



**BC Care
Providers**
ASSOCIATION



BEDLAM IN BC's CONTINUING CARE SECTOR:

Projecting Future Long Term Care Bed Needs

May 2019

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Message from the CEO

Today, seniors' care providers across British Columbia are experiencing challenges on several fronts. Our infrastructure for many of our care homes is out of date, staffing shortages are rampant, and demand keeps growing thanks to an aging demographic. More ominously, however, the data tells us that what we are starting to observe is just the beginning of something much more consequential.

As the Baby Boom Generation enters their retirement years, the pressure on long-term care and healthcare in general will continue to build.

Regardless of how you measure the data or what methodology you use to project future demand, the numbers show that tens of thousands of beds will be required to support the seniors who will need care between now and the year 2040. Organizations such as the Conference Board of Canada are projecting that over 30,000 new long-term care beds will be required just in B.C. alone over the next twenty years.

Furthermore, future demand does not stop by just creating more spaces. BCCPA estimates that almost 19,000 new care providers will be needed to meet demand — including 13,000 health care aides, 4,000 nurses and 2,000 allied health professionals just in our province alone.

As discussed throughout this paper – *Bedlam in BC's Continuing Care Sector: Projecting Future Long Term Care Bed Needs* – meeting this demand will require significant investments from the provincial government and health authorities, as well as the federal government. It will also require leveraging the existing non-government sector to meet this demand. Private non-profit and for-profit operators will need to play a major role to achieve success.

While adding new long-term care beds is a major part of the solution, we must also look at alternative approaches, such as new care models, regional initiatives and improving and expanding other supports such as home care and assisted living.

It is our hope that this paper helps to forge a dialogue within the continuing care sector, and among key stakeholders including those in government, so we can address this imminent need and ensure that care can be there for B.C.'s seniors in the decades to come.

If we do not prepare now and work collaboratively as a sector, the resources required to care for our aging population will very likely fall short. A future without adequate seniors care is one that British Columbians should not expect, nor deserve.

Sincerely,



Daniel Fontaine, Chief Executive Officer



About BCCPA

BC Care Providers Association (BCCPA) is the leading industry association for BC's continuing care sector. We have been serving non-government care providers for 40 years. Our growing membership includes over 350 long term care, assisted living, home support and commercial members across BC. Over 23,000 vulnerable adults—primarily seniors—receive their care from our members each day.

Special Recognition

The BCCPA would like to acknowledge its Board of Directors and the Emerging Issues and Policy Committee (EIPC), for agreeing to support the development of this report and dedicating the necessary resources to make it happen. The report's author is Michael Kary, Director of Policy and Research.

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EXECUTIVE SUMMARY

With a growing and rapidly aging population, the continuing care sector will require the addition of new resources to meet the needs of seniors in BC. BC is already facing a shortage of long term care beds, which is affecting people and families who are impacted by delays to care including transitions from hospital or home health care. As of 2016, the Conference Board of Canada projects **current bed demand in BC is approximately 33,300**, which is over 3,000 current bed levels if you include publicly subsidized and private pay beds. The **Conference Board of Canada also projects that BC requires an additional 31,000 (30,900) new long term care beds by 2035 to meet demand.**

While the Conference Board of Canada generally uses a population ratio based approach to forecasting demand for long term care beds including BC, the BC Care Providers Association (BCCPA) has also attempted to project future demand for long term bed equivalents (LTCBEs) based on the growth of the frail elderly population from data provided by the Ministry of Health. Using this approach, BC requires about 45,000 new long term care beds (or LTCBEs) by 2041/42 to meet growing demand for those identified as frail in residential care (or long term care). Most importantly, **regardless of how you measure or what methodology you use to project future demand for long term care beds, a significant number of beds are required.**

As outlined later in this paper, as of March 2018 there were about 1400 (1,379) persons waiting for admission into long term care – a 7 percent increase over the previous year. The majority or about 75 percent of those waiting for admission into long term care (1039 of 1379) were those living in the community compared to the rest who were waiting in hospital. The latter, namely those waiting in hospital, are part of what is referred to as alternate level of care (ALC) patients as discussed later on in this paper.

Overall, the access situation is only going to get worse unless there is an increase in the number of new beds. In BC, request for proposals (RFPs) for new long term care beds are generally posted on the BC Bid website. As of the end of 2018, no health authorities in BC, however, had an RFP for new care beds posted. In fact, over the past six months only one RFP for new long term care beds has been awarded.¹ When BCCPA contacted health authorities about their projections for future long term care beds they noted that their forecasts are in development and cannot be shared publicly.

While the focus of this paper is on the need for new long term care beds, some of this demand can be potentially offset through other areas in the continuing care sector particularly home health care and assisted living. While these areas and other approaches might mitigate some of the demand they will still be inadequate. In particular, no single intervention will offset demand for long term care beds in

¹ In January 2019, the BC Ministry of Health announced that over 120 new long term or residential care beds had been awarded to Golden Life Management for the Comox Valley region as part of an earlier RFP that had been posted on BC Bid (see: BC Ministry of Health News Release: Improving seniors' care for the Comox Valley accessed at: <https://news.gov.bc.ca/releases/2019HLTH0009-000040>). These were part of an RFP that had been issued by Island Health in March 2018 and which closed in May of the same year (See: BC Local News. No updates on Island Health RFP for 120 long-term care beds. November 4, 2018. Accessed at: <https://www.bcclocalnews.com/news/no-updates-on-island-health-rfp-for-120-long-term-care-beds/>).

Canada or BC as well as uphold individual preferences to remain in the community as long and as independently as possible.²

As outlined later in this paper, projecting the future demand of long-term care beds or LTCBEs can be a very difficult and complicated exercise as there are many different approaches which can be used to project LTCBE needs such as using population ratios or service utilization among others. Subsequently, variations may differ within each of these approaches.

While new approaches, such as Bill 16 for assisted living, and better ensuring those who enter long term care need to be there will offset some of the future demand, it will not mean that substantial numbers of new beds are not necessary. Meeting new demand will require significant investments from the provincial government and health authorities but also perhaps even the federal government. To meet current and future demand for long-term care, for example, the Canadian Association for Long Term Care (CALTC) has recommended that the federal government increase capacity by committing to funding the addition of 42,000 new long-term care beds across the country by 2023.³

Along with the provincial and perhaps federal government as well as health authorities, it will also **require leveraging the existing private sector to meet this demand**. This includes private-for-profit and private not-profit operators, which currently make up about two-thirds of BC's existing beds.

While a significant number of new long term care beds are projected to meet demand (i.e. over 30,000 in next 20 years), this does not account for existing beds which may be in care homes that are significantly outdated and require renovation or in some cases, rebuilding. As outlined later in the paper, for example, approximately 40% of long-term care homes in Canada require significant renovations or to be rebuilt, according to a survey of CALTC's provincial association members. This is why CALTC has also recommended the federal government invest in the construction, renovation and retrofit of 400 long-term care homes to meet current design standards and needs of today's seniors, especially those with dementia, by 2023.⁴

Along with new bed demand and ensuring current care homes are up to date, some of the other challenges explored briefly in this paper include rising levels of acuity or complexity as seniors are entering long term care later in life. While this may not significantly impact the number of new beds required, it will likely have a major impact particularly on health human resources (HHR).

Although HHR is also largely beyond the scope of this paper, higher levels of acuity and demand for new beds will require substantial new levels of health professionals particularly health care assistants. The BCCPA estimates that based on the Conference Board of Canada projection in which BC requires about 31,000 (30,900) new long term care beds by 2035, that to meet this demand it would require about

² Canadian Institute for Health Information. Seniors in Transition: Exploring Pathways Across the Care Continuum. Ottawa, ON: CIHI; 2017. Accessed at: <https://www.cihi.ca/sites/default/files/document/seniors-in-transition-report-2017-en.pdf>

³ Canadian Association for Long Term Care. Long Overdue: Improving Seniors Care in Canada. November 2018. Accessed at: <https://caltc.ca/wordpress/wp-content/uploads/2018/11/CALTC-budget-submission-ONLINE.pdf>

⁴ Canadian Association for Long Term Care. Long Overdue: Improving Seniors Care in Canada. November 2018. Accessed at: <https://caltc.ca/wordpress/wp-content/uploads/2018/11/CALTC-budget-submission-ONLINE.pdf>

19,000 new care providers including almost 13,000 health care aides, 4000 nurses and 2000 allied health professionals.

Based on what is outlined in this paper, the BCCPA has put forward twelve recommendations as seen in the following table below in order to improve access to seniors care and increase overall capacity in the long term care sector.

SUMMARY OF RECOMMENDATIONS

Current Access Issues

Short to Medium Term (Within the next 5 years)

1. That the BC government reduce the number of people on long term care wait lists by establishing a target within its Ministry of Health Annual Service Plan to ensure at least 65 per cent of those waiting for a bed can access one within 30 days.
2. That the BC government and health authorities establish a website to track wait time information for long term care, including potentially assisted living and home health care waits. This website should also be updated regularly or at least once every two months.

Immediate Term (within next 1 to 2 years)

3. That the BC Ministry of Health establish a target in its Annual Service Plan to have no more than 5 percent of acute care beds occupied each day by seniors who have been assessed as capable of being transferred into a more appropriate long term or home care setting and that this target be met by the end of 2024.

Future Strategy for Meeting Long Term Care Demand

Immediate Term (within next 1 to 2 years)

4. That the BC government develop a strategy to increase the number of long term care bed equivalents (LTCBE) by at least 30,000 over the next twenty years, including between 20,000 and 25,000 actual new beds. As part of any strategy, new beds should include an appropriate mix of government and private (for profit and non-profit) based roughly on the current distribution or allocation of beds.
5. That, as part of any strategy to meet future demand for long term care and assisted living, the BC government develop a BC Continuing Care Living Initiative (CCLI) to partner with

private and non-profit organizations as well as provide funding for new long term care and assisted living spaces.

6. That the federal government increase capacity by committing to funding the addition of 42,000 new long-term care beds across the country by 2023.

Short to Medium Term (within next 5 years)

7. That, as part of any new long term care bed strategy or a broader Continuing Care Health Human Resource Workforce Strategy, the BC government develop a provincial health human resource (HHR) plan to meet the requirement for new long term care beds over the next twenty years.
8. That the federal government collaborate with the provinces and the long-term care sector to immediately develop and implement a Pan-Canadian health human resources strategy, in order to improve access as well as meet the needs of a growing and aging population.
9. That the BC government and health authorities, in conjunction with stakeholders, develop a consistent approach to track and project future long term care bed requirements province-wide. A report on this should be developed by the end of 2022 and updated every two years to project long term care bed needs at least ten years into the future.

Addressing BC's Long Term Care Bed needs through alternative approaches

Short to Medium Term (within next 5 years)

10. That the BC government invest up to \$50 million per year over the next four years to support the introduction of new models or approaches of care such as the Continuing Care Hub to improve access to seniors care. Where appropriate, investments from this funding should be provided to initiatives or programs across the continuing sector including assisted living and home health care that can mitigate and/or reduce future demand for long term care.

Renovating existing care homes to meet LTC demand

Short to Medium Term (within next 5 years)

11. That the federal government immediately expand eligible projects for infrastructure funding to include seniors housing which incorporates long-term care. In particular, the federal government invest in the construction, renovation and retrofit of 400 long-term care homes

to meet current design standards and the needs of today's seniors, especially those living with dementia, by 2023.

Immediate Term (Within next 1 to 2 years)

12. In conjunction with developing a strategy to increase number of long term care beds over the next twenty years, the BC Government establish a new \$200 million Continuing Care Infrastructure Fund (CCIF), which over four years would:

- support the immediate renewal and replacement of older long term care and assisted living 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;
- funding to continue or expand the existing Seniors Safety and Quality Improvement Program; and
- invest in enhancements for improving dementia-friendly environments within existing homes to create more dementia friendly designs.

SECTION 1: BACKGROUND

Across Canada, jurisdictions are dealing with long-term care bed shortages. As a result, seniors in many cases are occupying beds in hospitals (Alternate Level of Care or ALC beds) which is a much higher cost to the health care system. In BC, for example, the cost of treating a senior in hospital ranges from \$825 to \$1,968 per day, whereas the cost of long term care is approximately \$200 per day.⁵ There are 7,550 acute care beds that are taken up by individuals who should be in long-term care or in rehabilitation. This represents about 7 per cent of all hospital beds in Canada.⁶

Not only are these individuals receiving a sub-optimal level of patient care, but the costs associated with this ALC are significantly more expensive. Shifting these patients to a more appropriate long term care setting would free up capacity for those requiring a more intensive level of care. Increasing long-term care capacity by building new facilities and renovating older homes will mean that we are better equipped to care for our aging and most vulnerable citizens. It will also mean that we can care for seniors who require 24/7 care in the best environment.

In Canada, long-term care is provided through both public and private (for-profit and non-profit) entities. Just under half of all long-term care homes are private for-profit entities (44%), while 29% are private non-profit and 27% are public entities.⁷ Despite the growth in the population of seniors and the resulting increased need for long-term care, the number of beds and long-term care homes across Canada decreased between 2005 and 2014.⁸

Table 1: Long-term care homes in Canada		
	2005	2014
Number of Care Homes	1630	1334
Number of Beds	173,376	147,926
Number of beds per 1,000 aged 65+	41.2	26.5

1 a) Information on BC's Continuing Care sector

In 2012/13, home and community care services were provided to 127,786 individual clients across BC, with 80,734 receiving professional services; 38,810 receiving home support services; 6,147 receiving adult day programs; 6,028 receiving assisted living services and 38,527 receiving residential or long term care. Of the 127,786 individuals receiving home and community care services in 2012/13; 98,250 or 77% were 65 or older. However, for those receiving long term care or assisted living services, 40,490 of 43,443 or

⁵ BCCPA. Op-ed: Let's Stop Seniors from Languishing in Hospitals. February 2016. Accessed at: <https://bccare.ca/2016/02/op-ed-lets-stop-seniors-languishing-hospitals/>

⁶ According to the OECD (*OECD Health Data 2011*), total hospital beds in Canada per 1,000 population is 3.3.

⁷ Canadian Health Coalition. Ensuring Quality Care For All Seniors. November 2018. Accessed at: <http://www.healthcoalition.ca/wp-content/uploads/2018/11/Seniors-care-policy-paper-.pdf>

⁸ Harrington, Charlene et al (2017). Marketization in Long-Term Care: A Cross-Country Comparison of Large For-Profit Nursing Home Chains. Health Services Insights 10: 1-23.

93% were 65 and older. Publicly subsidized long term care services are provided to approximately 5% of the total senior's population (65 and older).

British Columbia's over 300 long term care homes are home to approximately 42,000 residents annually, with an average age of 85 years (see table below). Many of these residents have one of more chronic conditions at varying levels of severity. For example, 61.4 % have dementia and 20.2% have diabetes. In addition, 6.7% have cancer while almost one-third have severe cognitive impairment. Although frail seniors in long term care represent only 1% of the population, they use about 21% of all health system expenditures and are a major cost driver.⁹

Table 2: Resident characteristics in Long Term Care (British Columbia)	
Number of Residents	41,619
Average Age	85
Younger Than 65 (%)	5.2
85 and Older (%)	58.7
Female (%)	65.3
Diagnosis of Dementia (%)	61.4
Diagnosis of Hypertension (%)	45.9
Diagnosis of Cancer (%)	6.7
Diagnosis of Diabetes (%)	20.2
Severe Cognitive Impairment (%)	32.6
Signs of Depression (%)	21.4
Daily Pain (%)	20.6
Some Aggressive Behaviour (%)	34.5
1+ Emergency Room Visits (%)	7.1
1+ Admissions to Hospital (%)	6.0

Aging population to increase costs

C.D. Howe estimates that the cost of long- term care services in Canada will roughly triple over the next 40 years, growing from around \$69 billion in 2014 to around \$188 billion in 2050, in inflation-adjusted dollars. As the baby boomer population heads into retirement, the share of so-called young seniors aged 65-74 will rise from roughly 9 percent to 12 percent of the total population by 2030. As the boomers continue to age, the number of elderly seniors – those aged 85 and up – will grow from around 3 percent in 2030 to 6 percent in 2060.¹⁰ Another 2019 report also highlights that provincial and federal

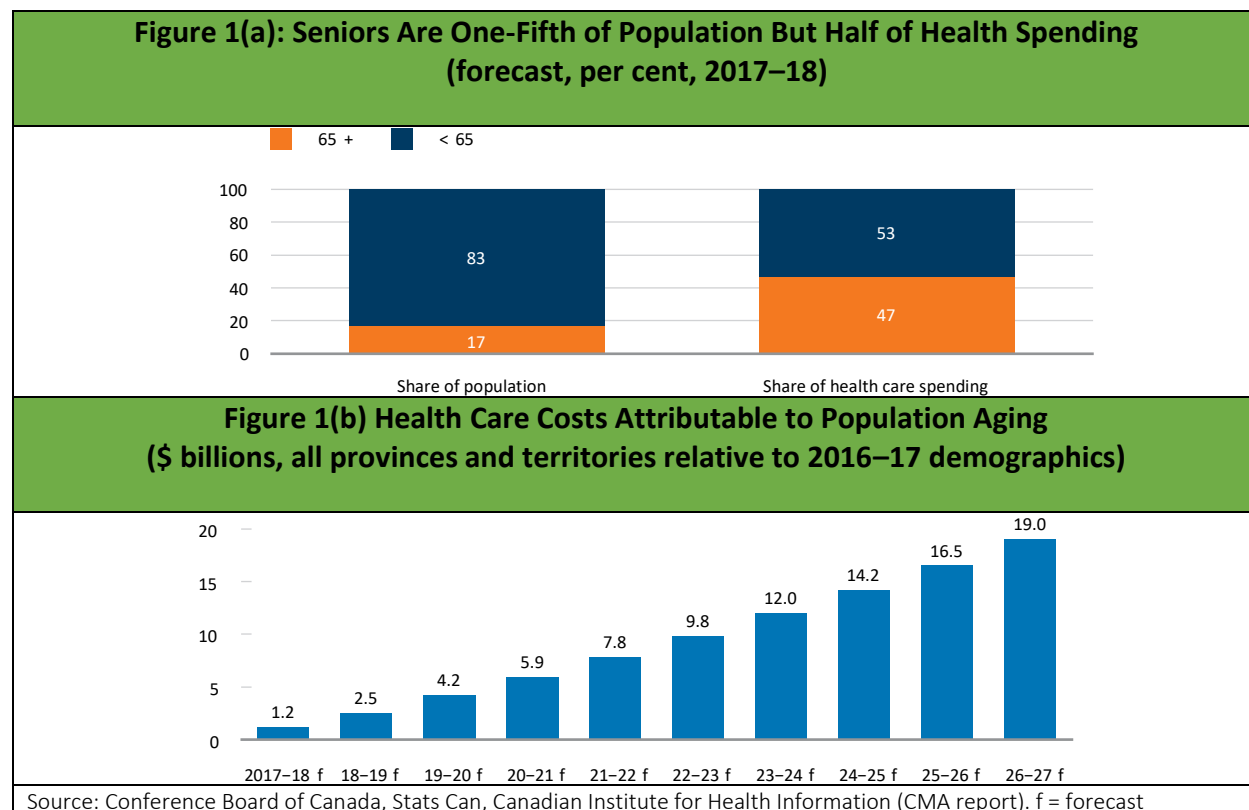
⁹ BC Ministry of Health. Primary and Community Care in BC: A Strategic Policy Framework. 2015. Accessed at:

<https://www.health.gov.bc.ca/library/publications/year/2015/primary-and-community-care-policy-paper.pdf>

¹⁰ CD Howe. Paying for the Boomers: Long-Term Care and Intergenerational Equity. Commentary No. 415. September 2014. Accessed at:

https://www.cdhowe.org/sites/default/files/attachments/research_papers/mixed/Commentary_415.pdf

government expenditures on home and long-term care are expected to reach \$53.5 billion by 2035.¹¹ Further information on this from the Conference Board is presented in the figures below.



If systemic reforms were able to transition all those in a hospital setting to a more appropriate long-term care setting, the savings to the health system according to one report would be roughly \$77 billion between 2012 and 2046. In addition, as noted in a report from the Canadian Life and Health Insurance Association (CLHIA), moving even 20 per cent of the resulting individuals out of long-term care and providing them with support in the home, the savings would be an additional \$62 billion. Together, structural reform to ensure long-term care patients are no longer cared for in acute care hospitals and that those that can, receive support in the home, would save governments almost \$140 billion over the next 35 years.¹²

As discussed later on in this paper, long-term care homes are dealing with significant capacity challenges. In particular, we know that even today there are capacity issues given the number of Canadians in hospitals waiting for appropriate long-term care beds to become available.

¹¹ Conference Board of Canada. Measures to Better Support Seniors and Their Caregivers. March 2019. Accessed at:

<https://www.cma.ca/sites/default/files/pdf/health-advocacy/Measures-to-better-support-seniors-and-their-caregivers-e.pdf>

¹² Canadian Life and Health Insurance Association Inc. Report on Long-Term Care Policy – Improving the Accessibility, Quality and Sustainability of Long Term Care in Canada. June 2012. Accessed at:

[https://www.clhia.ca/web/clhia_lp4w_ind_webstation.nsf/page/3C342451F891CF1D85257A240044F961/\\$file/LTC_Policy_Paper_1_EN.pdf](https://www.clhia.ca/web/clhia_lp4w_ind_webstation.nsf/page/3C342451F891CF1D85257A240044F961/$file/LTC_Policy_Paper_1_EN.pdf)

There are currently about 300,000 people residing in long-term care homes in Canada and the demand is growing exponentially.¹³ If we assume residency rates of the present population, it can be predicted that Canada will need over 800,000 long term care beds by the year 2047 – over 2.5 times what we have now. Even if we assume a much greater use of home care for Canadians, there will be a significant increase in the number of homes required for the long-term care needs of Canadians. Indeed, based on the average size of current long term care homes in Canada, to meet this future demand Canada will need almost 6,000 addition long term care homes to be built over the next 35 years. This works out to almost 170 new care homes per year over this period.¹⁴

1b) Response to LTC Demand from other provinces

Ontario

In Ontario, as of October 2017, there were nearly 34,000 people waiting for a bed in a care home with wait lists growing drastically over the last two years. As of April 2018, the average time for placement was 158 days.¹⁵ As a result, the Ontario Long Term Care Association (OLTCA) has recommended that the provincial government commit to the addition of up to 10,000 new long-term care beds over the next five years, solely dedicated to helping improve the viability of existing capital renewal projects throughout the province.¹⁶

In an earlier report by the OLTCA produced by the Conference Board of Canada, it notes that unless changes are made, the gap between the number of long term care beds required and the number supplied will grow to between 57,000 and 127,000 by 2035.¹⁷ The figure below provides an illustration of the expected long-term care bed needs of Ontario over the next 25 years. The pink line represents the growth in supply assuming the current ratio between supply and demand is maintained, which would result in a gap of 57,000 beds by 2035. The yellow represents the growth trend assuming an increase of 1.5 per cent beds per year, and would result in a gap of nearly 127,000 beds by 2035.

¹³ Canadian Healthcare Association. 2009. *New Directions for Facility-Based Long-term Care*. Accessed at: https://www.advantageontario.ca/oanhssdocs/Issue_Positions/External_Resources/Sept2009_New_Directions_for_Facility_Based_LTC.pdf

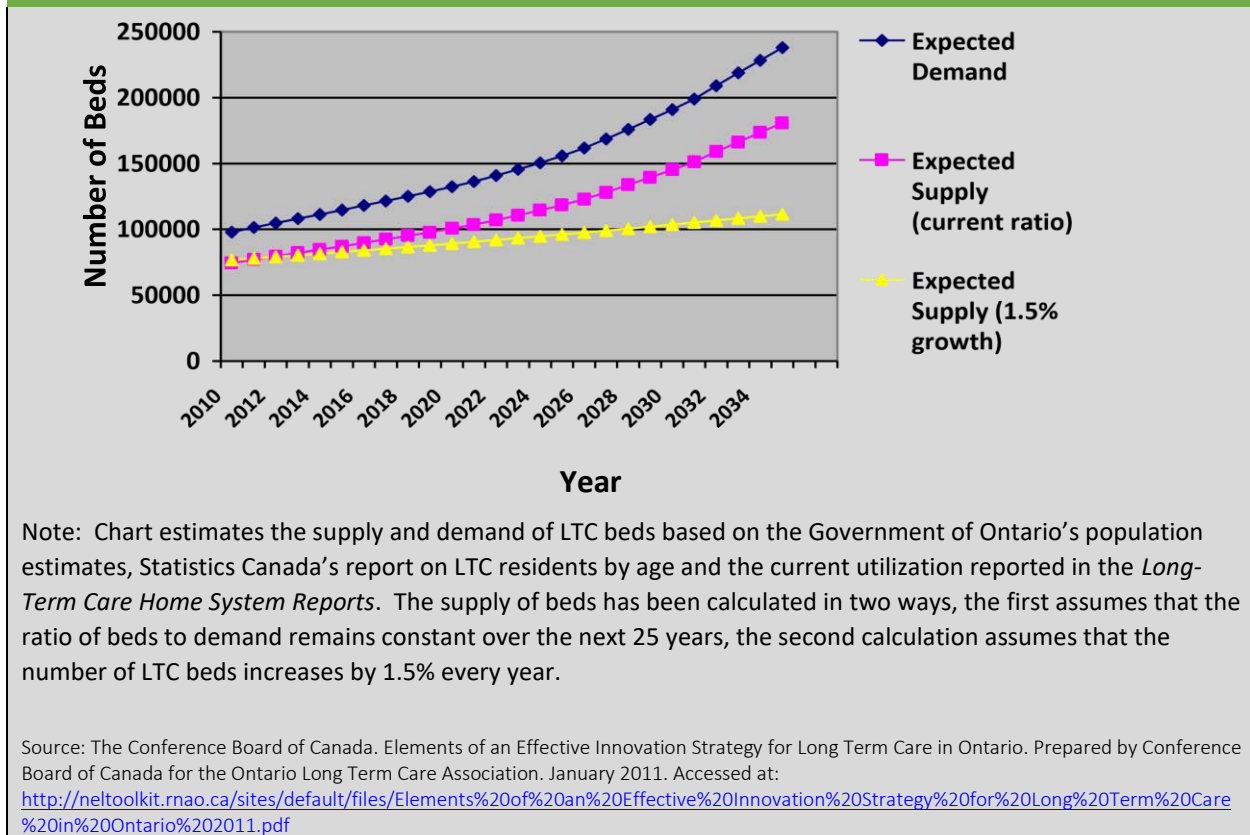
¹⁴ According to the Canadian Healthcare Association (*New Directions for Facility-Based Long-term Care*), in 2007 there were 2,577 long-term care facilities in Canada and 217,969 beds. Based on this the Conference Board uses average beds per facility to calculate the number of facilities required to meet expected future demand.

¹⁵ Ontario Long Term Care Association. 2019 Budget Submission. November 2018. Accessed at: <https://www.oltca.com/OLTCA/Documents/Reports/2019OLTCABudgetSubmission-LTCThatWorks.pdf>

¹⁶ Ontario Long Term Care Association. More Care. Better Care. 2018 Budget Submission. Accessed at: <https://www.oltca.com/OLTCA/Documents/Reports/2018OLTCABudgetSubmission-MoreCareBetterCare.pdf>

¹⁷ Conference Board of Canada. Elements of an Effective Innovation Strategy for Long Term Care in Ontario. Prepared by Conference Board of Canada for the Ontario Long Term Care Association. January 2011. Accessed at: <http://neltoolkit.rnao.ca/sites/default/files/Elements%20of%20an%20Effective%20Innovation%20Strategy%20for%20Long%20Term%20Care%20in%20Ontario%202011.pdf>

Figure 2: Expected Demand for LTC Beds in Ontario: 2010-2035



In response to current shortages, Ontario is planning to expand the number of long term care beds. In the 2018 provincial election all political parties pledged to expand the number of beds including the Progressive Conservative (PC) party which said it would introduce 15,000 beds in the next five years and 30,000 over next 10 years.¹⁸ Even if the newly elected PC Party is able to actually fulfil its pledges it will result in a 50-per-cent increase in the number of long term care beds over the next decade but will still be unlikely to keep up with demand.

As noted in one CBC report, just to move patients who are waiting for acute care out of hospital beds would require 5,000 long term care spots immediately. In Ontario, there are also thousands of people on the wait list for a long-term care bed, a list that is only expected to keep growing. As outlined in the CBC article and later in this paper, part of the solution will also require investing in further in home care.¹⁹

Most recently in October 2018, the Ontario government in a pledge to end hallway health care, announced the province is moving forward with building 6,000 new long-term care beds across the

¹⁸ In late 2017, the previous Liberal Ontario government also announced that it would be funding 30,000 more long-term care beds over the next decade, with 5,000 of those in the next four years.

¹⁹ CBC News. Hospital crowding: Why all 3 major Ontario parties are promising more LTC beds. Joanne Chianello. May 25, 2018. Accessed at: <http://www.cbc.ca/news/canada/ottawa/ontario-election-leaders-hospital-overcrowding-1.4674736>

province. These 6,000 new long-term care beds represent the first wave of more than 15,000 new long-term care beds that the government has committed to build over the next 5 years.²⁰

New Brunswick

According to the New Brunswick government, 751 people were waiting for placement in nursing (or long term care) homes as of end of October 2018. The majority (484) were waiting in hospital. The waiting list has increased from an average of 595 in 2017 and is up 35 per cent since January 2018. To alleviate some of these pressures, in February 2018 the provincial government announced it would create 1,000 new nursing home beds and memory care beds over the next several years.²¹

Alberta

Alberta is another province that is facing access issues with regards to long term care. In particular, Alberta Health Service's recently released annual report for 2017-18 showed that only 52 per cent of clients are being placed in continuing care within 30 days of being assessed, falling short of the government's target of 65 per cent. This number dropped from 56 per cent in 2016-17, and from 60 per cent in each of the two years prior to that. In 2013-14, 69 per cent of clients were placed within the 30-day period. To improve access, the NDP pledged during the 2015 election campaign to add 2,000 new long-term care and dementia beds over the course of its first term in office.²²

1c) Canada's Aging Population

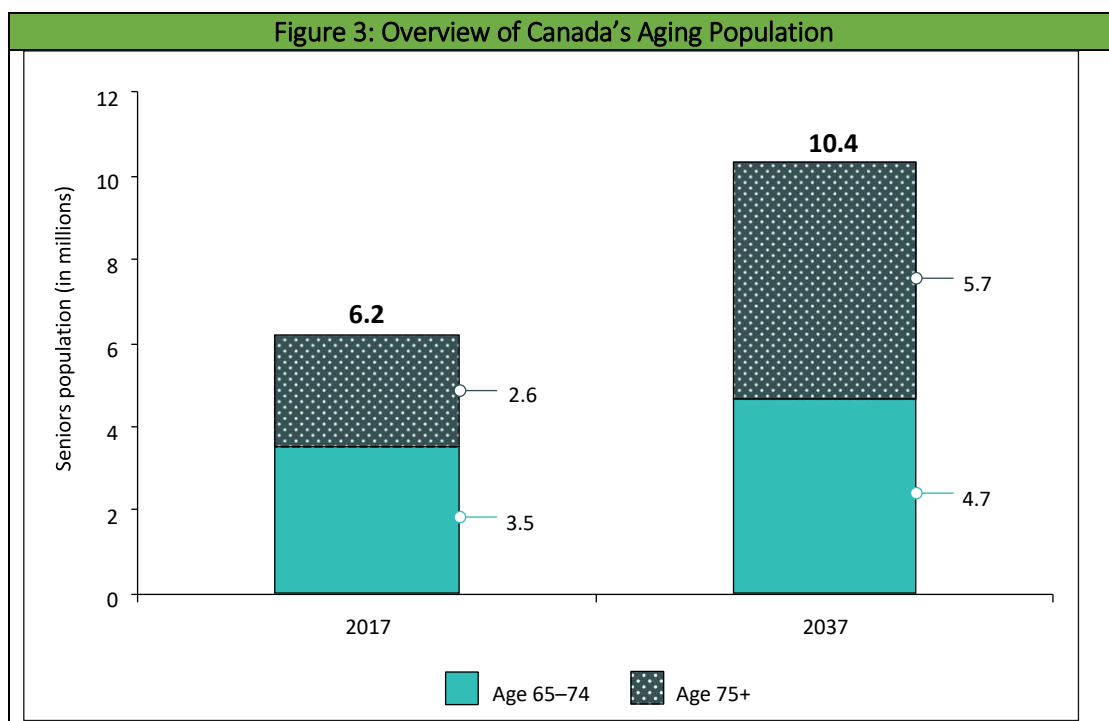
An analysis of today's demographics suggests that by the year 2036, 25 per cent of the entire Canadian population will be over the age of 65. It is estimated that Nova Scotia, New Brunswick and BC have highest proportions of older seniors in Canada.²³ Estimates for 2017 show that 17% of Canada's population is age 65 and older (i.e. 6.2 million seniors). Within this group, older seniors (those age 75 and older) represent 7% or 2.6 million of the population - a number that is expected to more than double over the next 20 years (see figure below).

²⁰ Ontario Government. Ontario's Government for the People Taking Immediate Action to End Hallway Health Care. October 3, 2018. Accessed at: <https://news.ontario.ca/opo/en/2018/10/ontarios-government-for-the-people-taking-immediate-action-to-end-hallway-health-care.html>

²¹ CBC News. Why are hundreds of seniors stuck in New Brunswick hospitals?. November 20, 2018. Accessed at: <https://www.cbc.ca/news/canada/new-brunswick/long-wait-for-nursing-homes-1.4913155>

²² Calgary Herald. Alberta government missing targets for accessing long-term care. James Wood. July 23, 2018. Accessed at: <https://calgaryherald.com/news/politics/government-missing-targets-for-accessing-continuing-care>

²³ Canadian Institute for Health Information. Seniors in Transition: Exploring Pathways Across the Care Continuum. Ottawa, ON: CIHI; 2017. Accessed at: <https://www.cihi.ca/sites/default/files/document/seniors-in-transition-report-2017-en.pdf>



While currently only a small fraction (approximately 9%) of seniors age 75+ live in long term care, the expected doubling of this population over the next 20 years will place unprecedented pressures on Canada's continuing care systems as this population generally rely most heavily on health care services and are the largest users.²⁴ According to Statistics Canada, the chances of requiring long-term care are one in ten by age 55, three in ten by age 65 and five in ten by age 75.²⁵

Increased demand for continuing care

The Conference Board of Canada has estimated a 2.4 million Canadians 65 years and older will need continuing care, both paid and unpaid, by 2026 — a 71% increase since 2011.²⁶ A CD Howe paper also projects that over the next 40 years the annual total cost of long term care will triple, from approximately \$69 billion in 2014 to about \$188 billion in 2050. The most rapid increase in costs occurs between 2025 and 2040, when aging baby boomers are expected to dramatically expand the number of frail elderly.²⁷

²⁴ Canadian Institute for Health Information. *Seniors in Transition: Exploring Pathways Across the Care Continuum*. Ottawa, ON: CIHI; 2017. Accessed at: <https://www.cihi.ca/sites/default/files/document/seniors-in-transition-report-2017-en.pdf>.

²⁵ Canadian Life and Health Insurance Association Inc. *Report on Long-Term Care Policy – Improving the Accessibility, Quality and Sustainability of Long Term Care in Canada*. June 2012. Updated July 2014. Accessed at: [https://www.clhia.ca/web/clhia_lp4w_lnd_webstation.nsf/page/3C342451F891CF1D85257A240044F961/\\$file/LTC_Policy_Paper_1_EN.pdf](https://www.clhia.ca/web/clhia_lp4w_lnd_webstation.nsf/page/3C342451F891CF1D85257A240044F961/$file/LTC_Policy_Paper_1_EN.pdf)

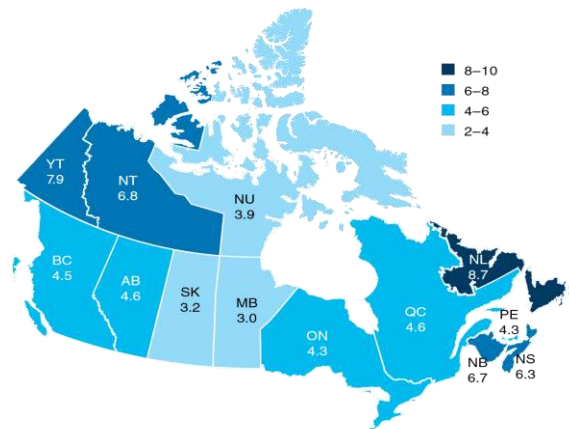
²⁶ Hermus G, Stonebridge C, Edenhoffer K. *Future care for Canadian seniors: a status quo forecast*. Ottawa: Conference Board of Canada; 2015. Accessed at: <http://www.conferenceboard.ca/e-library/abstract.aspx?did=7374>.

²⁷ Blomqvist A, Busby C. *Paying for the Boomers: Long-Term Care and Intergenerational Equity*. Commentary No. 415. Toronto: CD Howe Institute; September 2014. Accessed at: https://www.cdhowe.org/sites/default/files/attachments/research_papers/mixed//Commentary_415.pdf

Over 750,000 Canadians over the age of 65 will reside in health care institutions by 2036 compared to about 300,000 today.²⁸ In Canada today, on a daily basis:

- 7,550 of hospital beds, or roughly 7 per cent of all hospital beds in Canada, are taken up by individuals receiving long-term care;
- 7 per cent of Canadians age 65 and over reside in long-term care homes, and
- 8 per cent of Canadians aged 65 to 74, 20 per cent aged 75 to 84 and 42 per cent over 85 years of age receive home care.²⁹

Figure 4: Percentage change of over-65 population (2017–28)



Source: The Conference Board of Canada.

²⁸ Currently, 7 per cent of Canadians age 65 and over reside in health care institutions. By 2036, 25 per cent of the population will be over the age of 65. We estimate a 1 per cent growth rate in the Canadian population each year between now and then. According to the Canadian Healthcare Association (*New Directions for Facility-Based Longterm Care*) there were about 300,000 Canadians living in nursing homes, residences for senior citizens, and chronic and long-term care and related facilities.

²⁹ Canadian Life and Health Insurance Association Inc. Report on Long-Term Care Policy – Improving the Accessibility, Quality and Sustainability of Long Term Care in Canada. June 2012. Updated July 2014. Accessed at:

[https://www.clhia.ca/web/clhia_lp4w_lnd_webstation.nsf/page/3C342451F891CF1D85257A240044F961/\\$file/LTC_Policy_Paper_1_EN.pdf](https://www.clhia.ca/web/clhia_lp4w_lnd_webstation.nsf/page/3C342451F891CF1D85257A240044F961/$file/LTC_Policy_Paper_1_EN.pdf)

SECTION 2: ADDRESSING SYSTEM PRESSURES

2a) Dealing with Higher Levels of Acuity

A Canadian Institute for Health Information (CIHI) comparison of home care clients and seniors who are living in long term care found that seniors in the latter environment were more likely to require extensive assistance with activities of daily living (ADLs), such as bathing and toileting (74 per cent versus 18 per cent). They were also more likely to have moderate to severe cognitive impairment (60% versus 14%).³⁰

While the overall numbers of seniors are increasing, so too are acuity levels for those entering long term care as trends are showing people are entering care homes later in life. Like BC, and as outlined in a 2015 report, new entrants into long term care in Ontario have much higher levels of impairment. In Ontario, for example, in the 4th quarter of 2009/10, 76% of new admissions had high to very high levels of impairment (35% high and 41% very high). At the end of 2013/14, this figure for new admissions increased to 83%, with most of the growth in the very high category representing 47% of new admissions and growing at 3.9% per year.³¹ In BC, the growth in demand for health care for frail elderly living in long term care, who already utilize about 25% of health services, is projected to increase by 120% by 2036.³²

Acuity levels in B.C.'s care homes are already high and increasing. Using data from the CIHI, the BC Office of the Seniors Advocate reports that 30% of residents in long term care are completely dependent in their activities of daily living (ADL 5+). Furthermore, 63% of residents have dementia, with 30% having severe cognitive impairment (CPS 4+). The average CMI in B.C. is 0.575, which ranges from a low of 0.40 to a high of 0.90. An overview including a breakdown among health authority and affiliate care homes (i.e. private for profit and private non-profit) is provided below.

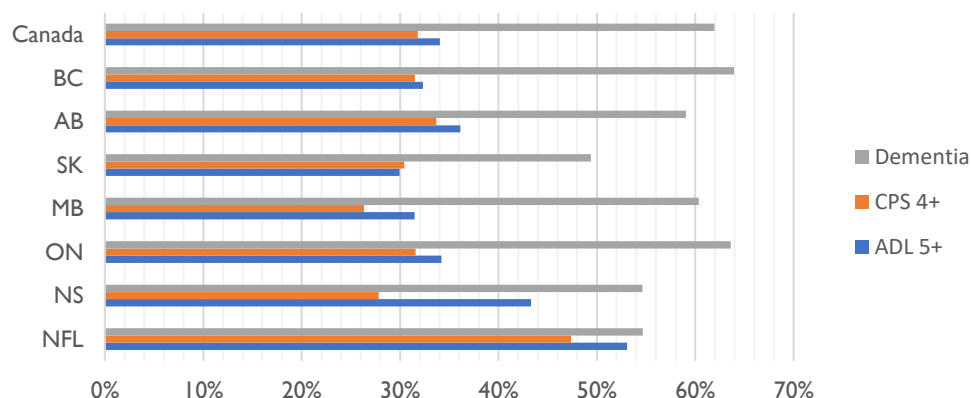
Table 3 – Acuity Levels in B.C. Long Term Care Homes			
	B.C.	HA	Affiliate
Average Case Mix Index (CMI)	0.575	0.596	0.565
% of residents dependent in activities of daily living (ADL 5+)	30%	34%	28%
% of residents with severe cognitive impairment (CPS 4+)	30%	31%	29%
% of residents with dementia	63%	59%	65%
Source: Office of the Seniors Advocate, Residential Care Quick Facts Directory, Summary, 2018.			

³⁰ Canadian Medical Association. CMA Submission: The Need for Health Infrastructure in Canada. March 18, 2013. Accessed at: https://www.cma.ca/Assets/assets-library/document/en/advocacy/Health-Infrastructure_en.pdf

³¹ Ontario Association of Non-Profit Homes and Services for Seniors. Submission to the Ontario Standing Committee on Finance and Economic Affairs. The Need Is Now: Addressing Understaffing in Long Term Care. Ontario. January 2015. Accessed at: <https://www.middlesex.ca/council/2015/january/27/C%207%20-%20CW%20Info%20-%20Jan%2027%20-%20OANHSS2015ProvincialBudgetSubmission.pdf>

³² 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>

Figure 5 – Acuity Levels of Long Term Care Residents by Province, 2016-17



Source: CIHI, Continuing Care Reporting System (CCRS), 2016-17.

According to data available from the CIHI, the acuity levels of residents in care homes across Canada (with the exception of Newfoundland) are fairly consistent. In particular, the figure above demonstrates that BC has the highest proportions of residents with dementia (64% versus the Canadian average of 62%). The rate of dementia in B.C. care homes has increased by 4.8% compared to five years ago.³³ BC is very similar to the Canadian average in terms of portions of residents that have severe cognitive impairment (CPS 4+) and completely dependent in their activities of daily living (ADL 5+).

In addition to long term care, B.C. home care clients are among the most frail in Canada, with 57% of B.C. home care clients assessed as having high or very high need based on the MAPLe algorithm. This is 8.2% higher than the Canadian average and has increased by 3% in B.C. in the last five years.³⁴

Along with increasing levels of acuity with a growing and aging population, a large percentage (41%) of Canadian seniors are dealing with two or more select chronic conditions, such as diabetes, respiratory issues, heart disease, and depression, and many are experiencing a decline in physical and/or cognitive functioning.³⁵ The aging Canadian population is also expected to create an increase of about 40% in cancer cases by 2030. This will result in 277,000 new cases of cancer in 2030.

In 2011, 747,000 Canadians were also living with cognitive impairment, including dementia – that’s 14.9 per cent of Canadians 65 and older. By 2031, this figure will increase to 1.4 million.³⁶ Furthermore, in BC

³³ BC Office of the Seniors Advocate. Seniors at Home & in Long-Term Care: A 2017/18 Snapshot. September 2018. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2018/09/SeniorsatHomeandinLTC-rpt.pdf>

³⁴ BC Office of the Seniors Advocate. Seniors at Home & in Long-Term Care: A 2017/18 Snapshot. September 2018. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2018/09/SeniorsatHomeandinLTC-rpt.pdf>

³⁵ 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

³⁶ Alzheimer’s Society Ontario. Facts about dementia. <http://www.alzheimer.ca/en/on/Aboutdementia/Dementias/What-is-dementia/Facts-about-dementia>.

is estimated the number of BC residents with dementia is expected rise from 70,000 to 110,000 by 2025³⁷, while number of Canadians living with dementia is expected to increase 66% over next 15 years.³⁸

2b) Future Care for Canadian Seniors: A Status Quo Forecast (Conference Board of Canada)

While it is difficult to forecast future demographic trends and utilization of health care services, current projections show that there will be a substantial increase in users particularly with a rapidly aging population. One such analysis was undertaken by the Conference Board of Canada and outlined in a report from November 2015, entitled *Future Care for Canadian Seniors: A Status Quo Forecast*. This report highlights, for example, that by 2026, an estimated 2.4 million Canadians age 65 years and older will require paid and unpaid continuing care supports—a 71 per cent increase over 2011. According to its report, by 2046 this number will reach nearly 3.3 million.³⁹ By 2046, the Conference Board also notes an estimated 458,000 seniors could express unmet or under-met needs—up substantially from the current estimate of about 200,000.⁴⁰

As outlined in the Conference report nearly 204,000 seniors received continuing care supports in various facilities in 2011. Continuing care supports are all forms of assistance provided to seniors who can no longer live independently, as well as the assistance provided to those who can.⁴¹ These supports are delivered in private homes, retirement communities, residential or long-term care homes, and other facilities in the community.⁴²

As outlined in the table below, an estimated 29 per cent of Canadian seniors currently receive continuing care services. The ratio of seniors receiving continuing care is estimated to be highest in Manitoba and lowest in Newfoundland and Labrador. For BC it was approximately 26.6%.

³⁷ Workforce Analysis, Health Sector Workforce Division, Ministry of Health, Dementia (age 45+ years) March 24, 2014, project 2014_010 PHC

³⁸ Canadian Institute for Health Information (CIHI). *Health Care in Canada, 2011: A Focus on Seniors and Aging*. Ottawa: The Institute; 2014 Nov. Accessed at: https://secure.cihi.ca/free_products/HCIC_2011_seniors_report_en.pdf.

³⁹ Conference Board of Canada. *Future Care for Canadian Seniors: A Status Quo Forecast*. November 2015. Report accessible at: https://www.conferenceboard.ca/press/newsrelease/15-11-03/Future_Care_For_Canadian_Seniors_Demand_And_Expenditures_Expected_To_Rise_Dramatically_By_2026.aspx

⁴⁰ Conference Board of Canada. *Future Care for Canadian Seniors: A Status Quo Forecast*. November 2015. Report accessible at: https://www.conferenceboard.ca/press/newsrelease/15-11-03/Future_Care_For_Canadian_Seniors_Demand_And_Expenditures_Expected_To_Rise_Dramatically_By_2026.aspx

⁴¹ Conference Board of Canada. *Future Care for Canadian Seniors: A Status Quo Forecast*. November 2015. Report accessible at: https://www.conferenceboard.ca/press/newsrelease/15-11-03/Future_Care_For_Canadian_Seniors_Demand_And_Expenditures_Expected_To_Rise_Dramatically_By_2026.aspx

⁴² The residential setting included long-term care homes, alternate levels of care, and complex continuing care. Long-term care homes provide medical and professional nursing supervision and residency to nearly 185,000 seniors.

Table 4: Share of Seniors Receiving Continuing Care Supports, by Residential Setting, 2011							
				Facility Living			
	Home living	Community	Total	LTC homes	ALC	Complex Cont. Care	Total
Total provinces	21.8	3.2	4.1	3.7	0.1	0.3	29.0
Newfoundland and Labrador	15.3	2.6	3.6	3.3	0.2	0.1	21.5
Prince Edward island	22.2	2.2	5.1	5.0	0.1	0.0	29.5
Nova scotia	24.7	1.5	4.2	3.9	0.2	0.1	30.4
New Brunswick	25.2	2.8	3.8	3.5	0.3	0.1	31.9
Quebec	19.0	5.4	3.6	3.2	0.1	0.3	28.1
Ontario	24.1	2.0	4.3	4.1	0.1	0.1	30.4
Manitoba	25.1	2.4	6.1	5.4	0.3	0.4	33.5
Saskatchewan	21.6	2.0	5.0	4.7	0.1	0.2	28.6
Alberta	19.4	4.5	4.4	3.9	0.1	0.4	28.4
British Columbia	20.5	2.4	3.7	3.1	0.1	0.4	26.6
Source: Conference Board of Canada. Future Care for Canadian Seniors: A Status Quo Forecast. November 2015. Report accessible at: https://www.conferenceboard.ca/press/newsrelease/15-11-03/Future_Care_For_Canadian_Seniors_Demand_And_Expenditures_Expected_To_Rise_Dramatically_By_2026.aspx							

According to the Conference Board of Canada, the base-case scenario estimates that over 2.4 million Canadian seniors will need and receive continuing care supports in 2026—a 71 per cent increase over 2011. As outlined below, the number of seniors needing and receiving continuing care is projected to exceed 3 million by 2036 and close to 3.3 million by 2046.

Table 5: Current and Projected Future Number of Seniors Receiving Continuing Care Supports, 2011–46				
	2011	2026	2036	2046
Total residential settings	1,434,261	2,454,868	3,016,521	3,288,862
Home living	1,074,340	1,840,022	2,264,457	2,468,067
Community living	156,081	265,691	322,338	351,334
Facility living	203,840	349,155	429,726	469,461
Long-term care home	184,566	316,035	389,074	424,960
Alternate level of care	6,407	10,981	13,517	14,707
Complex continuing care	12,867	22,139	27,135	29,794
Source: Conference Board of Canada. Future Care for Canadian Seniors: A Status Quo Forecast. November 2015. Report accessible at: https://www.conferenceboard.ca/press/newsrelease/15-11-03/Future_Care_For_Canadian_Seniors_Demand_And_Expenditures_Expected_To_Rise_Dramatically_By_2026.aspx				

As outlined in the table above, the number of seniors receiving continuing care at home is projected to increase to over 1.8 million by 2026 and continue to expand to reach nearly 2.3 million by 2036 and 2.5 million by 2046. Under the base-case scenario, it is estimated that long-term care institutions would provide medical and professional nursing supervision to nearly 320,000 seniors by 2026 and 390,000 by 2036. In 2046, over 420,000 seniors would receive this level of care in long-term care institutions. It is also estimated that nearly 30,000 seniors would receive continuing care services from a complex continuing care hospital in 2046.⁴³

System Pressures in Canada

As indicated earlier, all provinces will face significant increases in the seniors population with BC expected to have one of the highest. As outlined in the following table below, BC is expected to see a 150% increase in number of seniors between 2011 and 2046. This is also higher than the Canadian total at about 140% during the same period.

Table 6: Population Projections of Seniors Aged 65+, by Province					
	2011	2026	2036	2046	2011–2046 growth
Total provinces	4,938,430	8,610,429	10,702,866	11,812,670	139%
Newfoundland and Labrador	82,100	140,642	162,991	161,483	97%
Prince Edward island	22,780	39,429	48,117	49,729	118%
Nova scotia	153,365	248,643	287,292	282,941	84%
New Brunswick	123,635	204,155	237,790	239,269	94%
Quebec	1,257,700	2,063,651	2,402,434	2,563,988	104%
Ontario	1,878,290	3,348,935	4,308,312	4,787,566	155%
Manitoba	172,450	274,084	332,961	370,154	115%
Saskatchewan	153,695	233,053	278,900	316,402	106%
Alberta	405,700	820,263	1,086,390	1,322,041	226%
British Columbia	688,715	1,237,573	1,557,677	1,719,097	150%
Source: Conference Board of Canada. Future Care for Canadian Seniors: A Status Quo Forecast. November 2015. Report accessible at: https://www.conferenceboard.ca/press/newsrelease/15-11-03/Future_Care_For_Canadian_Seniors_Demand_And_Expenditures_Expected_To_Rise_Dramatically_By_2026.aspx					

⁴³ Conference Board of Canada. Future Care for Canadian Seniors: A Status Quo Forecast. November 2015. Report accessible at: https://www.conferenceboard.ca/press/newsrelease/15-11-03/Future_Care_For_Canadian_Seniors_Demand_And_Expenditures_Expected_To_Rise_Dramatically_By_2026.aspx

SECTION 3: CURRENT AND FUTURE ACCESS ISSUES

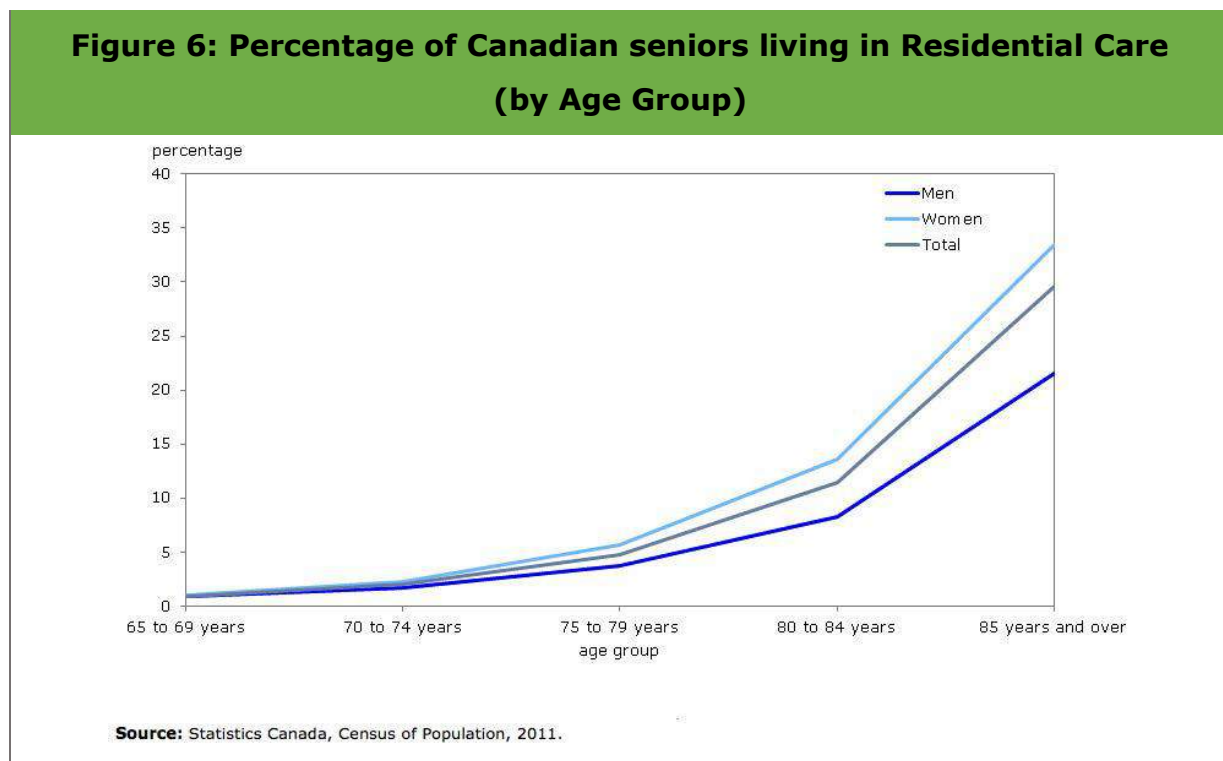
Allowing Seniors to Live in most Appropriate Care Setting

3a) Improved Access to LTC

One of the priorities outlined by the BC Ministry of Health is to allow more seniors to live at home whether this is in a single-family residence or apartment, assisted living or long term care home. As noted by the BC Seniors Advocate, most seniors in BC are living independently (93%), including approximately 90% who own their own home. In total, less than 2% of seniors in BC live in provincially subsidized assisted living (AL) setting, while about 4% live in long term care.

As demonstrated below, a higher percentage of the older age populations in Canada are living in long term care homes including 9% of those over 75 and about 15% of those over 85.⁴⁴ With these trends, it is anticipated the demand for long term care services will continue to increase in the future as the proportion of seniors living in care homes increases with age and the number of elderly seniors will also grow as the aging of the population accelerates.

As the figure below shows, about 1% of people between the age of 65 and 69 live in long term care homes in Canada, while the largest age group living in care-homes is 85 and older at 29.6%.⁴⁵



⁴⁴ 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>

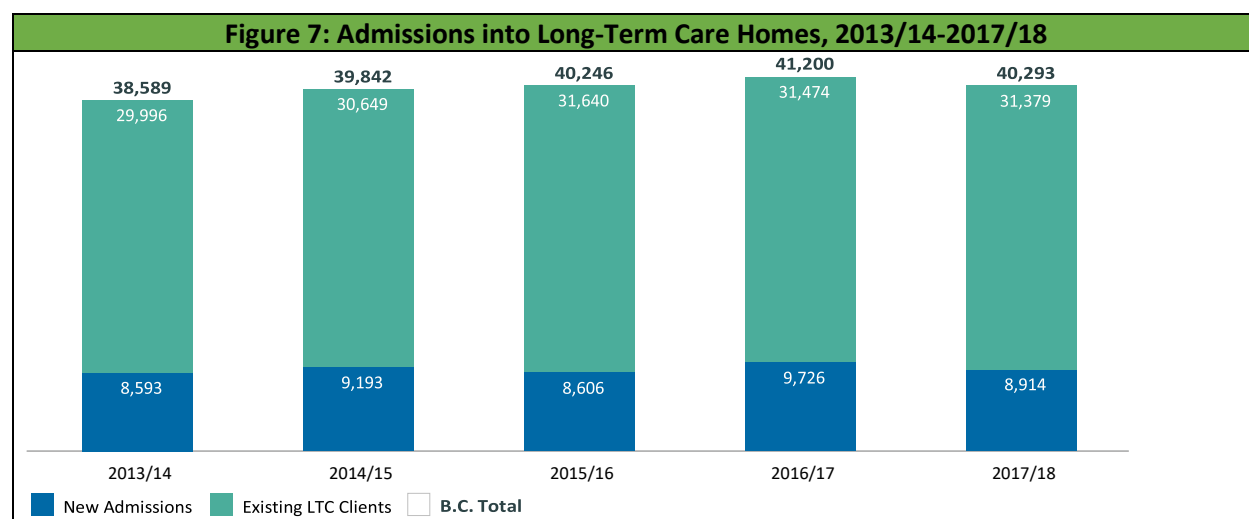
⁴⁵ A Policy Framework to Guide a National Seniors Strategy for Canada. CMA. August 2015. Accessed at: https://www.cma.ca/Assets/assets-library/document/en/about-us/gc2015/policy-framework-to-guide-seniors_en.pdf

In BC, the Ministry of Health has outlined that the growth in demand for health care for frail elderly living in long term care, who already utilize about 25% of health services, is projected to increase by 120% by 2036.⁴⁶ This will require a substantial new number of long term care beds. For example, as discussed further in this report, according to a 2017 Conference Board Canada report, Canada will need an additional 199,000 long-term care beds by 2035, nearly doubling current long-term care capacity. Of this portion BC ranks above the Canadian average of new bed demand by 2035 as a share of each province's 2016 population.⁴⁷

New Admissions to Long Term Care

Factors that influence admission to long term care include the need for physical assistance, cognitive impairment, wandering, living alone and having a caregiver who is unable to continue providing care. As outlined later in this paper, demand for long term care might be offset by developing or expanding home care or assisted living services to address these factors, as well as by further integrating the hospital and continuing care sectors. Seniors, for example, who received their initial assessment in hospital were significantly more likely to be admitted to long term care than seniors who received an initial assessment in the community.⁴⁸

Data from the BC Office of the Seniors Advocate's (OSA) most recent Monitoring Senior's Services report highlights that in 2017/18, there were 40,293 seniors living in long-term care, 2.2% fewer than in 2016/17. The number of residents in long-term care decreased across all health authorities, with the largest decline in Island Health (5%). As seen in the following figure below, in 2017/18, there were 8,914 new admissions (accounting for 22% of the total residents in 2017/18). The number of new admissions decreased 8% over 2016/17 with the largest decreases seen in Fraser Health and Northern Health.⁴⁹



⁴⁶ 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>

⁴⁷ Gibbard, Robyn. Sizing Up the Challenge: Meeting the Demand for Long-Term Care in Canada. Ottawa: The Conference Board of Canada, 2017.

⁴⁸ Canadian Institute for Health Information. Seniors in Transition: Exploring Pathways Across the Care Continuum. Ottawa, ON: CIHI; 2017. Accessed at: <https://www.cihi.ca/sites/default/files/document/seniors-in-transition-report-2017-en.pdf>.

⁴⁹ BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

Table 7: Long-Term Care Clients, 2013/14-2017/18						
Health Authority	2013/14	2014/15	2015/16	2016/17	2017/18	% Change in Last Year
IHA	8,990	9,536	9,548	9,578	9,516	-0.6%
FHA	11,197	11,642	12,131	12,767	12,519	-1.9%
VCHA	8,817	8,778	8,744	8,739	8,617	-1.4%
VIHA	8,088	8,384	8,380	8,546	8,136	-4.8%
NHA	1,623	1,670	1,612	1,781	1,781	0.0%
B.C.	38,589	39,842	40,246	41,200	40,293	-2.2%

Source: BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

First Appropriate Bed policy

Under the current BC “First Appropriate Bed” (FAB) policy adopted by all the health authorities, a senior who has been assessed as ready for a move to long term care must accept the first appropriate bed that becomes available in their chosen geographic catchment area. They have 48 hours to accept and move to the bed offered, or risk being removed from the priority list for a FAB. The FAB policy is essentially designed to ensure that those who are the most in need of a long term care home bed secure that bed as quickly as possible.⁵⁰ The FAB policy is currently, however, being revised with changes expected sometime in 2019. Under the revised policy it is expected it will provide persons with greater options including more choice of beds as well as not be limited to geographical area of residence.

A 2015 OSA report highlights the discrepancy between average wait times and median wait times, showcasing the fact that some people are waiting a very long time for a residential care FAB.⁵¹ In particular, wait times for placement are greater in the north than in the Lower Mainland and are greatest for those who require highly specialized care such as a secure dementia unit.⁵²

In its latest analysis, the OSA reports that in most health authorities clients are not receiving their preferred bed at initial admission. As outlined in BC, only about a third of clients (32%) achieved their preferred placement at initial admission – a rate which has declined over the past four years in Interior, Fraser Health and Vancouver Coastal (see figure below).

⁵⁰ British Columbia. Ministry of Health. (2014). Home and community care: Policy manual.

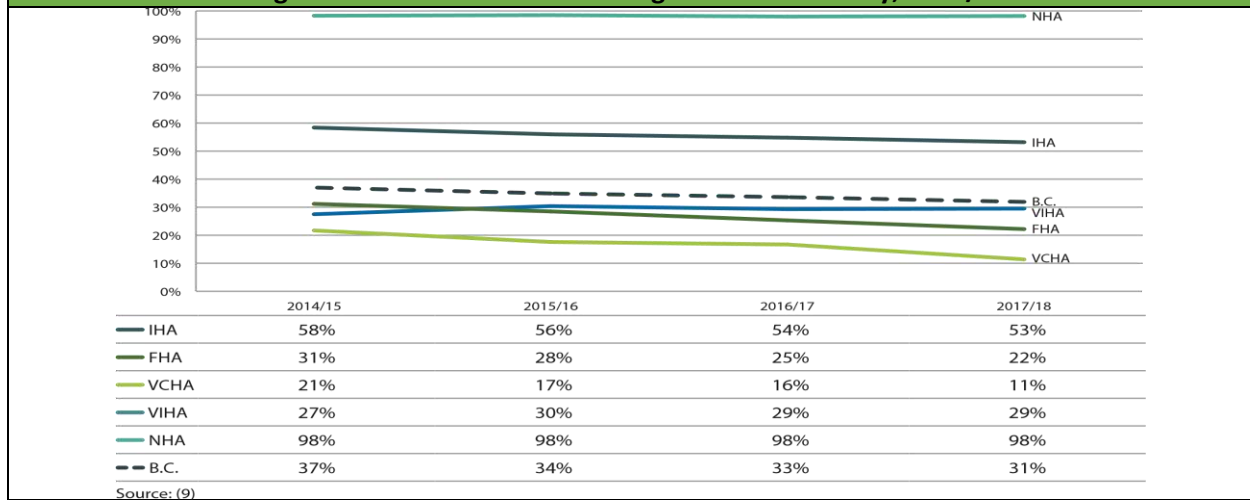
Victoria: Ministry of Health. Retrieved from http://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/hcc-policy-manual/6_hcc_policy_manual_chapter_6.pdf

⁵¹ 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>

⁵² As outlined in the Seniors Advocate *Affordable, Appropriate, Available* report: 67% of clients move to a FAB within 30 days; this ranges from a high of 80% in Vancouver Coastal to a low of 27% in Northern Health Authority; the average length of time waiting for residential care is 36 days and this ranges from a low of 25 days in Vancouver Coastal to a high of 122 days in Northern; the median waiting time is 15 days ranging from a low of 9 days in Vancouver Coastal to 96 days in Northern; seniors get their preferred bed at time of the FAB move anywhere from 23% to 45% of the time; seniors get to their preferred bed after moving to a FAB anywhere from 4% to 22% of the time; and overall, residents end up in their facility of choice anywhere from 34% to 67% of the time.

Figure 8: Access to Preferred Long-Term Care Facility, 2017/18



Source: BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

In a December 2016 OSA report, it also highlighted that wait times for long term care are getting longer. In particular, it notes that the average and median wait times for long term care increased in three of five regional health authorities and the proportion of residents admitted to long term care within the target window of 30 days decreased from 64% in 2014/15 to 57% in 2015/16.⁵³ The BCCPA believes that adopting new models, such as the Continuing Care Hub discussed later, may not only improve access to long term care and services for seniors in the community, but could also increase choice for seniors utilizing the current FAB policy.

Wait Lists into long term care

With a rapidly aging population, the demand for long term care in BC and Canada is growing. The BC Office of the Seniors Advocate (OSA) reported in 2016, for example, that average wait times for long term care grew in three of five regional health authorities between January 2016 and September 2016.⁵⁴

As outlined in the table below, as of March 2018 there were about 1400 (1379) persons waiting for admission into long term care – about a 7 percent increase from previous year. The majority or about 75 percent of those waiting for admission into long term care (1039 of 1379) were those living in the community compared to the rest who were waiting in hospital. The latter, namely those waiting in hospital are part of what is referred to as alternate level of care (ALC) patients, which is discussed later on in this paper.

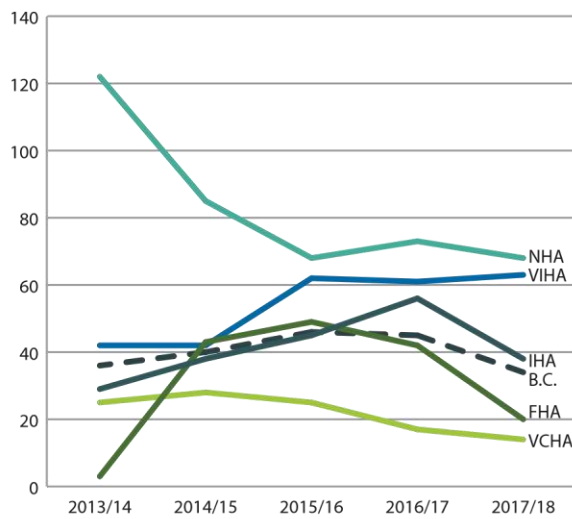
⁵³ Office of the Seniors Advocate. *Monitoring Seniors' Services* (2016). December 2016. Accessed at: <https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2016/12/OSA-MonitoringReport2016.pdf>

⁵⁴ Office of the Seniors Advocate. *Monitoring Seniors Services* 2016. Accessed at: <https://www.seniorsadvocatebc.ca/osa-reports/report-monitoring-seniors-services-2016/>

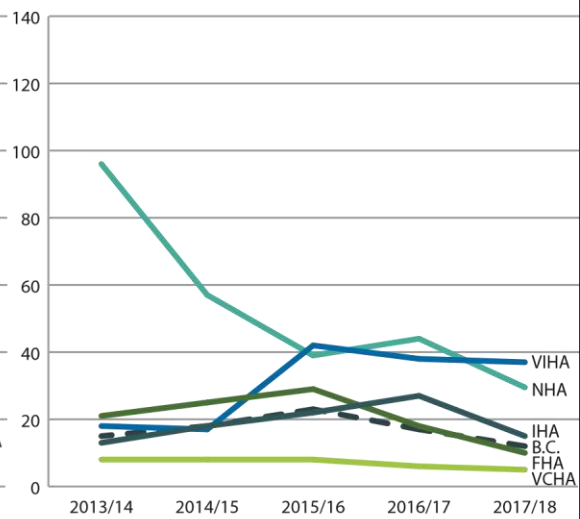
Table 8: Wait Times for Clients on the Waitlist for Long-Term Care, on March 31, 2018

Health Authority	Number on the Waitlist	Average Wait Time (Days)	Median Wait Time (Days)	Maximum Wait Time (Days)
IHA	480	134	55	1,196
FHA	99	41	22	632
VCHA	92	50	14	1,041
VIHA	446	99	63	648
NHA	262	282	147	2,627

Average Wait Time for Clients Admitted to Long-Term Care, 2013/14-2017/18



Median Wait Time for Clients Admitted to Long-Term Care, 2013/14-2017/18



IHA	29	38	45	56	38	13	18	22	27	15
FHA	3	43	49	42	20	21	25	29	18	10
VCHA	25	28	25	17	14	8	8	8	6	5
VIHA	42	42	62	61	63	18	17	42	38	37
NHA	122	85	68	73	68	96	57	39	44	29
B.C.	36	40	46	45	34	15	18	23	17	12

Source: (20)

Source: BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

Table 9: Percent of Seniors Admitted to Long-Term Care within 30 Days, 2013/14-2017/18					
Health Authority	2013/14	2014/15	2015/16	2016/17	2017/18
IHA	73%	63%	58%	53%	67%
FHA	62%	57%	52%	63%	82%
VCHA	80%	80%	82%	88%	90%
VIHA	60%	62%	40%	45%	45%
NHA	27%	36%	44%	45%	50%
B.C.	67%	64%	57%	61%	71%

Source: BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

As outlined in the above table, of the seniors who went into long-term care in 2017/18, 71% were admitted within the Ministry of Health's target window of 30 days. This is a major improvement over 2016/17 where the proportion of new admissions within 30 days was 61%. In Vancouver Coastal, 90% of new admissions were admitted within 30 days, while Island and Northern Health had the lowest proportion of clients admitted within the target window at 45% and 50% respectively. The lower numbers for these health authorities may be in part due to a lack of available care beds particularly in more rural and remote locations. As such, any future strategy to address the need for long term care beds should also address access challenges and availability of such beds in rural and remote locations.

It should be noted that both Fraser Health and Interior saw major increases in total percentage of seniors admitted to long term care home within 30 days (14% increase in Interior and 19% in Fraser). The increase in Fraser Health may in part attributable to its Residential Care Optimization initiative, which is explored in detail later in this paper.

While BC should be commended for its relatively low wait times, the BCCPA would still like to see these times reduced, where possible, in order to achieve an average of 30 days or less province-wide and across all health authorities. As noted later in the paper, the BCCPA believes this is feasible with additional investments to long term care.

While BC has no specific provincial target for long term care waits, Alberta has established having a target ensuring that at least 65 percent of those waiting can access long term care within 30 days.⁵⁸ The BCCPA believes that this is a target or goal that BC should also adopt going forward. The BCCPA would also like to see such a target outlined as a specific goal in its Ministry of Health Annual Service Plan.

⁵⁸ Calgary Herald. Alberta government missing targets for accessing long-term care. James Wood. July 23, 2018. Accessed at: <https://calgaryherald.com/news/politics/government-missing-targets-for-accessing-continuing-care>

Recommendation # 1

That the BC government reduce the number of people on long term care wait lists by establishing a target within its Ministry of Health Annual Service Plan to ensure at least 65 per cent of those waiting for a bed can access one within 30 days.

3b) Improving Access to Home Health Care and Assisted Living

In the early 2000s, it became apparent that the demand for long term care needed careful management due to a combination of factors, including rising costs, significant growth in the number of seniors and recognition that seniors value their independence highly, preferring to remain in the community for as long as possible. In response, many jurisdictions like BC began introducing new types of care in an effort to redirect people with less complex needs away from long term care.⁵⁹ These services (such as assisted living and supportive housing) allow individuals to enjoy the benefits of living more independently in the community but typically cost less to provide than long term care, in part because they do not provide more costly 24-hour nursing support.⁶⁰

As discussed later in this paper, some of the future demand for long term care could be potentially offset by ensuring appropriate supports are in place in other areas of the continuing care sector such as home health care and assisted living. As noted in a report from the Canadian Institute for Health Information (CIHI), the practice of admitting seniors to long term care who could have been supported in home care can have undesirable consequences, such as a longer stay in long term care, a negative impact on patient outcomes and potential displacement of higher-needs individuals (restricting patient flow).⁶¹

Access to home health care

Accessing home health care in BC also poses barriers to care for BC seniors. Between 2000/01 and 2015/16, the rate of home care client visits in BC declined by 15 per cent, in all but one health authority.⁶² BC Ministry of Health data also shows that between 2000/01 and 2015/16, access to home support in BC, measured by number of home support clients per 1,000 seniors aged 75 and older, fell by 30 per cent.⁶³ Along with a decline in access, the scope of home support services being provided has also diminished. For example, housekeeping and related tasks are now excluded.

Access issues to home health care are highlighted in an August 2017 report by the BC Office of the Seniors Advocate (OSA). The OSA, for example, notes that despite the increasing complexity of home

⁵⁹ Canadian Centre for Elder Law. *Discussion Paper on Assisted Living: Past, Present and Future Legal Trends in Canada*. 2008. (FN – 23)

⁶⁰ Canadian Institute for Health Information. *Seniors in Transition: Exploring Pathways Across the Care Continuum*. Ottawa, ON: CIHI; 2017. Accessed at: <https://www.cihi.ca/sites/default/files/document/seniors-in-transition-report-2017-en.pdf>

⁶¹ Canadian Institute for Health Information. *Seniors in Transition: Exploring Pathways Across the Care Continuum*. Ottawa, ON: CIHI; 2017. Accessed at: <https://www.cihi.ca/sites/default/files/document/seniors-in-transition-report-2017-en.pdf>

⁶² Whereas access decreased in Northern Health (–59 per cent), Vancouver Coastal Health (–25 per cent), Fraser Health (–23 per cent) and Interior Health (–1 per cent), the client visit access rate increased by 9 per cent in Vancouver Island Health.

⁶³ Home support access declined in all health authorities: Northern Health (–54 per cent), Vancouver Coastal Health (–49 per cent), Interior Health (–25 per cent), Vancouver Island Health (–19 per cent) and Fraser Health (–16 per cent).

support clients the number of home support hours for clients 65 or older increased by 2 per cent, but the average hours per day per client decreased by 5, signaling less intensive service. Access limitations appeared to extend beyond the home support realm, into other areas of the community care sector. In fact, the number of home support clients accessing adult day programs (ADP) also decreased by 5 per cent and the number of days delivered to these clients declined by 2 per cent.⁶⁴

As outlined in the latest OSA Monitoring Services report in 2017/18, there of the 43,831 clients receiving publicly subsidized home support services; approximately 88% were 65 or older and 73% were 75 or older. The number of home support clients, however, declined in Fraser, Island, and Northern health authorities in 2017/18 and remained essentially the same in Interior and Vancouver Coastal while the seniors population grew across the province (3.5% for 65 or older and 2.4% for 80 or older).⁶⁵

Table 10: Number of Clients Receiving Home Support, 2013/14-2017/18

Health Authority	2013/14	2014/15	2015/16	2016/17	2017/18	% Change in Last Year
IHA	8,361	8,797	9,291	9,460	9,471	0.1%
FHA	12,225	12,934	13,691	14,408	14,166	-1.7%
VCHA	9,318	8,937	8,674	9,457	9,449	-0.1%
VIHA ¹	9,470	9,492	9,335	9,553	9,286	-2.8%
NHA	1,545	1,598	1,696	1,744	1,670	-4.2%
B.C.¹	40,624	41,603	42,465	44,442	43,831	-1.4%

Source: BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

In 2017/18, 93,651 clients received professional home care services in B.C., 72% of whom were 65 or older, and 52% were 75 or older. While the number of professional services clients increased 1.5% this was largely due to an increase of 10.2% in Interior Health. There were decreases in Fraser Health (3.5%), Island Health (3.3%) and Northern Health (9.3%). Likewise, the number of visits increased 9.6% in Interior Health but decreased in all other health authorities so that the overall change was very small (-0.1%).

Table 11: Home Care Clients, 2013/14-2017/18

Health Authority	2013/14	2014/15	2015/16	2016/17	2017/18	% Change in Last Year
IHA	22,204	24,431	26,063	27,591	30,407	10.2%
FHA	20,652	20,786	21,246	22,616	21,819	-3.5%
VCHA	18,358	19,066	19,114	19,809	20,137	1.7%

⁶⁴ Office of the Seniors Advocate. Caregivers in Distress: A Growing Problem. August 2017. Accessed at: <https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2017/08/Caregivers-in-Distress-A-Growing-Problem-Final.pdf>

⁶⁵ BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

VIHA	17,946	17,811	17,823	19,067	18,444	-3.3%
NHA	3,882	3,673	3,508	3,653	3,315	-9.3%
B.C.	82,650	85,333	87,315	92,262	93,651	1.5%

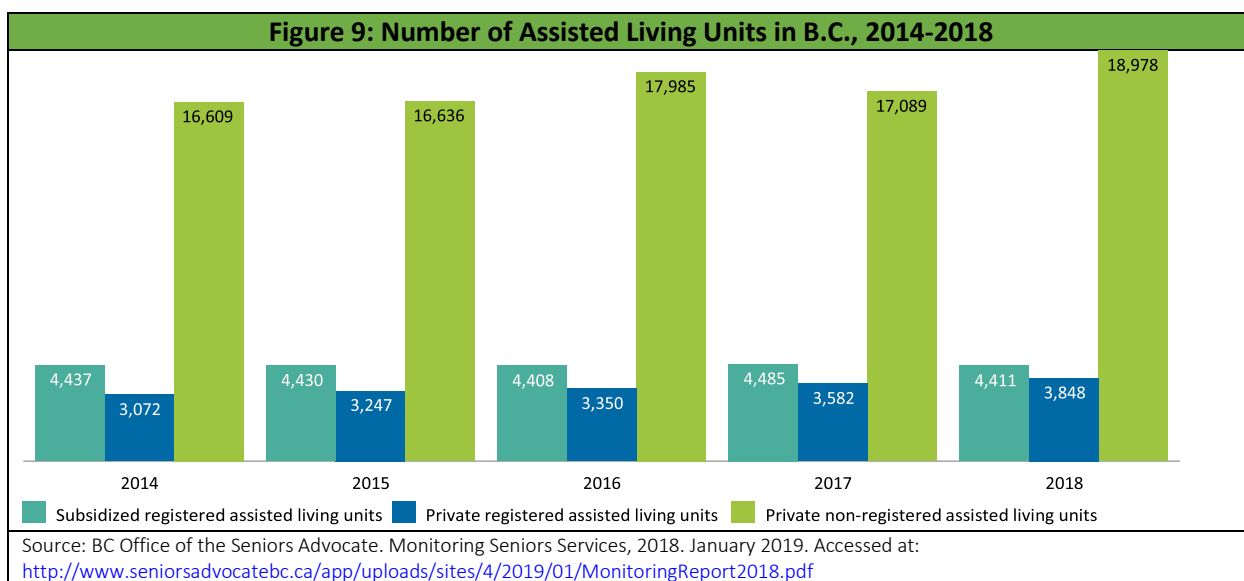
Source: BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

While home health care waits are not the focus of this report, ways to improve such access, however, are outlined in the 2018 BCCPA report entitled *Health Begins at Home*. In this report, for example, it recommended significant investments in areas such as increasing home health visit times and preventative visits.⁶⁶ As outlined later in this paper, there is also the possibility to offset some of the demand for long term care through the provision of greater home health care.

Access to Assisted Living

Like home health care, the assisted living sector in BC is in high demand. As of March 31, 2017, 750 individuals were on the waitlist for a subsidized registered assisted living unit in BC.⁶⁷ In BC, 141 registered assisted living buildings contain subsidized assisted living units.

As of March 31, 2018, there were 4,411 subsidized registered assisted living units, a 2% decrease over last year, and 3,848 private registered assisted living units, a 7% increase over 2017.⁶⁸ A breakdown is seen in the following figure below.

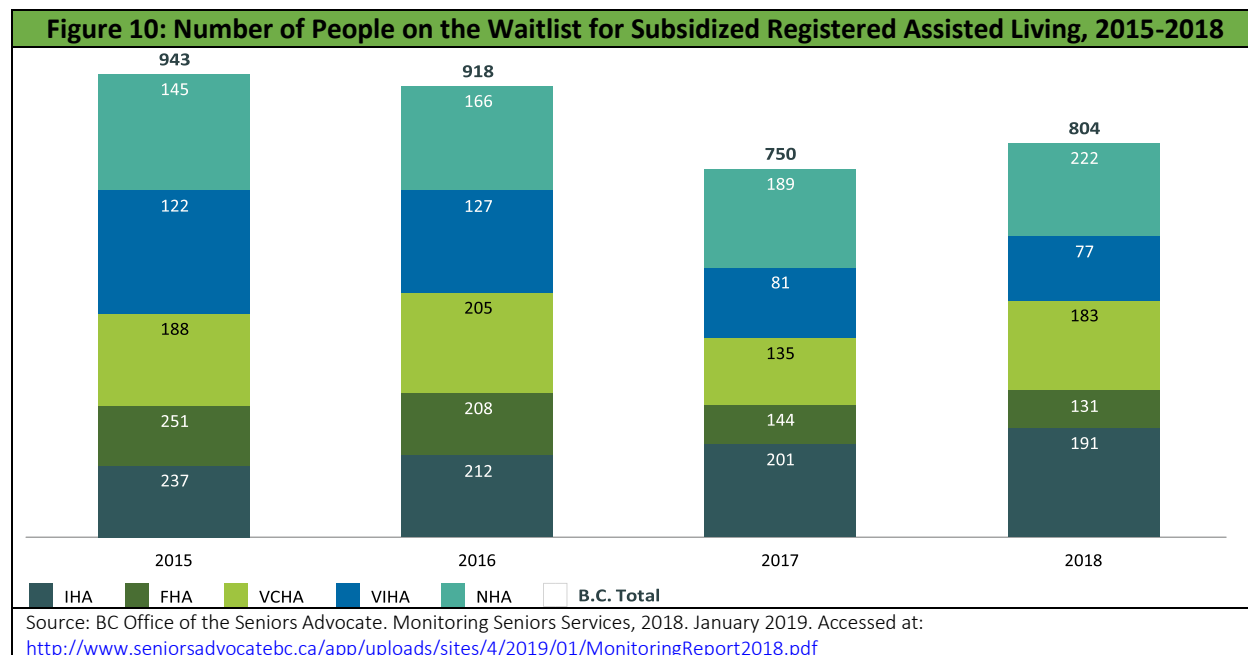


⁶⁶ BCCPA. Health Begins at Home: Strengthening BC's home health Care Sector. February 2018. Accessed at: <https://bccare.ca/wp-content/uploads/2018/02/BCCPA-Home-Health-Care-Paper-2018.pdf>

⁶⁷ BC Office of the Seniors Advocate. Monitoring Seniors Services, 2017. December 2017. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2017/12/MonitoringReport2017.pdf>

⁶⁸ BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

Despite relatively small numbers compared to long term care (one sixth that of number of LTC beds) the number on such wait lists is quite high relative to long term care. For example, while about 1400 persons were waiting for long term care in March of 2018, there were 804 individuals waiting for subsidized registered assisted living units.⁶⁹



Waits in Assisted Living

The BCCPA attempted to obtain specific wait time data for AL from the BC Ministry of Health. In response, however, the Ministry stated that because clients have the ability to choose an assisted living facility, and may be willing to wait longer for their preferred location, they do not calculate wait times.

As discussed later in this paper, with the pending changes to Assisted Living particularly with Bill 16, unless capacity is significantly expanded it is anticipated that the number of people on wait lists and perhaps wait times may increase substantially. Currently registered assisted living regulated under the Community Care and Assisted Living Act (CCALA), allows facilities to provide residents up to two out of six prescribed services; typically, assistance with activities of daily living (e.g., dressing) and administration of medication. Private non-registered assisted living residences, however, are not limited to two of the six prescribed services. Legislative changes to the CCALA have been approved that will eliminate the restriction to two prescribed services but regulations for the changes are still under review.

Similar to long term care there is limited choice also in assisted living. In Fraser Health, Interior Health, and Vancouver Coastal Health, for example, individuals may only be placed on one assisted living residence waitlist; however, they may choose which residence to apply. In Island Health and Northern

⁶⁹ BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

Health, individuals may place themselves on waitlists for multiple assisted living residences . While there is availability in some Island Health residences, seniors may choose to wait for a unit to become available in their preferred residence.⁷⁰

As discussed later in this paper, in Alberta grants have been made available to help private and non-profit operators build new continuing care spaces with many designated for supportive living (similar to assisted living in BC). These living arrangements are thought to be a less costly (for public payers) and more appropriate alternative to long-term care beds for many seniors. Research from B.C. has found that most assisted-living residents in that province come from the community, with some publicly funded home health services in place, and about half of the residents in assisted living subsequently move on to long term care.⁷¹

The BCCPA in a separate policy paper released in January 2019 addressed many of the key issues related to Bill 16 and the future of assisted living including improving access and quality of care.⁷² As such, the focus of this paper is on long term care, particularly ways to better meet increasing demand while improving access.

Monitoring and Reporting of Wait Times

While the BCCPA applauds the Office of the Seniors Advocate (OSA) for reporting wait list information for long term care and assisted living in their Annual Reports, the BCCPA would like to see greater reporting of such wait list and wait time information by the BC Ministry of Health and health authorities. Currently, aside from these annual reports, there is very limited information on long term care waits and even less so on future long term care bed projection demands. When BCCPA contacted Health Authorities about its projections for future long term care beds it noted that their forecasts are in development and/or cannot be shared publicly.

In particular, the BCCPA would support the development of a provincial website for home and community care waits similar to its surgical wait list registry where it reports on wait times for various procedures. Such a new website could include relevant wait time and wait list information for long term care as well as assisted living and potentially home health care. It should also be updated regularly or at least every couple of months to highlight areas such as average wait times or numbers for long term care. The BCCPA believes this would help assist in planning and meeting established wait time targets.

Recommendation # 2

That the BC government and health authorities establish a website to track wait time information for long term care, including potentially assisted living and home health care waits. This website should also be updated regularly or at least once every two months.

⁷⁰ BC Office of the Seniors Advocate. Monitoring Seniors Services, 2017. December 2017. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2017/12/MonitoringReport2017.pdf>

⁷¹ BC Legal Institute and Canadian Centre for Elder Law. Report on Assisted Living in British Columbia. September 2013. Accessed at: http://www.bcli.org/wordpress/wp-content/uploads/2013/10/report_72_assisted-living-in-BC.pdf

⁷² BCCPA. A Report on Bill 16 (2016) and the Future of Assisted Living. January 2019. Accessed at: <https://bccare.ca/wp-content/uploads/2019/01/BCCPA-Report-Bill-16-AL-2019.pdf>

3c) Alternate Level of Care (ALC) Beds

Alternate level of care (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 or beds (including long term care). In BC, the cost of treating a senior in hospital ranges from \$825 to \$1,968 per day, whereas the cost of long term care is approximately \$200 per day.⁷³

Currently, approximately 14% of Canadian hospital beds are filled with patients (85% of which are over 65) who are ready to be discharged but have no appropriate place to go. Over a single year, these patients' use of acute hospital beds exceeds 2.4 million days, which equates to over 7,500 acute care beds each day.⁷⁴ A conservative national estimate of additional costs to provincial governments for caring for ALC patients is approximately \$3 billion per year.^{75 76}

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.⁷⁷ 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.⁷⁸ The most recent data from the OSA shows that in 2017/18, there were approximately 406,000 hospital inpatient days designated as ALC in BC with the overwhelming majority being seniors.

⁷³ BCCPA. Op-ed: Let's Stop Seniors from Languishing in Hospitals. February 2016. Accessed at: <https://bccare.ca/2016/02/op-ed-lets-stop-seniors-languishing-hospitals/>

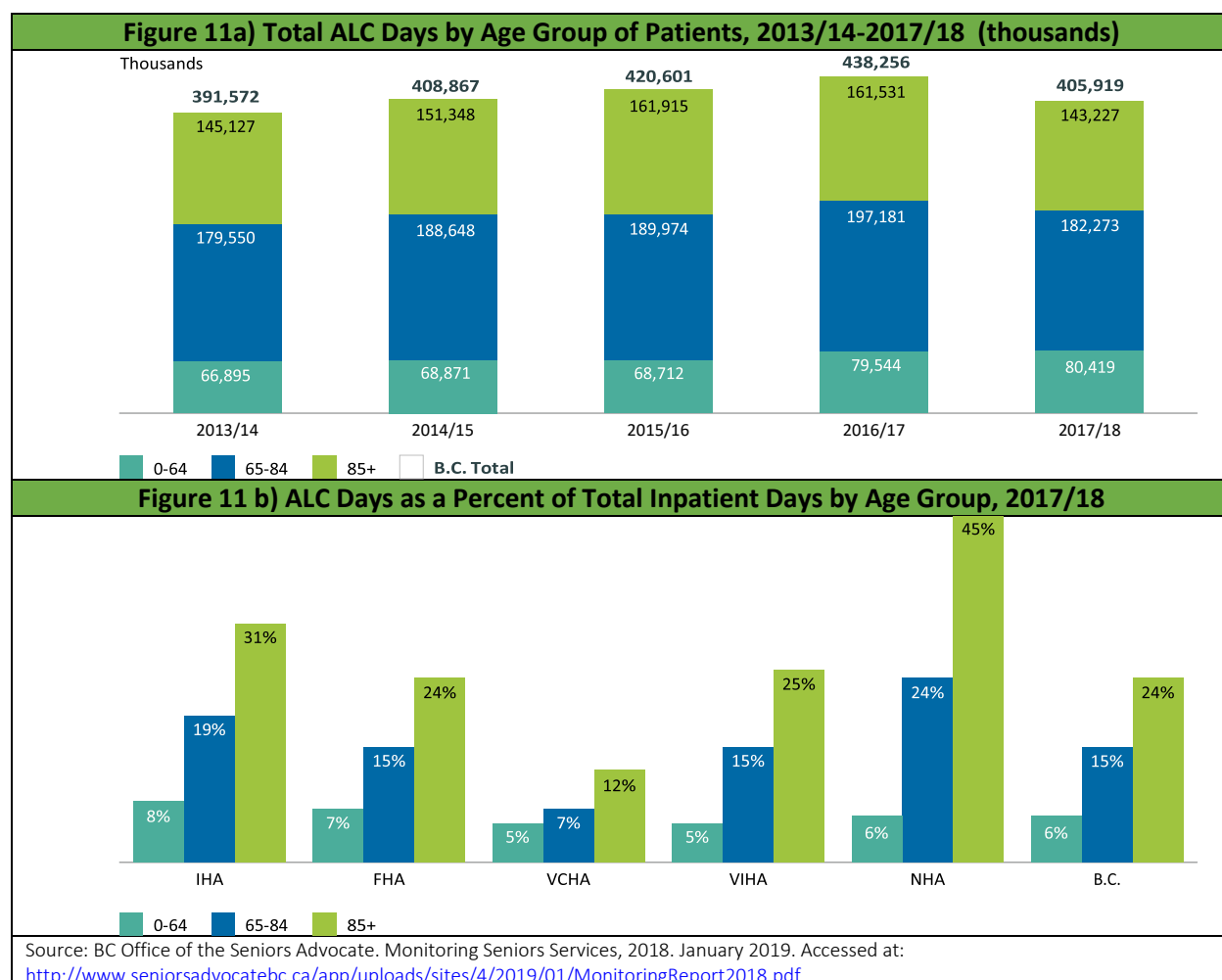
⁷⁴ Exploring alternative level of care (ALC) and the role of funding policies: An evolving evidence base for Canada. Canadian Health Services Research Foundation. September 2011. Accessed at: http://www.cfhi-fcass.ca/sf-docs/default-source/commissioned-research-reports/0666-HC-Report-SUTHERLAND_final.pdf

⁷⁵ CD Howe Institute. Commentary No. 443. Shifting Towards Autonomy: A Continuing Care Model for Canada. Ake Blomqvist and Colin Busby. 2016. Accessed at: https://www.cdhowe.org/sites/default/files/attachments/research_papers/mixed/Commentary_443.pdf

⁷⁶ 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: CLHIA. Improving the accessibility, quality and sustainability of long-term care in Canada. June 2012. Accessed at: http://www.longwoods.com/blog/wp-content/uploads/2012/06/LTC_Policy_Paper.pdf

⁷⁷ 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-QulC-FINAL-2015.pdf>

⁷⁸ 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



As outlined in the 2015 BCCPA *Quality-Innovation-Collaboration* (QIC) paper, a 50% reduction in ALC days could generate significant cost savings to the health system. For example, assuming 50% of ALC days could be reduced by caring for patients in long term 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.⁷⁹

The problem with ALC beds not only creates fiscal pressures, but with 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.⁸⁰ Such wait times and access issues have been well documented. In 2012, for example, it was reported that 461,000 Canadians were

⁷⁹ 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-QulC-FINAL-2015.pdf>

⁸⁰ 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>

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.⁸¹

There are many reasons for the high rates of ALC patients, including the lack of appropriate community supports to prevent hospitalizations, as well as to return patients to a more appropriate setting after they receive hospital care.⁸² 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 one 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.⁸³

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.⁸⁴ In particular, one critical area for improving the ALC situation is the better reporting of such data. The UK's National Health Service, for example, reports monthly ALC rates as delayed transfers of care including outlining the causes of delay by region and facility.⁸⁵

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, including developing strategies to reduce ALC beds and offset acute care pressures. The BCCPA, for example, has recommended the creation of a new publicly accessible online registry to report on ALC and vacant long term care beds, as well as the use of current vacant beds within care homes, assisted living units and home support to reduce acute care pressures. To assist in this process, the BCCPA also developed a website (Mycafinder.ca), which it will be updating later in 2019 to highlight the level of vacant long term care beds and assisted living units across the province.

Well designed home care and home support services with quick response capabilities can also be effective in getting seniors out of acute care. Vancouver Island Health's Quick Response Team, for example, provides crisis intervention at home to eligible clients when required, aimed at preventing avoidable hospital admission, providing crisis intervention at home, and facilitating early hospital discharge.⁸⁶

⁸¹ 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>

⁸² 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>

⁸³ 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.

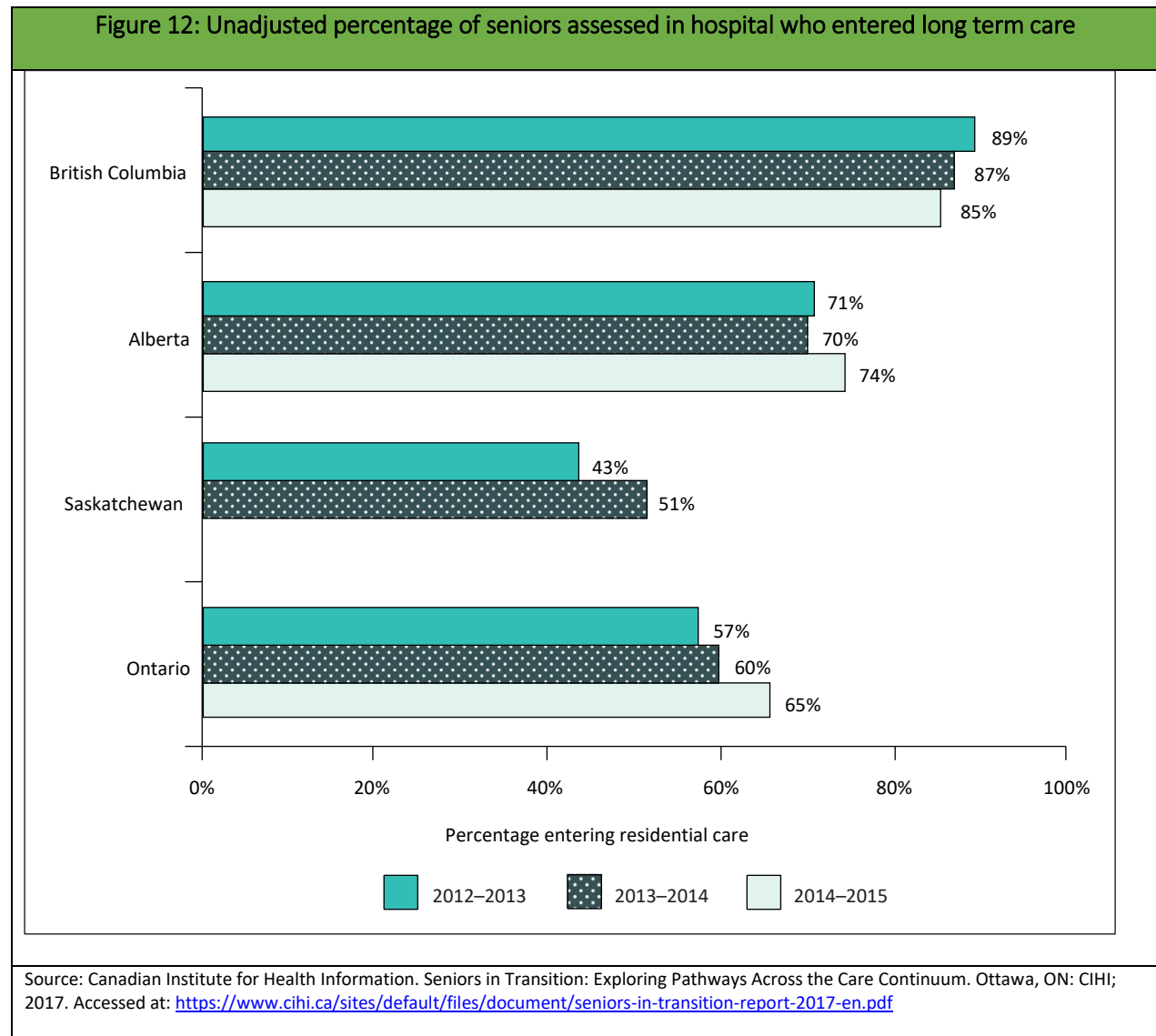
⁸⁴ Wait Time Alliance. 2015. Eliminating Code Gridlock in Canada's Health Care System: 2015. Wait Time Alliance Report Card Accessed at: <http://www.waittimealliance.ca/wp-content/uploads/2015/12/EN-FINAL-2015-WTA-Report-Card.pdf>

⁸⁵ 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

⁸⁶ 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/>

ALC and LTC Bed Projections

While reducing ALC days is a notable goal in itself, it also demonstrates the need for additional capacity in long term care. In BC, similar to the rest of Canada, many seniors go from a hospital to a residential or long term care setting. This is highlighted, for example, in the following figure from the Canadian Institute for Health Information (CIHI).



As of August 2017 in BC there were 1484 persons waiting for admission into long term care compared to 1309 in March 2017 (total increase of 13 percent). The majority or over 70 percent of those waiting for admission into long term care (1081 or 1484) were those living in the community compared to the rest who were waiting in hospital (i.e. ALC patients).

Table 12: Wait list for admission into Long Term Care						
	(As of March 2017)			(As of August 2017)		
HA	Community	Hospital	Total	Community	Hospital	Total
IHA	414	62	476	416	60	476
FHA	126	24	150	155	71	226
VCHA	69	41	128	55	55	110
VIHA	251	84	335	273	134	407
NHA	170	50	220	182	83	265
BC	1030	261	1309	1081	403	1484
Source: OSA, Monitoring Seniors Services (2017)						

Along with outlining wait lists for long term care, the OSA in its 2017 Monitoring Seniors Services report for the first time looked at the ALC issue. The table below, for example, highlights ALC days as a percent of total inpatient days from 2014-15 to 2016-17. As seen below, while there are differences among the different health authorities on average for seniors under 85 at about 15% ALC days as percent of total inpatient days, this increases to over 25% (26%) for those aged 85 or older.

Table 13: ALC Days as a Percent of Total Inpatient Days (2014-15 to 2016/17)								
	2014/15		2015/16		2016/17		Percentage change in last year	
HA	65-84	85+	65-84	85+	65-84	85+	65-84	85+
IHA	18.6%	33.7%	19.0%	37.5%	18.9%	34.4%	-0.5%	-8.2%
FHA	15.9%	26.2%	16.0%	26.5%	16.5%	25.8%	2.9%	-2.8%
VCHA	9.2%	14.6%	8.0%	12.8%	8.5%	13.8%	5.1%	7.3%
VIHA	15.1%	20.5%	16.7%	26.2%	15.9%	24.6%	-4.3%	-6.2%
NHA	25.3%	41.6%	23.0%	39.5%	25.8%	50.2%	12.3%	27.0%
BC	15.2%	24.4%	15.2%	26.0%	15.6%	25.7%	2.4%	-1.1%
Source: OSA, Monitoring Seniors Services (2017)								



In the table below the OSA also looked at average length of stay (in days) of ALC cases between 2014/15 to 2016/17. As highlighted, seniors who were classified as ALC, stayed on average 21 days (three weeks).

Table 14: Average Length of Stay (days) of ALC cases, 2014/15 to 2016/17								
	2014/15		2015/16		2016/17		% Change in last year	
HA	65-84	85+	65-84	85+	65-84	85+	65-84	85+
IHA	14.2	15.5	15	17.9	15.2	16.3	1.3%	-8.9%
FHA	23.6	21.7	23.7	21.2	18.5	17.4	-21.9%	-18.0%
VCHA	20.5	18	21.3	19	17.7	17.8	-17.0%	-6.3%
VIHA	37.8	26.5	45	39.9	45.1	38.7	0.1%	-3.2%
NHA	56.5	63.1	58.3	60	70.5	81.5	20.9%	35.9%
BC	22.9	20.9	24	23.5	21.6	21.4	-10.0%	-8.9%
Source: OSA. Monitoring Seniors Services (2017)								

Overall, the BCCPA believes that reducing ALC levels should continue to be a priority. As such, the BCCPA continues to advocate as recommended in the 2017 paper *Strengthening Seniors Care* that as a goal the BC Ministry of Health work to set a target 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.⁸⁷

In particular, the BCCPA recommends that as a new goal the BC Ministry of Health work to set as a target 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 long term or home care setting by the end of 2024. Similar to the earlier target to ensure that 65 percent of those waiting for a bed can access one within 30 days, the BCCPA believes the new ALC target should also be outlined in the BC Ministry of Health Annual Service Plan.

Recommendation # 3

That the BC Ministry of Health establish a target in its Annual Service Plan to have no more than 5 percent of acute care beds occupied each day by seniors who have been assessed as capable of being transferred into a more appropriate long term or home care setting and that this target be met by the end of 2024.

⁸⁷ BCCPA. Strengthening Seniors Care. January 2017. Accessed at: https://bccare.ca/wp-content/uploads/2017/01/BCCPA_Roadmap_Full_Jan2017.pdf

3d) Addressing Future Long Term Care Bed Access Issues (including excess capacity)

While the rate of residency in long-term care homes among seniors has been declining, as the aging of Canada's population accelerates, the demand for long term care will nonetheless increase significantly over the near term due to higher numbers of elderly seniors.⁸⁸ As outlined earlier, long-term care residents are older today than in previous years and have more complex health needs than ever before.

Despite the increased availability of home care, research commissioned for the Canadian Medical Association (CMA) indicates that demand for long term care will surge as the demographic shift progresses. In an earlier projection, the CMA forecasted the shortage of long term care beds between 2016 and 2020. In particular, by 2020 it projected a shortage of long term care beds across Canada to be over 38,000. It also estimated significant costs to address this shortage or close to \$10.3 billion.

Estimated cost to address forecasted shortage in long-term care beds, 2016–20 (\$ million)

Year	Forecasted shortage in long term care beds		Estimated cost to address shortage
2016	6,028		1,621.5
2017	6,604		1,776.5
2018	8,015		2,156.0
2019	8,656		2,328.5
2020	8,910		2,396.8
Total	38,213		10,279.3

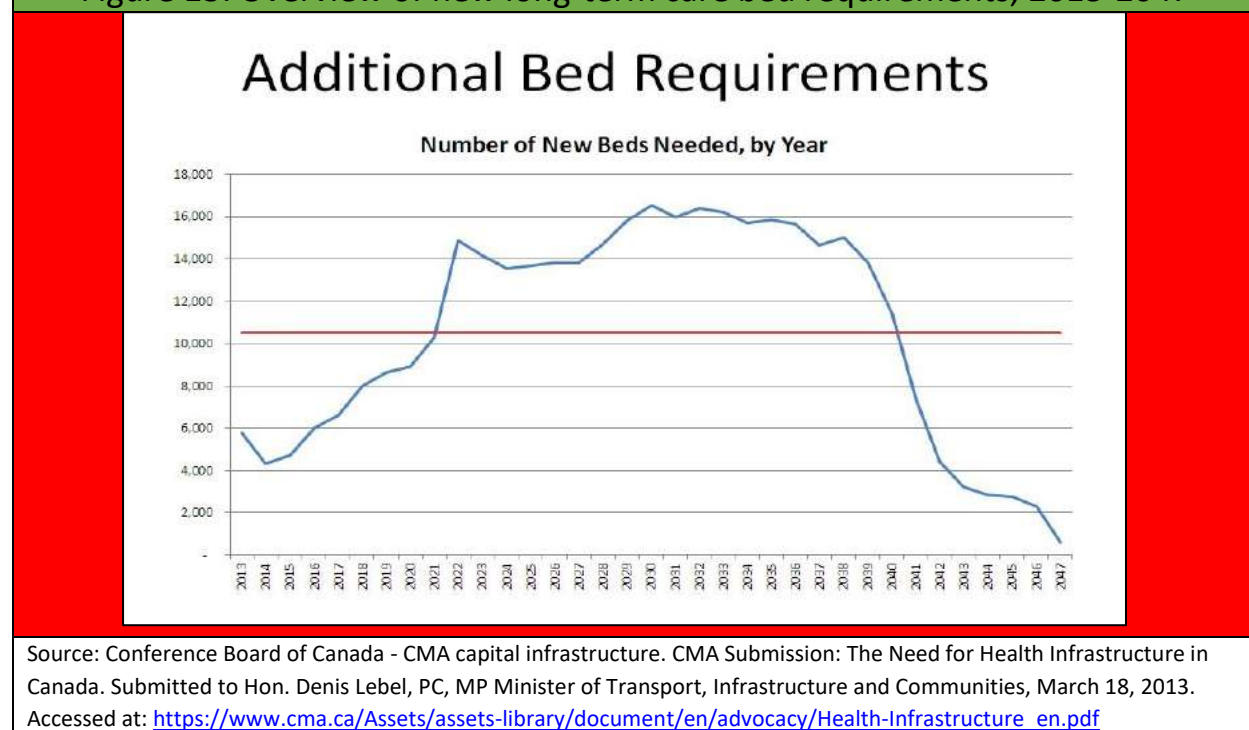
It is important to note that while the sector anticipates with a growing seniors population, particularly aging boomers, that demand for long term care, including beds, may also eventually plateau or even decline. As noted in a report from the Manitoba Centre for Health Policy, the baby boom will begin to turn 85 years old starting around 2031.⁸⁹ This in part reflected in the following chart by the CMA prepared by the Conference Board which shows that around 2031 there will be some decreases in new long term

⁸⁸ CMA. CMA Submission: The Need for Health Infrastructure in Canada. March 2013. Submitted to Hon. Denis Lebel, PC, MP Minister of Transport, Infrastructure and Communities. Accessed at: https://www.cma.ca/Assets/assets-library/document/en/advocacy/Health-Infrastructure_en.pdf

⁸⁹ Manitoba Centre for Health Policy. Projecting Personal Care Home Bed Equivalent Needs in Manitoba Through 2036. Chateau D, Doupe M, Walld R, Soodeen R, Ouelette C, Rajotte L. October 2012. Accessed at: http://mchp-appserv.cpe.umanitoba.ca/reference/MCHP_pch_days_report_WEB.pdf

beds required with a major decline in 2039.⁹⁰ This is partly due to these boomers aging out of the system and, therefore, not requiring such services.

Figure 13: Overview of new long-term care bed requirements, 2013-2047



As highlighted in the figure above, when planning for new the introduction of beds, consideration will also need to be given about excess capacity. In particular, government, care providers and other stakeholders will have to consider what to do when there are declining rates of demand and how any excess beds or long term care spaces could be converted to other uses. For example, some possible uses could be for additional seniors supportive housing (including independent / assisted living) and/or as part of a strategy to reduce homelessness. While this discussion is beyond the scope of this paper it will need to be considered nevertheless as part of any future strategy.

⁹⁰ Manitoba Centre for Health Policy. Projecting Personal Care Home Bed Equivalent Needs in Manitoba Through 2036. Chateau D, Doupe M, Walld R, Soodeen R, Ouelette C, Rajotte L. October 2012. Accessed at: http://mchp-appserv.cpe.umanitoba.ca/reference/MCHP_pch_days_report_WEB.pdf

SECTION 4: CHALLENGES PROJECTING FUTURE LONG TERM CARE NEEDS

As outlined in a 2017 Conference Board of Canada report, there are three categories of current demand for long term care including:

- Those currently in long-term care beds;
- Those who should be in long-term care beds, but who are occupying acute care beds in hospitals due to lack of space in long-term care home (i.e. alternate level of care); and
- Those who are living at home or with a caregiver but whose needs are not being met and who should be in a long-term care home.

As highlighted later in this paper, the Conference Board of Canada has produced a bed forecast tied to the growth of the population aged 75 and over and based on a decreased bed ratio demand of 0.59 per cent per year to reflect the greater shift to community-based services and supportive housing options being advanced at the provincial level.⁹¹ This bed ratio demand is also described by the Canadian Healthcare Association as representing a modest shift from the current reliance on long-term care to community services. Based on these assumptions, it has been estimated that Canada will require an average of 10,535 new beds per year over the next 35 years, for a total of 637,721 beds by 2047.

4a) Methods for projecting future long term care needs

While establishing a projection for future long term care bed needs can seem simple in theory, in reality it is quite difficult due to a constantly changing health care landscape. In BC, for example, this includes systemic health changes such as to assisted living with Bill 16 or policies such as Home is Best or Home First which encourage seniors to remain at home as long as possible.

In addition to these systemic changes, there are different approaches which can be used to project long term care bed forecasts each with its pros and cons. As outlined in a report by the North West Territories, the three basic approaches used in long term care demand projections include: 1) Set Ratio Approach; 2) Demand Based Approach; and 3) Needs Based Approach. Within these approaches there also different variations. An outline of these approaches and different variations is provided in Appendix A.⁹²

4b) Redefining LTC Bed Needs - Long Term Care Bed Equivalents (LTCBEs)

Manitoba Centre for Health Policy

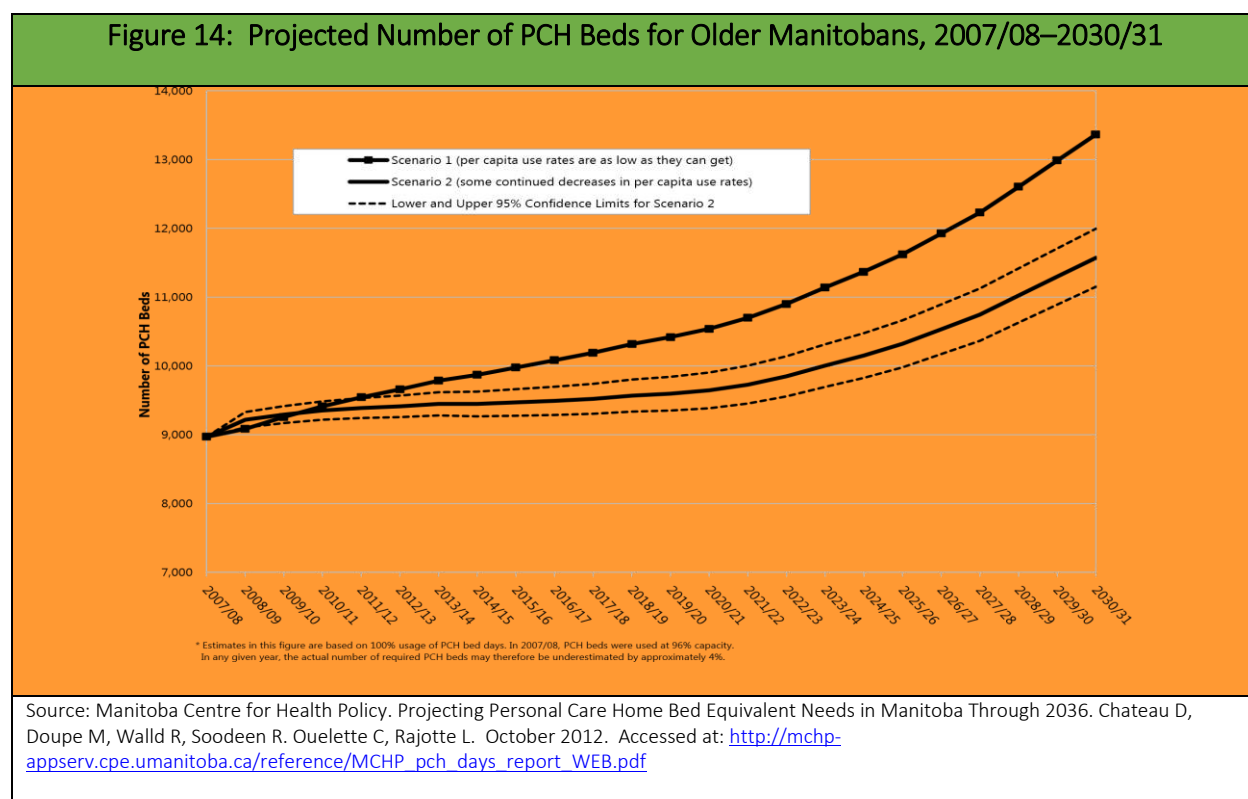
One of the most comprehensive long term care bed projections undertaken in Canada was seen in a November 2012 report by the Manitoba Centre for Health Policy (MCHP). The projections in that report,

⁹¹ The 0.59 per cent decrease in bed ratio is presented as Scenario 2 in Lazurko, M. and Hearn, B. Canadian *Continuing Care Scenarios 1999-2041*, KPMG Final Project Report to FPT Advisory Committee on Health Services, Ottawa. 2000. Presented in Canadian Healthcare Association, *New Directions for Facility-Based Long-Term Care*.

⁹² Government of the Northwest Territories. Northwest Territories Long-Term Care Program Review. Final Report. December 2015. Accessed at: <https://www.hss.gov.nt.ca/sites/hss/files/nwt-long-term-care-program-review.pdf>

however, are not for personal care home (PCH) beds but rather for the care that is currently being provided via PCH beds or what they define as PCH bed equivalents.

As outlined by the Institute of Public Policy and Research (IRPP), the MCHP report provides an excellent example of how this broader conceptualization can inform real-world policy and planning. In their projections of the future supply of personal care home beds in the province, the MCHP emphasizes that those determining rates of bed utilization must consider care that could have been provided by other means such as supportive housing or expanded home care. As such, they adopt the terminology of “bed equivalents” and conclude that after the first boomers turn 85, between 5,100 and 6,300 extra bed equivalents will be needed in personal care home beds, supportive housing and expanded home care (see figure below).⁹³



In the MCHP report it outlines that supportive housing is generally seen as a substitute for PCH care for those residents with relatively lower care requirements, and suggests that future analyses should, therefore, focus on PCH bed equivalent projections.⁹⁴ Supportive housing, particularly assisted living in

⁹³ Institute for Research and Public Policy. Integrating Long-Term Care into a Community-Based Continuum: Shifting from “Beds” to “Places”. A. Paul Williams, Janet Lum, et al. February 2016. Accessed at: <http://irpp.org/wp-content/uploads/2016/02/study-no59.pdf>

⁹⁴ Manitoba Centre for Health Policy. Projecting Personal Care Home Bed Equivalent Needs in Manitoba Through 2036. Chateau D, Doupe M, Walld R, Soodeen R. Ouelette C, Rajotte L. October 2012. Accessed at: http://mchp-appserv.cpe.umanitoba.ca/reference/MCHP_pch_days_report_WEB.pdf

BC, will also change bed projection demand needs. This is particularly true as discussed with the changes envisioned with Bill 16 as outlined later.

In the MCHP report, the number of people that could be expected to need PCH care (i.e., population projections for people 65+ years old) was combined with the PCH use rate for the same population in the future. Applying the rate to the number of people resulted in a total number of PCH bed equivalent days required. This was done separately by each age group and sex as the resulting numbers were added to get a total for a Regional Health Authority.⁹⁵ The total projected number of PCH days for a RHA was transformed into the number of beds by dividing the number of days by 365 (days in a year).⁹⁶

Table 15: PCH Bed Equivalent Projections Based on the Continuing Trends by RHA for Select Years

RHA	2011	2021	2031	2036
Western	1,886	1,730	1,885	2,083
Winnipeg	5,368	5,550	7,006	8,383
Southern	1,125	1,250	1,634	1,918
Interlake-Eastern	724	980	1,346	1,557
Northern	162	216	338	414
Manitoba	9,265	9,725	12,208	14,355

Source: Manitoba Centre for Health Policy. Projecting Personal Care Home Bed Equivalent Needs in Manitoba Through 2036. Chateau D, Doupe M, Walld R, Soodeen R, Ouelette C, Rajotte L. October 2012. Accessed at: http://mchp-appserv.cpe.umanitoba.ca/reference/MCHP_pch_days_report_WEB.pdf

The key message from the MCHP report is that the period from 2021 until 2036 the province of Manitoba will see a dramatic increase in the need for PCH bed equivalent care. This is mainly due to the increase in the number of individuals that fall into the age range where the majority of PCH care is provided (65+) and, in particular, the size of the population age 85+.

The timing of the increase in PCH bed equivalent need is also closely tied with the aging of the baby boom generation; they began to enter the 65–74 year age group in 2011, the 75–84 year age group in 2021, and the 85+ year age group in 2031. In total, the projected increased need in the capacity of care for the elderly is approximately 5,100 PCH bed equivalents.⁹⁷

As noted in the MCHP report, the reference to a PCH bed equivalent, rather than PCH beds is intentional and critical. A PCH bed equivalent is defined as being a PCH bed, a supportive housing bed, or some type of enhanced homecare service or services provided to group living. As noted by the researchers, in

⁹⁵ For instance, if an RHA was projected to have 2,000 85+ year-old females in the year 2031 and they were expected to require 80,000 days per 1,000 population, then the RHA would require 160,000 PCH bed equivalent days of care for this group in 2031. (the expected rate multiplied by the expected population). Assuming maximum occupancy rates, this would translate into about 438 PCH beds (i.e., 160,000 ÷ 365).

⁹⁶ Manitoba Centre for Health Policy. Projecting Personal Care Home Bed Equivalent Needs in Manitoba Through 2036. Chateau D, Doupe M, Walld R, Soodeen R, Ouelette C, Rajotte L. October 2012. Accessed at: http://mchp-appserv.cpe.umanitoba.ca/reference/MCHP_pch_days_report_WEB.pdf.

⁹⁷ Manitoba Centre for Health Policy. Projecting Personal Care Home Bed Equivalent Needs in Manitoba Through 2036. Chateau D, Doupe M, Walld R, Soodeen R, Ouelette C, Rajotte L. October 2012. Accessed at: http://mchp-appserv.cpe.umanitoba.ca/reference/MCHP_pch_days_report_WEB.pdf

Winnipeg, alternative services (non PCH beds) could potentially divert just over 12.5% of PCH days as outlined in data from a previous report published by MCHP (Doupe et al., 2011). A more optimistic view of the data in that report would indicate that around 19.5% of days may be able to be diverted from traditional PCH care. This would mean that of the 3,014 extra PCH bed equivalents projected for Winnipeg from 2011 to 2036, over half (1,635) could be supportive housing or enhanced homecare.⁹⁸

Follow-up from MCHP Report

While it is good to have such projections, it will also be important to ensure that provincial governments and health authorities also appropriately address the need for increased demand. This has not necessarily been the case in Manitoba despite these forecasts and pledges by government to increase demand. As noted in one recent article, a 100-bed Tabor Personal Care Home in Morden, Manitoba was the only new care home completed in 2017/18 and no new personal care home (PCH) beds were added the previous year.

In January of 2018, the Winnipeg Regional Health Authority estimated Winnipeg would need to add about 200 more PCH beds each year to fully serve its aging population. Between January 1 and March 31, 2018, there were 208 residents waiting for PCH beds within the Prairie Mountain Health Authority and 341 waiting within the Southern Health Authority.

The current Manitoba government had earlier pledged to add 1200 PCH beds over the next eight years.⁹⁹ As outlined in an October 2018 news article, the Manitoba government's election pledge to "fast-track" the construction of 1,200 new personal care home has been delayed further. According to updated mandate letters from Premier Brian Pallister to all cabinet ministers, the government is now saying they plan to have 1,200 new PCH beds open by 2025 or one year later than originally planned.¹⁰⁰

⁹⁸ Manitoba Centre for Health Policy. Projecting Personal Care Home Bed Equivalent Needs in Manitoba Through 2036. Chateau D, Doupe M, Walld R, Soodeen R, Ouellette C, Rajotte L. October 2012. Accessed at: http://mchp-appserv.cpe.umanitoba.ca/reference/MCHP_pch_days_report_WEB.pdf

⁹⁹ Winnipeg Sun. Province coming up short on personal care home beds, NDP accuse. Joyanne Pursaga. May 24, 2018. Accessed at: <http://winnipegsun.com/news/provincial/province-coming-up-short-on-pch-beds-ndp-accuse>

¹⁰⁰ Winnipeg Sun. BRODBECK: Tories' nursing home beds delayed further. October 30, 2018. Accessed at: <https://winnipegsun.com/opinion/columnists/brodbeck-tories-nursing-home-beds-delayed-further>

SECTION 5: ESTIMATE OF BC LTC PROJECTION NEEDS (POPULATION APPROACH)

5a) British Columbia Data

As outlined in its 2017 Monitoring Seniors Services report, the BC Office of the Seniors Advocate (OSA) provides current figures with respect to publicly funded long term care beds. For example, as of March 31, 2017, there were close to 28,000 (27,829) publicly funded long term care beds in BC (including health authority-owned and operated as well as contracted care homes). As outlined in the OSA report and seen in the table below the rate of change of long term care beds across the province does not, however, align with the rate of growth in the senior's population (i.e. 1.5% versus 3.5%).

Table 16: Publicly Funded Long Term Care Beds in BC (2013-2017)							
HA	2013	2014	2015	2016	2017	% change in last year	Percent Pop Change 75+ (2015/16)
IHA	5589	5708	5688	5695	5799	1.80%	2.60%
FHA	7997	8174	8265	8275	8569	3.60%	4.20%
VCHA	6815	6822	6852	6840	6816	-0.40%	3.80%
VIHA	5376	5381	5451	5434	5465	0.60%	3%
NHA	1144	1153	1170	1179	1180	0.10%	3.40%
BC	26,921	27,238	27,426	27,423	27,829	1.50%	3.50%
Source: OSA Monitoring Seniors Services, 2017							

If long term care beds grew at the population percentage increase for those 75 or older in BC (see table below), the increase in beds would have been over 500 more than what actually occurred. While over one year this may not seem significant, compounded over multiple years it can create a large gap. In particular, as outlined from Conference Board of Canada the actual current bed demand in BC (as of 2016) is 33,300 while the current bed figure or the number of current beds in BC is closer to 30,000.^{101 102}

Health Authority	If number of LTC beds grew by pop change (75+)	Actual growth	Difference
IHA	5843	5799	44
FHA	8623	8569	54
VCHA	7100	6816	284
VIHA	5597	5465	132
NHA	1220	1180	40
BC	28383	27829	554

¹⁰¹ The 30,000 figure is determined by adding the publicly funded beds (about 28,000) above along with approximately 1,600 private-pay licensed long term care beds.

¹⁰² BC Office of the Seniors Advocate. Seniors' Housing in B.C.: Affordable, Appropriate, Available. May 2015. Accessed at: <https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2015/09/SeniorsHousingReport.pdf>

According to the OSA's latest Monitoring Seniors Services report - as of March 31, 2018 the current number of long term care beds in BC was 27,846 – which is largely the same or only an increase of 17 beds from 2017. Additionally, as noted in the report from 2014 to 2018, while the number of publicly funded beds increased 2%, the seniors population aged 75 or older grew 14%.¹⁰³

Average and Median Length of Stay in BC LTC Homes

It is important to note and as discussed later in the paper, that some of the requirements in long term care beds may be offset by reductions in length of stay (LOS). The table below from the OSA highlights, for example, some of these changes over the past couple of years.

Table 17: Median and Average Length of Stay in Long Term Care, 2014/15 to 2016/17						
	2015/2016 Q1		2016/17 Q1		% change 2015/16 to 2016/17	
Health Authority	Median LOS (days)	Average LOS (days)	Median LOS (days)	Average LOS (days)	Median LOS (days)	Average LOS (days)
IHA	464	709	351	650	-24%	-8%
FHA	497	828	489	794	-2%	-4%
VCHA	462	863	637	1017	38%	18%
VIHA	513	844	350	730	-32%	-14%
NHA	783	1100	833	1091	6%	-1%
BC	500	822	447	806	-11%	-2%
Source: OSA Monitoring Seniors Services, 2017						

While there have been some changes over the past year, the overall average LOS in long term care homes in B.C. has either remained fairly constant or increased over the past five years across the five regional health authorities, contrary to anecdotal reports from health authorities and operators. For all of B.C., there was a 17.6% increase from 705 days in 2009/10 to 829 days in 2014/15, and a 4.7% increase from 2013/14 (791 days) to 2014/15 (829 days).¹⁰⁴

According to latest data, in 2017/18, the median length of stay in long-term care for all clients discharged during the year was 480 days - a 9% decrease over the previous year. The median length of stay varies between 1 and 2 years across all health authorities. The median length of stay is also probably a better measure as it is more stable than the ALOS and as such is outlined in the table below.¹⁰⁵

¹⁰³ BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

¹⁰⁴ BC Ministry of Health. Residential Care Staffing Review. March 2017. Accessed at: <https://www.health.gov.bc.ca/library/publications/year/2017/residential-care-staffing-review.pdf>

¹⁰⁵ BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

Table 18: Median Length of Stay in Long-Term Care, 2013/14-2017/18						
Health Authority	2013/14	2014/15	2015/16	2016/17	2017/18	% Change in Last Year
IHA	352	389	391	467	367	-21%
FHA	539	577	578	527	494	-6%
VCHA	617	566	620	580	620	7%
VIHA	481	463	510	517	480	-7%
NHA	645	802	766	710	719	1%
B.C.	495	498	533	529	480	-9%
Source: BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf						

As outlined later, health authorities including Fraser Health through its Residential Care Optimization initiative are attempting to reduce length of stay (LOS) as one way to reduce or mitigate the need for new long term care beds.

5b) Conference Board of Canada – Modeling or Projection Data

In its 2017 report, the Conference Board of Canada provides a detailed national and provincial demographic forecast of the Canadian population. As outlined earlier, that report also outlines several areas for determining demand for long term care including:

- Those currently in long-term care beds;
- Those who should be in long-term care beds, but who are occupying acute care beds in hospitals due to lack of space in long-term care home (i.e. alternate level of care); and
- Those who are living at home or with a caregiver but whose needs are not being met and who should be in a long-term care home.

After accounting for efforts to shift more long-term care into individuals' homes, the Conference Board estimates that by 2035, Canada will need an additional 199,000 beds in long-term care homes. This represents a near doubling of the current stock of 255,000 beds.¹⁰⁶

The Conference Board report also estimates that the annual operating cost for one long-term care bed is \$75,000 (in 2017 dollars) and that the average per bed cost of constructing long-term care homes is approximately \$320,000. By combining these figures with its demand projections, it estimates that the new long-term care beds will cost \$64 billion to build and \$130 billion, or an average of \$7 billion a year, to operate through 2035.¹⁰⁷

¹⁰⁶ Gibbard, Robyn. Sizing Up the Challenge: Meeting the Demand for Long-Term Care in Canada. Ottawa: The Conference Board of Canada, 2017.

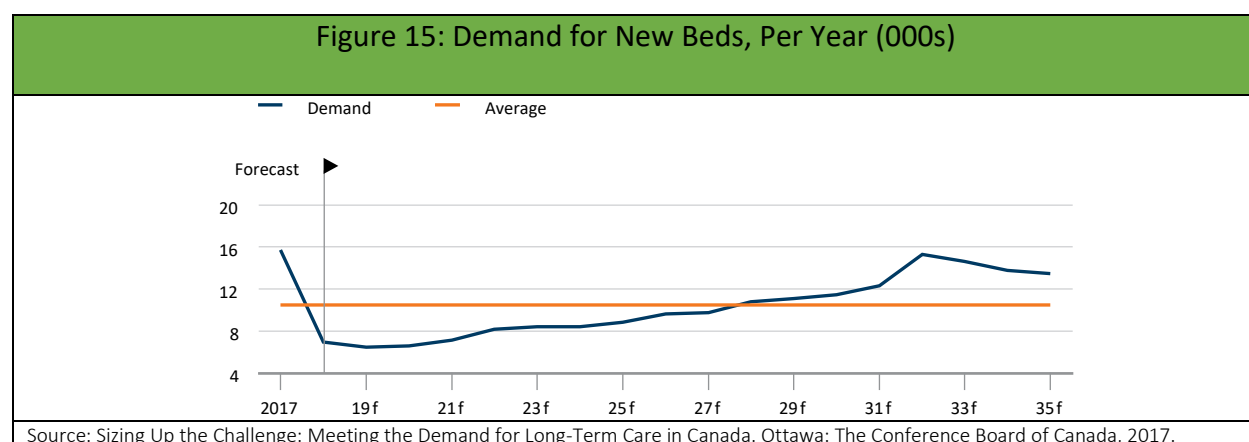
¹⁰⁷ Ibid.

Between current long-term care beds and ALC patients, the Conference Board estimates that the current demand for long-term care in Canada in 2016 is approximately 263,000 beds (of which 8,400 were unsatisfied demand in the form of ALC beds).¹⁰⁸

Among those aged 85 to 94 living in Canada in 2016, approximately 16.3 per cent were living in a long-term care home or in an ALC bed. This group's population was approximately 721,000 in 2016, meaning that the use of long-term care beds was approximately 118,000 among this age group. By 2035, the population in this age group will have more than doubled to 1,464,000. As a result, demand for long-term care beds among this cohort will also more than double to 239,000.¹⁰⁹

Based on research by Lazurko and Hearn (2000), the Conference Board assumes that the demand for beds in long-term care homes will grow at a rate that is 0.59 percentage points slower than demographics alone would indicate.¹¹⁰ After applying a home-care adjustment, the new demand required is equivalent to an average annual increase of approximately 10,500 beds from 2017 to 2035.

As outlined in the Conference Board report, their projection forecast shows the demand for new beds increasing steadily upward to a peak in 2032 before plateauing. According to its overall forecast, and as seen in the figure below, Canada will require 454,000 long-term care beds by 2035, an increase of 199,000 from 2016.



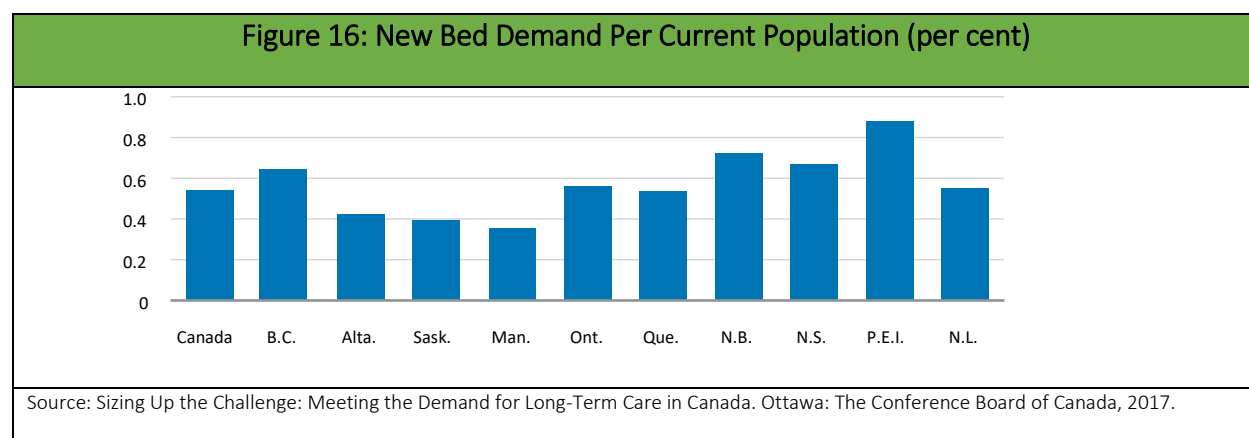
For the entire country, long-term care bed demand represented 0.7 per cent of the total population in 2016. Demand, however, was above 0.8 per cent in Nova Scotia, whereas it was below 0.5 per cent for Alberta's younger population. The figure below shows new bed demand by 2035 as a share of each province's 2016 population. As seen, the province facing the greatest challenge is Prince Edward Island where the number of new beds it must build by 2035 is equivalent to nearly 0.9 per cent of its current

¹⁰⁸ Ibid.

¹⁰⁹ Ibid.

¹¹⁰ For example, demographic calculations suggest that, in 2025, demand for long-term care beds will grow by 3.3 per cent from the previous year. In our final calculations, we instead apply a growth rate of 2.7 per cent in that year. This has the effect of lowering the utilization rate for each age category: for instance, utilization of long-term care beds among 85–94 year-olds falls from 16.3 per cent in 2016 to 13.7 per cent by 2035.

population. The other Maritime provinces are close behind, with new bed needs equal to about 0.7 per cent of their current population. Central Canada has demand closer to 0.6 or 0.5 per cent of its current population, with BC slightly above this.¹¹¹



As indicated in the above figure, BC has a higher new bed demand per current population than Canadian average and most provinces. The next section provides more specific information that the BCCPA obtained from the Conference Board of Canada.

5c) BC Data – Conference Board of Canada

In July 2018, the BCCPA was able to obtain data specific to BC which shows that the actual current bed demand in BC (as of 2016) is 33,300. This is higher than the current number of beds in BC, which when including private and publicly subsidized beds is closer to 30,000 (i.e. approximately 28,000 publicly subsidized beds and 1600 private pay). As outlined by the Conference Board, the current bed ratio as a share of population is about 7.2 per 1,000 population.

The Conference Board report also projects that by 2035 an additional 30,900 long term care beds in BC are needed above existing demand. That equates to approximately 64,000 beds that will be required to meet demand. As a percentage of population this equates to approximately 11.3 per 1,000.

As outlined by the Conference Board, the costs of these new beds are also quite significant including about \$10 billion (\$9.9 billion) for constructing new beds and \$20 billion for operating the beds or cumulatively about \$2.3 billion annually by 2035.

¹¹¹ Gibbard, Robyn. Sizing Up the Challenge: Meeting the Demand for Long-Term Care in Canada. Ottawa: The Conference Board of Canada, 2017.

BC Long Term Care Bed Demand (Information provided by Conference Board of Canada)

- Current bed demand in BC (as of 2016): 33,300
- New bed demand in BC by 2035: 30,900
- Current beds in BC as a share of population (2016): 7.2 per 1,000 population
- 2035 beds in BC as a share of population: 11.3 per 1,000 population
- New bed construction cost for BC: \$9.9 billion (2017 \$)
- New bed operating cost for BC: \$20.0 billion (2017 \$) cumulatively, or \$2.3 billion annually by 2035.

Figure 17: BC LTC Bed Demand Projections - Conference Board of Canada

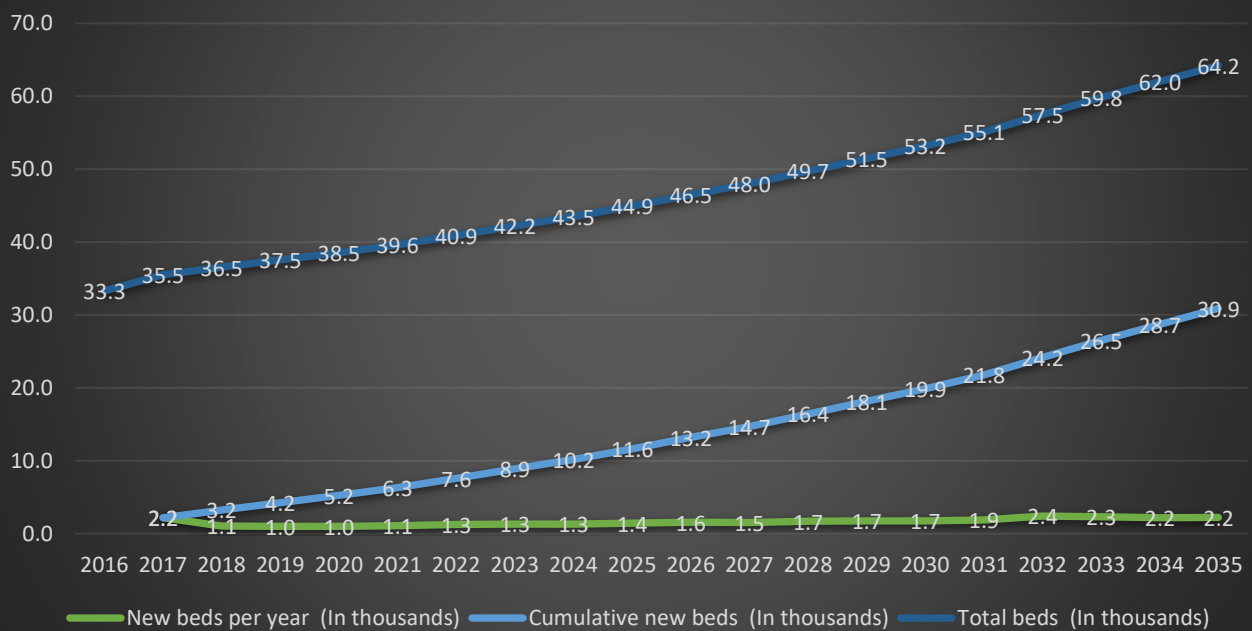


Table 19: BC Bed Projection Data: 2016 to 2020					
	2016	2017	2018	2019	2020
Population (thousands) (CANSIM)	4,758	4,817			
Total beds (thousands)	33.3	35.5	36.5	37.5	38.5
New beds per year (thousands)		2.2	1.1	1.0	1.0
Cumulative new beds (thousands)		2.2	3.2	4.2	5.2
New bed construction cost (2017 \$ millions)		697	336	323	321
New bed operating cost (2017 \$ millions)		159	235	309	382

As outlined above, based on the Conference Board of Canada projections in BC; in addition to requiring 33,300 beds which is over 3000 more than currently exists, the province will require over 5,000 new long term care beds by 2020. The construction (\$1.68 billion) and operating costs (\$1.09 billion) of these beds is about \$2.77 billion.

Table 20: BC Bed Projection Data: 2021 to 2025					
	2021	2022	2023	2024	2025
Total beds (thousands)	39.6	40.9	42.2	43.5	44.9
New beds per year (thousands)	1.1	1.3	1.3	1.3	1.4
Cumulative new beds (thousands)	6.3	7.6	8.9	10.2	11.6
New bed construction cost (2017 \$ millions)	345	410	415	416	457
New bed operating cost (2017 \$ millions)	460	554	648	743	847

As outlined above, based on the Conference Board of Canada projections, BC between 2021 and 2025 BC would require an additional 6,400 long term care beds. The construction (\$2.04 billion) and operating costs (\$3.25 billion) of these beds is about \$5.29 billion.

Table 21: BC Bed Projection Data: 2026 to 2030					
	2026	2027	2028	2029	2030
Total beds (thousands)	46.5	48.0	49.7	51.5	53.2
New beds per year (thousands)	1.6	1.5	1.7	1.7	1.7
Cumulative new beds (thousands)	13.2	14.7	16.4	18.1	19.9

New bed construction cost (2017 \$ millions)	501	487	542	557	559
New bed operating cost (2017 \$ millions)	961	1,072	1,195	1,322	1,449

As outlined above, based on the Conference Board of Canada projections, BC between 2026 and 2030, BC would require an additional 8,200 long term care beds. The construction (\$2.65 billion) and operating costs (\$6 billion) of these beds is about \$8.65 billion.¹¹²

Table 22: BC Bed Projection Data: 2031 to 2035					
	2031	2032	2033	2034	2035
Total beds (thousands)	55.1	57.5	59.8	62.0	64.2
New beds per year (thousands)	1.9	2.4	2.3	2.2	2.2
Cumulative new beds (thousands)	21.8	24.2	26.5	28.7	30.9
New bed construction cost (2017 \$ millions)	603	773	745	694	710
New bed operating cost (2017 \$ millions)	1,587	1,762	1,932	2,090	2,252

As outlined above, based on the Conference Board of Canada projections, BC between 2031 and 2035 BC would require an additional 11,000 long term care beds. The construction (\$3.53 billion) and operating costs (\$9.62 billion) of these beds is about \$13.15 billion.

Summary till 2035

In summary, BC requires about 64,200 long term beds by 2035 which represents an increase of 30,900 based on current demand projections (2016). The total estimated cost of constructing and operating these new beds are also significant as outlined in table below is close to \$30 billion.

New bed construction cost (2017 \$ millions)	9,890
New bed operating cost (2017 \$ millions)	19,958
Total	29,848

¹¹² As outlined in the Conference Board of Canada report it estimates the capital cost of each new long-term care bed at \$320,000 (2017 dollars) and operating cost of each new long-term care bed at approximately \$75,000 per year. According to an internal 2016 BCCPA study it estimated the construction costs at \$175,000 to \$220,000 per bed. These figures, however, exclude land, which has also risen significantly in cost, in keeping with rapidly escalating real estate prices in many parts of the province.

While operating and construction costs are not areas of focus for this paper there would, however, be some positive economic impacts including increases to GDP. A summary of these are highlighted below.

Economic impact results	Direct (GDP)	+ Indirect	+ Induced
Capital spending	3,792	5,926	8,136
Operating spending	15,100	18,244	27,120

5d) HHR Requirements - Projections

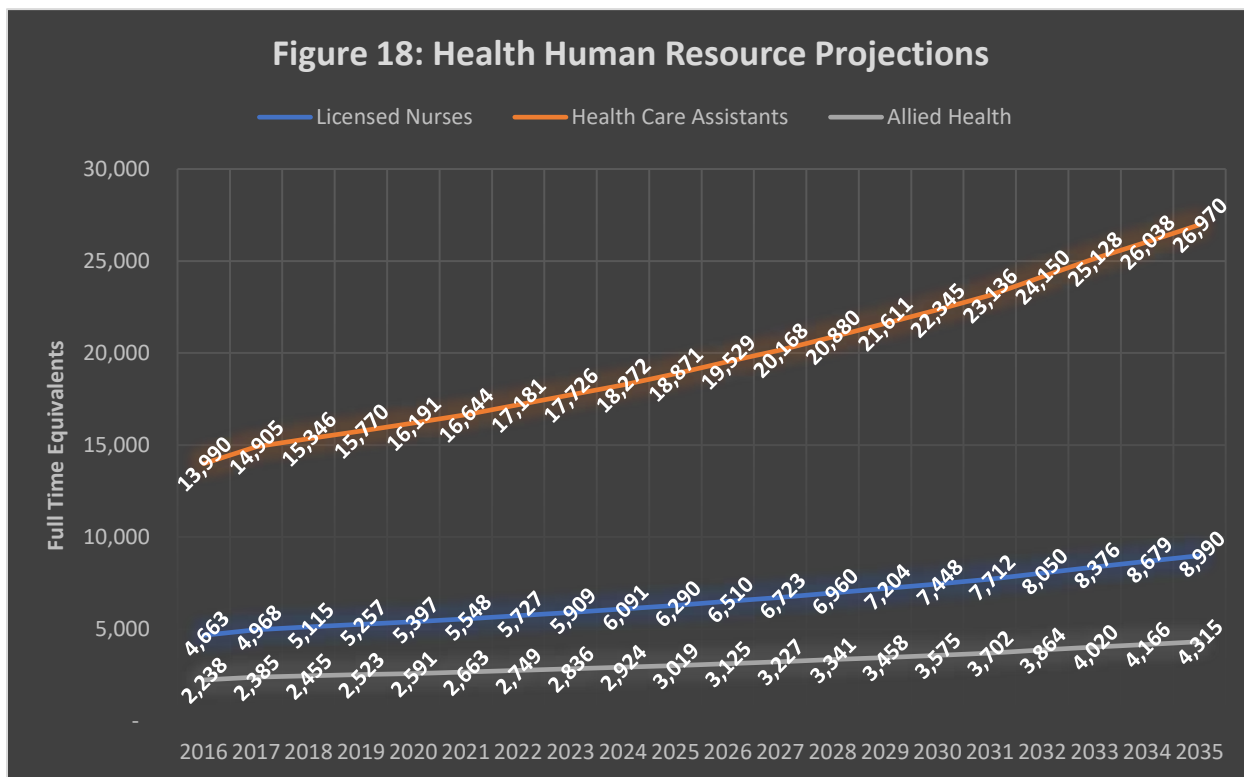
While largely outside the scope of this paper, the expected demand in new long term care beds will also require sufficient health human resources (HHR) to staff and care for residents in these new beds. Based on the projections provided by the Conference Board of Canada, the BCCPA has attempted to determine what some of the staffing requirements might be. A rough estimate is outlined in the following table below assuming a 37.5 hour work week and the current average rate of 3.15 direct care hours (DCH) per resident or if attempt to move towards the provincial guideline of 3.36 DCH (or hours per resident day).

Year	Expected Demand in LTC beds (Conference Board)	Estimated Staffing Requirements (hours / resident / day)					
		3.15 (worked)	3.36 (worked)	Total Nursing [RN, LPN, HCA] (3.00 worked)	Licensed Nurses [RN+LPN] (0.75 worked)	Non Professional [HCA] (2.25 worked)	Total Allied (0.36 Worked)
2016	33,309	19,586	20,891	18,653	4,663	13,990	2,238
2017	35,488	20,867	22,258	19,873	4,968	14,905	2,385
2018	36,538	21,485	22,917	20,462	5,115	15,346	2,455
2019	37,546	22,077	23,549	21,026	5,257	15,770	2,523
2020	38,549	22,667	24,178	21,588	5,397	16,191	2,591
2021	39,628	23,301	24,855	22,192	5,548	16,644	2,663
2022	40,908	24,054	25,657	22,908	5,727	17,181	2,749
2023	42,205	24,816	26,471	23,635	5,909	17,726	2,836
2024	43,505	25,581	27,286	24,363	6,091	18,272	2,924
2025	44,932	26,420	28,181	25,162	6,290	18,871	3,019
2026	46,498	27,341	29,163	26,039	6,510	19,529	3,125
2027	48,020	28,236	30,118	26,891	6,723	20,168	3,227
2028	49,715	29,233	31,181	27,840	6,960	20,880	3,341
2029	51,455	30,255	32,272	28,815	7,204	21,611	3,458
2030	53,201	31,282	33,368	29,793	7,448	22,345	3,575
2031	55,085	32,390	34,549	30,847	7,712	23,136	3,702
2032	57,499	33,809	36,063	32,199	8,050	24,150	3,864
2033	59,827	35,179	37,524	33,503	8,376	25,128	4,020
2034	61,996	36,453	38,884	34,718	8,679	26,038	4,166
2035	64,215	37,758	40,275	35,960	8,990	26,970	4,315

Staffing to meet new Long Term Care Beds

As outlined in the table above, based on the current demand (2016) for over 33,000 long term care beds, about 19,500 care workers are required to staff the beds at an average rate of 3.15 DCH. Using the target of 3.36 DCH, about 20,900 care workers are required including about 18,650 nursing (including RN, LPN and Health Care Assistants) and 2,200 allied health professionals. The former category is further broken down to about 4,660 licensed nurses and 14,000 HCAs. These targets are based on current Health Authority targets to reach 3.36 hours per resident day (or DCH) starting at 2.25 hours per resident day for Health Care Assistants, 0.75 hours per resident day for LPN's, and 0.36 hours per resident day for allied health professionals.

As also outlined in the table earlier, based on the projected demand for over 64,215 long term care beds by 2035 about 37,750 care workers are required to staff the beds at an average rate of 3.15 DCH. Using the target of 3.36 hours per resident day (or direct care hours), however, about 40,300 care workers are required including about 36,000 nursing (including RN, LPN and Health Care Assistants) and 4300 allied health professionals. The former category is further broken down to about 9000 licensed nurses and 27,000 HCAs.



The following table below and figure above outlines some of the increases in staffing requirements from 2016 to 2035 based on expected demand for long term care beds. **At a level of 3.36 DCH, the increase in staffing would equate to approximately 19,300 new care providers including nursing (4327), HCAs (12,980) and total allied health professionals (2077).**

Year	Expected Demand	Estimated Staffing Requirements (hours / resident / day)					
		3.15 (worked)	3.36 (worked)	Total Nursing [RN, LPN, HCA] (3.00 worked)	Licensed Nurses [RN+LPN] (0.75 worked)	Non Professional [HCA] (2.25 worked)	Total Allied (0.36 Worked)
2016	33,309	19,586	20,891	18,653	4,663	13,990	2,238
2035	64,215	37,758	40,275	35,960	8,990	26,970	4,315
Increase (2016 to 2035)	30,906	18,172	19,384	17,307	4327	12,980	2077

SECTION 6: ESTIMATING LTC BED NEEDS BASED ON GROWTH IN FRAIL ELDERLY

As discussed earlier, Canada is already seeing a rapidly aging population. In 2015, Ontario had the largest number of citizens aged 75+ at 0.974 million, B.C. was second largest at 0.354 million, followed by Alberta at 0.205 million.¹¹³ In BC, the number of seniors is expected to rise from approximately 853,000 in 2016 to an estimated 1.47 million over the next 20 years.¹¹⁴ As highlighted earlier, seniors also entering into long term care are doing so with higher levels of acuity.

6a) BC Ministry of Health Data

In BC, according to interRAI Minimum Data Set 2.0 assessment data among over 28,000 residents (28,156) in 2015, the majority of the residents are frail and have complex care needs. For example, the assessment data found the following:

- 93% of long term care clients had some level of cognitive impairment;
- 66% had moderate or higher cognitive impairment;
- 65% had a diagnosis of dementia;
- 93% had some level of impairment with their ability to perform activities of daily living;
- 73% required moderate to significant assistance;
- 69% had bladder incontinence and 47% had bowel incontinence;
- 21% had suffered a cerebral vascular accident;
- 12% had congestive heart failure;
- 55% of residents had some indication of frailty and health instability, and
- 10% had a higher level of medical complexity and were at serious risk of decline.¹¹⁵

While this paper earlier outlines a population ratio based approach to projecting demand for long term care beds (i.e. Conference Board of Canada data), it is even more challenging when attempting to develop projections for specific populations (i.e. frail elderly). The Ministry of Health does such projections which the BCCPA was able to obtain on a regional health authority basis. In the next section of the paper, we have used these figures to estimate the number of long term care beds that are required over time.

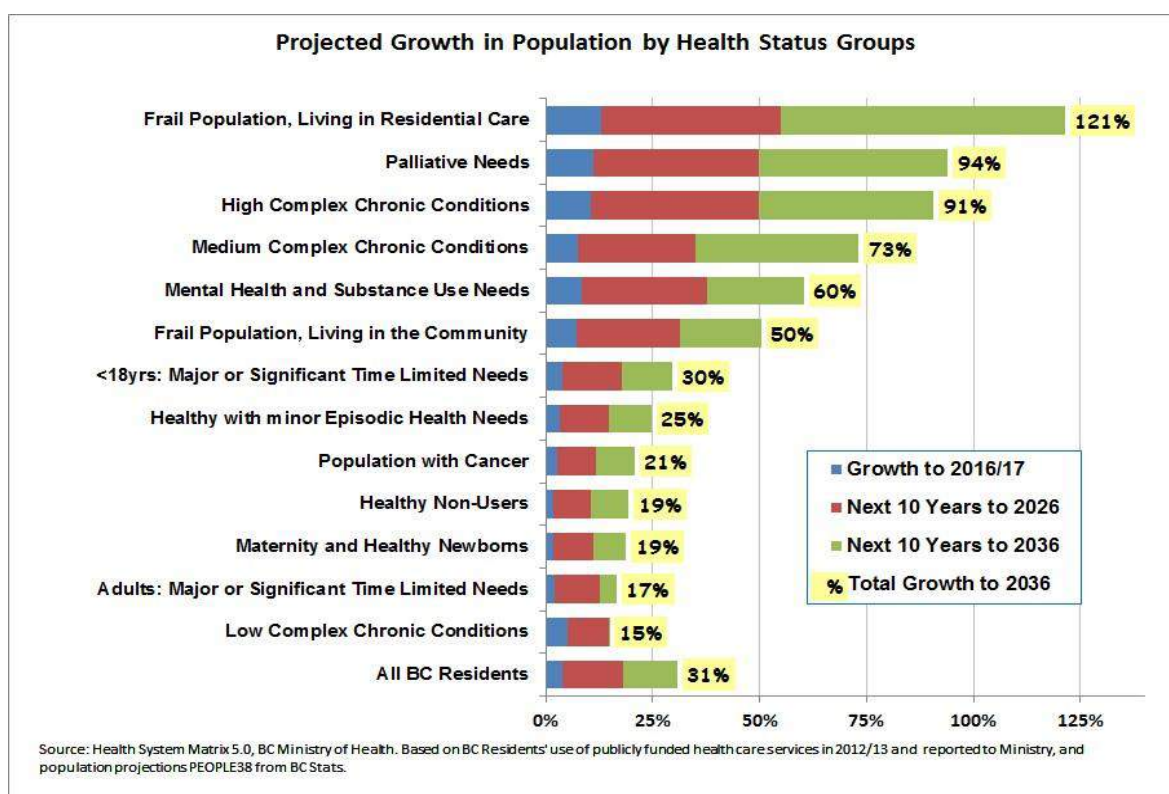
¹¹³ Statistics Canada, Table 051-0001 Estimates of population, by age group and sex for July 1, Canada, provinces and territories www5.statcan.gc.ca/cansim

¹¹⁴ PEOPLE v2016. BC STATS. Ministry of Technology, Innovation and Citizens' Services.

¹¹⁵ BC Ministry of Health. Residential Care Staffing Review. March 2017. Accessed at: <https://www.health.gov.bc.ca/library/publications/year/2017/residential-care-staffing-review.pdf>

BC Ministry of Health: Projected Growth in Population by Health Status Groups

While the BC Ministry of Health does not have public information on number of long term care beds that may be required in the future, it does have projections on the growth of populations as well as growth in demand for the health care system. The figure below, from an earlier BC Ministry of Health report shows, for example, the growth in population by various health status groups. Of particular importance is the top bar line (frail population, living in residential care) which shows a 121% growth in the frail population living in residential or long term care by 2036.¹¹⁶

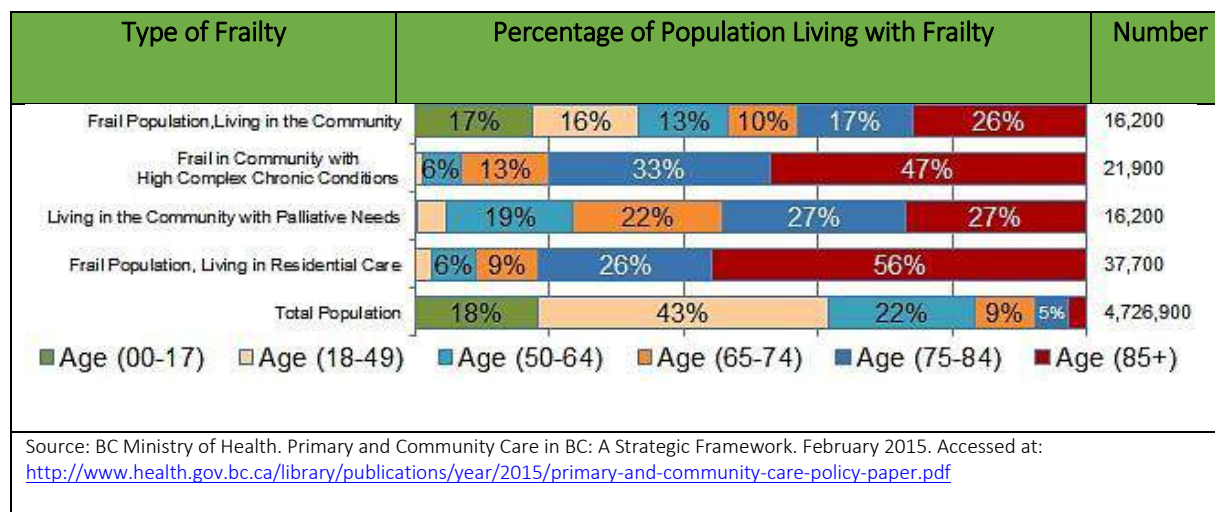


In a similar chart, outlined in the 2014 BC Ministry of Health paper *Setting Priorities for the BC Health System*, it also shows that the growth in demand for health care for frail in residential care (or long term care) is projected to increase by a similar amount or 120% by 2036.¹¹⁷

While some of those listed within the frail population in long term care are under the age of 65 the vast majority are seniors. This is outlined, for example, in another BC Ministry of Health diagram below which shows that over 90% of those living with frailty and living in long term care were seniors with over half (56%) 85 or older.

¹¹⁶ BC Ministry of Health. Primary and Community Care in BC: A Strategic Framework. February 2015. Accessed at: <http://www.health.gov.bc.ca/library/publications/year/2015/primary-and-community-care-policy-paper.pdf>

¹¹⁷ BC Ministry of Health. Setting Priorities for the BC Health System. February 2014. Accessed at: <https://www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf>



Through a request for information to the BC Ministry of Health, the BCCPA in 2018 obtained more recent information including broken down by individual health authority. These tables are outlined below with separate pages for each of the five regional health authorities (i.e. Fraser Health, Interior, Northern, Vancouver Coastal and Vancouver Island).

Table 23: Projected growth in population, by population segment, Fraser Health Authority

Population Segment (n)	2016/2017 (Base Year)	Growth to 2021/2022	Next 10 Years to 2031/2032	Next 10 Years to 2041/2042
PS01 Non User	242,338	255,867	282,355	307,779
PS02 Healthy	674,522	714,016	791,318	850,327
PS03 Adult Major Age 18+	52,712	57,314	65,623	73,174
PS04 Child and Youth Major <18 years	12,650	13,084	14,243	14,701
PS05 Low Chronic Conditions	466,784	509,760	589,517	665,156
PS06 Medium Chronic Conditions	140,388	164,362	213,194	259,355
PS07 Severe Mental Health & SU	31,223	33,575	37,429	41,021
PS08 Maternity & Healthy Newborns	42,544	45,820	49,208	49,948
PS09 Frail In Community	7,188	8,254	11,045	15,238
PS10 High Chronic w/o Frailty	73,140	87,337	119,906	154,044
PS11 High Chronic with Frailty	9,973	12,282	18,835	28,809
PS12 Cancer	24,523	27,847	34,470	40,476
PS13 Frail In Residential Care	12,280	15,227	23,376	37,467
PS14 End Of Life	6,466	7,822	11,230	15,948
All Fraser Health Authority Residents	1,796,731	1,952,566	2,261,749	2,553,441

Figure 19: projected growth in population, by population segment, Fraser Health Authority

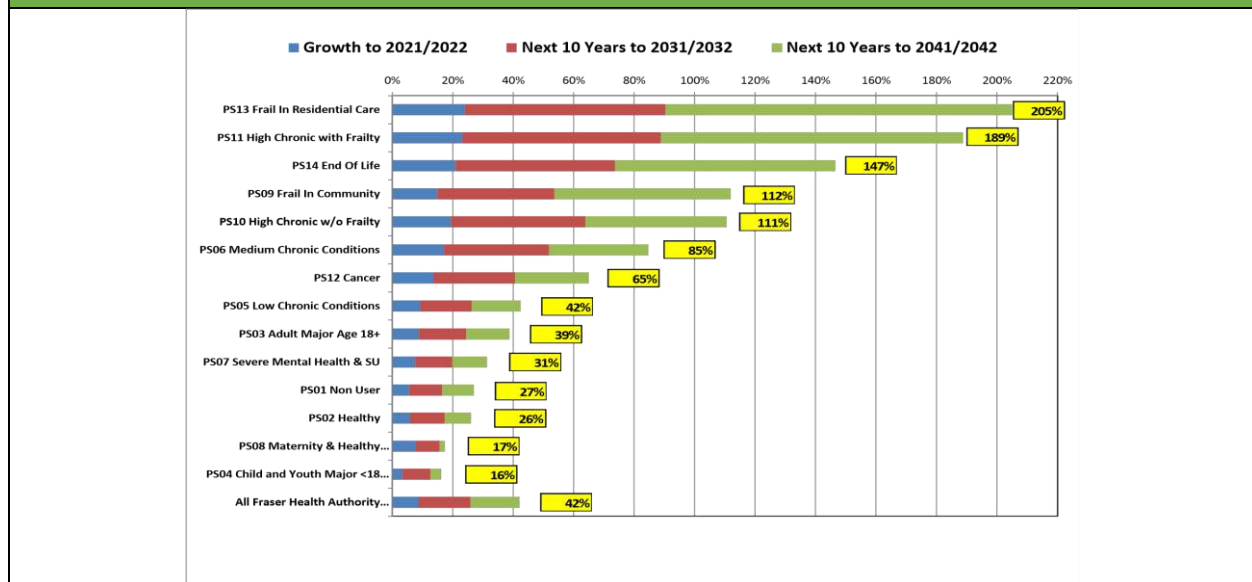


Table 24: Projected growth in population, by population segment, Interior Health

Population Segment (n)	2016/2017 (Base Year)	Growth to 2021/2022	Next 10 Years to 2031/2032	Next 10 Years to 2041/2042
PS01 Non User	104,023	106,805	111,725	116,575
PS02 Healthy	262,385	269,350	282,826	294,307
PS03 Adult Major Age 18+	29,222	29,925	31,117	32,759
PS04 Child and Youth Major <18 years	6,372	6,576	7,024	7,156
PS05 Low Chronic Conditions	202,359	210,793	222,428	233,136
PS06 Medium Chronic Conditions	81,153	89,628	102,813	108,909
PS07 Severe Mental Health & SU	14,762	15,219	15,832	16,571
PS08 Maternity & Healthy Newborns	14,305	15,562	16,185	16,165
PS09 Frail In Community	5,505	6,219	7,973	10,109
PS10 High Chronic w/o Frailty	37,459	42,557	52,651	58,908
PS11 High Chronic with Frailty	7,434	8,804	12,610	17,248
PS12 Cancer	11,708	12,660	14,159	14,917
PS13 Frail In Residential Care	7,504	8,931	12,894	18,700
PS14 End Of Life	4,561	5,284	7,001	8,873
All Interior Health Authority Residents	788,752	828,314	897,238	954,332

Figure 20: Projected growth in population, by population segment, Interior Health

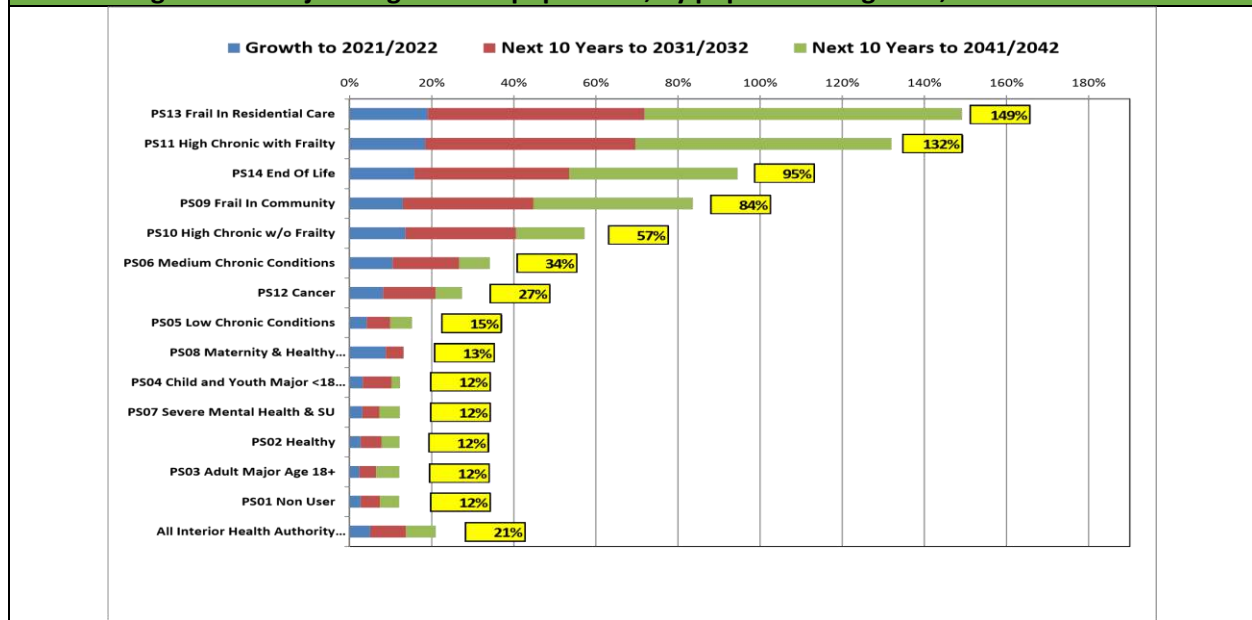


Table 25: projected growth in population, by population segment, Northern Health Authority

Population Segment (n)	2016/2017 (Base Year)	Growth to 2021/2022	Next 10 Years to 2031/2032	Next 10 Years to 2041/2042
PS01 Non User	46,490	47,492	47,555	47,381
PS02 Healthy	104,822	106,450	106,129	105,448
PS03 Adult Major Age 18+	9,832	10,110	10,414	10,618
PS04 Child and Youth Major <18 years	3,197	3,190	3,055	2,955
PS05 Low Chronic Conditions	73,402	76,385	79,221	80,639
PS06 Medium Chronic Conditions	23,037	25,959	30,499	32,750
PS07 Severe Mental Health & SU	5,631	5,743	5,798	5,793
PS08 Maternity & Healthy Newborns	7,940	8,097	7,676	7,808
PS09 Frail In Community	1,073	1,202	1,540	1,975
PS10 High Chronic w/o Frailty	13,020	15,179	19,467	22,023
PS11 High Chronic with Frailty	1,093	1,318	2,021	2,967
PS12 Cancer	4,297	4,644	5,190	5,432
PS13 Frail In Residential Care	1,370	1,672	2,589	3,852
PS14 End Of Life	1,329	1,577	2,186	2,810
All Northern Residents	296,533	309,018	323,338	332,452

Source: Health System Matrix, Version 9 (2018)

Figure 21: projected growth in population, by population segment, Northern Health Authority

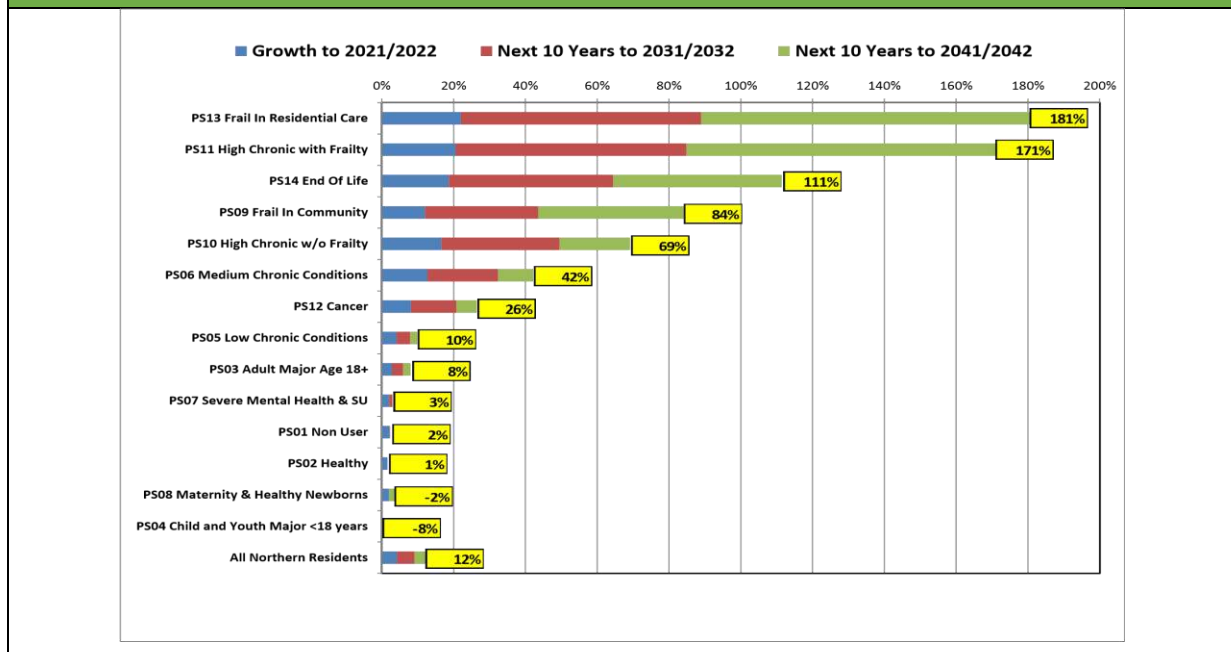


Table 26: projected growth in population, by population segment, Vancouver Coastal Health

Population Segment (n)	2016/2017 (Base Year)	Growth to 2021/2022	Next 10 Years to 2031/2032	Next 10 Years to 2041/2042
PS01 Non User	192,639	196,536	208,630	221,800
PS02 Healthy	475,843	491,610	523,958	540,881
PS03 Adult Major Age 18+	38,474	40,631	43,742	46,009
PS04 Child and Youth Major <18 years	6,275	6,911	7,597	7,562
PS05 Low Chronic Conditions	284,268	303,033	337,236	365,881
PS06 Medium Chronic Conditions	84,226	96,726	122,623	145,052
PS07 Severe Mental Health & SU	19,252	19,928	21,064	22,080
PS08 Maternity & Healthy Newborns	24,033	27,539	28,974	26,657
PS09 Frail In Community	4,196	4,827	6,365	8,884
PS10 High Chronic w/o Frailty	41,353	48,427	64,749	82,746
PS11 High Chronic with Frailty	5,571	6,821	9,905	15,094
PS12 Cancer	16,608	18,332	21,541	24,017
PS13 Frail In Residential Care	9,000	11,230	16,364	25,519
PS14 End Of Life	5,107	6,157	8,489	11,935
All VCHA Residents	1,206,845	1,278,710	1,421,238	1,544,117

Figure 22: projected growth in population, by population segment, Vancouver Coastal Health

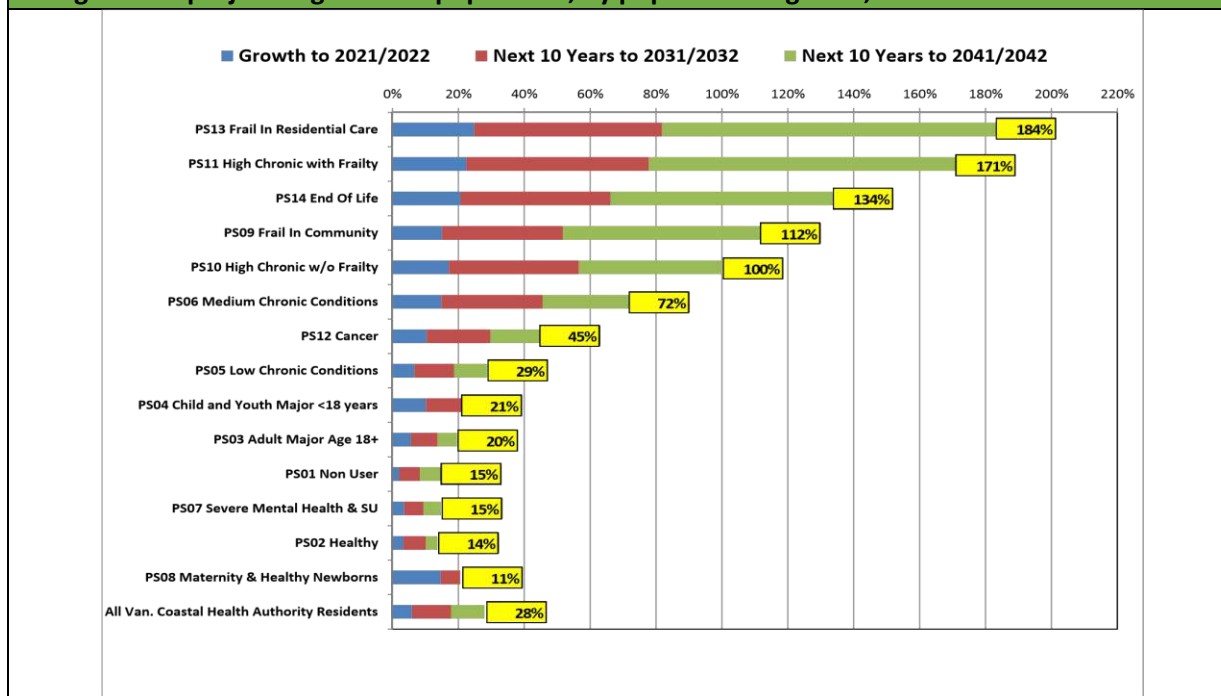
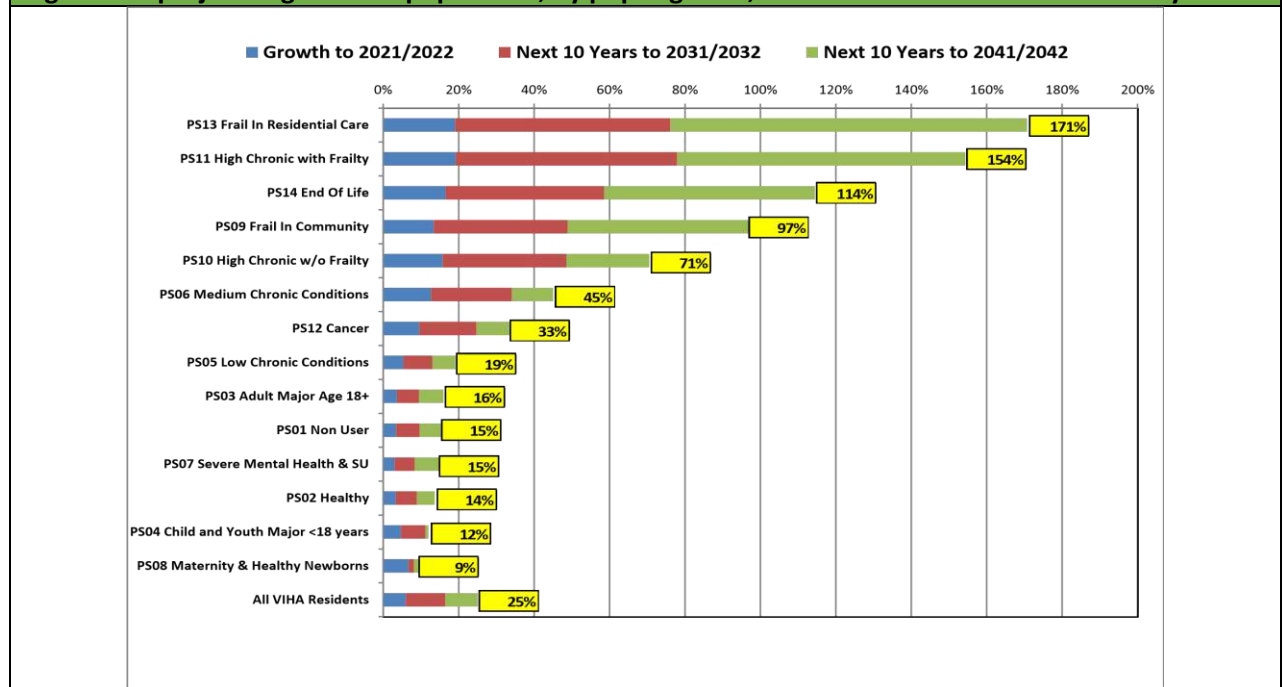


Table 27: projected growth in population, by population segment, Vancouver Island Health Authority

Population Segment (n)	2016/2017 (Base Year)	Growth to 2021/2022	Next 10 Years to 2031/2032	Next 10 Years to 2041/2042
PS01 Non User	98,066	101,420	107,545	113,018
PS02 Healthy	272,859	281,849	297,352	310,052
PS03 Adult Major Age 18+	27,579	28,566	30,199	31,986
PS04 Child and Youth Major <18 years	6,258	6,549	6,962	7,010
PS05 Low Chronic Conditions	219,506	231,184	248,107	261,540
PS06 Medium Chronic Conditions	81,455	91,787	109,242	118,140
PS07 Severe Mental Health & SU	16,278	16,761	17,633	18,733
PS08 Maternity & Healthy Newborns	14,820	15,814	16,023	16,195
PS09 Frail In Community	4,207	4,768	6,263	8,293
PS10 High Chronic w/o Frailty	37,064	42,915	55,059	63,202
PS11 High Chronic with Frailty	5,752	6,856	10,234	14,631
PS12 Cancer	13,904	15,229	17,340	18,552
PS13 Frail In Residential Care	7,714	9,183	13,585	20,883
PS14 End Of Life	5,629	6,560	8,923	12,072
All VIHA Residents	811,091	859,442	944,466	1,014,305

Figure 23: projected growth in population, by pop segment, Vancouver Island Health Authority



While there is quite a lot of information outlined above, the BCCPA has extracted the information on number of frail elderly in residential or long term care, and summarized in the following table below.

Total Numbers of Frail Elderly in Residential Care				
Health Authority	Base year 2016/17	Growth to 2021 to 2022	Next 10 years to 2031/32	Next 10 years to 2041/42
Fraser Health	12280	15227	23376	37,467
Interior Health	7504	8931	12894	18700
Vancouver Coastal	9000	11230	16364	25519
Vancouver Island	7714	9183	13585	20883
Northern Health	1370	1672	2589	3852
Totals	37868	46243	68808	106,421

As outlined in the following table, by 2041/42 BC is projecting to have over 100,000 frail elderly living in residential or long term care. This compares to about 38,000 for base year (2016/17).

Using base line data for 2016/17 on the total clients and number of publicly subsidized beds, the BCCPA has attempted to determine on average how many residents each long term care bed occupied over the course of a year (i.e. annual bed to resident ratio). This ratio is outlined in the following table below.

Health Authority	Base year 2016/17	Beds	Total Clients	Annual Bed to Resident Ratio
Fraser Health	12280	8569	12760	1.49
Interior Health	7504	5799	9554	1.65
Vancouver Coastal	9000	6816	8688	1.27
Vancouver Island	7714	5465	8520	1.56
Northern Health	1370	1180	1768	1.50

The annual bed to resident ratio (i.e. fifth column in above table) is determined by dividing number of residential or long term care clients for 2016/17 (fourth column) by the number of publicly subsidized beds (third column). This number largely determines how many residents or clients each bed in a health authority cared for over the course of a year.

The annual bed to resident ratio is then divided by projected increases in the frail elderly to project future demand for beds. Please note, however, these projections are only an estimate assuming various factors including that current demand is sufficient as well as not accounting for those who may be on waiting list and/or in hospital (ALC).

ESTIMATED BED PROJECTION INFORMATION

Table 28: Growth in frail population in residential care (2016/17 to 2021/22)

Health Authority	Base year 2016/17	Growth to 2021 / 2022	Growth in #s	Growth in %
Fraser Health	12280	15227	2947	24%
Interior Health	7504	8931	1427	19%
Vancouver Coastal	9000	11230	2230	25%
Vancouver Island	7714	9183	1469	19%
Northern Health	1370	1672	302	22%
Totals	37868	46243	8375	22%

Table 29: Projected Demand for Long Term care Beds (2016/17 to 2021/22)

Health Authority	Growth to 2021 to 2022	Bed projections (2022)	New Beds needed
Fraser Health	15227	10226	1657
Interior Health	8931	5421	-378
Vancouver Coastal	11230	8810	1994
Vancouver Island	9183	5890	425
Northern Health	1672	1116	-64
Totals	46243	31463	3634

Table 30: Growth in frail population in residential care (to 2031/32)

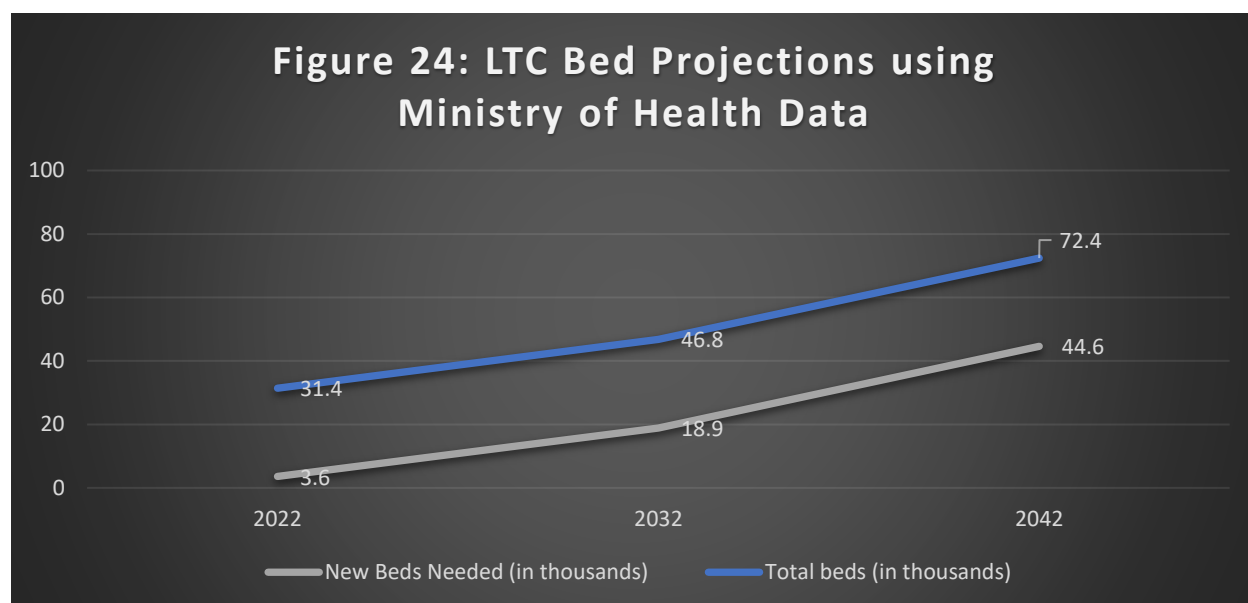
Health Authority	Base year 2016/17	Next 10 years to 2031/32	Growth in #s	Growth in %
Fraser Health	12280	23376	11096	90%
Interior Health	7504	12894	5390	72%
Vancouver Coastal	9000	16364	7364	82%
Vancouver Island	7714	13585	5871	76%
Northern Health	1370	2589	1219	89%
Totals	37868	68808	30940	82%

Table 31: Projected Demand for Long Term care Beds (to 2031/32)			
Health Authority	Next 10 years to 2031/32	Bed projections (2032)	New Beds needed
Fraser Health	23376	15698	7129
Interior Health	12894	7826	2027
Vancouver Coastal	16364	12838	6022
Vancouver Island	13585	8714	3249
Northern Health	2589	1728	548
Totals	68808	46804	18975

Table 32: Growth in frail population in long term care (to 2041/42)				
Health Authority	Base year 2016/17	Next 10 years to 2041/42	Growth in #s	Growth in %
Fraser Health	12280	37,467	25,187	205%
Interior Health	7504	18700	11,196	149%
Vancouver Coastal	9000	25519	16,519	184%
Vancouver Island	7714	20883	13,169	171%
Northern Health	1370	3852	2,482	181%
Totals	37868	106,421	68,553	181%

Table 33: Projected Demand for Long Term Care Beds (to 2041/42)			
Health Authority	Next 10 years to 2041/42	Bed projections 2042	New Beds Needed
Fraser Health	37,467	25161	16592
Interior Health	18700	11350	5551
Vancouver Coastal	25519	20020	13204
Vancouver Island	20883	13395	7930
Northern Health	3852	2571	1391
Totals	106,421	72498	44669

In total, as outlined in earlier tables, using these projections and methodology identified earlier, BC requires about 19,000 new long term care beds by 2031/32 to meet growing demand for those identified as frail in long term care (residential care). By 2041/42 BC needs close to 45,000 new long term care beds (or bed equivalents as discussed) as also depicted in the following figure below.



As outlined earlier, using Conference Board of Canada data it projects that by 2035 BC requires almost 31,000 long term care beds which also aligns with information outlined above. Later in the paper we also factor in reducing some of this demand by looking at people who may not need to be in long term care but could be cared for elsewhere including assisted living or home if appropriate supports are in place.

As outlined in section 7 of this paper, even with reducing the numbers by up to 15 percent¹¹⁸ a large number of new beds are still required. In summary, regardless of what methodology you use to project future demand or the various measures to mitigate or reduce future demand, a significant number of beds are required to meet a rapidly aging population.¹¹⁹

6b) New Strategy for Long Term Care Beds

Based on these revised projections and data provided by the Conference Board, the BCCPA believes it is incumbent on the provincial government to work with health authorities and stakeholders to develop a strategy to increase the number of long term bed equivalents by at least 30,000 over the next twenty years – of this at least 20,000 to 25,000 should be actual beds.

Role of the Private Sector

The BCCPA believes that new beds should also include an appropriate mix of government and private (including for profit and non-profit). Currently, as outlined in the tables below, approximately two thirds

¹¹⁸ The Canadian Institute for Health Information and BC Office of the Seniors Advocate has noted in previous reports that potentially up to 15 percent or more of those entering residential or long term care could be cared for elsewhere (i.e. home and community care).

¹¹⁹ With the revised projections, BC still requires a large number of new long term care beds even if as outlined later on up to 15 percent in long term care could be diverted elsewhere. In particular, by 2041/42 BC needs close to 38,000 new long term care beds.

of existing care home beds are operated privately with about a half each operated for-profit and non-profit. As outlined in the OSA's latest Monitoring Seniors Services, as of March 31, 2018, there were 27,846 publicly funded long-term care beds in BC with about 33% of these being health authority operated facilities and 67% in contracted care homes.¹²⁰

Overall, any new beds could also be added to existing care homes and/or newly developed ones. Assuming the latter approach is adopted and with an average bed size of 125 beds, approximately 200 new care homes would be required to be built over the next twenty years to meet new demand. That is about two-thirds the number of care homes that currently exists in BC. As noted earlier, as of the end of 2018, no health authorities in BC, however, had an RFP for new care beds posted. In fact, over the past six months only one RFP for new long term care beds has been awarded.¹²¹

Table 34: Total Number of HA Owned and Private (PNP and PFP) beds		
HEALTH AUTHORITY	Total Number of HA Operated Beds	Total Number of Private (PFP or PNP)
Fraser Health	1870	7496
Interior Health	2543	3307
Island Health	1690	3875
Northern Health	1022	130
Vancouver Coastal Health	1669	4919
TOTAL	8794	19727

Table 35: Total Number of Beds in non-HA Care Homes (PFP and PNP)			
NON-HEALTH AUTHORITY	PFP	PNP	TOTAL
Fraser Health	4176	3320	7496
Interior Health	2645	662	3307
Island Health	1876	1999	3875
Northern Health	130	0	130
Vancouver Coastal Health	1677	3242	4919
Totals	10,504	9223	19,727

Based on current breakdown and to meet future long term care demand, the BCCPA believes new beds added to the sector should include a mix of government and private (for profit and non-profit). As such the BCCPA recommends that the BC government develop a strategy to increase number of long term care beds equivalents (LTCBE) by at least 30,000 over the next twenty years, including between 20,000 to

¹²⁰ Source: BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

¹²¹ In January 2019, the BC Ministry of Health announced that over 120 new long term or residential care beds had been awarded to Golden Life Management for the Comox Valley region as part of an earlier RFP that had been posted on BC Bid (see: BC Ministry of Health News Release: Improving seniors' care for the Comox Valley accessed at: <https://news.gov.bc.ca/releases/2019HLTH0009-000040>). These were part of an RFP that had been issued by Island Health in March 2018 and which closed in May of the same year.

25,000 actual new beds. As part of any strategy, new beds should include an appropriate mix of government and private (for profit and non-profit) based roughly on the current distribution or allocation of beds.

Costs of public vs private (non-government) beds

To meet future demands, the role of the private sector (including for-profit and non-profit) will be critical in developing and operating new care beds, particularly from a financial perspective. The BC government recently announced that over the next two years, several health authorities (Fraser, Island and Vancouver Coastal) will be taking over the delivery of all funded home support services.¹²² This is likely to increase the costs of delivery of such care by as much as 30 percent. In response, the BCCPA has asked the BC Auditor General to review the Ministry of Health's decision to cancel contracts with 6 non-government home care providers and expropriate over 4,000 staff into government-operated health authorities.¹²³

Similar to the anticipated impacts of expropriating home support services, the BCCPA believes that the costs to tax payers would be considerably higher if the government were to move funded long term care beds from the private sector to the health authorities. Also, the construction and operation of new long term care beds by the government would add major new costs to the taxpayer. These new costs would include higher construction as well as operating costs.

With respect to implementation, various estimates show that construction costs of building new long term care beds can vary considerably. Data from the Conference Board, as outlined earlier, shows an estimate of \$320,000 per bed. Other reports, including an internal report developed by the BCCPA (between \$175,000 to \$220,000)¹²⁴ and a report from the Alberta Continuing Care Association (\$225,000),¹²⁵ show the costs to be considerably less. Using these estimates, the costs to taxpayers of building 13,000 new government run long term care beds, which is approximately two-thirds (i.e. current percentage of private beds) of the lower range of 20,000 new beds, would be considerable at \$2.275 billion to \$4.16 billion (i.e. between \$113.75M and \$208.M per year over 20 years).

Estimated Construction Costs of 13,000 New Long Term Care Beds	
Per Bed Cost	Total Costs (avg. over 20 years)
\$320,000 (Conference Board of Canada)	\$4.16 billion (\$208M)
\$175,000 (lower range BCCPA internal data)	\$2.28 billion (\$113.7M)
\$197,500 (average or mid-range of BCCPA internal data)	\$2.57 billion (\$128.4M)
\$225,000 (ACCA data and high range of BCCPA internal data)	\$2.92 billion (\$146.3M)
Sources: Gibbard, Robyn. Sizing Up the Challenge: Meeting the Demand for Long-Term Care in Canada. Ottawa: The Conference Board of Canada, 2017; Alberta Continuing Care Association. Review of Alberta Health Recommendation to Increase Accommodation Fees. March 2015; and Internal BCCPA Paper prepared by Westbridge Group. February 2016. Property Costs, Equity, Debt and Lease Rate Benchmarks For Long Term Care (LTC) Properties in British Columbia.	

¹²² BCCPA. No benefit to seniors in government "expropriation" of home support staff. March 2019. Accessed at: <https://bccare.ca/2019/03/no-benefit-to-seniors-in-government-expropriation-of-home-support-staff/>

¹²³ BCCPA. BCCPA writes to Auditor General asking for review of home support staff expropriation. March 2019. Accessed at: <https://bccare.ca/2019/03/bccpa-writes-to-auditor-general-asking-for-review-of-home-support-staff-expropriation/>

¹²⁴ According to an internal 2016 BCCPA study it estimated the construction costs at \$175,000 to \$220,000 per bed. These figures, however, exclude land, which has also risen significantly in cost, in keeping with rapidly escalating real estate prices in many parts of the province.

¹²⁵ Alberta Continuing Care Association. Review of Alberta Health Recommendation to Increase Accommodation Fees. March 2015.

As outlined in the table above, the costs of constructing approximately 13,000 new long-term care beds would be about \$2.28 billion to over \$4 billion when also incorporating land costs. If these beds were built and operated by the private sector, the cost to taxpayers would be significantly less as the majority of capital costs would be borne by the sector and not government.

Along with construction costs, the projected operating costs for the new 13,000 long term care beds would also be significant. Using the Conference Board of Canada data outlined earlier (\$75,000 per bed), the total operating costs over 20 years for 13,000 beds would be about \$8.4 billion.¹²⁶ The operating costs would likely be significantly higher if the government or health authorities operate such beds, as costs, including per diems for health authority care homes, are higher than for most privately operated care homes. Evidence of this is seen, for example, in the 2012 BC Ombudsperson report which shows that the average per diem rate is lower for most BC private care homes compared to those that are publicly owned and operated.¹²⁷

The BCCPA has also produced annual reports which highlight the various differences in per diem rates; although, unfortunately, the health authorities were unable to provide information. As noted in the recent Office of Seniors Advocate Quick Facts Directory for Long Term Care (2018), “per diem rates are not reported by health authority owned and operated facilities at this time, as it is challenging to separate costs from global budgets”. In that report, however, it noted that for contracted care homes the average per diem rate was \$211.92, a 3% increase over 2016/17 (\$206.35).¹²⁸

Aside from per diem rates, operating costs for private (non-government) care homes is also less. For example, according to a study from Alberta (based on 2013 data) it highlights a difference in total program costs (includes all costs such as direct nursing, therapeutic, general admin, etc.) of \$236.74 for publicly owned and operated versus \$211.42 for privately owned (difference of about \$25 or about 12%). More recent data projecting costs for 2014/15 highlights that for non-government care homes in Alberta (i.e. private and voluntary) it shows costs of about \$228.63, which is still over \$8 or over 3 percent higher than public / government operated care beds.¹²⁹

While an eight dollar difference between daily operating costs of a private vs public (government) bed may not seem significant, over the long term it can be. For example, a hypothetical one dollar difference in costs of a private vs government care bed can be significant. Assuming we are looking to introduce 13,000 new long term care beds (i.e. about two-thirds of the lower range of 20,000 to 25,000) in equal numbers over a 20 year period (i.e. 650 beds per year), a one dollar difference would equate to over \$237,000 in just the first year alone. Over the course of twenty years and cumulatively, as seen in the table below, this would equate to almost \$50M (\$49,822,500).

¹²⁶ As outlined earlier, the Conference Board of Canada projects that operating costs of 30,900 new long term beds would equal about \$20 billion.

¹²⁷ BC Ombudsperson. The Best of Care: Getting it Right for Seniors in British Columbia. (Part 2, Volume 2). February 2012. Accessed at: <https://bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2047%20The%20Best%20of%20Care-%20Volume%202.pdf>

¹²⁸ Office of Seniors Advocate. Long Term Care Facilities: Quick Facts Directory. November 2018. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2018/11/QuickFacts-Nov2018-Summary.pdf>

¹²⁹ Alberta Continuing Care Association. Review of Alberta Health Recommendation to Increase Accommodation Fees. March 2015.

Projected Additional Operating Costs of adding 13,000 new LTC beds over 20 years (assuming \$1 difference in total costs of public vs. government daily costs per bed)										
Year	Y1	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
New beds added	650	650	650	650	650	650	650	650	650	650
Cumulative new beds	650	1300	1950	2600	3250	3900	4550	5200	5850	6500
Amount in \$	237.2k	474.5k	711.7k	949k	1.186M	1.423M	1.660M	1.898M	2.135M	2.372M

Year	Y11	Y12	Y13	Y14	Y15	Y16	Y17	Y18	Y19	Y20
New beds added	650	650	650	650	650	650	650	650	650	650
Cumulative new beds	7150	7800	8450	9100	9750	10400	11050	11700	12350	13000
Amount in \$	2.609M	2.847M	3.084M	3.321M	3.558M	3.796M	4.033M	4.270M	4.507M	4.745M
Grand Total	\$49,822,500									

The example in the table above represents only one dollar difference between public vs. private beds. Using the 2013 Alberta data outlined earlier, assuming a \$25 difference, the cost differential would equal about \$1,245,562,500. The cost differential would be \$398,580,000 if using the more conservative \$8 gap. In summary, using even relatively low estimates (i.e. \$2.28 billion for construction + \$398.5M for operating) the savings by using the private sector to build and operate 13,000 long term care beds could be about \$2.7 billion over 20 years or on average about \$135M per year. In short, from a fiscal perspective it is imperative that the private sector (including for profit and non-profit) maintain and expand its existing role in the implementation of new care beds.

The BCCPA recommends that the BC government develop a strategy to increase the number of long term care bed equivalents (LTCBE) by at least 30,000 over the next twenty years, including between 20,000 to 25,000 actual new beds. As part of any strategy, new beds should include an appropriate mix of government and private (for profit and non-profit) based roughly on the current distribution or allocation of beds. Using the lower range of 20,000 beds, this would equate to about 13,000 new long term care beds that would be operated and owned by the private sector. To maintain the current balance, 6,500 private for profit and 6,500 private non-profit long term care beds, at minimum, should be introduced over the next twenty years.

Recommendation # 4

That the BC government develop a strategy to increase the number of long term care bed equivalents (LTCBE) by at least 30,000 over the next twenty years, including between 20,000 to 25,000 actual new beds. As part of any strategy, new beds should include an appropriate mix of government and private (for profit and non-profit) based roughly on the current distribution or allocation of beds.

6c) BC Continuing Care Living Initiative (CCLI)

The development of new beds or the implementation of any strategy as outlined above will require government support as well as assistance from the private sector. Other provinces, for example, have developed formal programs with funding to support the private or non-profit sectors in building new long term care beds or assisted living spaces. One such example was seen in Alberta.

In Alberta under its expiring Alberta Supportive Living Initiative (ASLI), the province partnered with private and non-profit organizations to build new long term care and supportive living spaces (similar to assisted living in BC) through a capital grant program.¹³⁰ The last grant application was 2014–2015.¹³¹

As outlined by the Alberta Continuing Care Association (ACCA), ASLI was a program set up by the former Progressive Conservative Government wherein the province provided up to a maximum of 50% of the construction costs to non-profit, faith-based and independent organizations selected through a comprehensive review process to build and operate new care centres throughout the province. In 2014–15, successful ASLI proponents were awarded an average of \$65,000 per unit—with many units constructed at costs much less than the 50% maximum contribution—to build 2,458 new Continuing Care spaces, all constructed to meet or exceed the relevant provincial building standards. Through the expertise, innovation and creativity of these organizations, many of the projects have already opened or are nearing completion.¹³²

The ACCA, which has generally supported of this program, has expressed concerns about this initiative expiring and that most new beds that are opening are government operated. In particular, ACCA notes that the new spaces cost significantly higher than what has been achieved through ASLI, with one previously announced project for Calgary potentially costing upwards of \$655,000 per unit.¹³³

While the earlier ASLI program relied heavily on the private sector, with nearly three quarters of the 2,000 beds operated by for-profit corporations, the next phase of the program seems to largely exclude this part of the sector. In October 2018, for example, the Alberta government outlined that the province will be looking largely to non-profits, indigenous communities and public agencies to add new units in the future, particularly in areas with high needs.¹³⁴

The BCCPA believes a similar program to Alberta’s ASLI should be adopted in BC to support the introduction of new long term care beds as per any provincial strategy. Similar to Alberta, the BCCPA believes that such a program should also apply to assisted living particularly as outlined later in this paper

¹³⁰ Calgary Herald. Alberta government missing targets for accessing long-term care. James Wood. July 23, 2018. Accessed at: <https://calgaryherald.com/news/politics/government-missing-targets-for-accessing-continuing-care>

¹³¹ Alberta Health. Affordable Supportive Living Initiative (ASLI). Accessed at: <http://www.health.alberta.ca/services/ASLI.html>

¹³² Alberta Continuing Care Association. ACCA Media Release: Meaningful Commitment to Our Seniors Requires a Diverse Continuing Care Industry. July 24, 2018. Accessed at: <https://www.ab-cca.ca/about-continuing-care/news/post/acca-media-release-meaningful-commitment-to-our-seniors-requires-a-diverse-continuing-care-industry>

¹³³ Alberta Continuing Care Association. ACCA Media Release: Meaningful Commitment to Our Seniors Requires a Diverse Continuing Care Industry. July 24, 2018. Accessed at: <https://www.ab-cca.ca/about-continuing-care/news/post/acca-media-release-meaningful-commitment-to-our-seniors-requires-a-diverse-continuing-care-industry>

¹³⁴ Edmonton Journal. Alberta NDP relies on private firms, then excludes them, in effort to build seniors beds. Keith Gerein. October 5, 2018. Accessed at: <https://edmontonjournal.com/news/local-news/alberta-ndp-relies-on-private-firms-then-excludes-them-in-effort-to-build-seniors-beds>

with the changes anticipated on Bill 16. Likewise, any such funding should be provided to private providers, including for-profit and non-profit.

Recommendation #5

That, as part of any strategy to meet future demand for long term care and assisted living, the BC government develop a BC Continuing Care Living Initiative (CCLI) to partner with private and non-profit organizations as well as provide funding for new long term care and assisted living spaces.

Role of Canadian Mortgage and Housing Corporation (CMHC)

While the strategy above refers largely to publicly subsidized care beds, part of the increase in demand could be offset in part by private pay beds. While data is very limited, in BC there are currently about 1600 private-pay licensed long term care beds in the province.¹³⁵ Unlike the cost of subsidized long term care which has a maximum monthly co-payments of about \$3200 per month, the cost of private long term care is higher can range from \$6,000 to \$10,000 per month. Licensing standards and enforcement, however, are the same for both private and publicly subsidized beds.¹³⁶ To assist with the increase of such beds it may require the federal government to take a more active role in seniors housing particularly through the Canadian Mortgage and Housing Corporation (CMHC), which provides financing options to borrowers offering retirement housing for seniors (including long term care).

The federal government, through legislation, particularly the National Housing Act (NHA) provisions administered by the CMHC, has in the past contributed to the development of care homes for the elderly in Canada. Overall, however, financial assistance for long term care has only been a small part of CMHC's total housing activities. With a rapidly and growing aging population, the CMHC could possibly play a greater role in providing loans to build new long term care beds including within the private and non-profit sector.

As outlined in a 2016 BCCPA report, one way for the federal government to assist provinces particularly around efforts to renew and where necessary replace existing infrastructure and increase capacity in long term care is to revive the historic role that the CMHC previously had in the sector. CMHC, for example, can help reduce the risks around financing and ensuring funding is loaned to better support the delivery of care and not diverted to interest payments.¹³⁷

¹³⁵ BC Office of the Seniors Advocate. Seniors Housing in BC: Affordable-Appropriate- Available. May 2015. Accessed at: <https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2015/09/SeniorsHousingReport.pdf>

¹³⁶ BC Office of the Seniors Advocate. Seniors Housing in BC: Affordable-Appropriate- Available. May 2015. Accessed at: <https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2015/09/SeniorsHousingReport.pdf>

¹³⁷ BCCPA. Sustainability and Innovation: Exploring Options For Improving BC's Continuing Care Sector: Part I. White Paper on Funding and Innovation. May 2016. Accessed at: https://bccare.ca/wp-content/uploads/BCCPA_part_1_HR-1.pdf

Role of Federal Government – Infrastructure

While the BCCPA believes that an overall provincial strategy and introduction of new long term care beds is critical it also believes that there is a potential role for the federal government as seniors and housing is a national issue.

In particular, the Canadian Association of Long Term Care (CALTC) has advocated that there is a role for federal government to investing in new beds when consider long term care as housing - an area where it is already significantly involved. As outlined by CALTC, although long-term care plays a large role in the continuum of care, viewing long-term care as a medical facility has been a common misconception. While clinical care is provided, a primary function of a long-term care home is to provide housing for the elderly population. This fact is not well understood and has led to our most vulnerable population not being able to access and benefit from new federal infrastructure investments, such as the National Housing Strategy.

As such and to meet current and future demand for long-term care, CALTC has recommended the federal government increase capacity by committing to funding the addition of 42,000 new long-term care beds across the country by 2023.¹³⁸

Recommendation # 6

That the federal government increase capacity by committing to funding the addition of 42,000 new long-term care beds across the country by 2023.

6d) Health Human Resources (HHR) Strategy

As discussed earlier in the paper, with the addition of a substantial number of new long term care beds it will require new staff including Health Care Assistants, nurses and other allied health professionals. As outlined earlier, based on the Conference Board of Canada estimated projected demand for beds, the BCCPA estimates that from 2016 to 2035 about 13,000 new Health Care Assistants, 4000 nurses and 2000 allied health professionals will be required to staff new beds in order to meet a designated 3.36 Direct Care Hours target.

As such, the BCCPA believes that as part of any new LTC bed strategy or perhaps as part of a broader Continuing Care HHR Workforce Strategy, that the BC government develop a health human resource plan to meet the requirements for additional care hours (i.e. to reach 3.36 DCH) and new long term care bed equivalents (i.e. 30,000 in next 20 years) particularly also as the acuity levels of residents rise.

Recommendation # 7

That, as part of any new long term care bed strategy or a broader Continuing Care Health Human Resource Workforce Strategy, the BC government develop a provincial health human resource (HHR) plan to meet the requirement for new long term care beds over the next twenty years.

¹³⁸ Canadian Association for Long Term Care. Long Overdue: Improving Seniors Care in Canada. November 2018. Accessed at: <https://caltc.ca/wordpress/wp-content/uploads/2018/11/CALTC-budget-submission-ONLINE.pdf>

Federal role – Health Human Resources

Along with the provinces, the federal government also has a role in recruiting and retaining health care workers. In 1999, Health Minister's from across Canada met to discuss the HHR challenges facing the health care system, recognizing it as an important issue that requires national collaboration. Nearly 20 years later, many of the themes that were discussed are still of critical importance. In particular, there is an even greater need now to evolve the HHR strategy in the long-term care sector to take into account changing demographics, the evolution of our health care system and the health needs of Canadians.¹³⁹

The BCCPA believes that is incumbent upon the federal government to work with provinces on the development of a HHR strategy in the long-term care sector to take into account changing demographics, the evolution of our health care system and the health care needs of Canadians. As outlined by the Canadian Association of Long Term Care (CALTC), a HHR strategy for the long-term care sector should focus on the right number, mix, and geographic distribution of providers, as well as the appropriate setting for providers to deliver services.

Along with facilitating the introduction of internationally educated health care assistants, CALTC in a 2018 report recommended that the federal government collaborate with the provinces and the long-term care sector to immediately develop and implement a Pan-Canadian health human resources strategy.¹⁴⁰

Recommendation # 8

That the federal government collaborate with the provinces and the long-term care sector to immediately develop and implement a Pan-Canadian health human resources strategy, in order to improve access as well as meet the needs of a growing and aging population.

6e) Developing a Consistent Approach to Measuring Future LTC Demand

As mentioned earlier in this paper, there is a need to better track information for long term care including length of waits. Currently this information is not reported regularly aside from annual reports from the BC Office of the Seniors Advocate. Previous data outlined in this report from the Conference Board of Canada and BC Ministry of Health also clearly demonstrate the need for a large number of new beds. Individual projections also from the Vancouver Coastal Health Authority estimate that population of frail residents needing long term care will grow by over 40 per cent between 2014/15 and 2025/26.¹⁴¹

Request for Proposals

In BC, request for proposals (RFPs) for new long term care beds are generally posted on the [BC Bid website](#). As of the end of 2018, no health authorities in BC, however, had an RFP for new care beds posted on BC Bid. In fact, over the past six months only one RFP for new long term care beds has been

¹³⁹ Canadian Association for Long Term Care. Long Overdue: Improving Seniors Care in Canada. November 2018. Accessed at: <https://caltc.ca/wordpress/wp-content/uploads/2018/11/CALTC-budget-submission-ONLINE.pdf>

¹⁴⁰ Canadian Association for Long Term Care. Long Overdue: Improving Seniors Care in Canada. November 2018. Accessed at: <https://caltc.ca/wordpress/wp-content/uploads/2018/11/CALTC-budget-submission-ONLINE.pdf>

¹⁴¹ Vancouver Coast Health Authority. 2016/17-2018/19 Detailed Operational Plan Supporting Detail and Analysis Part A June 15, 2016, 72.

awarded. In January 2019, for example, the BC Ministry of Health announced that over 120 new long term or residential care beds had been awarded to Golden Life Management for the Comox Valley region as part of an earlier RFP that had been posted on BC Bid.¹⁴² These were part of an RFP for 120 long term care beds that had been issued by Island Health in March of 2018 and which closed in May of the same year.¹⁴³ While the BCCPA welcomed the Ministry of Health's announcement in January many more beds will be required to meet current and future demand for long term care.¹⁴⁴

BC Health Authority data

Overall, in BC there is very limited information on long term care bed projection demands that have been made publicly available by either Health Authorities or the Ministry of Health.

When the BCCPA contacted Health Authorities in late 2018 about its projections for future long term care beds it noted that their forecasts are in development and/or cannot be shared publicly. The BCCPA was able to find some of the following information that was publicly available although it does not provide a very complete picture (see Appendix B). At the time of the release of this report, the BCCPA was also exploring the possibility of a freedom of information (FOI) to obtain such data.

Measuring and tracking future long term care bed requirements

While this paper provides some information from the Health Authorities as well as outlines long term care bed projections based on various approaches including population ratios (i.e. Conference Board of Canada) and expected demand based on distinct population groups (i.e. frail elderly in residential or long term care), it will be important to develop a common approach to tracking and projecting demand for new long term care beds across the province. In particular, it will be crucial to develop a consistent approach to track and project future long term care bed requirements province wide and by regional health authorities.

The BCCPA believes a report on this should be developed by the BC government, health authorities and stakeholders by the end of 2022 as well as potentially updated every two years in order to project long term care bed needs at least ten years into the future. The BCCPA believes this will help with future planning to determine appropriate level of long term care beds required to meet the needs of BC's aging population.

Recommendation # 9

That the BC government and health authorities, in conjunction with stakeholders, develop a consistent approach to track and project future long term care bed requirements province-wide. A report on this should be developed by the end of 2022 and updated every two years to project long term care bed needs at least ten years into the future.

¹⁴² BC Ministry of Health. Improving seniors' care for the Comox Valley. January 16, 2019. Accessed at: <https://news.gov.bc.ca/releases/2019HLTH0009-000040>

¹⁴³ No updates on Island Health RFP for 120 long-term care beds. BC Local News. November 4, 2018. Accessed at: <https://www.bcclocalnews.com/news/no-updates-on-island-health-rfp-for-120-long-term-care-beds/>

¹⁴⁴ BCCPA. BCCPA congratulates Golden Life Management on winning Island Health RFP. January 2019. Accessed at: <https://bccpa.ca/2019/01/bccpa-congratulates-golden-life-management-on-winning-island-health-rfp/>

SECTION 7: ADDRESSING BC'S LTC NEEDS THROUGH ALTERNATIVE APPROACHES

If we assume that health services will be provided in the future as they have been in the past, health systems would need to double existing long term care capacity over the next 20 years to keep up with population growth. Ensuring there is capacity to meet the pending demand of a growing population of seniors, as discussed earlier, requires more than just building new beds; it also requires transforming the way care is provided across the continuum.¹⁴⁵

As outlined earlier, based on information provided by Conference Board and the Ministry of Health, BC requires a significant number of new long term care beds over the next 10 and 20 years. Earlier in this paper, the BCCPA recommends a provincial strategy to implement at least 30,000 long term care bed equivalents within the next twenty years. While new beds are part of the solution, some of this demand, however, can be potentially offset through other areas such increased assisted living and home care / support. Although these areas will not offset the need for the majority of new long term care beds it may help offset some assuming appropriate supports are also in place for both home care and assisted living.

Where possible, substituting long term care with other areas such as home care and assisted living will also create cost savings. The per-person cost of caring for a frail senior through home health care services and/or assisted living services is less than half the cost of caring for them in long term care on an annual basis (e.g. long term care: \$59,210; community: \$20,290; and community with high chronic condition: \$29,690). This is true even though frail seniors in the community have a higher number of emergency department visits than those who live in long term care (i.e. 18 % for frail seniors living in the community versus 7.1 % for those living in long term care).¹⁴⁶

Initiatives to reduce long term care demand

An earlier project in the Toronto Central Local Health Integration Network (LHIN) estimated that between one third and one half of individuals waiting for long term care could potentially be diverted safely and cost-effectively to care in the family home or in supportive housing if adequate home and community care resources were available.¹⁴⁷ Subsequent projects in other parts of Ontario estimated diversion rates ranging from 10 to 40 percent based on conventional service-by-service home care, with higher estimates associated with more integrated and cost-effective delivery models such as supportive housing, where needed services could be more easily provided around older persons living in the same building.¹⁴⁸

¹⁴⁵ Canadian Institute for Health Information. Seniors in Transition: Exploring Pathways Across the Care Continuum. Ottawa, ON: CIHI; 2017. Accessed at: <https://www.cihi.ca/sites/default/files/document/seniors-in-transition-report-2017-en.pdf>

¹⁴⁶ Canadian Institute for Health Information. Seniors in Transition: Exploring Pathways Across the Care Continuum. Ottawa, ON: CIHI; 2017. Accessed at: <https://www.cihi.ca/sites/default/files/document/seniors-in-transition-report-2017-en.pdf>

¹⁴⁷ Institute for Research and Public Policy. Integrating Long-Term Care into a Community-Based Continuum: Shifting from “Beds” to “Places”. A. Paul Williams, Janet Lum, et al. February 2016. Accessed at: <http://irpp.org/wp-content/uploads/2016/02/study-no59.pdf>

¹⁴⁸ Institute for Research and Public Policy. Integrating Long-Term Care into a Community-Based Continuum: Shifting from “Beds” to “Places”. A. Paul Williams, Janet Lum, et al. February 2016. Accessed at: <http://irpp.org/wp-content/uploads/2016/02/study-no59.pdf>

A long term or personal care home (PCH) bed equivalent as is referred to in the previously discussed Manitoba project could either be a PCH bed itself, a supportive housing bed, or some type of enhanced homecare service or services provided to group living. In Winnipeg, these alternative services could potentially divert just over 12.5% of PCH days, according to data outlined in an earlier report published by Manitoba Centre for Health Policy (Doupe et al., 2011). A more optimistic view of the data in that report indicates that around 19.5% of days may be able to be diverted from traditional PCH care. This would mean that of the 3,014 extra PCH bed equivalents projected for Winnipeg from 2011 to 2036, many could be provided through supportive housing or enhanced homecare.¹⁴⁹

The conventional wisdom is that the growing number of older persons (as well as children with complex medical needs and adults with disabilities who are also aging) will necessitate a proportional increase in the supply of long term care beds. An alternative view, backed by growing evidence and analysis, however, is that one of the problems is also a lack of community-based care.¹⁵⁰

As outlined by in a 2016 paper by the Institute for Research on Public Policy (IRPP), instead of seeing long term care beds as the ultimate destination for growing numbers of older persons, policy-makers need to see them as only one, albeit important element of a broader continuum of care places that will allow older persons and their informal caregivers to remain closer to home.¹⁵¹

Where formal and informal community-based supports are more accessible, fewer long term care beds will likely be required, and older persons will be more likely to age at home or in home-like settings. Conversely, where needed community-based supports are less accessible, older persons will be more likely to require residential or long term care, even at lower levels of need.¹⁵²

In summary, due to changes in how we view seniors care a growing number of jurisdictions are instead thinking about places for long-term care by focusing on what people need to maintain their functional capacity and independence at the highest possible level for the longest possible time, regardless of setting (Billings and Leichsenring 2006; Schulz 2014).¹⁵³

7a) Assisted Living – Bill 16 changes

In BC we are also seeing a shift towards less long term care by focusing more on programs such as *Home is Best* and *Home First* to keep people longer at home. This along with some of the initiatives that health authorities are undertaking particularly Fraser Health in optimizing the process on who enters long term care are explored later in this paper.

The focus of this first section, however, is on the changes that are occurring in BC around assisted living particularly with Bill 16 and changes to the Community Care and Assisted Living Act (CCALA).

¹⁴⁹ Manitoba Centre for Health Policy. Projecting Personal Care Home Bed Equivalent Needs in Manitoba Through 2036. Chateau D, Doupe M, Walld R, Soodeen R, Ouelette C, Rajotte L. October 2012. Accessed at: http://mchp-appserv.cpe.umanitoba.ca/reference/MCHP_pch_days_report_WEB.pdf

¹⁵⁰ Institute for Research and Public Policy. Integrating Long-Term Care into a Community-Based Continuum: Shifting from “Beds” to “Places”. A. Paul Williams, Janet Lum, et al. February 2016. Accessed at: <http://irpp.org/wp-content/uploads/2016/02/study-no59.pdf>

¹⁵¹ Ibid.

¹⁵² Ibid.

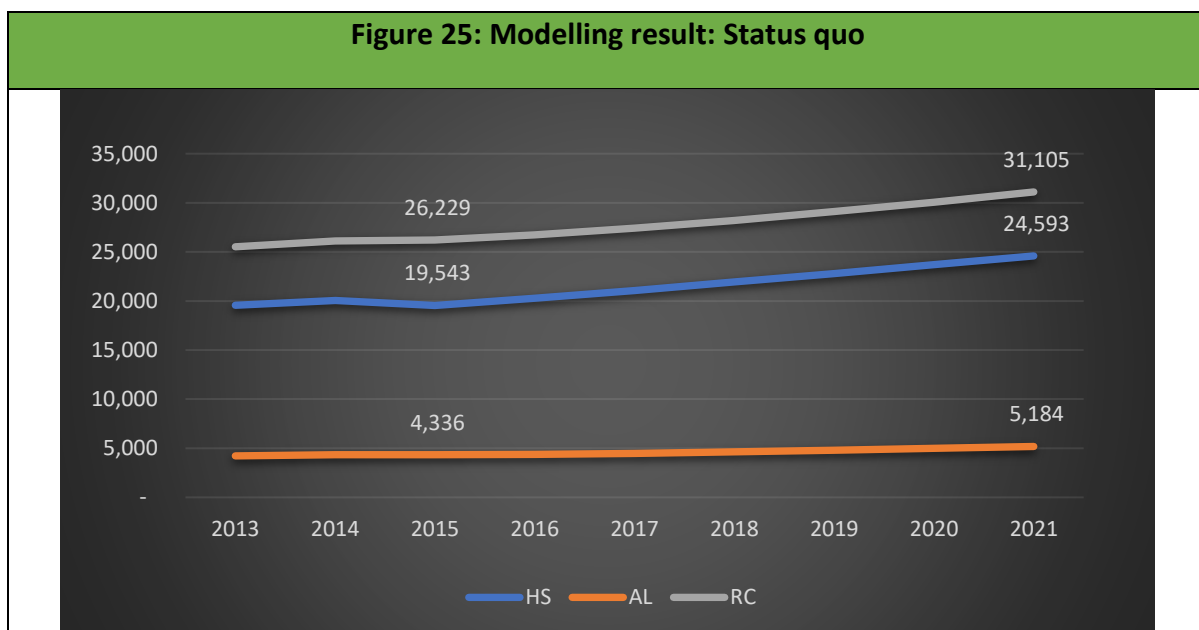
¹⁵³ Ibid.

Amendments to the CCALA announced March 7, 2016, received Royal Assent on May 19, 2016. Actual practical changes, however, are expected to occur after the provisions including new regulations are brought into force, which is anticipated sometime in 2019.

Currently, assisted living residents are supported with no more than two prescribed personal services (e.g., regular assistance with ADLs, medication management, financial management, behavior management, intensive physical therapy, psychosocial therapy). Beyond two services, clients are deemed no longer eligible for assisted living and would generally be transferred to long term or residential care. Under the legislative changes, the limit of two services, however, will be removed, enabling more individuals to qualify for Assisted Living.

Modeling Projections (potential impact of Bill 16)

According to projections from the Canadian Institute for Health Information (CIHI) that was provided to the BC Ministry of Health in 2018, the changes with Bill 16 could have the potential to delay or prevent some people from going into long term care. The highlights of the results are outlined below.

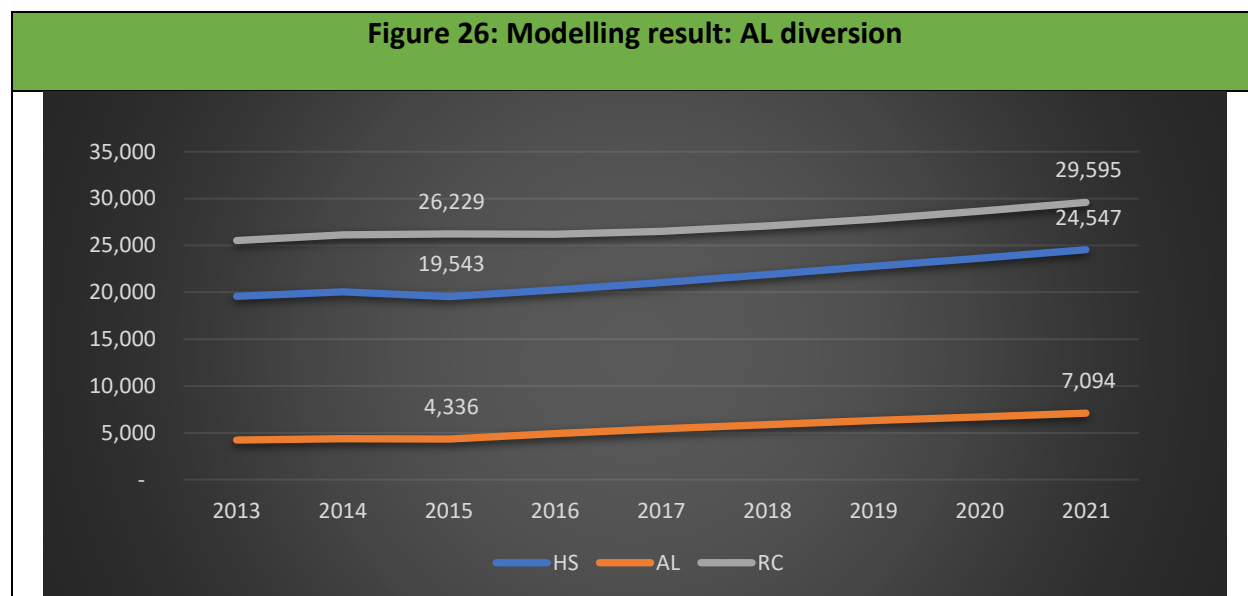


The figure above outlines at a given point for each year how many people are or are projected to require long term care (LTC), home support (HS) and assisted living (AL). As outlined, the future projections are based on the status quo with no increased diversions from LTC to HS or AL. The figure shows increases projected for each area including between 2015 to 2021:

- 19% increase in long term care (26,229 to 31,105);
- 25% increase in home support (19,543 to 24,593); and
- 20% increase in assisted living (4,336 to 5,184).

In summary, the figure above shows increases across the continuing care sector as would be expected with an aging population. As outlined in next figure below, however, with some of the expected changes to AL particularly with Bill 16, it is anticipated that even more people particularly seniors will enter or remain in assisted living as opposed to going into long term or residential care. The figure below, for example, shows increases projected for each area between 2015 to 2021, but with a greater increase in persons being diverted to assisted living particularly with the pending Bill 16 changes:

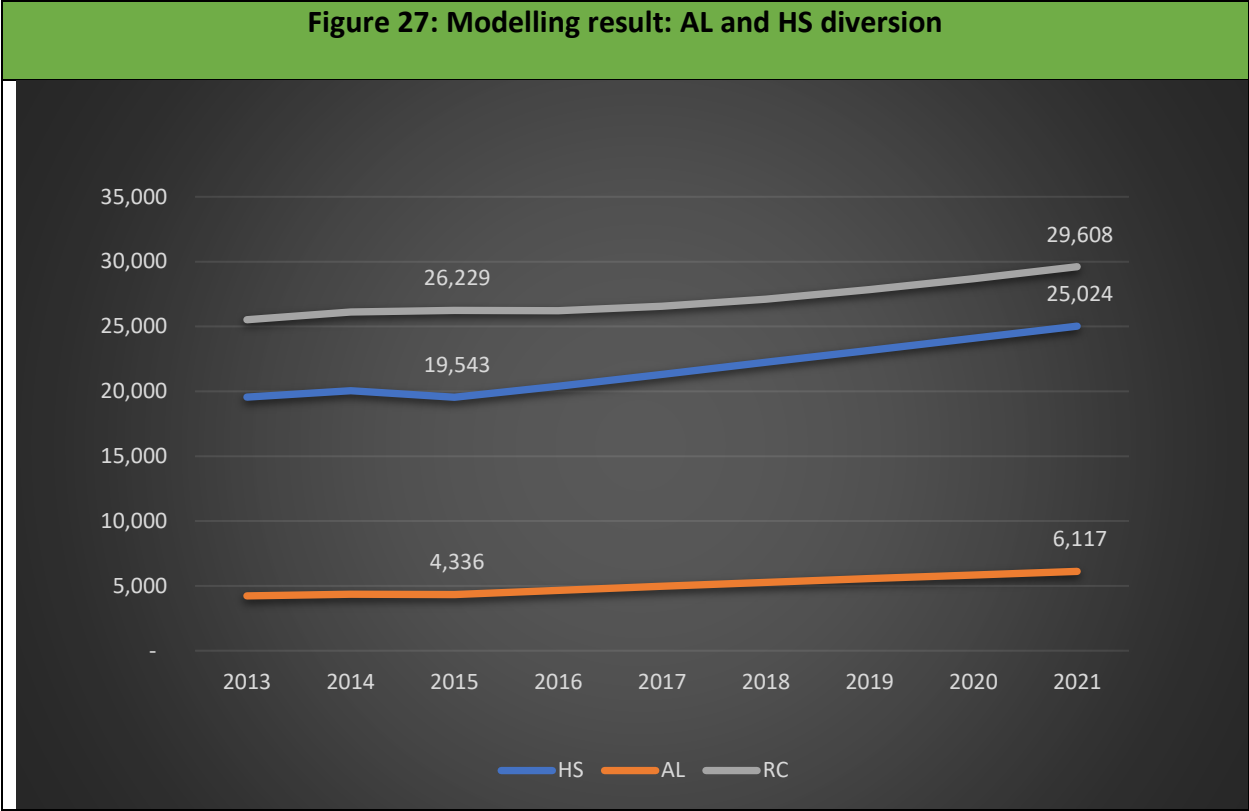
- 13% increase in long term care (6% less than status quo);
- 25% increase in home support (same as status quo); and
- 64% increase in assisted living (44% increase from status quo).



As can be seen in the figure above, increases for AL could be potentially significant with many more people entering or remaining in assisted living as opposed to going into long term care. With such potential changes, increasing capacity for assisted living will also have to be part of any policies or strategies going forward.

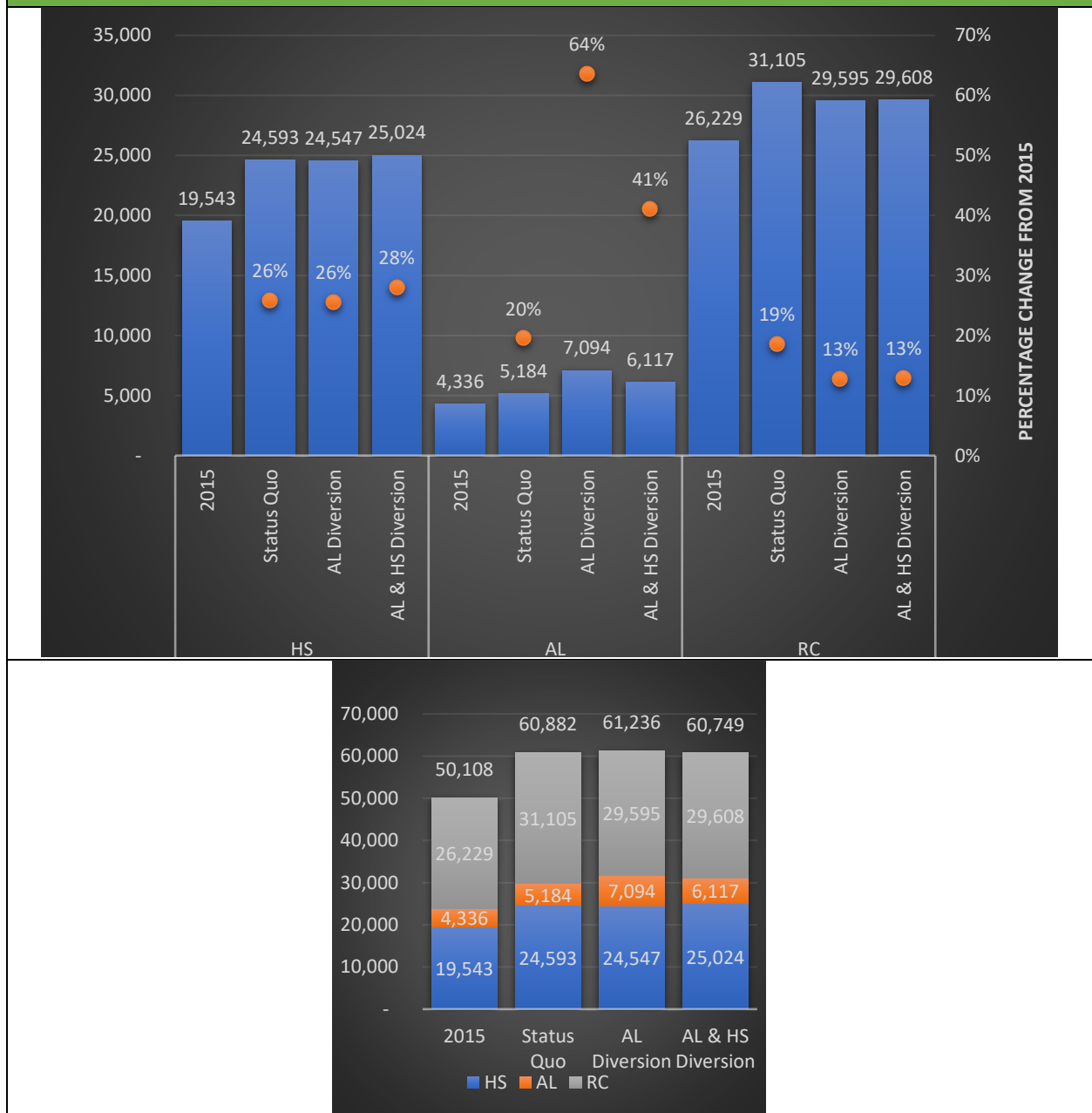
As outlined in the figure below, with some of the expected changes to assisted living (i.e. Bill 16) but also further emphases on home support it is anticipated that even more people particularly seniors will enter or remain in assisted living or home as opposed to going into long term care. The figure below, for example, shows increases projected for each area including between 2015 to 2021, but with a greater increase in persons being diverted to assisted living as well as home support:

- 13% increase in long term care (6% less than status quo);
- 28% increase in home support (3% increase from status quo); and
- 41% increase in assisted living (21% increase from status quo).



As can be seen in the figure above, the increases for assisted living could be potentially significant with many more people entering or remaining in assisted living as opposed to going into long term care. The overall increases, however, are not as significant as the earlier figure, as more people essentially who would have gone to AL would remain at home. A summary of the all of the above findings are outlined in the figure below.

Figure 28: Summary of Findings



Anticipated cost savings

As outlined in the following modeling analysis from CIHI, there are some projected cost savings to the continuing care sector by diverting more persons to home support and assisted living from long term or residential care. For example, with home support and assisted living diversions from long term care, there would be estimated cost savings of about \$56 million per year as highlighted in the table below.

Some of these additional cost savings, however, might be curtailed as new additional resources and supports would need to be provided to assisted living and home support to accommodate an influx of new clients. Likewise, it does not account for other areas where costs could potentially increase including acute or emergency care.

A recent study from Alberta, for example, found that the incidence of hospital admission was about 3 times higher among assisted or supportive living residents than among long term care residents (14%). In particular, nearly 40% of supportive living residents in Alberta were admitted to hospital over 1 year, a rate substantially higher than that for long term care residents.¹⁵⁴

Table 36: Estimated Cost Savings with Diversion from Residential care to AL and Home Support						
	Baseline 2015	Status quo	AL diversion low	AL diversion moderate	AL diversion high	AL and HS diversion
Home Support	\$367	\$461	\$461	\$461	\$461	\$470
Assisted Living	\$213	\$256	\$310	\$349	\$369	\$301
Residential Care	\$1,920	\$2,277	\$2,211	\$2,166	\$2,144	\$2,167
Total	\$2,500	\$2,994	\$2,981	\$2,976	\$2,974	\$2,938
Cost Avoidance (millions)			\$13	\$18	\$20	\$56
Cost Avoidance as % of Status Quo			-0.4%	-0.6%	-0.7%	-1.9%
* Figures are in millions of dollars						

¹⁵⁴ High rates of hospital admission among older residents in assisted living facilities: opportunities for intervention and impact on acute care. David Hogan et al. Open Medicine, Vol 8, No 1 (2014). Accessed at: <http://www.openmedicine.ca/article/view/622/541>

In summary, at this point it is difficult to accurately project how the Bill 16 changes to assisted living will impact long term or residential care as the legislation and regulations have yet to be formally implemented. Using CIHI's modeling analysis as outlined above, however, at least over the next few years (until 2021) the AL changes could potentially result in some reductions (up to 6%) of those entering long term care. As such, when factoring in future bed demand projections, changes to assisted living will also need to be taken into account as it may mitigate some demand although not considerably as would appear from the CIHI study.

Regardless of its impact on long term care, the changes anticipated with Bill 16 will require a significant amount of new resources and capital to meet expected demand for assisted living. As outlined earlier, in Alberta \$180 million in grants were made available to help private and non-profit operators build 2,600 new continuing care spaces over three years, with 2,200 of those for supportive living (similar to AL in BC).¹³ These living arrangements are thought to be a less costly (for public payers) as well as in some cases a more appropriate alternative to long-term care beds for many seniors.

7b) CIHI Data – Seniors in Transition

Similar to the earlier data outlined on assisted living, CIHI has done further studies which outline that too many people may be entering long term care who do not need to. This was also outlined in a 2016 report from the BC Office of the Seniors Advocate comparing BC with Alberta and Ontario noting that up to 15% people in residential or long term care could potentially be supported in other care settings.¹⁵⁵ As highlighted in the OSA report the up to 15% figure equates to about 1,500 to 4,400 individuals who could potentially live more independently.

Likewise, Fraser Health through their Residential Care Optimization initiative, as discussed later, has indicated that 4 to 5% (300 to 400 residents) of its current residential or long term care population could be cared at home with support in assisted living or other congregate housing with care settings. Overall, studies have shown that some seniors who are placed in long term care are clinically very similar to others who are able to remain in their homes in the community with the right supports.¹⁵⁶

In a 2017 CIHI study entitled *Seniors in Transition: Exploring Pathways Across the Care Continuum*, it highlights that about 1 in 5 (22%) seniors who entered long term care following an initial assessment had low to moderate MAPLe scores and might have been able to be supported elsewhere (i.e. home care or assisted living). The study also identified additional subpopulations of seniors for whom appropriate community-based supports could have helped delay or avoid admission to long term care. When these sub-populations are included, the ratio increases to about 1 in 3 (30%) in Canada or about 1 in 5 (21%) for BC.¹⁵⁷

¹⁵⁵ Office of the Seniors Advocate British Columbia. *Placement, Drugs and Therapy... We Can Do Better*. 2016.

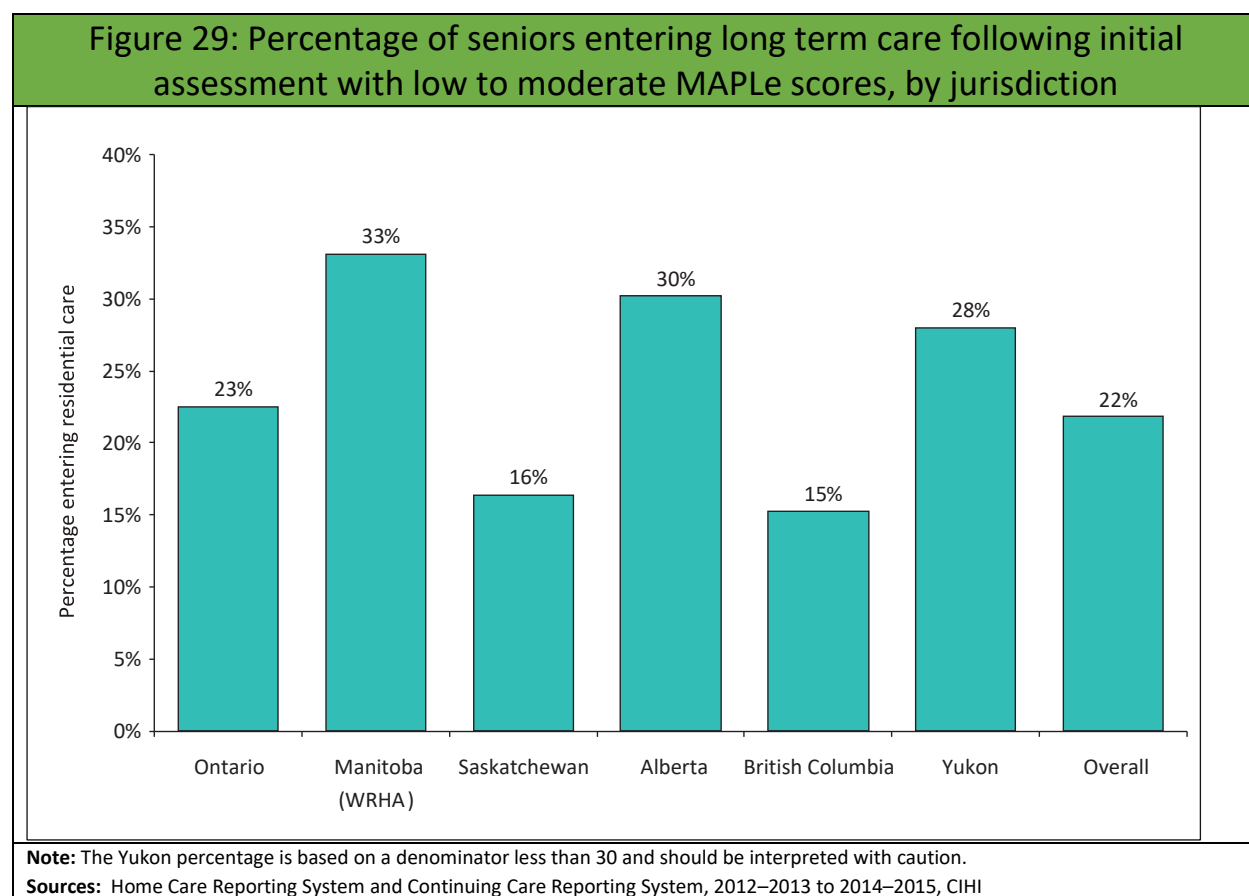
¹⁵⁶ Doupe M, John PS, Chateau D, Strang D, Smele S, Bozat-Emre S, Fransoo R, Dik N. *Profiling the multidimensional needs of new nursing home residents: Evidence to support planning*. *Journal of the American Medical Directors Association*. June 2012.

¹⁵⁷ Canadian Institute for Health Information. *Seniors in Transition: Exploring Pathways Across the Care Continuum*. Ottawa, ON: CIHI; 2017. Accessed at: <https://www.cihi.ca/sites/default/files/document/seniors-in-transition-report-2017-en.pdf>

As also noted in another report, seniors with high and very high MAPLe scores (4 and 5) are often prioritized for placement in residential or long term care homes, while those with low to moderate MAPLe scores (1 to 3) are typically supported in home care.¹⁵⁸

For the CIHI report, it examined various subpopulations which are highlighted in further detail in Appendix C. As mentioned, from the CIHI analysis about 1 in 5 (22%) seniors in the study who entered residential or long term care following an initial assessment had low to moderate MAPLe scores and might have been able to be supported in home care (or assisted living).

As outlined in the figure below, the percentage of seniors entering long term care who met this criterion was lowest in British Columbia (15%) and highest in Manitoba (WRHA only, 33%).¹⁵⁹



¹⁵⁸ Hirdes JP, Poss JW, Curtin-Telegdi N. [The Method for Assigning Priority Levels \(MAPLe\): A new decision-support system for allocating home care resources](#). *BMC Medicine*. March 2008.

¹⁵⁹ Canadian Institute for Health Information. *Seniors in Transition: Exploring Pathways Across the Care Continuum*. Ottawa, ON: CIHI; 2017. Accessed at: <https://www.cihi.ca/sites/default/files/document/seniors-in-transition-report-2017-en.pdf>

While the figure above highlights that BC is doing relatively better compared to the Canadian average (22%) and other jurisdictions in ensuring people who enter long term care should be there; from the CIHI data it appears there is still room for improvement. This is particularly the case when also look at additional sub-populations as outlined in the table below.

Table 37: Percentage of seniors entering residential care following an initial assessment, by jurisdiction and subpopulation					
Jurisdiction	MAPLe low–moderate	Physical needs	Lighter care needs	Dementia and light care needs	Any subpopulation
Ontario	23	20	3	10	31
Manitoba (WRHA)	33	21	15	16	47
Saskatchewan	16	13	4	5	21
Alberta	30	17	14	15	41
British Columbia	15	14	2	9	21
Yukon	28	16	12	28	44
Overall	22	18	4	10	30
Source: Home care Reporting System and Continuing Care Reporting System, 2012-2013 to 2014-2015, CIHI.					

As outlined in the table above, with additional subpopulations of seniors for whom appropriate community-based supports could have helped delay or avoid admission to long term care – the ratio increases to about 30% in Canada or about 21% for BC.

According to further data outlined in the CIHI report, seniors with high and very high MAPLe scores averaged 56 days between the initial assessment and entry to long term care (median 30 days), while those with low to moderate MAPLe scores averaged 73 days (median 26 days).¹⁶⁰

The percentage of seniors entering into a care home from hospital also ranged significantly among jurisdictions, from 43% in Saskatchewan to a high 89% in BC, potentially suggesting the need to reduce the number of seniors who are coming into residential or long term care from a hospital. As discussed later in this paper, this is one of the main focus areas of the FHA’s Residential Care Optimization project.

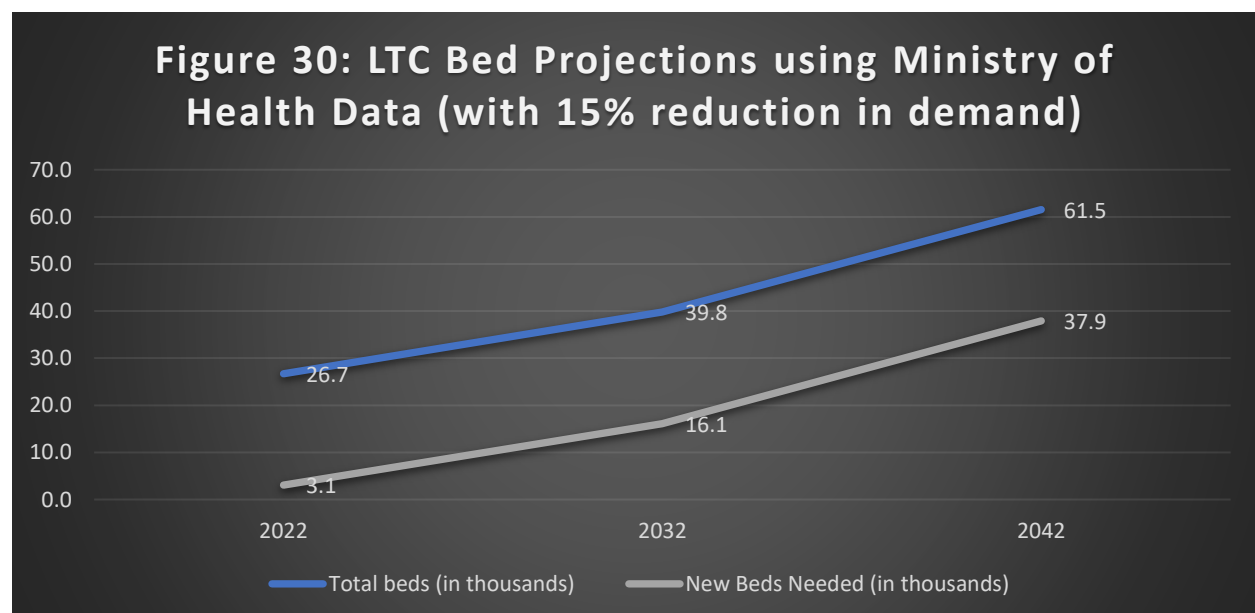
¹⁶⁰ Canadian Institute for Health Information. Seniors in Transition: Exploring Pathways Across the Care Continuum. Ottawa, ON: CIHI; 2017. Accessed at: <https://www.cihi.ca/sites/default/files/document/seniors-in-transition-report-2017-en.pdf>

Diverting some of LTC demand to Assisted Living and Home Care

While the projected demand beds as outlined earlier in this paper (section 6) do not include those waiting for long term care (in hospital or home) it also does not include addressing people who may not need to be in long term care but could be cared for elsewhere including assisted living or home if appropriate supports are in place. Assuming as noted from the earlier CIHI study or by the OSA that potentially up to 15 percent or more of those entering long term care could be cared for appropriately elsewhere, the following table below outlines revised long term care bed demand projections as seen earlier in section 6.

Table 38: Revised - Projected Demand for Long Term Care Beds (to 2041/42)			
Health Authority	Next 10 years to 2041/42	Bed projections 2042	New Beds Needed (with 15% reduction)
Fraser Health	31,847	21,387	14,103
Interior Health	15,895	9,648	4718
Vancouver Coastal	21,691	17,017	11,223
Vancouver Island	17,751	11,386	6741
Northern Health	3274	2185	1182
Totals	90,458	61,623	37,967

With the revised projections, BC still requires a large number of new long term care beds even if as outlined up to 15 percent in long term care could be diverted elsewhere. In particular, even factoring a 15% reduction, by 2041/42 BC would need close to 38,000 new long term care beds (see figure below).



Diverting new Long Term Care Demand through New Care Models

7c) Continuing Care Hubs

As discussed earlier, the BCCPA believes some of the demand for new long term care beds can be potentially addressed through new approaches to care whether it is the assisted living changes through Bill 16 or home health care including programs such as *Home is Best*. Likewise, approaches such as the Fraser Health Authority Residential Care Optimization initiative as discussed later may also assist in lessening or mitigating future demand for long term care beds.

While these programs or initiatives are part of the solution, it will also be important to look at new models of care. The BCCPA, for example, since 2015 in its *Quality-Innovation-Collaboration* paper has been advocating for what it calls the Continuing Care Hub model.¹⁶¹ While these hubs are envisioned to care primarily for the current and future seniors in long term care, they could also provide care (i.e. sub-acute, etc.) for seniors living in the larger community - particularly the vast majority of seniors who live in their home whether this be a single-family residence or apartment. The BCCPA believes that along with improving access to long term care, the new Continuing Care Hubs could also potentially offset demand for more costly care beds by allowing seniors to remain at home longer.

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

Continuing Care Hubs – Respite Care

As discussed in *Quality-Innovation-Collaboration*, one area of focus for the new Continuing Care Hubs could be the provision of respite care including for frail seniors. Respite care is the provision of short-term and/or temporary relief to those who are caring for family members or loved ones who might otherwise require permanent placement in long term care outside the home. Respite beds allow seniors to leave home and stay in a care home for up to 30 days in a one-year period. A typical residential or long term care home may allocate a small percentage of total beds to short-term respite care and may decrease the number of short-term beds if additional beds are needed to provide long-term residential care.

As outlined in one report, the level of demand for respite care in British Columbia is quite high compared to most jurisdictions.¹⁶² In a 2015 report entitled *Caregivers in Distress: More Respite Needed*, the BC OSA also highlights that the number of respite beds in BC fell by 12% between 2012 and 2015.¹⁶³ As the

¹⁶¹ BCCPA. *Quality-Innovation-Collaboration: Strengthening Seniors Care Delivery in BC*. September 2015. Accessed at: <https://bccare.ca/wp-content/uploads/BCCPA-White-Paper-QulC-FINAL-2015.pdf>

¹⁶² Respite for Family Caregivers: An Environmental Scan of Publicly-funded Programs in Canada". Prepared for Health Canada by Janet Dunbrack. February 2003. http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2003-respite-releve/2003-respite-releve-eng.pdf

¹⁶³ BC Office of the Seniors Advocate. *Caregivers in Distress: More Respite Needed*. September 2015. Accessed at: <https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2015/09/CaregiversReport.pdf>

following table demonstrates, there has been overall little increases since 2015 as the number of respite beds has remained relatively constant over the last five years.

Table 39: Number of Respite Beds on March 31, 2014-2018					
Health Authority	2014	2015	2016	2017	2018
IHA	63	61	62	62	60
FHA	40	41	45	43	43
VCHA	24	25	26	27	29
VIHA	41	39	38	38	38
NHA	32	34	34	34	33
B.C.	200	200	205	204	203
Source: BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf					

Continuing Care Hubs – First Appropriate Bed

Along with increasing access to services and beds for seniors to allow them to live in the most appropriate care setting, new LTC models, particularly the Continuing Care Hub, could also assist in increasing choice for seniors utilizing the current BC “First Appropriate Bed” (FAB) policy. Under this policy adopted by all the health authorities, a senior who has been assessed as ready for a move to residential or long term care must accept the first appropriate bed that becomes available in their chosen geographic catchment area. In particular, they have 48 hours to accept and move to the bed offered, or risk being removed from the priority list for a FAB. The FAB policy is designed to ensure that those who are the most in need of a long term care home bed secure that bed as quickly as possible.¹⁶⁴ This policy is currently, however, being revised with changes expected in 2019. Under the revised policy it is expected it will provide persons with greater options including more choice of beds and not be limited to geographical area of residence.

While this paper does not go into detail about the Continuing Care Hub, the BCCPA is leading a separate project on this, which will outline different potential models of care and how they could potentially improve access to care for seniors in the future, if implemented, on a province wide scale. A graphical depiction of the potential models as part of the Care Hub concept is outlined below.

¹⁶⁴ British Columbia. Ministry of Health. (2014). Home and community care: Policy manual. Victoria: Ministry of Health. Retrieved from http://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/hcc-policy-manual/6_hcc_policy_manual_chapter_6.pdf

Figure 31: Continuing Care Hub (Key Tenets)

Current Model	Enhanced Models			
Current long term care model (i.e. existing long term or residential care model in BC)	Integrated Home and Long Term Care Model (i.e. care homes or hubs provide home health care services, including home support to seniors in the community)	Enhanced Specialized Services Model (i.e. care homes or hubs with commensurate or appropriate funding provide enhanced specialized medical services to seniors in long term care and the community, such as sub-acute care, etc.)	Enhanced Community Health Services Model (i.e. care homes or hubs provide community health services to seniors in the community like primary care, health promotion, screening, etc.)	Community non-medical services model (i.e. care homes or hubs provide non-medical services to seniors in the community such as adult day or night programs, etc.)

As outlined in its 2018 provincial budget submission, the BCCPA advocated 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. In the context of this paper, the BCCPA also believes that the Continuing Care Hub model should be explored as a means to improve access to long term care but also potentially home health care and assisted living as well. Likewise, the BCCPA believes the Care Hub model along with reducing costly acute care or ER visits also has the potential to reduce some of the demand for new long term care beds by allowing seniors to remain in the community.

7d) Other Models / Approaches to reduce demand for long term care

Home Health Models

Along with Continuing Care Hubs and changes to Bill 16 on assisted living as discussed earlier, demand for long term care could be further mitigated by investing appropriately in various home health care models. This was a focal area of the BCCPA paper released in February 2018 entitled *Health Begins at Home: Strengthening BC's Home Health Sector* which recommended \$20 million per year for the Ministry of Health and all partners to support the adoption of new home health care models province-wide, in order to allow seniors to remain at home longer as well as reduce ALC days and improve overall quality care.

One such program outlined in the BCCPA paper is *Home is Best*. Under BC's 'Home is Best' program, in-home care is provided to individuals with the goal to keep people out of acute and long term care as well as to help seniors live safely at home and avoid future hospital emergency admissions. The main tenet is that the health care team can keep people safe at home and/or return them home from hospital as soon

as they are ready. By partnering with family doctors and other health care professionals, more in-depth care can be provided and attention placed on the client's full range of health care needs.¹⁶⁵

The philosophy states that home, not hospital or long term care, is the best place to recover from an illness or injury, manage long term conditions and live out final days. Although 'Home is Best' was pioneered by Fraser Health, it is now being adopted by other BC Health Authorities. At a system level, 'Home is Best' is a bundle of system enablers, such as proactive discharge planning, expanded community support services, increased access to home care services, and telephone outreach, that helps seniors stay in their homes for longer, return home after a hospital stay as soon as possible, and prevent or delay admission to hospital or long term care until necessary.¹⁶⁶

In March 2013, the BC government as part of a new funding announcement of \$50 million over three years for targeted primary and community care programs, noted that the 'Home is Best' Program would be rolled out in all five Health Authorities in BC. This program has had some positive impact with fewer admissions to acute and long term care. In Vancouver Coastal, the program, for example, resulted in a 30 per cent decrease in acute care use and a 25 per cent reduction in emergency department visits.¹⁶⁷ While there have been benefits to the 'Home is Best' model, ultimately it needs to be funded at higher rates to be sustainable. This, unfortunately, is not the case.

Geriatric Hospitals

While BCCPA and many other stakeholders have advocated, where appropriate, attempting to keep seniors out of hospital; meeting some of the future long term care demand may require looking further at the role of Geriatric Hospitals. This also includes exploring ways to make hospitals more senior friendly. This is particularly important as Canadians over 65 years old use over 40 per cent of hospital services and demand continues to rise. As noted in one recent article, the main problem is that hospitals remain better suited to care for healthy surgical patients and acute illnesses like pneumonia as most are not geared to help frail seniors cope with acute illnesses or flare-ups of chronic conditions.¹⁶⁸

An example of a senior or elder friendly hospital is Mount Sinai in Toronto, Ontario. In particular, Mount Sinai has implemented evidence-informed models and point-of-care interventions to demonstrate better patient, provider and system outcomes particularly through its Acute Care for Elderly (ACE) initiative. ACE is a seamless model of care for older adults that spans the continuum of the emergency department, inpatient, outpatient and community care. As part of this model, interprofessional teams of specialist physicians – particularly geriatricians and geriatric psychiatrists – advanced practice nurses, social workers, therapists, pharmacists, dieticians and volunteers work together to provide better, more coordinated care for patients. Using interprofessional teams and various tools, the hospital has also

¹⁶⁵ Canadian Home Care Association. Integrated Models of Care. Developing an Integrated Primary and Home & Community Care System. Accessed at: <http://www.cdnhomecare.ca/media.php?mid=4717>. November 2016.

¹⁶⁶ Canadian Home Care Association. Integrated Models of Care. Developing an Integrated Primary and Home & Community Care System. Accessed at: <http://www.cdnhomecare.ca/media.php?mid=4717>. November 2016.

¹⁶⁷ BC Ministry of Health. B.C. continues to expand primary and community care. March 1, 2013. Accessed at: <http://www.newsroom.gov.bc.ca/2013/03/bc-continues-to-expand-primary-and-community-care.html>

¹⁶⁸ Making Evidence Matter: The Evidence Network. Better information is the key to making hospitals more senior friendly. George Heckman and Paul Hébert. November 2018. Accessed at: <https://evidencenetwork.ca/better-information-is-the-key-to-making-hospitals-more-senior-friendly/>.

demonstrated significant improvements in overall quality of care outcomes, as well as reduced lengths of stay, admissions, readmissions and inappropriate resource utilization for seniors.¹⁶⁹

The Canadian Foundation for Healthcare Improvement (CFHI), in partnership with the Canadian Frailty Network also led a 12-month quality improvement collaborative aimed at supporting elder-friendly models of care and practices. A total of 18 improvement teams across Canada and internationally were accepted into the collaborative and received funding, coaching, educational materials and tools to support the adaptation of Mount Sinai Hospital's ACE Strategy elder-friendly components to their local context.¹⁷⁰

Reducing Length of Stay

Specific to long term care, the effects of programs such as the *Home is Best* or changes to Assisted Living as part of Bill 16 is in part to prevent or delay people from entering into long term care. As discussed earlier, the effects of such programs that delay entry into long term care is also resulting in higher acuity levels over time for seniors who enter such care. Likewise, one of the results may also be decreases to the overall average length of stay (ALOS).

The BCCPA believes that some of the future demand in long term care beds may be offset by reductions in ALOS, although as indicated by previous data this does not appear to be occurring to any large extent. For example, while there have been some changes over the past year; overall ALOS in long term care has either remained fairly constant or increased over the past five years across the five regional health authorities, contrary to anecdotal reports from health authorities and operators (see table below).¹⁷¹

Table 40: Median and Average Length of Stay in Residential Care, 2014/15 to 2016/17						
	2015/2016 Q1		2016/17 Q1		% change 2015/16 to 2016/17	
Health Authority	Median LOS (days)	Average LOS (days)	Median LOS (days)	Average LOS (days)	Median LOS (days)	Average LOS (days)
IHA	464	709	351	650	-24%	-8%
FHA	497	828	489	794	-2%	-4%
VCHA	462	863	637	1017	38%	18%
VIHA	513	844	350	730	-32%	-14%
NHA	783	1100	833	1091	6%	-1%
BC	500	822	447	806	-11%	-2%
Source: OSA, Monitoring Seniors Services (2017)						

¹⁶⁹ Canadian Foundation for Healthcare Improvement. About the Innovation. Accessed at: <https://www.cfhi-fcass.ca/WhatWeDo/ace/innovation>

¹⁷⁰ Canadian Foundation for Healthcare Improvement. About the Acute Care for Elders (ACE) Collaborative. Accessed at: <https://www.cfhi-fcass.ca/WhatWeDo/ace>

¹⁷¹ BC Ministry of Health. Residential Care Staffing Review. March 2017. Accessed at: <https://www.health.gov.bc.ca/library/publications/year/2017/residential-care-staffing-review.pdf>

As outlined in a BC Ministry of Health report, there was a 17.6% increase in ALOS from 705 days in 2009/10 to 829 days in 2014/15 for all of BC. This includes a 4.7% increase from 2013/14 (791 days) to 2014/15 (829 days).¹⁷² Regardless, changes in ALOS will need to be monitored when projecting need or demand for long term care beds.

According to the latest data, in 2017/18, the median length of stay in long-term care for all clients discharged during the year was 480 days - a 9% decrease over the previous year. The median length of stay varies between 1 and 2 years across all health authorities. The median length of stay is a better measure as it is more stable than ALOS and as such is outlined in the table below.¹⁷³

Table 41: Median Length of Stay in Long-Term Care, 2013/14-2017/18						
Health Authority	2013/14	2014/15	2015/16	2016/17	2017/18	% Change in Last Year
IHA	352	389	391	467	367	-21%
FHA	539	577	578	527	494	-6%
VCHA	617	566	620	580	620	7%
VIHA	481	463	510	517	480	-7%
NHA	645	802	766	710	719	1%
B.C.	495	498	533	529	480	-9%
Source: BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf						

As mentioned earlier, reducing LOS is one of the main tenets of the Residential Care Optimization initiative being undertaken in the Fraser Health Authority, as described below.

Residential Care Optimization – Fraser Health Authority

Like other health authorities, Fraser Health is facing significant challenges as demand for long term care increases. Between 2010 and 2016 while those aged 75 and over increased by 23% and those over 85 increased by 36%, the total long term care bed inventory in the region only increased by 8%. To meet demand for long term care, the 2016-2023 FHA Residential Care Facility Plan only included a modest increase in capacity (500 new beds and rejuvenation of 1500 beds) with the hope some of the demand will also decrease as fewer people enter long term care and/or are admitted later in life with a shorter length of stay.

Overall, the main focus of the FHA's Residential Care Optimization program is to reduce some of the demand as well as to better support people at home. As outlined by FHA, inappropriate and/or premature placements in long term care are costly, for both patients and the health system it also affects

¹⁷² BC Ministry of Health. Residential Care Staffing Review. March 2017. Accessed at: <https://www.health.gov.bc.ca/library/publications/year/2017/residential-care-staffing-review.pdf>

¹⁷³ Source: BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

current / projected residential or long term bed shortfalls.¹⁷⁴ As indicated in table below, using internal data presented at a November 2016 FHA meeting with stakeholders, a proportion of current residents in Fraser Health care homes are less complex than those in other health authorities and provinces.

Table 42: RAI 2.0 DATA of Individuals currently in RC	AB	ON	BC	FH
Profile 1: LIGHT PHYSICAL & COGNITIVE CARE NEEDS Relatively low care needs with relatively high levels of both cognitive and physical function	2.3%	5.6%	6.1%	8.1%
Profile 2: DEMENTIA CARE NEEDS Cognitive impairment that can make it challenging for them to live alone, but low physical care needs and low medical needs	0.9%	1.8%	5.4%	3.8%
Profile 3: HIGHER PHYSICAL CARE NEEDS Somewhat higher physical care needs but, in all other respects, could potentially receive care in the community	1%	3%	4.7%	1.1%
TOTALS	4.2%	10.4%	16.2%	13%

Preliminary project findings from FHA indicated that between 4 to 5% (approx. 300-400 residents) of Fraser Health's current long term care client population could be cared for at home with support, assisted living, or other congregate housing with care settings. As noted this would mean freeing up beds and further creating system capacity for individuals whose needs can not be met at home and truly need residential or long term care services.¹⁷⁵

While the FHA residential care optimization initiative is multi-faceted, one of the main components includes the redesign and implementation of more rigorous screening processes, including creating local Review Panels to assess long term care eligibility aligned with new Complex Care Criteria.¹⁷⁶ The initiative also involves increasing capacity through the redesign and implementation of more effective client facility placement processes to better meet client care needs and utilize current long term care bed inventory.

¹⁷⁴ Upcoming Changes to Residential Care Admission and Placement Process. Fraser Health Residential Care Optimization Plan. November 2016.

¹⁷⁵ Upcoming Changes to Residential Care Admission and Placement Process. Fraser Health Residential Care Optimization Plan. November 2016.

¹⁷⁶ Residential care is a service for adults 19 years and over whose ongoing complex physical, psychological and social needs require 24 clinical RN/PRN/LPN supervision. Their unscheduled, unpredictable or high intensity care needs cannot be managed at home and they have exhausted all formal and informal caregiving support. Typically, they have multiple long term irreversible health conditions with physical or cognitive impairment causing life-limiting frailty and are deemed as living at an intolerable level of risk to self and others.

Along with reducing number of people going into long term care, some of goals of the initiative include to decrease average length of stay (ALOS) from 2.7 years to 2 years; decrease arrival rates to long term care by 5% from 2015 rates; and reduce acute care arrival rates from ~60% to 40% (BC range is 50 to 74%).

Update on FHA Residential Care Optimization Initiative

As outlined in an update provided by FHA to BCCPA in February of 2019, Phase I of the FHA Residential Care Optimization work which has been completed focused on improving processes and decisions for determining when an individual requires residential or long term care (i.e. when individual's care needs meet care level for long term care and when all less intensive care options have been tried / exhausted, and there are no other options available). In this regard, Fraser Health has made some significant strides in improving its ability to better support clients with long-term complex care needs in their own homes within the community. In particular, this includes reducing demand for long term care in 2017/18 where:

- 82% of new admissions to long term care were occurring within 30 days (the previous four years it was under 60%);
- There were 16% less referrals to long term care in 2017 compared with the previous year; and
- A higher number (56%) of individuals were being placed directly from community versus acute.¹⁷⁷

As outlined in the update provided to BCCPA, the FHA is now focusing on phase II of Residential Care Optimization initiative which includes co-locating residents based on their Client Care Profile to ensure residents with similar needs will be grouped together, allowing for more needs-focused care, provided in an appropriate physical environment by staff who have the necessary skills and knowledge, resulting in a better resident experience. This includes the creation of Behavioral Support Transition Neighborhoods (BSTNs) which replace Special Care Units.

Funding for each bed within a BSTN has also been raised to 3.36 Hours Per Resident Day (HPRD), of which 3.0 hours is Nursing (RN, LPN, Care Aide) and 0.36 professional and non-professional allied. Likewise, there has been a focus on ensuring that the over 40 care homes in Fraser Health that have a BSTN have access to education to build capacity of in-house coaches (i.e. access to training in Gentle Persuasive Approaches in Dementia Care and P.I.E.C.E.S.).¹⁷⁸

More Preventative / Pro-Active Care (including Dementia Care)

Along with programs such as FHA's Optimization initiative, it may also be possible to reduce demand for long term care through more preventative and pro-active management of chronic diseases including dementia. A 2018 research study from the United States, for example, shows that a comprehensive,

¹⁷⁷ Fraser Health Authority. Correspondence to BCCPA. February 8, 2019.

¹⁷⁸ P.I.E.C.E.S.™ provides a practical framework for a comprehensive, systematic and holistic approach to understand all aspects influencing an individual's behaviour: Physical, Intellectual, Emotional, Capabilities, Environment, and Social aspects of an individual.

coordinated care program for people with dementia and their caregivers can potentially decrease the likelihood that individuals may need to enter a nursing or long term home.¹⁷⁹

The research, published in the December 2018 JAMA Internal Medicine,¹⁸⁰ analysing the UCLA Alzheimer's and Dementia Care Program, found that patients enrolled in the program reduced their risk of entering a nursing home by about 40 percent.¹⁸¹ As part of this program people with dementia and their caregivers meet with a nurse practitioner (NP) specializing in dementia care for a 90-minute in-person assessment and then receive a personalized dementia care plan that addresses the medical, mental health and social needs of both people. The NPs also work collaboratively with the patient's primary care provider and specialist physicians to implement the care plan, including adjustments as needs change over time.¹⁸² A similar program should be explored for adoption in BC particularly if able to reduce the demand or overall numbers of those with dementia who need to enter long term care.

In summary, the BCCPA believes that new approaches and models are required to improve access to seniors care but also, where appropriate, reduce demand for long term care. As such the BCCPA recommends that the BC government invest up to \$50 million per year over the next four years to support the introduction of new models or approaches of care such as the Continuing Care Hub to improve access to seniors care. Where appropriate, investments from this funding should also be provided to initiatives or programs across the continuing sector including assisted living and home health care that can mitigate and/or reduce future demand for long term care.

Recommendation #10

That the BC government invest up to \$50 million per year over the next four years to support the introduction of new models or approaches of care such as the Continuing Care Hub to improve access to seniors care. Where appropriate, investments from this funding should be provided to initiatives or programs across the continuing sector including assisted living and home health care that can mitigate and/or reduce future demand for long term care.

¹⁷⁹ Medical Xpress. Study shows dementia care program delays nursing home admissions, cuts Medicare costs. December 2018. Accessed at: <https://medicalxpress.com/news/2018-12-dementia-nursing-home-admissions-medicare.html>

¹⁸⁰ JAMA Internal Medicine. Health Care Utilization and Cost Outcomes of a Comprehensive Dementia Care Program for Medicare Beneficiaries. December 2018. Accessed at: <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2719196>

¹⁸¹ A total of 1,083 Medicare beneficiaries with dementia were enrolled in the program and were followed for three years. The study compared them to a similar group of patients living in the same ZIP codes who did not participate in the program. While there were differences for those going into long term care there were no differences between the two study groups in hospitalizations, emergency room visits or hospital readmissions.

¹⁸² Medical Xpress. Study shows dementia care program delays nursing home admissions, cuts Medicare costs. December 2018. Accessed at: <https://medicalxpress.com/news/2018-12-dementia-nursing-home-admissions-medicare.html>

SECTION 8: RENOVATING EXISTING CARE HOMES

8a) Infrastructure funding to renovate care homes

While the addition of new beds is part of the solution to increase access to continuing care services for seniors in BC, it is also important to highlight that much of the current bed stock will also need to be replaced over time. In particular, care homes are generally poorly equipped in physical infrastructure to meet the care needs of their residents, which are more complex now than when these facilities were originally built. For example, many care homes do not meet current building safety standards and the limited provincial and municipal funding available is usually insufficient to bring them up to code.¹⁸³ Also, there is a lack of units with shared space to better support residents with dementia, as well as a shortage of appropriate units to care for residents who are disabled or overweight. Renovations are also required to make better use of long-term care beds for other purposes such as providing short-stay respite care or transitional care.¹⁸⁴

Across Canada, long-term care homes are finding themselves increasingly constrained as a result of out-of-date infrastructure. While there has been some activity around BC in the planning and development of new beds, many of those will be replacing older sites that can no longer adequately meet the needs of today's residents. As outlined by the BC Ministry of Health, while about 500 new beds will open in 2016/17, and more are planned for 2017/18 and 2018/19; health authorities must also recognize how critical it is to either renovate or replace their older bed stock with improved facility design, including single rooms with a private washroom and shower, walking loops and smaller dining areas.¹⁸⁵

As highlighted by the Canadian Association for Long Term Care (CALTC), a significant portion of the housing for seniors in residential or long-term care in Canada is currently outdated or nearing the end of its functional life. In particular, many homes were built to design standards that are not suitable for today's seniors, featuring three to four-bedroom hospital like wards, shared washrooms and bathing areas, crowded dining rooms, small hallways and noisy nursing stations too close to resident's rooms.

In comparison, and as noted by CALTC, new or renovated homes feature larger, home-like private or semi-private resident rooms. These modifications along with multiple dining areas, wider hallways to accommodate wheelchairs and walkers, spacious common areas and updated washrooms and bathing facilities allow for more privacy and better care. Modern home designs and increased privacy, for example, are also very important for residents with dementia, who can become upset and aggressive when they are unable to get the personal space they need.¹⁸⁶

¹⁸³ Ontario Association of Non-Profit Homes and Services for Seniors. *Proposals for the Ontario Budget. Fiscal Year 2012-13*. March 2012.

¹⁸⁴ David Walker. *Caring for our aging population and addressing alternate level of care*. Report Submitted to the Minister of Health and Long-Term Care. June 30, 2011. Toronto.

¹⁸⁵ BC Ministry of Health. Residential Care Staffing Review. March 2017. Accessed at:

<https://www.health.gov.bc.ca/library/publications/year/2017/residential-care-staffing-review.pdf>

¹⁸⁶ Canadian Association for Long Term Care. *Caring for Canada's Seniors: Recommendations for meeting the needs of an aging population*. February 2017. Accessed at: https://www.oltca.com/OLTCA/Documents/Reports/CaringForCanadasSeniors_CALTC.PDF

As noted in a recent study, the importance of the physical environment in care homes is increasingly recognized as a key component in the care of residents with dementia. In particular, supportive environments can promote way finding and orientation, improve activities of daily living function, autonomy and meaningful activity, reduce anxiety, agitation, aggression and falls as well as provide better person-centred care for those with dementia.¹⁸⁷

Federal Government Role - Infrastructure

Approximately 40% of long-term care homes in Canada require significant renovations or a rebuild rebuilt, according to a recent survey of CALTC's provincial association members.¹⁸⁸ In Ontario, for example, 50% of homes are due for significant renovations or rebuild in order to meet current design standards.¹⁸⁹

As a result, CALTC has advocated the federal government immediately expand the eligible projects for infrastructure funding to include seniors housing which incorporates long-term care. In particular, CALTC has recommended the federal government invest in the construction, renovation and retrofit of 400 long-term care homes to meet current design standards and the needs of today's seniors, especially those living with dementia, by 2023. This also aligns with a recommendation from the 2016 report entitled *Dementia in Canada: A National Strategy for Dementia-friendly Communities* by the Standing Senate Committee on Social Affairs, Science and Technology, which among other recommendations called for a national Investment of \$540 million in long-term care infrastructure funding.¹⁹⁰

In the latest Federal Budget released on March 19, 2019 it outlined an investment of \$50 million over five years to fund Canada's first national dementia strategy.¹⁹¹ It is the hope of the BCCPA that when the federal government releases its national dementia strategy later in 2019 that it will also include some recognition including outlining the need for federal infrastructure investments for long term care particularly to meet the needs of residents with dementia.

Recommendation #11

That the federal government immediately expand eligible projects for infrastructure funding to include seniors housing which incorporates long-term care. In particular, the federal government invest in the construction, renovation and retrofit of 400 long-term care homes to meet current design standards and the needs of today's seniors, especially those living with dementia, by 2023.

¹⁸⁷ The Influence of the Physical Environment on Residents With Dementia in Long-Term Care Settings: A Review of the Empirical Literature. Gerontologist 2017, Vol 00, No. 00, 1-13. Habib Chaudhury, Heather Cooke et al. Accessed at: https://www.researchgate.net/publication/314514461_The_Influence_of_the_Physical_Environment_on_Residents_With_Dementia_in_Long-Term_Care_Settings_A_Review_of_the_Empirical_Literature

¹⁸⁸ Canadian Association for Long Term Care (CALTC). CALTC Provincial Association Survey: LTC Infrastructure Needs Across Canada. 2018.

¹⁸⁹ Ontario Long Term Care Association (OLTCA). 2018 Ontario Pre-Budget Submission: More Care. Better Care. Accessed at: <https://www.oltca.com/OLTCA/Documents/Reports/2018OLTCABudgetSubmission-MoreCareBetterCare.pdf>

¹⁹⁰ Canadian Association for Long Term Care. Caring for Canada's Seniors: Recommendations for meeting the needs of an aging population. February 2017. Accessed at: https://www.oltca.com/OLTCA/Documents/Reports/CaringForCanadasSeniors_CALTC.PDF

¹⁹¹ Alzheimer Society of Canada. Alzheimer Society welcomes \$50 million funding for national dementia strategy. March 20, 2019. Accessed at: <https://www.newswire.ca/news-releases/alzheimer-society-welcomes-50-million-funding-for-national-dementia-strategy-802554998.html>

According to an analysis undertaken from BCCPA as part of an earlier CALTC survey, in BC it is estimated that there are approximately 117 non-Health Authority operated care homes that need to be renovated. This figure was derived by taking percentage of non-HA care homes (36 out of 57) that have an available Facility Condition Index (FCI) rating listed poor (0.11 to 0.3 or 11 to 30%) multiplied by the number of publicly funded non-HA care homes (186). Furthermore, it is estimated that there are approximately 20 non-Health Authority operated care homes that need to be rebuilt. This is derived by taking percentage of non-HA care homes (6 out of 57) that have an available Facility Condition Index (FCI) rating listed as critical (0.3 or 30% and higher) multiplied by the number of publicly funded non-HA care homes (186). For further information on this breakdown see Appendix D of this paper.

BC Government Role - Infrastructure

The situation in BC is particularly critical as care homes are not able to afford capital investments to improve or modernize their physical infrastructure.¹⁹² 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 long term care homes, health authority operated care homes are funded fully for these property and infrastructure costs.¹⁹³

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 long term 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.¹⁹⁴

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 a renewed capital redevelopment plan for long term care homes similar to what was announced October 2014 in Ontario. This initiative has been well-received by its long term care 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 homes – many of them in small communities or rural locations – currently do not meet the most recent (2009) design standards.

¹⁹² BCCPA. White Papers. Sustainability and Innovation: Exploring Options for Improving BC's Continuing Care Sector. May 2016. Accessed at: <http://www.bccare.ca/whitepapers2016/>

¹⁹³ BCCPA. White Papers. Sustainability and Innovation: Exploring Options for Improving BC's Continuing Care Sector. May 2016. Accessed at: <http://www.bccare.ca/whitepapers2016/>

¹⁹⁴ 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>

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.¹⁹⁵

More recently in February 2018, the New Brunswick government also announced it would invest \$108 million over the next five years for renovations to its nursing or long term care homes across the province. As part of its 2018-2023 Nursing Home Plan¹⁹⁶ to be carried out in three phases, it will involve building ten 60-bed nursing homes around the province. An additional 407 beds for people living with Alzheimer's disease and other forms of dementia will also be provided in special care homes across that province.¹⁹⁷

Like other jurisdictions, 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) advocated 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 that paper, the BCCPA recommended a RCIF to assist with some of the following areas:

- support the immediate renewal and replacement of older long term 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.

Although the Ministry of Health Action Plan to Strengthen Home and Community Care for Seniors released in 2017 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 or long term care funding model to incorporate resident complexity, quality of care and flexibility could potentially also include looking at ways in which capital investment or infrastructure needs could be factored into any funding model.¹⁹⁸

If such a capital investment component is not incorporated as part of a new funding model, then the BCCPA would recommend that the provincial government reconsider, as outlined earlier, an infrastructure fund 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 new funding should also be explored particularly with the implementation of Bill 16 as discussed earlier.

As outlined in its 2019 Budget Submission, the BCCPA recommended that, in conjunction with developing a strategy to increase number of long term care beds over the next twenty years, the BC Government establish a new \$200 million Continuing Care Infrastructure Fund (CCIF), which over four years would

¹⁹⁵ 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>

¹⁹⁶ New Brunswick Government. 2018-2023 Nursing Home Plan. Accessed at: <https://www2.gnb.ca/content/dam/gnb/Departments/sd-ds/pdf/NursingHomes/2018-23NursingHomePlan.pdf>

¹⁹⁷ New Brunswick Government. \$108 million for renovations to nursing homes. February 15, 2018. Accessed at: https://www2.gnb.ca/content/gnb/en/news/news_release.2018.02.0175.html

¹⁹⁸ BC Ministry of Health. An Action Plan to Strengthen Home and Community Care for Seniors. March 2019. Accessed at: <http://www.health.gov.bc.ca/library/publications/year/2017/home-and-community-care-action-plan.pdf>

support the renewal and replacement of older long term care and assisted living homes including investing smaller infrastructure projects, expanding the existing Seniors Safety and Quality Improvement Program (including to assisted living) and creating more dementia friendly environments.¹⁹⁹ With regards to the final area, the BCCPA is also further working with the Alzheimer Society of BC to explore the development of criteria for dementia friendly care homes by looking at key areas such as physical infrastructure and staffing.²⁰⁰

Recommendation # 12

In conjunction with developing a strategy to increase number of long term care beds over the next twenty years, the BC Government establish a new \$200 million Continuing Care Infrastructure Fund (CCIF), which over four years would:

- support the immediate renewal and replacement of older long term care and assisted living 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;
- funding to continue or expand the existing Seniors Safety and Quality Improvement Program; and
- invest in enhancements for improving dementia-friendly environments within existing homes to create more dementia friendly designs.

¹⁹⁹ The [Seniors Safety and Quality Improvement Program](#) (SSQIP), which was established in 2017 with the \$10 million in funding and managed by the BCCPA, allows long-term care home operators to apply for funding for new equipment intended to improve safety and quality of life for residents. An advisory group, which includes representatives from the provincial government, BCCPA, Denominational Health Association and SafeCare BC, oversees the allocation of funding. Those approved may receive up to \$500 per publicly-funded bed to purchase equipment and enhance the safety and quality of life of seniors.

²⁰⁰ BCCPA. Creating Dementia Friendly Care Homes in BC. December 2018. Accessed at: <https://bccare.ca/2018/12/creating-dementia-friendly-care-homes-in-b-c/>

CONCLUSION

With a growing and rapidly aging population, the continuing care sector will require the addition of new resources to meet the needs of seniors in BC. BC is already facing a shortage of long term care beds, which is affecting people and families who are impacted by delays to care including transitions from hospital or home health care. As of 2016, the Conference Board of Canada projects **current bed demand in BC is approximately 33,300**, which is over 3,000 current bed levels province-wide if include publicly subsidized and private pay beds. The **Conference Board of Canada also projects that BC requires an additional 31,000 (30,900) new long term care beds by 2035 to meet demand.**

While the Conference Board of Canada generally uses a population ratio based approach to forecasting demand for long term care beds including BC, the BC Care Providers Association (BCCPA) has also attempted to project future demand for long term bed equivalents (LTCBEs) based on the growth of the frail elderly population from data provided by the Ministry of Health. Using this approach, BC requires about 45,000 new long term care beds (or LTCBEs) by 2041/42 to meet growing demand for those identified as frail in residential care (or long term care). Most importantly, **regardless of how you measure or what methodology you use to project future demand for long term care beds, a significant number of beds are required.**

As outlined earlier, as of March 2018 there were about 1400 (1,379) persons waiting for admission into long term care – an increase of 7 percent from the previous year. The majority or about 75 percent of those waiting for admission into long term care (1039 or 1379) were those living in the community compared to the rest who were waiting in hospital (i.e. alternate level of care or ALC patients).

Overall, the access situation is only going to get worse unless there is a significant increase in the number of new beds. In BC, request for proposals (RFPs) for new long term care beds are generally posted on the BC Bid website. As of the end of 2018, no health authorities in BC, however, had an RFP for new care beds posted. In fact, over the past six months only one RFP for new long term care beds has been awarded.²⁰¹ When BCCPA contacted health authorities about their projections for future demand of long term care beds they noted that their forecasts are in development and/or cannot be shared publicly.

While the focus of this paper is on the need for new long term care beds, some of this demand can be potentially offset through other areas in the continuing care sector particularly home health care and assisted living. While these areas and other approaches might mitigate some of the demand they will still be inadequate. In particular, no single intervention will offset demand for long term care beds in

²⁰¹ In January 2019, the BC Ministry of Health announced that over 120 new long term or residential care beds had been awarded to Golden Life Management for the Comox Valley region as part of an earlier RFP that had been posted on BC Bid (see: BC Ministry of Health News Release: Improving seniors' care for the Comox Valley accessed at: <https://news.gov.bc.ca/releases/2019HLTH0009-000040>). These were part of an RFP that had been issued by Island Health in March 2018 and which closed in May of the same year (See: BC Local News. No updates on Island Health RFP for 120 long-term care beds. November 4, 2018. Accessed at: <https://www.bcclocalnews.com/news/no-updates-on-island-health-rfp-for-120-long-term-care-beds/>).

Canada or BC as well as uphold individual preferences to remain in the community as long and as independently as possible.²⁰²

As outlined earlier, projecting the future demand of long-term care beds or LTCBEs can be a very difficult and complicated exercise as there are many different approaches which can be used to project LTCBE needs such as using population ratios or service utilization among others. Subsequently, variations may differ within each of these approaches.

While new approaches, such as Bill 16 for assisted living, and better ensuring those who enter long term care need to be there will offset some of the future demand, it will not mean that substantial numbers of new beds are not necessary. In particular, meeting new demand will require significant investments from the provincial government and health authorities but also perhaps even the federal government. To meet current and future demand for long-term care, for example, the Canadian Association for Long Term Care (CALTC) has recommended that the federal government increase capacity by committing to funding the addition of 42,000 new long-term care beds across the country by 2023.²⁰³

Along with the provincial and perhaps federal government as well as health authorities, it will also **require leveraging the existing private sector to meet this demand**. This includes private-for-profit and private not-profit operators, which currently make up about two-thirds of BC's existing beds.

While a significant number of new long care beds are projected to meet demand (i.e. over 30,000 in next 20 years), this does not account for existing beds which may be in care homes but are significantly outdated and require renovation or in some cases, rebuilding. As outlined earlier, approximately 40% of long-term care homes in Canada require significant renovations or to be rebuilt, according to a survey of CALTC's provincial association members. This is why CALTC has also recommended the federal government invest in the construction, renovation and retrofit of 400 long-term care homes to meet current design standards and needs of today's seniors, especially those with dementia, by 2023.²⁰⁴

Along with new bed demand and ensuring current care homes are up to date, some of the other challenges explored in this paper include rising levels of acuity or complexity as seniors are entering long term care later in life. While this may not significantly impact the number of new long term care beds required, it will likely have a major impact particularly on health human resources (HHR).

Although HHR is also largely beyond the scope of this paper, higher levels of acuity and demand for new beds will require substantial new levels of health professionals particularly health care assistants. The BCCPA estimates that based on the Conference Board of Canada projection in which BC requires about 31,000 (30,900) new long term care beds by 2035, that to meet this demand it would require about

²⁰² Canadian Institute for Health Information. Seniors in Transition: Exploring Pathways Across the Care Continuum. Ottawa, ON: CIHI; 2017. Accessed at: <https://www.cihi.ca/sites/default/files/document/seniors-in-transition-report-2017-en.pdf>

²⁰³ Canadian Association for Long Term Care. Long Overdue: Improving Seniors Care in Canada. November 2018. Accessed at: <https://caltc.ca/wordpress/wp-content/uploads/2018/11/CALTC-budget-submission-ONLINE.pdf>

²⁰⁴ Canadian Association for Long Term Care. Long Overdue: Improving Seniors Care in Canada. November 2018. Accessed at: <https://caltc.ca/wordpress/wp-content/uploads/2018/11/CALTC-budget-submission-ONLINE.pdf>

19,000 new care providers including almost 13,000 health care aides, 4000 nurses and 2000 allied health professionals.

Based on what is outlined in this paper, the BCCPA has put forward twelve recommendations as seen in the following table below in order to improve access to seniors care and increase overall capacity in the long term care sector.

SUMMARY OF RECOMMENDATIONS

Current Access Issues

Short to Medium Term (Within the next 5 years)

1. That the BC government reduce the number of people on long term care wait lists by establishing a target within its Ministry of Health Annual Service Plan to ensure at least 65 per cent of those waiting for a bed can access one within 30 days.
2. That the BC government and health authorities establish a website to track wait time information for long term care, including potentially assisted living and home health care waits. This website should also be updated regularly or at least once every two months.

Immediate Term (Within next 1 to 2 years)

3. That the BC Ministry of Health establish a target in its Annual Service Plan to have no more than 5 percent of acute care beds occupied each day by seniors who have been assessed as capable of being transferred into a more appropriate long term or home care setting and that this target be met by the end of 2024.

Future Strategy for Meeting Long Term Care Demand

Immediate Term (Within next 1 to 2 years)

4. That the BC government develop a strategy to increase the number of long term care bed equivalents (LTCBE) by at least 30,000 over the next twenty years, including between 20,000 and 25,000 actual new beds. As part of any strategy, new beds should include an appropriate mix of government and private (for profit and non-profit) based roughly on the current distribution or allocation of beds.
5. That, as part of any strategy to meet future demand for long term care and assisted living, the BC government develop a BC Continuing Care Living Initiative (CCLI) to partner with

private and non-profit organizations as well as provide funding for new long term care and assisted living spaces.

6. That the federal government increase capacity by committing to funding the addition of 42,000 new long-term care beds across the country by 2023.

Short to Medium Term (within next 5 years)

7. That, as part of any new long term care bed strategy or a broader Continuing Care Health Human Resource Workforce Strategy, the BC government develop a provincial health human resource (HHR) plan to meet the requirement for new long term care beds over the next twenty years.
8. That the federal government collaborate with the provinces and the long-term care sector to immediately develop and implement a Pan-Canadian health human resources strategy, in order to improve access as well as meet the needs of a growing and aging population.
9. That the BC government and health authorities, in conjunction with stakeholders, develop a consistent approach to track and project future long term care bed requirements province-wide. A report on this should be developed by the end of 2022 and updated every two years to project long term care bed needs at least ten years into the future.

Addressing BC's Long Term Care Bed needs through alternative approaches

Short to Medium Term (within next 5 years)

10. That the BC government invest up to \$50 million per year over the next four years to support the introduction of new models or approaches of care such as the Continuing Care Hub to improve access to seniors care. Where appropriate, investments from this funding should be provided to initiatives or programs across the continuing sector including assisted living and home health care that can mitigate and/or reduce future demand for long term care.

Renovating existing care homes to meet LTC demand

Short to Medium Term (within next 5 years)

11. That the federal government immediately expand eligible projects for infrastructure funding to include seniors housing which incorporates long-term care. In particular, the federal government invest in the construction, renovation and retrofit of 400 long-term care homes

to meet current design standards and the needs of today's seniors, especially those living with dementia, by 2023.

Immediate Term (Within next 1 to 2 years)

12. In conjunction with developing a strategy to increase number of long term care beds over the next twenty years, the BC Government establish a new \$200 million Continuing Care Infrastructure Fund (CCIF), which over four years would:

- support the immediate renewal and replacement of older long term care and assisted living 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;
- funding to continue or expand the existing Seniors Safety and Quality Improvement Program; and
- invest in enhancements for improving dementia-friendly environments within existing homes to create more dementia friendly designs.

If fully implemented, the recommendations outlined in this report would be significant. For example, the majority of new costs would be from the implementation of new long term care beds. As outlined earlier based on the Conference of Canada data, the total estimated cost of constructing and operating required for new long term care beds to 2035 in BC would be close to \$30 billion. Given the importance of seniors particularly with an aging population we believe that such investments, however, are worthwhile.

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. As outlined in Appendix E of this paper, the BCCPA believes that this could go a long way to improving access to seniors care and increasing the capacity in the long term care sector.

APPENDIX A: Different methodologies in measuring demand for LTC

Set Ratio Approach

In the set ratio approach there are two basic variations for projecting long term care demand which include:

- **Historical Financial Base Approach** - resources are allocated by some version of an across-the-board budget increase (common in global budgeting).
- **Arbitrary Resource Ratio Approach** - assumes a fixed resource to population ratio (e.g., 70 beds per 1,000 total population 65+ years).

Demand Based Approach

In the demand based approach there are several basic variations for projecting long term care demand which include:

- **Basic Utilization Ratio Approach** - projects future resource requirements based on the existing utilization ratio of resources per 1,000 people 65+ years.
- **Population-Based Utilization Approach** – this approach includes a couple of versions such as the *Age-Specific per Capita Method* which is essentially a modified version of the Historical Utilization Base Approach. Instead of using an arbitrary ratio of beds for those 65+ years, specific targets are set for either 5-year or 10-year age cohorts of those 65+ years. A second version is the *Socio-Demographic Utilization Approach* that uses socio-demographic variables to project future service needs.
- **Resource Flow Method** - combines utilization information with other data such as admission rates, length of stay (LOS), waiting list data, death rates, and discharge rates. This approach is intended to enable timely access to facility beds for clients in a given area.²⁰⁵

Needs based approach

In the needs-based approach there are several basic variations for projecting long term care demand which include:

- **Bed Survey Approach** - residents of long term care homes are assessed to determine the extent to which current bed utilization is clinically appropriate on an individual client basis.
- **General Survey Approach** - has two variations: (i) the *Expert Opinion Survey Approach* which polls 'experts' regarding need for Continuing Care Services in community; and, (ii) the *Population Survey Approach* is one in which a sample of the population is surveyed to determine their need for care.²⁰⁶

²⁰⁵ Government of the Northwest Territories. Northwest Territories Long-Term Care Program Review. Final Report. December 2015. Accessed at: <https://www.hss.gov.nt.ca/sites/hss/files/nwt-long-term-care-program-review.pdf>

²⁰⁶ Government of the Northwest Territories. Northwest Territories Long-Term Care Program Review. Final Report. December 2015. Accessed at: <https://www.hss.gov.nt.ca/sites/hss/files/nwt-long-term-care-program-review.pdf>

Pros and cons of different measurement approaches

There are various pros and cons with using these different approaches to measure long term care demand. As outlined in one article, future projections based on a fixed ratio of beds per population over age 75 may result in either excess capacity or long wait times for admission.²⁰⁷ The same study notes that because the service-based approach is driven by service levels, it is generally preferable to commonly used ratio-based approaches.²⁰⁸

Current practice in British Columbia, Canada and other countries has been to use a fixed ratio of beds per population as the basis for planning. This approach, however, can be deficient for several reasons, and resulting in either long wait times for admission to care or excess capacity.²⁰⁹ The shortcomings, for example, of the ratio-based approach are that it ignores:

- the year-to-year dynamics of the system;
- geography-specific differences in arrival and length of stay (LOS);
- clients in care and on the wait list at the beginning of each year;
- the population below age 75, who account for 20% of total clients; and
- differences in arrival rates and LOS between the two age groups (75–85 and over 85) and between the two gender groups.²¹⁰

Average Flow Model

As outlined in one article, another promising approach to forecasting bed needs is the average flow model (AFM). The AFM is based on the following two obvious client flow relationships:

- Formula 1: Number of beds needed next year = number of beds needed this year – client departures this year + client arrivals this year (1)
- Formula 2: Client departures this year = number of beds this year / average LOS (2)

Assuming ALOS is 3 years, the current bed capacity is 210 and 80 residents are estimated to arrive this year or as outlined below:

- Formula 2: 70 client departures this year = 210 beds this year / 3 years ALOS
- Formula 1: 220 beds needed next year = 210 beds this year – 70 (formula 2) + 80 residents estimated this year.²¹¹

²⁰⁷ Healthcare Policy. Vol. 7, No.4, 2012. Residential Long-Term Care Capacity Planning: The Shortcomings of Ratio-Based Forecasts. Zhang et al. Accessed at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3359086/>

²⁰⁸ Healthcare Policy. Vol. 7, No.4, 2012. Residential Long-Term Care Capacity Planning: The Shortcomings of Ratio-Based Forecasts. Zhang et al. Accessed at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3359086/>

²⁰⁹ Healthcare Policy. Vol. 7, No.4, 2012. Residential Long-Term Care Capacity Planning: The Shortcomings of Ratio-Based Forecasts. Zhang et al. Accessed at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3359086/>

²¹⁰ Healthcare Policy. Vol. 7, No.4, 2012. Residential Long-Term Care Capacity Planning: The Shortcomings of Ratio-Based Forecasts. Zhang et al. Accessed at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3359086/>

²¹¹ Healthcare Policy. Vol. 7, No.4, 2012. Residential Long-Term Care Capacity Planning: The Shortcomings of Ratio-Based Forecasts. Zhang et al. Accessed at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3359086/>

The AFM was founded to be more accurate in planning particularly across geographic regions although it slightly overestimates capacity levels. The table below summarizes some of the aspects of the ratio-based approach, service based approach and average flow model.

The advantage of the AFM over the other approaches is its transparency, its ease of implementation in a spreadsheet, the requirement for only annual demand and LOS forecasts as inputs and its ability to investigate sensitivity of plans to changes in inputs.²¹²

Table 1: Comparing the ratio-based approach, the service-based approach and the average flow model

Method	Inputs (Items below are needed on an annual basis over the planning horizon)	Analytic Tools Required	Comments
Current Ratio	Forecast of population over 75	Multiplication	<ul style="list-style-type: none"> • Easy to use but unreliable.
New Ratio A	Forecast of population over 75	Simple regression	<ul style="list-style-type: none"> • Requires output of service-based model for calibration – not transportable between regions.
New Ratio B	Forecast of population between 75 and 85 and over 85	Multiple regression	<ul style="list-style-type: none"> • Requires output of service-based model for calibration – not transportable between regions.
Service Based approach	Stratified forecasts of total demand and historical LOS distributions	Parametric survival analysis, simulation, optimization	<ul style="list-style-type: none"> • The “gold-standard.” Highly flexible but challenging to apply. Requires operations research expertise.
Average Flow Model	Forecast of total demand and average LOS	Survival analysis to estimate average LOS	<ul style="list-style-type: none"> • Easy to use, somewhat reliable and transparent to users. Facilitates sensitivity analysis.

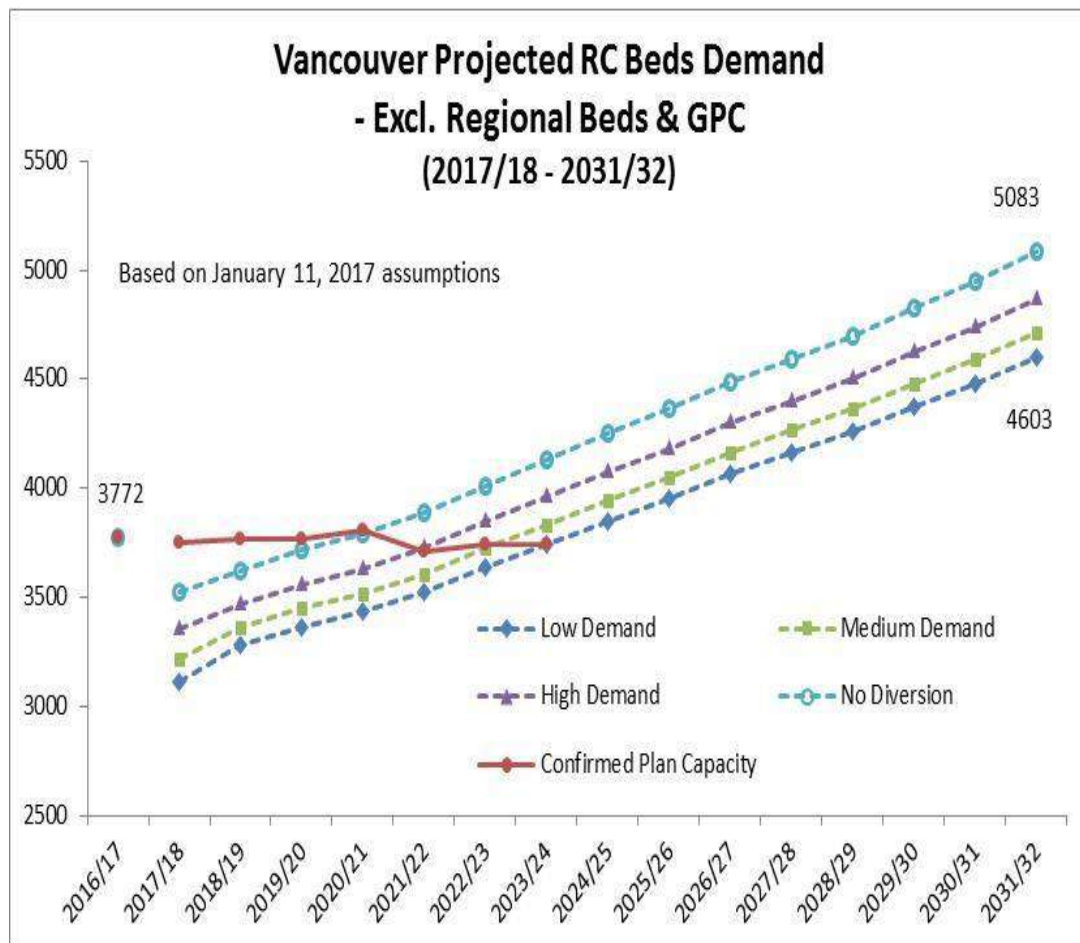
Source: Healthcare Policy. Vol. 7, No.4, 2012. Residential Long-Term Care Capacity Planning: The Shortcomings of Ratio-Based Forecasts. Zhang et al. Accessed at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3359086/>

²¹² Healthcare Policy. Vol. 7, No.4, 2012. Residential Long-Term Care Capacity Planning: The Shortcomings of Ratio-Based Forecasts. Zhang et al. Accessed at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3359086/>

Appendix B: Health Authority Data on LTC Bed Projections (Highlights of available information)

VANCOUVER COASTAL

- Projections from the Vancouver Coastal Health Authority estimate that population of frail residents needing long term care will grow by over 40 per cent between 2014/15 and 2025/26.²¹³

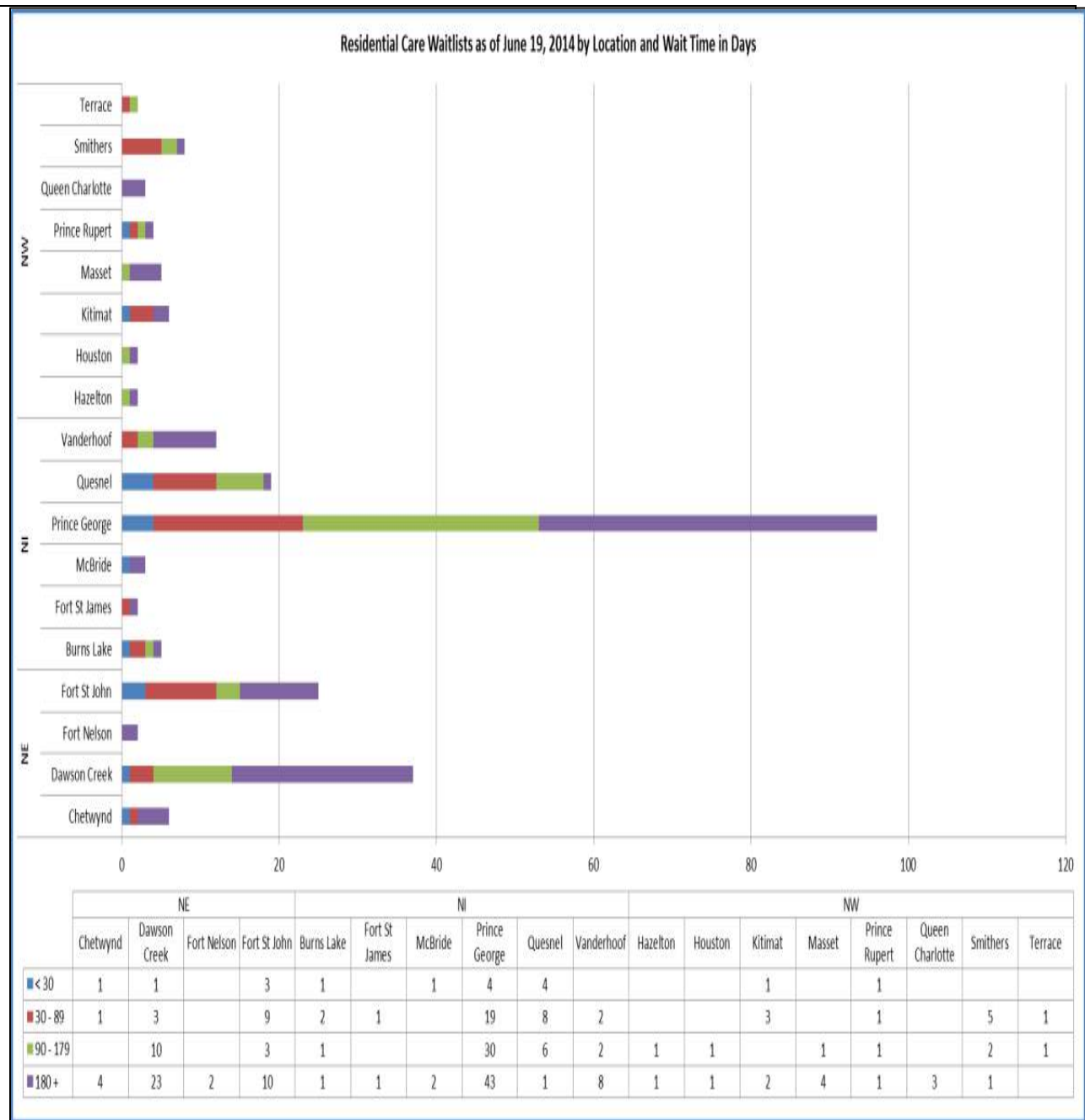


²¹³ Vancouver Coast Health Authority. 2016/17-2018/19 Detailed Operational Plan Supporting Detail and Analysis Part A. June 15, 2016, 72.

FRASER HEALTH

- Like other health authorities, Fraser Health is facing significant challenges as demand for long term care increases. Between 2010 and 2016 while those 75 and over increased by 23% and those over 85 increased by 36%, the total long term care bed inventory increased only by 8%.
- To meet demand for long term care, the 2016-2023 Fraser Health Residential Care Facility Plan only includes a modest increase in capacity (500 new beds and rejuvenation of 1500 beds) with hope some of the demand will also decrease as fewer people enter residential or long term care and/or are admitted later in life with a shorter average length of stay.
- As outlined in a 2016 presentation, Fraser Health projects a short fall of over 1000 long term care beds by 2021.

NORTHERN HEALTH



Source: Healthy Aging in the North: Action Plan (2015/16 - 2020/21). September 1, 2015. Accessed at: https://www.northernhealth.ca/sites/northern_health/files/about-us/reports/community-consultations/documents/aging-in-north-action-plan.pdf

	2012 Current	2012 Projections*		2017 Projections*		2022 Projections*	
	Beds Actua	Beds Projected	Variance from Actual	Beds Projected	Variance from Actual	Beds Projected	Variance from Actual
HSDA							
Northeast	245	335	90	377	132	420	175
Northern Interior	580	662	82	721	141	777	197
Northwest	267	315	48	343	76	368	101
Northern Health	1092	1312	220	1441	349	1565	473
*projections model required bed capacity to meet 90% in 90 days placement target 2015/16 - 2020/21							
Source: Healthy Aging in the North: Action Plan (2015/16 - 2020/21). September 1, 2015. Accessed at: https://www.northernhealth.ca/sites/northern_health/files/about-us/reports/community-consultations/documents/aging-in-north-action-plan.pdf							

INTERIOR HEALTH

- For residential / assisted living bed projections, the target for Interior Health Authority (IHA) is 93 beds per 1,000 age 75+ years. Planning assumes maintaining the current target of 93 beds per 1,000-population aged 75+. Moreover, this planning will look at existing buildings that are not appropriate for residents with complex care needs but rather are suitable to address alternative care / housing models for special populations.
- In the next ten years, IHA will need to add approximately 2,000 beds in order to maintain the target of 93 beds per 1,000 age 75+. This equates to 593 beds by 2017 and an additional 1,371 by 2022 or a 30% increase in capacity. These projections are based on P.E.O.P.L.E data.²¹⁴ The following is a high-level summary of the projected additional beds required based on the above targets.²¹⁵

Table 2: Projected Additional Acute and Long term Care / Assisted Living Beds									
Fiscal	Acute Care								Residential Care & Assisted Living
	CMH	EKRH	KGH	KBRH	PRH	RIH	SLGH	VJH	
Current Acute Beds 2011/12	28	69	351	75	134	216	40	148	6,472
Additional beds required 2016/17	0	9	41	0	32	30	7	15	593
Additional beds required 2021/22	3	6	33	4	13	21	4	14	1,371
Total New	3	15	74	4	45	51	11	29	1,964
Current ALC	13%	9%	15%	15%	14%	30%	13%	17%	
Current Occupancy	93%	99%	104%	94%	109%	106%	109%	105%	
*To mitigate demand for acute and LTC / AL services, alternate housing options will be considered moving forward.									
Source: Interior Health Capital Strategy: 2013-2023. March 2013. Accessed at https://www.interiorhealth.ca/AboutUs/BuildingForBetterHealth/Documents/IH%20Capital%20Strategy.pdf									

²¹⁴ Population Extrapolation for Organizational Planning with Less Error (P.E.O.P.L.E)

²¹⁵ Interior Health Capital Strategy: 2013-2023. March 2013. Accessed at <https://www.interiorhealth.ca/AboutUs/BuildingForBetterHealth/Documents/IH%20Capital%20Strategy.pdf>

Appendix C: CIHI Subpopulations (Seniors in Transition)

Sub-populations examined	
Canadian Institute for Health Information	
1.	MAPLe low–moderate — These seniors have a MAPLe score less than or equal to 3. Seniors with low to moderate (1 to 3) MAPLe scores are more likely to remain in the community, supported with home care services, while those with high (4) and very high (5) scores are often prioritized for placement in residential care facilities.
2.	Physical needs — This group of seniors could potentially be supported at home or in an assisted living type setting. This subpopulation consists of seniors with an Activities of Daily Living (ADL) Hierarchy Scale score greater than 0, no responsive behaviours, a Cognitive Performance Scale (CPS) score of 2 or less, no swallowing or eating problems and less than 2 recent falls (i.e., in the 90-day period prior to the assessment).
3.	Lighter care needs — These are seniors with lighter care needs who potentially could be supported in a home setting. This subpopulation consists of seniors with a CPS score of 0 or 1, an ADL score of 0 or 1, and a Changes in Health, End-Stage Disease and Signs and Symptoms (CHESS) score of 0 to 2, and who do not exhibit wandering behaviours.
4.	Dementia and light care needs — These seniors have dementia but otherwise have low cognitive and functional impairment. They tend to have high or very high MAPLe scores but can remain in the community with appropriate support. Some jurisdictions have implemented dwellings with specialized levels of care and supports designed to make it easier for this population to remain in the community. This subpopulation is defined as seniors with dementia (either Alzheimer or other dementia), an ADL score of 0 to 2 and a CPS score of 0 to 2.
Source: Canadian Institute for Health Information. Seniors in Transition: Exploring Pathways Across the Care Continuum. Ottawa, ON: CIHI; 2017. Accessed at: https://www.cihi.ca/sites/default/files/document/seniors-in-transition-report-2017-en.pdf	

Appendix D: Overview of Facility Condition Index (FCI) among Care Homes in BC

HA	City	Facility Name	Owner Type	Number of beds	FCI Rating	Last year of FCI assessment
IHA	Salmon Arm	Mount Ida Mews	PFP	71	26%	2013
FHA	Abbotsford	Bevan Lodge Residential	PFP	45	28%	2002
FHA	Agassiz	Glenwood Care Centre	PFP	32	26%	2002
FHA	Chilliwack	Eden Rest Home	PFP	89	11%	2004
FHA	Burnaby	Harmony Court Care Centre	PFP	80	27%	2004
FHA	Burnaby	Willingdon Care Centre	PFP	95	13%	2004
FHA	Coquitlam	Cartier House Care Centre	PFP	78	22%	2004
FHA	New Westminster	Royal City Manor	PFP	64	8%	2004
FHA	Langley	Simpson Manor	PFP	82	19%	2004
FHA	Surrey	Morgan Place	PFP	128	3%	2002
FHA	White Rock	White Rock Seniors Village	PFP	60	11%	2004
VCHA	North Vancouver	Lynn Valley Care Centre	PFP	141	18%	2004
VCHA	West Vancouver	Capilano Care Centre	PFP	205	18%	2004
VCHA	West Vancouver	Inglewood Lodge	PFP	234	18%	2004
VCHA	West Vancouver	West Vancouver Care Centre	PFP	79	18%	2004
VCHA	Richmond	Fraserview Residence	PFP	101	18%	2004
VCHA	Vancouver	Amherst Private Hospital	PFP	44	45%	2004
VCHA	Vancouver	Arbutus Care Centre	PFP	152	18%	2004
VCHA	Vancouver	Braddan Private Hospital	PFP	60	10%	2004
VCHA	Vancouver	Lake View Care Centre	PFP	165	18%	2004
VCHA	Vancouver	Point Grey Private Hospital	PFP	67	10%	2004
VCHA	Vancouver	Renfrew Care Centre	PFP	106	10%	2004
VCHA	Vancouver	Royal Ascot Care Centre	PFP	79	10%	2004
VCHA	Vancouver	Windermere	PFP	207	20%	2004
FHA	Abbotsford	MSA Manor Home	PNP	34	24%	2002
FHA	Abbotsford	Maplewood House	PNP	77	45%	2004
FHA	Abbotsford	Menno Home	PNP	196	22%	2002
FHA	Abbotsford	Tabor Home	PNP	118	28%	2002
FHA	Burnaby	St. Michael's Centre	PNP	144	8%	2002
FHA	New Westminster	Buchanan Lodge	PNP	112	11%	2002
FHA	Aldergrove	Jackman Manor	PNP	88	24%	2002
VCHA	Richmond	Pinegrove Place	PNP	75	26%	2004
VCHA	Richmond	Rosewood Manor	PNP	151	35%	2004
VCHA	Vancouver	Adanac Park Lodge	PNP	72	48%	2004
VCHA	Vancouver	Blenheim Lodge	PNP	94	24%	2004
VCHA	Vancouver	Broadway Pentecostal Lodge	PNP	114	23%	2004
VCHA	Vancouver	Central City Lodge	PNP	100	5%	2004
VCHA	Vancouver	Columbus Residence	PNP	76	22%	2004
VCHA	Vancouver	Finnish Home	PNP	64	2%	2004
VCHA	Vancouver	German Canadian Care Home	PNP	132	24%	2004
VCHA	Vancouver	Haro Park Centre	PNP	154	20%	2004
VCHA	Vancouver	Kopernik Lodge	PNP	87	9%	2004
VCHA	Vancouver	Little Mountain Place	PNP	117	14%	2004
VCHA	Vancouver	Louis Brier Home and Hospital (Dr. Irving & Phyl)	PNP	215	10%	2004
VCHA	Vancouver	Mount St Joseph Hospital(106)	PNP	100	11%	2004
VCHA	Vancouver	Royal Arch Masonic Homes Society	PNP	151	14%	2004
VCHA	Vancouver	S.U.C.C.E.S.S. Simon K.Y. Lee Seniors Care Home	PNP	110	1%	2004
VCHA	Vancouver	St. Judes Anglican Home	PNP	53	17%	2004
VCHA	Vancouver	St. Vincent's Hospital-Brock Fahrni Pav.	PNP	148	6%	2004
VCHA	Vancouver	St. Vincent's Langara ECU(143)	PNP	197	18%	2004
VCHA	Vancouver	The Fair Haven United Church Home	PNP	100	3%	2004
VCHA	Vancouver	Three Links Care Centre, The	PNP	90	17%	2004
VCHA	Vancouver	Villa Carital	PNP	76	8%	2004
VCHA	Vancouver	Villa Cathay	PNP	150	15%	2004
VCHA	Vancouver	Yaletown House Society	PNP	127	58%	2004
VCHA	Vancouver	Youville Residence	PNP	42	13%	2004
NHA	Prince George	Prince George Hospice Society	PNP	10	52%	2004

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%)	<ul style="list-style-type: none"> - 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 	<ul style="list-style-type: none"> - 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. 	<ul style="list-style-type: none"> - Resident complaints will be very high with an unmanageable level of frequency. - Lack of maintenance will affect resident attitudes and morale. 	<ul style="list-style-type: none"> - Staff will not be able to provide regular scheduled maintenance due to high level of “reactive” calls
Poor (11% to 30%)	<ul style="list-style-type: none"> - Facilities will look worn with apparent and increasing deterioration - Frequent component and equipment failure may occur. Occasional building shut down will occur 	<ul style="list-style-type: none"> - 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) 	<ul style="list-style-type: none"> - Resident complaints will be high with increased level of frequency. - Concern about negative resident morale will be raised and become evident. 	<ul style="list-style-type: none"> - Facilities staff time will likely be diverted from regular scheduled maintenance and forced to “reactive” mode
Fair (6% to 10%)	<ul style="list-style-type: none"> - Facilities are beginning to show signs of wear - More frequent component and equipment failure will occur 	<ul style="list-style-type: none"> - Repairs and replacement of specific systems, i.e. boiler, window replacements, interior renovations. 	<ul style="list-style-type: none"> - Resident complaints will occur with higher level of frequency - Resident morale may be affected 	<ul style="list-style-type: none"> - Facilities staff time may at times be diverted from regular scheduled maintenance
Good (0% to 5%)	<ul style="list-style-type: none"> - Facilities will look clean and functional - Limited and manageable component and equipment failure may occur 	<ul style="list-style-type: none"> - Repairs and replacement of more of an aesthetic or general nature, such as wall painting, carpet replacement, roof repair, window caulking. 	<ul style="list-style-type: none"> - Resident complaints will be low and manageable - Resident morale will be positive and evident 	<ul style="list-style-type: none"> - 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 E: Shifting resources from Acute to Home and Community Care

If fully implemented, the recommendations outlined in this report would be significant. For example, the majority of new costs would be from the implementation of new long term care beds. As outlined earlier based on the Conference of Canada data, the total estimated cost of constructing and operating required new long term care beds to 2035 in BC alone would be close to \$30 billion.

Given the importance of seniors particularly with an aging population, the BCCPA believes that this is a worthwhile investment to consider. 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 long term care; and
- 84% believe that as seniors enter long term care homes with increased acuity or medical complexity, government funding should increase to meet these care needs.²¹⁶

Along with new monies, some funding could be obtained by redirecting funds from the existing Health Authority acute care budgets to home and community care – an approach also generally supported by the Ministry of Health.²¹⁷ 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 2015 *Quality-Innovation-Collaboration* paper, 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.²¹⁸ In particular, as part of an earlier budget submission, the BCCPA recommended 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.

²¹⁶ 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.

²¹⁷ 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>

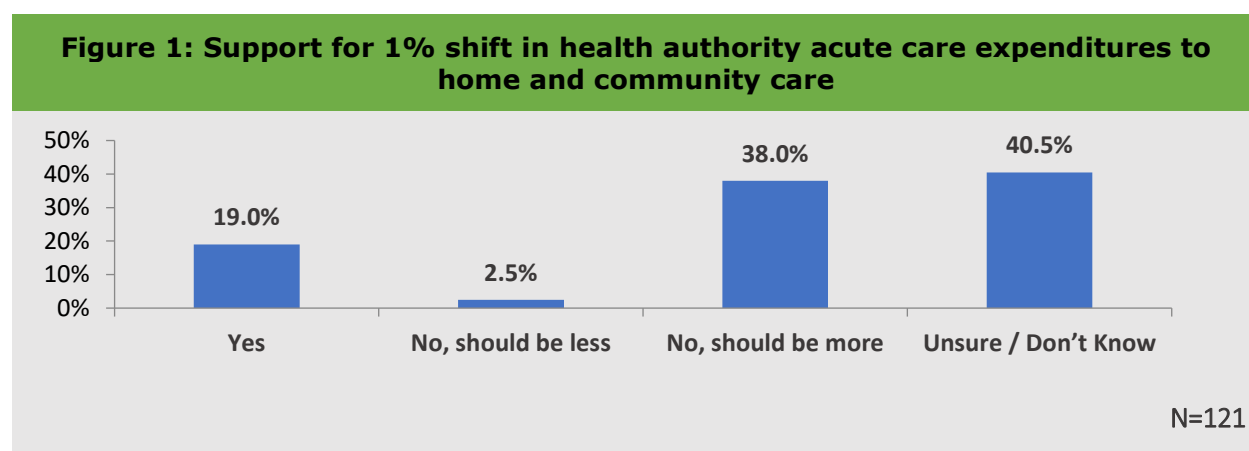
²¹⁸ BCCPA. Op-ed: Quality, Innovation, Collaboration – Strengthening Seniors Care Delivery in BC. October 2015. Accessed at: <http://www.bccare.ca/op-ed-quality-innovation-collaboration-strengthening-seniors-care-delivery-in-bc/>

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 below 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 (see below).

Overall, reinvesting in continuing care makes sense, as costs are substantially lower - the cost of treating a BC senior in hospital ranges from \$825 to \$1,968 per day (average is about \$1,200), whereas the cost of residential or long term care is approximately \$200 per day.²¹⁹ 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.

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 or long term care home. Initial estimates by the BCCPA suggest that if ALC days could be reduced by 50% by caring for patients in a residential or long term care bed rather than a hospital bed, it could generate over \$200 million in annual cost savings.²²⁰

When participants were asked at the 2016 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 (19%) or should be more (38%). Another 40% were unsure.

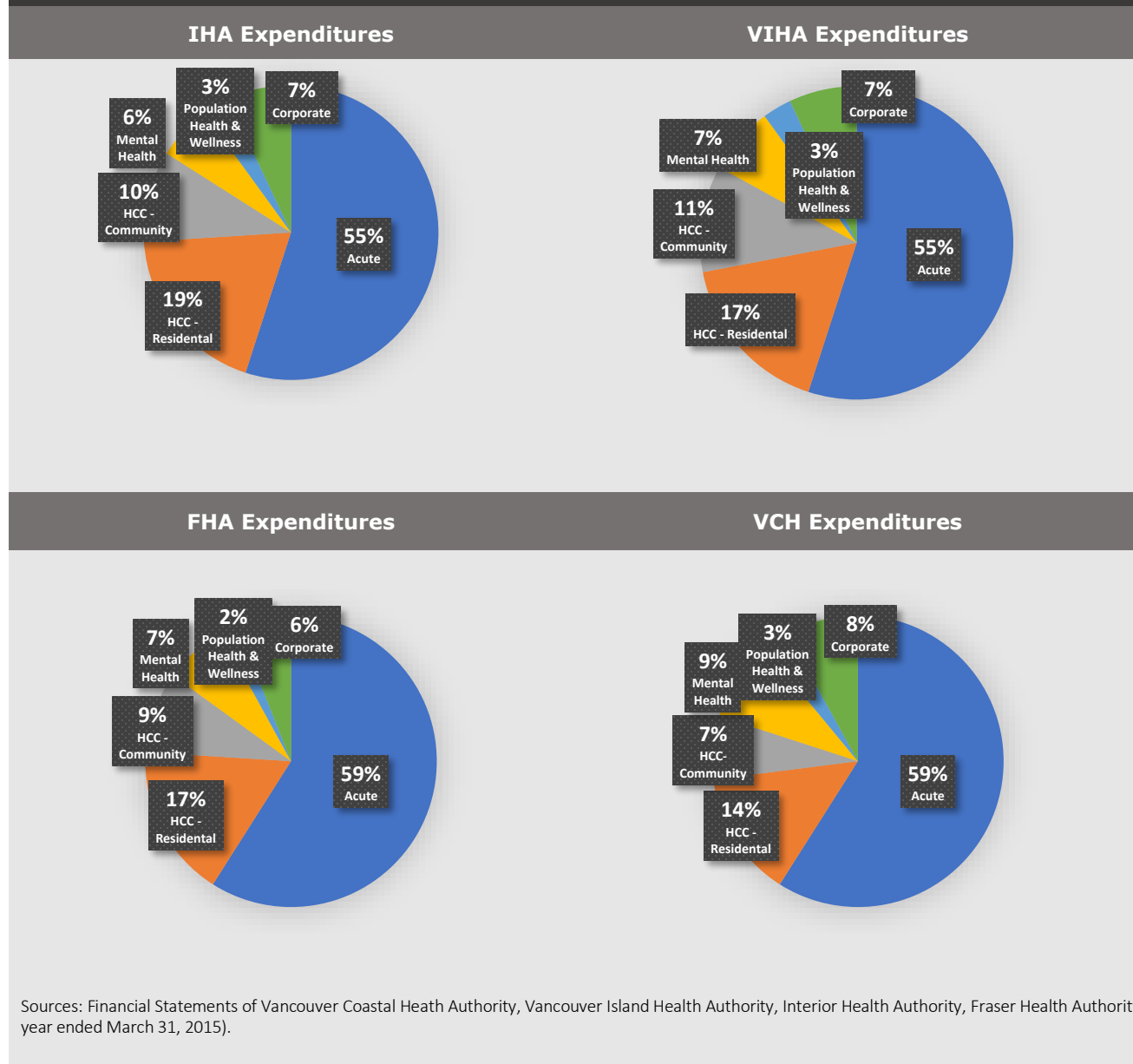


²¹⁹ BCCPA. Op-ed: Let's Stop Seniors from Languishing in Hospitals. February 2016. Accessed at: <https://bccare.ca/2016/02/op-ed-lets-stop-seniors-languishing-hospitals/>

²²⁰ 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>

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.

FIGURE 2: BREAKDOWN OF HEALTH AUTHORITY EXPENDITURES (2014/15)



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 Health Authority, Vancouver Island Health Authority, Interior Health Authority, Fraser Health Authority, and Northern Health Authority (year ended March 31, 2015).

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)	1 st Year	2 nd Year	3 rd Year	4 th Year	5 th 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 Health Authority, Vancouver Island Health Authority, Interior Health Authority, Fraser Health Authority, and Northern Health Authority (year ended March 31, 2015).						

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