BC Care Providers ASSOCIATION

Part 2

Sustainability and Innovation: Exploring Options For Improving BC's Continuing Care Sector

White Paper on New Care Models and Innovation

May 2016

Message from the CEO

According to Statistics Canada, for the first time in Canada's history we now have more seniors than youth under the age of 15. By 2036, over 25 percent of the population will also be over the age of 65. This highlights the critical need for us to explore new ideas and address the numerous challenges facing British Columbia's dynamic and ever-changing continuing care sector.

If we want to continue delivering top quality care for a growing number of seniors and other adults, many of whom are living with multiple chronic diseases, it is imperative we look at new innovative approaches. By doing so, we can also explore and adopt best practices in other regions as well develop our own made-in-BC solutions that will deliver better health outcomes for seniors.

The White Papers released today, which deal with sustainability and innovation in the continuing care sector, build on a longstanding BCCPA tradition of not only identifying problems, but also helping to resolve them. This can only be accomplished if we have established a true and effective collaboration with key partners such as the Ministry of Health and the Health Authorities.

The BCCPA, through its *Emerging Issues and Policy Committee*, has invested significant resources over the last year to research, draft and refine these White Papers. The first paper deals with issues around funding and financing of continuing care including approaches to improve sustainability. The second paper deals largely on innovative approaches focusing on five areas including exploring new care models for seniors, improving dementia care, use of technology as well as enhancing the safety and health of seniors.

The White Papers build on many of the key themes of the BCCPA Policy Paper released last year entitled *Quality-Innovation-Collaboration: Strengthening Seniors Care Delivery in BC*. This was in direct response to a series of policy papers released by the Ministry of Health in February 2015.

Over the next four to six months, we will be actively seeking input from those receiving care, our members, key partners and a wide range of other stakeholders.

The feedback we gather during the consultation period will be shared and deliberated with over 100 individuals and organizations who we plan to invite to the inaugural *BC Continuing Care Collaborative* at the SFU Wosk Centre for Dialogue in Vancouver. The *Collaborative* will take place in September 2016 and we anticipate active involvement from everyone who intersects with BC's continuing care sector. This includes clinicians, health care workers, academics, care aides, labour organizations as well as a broad cross section of our membership.

The BCCPA is encouraging everyone to review the White Papers and consider which ideas, concepts and funding models would help foster a vibrant and sustainable continuing care sector while ensuring excellent seniors care moving forward. We look forward to hearing from you over the coming months.

Sincerely,

Daniel Fontaine
CEO, BC Care Providers Association

BC Care Providers ASSOCIATION

Special Recognition

The BCCPA would like to acknowledge the following staff for their all of their hard work and dedication in helping to research and write this White Paper:

- Michael Kary, Director of Policy and Research, BCCPA
- Lara Croll, Policy Analyst, BCCPA

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- Sue Emmons, Chair – Northcrest Care Centre
- Elaine Price – Fraser Valley Care Centre Management
- Karen Baillie – Member – Menno Place
- Elissa Gamble – Member – Bayshore Home Health
- Al Jina – Member – Park Place Seniors Living
- Aly Devji – Member – Delta View Habilitation Centre and Life Enrichment Centres
- Tony Baena – BayBridge Senior Living

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- Jesse Adamson, Communications Coordinator
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In closing, the BCCPA Board of Directors deserves special thanks for having agreed to support this initiative and dedicating the necessary resources to make it all happen.

BC Care Providers ASSOCIATION

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EXECUTIVE SUMMARY

With the ageing population, the issue of seniors, including seniors' health and continuing care, has gained increased importance. Provincial/territorial (P/T) governments have also focused increasingly on seniors through the creation of various plans (i.e. BC Seniors Action Plan), as well as organizations and positions to better address seniors' issues. For example, in March 2014, British Columbia (BC) announced the appointment of Canada's first Seniors Advocate.

As part of this project, the BCCPA has created two separate white papers on the issues of sustainability and innovation in the continuing care sector. The first paper outlines issues around funding in the continuing sector. While Part II of this white paper will deal indirectly with some funding issues, the focus will largely be on other areas that could assist in advancing seniors' issues and improving the sustainability of the continuing care system, including:

- *Development of new care models and age-friendly approaches (i.e. Continuing Care Hub)*
- *Dementia*
- *Technology*
- *Seniors Safety*
- *Seniors Health Promotion (including Frail Seniors)*

The suggested areas also align well with those in the BC document Setting Priorities for the B.C. Health System that was released in February 2014. They also touch on many of the themes outlined in the Ministry of Health Policy papers released in February 2015 (see Appendix A).[1] Overall, the Ministry papers identify key population areas including caring for the frail elderly and chronically ill. As noted, the growth in demand for health care for frail elderly living in residential care, who already utilize about 25% of health services, is projected to increase by 120% by 2036.[2]

The BC Ministry of Health papers identify various cross-sector health strategic service priorities that will reposition the BC health system over the next five years to better meet both increasing and changing patterns of demand, including:

- Improving the effectiveness of primary, community care (including residential and home care), medical specialist and diagnostic and pharmacy services for patients with moderate to high complex chronic conditions, patients with cancer, patients with moderate to severe mental illness and substance use;
- To significantly reduce demand for emergency departments, medical inpatient bed utilization, and residential care;
- Significantly improving timely access to appropriate surgical treatments and procedures; and
- Establishing a coherent and sustainable approach to delivering rural health services.

In the process of developing this White Paper, the BC Ministry of Health in April 2016, also announced it will be undertaking a review of staffing guidelines in government-funded long-term care homes for

seniors after a report from the province's seniors advocate.[3] In particular, BC Heath Minister Terry Lake requested the Ministry undertake a review to examine how health authorities are funding seniors' homes. That includes looking at the care hours for different types of seniors, such as those facing dementia and other ailments.[4] Further details on this review will be forthcoming but the BCCPA, which supports such a review, hopes that some of the options outlined in this report may also assist the review process.

Development of new care models and age-friendly approaches

Consistent with Ministry of Health's cross health sector strategic priorities, the Ministry of Health, in conjunction with the BCCPA, should review options for new delivery models including, but not limited to, the creation of Continuing Care Hubs in order to optimize ER utilization, reduce acute care congestion and better care for the frail elderly and seniors with chronic conditions or dementia.

"Along with supporting the development of multidisciplinary practices within such models, it will be crucial to look at the role of new and emerging care providers including nurse practitioners and physician assistants."

Along with supporting the development of multidisciplinary practices within such models, it will be crucial to look at the role of new and emerging care providers including nurse practitioners and physician assistants. In particular, the paper suggests government explore the development of new nursing professional led teams to provide continuing care residents and clients and their care provider's access to timely, high-quality, urgent care support within the comfort of their own homes. It also suggests looking further at what role physicians, physician assistants, and nurse practitioners can play within the long-term care setting to help improve health outcomes for seniors, reduce emergency visits, and potentially reduce the burden faced by care aides and nurses.

Age-friendly approaches

"With respect to the development of new care models and age-friendly approaches, the paper suggests a program to better integrate residential care homes as part of any age-friendly community approach."

With respect to the development of new care models and age-friendly approaches, the paper suggests a program to better integrate residential care homes as part of any age-friendly community approach. The paper also explores innovative new models of care including the Green House Model. Likewise, it also suggests the adoption of new palliative care models, including where necessary, providing funding to improve integration between continuing care and end-of-life care. The paper also stresses the importance of informal caregivers to the continuing care sector and the potential of creating new funding supports and programs to support these caregivers.

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[1] On February 18, 2015 the BC Ministry of Health released a series of papers on its website covering five broad areas of the health system including: patient centered care, health human resources, rural health, surgical services as well as primary and community care. See: http://www.gov.bc.ca/health/setting_priorities.html

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

[3] Office of the Seniors Advocate. British Columbia Residential Care Facilities: Quick Facts Directory. January 2016. http://www.seniorsadvocatebc.ca/osa-reports/british-columbia-residential-care-facilities-quick-facts-directory/

[4] Vancouver Sun. BC Health Minister Orders Review of Staffing Guidelines in Long-Term Care Homes for Seniors. April 7, 2016. http://vancouversun.com/news/local-news/b-c-health-minister-orders-review-of-staffing-guidelines-in-long-term-care-homes-for-seniors

End-of-life Care

Improving end-of-life care is also critical for seniors as is outlined in this report. This includes not only ensuring end-of-life care beds are available but also improving the integration of end-of-life (EOL) care with continuing care. Currently, much of the care provided within residential care homes could be considered end-of-life as the average length of stay (ALOS) in a BC care home is approximately 16 months. If a senior living in such a home does not die there, they may instead spend some of their remaining days in an alternative care setting such as a hospital or hospice. As outlined in the BCCPA *Quality-Innovation-Collaboration* paper, while the existing unused capacity in residential care could be potentially used to reduce ALC days, it could also be used potentially to increase the number of end-of-life care beds. This option, from a fiscal perspective, would be preferred over a hospital, as costs for seniors receiving care in a residential care home is significantly less.

Dementia

On the issue of dementia, the paper explores various models of care including dementia villages, dementia friendly communities and butterfly care homes. Namely, this report suggests the establishment of a dementia friendly care homes program, in which a specific designation could be provided to residential care homes that have made redesigns or changes to better accommodate dementia residents and/or where specific dementia training has been provided to staff. Given the importance of the dementia issue, this paper also suggests BC endorse the advancement of a National Dementia Strategy or Declaration with federal participation, which should include investing in research and ensuring capacity and appropriate funding in the continuing care sector.

Technologies

With respect to the use of technology to improve sustainability and innovation in the continuing care sector, the paper looks at a number of areas including:

- The use of technology to facilitate seniors ageing in place or reducing the social isolation of seniors (i.e. home health monitoring and increasing internet access for seniors);
- The adoption of new electronic information systems that facilitate the sharing of resident information across the continuing care system; and
- New technologies that improve the safety of seniors, particularly through new monitoring systems.

Seniors Safety

Along with the use of technologies to improve senior's safety, this paper suggests the development of a collaborative Seniors Safety agenda, which could focus on specific issues including falls prevention, resident-on-resident aggression, reducing adverse drug events, suicide prevention, elder abuse and/or safety in home and community care.

Seniors Health Promotion and Frail Seniors

Finally, with respect to the issues of senior's health promotion and frail seniors this paper discusses the development of a National Seniors Health Promotion Strategy, which could outline various strategies to promote seniors physical and mental well-being, including outlining best practices among jurisdictions. It also addresses the issue of frail seniors as a critical part of any Seniors Health Promotion Strategy.

OPTIONS FOR REVIEW / CONSIDERATION

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

New Models of Care (Continuing Care Hubs)

1. That as a key priority any future Continuing Care Collaborative review options for new delivery models such as the Continuing Care Hub to reduce acute care congestion and ER visits as well as better care for frail elderly and seniors with chronic conditions and dementia.

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

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

Age Friendly Communities

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

Green House Models

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

Dementia Models of care

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

6. That in partnership with relevant stakeholders including care providers, health authorities and the BC Alzheimer's Society, government explore establishing a dementia friendly program, in which a specific designation could be provided to care homes that have made specific redesign changes to accommodate residents with dementia and/or where specific dementia training has been provided to staff.

End-of-Life / Palliative Care Models

7. The Ministry of Health and Health Authorities work with the BC Care Providers Association (BCCPA) and other stakeholders to develop strategies to better utilize the existing excess capacity in the continuing care sector to increase capacity with respect to end-of-life (EOL) care.

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

PRIORITY 2: DEMENTIA

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

PRIORITY 3: TECHNOLOGY

Social Isolation

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

Improving access to medical information through electronic records

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

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

New technologies to improve senior's safety

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

PRIORITY 4: SENIORS SAFETY

Provincial Seniors Safety Strategy

14. BC explore the advancement of a collaborative Provincial Seniors Safety Strategy which could focus on specific issues including falls prevention, resident-on-resident aggression, reducing adverse drug events, suicide prevention, elder abuse and/or safety within home and community care.

Ceiling lifts

15. That the federal government and/or provinces establish a joint fund to improve the safety of residents and health care workers including funding to install ceiling lifts and other retrofits to residential care homes across Canada.

PRIORITY 5: SENIORS HEALTH PROMOTION

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

ABOUT THE BCCPA

The BC Care Providers Association (BCCPA) has represented private and non-profit community care providers for over 30 years. We have over 150 residential care, home care and assisted living members across the province. Our members represent over one-third of all funded long-term care beds in B.C. – caring for over 25,000 seniors annually and creating more than 18,000 direct and indirect jobs across the province.

"Our members represent over one-third of all funded long-term care beds in B.C. – caring for over 25,000 seniors annually and creating more than 18,000 direct and indirect jobs across the province."

In July 2014, the BCCPA released a report entitled *Seniors Care for a Change*. It included five key recommendations to help improve BC's continuing care sector:

1. Strengthen client payment and collection of outstanding debts;
2. Develop a new funding and accountability model for government's role in care, including separating the bodies that fund, allocate funds, and regulate care delivery from those that deliver care and operate care homes;
3. Implement a person-centred approach to care;
4. Reduce overlap with the investigation and inspection process; and
5. Streamline and standardize reporting and data collection.

The BCCPA report *Quality-Innovation-Collaboration: Strengthening Seniors Care Delivery in BC* (QIC) was released in September 2015. The report, which contained five recommendations to improve the quality and sustainability of seniors care in BC, recommended that the Ministry of Health:

1. Work with the health authorities, the BCCPA, and other stakeholders to better utilize existing excess capacity in the continuing care sector (including residential care and assisted living) to reduce Alternate Level of Care (ALC) beds and offset acute care pressures. This strategy includes the creation of a public registry to track vacant continuing beds and ALC beds.
2. Establish a Continuing Care Collaborative with the BCCPA to support the long-term sustainability of the continuing sector and implement BCCPA and Ministry recommendations.
3. Review options for new service delivery models, particularly the Continuing Care Hub, to help reduce acute care congestion as well as increase quality of care for frail elderly and those with chronic conditions and dementia.
4. Include a specific target in the Health Authority Performance Agreements to redirect 1% of acute care expenditures each year for five years to home and community care services for seniors and the development of more responsive care models.
5. Redefine the existing eligibility criteria for complex care and Assisted Living to allow seniors to remain in the most appropriate care setting longer, as suggested by BC's Seniors Advocate. This includes removing restrictions relating to prescribed Assisted Living services (currently two).[5]

[5] On March 7, 2016 the BC Ministry of Health announced new amendments that will be made to the *Community Care and Assisted Living Act* (CCALA), which will remove the limit around the number of prescribed services in assisted living. Likewise, additional amendments will also include increased regulatory oversight for assisted-living residences, particularly permitting the registrar to inspect a residence at any time to determine if there is a risk to the health and safety of a resident. (Source: Ministry of Health. Legislation supports seniors and vulnerable adults. Accessed at: https://news.gov.bc.ca/releases/2016HLTH0014-000338)

The Quality-Innovation-Collaboration report also includes the BCCPA's Response to the Ministry of Health Policy Papers that were released in 2015 (see Appendix A). Here the BCCPA articulates the need for:

- Increased collaboration, including establishing a new BC *Continuing Care Collaborative*
- A review of funding lifts and Direct Care Hours in all health authority regions;
- A review of new funding models;
- Better dementia and palliative care, and
- Improvements in seniors' safety and quality of care.

BACKGROUND

Seniors make up the fastest-growing age group in Canada; in 2010, the median age in Canada was 39.7 years, while it was only 26.2 years in 1971.[6] This trend is expected to continue for the next several decades; in 2010, an estimated 4.8 million Canadians were 65 years of age or older, but by 2036 this number is expected to increase to 10.4 million. By 2038, BC's senior population will account for an estimated 24 to 27 per cent of the population, with the proportion of seniors nearly five percent higher than the Canadian average. Furthermore, the Ministry of Health reports that the percentage of BC seniors over 80 years old will grow from 4.4% of the population in 2012 to 7.4% by 2036. At the same time, it is projected that the prevalence of chronic conditions for those 80+ may increase by 58 per cent over next 25 years.

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

The ageing of the population will put increased pressure on the health system, due in part to the greater prevalence of chronic diseases and mental health issues, including dementia. This is in part because health services tend to be used at higher rates as the population ages, with increased demand for home and residential care.[7] In BC, the total public cost of subsidies for residential care were approximately $1.7 billion in 2013, which amounts for 10 per cent of the provincial health budget. These costs are expected to increase to $2.7 billion by 2035.

Furthermore, in British Columbia, spending on seniors accounted for 54 per cent of the $9.2 billion spent on health care services in 2009. Total demand in BC for health care services by seniors is expected to increase by 41% over the next 10 years from population growth and ageing alone. In comparison, demand for health services from the population under age 65 will only increase by 13%.[8] A 2015 Conference Board of Canada report notes that total spending on continuing care supports for seniors is projected to increase from $28.3 billion in 2011 to $177.3 billion in 2046. With nearly two-thirds of this spending likely to continue to be provided by governments, spending growth will significantly exceed the pace of revenue growth in most provinces. [9]

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

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

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

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

The ageing population will put additional pressures on the health care system, particularly in dealing with mental health and chronic diseases. A large percentage (41%) of Canadian seniors, for example, are dealing with two or more select chronic conditions, such as diabetes, respiratory issues, heart disease, and depression, and many are experiencing a decline in physical and/or cognitive functioning.[10]

> "Over the next decade, federal spending on the elderly and health care will also increase by $10 billion and $7.4 billion, respectively."

Over the next decade, federal spending on the elderly and health care will also increase by $10 billion and $7.4 billion, respectively. Together, that spending represents about half of all new federal spending anticipated between 2013-14 and 2017-18. Even without enriching any existing programs, spending on the elderly will take up almost a fifth of every dollar spent by Ottawa.

In 2009, about 45% of provincial and territorial governments' health care expenditure was spent on seniors, yet this group accounted for only 14% of the population. Seniors also use several sectors of Canada's health care system more frequently than younger portions of the population, and utilize the system in different ways and with different intensity than other age groups.[11] In addition to using more hospital care than other segments of the population, seniors are high users of several other sectors of Canada's health care system. For example, in 2009-2010, 95% of people in residential care and 85% of people in hospital-based continuing care were 65 or older. Similarly, in that same year, 82% of home care clients were age 65 or older.[12]

Overall, it will be important for BC to work collaboratively with the federal government and also other provinces and territories (P/Ts) to meet the challenges facing governments and seniors due to an ageing population. In the past, such collaboration has led to agreements such as in 2004, when federal/ provincial/ territorial (F/P/T) governments agreed on first-dollar coverage for home care services in several areas. In particular, under the *2004 10-Year Plan to Strengthen Health Care*, governments agreed to publicly fund two weeks of short-term acute home care after discharge from hospital; two weeks of short-term acute community mental health home care; and end-of-life care.[13]

Continuing Care Collaborative

> "…it will also be important for the Health Authorities and Ministry of Health to work further with care providers going forward."

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

As outlined in the Quality-Innovation-Collaboration (QIC) paper released in 2015, the BCCPA recommended the establishment of a Continuing Care Collaborative with senior representation from Ministry of Health,

[10] Health Council of Canada. Seniors in Need, Caregivers in Distress (March 2012). Accessed at: http://www.alzheimer.ca/kw/~/media/Files/on/Media%20Releases/2012/April%202012/HCC_HomeCare_2d.ashx
[11] Canadian Institute for Health Information. Health Care in Canada, 2011: A Focus on Seniors and Aging. Accessed at: https://secure.cihi.ca/free_products/HCIC_2011_seniors_report_en.pdf
[12] Ibid.
[13] 2004 10 Year Plan to Strengthen Health Care. Accessed at: http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php

Health Authorities and BCCPA. The Continuing Care Collaborative is based on a model of collaboration that has been successfully implemented in Alberta to address pressing issues in the sector. In Alberta, their collaborative brings together senior leadership within the continuing care sector including care providers, Alberta Health Services and its Ministry of Health. It meets on a regular basis and has a number of key sub-committees which are focused on collectively coming up with short- and long-term solutions to the many issues facing seniors care in Alberta. In the BC context, some of the initial key issues that a Collaborative could address include addressing the options for consideration in this report and Part I of the White Paper in order to support the long-term sustainability of the sector and improve seniors care across the province.

PRIORITY 1: NEW MODELS OF CARE – EXPANDING THE ROLE OF CONTINUING CARE

In February 2015, the BC Ministry of Health released a series of papers on its website covering five broad areas of the health system including: patient centred care, health human resources, rural health, surgical services, as well as primary and community care. The most relevant of the papers with respect to the continuing care sector and seniors is the report on primary and community care.

One of the major themes noted in this paper is that existing expenditures will be protected, while appropriate reallocations from the acute to the community services sector must become part of health authority planning going forward and a majority of new net funding must be assigned to developing primary and community services.

The BC Ministry of Health papers also identify various cross-sector health strategic service priorities that will result in substantive first steps to a repositioning of the BC health system over the next five years to better position it to meet both increasing and changing patterns of demand, including:

- Improving the effectiveness of primary, community care (including residential and home care), medical specialist and diagnostic and pharmacy services for patients with moderate to high complex chronic conditions, patients with cancer, patients with moderate to severe mental illness and substance use;
- To significantly reduce demand on emergency departments, medical in patient bed utilization, and residential care;
- Significantly improving timely access to appropriate surgical treatments and procedures; and
- Establishing a coherent and sustainable approach to delivering rural health services.

Rationale for exploring new continuing care models

Improved access and allowing seniors to live in most appropriate care setting

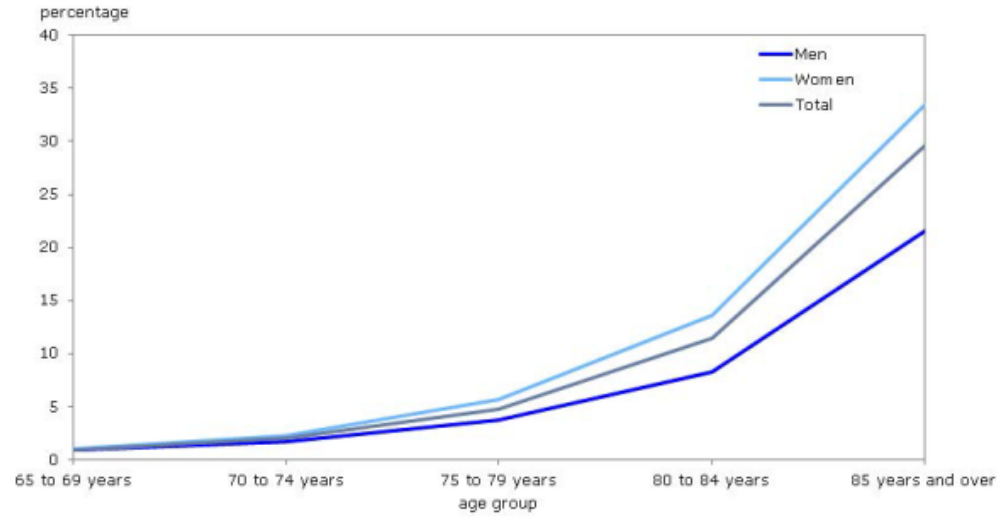
One of the major reasons for establishing new continuing care models is to improve access to care, as well as allowing seniors the opportunity to live in the most appropriate care setting. One of the priorities outlined by the Ministry of Health, for example, is to allow more seniors to live at home whether this is in a single family residence or apartment, assisted living or residential care. As noted by the BC Seniors Advocate, the vast

majority of seniors in BC are living independently (93%), including approximately 90% who own their own home. In total, less than 2% of seniors in BC live in provincially subsidized Assisted Living (AL) setting, while about 4% live in residential care.

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

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

Figure 1: Percentage of Canadian seniors living in Residential Care (by Age Group)



Source: Statistics Canada, Census of Population, 2011.

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

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

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

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

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

In particular, one focus of the new Continuing Care Hubs could also be the provision of respite care including for frail seniors. Respite care is the provision of short-term and/or temporary relief to those who are caring for family members or loved ones who might otherwise require permanent placement in residential care outside the home. As outlined in one report the level of demand for residential care based respite in British Columbia is quite high compared to most jurisdictions.[16]

Along with increasing access to services and beds for seniors to allow them to live in the most appropriate care setting, new LTC models, particularly the Continuing Care Hub outlined later in this paper, will also assist increasing choice for seniors utilizing the current BC "First Appropriate Bed" (FAB) policy. Under this policy adopted by all the health authorities, a senior who has been assessed as ready for a move to residential care must accept the first appropriate bed that becomes available in their chosen geographic catchment area. They have 48 hours to accept and move to the bed offered, or risk being removed from the priority list for a FAB. The FAB policy is designed to ensure that those who are the most in need of a residential care home bed secure that bed as quickly as possible.[17]

A 2015 Seniors Advocate report[18] highlights the discrepancy between average wait times and median wait times, showcasing the fact that some people are waiting a very long time for a residential care FAB. In particular, wait times for placement are greater in the north than in the Lower Mainland and are greatest for those who require highly specialized care such as a secure dementia unit.[19] The BCCPA believes that adopting new models, such as the Continuing Care Hub discussed later, will not only improve access to residential care

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

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

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

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

and services for seniors in the community, but will also increase choice for seniors utilizing the current FAB policy.

Dealing with higher levels of acuity

Overall, there are a number of reasons why it is crucial to explore the development of new LTC models. The first is to deal with the increasing levels of acuity within the continuing care sector. Similar to BC, and as outlined in a 2015 report, new entrants into residential care in Ontario have much higher levels of impairment. In Ontario, for example, in the 4th quarter of 2009/10, 76% of new admissions had high to very high levels of impairment (35% high and 41% very high). At the end of 2013/14, this figure for new admissions increased to 83%, with most of the growth in the very high category representing 47% of new admissions and growing at 3.9% per year.[20] In BC, the growth in demand for health care for frail elderly living in residential care, who already utilize about 25% of health services, is projected to increase by 120% by 2036.[21]

Along with increasing levels of acuity with a growing and ageing population, a large percentage (41%) of Canadian seniors are dealing with two or more select chronic conditions, such as diabetes, respiratory issues, heart disease, and depression, and many are experiencing a decline in physical and/or cognitive functioning.[22] Mental health challenges will also become more prevalent, as it is estimated the number of BC residents with dementia is expected rise from 70,000 to 110,000 by 2025.[23]

Alternate Level of Care (ALC) Beds

Along with increasing levels of acuity, another major reason to explore the development of new continuing care models is to reduce the pressures faced in the costlier acute and emergency care system, including reducing alternate level of care (ALC) beds. ALC beds are those occupied by patients who no longer require acute care, but who continue to occupy a hospital bed because they are unable to access home and community care services. In BC, the cost of treating a senior in hospital ranges from $825 to $1,968 per day, whereas the cost of residential care is approximately $200 per day.[24]

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

Currently, approximately 14% of Canadian hospital beds are filled with patients (85% of which are over 65) who are ready to be discharged but for whom there is no appropriate place to go. Over a single year, these patients' use of acute hospital beds exceeds 2.4 million days, which equates to over 7,500 acute care beds each day.[25] A conservative national estimate of resulting costs to provincial governments is approximately $3 billion per year.[26]

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

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

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

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

[24] Caring for BC's Aging Population Improving Health Care for All. Canadian Centre for Policy Alternatives (CCPA). Marcy Cohen. July 2012. BC Ombudsperson, 2012, Volume 2:239. Accessed at: http://www.policyalternatives.ca/sites/default/files/uploads/publications/BC%20Office/2012/07/CCPABC-Caring-BC-Aging-Pop.pdf

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

[26] CD Howe Institute. Commentary No. 443. Shifting Towards Autonomy: A Continuing Care Model for Canada. Ake Blomqvist and Colin Busby. As noted in one report from the Canadian Life Health Insurance Association (CLHIA), 7,550 acute care beds are taken up by individuals who should be in

According to recent data from Alberta, on a daily basis approximately 822 people in that province are in an acute care setting who could be cared for less expensively in the community. If these patients were in more appropriate care setting such as a care home - as opposed to a hospital, which is about four times as expensive - it could result in savings of over $170 million per year. The data show that over a 33-month period through December 2014, the number of alternative level of care (ALC) days doubled and that on average about 11 per cent of Alberta's acute care capacity was occupied by ALC patients.[27]

As outlined in the 2015 BCCPA Quality-Innovation-Collaboration (QIC) paper, there were over 400,000 reported ALC days in BC in 2014/15, accounting for 13% of total hospital days across the five regional health authorities. There were also significant variations across the Health Authorities from a low of 8% in Vancouver Coastal to 18.1% in Northern Health.[28] BC's health authorities also report that about one-half of ALC patients are awaiting discharge into long-term care, while others are waiting for home care, assisted living, rehabilitation or are residing in acute care due to an inefficient transfer processes.[29]

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

As outlined in the 2015 BCCPA Quality-Innovation-Collaboration (QIC) paper, a 50% reduction in ALC days could generate significant cost savings to the health system. For example, assuming 50% of ALC days could be reduced by caring for patients in residential care homes (average daily cost of $200) instead of in a hospital (average daily cost of $1,200) it could generate over $200 million in annual cost savings.[30]

The problem of ALC beds not only creates fiscal challenges, but quality of care and access issues as well. The Wait Time Alliance (WTA), for example, has noted that the ALC issue represents the single biggest challenge to improving wait times across the health care system.[31] Such wait times and access issues have been well documented. In 2012, for example, it was reported that 461,000 Canadians were not getting the home care they thought they required, while wait times for access to long-term care in Canada also ranged anywhere from 27 to 230 days.[32]

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home and community care or in rehabilitation. This represents about 7% of all hospital beds in Canada. The report also notes that if systemic reform were able to transition all those in a hospital setting to a more appropriate continuing care setting, the savings to the system would be about $77 billion over the time period examined (35 years). Source: Improving the accessibility, quality and sustainability of long-term care in Canada. CLHIA Report on Long-Term Care Policy. June 2012)

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

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

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

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

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

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

There are many reasons for the high rates of ALC patients, including the lack of appropriate community supports to prevent hospitalizations, as well as to return patients to a more appropriate setting after they receive hospital care.[33] The ALC issue is also one that is closely tied to dementia, a common diagnosis among ALC patients. In particular, a dementia diagnosis often results in at least once instance of hospitalization and escalates ALC rates when persons with dementia have other chronic diseases (i.e. 90% of community-dwelling persons with dementia have two or more chronic diseases). A study in New Brunswick found that one third of the hospital beds in two hospitals were occupied by ALC patients, of whom 63% had been diagnosed with dementia. It also found their mean length of stay was 380 days, with 86% of these patients waiting for a bed in a long-term care home while their health declined.[34]

As outlined by the WTA, adequate attention to seniors' care - such as having the necessary health human resources, treating seniors where they live thereby preventing unnecessary emergency department visits and hospitalizations, as well as collaborative care models - are key to reducing the numbers of ALC patients.[35] In particular, one critical area for improving the ALC situation is the better reporting of such data. The UK's National Health Service, for example, reports monthly ALC rates as delayed transfers of care including outlining the causes of delay by region and facility.[36]

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

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

Well designed home care and home support services with quick response capabilities can also be effective in getting seniors out of acute care. Vancouver Island Health's Quick Response Team, for example, provides crisis intervention at home to eligible clients when required, aimed at preventing avoidable hospital admission, providing crisis intervention at home, and facilitating early hospital discharge.[37]

Reducing hospitalizations

As outlined in various studies, once residents are in long term care there is a significant reduction in hospitalizations. A recent study from Alberta, for example, found that that the incidence of hospital admission was about 3 times higher among Assisted Living residents than among long term care residents (14%). In

[33] Wait Time Alliance. 2015. Eliminating Code Gridlock in Canada's Health Care System: 2015. Wait Time Alliance Report Card Accessed at: http://www.waittimealliance.ca/wp-content/uploads/2015/12/EN-FINAL-2015-WTA-Report-Card.pdf
[34] McCloskey R, Jarrett P, Stewart C, Nicholson P. Alternate level of care patients in hospitals: What does dementia have to do with this? Can Geriatr J 2014;17(3):88–94.
[35] Wait Time Alliance. 2015. Eliminating Code Gridlock in Canada's Health Care System: 2015. Wait Time Alliance Report Card Accessed at: http://www.waittimealliance.ca/wp-content/uploads/2015/12/EN-FINAL-2015-WTA-Report-Card.pdf
[36] NHS England. Delayed transfers of care statistics for England 2014/15. 2014/15 annual report. London: NHS England; 2015 May 29. Available: www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/2014-15-Delayed-Transfers-of-Care-Annual-Report.pdf
[37] BCCPA. Op-ed: Let's Stop Seniors from Languishing in Hospitals. February 19, 2016. Accessed at: http://www.bccare.ca/op-ed-lets-stop-seniors-languishing-hospitals/

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

particular, nearly 40% of Assisted Living residents in Alberta were admitted to hospital over 1 year, a rate substantially higher than that for long term care residents.[38]

As also outlined in BC Ministry of Health Setting Priorities document one large driver of total cost occurs in the year prior to, and the year of, entry into residential care - with high rates of hospitalization via emergency departments en route to residential care. For example, more than seven out of every ten new entrants to residential care have at least one inpatient hospitalization in the year. In particular, more than 60 per cent of people entering residential care have been identified as having a high complexity chronic condition in the previous year, and it is likely that many will also have fallen into the "frail in community" category as well.[39]

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

Table 3: ER Visits for Seniors for 2014/15 (65+)

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

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

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

Overall, according to a 2014 report from the Canadian Institute for Health Information (CIHI) seniors in long term care homes make up less than 1% of emergency room visits in Canada, with 1 of 3 of these visits being potentially avoidable as they could have been addressed in the care home itself. Common avoidable reasons for visits to ER for seniors in care were urinary tract infections, pneumonia, and falls.[40] In British Columbia, residents in continuing care homes who visited the ER twice or more only made up 1% of ER visits.[41] As outlined by CIHI, with earlier diagnosis and improved access to on-site treatment, some of these conditions could be managed at the care home and a visit to the ER avoided altogether.

Although ER visits are relatively low for seniors and decrease once a resident is admitted to residential care, there is also a need to look at ways to reduce such visits, particularly during the first year of residential care.

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

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

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

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

Although data is limited in this regard, one of the reasons for a high number of visits during the initial stay in residential care is due to care staff wanting to minimize any potential health risks for the resident. To deal with this a number of solutions need to be explored including:

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

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

ENHANCING THE ROLE OF CONTINUING CARE: NEW CONTINUING CARE MODELS

In 2010, the Ontario Long Term Care Association (OLTCA) commissioned the Conference Board of Canada to investigate the innovation potential of Ontario's long term care homes. The result was *Why not now?* A five-year strategy published in 2012 by the expert panel, co-chaired by William Dillane, President, The Response Group, and Dr. William Reichman, President and CEO of Baycrest. The panel envisions long term care homes as hubs of innovation that work closely with hospitals, ensuring accessibility, and handling all sorts of short-term, long term, and cyclical care.[42] As outlined in OLTCA paper with the development of new models, highly integrated care teams would require new roles and a different mix of skills. Staffing models would also have to be developed to allow the same service providers to provide care in and out of hospital. The main background and expert panel recommendations of the OLTCA paper are outlined in Appendix B. In particular, it identifies a number of new continuing care models such as the post-acute care model, specialized stream model, integrated care model, and the Hub Model.

> "Staffing models would also have to be developed to allow the same service providers to provide care in and out of hospital."

Continuing Care Hubs

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

Although not exhaustive, services that could be delivered by a Continuing Care Hub could include: primary care, chronic disease management, rehabilitation, sub-acute, dialysis, oral care, foot care, adult day/night programs, meals on wheels, caregiver support such as home monitoring and satellite specialized geriatric

[42] WHY NOT NOW? A Bold, Five-Year Strategy for Innovating Ontario's System of Care for Older Adults. LTC Innovation Expert Panel. March 2012. Accessed at: http://www.oltca.com/oltca/Documents/Reports/WhyNotNowFULL_March2012.pdf

services collaboratively delivered with hospital and community partners (see Figure 2). This model takes advantage of investments in physical infrastructure and existing LTC programs and services by centralizing care and expertise.

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

Integration of health professionals and family in seniors care

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

New roles for care providers

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

New funding models (outcome-based funding)

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

Figure 2: Components of the Current 24/7 Residential Care Model and New Continuing Care Hubs

Current 24/7 Residential

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

New Continuing Care Hub

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

<u>New Services Offered</u>

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

Expanded role and co-location of services

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

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

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

Likewise, it is also feasible that Health Authority operated care homes could be part of a network with privately operated care homes.

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

> "…turning continuing care homes into hubs of innovation in ageing care will also require new roles, a different skill mix and well integrated care teams."

As outlined in the Ontario paper, turning continuing care homes into hubs of innovation in ageing care will also require new roles, a different skill mix and well integrated care teams. One such example being used in Ontario are Long-Term Care Nurse-Led Outreach Teams (NLOTs) which the Ontario Ministry of Health established in 2008 in each Local Health Integration Network (LHIN) as one of several projects implemented under its Emergency Room and Alternate Level of Care (ER/ALC) Strategy. NLOTs bring together a dedicated team of nursing professionals to provide continuing care residents and their care provider's access to timely, high quality urgent care support within the comfort of their own homes (see Appendix C).[43]

New integrated care teams and LTC models could also utilize nurse practitioners (NPs) into care homes.[44] Overall, progress in implementing NPs has lagged behind other provinces including Ontario and Alberta. One of the major problems has been that insufficient funding has left many NPs unable to obtain employment.[45] Although in 2012 the BC government announced $22.2 million to pay for 190 positions over the next three years, it is not clear whether some commitments will continue in the future.[46] As of January 2014, there were only 287 NPs registered in BC. Another survey also shows that less than 10% NPs who responded (8% or 7 in total) identified residential care as a practice setting.[47]

There is evidence that shows NPs improve family satisfaction and staff confidence. They also reduce transfers to the emergency department, hospital admissions and length of stay and workload for continuing care physicians. Physician competence and engagement are also associated with lower hospitalization rates, higher functional status and resident satisfaction and reduced rates of regulatory non-compliance.[48]

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

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

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

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

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

[48] WHY NOT NOW? A Bold, Five-Year Strategy for Innovating Ontario's System of Care for Older Adults. LTC Innovation Expert Panel. March 2012. Accessed at: http://www.oltca.com/oltca/Documents/Reports/WhyNotNowFULL_March2012.pdf

Integration of physicians into new continuing care models

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

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

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

With the GPSC's commitment of up to $12 million annually, the initiative is attempting to meet the needs of residential care clients in over 100 communities across BC. The initiative also includes the establishment of new fee codes for seniors care. Starting in July 1, 2015, divisions/self-organizing groups can potentially access a quarterly lump sum incentive, calculated for equity at an annual $400 per residential care bed, to implement local solutions.[49] While the BCCPA is encouraged by this initiative, it is not clear whether $400 per bed will be sufficient or whether the up to $12 million in funding would be better spent if it were provided directly to care homes to recruit and retain physicians.

Along with programs such as the GPSC residential care initiative, new models of continuing care should look at alternative approaches to integrating physicians. One such model recently implemented in Nova Scotia's Capital District Health Authority is called Care by Design (CBD), which attempts to addresses concerns of a previously uncoordinated care system in long term care homes, reduction of family physician services and on-call coverage for LTC home residents, and high rates of ambulance transports to emergency departments (EDs). The core of CBD is dedicated family physician coverage for each LTC home floor, with regular on-site visits; on-call coverage, 24 hours a day, 7 days a week; and standing orders and protocols. Other key aspects of CBD include an extended care paramedic (ECP) program, providing on-site acute care and facilitating coordinated transfers to the ED; a new comprehensive geriatric assessment tool; performance measurements; and interdisciplinary education.[50]

Preliminary results from CBD include that the initiative has improved clinical efficiency by reducing travel time to visit residents in multiple long term care homes and that continuity and quality of care has improved for residents. In particular, data also show that there has been a 36 per cent reduction in transfers from LTC homes to

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

[49] General Practice Services Committee (GPSC). Residential Care Initiative. Accessed at: http://www.gpscbc.ca/family-practice-incentive/residential-care.

[50] Nova Scotia Capital District Health Authority. Care by Design. http://www.cdha.nshealth.ca/care-by-design

Emergency Department over a six-month period (see Appendix C).[51]

Along with integrating physicians better into long term care, it may also require looking at new health providers, particularly physician assistants. Physician Assistants (PAs) are essentially healthcare professionals educated in the medical model to practice medicine under the direction of a physician.[52] Recent studies have highlighted the benefits of PAs including that they can increase access to medical care for seniors. In particular, having a full-time PA on staff at a long term care home can translate into residents being evaluated sooner and can prevent transfers to the hospital in many cases. A study from the U.S. shows that PAs in long term care settings have decreased hospital admission rates by 38% for seniors. PAs can also have an important preventive role in care of geriatric patients.[53]

Rural Considerations

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

- Providing multidisciplinary health care team members with access to up-to-date patient health information, at the point of care;
- Enabling multidisciplinary health care teams to contribute to the residents' health care plan;
- Improving the quality of health data;
- Standardizing and expanding use of telehealth, including use of videoconferencing technologies; and
- Support telehealth policy recommendations to ensure emerging technologies are leveraged for key populations including the frail senior population living in residential care.[54]

Overall, linking rural based care homes into new continuing care models such as new hubs particularly through the use of new technologies and where necessary referrals will be critical going forward. Likewise, as outlined in the next section, such care homes in rural areas should also be linked where possible to new geriatric centres of excellence / innovation.

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

GERIATRIC CENTRES OF EXCELLENCE / INNOVATION

Related to the creation of Continuing Care Hubs is the concept of geriatric centres of excellence, in which residential care homes, including Continuing Care Hubs, could provide specialized services similar to those in the Specialized Stream Model, particularly, higher levels of care and for special needs populations such as

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

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

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

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

persons with late stage dementia, severe mental illness and addictions, and those at end-of-life. Such centres, along with leading care in areas such as dementia, mental illness, and end-of-life could also lead development of research and innovation within the continuing care sector.

In particular, finding effective, innovative solutions that can efficiently integrate into current care models and move towards self-guided care are critical for the long-term sustainability of the health care system. For example, Retirement Concepts, the largest private provider of long-term care in BC, is looking to technology advances and innovative processes to personalize and improve care in a cost effective manner.[55] They have also developed a framework proposal to change health care utilization patterns for BC's frail older adult population (see Appendix D).

Along with fostering innovation and new models of care, innovation centres such as Retirement Concepts or new geriatric centres of excellence could link with a new provincial centre for excellence in ageing. As outlined earlier, in conjunction with care providers such a centre could facilitate research and sharing of best practices and technological advances to support seniors. This includes facilitating use of the private operator's expertise and capacity through the trialing of demonstration projects.

OPTION 1 FOR CONSIDERATION:

That as a key priority any future Continuing Care Collaborative as a key priority review options for new delivery models such as the Continuing Care Hub to reduce acute care congestion and ER visits as well as better care for frail elderly and seniors with chronic conditions and dementia.

Financing the creation of Continuing Care Hubs / Geriatric Centres of Excellence

As outlined earlier, the BCCPA is encouraged by the BC Ministry of Health commitment to reinvest from acute to continuing care. To ensure that this does occur and as outlined in the BCCPA QIC paper, we recommend that in their Performance Agreements, the Ministry of Health and the Health Authorities specifically outline a commitment to reinvest expenditures - such as a minimum target of 1% per year being relocated from acute care to continuing care over a five-year period.

> "… the BCCPA is encouraged by the BC Ministry of Health commitment to reinvest from acute to continuing care."

Using 2014/15 budget figures a one per cent re-allocation from acute to community care for the five regional health authorities would amount to approximately $64 million in the first year. Excluding any annual funding increases to health authorities that would have occurred anyways, this would equate to a reinvestment of $320 million in additional services after five years. This new funding directed to the continuing care sector

[55] As part of the Retirement Concepts Innovation Centre (RCIC) partnership, members are being brought together to direct technology development towards seniors needs. The three key objectives include: 1) maximizing innovations in client care, 2) embedding research in the care environment and 3) getting products and services to market. RCIC has multiple projects underway, including the testing and development of a wheelchair airbag in partnership with MobiSafe Systems Inc., the development and implementation of a brain vital sign system for dementia care, and the integration of video surveillance in the analysis and care provider training of falls and aggression in long term care.

could potentially fund the following services: the annual operation of 4,395 residential care beds;[56] or 12,832,000 care aide hours;[57] or 8,020,000 home support hours.[58]

If there was any new continuing care funding diverted from acute care expenditures, it could be divided based on current Health Authority expenditures for residential care and home support. For example, as part of their 2013/14 budget for community and residential care, Health Authorities spent approximately $425 million on home support care versus $1.8 billion for residential care. While it would be ultimately up to Health Authorities to reinvest how they deem appropriate, the BCCPA suggests some of the new funding be reinvested into residential care to support the creation and development of new Continuing Care Hub networks and/or geriatric centres of excellence.

NEW HOME CARE MODELS / INNOVATIONS

Along with exploring development of new continuing care models, it will also be important to look at new models for home care and home support within the continuing care sector. This paper explores a couple of home care models from Ontario that could serve as a best practice including its Seniors Managing Independent Living Easily (SMILE) and Integrated Comprehensive Care Program (ICC) programs. Another initiative is Ontario's Bundled Care program which better attempts to integrate home and acute care.

Seniors Managing Independent Living Easily (SMILE) program

The Seniors Managing Independent Living Easily (SMILE) program was implemented in 2008 as a pilot project by the South East Local Health Integration Network (LHIN), as part of the *Aging at Home strategy* of the Ontario Ministry of Health and Long-Term Care. The Southeast LHIN is one of 14 agencies put in place by Ontario to provide regional-decision making and accountability for the following healthcare services: homecare, continuing care, mental health, and hospital services.[59]

The primary goal of the LHIN is to provide person centred care within their designated regions. At the same time, LHIN's develop innovative and collaborative initiatives to increase access to care for patients, they are the only organizations that bring together various sectors (hospitals, community care, long term care, etc.) in order to provide care to citizens.[60] The SMILE program was

[56] The Best of Care: Getting It Right for Seniors in British Columbia (Part 2) at p. 216-17. Accessed at: https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2047%20The%20Best%20of%20Care-%20Volume%202.pdf
[57] Assuming a wage of $25 per hour, as quoted by Welcome BC: http://www.welcomebc.ca/Work/fqr/Your-Qualifications-Intro/occupational-guides/Occupation/Health-Care-Assistant.aspx
[58] Assuming that each hour of subsidized home support costs the health authorities $40, as reported in the Ombudsperson (2012) "Home Support Backgrounder". Accessed at: https://www.bcombudsperson.ca/sites/default/files/BOC2%20-%20Health%20Sector%20Backgrounders.pdf
[59] Quick Facts about the South East Local Health Integration Network, accessed at: http://southeastlhin.on.ca/Page.aspx?id=1302
[60] Our Mission, Vision & Values, accessed at: http://southeastlhin.on.ca/AboutUs/MissionVisionValues.aspx

initiated by the LHIN, through consultation with seniors and healthcare providers and emphasizes the need to provide care to frail seniors at home who are at risk of losing their independence. The project funds services such as housekeeping, shopping, laundry, seasonal chores, and transportation to healthcare appointments.[61] Such support services cost $80 per day.

The SMILE program offers seniors a chance at managing their own care where they can choose what kinds of services they need, when they need them and who will provide these services, such as funded organizations (by the LHIN) or non-traditional service providers (family, friends, third party etc.).[62] The philosophy behind the program is based on the belief that attending to senior care is more than just about their medical needs but allowing them to stay in an environment that is beneficial to their well-being, that home is a good place to live, and that dignity and choice go hand in hand.[63] Based on a February 2012 survey, a majority of clients enlisted in the program reported satisfaction with SMILE services, with 49% expressing that their physical health had improved since being on the program[64].

The SMILE program was recognized as an Emerging Practice by the Health Council of Canada using the Health Innovation Portal Evaluation Framework. Although SMILE, remains only eligible for seniors who require assistance with activities of daily living and at risk of increasing frailty, the Community and Home Assistance to seniors (CHATS) program offers a range of home care and community services for seniors of all care levels.

CHATS is a non-for-profit organization which offers services to seniors such as: meals on wheels, transportation, diversity outreach programs, homecare and caregiver support/education.[65] CHATS provides services to over 7,600 York Region and South Simcoe seniors and caregivers each year where services are provided through dedicated volunteers, 220 staff and a Board of Directors.[66] CHATS envisions to provide innovative leadership in order to promote the wellness of seniors and caregivers in Ontario.[67] Since its launch in 1980, CHATS has provided a continuum of care services to over 700 culturally, economically, and geographically diverse seniors.[68] CHATS was also accredited with exemplary standing by Accreditation Canada and met 100 per cent of the 852 standards during its evaluation period.

Integrated Comprehensive Care Program (ICC)

The Integrated Comprehensive Care Program (ICC) was undertaken at St. Joseph's Health System. The pilot project ran for a year and integrated case management between hospital and community based care.[69] The idea behind ICC was that after patients undergo surgery and leave to their home, they would receive access to the same care team on a 24/7 basis, if needed. In order to deliver care services, ICC requires inexpensive technology such as a computer/ telephone so patients can access their care team via skype or phone and maintain an electronic health record.[70] Dedicated care coordinators keep track of complex care patients, from the moment they are admitted to the hospital, to when they are discharged. The use of technology to

[61] Donner G., McReynolds, J., Smith, K., Fooks, C., Sinha, S., & Thomson, D. (2015) "Bringing Care Home: Report of the Expert Group on Home & Community Care". Accessed at: http://www.osot.on.ca/imis15/TAGGED/News/Bringing_Care_Home_-_Report_of_Expert_Group_on_Home___Community_Care_Released.aspx
[62] SMILE Program Information. Accessed at: http://www.von.ca/smile/programs_info.aspx
[63] South East Local Health Integration Network (2008) "A Plan to help seniors stay at Home".
[64] Accreditation Canada (2013) "Seniors Managing Independent Living Easily (SMILE)". Accessed at: https://www.accreditation.ca/seniors-managing-independent-living-easily-smile
[65] Donner G., McReynolds, J., Smith, K., Fooks, C., Sinha, S., & Thomson, D. (2015) "Bringing Care Home: Report of the Expert Group on Home & Community Care". Accessed at: http://www.osot.on.ca/imis15/TAGGED/News/Bringing_Care_Home_-_Report_of_Expert_Group_on_Home___Community_Care_Released.aspx
[66] About CHATS. Accessed at: http://www.chats.on.ca/about-chats
[67] CHATS: Community and home Assistance to seniors (2009-2010) "Annual Report: A Year to Grow".
[68] CHATS: Community and home assistance to seniors (2-13-2014) "Annual Report".
[69] Donner G., McReynolds, J., Smith, K., Fooks, C., Sinha, S., & Thomson, D. (2015) "Bringing Care Home: Report of the Expert Group on Home & Community Care". Accessed at: http://www.osot.on.ca/imis15/TAGGED/News/Bringing_Care_Home_-_Report_of_Expert_Group_on_Home___Community_Care_Released.aspx
[70] Integrated Comprehensive Care Project. Accessed at: http://www.sjhs.ca/integrated-comprehensive-care-project.aspx

connect with patients ensures that there will be reduced duplications, shorter hospital stays and fewer re-admissions.[71]

Important features of the program include having one contact number so the patient can direct their needs to one individual on the team, a shared electronic health record, flexibility in communications by using the latest technology to connect, and community partner support.[72] So far, the project has reduced length of hospital stay by 24 per cent and has seen a 15% drop in hospital re-admissions after surgery.[73]

Ontario's Bundled Care Initiative

Another innovative approach being piloted in Ontario is Bundled Care where hospital and home-care funding is essentially combined and tied to individual patients. In particular, under this model, a single payment to a team of health care providers is provided to cover care for patients both in the hospital and at home.[74] This initiative, which started four years ago in Hamilton began as a three-year pilot that has now been renewed and targets three groups – those undergoing lung-cancer surgery, hip and knee replacements, and those with chronic obstructive pulmonary disease (COPD) or congestive heart failure.

Under this model, hospital staff and community workers work as a single team. Nurses, personal support workers and other professionals making home visits have weekly rounds to share information. They treat clients with similar conditions and get training and support from the hospital, so they gain expertise and know, for instance, when a picture of a wound might need to be sent to a care co-ordinator for a doctor to review. Each patient leaves the hospital with a 1-800 number that puts her in touch with a member of the care team who has access to their records. The bundle-care model is being expanded to nine hospitals at 22 sites in the Hamilton area for patients with COPD and congestive heart failure – about 2,400 patients annually. It also is being used in Kitchener-Waterloo by another hospital.[75]

[71] St. Mary's General Hospital (2013) Successful model for complex care patients expands to St. Mary's. Accessed at: http://www.smgh.ca/successful-model-for-complex-care-patients-expands-to-st-marys/

[72] Ministry of health and long-term care (2013) "Integrated Comprehensive Care Project". Accessed at: http://news.ontario.ca/mohltc/en/2013/09/integrated-comprehensive-care-project.html

[73] Ministry of health and long-term care (2013) "Ontario Helping More Patients to Benefit from New Model of Care".

[74] Ontario Ministry of Health and Long-term care. Ontario Funds Bundled Care Teams to Improve Patient Experience. September 2, 2015. Accessed at: https://news.ontario.ca/mohltc/en/2015/09/ontario-funds-bundled-care-teams-to-improve-patient-experience.html

[75] Program linking hospital staff to home-care workers pays off. Elizabeth Church. Globe and Mail. February 14, 2016. Elizabeth Church. Accessed at: http://www.theglobeandmail.com/news/national/program-linking-hospital-staff-to-home-care-workers-pays-off/article28757453/

ADULT CARE CENTRES – INTEGRATION OF HOME CARE AND LONG TERM CARE

Other Jurisdictions

Finding models of care that can prevent senior's isolation from occurring is an important step in improving quality of care and the safety of our elders. Various homecare models have also emerged in the United States and Canada that attempt to better integrate long term and home care including by providing recreational activities at an adult day centre, as well as home support and community care services to the elderly.

Developed in 1996, the Comprehensive Home Options of Integrated Care for the Elderly (CHOICE) program in Edmonton, Alberta has become a recognized delivery model for homecare to elderly adults. In partnership with Capital Care and The Good Samaritan Society, the CHOICE program provides adults over the age of 60 options for care at home and at the same time operates itself like a day clinic. The program also offers a variety of services to seniors throughout the week and is run by a multi-disciplinary team of physicians, nurses, pharmacists, dieticians, occupational and physiotherapists and social workers.[76] Under CHOICE, seniors are delivered all basic health services - this includes personal care (bathing, dressing, etc.), dental care, respite care, meals and snacks, medication and home care services.[77]

The program offers care to seniors who have complex long-term care issues and live at home. Clients must be willing to change their health care provider and should be able to use transportation provided by the program.[78] Two examples of the CHOICE Program are the independent living complex of the Good Samaritan Place and onsite at the continuing care centre/ auxiliary hospital of Dr. Gerald Zetter Care Centre in Edmonton.[79] According to Alberta Health Services, six months after joining the program, all CHOICE clients saw a drop in emergency visits by 30 per cent.[80]

The CHOICE program in Edmonton was modeled off the Program of All-inclusive Care for the Elderly (PACE). Developed in the early 1970s, the PACE model first emerged in Northern California, where it was co-founded by dentist Dr. William L. Gee, and Social Worker Marie-Louise Ansak.[81] The idea developed to address the needs of elders immigrated from Italy, China, and the Philippines whom required continuing care services, in

[76] DeSantis, B. (2014) "CHOICE Edmonton Day Program: An outlet for social seniors". Senior Care Canada. Accessed at: http://seniorcarecanada.com/articles/choice_edmonton_day_program#sthash.nxuSwoyF.C8bmbATx.dpuf
[77] Hollander Analytical Services Ltd. (2006). Home care program review: Final report. Accessed at: http://www.health.gov.sk.ca/HomeCareReview2006_FinalReport.pdf
[78] Choice© Program. The Good Samaritan Society, accessed at: https://www.gss.org/find-housing-support-services/community-care/choice/
[79] For more information on the Good Samaritan Place & Dr. Gerald Zetter Care Centre, see: https://www.gss.org/find-housing-support-services/community-care/choice/
[80] Alberta Health Services. Accessed at: http://www.albertahealthservices.ca/1362.asp
[81] McGregor Pace. "History of Pace". Accessed at: HTTP://WWW.MCGREGORPACE.ORG/ABOUT/HISTORY/

order to create a "community hub" where seniors medical, emotional, and physical needs could all be met in one place. Gee and Ansak formed a non-profit corporation called On Lok Senior Health Services, to provide community care to elders.[82]

Similar to the CHOICE program, On Lok Lifeway care providers work in interdisciplinary teams to offer similar services at a specific location or centre. The PACE model's key features include flexibility (i.e. coordinating care based on individual needs), all-inclusive care (preventive, primary, acute and continuing care), interdisciplinary teams and capitation funding.[83] The PACE program offers community care to seniors aged 55 and up, where CHOICE offers the program to anyone 60 or older. One disadvantage of both the PACE and CHOICE programs are that they cannot include frailer portions of society, as one of the program requirements is that seniors must be certified by government to require homecare.

British Columbia – Adult Day Programs

Adult Day Programs (ADPs) in BC provide up to seven hours per day of services to the client, where services include social activities, meals and sometimes health services such as rehabilitation. However, a 2015 report released by the BC Seniors Advocate, reviewing respite care services for informal caregivers (including ADPs), found that while ADPs provide important benefits to both clients and their informal caregivers, ADPs in British Columbia face a number of challenges and limitations.

In particular, several factors limit access to ADP services. For example, in order to be eligible to access ADP in British Columbia, a senior must be able to function independently and have been assessed as requiring adult day services as part of their care plan. Similarly, ADPs in BC are mostly limited to basic social type supports with limited support from health care professionals. These restrictions have the effect of excluding those with more advanced dementia and/or low physical function from benefiting from ADP services.

Furthermore, the ADP may not provide transportation, thus forcing clients to rely on volunteers, or other community buses. While in some regions, such as Metro Vancouver, the client may arrange transportation independently via HandyDART, the client must bear the full cost of these services, thus potentially excluding some low-income seniors. In line with this analysis, the Seniors Advocate report found that updake of ADP services was low: of the 54% of people identified as potentially benefiting from ADP services, only 7% had accessed ADP services in the previous seven days. Furthermore, in 2013/14, 25% of ADP days across the province went unused (see Table 4).

Table 4: Adult Day Program (ADP) Vacancy Rate in BC

Health Authority	2012/2013 % Used	2013/14 % Used
NHA	48%	44%
IHA	30%	27%
FHA	6%	7%
VCH	25%	30%
VIHA	32%	25%
BC	**26%**	**25%**

Finally, analysis of Ministry of Health data by the Seniors Advocate indicates that the capacity of ADPs in BC has not kept pace with our populations' ageing demographics. The report indicates that in real terms, the number of ADP clients decreased 20 per cent, and the number of days utilized has decreased 18 per cent between 2011 and 2014. Based on this analysis, the Seniors Advocate concludes that there is "sufficient evidence to suggest that B.C. needs to deliver ADPs to an increased number of clients and increase the number of days per week clients are able to attend an APD."

[82] Wong, J. (2013) "For Chinese Speaking Seniors, Better Service in San Francisco and Toronto". *The Tyee*. Accessed at: http://thetyee.ca/News/2013/04/04/Chinese-Speaking-Seniors/print.html
[83] What is PACE? On Lok PACEpartners, accessed at: http://pacepartners.net/what-is-pace/

OPTION 2 FOR CONSIDERATION:

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

OTHER CONTINUING CARE MODELS AND AGE-FRIENDLY COMMUNITIES

British Columbia has been particularly active in the area of Ageing in Place. In July 2013, for example, BC held focus groups with seniors and near seniors to communicate the need to plan for healthy ageing, identify barriers to planning, and inform the development of a toolkit to motivate older adults to plan.

BC has also implemented a number of programs to facilitate Ageing in Place, including the expansion of its "Better at Home" program, which will provide non-medical home supports to serve seniors in up to 68 communities across BC; and its "Home is Best" program, to help seniors, who otherwise would need residential care, live safely at home and avoid future hospital emergency admissions (see Part I of White Paper).[84]

Research indicates that older adults prefer to age in place, but are unaware of the services available and have not made modifications to accommodate future age-related changes.[85] Ageing in place requires a diverse range of supports, programs, housing options and other services to enable seniors to maintain personal dignity and functional independence in their homes, neighbourhoods, and communities for as long as possible and appropriate.

The desire of seniors to age in place is also driving much of the increased focus on home and community care as outlined in one report, which notes that 93% of Canadian seniors live at home and want to stay there as long as possible.[86] Another important factor driving the increased demand and use of publicly funded home care is the large number of hospital beds that are occupied by patients who no longer need acute care, but who still require a lower level of care and cannot manage independently.

NEW MODELS – INTEGRATING RESIDENTIAL CARE INTO COMMUNITY

"While the BCCPA supports the development of new models in continuing care, it is important to ensure that they are piloted where possible, and that any large-scale implementation is evidence based."

While the BCCPA supports the development of new models in continuing care, it is important to ensure that they are piloted where possible, and that any large-scale implementation is evidence based. In this light, the BCCPA would support the development of new models that focus on two particular areas namely: 1) Integration of residential care homes as part of new age-friendly communities and 2) Development of new residential care homes that reduce the perceived institutionalization of care.

Age-friendly Communities

Healthy Ageing is defined by Health Canada as "a lifelong process of optimizing opportunities for improving and preserving health and physical, social, and mental wellness, independence, quality of life and enhancing

[84] Pilot projects show Home is Best has led to significant decreases in acute care use and emergency department visits (Vancouver Coastal - program resulted in a 30 per cent decrease in acute care use, and a 25 per cent reduction in emergency department visits).
[85] The Silver Economy - Aging in Place: A market with no end in sight (2011). Don Shiner.
[86] Health Council of Canada. Seniors in Need, Caregivers in Distress (March 2012). Accessed at: http://www.alzheimer.ca/kw/~/media/Files/on/Media%20Releases/2012/April%202012/HCC_HomeCare_2d.ashx

successful life-course transitions." Healthy ageing requires a broad, preventive focus that extends beyond current health systems and takes a holistic view of health framed by population health determinants.

Creating supportive environments, such as age-friendly communities (AFCs), supports healthy ageing. AFCs have been successful in its widespread uptake in Canada. In AFCs, the community is set up to help seniors live safely, enjoy good health and stay active. For example, in an age-friendly community: sidewalks are well lit and kept in good shape; buildings have automatic door openers and elevators; and seniors take part in all sorts of community activities, such as visiting museums or libraries, taking courses or volunteering for charities or civic duties.[87]

In fact, Canada has undertaken many age-friendly initiatives with 8 provinces and over 500 communities currently adopting such practices. AFCs support older adults in leading active, socially engaged lifestyles that contribute to healthy ageing.

As outlined earlier, most Canadian seniors want to remain in their own homes for as long as possible. The perceived advantages of doing so include a sense of wellbeing that comes from living independently, comfort with familiar surroundings and routines, and social interaction and support from established social networks and family.

> "Along with healthy ageing, BC has been particularly active in supporting Age Friendly Communities."

Along with healthy ageing, BC has been particularly active in supporting Age Friendly Communities. In September 2013, for example, the BC Government announced continued funding of $500,000 for the Age-friendly Community Planning and Project Grant program to help support seniors in every region of British Columbia.[88] As of April 2013, 117 communities had been offered grants to complete community planning initiatives and/or projects focused on the ability of seniors to age in place. In 2014, 26 communities throughout BC were to receive 2014 Age-friendly BC grants.

One possible idea that BC may want to put forward is a program to better integrate residential care homes as part of age-friendly communities. Such a program, for example, could highlight AFCs and what they are doing to assist seniors. Along with highlighting such communities and/or best practices, funding could be provided to current or future care home operators to better integrate such homes as part of the community.

Ensuring that residential care homes are integrated appropriately into age-friendly communities may also require addressing some of the issues regarding municipal zoning requirements. In a number of cases, requiring approval for development of a residential care home can be hampered by municipalities, particularly their strict zoning requirements. Streamlining the approval of such homes, particularly those that are to be integrated into the community will be critical.

OPTION 3 FOR CONSIDERATION:
That the BC government support a program to better integrate residential care homes as part of any age-friendly community approaches.

[87] Public Health Agency of Canada. Age-friendly Communities. Accessed at: http://www.phac-aspc.gc.ca/seniors-aines/afc-caa-eng.php

[88] The Age-friendly Community Planning and Project Grant program is a partnership between the Government of BC and the Union of British Columbia Municipalities. This funding will support the annual distribution and administration of between 20 and 25 grants of up to $20,000 to help establish or continue a variety of projects that support healthy, active seniors. The program was one of government's platform commitments for seniors and reflects the goals of the BC Family Agenda, which supports seniors by encouraging healthy, active aging.

New models of care

As outlined earlier, assisted living was introduced in BC in 2001. The concept of assisted living which began in the early 1980s in the United States was initially designed to essentially replace nursing homes altogether by creating more home like environments for seniors but has instead evolved to become almost anything related to supportive housing. Although the current state of assisted living provides additional options for seniors, they are not suitable for more acute needs and care provided in residential care. Along with assisted living, author Atul Gawande in his book Being Mortal discusses other new models or approaches to nursing or long term care homes such as the Eden Alternative and Green Houses, which are also intended to reduce the institutional aspects of continuing care and create a more home like environment.[89] Although still largely in the infancy stage, these models are increasingly being looked at as alternatives to the status quo.

Green House Models

"Unlike conventional nursing homes, the Green House Model has become an increasingly popular method of delivering care to seniors within the United States."

Unlike conventional nursing homes, the Green House Model has become an increasingly popular method of delivering care to seniors within the United States. According to the Green House Project, as of May 2012, the Green House design has been implemented in 32 states with 144 homes open and 120 homes in development.[90] Founder of both the Eden Alternative[91] and Green House Model Dr. William Thomas, harmonized the Green House design after the principles of the Eden Alternative, which attempts to resolve the effects of boredom, loneliness and lack of meaning of life that can potentially affect seniors within traditional housing methods.[92]

Thomas's approach for both models of care was to deinstitutionalize care homes and enliven the environment with an atmosphere reminiscent of home; this includes restructuring and broadening nursing roles as well as giving resident's access to outdoor spaces, plants, and animals.[93] The core philosophy behind the design is taking a more person-directed approach to care; therefore, the Green House Home itself is a self-contained residence designed to house a small group of 10-12 seniors, with each individual accessing their own private bedroom and bathroom.[94]

Certified Nursing Assistants (CNAs) are referred to as Shahbazim within these care homes. Derived from the Persian word "royal falcon" the Shahbaz dedicates its life to protect, sustain and nurture the people it serves, by doing daily tasks such as laundry, cooking and housekeeping.[95] The model itself reorganizes the traditional hierarchal structure of care homes and works in self-directed teams in order to support normal routines of the elder. Shahbazims report back to a Guide, otherwise known as the nursing home administrator.[96] Self-

[89] The Green House Effect: Homes for the Elderly to Thrive. Jane E. Brody. New York Times. December 15, 2014. Accessed at: http://well.blogs.nytimes.com/2014/12/15/moving-away-from-nursing-homes/?_r=3
[90] Evaluating the Green House Model. Accessed at: http://thegreenhouseproject.org/research-advocacy/research
[91] For more on the Eden Alternative, see: http://www.edenalt.org/about-the-eden-alternative/mission-vision-values/
[92] Rabig, J., Thomas, W., Kane, R., Cutler, L., and McAlilly, S. (2006) "Radical Redesign of Nursing Homes: Applying the Green House Concept in Tupelo, Mississippi." *The Gerontological Society of America, 4 (46).*
[93] Brownie, S., and Nancarrow, S. (2012) "Effects of person-centered care on residents and staff in aged-care facilities: a systematic review". *Clinical Intervention in aging.*
[94] Jenkens, R., Sult, T., Lessell, N., Hammer, D., and Ortigara., A. (2011) "Financial Implications of THE GREEN HOUSE® Model" *Senior Housing & Care Journal 1(19).*
[95] "What is THE GREEN HOUSE® Model?" Accessed at: http://www.bartramlakes.org/memory-care/what-is/
[96] Jenkens, R., Sult, T., Lessell, N., Hammer, D., and Ortigara., A. (2011) "Financial Implications of THE GREEN HOUSE® Model" *Senior Housing & Care Journal 1(19).*

directed teams work in groups of 3 to 15 in designated neighbourhoods and decide within that group what work needs to be done for that day including overseeing both care practices and management issues.[97]

According to Thomas, traditional models succumb to hierarchical practices such as consistent medical and meal times, assigned bath days and specific job descriptions for nurses.[98] In contrast, the self-directed approach provides the highest quality of care by broadening nursing roles and allowing residents to spend time according to their preferences.[99]

As opposed to conventional nursing homes, the Green House Method intends to empower elders within care homes as unique individuals with a right to privacy and autonomy. It also offers them a chance at an improved quality of life by doing meaningful activities and building relationships with others, including their Shahbazim's.[100] Improved quality of care by being able to maintain self-care abilities, improved family satisfaction and improved staff satisfaction with Shahbazim's reporting a higher rate of job satisfaction and longevity, are all outcomes of the Green House model.[101]

> "…the Green House Method intends to empower elders within care homes as unique individuals with a right to privacy and autonomy."

The Green House Model's cost of operations was comparable to those of traditional nursing homes with respect to the additional direct care, food services, and leadership/management needed to run such a housing.[102] In general, the capital costs for Green House homes were found to be equivalent to or less than similar culture change models yet, occupancy and private pay revenues were found to increase[103].

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

Dementia Models of Care

Dementia Friendly Communities

With roughly 70,000-75,000 British Columbians currently being impacted by dementia and this expected to rise to 105,000-110,000 by 2025[104], exploring options such as building dementia-friendly communities in BC will help reduce stigmas surrounding people with dementia and allow for chronically ill seniors to continue to participate positively to the larger community.

Dementia-friendly communities are ones that empower elders with dementia to contribute to their community and give them the confidence to continue to participate in activities that are meaningful to

[97] Foy White-Chu, E., William, J., Graves, BS., Sandra, M., Godfrey, RN., Bonner, A., and Sloane, P. (2009). "Beyond the Medical Model: The Culture Change Revolution in Long-Term Care." *American Medical Directors Association.* DOI: 10.1016/j.jamda.2009.04.004.
[98] Andersen E., Smith M., and Havaei, F (2014) Nursing home models and modes of service delivery: Review of outcomes. *Healthy Aging Research* 3:13. doi:10.12715/har.2014.3.13.
[99] Lum, T., Kane, R., Cutler, L., and Yu, T. (2008) "Effects of Green House Nursing Homes on Residents' Families". Accessed at: http://www.ncbi.nlm.nih.gov/pubmed/19361115
[100] Polivka, L., and Moore, L. "The Green House Project: Changing the Way that Nursing Home Care is delivered." Accessed at: http://claudepeppercenter.fsu.edu/sites/claudepeppercenter.fsu.edu/files/The%20Green%20House%20Project_paper%20(1).pdf
[101] "Jewish Home Lifecare to Incorporate GREEN HOUSE Model into Westchester Campus". Accessed at: http://www.jewishhome.org/news/press-room/press-releases/jewish-home-lifecare-to-incorporate-green-house-model-into-westchester-campus
[102] "Guidebook for transforming long-term care." Accessed at: http://blog.thegreenhouseproject.org/wp-content/uploads/2011/09/TheGreenHouseProject-GuideBook-2010-0413.pdf
[103] "Financial Implications of THE GREEN HOUSE® Model Overview." Accessed at: http://thegreenhouseproject.org/doc/30/GHP-Financial.pdf
[104] Workforce Analysis, Health Sector Workforce Division, Ministry of Health, Dementia (age 45+ years) March 24, 2014, project 2014_010 PHC

them.[105] In order to achieve this, communities must focus on ensuring that they are shaped to the needs and aspirations of those with dementia, that people with dementia acknowledge themselves the positive contribution they can make to the community, and promote an awareness of dementia.[106]

Key areas of dementia friendly communities include making the physical environment easier to navigate by creating clearer signage and directional information for elders,[107] as well as reducing the stigma surrounding dementia in order for seniors to participate in daily activities, and reducing barriers surrounding such illnesses.[108] Similarly, the World Health Organization (WHO) defines an age-friendly community as being one that adapts its structures and services to be accessible to, and inclusive of, older people with varying needs and capacities.[109]

According to WHO, an age-friendly environment will include domains such as accessible outdoor spaces and buildings, cheap public transportation, venues for social participation for seniors, respect and social inclusion of seniors, civic participation and employment opportunities and an adequate amount of health services for seniors.[110]. Although not specifically meant for seniors with dementia, these guidelines can assist communities that are shifting towards dementia inclusive environments. Dementia-friendly care homes will create environments that are legible, distinctive, safe, and familiar to seniors.[111] This includes, ensuring that areas are well-lit, avoiding reflective and slippery floor surfaces, easy to use street furniture, and distinctive landmarks to assist with navigation.[112]

As outlined earlier, the development of dementia friendly communities, much like integrating residential care homes into age-friendly communities, may also require addressing some of the issues regarding strict municipal zoning requirements. In particular, streamlining the approval of such care homes, particularly those that are to be integrated into the community will be critical.

The BCCPA is looking further at the idea of dementia friendly care homes, including a specific designation that could be provided to homes that have made specific redesign changes to accommodate dementia residents and/or where specific dementia training has been provided to staff. The BCCPA believes such a program or designation merits further consideration in partnership with relevant stakeholders including government, health authorities, and the Alzheimer's Society of BC.

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[105] "Dementia-friendly communities". Alzheimer's Society, accessed at: http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=1843

[106] Green, G and Lakey, L. (2013) "Building dementia-friendly communities: A priority for everyone." Alzheimer's Society.

[107] Developing dementia-friendly communities: Learning and guidance for local authorities. *Local Government Association*, May 2012.

[108] Haggarty, M (2013). "Dementia Friendly Communities Worldwide: A Summary of Web Searches." *Centre for Education and Research on Aging and Health,* Lakehead University.

[109] "Building Dementia and Age- Friendly Neighbourhoods." Alzheimer's Australia. Discussion Paper, July 2011.

[110] "Checklist of Essential Features of Age-friendly Cities." *World Health Organization* 2007.

[111] "At a Glance: a Checklist for Developing Dementia Friendly Communities." *Housing Learning & Improvement Network*, June 2012.

[112] "Live Life to the full Making Kirklees a dementia friendly place to live: Checklist for dementia friendly environments." October 2012.

Dementia Villages

The Netherland's and Switzerland are two countries who have implemented dementia-friendly communities through their unique model of care to seniors who suffer from severe cases of dementia. These communities or care homes are often referred to as Dementia Villages.

The village of Hogeweyk, otherwise referred to as "Dementiaville" in the Netherlands, was the first established Dementia Village and currently has over 150 seniors living with severe cases of dementia, as well as creates an alternate reality for seniors who are encouraged to roam around the confines of the village enjoying everyday pleasures such as shopping, cooking and going to the movies.[113] The Village, which features 23 residential units shared by 6-8 seniors each, closely resembles the period when resident's short-term memory began to decline in order to promote a home-like environment for seniors.[114]

Founded by Yvonne van Amerongen, the design and idea of the Villages was to find a way for seniors to participate in daily life the same way they did prior to needing dementia care.[115] The model attempts to minimize disability and maximize well-being by providing seniors an environment that is reflective of their past physical and social surroundings.[116] In order to do so, residents with the help of their family, fill out a questionnaire regarding several lifestyle choices that reflect their values, beliefs, and norms, in order to ensure that elders are placed within a unit that is similar to their worldviews.[117] Such lifestyle choices include options such as: homey; those who focus on housekeeping and family; Indonesian for those who have an interest in nature and spirituality; and Urban, the more outgoing and informal individuals.[118]

Within the confines of the village, caregivers and Geriatric nurses monitor and provide seniors with care disguised as "villagers" in everyday street clothes, administrating medicine, cooking meals and planning activities.[119] However, residents of Hogeweyk are administered less medication than seniors living in conventional care homes due to living a more active lifestyle, eating better, and because of the added psychological benefits of living within a residence tailored to their specific needs.[120] Along with decreasing levels of stress and anxiety including the use of antipsychotics, the Netherland's dementia village has also resulted in reductions in the overall levels of aggression and violence.

Butterfly Care Homes

Another innovative dementia care model that uses many of the same approaches taken in the dementia village is that of Butterfly Care Homes. Following its initial introduction at Merevale House in Atherstone, UK in 1995 – a care home for 36 people living with a dementia – the approach has spread across the UK but also other countries including Ireland, Australia and most recently Canada. Known as Butterfly Service homes, there are over 50 project homes adopting this model. In Butterfly Care Homes a wide range of quality of life and quality of service outcomes are focused upon some of the following aspects:

[113] Anderson, J (2013) "Global Approaches to Dementia Care." Seniors living blog, Accessed at: http://www.aplaceformom.com/blog/dementia-care-around-the-world-4-2-2013/
[114] Planos, J. (2014) "The Dutch Village Where Everyone Has Dementia." The Atlantic, accessed at: http://www.theatlantic.com/health/archive/2014/11/the-dutch-village-where-everyone-has-dementia/382195/
[115] "An Amazing Village Designed Just For People With Dementia." Accessed at: http://gizmodo.com/inside-an-amazing-village-designed-just-for-people-with-1526062373
[116] Jenkins, C., and Smythe, A. (2013) "Reflections on a visit to a dementia care village." Nursing Older People, RCN Publishing Company, 6(25).
[117] Ibid.
[118] Glass, A. (2014) "Innovative Seniors Housing and Care Models: What We Can Learn from the Netherlands." *Seniors Housing & Care Journal, 1(22).*
[119] "Dementia Care: What in the World is a Dementia Village?" Accessed at: http://www.alzheimers.net/2013-08-07/dementia-village/
[120] Schmid, C. (2013) "Hogewey Dementia Village | The Future of Dementia Care?" Best Alzheimer's Products. Accessed at: http://www.best-alzheimers-products.com/hogewey-dementia-village.html

- *A house model* – breaking the care home up into domestic scale and recognisable houses;
- *Creating housekeepers* – transforming ways of working as domestic and catering staff into housekeepers being the heart of the home in each house;
- *Removing boundaries and barriers* that separate staff from feeling peoples lived experience;
- *Removing central dining rooms* – preventing the 'herding' of people from one room to another and creating in lounge/diners a positive, engaging, social occasion;
- *Matching* – preventing people experiencing unnecessary stress by being put together at different 'points' of a dementia and by grouping people together in 'houses' at similar point of experience;
- *Relaxing the routines* – freeing up the staff team, by giving them permission to be with people, whilst fostering team work to still flexibly also achieve the discreet running of the home;
- *Enjoying mealtime experiences* – training staff how to sit and 'be with' people sharing a meal;
- *Turning staff into butterflies* – helping staff to draw on a wide variety of ways to engage and occupy people in the moment, from staff wearing 'activity' belts' and connecting with people;
- *Feelings before behaviours* – providing a set of 'recipes' for staff on meanings behind behaviours; and
- *Measuring well being* – giving staff practical tools to increase peoples well being including helping staff to see that quality of well being is the primary indicator of good quality dementia care.[121]

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

OPTION 6 FOR CONSIDERATION:
That in partnership with relevant stakeholders including care providers, health authorities and the BC Alzheimer's Society, government explore establishing a dementia friendly program be established in which a specific designation could be provided to care homes that have made specific redesign changes to accommodate people with dementia and/or where specific dementia training has been provided to staff.

End-of Life / Palliative Care Models

A 2007 British Columbia study found that one in four deaths among residents of free-standing (not attached to a hospital) residential care homes still occurs in hospital.[122] A survey done in one British Columbia health region also found that less than half of all homes had implemented medical and nursing protocols for palliative care.[123]

Ensuring seniors are cared for appropriately in their end-of-life will require a commitment to build upon the existing capacity as well as improving continuity of care with residential care. It will be important to ensure

[121] Mattering in a dementia care home – The Butterfly Approach. Dr David Sheard – Chief Executive / Founder, Dementia Care Matters Accessed at: http://www.dementiacarematters.com/pdf/modern.pdf

[122] McGregor, M.J., R.B. Tate, K.M. McGrail. 2007. "Variation in Site of Death among Nursing Home Residents in British Columbia, Canada." *Journal of Palliative Medicine* 10 (5): 1128-36.

[123] McGregor M.J., J. Baumbush, R.B. Abu-Laban, K.M. McGrail, D.Andrusiek, J. Globerman, et al. 2010a. "A Survey of Nursing Home Organizational Characteristics Associated with Hospital Transfers and Care Quality in One Large British Columbia Health Region." Unpublished paper.

that along with building the necessary infrastructure, that continuing care homes are also appropriately resourced to meet increased demands and staff are appropriately trained as such. [124]

Most recently, Health Quality Ontario's End-of-Life Health Care report,[125] shows that we need to better address issues around palliative care. The Ontario report highlights that just 30 per cent of people with chronic illnesses have access to team-based palliative care – most being people with cancer.[126] Not only is there a need to look at the resources provided towards palliative care, including potential development of a national strategy, but there is a need to address tough issues such as over medicalization, institutionalization and seeking ways to improve well-being at end-of-life, including ensuring a dignified death.

> ***DID YOU KNOW:*** By 2026, with the ageing population, the number of Canadians dying each year will increase by 40 per cent to 330,000 people.

Now is the time for action on these issues, as the situation is only going to grow over time. By 2026, with the ageing population, the number of Canadians dying each year will increase by 40 per cent to 330,000 people. Each of these deaths will affect the well-being of an average of five other people, including families and loved ones, or in excess of 1.6 million.[127] Although the BC Government has made some progress in area such as the creation of the Provincial End-of-Life Care Action Plan[128] and committing to double number of hospice beds by 2020, more action and discussion is required.

Integration of Long Term Care and End-of-life

> "…much of the care provided within residential care homes could be considered end-of-life."

Currently much of the care provided within residential care homes could be considered end-of-life. For example, the average length of stay (ALOS) in a BC care home is approximately 16 months. If a senior living in such a home does not die there, they may instead spend some of their remaining days in an alternative care setting such as a hospital or hospice. The BCCPA believes that given the existing unused capacity within residential care homes that some of these unutilized beds could be transitioned into end-of-life (EOL) beds, provided appropriate supports are available.

As outlined earlier and in the 2015 BCCPA Quality-Innovation-Collaboration paper, while the existing unused capacity in residential care could be used to reduce ALC days, it could also be used potentially to increase the number of end-of-life care beds. This option, from a fiscal perspective, would be preferable to a hospital as costs for seniors receiving care in a residential care home are significantly less. According to one report, the cost of treating a BC senior in hospital ranges from $825 to $1,968 per day, whereas the cost of residential care is approximately $200 per day.[129] A residential hospice bed meanwhile costs approximately $440 per day to operate. In particular, according to a 2015 report from Ontario the annual cost of a 10-bed residential hospice is approximately $1,600,000.[130]

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[124] BCCPA 2015 Budget Submission. October 2015. Accessed at: http://www.bccare.ca/file/BCCPA-Budget-Submission-2015-Final.pdf

[125] *End-of-Life Health Care in Ontario*. Health Quality Ontario. December 2014. Accessed at: http://www.hqontario.ca/Portals/0/Documents/eds/synthesis-report-eol-1412-en.pdf

[126] Local Health Integration Networks, Quality Hospice Palliative Care Coalition of Ontario. Advancing high quality, high value palliative care in Ontario: a declaration of partnership and commitment to action. Accessed at: http://health.gov.on.ca/en/public/programs/ltc/docs/palliative%20care_report.pdf

[127] Quality End-of-Life Coalition of Canada. Blueprint for action 2010 to 2020. 2010, p. 19

[128] In March 2013, the BC government announced its *Provincial End-of-Life Care Action Plan for British Columbia* to improve access to end-of-life care so people can remain at home and in their community longer. This included funding to establish a centre for excellence.

[129] Caring for BC's Aging Population Improving Health Care for All. Canadian Centre for Policy Alternatives (CCPA). Marcy Cohen. July 2012. BC Ombudsperson, 2012, Volume 2:239. Accessed at: http://www.policyalternatives.ca/sites/default/files/uploads/publications/BC%20Office/2012/07/CCPABC-Caring-BC-Aging-Pop.pdf

[130] Environmental Scan for Strengthening Residential Hospice Care in Ontario. Report of the Residential Hospice Working Group. March 2015. Accessed at: https://www.oma.org/Resources/Documents/EnvironmentalScanforStrengtheningResidentialHospiceCareinOntario.pdf

Along with improving capacity through the building of new hospice beds, it will be important to ensure greater continuity with end-of-life and the continuing care sector.

Similar to the earlier section regarding new continuing care models including development of Continuing Care Hub networks, there is also an opportunity for residential care homes, particularly new Continuing Care Hubs, to expand their role and provide care to those in palliative or end-of-life care. Along with providing, for example, less intensive hospice care, residential care homes could also work together to provide centres of excellence in palliative care or end-of-life. Such homes, for example, could provide specialized services as outlined in the Specialized Stream Model, including higher levels of care and care for special needs populations (i.e. including those with late stage dementia, severe mental illness and addictions and those at end-of-life). Such centres, along with leading care in areas such as dementia, mental illness, and end-of-life, could also lead development of research and innovation within the continuing care sector.

Palliative Care Models

Overall, there are a large number of excellent palliative care models. A report prepared by the Canadian Hospice Palliative Care association, for example, highlights eleven such models, including the Fraser health end-of-life care program in British Columbia.[131] Each of the 11 models has taken different approaches to providing an integrated palliative approach to care in their communities, yet all share common elements that make them successful and transferrable to other locations, including across Canada. In the report, the success factors for the models (see below) are organized into four key components that contribute to an effective, sustainable program: vision, people, delivery of care and supportive tools.

Palliative Care Models: Success Factors
1. Commitment to person-centred care
2. Focus on building capacity in the community
3. Focus on changing organizational culture
4. Senior management support
5. Dedicated coordinators
6. Inter-professional teams
7. Strong role and more support for family physicians
8. Support for providers in continuing care homes
9. Key roles for nurses
10. Relationships, partnerships and networks
11. Integration of primary-secondary-tertiary care
12. Cultural sensitivity
13. Single access point and case management
14. 24/7 community support and care
15. Advance care planning
16. Common frameworks, standards and assessment tools
17. Flexible approaches to education
18. Shared records
19. Research, evaluation and quality improvement

[131] Canadian hospice Palliative Care Association, *Innovative Models of Integrated Hospice Palliative Care*, the Way Forward Initiative: an Integrated Palliative Approach to care, 2013. Accessed at: http://www.hpcintegration.ca/media/40546/TWF-innovative-models-report-Eng-webfinal-2.pdf

OPTION 7 FOR CONSIDERATION:

The Ministry of Health and Health Authorities work with the BC Care Providers Association (BCCPA) and other stakeholders to develop strategies to better utilize the existing excess capacity in the continuing care sector to increase capacity with respect to end-of-life (EOL) care.

OPTION 8 FOR CONSIDERATION:

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

PRIORITY 2: DEMENTIA

In November 2012, BC's Provincial Dementia Action Plan was released with the goal to increase individual, community and health service capacity to provide early, appropriate and effective care and support to assist people with dementia to remain at home and in their communities to the greatest extent possible. The Plan outlines government's priorities for improved dementia care province-wide, and includes three priorities with specific actions for health authorities and others to address, including: 1) support prevention and early intervention of dementia; 2) ensure quality person-centred dementia care; and 3) strengthen system capacity and accountability.

Although some other provinces / territories (P/Ts) have developed dementia strategies, media releases from the G8 Dementia Summit held in December 2013 highlights Canada as the only G8 country without a national strategy on dementia. The challenges of developing a national approach include considering whether a national strategy/framework would be more successful as a P/T initiative, Health Care Innovation Working Group (HCIWG) initiative, or a federal initiative.

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

At the political and stakeholder level, organizations such as the Canadian Medical Association (CMA) and the Alzheimer's Society of Canada (ASC) have been advocating for a national dementia strategy. The House of Commons' Standing Committee on Finance, which includes members of all federal political parties, also recommended that government "move expeditiously" on developing a national dementia plan. Currently there are 747,000 Canadians living with Alzheimer's disease and other forms of dementia. That number is expected to increase to 1.4 million by 2031.

In December 2013, Health Ministers from G8 countries, including former Federal Conservative Health Minister Rona Ambrose and former Alberta Health Minister Fred Horne, participated in a Dementia Summit and committed to work to address the growing problem of dementia through increased research, innovation and partnerships. Along with its participation at the G8 summit on dementia, the 2014 federal budget outlined the creation of the Canadian Consortium on Neurodegeneration in Aging.

> ***DID YOU KNOW:*** Currently there are 747,000 Canadians living with Alzheimer's disease and other forms of dementia. That number is expected to increase to 1.4 million by 2031.

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

As a first step to ensuring funds match the costs of delivering complex care, the BCCPA suggests that continuing care funding appropriately account for the growing population of residents with dementia. According to BC's Dementia Action Plan, the number of people with dementia in the province is between 60,000 and 70,000. The Alzheimer Society of BC cites that this number is expected to double within the next 25 years. [132]

The dementia epidemic is particularly critical in the continuing care sector. A 2012 report from the Canadian Institute for Health Information (CIHI) notes that 61.5% of seniors in residential care are living with dementia. In a recent survey of BCCPA members, it was identified that the average number of residents living with Alzheimer's and dementia was 69% in Residential Care, 32% in Assisted Living, 32% in Home Care and 8% in Independent Living. As a result, increasing levels of dementia are placing strains on care providers.

The costs of caring for a person with advanced dementia are indeed high. Dementia currently costs Canada roughly $33 billion per year, both in direct health care expenses and in indirect costs, such as lost earnings of the person's caregivers. These costs are expected to total $293 billion by 2040. The costs of caring for a person with advanced dementia are also particularly high. According to the USC Leonard D. Schaeffer Centre for Health Policy and Economics the annual per-person cost of the disease (including direct and indirect costs) was $71,000 (US) in 2010 and is expected to double by 2050.[133] However, the per-person cost also varies depending on the type of dementia, and the severity.

> "Any new BC Dementia Plan, such as the one which was originally to be released in 2015, should outline the need for investments including in the prevention and early treatment of dementia."

Any new BC Dementia Plan, such as the one which was originally to be released in 2015, should outline the need for investments including in the prevention and early treatment of dementia. It should also address the occupation of acute-care hospital beds by patients with dementia while awaiting placement in more appropriate continuing care settings. This only causes undue expenditures to the total health care budget, hospital overcrowding, and inefficient use of health care resources. Finally, any BC strategy must ensure that continuing care

[132] The Provincial Dementia Action Plan for British Columbia. *Priorities and Actions for Health System and Service Redesign.* Ministry of Health November 2012. Accessed at: http://www.health.gov.bc.ca/library/publications/year/2012/dementia-action-plan.pdf .
[133] Press Room. Study: Baby Boomers Will Drive Explosion in Alzheimer's-Related Costs in Coming Decades. November 11, 2014. Accessed at: https://pressroom.usc.edu/study-baby-boomers-will-drive-explosion-in-alzheimers-related-costs-in-coming-decades/

operators have the necessary fiscal support to care appropriately for dementia residents.

As mentioned, the provincial government had also previously committed to revise its earlier Dementia Action Plan. The BCCPA has developed the following motions for its 2016 AGM where it recommends:

- That the provincial government, as originally intended, commit to develop and implement a separate three-year Provincial Dementia Action Plan, which focuses on various priorities such as: increasing public awareness and early recognition of dementia including programs such as First Link; improving quality of care for people with dementia in residential care homes, as well as improving palliative and end-of-life care, and increasing system supports; as well as the adoption of best practices in dementia including increased access to dementia training for care providers; and

- Along with increasing public awareness and focusing on various dementia priorities, any new provincial dementia plan should include tangible initiatives and measurable outcomes as well as align, where possible, with any national dementia strategy.

The Ministry of Health document *Setting Priorities for the BC Health System* (2014) also outlines the intention to develop residential care models and province-wide quality standards appropriate to the changing care needs of residents, with particular attention to people with dementia. The BCCPA and its members hope, as outlined in earlier budget submission, it will consulted further regarding this, particularly around the development of new licensed dementia housing or specialized housing for clients with various forms of dementia.

The BCCPA has advocated previously for the development of a National Dementia Strategy including in a 2014 op-ed published in the Vancouver Sun.[134] In this article, for example, it advocates for the development of a national dementia strategy to build on existing provincial strategies and highlighting areas such as:

- Investment in dementia research, early detection and prevention;
- Expand and improve quality across continuum of care, including primary care, continuing care and palliative care;
- Improve care and supports provided to family caregivers;
- Expand education and development among workforce; and
- Develop resources to address stigma and public awareness of dementia issues including resident-on-resident aggression.

[134] National dementia strategy urgently needed. Vancouver Sun. September 30, 2014. Daniel Fontaine. Accessed at: http://www.vancouversun.com/opinion/op-ed/National+dementia+strategy+urgently+needed/10249816/story.html

Along with this, any national strategy must outline investments in the prevention and early treatment of dementia. It should also address the occupation of acute-care hospital beds by patients with dementia while awaiting placement in more appropriate continuing care settings. According to a 2015 Insights West survey commissioned by the BCCPA, 91% of British Columbians support the development of a national dementia strategy, which would outline investments in continuing care, including the prevention and early treatment of dementia.

In October 2014, P/Ts and the federal government agreed to explore the development of a national dementia strategy although no further specifics were provided on the scope or timelines of such a strategy. The new federal Liberal government also committed during the 2015 election to work with provinces on a national dementia strategy.

Support for dementia training

Another important aspect will be to ensure care homes have the necessary resources, including training, to care appropriately for dementia residents as well as deal with incidents of resident-on-resident aggression. Along with SafeCare BC's violence prevention workshops other examples include training programs such as the one with the Alzheimer Society of BC and SafeCare BC (Creating Connections: Working with People with Dementia) to better train front-line staff dealing with residents living with dementia as well as Behavioral Supports Ontario (BSO) that was established in 2012.

As part of the BSO program, which has received almost $60 million in government funding, staff take specialized training to gently approach and redirect residents with challenging behaviors. Staff also work with care teams to reduce aggressive or challenging behaviors. Initial results show BSO has been successful, including in one care home which has reduced antipsychotic medication use in half while lowering rates of agitation, restlessness and conflict.[135]

In 2015 the Ontario Long-Term Care Association was lobbying the Ontario government for $60 million over three years to support BSO so teams of experts can be placed in more care homes.[136] In its 2016 budget, the Ontario government announced it will invest an additional $10 million annually in BSO to help long-term care home residents with dementia and other complex behaviors.[137]

> "For its part the BCCPA's partner organization, SafeCare BC, has also undertaken a partnership with the BC Alzheimer's Society to train staff to better deal with residents with dementia including those with responsive or aggressive behaviours."

The BCCPA believes that a similar program and investments should be considered here in BC, which also faces increasing levels of dementia and challenges with regards to responsive behaviors. For its part the BCCPA's partner organization, SafeCare BC, has also undertaken a partnership with the BC Alzheimer's Society to train staff to better deal with residents with dementia including those with responsive or aggressive behaviours.

Such investments in dementia care should provide future cost savings in the long-term by better dealing with seniors with dementia and reducing unnecessary hospitalizations. A study from the Unites States shows that medical advances that delay the onset of dementia by five years add about 2.7 years of life for patients. The study also

[135] Ontario Long Term Care Association. This is Long-Term Care 2015.November 23, 2015. Accessed at: http://bluetoad.com/publication/?i=281415.
[136] Nursing homes ask province to help reduce violence among elderly. Jonathan Sher. Ottawa Citizen. January 4, 2016. Accessed at: http://ottawacitizen.com/news/local-news/nursing-homes-ask-province-for-help-to-reduce-violence-among-elderly
[137] Transforming Health Care. Ontario Government. February 25, 2016. Accessed at http://www.fin.gov.on.ca/en/budget/ontariobudgets/2016/bk8.html

noted that this could result in a 41% lower prevalence of the disease in the population, thus having the potential to lower overall costs to society by 40%.[138]

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

PRIORITY 3: TECHNOLOGY

Today's health system relies heavily on the use of technology to improve quality of care and patient outcomes as well as potentially reduce costs. With the ageing population, use of technology represents great opportunities within the continuing care sector. Although this report will not go through all the technologies, some prominent ones include:

- Sensors - which can detects fall as well as inactivity and other situations.
- GPS-tracking technologies - to allow families, health workers, or law enforcement professionals to locate seniors in case of emergency.
- Mobile applications - from monitoring to communication, mobile applications can give caregivers peace of mind while allowing seniors to get in touch with a few taps on their phones.
- Remote monitoring technologies - for elderly or infirm patients who need regular monitoring, these technologies can connect to smart phones and can reduce expensive, time-consuming doctor visits that might further endanger their health.
- Telehealth - use of teleconference and videoconferencing systems to connect patients with doctors, and other health professionals.
- Electronic health records - to provide greater access to medical and prescription records and potentially reduce adverse events, etc.

While these and other technologies can potentially offer significant benefits they also come with various challenges including issues around privacy and surveillance, initial start-up costs, ease of use, etc. For the purposes of this paper, we focus on use of technologies in the context of reducing social isolation, improving safety through monitoring of seniors and improving access to medical information particularly through electronic records.

Social Isolation

Social isolation touches many areas of seniors' lives, including active participation in the community and healthy ageing. According to a 2012 study of the National Academy of Sciences, both social isolation and loneliness are associated with a higher risk of mortality in adults aged 52 and older.[139] As people get older, their likelihood of living alone increases. With the ageing population and

"Social isolation touches many areas of seniors' lives, including active participation in the community and healthy ageing."

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

[139] Social isolation, loneliness, and all-cause mortality in older men and women. Andrew Steptoe et al. February 15, 2013. Accessed at: http://www.pnas.org/content/110/15/5797.full

approximately 25% of the Canadian population to be over 65 in the next twenty years, the problem is likely to increase.

In a 2012 Statistics Canada report, nearly one in four seniors reported that they would like to participate more in social activities. Statistics Canada's 2008/09 Canadian Community Health Survey also found that about one-fifth of seniors felt left out, isolated from others, or that they lacked companionship.[140]

Research shows that social isolation can have detrimental effects on health. As reported in a 2009 U.S. study using data from the National Social Life, Health, and Aging Project, seniors who feel lonely and isolated are more likely to report having poor physical and/or mental health.[141] One study notes isolation is as strong a factor in early death as smoking 15 cigarettes a day,[142] while another notes loneliness can be twice as unhealthy as obesity, increasing changes of early death by 14 per cent.[143]

Social isolation is a factor in the development of chronic illnesses such as chronic lung disease, arthritis, and impaired mobility.[144] Research also shows that increased loneliness can lead to depression, as well as cognitive decline, and increased risk of dementia. Along with increasing the risks of mental and physical illness, social isolation can also lead to increased vulnerability to elder abuse and development of addictions.[145] Finally, according to a 2004 BC Ministry of Health report, loneliness and social isolation are major predictors of seniors utilizing home care services and entering residential care.[146]

Many factors can lead to increased social isolation among seniors including one's mental and physical health status, elder abuse and neglect, physical and geographic isolation, loss of spouse, transportation challenges, and sexual orientation. There are a variety of ways to deal with social isolation including encouraging greater community participation such as volunteering and classes to provide education

[140] Canadian Community Health Survey - Healthy Aging (CCHS). May 2010. Accessed at: http://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=5146

[141] Social Disconnectedness, Perceived Isolation and Health among Older Adults. Erin Cronwell and Linda Waite. Journal Health Soc Behav. March 2009; 50(1): 31-48. Accessed at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2756979/

[142] Holt-Lunstadt, J., Smith, T.B., and Layton, B.L. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Medicine*, p. 12. Retrieved from http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000316 and Duncan Selbie: 'Being isolated is equivalent to 15 cigarettes a day'. The Guardian. March 12, 2013. http://www.theguardian.com/society/2013/mar/12/duncan-selbie-isolated-bad-health

[143] Loneliness twice as unhealthy as obesity for older people, study finds. The Guardian. Ian Sample. February 16, 2014. Accessed at: http://www.theguardian.com/science/2014/feb/16/loneliness-twice-as-unhealthy-as-obesity-older-people. The scientists tracked more than 2,000 people aged 50 and over and found that the loneliest were nearly twice as likely to die during the six-year study than the least lonely.

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

[145] 20 Facts About Senior Isolation That Will Stun You. Posted On 17 Oct 2014 By : Sarah Stevenson http://www.aplaceformom.com/blog/10-17-14-facts-about-senior-isolation/

[146] Social Isolation Among Seniors: An Emerging Issue; An Investigation by the Children's Women's and Seniors Health Branch. BC Ministry of Health. Accessed at: https://www.health.gov.bc.ca/library/publications/year/2004/Social_Isolation_Among_Seniors.pdf

and physical activity opportunities for seniors. Technology is also one potential way to reduce isolation by encouraging seniors, who may have limited mobility, to use the internet and on-line technologies to communicate.

In particular, one area of focus could be on the use of technologies in the home or assisted living setting including areas such as telehome monitoring as a way to reduce social isolation. Electronic home monitors, for example, enable health providers to work effectively with complex clients in assisting them to better manage their illness and stabilize their health, regardless of where they live.

Along with potentially reducing social isolation, the use of electronic home monitors also facilitates early intervention by the health provider, thus preventing unnecessary hospital visits and enabling early discharge. Telehome Monitoring pilot projects in BC (i.e. IHA and VIHA) have also shown decreased emergency department visits and hospital admissions leading to cost reductions in the health system.

Along with telehome monitoring, the development of programs to encourage internet usage among seniors is another option. In Vancouver, for example, a recent program was started (Cyberseniors) in which teenagers go to senior's residences and help them use computers and the internet to connect socially through computer programs like Facebook, Skype, etc. Another example is Can Connect software, which is being used in BC's health authorities for seniors who have difficulty using a phone or computer to stay in touch with family and caregivers through a live visual connection (e.g. Skype). Users of the technology simply touch a photo on their computer screen to connect.

"There are encouraging signs that governments and stakeholders are starting to look more seriously at the issue of social isolation and its impact on seniors."

There are encouraging signs that governments and stakeholders are starting to look more seriously at the issue of social isolation and its impact on seniors. In October 2014, for example, the Federal-Provincial Ministers Responsible for Seniors' directed work on two priority areas one of which included sharing promising approaches and innovative solutions to address social isolation among seniors, including those living in rural and remote communities.[147]

In 2013, the National Seniors Council (NSC), which consists of various experts on seniors, was also tasked to assess how social isolation affects seniors and explore ways to prevent and reduce social isolation of seniors in Canada. In this regard, the NSC hosted a series of forums across Canada and released a comprehensive report on the topic on November 24, 2014 focusing on four areas including: 1) raising public awareness, 2) improving access to information and services for seniors, 3) building collective capacity through social innovation and 4) supporting research.[148] The federal government has also invested funding through its New Horizons for Seniors Program (NHSP). Since 2006, the NHSP has funded more than 13,000 projects across Canada that focus on issues like elder abuse, social isolation, and intergenerational learning. Most recently, it approved 24 NHSP pilot projects—an investment of more than $1.7 million—aimed at addressing the social isolation of seniors.[149]

While these investments are encouraging, governments should continue to work jointly with seniors and stakeholders, including those in the continuing care sector, to develop concrete solutions that can address

[147] Press Release – On-going collaboration to support the well-being of seniors living in Canada. FPT Ministers Responsible for Seniors Meeting. October 16, 2014. Accessed at: http://www.scics.gc.ca/english/Conferences.asp?a=viewdocument&id=2242

[148] National Seniors Council exploring adverse effects of social isolation. March 3, 2014. Accessed at: http://news.gc.ca/web/article-en.do?crtr.sj1D=&crtr.mnthndVl=3&mthd=advSrch&crtr.dpt1D=&nid=820699&crtr.lc1D=&crtr.tp1D=&crtr.yrStrtVl=2008&crtr.kw=social+isolation&crtr.dyStrtVl=26&crtr.aud1D=&crtr.mnthStrtVl=2&crtr.page=1&crtr.yrndVl=2014&crtr.dyndVl=6

[149] Minister Wong meets with National Seniors Council and holds roundtable on social isolation of seniors. July 16, 2014. Accessed at: http://news.gc.ca/web/article-en.do?nid=868029

the main causes and concerns behind the issue of social isolation among seniors. As a first step, the federal government should commit to work with stakeholders to implement the recommendations outlined in the NSC report. The BCCPA shares the federal governments concern over the issue of social isolation of seniors and believes further work in this regard may be warranted.

Another potential way to address the issue of senior's isolation could be to use the existing residential care infrastructure, including care homes to provide social services and/or home care supports for seniors who are living at home and possibly more isolated. A number of strategies in this regard could be to provide funding to help residential care homes to provide social supports including acting as a seniors' drop in centre or lodge for those elderly that are living at home and potentially isolated.

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

Improving access to medical information through electronic records

The adoption of Electronic Health Records (EHRs) or Electronic Medical Records (EMRs) by primary care physicians has more than doubled from 26 per cent in 2006 to 56 per cent in 2012.[150] Yet, Canada still lags behind other countries, notably Australia, New Zealand, and the United Kingdom, who report use of EHRs by care physicians to be over 90 per cent.[151]

EHRs are electronic versions of medical information collected by healthcare professionals and organizations, pertaining to a patient to whom they provide care.[152] According to the Ministry of Public Works and Government Services Canada's audit report 2010, the core components of an EHR include the following:

- *Client registry*—a list of all patients and their relevant personal information
- *Provider registry*—a list of participating health care professionals who are authorized to use system
- *Diagnostic imaging system*—electronically collects, stores, manages, distributes, and displays a patient's images and reports, such as x-rays, ultrasounds, MRIs (magnetic resonance imaging) and CT (computed tomography) scans

[150] Canada Health Infoway – Infoway. (2013) "Canada Health Infoway: The emerging benefits of electronic medical record use in community-based care." Accessed at: file:///C:/Users/Gagan/Downloads/emr_benefits_full_report_en_apr2013.pdf
[151] Schoen, C., Osborn, R., Squires, D., Doty, M., Rasmussen, P., Pierson, R., and Applebaum, S. (2012) "A Survey Of Primary Care Doctors In Ten Countries Shows Progress In Use Of Health Information Technology, Less In Other Areas." *Health Affairs, 31, no.12* :2805-2816.
[152] Health Workforce Information Centre. (2013) "Health Information Technology, Telehealth, and the Health Workforce." Accessed at: http://ruralhealth.und.edu/projects/hwic/pdf/hit-telehealth.pdf

- *Drug information system*—allows health care professionals to access, manage, share, and safeguard a patient's medication history
- *Laboratory information system*—no matter where a patient is tested, allows laboratory technicians to enter results into database that will be linked to the patient's EHR and will be available for viewing
- *Interoperable EHR*—allows authorized health care professionals to view and, in some cases, update a patient's essential health information.[153]

Electronically based health records are an effective way of providing integral improvement to seniors' health outcomes, reducing avoidable hospitalizations and medication errors.[154] Unlike traditional paper charts, EHRs make it easier for physicians to access medical records both inside and outside of the office, accurately retain and retrieve information that could otherwise get lost and transmit clinical information to consultants and specialists.[155] Overall, electronic records can offer more accuracy and efficiency with regards to providing care for individuals of all ages.

Conversely, another way to enhance the delivery of medical services, especially to seniors in rural areas, is through Telehealth technologies. Telehealth is the use of communications and information technology to deliver healthcare services over large and small distances.[156] Patients can access and receive care from four domains of Telehealth which include: live video, which allows for a live two-way interaction between the patient, caregiver or provider regarding medical issues; transmissions of health records to a specialist via online technologies; and mobile health which foster education through mobile devices such as cellphones, where the receiver gets access to disease outbreaks and healthy living tips.[157]

The final domain is Remote Patient Monitoring (RPM), which refers to a broad range of point-of-care monitoring devices such as weight scales, glucometers, implantable cardioverter defibrillators, and blood pressure monitors which individually collect and report health data.[158] These devices track data that are sent to a physician's office where medical conditions are monitored and interventions can take place if needed.[159] Notably, RPM technologies are frequently used by the elderly and chronically ill.

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[153] Ministry of Public Works and Government Services Canada. (2010) "Electronic Health Records in Canada—An Overview of Federal and Provincial Audit Reports". Accessed at: http://www.oag-bvg.gc.ca/internet/English/parl_oag_201004_07_e_33720.html

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

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

[156] Centre for Health Information Newfoundland and Labrador (2010) "Evaluating the benefits: Improved health through quality health information." Accessed at: http://www.nlchi.nl.ca/index.php/telehealth

[157] Centre for Connected Health Policy: The National Telehealth Policy Resource Centre. "What is Telehealth?" Accessed at: http://cchpca.org/what-is-telehealth

[158] Centre for Technology and Aging. (2010) "Technologies for Remote Patient Monitoring for Older Adults." Accessed at: http://www.techandaging.org/RPMpositionpaperDraft.pdf

[159] Rouse, M. (2014) "remote patient monitoring (RPM)". *ConnectCare: Solutions Transitioning Healthcare Information*. Accessed at: http://searchhealthit.techtarget.com/definition/remote-patient-monitoring-RPM

Recent findings from Healthsense, a Minneapolis-based remote monitoring solutions provider revealed that over a 12-month period Healthsense users experienced 38 per cent fewer visits to the emergency room, 14 per cent fewer days in long term care and 7 per cent fewer inpatient admissions[160] when compared to a control group that did not have the RPM technology installed.[161]

Essentially, telehealth technologies can be beneficial to both the patient and the physician, with patients having more control and understanding of their long-term conditions and clinicians being able to proactively monitor and assess the patient's well-being from a distance.[162] E-health technologies such as telehealth and electronic health records have become an effective way of improving access to care for seniors, promoting efficiency and reducing unnecessary hospital visits via communication technologies that facilitate and monitor senior's health in an ambient environment.[163]

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

Sharing of information: Return from Hospital Stays

In BC there is a need for systems to better enable clinical information to be shared when residents return to a care home from a hospital stay. As outlined in the BCCPA report *Seniors Care for A Change* (2014), care providers must obtain information of medications that were prescribed and procedures that took place at a hospital from the client.[164]

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

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

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

[160] Percentages per 1,000 plan members

[161] Oliva, J. (2015) "Study: Remote Monitoring at Home Brings Lower Costs and Better Outcomes". *Senior Housing News*. Accessed at: http://seniorhousingnews.com/2015/01/07/new-study-uncovers-big-cost-savings-for-remote-monitoring-tech/

[162] Telecare Services Association. "What is Telehealth?" Accessed at: http://www.telecare.org.uk/consumer-services/what-is-telehealth

[163] Barakat, A., Woolrych, R.D., Sixsmith, A., Kearns, W.D., and Kort, H. (2013) "eHealth Technology Competencies for Health Professionals Working in Home Care to Support Older Adults to Age in Place: Outcomes of a Two-Day Collaborative Workshop." *Med 2.0 2013;2(2):e10.* DOI: 10.2196/med20.2711

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

remove this cost and lead to better continuity of care for the hospitalized client and increase the hours of care available to other clients by over 664 hours over 10 years.

OPTION 12 FOR CONSIDERATION:

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

Improving senior's safety through monitoring

According to Statistics Canada, over 92.1% of seniors (65 and over) are living in private households or dwellings, either as couples or alone.[165] Ageing Service Technologies (ASTs) can significantly assist seniors who choose to live independently and outside of long term care homes. ASTs are broadly defined as any technology that meets the healthcare needs of seniors or individuals with disabilities.[166] Such technologies improve quality of life for seniors and allow them to live in in their desired community while still receiving care.

Andrew Sixsmith et al (2013) cites three major generations of care technologies. The first includes telephone-based alarms requires seniors to push a button/or alarm to alert a care-giver of any potential dangers, while the second is passive technologies that are body-worn and track events such as falls or hazards.[167] Finally, the third generation which include Ambient Assisted Living technologies (AAL), aim to enhance users quality of life by linking seniors to a wider care network and providing remote services through communication devices.[168]

Assistive technologies such as sensors can also be placed around the home and alert caregivers if the senior has missed a meal, falls, or doesn't get out of bed.[169] Similarly, Telecare systems use a series of sensors to aid seniors with daily living, which alert a central monitoring unit of potentially dangerous situations. Telecare also includes technologies that can sense movement, turn on lights and remind seniors to turn off electrical appliances.[170] Technologies such as Sensors and Telecare systems can be beneficial to seniors who live alone and are faced with chronic illnesses such as Dementia.

> "social media and mobile apps have become an increasingly popular method for seniors to stay in touch with caregivers and/or family."

Wander management systems such as GPS tracking and/or radio frequency monitoring have also emerged and allow for family members or care-givers to track movements of loved ones to ensure their safety.[171] Similarly, social media and mobile apps have become an increasingly popular method for seniors to stay in touch with caregivers and/or family. Mobile apps such as Philips Lifeline, 5Star Service, and TrackerAssist are alert systems that (at

[165] Statistics Canada (2011). "Living arrangements of seniors: Families, households and marital status Structural type of dwelling and collectives, 2011 Census of Population". Catalogue no. 98-312-X2011003.
[166] U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy (2012). "Report to Congress: Aging Services Technology Study". Accessed at: http://aspe.hhs.gov/daltcp/reports/2012/astsrptcong.cfm
[167] Mortenson, B., Sixsmith A., and Woolrych, R. (2013) "The power(s) of observation: theoretical perspectives on surveillance technologies and older people." *Ageing and Society*. doi:10.1017/S0144686X13000846
[168] Turner, K., and McGee-Lennon, M. (2013) "Advances in Telecare over the past 10 years." Dove Press Journal: Smart Homecare Technology and TeleHealth. Accessed at: http://www.dovepress.com/advances-in-telecare-over-the-past-10-years-peer-reviewed-article-SHTT
[169] Diana, A. (2014). "8 Technologies Changing Home Healthcare." Information week Healthcare: Connecting the healthcare technology community. Accessed at: http://www.informationweek.com/healthcare/patient-tools/8-technologies-changing-home-healthcare/d/d-id/1318200
[170] Poutney, D. (2009). "Telecare and telehealth: Enabling independent living." *Nursing & Residental Care 3 (11).*
[171] Center for Aging Services Technologies (2011). "State of Technology in Aging Services Report." Accessed at: http://www.leadingage.org/State_of_Technology_in_Aging_Services_Report.aspx#Safety technologies

the push of a button) notify emergency personnel of a senior in need of care and help them to gain access to the individual.[172]

The use of such technologies can be highly assistive in monitoring seniors who remain outside of residential care and can give family members a piece of mind with regards to their safety.[173] Other advancements, such as the Ambient Assisted Living Joint Programme within the European Union has looked to various technologies that will promote independent, active and higher quality lifestyles for seniors through the use of Information and Communication Technologies (ICTs).[174]

Essentially, ambient assisted living (AAL) is a combination of assistive devices such as in-home sensors and smart interfaces that provide communication support to elders.[175] AAL systems track and monitor seniors through wireless and medical sensors, collect and store the data for processing and gives recognition to activities of daily living (ADL) which offer an opportunity to gain a better understanding of the changing routines and needs of seniors.[176]

AAL systems consist of medical sensors, wireless sensors, and actuator networks (WSANs), which are all interconnected to exchange data and information in a home environment.[177] Currently, the first prototypes for context-detection algorithms combined with fixed and wearable sensors are being developed that can track user history, including past and current physical activity and develop personalized feedback via a mobile device for seniors.[178]

Ageing Service Technologies such as sensors, GPS tracking systems and Telecare have come a long way in providing seniors an opportunity to live independently in an ambient environment. The application of third generation technologies such as AAL devices will further assist monitoring seniors who choose to live independently and outside of long term care homes.

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

PRIORITY 4: SENIORS SAFETY

As noted earlier, Canada's population is ageing. By 2036, the number of seniors aged 65 years or older will more than double, making up to approximately 25 per cent of the total population. In addition, it is important to note that the population of seniors 85 years and older is set to quadruple[179]. This demographic reality should be seen as imperative and a critical opportunity for better understanding and meeting the needs of the ageing population.

[172] Bhattacharya, C. (2014) "Choosing a Senior Medical Alert Service Mobile App." Independent Living. Accessed at: http://www.lifelinesys.com/content/blog/seniors/independent-living/choosing-a-senior-medical-alert-service-mobile-app
[173] U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy (2012). "Report to Congress: Aging Services Technology Study". Accessed at: http://aspe.hhs.gov/daltcp/reports/2012/astsrptcong.cfm
[174] "Europa: Summaries of EU Legislation. Ageing well in the Information Society: Action Plan on Information and Communication Technologies and Ageing". Accessed at: http://europa.eu/legislation_summaries/information_society/strategies/l24292_en.htm
[175] Mortenson, B., Sixsmith A., and Woolrych, R. (2013) "The power(s) of observation: theoretical perspectives on surveillance technologies and older people. Ageing and Society." doi:10.1017/S0144686X13000846
[176] Wan, J., O'Grady, M., and O'Hare, G. (2013) "Towards a Scalable infrastructure for Ambient Assisted Living". *IEEE Third International Conference on Consumer Electronics - Berlin (ICCE-Berlin).* DOI: 10.1109/ICCE-Berlin.2013.6697993
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[178] AALIANCE – The European Ambient Assisted Living Innovation Platform (2010) "Ambient Assisted Living – Roadmap". Accessed at: http://www.aaliance2.eu/sites/default/files/RM2010.pdf
[179] https://www.cma.ca/Assets/assets-library/document/en/advocacy/election-toolkit-members-public-e.pdf

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

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

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

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

> "Falls are the most common cause of injury among BC seniors."

A February 2013 report from the Canadian Institute for Health Information (CIHI) notes that 1 in 200 Canadian seniors also had to be admitted to hospital because of adverse reaction to a drug. Although it may be appropriate for some seniors to take several drugs, the use of multiple medications, known as polypharmacy, can increase the risks of drug interactions and side effects. In particular, polypharmacy increases risk for adverse drug reactions (ADRs), adverse drug events (ADEs), falls, hospitalization, institutionalization, mortality, and other adverse health outcomes among seniors. According to one study, 13% of seniors taking 5 or more prescription medications experience ADEs that require medical attention, compared with 6% of those taking 1 or 2 drugs.[180]

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

> "…men aged 85 to 89 have the highest rate of suicide among any age group in Canada, at a rate of about 31 per 100,000."

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

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

Ceiling Lifts: Resident and Worker Safety

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

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

Similar to the AED program, the federal government and/or provinces could work to establish a joint patient / worker safety fund for health care workers. One such priority that could be funded is an initiative is to install ceiling lifts and other retrofits to residential care homes across Canada. To address some of the safety issues related to workers in long term care a provincial health and safety association, SafeCare BC, was created in 2014 via a concerted effort by continuing care providers with support from WorkSafeBC and the BCCPA to address this issue. Worker injury trends in continuing care have widespread implications.[181] Over $23 million is spent each year on WorkSafeBC claims alone. For every dollar spent on direct claims costs, an additional $4 is spent on indirect costs such as incident investigations, rescheduling, and lost productivity.

> *"* Workplace injuries have consequences that stretch beyond financial implications. *"*

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

Building on experiences from Alberta[182], SafeCare BC endeavours to support the sector in reducing workplace injuries. As a sector-funded and driven association, they have been actively engaging with key stakeholders across the province to identify concerns and raise awareness of the issues. From delivering dementia care training in partnership with the Alzheimer Society of BC, to launching the Be Care Aware communications campaign, they have also responded to sector feedback with tangible initiatives.

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

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

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

OPTION 14 FOR CONSIDERATION:
BC explore the advancement of a collaborative Provincial Seniors Safety Strategy which could focus on specific issues including falls prevention, resident-on-resident aggression, reducing adverse drug events, suicide prevention, elder abuse and/or safety within home and community care.

OPTION 15 FOR CONSIDERATION:
That the federal government and/or provinces establish a joint fund to improve the safety of residents and health care workers including funding to install ceiling lifts and other retrofits to residential care homes across Canada.

PRIORITY 5: SENIORS HEALTH PROMOTION

As noted earlier, Canada's population is ageing. By 2036, the number of seniors aged 65 years or older will more than double, making up approximately 25 per cent of the total population. In addition, the population of seniors 85 years and older is set to quadruple.[183] Between 2011 and 2031, BC's senior's population (age 65+) is expected to increase 93% compared to a 14% increase in the working age population and a 21% increase in the population under 15 years of age.[184]

Health care spending is significantly more expensive for seniors than for the rest of the population. The cost of providing health care to those between 65 and 90 years old is approximately double the cost of providing care to all those under age 65.[185]

These costs, however, are not spread evenly amongst seniors. While many seniors are fit and require relatively little care, some seniors require significant acute and long-term care.

In general, the ageing population will put additional pressures on the health care system, particularly in dealing with mental health and chronic diseases. As outlined in *Setting Priorities for the BC Health System*, the ageing of the population is important as the likelihood that a person will have at least one chronic condition or life-limiting illness increases significantly with age. As a result, so does their need for health services. A large percentage (41%) of Canadian seniors are also dealing with two or more select chronic conditions, such as diabetes, respiratory issues, heart disease, and depression and many are experiencing a decline in physical and/or cognitive functioning[186].

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

[184] British Columbia's population is growing and aging, with the fastest growing seniors' population in Canada. The population over 65 is expected to increase from about 14 per cent to 24 per cent of the total provincial population between 2006 and 2036.

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

[186] Health Council of Canada. Seniors in Need, Caregivers in Distress (2012).

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

Such a strategy, for example, could outline various initiatives or approaches to promote seniors physical and mental well-being, including outlining best practices among jurisdictions in these areas. This could include areas such as reducing impacts of ageing, falls prevention, nutrition and exercise guidelines, mental health, senior's isolation, etc...

Frail Seniors

As outlined in *Setting Priorities for the BC Health System*, while seniors use more health services, they are not a homogenous group and only a subset of seniors requires high cost services. Those using residential care represent 1% of the total population and only 9% of the population over 75, but use 25% of health system resources.[187]

Once people enter residential care, the majority of their publicly funded health care is provided by the residential care home (91%). However, a large driver of total cost occurs in the year prior to, and the year of, entry into residential care - with high rates of hospitalization via emergency departments en-route to residential care. For example, more than seven out of every 10 new entrants to residential care have at least one inpatient hospitalization in that year.

"Once people enter residential care, the majority of their publicly funded health care is provided by the residential care home (91%)."

The health status of seniors prior to entering residential care is an important factor in the analysis of population and patient needs. More than 60% of people entering residential care have been identified as having a high complexity chronic condition in the previous year and it is likely that many will also have fallen into the "frail in community" category as well. These seniors require a range of health supports to manage the challenges of increasing frailty, which is often combined with chronic diseases such as dementia that can profoundly affect their ability to maintain independence.[188]

It is estimated frail seniors may be under-served by existing community and support services, which may only hasten the need for high-intensity residential care. Once in residential care, there are challenges as to how to provide dignified and compassionate care given the increasing number of patients suffering with moderate to advanced dementia and the associated care and behavioural challenges this presents.

This confirms the continued need for a strategic and operational focus on improving health interventions and services for a subset of seniors using a targeted population approach to better manage chronic conditions, avoid unnecessary emergency department visits and hospitalizations, and better plan for the impact of frailty on a senior's ability to continue to live safely in the community. Improving the quality of geriatric care across the entire health care system continuum is critical to ensuring that seniors receive the most appropriate care to promote the best outcomes and quality of life, including the need for palliative care as they approach end-of-life. The costs of inappropriate hospitalization versus expanded and more effective care options in community is a key consideration in any strategy going forward.[189]

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

As discussed earlier, preventative services for seniors are vitally important. Prolonged inactivity during hospitalization can lead to a loss of function and mobility. Seniors who are admitted to acute care are often discharged with a reduced level of functional ability and never recover their previous level of independence. The issue of frail seniors is one that may warrant further collaboration amongst provinces either as a stand-alone issue and/or one that could be addressed as part of other areas such as ageing in place, dementia, healthy ageing / age-friendly communities or senior's health promotion.

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

CONCLUSION

With the ageing population, the issue of seniors, including seniors' health and continuing care, has gained increased importance. Provincial/territorial (P/T) governments have also focused increasingly on seniors through the creation of various plans (i.e. BC Seniors Action Plan), as well as organizations and positions to better address seniors issues. For example, in March 2014 British Columbia (BC) announced the appointment of Canada's first Seniors Advocate.

As part of this project, the BCCPA has created two separate White Papers on the issues of sustainability and innovation in the continuing care sector. The first paper, which was released, outlines issues around funding such as:

- Separation of operation and funding;
- Provision of long-term sustainable funding to the continuing care sector to better account for acuity and other factors;
- Reallocation of acute care funding to home and community care;
- Ensuring greater transparency in developing funding models and allowing further input among care providers;
- Explore new ways to fund continuing care, including the creation of a federal infrastructure fund, outcome based funding and social financing; and
- Explore new funding mechanisms for the continuing care sector including long term care insurance and vouchers.

While this second paper deals indirectly in some cases with funding issues, the focus is largely on other areas that could assist in advancing seniors care and improving the sustainability of the continuing care sector, including:

- Development of new care models and age-friendly approaches (i.e. Continuing Care Hub, etc.);
- Dementia;
- Technology
- Seniors Safety; and
- Seniors Health Promotion (including Frail Seniors).

The suggested areas also align well with those in the BC document Setting Priorities for B.C. Healthy System that was released in February 2014. They also touch on many of the themes outlined in the Ministry of Health Policy papers released in February 2015 (see Appendix A).[190] Overall, the Ministry papers identify key population areas including caring for the frail elderly and chronically ill. As noted, the growth in demand for health care for frail elderly living in residential care, who already utilize about 25% of health services, is projected to increase by 120% by 2036.[191]

The BC Ministry of Health papers also identify various cross-sector health strategic service priorities that will result in substantive first steps to a repositioning of the BC health system over the coming five years to better meet both increasing and changing patterns of demand, including:

- Improving the effectiveness of primary, community care (including residential and home care), medical specialist and diagnostic and pharmacy services for patients with moderate to high complex chronic conditions, patients with cancer, patients with moderate to severe mental illness and substance use;
- To significantly reduce demand on emergency departments, medical in patient bed utilization, and residential care;
- Significantly improving timely access to appropriate surgical treatments and procedures; and
- Establishing a coherent and sustainable approach to delivering rural health services.

Development of new care models and age-friendly approaches

Utilizing capacity and further collaboration on new Continuing Care models

Consistent with Ministry of Health's cross health sector strategic priorities, it will be important for any future Continuing Care Collaborative to review options for new delivery models including, but not limited to the creation of Continuing Care Hub networks and geriatric centres of excellence in order to optimize ER utilization, reduce acute care congestion and better care for the frail elderly as well as those with chronic conditions and dementia.

Along with supporting the development of multidisciplinary practices to support such models, it will be crucial to look at the role of new and emerging care providers including nurse practitioners and physician assistants. In particular, this paper suggests government explore the development of new nursing professional led teams to provide continuing care residents and their care provider's access to timely, high quality urgent care support within the comfort of their own homes. It also suggests looking further at what role physicians, physician assistants, and nurse practitioners can play within the continuing care setting to help improve

[190] On February 18, 2015 the BC Ministry of Health released a series of papers on its website covering five broad areas of the health system including: patient centered care, health human resources, rural health, surgical services as well as primary and community care. See: http://www.gov.bc.ca/health/setting_priorities.html

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

health outcomes for seniors, reduce emergency visits and potentially reduce the burden faced by care aides and nurses.

Age-friendly approaches

With respect to the development of new care models and age-friendly approaches, this paper advocates a program to better integrate residential care homes as part of any age-friendly community approach. The paper also explores innovative new models of care including the Green House Model. Likewise, it also advocates for the adoption of new palliative care models, including where necessary, providing funding to improve integration between continuing and end-of-life care.

End-of-life Care

Improving end-of-life care is also critical for seniors as is outlined in this report. This includes not only ensuring end-of-life care beds are available but also improving the integration of end-of-life (EOL) care with continuing care. Currently much of the care provided within residential care homes could be considered end-of-life as the average length of stay (ALOS) in a BC care home is approximately 16 months. If a senior living in such a home does not die there, they may instead spend some of their remaining days in an alternative care setting such as a hospital or hospice. As outlined in the 2015 BCCPA *Quality-Innovation-Collaboration* paper, while the existing unused capacity in residential care could be potentially used to reduce ALC days, it could also be used potentially to increase the number of end-of-life care beds.

This option from a fiscal perspective would be preferable then a hospital as costs for seniors receiving care in a residential care home is significantly less.

Dementia

With respect to the issue of dementia, the paper explores various models of care including dementia villages, dementia friendly communities and Butterfly Care Homes. Namely this report suggests the establishment of dementia friendly care homes program in which a specific designation could be provided to residential care homes that have made redesigns or changes to accommodate dementia patients and/or where specific dementia training has been provided to staff. Given the importance of the dementia issue, it also suggests BC endorse the advancement of a National Dementia Strategy or Declaration with federal participation, which should include investing in research and ensuring capacity and appropriate funding in the continuing care sector.

Technologies

With respect to the use of technology to improve sustainability and innovation in the continuing care sector, this paper looks at a number of areas including: the use of technology to facilitate seniors care ageing in place or reducing social isolation of seniors (i.e. home health monitoring and increasing internet access for seniors); the adoption of new electronic information systems that facilitate the sharing of resident information across the continuing care system; and new technologies that improve the safety of seniors particularly through new monitoring systems.

Seniors Safety

Along with the use of technologies to improve senior's safety this paper advocates for the development of a collaborative Seniors Safety agenda which could focus on specific issues including falls prevention, resident-on-resident aggression, reducing adverse drug events, suicide prevention, elder abuse and/or safety in home and community care facilities.

Seniors Health Promotion and Frail Seniors

Finally, with respect to the issues of senior's health promotion and frail seniors this paper discusses the development of a Seniors Health Promotion Strategy Framework, which could outline various strategies to promote seniors physical and mental well-being, including best practices among jurisdictions. It also addresses the issue of frail seniors as a critical part of any Seniors Health Promotion Strategy.

OPTIONS FOR REVIEW / CONSIDERATION

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

New Models of Care (Continuing Care Hubs)

1. That as a key priority any future Continuing Care Collaborative as a key priority review options for new delivery models such as the Continuing Care Hub to reduce acute care congestion and ER visits as well as better care for frail elderly and seniors with chronic conditions and dementia.

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

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

Age-friendly Communities

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

Green House Models

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

Dementia Models of care

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

6. That in partnership with relevant stakeholders including care providers, health authorities and the BC Alzheimer's Society, government explore establishing a dementia friendly homes program, in which a specific designation could be provided to care homes that have made specific redesign changes to accommodate dementia patients and/or where specific dementia training has been provided to staff.

End-of-Life / Palliative Care Models

7. The Ministry of Health and Health Authorities work with the BC Care Providers Association (BCCPA) and other stakeholders to develop strategies to better utilize the existing excess capacity in the continuing care sector to increase capacity with respect to end-of-life (EOL) care.

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

PRIORITY 2: DEMENTIA

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

PRIORITY 3: TECHNOLOGY

Social Isolation

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

Improving access to medical information through electronic records

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

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

New technologies to improve senior's safety

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

PRIORITY 4: SENIORS SAFETY

Provincial Seniors Safety Strategy

14. BC explore the advancement of a collaborative Provincial Seniors Safety Strategy which could focus on specific issues including falls prevention, resident-on-resident aggression, reducing adverse drug events, suicide prevention, elder abuse and/or safety within home and community care.

Ceiling lifts

15. That the federal government and/or provinces establish a joint fund to improve the safety of residents and health care workers including funding to install ceiling lifts and other retrofits to residential care homes across Canada.

PRIORITY 5: SENIORS HEALTH PROMOTION

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

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APPENDICES

Appendix A: KEY POINTS FROM THE MINISTRY OF HEALTH POLICY PAPERS RELEVANT TO CONTINUING CARE SECTOR AND BCCPA RESPONSE

- Existing expenditures will be protected, appropriate reallocations from the acute to the community services sector must become part of go forward health authority planning and going forward a majority of net new funding must be assigned to developing primary and community services.
- Available primary and community care operational and capital funding will be used to improve community-based services in a manner that is reflective of the changing population health care needs and the principles of community based services, integration, quality and value for money.
- Recommendations will be subject to consultation and refinement over winter but it is intended that the final recommendations will be implemented as part of a multi-year primary and community care transformational plan, starting April 2015.
- The Ministry of Health will collaboratively conduct a review of the major primary and community care policy, initiatives and incentives reviewed in this paper late spring of 2015 to ensure they are aligned with the common set of principles set out above and streamlined into a coherent go forward policy framework.
- A single oversight and shared governance model will be developed for primary and community care that includes representation from key players involved in primary and community care. There will be a two-day forum in late spring to discuss the outcome of the review and feedback on the proposed directions set out.
- A range of multidisciplinary practices will be developed across communities with the capacity to address longitudinal health care needs of older adults with chronic medical conditions, potentially requiring home support, cancer care, and/or palliative care; they will have ability to respond effectively to urgent and emergency care where required for short periods of time with effective linkages to higher levels of services.
- These practices will be linked to residential care services that include bed capacity designated for short term acute medical care needs including short-term stays for respite, end-stage palliative care or more short stay interventions than can be provided through home physician and nursing care.
- Over the next 3 years, implement the Refreshed Dementia Action Plan including the four priorities with their concrete actions: increase public awareness and early recognition; support individuals to live independently and safely; improve the quality of care in residential care facilities and improve palliative and end-of-life care; and increase system supports and adoption of best practice in dementia care.
- Continue the implementation the End-of-Life Care Action Plan and its key actions to improve the way health care providers meet the needs of people coping with end of life, including their families and caregivers.
- Improving geriatric care across the continuum of health service delivery is a key factor in ensuring appropriate care designed to promote the best outcomes and quality of life.
- Related to the above challenges is the way that home and community care services are currently funded, with a co-payment model with user fees charged to clients based on their income for home support, assisted living and residential care services.
- With redesign of services and the transition to new innovative care models focused on interdisciplinary teams, new options for subsidizing clients who may not be able to afford the cost of necessary services

need to be explored. This will include exploring how other jurisdictions fund home support, assisted living and residential care services, and include a dialogue with health authorities and major stakeholders on how to provide the services.

- For the balance of 2015/16 through 2016/17 it is proposed that there will be three cross-sector health sector strategic service priorities that will result in substantive first steps to a repositioning of the BC health system over the coming five years to better position it to meet both increasing and changing patterns of demand:
    - Improving the effectiveness of primary, community (including residential care), medical specialist, and diagnostic and pharmacy services for patients with moderate to high complex chronic conditions, patients with cancer, patients with moderate to severe mental illness and substance use such as to significantly reduce demand on emergency departments, medical in patient bed utilization, and residential care.
    - Significantly improving timely access to appropriate surgical treatments and procedures.
    - Establishing a coherent and sustainable approach to delivering rural health services
- B.C. utilization and current funding approaches to residential care services are suboptimal from a number of perspectives:
    - There are opportunities to provide support services to patients both in the community and assisted living facilities that could reduce the need for residential care;
    - There are opportunities to increase planned admissions to residential care rather than admissions through the ER and in-hospital bed use;
    - There are opportunities to better meet the care (including the increasing number of patients with dementia) and health needs of elderly patients in residential care facilities rather than through hospitals, including the development of short term respite beds for community patients with less acute medical conditions and complications;
    - There is increased fiscal capacity to add placements through private capital funding and longer term publicly funded contracting of placements.
- Over the coming three months we will be asking people across the health sector to read, think and dialogue the Cross Sector Policy Discussion Papers. We will be seeking feedback through a formal process with Health Authorities, Patients as Partners, Professional Colleges/Associations, the Doctors of BC, ARNBC, Post-Secondary Institutions and research community, and Health Service Unions.
- Following consultation with Health Authority Boards and the Minister of Health, we will report out by mid-spring on the feedback, our assessment of consensus, any changes to the policy direction, and the concrete actions we are proposing to move forward on over the coming two years.
- The Ministry of Health will create further space for dialogue with stakeholders and Patients as Partners by hosting a primary and community care public forum in late spring 2015. By attending the forum to share your experiences and by taking advantage of other opportunities for dialogue in your communities you could help shape the pace of change.
- The Ministry of Health in collaboration with Health Authorities, Colleges, Associations and Unions, Educators, and other stakeholders, will establish a single provincial Health Human Resource Framework that will be used to plan, link and coordinate go-forward actions and initiatives.
- British Columbia has the fastest growing senior's population in Canada. The number of seniors in BC is expected to almost double by 2036, and the 75+ population will grow by almost 130 per cent over the

same time. While the majority of seniors are comparatively healthy and have few serious health concerns, others within this age cohort are not as fortunate.

- Residential care accounts for, by far, the majority of expenditures in this area. Although frail seniors in residential care represent only one per cent of the population, they use 21 per cent of all health system expenditures included in the matrix. A large driver of this cost is the provision of 24/7 residential care.
- British Columbia's 303 residential care facilities are home to almost 42,000 residents, with an average age of 85 years. Many of these residents have one of more chronic conditions at varying levels of severity. For example, 61.4 per cent have dementia and 20.2 per cent have diabetes. In addition, 6.7 per cent have cancer while almost one-third have severe cognitive impairment. These seniors require a wide range of health supports to help manage such medical challenges, which are often what precipitated the entry into residential care in the first place.
- Most seniors prefer to remain in their homes and communities rather than move to a care facility. When community care provides a viable alternative, patient experience is enhanced. When seniors are admitted to acute care, they can experience prolonged periods of inactivity during which time their level of functional ability is reduced and may never recover. The quality of life is better when an individual is able to be sustained in their home and community.
- The per-person cost of caring for a frail senior through home and community support is less than half the cost of caring for them in residential care (e.g., residential care: $59,210; community: $20,290; community with high chronic condition: $29,690). This is true even though frail seniors in the community have a higher number of emergency department visits than those who live in residential care (i.e., 18 per cent for frail seniors living in the community versus 7.1 per cent for those living in residential care).
- In 2015/16, Regional Health Authorities will develop three year local community plans for all rural and remote communities to create environments that foster healthy behaviours and programming that improves the health of the population. These plans will be developed in collaboration with local communities. The plans will be referenced in their Service Plans, be available on the health authority web site, and attached to their Detailed Service and Operational Working Papers.
- By September 30, 2015, each of the Regional Health Authorities will provide an assessment of the status of primary and community care services across all rural, small rural and remote communities and a specific three year plan on how they intend to move forward with this policy direction as a region. This plan will be referenced in their Service Plans, be available on the health authority web site, and attached to their Detailed Service and Operational Working Papers. It is recognized that this process will take time and engagement.
- Home Support and Residential Care in Rural Communities (Section 2.2): In collaboration with communities and patients, Regional Health Authorities will initiate work on exploring innovative and cost effective service options to better support ageing in place but also clarity on residential care options for when they are required to allow active preplanning by older adults and their families. This work will be reported in their Service Plans, be available on the health authority web site and attached to their Detailed Service and Operational Working Papers starting 2015/16.
- The Provincial Surgery Executive Committee (PSEC) has been given the mandate and authority to drive a common vision and a comprehensive policy framework, inclusive of the entire surgical care continuum, that gives priority to improving the quality of surgical services and embed the philosophy of patient centred care into strategic and operational processes. PSEC will facilitate collaborative partnerships between patients, health authorities, physicians, the Ministry of Health, the BC PSQC, Doctors of BC and other relevant nursing and allied health stakeholders.

- A growing number of elective surgeries are now being undertaken when patients are into their 80s. The increasing longevity of the seniors' population is a key driver of surgical repair following hip fracture. The elderly are at a higher risk of fracture from falls due to poorer vision, poorer coordination, and reduced strength. As the 85 year old plus age group increases, the demand for hip replacement following fracture will increase, particularly in the female population.

BCCPA Response to MOH Policy Papers

In regards to the Ministry of Health policy papers the BCCPA would like to see more concrete solutions to reduce unnecessary hospitalizations, including through the greater use of residential care, assisted living and home care / support. As outlined in *Setting Priorities for the BC Health System*, a large driver of total cost occurs in the year prior to, and the year of, entry into residential care - with high rates of hospitalization via emergency departments en-route to residential care. As outlined later in this paper, we provide proposals to reduce unnecessary hospitalizations including through the development of new long-term care models.

Following a review of the Ministry papers, the BCCPA agrees with a number of recommendations. In particular, some of the potential positive points and/or opportunities as outlined in the papers include:

- Protection of existing expenditures in primary and community care while reallocating funding away from more costly acute care.
- Openness by the Ministry of Health to engage with various stakeholders on the ideas presented in the paper, including a review of major primary and community care policy.
- Development of new Dementia Action Plan, in which the BCCPA is currently providing input on.
- Implementation of the End-of-Life Care Action Plan, including commitments to double number of hospice spaces by 2020.
- Exploring how other jurisdictions fund home support, assisted living and residential care services as well as further dialogue with health authorities and major stakeholders on how to provide services.
- Highlighting alternate level of care (ALC) beds issue including opportunities to increase planned admissions to residential care rather than admissions through the ER and in-hospital bed use.
- Having single oversight and shared governance model for primary and community care that includes representation from key players involved in primary and community care.

Some of the potential concerns as outlined in the documents include the overt focus to reduce residential care services with greater home care. In particular, the Primary and Community Care Paper notes BC utilization and current funding approaches to residential care services are suboptimal and that there are opportunities to provide support services to patients both in community and AL facilities to reduce need for residential care. The paper also notes a couple of times, seniors' strong preference to remain in their homes and communities rather than move to a care home.[192]

As mentioned earlier, although younger seniors may prefer to age in place this may change as they get older. As a result, we suggest undertaking a research project to review how a senior's preference for ageing in place or at home may change over time depending on their specific age and/or level of acuity. In addition, there should be further studies on the costs of home care versus long-term care for seniors as their levels of acuity rise. Along with the earlier concerns about ensuring seniors with higher levels of acuity are cared for

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

appropriately, it will be important that stakeholders including BCCPA are involved in any process or assessment with respect to changing the delivery of rural health services for seniors.

Other positions, although not specifically outlined in the papers, that the BCCPA would like to put forward for consideration include:

Increased collaboration

- Establishing a new *BC Continuing Care Collaborative* involving the Health Authorities, Ministry of Health, Denominational Health Association, and the BC Care Providers Association.
- Reintroduce the Managing Changing Need Policy as part of BC's Home and Community Care Policy Manual or at minimum ensure that similar provisions exist elsewhere.

Review of funding lifts and Direct Care Hours

- Working in consultation with operators and health authorities to develop a residential care funding model that accurately factors in increases to operating costs including a standard province-wide methodology on how base funding and/or annual funding increases are calculated for contracted service care providers.
- Reviewing funding lifts within Health Authorities with the goal of consistency, fairness, and sustainability with respect to per diem rates, including as outlined in the 2012 Ombudsperson report, working with the Health Authorities to conduct an evaluation on whether residential care budgets are sufficient to meet the current needs of the population.
- Development of a continuing care funding model that is responsive to and appropriate to the acuity and complexity of clients in care as well as adheres to the core principles of timeliness, sustainability, equity and transparency.
- Establishment of a long-term predictable funding model by end of fiscal 2018 that is outlined in any contract arrangements with the health authorities, including more long-term budgeting with increases to per diem client rates outlined over a 3 to 5 year period.
- Reviewing Direct Care Hours (DCH) provided per resident to ensure greater consistency among care homes and more fairness in the provision of care to clients across the sector. This includes providing care operators with greater flexibility to manage their DCH over a reasonable period, namely at minimum on an annual basis as opposed to quarterly.

Review of new funding models

- Reviewing further the concept of long-term care insurance to address issues of an ageing population and increasing continuing care expenditures.
- Explore use of vouchers including whether it could be provided to seniors to pay for continuing care, including residential care, home care and assisted living services in lieu of government provision of such services.
- Provide clearer lines of responsibility and accountability to taxpayers and residents by separating bodies that regulate care homes and that provide and allocate funds from those that operate them.

Better Dementia and Palliative Care

- Development of a program to better integrate residential care homes as part of any age-friendly community approaches, including Dementia Friendly Communities with funding to retrofit existing care homes to support such an approach.

- Development of a dementia friendly care home program in which a specific designation could be provided to care homes that have made specific redesign changes to accommodate dementia patients and/or where specific dementia training has been provided to staff.
- Endorsement of a National Dementia Strategy with federal participation, which should include investing in research and ensuring capacity and appropriate funding in the continuing care sector.
- Adoption of new palliative care models including where necessary providing funding to improve the integration between long-term and end-of-life care, including new long-term care models with expanded roles in caring for seniors.

Improving Seniors Safety and Quality Care

- Funding to support use of technology and the existing residential care infrastructure to facilitate seniors care ageing in place or reducing social isolation of seniors (i.e. home health monitoring, increasing internet access for seniors and seniors drop in centres) as well adoption of new technologies that improve the safety of seniors (i.e. new monitoring and surveillance systems).
- Implement legislation that allows patient information to flow through the health care system with the resident particularly the sharing of information after a return from a hospital stay.
- Advancement of a collaborative Seniors Safety agenda which could focus on specific issues including falls prevention, resident-on-resident aggression, reducing adverse drug events, suicide prevention, elder abuse and/or safety in home and community care facilities.
- Development of a provincial coordinated strategy to deal with workplace injuries in the continuing care sector including dedicated funding to install patient lifts and other retrofits to residential care homes across BC.

APPENDIX B: REVIEW OF OLTCA REPORT

REVIEW OF OLTCA REPORT ON LONG-TERM CARE (LTC)

BACKGROUND

- In April 2011, the Ontario Long Term Care Association (OLTCA) established a 22-member Long Term Care Innovation Expert Panel to develop a consumer-oriented strategy that would stimulate innovation, help address growing demand, and support sustainability within the LTC sector.
- The Expert Panel released a report in March 2012, titled "Why Not Now: A Bold Five Year Strategy for innovating Ontario's System of Care for Older Adults."
- The Why Not Now report sets out a vision and comprehensive five-year strategy for the long term care sector in Ontario, including 67 recommendations that aim to improve access to care, while also providing high quality and cost-effective care for seniors in Ontario.
- While long term care in Ontario is currently delivered through one predominant model of care, six models proposed in the Why Not Now report challenges long term care providers to think about how to best structure and deliver services to meet the needs of seniors.
- The six models of care include: Post-Acute Skilled Nursing Model; Specialized Stream Model; Hub Model; Integrated Care Model; Designated Assisted Living Model; and Culture Change Model.

Post-Acute Model

Specializes in short-term skilled nursing and intensive rehabilitation for medically complex and injured or disabled older adults returning to the community following a hospital admission (i.e. assess and restore programs). Care is provided by a team of health professionals (i.e. nurses, occupational therapists, physiotherapists, speech language pathologists, audiologists) with a focus on stabilizing or improving the person's condition and enabling their return to the community. Applicable to homes in urban settings or locations close to a hospital.

Specialized Stream Model

Provides specialized care for specific high need populations, such as persons with late stage dementia, severe mental illness and addictions, and those at end of life. Combines specialized medical care, including pain and symptom management, with social supports to maintain residents' quality of life, and support relatives and other caregivers. Applicable to small homes, wings within larger homes, or collaborative initiatives between LTC homes and system partners.

Integrated Care Model

Integrates housing and home and community care to support a certain population of seniors as their care and housing needs change over time. Could provide incentives for effectively managing chronic conditions, reducing emergency department visits and avoiding hospital admissions, as well as managing LTC admissions within the continuum. Could be modified to support residents discharged from hospital or short-stay beds that require further follow-up or intensive but intermittent care. Well-suited to ethnic, rural, or faith-based homes.

Hub Model

Integrates LTC with other services for seniors (i.e. primary care, chronic disease management, oral care, community support services, specialized geriatric services, etc.). Services could be co-located or managed by the LTC home. Capitalizes on available physical space and centralizes expertise to improve advantage of investments in physical plant and existing LTC programs and services. Applicable to homes in smaller or more rural communities, or those with space for colocation of additional services.

Designated Assisted Living Model

Provides a safe and secure environment for physically and/or mentally frail older adults that need assistance with the activities of daily living or require light nursing care to continue to live independently. Bridges the gap in service delivery for clients with moderate care needs, as traditional LTC homes almost exclusively house seniors with high acuity. Could enable providers with excess capacity in retirement homes to designate units or floors as supportive housing services, which would be eligible for public funding. Well-suited to northern or rural communities looking to redevelop to provide additional housing options for seniors, which are often lacking.

Culture Change Model

Resident-centred model of the traditional long stay LTC home. Focuses on creating a home-like environment that places the resident's needs, interests and lifestyle choices at the centre of the care plan and daily routine, and encourages all residents, including those with dementia, to participate in decisions related to their care and care environment. Relevant to all residential care settings. Particularly applicable to homes that have a younger population or population with more moderate care needs, as well as homes that specialize in palliative end of life care.

APPENDIX C: INTEGRATING HEALTH PROVIDERS INTO LONG TERM CARE

Integrating Physicians into Long Term Care

Nova Scotia – Care by Design (CBD)

A new model of care in long-term care facilities (LTCFs) called Care by Design (CBD) recently implemented within the Capital District Health Authority (CDHA) in Halifax, NS, addresses concerns of a previously uncoordinated care system in LTCFs, reduction of family physician services and on-call coverage for LTCF residents, and high rates of ambulance transports to emergency departments (EDs).

The core of CBD is dedicated family physician coverage for each LTCF floor, with regular on-site visits; on-call coverage, 24 hours a day, 7 days a week; and standing orders and protocols. Other key aspects of CBD include an extended care paramedic (ECP) program, providing on-site acute care, and facilitating coordinated transfers to the ED; a new comprehensive geriatric assessment (CGA) tool; performance measurements; and interdisciplinary education.

Care by Design improves on-site care for long-term care facility residents and improves family physicians' experiences of providing care in several ways:

- The model improves clinical efficiency by reducing travel time to visit residents in multiple long-term care facilities;
- The Care by Design physician team provides peer support when addressing clinical challenges;
- The Care by Design physician team shares on-call time, reducing individual burden;
- Regular visits within one long-term care facility floor or wing promote better communication among care teams, residents, and family members; and
- The coordinated interdisciplinary team improves continuity and quality of care for residents.

Physician Assistants

Physician Assistants (PAs) are essentially healthcare professionals educated in the medical model to practice medicine under the direction of a physician. In a formal practice arrangement with a physician, PAs practice medicine which includes obtaining medical histories and performing physical exams, ordering and interpreting laboratory and diagnostic tests, providing therapeutic procedures, prescribing medications, and educating and counselling patients.[193]

Recent studies have highlighted the benefits of PAs including that they can increase access to medical care for seniors. In particular, having a full-time PA on staff at a nursing home or long-term care can translate into patients being evaluated sooner and can prevent transfers to the hospital in many cases. A study from the U.S. shows that PAs in long-term care settings have decreased hospital admission rates by 38% for seniors. PAs can also have an important preventive role in care of geriatric patients.[194]

While relatively new in the Canadian health care setting, PAs have been practicing in the Canadian Armed Forces for over 50 years and have been instrumental in providing a high level of care to soldiers on the front

[193] Although educated and qualified as generalists, PAs receive additional education, training, and experience on the job and may work in primary care or specialty areas in a wide variety of practice settings. University of Manitoba. What is a Physician Assistant? Accessed at: http://umanitoba.ca/faculties/health_sciences/medicine/education/paep/whatisapa.html

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

lines. PAs also practice in a variety of specialties including emergency rooms, primary care, orthopedics, psychiatry, neurosurgery in a number of provinces including Alberta, Manitoba, Ontario, and New Brunswick. [195]

Integrating Nurses into LTC

Nurse Practitioners

With respect to NPs, a UK study estimates that they could perform about 20% of the work currently undertaken by GPs.[196] Since 2005, BC began graduating and regulating NPs, with about 45 students per year. [197] Overall, progress in implementing NPs has lagged behind other provinces including Ontario and Alberta. One of the major problems has been that insufficient funding has left many NPs unable to obtain employment.[198] Although in 2012 the BC government announced $22.2 million to pay for 190 positions over the next three years, it is not clear whether some commitments will continue in the future.[199] As of January 2014 there were only 287 NPs registered in BC. Another survey also shows that less than 10% NPs who responded (8% or 7 in total) identified residential care as a practice setting.[200]

Integrated Nursing Teams

One example of an integrated team are the Long-Term Care Nurse-Led Outreach Teams (NLOTs) that the Ontario Ministry of Health established in 2008 in each LHIN as one of several projects implemented under its Emergency Room and Alternate Level of Care (ER/ALC) Strategy. NLOTs bring together a dedicated team of nursing professionals to provide long-term care residents and their care provider's access to timely, high quality urgent care support within the comfort of their own homes. The NLOT model emphasizes three essential components:

1. Prevention: NLOT nurses visit their affiliated long-term care homes to build front-line provider capacity to detect and respond to acute changes in a resident's condition.
2. Avoidance: Long-term care providers contact the NLOT nurses to allow them to provide telephone mediated assessment and coaching and/or an on-site visit to assist in assessing urgent issues and determining the need for hospital care. Finally, NLOT nurses provide interventions such as intravenous therapies, antibiotic management, oxygen administration, and palliative support that can allow a resident to receive the care they need at home and, thereby, prevent an unnecessary transfer to an acute care setting.
3. Flow: NLOT nurses work in partnership with local ED and hospital care providers to enable rapid transfer, intervention, and discharge for care that requires an acute care setting.

The NLOT model is intended to minimize avoidable transfers to EDs and hospital admissions, to reduce hospital lengths-of-stay for residents who can be discharged home earlier with appropriate supports and

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[195] CAPA. New Study Shows Canadians Want Physician Assistants to Play a Greater Role in Their Health Care. October 24, 2014. Accessed at: http://www.newswire.ca/en/story/1433470/new-study-shows-canadians-want-physician-assistants-to-play-a-greater-role-in-their-health-care.
[196] Ministry of Health. Primary and Community Care Policy Paper. February 2015. Accessed at: http://www.health.gov.bc.ca/library/publications/year/2015/primary-and-community-care-policy-paper.pdf
[197] In BC a NP is a Registered Nurse with a Master's Degree, advanced knowledge and skills who provides health care services. NPs are able to diagnose, consult, order interpret tests, prescribe, and treat health conditions. They also work independently and collaboratively to provide British Columbians with Primary and Specialized Health Care using a team-based approach.
[198] Are nurse practitioners the cure for B.C.'s family doctor shortage? Globe and Mail. Rod Mickelburgh. January 5, 2013. Accessed at http://www.theglobeandmail.com/news/british-columbia/are-nurse-practitioners-the-cure-for-bcs-family-doctor-shortage/article6970838/
[199] BC funds more Nurse Practitioner positions. Ministry of Health media release. May 31, 2012. Accessed at: http://www.newsroom.gov.bc.ca/2012/05/bc-funds-more-nurse-practitioner-positions.html
[200] A Survey of Nurse Practitioner Practice Patterns in British Columbia. University of Victoria and Michael Smith Foundation for Health Research. January 2014. Accessed at: http://www.uvic.ca/research/projects/nursepractitioners/assets/docs/NP%20Practice%20Patterns%20Report.pdf

follow-up, and to build the clinical capacity of long-term care providers with knowledge around the management of urgent and palliative issues.[201]

In the U.S., the Centres for Medicare and Medicaid sponsored the development of the INTERventions to avoid Acute Care Transfers (INTERACT) II initiative. The program was implemented to build front-line clinical capacity to improve the quality of care of long-term care residents through the implementation of an evidenced-based system of assessment tools, protocols, and care pathways. In its evaluations, this model has shown its ability to encourage inter-professional collaboration in the creation of resident care plans, avoid unnecessary ED transfers and facilitate appropriate ones.

Teaching Long Term Care Homes

Teaching Nursing Homes (TNH) or Teaching LTC Homes (TLTCH) show promise as sites for preparing a health workforce to care for older adults and providing a platform for research into better care. TLTCHs allow nursing students to gain a more practical perspective on the skills required for a career in geriatrics, and also help to improve perceptions about LTC homes, notably that among medical practitioners.

Teaching Nursing Homes in the United States: Early Lessons

A U.S. TNH initiative was funded by the Robert Wood Johnson Foundation and was later implemented by the National Institute on Aging between 1982 and 1987. Eleven schools and twelve nursing homes participated in the early phases of this project, which aimed "to increase the quality of care; to increase the interest in geriatrics in the school of nursing; to improve staff development; and to ensure independent financial survival for the program."

While the initiative achieved some good results, the program ended in the late 1980s due to insufficient long-term funding. As TNH homes take some years to produce measurable success, and many stakeholders and state governments were impatient for results, additional funding and support was not available after the Foundation's resources were depleted. The initiative also suffered from the persistence of a "culture gap" between academic nursing schools and nursing homes, which contributed to miscommunication, and misunderstanding. Moreover, because it was modeled after the medical school system, the TNH initiative emphasized medical care whereas others thought that more emphasis should have been placed on the 'social' dynamics of nursing care.

Despite its challenges, the U.S. initiative produced some positive outcomes. For instance, at one participating school—Rutgers University—patient care and conditions significantly improved within the first year, including: a 50 per cent decrease in bedsores; a 23 per cent decrease in the use of physical restraints in one unit; a 25 per cent decrease in the use of enemas; an 18 per cent fewer acute care transfers than previous years; and a 7 per cent drop in hospitalization rates during the first three months.

The TNH program significantly improved undergraduate and graduate students' attitudes toward older adults and strengthened geriatric curriculum clinical experiences, faculty preparation, and research. Lower turnover rates of nursing leadership and staff, and improved research opportunities for faculty also emerged.

Teaching Nursing Homes in Norway: A Model Initiative

The Norwegian TNH program differs significantly from the U.S. model, as it is was designed in collaboration with, and is funded by, the Norwegian government. The TNH program aims to improve the competence of

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

staff, enhance the prestige of working with older people, stimulate the development of services, facilitate research on the care of older persons, and develop strong learning environments for students. Norwegian TNHs were established on a permanent basis as of 2004 with funding from the Department of Health and Social Services.

Design and development of the Norwegian program was more gradual and strategic than the U.S. initiative. Four developmental phases were completed prior to the introduction of the national, permanent TNH program:

1. In Phase 1, extensive research was conducted to inform the initial design of the program;
2. Phase 2 involved experimentation wherein each participating institution developed a 'research and development unit' to monitor and measure early performance with the assistance of health professionals, consultants, and partners in education.
3. In Phase 3, the pilot initiatives were evaluated through a process that included annual reporting to government agencies and two formal evaluations each.
4. Phase 4 involved the full implementation of the national TNH program on a permanent basis after receiving approval and assistance from government.[202]

[202] Elements of an Effective Innovation Strategy for Long Term Care in Ontario. Prepared for OLTCA by Conference Board of Canada. January 2011. Accessed at: http://seniorshealthknowledgenetwork.ca/sites/seniorshealthknowledgenetwork.ca/files/march11_cboc_report.pdf

Appendix D: RETIREMENT CONCEPTS' FRAIL ELDERLY CARE MODEL

A proposal to change health care utilization patterns for BC's frail older adult population

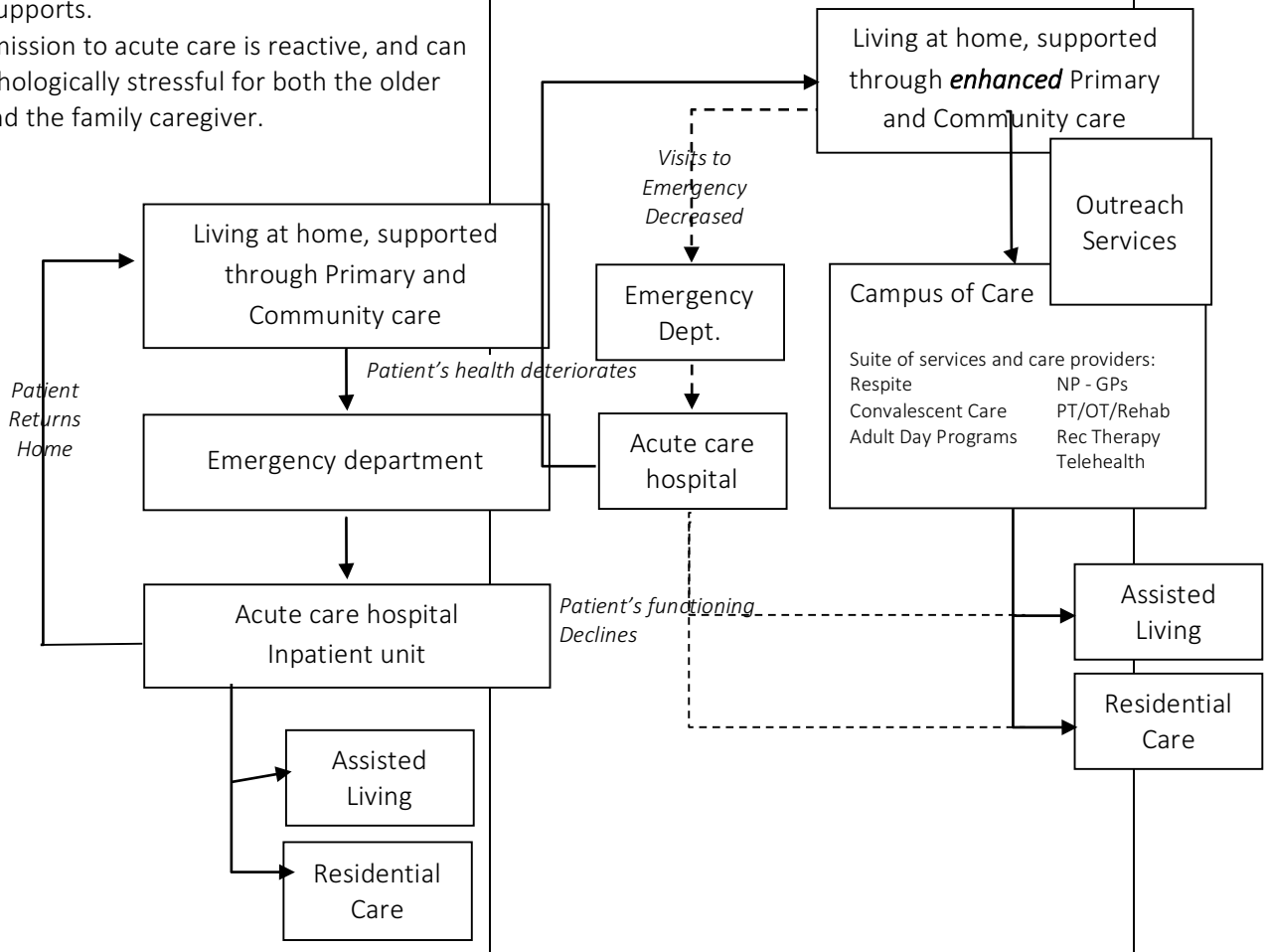
Current situation:

- Many frail older adults enter residential care 'post crises', following one or more visits to Emergency and/or an acute care hospital.
- Along with the deterioration in physical health, requiring a visit to the Emergency, the patient's stay in the acute care hospital can cause additional declines in the individual's functional status. This may mean that it is no longer safe for the senior to return home, even with added home supports.
- The admission to acute care is reactive, and can be psychologically stressful for both the older adult and the family caregiver.

Future state with proposed alternatives/enhancements:

Goal: change the trajectory of care for the frail older adult patient population to prevent or reduce inappropriate hospitalizations and defer, where possible, the need for residential care

Desired outcome: increase capacity to care for frail older adults in the community to decrease their need to access Emergency services by 25 per cent.



Value proposition

Patient and health system outcomes and supporting evidence: • In Canada, over 55% of acute care hospital beds are currently occupied by seniors on any particular day[203] • Thirty per cent of seniors admitted to acute care will be discharged at a significantly reduced level of functional ability and most will never recover to their previous level of independence[204] • Health care costs, especially hospitalization expenditures, rise in the year before a patient enters residential care[205] • Inappropriate use of acute care resources, as evidenced by a high Alternative Level of Care rate, particularly in Fraser Health[206]	• Prevent inappropriate use of Emergency services and acute care admissions • Flexible range of services in the community to meet the individualized person centred needs of seniors • Enable frail seniors to remain safely at home longer and/or indefinitely where appropriate • Optimize existing human and capital resources (e.g. Municipal Resources & Community Campus of Care® • Support proactive and planned community-based admissions to Residential Care when required. **Proposed enhancements:** • Integrated Primary and Community Care teams, with links to strengthened network of community services[207] • Improved Home Health monitoring technologies (e.g. Integrated Home System®) • Campus of Care Amenities – activity/dining/bathing/respite/short stay • Adult Day Program options • 'Outreach' services to keep seniors safe at home and avoid acute care –Home Visits • Community services - Navigator • 24/7 Interdisciplinary care providers to meet the episodic needs – i.e. pharmacy, OT/PT, dining, bathing, dressing, IVT, Psycho social • Hospital at Home team` to provide short-term acute medical care to seniors at home, similar to UK model

[203] BC Patient Safety and Quality Council (Nov 2014). Hospital Care for Seniors Clinical Care Management Guideline: 48/6 Model of Care. Retrieved from https://bcpsqc.ca/clinical-improvement/48-6/practice-statements/
[204] Ibid.
[205] BC Ministry of Health (2015). Primary and Community Care in BC: A Strategic Policy Framework. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2015/primary-and-community-care-policy-paper.pdf
[206] Fraser Health Feb 2015 Report Card. Retrieved from http://www.fraserhealth.ca/media/022415_Overall_Report_Card.pdf
[207] Bellows, J., Young, S., and Chase, A. (2014). Person-focused care at Kaiser Permanente. The Permanente Journal, 18(1). Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3951036/pdf/permj18_1p0090.pdf Oxford Health NHS Foundation Trust. Hospital at Home. Retrieved from http://www.oxfordhealth.nhs.uk/?service_description=hospital-at-home