 1A
LIVING
BEDROOM
158
UNIT–1A
KITCHEN
CLOSET
EATING


LIVING
ROOM
PATIO
154
UNIT–3A
EATING
BEDROOM
KITCHEN
UNIT 3A
CLOSET

Appendix C

Items Covered by the Monthly Fees at LHS

LHS clients' monthly fees pay for a variety of services and they may select additional services for an additional charge. Both are listed in Table C-1.

Table C -1: What the LHS Standard Monthly Fee Covers		
Service	Included in Fees	Additional charge
A suite	Yes	
Three full meals	Yes	
Coffee and tea between meals[57]	Yes	
Supplementation between meals (if required)	Yes	
Kitchen equipment, furniture, plates, cutlery etc.	Yes	
Kitchen and serving staff	Yes	
Housekeeping and laundry staff	Yes	
Housekeeping and laundry supplies	Yes	
Facility laundry (towels, bedding, etc.)	Yes	
Building upkeep and repair	Yes	
Landscaping	Yes	
Snow removal from public areas	Yes	
Maintenance staff	Yes	
Security services and equipment	Yes	
Building operation	Yes	
Gas	Yes	
Electricity	Yes	
Water	Yes	
Sewer	Yes	
Furnishings for public areas	Yes	
Recreation space and equipment	Yes	
Administrative staff	Yes	
Office equipment	Yes	
General office services	Yes	
Accounting/billing/purchasing	Yes	
Benefits/labour administration payroll, WCB	Yes	
Trust account maintenance	Yes	
Building and liability insurance	Yes	
Audit, legal services, taxes	Yes	
Medically required ambulance transportation for clients	Yes	
Medically required ambulance transportation for companions		Yes
Toiletries/grooming products		Yes
Personal laundry		Yes
Private telephone		Yes
Cable television		Yes
Personal choice recreational activities[58]		Yes
Non-emergency travel		Yes

[57] At the time of the evaluation residents were allowed to take additional deserts from the meals to eat as a snack if the wished. Since the evaluation LHS has begun providing snacks to all residents.
[58] A number of recreation activities are available at no additional charge.

Appendix D:

Participants in the Three Interviews

Of the 36 clients, 16 spouses, and 47 family members who were interviewed through the course of the evaluation, only 4 clients and 4 spouses represented the group who did not choose to move into LHS. They had 16 family members associated with them who were interviewed. Although all of the individuals interviewed at T1 were encouraged to participate in interviews at T2 and T3, not all did. Moreover, not all participants were interviewed in each of the three interviews. Table 1 shows the number of clients, spouses, family members, and family units who participated in the T1, T2, and T3 interviews.

Table D1:
Interviews Completed

Total Number of People Interviewed			
	T1	**T2**	**T3**
Clients	26	23	15
Spouses	14	10	7
Family Members	38	23	24
Family Units*	47	36	27
Number Interviewed Who Were either Clients or Were Associated with Clients, Who Moved to LHS			
	T1	**T2**	**T3**
Client	22	23	15
Spouses	10	8	5
Family Members	22	15	20
Family Units*	34	28	21
Number Interviewed Who Were either Clients or Were Associated with Clients, Who Did not move to LHS			
	T1	**T2**	**T3**
Client	4	0	0
Spouses	5	2	2
Family Members	13	6	4
Family Units*	13	8	6

* Family Units were defined as the cluster of people interviewed that were related to the same client. The responses of these people were compared and discussed as a unit to facilitate general comparisons between clients.

T1 Interviews: Between June 19, 2001 and July 31, 2002, 78 individuals related to 47 different clients completed the T1 interview. The interviews at T1, conducted approximately one month after the initial inquiry regarding LHS, involved 26 clients, 14 spouses, and 38 family members. The majority of the clients were interviewed with another person present (62%) and for most (88%) that person was a spouse. In two instances, both persons of a married couple were clients. The majority of spouses were interviewed with the client present (71%). The majority of family members (76%) were interviewed alone. When another was

present at a family interview, it was usually another family member (44%) or the client (11%). Most interviews with clients took place in the interviewee's home (55%), with others conducted in a continuing care centre (29%), over the phone (8%), at a place of work (4%), a restaurant (3%), and a church (1%).

T2 Interviews: Between November 10, 2001 and August 9, 2002 56 individuals related to 36 different clients completed the T2 interview. The T2 interviews, conducted approximately one month after the client made a choice about a move, involved 23 clients, 10 spouses, and 23 family members. Two clients were dropped from the study and were not included in the results because they could not complete the interview.[59] The majority of clients were interviewed with another person present (57%), most frequently a spouse (69% of such interviews), but some included a family member, and in two instances an advising professional was present. Again, in two instances both persons of a married couple were clients. The majority of spouses were interviewed with the client present. Again, the majority of family members (83%) were interviewed alone. The location for the majority of the interviews was typically the client's continuing care centre (61%). For the clients and spouses who did not move, and for some family members, the home of the interviewee was used (18%). In addition, some interviews were completed over the phone (14%), at the interviewee's place of work (5%), or at a restaurant (2%).

T3 Interviews: Between September 18, 2002 and August 8, 2003, 46 individuals related to 27 different clients completed the T3 interviews. The T3 interviews, approximately one year after the decision to move, involved 15 clients, 7 spouses, and 24 family members. The majority of clients were interviewed with another person present (60%), usually a spouse (78%), although others included other family members. The two couples where both were clients were interviewed together. One of these couples included a family member. The majority of interviews took place in the client's continuing care centre (54%), but some were held in the interviewee's home (17%), over the phone (13%), at a place of work (9%), at another family member's home (2%), at the client's and/or the spouse's home (2% - for clients who had not moved), and a restaurant (2%). The pattern of spouses being interviewed with clients and family members being interviewed alone continued through the T3 interviews.

[59] One stated during the interview that she no longer wished to participate, and the other fell asleep on two separate occasions before more than two questions had been asked.

Note: Appendix E-Appendix K may be found in:

LIFE LEASE SUPPORTIVE HOUSING:COMBINING THE BEST ASPECTS OF HOUSING AND COMPLEX CARE Volume 2.

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