BC Care Providers ASSOCIATION

Celebrating 40 Years | 1977 – 2017

# BCCPA Report

## Doubling Hospice & End-Of-Life Bed Capacity In British Columbia By 2020

December 2016

# BCCPA Report: Doubling Hospice & End-Of-Life Bed Capacity in British Columbia by 2020

## OVERVIEW

Although the BC Government has made some progress in end-of-life care such as the release of its 2013 Provincial End-of-Life Care Action Plan, as well as committing to double number of hospice beds by 2020, more action and discussion is required.[1] In particular, this paper is the BCCPA's response on how to meet the BC government's commitment.

As Canada's population ages, the number of Canadians dying each year will increase to 330,000 by 2026.[2] The Canadian Hospice Palliative Care Association (CHPCA) estimates that each of these deaths will affect the well-being of an average of five other people, including families and loved ones, or in excess of 1.6 million Canadians.[3] In British Columbia alone, over 30,000 people die annually, 53% of whom die in hospital.[4,5]

More recently, Health Quality Ontario's End-of-Life Health Care 2014 report,[6] shows that we need to better address issues around palliative care. The report, for example, highlights that just 30 per cent of people with chronic illnesses have access to team-based palliative care – most being people with cancer.[7]

Currently much of the care provided within residential care homes could be considered end-of-life. For example, the average length of stay (ALOS) in a BC care home is approximately 24 months.[8] If a senior living in such a home does not die there, they may instead spend some of their remaining days in an alternative care setting such as a hospital or hospice.

While this paper does not advocate one care setting over the other, allowing British Columbians to die in their preferred setting is the best approach, whether this is at home, residential care or a hospice. While research indicates that most Canadians would prefer to die at home,[9] this paper focuses on end-of-life care for those older adults living in the community for whom hospice-palliative care is more appropriate and desirable than death at home.

To allow older adults to live their remaining days in a residential care home may, however, require expanding existing capacity, as the majority of EOL beds in BC are in stand-alone hospice centers or as

[1] BC government. March 2013. Provincial End-of-Life Care Action Plan for British Columbia. http://www.health.gov.bc.ca/library/publications/year/2013/end-of-life-care-action-plan.pdf
[2] Quality End-of-Life Coalition of Canada. Blueprint for action 2010 to 2020. 2010, p. 2
[3] Quality End-of-Life Coalition of Canada. Blueprint for action 2010 to 2020. 2010, p. 19
[4] Statistics Canada. *Table 102-0503 - Deaths, by age and sex, Canada, provinces and territories, annual (2012),* CANSIM (database). (accessed: January 5, 2016)
[5] Canadian Institute for Health Information, *Health Care Uses at the End of Life in British Columbia*. (Ottawa: CIHI, 2008). https://secure.cihi.ca/free_products/EOL_Report_BC.pdf
[6] *End-of-Life Health Care in Ontario*. Health Quality Ontario. December 2014. Accessed at: http://www.hqontario.ca/Portals/0/Documents/eds/synthesis-report-eol-1412-en.pdf
[7] Local Health Integration Networks, Quality Hospice Palliative Care Coalition of Ontario. Advancing high quality, high value palliative care in Ontario: a declaration of partnership and commitment to action. Accessed at: http://health.gov.on.ca/en/public/programs/ltc/docs/palliative%20care_report.pdf
[8] BC Ombudsperson, 2012, Volume 2:230. Accessed at: http://www.policyalternatives.ca/sites/default/files/uploads/publications/BC%20Office/2012/07/CCPABC-Caring-BC-Aging-Pop.pdf
[9] Donna M. Wilson, Joachim Cohen, Luc Deliens, Jessica A. Hewitt, and Dirk Houttekier. Journal of Palliative Medicine. May 2013, 16(5): 502-508. doi:10.1089/jpm.2012.0262.

part of a hospital setting. It will also require additional resources to ensure that the EOL care is high-quality and person-centred. Such resources may include additional funding, increased access to medications and equipment, as well as enhanced palliative care training for care providers.

The BC Care Providers Association (BCCPA) believes that given the existing under-used capacity within the continuing care sector, that some of these under-used beds could be transitioned into end-of-life (EOL) beds, provided appropriate support is available. As such, the BCCPA makes the following recommendations for further consideration.

| RECOMMENDATIONS |
| --- |
| 1. That the Ministry of Health and Health Authorities work with the BC Care Providers Association (BCCPA) and other stakeholders to develop strategies to better utilize the existing excess capacity in the continuing care sector to increase capacity with respect to end-of-life (EOL) care. |
| 2. That the Ministry of Health and Health Authorities, where feasible, use existing capacity in residential care homes by using a portion of under-used residential care beds and transitioning them to end-of-life (EOL) beds. In particular, to meet the provincial government's commitment to double the number of such beds by 2020, between 100 and 150 new EOL beds should be established within residential care homes by 2020 with the remaining added to existing hospices/hospitals. |
| 3. To facilitate the transition of under-used residential care beds to EOL beds, as well as to support the provision of high-quality, person-centred hospice-palliative care in such settings, the BC Ministry of Health and Health Authorities support the re-direction of some acute care funding to continuing care for these purposes. |
| 4. That the BC government support the adoption of new palliative / EOL care models including, where necessary, providing funding to improve the integration between continuing and end-of-life care. |

## DEFINITIONS

| TERM | DEFINITION |
|---|---|
| Hospice Palliative Care | "Hospice palliative care" is a philosophy of care that stresses the relief of suffering and improvement of the quality of living and dying. It helps patients and families to:<br>• address physical, psychological, social, spiritual and practical issues and their associated expectations, needs, hopes and fears;<br>• prepare for and manage self-determined life closure and the dying process; and<br>• cope with loss and grief during illness and bereavement.<br><br>Note: while "Palliative care" is generally associated with hospitals and other large institutions, and "hospice care" is generally associated with community programs that have usually been developed as separate, voluntary organizations, the term "hospice-palliative care" is intended to encompass both sets of principles and objectives. |
| End-of-Life Care | "End-of-life care" is the term used for the range of clinical and support services appropriate for dying people and their families. The goal of end-of-life care is the same regardless of the setting – to ensure the best possible quality of life for dying people and their families.<br><br>End-of-life care is associated with advanced, life-limiting illnesses, and focuses on comfort, quality of life, respect for personal health care treatment decisions, support for the family, psychological and spiritual concerns. |
| Hospice | The physical building in which individuals receiving hospice-palliative care and/or end-of-life care spend their last days. |

## THE NEED FOR HOSPICE-PALLIATIVE CARE & END-OF-LIFE CARE IN CANADA

According to the Canadian Institute for Health Information (CIHI), only 16 to 30 per cent of Canadians who die currently have access or receive hospice-palliative care and end-of-life care services, and access varies considerably depending on where people live.[10] Even fewer family members receive grief and bereavement services.[11] In addition, despite the fact that the majority of British Columbians express a

[10] Canadian Institute for Health Information, *Health Care Use at the End of Life in Western Canada* (Ottawa: CIHI, 2007).
[11] Canadian Hospice Palliative Care Association, Fact Sheet: Hospice Palliative Care in Canada, May 2006. http://www.chpca.net/media/466867/Fact_Sheet_HPC_in_Canada%20Fall%202015%20Final.pdf

wish to die at home or in a home-like setting, over half will die in a hospital as outlined in the following table below.[12]

Table 1: Dying in British Columbia (2004-2008)

| Age (years) | Home (%) | Hospital (%) | Long-term Care (%) | Other (%) |
|---|---|---|---|---|
| All | 16.5 | 51.0 | 29.0 | 3.5 |
| 70-79 | 17.7 | 58.4 | 22.3 | 1.6 |
| 80-89 | 11.8 | 51.8 | 35.8 | 0.8 |
| ≥90 | 7.4 | 39.6 | 52.6 | 0.3 |
| Dementia Diagnosis | 2.6 | 22.0 | 75.2 | 0.1 |

Source: Jayaraman and Joseph BMC Palliative Care 2013, 12:19

As outlined above most Canadians die in an acute care setting, despite strong and growing evidence that access to a hospice-palliative approach to care, combined with treatment, leads to better outcomes for persons and their family caregivers, including: palliation of symptoms; quality of life and patient/resident/client satisfaction; less burden on caregivers; more appropriate referral to and use of hospice; and less use of intensive care.

This lack of access to high-quality, person-centred palliative care is problematic because the number of Canadians for whom palliative care services could be beneficial is expected to increase, due to factors such as the aging population, increasing number of people living with chronic, life-limiting illness and co-morbidities. And while the cost of dying in Canada ranges from as low as $10,000 for a sudden death to between $30,000 and $40,000 for someone with a terminal disease such as cancer or chronic obstructive pulmonary disease,[13] it is estimated that, compared to usual acute care, hospice-palliative care may save the health care system approximately $7,000 to $8,000 per patient.[14] Specifically, hospice-based palliative care reduces the cost of end-of-life care by 50% or more, primarily by reducing the number of intensive care unit admissions, diagnostic testing, interventional procedures and overall hospital length of stay.[15]

## Medical Assistance in Dying (MAiD)

One additional issue this paper does not discuss in detail is Medical Assistance in Dying (MAiD), which is defined as the administering, prescribing or providing of a substance by medical practitioner or nurse practitioner, at the request of the patient, that causes death. Following a Supreme Court of Canada ruling on February 6, 2015 which overturned the previous criminal laws prohibiting assistance in dying, the Federal Liberal Government enacted new Legislation on June 17, 2016, creating a criminal code exemption for medical practitioners or nurse practitioners providing medical assistance in dying to eligible patients, as well as to the pharmacists prescribing medications, and for anyone assisting a medical

[12] Jayaraman and Joseph BMC Palliative Care 2013, 12:19.
[13] Fassbender K, Fainsinger R, Carson M, et al. *Cost trajectories at end of life: the Canadian experience.* Journal of Pain and Symptom Management, 2009; 38(1):75-80.
[14] The Way Forward. Cost Effectiveness of Palliative Care: A Review of the Literature (December 2012). http://www.hpcintegration.ca/resources/discussion-papers/economic-review.aspx
[15] Ibid.

practitioner to provide this service. Under the new legislation, eligibility for a medically assisted death is limited to those Canadians who are consenting adults in an advanced stage of irreversible decline" from a serious and "incurable" disease, illness or disability and for whom natural death is "reasonably foreseeable." MAiD in Canada has not been extended to mature minors, or those individuals living with conditions that cause suffering, but are not terminal. Nor does it allow people diagnosed with competence-impairing conditions like dementia to make advance requests for medical help to die.

If the Canadian experience of MAiD is similar to that of Oregon, where MAiD has been legal since 1997, only a very few British Columbians will seek and follow through with a medically assisted death. Since Oregon's Death with Dignity Act (DWDA) was enacted in 1997, physicians have written a total of 1,545 prescriptions for lethal doses of medication, and 991 people died as a result of taking the medications.[16] Given that this represents only 0.4% of deaths in any given year and that 92% of those that died from ingesting DWDA were enrolled in hospice-palliative care programs, the availability of MAiD in Canada should not invalidate the need for high-quality hospice-palliative care, including End-of-Life Care.

## EXISTING UNDER-USED RESIDENTIAL CARE CAPACITY

In 2014, the BC Care Providers Association (BCCPA) surveyed its care provider members in the Fraser Health Authority (FHA) to better understand the extent of under-used residential care beds. In follow-up to the 2014 survey, in July of 2015 the BCCPA launched a second Vacant Beds Survey to gain a better understanding of the existing capacity of residential care beds and assisted living units among its membership province-wide. In particular, the survey requested information in the following areas:

- Existing and vacant residential care beds (Permanent, Temporary and Private);
- Existing and vacant assisted living (AL) units (Publicly Subsidized and Registered, Private and Registered as well as, Private and Unregistered) and;
- Existing and vacant specialty beds (Convalescent, End-of-Life and Respite).

The survey received a 30% response rate with over 50 members responding between July 28 and August 21, 2015. Table 2 below provides a summary of the findings outlined from each health authority.

The survey highlights that there is some existing capacity that can be better utilized within care homes and assisted living residences across BC. More specifically, vacant residential care beds and assisted living suites were the highest in the Fraser Health Authority, which had 316 empty beds and 186 empty units, respectively.

[16] Oregon Death with Dignity Act: 2015 Data Summary. Oregon Public Health Division, February 4, 2016. https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf

TABLE 2: RESULTS FROM THE BCCPA'S 2015 VACANT BEDS SURVEY

| HEALTH AUTHORITY | VACANT RESIDENTIAL CARE BEDS (% VACANT) | VACANT ASSISTED LIVING UNITS (% VACANT) |
|---|---|---|
| Interior Health | 57 (3.7%) | 68 (12.2%) |
| Fraser Health | 316 (10.3%) | 186 (21.7%) |
| Vancouver Coastal | 8 (0.6%) | 12 (7.7%) |
| Island Health | 28 (1.7%) | 47 (10.9%) |
| **Total** | **409 (5.4%)** | **313 (15.6%)** |

Note: there were no respondents for the Northern Health Authority

Furthermore, in April 2016, the BCCPA launched a new public registry of vacant and unsubsidized residential care beds and assisted living suites across BC, called MyCareFinder.ca. The registry, which is presented in the format of a filterable Google Map, reports that as of May 2016, there are 110 vacant residential care beds across the province. It should be noted, however, that this figure represents only 25 reporting BCCPA members, and thus the real figure across the province is likely much higher.

The BCCPA's 2015 policy paper entitled *Quality-Innovation-Collaboration: Strengthening Seniors Care Delivery in BC,*[17] used this data to demonstrate that this existing excess capacity could potentially be used to reduce BC's Alternate Level of Care (ALC) days significantly, resulting in significant cost savings for the health care sector, as well as more appropriate care for British Columbians. The paper included recommending the creation of a public registry to report on ALC and vacant residential care beds, as well as use of under-used beds within residential care, assisted living units and home support services to reduce acute care pressures, and to reduce the use of expensive acute care resources.

## OPTIONS FOR MEETING THE COMMITMENT TO DOUBLE HOSPICE & END-OF-LIFE BEDS BY 2020

While the *Quality Innovation and Collaboration* paper and more recently the BCCPA White Papers on Sustainability and Innovation in BC's continuing care sector (May 2016)[18] advocates using the existing under-used capacity of the residential care sector to reduce ALC days in BC's acute care sector, this capacity could also be leveraged to help the provincial government meet its 2020 commitment to double the number of hospice beds in BC.

As outlined in in the 2015 Facilities report, the overall number of community end-of-life (EOL) beds in British Columbia is just over 250, distributed across 35 care homes (see Table 3). Half (17) of the care homes are stand-alone hospices or hospitals with no other residential care beds, while the other remaining 18 have other types of residential care (RC) beds. In addition to the more than 260 end-of-life

[17] BCCPA. *Quality-Innovation-Collaboration: Strengthening Seniors Care Delivery in BC*. September 2015. Accessed at: http://www.bccare.ca/wp-content/uploads/BCCPA-White-Paper-QuIC-FINAL-2015.pdf

[18] BCCPA. BCCPA Publishes Two Major White Papers (Sustainability and Innovation in BC's Continuing Care Sector). May 16, 2016. Accessed at: http://www.bccare.ca/whitepapers2016/

care beds in community settings, there are over 100 palliative care beds in acute care settings in BC as well (see Table 4).

TABLE 3: OVERVIEW OF COMMUNITY END-OF-LIFE BEDS IN BRITISH COLUMBIA

| CARE SITE | 2015 | | 2016 | |
|---|---|---|---|---|
| | END OF LIFE BEDS | RC BEDS (EXCLUDING EOL) | END OF LIFE BEDS | RC BEDS (EXCLUDING EOL) |
| Central Okanagan Hospice Centre (IHA) | 24 | 0 | 24 | 0 |
| Moog and Friends Hospice House (IHA) | 12 | 0 | 12 | 0 |
| Vernon and District Hospice Centre (IHA) | 12 | 0 | 12 | 0 |
| Fischer Place/ Millsite Lodge (IHA) | 0 | 65 | 1 | 78 |
| Marjorie Willoughby Memorial Hospice (IHA) | 12 | 0 | 12 | 0 |
| Mt Cartier Court (IHA) | 1 | 43 | 1 | 43 |
| Cascade Lodge (FHA) | 10 | 96 | 10 | 94 |
| Fraser Canyon Hospital (FHA) | 2 | 0 | 2 | 0 |
| Mission Memorial Hospital (FHA) | 10 | 0 | 10 | 0 |
| St. Michael's Centre (FHA) | 16 | 128 | 16 | 128 |
| McKenny Creek Hospice (FHA) | 10 | 0 | 10 | 0 |
| Cross Roads Inlet Hospice (FHA) | 10 | 0 | 10 | 0 |
| Irene Thomas Hospice Centre (FHA) | 10 | 0 | 10 | 0 |
| Langley Health Services Hospice (FHA) | 10 | 0 | 10 | 0 |
| Laurel Place (FHA) | 20 | 170 | 20 | 170 |
| Peace Arch (FHA) | 7 | 234 | 7 | 234 |
| North Shore Hospice (VCH) | 10 | 0 | 10 | 0 |
| Sechelt Intermed. Care Soc. – Shorncliffe (VCH) | 2 | 57 | 2 | 57 |
| Rotary Hospice House (VCH) | 8 | 0 | 8 | 0 |
| May's Place (VCH) | 6 | 0 | 6 | 0 |
| St. James Cottage Hospice (VCH) | 10 | 0 | 10 | 0 |
| St. John's Hospice (VCH) | 12 | 0 | 12 | 0 |
| Chemanius Health Centre (Island Health) | 1 | 74 | 1 | 74 |
| Lodge on 4$^{th}$ (Island Health) | 2 | 87 | 2 | 87 |
| Trillium Lodge | 0 | 89 | 5 | 85 |
| Eagle Park Health Care Facility (Island Health) | 1 | 74 | 0 | 75 |
| Victoria Hospice (Island Health) | 10 | 0 | 4 | 117 |
| Rotary Manor (NHA) | 1 | 114 | 10 | 0 |
| Peace Villa (NHA) | 1 | 123 | 2 | 113 |

| | | | | |
|---|---|---|---|---|
| Prince George Hospice Society (NHA) | 10 | 0 | 2 | 122 |
| Dunrovin Park Lodge (NHA) | 2 | 115 | 10 | 0 |
| Acropolis Manor (NHA) | 0 | 61 | 2 | 59 |
| Bulkley Lodge (NHA) | 1 | 69 | 1 | 69 |
| Terrace View Lodge (NHA) | 2 | 93 | 3 | 92 |
| **Total Beds** | **245** | **1477** | **260** | **1871** |

Source: Ministry of Health 2015 Facilities Report (as of March 31, 2015); Ministry of Health 2016 Facilities Report (as of March 31, 2016).
Note: Data does not include beds that the Health Authorities fund through independent hospice providers.

Table 4: End-of-Life and Palliative Care Beds in British Columbia, 2016/17

| Health Authority Region | Community | Acute Care | Total |
|---|---|---|---|
| IHA | 62 | 0 | 62 |
| FHA | 105 | 30 | 135 |
| VCH | 50 | 43 | 93 |
| VIHA | 22 | 34 | 56 |
| NHA | 23 | 0 | 23 |
| **Total** | **262** | **107** | **369** |

Source: Home and Community Care Facilities Report, August 25 2016, FOI request HLTH-2016-63300. Accessed at: http://www2.gov.bc.ca/enSearch/detail?id=7AFDBC16F15F42E289E9F7DDB0F80C40&recorduid=HTH-2016-63300
Note: Data does not include beds that the Health Authorities fund through independent hospice providers. With these numbers the total is approximately 386 as of December 2016.

The BCCPA believes that there are essentially five ways that the Ministry of Health and the Health Authorities could meet their commitment to double the number of beds in the province by 2020.

- Option 1 – Build New Hospice Beds in stand-alone hospice buildings;
- Option 2 – Add new EOL care beds in acute care / hospitals;
- Option 3 – Add new EOL care beds in residential care homes already offering EOL care;
- Option 4 – Add new EOL care beds to residential care homes not offering EOL care; and
- Option 5 – Add new EOL care beds to every residential care home in BC by converting some residential care beds to EOL beds.

The advantages and disadvantages of these options are presented below.

## Option 1: Build New Hospice Beds in stand-alone hospice buildings

The first option is to add additional beds by building new stand-alone hospices. While this option may be appropriate in specific contexts (such as in the case of specific cultural needs or in rural settings), it is also the mostly costly option, as it will require a significant capital cost investment in order to develop the

required physical infrastructure. In particular, according to a 2015 from Ontario the annual cost of a 10-bed residential hospice is approximately $1,600,000, or approximately $438 per bed per day.[19]

| PROS: | CONS: |
|---|---|
| ▪ May be most appropriate in specific cultural contexts where dying in a hospital or at a residential care home is not preferred, such as for younger adults.<br>▪ May be most appropriate for rural settings where individuals do not currently have access to existing residential care homes, hospices or hospitals. | ▪ Most expensive option per bed, due to the high fixed capital costs of constructing a new building, with appropriate. amenities (i.e. kitchen, laundry, etc.).<br>▪ May not be appropriate for cultural groups who prefer to die in hospital or residential care. |

Option 2: Add new EOL care beds in acute care/ hospitals

Conceivably, new end-of-life care beds could be added to existing acute care or hospital settings, such as the 17 listed above in Table 3. Compared to option 1, this may be an appropriate approach as it takes advantage of economies of scale, and may not require capital investments on the same scale as building new hospice buildings. However, it may not address the need for EOL in some rural or remote settings which currently lack a local hospital.

| PROS: | CONS: |
|---|---|
| ▪ May be most appropriate for specific cultures where dying at home or in a residential care home is not preferred.<br>▪ May be the most appropriate option for those adults who would otherwise die in acute care setting.<br>▪ Requires fewer capital costs than building new hospice beds in stand-alone facilities. | ▪ May only be appropriate for communities where a local hospital already exists, and therefore, may not be appropriate for some rural and remote communities. |

Option 3: Add new EOL beds in residential care homes already offering EOL care

The third option is to transition existing, under-used residential care beds to end-of-life beds, specifically in residential care homes that already operate end-of-life beds (such as the 14 residential care homes listed above in Table 3). While this would still require some additional resources to provide enhanced end-of-life care, improved access to appropriate medications and equipment, as well as additional training and education for staff, this is a less costly option as the physical infrastructure is already in place. Furthermore, this option takes advantage of the existing palliative-care expertise of staff, and may even enable the creation of dedicated palliative teams within the care home.

This option may not be appropriate in all settings, particularly rural and remote areas without existing residential care homes, or in the case of cultural preferences to die in other care settings.

[19] Environmental Scan for Strengthening Residential Hospice Care in Ontario. Report of the Residential Hospice Working Group. March 2015. Accessed at: https://www.oma.org/Resources/Documents/EnvironmentalScanforStrengtheningResidentialHospiceCareinOntario.pdf

| PROS: | CONS: |
|---|---|
| ▪ Low cost option due to the existence of the necessary physical infrastructure.<br>▪ May be able to take advantage of an existing palliative care expertise of staff.<br>▪ May be the most appropriate setting for older adults. | ▪ May not be appropriate for rural or remote settings where residential care homes are not offering EOL care.<br>▪ May not meet the preferences of all cultural groups. |

Option 4: Add new EOL care beds to residential care homes not offering EOL care

The fourth option is to expand the number of residential care homes offering end-of-life services, particularly by transitioning under-used residential care beds to EOL beds in care homes not currently offering EOL care. Similar to the previous option outlined (option 3), this is a less costly approach due to pre-existing physical infrastructure. This option would further utilize existing residential care capacity more efficiently by eliminating under-used beds. In particular, it may be effective to transition residential care beds in semi-private or multi-person rooms to EOL beds, as these larger units could accommodate the additional furniture and equipment necessary for high-quality, EOL care.

However, adding a few EOL beds to each residential care home may not create the density necessary to support dedicated palliative care teams within each home, and therefore may be less efficient than the previous option.

| PROS: | CONS: |
|---|---|
| ▪ Lowest cost option as the physical infrastructure is already in place.<br>▪ Better utilizes existing residential care capacity.<br>▪ May bring EOL care to new communities.<br>▪ May be the most appropriate setting for older adults. | ▪ May not be appropriate for rural settings where residential care homes do not already exist.<br>▪ May not meet the cultural preferences of all groups.<br>▪ May not create the density required to support a dedicated palliative care team within the care home. |

Option 5: Add new EOL care beds to all residential care homes in BC

The final and perhaps most comprehensive option is to increase the number of EOL care beds by converting a small number of complex care beds in all residential care homes across the province to EOL beds along with providing appropriate resources and support. The benefit of this option is that it would significantly increase the capacity of British Columbia to provide EOL care, including assisting the BC government to reach its commitment to double the number of hospice beds by 2020. This option would also bring EOL care to communities that previously did not have access to these services or to individuals who would have had to travel long distances to obtain access. This would also be a lower cost option than building new dedicated hospice facilities, as the physical infrastructure is already in place.

One drawback of this option is it could reduce the current stock of complex care beds across the province, especially in health authorities that do not have an existing stock of under-used private pay beds. Furthermore, by converting only a small number of residential care beds in each home, this may not create the density required for economies of scale or to establish dedicated palliative care teams within each home. Finally, as outlined earlier, establishing EOL care beds within residential care homes may not meet the preferences of all cultural groups, and would not be able to meet the need for EOL care in communities that do not have a pre-existing residential care home.

| PROS: | CONS: |
|---|---|
| ▪ Significantly increase the capacity of EOL across British Columbia<br>▪ Would bring EOL care to new communities<br>▪ Lower cost option than building new dedicated hospice facilities, as the physical infrastructure is already in place.<br>▪ May be the most appropriate setting for older adults. | ▪ Would reduce the stock of complex care beds across the province.<br>▪ May be difficult to implement or unsustainable, especially among smaller care homes that do not have the density to create dedicated palliative care teams within the home.<br>▪ May not meeting the preferences of all cultural groups.<br>▪ Cannot address the need for EOL care in communities that do not have a pre-existing residential care home. |

## EXPANDING THE ROLE OF RESIDENTIAL CARE IN END-OF-LIFE

As outlined in options 3, 4 and 5 above, the BCCPA believes that there is an opportunity for residential care homes to expand their role and provide care to those in palliative or end-of-life care. In particular, this could include adding new EOL care beds in residential care homes that may or may not have existing EOL beds. Overall, the benefits of such approaches will not only reduce costs but better use the existing under-used capacity in the residential care sector.

### New Palliative / EOL Care Models

Along with providing palliative-hospice care, for example, residential care homes could also work together to provide models of excellence in palliative care or end-of-life. Such homes, for example, could provide specific services as outlined in the Specialized Stream Model highlighted in a 2012 paper by the Ontario Long Term Care Association (OLTCA).[20]

In particular, as outlined in the OLTCA paper, a Specialized Stream Model could provide higher levels of care and for special needs populations including persons with late stage dementia, severe mental illness and addictions as well as those at end of life. Such centers along with leading care in areas such as dementia, mental illness and end-of-life could also lead the development of research and innovation

[20] Report of the Residential Hospice Working Group. Environmental Scan for Strengthening Residential Hospice Care in Ontario: Evidence and Practice. March 2015. Accessed at https://www.oma.org/Resources/Documents/EnvironmentalScanforStrengtheningResidentialHospiceCareinOntario.pdf

within the continuing care sector. The BCCPA discusses a similar type of model as part of its Continuing Care Hub approach in its *Quality-Innovation-Collaboration* paper.

As outlined in the BCCPA White Papers on Sustainability and Innovation in BC's continuing care sector (May 2016), there are also a number of excellent palliative care models that also merit further consideration in the BC context. A report prepared by the Canadian Hospice Palliative Care Association (CHPCA), for example, highlights eleven such models, including the Fraser health end-of-life care program in British Columbia.[21]

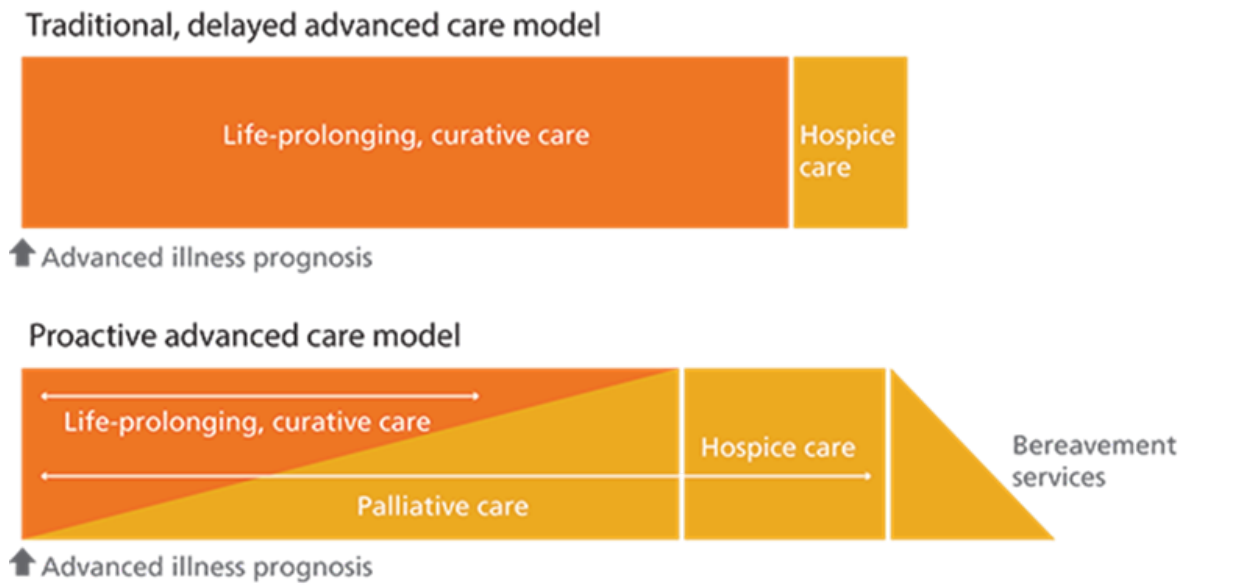
Each of the 11 models has taken different approaches to providing an integrated palliative approach to care in their communities, yet all share common elements that make them successful and transferrable to other locations, including across BC or Canada. In the report, the success factors for the models (see below) are organized into four key components that contribute to an effective, sustainable program: vision, people, delivery of care and supportive tools.

| PALLIATIVE CARE MODELS: SUCCESS FACTORS | |
|---|---|
| 1. Commitment to person-centred care<br>2. Focus on building capacity in the community<br>3. Focus on changing organizational culture<br>4. Senior management support<br>5. Dedicated coordinators<br>6. Inter-professional teams<br>7. Strong role and more support for family physicians<br>8. Support for providers in continuing care homes<br>9. Key roles for nurses<br>10. Relationships, partnerships and networks | 11. Integration of primary-secondary-tertiary care<br>12. Cultural sensitivity<br>13. Single access point and case management<br>14. 24/7 community support and care<br>15. Advance care planning<br>16. Common frameworks, standards and assessment tools<br>17. Flexible approaches to education<br>18. Shared records Research, evaluation and quality improvement |

The following figure below also highlights the example of an integrated hospice palliative care model (i.e. pro-active advanced care model), which potentially incorporates many of the key success factors identified above.

[21] Canadian hospice Palliative Care Association, *Innovative Models of Integrated Hospice Palliative Care*, the Way Forward Initiative: an Integrated Palliative Approach to care, 2013. Accessed at: http://www.hpcintegration.ca/media/40546/TWF-innovative-models-report-Eng-webfinal-2.pdf

Figure 1: Integrated Hospice Palliative Care Model (pro-active advanced care model)




Source: Optum. Integrated and informed care. Accessed at: http://campaign.optum.com/hospice/clinical-professionals/integrated-informed-care.html

## Standards and Regulations

The development of new care models as well as the expansion of EOL beds within residential care may also require the development of new standards and/or regulations. One such approach, for example, that has been taken in this regard is the Gold Standards Framework in the United Kingdom (see Appendix A).

## CONCLUSION

With the aging population, by 2026 the number of Canadians dying each year will increase by 40 percent to 330,000 people. Each of these deaths will affect the well-being of an average of five other people, including families and loved ones or in excess of 1.6 million.[22] Although the BC Government has made some progress in end-of-life care such as the release of its 2013 Provincial End-of-Life Care Action Plan[23] and committing to double number of hospice beds by 2020, more action and discussion is required.

Currently much of the care provided within residential care homes could be considered end of life. For example, the average length of stay (ALOS) in a BC care home is approximately 24 months.[24] If a senior living in such a home does not die there, they may instead spend some of their remaining days in an alternative care setting such as a hospital or hospice.

While this paper does not advocate one care setting over the other, allowing British Columbians to die in their preferred setting is the best approach, whether this is at home, residential care or a hospice. And while research indicates that most Canadians would prefer to die at home,[25] this paper focuses on end-of-life care for those older adults living in the community for whom hospice-palliative care is more appropriate and desirable than death at home. In particular, this paper explores how the current stock of under-used residential care beds in the province may be better utilized to allow British Columbians greater choice with respect to where they spend their final days.

To allow older adults to live their remaining days in a residential care home may, however, require expanding existing capacity, as the majority of EOL beds in BC are in stand-alone hospice centers or as part of a hospital setting. It will also require additional resources to ensure that the end-of-life care provided in such settings is high-quality and focuses on person-centred hospice-palliative care. This may include additional funding, increased access to medications and equipment, as well as enhanced palliative care training for care providers.

The BC Care Providers Association (BCCPA) believes that given the existing under-used capacity within residential care homes that some of these under-used beds could be transitioned into end-of-life (EOL) beds provided appropriate support is available. As such, as outlined earlier in this paper, the BCCPA makes the following recommendations for further consideration.

[22] Quality End-of-Life Coalition of Canada. Blueprint for action 2010 to 2020. 2010, p. 19
[23] In March 2013, the BC government announced its *Provincial End-of-Life Care Action Plan for British Columbia* to improve access to end-of-life care so people can remain at home and in their community longer. This included funding to establish a center for excellence.
[24] BC Ombudsperson, 2012, Volume 2:230. Accessed at:
http://www.policyalternatives.ca/sites/default/files/uploads/publications/BC%20Office/2012/07/CCPABC-Caring-BC-Aging-Pop.pdf
[25] This study of Albertans found that 70.8% preferred to be at home near death; while 14.7% preferred a hospice/palliative care facility, 7.0% a hospital, and 1.7% a nursing home; 5.7% had no stated preference. Source: Donna M. Wilson, Joachim Cohen, Luc Deliens, Jessica A. Hewitt, and Dirk Houttekier. Journal of Palliative Medicine. May 2013, 16(5): 502-508. doi:10.1089/jpm.2012.0262.

| RECOMMENDATIONS |
| --- |
| 1. That the Ministry of Health and Health Authorities work with the BC Care Providers Association (BCCPA) and other stakeholders to develop strategies to better utilize the existing excess capacity in the continuing care sector to increase capacity with respect to end-of-life (EOL) care. |
| 2. That the Ministry of Health and Health Authorities, where feasible, use existing capacity in residential care homes by using a portion of under-used residential care beds and transitioning them to end-of-life (EOL) beds. In particular, to meet the provincial government's commitment to double the number of such beds by 2020, between 100 and 150 new EOL beds should be established within residential care homes by 2020 with the remaining added to existing hospices/hospitals. |
| 3. To facilitate the transition of under-used residential care beds to EOL beds, as well as to support the provision of high-quality, person-centred hospice-palliative care in such settings, the BC Ministry of Health and Health Authorities support the re-direction of some acute care funding to continuing care for these purposes. |
| 4. The BC government support the adoption of new palliative / EOL care models including, where necessary, providing funding to improve the integration between continuing and end-of-life care. |

## REFERENCES

BC government. March 2013. Provincial End-of-Life Care Action Plan for British Columbia. Accessed at: http://www.health.gov.bc.ca/library/publications/year/2013/end-of-life-care-action-plan.pdf

BCCPA 2015 Budget Submission. Accessed at: http://www.bccare.ca/file/BCCPA-Budget-Submission-2015-Final.pdf

BCCPA. BCCPA Publishes Two Major White Papers (Sustainability and Innovation in BC's Continuing Care Sector). May 16, 2016. Accessed at: http://www.bccare.ca/whitepapers2016/

BCCPA. Quality-Innovation-Collaboration: Strengthening Seniors Care Delivery in BC. September 2015. Accessed at: http://www.bccare.ca/wp-content/uploads/BCCPA-White-Paper-QuIC-FINAL-2015.pdf

Bio Med Central. Determinants of place of death: a population-based retrospective cohort study. Jyothi Jayaraman and Joseph BMC Palliative Care 2013, 12:19.

Canadian Hospice Palliative Care Association, Fact Sheet: Hospice Palliative Care in Canada, May 2006. http://www.chpca.net/media/466867/Fact_Sheet_HPC_in_Canada%20Fall%202015%20Final.pdf

Canadian hospice Palliative Care Association, *Innovative Models of Integrated Hospice Palliative Care*, the Way Forward Initiative: an Integrated Palliative Approach to care, 2013. Accessed at: http://www.hpcintegration.ca/media/40546/TWF-innovative-models-report-Eng-webfinal-2.pdf

Canadian Institute for Health Information, Health Care Uses at the End of Life in British Columbia. (Ottawa: CIHI, 2008). https://secure.cihi.ca/free_products/EOL_Report_BC.pdf

Caring for BC's Aging Population Improving Health Care for All. Canadian Centre for Policy Alternatives (CCPA). Marcy Cohen. July 2012. BC Ombudsperson, 2012, Volume 2:239. Accessed at: http://www.policyalternatives.ca/sites/default/files/uploads/publications/BC%20Office/2012/07/CCPABC-Caring-BC-Aging-Pop.pdf

Donna M. Wilson, Joachim Cohen, Luc Deliens, Jessica A. Hewitt, and Dirk Houttekier. Journal of Palliative Medicine. May 2013, 16(5): 502-508. doi:10.1089/jpm.2012.0262.

End-of-Life Health Care in Ontario. Health Quality Ontario. December 2014. Accessed at: http://www.hqontario.ca/Portals/0/Documents/eds/synthesis-report-eol-1412-en.pdf

Environmental Scan for Strengthening Residential Hospice Care in Ontario. Report of the Residential Hospice Working Group. March 2015. Accessed at: https://www.oma.org/Resources/Documents/EnvironmentalScanforStrengtheningResidentialHospiceCareinOntario.pdf

Fassbender K, Fainsinger R, Carson M, et al. Cost trajectories at end of life: the Canadian experience. Journal of Pain and Symptom Management, 2009; 38(1):75-80.

Home and Community Care Facilities Report, August 25 2016, FOI request HLTH-2016-63300. Accessed at: http://www2.gov.bc.ca/enSearch/detail?id=7AFDBC16F15F42E289E9F7DDB0F80C40&recorduid=HTH-2016-63300

Island Health. Island Health End of Life Program – Priorities Update 2014. June 2014. Accessed at: http://www.viha.ca/NR/rdonlyres/C5CDC971-A3B6-4899-AF88-ECBB1A4601A5/0/ENDOFLIFEPROGRAM_01Aug14_WEB.pdf

Local Health Integration Networks, Quality Hospice Palliative Care Coalition of Ontario. Advancing high quality, high value palliative care in Ontario: a declaration of partnership and commitment to action. Accessed at: http://health.gov.on.ca/en/public/programs/ltc/docs/palliative%20care_report.pdf

National Post. Last month of life costs health care system $14K on average: report. April 7, 2015. Tom Blackwell. Accessed at: http://news.nationalpost.com/news/canada/last-month-of-life-costs-health-care-system-14k-on-average-report

Oregon Death with Dignity Act: 2015 Data Summary. Oregon Public Health Division, February 4, 2016. https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf

Quality End-of-Life Coalition of Canada. Blueprint for action 2010 to 2020. 2010, p. 2, p.19

Report of the Residential Hospice Working Group. Environmental Scan for Strengthening Residential Hospice Care in Ontario: Evidence and Practice. March 2015. Accessed at https://www.oma.org/Resources/Documents/EnvironmentalScanforStrengtheningResidentialHospiceCareinOntario.pdf

Seniors Care for A Change. BCCPA. Prepared by Izen Consulting. July 2014. Accessed at: http://www.bccare.ca/file/Seniors-Care-for-a-Change-FC.pdf

Statistics Canada. Table 102-0503 - Deaths, by age and sex, Canada, provinces and territories, annual (2012), CANSIM (database). (accessed: January 5, 2016)

The Best of Care: Getting It Right for Seniors in British Columbia (Part 2) at p. 216-17. Accessed at: https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2047%20The%20Best%20of%20Care-%20Volume%202.pdf

The Health Care Cost of Dying: A Population-Based Retrospective Cohort Study of the Last Year of Life in Ontario, Canada. PLOS One. March 26, 2015. DOI: 10.1371/journal.pone.0121759. Peter Tanuseputro et al. Accessed at: http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0121759

The Way Forward. Cost Effectiveness of Palliative Care: A Review of the Literature (December 2012). http://www.hpcintegration.ca/resources/discussion-papers/economic-review.aspx

Vancouver Coastal Health. March 18, 2016. VCH seeks to increase Vancouver hospice beds. Accessed at: http://www.vch.ca/about-us/news/news-releases/VCH-to-increase-Vancouver-hospice-beds

WHY NOT NOW? A Bold, Five-Year Strategy for Innovating Ontario's System of Care for Older Adults. LTC Innovation Expert Panel. March 2012. Accessed at: http://www.oltca.com/oltca/Documents/Reports/WhyNotNowFULL_March2012.pdf

## APPENDIX A: STANDARDS AND REGULATIONS

The development of new care models as well as the expansion of EOL beds within residential care may also require the development of new standards and/or regulations. One such approach, for example, that has been taken in this regard is the Gold Standards Framework in the United Kingdom. An overview of this framework is provided in the table below.

### TABLE 4: GOLD STANDARDS FRAMEWORK (UK)

OVERVIEW

- The Gold Standards Framework (GSF) in the United Kingdom (UK) is a national approach to provide end-of-life care that focuses on capacity building for frontline, primary care which results in strengthened organization and quality of palliative care.

- GSF focuses on enhanced quality care that improves health service provider skills and confidence in palliative care, leading to a better care experience for clients; improved communication, coordination and integration across settings of care; and improved outcomes for clients which allows them to live and die where they choose resulting in reduced hospitalizations and cost.

- GSF is based on the 7 Cs of care, regardless of care setting:

  C1 – Communication
  - Set up the register and meet regularly as a team
  - Ensure that the patients have the information they need e.g. in home packs
  - Ensure that the patient's wishes are taken into account e.g. re place of care

  C2 – Coordination
  - Appoint a coordinator and a lead GP and DN.

  C3 - Control of Symptoms
  - Pool knowledge and expertise to address physical, psychological, social and spiritual needs
  - Use symptom assessment tools

  C4 - Continuity of Care
  - Inform the out of hours service about the patients
  - Work together with the secondary care teams

  C5 - Continued Learning
  - Use audit (e.g. place of death) and significant event or after death analysis
  - Identify and address knowledge gaps
  - Develop practice protocols

  C6 - Carer Giver Support
  - Identify and address their emotional, practical, and financial needs

- Extend care into the bereavement phase

C7 - Care of the Dying Pathway

- Use a protocol for the last 48hrs of life
- Ensure that drugs are prescribed in anticipation of need

- More specifically it helps health care organization achieve standards of care that are aligned with quality outcomes for palliative care.

- The goal of GSF is to help organizations improve things such as: patients' pain and symptom management, the likelihood of dying in patients' place of choice, avoiding crisis and ED/hospitalization, improved health service provider support and coordination, and improved coordination and communication between providers.

- Implementation of GSF at the local level occurs through GSF Facilitators who are appointed by local care organizations to act as champions for adopting the approach to care. Facilitators are typically family physicians or specialist nurses.

- A national GSF team provides support to the local facilitators by offering workshops, an advice line, a newsletter and web based resources.

- GSF addresses all settings of care by focusing on integrating care across settings and building capacity of the health service providers; it offers training modules to providers through various formats including distance learning and virtual learning opportunities.

Source: Environmental Scan for Strengthening Residential Hospice Care in Ontario. Report of the Residential Hospice Working Group. March 2015. Accessed at: https://www.oma.org/Resources/Documents/EnvironmentalScanforStrengtheningResidentialHospiceCareinOntario.pdf