BC CARE PROVIDERS ASSOCIATION

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.

BOARD MEETING AGENDA

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

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.	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.	D Cheperdak	2 min	**A**	
CONTINUING BUSINESS						
(attachment)	**2.1**	**Core Review Interim Report – request for feedback**	Guests: Michael Izen Rebecca Livernois @9:35	25 min	**D**	**3.4**
	2.2	**BCCPA Membership Value Proposition**	M McDougall	20 min		**1.4 + 1.2**
(attachment)	**2.3**	**SafeCare BC – create a new society** **Proposed Motion:** Be it resolved that the society bylaws for the new SafeCare BC Association be approved as submitted. **Proposed Motion:** Be it resolved the constitution for the new SafeCare BC Association be approved as submitted.	Guests: Jennifer Hystad Wynona Giannasi @10:30	60 min	**A**	**3.1**
	2.4	**HBT Update**	I Mackenzie	5 min	**I**	

Notes	ITEM #	TOPIC	PRESENTER	TIME	* Action required	Strategic Goal
			H Campbell			
STANDING REPORTS						
(to be circulated)	**3.2**	**CEO Report**	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 **Proposed Motion:** Be it resolved that the CEO Performance Review Tool be approved as submitted**.** • Selection of participants for performance review feedback	D Cheperdak	5 min		
(attachment)	**4.2**	**Top Chef Canada – Proposal and feedback**	D Fontaine	15 min	**D**	**1.1 + 1.3 + 2.1 + 2.2 + 2.3**
(attachment)	**4.3**	**Sponsorship Policy – Revera proposal**	L Monrad & D Fontaine	10 min	**D**	**n/a**
(attachment)	**4.4**	**BCCPA Lease at 1338 West Broadway** **Proposed Motion:** Be it resolved that the Association seek to sublet current property and proceed to find premises to accommodate BCCPA and SafeCare BC.	D Fontaine	10 min	**A**	**3.1**
	4.5	**Membership Support Programs**	D Fontaine	5 min	**D**	**1.5 + 1.2 + 1.4**
(attachment)	a	Consultant Report – Patrick O'Connor	Guest: P O'Connor *@ 1:30 pm*	15 min	**D**	**1.5 + 1.2 + 1.4**
(attachment)	b	BC Non Profit Housing Association (BCNPHA) (Tony Roy, Executive Director & Jacqui Mendes, Dir Member Services & Admin)	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**	A Van Ryk	5 min	**I**	**1.4**
(attachment)	**5.2**	**Annual Conference Update**	D Fontaine	5 min	**I**	**1.3 + 4.2**
	5.3	**Standardized Contract Working Committee**	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: Proposed Motion:** Be it resolved that the Board approve the recommendations of the 2013 Awards Committee as circulated.	D Marasco	5 min	**I**	**2.3**

Notes	ITEM #	TOPIC	PRESENTER	TIME	* Action required	Strategic Goal
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

BOARD MEETING MINUTES

Thursday November 21, 2013 – 9:30 am IN-PERSON
BCCPA Boardroom 301 – 1338 W Broadway, Vancouver BC

In attendance:	David Cheperdak, Al Jina, Aly Devji, Elaine Price, Will McKay, Mary McDougall, Andre Van Ryk, Sue Emmons, Liz Dutton
Via tele-conference:	Isobel Mackenzie, Donna Morasco, Ron Pike, Bob Attfield (left at 11:10)
Not in attendance:	Azim Jamal, Liz Monrad

AGENDA

David Cheperdak convened the Membership Review Committee; being comprised of all Board members.

1.1 Approval of Consent Agenda:

- October 17, 2013 minutes as circulated.
- October Motions as circulated to Board members by email.
- Membership Review Committee

Motion: Be it resolved that the consent agenda be approved in its entirety.

Moved by: Sue Emmons Seconded: Al Jina **APPROVED**

1.2 Membership Review Committee

Motion: Be it resolved that the new members be accepted as received with the addition of Howe Group and De Jager Volkenant & Company.

Moved by: Sue Emmons Seconded: Al Jina **APPROVED**

1.3 Approval of Agenda

Proposed Motion: Be it resolved that the agenda be approved in its entirety.

Moved by: Mary McDougall Seconded by: Elizabeth Dutton **APPROVED**

STANDING REPORTS

2.1 Financial Report

Andre reviewed the Financial Statements as submitted, elaborating on key items for the Board.

- First installment of the SafeCare BC contract has been received in November.

Approved by:

CEO Director

- Separate financials will be set-up for SafeCare BC in new year.
- First Care to Chat complete – revenue is positive for these sessions.
- New budget figures will be noted on next financial statements.

The Financial Statements were accepted as submitted.

PROPOSED AGENDA ITEM FOR NEXT MEETING: Board to have a general discussion about Association membership. This discussion will be a precursor to the upcoming review of the Association dues structure.

2.2 CEO Report

Daniel introduced Keivan Hirji, recently contracted to assist with events and communications for SafeCare BC and BCCPA.

Daniel reviewed his report and clarified questions from Board members.

The following comments were noted:

- Suggestion: 2014 Ministers Lunch – comp tickets to HA (2 per HA)
- Suggestion: Care to Chat -provincial outreach – technology for remote areas
- BC Care Day in Victoria – as many BOD members as possible.
- Awards Committee – to be reviewed at Jan Meeting.
- (Suggested campaign: Draw to get employees to tweet/facebook – win trip for two to awards ceremony in Victoria)
- D Fontaine care aide for day at Elim Village
- (Tie CEO report items to strategic plan)

PROPOSED AGENDA ITEM FOR NEXT MEETING: Strategy discussion regarding improved future HA's engagement
PROPOSED AGENDA ITEM FOR MARCH MEETING: Include final Core Review Report (Heather//Rebecca)

NEW BUSINESS

3.1 Board Vacancy (Vancouver Island)

David Cheperdak reminded the Board that the Vancouver Island position is available should the Board wish to appoint a member prior to the next AGM.

Following discussion it was agreed to leave position vacant until the May 2014 AGM.

3.2 Future Meeting Dates

The board discussed the merits of future board meeting schedule submitted. The following comments were noted:

- Board policy needs to align with any changes to the Board meeting schedule - Governance Committee to address.

Approved by:

CEO Director

- A lot of business being conducted currently – may need more time for meetings.
- Noted that committees are active between meetings working on specific items.
- March 20 (spring break) – David/Daniel to consider re-schedule of this date.
- Board members in agreement to try schedule until new fiscal year.

Motion: Be it resolved that the meeting dates be approved up to May 2014 as circulated.

Moved by: Sue Emmons Seconded: Elaine Price **APPROVED**

CONTINUING BUSINESS

4.1 Governance Review Task Group

a. Recommendations & Update

The Board suggested the following items/suggestions be reviewed/incorporated:

- Add language regarding function carried out as to matrix of the Board (skills levels etc)
- Board effectiveness
- Move # 5 from Executive TOR to Governance TOR
- Note on Executive and Governance OR indicating CEO is non-voting
- Annual CEO review to be added to Executive Committee point #6
- CEO review: Meeting requirement - one meeting annually and at the call of the Chair Governance or executive)
- Executive TOR # 6 – move to Governance.
- Each committee to meet annually and at the call of the chair (add)
- 7.0 - change wording to "preferred" to have sat on……"
- 8.0 - Change language: instead of "they are" should be "he/she"
- Policy – need to be on BOD for at least one year to be on executive – check that it is included.
- Clarification: Meeting following AGM – elect officers as per governance committee recommendations (to be reviewed by BOD in advance of AGM)
- Clarification as to procedures when multiple interest in position (ie. VP)
- (Terms of reference to include CEO review)
- 10.0 change wording ….. "each HA should be represented where members reside"

Motion: Be it resolved that the recommendations from the Governance Task Group be approved with amendments as request by the Board of Directors.

Moved by: Elaine Price Seconded: Sue Emmons **APPROVED**

PROPOSED AGENDA ITEM FOR NEXT MEETING: Review/determine number of terms for Board members and/or executive.

Approved by:

CEO Director

b. **Association Policy Review**

The Board discussed the three Policy changes brought forward:

i Election of Executive Policy (first adopted Sept 2003)

ii. Nominating (governance) Committee Policy (first adopted Nov 2003)

iii. At Large Director Policy first adopted July 2006) be discontinued.

Comments:

- MATRIX notes: "voting member" representation rather than stakeholder
- Remove Northern?

PROPOSED AGENDA ITEM FOR NEXT MEETING: The Board agreed to bring these items forward with amendments discussed on the consent agenda for the next meeting.

MOTION: Be it resolved that the Governance Task Force be dissolved and work transferred to Governance Committee.

Moved by: Aly Devji Seconded: Mary McDougall APPROVED

David asked for volunteers to participate on the Governance Committee. The following members volunteered:

- Sue Emmons
- Mary McDougall
- Isobel Mackenzie (to be confirmed)

4.2 **Best Practice Guide – Partnership with OLTCA**

Daniel/Heather updated the Board on this project. The following suggestions were made by the Board:

- Review of software for rec therapy available
- Contact schools - Recreation Therapy (Steinberg college)

4.3 **HEABC Negotiating Mandate Position**

Information received as circulated.

4.4 **BC Care Provider Day – Delegation – February 19 2014**

Daniel updated the board on progress of this event to-date noting that the event will be held at the Fairmont Empress - more information to come.

Daniel encouraged all Board members to mark this in their calendar as their participation is needed to make this a successful event.

Approved by:

CEO Director

4.5 BC Budget Submission

Daniel reviewed the information submitted and following discussions and suggestions it was agreed that Daniel will discuss further with Board members and bring forward to next meeting.

4.6 Association Partnerships Update (BCSLA + DHA)

David updated the Board on recent meetings with DHA. Liz Dutton noted that she had received very positive feedback on shared initiatives from DHA and members.

It was suggested that ways to include DHA members be considered for future initiatives.

BOARD COMMITTEE REPORTS

5.1 Annual Conference Update

Information received as circulated.

5.2 Standardized Contract Working Committee

Item deferred to next meeting.

5.3 SafeCare BC Update

a. ***Implementation Working Committee*** - Jennifer Hystad, Howe Group provided the Board with an update on actions taken to date.

Daniel noted that he has received positive response from DHA regarding the progress and structure SafeCare BC.

b. ***Hiring Committee Update*** – Jennifer reported on the process taken to-date and the positive response received from applicants for the Executive Director position. Interview of final selection will take place in early December.

Liz Dutton noted that the committee would like to review final selection with the Board of Directors by December 18th.

The Board agreed that a conference call meeting could be arranged to accommodate the approval/selection of the final candidate.

5.4 Awards Committee

Information received as circulated. Donna Morasco and Al Jina agreed to sit on the committee along with Daniel Fontaine.

MOTION: Be it resolved that Awards Committee terms of reference and guidelines be approved as circulated.

Moved by: S Emmons Seconded: D Cheperdak APPROVED

Approved by:

CEO Director

Upcoming Events

- Christmas Open-House – Thurs Dec 5, 2013
- Care to Chat Series #2 – Jan 22 2014
- Victoria BCCPA Day – Feb 19 2014
- Care to Chat Series #3 – Mar 12 2014 (tbc)
- BCCPA Annual Conference – May 25-27 2014
- CALTC Conference – Aug 24, 25, 26 2014 (Hosted by BC)

Adjournment + Next Meeting

The meeting was adjourned at 12:15 pm.
The next meeting is scheduled for **January 16, 2014** in-person, BCCPA Boardroom.

Minutes approved by:

_____
Signature

Daniel Fontaine, CEO

_____
Director Signature

_____
Director (Print Name)

301 - 1338 West Broadway
Vancouver BC V6H 1H2
www.bccare.ca

Approved by:

_____ _____
CEO Director

BCCPA BOARD MEETING MINUTES

Thursday December 18, 2013 – 10:00 am
via Conference Call

IN-CAMERA MEETING

In attendance:	David Cheperdak, Al Jina, Aly Devji, Elaine Price, Will McKay, Mary McDougall, Andre Van Ryk, Sue Emmons, Liz Dutton Bob Attfield
Regrets:	Azim Jamal, Liz Monrad, Isobel Mackenzie, Donna Morasco, Ron Pike

1 Recommendation of the SafeCare BC Hiring Committee

Recommendations were presented by Liz Dutton, Chair of the SafeCare BC Hiring Committee. The board reviewed and discussed the information provided.

Motion: Be it resolved that the Board recommend to the new SafeCare BC Society the hiring of Jennifer Lyle as the Executive Director for SafeCare BC.

Moved by: Will Mackay Seconded: Sue Emmons **APPROVED**

MEETING ADJOURNMENT

The meeting was adjourned at 11:00 am.

Minutes approved by:

_____
Signature

Daniel Fontaine, CEO

_____
Director Signature

_____
Director (Print Name)

Approved by:

CEO Director

BC CARE PROVIDERS ASSOCIATION
Advocating service excellence for seniors

301 -1338 West Broadway
Vancouver, BC V6H 1H2
Telephone: (604) 736-4233
Fax: (604) 736-4266

SECTION: ASSOCIATION POLICY	**TOPIC: ELECTION OF OFFICERS**
	PAGE: 1 OF 2
AUTHORIZATION: BOARD	**DATE ADOPTED: SEPTEMBER 2003**
	REVISED DATE: January 16 2014

The Executive Positions of the Association will be elected at the first Board meeting following the Annual General meeting. The Executive Positions include:

President
Past-President (if still a member of the Board)
Chair, Finance & Audit Committee (Secretary-Treasurer)
Chair, Governance Committee (Vice-President)
CEO – Staff representative

PROCESS PRIOR TO ELECTION

To ensure that all Board members are familiar with the process and that every effort is made to ensure reasonableness and unanimity, the following process will be followed:

- The members of the Existing Board will be advised that the first Board meeting of the new Board will be held immediately after the Annual General Meeting or an alternate date will be specified.
- All Board members will receive written notice in advance of the date, time, and location of this meeting. An agenda listing the selection of the Executive as the major point of business will be provided. This will include the election of President, Chair of the Finance & Audit (Secretary-Treasurer), Chair of the Governance Committee (Vice-President).
- Board members who are not able to be present at the scheduled Board meeting that includes the election of Executive Officers, will be able to provide their proxy vote to another Board member.
- The signed proxy is required to be completed and submitted to the CEO in the form outlined below:

I _____ (the undersigned), a duly elected member of the Board of Directors of BC Care Providers Association, hereby provide my proxy vote to _____ (a duly elected member of the Board of Directors) to vote for and on behalf of myself at the Board meeting to be held the _____ day of _____, 2____, for the selection of the Executive Officers of the BC Care Providers Association.

Signed this _____ day of _____, 2___.

_____

(Signature)

SECTION: ASSOCIATION POLICY	**TOPIC: ELECTION OF OFFICERS**
	PAGE: 2 OF 2
AUTHORIZATION: BOARD	**DATE ADOPTED: SEPTEMBER 2003**
	REVISED DATE: n/a

- The President of the BCCPA will be serve a maximum two-year term, but shall be elected each year. Before assuming the position, it is preferred he/she has sat as a voting member on the Executive Committee for a minimum of one year.
- The Vice-President will be elected in the context of a succession plan with the intention of being elected as president once the current president has completed their term.
- The Governance Committee will provide recommendations for the next term's Executive positions to the Board Board at the final Board meeting prior to the Annual General Meeting. Board directors must have served a minimum of one year prior to seeking an Executive position.

PROCEDURE FOR ELECTION:

The election process at the Board Meeting for the selection of the Officers will be as follows:

I Call for nomination(s) for the position of President:

a. Confirm nominee(s) are willing to stand.
b. If more than 1 nominee - ballots circulated and counted.
c. Position elected.

II Nomination(s) for Vice-President :

a. Confirm Nominee(s) are willing to stand.
b. If more than 1 nominee - ballots circulated and counted.
c. Position elected.

III Nomination(s) for Secretary Treasurer

a. Confirm Nominee(s) are willing to stand.
b. If more than 1 nominee - ballots circulated and counted.
c. Position elected

Related Policies: Nominating Committee

BC CARE PROVIDERS ASSOCIATION
Advocating service excellence for seniors

301 - 1338 West Broadway
Vancouver, BC V6H 1H2
Telephone: (604) 736-4233
Fax: (604) 736-4266

SECTION: ASSOCIATION POLICY	**TOPIC: NOMINATING COMMITTEE**
	PAGE: 1 OF 2
AUTHORIZATION: BOARD	**DATE ADOPTED: NOVEMBER 2002**
	REVISED DATE: January 16, 2014

COMMITTEE STRUCTURE

The Governance Committee consists of the, Vice-President (Chair), CEO (ex-officio), plus up to three other currently serving Board Directors. The CEO will serve as a non-voting staff representative.

The Governance Committee shall perform the duties of Nominating Committee.

The Nominating Committee shall be a sub-committee of Board. It shall discharge all duties with respect to overseeing the nomination process for seeking members to stand as Board Directors.

The Nominating Committee shall report to the Board and ensure that the elections to the Board of Directors are conducted according to the Societies by-laws.

The Committee shall monitor when positions of the Board expire and submit nominations to the Board and membership in accordance with policies determined by the Board.

FUNCTION

The Nominating Committee shall:

1. Propose at least one candidate for election to fill vacancies for the Board of Directors as they arise. Proposed candidates will have demonstrated understanding of the purpose and role of a Board Director and can provide the best possible potential for providing visionary leadership and direction for the Association;
2. Ensure that an integrated slate of candidates is presented for election to vacancies for the Board of Directors;
3. Keep in mind the need for the various committees and to be as broadly representative of the membership and the need for specialist expertise in some committees;
4. Ensure the Matrix (Appendix 1) is used to guide their recruiting efforts.

NOMINATIONS AND SUCCESSION PLANNING PROCEDURES

The Nominating Committee will be responsible for the filling of vacancies, both for officers and directors, at the AGM. The Committee will:

1. Routinely and as necessary, receive from the CEO a detailed list of the vacancies that must be filled.
2. Routinely publicize to the membership any vacancies, and call for nominations to be given in writing to the Chair of the Committee; all nominations must have the consent of the nominees.

3. Canvass the current Board to determine the number of vacancies to be filled.
4. Canvass the current Board for the skills, attributes and characteristics needed to complement the existing Board.
5. Canvass of the current Board for possible nominees that fit the desired profile.
6. Develop a list of potential nominees will be interviewed. In addition to the current skills/attributes and characteristics, all potential board members must be prepared to sign both a Conflict of Interest Statement and Oath of Confidentiality.
7. Canvass the Board for nominations from the current Board to fill the officer positions.
8. Present the nominees for election at least 90 days prior to the Annual General Meeting.
9. Seek candidates who represent the following critical areas:
    - The Health Authorities where members reside
    - Home and Community Care:
        - Residential care
        - Home care
    - Denominational
    - Assisted Living
    - For profit
    - Not for profit

Related Policies: Election of Officers

APPENDIX 1
Policy – Nominating Committee
Date: January 16, 2014

BC Care Providers Association
Board Membership Matrix

A Board of Directors annually recruits new members and, as such, replaces skills and expertise brought to the table by incumbents. The following matrix defines the mix of skills, characteristics and voting member representatives seen to be necessary and desirable to have on the Board of the BCS.

SKILLS
- Financial management
- Legal
- Communications/public relations
- Health care (delivery, research and/or education)
- Government relations
- Leadership
- Business relations/development
- Fundraising

VOTING MEMBER
- Each Health Authority should be represented
- Home and Community Care
- Residential care
- Home care
- Denominational
- Assisted Living
- For profit
- Not for profit

CHARACTERISTICS
- The Board will actively seek diversity in its composition. Specifically, diversity for this purpose is broadly defined to include gender, ethnicity, age, ability, business experience, functional expertise, personal skills and stakeholder perspectives.
- The Board will actively ensure it reflects the interests of its membership in every region of the province.

In addition to the above, following is a list of desirable attributes for individuals joining the board of directors.

ATTRIBUTES

- Ethical
- Team player
- Sense of humour
- Community contacts
- Community profile
- Board experience

Revised: January 2014

Item 1.1.d.

Executive Committee

Terms of Reference

RESPONSIBLE TO: Board of Directors

MEMBERSHIP:
President
Past-President (if still a member of the Board)
Chair, Finance & Audit Committee (Secretary-Treasurer)
Chair, Governance Committee (Vice-President)
CEO – Staff representative – non-voting

MEETINGS: One meeting required annually and additional meetings at the call of the chair.

QUORUM: A simple majority shall constitute a quorum

Responsibilities:

1. Recommend an annual process for developing and reviewing the Association's Strategic Plan.
2. Conduct the annual CEO performance review.
3. Deal with duties or matters delegated to it by the Board in the intervals between meetings of the Board.
4. Dealing with issues or matters which may arise and for which a specific committee of the Board is unavailable or had not been struck.
5.

Date: January 16, 2014

Item 1.1.d.

Governance Committee

Terms of Reference

RESPONSIBLE TO: Board of Directors

MEMBERSHIP:

Vice-President (Chair)	
Members (max 3)	Appointed by Board
President:	Ex-officio
CEO (non-voting)	Staff Representative

MEETINGS: As determined by the committee

QUORUM: Three voting members

FUNCTIONS:

The committee's general duties are to monitor and review the legal parameters, structures, and obligations of those legal entities operating as BC Care Providers Association as well as their by-laws, regulations and Board Policies.

The committee shall also be responsible for the annual recruitment of candidates for the Board and maintaining a succession plan for leadership on the Board.

One meeting required annually and additional meetings at the call of the chair.

Responsibilities:

1. Review existing constitution and by-laws and recommend appropriate changes to the Board;
2. Evaluate specific issues and recommend any new bylaws or policies as necessary;
3. Evaluate effectiveness of Board policies and regulations and recommend any changes as necessary;
4. Work to maintain consistency amongst various by-laws, policies and regulations;
5. Facilitating an annual assessment of the effectiveness of the Board and its committees.
6. Periodically reviewing and recommending good governance practices to the Board.

The Governance Committee shall also act as a Nominating Committee for the purpose of actively recruiting candidates for the Board of Directors who are committed to the mission and governing process of the BC Care Providers Association; and who collectively will represent the broad geographic and demographic diversity of its membership.

Date: November 21, 2013

BC CARE PROVIDERS ASSOCIATION www.bccare.ca

Advocating service excellence for seniors

OUR VISION

The BC Care Providers Association delivers effective leadership and valued resources that support progressive change, promoting the growth and success of its members

ITEM 1.1.f

STRATEGIC PLAN 2013 – 2016 – Update Jan 16. 2014

In Development
On Track
Caution
Off Track

Progress Status

STRATEGIC GOAL #1: Strengthen Value Proposition for Members

OBJECTIVES	Acc'ability	20013-14 Target	3 Year Target – 2015/16	Outcome Indicators	Progress	Comments
1.1 Ensure members have increased access to better tools and resources	CEO	Develop a new member-only library and resource section on the BCCPA website	Increase the quantity and quality of resources available through password protection.	Increased positive feedback from members regarding access to resources. Members increasingly using the BCCPA website to download resource materials. Web traffic on the member only portion of the website increases by 10% per year.		A new member only section of our website is now operational. We are getting a good number of hits and logins to various posts and resources. More work remains on increasing the overall number of posts and quality of information.
		Produce an instructional set of online modules aimed at demystifying the different levels of care provided. Seek out partner funding	BCCPA YouTube page is used extensively by our members as a training and resource tool. Secured partner funding to work on member resource project	People are sharing these resources through social media Media using it as a resource and incorporating into stories Positive feedback from family members and external stakeholders External stakeholders willing to co-fund the project Over 1,500 views as tracked by YouTube or equivalent.		We have met with MoH in late 2013 to discuss possible partnership. They are reviewing budgets to determine feasibility.
		Seek out and obtain another resource from other regions that can be re-purposed for use in BC.	Develop one in-house resource as well as re-purposed two additional resources.	We have collaborated with CALTC partners on at least one of these projects.		We are seeking to obtain access to new communication toolkits being produced in Ontario region. We will try and adopt for use in BC in 2014.
1.2 Ensure fee and benefit structure is conducive for growth in membership	CEO	Undertake a fee structure review in consultation with current and potential new members. Establish and conduct baseline customer service and value for money survey with members.	Grow our commercial membership annually by 5% Grow our facility members by 5% annually. Ensure BCCPA represents at least	Growth in new members who have never joined before. Growth in renewal by members who have had membership lapse more than two years		Board discussion on the value of membership to take place at January Board meeting. Work is currently being undertaken to determine how we can possibly use affinity programs to help fund long-term growth in membership to meet targets.

BC CARE PROVIDERS ASSOCIATION www.bccare.ca

Advocating service excellence for seniors

In Development
On Track
Caution
Off Track

Progress Status

STRATEGIC PLAN –2013 - 2016

OBJECTIVES	Acc'ability	20013-14 Target	3 Year Target – 2015/16	Outcome Indicators	Progress	Comments
			80% of all HomeCare services Over 90% of members satisfied with services and resources available through BCCPA	Satisfaction surveys indicate BCCPA is either maintaining or increasing customer satisfaction levels. BCCPA represents a greater % of the overall sector compared to 2013.		We are developing a member survey to be sent out annually. It may be distributed as early as this spring.
		Conduct exit surveys with non-renewing members.	Ensure 80% of BCSLA members who provide assisted living services are also members of the BCCPA	Fewer members identifying high fee structure as reason for leaving BCCPA.		Will be drafting survey and will send to members who had their memberships lapse at end of 2013. We will also survey former members who have left BCCPA over last 5 years to find out why they left, and what it would take to get them back as members. Preliminary results should be available in spring/summer 2013.
1.3 Increase opportunities for member engagement	CEO	Develop a new speaker series. Host three sessions in Lower Mainland.	Host a minimum 10 speaker sessions with at least 25% outside Lower Mainland over three years. Ensure adequate topic representation for Homecare	Members submit future topic ideas Attendee satisfaction increases regarding our choice of topics, frequency of events, venue etc Active audience participation An increase in ticket price does not result in lower attendance Event is independently promoted by third parties We attract new sponsors and increase overall revenue		Our first Care to Chat speaker event was held in November. The event was sold out with approximately 150 attendees. The second Care to Chat event has already sold over 100 tickets and will take place on January 22. The third Care to Chat is being planned for early April. The final event will take place to close out our annual conference in Whistler. We will assess how this first series went with a goal of providing better province-wide access in the next round for 2014/15. Approximately 20-25% of attendees have been non-

In Development
On Track
Caution
Off Track

Progress Status

STRATEGIC PLAN –2013 - 2016

OBJECTIVES	Acc'ability	20013-14 Target	3 Year Target – 2015/16	Outcome Indicators	Progress	Comments
				Significant non-member participation More robust and accurate stakeholder database		members. The events are self-funded and costs are being covered through ticket sales and sponsorships.
		Conduct regional facility member consultation sessions. Conduct consultation session with HomeCare members. Conduct consultation session with commercial members at the Annual Conference.	Conduct annually regional facility member consultation sessions Conduct annual consultation session with HomeCare members. Regularly conduct consultation session with commercial members at our annual conference.	Active member participation in each event in each region. BCCPA receives a fair number of suggestions and ideas we can incorporate into future planning.		Four separate conference calls were conducted with our membership last fall in each of the Health Regions. There was low participation, therefore more should be done to promote and increase engagement. Plans are underway to conduct a special consultation session with commercial members at the May conference.
		Undertake to more actively engage non-board directors involved in committees, task forces and other special projects	Non-board members who participated in BCCPA activities seek out positions on the board. Use this strategy to support our overall succession plan for retiring board members.	Increased response rate to requests for volunteers to support BCCPA activities Unsolicited requests for get more involved. Broader participation of non-directors outside of the Lower Mainland. Non-board members use volunteer work as a stepping stone to secure position on the BCCPA board.		The Governance Committee has been established and will be considering this in their recommendations to the board and membership. Two commercial members are now on the Annual Conference Committee. One non-board member is also on the committee. Seven non-board members are on the Care Aide Registry Subcommittee.
1.4 Optimize the size of organization	CEO	Increase membership base by a minimum 5%	Increase overall membership by 15% over three years.	The BCCPA does not need to increase association dues as a result new revenue. Revenue growth outpacing annual		There is limited capacity within the current staff structure to reach out to non-members and increase growth. Work is being done to determine how the

BC CARE PROVIDERS ASSOCIATION www.bccare.ca

Advocating service excellence for seniors

In Development
On Track
Caution
Off Track

Progress Status

STRATEGIC PLAN –2013 - 2016

OBJECTIVES	Acc'ability	20013-14 Target	3 Year Target – 2015/16	Outcome Indicators	Progress	Comments
				costs.		establishment of new affinity programs could fund additional support to facilitate and encourage increased membership in BCCPA during this period.
		Maintain a renewal rate of 85% or higher.	Maintain a renewal rate of 90% or higher	The BCCPA limits need to increase association dues as a result diversified revenue strategy. Revenue growth outpacing annual increased costs.		CEO has been making personal phone calls/emails to members who are about to lapse. Our renewal rate for facility members should exceed our 85% target in 2013. Association dues have not been increased in the last several years…nor are they anticipated to rise in 2014 – this is despite increasing staff capacity and scope of activities in 2013.
		Gather necessary data to provide compare BCCPA to other similar organizations.	Board better understands how BCCPA compares to other similar industry associations.	We are able to better speak to whether BCCPA is within the "norm" when it comes to size, strength of voice for an organization our size.		Nothing to report in this area yet as this is in early stages of development.
1.5 Diversify funding sources	CEO	Increase by 5% new non-dues and non-conference related revenue	Increase by 10% new non-dues and non-conference related revenue by end of 2015/16 Increase our capacity to broaden service offerings to members without having to increase pressure on association dues.	More companies willing to invest in BCCPA core products and events. Reduced pressure to increase association dues. Easier to undertake special projects requiring new funding.		We have been able to secure additional non-dues revenue through new sponsorships and contract management for SafeCare BC. We should be in a position to meet or exceed our 5% target in 2014. New resources dedicated to increasing our overall sponsorships and participation in affinity programs should also help us reach this target.

BC CARE PROVIDERS ASSOCIATION www.bccare.ca

Advocating service excellence for seniors

In Development
On Track
Caution
Off Track

Progress Status

STRATEGIC PLAN –2013 - 2016

STRATEGIC GOAL #2: Effectively Manage our Brand and Reputation

OBJECTIVES	Acc'ability	2013/14 Target	3 Year Target – 2015/16	Outcome Indicators		Comments
2.1 Become respected thought-leader and policy resource for continuing care sector in BC	CEO	Regularly draft and submit opinion pieces to BC dailies and/or public policy journals to raise our profile with decision-makers. Develop a research strategy and workplan. Work with Mitacs in order to hire top researchers in order to better link us to wider academic community.	BCCPA appears frequently on the opinion pages of BC's major dailies. Develop our own unique research that we can share with members, the media and public Develop another successful resource tool similar to the Anti-psychotic best practices guide.	Our grant applications are approved We are approached to partner on a project with an external agency Our OpEds increasingly get published by respected dailies or policy journals We are cited by a stakeholder or media in the public domain. Some of our research is peer-reviewed. Receive unsolicited requests from media wanting comment on more policy-focused stories.		We continue to draft regular opinion articles and are being approached by media to comment on a number of care home related issues. We have secured partner funding with the OLTCA to develop a new Recreational Therapy Best Practices Guide which will be launched in 2014. Work will get underway in February/March. Our Director of Policy has develop a research strategy and work plan which will be incorporated into our 2014/15 Operating Plan. Mitacs will be submitting our application to hire an intern to work on our new best practices guide. It must be peer-reviewed prior to approval.
2.2 Develop effective communication strategies	CEO	Draft a communications plan for review by the Board	Annual development and review of the strategic communications plan. Increase our communications capacity by jointly hiring a communications officer/contractor in partnership with SafeCare BC.	Significant earned media Widespread use of communication tools and resources by members. Public expectations and attitudes re delivery of seniors care are more aligned with sector's ability to deliver More balanced media coverage of "hot spot" issues Ability to better utilize 3rd party		The 2014/15 Communications Plan will be presented to the board in April.

In Development
On Track
Caution
Off Track

Progress Status

STRATEGIC PLAN –2013 - 2016

OBJECTIVES	Acc'ability	2013/14 Target	3 Year Target – 2015/16	Outcome Indicators		Comments
				stakeholders willing to validate industry Better "real time" communications and we are very engaged on social media Better prepared to handle issues in the news		
2.3 Regularly advocate, engage and educate key decision-makers and thought-leaders	CEO	Host the first annual BC Care Providers Day in Victoria in Feb 2014. Regularly meet quarterly with key representatives from VIHA, FHA, VCHA, IHA and MoH to discuss ideas, concerns and opportunities. Develop a strategy to engage BC's MLAs in order to educate them on the continuing care sector. Develop a working partnership with one of BC's main research universities Include 3rd party stakeholders in more of our external communications. Work effectively with Minister of Finance, Minister of Health and other key cabinet members to ensure they are aware of what we believe should be government fiscal priorities and opportunities	Regularly involve BC Premier and/or Leader of the Opposition with BC Care Provider Day (BCCPD) events in Victoria. Ensure active participation and engagement with BC's Seniors Advocate. Annual event in Victoria is well attended by MLAs, political staff and key cabinet members. Create opportunities to engage and have dialogue with MoH staff above the executive director level. Apply for and receive partnership funding from MoH on a joint project. Regularly receive invites from MoH and/or HAs to provide feedback or make presentation on a various issues/topics. Have the capacity to tailor information we provide by region to key decision-makers.	Government and Seniors Advocate use our submissions to shape future public policy and/or recommendations Government seeks out our advice prior to implementing and/or amending policies and regulations More streamlined access to senior administrators within the MoH Decision-maker's expectations regarding ability for sector to deliver care are aligned with our ability to respond. Invitation lists for key events are comprehensive and include all identified stakeholders. BCCPA regularly responds to requests for feedback such as the annual Ministry of Finance budget submissions. We are asked by stakeholders to be included in their news releases or publications as 3rd party validator.		Almost 20 MLAs have already confirmed their attendance at our 1st Annual BC Care Provider Day in Victoria. Premier of BC was invited to hand out an award, but she is unable to attend. Quarterly meetings took place last fall with VIHA, Vancouver Coastal and FHA. Work is being undertaken to ensure regular meetings with IHA in 2014. Meetings are being established with a number of MLAs to educate them about our sector. We also plan to hold info-breakfast sessions between Feb-June. Work is underway to develop a new Minister's Continuing Care Council to be launched in the Fall 2014. CEO - Member Reports are now being sent to all key representatives in MoH and Health Authorities. BCCPA was cited in the news release announcing the hiring process for BC's new Seniors Advocate. Work is underway to more closely involve HA and

In Development
On Track
Caution
Off Track

Progress Status

STRATEGIC PLAN –2013 - 2016

OBJECTIVES	Acc'ability	2013/14 Target	3 Year Target – 2015/16	Outcome Indicators		Comments
		for efficiencies.				MoH staff at our upcoming Annual Conference and Care to Chat events. They will be invited to speak on various panels and provide their expertise. BCCPA attended Deputy Minister's dinner in Victoria organized by BC Chamber of Commerce. President was at DM for Health table. BCCPA met with SFU professor to discuss research collaboration and Surrey's Innovation Boulevard.
2.4 Develop better education strategies for residents and family members in order to better align their expectations with our ability to deliver	CEO	Provide access to better online and print materials that have sector-wide application. Begin work with new Seniors Advocate to develop strategies that can address issues related to heightened expectations Provide access to additional stories and information via BCCPA website. A focus will be placed on highlighting role of family councils and challenges faced by front-line workers. Seek out and secure a partner to co-fund a series of online modules to help act as a resource for family members seeking to learn more about the types of care available.	Develop better educational modules aimed at "demystifying" the continuum of care for use by family members and media. Complete a joint project with the Office of the Seniors Advocate Regional representatives from local family councils and seniors will be more engaged in the development of educational materials	Seniors Advocate promotes BCCPA as a resource for information to families. More balanced media stories regarding what type of service a senior has contracted with a facility to receive vs what their family thought was provided. Health Authorities feel in a better position to defend decisions made by non-government service providers. More family members willing to speak out in support of care providers. Non-government service providers continue to rate higher satisfaction levels compared to HA run facilities		Not able to provide additional details at this time.

BC CARE PROVIDERS ASSOCIATION www.bccare.ca

Advocating service excellence for seniors

In Development
On Track
Caution
Off Track

Progress Status

STRATEGIC PLAN –2013 - 2016

STRATEGIC GOAL #3: Maintain a Focus on Quality

OBJECTIVES	Acc'ability	2013/14 Target	3 Year Target – 2015/16	Outcome Indicators		Comments
3.1 Support development of SafeCare BC and other workplace injury prevention initiatives	CEO	Draft and sign a contract with WorkSafe BC. Develop an action plan and strategy to ensure Board is established and founding meeting takes place in May 2014. Identify and secure opportunities for shared services and reduced costs with SafeCare BC.	BCCPA and SafeCare BC remain co-located and operate through an array of shared services. Better control operating expenses due to shared services opportunities. Continue to hold joint AGMs at our Annual Conference.	WorkSafe BC willing to continue direct working relationship with BCCPA Better flexibility to use operating budget for new initiatives and pilot projects Workplace injuries begin to level off and show early signs of declining. SafeCare BC is governed independently, but continues to co-locate and use shared services. Over 75 attendees at founding meeting held in May 2014 in Whistler, BC. WorkSafe BC confirms we have met deliverables as set out in the original contract. SafeCare BC has well established board governance and is providing valued service to its members.		Contract was signed with WorkSafe in October 2013. Action Plan was developed and approved by the Board in the fall. BCCPA has identified and secured opportunities for shared services with SafeCare BC. New Executive Director recruitment process almost complete and they should be starting on Feb 3, 2014. New SCBC website ready to launch in January. SCBC database cleaned and updated in December. New by-laws and constitution to be submitted for new SCBC society in January. New interim board to be established. Work has begun to organize the SCBC founding meeting in Whistler in May.

BC CARE PROVIDERS ASSOCIATION www.bccare.ca

Advocating service excellence for seniors

In Development
On Track
Caution
Off Track

Progress Status

STRATEGIC PLAN –2013 - 2016

OBJECTIVES	Acc'ability	2013/14 Target	3 Year Target – 2015/16	Outcome Indicators		Comments
3.2 Advocate for reforms to the BC Care Aide Registry	CEO	Develop a strategy which will provide an alternative delivery model that can be shared with government. Work with 3rd parties who have a shared in interest in the future success and sustainability of the BCCAR Actively participate in the follow-up activities pertaining to the Murtagh Report. BCCAR agrees to allow out-of-province applicants register as of July 31, 2014.	The new model is in place and helping to effectively improve standards of care and remove abusive care aids from both private and public sector in a timely and cost-effective manner. The new model is truly cost-neutral to employers. The new model is self-sufficient in that care aides are now co-funding. BC Government agrees with BCCPA position of zero tolerance for abuse of seniors.	Institutional abuse decreases. BC being recognized by media for its proactive work in this policy area. No more loopholes exist in the system to allow abusive care aides access to seniors in care. We have moved beyond a "letter of understanding" into a more formal and inclusive structure that is more in line with a self-regulatory model. 3rd parties endorse our alternative model and/or suggestions to reform BCCAR.		Director of Policy and Research has been working on an internal task force for the last five months. A report including a series of recommendations is being drafted and will be submitted to the Board for review/action in the Spring. BCCPA asked by BC Care Aide Registry to submit feedback as part of fallout from Murtagh Report. We held a meeting last Fall with approximately 15 stakeholders to apprise them of deficiencies within the current registry.
3.3 Better utilize InterRAI to demonstrate comparability of our clients to those in HA facilities	CEO	Begin work to establish a workshop at the 2014 conference to help educate regarding impacts of InterRAI on funding decisions. Follow-up with CALTC re the development of an online training tool on how InterRAI can impact local care homes and funding. For example, work on a joint research with CALTC partners demonstrating need to reform InterRAI in order to better capture impacts of dementia.	InterRAI develops a new algorithm to reward care providers who improve quality of life. In partnership with CALTC, develop online resources for front-line staff in order that they more effectively utilize InterRAI. Increased funding for non-government service providers to support seniors in care with dementia.	MoH acknowledges that increased acuity due to dementia justifies additional resource allocation. CALTC partners see this as an issue important enough to undertake joint collaboration. We are able to quantify if there is a difference in acuity levels between government and non-government facilities. InteRAI better incorporates the impacts of dementia on human resource needs.		CALTC has not been very active the last several months. Therefore not much progress has been made on this file to date. Due to the complexity of this file, it may take a bit longer to get off the ground.

In Development
On Track
Caution
Off Track

Progress Status

STRATEGIC PLAN –2013 - 2016

OBJECTIVES	Acc'ability	2013/14 Target	3 Year Target – 2015/16	Outcome Indicators		Comments
				The gap closes between HA and NG care providers in relation to reported levels of acuity.		
3.4 Identify and transfer "Red Tape" dollars to front-line care	CEO	Undertake comprehensive industry analysis to identify key areas of red tape that are negatively impacting front-line care.	Produce annual progress report on our key recommendations that we will share with our members and media.	Government has accepted our recommendations and is moving to adopt them. Government pro-actively seeks out our opinion regarding opportunities to save costs and increase quality of care.		Red Tape Review underway and interim report ready for Board review in January. Final report will be submitted to government this spring. MoH and HA will be provided an advance copy in order to provide their own input – prior to public release.
3.5 Pro-actively lead the development of new tools and resources that will support the delivery of quality care	CEO	Commence needs analysis and development on our next "Best Practices Guide".	Develop an online training tool to support the more effective use of InterRAI by frontline staff Develop another "Best Practices Guide" in partnership with key stakeholders.	Frontline staff are incorporating our tools and resources into their daily operations. Website hits and downloads pertaining to these new tools shows significant activity.		The new Recreational Therapy Best Practices Guide has been approved by the Board last fall. Work/research to commence in Feb/March.

STRATEGIC GOAL #4: Enhance and Build New Relationships

OBJECTIVES	Acc'ability	2013/14 Target	3 Year Target – 2015/16	Outcome Indicators		Comments
4.1 Develop a more unified voice for the sector to government. -Lead and establish sector-	CEO	Undertake to develop a formal agreement to collaborate on key areas of common interest between the BCSLA and the DHA.	A formal cooperation agreement has been signed between the DHA and BCSLA in order to provide a platform for join collaboration and partnerships.	Government is no longer getting "mixed messages" regarding priorities from the sector. BCCPA would have a better		Exploratory meetings were established with both BCSLA and DHA. DHA and BCCPA submitted joint submission to HEABC regarding collective bargaining mandate.

In Development
On Track
Caution
Off Track

Progress Status

STRATEGIC PLAN –2013 - 2016

OBJECTIVES	Acc'ability	2013/14 Target	3 Year Target – 2015/16	Outcome Indicators		Comments
wide partnership initiatives		Establish the 1st Annual Minister's Luncheon in partnership with DHA and BCSLA		understanding of what all the key messages being delivered to government are from the various senior care associations. More of a willingness to partner on the part of all three organizations beyond stand-alone events. BCCPA regularly co-hosting events with DHA and BCSLA BCCPA participates in meetings to exchange ideas and share intelligence with DHA, BCSLA. DHA and BCSLA board members attend our annual Christmas Open House Worked in partnership with BCSLA and DHA to co-fund, develop family education modules. BCSLA, DHA, BCCPA host a joint annual conference. BCCPA representatives attend AGMs and/or conferences of the BCSLA and DHA		First Annual Minister's Lunch event a huge success. Almost 350 people in attendance and BCCPA netted approximately $3K in new revenue. DHA and BCSLA have agreed to host 2nd Annual Event in November 2014. Planning will get underway in the Spring. DHA and BCSLA board members/staff invited to our Christmas Open House. Several were in attendance.
4.2 Become a more effective and influential voice with Health Authorities and MOH	CEO	Develop a plan to regularly meet with key officials throughout the year.	BCCPA regularly consulted as HA and MoH develop key policies for implementation.	We are considered by HA and MoH as a partner, rather than a service delivery agent.		Regular meetings held VIHA, Vancouver Coastal and FHA. Work underway to establish better links with IHA.

BC CARE PROVIDERS ASSOCIATION www.bccare.ca

Advocating service excellence for seniors

In Development
On Track
Caution
Off Track

Progress Status

STRATEGIC PLAN –2013 - 2016

OBJECTIVES	Acc'ability	2013/14 Target	3 Year Target – 2015/16	Outcome Indicators		Comments
		Identify opportunities for BCCPA to work as partner vs an agency for funded service providers. Expand the opportunities to engage and provide direct feedback/advice beyond the Home and Community Care Council and regular MoH conference calls.	BCCPA considered a valued partners "at the table".	They adhere more strictly to the "no surprises" rule and ensure we are adequately consulted on a regular basis. More MoH and HA officials attend and actively participate at our Annual Conference. Share findings of BCCPA led research where applicable. BCCPA partners on pro-active projects such as Anti-Psychotic Best Practices Guide. MoH or HA co-fund. BCCPA meets at least once per year with MoH DM and/or ADM level staff.		BCCPA shared copy of letter sent to Minister of Finance regarding budget submission to Health Authorities – in advance of it becoming public. MoH and HA reps are indicating an interest in attending our Annual Conference and have been participating in our Care to Chat series. A special discounted rate has been established for MoH and HA reps who want to attend our conference and C2C. We plan to work with Health Authorities in the development of our new Recreational Therapy Best Practices Guide. Board President attended dinner hosted by DM for Health last Fall.
4.3 Undertake a more pro-Active and solution-oriented approach to issues	CEO	Identify opportunities to acknowledge publicly the positive work government is doing in key areas of interest. Establish a speaker series to highlight emerging issues. Better utilize our annual conference to develop solutions to challenges facing the sector Not only identify problems, but	Government is taking our solutions and beginning implementing them. Our sector is taking our solutions and voluntarily implementing them. Identify key areas where we have been able to self-regulate when government may have imposed a more costly and administratively complex "solution". Develop a new *Social Partnership*	Our sector is less reactionary. Government doesn't feel need to impose new regulations and policies. They are more open to industry attempting to solve issues first. Public perception of private providers has improved compared to baseline polling. Positive media and outcomes garnered from our *Social Partnership Fund*		Red Tape Review will be highlighting areas where MoH and HA have gotten it right. C2C speaker series now well underway. Annual Conference is putting a new focus on HomeCare…as well as developing a stream of workshops for workplace safety and residential care. A special Request for Speakers was distributed to all of our commercial members + beyond. This will be used by Annual Conference Committee to select speakers.

BC CARE PROVIDERS ASSOCIATION www.bccare.ca

Advocating service excellence for seniors

In Development
On Track
Caution
Off Track

Progress Status

STRATEGIC PLAN –2013 - 2016

OBJECTIVES	Acc'ability	2013/14 Target	3 Year Target – 2015/16	Outcome Indicators		Comments
		also develop and fund appropriate solutions. Advocate for more self-regulation where feasible.	*Fund* to allow for BCCPA to partner with small external partners undertaking innovations.			New Social Partnership Fund will be included in the 2014/15 Operating Budget.

STRATEGIC GOAL #5: Safeguard Member Viability and Sustainability

OBJECTIVES	Acc'ability	2013/14 Target	3 Year Target – 2015/16	Outcome Indicators		Comments
5.1 Provide direct influence regarding HEABC negotiating mandate	CEO	Prepare a submission to HEABC requesting more direct participation in establishing negotiating mandate	BCCPA will become a valued partner and will work more directly with HEABC to establish negotiating mandate	BCCPA has more influence into the collective agreement and helps to reduce inflationary pressures related to increased costs for human resources.		BCCPA continues to provide feedback into the collective bargaining process through the HEABC Affiliate Working Group. HEABC attended a board meeting to receive feedback regarding negotiating mandate. Reality is the Health Authorities continue to play a dominate role with non-government representatives often marginalized. Our window to influence the outcome of these negotiations is vary narrow. 5 year collective agreements are being negotiated. HEABC is indicating that the contracts will be fully-funded by Health Authorities – and they have done their best to ensure this will happen.
5.2 Establish openness and transparency regarding funding for similar Health	CEO	Introduce concept of FIRM established in Alberta to BC Minister of Health.	BC has adopted policies which ensure complete openness and transparency in the reporting of cost	The media and public have a better appreciation for the value-proposition provided by BCCPA members under		We are beginning to determine how we can apply FIRM in BC. No real progress on this file to date. There should be more activity by Fall 2014.

BC CARE PROVIDERS ASSOCIATION www.bccare.ca

Advocating service excellence for seniors

In Development
On Track
Caution
Off Track

Progress Status

STRATEGIC PLAN –2013 - 2016

OBJECTIVES	Acc'ability	2013/14 Target	3 Year Target – 2015/16	Outcome Indicators		Comments
Authority and affiliate facilities		Commence independent research to update and quantify cost differential between government and non-government providers	differentials between HA and non-HA facilities. Complete updated research regarding cost differentials between gov't and non-gov't service providers.	contract to provide care for seniors. Polling indicates positive movement in the public's perception of the non-government care providers.		We plan to FOI and seek out information to analyze later this year when we bring on our new summer intern.
5.3 Develop a new province-wide service provider agreement	CEO	Formally approach MoH to determine interest in pursuing new province-wide service agreement.	A new service agreement will be in place.	Additional openness and transparency in the funding process. Level the playing field amongst service providers.		

STRATEGIC GOAL #6: Improve Internal Operations

OBJECTIVES	Acc'ability	2013/14 Target	3 Year Target – 2015/16	Outcome Indicators		Comments
6.1 Modernize governance structure	CEO	Establish a Governance Task Group (GTG) The GTG will provide recommendations to the Board to modernize governance and policies. Update 80% of Board and personnel policies	All board and personnel policies are current and reviewed on an annual basis. Recommendations from GTG are integrated into current operations Conduct an annual review of policies and procedures for relevance.	More efficient board meetings Board satisfaction regarding board operations improves over time (can track through annual surveys). More effective Annual General Meetings with greater participation from members.		Governance Task Group was established and has now been morphed into our new Governance Committee. The GTG provided a series of recommendations to the Board which were adopted last fall. Work continues on updating our by-laws and constitution to be presented to the members at the AGM in May. Work continues to update a variety of BCCPA internal policies and procedures.

BC CARE PROVIDERS ASSOCIATION www.bccare.ca

Advocating service excellence for seniors

In Development
On Track
Caution
Off Track

Progress Status

STRATEGIC PLAN –2013 - 2016

OBJECTIVES	Acc'ability	2013/14 Target	3 Year Target – 2015/16	Outcome Indicators		Comments
6.2 Develop more effective planning tools	CEO	Finalize the development of a 2013/14 Strategic Plan Draft the 2014/15 Strategic Plan Develop a rolling three-year Financial Plan	In a better position to provide multi-years financial forecasting and planning Strategic Plan is reviewed by the Board on an annual basis.	Better use of limited resources in a more targeted manner. Less likely to move into non-priority areas without a focused discussion on what the opportunity costs will be. More focus on long-term planning that will help achieve identified goals and objectives. An *Operational Plan* and *Communications Plan* can be developed from the Strategic Plan At least 85% of the items identified in the 2013/14 Strategic Plan are accomplished.		The 2013/14 Strategic Plan was approved by the board in September 2013. An updated 2014/15 Strategic Plan will be reviewed by the board this spring. An operating plan and communications plan are being developed and should be reviewed in conjunction with updated 2014/15 Strategic Plan.

howegroup | public sector consultants

Project Status Report

Overall Status: **On Track**

Project Name: SafeCare BC

January 10, 2014

Status Code Legend

- On Track: Project is on schedule
- At Risk: Milestones missed but date intact
- High Risk: At risk, with a high risk of going off track
- Contingent on approval of interim Bylaws

Best Practice Review	● The **Best Practice Review Report** has been accepted by the Implementation Working Group (IWG) and forwarded to BCCPA Board for consideration (attached). ● A second document**, Implementation Recommendations**, was created to inform the strategic direction of SafeCare BC. This document has been accepted by the IWG and forwarded to the BCCPA Board for consideration (attached).
Organizational Framework & Governance	● Establish **Implementation Working Group** (complete) and act as Secretariat to support meetings (ongoing) - Meeting #1, November 12, 2013 (meeting actions attached) - Meeting #2, December 10, 2013 (meeting actions attached) ● **Constitution and Bylaws** for have been developed for the interim SafeCare BC Board and awaiting approval along with a **framework/roadmap** to guide next steps with respect to governance (attached). ● Inaugural meeting of SafeCare BC Board planned for January 23, 2014. ● Phase 2 Bylaws to be developed (January/February 2014)
Legal	● Register SafeCare BC as a **legal entity** (planned for January 24, 2014) ● Apply for $5 M **liability insurance** (planned for January 24, 2014) ● Obtain **business license**
Personnel	● ED job description (complete) ● TOR for Hiring Committee (complete) ● Posting, screening and interviewing ED candidates (complete)

	● An **Executive Director** has been selected, approved and has unofficially accepted the position. A final written letter of offer is prepared and awaiting the formalization of SafeCare BC as a legal entity (offer planned for January 25, 2014).
Finance and Accounting	● Establish SCBC **budget and invoicing** procedures with BCCPA (complete) ● Confirm **operating budget** (complete) ● Develop **interim budget** (complete)
Communications	● Hire communications firms (complete) ● Set-up **virtual office** through on-line presence, email availability and telephone messaging (complete) ● Develop **brand identity/logo** (see Myron Brand Guidelines Attached) (complete) ● Develop **graphic art** including letter head, business cards, envelopes and PPT presentation (complete) ● Design and launch **SafeCare BC website** (planned for January 13, 2014) ● Set-up **social media** accounts (Facebook, Twitter) (complete) ● Update membership **database** (complete) ● Update and ensure functional **email distribution list** (complete) ● Arrange **photo and business cards** for new ED (planned for late January) ● Develop **Communications Plan** (Ready to be reviewed by IWG at next meeting)
Stakeholder Engagement	● Conduct **training needs assessment** (on-line surveys underway; interviews planned for late January) - The draft on-lines surveys received feedback from BCCPA, DHA, WorkSafeBC, HEABC, BCNU and HEU. We are pleased to report that these agencies have agreed to help us disseminate the on-line surveys through e-mail distribution lists and/or posting on their websites. ● Final training needs assessment **report** (planned March 30, 2014) ● **Teleforum** to communicate results of needs assessment and SafeCare BC next steps (Planned for March 2014)
Hand-off	● Debrief ED and hand over materials/file (scheduled for February)

Next Steps

We estimate that approximately 85% contracted deliverables are complete with the following to be completed by May 2014:

- **Implementation Working Group Meeting #3, February 4, 2014**: Act as Secretariat (schedule meeting, prepare agenda, prepare meeting notes).
- Complete **legal requirements** for SafeCare BC including registration and liability insurance.
- Finalize **Communications Plan**. The plan is compete in draft form and ready for circulation to the IWG for feedback at the next meeting.
- Arrange for **photo and business cards** for new Executive Director.
- **Hand off** materials and update new Executive Director, early February
- Confirm **training** for new Executive Director on maintaining and **updating the SafeCare BC website**, February
- Finalize Phase 2 Bylaws for Board approval
- Complete **training needs assessment**, including final report (March 2014)
- **Facilitate teleforum** with Conduit Coaching to communicate results of training needs assessment (mid-March)
- **Implementation Working Group Meeting #4:** Act as Secretariat (schedule meeting, prepare agenda, prepare meeting notes)

howegroup | public sector consultants

SafeCare BC

SafeCare BC

Implementation Recommendations

January 7, 2014

Implementation Recommendations

Introduction

Led by the BC Care Providers Association, the Denominational Health Association, together with stakeholders in the long term care sector, an application was submitted and subsequently approved by WorkSafeBC to create a health and safety association for the long term care sector in BC. Upon receiving funding on October 1, 2013, work began on establishing the foundation of SafeCare BC (SCBC) in four key areas including organizational structure, constitution and bylaws, training, and communications.

Following an in-depth best practice review (see *A Best Practice Review of Health and Safety Associations in British Columbia and Alberta, Howegroup, January 2014*) the following recommendations were developed to support the decisions of the Board and the work of the SafeCare BC Implementation Working Group and Executive Director. The recommendations were based on:

1. WorkSafeBC criteria for health and safety associations.
2. Best practices from existing health and safety associations in British Columbia and Alberta as referenced throughout this document.
3. Existing strategic and operational decisions already underway.
4. Consultant expertise.

Recommendations

1. Establish the SafeCare BC Society & Governing Board

   a. Establish the SafeCare BC as a Society and separate legal entity (reference Best Practice 1.1) with an interim Board until the Fall of 2014. This should be conducted prior to hiring an Executive Director to ensure that SCBC is acting under its own legal mandate when the ED is hired. As a separate legal entity the health and safety association will act solely on the health and safety mandate, leaving the host organization BCCPA to focus on the associations' advocacy role (Best Practice 1.1).

   b. Establish a permanent governing board constituted according to WorkSafeBC criteria including: industry, union, employee, DHA and BCCPA representation (Best Practice 1.4).

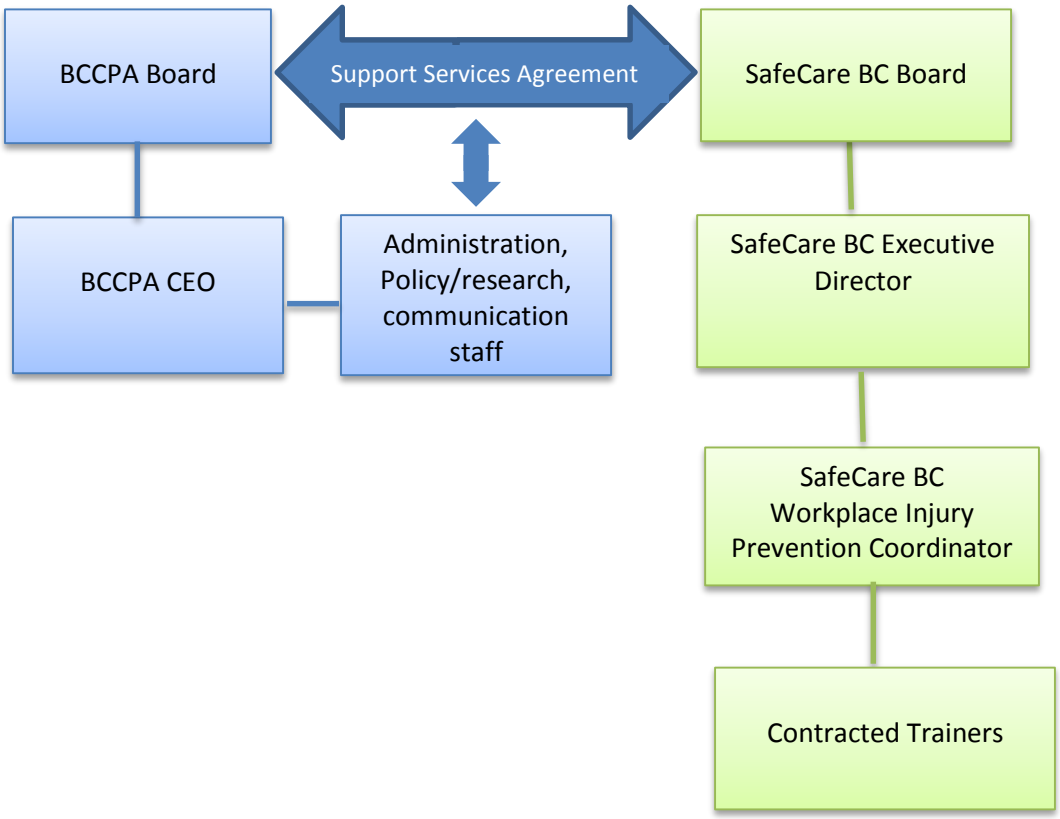
   c. Develop the initial SCBC constitution, bylaws and key policies, keeping by-laws to a minimum to facilitate flexibility and future growth (Best Practice 1.6 and 1.8). Develop a Board orientation package that includes additional support to employee Board members (Best Practice 1.6 and 1.7).

   d. Set board term of two years, with staggered terms and limits for two to three consecutive terms (Best Practice 1.5).

2. Hire an Executive Director to oversee the strategic direction and day-to-day operation with a business development background combined with industry experience (Best Practice 1.10).

3. Establish a shared service agreement.
    a. To minimize cost overhead and infrastructure, establish a support services agreement between SafeCare BC and BCCPA (Best Practices 1.2 and 1.12). For the two organizations, clearly delineate roles and responsibilities, reporting relationships and the interrelationships associated with the service agreement (Best Practice 1.3). Avoid any dual lines of reporting for staff (Best Practice 1.13). Please see Figure 1.
    b. Determine the cost sharing & financial accounting model associated with the shared service agreement (Best Practices 2.5, 2.6, 2.7).

Figure 1. Recommended Organizational Framework



4. Develop a Communications Platform
    a. Develop a SafeCareBC brand, website and social media profile. Segment target markets and develop targeted messaging to specific audiences (Best Practice 4.1, 4.2, 4.3, 4.4, 4.5.).
    b. Leverage existing communication tools and materials from existing health & safety associations (Best Practice 4.6.)
    c. Deploy a mixed activity and channel approach to marketing SafeCareBC, ensuring that stakeholders are attracted through multiple avenues (Best Practice 4.7, 4.8).
    d. Evaluate and validate communication activities and channels for maximum impact on stakeholders (Best Practice 4.10, 4.11, 4.12).

5. Develop Planning & Reporting Systems.
    a. Follow the financial regulations as set out in the Society Act and comply with WorkSafeBC contractual requirements.
    b. Develop an operational plan & financial reports (including budget) in accordance with WorkSafe BC criteria. Report to WorkSafeBC on financial operations per the signed contract. Implement operational plan. Establish financial vehicle for reserve funds to maximize return on investment (Best Practices 2.1, 2.2, 2.3, 2.4, and 2.11).

6. Establish a Training Program.
    a. Hire a Workplace Injury Prevention Coordinator (training manager) to oversee either employed or contracted trainers (Best Practices 1.11).
    b. Conduct a training needs assessment to include: a review of requirements; programs that already exists or need to be developed; a repository of existing training programs and resources; identify effective methodologies; potential leverage of existing corporate-wide programs; potential partnerships with organizations (Best Practices 3.3, 3.4 , 3.5, 3.6, 3.9).
    c. Develop a strategic training plan that aligns with WorkSafeBC's High Risk strategy to target the most common causes of injury in the long term care sector, considers the long term vision for SafeCareBC, and integrates with employers' situational contexts (Best Practices 3.1, 3.2 3.8.).
    d. Incorporate evidence based training practices including embedding adult based learning principles to ensure training meets the needs of front line staff, offering training programs based on occupational category, learning styles, training preferences and focusing on topics with the highest impact on injury claims within the sector. (Best Practices 3.7, 3.8.).
    e. Develop a training evaluation plan inclusive of satisfaction and injury reduction indicators as well as utilization of training and education materials (Best Practices 3.10, 4.10).
    f. Identify costs associated with training and cost recovery points. Determine if training should be offered to non-members organizations (Best Practices 2.8, 2.9, 2.10).
    g. Establish a Technical Advisory Committee that reports to the Board once the vision and mission of SafeCareBC have been established and a training needs assessment has been completed. Membership should adequately represent diverse stakeholders with the knowledge and skillset to fulfil the mandate & collaborative nature of SafeCare BC (Best Practice 1.9).

STAKEHOLDER ENGAGEMENT
CHANGE MANAGEMENT
STRATEGIC PLANNING
PERFORMANCE MANAGEMENT
PROJECT/PROGRAM EVALUATION

The Howegroup is a boutique consulting practice specializing in serving public sector clients.

.

howegroup | public sector consultants

www.howegroup.ca

ph 604.506.5486

howegroup | public sector consultants

SafeCare BC

SafeCare BC

A best practice review of health and safety associations in British Columbia & Alberta

January 7, 2014

Acknowledgements

The Howegroup gratefully acknowledges the time and valuable input from the following representatives from the health and safety associations in Alberta and British Columbia:

- Darryl Kutchinsky, CEO Continuing Care Safety Association (Alberta)
- Denise MacDonald, Director Member Services & Special Projects, Alberta Continuing Care Association (Denise also provided insights into the Continuing Care Safety Association of New Brunswick)
- Joanne Leisman, Communications, Continuing Care Safety Association (Alberta)
- Arlene Keis, CEO, Go2
- Dennis Green, Seniors Manager, Industry training, Go2
- Trina Macdonald, Business Development Manager, Go2
- Don Parman, Massey Theatre
- Geoff Teoli, Executive Director, Actsafe
- John McMahon, Executive Director, Safety Driven
- Mark Slobin, Executive Director, Affiliate & OHS Services, Health Employers Association of BC

There is an unprecedented culture of collaboration and information sharing among BC's Health and Safety Associations. SafeCare BC is well positioned to join an existing community of experts and collaborators.

About the Consultants

This independent best practice review of the health and safety associations was conducted by the **Howegroup Public Sector Consultants Inc.**, Wynona Giannasi and Jennifer Hystad.

Table of Contents

Section 1: Introduction

Background

Through an unprecedented collaboration led by the BC Care Providers Association (BCCPA), the Denominational Health Association, and stakeholders in the long term sector of BC, an application was submitted to WorkSafeBC in December 2012 for a health and safety association for the long term care sector.

As industry support was achieved from the BCCPA's membership, two province-wide teleforums were held over the next nine months to engage the long term sector partners. Following notice in June 2013 that the application was delayed, the BCCPA received final approval to launch SafeCare BC on October 1, 2013. Upon the signing of the contract between WorkSafeBC and the BCCPA, as the host organization, and BCCPA receiving funding, a best practice review was commissioned to inform the creation of the organizational structure, constitution and bylaws, and communication strategies for SafeCare BC.

Purpose and Scope of the Best Practice Review

Grounding SafeCare BC in industry best practices is paramount, thus driving the need for a best practice review of health and safety associations. The purpose of this best practice review was to synthesize and present best practices to support the work of the SafeCare BC Implementation Working Group and Executive Director and inform decisions on the foundation and direction for SafeCare BC.

The intention of this report is to highlight best practices that are applicable to SafeCare BC, particularly considering the context of the long term care sector in BC and meeting WorkSafeBC criteria for health and safety associations, including streamlined administration and cost efficiency. Additionally the size of other associations, the scope/mandate, political climate and relationship with the host organization was taken into account. As such, only best practices that have a similar criteria and scope to SafeCare BC are included in this practical report.

About SafeCare BC

SafeCare BC will be a non-profit society whose mandate is to ensure injury free, safe and healthy working conditions for non-profit and private employers in the long term care sector (WorkSafeBC Classification Unit 766011). SafeCare BC will maintain a strong emphasis on injury prevention and safe return to work programming through:

- Offering workshops and certifications for long term care workers.
- Offering online based learning for health care professionals working in the long term care sector.
- Recognizing and resolving workplace challenges of long term care workers.
- Improving health and safety protocols within the workplace.
- Providing long term care workers with workplace safety training.
- Providing management with training on creating an organizational culture of safety.
- Providing materials and resources to make workplaces safer.
- Providing tools and education on best practices.

SafeCare BC will focus on establishing operations and training activities targeting the long term care sector in BC in the first year of operation. Once a strong organizational

structure is established, SafeCare BC will develop a business case to expand into other sectors, home care being a priority.
Planned outcomes for year one include an efficient safety association with strong member support and engagement, increased member awareness around safety issues with an improved knowledge of regulations, and a high demand for SafeCare BC services. Activities beyond year one focus on accessible training programs, on-line best practice tools, and innovations in best practice and knowledge translation thereby positioning SafeCare BC as an industry leader for health and safety training and resources. While an evaluation framework is not within the scope of this best practice review mention is provided to evaluating specific training and communication activities throughout this report.

SafeCare BC is accountable for success ***criteria*** set out by WorkSafeBC including:

- Demonstrating more than 50% of support from stakeholders in the industry (completed with the application).
- Developing a governance structure which represents the industry, including large and small employers, public and privately funded operations, worker representatives from unions and employers from relevant employer associations.
- Developing an annual action plan aligned with WorkSafeBC high risk strategy focusing activities on major drivers of time loss claims including overexertion, violence, falls and infectious disease.
- Cooperating with WorkSafeBC to develop industry prevention strategies.
- Sharing information regarding best practices, transferring research knowledge to WorkSafeBC and industry partners.
- Streamlining administration functions and reducing duplication in the delivery of services.
- Sharing information on benchmarking and measurements.
- Developing a communication plan consistent with WorkSafeBC's mandate.

About Health and Safety Associations in British Columbia

WorkSafeBC supports industry health and safety associations to deliver activities that reduce injuries and promote safe workplaces. This includes:

- Reducing workplace injury and disease.
- Promoting safe return to work of injured or disabled workers.
- Furthering the health and safety priorities of WorkSafeBC.

The health and safety associations work with employers and managers in their sector to implement programs that address occupational health and safety issues. Activities eligible for funding include education, training, promoting awareness and other initiatives that prevent injuries and support return to work of injured workers. Funding is not intended for activities employers are required to meet under the *Workers Compensation Act* nor may funds be used for advocacy work. Funding to support health and safety associations is provided through a special industry levy.

A multitude of health and safety associations exist in the province of British Columbia to promote safer workplaces and return to work training, education and resources. These include, but are not limited to:

- Actsafe: Motion picture and performing arts industry
- BC ARC: BC Association of Restoration Contractors
- BC Association for Crane Safety
- BC Construction and Safety Alliance
- BC Forest Safety
- BC MEA: Maritime Employers Association
- BC Municipal Safety Association
- ENFORM: Safety Association for Upstream Oil and Gas Industry
- FARSHA: Farm and Ranchers Safety Association
- FishSafe: Commercial fishing industry

- FIOSA MIOSA: Food and Beverage Safety Alliance (processing and manufacturing)
- go2hr: Tourism and hospitality industry
- Safety Driven: Trucking Safety Council

For the purpose of the this best practices review, health and safety associations were included based on alignment with the stakeholder groups, operating budget, staffing composition, size and the scope of SafeCare BC.

Figure 1: Associations Reviewed

The four associations closely reviewed include the Trucking Safety Council, go2, Actsafe, and the Continuing Care Safety Association (Alberta). Please see Appendix A for a profile of these organizations.

About the Long Term Care Sector in British Columbia

SafeCare BC is mandated to target activities within the long term care sector, Classification Unit 766011. Long term care, also referred to as extended care, complex care, intermediate care or residential care is provided in a community care facility and are "for people who require 24-hour supervision, personal nursing care, and/or treatment by skilled nursing staff"[1] and provides a higher level of care than assisted living where the residents must be able to direct their own care. There are a total of 348 residential care facilities for seniors in the province.[2]

Definition of long term care facility: A long term care facility is defined under the Community Care and Assisted Living Act as:
A premise or part of a premise in which a person provides care to 3 or more persons who are not related by blood or marriage to the person and includes any other premise or part of a premise that, in the opinion of the medical health officer, is used in conjunction with the community care facility for the purpose of providing care, or designated by the Lieutenant Governor in Council to be a community care facility.

WorkSafeBC statistical data[3] report the occupation groups reporting short term, long term and fatal claims in the long term care sector include (in decreasing order of claims):

- Nurse aides, orderlies and patient service associates (57% of claims)
- Licensed practical nurses (16%)
- Social and community service workers (5%)
- Registered nurses and registered psychiatric nurses (5%)
- Food counter attendants, kitchen helpers and related support occupations (4%)
- Light duty cleaners (3%)
- Cooks (2%)
- Program leaders and instructors in recreation, sport and fitness (2%)

Within the occupation groups listed above, 90% of claims are from female workers and 10% from male workers. The most common *accident* types are overexertion (51%), fall on the same level (10%), acts of violence/force (10%), and other bodily motion (8%). Most common *injuries* include 'other strains' (44%), back strains (30%), contusion (8%) and infectious disease (5%)[3].

About this Report

This report opens with the methodology, followed by an in-depth exploration of the best practices uncovered during this review. Best practices are presented within four key areas for action (Figure 2). The intention is to enable the SafeCare BC Implementation Working Group to utilize the best practices to inform the strategic and operational decisions already underway and to be undertaken in the near future.

Figure 2. Key areas of action

[1] BC Ministry of Health Glossary of Terms. www.health.gov.bc.ca/assisted/glossary
[2] Seniors Ombudsperson Report, Volume 2, 2012
[3] WorkSafeBC Classification Profile 766011 Long Term Care, October 3, 2013

Section 2: Methodology

Overview

Three specific data sources were utilized to inform this best practice review: interviews with key informants from other health and safety associations across the province, a review of current resources shared from five health and safety associations across the province, and a review of relevant literature supporting the need for and operational goals of health and safety associations across the province.

1. Key Informant Interviews

One hour interviews were conducted with eight individuals representing six organizations (five health and safety associations and one long term care member organization). Specific questions were developed by the Howegroup (see Appendix A) and used to guide the interviews with key informants. Questions focused on the organizational framework, inclusive of the relationship with industry associations, leadership and staffing; training programs, including the development and delivery; communications requirements; and, financial considerations for the associations. Specific organizations were selected as follows:

- The *Continuing Care Safety Association (Alberta)* was selected as the flagship health and safety association for comparison to SafeCare BC as Alberta was the first jurisdiction in Canada to implement a health and safety association for long-term care.
- *go2* (tourism and hospitality industry), *Actsafe BC* and the T*rucking Safety Council of BC* were selected based on the similarity of their operating budgets.
- The *Continuing Care Safety Association of New Brunswick*, while considerably smaller in size, was selected based on the similar timeframe of commencing initial operations. As the Continuing Care Safety Association of New Brunswick is in its infancy stage of establishment, there are minimal best practices coming from this association. Rather, it was reviewed for comparisons to BC's processes.

2. Review of Current Documentation

All health and safety associations graciously shared information for use by SafeCare BC. In addition, a wealth of information exists within all health and safety association websites. A thorough review was conducted of materials including: workplans, training materials, communications strategies, staff job descriptions, board constitutions and bylaws, board and technical committee terms of reference, and financial arrangements with partner organizations.

3. Review of Relevant Literature

A brief scan of existing literature supporting the need for and operational goals of health and safety associations across the province was reviewed to provide further evidence into the recommended best practices for SafeCare BC.

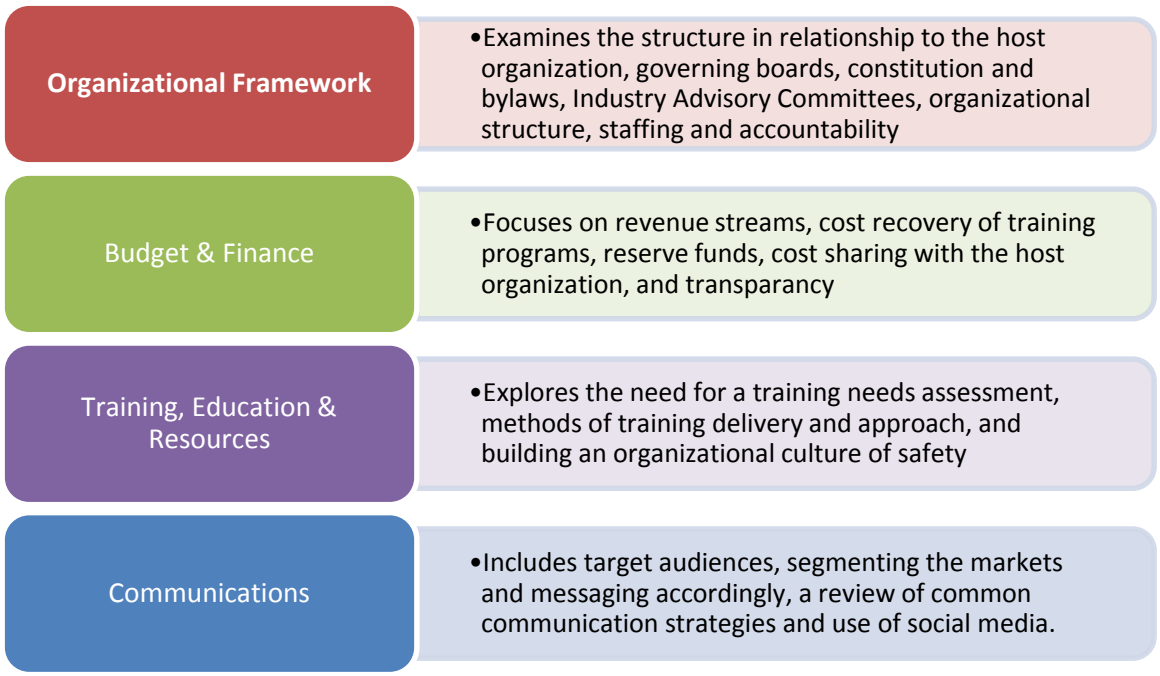
Limitations

An exhaustive review of health and safety associations was not conducted. As well, the focus remained primarily in BC, with two associations across the country and none internationally. The reason for this was, however, intentional as the intent was to select similar associations (based on the criteria described above – operating budget, industry and organizational maturity) and to keep the scope of the review based on the practicality and feasibility of implementation within BC's current health and safety climate.

Section 3: Best Practices

Best practices are presented for four key areas for action for SafeCare BC (Figure 3). In many cases, best practices are based on multiple sources. The intention of this report is to focus on practices that were applicable to SafeCare BC, particularly considering the context of the long term care sector in BC and meeting WorkSafeBC criteria for health and safety associations. Additionally, the size of the association, scope, political climate and relationship with the host organization was taken into account. As such, best practices that did not meet these criteria were not included. After each subsection best practices are highlighted and at the end of each area for action a best practice matrix, which highlights lessons learned and implications for SafeCare BC is provided.

Figure 3: Areas for Action



1. Organizational Framework

Relationship to Host Industry Employer Association

Health and safety associations are provided a significant amount of autonomy by WorkSafeBC with respect to their organizational structure and relationship to the host organization, an industry employer group. In most health and safety associations the two organizations are separate *legal* entities. Two models are most common: one where the health and safety association is closely situated with the host/industry association and one where the two organizations *function* as entirely separate entities. There are certain benefits attributed to each model.

In several instances the industry health and safety portfolio may fall under one program within the greater mandate of a host organization. This is the case with the Health and Safety Program embedded in go2. Benefits include shared overhead and administration costs (therefore reduced costs to both organizations), streamlined reporting, high accountability to members and a shared mandate. The risk in embedding a health and safety association within the Industry Employer group is the perception that the health and safety association may advocate on behalf of members, a clear infringement of WorkSafeBC regulations. Go2, for example, avoids such perceptions as the organization does not lobby on behalf of members. Go2 has also worked hard to gain the credibility of its membership and build trust to ensure lobby and training operate as two entirely distinct functions.

Alternatively, the health and safety association may be established as a completely separate entity from the host organization, such as with the Continuing Care Safety Association in Alberta. The two organizations began as an intertwined initiative, but over time different directions and goals arose, necessitating distinct organizations. Currently, all that remains shared is a physical space and receptionist and administrative support. Benefits include shared costs and streamlined administration and clear, distinct mandates for both organizations. However, in this case, accountability to industry (both employer and employee) may be compromised by a lack of aligned values and understanding of member needs. Another drawback is the one shared staff has dual lines of reporting, to leaders of both organizations.

Figure 4. Best practices: Relationship to host organization

1.1.	Establish the health and safety association as a separate legal entity from the host industry association. As a separate legal entity the health and safety association may fulfil its mandate without infringing on the industry association's advocacy role.
1.2.	Develop an organizational structure that maximizes cost efficiencies through shared overhead.
1.3.	Determine which operational areas will fall under the responsibility of the host organization versus the health and safety association.

Governing Board of Directors

All governing Boards of health and safety associations included representation from major industries included within their classification unit, employees and unions, Board members from the host organization (where appropriate) and WorkSafeBC as a non-voting member. Board Officers most often include Chairperson, Vice-Chairperson, Secretary, Treasurer and in some instances the Past Chair. The most common term for Board members was two years, with staggered terms and limits ranging from two or three consecutive terms (Continuing Care Safety Association) to unlimited terms (Safety Driven).

All health and safety associations commented on the need to develop a Board manual, inclusive of the constitution and bylaws and relevant policies. This serves as an important tool for orientating Board members and helping to support Board members new to serving on Boards.

The Continuing Care Safety Association spoke of the importance of working with Board members individually, from time to time, to check in on their perceptions. This helps to open up lines of communication, build trust, ensure Board members feel valued and working through any areas of concern. The latter is particularly important for engaging employee representatives of the Board. Employee representatives provide an important role but may need some extra support to be effective in their role.

Figure 5. Best practices: Governing Board of Directors

1.4.	Establish a governing board that complies with WorkSafeBC criteria, including industry, union, host organization and employee representation.
1.5.	Set the Board term for two years, with staggered terms and limits for two to three consecutive terms.
1.6.	Develop a board manual inclusive of constitution and bylaws and important procedures. Provide to all Board members and incorporate into orientation.
1.7.	Provide additional support to employee Board members to support their contributions.

Constitution and Bylaws

As legal non-profit entities, all health and safety associations are governed by a Constitution and Bylaws. The development and adoption of these legal requirements by the governing Board are an important first step in establishing health and safety associations as separate legal entities from the host organizations. Go2 and the Continuing Care Association spoke of the importance of developing the Constitution in such a way that does not restrict the association or stall changes that require member voting, but rather allows for flexibility and future growth by keeping the bylaws as minimal as possible. This goal is to enable efficient governance of the association.

Figure 6. Best practice: Constitution and Bylaws

1.8.	Develop the Constitution in such a way that allows for flexibility and future growth by keeping the bylaws as minimal as possible.

Industry Advisory Committees

All health and safety associations included in this review have an Industry Advisory Committee (also called Technical Advisory Committees) to advise on health and safety issues, key trends, vet resources and training curriculum and share best practices. The committees are comprised of occupational health and safety specialists from within the sector and report through the Chair to the Board. Key elements of two Committees are highlighted in figure 6. A couple of health and safety associations advised the importance of establishing the vision and direction of the health and safety association and completing a training needs assessment before initializing an advisory committee. The intention is to ensure Technical Advisory Committee members are recruited with the knowledge and skillset to fulfill the mandate of and adequately represent the health and safety association. Best practices find that the Technical Advisory Committee should meet, minimally, quarterly and provide technical advice, best practices and review tools, resources, and training curriculum. This committee should also bring forward emerging trends in the long term care sector.

Figure 7. Industry Advisory Committees

	go2[4]	Safety Driven[5]
Committee Name	Technical Advisory Committee	Technical Advisory Committee
Chair	go2 industry Go2 Board member	Chair and Vice Chair
Purpose	Provide strategic direction to health and safety associations and COR program	Guide the Council on COR training programs, quality assurance programs, standard for auditing, programs and industry safety
Members	Board and non-board members 3 major sectors represented Ex-officio WorkSafeBC	Minimum of 7 persons, max. 15; Voting members: members enlisted from industry with representation from across classification unit including owner operator, small, medium and large employers Non-voting members: WorksafeBC, Human Resources and Skills Development Canada,
Term	One year term, renewable for subsequent years	Two-year, renewable term
Meetings	Once each quarter, in-person or conference call	Bi-monthly, additional meetings as required
Note:	Also serves as Statutory (Advisory) Committee	

Figure 8. Best practice: Technical Advisory Committee

1.9. Develop a Technical Advisory Committee which reports to the Board once the vision and direction of the organization have been established and a training needs assessment is complete (approximately 1 year after SafeCare BC is established). Ensure the membership adequately represents diverse stakeholders. Determine the term of membership. Set a practical meeting schedule as laid out in a terms of reference.

Staffing

Staffing for health and safety training ranged from 2-7 FTE and most often included the CEO or Executive Director, administration/ office management and communications.[6] All health and safety association leaders had industry experience and most had health and safety education, training or experience. Filling the leadership position by an individual with a business development background combined with industry experience was cited as a key success factor for developing a credible and trusting relationship with front line staff.

Where appropriate, program managers administered Partners in Injury Reduction (PIR) and Certificate of Recognition (COR) programs and direct training was provided by contracted trainers. These educators had backgrounds in teaching (adult education), occupational health and safety and/or industry specific experience. Examples of organizational structures from Safety Driven (figure 9) and go2's Health and

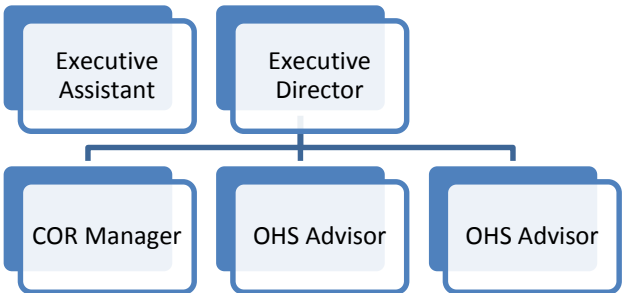
[4] Go2 HIS Committee Terms of Reference, June 21, 2011

[5] Safety Driven Technical Advisory Committee Terms of Reference

[6] While the Alberta Continuing Care Safety Association has played an instrumental role in the development of SafeCare BC thus far, the staffing model for the association is not being used to inform SafeCare BC as it follows a much larger and more diversified composition.

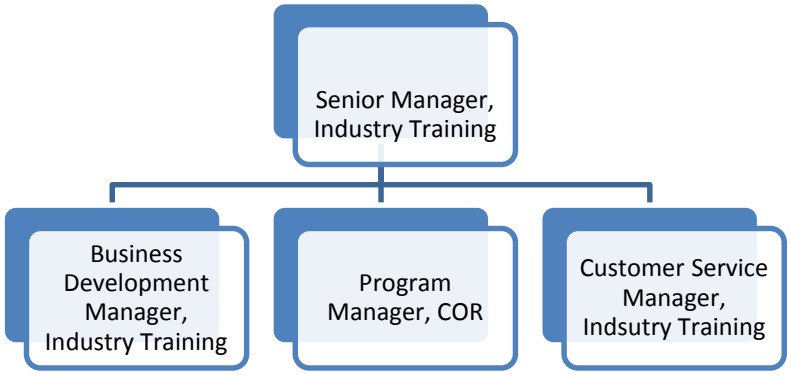
Safety Program (figure 10) are shown below. In both cases, the training manager oversees the training portfolio for the association and has the ability to ensure those providing hands on training are geographically dispersed/available throughout the province.

Figure 9. Safety Driven organizational structure



In the case of Safety Driven administration and program managers/advisors report to the Executive Director who is accountable to the Board of Directors. This is contrasted with go2, in which the manager responsible for health and safety programming (listed as Business Development Manager, Industry Training) and COR Program Managers report to Senior Management.

Figure 10. go2 Health and Safety Program organizational structure



Sharing staff between the host and the health and safety association creates synergies and cost efficiencies. Where appropriate, it was most often the administration or communication position shared between organizations as in most cases a full time resource was neither affordable within the operating budget and/or necessary to fulfill the workload. It was noted that challenges arose when shared staff reported to two managers or the workload in one organization outweighed the other, creating an imbalance in time allocation. Instead, what is a more effective solution is to have one line of reporting and a service agreement that clearly delineates roles and responsibilities between organizations.

Figure 11: Best practices: Staffing

1.10. Hire an Executive Director to oversee the strategic direction and day-to-day operations with a business development background combined with industry experience.
1.11. Hire a training program manager to oversee either employed or contracted trainers.
1.12. Develop a service agreement between the industry association and the health and safety association to delineate roles and responsibilities, expectations and shared costs.
1.13. Avoid dual lines of reporting for staff. Minimize this through one point of contact.

Key learnings are summarized in Table 1.

Table 1: Key organizational framework learnings

Source	Relationship between Safety Association and Industry Employer Association	Structure of the Board of Directors	Composition of the Board of Directors	Lessons Learned
Continuing Care Safety Association (CCSA) – prior to 2008	The Alberta Continuing Care Association was the sponsoring organization in the initial application	One member from each long term care sector (public, private, volunteer/non-profit), ED of (CCSA) and two employee representatives	Public (Capital Care, CareWest), Private, Voluntary, Employee. No determined effort to recruit geographically	ACCA is an advocacy organization and orgs funded by WCB cannot be engaged in Safety at all, must ensure these lines are not blurred (differing mandates)
Continuing Care Safety Association (CCSA) – after 2008	As of 2008 the two Associations are completely separate entities	As above	as per application *note WorkSafe representation as a non-voting member	Recommends CEO of Employee member groups (BCCPCA) be chairperson of the board for health and safety associations
New Brunswick Association of Nursing Homes (NBANH)	CEO of member-based associations will become chair of Safety Association	Provisional board will be appointed prior to election of permanent board	3 NBANH Board members, 3 employers and 1 employee	
Go2: Health and safety for the tourism and hospitality industry	Board for go2 oversees all program	Board Statutory Committee (also serves as the COR Technical Committee)	Chaired by go2 board member from the industry and represented by go2 board and non-board members. IH&S committee has representatives from organizations in the sector	
Safety Driven		14 member Board of Directors	Non voting members and rep from unions (labour unions), Have CU member rep and sector related CUs	Recruit a good cross section of the industry and the skill sets needed to meet the mandate of the organization
Actsafe	Stand alone organization	2 Standing Committees (motion picture & performing arts)	6 members: Chair (non-voting), treasurer + 4 from industry. WorkSafe is an invited guest for the board but is non-voting	

2. Budget & Finance

Fiduciary Responsibility

All health and safety associations have a fiduciary responsibility for the proper management of funds to:

- WorkSafe, the funder.
- Members, the levied employers within the specific classification unit(s).
- Board of Directors, the governing body.

It is a requirement that health and safety associations develop and maintain operating budgets in accordance with WorkSafeBC criteria and that workplans, inclusive of financial details, be made publically available. To ensure transparency and financial accountability, all health and safety associations post information on their websites and provide reports to WorkSafe, as outlined in their contracts.

Figure 12. Best Practice: Budget & finance

2.1	Develop an operating budget in accordance with WorkSafeBC criteria.
2.2	Make workplans, inclusive of financial details publically available.
2.3	Report to WorkSafeBC on the financial operations of SafeCare BC as per the signed contract.
2.4	Report to members and the public on an annual basis (see Communication section for channels).

Revenue Streams

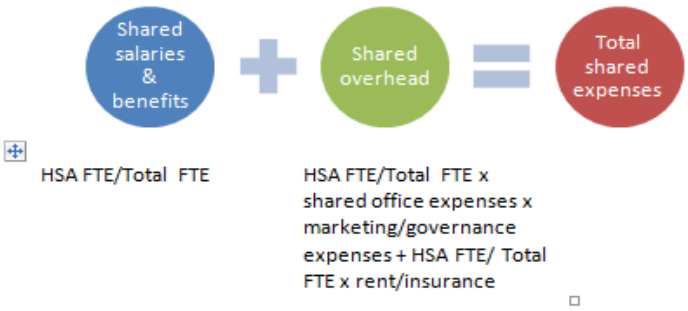
While all associations receive revenue from the WorkSafe classification unit levy, some have matured into associations which also receive grant funding from other public sources. As well, some associations receive revenue from their COR certification. There is currently an implicit knowledge that SafeCare BC is focusing its *initial* efforts on developing and delivering health and safety training programs from employer funds levied via WorkSafeBC rather than seeking to diversify funds and pursue COR certification and grant funding right from the get go. One of the outcomes for SafeCare BC by the end of the first year is to develop a COR proposal.

Cost Sharing with Host Industry Organization

The cost sharing arrangement between the host and the health and safety association is clearly aligned with the operational framework between the two organizations. Health and safety associations all vary in the financial cost sharing relationship they have with their host industry associations:

- One simply shares office space and splits the rent at 50/50. This represents two stand alone associations with no collaboration.
- Another pays a $20,000 annual fixed administration fee to the Association. This takes into consideration oversight for the health and safety association, shared space and shared staff.
- Yet another uses a comprehensive formula (Figure 13) that takes into account shared salaries and benefits as well as shared overhead, including shared office expenses (rent, insurance, general office expenses, telecommunications and IT, leased equipment, amortization and professional fees), marketing and governance expenses and revenue.

Figure 13: Cost sharing formula



Health and safety associations with shared staffing cautioned against tracking specific staff time as this can become a very onerous task. Instead time is allocated to each association (host and health and safety) based on workload. This is reviewed annually.

While the pros and cons to the cost sharing arrangements are likened with the benefits and drawbacks of the organizational frameworks (see section 1), regardless of the financial arrangement it is important that the host association recover costs for oversight of the health and safety association. It is also important that the financial arrangement is transparent and the financial reporting and invoicing process between the two organizations is as streamlined as possible.

Figure 14. Best practices: Cost sharing

2.5	Determine the cost sharing model which aligns with the organizational framework, taking into account the key elements including an administration fee; overhead, including rent, equipment, office furniture, IT, telecommunications; and, the percentage of host association staff time allocated to the health and safety association. Ensure this is clearly documented in the service agreement.
2.6	Confirm the proportion of host organization staff time to support the health and safety association and ensure this is clearly documented in the service agreement.
2.7	Determine a financial reporting framework and invoicing process between the host organization and the health and safety association and ensure this is clearly documented in the service agreement.

Training Cost Recovery

All health and safety associations receive some revenue from their training programs either through cost recovery for members and/or profit from non-member training fees. Fees vary greatly, from being provided at no cost to members to a substantial cost of $800/session/employee. This depends on the type, duration, and location of the training (see Training, Education and Resources).

Figure 15. Best practices: Cost recovery

2.8	Set the budget for and determine the actual cost of training.
2.9	Determine the cost recovery point for training.
2.10	Determine whether the Association wishes to open up training opportunities to non-members and if so, at what cost.
The Training Needs Assessment being conducted in November 2013 – March 2014 by the Howegroup will inform the financial model of the SafeCare BC training portfolio	

Reserve Fund

Through the contracts with WorkSafeBC, health and safety associations may keep a reserve fund, to the maximum of one quarter of annual revenue for un-used funds. There are stipulations on the amount and use of such funds, but one association keeps the reserve funds in a GIC to yield maximum allowable return on investment. Other health and safety associations have advised that it is likely that SafeCare BC will have a surplus of funds in the first year.

Figure 16. Best Practice: Reserve fund

2. 11	Anticipate for a surplus in year 1 and explore options for yielding the maximum return on investment for future use.

Key learnings are summarized in Table 2.

Table 2. Key budget and finance learnings

Source	Key revenue streams	Training fees	Host organization cost recovery
Continuing Care Safety Association (CCSA)	Core funding is provided through WorkSafe levy and covers 7 core staff. An equal amount of additional grant money covers all educator costs.	Training fees are cost recovery only and are estimated at: $50/member $75/non-member for a half day course.	Cost for office space is shared 50/50 between CCSA and the industry association.
Go2: Health and safety for the tourism and hospitality industry	All funding is from WorkSafeBC levy. No additional revenue is raised through training fees.	N/A	*Formula used for shared salaries and benefits as well as shared overheads (see below).
Safety Driven	Funding is from WorkSafeBC levy. Some revenue generated through partners not included in classification unit.	Members are not charged a fee or are charged a reduced fee for training courses. Fees range from $0-$400 for members and $34.95-$800 for non-members.	$20,000 annual fixed administration fee paid to the Association.
Actsafe	Funding is from WorkSafeBC levy. No revenue from training. Reserve funds are held as a GIC.	Training is only offered to those working in the sector. Training fees range from $0-$120.	N/A

3. Training, Education & Resources

Alignment with WorkSafeBC's High-Risk Strategy

Prior to examining best practices within other health and safety associations it is important to emphasize that it is the mandate of SafeCare BC to align activities with WorkSafeBC's High-Risk Strategy, targeting main causes of injury in the long term care sector. The training programs, therefore should address the following most common causes of injury as reported in the WorkSafeBC Long Term Care Statistical Report (October 3, 2013):

1. Over-exertion (51% of claims)
2. Falls on the same level (10%)
3. Acts of violence or force (10%)
4. Other bodily motion (8%)

Figure 17: Best Practice: Alignment with WorkSafe BC's High Risk Strategy

3.1	Prioritize training, education and resources to align with WorkSafeBC's High Risk Strategy to target the most common causes of injury in the long term care sector.

Strategic Training Plan

Developing and providing industry specific health and safety training and resources is undoubtedly a fundamental deliverable for all health and safety associations. Associations differ in whether they provide only health and safety training and/or whether they provide COR certification. The focus of this summary is on industry health and safety training as SafeCare BC is not yet implementing COR certification. That said existing health and safety associations emphasized the importance of considering the eventual expansion of training programs from the onset of the training plan for SafeCare, inclusive of COR training and growth/expansion into other sectors.

Figure 18: Best Practice: Strategic Training Plan

3.2	Consider the long term strategic training vision in the initial training plan for SafeCare, inclusive of COR training and growth/expansion into other sectors.

Training and Resource Development

As a critical starting point all health and safety associations have conducted **training needs assessments** to understand what training and resources are available, how materials may be adapted for the sector and front line employees specifically, how training and resources may be accessed, implemented, shared and evaluated. Such assessments have been supported by and updated on an ongoing basis with input from the Technical Advisory Committees.

Additionally, stakeholders emphasized the importance of utilizing existing resources wherever possible, leveraging the skills and expertise of industry experts to conduct training and partnering with training experts, providing training and access to resources in a way that is practical and feasible for the front line workers.

Figure 19: Best Practice: Training and Resource Development

3.3	Conduct a training needs assessment to determine what programs and resources are required, exist and need to be developed (based on emerging trends) for the industry.
3.4	Develop a repository of existing training programs and resources from jurisdictions across Canada.
3.5	Leverage existing resources to develop and implement their programs. Where known providers offer training common to a variety of industries (i.e. WHIMIS, first aid), work with contracted training providers to provide resources and deliver training.
3.6	Partner with existing training programs to leverage local skills and expertise and to demonstrate a quick win for SafeCare BC

Training Delivery

Some associations have hired trainers to develop curriculum and teaching materials (most notably the CCSA). What differs across the associations is the background of trainers. Most have chosen to hire trainers with content knowledge, while one in particular (CCSA) has chosen to hire educators who are then trained on the subject matter. CCSA cautioned against having clinical staff provide training due to biases inherent in their own clinical practices and felt that an individual with the right process knowledge to teach could be more objective.

All consulted health and safety associations have developed and implemented their training using **adult based learning principles**. Adult learners are known to learn needed information quickly, need to be treated with respect, learn best by doing, need to know where they are heading, need information reinforced and repeated and learn best when information is presented in different ways. This is particularly important for training offered to staff working shifts, who may be speaking (and reading/writing) English as a second language and who may be re-trained from other industries.

Figure 20: Best Practice: Training Delivery

3.7	Utilize subject matter experts to provide training but work with adult educators to incorporate adult based learning principles to ensure training meets the needs of front line staff.

Training Methods and Approach

The feeling by most associations is that training, however it is offered, needs to be **flexible** and provided in a way that lends itself to both employers and employees feeling that training is **adding value**. The majority of health and safety associations felt that online training was most appropriate for front line staff. In keeping with adult based learning, the classroom style was not found to be particularly well received. Some associations are using webinars and offering online training in groups. Stakeholders emphasized that it will be important to consider what will be most appropriate for front line staff providing long term care. They cannot be away from their patients/clients for long periods of time and are not working in an environment in which providing back filled staff is particularly easy.

Leaders from health and associations discussed some of the initial challenges, and importance of positioning the association as an industry expert. This was particularly the case with CCSA. Just as SafeCare BC will be doing, CCSA came into existence in an already competitive training market as numerous programs and institutions already exist to provide specific training opportunities, such as private companies, colleges, health authorities, etc.). Other associations, such as Actsafe BC had somewhat of an easier time as training for the sector was so limited. In the case of BC's long term care providers, there is such a range of size and scope of training available. Some may only have a few staff

and have no formal training programs, some may have in-house trainers and some may be expected to follow national training programs that need to be adapted to BC specifically. Regardless of the type and approach of offered training, health and safety associations stressed the importance of gaining the trust of the sector as being the leading experts in delivering health and safety training. All said this takes time and will require strong stakeholder relationship building.

In addition to the softer elements, it is important to tailor training to meet specific employer organizations. For example, the Trucking Council provides training for employees of specific employer types: owner/operator, small companies and large companies. SafeCare BC could also do this, targeting front line staff who work for small, medium and large/corporate organizations.

The CCSA contracts their trainers so that they can be responsive to providing training that meets current needs and so that they trainers are strategically located across the province. Other health and safety associations act as more of a training broker and partner with existing programs to deliver the training.

Figure21: Best Practice: Training methods approach

3.8	Offer training programs that meet the different needs of employees as well as the employers. Training offered to employees should consider the occupational category (i.e. Care Aide, LPN, kitchen staff), learning styles, training preferences (mode of delivery) as well as topics with the highest impact to injury claims in the sector (i.e. slips, violence, communicable diseases). Employer context will reflect internal training programs, in-house clinical educators as well as those with no training supports.
3.9	Determine what types and methods of training will work most effectively for staff and how existing corporate-wide programs can be leveraged.

Evaluation

All health and safety associations evaluate their training programs to ensure they are offering both satisfactory training and that training is making an impact on injury prevention. Health and safety associations focus evaluation efforts on understanding whether the training was satisfactory from the perceptions of front line staff primarily through surveys. The impact of targeted injury reduction is examined in partnership with WorkSafe statistics. Evaluation is critical in determining whether the training is making an impact across the sector.

Figure 22: Best Practice: Evaluation

3.10	Develop a training evaluation plan inclusive of satisfaction and injury reduction indicators.

Key learnings are summarized in Table 3.

Table 3: Key training, education and resource learnings

Source	Training development	Training methods	Training approach	Comments
Continuing Care Safety Association (CCSA)	Training materials were originally developed by adapting existing content. In Alberta the training must meet provincial laws and all content is reviewed by the Alberta government.	Adult based education methodology is utilized. Trainers all have education backgrounds rather than clinical/safety backgrounds. CCSA cautions against having clinical educators so as to keep the training more objective.	In person training sessions are most common for CCSA. Some training is done via webinars. Training ranges from a few hours to a few days depending on the content. On-site or hosted by CCSA. Very little on-line training as front line staff do not have access to computers on-site	5 person minimum for cost recovery; 15 manuals are taken to sites and left as reference material (too costly to print a manual for all participants and they are often not referenced). Noted that cost and time is a barrier for staff to attend training, started with online training but then found that staff don't have access to computers at work so they sold the benefits to employers on the need for in person training. CCSA spoke of the importance of change management and stakeholder/member relations being really critical for the successful adoption of training.
Go2: Health and safety for the tourism and hospitality industry	go2 conducted an industry search to understand what training programs exist, what programs can be modified and what new programs must be developed to target emerging issues of concern and suggestions from the industry.	Adult learning principles are utilized.	Online training is used as much as possible.	go2 engages members to determine training needs on an ongoing basis.
Safety Driven	The development and delivery of training is contracted out.	Adult based learning.	Traditional classroom based training didn't resonate well with front line staff. They didn't enjoy the experience. Training is being offered more online now so it can be taken anytime. Webinars are being explored more now as an effective solution for offering flexible training that can be taken as a group or by front line staff individually. Training is	Safety Driven targets specific employers: owner/operator, small and large and has different toolkits available for each employer type.

Source	Training development	Training methods	Training approach	Comments
			customized to fit the needs of trainees. There are podcasts, videos and interactive talks available online. Mentorship opportunities are being developed to further support employers in providing an effective safety culture on site.	
Actsafe	The development and delivery of training is contracted out.	Adult based learning.	Training offered by workshops and seminars focusing on the implementation of safety. Training is often provided on site. Resources are also available online and in hard copy.	

Table 4 provides an overview of the type of training offered by each association.

Table 4. Course listings offered by Health and Safety Associations

Source	*Course Listings
Continuing Care Safety Association (CCSA)	Auditor Training; Hazard Assessment & Control (Train the Trainer); Hazard Assessment and Control Workshop; Health and Safety Management Systems; Incident Investigation (Train the Trainer); Incident Investigation Workshop; Joint Worksite Health & Safety Committee; Musculoskeletal Injury Prevention (MIP) Program; Musculoskeletal Injury Prevention (MIP) Train the Trainer; Workplace Hazardous Materials Information System (WHMIS) Train the Trainer; Workplace Hazardous Materials Information System (WHMIS) Workshop; Workplace Inspections – Train the Trainer; Workplace Inspections Workshop.
Go2: Health and safety for the tourism and hospitality industry	Certificate of Recognition (COR) External Auditor Training; Internal Auditor Training Website also includes a comprehensive listing of Health and Safety Training Providers: Occupational Health and Safety Training Providers; BC Employers' Advisers Office (EAO), Canadian Centre for Occupational Health and Safety (CCOHS) Podcasts; Canadian Centre for Occupational Health and Safety Webinars; WorkSafe Education Network.
Safety Driven	Making Dollars and Sense of OH&S; SECOR Internal Auditor Certification; OH&S and Criminal Liability (Bill C-45); ABC's of Fire Extinguishers; WHMIS Awareness; Hazard Assessment; Lockout/ Tagout Awareness; Health and Safety Leadership; Health and Safety Program Development; Internal Auditor Course; Legislation, Law and You; Safety Communications; Incident Investigations.
Actsafe	Aerial Platform for Experienced Participants; Aerial Platform for Inexperienced Participants; Counterbalance forklift for Experienced Participants; Counterbalance forklift for Inexperienced Participants; Fall Protection Training; Firearm Safety Level One; Live Performance Electrical Certificate; Motion Picture Safety Awareness; Motion Picture Supervisor Safety; Occupational Health & Safety Level One First Aid; Performing Arts Supervisor Safety; Propane Safety Awareness Training; Rough Terrain Forklift-Experienced; Transportation of Dangerous Good; WHMIS.

**courses were extracted from information available on-line*

4. Communications

Communication is discussed in this section as it relates to (a) the general promotion of the health and safety association and (b) the dissemination of training materials and resources.

Target Audiences

For communication purposes, health and safety associations most commonly segmented their target audiences into two groups, employer (including owners and managers) and employee (front line workers and supervisors). Often, specific employers were targeted for one-on-one meetings or 'cold calls' to increase brand recognition. Front line staff was engaged through the website (for training information and registration purposes), social media, e-blasts and print materials. Health and safety associations spoke of the importance of segmenting their employees by occupation, given consideration to those with the highest injury claims in order to have the most significant impact on reducing injury rates.

Figure 23: Best Practice: Target Audience

4.1	Segment the target markets into employer and employee groups both for communication strategy (delivery) and messaging.
4.2	Segment employer groups by size including owner operator, small, medium and large (such as Safety Driven) as each will have differing service needs, budgets and organizational support.
4.3	Segment employees by occupation, giving consideration to staff with the highest injury claims.

Key Messaging

Key messaging was also segmented by employer (executive) and employee. Employer messaging focused on safety culture within an organization, communicating that 'safety starts at the top'. Communicating the cost benefit of a health and safety program resulting in decreased premiums was key for employer level messaging. Once employers were engaged, messaging focused on basic occupational health and safety requirements and best practices, using employers as conduits for staff.

For front line staff, messaging focused on raising awareness about unsafe practices, communicating safe practices and finally linking these with patient safety. Increasingly, health and safety leaders are linking employee perceptions of safety culture, health and safety outcomes with patient/client outcomes. While this triangulation is beyond the scope of SafeCare BC, it will be important for SafeCare BC, as an upcoming industry leader to establish high standards for integrating patient/client safety with staff safety. For many front line staff this is the tipping point for gaining their time, interest and respect. Only the Trucking Safety Council reported translating messaging into a second language, Punjabi.

go2 market segmentation and key messaging

For the first three years of operation, go2 targeted "large" employers (selected based on representation of assessable payroll as well as safety claims costs). Targeted individuals included general manager, human resource professional, occupational health and safety professional. go2 strategically partners with other industry associations to deliver messages to the primary target market. Moving forward, go2 will be targeting small employers. go2 regularly assesses market segmentation and penetration to identify key prospects and evaluate performance.

"The key ingredient to injury prevention is creating a culture of safety first, which relies heavily on all levels of management. An understanding as to why a safer organizational culture is imperative must be entrenched in the minds of all employees. "
-New Brunswick Association of Nursing Homes Safety Association Proposal

Maintaining awareness and communicating key trends, best practices and trending issues creates the foundation for messaging

Figure 24: Best Practice: Key messaging

4.4	Target messaging for employee groups on the impact of safe workplaces on client care.
4.5	Focus messaging for employer groups on importance of organizational safety culture and cost benefit of investments in health and safety.

Leveraging Existing Materials

In the true spirit of collaboration inherent with health and safety associations all leaders spoke of the importance of re-writing and re-branding existing materials from other health and safety associations, WorkSafeBC, and other industry groups (i.e. health authorities in the context of SafeCare BC). With an emphasis on citing appropriate resources, information sharing was encouraged for the development of content for e-blasts, newsletters, social media and print communications.

Figure 25: Best Practice: leveraging existing materials

4.6	Re-write/re-brand existing health and safety materials from existing health and safety associations, WorkSafeBC and health authorities for new target audiences for e-blasts, newsletter, social media and print communications (citing appropriate source).

Communication Activities

Safety Driven, the Trucking Safety Council of BC has identified key communication activities as developing promotional videos and accompanying brochures for the business areas including the association's role, benefits, services and resources, COR processes and benefits, a Tool Kit, and Learning Centre. Additional external communications include COR awards and promotions, attending trade shows and events, use of website and social media channels, and blogging. Safety Driven ran two advertising campaigns through media outlets to raise the profile of the Association. A monthly newsletter includes updates, industry news and examples of safety best practices.

The CCSA engages members through monthly newsletters distributed electronically in HTML format. These newsletters are sent to Occupational Health and Safety Managers on-site who often print and post the newsletter. The CCSA strategically moved all training event information and registration on-line, increasing traffic to their website. The CCSA collects and communicates quantitative data to support statistical achievements. This is often presented as a 'success story' and receives positive feedback from members.

Go2 develops articles on key health and safety trends, created brochures showcasing industry trends and available resources, creates on-line information sessions on programming and hosts an annual meeting of all Technical Advisory Committee members to share and generate best practices, which are

then communicated industry wide. Additional communication strategies include presentations, one-on-one meetings with employers and attending industry events.

Figure 26: Best Practice: Communication activities

4.7	Focus communication activities on: e-blasts of best practices, trends and emerging issues in safety, printable newsletters, social media to engage employers/executives, one-on-one meetings with targeted employers to raise awareness of SafeCare BC, bringing members to website for training information and registration, and validating access to and use of on-line resources and social media by front line staff
4.8	Profile employer and employee success stories on a regular basis to provide stories of interest, particularly to the front line audience.

Website

Health and safety associations are accountable, through the agreement with WorkSafeBC, for transparency of operations and sharing resources with members and stakeholders. As such, the websites are used to communicate operational information about the association as well as act as member portal to course listings, resources and tools. Health and safety associations must publish on its website the following information:

- Names of the member of Board of Directors
- Terms of reference for the Board of Directors
- Three-year service plan
- Annual workplan
- Annual budget
- Annual audited financial statements
- Annual activity report
- A member awareness and market penetration survey (for a *three-year cycle*, i.e. March 31, 2015)
- A service plan evaluation (for a *three-year cycle*, i.e. March 31, 2015)

In addition to asking for direct feedback from website users, tracking hits to specific pages, tools and resources is an effective way to measure uptake of training materials and resources used by other health and safety associations.

Figure 27: Best Practice: Website

4.9	Use the website to ensure accountability to members and transparency of operations (i.e. governance, survey results, workplans and evaluations) in addition to member services.
4.10	Track user visits to the website to determine the most used resources.

Use of Social Media

The majority of health and safety associations included in this review use social media to recruit and engage members. Social media channels include Twitter, Facebook, YouTube, e-blasts and blogging. The exception being the Continuing Care Safety Association, who have found through direct programming that front line staff working in long term care facilities most often do not have access to a

computer on their worksite. While there may be a computer to use, access to social media may be blocked.

Tracking the number of followers, tweets and likes, etc. as a way of measuring the spread of information is an effective way to measure uptake of training materials and resources used by other health and safety associations.

Figure 28: Best Practice: Use of social media

4.11	Validate the use of, and access to, social media by target audience employer and employee and clarify if access is available on work as well as personal time.
4.12	Track user visits to the various forms of social media to determine the most used resources and preferred communication channels.

Key learnings are summarized in Table 5.

Table 5: Key communication learnings

Source	Formal communications plan	External communication channels	Market segmentation	Use of social media	Key messaging
Continuing Care Safety Association (CCSA) – prior to 2008	Formal communications plan is one component of the business plan	HTML monthly newsletters On-line resources Segmented distribution list Website e-blasts	Front line communication stream and executive	Twitter No use of Facebook or YouTube as front line staff cannot access from worksite	Focus on employee safety then create link to patient care Injury reduction program improved association credibility Include qualitative data in communications (positive stories) Safety starts at the top of an organization & safety has a good return on investment
Go2: Health and safety for the tourism and hospitality industry	Detailed plan, including objectives and strategies included in business plan	Key articles on H&S issues Industry specific H&S brochures with industry trends and resources Develop H&S 101 online sessions Maintain awareness of key trends and best practices and regulations in the industry Host annual meeting or all Technical Committee members Quarterly profile of COR success story	Primary target is employers	Daily social media communications via LinkedIn, Twitter, Facebook, and blog	Promote safety as a need Educate employers Communicate cost benefit of H&S to employers (decreasing premiums)
Safety Driven	Communication outcomes and activities included in workplan and business plan	Promotional videos on COR, training centre, and Tool Kit COR awards program Attend trade shows and conferences		Use Twitter and Facebook, blogs and on-line news updates to enhance connections with members	
Actsafe	Communications included in business plan	Newsletter	Identify and utilize champions in the sector, employer safety awards	Facebook, Twitter, e-newletter	"When our industry perceives a need, ActSafe responds"

Appendix A: Profile of Health and Safety Associations Reviewed

The **Trucking Safety Council of BC** was established in 2010 as a non-profit organization representing the health and safety needs of BC's trucking industry and related businesses in the transportation, warehousing and logistics sector. The Council delivers safety services focused on injury prevention and risk management.

- The key take away for SafeCare BC from Safety Driven is to ***target specific employee and employer groups to provide appropriate communication and tailored training***. For example, Safety Driven targets employees of three specific employer groups (owner/operator, small and large) and has different toolkits available for each employer type.

Formerly known as the Hospitality Industry Education Advisory Committee (HIEAC), **go2** was rebranded in 2003, in conjunction with an expanded mandate to coordinate the BC Tourism HR Action Plan. Working in partnership with industry and WorkSafeBC, go2's goal is to assist the tourism and hospitality industry in becoming a leader in best occupational health and safety practices. Through its programs, go2 provides customized health and safety resources as well as administration of the Certificate of Recognition (COR) program, an incentive program which provides employers rebates on WorkSafeBC premiums if they implement systems that go above and beyond regulatory compliance.

- The key take away for SafeCare BC from go2 is the ***importance of a strong partnership between the host and health and safety associations***, with the need for a formalized reporting and financial accountability structure (i.e. shared infrastructure and staffing costs).

Actsafe partners with BC's entertainment industries to keep workers safe. Collaborating with BC's motion picture and performing arts industries to provide innovative, accessible health and safety training and resources, Actsafe is where people in the industry connect with others who share their safety concerns.

- The key take away for SafeCare BC from Actsafe is the importance of planning for a surplus in year 1 and thinking ahead to where the funds should be held.

The **Continuing Care Safety Association** (CCSA) in Alberta provides industry-specific health and safety training to the Alberta continuing care sector. The CCSA provides industry and the public facts, data and safety alerts regarding employee health and safety and offers health care consulting and forms professional relationships with continuing care organizations. This Association is a separate entity from the founding organization, the Alberta Continuing Care Association.

- The key take away for SafeCare BC from CCSA and the host association, Alberta Continuing Care Association the is the ***need to determine the relationship between the two associations from the onset of the partnership, as well as the importance of embedding adult based learning into all training and education***.

Appendix B: Best Practice Interview Guide

1. Can you walk us through the development of your constitution and bylaws? Are there any learnings you can share with us as we work to develop our own for SafeCare BC? To what extent was a legal firm involved? What was the process for approving the C&B's?

2. Considering the composition of the Board of Directors, what would you identify as success factors?
    a. How was the board recruited? Do you have staggered terms?
    b. Do you have terms of reference you can share with us?

3. What are the key functions of the technical advisory committee? Please describe the composition. How often does it meet? When do you recommend BC initiate a technical committee?
    a. Do you have a terms of reference for the TAC?

4. How is your Association staffed?
    a. Were staff all hired at the same time or was the hiring staggered?
    b. Do you have personnel policies that you would share with us?
    c. Position descriptions or TOR?
    d. What kind of staffing models were considered in collaboration with the host organization? What are the key lessons learned with respect to staffing and line(s) of reporting?

5. Can you identify for us, please, the key revenue streams for your Association? (Grants, membership fees, training fees, etc)
    a. Do training fees cover the development and delivery of the programs themselves?

6. Do you have a host organization to which you pay a service charge? If so, can you identify the rate or formula used?
    a. How well is this working?
    b. Do you feel it's a fair amount?
    c. Has it ever been revisited?

7. Do you have a formalized communications plan?
    a. What are your key external communication channels?
    b. How are members communicated with?
    c. How frequently?
    d. How do your members prefer to receive information?
    e. What feedback have you received over the years about communication?
    f. How is it different for employers vs front-line workers?
    g. Do you work with a communications firm?
    h. What are the key lessons learned with respect to communication?
8. What portion of your activities is dedicated to training?

a. What methods of training do you use (approach/model/format/required time/evaluation, etc. ?
b. Was there a training needs assessment (maybe they can share)?
c. How do you determine training needs?
d. What are your key learnings from delivering training over the past 7 years?
e. Would trainers be available on contract to support SafeCare BC?

9. How is the work of the Association being evaluated?

10. What is the reporting relationship like to the funding organization?

STAKEHOLDER ENGAGEMENT
CHANGE MANAGEMENT
STRATEGIC PLANNING
PERFORMANCE MANAGEMENT
PROJECT/PROGRAM EVALUATION

The Howegroup is a boutique consulting practice specializing in serving public sector clients.

.

howegroup | public sector consultants

www.howegroup.ca

604.506.5486 ph

SafeCare BC Implementation Working Group
Meeting #2 – December 10, 2013 ACTIONS

Attendees

Committee members

- Sue Emmons, BCCPA Board Member, Director at Large
- Daniel Fontaine, CEO, BCCPA
- Mary McDougall, BCCPA Board Member, Past President
- Stephen Symon, Manager Industry and Labour Services, Healthcare Industry WorkSafe BC
- Carla Gregor, Clinical and Systems Transformation and Special Projects for PHSA

Secretariat

- Jennifer Hystad, SafeCare BC Co-Project Manager, Howegroup/Hystad Consulting
- Wynona Giannasi, SafeCare BC Co-Project Manager, Howegroup

Regrets

- Jeannette Thompson, Administrator, Broadway Lodge & Denominational Health Association representative

Actions

Item	Comments / Actions
1. Introductions	New member: Carla Gregor
2. SafeCare BC Best Practice Review: Report	See attached document, Meeting Notes_December 10, 2013
3. SafeCare BC Training Needs Assessment	SafeCare BC Training Needs Assessment Charter shared with group and received the following feedback: Scope: • Ensure language around sector is reflective of residential care/long term care with accurate definitions • Be aware the audience may extend into Home Care with some training/resources. Ensure language allows for this flexibility while maintaining clear focus on CU 766011 • Consider WorkSafe BC employer segmentation (small (<20 FTE, medium 20-100 FTE, and large >100 FTE) Resources: • WorkSafeBC evaluation reports and ACCA (Alberta) may provide background for critical training elements • WorkSafeBC to forward industry report links to Howegroup Considerations: • Note which employers have sites beyond BC when filtering for size. Employers with multiple sites outside of BC may have increased access to training and resources

	• Use open and closed questions for generating information on critical training factors. Ensure these are prioritized • Include examination of industry *response* to injury incidence vs. proactive *risk prevention* On-line Survey Dissemination: • Consider ways for WorkSafe to disseminate surveys on our behalf without compromising privacy • Request employers circulate on-line surveys to 5 employees (as opposed to blanket email requests) • HG will explore avenues with the unions and other partners to reach front line employees and employers (i.e. fitting into existing communication channels) • Committee members requested to send further suggestions to Howegroup **by December 17, 2013** • HG to use a small incentive for the front line survey (i.e. Chapters or Superstore giftcard)
Next Meeting	Previously scheduled for January 14th will be cancelled and rebooked

SafeCare BC Implementation Working Group

ITEM 1.1.g

Meeting #1 – November 12, 2013 ACTIONS

Attendees

- Daniel Fontaine, CEO, BCCPA
- Mary McDougall, BCCPA Board Member, Past President
- Jeannette Thompson, Administrator, Broadway Lodge & Denominational Health Association representative
- Stephen Symon, Manager Industry and Labour Services, Healthcare Industry WorkSafe BC
- Kyle Balagno, Myron Creative (guest)
- Peter Desmet, Myron Creative (guest)
- Lisa Steinson, Myron Creative (guest)
- Jennifer Hystad, SafeCare BC Co-Project Manager, Howegroup/Hystad Consulting (Secretariat)
- Wynona Giannasi, SafeCare BC Co-Project Manager, Howegroup (Secretariat/ meeting Chair)

Regrets

- Sue Emmons, BCCPA Board Member, Director at Large

Action Items

Item	Comments/Actions
1. SafeCare BC Implementation Working Group operations: a) Adopt Terms of Reference b) Confirm Chair c) Reporting to the Board	Terms of Reference adopted as is, with clarification that the Hiring Committee will be overseeing the recruitment of the ED. Wynona acted as the interim Chair and the Committee supported Sue being the Chair for the remainder of the Committee (and Sue has since accepted this role via email correspondence). Howegroup will be the Secretariat for the duration of the Committee. This committee will formally report to the Board via the Chair's report and sharing of meeting minutes.
2. SafeCare BC branding strategy a) Presentation by Myron Creative b) Input requested from Committee to inform branding strategy	Myron discussed the branding strategy. Needs and input was solicited from the Committee. Key points include: • Ensure focus remains on the employee. • Ensure branding reflects all employees, not just those represented by BCCPA or DHA. • Ensure branding represents employee and patient safety. • Consider growth in SafeCare BC over the next 3 years, in services (i.e. COR) as well as sector (may include home care, other health sectors). • Consider injury and safety prevention as well as return to work and stay at work programming. • Next steps include: draft concepts by November 18th (with feedback requested by November 21st), subsequent concepts by November 25th and final branding elements by November 29th

3. SafeCare BC best practice review a) Presentation from Howegroup b) Input requested from Committee to inform final report	The purpose and methodology was reviewed and comments were solicited, with the caveat that the full report will be shared by November 22nd. Comments surrounded the need to ensure: • Recommendations are developed from the employee as well as the employer lens. • Financial accountability includes accountability to the membership as well as to the funder. • The longer term organizational infrastructure for SafeCare BC, balancing independence with strategic partnerships and growth across the sector is considered.
Next Meeting	December 10, 2013, 1pm

DRAFT

Interim Report
Seniors Care for a Change:
Recommendations for Modernizing the Continuing Care Sector in BC

Prepared for
BC Care Providers Association

Prepared By
Izen Consulting
& Rebecca Livernois

January 9, 2014

INTERIM REPORT
SENIORS CARE FOR A CHANGE:
RECOMMENDATION FOR MODERNIZING THE CONTINUING CARE SECTOR IN BC

TABLE OF CONTENTS

INTERIM REPORT
SENIORS CARE FOR A CHANGE:
RECOMMENDATION FOR MODERNIZING THE CONTINUING CARE SECTOR IN BC

1.0 INTRODUCTION

1.1 OVERVIEW

The BC Government is currently undertaking a Core Review of its services, with a purpose 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 services available to British Columbians.

This Interim Report is in response to the Core Review; it illustrates how the Core Review applies in the continuing care sector in particular.

The aim of this report is for the BC Care Providers Association (BCCPA) to provide the government with key recommendations that could streamline administrative, regulatory and reporting processes with the purpose of reducing costs and enhancing the quality of resident care in the continuing care sector.

The BCCPA presents a set of targeted recommendations to the Core Review process that provide simple and strategic ways to reduce the administrative burden of regulatory and reporting overlap. The implementation of these recommendations would allow care providers to direct more attention to client care and less to duplicating bureaucratic services.

This Interim Report of initial findings is based on preliminary consultations with stakeholders in the continuing care sector in BC. The sector interacts with several government agencies in multiple settings, from worker registration to facility designation, to a multi-faceted complaint process, as well as the typical business-government regulation. These interactions are presented in the Dis-Org Chart in Appendix A, which is a chart that illustrates the continuing care sector's relationships with government and non-government organizations. This chart is the basis for this report: simplifying relationships, as per the recommendations outlined in this report, would allow for a redistribution of time from bureaucratic responsibilities toward client care.

This interim report serves as the first collection of issues and recommendations, identified in Section 2.0 and summarized in Section 3.0 below. A subsequent report based on this Interim Report will be submitted to the government in March 2014 and will outline the BCCPA's central recommendations for the Core Review.

1.2 BC CARE PROVIDERS ASSOCIATION

The BC Care Providers Association is a non-profit society, which has been serving private and non-profit community care providers for over 35 years. It has over 230 facility and commercial members across British Columbia. In addition to creating over 15,000 direct and indirect jobs in the continuing care sector, BCCPA members care for more than 11,000 seniors each day in residential care and assisted living, and over 10,000 each year through home support.

The BCCPA focuses its efforts in five key areas:

- Foster Standards and Quality of Care: Advocate & enhance quality of life for seniors.

- Sustainability of Services: Ensure adequate funding to enhance quality care.
- Relationship Building: Focus on government, health authorities and key stakeholders.
- Membership Services: Provide services to members to foster quality of care.
- Human Resources/Labour Relations: Provide support and effective responses to meet staffing and training needs.

Vision

The BCCPA 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.

Mission

Members of the BCCPA are independently owned organizations that provide the best possible care services to seniors. Members benefit from belonging to the Association because it:

- Advocates on and responds effectively to industry issues such as appropriate legislation, policy and funding.
- Actively supports the provision of the best possible care through the adoption of recognized standards.
- Enhances the profile of its members as providers of service excellence for seniors in care.
- Educates the public and serves as the voice on behalf of the seniors' care sector.
- Facilitates timely communications and networking opportunities.

1.3 BC GOVERNMENT CORE REVIEW

In July 2013, the Honourable Bill Bennett, Minister of Energy and Mines and Minister Responsible for Core Review, released the Terms of Reference for the Core Review process, which focuses on ensuring the best possible use of government resources and respect for the interests of taxpayers.

The scope of the Core Review has been established to include the mandates and program delivery models of all ministries, boards, commissions, Crown agencies and the SUCH sector (schools, universities, colleges, and hospitals).

The objectives of the Core Review include:

- Ensuring ministry programs and activities are focused on achieving government's vision of a strong economy and secure tomorrow.
- Confirming government's core responsibilities and eliminating programs that could provide better service at less cost through alternative service delivery models.
- Ensuring public-sector management wage levels are appropriate.

The review will include targeted industry and stakeholder consultations with recommendations expected before the end of fiscal year 2013-14 and completion of the process by December 31, 2014.

The full terms of reference of the Core Review can be viewed in Appendix C.

1.3.1 MINISTRY OF HEALTH MANDATE

Two key documents guide the Ministry of Health in its relationship with stakeholders including the care providers of British Columbia. First, with the appointment of each new Minister in June 2013, the Premier provided a publicly accessible mandate letter to guide the Minister. Second the Minister's annual Service Plan sets out the operational aspects of the various department functions and priorities. The key relevant highlights of each are presented below for context.

Highlights – Minister of Health Mandate Letter, June 10, 2013

- Live within the funding envelope provided by the Minister of Finance while at the same time continuing to innovate and improve resident services.
- Eliminate red tape so that we can stimulate economic development without needless delay.
- Innovate and find savings through the health system and continue to decrease the cost of administration and overhead to focus as much of the resources as possible on direct resident care.
- Driving innovation and change will be necessary in community and home care to control growth of health-care spending (needed to ensure successive balanced budgets) - strive for better outcomes for residents while ensuring best value for money.

Highlights – Ministry of Health Service Plan 2013/14 - 2015/16

- Objective 2.1: Providing a system of community based health care and support services built around attachment to a family doctor and an extended health care team with links to local community services.

  An integrated system of primary and community care health services will improve care particularly for those with complex needs such as the frail senior population, which is increasing as the population ages.

- Objective 4.1: Optimize the supply and mix of health human resources, information management, technology and infrastructure in service delivery.

  Support an affordable, sustainable health system by ensuring that British Columbia has the required supply of health care providers and that their skills are being used effectively.

- Objective 4.2: Drive efficiency and innovation to ensure sustainability of the publicly funded health system

  An efficiently managed health system ensures resources are spent where they will have the best health outcome. Improvements in innovation, productivity and efficiency must be continually pursued to make sure our publicly funded health system is both effective and affordable for the citizens of British Columbia.

The Minister's Mandate Letter can be viewed in Appendix D, and the Ministry's Service Plan can be downloaded on its website at www.gov.bc.ca/health.

1.4 METHODOLOGY

The project team of Michael Izen, B.A. (Hons.), M.P.A., and Rebecca Livernois, B.A. (Hons.), M.A. (economics), reviewed the available literature of government and industry reports and literature, including past BCCPA documents. 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. Interviewees had both public and private beds and represented all regions across BC. Seven online surveys containing similar questions to the interviews were also completed. Therefore, a total of twenty-three care professionals representing twenty-two organizations across all health authority jurisdictions in the province were consulted.

Those interviewed 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.

2.0 SUMMARY OF KEY ISSUES

2.1 CARE INDUSTRY ORGANIZATION

The operation of a care facility in BC is complicated; in order to operate, each facility must be connected to a plethora of organizations that accredit, audit, regulate, advocate, inspect etc. The large number of organizations that a care provider must encounter is illustrated in the Dis-Org chart in Appendix A. The types of relationships a care provider has with these organizations as well as the outcome of the relationship (e.g. submitting a report) are presented in the Dis-Org chart in Appendix B.

The majority of the following recommendations are essentially based on the fact that interacting with many organizations takes more time than interacting with fewer organizations to fulfill the same requirements. That is, the recommendations would streamline the Dis-Org Chart, which is synonymous with minimizing time spent fulfilling administrative duties without a reduction in the outcomes of the administration duties, such as the type and quality of clinical information provided to the government.

When the number and level of complexity of interactions care providers have with organizations is reduced, time is saved, just like time is saved when one shops at one grocery store instead of at four specialty stores. One-stop shopping saves time and it would save time for care providers as well if a similar principle were in part applied to administrative duties.

One possible effect of saved time for care providers is that administrator wage costs are reduced. A second possibility is that care aides and nurses can spend more time on front-line care and less time on administrative duties. Hence the time saved can have both a monetary and quality of care benefit. The way a care provider benefits from this time-savings will differ, but in all cases it will benefit the resident either in terms of more direct care hours available, which improves quality of life and reduces hospital visits in the long run or will reduce wage costs previously spent on administration, which frees up money that could be used to invest in the quality of the care home and thus improve the quality of care of residents in the long run. The specific benefits and cost savings of saved time are difficult to measure; however improving quality is generally associated with improving health of residents, as well as reducing costs and improving productivity in the log run.[1]

2.2 CARE INDUSTRY ISSUES

A review of the literature and direct input from care provider owners and operators yielded a wide variety of issues that affect the administrative process of adhering to the wide-range of government regulations and expectations, as well as related practical solutions. In all instances, resident care and accountability remains paramount; the issues raised reflect redundancies, overlap and omissions.

This section identifies ten areas, several of which contain sub-issues, along with examples of the overlap. A specific recommendation on how to update the system to reduce the administrative burden in order to increase staff time available for resident care follows each description of an issue. Each recommendation also identifies areas for cost savings, most of which are savings in administrative and staff time.

[1] See W. Edwards Deming, "Improvement of quality and productivity through action by management" in *(*eds) Michael Lewis and Nigel Slack, *Operations Management: Critical Perspectives on Business Management, Vol 2,* Taylor and Francis, 2003. *pp 255-270*

2.2.1 REPORTING PROCESSES

Reporting is the main regular interaction among care providers and various government agencies. Three main issues in reporting have been identified that negatively impact care providers and the seniors in their care.

1) Standardizing Reports Across Health Authorities

a) Currently, care providers who have facilities 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. In Vancouver Coastal health authority, direct care is defined as care for a resident by a Registered Nurse (RN), a Licensed Practical Nurse (LPN), or a Resident Care Attendant (RCA). In Fraser Health, 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 facilities must create separate charts of accounts for different health authorities and spend extra time complying with slight administrative inconsistencies.

It is the understanding of care providers that these reports get sent from the health authorities to the Ministry of Health. If so, then all reports are ultimately sent to one place, and having a reporting system that is standardized across British Columbia could save time and resources for the government bodies processing the reports.

Care providers applaud the health authorities for developing the practice of reporting on quality indicators that set standards and hold service providers accountable, however they recommend the system progresses to the next step by creating consistency among the reports submitted to health authorities. This will reduce administrative costs significantly for care providers with facilities in multiple health authority jurisdictions.

The current duplication in reporting to health authorities and lack of standardization takes scarce resources away from client care and puts it into administration with no additional benefits to the system.

Recommendation #1: Standardize reports across health authorities

Administrative time spent by Ministry of Health staff consolidating information from different health authorities could be saved since all reports would be in the same format. Administrative time also could be saved at the facility-level since care providers would no longer have to re-group the same information in different ways to satisfy different reports. The time saved would be redirected towards improving the quality of resident care. This would allow for better and more services to delivered to British Columbians at the same cost.

b) Only some health authorities require the Provincial Performance Management Framework Reports. This framework is designed to help support health outcomes at care facilities; however other procedures perform the same function such as InterRAI, which is a tool used to assess clients for their needs and to determine whether the current care levels are appropriate. The Provincial Performance Management Framework reporting task is onerous and it is unclear to care providers

the benefit the sector is gaining from these reports, especially if some health authorities no longer use this framework.

Recommendation #2: Eliminate the Provincial Performance Management Framework reports

Administrative time would be saved 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 facilities.

2) Consolidating Data Reporting

Currently, care providers input the same or very similar data into multiple systems for different data-collection bodies. These include the health authorities, MDS InterRAI, Statistics Canada, and the Canadian Institute for Health Information (CIHI).

Care providers suggest submitting all the same data but in one format that all bodies can access. Alternatively, primary reporting bodies such as the health authorities could make the data accessible to the secondary bodies such as the CIHI.

Recommendation #3: A single primary reporting agency to collect one report and distribute to secondary reporting agencies

Administrative time would be saved since the same information would only be reported in one format.

Fraser Health Authority originally planned for data to seamlessly flow from the facility to the health authority when the facility had the same software – GoldCare – as Fraser Health. Care providers would like to see this initiative happen as soon as possible, since currently they are inputting data into their own system and then again into the health authority system even though they have the GoldCare software. This creates needless duplication in administrative duties.

Recommendation #4: Implementation of standardized software in three to five years across BC and eliminate duplicate reporting

Administrative time would be saved since the same information would only be reported in one format.

Recommendation #5: Funding to be dependent on quality of care determined by data collected through MDS InterRAI

Funding dependent on quality indicators would improve efficiency because acuity level of residents would be identified so that appropriate funding, and therefore appropriate services, could be provided.

3) Consolidating Reports

Care providers must complete two types of financial reports that overlap. The Quarterly Financial Reports to the health authorities, and semi-annual financial reports to the Ministry of Health, through the Health Sector Compensation Information System (HSCIS). Both reports include payroll information.

Preparing these reports is labour intensive because although they collect similar information, they are in different formats, are collected at different times, and operate on different definitions of a year (one uses the calendar year while the other uses the fiscal year).

Furthermore, HSCIS was implemented in 2000 to assist the Health Employers Association of BC (HEABC) with its bargaining objectives. Many long-term care homes are no longer members of HEABC but still have to submit this report to the Ministry of Health. This reporting requirement for care providers that are no longer affiliates appears to be unnecessary.

Recommendation #6: Consolidate financial reporting to the health authorities and through HSCIS

Administrative time would be saved since the same information would only be reported in one format.

2.2.2 INSPECTIONS & AUDITS

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 Accreditation Canada. Inspections are conducted by Accreditation Canada every four years and are intended to ensure that the facility is meeting a shared set of standards concerning all aspects of the quality of care. The health authority also conducts its own quality review, as does WorkSafeBC and the Community Care and Licensing Branch of the Ministry of Health. This creates duplication because several different bodies inspect similar factors. Care providers believe that the same standards can 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 to clean. WorkSafeBC also conducts an inspection and notes the same issue. The quality review by the health authority may or may not catch that particular issue, and every four years Accreditation Canada will also ensure the facility is complying with required operating practices on hazardous materials. That is, there are several different people looking for the same issues and making equivalent recommendations. Care providers believe that it is important that they are inspected to ensure standards are being met, but also are faced with the reality that inspecting the same things many times takes time away from providing quality care to residents. As such, they believe that streamlining this process would improve quality of care and improve the efficiency of the inspection process.

Recommendation #7: Streamline Licensing, Quality Review, WorkSafeBC and Accreditation Canada inspections so that the same criteria are not the responsibility of multiple inspection bodies

This would save time of staff at care facilities that could be redirected toward quality of care.

For example, if criteria such as sufficient controls on chemicals used were the responsibility of one body, such as Licensing, a half hour could be saved on the Quality Review inspection and the same amount of time could be saved on the WorkSafeBC inspection. This would save an estimated total of $30 per WorkSafeBC and Quality Review inspection, or $67,500 over 10 years in health inspector time across the province.[2]

[2] 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" <www.bcit.ca/study/programs/8500dbtech#graduating>). 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 around 225 facilities in British Columbia, inspecting each facility once with the streamlined system that saves only one hour would save the province $6,750 a year.

2.2.3 INVESTIGATION PROCESSES

Care providers recommend a consolidation of investigatory responsibilities among government organizations.

1) Consolidating Investigations

Care providers would like a simplified investigation process for the sake of the wellbeing of residents, the quality of the provision of care and investigation costs.

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. Licensing also performs an external investigation. Occasionally the Patient Care Quality Office (PCQO) will also become involved when it is requested by the client or their family. When the allegation falls within the scope of the BC Care Aide & Community Worker Registry (the Registry), the Registry also conducts its own investigation. This is a costly duplication to the health authorities considering the cost of an investigation by Licensing or PCQO could cost $1,200.[3]

Furthermore, care providers find that when multiple organizations are conducting independent investigations of the same incident, the process becomes complicated, untimely and costly. There can be conflicting findings among the investigations, and it is difficult for the care provider to know how to satisfy all the findings.

For example, consider an event that is being investigated by both Licensing and the PCQO where a female and male resident are found together naked. After the investigations are complete, a non-nurse Licensing Officer finds that there is inappropriate behaviour and that steps must be taken concerning the male resident involved to ensure the same incident is not repeated. PCQO has a nurse investigator who instead recognizes that you cannot determine what occurred because both residents are borderline cognizant. It could have been consensual, so the nurse investigator develops a care plan where the two residents have to be assessed by a psycho geriatrist, and the care provider must separate the two and monitor the situation on an ongoing basis. This means that there are now two sets of regulations and the administrator has to determine how to proceed to comply with both regulations.

Multiple investigations also detract from the quality of care because every time there is an investigation, everyone involved has to be interviewed. This takes staff away from front-line care. Furthermore, an unnecessary psychological and time burden is placed on all parties involved, including the victim and their family, when they must be interviewed multiple times.

Recommendation #8: Streamline the investigation process so that there is one external body investigating allegations of abuse at a time

If the PCQO only got involved after the licensing investigation was complete and the client was given a chance to decide whether they were satisfied with the outcome or not, then this could save the health authorities $1,200 on a single investigation where the client is satisfied with the outcome of the Licensing investigation and therefore

[3] If the investigation takes a week (40 hours) and the inspector is paid $30 per hour, the investigation costs the government $1,200 (30x40=1200). This cost is in line with other average reports of investigation costs.

does not request another investigation from PCQO.[4] It is estimated that this could save the health authorities $192,000 over 10 years in wage costs for investigations.[5]

In addition to monetary savings, this would also reduce stress on all parties involved since they would not necessarily have to be involved in multiple investigations.

2) Reviewing Care Aide Registry Investigations

Care providers applaud the government on establishing the Registry and support its mandate to eliminate abuse in the continuing care sector across BC; however care providers suggest that there are issues with the way the Registry currently operates. 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 usually in an untimely manner, is very expensive to the care provider, and is often more lenient than the internal and the other external investigations.

Oftentimes, the internal investigation and the Licensing investigation have been completed for months before the Registry begins its investigations. This brings the issue up again 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, 139 employees have been reported to the Registry as being terminated for abuse. This means that Licensing and the employer found in their investigations that abuse did occur, and that the employee was no longer suitable to be working in that facility. Of these reported employees, the Registry investigated 73 cases because the employee contested their employment termination. Seven investigations are currently underway, and 55 employees were reinstated on the Registry after certain requirements were fulfilled such as further education. Only 12 employees have been removed from the Registry. This means that in 83% of the cases where abuse was substantiated by Licensing and the employer, the employee continues to work in the industry. Furthermore, future employers are incapable of knowing that their employment was terminated in the past for abuse. This is an enormous concern for care providers.

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 cost, which normally ranges from $5,000 to $15,000.

While care providers believe that the effective functioning of the Registry is an important issue to acknowledge because of the time and money losses associated with its current practices that impede internal advancements of the quality of care, it is not as

[4] If the investigation takes a week (40 hours) and the inspector is paid $30 per hour, the investigation costs the government $1,200 (30x40=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.

[5] There were 2 reports in our sample of 23 of investigations in the past year where both licensing and PQCO were involved. Extrapolating this figure to all private care homes in BC (188), this would suggest 16 in the past year [(2/23)x188=16]. Therefore, having one investigation at a time could save up to $19,200 annually in wages for investigators (16x1200=19200).

relevant for the Core Review as other recommendations. BCCPA will submit a report to the government in the spring of 2014 with specific recommendations on how the Registry can be improved.

Recommendation #9: Improve the operation of the Registry to better support its mandate of eliminating abuse.

There is a cost associated if the Registry reinstates an employee that Licensing and the employer believe to be abusive. If an abusive care aide is reinstated to the Registry, this person can then become employed in another facility. Here, they may commit abuse again. This care aide will then bring about another investigation costing the government at least $1,200 in addition to the previous investigation costs. This is a highly costly duplication considering both these extra investigation costs and considering the immeasurable psychological or physical cost abuse causes a victim.

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

2.2.4 COLLECTING CLIENT USER FEES

Care providers have experienced situations where a family keeps a resident's pension income rather than paying the required 80% of that income to cover the client user fees. Currently, if the resident is found to be mentally capable, the Public Trustee usually will not step in when care providers report the issue to the Office of the Public Guardian and Trustee. In this case, care providers must act as collection agencies to obtain the client user fees from the family. It is extremely unfavorable 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.

Currently, the Public Trustee will intervene only when the resident is not mentally capable of handling their own finances. However there is a grey area in terms of the Public Trustee's duties when a resident is vulnerable but mentally capable. When someone has not been paying client user fees in a public bed, it is not because they do not have the money since user fees are based on pension income. The issue is that the family has been absconding pension income, which is a clear indication of the vulnerability of the resident.

The time care providers spend collecting debt is time they do not spend providing social services to residents. Social service provision is one component of the 3.2 hours a day that care providers are subsidized to spend with a resident. Debt collection is categorized as a social service. Therefore, when client user fees are not being paid and debt collection must occur, other social services provided to that resident suffer.

We propose two ways to resolve this issue, both based on the system in Ontario. Firstly, when this situation arises the government pays the client user fees until the issue is resolved. Alternatively or additionally, the government takes the family to court immediately when client user fees are not being paid. This ensures that the problem is 'nipped in the bud:' the relative is involved immediately and by the time the issue is resolved, there is not an exorbitant bill for the family to pay.

Recommendation #10: After a certain number days of nonpayment of client user fees for a mentally capable resident who's finances are controlled by a third party, the government pays user fees until the issue is resolved and/or takes the third party to court.

A well-defined mechanism such that the legal system becomes involved after a certain number of days that client user fees are not paid would ensure that residents are never evicted, social service time is not wasted on debt collection, the burden of deciding whether to take on cases is taken off the Public Trustee, and anxiety caused by non-payment of fees for residents and care providers is minimized.

Furthermore when frail residents are evicted 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.

2.2.5 CLIENT COMPLAINTS

Generally, the system that has been set up by the BC government and the Health Authorities for clients to make a complaint is well functioning. However, care providers express concern in cases where there are multiple simultaneous investigations. For example, licensing and the Patient Care Quality Office (PCQO) can investigate a complaint at the same time. This is problematic because the process and the recommendations can become confusing and conflicting while also creating needless duplication. Care providers recommend ensuring that one investigation is complete before another investigation begins.

Recommendation #11: Streamline the client complaint process so that there is only one external body looking into complaints at a time

For example, clients could be directed to licensing first, and only if the outcome of the Licensing investigation is unsatisfactory to the client should the PCQO become involved.

This could save tax-payer dollars since only the necessary number of investigations would be required. If two investigations are happening at once, the client may be satisfied with the outcome of the Licensing investigation, rendering the investigation of the PCQO redundant with regards to the concerns of the client. This recommendation would also improve quality of care because it would allow care providers to spend more time caring for residents rather than consulting with multiple investigators.

2.2.6 LEGISLATION & REGULATION

Care providers appreciate that legislation is in place to ensure the quality of care of residents. However, they feel that there are particular regulations that can detract from the quality of care of residents.

1) Reducing the rigidity of nutrition regulations

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 quality of life.

Regulation 64 (1), Food Service Schedule in the *Residential Care Regulations*[6] is a concern for many care providers. This regulation is at odds with resident-centered care because it

[6] BC Government, "Residential Care Regulation, BC Reg 96/2009," May 31, 2012. <http://canlii.ca/t/52112> retrieved on 2013-12-13

prescribes specific meal times. Breakfast that is served only between 7am and 9am is not ideal for some residents who are on alternative sleep schedules. Care providers must put in a specific request for a resident to eat meals outside the stipulated times; however the inability of care providers to easily adjust meal times for certain residents detracts from some residents' quality of life.

Division 3, Regulation 62 in the *Residential Care Regulations* 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. This means that when a resident wants a piece of cake, although the care providers would like to give them the dessert to bring added joy and decadence into their life, they must refuse in order to adhere to the nutrition regulations. Furthermore, some food items that are very popular cannot be repeated as often as residents may like because *Regulation 62 (2)* requires menus are changed every 4 weeks.

Recommendation #12: Increased flexibility in nutrition regulations, specifically *Regulation 64 (1) and 62 in the Residential Care Regulations*

This would allow care providers to enhance the wellbeing of clients by providing the food the like the best at times they prefer. This would also save time since adapting menus to meet specific needs of residents would be easier. This would mean that they could direct time toward the quality of care such as making the meals more appealing and appetizing. This recommendation could improve the quality of life for residents without extra cost to the government.

2) WorkSafeBC requirements

WorkSafe BC regulations have become rigid in many areas that determine how care homes can care for residents on a daily basis. In some cases, care providers can see a way to better care for a resident in a more dignified way, but cannot provide care in such a way because of WorkSafeBC requirements.

Some residents in care homes are young individuals who have suffered from strokes. Care providers find that some WorkSafe regulations that presumably are designed with elderly residents in mind are not appropriate for these young, strong residents. For example, there are two devices that lift residents to move them out of bed: a device called a sit/stand lift and a sling lift. WorkSafe stipulates that if you cannot use both hands to hold onto the sit/stand lift, then you have to be lifted with a sling lift, which is less dignified and less mobile.[7] Some young residents are highly capable of holding on to the sit/stand lift safely with one hand because they are strong, however this is not allowed by WorkSafe.

The quality of life of some residents would be greatly improved by being able to use this lift because they could be moved around in an easier and more dignified manner. Employers see value in their ability to use discretion in order to properly care for residents with differing abilities and needs.

Recommendation #13: WorkSafeBC to allow more discretion by care providers to enhance the quality of care for residents with differing abilities and needs.

This would improve the quality of care of patients. Where care providers see it is safe, more time-effective devices could be used with particular patients. This would allow

[7] Workers Compensation Board of BC, "High Risk Manual Handling of Patients in Healthcare," *WorkSafeBC*, 2006, p 5

more time to be redirected to quality of care, and would also directly improve the quality of life of some patients.

3) Regulations concerning private and semi-private rooms

Under *Section 25 of the Residential Care Regulations*, legislated under the *Community Care and Assisted Living Act*, a private facility can only have 5% of their rooms as semi-private rooms (multiple occupancy rooms).

Care providers suggest that having 95% of all residents in private and non-profit facilities in single-occupancy rooms is financially unsustainable, and believe this is shown by the fact that some health authority residences have only 6% of their rooms as single-occupancy rooms (for example, this is the case at Banfield Pavilion in the Vancouver Coastal Health Authority[8]), while the rest are multiple-occupancy rooms.

Furthermore, semi-private rooms can be valuable for some residents for several reasons: it provides significant cost savings for the resident; a roommate helps ease the transition into the new community; it helps avoid loneliness and feelings of isolation; a roommate provides additional monitoring; and having stronger relationships improves the health of seniors.[9] Furthermore, there are more married couples now than there were in the past who would greatly benefit from double-occupancy rooms.

At the time this report was written, research could not be found on the costs and benefits of private versus semi-private rooms in residential care homes. We propose to undertake a study of this issue with the government and/or the health authorities. A survey could be conducted to determine the percent of residents who would prefer a semi-private room, which would be informative for an adjustment in the regulated percentage of semi-private rooms in care homes.

Recommendation #14: The 5% maximum semi-private room rule regulated under *Section 25* of the *Residential Care Regulations* should be amended based on a future study conducted by BCCPA and the BC government and/or health authorities.

If private facilities were allowed to have more semi-private rooms, there would be more beds, and more affordable options for residents. This could potentially reduce wait lists and reduce mortgage payments for facilities. It would also lower the construction costs of building new care facilities and as such, make it more sustainable to operate such facilities in the long-run.

4) Regulations requiring locks on bathroom doors

Care providers are concerned with a recently implemented regulation, *Regulation 30(a)* of the *Residential Care Regulations,* that requires locks on all bathroom doors.

The first concern is for the safety of residents. The Alzheimer's Society of Canada and the National Institute on Aging both recommend the removal of locks on bathroom doors for residents with dementia to prevent them from accidentally locking themselves

[8] See <www.vch.ca/Banfield_Pavilion>

[9] Accent on Seniors, California's Senior Living Experts, "Assisted Living Facilities: Five reasons to consider a roommate" < http://www.accentonseniors.com/assisted-living-facilities-5-reasons-to-consider-a-roommate/> Accessed January 3, 2014

in the bathroom.[10,11] Although locks would be accessible from the outside so that care providers could help a resident locked in a bathroom, this would cause unnecessary anxiety for the resident. Furthermore, bathroom locks could take care providers' time away from providing quality care when they have to help residents locked in bathrooms and comfort them after the stressful experience.

The second concern is with the cost of retro fitting care homes that were built before this regulation came into effect. After an older building was required by Licensing to install locks on all their bathroom doors, the facility found that it would cost them $100 to install one lock, for a total cost of $110,000. This is an added expense that is difficult for care homes to cover. As such, government funding is needed to help retrofit older buildings.

Recommendation #15: Remove requirement for locks on all bathroom doors.

In one facility alone, this recommendation will save $110,000. This money could be spent in an area that could improve the quality of life and care of residents. The quality of life of residents with dementia would also be increased. Furthermore, quality of care in general could increase due to increased availability of funds.

5) Appropriate categories to assess residential care homes

Some smaller cities do not have an appropriate category to assess residential care homes for property taxes. In the past, they have been assessed as condos rather than a service provider. This adds unwarranted taxation costs to the care provider since they are treated as a profitable enterprise rather than a service provider. Care providers request that the provincial government requires all municipal governments to implement appropriate taxation categories for care homes. This is especially important as the populations ages and more care homes are built across the province. While this is not a recommendation for the Core Review, it is a serious concern for this industry.

Recommendation #16: Properly assess residential care facilities for tax purposes.

Excessive and inappropriate taxes would not have to be paid by care providers, which would save them money that can be redirected toward the quality of care of residents.

2.2.7 PRIVACY

Issues of client privacy are governed by two sets of legislation, and can often impede the quality of service and safety for residents. Three sets of issues arise:

1) Duplication

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

There is a need for a regulation that allows for the continuation of nursing charts when a resident moves from a privately funded bed (where their privacy is protected by *Personal*

[10] Alzheimer's Society of Canada, "Guidelines for Care: Person-centred care of people with dementia living in care homes" *Framework,* January 2011, page 24

[11] National Institute on Aging, "Home Safety Caregiver Guide: Tips for caregivers of people with Alzheimer's Disease," *Alzheimer's Disease Education and Referral Center,* October 17, 2013, <http://www.nia.nih.gov/alzheimers/publication/caregiver-guide>

Information Protection Act) to a publicly funded bed (where their privacy becomes protected by *Freedom of Information and Protection of Privacy Act*).

For example, a resident may move into a privately funded bed in a care home before they qualify for government funding. While they are there a nursing chart is built for them. Then, some time later the resident may qualify for, and move to, a government-funded bed within the same facility. When this change happens a resident's nursing chart that was built when they were in a privately funded bed cannot be continued. A completely new chart must be built for the same resident because the privacy legislation changes. Without a regulation that allows for the continuation of existing charts when a resident moves from a private to a public bed, there is duplication in clinical activities that hampers the efficiency of the provision of care and increases costs.

Recommendation #17: Instate a regulation that enables privacy protection and the sharing of information to follow the resident, not the type of funding received

More time spent with residents can be directed toward care rather than collecting information that has already been collected.

2) Return from Hospital Stay

Similarly, there is need for legislation to allow clinical information to be passed over 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 resident. *The Hospital Act 51(1)* stipulates that a record prepared at a hospital is the property of the hospital. The privacy of that record is protected by the *Freedom of Information and Protection of Privacy Act 22(3)(a)* which stipulates that this personal medical information that is owned by the hospital cannot be acquired by a third party. However, if documentation on treatments and diagnoses relevant to the continuing care of the resident 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 continuity in the treatment of a resident, which would enhance the quality of care at residential care facilities.

Recommendation #18: Allow clinical information to be passed over when a resident returns to a residential care facility from a hospital stay.

More time spent with residents can be directed toward care rather than collecting information that has already been documented by hospital staff.

3) Care Aide Registry Investigation

There is confusion about how a care provider can uphold 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 Act* and as such law prohibits the provision of the information by the care provider to the union. Care providers would like 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.

Recommendation #19: Care providers would like guidance on how to satisfy privacy regulations during an investigation by the registry.

2.2.8 HUMAN RESOURCES

According to *Regulation 78 (1)(c)*, a licensed care provider must keep, for each person in care, a record showing the name and telephone number of the person in care's primary health care provider. To be in compliance with this regulation, care providers must ensure that each resident has a family doctor before they are admitted to the home. However, in remote areas, it is hard to find a physician that will take on residents in long-term care homes. We need to look at how to appropriately compensate physicians of residents in long-term care facilities.

Recommendation #20: Compensate physicians more appropriately when they take on residents who are in residential care facilities.

If more physicians were willing to take on residents as patients, the admittance process of individuals into a care home would be more efficient since time would not be wasted trying to locate a physician. Furthermore, quality of care would increase since physicians would be more readily available. Improved medical attention for residents could reduce hospital costs in the future.

2.2.9 LEGISLATIVE CONSISTENCY

The difference between facilities operated under the *Hospital Act* (*HA*) and under the *Community Care and Assisted Living Act* (*CCALA*) is confusing for both clients and operators. Operators with multiple facilities must use two separate database systems for medication management for their hospitals, legislated under the *HA*, and their homes, legislated under the *CCALA*. Furthermore, services provided by the government differ depending on which legislation the facility operates under.

For example, when a resident is in a facility that operates under the *HA*, all their medications, incontinent product, and wound care is provided without charge to the resident. However, if they move to a facility under *CCALA*, they must pay for those products if it is not provided by the Medical Service Plan.

Recommendation #21: Create more consistency between the *CCALA* and the *HA*

Administrative time would be saved deciphering the differences between facilities owned by the same organization but legislated under different acts. For example, time would be saved learning and using separate database systems.

2.2.10 REQUEST FOR PROPOSALS

Care providers highly value the request for proposals (RFP) process; however they have identified some areas in which this process can be improved to enhance the industry's competitiveness.

1) Follow Process

Care providers have indicated that there have been times when a health authority has gone ahead with renovations without opening the project to bids, such as with the Interior Health Authority's renovation of Deni House. Care providers feel that this practice can result in a sub-par product at a higher cost. The RFP process may take slightly longer since proposals must be processed, but this process ensures that tax payers receive the best product at the best price.

Recommendation #22: Ensure that a RFP process is followed whenever possible.

This will ensure that the best product is provided at the lowest cost; that is, the best use of tax-payer dollars is made possible by the RFP process. Quality of care could increase because the best possible facility will be provided to British Columbians.

2) Feedback

Care providers would highly value feedback on unsuccessful proposals. They would also value having a central authority that processes proposals that posts publicly available parameters of selection. This would enhance the competitiveness of the industry, which ensures that the best product is delivered at the best price.

Recommendation #23: Establish a central provincial body that runs RFP processes, uses unbiased publicly available parameters when selecting a preferred proponent and provide feedback for unsuccessful proposals upon request.

This will allow the public to ensure the best product is provided since they can see why certain operators were chosen over others. Operators also will be able to learn from their past unsuccessful proposals and as such improve in the future, ensuring a superior product is always offered. This will enhance the industry's competitiveness and openness.

3) Consider Operators Size

Larger care providers are concerned that some of the RFP criteria unfairly favour smaller operators. For example, one criterion is to provide the number of substantiated complaints the operator has had to licence. Providing a percentage instead would give a more accurate comparison across different sizes of operators.

Recommendation #24: Establish criteria that are not skewed toward larger multi-site operators.

This will ensure an accurate comparison is given between small and large operators, and ensure the best product is delivered. Furthermore, it could improve the quality of care because the best possible facility will be provided for British Columbians.

3.0 SUMMARY OF RECOMMENDATIONS

FIGURE 1: SUMMARY OF RECOMMENDATIONS – DESCRIPTIONS AND SAVINGS

ISSUE	RECOMMENDATION	DESCRIPTION	SAVINGS
2.2.1 Reporting Processes 1) Standardizing Health Authority Reports	1) Standardize reports across health authorities	Different health authorities require similar information in different formats.	Province-wide standardized reports would save administrative time for the Ministry of Health and care providers.
	2) Eliminate the Provincial Performance Management Framework Reports	All health authorities do not require this report, and the information is provided in other reports.	Administrative time would be saved since this report would not have to be submitted by care providers or processed by Health Authorities.
2) Consolidating Data Reporting	3) A single reporting agency to collect one report and distribute to secondary reporting agencies	Care providers input the same or very similar data into multiple systems for different data-collection bodies, including: health authorities, MDS InterRAI, Statistics Canada, and CIHI.	Streamlining data reporting would mean that care providers spend less time inputting data and more time in front-line care.
	4) Implement standardized software in 3-5 years across BC to eliminate duplicate reporting	Care providers input the same data into their own system and the health authority system. Software that allows internal data to flow to the health authority would halve time spent inputting this data.	
	5) Funding dependent on quality of care determined by MDS InterRAI	Funding dependent on quality indicators would improve efficiency because funding would be provided based on residents' needs.	
3) Consolidating Reports	6) Consolidate financial reporting to health authorities and through HSCIS	The Quarterly Financial Reports to health authorities and semi-annual HSCIS reports to HEABC and Ministry of Health both include payroll information.	Administrative time would be saved since the same information would be reported in one format.
2.2.2 Inspections & Audits	7) Streamline inspections so that the same criteria are not the responsibility of multiple inspection bodies	Care providers believe that Licensing, WorkSafeBC, Accreditation Canada, and Quality Review inspections could be streamlined without losing the rigour of the current system.	If five areas become the responsibility of one BC inspection body rather than three, the government would save an estimated $337,500 over 10 years in health inspector time. Care provider's time would be saved through reduced inspection time.
2.2.3 Investigation Process 1) Consolidating Investigations	8) Streamline investigation process so that one body investigates allegations of abuse at a time	Investigations could be conducted more efficiently if one body conducts an investigation at a time, and a subsequent investigation only takes place when necessary.	This could save the health authorities $192,000 over 10 years in wage costs for investigations. This could also improve quality of care by reducing time care providers spend accommodating investigators and would reduce stress on all parties involved.

ISSUE	RECOMMENDATION	DESCRIPTION	SAVINGS
2) Reviewing Care Aide Registry Investigations	9) Review the Care Aide Registry to ensure it is operating efficiently and in line with its mandate.	Care providers are concerned that the Registry reinstates individuals that have been involved in situations where other government bodies have substantiated the occurrence of abuse.	A well-functioning Registry would save taxpayer dollars by minimizing the number of investigations by repeat-offenders. This would drastically improve the quality of care of residents, as it would minimize the risk of encountering an abusive care aide.
2.2.4 Collecting Client User Fees	10) For very late client use fee third party payments, the government pays user fees until the issue is resolved.	Collecting debts from families of clients the Public Trustee will not take requires extensive resources. Care providers never want to evict clients because a family member is absconding income.	This could improve the life of the financially abused resident drastically. By eliminating the possibility of evicted residents, this recommendation could also reduce hospital and relocations costs brought about by eviction.
2.2.5 Client Complaints	11) Streamline client complaint process so that there is only one external body looking into complaints at a time	When there are multiple bodies investigating the same complaint at the same time, the recommendations can become confusing and contradictory. (See 2.2.3 (2) above)	This could save tax-payer dollars since only the necessary number of investigations would be required. This could also improve quality of care as it would allow care providers to spend more time caring for residents rather than multiple investigators.
2.2.6 Legislation & Registration 1) Nutrition Regulations	12) Increased flexibility in nutrition regulations: i.e., *Regulation 64 (1) and 62 in the Residential Care Regulations*	Flexibility in meal provision is a priority for residents, families and care providers because accommodating different tastes, eating habits and sleeping habits greatly improves the quality of life of residents.	This would allow care providers to enhance the wellbeing of clients by providing the food they favour at times they prefer.
2) WorkSafe Regulations	13) WorkSafeBC to allow more discretion to enhance quality of care for residents with differing abilities and needs.	Some WorkSafe requirements have become rigid in areas that determine how facilities can care for residents on a daily basis.	The use of discretion by care providers allows improved quality of care of residents.
3) Regulations: Private and Semi-Private Rooms	14) Amend the 5% maximum multiple-occupancy room rule regulated under *Section 25 of the Residential Care Regulations*.	BCCPA proposes to conduct research with the government to determine an ideal percentage of double-occupancy rooms in a care home.	There would be more beds available and more affordable options for clients. This would also reduce construction costs and mortgage payments, making it more sustainable to operate care homes in BC.
4) Regulations requiring locks on bathroom doors	15) Eliminate requirement for locks on bathroom doors	Care providers are concerned that compliance with this regulation is both dangerous for residents with dementia and costly.	In one facility alone, this would save $110,000 that could be redirected toward quality of care. This recommendation would also improve the quality of life of residents with dementia.
5) Assessment categories	16) Properly assess residential care homes for tax purposes.	In some smaller cities homes have been assessed as condos rather than service providers.	This would reduce unwarranted tax costs to the care provider. This saved money could be redirected to the quality of care.
2.2.7 Privacy 1) Duplication	17) Privacy and the ability to share information needs to follow the resident, not the type of funding.	There is a need for regulation that allows nursing charts to be passed over when a resident moves from a privately funded bed to a publicly funded bed.	More time spent with residents can be directed toward care rather than collecting medical information that has already been collected prior to the change in funding sources.

Issue	Recommendation	Description	Savings
2) Return from hospital stay	18) Allow clinical information to be shared when a resident returns to a residential care home from a hospital stay	There is need for regulation that allows medical information to be passed from a hospital back to the care provider after a resident's stay in a hospital.	Time spent with residents can be directed toward care rather than collecting information that has already been documented by hospital staff. This would also improve the continuity of care of an individual.
3) Care Aide Registry investigation	19) Care providers would like guidance on how to satisfy privacy regulations during an investigation by the Registry.	There is confusion about how a care provider can uphold privacy laws when there is an investigation by the Registry.	Privacy regulations can be upheld and investigations can be conducted appropriately. This is of utmost concern to the quality of life of residents who must have their privacy protected.
2.2.8 Human Resources	20) Compensate physicians more appropriately when they take on residents in residential care facilities	In some areas, it is hard to find a physician that will take on residents in long-term care homes, although it is a requirement that care providers ensure that all residents have a physician before they are admitted.	If more physicians were willing to take on residents as patients, the admittance process of individuals into a care home would be more efficient since time would not be wasted trying to locate a physician.
2.2.9 Legislative Consistency	21) Create more consistency between the *CCALA* and the *HA*	The difference between facilities operated under the *HA* and under the *CCALA* is confusing for clients and operators.	Administrative time would be saved deciphering the differences between facilities owned by the same organization but legislated under different acts.
2.2.10 Requests for Proposals 1) Follow Process	22) Ensure that a RFP process is followed whenever possible.	This improves the competitiveness of the industry and ensures the best product is delivered.	RFPs ensure the provision of the best product at the lowest price. This ensures that taxpayer dollars are used in the most efficient way possible.
2) Feedback	23) Establish a central provincial RFP body that when selecting a proponent; provides feedback for unsuccessful proposals.	Having a centralized body would ensure a standardized, fair, and open RFP process.	This would allow the public to ensure the best product is provided, could enhance the industry's competitiveness and operators would be able to learn from their past unsuccessful proposals and improve products in the future.
3) Consider Smaller Operations	24) Establish criteria that are not skewed against larger multi-site operators.	Using measures such as percentages rather than raw numbers will ensure that the size of an operator does not damage its chances in the RFP process.	This will ensure an accurate comparison is given between small and large operators, and ensure the best product is delivered.

FIGURE 2: SUMMARY OF RECOMMENDATIONS AND BENEFITS

ISSUE	RECOMMENDATION	BENEFIT TO BC GOVERNMENT	BENEFIT TO CARE PROVIDER	BENEFIT TO RESIDENTS
2.2.1 Reporting Processes 1) Standardizing Health Authority Reports	1) 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	Improved quality of care due to increased availability of care providers.
	2) Eliminate the Provincial Performance Management Framework Reports	Save administrative time processing these reports Better services provided by care providers at the same cost	Save administrative time preparing these reports	Improved quality of care due to increased availability of care providers.
2) Consolidating Data Reporting	3) A single reporting agency to collect one report and distribute to secondary reporting agencies	Better services provided by care providers at the same cost	Care providers spend less time inputting data and more time in front-line care.	Streamlining data reporting would mean that care providers spend less time inputting data and more time in front-line care. Therefore the quality of life and quality of care would increase for residents.
	4) Implement standardized software in 3-5 years across BC to eliminate duplicate reporting	Better services provided by care providers at the same cost	Care providers spend less time inputting data and more time in front-line care.	
	5) Funding to be dependent on quality of care determined by data collected through MDS InterRAI	Better services provided by care providers at a decreased cost, since funding would be allocated efficiently.	Care providers to provide the best services to residents, which reduces costs by improving health.	
3) Consolidating Reports	6) Consolidate financial reporting to the health authorities and through HSCIS	Better services provided by care providers at the same cost	Administrative time would be saved since the same information would be reported in one format.	Improved quality of care due to increased availability of care providers.
2.2.2 Inspections & Audits	7) Streamline inspections so that the same criteria are not the responsibility of multiple inspection bodies	Five areas under one BC inspection body rather than three, government would save an estimated $337,500 over 10 years in health inspector time.	Care providers' time would be saved because inspection time would be reduced.	Improved quality of care due to increased availability of care providers
2.2.3 Investigation Process 1) Consolidating Investigations	8) Streamline investigation process so that one body investigates allegations of abuse at a time	This could save the health authorities $192,000 over 10 years in wage costs for investigations.	This would improve quality of care by reducing care provider time spent accommodating investigations.	Reduced stress on the parties involved. Improved quality of care due to increased availability of care providers.

Issue	Recommendation	Benefit to BC Government	Benefit to Care Provider	Benefit to Residents
2) Reviewing Care Aide Registry Investigations	9) Review the Care Aide Registry to ensure it is operating efficiently and in line with its mandate.	A well-functioning Registry would save taxpayer dollars by minimizing the number of future investigations that would be caused by repeat-offenders.	Care providers would not need to conduct costly investigations and engage in costly arbitration with a previously abusive staff member.	This would drastically improve the quality of care of residents, as it would minimize risk of an abusive care aide.
2.2.4 Collecting Client User Fees	10) For very late third party payment of client user fees, the government pays user fees until the issue is resolved and/or takes the third party to court.	By eliminating the possibility of evicted residents, hospital and relocations brought about by eviction could be reduced. Better services provided by care providers at the same cost	Time would be saved collecting debt that could be redirected toward providing more social services for residents.	Improve the life of the financially abused resident drastically. Improved quality of care due to increased availability of care providers
2.2.5 Client Complaints	11) Streamline the client complaint process so that there is only one external body looking into complaints at a time	Save tax-payer dollars since only the necessary number of investigations would be required.	Improve quality of care as it would allow care providers to spend more time caring for residents rather than meeting with multiple investigators.	Improved quality of care due to increased availability of care providers
2.2.6 Legislation & Registration 1) Nutrition Regulations	12) Increased flexibility in nutrition regulations: *Regulation 64 (1) and 62 in the Residential Care Regulations*	Better services provided by care providers at the same cost	Care providers would be able to enhance the wellbeing of clients by providing the food they favour at times they prefer.	Residents would receive improved and more individualized meals at times that accommodate their sleep habits.
2) WorkSafe Regulations	13) WorkSafeBC to allow more discretion to enhance the quality of care for residents with differing abilities and needs.	Better services provided by care providers at the same cost	Care providers could be able to enhance the wellbeing of clients.	The use of discretion by care providers allows improved quality of care of residents.
3) Regulations Concerning Private and Semi-Private Rooms	14) Amend the 5% maximum multiple-occupancy room rule regulated under *Section 25 of the Residential Care Regulations*.	Better services provided by care providers at the same cost More beds available at a wider range of prices for British Columbians Make operation of care homes a more sustainable endeavour in BC	Reduced mortgage payments due to lower construction costs More sustainable to operate care homes	More affordable living options and shorter wait lists More living options for couples Improved quality of care due to funds being diverted from mortgage payments toward quality of care
4) Regulations requiring locks on bathroom doors	15) Eliminate requirement for locks on bathroom doors	Better services provided by care providers at the same cost	In one facility alone, this would save $110,000 that could be redirected toward quality of care.	Improve the quality of life of residents with dementia. Improved quality of care due to increased availability of funds

Issue	Recommendation	Benefit to BC Government	Benefit to Care Provider	Benefit to Residents
5) Appropriate categories to asses resident care homes	16) Properly assess residential care homes for tax purposes.	Better services provided by care providers at the same cost	This would reduce unwarranted tax costs to the care provider.	Improved quality of care due to increased availability of funds redirected toward quality of care
2.2.7 Privacy 1) Duplication	17) Privacy and the ability to share information needs to follow the resident, not the type of funding.	Better services provided by care providers at the same cost	More time spent with residents can be directed toward care rather than collecting duplicated medical information.	Improved quality of care due to increased availability of care providers Improved continuity of care
2) Return from hospital stay	18) Allow clinical information to be shared when a resident returns to a care home from a hospital stay	Better services provided by care providers at the same cost	Time spent with residents can be directed toward care rather than collecting redundant information.	Improved quality of care due to increased time of care providers Improved continuity of care
3) Care Aide Registry investigation	19) Care providers would like guidance on how to satisfy privacy regulations during an investigation by the Registry.	Better protection of the privacy of British Columbians.	Privacy regulations can be upheld and investigations can be conducted appropriately.	This is of utmost concern to the quality of life of residents who must have their privacy protected.
2.2.8 Human Resources	20) Compensate physicians more appropriately when they take on residents in residential care facilities	Improved medical attention for residents from physicians. Reduced hospital costs in the long run.	More physicians willing to take on residents as patients, the admittance process would be more efficient, as less time locating a physician.	Improved quality of care since physicians would be more readily available.
2.2.9 Legislative Consistency	21) Create more consistency between the *CCALA* and the *HA*	Better services provided by care providers at the same cost	Administrative time would be saved reconciling same ownership/different legislation.	Improved quality of care due to increased availability of care providers
2.2.10 Requests for Proposals 1) Follow Process	22) Ensure that a RFP process is followed whenever possible.	RFPs ensure the provision of the best product at the lowest cost.	Development opportunities to the most deserving bidder	Improved quality of care due to the best possible facility
2) Feedback	23) Establish a central RFP body, when selecting a preferred proponent; provide feedback for unsuccessful proposals.	This would allow the public to ensure the best product is provided and could enhance the industry's competitiveness	Operators would be able to learn from their past unsuccessful proposals and improve proposals in the future.	Improved quality of care due to the provision of the best possible facility
3) Consider Smaller Operations	24) Establish criteria that are not skewed against larger multi-site operators.	This would ensure an accurate comparison is given between small and large operators and ensure the best product is delivered.	Development opportunities would be given to the most deserving bidder	Improved quality of care due to the provision of the best possible facility

4.0 CONCLUSION

4.1 SUMMARY

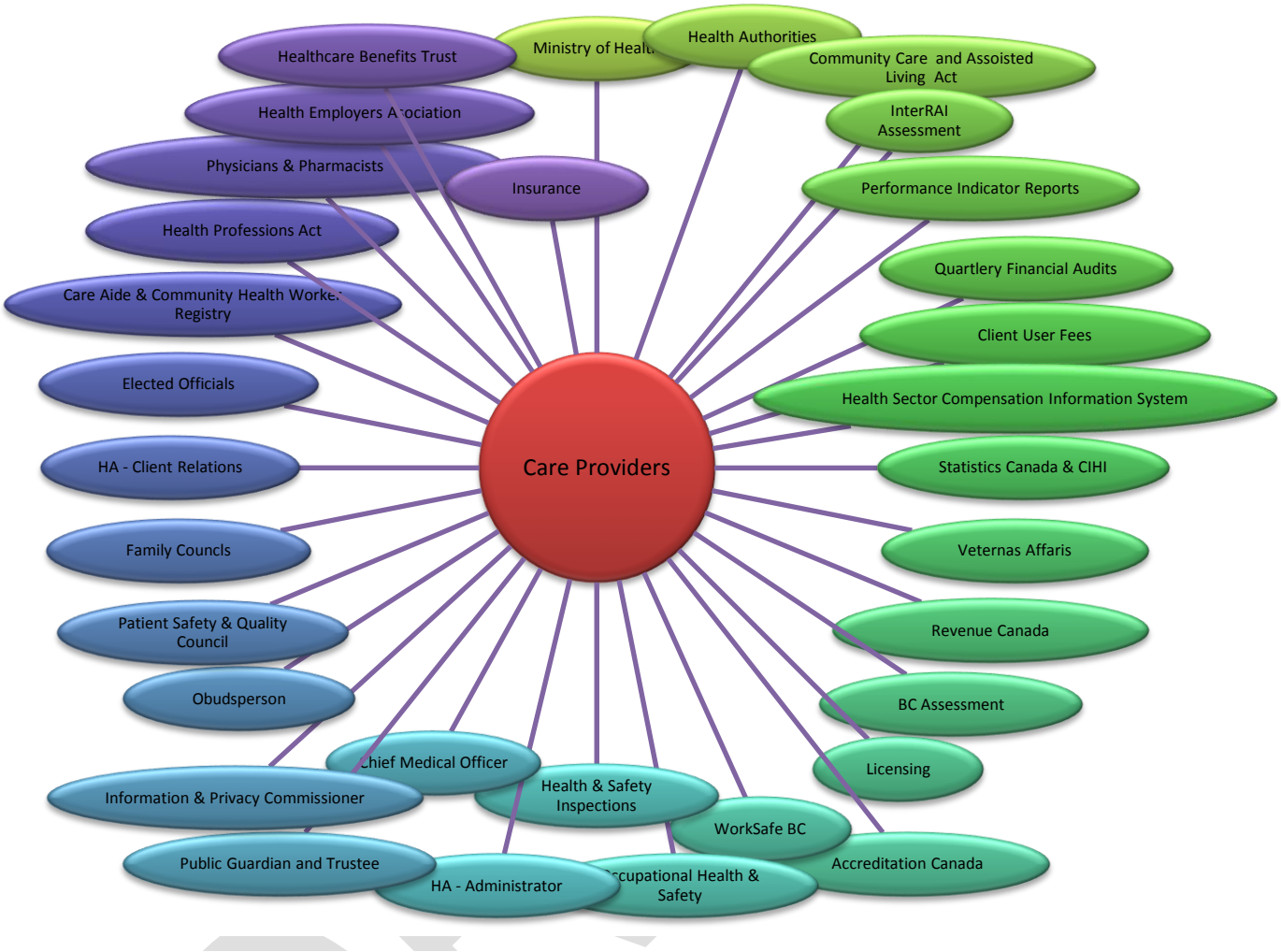
The BC care providers serve residents, families, and the health care sector by providing top quality care to those in need. As the role of this industry is evolving, and as the need for these service is set to dramatically increase, the industry needs certain rationalizations from government regulations and requirement, in order to reduce duplications and inefficiencies, save time and money, and to increase client care.

Objective 2.1 of the Ministry Service Plan states, "An integrated system of primary and community care health services will improve care particularly for those with complex needs such as the frail senior population, which is increasing as the population ages." The issues and recommendations are all directed toward enhancing efficiency of the community care sector will ensure that the best quality of care can be provided. In the future, there will only be higher demand for community care. Ensuring that this sector is operating in the most efficient and cost effective way is imperative to ensuring the financial security of British Columbia.

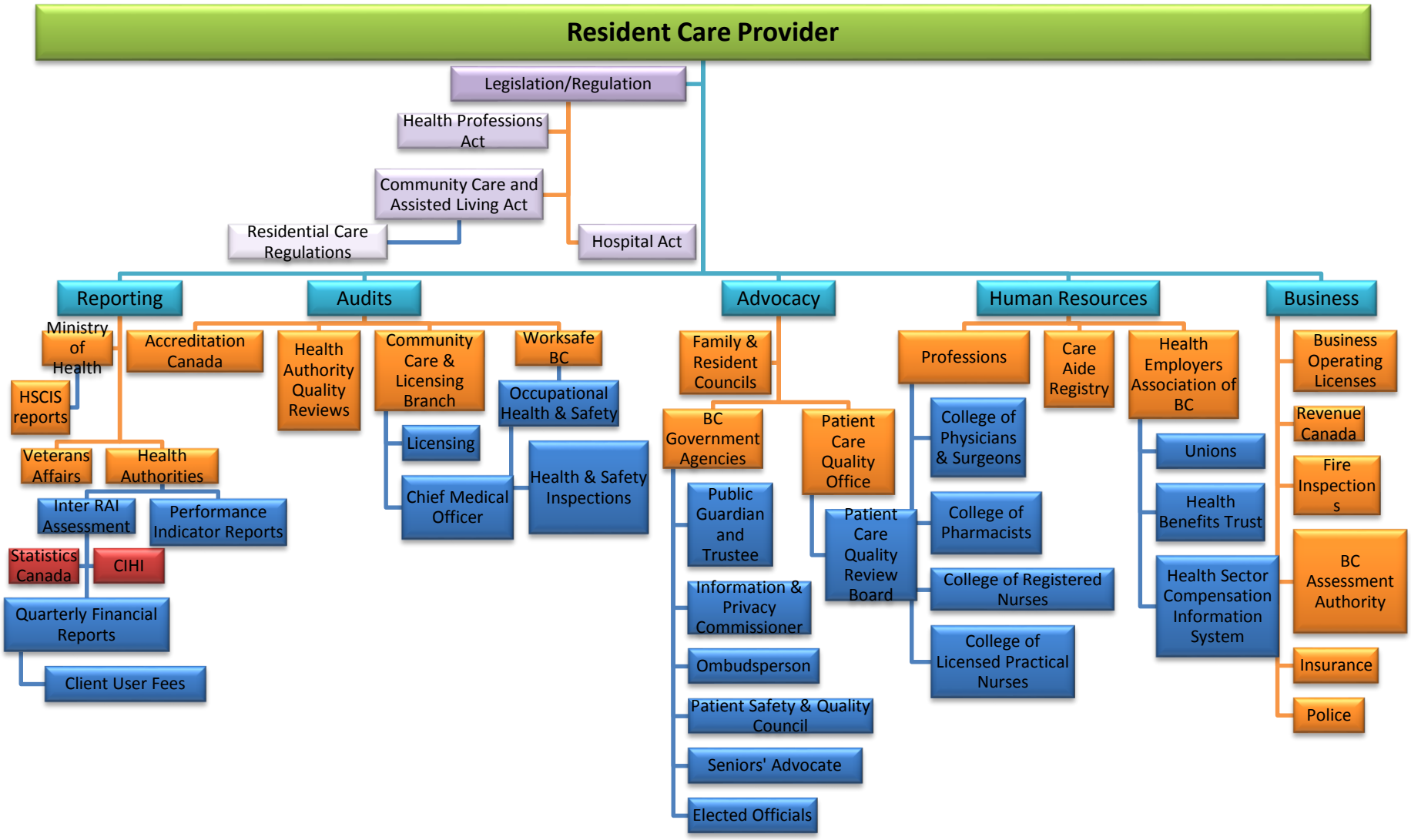
Objective 4.1 of the Service Plan suggests to…"Optimize the supply and mix of health human resources, information management, technology and infrastructure in service delivery." The care providers have raised issues and recommendations to improve the mix of human resource, information management and technology to improve accountability and reduce the administrative burden. Because of the extensive reporting requirements of facilities, it is often nurses who take over the excess administrative duties. However, it is more efficient to have nurses nursing rather than administrating and reporting data.

The Mandate Letter to the Minister and Objective 4.2 of the Service Plan seek to drive efficiency and innovation of the sector, and are supported by these recommendations to reducing duplication in administrative tasks reduces red tape, allows private businesses to function more efficiently and therefore more cost effectively. Furthermore, streamlining administrative duties reduces costs at the health authority and ministry of health, helping the ministry stay within its funding envelope. At the same time as reducing costs, streamlining administrative duties allows more care provider time to be directed toward quality of care. Not only does this improve the quality of life of British Columbians, it also reduces the incidence of acute health problems for seniors, and therefore reduces visits to the hospital.

APPENDIX A: CONTINUING CARE SECTOR – DIS-ORG CHART



APPENDIX B: CONTINUING CARE SECTOR – UPDATED DIS-ORG CHART



APPENDIX C: CORE REVIEW TERMS OF REFERENCE

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.

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 D: MINISTER OF HEALTH MANDATE LETTER

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.

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)

APPENDIX E: BIBILOGRAPHY

Accent on Seniors, California's Senior Living Experts, "Assisted Living Facilities: Five reasons to consider a roommate" < http://www.accentonseniors.com/assisted-living-facilities-5-reasons-to-consider-a-roommate/>

Alzheimer's Society of Canada, "Guidelines for Care: Person-centred care of people with dementia living in care homes," *Framework,* January 2011

BC Care Providers Association, "2012-2013 BCCPA Seniors Care Action Plan – Putting Seniors First," Fall 2012

BC Government, "A Review of the BC Care Aide & Community Health Worker Registry: An Action Plan," 2013

BC Government, "Community Care and Assisted Living Act" [SBC 2002] Chapter 75, November 26, 2002 <http://www.bclaws.ca/Recon/document/ID/freeside/00_02075_01>

BC GOVERNMENT, "HOSPITAL ACT" [RSBC 1996] CHAPTER 200, DECEMBER 31, 2013 <http://www.bclaws.ca/Recon/document/ID/freeside/00_96200_01>

BC Government, "Residential Care Regulation, BC Reg 96/2009," May 31, 2012. <http://www.bclaws.ca/Recon/document/ID/freeside/96_2009>

BC Ministry of Health, "A Guide to Community Care Facility Licensing in British Columbia," February 2012

BC Ministry of Health, "British Columbia Ministry of Health Home and Community Care Policy Manual," October 15, 2012

BC Ministry of Health, "Preparing RFPs: A Ministry Guide to the Request for Proposals Process, Shared Services BC Procurement," January 2010

BC Ministry of Health, "Revised Service Plan 2013/14 – 2015/16"

BC Ministry of Health, "Social Isolation Among Seniors: An Emerging Issue, An investigation by the Children's, Women's and Seniors Health Branch, British Columbia Ministry of Health," March 2004

Blomqvist, Ake and Colin Busby, "Long-Term Care for the Elderly: Challenges and Policy Options," *Health Policy*, C.D. Howe Institute, November 2012

British Columbia Institute of Technology, School of Health Sciences, Public Health Inspection, "Graduating and Jobs" < www.bcit.ca/study/programs/8500dbtech#graduating>

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

Deming, W. Edwards "Improvement of quality and productivity through action by management" in (eds) Michael Lewis and Nigel Slack, *Operations Management: Critical Perspectives on Business Management, Vol 2,* Taylor and Francis, 2003

Dieticians of Canada, "Best Practices for Nutrition, Food Service and Dining in Long Term Care Home: Revised Working Paper," April 2013.

Foerster, Vicki and James Murtagh, "British Columbia Care Aide & Community Health Worker Registry: A Review," Feb 1 2013.

Health Council of Canada, "Seniors in need, caregivers in distress: What are the home care priorities for seniors in Canada?" 2012

National Institute on Aging, "Home Safety Caregiver Guide: Tips for caregivers of people with Alzheimer's Disease," *Alzheimer's Disease Education and Referral Center,* October 17, 2013
http://www.nia.nih.gov/alzheimers/publication/caregiver-guide

Patient Care Quality Review Board, "Annual Report 2012/2013"

Torjman, Sherri, "Financing Long-term care: More money in the mix" *Caledon Institute of Social Policy,* February 2013

Workers Compensation Board of BC, "High Risk Manual Handling of Patients in Healthcare," *WorkSafeBC*, 2006

BC Care Providers

Interim Report: Core Review - Priorities of Recommendations

Top Priorities

2.2.1 Reporting

2.2.2 Inspections

2.2.3 Investigations & Complaints

2.2.4 Collecting Client User Fees

2.2.7 Room Privacy

2.2.10 RFP

2.2.6 (4) Locks on Bathroom Doors

2.3.2 (3) Care Aide Registry

2.2.6 (1) Nutrition Legislation

2.2.6 (5) Tax Categories

2.2.8 Physicians

2.2.9 Legislative Consistency

2.2.10 WorkSafeBC requirements

Relevant to Core Review:

1. Reporting
2. Inspections
3. Complaints
4. User Fees
5. Privacy (nursing charts and hospital info)
6. RFP
7. Locks

Not as relevant to Core Review:

1. Registry (investigations and privacy issue)
2. Private/Semi-private rooms
3. Nutrition Regulations
4. Tax Categories
5. Physicians
6. Legislative Consistency
7. WorkSafeBC requirements

FIGURE 1: SUMMARY OF RECOMMENDATIONS – RECOMMENDATIONS

ISSUE	RECOMMENDATION	PRIORITY
2.2.1 Reporting Processes 1) Standardizing Health Authority Reports	1) Standardize reports across health authorities	• High • Relevant to Core Review
	2) Eliminate the Provincial Performance Management Framework Reports	• High • Relevant to Core Review
2) Consolidating Data Reporting	3) A single reporting agency to collect one report and distribute to secondary reporting agencies	• High • Relevant to Core Review
	4) Implement standardized software in 3-5 years across BC to eliminate duplicate reporting	• High • Relevant to Core Review
	5) Funding dependent on quality of care determined by MDS InterRAI	• High • Relevant to Core Review
3) Consolidating Reports	6) Consolidate financial reporting to health authorities and through HSCIS	• High • Relevant to Core Review
2.2.2 Inspections & Audits	7) Streamline inspections so that the same criteria are not the responsibility of multiple inspection bodies	• High • Relevant to Core Review
2.2.3 Investigation Process 1) Consolidating Investigations	8) Streamline investigation process so that one body investigates allegations of abuse at a time	• High • Relevant to Core Review
2) Reviewing Care Aide Registry Investigations	9) Review the Care Aide Registry to ensure it is operating efficiently and in line with its mandate.	• High • Not relevant to Core Review
2.2.4 Collecting Client User Fees	10) For very late client use fee third party payments, the government pays user fees until the issue is resolved and/or the third party is taken to court.	• High • Relevant to Core Review
2.2.5 Client Complaints	11) Streamline client complaint process so that there is only one external body looking into complaints at a time	• High • Relevant to Core Review
2.2.6 Legislation & Registration 1) Nutrition Regulations	12) Increased flexibility in nutrition regulations: i.e., *Regulation 64 (1) and 62 in the Residential Care Regulations*	• Medium • Not relevant to Core Review
2) WorkSafe Regulations	13) WorkSafeBC to allow more discretion to enhance quality of care for residents with differing abilities and needs.	• Eliminate, different process • Not relevant to Core Review
3) Regulations: Private and Semi-Private Rooms	14) Amend the 5% maximum multiple-occupancy room rule regulated under *Section 25 of the Residential Care Regulations*.	• Medium • Not relevant to Core Review

ISSUE	RECOMMENDATION	PRIORITY
4) Regulations requiring locks on bathroom doors	15) Eliminate requirement for locks on bathroom doors	• Medium • Relevant to Core Review
5) Assessment categories	16) Properly assess residential care homes for tax purposes	• Medium • Not relevant to Core Review
2.2.7 Privacy 1) Duplication	17) Privacy and the ability to share information needs to follow the resident, not the type of funding	• High • Relevant to Core Review
2) Return from hospital stay	18) Allow clinical information to be shared when a resident returns to a residential care home from a hospital stay	• High • Relevant to Core Review
3) Care Aide Registry investigation	19) Care providers would like guidance on how to satisfy privacy regulations during an investigation by the Registry	• Medium • Not relevant to Core Review
2.2.8 Human Resources	20) Compensate physicians more appropriately when they take on residents in residential care facilities	• Medium • Not relevant to Core Review
2.2.9 Legislative Consistency	21) Create more consistency between the *CCALA* and the *HA*	• Medium • Relevant to Core Review
2.2.10 Requests for Proposals 1) Follow Process	22) Ensure that a RFP process is followed whenever possible.	• High • Relevant to Core Review
2) Feedback	23) Establish a central provincial RFP body that provides feedback for unsuccessful proposals.	• High • Relevant to Core Review
3) Consider Smaller Operations	24) Establish criteria that are not skewed against larger multi-site operators.	• Medium • Relevant to Core Review

SAFECARE BC HEALTH AND SAFETY ASSOCIATION

BYLAWS (INTERIM) - DRAFT #3 (DECEMBER 2013)

PART I - INTERPRETATION

1.1 In these bylaws and the constitution of the Association, unless the context otherwise requires:

(a) "address of the Association" means the address of the Association as filed from time to time with the Registrar in the Notice of Address;

(b) "Association" means SafeCare BC Health and Safety Association;

(c) "Board" means the directors acting as authorized by the constitution and these bylaws in managing or supervising the management of the affairs of the Association and exercising the powers of the Association;

(d) "Board Resolution" means:

(i) a resolution passed at a meeting of the Board by a simple majority of the votes cast by those directors entitled to vote at such a meeting

(ii) a resolution that has been submitted to all of the directors and consented to in writing by 75% of the directors who would have been entitled to vote on it in person at a meeting of the Board;

(e) "bylaws" means the bylaws of the Association as filed in the office of the Registrar;

(f) "Chair" means a person elected to the office of Chair of the Association in accordance with these bylaws;

(g) "constitution" means the constitution of the Association as filed in the office of Registrar;

(h) "directors" means those persons who have been elected as directors or appointed as replacement directors in accordance with these bylaws and have not ceased to be directors, and a "director" means any one of them;;

(i) "Income Tax Act" means the *Income Tax Act* of Canada, as amended from time to time;

(j) "members" means those persons who have become members in accordance with these bylaws and have not ceased to be members, and a "member" means any one of them;

(k) "ordinary resolution" means:

(i) a resolution passed at a general meeting of the Association by a simple majority of the votes cast by those members entitled to vote at such meeting; or

(ii) a resolution that has been submitted to all of the members and consented to in writing by 75% of the members who would have been entitled to vote on it in person at a general meeting of the Association;

(l) "Registrar" means the Registrar of Companies of the Province of British Columbia;

(m) "Secretary" means a person elected to the office of Secretary of the Association in accordance with these bylaws;

(n) "Society Act" means the *Society Act* R.S.B.C. 1996, c. 433 as amended from time to time;

(o) "special resolution" means:

(i) a resolution passed at a general meeting of the Association by a majority of not less than 75% of the votes cast by those members entitled to vote at such meeting; or

(ii) a resolution consented to in writing by every member who would have been entitled to vote in person at a general meeting of the Association.

(p) "Treasurer" means a person elected to the office of Treasurer of the Association in accordance with these bylaws;

(q) "Vice-Chair" means a person elected to the office of Vice-Chair of the Association in accordance with these bylaws.

1.2 Except where they conflict with the definitions contained in these bylaws, the definitions in the *Society Act* on the date these bylaws become effective apply to these bylaws and the constitution.

PART II - MEMBERSHIP

2.1 The members of the Association are the original applicants for incorporation of the Association, the persons listed on the List of First Directors filed with these bylaws and those persons who subsequently have been accepted as members in accordance with these bylaws and, in either case, have not ceased to be members.

2.2 Agreement with and commitment to the following Mission Statement and Guiding Principles shall be expected as a reasonable standard for the members of the Association.

(a) **Mission Statement**: to promote safe and healthy workplaces across BC's long term care sector by providing training to reduce the severity and overall number of injuries among long term care workers and thereby lowering costs related to WorkSafeBC premiums

(b) **Guiding Principles**: The Association intends to achieve its mission through the following guiding principles:

(i) Openness and transparency
(ii) Providing value for money
(iii) Ensuring access to programs/services across BC
(iv) Collaborating with long term care industry associations in a cooperative and supportive manner
(v) Partnerships with key stakeholders
(vi) Focusing on evidence based programs and initiatives
(vii) Constantly innovating and sharing best practices

2.3 There shall be no annual membership dues.

2.4 A member may withdraw from the Association by delivering his or her resignation in writing to the secretary of the Association or delivering the resignation to the address of the Association.

2.5 A person shall immediately cease to be a member of the Association:

(a) upon the date which is the later of the date of delivering his or her resignation in writing to the secretary of the Association or to the address of the Association and the effective date of the resignation stated therein; or

(b) upon his or her death; or

(c) on being expelled.

2.6 A member may be expelled by a two-thirds (2/3rds) majority vote of the members. The Board shall give to a member notice in writing not less than seven (7) days prior to a meeting at which a proposed resolution to expel him or her from membership in the Association will be considered and such notice shall be accompanied by a brief statement

of the reason or reasons for the proposed expulsion and the directors may give the membership similar notice thereof. The person who is the subject of the proposed resolution shall be given an opportunity to be heard at the members meeting before the resolution is put to a vote. All members of the Association agree that any of the following shall be full and sufficient reasons for expulsion from membership in the Association:

(a) immoral or unethical conduct occurring under the auspices of the Association;

(b) failure to be in good standing as described in bylaw 2.7.

2.7 All members are in good standing except a member who the Board, in its sole discretion, determines is no longer committed to furthering the objects of the Association as set out in the constitution.

2.8 The membership of a person in the Association is not transferable.

PART III - MEETINGS OF MEMBERS

3.1 The general meetings of the Association shall be held at such time and place, in accordance with the *Society Act*, as the Board shall decide.

3.2 Every general meeting other than an annual general meeting is an extraordinary general meeting.

3.3 The Board may, whenever it thinks fit, convene an extraordinary general meeting.

3.4 The Association shall give not less than 14 days written notice of a general meeting to its members entitled to receive notice; but those members may waive or reduce the period of notice for a particular meeting by unanimous consent in writing.

3.5 Notice of a general meeting shall specify the place, the day and the hour of the meeting.

3.6 The accidental omission to give notice of a general meeting to, or the non-receipt of notice by, any of the members entitled to receive notice does not invalidate the proceedings at that meeting.

3.7 An annual general meeting shall be held at least once in every calendar year and not more than 15 months after the holding of the last preceding annual general meeting.

PART IV - PROCEEDINGS AT GENERAL MEETINGS

4.1 Special business is:

(a) all business at an extraordinary general meeting except the adoption of rules of order; and

(b) all business that is transacted at an annual general meeting, except;
- (i) the adoption of rules of order;
- (ii) consideration of the financial statements;
- (iii) consideration of the report of the directors;
- (iv) consideration of the report of the auditor;
- (v) the election of the directors;
- (vi) the appointment of the auditor; and
- (vii) such other business that, under these bylaws or any governing statues, ought to be transacted at an annual general meeting, or business which is brought under consideration by the report of the directors if the report was issued with the notice of the meeting.

4.2 No business, other than the election of a person to chair the meeting and the adjournment or termination of the meeting, shall be conducted at a general meeting at a time when a quorum is not present.

4.3 If at any time during a general meeting there ceases to be a quorum present, business then in progress shall be suspended until there is a quorum present or until the meeting is adjourned or terminated.

4.4 A quorum at a general meeting is a simple majority of the members present.

4.5 If within 15 minutes from the time appointed for a general meeting a quorum is not present, the meeting, if convened on the requisition of members, shall be terminated; but in any other case, it shall stand adjourned to the same day in the next week, at the same time and place, and if, at the adjourned meeting, a quorum is not present within 15 minutes from the time appointed for the meeting, the members present shall constitute a quorum.

4.6 The Chair of the Association shall, subject to a Board Resolution appointing another person, chair all general meetings; but if at any general meeting the Chair, or such alternate person appointed by a Board Resolution, is not present within fifteen (15) minutes after the time appointed for the meeting or requests that he or she not chair that meeting, the Vice-Chair shall chair the meeting, provided further that if the Chair, alternate or Vice-Chair is not present within fifteen (15) minutes after the time appointed for the meeting or requests that he or she not chair that meeting, the members present may choose one of their number to chair that meeting.

4.7 If a person presiding as chair of a general meeting wants to step down as chair for all or part of that meeting, he or she may designate the Vice-Chair or, if the Vice-Chair is unavailable or unwilling to act as chair an alternate, to chair such meeting or portion thereof, and upon such designated alternate receiving the consent of the majority of the members present at such meeting, he or she may preside as chair.

4.8 A general meeting may be adjourned from time to time and from place to place, but no business shall be transacted at an adjourned meeting other than the business left unfinished at the meeting from which the adjournment took place.

4.9 It is not necessary to give notice of an adjournment or of the business to be transacted at an adjourned meeting except where a meeting is adjourned for more than 14 days, in which case notice of the adjourned meeting shall be given as in the case of the original meeting.

4.10 All resolutions proposed at a general meeting must be seconded. The person chairing such a meeting may move or propose a resolution.

4.11 Any issue at a general meeting which is not required by these bylaws or the *Society Act* to be decided by a special resolution shall be decided by an ordinary resolution.

4.12 A member in good standing is entitled to one vote.

4.13 The person chairing a general meeting may vote but, if he or she does so and the result is a tie, the person chairing a general meeting shall not be permitted to vote again to break the tie and the resolution being voted on shall be deemed to have failed.

4.14 Voting shall be by show of hands or voice vote recorded by the secretary of the meeting; except that, at the request of any five members present at the meeting, a secret vote by written ballot shall be required.

4.15 Voting by proxy is permitted provided that the proxy has previously been appointed in writing by the member appointing the proxy and the proxy has the written appointment at the meeting. However, a permanent proxy or a proxy entitling a person or member to vote at other than one meeting and any adjournment of that meeting is void. In the case of written proxy votes on specific issues, such written proxy votes are also to be counted and added to the total of votes by hand or voice.

4.16 A resolution in writing which is identified as an ordinary resolution and has been submitted to all the members and signed by a minimum of 75% of the members who would have been entitled to vote on it in person at a general meeting of the Association is as valid and effectual as an ordinary resolution as if it had been passed at a meeting of members duly called and constituted and shall be deemed to be an ordinary resolution in writing. Such ordinary resolution shall be filed with minutes of the proceedings of the members and shall be deemed to be passed on the date stated therein or, in the absence of such a date being stated, on the latest date stated on any counterpart.

4.17 A resolution in writing which is identified as a special resolution and has been signed by all the members who would have been entitled to vote on it in person at a general meeting of the Association is as valid and effectual as a special resolution as if it had been passed at a meeting of members duly called and constituted and shall be deemed to be a special resolution. Such a resolution may be in two or more counterparts which together shall be

deemed to constitute one special resolution in writing. Such special resolution shall be filed with the minutes of the proceedings of the members and shall be deemed to be passed on the date stated, on the latest date stated on any counterpart.

PART V - DIRECTORS

5.1 The Board may exercise all such powers and do all such acts and things as the Association may exercise and do, and which are not by these bylaws or by statue or otherwise lawfully directed or required to be exercised or done by the members in general meeting, but subject, nevertheless, to the provisions of:

(a) all laws affecting the Association;

(b) these bylaws; and

(c) rules, not being inconsistent with these bylaws, which are made from time to time by the Association in general meeting.

5.2 No rule made by the Association in general meeting invalidates a prior act of the Board that would have been valid if that rule had not been made.

5.3 The property and the affairs of the Association shall be managed by the Board.

5.4 The number of directors shall be **15** (15) or such greater number as may be determined from time to time by ordinary resolution.

5.5 Directors shall wholeheartedly accept, adopt, and subscribe in writing to the purposes of the Association as set out in the constitution and the Mission Statement and Guiding Principles of the Association as stated in section 2.2 prior to being elected as a director and thereafter on an annual basis in advance of each year of service as a director

5.6 Directors shall be elected by the members at a general meeting and shall take office commencing at the close of such meeting.

5.7 Elections for directors shall normally be held at the annual general meeting and the term of office of elected directors shall normally be one (1) year. For purposes of calculating the duration of an elected director's term of office, the term shall be deemed to commence at the close of the annual general meeting at which such director was elected. If, however, the director was elected at an extraordinary general meeting his or he term of office shall be deemed to have commenced at the close of the annual general meeting next following such extraordinary general meeting.

5.8 Directors may be elected to a maximum of two (2) terms for a period of three (3) years.

5.9 In elections where there are more candidates than vacant positions for elected directors, election shall be by secret ballot with the name of each duly nominated candidate appearing individually on the ballot. Candidates shall be deemed to be elected in order of those candidates receiving the most votes.

5.10 No member shall vote for more elected directors than the number of vacant positions for elected directors. Any ballot on which more names are voted for than there are vacant positions shall be deemed to be void.

5.11 A person need not be a member of the Association to be eligible to be a director of the Association.

5.12 Every director serving a term of office shall retire from office at the close of the annual general meeting in the year in which his or her term expires; but if no successor is elected and the result is that the number of directors would fall below three, the person previously elected as director shall continue to hold office until such time as successor directors are elected.

5.13 The members may by ordinary resolution remove an elected director before the expiration of such director's term of office and may elect a person as a replacement director and determine the term of such replacement director.

5.14 Notwithstanding the foregoing bylaws, if a director ceases to hold office during his or her term for any reason other than removal by ordinary resolution, the Board may appoint a person as a replacement director to take the place of such director until the next annual general meeting.

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

5.16 A person shall immediately cease to be a director of the Association:

(a) upon the date which is the later of the date of delivering his or her resignation in writing to the Secretary or to the address of the Association and the effective date of the resignation stated therein; or

(b) upon his or her death; or

(c) upon being removed by an ordinary resolution.

5.17 The directors shall serve as directors without remuneration and no director shall directly or indirectly receive any profit from his position as a director; provided that a director may be paid reasonable expenses incurred by him or her in the performance of his or her duties.

5.18 The Board shall have the power to make expenditures and loans whether or not secured or interest bearing for the purpose of furthering the purposes of the Association. The Board shall also have the power to enter into trust arrangements or contracts on behalf of the Association for the purpose of discharging obligations or conditions either imposed by a person donating, bequeathing, advancing or lending funds or property to the Association, or assumed by the Association in expectation of such donations, bequests advances or loans. Such arrangements or contracts shall be in accordance with the terms and conditions that the Board may prescribe.

5.19 The Board shall take such steps as it deems necessary to enable the Association to receive donations, bequests, funds, property, trusts, contracts, agreements and benefits for the purposes of furthering the purposes of the Association. The Board in its sole and absolute discretion may refuse to accept any donation, bequest, trust, loan, contract or property.

5.20 In investing the funds of the Association, the Board shall not be limited to securities and investments in which trustees are authorized by law to invest but may make any investments which in its opinion are prudent. Subject to the provisions of the *Society Act*, a director shall not be liable for any loss which may result from any such investment.

PART VI - PROCEEDINGS OF THE BOARD

6.1 A meeting of the Board may be held at any time and place determined by the Board, provided that 5 days' notice of such meeting shall be sent in writing to each director. However, no formal notice shall be necessary if all directors were present at the preceding meeting when the time and place of the meeting were determined or are present at the meeting or waive notice thereof in writing or give a prior verbal waiver to the secretary of the Association.

6.2 The Board may from time to time fix the quorum necessary to transact business, and unless so fixed the quorum shall be a majority of the directors in office at the time when the meeting convenes.

6.3 The Chair of the Association shall, subject to a Board Resolution appointing another person, chair all meetings of the Board, but if at any Board meeting the Chair or such alternate person appointed by a Board Resolution is not present within fifteen (15) minutes after the time appointed for the meeting, or requests that he or she not chair that meeting, the Vice-Chair shall chair the meeting, provided further that if the Chair, alternate or Vice-Chair is not present within fifteen (15) minutes after the time appointed for the meeting or requests that he or she not chair that meeting, the directors present may choose one of their number to chair that meeting.

6.4 If the person presiding as chair of a meeting of the Board wants to step down as chair for all or part of that meeting, he or she may designate the Vice-Chair or, if the Vice-Chair is unavailable or unwilling to act as chair, an alternate to chair such meeting or portion

thereof, and upon such designated alternate receiving the consent of a majority of the directors present at such meeting, he or she may preside as chair.

6.5 Any three (3) directors may at any time, and the Secretary on the request of any three (3) directors shall, convene a meeting of the Board.

6.6 For the purposes of the first meeting of the Board held immediately following the election of a director or directors at an annual or other general meeting, it is not necessary to give notice of the meeting to the newly elected director or directors for the meeting to be property constituted.

6.7 All resolutions proposed at a meeting of the Board must be seconded. The person chairing a meeting may move or propose a resolution.

6.8 Any issue at a meeting of the Board which is not required by these bylaws or the *Society Act* to be decided by a resolution requiring more than a simple majority shall be decided by a Board Resolution.

6.9 The person chairing a meeting may vote but, if he or she does so and the result is a tie, he or she shall not be permitted to vote again to break the tie and the resolution being voted on shall be deemed to have failed.

6.10 Voting shall be by show of hands or voice vote recorded by the secretary of the meeting except that, at the request of any one director, a secret vote by written ballot shall be required.

6.11 A Board Resolution in writing which has been deposited with the Secretary is as valid and effectual as if it had been passed at a meeting of the Board duly called and constituted. Such Board Resolution may be in two or more counterparts which together shall be deemed to constitute one resolution in writing. Such resolution shall be filed with minutes of the proceedings of the Board and shall be deemed to be passed on the date stated therein or, in the absence of such a date being stated, on the latest date stated on any counterpart.

6.12 A director who contemplates being or is temporarily absent from British Columbia may, by letter, facsimile or e-mail, send or deliver to the address of the Association a waiver of notice of any meeting of the Board for a period not longer than one year and may, at any time, withdraw the waiver in like manner. Until the waiver is withdrawn:

(a) no notice of meetings of the Board need be sent to that director; and

(b) any and all meetings of the Board, notice of which has not been given to that director shall, if a quorum is present, be valid and effective.

PART VII - COMMITTEES

7.1 The Board may delegate any, but not all, of its powers to committees which may be in whole or in part composed of directors as it thinks fit.

7.2 A committee, in the exercise of the powers delegated to it, shall conform to any rules that may from time to time be imposed by the Board, and shall report every act or thing done in exercise of those powers at the next meeting of the Board held after it has been done, or at such other time or times as the Board directs.

7.3 The members of a committee may meet and adjourn as they think proper and meetings of committees shall be governed *mutatis mutandis* by the rules set out in these bylaws governing proceedings of the Board.

7.4 There may be a Finance and Audit Committee consisting of three (3) directors elected at the first regular board meeting during each membership year. All members of the Finance and Audit Committee shall be at arm's length and a majority of the members of the Finance and Audit Committee shall constitute a quorum. The Board shall appoint the chairperson of the Finance and Audit Committee and the Finance and Audit Committee may appoint its own secretary. In addition to advising the Board in regard to all the financial aspects of the Association's operations, the responsibility of the Finance and Audit Committee shall include making recommendations to the board regarding the annual and periodic budgets and the financial statements of the Association and the reports and activities of the auditor. A Finance and Audit Committee member may be removed by a majority vote of the directors.

7.5 There shall be an Executive Committee consisting of the Chair, Vice-Chair, Secretary and Treasurer and any other directors appointed by the Board.

7.6 Subject to the control of the Board, the Executive Committee shall have power to transact all business of the Association in the interim between meetings of the Board. The Executive Committee shall meet at the call of the chair of the Executive Committee.

7.7 There shall be a Governance Committee consisting of persons appointed by the Board to ensure prudent Board development, recruitment and planning. The Governance Committee shall seek and recommend suitable candidates for election to the Board.

7.8 The Board may create such standing and special committees as may from time to time be required. Any such committee shall limit its activities to the purpose or purposes for which it is appointed, and shall have no powers except those specifically conferred by a Board Resolution. Unless specifically designated as a standing committee, any special committee so created must be created for a specified time period only. Upon completion of the earlier of the specified time period or the task for which it was appointed, a special committee shall automatically be dissolved.

PART VIII - DUTIES OF OFFICERS

8.1 At the first meeting of the Board held after an annual general meeting, the Board shall elect from among the directors a Chair who shall hold office until the first meeting of the Board held after the next following annual general meeting.

8.2 A director may be removed as an officer by a resolution passed at a meeting of the Board by a majority of not less than two-thirds of the directors present.

8.3 Should the Chair or any other officer for any reason not be able to complete his or her term, the Board shall elect a replacement without delay.

8.4 The Chair shall:

(a) maintain regular communication with the Executive Director

(b) provide the supervision and oversee the administration of the affairs of the Board and ensure that all policies and actions approved by the Board are duly and properly implemented;

(c) prepare the agenda for all meetings of the Board and the Executive Committee;

(d) provide the annual report for the Association to the members;

(e) when present, preside at all meetings of the Board and of the members; and

(f) carry out such other duties and powers as the Board may specify.

8.5 If the Chair is absent or is unable or refuses to act, the Vice-Chair shall, when present, preside at all meetings of the Board and of the members. The Vice-Chair shall have such other duties and powers as the Board may specify.

8.6 The Secretary shall be responsible for making the necessary arrangements for:

(a) the issuance of notices of meetings of the Association and Board;

(b) the keeping of minutes of all meetings of the Association and Board;

(c) the custody of all records and documents of the Association except those required to be kept by the Treasurer;

(d) the custody of the common seal of the Association;

(e) the maintenance of the register of members; and

(f) the conduct of the correspondence of the Association.

8.7 The Treasurer shall be responsible for making the necessary arrangements for:

(a) the keeping of such financial records, reports and returns including books of account as are necessary to comply with the *Society Act* and the *Income Tax Act*; and

(b) the rendering of financial statement to the directors, members and others when required.

8.8 If the Secretary is absent from any meeting of the Association or the Board, the directors present shall appoint another person to act as secretary at that meeting.

8.9 The offices of Secretary and Treasurer may be held by one person who shall be known as the Secretary-Treasurer.

8.10 Notwithstanding the foregoing bylaws, the Board may appoint a secretary of the Board to be responsible for preparation and custody of minutes of meetings of the Board and the correspondence of the Board.

PART IX - SEAL

9.1 The Board may provide a common seal for the Association and it shall have power from time to time to destroy a seal and substitute a new seal in its place.

9.2 The common seal shall be affixed only when authorized by a resolution of the Board, and then only in the presence of the persons prescribed in the resolution or, if no persons are prescribed in the presence of any two directors.

PART X – EXECUTIVE DIRECTOR

10.1 The Board shall select and appoint an Executive Director of the Association for a fixed or indefinite term, and set the terms of his or her duties, responsibilities and employment.

10.2 The Executive Director shall be responsible for the oversight of all employees of the Association and the implementation of the policies of the Association as determined by the Board.

PART X - BORROWING

11.1 In order to carry out the purposes of the Association the Board may, on behalf of and in the name of the Association, and subject to the limitations contained within the *Income Tax Act*, raise or secure the payment or repayment of money in any manner it decides

including the granting of guarantees, and in particular, but without limiting the foregoing, by the issue of debentures.

11.2 No debenture shall be issued without the authorization of a special resolution.

11.3 The members may by ordinary resolution restrict the borrowing powers of the Board.

PART XII - AUDITOR

12.1 This Part applies only where the Association is required or has resolved to have an auditor.

12.2 The first auditor shall be appointed by the Board which shall also fill any vacancy occurring in the office of auditor.

12.3 At each annual general meeting, the Association shall appoint an auditor to hold office until he or she is reappointed or his or her successor is appointed at the next following annual general meeting in accordance with the procedures set out in the *Society Act*.

12.4 An auditor may be removed by ordinary resolution in accordance with the procedures set out in the *Society Act*.

12.5 An auditor shall be promptly informed in writing of his appointment or removal.

12.6 No director or employee of the Association shall be auditor.

12.7 The auditor may attend general meetings.

PART XIII - NOTICES

13.1 A notice may be given to a member, either personally or by mail or by electronic mail or by facsimile to him or her at the address of that person as recorded in the register of members or the register of directors.

13.2 A notice sent by mail shall be deemed to have been given on the third day following that on which the notice is posted, and in proving that notice has been given it is sufficient to prove that the notice was properly addressed and put in a Canadian post office receptacle. In the case of notice by either electronic mail or facsimile, an acknowledgment of receipt by return facsimile or electronic mail shall be obtained from the member.

13.3 Notice of a general meeting shall be given only to:

(a) every member shown on the register of members on the day notice is given, and

(b) the auditor.

PART XIV - MISCELLANEOUS

14.1 The members shall from time to time determine whether and to what extent and at what times and places and under what conditions or regulations the documents, including the books of account, of the Association and minutes of the meetings of the Board shall be open to the inspection of members of the Association not being directors. In the absence of such determination by the members, the document, including the books of account, of the Association shall not be open to inspection by any member of the Association not being a director.

14.2 Any meeting of the Association, the Board, or any committee may also be held, or any member, director or member of the committee may participate in any meeting of the Association, the Board or any committee by conference call or similar communication equipment or device so long as all the members, directors, or persons participating in the meeting can hear and respond to one another. All such members, directors, or persons so participating in any such meeting shall be deemed to be present in person at the stated location of such meeting and, notwithstanding the foregoing bylaws, shall be entitled to vote by a voice vote recorded by the secretary of such meeting.

14.3 The rules governing when notice is deemed to have been given set out in these bylaws shall apply *mutatis mutandis* to determine when a Board Resolution shall be deemed to have been submitted to all of the directors and when an ordinary resolution shall be deemed to have been submitted to all of the members.

14.4 The Association shall have the right to subscribe to, become a member of and to cooperate with any other Association, corporation or association whose purposes or objectives are in whole or in part similar to the Association's purposes.

14.5 Subject to an order of the Registrar pursuant to the *Society Act* stating that the Association is a "reporting Association" as defined under the *Society Act*, the Association shall be deemed not to be a "reporting Association".

14.6 The Association may establish and maintain one or more branch societies with the powers, not exceeding the powers of the Association, that the Association confers.

14.7 The Association shall be deemed not to be a subsidiary of any other Association or corporation.

PART XIV - INDEMNIFICATION

15.1 Subject to the provisions of the *Society Act*, each director or officer of the Association who has properly undertaken or is about to undertake any liability on behalf of the

Association or any Association controlled by it and their heirs, executors, administrators or personal representatives respectively, shall from time to time and at all times, be indemnified and saved harmless out of the funds of the Association, from and against:

(a) all costs, charges, and expenses whatsoever which such director or officer of the Association actually and reasonably sustains or incurs in or about any action, suit, or proceeding which is brought, commenced, or prosecuted against him, or in respect of any act, deed, matter or thing whatsoever, made, done, or permitted by him, in or about the execution of the duties of his office or in respect of any such liability; and

(b) all other costs, charges, and expenses which he actually and reasonably sustains or incurs in or about or in relation to the affairs thereof, except such costs, charges, or expenses as are occasioned by his own willful neglect or default

provided that:

(c) the director or officer of the Association acted honestly and in good faith with a view to the best interests of the Association; and

(d) in the case of criminal or administrative proceedings, the director or officer of the Association had reasonable grounds for believing that their conduct was lawful.

15.2 The Association may purchase and maintain insurance for the benefit of any or all directors or officers against personal liability incurred by any such person as a director or officer.

PART XVI - BYLAWS

16.1 On being admitted to membership, each member is entitled to and upon request the Association shall provide him or her with a copy of the constitution and bylaws of the Association.

16.2 These bylaws shall not be altered or added to except by special resolution.

Dated this _____ day of _____, 20___.

SOCIETY ACT

SAFECARE BC HEALTH AND SAFETY ASSOCIATION

CONSTITUTION

Part 1 - Name

1. The name of the society is **SafeCare BC Health and Safety Association** (the "Association")

Part 2 - Purposes

2. The Association is a workplace safety association for the continuing care sector with the following purposes:

   (a) Reducing the severity and frequency of injuries for people employed in long term care facilities in British Columbia by:

      (i) Providing members with cost-effective training, educational services and industry safety performance metrics;
      (ii) Promoting effective health and safety management systems;
      (iii) Communicating government health and safety legislation and policies which impact members;
      (iv) Establishing health and safety programs and management systems to reduce workplace injuries;
      (v) Promoting effective and collaborative return to work and stay at work initiatives;
      (vi) Creating and maintaining communication infrastructure that can exchange best practices and identify emerging trends including conducting stand-alone industry research where required;
      (vii) Working cooperatively with members and their respective industry associations across British Columbia to ensure their needs are incorporated into the planning process; and
      (viii) Ensuring there is no duplication of service delivery with other third-party or government agencies.

   (b) For the purposes aforesaid, to hire staff, rent or own facilities, to employ and pay such assistants, clerks, agents, representatives, and employees and to procure and equip and maintain such offices and other facilities and to incur such reasonable expenses, as may be necessary;

   (c) To receive, acquire, hold, maintain, invest, administer, distribute and operate all types of property, directly or indirectly, through any form of ownership or to dispose of such property in furtherance of the purposes of the Association stated in paragraphs (a) above;

(d) To do all such things as are incidental and ancillary to the attainment of the purposes of the Association stated in paragraphs (a) to (c) inclusive above.

Part 3 - Non-Profit

3. The activities of the Association shall be carried on without purpose of gain for the members and any profits or other accretions to the Association shall be used in promoting the purposes of the Association. This clause is unalterable.

Part 4 - Dissolution

4. In the event of dissolution or winding up of the Association, all its remaining assets, after payment of liabilities, shall be distributed to B.C. Care Providers Association provided that if B.C. Care Providers Association no longer exists, all its remaining assets, after payment of liabilities, shall be distributed to such non-profit organization or organizations, having purposes similar to the Association, as shall be designated by the members at a meeting of the Association by two-thirds or a greater number of the members of the Association who are not subject to discipline or suspension under the Bylaws and are present at the meeting. This clause is alterable.

January 16, 2014

Chief Executive Officer – Performance Review

NOTE: Your responses will be kept strictly anonymous.
Survey results will be shared with the CEO in a summarized form.

Please answer each individual statement using the following rating scale:

Rating Scale

On a scale of 1 through 6, Where:

1 means: Strongly Disagree
2 means: Disagree
3 means: Undecided
4 means: Agree
5 means: Strongly Agree
6 means: No Knowledge

Planning

Performance:		5	4	3	2	1	6
		Rating					
1.	Provides effective leadership for BCCPA planning processes.						
2.	Anticipates trends and opportunities affecting the future of BCCPA and develops effective and timely responses.						
3.	Ensures that BCCPA has a current and effective strategic plan in place that maximizes its capacity to achieve its organizational mission.						
4.	Creates an organizational culture that encourages innovation and change to respond to changes in the operating environment.						
5.	Willing to challenge the status quo and advocates for change when appropriate.						
6.	Proposes restructuring when necessary, based upon strategic needs, and ensures change is effectively managed.						

Advocacy

Performance:		5	4	3	2	1	6
		Rating					
1.	Promotes a positive image of BCCPA, and helps to create awareness of available services to the local community.						
2.	Maintains an active advocacy role in promoting the needs of the BCCPA and its mission.						

3.	Builds effective relationships with the Health Authorities, Ministry of Health and other partner health care organizations.						

Organizing and Delegating

Performance:		**5**	**4**	**3**	**2**	**1**	**6**
		Rating					
1.	Effectively leads the Management Team, fostering a cohesive leadership team.						
2.	Effectively delegates responsibility and tasks.						
3.	Empowers others to make decisions within their areas of responsibility.						
4.	Recognizes and rewards the performance of teams and individuals.						

Decision Making, Initiative and Acceptance of Responsibility

Performance:		**5**	**4**	**3**	**2**	**1**	**6**
		Rating					
1.	Is willing to make decisions and take full responsibility for the consequences for those decisions.						
2.	Is willing to face difficult situations and responds in a professional and principled manner.						
3.	Makes effective decisions with the Management Team's participation. Considers alternatives, uses effective decision-making processes.						

Leadership, Management, Adaptability and Effectiveness

Performance:		**5**	**4**	**3**	**2**	**1**	**6**
		Rating					
1.	Provides effective leadership and direction						
2.	Provides clear vision and direction for the organization.						
3.	Develops an environment that encourages staff to support and learn from each other, take risks, communicate openly, resolve issues and view mistakes as opportunities to learn.						
4.	Functions as a self-starter, setting high personal standards and pursuing goals with a high level of personal drive and energy.						
5.	Creates an organizational culture that is needed to carry out the mission, strategic direction and organizational goals.						
6.	Leads with integrity – demonstrates honesty and maintains ethical standards and principles in all actions.						
7.	Nurtures leadership abilities in senior staff.						

Communication

Performance:	5	4	3	2	1	6
	Rating					
1. Communicates effectively to: • the Board						
• Board Sub-Committees						
• Staff, on matters of importance						
2. Challenges and motivates managers and staff toward the achievement of goals and objectives.						
3. Is willing to listen to diverse views.						
4. Shares ideas willingly and communicates in an honest, forthright manner.						
5. Ensures that written and verbal communication is easy to understand and appropriate for the situation and the people concerned.						

Interpersonal Relations

Performance:	5	4	3	2	1	6
	Rating					
1. Maintains a work style that is open to constructive suggestions.						
2. Affirms the unique contributions of all people recognizing their diverse backgrounds and varying needs in the workplace.						
3. Values people and shows genuine concern for their well being.						
4. Creates an environment in the organization that promotes effective two-way communication between staff and management.						
5. Works cooperatively with individuals, teams or workgroups in the organization.						

Finance and Human Resource Management

Performance:	5	4	3	2	1	6
	Rating					
1. Demonstrates a thorough understanding of financial management and consistently works towards 'best practice' standards in BCCPA.						
2. Provides leadership and stewardship that ensures financial sustainability and balances short and long-term needs.						
3. Aligns financial planning with identified program and service priorities.						
4. Utilizes performance review processes with management to provide appropriate feedback and mentoring.						
6. Provides opportunities to Management for professional development and growth – and to pursue specific areas of professional interest where possible.						

Strengths:

Areas for Growth:

Other comments:

CONFIDENTIAL BRIEFING NOTE

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

Item 4.2

		BCCPA- Chef Stowe Partnership
1.	**Presented For**	☑ Approval ☐ Discussion ☐ Information
2.	**Presented To**	Board of Directors
3.	**Date Presented**	January 16, 2014
4.	**Prepared & Submitted By**	Keivan Hirji
5.	**CEO Approval**	☑ Daniel Fontaine
6.	**Board Committees Consulted**	☐ Annual Conference ☐ Awards ☐ Membership ☐ Finance and Audit ☐ Governance ☐ Other _____
7.	**Date of Approval**	January 09, 2014
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 close relationship between food and happiness is unquestionable, and one that each of us have explored throughout our lifetimes. Food is the source of energy we begin each day with and the nourishment we use to regenerate our bodies. Food has the power to bring together families on special occasions, is often the highlight of travels, and has the unique ability to provide us comfort and memories of the past. It is a staple of daily life and an important source of happiness for all. When the public thinks of care home meals, it often evokes images of packaged, overcooked, and bland food that has been mass produced in a central location only to be shipped to a care home and reheated. Nutrition, hydration and dining all play an essential role in the health and well-being of residents in long-term care. Through providing appetizing food and dining, we can immensely affect the mood and happiness of our residents.

		BCCPA- Chef Stowe Partnership
9.	**Recommendation(s)**	The BC Care Providers Association proposes to undertake a partnership with Top Chef Canada winner, Chef Matthew Stowe. Chef Stowe will be offering his talents to chefs working in the continuing care sector in designing a suggested model for nutrition in care homes. The model embraces a holistic approach, recognizing that food, beverages and pleasurable dining influence residents' psychological and social well-being as well as their physical well-being. Chef Stowe's commitment will include: • Participating in one media event in downtown Vancouver in March • Attending our 37th Annual Conference in May 2014 in Whistler and coordinating the development of several tasting stations in collaboration with sector chefs. The tasting stations will help demonstrate how low cost meals can both taste and look good. • Participate in one province-wide "Chat with Matt" two hour workshop whereby Chef Stowe will provide tips and answer questions to continuing care sector chefs/cooks. • Produce four bulletins each season (winter, spring, summer, fall) that will be electronically distributed to each care home providing advice as to which BC-based fresh vegetables/fruit is available for use in our commercial kitchens.
10.	**Description**	<u>The BCCPA- Chef Stowe Partnership will encompass the following key initiatives:</u> **Chef Stowe Vancouver Showcase:** In late March 2014, Chef Stowe will work with various care home chefs in BC to design several unique dishes for potential use in care homes across BC. The public announcement and organization of the event will be contracted to Pace Group Communications Inc. In support of *Grow BC*, the Minister of Agriculture is being invited to attend as part of this announcement. We will announce a goal to increase the purchase of BC-based fruits and vegetables by over 20% in the next 5 years. The event will have Chef Stowe work with various care home chefs and culinary students in an effort to achieve the best balance among nutritional, appetizing, and

BCCPA- Chef Stowe Partnership

cost sensitive dining for residents in long-term care. The event will feature the food creations of various care home chefs from BC in a friendly spirited competition judged by a panel of seniors in care.

The Chat with Matt Workshop

The *Chat with Matt* workshop will take place in Vancouver and broadcasted via web across BC. Chef Stowe will provide tips and latest industry information regarding how to cook appetizing, nutritious, and cost effective food within care homes. A particular focus will be placed on how to improve presentation and use BC grown produce. The video resource will be accessible by BCCPA member care home chefs across BC. We will seek out partnership funds from the Ministry of Agriculture to promote attendance and increase production level of the video.

Through a two-way dialogue, care home chefs will be able to interact with Chef Stowe regarding ways incorporate his ideas into their commercial kitchens.

Chef Stowe Annual Conference Showcase

On May 25-27, 2013 Chef Stowe's creations will be featured at the BCCPA 2014 Annual Conference to raise awareness of the BCCPA-Chef Stowe initiative.

On the evening of Sunday, May 25th Chef Stowe will guide the development and present a showcase of eye-pleasing and cost effective dishes. The dishes will be produced by select chefs/cooks working within the continuing care sector.

The showcase will be an interactive exhibit in which conference attendees will try each of the dishes and then attempt to guess the price point. This will allow Chef Stowe to illustrate the exceptional and cost-effective food that can be produced.

Each station will have one winner, selected as the individual who came closest to guessing what the dishes cost, and Chef Stowe will present them with a prize on stage. He will also make some remarks to the 200+ delegates in attendance.

		BCCPA- Chef Stowe Partnership
11.	**Financial Implications**	• The estimated cost of the partnership is $10k. o $5K will be allocated towards the media announcement of the partnership at the Vancouver Showcase. This figure has been previously built into the communications budget. o The remaining $5k will be used to negotiate Chef Stowe's contract. • The partnership will be based on a year-long contractual agreement. Nearing the end of the contract, the partnership will be reassessed with the possibility of extension.
12.	**Risks**	• Care home chefs may not be in a position to replicate Chef Stowe's dishes • Client meal expectations may go beyond what individual care homes can deliver within their existing budgets. • The target of using 20% locally sourced food products may not be achieved over five years. • It may also be difficult to track and establish a baseline. • The emphasis on improving care home food leads media to believe current condition of care come food service is sub-standard. By extension, they may also believe that non-BCCPA facilities are not placing an emphasis on designing and creating good meals.
13.	**Alignment with BCCPA Strategic Plan**	• **Strategic Goal #1: Strengthen Value Proposition for Members** o The initiative will offer BCCPA members access to food preparation resources that offer tips for reducing costs and improving Care. • **Strategic Goal #2: Effectively Manage Our Brand and Reputation** o This unprecedented initiative will further our reputation as a respected thought leader and innovator for the continuing care sector in BC • **Strategic Goal #3: Maintain a Focus on Quality** o The BCCPA-Chef Stowe initiative will allow us to pro-actively lead the development of new tools and resources that will support the delivery of quality care
14.	**Attached Documentation**	

CONFIDENTIAL BRIEFING NOTE

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

Item 4.2

		BCCPA- Chef Stowe Partnership
15.	**Other Documentation**	☐ **Leave Behinds** ☐ **Advance Info Sent**
16.	**Additional Information**	The Canadian Society of Nutrition Management has expressed interest in the project.
FOLLOW-UP / ACTION ITEMS *For completion following report delivery, discussion, approval etc.*		

Item 4.3

From: Liz Monrad (Provincial Director - British Columbia LTC) [mailto:Liz.Monrad@reveraliving.com]
Sent: Friday, November 29, 2013 5:08 PM
To: Daniel Fontaine
Subject: FW: Canadian Culture Conference

Hi Daniel
Revera and the Research Institute for Aging are partnering together to bring the inaugural Canadian National Conference on Culture Change to Toronto in March 2014. Pioneer Network was the driver in the US to raise awareness of person –centred care in residential care and was the inspiration for developing a Canadian organisation to carry the work forward in Canada.

I have been asked to approach you with sponsorship invitation and attach the package for your review. We are hoping for a $5000 sponsorship. My colleague in the Revera Retirement division will be approaching BCSLA.

This is a vital endeavour, aligned with the mission of BCCPA, to promote quality care for the elders across Canada. I would be delighted as a Board member of BCCPA to see us publicly support this initiative and reinforce our commitment to being on the leading edge of change.

I would be happy to discuss further with you Daniel. Please call me at your convenience.

Liz

Liz Monrad, M.A., M.P.A.
Provincial Director - British Columbia LTC
c/o Lakeview Care Centre
3490 Porter Street, Vancouver BC V5N 5W4
Cell: 604-365-7281
liz.monrad@reveraliving.com
www.reveraliving.com

SPONSORSHIP OPPORTUNITIES

WALK *with* ME

Changing the culture of aging in Canada

March 24 & 25, 2014 | Hyatt Regency | Downtown Toronto, Ontario

The Inaugural Canadian conference on culture change

Join together with older adults/residents, family members, professionals, educators, policy-makers and researchers to learn with and from each other.

Join us for the inaugural Canadian National Conference dedicated to changing the culture of aging and creating communities where person-centred living is the norm.

WHO WILL ATTEND THIS CONFERENCE?

The conference will attract 400 administrators, senior managers, researchers, staff at all levels, and older adults/residents[1] – all who influence policy and purchasing.

By exhibiting at this conference, you have a premiere opportunity to increase your presence among respected decision-making leaders who are on the forefront of this progressive movement to change the culture of aging.

Increase your company's visibility, meet professionals face-to-face, provide hands-on demonstrations, distribute educational materials and influence professionals committed to empowering and engaging Canadians of all ages and fostering healthy communities.

This event promises to be a signature event in Canada, sparking a social movement punctuated by annual conferences and supported by a national culture change network. Be there and you will demonstrate your company's commitment to being on the leading edge of change.

WHY YOUR SPONSORSHIP MATTERS

There are many exciting initiatives and projects underway in Canada that are shifting, in significant and positive ways, the culture of aging and long-term care.

The first Canadian National Conference to change the culture of aging aims to accelerate and give profile to this social movement.

It will bring diverse stakeholders together, including older adults/residents, family members, professionals, educators, policy-makers and researchers. Book early as space is limited in this unparalleled networking opportunity.

OBJECTIVES OF THE CONFERENCE

- To showcase innovations in culture change specific to aging and long-term care in Canada.
- To build partnerships and networks to support culture change in aging and long-term care in Canada.
- To launch a national culture change network and accelerate the movement already underway across Canada.

1. *Includes older adults and others residing in long-term care, as well as older adults residing in retirement/independent living, and/or in community settings.*

SPONSORSHIP OPPORTUNITIES

Six Compelling Reasons to Sponsor or Exhibit

- Showcase your products and services
- Build relationships with existing customers and prospects
- Generate sales leads
- Build your brand and gain a competitive advantage
- Network with key decision makers and learn more about the issues they are facing
- Gain industry knowledge and position your company as an industry leader

CULTURE CHANGE FEATURE SPONSORS

$20,000 (3 available)

Package includes:

- Prominent verbal and visual recognition at one keynote session
- Introduction of one of the keynote speakers
- Prominent position of logo in conference program
- Half-page ad in conference program on inside or back cover
- Logo and company description on Canadian Culture Change Conference website
- Premium exhibit space
- Logo on signage in registration area and reception
- Ability to place a promotional item or flyer in delegate bag
- Ability to display your company signage/banner in prominent location
- Two conference registrations including banquet, lunches & breakfasts
- First right-of-refusal for culture change feature sponsorship for 2015

SPONSORSHIP OPPORTUNITIES

SPARKING THE CULTURE CHANGE NETWORK SPONSOR

$15,000 (only 1 available)

Package includes:

- Verbal and visual acknowledgement on the first day during the plenary session focused on formalizing the culture change network across Canada
- A progressive sponsorship opportunity to support the continuation of a conversation that began at the Canadian Association on Gerontology in Vancouver, BC in 2012
- Prominent position of logo in conference program
- Half-page ad in conference program
- Logo and company description on Canadian Culture Change Conference website
- Logo on signage in registration area and reception
- Ability to place a promotional item or flyer in delegate bag
- Exhibit space
- Two conference registrations including banquet, lunches & breakfasts

BUILDING COMMUNITY SPONSOR

$10,000 (4 available)

Acknowledged as (choose one):

1. Monday Luncheon Sponsor
2. Monday Evening Reception Sponsor
3. Tuesday Breakfast Sponsor
4. Tuesday Luncheon Sponsor

Package includes:

- Prominent position of logo in conference program
- Quater-page ad in conference program
- Logo and company description on Canadian Culture Change Conference website
- Verbal and on-screen acknowledgement and recognition at respective selected event
- Logo on signage in registration area and reception
- Ability to place a promotional item or flyer in delegate bag
- First right-of-refusal for building community sponsorship for 2015
- Two conference registrations including banquet, lunches & breakfasts
- Option to purchase exhibit space at 50% off ($1250) - includes lunch both days

SPONSORSHIP OPPORTUNITIES

BUILDING RELATIONSHIPS SPONSOR

$5,000 (4 available)

Package includes:

- Acknowledged as coffee break sponsor (Pick one: Monday or Tuesday AM or PM)
- Company logo in conference program
- Logo, web link on Canadian Culture Change Conference website
- Logo on prominent signage in registration area
- On-screen acknowledgement
- Two conference registrations including banquet, lunches & breakfasts
- Option to purchase exhibit space at 50% off ($1250) – includes lunch both days

ENGAGED RESIDENTS CHALLENGE SPONSOR

$2,500 (4 available)

Residents are invited to contribute a vision for changing the culture of aging and creating communities where person-centred living is the norm. Four resident submissions will be chosen. Each winner will receive a prize package that includes conference registration plus hotel, meals & travel for one resident and one companion.

Engaged Residents Sponsor package includes:

- Acknowledgement in conference program
- Acknowledgement on Canadian Culture Change Conference website
- Company logo on poster promoting competition
- On-screen acknowledgement
- Option to purchase exhibit space at 50% off ($1250), including lunch both days

SPONSORSHIP OPPORTUNITIES

CONTINUOUS TRANSFORMATIONS EXHIBITER

$2,500 (10 available)

Exhibitor Package includes:

- Two days of exhibit opportunities
- Two exhibitor registrations (*note: conference registration is separate*)
- Acknowledgement in conference program
- One six-foot exhibit table
- Free access to internet and electricity
- Acknowledgement on Canadian Culture Change Conference website
- Lunch provided on both days

ADDITIONAL SPONSORSHIP OPPORTUNITIES

1. Registration Sponsor

- Prominent signage in registration area
- Acknowledgement in conference program
- Cruiser table (unmanned) in registration area
- *Contribution of $1500*

2. Concurrent Sessions Sponsor

- Acknowledgement in conference program
- Opportunity to distribute materials at your chosen session(s)
- Verbal acknowledgement at sponsored sessions
- *Contribution of $500 for one session, $250 for each additional session*

Customized Packages available on request

CONTACT INFORMATION

For more sponsorship information or to customize a sponsorship package, please contact:

Joanne Dykeman at joanne.dykeman@reveraliving.com or

Kristine Theurer at kristine@javamusicclub.com

To register as a sponsor, please contact:

Silvija Davidovac at silvija.davidovac@reveraliving.com

For general conference inquiries, please contact:

Hilary Dunn at hadunn@uwaterloo.ca

This inaugural national conference will bring together diverse stakeholders from across the care continuum (long-term care, retirement and independent living, community) to learn with and from each other about changing the culture of aging in Canada.

The conference will showcase the work of the Ontario Centres for Learning, Research & Innovation in Long-Term Care (Baycrest, Bruyère & Schlegel). It will also highlight culture change initiatives from across Canada.

To be added to the conference communication list, please email info@the-ria.ca with your request.

Supported in part with funding from the Government of Ontario.

LEARN MORE

www.the-ria.ca/walkwithme #culturechange2014

RIA Research Institute for Aging
Schlegel • UWaterloo • Conestoga

CONFIDENTIAL BRIEFING NOTE

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

ITEM 4.4

Report Title		**Co-location – SafeCare BC + BCCPA**
1.	**Presented For**	☑ Approval ☐ Discussion ☐ Information
2.	**Presented To**	Board of Directors
3.	**Date Presented**	January 16, 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**	January 8, 2014
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 5 year lease for 1338 West Broadway was signed on February 1, 2011 and will expire on January 31, 2016. We are currently paying approximately $15.50 per sq ft + operating expenses. We are currently paying $4731 per mo for a total of $56,868 per year. There were no improvements (i.e. paint, carpets) made to the interior when the lease was resigned. The interior paint is in very poor condition as are the carpets. There were a number of deficiencies within our unit which needed to be addressed in the last 12 months including lack of hot water, low water pressure, parking and uneven temperature control. We also experienced two separate incidents of theft within our office which resulted in the loss of two laptops + one overhead projector. On October 1st BC Care Providers signed a contract with WorkSafe BC to establish SafeCare BC. Shared office space has been identified by the Board as one opportunity for cost savings. The current location has four separate offices and a reception. Assuming the CEO and ED retain a private office, there would be two private offices remaining + open floor space and a reception. The existing configuration could accommodate up to 7 employees in total – but this would not be optimal.

	Report Title	Co-location – SafeCare BC + BCCPA
		Assuming the two organizations share an office, we would need the following work spaces: - CEO, BCCPA - ED, SafeCare BC - Director of Policy and Research - Communications Coordinator - Office Administration (X2) - Injury Prevention Training Coordinator - Intern/COOP students X2 (3 students per year/4 mo) - SafeCare Trainers (open drop in work stations) X2 BCCPA met with the agent who secured our lease at 1338 West Broadway. He indicates: - Due to the size of our office (<2000 sq ft) and location, we should be able to sublet within 6 mos. - There is plenty of office space available and the market is favourable at the moment. - There is an opportunity for us to find cost savings if we are prepared to move outside the Broadway Corridor. But there are also some good rental opportunities within this same neighbourhood. The growth for the BCCPA in its membership over the last decade has been outside of Vancouver. This trend should continue into the foreseeable future. A number of our board directors also live outside of Vancouver. We are currently paying rent for a large boardroom that is only used about 5% of the business hours. There are many new rental options that allow for common boardroom use on a pay-as-you-go service which is much more cost effective.
9.	**Recommendation(s)**	Advise landlord we are going to sublet property. Seek out a new office that can adequately house both BCCPA and SafeCare BC over the next 5 years. Look at properties in the Broadway corridor, Downtown, Metrotown (Burnaby) and New Westminster – as long as they are directly adjacent to a SkyTrain line. Aim to move no earlier than summer 2014 (post conference).

Report Title		Co-location – SafeCare BC + BCCPA
10.	**Alternatives**	Option 1: Work with landlord to reconfigure & refurbish current office to accommodate new staff and sign a 5 year renewal lease. This will likely result in the boardroom needing to be removed. Option 2: Secure larger space (if available) within current building to ensure we can accommodate staff + boardroom.
11.	**Financial Implications**	As a result of BCCPA and SafeCare BC sharing accommodation costs, we will be in a position to reduce our annual payable in rent. This will be determined by which location we choose (downtown more costly, Burnaby/New West cheaper). The moving + setup costs are anticipated to be less than $5K.
12.	**Risks**	There could be a disruption of service (in-person/online) to our membership during the move. We may not be able to secure a location in time after we have sublet our office. *Although it should be noted our leasing agent indicates this is highly unlikely given the current market.* The newly elected SafeCare BC Board (October/November 2014) may not want to co-locate the office and may seek to break the new lease agreement in 2015 +.
13.	**Alignment with BCCPA Strategic Plan**	3.1
14.	**Attached Documentation**	N/A

CONFIDENTIAL BRIEFING NOTE

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

Report Title		Co-location – SafeCare BC + BCCPA
15.	**Other Documentation**	☐ **Leave Behinds** ☐ **Advance Info Sent**
16.	**Additional Information**	BCCPA has been meeting with Brad Haw, Associate Vice President, Office Buildings, CB Richard Ellis in relation to possible rental opportunities. He was the agent that originally secured our current location and negotiated our renewal lease.
FOLLOW-UP / ACTION ITEMS *For completion following report delivery, discussion, approval etc.*		

BC CARE PROVIDERS ASSOCIATION

ITEM 4.5.a

Membership Support Programs

– An Opportunity for Growth –

Presented by Patrick O'Connor - Consultant

January 2014






Overview

- **Spring 2013 BCCPA approached by Johnson with proposal**
- **Resulted in hiring of consultant to review opportunities – summer 2013**
  - Conducted Needs Analysis
  - Financials
- **BCCPA meets BCNPHA in December 2013**
- **Determine Board interest – January 2014**
- **Next Steps will depend on board feedback**

Overview

- BCCPA 2013-16 Strategic Plan indicates interest in diversifying revenue streams + increasing membership
- Membership support programs can be used as a tool to attract new members – estimated 60% of sector remains non-BCCPA
- Individual phone interviews conducted with BCCPA members + non-members + ACCA

The Risks

- Potential loss of revenue (sponsorships and advertisements) from commercial members in competing class i.e. insurance companies
- Potential reduction in commercial memberships
- Don’t meet our revenue target

Johnson Proposal

BC CARE PROVIDERS ASSOCIATION

- Reduced costs and enhanced benefits for BCCPA members
- 10% participation rate would result in approximately $250K net annual revenue for BCCPA
- Requires BCCPA endorsement and promotion

JOHNSON

Where should you go…

- Stay focused on core programming with high revenue potential – insurance, pooled revenue, energy cost reduction
- Use new program revenue to meet demands of membership which should further increase growth
- Avoid low yield areas such as WiFi, credit cards, cell phones etc…

What members want…

BC CARE PROVIDERS ASSOCIATION

Education – organize and execute various training sessions across BC

Pros:

- **Members get better access to valued and necessary training normally afforded only to Health Authority staff**
- **Allows for revenue generation and cost-recovery**

Cons:

- **Very resource intensive and would require more start up costs.**
- **Revenue stream limited**
- **Not part of core mandate or identified as priority in Strategic Plan**

What members want…

Policy Development – Centrally coordinate development of new policies and procedures

Pros:

- **Smaller members can gain access to standardized policies developed by BCCPA – potential marketing tool for new membership**
- **Policies are more equally applied throughout BC**
- **Available on a pay-as-you-go basis**

Cons:

- **Very resource intensive**
- **Policies constantly evolving and changing. Would need to have access to in-house resources.**
- **Revenue stream limited – as documents can be easily reproduced once purchased**

What members want…

Purchasing Groups – The BCCPA could do RFPs for the purchase of key products and services

Pros:

- **Better pricing and more certainty for goods and services**
- **Revenue generation – moderate/high**
- **Attractive to smaller facilities who are non-members**

Cons:

- **Duplicates services some members already provide**
- **Resource intensive and would result in different business model**
- **Competes with BCCPA commercial members**

What members want…

Disability Management – assist with the management or workplace injuries and long-term disabilities

Pros:

- **Lots of small stand-alone sites don't have capacity to manage this currently.**
- **Economy of scale to do this centrally and develop in-house expertise**
- **Could lower overall operating costs for care providers**

Cons:

- **Likely resource intensive if not linked in to a partner such as Johnson**
- **Association lacks in-house expertise**
- **Not part of core mandate or identified as priority in Strategic Plan**
- **Revenue generation could be limited**

What members want…

Labour Relations – Provide expertise, research and support to negotiate and manage collective agreements

Pros:

- Every non-HEABC care provider must negotiate individually and don't have in-house expertise
- Allows for additional collective bargaining power
- Reduces whipsaw effect and labour costs
- Revenue generation – low/moderate

Cons:

- Very human resource intensive
- No longer an area of expertise for the Association. Got out of this business years ago.
- Not part of core mandate or identified as priority in Strategic Plan
- Unsure what real market is for this type of expertise
- 5 year labour cycles

BCNPHA Member Support Programs

BC CARE PROVIDERS ASSOCIATION

- **Continue to lower dependency on membership dues (19% of overall budget)**
  - BCCPA membership dues form XX% of revenue
- **Generate $400K per year in revenue from affinity programs – insurance largest revenue stream**
- **Multiple programs including energy audits in partnership with BC Hydro + Fortis.**
- **PIE – Pools for Increased Investment**
- **Group Health and Dental**
- **Waste and Recycling Services**

Where Could We Go From Here?

- **Develop limited number of member support programs**
  - focus on insurance, investments and energy cost reduction
- **Aim to generate new annual revenues > $300K+**
- **Member support programs becomes valuable tool in recruiting and retaining new members**
  - BCCPA membership would essentially "pay for itself"
- **Develop formal business case and incorporate into 2014/15 Operating Plan**

Where Could We Go From Here?

- **Freeze membership dues**
  - Introduce reduced introductory membership rates
- **Formalize partnership with BCNPHA**
- **Opportunity to introduce new and enhanced membership services**
- **Additional FTE to focus on:**
  - Manage membership recruitment and retention
  - Sale of promotion of membership support programs, corporate sponsorships, conference booths, advertisements and products such as Care to Chat.

ITEM 4.5.b

BC Non-Profit Housing Association

Member Support Programs

Programs that reflect your needs

BCNPHA provides programs designed to support members in their daily operations.

POOLING FOR INCREASED EARNINGS (PIE)

PIE turns numerous non-profit society accounts into one large depositor, making your accounts eligible for higher interest rates. Through partnerships and joint negotiations with other non-profit organizations, BCNPHA has accumulated an aggregate total of over $100 million that continues to gain interest and deliver outstanding value for members. With the PIE program, your society will continue to have easy day-to-day access to your independent accounts and standard service charges remain low. Participating credit unions, Vancity Savings and Coast Capital Savings are involved in community initiatives with an extensive history of working with the non-profit housing sector.
For information, contact Jacqui Mendes, BCNPHA (T) 604-291-2600 x225 or 1-800-494-8859 (e) jacqui@bcnpha.ca

COMPREHENSIVE GENERAL INSURANCE

As one of the longest running and strongest BCNPHA member support programs, Marsh Canada provides insurance packages to non-profit housing societies at exclusive bulk premium rates. Available insurance includes: Building & Contents, Property & Rental Income, Boiler & Machinery, Crime, Commercial General Liability, Directors & Officers Liability, Volunteer Accident, and Errors & Omissions Liability. BCNPHA undertakes a rigorous annual program review to ensure premiums and coverage levels are consistent with a standard approved by both BCNPHA and BC Housing.
For further details, please contact Edna Wong at Marsh Canada (T) 604-692-4828 (e) edna.wong@marsh.com

MAINTENANCE AND REPAIR PRODUCTS

This exclusive program with HD Supply Facilities Maintenance offers access to bulk rates for all BCNPHA member societies. BCNPHA members can buy maintenance and repair supplies using the HD catalogue by telephone with no minimum order quantity. All products are offered at bulk discount rates, with 10% on the 1st order and 3.99% thereafter. Delivery is same or next day and free of charge, depending upon location.
For all inquiries, contact Stanley Newman at HD Supply (Toll free) 1-800-782-0557 (e) stanley.newman@hdsupply.com

GROUP HEALTH & DENTAL BENEFITS

This program, exclusive to BCNPHA members, is offered through Morneau Shepell. In-person consulting services help non-profit housing societies make informed decisions regarding benefit plan development. Quotations allow for comparisons with existing plans, and offer a number of alternatives for premiums, plan design and insurers, making certain that specific needs (large or small) are met at competitive rates.
To learn more, contact Lori Moffat at Morneau Shepell (T) 778-327-5384 (e) bcnpha@morneausobeco.com

GREEN CLEANING PRODUCTS

BCNPHA members are able to source a wide range of environmentally friendly cleaning products at preferential rates with Planet Clean International. Members can access a discount of 15% on all items. (Some exclusions apply). Planet Clean is the leading distributor of high quality, environmentally considerate cleaning supplies, restoration and safety products and works with non-profit organizations across BC.
Contact Norman van Vooght at Planet Clean (T) 604-540-5343 (e) nvanvooght@planetclean.com

WASTE & RECYCLING SERVICES

BFI Canada offers BCNPHA members a custom waste and recycling program in the Lower Mainland at preferential, sustainable rates. Committed to providing clients with premium service, BFI offers quick responses to rectify challenges, saving time for property managers. Recycling is easier, as all paper products go into one bin, with no separating or sorting. BCNPHA members access special rates for landfill increases.
To participate, contact Rob Barr at BFI Canada (T) 604-517-2605 (e) rob.barr@bficanada.com

LAUNDRY SERVICES

Coinamatic Canada offers BCNPHA members exclusive pricing for laundry services, preferential revenue arrangements and rebates for the first 6 months of a new or renewed laundry services contract. Coinamatic, a BCNPHA Associate Member for many years, works extensively with the non-profit housing sector in BC to supply high quality products and service excellence at affordable prices. Coinamatic aims to provide flexible laundry solutions that help reduce operating costs while maintaining high quality results.
To participate, contact Maxi Castillo at Coinamatic (T) 604-270-8441 (e) mcastillo@coinamatic.com

BEDS AND MATTRESSES

Restwell Sleep Products offer preferential bulk pricing on selected Restwell beds and mattresses. All products meet BCNPHA & BC Housing standards, with excellent life cycle profiles. Through manufacturing recycling programs, Restwell recycles 100% of plastic and cardboard waste. Restwell gives back to the community by supporting local charities and gives a percentage of sales each year to donate mattresses to shelters.
To learn more, contact Ashley Allen at Restwell Sleep Products (T) 604-576-2339 x111 (e) ashleya@restwell.com

EMERGENCY PREPAREDNESS KITS

Braidner Survival Kits offers BCNPHA members a wide selection of emergency workplace kits, first aid supplies and assistance in emergency management planning. Members can access a 10% discount on all product items. Emergency kits can be purchased ready-made, customized to specific requirements or existing kits can be upgraded or replenished with products available through Braidner Survival Kits.
To learn more, contact Andy Nieman at Braidner Survival Kits (T) 604-254-0455 (e) bsk@preparecentre.com

The BC Non-Profit Housing Association provides member support programs designed to assist members in their day-to-day operations and meet the needs of its members in the most cost-effective and efficient manner. BCNPHA membership gives your organization access to programs that can save money and increase income through the aggregated strength of the non-profit housing sector.

BC Non-Profit Housing Association

BC Non-Profit Housing Association
303 – 3680 E. Hastings St. Vancouver,
BC Canada V5K 2A9
www.bcnpha.ca

T: 604-291-2600
Toll Free: 1-800-494-8859
F: 604-291-2636
E: admin@bcnpha.ca

summarized financial statements

Independent Auditors' Report

The accompanying summarized statements of financial position, operations, comprehensive income and changes in net assets are derived from the complete financial statements of British Columbia Non-Profit Housing Association as at August 31, 2013 and for the year then ended on which we expressed an opinion without reservation in our report dated October 22, 2013. The fair summarization of the complete financial statements is the responsibility of management. Our responsibility is to express an opinion on these financial statements based on our audit.

In our opinion, the accompanying summarized financial statements fairly summarize, in all material respects, the related complete financial statements in accordance with Canadian generally accepted auditing standards.

These summarized financial statements do not contain all the related disclosures required by Canadian generally accepted accounting principles. Readers are cautioned that these statements may not be appropriate for their purposes. For more information on the entity's financial position, results of operations and cash flows, reference should be made to the related complete financial statements.

W. Bruce & Associates Ltd., Certified General Accountants

BRITISH COLUMBIA NON-PROFIT HOUSING ASSOCIATION — **Statement 1**
STATEMENT OF OPERATIONS, COMPREHENSIVE INCOME AND CHANGES IN NET ASSETS
YEAR ENDED AUGUST 31, 2013

	2013	2012
Revenues		
Incentive rebates	$ 399,241	$ 359,419 *Affinity Program Revenue
Sponsorships and special project grants	425,798	384,036
Membership fees	253,679	251,877
Professional services	10,211	92,821
Interest income	24,714	22,456
Registration fees	227,738	226,055
Other income	23,851	20,217
Transfer from internal reserve funds	(62,970)	76,649
	1,302,262	**1,433,530**
Expenses		
Amortization	1,499	2,202
Board and committee	30,475	36,274
Communications	15,618	14,113
Educational workshops	33,507	23,700
External consultants	37,312	150,487
Office and general	161,671	176,186
Professional and management fees	21,987	13,697
Regional outreach and member support	9,191	4,746
Salaries and benefits	755,151	714,943
Special project costs	122,259	77,565
Transfer (to)/from internal reserve	(62,970)	76,649
Venue rental and catering	138,647	122,630
	1,264,347	**1,413,192**
Excess of revenues over expenses	37,915	20,338
Fund balance, beginning of year	646,010	698,527
Transfer to current year	62,970	(76,649)
Unrealized gain on investments	(7,285)	3,794
Fund balance, end of year	**$ 739,610**	**$ 646,010**

BC CARE PROVIDERS ASSOCIATION www.bccare.ca
Advocating Service Excellence for Seniors.

Item 5.2

2013 Conference Planning Committee
10:30 AM – December 9, 2013
Conference Call

MINUTES

Participants: Hendrik Van Ryk, Isobel Mackenzie, Michael Atkins, Andrew Crombie, Daniel Fontaine, Maria Capostinsky, Heather Campbell

Regrets: Jeff Nider

Andrew Crombie was welcomed to the committee for 2014.

1. **Information** - The following documents were accepted as submitted.

   a. Minutes from last meeting
   b. Program Outline – working document
   c. Sponsorship Opportunities for 2014 – as approved by committee

2. **Conflict of Interest** - Daniel noted to committee members that if at any time business of the committee is determined to be of a conflict of interest with any committee member – they should excuse themselves from the committee until such business has been concluded. All committee members were in agreement.

3. **Program** – the committee reviewed the draft program schedule and following discussion agreed to the following updates/changes:

   1. Cancel breakfast in exhibit hall on Monday
   2. Provide breakfast in foyer of meeting rooms on Monday
   3. Present door prizes from exhibitors during Tuesday AM coffee break
   4. Cancel lunch in exhibit hall on Tuesday
   5. Provide "bag lunch" in foyer of meeting rooms on Tuesday

   It was also suggested that the BCCPA + SafeCare BC AGMs be held from 4:30 to 5:30 in a separate meeting room thus allowing for 3 concurrent session from 3:30 – 4:30 in the main meeting hall. (Board of Directors meeting to follow at 5:30 pm).

4. **Sponsorship Opportunities** – Daniel/Hendrik updated the committee on the rationale for the changes to the Sponsorship Opportunities as finalized by the committee. Following discussion the committee agreed to the following change:

   Commercial representative fee (to attend as a delegate): $1400 + GST per representative.

   Sponsorship Opportunities will now be distributed to potential sponsors.

5. **Call for Presentations** – following discussion the committee agree to proceed with the Call for Presentations as submitted – noting that the conference theme & general topic streams be noted. It was also suggested that the deadline for submission be changed to January 15, 2014.

6. **Speakers** – Daniel informed the committee that Teepa Snow is not available for 2014 and is booking for 2015. Daniel suggested that the committee consider confirming Teepa Snow for the 2015 conference.

   Following discussion the committee agreed to BCCPA confirming one of the following three choices for a keynote on Monday evening:

   1st- Mark Tewksbury, 2nd–Clara Hughes, 3rd- Maelle Rickler

7. **Next meeting** – Friday January 31, 2014 at 10:30 via conference call.

Item 5.4.

BCCPA Governance Committee

December 9, 2013

MINUTES

In attendance: Elaine Price (Chair), David Cheperdak, Isobel Mackenzie, Daniel Fontaine, Maria Capostinsky

1. **Nominations Committee**

   a. **Upcoming Vacancies/Terms of Office** – Elaine reviewed the draft Board Terms of Office document as submitted. It was agreed that the list would be updated/finalized prior to proceeding.

   Elaine will contact current Board members to determine their willingness to stand for election for 2014/2015.

   Following discussion the committee agreed to support 2 3-year terms (total of 6 years) for Board Terms starting in 2015/16 fiscal year.

   It was agreed that how to proceed to achieve staggered terms requires further review.

   b. **Process for election/nominations from the floor** – The committee discussed the current bylaws which allow elections from the floor at the AGM, noting that as we currently determine nominees in advance it is unlikely that nominations from the floor will be received, but the Association must be prepared for the possibility.

   c. **Must work under current bylaws until May 2014** – it was confirmed that any changes to the current system would be brought to the members at the AGM for approval and then registered with the society registry, therefore new system would be in effect for 2015/16 election year.

2. **BCCPA By-laws/Constitution changes to reflect recently updated policies**

   a. **Initial review of Bylaws** – Elaine and Daniel will review which items need to be updated prior to forwarding to lawyers to be drafted. (It was noted that clarification of the term "home support" in membership categories be considered.)

   b. **Meeting with lawyers to draft revised Bylaws** – Daniel will consider lawyer to approach. David suggested that Margaret Mason of Bull Housser Tupper be considered.

   c. **New Bylaw Approval** - Bylaws to be drafted for Board review in February 2014 prior to presenting to the membership for approval at the May 2014 AGM.

3. **Governance Task Group**

   a. Review outstanding work items/status report – Elaine reviewed the current outstanding items.

Following discussion Elaine agreed to contact Andre request he recruit 1 or2 more board members to participate on the Finance Committee.

Daniel/Elaine will updated changes to policies as per last Board meeting to bring forward to January meeting consent agenda.

4. **Next Meeting** – Will be at the call of the Chair.

Item 5.5

Criteria for Awards

Long-Service Excellence Award

Awarded to a member owner/operator or a member employee/contractor who has a 15+ year industry track record of developing and delivering quality care for individuals in care.

Criteria

- Must have been a member of BCCPA for at least 5 years.
- Demonstrated a commitment to supporting the continuing care sector
- Years of service can be in broken periods, but the time so involved must add up to at least 15 years.
- The recipient can be presently working in the sector or might now be retired from the field.

BC Care Provider of the Year

Awarded to a frontline care provider employed by one of our members who has demonstrated a commitment to quality, compassion and excellence in delivering care to one or more of our residents and/or clients.

Criteria

- Specific examples must be provided to help support how the employee demonstrated a commitment to quality, compassion and excellence.
- Examples cited must go beyond the average daily interactions between an employee and individuals in care.
- Demonstrate how this commitment may have already been recognized by their colleagues, supervisor, resident or a member of their family.

Innovation of the Year

Awarded to a member care provider or one of their employees who can demonstrate an innovation they have developed or introduced within the sector to improve the quality of care delivered.

Criteria

- Provide detailed information regarding how the innovation can be attributed specifically to the nominee.
- The innovation can be described as something new that has not been attempted or implemented before either at a particular site or with an individual.
- The innovation has potential for sector-wide application.

Details:

- Nominations will be only be accepted via the online application forms found on the BC Care Providers Association website.
- Nominators must demonstrate they are members in good standing of the BCCPA at the time of submitting the nomination.

- Nominees must be a member in good standing with the BCCPA or employed by a member in good standing.
- Once the deadline has passed, no further information can be submitted to the Adjudication Committee in relation to the nomination.
- The deadline to submit a nomination is midnight on Tuesday, December 31, 2013.
- Award winners will be notified in advance that they have been selected. They will also be asked to attend a special awards ceremony in Victoria, BC on the evening of February 19, 2014.
- Final award recipients will be recommended by the Adjudication Committee and will be approved by the BCCPA Board.
- Nominees will be judged on how best they align with the stated criteria and intent of the award.
- The finalists will be required to sign a release allowing for BCCPA to publicize their photo and other information pertaining to the award.

Suggested Information

Please provide specific, detailed examples and dates to support the nomination. The information provided will be used by the Adjudication Committee to determine the recipient of this award.

- Description of the accomplishment.
- Why does the nominee deserve to receive the Award?
- What impact has the nominee's accomplishment had in either a home or residential care setting?
- This individual has demonstrated most or all of the criteria listed above.
- How has the nominee's accomplishment supported the employer's Vision, Mission, Key Directions or Guiding Principles?
- Include additional comments.

BRITISH COLUMBIA

998828

November 28, 2013

Mr. Daniel Fontaine
Chief Executive Officer
BC Care Providers Association
301 – 1338 W Broadway
Vancouver BC V6H 1H2

Dear Mr. Fontaine:

In *Together to Reduce Elder Abuse – BC's Strategy* (TREA Strategy), released March 6, 2013, the BC Government committed to taking action to reduce elder abuse. Recognizing that no one group on its own can address an issue with such broad societal implications, the government committed to establishing a multi-sector Council to Reduce Elder Abuse (the Council) to intensify collaboration and coordinate efforts to reduce elder abuse in British Columbia. An Interim Council, with secretariat support from the Office to Reduce Elder Abuse (the Office), Ministry of Health, was formed to explore options for governance structure, mandate and process to establish the Council.

As Assistant Deputy Minister for the Office and on behalf of the Interim Council, I am writing to follow up on a telephone conversation you had with Ms. Christine Massey, on November 22, 2013 during which you expressed interest in joining the Council. It is our pleasure to invite you to be a member. As was discussed during the call, the Council's first task is to finalize the governance structure, mandate and membership (please see Attachment 1). You will be provided with additional background information to support you in your new role.

We hope you will accept the invitation to be a part of this model partnership – an innovative approach to elder abuse prevention, recognition and response. The power of collective action comes from the coordination of the activities and efforts of multiple committed participants. As a member of the Council, your experience, expertise, and sectoral connections, as well as the issues you could bring to the table, would make a significant contribution to our shared objective of reducing elder abuse in the province. The initial term would be for two years, renewable in the third year for one or two years.

...2

Ministry of Health
Assistant Deputy Minister's Office
Health Sector Planning and Innovation Division
5-3, 1515 Blanshard Street
Victoria BC V8W 3C8

We are planning for the first meeting to take place in Vancouver, on the afternoon of December 13, 2013, and will be sending a meeting invitation shortly along with briefing materials. Please do not hesitate to contact Kelly Acker, Manager, Seniors' Strategic Planning, Seniors' Directorate, Ministry of Health at: kelly.acker@gov.bc.ca, if you have any questions about the TREA Strategy or the Council.

Sincerely,

Heather Davidson

Heather Davidson
Assistant Deputy Minister
Ministry of Health

Attachment 1

In *Together to Reduce Elder Abuse – BC's Strategy* (TREA Strategy), released March 6, 2013 and available at: www.seniorsbc.ca/elderabuse, the BC Government committed to establish a multi-sector Council to Reduce Elder Abuse (Council). It was clear from the province-wide consultations, held by the Ministry of Health in early 2012 to inform development of the TREA Strategy, that no one organization or government body can singlehandedly address elder abuse. Preventing and responding to this complex issue requires coordinated action across all sectors. Many key partners and stakeholders need to be collaboratively engaged in preventing elder abuse, assisting with public education and awareness, and providing appropriate support and response.

In response to the commitment, a Start-Up Group was formed to develop options for the mandate and governance structure for the Council, and initiate the process for its formation. The Start-Up Group identified additional potential members, who were then invited to join the Start-Up Group to form an Interim Council. The Interim Council further refined options for the mandate and governance structure, as well as potential additional members.

The envisioned mandate for the Council is to collaborate and coordinate across sectors and with organizations and communities to galvanize society, both sectoral and individual, to commit to taking action to prevent elder abuse, and to promote awareness building and training on elder abuse prevention, recognition and response.

One of the options calls for the Council to comprise up to 15 people, representing a variety of organizations and sectors, with action and advisory groups to implement and support the work of the Council, and secretariat support from the Office to Reduce Elder abuse, in the Seniors' Directorate, Ministry of Health. The governance structure and mandate for the Council will be finalized at the Council's first meeting.

The benefits of providing a mechanism for coordination through a multi-sector entity, such as the Council, include:

- The increased power, credibility and opportunities for collaboration that come from distributed and shared leadership.
- A greater capacity to deal with issues that are bigger than any one organization or sector, and are complex and overlapping.
- The strength that arises when rewards and risks are shared by all.
- A more comprehensive process to actively engage the many other organizations that are involved in elder abuse prevention, perhaps through action groups or a larger network.
- The increased ability to harness the significant number of resources available in the community and government when players are all working together toward the same goals and objectives.
- Executive/strategic-level involvement helps to generate support for the issue, both within the organizations and from possible funders/collaborators.

This type of collaborative model has been successful in other areas (e.g., UK Dementia Action Alliance, BC Healthy Living Alliance, Mental Health Directorate, Fetal Alcohol Spectrum Disorder Initiative, Healthy Child Development Alliance).

The term for membership on the Council will be agreed upon at the first Council meeting, but the Interim Council has suggested an initial term of two years, with subsequent staggered terms to facilitate flexibility and dealing with emerging issues. Meetings will be held in-person or by teleconference, in a locations and with a frequency to be determined by the Council (perhaps three or four times per year). Travel expenses will be reimbursed for Council members from organizations that are not able to financially support their member's participation in meetings.

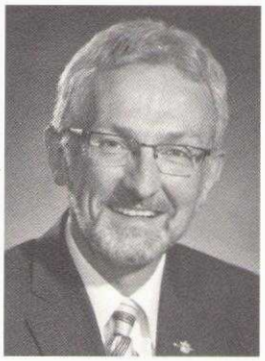
Invited members of the Council include:

- Designated Agency – Suzanne Johnston, Vice President, Northern Health Authority
- Provincial Government –Heather Davidson, Assistant Deputy Minister, Ministry of Health
- Policing – Mark Fisher, Oak Bay Police Chief
- Legal – Canadian Bar Association – Joan Braun, Lawyer and Mediator
- Financial – Credit Unions – Wendy King, Vice-President
- Informal Caregivers –Barb MacLean, Executive Director, Family Caregivers' Network Society
- BC Centre for Elder Advocacy and Support – Martha Jane Lewis, Executive Director
- BC Association of Community Response Networks – Sherry Baker, Executive Director
- Banking sector–Linda Routledge, Director of Consumer Affairs, Policy and Operations, Canadian Bankers Association
- Council of Senior Citizens Organizations (COSCO) – Art Kube, President
- BC Care Providers Association – Daniel Fontaine, Chief Executive Officer
- Aboriginal organization – to be confirmed
- The Affiliation of Multicultural Societies and Service Agencies (AMSSA) – Lynn Moran, Executive Director

Leonard Krog, MLA
(Nanaimo)
Room 201
Parliament Buildings
Victoria, BC V8V 1X4
Phone: 250 953-4698
Fax: 250 387-4680

Community Office:
4 – 77 Victoria Crescent
Nanaimo, BC V9R 5B9
Phone: 250 714-0630
Fax: 250 714-0859
e-mail: leonard.krog.mla@leg.bc.ca
website: www.leonardkrog-mla.ca

Province of
British Columbia
Legislative Assembly



Leonard Krog, MLA
(Nanaimo)

December 4, 2013

Mr. Daniel Fontaine
CEO, BC Care Providers Association
301-1338 West Broadway
Vancouver, BC V6H 1H2

Dear Mr. Fontaine:

Thank you so much for your kind invitation of November 28th. Unfortunately, or fortunately depending on your perspective, my wife and I will be away in Cancun on January 22nd, on holiday. I very much appreciate you thinking of me, and I very much enjoyed your generous hospitality when the Minister of Justice spoke at your last *Care to Chat* session. Keep up the good work.

Yours very truly,

Leonard Eugene Krog, MLA
New Democrat Official Opposition
Critic for the Attorney General
Nanaimo

LK/sl

BRITISH COLUMBIA

DEC 2 3 2013

333094

Daniel Fontaine, Chief Executive Officer
BC Care Providers Association
301 – 1338 West Broadway
Vancouver BC V6H 1H2

Dear Mr. Fontaine:

Thank you for your letter of November 27, 2013, regarding the BC Care Providers Association's recommendations for Budget 2014, addressed to the Honourable Michael de Jong, Q.C., Minister of Finance.

Your inquiry falls under the jurisdiction of the Ministry of Health. I note you have copied the Honourable Dr. Terry Lake, Minister of Health, on your correspondence.

I would like to thank you again for taking the time to write.

Sincerely,

Heather D. Wood

for
Peter Milburn
A/ Deputy Minister

cc: Honourable Dr. Terry Lake
Minister of Health

Ministry of Finance
Office of the Deputy Minister
Mailing Address:
PO Box 9417 Stn Prov Govt
Victoria BC V8W 9V1
www.gov.bc.ca/fin
Location Address:
Room 109
617 Government Street
Victoria BC

Healthcare Benefit Trust

A Review of Progress

Donnie Wing, Interim CEO

Presentation to Affiliate Advisory Group

December 13, 2013

HEALTHCARE BENEFIT TRUST

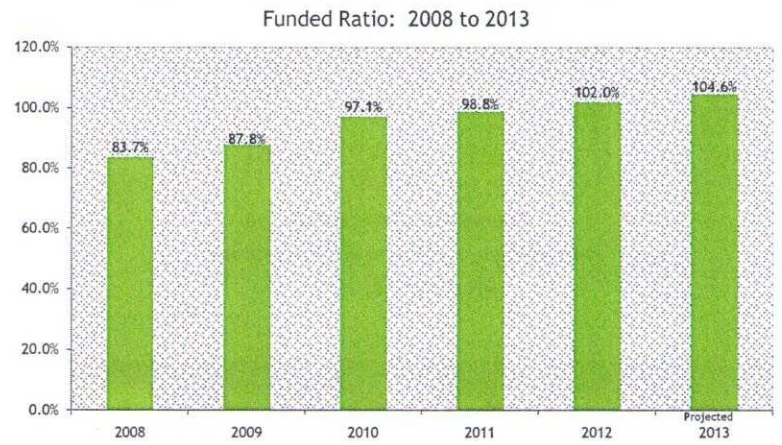
HBT

BENEFIT FROM EXPERIENCE

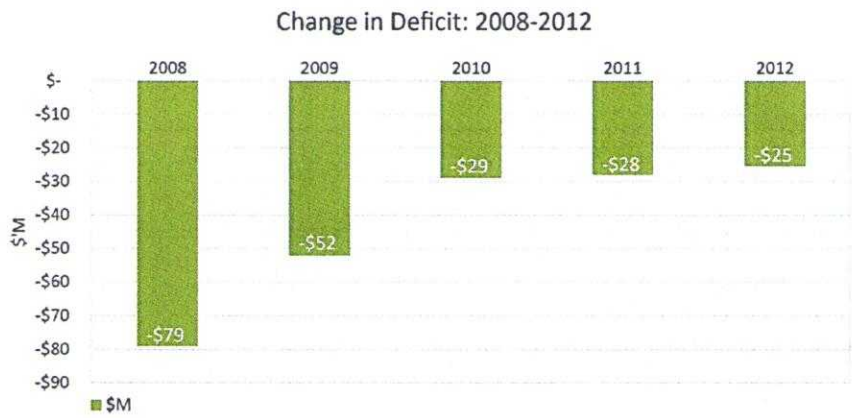
By the Numbers

Member Employers	7 Health Authorities (includes Providence) 188 healthcare, 165 community, social service and housing organizations
Contributions	$473M
Invested Assets	$1.2B
Covered Lives	90,000 employees
Active LTD Claims	6,400
Number of Collective Agreements	8
Number of Non-Contract and Management Benefit Plans	400

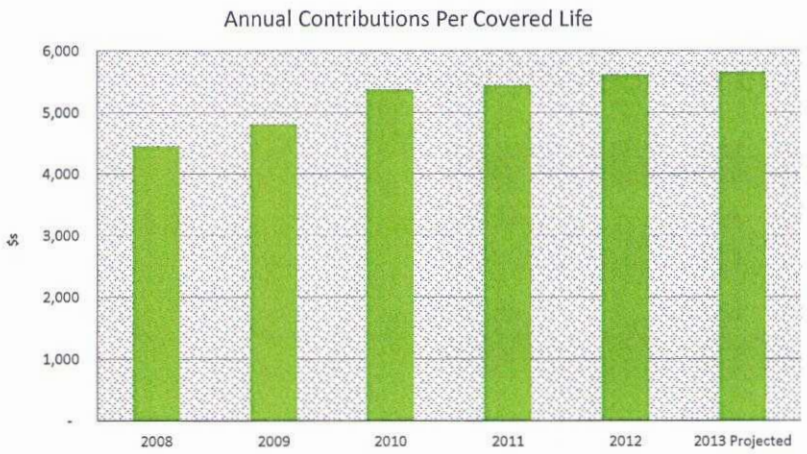
Improved Balance Sheet



Reduced Deficit - Healthcare Employers

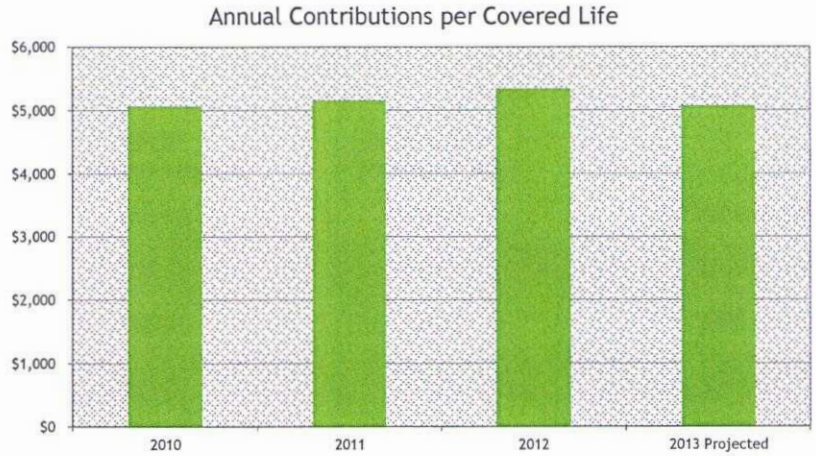


Rate Stability - HBT Overall



HEALTHCARE BENEFIT TRUST 5

Rate Stability - Affiliates



HEALTHCARE BENEFIT TRUST 6

Broad Rate Changes for Affiliates

» Average April 1, 2014 rate changes for 5 major benefit lines:

1.	Group Life	-7.7%
2.	AD&D	-20.0%
3.	EHC	-13.9%
4.	Dental	-4.1%
5.	LTD	-4.5%

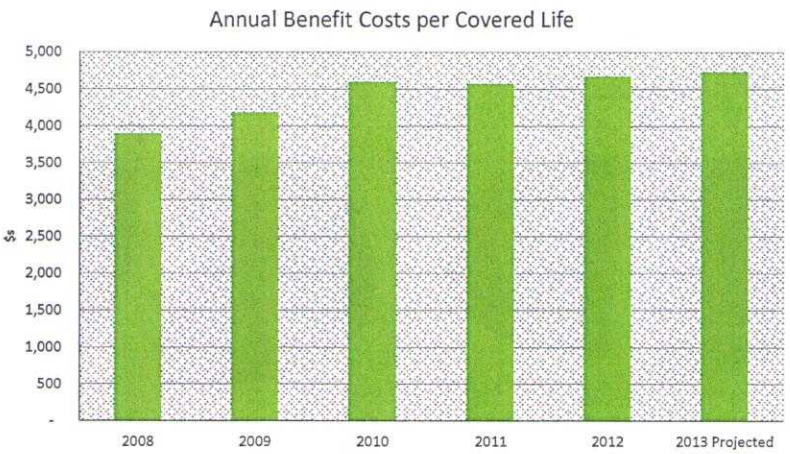
Weighted Average Rate Change

The weighted average rate change is based on the 5 major benefits: Group Life, AD&D, EHC, Dental and LTD.

Year	HBT Overall (all employers)	HEABC (Affiliate employers)
2010 to 2011	-0.73%	-4.24%
2011 to 2012	4.42%	-2.80%
2012 to 2013	0.73%	-0.54%
2013 to 2014	-4.81%	-6.59%

Improved Investment Results

Benefit Coverage and Costs

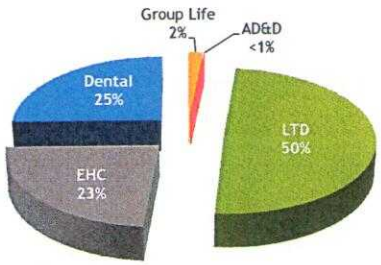


Where the Dollars Go

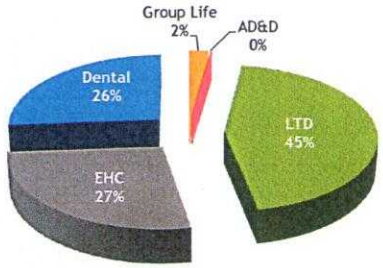
CONTRIBUTIONS BY BENEFIT

For the period October 2012 to September 2013

AFFILIATES



HBT OVERALL

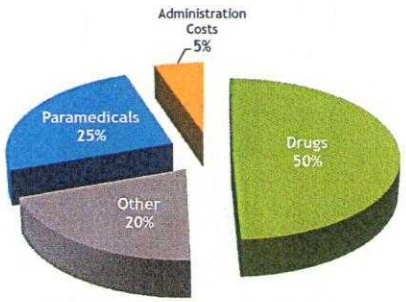


Where the Dollars Go

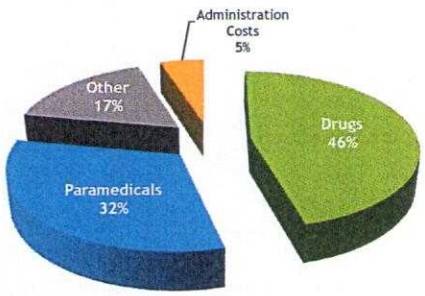
EXTENDED HEALTH CLAIMS PAID

For the period October 2012 to September 2013

AFFILIATES



HBT OVERALL

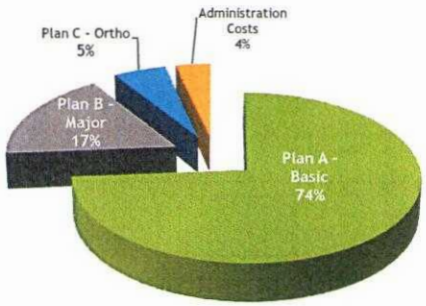


Where the Dollars Go

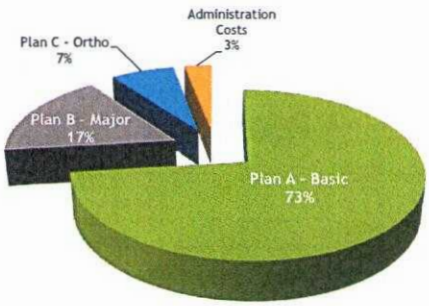
DENTAL CLAIMS PAID

For the period October 2012 to September 2013

AFFILIATES



HBT OVERALL



Where the Dollars Go

OPEN LTD CLAIMS

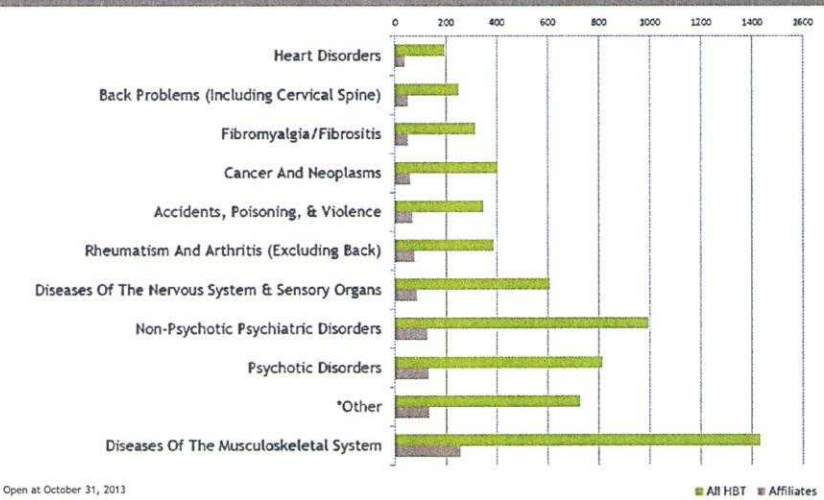
	2009	2010	2011	2012	2013
HBT	6606	6256	6171	6337	6457
Affiliate	1121	1077	1082	1051	1070
CSSEA Groups	469	450	438	446	429

LTD Incidence Rates

- Average Incidence for Pool (2008-2012)
  - HEABC 18.7
  - CSSEA 15.3
  - Permitted 12.5

Where the Dollars Go

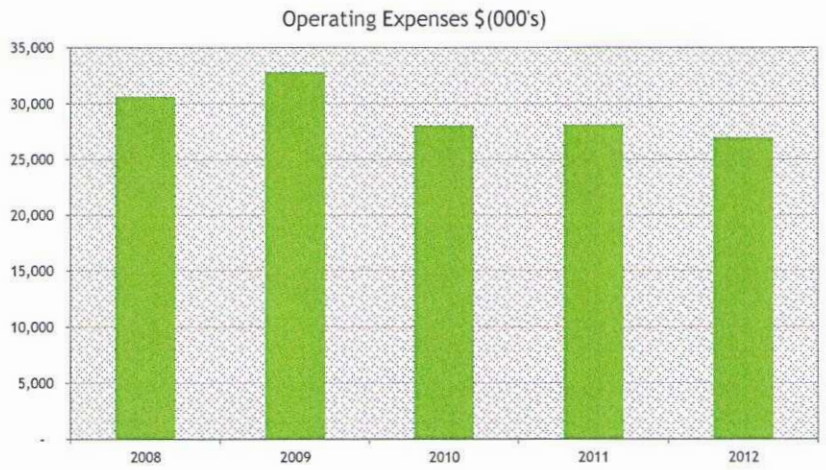
OPEN CLAIMS BY TOP 10 DIAGNOSIS



Open at October 31, 2013

*Other includes - Diseases of the: Digestive System; Genito-Urinary System; Skin And Cellular Tissue; Respiratory System; Blood & Blood Forming Organs; Circulatory System • Infective And Parasitic Diseases • Endocrine, Nutritional, Metabolic, & Immunity Disorder • Senility And Ill-Defined Conditions • Epstein Barr Syndrome, Chronic Fatigue, etc. • Congenital Conditions • Alcohol And Drug Abuse • Pregnancy And Childbirth • Disorders Of The Circulatory System • Unknown

Lower Operating Costs



Looking Ahead

- **Streamline our operations further**
  - Full core review of HBT operations
  - Leverage service provider infrastructure and expertise
- **Build on our progress and successes**
  - Board and executive expertise, focus and tone
  - Accountability to employers through collaboration, transparency and reporting
  - Financial stability based on sound policies
  - Contain costs directly or through influencing benefit design
  - Strategy of outsourcing and leading practices vendor management
- **Improve customer and stakeholder relations through collaboration and innovation**

BC Care Aide & Community Health Worker Registry ***November, 2013***

There are 50,253 Care Aide/ Community Health Workers (CA/CHWs) currently registered. At the Registry we now call CA/CHWs, - Health Care Assistants (HCAs)

Since January 29, 2010, the Registry has received 242 alleged abuse reports from employers. All of these HCAs were immediately removed from the Registry. Some cases were quickly resolved through the normal grievance process. If the allegations were unfounded or if only temporary suspensions were warranted, under the collective agreements, the HCAs were reinstated to the Registry. Of these, 139 individuals were terminated by their employers and 103 were temporary suspensions and the employee returned to work and therefore was reinstated to the Registry.

Of the 139 terminations, 50 employees have been indefinitely removed from the Registry for alleged abuse. Neither the terminated employee (if non-union) nor the union have requested an investigation.

Where the grievance procedure was not sufficient to resolve the case and it was contested by the employee or their union representative, the Registry was requested to appoint an investigator. The highlights are:

- 73 investigations have been initiated.
- 12 employees have been deregistered as a result of an investigation where abuse was confirmed and remedial action was not warranted.
- 24 employees were temporarily deregistered, but allowed to re-register after the conditions placed on them by the investigator were met (i.e. educational upgrading or a medical condition resolved)
- 22 employees were re-registered after an investigation was completed and no abuse was attributed to the employee.
- 8 employees are temporarily deregistered and may be reinstated after fulfilling educational conditions placed on them by the investigator.
- 7 employees are currently under investigation.

The Registry launched a new interactive web site on April 29, 2013. This site has the capacity to inter act and compile reporting statistics with regards to HCAs, HCA employers and HCA educators. The Registry will be conducting educational assessments of the 50 educational providers of BC Health Care Assistant (HCA) training courses. Part of the Care Aide Registry's mandate is to ensure that the standard of HCA training is consistent and at a high standard.

The Registry will post a list of recognized educational institutes that are training HCAs to the Provincial Curriculum standard so that students can choose an educational institute that is recognized which will enable them to become registered upon completion of their HCA training.

BC CARE PROVIDERS ASSOCIATION

Advocating service excellence for seniors

22 November 2013

The Honourable Christy Clark
Premier
Parliament Buildings
Victoria, BC V8V 1X4

Dear Premier:

It is with great pleasure that the BC Care Providers Association extends two opportunities for you to address the continuing care sector.

The BCCPA will be holding its inaugural *BCCPA Dinner and Awards Ceremony* on the evening of **Wednesday February 19, 2014** at the Fairmont Empress Victoria in the Ivy Ballroom. The BCCPA is pleased to invite you to provide opening remarks and present one of three prestigious awards.

In addition, the BCCPA will be holding its next *BCCPA Annual Conference* in Whistler on **May 25-27, 2014**. We would like to extend an invitation to provide a keynote address to over 200 members of the continuing care community.

It is an honour and privilege to invite you to participate in both the *BCCPA Dinner and Awards Ceremony* and the *BCCPA Annual Conference*. Your ongoing contributions and generous support of the continuing care sector have been highly regarded and most appreciated.

We look forward to hearing from you regarding your availability to participate in our two upcoming events.

Sincerely,

Daniel Fontaine
CEO

Christy
I sure hope you can attend at least one of these events! Talk soon.

Ph: 604 736 4233
Fx: 604 736 4266
www.bccare.ca

301 - 1338 West Broadway
Vancouver BC V6H 1H2
info@bccare.ca