BC Care Providers ASSOCIATION

Celebrating 40 Years | 1977 – 2017

It's About...Time

Improving Quality of Life for BC Seniors

BCCPA Budget Submission: 2017

Message from the CEO

Dear Members of the Select Standing Committee on Finance and Government Services:

On September 20, 2016, the BC Care Providers Association invited over 150 people from across our province to assemble for the inaugural BC Continuing Care Collaborative, an historic gathering at the SFU Wosk Centre for Dialogue in Vancouver. The stakeholders in attendance represented care providers, seniors and their family members, clinicians, non-government organizations, labour, the Ministry of Health, and all of the provincial health authorities.

The event was the culmination of a five-month consultation process prompted by the release of two White Papers the BC Care Providers Association released in May of 2016. Over 750 British Columbians — the majority of whom were seniors — also had their opportunity to weigh in with their thoughts on the papers through a public survey.

Over the course of the day, participants contributed their feedback on key ideas and concepts contained within the White Papers. The goal of the Collaborative was to develop a direction on what solutions we could implement that would help to improve the quality of life for BC seniors in the short term. A final set of recommendations will be submitted to the Minister of Health by the beginning of December.

With a rapidly ageing population, the Government of BC understands that we must place the needs of our seniors among their top priorities. To that end, we are pleased to provide the Select Standing Committee with a comprehensive set of recommendations for adoption as part of Budget 2017.

Improving the quality of life for British Columbia's seniors, ensuring the long-term sustainability of the sector, and training the workforce of the future are all key topics that require the focus and the resources of the provincial government. These are all areas that the BC Care Providers Association believe should form the priorities of government over the coming years.

We look forward to collaborating with the Government of British Columbia to build upon a system of excellence in seniors care that not only honours our elders, but one that all of us will someday depend upon.

Sincerely,

Daniel Fontaine
CEO, BC Care Providers Association

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OUTLINE

EXECUTIVE SUMMARY

For 40 years, the BC Care Providers Association (BCCPA) has represented non-government care providers in British Columbia. We have over 300 residential care, home care, assisted living and commercial members across the province. Our members represent over one-third of all funded long term care beds in B.C. – caring for over 25,000 seniors annually and creating more than 18,000 direct and indirect jobs across the province.

The slogan for our inaugural *BC Continuing Care Collaborative* — which was held this fall and featured stakeholders across the home and community care sector — was "It's About … Time." As in, now is the time to work together to find solutions to the challenges of a rapidly ageing population, while also improving the overall quality of seniors' care.

Redesigning the existing health system with new care models and providing targeted investments that can improve care will be an integral part of this process. In particular, there is a need to explore alternative ways to sustain and innovate to create a health system so that it is less acute oriented and better designed to provide care for those with ongoing care needs, particularly the chronically ill and frail elderly, as well as those with dementia.[1]

To deal with the challenges of an ageing population, in May 2016 the BCCPA released two major White Papers outlining potential options to improve sustainability and innovation for seniors and the continuing care sector.[2] The first White Paper deals primarily with issues around funding and financing of continuing care in order to improve sustainability and enhance quality within the sector, including for care providers and seniors. While the second White Paper also touches on funding matters, it deals more with identifying innovative approaches, focusing on five key areas: exploring new care models for seniors, improving dementia care, effective use of technology, as well as enhancing the health, safety and well-being of seniors.

Along with better meeting the needs of an ageing population, the approaches outlined in both White Papers highlight potential ways to reduce acute care congestion (including alternate level of care days) and emergency room visits, as well as providing better care in the community for the frail elderly, including seniors with chronic conditions and dementia. These are also all priority areas of the BC Ministry of Health.

The BCCPA has recently finished a major public consultation on the White Papers culminating in the Inaugural Continuing Care Collaborative held on September 20, 2016 as well as a major public survey on the options outlined in the paper (see Appendix A). Overall the public survey received considerable attention including over 750 responses with over half being seniors. While a final document with recommendations will be released later in late 2016 or early 2017 this budget submission focuses for now on seven specific areas including:

1. Shifting Resources from Acute to Home and Community Care;
2. Increasing Direct Care Hours (DCH);
3. Increasing Openness and Transparency;
4. Improving Quality of Life for seniors;
5. Improving Sustainability and Accountability;
6. Health Human Resources (HHR); and
7. Federal funding for Seniors Care

Overall, it is important to note that the focus of the key themes and 11 recommendations outlined in this report are about enhancing the quality of life for seniors in their remaining years, including through initiatives to increase health human resources (HHR) and direct care hours (DCH) as well as specific targeted funding initiatives or programs for the elderly. Quality of care and quality of life for seniors must be the focus. For the purposes of this paper, quality of life is defined as the mental, physical, psychosocial and spiritual well-being that allows seniors to enjoy normal life activities while remaining in the appropriate care setting and as measured by various indicators both clinical and non-clinical.

Key Recommendations

Section 1: Shifting Resources from Acute to Home and Community Care

1. That starting in fiscal year 2017/18, the Performance Agreements between British Columbia's Ministry of Health and Health Authorities should include a specific target for redirecting acute care expenditures such as a minimum of 1 per cent annually over a five-year period to the home and community care sector. Along with supporting initiatives outlined in this paper, such expenditures should be directly reinvested into residential care and home care / support to deal with existing cost pressures facing service providers as well as support development of new continuing care models to reduce acute care pressures (including Alternate Level of Care days), improve access to care while also allowing seniors to receive services in the most appropriate setting.

Section 2: Direct Care Hours

2. That the BC government invest in new annual funding for care homes to meet a minimum 3.36 Direct Care Hours (DCH) target, where feasible. This funding would cover actual and quantifiable costs.
3. That commensurate with this new funding, care homes be required to report annually on how they are meeting the 3.36 DCH, including current levels of DCH and any steps taken to meet the target.
4. That a standard definition of DCH be developed by the Ministry of Health and Health Authorities in partnership with the sector by 2017; and that in the interim DCH be defined as including a 20% professional component and 80% non-professional, with the professional component consisting of the clinical functions performed by Directors and Assistant Directors of Care as well as those occupations outlined in the BC Health Professions Act.

Section 3: Improving Openness and Transparency

5. That the BC government, through a new Continuing Care Collaborative, undertake the following:
    - Review funding lifts in all Health Authorities with the goal of ensuring consistency, fairness and sustainability with respect to per diem rates, including providing greater public transparency on how funding lifts provided for residential care are determined;
    - Provide annual site by site public reporting regarding the level of funded direct care hours;
    - Establish a long-term predictable funding model by end of fiscal 2017-18 that is outlined in any contract arrangements with the health authorities, including more long-term budgeting with increases to per diem rates outlined over a 3 to 5-year period; and
    - Undertake a joint government-industry red tape review on where greater efficiencies can be obtained in the continuing care sector, including, where feasible, potentially expanding the role of non-government operators as well as reducing unnecessary regulations and duplication that do not improve the quality of life for seniors.

Section 4: Improving Quality of Life for Seniors

6. That the BC government establish a Seniors Quality of Life Fund (SQLF) to support quality of life for seniors in residential care and the community, which focuses on improving the physical, spiritual, psychosocial and mental well-being through various initiatives including:

    - Increased access to recreational therapy as well as occupational and physiotherapy in continuing care;
    - Increased access to a broad array of therapy programs such as Concerts in Care and Sing for Your Life, both in residential care and the broader community;
    - Reducing seniors' isolation through increased Adult Day and similar programs;
    - Maintaining and enhancing the overall quality of food and nutrition in residential care homes including meeting therapeutic diet requirements; and
    - Increasing the minimum time for home support visits from the current 15 minutes.

7. That the Ministry of Health be asked to regularly report on the use of the SQLF, including what initiatives are being undertaken and how they are improving the overall quality of life for seniors in the province.

Section 5: Infrastructure Investments and Accountability

8. That the BC government establish a new *Residential Care Infrastructure Fund* (RCIF) to support the immediate renewal and modernization of older residential care homes. The fund, which could be matched by the Federal Government, would be used for capital improvements such as the installation of ceiling lifts and sprinkler systems. Care homes will be accountable for any investments including outlining how they spent any new funds received and how it has improved senior's quality of life.

9. That the BC government, working with municipalities, exempt property taxes for residential care homes to allow non-government operators to recoup capital operating expenses and further encourage private investment in the continuing care sector.

Section 6: Health Human Resources (HHR)

10. That the BC government establish a *Continuing Care Health Human Resource (CCHHR) Fund* to help meet increased DCH targets and support initiatives to increase the number of care aides and other health professionals in residential care and home care as well as training, education and resources to improve dementia care, including:

    - Funding for a new BC Cares Program between the BC Ministry of Health, Health Authorities, the Health Employers Association of BC and BCCPA to improve the recruitment and retention of care aides and health professionals who provide continuing care;
    - Funding for a BC Behaviour Supports Program (BCBSP) between the BC Ministry of Health, Health Authorities, Alzheimer's Society of BC and SafeCare BC to provide training, education and resources to improve dementia care province-wide; and
    - Matching funding from the CCHHR fund with the Health Employers Association of British Columbia (HEABC) to develop a coordinated province-wide approach to HHR development for all continuing care providers.

Section 7: Federal Funding for Seniors Care

11. That the provincial government as part of any new Health Accord advocate that the following elements be included:
    - The establishment of an age-adjusted Canada Health Transfer that reallocates funding to provinces such as British Columbia with higher and growing portions of seniors;
    - New and/or reallocated funding to improve capacity and build infrastructure, reduce wait times and support new continuing care models for residential care and home support; and
    - Meet commitments outlined in the federal Liberal platform including a long term agreement on funding; invest $3 billion over the next four years to deliver more and better home care services for all Canadians; develop a pan-Canadian collaboration on health innovation; as well as improve access to necessary prescription medications, particularly for seniors.

It's About … *Time* – Improving Quality of Life for BC Seniors

Section 1: Shifting resources from Acute Care to Continuing Care

If fully implemented, the recommendations outlined in this report could cost in the range of $300 to $500 million. Given the importance of seniors, particularly with an ageing population, we believe that this is a worthwhile investment. It is also consistent with public opinion. For example, a 2015 poll conducted by Insights West, indicates that British Columbians believe government should increase funding for long- term care, including that:

- 62% believe health care system focuses too much on acute care and not on providing ongoing care needs, such as long term care or caring for the chronically ill elderly;
- 68% believe government does not provide adequate funding for residential care; and
- 84% believe that as seniors enter residential care homes with increased acuity or medical complexity, government funding should increase to meet these care needs.[3]

Along with new monies, some of the funding could be obtained by redirecting funds from the existing Health Authority acute care budgets to home and community care – an approach also advocated by the Ministry of Health.[4] One of the major themes of the BC Ministry of Health Primary and Community Care paper released in February 2015, for example, was that existing expenditures would be protected, while appropriate reallocations from acute to community care services would become part of health authority planning going forward.

As outlined in the *Quality-Innovation-Collaboration* paper (2015) the BCCPA has previously recommended that that Health Authorities redirect acute care expenditures such as a minimum of 1% annually over a five-year period to the home and community care sector.[5] In particular, as part of this budget submission the BCCPA recommends that, beginning in the 2017/18 fiscal year, the Performance Agreements between the Ministry of Health and the Health authorities include a specific target to reinvest expenditures from acute care to continuing care – specifically, a minimum target of 1% per year over a five-year period.

Based on 2014/15 budget figures, expenditures by Health Authorities for acute care is at over $6.4 billion or between 55% to 59% of total budgets (see Appendix B for breakdown of health authority funding). Using 2014/15 Health Authority budget figures, a one per cent re-allocation from acute to community care for the five regional health authorities would amount to approximately $64 million in the first year. Excluding any annual funding increases to health authorities that would have occurred anyways this would equate to a five-year

reinvestment from acute to home and community care of approximately $320.8 million by the fifth year (Appendix C). Along with potentially funding many of the recommendations outlined in this budget submission, this amount equates to the annual operation of 4,395 new care beds; or 12,832,000 care aide hours; or 8,020,000 home support hours.

Overall, reinvesting in continuing care makes sense, as costs are substantially lower - the cost of treating a BC senior in hospital ranges from $825 to $1,968 per day (average is about $1,200), whereas the cost of residential care is approximately $200 per day. Not only will it reduce costs in emergency and acute care, it will improve the overall quality of seniors' care in BC by allowing seniors to live at home longer or most appropriate care setting.

Redirecting existing funding from acute to continuing care could also help address some of the health human resource issues facing care operators particularly around the recruitment and retention of health professionals including care aides, licensed practical nurses and registered nurses. Currently, particularly in rural areas of BC, it is often difficult to recruit and retain such professionals as, along with significant shortages, there are high staff turnover rates and workplace injuries.

As outlined further in the *Quality-Innovation-Collaboration* paper redirected funding could also be used to support the integration of physicians as well as new health professions such as nurse practitioners and physician assistants into continuing care. Finally, the funding could also be used to invest and direct more labour market training efforts to encourage people to enter into the continuing care sector as a career.

The BCCPA believes that re-directing funding from acute care to continuing care could also be achieved partially through a reduction of alternate level of care (ALC) beds. In 2014/15, there were 407,255 reported ALC days in BC, accounting for 13% of total hospital days across the five regional health authorities. As many as half of these ALC days represent older adults waiting for placement in a residential care home.

As noted in *Quality-Innovation-Collaboration,* initial estimates by the BCCPA suggest that if ALC days could be reduced by 50% by caring for patients in a residential care bed rather than a hospital bed, it could generate over $200 million in annual cost savings. These savings could be invested into continuing care or to reduce wait times for elective surgeries for seniors that are in high demand such as joint replacements or cataract surgeries.

Along with reviewing how funds are allocated, it may also require exploring new revenue sources. Although beyond the scope of this paper, dealing with these fiscal challenges should be a priority for governments, including finding ways to redirect existing funding from more-costly acute care as well as looking at new ways to finance seniors and continuing care in the future.

Some of these options, such as long-term care insurance or greater federal role in funding seniors care, are also outlined in the BCCPA White Papers and were also areas of discussion at the inaugural BC Continuing Care Collaborative on September 20, 2016 at the SFU Wosk Centre for Dialogue. While further analysis needs to be undertaken, as identified through the initiatives and recommendations outlined in this paper, there is the potential for significant cost savings and other benefits including:

- Improving the overall quality of seniors' life and care, including physical, spiritual, psychosocial and mental well-being in their remaining years through targeted initiatives (i.e. RT, OT, PT, music therapy, food and nutrition, etc.);
- Ensuring the necessary resources, including human and physical infrastructure are available, particularly in rural and remote communities to provide appropriate care and living for seniors;
- Keeping seniors in the community healthier including reducing levels of chronic disease and achieving overall better health outcomes;
- Reducing unnecessary hospitalizations including seniors who occupy a more-costly acute care bed;
- Improving social engagement and reducing levels of seniors' isolation;
- Better meeting the needs of a growing elderly population particularly those with high needs such as the frail elderly and dementia care;
- Strengthening the role and sustainability of the continuing care including residential care, assisted living and home support to reduce overall health system costs;
- Finding greater efficiencies in the continuing care sector including potentially expanding the role for non-government operators and reducing unnecessary regulations;
- Improved dementia care for seniors including reducing levels of resident-on-resident aggression and use of anti-psychotics;
- Improving collaboration and working relationships with the continuing care sector; and
- Redirecting funding from more-costly acute to home and community care.

SECTION 1: RECOMMENDATION ON REDIRECTING RESOURCES FROM ACUTE TO HOME AND COMMUNITY CARE

- That starting in fiscal year 2017/18, the Performance Agreements between British Columbia's Ministry of Health and Health Authorities should include a specific target for redirecting acute care expenditures such as a minimum of 1 per cent annually over a five-year period to the home and community care sector. Along with supporting initiatives outlined in this paper, such expenditures should be directly reinvested into residential care and home care / support to deal with existing cost pressures facing service providers as well as support development of new continuing care models to reduce acute care pressures (including Alternate Level of Care Days), improve access to care while also allowing seniors to receive services in the most appropriate setting.

Section 2: Ensuring appropriate level of Direct Care Hours for seniors living in residential care

Direct Care Hours (DCH) are the time that healthcare providers, including Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Physiotherapy and Occupational Therapists, Care Aides and others, dedicate to caring for their residents each day. DCH do not include hospitality services such as meals, laundry or housekeeping.

As highlighted by both the BC Office of the Seniors Advocate (OSA) and the BCCPA, significant disparities exist in British Columbia (BC) with respect to Direct Care Hours (DCH) among care homes within and between Health Authorities. The differences in DCH are outlined in the *Quick Facts Directory* recently published by the OSA, which demonstrates discrepancies both by health authority region, as well as ownership type.[6] Overall, such disparities make it difficult to provide equal and consistent levels of care leaving some residents at a disadvantage over others depending on where they live.

According to a 2015 Insights West survey of over 800 British Columbians, 78% of respondents believe regardless of where you reside, the number of DCH funded by Health Authorities for a senior with similar levels of acuity should be consistent.[7]

The BC Ministry of Health has established a target of 3.36 hours of direct care provided per day per resident (3.00 hours nursing and 0.36 allied, or supporting, care) as a guide for health authorities.[8] As outlined further in Appendix D, there are, however, significant differences currently in the levels of DCH among care homes in BC. While the OSA has suggested moving towards the minimum 3.36 DCH, the BCCPA has also recommended where feasible, the province move toward a standard of 3.36 hours of care per resident per day target and that any necessary staffing increases to meet this requirement be fully funded by Health Authorities and/or Ministry of Health.[9]

In February 2009, the BC Ministry of Health issued a directive to health authorities (HAs) requiring each of them to create a three-year plan to address a number of issues, including details of how they could provide 3.36 DCH per resident per day in their plans. The HAs responded to the Ministry as follows:

- Fraser Health would need to invest an additional $79 million in staffing to achieve guideline (24 per cent increase in staffing costs);
- Interior Health estimated it would cost $39 million to achieve guideline;
- Northern Health would require additional $11.6 million to meet the guideline (increase staffing costs for registered nurses, licensed practical nurses and residential care attendants by 25 per cent);
- Vancouver Coastal estimated it would cost approximately $57 million to achieve the guideline and that it could reallocate $6.7 million to help fund this; and

- Vancouver Island could not fund increased staffing by reallocating its resources and that it would not be able to achieve the guideline without additional resources.[10]

More recent initial estimates from the Ministry of Health show that it would require between $180 million to $385 million in new funding for all care homes to reach the minimum 3.36 DCH target. As such this paper recommends new annual funding to meet the target, along with additional monies from a new HHR fund as outlined in section 5.

Along with additional funding, there must also be greater clarity and standardization with respect to a definition for DCH as this also varies among health authorities (see Appendix E). In particular, there should be a standard definition for DCH that includes RNs, LPNs, Care Aides as well as other allied health professionals and activity staff, and that clinical support provided by Directors of Care (DOC), assistant DOC, and clinical coordinators be included consistently in the calculation of DCH. In particular, the professional support component of DCH should include those occupations outlined in the *Health Professions Act*.[11] Along with a consistent DCH definition, there will also need to be a strategy to deal with health human resources (HHR) to ensure that DCH targets are being met.

While the minimum 3.36 DCH should be the target, it should be acknowledged that many care homes are required to provide above this level due to the acuity level of their resident population. Increased funding for resident populations and/or individuals with a higher level of acuity should be considered beyond the minimum 3.36 DCH target.

SECTION 2: RECOMMENDATIONS ON DIRECT CARE HOURS

- That the BC government invest in new annual funding for care homes to meet a minimum 3.36 Direct Care Hours (DCH) target, where feasible. This funding would cover actual and quantifiable costs.
- That commensurate with this new funding, care homes be required to report annually on how they are meeting the 3.36 DCH, including current levels of DCH and any steps taken to meet target.
- That a standard definition of DCH be developed by the Ministry of Health and Health Authorities in partnership with the sector by 2017; and that in the interim DCH be defined as including a 20% professional component and 80% non-professional, with the professional component consisting of the clinical functions performed by Directors and Assistant Directors of Care as well as those occupations outlined in the BC Health Professions Act.

Section 3: Improving openness and transparency within the continuing care sector

The ageing of the population will put increased pressure on the health system, due in part to the greater prevalence of chronic diseases and mental health issues, including dementia. This is in part because health services tend to be used at higher rates as the population ages, with increased demand for home and residential care.[12] According to the BC Ministry of Health, the growth in demand for health care for frail elderly living in residential care, who already utilize about 25% of overall health services, is projected to increase by 120% by 2036. Currently, this population accounts for almost $2.5 billion in health expenditures including $1.9 billion in residential care and $380 million for hospital care. [13]

Total demand in BC for health services by seniors is expected to increase by 41% over the next 10 years from population growth and ageing alone. In comparison, demand for health services from the population under age 65 will only increase by 13%.[14] A 2015 Conference Board of Canada report notes total spending on continuing care supports for seniors is projected to increase from $28.3 billion in 2011 to $177.3 billion in 2046. With nearly two-thirds of this spending likely to continue to be provided by governments, spending growth will significantly exceed the pace of revenue growth in most provinces.[15]

Dealing with these fiscal challenges should be a priority for governments, including finding ways to redirect existing funding from more-costly acute care, which currently comprises between 55% to 60% of BC's health authority budgets already as well as looking at new ways to finance continuing care. Part of the solution will also require looking at obtaining better value for money as well as finding greater efficiencies in the system. This could include exploring a greater role for non-government operators.

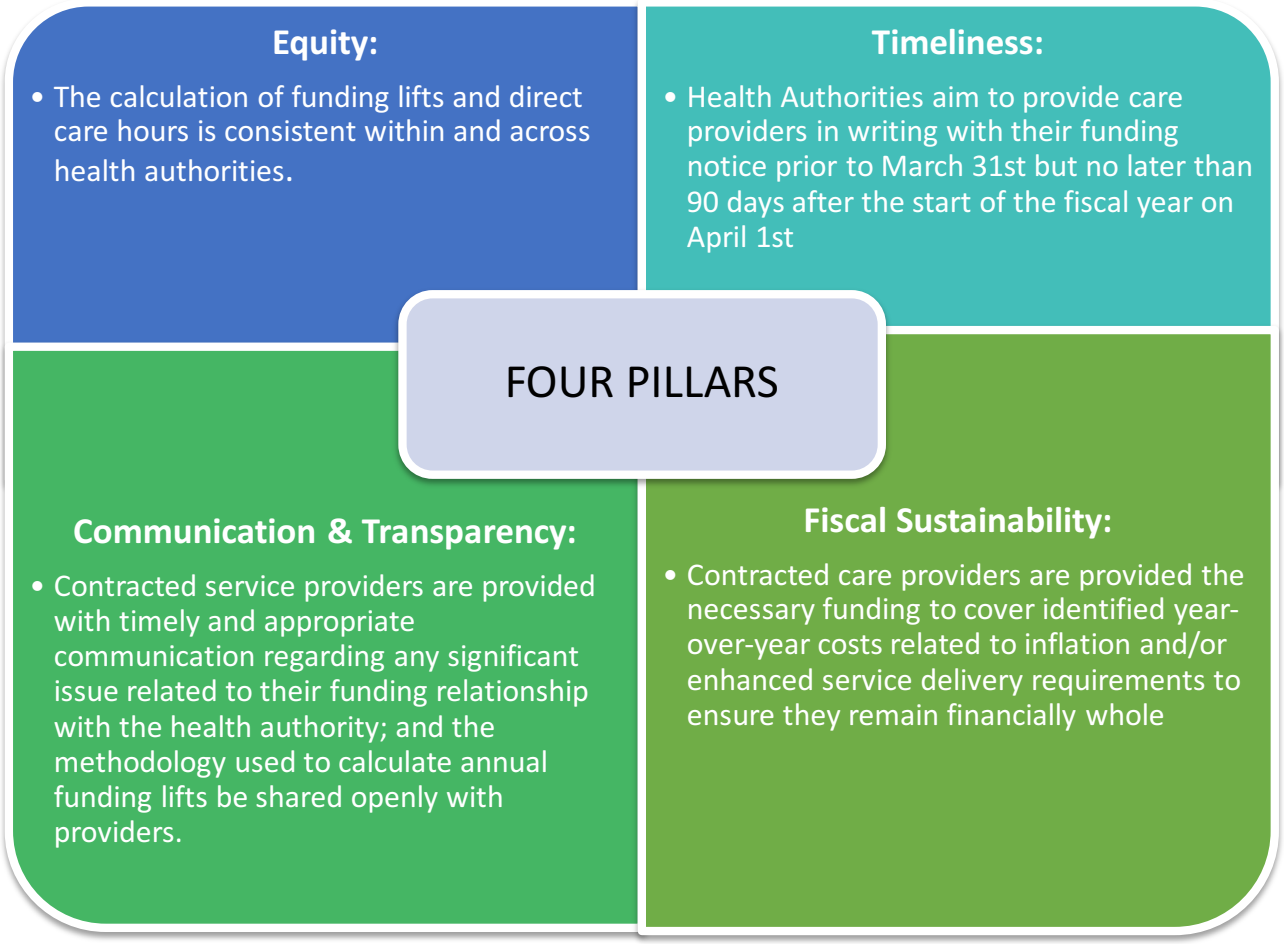
Along with exploring an increased role for non-government operators in the delivery of care, another area that could be looked at to increase efficiencies is finding ways to reduce the administrative burden of regulatory and reporting overlap for publicly funded beds within the continuing care sector, and to redirect resources to frontline care. This was an earlier focus of a BCCPA report in 2014 and continues to be a major issue as new and at times burdensome regulations are introduced.[16] In June 2016, Alberta announced it would also be undertaking a review of all its regulations within the continuing care sector - a process BC should explore as well.[17] This could also include as recently announced in Ontario, reducing the level of annual inspections for care homes.[18]

In BC, continuing care providers consistently deliver high quality care for seniors. Despite the fact that new entrants into home and community care have much higher levels of acuity than in previous years, and are increasingly living with multiple chronic conditions, funding lifts for care operators are often less than collective agreement increases. Furthermore, cost of living increases are not fully recognizing inflationary pressures (including wages) and/or enhanced service delivery requirements.

To meet the needs of residential care operators and improve the sustainability of the continuing care system, the first priority must be the establishment of a predictable, long-term funding model that is included in any contract arrangements with the health authorities. Ideally, this would include more long- term budgeting with increases to per diem rates outlined over a 3-to-5-year period. These rates should also accurately factor in increases to operating costs including wages, inflation and overhead as well as other areas such as increasing levels of acuity among residents.

Another major issue is that some residential care provider members are not being advised of their annual fiscal year funding amounts in a timely basis. This adds undue financial stress and operational challenges for care operators, who are unaware of what their final operating budgets are until well into or even after the fiscal

year in which the services were delivered. Likewise, it also hampers the delivery and planning of quality of care for seniors. In 2015, the BCCPA endorsed the following principles on timeliness, equity, sustainability and communication / transparency which this report believes should serve as a guide.



In summary, this budget submission encourages an immediate and independent review of funding lifts in all Health Authorities with the goal of consistency, fairness, and sustainability with respect to per diem rates. As outlined in the 2012 Ombudsperson report on seniors' care, the Ministry of Health should also work with health authorities to conduct an evaluation to determine whether residential care budgets in each health authority are sufficient to meet the current needs of its population.[19]

While not discussed in detail in this submission one of the critical issues regarding fiscal sustainability is ensuring that any new initiatives or programs introduced by government or Health Authorities in the continuing care sector have the necessary and appropriate resources in place to support over the long-term. Ideally, care providers should not be required to assume the costs of a project or program once any short term funding ceases. Likewise, for any new requirements imposed in the continuing care sector such as most recently on providing a basic wheelchair and maintenance, appropriate funding and resources should be available over the long term to compensate providers.

This budget submission also advocates that Health Authorities provide greater transparency with respect to how the funding lifts provided for residential care are determined. This includes outlining in detail how changes are derived as part of any funding model, as well as involving operators in the process so they are prepared well in advance of any changes.

Developing greater openness and transparency will also likely require some formal mechanism and/or committee structure in which care providers, the Ministry of Health and Health Authorities can meet and discuss relevant issues. An example of this, as proposed in the 2015 BCCPA paper entitled *Quality, Innovation, Collaboration: Strengthening Seniors Care Delivery in BC,* is the establishment of a continuing care collaborative based on a model that has been successfully implemented in Alberta to address pressing issues in the sector.

While the BCCPA Continuing Collaborative hosted in September 2016 is a starting point for dialogue, Alberta has a more formalized process to engage the sector with established committees that merits consideration here. In Alberta their collaborative brings together senior leadership within the continuing care sector including care providers, Alberta Health Services and its Ministry of Health. It meets on a regular basis and has a number of key sub-committees which are focused on collectively coming up with short and long-term solutions to the many issues facing seniors care in Alberta.[20]

SECTION 3: RECOMMENDATIONS ON OPENNESS AND TRANSPARENCY

That the BC government, through a new Continuing Care Collaborative, undertake the following:

- Review funding lifts in all Health Authorities with the goal of ensuring consistency, fairness and sustainability with respect to per diem rates, including providing greater public transparency on how funding lifts provided for residential care are determined;
- Provide annual site by site public reporting regarding the level of funded direct care hours;
- Establish a long-term predictable funding model by end of fiscal 2017-18 that is outlined in any contract arrangements with the health authorities, including more long-term budgeting with increases to per diem rates outlined over a 3 to 5-year period; and
- Undertake a joint government-industry red tape review on where greater efficiencies can be obtained in the continuing care sector, including, where feasible, potentially expanding the role of non-government operators as well as reducing unnecessary regulations and duplication that do not improve the quality of life for seniors.

Section 4: Improving quality of life for seniors in residential care and in the community

While improving staffing levels, including Direct Care Hours as outlined in section 2, will improve seniors care over the long term, further initiatives will need to be undertaken to improve the overall quality of life for seniors including those living in residential care, assisted living and the broader community.

By 2036, over twenty-five per cent of BC's population will be 65 years or older. The health system, however, is not prepared to meet the challenges of an ageing population, including dealing with mental health and

chronic diseases. Likewise, the health system is still largely acute care oriented and not optimally designed to provide care for those with ongoing care needs, such as chronically ill or frail elderly.[21] Today's seniors face critical challenges such as having multiple chronic conditions, increasing levels of dementia and mental health concerns, high rates of falls, as well as escalating levels of social isolation and depression. These have very negative effects on quality of life and strategies to address these areas will be critical going forward.[22]

The OSA, for example, has addressed some of these challenges in a report highlighting the need for greater support of Adult Day Programs (ADPs). A 2015 OSA report, for example, found that while ADPs provide important benefits to both clients and their informal caregivers, they face a number of challenges and limitations. In particular, the OSA indicates that the capacity of ADPs in BC has not kept pace with the ageing demographics. The report indicates that in real terms, the number of ADP clients decreased 20 per cent, and the number of days utilized has decreased 18 per cent between 2011 and 2014.[23] Along with this the OSA has highlighted the need for greater recreational therapy as well as occupational and physical therapy programs in residential care. In particular, a 2015 OSA report notes:

- The number of seniors who received physiotherapy (PT) was 12 per cent in B.C. compared to 25 per cent in Alberta and 58 per cent in Ontario;
- Only 9 per cent of residents received occupational therapy (OT), compared to 22 per cent in Alberta and 2 per cent in Ontario; and
- Only 22 per cent of seniors received any recreational therapy (RT) in the last seven days, when they were assessed, compared to 42 per cent in Alberta.[24]

To help meet some of these gaps, this budget submission recommends new funding for the creation of a *Seniors Quality of Life Fund* (SQLF) to address some of the challenges seniors face in receiving appropriate supports such as RT/OT/PT as well as music, pet and aroma therapy. The benefits of such programs, including BC's Concerts in Care, have been well documented and should be expanded, where feasible, province-wide.[25]

Additional areas that should also be addressed as part of any SQLF include the provision of more ADPs or other initiatives to deal with issues of seniors' isolation which touches many areas of seniors' lives, including their active participation in the community. According to a 2012 study of the National Academy of Sciences, social isolation and loneliness are associated with a higher risk of mortality in older adults.[26] One study notes isolation is as strong a factor in early death as smoking 15 cigarettes a day,[27] while another notes it can be twice as unhealthy as obesity, increasing chances of early death by 14 per cent.[28]

Social isolation is also a factor in the development of chronic illnesses such as lung disease, arthritis, and impaired mobility. In particular, research also shows that increased loneliness can lead to depression, as well as cognitive decline and an increased risk of dementia.[29] Depression is also the most common mental health

problem in the elderly and is associated with a significant burden of illness that affects seniors, their families, and communities and also has major economic costs as well.[30]

Along with recreational programs, the provision of appropriate food and nutrition to seniors living in residential care is critical, particularly for improving quality of life. With current budget constraints it will become increasingly challenging for care operators to continue to provide sufficient food and nutrition. As outlined in a 2015 survey, although British Columbians believe care homes are allocated about $70 on average to provide meals to residents on a daily basis, the amount spent on average is considerably less. While funding is allocated by health authorities, most care homes with existing budget constraints and other expenses are only able to allocate on average about $6 to 7 on meals to residents.[31] These amounts, which are minimal will need to be increased particularly given rapidly rising food costs that are well above inflation. While care homes in BC are providing the best high quality food they can with limited resources, there is still an opportunity to enhance and make improvements. Likewise, funding should also help assist, where appropriate, to allow care homes to meet the increasingly high number of residents who have therapeutic diet requirements such as puree meals or textured diets.

Overall such initiatives will improve the overall mental health and physical well-being of seniors. While there has been a major focus on such activities for younger populations (i.e. ParticipACTION, school lunch programs and childhood obesity) there is a lack of initiatives targeted towards seniors. Even in advanced years, such programs including those that encourage physical activity or improved nutrition can have significant impacts. A study from Finland, for example, found a positive correlation between weekly physical activity and positive health outcomes among older adults (aged 65-84 at the outset) living in the community.[32]

Likewise, exercise has also been found to be beneficial for promoting mental health in older adults (aged 65+) living in the community, supportive housing, and in residential care.[33] Physical activity among older adults with cognitive impairment, including Alzheimer's disease and other dementias, has also been linked with long- term improvements in cognitive function.[34]

Home Support

Home support is a critical area of the health system and that government and health authorities, where possible, should support a re-allocation of funding away from costlier acute care to less expensive areas of the system including home care. Similar to residential care, home support providers are also facing challenges to remain fiscally sustainable due to an identified shortage of funding to cover inflationary costs. In particular, for home care / support providers these can be attributed to a lack of recognition and compensation for travel time, increasing levels of acuity for seniors as well as higher compensation and benefits costs. In fact, many home care providers have not seen funding increases for several years. These and similar pressures are also compounded by very short client visits (i.e. 15 minutes) by home support workers, which are insufficient to provide adequate care for seniors.

A 2016 report from the BC Office of the Seniors Advocate also highlights some of the negative trends with respect to home support in British Columbia, including:

- The total number of home support clients in B.C. increased by 2% over 2013/14, while the population aged 75 and over increased by 4%;
- The number of home support hours is trending down in three out of five health authorities, while the number of clients has increased in four out of five (discrepancy greatest in NHA); and
- In 2014/15, the average hours delivered per client per year was 268, or 5.1 hours per week. This represents a provincial average decrease of 1% from 2013/14.[35]

To address some of these and other challenges facing home care and support, a portion of the SQLF could also go towards community programs such as Adult Day Programs (ADPs) or others that could be offered potentially by residential care home operators to provide care to clients or residents who wish to remain living at home.

On a final note, while RT/OT/PT and other related therapies have been emphasized in other provinces such as Alberta and Ontario, including their funding models for continuing care, they have also struggled to ensure an appropriate number of professionals to provide such services. As outlined further in Section 6 on Health Human Resources it will critical to ensure that there are there appropriate personnel resources (i.e. PTs/OTs) in place and that BC therapy programs are producing an adequate number of graduates particularly in rural areas. Part of the solution could also be the further use of rehabilitation assistants as part of the staffing mix who can complement the services provided by PTs and OTs and ensure consistency in therapy practices including in rural areas.

SECTION 4: RECOMMENDATIONS ON IMPROVING QUALITY OF LIFE FOR SENIORS

- That the BC government establish a *Seniors Quality of Life Fund* (SQLF) to support quality of life for seniors in residential care and the community, which focuses on improving the physical, spiritual, psychosocial and mental well-being through various initiatives including:
    - Increased access to recreational therapy as well as occupational and physiotherapy;
    - Increased access to a broad array of therapy programs such as Concerts in Care and Sing for Your Life, both in residential care and the broader community;
    - Reducing seniors' isolation through increased Adult Day and similar programs;
    - Maintaining and enhancing upon the overall quality of food and nutrition in residential care homes including meeting therapeutic diet requirements; and
    - Increasing the minimum time for home support visits from the current 15 minutes.
- That the Ministry of Health be asked to regularly report on the use of the SQLF, including what initiatives are being undertaken and how they are improving the overall quality of life for seniors in the province.

Section 5: Improving Sustainability & Accountability within continuing care

As mentioned earlier in Section 2, there are significant differences that exist among care homes with respect to their DCH levels. It is important to note, however, that care homes are funded differently by health authorities based on various factors including the level of DCH they are required to meet. As such, the per diem rates provided to care homes can also vary widely. Moving to a target of a minimum 3.36 DCH should help to make the per diems more consistent recognizing that there will nevertheless be some differences due to differing populations including levels of acuity or other factors.

Overall, as noted earlier, seniors entering into residential care have much higher levels of acuity than in previous years and are increasingly living with multiple chronic conditions, while funding lifts for residents and operators are not keeping up. The funding challenges facing care operators is particularly prevalent as care homes in BC are not able to afford capital investments to improve or modernize their physical infrastructure. While non-government care home operators have invested large amounts of capital into their operations, including their physical infrastructure, this is becoming increasingly difficult in the current fiscal environment, as funding lifts currently do not account appropriately for these costs. In particular, while non-government care operators have historically not been adequately compensated for the costs of the building, maintaining, upgrading and eventually replacing residential care homes, health authority operated care homes are funded fully for these property and infrastructure costs. [36]

Compounding these inequities are unfunded wage and non-wage inflation costs, both of which have gradually eroded operating efficiencies used to offset capital costs. The result has led to a reduction in the attractiveness of investment within the residential care sector. It has also increased the difficulty some operators are having in maintaining the financial viability of their businesses. This runs contrary to the BC government's direction of including private sector involvement in public infrastructure development such as the use of public-private partnerships (P3s).

Currently, areas with comparatively high land and building costs such as Vancouver Coastal Health and Fraser Health regions have had the most difficulty in attracting private sector investment to residential care. As a result, highly capitalized, multi-site operators are largely becoming the only organizations to leverage sufficient funds to develop new care homes or renovate existing ones. Similar to other provinces such as Ontario, in BC, smaller care homes have very limited care administration resources and fewer direct care resources than larger ones to meet growing demands, including funds for redevelopment. [37]

Over time, the growing gap between the actual capital cost of maintaining, upgrading or replacing a care home and its ability to recoup efficiencies in staffing, administration or other operating savings to devote to capital has seriously diminished. In particular, the erosion of their ability to cover direct care costs for seniors is one of the most critical aspects of the lack of capital funding for non-government care operators. This is especially troubling since, as noted earlier, government owned and operated care homes continue to have their entire property costs fully covered while others, including private operators, do not.

Overall, any funding models that are developed should adequately reflect any capital replacement costs. As many care homes age and become physically or functionally obsolete they will need to be replaced. By partnering with the private sector, government would be demonstrating or re-affirming its commitment to reducing health costs and promoting development of an appropriate health infrastructure. [38]

In summary, property related funding inequities reduce private sector investment and increase the aggregate cost of providing residential care infrastructure province-wide. In addition, the costs of renovating or upgrading care homes are significant and for the most part are not economically feasible for many operators under current capital compensation arrangements.

Funding for infrastructure investments

Another potential option is that taken by Ontario, which in October 2014 announced a renewed capital redevelopment plan for long term care (LTC) homes. This has been well-received by LTC home operators in that province who want to bring their homes up to current standards. As outlined by the Ontario Long- Term Care Association, some 52% of Ontario's older LTC Homes – many of them in small communities or rural locations – currently do not meet the most recent (2009) design standards. For example, older homes have three or four-bed wards and cramped living spaces, which do not meet the needs of residents living with dementia and Alzheimer's.[39]

Like Ontario, BC faces similar challenges in the redevelopment of its long-term care infrastructure. To meet these challenges, this report advocates the development of a residential care infrastructure fund (RCIF). Care homes who receive monies from this fund should also be accountable including outlining any expenditures and how any new investments through the RCIF has improved senior's quality of life.

Along with new capital investments, this report suggests considering exempting care home operators from paying property taxes, which is currently done in other provinces such as Alberta. This change, for example, would go a significant way in allowing non-government operators to recoup capital operating expenses, as well as encouraging further private investment in continuing care sector in order to improve access to new residential care beds and for senior's care. [40]

SECTION 5: RECOMMENDATIONS ON FUNDING AND ACCOUNTABILITY

- That the BC government establish a new *Residential Care Infrastructure Fund* (RCIF) to support the immediate renewal and modernization of older residential care homes. The fund, which could be matched by the Federal Government, would be used for capital improvements such as the installation of ceiling lifts and sprinkler systems. Care homes will be accountable for any investments including outlining how they spent any new funds received and how it has improved senior's quality of life.
- That the BC government, working with municipalities, exempt property taxes for residential care homes to allow non-government operators to recoup capital operating expenses and further encourage private investment in the continuing care sector.

Section 6: Health Human Resources (HHR)

One of the most pressing issues facing the continuing care sector is ensuring sufficient levels of health human resources (HHR) exist. Along with geriatricians, there are shortages of nurses in the continuing care sector, including registered nurses and licensed practical nurses. Likewise, many care providers are facing challenges

with the recruitment and retention of care aides. Care aides are a vital part of seniors care as they provide up to 80 per cent of the direct care received by older Canadians living in long term care.[41]

With a rapidly growing population and strengthening economy, the ability to attract qualified care aides to British Columbia has increasingly become a challenge. The problem is particularly acute for residential care operators in the Interior and Vancouver Island. For home support employers it is also a province-wide issue with chronic shortages in the North.[42]

To better deal with issues around the recruitment and retention of health care providers for seniors there must be a coordinated role between the continuing care sector, Ministry of Health and Health Authorities working collaboratively with colleges and universities. In particular, not only is there a role for colleges and universities in educating and training appropriate numbers of such health providers but they also have a role in ensuring that such training is relevant and practical. This includes allowing nurses and care aides opportunities to gain more practical hands on experience or training in seniors care, as well as perhaps ultimately improving public perceptions of such careers. Aside from such shortages, another issue related to HHR is the need to better integrate health professionals, including physicians and nurses into residential care.[43]

The issue of HHR will be even more critical in order to reach a DCH target of 3.36 hours. In particular, attempting to reach a target of 3.36 hours per resident day could drastically increase the amount of staff in a short period of time that are required to care for seniors within residential care. To address these challenges, this report recommends that new funding be provided to ensure care homes are able to meet the 3.36 DCH target, including funds to support initiatives to increase level of care aides and other health professionals who provide seniors care on a daily basis. As outlined below, this include programs to improve the recruitment and retention of health professionals, particularly in rural and remote communities as well as training and resources to improve dementia care.

BC Cares Program

Overall, a portion of the HHR funding could go towards new campaigns or initiatives to improve the recruitment and retention of those caring for seniors. An example of an earlier such campaign was the BC Cares initiative. In 2007, the BCCPA initiated BC Cares, a successful partnership between the BC Ministries of Health and Advanced Education as well as 20 public and accredited private BC universities and colleges. BC Cares encouraged and provided easier access to the required courses prospective candidates would need in order to become a qualified care aide. In particular, a focus was placed on increasing the enrollment rate of immigrants, youth and those living in Aboriginal or rural communities. [44]

The BC Cares campaign was able to boost enrollment by 75-100% for much-needed residential care aides (RCAs) and home support workers (HSWs). By the fall of 2008 almost all participating post-secondary institutions reported their courses were near or at capacity. The campaign featured radio and print advertising, brochure distribution, a comprehensive website and social media marketing tactics. [45]

Dementia – Behavioral Supports Program

According to BC's Dementia Action Plan, the number of people with dementia in the province is between 60,000 and 70,000. The Alzheimer Society of BC notes that this number is expected to double within the next 25 years.[46] With increasing levels of dementia it will be an important component of any HHR strategy particularly in residential care as well over 60% of residents have some level of dementia. In particular, it will critical to ensure care homes have the necessary resources, including training and education, to care appropriately for dementia residents as well as deal with incidents of resident-on-resident aggression as also outlined in a June 2016 OSA

report.[47] An example of such a program to better train front-line staff dealing with residents with dementia is Behavioral Supports Ontario (BSO) that was established in 2012.

As part of the BSO program, which has received almost $60 million in government funding, staff take specialized training to gently approach and redirect residents with challenging behaviors. Staff also work with care teams to reduce aggressive or challenging behaviors. Initial results show BSO has been successful, including in one care home which has reduced antipsychotic medication use in half while lowering rates of agitation, restlessness and conflict.[48]

In its 2016 budget, the Ontario government announced it will invest an additional $10 million annually in BSO to help long-term care home residents with dementia and other complex behaviors.[49] This report believes that a similar program and investments should be considered here in BC, which also faces increasing levels of dementia and challenges with regards to responsive behaviors. Such an initiative could also align with the concept of dementia friendly communities[50] or as outlined in the BCCPA White Papers a dementia friendly program in which a specific designation could be provided to care homes where specific dementia training has been provided to staff. [51] Along with government and Health Authorities, Alzheimer's Society of BC and SafeCare BC, whose mandate is to reduce worker injury rates in BC's continuing care sector, could oversee such as program.[52] Ideally, this program should also include some funding to care homes to cover staffing costs to allow for a care aide or other staff worker to attend such training. Without such resources it can be difficult for care homes or workers to take advantage of such training or education opportunities.

HHR strategies for continuing care sector

In addition to specific programs such as those outlined above, there will be a need for provincially coordinated HHR strategies to ensure the health system has sufficient numbers and competently trained workers to meet current and future care needs of seniors. One critical aspect in the development of such strategies will be improving access to relevant HHR information and/or data. It could also include the development of a province-wide HHR strategy, led by the Health Employers Association of BC (HEABC), outlining the projected supply and demand of continuing care providers as well as highlighting approaches or strategies to ensure the care needs of seniors are being met appropriately. Alternatively, another idea could be the creation of a health workforce impact assessment tool that can be applied to any new continuing care policies or programs that are being developed. Australia, for example, has developed a workforce impact checklist to apply to all health policies as they are developed. [53]

SECTION 6: RECOMMENDATIONS ON HEALTH HUMAN RESOURCES

- That the BC government establish a *Continuing Care Health Human Resource (CCHHR) Fund* to help meet increased DCH targets and support initiatives to increase the number of care aides and other health professionals in residential care and home care as well as training, education and resources to improve dementia care, including:
    - Funding for a new BC Cares Program between the BC Ministry of Health, Health Authorities, the Health Employers Association of BC and BCCPA to improve the recruitment and retention of care aides and health professionals who provide continuing care;
    - Funding for a BC Behaviour Supports Program (BCBSP) between the BC Ministry of Health, Health Authorities, Alzheimer's Society of BC and SafeCare BC to provide training, education and resources to improve dementia care province-wide; and
    - Matching funding from the CCHHR fund with the Health Employers Association of British Columbia (HEABC) to develop a coordinated province-wide approach to HHR development for all continuing care providers.

Section 7: Federal funding for seniors, including investments for continuing care

Although health care, as outlined in section 91 of the Constitution, is largely a provincial responsibility the federal government does still have a role in particular areas including funding, public health, research as well as fostering best practices and innovation. The federal government also has specific responsibility for particular populations including First Nations living on reserves. As outlined in the last federal election, the Liberal Party committed to invest $3 billion over its first term to provide improved health care services for nearly two million people currently receiving care at home as well as investments to the infrastructure of care homes as part of a $20 billion investment in social infrastructure over a ten-year period.

New federal investments are of the upmost importance for reasons outlined earlier in this report – namely our province's ageing population, meeting current fiscal challenges and the expected increases in demand for health care services. Given these significant challenges, the BCCPA advocates that the Ministry of Health ensure that the province receive an appropriate share of any new federal funding. This funding should be used both to invest in continuing care immediately and to invest in future long-term care infrastructure. For example, the Canadian Medical Association (CMA) recently advocated the federal government allocate $2.3 billion over a five-year period in the next long-term infrastructure plan for the construction, renovation, and retrofitting of long-term care homes.[54]

As discussed earlier, new federal funding could also be re-directed to support the recruitment and retention of health professionals including care aides, licensed practical nurses and registered nurses, as well as the integration of physicians and new health professions such as nurse practitioners and physician assistants into continuing care.

As part of any new health accord, the BCCPA also advocates for the establishment of an age-adjusted Canada Health Transfer (CHT) that reallocates funding to provinces such as BC with higher and growing portions of seniors; as well as new and/or reallocated funding to improve capacity and build infrastructure, reduce wait times and support new care models for residential care and home care.

The BCCPA believes that changes to the CHT along with new investments would help assist in meeting some of the capacity challenges facing the continuing care sector as well as improving seniors care overall. In 2012, it was reported that 461,000 Canadians were not getting the home care they thought they required. Wait times for access to long-term care in Canada also ranged anywhere from 27 to 230 days. Other key concerns facing the sector include health human resource challenges – particularly the shortage of geriatricians and other health care providers.

A new health accord should also meet the Liberal commitments outlined during the last election including a long term agreement on funding; investments of $3 billion over next four years to deliver more and better home care services for Canadians; a pan-Canadian collaboration on health innovation; as well as improving access to necessary prescription medications, particularly for seniors.

Other areas, as outlined in more detail in the White Papers that the BCCPA believes the federal government should take a more collaborative role with provinces include the development of a National Dementia Strategy as well as potentially a National Seniors Health Promotion Strategy.

SECTION 7 RECOMMENDATION: FEDERAL FUNDING FOR SENIORS CARE

That the provincial government as part of any new Health Accord advocate that the following elements be included:

- The establishment of an age-adjusted Canada Health Transfer that reallocates funding to provinces such as British Columbia with higher and growing portions of seniors;
- New and/or reallocated funding to improve capacity and build infrastructure, reduce wait times and support new continuing care models for residential care and home support; and
- Meet commitments outlined in the federal Liberal platform including a long term agreement on funding; invest $3 billion over the next four years to deliver more and better home care services for all Canadians; develop a pan-Canadian collaboration on health innovation; as well as improve access to necessary prescription medications, particularly for seniors.

CONCLUSION

With BC's population rapidly ageing, now is the time to explore new solutions to meet the fiscal challenges we face, while also improving the overall quality of seniors' care. Redesigning the existing health system with new care models and providing targeted investments that can improve care will be an integral part of this process. In particular, there is a need to explore alternative ways to sustain and innovate to create a health system so that it is less acute oriented and better designed to provide care for those with ongoing care needs, particularly the chronically ill and frail elderly.[55]

In May 2016, for example, the BCCPA released two major White Papers outlining potential options to improve sustainability and innovation for seniors and the continuing care sector.[56] The following budget submission has also looked at these and other various reports to highlight seven priorities with eleven recommendations in the following areas:

1. Shifting resources from acute to home and community care
2. Increasing Direct Care Hours (DCH);
3. Increasing Openness and Transparency;
4. Improving Quality of Life for seniors;
5. Improving Sustainability and Accountability;
6. Health Human Resources (HHR); and
7. Federal funding for Seniors Care

Overall, the focus of the key themes and recommendations outlined in this report are about enhancing the quality of life for seniors[57] in their remaining years, including through initiatives to increase health human resources (HHR) and direct care hours (DCH) as well as specific targeted funding initiatives or programs.

As outlined at the BCCPA Inaugural Continuing Care Collaborative held on September 20, 2016 which featured stakeholders across the home and community care sector now is the time to work together to find solutions to the rapidly ageing population while also improving the overall quality of seniors' care. In particular, as outlined at the Collaborative, It's about … *time!*

Appendix A: Overview of Options for Consideration from Sustainability and Innovation White Papers

Funding and Financing of Continuing Care

- Ensuring that funding for care providers better accounts acuity and complexity of clients in care, as well adhering to the core principles of timeliness, sustainability, equity and transparency.
- Moving towards a funding model that separates the bodies that fund, allocate funds and regulate care homes from those that operate care homes.
- Development of funding models that accurately factor in increases to operating costs including wages, inflation, overhead as well as other areas such as increasing levels of acuity.
- Increasing stability in the sector through policies such as Managing Changing Need and ensuring a fair and equitable return on the cost of capital.
- Exempting property taxes for residential care homes to allow non-government operators to recoup capital operating expenses.
- Review of new funding models such as activity and outcome based funding, social finance and vouchers in continuing care as well as new financing approaches such as long term care insurance and co-payments.

New Care Models

- Explore new delivery models such as the Continuing Care Hub to reduce acute care congestion and ER visits as well as better care for frail elderly and seniors with chronic conditions and dementia.
- The development of new continuing care models in which residential care homes could provide home support services to seniors and/or be integrated as part of age friendly communities.
- Development of new care models such as Green House care homes and specific models of care for dementia (i.e. Butterfly Care Homes and Dementia Villages).
- Establishing a dementia friendly program, in which a specific designation could be provided to care homes that have made specific redesign changes to accommodate residents with dementia and/or where specific dementia training has been provided to staff.
- Better utilize the existing excess capacity in the continuing care sector to increase capacity with respect to end-of-life (EOL) care.
- Adoption of new palliative care models including, where necessary, providing funding to improve the integration between long-term and end-of-life care.

Dementia and use of technology

- Advancement of a National Dementia Strategy / Declaration with federal participation.
- Use of technology and the existing residential care infrastructure to facilitate seniors ageing in place and/or reducing social isolation of seniors.
- Adoption of new electronic information systems, including electronic health records and telehealth that facilitate the sharing of resident information across the continuing care system.

- Adoption of new technologies that improve the safety of seniors particularly through new monitoring and surveillance systems.

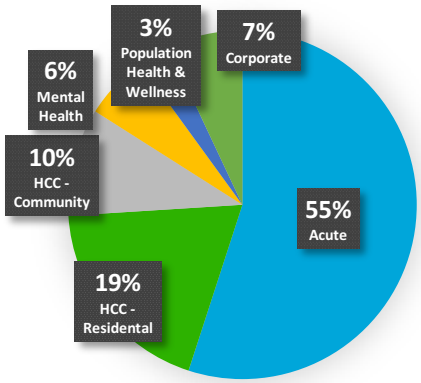
Seniors Safety and Health Promotion

- Advancement of a collaborative Provincial Seniors Safety Strategy focusing on specific issues including falls prevention, resident-on-resident aggression, reducing adverse drug events, suicide prevention, elder abuse and/or safety within home and community care.
- A joint federal-provincial fund to improve the safety of residents and health care workers including funding to install ceiling lifts and other retrofits to residential care homes across Canada.
- Development of a National Seniors Health Promotion Strategy to promote seniors physical and mental well-being, including for the frail elderly.

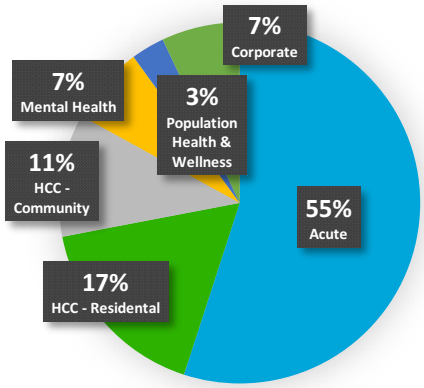
APPENDIX B: BREAKDOWN OF HEALTH AUTHORITY EXPENDITURES

BREAKDOWN OF HEALTH AUTHORITY EXPENDITURES (2014/15)

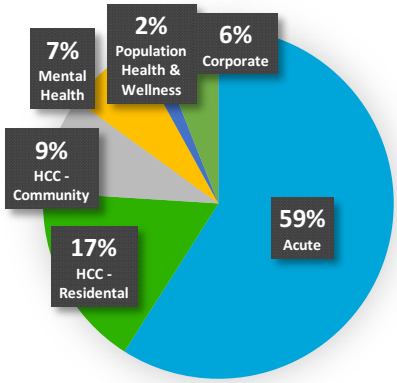
IHA Expenditures



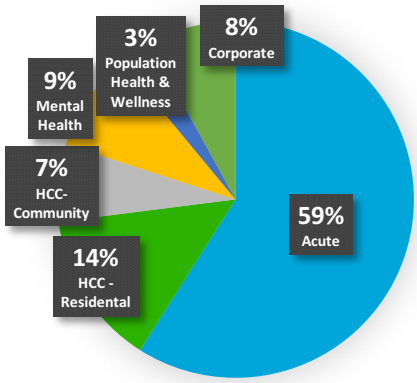
VIHA Expenditures



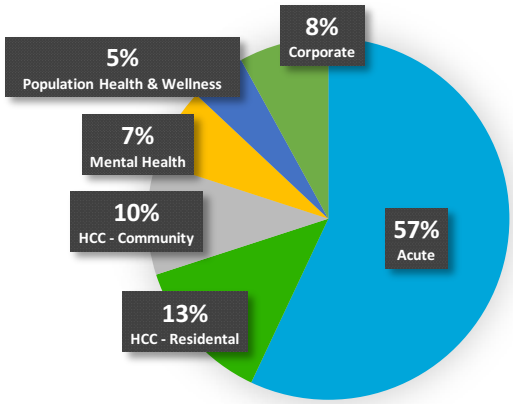
FHA Expenditures



VCH Expenditures



NHA Expenditures



Sources: Financial Statements of Vancouver Coastal Heath Authority, Vancouver Island Health Authority, Interior Health Authority, Fraser Health Authority, and Northern Health Authority (year ended March 31, 2015).

HEALTH AUTHORITY SPENDING (2014/15) (all figures in 000s of dollars)							
	Dollars spent on Acute Care	HCC - Residential	HCC - Community	Corporate	Mental Health	Pop Health and Wellness	TOTAL
Vancouver Coastal Health	$1,856,996 (59%)	$443,387 (14%)	$234,385 (7%)	$239,816 (8%)	$284,293 (9%)	$98,396 (3%)	$3,157,273 (100%)
Vancouver Island Health	$1,150,853 (55%)	$357,994 (17%)	$229,994 (11%)	$157,498 (7%)	$156,549 (7%)	$57,732 (3%)	$2,110,570 (100%)
Interior Health	$1,079,080 (55%)	$367,783 (19%)	$196,492 (10%)	$132,738 (7%)	$113,06 (6%)	$55,762 (3%)	$1,944,916 (100%)
Fraser Health	$1,893,608 (59%)	$544,780 (17%)	$289,088 (9%)	$200,612 (6%)	$228,747 (7%)	$79,077 (2%)	$3,235,912 (100%)
Northern Health	$435,760 (57%)	$99,153 (13%)	$75,878 (10%)	$63,711 (8%)	$49,677 (7%)	$37,330 (5%)	$761,509 (100%)
TOTAL	$6,416,297 (57%)	$1,813,097 (16%)	$1,025,787 (9%)	$794,375 (7%)	$832,327 (7%)	$23,532 (3%)	$11,210,180 (100%)
Sources: Financial Statements of Vancouver Coastal Heath Authority, Vancouver Island Health Authority, Interior Health Authority, Fraser Health Authority, and Northern Health Authority (year ended March 31, 2015).							

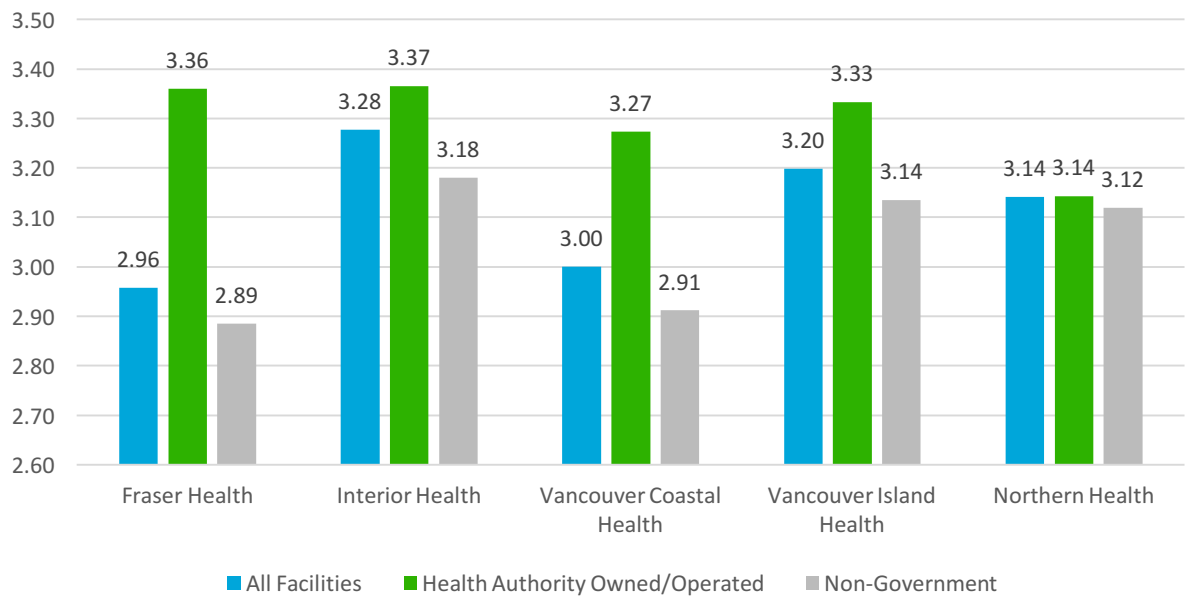
APPENDIX C: HEALTH AUTHORITY 1% REINVESTMENT FROM ACUTE TO HOME AND COMMUNITY CARE

HEALTH AUTHORITY 1% REINVESTMENT FROM ACUTE TO HOME AND COMMUNITY CARE						
	Dollars spend on Acute Care (2014/15)	1st Year	2nd Year	3rd Year	4th Year	5th Year
Vancouver Coastal Health	$1,856,996,000	$18,569,960	$37,139,920	$55,709,880	$74,279,840	$92,849,800
Vancouver Island Health	$1,150,853,000	$11,508,530	$23,017,060	$34,525,590	$46,034,120	$57,542,650
Interior Health	$1,079,080,000	$10,790,800	$21,581,600	$32,372,400	$43,163,200	$53,954,000
Fraser Health	$1,893,608,000	$18,936,080	$37,872,160	$56,808,240	$75,744,320	$94,680,400
Northern Health	$435,760,000	$4,357,600	$8,715,200	$13,072,800	$17,430,400	$21,788,000
Total	$6,416,297,000	$64,162,970	$128,325,94	$192,488,910	$256,651,880	$320,814,850

Sources: Financial Statements of Vancouver Coastal Heath Authority, Vancouver Island Health Authority, Interior Health Authority, Fraser Health Authority, and Northern Health Authority (year ended March 31, 2015).

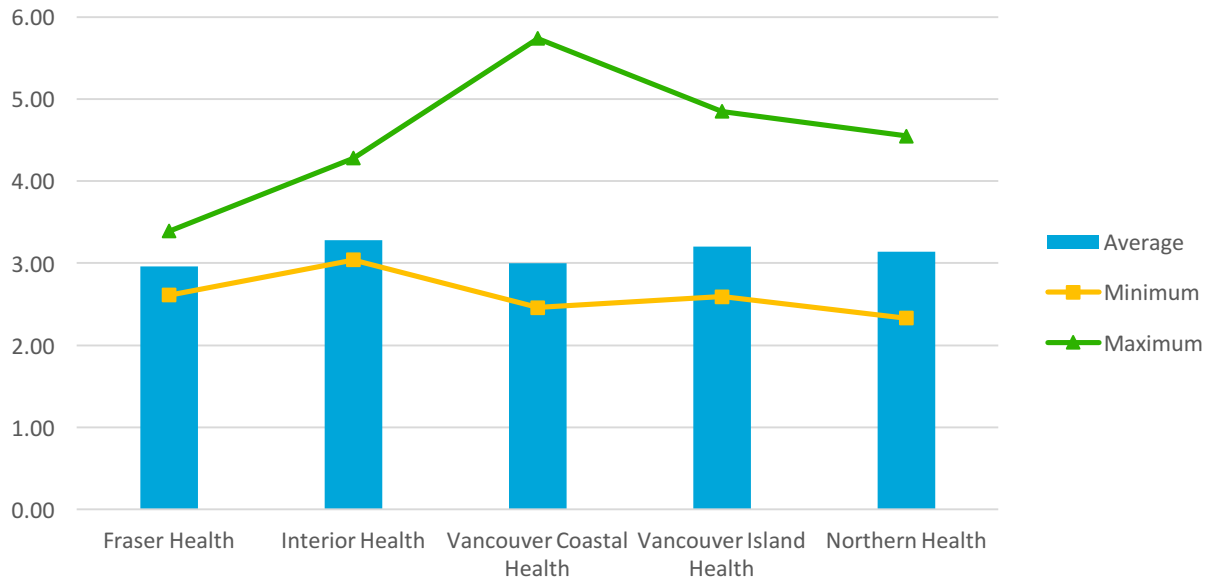
APPENDIX D: VARIATION OF DIRECT CARE HOURS (DCH) AMONG HEALTH AUTHORITIES

Average Direct Care Hours by Ownership Type in BC Health Authorities



Source: Adapted from the OSA, *British Columbia Residential Care Facilities Quick Facts Directory*, January 2016.

Range and Average of Direct Care Hours by BC Health Authorities



Source: Adapted from the OSA, *British Columbia Residential Care Facilities Quick Facts Directory*, January 2016.

APPENDIX E: DIRECT CARE HOURS (DCH) REQUIREMENTS BY HEALTH AUTHORITY

DCH Requirements by Health Authorities		
Health Authority	**Breakdown**	
Fraser Health	Professional: Allied Professional: Non-Professional: ***Total***	20%* N/A 80% ***100%***
Vancouver Island Health	Professional Allied Professional Non-Professional ***Total***	20%* N/A 80% ***100%***
Interior Health	Direct Care: (Professional Nursing) (Non-Professional) Allied Professional Non-Professional ***Total***	89% (18%)* (71%) 7% 4% ***100%***
Vancouver Costal	Professional Allied Professional Non-Professional ***Total***	25%* N/A 75% ***100%***
Northern Health	No information	
*Minimum required		

DIFFERENCES IN DIRECT CARE HOURS (DCH) DEFINITIONS AMONG HEALTH AUTHORITIES					
Health Authority	DCH Target	Breakdown	Included in HA DCH Calculation: (Yes/No/Inconsistent/No information)		Designated as Professional/Non-Professional/Other
Fraser Health Authority	2.52 – 3.37 DCH (includes 24/7 RN coverage)	20% Professional 80% Non-Professional	DOC (Clinical Hours)	Inconsistent	Professional (where included)
			ADOC/ Clinical Coordinators	Inconsistent	Professional
			RN	Yes	Professional
			LPN	Yes	Professional
			Care Aide	Yes	Non-Professional
			Rehab Aide	Yes	Non-Professional
			Activity Aide	Yes	Non-Professional
			Dietician	Yes	Professional
			Occupational Therapist	Yes	Professional
			Physiotherapist	Yes	Professional
			Music Therapist	Yes	Inconsistent
			Chaplain	Yes	Non-Professional
			Social Worker	Yes	Professional
			Dental	Yes	Non-Professional
Vancouver Island Health Authority	3.08 to 3.24 DCH (includes 24/7 RN coverage)	20% Professional 80% Non-Professional	DOC (Clinical Hours)	No	N/A
			ADOC/ Clinical Coordinators	Inconsistent	Professional
			RN	Yes	Professional
			LPN	Yes	Professional
			Care Aide	Yes	Non-Professional
			Rehab Aide	Yes	Non-Professional
			Activity Aide	Yes	Non-Professional
			Dietician	Yes	Professional
			Occupational Therapist	Yes	Professional
			Physiotherapist	Yes	Professional
			Music Therapist	Yes	Inconsistent
			Chaplain	Yes	Non-Professional
			Social Worker	Yes	Professional
			Dental	Yes	Non-Professional
Interior Health Authority	3.15 (includes 24/7 RN coverage)	89% Direct Care* 4% Allied Professional 7% Allied Non-Professional	DOC (Clinical Hours)	Yes (60%)	Professional
			ADOC/ Clinical Coordinators	Inconsistent	Professional
			RN	Yes	Professional
			LPN	Yes	Professional
			Care Aide	Yes	Non-Professional

			Rehab Aide	Yes	Allied Non-Professional
			Activity Aide	Yes	Allied Non-Professional
			Dietician	Yes	Allied Professional
			Occupational Therapist	Yes	Allied Professional
			Physiotherapist	Yes	Allied Professional
			Music Therapist	Yes	Allied Professional
			Chaplain	No info.	No info.
			Social Worker	Yes	Allied Professional
			Dental	No info.	No info.
Vancouver Coastal Health	2.45 DCH (includes 24/7 RN coverage and Min 4.30 FTE for RN)	25% Professional 75% Non-Professional	DOC (Clinical Hours)	No	N/A
			ADOC/ Clinical Coordinators	No info.	N/A
			RN	Yes	Professional
			LPN	Yes	Professional
			Care Aide	Yes	Non-Professional
			Rehab Aide	Yes	Non-Professional
			Activity Aide	Yes	Non-Professional
			Dietician	Yes	Professional
			Occupational Therapist	Yes	Professional
			Physiotherapist	Yes	Professional
			Music Therapist	Yes	Non-Professional
			Chaplain	No info.	No info.
			Social Worker	No info.	No information
			Dental	Yes	Professional
Northern Health Authority	N/A	N/A	N/A	N/A	N/A

*including 18% Professional (i.e. RN/LPN) and 71% Non-Professional (i.e. care aides etc.)
Inconsistent = BCCPA received contradictory information across care sites
No info. = BCCPA was not able to obtain any information on this role.

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