BC Care Providers
ASSOCIATION

Celebrating 40 Years | 1977 – 2017

Strengthening Seniors Care: Supporting Paper

#CareCanBeThere

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SUPPORTING DOCUMENT: BCCPA WHITE PAPERS CONSULTATION AND ANALYSIS

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MESSAGE FROM THE CHIEF EXECUTIVE OFFICER

"Making Sure the Care Will Be There"

With a provincial election on the horizon, British Columbians will soon be asked to decide who will lead the province for the next four years. There is no shortage of social and economic choices to command the public's attention, but there is one issue that is having a significant impact on many BC families.

Faced with the dual pressures of running their households while supporting aging parents, a so-called "Sandwich Generation" has emerged whose top priority is the availability of care for elderly family members today and into the future.

New and incumbent candidates running for office this spring are well-advised to acknowledge this societal shift.

We know that BC's seniors have worked their whole lives contributing to the social fabric of our community, and our economy. They – and the family members who support them – deserve to know that there is a plan in place, that is appropriately funded, to ensure our seniors will receive the right level of care, at the right time, and in the right place.

Beginning last May, the BC Care Providers Association (BCCPA) kicked off an important discussion on the future of seniors care. It started with the release of two major White Papers that outlined a number of new and innovative options to reform the way we deliver seniors care in BC. The first review of the White Papers took place soon after, at our annual conference's policy forum.

Then followed a wide-ranging consultation process, where we asked the public and key stakeholders to weigh in on the White Paper proposals – to tell us which of the concepts they most supported, and how they should be implemented. We were struck by the fact that over 750 British Columbians took the time to complete our online survey, with nearly 60% of those respondents identifying themselves as seniors.

Next, on September 20, 2016, BCCPA welcomed 140 participants representing organizations and groups from across the province for the inaugural *BC Continuing Care Collaborative* – a historic gathering at the SFU Morris J. Wosk Centre for Dialogue in Vancouver. Stakeholders in attendance represented care providers, as well as individual seniors and their family members, clinicians, non-government organizations, labour unions, the Ministry of Health, the BC Seniors Advocate, and all of the provincial health authorities.

The day-long event allowed participants the opportunity to voice their views on the proposals contained in the White Papers. The event was the culmination of our five-month consultation process.

Based upon the feedback provided by hundreds of respondents, it became clear that British Columbians see the provision of quality seniors care as an urgent priority.

To accomplish this goal, the BCCPA is releasing a new report titled "*Strengthening Seniors Care: A Made-in-BC Roadmap",* which includes 30 strategic recommendations that will help guide government decision-makers responsible for the delivery of seniors care.

BCCPA is calling on the BC government for an immediate annual investment of up to $337 million toward seniors care over the next five years.

This new funding investment will:

- ✓ **Invest in People**: by improving seniors' access to care workers by ensuring that each residential care home is able to provide a minimum of 3.36 direct care hours (DCH) for every senior each day, and increasing the minimum home care visits from 15 to 30 minutes; as well, by funding the development of a comprehensive province-wide health human resource strategy aimed at retaining and attracting the next generation of continuing care and home health workers;
- ✓ **Invest in Infrastructure**: by targeting up to $100M of existing federal/provincial infrastructure funding toward the renewal and replacement of aging care homes across BC;
- ✓ **Invest in Quality of Life**: by establishing a new *Seniors Quality of Life Fund* which would increase access to programs such as recreational therapy, music therapy, occupational therapy – for both seniors in residential care and receiving home care;
- ✓ **Invest in Innovation**: by increasing seniors' choice to select service provider through a new Care Credit model, and support the creation of Continuing Care Hubs.

Over the past year we reached out to British Columbians for their views on seniors care in our province. It is thanks to them that we now have this roadmap to create 21st Century care for BC's elderly population.

In the days ahead, BCCPA looks forward to collaborating with our elected leaders in the BC government to build upon a system of excellence in seniors care that not only honours our elders, but ensures care will be there when we need it.

Sincerely,

Daniel Fontaine
Chief Executive Office

Special Recognition

The BC Care Providers Association (BCCPA) would like to acknowledge its Board of Directors, for agreeing to support this initiative and dedicating the necessary resources to make it happen.

- Karen Baillie, BCCPA Board President, CEO of the Menno Place
- Aly Devji, BCCPA Board Vice President, Director of HR/ Operators for Delta View Habilitation Centre
- Rizwan Gehlen, BCCPA Treasurer, Vice President of Finance for Park Place Seniors Living
- Bob Boulter, CEO of Beacon Community Services
- Ann Marie Leijen , CEO of Logan Manor
- Sue Emmons, Executive Director of Northcrest Care Centre
- Elissa Gamble, National Director of Home Health Operations at Bayshore HealthCare
- Debra Hauptman, CEO of Langley Lodge
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- Sue Emmons, EIPC Chair, Executive Director of Northcrest Care Centre
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- Michael Kary, Director of Policy and Research, BCCPA
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The authors of the report would also like to acknowledge the ongoing support of the staff at BC Care Providers Association.

About the BCCPA

The BC Care Providers Association (BCCPA) has represented non-government care providers for 40 years. We have over 300 residential care, home care, assisted living and commercial members across the province. Our members provide care for over 25,000 seniors annually and creating more than 18,000 direct and indirect jobs across the province.

About BC's Continuing Care Sector

BC's Home and Community Care budget exceeds $2.0 billion, which is on par with the fifth largest Ministry. Over two-thirds of all seniors care in the province is delivered by the private sector – which includes both for-profit and non-profit providers. Many of BC's private care providers are funded directly by the regional health authorities to deliver seniors care services across the province.

EXECUTIVE SUMMARY

Seniors make up the fastest-growing age group in Canada; in 2010, the median age in Canada was 39.7 years, while it was only 26.2 years in 1971.[1] This trend is expected to continue for the next several decades; in 2010, an estimated 4.8 million Canadians were 65 years of age or older, but by 2036 this number is expected to increase to 10.4 million. By 2038, BC's senior population will account for an estimated 24 to 27 per cent of the population, with the proportion of seniors nearly five percent higher than the Canadian average. Furthermore, the Ministry of Health reports that the percentage of BC seniors over 80 years old will grow from 4.4% of the population in 2012 to 7.4% by 2036. At the same time, it is projected that the prevalence of chronic conditions for those 80 or over may increase by 58 per cent within the next 25 years.

"By 2038, BC's senior population will account for an estimated 24 to 27 per cent of the population, with the proportion of seniors nearly five percent higher than the Canadian average. "

The aging 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.[2] In BC, the total public cost of subsidies for residential care were approximately $1.7 billion in 2013, which amounts for 10 per cent of the provincial health budget. These costs are expected to increase to about $2.7 billion by 2035.

Furthermore, in British Columbia, spending on seniors accounted for 54 per cent of the $9.2 billion spent on health care services in 2009. Total demand in BC for health care services by seniors is expected to increase by 41% over the next 10 years from population growth and aging alone. In comparison, demand for health services from the population under age 65 will only

"…. In British Columbia spending on seniors accounted for 54 per cent of the $9.2 billion spent on health care services in 2009. "

[1] Median age means that half of the population was older than that and half was younger.
[2] BC Stats. British Columbia Populations 2012-2036 – September 2012. Retrieved July 10, 2013 from: www.bcstats.gov.bc.ca/StatisticsBySubject/Demography/PopulationProjections.aspx

increase by 13%.[3] A 2015 Conference Board of Canada report notes that 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.[4]

Overall, the province's health system is not prepared to meet the challenges of an aging population, as the health system in BC, much like the rest of Canada, is still largely acute care oriented and not optimally designed to provide care for those with ongoing care needs, such as the chronically ill or frail elderly.

British Columbia's aging population, however, presents significant opportunities to enhance the province's economic strength by capitalizing on care providers' entrepreneurial spirit and enhancing the efficiency, sustainability, and quality of our seniors' care system. As will be outlined in this paper, with among the highest average life expectancies and healthiest seniors' population in Canada, there is a real opportunity for BC to become a leader in aging.

The aging population will put additional pressures on the health care system, particularly in dealing with mental health and chronic diseases. A large percentage (41%) of Canadian seniors, for example, are dealing with two or more select chronic conditions, such as diabetes, respiratory issues, heart disease, and depression, and many are experiencing a decline in physical and/or cognitive functioning.[5] To deal with some of these challenges, the BC Care Providers Association (BCCPA) outlines approximately 30 recommendations following the release of two White Papers in May 2016 and after engaging in a thorough consultative process which culminated in the Inaugural Continuing Care Collaborative.

As outlined at the BCCPA Inaugural Continuing Care Collaborative held on September 20, 2016 which featured over 150 stakeholders across the home and community care sector now is the time to work together to find solutions to the rapidly aging 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.

[3] Blue Matrix. BC Ministry of Health Data.
[4] Greg Hermus, Carole Stonebridge, and Klaus Edenhoffer. Future Care for Canadian Seniors: A Status Quo Forecast. Ottawa: The Conference Board of Canada, 2015
[5] Health Council of Canada. Seniors in Need, Caregivers in Distress (March 2012). Accessed at: http://www.alzheimer.ca/kw/~/media/Files/on/Media%20Releases/2012/April%202012/HCC_HomeCare_2d.ashx

To deal with the challenges of an aging population in May of 2016, the BCCPA released two major White Papers outlining potential options to improve sustainability and innovation for seniors and the continuing care sector.[v] The first White Paper dealt 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 particularly: 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 (see Appendix A of BCCPA Supporting Documents).

Along with better meeting the needs of an aging population, the approaches outlined in the White Papers highlight potential ways to reduce acute care congestion (including alternate level of care days) and ER 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 also recently finished a significant public consultation on the White Papers culminating in the Collaborative in September as well as a major public survey on the options outlined in the paper (see Appendix B of BCCPA Supporting Documents). Overall the public survey received considerable attention including over 750 responses with over half being from seniors.

Along with aligning in many cases with BC government documents such as Setting Priorities for the B.C. Health System (February 2014) as well as the themes outlined in the Ministry of Health Policy papers released in February 2015 [6] this paper aligns with many of the concerns expressed by the BC Seniors Advocate, Isobel Mackenzie, including in areas such as increasing Direct Care Hours (DCH) as well as improving overall quality of care for BC seniors.

Within the 30 recommendations, the BCCPA has identified the following short-term [1-2 years] areas which we believe have significant public and stakeholder support. They are broken into four key areas of investment:

[6] On February 18, 2015 the BC Ministry of Health released a series of papers on its website covering five broad areas of the health system including: patient-centered care, health human resources, rural health, surgical services as well as primary and community care.

Investing in People

- $230 million in annual funding for care homes to meet a minimum 3.36 direct care hours (DCH) target per care home per resident per day across BC; and increase home care visits to a minimum of 30 minutes.

- $20 million in annual funding to 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; and further support the enhancement of the MyCareFinder.ca website as a tool to better identify empty residential care beds in "real-time."

- $25 million *Continuing Care Health Human Resource* (CCHHR) Fund to be invested over 5 years to address the chronic labour shortages currently facing the continuing care sector including up to half of the funding for education, training and resources for staff to provide improved dementia care.

Investing in Infrastructure

- Establish a new Residential Care Infrastructure Fund (RCIF) of $100 million over three years, including:
  - $80M to support the immediate renewal and replacement of older residential care homes.
  - $20M to support investments in smaller infrastructure projects such as sprinkler and ceiling lift installations, security, automated medication management and data collection systems.

Investing in Quality of Life

- Establish a new Seniors Quality of Life Fund (SQLF) to support quality of life for seniors in residential care and in the community. Along with providing services to community the SQLF would provide up to $100 per month per senior living in a non-government operated residential care setting (total approximately $22 million per year).

Investing in Innovation

- Allocate up to $2M per year to launch a new *Care Credits* program which provides seniors [or the family members that care for them] the option to select the service provider of their choice.

- Invest up to $28M per year over the next five years to support the introduction and/or expansion of the Care Hub concept throughout B.C.

While the operational costs of these short-term initiatives are considerable including approximately $337 million in the first year; given the importance of seniors and the fact the Province of B.C. is forecasting surplus budgets into the future, we believe the time is now for these critical investments.

Some of the funds required to undertake these initiatives could also be obtained by re-allocating existing Health Authority acute care budgets to home and community care – an approach also advocated by the Ministry of Health.[7] 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.

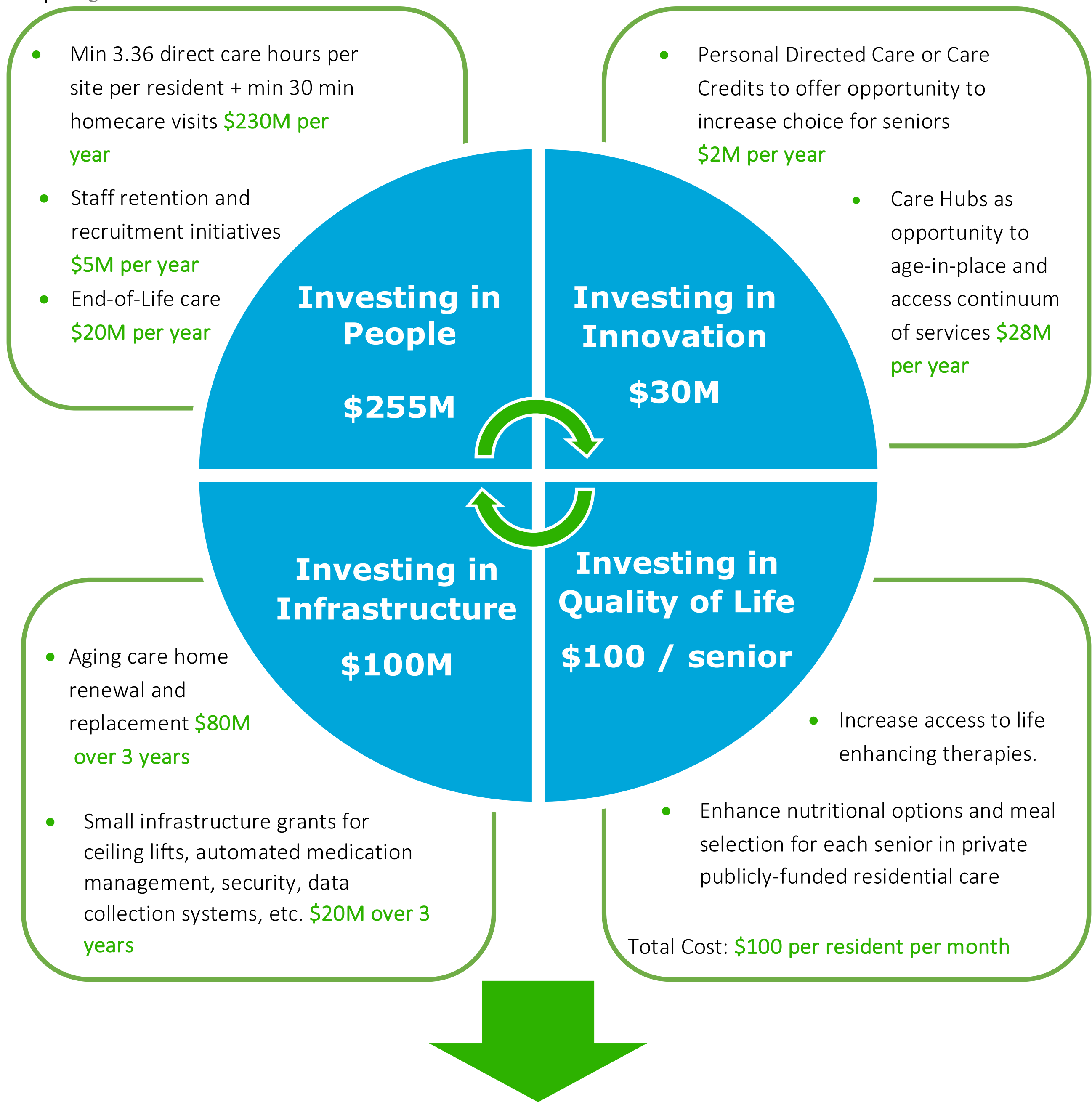
Did You Know? … shifting only 1% of the acute care budget in BC to home and community care would allow for the development of 4,400 new residential care beds; or 8 million additional home support hours; or 12 million more home care hours.

As outlined in the Quality-Innovation-Collaboration paper (2015) the BCCPA has previously recommended 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.[8] This paper also recommends 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 percent annually over a five- year period to the home and community care sector.

As outlined in this paper by shifting resources from acute to continuing care, there is the potential for significant cost savings and other benefits including:

[7] Primary and Community Care in BC: A Strategic Policy Framework. BC Ministry of Health. February 2015. Accessed at: http://www.health.gov.bc.ca/library/publications/year/2015/primary-and-community- care-policy-paper.pdf

[8] BCCPA. Op-ed: Quality, Innovation, Collaboration – Strengthening Seniors Care Delivery in BC. October 2015. Accessed at: http://www.bccare.ca/op-ed-quality-innovation-collaboration-strengthening-seniors-care-delivery-in-bc/



- ✓ Increase Choice
- ✓ Better Health
- ✓ Higher Satisfaction

- 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. Recreational Therapy, Occupational therapy, Physical therapy, 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 better health outcomes;
- Reducing unnecessary hospitalizations including seniors who occupy a more-costly acute care bed;
- Minimizing the deterioration in physical and mental functioning that can occur among seniors from prolonged stays in acute care;
- 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;
- Improving collaboration and working relationships with the continuing care sector; and
- Redirecting funding from more-costly acute to home and community care.

Please note: all research and analysis to form the basis of our recommendations is detailed below.

SUMMARY OF RECOMMENDATIONS

Section 1: Sustainable Long Term Funding

IMMEDIATE TERM (1-2 YEARS)

1. That the BC government immediately support a minimum 3.36 Direct Care Hours (DCH) target per care home per resident per day across BC; and that 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.

2. That a standard definition of DCH be developed by the Ministry of Health and Health Authorities in partnership with the sector by 2017.

3. That the BC Government establish a new Residential Care Infrastructure Fund (RCIF), which would:

- support the immediate renewal and replacement of older residential care homes;
- support investments in smaller infrastructure projects such as sprinkler and ceiling lift installations, automated medication management, online training technology, security and data collection systems; and
- invest in enhancements for improving dementia-friendly environments within existing homes to make them more home like.

4. That the BC Ministry of Health undertake an immediate review of funding lifts in all Health Authorities with the goal of consistency, fairness, and sustainability with respect to per diem rates. This includes a process for providing greater transparency and province-wide standardization in respect to how funding lifts provided for home and community care are determined.

5. 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.

MEDIUM TERM (3-5 YEARS)

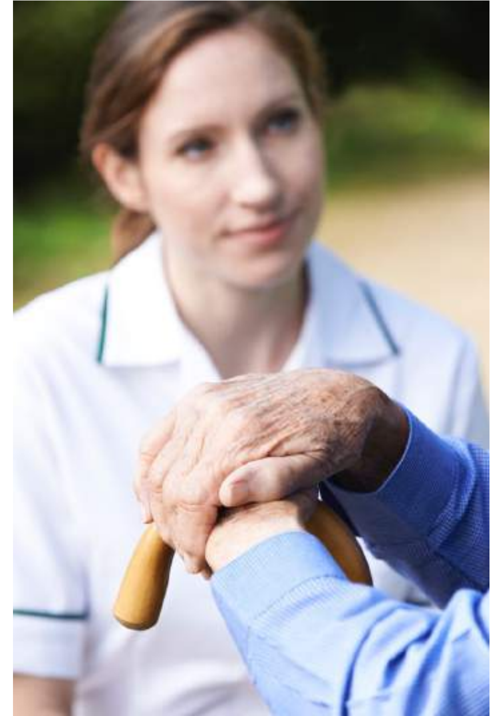
6. That the BC government and Health Authorities work with care operators to develop home and community care funding models that are responsive to and appropriate to the acuity and complexity of clients in care, as well as adhering to the core principles of timeliness, sustainability, equity and transparency.

7. That the BC government, in consultation with operators, develop home and community care 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 among residents and clients.

8. That the BC government work towards the establishment of a long-term predictable funding model by end of fiscal 2020 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.

9. That the Ministry of Health and the Health Authorities fully honour negotiated funding agreements by recognizing increases in labour-market costs to care providers to levels at least consistent with the master collective agreement.



LONG TERM (5-10 YEARS)

10. That the BC government remove the perception of a conflict of interest by implementing a funding model that separates the bodies that fund, allocate funds and regulate care homes from those that operate care homes.

Section 2: New Funding Models and Approaches

IMMEDIATE TERM (1-2 YEARS)

11. That the BC government introduce a Care Credit or Personal Directed Care model in the home care sector and undertake a study including possible pilot project on their potential use in residential care. The study should analyze best practices from Community Living B.C. which offers their clients direct opportunities to select the care provider of their choice.

MEDIUM TERM (3-5 YEARS)

12. That the BC Ministry of Health undertake a comprehensive review of the outcomes and lessons learned in the use of activity and outcome-based funding for provision of home and community care, particularly reviewing any results from Alberta and Ontario's experimentation with these initiatives.

13. That the BC government review existing co-payments for continuing care to ensure that they better reflect actual costs of delivering care and a resident's/client's ability to pay, while ensuring seniors with lower incomes are protected.

Section 3: New Continuing Care Models

IMMEDIATE TERM (1-2 YEARS)

14. That as a key priority any future BC Continuing Care Collaborative review options for 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. In particular, the BC government and Health Authorities should expand and/or introduce the Continuing Care Hub model in rural areas to increase the level of medical and social services provided to seniors in the community.

MEDIUM TERM (3-5 YEARS)

15. That the Ministry of Health set as a target by the year 2021 to have no more than 5% of acute care beds occupied each day by seniors who have been assessed as capable of being transferred into a more appropriate residential care or home care setting.

16. That the BC government accelerate the adoption of new electronic information systems, including electronic health records and telehealth that facilitate the sharing of resident information across the continuing care system – including private care providers.

17. That the BC government consider implementing systems that better enable patient information to flow through the health care system with the resident, particularly the sharing of information after a patient's return from a hospital stay.

Section 4: Health Human Resources

IMMEDIATE TERM (1-2 YEARS)

18. That the BC government establish a Continuing Care Health Human Resource (CCHHR) Fund to be invested over 5 years and potentially matched by the Federal Government to address the need for staff training and chronic labour shortages currently facing the continuing care sector, including:

- funding for a renewed 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 other key health professionals who provide frontline continuing care;
- funding for a BC Behavioural 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
- general dementia care education for care providers and support staff.

Section 5: End-of-Life Care

IMMEDIATE TERM (1-2 YEARS)

19. That the Ministry of Health and Health Authorities, better utilize 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. 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.

MEDIUM TERM (3-5 YEARS)

20. That the BC government support the adoption of new palliative / EOL care models including, where necessary, provide new funding to improve the integration between continuing and end-of-life care.

21. That the Ministry of Health and Health Authorities work with the 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.

Section 6: Seniors Well-Being

IMMEDIATE TERM (1-2 YEARS)

22. That the BC government establish a new 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 the overall quality of food and nutrition in residential care homes including meeting therapeutic diet requirements (currently the average care home allocates approximately $6 per day to feed each resident) and providing culturally appropriate meal options; and
- Regular reporting by the Ministry of Health, including what initiatives are being undertaken through the SQLF and how they are improving the overall quality of life for seniors in BC.

23. That the Health Authorities increase the minimum home care visit time from 15 to 30 minutes.

MEDIUM TERM (3-5 YEARS)

24. That as part of any Continuing Care Collaborative it includes a permanent sub-committee to deal with the unique and considerable challenges facing the home care sector including a review of funding, unfunded service expectations, travel costs and improving quality care. Likewise, this sub-committee should explore different innovative models in home care to determine their use or adoption in British Columbia.

25. That the BC government, working with stakeholders, develop a collaborative Provincial Seniors Safety Strategy which could focus on specific issues including use of technology, falls prevention, resident-on-resident aggression, reducing adverse drug events, suicide prevention, elder abuse and/or safety within home and community care.

Section 7: Shifting Resources from Acute to Home & Community

IMMEDIATE TERM (1-2 YEARS)

26. Starting in fiscal year 2017/18, that the Performance Agreements between British Columbia's Ministry of Health and Health Authorities include a specific target for redirecting acute care expenditures such as a minimum of 1 percent annually over a five-year period to the home and community care sector. Along with supporting initiatives outlined earlier, 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 care models particularly Continuing Care Hubs to reduce acute care pressures (including ALC days), improve access to care while also allowing seniors to receive services in the most appropriate setting.

Section 8: Federal Role in Seniors Care

IMMEDIATE TERM (1-2 YEARS)

27. 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.

MEDIUM TERM (3-5 YEARS)

28. British Columbia endorse the advancement of a *National Dementia Strategy* with federal participation which should include investing in research and ensuring capacity and appropriate funding in the continuing care sector.

29. As part of any National or Provincial Dementia Strategy the BC government explore, where appropriate, the creation of new care models or initiatives to support seniors with dementia including but not limited to Dementia Villages, Butterfly Care Homes and Dementia Friendly Communities (DFCs). Where appropriate, the Residential Care Infrastructure Fund should also be provided to support the development of such initiatives including retrofitting existing care homes as part of any strategy to create DFCs.

30. BC work with other provinces to advance the development of a *National Seniors Health Promotion Strategy*, which could outline various strategies to promote seniors physical and mental well-being, including outlining best practices among jurisdictions.

OVERVIEW

As outlined in the Executive Summary of *Strengthening Seniors Care: A Made-in-BC Roadmap*, the province's health system is not prepared to meet the challenges of an aging population, as the health system in BC, much like the rest of Canada, is still largely acute care oriented and not optimally designed to provide care for those with ongoing care needs, such as the chronically ill or frail elderly. To deal with some of these challenges, the BC Care Providers Association (BCCPA) outlines approximately 30 recommendations following the release of two White Papers in May 2016 and after engaging in a thorough consultative process which culminated in the Inaugural Continuing Care Collaborative.

As presented at the BCCPA Collaborative held on September 20, 2016 which featured over 150 stakeholders across the home and community care sector, now is the time to work together to find solutions to the rapidly aging 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. 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.

To deal with the challenges of an aging population in May of 2016, the BCCPA released two major White Papers outlining potential options to improve sustainability and innovation for seniors and the continuing care sector. The first White Paper dealt primarily with issues around funding and financing of continuing care 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 particularly: 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 aging population, the approaches outlined in the White Papers highlight potential ways to reduce acute care congestion (including alternate level of care days) and ER 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 also recently finished a significant public consultation on the White Papers culminating in the Collaborative in September as well as a major public survey on the options outlined in the paper (see Appendix B). Overall the public survey received considerable attention including over 750 responses with over half being from seniors. This final paper incorporates the feedback from the consultation process and outlines about 30 recommendations dealing with various topics in eight priority areas.

Along with aligning in many cases with BC government documents such as Setting Priorities for the B.C. Health System (February 2014) as well as the themes outlined in the Ministry of Health Policy papers released in February 2015 this paper aligns with many of the concerns expressed by the BC Seniors Advocate, Isobel Mackenzie, including in areas such as increasing Direct Care Hours (DCH) as well as improving overall quality of care for BC seniors. Within the 30 recommendations, the BCCPA has identified the following short-term [1-2 years] areas which we believe have significant public and stakeholder support (see table 1). Some of these areas were also highlighted in the recent Select Standing Committee on

Table 1: Strengthening Seniors Care: A Made-in-BC Roadmap (Key Investment Areas)

Invest in People

- Invest $230 million in annual funding for care homes to meet a minimum 3.36 Direct Care Hours (DCH) target per resident care home across BC and increase minimum home care visit times to 30 minutes;
- $20 million in annual funding to 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; and further support the enhancement of the MyCareFinder.ca website as a tool to better identify empty residential care beds in "real-time."
- $25 million Continuing Care Health Human Resource (CCHHR) Fund to be invested over 5 years to address the chronic labour shortages currently facing the continuing care sector including up to half of the funding for education, training and resources for staff to provide improved dementia care.

Invest in Infrastructure

- Establish a new Residential Care Infrastructure Fund (RCIF) of $100 million over three years, including: $80M to support the immediate renewal and replacement of older residential care homes; and $20M to support investments in smaller infrastructure projects such as sprinkler and ceiling lift installations, security, automated medication management and data collection systems.

Invest in Quality

- Establish a new Seniors Quality of Life Fund (SQLF) to support quality of life for seniors in residential care and in the community. The SQLF would provide up to $100 per month per senior living in a non-government operated residential care setting (approximately $22 million per year).

Invest in Innovation

- Allocate up to $2M per year to launch a new Care Credits program which provides seniors [or the family members that care for them] the option to select the service provider of their choice.
- Invest up to $28M per year over the next five years to support the introduction and/or expansion of the Continuing Care Hub concept throughout B.C.

Other Priorities

- Starting in fiscal 2017/18 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.
- That the BC Ministry of Health undertake an immediate review of funding lifts in all Health Authorities with the goal of consistency, fairness, and sustainability with respect to per diem rates.
- 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.

Finance and Government Services Report on the Budget 2017 Consultations, which also put seniors as a focus of new health care spending and that the BCCPA provided considerable input on.[9]

While the costs of these short-term initiatives are considerable (about $337 million in the first year) given the importance of seniors particularly with an aging population we believe that this is a worthwhile investment. 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.[10]

[9] BCCPA. BC Care Providers Association Responds to Provincial Budget Consultation Report. November 16, 2016. Accessed at: http://www.bccare.ca/bc-care-providers-association-responds-to-provincial-budget-consultation-report/

[10] Primary and Community Care in BC: A Strategic Policy Framework. BC Ministry of Health. February 2015. Accessed at: http://www.health.gov.bc.ca/library/publications/year/2015/primary-and-community- care-policy-paper.pdf

SECTION 1: LONG TERM SUSTAINABLE FUNDING

Direct Care Hours

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.[11] 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.[12]

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.[13] As outlined further in Appendix C, 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.[14]

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

[11] Office of the Seniors Advocate. British Columbia Residential Care Facilities: Quick Facts Directory. January 2016. http://www.seniorsadvocatebc.ca/osa-reports/british-columbia-residential-care-facilities- quick-facts-directory/
[12] The results included from this poll are based on an online study conducted by Insights West from March 25 to March 29, 2015, among a representative sample of 814 British Columbian adults. The data has been statistically weighted according to Canadian census figures for BC for age, gender and region. Results have a margin of error of ±3.5 percentage points, 19 times out of 20.
[13] Home and Community Care Program, "Costing Assumptions #3 for the Proposed Staffing Framework for Residential Care Facilities," 11 August 2009, 1; and Home and Community Care Program, "Residential Care Staffing and Reporting Tool Frequently Asked Questions," internal document, 3.
[14] BCCPA. Op-ed: Direct Care Hours. May 2, 2016. Accessed at: http://www.bccare.ca/op-ed-direct-care-hours/

- 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.[15]

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 4.

There must also be greater clarity and standardization with respect to a definition for DCH as this also varies among health authorities (see Appendix D). 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. The professional support component of DCH should include those occupations outlined in the *Health Professions Act*.[16] 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.

As outlined in Strengthening Seniors Care: A Made-in-BC Roadmap, the BCCPA recommends $230 million in annual funding to support a minimum 3.36 Direct Care Hours (DCH) target per care home per resident per day across BC; and that 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. A standard definition of DCH should also be developed by the Ministry of Health and Health Authorities in partnership with the sector by 2017.

Recommendation ***Immediate: 1 to 2 years***

- That the BC government immediately support a minimum 3.36 Direct Care Hours (DCH) target per care home per resident per day across BC; and that 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.

[15] Ombudsperson. The Best of Care: Getting It Right for Seniors in British Columbia. Part 2. February 2012. Accessed at https://www.bcombudsperson.ca/seniors/seniors-care-investigation/seniors-report-part-two
[16] BC Health Professions Act. 1996. Accessed at: http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96183_01

Investing in Infrastructure:

Capital Investments in Continuing Care

Seniors entering 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. 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.[17]

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. Like 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.[18]

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.[19]

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.

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[17] BCCPA. White Papers. Sustainability and Innovation: Exploring Options for Improving BC's Continuing Care Sector. May 2016. Accessed at: http://www.bccare.ca/whitepapers2016/

[18] BUILDING resident-centered long-term care, now and for THE FUTURE. Ontario Long Term Care Association. January 2015. Ontario Long Term Care Association Pre-Budget Submission to the Ontario Government 2015/2016.

[19] BCCPA. White Papers. Sustainability and Innovation: Exploring Options for Improving BC's Continuing Care Sector. May 2016. Accessed at: http://www.bccare.ca/whitepapers2016/

Funding for infrastructure investments

Another potential option is that seen in 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.[20]

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.

As outlined in *Strengthening Seniors Care: A Made-in-BC Roadmap*, the BCCPA recommends the establishment of a $100 million residential care infrastructure fund (RCIF) to assist with the following:

- support the immediate renewal and replacement of older residential care homes;
- support investments in smaller infrastructure projects such as sprinkler and ceiling lift installations, automated medication management, online training technology, security and data collection systems; and
- invest in enhancements for improving dementia-friendly environments within existing homes to make them more home like.

Recommendation ***Immediate: 1 to 2 years***

That the BC Government establish a new Residential Care Infrastructure Fund (RCIF), which would:

- support the immediate renewal and replacement of older residential care homes;
- support investments in smaller infrastructure projects such as sprinkler and ceiling lift installations, automated medication management, online training technology, security and data collection systems; and
- invest in enhancements for improving dementia-friendly environments within existing homes to make them more home like.

Principles for Funding

In British Columbia, continuing care providers consistently deliver high quality care for seniors. Yet even though 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, while funding lifts for residents/clients and operators are often less than collective agreement increases. Furthermore, cost of living increases are not fully recognizing inflationary pressures and/or enhanced service delivery requirements.

Another major issue is that some residential care provider members are not being advised of their annual fiscal year funding increases until well into the fiscal year, while many of BCCPA contracted home care members have

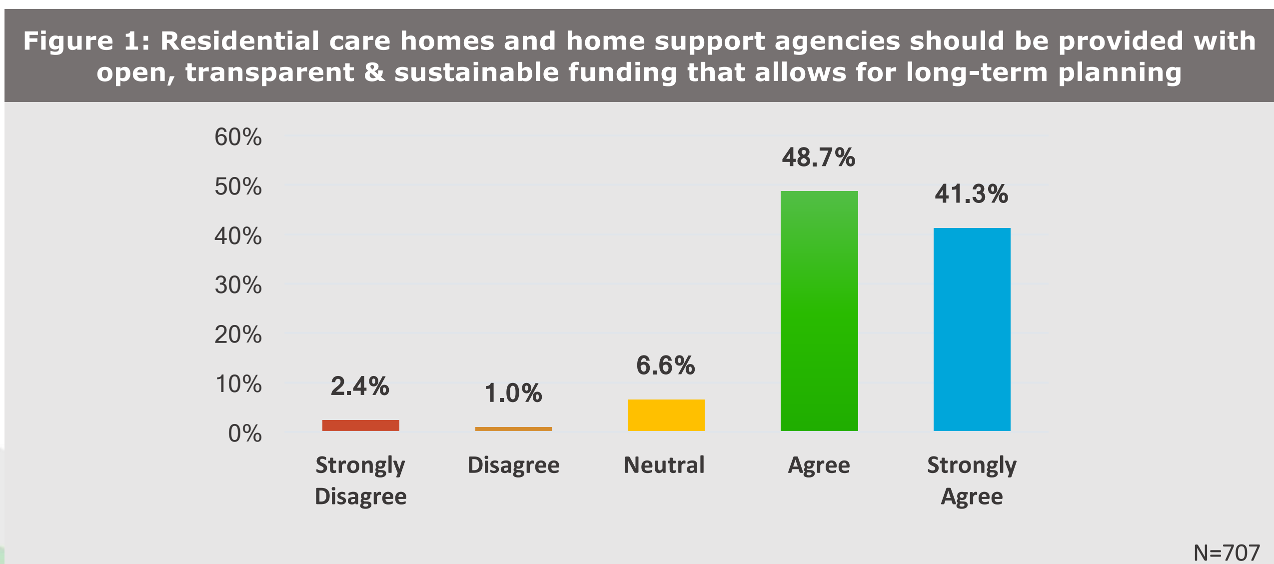
[20] BUILDING resident-centered long-term care, now and for THE FUTURE. Ontario Long Term Care Association. January 2015. Ontario Long Term Care Association Pre-Budget Submission to the Ontario Government 2015/2016.

not seen funding increases for several years. This adds undue financial stress and operational challenges for BCCPA members, 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. In light of these concerns, the BCCPA has endorsed the following funding principles at its Annual General Meeting in 2015.

Table 2: BCCPA Key Funding Principles
Timeliness: • Health Authorities will aim to provide care providers in writing with their funding notice prior to March 31st but no later than 90 days after the start of the fiscal year on April 1st.
Fiscal Sustainability: • Contracted care providers are provided the necessary funding to cover identified year-over-year costs related to inflation in order to ensure they remain financially whole.
Equity: • The calculation of funding lifts and direct care hours is consistent within and across health authorities.
Communication and Transparency: • Contracted service providers are provided with timely and appropriate communication regarding any significant issue related to their funding relationship with the health authority; • The methodology used to calculate annual funding lifts will be shared openly with care providers.

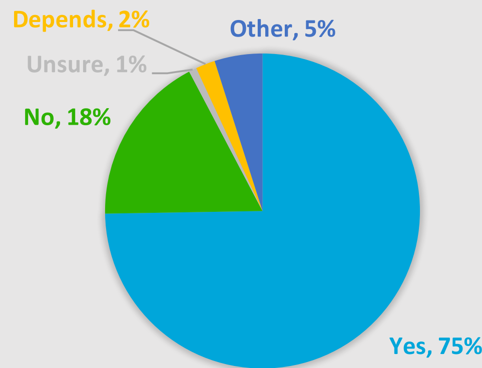
As a result, the BCCPA encourages an immediate government review of funding lifts in all Health Authorities with the goal of consistency, fairness, and sustainability with respect to per diem rates. This aligns also with the survey results on the White Papers in which respondents were asked to indicate their degree of support or opposition to the principle that operators in the continuing care sector receive open, transparent and sustainable funding in order to allow for long-term planning. As outlined in figure 1 below, ninety per cent of survey respondents indicated that they agreed with this statement. Only 3.5% indicated disagreement, with 7 per cent remaining neutral.

Figure 1: Residential care homes and home support agencies should be provided with open, transparent & sustainable funding that allows for long-term planning



Survey respondents were asked to provide their opinion on whether the funding provided to seniors' care providers should be linked to the acuity of the residents/clients that they care for, such that care homes and home support operators with more challenging clients would receive higher levels of funding. As outlined in figure 2, this option received good support, with 75% of survey respondents indicating support for this concept, and an additional 2 percent indicating depends. Almost twenty percent of survey respondents indicated that they did not support this proposal, many citing the fact that they believe such a system would be good in theory but difficult to implement and manage in practice.

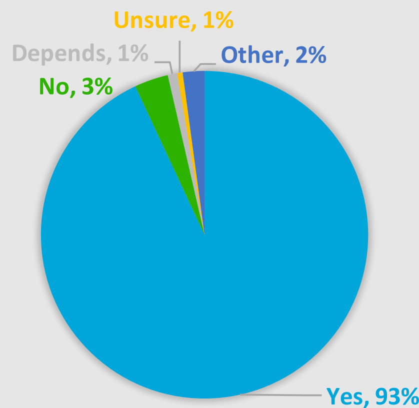
Figure 2: Do you think funding levels for Residential Care Homes and Home Support Providers should be linked to the actual health conditions of the seniors they are caring for?



Finally, survey respondents were asked whether they believed that continuing care, including residential care as well as home care and support providers in BC, should receive annual funding lifts linked to the rate of inflation. As outlined in Figure 3 below, this concept received overwhelming supporting from survey respondents, with 93% supporting, and another one percent providing indicating depends. Only 3 per cent of survey respondents indicated that they would not support such a proposal, as they did not believe that a general inflation rate (such as the Consumer Price Index reported by Statistics Canada) would be a good yardstick, because the fluctuations in costs in the industry are often different or higher than CPI (e.g. wage increases due to collective bargaining).[21]

[21] It should be noted that the responses to this question may not be completely reliable; several survey respondents gave answers that indicated that they were thinking about how much of a public subsidy seniors should get when paying for care (captured under the "other" category in the chart below), rather than the funding provided to the operator of the home. This confusion may be due to the wording of the question, or may point towards a lack of understanding in the general public regarding how care homes are funded.

Figure 3: Do you think funding levels for Residential Care Homes and Home Support Providers should be linked to inflation?



N=752

RECOMMENDATIONS	*Immediate: 1 to 2 years*

- That the BC government and Health Authorities work with care operators to develop home and community care funding models that are responsive to and appropriate to the acuity and complexity of clients in care, as well as adhering to the core principles of timeliness, sustainability, equity and transparency.

RECOMMENDATIONS	*Medium term: 3 to 5 years*

- That the BC government and Health Authorities work with care operators to develop home and community care funding models that are responsive to and appropriate to the acuity and complexity of clients in care, as well as adhering to the core principles of timeliness, sustainability, equity and transparency.

Sustainable Long-Term Funding

One group facing major fiscal pressures are those that deliver care and operate care homes. The allocated budgets or per diem rates of these non-government operators are increasing only marginally, if at all. This is despite an aging population and increasing levels of acuity.[22] 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 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. [23]

[22] Health Council of Canada Report – Seniors in Need, Caregivers in Distress (April 2012). Accessed at: http://www.healthcouncilcanada.ca/rpt_det_gen.php?id=348
[23] Setting Priorities for BC's Health System. BC Ministry of Health. February 2014. Accessed at: http://www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf

Along with aging, there are other various cost drivers in the health system including inflation (which accounts for about 2% in annual growth), followed by utilization of services, infrastructure maintenance and replacement.[24] 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 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.

"In BC, the shift to complex care delivery due to new investments in home care has resulted in a significant increase in the acuity level of seniors in residential care. Increases in funding, however, have not matched this rising acuity."

In BC, the shift to complex care delivery due to new investments in home care has resulted in a significant increase in the acuity level of seniors in residential care. Increases in funding, however, have not matched this rising acuity. For example, similar to BC, a large percentage of Canadian seniors (over 40%), are dealing with two or more select chronic conditions, such as diabetes, respiratory issues, heart disease, and depression, and many are also experiencing a decline in physical and/or cognitive functioning.[25]

Despite increasing levels of acuity and multiple chronic conditions, funding is often less than collective agreement increases or cost of living increases, as health authorities rarely recognize inflationary pressures. One such example of this pressure is new and increasing Medical Service Plan (MSP) fees that are placing increased fiscal burdens on residential care operators and diverting funding away from direct resident care.

As a result of these deficiencies, funding shortfalls in the continuing care sector increase year after year. These funding shortfalls also come at a time when there are calls from the public and the families of those in care to provide an even higher level of service for their loved ones.

While BCCPA members deliver the best care possible and creatively find ways to get by with the resources available through government funding, shortfalls are ultimately to the detriment of seniors in care. This system of having care homes operate at a financial disadvantage is inefficient and unsustainable. An efficient and sustainable system requires collective agreements to be fully funded and other care costs fairly compensated. Accordingly, we advocate that government ensure funding matches the cost of delivering complex care. In addition, this may also require looking at new funding models to ensure continuing care operators receive appropriate funds and that residents receive the care they need.

As such the BCCPA encourages an immediate government review of funding lifts in all Health Authorities with the goal of consistency, fairness, and sustainability with respect to per diem rates. In particular, as outlined in the 2012 Ombudsperson report, 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.

Finally, the BCCPA 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.

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[24] Ibid.

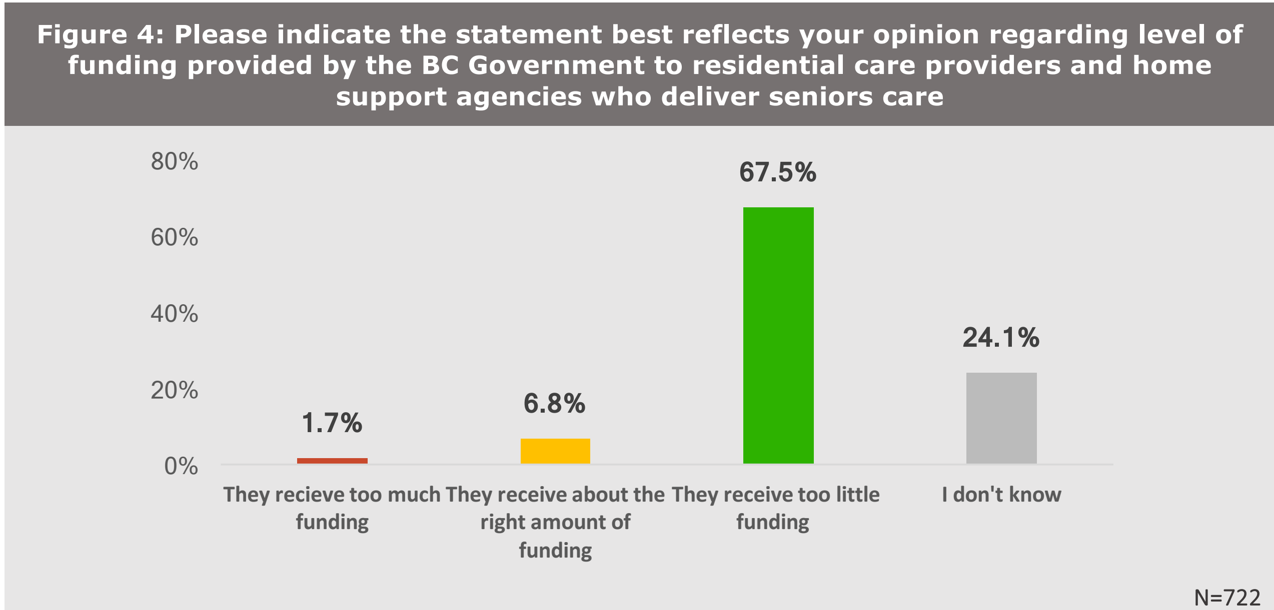
[25] Health Council of Canada. Seniors in Need, Caregivers in Distress (March 2012). Accessed at: http://www.alzheimer.ca/kw/~/media/Files/on/Media%20Releases/2012/April%202012/HCC_HomeCare_2d.ashx

Escalating wage pressures

While the Health Employers Association of British Columbia (HEABC) is responsible for negotiating collective agreements on behalf of the provincial government, these agreements can also significantly impact the operating costs of care providers. In particular, care provider members, both those included in the master collective agreement and those not, are required to pay completive wages rates, which are determined by the master collective agreement. These collective agreements, including new labour wage increases, place increased fiscal and labour market cost pressures on care operators. As such, it is important that the Ministry of Health and the Health Authorities fully honour negotiated funding agreements by recognizing increases in labour-market costs to care providers to levels at least consistent with the master collective agreement.

This also aligns with the survey results from the White Papers where respondents were asked about their perception of the funding levels provided to care operators in BC. Nearly 70 per cent of survey respondents indicated that they perceived that care operators in BC were receiving too little funding (67.5%); while 24.1% indicated, they had no opinion. Only 7 per cent of respondents indicated that they felt that current funding levels were sufficient, while less than 2 per cent indicated that care operates receive too much funding.

Figure 4: Please indicate the statement best reflects your opinion regarding level of funding provided by the BC Government to residential care providers and home support agencies who deliver seniors care



RECOMMENDATIONS ***Medium term: 3 to 5 years***

- That the BC government, in consultation with operators, develop home and community care 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 among residents and clients.
- That the BC government work towards the establishment of a long-term predictable funding model by end of fiscal 2020 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.

- That the Ministry of Health and the Health Authorities fully honour negotiated funding agreements by recognizing increases in labour-market costs to care providers to levels at least consistent with the master collective agreement.

While not discussed in detail in this paper 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. As discussed in earlier BCCPA paper Seniors Care for A Change (2014) for any new requirements or regulations imposed in the continuing care sector (such as most recently for operators to provide residents with a basic wheelchair and maintenance at no cost) appropriate funding and resources should be available over long term.

Exemption of property taxes

Along with new capital investments, this report recommends considering exempting care home operators from paying property taxes, which is currently done in other provinces such as Alberta. In that province, for example, Section 362(1)(h) of the province's Municipal Government Act exempts all nursing homes, as defined in the Nursing Homes Act, from paying property taxes whether they are owned by the Crown or by non-profit or for-profit organizations.[26]

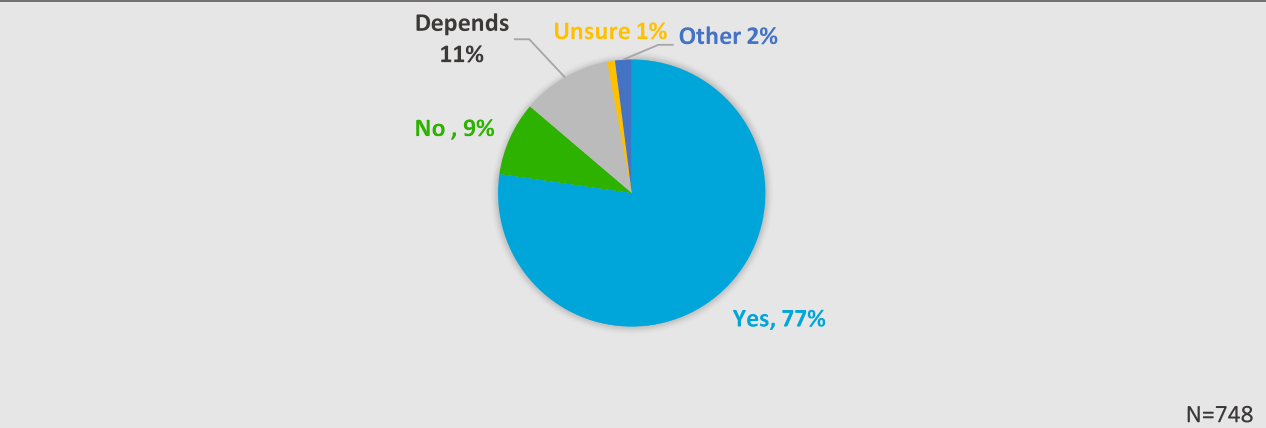
This change would go a significant way in allowing non-government operators to recoup capital operating expenses, as well as encouraging further private investment in continuing care sector in order to improve access to new residential care beds and for senior's care.[27]

This also aligns with the results of the White Papers survey in which participants were asked to indicate their level of support for exempting BC care homes from municipal taxes, similar to a policy that is currently in effect in Alberta. Specifically, over three-quarters of survey respondents indicated support for this option (77%). An additional 11% of survey respondents indicated depends for this option, as they would support this option only for non-profit care homes (7%), or if there were specific oversights to ensure that the funds were devoted to improving care for residents (4%). Only 9% of survey respondents indicated that they would oppose this policy outright. The most common reason given for opposing this policy was that it would tend to decrease municipal tax revenues.

[26] Alberta Senior Citizens Housing Association. A New Approach to Property Taxes. June 2014. Accessed at: http://www.ascha.com/PDF_forms/TaxationReportFinalJune122014.pdf

[27] BCCPA. White Papers. Sustainability and Innovation: Exploring Options for Improving BC's Continuing Care Sector. May 2016. Accessed at: http://www.bccare.ca/whitepapers2016/

Figure 5: In Alberta, residential care homes are exempt from paying municipal property taxes so that funds can be focused on providing care for seniors. Do you think BC should implement the same policy?



RECOMMENDATIONS ***Immediate: 1 to 2 years***

- 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.

Separation of funding and operation of care homes

The current model of care operations has been in place for over a decade, since the Health Authorities restructured it in 2001. No substantial review has been conducted on how private care homes are funded and regulated. At present, the model has the health authorities as funder, regulator, and operator. The Ministry of Health provides the funding, and the health authorities allocate the funding and regulate both private and non-profit care homes. That is, health authorities compete for resources with private industries since they are operators of care homes, yet at the same time also regulate and allocate funds to themselves and to private care homes. The overlap in responsibilities could skew the industry and as such reduce market efficiency. Figure 6 below shows the current, overlapping model that separate the bodies that fund, allocate funds, and regulate care homes, from those that operate care homes.

Overall government can provide cleaner lines of responsibility and accountability to taxpayers and residents by separating the bodies that regulate care homes and that provide and allocate funds from those that operate them. If the Ministry of Health were to provide and allocate funds while the health authorities and private and non-profit organizations operate care homes, then possible conflicts of interest could be minimized. This will increase transparency and competitiveness, and in doing so, improve the efficiency of the sector without any reduction in the quality of care. The diagram below shows new model with responsibilities no longer overlapping. Although this new model may not perfectly level the playing field between health authority and private care homes, it could help clarify the lines of accountability.

Figure 6: Current Model of Government's Role in Care

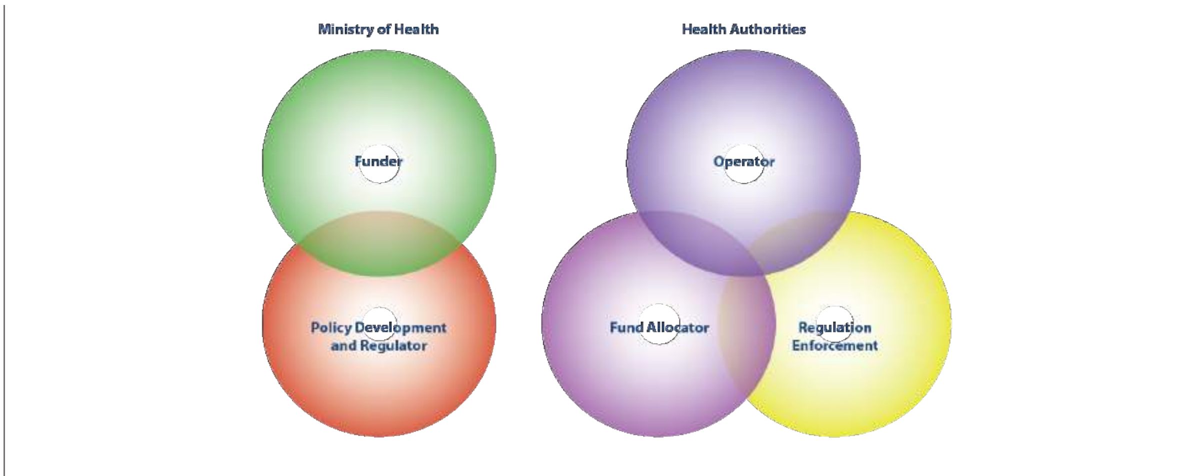
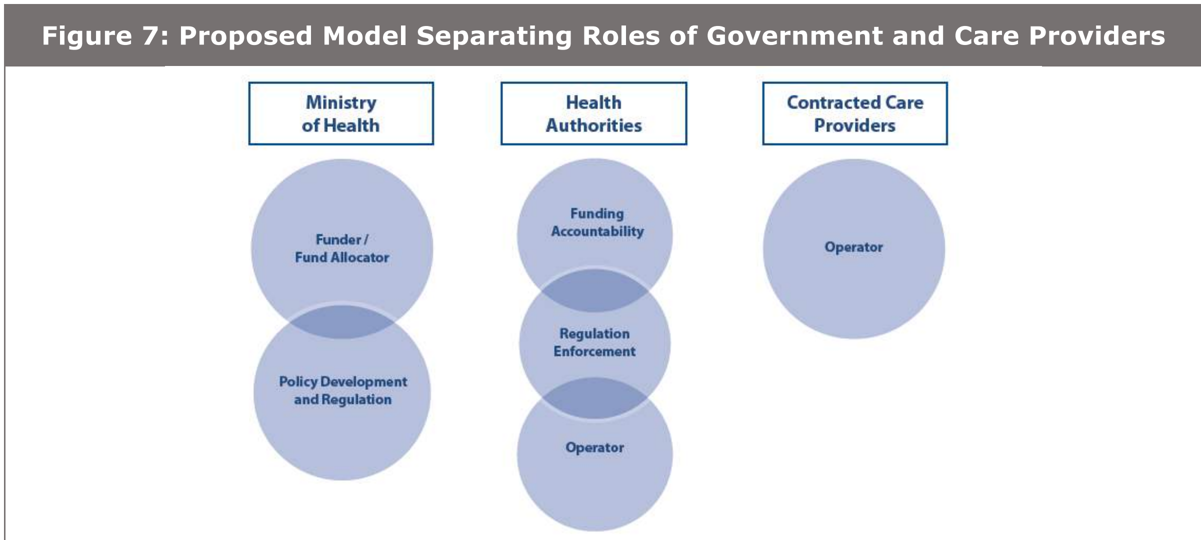


Figure 7: Proposed Model Separating Roles of Government and Care Providers



Alternatively, if health authorities in BC continue to operate their own care homes as well as fund affiliate providers one possibility to consider is for the Ministry of Health to provide funding to another entity such as the Provincial Health Services Authority (PHSA) which could manage and allocate funding as appropriate to non-government care homes. PHSA or another entity could also work with non-government providers to establish a more provincial approach to negotiations even potentially a province-wide contract for non-government care operators.

RECOMMENDATION ***Long-Term: 5 to 10 years***

- That the BC government remove the perception of a conflict of interest by implementing a funding model that separates the bodies that fund, allocate funds and regulate care homes from those that operate care homes.

SECTION 2: NEW FUNDING MODELS AND APPROACHES

Care Credits & Personal Directed Care

In Canada – in contrast to countries such as France, Germany, Sweden, Finland, and Denmark – the provision of subsidized long-term care is almost entirely in kind rather than in cash or care credits (commonly referred as vouchers). Resident co-payments for both home care and residential-based services are fixed, and the provincial government, not the resident, pays the residual costs of services supplied to subsidized residents.[28]

> *“In Canada – in contrast to countries such as France, Germany, Sweden, Finland, and Denmark – the provision of subsidized long-term care is almost entirely in kind rather than in cash or vouchers.”*

As outlined in a 2012 C.D. Howe report, new funding models such as vouchers are intended to be more reactive to clients’ needs by enhancing the ability of people to stay in their homes for as long as possible. In particular, financial and service flows for funding long-term care in France and the Nordic countries are intended to give clients a greater say over their path of care. [29] Instead of acting as the agent that pays for long-term care on behalf of recipients, government provides needs and risk-adjusted transfers to clients with which they can purchase services from a variety of potential providers. While government in these countries still plays a critical role in regulating providers and ensuring they meet a minimum quality of care, they no longer contract with providers, who now engage clients directly. [30]

The trend in many advanced countries toward the use of vouchers rather than providing services in kind was motivated in part by the belief that more choice for clients and competition among providers would lead to efficiency gains in the system and promote independence, if possible. The available evidence so far is not clear as to whether these efficiency gains have materialized, although providing greater choice generally has seemed to increase the reported satisfaction of clients.

Although many clients who were receiving cash or voucher transfers were not aware of the choices available to them and very few reported switching from one provider to another (OECD 2011), they nevertheless appear to have valued being involved in decisions about their long-term care, especially when also required to pay significant private costs. [31]

Australia is one country that is proceeding with the introduction of vouchers or care credits, particularly in the home care sector. For example, as of February 2017, citizens in that country will be able to receive funding directly to choose the home care package of their choice.[32] While Australia is undertaking greater consumer directed care models in home care it is still reviewing their use in residential care. One recent study from the UK, for example, shows that an experiment to introduce vouchers into residential care in that country has had limited success, after pilots showed poor uptake among seniors. In that case the British government offered 20 local authorities the option to participate in the pilots, whereby funding that would normally go to the care home went instead to the resident as a direct payment. The pilots initially saw direct payments being offered to

[28] Long-Term Care for the Elderly: Challenges and Policy Options. CD Howe Institute. Commentary 367. Ake Blomqvist and Colin Busby. November 2012.
[29] Ibid.
[30] Ibid.
[31] Ibid
[32] Australian Government: Department of Health. Consumer Directed Care Fact Sheet. October 14, 2016. Accessed at: https://agedcare.health.gov.au/programs/home-care/consumer-directed-care.

existing residents, who may have been living in the facilities for years although the majority declined to partake feeling it would change their relationship with their provider.[33]

Although there are some potential benefits of vouchers (or care credits), they do have possible drawbacks. One concern is that providers will seek out clients with low-care needs relative to costs (i.e. the cream-skimming problem familiar from private health insurance). Another concern is the increased difficulty of governments to exercise a high level of control over their annual health budgets. Furthermore, under a voucher or care credit system, providers could increase the prices of their services knowing that the government subsidizes the cost for the individuals with the lowest ability to pay. A final potential weakness of a voucher system is that the size of the voucher, or public subsidy, needs to change over time with a client's needs. [34]

As noted by authors Blomqvist and Busby, establishing a new comprehensive self-directed model such as the use of a voucher system would require the following: an assessment system; means testing; a funding mechanism that is based on need but controls government costs; an oversight system to ensure quality and enforce restrictions on use; and establish who will oversee, coordinate and be accountable for care. [35]

Pros	Cons
• Vouchers (or care credits) are intended to be more reactive to clients' needs by enhancing the ability of people to stay in their homes rather than in residential care homes for as long as possible. • Increases client satisfaction, as well as gives clients a greater choice and say over their path of care. • More choice for clients and competition among providers could lead to efficiency gains in the system and promote independence. • Has been implemented with relative success in other jurisdictions (i.e. Nordic countries, France, Germany, etc.).	• Not clear as to whether efficiency gains have materialized. • Administrative costs to implement a voucher system, including adjusting the size of the voucher, or public subsidy, to change over time with a client's needs. • Under such system, providers may seek out clients with low-care needs relative to costs (i.e. cream-skimming). • Could decrease governments ability to exercise a high level of control over their annual health budgets. • Providers could increase the prices of their services knowing that the government subsidizes the cost for the individuals with the lowest ability to pay. • Unclear whether financial institutions will provide funding for capital development within the residential care sector based on projected public expenditures through a voucher system.

Based on available information, the use of vouchers or care credits should be explored further for adoption. Mitigating drawbacks such as cream skimming and increasing prices for services will also need to be looked at further if such a model of funding is adopted on a wide scale.

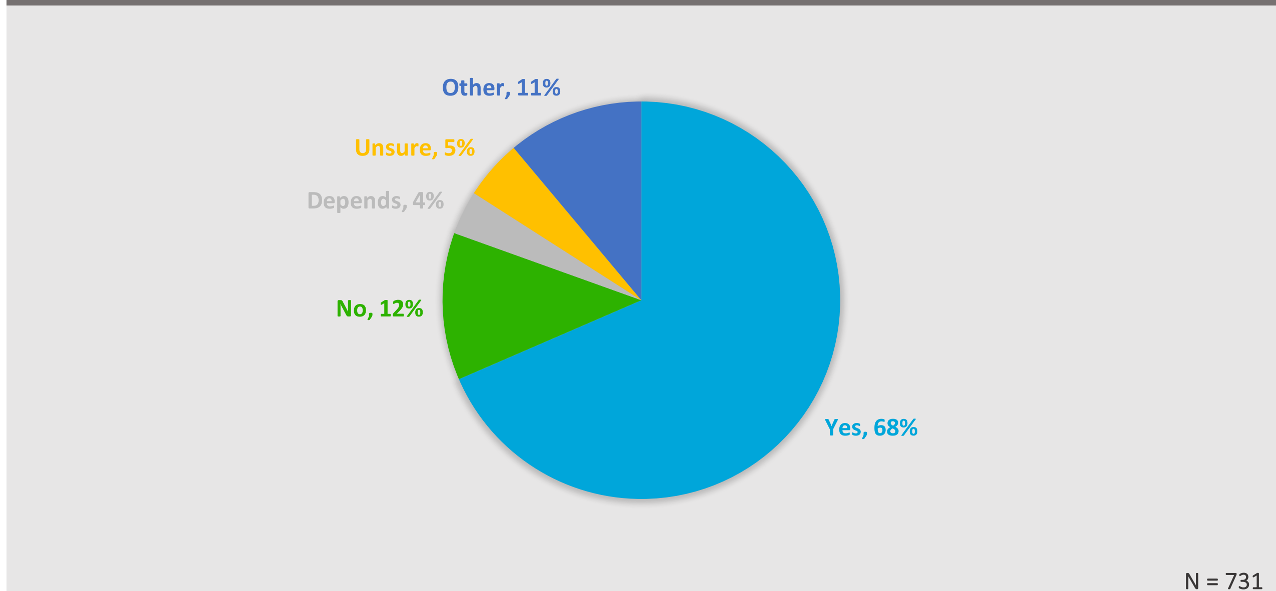
[33] Challenges of CDC in residential emerge in UK pilots. Australian Ageing Agenda News. Darragh O'Keeffe. July 8, 2016. Accessed at: http://www.australianageingagenda.com.au/2016/07/08/challenges-cdc-residential-emerge-uk-pilots/

[34] Long-Term Care for the Elderly: Challenges and Policy Options. CD Howe Institute. Commentary 367. Ake Blomqvist and Colin Busby. November 2012.

[35] CD Howe Institute. Commentary No. 443. Ake Blomqvist and Colin Busby. Shifting Towards Autonomy: A Continuing Care Model for Canada.

As part of the White Paper survey respondents were asked if they would support the use of vouchers or care credits for seniors to purchase directly continuing care support services. As outlined in the following figure below the proposal received good support, with 68% indicating support, and an additional 4 percent indicating depends. While 12 percent of respondents did not support this proposal, an additional 5% were unsure and 11% provided responses that could not be categorized as yes, no, unsure, or depends. Similar support was also seen at the BCCPA Inaugural Continuing Care Collaborative event with over 70% support.

Figure 8: Do you think seniors should be able to choose their own Residential Care or Home Support Provider through the allocation of "Care Credits" - i.e. a government subsidized voucher for seniors care services?



Based on the above results from the consultation process and as outlined in *Strengthening Seniors Care: A Made-in-BC Roadmap*, the BCCPA recommends the BC government allocate up to $2 million per year to launch a new Care Credits program which provides seniors [or the family members that care for them] the option to select the service provider of their choice. In particular, a Care Credit or Personal Directed Care model should be introduced initially in the home care sector as well as to a study including possible pilot project on their potential use in residential care.

The study should also analyze best practices from Community Living B.C. (CLBC) which offers their clients direct opportunities to select the care provider of their choice. CLBC's Individualized Funding program assists people with disabilities to participate in activities and live in their community by allowing individuals (and their families) to access services from a provider of their choice.[36] CLBC provides two different options to manage funds. In the first option, the client and an identified agent (e.g. a chosen friend, family member or other representative who can act responsibility) manage the funds direct, pay the employees, and report to CLBC on how they spend the money. The second option is to work with a Host Agency that has been approved by CLBC to administer the

[36] The program operates through a five-step process. Once eligibility for the program is confirmed, individualized funding is allocated based on the client's assessed need and the estimated costs of the supports required. CLBC then works with the client to identify, review, and then finally select a qualified service provider based on the person's preferences. Finally, CLBC works with the client and providers to arrange services and to create a contract that ensures quality standards and reasonable costs.

money; this option gives the client the benefits of Individualized Funding, but with fewer paperwork and record-keeping responsibilities.[37]

RECOMMENDATION ***Immediate: 1 to 2 years***

- That the BC government introduce a Care Credit or Personal Directed Care model in the home care sector and undertake a study including possible pilot project on their potential use in residential care. The study should analyze best practices from Community Living B.C. which offers their clients direct opportunities to select the care provider of their choice.

Activity Based Funding for Home and Community Care

Recently we have seen examples where jurisdictions are attempting to change the way they fund the provision of home and community care services. Alberta Health Services, for example, is changing the way it allocates money to long-term care operators around the province where funds are distributed based on a new formula that calculates the needs of each resident and provides a standard funding amount to the care provider.[38] Studies, however, have shown serious concerns with this model.[39]

In Alberta, the former long term care (LTC) funding system was similar to that of global budgeting for hospital care. The strengths of this system are its budgetary predictability and the ability to control costs, but as noted in the literature, it fails to create any financial incentives for providers to increase volume or to transition residents to less intense care when appropriate.[40]

To try and overcome the limitations of global budgeting, Alberta and Ontario recently announced plans to implement activity-based funding (ABF) for long term care in their respective provinces. In Australia and the United States, ABF has also been implemented as a basis for remunerating long-term care or nursing homes, as well as skilled nursing facilities and inpatient rehabilitation.

As outlined in a document from Alberta Health Services (AHS), ABF is a method used by funders to pay for desired health services. It is an output based allocation method that classifies residents/patients by clinical acuity and resource use, thus attempting to enable consistent and appropriate funding. ABF provides funding based on care provided to residents/patients as opposed to funding a specific type of bed. The key objective of ABF is to align incentives within the health system so that most appropriate services are delivered for the most efficient funding levels. There are two key aspects of ABF: 1) Grouping residents/patients of similar clinical acuity and resource consumption and 2) Quantifying resource use of these groups.[41] As noted by AHS, the key objectives of ABF model include:

- Achieve equity in funding allocation by focusing on the equitable access and quality of services for residents with similar needs;

[37] Community Living BC, Individualized Funding, CLBC Fact Sheet. Accessed at: http://www.communitylivingbc.ca/wp-content/uploads/Individualized-Funding-Fact-Sheet.pdf

[38] Long-term-care centres brace for cuts under new funding model By Tamara Gignac and Bryan Weismiller, Calgary Herald March 5, 2013. Accessed at: http://www.calgaryherald.com/health/Long+term+care+centres+brace+cuts+under+funding+model/8054364/story.html

[39] The Alberta Health Services Patient/Care– Based Funding Model for Long Term Care: A Review and Analysis. UBC Centre of Health Services and Policy Research. Jason Sutherland, Nadya Repin and Trafford Crump. September 2012. Accessed at: http://www.albertahealthservices.ca/Publications/ahs-pub-ltc-pcbf.pdf

[40] Long Term Care Funding. UBC Centre for Health Services and Policy Research (CHSPR) accessed at: http://healthcarefunding.ca/activity-based-funding/long-term-care/

[41] Patient/Care-Based Funding Long Term Care: User Summary. May 2013. Alberta Health Services. Accessed at: http://www.albertahealthservices.ca/hp/if-hp-in-ltc-user-summary.pdf. In this document, AHS refers to Activity Based Funding as Patient/Care Based-Funding.

- Support consistency in access to care, standards of care, and the amounts paid for care for residents with similar care needs;
- Provide transparent, predictable funding consistent with the quantity, complexity and quality of the services needed by residents;
- Enhance funding predictability for residents, operators, decision-makers and other stakeholders; and
- Provide incentives for improving efficiency and quality in LTC service delivery.[42]

As the use of ABF or resident focused funding for long-term care is relatively new in Alberta it is not clear what impact it has had on the provision of care for the elderly. To date, the results outlined in the literature seem to be mixed. For example, according to one analysis, ABF in the United States seems to have adversely effected cost-efficiency in long-term care and the evidence regarding its impact on the quality of care are mixed (Grabowski 2001; Zinn et al 2008). The reduction in cost-efficiency is related to an increase in administrative nursing costs (of approximately 4%).[43]

In some for-profit long-term care homes, a reduction in nurse staffing levels has also been observed (Starkey et al 2005); this is a concern given the finding of a positive relationship between staffing levels and quality of care (Castle et al 2007; Briesacher et al 2009). For example, ABF has been associated with a reduction in rehabilitative services, and the observed association was stronger in private care homes. Despite this, there is some evidence to suggest that more intense competition between care homes is associated with higher scores on quality measures (Liu et al 2003; Schlenker et al 2005; CIHI 2007).[44]

Recently some concerns were expressed about Alberta's activity based funding approach in long-term care, including that one-third of the province's nursing homes were unintentionally inflating their assessments of resident needs and receiving extra funding according to audits by the province's health authority. In particular, according to the audit of the 81 that were reviewed (170 in total), only one care home was found to be "under-coding" the care residents required, while 28 others were "over-coding" resident needs. Of the nursing homes found to have problems, 17 were operated by AHS, six were non-profits, and six were privately owned.[45]

> *"...one-third of Alberta's nursing homes were unintentionally inflating their assessments of resident needs and receiving extra funding according to audits by the province's health authority."*

While the use of activity based funding for home and community care fits well with BC's emphasis on innovative funding,[46] it may be prudent at this point to evaluate the results of Alberta's experience with ABF in continuing care before proceeding in that direction. A summary of the pros and cons with respect to this funding model are outlined in the table below.

Pros	Cons
• Provides greater financial incentives for providers to increase volume or transition	• Use of global funding provides greater budgetary predictability and potential ability to control costs.

[42] Ibid.
[43] Long Term Care Funding. UBC Centre for Health Services and Policy Research (CHSPR) accessed at: http://healthcarefunding.ca/activity-based-funding/long-term-care/
[44] Ibid.
[45] One-third of nursing homes "over-coding" to get bigger share of $930M pie. Matt McClure, Calgary Herald. December 12, 2014. Accessed at: http://calgaryherald.com/news/politics/one-third-of-nursing-homes-over-coding-to-get-bigger-share-of-930m-pie
[46] BC launches patient-focused funding province wide. April 12, 2010. Accessed at: http://www2.news.gov.bc.ca/news_releases_2009-2013/2010HSERV0020-000403.htm

residents/patients to less intense care when appropriate. • Use of activity based funding for long-term care fits well with BC's emphasis and innovations in resident/patient focused funding, particularly for hospital care.	• Not clear what impact it has had on the provision of care for the elderly. To date as outlined in the literature the results seem to be mixed. • Could result in deliberate or unintentional under coding or over coding of residents/patients. • Has resulted in reductions nurse staffing levels in some cases. • Could create excessive administrative burdens and red-tape.

Outcome-Based Funding

> "... *the BCCPA believes that government should undertake a comprehensive review of the lessons learned in the use of patient/resident and outcome based funding... to date, for example, these initiatives have been less than positive.*"

In the continuing care sector, outcome based or performance based funding is not widely used. Outcome or performance based funding is incentive based funding for service providers where they must reach pre-determined outcomes on a quality or performance scale to receive extra or bonus compensation.[47] The idea behind outcome based funding is to reward providers through performance and quality benchmarks that correlate to higher quality of care within the sector. The model measures quality of care based off a points system where care providers can gain points by achieving various indicators including access to care, efficiency, and client satisfaction.[48]

The Vancouver Coastal Health Authority has experimented with an outcome or performance based funding model in homecare, through implementing the Accountability, Responsiveness, and Quality for Clients Model of Home Support (ARQ Model). The ARQ model integrates cluster care in high-density neighborhoods/buildings with performance based funding off measurable outcomes.[49] Essentially, cluster care seeks to provide consistent care using a single home support team in neighborhood/building areas where client needs are fluctuating, and by shifting from traditional hour-based funding to block funding.[50]

By focusing on performance management as opposed to just hourly wages, VCH hopes to improve client satisfaction with their homecare by ensuring high quality services through accurate reporting on performance, and creating joint performance requirements with VCH and contracted homecare providers.[51] Evaluation of the ARQ model found higher efficiency in care due to clients being clustered in close proximity to each other, appropriate matching between the client and caregiver abilities, and higher levels of client satisfaction.[52] As outlined later, the BCCPA will be looking further at this model including its challenges in a separate paper it will be developing on home support.

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[47] University of British Columbia. "Glossary", accessed at: http://healthcarefunding.sites.olt.ubc.ca/glossary/

[48] Yan, C., Riechers, J., & Chuck, A. (2009) "Financial Incentives to Physician Practices: A literature review of evaluations of physician remuneration models". Institute of Health Economics, Alberta Canada. Accessed at: http://www.ihe.ca/publications/financial-incentives-to-physician-practices-a-literature-review-of-evaluations-of-physician-remuneration-models

[49] KPMG (2008). "Central LHIN Health Service Needs Assessment and Gap Analysis. Appendix Q: Jurisdictional review". Slide 16.

[50] Sutherland, J., Repin, N., Crum, R. (2008). "Reviewing the Potential Roles of Financial Incentives for Funding Healthcare in Canada". *Canadian Foundation for Healthcare Improvement.* Accessed at: http://www.cfhi-fcass.ca/Libraries/Reports/Reviewing-Financial-Incentives-Sutherland-E.sflb.ashx

[51] Vancouver Coastal Health. "A Model for Improved Home Support in Vancouver". Accessed at: http://www.crncc.ca/knowledge/related_reports/pdf/AModelforImprovedHomeSupportinVancouver.pdf

[52] University of British Columbia. "Evidence and Perspective on Funding Healthcare in Canada". Accessed at: http://healthcarefunding.ca/home-care/

In 2011/12, Alberta Health Services also experimented with a Pay for Performance (P4P) model within long-term care, making a 0.2% funding lift available to government owned and operated providers who exceeded five specific quality metrics. Within this model, providers expressed that there could be links between funding and quality and that the funding lift percentage combined with the quality metrics could enable higher quality of care. However, some providers expressed that the lag between payment and the activity occurring was too long, as well as some of the quality metrics being unreasonably difficult to reach.[53]

Other jurisdictions including Nova Scotia are also looking very closely at outcome or performance based funding. In July 2015, for example, Nova Scotia released its *Continuing Care – A Path to 2017* document outlining a path forward for long-term care, home care, and related services.[54] As outlined in the report implementing performance-based contracts for long-term and home-care providers, with key performance indicators and targets to measure and monitor access, efficiency, and outcomes, will help to create a more accountable, sustainable system.[55]

Overall, the BCCPA believes that government should undertake a comprehensive review of the lessons learned in the use of patient/resident and outcome based funding for provision of home and community care, particularly reviewing any outcomes and/or results from Alberta and Ontario's experimentation with the initiatives. To date, for example, these initiatives have been less then positive and, in some cases, have had unintended consequences such as inappropriate coding, as well as resulting in differing levels of care across a particular jurisdiction.

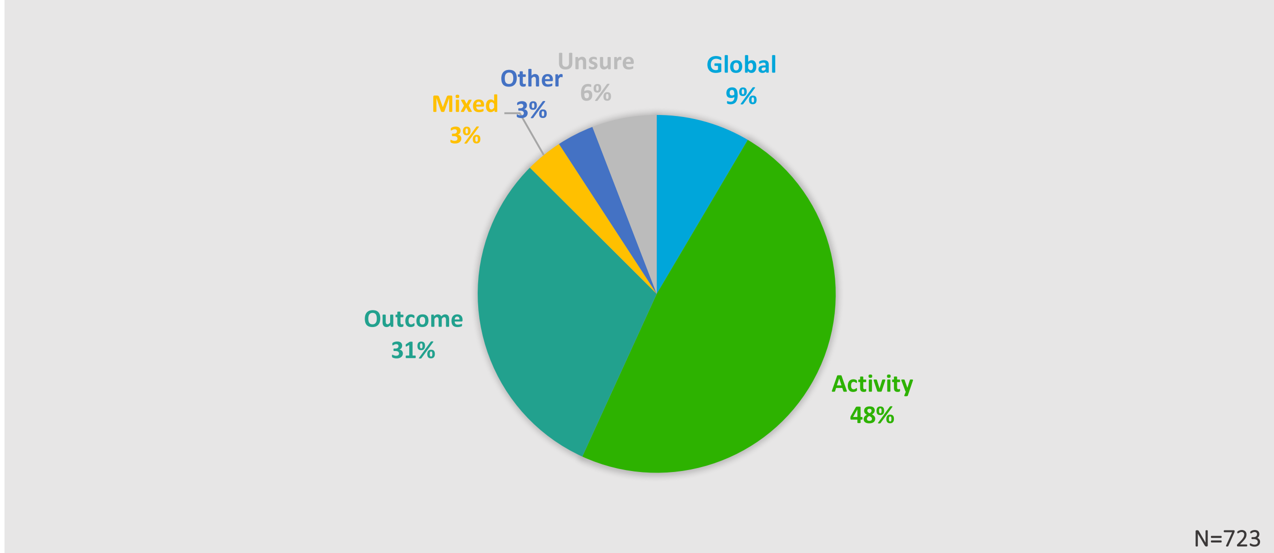
In the survey on the earlier BCCPA White Papers, respondents were also asked to indicate what they believe to the most appropriate funding mechanism for seniors' care operators: global funding, activity-based funding, outcome-based funding, or another option not listed. As outlined in the figure below, almost half of survey respondents (48%) indicated that they believed that funding for care should be provided based on the actual activities and services that care operators are providing (i.e. activity based funding). An additional thirty percent indicated that they would support Outcome Based Funding. Only 9% of respondents indicated that they support the status quo – Global Funding. While not an option outlined in the survey, 3% of survey respondents indicated that they felt that funding should be based on a mix of outcome and activity based funding, as well as considering the acuity of the population that they are serving.

[53] Sutherland J., Repin, N., Crump, R. (2013) "The Alberta Health Services Patient/Care– Based Funding Model for Long Term Care: A Review and Analysis". University of British Columbia. Accessed at: http://www.albertahealthservices.ca/Publications/ahs-pub-ltc-pcbf.pdf

[54] Nova Scotia Health and Wellness. Nova Scotia Government Seeks Input on Continuing Care Plan. July 30, 2015. Accessed at http://novascotia.ca/News/Release/?id=20150730002

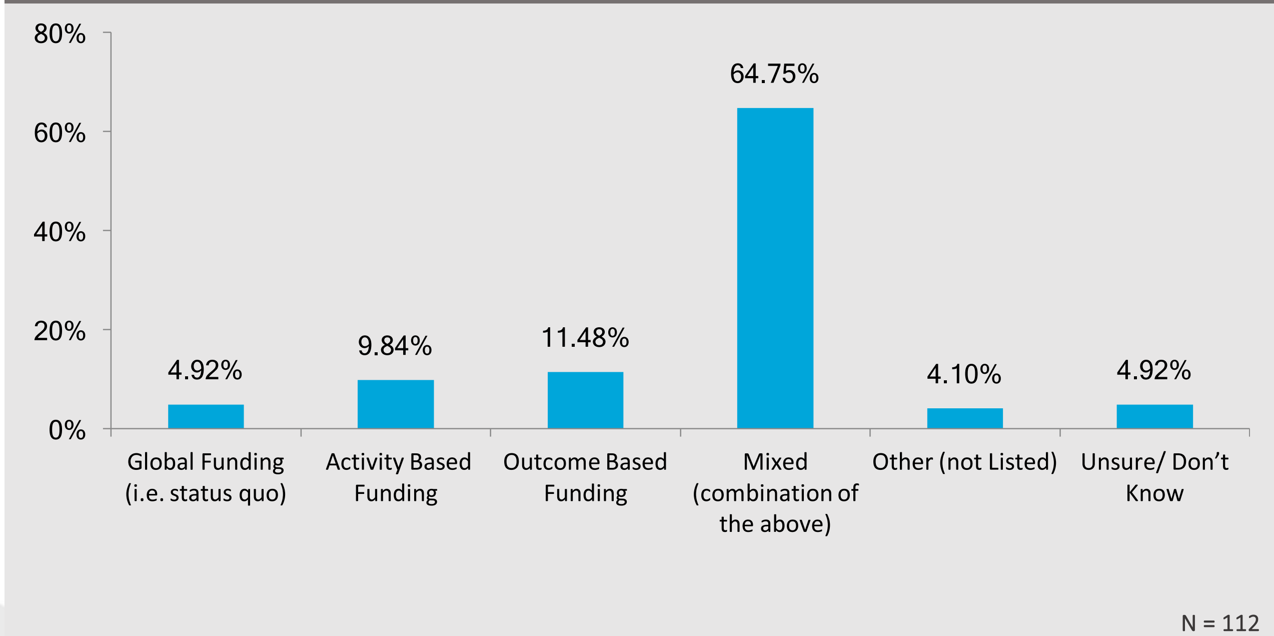
[55] Continuing Care – A Path to 2017. Nova Scotia Government. Accessed at: http://novascotia.ca/dhw/continuingcarerefresh/DHW-ContinuingCare-en.pdf

Figure 9: Please indicate the statement that best reflects your opinion regarding how seniors care should be funded in British Columbia.



While the results of the public survey seemed to indicate greater use of outcome or activity based funding, the results from the BC Continuing Care Collaborative (see Appendix E) seemed to prefer a mixed approach with almost two thirds favoring this over purely outcome, global or activity based funding.

Figure 10: What do you think is the optimal funding approach for continuing care? (Multiple Choice)



RECOMMENDATION: ***Medium term: 3 to 5 years***

- That the BC Ministry of Health undertake a comprehensive review of the outcomes and lessons learned in the use of activity and outcome-based funding for provision of home and community care, particularly reviewing any results from Alberta and Ontario's experimentation with these initiatives.

Reviewing Existing Co-Payments for Residential Care

In BC under residential care arrangements, seniors pay up to 80% of their after-tax income on a monthly basis to cover the cost of housing and hospitality services including meals, routine laundry and housekeeping, subject to a minimum and maximum monthly rate. As of 2016, the maximum monthly rate for a client receiving family care home or residential care services is $3,198.50 per month. The maximum client rate is also adjusted annually based on changes to Consumer Price Index.[56] Similarly, publicly subsidized Assisted Living residents pay a maximum of 70 per cent of their after-tax income (unless that figure exceeds the actual cost of the service).[57]

As noted in a recent report from the Conference Board of Canada, although the maximum monthly rate that British Columbia's long term care homes can charge residents is over $3,000, the average resident pays considerably less. In BC, less than ten per cent of seniors in residential care pay the maximum amount. In particular, the average resident in 2012 only paid around $1,200, which represented 23 per cent of the actual cost that year. Like BC, most of the overall long term care funding in Canada comes from public sources. As the following table below summarizes, in no province in 2012 did the average resident pay more than a quarter of average long term care (LTC) operational costs (see Table 3).[58]

> “*…although the maximum monthly rate that British Columbia's long term care homes can charge residents is over $3,000, the average resident pays considerably less.*”

Table 3: LTC Cost Structure and Percentage Covered by Resident, Averages, by Province, 2012

	Annual cost to resident ($)	Monthly cost to resident ($)	Actual total annual cost per resident ($)	Actual total monthly cost per resident ($)	Cost covered by resident %
B.C.	15,337	1,278	66,531	5,544	23
Alta.	11,552	963	60,791	5,066	19
Sask.	13,965	1,164	97,543	8,129	14
Man.	13,138	1,095	69,634	5,803	19
Ont.	16,002	1,334	66,022	5,502	24
Que.	N/A	N/A	N/A	N/A	N/A

[56] In each province, including BC, minimum private care home-based costs are closely integrated with the federal public income-support system for seniors. For single individuals and couples, minimum care home fees are set according to Old Age Security (OAS) and Guaranteed Income Supplement (GIS) maximum monthly payments. Each individual living in a residential care home is also entitled to a minimum monthly allowance for personal expenses. Those with incomes greater than basic OAS/GIS levels face a claw back of their subsidy (i.e. must pay higher long-term care fees, up to a specified maximum). In most jurisdictions, the claw back rate is 100%.

[57] Ombudsperson Report. The Best of Care: Getting It Right for Seniors in British Columbia (Part 1) - Public Report No. 47. Accessed at: https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2047%20The%20Best%20of%20Care-%20Volume%201.pdf

[58] Understanding Health and Social Services for Seniors in Canada. Conference Board of Canada. David Verbeeten, Philip Astles, and Gabriela Prada. April 2015.

N.B.	11,598	967	76,713	6,393	15
P.E.I.	14,497	1,208	72,590	6,049	20
N.S.	15,766	1,314	72,703	6,059	22
N.L.	11,635	970	70,832	5,903	16
TE[1]	8,254	688	116,822	9,735	7

1 TE = Territories. Information was not available for individual territories. Sources: The Conference Board of Canada; Statistics Canada.

In summary, the BCCPA believes co-payments for home and community care should be explored further including potentially to ensure that they better reflect the actual costs of delivering care and a resident's / client's ability to pay. One such alternative could be to get rid of the co-payment cap and, thus, require people to pay closer to the full costs of care. For example, one potential proposal is that those with incomes over the projected total costs of residential care in BC (i.e. $66,500) could have their income clawed back at a rate of up to 100% until threshold is met. For incomes below amount, the thresholds could be lower. As is currently the case, a certain amount could also be left over each month for personal expenses (i.e. similar to $325 that is left over for very low income seniors). Additionally, different rates for private versus shared rooms could also be considered.

Table 4: Provincial Co-Payment Rates

Province	Co-payment per day
NB	$107.00
NS	$102.50
BC	$100.57
NL	$92.05
MB	$79.20
PEI	$77.60
SK	$64.57
ON	$48.15
AB	$48.15
QC	$36.10

Source: BUILDING resident-centered long-term care, now and for THE FUTURE. OLTCA. January 2015. Ontario Long Term Care Association Pre-Budget Submission to the Ontario Government 2015/2016

Along with generating additional revenue and better reflecting an individual's ability to pay for residential care, one other advantage of such a proposal is that it could assist with creating more demand for additional private pay beds. As most of the continuing care system costs are currently publicly subsidized, including for seniors with higher incomes, there is less demand for private pay beds. If co-payments for publicly subsidized beds increased there would likely be a greater market for private pay beds including additional capital stock of beds created as individuals who otherwise would have went to publicly subsidized beds would opt to go to private-pay beds instead.

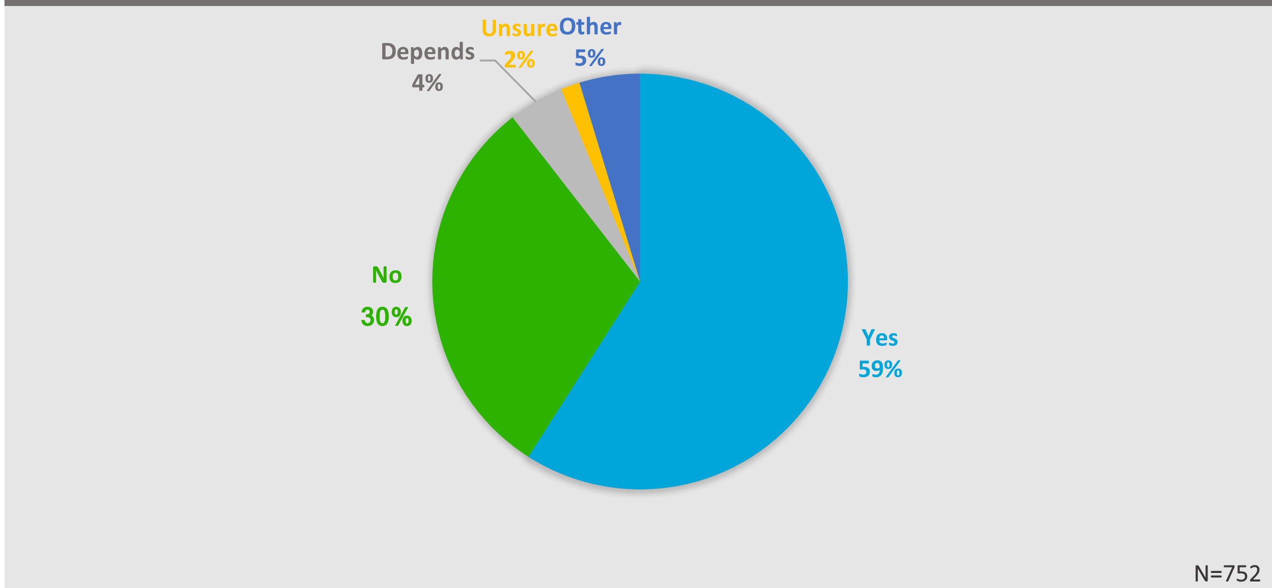
Any changes or review of co-payments should, however, ensure that it does not have any unintended consequences which negatively impact the financial situation of seniors. In particular, seniors with lower incomes should be protected. As outlined earlier, the provincial government does not pay the full cost of residential care and generally requires residents to pay most of their 'room and board' expenses. The government sets the amount residents must pay through co-payments. Like other provinces, the BC government has been increasing resident co-payments annually largely based on CPI. Actual co-payment rates vary by province, with BC already having among the highest maximum rates in Canada (see table 4).

Along with potentially removing the cap for co-payments to residential care, another option could be to look at implementing a total cap for all payments that an individual could pay. The UK, for example, recently announced changes to its funding for elderly care, including introducing a cap in April 2016 on total costs an individual can pay for long-term care at £72,000 over their lifetime.

Overall, there also seems to be public support with removing the cap on co-payments. As outlined in the survey on the White Papers respondents were asked to provide their opinion regarding the level of resident co-

payments for residential care, and whether they would support increasing the maximum co-payment to better reflect an individual's ability to pay. This proposal received moderate support, with sixty percent indicating support for this change. An additional 4 percent indicated that they may support such an initiative, depending on how it is implemented; while many indicated that their support would depend on how 'higher incomes' are defined, and if there is some protection for a spouse or other dependent still living in the family home. Just over 30 percent of survey respondents indicated that would not support such an initiative, and 2% were unsure.[59]

Figure 11: Currently the market cost to deliver residential care, including housing and health services, in BC is approximately $7,000 per month...Do you think the maximum fee should be increased so that British Columbians with higher incomes pay a greater percentage of the cost of their care?



RECOMMENDATION: ***Medium term: 3 to 5 years***

- That the BC government review existing co-payments for continuing care to ensure that they better reflect actual costs of delivering care and a resident's/client's ability to pay, while ensuring seniors with lower incomes are protected.

Long-Term Care Insurance

One approach to meet future financing needs for continuing care is long-term care insurance, which is currently very limited in Canada. Long-term care (LTC) insurance is a relatively new product (since about the early 1980's), with policies only beginning to mature in measurable numbers. Long-term care insurance provides policy holders with coverage for a set period of time (e.g. 150 weeks) to cover home and community care expenses (including residential care, as well as home care and support). Individual policy features, however, can vary significantly.

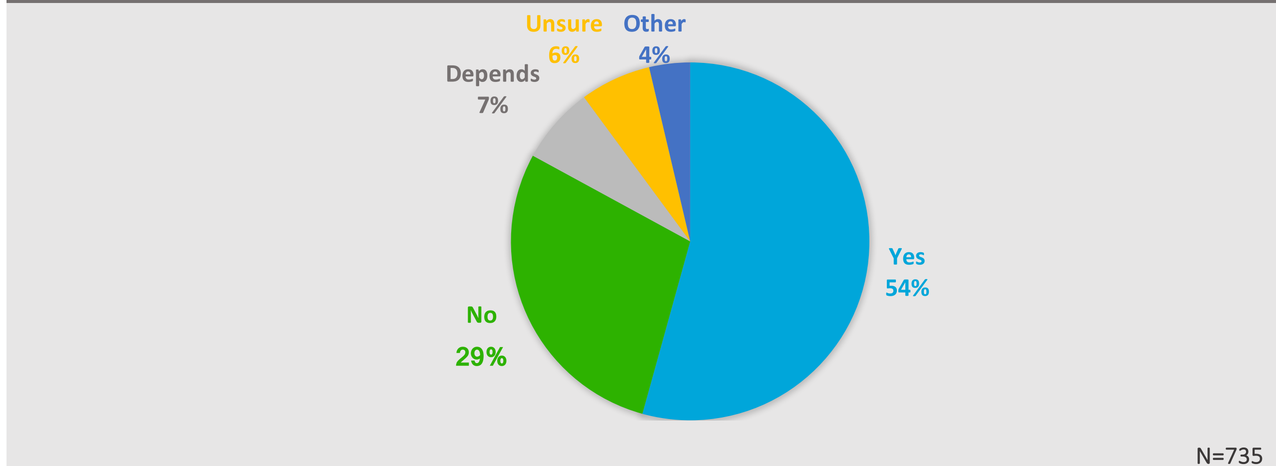
[59] 115 responses were provided as comments, which were coded as yes, no, depends, unsure, or other depending on the contents of the comment. Analysis of the survey responses indicate that respondents have a low level of understanding of how co-payments for residential care are determined, and how eligibility for public subsidies are calculated – with many indicating a mistaken belief that those with higher incomes are disqualified for publicly-subsidized care.

A report from the Institute for Research on Public Policy (IRPP) notes that relying on private savings is not an efficient way for individuals to provide for their potential future care needs, as they are likely to save too much or too little. The IRRP report recommends governments adopt a universal public insurance plan that provides full coverage based on a standard evaluation of care needs in order to reduce uncertainty for aging Canadians and be more equitable. [60]

An earlier Quebec government had proposed creating Autonomy Insurance, which would provide home care services through a protected funding mechanism that optimizes resource allocation. The insurance would be available to seniors with functional or cognitive loss of autonomy, adults with physical disabilities, and adults with intellectual disabilities. The insurance would be funded through the annual government amount available for long-term services, user fees, and fiscal expenditures equal to Quebec's Tax Credit for Home-Support Services for Seniors.

As part of the survey on the White Papers respondents were asked whether they believe that Canada should establish a new mandatory long-term care insurance plan to help cover the costs of seniors care. Only 54% of survey respondents indicated support for such an initiative, with an additional 7% indicating depends. Of those indicating support, many where concerned about how such a program would be financed (e.g. through general tax dollars, or a program like EI).

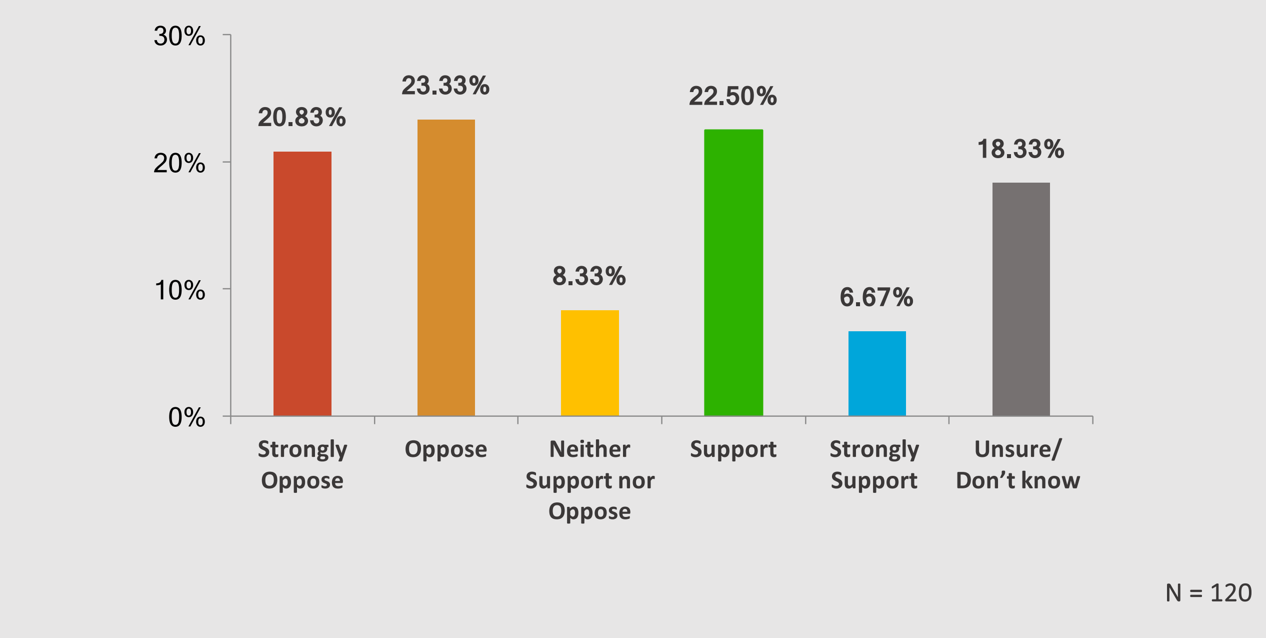
Figure 12: Do you think Canada should establish a new mandatory Long-Term Care Insurance plan to help cover the costs of seniors care?



While there was modest support in the public survey for long term care insurance, at the BCCPA Wosk event the support was even more tepid (see Appendix E). In particular, when participants were asked whether they would support establishing a new mandatory Long-Term Care Insurance to help cover the costs of seniors care, less then 30% indicated support.

[60] Ibid.

Figure 13: Based on what you know, would you support or oppose Canada establishing a new mandatory Long-Term Care Insurance to help cover the costs of seniors care? (Multiple Choice)



SECTION 3: NEW CONTINUING CARE MODELS

One of the major focuses of the White Papers, particularly Part II was the need to develop new care models to better meet the needs of an aging population, particularly for the chronically ill, frail elderly and those with dementia. A summary of the reasons for exploring new continuing care models are outlined below.

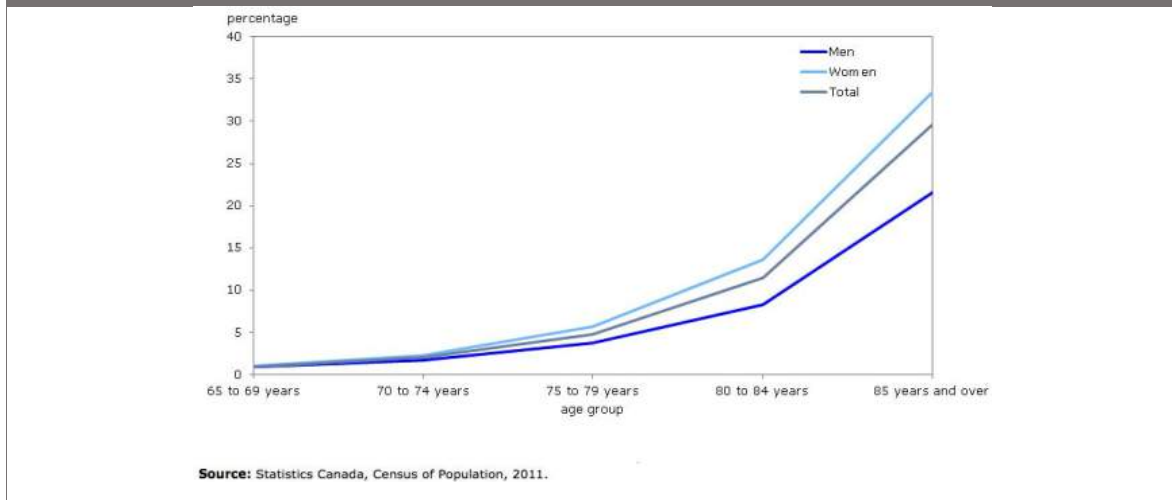
Improved Access and Allowing Seniors to Live in most Appropriate Care Setting

One of the major reasons for establishing new continuing care models is to improve access to care, as well as allowing seniors the opportunity to live in the most appropriate care setting. One of the priorities outlined by the Ministry of Health, for example, is to allow more seniors to live at home whether this is in a single-family residence or apartment, assisted living or residential care. As noted by the BC Seniors Advocate, the vast majority of seniors in BC are living independently (93%), including approximately 90% who own their own home. In total, less than 2% of seniors in BC live in provincially subsidized Assisted Living (AL) setting, while about 4% live in residential care.

DID YOU KNOW: As noted by the BC Seniors Advocate, the vast majority of seniors in BC are living independently (93%), including approximately 90% who own their own home. In total, less than 2% of seniors in BC live in provincially subsidized Assisted Living (AL) setting, while about 4% live in residential care.

The figures with regards to residential care, however, are higher among older age populations, including 9% of those over 75 and about 15% of those over 85.[61] In particular, the demand for residential care will increase significantly in the future because the proportion of seniors living in care homes increases with age and the number of elderly seniors will grow as the aging of the population accelerates. As Figure 14 below shows, about 1% of people between the age of 65 and 69 live in residential care homes in Canada, while the largest age group living in care-homes is 85 and older at 29.6%.[62]

Figure 14: Percentage of Canadian seniors living in Residential Care (by Age Group)



[61] Seniors' Housing in BC: Affordable, Appropriate, Available. BC Office of the Seniors Advocate. May 2015. Accessed at: https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2015/05/Seniors-Housing-in-B.C.-Affordable-Appropriate-Available.pdf

[62] A Policy Framework to Guide a National Seniors Strategy for Canada. CMA. August 2015. Accessed at: https://www.cma.ca/Assets/assets-library/document/en/about-us/gc2015/policy-framework-to-guide-seniors_en.pdf

> *While the new continuing models outlined later in this paper are envisioned to care primarily for the current and future seniors in residential care, they could also provide care (i.e. sub-acute, etc.) for seniors living in the larger community -…*

While the new continuing models outlined later in this paper are envisioned to care primarily for the current and future seniors in residential care, they could also provide care (i.e. sub-acute, etc.) for seniors living in the larger community - particularly the vast majority of seniors who live in their home whether this be a single-family residence or apartment.

Along with providing a wide array of care services for seniors, the new Continuing Care Hubs with appropriate funding, would also increase the ability of the health authorities to provide residential care beds closer to the senior's former single family home / apartment when they need it. This includes for example the provision of short term or temporary residential care beds, sub-acute beds as well as end-of-life and respite beds.

One focus of the new Continuing Care Hubs could also be the provision of respite care including for frail seniors. Respite care is the provision of short-term and/or temporary relief to those who are caring for family members or loved ones who might otherwise require permanent placement in residential care outside the home. Respite beds allow seniors to leave home and stay in a care home for up to 30 days in a one-year period. A typical residential care home may allocate a small percentage of total beds to short-term respite care and may decrease the number of short-term beds if additional beds are needed to provide long-term residential care. As outlined in one report, the level of demand for residential care based respite in British Columbia is quite high compared to most jurisdictions.[63] In a 2015 report entitled *Caregivers in Distress: More Respite Needed*, the BC OSA notes that the number of respite beds in BC fell by 12% between 2012 and 2015.

Along with increasing access to services and beds for seniors to allow them to live in the most appropriate care setting, new LTC models, particularly the Continuing Care Hub outlined later in this paper, will also assist increasing choice for seniors utilizing the current BC "First Appropriate Bed" (FAB) policy. Under this policy adopted by all the health authorities, a senior who has been assessed as ready for a move to residential care must accept the first appropriate bed that becomes available in their chosen geographic catchment area. They have 48 hours to accept and move to the bed offered, or risk being removed from the priority list for a FAB. The FAB policy is designed to ensure that those who are the most in need of a residential care home bed secure that bed as quickly as possible.[64]

A 2015 Seniors Advocate report highlights the discrepancy between average wait times and median wait times, showcasing the fact that some people are waiting a very long time for a residential care FAB. [65] In particular, wait times for placement are greater in the north than in the Lower Mainland and are greatest for those who require highly specialized care such as a secure dementia unit.[66] In a December 2016 OSA report it also highlights that wait times for residential care are getting longer. In particular, it notes that the average and median wait times for residential care grew longer in three of five regional health authorities and the proportion of residents admitted to residential care within the target window of 30 days decreased from 64% in 2014/15 to

[63] Respite for Family Caregivers: An Environmental Scan of Publicly-funded Programs in Canada". Prepared for Health Canada by Janet Dunbrack. February 2003.http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2003-respite-releve/2003-respite-releve-eng.pdf

[64] British Columbia. Ministry of Health. (2014). Home and community care: Policy manual. Victoria: Ministry of Health. Retrieved from http://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/hcc-policy-manual/6_hcc_policy_manual_chapter_6.pdf

[65] Seniors' Housing in BC: Affordable, Appropriate, Available. BC Office of the Seniors Advocate. May 2015. Accessed at: https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2015/05/Seniors-Housing-in-B.C.-Affordable-Appropriate-Available.pdf

[66] As outlined in the Seniors Advocate Affordable, Appropriate, Available report: 67% of clients move to a FAB within 30 days; this ranges from a high of 80% in Vancouver Coastal to a low of 27% in Northern Health Authority; the average length of time waiting for residential care is 36 days and this ranges from a low of 25 days in Vancouver Coastal to a high of 122 days in Northern; the median waiting time is 15 days ranging from a low of 9 days in Vancouver Coastal to 96 days in Northern; seniors get their preferred bed at time of the FAB move anywhere from 23% to 45% of the time; seniors get to their preferred bed after moving to a FAB anywhere from 4% to 22% of the time; and overall, residents end up in their facility of choice anywhere from 34% to 67% of the time.

57% in 2015/16).[67] The BCCPA believes that adopting new models, such as the Continuing Care Hub discussed later, will not only improve access to residential care and services for seniors in the community, but will also increase choice for seniors utilizing the current FAB policy.

Dealing with Higher Levels of Acuity

Overall, there are a number of reasons why it is crucial to explore the development of new LTC models. The first is to deal with the increasing levels of acuity within the continuing care sector. Like BC, and as outlined in a 2015 report, new entrants into residential care in Ontario have much higher levels of impairment. In Ontario, for example, in the 4th quarter of 2009/10, 76% of new admissions had high to very high levels of impairment (35% high and 41% very high). At the end of 2013/14, this figure for new admissions increased to 83%, with most of the growth in the very high category representing 47% of new admissions and growing at 3.9% per year.[68] In BC, the growth in demand for health care for frail elderly living in residential care, who already utilize about 25% of health services, is projected to increase by 120% by 2036.[69]

Along with increasing levels of acuity with a growing and aging population, a large percentage (41%) of Canadian seniors are dealing with two or more select chronic conditions, such as diabetes, respiratory issues, heart disease, and depression, and many are experiencing a decline in physical and/or cognitive functioning.[70] Mental health challenges will also become more prevalent, as it is estimated the number of BC residents with dementia is expected rise from 70,000 to 110,000 by 2025.[71]

Alternate Level of Care (ALC) Beds

Along with increasing levels of acuity, another major reason to explore the development of new continuing care models is to reduce the pressures faced in the costlier acute and emergency care system, including reducing alternate level of care (ALC) beds. ALC beds are those occupied by patients who no longer require acute care, but who continue to occupy a hospital bed because they are unable to access home and community care services. In BC, the cost of treating a senior in hospital ranges from $825 to $1,968 per day, whereas the cost of residential care is approximately $200 per day.[72]

> “*Currently, approximately 14% of Canadian hospital beds are filled with patients (85% of which are over 65) who are ready to be discharged but for whom there is no appropriate place to go.*”

Currently, approximately 14% of Canadian hospital beds are filled with patients (85% of which are over 65) who are ready to be discharged but for whom there is no appropriate place to go. Over a single year, these patients' use of acute hospital beds exceeds 2.4 million days, which equates to over 7,500 acute care beds each day.[73] A conservative national estimate of resulting costs to

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[67] Office of the Seniors Advocate. *Monitoring Seniors' Services* (2016). December 2016. Accessed at: https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2016/12/OSA-MonitoringReport2016.pdf

[68] OANHSS Submission to the Ontario Standing Committee on Finance and Economic Affairs. The Need Is Now: Addressing Understaffing in Long Term Care Ontario Association of Non-Profit Homes and Services for Seniors. January 2015.

[69] Setting Priorities for BC's Health System. BC Ministry of Health. February 2014. Accessed at: http://www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf

[70] Health Council of Canada Report – Seniors in Need, Caregivers in Distress (April 2012). Accessed at: http://www.healthcouncilcanada.ca/rpt_det_gen.php?id=348

[71] Workforce Analysis, Health Sector Workforce Division, Ministry of Health, Dementia (age 45+ years) March 24, 2014, project 2014_010 PHC

[72] 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

[73] Exploring alternative level of care (ALC) and the role of funding policies: An evolving evidence base for Canada. Canadian Health Services Research Foundation. September 2011. Accessed at: http://www.cfhi-fcass.ca/sf-docs/default-source/commissioned-research-reports/0666-HC-Report-SUTHERLAND_final.pdf

provincial governments is approximately $3 billion per year.[74]

According to recent data from Alberta, on a daily basis approximately 822 people in that province are in an acute care setting who could be cared for less expensively in the community. If these patients were in more appropriate care setting such as a care home - as opposed to a hospital, which is about four times as expensive - it could result in savings of over $170 million per year. The data show that over a 33-month period through December 2014, the number of alternative level of care (ALC) days doubled and that on average about 11 per cent of Alberta's acute care capacity was occupied by ALC patients.[75]

As outlined in the 2015 BCCPA Quality-Innovation-Collaboration (QIC) paper, there were over 400,000 reported ALC days in BC in 2014/15, accounting for 13% of total hospital days across the five regional health authorities. There were also significant variations across the Health Authorities from a low of 8% in Vancouver Coastal to 18.1% in Northern Health.[76] BC's health authorities also report that about one-half of ALC patients are awaiting discharge into long-term care, while others are waiting for home care, assisted living, rehabilitation or are residing in acute care due to an inefficient transfer processes.[77]

DID YOU KNOW: …there were over 400,000 reported ALC days in BC in 2014/15, accounting for 13% of total hospital days across the five regional health authorities.

As outlined in the 2015 BCCPA Quality-Innovation-Collaboration (QIC) paper, a 50% reduction in ALC days could generate significant cost savings to the health system. For example, assuming 50% of ALC days could be reduced by caring for patients in residential care homes (average daily cost of $200) instead of in a hospital (average daily cost of $1,200) it could generate over $200 million in annual cost savings.[78]

The problem of ALC beds not only creates fiscal challenges, but quality of care and access issues as well. The Wait Time Alliance (WTA), for example, has noted that the ALC issue represents the single biggest challenge to improving wait times across the health care system.[79] Such wait times and access issues have been well documented. In 2012, for example, it was reported that 461,000 Canadians were not getting the home care they thought they required, while wait times for access to long-term care in Canada also ranged anywhere from 27 to 230 days.[80]

There are many reasons for the high rates of ALC patients, including the lack of appropriate community supports to prevent hospitalizations, as well as to return patients to a more appropriate setting after they receive hospital care.[81] The ALC issue is also one that is closely tied to dementia, a common diagnosis among ALC patients. In particular, a dementia diagnosis often results in at least once instance of hospitalization and

[74] CD Howe Institute. Commentary No. 443. Shifting Towards Autonomy: A Continuing Care Model for Canada. Ake Blomqvist and Colin Busby. As noted in one report from the Canadian Life Health Insurance Association (CLHIA), 7,550 acute care beds are taken up by individuals who should be in home and community care or in rehabilitation. This represents about 7% of all hospital beds in Canada. The report also notes that if systemic reform were able to transition all those in a hospital setting to a more appropriate continuing care setting, the savings to the system would be about $77 billion over the time period examined (35 years). Source: Improving the accessibility, quality and sustainability of long-term care in Canada. CLHIA Report on Long-Term Care Policy. June 2012)

[75] Seniors stuck in hospital wastes $170 million a year, Liberals say. Matt McClure. Calgary Herald. April 1, 2015. Accessed at: http://calgaryherald.com/news/politics/seniors-stuck-in-hospital-wastes-170-million-a-year-liberals-say

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

[77] Exploring alternative level of care (ALC) and the role of funding policies: An evolving evidence base for Canada. Canadian Health Services Research Foundation. September 2011. Accessed at: http://www.cfhi-fcass.ca/sf-docs/default-source/commissioned-research-reports/0666-HC-Report-SUTHERLAND_final.pdf

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

[79] Wait Time Alliance. 2015. Eliminating Code Gridlock in Canada's Health Care System: 2015. Wait Time Alliance Report Card Accessed at: http://www.waittimealliance.ca/wp-content/uploads/2015/12/EN-FINAL-2015-WTA-Report-Card.pdf

[80] Canadian Medical Association. Doctors to leaders: Canadians want a Seniors Care Plan in election. August 2, 2015. Accessed at: http://www.newswire.ca/news-releases/doctors-to-leaders-canadians-want-a-seniors-care-plan-in-election-520419582.html

[81] Wait Time Alliance. 2015. Eliminating Code Gridlock in Canada's Health Care System: 2015. Wait Time Alliance Report Card Accessed at: http://www.waittimealliance.ca/wp-content/uploads/2015/12/EN-FINAL-2015-WTA-Report-Card.pdf

escalates ALC rates when persons with dementia have other chronic diseases (i.e. 90% of community-dwelling persons with dementia have two or more chronic diseases). A study in New Brunswick found that one third of the hospital beds in two hospitals were occupied by ALC patients, of whom 63% had been diagnosed with dementia. It also found their mean length of stay was 380 days, with 86% of these patients waiting for a bed in a long-term care home while their health declined.[82]

As outlined by the WTA, adequate attention to seniors' care - such as having the necessary health human resources, treating seniors where they live thereby preventing unnecessary emergency department visits and hospitalizations, as well as collaborative care models - are key to reducing the numbers of ALC patients.[83] In particular, one critical area for improving the ALC situation is the better reporting of such data. The UK's National Health Service, for example, reports monthly ALC rates as delayed transfers of care including outlining the causes of delay by region and facility.[84]

The BCCPA believes adopting this type of comprehensive public reporting across Canada, including British Columbia, would greatly assist efforts to tackle the ALC issue. Along with reinvestments in continuing care and the development of new collaborative care models, the BCCPA has advocated that the Health Authorities and Ministry of Health better utilize the existing capacity and expertise amongst non-government care operators – this includes developing strategies to reduce ALC beds and offset acute care pressures. The BCCPA has recommended the creation of a new publicly accessible online registry to report on ALC and vacant residential care beds, as well as the use of current vacant beds within residential care homes, assisted living units and home support to reduce acute care pressures. To assist this process the BCCPA also developed a website (Mycarefinder.ca) to highlight the level of vacant care beds and assisted living units across the province.

> *"Well designed home care and home support services with quick response capabilities can also be effective in getting seniors out of acute care."*

Well designed home care and home support services with quick response capabilities can also be effective in getting seniors out of acute care. Vancouver Island Health's Quick Response Team, for example, provides crisis intervention at home to eligible clients when required, aimed at preventing avoidable hospital admission, providing crisis intervention at home, and facilitating early hospital discharge.[85]

While the BCCPA believes the development of the continuing care hub model may help address issue of ALC, we also believe as a medium-term goal the Ministry of Health should also work to set as a target by the year 2021 to have no more than 5% of acute care beds occupied each day by seniors who have been assessed as capable of being transferred into a more appropriate residential care or home care setting.

RECOMMENDATION: ***Medium term: 3 to 5 years***

- That the Ministry of Health set as a target by the year 2021 to have no more than 5% of acute care beds occupied each day by seniors who have been assessed as capable of being transferred into a more appropriate residential care or home care setting.

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[82] McCloskey R, Jarrett P, Stewart C, Nicholson P. Alternate level of care patients in hospitals: What does dementia have to do with this? Can Geriatr J 2014;17(3):88–94.

[83] Wait Time Alliance. 2015. Eliminating Code Gridlock in Canada's Health Care System: 2015. Wait Time Alliance Report Card Accessed at: http://www.waittimealliance.ca/wp-content/uploads/2015/12/EN-FINAL-2015-WTA-Report-Card.pdf

[84] NHS England. Delayed transfers of care statistics for England 2014/15. 2014/15 annual report. London: NHS England; 2015 May 29. Available: www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/2014-15-Delayed-Transfers-of-Care-Annual-Report.pdf

[85] BCCPA. Op-ed: Let's Stop Seniors from Languishing in Hospitals. February 19, 2016. Accessed at: http://www.bccare.ca/op-ed-lets-stop-seniors-languishing-hospitals/

Reducing Hospitalizations

> *...once residents are in long term care there is a significant reduction in hospitalizations.*

As outlined in various studies, once residents are in long term care there is a significant reduction in hospitalizations. A recent study from Alberta found that that the incidence of hospital admission was about 3 times higher among Assisted Living (AL) residents than among long term care residents (14%). In particular, nearly 40% of AL residents in Alberta were admitted to hospital over 1 year, a rate substantially higher than that for long term care residents.[86]

As also outlined in the BC Ministry of Health Setting Priorities document one large driver of total cost occurs in the year prior to, and the year of, entry into residential care - with high rates of hospitalization via emergency departments en-route to residential care. For example, more than seven out of every ten new entrants to residential care have at least one inpatient hospitalization in the year. More than 60 per cent of people entering residential care have been identified as having a high complexity chronic condition in the previous year, and it is likely that many will also have fallen into the "frail in community" category as well.[87]

As outlined in the table below, the use of emergency rooms (ERs) by seniors overall is quite high with close to one quarter of ER visits (24%) being for patients over age 65. In total, among BC health authorities, there were close to 350,000 ER visits (346,820) by seniors for 2014/15.

Table 5: ER Visits for Seniors for 2014/15 (65+)

Health Authority	Number ER Visits (Patients Aged 65+)	Total # of ER Visits	Proportion (%) of ER Visits for Patients Aged 65+
Interior	32,612	133,580	24%
Fraser	148,749	652,779	23%
Vancouver Coastal	80,115	332,334	24%
Vancouver Island	78,168	269,745	29%
Northern	7,176	44,528	16%

Source: CIHI 2015 data - Report contains open year data for fiscal year 2014-2015 from eNACRS

Overall, according to a 2014 report from the Canadian Institute for Health Information (CIHI) seniors in long term care homes make up less than 1% of emergency room visits in Canada, with 1 of 3 of these visits being potentially avoidable as they could have been addressed in the care home itself. Common avoidable reasons for visits to ER for seniors in care were urinary tract infections, pneumonia, and falls.[88] In BC, residents in continuing care homes who visited the ER twice or more only made up 1%

> *...according to a 2014 report from the Canadian Institute for Health Information (CIHI) seniors in long term care homes... make up less than 1% of emergency room visits in Canada ...*

[86] High rates of hospital admission among older residents in assisted living facilities: opportunities for intervention and impact on acute care. David Hogan et al. Open Medicine, Vol 8, No 1 (2014). Accessed at: http://www.openmedicine.ca/article/view/622/541

[87] Setting Priorities for BC's Health System. BC Ministry of Health. February 2014. Accessed at: http://www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf

[88] Canadian Institute for Health Information (CIHI). "Nearly 1 in 5 Patient Visits to Emergency Could Potentially Be Treated Elsewhere". Accessed at: https://www.cihi.ca/en/types-of-care/hospital-care/emergency-and-ambulatory-care/nearly-1-in-5-patient-visits-to-emergency

of ER visits.[89] As outlined by CIHI, with earlier diagnosis and improved access to on-site treatment, some of these conditions could be managed at the care home and a visit to the ER avoided altogether.

Although ER visits are relatively low for seniors and decrease once a resident is admitted to residential care, there is still a need to look at ways to reduce such visits, particularly during the first year of residential care. Although data is limited in this regard, one of the reasons that has been outlined for a high number of visits during the initial stay in residential care is due to care staff wanting to minimize any potential health risks for the resident. To deal with this a number of solutions need to be explored including:

1. Greater involvement from the family with staff in overall care and planning;
2. Co-location of ambulatory and sub-acute care with residential care;
3. Development of integrated programs such as the Comprehensive Home Options of Integrated Care for the Elderly (CHOICE) model (see Appendix F);
4. Greater use of physicians including possibly Physician Assistants and Nurse Practitioners in continuing care settings; and
5. Earlier diagnosis as well as better management and preventative care for seniors within care homes, including improved resident safety measures, chronic disease management, and dementia care.

In summary, there is a critical need to reduce more expensive and unnecessary hospitalizations including ALC days. To accomplish this, it will require enhancing the role of continuing care as well as looking at new care models. That is the focus of the next section of this paper.

Continuing Care Hubs: Enhancing the role of Continuing Care

In 2010, the Ontario Long Term Care Association (OLTCA) commissioned the Conference Board of Canada to investigate the innovation potential of Ontario's long term care homes. The result was *Why not now?* A five-year strategy published in 2012 by the expert panel, co-chaired by William Dillane, President, The Response Group, and Dr. William Reichman, President and CEO of Baycrest. The panel envisions long term care homes as hubs of innovation that work closely with hospitals, ensuring accessibility, and handling all sorts of short-term, long term, and cyclical care.[90] As outlined in OLTCA paper with the development of new models, highly integrated care teams would require new roles and a different mix of skills. Staffing models would also have to be developed to allow the same service providers to provide care in and out of hospital. In particular, it identifies a number of new continuing care models such as the post-acute care model, specialized stream model, integrated care model, and the Hub Model.

Continuing Care Hubs

The BCCPA believes the six models outlined in the Ontario paper, including the post-acute, specialized stream, and integrated models of care should be explored further in the context of British Columbia. In particular, BCCPA supports the development of a hub model where the continuing care home could be a centre for the delivery of a wide range of seniors' services; some co-located and others managed by the continuing care home.

Although not exhaustive, services that could be delivered by a Continuing Care Hub could include: primary care, chronic disease management, rehabilitation, sub-acute, dialysis, oral care, foot care, adult day/night programs, meals on wheels, as well as caregiver support such as home monitoring and satellite specialized geriatric services collaboratively delivered with hospital and community partners. This model takes advantage of investments in physical infrastructure and existing LTC programs and services by centralizing care and expertise.

[89] Canadian Institute for Health Information (CIHI). "Quick Stats". Accessed at: https://www.cihi.ca/en/quick-stats?xQSType=Interactive%2520Data&pageNumber=2&resultCount=10&filterTypeBy=2&filterTopicBy=undefined&autorefresh=1
[90] 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

Although the exact features of Continuing Care Hubs need to be established some of the common features could potentially involve elements from the four areas below:

Table 6: Four Key Elements of Continuing Care Hub Model

Integration of health professionals and family in seniors care

- Use of other health and emergency professionals including but not limited to paramedics and firefighters with enhanced training.
- Integrating the practice of Nurse Practitioners, family physicians and potentially Physician Assistants into continuing care.
- Increasing the proportion of LTC nurses with advanced or specialized training, particularly in areas such as behaviours and pain and symptom management.
- Development of alternate LTC physician and nurse practitioner reimbursement models which provide incentives for mentoring LTC staff and students and achieving key care outcomes targets such as reducing hospital transfers.
- All self-regulated professions work to full scope of practice, which includes delegation of acts to other health professionals and unregulated staff.
- Better integration of the family in the care team and overall care of the resident as a strategy to potentially reduce hospitalizations.

New roles for care providers

- Creation of new Health Care Aide roles that enable nursing staff to focus on clinical care and leadership rather than routine tasks that can be safely delegated.
- Creation of a multidisciplinary LTC team core competencies task force to examine the composition, skill set and level of interdisciplinary integration required to support the delivery of safe, high-quality care in skilled nursing centres and other models of care delivery.
- A comprehensive review and update to college and university curricula to better prepare front-line workers for the emerging continuing care environment.

New funding models (outcome-based funding)

- Performance-based funding that considers optimal staffing mix for different groups of residents, along with care outcomes.
- Greater use of funding that is outcomes-based on pre-selected quality indicators in continuing care including incentives to encourage integration of care and team based models (i.e. paramedics, rehabilitation, pharmacy, etc.).

Expanded role and co-location of services

- Use of physical infrastructure to provide community services for seniors in order to reduce seniors' isolation (i.e. seniors care lodges).
- Physical co-location of urgent care centres or sub-acute care homes as well as ambulatory care / paramedics to reduce acute care and emergency hospitalizations.
- Expanded sub-acute care and paramedic services including but not limited to less complicated surgical treatments, greater wound care, dialysis and intravenous (IV) care.
- Greater preventative and health promotion services for seniors such as frailty screening, chronic disease management programs, etc.
- Expansion and integration of end-of-life care including palliative and hospice care.
- Expanded pharmacy services including medication management, etc.
- Expanded mental health services for seniors including but not limited to treating dementia, depression and integrating psychologists as part of the care team.
- Provision of some diagnostic and laboratory services such as minor x-rays, blood tests, etc.
- Provision of supplemental care services including dental / oral health care, optical, foot care, etc.
- Expanded rehabilitation and recovery care including occupational therapy, physical therapy and post-operative care.
- Use of technologies to link with care homes in smaller rural and/or remote communities.

Figure 15: Components of the Current 24/7 Residential Care Model and New Continuing Care Hubs

Current 24/7 Residential Care Model

- Accommodation
- Development and maintenance of resident's Care Plan
- Clinical Support Services
- Ongoing, Planned Physical, Social and Recreational Activities
- Meals, Meal Replacements and Nutrition Supplements
- Laundry Service
- General Hygiene Supplies
- Routine Medical Supplies
- Medication supervision
- 24-hour surveillance
- Professional nursing care and/or supervision
- Incontinence Management
- Any other specialized services

New Continuing Care Hub

- All services currently provided in 24/7 residential care model
- Could be physically co-located (i.e. Continuing Care Campus or Campus of Care) or provided as part of virtual affiliated network of care homes
- No one size fits all – services provided will differ based on expertise and needs of the community

<u>New Services Offered</u>

- Use of physical infrastructure to provide community services for seniors
- Respite care for frail elderly
- Physical co-location of urgent care or sub –acute
- Expanded sub-acute care and paramedic services (i.e. wound care, dialysis and IV care)
- Greater preventative and health promotion services (i.e. CDM and frailty screening)
- Expansion and integration of end-of-life care
- Expanded pharmacy services and medication management
- Expanded mental health services for seniors including dementia care
- Provision of some diagnostic and laboratory services (X-rays, blood tests etc.)
- Provision of supplemental care services (i.e. dental, oral, optical, and foot care, etc.)
- Expanded rehabilitation and recovery care (i.e. OT/PT and post-operative care)
- Use of technologies to link with care homes particularly to rural areas
- New funding models (outcome-based funding)
- New roles for care providers (creation of new care aide roles and multidisciplinary LTC team)
- Integration of health professionals (Nurse Practitioners, Physician Assistants / Paramedics and family in seniors care)

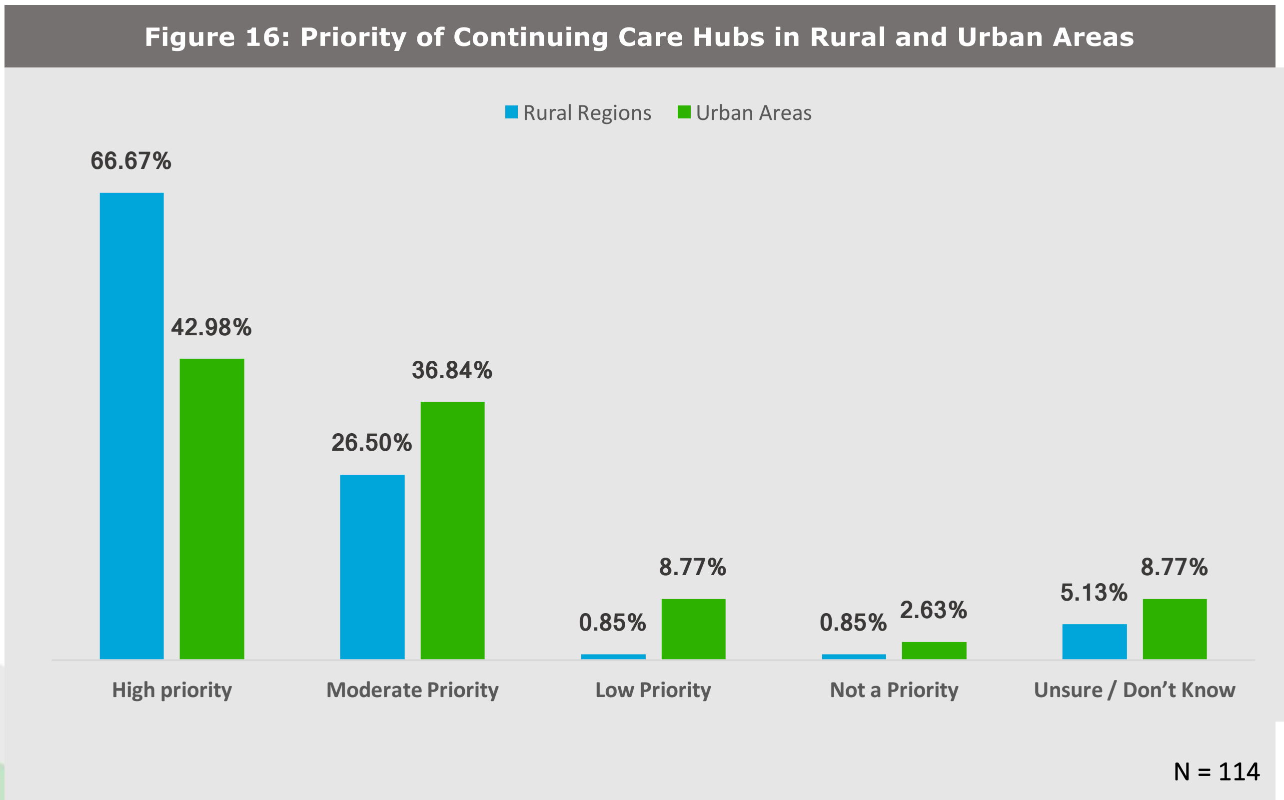
Overall, as noted above, one of the key features of such a Continuing Care Hub model is the provision of procedures or services that may be commonly performed in alternative care settings such as a hospital or in primary care setting including dialysis, rehabilitation, frailty screening, seniors health promotion, and other potentially non-complicated surgical treatments. Such services would be based on needs of the community.

While the provision of expanded services within continuing care such as IV, dialysis, rehabilitation and palliative care could be co-located in one physical location it is also possible that such services could be provided as part of a group of care homes who have decided to work collaboratively to provide such care amongst themselves as part of a cluster or network arrangement. For example, two or more care homes could potentially join together within a virtual or affiliated network to provide services with each providing different types of specialty or other services for seniors. Such a network or affiliated group could also potentially operate within a specific geographical location to provide care for seniors. Some could also operate across Health Authorities provided appropriate arrangements are in place. Likewise, it is also feasible that Health Authority operated care homes could be part of a network along with privately operated care homes.

While the exact details of what an affiliated or virtual network would look like will differ based on the capacity and expertise of operators as well as various needs of a given population, with the development of such networks it will be important to develop appropriate funding models between care operators and the Health Authorities. In particular, revised contracts or funding arrangements between the Health Authorities and operators will need to account for an expanded level of services provided as well as new staffing models which better integrate health professionals into continuing care.

As outlined at the September 20, 2016 Continuing Care Collaborative there was also considerable support for Continuing Care Hubs. Close to 80% identified them as a moderate or high priority in urban areas, while the numbers were even higher for rural areas (over 90%).

Figure 16: Priority of Continuing Care Hubs in Rural and Urban Areas



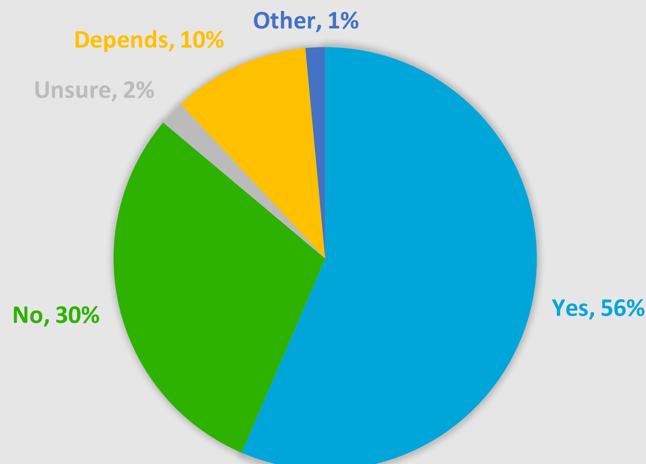
Additional Onsite Services

In the BCCPA survey on the White Papers, respondents were asked to indicate their support or opposition for residential care homes offering additional onsite services in the community, such as sub-acute care services or community care services (e.g. day care). This policy option received modest support, with 56% of survey respondents indicating support, and an additional 10% indicating depends. Thirty percent of survey respondents indicated that they did not support this option. Of those survey respondents that indicated depends, common themes were that it would depend on:

- the type of services being provided (i.e. many support sub-acute care services but not child care);
- appropriate funding and staffing levels;
- the availability of these services in the community; and
- whether those accessing services would pay a small fee.

While many survey respondents indicated that they were opposed to care homes offering child care services, there seemed to be some confusion about why a care home would provide this. This may indicate that any public discussion on the provision of child care by care homes would need to clearly demonstrate the benefits of intergenerational interaction for seniors, as well as clearly outlining that child care services wouldn't be provided to the detriment of seniors.

Figure 17: Do you think residential care homes should be offering additional onsite services in your local community such as IV therapy, dialysis, child care?

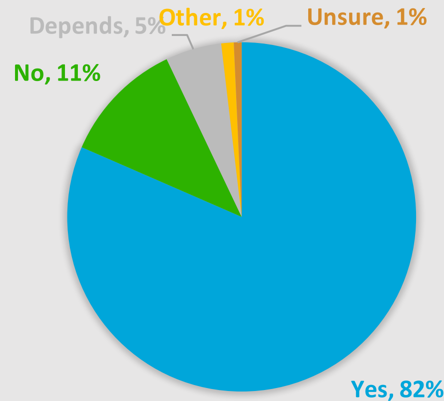


N=735

Additional Offsite Services

Survey respondents were also asked to indicate their support or opposition for residential care homes offering additional offsite services, such as adult day programs, recreational therapy and occupational therapy programs. This policy option received overall very good support from survey respondents, with over 80% supporting, and an additional 5 per cent indicating depends. Only 11% of respondents indicated they would not support this.

Figure 18: Do you think Residential Care Homes should be providing services to seniors who actually live off site in the community?.



N=744

New Health Care Teams

As outlined in the earlier Ontario paper Why Not Now? turning continuing care homes into hubs of innovation in aging care will also require new roles, a different skill mix and well integrated care teams. One such example being used in Ontario are Long-Term Care Nurse-Led Outreach Teams (NLOTs) which the Ontario Ministry of Health established in 2008 in each Local Health Integration Network (LHIN) as one of several projects implemented under its Emergency Room and Alternate Level of Care (ER/ALC) Strategy. NLOTs bring together a dedicated team of nursing professionals to provide continuing care residents and their care provider's access to timely, high quality urgent care support within the comfort of their own homes.[91]

New integrated care teams and LTC models could also utilize nurse practitioners (NPs) into care homes.[92] Overall, progress in implementing NPs has lagged behind other provinces including Ontario and Alberta. One of the major problems has been that insufficient funding has left many NPs unable to obtain employment.[93] Although in 2012 the BC government announced $22.2 million to pay for 190 positions over the next three years, it is not clear whether some commitments will continue in the future.[94] As of January 2014, there were only 287 NPs registered in BC. Another survey also shows that less than 10% NPs who responded (8% or 7 in total) identified residential care as a practice setting.[95]

There is evidence that shows NPs improve family satisfaction and staff confidence. They also reduce transfers to the emergency department, hospital admissions and length of stay and workload for continuing care physicians.

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[91] Living Well, Living Longer. Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to Inform a Seniors Strategy for Ontario. December 2012. Accessed at: http://www.health.gov.on.ca/en/common/ministry/publications/reports/seniors_strategy/docs/seniors_strategy_report.pdf

[92] In BC, a NP is a Registered Nurse with a Master's Degree, advanced knowledge, and skills who provides health care services. NPs are able to diagnose, consult, order interpret tests, prescribe, and treat health conditions. They also work independently and collaboratively to provide British Columbians with Primary and Specialized Health Care using a team-based approach. Since 2005, BC began graduating and regulating NPs, with about 45 students per year.

[93] Are nurse practitioners the cure for B.C.'s family doctor shortage? Globe and Mail. Rod Mickelburgh. January 5, 2013. Accessed at http://www.theglobeandmail.com/news/british-columbia/are-nurse-practitioners-the-cure-for-bcs-family-doctor-shortage/article6970838/

[94] BC funds more Nurse Practitioner positions. Ministry of Health media release. May 31, 2012. Accessed at: http://www.newsroom.gov.bc.ca/2012/05/bc-funds-more-nurse-practitioner-positions.html

[95] A Survey of Nurse Practitioner Practice Patterns in British Columbia. University of Victoria and Michael Smith Foundation for Health Research. January 2014. Accessed at: http://www.uvic.ca/research/projects/nursepractitioners/assets/docs/NP%20Practice%20Patterns%20Report.pdf

Physician competence and engagement are also associated with lower hospitalization rates, higher functional status and resident satisfaction and reduced rates of regulatory non-compliance.[96]

Integration of physicians into new continuing care models

Going forward, better integrating physicians into new long term care models will also be critical, particularly in an attempt to reduce unnecessary hospitalizations and ER visits. In the last 10 years, while the number of community-based family physicians in BC has increased by about 10%, the number of family physicians delivering residential care services has dropped by about 13%. This downward trend is occurring at the same time as it is anticipated that there will be a 120% growth in the residential care population in the next 20 years. To deal with this issue the BC government and Doctors of BC through the General Practice Services Committee (GPSC) is supporting physicians through its residential care initiative.

> *… better integrating physicians into new long term care models will be critical, particularly in an attempt to reduce unnecessary hospitalizations and ER visits.*

> ***DID YOU KNOW:*** *In the last 10 years, while the number of community-based family physicians has increased by about 10%, the number of family physicians delivering residential care services has dropped by about 13%.*

With the GPSC's commitment of up to $12 million annually, the initiative is attempting to meet the needs of residential care clients in over 100 communities across BC. The initiative also includes the establishment of new fee codes for seniors care. Starting in July 1, 2015, divisions/self-organizing groups can potentially access a quarterly lump sum incentive, calculated at an annual $400 per residential care bed, to implement local solutions.[97] While the BCCPA is encouraged by this initiative, it is not clear whether $400 per bed will be sufficient and/or whether the up to $12 million in funding would be better spent if it were provided directly to care homes to recruit and retain physicians.

Along with programs such as the GPSC residential care initiative, new models of continuing care should look at alternative approaches to integrating physicians. One such model recently implemented in Nova Scotia's Capital District Health Authority is called Care by Design (CBD), which attempts to addresses concerns of a previously uncoordinated care system in long term care homes, reduction of family physician services and on-call coverage for LTC home residents, and high rates of ambulance transports to emergency departments (EDs). The core of CBD is dedicated family physician coverage for each LTC home floor, with regular on-site visits; on-call coverage, 24 hours a day, 7 days a week; and standing orders and protocols. Other key aspects of CBD include an extended care paramedic program, providing on-site acute care and facilitating coordinated transfers to the ED; a new comprehensive geriatric assessment tool; performance measurements; and interdisciplinary education.[98]

Preliminary results from CBD include that the initiative has improved clinical efficiency by reducing travel time to visit residents in multiple long term care homes and that continuity and quality of care has improved for residents. The data also shows that there was a 36 per

> *Along with integrating physicians better into long term care, it may also require looking at new health providers, particularly physician assistants.*

[96] 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
[97] General Practice Services Committee (GPSC). Residential Care Initiative. Accessed at: http://www.gpscbc.ca/family-practice-incentive/residential-care.
[98] Nova Scotia Capital District Health Authority. Care by Design. http://www.cdha.nshealth.ca/care-by-design

cent reduction in transfers from LTC homes to Emergency Department over a six-month period.[99]

Along with integrating physicians better into long term care, it may also require looking at new health providers, particularly physician assistants. Physician Assistants (PAs) are essentially healthcare professionals educated in the medical model to practice medicine under the direction of a physician.[100] Recent studies have highlighted the benefits of PAs including that they can increase access to medical care for seniors. In particular, having a full-time PA on staff at a long term care home can translate into residents being evaluated sooner and can prevent transfers to the hospital in many cases. A study from the U.S. shows that PAs in long term care settings have decreased hospital admission rates by 38% for seniors. PAs can also have an important preventive role in care of geriatric patients.[101]

Continuing Care Collaborative

Along with BC working collaboratively with the federal government, it will also be important for the Health Authorities and Ministry of Health to work further with care providers going forward. At the 2015 Annual General Meeting, BCCPA members voted unanimously to endorse the concept of a Continuing Care Collaborative and to encourage all the parties to create this new mechanism. The resolution outlined the need to establish a Collaborative to help improve health outcomes for seniors as well as further enhance partnerships, dialogue, and planning between government, health authorities, and service providers.

As outlined in the Quality-Innovation-Collaboration (QIC) paper released in 2015, the BCCPA recommended the establishment of a Continuing Care Collaborative with senior representation from Ministry of Health, Health Authorities and BCCPA. This Collaborative is based on a model of collaboration that has been successfully implemented in Alberta to address pressing issues in the sector. 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. In the BC context, some of the initial key issues that a formal Collaborative could address include identifying key recommendations in this report such as reviewing options for new delivery models like 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.

To support this initiative and to foster innovation, as outlined in *Strengthening Seniors Care: A Made-in-BC Roadmap*, the BCCPA recommends the BC government invest up to $28M per year over the next five years to support the introduction and/or expansion of the Care Hub concept throughout B.C.

RECOMMENDATION ***Immediate: 1 to 2 years***

- That as a key priority any future BC Continuing Care Collaborative review options for 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. In particular, the BC government and Health Authorities should expand

[99] Evaluating "Care by Design" –a New Model of Long-term Care from Physicians Perspectives. Emily Marshall et al. Accessed at: http://www.cdha.nshealth.ca/system/files/sites/12558/documents/evaluating-%E2%80%9Ccare-design%E2%80%9D-new-model-long-term-care.pdf

[100] In a formal practice arrangement with a physician, PAs practice medicine which includes obtaining medical histories and performing physical exams, ordering and interpreting laboratory and diagnostic tests, providing therapeutic procedures, prescribing medications, and educating and counselling patients. University of Manitoba. What is a Physician Assistant? Accessed at: http://umanitoba.ca/faculties/health_sciences/medicine/education/paep/whatisapa.html

[101] Hooker, Cawley and Asprey. (2010). Physician Assistant Specialization: Nonprimary care. PA Specialty Care. Ch. 7. p.p. 235. Accessed at: http://capa-acam.ca/wp-content/uploads/2013/09/PA-FACT-SHEET-2013_FINALcopy.pdf

and/or introduce the Continuing Care Hub model in rural areas to increase the level of medical and social services provided to seniors in the community.

Rural Considerations – New Technologies

The Continuing Care Hub model outlined earlier would ideally function in more urban centres given larger and centralized senior populations. However, there is the potential for such care hub models to link virtually with care homes in rural and/or remote communities through the use of integrated technologies such as telehealth. Funding to support this should be part of the province's overall e-Health strategy, including strategies outlined in the Ministry's recent policy paper on IM/IT in areas such as:

- Providing multidisciplinary health care team members with access to up-to-date patient health information, at the point of care;
- Enabling multidisciplinary health care teams to contribute to the residents' health care plan;
- Improving the quality of health data;
- Standardizing and expanding use of telehealth, including use of videoconferencing technologies; and
- Support telehealth policy recommendations to ensure emerging technologies are leveraged for key populations including the frail senior population living in residential care.[102]

Overall, linking rural based care homes into new continuing care models such as new hubs particularly through the use of new technologies and where necessary referrals will be critical going forward.

Electronic Health Records

One critical component of the new technologies will also be the adoption of Electronic Health Records (EHRs) or Electronic Medical Records (EMRs). While the use of such technologies among primary care physicians in Canada has more than doubled from 26 per cent in 2006 to 56 per cent in 2012[103] it still lags behind other countries, notably Australia, New Zealand, and the United Kingdom, who report use of EHRs by care physicians to be over 90 per cent.[104] EHRs are electronic versions of medical information collected by healthcare professionals and organizations, pertaining to a patient to whom they provide care.[105]

Electronically based health records are an effective way of providing integral improvement to seniors' health outcomes, reducing avoidable hospitalizations and medication errors.[106] Unlike traditional paper charts, EHRs make it easier for physicians to access medical records both inside and outside of the office, accurately retain and retrieve information that could otherwise get lost and transmit clinical information to consultants and specialists.[107] Overall, electronic records can offer more accuracy and efficiency with regards to providing care for individuals of all ages.

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[102] BC Ministry of Health. Enabling Effective, Quality Population and Patient-Centred Care: A Provincial Strategy for Health Information Management and Technology. June 2015. Accessed at: http://www.health.gov.bc.ca/library/publications/year/2015/IMIT-policy-paper.pdf

[103] Canada Health Infoway – Infoway. (2013) "Canada Health Infoway: The emerging benefits of electronic medical record use in community-based care."

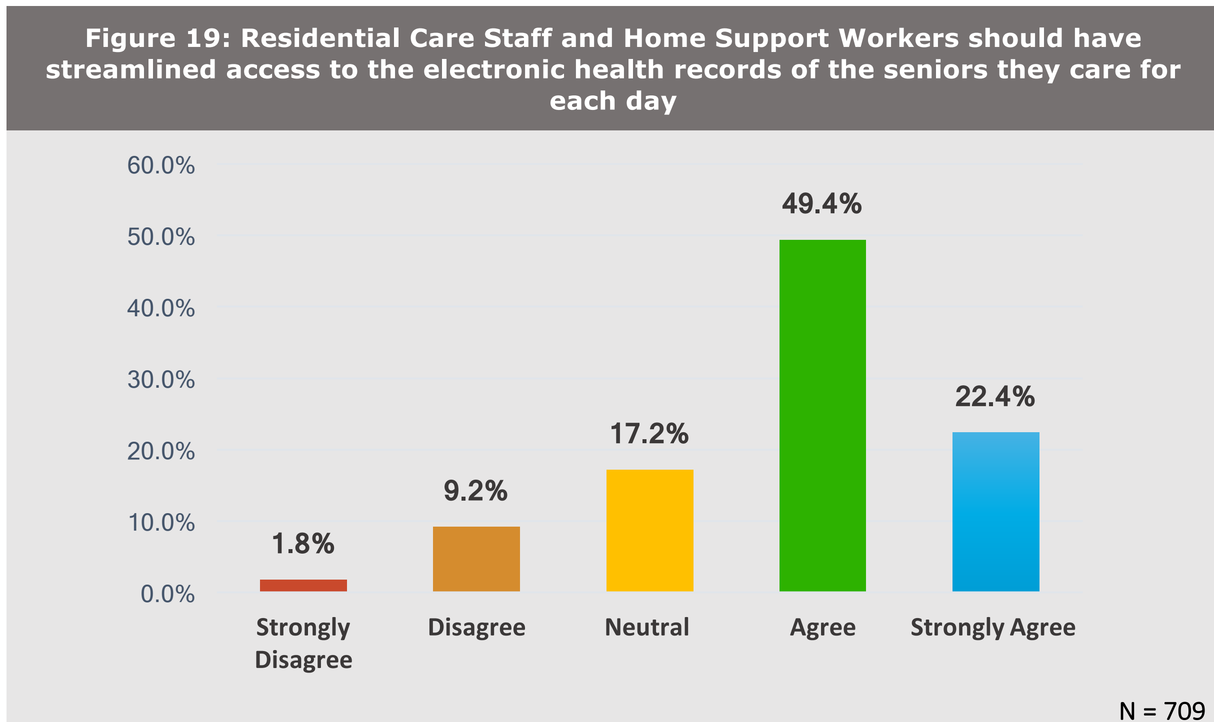
[104] Schoen, C., Osborn, R., Squires, D., Doty, M., Rasmussen, P., Pierson, R., and Applebaum, S. (2012) "A Survey Of Primary Care Doctors In Ten Countries Shows Progress In Use Of Health Information Technology, Less In Other Areas." *Health Affairs, 31, no.12* :2805-2816.

[105] Health Workforce Information Centre. (2013) "Health Information Technology, Telehealth, and the Health Workforce." Accessed at: http://ruralhealth.und.edu/projects/hwic/pdf/hit-telehealth.pdf

[106] Senior Living Smart: Smart solutions and savings for independent operators. (2013) "5 Key findings you should know about Electronic Health Records (EHR)". Accessed at: http://seniorlivingsmart.com/5-key-findings-know-electronic-health-records-ehr/

[107] Community Care Physicians. "Information Technology in Healthcare - No Age Limit." Accessed at: http://www.communitycare.com/ehr/ehr_and_seniors.asp

In the BCCPA Survey on the White Papers respondents were asked whether they believed that seniors care workers should have access to the electronic health records of their patients/clients/residents. This option received good support, with 72% of survey respondents indicating that they agree or strongly agree. Eleven percent of respondents indicated that they disagreed with this proposal, while another 17% were neutral.



Conversely, another way to enhance the delivery of medical services, especially to seniors in rural areas, is through Telehealth technologies. Telehealth is the use of communications and information technology to deliver healthcare services over large and small distances.[108] Patients can access and receive care from four domains of Telehealth which include: live video, which allows for a live two-way interaction between the patient, caregiver or provider regarding medical issues; transmissions of health records to a specialist via online technologies; and mobile health which foster education through mobile devices such as cellphones, where the receiver gets access to disease outbreaks and healthy living tips.[109]

Essentially, telehealth technologies can be beneficial to both the patient and the physician, with patients having more control and understanding of their long-term conditions and clinicians being able to proactively monitor and assess the patient's well-being from a distance.[110] E-health technologies such as telehealth and electronic health records have become an effective way of improving access to care for seniors, promoting efficiency and reducing unnecessary hospital visits via communication technologies that facilitate and monitor senior's health in an ambient environment.[111]

[108] Centre for Health Information Newfoundland and Labrador (2010) "Evaluating the benefits: Improved health through quality health information." Accessed at: http://www.nlchi.nl.ca/index.php/telehealth
[109] Centre for Connected Health Policy: The National Telehealth Policy Resource Centre. "What is Telehealth?" Accessed at: http://cchpca.org/what-is-telehealth
[110] Telecare Services Association. "What is Telehealth?" Accessed at: http://www.telecare.org.uk/consumer-services/what-is-telehealth
[111] Barakat, A., Woolrych, R.D., Sixsmith, A., Kearns, W.D., and Kort, H. (2013) "eHealth Technology Competencies for Health Professionals Working in Home Care to Support Older Adults to Age in Place: Outcomes of a Two-Day Collaborative Workshop." *Med 2.0 2013;2(2):e10.* DOI: 10.2196/med20.2711

RECOMMENDATION ***Medium term: 3 to 5 years***

- That the BC government accelerate the adoption of new electronic information systems, including electronic health records and telehealth that facilitate the sharing of resident information across the continuing care system – including private care providers.

Sharing of information: Return from Hospital Stays

In BC there is a need for systems to better enable clinical information to be shared when residents return to a care home from a hospital stay. As outlined in the BCCPA report *Seniors Care for A Change* (2014), care providers must obtain information of medications that were prescribed and procedures that took place at a hospital from the client.[112]

If documentation on treatments and diagnoses relevant to the continuing care of the client were passed directly from the hospital to the care home, care providers would be able to implement a care plan more efficiently and accurately. This would allow for better continuity in the treatment of a resident, which could enhance the quality of care at care homes.

> *… it costs care homes $23 every time a client returns from hospital to gather new medical information.* ”

It should also be noted that it can be difficult to gather information from clients with dementia, adding to the risk of error. For example, as noted in *Seniors Care for A Change,* it costs care homes about $23 every time a client returns from hospital to gather new medical information. In particular, it found that 0.36 clients per care home per year are hospitalized, and another found that on average 0.825 clients per care home per year are hospitalized. Using the lower figure to account for clients that may not return to the care home after hospitalization, these rates imply that over 10 years, the industry spends $20,369 gathering new medical information upon a client's return from the hospital. Having information sent directly from the hospital could remove this cost and lead to better continuity of care for the hospitalized client and increase the hours of care available to other clients by over 664 hours over 10 years.

RECOMMENDATION ***Medium term: 3 to 5 years***

- That the BC government consider implementing systems that better enable patient information to flow through the health care system with the resident, particularly the sharing of information after a patient's return from a hospital stay.

[112] The Hospital Act 51(1) stipulates that a record prepared at a hospital is the property of the hospital. The privacy of that record is protected by the Freedom of Information and Protection of Privacy Act 22(3)(a) which stipulates that this personal medical information that is owned by the hospital cannot be acquired by a third party. Source: BCCPA. Seniors Care for A Change. June 2014.

SECTION 4: HEALTH HUMAN RESOURCES (HHR) – INVESTING IN PEOPLE

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.[113]

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 critical 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.[114]

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. 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 to better integrate health professionals, including physicians and nurses into residential care.[115]

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 number 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 earlier 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 Initiative

Overall, a portion of new 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.[116]

The BC Cares campaign was able to boost enrollment by 75 to 100% for much-needed residential care aides (RCAs) and home support workers (HSWs). By the fall of 2008 almost all participating post-secondary

[113] Whitney Berta, Audrey Laporte, Raisa Deber, Andrea Baumann and Brenda Gamble, "The evolving role of health care aides in the long-term care and home and community care sectors in Canada," *Human Resources for Health* 2013, 11:25 at 1.
[114] BCCPA. Rapidly Ageing Population Triggers Shortages of Care Aides. April 27, 2016. Accessed at: http://www.bccare.ca/shortage-care-aides-outside-metro-vancouver/
[115] BCCPA. Op-ed: Addressing Health Human Resource Challenges in BC's Continuing Care Sector. April 26, 2016. Accessed at: http://www.bccare.ca/op-ed-addressing-health-human-resource-challenges-bcs- continuing-care-sector/
[116] BCCPA. Rapidly Ageing Population Triggers Shortages of Care Aides. April 27, 2016. Accessed at: http://www.bccare.ca/shortage-care-aides-outside-metro-vancouver/

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.[117]

Dementia – Behavioral Supports Program

According to BC's Dementia Action Plan (2012), 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.[118] 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.[119] 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.[120]

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.[121] 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[122] 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.[123] 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.[124]

Such a program would also align well with deliverable 3.4 of the BC Ministry of Health's *Seniors Services: A Provincial Guide to Dementia Care in British Columbia* (2016), which stresses the need to increase the capacity

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[117] BCCPA. Rapidly Ageing Population Triggers Shortages of Care Aides. April 27, 2016. Accessed at: http://www.bccare.ca/shortage-care-aides-outside-metro-vancouver/

[118] The Provincial Dementia Action Plan for British Columbia. *Priorities and Actions for Health System and Service Redesign.* Ministry of Health November 2012. Accessed at: http://www.health.gov.bc.ca/library/publications/year/2012/dementia-action-plan.pdf.

[119] BC Office of the Seniors Advocate. Resident to Resident Aggression in BC Care Homes. June 2016. Accessed at: http://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2016/06/SA- ResidentToResidentAggressionReview-2016.pdf

[120] Ontario Long Term Care Association. This is Long-Term Care 2015.November 23, 2015. Accessed at: http://bluetoad.com/publication/?i=281415.

[121] Transforming Health Care. Ontario Government. February 25, 2016. Accessed at http://www.fin.gov.on.ca/en/budget/ontariobudgets/2016/bk8.html

[122] Dementia-friendly communities empower elders with dementia to contribute to their community and give them the confidence to continue to participate in activities that are meaningful to them. To achieve this, communities must focus on ensuring that they are shaped to the needs and aspirations of those with dementia, that people with dementia acknowledge themselves the positive contribution they can make to the community, and promote an awareness of dementia. Key areas of dementia friendly communities include making the physical environment easier to navigate by creating clearer signage and directional information for elders, as well as reducing the stigma surrounding dementia for seniors to participate in daily activities, and reducing barriers surrounding such illnesses.

[123] BCCPA. White Papers. *Sustainability and Innovation: Exploring Options for Improving BC's Continuing Care Sector*. May 2016. Accessed at: http://www.bccare.ca/whitepapers2016/

[124] Established in 2013, SafeCare BC (SCBC) is an industry funded, non-profit society working to ensure injury free, safe working conditions for long term care (LTC) workers in BC. SafeCare strives to be the industry leader in advancing injury prevention and safety training for LTC workers. It is committed to improving health and safety within the work place and responding to the needs and priorities of our members. SafeCare maintains a strong emphasis on injury prevention in the field of long term care through the following methods: Offering online/in-person learning for health care professionals working in the long term care sector; Improving health and safety protocols within the workplace; Providing management with training on creating and fostering an organizational culture of safety; and Providing materials and resources to support safer workplaces. For further information: http://safecarebc.ca/

of the residential care sector to provide appropriate assessment and care for persons experiencing behavioral and psychological symptoms of dementia, including reducing the inappropriate use of antipsychotic drugs.[125]

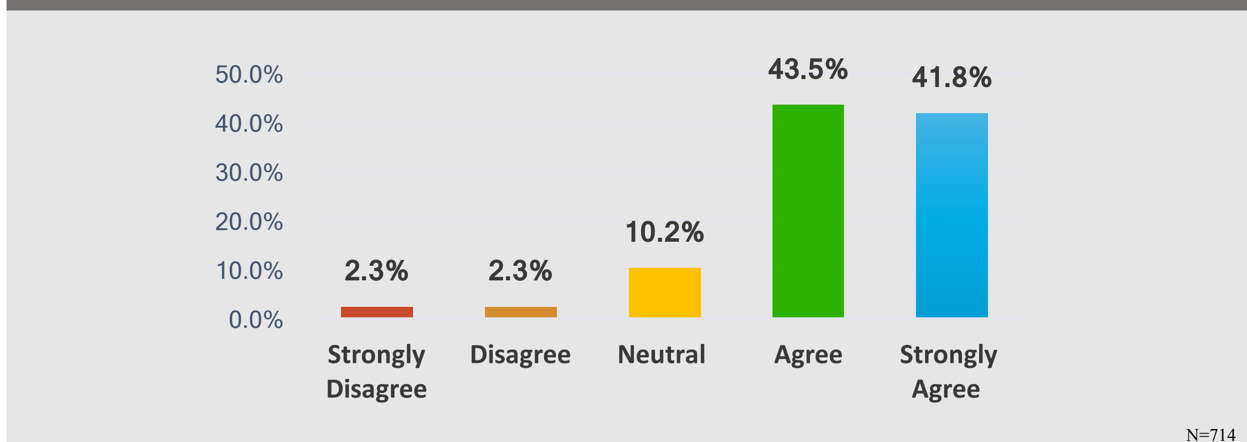
Ideally, such a program should also include some funding to care homes to cover staffing costs to allow for a care aide or other staff worker to attend such training. Without such resources it can be difficult for care homes or workers to take advantage of such training or education opportunities.

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.[126]

What is outlined above also align with the results from the BCCPA survey on the White Papers where survey respondents were asked to indicate their agreement or disagreement regarding the need to increase levels of funding in BC's residential care homes in order to increase overall staffing levels. Survey participants overwhelming indicated agreement with this statement, with 85 percent in agreement.

Figure 20: The BC Government needs to increase the overall level of funding in BC's publicly-funded residential care homes in order to increase staffing levels.



Along with $230 million to support increasing Direct Care Hours (see Section 1) and as outlined in *Strengthening Seniors Care: A Made-in-BC Roadmap*, the BCCPA recommends the creation of a $25 million Continuing Care Health Human Resource (CCHHR) Fund to be invested over 5 years to address the chronic labour shortages currently facing the continuing care sector including up to half of the funding for education, training and resources for staff to provide

[125] BC Ministry of Health. Seniors Services: A Provincial Guide to Dementia Care in British Columbia. May 2016. Accessed at: http://www.health.gov.bc.ca/library/publications/year/2016/bc-dementia-care-guide.pdf

[126] Huffington Post. How Will We Best Serve Our Aging Population? Ivy Lynn Bourgeault and Gregory Huyer. June 9, 2016. Accessed at: http://www.huffingtonpost.ca/ivy-lynn-bourgeault/health-workforce- aging-population_b_10360402.html

improved dementia care. These funds would help, as outlined earlier, in establishing a renewed BC Care Program as well as providing appropriate supports for those with dementia and the workers who care for them.

RECOMMENDATION ***Immediate: 1 to 2 years***

That the BC government establish a Continuing Care Health Human Resource (CCHHR) Fund to be invested over 5 years and potentially matched by the Federal Government to address the need for staff training and chronic labour shortages currently facing the continuing care sector, including:

- funding for a renewed 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 other key health professionals who provide frontline continuing care;
- funding for a BC Behavioural 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
- general dementia care education for care providers and support staff.

SECTION 5: END-OF-LIFE CARE

Although the BC Government has made some progress in end-of-life (EOL) 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. As Canada's population ages, the number of Canadians dying each year will increase to 330,000 by 2026.[127] 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 more than 1.6 million Canadians.[128] In British Columbia alone, over 30,000 people die annually, 53% of whom die in hospital.[129,130]

More recently, Health Quality Ontario's End-of-Life Health Care 2014 report,[131] shows that we need to better address issues around palliative care. The report highlights that just 30 per cent of people with chronic illnesses have access to team-based palliative care – most being people with cancer.[132] 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.[133] 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,[134] for this paper we focus 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 will require expanding existing capacity, as the majority of end of life (EOL) beds in BC are in stand-alone hospice centers or as part of a hospital setting (see table 7). 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 BCCPA believes that given the existing unused capacity within the continuing care sector, that some of these under-used beds could be transitioned into EOL beds, provided appropriate support is available. This is further outlined in a paper the BCCPA released in 2016 entitled *Doubling Hospice & End-of-Life Bed Capacity in British Columbia by 2020*, which makes several recommendations on EOL care.[135]

Table 7: End-of-Life and Palliative Care Beds in British Columbia (2016/17)

[127] Quality End-of-Life Coalition of Canada. Blueprint for action 2010 to 2020. 2010, p. 2
[128] Quality End-of-Life Coalition of Canada. Blueprint for action 2010 to 2020. 2010, p. 19
[129] Statistics Canada. *Table 102-0503 - Deaths, by age and sex, Canada, provinces and territories, annual (2012),* CANSIM (database). (accessed: January 5, 2016)
[130] 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
[131] *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
[132] 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
[133] 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
[134] 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.
[135] BCCPA. *Doubling Hospice & End-of-Life Bed Capacity in British Columbia by 2020, which makes several recommendations*. December 2016. Accessed at: http://www.bccare.ca/wp-content/uploads/2016/12/BCCPA-EOL-Paper-December-2016.pdf

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&recordid=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.

To better assist government, Health Authorities and seniors in identifying some of the unused capacity in April 2016, the BCCPA launched a new interactive micro website called MyCareFinder which serves as a unique and easy way to locate care for seniors across BC. Among other features, it provides seniors and their families with a partial listing of member sites including vacant care beds or assisted living (AL) units. In a 2015 report to the Government of BC, the BCCPA made a series of recommendations that helped to form the establishment of MyCareFinder. According to MyCareFinder data, as of November 2016, there were 117 vacant residential care beds across BC. This figure, however, represents only 21 reporting BCCPA members out of about 120 province-wide with private pay beds, and thus actual figure across BC are likely much higher.

Building from the recommendations in the BCCPA End-of-Life paper and as outlined in *Strengthening Seniors Care: A Made-in-BC Roadmap*, the BCCPA recommends that the Ministry and Health Authorities invest up to $20 million in annual funding to use existing capacity in residential care by using a portion of under-used residential care beds and transitioning them to end-of-life (EOL) beds. The BCCPA also suggests further support for the enhancement of the MyCareFinder.ca website as a tool to better identify empty residential care beds in "real-time".

RECOMMENDATION ***IMMEDIATE:1 TO 2 YEARS***

- That the Ministry of Health and Health Authorities, better utilize 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. 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.

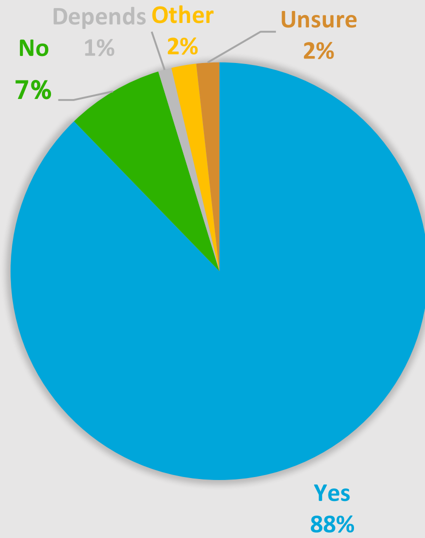
RECOMMENDATIONS **MEDIUM TERM: 3 TO 5 YEARS**

- That the BC government support the adoption of new palliative / EOL care models including, where necessary, provide new funding to improve the integration between continuing and end-of-life care.
- That the Ministry of Health and Health Authorities work with the 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.

These recommendations are also consistent with response from the BCCPA White Papers survey in which respondents were asked about whether they would support the use of under-used private-pay residential care beds and/or assisted living units being repurposed to deliver end-of-life care. Respondents overwhelmingly

indicated support for this option, with almost ninety percent (88%) indicating support. Of those that indicated that they would not support this option, some indicated that this is because they would prefer that vacant private-pay beds be used for publicly-subsidized residential care clients, while others indicated that they would prefer that hospice and end-of-life care be provided in standalone hospices.

Figure 21: Do you think the BC Government should work with Seniors Care Providers to develop a strategy to better utilize empty private-pay seniors care beds in order to increase the delivery of hospice and end-of-life care in BC?



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SECTION 6: SENIORS WELL-BEING

Improving Quality of Life for Seniors in Residential Care and in Community

While improving staffing levels, including Direct Care Hours as outlined in section 1, 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 aging 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.[136] 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.[137]

The BC Office of the Seniors Advocate (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. The OSA indicates that the capacity of ADPs in BC has not kept pace with the aging 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.[138] 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.[139]

While the OSA's update report released in November 2016 shows some improvements including increases in physiotherapy (7.8%) and recreational therapy (10.6%) there was a 16.9 percent decrease in the percentage of residential clients receiving occupational therapy.[140]

Seniors Quality of Life Fund

[136] National Health Leadership Conference. The Great Canadian Healthcare Debate. Issue Briefs: Top 5 motions. Second Edition. June 2016. Accessed at: http://www.nhlc-cnls.ca/assets/2016%20Ottawa/E- Issues%20Brief%20Booklet.pdf
[137] Ibid.
[138] BC Office of the Seniors Advocate. Caregivers in distress: More respite needed. September 2015. Accessed at: http://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2015/09/CaregiversReport.pdf
[139] BC Office of the Seniors Advocate. Placement, drugs, therapy … we can do better. April 2015. Accessed at http://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2015/09/PlacementReport.pdf
[140] BC Office of the Seniors Advocate. November 2016. Making Progress: Placement, Drugs and Therapy Update. Accessed at: https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2016/11/PDT-Update-Report-Final-November-2016.pdf

To help meet some of these gaps, this paper 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.[141]

It is important to note that 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 in the previous section on Health Human Resources it will critical also 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.

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.[142] One study notes isolation is as strong a factor in early death as smoking 15 cigarettes a day,[143] while another notes it can be twice as unhealthy as obesity, increasing chances of early death by 14 per cent.[144]

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.[145] 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.[146]

As outlined in the survey on the White Papers, participants were also asked to indicate their agreement or disagreement with the opinion that the BC government is investing enough in technological solutions to address the issue of seniors living in social isolation. The majority of survey respondents indicated that they did not think that the provincial government is investing enough (62%), while almost a third of respondents were neutral. The remaining 8%indicated they believe that the Government is performing well in this area.

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[141] Globe and Mail. The benefits of music therapy help orchestrate its rise in patient care. Sarah Black. March 29, 2016. Accessed at http://www.theglobeandmail.com/life/health-and-fitness/health- advisor/the-benefits-of-music-therapy-help-orchestrate-its-rise-in-patient-care/article23669818/

[142] Social isolation, loneliness, and all-cause mortality in older men and women. Proceedings of the National Academy of Sciences of the United States of America. Andrew Steptoe et al. February 15, 2013. Accessed at: http://www.pnas.org/content/110/15/5797.full

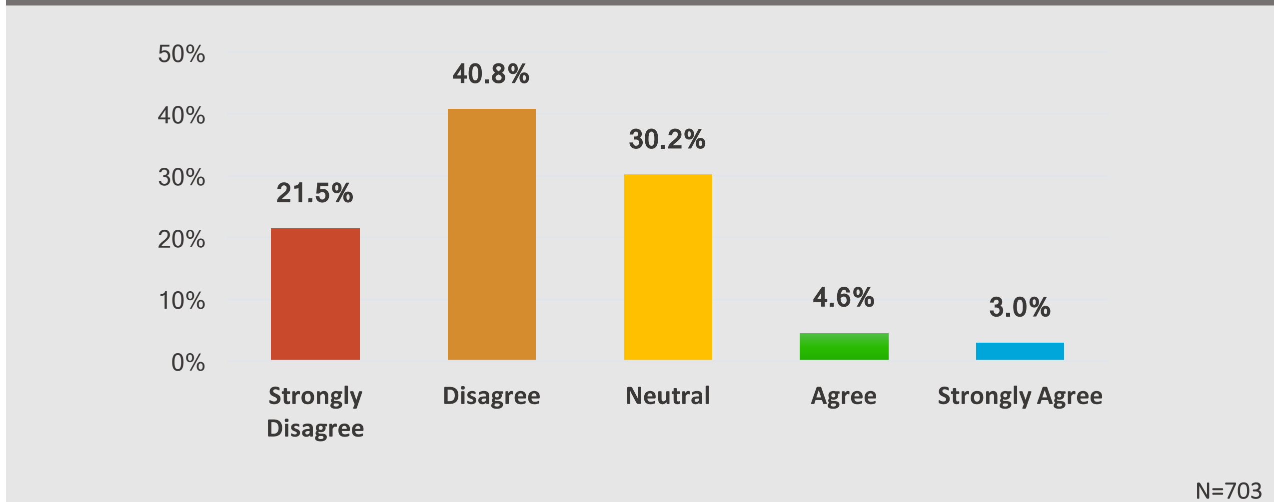
[143] Holt-Lunstadt, J., Smith, T.B., and Layton, B.L. (2010). Social relationships and mortality risk: A meta- analytic review. PLoS Medicine, p. 12. Retrieved from http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000316

[144] Loneliness twice as unhealthy as obesity for older people, study finds. The Guardian. Ian Sample. February 16, 2014. Accessed at: http://www.theguardian.com/science/2014/feb/16/loneliness-twice-as- unhealthy-as-obesity-older-people.

[145] Steptoe, A., Shankar, A., Demakakos, P., and Wardle, J. (2013). Social isolation, loneliness, and all-cause mortality in older men and women, p. 5797. Accessed at: http://www.imfcanada.org/sites/default/files/Growing_Old_Alone_April_2014.pdf

[146] Canadian Coalition for Seniors' Mental Health. National guidelines for seniors' mental health: The assessment and treatment of depression. Toronto, ON: Canadian Coalition for Seniors' Mental Health; 2006. Accessed at www.ccsmh.ca/en/guidelinesUsers.cfm.

Figure 22: The BC government is doing enough to invest in the technological solutions to address the issue of seniors living in social isolation.



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 has 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 for providing allocate on average about $6 to 7 on meals to residents.[147]

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.[148]

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.[149] Physical activity among older adults with

[147] The results included from this poll are based on an online study conducted by Insights West from March 25 to March 29, 2015, among a representative sample of 814 British Columbian adults. The data has been statistically weighted according to Canadian census figures for British Columbia for age, gender and region. Results have a margin of error of ±3.5 percentage points, 19 times out of 20.
[148] Journal of Aging and Physical Activity. Physical Exercise in Old Age: An Eight Year Follow-up Study on Involvement, Motive and Obstacles among persons Age 65-84. 1998. Mirja Hirvensalo et al. http://journals.humankinetics.com/AcuCustom/Sitename/Documents/DocumentItem/1607.pdf
[149] Windle, G., Hughes, D., Linck, P., Russell, I., & Woods,B. (2010). Is exercise effective in promoting mental well-being in older age? A systematic review. Aging & Mental Health, 14(6), 652-669. Accessed at: http://www.healthevidence.org/view-article.aspx?a=20784

cognitive impairment, including Alzheimer's disease and other dementias, has also been linked with long- term improvements in cognitive function.[150]

As outlined in *Strengthening Seniors Care: A Made-in-BC Roadmap*, the BCCPA recommends that the BC government establish a new Seniors Quality of Life Fund (SQLF) to support quality of life for seniors in residential care and in the community. Along with providing services to community the SQLF would provide up to $100 per month per senior living in a non-government operated residential care setting. Overall this would total approximately $22 million per year provided to care homes based on the fact there are approximately 18,300 non-government operated care beds that receive public funding.[151]

RECOMMENDATION ***Immediate – 1 to 2 years***

That the BC government establish a new 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 the overall quality of food and nutrition in residential care homes including meeting therapeutic diet requirements (currently the average care home allocates approximately $6 per day to feed each resident) and providing culturally appropriate meal options; and
- Regular reporting by the Ministry of Health, including what initiatives are being undertaken through the SQLF and how they are improving the overall quality of life for seniors in BC.

Home Support

Home support is also 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. Like 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 in part 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 exacerbated 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%;

[150] Journal of American Medicine. Effect of Physical Activity on Cognitive Function in Older Adults at Risk for Alzheimer Disease. Nicola T. Lautenschlager et al. JAMA. 2008;300(9):1027-1037 Accessed at: http://jama.jamanetwork.com/article.aspx?articleid=182502

[151] According to the March 2016 Facilities report, in BC there were approximately 27,422 residential care beds in BC including 18,338 non-government and 9,084 government operated. To determine SQLF it equates to number of non-government operated care beds (18,338) x $100 x 12 months.

- 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.[152]

In its latest updated Monitoring Seniors Services report the OSA found that the while the number of home support clients has increased, the hours of service are trending downward overall (i.e. in 2015/16, on a provincial level, the average home support hours delivered per year per client decreased by approximately 2% from the previous year, while the number of clients increased by 2%).[153]

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 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. In 2017 the BCCPA will be developing a policy paper on some of the home care / support challenges facing operators including:

- **Punitive Funding:** The performance-based home support funding model in BC has shifted over time from its original intention as a bonus-based system to create additional incentives to a punitive system which cuts funding. This shift is the result of funding not keeping pace with cost increases. The BC's Office of the Seniors Advocate (OSA) after her review of Home Support, also observed that this funding schema may result in unintended consequences as providers are funded at different levels in different geographies in BC.

- **Unfunded service expectations:** Contracted home support providers are paid on a per hour basis for approved services provided. In particular, they are required to deliver education courses to all Community Health Workers (CHWs) but are unable to be reimbursed for these costs. The programs are designed and defined by the Health Authorities (HAs) as well as made mandatory for providers to deliver without any additional compensation for the direct labour or associated costs.

- **Travel Costs:** The current funding model pays all providers at the same hourly rate. This is even though there are significant differences in travel compensation costs due to geographic service areas. An all-inclusive rate that includes these material differences creates the risk of unintended consequences when in effect it leaves some providers significantly more well-funded than others.

- **Short Visits:** As currently funded, BC's Home Care sector is not sustainable and will struggle to deliver consistent high quality care, despite the best effort of publicly-subsidized home care providers. Inadequate funding to meet the demand for services from residents, have resulted in a steady reduction in time spent with each client.
    - In congregate settings (e.g. assisted living and supportive housing settings), visits are often as short as 15 minutes including time for documentation and charting. In neighbourhood settings, it is 30 minutes, again less travel and documentation time. BC residents are not being provided with the high quality care intended by the Home Care program.
    - In other jurisdictions (e.g. Ontario), they are only now beginning to consider shortening the 1 hour minimum to 45 minutes. For that 75% of the hour, they are considering compensation rates around 85% the hourly rate in recognition that shorter visits are more expensive to deliver.

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[152] BC Office of the Seniors Advocate. *Monitoring Seniors' Services*. January 2016. Accessed at: http://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2016/01/SA-MonitoringSeniorsServices-2015.pdf

[153] Office of the Seniors Advocate. *Monitoring Seniors' Services* (2016). December 2016. Accessed at: https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2016/12/OSA-MonitoringReport2016.pdf

- Short Visits Hurt Client Satisfaction: As care visits get shorter client satisfaction also drops. The BC OSA's Home Support report[154] shows that in many jurisdictions in BC, clients do not feel that their workers have adequate time to deliver the care that is needed. Client satisfaction is one of the performance based funding metrics and providers may have their hourly rate cut if satisfaction rates do not hit the set targets, despite having no control over these variables.

Like residential care, the effective delivery of high quality Home and Community Care services in BC relies on a strong partnership between clients, government, CHWs, and health care service providers. Currently, clients, CHWs and health care service providers are expressing dissatisfaction and serious concerns about how funding decisions are negatively impacting care delivery. Increasing care demands and a lack of proper government funding threatens the sustainability of BC's vital Home Care sector. A call to action is required to protect these necessary services for current and future BC residents.

As such the BCCPA recommends that as part of any Continuing Care Collaborative it include a permanent sub-committee to deal with the unique and considerable challenges facing the home care sector including a review of funding, unfunded service expectations, travel costs, increasing time for home support visits and improving quality care. This committee could also be tasked with exploring the adoption of innovative care home models used in Canada and abroad (a few examples of these are highlighted in Appendix F).

The BCCPA also recommends as outlined in *Strengthening Seniors Care: A Made-in-BC Roadmap that in the* immediate term the Health Authorities increase the minimum home care visit time from 15 to 30 minutes.

RECOMMENDATION ***Immediate: 1 to 2 years***

- That the Health Authorities increase the minimum home care visit time from 15 to 30 minutes.

RECOMMENDATION ***Medium term: 3 to 5 years***

- That as part of any Continuing Care Collaborative it includes a permanent sub-committee to deal with the unique and considerable challenges facing the home care sector including a review of funding, unfunded service expectations, travel costs and improving quality care. Likewise, this sub-committee should explore different innovative models in home care to determine their use or adoption in BC.

Seniors Safety

As noted earlier, Canada's population is aging. By 2036, the number of seniors aged 65 years or older will more than double, making up to approximately 25 per cent of the total population. In addition, the population of seniors 85 years and older is set to quadruple[155]. This demographic reality should be seen as imperative and a

[154] Listening to your voice: Home support survey results released. September 2016. Accessed at: https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2016/09/SA-HomeSupportSurveyReport-Sept2016-Final.pdf

[155] CMA Election Toolkit, 2015. Canada needs a national seniors strategy: make your voice heard. Accessed at: https://www.cma.ca/Assets/assets-library/document/en/advocacy/election-toolkit-members-public-e.pdf

critical opportunity for better understanding and meeting the needs of the aging population. Health care spending is significantly more expensive for seniors than for the rest of the population. The cost of providing health care to those between 65 and 90 years old is approximately double the cost of providing care to all those under age 65. These costs, however, are not spread evenly amongst seniors. While many seniors are fit and require relatively little care, some seniors require significant acute and continuing care.

DID YOU KNOW: By 2036, the number of seniors aged 65 years or older will more than double, making up to approximately 25 per cent of the total population.

It has been projected that total demand in BC for health care services by seniors is expected to increase by 41% over the next 10 years from population growth and aging alone (ignoring all other growth factors). In comparison, demand from the population under age 65 will only increase by 13%.

In BC, seniors represent almost 48 per cent of the total number of people with diabetes and 60 per cent of older adults are largely inactive. Falls are the most common cause of injury among BC seniors. Each year, one in three BC seniors experience at least one fall. Injuries from falls account for 85 per cent of all injuries to seniors and cost the BC government over $155 million annually in health costs.

A February 2013 report from the Canadian Institute for Health Information (CIHI) notes that 1 in 200 Canadian seniors also had to be admitted to hospital because of adverse reaction to a drug. Although it may be appropriate for some seniors to take several drugs, the use of multiple medications, known as polypharmacy, can increase the risks of drug interactions and side effects. As outlined further in a 2016 BCCPA Backgrounder, polypharmacy increases risk for adverse drug reactions (ADRs), adverse drug events (ADEs), falls, hospitalization, institutionalization, mortality, and other adverse health outcomes among seniors.[156] According to one study, 13% of seniors taking 5 or more prescription medications experience ADEs that require medical attention, compared with 6% of those taking 1 or 2 drugs.[157]

A 2009 report by Statistic Canada states that men aged 85 to 89 have the highest rate of suicide among any age group in Canada, at a rate of about 31 per 100,000. The issue of elder abuse is also one of significant importance for BC, as seen by the 2013 release of its Elder Abuse strategy and the creation on an Office of Elder Abuse, which the BCCPA is also a member. Likewise, the issue of safety in continuing care has gained significant media attention with high profile events including fires and cases of elder abuse across Canada, including BC.

With the aging population, it will be important to focus on how to prevent serious injuries from occurring in the first place. To achieve this one potential area that should be of focus is that of Seniors Safety. A cross-collaborative initiative, for example, could focus on specific issues that have received significant attention both here in BC and nationally including falls prevention, reducing adverse drug events, suicide prevention, elder abuse, resident-on-resident aggression and/or safety within home and community care.

RECOMMENDATION ***Medium – 3 to 5 years***

- That the BC government, working with stakeholders, develop a collaborative Provincial Seniors Safety Strategy which could focus on specific issues including use of technology, falls

[156] BCCPA. BCPA Backgrounder: Reducing polypharmacy in BC's continuing care sector. December 2016. Accessed at: https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2016/09/SA-HomeSupportSurveyReport-Sept2016-Final.pdf

[157] Deprescribing in Clinical Practice: Reducing Polypharmacy in Older Patients Linda Brookes. November 26, 2013. Accessed at: http://www.medscape.com/viewarticle/814861_2. Another Australian study shows that if a patient is taking two drugs, the likelihood of an adverse event is 13 per cent; at four drugs, that increases to 38 per cent; and once you take seven or more drugs, it jumps to 82 per cent. Source: Seniors are given so many drugs, it's madness. Andre Picard. Globe and Mail. March 8, 2016. http://www.theglobeandmail.com/opinion/seniors-are-given-so-many-drugs-its-madness/article29061583/.

prevention, resident-on-resident aggression, reducing adverse drug events, suicide prevention, elder abuse and/or safety within home and community care.

Ceiling Lifts: Resident and Worker Safety

Another possible area that should be explored is a federal and/or provincial fund to support resident and worker safety. An example of such a fund is the federal government initiative to spend $10 million to put more defibrillators in Canada's hockey rinks. The goal of the program delivered by the Public Health Agency of Canada working collaboratively with the Heart and Stroke Foundation of Canada (HSFC) is to ensure that every arena in Canada is appropriately equipped with automated external defibrillators (AEDs) and to support training for attendants in using them.

DID YOU KNOW: For every dollar spent on direct claims costs, an additional $4 is spent on indirect costs such as incident investigations, rescheduling, and lost productivity.

Like the AED program, the federal government and/or provinces could work to establish a joint patient / worker safety fund for health care workers. One such priority that could be funded is an initiative is to install ceiling lifts and other retrofits to residential care homes across Canada. To address some of the safety issues related to workers in long term care a provincial health and safety association, SafeCare BC, was created in 2014 via a concerted effort by continuing care providers with support from WorkSafeBC and the BCCPA to address this issue. Worker injury trends in continuing care have widespread implications.[158] Over $23 million is spent each year on WorkSafeBC claims alone. For every dollar spent on direct claims costs, an additional $4 is spent on indirect costs such as incident investigations, rescheduling, and lost productivity.

Workplace injuries have consequences that stretch beyond financial implications. Staff retention, recruitment and job satisfaction are all negatively affected by workplace injuries. With nearly a quarter of BC's population expected to be aged 65 or older in the next 20 years, the ability to recruit and retain continuing care workers will become increasingly important.

Building on experiences from Alberta[159], SafeCare BC endeavours to support the sector in reducing workplace injuries. As a sector-funded and driven association, they have been actively engaging with key stakeholders across the province to identify concerns and raise awareness of the issues. From delivering dementia care training in partnership with the Alzheimer Society of BC, to launching the Be Care Aware communications campaign, they have also responded to sector feedback with tangible initiatives.

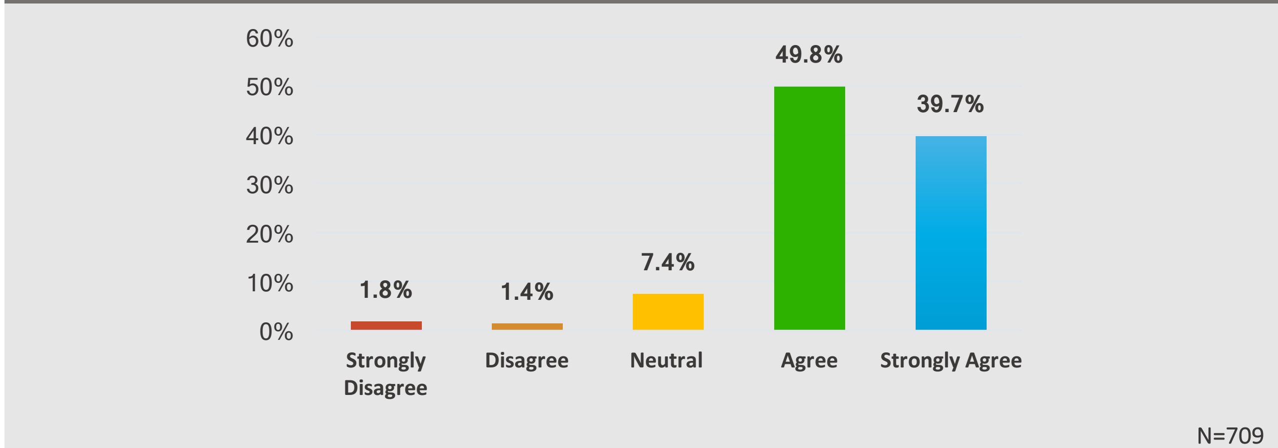
These initiatives are just a starting point. Tackling the issue of workplace injuries in continuing care will require a sustained and multi-pronged approach. Engagement of those who work in or use services in the continuing care sector is critical as is raising awareness of the need for change.

As outlined in the BCCPA Survey on the White papers participants were asked to indicate their overall support or opposition to the Federal and BC Provincial Government investing in infrastructure spending to renew care homes in BC, including installing ceiling lifts, sprinkler systems, and other retrofits. This policy option received overwhelming support, with almost 90 per cent of survey respondents indicating some level of agreement, and only 3 per cent indicating disagreement.

[158] Overexertion (51 per cent), acts of violence or aggression (11 per cent), and slips or trips (10 per cent) form the top three ways that staff are hurt on the job. Care aides are the most affected as nearly 60 per cent of all workplace claims in long term care involve care aides. Licensed practical nurses are the second-most affected group at just under 15 per cent, while social and community support workers and registered nurses/registered psychiatric nurses round out the top four at 4.7 per cent and 4.5 per cent, respectively.

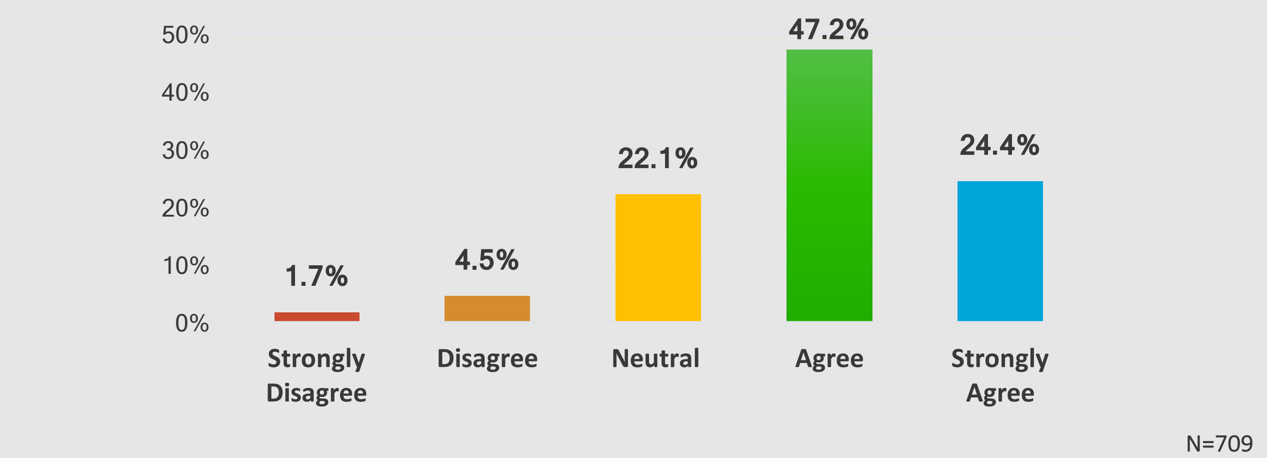
[159] Similar to B.C., the Alberta continuing care sector faced significant challenges with regards to workplace safety. The Alberta Continuing Care Safety Association was established to address workplace injuries in long term and home care. Since 2005, overall injury rates for the continuing care sector have decreased by 20 per cent. Moreover, organizations who actively participated in the CCSA's injury reduction program experienced an average decrease of 64 per cent in workplace injuries in their first year of participation.

Figure 23: The Federal and Provincial governments should set aside infrastructure funding to improve the safety of residents and health care workers, including targeted funding to install ceiling lifts, sprinkler systems and other retrofits to older residential care homes.



Survey respondents were also asked to indicate their agreement or disagreement with the idea that the BC Government should be investing in new and innovative technologies to improve the safety of seniors, including through new monitoring and surveillance systems. This policy option received good support, with just over 70 per cent indicating agreement, including 24 per cent indicating strong support. A significant portion of survey respondents were neutral on this option (22%), with the remaining 6 per cent indicating disagreement.

Figure 24: The BC government should be investing in technology to improve the safety of seniors, particularly through new monitoring and surveillance systems.



To deal with these concerns regarding seniors and worker safety and as outlined in **Strengthening Seniors Care: A Made-in-BC Roadmap**, the BCCPA has recommended that a portion of the earlier mentioned Residential Care Infrastructure Fund (RCIF) or about $20M over three years be used to support investments in smaller infrastructure projects such as sprinkler and ceiling lift installations, security, automated medication management and data collection systems.

SECTION 7: SHIFTING RESOURCES FROM ACUTE TO CONTINUING CARE

If fully implemented, the recommendations outlined in this report would be significant. Given the importance of seniors particularly with an aging population we believe that this is a worthwhile investment. It is also consistent with public opinion. For example, a 2015 poll 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.[160]

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.[161] 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.

One percent solution

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.[162] 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 over $6.4 billion or between 55 to 59% of total budgets (see Appendix G 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 H). Along with potentially funding many of the recommendations outlined in this paper it also 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

[160] The results included from this poll are based on an online study conducted by Insights West among a representative sample of 814 British Columbian adults. The data has been statistically weighted according to Canadian census figures for British Columbia for age, gender and region. Results have a margin of error of ±3.5 percentage points, 19 times out of 20.
[161] Primary and Community Care in BC: A Strategic Policy Framework. BC Ministry of Health. February 2015. Accessed at: http://www.health.gov.bc.ca/library/publications/year/2015/primary-and-community- care-policy-paper.pdf
[162] BCCPA. Op-ed: Quality, Innovation, Collaboration – Strengthening Seniors Care Delivery in BC. October 2015. Accessed at: http://www.bccare.ca/op-ed-quality-innovation-collaboration-strengthening-seniors-care-delivery-in-bc/

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.

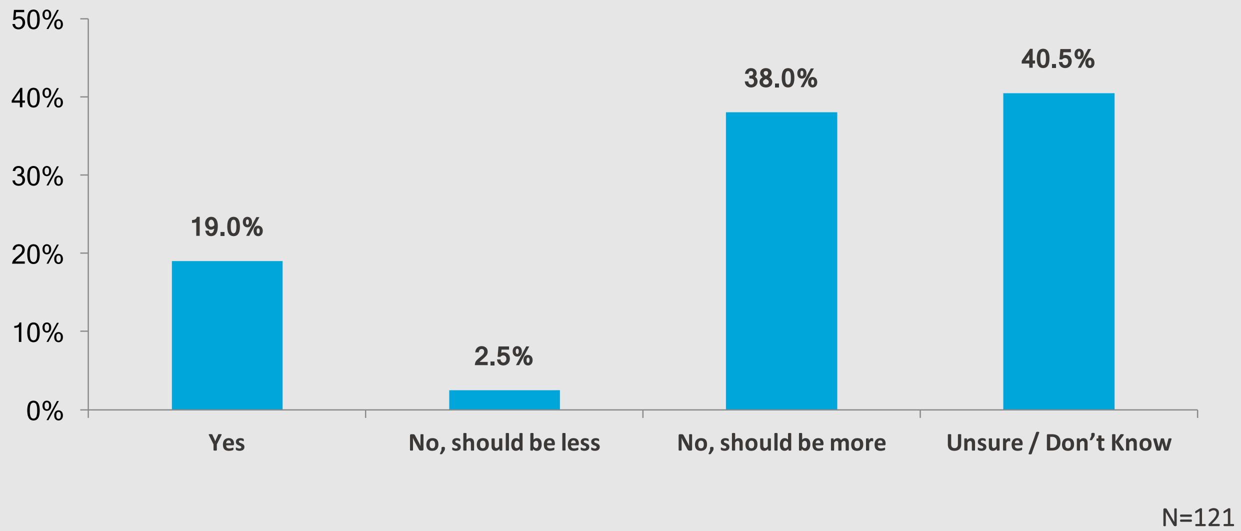
As outlined further in the BCCPA *Quality, Innovation, Collaboration* paper redirected funding could also be used to support the integration of physicians as well as new health professions such as nurse practitioners and physician assistants into continuing care. The funding could also be used to invest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

When participants were asked at the BCCPA Continuing Care Collaborative, whether the proposed 1% shift in health authority acute care expenditures to home and community care is the right amount to meet the growing demands of an aging population, there was broad consensus as close to 60% said was enough or should be more. Another 40% were unsure.

Figure 25: Support for 1% shift in health authority acute care expenditures to home and community care



Furthermore, when asked whether they support or oppose reinvesting part of the 1% in health authority acute funding to support development or creation of continuing care hubs two-thirds of respondents said they would support this.

RECOMMENDATION ***Immediate: 1 to 2 years***

- Starting in fiscal year 2017/18, that the Performance Agreements between British Columbia's Ministry of Health and Health Authorities include a specific target for redirecting acute care expenditures such as a minimum of 1 percent annually over a five-year period to the home and community care sector. Along with supporting initiatives outlined earlier, 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 care models particularly Continuing Care Hubs to reduce acute care pressures (including ALC days), improve access to care while also allowing seniors to receive services in the most appropriate setting.

SECTION 8: FEDERAL ROLE IN SENIORS 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 certain 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 2015 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.

Federal Funding

New federal investments are of the upmost importance for reasons outlined earlier in this report – namely our province's aging 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) has previously 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.[163] In November 2016 the Standing Senate Committee on Social Affairs, Science and Technology committee also recommended the federal government invest $540 million in continuing care infrastructure to increase the capacity for long-term care in provinces and territories.[164]

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.[165] 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

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[163] CMA. Improving Seniors Care in an Era of Surplus. 2014-2015 pre-budget consultation submission to the House of Commons Standing Committee on Finance. August 6, 2014. Accessed at: https://www.cma.ca/Assets/assets-library/document/en/Pre-Budget%20Submission%202014-2015%20Final%20Version%20(English).pdf. As outlined in the CMA paper, long-term care homes also include assisted living units and other types of innovative residential models that ensure residents are in the care setting most appropriate to their needs.

[164] Standing Senate Committee on Social Affairs, Science and Technology committee. Dementia in Canada. A National Strategy for Dementia Friendly Communities. November 2016. Accessed at: http://www.alzheimer.ca/~/media/Files/national/Advocacy/SOCI_6thReport_DementiaInCanada-WEB_e.pdf

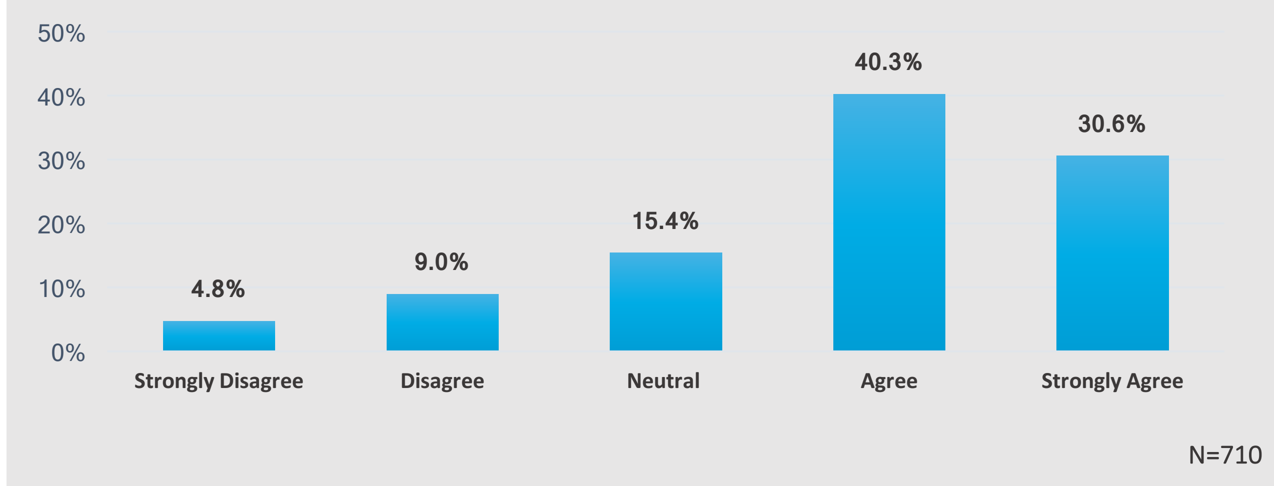
[165] In a December 2016 OSA report it also highlights that wait times for residential care in British Columbia are getting longer. In particular, it notes that the average and median wait times for residential care grew longer in three of five regional health authorities and the proportion of residents admitted to residential care within the target window of 30 days decreased from 64% in 2014/15 to 57% in 2015/16).

home care services for Canadians; a pan-Canadian collaboration on health innovation; as well as improving access to necessary prescription medications, particularly for seniors.

While the BCCPA is encouraged by the federal government indicating in late 2016 that it is willing to provide provinces an annual increase to the CHT of 3.5 percent over the next five years along with $11.5 billion in targeted spending (including $6 billion for home care and $5 billion on mental health) over the next ten years[166] further investments to seniors may still be required by all levels of government.

As outlined in the White Papers survey participants were asked to indicate their opinion on an Age-Adjusted Canada Health Transfer (CHT), where provinces with higher proportions of seniors receive additional funding on a per person basis. This concept received good support, with just over 70% of respondents indicating support for this policy option. Fifteen per cent of survey respondents indicated that they were neutral on this issue, while 14% indicated that they disagreed.

Figure 26: Provinces with higher proportions of seniors as part of their overall population should receive more federal funding per person compared to other provinces.

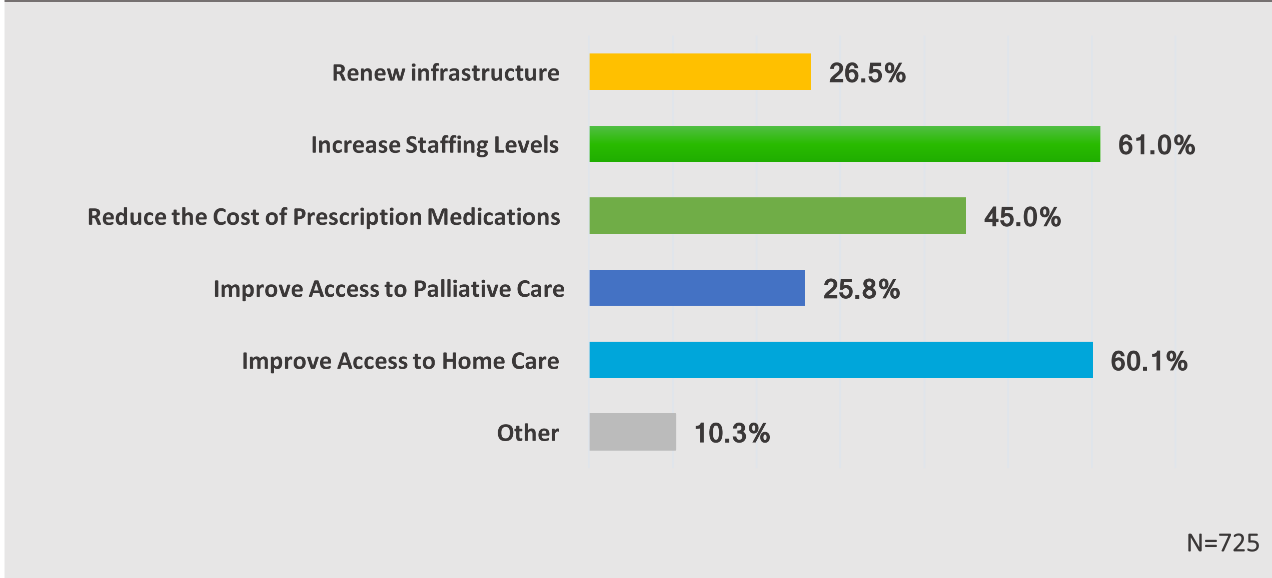


Survey respondents were also asked what areas of health care the Federal Liberal Government should be investing in, given the $3 billion commitment that was made during the election campaign. Respondents, who could identify up to three areas, indicated that their top priorities were:

- Increasing staffing levels for care (61%);
- Improving access to home care (60%); and
- Reducing the cost of prescription medications (45%).

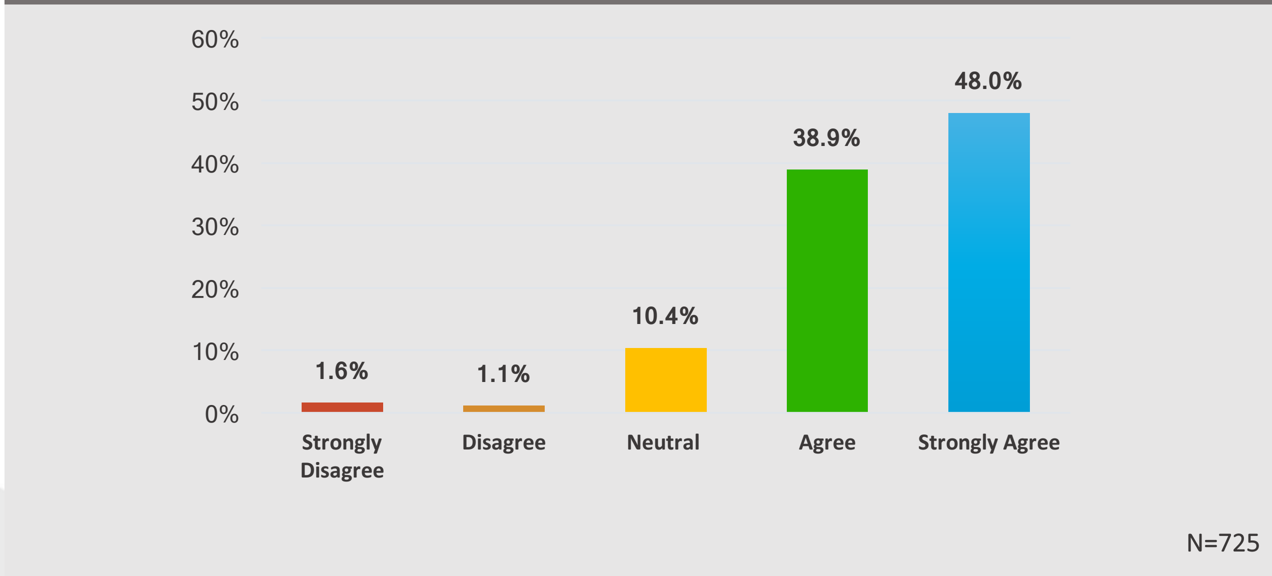
[166] CBC News. Ottawa, provinces fail to reach a deal on health spending. John Tasker. December 19, 2016. Accessed at: http://www.cbc.ca/news/politics/health-accord-meeting-1.3903508

Figure 27: The Federal Government has committed over $3 billion dollars in new investments in Health Care services, including for seniors. What should be the key priority areas for this new funding? Choose three or fewer.



Finally, survey participants were also asked to indicate their overall agreement or disagreement to the opinion that Canada should improve access to necessary prescription medications, particularly for seniors. Survey participates indicated overall agreement with this statement, with 87% stating either that they agree or strongly agree. Just over 10 per cent of survey respondents indicated that they were neutral, with less than 3 per cent indicating disagreement.

Figure 28: Canada needs to improve access to necessary prescription medications, including for seniors.



RECOMMENDATION: ***Immediate: 1 to 2 years***

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.

National Dementia Strategy

Although some other provinces / territories (P/Ts) have developed dementia strategies, media releases from the G8 Dementia Summit held in December 2013 highlights Canada as the only G8 country without a national strategy on dementia. At the political and stakeholder level, organizations such as the Canadian Medical Association (CMA) and the Alzheimer's Society of Canada (ASC) have been advocating for a national dementia strategy. The House of Commons' Standing Committee on Finance, which includes members of all federal political parties, also recommended that government "move expeditiously" on developing a national dementia plan. More recently in November 2016 the Standing Senate Committee on Social Affairs, Science and Technology committee also recommended that the federal government immediately establish the Canadian Partnership to Address Dementia with a mandate to create and implement a National Dementia Strategy.[167]

> *"… the G8 Dementia Summit held in December 2013 highlights Canada as the only G8 country without a national strategy on dementia."*

Currently there are 747,000 Canadians living with Alzheimer's disease and other forms of dementia. That number is expected to increase to 1.4 million by 2031. 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 cites that this number is expected to double within the next 25 years. [168]

The dementia epidemic is particularly critical in the continuing care sector. A 2012 report from the Canadian Institute for Health Information (CIHI) notes that 61.5% of seniors in residential care are living with dementia. In a recent survey of BCCPA members, it was identified that the average number of residents living with Alzheimer's and dementia was 69% in Residential Care, 32% in Assisted Living, 32% in Home Care and 8% in Independent Living. Increasing levels of dementia are placing strains on care providers. As such along with recommending earlier increased funding for dementia training and education for care providers, the BCCPA has previously recommended that to match the costs of delivering complex care, that continuing care funding appropriately account for the growing population of residents with dementia.

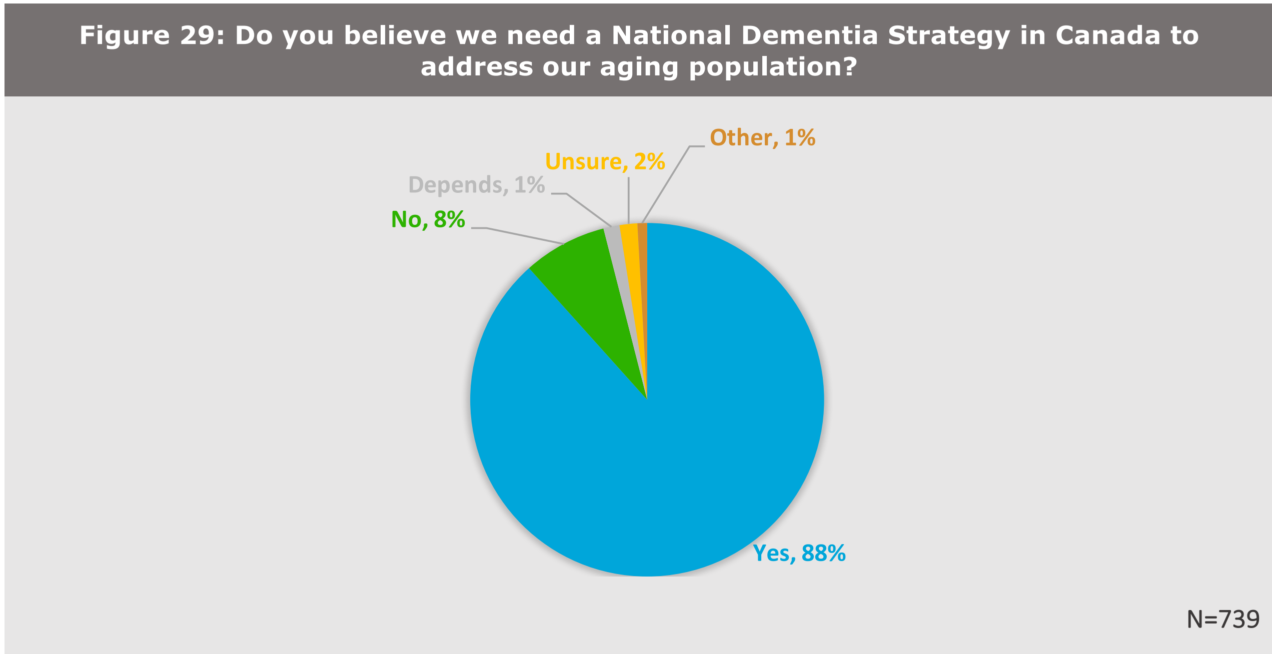
The costs of caring for a person with advanced dementia are indeed high. Dementia currently costs Canada roughly $33 billion per year, both in direct health care expenses and in indirect costs, such as lost earnings of the person's caregivers. These costs are expected to total $293 billion by 2040. The costs of caring for a person with advanced dementia are also particularly high. According to the USC Leonard D. Schaeffer Centre for Health

[167] Standing Senate Committee on Social Affairs, Science and Technology committee. Dementia in Canada. A National Strategy for Dementia Friendly Communities. November 2016. Accessed at: http://www.alzheimer.ca/~/media/Files/national/Advocacy/SOCI_6thReport_DementiaInCanada-WEB_e.pdf
[168] The Provincial Dementia Action Plan for British Columbia. *Priorities and Actions for Health System and Service Redesign.* Ministry of Health November 2012. Accessed at: http://www.health.gov.bc.ca/library/publications/year/2012/dementia-action-plan.pdf .

Policy and Economics the annual per-person cost of the disease (including direct and indirect costs) was $71,000 (US) in 2010 and is expected to double by 2050.[169] However, the per-person cost also varies depending on the type of dementia, and the severity.

In the BCCPA survey on the White Papers respondents were asked whether Canada should develop a National Dementia Strategy to address the country's aging population. This option received overwhelming support, with 88% of respondents indicating support, and an additional one percent indicating depends. Of the eight percent of survey respondents that would not support a National Dementia Strategy, many indicated that they would prefer this work to be done at the provincial level. Similar results were also outlined at the BCCPA Continuing Care Collaborative held in September of 2016.

Figure 29: Do you believe we need a National Dementia Strategy in Canada to address our aging population?

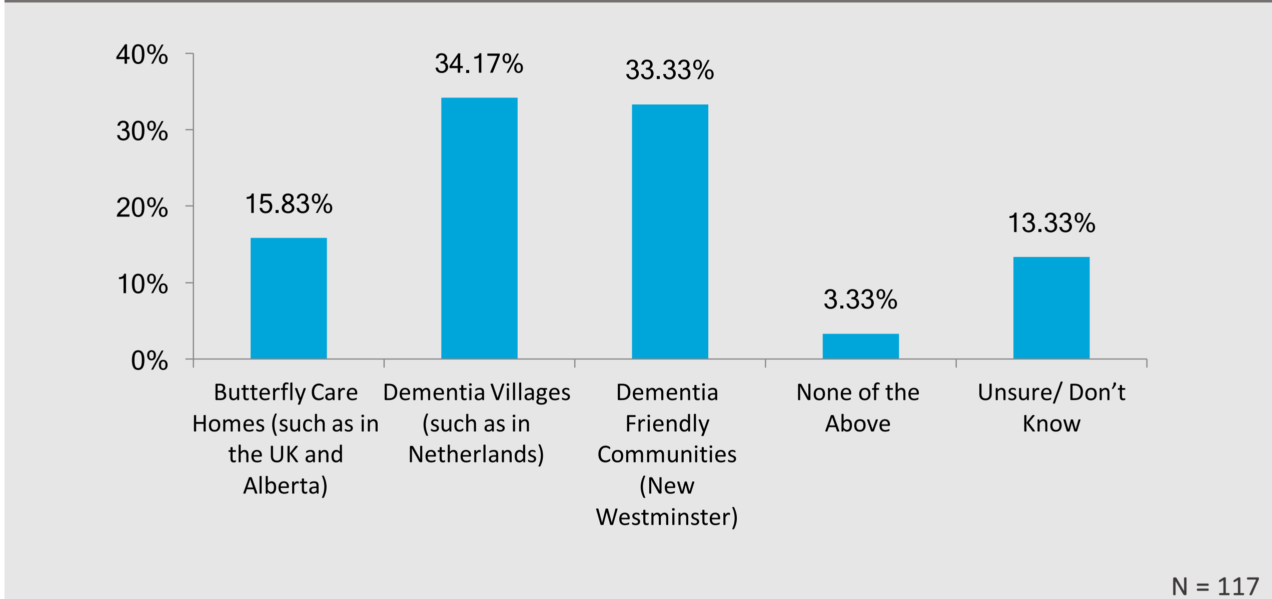


Survey respondents were also asked whether they believed that British Columbia needs a Provincial Dementia Strategy – a topic which is also discussed at length in the earlier BCCPA White Papers. Like the previous question, this option received overwhelming support as 86% survey respondents indicated support. An additional 2% indicated depends; as these survey respondents expressed concerns about how a Provincial Dementia Strategy would operate within the context of a National Dementia Strategy. Others expressed that while we may need a National or a Provincial Dementia Strategy, we do not need both.

At the Continuing Care Collaborative participants also discussed which dementia care models or initiatives should be prioritized for development in BC. Of the options proposed there seemed strong support for dementia friendly communities and dementia villages, with some support for butterfly care homes. Details of these models are detailed further in the White Papers and Appendix I of this paper.

[169] Press Room. Study: Baby Boomers Will Drive Explosion in Alzheimer's-Related Costs in Coming Decades. November 11, 2014. Accessed at: https://pressroom.usc.edu/study-baby-boomers-will-drive-explosion-in-alzheimers-related-costs-in-coming-decades/

Figure 30: Which of the following dementia models or initiatives should be prioritized for development in BC



With respect to Dementia, there is an opportunity for BC to take leadership nationally on this issue. One such area, for example, could be the development of a National Dementia Strategy. BC could attempt to advance this nationally with federal participation or amongst provinces and territories (P/Ts) through the Council of the Federation (COF) Health Care Innovation Working Group.

RECOMMENDATION ***Medium term: 3 to 5 years***

- British Columbia endorse the advancement of a National Dementia Strategy with federal participation which should include investing in research and ensuring capacity and appropriate funding in the continuing care sector.

- That as part of any National or Provincial Dementia Strategy the BC government explore, where appropriate, the creation of new care models or initiatives to support seniors with dementia including but not limited to Dementia Villages, Butterfly Care Homes and Dementia Friendly Communities (DFCs). Where appropriate, the Residential Care Infrastructure Fund should also be provided to support the development of such initiatives including retrofitting existing care homes as part of any strategy to create DFCs.

National Seniors Health Promotion Strategy

As noted earlier, Canada's population is aging. By 2036, the number of seniors aged 65 years or older will more than double, making up approximately 25 per cent of the total population. In addition, the population of seniors

85 years and older is set to quadruple.[170] Between 2011 and 2031, BC's senior's population (age 65+) is expected to increase 93% compared to a 14% increase in the working age population and a 21% increase in the population under 15 years of age.[171]

Health care spending is significantly more expensive for seniors than for the rest of the population. The cost of providing health care to those between 65 and 90 years old is approximately double the cost of providing care to all those under age 65.[172] These costs, however, are not spread evenly amongst seniors. While many seniors are fit and require relatively little care, some seniors require significant acute and long-term care.

In general, the aging population will put additional pressures on the health care system, particularly in dealing with mental health and chronic diseases. As outlined in the BC Ministry of Health paper *Setting Priorities for the BC Health System*, the aging of the population is important as the likelihood that a person will have at least one chronic condition or life-limiting illness increases significantly with age. As a result, so does their need for health services. A large percentage (41%) of Canadian seniors are also dealing with two or more select chronic conditions, such as diabetes, respiratory issues, heart disease, and depression and many are experiencing a decline in physical and/or cognitive functioning[173].

With the aging population, it will be important to focus on how to prevent serious chronic diseases from occurring in the first place. To achieve this one potential area of provincial/territorial (P/T) collaboration that BC could advance is that of Seniors Health Promotion. In particular, a future deliverable could be the development of a National Seniors Health Promotion Strategy (NSHPS).

A NSHPS could outline various initiatives or approaches to promote seniors physical and mental well-being, including outlining best practices among jurisdictions. Along with initiatives in Canada, best practices internationally could be explored such as New Zealand's Guidelines on Physical Activity for Older People.[174] Without taking action, dementia and falls are likely to increase over time, as are largely preventable diseases such as diabetes, hypertension, heart disease, stroke, cancer, mental illness and musculoskeletal conditions.[175] Approximately 4 in 5 Canadian adults have at least one modifiable risk factor for chronic disease.[176] By taking action it will improve senior's quality of life and lessen some of the pressures facing the health system, including reducing unnecessary hospitalizations.

Less than 1 per cent of total health-care spending in Canada is devoted to health promotion, physical activity/education and sport despite the touted benefits.[177] In the US, for example, it has been estimated that an investment of $10 (US) per person per year for proven community-based disease prevention programs on physical activity, nutrition, and reducing tobacco use can lead to reductions of: type 2 diabetes and high blood pressure by 5% in 1 to 2 years; heart disease, kidney disease and stroke by 5% in 5 years; and some forms of cancer, COPD and arthritis by 2.5% in 10 to 20 years.[178] A US study also shows that medical advances that delay the onset of dementia

[170] CMA Election Toolkit, 2015. Canada needs a national seniors strategy: make your voice heard. Accessed at: https://www.cma.ca/Assets/assets-library/document/en/advocacy/election-toolkit-members-public-e.pdf
[171] British Columbia's population is growing and aging, with the fastest growing seniors' population in Canada. The population over 65 is expected to increase from about 14 per cent to 24 per cent of the total provincial population between 2006 and 2036.
[172] Total demand in BC for health care services by seniors is expected to increase by 41% over the next 10 years from population growth and aging alone (ignoring all other growth factors). In comparison, demand from the population under age 65 will only increase by 13%.
[173] Health Council of Canada. Seniors in Need, Caregivers in Distress (2012).
[174] New Zealand's Guidelines on Physical Activity for Older People (aged 65 years and over), Ministry of Health, New Zealand, January 2013. Accessed at: http://www.health.govt.nz/publication/guidelines-physical-activity-older-people-aged-65-years-and-over
[175] Canadian Public Health Association. Making the Economic Case for Investing in Public Health and the SDH. Accessed at: http://www.cpha.ca/en/programs/social-determinants/frontlinehealth/economics.aspx
[176] Government of Canada. New projects track factors that lead to chronic disease and injury. April 21, 2016. Accessed at: http://news.gc.ca/web/article-en.do?nid=1055489&tp=1
[177] Prevention gets left out of health-care debate. Toronto Star. Chris Jones. December 26, 2012. Accessed at: https://www.thestar.com/opinion/editorialopinion/2012/01/20/prevention_gets_left_out_of_healthcare_debate.html
[178] Canadian Public Health Association. Making the Economic Case for Investing in Public Health and the SDH. Accessed at: http://www.cpha.ca/en/programs/social-determinants/frontlinehealth/economics.aspx

by five years add about 2.7 years of life for patients. The study also noted that this could result in a 41% lower prevalence of the disease in the population, thus, having the potential to lower overall costs to society by 40%.[179]

While there has been a major focus on health promotion 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, a focus on senior's health promotion can have significant impacts. A study from Finland 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.[180] 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.[181] Physical activity among older adults with cognitive impairment, including Alzheimer's disease and other dementia, has also been linked with long-term improvements in cognitive function.[182]

A NSHPS could focus on the following key areas: 1) Outline various approaches to promote seniors physical and mental well-being, including outlining best practices among jurisdictions in these areas; 2) Strategies and/or best practices to reducing impacts of aging such as falls prevention; 3) Development of appropriate nutrition and exercise guidelines for seniors; and 4) Strategies to improve senior's mental health, including reducing senior's isolation, etc. As part of this initiative and to deal with issues outlined above, the federal government through the Public Health Agency of Canada, could work jointly with health care stakeholders and provinces to provide grant funding to support various initiatives and/or pilot projects across the country.

As outlined in the BCCPA White Papers survey, respondents were asked to indicate their level of agreement with the idea of the BC Government promoting the development of a National Seniors Health Promotion Strategy that would address senior's mental and physical health. 85% of survey respondents indicated that they would support such an initiative, while 12% were neutral, and 3.5% indicating disagreement. Similar results were also outlined at the BCCPA Continuing Care Collaborative in September 2016.

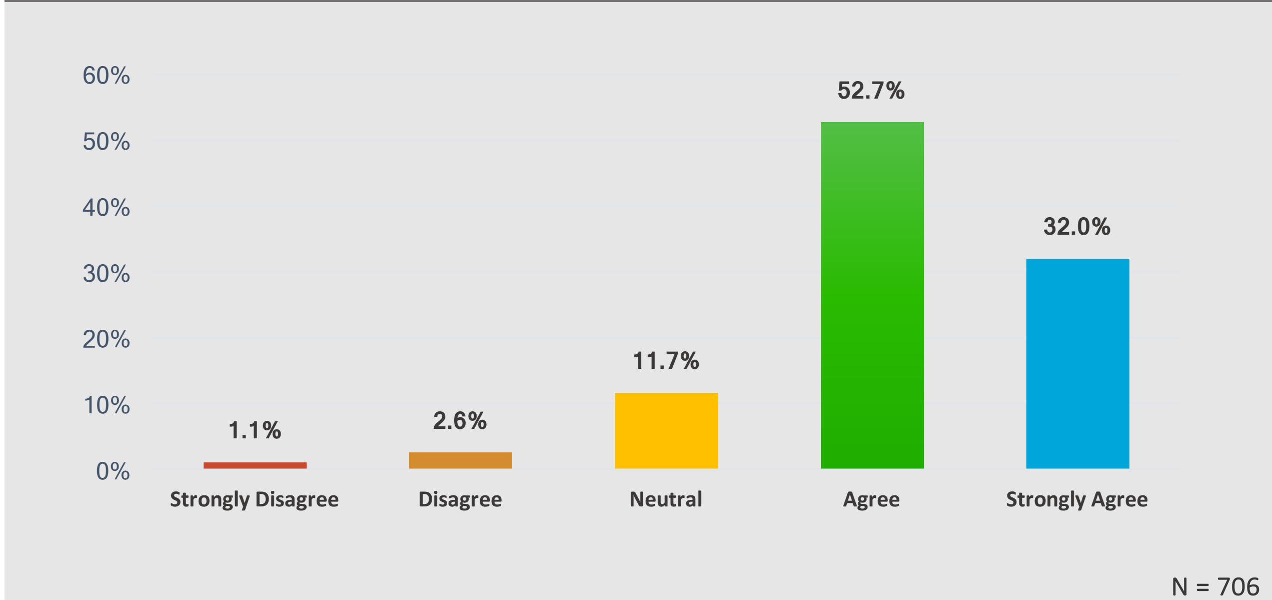
[179] Press Room. Study: Baby Boomers Will Drive Explosion in Alzheimer's-Related Costs in Coming Decades. November 11, 2014. Accessed at: https://pressroom.usc.edu/study-baby-boomers-will-drive-explosion-in-alzheimers-related-costs-in-coming-decades/

[180] Journal of Aging and Physical Activity. Physical Exercise in Old Age: An Eight Year Follow-up Study on Involvement, Motive and Obstacles among persons Age 65-84. 1998. Mirja Hirvensalo et al. http://journals.humankinetics.com/AcuCustom/Sitename/Documents/DocumentItem/1607.pdf

[181] Windle, G., Hughes, D., Linck,P., Russell,I., & Woods, B. (2010). Is exercise effective in promoting mental well-being in older age? A systematic review. Aging & Mental Health, 14(6), 652-669. Accessed at: http://www.healthevidence.org/view-article.aspx?a=20784

[182] Journal of American Medicine. Effect of Physical Activity on Cognitive Function in Older Adults at Risk for Alzheimer Disease. Nicola T. Lautenschlager et al. JAMA. 2008;300(9):1027-1037 Accessed at: http://jama.jamanetwork.com/article.aspx?articleid=182502

Figure 31: The BC Government should be working with other provinces to develop a new National Seniors Health Promotion Strategy that would outline strategies to promote seniors physical and mental well-being.



RECOMMENDATION **Medium term: 3 to 5 years**

- BC work with other provinces to advance the development of a National Seniors Health Promotion Strategy, which could outline various strategies to promote seniors physical and mental well-being, including outlining best practices among jurisdictions.

CONCLUSION

As outlined at the BCCPA Inaugural Continuing Care Collaborative held on September 20, 2016 which featured over 140 stakeholders across the home and community care sector now is the time to work together to find solutions to the rapidly aging population while also improving the overall quality of seniors' care. As outlined at the Collaborative, It's about … time!

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. 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.

To deal with the challenges of an aging population in May of 2016, the BCCPA released two major White Papers outlining potential options to improve sustainability and innovation for seniors and the continuing care sector. The first White Paper dealt 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 particularly: 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 (see Appendix A).

Along with better meeting the needs of an aging 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 also recently finished a major public consultation on the White Papers culminating in the Continuing Care Collaborative in September 2016 as well as a major public survey on the options outlined in the paper (see Appendix B). Overall the public survey received considerable attention including over 750 responses with over half being from seniors.

In summary, this final paper incorporates the feedback from the consultation process and outlines about 30 recommendations dealing with various topics in eight priority areas: 1) long term sustainable funding; 2) new funding models and approaches; 3) new continuing care models; 4) health human resources; 5) end of life care; 6) seniors well-being; 7) shifting resources from acute to home and community care; and 8) federal role in seniors care.

While it will not be feasible to implement all the recommendations outlined in the short term it should be incumbent on government, health authorities and relevant stakeholders to address those of critical importance within the next two years. As outlined below the BCCPA has identified approximately 10 recommendations to prioritize over the next one to two years including:

Invest in People

- Invest $230 million in annual funding for care homes to meet a minimum 3.36 Direct Care Hours (DCH) target per resident per care home across BC and increase minimum home care visit times to 30 minutes.
- $20 million in annual funding to 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; and support the enhancement of the MyCareFinder.ca website as a tool to better identify empty care beds in "real-time".
- $25 million Continuing Care Health Human Resource (CCHHR) Fund to be invested over 5 years to address the chronic labour shortages currently facing the continuing care sector including up to half of the funding for education, training and resources for staff to provide improved dementia care.

Invest in Infrastructure

- Establish a new Residential Care Infrastructure Fund (RCIF) of $100 million over three years, including: $80M to support the immediate renewal and replacement of older residential care homes; and $20M to support investments in smaller infrastructure projects such as sprinkler and ceiling lift installations, security, automated medication management and data collection systems.

Invest in Quality

- Establish a new Seniors Quality of Life Fund (SQLF) to support quality of life for seniors in residential care and in the community. Along with providing services to community the SQLF would provide up to $100 per month per senior living in a non-government operated residential care setting (total approximately $22 million per year).

Invest in Innovation

- Allocate up to $2M per year to launch a new Care Credits program which provides seniors [or the family members that care for them] the option to select the service provider of their choice.
- Invest up to $28M per year over the next five years to support the introduction and/or expansion of the Care Hub concept throughout B.C.

Other Short term or Immediate Priorities

- Starting in fiscal 2017/18 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.
- That the BC Ministry of Health undertake an immediate review of funding lifts in all Health Authorities with the goal of consistency, fairness, and sustainability with respect to per diem rates. This includes a process for providing greater transparency and province-wide standardization in respect to how funding lifts provided for home and community care are determined.
- 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.
- 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.

TABLE 8: COST OF INITIATIVES	
Initiative(s)	**Annual Funding (starting in 2017/18)**
Investing in People	**$250 per year**
• Increasing staffing through DCH funding and increase length of home care visits	$230 M per year
• Enhance the delivery of End-of-Life Care	$20M per year
Continuing Care Health Human Resource Fund	**$5M per year**
Residential Care Infrastructure Fund (RCIF)	**$30M - $40M per year**
Seniors Quality of Life Fund (SQLF)	**$22M per year**
Innovation Fund	**$30M per year**
• Continuing Care Hub	$28M per year
• Care Credit Program	$2M per year
Annual Funding (over next five years)	**$307M - $347M* per year**

* For 2017/18 and 2018/19 annual amount would be $337M which would increase to $347M in 2019/20 with additional $10M from the RCIF. For 2020/21 and 2021/22 overall annual amount would decrease to $307M with expiration of the RCIF and then $302M in subsequent years (2022/23 on) with expiration of CCHHR Fund.

While the costs of these short-term initiatives are considerable including about $337 million in the first year (see table below); given the importance of seniors particularly with an aging population we believe that this is a worthwhile investment. Some of these areas were also highlighted in the recent Select Standing Committee on Finance and Government Services Report on the Budget 2017 Consultations, which also put seniors as a focus of new health care spending and that the BCCPA provided considerable input on.[183]

Along with new monies, some of the funding could be obtained by redirecting funds from Health Authority acute care budgets to home and community care – an approach also advocated by the BC Ministry of

[183] BCCPA. BC Care Providers Association Responds to Provincial Budget Consultation Report. November 16, 2016. Accessed at: http://www.bccare.ca/bc-care-providers-association-responds-to-provincial-budget-consultation-report/

Health.[184] One of the major themes of the BC Ministry of Health Primary and Community Care paper released in February 2015 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.[185] This paper also recommends:

> *Starting in fiscal year 2017/18, that the Performance Agreements between British Columbia's Ministry of Health and Health Authorities include a specific target for redirecting acute care expenditures such as a minimum of 1 percent annually over a five-year period to the home and community care sector. Along with supporting initiatives outlined earlier, 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 care models particularly Continuing Care Hubs to reduce acute care pressures (including ALC days), improve access to care while also allowing seniors to receive services in the most appropriate setting.*

As outlined in this paper by shifting resources from acute to continuing care, 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. Recreational Therapy, Occupational therapy, Physical therapy, 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 better health outcomes;
- Reducing unnecessary hospitalizations including seniors who occupy a more-costly acute care bed;
- Minimizing the deterioration in physical and mental functioning that can occur among seniors from prolonged stays in acute care;
- 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 nongovernment operators and reducing unnecessary regulations;
- Improved dementia care for seniors including reducing levels of resident-on-resident aggression;
- Improving collaboration and working relationships with the continuing care sector; and

[184] Primary and Community Care in BC: A Strategic Policy Framework. BC Ministry of Health. February 2015. Accessed at: http://www.health.gov.bc.ca/library/publications/year/2015/primary-and-community- care-policy-paper.pdf

[185] BCCPA. Op-ed: Quality, Innovation, Collaboration – Strengthening Seniors Care Delivery in BC. October 2015. Accessed at: http://www.bccare.ca/op-ed-quality-innovation-collaboration-strengthening-seniors-care-delivery-in-bc/

- Redirecting funding from more-costly acute to home and community care.

SUMMARY OF RECOMMENDATIONS

SECTION 1: SUSTAINABLE LONG TERM FUNDING

IMMEDIATE: NEXT 1 TO 2 YEARS

1. That the BC government immediately support a minimum 3.36 Direct Care Hours (DCH) target per care home per resident across BC; and that 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.

2. That a standard definition of DCH be developed by the Ministry of Health and Health Authorities in partnership with the sector by 2017.

3. That the BC government establish a new *Residential Care Infrastructure Fund* (RCIF) which would:

    - support the immediate renewal and replacement of older residential care homes;
    - support investments in smaller infrastructure projects such as sprinkler and ceiling lift installations, automated medication management, online training technology, security and data collection systems; and
    - invest in enhancements for improving dementia-friendly environments within existing homes to make them more home like.

4. That the BC Ministry of Health undertake an immediate review of funding lifts in all Health Authorities with the goal of consistency, fairness, and sustainability with respect to per diem rates. This includes a process for providing greater transparency with respect to how funding lifts provided for home and community care are determined.

5. 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.

MEDIUM TERM: 3 TO 5 YEARS

6. That the BC government and Health Authorities work with care operators to develop home and community care funding models that are responsive to and appropriate to the acuity and complexity of clients in care, as well as adhering to the core principles of timeliness, sustainability, equity and transparency.

7. That the BC government, in consultation with operators, develop home and community care 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 among residents and clients.

8. The BC government work towards the establishment of a long-term predictable funding model by end of fiscal 2020 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.

9. That the Ministry of Health and the Health Authorities fully honour negotiated funding agreements by recognizing increases in labour-market costs to care providers to levels at least consistent with the master collective agreement.

LONG-TERM: 5 TO 10 YEARS

10. That the BC government, in order to remove the perception of a conflict of interest, move towards a funding model that separates the bodies that fund, allocate funds and regulate care homes from those that operate care homes.

SECTION 2: NEW FUNDING MODELS AND APPROACHES

IMMEDIATE: NEXT 1 TO 2 YEARS

11. That the BC government introduce a Care Credit or Personal Directed Care model in the home care sector and undertake a study including possible pilot project on their potential use in residential care. The study should analyze best practices from Community Living B.C. which offers their clients direct opportunities to select the care provider of their choice.

MEDIUM TERM: 3 TO 5 YEARS

12. That the BC Ministry of Health undertake a comprehensive review of the outcomes and lessons learned in the use of activity and outcome based funding for provision of home and community care, particularly reviewing any results from Alberta and Ontario's experimentation with these initiatives.

13. That the BC government review existing co-payments for continuing care to ensure that they better reflect actual costs of delivering care and a resident's/client's ability to pay, while ensuring seniors with lower incomes are protected.

SECTION 3: NEW CONTINUING CARE MODELS

IMMEDIATE: 1 TO 2 YEARS

14. That as a key priority any future BC Continuing Care Collaborative review options for 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. In particular, the BC government and Health Authorities should expand and/or introduce the Continuing Care Hub model in rural areas to increase the level of medical and social services provided to seniors in the community.

MEDIUM TERM: 3 TO 5 YEARS

15. That the Ministry of Health set as a target by the year 2021 to have no more than 5% of acute care beds occupied each day by seniors who have been assessed as capable of being transferred into a more appropriate residential care or home care setting.

16. That the BC government accelerate the adoption of new electronic information systems, including electronic health records and telehealth that facilitate the sharing of resident information across the continuing care system – including private care providers.

17. That the BC government consider implementing systems that better enable patient information to flow through the health care system with the resident, particularly the sharing of information after a patient's return from a hospital stay.

SECTION 4: HEALTH HUMAN RESOURCES

IMMEDIATE: 1 TO 2 YEARS

18. That the BC government establish a Continuing Care Health Human Resource (CCHHR) Fund to be invested over 5 years and potentially matched by the Federal Government to address the need for staff training and chronic labour shortages currently facing the continuing care sector, including:

    - funding for a renewed 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 other key health professionals who provide frontline continuing care;

    - funding for a BC Behavioural 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

    - general dementia care education for care providers and support staff.

SECTION 5: END OF LIFE CARE

IMMEDIATE: 1 TO 2 YEARS

19. That the Ministry of Health and Health Authorities, invest up to $20 million annually to 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.

MEDIUM TERM: 3 TO 5 YEARS

20. That the BC government support the adoption of new palliative / EOL care models including, where necessary, provide new funding to improve the integration between continuing and end-of-life care.

21. That the Ministry of Health and Health Authorities work with the 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.

SECTION 6: SENIORS WELL-BEING

IMMEDIATE: 1 TO 2 YEARS

22. That the BC government establish a new 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 the overall quality of food and nutrition in residential care homes including meeting therapeutic diet requirements (currently the average care allocates approximately $6 per day to feed each resident) and providing culturally appropriate meal options; and
    - Regular reporting by the Ministry of Health, including what initiatives are being undertaken through the SQLF and how they are improving the overall quality of life for seniors in BC.

23. That the Health Authorities increase the minimum home care visit time from 15 to 30 minutes.

MEDIUM TERM: 3 TO 5 YEARS

24. That as part of any Continuing Care Collaborative it includes a permanent sub-committee to deal with the unique and considerable challenges facing the home care sector including a review of funding, unfunded service expectations, travel costs and improving quality care. Likewise, this sub-committee should explore different innovative models in home care to determine their use or adoption in British Columbia.

25. That the BC government, working with stakeholders, develop a collaborative Provincial Seniors Safety Strategy which could focus on specific issues including use of technology, falls prevention, resident-on-resident aggression, reducing adverse drug events, suicide prevention, elder abuse and/or safety within home and community care.

SECTION 7: SHIFTING RESOURCES FROM ACUTE TO HOME AND COMMUNITY CARE

IMMEDIATE: 1 TO 2 YEARS

26. 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 percent annually over a five- year period to the home and community care sector. Along with supporting initiatives outlined earlier, 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 ALC days), improve access to care while also allowing seniors to receive services in the most appropriate setting

SECTION 6: SENIORS WELL-BEING

IMMEDIATE: 1 TO 2 YEARS

27. 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.

MEDIUM TERM: 3 TO 5 YEARS

28. British Columbia endorse the advancement of a National Dementia Strategy with federal participation which should include investing in research and ensuring capacity and appropriate funding in the continuing care sector.

29. As part of any National or Provincial Dementia Strategy the BC government explore, where appropriate, the creation of new care models or initiatives to support seniors with dementia including but not limited to Dementia Villages, Butterfly Care Homes and Dementia Friendly Communities (DFCs). Where appropriate, funding should also be provided to support the development of such initiatives including retrofitting existing care homes as part of any strategy to create DFCs.

30. BC work with other provinces to advance the development of a National Seniors Health Promotion Strategy, which could outline various strategies to promote seniors physical and mental well-being, including outlining best practices among jurisdictions.

APPENDIX A: OPTIONS FROM BCCPA SUSTAINABILITY AND INNOVATION WHITE PAPERS

Part I: OPTIONS FOR REVIEW / CONSIDERATION

Long-term sustainable funding:

1. The BC government and Health Authorities work with care operators to develop home and community care funding models that are responsive to and appropriate to the acuity and complexity of clients in care, as well adhering to the core principles of timeliness, sustainability, equity and transparency.

2. The BC Care Providers Association (BCCPA) encourages an immediate government review of funding lifts in all Health Authorities with the goal of consistency, fairness, and sustainability with respect to per diem rates. This includes a process for providing greater transparency with respect to how funding lifts for home and community care are determined.

3. That the BC government, in order to remove the perception of a conflict of interest, consider moving towards a funding model that separates the bodies that fund, allocate funds and regulate care homes from those that operate care homes.

4. That the BC government, in consultation with operators, develop residential care 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 among residents and clients.

5. The BC government work towards establishing predictable long-term funding models by end of fiscal 2018, that are 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.

6. That the Ministry of Health and the Health Authorities fully honour negotiated funding agreements by recognizing increases in labour-market costs to care providers to levels at least consistent with the master collective agreement.

New Federal Health Accord:

7. That the provincial government as part of any new federal 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 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.

Managing Changing Need:

8. The BC government clarify or re-affirm its position regarding Managing Changing Need and at minimum reintroduce the policy, or similar policy on an interim basis as part of BC's Home and Community Care (HCC) Policy Manual; and that in the long term the Managing Changing Need Policy or an updated policy be incorporated as part of the existing Community Care and Assisted Living Act and/or accompanying residential care regulations.

Capital Investment in Continuing Care:

9. To increase private sector investment and development of residential care capacity across the province, there should be fair and equitable return on the cost of capital.

10. That an industry, government and Health Authority committee or working group be established to study options around creating equitability and sustainability with regards to funding models and private sector investment in continuing care.

11. 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, thus allowing residential care homes to have the same tax free status as other health care facilities.

Activity and Outcome Based Funding:

12. That the BC Ministry of Health undertake a comprehensive review of the outcomes, results and lessons learned in the use of activity and outcome based funding for provision of home and community care, particularly reviewing any outcomes and/or results from Alberta and Ontario's experimentation with these initiatives.

Social Finance – New Partnerships:

13. The BC government explore further the use of Social Finance arrangements including Social Impact Bonds to fund new potential investments within the continuing care sector.

Long-Term Care Insurance:

14. That provincial and/or federal governments explore reviewing further the concept of long-term care or autonomy insurance to address issues of an aging population and increasing home and community care expenditures.

Review of co-payments for continuing care:
15. That government explore existing co-payments for continuing care to better reflect actual costs of delivering care, and a resident's/client's ability to pay, while also ensuring seniors with lower incomes are protected.
Vouchers:
16. BC government explore the use of vouchers and whether they could be provided to seniors to pay for long-term care and/or assisted living services in lieu of government provision of such services.

Part II: OPTIONS FOR REVIEW / CONSIDERATION

PRIORITY 1: DEVELOPMENT OF NEW CARE MODELS AND AGE-FRIENDLY COMMUNITIES

New Models of Care (Continuing Care Hubs)

1. That as a key priority any future Continuing Care Collaborative review options for 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.

Adult Care Centres - Integration of Home Care and Long-Term Care

2. That the BC Government explore the development of new continuing care models in which residential care homes could provide home support services to seniors whose preference is to continue to live in their residence.

Age Friendly Communities

3. That the BC government explore a program to better integrate residential care homes as part of any age-friendly community approaches.

Green House Models

4. The BC government explore, where appropriate, the creation of new green-house type models including funding to retrofit existing care homes to support such an approach.

Dementia Models of Care

5. That the BC government explore, where appropriate, the creation of new care models to support seniors with dementia including but not limited to Dementia Villages and Butterfly Care Homes. Where appropriate funding should also be provided to retrofit existing care homes as part of any strategy to create dementia friendly communities.

6. That in partnership with relevant stakeholders including care providers, health authorities and the BC Alzheimer's Society, government explore 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.

End-of-Life / Palliative Care Models

7. 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.

8. The BC government explore the adoption of new palliative care models including, where necessary, providing funding to improve the integration between long-term and end-of-life care, including new long-term care models with expanded roles in caring for seniors.

PRIORITY 2: DEMENTIA

9. British Columbia endorse the advancement of a National Dementia Strategy or Declaration with federal participation which should include investing in research and ensuring capacity and appropriate funding in the continuing care sector.

PRIORITY 3: TECHNOLOGY

Social Isolation

10. British Columbia explore the use of technology and the existing residential care infrastructure to facilitate seniors aging in place or reducing social isolation of seniors (i.e. home health monitoring, increasing internet access for seniors and seniors drop-in centres).

Improving Access to Medical Information through Electronic Records

11. The BC government continue to support the adoption of new electronic information systems, including electronic health records and telehealth that facilitate the sharing of resident information across the continuing care system.

12. That the BC government consider implementing systems that better enable patient information to flow through the health care system with the resident, particularly the sharing of information after a patient's return from a hospital stay.

New Technologies to Improve Senior's Safety

13. The BC government explore the adoption of new technologies that improve the safety of seniors particularly through new monitoring and surveillance systems.

PRIORITY 4: SENIORS SAFETY

Provincial Seniors Safety Strategy

14. BC explore the advancement of a collaborative Provincial Seniors Safety Strategy which could focus 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.

Ceiling lifts

15. That the federal government and/or provinces establish a joint 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.

PRIORITY 5: SENIORS HEALTH PROMOTION

16. BC work with other provinces to explore the development of a National Seniors Health Promotion Strategy, which could outline various strategies to promote seniors physical and mental well-being, including outlining best practices among jurisdictions and improving quality of care for the frail elderly.

APPENDIX B: PUBLIC CONSULTATION SURVEY: FINAL REPORT

October, 2016

Executive Summary

In May of 2016 the BC Care Providers Association (BCCPA) released two major white papers focusing on the future of Seniors' Care British Columbia. The first paper focused on issues of funding, including issues such as long-term care insurance, and the potential use of vouchers ("care credit") to allocate public subsidies, among other concepts. The second paper focused on innovations, including new care models for seniors, improving dementia care, effective use of technology, and enhancing the health, safety and well-being of seniors.

Following the release of these two major white papers, the BCCPA conducted a public consultation survey focused on obtaining feedback regarding the options outlined in the White Paper. The online survey collected results from the public for eight weeks over the summer of 2016, promoted through online advertisements on Facebook and Twitter, as well as through the BCCPA website. The survey received over 750 responses, 56% of which were seniors over the age of 65.

Policy options that received broad support from the survey respondents are outline below. Full results from the survey are detailed in the body of this report.

Funding and Financing of Senior's Care:

- 93% of survey respondents agree that care operators should receive annual funding lifts linked to the rate of inflation, and 90% agree that care operators should have open, transparent & sustainable funding that allows for long-term planning.
- 68% of survey respondents indicated that they believe the seniors' care operators receive too little funding; this proportion increases to 89% when you exclude those with no opinion.
- 77% of survey respondents agree that residential care homes should be made exempt from municipal taxes; this proportion increases to 88% when you include those who agree as long as there is some oversight to ensure that savings are dedicated to improving care for the seniors.
- 89% of survey respondents agree that the Federal and Provincial Government should be setting aside funding to renew the infrastructure of BC's residential care homes, including installing ceiling lifts and sprinkler systems.

The Federal Role in Senior's Care:

- When asked to identify the top three priority areas where the Federal Liberal Government should be investing new dollars for health care, survey respondents indicated increasing staffing levels (61%), improving access to health care (60%), and reducing the cost of prescription medications (45%) as their top three priorities.

End of Life and Innovative Care Models:

- 88% of survey respondents agree that vacant or under-used residential care beds reserved for private pay clients should be converted to dedicated end-of-life care beds.
- 82% agree that residential care homes should be providing eligible seniors living off-site in the community (i.e. in a single family home, apartment or condo) with access to services such as adult care programs, and recreational or occupation therapy.

Dementia:

- 88% and 86% of survey respondents indicated that they believe that we need a National and Provincial Dementia strategy, respectively, to address the growing issue of dementia.

Senior’s Well-Being:

- 85% of survey respondents agreed that British Columbia should be spearheading the development of a National Senior’s Health Promotion Strategy that would outline strategies to promote seniors physical and mental well-being.
- 85% of survey respondents agree that Canada should be improving access to necessary prescription medications, including for seniors.

Methodology:

The survey was developed by BCCPA staff, and program using SurveyMonkey, an online survey tool. Surveys were promoted through BCCPA e-blasts to members, as well as online through the BCCPA website, twitter handle, and paid ads on social media (i.e. Facebook).

The survey collected responses for eight weeks, in July and August 2016. Respondents were offered an incentive to complete the survey – a $50 Tim Horton's Gift Card.

The survey utilized a number of question types, including:

- **Yes/No:** Participants were asked to indicate their support or opposition to policy options through *Yes/No/ Other -please explain* choices. Text responses were then coded as *yes, no, unsure, depends,* and *other* depending on the content of the comment.
- **Position Statements** Participants were asked to choose from a number of closed-response multiple choice options to indicate the statement that best represents their position on a number of issues in the continuing care sector.
- **Multiple Choice (Multiple Responses):** Participants were asked to prioritize areas funding areas by choosing the top three areas to focus additional revenue on.
- **Likert Questions:** Participants were asked to indicate their agreement or disagreement to a series of statements regarding issues in the continuing care sector.
- **Demographic Questions:** Respondents were asked to answer demographic questions on age, income and gender.

Demographics:

Over 750 people took the survey over two months in July and August, 2016. Ultimately completion rates were high at 94%. The demographics of survey respondents breaks down as follows:

- The majority of respondents were women at 87%.
- While respondents from all age rages were represented, the most common age brackets were 65 to 74 (at 42%), and 55 to 64 (at 31%) respectively.
- Respondents from all income brackets were represented, though the most common was $20,000 - $39,999; likely reflecting the fact that the survey population was largely composed of older adults, who may be retired and on fixed incomes.

Figure 1: What is your gender?

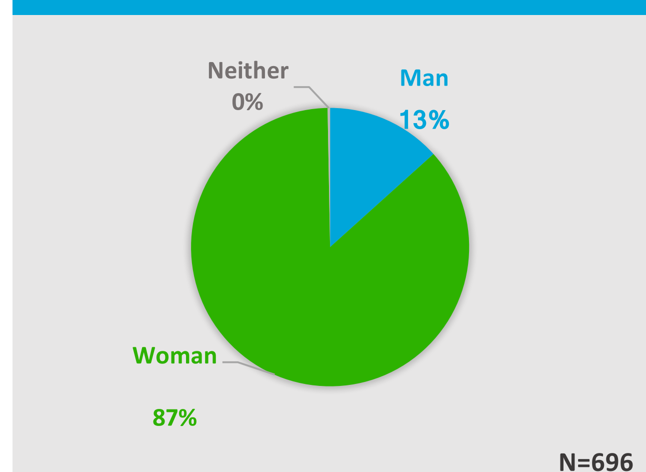


Figure 2: What is your gross annual household income

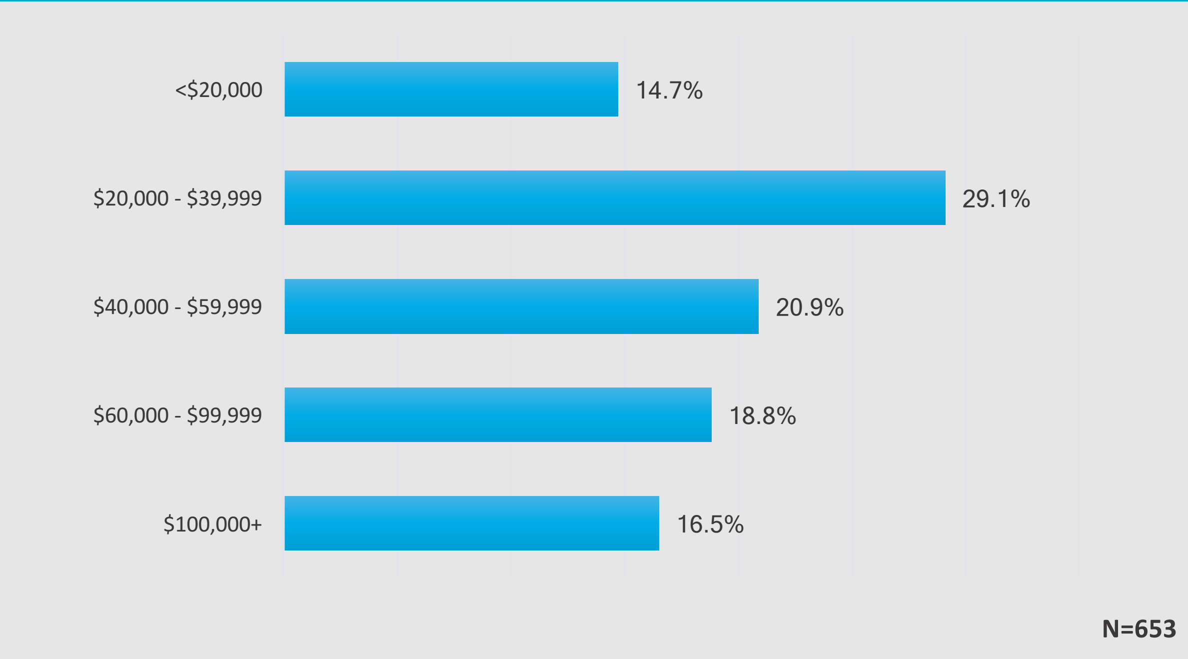
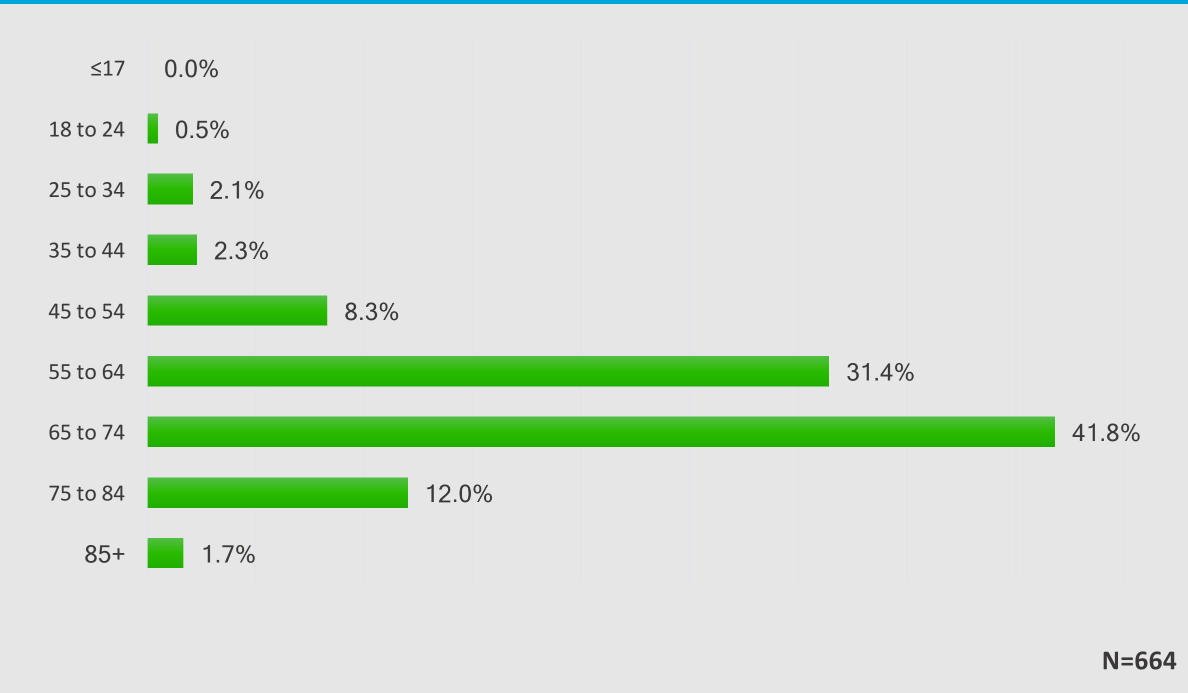


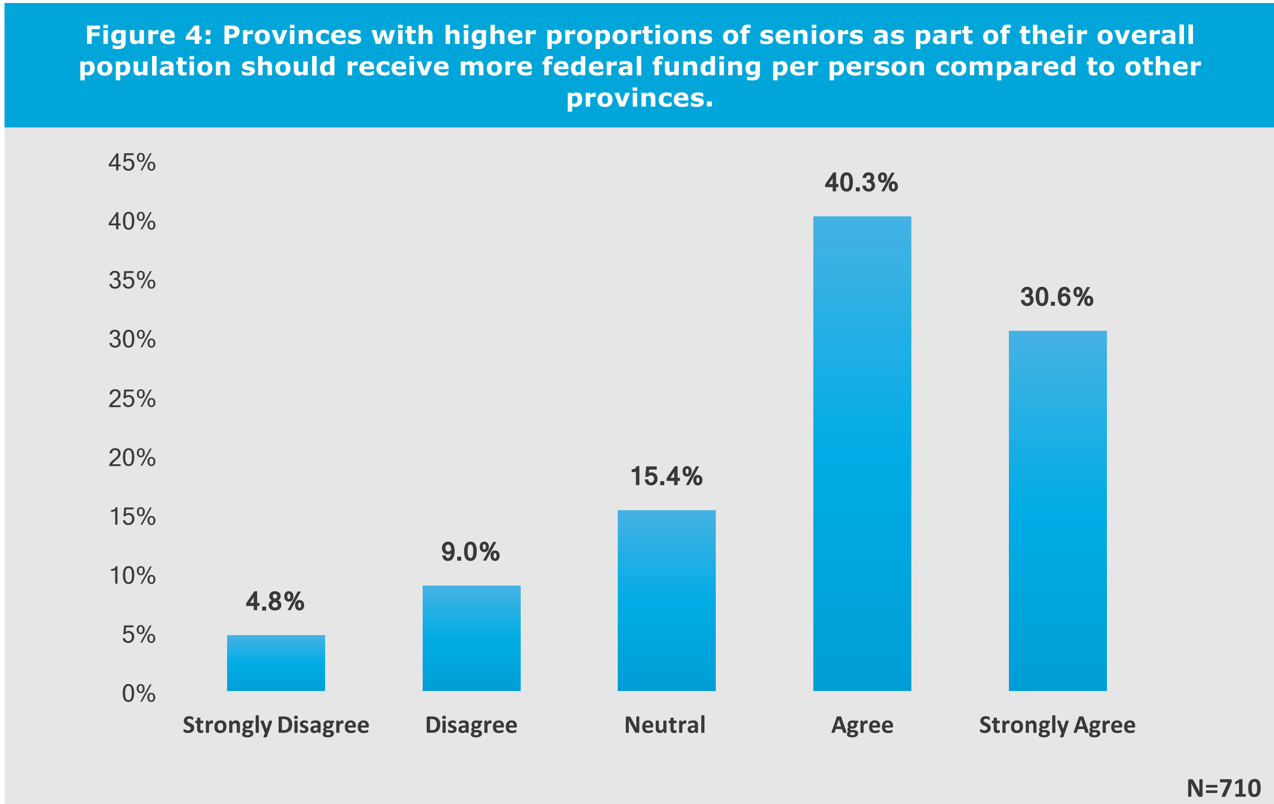
Figure 3: What is your age?



Federal Funding & Financing of Seniors Care

Age-Adjusted Canada Health Transfer (Q15)

Survey participants were asked to indicate their opinion on the idea of an Age-Adjusted Canada Health Transfer (CHT), where provinces with higher proportions of seniors receive additional funding on a per person basis. This concept received moderate support, with just over 70% of respondents indicating support for this policy option. Fifteen per cent of survey respondents indicated that they were neutral on this issue, while 14% indicated that they disagreed.



Attendees at the BC Care Providers Association's (BCCPA) Inaugural Continuing Care Collaborative (BCC3) were asked about the level of funding and distribution of funding provided by the Canada Health Transfer). 57% of respondents indicated that the overall level of funding provided to the Provinces/ Territories through the CHT should be increased with conditions attached (such as setting aside specific funding for seniors care). 24% of respondents indicated that they did not believe the overall level of funding allocated by the CHT needed to be increased, but that its distribution should be shifted through an age-adjusted CHT.

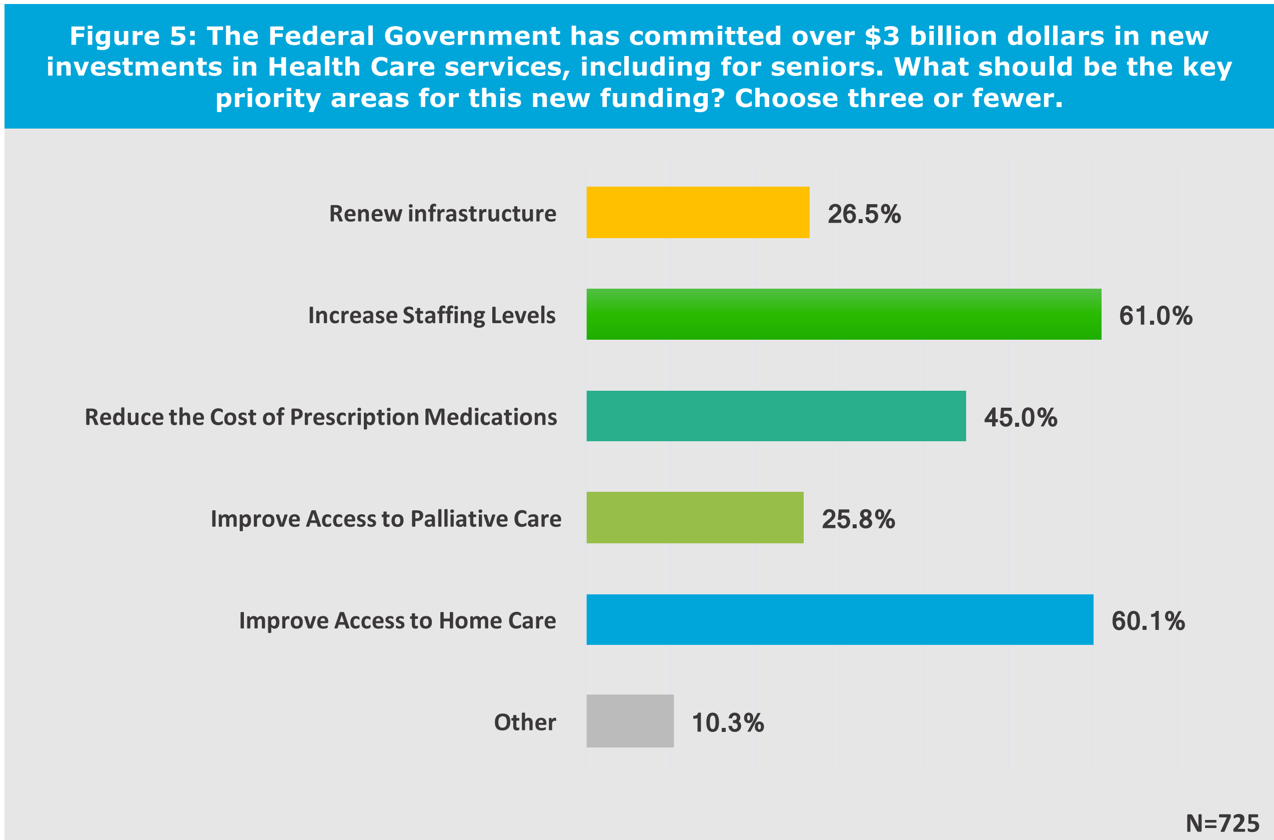
Federal Liberal Campaign Commitments (Q14)

Survey respondents were asked what areas of health care the Federal Liberal Government should be investing in, given the $3 Billion commitment that was made during the 2015 election campaign. Respondents, who were allowed to identify up to three areas, indicated that their top priorities were:

- Increasing staffing levels for care (61%);
- Improving access to home care (60%); and

- Reducing the cost of prescription medications (45%).

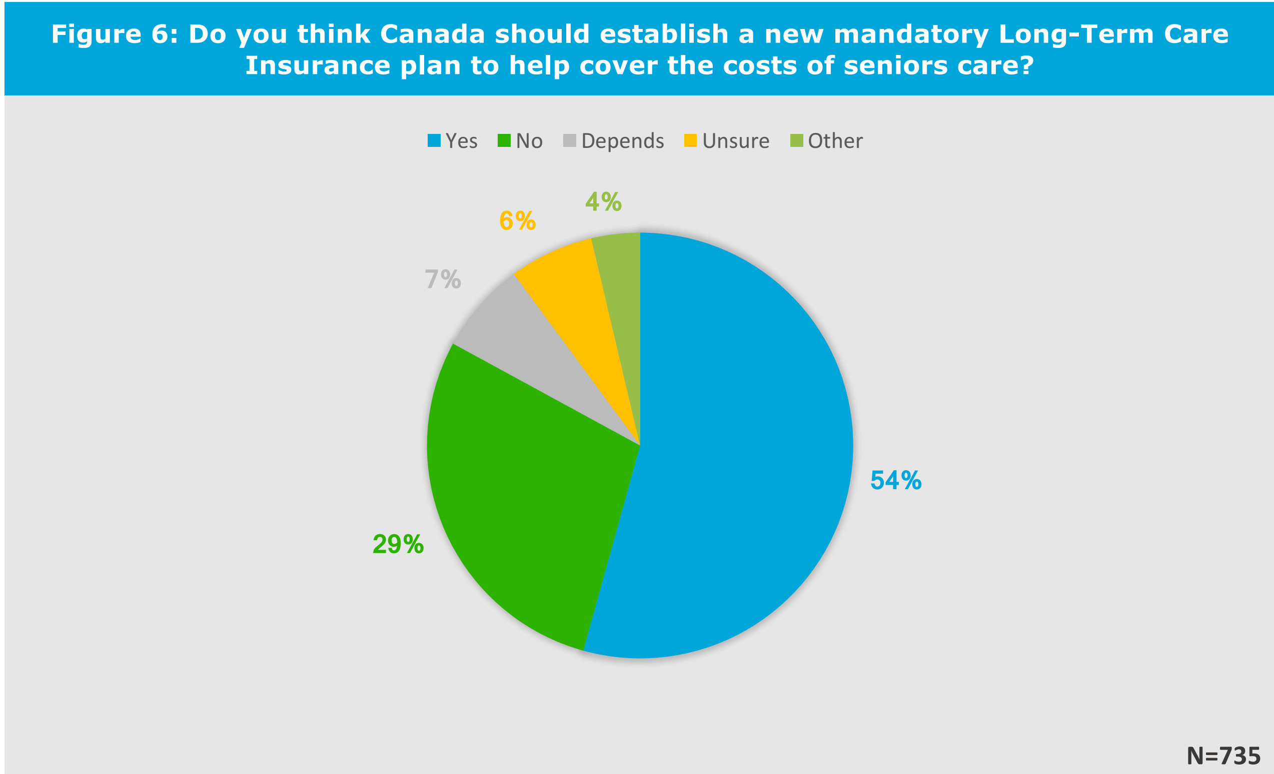
Figure 5: The Federal Government has committed over $3 billion dollars in new investments in Health Care services, including for seniors. What should be the key priority areas for this new funding? Choose three or fewer.



Attendees at the BCC3 were similarly asked about where the Federal Government should be prioritizing new funding for the senior's care sector. Their top three priorities were improving access to home care & support (34.8%); increasing staffing levels in care homes (26.7%); and reducing the cost of prescription medications (13.9%). Lesser priorities were increasing access to subsidized assisted living, renewing infrastructure, and improving access to palliative care.

Long-Term Care Insurance (Q4)

Survey respondents were whether they believe that Canada should establish a new mandatory long-term care insurance plan to help cover the costs of seniors care. Only 54% of survey respondents indicated support for such an initiative, with an additional 7% indicating depends. Of those indicating support, many where concerned about how such a program would be financed (e.g. through general tax dollars, or a program like EI). Several survey respondents indicated that they would only support such a program if some form of protection were included for low-income seniors to ensure that those of little means wouldn't be over burdened.

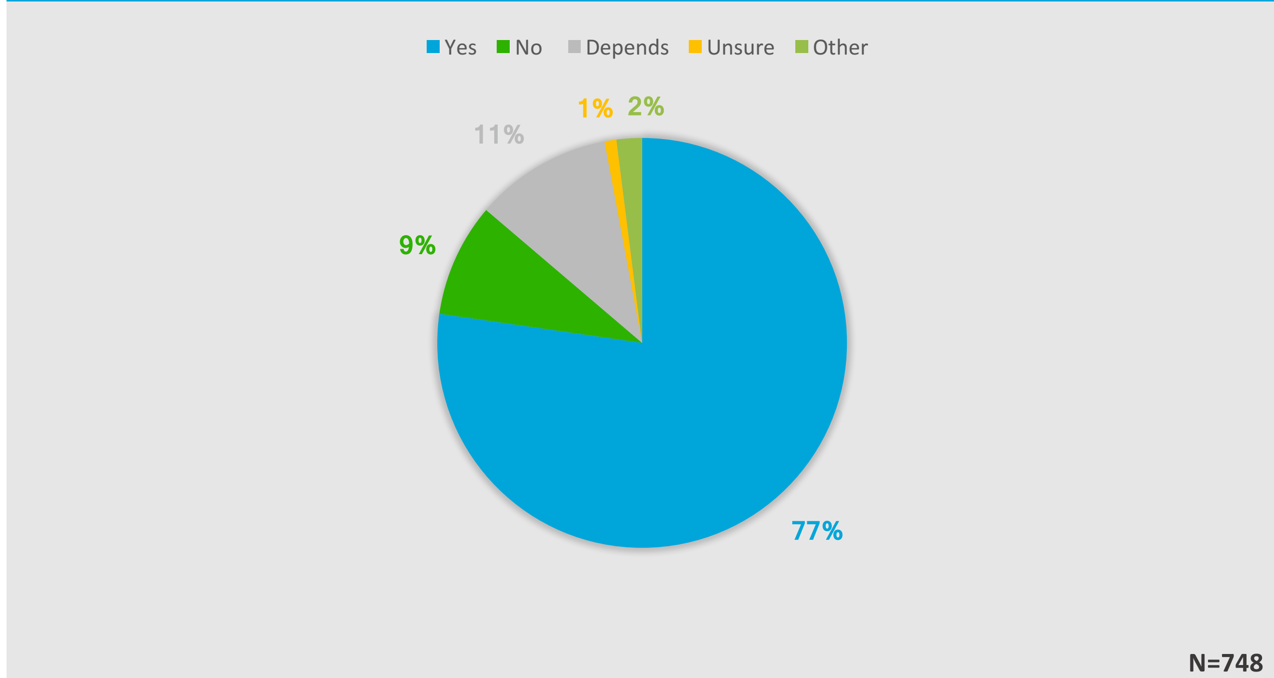


Attendees at the BCC3 were similarly asked about their support for a new mandatory long-term care insurance plan. 44% of attendees indicated that they would oppose such an initiative, with only 29% indicating support. The remaining attendees where either neutral or didn't know.

Municipal Taxes (Q3)

Survey participants were asked to indicate their level of support for exempting BC care homes from municipal taxes, similar to a policy that is currently in effect in Alberta. Over three-quarters of survey respondents indicated support for this option (77%). An additional 11% of survey respondents indicated depends for this option, indicating that they would support this option only for non-profit care homes (7%), or if there were specific oversights to ensure that the funds were devoted to improving care for residents (4%). Only 9% of survey respondents indicated that they would oppose this policy outright. The most common reason given for opposing this policy was that it would tend to decrease municipal tax revenues.

Figure 7: In Alberta, residential care homes are exempt from paying municipal property taxes so that funds can be focused on providing care for seniors. Do you think British Columbia should implement the same policy?



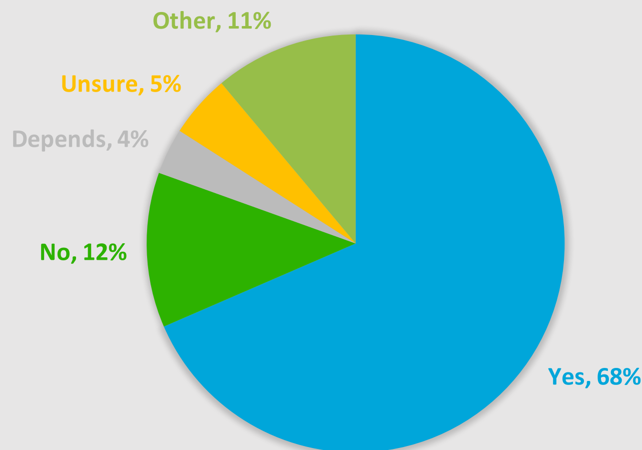
Provincial & Health Authority Funding & Financing

Care Credits (Q6)

Survey respondents were asked if they would support the use of vouchers or care credits for seniors to purchase directly continuing care support services. This proposal received moderate support, with 68% indicating support, and an additional 4 percent indicating depends. While 12 percent of respondents did not support this proposal, an additional 5% were unsure and 11% provided text responses that could not be categorized as *yes*, *no*, *unsure*, or *depends*.

The content of the text responses indicated that the survey respondents, in general, where not particularly familiar with the concept of providing cash subsidies for care instead of in-kind provision. Respondents expressed concerns and questions regarding how the value of the subsidy would be determined (i.e. who would decide how much care an individual received, and whether it would be dependent on the senior's finances), whether it would create waitlists at some care homes, and how such a program would work for individuals with cognitive decline (e.g. dementia) or without family and friends as support. Finally, some expressed concerns regarding how care providers and operators would be licensed and regulated.

Figure 8: Do you think seniors should be able to choose their own Residential Care or Home Support Provider through the allocation of "Care Credits" - i.e. a government subsidized voucher for seniors care services?



N = 731

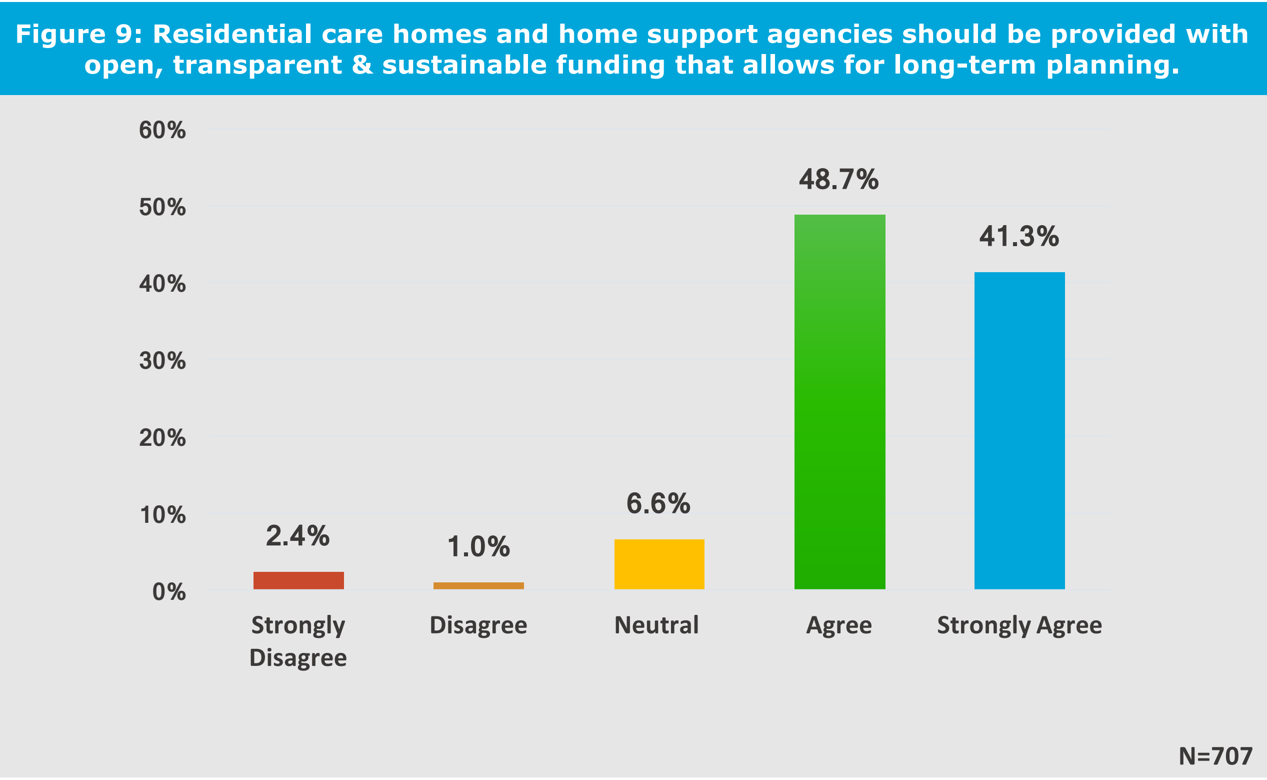
Attendees of the BCCPA's Inaugural Continuing Care Collaborative event on September 20th at the Wosk Centre for Dialogue were asked a similar question regarding the use of care credits: specifically, they were asked if they believed that care credits would be an effective way to provider seniors with greater consumer choice regarding their care. 72% of Wosk attendees indicated that they agreed with this statement, while 12% indicated that they disagreed; the remaining seven percent remained neutral.

Long-Term Sustainable Funding (Q17)

Survey respondents were asked to indicate their degree of support or opposition to the principle that operators in the continuing care sector receive open, transparent and sustainable funding in order to allow for long-term

planning. Ninety per cent of survey respondents indicated that they agreed with this statement. Only 3.5% indicated disagreement, with the residual 7 per cent remaining neutral.

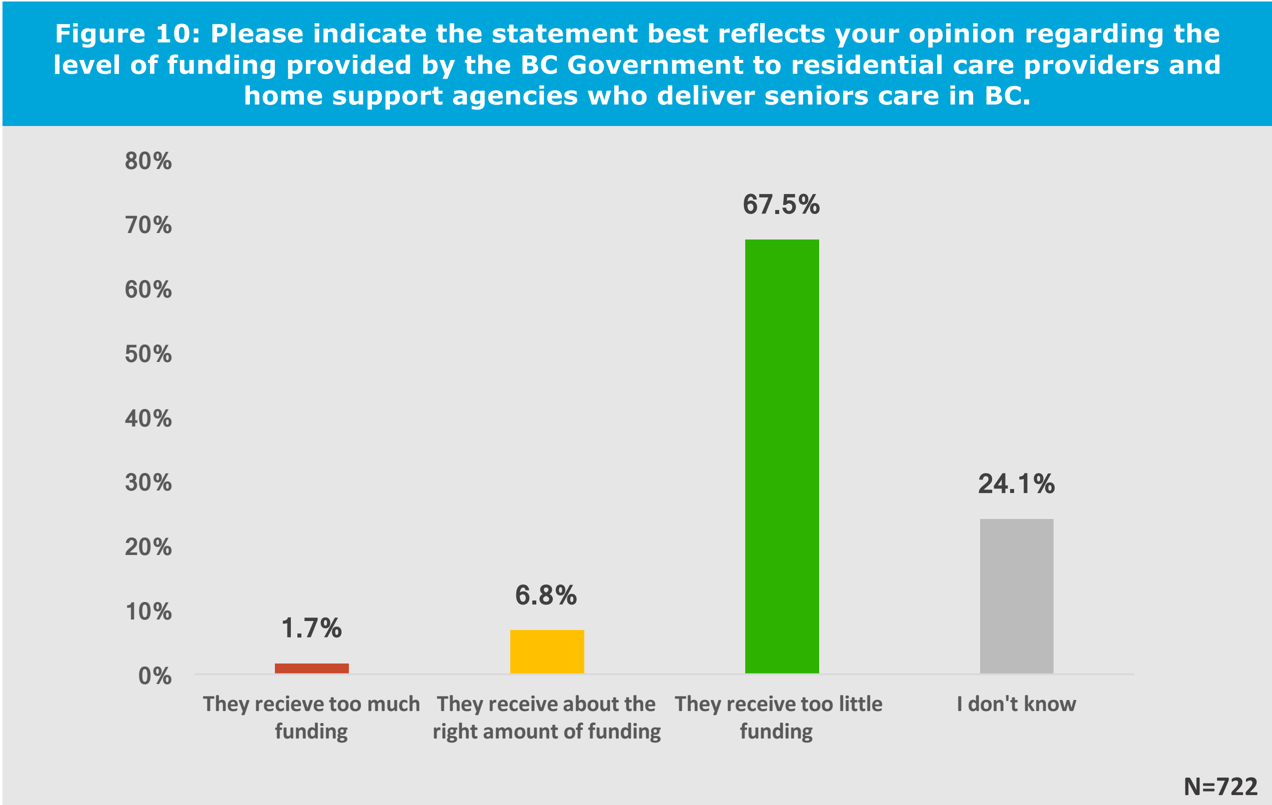
Figure 9: Residential care homes and home support agencies should be provided with open, transparent & sustainable funding that allows for long-term planning.



Levels of Funding for Care Operators (Q12)

Survey respondents were asked about their perception of the funding levels provided to care operators in BC. Nearly 70 per cent of survey respondents indicated that they perceived that care operators in BC were receiving too little funding (67.5%); while 24.1% indicated they had no opinion. Only 7 per cent of respondents indicated that they felt that current funding levels were sufficient, while less than 2 per cent indicated that care operates receive too much funding.

Figure 10: Please indicate the statement best reflects your opinion regarding the level of funding provided by the BC Government to residential care providers and home support agencies who deliver seniors care in BC.

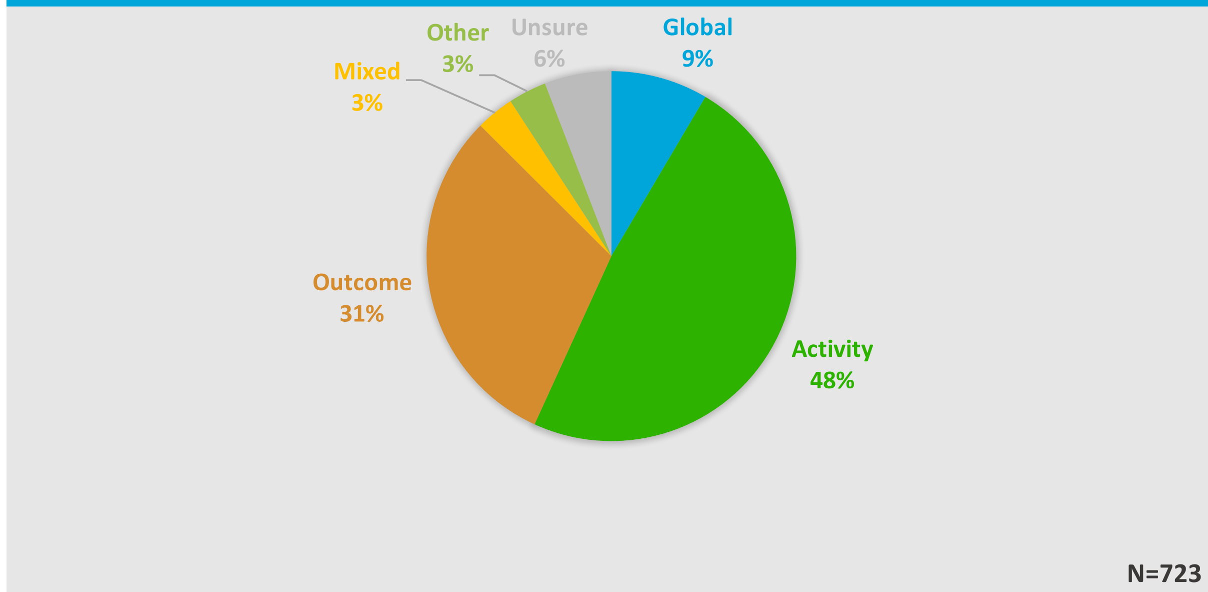


Funding Mechanisms: Global, Activity & Outcome Based Funding (Q13)

Survey respondents were also asked to indicate what they believe to the most appropriate funding mechanism for seniors' care operators: global funding, activity-based funding, outcome-based funding, or another option not listed. Almost half of survey respondents (48%) indicated that they believed that funding for care should be provided based on the actual activities and services that care operators are providing (i.e. activity based funding). An additional thirty percent indicated that they would support Outcome Based Funding. Only 9% of respondents indicated that they support the status quo – Global Funding.

While not an option outlined in the survey, 3% of survey respondents indicated that they felt that funding should be based on a mix of outcome and activity based funding, as well as taking into account the acuity of the population that they are serving.

Figure 11: Please indicate the statement that best reflects your opinion regarding how seniors care should be funded in British Columbia.



Attendees at the BCC3 were also asked about their preferences for funding mechanisms. When given the choice between global (i.e. status quo), activity, outcome, mixed and other, 65% of respondents chose mixed. When asked about global funding versus mixed, 84 percent chose mixed.

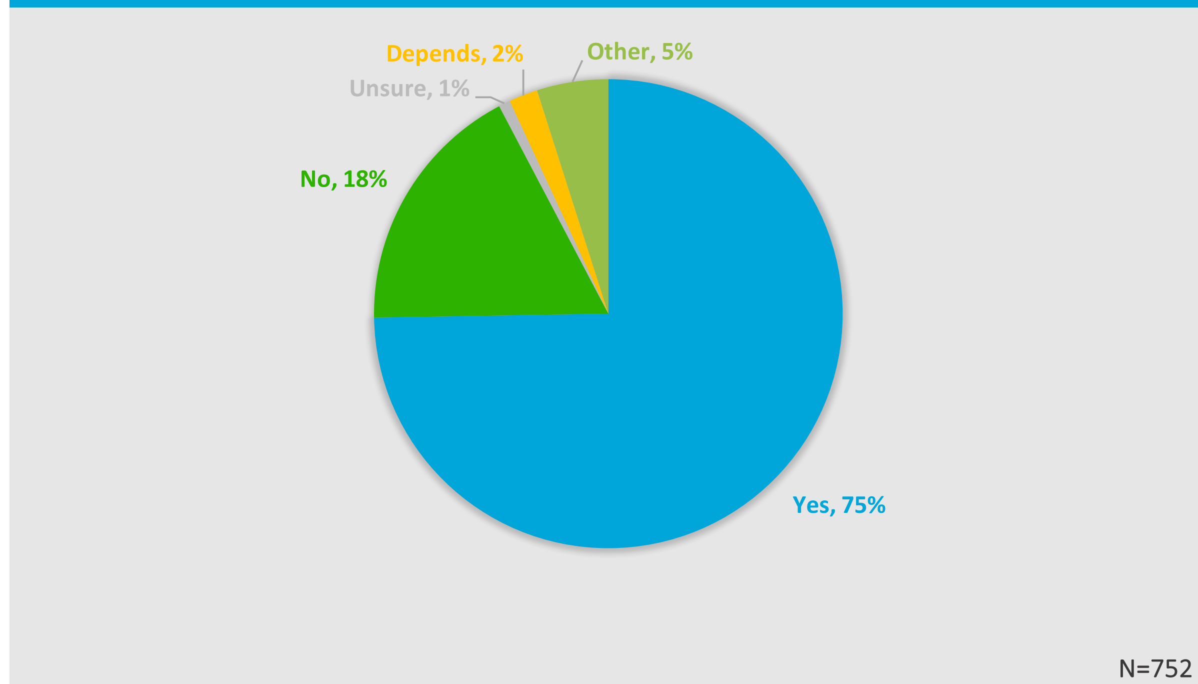
Funding Linked to Acuity (Q1)

Survey respondents were asked to provide their opinion on whether the funding provided to seniors' care providers should be linked to the acuity of the residents/clients that they care for, such that care homes and home support operators with more challenging clients would receive higher levels of funding. This option received moderate support, with 75% of survey respondents indicating support for this concept, and an additional 2 percent indicating depends.

Almost twenty percent of survey respondents indicated that they did not support this proposal, many citing the fact that they believe such a system would be good in theory but difficult to implement and manage in practice.

However, it should be noted that the responses to this question may not be completely reliable as several survey respondents gave answers that indicated that they were thinking about how much of a public subsidy seniors should get when paying for care (captured under the "other" category in the chart below), rather than the funding provided to the operator of the home. This confusion may be due to the wording of the question, or may point towards a lack of understanding in the general public regarding how care homes are funded.

Figure 12: Do you think funding levels for Residential Care Homes and Home Support Providers should be linked to the actual health conditions of the seniors they are caring for (in other words, the less healthy the senior, the higher the level of funding)?

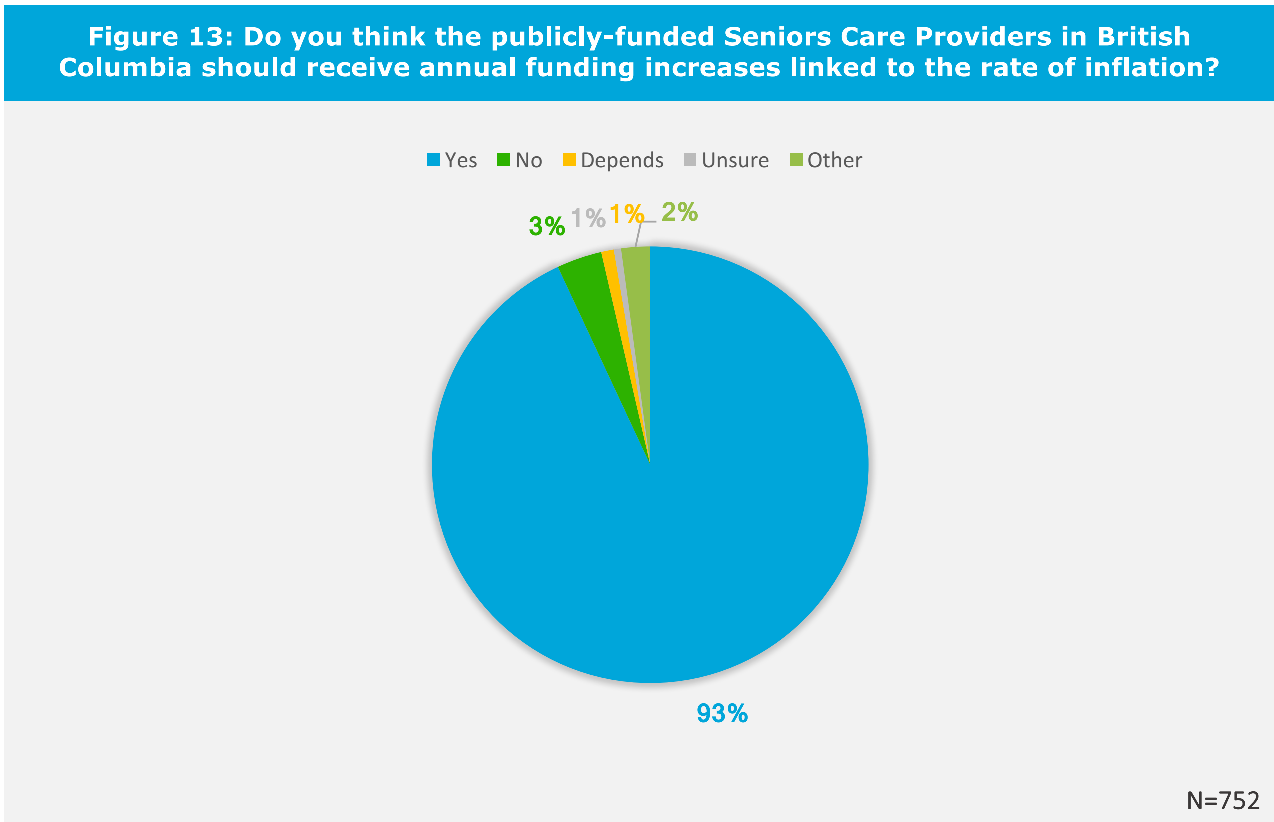


Funding Linked to Inflation (Q2)

Survey respondents were asked whether they believed that continuing care including residential care and home care & support providers in BC should receive annual funding lifts linked to the rate of inflation. This concept received overwhelming supporting from survey respondents, with 93% supporting, and another one percent providing indicating depends.

Only 3 per cent of survey respondents indicated that they would not support such a proposal. These survey respondents indicated that they did not believe that a general inflation rate (such as the Consumer Price Index reported by Statistics Canada) would be a good yardstick, because the fluctuations in costs in the industry are often different or higher than CPI (e.g. wage increases due to collective bargaining).

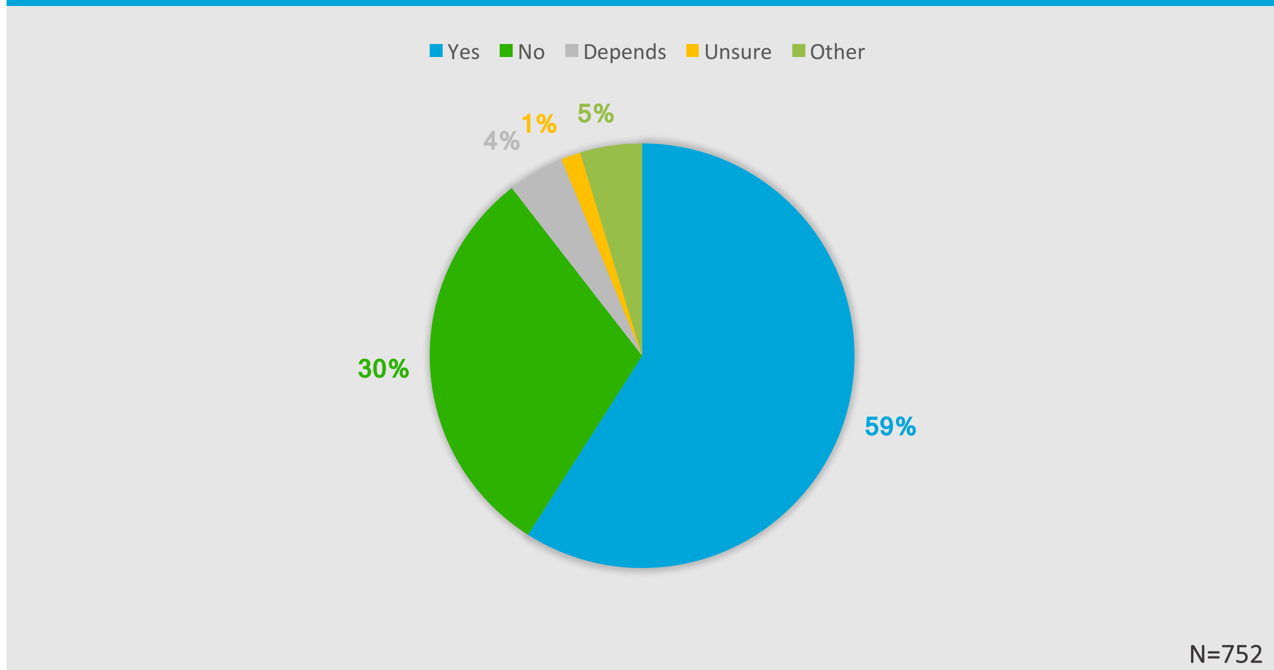
Figure 13: Do you think the publicly-funded Seniors Care Providers in British Columbia should receive annual funding increases linked to the rate of inflation?



Resident Co-Payments (Q5)

Survey respondents were asked to provide their opinion regarding the level of resident co-payments for residential care, and whether they would support increasing the maximum co-payment in order to better reflect an individual's ability to pay. This proposal received moderate support, with sixty percent indicating support for this change. An additional 4 percent indicated that they may support such an initiative, depending on how it is implemented; while many indicated that their support would depend on how 'higher incomes' are defined, and as long as there is some protection for a spouse or other dependent still living in the family home. Just over 30 percent of survey respondents indicated that would not support such an initiative, and 2% were unsure.

Figure 14: Currently the market cost to deliver residential care, including housing and health care services, in British Columbia is approximately $7,000 per month…Do you think the maximum fee should be increased so that British Columbians with higher incomes pay a greater percentage of the cost of their care?



115 responses were provided as comments, which were coded as *yes*, *no*, *depends*, *unsure,* or *other* depending on the contents of the comment. Analysis of the survey responses indicate that respondents have a low level of understanding of how co-payments for residential care are determined, and how eligibility for public subsidies are calculated – with many indicating a belief that those with higher incomes are disqualified for publicly-subsidized care.

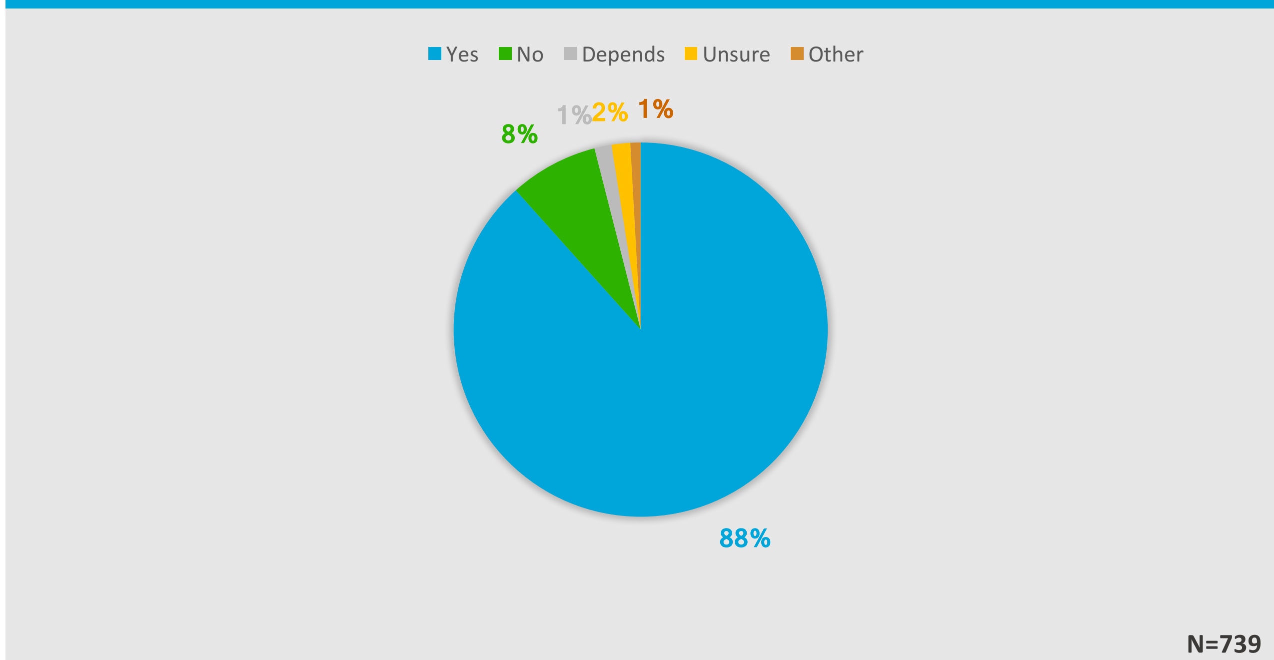
Dementia

National Dementia Strategy (Q10)

Survey respondents were asked whether Canada should develop a National Dementia Strategy to address the country's aging population. This option received overwhelming support, with 88% of respondents indicating support, and an additional one percent indicating depends.

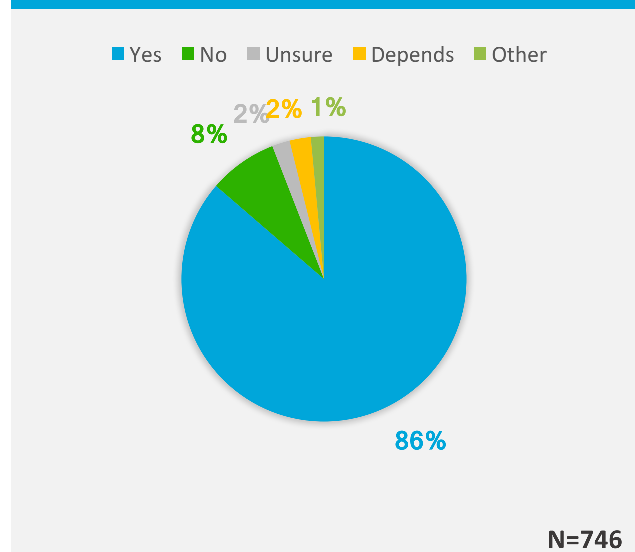
Of the eight percent of survey respondents that would not support a National Dementia Strategy, many indicated that they would prefer this work to be done at the Provincial Level. Others were more pessimistic about the efficacy of such a strategy, expressing doubts about what a such a strategy could accomplish, especially in light of the significant amount of funding that it would likely require. Finally, others expressed frustration at what they perceived as tax payer monies being used for endless research and dialogue, rather than on providing care for those with dementia.

Figure 15: Do you believe we need a National Dementia Strategy in Canada to address our aging population?



Provincial Dementia Strategy (Q11)

Survey respondents were also asked whether they believed that British Columbia needs a Provincial Dementia Strategy. Similar to the previous question, this option received overwhelming support as 86% survey respondents indicated support. An additional 2% indicated depends; as these survey respondents expressed concerns about how a Provincial Dementia Strategy would operate within the context of a National Dementia Strategy. Others expressed that while we may need a National or a Provincial Dementia Strategy, we do not need both.



Attendees at the BCC3 were similarly asked about the need for a Dementia Strategy – specifically who should be leading such an initiative. 53% indicated that it is provincial and territorial governments that should be developing, while 18% said the Federal Government should be a leader on this issue. Less preference was given to International organizations (3.4%), municipal governments (6.8%), non-government agencies (10.3%).

Attendees also identified that any Dementia Strategy that is developed should focus on promoting dementia friendly communities (32%), developing appropriate care models (26%) and delivering education and training (24%). Attendees identified that care models to prioritize included Dementia Villages (34%) and Dementia Friendly Communities (33%). Finally, attendees at the WOSK event overwhelmingly indicated that they did not believe that the resources and supports that BC currently has in place to support those living in single family homes, condos or apartments are adequate (90.7%).

New Care Models and Approaches

Additional Onsite Services (Q7)

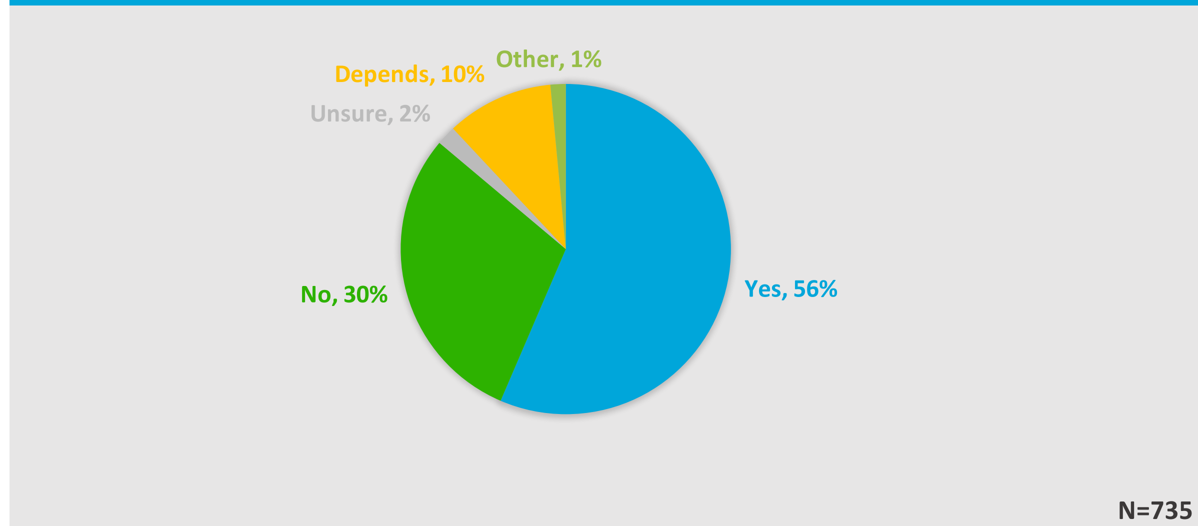
Survey respondents were asked to indicate their support or opposition for residential care homes offering additional onsite services in the community, such as sub-acute care services, or community care services (e.g. day care). This policy option received modest support, with 56% of survey respondents indicating support, and an additional 10% indicating depends. Thirty percent of survey respondents indicated that they did not support this option.

Of those survey respondents that indicated depends, common themes were that it would depend on:

- Type of services being provided (i.e. many support sub-acute care services but not child care);
- Appropriate funding and staffing levels;
- Availability of these services in the community; and
- Whether those accessing services would pay a small fee.

While many survey respondents indicated that they were opposed to care homes offering child care services, there seemed to be some confusion about why a care home would offer child care. This may indicate that any public discussion on the provision of child care by care homes would need to clearly demonstrate the benefits of intergenerational interaction for seniors, as well as clearly outlining that child care services wouldn't be provided to the detriment of seniors.

Figure 17: Do you think residential care homes should be offering additional onsite services in your local community such as IV therapy, dialysis, child care?



Attendees at the BCC3 were also asked about the types of additional services that could be offered by continuing care hubs in addition to traditional seniors' care services. No strong preferences emerged, with the top three priorities being adult day programs & respite care (16%), chronic disease management & health promotion (14%), and end of life & hospice care (14%).

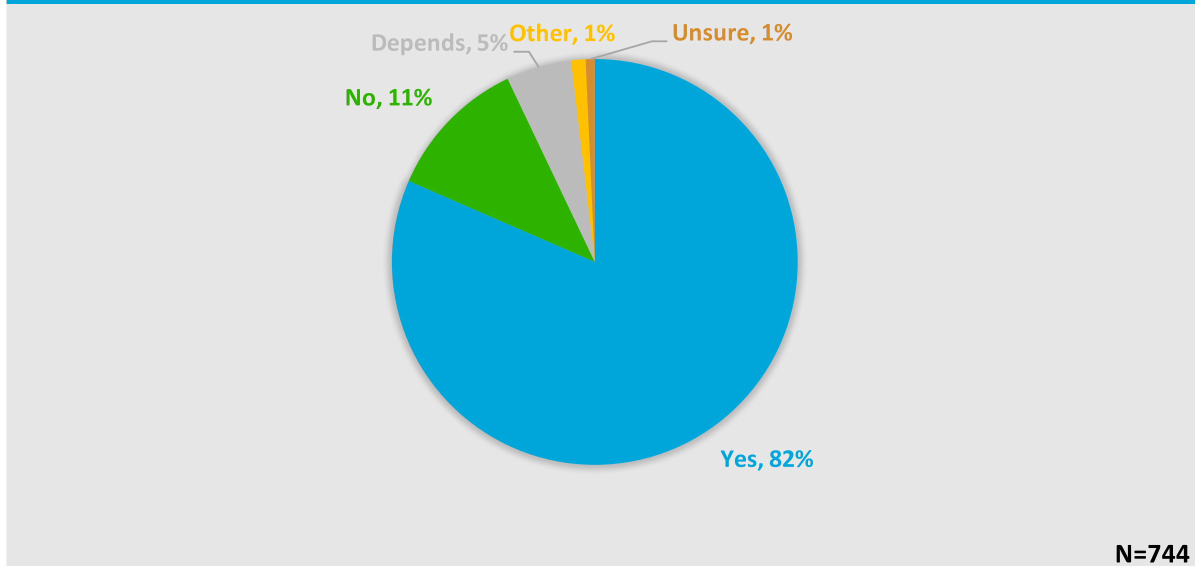
Additional Offsite Services (Q8)

Survey respondents were asked to indicate their support or opposition for residential care homes offering additional offsite services, such as adult day programs, recreational therapy and occupational therapy programs. This policy option received overall support from survey respondents, with over 80% supporting, and an additional 5 per cent indicating depends. Only 11% of survey respondents indicated that they would not support such an option.

Of those survey respondents that indicated depends for these options, common themes were that it would depend on:

- Whether those accessing the service would be charged a small fee – many survey respondents felt that those accessing the services should pay at least part of the cost of the service;
- The care home having appropriate resources, including funding and staffing levels; and
- The physical qualities of the building – some survey respondents felt that only specific built environments could accommodate these additional services.

Figure 18: Do you think Residential Care Homes should be providing services to seniors who actually live off site in the community? For example, eligible seniors living off site could have access to adult care programs, recreational therapy & occupational therapy delivered by the Residential Care Home.

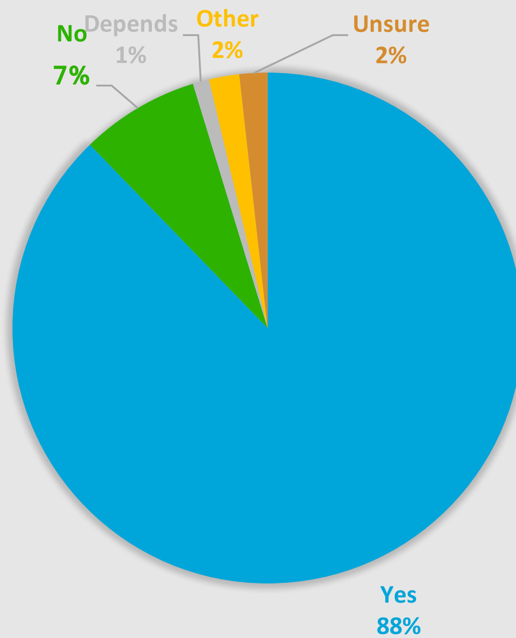


Attendees at the BCC3 were similarly asked whether they believed that residential care homes should be providing more support services to seniors living in single family homes, apartments or condo settings. 44% of attendees indicated that they agreed with this statement, while an additional 34% indicated that this would depend on the circumstances. The remaining attendees either did not support this concept (10%), or were unsure (13%).

End of Life Care (Q9)

Survey respondents were asked about whether they would support the use of under-used private-pay residential care beds and/or assisted living units being repurposed to deliver end-of-life care. Respondents overwhelmingly indicated support for this option, with almost ninety percent (88%) indicating support. Of those that indicated that they would not support this option, some indicated that this is because they would prefer that vacant private-pay beds be used for publicly-subsidized residential care clients, while others indicated that they would prefer that hospice and end-of-life care be provided in stand-alone hospices.

Figure 19: Do you think the BC Government should work with Seniors Care Providers to develop a strategy to better utilize empty private-pay seniors care beds in order to increase the delivery of hospice and end-of-life care in BC?



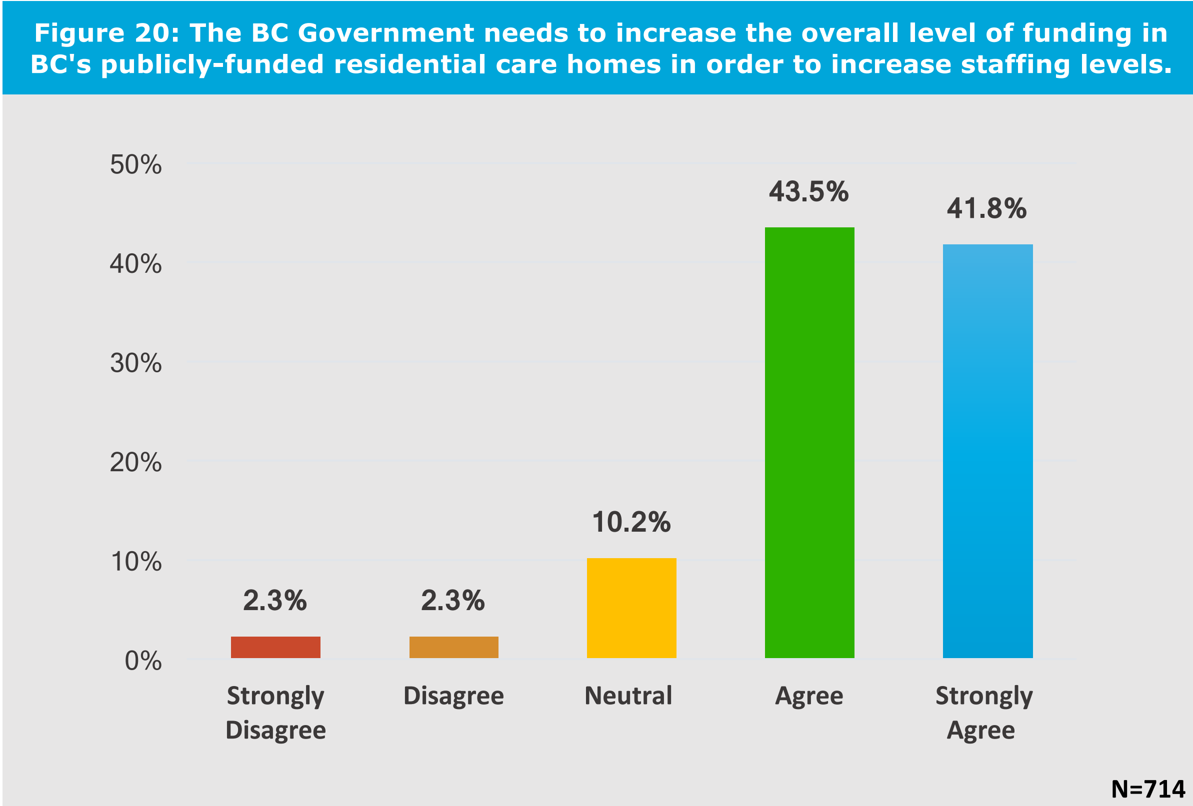
N=737

Health Human Resources

Staffing Levels in Residential Care Homes (Q16)

Survey respondents were asked to indicate their agreement or disagreement regarding the need to increase levels of funding in BC's residential care homes in order to increase overall staffing levels. Survey participants overwhelming indicated agreement with this statement, with 85 per cent agreement, and only 5 per cent indicating disagreement.

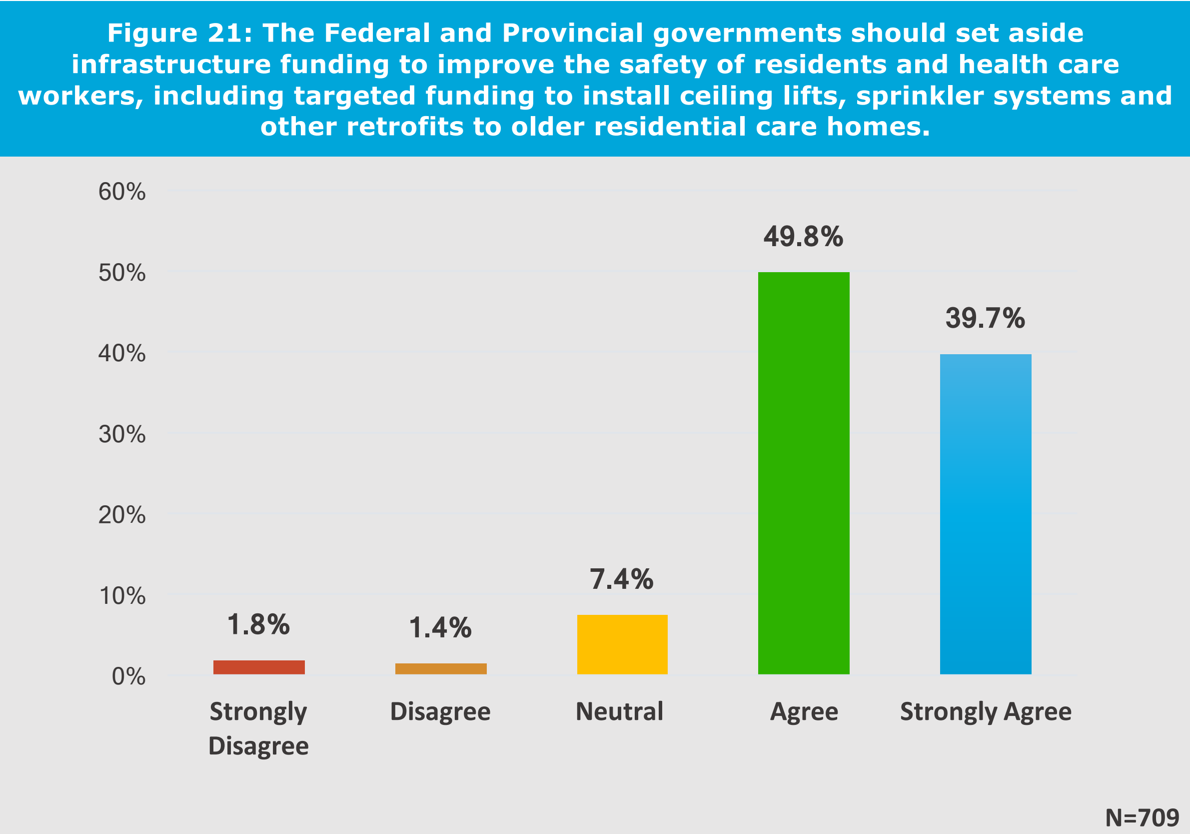
Figure 20: The BC Government needs to increase the overall level of funding in BC's publicly-funded residential care homes in order to increase staffing levels.



Seniors' Safety & Well-Being

Infrastructure Spending (Q18)

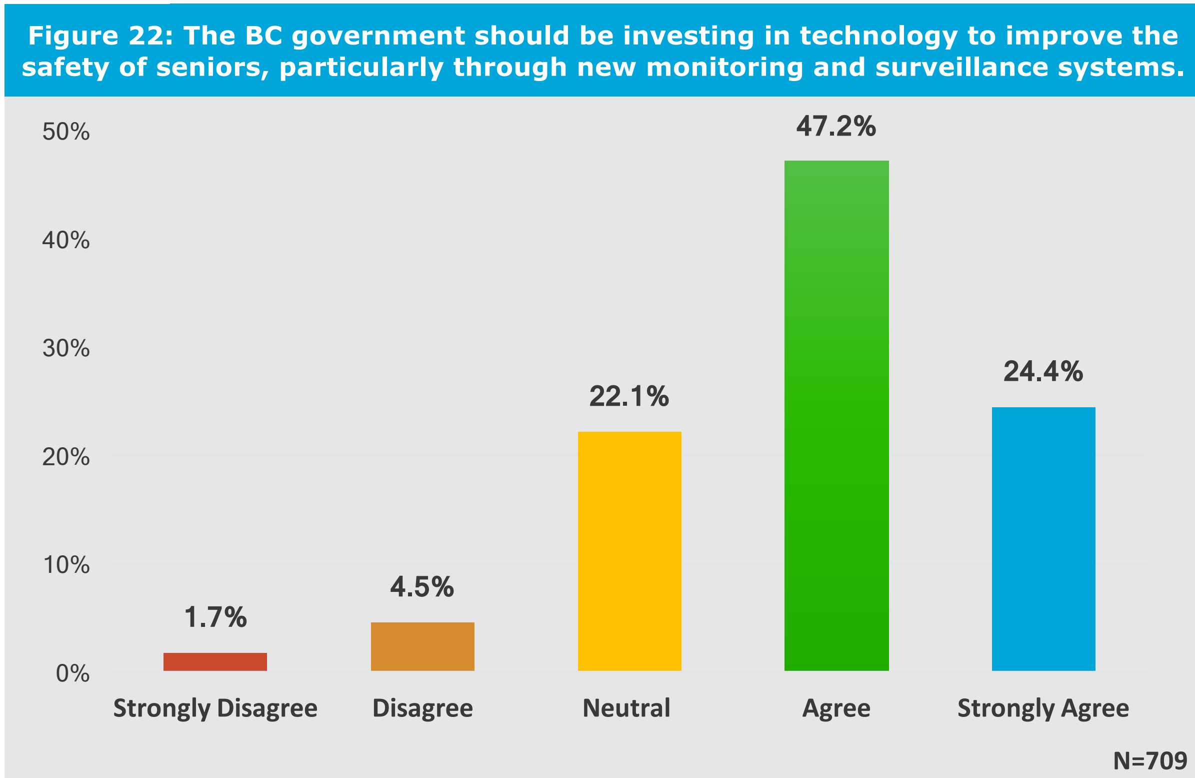
Survey participants were asked to indicate their overall support or opposition to the Federal and BC Provincial Government investing in infrastructure spending to renew care homes in BC, including installing ceiling lifts, sprinkler systems, and other retrofits. This policy option received overwhelming support, with almost 90 per cent of survey respondents indicating some level of agreement, and only 3 per cent indicating disagreement.



New Technology (Q20 & Q21)

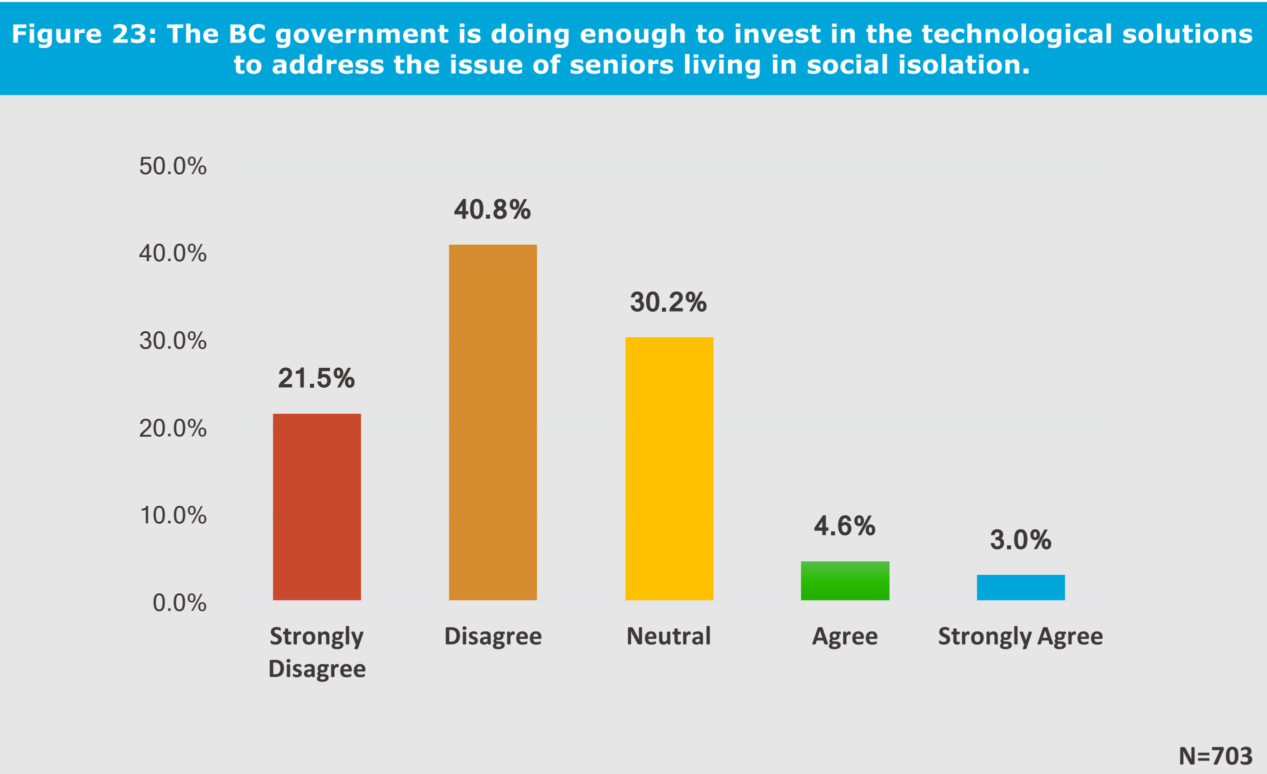
Survey respondents were asked to indicate their agreement or disagreement with the idea that the BC Government should be investing in new and innovative technologies to improve the safety of seniors, including through new monitoring and surveillance systems. This policy option received moderate support, with just over 70 per cent indicating agreement, including 24 per cent indicating strong support. A significant portion of survey respondents were neutral on this option (22%), with the remaining 6 per cent indicating disagreement.

Figure 22: The BC government should be investing in technology to improve the safety of seniors, particularly through new monitoring and surveillance systems.



Survey participants were also asked to indicate their agreement or disagreement with the opinion that the BC government is investing enough in technological solutions to address the issue of seniors living in social isolation. The majority of survey respondents indicated that they did not think that the government is investing enough (62%), while almost a third of respondents were neutral. The remaining 8 per cent indicated that they did believe that the government is performing well in this area.

Figure 23: The BC government is doing enough to invest in the technological solutions to address the issue of seniors living in social isolation.

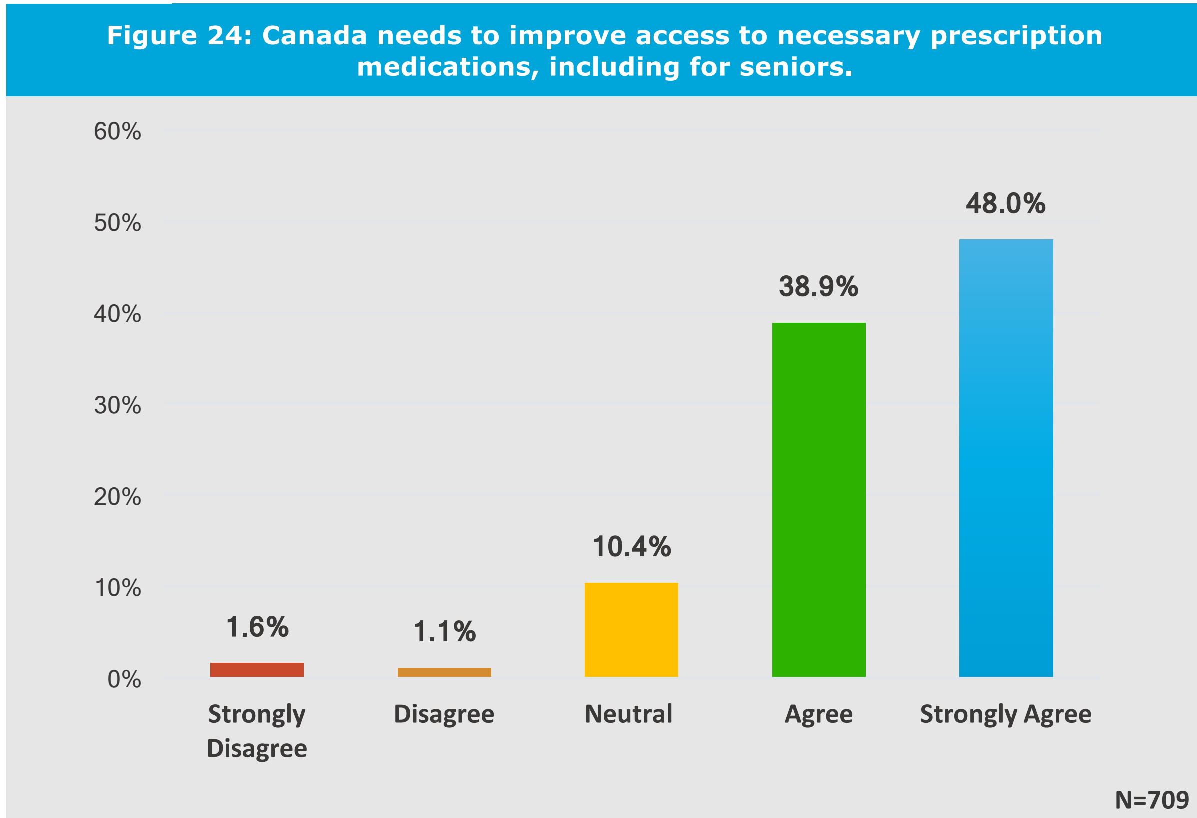


Attendees at the BCC3 were asked a number of questions regarding technology and the social isolation of seniors. 62% of attendees indicated that they believed that social isolation of seniors was an issue that should be prioritized by the BC government. Attendees were also asked to indicate whether they believed that technology should play a major role in address the issue of social isolation for seniors or whether we should be focusing more on in-person and human interactions. 69% of attendees indicated that they believed that we need both technology and human interaction equally, while 12% of respondents said we should focus more on human interaction.

Finally, when asked what strategies we should prioritize senior's social isolation, attendees indicated that new technologies were a low priority at 4%. Instead attendees indicated that we should be prioritizing adult day programs (29%), increased home support hours (21%), increased minimum times for home support visits (17%), and other strategies that were not listed (20%).

Prescription Medication (Q19)

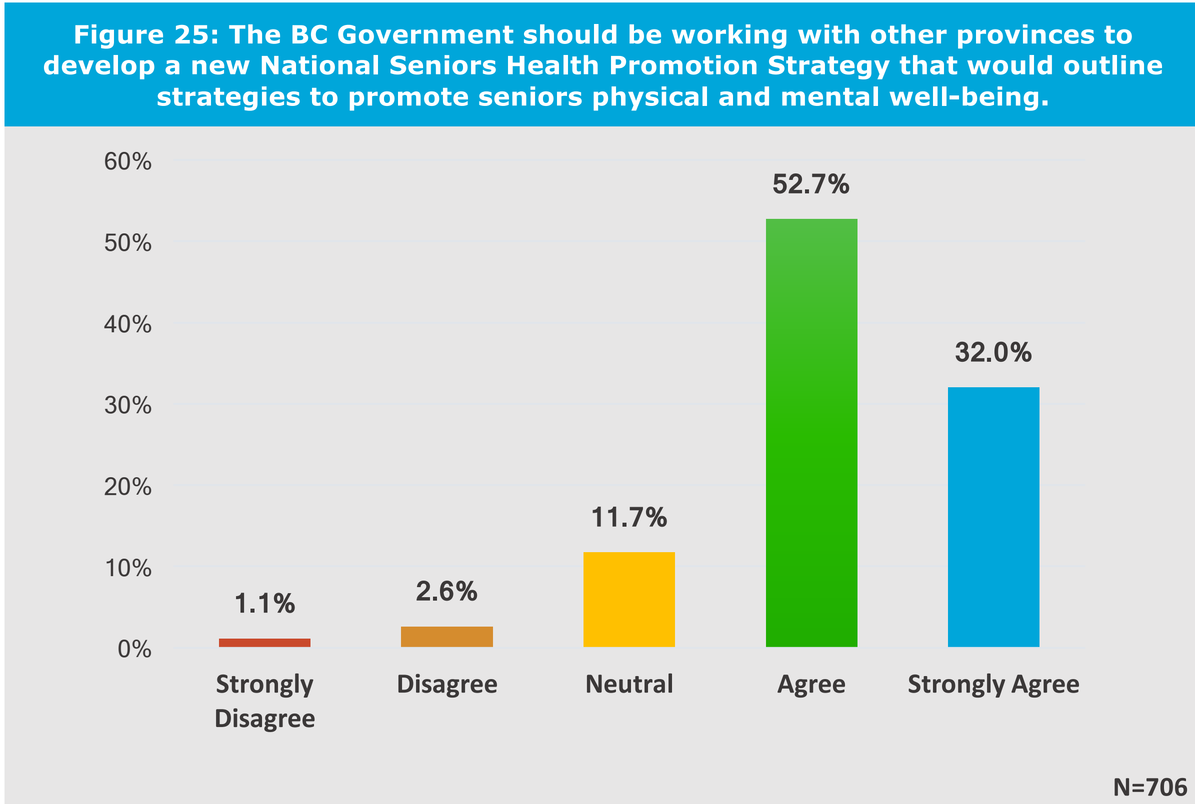
Survey participants were asked to indicate their overall agreement or disagreement to the opinion that Canada should improve access to necessary prescription medications, in particular for seniors. Survey participates indicated overall agreement with this statement, with 87% stating either that they agree or strongly agree. Just over 10 per cent of survey respondents indicated that they were neutral, with less than 3 per cent indicating disagreement.



National Health Promotion (Q22)

Survey respondents were asked to indicate their level of agreement with the idea of the BC Government promoting the development of a National Seniors Health Promotion Strategy that would address senior's mental and physical health. 85% of survey respondents indicated that they would support such an initiative, while 12% were neutral, and 3.5% indicating disagreement.

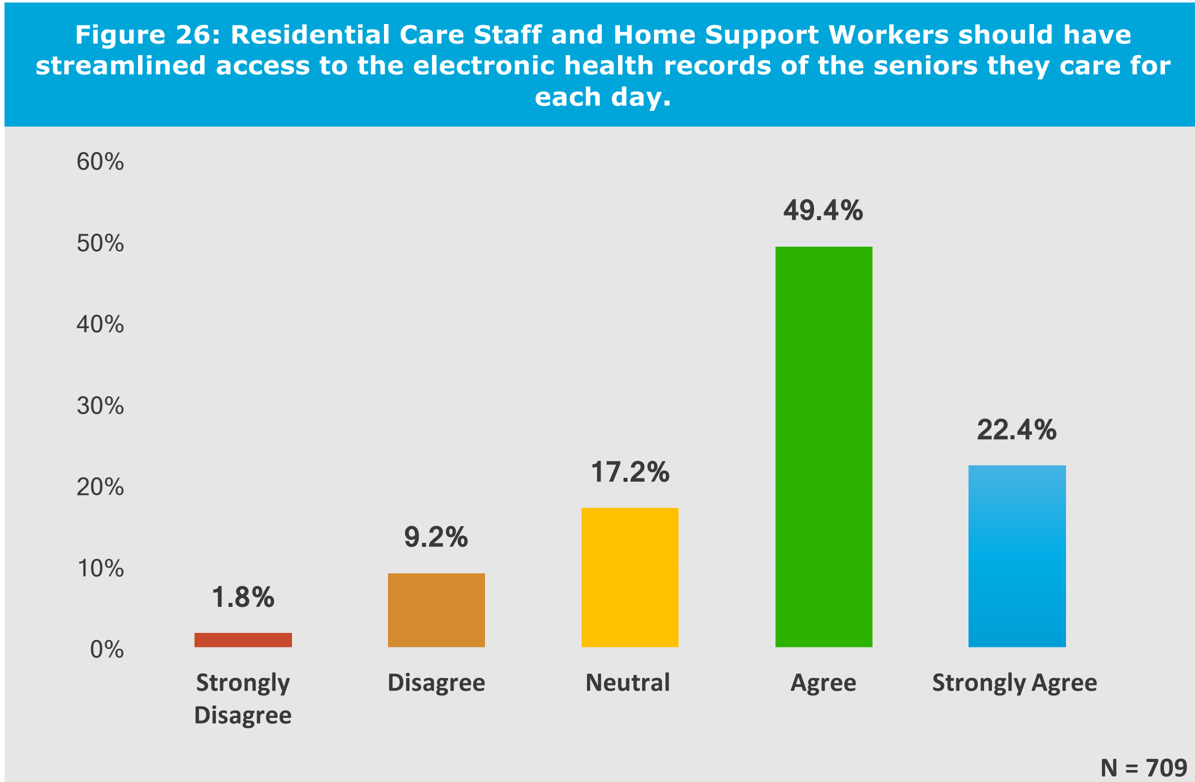
Figure 25: The BC Government should be working with other provinces to develop a new National Seniors Health Promotion Strategy that would outline strategies to promote seniors physical and mental well-being.



44% of attendees at the BCC3 event indicated that they believed that the BC government should be spearheading and advocating for the development of a new National Seniors Health Promotion Strategy, while an additional 22% said that their support would depend on the circumstances. The remaining attendees where either unsupportive (26%) or unsure (8%). Furthermore, attendees indicated that any funding for additional health promotion initiatives for seniors should come from a reallocation of existing HA revenue (49%).

Electronic Health Records (Q23)

Survey respondents were asked whether they believed that seniors care workers should have access to the electronic health records of their patients/clients/residents. This option received modest support, with 72% of survey respondents indicating that they agree or strongly agree. Eleven percent of respondents indicated that they disagreed with this proposal, while another 17% were neutral.



Survey Questions & Summary

Survey respondents were asked a series of *yes/no/ other* questions, outlined below. Other questions were analyzed and further coded as *yes*, *no*, *unsure*, *depends*, and *other*. Respondents answers to these questions are summarized in Table 1. Further analysis to these questions is presented in the body of this report.

- **Acuity Based Funding:** Do you think funding levels for Residential Care Homes and Home Support Providers should be linked to the actual health conditions of the seniors they are caring for (in other words, the less healthy the senior, the higher the level of funding)?
- **Funding Linked to Inflation:** Do you think the publicly-funded Seniors Care Providers in British Columbia should receive annual funding increases linked to the rate of inflation?
- **Municipal Taxes:** In Alberta, residential care homes are exempt from paying municipal property taxes so that funds can be focused on providing care for seniors. Do you think British Columbia should implement the same policy?
- **Long-Term Care (LTC) Insurance:** Do you think Canada should establish a new mandatory Long-Term Care Insurance plan to help cover the costs of seniors care?
- **Resident Co-Payments:** Currently the market cost to deliver residential care, including housing and health care services, in British Columbia is approximately $7,000 per month. However, the maximum fee any senior pays for a publicly funded residential care bed is approximately $3,200. The remaining funding gap is subsidized by taxpayers. Do you think the maximum fee should be increased so that British Columbians with higher incomes pay a greater percentage of the cost of their care?
- **Care Credits:** Do you think seniors should be able to choose their own Residential Care or Home Support Provider through the allocation of "Care Credits" - i.e. a government subsidized voucher for seniors care services?
- **Additional Onsite Services:** Do you think residential care homes should be offering additional onsite services in your local community such as IV therapy, dialysis, child care?
- **Additional Offsite Services:** Do you think Residential Care Homes should be providing services to seniors who actually live off site in the community? For example, eligible seniors living off site could have access to adult care programs, recreational therapy & occupational therapy delivered by the Residential Care Home.
- **End of Life Care:** Do you think the BC Government should work with Seniors Care Providers to develop a strategy to better utilize empty private-pay seniors care beds in order to increase the delivery of hospice and end-of-life care in BC?
- **National Dementia Strategy:** Do you believe we need a National Dementia Strategy in Canada to address our aging population?
- **Provincial Dementia Strategy**: Do you believe we need a Provincial Dementia Strategy in British Columbia?

Per cent Responses

Option / Issue	Yes	No	Depends	Unsure	Other	N

Acuity Based Funding	75%	18%	1%	2%	5%	752
Funding Linked to Inflation	93%	3%	1%	1%	2%	748
Municipal Taxes	77%	9%	11%	1%	2%	748
LTC Insurance	54%	29%	7%	6%	4%	735
Resident Co-Payments	60%	31%	4%	2%	4%	742
Care Credits	72%	11%	0%	4%	13%	731
Additional Onsite Services	56%	30%	2%	10%	1%	735
Additional Offsite Services	82%	10%	5%	1%	1%	744
End of Life Care	88%	7%	1%	2%	2%	737
National Dementia Strategy	88%	8%	2%	2%	1%	739
Provincial Dementia Strategy	86%	8%	2%	2%	1%	746

Table 2: The Federal Government has committed over $3 billion dollars in new investments in Health Care services, including for seniors. What should be the key priority areas for this new funding?

Choose three or fewer.

Federal Liberal Campaign Commitments (choose up to three)	Response Percent
Increase Staffing Levels	61%
Improve Access to Home Care	60%
Reduce the Cost of Prescription Medications	45%
Renew infrastructure	27%
Improve Access to Palliative Care	26%
Other	10%

Table 3: Please indicate the statement that best reflects your opinion regarding how seniors care should be funded in British Columbia.

Funding Mechanisms	Response Percent
Global	8%
Activity	48%
Outcome	30%
Mixed	4%
Other	4%
Unsure	6%

Table 4: Please indicate the statement best reflects your opinion regarding the level of funding provided by the BC Government to residential care providers and home support agencies who deliver seniors care in BC.

Perceptions of Funding for Care Operators	Response Percent
They receive too much funding	2%
They receive about the right amount of funding	7%
They receive too little funding	68%
I don't know	24%
They receive too much funding	2%

Survey respondents were asked a series of *agree/ disagree* questions, outlined below. Respondents answers to these questions are summarized in Table 5 below, and further analysis to these questions is presented in the body of this report.

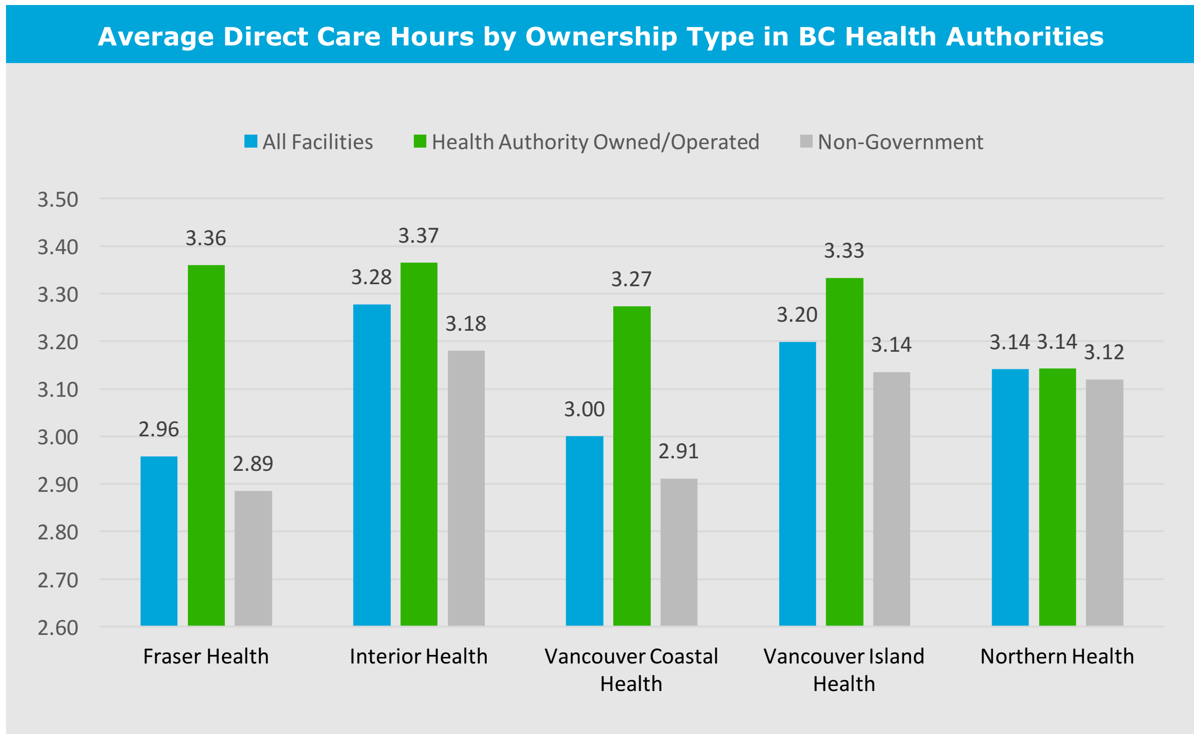
- **Age Adjusted Health Transfer:** Provinces with higher proportions of seniors as part of their overall population should receive more federal funding per person compared to other provinces.
- **Increase Funding for Staffing Levels:** The BC Government needs to increase the overall level of funding in BC's publicly-funded residential care homes in order to increase staffing levels.
- **Transparent Funding:** Residential care homes and home support agencies should be provided with open, transparent & sustainable funding that allows for long-term planning.
- **Funding for Infrastructure:** The Federal and Provincial governments should set aside infrastructure funding to improve the safety of residents and health care workers, including targeted funding to install ceiling lifts, sprinkler systems and other retrofits to older residential care homes.
- **Prescription Medications:** Canada needs to improve access to necessary prescription medications, including for seniors.
- **Monitoring Technology for Safety:** The BC government should be investing in technology to improve the safety of seniors, particularly through new monitoring and surveillance systems.
- **Reducing Social Isolation through Technology:*** The BC government is doing enough to invest in the technological solutions to address the issue of seniors living in social isolation.
- **National Seniors Health Promotion Strategy:** The BC Government should be working with other provinces to develop a new National Seniors Health Promotion Strategy that would outline strategies to promote seniors physical and mental well-being.
- **Access to eHealth Records:** Residential Care Staff and Home Support Workers should have streamlined access to the electronic health records of the seniors they care for each day.

Table 5: Per cent Responses to Agree/ Disagree Questions

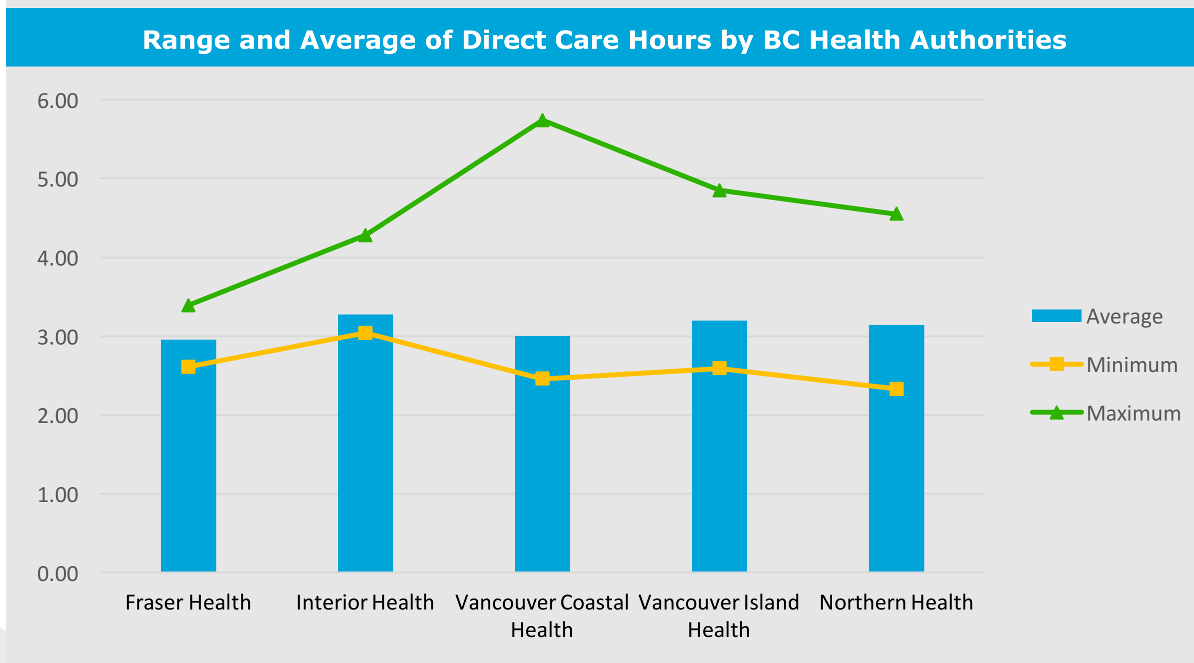
Option / Issue	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Age Adjusted Health Transfer	4.8%	9.0%	15.4%	40.3%	30.6%
Increase Funding for Staffing Levels	2.4%	2.5%	10.4%	43.6%	41.2%
Transparent Funding	2.4%	1.0%	6.6%	48.7%	41.3%
Funding for Infrastructure	1.8%	1.6%	7.3%	50.6%	38.6%
Prescription Medications	1.6%	1.1%	10.4%	38.9%	48.0%
Monitoring Technology for Safety	1.7%	4.5%	22.1%	47.2%	24.4%
Reducing Social Isolation through Technology*	21.5%	40.8%	30.2%	4.6%	3.0%
National Seniors Health Promotion Strategy	1.1%	2.5%	11.5%	53.3%	31.6%
Access to eHealth Records	1.8%	9.2%	17.2%	49.4%	22.4%

* question is posed as a negative, so response scale is flipped.

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



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



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

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

DCH Requirements by Health Authorities		
Health Authority	**Breakdown**	
Fraser Health	Professional:	20%*
	Allied Professional:	N/A
	Non-Professional:	80%
	Total	***100%***
Vancouver Island Health	Professional	20%*
	Allied Professional	N/A
	Non-Professional	80%
	Total	***100%***
Interior Health	Direct Care:	89%
	(Professional Nursing)	(18%)*
	(Non-Professional)	(71%)
	Allied Professional	7%
	Non-Professional	4%
	Total	***100%***
Vancouver Costal	Professional	25%*
	Allied Professional	N/A
	Non-Professional	75%
	Total	***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.

APPENDIX E: VOTING RESULTS FROM THE INAUGURAL BC CONTINUING CARE COLLABORATIVE

September 20, 2016

SUMMARY OF RESULTS:

In May of 2016 the BC Care Providers Association (BCCPA) released two major white papers focusing on the future of Seniors' Care British Columbia. The first paper focused on issues of funding, including issues such as long-term care insurance, and the potential use of vouchers ("care credits") to allocate public subsidies, among other concepts. The second paper focused on innovations, including new care models for seniors, improving dementia care, effective use of technology, and enhancing the health, safety, and well-being of seniors.

Following the release of the White Papers, the BCCPA, in partnership with the Ministry of Health, brought together over 150 stakeholders from across the continuing care sector to turn ideas into action at the inaugural BC Continuing Care Collaborative (BCC3) on September 20, 2016. Discussions at the BCC3 were focused around five topic areas: funding and financing for continuing care; Dementia Care and Strategies; Continuing Care Hubs; and Senior's Well-being (including Health Promotion and Social Isolation).

Attendees at the event were asked a series of multiple choice questions on these five topic areas throughout the day and asked to vote in real time. An overview of the results from these questions are outlined below. Full results are reported on pages 5 through 16.

Funding for Continuing Care:

- The concept of providing seniors in BC with increased consumer choice regarding their care through the allocation of vouchers for public subsidies ('care credits') received moderate support from BCC3 attendees, with 72% indicating that they agreed with the concept.
- When presented with five funding options for senior's care (Global, Outcome, Activity, Mixed, and Other), the majority of BCC3 attendees expressed a preference for a Mixed System (65%). When only given a choice between Global Funding and Mixed, the support for a Mixed system increased to 84% of respondents.

Financing of Continuing Care:

- The concept of a new mandatory long-term care insurance plan in Canada received moderate opposition, with 44% of attendees indicating some level of disagreement with the concept, and only 29% indicating support.
- When asked about how a new Long-Term Care insurance plan should be financed, almost half of BCC3 attendees indicated out of general tax revenue (44%), and 30% indicating that they were unsure or didn't know.
- BCC3 attendees largely indicated that they were unsure if a 1% shift in health authority acute care expenditures to home and community care (HCC) would be sufficient, with 41% choosing *I don't know.* 38% of attendees indicated that the shift from acute to HCC should be more than 1%, and 19% indicated that it would be sufficient in their opinion. Only 3% indicated that 1% was too much.

- When asked about the use of asset testing for determining resident co-payments in the continuing care sector, the majority of BCC3 attendees opposed this concept (53%), and only 29% supported the idea.

The Role of the Federal Government in Care:

- When asked to identify their top two priority areas for new Federal investments in care, BCC3 attendees indicated that they would prioritize improving access to home care and support (35%), and increasing staffing levels in care homes (27%). Other priorities included reducing the cost of prescription medications (14%), and increasing access to subsidized assisted living (10%). Initiatives that were identified as less priorities by the majority of attendees included renewing aging infrastructure (7%), and improving access to palliative care (8%).

- Attendees were asked about level and distribution of funding being provided by the Federal Government through the Canada Health Transfer (CHT). The majority of BCC3 attendees indicated that they believe that the total level of funding provided through the CHT should be increased with a portion be dedicated to seniors (57%), while a quarter of respondents indicated that the overall funding level was sufficient but that the distribution should be adjusted through an age-adjusted health transfer.

Dementia Care:

- BCC3 attendees were asked a series of questions regarding their beliefs about Dementia Strategies. Only 44% of attendees indicated that they believed that a National Dementia Strategy would have a positive effect on the lives of people living with Dementia in BC, with 28% indicating neither agreement nor disagreement. Similarly, 48% of survey respondents indicated that they believed that it is unlikely that we will have an effective National Dementia Strategy within the next five years. Furthermore, two-thirds of participants indicated that they did not believe that there is enough coordination and collaboration in BC to ensure that the needs of people living with Dementia are being taken care of.

- There was a lack of consensus among BCC3 attendees about whether we are using a lack of a National Dementia Strategy as an excuse to not address the growing issue of Dementia, with 33% indicating disagreement, 39% indicating agreement, and 15% indicating neither agreement nor disagreement. The remaining 15% of attendees didn't know.

- When asked to identify the jurisdiction or organization that should be developing and spearheading a Dementia Care Strategy, the majority of BCC3 respondents indicated that the Provincial (53%) Government should be leading such an initiative. The Federal Government was a distant second at 18%.

- If a National Dementia Strategy were to be developed, BCC3 attendees indicated that they believe that it should focus on promoting dementia friendly communities (32%), developing appropriate care models (26%), and focusing on education and training (24%). Research was not identified as a high priority (11%).

- When asked which Dementia Care Models or initiatives should be prioritized for development in BC, a third of participants chose Dementia Villages (34%), and Dementia Friendly Communities (33%). Butterfly Care Homes were chosen as a priority by only 16% of attendees.

- Finally, attendees were asked whether they believed that the resources and supports that BC has in place to support people living with dementia in neighbourhood settings (i.e. in single family homes, apartments or condos) are sufficient: overwhelmingly, 91% of attendees indicated that they disagreed with this statement.

Continuing Care Hubs:

- BCC3 attendees overwhelmingly identified Continuing Care Hubs as a priority for development in both urban centres (79.8%) and rural areas (93.2%).
- The majority of attendees (66.6%) were supportive of reinvesting existing Health Authority (HA) acute care funding for the development of Continuing Care Hubs.
- Attendees identified that reducing red tape (36.4%) and ensuring that health human resources are available and working in integrated teams (21.2%) are the most critical factors in establishing Care Hubs.
- No clear priorities emerged in terms of which services should be prioritized for delivery at Continuing Care Hubs: Adult Day Programs (16%); Chronic Disease Management & Health Promotion (14%); End of Life & Hospice Care (14%); Sub-acute care & Paramedic services (12%); Diagnostic & Laboratory Services (11%); Mental Health Services (11%); Supplement Services (9%); rehabilitation services (9%); and pharmacy services (5%).

Health Promotion

- While the majority (70%) of BCC3 attendees indicated that they felt that the current health system focuses too much on disease treatment and not enough on health promotion, attendees indicated only moderate support for the idea of BC spearheading the development of a National Seniors Health Promotion Strategy (43.9%). 22%, however, indicated depends.
- Respondents indicated that funding for any additional health promotion initiatives should primarily come from a reallocation of existing Health Authority acute care funding (49.1%).

Senior's Social Isolation & Technology

- While attendees did not identify technology as being a priority in terms of addressing senior's social isolation (3.6%) - and instead prioritized adult day programs (29.1%), increasing home support hours (20.9%), and increasing the minimum time for home care visits (17.3%) – they did indicate that we need to be using both technology and human interaction in partnership to address the issue (69%).

Continuing the Conversation

- The vast majority of BCC3 attendees (97%) indicated that they believe that the BCCPA should be working on future collaborative events similar to the September 20th event, with 79% of attendees choosing *yes* and 18% choosing *depends.*
- When asked how follow up work focused on the issues discussed at the BCC3 event should be pursued, attendees indicated that they would like to see both the establishment of committees on specific issues (30%) and a summary report of the findings (27%). Attendees also expressed some support for initiating regular group teleconferences (11%), conducting research papers (13%), and establishing regular webinars (12%).

Topic 1: Are there better ways to Fund Senior's Care?

1. If BC seniors were directly provided with Care Credits as a means to access continuing care services, do you think this would be an effective way to provide them with more consumer choice? (Multiple Choice)

Answer Options	Percent	Count
Strongly Disagree	4.1%	5
Disagree	8.1%	10
Neither Agree nor Disagree	6.5%	8
Agree	39.8%	49
Strongly Agree	31.7%	39
Unsure / Don't Know	9.8%	12
Totals	100%	123

2. What do you think is the optimal funding approach for continuing care? (Multiple Choice)

Answer Options	Percent	Count
Global Funding (i.e. status quo)	4.9%	6
Activity Based Funding	9.8%	12
Outcome Based Funding	11.5%	14
Mixed (combination of the above)	64.8%	79
Other (not Listed)	4.1%	5
Unsure / Don't Know	4.9%	6
Totals	100%	122

3. Between a system of Global Funding and a Mixed System, which do you prefer? (Multiple Choice)

Answer Options	Percent	Count
Global Funding (i.e. status quo)	5.8%	7
Mixed	84.2%	101
Unsure / Don't Know	10.0%	12
Totals	100%	120

4. What do you think should be the key priority area(s) for new Federal Funding? Choose Two. (Multiple Choice - Multiple Response)

Answer Options	Percent	Count
Increase staffing levels in care homes	26.7%	50
Improve access to home care and home support	34.8%	65
Increase access to subsidized assisted living	10.2%	19
Reduce cost of prescription medications	13.9%	26
Renew infrastructure	7.0%	13
Improve access to palliative care	7.5%	14
Totals	100%	187

Topic 2: Dementia: When is Strategy Just Not Enough?

1. Are we using a lack of a National Dementia Strategy as an excuse not to address the growing issue of Dementia? (Multiple Choice)

Answer Options	Percent	Count
Strongly Disagree	7.7%	9
Disagree	24.8%	29
Neither Agree nor Disagree	14.5%	17
Agree	24.8%	29
Strongly Agree	13.7%	16
Unsure / Don't Know	14.5%	17
Totals	100%	117

2. Which of the following should be leading the development of a Dementia Strategy? (Multiple Choice)

Answer Options	Percent	Count
International (e.g. the WHO)	3.4%	4
Federal	17.9%	21
Provincial /Territorial	53.0%	62
Municipal	6.8%	8
Non-Gov't Agency	10.3%	12
Unsure / Don't Know	8.5%	10

Totals	100%	117

3. What do you think the odds are that in the next 5 years, that we will have an effective National Dementia Strategy: (Multiple Choice)

Answer Options	Percent	Count
Very Unlikely	21.7%	26
Somewhat unlikely	25.8%	31
Somewhat likely	33.3%	40
Very likely	11.7%	14
Unsure / Don't Know	7.5%	9
Totals	100%	120

4. The development of a National Dementia Strategy will have a positive effect on the lives of people living with Dementia in BC. (Multiple Choice)

Answer Options	Percent	Count
Strongly Disagree	2.4%	3
Disagree	16.3%	20
Neither Agree nor Disagree	27.6%	34
Agree	36.6%	45
Strongly Agree	7.3%	9
Unsure / Don't Know	9.8%	12
Totals	100%	123

5. If a National Dementia Strategy were to be developed, what should its primary focus be? (Multiple Choice)

Answer Options	Percent	Count
Developing Appropriate Care Models	25.8%	31
Research	10.8%	13
Educating & Training	24.2%	29
Promoting Dementia Friendly Communities	31.7%	38
Other / Not Listed	5.0%	6
Unsure / Don't Know	2.5%	3

Totals	100%	120

6. Based on what you know, which of the following dementia models or initiatives should be prioritized for development in BC? (Multiple Choice)

Answer Options	Percent	Count
Butterfly Care Homes (such as in the UK and Alberta)	15.8%	19
Dementia Villages (such as in Netherlands)	34.2%	41
Dementia Friendly Communities (i.e. New Westminster)	33.3%	40
None of the Above	3.3%	4
Unsure / Don't Know	13.3%	16
Totals	**100%**	**120**

7. There is enough collaboration and coordination in BC to ensure that the needs of people living with Dementia are being taken care of (Multiple Choice)

Answer Options	Percent	Count
Strongly Disagree	21.8%	26
Disagree	44.5%	53
Neither Agree nor Disagree	10.1%	12
Agree	14.3%	17
Strongly Agree	1.7%	2
Unsure / Don't Know	7.6%	9
Totals	**100%**	**119**

8. The resources and supports we currently have in place to support people living with dementia living in a single family home/condo/apartment setting longer are adequate (Multiple Choice)

Answer Options	Percent	Count
Strongly Disagree	40.3%	48
Disagree	50.4%	60
Neither Agree nor Disagree	1.7%	2
Agree	0.8%	1
Strongly Agree	1.7%	2
Unsure / Don't Know	5.0%	6

Totals	100%	119

Topic 3: Dollars and Sense: Exploring other Options to Finance Seniors Care

1. Based on what you know, would you support or oppose Canada establishing a new mandatory Long-Term Care Insurance to help cover the costs of seniors care? (Multiple Choice)

Answer Options	Percent	Count
Strongly Oppose	20.8%	25
Oppose	23.3%	28
Neither Support nor Oppose	8.3%	10
Support	22.5%	27
Strongly Support	6.7%	8
Unsure / Don't know	18.3%	22
Totals	100%	120

2. If the Government of Canada were to establish a new mandatory Long-Term Care Insurance program, how best might it be financed? (Multiple Choice)

Answer Options	Percent	Count
Fee charged off of payroll (similar to EI and CPP)	15.3%	18
General Revenue (similar to OAS)	44.1%	52
Other/ Not Listed	11.0%	13
Unsure / Don't know	29.7%	35
Totals	100%	118

3. Is the proposed 1% shift in health authority acute care expenditures to home and community care the right amount to meet the growing demands of an aging population? (Multiple Choice)

Answer Options	Percent	Count
Yes	19.0%	23
No, should be less	2.5%	3
No, should be more	38.0%	46
Unsure / Don't Know	40.5%	49
Totals	100%	121

4. Should the Federal Government increase funding for seniors care? (Multiple Choice)

Answer Options	Percent	Count
Yes, increase the Canada Health Transfer – with conditions attached (i.e. funding dedicated to seniors care)	56.7%	68
Yes, should increase the Canada Health Transfer (CHT), but no conditions	5.0%	6
No, but reallocate existing funds through an age-adjusted Health Transfer.	24.2%	29
No changes required	0.8%	1
Unsure / Don't Know	13.3%	16
Totals	100%	120

5. Which of the following statements best describes what you believe? (Multiple Choice)

Answer Options	Percent	Count
The aging of our population can be managed effectively.	50.4%	62
The aging of our population will put a severe strain on the system & potentially jeopardize other government programs.	44.7%	55
Not sure / Don't know.	4.9%	6
Totals	100%	123

6. Would you support or oppose implementing asset testing with respect to determining co-payments for residential care? (Multiple Choice)

Answer Options	Percent	Count
Strongly Oppose	20.3%	25
Oppose	32.5%	40
Neither Support nor Oppose	6.5%	8
Support	20.3%	25
Strongly Support	8.9%	11
Unsure / Don't Know	11.4%	14
Totals	100%	123

Topic 4: Care Hubs: The Way of the Future?

1. How would you prioritize the development of Continuing Care Hubs in urban areas of BC? (Multiple Choice)

Answer Options	Percent	Count
High priority.	43.0%	49
Moderate Priority.	36.8%	42
Low Priority.	8.8%	10
Not a Priority.	2.6%	3
Unsure / Don't Know	8.8%	10
Totals	**100%**	**114**

2. How would you prioritize the development of Continuing Care Hubs in rural/ remote areas of BC? (Multiple Choice)

Answer Options	Percent	Count
High priority	66.7%	78
Moderate Priority	26.5%	31
Low Priority	0.9%	1
Not a Priority	0.9%	1
Unsure / Don't Know	5.1%	6
Totals	**100%**	**117**

3. Which of the following do you believe is the most critical factor in establishing new Continuing Care Hubs? (Multiple Choice)

Answer Options	Percent	Count
Appropriate Health Human Resources in Integrated Teams	21.2%	25
Increased funding for infrastructure and new services	18.6%	22
Reducing regulations	36.4%	43
Addressing limiting scope of services	11.0%	13
Unsure / Don't Know	12.7%	15
Totals	**100%**	**118**
Appropriate Health Human Resources in Integrated Teams	21.2%	25

4. Which additional services should Care Hubs provide? Choose up to 3. (Multiple Choice - Multiple Response)

Answer Options	Percent	Count
Adult Day Programs & Respite Care	16.2%	55
Chronic Disease Management & Health Promotion	13.8%	47
Sub-acute care & Paramedic services	11.8%	40
Diagnostic & Laboratory Services	10.6%	36
End of Life & Hospice Care	13.8%	47
Mental Health Services	10.6%	36
Pharmacy Services	5.3%	18
Supplemental Services (e.g. oral care / foot care)	9.4%	32
Rehabilitation services	8.5%	29
Totals	**100%**	**340**

5. Would you support or oppose reinvesting part of the 1% in health authority acute funding discussed earlier to support development or creation of continuing care hubs? (Multiple Choice)

Answer Options	Answer Options	Answer Options
Strongly Oppose	7.0%	8
Oppose	11.4%	13
Neither Support nor Oppose	10.5%	12
Support	37.7%	43
Strongly Support	28.9%	33
Unsure / Don’t know	4.4%	5
Totals	**100%**	**114**

6. Do you think residential care homes should be providing more support services to seniors who live in a single family home/apartment/condo setting? (Multiple Choice)

Answer Options	Percent	Count
Yes	44.0%	51
No	9.5%	11
Depends	33.6%	39
Don’t Know / Unsure	12.9%	15

Totals	100%	116

Topic 5: Senior's Health Promotion: A Priority?

1. "Social isolation of seniors is an issue that should be prioritized by the BC Government." (Multiple Choice)

Answer Options	Percent	Count
Strongly Disagree.	1.1%	1
Disagree	7.8%	7
Neither Agree nor Disagree	25.6%	23
Agree	45.6%	41
Strongly Agree	16.7%	15
Unsure / Don't know	3.3%	3
Totals	**100%**	**90**

2. Should technology play a major role in addressing the issue of social isolation for seniors or should be we focusing more on in-person and human interactions? (Multiple Choice)

Answer Options	Percent	Count
Yes, technology is the future and cost effective	5.6%	6
No, we should continue to focus on the human touch	23.1%	25
We equally need both in partnership	69.4%	75
Unsure / Don't Know	1.9%	2
Totals	**100%**	**108**

3. To reduce seniors isolation what would you see as main priority? Choose one (Multiple Choice)

Answer Options	Percent	Count
New Technologies	3.6%	4
Adult Day Programs	29.1%	32
Increased Home Support & Care Hours	20.9%	23
Increase the Minimum Time for Home Care Visits (15 min)	17.3%	19
Other	20.0%	22

Unsure / Don't Know	9.1%	10
Totals	**100%**	**110**

4. Which of the following statements best represents your position on the current balance between health promotion and treatment? (Multiple Choice)

Answer Options	Percent	Count
Too much focus on disease treatment.	70.3%	78
Too much focus on health promotion.	2.7%	3
Balance is more or less correct.	18.0%	20
Don't Know / Not Sure	9.0%	10
Totals	**100%**	**111**

5. If funding were increased for the support of health promotion for seniors, where should the dollars primarily come from? (Multiple Choice)

Answer Options	Percent	Count
Philanthropy/ Charity	2.8%	3
Increase in MSP premiums	4.6%	5
Reallocation of existing Health Authority revenue	49.1%	53
Other (not listed)	24.1%	26
Not Sure / Don't Know	19.4%	21
Totals	**100%**	**108**

6. Should the BC government be spearheading and advocating for the development of a new National Seniors Health Promotion Strategy? (Multiple Choice)

Answer Options	Percent	Count
Yes	43.9%	47
No	26.2%	28
Depends	22.4%	24
Unsure / Don't Know	7.5%	8
Totals	**100%**	**107**

Continuing the Conversation

1. Based on your experience, do you believe the BCCPA should begin work on future collaborations similar to today? (Multiple Choice)

Answer Options	Percent	Count
Yes	79.2%	80
No	2.0 %	2
Depends	17.8%	18
Not Sure/ Don't Know	1.0%	1
Totals	**100%**	**101**

2. Through which avenues do you believe follow up work on the issues discussed here today should proceed? Please choose up to three. (Multiple Choice - Multiple Response)

Answer Options	Percent	Count
Regular Group Teleconferences	11.2%	25
Establishment of Committees on Specific Issues	30.4%	68
Conduct Research Papers	13.4%	30
Regular Webinars	12.1%	27
Summary report of findings	26.8%	60
None of the Above	2.7%	6
Unsure / Don't Know	3.6%	8
Totals	**100%**	**224**

APPENDIX F: NEW HOME CARE MODELS & INNOVATIONS

Along with exploring development of new continuing care models, it will also be important to look at new models for home care and home support within the continuing care sector. This paper explores a couple of home care models from Ontario that could serve as a best practice including its Seniors Managing Independent Living Easily (SMILE) and Integrated Comprehensive Care Program (ICC) programs. Another initiative is Ontario's Bundled Care program which better attempts to integrate home and acute care.

Seniors Managing Independent Living Easily (SMILE) program

The Seniors Managing Independent Living Easily (SMILE) program was implemented in 2008 as a pilot project by the South East Local Health Integration Network (LHIN), as part of the *Aging at Home strategy* of the Ontario Ministry of Health and Long-Term Care. The Southeast LHIN is one of 14 agencies put in place by Ontario to provide regional-decision making and accountability for the following healthcare services: homecare, continuing care, mental health, and hospital services.[186]

The primary goal of the LHIN is to provide person centred care within their designated regions. At the same time, LHIN's develop innovative and collaborative initiatives to increase access to care for patients, they are the only organizations that bring together various sectors (hospitals, community care, long term care, etc.) to provide care to citizens.[187] The SMILE program was initiated by the LHIN, through consultation with seniors and healthcare providers and emphasizes the need to provide care to frail seniors at home who are at risk of losing their independence. The project funds services such as housekeeping, shopping, laundry, seasonal chores, and transportation to healthcare appointments.[188] Such support services cost $80 per day.

The SMILE program offers seniors a chance at managing their own care where they can choose what kinds of services they need, when they need them and who will provide these services, such as funded organizations (by the LHIN) or non-traditional service providers (family, friends, third party etc.).[189] The philosophy behind the program is based on the belief that attending to senior care is more than just about their medical needs but allowing them to stay in an environment that is beneficial to their well-being, that home is a good place to live, and that dignity and choice go hand in hand.[190] Based on a February 2012 survey, a majority of clients enlisted in the program reported satisfaction with SMILE services, with 49% expressing that their physical health had improved since being on the program[191].

The SMILE program was recognized as an Emerging Practice by the Health Council of Canada using the Health Innovation Portal Evaluation Framework. Although SMILE, remains only eligible for seniors who require assistance with activities of daily living and at risk of increasing frailty, the Community and Home Assistance to seniors (CHATS) program offers a range of home care and community services for seniors of all care levels.

CHATS is a non-for-profit organization which offers services to seniors such as: meals on wheels, transportation, diversity outreach programs, homecare and caregiver support/education.[192] CHATS provides services to over

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[186] Quick Facts about the South East Local Health Integration Network, accessed at: http://southeastlhin.on.ca/Page.aspx?id=1302
[187] Our Mission, Vision & Values, accessed at: http://southeastlhin.on.ca/AboutUs/MissionVisionValues.aspx
[188] Donner G., McReynolds, J., Smith, K., Fooks, C., Sinha, S., & Thomson, D. (2015) "Bringing Care Home: Report of the Expert Group on Home & Community Care". Accessed at: http://www.osot.on.ca/imis15/TAGGED/News/Bringing_Care_Home_-_Report_of_Expert_Group_on_Home___Community_Care_Released.aspx
[189] SMILE Program Information. Accessed at: http://www.von.ca/smile/programs_info.aspx
[190] South East Local Health Integration Network (2008) "A Plan to help seniors stay at Home".
[191] Accreditation Canada (2013) "Seniors Managing Independent Living Easily (SMILE)". Accessed at: https://www.accreditation.ca/seniors-managing-independent-living-easily-smile
[192] Donner G., McReynolds, J., Smith, K., Fooks, C., Sinha, S., & Thomson, D. (2015) "Bringing Care Home: Report of the Expert Group on Home & Community Care". Accessed at: http://www.osot.on.ca/imis15/TAGGED/News/Bringing_Care_Home_-_Report_of_Expert_Group_on_Home___Community_Care_Released.aspx

7,600 York Region and South Simcoe seniors and caregivers each year where services are provided through dedicated volunteers, 220 staff and a Board of Directors.[193] CHATS envisions to provide innovative leadership in order to promote the wellness of seniors and caregivers in Ontario.[194] Since its launch in 1980, CHATS has provided a continuum of care services to over 700 culturally, economically, and geographically diverse seniors.[195] CHATS was also accredited with exemplary standing by Accreditation Canada and met 100 per cent of the 852 standards during its evaluation period.

Integrated Comprehensive Care Program (ICC)

The Integrated Comprehensive Care Program (ICC) was undertaken at St. Joseph's Health System. The pilot project ran for a year and integrated case management between hospital and community based care.[196] The idea behind ICC was that after patients undergo surgery and leave to their home, they would receive access to the same care team on a 24/7 basis, if needed. In order to deliver care services, ICC requires inexpensive technology such as a computer/ telephone so patients can access their care team via skype or phone and maintain an electronic health record.[197] Dedicated care coordinators keep track of complex care patients, from the moment they are admitted to the hospital, to when they are discharged. The use of technology to connect with patients ensures that there will be reduced duplications, shorter hospital stays and fewer re-admissions.[198]

Important features of the program include having one contact number so the patient can direct their needs to one individual on the team, a shared electronic health record, flexibility in communications by using the latest technology to connect, and community partner support.[199] So far, the project has reduced length of hospital stay by 24 per cent and has seen a 15% drop in hospital re-admissions after surgery.[200]

Ontario's Bundled Care Initiative

Another innovative approach being piloted in Ontario is Bundled Care where hospital and home-care funding is essentially combined and tied to individual patients. In particular, under this model, a single payment to a team of health care providers is provided to cover care for patients both in the hospital and at home.[201] This initiative, which started four years ago in Hamilton began as a three-year pilot that has now been renewed and targets three groups – those undergoing lung-cancer surgery, hip and knee replacements, and those with chronic obstructive pulmonary disease (COPD) or congestive heart failure.

Under this model, hospital staff and community workers work as a single team. Nurses, personal support workers and other professionals making home visits have weekly rounds to share information. They treat clients with similar conditions and get training and support from the hospital, so they gain expertise and know, for instance, when a picture of a wound might need to be sent to a care co-ordinator for a doctor to review. Each patient leaves the hospital with a 1-800 number that puts her in touch with a member of the care team who has access to their records. The bundle-care model is being expanded to nine hospitals at 22 sites in the Hamilton

[193] About CHATS. Accessed at: http://www.chats.on.ca/about-chats
[194] CHATS: Community and home Assistance to seniors (2009-2010) "Annual Report: A Year to Grow".
[195] CHATS: Community and home assistance to seniors (2-13-2014) "Annual Report".
[196] Donner G., McReynolds, J., Smith, K., Fooks, C., Sinha, S., & Thomson, D. (2015) "Bringing Care Home: Report of the Expert Group on Home & Community Care". Accessed at: http://www.osot.on.ca/imis15/TAGGED/News/Bringing_Care_Home_-_Report_of_Expert_Group_on_Home___Community_Care_Released.aspx
[197] Integrated Comprehensive Care Project. Accessed at: http://www.sjhs.ca/integrated-comprehensive-care-project.aspx
[198] St. Mary's General Hospital (2013) Successful model for complex care patients expands to St. Mary's. Accessed at: http://www.smgh.ca/successful-model-for-complex-care-patients-expands-to-st-marys/
[199] Ministry of health and long-term care (2013) "Integrated Comprehensive Care Project". Accessed at: http://news.ontario.ca/mohltc/en/2013/09/integrated-comprehensive-care-project.html
[200] Ministry of health and long-term care (2013) "Ontario Helping More Patients to Benefit from New Model of Care".
[201] Ontario Ministry of Health and Long-term care. Ontario Funds Bundled Care Teams to Improve Patient Experience. September 2, 2015. Accessed at: https://news.ontario.ca/mohltc/en/2015/09/ontario-funds-bundled-care-teams-to-improve-patient-experience.html

area for patients with COPD and congestive heart failure – about 2,400 patients annually. It also is being used in Kitchener-Waterloo by another hospital.[202]

Adult Care Centres – Integration of Home Care and LTC

Other Jurisdictions

Finding models of care that can prevent senior's isolation from occurring is an important step in improving quality of care and the safety of our elders. Various homecare models have also emerged in the United States and Canada that attempt to better integrate long term and home care including by providing recreational activities at an adult day centre, as well as home support and community care services to the elderly.

Developed in 1996, the Comprehensive Home Options of Integrated Care for the Elderly (CHOICE) program in Edmonton, Alberta has become a recognized delivery model for homecare to elderly adults. In partnership with Capital Care and The Good Samaritan Society, the CHOICE program provides adults over the age of 60 options for care at home and at the same time operates itself like a day clinic. The program also offers a variety of services to seniors throughout the week and is run by a multi-disciplinary team of physicians, nurses, pharmacists, dieticians, occupational and physiotherapists and social workers.[203] Under CHOICE, seniors are delivered all basic health services - this includes personal care (bathing, dressing, etc.), dental care, respite care, meals and snacks, medication and home care services.[204]

The program offers care to seniors who have complex long-term care issues and live at home. Clients must be willing to change their health care provider and should be able to use transportation provided by the program.[205] Two examples of the CHOICE Program are the independent living complex of the Good Samaritan Place and onsite at the continuing care centre/ auxiliary hospital of Dr. Gerald Zetter Care Centre in Edmonton.[206] According to Alberta Health Services, six months after joining the program, all CHOICE clients saw a drop in emergency visits by 30 per cent.[207]

The CHOICE program in Edmonton was modeled off the Program of All-inclusive Care for the Elderly (PACE). Developed in the early 1970s, the PACE model first emerged in Northern California, where it was co-founded by dentist Dr. William L. Gee, and Social Worker Marie-Louise Ansak.[208] The idea developed to address the needs of elders immigrated from Italy, China, and the Philippines whom required continuing care services, in order to create a "community hub" where seniors medical, emotional, and physical needs could all be met in one place. Gee and Ansak formed a non-profit corporation called On Lok Senior Health Services, to provide community care to elders.[209]

Similar to the CHOICE program, On Lok Lifeway care providers work in interdisciplinary teams to offer similar services at a specific location or centre. The PACE model's key features include flexibility (i.e. coordinating care based on individual needs), all-inclusive care (preventive, primary, acute and continuing care), interdisciplinary

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[202] Program linking hospital staff to home-care workers pays off. Elizabeth Church. Globe and Mail. February 14, 2016. Elizabeth Church. Accessed at: http://www.theglobeandmail.com/news/national/program-linking-hospital-staff-to-home-care-workers-pays-off/article28757453/

[203] DeSantis, B. (2014) "CHOICE Edmonton Day Program: An outlet for social seniors". Senior Care Canada. Accessed at: http://seniorcarecanada.com/articles/choice_edmonton_day_program#sthash.nxuSwoyF.C8bmbATx.dpuf

[204] Hollander Analytical Services Ltd. (2006). Home care program review: Final report. Accessed at: http://www.health.gov.sk.ca/HomeCareReview2006_FinalReport.pdf

[205] Choice© Program. The Good Samaritan Society, accessed at: https://www.gss.org/find-housing-support-services/community-care/choice/

[206] For more information on the Good Samaritan Place & Dr. Gerald Zetter Care Centre, see: https://www.gss.org/find-housing-support-services/community-care/choice/

[207] Alberta Health Services. Accessed at: http://www.albertahealthservices.ca/1362.asp

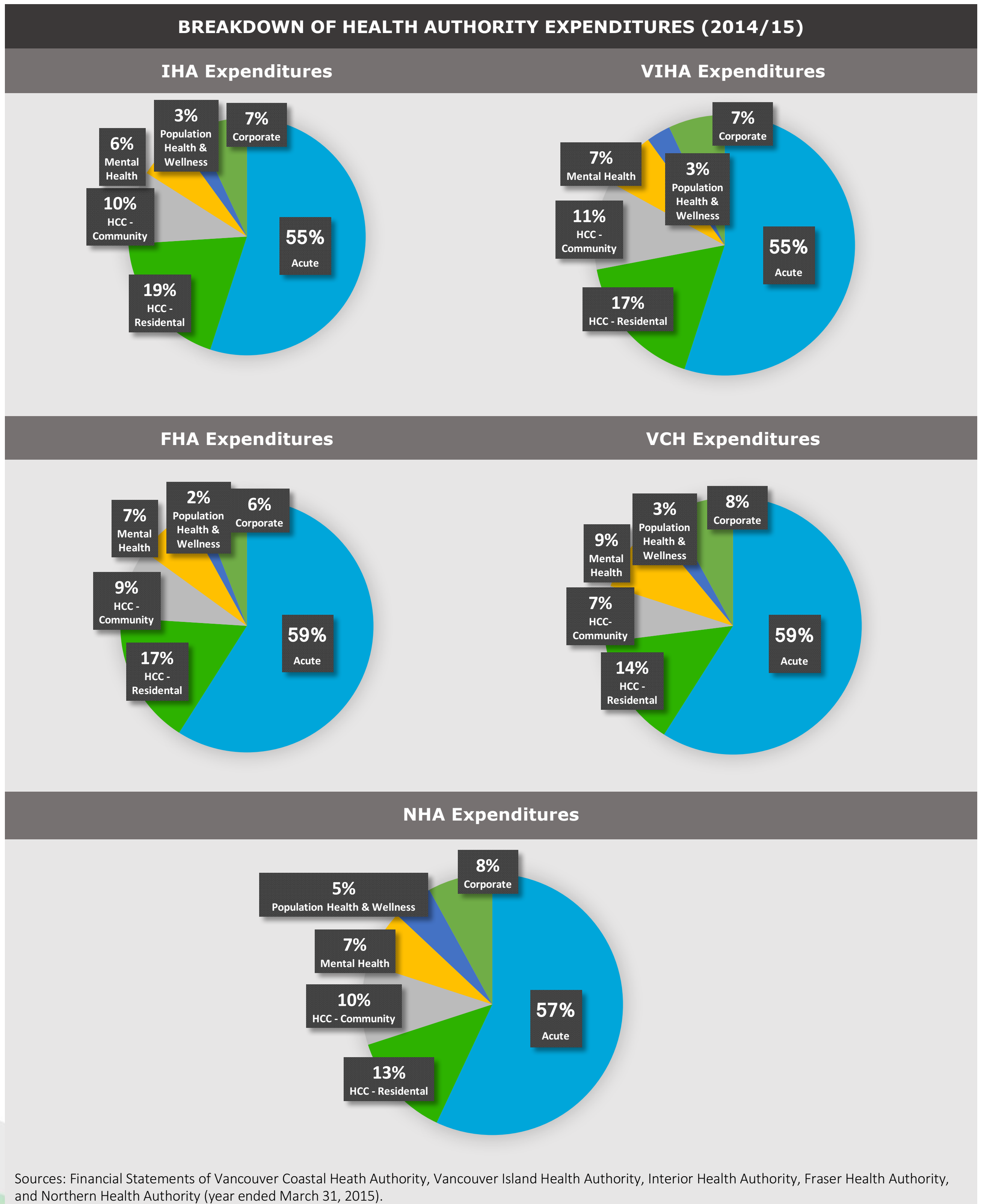
[208] McGregor Pace. "History of Pace". Accessed at: HTTP://WWW.MCGREGORPACE.ORG/ABOUT/HISTORY/

[209] Wong, J. (2013) "For Chinese Speaking Seniors, Better Service in San Francisco and Toronto". *The Tyee*. Accessed at: http://thetyee.ca/News/2013/04/04/Chinese-Speaking-Seniors/print.html

teams and capitation funding.[210] The PACE program offers community care to seniors aged 55 and up, where CHOICE offers the program to anyone 60 or older. One disadvantage of both the PACE and CHOICE programs are that they cannot include frailer portions of society, as one of the program requirements is that seniors must be certified by government to require homecare.

[210] What is PACE? On Lok PACEpartners, accessed at: http://pacepartners.net/what-is-pace/

APPENDIX G: BREAKDOWN OF HEALTH AUTHORITY 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)							
	Dollars spent on Acute Care	HCC -Residential	HCC - Community	Corporate	Mental Health	Pop Health and Wellness	TOTAL
Vancouver Coastal Health	$1,856,996,000 (59%)	$443,387,000 (14%)	$234,385,000 (7%)	$239,816,000 (8%)	$284,293,000 (9%)	$98,396,000 (3%)	**$3,157,273,000 (100%)**
Vancouver Island Health	$1,150,853,000 (55%)	$357,994,000 (17%)	$229,994,000 (11%)	$157,498,000 (7%)	$156,549,000 (7%)	$57,732,000 (3%)	**$2,110,570,000 (100%)**
Interior Health	$1,079,080,000 (55%)	$367,783,000 (19%)	$196,492,000 (10%)	$132,738,000 (7%)	$113,061,000 (6%)	$55,762,000 (3%)	**$1,944,916,000 (100%)**
Fraser Health	$1,893,608,000 (59%)	$544,780,000 (17%)	$289,088,000 (9%)	$200,612,000 (6%)	$228,747,000 (7%)	$79,077,000 (2%)	**$3,235,912,000 (100%)**
Northern Health	$435,760,000 (57%)	$99,153,000 (13%)	$75,878,000 (10%)	$63,711,000 (8%)	$49,677,000 (7%)	$37,330,000 (5%)	**$761,509,000 (100%)**
TOTAL	**$6,416,297,000 (57%)**	**$1,813,097,000 (16%)**	**$1,025,787,000 (9%)**	**$794,375,000 (7%)**	**$832,327,000 (7%)**	**$23,532,287 (3%)**	$11,210,180,000 (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 H: 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 I: DEMENTIA CARE MODELS

Dementia Friendly Communities

With roughly 70,000-75,000 British Columbians currently being impacted by dementia and this expected to rise to 105,000-110,000 by 2025[211], exploring options such as building dementia-friendly communities in BC will help reduce stigmas surrounding people with dementia and allow for chronically ill seniors to continue to participate positively to the larger community.

Dementia-friendly communities are ones that empower elders with dementia to contribute to their community and give them the confidence to continue to participate in activities that are meaningful to them.[212] In order to achieve this, communities must focus on ensuring that they are shaped to the needs and aspirations of those with dementia, that people with dementia acknowledge themselves the positive contribution they can make to the community, and promote an awareness of dementia.[213]

Key areas of dementia friendly communities include making the physical environment easier to navigate by creating clearer signage and directional information for elders,[214] as well as reducing the stigma surrounding dementia in order for seniors to participate in daily activities, and reducing barriers surrounding such illnesses.[215] Similarly, the World Health Organization (WHO) defines an age-friendly community as being one that adapts its structures and services to be accessible to, and inclusive of, older people with varying needs and capacities.[216]

According to WHO, an age-friendly environment will include domains such as accessible outdoor spaces and buildings, cheap public transportation, venues for social participation for seniors, respect and social inclusion of seniors, civic participation and employment opportunities and an adequate amount of health services for seniors.[217]. Although not specifically meant for seniors with dementia, these guidelines can assist communities that are shifting towards dementia inclusive environments. Dementia-friendly care homes will create environments that are legible, distinctive, safe, and familiar to seniors.[218] This includes, ensuring that areas are well-lit, avoiding reflective and slippery floor surfaces, easy to use street furniture, and distinctive landmarks to assist with navigation.[219]

As outlined earlier, the development of dementia friendly communities, much like integrating residential care homes into age-friendly communities, may also require addressing some of the issues regarding strict municipal zoning requirements. In particular, streamlining the approval of such care homes, particularly those that are to be integrated into the community will be critical.

The BCCPA is looking further at the idea of dementia friendly care homes, including a specific designation that could be provided to homes that have made specific redesign changes to accommodate dementia residents and/or where specific dementia training has been provided to staff. The BCCPA believes such a program or

[211] Workforce Analysis, Health Sector Workforce Division, Ministry of Health, Dementia (age 45+ years) March 24, 2014, project 2014_010 PHC
[212] "Dementia-friendly communities". Alzheimer's Society, accessed at: http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=1843
[213] Green, G and Lakey, L. (2013) "Building dementia-friendly communities: A priority for everyone." Alzheimer's Society.
[214] Developing dementia-friendly communities: Learning and guidance for local authorities. *Local Government Association*, May 2012.
[215] Haggarty, M (2013). "Dementia Friendly Communities Worldwide: A Summary of Web Searches." *Centre for Education and Research on Aging and Health,* Lakehead University.
[216] "Building Dementia and Age- Friendly Neighbourhoods." Alzheimer's Australia. Discussion Paper, July 2011.
[217] "Checklist of Essential Features of Age-friendly Cities." *World Health Organization* 2007.
[218] "At a Glance: a Checklist for Developing Dementia Friendly Communities." *Housing Learning & Improvement Network*, June 2012.
[219] "Live Life to the full Making Kirklees a dementia friendly place to live: Checklist for dementia friendly environments." October 2012.

designation merits further consideration in partnership with relevant stakeholders including government, health authorities, and the Alzheimer's Society of BC.

Dementia Villages

The Netherland's and Switzerland are two countries who have implemented dementia-friendly communities through their unique model of care to seniors who suffer from severe cases of dementia. These communities or care homes are often referred to as Dementia Villages.

The village of Hogeweyk, otherwise referred to as "Dementiaville" in the Netherlands, was the first established Dementia Village and currently has over 150 seniors living with severe cases of dementia, as well as creates an alternate reality for seniors who are encouraged to roam around the confines of the village enjoying everyday pleasures such as shopping, cooking and going to the movies.[220] The Village, which features 23 residential units shared by 6-8 seniors each, closely resembles the period when resident's short-term memory began to decline in order to promote a home-like environment for seniors.[221]

Founded by Yvonne van Amerongen, the design and idea of the Villages was to find a way for seniors to participate in daily life the same way they did prior to needing dementia care.[222] The model attempts to minimize disability and maximize well-being by providing seniors an environment that is reflective of their past physical and social surroundings.[223] In order to do so, residents with the help of their family, fill out a questionnaire regarding several lifestyle choices that reflect their values, beliefs, and norms, in order to ensure that elders are placed within a unit that is similar to their worldviews.[224] Such lifestyle choices include options such as: homey; those who focus on housekeeping and family; Indonesian for those who have an interest in nature and spirituality; and Urban, the more outgoing and informal individuals.[225]

Within the confines of the village, caregivers and Geriatric nurses monitor and provide seniors with care disguised as "villagers" in everyday street clothes, administrating medicine, cooking meals and planning activities.[226] However, residents of Hogeweyk are administered less medication than seniors living in conventional care homes due to living a more active lifestyle, eating better, and because of the added psychological benefits of living within a residence tailored to their specific needs.[227] Along with decreasing levels of stress and anxiety including the use of antipsychotics, the Netherland's dementia village has also resulted in reductions in the overall levels of aggression and violence.

Butterfly Care Homes

Another innovative dementia care model that uses many of the same approaches taken in the dementia village is that of Butterfly Care Homes. Following its initial introduction at Merevale House in Atherstone, UK in 1995 – a care home for 36 people living with a dementia – the approach has spread across the UK but also other countries including Ireland, Australia and most recently Canada. Known as Butterfly Service homes, there are over 50 project homes adopting this model. In Butterfly Care Homes a wide range of quality of life and quality of service outcomes are focused upon some of the following aspects:

- *A house model* – breaking the care home up into domestic scale and recognisable houses;

[220] Anderson, J (2013) "Global Approaches to Dementia Care." Seniors living blog. Accessed at: http://www.aplaceformom.com/blog/dementia-care-around-the-world-4-2-2013/
[221] Planos, J. (2014) "The Dutch Village Where Everyone Has Dementia." The Atlantic, accessed at: http://www.theatlantic.com/health/archive/2014/11/the-dutch-village-where-everyone-has-dementia/382195/
[222] "An Amazing Village Designed Just For People With Dementia." Accessed at: http://gizmodo.com/inside-an-amazing-village-designed-just-for-people-with-1526062373
[223] Jenkins, C., and Smythe, A. (2013) "Reflections on a visit to a dementia care village." Nursing Older People, RCN Publishing Company, 6(25).
[224] Ibid.
[225] Glass, A. (2014) "Innovative Seniors Housing and Care Models: What We Can Learn from the Netherlands." *Seniors Housing & Care Journal, 1(22).*
[226] "Dementia Care: What in the World is a Dementia Village?" Accessed at: http://www.alzheimers.net/2013-08-07/dementia-village/
[227] Schmid, C. (2013) "Hogewey Dementia Village | The Future of Dementia Care?" Best Alzheimer's Products. Accessed at: http://www.best-alzheimers-products.com/hogewey-dementia-village.html

- ***Creating housekeepers*** – transforming ways of working as domestic and catering staff into housekeepers being the heart of the home in each house;
- ***Removing boundaries and barriers*** that separate staff from feeling peoples lived experience;
- ***Removing central dining rooms*** – preventing the 'herding' of people from one room to another and creating in lounge/diners a positive, engaging, social occasion;
- ***Matching*** – preventing people experiencing unnecessary stress by being put together at different 'points' of a dementia and by grouping people together in 'houses' at similar point of experience;
- ***Relaxing the routines*** – freeing up the staff team, by giving them permission to be with people, whilst fostering team work to still flexibly also achieve the discreet running of the home;
- ***Enjoying mealtime experiences*** – training staff how to sit and 'be with' people sharing a meal;
- ***Turning staff into butterflies*** – helping staff to draw on a wide variety of ways to engage and occupy people in the moment, from staff wearing 'activity' belts' and connecting with people;
- ***Feelings before behaviours*** – providing a set of 'recipes' for staff on meanings behind behaviours; and
- ***Measuring well being*** – giving staff practical tools to increase peoples well being including helping staff to see that quality of well-being is the primary indicator of good quality dementia care.[228]

[228] Mattering in a dementia care home – The Butterfly Approach. Dr David Sheard – Chief Executive / Founder, Dementia Care Matters Accessed at: http://www.dementiacarematters.com/pdf/modern.pdf

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