**DEBATES OF THE LEGISLATIVE ASSEMBLY**

**(HANSARD)**

---

**COMMITTEE C BLUES**
**TUESDAY, MAY 12, 2015**
**Afternoon Sitting**

---

**J. Darcy:** I'd like to shift to another issue. It relates, of course, to quality and continuity of care for seniors. It also relates to staffing in residential care. I assume the minister is familiar with a situation that developed earlier this year regarding Vancouver Coastal Health and the Inglewood Care Centre.

The minister has received correspondence on that issue. The letter raised very serious concerns about the number of times that the facility owner had flipped subcontractors and the impact of these flips on quality of care for seniors. There were questions raised by the Hospital Employees Union about inspection reports from the health authority and other documents that indicated that care had been compromised at the facility.

Another issue flagged was the application of health authority funding to the provision of care. It was estimated that less than half of it was actually applied to front-line care. That situation is at least temporarily resolved, as the minister may well be aware, but that incident highlighted a much, much larger problem that exists when it comes to contract flipping in residential care.

This spring, in addition to Inglewood, there were major contract flips at two other Lower Mainland health facilities — at Laurel Place, in Surrey, where 240 workers will be contracted out, effective June 1, as the owner of the facility prepares to sell it; and last month 80 workers at Harmony Court, as the owner of that facility flipped its contract for care services.

I know that the minister has had an opportunity to hear directly from some of those employees and from the HEU about the impact on seniors care. We all heard from them when they were here for a lobby earlier this year.

I want to ask the minister if he has any general observations about this problem of the impact of contract-flipping on care for seniors and whether he has any plans to address it.

**Hon. T. Lake:** The issue is contracts that are changed with the private sector providing complex residential care under contract to health authorities. The member mentioned a specific one, I think, in West Vancouver. That is a concern. We all recognize that change has impact on the residents, and they're the most important people that we should take into account when we're discussing this — also employees. At the same time, it is the legal right, through **Bill 29**, for companies to change contracts. That is clear in legislation.

However, the Ombudsperson, in their report on February 4, 2012, noted that there was concern and asked the Ministry of Health to work with health authorities to develop safeguards to ensure that seniors in residential care are not adversely affected by large-scale staff replacement.

To address this recommendation, the Ministry of Health developed a new policy, which is policy 6.K, "Large-Scale Staff Replacements." That is included in the *Home and Community Care Policy Manual,* and that's to ensure that the quality and safety of client care is maintained during a large-scale staff replacement.

The large-scale staff replacement is defined in the policy as mass staff turnover through the change from one contracted service provider to another or through a change in ownership.

With this new policy, health authorities must ensure that service providers plan and manage the change process for clients where a service provider is planning a large-scale staff replacement consistent with the following requirements: to ensure that maintenance of the quality and safety of the client's care is the priority throughout the process; provide the client with information about the upcoming change; offer clients and families an opportunity to meet with service provider staff to identify key concerns in the changeover in staff; and ensure that the staff replacement does not happen until all clients are informed and have had an opportunity to have their concerns heard.

This policy was introduced in April of 2015. It applies to all publicly subsidized residential care facilities, both health authority–owned and –operated and contracted. Health authorities have six months to ensure implementation.

Just a note, too, that we have clarified that policy to ensure that health authorities have the same accountabilities when decisions are made to close even a few residential care beds within a particular facility. Any change of magnitude has to go through this change management process to reduce as much as possible the impact on residents.

**J. Darcy:** I'm wrestling with understanding whether that policy actually does something to halt this trend, to arrest this trend that we have seen across residential care — also in other sectors of health care, but we're talking about residential care — since the introduction of Bill 29.

The minister I'm sure is very well aware that these situations arise monthly, I would estimate, sometimes even more. The minister is shaking his head. I can tell you that there have been times in the past where there were several incidents going on in the same week, in the same month period. There have been many, many of these situations since 2002, and whenever they occur, there has been a significant impact on continuity of care for seniors.

The staff who care for them are caring for their most intimate care needs. There have been numerous studies done on the importance of continuity of care for seniors and the impact of disruption of continuity of care on mortality, on morbidity, on the emotional health and well-being of seniors — not to mention the loss of family-supporting jobs held mainly by women.

Focusing on the impact on care — the minister is right. The Ombudsperson spoke about that extensively. So the minister now has explained a policy that, I guess, has been in effect for a few weeks.

It says there should be a priority on the residents. Okay. Clients should receive information about what's about to happen. They should have the opportunity to meet with staff about it and so on. I'm not understanding what that policy does to stop this from occurring.

If the issue is continuity of care for seniors, surely a policy that is going to address that should speak to continuity of staffing for seniors. It's one thing for one contractor to replace another. Understood. Large parts of residential care are now in the private sector. People have the right to change contractors.

But why does that need to mean pink slips for the care providers and then a process of rehiring and all the labour relations turbulence that also goes with that situation? It is not good for seniors when care providers are caught up in that kind of turbulence.

How does this new policy actually get at the heart of the problem? I fail to understand that. Perhaps the minister can explain it.

**Hon. T. Lake:** The member mentioned that companies have the right to change contractors. We agree that they have that right. A large part of residential care is provided under contract by the private sector. I have had the opportunity to visit a lot of residential care facilities throughout the province, opening some brand-new ones in my own constituency, and I can tell you that these are amazing facilities.

One of the members of the Legislature spoke today about the new facility next to the Mission Memorial Hospital. I toured that when it was under construction, near the end of construction, and I know that it is an outstanding state-of-the-art facility. That one, I believe, is run by the health authority. But there are many that are absolutely marvellous.

I remember the opening of Brocklehurst Gemstone in Kamloops a couple of years ago. Buron is the company that built and runs that facility; 175 beds, I think, are contracted to the Interior Health Authority. One of the residents there being interviewed on television said: "It's like being in Las Vegas. I just need a casino in the lobby." He said that the facilities were amazing in terms of the structure and the care that he was getting.

So we recognize that the private sector does an extremely good job of providing a service that is contracted to the public system. And they have the right to change contractors because, obviously, this is their business, and they need to make sure that the bottom line is looked after as well.

But it does have an impact on residents when that occurs, and that's why the policy is in place so that the health authority has to make sure that when a service provider is planning a large-scale change in staff, they ensure that, first of all, the quality and safety of the clients' care is the

priority; that the client and their families are provided with information about the change; and in fact that they have an opportunity to meet with the service provider.

So they can't just go in there and do it willy-nilly. They have to go through a process. We know that in the vast majority of cases, most of the staff are unchanged. They are often rehired by the second contractor, and so there isn't as much impact on the patient as people worry about.

Now, I know that that still provides some anxiety for residents and their families. I have expressed my concern to the **B.C. Care Providers Association**, just in conversation, about this practice of some in the private sector and the multiple turning over of contracts. We have implemented this policy. We will monitor this policy closely. If we see any abuse, we will take steps.

I want to add also that having the first seniors advocate office in Canada, I know that our seniors advocate is interested in this issue. She is doing some excellent work, particularly around residential care, and so we will work with our seniors advocate as well, monitoring this policy to make sure that it is having the result we want, which is to reduce any negative impact on residents when there are large-scale staff changes.

**J. Darcy:** The issue here is not whether or not there are some wonderful care facilities in the private sector. I have certainly visited many of them myself, and some of them are quite magnificent.

Physical surroundings are important, but it's the quality of care and continuity of care that are the most important, surely, when it comes to caring for seniors.

We know that people who live in residential care are there for significantly shorter periods of time than they were historically — that it is the last few months, the last year or year and a half of people's lives, very often. The minister says a lot of the care is provided by private care providers. That's the case, but the funding source is still, largely, government. The funding is still, largely, public funding.

That means government has levers. Government could do one of two things. They could go back and revisit the changes that were made to Bill 29 that resulted in these things. Even if the government is not prepared to do that, surely the government has funding levers. The government could set conditions on funding that is provided to private care operators that have to do with continuity of care.

Has the minister considered, or will the minister consider…? In addition to the policy that he talked about, which is a step forward but does not ensure continuity of care, is the minister prepared to use other policy levers, based on the funding that government provides to private care operators, in order to ensure continuity of care?

**Hon. T. Lake:** I mentioned policy. The process that the health authorities will use to enforce the policy is outlined thusly.

"Health authorities must ensure service providers develop operational policy and procedures that include the following: timely communication with the client and an opportunity for follow-up discussion of questions and concerns, timely communication to the community care licensing

office, measures to assist clients with the loss of continuity in their care, a process to communicate the client's current clinical and special clinical needs to new staff, and the process to monitor and mitigate impacts from the change.

If large-scale staff changes occur, then the provider must develop this plan, and it will be monitored by health authorities for compliance against the process that I just outlined. This is a new policy. It came into effect April 1. Health authorities have six months in which to comply.

I believe that we need to allow this policy, this change, to have some time and see how effective it is. I'm hopeful and optimistic that we will see the impact on patients, on residents in care be mitigated through the use of this policy.

**J. Darcy:** Is the minister prepared to share a copy of that policy?

**Hon. T. Lake:** Of course.

**J. Darcy:** In the same situation that I referenced earlier, Inglewood, in the correspondence that the Minister of Health received on the subject…. Well, the Vancouver Coastal Health received it. The minister was copied on it, and I know that there's been subsequent discussion about it.

In this case, the particular care operator, Unicare, received substantial funding from Vancouver Coastal Health — $11.4 million in the last fiscal year — to provide residential care services. It's estimated that the wage bill for the bulk of the staff — care staff and support staff — accounted for less than $5 million of this amount, which seemed out of line with the expenditure pattern for staffing in most long-term care operations.

It was also brought to light that a licensing inspection of the facility in December of 2014 by Vancouver Coastal Health flagged a number of areas where the care operator had failed to be in compliance with the residential care regulation, including a failure to provide adequate food and fluids to meet the nutritional needs of residents.

The concern here is that inadequate investments, in this case, were being made in order to ensure the well-being of residents. My question to the minister is: has the ministry taken any steps to systematically audit the funds it transfers from health authorities to care home operators to ensure that those funds are substantially applied to the care of seniors?

**Hon. T. Lake:** Vancouver Coastal, like all health authorities, has licensing officers that enforce the licensing requirements for health and safety. We are unaware of any reports that Vancouver Coastal has that reflect the comments of the member.

**J. Darcy:** There was a letter addressed to Vancouver Coastal Health, January 27, 2015, from Bonnie Pearson, secretary, business manager of HEU, that outlined exactly what it is I just detailed here. The minister was copied on that. This is also an issue that has been canvassed in question period. It was the subject of considerable media attention. I'm surprised that the minister is not aware of this situation, because very, very serious concerns were brought forward, and the minister was copied on that correspondence.

Just further to that, that correspondence deals with the contract flipping as well. That's not the issue I'm speaking to at this point. That issue was resolved. The outstanding issue and the question that I asked was the systematic audit of funds that are transferred from health authorities to care home operators to ensure that those funds are substantially applied to the care of seniors. It is certainly being stated in this case that there were serious, serious problems with the operator in place at that care home at that time, and this bigger question arises from that.

**Hon. T. Lake:** I have a copy of the letter in response to Ms. Pearson of the HEU from Vancouver Coastal, which says: "Vancouver Coastal is aware the instability of staffing and other supports can potentially impact ongoing care and well-being. That's why we're going to follow up on this matter to determine if there are factors that need to be addressed further. VCH will be in touch with you shortly to arrange a meeting to clarify your concerns and discuss next steps."

Obviously Vancouver Coastal acknowledges the concerns expressed by the Hospital Employees Union and indicated at that time to meet and follow up on their concerns.

In terms of the earlier concerns expressed by the member, that's what I had no knowledge of. We did not have a letter outlining the lack of fluid or nutrition or other things. But, as I mentioned, that is the role of licensing officers — to ensure that care is being delivered in terms of health, safety and licensing requirements.

We do not plan an audit at this time, but certainly if there are indications as to any particular facility that is at question, we have the opportunity through the health authorities to conduct inspections and look at the books to ensure that the money is going as directed. We would do that on an as-needed basis. We have no plans to do a system-wide audit at this particular time.

Again, as I said, we have the seniors advocate, and we rely heavily already, after just one year…. She is making some really good inroads in terms of the needs of seniors in the province of British Columbia. If she were to develop work that suggested some of this auditing is required, we'd certainly listen to her recommendations in that regard.

**M. Karagianis:** I have a couple of questions off the top that are just, kind of, general questions about a random number of items, and then I want to talk a little bit about the report that came out from the seniors advocate on *Placement, Drugs and Therapy*, and then I want to talk a little bit about the Ombudsperson's report.

My first question to the minister is with regards to the provincial office of domestic violence. When I've asked questions in the Ministry of Children and Families estimates, last year the minister made reference to the fact that the Ministry of Health works very closely with the provincial office of domestic violence, that there were program dollars within the Health Ministry that were related to domestic violence. I just wanted to ask what those program dollars are used for. What concrete programs or services are directly related to women or families experiencing domestic violence?

**Hon. T. Lake:** It's difficult to tease out all the separate funding that comes from different ministries, because a lot of the actions are cross-ministerial. Let me just tell you about some targeted Health Ministry funding that goes towards elder abuse prevention programs, and then I'll get into the more coordinated cross-ministerial programs that we have.

The ministry provided funding of $1.4 million in 2011-12, $350,000 in 2013-14, $350,000 in '14-15. I'll have to check on this number here, on the total number, because there are two different numbers.

This all is going to the B.C. Association of Community Response Networks for elder abuse services and programs in the province. We are still looking at funding for this coming year. As part of that, $700,000 is for community capacity building grants.

The Provincial Health Services Authority provided $850,000 in 2012-13 to the B.C. Centre for Elder Advocacy and Support to expand the capacity and hours of its seniors abuse and information line.

In the February 2014 throne speech government committed to developing a long-term comprehensive strategy to ensure all women have the supports they need to prevent violence, to escape from violent situations and to recover if they've been victims of crime. The violence-free-B.C. strategy was released on February 6 of this year, alongside a commitment of up to $3 million in civil forfeiture funding to support anti-violence and prevention initiatives.

We worked with the Ministry of Children and Families particularly to build a strategy to prevent violence against women, and we have Together to Reduce Elder Abuse, which was also a coordinated, cross-government, multisector approach led by the Ministry of Health that was launched in March 2013.

So a number of key initiatives funded from the Ministry of Health, through the ministry or through other organizations like the community response networks and also multi-ministry initiatives like the violence-free-B.C. strategy that bring together Children and Families, Ministry of Health and Ministry of Justice as well.

**M. Karagianis:** It would seem to me that the elder abuse issues here and the way the services are provided for that are much easier to track than support for the provincial office of domestic violence or the general violence-free-B.C. initiative. Are there performance measures or any tracking and reporting done on how these funds are affecting the communities — you know, their reduction in elder abuse or…? I mean, one would assume that more services out there raises the awareness of elder abuse.

Are there any kinds of performance measures that the government has up to this point that they can share with us?

**Hon. T. Lake:** There are a variety of different metrics that are employed to look at the effectiveness of some of the programs. The community response networks, for instance, often in the past have received grants for capacity-building and to put measures in place in different

communities. Some of the outcomes there would be how many communities have been organized with the community response networks.

We also do surveys through B.C. Stats. Also, there's a survey that we contribute to, to oversample in British Columbia, and that's the National Initiative for the Care of the Elderly. That will give us some idea of prevalence. Importantly, the office of the seniors advocate is working on this to try to standardize the reporting system with the different health authorities. As delegated agencies, they are compelled to report any incidents of abuse that they come across.

So if they're doing home support services or assisted living residential care, if they hear of any instance of elder abuse, then they are to report that.

The system is not standardized at the moment, so the office of the seniors advocate has formed a working group with the Ministry of Health and the health authorities to look at best practices. Currently the model used at Vancouver Coastal appears to be a model that is sort of considered the standard. They will take a look at that model, work with other health authorities, and then the seniors advocate is committed to having that standardized reporting system available on their website, hopefully later this year.

**M. Karagianis:** Well, I had listened earlier to the exchange between our Health critic and the minister with regard to residential care contract flipping and that kind of thing. The minister had referred to the seniors advocate many times in that conversation. I think I'll turn to that report, then, if you don't mind.

The most recent report that came out, *Placement, Drugs and Therapy*, has three very clear issues that have arisen here. I'd just like to touch on those a little bit. The minister and I have talked a little bit about this, both in the Legislature and in the hallway discussing it. There are three main issues that she has highlighted here: premature admissions to residential care, the overuse of drugs in care facilities and the lack of physiotherapy and recreational therapy for seniors. I'd like to ask just a few questions on that.

The issue of appropriate placement in residential care. This report has come out subsequent to the government planning their budgets for the year. I would like the minister to maybe address how there's going to be a response to some of these. Or will there be a response, given that the budget was already set? How do you allow within the budget for some of the recommendations that have come out of here?

Now, there haven't been any strong and harsh recommendations per se from this report. But I would certainly assume that it has got the government thinking and concerned about these topics. I know that the minister alluded to that earlier in conversation with the Health critic. Maybe if the minister could elaborate a little bit on the issue of appropriate placement in residential care, premature placement, and what steps the government's taking and how that fits in to the existing budget.

**Hon. T. Lake:** This was the report that was released earlier this year about placement, drugs and therapy. Some really interesting findings, which I think is really the strength of the seniors

advocate office — able to take a step back and say: "Okay, how are we doing or why are we doing this? How are other provinces doing?" You know, looking at different measurements.

I think there was about 15 percent, if I remember correctly, of the population in residential care that may be able to be still looked after, if you like, or live their lives appropriately in either a home care with supports or in assisted living. That's based on this resident assessment instrument that looks at and evaluates individuals and determines the appropriateness of their placement.

When you compare Alberta and Ontario to British Columbia, what we find is that there are some people in B.C. that, by comparison, look like, if they were living in Alberta or Ontario, may be living in assisted living or at-home care with supports.

That's a very interesting finding, and obviously, we are very interested in that. If we can, in fact, look at the RAI instrument that we use and make sure we're working with health authorities to make sure that it is used appropriately…. I mean, this is something that we all will learn together. If there are things about that instrument that need to be done differently so that we can free up residential care spaces, that's a good thing. That means that there's more capacity in the system.

It also means that some people that may have been placed in residential care would be able to be rehomed, either in assisted living or at home with supports. Again, better for the patient or the resident and certainly, I think — I should say likely — more economical in terms of taxpayer support.

We will take this information. Our ministry is studying it closely. Of course, we work closely with the seniors advocate office so we can explore this data, test it out and work with the health authorities — get their opinion on this residential assessment instrument and its use compared to Alberta, Ontario. We will meet and discuss with the other provinces the way they do things to make sure that the assumptions in this report are correct.

We will take this information, because if it is, in fact, the case that people are not appropriately housed, we want to correct that, because it's better for the patient, the person, but also better for the system to make sure that people are in the appropriate setting for their needs.

**M. Karagianis:** Great. Thank you very much, and the minister and I would agree 100 percent on that. Certainly, the findings from the seniors advocate report here would indicate — I'm accepting as fact much of her findings here — that there needs to be a significant shift, then, in the funding of home care and how the evaluations are done and all of that.

I guess my concern would be this. When the ministry does its evaluations, at some point there's going to have to be a starting point to say: "Well, now we are going to move to trying to keep seniors in their homes longer." Therefore, there's going to be a shift in the requirement for supportive funding for that — and just shifting the entire system, not just for this, but for other parts of this report that we're going to explore.

My concern is how this might be done. I'm sure that the ministry must be thinking — as with any new initiatives and new information that come in and just, you know, best practices from elsewhere that continue to move into the system — how do you make that graduation? It's not as if you can turn the light switch on, and tomorrow everything will be done in a new way. It always requires investment up front to make the shift. Is that something that the ministry is contemplating?

You know, we talk often in the Legislature here about money being extremely tight and about the demands on the health care system and about the growing demands on the health care system.

Just taking the 15 percent figure that the advocate has given us. I mean, that's thousands of individuals that are going to need a much more intensive kind of support system at the early stages in order to change the way they flow through the system. I'm just wondering what the ministry's thinking is on this and how you might be approaching it.

**Hon. T. Lake:** There are about 27,000 people in residential care in British Columbia, so 15 percent of that would be about 400 people. It's hundreds, not thousands, but the member's point is well taken — that you can't flip a switch and turn things around overnight.

I only wish she was here yesterday when we were talking about medical training and the number of physicians, because that's the dilemma. You can't flip a switch and automatically produce doctors.

An important concept that the member has brought up is how do you make that shift. We had a good discussion yesterday about this great big ship that we are in command of — the health care system — and how you turn that ship in a different direction, and it is extremely…. It's not nimble because of history, interests of professions, unions, institutions, patients. I mean, there's a lot of factors there. You're right, you cannot shift this instantly.

We have a primary and community care two-day workshop in Vancouver June 1 and 2. Once our staff has finished all the work that they're doing this week and the last week of session they'll be looking at this workshop that we're going to do in Vancouver with health authorities — with a whole wide variety of stakeholders — and that will include residential care, home and community care, community nursing and primary care. The seniors advocates office will be in attendance.

This will be a great opportunity for health authorities that provide home and community care to test the assumptions in the seniors advocate's report.

If we accept these assumptions and decide that there are some appropriateness questions that need to be answered, how do we make that shift?

We'll take the findings from that workshop and do some work over the summer. Then starting in the fall, we will devise mechanisms that, through the funding of health authorities, will see that shift into home and community care in the ways that have been identified through the work we've done to date. It is a process, and we look forward to the two days in June when a lot of this information will be discussed. HAs that are on the front line of health care will be able to give

their input to how best to make that shift so that we can keep more people at home and in community.

**M. Karagianis:** Just to go back to the earlier comments about hundreds versus thousands. The report actually says that these results were surprising. It appears in this data that somewhere between 5 and 15 percent of seniors living in residential care fit one or more of these profiles, which could be 1,500 to 4,000. That's significant even just at a very cursory level on that.

I'd be very interested to see the progress of this initiative, where all of the various factors and sectors of the health system get together. Will some of those findings be made public? I think about our role in opposition, but I know I've been with your deputy minister to the **B.C. Care Provider Association** forums and things. Obviously, there will be places for this dialogue to also be conducted with other parts of the community, I would hope and assume.

**Hon. T. Lake:** As we develop policy changes as a result of the work, obviously, they will be made public and be implemented. **The B.C. Care Provider Association's** lunch in October would be an opportunity to talk about any policy changes if they are completed by that time. Certainly, we will keep people informed of the progress we're making, as we have with all of these policy papers. They've all been on the website. They've been out there in the public.

Great discussion, particularly in the health care professions and unions and associations, so we'll continue to let people know the direction in which we're moving so that we can make sure that there's a consensus there. Although you'll never get unanimity, there is a clear indication of the way we're moving in terms of the shift from acute care to home and community care.

**M. Karagianis:** The second part of the report, I think, that was of concern to all of us — and I know that the minister and I have discussed this just briefly, but I thought we would perhaps have a discussion here — is the appropriate use of medication. This is a great concern to British Columbians generally, but I'm trying to find the root cause of this.

Are we putting some of this responsibility on doctors? Are we putting this responsibility to care environments that are not quite prepared to meet the depth of need or the extreme need of care? Or is this more of a way to manage a very difficult population or a very challenging population without adequate staffing or other infrastructure for them?

I mean, I think about the great move during the 1990s and into the early 2000s to build assisted living. Many of the assisted-living providers knew that they would be developing settings that might very likely have to provide a much higher level of care for seniors because there wasn't always necessarily the next level of care for them.

I wonder about some of the root causes of this. Has the minister been able to begin to look at the root causes of some of this medication, overmedication and overuse of, certainly, psychological drugs and antidepressants and things like this in these settings?

**Hon. T. Lake:** The use of antipsychotics and other medication is, I think, a topic of concern to physicians, care providers, certainly the Ministry of Health and health authorities.

I have this discussion with people a lot. We have elderly people that are at the very end of their life and yet are on medications to lower their cholesterol. It seems incongruous. There is a lively discussion going on, and I think there is a realization in the health community that we need to reduce the use of all types of drugs as we near the end of life.

The B.C. Patient Safety and Quality Council did an initiative called CLeAR, which is call for less antipsychotics in residential care. The early results show a 38 percent reduction in antipsychotic use. It says 24 percent of residential care clients are assessed with depression, yet 47 percent are prescribed antidepressant medications. That would indicate that even though there's not a diagnosis of depression, these medications are being used for other reasons, because they do have other effects.

The question is: are they being used to manage behaviour? I think that is the member's point, and I think that is a lively question. I don't have the answer to that. We are working with the B.C. Patient Safety and Quality Council on that issue. I know that gerontologists at UBC are working on that issue as well.

There's, I think, a general realization that we have to reduce the amount of drugs, particularly the amount of drugs that are used if they're being used to control behaviour. I'm not a physician, but I think we would expect that physicians are using appropriateness when prescribing these medications.

A discussion with the doctors of B.C., with the College of Physicians and Surgeons around this topic I think is important. That may be explored further in our primary and community care session that we're doing in June.

The first step in doing something about a problem is recognizing the problem. It's not the first time that we've heard this, but it adds to the information that is clearly showing that the use of antipsychotics and antidepressants in residential care is something that we need to address. We are certainly going to do that.

There is a best-practice guideline for accommodating and managing behavioural and psychological symptoms of dementia in residential care. That was issued in October of 2012. That's when this issue started to be addressed.

The PIECES program was a program developed by Dr. Carol Ward, actually, in Ontario. She has moved to Kamloops and is a geriatric psychiatrist. She has really been a champion of that program, which looks at the psychological, intellectual and emotional aspects of behaviour and teaches staff how to manage without the use of drugs the behaviours that can be disconcerting or cause potential violence, patient on patient or patient on staff.

That program has been initiated throughout the Interior Health Authority. By training people in the PIECES program, we are now expanding that throughout the health authority.

Again, there are a lot of initiatives going on — the CLeAR initiative, the PIECES program — that we hope will see a reduction in the amount of antipsychotics and antidepressants being used. It is something that we want to make sure that we do.

**M. Karagianis:** I do note from the seniors advocate report as well that one of the more critical aspects of overmedication is medication error. What is the ministry action on this, around how you manage medication error? What percentage of this medication problem is around overmedication? Could this be because of inexperienced staff?

I mean, I would certainly guess and assume, given the general crisis around general practitioners, that we're not seeing doctors going in and administering these medications in these facilities and that it, in fact, is left to staff.

Who is it that's responsible for administering these medications, and what percentage of overmedication is because of medication errors, inexperience or undertrained individuals?

**Hon. T. Lake:** There's a lot of work going on in this area, as reflected in the time it has taken me to put it all together here.

We mentioned the CLeAR initiative. We mentioned some of the other initiatives, the PIECES program. The Doctors of B.C. also have a Shared Care poly pharmacy initiative that supports family and specialist physicians to improve the management of elderly patients on multiple medications that may impact their safety and quality of life.

I wanted to start out by saying that all of these prescriptions, of course, are made by physicians. It's not the staff at a residential care facility saying: "Oh, let's give Mr. Beaton more of this today." Obviously, they're following a care plan that has been outlined…. The prescriptions are outlined by a physician. I did point out that we have the general practitioner guidelines that have been developed on poly pharmacy.

A very important initiative in terms of general practitioners looking after residential care patients is the General Practice Services Committee residential care initiative. This actually just started, I believe, a couple of days ago. This is our new agreement with Doctors of B.C., and some of these new initiatives were put in place as part of the physician master agreement.

This is to have dedicated general practitioner services in residential care. It provides a fee that is attributed to each placement in residential care. In order to have that payment initiative, there are five things they have to do. One of the biggest things they have to do is a medication review. They go in and look at all the medications that that particular patient is on and review what is necessary and what is not necessary — again, this growing realization that if we know that someone is in the final year of their life, then perhaps they don't need to be on some of the medication that normally you would be on for 20 or 30 years.

They also have to commit to 24-7 availability to those patients and do proactive visits to the residents to reassess them, complete all the documentation that's necessary to track the health

of the patient and also attend case conferences with other physicians around the care of the patients.

That's an initiative that I think will result in better care from GPs for patients that are in residential care.

**M. Karagianis:** Well, it occurs to me…. Given the shortage of doctors, how are these doctors going to dedicate themselves to being available and to doing this work in seniors care?

I talk to individuals around the province. There is a growing crisis of families who don't have a GP and who now have aging parents. I have a constituent who has a mother with vascular dementia who is having some real issues getting her placed because she doesn't have a dedicated GP. It seems to me this is a lot of responsibility, now, on a group of docs. Are they dedicated to simply providing seniors care, or are these docs that are now working in general practice in communities who now have got to add to their workload these medication reviews, 24-7 availability, proactive visits? I think that's, again, time out of the office.

How is that possible, given the crisis with general practitioners?

**Hon. T. Lake:** I want to make sure that we characterize the challenge appropriately.There is no crisis in terms of family practitioners. There is a challenge, for sure, and, in some communities, that challenge is greater than others. But the numbers demonstrate that British Columbia has the same challenge as the average in Canada. There are some provinces that are doing a little better in terms of the availability of physicians. There are some provinces that are doing much worse. I would not characterize the challenge as a crisis.

Having said that, the divisions of family practice around the province are work shopping this initiative. There will be different solutions in different parts of the province.

There may be general practitioners who currently only work three days a week, and they may want to dedicate a day to residential care commitments through this initiative. There may be groups of physicians that get together to do a team-based initiative so that they are essentially working as a team to do residential care, medicine, in their community.

There may be different solutions and different approaches, but this initiative, I think, will be one more incentive to make sure that doctors take on complex patients. You can imagine, if a physician has a patient load of 1,200 to 1,400 patients, and if a high proportion of them are complex, then that's going to take more time.

We have tried to incentivize attachment with attachment to complex patients through the GPSC previously. This is one more of those incentive programs to allow physicians to be compensated appropriately for the increased amount of work that it takes to look after someone with complex disease and more than one problem than it takes for someone that has a simple, relatively short-lived health challenge.

**M. Karagianis:** I understand that the minister is saying this is a new initiative, so it's in its fledgling stages, I guess. How are you going to monitor whether that's working or not?

It would seem to me that if a doctor has chosen to work three days a week, I'm not sure what kind of incentivizing it would take to get them to work four days a week in a much more complex kind of environment, as the minister has categorized it. How is that going to be tracked? Is there a check-in point, an evaluation at six months, at a year?

The minister doesn't want to call it a crisis, but for those of us in communities that do not have a family doctor — and I count myself as one of those people — it is critical. It concerns me greatly that as I age, I don't have any kind of a family doctor who knows anything about my health history or could judge whether I'm showing early signs of dementia or anything else. It's up to my family or myself to monitor those because I don't have a family doctor.

So I do really identify with many British Columbians who don't have this. It's a great concern. It worries me a lot that I could have health problems that I'm not even aware of, that early intervention could change the outcome.

Moving any of those resources into this new initiative means that they're being taken away from someplace else. In an ideological world, maybe doctors are now going to work an extra day a week in order to provide this kind of service in this particular environment. But common sense says that's not going to happen in 100 percent of cases and that somewhere it's going to drain the system.

How is this going to be evaluated? When is it going to be evaluated? What are the measures along the way to see what kind of impact that's having — not just on seniors care but on family care and the rest of the province and the rest of the communities' care — if resources are now being focused in this new way on seniors care?

**Hon. T. Lake:** Well, the General Practice Services Committee tracks these because physicians have to bill the GPSC for these services. We will track these in the same way we have the other incentive programs. I just want to briefly go over those.

The unattached complex high-needs patient intake incentive that we instituted a number of years, where physicians can bill $200 per patient. That's to take on high-needs patients, those with severe disabilities, mental health, substance use, maternity, high-needs chronic conditions and cancer, for instance. They can bill that $200. As of December 21, 2014, tracking through the GPSC, we can see that over 54,600 previously unattached complex patients received care from about 1,900 general practitioners.
There is also an expanded access to complex care initiative — again, this is for people in community — where physicians can actually bill $315 per patient per calendar year. These are for frail patients. About 17,600 have received care under that incentive.

We will do the same tracking for the residential care incentive. They will have to bill GPSC for each of those spaces that they are looking after. We have built in an evaluation process at the front end of this initiative to track its effectiveness.

**M. Karagianis:** What's the budget for this particular piece of work?

**Hon. T. Lake:** Thank you for reminding me. There's $12 million set aside in the new physician master agreement for this work.

**M. Karagianis:** I'll look forward to watching this to see how successful it is, because it would be great if it is successful.

The third part of the seniors advocate report here had to do with physical activity, physiotherapy. I'm just wondering what steps the government anticipates taking with this regard.

Much of this is, of course, provided by the residential care provider, but kind of alarming numbers when you see how inactive many of our seniors are. I would expect that this probably excludes those who are in very advanced stages of frailty. I'm not exactly sure how it applies to dementia care either, but I think that's very important.

I'd be interested to hear what the minister's perspective is on this.

**Hon. T. Lake:** We had a really good discussion over this. First of all, if we go back to the appropriateness of placement…. If, in fact, 15 percent of people in residential care could better be living in community or assisted living…. If we took those numbers out, then proportionately there would probably be a higher percentage of people getting physiotherapy, because those people that may be in residential care inappropriately could function outside of that and you'd have a higher complexity of care that would need more rehabilitation and occupational therapy.

That's a subject of debate that we just had, so I come to no conclusions on that, other than to say that perhaps that's one of the factors.

This is the kind of discussion that will take place when we go to the health authorities in June at our two-day — talking about primary community care and saying: "What are we focused on in residential care? Is it care and comfort? Is that the kind of…? Is that where we should be placing our energy?"

If you look at recreational therapy, B.C. has significantly more than Ontario. Is that because the care providers and health authorities think that recreational therapy is actually better for their quality of life than more physical therapy or occupational therapy? Those are the kinds of discussions that I think will come out.
While I think of it — because I know that the member is keenly interested in this — I was watching a documentary last night on Netflix called *Alive Inside*. I really recommend that, about the power of music to bring people back.

Some of these interviews were phenomenal, hon. Chair. I hope you'll indulge me a little bit because it really was amazing. You know, they'd ask someone, "Well, what did you do when you were young?" and they couldn't really remember. And then when you put the music on, they would say: "Well, when I was your age, I did this." They would recount in intimate detail some of the memories that they had — just by putting on music that their family had identified that they need.

That's the kind of therapy, I think, that we recognize is important. I remember when I was in veterinary school, we started a pet visitation program. The same thing happened with people with severe dementia. You'd put a cat on their lap, and they would, all of a sudden, start talking when they were uncommunicative before. But I really recommend that for the member because I know she's keenly interested in that.

This will be a subject of our discussion. The deputy to the seniors advocate has a background in rehabilitation therapy, rehabilitation medicine, so he will be able to provide a lot of good input into this. Clearly, if we look at things like falls and hip fractures, one would think that activity levels and physical and occupational therapy are important to prevent that from happening. It is something that we're keenly interested in following up on.

**M. Karagianis:** *Alive Inside* — I'm familiar with that. There's actually a group called Forever Young in the U.S. that has seniors who have had singing experience or careers in their lives. Many seniors who were almost immobilized start singing. They perform with these groups. It's actually the most inspiring thing you could imagine — some of these people in their 90s that suddenly are reinvigorated by singing again and by performing with a seniors singing group. Yeah, I think there are a lot of really excellent therapies out there.

You did touch on something here that was another series of questions I had. Taking those seniors out of the system that could do better at home for a longer period of time — or in assisted living — I think is great, but we also have this other growing wave of complex care coming, which is the increased dementia situation. I think statistics have shown and it's very evident that there will be more seniors suffering from some forms of dementia as the baby boomer group comes through and reaches that stage.

How are these discussions affected by the overlay of dementia care, which, of course, adds a whole different complexity to this story? What are the government and the ministry thinking regarding that — the growing incidence of dementia?

**Hon. T. Lake:** Well, certainly, the prevalence of dementias, including Alzheimer's, is a daunting prospect as the population ages, although there are some good things going on out there.

For instance, there is evidence that suggests that with the better stroke management that we have today, the incidence of vascular dementia may actually go down. So that's part of the good news. There's promising research going on, a fascinating documentary that, I think, *The Nature of Things* did on dementia, and work going on in New York that actually seems to equate dementia as a type 3 diabetes, where the brain actually has some insulin resistance — and developing aerosols of insulin that would go through the cribriform plate into the brain rather than affecting the whole body. Very fascinating stuff going on.

There's work going on all around the world, including here in Vancouver. I was at the opening of the Djavad Mowafaghian Centre for Brain Health at UBC, oh, probably, 12 to 14 months ago. Amazing facility. Some tremendous work that's going on there. I'm actually very hopeful that there will be some real significant steps forward in terms of prevention and treatment of dementia.

We obviously have to deal with what we have in front of us, and so the dementia action plan has a number of priorities. The refresh plan focuses on four priorities.

Increasing public awareness and early recognition of dementia. We work with the Alzheimer Society of British Columbia, and we have contributed, I believe, a total of $10 million to the First Link program, which links families — when you get an initial diagnosis of Alzheimer's — to services in the community that are available. That is hugely important. You can imagine the impact on a family to hear that a loved one has Alzheimer's and where to go to seek help.

The second priority is to support people with dementia to live independently as long as possible and to live safely. There was no better example of that than at the University of Victoria yesterday at the CanAssit lab, where we contributed another $3 million to the work they're doing.

They have an anti-wandering initiative. It was really great to see. It's a series of screens that are placed in the home and sensors. Essentially what would happen is if a patient with Alzheimer's is living at home, goes to the front door to go out at an inappropriate time of day…. First of all, there's a screen that shows that it is daytime or nighttime, and then if it is an inappropriate time of day — nighttime, for instance — and the person tries to go out, a picture will come up. It's a recording of their daughter, their son, their other caregiver, saying: "Hey, Dad, it's nighttime. You should go back to bed now. I'll call you in the morning."

It also has reminders about medications that automatically come up on the screen. That initiative has been piloted here on Vancouver Island at the Wellesley, actually, and has had tremendous success. They are now, with this money, able to take it out to the rest of the province. They also have a phone-in monitoring system that's developed, so you don't need to have an Internet connection. You just have a land line. There are sensors in the bed and in different rooms that will alert someone, that phones in and punches a particular code to find out where their dad or their mom or the other person that they're concerned about, where they've been in their house, the last time they slept in their bed, what activity has been happening on their telephone. That again, is another way for people to check in on their loved ones, and that all helps keep people at home as long as possible.

Then the third priority is to improve quality of care in residential care homes and improve palliative and end-of-life care. This is, of course, critical to…. When we talk about end-of-life care, the Premier has tasked me with developing an end-of-life care plan and to increasing the number of hospice spaces available around the province, and we're working hard on that initiative.

I'm sure the member has had the opportunity to go to some of the new residential care facilities. What they will have is security, of course, to make sure that people do not wander out of the facility, but they also have, through their building design, incorporated designs that will help with the behaviour of dementia. Many people with dementia have repetitive walking patterns, and so there are hallways designed to accommodate that — hand rails and signage and familiarity to help people as they exhibit those behaviours. That will keep their stress levels down.

The priority 4 is to increase system supports and adoption of best practices in dementia care. All of that is ongoing. The implementation will be phased in over the next three fiscal years through to 2017-18.

**M. Karagianis:** Well, new residential care facilities are indeed very attractive and interesting. But it touches on one of the other questions I'm going to ask here about facilities.

Certainly, exciting new work coming, but all of it is very expensive and requires a great deal of money in order to make it happen. The minister talked about early diagnosis for Alzheimer's and things. That's hard to do if you don't have a GP. So some of these things are tied very much to the issues around not having a general practitioner.

I do note that, when we talk about new residential care facilities, that is different from existing facilities. Around dementia care and just the whole issue of how we provide some of these services, can the minister address the issue of facility capacity?

I know from being involved building some assisted living in the early 2000s that the discussion, even then — on how the assisted living was equipped, and at what stage the residents there had to move into more advanced care — was a pretty hot topic. Many facilities, even now, that are currently used to maximum capacity do not have the ability to address some of these issues.

I live just up the street from Sunset Lodge, so I've really watched the evolution there. I have been to tour the facility often, because it is in my neighbourhood, and there's many challenges with these facilities and their capacity.

What steps are the government taking to try and mesh all of these great new ideas and all of these wonderful new therapies and treatments and initiatives and a lot of aging infrastructure that doesn't have the capacity to even address some of the very basic things that we've been talking about?

**Hon. T. Lake:** I just wanted to talk about the capacity, what we have in the system, and where we've come from.

In June of 2001 we had a total of 25,360 residential care beds and 20 assisted-living units for a total of 25,380 total capacity, which was residential care, assisted living and group homes. As of March 31, 2014 we have 27,308 residential care beds. We have 4,438 assisted living unit.
Again, the member mentioned, that it was the late '80s-early '90s when assisted living really started to take off. It's not surprising that we're seeing that come up over the years. And 83 group home beds. So there's a total capacity in the system of 31,829. Total capacity has increased about 25 percent over that period of time.

What we're doing with our primary and community care policy paper is we've sent it out to consultation. We've received some information back from health authorities, for instance, and we'll be work shopping this June 1 and 2, as I mentioned. But what we're doing with health authorities is breaking down, to a more granular level, to look at those communities. Looking at essentially 64 communities of care around the province.

I think we're going to pick ten or 12 of those to focus on initially and look at the suite of services in independent living, assisted living and residential care, along with their primary care and community care needs, and do an assessment of exactly what the status quo is and where we need to be. There would be some areas of the province that the housing stock would be newer and other areas of the province where it's older.

Northern health, I know, for instance, has a particular challenge because of an older population. And the sparsity of the population doesn't attract private investment in residential care because you don't have the critical mass that you have in other areas of the province.

We're going to take a more granular look at those 64 communities and look at the range of different options they have for living for seniors and then dedicate resources to make that change in each of those communities, based on looking at them holistically, rather than just saying: "Well, 40 percent of the stock we have now is old. It needs to be replaced." Where do we need to focus those resources to make the biggest change in the shortest period of time?

**M. Karagianis:** How long is that project scheduled to take? What's the timeline on that?

**Hon. T. Lake:** We don't have specific timelines for when all of this will be done. Obviously, it's a moving target as population ages and as care models change.

But we are doing several things. I mentioned that we, with the health authorities, have broken it down to 64 different communities. We'll take the first ten or 12 communities and pilot changes in those communities. That will take some time. Starting in the fall, probably it will take the better part of a year to go through the changes in those different communities. Then we will go to the next tranche and take what we've learned from the first batch of communities and put those initiatives in place in the other communities.

Not to say that health authorities don't now look at their housing stock. They do, on a regular basis. Vancouver Coastal, for instance, is embarking on a phased approach to replace or rejuvenate their outdated residential care beds across the region. Each health authority takes stock, and that is the information that we now need to plug in on a provincewide basis and look at where the needs are highest — focus on those communities, initially, and then roll it out across the province.
Things are happening concurrently. Health authorities are doing their work in replacing stock, which is just the normal thing that we would do. I've been told that about 40 percent of the current housing stock is under the Hospital Act. Those would be older facilities, rather than the 60 percent that are under the Community Care and Assisted Living Act. There's still some work to do to replace that stock, and that work is ongoing.

What we are trying to do with the primary and community care is not do it independently — not just replace the residential care alone but think about care in the community, perhaps a wider ability to stay in assisted living. I think that's what the seniors advocate has found — that there is probably a way to increase capacity in assisted living and keep people there longer. With some

of the technologies we saw demonstrated at UVic yesterday, that may be very, very helpful in helping us achieve that.

I don't have a specific timeline when all this work will be done. We'll start with the prototype communities in the fall, and that will take probably the better part of a year to see some results there.

**M. Karagianis:** I know that the ministry has published a number of cross-sector policy discussion papers. The one on primary and community care I was particularly interested in. It dovetails with this discussion. The paper contains pretty ambitious plans, I think — for instance, things like reducing the pressure on ERs and medical in-patient beds for seniors with moderate to complex chronic conditions. The plan, as laid out, I think, requires quite a high degree of coordination with residential care operators, given some of the expectations here.

My question is: how are the privately operated facilities responding to this? Are they willing to partner in implementing some of these ideas?

**Hon. T. Lake:** There was a very well attended consultation on the primary and community care policy paper with the **B.C. Care Providers Association** and the Denominational Health Association, with a follow-up session, actually, with staff as well. So they have all been very interested in collaborating. We do monthly calls with those associations. They provided written feedback on that paper as well, and they will be part of the June 1 and 2 symposium that we're doing on primary and community care. I believe they'll be there on the second day.

They're very interested in all of the objectives of the primary and community care paper and, certainly, willing partners. Obviously, funding is a part of that, and that is something that the ministry will have to deal with as we move resources into primary and community care. There has got to be a shift of some type out of acute care. Hopefully, what will happen is the need for acute care will go down, reducing the demands on acute care so that those resources can be placed in home and community care.

Of course, that change sometimes takes a while to accomplish. So we're working hard with the health authorities and will be discussing that with them at the June 1 and 2 conference.

**M. Karagianis:** Certainly, I would anticipate that the shift would be costly. We'll certainly…. The private providers would be, I'm sure, looking for a good incentive there to do this as well. It does occur to me…. I know that the minister had quite an exchange with our critic earlier this afternoon about things like contract flipping. Really, these private contracts are not always that easy. The agreements they have and the provisions within their contracts and things don't always make it easy to control them after the fact.

Will there be contractual requirements if they engage in some of these new initiatives that will...? I heard the exchange with the minister about how we know that whenever these contracts are flipped and staffing changes.... Seniors care is very relationship-oriented, and so often there are effects on this.

Certainly, you can give directives, and you can have expectations of a private contractor, but their contract with the health authorities really is what it is. They negotiate that. What kind of requirements will be put upon them if they engage in these new initiatives around trying to reduce the pressures on emergency room access? How are you going to ensure that they adhere to that?

Two or three contracts get changed down the way, and now suddenly you don't have that same agreement in place for some of the services that are being provided here. Multidisciplinary practices — OTs, physios, dietitians, all of those things — are they going to be part of the requirement, I guess, for future providers in these private residential facilities?

**Hon. T. Lake:** There will need to be a shift if we're looking at things like providing sub-acute care in residential care facilities. I talk to people who say: "You know, if only we had the ability to just put in an IV and rehydrate someone, that would mean that they don't have to go to hospital. They could be cared for in what is their home." That would take pressure off the acute care system, and it would be more appropriate care — you know, nurse- and physician-led initiatives that would keep people out of the acute care system.

We will have to think through how contracts are structured with private providers and also, of course, have the regulatory framework in place that is necessary to allow those kinds of activities to occur. That's all part of the thinking that we're doing at the moment, and looking for feedback from all the stakeholders. So that, I'm sure, will be a lively part of the discussion on June 2.

**M. Karagianis:** It'll be very interesting to see how those discussions go, because certainly we're talking about an evolution in residential care that is much more complicated, much more clinical, much more medical, much more expensive in many ways, from new initiatives to having nurse practitioners or someone on staff to handle some of these higher medical requirements. All of it very interesting to see how it unfolds and how pragmatic it is.

I've certainly heard the deputy minister talk about some of these initiatives and how we need to shift our thinking. It's interesting.

The seniors advocate report, of course, follows on top of the Ombudsman's report, and I'd like to just talk about that a little bit here in the time that we have remaining, and then I have a couple of community questions from my community.
There is, it looks like, constant pressure within the ministry and the ombuds's office on the recommendations that were brought forward in the ombuds's report *The Best of Care*. Looking at the latest update on the status of the recommendations, there are a lot of recommendations here that have no progress on them or, in some cases, I think we even have a couple that were not accepted. I wouldn't mind touching on those a little bit.

There were 142 recommendations in the initial report that came out of the Ombudsperson's office.

It seems that there are not nearly as many of them in progress or completed as we would have hoped. It looks like accepted with no progress, about 43 of them; recommendation to be

considered, without any indication of what might come next; some that are labelled ongoing. I wouldn't mind just touching on a few of those and then, perhaps, those that were not accepted as well.

The minister said that most of the actions of the plan were completed in the first year. And yet the list I've got really talks extensively about no progress, and the evaluation here is that at least 43 of them have no progress, 39 recommendations to be considered and nine that are underway in some form or other.

I wouldn't mind an update from the minister on this and just see what the status is today and how the minister kind of reconciles it. The Ombudsperson is saying that a vast number of them have not been completed, and the minister has been on record saying that many of them are. An update would be great.

**Hon. T. Lake:** When I first became minister, this was one of the first big reports I looked at and reviewed with our staff. At that time we had taken kind of a themed approach to the recommendations. The Ombudsperson, when I met with her, was not satisfied with that approach, and we agreed that we needed to go back and take another approach in terms of meeting those recommendations.

We've actually done a lot of work. The Ombudsperson does an annual update on the work. We have updated the Ombudsperson on a regular basis. In April of 2013 we did a one-year update on actions completed from the seniors action plan as well as other work related to improve seniors care in the province.

February 2014 is when my deputy and I discussed this and made a commitment to go back and put more resources into meeting those recommendations. We took a second look at the report, and instead of taking a themed approach, we looked at them individually.

On March 24 of 2014 the ministry met with staff from the Ombudsperson's office. We provided them with a response to 89 of their recommendations that we considered complete or where a significant amount of work had been initiated. On May 9 the ministry met again with staff from the Ombudsperson's office and provided them with responses to the remaining 70 recommendations.

Now, we don't always agree on whether or not the recommendations have been met — the Ombudsperson and the ministry staff. The Ombudsperson on June 25 of 2014 released her annual report and gave her assessment of whether or not we were complete or not. There was some disagreement on whether there was significant progress made on a number of these recommendations. At that time, which was almost a year ago now, we committed to a four-year workplan, and we are working through that plan.

In April of this year we provided an update to the Ombudsperson on all outstanding recommendations for her annual report, which should appear, actually, at the end of this month

or early in June of 2015. We believe that we have completed work on an additional 22 recommendations, most of which are from the first year of the workplan. There are 133 recommendations remaining. Of course, some of the work is ongoing in these. But 75 of those will be addressed in year 2; 36 in year 3; and 22 in year 4.

It will be interesting at the end of this month to see the Ombudsperson's assessment of our work and whether she feels that it is meeting her recommendations, but we do have a four-year workplan, tackling each of those recommendations in that workplan.

**M. Karagianis:** Well, rather than going through the 176 that I have here individually and reading them into the minutes — we don't have time for that — is it possible for the ministry to provide me with a more recent report on progress on these?

I have many of them that say "no progress." I have some that say "ongoing." There are a number of "ongoing." Now, this would have been a year-old, this information that I have here. "Recommendation to be considered." A couple that are not accepted, and I'd like to talk about those a little bit. Some it says the timeline has passed. I guess that's sensible, that some things have just expired over time.

Is it possible to get an updated evaluation of the ministry's views of the work and the stage of completion on it?

**Hon. T. Lake:** I'd be happy to provide the member with our report on progress. Of course, as I mentioned, the Ombudsperson will be posting her evaluation of that report on progress at the end of this month. But we will provide that list to the member.

**M. Karagianis:** That'd be excellent. Thank you very much. Two recommendations were not accepted. I'm curious as to why not. They seem to be, actually, good, in view of the conversation we've been having. A big section of this was about home care.

The two recommendations that were not accepted, No. 39 and No. 166. One recommends that the Ministry of Health extend the $300 monthly cap to seniors who do not have earned income so that they can be treated the same as seniors who do have earned income. The other recommends that the ministry expand enforcement options to create a system of administrative penalties for facility operators that do not comply with legislation and regulatory requirements.

Maybe we'll just take those one at a time. Certainly the second one has implications based on our discussions here today about shifting residential care and facility operations. Perhaps the first one first around extending the $300 monthly cap to seniors. Can we please hear what the minister says about that?

**Hon. T. Lake:** As always when we are looking at entitlement programs, we look first of all at the fiscal ability to meet all the demands that government has. We also look at fairness and equity. Home support, as the member knows, is help with activities of daily living. If someone is on income assistance — PWD, OAS, GIS — if that is where their income is coming from, they're not paying anything for home support services. So 70 percent of people using home support services pay nothing. So that's the first thing that we need to understand.

The 30 percent that are paying some of the costs of home support, we base that on income. If you have an earned income, then a maximum of $300 is the monthly cap. That cap does not apply if someone has investment income or pension income that is higher. That essentially shows that they have an ability to pay which is higher than those with a small earned income. As I mentioned, those on assistance programs, or OAS/GIS, are paying no fee.

It is a matter of choice, no question. We have to use tax dollars in the most effective way possible. This is one of those policy decisions that we have made, trying to put the fairness, equity and fiscal responsibility lenses on that policy decision.

**M. Karagianis:** The second recommendation that was not accepted was around enforcement options for facilities that don't comply with legislative or regulatory requirements. I would think that given the conversation that's been had this afternoon about residential care, this is a particularly critical one. I'm not sure why it was not accepted by the government.

**Hon. T. Lake:** The Community Care and Assisted Living Act provides licensing officers in health authorities a range of levers at their disposal if the operators of residential care facilities are not following legislative and regulatory requirements.

Those include suspending the licence, revoking the licence or imposing conditions on the licence and, in fact, even the appointment of an administrator. So it is the ministry's view that adding further final penalty to these existing options would not promote further compliance. We feel that the range of enforcement tools that are available to licensing officers is sufficient to make sure that operators are compliant with the act and the regulations.

**M. Karagianis:** How many times have those punitive measures been enacted?

**Hon. T. Lake:** We do not have that information available. We will try to ascertain it. I do know of one particular incident in Interior Health where an administrator was appointed to a facility after an incident.
These tools, I know, are used, but we will try to get a little more detail on those for the member.

**M. Karagianis:** Of the recommendations in the list that had been accepted but no progress made on, 14 of them are very specific to health authorities. When the minister reports out on progress being made in his report, and in his view, will that include the health authorities as well, or is that going to be a separate group of recommendations and progress reporting?

**Hon. T. Lake:** In the Ombudsperson's report from June 2014, there were six recommendations to health authorities, and they are responding individually to the Ombudsperson.

**M. Karagianis:** Great. So I'll guess we'll find that out when the Ombudsperson reports out. I just want to tease a couple of things within the actual items in the report. I know that the minister is going to give me an updated evaluation, but there were just a couple things. One is around the issue…. This was recommendation 15, which talked about resident and family councils and their ability to raise general care quality issues with a facility, and getting consent of the resident.

This has been a very difficult issue. A very tricky issue, I know, is around the role that family councils play in evaluating or monitoring or speaking up for individuals in care, often perhaps frail individuals who can't always make that same evaluation themselves.

This has been an ongoing issue that has raised its head many times. Can the minister report out on any progress being made around how family councils' relationships are with the facility providers?

**Hon. T. Lake:** There are, I guess, two mechanisms whereby a family council could make their concerns known. One is through the licensing officer of the health authority. So if there were systemic concerns in a residential care facility that the family council has identified, they could go to the HA and the licensing officer.

The patient care quality office is a consent-based process. So the patient has to consent to going forward with a complaint to the patient care quality office. We have identified in year 2 of the four-year workplan that I mentioned earlier that we are taking a look at the Patient Care Quality Review Board Act directives, because the act actually says it's consent based.

So we have identified in year 2 — of the four-year work plan that I mentioned earlier — that we are taking a look at the Patient Care Quality Review Board Act directives, because the act actually says it's consent-based.

We have to look at the act and see if it is possible for family councils to move forward with a complaint to the patient care quality office, given the fact that it's a consent-based process. So that's work that's ongoing in year 2 of the four-year work plan that I mentioned. We haven't ruled it out. We are looking at how it fits with the legislation and how the consent around that process would work — and that is currently being part of the year 2 work plan.

**M. Karagianis:** That's reassuring, because certainly there are pros and cons to that particular issue, I think. I'm glad that the ministry is going to look at it.
I have one more question that kind of came out of the recommendations. Being sort of conscious of the time, I do have two community questions to ask. So I'm going to try and squeeze this next one in and then ask my community questions.

It said that recommendations were being considered around health authorities developing a province wide process for determining time allotments for home care. This is an ongoing issue that I know the seniors advocate and I have talked about. Seniors activists in the province — COSCO and others — are very concerned about the numbers of hours of home care.

Given the discussion we are having about how we want to start doing more in the way of home care supports and try and provide more of those things to keep seniors in their homes longer, it seems to me that that would be one of the leading-edge pieces to consider — how you increase the number of hours of home care that are being provided.

There have been cutbacks and cutbacks and cutbacks — and lots of anecdotal reports that I have heard at forums and things around not enough time to keep relationships with seniors that are important. Again, it's that all kinds of seniors care is very relationship-based.

I'm just wondering, specifically teasing that piece out, what kind of thinking there is here, as we look at trying to evolve to a different kind of care. That seems to me to be a really central question. It's probably the leading-edge piece that the government would have to start really investing in up front — more home care and better home care supports and all of that. What is the thinking around that particular piece?

**Hon. T. Lake:** I'll get a more comprehensive answer, but I couldn't resist the need to stand up and refute the member's assertion that there have been cuts and cuts and cuts. In fact, in 2013-14 health authorities spent $2.8 billion on home and community care, which is up $1.2 billion from 2001 — an increase of 79 percent. Community care services are part of that, and they went from $404 million in 2001 to $994 million today. It's an increase of 146 percent. I think the member should resist the temptation to characterize a 146 percent increase as a cut.

Just a few more data to add. In 2012-13 there were 7.37 million hours of home support provided, 23 percent more than just three years earlier. So the shift is definitely there to more home support services, both in money and in number of hours. That will have to continue, as the member has indicated.

We are trying to move resources so that we're not so reliant on the acute care system and we can keep people at home, in the community, longer. That will necessarily mean more home support, whether that is activities of daily living or whether it's case management, nursing, rehab, respiratory therapy, occupational therapy — all those supports. We'll have to shift resources into the community so that we can get reduced reliance on acute care.

The member is very familiar with the term "ALC," which is alternate level of care, and that varies from health authority to health authority. There are some health authorities that have 10 to 14 percent of their beds in acute care that essentially are being used for caring of elderly residents that could live independently and be cared for either at home or be cared for in the community.

Shifting those resources will take the pressure off of hospitals, which will have a knock-on effect, allowing beds to be freed up. That will reduce costs and also provide extra space for post-surgical care, which is sometimes a limiting factor in the number of surgeries that can be done.

The seniors advocate is actually doing a survey in September of all 30,000 recipients. We will have that report in late November — so, again, active work on the part of the seniors advocate.

**M. Karagianis:** I know we're running out of time. I'm sure that on the issue of hours of home care — cuts versus no cuts — I'll hear from seniors groups on this. We may talk about it again at some point, I'm sure, their perception being completely different from what the minister has portrayed.

The committee rose at 6:17 p.m.