BC CARE PROVIDERS ASSOCIATION

BOARD MEETING AGENDA

IN-PERSON Thursday April 17, 2014 – 9:30 am – 12:30 pm

VISION

The BC Care Providers Association delivers effective leadership and valued resources that support progressive change, promoting the growth and success of its members who provide the best possible care services for seniors.

Action Required: A=Approval I=Information D=Discussion

Notes	ITEM #	TOPIC	PRESENTER	TIME	* Action req'd	Strat Plan
AGENDAS | MINUTES						
	1.0	**Approval of Consent Agenda** **Proposed Motion:** Be it resolved that the consent agenda be approved in its entirety.	D Cheperdak	9:30-9:32	**A**	
(attachment)	**a**	Board meeting minutes approval: January 16th, 2014				
(attachment)	**b**	BCCPA Amended Bylaws				
(attachment)	**c**	Annual General Meeting Agenda				
	d	**Approval of BCCPA 2015 Conference Dates and Location** **Proposed Motion:** Be it resolved that the BCCPA be held at the Fairmont Chateau Whistler on May 24-26 2015.				
(attachment)	**e**	**Approval of Potential New BCCPA Members** **Proposed Motion:** Be it resolved that the new residential care, home care and commercial member applications for membership be approved as circulated.				
	1.1	**Approval of Agenda** **Proposed Motion:** Be it resolved that the agenda be approved.				
CONTINUING BUSINESS						
	2.0	**Action Items from Previous Minutes**	D Cheperdak	9:32-9:34	**A**	
(attachment)	**2.1**	**Core Review Draft Report** **Proposed Motion:** Be it resolved that the draft core review report be approved as Circulated.	H Campbell	9:34-9:44	**A**	**2.3, 3.2, 3.4, 4.3**
	2.2	**Membership Reactivation | Affinity Program**	H Dashevsky D Fontaine	9:45:-10:15	**D**	**1.3,1.5**
STANDING REPORTS						
(attachment)	**3.0**	**CEO Report (includes Annual Conference Update)**	D Fontaine	10:15-10:35	**I**	
NEW BUSINESS						
(attachment)	**4.1**	**Safe Care BC Support Services Agreement** **Proposed Motion:** *Be it resolved that the SafeCare BC-BCCPA support services agreement be approved.*	D Fontaine	10:35-10:45	**A**	**3.1**
(attachment)	**4.2**	**Draft Budget 2014 | 2015** **Proposed Motion:** *Be it resolved that the 2014/15 operating budget be approved.*	A Van Ryk	10:45-11:15	**A**	
IN CAMERA	**4.3**	**HR Update**	D Fontaine	11:15:-11:20	**I**	

Notes	ITEM #	TOPIC	PRESENTER	TIME	* Action req'd	Strat Plan
(attachment)	**4.4**	**Burquitlam Manor**	D Fontaine	11:20-11:35	**D**	
BOARD COMMITTEE REPORTS						
(attachment)	**5.1**	**Finance and Audit Committee**	A Van Ryk	11:35-11:40	**I**	
	5.2	**Standardized Contract Working Committee**	L Monrad	11:40-11:45	**I**	
(attachment)	**5.3**	**Governance Committee** • Nominations Committee	E Price	11:45-11:55	**I**	
IN CAMERA	**5.5**	**Executive Committee** • CEO Performance Review	D Cheperdak	11:55-12:25	**D**	
IN CAMERA	**5.6**	**Participation in Board in Camera Meeting**	Ron Pike	12:25-12:35	**D**	
UPCOMING EVENTS						
	6.1	BCCPA Annual Conference: May 25-27 2014		12:35 – 12:40	**I**	
	6.2	CALTC Conference: August 24-26 2014 (hosted by BC)			**I**	
ADJOURNMENT						
	7.1	**The next meeting is scheduled for May 26th 2014 (Whistler)**			**A**	
BOARD OF DIRECTORS DEBRIEF – 5 MIN						
Lunch – 12:40 pm – 1:00 pm						

STANDING COMMITTEES
Executive Committee: D Cheperdak, A Van Ryk, E Price, M McDougall, Daniel Fontaine
Governance Committee: D Cheperdak, S Emmons, E Price (Chair)
Annual 2014 Conference Committee: Michael Aikins, Hendrik Van Ryk (Chair)
Membership Review Committee: All Board members
Finance & Audit Committee: Andre Van Ryk (Chair)
AD HOC COMMITTEES
Awards 2015 Committee: vacant (2)
EXTERNAL COMMITTEES
Ministry of Health – Standardized Contract Working Committee: Liz Monrad
HEABC Affiliate Committee: Aly Devji + Daniel Fontaine

attachment: 1.a

BC CARE PROVIDERS ASSOCIATION

BOARD MEETING AGENDA

IN-PERSON Thursday January 16, 2014 – 9:30 am – 2:30 pm
BCCPA Boardroom 301 – 1338 W Broadway, Vancouver BC

In attendance: Al Jina, Aly Devji, Elaine Price, Sue Emmons, Donna Morasco, Ron Pike, Azim Jamal, Liz Monrad

Via tele-conference: Mary McDougall (left at 10:40), Andre Van Ryk (joined at 10 am) Bob Attfield, David Cheperdak

Not in attendance: Will McKay, Liz Dutton, Isobel Mackenzie

Action Required: A=Approval I=Information D=discussion

Notes	ITEM #	TOPIC	PRESENTER	TIME	* Action required	Strategic Goal
AGENDA/ MINUTES						
	1.1	**Approval of Consent Agenda** **Proposed Motion:** Be it resolved that the consent agenda be approved in its entirety. **Moved by: Sue Emmons Seconded: Aly Devji APPROVED**	D Cheperdak		**A**	
(attachment)	**a**	Board meeting minutes approval: i November 21, 2013 ii December 18, 2013 (in-camera)				
(attachment)	**b**	Policy - Election of Officers				**6.1**
(attachment)	**c**	Policy - Nominating Committee				**6.1**
(attachment)	**d**	Terms of Reference – Executive Committee + Governance Committee				**6.1**
	e	Governance Committee – Appoint Isobel Mackenzie to the Governance Committee				**n/a**
(attachment)	**f**	Strategic Plan: Quarterly Update				**n/a**
(attachment)	**g**	SafeCare BC Reports: • Project Status Reports • Implementation Recommendations • Best Practice Review • Working Group Actions (Nov/Dec)				**3.1**
	1.2	**Approval of Agenda** **Proposed Motion:** Be it resolved that the agenda be approved in its entirety. **Moved by: Sue Emmons Seconded: Aly Devji APPROVED**	D Cheperdak	2 min	**A**	

Notes	ITEM #	TOPIC	PRESENTER	TIME	* Action required	Strategic Goal
CONTINUING BUSINESS						
(attachment)	**2.1**	**Core Review Interim Report – request for feedback** Michael informed the board that the purpose of this meeting is to get feedback from the Board. He noted that with the Assistance of Rebecca – highlighted the research completed and main issues. • Public/Private providers – moving to more private 15% savings. • FHA takes more of the severe cases currently. • Recognize trends. Encourage them to utilize our sector. • Disparity is larger than perceived due to capital. • High acuity patients • Comparison of funding – ie equity levels. • Ron:Split capital from operating budget – clearer comparison- may be easier to compare costs of various levels of care. • RFPs handled by "provincial health' rather than HA – which is in competition with private/non-profit providers - ie separate ministry. (Concern HA is funder as well as operator). • Social messaging key for public perception. Landscape change. • Operating dollars from provincial not HA? • Breakdown between HA + MOH re funding. Value model. Open level playing field to compete for the $. • Reframe to create best outcomes for all service providers (HA + private + non-profit) • Regulations to be consistent between all groups. Questions will be sent out to Board members and/or conference call to further discuss next items that needs to be developed. Rebecca & Michal thanked for the board for their feedback and they will incorporate changes discussed and will further update the report.	Guests: Michael Izen Rebecca Livernois @9:35	25 min	**D**	**3.4**
	2.2	• **BCCPA Membership Value Proposition** • Position association in public form as leading value and services. • i.e. project with Chef Matt Stowe to improve perception of food provided by all service providers. • Continue to profile the industry to acknowledge quality of life provided for seniors. • What do you get as a member? What is the value for providers? • Proactive in front of issues (i.e. Matt Stowe) Raise the sector to a new level.	M McDougall	20 min		**1.4 + 1.2**

Notes	ITEM #	TOPIC	PRESENTER	TIME	* Action required	Strategic Goal
		• "Buy local" – Minister of Agriculture. Would like to be involved in development of event to encourage 'buy local" initiatives. • Create partnerships on various initiatives. • Bring forward to another meeting for broader discussion to add to strategic plan. What to focus on etc.				
(attachment)	**2.3**	**SafeCare BC – create a new society** • J & W reviewed the process of the transition of the Bod to Safecare BC. Advice from lawyer as per C & B to create Assn as separate entity. • Constitution standard – bylaws perhaps need some tweaking. • Sue- interim bylaws in effect for short time until permanent bylaws are produced by new SafeCare BC Board. • 4.4 reword remove 'present' Will new association be applying for charitable status? Should wording be reviewed with that in mind? • New Working Group: Al/Dave/Sue /Daniel /Heather/Elaine – group to work on next set of bylaws for SafeCareBC. • (Suggested by Sue that the bylaws be shared with Board prior to BOD meeting to allow more time to review with explanatory notes) • Wynona reviewed the timelines moving forward for the establishment of SafeCareBC. • Nominating Committee for election of officers. • Inaugural meeting of SafeCare BC May 26 2014 • (Wynona to forward timelines for inclusion in minutes) **Proposed Motion:** Be it resolved that the interim society bylaws for the new SafeCare BC Association be approved with revisions as discussed. **Moved by: Ron Pike Seconded by: Sue Emmons APPROVED** **Proposed Motion:** Be it resolved the interim constitution for the new SafeCare BC Association be approved as submitted. **Moved by: Ron Pike Seconded by: Sue Emmons APPROVED** **Action: Suggested that WCB joint with Assn that a memo be sent to all providers to let them know that SafeCare BC is created and increase in fees.**	Guests: Jennifer Hystad Wynona Giannasi @10:30	60 min	**A**	**3.1**
HANDOUT	**2.4**	**HBT Update** • Al Jina provided his feedback as to the meetings he has attended. • The information submitted by Isobel as a handout was reviewed.	I Mackenzie H Campbell	5 min	**I**	

Notes	ITEM #	TOPIC	PRESENTER	TIME	* Action required	Strategic Goal
		• The committee discussed what the role should the association should play moving forward regarding these issues.				
STANDING REPORTS						
(to be circulated)	**3.2**	**CEO Report** • Daniel updated the board regarding current activities: • Care to Chat #2– met target registrations • Care to Chat #3 – Apr 8th (Maureen McGrath to be Keynote) • Care to Chat #4 – (at conference) "Silver Alert Program" draft topic • (Questionnaire regarding locations for next year's C2C series) • Delegate Day – Victoria – Terry Lake will attend and hand out awards. Approx. 25 MLAs have confirmed. (Brief for the Board?) • Daniel reviewed process of day delegates to the legislature. • Breakfast session in AM. • Daniel has been invited to sit on the Council to End Elder Abuse • Care Aide Registry – Heather is drafting report for Board. • Daniel noted importance of members notifying the association as soon as possible regarding any media items. • Meeting with Michael Marchbank this week. • Membership reviewed at end of year 2013. Invoicing to be moved up for next year • Mitacs to partner (co-op student program) with us for the Residential Therapy project with OLTCA. • Video project in process. • Social media is growing – twitter & LinkedIn etc • Website traffic is strong and growing.	D Fontaine	20 min	**I**	**n/a**
LUNCH BREAK (12-12:30 PM)						
NEW BUSINESS						
IN CAMERA *(attachment)*	**4.1**	**CEO Performance Review** • CEO Performance Review Performance Tool	D Cheperdak	5 min		

Notes	ITEM #	TOPIC	PRESENTER	TIME	* Action required	Strategic Goal
		Proposed Motion: Be it resolved that the CEO Performance Review Tool be approved as submitted**.** Selection of participants for performance review feedback **Moved by: Al Jina Seconded by: Sue Emmons** **APPROVED**				
(attachment)	**4.2**	**Top Chef Canada – Proposal and Feedback** • Hoping to secure some funds for this project from the ministry of Agriculture as ties into their emphasis on food "close to home". • Keivan provided overview of proposal provided • Cost effective and appetizing menus/foods for residents. Chef Stowe to work with industry chefs to develop program. BC Dieticians will be included in development of program etc. • The board provided feedback regarding development of program ie. Positive messaging etc.	D Fontaine	15 min	**D**	**1.1 + 1.3 + 2.1 + 2.2 + 2.3**
(attachment)	**4.3**	**Sponsorship Policy – Revera proposal** • Liz provided background etc regarding program details • Daniel noted that there is no policy guidelines regarding the Association sponsoring of events. • Discussion ensued as to whether sponsorship be considered and whether a policy in this regard in necessary. • It was agreed that the board not approve this sponsorship at this time. • Following discussion it was decided that a policy was not necessary at this time.	L Monrad & D Fontaine	10 min	**D**	**n/a**
(attachment)	**4.4**	**BCCPA Lease at 1338 West Broadway** Daniel reviewed the staffing growth expected over the near future and the potential need for more office space within the next year and the possibility of sub-letting the current space and looking at alternate space to accommodate both BCCPA and SafeCareBC. **Proposed Motion:** Be it resolved that the Association seek to sublet current property and proceed to find premises to accommodate BCCPA and SafeCare BC. **Moved by: Al Jina Seconded by: David Cheperdak** **APPROVED**	D Fontaine	10 min	**A**	**3.1**
	4.5	**Membership Support Programs** Daniel reported on his discussions with non –members and the need to increase membership by providing services that encourage participation, which initiated the research into membership support programs. Daniel also noted the many suggest	D Fontaine	5 min	**D**	**1.5 + 1.2 + 1.4**

Notes	ITEM #	TOPIC	PRESENTER	TIME	* Action required	Strategic Goal
		services/items that could be included in the program.				
(attachment)	a	Consultant Report – Patrick O'Connor Guest: P O'Connor - Patrick reviewed the report as prepared for the Board outlining his process in compiling the information. • Board questions; How to cancel plan if members does not renew with BCCPA. • Benefit for Association – etc	Guest: P O'Connor *@ 1:30 pm*	15 min	**D**	**1.5 + 1.2 + 1.4**
(attachment)	b	BC Non Profit Housing Association (BCNPHA) Guests: Tony Roy, Executive Director & Jacqui Mendes, Dir Member Services & Admin BCNPHA • Tony and Jacqui reported on the program they currently have in place and answered questions of the board directors. • Partner programs approx. 31% of revenue sources/membership fees 19% of revenue sources.	Guests: Tony Roy Jacqui Mendes *@ 2:00 pm*	20 min	**D**	**1.5 + 1.2 + 1.4**
BOARD COMMITTEE REPORTS						
(to be circulated)	**5.1**	**Finance and Audit Committee** • Andre reported on the statements circulated to the board. • Andre noted that some changes have been made to the Balance Sheet/Accounts to reflect accrual payment methods being used. Andre also explained some of the expenses noted and the recording of SafeCareBC revenue • Overall the finances are positive in comparison to previous year. Action: Circulate SafeCareBC Financials with Agenda for first SafeCareBC Board Meeting in March	A Van Ryk	5 min	**I**	**1.4**
(attachment)	**5.2**	**Annual Conference Update** Daniel updated the Board on work to-date and informed the Board that Mark Tewksbury has been selected as a keynote for Monday evening.	D Fontaine	5 min	**I**	**1.3 + 4.2**
	5.3	**Standardized Contract Working Committee** Liz reported on several meetings on drafts for Residential Care.	L Monrad	5 min	**I**	**2.3 + 3.5**
(attachment)	**5.4**	**Governance Committee**	E Price	5 min	**I**	**6.1**
(attachment)	**5.5**	**Awards Committee** **Proposed Motion:** Be it resolved that the long service award be named the Ed Helfrich Award.	D Marasco	5 min	**I**	**2.3**

Notes	ITEM #	TOPIC	PRESENTER	TIME	* Action required	Strategic Goal
		Moved by: Donna Marasco Seconded by: Aly Devji **APPROVED** **Proposed Motion:** Be it resolved that the Board approve the recommendations of the 2013 Awards Committee as circulated. **Moved by Donna Marasco Seconded by: Liz Dutton** **APPROVED**				
UPCOMING EVENTS						
	6.1	Care to Chat Series #2 – Jan 22 2014		5 min	I	
	6.2	Victoria BCCPA Day – Feb 19 2014			I	
	5.3	Care to Chat Series #3 – Mar 12 2014 (tbc)			I	
	6.4	BCCPA Annual Conference – May 25-27 2014			I	
	6.5	CALTC Conference – Aug 24, 25, 26 2014 (Hosted by BC)			I	
ADJOURNMENT						
	7.1	**The next meeting is scheduled for March 20, 2014 (in-person)**			A	
BOARD OF DIRECTORS DEBRIEF – 5 MIN						

Correspondence:

- Ltr from H Davidson, ADM re Council to Reduce Elder Abuse, Nov 28 13
- Ltr from L Krog, MLA re Care to Chat, Dec 4 13
- Ltr from P Milbrun, DM re Budget, Dec 23 13
- HBT Report, Dec 2013
- Ltr to Premier, re Invite to awards, Nov 22 13

STANDING COMMITTEES

Executive Committee: D Cheperdak, A Van Ryk, E Price, M McDougall, Daniel Fontaine
Governance Task Group – Chair D Cheperdak, S Emmons, E Price, I Mackenzie
Annual 2014 Conference Committee: Isobel Mackenzie (Vice-Chair), Michael Aikins, Hendrik Van Ryk (Chair)
Membership Review Committee: All Board members
Finance & Audit Committee: Andre Van Ryk (Chair)

AD HOC COMMITTEES

SafeCare BC Hiring Committee - (Aly Devji, Liz Dutton (Chair), Daniel Fontaine
Awards Committee: Al Jina, Donna Marasco
SafeCare BC Implementation Working Group: Sue Emmons (chair), M McDougall, J Thompson (DHA), Stephen Symon (WCB), D Fontaine (CEO, BCCPA)

EXTERNAL COMMITTEES

Ministry of Health – Standardized Contract Working Committee: Liz Monrad
HEABC Affiliate Committee: Aly Devji + Daniel Fontaine

attachment 1.b

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BC CARE PROVIDERS ASSOCIATION

Advocating service excellence for seniors

Constitution & Bylaws

Effective May 2014

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"SOCIETY ACT"

CONSTITUTION

1. The name of the Society is "B.C. Care Providers Association".

2. The purposes of the Society are:

   (a) To create, promote and encourage better understanding, unity, harmony and co-operation amongst the members of the Society;

   (b) To seek, obtain and encourage the support, recognition and understanding of the public and all levels of government and government agencies or bodies for the continued improvement of residential care, assisted living, home care, home support and, community care in British Columbia;

   (c) To encourage and support the members of the Association in maintaining a high standard of service delivery in British Columbia and to promote and support the best interests and welfare of the residents, clients, patients, owners, administrators and staff of facilities and community care agencies in British Columbia;

   (d) To serve and represent the best interests of the members of the Society and the public in the provision of economical services, including: the creation and provision of greater opportunities for the establishment and expansion of agencies and facilities in British Columbia; the co-ordination and liaison between, and the promotion of concerned efforts and action by, the Society; and the liaison with other sympathetic and interested organizations and agencies of a similar or allied nature;

   (e) To establish and promote programs of education to elevate the standards of service delivery in British Columbia;

   (f) To help lead the development of legislation and policies for the health and welfare of the residents and clients of facilities and community care agencies in British Columbia; to encourage the growth and development of facilities and community care agencies; and to study and inform the public on pending and enacted legislation having application to public health and welfare;

   (g) To provide directly or through referral, guidance and advice on matters relating to employee relations, human resources and labour relations.

3. The operations of the Society will be carried on chiefly in the Province of British Columbia.

4. The Society shall be carried on without the purpose of gain for its members and any profits or benefits to the Society shall be used for promoting its objectives.

5. In the event that the Society should at any time be wound up or dissolved, the remaining assets after payment of all debts and liabilities shall be donated to a recognized charitable organization in the Province or elsewhere in Canada as directed by its members.

6. Clauses 4, 5 and 6 of this Constitution are unalterable.

BYLAWS

PART 1 - INTERPRETATION

1.1 "Board" means the Directors of the Society elected to serve on the Board of Directors as provided in Part 5 of these Bylaws.

1.2 "Director" means a person elected to serve on the Board of Directors pursuant to these Bylaws.

1.3 "Society Act" means the Society Act of the Province of British Columbia from time to time in force and all amendments to it.

1.4 "Chief Executive Officer" means an employee who holds the senior management position of the Society reporting directly to the Board.

1.5 "Membership Sectors" shall include each of the following:

(a) Residential Care
(b) Home Care
(c) Home Support
(d) Community Care

1.7 "Sector" means a specific subset of the overall continuing care industry

1.6 The "Membership Review Committee" means the committee chaired by a Board appointee established to review any member who may be in contravention of the Code of Ethics. If the committee chairperson is not a current Board Director, the chairperson will be an ex-officio member of the Board.

1.7 The definitions in the Society Act on the date these Bylaws come into effect apply to these Bylaws.

1.8 In these Bylaws, words importing a male person include a female person and words importing a female person include a male person and either word includes a corporate entity. Words importing the singular include the plural and vice versa.

PART 2 - MEMBERSHIP

2.1 QUALIFICATION FOR MEMBERSHIP

a) Membership shall be confined to corporations, firms, agencies, societies, partnerships or persons engaged or interested in or connected with the provision of residential care, assisted living, home care, home support and, community care in British Columbia.

(b) The Board of Directors has discretion to accept or reject application for membership in the Society, provided that before membership is accepted, the applicant must pay to the

Society the membership dues, if any.

2.2 MEMBERSHIP CLASSIFICATIONS

There shall be the following classes of membership:

(a) Service Provider
(b) Commercial
(c) Associate
(d) Honourary
(e) Honourary Lifetime Achievement

2.3 SERVICE PROVIDER

A Service Provider member shall be a person, partnership, corporation or other legal entity who/which provides residential care, assisted living, home care, home support and, community care in British Columbia. When a Service Member divests itself of providing such services, its membership in the Society shall be transferable to the new service provider.

2.4 COMMERCIAL

A commercial member shall be such person, partnership, firm, corporation or other legal entity, who is interested in conducting business with the members of the Society. The commercial members shall not be entitled to vote at, but may receive notice of and attend, meetings of the members of the Society.

2.5 ASSOCIATE

An associate member shall be such person, partnership, firm, corporation, or other legal entity which supports the purposes of the Society and wishes to be informed of the activities of the Society. Associate members shall not be entitled to vote at, but may receive notice of and attend meetings of the members of the Society. Associate members do not normally market or sell products/services to Residential Care & Assisted Living or our Home and Community Care members.

2.6 HONOURARY

An honorary member shall be such person as selected by the Board of Directors on the basis that such individual shall have contributed to the welfare, interest and well-being of care facilities and community care agencies in British Columbia. The honorary members shall not be entitled to vote at, but may receive notice of and attend meetings of the members of the Society.

LIFETIME ACHIEVEMENT

The Board of Directors may, by a 75% vote of all Board Directors, confer Honorary Lifetime Achievement Membership upon any person who has rendered outstanding

service to the Association or to its purposes. An Honourary Lifetime Achievement Member shall receive notice of and attend meetings of the Society.

2.7 The Membership Review Committee shall:

1. Interpret and apply the Code of Ethics.
2. Review and evaluate the Code of Ethics and make recommendations to the Board.
3. Review concerns brought forth regarding breaches of the Code of Ethics and make recommendations to the Board.

2.8 The membership dues or other fees payable by members shall be determined by the Board of Directors and shall become effective only when confirmed by the members at the annual or special meeting of members.

2.9 The Board of Directors shall determine the day in each year when the membership dues, if any, from each member shall be paid.

2.10 Associate members, honourary members and honourary lifetime achievement members shall be entitled to speak at any meeting of the members of the Society.

2.11 In order to remain in good standing in the Society, a members shall comply with the Bylaws of the Society and pay within ninety (90) days of the due date the membership dues or other fees, if any, for the current year.

2.12 A Service Provider Member who operates or is affiliated with more than one facility or agency shall only be required to pay membership dues or other fees for each facility or agency of which they are the sole proprietor or majority shareholder.

2.13 The membership dues may be waived for a specified period of time for a new or existing Service Provider Member subject to approval by the Board.

2.14 CODE OF ETHICS

The Code of Ethics which the member of the Society will practice and which must govern their conduct shall be as follows:

Service Provider Members shall:

(a) comply with all bylaws of the Association and will conduct all activities with honesty, integrity, respect, fairness and good faith in a manner which will reflect well upon the industry;

(b) provide adequate facilities and shall serve the residents or clients for whom they are responsible, to the best of their ability, having regard to the total physical, mental and spiritual, and cultural needs and safety of those residents or clients;

(c) promote competence of service delivery management through ongoing education and shall endeavour to employ staff with the personality, ability and temperament necessary to manage or work with persons in care and satisfactory experience, competency and

compassion;

(d) strive at all times to be courteous and treat persons in care, clients, their families and the public with consideration and dignity;

(e) comply with all acts, regulations and standards relevant to the sector in which services are provided;

(f) hold that professional relationships are not to be exploited for personal advantage;

(g) refrain from conduct that undermines the role of the Association and the credibility of the sector;

Commercial members shall:

(h) refrain from using the Association's credentials or affiliation to promote or endorse external commercial products or services;

PART 3 - TERMINATION OF MEMBERSHIP

3.1 Any member who desires to withdraw from membership in the Society must notify the Board of Directors in writing to that effect and on receipt by the Board of Directors of such notice, the member shall cease to be a member. There shall be no refund of subscription or other fees paid.

3.2 Subject to ratification by the Board of Directors, a member shall cease to be a member if the member fails to pay the membership dues or other fees, if any, within ninety (90) days of the due date.

3.3 Any member may be expelled from membership for cause by the Board of Directors or by a special resolution of the members at an annual or special general meeting of the Society. The notice calling the meeting, whether an annual or special general meeting, shall contain a specific reference to the fact that such a motion is to be proposed at the meeting.

The Membership Review Committee may recommend termination of membership or any other action it considers appropriate for any member who is in contravention of the Code of Ethics.

The member must receive written notice of the Membership Review Committee's decision to recommend termination or any other action, and must be given an opportunity to be heard at the annual or special general meeting before the special resolution is put to a vote.

3.4 Appeal Process

(a) If the Service Provider Member wishes to appeal a finding of the Membership Review Committee, a written request must be submitted to the Membership Review Committee within thirty (30) days of receiving a formal notice of termination.

(b) Appeals will be forwarded by the Membership Review Committee to the Appeal Committee.

(c) The Appeal Committee shall consist of the Board of Directors

(d) The Appeal Committee must review the appeal and make a final decision within 90 days of the appeal being filed and received by the Association.

(e) At least thirty (30) days notice of the formation of the Appeal Committee, date and location of hearing shall be given to all parties concerned.

(f) A written copy of the final decision of the Appeal Committee will be provided to the appellant no later than 30 days after the decision has been rendered.

PART 4 - MEETINGS OF MEMBERS

4.1 The annual meeting shall be held within 180 (one hundred and eighty) days following the fiscal year end of March 31st, of each year at a place within the Province and on a day to be fixed by the Board of Directors. At every annual meeting, in addition to any other business that may be transacted, the report of the Directors, the financial statement and the report of the auditors shall be presented. A Board of Directors will be elected and auditors appointed for the ensuing year and the remuneration of the auditors shall be fixed at the annual meeting or if the members of the Society so resolve, by the Board of Directors.

4.2 Every notice of an annual or special meeting of the Society shall state the nature of the business of the meeting and such notice shall be given to every member thirty (30) days before such general or special meeting.

4.3 Notice of any annual or special meeting shall be deemed to be given to every member if mailed or handed to every member, and in addition notice shall be deemed to be given to every member if a notice of the annual or special meeting is advertised in any daily newspaper circulating throughout the province or the Society's website or publications distributed in electronic form or hardcopy to all members.

4.4 The Board of Directors of the Society may call a special meeting of the Society for any purpose.

4.5 The rules of procedure at an annual or special meeting shall be determined by the Board of Directors, or if any member objects, the Roberts' Rules of Order shall apply.

4.6 Any meetings of the Society may be adjourned to any time and from time to time and such business may be transacted at such adjourned meeting as might have been transacted at the original meeting from which such adjournment took place. No notice shall be required of any such adjournment.

4.7 No business shall be transacted at any meeting of the Society unless a quorum is present. Twenty-five percent (25%) of the voting delegates, attending either in-person or by proxy, shall constitute a quorum of an annual general or extraordinary general meeting of the Society but never less than six (6) persons.

4.8 The accidental omission to give notice of a meeting to, or the non-receipt of a notice by, any of

the members entitled to receive notice does not invalidate proceedings at that meeting.

4.9 VOTING RIGHTS OF MEMBERS

Ten percent of the Service Provider Members can require the Directors to call a special meeting of the members of the Society.

4.10 Each Service Provider Member shall appoint annually one voting delegate. Only Service Provider Members of the Society in good standing and who have been Service Provider Members for a period greater than 60 days prior to the annual or special meeting can appoint voting delegate(s). Commercial, associate, honourary lifetime achievement and honourary members shall have no voting rights.

4.11 Each Service Provider Member shall notify in writing the President and Chief Executive Officer of the Society in writing of the names, addresses and occupations of the voting delegates appointed by it. Until the Society shall have been notified of any changes or additions to such voting delegates, the current list of such voting delegates at any particular time shall be deemed to be the list of such voting delegates. Each Service Provider Member may replace the voting delegate appointed by it, as necessary.

4.12 Voting rights shall be exercised at any meeting of the Society only by voting delegates or their proxies, established in writing. A proxy shall be deposited at the registered office of the Society no later than 30 days prior to the meeting, or such other place as is specified for that purpose in the notice calling the meeting, prior to the time for holding the meeting at which the voting delegate named in the proxy proposes to vote. The proxy may be given to any other voting delegate, who shall be entitled to vote on behalf of the voting delegate who gave the proxy. Proxy votes shall be allowed and shall be valid in respect of one meeting (including adjournments thereof) only.

4.13 A vote given in accordance with the terms of a proxy shall be valid, notwithstanding the previous death or mental incapacity of the voting delegate or revocation of the proxy, provided no prior notice in writing of the death, mental incapacity or revocation as aforesaid shall have been received at the registered office of the Society or by the Chairman of the meeting or adjourned meeting at which the vote was given.

4.14 Unless, in the circumstances, the Society Act requires any other form of proxy, a proxy appointing a proxy holder, whether for a specified meeting or otherwise, shall be in the form following, or in any other form that the Board shall approve:

> *The undersigned, being a voting delegate of (name of Service Provider Member) hereby appoints _____, a voting delegate of _____, (or failing that person, _____, a voting delegate of_____) as a proxy holder for the undersigned to attend at and vote for and on behalf of the undersigned at the general meeting of the Society to be held on the ___ day of _____, 20__, and at any adjournment of that meeting.*
>
> *Signed this____day of _____, 20___.*
>
> *(signature of voting delegate)*

4.15 In case of an equality of votes, the Chair will not have a casting or second vote in addition to the vote to which he may be entitled as a member and the proposed resolution shall not pass.

4.16 The President of the Society, the Vice-President, or in the absence of both, one of the other Directors shall preside as chairman of a members' meeting.

4.17 Unless voting on special resolutions, or as otherwise required by the Bylaws, every question shall be decided by a majority of votes. These votes can be conducted through secret ballot or by a show of hands.

4.18 Unless a poll is requested by ten percent (10%) of the voting delegates present at any meeting and except as provided in the Bylaws, a declaration by the presiding officer that a resolution is carried or defeated, or is carried or defeated by a particular majority, shall be conclusive. If a poll is required, it shall be taken in a manner directed by the presiding officer and the result declared by that officer shall be deemed the resolution of the meeting.

4.19 The scrutineers for the annual general meeting, and for any extraordinary general meeting of the Society, shall be appointed by the chairman.

4.20 At a general meeting, resolutions shall only be considered if they have been submitted in writing by a Member Organization to the Resolutions and Annual General Meeting Committee on or before a date established each year by the Board.

4.21 Notwithstanding the provisions of Bylaws 4.20 above and subject to the provisions of the Society Act, a resolution submitted in writing to the chair of the meeting at which the resolution is to be considered may be considered when moved and seconded and upon approval to consider the resolution by a majority of the Member Organizations who, being entitled to do so, vote in person or by proxy.

4.22 The Board shall have the same right as Member Organizations to propose resolutions in accordance with the provisions of Bylaws 4.20 and 4.21 above.

PART 5 - DIRECTORS

5.1 The number of Directors shall not be more than sixteen (16) excluding the past president, and not less than 3.

5.2 The Board will be increased by not more than one to include the immediate past president and this privilege is offered only to those past presidents who remain as active or associate members of the Society, in good standing, throughout their term of office. The immediate past-president will have full voting and other privileges as bestowed upon the Board of Directors under the terms of these Bylaws.

5.3 Except for the honorary Directors a director must be a Service Provider Member in good standing or a shareholder, officer, director or employee of a Service Provider Member in good standing. No person shall be qualified for election as a Director of the Society if he has not attained the age of 21 years.

5.4 Where a person ceases to be a director of the Society for any cause, the Board may fill that vacancy until the date of the next annual general meeting, at which time the Society shall elect a person to serve for the unexpired portion of the term then remaining if any.

5.5 No act or proceeding of the Directors is invalid only by reason of there being less than the prescribed number of Directors in office.

5.6 Directors shall hold office for a term of two years and as far as possible, the election of Directors shall be staggered so that approximately one half of the new Board of Directors shall be elected each year. Directors are entitled to sit on the Board for a maximum of six consecutive years effective May 2015.

5.7 The management and the administration of the affairs of the Society shall be vested in the Directors. In addition to the powers and authority given by the Bylaws or otherwise expressly confirmed upon them, the Directors may exercise all such powers of the Society and do all such acts on its behalf as are not by the Society Act or any of these Bylaws required to be exercised or done by the Society at an annual or special meeting and the Directors shall have full power to make such rules and regulations as they deem necessary, provided that such rules and regulations are not inconsistent with the Constitution and Bylaws of the Society or the Societies Act

5.8 The Directors shall determine their own procedure and the quorum shall be simple majority. Meetings of the Directors may be called by the President or two or more members of the Board of Directors. Questions arising at any meeting of the Directors shall be decided by a majority of votes. In case of an equality of votes the chairperson shall call for a series of secret ballots. All votes at any such meeting shall be taken by ballot if so demanded by any director present, but if no demand be made, the vote shall be taken in the usual way by assent or by show of hands. A declaration by the chairperson that a resolution has been carried and an entry to that effect in the minutes shall be prima facie evidence of the fact without proof of the number or proportion of the votes recorded.

5.9 A resolution in writing signed by all the Directors personally shall be valid and effectual as if it has been passed at a meeting of Directors duly called and constituted.

5.10 Directors shall be reimbursed by the Society for their receipted out-of-pocket expenses incurred in attending Board and Committee meetings if they are submitted within 90 days

5.11 Directors shall cease to hold office if they or the entities they are representing cease to be Service Provider Members of the Society. A Director who fails to attend in whole or in part three consecutive regular board meetings will be asked to resign.

5.12 No member organization shall have more than 20% of the complete complement of the available Director positions on the Board.

5.13 NOMINATIONS

Nominations to the Board of Directors as contained in the report of the Nominating Committee, shall be prominently posted in the general vicinity of the place where the annual

meeting shall be held, at least twenty-four hours prior to the date of the annual meeting, provided however, that nominations shall remain open until the holding of such election and further nominations may be made from the floor by an individual who is a voting member.

PART 6 - OFFICERS

6.1 The officers of the Society shall consist of the President, the Vice-President and the Secretary-Treasurer.

6.2 The officers of the Society shall be elected by the Directors from among the Directors at the first meeting of the Directors next following the meeting of the members at which the Directors are elected. To be eligible to act as President, Vice-President and Secretary-Treasurer, they shall have served on the Board for one full year. No person shall hold more than one of the aforesaid elected offices. No person can be elected an officer of the Society unless he shall have been a Service Provider Member for at least a period of one year.

6.3 COMMITTEES

The Board of Directors may appoint committees as they shall deem necessary and which shall have such authority and shall perform such duties as from time to time shall be prescribed by the Board.

6.4 PRESIDENT

The President, when present, shall be the chairperson at all meetings. The President shall sign all instruments which require the President's signature and shall have such other powers and duties as may be assigned to them from time to time by the Board of Directors. The President will be elected by the Board of Directors on an annual basis.

6.5 VICE-PRESIDENT

The Vice-President shall be vested with all powers and shall perform the duties of the President when the President is for any reason unwilling or unable effectively to act and shall perform such other duties as may from time to time be assigned by the Board. The Vice-President will be elected by the Board of Directors on an annual basis.

6.6 SECRETARY-TREASURER

The Secretary-Treasurer shall issue or cause to be issued notices for all meetings of the Board of Directors and members when directed to do so; have charge of the minute book, and sign with the President or other signing officer or officers such instruments as require his signature. The Secretary-Treasurer shall keep or cause to be kept full and accurate books of account in which shall be recorded all receipts and disbursements and shall have the care and custody of all funds and securities and shall deposit the same in the name of the Society in such banks or with such depository or depositories as the Board of Directors may direct. He shall at all reasonable times exhibit his books and accounts to any Director upon application to the offices of the Society during business hours.

6.7 Officers of the Society may be removed as officers by a majority vote of the Directors. Officers so removed shall remain members of the Board of Directors.

PART 7 – CHIEF EXECUTIVE OFFICER

7.1 The Board of Directors shall have the right by resolution to employ the Chief Executive Officer, fix and alter the amount of the CEO's compensation and dismiss the CEO from the employ of the Society.

PART 8 - BORROWING POWERS

8.1 The Society shall have the power to borrow or raise or secure the payment of money in such manner as the Society shall think fit and without limiting the foregoing, the Society may issue debentures or debenture stock, perpetual or otherwise, charged upon all or any of the Society's present or future prosperity, and to purchase, redeem or pay off any such security; provided that debentures shall not be issued without the authority of a special resolution of the Society.

PART 9 - AUDITS OF THE ACCOUNTS OF THE SOCIETY

9.1 The Directors shall present before the members of the Society at the annual meeting a financial statement showing the income and expenditure, assets and liabilities, of the Society during the preceding fiscal year; the said financial statement shall be signed by two or more Directors or by the Society's auditor.

PART 10 - THE SEAL

10.1 The seal of the Society shall be kept in the custody of the secretary of the Society

10.2 The seal of the Society shall not be affixed to any document or instrument unless authorized by the Directors and then only be and in the presence of such officers as the Directors may authorize and such persons as shall be authorized to affix the seal of the Society and shall sign every instrument to which the seal is affixed in their presence.

PART 11 - MAINTENANCE OF MINUTES AND OTHER BOOKS AND RECORDS

11.1 The Directors shall see that the minutes of members' meetings and minutes of Directors' meetings, and all other necessary books and records of the Society required by the Bylaws of the Society or by any applicable statute or law are regularly and properly kept.

PART 12 - INSPECTION OF THE RECORDS OF THE SOCIETY

12.1 The books and records of the Society shall be open to the inspection by the Service Provider Members at all reasonable times at the office of the Society during regular business hours.

PART 13 - ALTERING BYLAWS

13.1 These Bylaws shall not be altered or added to except by special resolution.

13.2 On being admitted to membership, each member is entitled to and the Society shall give him, without charge, on request, a copy of the Constitution and Bylaws of the Society.

attachment 1.c

BC CARE PROVIDERS ASSOCIATION www.bccare.ca
Advocating service excellence for seniors

2014 Annual General Meeting

Monday May 26th, 2014 4:30 pm – 5:00 pm

Empress B Ballroom

Fairmont Chateau Whistler, Whistler BC

Agenda

1. Call to Order | Establishment of Quorum — David Cheperdak | President
2. Approval of Agenda
3. Recognition of Board of Directors 2013 | 2014
4. Association Annual Report — Daniel Fontaine | CEO
5. Treasurer's Report — Andre Van Ryk | Treasurer
   a) Financial Statements 2013 |2014 (attached)
   b) 2014 |2015 Budget (attached)
   c) Appointment of Financial Auditors
6. Resolutions: — David Cheperdak | President
   a) Update amendments for BCCPA Bylaws
   b) Proposed Motion: *Be it resolved that the amendments to the BC Care Providers Association's By-Laws be approved as circulated (attached)*
7. Other Business | Open Forum
8. Adjournment

attachment: 1.e

BC CARE PROVIDERS ASSOCIATION
Advocating service excellence for seniors

Memo

To: Daniel Fontaine

From: Hart Dashevsky

cc: Cathy Szmaus

Date: April 7, 2014

Re: New Memberships Proposed

Dear Daniel,

Please be advised that the following residential and home care and commercial organizations have applied to and submitted payment for membership into the BC Care Providers Association within the last three months, for the period commencing April 1, 2014 until March 31, 2015.

Upon reviewing these applications, I would recommend approval for all organizations to the Board.

Residential Home Care

- Tremont Village
- German-Canadian Care Home (rejoined from 2012)
- Little Mountain Place
- Adanac Park Lodge

Home Care

- Happy Homecare Homemakers

Commercial

- Advanced Health Care Products
- Presto Absorbent
- Trillium Talent Resource Inc.
- Tandus-Centevia Flooring
- Centric Health

cont'd…

- Houle Electric
- Preferred Capital Realty Inc.
- Silver Dental Group
- Associated Health Systems
- Ecclesiastical Insurance
- Select Sound
- Galaxy Medical Alert Systems
- Hospitality Design

- Approval of these pending memberships will result in a total of $20,090 per annum, in addition to potential revenue generated by BCCPA annual conference and event participation.

attachment: 2.1

CONFIDENTIAL DRAFT. NOT FOR DISTRIUTION.

To be approved, edited and designed.

Seniors Care for a Change:

Stories of how reducing red tape can enhance frontline service delivery

Prepared for the BC Care Providers Association

By Izen Consulting & Rebecca Livernois, M.A. (Economics)

April 2014

Table of Contents

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Stories of how reducing red tape can enhance frontline service delivery

Foreword

(by family member of parent in care).

Introduction

The need for additional care homes is expected to increase significantly over the next ten to twenty years because the population is aging and life expectancies are increasing. The number of seniors in British Columbia is projected to increase from 732,900 in 2012 to 1,494,200 in 2036.[1] That is, by 2036 a quarter of BC's population is expected to be over 65.[2]

This increase in demand for care homes coupled with the need to modernize and renovate existing, aging infrastructure indicates that a well-functioning system is needed to ensure that demand does not outstretch BC's ability to supply seniors with beds in care homes. Significant investment will likely be required on the part of the BC Government to provide seniors with quality care.

This is a particularly important issue to British Columbians: 10 percent of BC residents place an aging population as the leading concern and challenge facing the health care system in BC today.[3]

BC has a two-tiered, private/public care home system. About one third of care homes are owned and operated by the health authorities.[4] All beds in these homes are publicly funded. About two thirds of care homes are owned and operated by private or non-profit organizations. These homes have privately and publicly funded beds.

In 2002, changes to the industry began an inversion in the number and proportion of private[5] care homes versus the previously dominant public care homes.[6] The systems and regulations for private care homes were generally put in place piece-meal rather than from a strategic approach because the change occurred gradually.[7]

Partly resulting from this, the operation of a private or non-profit care home in BC is complicated: in order to operate, each site must be connected to a plethora of organizations that accredit, audit, regulate, advocate, inspect, etc. The large number of organizations that a

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[1] BC Stats, "British Columbia Population Projections, 2013 to 2036," August 2013, p.3

[2] BC Stats, p.3

[3] British Columbia Medical Association, "Charting the course: Designing British Columbia's health care system for the next 25 years" *BCMA Submission to the Select Standing Committee on Health*, January 2012

[4] In this report, "health authorities" refers to the five health authorities in BC, namely Fraser Health Authority (FHA), Vancouver Coastal Health Authority (VCHA), Interior Health Authority (IHA), Northern Health Authority (NHA) and Vancouver Island Health Authority (VIHA).

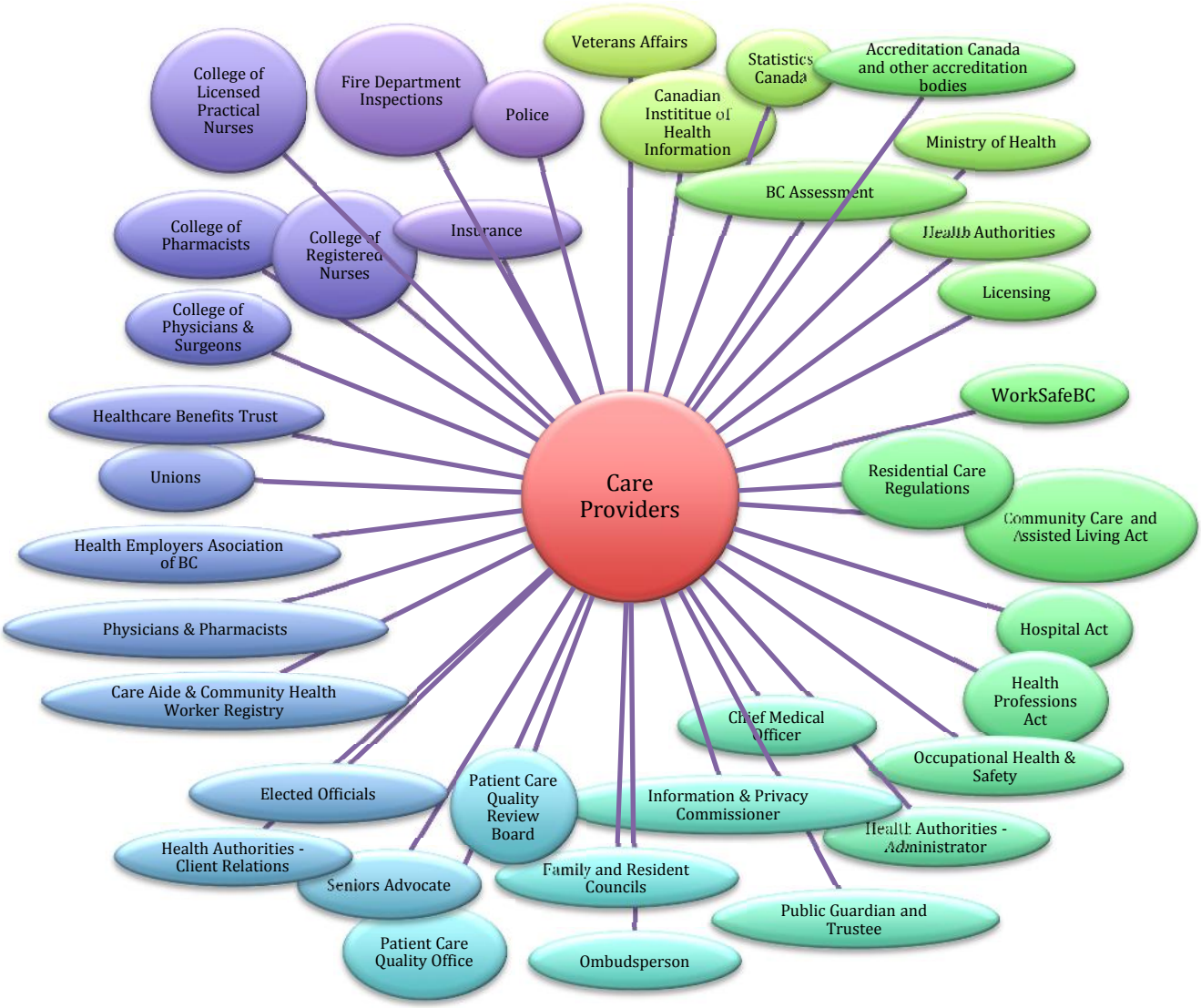
[5] For conciseness, "private" includes non-profit at times.

[6] In 2002, the BC Government implemented Bill 29, which enabled the private sector to expand and for health authorities to contract out their services to private care homes. See *Regulation 4* in "*Health and Social Services Delivery Improvement Act, Bill 29*," 2002

[7] Marcy Cohen, "Caring for BC's Aging Population: Improving health care for all" Canadian Centre for Policy Alternatives, July 2012, p.5

private or non-profit care provider must encounter is illustrated in the Dis-Org Chart 2.0, below. This chart is an updated version of the Dis-Org Chart developed by the BC Care Providers Association (BCCPA)[8] in 2010, as layers of complexity continue to be added over time.

Dis-Org Chart 2.0



Despite the complicated system for private and non-profit care homes in BC, the February 2012 report from the BC Ombudsperson identifies that, on average, beds in private care homes can cost up to 13.34 percent[9] less than beds in public care homes without compromising the quality

[8] See Appendix A for an infographic that describes the BCCPA.

[9] While this is the amount calculated from figures presented in the Ombudsperson report, the authors acknowledge that some groups believe that the actual amount is a few percent lower, while others believe that it is a few percent higher, depending on the variables that are taken into account when the numbers are calculated. Either way, the higher efficiency associated with private and non-profit care homes indicates that future benefits could be reaped from investing in private and non-profit care homes. This could ensure that the industry operates efficiently, without compromising quality of care.

of care.[10] This indicates that private care homes are operating efficiently and, as such, there could be significant cost savings by investing in private care homes as the Government prepares the health system for the increase in demand for care homes in the near future. Furthermore, a streamlined system with less red tape could result in even greater efficiency for private care homes.

A commendable first step towards addressing the need to streamline the current continuing care system is the Core Review of services that the BC Government is currently undertaking. The purpose of the Core Review is to identify where there is red tape, or unnecessary regulations, and to advise on strategies to reduce associated waste of resources. The ultimate goal is to improve the quality of all Government services for British Columbians at a reduced cost.[11]

The BCCPA commissioned this report to highlight how the Core Review applies in the continuing care sector.

The aim of this report is to provide the Government with a set of targeted recommendations that provide simple and strategic ways to reduce the administrative burden of regulatory and reporting overlap in the continuing care sector and that redirect resources to frontline care. The report is based on the authors' consultations with stakeholders in the continuing care sector in BC and a review of the literature. The methodology is described in detail in the next section.

The following section consists of five thematic recommendations that are accompanied by specific examples that show how the recommendation can be fulfilled. In all instances, quality of care and accountability are paramount; the issues raised reflect overlaps and omissions that detract from the quality of care.

The recommendations are:

1. Enhance fairness and transparency in the continuing care sector.
2. Reassess prescriptive regulations to ensure they allow for person-centred care.
3. Implement a clear process that care providers can follow in the event of nonpayment of client user fees.
4. Streamline investigation and inspection processes.
5. Streamline and standardize reporting and data collection processes.

The implementation of each recommendation could allow care providers to direct more attention to client care and less to duplicating bureaucratic services.

Finally, a table is presented at the end of the report that summarizes the recommendations and their associated benefits to residents and their families, to the Government and to care providers. This is followed by a brief conclusion.

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[10] BC Ombudsperson, "The Best of Care: Getting it Right for Seniors in British Columbia," Public Report No.47, to the Legislative Assembly of British Columbia, February 2012, p.217
Table 28 in the Ombudsperson's report shows average daily per-bed funding for public beds in private and public care homes in 2010/11 in the five health authorities. In IHA, the average bed in a public home costs $200.15 and an average bed in a private home costs $190.15. So, in IHA, a bed in a private home costs 95% of the cost of a bed in a public home (($190.15/200.15)*100). The following percentages are calculated in the same way. In the NHA, a bed in a private home costs 89.98% of the cost of a bed in a public home. In VCHA, a bed in a private home costs 97.17% of the cost of a bed in a public home. In VIHA, a bed in a private home costs 86.66% of the cost of a bed in a public home. Hence, in these four Health authorities, the cost of a bed in a private home ranges from 2.83% (in VCHA) to 13.34% (in VIHA) less than the cost of a bed in a public home. In FHA, the average bed in a public care home costs 93% of the cost of a bed in a private care home.

[11] See Appendix B for the complete terms of reference.

Methodology

The project team of Michael Izen and Rebecca Livernois reviewed the available Government and industry literature. The team then interviewed twenty-one owners and administrators in the continuing care sector across BC (both members and non-members) to elicit information about red tape in the sector. Seven online surveys containing similar questions to the interviews were also completed. Therefore, a total of 28 care professionals representing 27 organizations (68 care homes[12]) across all health authority jurisdictions in the province were consulted. The majority of care homes represented by the interviewees are composed of publicly and privately funded beds. At least half of the total number of beds in most of these care homes are publicly funded.

Considering there are approximately 246 private and non-profit care homes in BC,[13] that these consultations were voluntary[14] and that time and resources were limited, a sample of 68 is relatively high: over 27 percent of the industry was consulted.

Those interviewed and surveyed had the opportunity to raise further concerns outside the scope of the interview questions, which allowed for a comprehensive collection of concerns. Commonalities and trends in responses were assessed and aggregated and are presented in this report.

Recommendations

The following recommendations offer ways to streamline administrative duties and improve the quality of care without reducing accountability. Reducing red tape is associated with improved efficiency because time is saved on administrative overlap that can be redirected to frontline service delivery.[15]

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[12] Some interviewees were representatives of organizations that operate several individual care homes in BC.

[13] BC Ministry of Health, Community Care Licensing Branch, "Find a Care Facility by Health authority"

[14] All BCCPA members were offered the opportunity to complete the online survey.

[15] In this report we assume that saved administrative time is redirected to frontline service delivery. The most obvious way this could occur is if social workers, care aides, nurses etc., spend less time fulfilling overlapping administrative duties and more time caring for residents. Another way this could occur is if the hours of administrators were reduced and, with the freed-up resources, more care aides were hired to increase direct care hours. The authors assume in this report that administrator time is not reduced without the freed-up resources being redirected toward improvements in care home service delivery. This assumption is supported by the Government of Canada's finding that businesses in general tend to reinvest a portion of savings they obtain from a reduction in red tape. See Government of Canada, "Analysis of Regulatory Compliance Costs: Part II, Paperwork time burden, costs of paperwork compliance and paperwork simplification," December 2010, p. 17

If it were the case that no substitution was made in line with this assumption, profits would generally increase and higher profits cause more businesses to enter the industry. This would have the effect of increasing competition, which leads to lower prices and higher quality services in the long run as care home compete to attain funding and attract residents. Hence streamlining administrative duties improves the value for money the Government receives from contracted beds because quality improves without an increase in cost, if not in the short run, then at least in the long run.

Canadians are often uncomfortable with the idea of profits being made in a health care setting. Profit is the leftover revenue that is acquired after all normal payments are made, such as wages and bills. Excess revenue needs to be built up to enable companies to reinvest either in current care homes or in new care homes, or perhaps in paying off mortgages. Therefore increased profits does not always mean someone is getting rich, it can mean that an organization can increase investments and therefore provide more care homes, and more services, to British Columbians.

Furthermore in BC where there is already a two-tiered system in place, ideally private care homes will indeed make a profit if the system is to function: without any profit, there would be no private care homes in operation. If British Columbians have decided to have private care homes in BC, then they must also, by default, want them to make profits. If

> "The deadweight cost of regulation includes things such as the lost output from the businesses that never start as a result of regulatory burden and lost output from businesses whose resources are diverted away from production towards compliance. These costs are likely substantial but impossible to quantify.
>
> - CFIB, "Prosperity Restricted by Red Tape, p.3

Reducing red tape is a priority of the BC Government.[16] The number of regulatory requirements in BC has decreased by 42 percent since 2001 when the Government first started measuring its regulations.[17] BC was the first province, now only one of two provinces in Canada, which publicly reports red tape measures on a regular basis and that has legislated a requirement to report these measures annually.[18] BC received an "A Grade"– the best score in Canada – in the 2013 and 2014 Red Tape Report Card released by the Canadian Federation of Independent Business (CFIB).[19] Here, the authors offer the BC Government ways it can further extend its success into the continuing care sector.

Red tape is a barrier to the provision of quality services for seniors and families. The more time care providers have to spend fulfilling overlapping requirements is time taken away from the provision of care.

Red tape is an economic barrier that leads to lost business activity, which results in fewer businesses, fewer jobs, higher prices, and less room for wage increases.[20] Red tape has the same effect in the continuing care sector: the burden of regulatory requirements to private care providers can lead to fewer providers entering the market, and therefore fewer care homes in BC. This is particularly costly to the healthcare system because it could increase wait times and increase the burden on hospitals, the most expensive area of care in the health system, when patients must wait longer in a hospital bed for a bed in a care home to open up.[21]

The continuing care sector differs from other industries because the clients of care homes are some of the most vulnerable individuals in society. Therefore, the Government and care providers are responsible for ensuring that the highest possible quality of care is provided.

However there are regulations that, rather than doing their intended job of protecting clients, are instead interfering with care providers' ability to provide high quality person-centred care, while simultaneously they are increasing regulatory compliance costs. It is this type of red tape the authors aim to highlight in this report.

Redirecting time to frontline service delivery increases direct care hours, such as nursing and social service hours. In the literature, this has been linked to better health outcomes, fewer hospitalizations[22] and improved wellbeing.[23] Hence reducing administrative overlaps could result in better value for money, a goal of the BC Government in the 2014/15 - 2016/17 Ministry of Health Service Plan,[24] because quality of care could increase resulting in increased quality of

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private care homes make profits, more people will be drawn to this quality-of-life business, and more care homes will be built. The result would be more seniors having access to care homes that provide them with a high level of quality care.

[16] For example, see Honourable Terry Lake, Minister of Health Mandate Letter

[17] CFIB, "Red Tape Report Card 2014" p.2

[18] CFIB, p.2-3; BC Government, "Regulatory Reporting Act, Bill 7," 2011

[19] CFIB, p.2

[20] Government of Canada, "Analysis of Regulatory Compliance Costs: Part II, Paperwork time burden, costs of paperwork compliance and paperwork simplification," December 2010, p.10

[21] The costs of treating a senior in a hospital ranges from $825 to $1968 per day while it costs around $200 per day to treat a senior in a care home. See Marcy Cohen, p.7

[22] Hospital overcrowding is a current issue in BC hospitals. For example, at the Royal Columbian Hospital (RCH), the emergency room is overcrowded to the point that the emergency room physicians are publicly calling on the Ministry of Health, Fraser Health Authority and RCH Administration to take immediate steps to resolve the issue.

[23] For example, see Janice M. Murphy, "Residential care quality: A review of the literature on nurse and personal care staffing and quality of care," Prepared for Nursing Directorate, British Columbia Ministry of Health, November 2006, p.20

[24] BC Ministry of Health, "2014/15 - 2016/17 Service Plan," February 2014, p.16

life for residents and lower health care costs for taxpayers, without an increase in client user fees.

1. Enhance fairness and transparency in the continuing care sector.

The first recommendation is to enhance fairness and transparency in the continuing care sector, which promote accountability and credibility.[25] A fair and transparent system also attracts business to the industry and minimizes deadweight loss that is caused by convoluted processes that impede innovation and efficiency. Generally, they also have a positive, stabilizing effect on the economy. For example, fairness and transparency give financial lending institutions confidence and as a result, keep lending rates down.[26]

The following sub-sections present specific ways the Government can improve fairness and transparency in the continuing care sector.

A New Model

1a: Separate the bodies that fund, allocate funds and regulate care homes from those that operate care homes.

A two-tiered, public/private continuing care system can create market distortions particularly because public and private care providers do not have access to the same resources. The most prominent example of this is the generally higher wage[27] structure in public care homes.

In a standard industry, private businesses can compete with their public counterparts by offering higher wages with fewer benefits than in the public sector, and to consumers providing a different product (for example, higher quality) at a higher price than is charged in the public sector to cover their higher wage costs.

However, the continuing care industry is significantly different. A large proportion of beds in the majority of private care homes are contracted by the public sector. This means that the Government sets a large share of client user fees, so private care homes' ability to increase profits is minimal. As such, private care homes face barriers that prevent them from offering wages comparable to those in the public sector. This results in a high staff turnover rate in private homes.

A high staff turnover rate detracts from the quality and continuity of care of residents. Furthermore, it is inefficient because it skews upward the costs of private facilities since hiring new employees is costly. Nova Scotia and Saskatchewan implemented legislation that governs wages for personal support workers to mitigate this issue.[28]

The authors propose a new model of care home operations, which could reduce market distortions and ensure the industry operates as efficiently as possible, by ensuring public and private care homes operate on a level playing field.

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[25] BC Ombudsperson, p.12

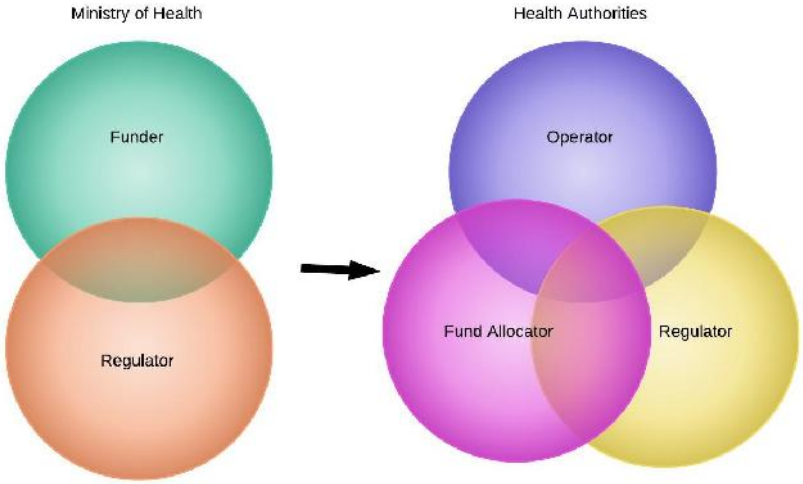
[26] Around 2010, a clause was removed from the Home and Community Care Policy Manual that allowed care homes to submit a plan to work with the Health authorities when a Health authority proposed to cease funding. This reduces stability for private and non-profit care home operations. For example, the announcement that Fraser Health Authority will cease funding of a 76-bed care home with one-year notice is an action that could make lenders nervous. If agreements can come to an end without care homes being able to propose an alternative plan, it may become harder for care homes to get loans such as mortgages.

[27] Taking wage to mean the value of the employment package, which includes wage and benefits.

[28] Health Council of Canada, "Seniors in need, caregivers in distress: What are the home care priorities for seniors in Canada?" April 2012, p.49

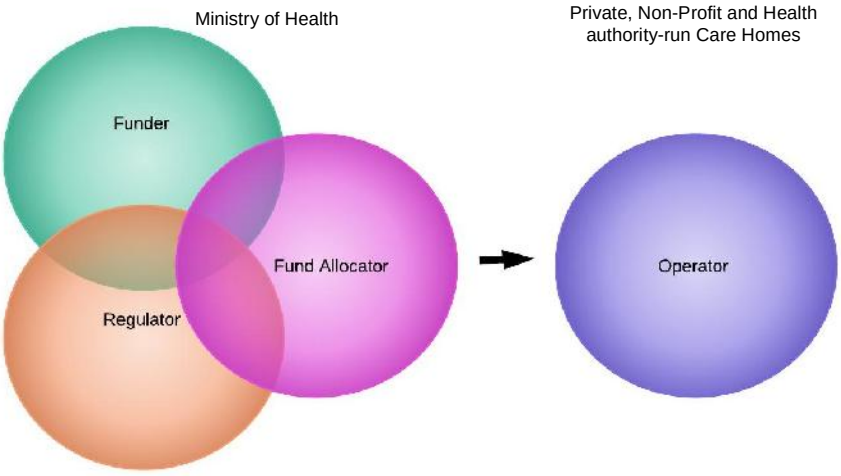
The current model of care operations has the health authorities as funder, regulator and operator. The Ministry of Health provides the funding, health authorities allocate the funding and both regulate private and non-profit care homes. That is, health authorities compete for resources with private industries since they are operators of care homes even though they also regulate and allocate funds to themselves and to private care homes. The overlap in responsibilities could skew the industry and as such reduce market efficiency. Figure 1 below shows the current, overlapping model.

Figure 1: Current Model of Government's Role in Care



In a new suggested model, the Government can provide cleaner lines of responsibility and accountability to taxpayers and residents by separating the bodies that regulate care homes and that provide and allocate funds from those that operate facilities. If the Ministry of Health were to provide and allocate funds while the health authorities and private and non-profit organizations operate facilities, then possible conflicts of interest could be minimized. This could increase transparency and competitiveness, and in doing so, improve the efficiency of the sector without any reduction in the quality of care. The diagram below shows the new model with the responsibilities no longer overlapping.

Figure 2: Proposed Model Separating Roles of Government & Care Providers



This new model could reduce the market distortion exemplified by differential wage structures because the same body that determines public sector wages and funding would not also determine client user fees paid to contracted beds in private homes. Although this new model may not perfectly level the playing field between health authority and private care homes, it could clarify the lines of accountability.

Request for Proposals

1b: Improve the request for proposals (RFP) process by ensuring that a RFP process is followed whenever possible and using criteria that are not skewed against larger operators.

Care providers highly value the RFP process in place in BC; however there appear to be areas in which this process could be improved to enhance the industry's competitiveness to the benefit of residents, families, and taxpayers.

Care providers have indicated that there have been times when a Health authority has issued an RFP to general contractors for construction or renovation but not for operation of a care home. For example, FHA issued an RFP only to general contractors for the construction of a new seniors' complex in Abbotsford. FHA will pay $21.12 million for construction costs in addition to annual operation costs.[29]

[29] Alex Butler, "Senior's care centre proposed for MSA Hospital site," *Abbotsford News*, Feb 5 2014

It is possible that with an RFP for ownership or operation of the site, costs could have been lower for taxpayers because a number of different proposals could have been submitted (including on by the health authority), and decision-makers could have been able to choose the group that offered the operation and construction plan with the best value – the highest quality home at the best price.

> When we fill out a RFP form, we are asked to provide the number of complaints the organization has received during the construction of a care home. However, we are a large organization; the number of complaints we've received will look much larger in raw numbers, just as a function of our size, compared to a small company. A percentage would give a more accurate comparison among different sizes of operators.
>
> -Administrator of a large care home organization

More recently, it was released that FHA decided to discontinue funding for 76 beds at Burquitlam Lions Care Centre.[30] These 76 publicly-funded beds would be given to another private or non-profit care home; however instead of issuing an RFP for the newly available beds, FHA folded these beds into a previous set of beds that had already been bid on, and awarded to a care home organization. That is, 76 beds were awarded to a care home without an RFP for those particular beds. If it was known by the bidders that the RFP for the previous set of bed would actually include an extra 76 beds than it stated, bids may have differed and taxpayers could be sure they were getting the best value.

The authors also heard that care providers are concerned that some RFP criteria include measures that do not properly represent care homes of differing sizes. For example, raw figures are sometimes required in RFP forms; however percentages provide better comparisons among the varying sizes of care home organizations.[31]

The best use of tax-payer dollars is made possible by the RFP process. By improving the RFP process, the best possible care homes can be delivered at the best possible price to British Columbians.

2. Reassess prescriptive regulations to ensure they allow for person-centred care.

Care providers appreciate that legislation is in place to ensure the quality of care of residents. However, it appears as though there are some regulations that detract from person-centred care, and therefore the quality of care, because of their prescriptive nature.

Prescriptive regulations may be implemented as a reaction to a single adverse event. This often means that person-centred

> "The Expert Panel strongly believes that the sector must move away from prescriptive staffing, regimented work environments and punitive approaches that discourage initiative, critical thinking and creative problem-solving. This requires a shift from a focus on compliance to a focus on the customer – the resident, the family, and the taxpayer."
>
> -Long Term Care Innovation Expert Panel, "Why Not Now? A Bold, Five-Year Strategy For Innovating Ontario's System of Care for Older Adults," March 2012, p.30

[30] "Coquitlam Seniors Care Centre to Close?," *The Tri-Cities Now News*, February 6, 2014

[31] Take, for example, an RFP form that requires the bidder to report the number of complaints the company has received during the construction of a care home. Consider a company that has built 20 care homes compared to one that has built four care homes. Four complaints for the former operator in raw numbers looks worse than one complaint for the latter operator; however, the former has had complaints in 20% of their builds whereas the latter has had complaints in 25% of their builds. A percentage provides a more representative description of the operator because it takes into account the size of the operator.

care suffers because a reactionary approach is taken instead of a proactive approach.[32]

A less prescriptive style of regulation could allow care providers to react more quickly to pressing issues by allowing flexible reactions in different regions and among different types of homes. This could enable care providers to be more responsive to clients, families and funders, and in effect enable the provision of person-centred care.

The following subsections present specific prescriptive regulations that could be altered to enhance person-centred care.

Nutrition Regulations

2a: Increased flexibility in nutrition regulations, specifically *Regulation 64 (1)* and *62* in the *Residential Care Regulations.*

> "Suddenly being regarded as unable to make decisions you've made all your life contributes to a feeling of disempowerment. In our attempt to remove all risk in nursing homes we have ended up with regulations that are so extreme that residents may no longer have autonomy or feel at home."
>
> -Saskia Sivananthan, "Old like me. Why elderly care needs more risk," *The Globe and Mail,* March 23, 2014

Meal Times

Care providers have indicated that many clients have lost much of their hearing and vision, and as such meals are a highly valued sensory experience. Therefore, being able to provide residents with meals they favour at their preferred times would improve their quality of life.

Regulation 64 (1), Food Service Schedule in the *Residential Care Regulations* is a concern for many care providers.[33] This regulation is at odds with person-centred care because it prescribes specific meal times. For example, breakfast can only be served between 7am and 9am. This may not be ideal for some residents who are on alternative sleep schedules.

> I've always been a night owl. Now that I'm older, it takes me longer to get ready in the morning. This means that if I want to make it to breakfast, I have to get up much earlier than I would like.
>
> - Resident of a care home

Furthermore, the Alzheimer's Society of Canada states that "a person with Alzheimer's disease may experience increased confusion and anxiety during meal times so staff need to be aware of individual reactions to meal times and respond with both patience and sensitivity to the unique needs of the individual."[34] *Regulation 64 (1)* interferes with care providers' ability to easily adjust meal times for certain residents, and as such this detracts from some residents' quality of life and hampers the ability to provide person-centred care.

Nutrition and the Cycle of Menus

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[32] Long Term Care Innovation Expert Panel, "Why Not Now? A Bold, Five-Year Strategy For Innovating Ontario's System of Care for Older Adults," March 2012, p.77

[33] BC Government, "Residential Care Regulation, BC Reg 96/2009," May 31, 2012
This regulation states: A licensee, other than a licensee who provides a type of care described as Child and Youth Residential, must ensure that
(a) a morning meal is available between 7:00 a.m. and 9:00 a.m.,
(b) a noon meal is available between 11:45 a.m. and 1:00 p.m.,
(c) an evening meal is served after 5:00 p.m., and
(d) snacks are provided at times that meet the needs of the persons in care.

[34] Alzheimer's Society of Canada, "Guidelines for Care: Person-centred care of people with dementia living in care homes," Framework January 2011, p.22

Division 3, Regulation 62 in the *Residential Care Regulations*[35] places strict requirements on nutrition and the cycle of menus, which can also detract from the quality of life of residents. In particular, *Regulation 62 (2)* requires that meals abide strictly to the Canada Food Guide and to a personalized nutrition plan, which often sets caloric restrictions for residents. [36] Allowing more flexibility in meal plans could allow care providers, working with nutritionists, to develop meal plans for residents that give them the best possible balance of health and personal enjoyment.

For example, some flexibility in this regulation could allow a favourite dessert to be offered occasionally even if it puts a resident over their normal daily calorie limit.

"A person-centred approach to meals and nutrition is founded on getting to know the individual, their needs and preferences,"[37] and these particular regulations, although instated initially to protect residents and ensure proper nutrition guidelines are followed, in practice can result in a reduction in person-centred care.

Reassessing these regulations could improve the quality of life for residents by enabling care providers to cater more directly to personal needs.

> After a recent Licensing inspection, we found out that we were required to install locks on all bathroom doors in our care home that was built before this regulation came into effect. We then received a quote and found out that it will cost us $100 to install one lock – that means a total cost of $110,000. This is an added expense that is very difficult for us to cover. Government funding would ease the financial cost of retrofitting older buildings.
>
> - Care home administrator

> Linda asked for a piece of lemon cake after a meal because it is her favourite dessert. She tells us that she has always been a dessert enthusiast and used to love baking before she moved to our care home. Desserts bring joy and decadence into her life; however we must refuse her the cake in order to adhere to nutrition regulations.
>
> - Care provider

Regulations Requiring Locks on Bathroom Doors

2b: Increase flexibility of the regulation requiring locks on all bathroom doors.

During consultations, the authors heard that care providers are concerned with *Regulation 30(a)* of the *Residential Care Regulations,* which requires locks on all bathroom doors.[38]

The first concern is for the safety of residents. The Alzheimer's Society of Canada[39] and the National Institute on Aging[40] both recommend the removal of locks on bathroom doors for

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[35] BC Government, "Residential Care Regulation, BC Reg 96/2009," May 31, 2012

[36] This regulation states: "A licensee must ensure that each menu provides
(a) for each day, a nutritious morning, noon and evening meal, with each meal containing at least 3 food groups as described in Canada's Food Guide,
(b) for each day, at least 2 nutritious snacks, with each snack containing at least 2 food groups as described in Canada's Food Guide,
(c) a variety of foods, taking into consideration
(i) the nutrition plan of each person in care and the nutrition needs, age, gender and level of activity of the persons in care,
(ii) the food preferences and cultural background of the persons in care,
(iii) seasonal variations in food, and
(iv) the texture, colour and matters that affect food safety, taste and visual appeal, and
(d) for substitutions to be made that are from the same food group and have a similar nutritional value."

[37] Alzheimer's Society of Canada, p.22

[38] This regulation states: "A licensee must ensure that all bathrooms have (a) a door, equipped with a lock that can be opened from the outside in the case of an emergency."

[39] Alzheimer's Society of Canada, p.24

[40] National Institute on Aging, "Caregiver Guide: Tips for caregivers of people with Alzheimer's Disease," *Alzheimer's Disease Education and Referral Center,* October 17, 2013, p.13

residents with dementia to prevent them from accidentally locking themselves in the bathroom. Although locks required by this regulation would be accessible from the outside so that care providers could help a resident locked in a bathroom, this would likely cause unnecessary stress for the resident.[41]

Furthermore, bathroom locks could take care providers' time away from providing quality care if they have to help residents locked in bathrooms and comfort them after the stressful experience. Flexibility in this requirement could enable the provision of person-centred care by ensuring the safest care homes are provided according to each individual's needs.[42]

The second concern is with the high cost of retrofitting care homes that were built before this regulation came into effect. One interviewee reported that it will cost them $110,000 to install locks on all their bathroom doors, and that this is a cost that will be difficult for the care home to cover. Government funding would help ease the financial burden of retrofitting older buildings in the case that the regulation cannot be made more flexible.

Regulations Concerning Private and Semi-Private Rooms

2c: Assess the potential need to amend the maximum number of semi-private rooms in private and non-profit care homes.

Section 25 of the *Residential Care Regulations*, legislated under the *Community Care and Assisted Living Act*, states that a private or non-profit care home can only have 5 percent of their rooms as multiple occupancy rooms.[43]

A multiple occupancy room can be valuable for some residents for several reasons: it provides significant cost savings for the resident (in privately funded beds); a roommate helps ease the transition into a new community; it helps avoid loneliness and feelings of isolation; a roommate provides additional monitoring; and having stronger relationships improves the health of seniors.[44]

The authors suggest that the BCCPA undertakes more in-depth research with the BC Government and/or Health authorities, such as conducting a literature review and a survey, to determine the percent of seniors who would prefer a multiple occupancy room. This information would be informative for an adjustment in the regulated percentage of multiple occupancy rooms in care homes.

Based on consultations, it appears it may be financially unsustainable for the industry to have 95 percent of all residents in private and non-profit facilities in single-occupancy rooms. This can be illustrated by the fact that some Health authority residences have only six percent of their rooms as single-occupancy rooms (for example, this is the case at Banfield Pavilion in the Vancouver Coastal Health authority), while the rest are multiple-occupancy rooms.[45]

According to an interviewee, construction costs are approximately $250,000 per bed in a single-occupancy (single) room and $140,000 per bed in a double-occupancy (double) room. Currently, a facility with 100 beds that must have at least 95 percent of the rooms as single rooms would cost a minimum of $24,500,000 to build. If instead 75 percent of the beds were single rooms, a facility with 100 beds would cost $22,250,000 to build. This is a savings of

[41] National Institute on Aging, p.13
[42] Alzheimer's Society of Canada, p.24
[43] BC Government, "Residential Care Regulation, BC Reg 96/2009"
[44] Accent on Seniors, California's Senior Living Experts, "Assisted Living Facilities: Five reasons to consider a roommate"
[45] See <www.vch.ca/Banfield_Pavilion>

$2,250,000 in construction costs per care home, or a savings of almost 10 percent of current construction costs.

These substantially lower construction costs would make operating a private care home in BC more sustainable in the long-run. This could attract business and therefore industry competition, which could improve the number of options available to clients, reduce fees, improve quality of care and reduce wait lists.

Funeral Planning

2d: Clarify *Regulation 5(1)* of the *Cremation, Interment, and Funeral Services Act*

When a resident of a care home passes away, the care home legally cannot send the body to the deceased's chosen funeral home until the funeral home receives authorization to do so from a person with a specific relation to the deceased, as prescribed by *Regulation 5(1)* of the *Cremation, Interment, and Funeral Services Act*.[46]

This regulation lists, in order of priority, the type of relation that gives someone the authority to approve the funeral home to transfer the body. For example, if the executor of the will cannot be contacted, then the spouse of the deceased has the authority to approve the transfer. If the spouse cannot be contacted, then authority goes to an adult child of the deceased, and so on. The last person that can be contacted is someone with a personal or kinship relationship with the deceased.

This presents a serious issue: some residents may not have any contactable relations, or any relations at all, as defined in *Regulation 5(1)*. *Regulation 5(1)(j)* states that a minister, or the official administrator of the estate (understood to be the Public Guardian and Trustee) can give approval in this case. However, there is a problem if they cannot be reached promptly, as could be the case in the evening or on the weekend.[47] In this situation, a care provider would be required to keep a body at a care home until the funeral home has contacted someone who can approve the transfer. It is perceivable that this could take several days over the weekend.

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[46] BC Government, "*Cremation, Interment and Funeral Services Act*, [SBC 2004] Chapter 35," March 18, 2013, states:
Subject to this section and section 8 (3) (b) (i) *[requirement for authorization before funeral services or disposition]*, the right of a person to control the disposition of the human remains or cremated remains vests in, and devolves on, the following persons in order of priority:
(a) the personal representative named in the will of the deceased;
(b) the spouse of the deceased;
(c) an adult child of the deceased;
(d) an adult grandchild of the deceased;
(e) if the deceased was a minor, a person who was a guardian who had care and control of the deceased at the date of death;
(f) a parent of the deceased;
(g) an adult sibling of the deceased;
(h) an adult nephew or niece of the deceased;
(i) an adult next of kin of the deceased, determined on the basis provided by sections 89 and 90 of the *Estate Administration Act*;
(j) the minister under the *Employment and Assistance Act* or, if the official administrator under the *Estate Administration Act* is administering the estate of the deceased under that Act, the official administrator;
(k) an adult person having a personal or kinship relationship with the deceased, other than those referred to in paragraphs (b) to (d) and (f) to (i).

[47] The authors heard that it was suggested that nurses can be considered to have a personal relationship and therefore, by Regulation 5(1k), could approve the transfer of the body. However nurses have responded in conversations with the BCCPA that they, understandably, can only have a professional relationship with their patients and therefore cannot have this authority. The Coroners Office, also in conversations with the BCCPA, stated that they also cannot have this authority. As such, at the time this report was written, there was no clear solution to this problem.

It is paramount that this issue is addressed to ensure that care providers are not faced with a situation where a regulation requires them to store bodies for an extended length of time in care homes that do not have the proper facilities to do so.

> Sometimes, a client moves into a privately funded bed in a care home before they qualify for Government funding. While they are there we build a nursing chart for them. Then, some time later the resident qualifies for, and moves to, a publicly funded bed within the same home. When this change happens, a client's chart that was built when they were in a privately funded bed must be rebuilt because there is a change in privacy legislation. This means that we have to throw out all the information we put together and start over again. This wastes nursing time that could be better spent elsewhere.
>
> - Nurse

Privacy Legislation

2e: Implement legislation that allows patient information to flow through the health care system with the resident.

Nursing Charts

Currently there is duplication in the process of creating nursing charts when a resident moves from a privately to a publicly funded bed.

When a resident moves from a privately funded bed to a publicly funded bed, the legislation that protects the privacy of their medical information changes from the *Personal Information Protection Act*[48] to the *Freedom of Information and Protection of Privacy Act*.[49] Since the privacy legislation changes, the nursing chart cannot be continued even if the resident stays in the same care home with the same staff. This is an inefficient use of nursing time.

It costs care homes $80 to create a nursing chart from scratch.[50] This accounts for nearly 20,000 hours across the industry over 10 years that are spent duplicating clinical activities rather than providing care to clients because of the lack of legislation that allows for the continuation of existing charts when funding sources change.[51]

Hence legislation is needed that allows for the continuation of medical records when there is a change in the source of funding for client user fees. Implementing this recommendation could allow nurses to spend more time caring for clients rather than recompiling nursing charts.

Return from a Hospital Stay

Similar to the previous issue, there is need for legislation to allow clinical information to be shared when a resident returns to a care home from a hospital stay. Currently, care providers must attain information of medications that were prescribed and procedures that took place at a hospital from the client.

The Hospital Act 51(1) stipulates that a record prepared at a hospital is the property of the hospital. The privacy of that record is protected by the *Freedom of Information and Protection of Privacy Act 22(3)(a)*[52] which stipulates that this personal medical information that is owned by the hospital cannot be acquired by a third party.

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[48] BC Government, "Personal Information Protection Act, [SB 2003], Chapter 63," October 23, 2003.
[49] BC Government, "Freedom of Information and Protection of Privacy Act, [RSBC 1996], Chapter 165"
[50] According to interviewees, it takes 2 hours to create a new nursing chart. Nurses who create these charts are paid $40/hour
[51] ((2 hours * 4 moves)*246 care homes)*10 years = 19,680 hours
[52] BC Government, "Freedom of Information and Protection of Privacy Act, [RSBC 1996], Chapter 165"

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

It costs care homes $23 every time a client returns from hospital to gather new medical information.[53]

Having information sent directly from the hospital could remove this cost and lead to better continuity of care for the hospitalized client, and increase the hours of care available to other clients by over 664 hours over 10 years.[54]

> We try our best to make sure that as few residents as possible go to the hospital through initiatives such as fall prevention programs. Upon the return of a resident who does end up going to the hospital, we spend around 45 minutes gathering new information from them about new treatments and diagnoses. We could get more accurate medical information more quickly if the hospital could send us the information directly.
>
> - Nurse

3. Implement a clear process that care providers can follow in the event of nonpayment of client user fees.

The third recommendation is to implement a clear process that is followed in the event of nonpayment of client user fees for a mentally capable resident in a publicly funded bed. In publicly funded beds in private care homes, residents pay 80 percent of their pension income in client user fees and the Government covers the remaining costs. That is, in all public beds residents have sufficient income to pay their client user fees; still, fees occasionally go unpaid. Care providers have indicated that when fees are unpaid, it is sometimes the case that the family is absconding the resident's pension income rather than paying the client user fees.

During the authors' consultations, they heard concerns from care providers that the Public Guardian and Trustee (PGT) may not take control of the resident's finances to ensure client user fees are paid when a resident is mentally capable.[55]

When this happens, care providers must act as collection agencies to obtain the client user fees from the family. It is extremely unfavourable to evict someone from a care home and eviction only occurs as a last resort, which means that debt collection efforts are often a prolonged process. [56]

Even if the PGT does take control of the resident's finances, there is no clear mechanism to help the care home retrieve the outstanding debt owed by the family.

Care providers indicated that social service provision is one component of the daily direct care hours that care providers are subsidized by the Government to spend with a resident in a publicly funded bed. Furthermore, debt collection efforts are categorized as a social service.[57]

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[53] According to interviewees, it takes about 45 minutes to gather new medical information upon return from the hospital. The staff that collects this information is paid $35/hour.

[54] (0.75 hours * 0.36 clients)*246 care homes)*10 years=664.2 hours

[55] Government of BC, Public Guardian and Trustee, "Assessment and Investigation Services"

[56] When frail residents are evicted it is a highly distressing event. Furthermore, it is possible that relocation costs and hospital costs associated with that senior's eviction would exceed the cost of the payment of client user fees by the Government or legal proceedings, especially considering accommodating a resident in a care home is a fraction (10 to 24 percent) of the cost of accommodating the same resident in a hospital. The costs of treating a senior in a hospital ranges from $825 to $1968 per day while it costs around $200 per day to treat a senior in a care home. See Marcy Cohen, "Caring for BC's Aging Population: Improving health care for all" Canadian Centre for Policy Alternatives, July 2012 p.7

[57] BC Care Providers Association, "Residential Care Health and Safety Guidelines," Spring 2009, p.3

Therefore, when client user fees are not paid, other social services suffer because the time care providers spend collecting debt is time they cannot spend providing social services to residents.

> I am a social worker who works part-time at a care home in BC. I chose this profession because I love to help improve the lives of frail seniors. However we have two residents who have not been paying their client user fees. This means that instead of spending time with residents, I spend much of my time trying to track down the family members who are supposed to be paying the fees. I'm essentially working as a debt collector rather than a social worker. My abilities would be used more appropriately if I were directly interacting with the residents instead.
>
> - Social Worker

Ontario, unlike BC, has a specific policy to handle this type of situation: the Long Term Care Home (LTCH) Bad Debt Reimbursement Policy. This policy recognizes that the unique nature of care homes requires that they continue to provide care to residents even when they have stopped paying their accommodation charges.[58]

This policy clearly sets out the steps a care home in Ontario should take in the event of nonpayment of client user fees. The care home is required to make a reasonable number of attempts to acquire fees from the responsible party and to take the case to a small claims court when appropriate.[59] After three months without success, the Local Health Integration Networks "reimburse one-half (50%) of eligible bad debt costs, to prevent these costs from impacting the operation of affected homes, as per this policy."[60]

The authors suggest the BC Government develops a policy similar to Ontario's LTCH Bad Debt Reimbursement Policy. A well-defined mechanism that care providers are to follow could ensure that the relative is involved immediately so that by the time the issue is resolved, there is not an exorbitant bill for the family to pay. Furthermore, if the Government shared the burden of the debt with the care home after a pre-specified length of time, it could ensure that costs do not impede the care home's operations.

This type of policy could ensure that residents never need to be evicted, social service time is not wasted on excessive debt collection efforts, and anxiety caused by non-payment of fees for residents and care providers is minimized.

4. Streamline investigation and inspection processes.

The fourth recommendation is to streamline investigation and inspection processes so that the same incident or standard is not the responsibility of multiple Government bodies.

Positive steps have been taken in the past to improve investigation and inspection processes in BC. For example, FHA recognized that it is problematic to have Licensing Officers with backgrounds in childcare inspect or investigate care homes. In response, they recently underwent a reorganization such that only specialists in residential care will inspect and investigate care homes.[61]

Furthermore, the authors heard that the process that has been set up by the BC Government and the Health authorities for clients to make complaints is generally functioning well. For

[58] Government of Ontario, Ministry of Health and Long Term Care, Long Term Care Homes Policy, "Policy: LTCH Bad Debt Reimbursement," July 1, 2010, p.1
[59] Government of Ontario, p.1-2
[60] Government of Ontario, p.1
[61] Fraser Health Authority, "Restructuring of Program Services, Bulletin to Licensees of Licensed Community Care Facilities in Fraser Health," Dec. 2013, p.1

example, the Patient Care Quality Review Board (PCQRB) will only get involved after the Patient Care Quality Office (PCQO) has attempted to handle the issue. This means that overlapping investigations and responsibilities are minimized between these groups.

Based on the authors' consultations, it appears as though a similar principle would be useful in investigation and inspection processes. Consolidating investigation and inspection processes could result in savings, without loss of quality, which could be redirected toward quality of care for residents.

The following sections present specific ways the Government can streamline firstly investigations, and secondly inspections, in the continuing care sector.

The Care Aide Registry

4a: Improve the operation of the Registry to better support its mandate of protecting vulnerable clients based on recommendations in BCCPA's forthcoming report.

Care providers commend the Government on establishing the Registry and support its mandate to protect vulnerable clients in the continuing care sector;[62] however, care providers suggest that there are concerns with the way the Registry operates. BCCPA is currently undertaking a research project that will be released in Spring 2014 to identify a sustainable model for the Registry that supports a "zero-tolerance" approach to elder abuse. This report will contain detailed recommendations; here the authors outline issues with the Registry that are particularly relevant to the Core Review.

Registry Investigations

The Registry's investigations are of particular concern to care providers. When the Registry investigates an allegation of abuse of a resident by staff, it is reported to be in an untimely manner, is expensive to the care provider, and is often more lenient than the internal and the other external investigations. Care providers have found that the internal investigation and the Licensing investigation have often been completed for months before the Registry begins its investigations. This causes the issue to re-surface after residents and life at the care home have returned to normal.

Furthermore, the Registry seems to often have conflicting findings to the other investigations. Since the Registry's conception in 2010 and as of January 2014, 139 employees were reported to the Registry as being terminated or suspended for abuse. This means that the internal investigation and external investigation conducted by Licensing found that abuse occurred, and that the employee was no longer suitable to be working in that home. Of these reported employees, the Registry investigated 73 cases because the employee contested their employment termination or suspension, and seven investigations were currently underway.[63]

Of the 66 investigations that were completed, 54 employees were reinstated to the Registry after certain requirements were fulfilled such as further education. That is, only 12 employees were removed from the Registry. This means that in over 80 percent of the cases where abuse was substantiated by Licensing and the employer, the employee is still eligible to work in the industry.[64] Furthermore, there is no documentation for future employers to inform them that a care aide had their employment terminated in the past for abuse. This is an enormous concern for residents, families and care providers.

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[62] BC Care Aide & Community Worker Registry, "Role and Mandate"
[63] Need to cite PPT presentation by Registry.
[64] (54/66)*100=81.8%

There is a cost associated with the Registry if it is not functioning as effectively as possible. If the Registry reinstates an employee that Licensing and the employer believe to be abusive, this person can then become employed in another facility. In the new facility, this care aide may be abusive again. This imposes an immeasurable psychological and physical cost for the victim of a repeat offender.

Furthermore, if a care aide were a repeat offender, they would bring about another Licensing investigation, which could cost the Government $1,200 in addition to the previous investigation costs.

A well-functioning Registry could drastically improve the quality of care of residents and could save taxpayer dollars in terms of eliminating the need for future investigations of abuse caused by care aides who have already been found to be abusive.

Considering these issues with Registry investigations, care providers do not see the value added in the investigations especially considering they must pay for half of the investigation costs, which can be up to $15,000.[65]

This concern is avoided in Ontario because the Registry directs complaints about care aides to other appropriate investigation bodies rather than conducting the investigation themselves. That is, in Ontario the Registry is simply a registry of care aides rather than a registry and an investigatory body, as is currently the case in BC.[66]

Privacy Concerns During Registry Investigations

There is confusion about how a care provider can adhere to privacy laws when there is an investigation by the Registry. During an investigation, the investigator must see the allegedly abused resident's clinical information in order to properly conduct the investigation. The Registry has indicated that a resident's clinical information can be made available by the investigator to the union that is representing the accused employee. However, clinical information is confidential, as legislated by either the *Personal Information Protection Act* or the *Freedom of Information and Protection of Privacy Ac*t and as such, law prohibits the provision of the information by the care provider to the union. Based on the authors' consultations, care providers would benefit from guidance on how to satisfy privacy legislation during an investigation by the Registry since there seems to be contradiction between legal requirements and the requests made by the Registry during an investigation.

Inspections and Audits

4b: Streamline Licensing, Quality Review, WorkSafeBC and accreditation inspections so that the same criteria are not the responsibility of multiple inspection bodies.

In the past, it was optional for care homes to be accredited by an external accreditation body; however now, although not legislated, all new contracts stipulate that care homes be accredited by an approved accreditation body such as Accreditation Canada.

Inspections are conducted by Accreditation Canada every four years and are intended to ensure that the care home is meeting a shared set of standards concerning all aspects of the quality of care.[67] The Health authority also conducts its own quality review, as does WorkSafeBC and Licensing. This creates duplication because several different bodies inspect similar factors.

[65] Investigation costs were reported by a number of different care providers who were interviewed.
[66] PSW Registry Ontario, "General Public, Complaint(s) about a PSW"
[67] Accreditation Canada, "Accreditation Basics"

Based on the authors' consultations, it appears as though the same standards could be monitored more efficiently by consolidating inspections.

An interviewed care provider gave an example of duplications in facility inspections. Licensing inspects the facility and suggests that there are inadequate controls on the chemicals being used for cleaning. WorkSafeBC also conducts an inspection and notes the same issue. The quality review by the Health authority may not raise the issue if the care home's controls on chemicals fall within their acceptable range while it falls over the threshold of the other inspection bodies. Every four years Accreditation Canada will also ensure the care home is complying with required operating practices on hazardous materials. That is, there are several different inspectors looking for the same issues and making equivalent recommendations, or having slightly different thresholds of acceptability that confuses the process.

The authors heard from care providers that they feel it is important that they are inspected to ensure standards are being met, but also are faced with the reality that inspecting what are seemingly the same things several times takes time away from providing quality care to residents. As such, streamlining this process could improve quality of care and improve the efficiency of the inspection process.

If criteria such as sufficient controls on chemicals were the responsibility of one body, such as Licensing, a half hour, for example, could be saved on the Quality Review inspection and the same amount of time could be saved on the WorkSafeBC inspection. This could save an estimated total of $30 per WorkSafeBC and Quality Review inspection, or $73,800 over 10 years in health inspector time across the province.[68]

Saving a total of an hour of inspection time could also save care homes 2,460 hours over 10 years across BC that could be spent providing care to residents rather than duplicating processes.[69] Equivalently, saving one hour of inspection time could save care providers $55 per inspection, or $135,300 over 10 years in care providers' time across the province.[70]

This amounts to a total savings of $209,100 from reducing WorkSafeBC and Licensing inspections by a half hour each.[71]

This is a conservative estimate; it is likely that better communication between inspection agencies could lead to more streamlined inspections with less duplication, and drastic administrative time-savings that could be reallocated to caring for clients.

Consolidating Investigations

4c: Streamline the investigation process so that there is one external body investigating allegations of abuse at a time.

A simplified investigation process could improve the wellbeing of residents and the quality of care while reducing investigation costs.

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[68] An average annual salary for health inspectors is estimated at $62,000 (from British Columbia Institute of Technology, School of Health Sciences, Public Health Inspection, "Graduating and Jobs." The associated hourly rate is roughly $30 based on a 40-hour workweek. If one hour is saved during an inspection, then $30 is saved. Given that there are 246 care homes in British Columbia, inspecting each facility once a year with the streamlined system that saves only one hour would save the province $7,380 a year (30*246=7,380) or $73,800 over 10 years.

[69] ((1 hour*246 care homes)*10 years)=2,460 hours

[70] Interviewees reported that the employees present during inspections are paid $55 per hour. Both licensing and WorkSafeBC inspections occur once per year in every care home. If one hour total is saved, then care homes save $55 per year. This would save all care homes a total of $55*246 = $13,530 per year. Across 10 years, this amounts to an industry savings of $135,300.

[71] $73,800+$135,300=$209,100

When there is an allegation of abuse, many different bodies may perform their own independent investigation of the same event. The care provider conducts an internal review when there is an allegation of abuse. The Community Care Licensing Branch of the Health authority (Licensing) also performs an external investigation. Occasionally the Patient Care Quality Office (PCQO) will also become involved when requested by the client or their family. When the allegation falls within the scope of the BC Care Aide & Community Worker Registry (the Registry), it also conducts an investigation.

> We had an adverse event at our care home where a female and male resident were found together, naked. Investigations were conducted internally by the care home and externally by Licensing and the PCQO. The non-nurse Licensing officer concluded that there was inappropriate behaviour and that steps must be taken concerning the male resident to ensure the incident is not repeated. On the other hand, the nurse PCQO investigator recognized that both residents are borderline cognizant, and that it is possible the event was consensual. The nurse developed a care plan that required a geriatric psychiatrist to assess the two residents and for the situation to be monitored on an ongoing basis. This means that as administrators of the care home, we have two separate requirements set out by two investigation bodies that do not coincide. It is difficult to determine how we should proceed to comply with both regulations.
>
> - Care Home Administrator

Multiple investigations detract from the quality of care because every time there is an investigation, everyone involved must be interviewed. Care providers indicated that this causes an unnecessary psychological and time burden on all parties involved, including the victim and their family. It also takes staff away from frontline service delivery.

Furthermore, when there are multiple investigations, care providers find that the process can become more complicated, untimely and costly. There can be conflicting findings among the investigators and as such it is difficult for the care provider to know how to satisfy the different requirements set out by the different investigators.

Consider the case that PCQO only investigated if the Licensing investigation was complete and if the outcome of that investigation were unsatisfactory to the resident or their family. This would give the family and resident a chance to decide whether they were satisfied with the outcome. In the event that the family decided they were satisfied with the Licensing investigation when they had been planning on contacting PCQO, the health authorities could save an estimated $1,200 per investigation.[72]

Streamlining the investigations such that the processes are not duplicated could improve quality of care, reduce stress for residents and save taxpayer dollars.

5. Streamline and standardize reporting and data collection processes.

Reporting and data collection duties are an important interaction among care providers and various Government agencies. However, a number of issues have been identified that make these duties more time consuming, and therefore more costly, than necessary, which negatively impact clients and their care providers.

The following subsections show specifically how the Government could streamline reporting and data collection processes.

[72] If the investigation takes a week (40 hours) and the inspector is paid $30 per hour, the investigation costs the Government $1,200 (30*40=1200). This cost is in line with other average reports of investigation costs. If both Licensing and the PCQO perform an investigation for the same incident, the cost of the duplication to the Government would be $1,200 since they would now be paying $2,400 instead of $1,200.

Reports Across Health Authorities

5a: Standardize reports across health authorities.

Currently, care providers who have care homes in multiple Health authority jurisdictions are required to report similar information in different ways to each of the different health authorities.

For example, each Health authority collects data on direct care hours in the quarterly financial reports, but the way direct care hours are reported differ slightly among health authorities. According to interviewees, direct care is defined by VCHA as care for a resident by a Registered Nurse (RN), a Licensed Practical Nurse (LPN), or a Resident Care Attendant (RCA). On the other hand, in FHA, direct care is broken into different categories that include professional [RN, LPN, Occupational Therapy/Physical Therapy (OT/PT)], social workers, dietician), non-professional allied and professional allied. This often means that care providers with homes in different Health authorities must create separate charts of accounts for different Health authorities and spend extra time complying with slight administrative inconsistencies.

Based on the authors' consultations, it appears as though these reports are sent from the Health authorities to the Ministry of Health. If so, then all reports are ultimately sent to one place and the standardization of reports could presumably save time and resources for the Government bodies processing the reports since time could no longer be wasted consolidating information reported in different formats.

The implementation of this recommendation also could save time at the care home-level since care providers would no longer have to re-group the same information in different ways to satisfy different reports. The time saved could be redirected to caring for clients.[73]

Provincial Performance Management Framework Reports

5b: Reassess the purpose and the need for the Provincial Performance Management Framework reports.

Only some health authorities require the Provincial Performance Management Framework Reports.[74] This framework was designed to help support health outcomes at care homes. The authors heard that the Provincial Performance Management Framework reporting task is onerous and that some care providers are unclear the benefit the sector is gaining from these reports, especially if some health authorities no longer require this report. However, some care providers have identified some value in these reports as a standardized accountability tool.

An assessment could determine the level of need for this report. If it were found to no longer be necessary because similar information is reported elsewhere, then administrative time could be saved through its removal since this report would not have to be submitted by care providers or processed by health authorities. This time could be re-directed toward quality of care in care homes.

If this report were found to still be necessary, updating the report and renewing its purpose through initiatives such as using it to provide feedback to care providers could improve accountability and the report could become a valuable feedback tool for care providers.

[73] The Government of Canada found that businesses in general normally reinvest a portion of savings they obtain from a reduction in red tape. Government of Canada, p. 17

[74] For example, interviewed care providers indicated that Vancouver Island Health Authority requires it while Fraser Health Authority does not.

Health Sector Compensation Information System (HSCIS) Reporting

5c: Gather a sample rather than a census of financial data through HSCIS.

Care providers must complete two types of financial reports: the Quarterly Financial Reports to the health authorities, and semi-annual financial reports to the Health Employers Association of BC (HEABC),[75] through the Health Sector Compensation Information System (HSCIS).[76] Both reports include payroll information.

Preparing these reports is labour intensive because although they collect similar information, they are in different formats and are collected at different times.

The purpose of HSCIS is to gather data on workers in the BC health system. This data is used for collective bargaining strategies, calculating required funding adjustments and for pay equity adjustments.[77] A representative sample of the industry, rather than a census, could suffice for these objectives. This is because an informed estimate of variables of interest provides a relatively accurate picture of the industry; an exact figure may not be necessary for HEABC's purposes.[78] Compliance costs of data reporting are high, and reducing the cost burden on the industry may increase efficiency since more time could be spent providing quality care rather than providing data in excess to HEABC's needs.

HEABC also states that one use of HSCIS is to create industry wide financial statistics. This is an important endeavor, one that is currently a focus of the Canadian Institute of Health Information (CIHI). However, it does not appear to be efficient for HEABC to create industry wide statistics because the other needs of HEABC seems to only require a sample. Instead, the authors recommend that the creation of industry wide statistics be taken over by the health authorities that require a census of financial information in any case because they use data from the Quarterly Financial Reports for funding calculations.

Taking a sample rather than a census could meet the needs of HEABC and reduce the costs of compliance for care providers, allowing them to redirect resources toward quality of care.

Higher Compliance Costs for Smaller Operators

5d: Aid small operators with HSCIS and InterRAI data reporting efforts keeping in mind economies of scale in regulatory compliance costs.

It is particularly costly for small organizations to provide HSCIS and interRAI data. The Government of Canada identifies a disproportionate impact of regulatory compliance costs on smaller organizations. They found that businesses with 1-4 employees spend twice as much per employee for compliance as those with 5-19 employees ($657 versus $313 per employee annually). Organizations with 5-19 employees spend four times as much as businesses with 100-499 employees ($313 versus $74). That is, organizations with 1-4 employees spend almost 9 times more on regulatory compliance costs per employee than organizations with 100-499

[75] HEABC coordinates the human resource and labour relations interests of publicly funded health care employers in BC, including the Health authorities, non-profit and private health employers.
[76] All care homes that are members of HEABC or that receive funding from the Ministry of Health must complete HSCIS. This covers most care homes in BC. See HEABC.
[77] Health Employers Association of British Columbia, "HSCIS"
[78] A representative sample is a subset of individuals of the population of interest, with a similar distribution of characteristics as the entire population, which is used to predict characteristics of the entire population of interest. A census is where data is collected on the entire population of interest.

employees.[79] Hence compliance costs per employee decrease as the number of employees increase, or there are economies of scale in compliance costs.

In addition to higher costs, smaller facilities may not have the resources required for accurate interRAI data reporting. For example, these organizations may not have a sufficient number of employees with time to attend information sessions. In larger care homes there are likely enough resources to hire an officer that is trained in interRAI reporting.

The authors acknowledge that the provision of high quality data from all care homes is an important resource that can be used to improve seniors' care through research and supervision. Therefore the authors recommend the Government acknowledges the substantially higher compliance costs for small facilities by providing support and funding accordingly. For example the Government could provide data collection officers and/or provide extra funding for reporting duties based on the size of the organization. This could allow smaller operators to provide high quality data and it could reduce the financial burden of complying with HSCIS and interRAI requirements. The implementation of this recommendation could allow small facilities to direct more of their limited resources toward caring for clients rather than toward administrative tasks.[80]

An alternative is for the Government to only require HSCIS and interRAI data from large private organizations, for example, homes with over 100 beds. However, this could be problematic because information would not be gathered on an important group of the industry: small private care homes. To ensure that the data collected is representative of the entire sector, small site data should be collected with Government support.

[79] Government of Canada, p. 3

[80] This is assuming that we do not want to move to a model where only large care homes can survive in the market so that British Columbians can choose among different sizes of care homes when deciding where they want to live.

Summary of Recommendations and Benefits (to be streamlimed/formatted)

Recommendations	Examples	Benefit to BC Government	Benefit to Care Provider	Benefit to Clients and their families
1. Enhance fairness and transparency in the continuing care sector.	1a: Separate the bodies that fund, allocate funds and regulate care homes from those that operate care homes.	Improved transparency in the continuing care industry.	Improved transparency in the continuing care industry. Improved transparency and fairness in how care homes are funded.	Improved transparency in the care home system.
	1b: Improve the request for proposals (RFP) process by ensuring that a RFP process is followed whenever possible and by using criteria that are not skewed against larger operators.	RFPs ensure the best care homes are provided to taxpayers at the lowest cost.	Development opportunities are given to the most deserving bidder.	Improved quality of care due to the provision of the best possible care homes.
2. Reassess prescriptive regulations to ensure they allow for person-centred care.	2a: Increased flexibility in nutrition regulations, specifically *Regulation 64(1)* and *62* in the *Residential Care Regulations.*	Higher quality of life for residents at the same cost to the Government.	Care providers could be able to enhance the wellbeing of clients by providing the food they favour at the times they prefer.	Improved quality of life because residents could receive improved and more individualized meal times and meals.
	2b: Increase flexibility of the regulation requiring locks on all bathroom doors.	Higher quality of life for some residents at the same cost to the Government.	Enhance the safety of care homes for residents with dementia. Reduced cost for retrofitting older care homes.	Enhanced quality of life for some residents who may have a stressful experience if they accidentally locked themselves in a bathroom.
	2c: Assess the potential need to amend the maximum number of	Better services provided by care providers at the same cost.	Reduced mortgage payments. Savings of $2,250,000 in constructions per care home if	Greater availability of affordable living options and shorter wait lists.

	semi-private rooms in private and non-profit care homes.	More beds available at a wider range of prices for British Columbians. Operation of care homes a more sustainable endeavour in BC.	the 5 percent requirement was increased to 25 percent. More sustainable to operate care homes.	More living options for couples. Improved quality of care due to funds being reallocated from mortgage payments to quality of care.
	2d: Clarify *Regulation 5(1)* of the *Cremation, Interment, and Funeral Services Act.*	Clarifying this regulation will ensure that care providers are never forced to store a body at a care home, without the facilities to do so, for any length of time.		
	2e: Implement legislation that allows patient information to flow through the health care system with the resident.	Better services provided by care providers at the same cost.	Time spent with residents collecting health information that has already been documented by another health professional could instead be directed toward care. The industry could save $787,200 over 10 years if only 4 clients per care home per year transferred from a private to a public bed and a nursing chart could flow with them during this transfer. The industry could save $20,369 over 10 years if information flowed from hospitals to care homes with a resident.	Improved quality of care due to increased availability of care providers. Improved continuity of care. 19,680 extra hours of care provider time over 10 years directed to care rather than duplication of nursing charts. 664 extra hours over 10 years directed to care rather than duplication of collecting clinical information upon return from the hospital.

3. Implement a clear process that care providers can follow in the event of nonpayment of client user fees.	Implement a clear process that can be followed in the event of nonpayment of client user fees for a mentally capable resident in a publicly funded bed.	Relocations brought about by eviction could be eliminated. Better quality of care at the same cost to the Government.	Time saved collecting debt could be redirected toward providing more social services for residents.	Improved quality of life of the financially abused resident. Improved quality of care due to increased availability of social services.
4. Streamline investigation and inspection processes.	4a: Streamline the investigation process so that there is one external body investigating allegations of abuse at a time.	This could help the Health authorities avoid paying investigator wages that are duplicating investigation processes.	This could improve the quality of care by reducing care provider time spent accommodating investigators.	Reduced stress on the parties involved. Improved quality of care due to increased availability of care providers
	4b: Improve the operation of the Registry to better support its mandate of protecting vulnerable clients based on recommendations in BCCPA's forthcoming report.	Improved quality of care. A well-functioning Registry could save taxpayer dollars by minimizing the number of future investigations that would be caused by repeat offenders.	Minimize the chance of hiring a care aide with a history of elder abuse. Improved efficiency of investigations reduces costs.	This could drastically improve the quality of care of residents because it would minimize the risk of a resident encountering an abusive care aide.
	4c: Streamline Licensing, Quality Review, WorkSafeBC and Accreditation Canada inspections so that the same criteria are not the responsibility of multiple inspection bodies.	Reducing the length of inspections by one hour by reducing duplications could save $73,800 over 10 years in health inspector time.	Reduce compliance costs. Reducing investigations by one hour could save the industry $135,300 over 10 years.	Improved quality of care due to an extra 2,460 hours of care provider time available to residents over 10 years across BC by reducing inspection by 1 hour.

5. Streamline and standardize reporting and data collection processes.	5a: Standardize reports across health authorities.	Save administrative time for the Ministry of Health. Better Services provided by care providers at the same cost.	Save administrative time, which reduces compliance costs.	Improved quality of care due to increased availability of care providers.
	5b: Reassess the purpose and the need for the Provincial. Performance Management Framework reports.	Make better use of administrators' time by reassessing the need for the report.	Make better use of investigator time by reassessing the need for this report.	Improved quality of care due to increased availability of care providers and increased accountability.
	5c: Gather a sample rather than a census of financial data through HSCIS.	Better services provided by care providers at the same cost because staff time could be reallocated from reporting duties to care for clients.	Care providers spend less time inputting data and more time caring for residents. Reduction in compliance costs.	Care providers spend less time inputting data and more time caring for residents. Therefore the quality of life and quality of care could increase for residents.
	5d: Aid small operators with HSCIS and InterRAI data reporting efforts keeping in mind economies of scale in regulatory compliance costs.	Improved quality of data from smaller operators.	Decreased burden of relatively high compliance costs for smaller operators compared to larger operators.	

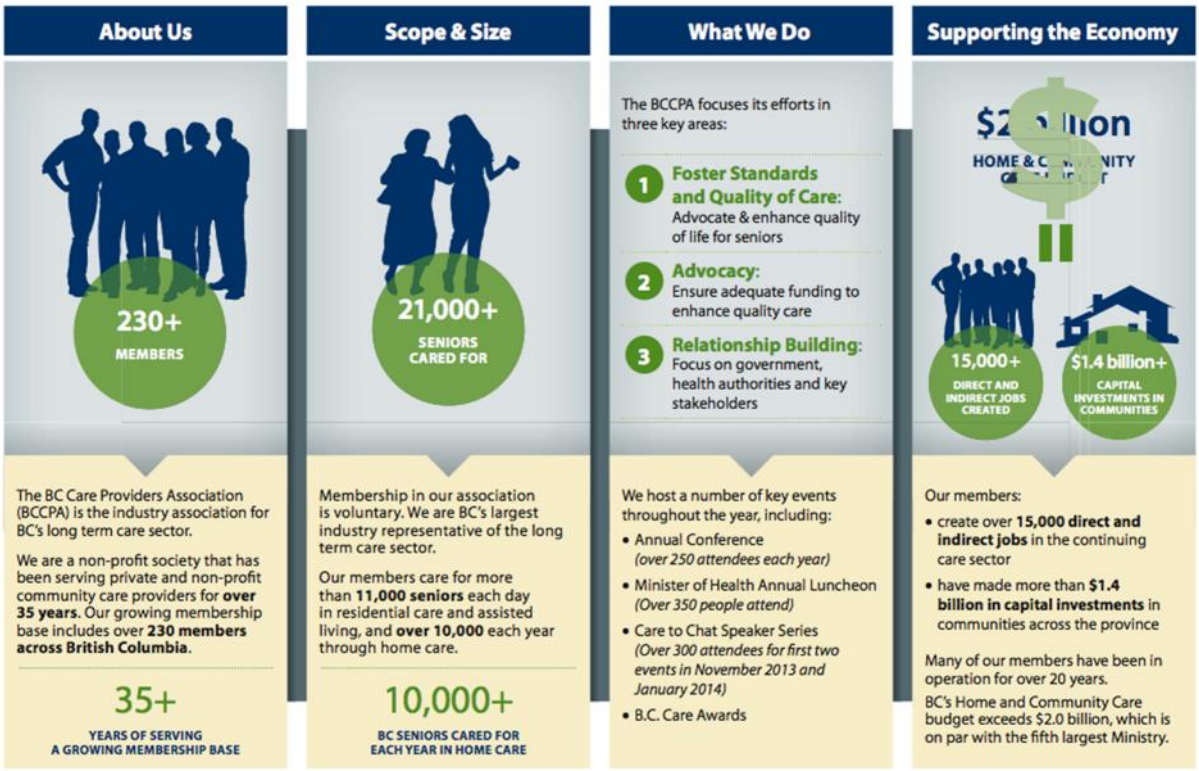
Conclusion

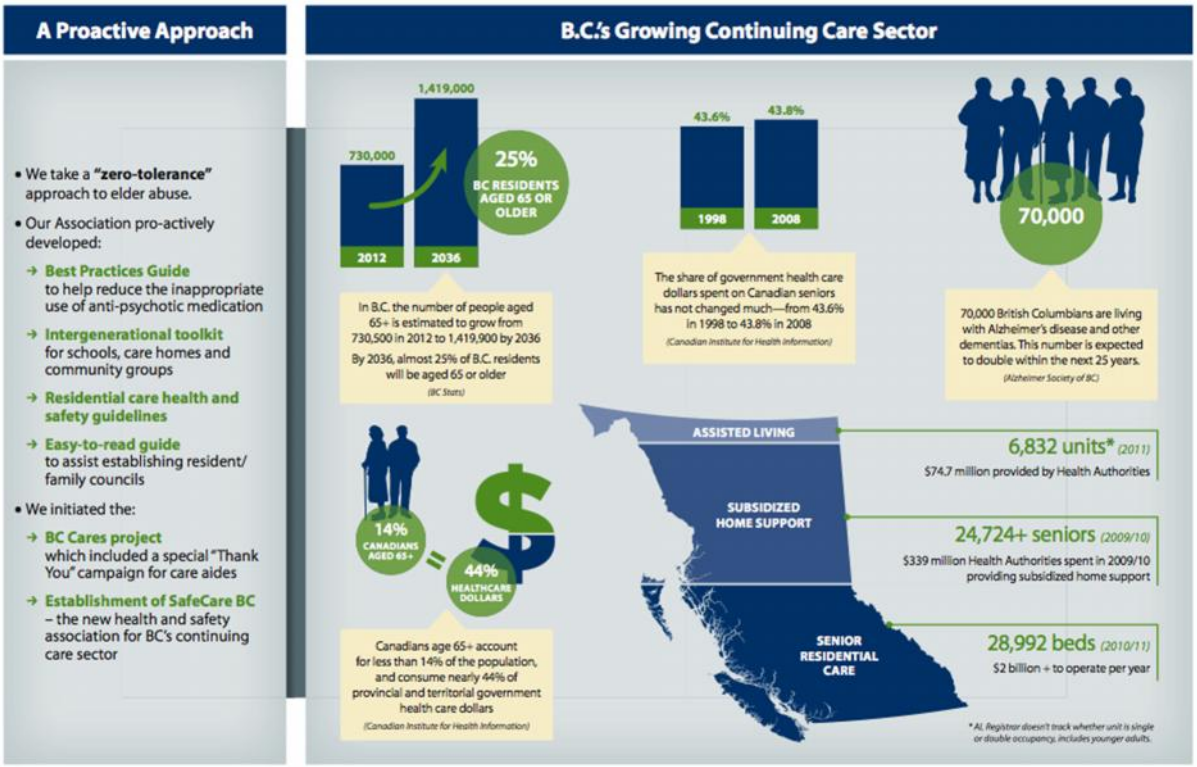
To accommodate the aging population that is placing increasing pressure on the health care system, we need to ensure that the continuing care system is operating as efficiently as possible, providing the best possible care to seniors and the best possible value to taxpayers.

Reducing red tape is an important step toward enhancing the efficiency of care homes. In four of the five health authorities, a public bed in a private care home already ranges in cost from 2 to 13 percent less than beds in public care homes, while providing the same services. With a reduction in red tape, an even higher level of quality care could be provided at no extra cost to taxpayers.

The recommendations outlined in this report are all aimed at addressing areas where a regulation or required process is not having its intended effect of protecting residents but instead is hampering the provision of person-centred care. Hence reducing red tape as per the recommendations should result in a net benefit: reducing compliance costs for care homes while simultaneously improving the quality of care provided by care homes.

Appendix A: The BC Care Providers Association[81]





[81] BC Care Providers Association

Appendix B: Core Review Terms of Reference[82]

Purpose:

Government is committed to controlling spending and balancing the budget. Government also is committed to ensuring that the Province is best positioned for economic growth fuelled by a strong economy as the best way to ensure British Columbians can afford the high-quality public services required by our growing and aging population.

The overarching goal of the core review process is to ensure the best possible use of Government resources and respect for the interests of taxpayers. The Cabinet Working Group on Core Review will be tasked to be bold in their ideas to ensure this goal is achieved.

More than 10 years have passed since Government took a comprehensive mandate review to ensure that programs and services respond in an effective and efficient way to current service drivers, deliver results, and best position the Province to achieve the goals of a strong economy and secure tomorrow.

Scope:

The scope includes all ministries and their agencies, boards, commissions and all Crown agencies and the SUCH sector.

Role of the Cabinet Working Group on Core Review:

The role of the Cabinet Working Group on Core Review (CWGCR) is to oversee the process, review the analyses completed by ministries and make recommendations to Cabinet for final decisions. The CWGCR will ensure that the objectives of Core Review are achieved by Dec. 31, 2014.

Objectives:

The objectives for core review are to:

- Ensure that the programs and activities of ministries are focused on achieving Government's vision of a strong economy and secure tomorrow.
- Ensure that Government is operating as efficiently and effectively as possible by:
    - Eliminating overlap and duplication between ministries and within the broader public sector.
    - Reducing red tape and unnecessary regulations that hinder economic development.
    - Restructuring Government program delivery and governance models where costs can be reduced and outcomes improved for the public.
- Confirm Government's core responsibilities and eliminate programs that could provide better service at less cost through alternative service delivery models.
- Ensure budget targets are achieved consistent with Budget 2013 (June Update).
- Identify opportunities where further savings can be re-directed to high-priority programs.
- Ensure public-sector management wage levels are appropriate while recognizing the need for leaders who can positively impact the effectiveness and productivity of public-sector agencies.

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[82] "Core Review Terms of Reference released," *BC Newsroom*, Wednesday July 31, 2013

The Core Review process will not make recommendations on those services provided to the most vulnerable of citizens except to the extent that they are not achieving intended results.

Timelines:

- Approval of a Core Review plan by the Priorities and Planning Committee by Aug. 30, 2013.
- Presentations on mandate by ministries in fall 2013.
- Refinement of ministry ideas, informed by targeted industry and stakeholder consultations during winter 2014.
- Cabinet approval of CWGCR recommendations before the end of fiscal year 2013-14.
- Complete by Dec. 31, 2014.

Appendix C: Minister of Health Mandate Letter [83]

June 10, 2013

Honourable Terry Lake
Minister of Health
Parliament Buildings
Victoria, British Columbia
V8V 1X4

Dear Colleague:

Congratulations on your new appointment as Minister of Health.

British Columbians have asked us to build a strong economy, a secure tomorrow and a lasting legacy for generations to come. Now it's time to deliver.

We must be alive to the challenges of a fragile global economy. We have a duty to be disciplined for taxpayers today, and a responsibility to be fair to future generations. Protecting British Columbia for us and our children means making tough choices now to control spending and balance the budget. By charting a course for a debt-free BC, our children can be free to make their own choices when it's their turn to lead.

To grow our economy and create high-paying jobs for British Columbians, I am asking you to keep your ministry focused on the *BC Jobs Plan*. Our province is blessed with both abundant natural resources, and the resourcefulness and diversity of our people and businesses. We have a generational opportunity to develop Liquefied Natural Gas. This will demand determination and purposeful work.

We are committed to building a strong economy in the province because we know that it is the only way we will be able to afford strong public services for our citizens. World class health care, education, skills training and social safety nets are only possible if we have an economy that can sustain them over the long term.

To that end our first priorities across government are:

- To bring back the legislature to pass *Balanced Budget 2013*;
- To ensure that government does not grow;
- To conduct a core review of government to make sure we are structured for success on all of our objectives; and
- To eliminate red-tape so that we can get to yes on economic development without needless delay.

[83] Honourable Terry Lake, Minister of Health Mandate Letter

In the course of our decision making we must always maintain respect for taxpayers and remember that our fellow British Columbians are looking to us to help make life more affordable for them and their families.

These priorities, along with your specific ministerial objectives, will allow us to achieve results that reflect our shared values.

The Minister of Health is responsible protecting and enhancing the health care system in British Columbia while ensuring the best possible value for taxpayers. Currently, British Columbia has the best outcomes for patients in Canada while having the second best spending on a per capita basis. I expect this to continue, despite significant demand pressures that arise from a growing and aging population.

Your job will be to live within the funding envelope provided by the Minister of Finance while at the same time continuing to innovate and improve patient services. In *Balanced Budget 2013*, your ministry received predicted increases of $2.4 billion over the next three fiscal years. We must meet our objectives to balance the budget and get onto the path of a debt-free B.C. This means that your task will be to continue to innovate and find savings throughout the health system and continue to drive the cost of administration and overhead down in order to focus as much of our resources as possible on direct patient care.

In your role as Minister of Health I expect that the following initiatives are completed by you and your ministry over the coming years:

1. Balance your ministerial budget in order to control spending and ensure an overall balanced budget for the province of British Columbia.

2. Ensure services are delivered within health authority budget targets.

3. Review and recommend to Cabinet within eight months the priorities of a new government to ensure maximum value for taxpayers while providing maximum benefit to patients.

4. Continue our governments' change and innovation agenda within the health care sector. We will continue to strive for better outcomes for patients while ensuring the best possible value for money. As our population continues to age, controlling the growth of health care spending will be a critical component to ensuring successive balanced budgets. Driving innovation and change will be necessary within the following sectors:

    - Primary Care;
    - Community and Home Care;
    - Hospitals (care team design and pay for performance initiatives); and
    - Prevention.

5. Ensure full implementation of provincial mental health plan, *Healthy Minds, Healthy People.*

6. Successfully conclude labour negotiations within the health sector for the 2014 round of collective bargaining.

7. Complete laboratory reform initiative and achieve required savings.

8. Increase the scope of practice for Nurse Practitioners in British Columbia by working with the BC College of Physicians and Surgeons and other credentialing organizations.

9. Create and implement addiction space expansion that includes a significant role for the non-profit sector in the delivery of these new spaces by 2017 as committed in *Strong Economy, Secure Tomorrow.*

10. Continue executing our government's end of life care strategy and create plan for hospice plan expansion and begin process of doubling the number of hospice spaces in British Columbia by 2020.

11. Work with the provincial health authorities to develop a preventative health plan for the province.

I have outlined in a separate letter my requirements for conduct of all members of Cabinet. It is imperative that you review and understand this letter, and the *Members' Conflict of Interest Act*, and that you act in accordance with both as you carry out the duties of a Minister of the Crown. I will evaluate any circumstances that may call into question the conduct of a Minister against the expectations and obligations set out in applicable statutes and this letter.

To assist you in the transition to your new role, I ask that you also review the attached document that provides further direction for you as a Minister.

I look forward to discussing your ideas and priorities for your ministry in the coming weeks and working with you to fulfill the mandate we were elected to fulfill.

Our government faces many exciting challenges and opportunities in the months ahead. Our success will be defined by our ability to develop and implement an agenda that reflects priorities and circumstances of BC citizens. Our ability to make this connection is a function of the degree to which we engage citizens and stakeholders in pursuing change. I am confident that we will succeed in this, and have every expectation that you will make a significant contribution to our success.

I look forward to working with you.

Sincerely,

Christy Clark
Premier

Attachments (2)

attachment: 3.0

BC CARE PROVIDERS ASSOCIATION

CEO Report

April 2014

Emerging + Ongoing Issues

BC CARE PROVIDERS ASSOCIATION

- Burquitlam Closure
- Vancouver Island – hotspot
- Funeral Homes
- Fire Prevention Standards
- Red Tape Reduction
- BC Care Aide Registry
- Seniors Advocate

Minister Terry Lake/Gov't

- 2nd Annual Minister's Lunch being planned for this fall
- Lake may attend portion of our Annual Conference – still under negotiation
- Linda Larson MLA confirmed for opening remarks
- April 30th follow-up from Delegate Day
  - Meetings planned with 5 MLAs
- Find opportunities through social media

Policy Projects

Core Review

- Will be ready to distribute to Health Authorities and Ministry of Health after Board review
- Publicly distributed in May/June via website to our membership

Care Aide Registry

- For member release in June/July – after review by Board

Recreational Therapy Best Practice

- Project was delayed, but will get underway this spring

Sector Statistics

- Intern working this summer

SafeCare BC

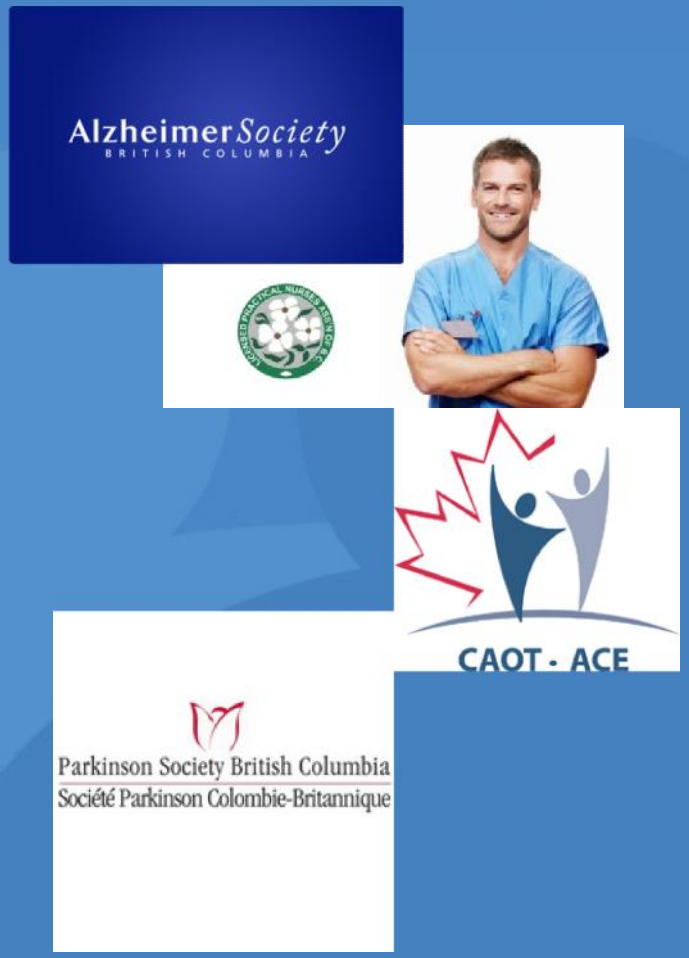
- **Ongoing focus on mentorship, admin support and developing communications and marketing material**
- **Support Services Agreement drafted**
  - Exit from agreement with 180 days written notice
  - Support Services Agreement would cover entire 2014/15 fiscal year
- **EA + Communications position now 50% co-funded.**
- **Part of EA duties transferred to bookkeeper**
- **Policy/Research accessible 15%**
- **By summer, CEO chargeback drops to under 10%**

Stakeholder Engagement

BC CARE PROVIDERS ASSOCIATION

Eight Annual Conference stakeholder tables confirmed

- Alzheimer Society of BC
- BC Centre for Elder Advocacy & Support
- Canadian Association of Occupational Therapists – BC Chapter
- Concerts in Care
- Licensed Practical Nurses Association of BC
- Leisure Practitioners Association of BC
- Parkinson Society British Columbia
- Sing for Your Life Foundation BC.



Stakeholder Engagement

BC CARE PROVIDERS ASSOCIATION

- Attended 3rd meeting for BC Committee to Reduce Elder Abuse
- HEABC Affiliate Committee
- Michael Marchbank – HEABC
- HBT invitation to sit at awards dinner
- DHA + BCSLA re Minister's Lunch Planning
- BC Non-Profit Housing re Affinity Program
- Tour of Medical Pharmacies
- EPS regarding Affinity Program

Membership Growth

- **Met with CEOs for SUCCESS and Providence Health Care**
  - Follow-up meeting with Providence
  - SUCCESS indicates funding pressures limit ability to join
- **Broadway Lodge meeting with Jeanette Thompson**
  - Funding pressures also limit ability to join – though very interested
- **3 new residential care members including German Canadian Care Home + Little Mountain Place and Adanac Lodge.**
- **Happy Homecare Makers also applied**

37th Annual Conference

BC CARE PROVIDERS ASSOCIATION

- **Residential and Homecare delegates up significantly compared to 2013**
  - 118 delegates in 2013. So far 185 registered delegates*
- **Total attendees expected to increase from 220 last year, to 350-400.**
- **Better value for corporate members**
- **Golf registrations slower**

*estimate based on April 8 sales data

Care to Chat – Wrap Up

- Over 300 paid attendees (target 300)
- 70% members – 30% non-members
- Sponsorship revenue
- Approx 10 MLAs attended
- Good stakeholder engagement and attendance
- Great earned media
- Final report in June/July
- RFS to be issued for 2014/15 series
- BCCPA profile raised
- Supports Strategic Plan

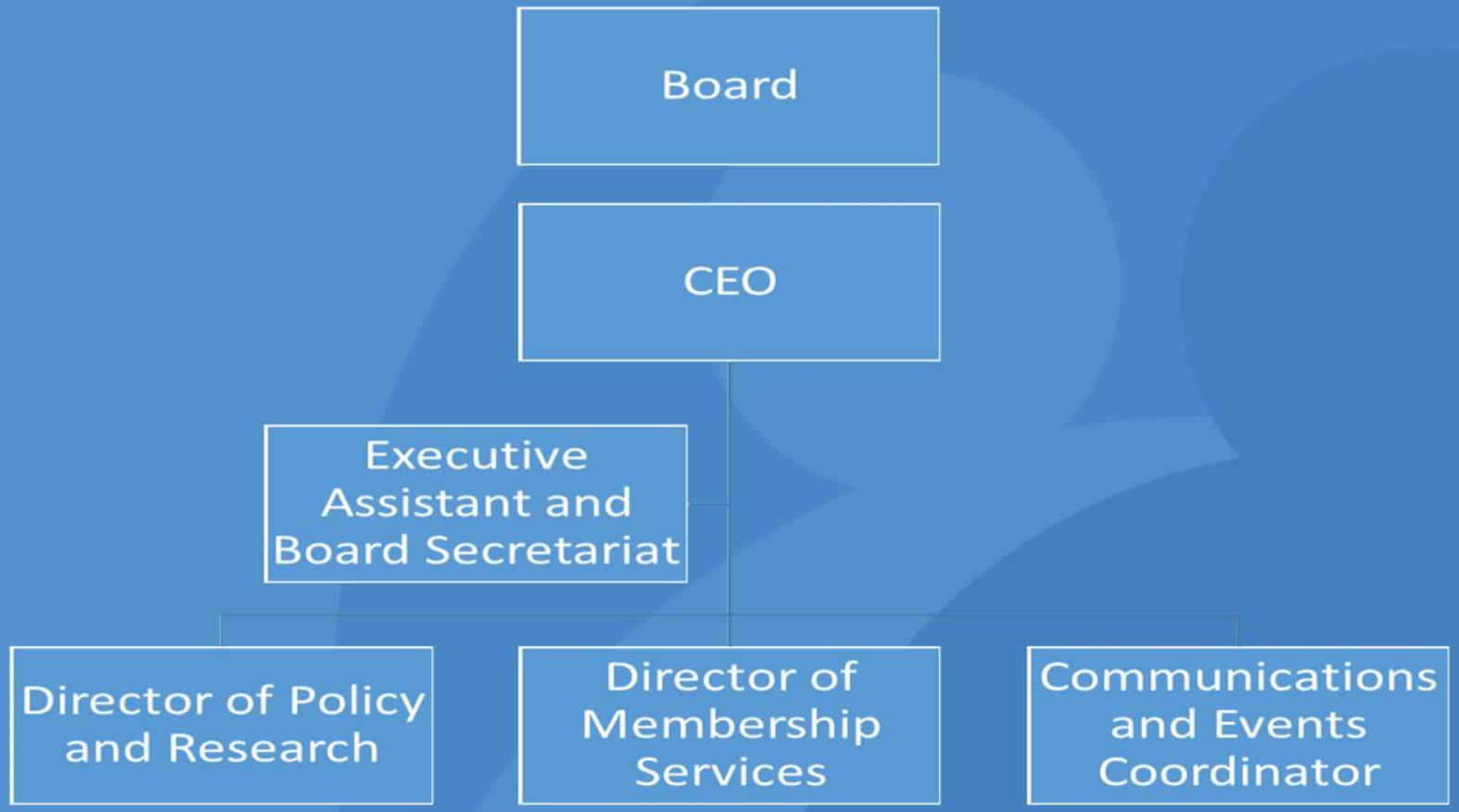
Hon. Suzanne Anton

Human Resources

- **Three permanent FT employees**
  - CEO, EA + Director of Policy and Research
- **Two contract employees**
  - Director of Membership Services, Communications and Events Coordinator
- **Rebecca Livernois temp contract expired**
- **New intern to start this summer – 4 mos**
- **Bookkeeper on contract**

Proposed Organization Chart

BC CARE PROVIDERS ASSOCIATION



Office Administration

- **Shifted from Simply Accounting to Sage**
  - Facilitates annual audit and accounting
- **Office infrastructure now fully modernized**
- **Several inquiries about sub-lease, no offers.**
- **Current lease expires in Jan 2016.**
- **Limited space to handle summer interns + SCBC drop in**
- **Lobbyist Registry updated by EA**

BC Care Provider Day and Awards

- Over 125 attendees – planned target was 75
- Engaged over 20 MLAs in one day
- Positive feedback from Minister and attendees
- Significant MLA involvement + social media activity
- Cost approx $20K. Above budget due to larger # attendees + lack of sponsor
- Nominations for 2015 now open

Communications and PR

- **CEO Member Report issued in March**
  - Significant downloads + tracking issues of interest
- **Global TV and Vancouver Sun re Care to Chat**
- **CKNW story on "bed blockers"**
- **Numerous other media coverage**


Care homes address touchy subject

Forum to discuss strategies around intimate relationships in residential care

HARO PARK CENTRE


VANCOUVERcourier

Sex among seniors can be part of a healthy lifestyle

Forum on intimacy and sexuality in senior care homes scheduled for April 8.

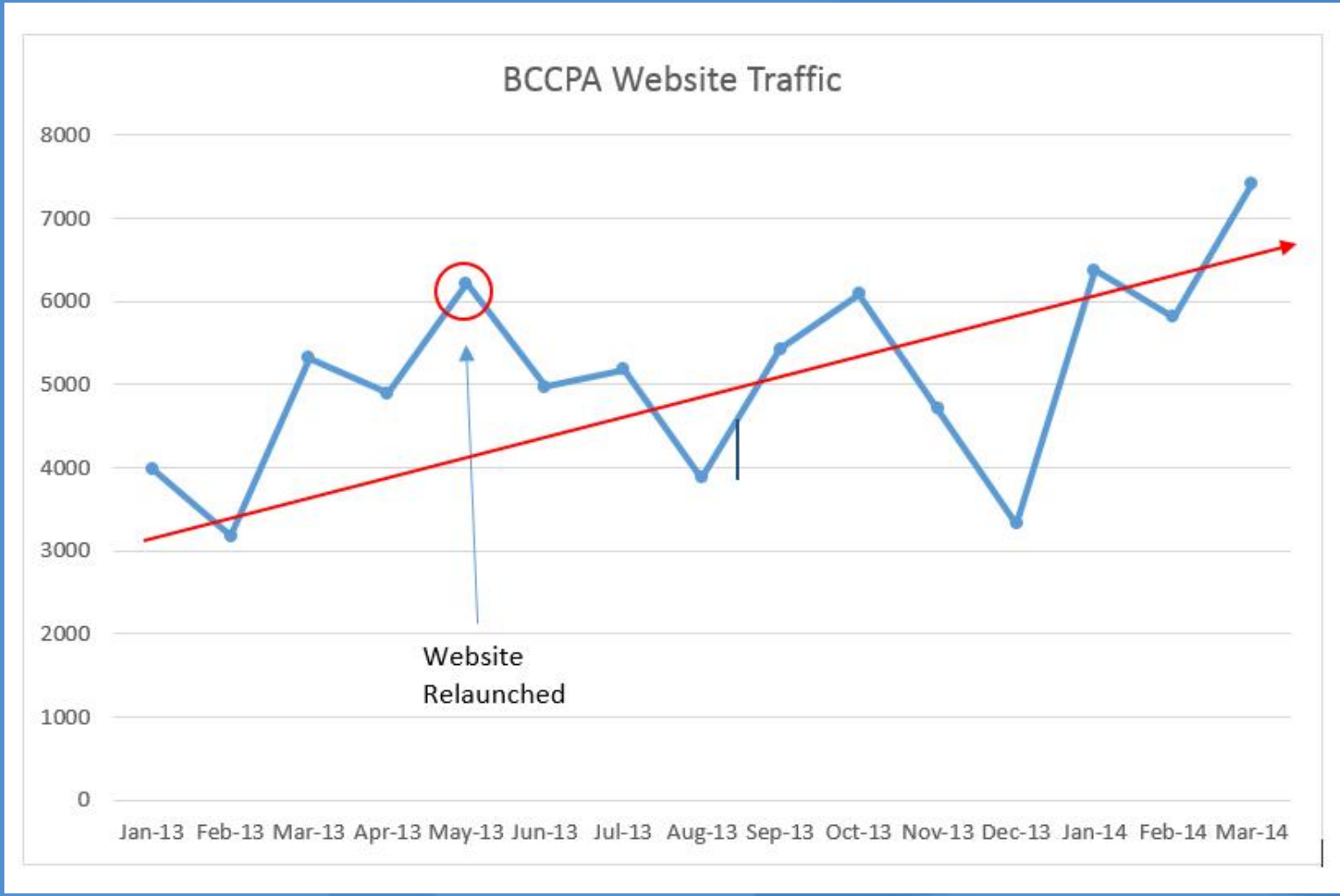
THROWBACK PRICING

Entering a long-term care home shouldn't be a sexual death sentence.

Social Media Update

- **725 Twitter followers**
  - Less than 75 one year ago
  - BCSLA <500 and started before us
- **Facebook has 53 likes**
  - Last April we were at 0
- **LinkedIn Group has 125 members**
  - In April we were at 0
- **Website traffic**
  - 6087 page views in October
  - 3179 page views in February

BCCPA Website Traffic Trends



Other…

- Video Project – Put on hold due to Christine Massey's departure
- Chef Matt Stowe Project proceeding slowly but remain hopeful. Min of Agriculture remains very interested.
- Chargeable Extras Survey – continued radio silence. But will eventually become public.
- Significant staff changes at MoH continue to limit consistent engagement
- Pressures on workload in communications + events planning – .5FTE
- Better volunteer engagement

View from Victoria

- **NDP anoint new leader – John Horgan**
  - Struggling to capture public attention
- **Legislature in session until late May**
- **Government remains focused on natural resource development**
- **BC Liberal convention in Kelowna in May**
- **NDP convention this fall**

attachment: 4.1

Support Services Agreement

Date: April 17, 2014

The BC Care Providers SafeCare BC, "BCCPA" will provide services as described in this agreement “the agreement” to SafeCare BC Health and Safety Association "SafeCareBC".

Term:	April 17, 2014 – March 31, 2015.
Renewal:	Both parties will confirm a renewal and/or extension of the agreement by no later than December 31, 2014.
Cancellation:	Upon 180 days prior written notice without cause by either party or by mutual agreement.
Modify Agreement:	At any time during the contract, both parties may choose to modify (add or reduce) the scope of services within the contract by mutual agreement.

SCOPE OF SERVICES

BCCPA: The BC Care Providers Association is located in Vancouver and has been serving the needs of BC’s continuing care sector for over 35 years. It is an industry association representing non-denominational & faith-based care providers across the province.

The BCCPA proposes to support SafeCare BC operations by providing it with access to number of key support services. The provision of these services will allow SafeCare BC staff to better focus on program development and delivery, conduct ongoing needs assessments and meet contractual commitments to WorkSafeBC.

COMMUNICATIONS:

Media Relations

- Support proactive media relations, including providing advice relating to media/public issues to staff, and organize news conferences when required, to support and promote SafeCare BC initiatives.
- Track media stories of significant interest.

Internal and External Communications:

- Implement internal and external communications strategies as assigned to communicate corporate and strategic information to targeted audiences; research, develop and coordinate publishing of website stories and content; liaise with our web developer and maintain accurate, up-to-date content, as well as initiate website improvements.

- Develop new content and manage social media presence on Twitter, LinkedIn, Facebook and other online communication tools.
- Develop print and electronic marketing materials such as invitations, posters, html links, brochures and flyers.
- Manage and regularly update stakeholder e-distribution databases
- Develop and manage electronic media distribution lists

Communications Plans:

- Assist with the implementation of the communications plan, and help assess the effectiveness of it to determine whether objectives were met.

Writing and Editing Materials:

- Compile information and write a number of collateral materials including presentations, briefing notes, news releases, speeches, brochures, backgrounders, newsletters, profiles, bios, articles for publications and websites to support SafeCare BC goals and objectives.
- Coordinate the development of SafeCare BC corporate materials

Event Management:

- Coordinate events such as the annual general meeting.
- Coordinating logistics and liaising with consultants
- Manage RSVPs and promotion of key corporate events
- Develop regular e-blasts

Communications Support and Advice:

- Provide advice and support to staff on communications strategies to ensure a consistent approach across the organization

ADMINISTRATION:

General

- Order office supplies
- Liaise with building management
- Filing and digital record keeping
- Draft correspondence
- Order catering for in-office meetings
- Provide template board policies and procedures
- Produce forms i.e. annual leave, travel expense claims

Membership Services/Office Management/Misc

- Manage spreadsheet records of membership
- Answer membership questions from telephone/e-mail inquiries
- Communicate SafeCare BC information and letters regarding membership
- Setup membership records – Accounting, listings etc

Executive Director Support

- Assist ED in preparing proposals and reports
- Organize meetings between ED and Board members/key stakeholders
- Prepare briefing materials for ED in advance of key meetings
- Manage ED calendar and book travel

POLICY AND RESEARCH:

- Provide strategic thought leadership on policy issues affecting the provision of workplace injury prevention training.
- Advise the ED and/or government on the implications of policies, including trends, risks, and developments.
- Lead and manage the research and analysis required to produce SafeCare BC research papers, policy memos and reports.
- Produce talking points, briefings, research notes, and PowerPoint presentations for both internal and external audiences.
- Conduct various forms of research including phone and in-person interviews as well as statistical analysis of workplace injury prevention data in BC.
- Attend meetings, coalitions, panels and at conferences on behalf of SafeCare BC when required.
- Meet with key workplace injury stakeholders across the province to both gather input for research and then help ensure that research is put into practice
- Supervise both graduate and undergraduate interns
- Assist with grant-writing
- Write articles and updates and to advice on content for SafeCare BC newsletter and website and other materials as required.

EXECUTIVE MENTORSHIP/SUPERVISION:

- Regularly meet and work with the ED to provide mentorship and support regarding decision-making and Board resource development
- Manage and supervise BCCPA contracted staff and coordinate staff work allocation
- Coordinate deliverables from Support Services Agreement

INFRASTRUCTURE:

- Telephones (both VOIP + one cel phone)
- Maintain and supply two SurfacePro tablets + monitors
- Maintain and supply two furnished offices + access to additional drop-in work stations
- Office supplies
- IT support for VOIP phones + laptops
- Reception and mail services
- Postage up to $200 per month ($2,400 per year)
- Hosting up to $200 per month ($2,400 per year)
- Conference call access
- Office insurance (theft, liability)

- Kitchen supplies

BOARD SUPPORT:

- Prepare Board briefing packages
- Confirm quorum and meeting attendance
- Coordinate Board annual meeting calendar
- Record minutes and distribute in a timely manner
- Act as secretariat support for various Board committees
- Post minutes and board materials on secure section of SafeCare BC website
- Assist with the administration of the Annual General Meeting of members

Bookkeeping and Administration:

- Accounts receivable
- Accounts payable
- Prepare monthly financial statements for review by ED/Treasurer
- Work with auditor for year-end reports
- Payroll records and prepare cheques
- Manage all accounts

Marketing:

- Coordinate online and print advertisements
- Develop print collateral
- Coordinate booth, pop up banners and trade show display development

Fee Structure and Work Allocation

BCCPA will allocate a portion of its staff time (see Appendix 1) to provide the above noted scope of services to SafeCare BC.

The scope of services shall serve only as a general guide of activities to be undertaken by BCCPA in support of SafeCare BC operations. The actual provision of services provided on a monthly basis will be mutually agreed upon between the CEO for BCCPA and the ED for SafeCare BC. The services provided by BCCPA are subject to estimated staff time allotments as noted in Appendix 1.

The support services agreement fee will be invoiced at $13,500 per month. No additional service fees will be charged beyond those stated above for hosting and postage. This will be inclusive of all administrative charges and staff time allocation chargebacks.

Information & Property

All computer data and paper records prepared by BCCPA specifically for SafeCareBC or prepared or provided by the BCCPA, its officers, directors, members, or agents, along with supplies purchased by SafeCare BC are the property of SafeCare BC. Upon termination of this agreement, all SafeCare BC property will be returned to SafeCare BC and all outstanding BCCPA bills will be paid by SafeCare BC.

Representation

BCCPA is authorized, subject to the approved annual plan and Board/SafeCare BC representative approval, to acquire on SafeCare BC's behalf and for its benefit, goods and services. Any resulting agreements and/or contracts are the responsibility of SafeCare BC.

Confidentiality

BCCPA acknowledges and agrees to keep confidential all information provided to it by the SafeCare BC or confidential information it receives from members of the SafeCare BC. In addition, BCCPA shall deliver upon expiry or termination of this Agreement all such confidential information to the SafeCare BC. This confidentiality clause shall survive the expiry or termination of the Agreement.

Force Majeure

Neither SafeCare BC nor BCCPA shall be liable for any delays resulting from circumstances or causes beyond its reasonable control, including, without limitation, fire or other casualty, act of God, strike or labour dispute, war or other violence, or any law, order or requirement of any governmental agency or authority.

Miscellaneous

This Agreement represents the entire understanding of the SafeCare BC and BCCPA and supersede any prior agreements. This agreement may be amended only by further written agreement signed by the authorized representatives of the SafeCare BC and BCCPA.

We indicate by our signatures below that we agree with the Terms and Conditions contained within this agreement.

Board Approval

The agreement must be approved by the Boards of SafeCare BC and BC Care Providers Association.

Review Period

The BCCPA staff chargeback schedule will be reviewed on a quarterly basis in March, June, Sept and December each year.

The overall agreement will be reviewed on an annual basis.

BC Care Providers Association	**SafeCare BC**
_____	_____
Daniel Fontaine, CEO	Jennifer Lyle, Executive Director
_____	_____
Date	Date

attachment: 4.2

CONFIDENTIAL BRIEFING NOTE

BC CARE PROVIDERS ASSOCIATION www.bccare.ca
Advocating service excellence for seniors

	Report Title	Topic HERE
1.	**Presented For**	☑ Approval ☐ Discussion ☐ Information
2.	**Presented To**	Andre Van Ryk - Treasurer
3.	**Date Presented**	March 4, 2014
4.	**Prepared & Submitted By**	Daniel Fontaine
5.	**CEO Approval**	☑ Daniel Fontaine
6.	**Board Committees Consulted**	☐ Annual Conference ☐ Awards ☐ Membership ☑ Finance and Audit ☐ Governance ☐ Other _____
7.	**Date of Approval**	
8.	**Background** *Can include purpose, context, discussion areas, requested by, interaction/meeting history, profiles on individuals, status of funding, status of BCCPA program activities and/or other relevant information*	• The BCCPA Board approves the Association's annual operating budget • This is the first full year of operation with a support services agreement between BCCPA and SafeCare BC • The Association currently has 3 full-time permanent employees; Daniel Fontaine, CEO; Heather Campbell, Director of Policy and Research; Cathy Szmaus, EA and Board Secretariat. • The Association currently has two contracted support staff; Hart Dashevsky, A/Director of Membership Services; Keivan Hirji; Communications and Events Coordinator • The temporary service contract for the Communications Coordinator ends on April 30, 2014. • The temporary service contract for the Director of Membership Services ends on March 30, 2014 • Bookkeeping and accounting/audit services are currently contracted out. • Additional support is provided through the hiring of interns and COOP students. • The BCCPA is now undertaking significant member engagement through the Care to Chat Speaker series and other high profile events. These have required additional staff support (both in-house + contracted) over the last year. • The Board has already received a briefing regarding the potential opportunities that exist in relation to the creation of a new Affinity Program. • The Board has requested that 3 year budget forecasts be brought forward for discussion.

CONFIDENTIAL BRIEFING NOTE

BC CARE PROVIDERS ASSOCIATION www.bccare.ca
Advocating service excellence for seniors

Report Title		Topic HERE
9.	**Recommendation(s)**	• Approve the proposed 2014/15 budget as presented. • Approve the inclusion of funding from the development of a new BCCPA Affinity Program. • Approve the creation of a two new permanent on-contract positions; Director of Membership Services and Communications Coordinator. The contract length will be extended to end on March 31, 2015. • Fund these two positions in part through the development of a new affinity program + support services agreement with SafeCare BC + increased membership sales + corporate sponsorship. • Approve the creation of a new $20,000 annual partnership fund. The fund will allow the BCCPA to partner with key stakeholders on project that help to support our overall strategic vision, goals and objectives. Partnership grants will be subject to Board approval. Unused funds will not be forwarded to future fiscal years.
10.	**Alternatives** **Operational Implications**	• Retain staffing levels at 3 permanent FTEs and do not extend the contracts of either the Communications Coordinator or Director of Membership Services. • Contract out communications services when required. • Eliminate the Partnership Fund • Halt development of Affinity Program • Membership support service activities (exhibit booth sales, advertising sales, sponsorships, new member recruitment, member retention) will be undertaken by Executive Assistant and Chief Executive Officer. • Partnership activities and subsequent media opportunities will be limited • Capacity for communication activities on our website, e-blasts, CEO Reports and other communiques will be reduced. • May be challenging to locate .5FTE to meet *SCBC Support Service Agreement* obligations vis a vis communications.

CONFIDENTIAL BRIEFING NOTE

BC CARE PROVIDERS ASSOCIATION www.bccare.ca
Advocating service excellence for seniors

Report Title		Topic HERE
11.	**Financial Implications**	Additional Costs/Reduced Revenue • Wages + Benefits: **2013/14** $285K vs. **2014/15** $402K • $20K allocated for new Partnership Fund • Board - increased from $8K to $12K • Travel - increased from $15K to $22K • Advertising - decreased from $18K to $5K (no more printing costs for Care Quarterly) • Staff Training/Workshops – increased from $0 to $5K • Public Relations/Web was $40K now $55K in Communications Additional Revenues • SafeCare BC Support Services Agreement: $83K personnel chargeback; $25K offset rent; $79K is 15% overhead • Care to Chat $13K • Minister's Lunch $4K • Membership Dues $8K • Affinity Program $12K • Advertising - $5K Other • Annual Conference projected to net $85K vs. $60K last year. Actual net in 2012 and 2013 was approximately $100K. • SCBC support service agreement will be in place for entire 2013/14 fiscal year.
12.	**Risks**	• New SCBC board may ask in 2014/15 to extricate itself from the support services agreement. • Reduced funding could jeopardize momentum in website traffic, new memberships, sponsorships and advertising • Affinity Program is halted and new revenues to BCCPA and cost savings to members is eliminated. • Sponsorship for *Care to Chat* comes in below less than anticipated. • Conference revenue is lower than forecast.
13.	**Alignment with BCCPA Strategic Plan**	Yes
14.	**Attached Documentation**	

CONFIDENTIAL BRIEFING NOTE

BC CARE PROVIDERS ASSOCIATION www.bccare.ca
Advocating service excellence for seniors

Report Title		Topic HERE
15.	**Other Documentation**	☐ **Leave Behinds** ☐ **Advance Info Sent**
16.	**Additional Information**	
FOLLOW-UP / ACTION ITEMS *For completion following report delivery, discussion, approval etc.*		

attachment: 4.4

BC CARE PROVIDERS ASSOCIATION www.bccare.ca
Advocating service excellence for seniors

April 3, 2014

VIA EMAIL

Fraser Health
Suite 400, Central City Tower
13450 – 102nd Avenue
Surrey, BC V3T 0H1
nigel.murray@fraserhealth.ca

Attn: Dr. Nigel Murray, President & Chief Executive Officer

Dear Dr. Murray:

Re: Request for Independent Review
76 Residential Care Beds

As B.C.'s residential care industry association, we are deeply concerned about several issues that have arisen due to the Fraser Health Authority's (FHA) impending decision to end its Affiliation Agreement with the Burquitlam Lions Care Centre (BLCC), a 76 complex care facility owned by the Burquitlam Care Society (BCS), and directly award the 76 beds to Baltic Properties.

In particular, it appears that FHA's actions lacked administrative fairness and transparency, which could have a significant negative financial impact on B.C.'s continuing care sector. FHA's actions appear to be arbitrary and do not support the long-term interests of B.C.'s seniors, provincial taxpayers or residential care operators.

Brief Background

In 2012, FHA issued a Request for Proposals (RFP) for 403 residential complex care beds and 24 mental health beds.

FHA awarded part of the RFP to Baltic Properties (136 new residential care beds and 24 mental health beds). FHA also directly awarded BLCC's 76 beds to Baltic Properties. The 76 beds were not part of the RFP.

FHA retained John Singleton, QC, to act as a Fairness Advisor to review the direct award to Baltic Properties. Keith McBain, Executive Director, Residential Care, Assisted Living & Specialized Populations, has advised us that FHA's submissions to Mr. Singleton, and Mr. Singleton's opinion supporting the direct award, were both provided verbally.

In late January 2014, Mr. McBain advised BCS that FHA had decided it would be terminating its Affiliation Agreement with BLCC. The decision would see BLCC closed by mid-2016.

As reported in *The Tri-Cities Now*, David Dines, BLCC administrator, said "It will be a huge surprise to residents and families." "It will be a shock."

FHA did not provide BLCC with an opportunity to submit a redevelopment proposal.

Mr. McBain has advised us that operating care homes with less than 125 beds is not economically feasible.

Lack of Administrative Fairness & Transparency

The situation with BLCC has unfolded in a manner that lacks administrative fairness and transparency in at least two respects: (1) the RFP and direct award process, and (2) the failure to provide an opportunity to submit a redevelopment proposal.

1. RFP Process & Direct Award

The RFP issued in 2012 did not include BLCC's 76 beds. This is despite the fact it has become apparent the FHA had no intention of continuing to fund BLCC's beds beyond mid-2016.

Rather than proceeding with a formal RFP process for the 76 beds, FHA decided to provide a significant direct award.

Had the 76 beds been included in the 2012 RFP, there is a strong likelihood that taxpayers would have been able to achieve even further savings – as proponents would have been bidding on a larger package of beds.

In addition to a missed opportunity for further savings, it is troubling that the Fairness Advisor's review process was conducted verbally. This is out of step with administrative fairness, transparency and accountability.

2. Lack of Opportunity to Submit Redevelopment Proposal

Further, FHA's failure to provide an opportunity to submit a redevelopment proposal is contrary to fair business practice. It demonstrates a lack of respect for the business relationship between health authorities and operators.

Even more, the failure to provide operators with an opportunity to submit a redevelopment plan is contrary to provincial policy. It is our understanding that in 2005, after extensive consultation with the industry, Treasury Board staff drafted and the Ministry of Health approved, the *Policy on Managing Change* (the Policy).

The Policy applies to termination of contracts and preferential consideration of existing providers. It ensures an existing facility is given priority consideration and an opportunity to submit a redevelopment proposal, rather than having to compete in an open competitive tender.

The Ministry of Health placed the Policy in the Home and Community Care Policy Manual (the HCC Manual), as section 6D 1-2. When the Ministry of Health revised the HCC Manual in 2010, section 6D 1-2 was removed.

We have been advised that the FHA no longer considers the Policy as being in effect. However, our Association is not aware that the Ministry of Health has formally revoked the Policy. In particular, we are not aware of any correspondence from the Ministry advising the industry that the Policy is no longer in effect.

If FHA no longer considers the Policy to be in effect, we are deeply concerned about the negative financial implications on the sector. Without stability, the cost of borrowing goes up for all contracted care providers and that cost must be passed on to taxpayers.

The Policy is very positive for the sector, as it stabilizes the market – thus, providing confidence to financial lending institutions.

We acknowledge that government has a responsibility to ensure older seniors' facilities are refreshed, renovated and, when necessary, rebuilt. To do this, however, owners/operators need access to capital.

When contracts for funded beds are seemingly arbitrarily terminated, financial institutions become less willing to provide mortgages to anyone in the sector. Financial institutions need assurances of stable revenue from funded beds – something the Policy helps ensure. We believe that the lack of access to affordable mortgages will result in fewer operators being able to refresh, renovate or rebuild. This is contrary to the best interests of B.C.'s seniors in need of residential care.

We will be asking the Ministry of Health to reaffirm the *Policy on Managing Change*, and we will seek to establish a working committee between industry and government to determine best practices regarding the renewal and rebuild of older care home stock.

Managing Conflict of Interest

It is important to note that both BLCC and Baltic Properties are members of our Association. Further, Will McKay, a managing partner at Baltic Properties, is a member of our board. Given this situation, we have taken steps to manage this conflict of interest. For instance, Mr. McKay has recused himself from all board discussions regarding this matter.

Additionally, our Association's concerns are focused on the potential negative impact FHA's actions may have on the residential care sector as a whole, as well as B.C. seniors and provincial taxpayers.

Request for Independent Review

Based on the foregoing, and to help ensure the BLCC matter does not set a negative precedent, we request that the FHA confirm by April 11, 2014 that it will commission an independent review regarding:

1. FHA's direct award of BLCC's 76 beds to Baltic Properties, including but not limited to the decision to conduct the Fairness Advisor process verbally.
2. The 2012 RFP process for the 403 complex care beds and the 24 mental health beds.
3. FHA's impending decision to end its Affiliation Agreement with BLCC.

Should you require any clarification, please contact me directly at 604.736.4233 ext. 229 or dfontaine@bccare.ca.

I look forward to hearing from you, and continuing to work as a valued partner in the delivery of seniors care in B.C.

Sincerely,

Daniel Fontaine
Chief Executive Officer

cc: Fraser Health Authority
Board of Directors

About BCCPA: The BC Care Providers Association is the leading industry association for B.C.'s residential care, home and community care sectors. We have been serving private and non-profit community care providers for over 35 years. Our growing membership base includes over 115 residential care, assisted living and home support members, as well as over 110 commercial members across British Columbia.

Ph: 604 736 4233
Fx: 604 736 4266
www.bccare.ca
301 - 1338 West Broadway
Vancouver BC V6H 1H2
info@bccare.ca

attachment: 5.1

BC CARE PROVIDERS ASSN

Comparative Income Statement

	Actual Apr 01, 2013 to Feb 28, 2014	Budget Apr 01, 2013 to Feb 28, 2014	Difference
REVENUE			
Association Income (Revenue)	794,650.82	759,249.67	35,401.15
Income - Other Projects	77,735.73	0.00	77,735.73
TOTAL REVENUE	872,386.55	759,249.67	113,136.88
EXPENSE			
Payroll Expenses	288,973.10	271,666.46	17,306.64
Expenses - Association	237,634.08	258,165.82	(20,531.74)
Expenses - Anti-Psychotic Project	9,411.20	0.00	9,411.20
Expenses - BC Cares	50,333.86	0.00	50,333.86
Expenses - Conference	148,212.89	168,250.00	(20,037.11)
TOTAL EXPENSE	734,565.13	698,082.28	36,482.85
NET INCOME	137,821.42	61,167.39	76,654.03

Generated On: Mar 12, 2014

BC CARE PROVIDERS ASSOCIATION

Advocating service excellence for seniors

Memo

To:	Members of the Board of Directors
From:	Elaine Price, Chair of Governance | Nominating Committee
cc:	Daniel Fontaine
Date:	April 10, 2014
Re:	Governance | Nominating Committee Recommendations to the Board

---

Based on qualifications and open vacancies, the committee proposes the following for consideration:

1. Rowena Rizzotti (Retirement Concepts) – Vancouver Coastal – 1 year appointment (new)
2. Kristan Ash (We Care) – Vancouver Coastal – 2 year appointment (new)
3. Will McKay (Baltic Properties) – Interior Health – 2 year appointment (incumbent)
4. Elaine Price (Eden Care Centre/West Shore Laylum) – Fraser Health – 2 year (incumbent)
5. David Cheperdak (Broadmead) Vancouver Island – 2 year (incumbent)
6. Elissa Gamble (Bayshore Home Health) – Home Care Sector – 2 year (new)
7. Andre Van Ryk (H & H Total Care) Congregate Care/Assisted Living – 2 year (incumbent)

Retiring from the board in May will be Bob Attfield (Home Care), Liz Dutton and Liz Monrad (both from Vancouver Coastal). Isobel McKenzie (Vancouver Island) resigned in Mach.

Sue Emmons, Donna Morasco, Ron Pike, and Debra Hauptman are all willing to stand as board appointment directors; which will occur immediately after the AGM.

Azim Jamal, Al Jina and Aly Devji have one year remaining. Mary McDougall is prepared to serve as past president again next year

The total number of board members required is 15. It has been problematic recruiting Regional representation for Vancouver Coastal (although that was achieved) and Vancouver Island (unsuccessful). The committee felt that Board members should be either owners or a senior executive (CEO/ED) within their own organization and for this reason a proposed candidate was not considered.

The committee also considered Karen Baillie, CEO of Menno Place. However, Menno Place has only recently joined the association and the bylaws require one year membership for board participation.

The resumes/CV's and nominations form of new/prospective board members have been provided to the board for review. The resume of Elissa Gamble will follow when available.

attachment: 5.3

KRISTAN ASH

63-15037 58 Avenue • Surrey, British Columbia V3S 8Z5 • (604)347-0112 • kristan_ash@wecare.ca

PROFESSIONAL EXPERIENCE

DIRECTOR, HOME HEALTH, BC, 2013 – Present
WE CARE/CBI HOME HEALTH SERVICES – Surrey, BC

EXECUTIVE DIRECTOR, 2012 – Present
BEAR CREEK VILLA – Surrey, BC

DIRECTOR OF OPERATIONS, 2008 – 2012
HELPING HANDS REHABILITATION CLINIC INC. – Fraser Valley, BC

LEAN STRATEGY CONSULTANT, 2004- Present
Kristan Ash Consulting – Greater Vancouver, BC

VP FRANCHISE & BUSINESS DEVELOPMENT, CONTINUOUS IMPROVEMENT CHAMPION, 2007 - 2008
DIRECTOR OF OPERATIONS, 2006 - 2007
DIRECTOR OF MARKETING, 2005 - 2006

OWNER/DIRECTOR, 2003 - 2005
Generations Home Care Solutions – Fraser Valley, British Columbia

EDUCATION & CREDENTIALS

Master of Business Administration, expected completion 2014
• Athabasca University – Alberta
Demystifying Roberts Rules, 2012
Lean Management Workshops, Lean Sensei International, 2006-2011
Lean Black belt, Lean Sensei International, 2008
Lean Greenbelt, Lean Sensei International, 2007
Jack Daly, Sales & Management Summit, 2007
Jack Stack: The Great Game of Business, Springfield Missouri, 2006
Bachelor of Business Administration, Entrepreneurial Leadership, 2003
• Kwantlen Polytechnic University– British Columbia

…Continued…

MEMBERSHIPS & AFFILIATIONS

- ***Board Member*** Kwantlen Polytechnic University Board of Governors
- ***Board Member*** (Past Chair) Kwantlen Polytechnic University Alumni Association
- ***Senator*** Member of Kwantlen Polytechnic University Senate
- ***Kwantlen Polytechnic University*** (Committee Member) Bicameral Governance Taskforce, Distinguished Alumni Selections, Legacies Naming Committee, Student and Academic Life Committee, Board Representative at Senate
- ***JDRF*** Annual Walk Family Committee Member
- ***JumpKick Martial Arts Foundation*** Board Member

AWARDS & RECOGNITION

- ***Surrey Board of Trade*** **– Business Woman of the Year** - Finalist, 2012, 2013
- ***Business in Vancouver*** – **Best Health & Science Service Company to Work For** – 3rd Place, 2011 (Helping Hands Rehabilitation Clinic Inc.)
- ***Business in Vancouver*** – **Best Health & Science Service Company to Work For** – 2nd Place, 2007 (Nurse Next Door Home Health Care Services)

attachment: 5.3

ROWENA L. RIZZOTTI

2394 Carmaria Courtæ North Vancouver, B.C.æV7J 3M4
(604)763-8786♦Rowenar@outlook.com

PROFESSIONAL EXPERIENCE

FRASER HEALTH September 2008 – June 2013

Executive Director – Clinical Programs & Operations

Provide strategic leadership and operational oversight for a number of clinical programs and operations across a large network of community and acute care hospitals and programs including but not limited to the following:

- Responsible for the strategic planning, executive leadership as well as oversight of Clinical Programs and operations across Fraser Health to ensure optimal clinical standardization, resource allocation, improved quality of care and operational efficiency.
- Program and operational responsibilities include Public and Population Health as well as Health Protection services for a very large geography and ethnically diverse population
- Strategic development and implementation of a new Women & Children's Program of services for all of Fraser Health ranging from tertiary NICU to community based ambulatory services serving communities from Burnaby to Boston Bar
- Operational oversight and initiation of model redesign initiative to improve efficiency and capacity of Critical Care, Trauma and Emergency programs across FH communities
- Oversight of Acute Site operations including Abbotsford Regional Hospital and Cancer Centre and Surrey Memorial Hospital (SMH) as well as Fraser Canyon Hospital and Chilliwack General Hospital
- Lead the redevelopment and implementation of largest capital health project in BC history at Surrey Memorial Hospital including the development of a renewed service profile
- Responsible for the implementation of care model redesign and process improvement strategies across a number of program areas to ensure future resources, capacity and quality practice
- Development of strategic partnerships and stakeholder collaboration including a number of Provincial Agencies to enable and enhance FH capacity and resources
- Responsible for the redesign and implementation of Ministry directed Public Health Prevention strategies including BC's first Women's Health and School health programs
- Development and implementation of a comprehensive Research, Academic and Innovation Strategy for Fraser Health in partnership with external agencies.

NORTHERN HEALTH AUTHORITY March, 2004 – August, 2008

Chief Operating Officer – NW Health Service Delivery Area (HSDA)

As an active member of the strategic and executive team for Northern Health, I was responsible to meet the strategic objectives of the organization and for the overall delivery of health services across the NW HSDA as well as:

- Provided executive leadership to clinical teams across a vast geography and numerous communities including all Acute, Support, Residential and Community Programs.

- Participated in the design, development, implementation the overall strategic plan for Northern Health.

- Designed and implemented an effective organizational structure within the HSDA by identifying critical issues related to service requirements and establishing short, medium and long term goals and objectives required to effectively and efficiently deliver services.

- Developed and managed an annual operating budget over $150 Million as well as oversight of capital projects including Residential Care Centres and new Hospital projects

- Development of budgets and responsibility for the allocation and distribution of financial resources to meet service requirements.

- Built collaborative relationships with numerous levels of Government including provincial and municipal, as well as build strong partnerships with private partners and affiliates, including Aboriginal communities, various community organizations and other stakeholders.

- Built and maintained positive and effective relationships with the medical staff.

- Developed and implemented a number of innovative program and service models to meet the needs of communities in the HSDA, including leading models in Primary Care.

- Developed numerous business and operational plans to ensure the success of objectives as set out by Ministry of Health, and Northern Health Board, particularly in an environment of limited human resources.

- Developed and implemented a number of regional standards, within a Quality Framework for programs and services across the healthcare continuum.

- Understanding population health information to best understand priorities of local communities and all subpopulations.

- Develop some of the first primary care networks in an effort to improve integration and overall health outcomes for residents of surrounding communities.

Health Services Administrator – Central NW HSDA

As Health Services Administrator, I was responsible for the successful implementation of strategic objectives for areas within the Northwest HSDA, as designed by Northern Health Executive Team. In addition, the Health Services Administrator (H.S.A) participates in the development of various operational plans that will ensure the effective and efficient delivery of health services that meet the needs of the local communities that it serves. The H.S.A is responsible to provide ongoing leadership to nearly 1000 employees representing various disciplines across the health continuum, including those that do not report directly through acute care services. I work collaboratively with all stakeholders within my communities, my peers, the clinical teams and the

senior leadership team in the planning, integration, and delivery of health services to all persons within this geographic area.

Responsibilities

- Participate as a member of the HSDA Senior Leadership Team to set the direction of health care services and delivery within the context of a regional system of services in order to sustain and improve health services within existing resources.

- Provide ongoing coaching mentoring, guidance and direction to Managers and staff as well as develop and foster improved working relationships with Physicians and allied health professionals.

- Promote and model a culture of respect, integrity and teamwork.

- Collaborate with key stakeholders within the corporate office and within the HSDA community to ensure the acquisition of fiscal, technological physical and human resources to fulfill service delivery requirements within current administration policy.

- Ensure access of health services to all people of the north including areas where there are resource and accessibility challenges

- Operate within a best practices model of care while promoting accountability to fiscally responsible business and management principles. Currently oversee an operating budget of approximately $26 M.

- Build and foster positive relations with all stakeholders, organizations, agencies, unions, institutions, government representatives, funding donors, media and interest groups through a culture of collaboration and communication, to promote trust and transparency.

- Provide coordination and operational leadership across the care continuum, to each community within the Central Northwest.

NETWORC HEALTH INC June 2000 – March 2004

Networc Health Inc. is national market leader in providing comprehensive medical/surgical and rehabilitation services to third party agencies, including publicly funded Health Authorities across Canada. Networc Health Inc. operates Canada's first private acute care inpatient facility in Calgary Alberta that provides surgical and diagnostic procedures as well as inpatient medical and rehabilitation services, currently performing over 1400 total joint replacement surgeries per year in the first public-private partnership of its kind.

Director of Operations - Networc Health Inc.
Calgary Alberta

Director of Operations is responsible for the ongoing management of all hospital departments, including: surgical services, day surgery unit, a 37 bed surgical inpatient unit, rehabilitation, preoperative assessment clinics, ambulatory clinics for 20 orthopedic surgeons, anesthesia, internal medicine, administration and medical records, purchasing, human resources, accounting and finance, pharmacy, linen services, food services/dietary, housekeeping and maintenance.

The design and development of the model and operations within this facility has resulted in the

performance of over 1000 total joint replacement procedures through the first innovative 'arthroplasty care pathway' signed specifically to improve clinical outcomes, increase capacity for the provincial system and to reduce wait times for Orthopedic services in this innovative partnership between the public and private sector.

Responsibilities

- Developed Business and Strategic Plans designed to demonstrate the fiscal benefits of the Private Care model
- Lobby at various levels of government and third party agencies to support Private model of care delivery
- Responsible for the development and execution the strategic plans
- Responsible for the development and management of the annual budget and any special operating budgets.
- Developed a team to design care pathway and engage expert resources to participate in the design and delivery of the models
- Responsible to build and oversee all department operations including support and ambulatory services
- Oversight of capital projects to design the former maternity hospital to a state of the art innovative surgical facility
- Created and implemented a new organizational structure and model for service delivery and redesigned service delivery teams to accommodate significant increase in service volume with a focus to achieve and demonstrate extraordinary results.
- Negotiated and collaborated with Calgary Health Region to develop the first public-private partnership in Canada.
- Responsible to ensure the reconciliation of clinical processes within a tri-partied relationship between Health Region, a non hospital surgical facility and standards required by the Alberta College of Physicians & Surgeons.
- Responsible for ongoing communication and public relations to various stakeholders regarding the public benefit of a new health service delivery model.

Director of Client Relations –Networc Health Inc.

The Manager of Client Relations was a member of the Senior Management Team and responsible for budgeting, business planning, business development and implementation of all new programs and services. Additional responsibilities include the development and design of proposals, procedures and protocols in order to consider becoming the first Non Hospital Surgical Facility to perform extended stay surgery. Primary role was also to develop and maintain relationships with health care professionals, private industry stakeholders, Provincial and Federal government agencies as well as the public.

Responsibilities

- Project Leader for the research, design and proposal for changes to approval policy on Non Hospital Surgical Facilities in Alberta.
- Performed research of clinical practice and created a business case around the safety of performance of ES procedures within an NHSF that was subsequently accepted by the Alberta College of Physicians & Surgeons (CPSA).
- Responsible to lobby and communicate with local politicians and stakeholders to present the

option of public/private partnerships in health service delivery.

- Conducted numerous focus groups and presentation sessions to educate and communicate with stakeholders, including public, staff and media.
- Development of standards, policies & procedures for Canada's first Extended-Stay Non Hospital Surgical Facility.
- Creation of new programs developed in response to limitation in resources, such as a Hand Clinic and Telemedicine Program.
- Provided leadership and guidance to staff on program efficiencies, quality assurance, and improved customer service

Business Development Manager – Networc Health Inc.

Roles

The Business Development Manager is a member of the corporate senior management team and is responsible for all elements of business development for new and existing Health Services and Programs across all Networc Health Locations in BC and Alberta.

Responsibilities

- Developed an Occupational Health Division for Networc Health Inc.
- Responsible for the development and successful execution of the business and strategic plan for 2002-2004.
- Introduced and implemented Occupational Health Clinics into seven (7) facilities across BC and Alberta.
- Designed and developed a very successful Occupational Injury Center for walk-in services in Northeast Calgary.
- Developed a national Occupational Health/Disability Management Program for large national employers
- Project leader and author of successful service proposals including large proposals for Health Services within Municipalities, Health Regions and various levels of Government.
- Accomplishments also include the design, development and implementation of numerous innovative Health and Wellness programs and services; Responsible for the design and development of Clinical Best Practices Manual.

DALTEC OCCUPATIONAL HEALTH SERVICES INC – July 1998 - June 2000
Calgary, Alberta

Manager of Business and Operations

Responsible for all aspects of management, marketing and overall service delivery, including recruiting and related HR functions relating to Nursing and Professional resources across five (5) clinical operating sites. Executive leadership included the development of business plans, executing service and delivery strategies, developing best practices and the development of new operations across Alberta.

Responsible for all aspects of Clinic Operations including supervising staff, maintenance and provision of costs, purchasing, coordination and scheduling of Medical and Nursing staff, maintenance of equipment and accreditation, establishment of best practices, policy and procedures, as well as maintaining high level of clinical service and customer satisfaction.

C.S. WILLIAMS HEALTH CENTRE / RIVERSIDE MEDICAL ASSOCIATES - May 1990-September 1995
Trail, BC

Nurse Manager

Clinical Management and Coordination of services within a 10 physician comprehensive medical center, including specialty procedures relative to Orthopedics, Occupational medicine, Pediatrics, OB/GYN, and Family Practice. Responsibilities included the coordination of all Professional, Nursing and Administrative staff, budgeting and accountabilities as related to Medical Equipment and Purchasing, quality assurance related to all policies, procedures and medical protocols/practices.

BC AMBULANCE SERVICE- May 1986-May 1990
Castlegar/Quesnel, BC

Attendant/Driver

Part-time Emergency Medical Attendant/Driver. Responsibilities included numerous medical responses to medical emergencies ranging in acuity from routine transfers to multiple poly trauma/victim settings. Industrial First Aid level 'A', and former CPR and Survival First Aid Instructor.

GR BAKER HOSPITAL - February 1988-September 1990
Quesnel BC
Casual Nurse
Nursing in various areas including both Acute and Continuing Care units.

WCB -BC - February 1989-September 1990
Quesnel BC
Survival First Aid Instructor
Teaching Survival First Aid and CPR, weekly, for remote industrial employees.

EDUCATION

Masters Business Administration – Lansbridge University, New Brunswick (*April 2006*)
Masters Management – American Graduate School of Management (*April 2006)*
Bachelor of Art Degree- Psychology (UBC/OUC) 1999
Associate Science Degree- Biology (Selkirk College/OUC) 1997
Diploma/Practical Nursing- Selkirk College, 1986
Business Administration- Selkirk College, 1983

RECOGNITION

Selkirk College Academic Excellence in Biology, 1996
Selkirk College English Composition Award, 1997
Jim Johnson Academic Achievement Award, 1997
Selkirk College Athlete of the Year Award, 1997
BC Ambulance 'Good Samaritan Award' 1997

REFERENCES

Available upon request

attachment: 5.3

BC CARE PROVIDERS ASSOCIATION
Advocating service excellence for seniors

#301 - 1338 West Broadway
Vancouver, BC V6H 1H2
T: (604) 736-4233 F: (604) 736-4266
E-mail: info@bccare.ca

NOMINATION FORM

2013/2014 ELECTIONS TO THE BOARD OF DIRECTORS

Complete all highlighted areas. Return form by April 4 2014

The Association's Board of Directors plays a key role in representing the membership and performing the business of the Association.

Each year nominations are required for the vacant seats on the Board. A strong Board means a strong Association. (Membership on the Board requires attendance at monthly Board meetings and participation on selected committees).

Please complete the form giving details of your nomination. Members are permitted to self-nominate if they are prepared to stand. The Nominating Committee will also put forward names for vacant Board positions.

DETAILS OF NOMINEE

Name of Nominee: Debra Hauptman

Facility/Agency: Langley Care Society

Address: 5451-204th Street, Langley Lodge

Postal Code: V3A5M9

Telephone: 604-532-4216

E-mail: dhauptman@langleylodge.org

BOARD POSITION REQUESTED: Fraser Health Regional Director

Qualities you feel would be of value to the Association: I have a 30 year background in healthcare and have worked in the public sector and private sector. I have solid business skills, excellent interpersonal communication skills. I have served on various Boards in the past, and I am familiar with Board roles and responsibilities and governance principles. I have loads of enthusiasm and a strong desire to advocate on behalf of the residents who rely on our voice to represent them in the ever-changing and political healthcare environment.

Has the Nominee agreed to let their name be submitted? ☒ YES ☐ NO

DETAILS OF NOMINATOR

Name: Self nomination

Facility/Agency: As above.

Telephone: _____

E-mail: _____

Once complete, use the **"Sent to" "mail recipient (as attachment)"** under the **FILE menu** to return *to* ***"info@bccare.ca***. or **print and fax** to BC**CPA** at **F: (604) 736-4266.**

attachment: 5.3

DEBRA HAUPTMAN, M.B.A

21092 – 80th Avenue Langley, B.C. V2Y 0H2 cell: 604-862-5569
email: debra.hauptman@telus.net

EXECUTIVE LEADERSHIP

A Proven Management Professional with a significant record of achievement in the areas of Organizational Development, Operations Management, Human Resources, Strategic Planning, Marketing and Communications, and Stakeholder Relations. Applied strong leadership, excellent interpersonal skills and an effective management style – to successfully lead a multi-disciplinary team of professionals and achieve organizational goals.

SELECTED PROFESSIONAL BACKGROUND

Langley Care Society Sept 2009 – present

The Langley Care Society owns and operates Langley Lodge, a licensed, accredited, 139 bed residential care facility for seniors and persons with disabilities who require 24 hour nursing care. The Langley Care Foundation is a public foundation and registered charity that actively fundraises to enhance programs and facilities at Langley Lodge.

Chief Executive Officer – Care Society and Foundation

Reporting to the Board of Directors, with an $10.9 million operating budget, the CEO is responsible for operations and delivery of complex care services for the Langley Care Society (LCS) and oversees the activities of the Care Foundation. The CEO ensures legislative and regulatory responsibilities are met. As an accredited service provider, the CEO guides continuous quality improvement processes. Additional responsibilities include:

- Coordinate delivery of services during full scale renovations of an occupied 60,000 s.f. residential care facility. Represent the LCS's interests on the renovations project team and provide guidance to the project consultants on operations impacts to ensure minimal disruption to the residents and completion of the project is on time and within budget. In May 2011, achieved completion of the renovations and construction project, on time and within budget.
- Create a marketing strategy and plan for the society. Implement a range of new initiatives including website development and content management, advertising plans, and social media to engage donors and private pay clients. In 2013, these marketing efforts have resulted in 98% occupancy of private pay capacity.
- Lead an inter-disciplinary team of over 150 staff and 170 volunteers. Ensure Human Resources and labour relations procedures and processes are adequate to support employees.

- Manage external contracts; Westcana Services, ProVita Care Management Inc, building maintenance contracts, wireless communications clients and suppliers.
- Develops an Operations Strategic Plan to coincide with the 4 year accreditation cycle. Develop objectives and actions towards continuous quality improvement.
- Coordinate accreditation activities and organization preparations for 4-yearly accreditation. In 2012 achieved Accreditation with Exemplary Standing.
- Participates on various industry councils with regional healthcare leaders and on local business and community associations.

Vancouver Coastal Health Authority 2007 – 2009

Vancouver Coastal Health (VCH) provides a full range of health care services ranging from hospital treatment to community-based residential, home health, mental health and public health services for residents in the coastal mountain communities, Vancouver, North Vancouver, West Vancouver and Richmond.

Manager – Downtown Community Health Centre

Reporting to the Operations Director, with a $6.5 million operating budget, the Community Health Centre Manager is responsible for the delivery of effective and efficient primary health care services both on and off site. These interdisciplinary services include:

- A primary care clinic, Home Health support services, women's health clinic; Downtown Community Pharmacy, Maximally Assisted Therapy (MAT) Program that provides intensive and assertive case management for people living with HIV, tobacco dependence clinic.
- Works collaboratively with the Manager of Addiction Services provided on site.
- Provides leadership and direction for operations management, planning, implementation and evaluation of services and activities related to utilization and risk management, and quality of the service.
- Plays a critical role in addressing the ongoing issues/needs of clients and their families.
- Leads an inter-disciplinary team of over 100 staff and works as a team player with physicians, colleagues and co-workers and in collaboration with key internal and external stakeholders to achieve excellence in client and family centred care, education and research.
- Primary interactions and communications are with the Medical Director for Inner City Primary Health Care, the Medical Coordinator for DCHC, other CHA and VC Managers and Directors, members of the Addictions and Mental Health teams, physicians within the CHA and community and health authority partners such as municipal government, community organizations, police, and emergency services.

SRS Vocational Services Society 1993 – 2005
Vocational Rehabilitation Services agency, providing a range of employment development programs for individuals with disabilities in the Fraser Valley Region.

Executive Director

Reporting to the Board of Directors with a $3.5 million operating budget, responsible for the organization's strategic direction, program development and financial growth.

- Developed and implemented operational and financial management practices resulting in the successful growth of an established non-profit organization
- Developed and implemented operating policies and procedures which facilitated consistent standards of service quality during the society's growth phase.
- Raised the public profile of the organization by developing and coordinating comprehensive marketing and communications activities
- Initiated and facilitated annual strategic planning for the Society's Board of Directors resulting in achievement of annual goals and objectives and long term plans
- Elevated professional standards of practise by initiating requirements and supports for completion of a certification program for rehabilitation professionals
- Created a business strategy and marketing plan for the society's business division, SRS Packaging Services, resulting in year-to-year growth in revenues
- Developed HR policies and practises resulting in a fair, flexible, responsive and people-oriented work environment that the society's 80+ employees regarded as one of the best places to work
- Established a unique workplace culture through regular staff and volunteer recognition activities and employee communications
- Increased internal data management and communications capacity by initiating infrastructure improvements which enabled establishment of local area networks and internet capability for over 80 computers in the organization's five centres
- Initiated an employee Health and Safety program and Emergency Response protocols for five locations bringing the organization up to WCB standards and achieving an accident free workplace
- Collaborated with Board of Directors on major projects, including capital equipment acquisition and facilities expansion

Delta Advocates for Community Mental Health Society 1990 – 1993
Psychiatric rehabilitation services agency serving the communities of North Delta, Ladner and Tsawwassen.

Executive Director

Established base funding and implementation of primary programs with an operating budget of $350,000.

- Undertook efforts to successfully establish the fledgling organization in the community as a credible and effective service for supporting individuals with mental illness.
- Implemented a range of specialized community support services for individuals with psychiatric disabilities and successfully secured funding to deliver these services
- Successfully designed and implemented the operational framework for the new organization which continues to be active today
- Advocated for the successful acquisition of a permanent facility for the agency's services

Langley Stepping Stone Rehabilitative Society 1989 – 1990

Community social and health services agency serving Langley, Fort Langley and Aldergrove, serving adults with chronic, persistent mental illness with day rehabilitation, pre-employment, independent living support and volunteer work initiatives.

Program Coordinator

Supervised the pre-vocational "Clubhouse" program, three staff and additional volunteers. Program objective was to assist clients to develop pre-employment skills through the provision of vocational skill development activities.

- Assisted in the implementation and development of an innovative psycho-social model of pre-vocational rehabilitation services in a suburban setting.
- Directed program development and service delivery including the provision of life skills, pre-vocational and social/recreation services.
- Supervised staff team, volunteers, consumer-leaders and practicum students.
- Coordinated services with other community mental health professionals.

Developed rehabilitation plans for clients in collaboration with the client, family and Mental Health Services Workers.

Community Health, Mental Health and Youth Services Prior to 1989

- Health practitioner (Registered Psychiatric Nurse) in Acute Care Psychiatry, Community Mental Health and Intermediate Care organizations in the Lower Mainland.

EDUCATION

Master of Business Administration, Simon Fraser University 2002
Diploma in Psychiatric Nursing, British Columbia Institute of Technology
Real Estate Trading Services Licensing Program UBC Sauder School of Business and the Real Estate Council of British Columbia 2006
LEADS – 10 month pilot program for LEADS in a Caring Environment: Royal Roads University, January - October 2008
LEAN Healthcare Certificate Program – University of Michigan - 2009
Writing and Editing for the Web – SFU – Fall 2010

PROFESSIONAL DEVELOPMENT

Presenter: Canadian Society of Association Executives, 2004 Annual Conference "A New Approach to Revenue Generation: Building a Commercial Enterprise"
Training Enhancement in Applied Cessation Program I and II – CAMH 2008
- tobacco dependence treatment model
Master's Thesis: A Strategic Analysis of a For-Profit Contract Packaging Business Operated within a Not-For Profit Organization; available at the Belzberg Library, Simon Fraser University.
Computer Skills – current competencies; MS Office, internet applications, website content management software, social media
Disaster Preparation Training – Justice Institute
Supervisory Skills Training – Justice Institute
General Sciences Studies – University of Alberta
Mathematics and Accounting Upgrading – Kwantlen University College

PROFESSIONAL AFFILIATIONS

Downtown Surrey Business Improvement Association – Founding Member & Director 2002 - 2007
Simon Fraser University Alumni Association
Surrey Board of Trade – Director - 2002-2004
Registered Psychiatric Nurses Association of BC – Active Registration #5029
Canadian College of Health Leaders – Since Oct 2009
LinkedIn Professional Network
BC Care Providers Association member

attachement: 5.3

ELISSA KRAUS GAMBLE

3301 Abbey Lane ♦ Coquitlam, BC, Canada V3E 3G5
E-mail: egamble@bayshore.ca
Office: 604-552-3852 Mobile: 604-837-0033

SKILLS HIGHLIGHTS

- **Strong leadership**: Ability to inspire, motivate and achieve committed and engaged teams. Sound judgement, strong analytic skills and excellent problem solving capacity
- **Skilled communicator and Facilitator**: Captivating speaker - skilled writer. Able to reach people at different levels with different learning styles and abilities.
- **Project Management:** Experience with complex projects and implementations across, divisions, sites and across various levels of the organization. Developed tools and processes to support projects across the organization.
- **Systems and Process Improvement:** Relentless pursuit of excellence has inspired a consistent improvement approach. Strong ability to inspire and lead individuals and team to achieve improvement goals and to sustain them into the future.
- **Change Management:** Worked with people at all levels of the organization to manage change as we moved through many significant periods of restructuring and re-organization.
- **Business Information Technology:** Understanding how leveraging technology can improve the efficiency and effectiveness of organizations. Advanced user of Microsoft Office applications, Procura, and other end user application software.
- **Bilingual:** French/English

RECENT PROFESSIONAL EXPERIENCE

Director of Regional Development | February 2005 to Present
Bayshore Home Health, Western Canada

Bayshore Home Health is one of Canada's leading providers of home health care and since February 2007, has been named one of Canada's 50 best managed companies. In BC Bayshore provides service to a variety of customer groups including private pay and government funded home care services under contract with 3 health authorities and MCFD.

Responsibilities:

- Serves as a member of the Senior Management team and oversees branch and clinic operations across Western Canada to ensure ongoing effectiveness and efficiency as independent Business Units.
- Provide support with respect to the development of new operating locations and closure of current locations.
- Provide guidance to Area Directors with respect to meeting or exceeding anticipated sales and profit goals, human resource management, strategic planning and continued growth, problem resolution and company promotion.

Selected Accomplishments:

- Provided leadership in the remodeling and improvement of the infusion clinic network across the country which included cross divisional integrated approach to change management, education and the roll out of new process to 54 branch clinic sites across multiple branches and divisions in the organization.
- Led a large scale implementation of mobile technology and business process re-design in the largest Bayshore branch with over 1000 staff.

- Developed new business processes to improve organizational efficiency and effectiveness. Rolled out new processes to 33 branches across Canada.
- Led a dysfunctional underperforming branch through major restructuring and business process redesign so as to achieve people and financial goals. Managed the changes associated with management and staff turnover as well as the resulting training and recruitment in one of the tightest labour markets in Canada.
- Consistently meets sales and profit targets including the highest single site sales in the company for 14 years running.
- Mentors new leaders into leadership roles and always seeks future leaders for development.

Area Director June 2000 to February 2005

Bayshore Home Health, BC Government Operations

Bayshore Home Health is one of Canada's leading providers of home health care and in February 2007, was named on of Canada's 50 best managed companies. In BC our Government Services branch provides services to Vancouver Island, Vancouver Coastal and Fraser Health Authorities as well as the Ministry of Children and Family Development providing government funded home care services.

Responsibilities:

- Accountable for all aspects of Branch operations for the largest of the Bayshore branches including business development through marketing and sales, human resources, budget and finance, quality management, information systems, and the integration of directives from as well as communication with head office, local health authorities and provincial ministries and regulating bodies. Responsible for approximately 600 employees - union and non-union; unlicensed, licensed and professional.

Selected Accomplishments:

- Approximately tripled total annual revenue over a three year period
- Implemented major contract awards that doubled branch business over a 3 month period
- Led the implementation of ISO Quality Management System. First branch to be externally audited.
- Led the organization through fast paced growth and managed the associated change
- Instigated and rolled out national CRM program in all 26 Bayshore branches across Canada
- Consistently meets or exceeds HR, Financial and Quality targets as well as company growth objectives

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Director of Operations 1999 to 2000 – Contract position

BC Provincial Renal Agency, Vancouver, BC, Canada

The BC Renal Agency is a provincial agency whose mission is to improve the health of British Columbians through the development, ongoing monitoring, and dissemination of comprehensive investigative and treatment programs for patients with end-stage renal disease.

Administration Fellow 1998 to 1999 – 1 year term

Providence Health Care, Vancouver, BC, Canada

Awarded the Administrative Fellowship with Providence Health Care, a faith-based care provider that operates seven facilities in Vancouver, Canada.

Resident Activity Aide, Housekeeper and Dietary Aide 1990 – 1995

Extendicare Skilled Nursing Facility, Saskatoon, SK, Canada

Provided direct patient care and service in a number of positions while attending university. Acquired a passion for caring for and supporting seniors.

EDUCATION

1998 – Present
Ongoing professional development in a multitude of areas, including:

- Labour Relations and Human Resource Management
- Leadership development and Performance Management
- Dealing with difficult people
- Microsoft Office Applications including advance Excel and Word
- Quality Management and ISO 200 certification
- Indicator Development and Measurement

1998 Master of Health Administration (MHA) degree
University of British Columbia..

- Awarded the UBC Health Care and Epidemiology Alumni Prize for excellence in academic achievement and significant contribution to the Alumni Association.

1995 BA (Honours) degree in Economics
University of Saskatchewan.

- Awarded position on Dean's Honour List for 1992-1993 academic year – academic standing in the top 5% of all students pursuing Arts degrees at the University of Saskatchewan

PROFESSIONAL AFFILIATION and VOLUNTEER EXPERIENCE

- Session and Ministry and Personnel Committee, Eagle Ridge United Church
- Canadian College of Health Service Executives, Associate member
- BC Health Care Leaders' Association – Associate member
- Health Care and Epidemiology Alumni Association, President 2000 - 2005
- Pacific Health Forum Steering Committee, Co-Chair 1998 – 2000 Chair 2000 - 2004

REFERENCES

References are available upon request.