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BC Care Providers Association

Celebrating 40 Years | 1977 – 2017

Making the Shift

Strengthening Seniors Care in BC

October 2017

Submitted by BC Care Providers Association

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MESSAGE FROM THE CHIEF EXECUTIVE OFFICER

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

Over the past year we have seen some extraordinary developments in British Columbia's continuing care sector. Last January, BC Care Providers Association ("BCCPA") launched its "Care Can Be There" campaign, and raised awareness in the public about the challenges faced by the "sandwich generation" who are struggling to meet the needs of aging family members.

The following month, Canada's Minister of Health Honorable Jane Philpott arrived in B.C. to announce a $1.4 billion 10-year health investment for our province, much of it earmarked for home and community care.

Then in March, the B.C. government released its own Action Plan to Strengthen Home and Community Care for Seniors directing $500 million over the next four years toward raising staffing levels and direct care hours in residential care homes. The B.C. government also directed $10 million toward a new industry-led Seniors Safety and Quality Improvement Program, to be managed by the BCCPA.

This good news, however, brings with it some new challenges. The continuing care sector faces some critical shortfalls in the number of care workers on the frontlines. The government's own goal is to hire 1,500 new care workers over four years, factoring in that a large number of these workers are going to retire during that time period. The BCCPA is developing a robust health human resources plan to address these shortfalls, and is seeking to partner with the provincial government and labour groups in the recruitment effort.

With a rapidly aging population, the Government of B.C. understands that we must place the needs of our seniors among their top priorities. We are pleased to provide the Select Standing Committee with a comprehensive set of recommendations for adoption as part of Budget 2018.

Strengthening the quality of life of our seniors, supporting the delivery of culturally appropriate care, and training the workforce of the future are all key issues that require the focus and the resources of the provincial government. These are also areas that should form the priorities of government over the coming years.

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

Sincerely,

Daniel Fontaine
Chief Executive Office

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 creates 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 $2.5 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 coming 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.

The aging of the population will put increased pressure on the health system, due in part to the greater prevalence of chronic diseases and an increase in major neurocognitive disorders 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 for residential care was 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.

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 65 will only 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]

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[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
[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.

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 has not been optimally designed to provide care for people with ongoing care needs, such as the chronically ill or frail elderly.

The aging population will put additional pressures on the health care system, particularly in supporting people with dementia, 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) in January 2017 outlined approximately 30 recommendations following the release of two White Papers in May 2016 which followed a thorough consultative process which culminated in the Inaugural Continuing Care Collaborative.

British Columbia's aging population 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 budget submission, 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 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 that is less acute oriented and better designed to provide care for people with ongoing care needs, particularly the chronically ill and frail elderly as well as people with dementia.

BC's Action Plan to Strengthen Home and Community Care for Seniors

On March 9, 2017 the BC Ministry of Health released a new Action Plan to Strengthen Home and Community Care for Seniors. This coincided with a Ministry of Health announcement of $500 million in new funding for seniors care over four years, along with the release of the final Residential Care Staffing Review report by a former Parliamentary Secretary for Seniors to the Minister of Health.

The BCCPA was very pleased with the announcement as it will help boost direct care hours (DCH) and health human resources (HHR) in the continuing care sector. These and other initiatives, as outlined, should help improve the quality of life for BC seniors, and will also provide better care in the community for the frail elderly, including seniors with chronic conditions and dementia.[6]

As outlined in its announcement, BC is investing $500 million in new funding over the next four years as part of an Action Plan to improve care for seniors across the system, including increasing direct care hours (DCH) for seniors in residential care. Included in the $500 million is $275 million to be provided over the next four years for home and community-care (HCC) services as part of the recent health funding agreement with the federal government. Along with the $500 million, Health Authorities also will continue increasing their budgets for home and community care over the next four years, reaching about $200 million above current levels by 2020-21.

[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

[6] BCCPA. How the Plecas Plan will strengthen home and community care for BC seniors. March 26, 2017 Accessed at: http://bccare.ca/2017/03/how-the-plecas-plan-will-strengthen-home-and-community-care-for-b-c-seniors/

As outlined in the media release, over the next four years annual funding increases from the Ministry of Health will enable the health authorities to reach a consistent average of 3.36 DCH per resident day across both publicly administered and contracted residential care homes.[7] Using the current staffing framework and the labour costs provided by the Health Employers Association of BC (HEABC), the Ministry calculates it could cost upwards of $113.7 million for an increase of 1,511 full time equivalents (FTEs) to meet a standard average of 3.36 hours per resident day by health authority. Nearly 900 of these FTEs are expected to be health care aides.

Along with outlining the current seniors population in BC, the Action Plan includes key actions in the areas of:

- Focus on healthy aging (i.e. initiatives on healthy aging and self-care);
- Provide better coordinated and integrated community care for seniors with complex medical needs and/or frailty (i.e. Specialized Community Services Program for seniors living in community);
- Work with assisted living residences to implement the new Community Care and Assisted Living Act provisions (i.e. Bill 16);
- Strengthen role and quality of residential care;
- Health Human Resources (i.e. Specialized Community Services Program for Seniors and 1,500 FTEs for residential care);
- Monitoring, Evaluation (i.e. develop monitoring & evaluation plan); and
- Funding (i.e. overview of funding increases to 2020/21).

While not outlined in detail in the Action Plan, the province will also spearhead several other measures to improve supports for seniors, such as additional home-support services and hours, as well as increased home-health monitoring. In addition, it provided $10 million to the BCCPA to help industry fund equipment like wheelchairs and patient lifts to help people with limited mobility in publicly funded facilities.

While the Action Plan does not address all of the 30 recommendations from the BCCPA paper *Strengthening Seniors Care: A Made-in-BC Roadmap* released in January 2017, it does deal with three of four pillars identified by the BCCPA: investments in health human resources (HHR); quality of life; as well as infrastructure.

Overall, the content of the Action Plan much like the former Parliamentary Secretary's report is positive as it recognizes many of the issues identified by the BCCPA in earlier reports such as increasing DCH levels; improving HHR; and improving seniors quality of life. In particular, the action area to increase number of FTEs (i.e. 1,500 FTEs) to meet the DCH standard is very encouraging. In summary, the BCCPA is very pleased the B.C. Government is responding to calls from the province's seniors care providers, and will implement many BCCPA's recommendations to help strengthen seniors care delivery in British Columbia. [8]

The BCCPA is also encouraged by the new NDP government's commitment to continue the key tenets of the Action Plan, particularly increasing DCH and staffing levels. It is also encouraged by the new NDP government which in its budget update indicated that there is $189M in "new funding" for seniors care over 3 years due to the Federal-Provincial Health Accord. While the details of this new funding have to be worked out the BCCPA as outlined in this 2018 budget submission would like to put to put a few ideas forward particularly new investments in infrastructure to replace aging care homes; addressing HHR shortages facing the sector as well as improving quality of seniors care and fostering greater innovation in the continuing care sector. These four

[7] BC Ministry of Health. Significant funding boost to strengthen care for B.C. seniors. March 9, 2017. Accessed at: https://news.gov.bc.ca/releases/2017HLTH0052-000529

[8] BCCPA. How the Plecas Plan will strengthen home and community care for BC seniors. March 26, 2017 Accessed at: http://bccare.ca/2017/03/how-the-plecas-plan-will-strengthen-home-and-community-care-for-b-c-seniors/

key areas are outlined below and provide the basis for the fourteen recommendations to strengthen the sector and improve the lives of seniors whether they live at home, in assisted living or residential care.

Investing in Infrastructure

- Establish a new Residential Care Infrastructure Fund (RCIF) of $150 million over three years, including:
    - $120M to support the immediate renewal and replacement of older residential care homes.
    - $30M to support investments in smaller infrastructure projects such as sprinkler and ceiling lift installations, security, automated medication management and data collection systems.

Investing in People

- $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 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 $25 million per year, including up to $3 million for a province-wide quality initiative coordinated by BCCPA).

- $50 million in annual funding to increase minimum home care and support visit times from 15 to at least 30 minutes as outlined in a new provincial guideline.

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 $25M per year over the next four years to support the introduction and/or expansion of the Care Hub concept throughout B.C.

- $20 million in annual funding over four years to support the adoption of new home health models province-wide to allow seniors to remain at home longer as well as reducing alternate level of care (ALC) days and improving overall quality care by focusing on several areas particularly models that: advance the hospital at home model; better integrate home health and long term care; better integrate home health and acute care; and support greater end of life care at home.

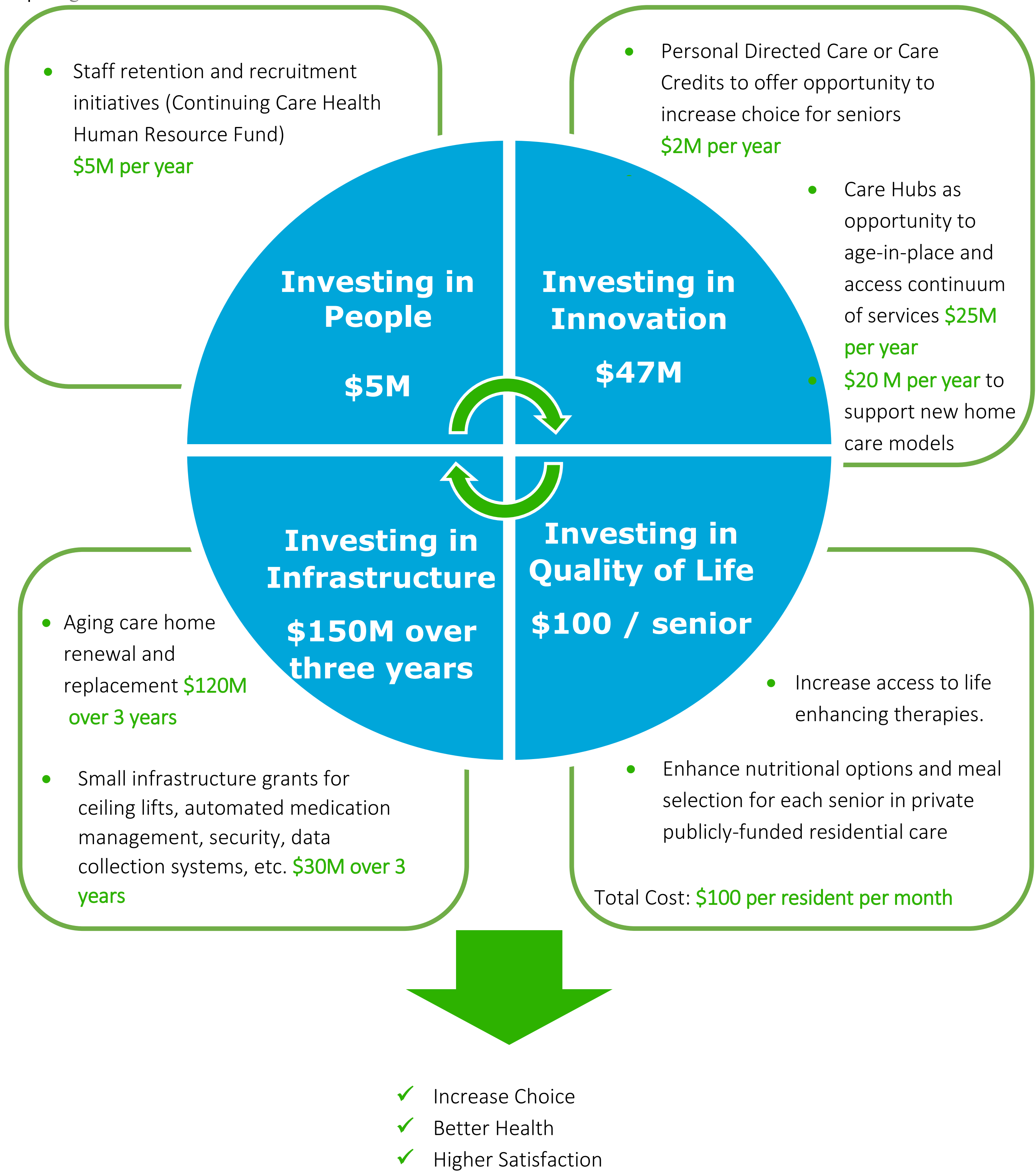
While the costs of these short-term initiatives are considerable, including approximately $175 million ($177 million) in the first year; given the importance of seniors and a rapidly aging population as well as the fact the Province of B.C. is forecasting surplus budgets into the future, we believe the 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.[9] One of the major themes of the BC Ministry of Health Primary and Community Care paper released in February 2015, for example, was that existing expenditures would be protected, while appropriate reallocations from acute to community care services would become part of health authority planning going forward. As outlined in the Quality-Innovation-Collaboration paper (2015) the BCCPA has previously recommended that 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.[10]

This budget submission also recommends that starting in the fiscal year 2018/19, 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:

- 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.

[9] 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
[10] 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

SUMMARY OF RECOMMENDATIONS

1. That the BC Government establish a new $150 million Residential Care Infrastructure Fund (RCIF), which over three years 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.
2. 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.
3. That the BC government work towards the establishment of a long-term predictable funding model by the end of fiscal 2020 that is outlined in all 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.
4. 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.
5. That the BC government, working with municipalities, exempt property taxes for residential care homes and assisted living to allow non-government operators to recoup capital operating expenses and further encourage non-government investment in the continuing care sector.
6. That the BC government provide $2 million in annual funding to introduce a Care Credit or Personal Directed Care model in the home care sector and undertake a study including possible pilot project on their use in residential care.
7. That the BC government provide $25 million in annual funding to support 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 including dementia.
8. That the BC government, through a new BC Cares Program, establish a Continuing Care Health Human Resource (CCHHR) Fund with $25 million 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 Society of B.C. 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.

9. That the BC government establish a new Seniors Quality of Life Fund with annual funding of $25 million per year 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 music 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 about $6 to $7 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.

10. Where feasible, Health Authorities increase the minimum home care and support visit times from 15 to at least 30 minutes; and that a new provincial guideline also be established to limit home health visits shorter than 30 minutes only if workers are fulfilling specific, time limited functions – such as ensuring medicine has been taken, or checking a person's welfare. $50 million in annual funding should be provided to support the implementation of the new guideline to increase the minimum home care and support visit times from 15 to at least 30 minutes.

11. That the BC government provide $20 million in annual funding over four years to support adoption of new home health models province-wide to allow seniors to remain at home longer as well as reducing alternate level of care (ALC) days and improving overall quality care by focusing on several areas particularly models that: advance the hospital at home model; better integrate home health and long term care; better integrate home health and acute care; and support greater end of life care at home.

12. That the BC Ministry of Health partner with the BCCPA to perform a formal review of Assisted Living, including funding and implications of Bill 16 with the aim to:

    - Increase consistency of services within the sector;
    - Decrease unnecessary administrative or regulatory burdens on Assisted Living operators;
    - Ensure the flexibility necessary to meet the needs of seniors; and
    - Secure the funding, staffing and equipment levels necessary to support seniors to live longer in Assisted Living particularly with increasing levels of acuity.

13. 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, impacts of responsive behaviours, reducing adverse drug events, suicide prevention, elder abuse and/or safety within home and community care.

14. Starting in fiscal year 2018/19, 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.

OVERVIEW

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 people 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) outlined approximately 30 recommendations as part of a paper entitled Strengthening Seniors Care: A Made in BC Road Map (2017) 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. This budget submission makes recommendations based on a few selected areas in the Strengthening Seniors Care paper and as outlined in the following table.

Table 1: Key Investment Areas
Invest in People • $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 $150 million over three years, including: $120M to support the immediate renewal and replacement of older residential care homes; and $30M 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 (total approximately $25 million per year, including up to $3 million for a province-wide quality initiative coordinated by BCCPA). • $50M in annual funding to increase home care and support visit times to at least 30 minutes as outlined in new provincial guideline.
Invest in Innovation • 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. • Invest up to $25 million per year over the next five years to support the introduction and/or expansion of the Continuing Care Hub concept throughout B.C. • $20 million annually over four years to support the adoption of new home health models province-wide to allow seniors to remain at home longer as well as reducing ALC days and improving overall quality care by focusing on several areas: o Models that advance the hospital at home model; o Models that better integrate home health and long-term care; o Models that better integrate home health and acute care; and o Models to support greater end of life care at home.

Other Priorities

- Starting in fiscal 2018/19 Health Authorities redirect acute care expenditures such as a minimum of 1% annually over a five-year period to home and community care sector.
- Develop a Provincial Seniors Safety Strategy which could focus on specific issues including use of technology, falls prevention, impacts of responsive behaviours, etc.
- That the BC government, working with municipalities, exempt property taxes for residential care homes to allow non-government operators to recoup capital operating expenses and further encourage private investment in the continuing care sector.

SECTION 1: Investing in Infrastructure - Capital Investments in Continuing Care

As many care homes age and become physically or functionally obsolete they will need to be renewed or replaced. While overall data on the condition of care homes is limited it can be found in part from earlier Facilities Reports which includes the Facility Condition Index (FCI) for some care homes (particularly older buildings). As outlined by BC Housing, the FCI is an industry standard asset management tool which measures the "constructed asset's condition at a specific point in time".[11] It is a functional indicator resulting from an analysis of different but related operational indicators (such as building repair needs) to obtain an overview of a building's condition as a numerical value.[12] In general, the lower the value of FCI, the better condition a building is in. Typically, a facility with a 0 to 5% rating is deemed to be in good condition, 5 to 10% is fair, 10 to 30% is poor and over 30% is critical (see Appendix A for further details).

Following an overview of earlier Facilities Report (March 2016), the overwhelming majority (80%) of care homes that had an FCI rating listed were identified as being in either poor or critical condition (see Table 2). While this may significantly overstate the extent of the issue as the vast majority of newer care homes have no FCI assessment reported, almost 50 privately owned care homes across the province are still listed in poor or critical condition and as such maybe in immediate need of renewal or replacement (see Table 3).

Table 2: Facility Condition Index (FCI) Levels of Residential Care Homes in BC

FCI Level	Number of Care Homes	Number of LTC beds
Critical (Over 30%)	48	3,423
Poor (11% to 30%)	77	6,419
Fair (6% to 10%)	17	1,404
Good (0% to 5%)	12	1,174

Notes: FCI ratings were conducted between 2002 and 2015. Source: Facilities Report, March 2016. Accessed at: http://docs.openinfo.gov.bc.ca/Response_Package_HTH-2016-62311.pdf

Table 3: Facility Condition Index (FCI) Levels of Residential Care Homes in BC

	HA Owned and Operated	Privately Owned	All BC Care Homes
Critical (Over 30%)	42	6	48
Poor (11% to 30%)	34	40	74

[11] BC Housing. Facility Condition Index. Accessed at: https://www.bchousing.org/publications/Facility_Condition_Index-Asset_Management_Tool.docx%20

[12] FCI is obtained by aggregating the total cost of any needed or outstanding repairs, renewal or upgrade requirements at a building compared to the current replacement value of the building components. It is the ratio of the "repair needs" to replacement value" expressed in percentage terms. Land value is not considered when evaluating FCI. FCI = Total of Building Repair/Upgrade/Renewal Needs ($) divided by Current Replacement Value of Building Components ($).

Fair (6% to 10%)	7	10	17
Good (0% to 5%)	7	6	13
Notes: FCI ratings were conducted between 2002 and 2015. Source: Facilities Report, March 2016. Accessed at: http://docs.openinfo.gov.bc.ca/Response_Package_HTH-2016-62311.pdf			

The situation is particularly critical as care homes in BC are not able to afford capital investments to improve or modernize their physical infrastructure.[13] Overall, 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 or funding arrangements.

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 existing fiscal environment, as current funding lifts 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.[14]

In addition, 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 fewer resources than larger ones to meet growing demands, including funds for capital re-development.[15]

To deal with the growing capital infrastructure deficit, there are essentially two approaches that could be taken. While one approach is to include such infrastructure costs as part of any new funding model, the other alternative is the introduction of renewed capital redevelopment plan for long term care (LTC) homes like what was announced October 2014 in Ontario. This initiative has been well-received by LTC home operators in that province who wanted 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 reflect best practices, particularly for those residents living with Alzheimer's disease and other dementias.[16]

Like Ontario, BC faces similar challenges in the redevelopment of its long-term care infrastructure. To meet some of these challenges, the BCCPA in its *Strengthening Seniors Care* paper (2017) advocates the development of a residential care infrastructure fund (RCIF) in which care homes who receive monies would also be accountable by outlining how any new investments have improved senior's care. In the paper, the BCCPA recommends a RCIF to assist with the following:

- support the immediate renewal and replacement of older residential care homes;

[13] BCCPA. White Papers. Sustainability and Innovation: Exploring Options for Improving BC's Continuing Care Sector. May 2016. Accessed at: http://www.bccare.ca/whitepapers2016/
[14] BCCPA. White Papers. Sustainability and Innovation: Exploring Options for Improving BC's Continuing Care Sector. May 2016. Accessed at: http://www.bccare.ca/whitepapers2016/
[15] 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. Accessed at: https://www.oltca.com/oltca/Documents/Reports/PreBudgetSubmission2015-2016.pdf
[16] 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. Accessed at: https://www.oltca.com/oltca/Documents/Reports/PreBudgetSubmission2015-2016.pdf

- 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.

Although the Ministry of Health Action Plan for seniors, as discussed earlier, does not largely address the capital infrastructure challenges facing care operators, some of the future work outlined in the Plan including moving towards a province-wide standard residential care funding model to incorporate resident complexity, quality of care and flexibility could potentially include looking at ways in which capital investment or infrastructure needs could be factored into any funding model.

To assist this process, the BCCPA has been looking further at the capital investments that have been made and that are required in the residential care sector. This project will attempt to formalize a position on the value of capital that care providers have or will be investing and/or contributing into their organizations and a mechanism to formalize this funding in an equitable manner.

It is the hope of the BCCPA that this work might help assist the Ministry of Health with the development of a fair funding model for care providers that can also potentially account for some of the existing capital infrastructure challenges facing the residential care sector. If such a capital investment component is not incorporated as part of a new funding model then the BCCPA, however, would recommend that the provincial government reconsider as outlined earlier a residential care infrastructure fund (RCIF) to ensure seniors have a high quality and supportive living environment in their remaining years. Likewise, a further review of infrastructure needs for assisted living including possibility of new funding should also be explored particularly with the implementation of Bill 16 as discussed later in this budget submission.

RECOMMENDATION #1

That the BC Government establish a new $150 million Residential Care Infrastructure Fund (RCIF), which over three years 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.

Section 2: 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.[17] 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. [18]

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.[19] 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 also 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.[20]

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. 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 people 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

[17] 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
[18] 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
[19] Ibid.
[20] 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

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.

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.

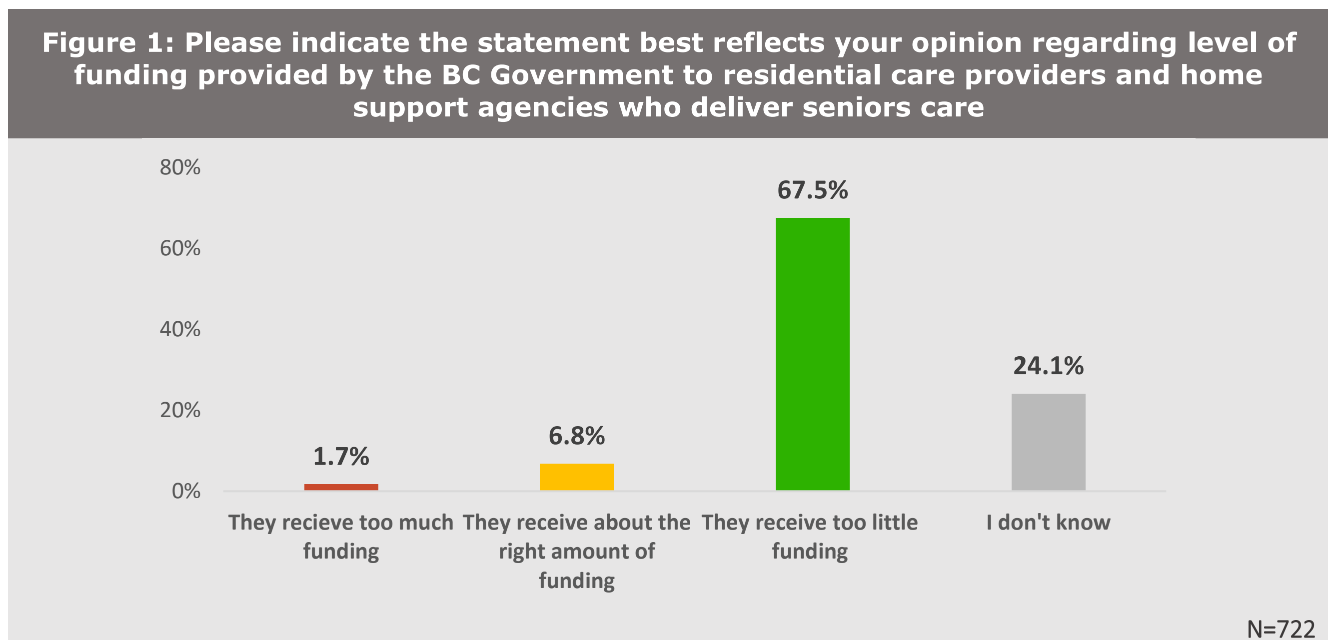


Figure 1: Please indicate the statement best reflects your opinion regarding level of funding provided by the BC Government to residential care providers and home support agencies who deliver seniors care

RECOMMENDATIONS #2 to 4

- 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.

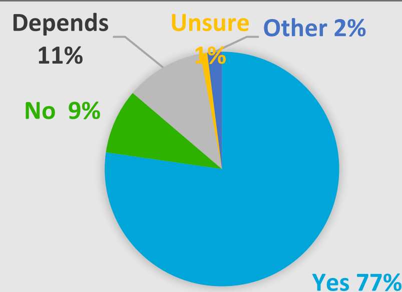
- That the Ministry of Health and the Health Authorities fully honour negotiated funding agreements by recognizing increases in labour-market costs to care providers to levels at least consistent with the master collective agreement.

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.[21]

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 to improve access to new residential care beds and for senior's care.[22] 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. The most common reason given for opposing this policy was that it would tend to decrease municipal tax revenues.

Figure 2: 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?



RECOMMENDATION #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.

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

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

SECTION 3: 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.[23]

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. [24] 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. [25]

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. 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, they nevertheless appear to have valued being involved in decisions about their long-term care, especially when also required to pay significant private costs. [26]

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.[27] 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 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.[28]

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

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[23] Long-Term Care for the Elderly: Challenges and Policy Options. CD Howe Institute. Commentary 367. Ake Blomqvist and Colin Busby. November 2012.
[24] Ibid.
[25] Ibid.
[26] Ibid
[27] 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.
[28] 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/

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. [29]

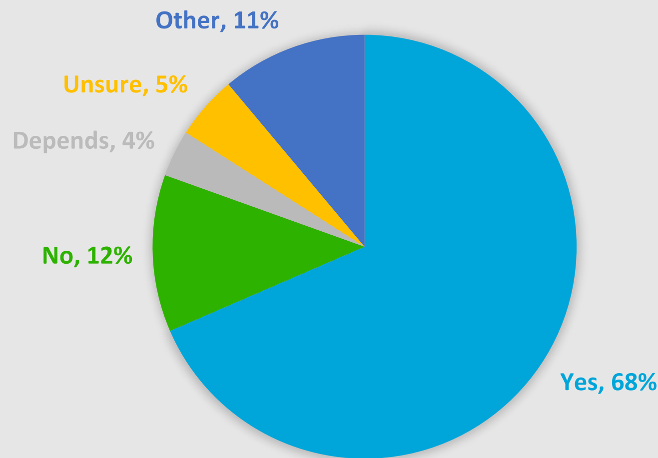
As noted by authors Blomqvist and Busby, establishing a new comprehensive self-directed model such as the use of a voucher system would require the following: an assessment system; means testing; a funding mechanism that is based on need but controls government costs; an oversight system to ensure quality and enforce restrictions on use; and establishing who will oversee, coordinate and be accountable for care. [30]

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. As part of a BCCPA 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.

[29] Long-Term Care for the Elderly: Challenges and Policy Options. CD Howe Institute. Commentary 367. Ake Blomqvist and Colin Busby. November 2012.
[30] CD Howe Institute. Commentary No. 443. Ake Blomqvist and Colin Busby. Shifting Towards Autonomy: A Continuing Care Model for Canada.

Figure 3: 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

Based on the above results from the consultation process and as outlined in *Strengthening Seniors Care: A Made-in-BC Roadmap,* the BCCPA recommended 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.[31] CLBC provides two different options to manage funds. In the first option, the client and an identified agent (e.g. a 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 money; this option gives the client the benefits of Individualized Funding, but with fewer paperwork and record-keeping responsibilities.[32]

RECOMMENDATION #6

That the BC government provide $2 million in annual funding to 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.

[31] 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.

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

SECTION 4: NEW CONTINUING CARE MODELS

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.[33] 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, the 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, 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. 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 outlined below.

[33] 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

Table 4: 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 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 people living with 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 4: 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>

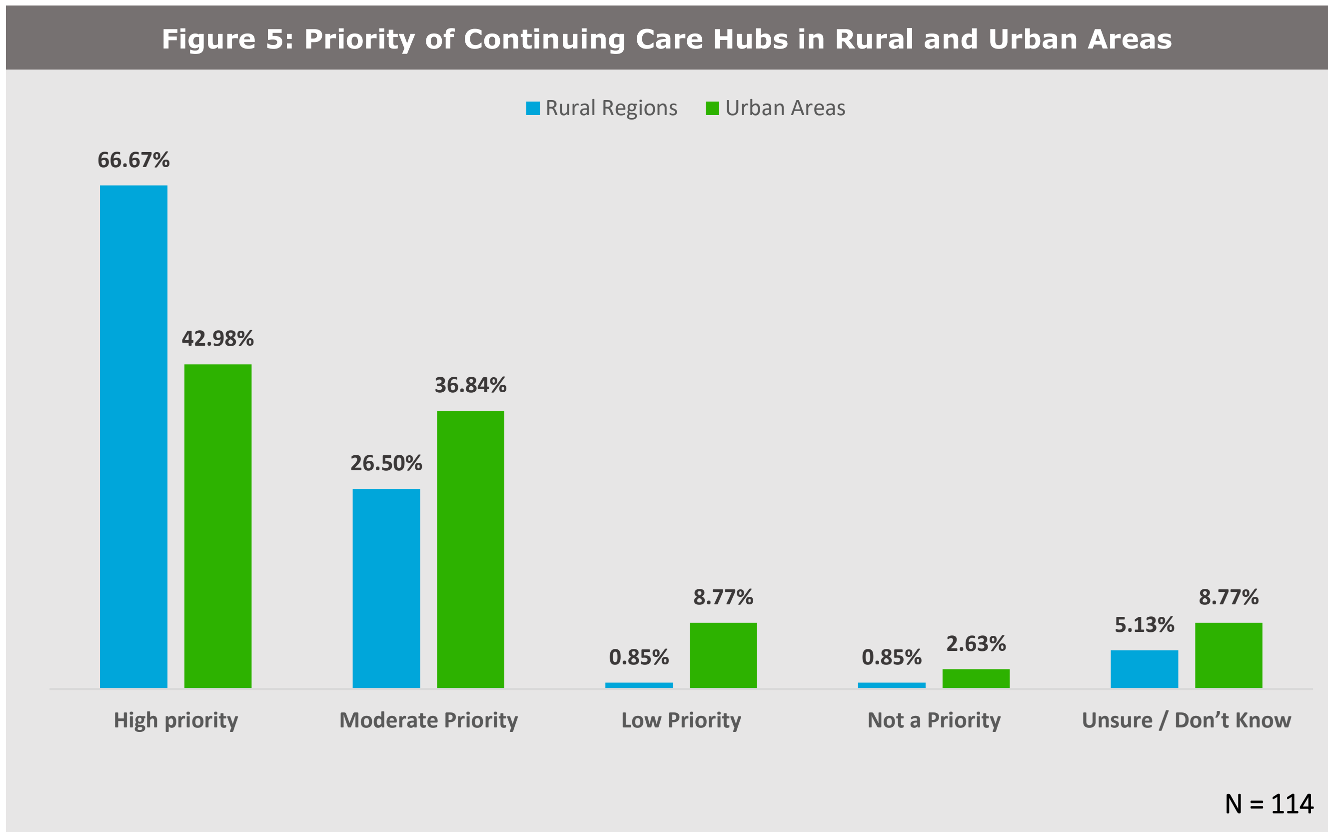
- Use of physical infrastructure to provide community services for seniors
- Respite care for frail elderly
- Physical co-location of urgent care or sub –acute
- Expanded sub-acute care and paramedic services (i.e. wound care, dialysis and IV care)
- Greater preventative and health promotion services (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 work 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%).

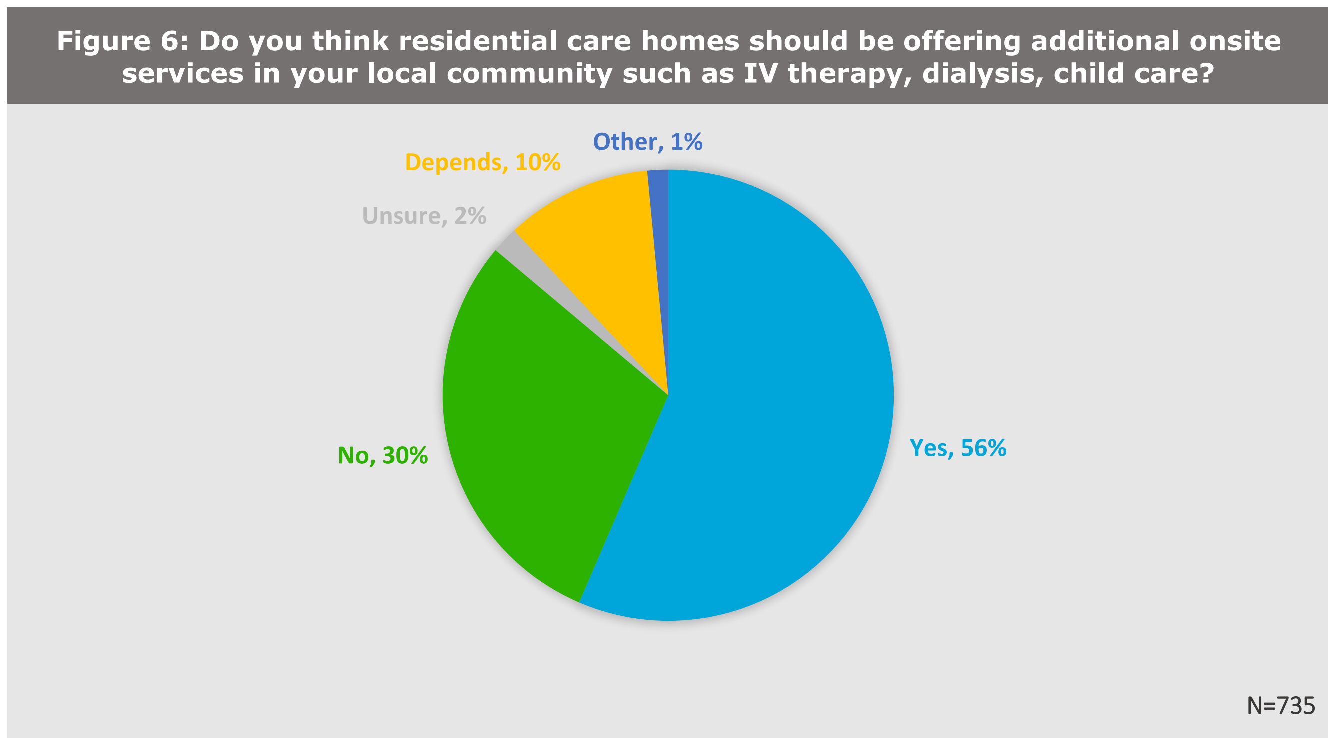


Additional Onsite Services

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.

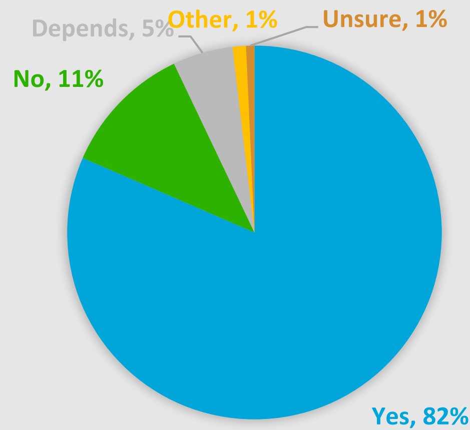
While many survey respondents indicated that they were opposed to care homes offering child care services, there seemed to be some confusion about why a care home would provide this. This may indicate that any public discussion on the provision of child care by care homes would need to clearly demonstrate 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.



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



N=744

RECOMMENDATION #7

That the BC government provide $25 million in annual funding to support 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 including dementia.

SECTION 5: 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.[34]

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.[35]

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.[36]

The issue of HHR will be even more critical 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.

BC Cares Initiative

Overall, a portion of new HHR funding should 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 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.[37]

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 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.[38]

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[34] 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.

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

[36] 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/

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

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

Dementia – Behavioral Supports Program

According to the Ministry of Health's Provincial Guide to Dementia Care in BC, dementia currently impacts roughly 62,000 British Columbians and is expected to rise to 87,000 by 2024. The increasing number of people diagnosed with dementia correlates to British Columbia's aging population. In 2014/15, 47% of those with dementia were aged 85 or older, followed by 45% aged 65 to 84, and 8% with early onset under the age of 65.[39]

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. [40] 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.[41] 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 since its inception, 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.[42]

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.[43] 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[44] 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.[45] Along with government and Health Authorities, Alzheimer Society of B.C. and SafeCare BC, whose mandate is to reduce worker injury rates in BC's continuing care sector, could oversee such as program.[46]

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

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

[41] 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

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

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

[44] 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.

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

[46] 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/

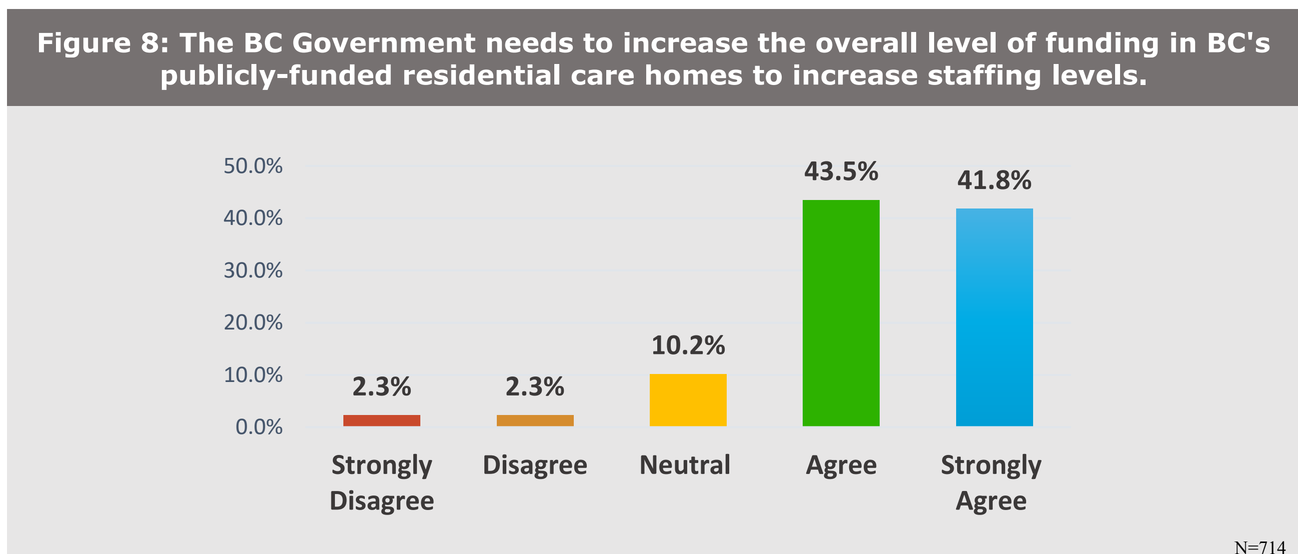
of the residential care sector to provide appropriate assessment and care for persons experiencing behavioral and psychological symptoms of dementia, including reducing the inappropriate use of antipsychotic drugs.[47]

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 training. Without such resources, it can be difficult for care homes or workers to take advantage of 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.

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 to increase overall staffing levels. Survey participants overwhelming indicated agreement with this statement, with 85 percent in agreement.



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

[47] 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

RECOMMENDATION #8

That the BC government, through a new BC Cares Program, establish a Continuing Care Health Human Resource (CCHHR) Fund with $25 million 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 Society of B.C. 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 6: SENIORS WELL-BEING

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

While improving staffing levels, 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 at home or 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 dementia, 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.[48] 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. Isolation and depression have very negative effects on quality of life and strategies to address these areas will be critical going forward.[49]

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 many 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.[50] 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:

- 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.[51]

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.[52] Most recently the OSA in their 2017 report entitled Every Voice Counts which surveyed all publicly subsidized care homes in BC found similar concerns including lack of staffing and ability of seniors to partake in various social or physical activities. For example, the survey found almost 46% of residents report there is no one living in the facility that they consider a close friend while 45% report there is no one for them to do things with.[53]

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[48] 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
[49] Ibid.
[50] 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
[51] 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
[52] 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
[53] BC Office of the Seniors Advocate. Every Voice Counts: Office of the Seniors Advocate Residential Care Survey Provincial Results. September 2017. Accessed at http://www.seniorsadvocatebc.ca/osa-reports/residential-care-survey/

Seniors Quality of Life Fund

To help meet some of these gaps, this Budget Submission recommends new funding for the creation of a *Seniors Quality of Life Fund* (SQLF) to address some of the challenges seniors face in receiving appropriate supports such as RT/OT/PT as well as music, pet and aroma therapy. The benefits of such programs, including BC's Concerts in Care, have been well documented and should be expanded, where feasible, province-wide.[54]

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.[55] One study notes isolation is as strong a factor in early death as smoking 15 cigarettes a day,[56] while another notes it can be twice as unhealthy as obesity, increasing chances of early death by 14 per cent.[57]

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.[58] 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.[59]

As outlined in a survey on the BCCPA 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. Only 8% indicated they believe that the Government is performing well in this area.

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[54] 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/

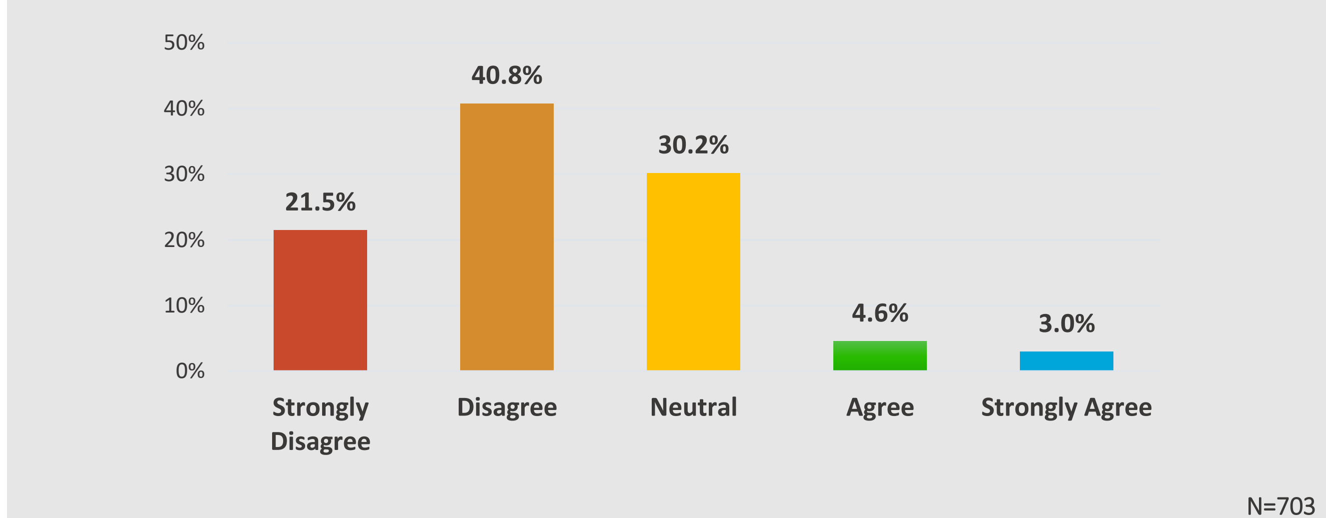
[55] Social isolation, loneliness, and all-cause mortality in older men and women. Proceedings of the National Academy of Sciences of the United States of America. Andrew Steptoe et al. February 15, 2013. Accessed at: http://www.pnas.org/content/110/15/5797.full

[56] 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

[57] 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.

[58] 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

[59] 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.



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.[60]

These amounts, which are minimal will need to be increased particularly given rapidly rising food costs that are well above inflation. While residential care homes in BC are providing the best quality food they can with limited resources, there is still an opportunity to enhance and make improvements. Likewise, this funding should also help assist in providing more culturally appropriate food choices and 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.[61]

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.[62] Physical activity among older adults with

[60] 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.
[61] 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
[62] 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.[63]

As outlined in *Strengthening Seniors Care: A Made-in-BC Roadmap*, the BCCPA recommended 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 up to $22 million per year would be provided to care homes based on the fact there are approximately 18,300 non-government operated care beds that receive public funding.[64] The additional $3 million would be used for BCCPA-managed province-wide programming that directly improves the health and well-being of seniors across BC.

RECOMMENDATION #9

That the BC government establish a new Seniors Quality of Life Fund (SQLF) with annual funding of $25 million per year to support quality of life for seniors in residential care and the community, including up to $3 million for a province-wide quality initiative coordinated by BCCPA. This will include funding 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 music 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 about $6 to $7 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 HEALTH

Short Visit Times

One of the major issues that has been identified in home health, which also relates to quality of life and seniors isolation, is the inadequate time that is available in many cases for home support workers (HSWs) to provide necessary care for their clients. This is highlighted, for example in a recent OSA survey which shows that only 68% of Vancouver Coastal Health clients report that their workers have enough time to provide all prescribed services. Furthermore, 13% of clients in this region report their workers rarely or never have enough time, which is more than double the rate of the same measure for the Fraser Health region. [65]

The current funding model of BC's home care and support sector is not sustainable and will struggle to deliver consistent high-quality care, despite the best effort of publicly-subsidized home health providers. Inadequate funding to meet the demand for services, has resulted in a steady reduction in time spent with each client.

[63] 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

[64] 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.

[65] BC Office of the Seniors Advocate. Listening to your voice: Home support survey results. September 2016. Accessed at: https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2016/09/SA-HomeSupportSurveyReport-Sept2016-Final.pdf

For home support, visits are often as short as 15 minutes. As outlined earlier, 15 minute visits generally happen in cluster care situations (i.e. congregate building settings and cluster neighborhoods). Even a six-block radius circle in Point Grey, Vancouver can be deemed a "cluster", which can make it difficult meet the needs of all clients. In community care (non-cluster) visits are a minimum of 20 minutes and the visit is generally funded at 30 minutes, 10 of which is allocated for travel. HSWs must do personal care as well as complex delegated nursing tasks in very short periods of time and no longer receive any funding to deliver housekeeping tasks.

With such short visit times, BC residents are not being provided with the high-quality care intended by the government's home health program. As care visits get shorter, client satisfaction also drops. As outlined in the BC OSA's Home Support report it shows that in many jurisdictions in BC, clients do not feel that their workers have adequate time to deliver the needed care. [66] Client satisfaction, for example, 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. Client satisfaction may also be influenced by parameters set by the Health Authority, such as which services they are eligible for.

An example of a working model can be seen after an evaluation of Richmond's cluster care model in March 2010 showed a 58 per cent reduction in the number of different home support workers per month of 18 clients who receive frequent service. In one cluster on the North Shore, it was reported that clients had the same worker each day, except for occasional sick leave replacements. [67]

As discussed earlier and will be further discussed later in this paper, the short visit times affect continuity and consistency of care which can impact quality of care. Continuity makes it possible for HSWs to establish a relationship with their client and monitor and report on any changes in their health status.[68] However, as noted in a 2015 report from the BC Health Coalition, continuity is more difficult to achieve with rotating short-term schedules and a high proportion of casual workers. As discussed earlier, many visits are very short (less than 30 minutes depending on the task) to maximize the number of clients that can be served on each shift. As such, HSWs are less likely to develop a meaningful and trusting relationship with their clients. [69] Like BC, other jurisdictions are also facing the issue of short home health visits. The table below outlines the approach the UK has taken to deal with the issue including the implementation of the following guidelines.

Table 5: United Kingdom: Case Study on 15 Home Care Visit Times
In 2015, the UK ordered an end to 15-minute home care visits, after a series of investigations found elderly people being forced to choose between bathing or feeding, under "clock-watching" practices by councils. New draft guidance from the National Institute of Health and Care Excellence (NICE) now says that in the future, care workers must stay at least half an hour if they are providing personal help, such as dressing or feeding. The new NICE guidance states visits shorter than 30 minutes should only be allowed if they are fulfilling "specific, time limited" functions such as establishing medicine has been taken, or checking a person's welfare. [70] In particular, home care visits shorter than half an hour should

[66] 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

[67] BC Ombudsperson. The best of care: getting it right for seniors in British Columbia (Part 2). Public report no. 47 to the Legislative Assembly of British Columbia – Vol 1. February 2012. Accessed at: https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2047%20The%20Best%20of%20Care-%20Volume%201.pdf

[68] Canadian Centre for Policy Alternatives. Cohen et al. (2006). From Support to Isolation: The High Cost of BC's Declining Home Support Services. Accessed at: http://www.policyalternatives.ca/sites/default/files/uploads/publications/BC_Office_Pubs/bc_2006/support_to_isolation.pdf

[69] Integrated Care Advocacy Group and the BC Health Coalition. Living Up to the Promise: Addressing the high cost of underfunding and fragmentation in BC's home support system. May 2015. Accessed at: http://www.bchealthcoalition.ca/sites/default/files/uploads/Living%20Up%20To%20The%20Promise%20-%20Full%20Report%20-%20press%20-%20%20new%20appendixA.pdf

[70] Ministers pledge an end to 15-minute elderly home care visits. Laura Donnelly. March 5, 2015. Accessed at

only be made if the home care worker is known to the person and the visit is part of a wider package of support and the purpose of the visit can be properly undertaken in that time. [71]

As outlined by NICE, one of the recommendations is that the National Health Service (NHS) commissioners ensure that home care workers be given enough time to do their job without being rushed or compromising the dignity of the person who uses services. This includes having enough time to talk to the person and their carer, and adequate travel time between appointments. [72] While this is a positive development, a recent report, shows that more than a fifth of councils in England are still commissioning 15-minute social care visits, despite the Government agreeing half an hour should be the minimum standard.

As seen in the UK, and as recommended in the BCCPA paper *Strengthening Seniors Care*, BC Health Authorities should consider increasing the minimum home care and support visit times from 15 to at least 30 minutes. The BCCPA would suggest that specific guidelines, like the UK, be developed to help ensure that this becomes a reality. Funding to ensure this occurs is also critical. In the 2017 BCCPA paper, it had recommended that a portion of the $230 million in annual provincial funding go towards increasing home visit times. [73]

For this budget submission, the BCCPA recommends that $50 million in annual funding should be provided to support the implementation of the new guideline which will increase the minimum home care and support visit times to ensure the care needs of the client receiving care are appropriately met. Along with ensuring care needs are appropriately met it could also significantly reduce social isolation faced by many seniors living at home as discussed later in the quality of life section of this paper.

RECOMMENDATION #10

Where feasible, Health Authorities increase the minimum home care and support visit times from 15 to at least 30 minutes; and that a new provincial guideline also be established to limit home health visits shorter than 30 minutes only if workers are fulfilling specific, time limited functions – such as ensuring medicine has been taken, or checking a person's welfare. $50 million in annual funding should be provided to support implementation of the new guideline to increase the minimum home care and support visit times from 15 to at least 30 minutes.

Similar to the continuing care hub outlined earlier it will be critical to support the development of new care models in the home health that can improve seniors care and also allow them to remain in the community. The main tenets of these models should allow seniors to remain at home as opposed to having to go to hospital or hospice at end of life. Likewise, they should also better integrate home health with other areas including long term and acute care. Examples of such models are outlined further in Appendix B. The idea of an innovation fund to support such models will be explored further in a paper on home health that the BCCPA is developing to be released later in 2017-18.

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http://www.telegraph.co.uk/news/health/news/11449948/Ministers-pledge-an-end-to-15-minute-elderly-care-visits.html

[71] Most care home visits should be at least half an hour. NICE. March 12, 2015. Accessed at http://www.nice.org.uk/news/articles/most-home-care-visits-should-be-at-least-half-an-hour

[72] UK Telegraph. Around 16, 000 people still receiving 'flying visits' by carers despite Government's minimum standard. January 10, 2017. Accessed at http://www.telegraph.co.uk/2017/01/10/around-16000-people-still-receiving-flying-visits-carers-despite/

[73] BCCPA. Strengthening Seniors Care: A Made-in-BC Roadmap. January 2017. Accessed at: http://bccare.ca/wp-content/uploads/2017/01/BCCPA_Roadmap_Full_Jan2017.pdf

For now, however, the BCCPA recommends that the BC government provide $20 million in annual funding over four years to support the adoption of new home health models province-wide, including new technologies, to allow seniors to remain at home longer as well as reduce ALC days and improve overall quality care by focusing models that: advance the hospital at home model; better integrate home health and long-term care; better integrate home health and acute care; and support greater end of life care at home.

RECOMMENDATION #11

That the BC government provide $20 million in annual funding over four years to support the adoption of new home health models province-wide to allow seniors to remain at home longer as well as reducing alternate level of care (ALC) days and improving overall quality care by focusing on several areas particularly models that: advance the hospital at home model; better integrate home health and long term care; better integrate home health and acute care; and support greater end of life care at home.

ASSISTED LIVING

Assisted Living (AL) is an important component of the continuum of care, as it supports seniors to age in their communities, while they receive the supports they need to remain as independent as possible. AL is a relatively new form of care in British Columbia and is a middle option between independent living (with some limited support) in one's own home, and living in a residential care home.

Established in 2002, AL is a care setting that combines publicly subsidized apartments with support services for frail seniors and people with disabilities who can no longer live at home, yet do not require the 24-hour professional care and supervision provided in residential care homes. AL residences can range from a unit in a high-rise apartment complex to a private home. Units can vary from one room to private, self-contained apartments. Residents pay an inclusive fee for which they receive room, board, meals, weekly laundry and housekeeping and only one or two prescribed personal care services to assist with the activities of daily living. In BC, residents pay 70 percent of their after-tax income for publicly-funded AL services and are responsible for the cost of other services they would normally pay for if they lived in their own home.[74]

A May 2015 report from the Seniors Advocate BC entitled *Seniors Housing in BC: Affordable, Appropriate, Available*[75] notes as of March 2014, BC has about 23,000 AL units including 4,400 that are subsidized while the remaining are private registered (3,200) or private non-registered (15,200). According to a 2012 study, half of AL residents are 85 or over, three-quarters are female, and about half subsequently move on to residential care. Approximately a quarter of people leave AL after less than one year.[76] Only one-third of people who die do so in AL, suggesting a possible need for more attention to end of life care in this type of care setting.[77]

BC was the first province in Canada to regulate AL residences. By law, AL operators must offer five hospitality services: one to three meals a day plus snacks; light housekeeping once a week; laundering of flat linens once a week; social and recreational opportunities; and a 24-hour emergency response system. Operators are also to

[74] Centre for Health Services and Policy Research. Home Health Services in BC: A Portrait of Users and Trends Over Time. Kim McGrail et al. October 2008. Accessed at: http://www.chspr.ubc.ca/sites/default/files/publication_files/chspr08-15.pdf

[75] 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

[76] Just over one-half (51%) of all Assisted Living residents eventually move to residential care facilities. One-half of those move directly from Assisted Living to residential care, while the other half seem to be triggered to move to residential care following a hospital stay. Another 34% of Assisted Living clients die: 11% die in Assisted Living, 22% die after being admitted to hospital, and 1% die within 30 days of admission to residential care. A full 15% of Assisted Living residents appear to move back to the community: one-third of those with community based home health services, and two-thirds without any publicly-funded services.

[77] Centre for Health Services and Policy Research. Who uses Assisted Living in BC: An Initial Exploration. April 2012. Kim McGrail et al. Accessed at: http://www.chspr.ubc.ca/sites/default/files/publication_files/assistedliving.pdf

provide at least one, and not more than two, of six “prescribed services”, which as outlined in the *Community Care and Assisted Living Act* include: regular assistance with activities of daily living (i.e. eating; mobility, dressing, etc.); medication management; personal financial management; monitoring of food intake; structured behaviour management and intervention; and psychosocial rehabilitative therapy or intensive physical rehabilitative.[78]

As outlined under the *Community Care and Assisted Living Act* registered AL operators must nominate two of six prescribed services that will be offered to residents. The two most commonly prescribed services offered by AL operators are: assistance with the activities of daily living, and central storage / distribution of medications. If a resident requires one or more of the other four prescribed services, their care will be deemed as too complex for registered AL and a discharge plan will be implemented or, in the case of a senior attempting to move in, the move will not occur. In addition, if a senior requires two prescribed services or needs only one prescribed service, but it is not the prescribed service offered by that operator, then they will not be admitted to Registered AL and may be referred directly to residential care.

With the introduction of Bill 16 in 2016 (not yet in force), however, the government will effectively remove the two-service limit on prescribed services[79]; as well as increase regulatory oversight for Assisted Living residences, allow the Assisted Living Registrar to inspect a residence at any time to determine if health and safety of residents are at risk, and improve Assisted Living service options.

To deal with some of the issues related to Bill 16, the BCCCPA established a AL Task Force in 2017[80]. This report identified a number of challenges with respect to Bill 16 including whether operators will be able to effectively deal with growing acuity levels of residents under current funding levels. Similar to residential care the type of seniors living in Assisted Living has changed over time, with the Assisted Living sector caring for more complex seniors than a decade ago.

In particular, the Assisted Living Task Force, found operators and health authorities need further clarification on Bill 16, including roles and responsibilities and timelines for implementation; and also determined that there is a lack of understanding in the scope and ramifications of Bill 16 from the perspective of both operators and health authorities and that operators are concerned about the potential for all services to be required, the lack of definition of terms, changes to staffing composition and increases in operating costs.

RECOMMENDATION #12

That the BC Ministry of Health partner with the BCCPA to perform a formal review of Assisted Living, including funding and implications of Bill 16, with the aim to:

- Increase consistency of services within the sector;
- Decrease unnecessary administrative or regulatory burdens on Assisted Living operators;
- Ensure the flexibility necessary to meet the needs of seniors; and
- Secure the funding levels necessary to support seniors to live longer in Assisted Living particularly with increasing levels of acuity.

[78] Ibid.
79 Prescribed services include: assistance with daily living activities such as eating; mobility; dressing or personal hygiene; medication management; therapeutic diets; financial management; intensive rehabilitation therapy; and behavioural management.
80 The BC Care Providers Association. Assisted Living Tenancy Task Force Review: A Report of Findings and Recommendations. July 2017. Accessed at http://bccare.ca/wp-content/uploads/2017/07/Assisted-Living-Task-Force-Report-July-2017.pdf

Section 7: 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 25 per cent of the total population. In addition, the population of seniors 85 years and older is set to quadruple[81]. This demographic reality should be seen as a 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 physically fit and require relatively little care, some seniors require significant acute and continuing care.

It has been projected that the 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.[82]

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, impacts of responsive behaviours (i.e. resident-on-resident aggression) and/or safety within home and community care.

RECOMMENDATION #13

- 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, impacts of responsive behaviours, reducing adverse drug events, suicide prevention, elder abuse and/or safety within home and community care.

[81] 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
[82] 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

Section 8: Shifting Resources from Acute To Continuing Care

If fully implemented, the recommendations outlined in this report would be significant or approximately $174 million per year. 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.[83]

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.[84] 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.[85] 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 C 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 D). Along with potentially funding many of the recommendations outlined in this budget submission 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

[83] 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.
[84] 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
[85] 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 in the 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.

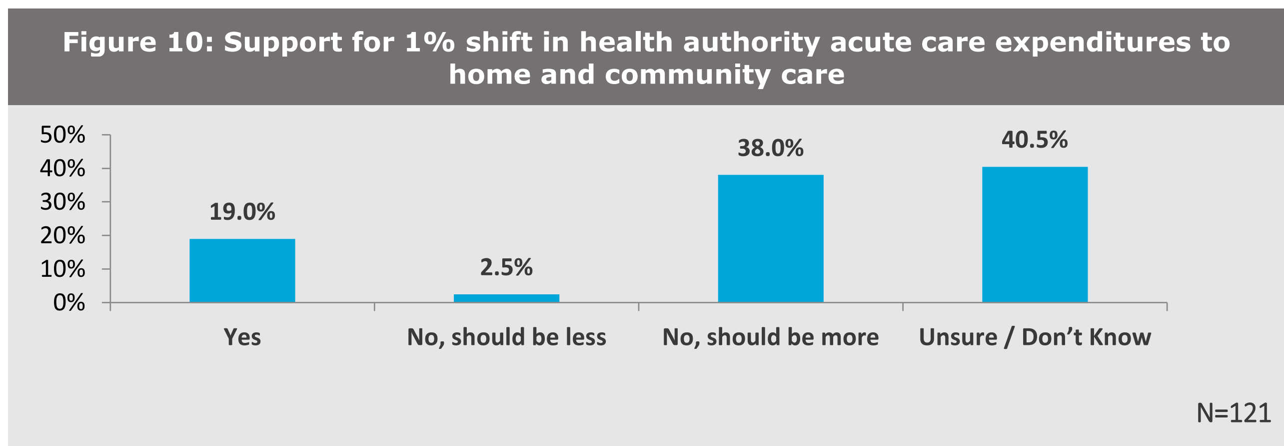
As outlined further in the BCCPA *Quality, Innovation, Collaboration* paper redirected funding could also be used to support the integration of physicians as well as new health professions such as nurse practitioners and physician assistants into continuing care. The funding could also be used to invest 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 are even higher if more patients are cared for at home.

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 in earlier documents such as BCCPA White Papers and were also areas of discussion at the inaugural BC Continuing Care Collaborative held 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 10: 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 #14

- Starting in fiscal year 2018/19, 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.

CONCLUSION

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.[86] 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.

The aging of the population will put increased pressure on the health system, due in part to the greater prevalence of chronic diseases 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.[87] 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.

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 increase by 13%.[88] 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.[89]

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.[90] To deal with some of these challenges, the BCCPA in January 2017 outlined 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.

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 outlined earlier, with among the highest average life expectancies and healthiest seniors' in Canada, there is a real opportunity for BC to become a leader in seniors care.

[86] Median age means that half of the population was older than that and half was younger.
[87] BC Stats. British Columbia Populations 2012-2036 – September 2012. Retrieved July 10, 2013 from: www.bcstats.gov.bc.ca/StatisticsBySubject/Demography/PopulationProjections.aspx
[88] Blue Matrix. BC Ministry of Health Data.
[89] Greg Hermus, Carole Stonebridge, and Klaus Edenhoffer. Future Care for Canadian Seniors: A Status Quo Forecast. Ottawa: The Conference Board of Canada, 2015
[90] 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

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.

BC's Action Plan Action Plan to Strengthen Home and Community Care for Seniors

On March 9, 2017 the BC Ministry of Health released a new Action Plan to Strengthen Home and Community Care for Seniors. This coincided with a Ministry of Health announcement of $500 million in new funding for seniors care over four years, along with the release of the final Residential Care Staffing Review report by a former Parliamentary Secretary for Seniors to the Minister of Health.

The BCCPA was very pleased with the announcement as it will help boost direct care hours (DCH) and health human resources (HHR) in the continuing care sector. In addition, these and other initiatives as outlined should help improve the quality of life for BC seniors, as well as providing better care in the community for the frail elderly, including seniors with chronic conditions and dementia.[91]

As outlined in its announcement, BC is investing $500 million in new funding over the next four years as part of an Action Plan to improve care for seniors across the system, including increasing direct care hours (DCH) for seniors in residential care. Included in in the $500 million is $275 million to be provided over the next four years for home and community-care (HCC) services as part of the recent health funding agreement with the federal government. Along with the $500 million, Health Authorities also will continue increasing their budgets for home and community care over the next four years, reaching about $200 million above current levels by 2020-21.

As outlined in the media release, over the next four years annual funding increases from the Ministry of Health will enable the health authorities to reach a consistent average of 3.36 DCH per resident day across both publicly administered and contracted residential care homes.[92] Using the current staffing framework and the labour costs provided by the Health Employers Association of BC (HEABC), the Ministry calculates it could cost upwards of $113.7 million for an increase of 1,511 full time equivalents (FTEs) to meet a standard average of 3.36 hours per resident day by health authority. Nearly 900 of these FTEs are expected to be health care aides.

Along with outlining the current seniors population in BC, the Action Plan provides an overview of home support services, assisted living and residential care including populations receiving such care. It also includes key actions in the areas of:

- Focus on healthy aging (i.e. initiatives on healthy aging and self-care);
- Provide better coordinated and integrated community care for seniors with complex medical needs and/or frailty (i.e. Specialized Community Services Program for seniors living in community);
- Work with assisted living residences to implement the new Community Care and Assisted Living Act provisions (i.e. Bill 16);
- Strengthen role and quality of residential care;
- HHR (i.e. Specialized Community Services Program for Seniors and 1,500 FTEs for residential care);
- Monitoring, Evaluation (i.e. develop monitoring & evaluation plan); and
- Funding (i.e. overview of funding increases to 2020/21).

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[91] BCCPA. How the Plecas Plan will strengthen home and community care for BC seniors. March 26, 2017 Accessed at: http://bccare.ca/2017/03/how-the-plecas-plan-will-strengthen-home-and-community-care-for-b-c-seniors/

[92] BC Ministry of Health. Significant funding boost to strengthen care for B.C. seniors. March 9, 2017. Accessed at: https://news.gov.bc.ca/releases/2017HLTH0052-000529

While not outlined in detail in the Action Plan, the province will also spearhead several other measures to improve supports for seniors, such as additional home-support services and hours, as well as increased home-health monitoring. In addition, it provided $10 million to the BCCPA to help industry fund equipment like wheelchairs and patient lifts to help people with limited mobility in publicly funded facilities.

While the Action Plan does not address all of the 30 recommendations from the BCCPA paper *Strengthening Seniors Care: A Made-in-BC Roadmap* released in January 2017, it does deal with three of four pillars identified: investments in health human resources (HHR); quality of life; as well as infrastructure.

Overall, the content of the Action Plan is positive as it recognizes many of the issues identified by the BCCPA in earlier reports such as increasing DCH levels; improving HHR; and improving seniors quality of life. In particular, the action area to increase number of FTEs (i.e. 1,500 FTEs) to meet the DCH standard is very encouraging. In summary, the BCCPA is very pleased the B.C. Government is responding to calls from the province's seniors care providers, and will implement many BCCPA's recommendations to help strengthen seniors care delivery in British Columbia. [93]

The BCCPA is also encouraged by the new NDP government's commitment to continue the key tenets of the Action Plan, particularly increasing DCH and staffing levels. It is also encouraged by the new NDP government which in its budget update indicated that there is $189M in "new funding" for seniors care over 3 years due to the Federal-Provincial Health Accord. While the details of this new funding have to be worked out the BCCPA as outlined in this 2018 budget submission would like to put to put a few ideas forward particularly new investments in infrastructure to replace aging care homes; addressing HHR shortages facing the sector as well as improving quality of seniors care and fostering greater innovation in the continuing care sector. These four key areas are outlined below and further in the paper along with approximately fourteen recommendations to strengthen the sector and improve the lives of seniors whether living at home, assisted living or residential care.

Investing in Infrastructure

- Establish a new Residential Care Infrastructure Fund (RCIF) of $150 million over three years, including:
  - $120M to support the immediate renewal and replacement of older residential care homes.
  - $30M to support investments in smaller infrastructure projects such as sprinkler and ceiling lift installations, security, automated medication management and data collection systems.

Investing in People

- $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 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 (~$25 million per year).

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[93] BCCPA. How the Plecas Plan will strengthen home and community care for BC seniors. March 26, 2017 Accessed at: http://bccare.ca/2017/03/how-the-plecas-plan-will-strengthen-home-and-community-care-for-b-c-seniors/

- $50 million in annual funding to increase minimum home care and support visit times from 15 to at least 30 minutes as outlined in a new provincial guideline.

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 $25M per year over the next four years to support the introduction and/or expansion of the Care Hub concept throughout B.C.

- $20 million in annual funding over four years to support the adoption of new home health models province-wide to allow seniors to remain at home longer as well as reducing alternate level of care (ALC) days and improving overall quality care by focusing on several areas particularly models that: advance the hospital at home model; better integrate home health and long term care; better integrate home health and acute care; and support greater end of life care at home.

TABLE 6: COST OF INITIATIVES

Initiative(s)	Annual Funding (starting in 2018/19)
Continuing Care HHR Fund	**$5M per year**
Residential Care Infrastructure Fund	**$50M per year**
Seniors Quality of Life Fund (SQLF)	**$25M per year**
Increasing home visit times	**$50M per year**
Funding for new home health models	**$20M per year**
Innovation Fund	**$27M per year**
• Continuing Care Hub ($25M per year) and Care Credit Program ($2M per year)	
Annual Funding (over next five years)	**$177M per year**

While the costs of these short-term initiatives are considerable including approximately $175 million ($177 million) in the first year; given the importance of seniors and the fact the provincial government 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.[94] One of the major themes of the BC Ministry of Health Primary and Community Care paper released in February 2015, for example, was that existing expenditures would be protected, while appropriate reallocations from acute to community care services would become part of health authority planning going forward. As outlined in the Quality-Innovation-Collaboration paper (2015) the BCCPA has previously recommended that 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.[95]

This budget submission also recommends that starting in fiscal year 2018/19, 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 submission 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 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.

[94] 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
[95] 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/

SUMMARY OF RECOMMENDATIONS

1. That the BC Government establish a new $150 million Residential Care Infrastructure Fund (RCIF), which over three years 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.
2. 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.
3. 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.
4. 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.
5. That the BC government, working with municipalities, exempt property taxes for residential care homes and assisted living to allow non-government operators to recoup capital operating expenses and further encourage private investment in the continuing care sector.
6. That the BC government provide $2 million in annual funding to 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.
7. That the BC government provide $25 million in annual funding to support 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 including dementia.
8. That the BC government, through a new BC Cares Program, establish a Continuing Care Health Human Resource (CCHHR) Fund with $25 million 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 Society of B.C. 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.

9. That the BC government establish a new Seniors Quality of Life Fund with annual funding of $25 million per year 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 about $6 to $7per 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.

10. Where feasible, Health Authorities increase the minimum home care and support visit times from 15 to at least 30 minutes; and that a new provincial guideline also be established to limit home health visits shorter than 30 minutes only if workers are fulfilling specific, time limited functions – such as ensuring medicine has been taken, or checking a person's welfare. $50 million in annual funding should be provided support the implementation of the new guideline to increase the minimum home care and support visit times from 15 to at least 30 minutes.

11. That the BC government provide $20 million in annual funding over four years to support the adoption of new home health models province-wide to allow seniors to remain at home longer as well as reducing alternate level of care days and improving overall quality care by focusing on several areas particularly models that: advance the hospital at home model; better integrate home health and long term care; better integrate home health and acute care; and support greater end of life care at home.

12. That the BC Ministry of Health partner with the BCCPA to perform a formal review of Assisted Living, including funding and implications of Bill 16, with the aim to:

    - Increase consistency of services within the sector;
    - Decrease unnecessary administrative or regulatory burdens on Assisted Living operators;
    - Ensure the flexibility necessary to meet the needs of seniors; and
    - Secure the funding, staffing and equipment levels necessary to support seniors to live longer in Assisted Living particularly with increasing levels of acuity.

13. 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, impacts of responsive behaviours, reducing adverse drug events, suicide prevention, elder abuse and/or safety within home and community care.

14. Starting in fiscal year 2018/19, 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.

Appendix A:

Facility Condition Index Levels and Impact to Component Failure Risk, Residents and Staff

Common Implications of FCI to Housing Portfolios				
FCI Levels	Impact to Buildings and Components	Examples of Component Issues	Resident Complaints and Morale	Maintenance Staff Impact
Critical (Over 30%)	- Facilities will look worn with obvious deterioration. - Equipment failure occurring frequently. Occasional building shut down will likely occur. Management risk is high. - Health and safety issue figure prominently	- Replacement of multiple systems required (i.e. Mechanical, Electrical, Architectural and Structural - Building heating system failure. - Evacuation of upper floor due to unaddressed roof leakage. - Structural issues including envelope replacement.	- Resident complaints will be very high with an unmanageable level of frequency. - Lack of maintenance will affect resident attitudes and morale.	- Staff will not be able to provide regular scheduled maintenance due to high level of "reactive" calls
Poor (11% to 30%)	- Facilities will look worn with apparent and increasing deterioration - Frequent component and equipment failure may occur. Occasional building shut down will occur	- Replacement of specific major systems required, such as heating and plumbing systems, complete interior renovations, building envelope restoration. - Shut down may affect some units (i.e. roof or pipe leakage)	- Resident complaints will be high with increased level of frequency. - Concern about negative resident morale will be raised and become evident.	- Facilities staff time will likely be diverted from regular scheduled maintenance and forced to "reactive" mode
Fair (6% to 10%)	- Facilities are beginning to show signs of wear - More frequent component and equipment failure will occur	- Repairs and replacement of specific systems, i.e. boiler, window replacements, interior renovations.	- Resident complaints will occur with higher level of frequency - Resident morale may be affected	- Facilities staff time may at times be diverted from regular scheduled maintenance
Good (0% to 5%)	- Facilities will look clean and functional - Limited and manageable component and equipment failure may occur	- Repairs and replacement of more of an aesthetic or general nature, such as wall painting, carpet replacement, roof repair, window caulking.	- Resident complaints will be low and manageable - Resident morale will be positive and evident	- Facilities staff time will be devoted to regular scheduled maintenance
Source: BC Housing. Facility Condition Index. Accessed at: https://www.bchousing.org/publications/Facility_Condition_Index-Asset_Management_Tool.docx%20				

APPENDIX B: NEW HOME CARE MODELS & INNOVATIONS

New Home Care & Support models

This part of the budget submission will look at new models of home care and support, including funding models. This is particularly critical as one of the priorities outlined by the Ministry of Health, is also to allow more seniors to live at home. As noted by the BC Seniors Advocate, most seniors in BC are living independently (93%), including approximately 80% who own their own home. In total, less than 2% of seniors in BC live in provincially subsidized Assisted Living setting, while about 4% live in residential care.[96]

The increased emphasis to enable seniors to remain at home is having a two-fold effect including highlighting the need for greater investments in home health as outlined earlier in this paper as well as increasing levels of acuity of those seniors who are entering residential care.

To meet the increased need and demand for home care will not only require increased investments but also looking at new care models that can support seniors to live and remain at home longer until going into other care settings such as residential or end of life care. These models should also focus at least in part on reducing pressures in the health system particularly acute care and alternate level of care (ALC) days [97] as outlined in the next section.

Alternate Level of Care (ALC) Beds

Research has shown that home care, including professional and home support services, can prevent admission to hospitals and long-term care homes; and can improve clinical outcomes for people. A 2008 study by Professor Markle-Reid and colleagues from McMaster University demonstrated the pivotal role of non-professional home support services in preventing, delaying, or substituting for admission to institutional care, at a lower cost. Markle-Reid's work also shows that for a sizeable proportion of older people 75 years of age or more, minimal levels of home support services are associated with improvements in health and related quality of life.[98]

One of the critical reasons for increased home health 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.[99] The costs are even less for home care at less then $50 per day. [100]

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'

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

[97] According to the Home Care Ontario (2011) estimated the daily cost of care at home at $42, of a long-term care bed at $126 and of a hospital bed at $842. The Ombudsperson also notes it costs Health Authorities only about $30 to $40 for each hour of subsidized home support.

[98] Ontario Homecare Association. OHCA Submission to Drummond. October 2011. Accessed at: http://www.homecareontario.ca/docs/default-source/ohca-submissions/drummond-submission-2011.pdf?sfvrsn=6

[99] 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

[100] According to the Home Care Ontario (2011) estimated the daily cost of care at home at $42, of a long-term care bed at $126 and of a hospital bed at $842. The Ombudsperson also notes it costs Health Authorities only about $30 to $40 for each hour of subsidized home support.

use of acute hospital beds exceeds 2.4 million days, which equates to over 7,500 acute care beds each day.[101] A conservative national estimate of resulting costs of these ALC days to provincial governments is approximately $3 billion per year.[102]

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 ALC days doubled and that on average about 11 per cent of Alberta's acute care capacity was occupied by ALC patients.[103]

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.[104] 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.[105]

As outlined in the 2015 BCCPA 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.[106] The savings would be even greater if able to care for patients at home. [107]

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.[108] 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.[109]

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

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[101] 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

[102] 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)

[103] 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

[104] 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

[105] 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

[106] 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

[107] According to the Home Care Ontario (2011) estimated the daily cost of care at home at $42, of a long-term care bed at $126 and of a hospital bed at $842. The Ombudsperson also notes it costs Health Authorities only about $30 to $40 for each hour of subsidized home support.

[108] 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

[109] 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

receive hospital care.[110] 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 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.[111]

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. [112] 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.[113]

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.

Well-designed home care and home support services with quick response capabilities can also be effective in getting seniors out of acute care. For example, Island Health's Quick Response Team, 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.[114]

As outlined in an August 2011 report entitled *Home Care is the Future*, research indicates that a substantial portion of ALC patients waiting for LTC placement in acute and complex care hospitals may be more appropriately cared for in community with intensive and targeted home care services or with supportive living options. A transitional care model (such as Home First) has an important role in returning ALC patients back to their community setting.[115]

Home care support is also important for ALC patients who are discharged home, as many of them are still vulnerable and require varying levels of assistance. If appropriate supports for patients and caregivers are not available when patients are discharged home, then patients may be at higher risk for readmission to hospital or for requiring more extensive care in long-term homes at an earlier stage than necessary. Clients are often discharged directly from the acute care setting to the home setting to minimize hospital length of stay.

[110] 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
[111] 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.
[112] 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
[113] 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
[114] 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/
[115] Ontario Home Care Association. Home Care is the Future: Supporting Seniors to remain at home. August 2011. Accessed at: homecareontario.ca/docs/default-source/position-papers/home-care-is-the-future---supporting-seniors-to-remain-at-home.pdf

Considering the continuing increase in service demand and an aging population, home care is increasingly regarded as a crucial component for the effective functioning of the health system.[116]

Given the significance of the ALC issue, in the BCCPA paper *Strengthening Seniors Care* (2017) it recommends 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. Some of the potential home health models that may support this as well as provide better quality of care are outlined in the following section.

New Home Health Models / Innovations

One of the biggest factors contributing to dissatisfaction with home care is its design according to Anne Wojtak, the chief performance officer and senior director of Performance Improvement and Outcomes at the Toronto Central Community Care Access Centre. While publicly funded home care was first tried as a pilot nearly 50 years ago, its design has not evolved to reflect the increasingly complex and chronic patients who need care in the home. [117]

This White Paper outlines 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.[118]

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.[119] 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.[120] 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.).[121] The philosophy behind the program is based on the belief that attending to seniors 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,

[116] Accreditation Canada and Canadian Home Care Association. Home Care in Canada: Advancing Quality Improvement and Integrated Care. May 2015. Accessed at: https://www.accreditation.ca/sites/default/files/home-care-in-canada-report.pdf
[117] Healthy Debate. Are home care complaints being heard? March 16, 2017. Karen Palmer et al. Accessed at: http://healthydebate.ca/2017/03/topic/ccac-home-care-complaints
[118] Quick Facts about the South East Local Health Integration Network, accessed at: http://southeastlhin.on.ca/Page.aspx?id=1302
[119] Our Mission, Vision & Values, accessed at: http://southeastlhin.on.ca/AboutUs/MissionVisionValues.aspx
[120] 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
[121] SMILE Program Information. Accessed at: http://www.von.ca/smile/programs_info.aspx

and that dignity and choice go hand in hand.[122] 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[123].

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.[124] CHATS provides services to over 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.[125] CHATS envisions to provide innovative leadership in order to promote the wellness of seniors and caregivers in Ontario.[126] Since its launch in 1980, CHATS has provided a continuum of care services to over 700 culturally, economically, and geographically diverse seniors.[127] 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.[128] 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.[129] 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 duplication, shorter hospital stays and fewer re-admissions.[130]

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.[131] 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.[132]

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[122] South East Local Health Integration Network (2008) "A Plan to help seniors stay at Home".
[123] Accreditation Canada (2013) "Seniors Managing Independent Living Easily (SMILE)". Accessed at: https://www.accreditation.ca/seniors-managing-independent-living-easily-smile
[124] 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
[125] About CHATS. Accessed at: http://www.chats.on.ca/about-chats
[126] CHATS: Community and home Assistance to seniors (2009-2010) "Annual Report: A Year to Grow".
[127] CHATS: Community and home assistance to seniors (2-13-2014) "Annual Report".
[128] 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
[129] Integrated Comprehensive Care Project. Accessed at: http://www.sjhs.ca/integrated-comprehensive-care-project.aspx
[130] 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/
[131] 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
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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. 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.[133] 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 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.[134]

Adult Care Centres – Integration of home care and long term care

Finding models of care that can prevent senior's isolation is an important step in improving quality of care and the safety of seniors. Various homecare models have also emerged in the United States and Canada that attempt to better integrate long term and home care 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.[135] 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.[136]

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.[137] 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.[138] According to Alberta Health Services, six months after joining the program, all CHOICE clients saw a reduction in emergency visits by 30 per cent.[139]

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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.[140] 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.[141]

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 teams and capitation funding.[142] 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.

Hospital at Home Model

If faced with a choice to obtain safe, high-quality, hospital-level care in the comfort of one's home during an acute illness versus in the hospital, most older adults would opt to receive their care at home. [143] In studies comparing the outcomes of older adults receiving hospital-level care at home for common illnesses versus routine in-hospital care, it has been demonstrated that Hospital at Home patients are less likely to experience clinical complications such as delirium and functional decline, are more likely to be alive at six months, and along with their families are more likely to be satisfied and less stressed with the care they receive, which can cost nearly one third less overall. [144]

In North America, the Hospital at Home model was developed by researchers at the Johns Hopkins University Schools of Medicine and Public Health as an innovative model that sought to provide older adults the opportunity to receive hospital-level care at home as a complete replacement for acute hospital care. After arriving at an emergency department, the model offers eligible older patients, who require hospital admission for certain medical conditions like community-acquired pneumonia, congestive heart failure and chronic obstructive pulmonary disease, dehydration, urinary tract infection, deep venous thrombosis and pulmonary embolism, the opportunity to receive their treatment and ongoing care at home.[145]

Not only were better care outcomes realized at lower overall costs, but patients and family members were found to judge the quality of the care provided through the Hospital at Home model to be better than the care provided in an acute hospital.[146] The Hospital at Home Model has four principal components:

1. *Assessment:* the clinician determines that patient has an acute illness that could be treated at home.
2. *Transportation:* the patient is then transported home with a nurse or physician and any necessary equipment.

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3. *Home Care:* the designated nurse remains with the patient and provides the necessary care with the support of an on-call physician and in conjunction with the patient's primary care provider.
4. *Discharge*: the care team, including the patient, family or caregiver, and physician, develop a discharge and follow-up care plan.

In Australia, the State of Victoria has also experienced similar results from their Hospital at Home model which has now become an established model of acute care that is highly valued by patients and caregivers, and used to treat a range of conditions. With nearly all state hospitals offering this care, in 2008-09 32,462 patients received care through this model.[147]
In Canada, there have been a few small-scale trials of models substituting acute care services in hospital with acute care being provided in the home. However, these models appear to vary in the type of clients they served, the model designs, and resources utilized. Many of these early trials were not entirely substitution models, so they resulted in duplication of home care services and were not developed in a sustainable way that could be integrated into the overall health care system.[148]

Similar to the Hospital at Home model concept, in April of 2017, the Winnipeg Regional Health Authority (WRHA) announced that it was planning to launch a new intensive home care service within six months aimed at keeping seniors out of hospitals and care homes. Clients will be able to access up to three months of intensive medical care to stay in their own home after being released from hospital. With a budget of about $8 million for the first year, the program will include physicians and rapid response nurses, but primarily staffed by health care aides. As noted by one official, jurisdictions in Ontario and Alberta that have brought in a similar model have found about 70 percent of clients discharged do not need to go to a personal care home.[149]

Home Dialysis

While BC has not fully implemented the home hospital model or invested largely in intensive home care services, one area that has seen success is home dialysis. In particular, BC has the highest rates of home dialysis in Canada with about 35 percent of patients now on home therapies. Along with being generally preferred by patients, home-based dialysis is less expensive.[150] A recent report from the Canadian Agency for Technologies in Health (CADTH), for example, recommends home-based dialysis for all patients who are deemed eligible for home therapies by their care provider. Along with finding no overall difference in quality between home dialysis and in-centre dialysis, it notes significant cost savings.[151]

The U.K.'s National Institute for Health and Care Excellence (NICE) has also estimated that 30 percent of patients would be suitable for home dialysis, and Australia's 2015 rates are around 33 percent — though that ranges widely depending on location. Ontario has seen a similar variation, with home dialysis rates ranging from as high as 42 percent to as low as 14 percent across regions. The provincial average is 26 percent.[152] In response, the Ontario Renal Network is supporting home dialysis by promoting access to personal support workers and nurses, ensuring faster access to catheters, and ranking regions against each other on their home dialysis rates.

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End of Life / Palliative Care at home

In December 2016, the BCCPA released a report on end of life care with recommendations to assist the BCCPA government in its commitment to double the number of hospice spaces province-wide by 2020. In particular, this paper included specific recommendations to better utilize the existing excess capacity in the continuing care sector to increase capacity with respect to end-of-life (EOL) care.[153] While the focus of this paper was on using existing residential care capacity, there is also a potential for greater end-of-life care to be provided at home.

In British Columbia alone, over 30,000 people die annually, 53% of whom die in hospital.[154] This is despite the fact research indicates that most Canadians would prefer to die at home.[155] Not only it is the preferred option it is also less expensive. As outlined in a report by the Auditor General of Ontario, it estimates that the costs of caring for terminally ill patients in an acute-care hospital is more than double the cost of providing care in a hospice bed, and over 10 times more than providing at home care. As outlined below, the cost of providing palliative care in the last month of a patient's life averages about:

- $1,100 per day in an acute-care hospital bed;
- $630 to $770 per day in a bed in a palliative-care unit (at the two hospitals visited that tracked this information in a comparable way);
- $460 per day in a hospice bed; and
- Under $100 per day where at-home care is provided.[156]

As also outlined also in a report from Health Quality Ontario people who receive palliative home care are more satisfied with their care, and less likely to go to the emergency department, be admitted to hospital, or die in hospital.[157] 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 recommended 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 would support funding also to allow for more end of life care to be provided at home along with the other areas outlined earlier.

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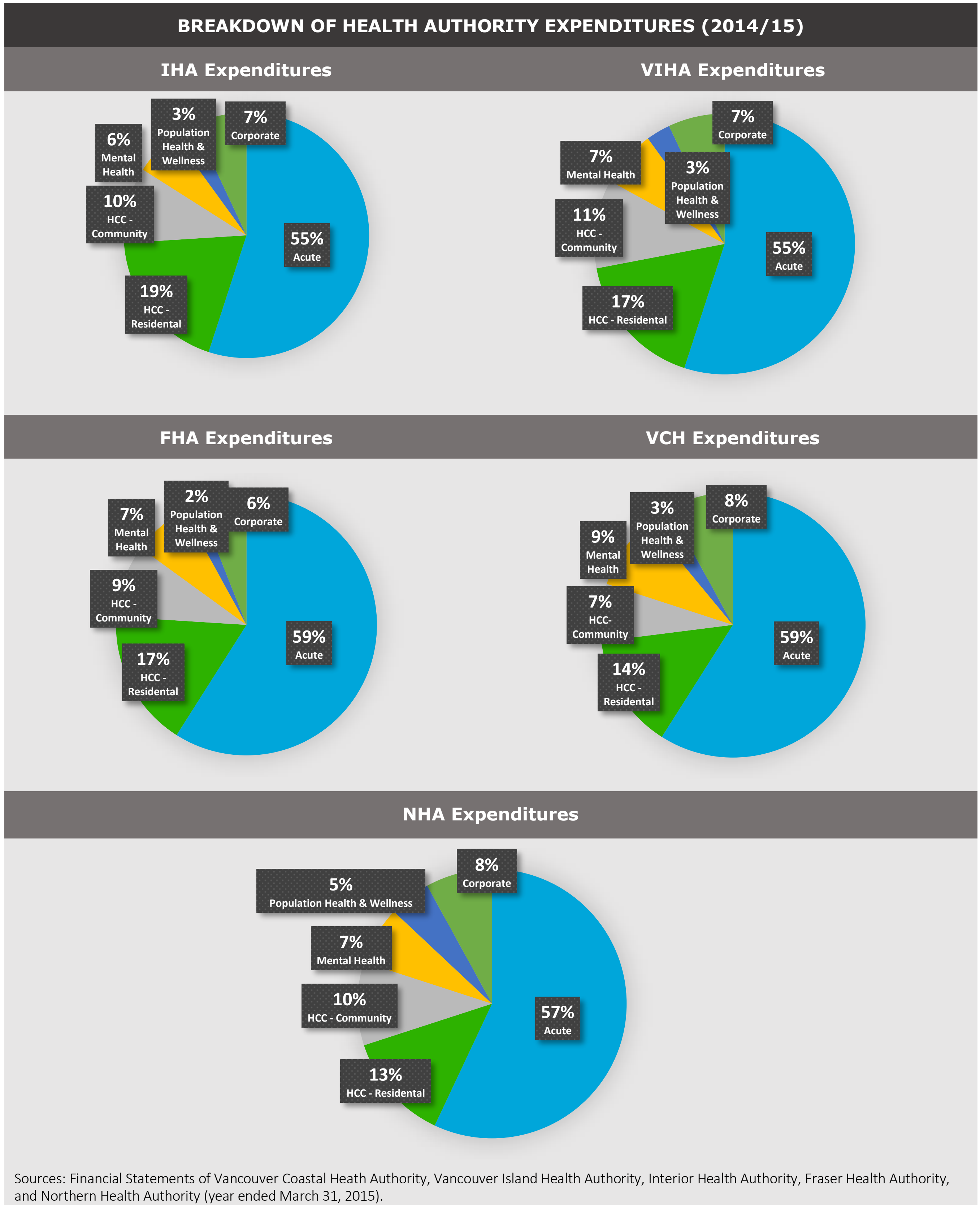
APPENDIX C: BREAKDOWN OF HEALTH AUTHORITY EXPENDITURES



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 D:

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).

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