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Seniors Care for a Change

Stories of how reducing red tape can enhance frontline service delivery

Prepared for the BC Care Providers Association
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BC CARE PROVIDERS ASSOCIATION
Advocating service excellence for seniors

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On behalf of the BC Care Providers Association, we are pleased to introduce our *Seniors Care for a Change* report.

A year in the making, this report focuses on practical opportunities to reduce red tape within BC's continuing care sector while maintaining or improving the quality of care provided to our seniors.

All too often limited resources intended for front-line care for our residents get diverted into supporting activities and processes with lesser value. Our report provides not only real-life examples of that unnecessary red tape, but also offers solutions.

Seniors Care for a Change focuses on 5 key recommendations. Implemented in their entirety, we are confident they would allow front-line workers and care operators to enhance the level of care provided, improve the use of tax dollars and protect vulnerable seniors.

In a spirit of open dialogue, a draft copy of this report was shared in advance with the BC Ministry of Health, the regional Health Authorities as well as the new Senior's Advocate. As valued partners, we thought it was important to seek out their opinion and feedback in order to strengthen the recommendations.

While a report of this nature is by no means all encompassing, it does shed light on some key areas our sector feels should be addressed.

Most importantly, it illustrates that on-going dialogue and two way consultation between government and the continuing care sector is key if we are to collectively prepare ourselves for a rapidly ageing population.

During the process of developing *Seniors Care for a Change*, it became evident that we need a more formalized mechanism of dialogue between the continuing care sector and government. We intend on exploring possible opportunities with our partners regarding this in the coming months.

In closing, we would like to express our sincerest thanks to our Association Board of Directors and countless members who helped to develop *Seniors Care for a Change*. Without your input, we simply could not have produced the quality of report we have released today.

Sincerely,

Dave Cheperdak
President

Daniel Fontaine
Chief Executive Officer

About Us: We are the industry association for B.C.'s long term care sector. We have been serving private and non-profit community care providers for over 35 years. Our growing membership base includes over 115 residential care, assisted living and home support members, as well as over 110 commercial members across British Columbia.

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Table of Contents

Seniors Care for a Change:

Stories of how reducing red tape can enhance frontline service delivery

Executive Summary

The Seniors Care for a Change report by the BC Care Providers Association was commissioned to provide the BC Government with a set of targeted recommendations that deliver simple and strategic ways to reduce the administrative burden of regulatory and reporting overlap for the publicly funded beds within the continuing care sector, and to redirect resources to frontline care.

The report is based on a review of relevant and existing literature, in tandem with consultations with stakeholders in the BC continuing care sector. Stakeholder consultations accounted for approximately 30 percent of the industry, consisting of 28 care professionals speaking on behalf of 27 organizations representing 68 care homes overall. Participant responses to interviews and/or surveys were compiled, summarized and formed the basis of the recommendations presented in the report.

The following recommendations, and their sub-sections, offer ways to streamline administrative duties and improve the quality of care without reducing accountability.

1. **Strengthen client payment and collection of outstanding debts.**

    - Develop a policy similar to Fraser Health Authority's *Residential Care Contracted Service Provider Collections Policy*, a well-defined mechanism that if followed, care providers could ensure that the debt is 100% covered.

2. **Develop a new funding and accountability model.**

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

    - Improve the request for proposals (RFP) process by ensuring that a RFP process is followed whenever possible.

3. **Implement a person-centred approach to care.**

    - Increase flexibility in nutrition regulations, specifically *Regulation 64 (1)* and *62* in the *Residential* Care *Regulations,* regarding meal times, nutrition, and the cycle of menus**.**

    - Implement legislation that allows patient information to flow through the health care system with the resident, especially regarding the duplication of nursing charts and shared information after a patient's return from a hospital stay.

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

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

    - Increase flexibility of the regulation requiring locks on all bathroom doors

4. **Reduce overlap with the investigation and inspection process**

    - Streamline the investigation process so that there is one external body investigating allegations of abuse, or other complaints, at a time.

    - Improve the operation of the Care Aide Registry to better support its mandate of protecting vulnerable clients based on recommendations in BCCPA's forthcoming report.

    - Streamline Licensing, Quality Review, WorkSafeBC and Accreditation Canada inspections so that the same criteria are not the responsibility of multiple inspection bodies.

5. **Streamline and standardize reporting and data collection.**

- Standardize reports across health authorities.
- Reassess the purpose and the need for the Provincial Performance Management Framework reports.
- Gather a sample rather than a census of financial data through the Health Sector Compensation Information System (HSCIS).
- Aid small operators with HSCIS and InterRAI data reporting efforts keeping in mind economies of scale in regulatory compliance costs.

The implementation of each recommendation would effectively reduce red tape, allowing BC's care providers to direct more attention to client care and less to duplicating bureaucratic services, thereby improving the quality of care at no extra cost to taxpayers.

Introduction

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

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

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

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

The operation of a care home in BC is complicated: in order to operate, each site must be connected to a plethora of organizations that accredit, audit, regulate, advocate, inspect, etc. The large number of organizations that a private or non-profit care provider must encounter is illustrated in Figure 1 below. This chart is an updated version of the "Dis-Org Chart" developed by the BC Care Providers Association (BCCPA)[5] in 2010, as layers of complexity continue to be added over time.

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

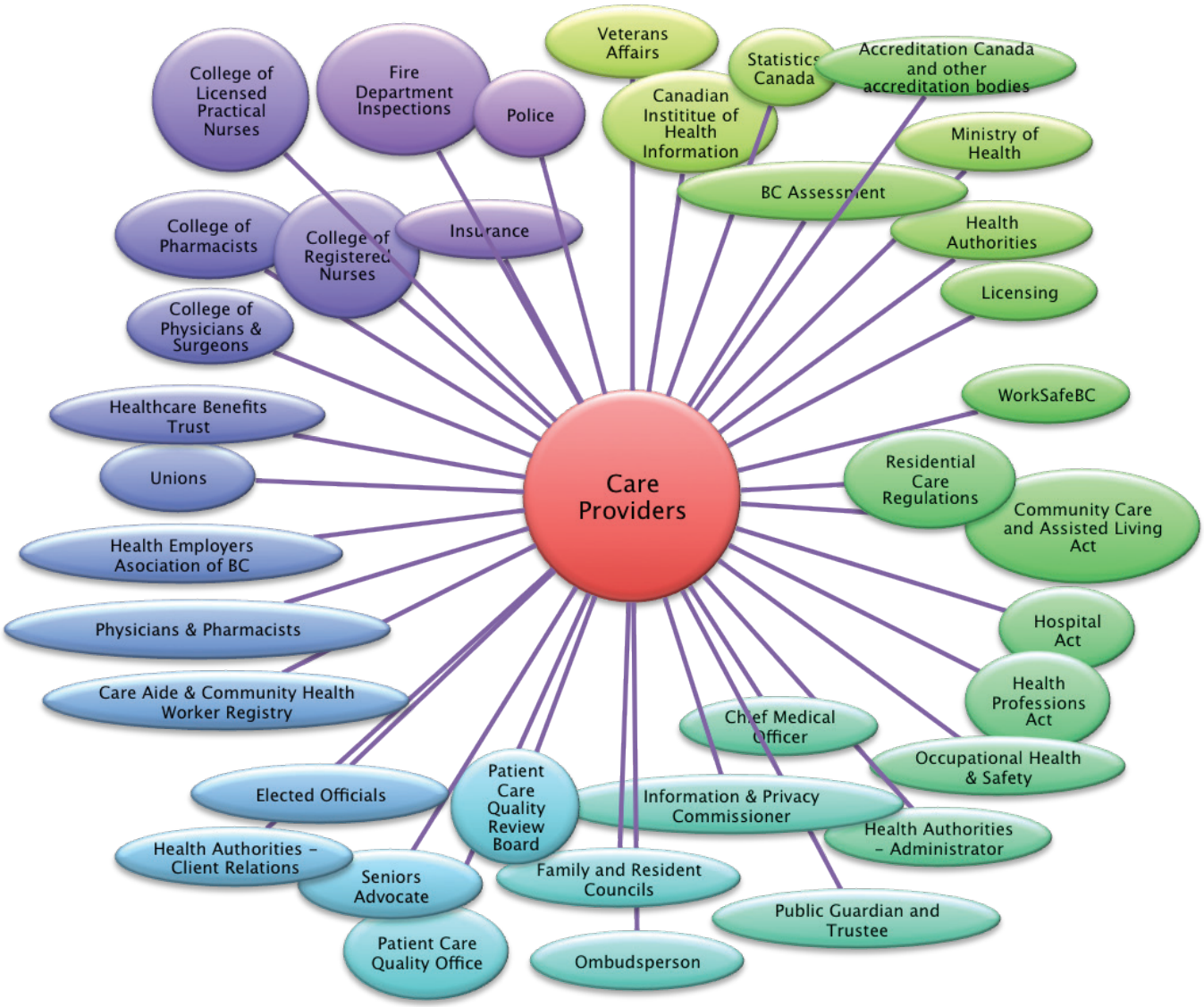
2 BC Stats, p.3

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

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

5 See Appendix A for an info-graphic that describes the BCCPA.

Figure 1: BC Care Providers Regulatory Environment



Despite the complicated system for private and non-profit care homes in BC, the February 2012 report from the BC Ombudsperson identifies that, on average, beds in private care homes can cost up to 13.34 percent[6] less than beds in public care homes without compromising the quality of care.[7] This indicates that private care homes are operating efficiently and, as such, there could be significant cost savings by investing in private care homes as the Government prepares the health system for the increase in demand for care homes in the near future. Furthermore, a streamlined system with less red tape could result in even greater efficiency for private care homes.

A commendable first step towards addressing the need to streamline the current continuing care system is the Core Review of services that the BC Government is currently undertaking. The purpose of the Core Review is to identify where there is red tape, or unnecessary regulations, and to advise

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

7 BC Ombudsperson, "The Best of Care: Getting it Right for Seniors in British Columbia," Public Report No.47, to the Legislative Assembly of British Columbia, February 2012, p.217

Table 28 in the Ombudsperson's report shows average daily per-bed funding for public beds in private and public care homes in 2010/11 in the five health authorities. In IHA, the average bed in a public home costs $200.15 and an average bed in a private home costs $190.15. So, in IHA, a bed in a private home costs 95% of the cost of a bed in a public home (($190.15/200.15)*100). The following percentages are calculated in the same way. In the NHA, a bed in a private home costs 89.98% of the cost of a bed in a public home. In VCHA, a bed in a private home costs 97.17% of the cost of a bed in a public home. In VIHA, a bed in a private home costs 86.66% of the cost of a bed in a public home. Hence, in these four Health authorities, the cost of a bed in a private home ranges from 2.83% (in VCHA) to 13.34% (in VIHA) less than the cost of a bed in a public home. In FHA, the average bed in a public care home costs 93% of the cost of a bed in a private care home.

on strategies to reduce associated waste of resources. The ultimate goal is to improve the quality of all Government services for British Columbians at a reduced cost.[8]

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

Methodology

The project team of Michael Izen and Rebecca Livernois reviewed the available Government and industry literature. The team then interviewed twenty-one owners and administrators in the continuing care sector across BC (both members and non-members of the BCCPA) to elicit information about red tape in the sector. Seven online surveys containing similar questions to the interviews were also completed. Therefore, a total of 28 care professionals representing 27 organizations (68 care homes[9]) across all health authority jurisdictions in the province were consulted. The majority of care homes represented by the interviewees are composed of publicly and privately funded beds. At least half of the total number of beds in most of these care homes are publicly funded.

Considering there are approximately 246 private and non-profit care homes in BC,[10] that these consultations were voluntary[11] and that time and resources were limited, a sample of 68 is relatively high: over 27 percent of the industry was consulted.

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

Recommendations

The following recommendations offer ways to streamline administrative duties and improve the quality of care without reducing accountability. Reducing red tape is associated with improved efficiency because time is saved on administrative overlap that can be redirected to frontline service delivery.[12]

Reducing red tape is a priority of the BC Government.[13] The number of regulatory requirements in BC has decreased by 42 percent since 2001 when the Government first started measuring its regulations.[14] BC was the first province, now only one of two provinces in Canada, which publicly reports red tape measures on a regular basis and that has legislated a requirement to report these measures annually.[15] BC received an "A Grade"– the best score in Canada – in the 2013 and 2014 Red Tape Report Card released by the Canadian Federation of Independent Business (CFIB).[16] Here, the BC Government is provided with ways it can further extend its success into the continuing care sector.

8 See Appendix B for the complete terms of reference.

9 Some interviewees were representatives of organizations that operate several individual care homes in BC.

10 BC Ministry of Health, Community Care Licensing Branch, "Find a Care Facility by Health authority"

11 All BCCPA members were offered the opportunity to complete the online survey.

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

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

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

Furthermore in BC where there is already a two-tiered system in place, ideally private care homes will indeed make a profit if the system is to function: without any profit, there would be no private care homes in operation. If British Columbians have decided to have private care homes in BC, then they must also, by default, want them to make profits. If private care homes make profits, more people will be drawn to this quality-of-life business, and more care homes will be built. The result would be more seniors having access to care homes that provide them with a high level of quality care.

13 For example, see Honourable Terry Lake, Minister of Health Mandate Letter

14 CFIB, "Red Tape Report Card 2014" p.2

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

16 CFIB, p.2

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

Red tape is an economic barrier that leads to lost business activity, which results in fewer businesses, fewer jobs, higher prices, and less room for wage increases.[17] Red tape has the same effect in the continuing care sector: the burden of regulatory requirements to private care providers can lead to fewer providers entering the market, and therefore fewer care homes in BC. This is particularly costly to the healthcare system because it could increase wait times and increase the burden on hospitals, the most expensive area of care in the health system, when patients must wait longer in a hospital bed for a bed in a care home to open up.[18]

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

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

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

Redirecting time to frontline service delivery increases direct care hours, such as nursing and social service hours. In the literature, this has been linked to better health outcomes, fewer hospitalizations[19] and improved wellbeing.[20] Hence reducing administrative overlaps could result in better value for money, a goal of the BC Government in the 2014/15 - 2016/17 Ministry of Health Service Plan,[21] because quality of care could increase resulting in increased quality of life for residents and lower health care costs for taxpayers, without an increase in client user fees.

1. Strengthen client payment and collection of outstanding debts.

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

It should be noted that for individuals receiving long-term residential care services for which the payment of the assessed monthly rate would cause them or their family serious financial hardship, they may be eligible for a reduced rate.

During consultations, care providers shared their concerns that the Public Guardian and Trustee (PGT) may not take control of the resident's finances to ensure client user fees are paid when a resident is mentally incapable.[22]

When this happens, care providers must act as collection agencies to obtain the client user fees from the family. It is extremely undesirable to evict

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

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

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

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

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

22 Government of BC, Public Guardian and Trustee, "Assessment and Investigation Services"

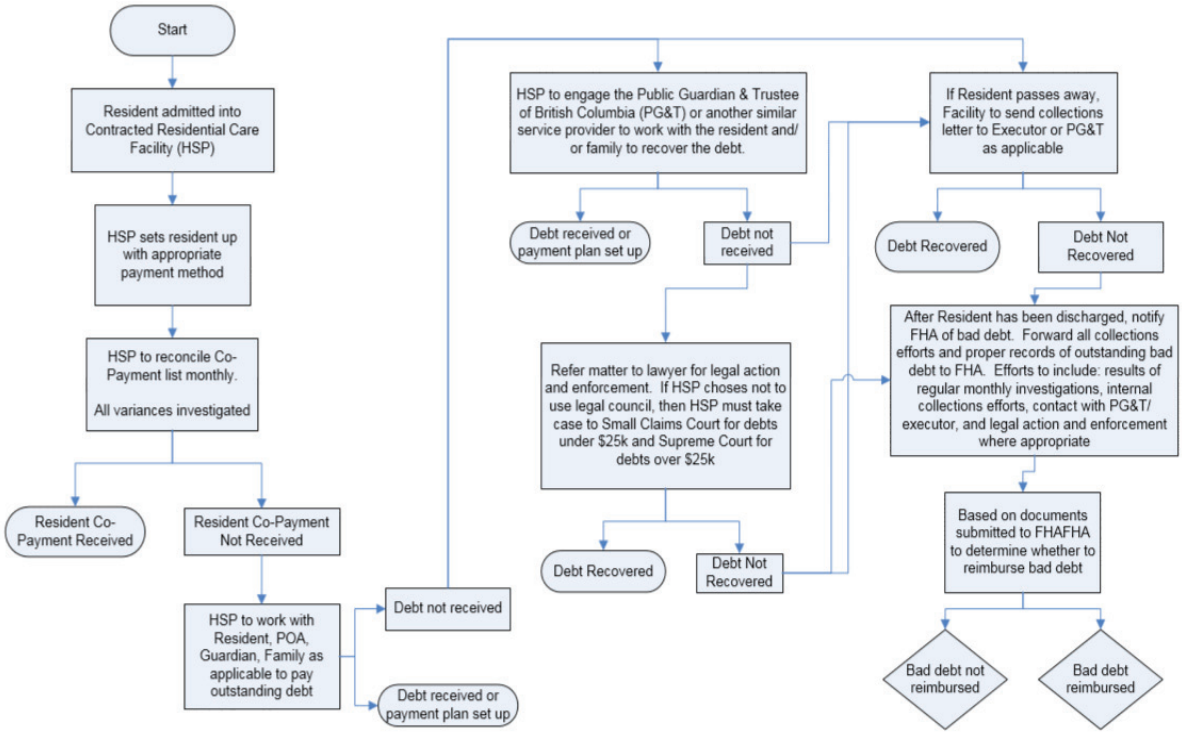
someone from a care home and eviction only occurs as a last resort, which means that debt collection efforts are often a prolonged process. [23]

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

Care providers indicated that social service provision is one component of the daily direct care hours that care providers are subsidized by the Government to spend with a resident in a publicly funded bed. Furthermore, debt collection efforts are categorized as a social service.[24] Debt collection efforts consume many hours of social service. As debt collection workload increases, hours available for other care, service and support decline in direct proportion.

The Fraser Health Authority has a unique payment Contracted Service Provider Bad Debt Policy, which has proven to be successful in debt collection for debts over $1,000. The service provider is required to document and provide evidence of all requested bad debt reimbursement and efforts made at collection, using the algorithm presented in the figure below.

Figure 2: Residential Care Contracted Service Provider Collections Algorithm



The BC Government should develop a policy similar to Fraser Health Authority's Residential Care Contracted Service Provider Collections Policy. A well-defined mechanism that if followed, care providers could ensure that the debt is 100% covered.

The B.C. Government should also direct the Public Guardian and Trustee to develop an expedited intervention process where resident's client user fees remain unpaid.

2. Develop a new funding and accountability model

The second recommendation is to enhance fairness and transparency in the continuing care sector, which promote accountability and credibility.[25] A fair and transparent system also attracts business to the industry and minimizes deadweight loss that is caused by convoluted processes that impede

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

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

25 BC Ombudsperson, p.12

innovation and efficiency. Generally, they also have a positive, stabilizing effect on the economy. For example, fairness and transparency give financial lending institutions confidence and as a result, keep lending rates down.[26]

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

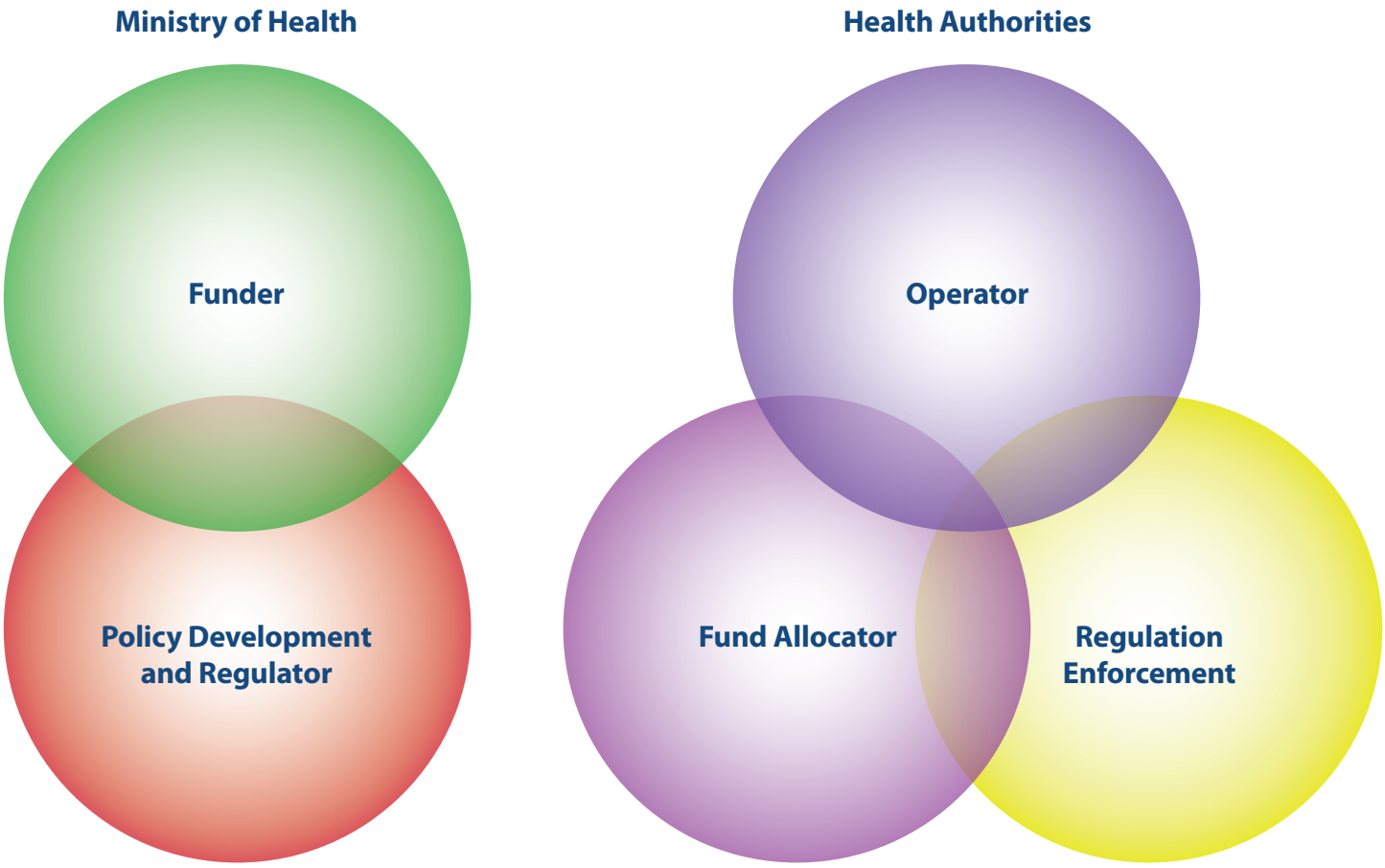
A New Model

2a: Separate the bodies that fund, allocate funds, and regulate care homes, from those that operate care homes.

The current model of care operations has been in place for over a decade when the Health Authorities restructured it in 2001. No substantial review has been conducted on how private care homes are funded and regulated.

At present, the model has the health authorities as funder, regulator and operator. The Ministry of Health provides the funding, health authorities allocate the funding and both regulate private and non-profit care homes. That is, health authorities compete for resources with private industries since they are operators of care homes even though they also regulate and allocate funds to themselves and to private care homes. The overlap in responsibilities could skew the industry and as such reduce market efficiency. Figure 3 below shows the current, overlapping model.

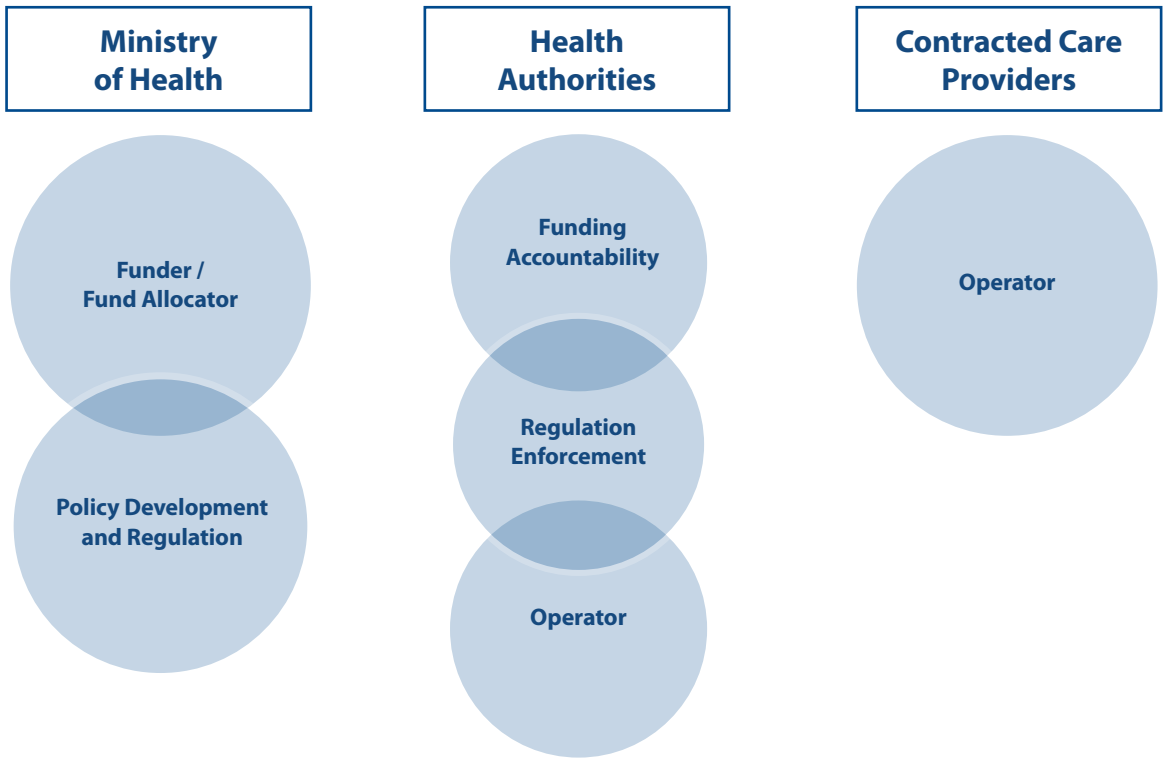
Figure 3: Current Model of Government's Role in Care



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

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

Figure 4: Proposed Model Separating Roles of Government and Care Providers



Although this new model may not perfectly level the playing field between health authority and private care homes, it could clarify the lines of accountability.

Request for Proposals

2b: Improve the request for proposals (RFP) process by ensuring that a RFP process is followed whenever possible**.**

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

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

-Administrator of a large care home organization

Care providers have indicated that there have been times when a Health authority has issued an RFP to general contractors for construction or renovation but not for operation of a care home. For example, FHA issued an RFP only to general contractors for the construction of a new seniors' complex in Abbotsford. FHA will pay $21.12 million for construction costs in addition to annual operation costs.[27]

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

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

More recently, it was released that FHA decided to discontinue funding for 76 beds at Burquitlam Lions Care Centre.[28] These 76 publicly-funded beds would be given to another private or non-profit care home; however instead of issuing an RFP for the newly available beds, FHA folded these beds into a previous set of beds that had already been bid on, and awarded to a care home organization. That is, 76 beds were awarded to a care home without an RFP for those particular beds. If it was known by the bidders that the RFP for the previous set of bed would actually include an extra 76 beds than it stated, bids may have differed and taxpayers could be sure they were getting the best value.

Care providers are also concerned that some RFP criteria include measures that do not properly represent care homes of differing sizes**.** For example, raw figures are sometimes required in RFP forms; however percentages provide better comparisons among the varying sizes of care home organizations.[29]

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

3. Implement a person-centred approach to care.

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

Prescriptive regulations may be implemented as a reaction to a single adverse event. This often means that person-centred care suffers because a reactionary approach is taken instead of a proactive approach.[30]

"The Expert Panel strongly believes that the sector must move away from prescriptive staffing, regimented work environments and punitive approaches that discourage initiative, critical thinking and creative problem-solving. This requires a shift from a focus on compliance to a focus on the customer – the resident, the family, and the taxpayer."

-Long Term Care Innovation Expert Panel, "Why Not Now? A Bold, Five-Year Strategy For Innovating Ontario's System of Care for Older Adults," March 2012, p.30

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

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

Nutrition Regulations

3a: Increased flexibility in nutrition regulations, specifically *Regulation 64 (1)* and *62* in the *Residential Care Regulations.*

Meal Times

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

Regulation 64 (1), Food Service Schedule in the *Residential Care Regulations* is a concern for many care providers.[31] This regulation is at odds with person-centred care because it prescribes specific meal times. For example, breakfast can only be served between 7am and 9am. This may not be ideal for some residents who are on alternative sleep schedules.

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

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

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

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

Furthermore, the Alzheimer's Society of Canada states that "a person with Alzheimer's disease may experience increased confusion and anxiety during meal times so staff need to be aware of individual reactions to meal times and respond with both patience and sensitivity to the unique needs of the individual."[32] *Regulation 64 (1)* interferes with care providers' ability to easily adjust meal times for certain residents, and as such this detracts from some residents' quality of life and hampers the ability to provide person-centred care.

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

Nutrition and the Cycle of Menus

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

Division 3, Regulation 62 in the *Residential Care Regulations*[33] places strict requirements on nutrition and the cycle of menus, which can also detract from the quality of life of residents. In particular, *Regulation 62 (2)* requires that meals abide strictly to the Canada Food Guide and to a personalized nutrition plan, which often sets caloric restrictions for residents.[34] Allowing more flexibility in meal plans could allow care providers, working with nutritionists, to develop meal plans for residents that give them the best possible balance of health and personal enjoyment.

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

"A person-centred approach to meals and nutrition is founded on getting to know the individual, their needs and preferences,"[35] and these particular regulations, although instated initially to protect residents and ensure proper nutrition guidelines are followed, in practice can result in a reduction in person-centred care.

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

Regulations Requiring Locks on Bathroom Doors

3b: Increase flexibility of the regulation requiring locks on all bathroom doors.

32 Alzheimer's Society of Canada, "Guidelines for Care: Person-centred care of people with dementia living in care homes," Framework January 2011, p.22
33 BC Government, "Residential Care Regulation, BC Reg 96/2009," May 31, 2012
34 This regulation states: "A licensee must ensure that each menu provides
(a) for each day, a nutritious morning, noon and evening meal, with each meal containing at least 3 food groups as described in Canada's Food Guide,
(b) for each day, at least 2 nutritious snacks, with each snack containing at least 2 food groups as described in Canada's Food Guide,
(c) a variety of foods, taking into consideration
(i) the nutrition plan of each person in care and the nutrition needs, age, gender and level of activity of the persons in care,
(ii) the food preferences and cultural background of the persons in care,
(iii) seasonal variations in food, and
(iv) the texture, colour and matters that affect food safety, taste and visual appeal, and
(d) for substitutions to be made that are from the same food group and have a similar nutritional value."
35 Alzheimer's Society of Canada, p.22

During consultations, care providers shared their concerns for *Regulation 30(a)* of the *Residential Care Regulations,* which requires locks on all bathroom doors.[36]

The first concern is for the safety of residents. The Alzheimer's Society of Canada[37] and the National Institute on Aging[38] both recommend the removal of locks on bathroom doors for residents with dementia to prevent them from accidentally locking themselves in the bathroom. Although locks required by this regulation would be accessible from the outside so that care providers could help a resident locked in a bathroom, this would likely cause unnecessary stress for the resident.[39]

Furthermore, bathroom locks could take care providers' time away from providing quality care if they have to help residents locked in bathrooms and comfort them after the stressful experience. Flexibility in this requirement could enable the provision of person-centred care by ensuring the safest care homes are provided according to each individual's needs.[40]

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

- Care home administrator

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

Regulations Concerning Private and Semi-Private Rooms

3c: Assess the potential need to amend the maximum number of semi-private rooms in private and non-profit care homes.

Section 25 of the *Residential Care Regulations*, legislated under the *Community Care and Assisted Living Act*, states that a private or non-profit care home can only have 5 percent of their rooms as multiple occupancy rooms.[41]

A double occupancy room can be valuable for some residents for several reasons: it provides significant cost savings for the resident (in privately funded beds); a roommate helps ease the transition into a new community; it helps avoid loneliness and feelings of isolation; a roommate provides additional monitoring; and having stronger relationships improves the health of seniors.[42]

BCCPA should undertake more in-depth research with the BC Government and/or Health authorities, such as conducting a literature review and a survey, to determine the percent of seniors who would prefer a double occupancy room. Also, a growing number of elderly couples in care can be better accommodated in a double occupancy room. This information would be informative for an adjustment in the regulated percentage of double occupancy rooms in care homes.

Based on consultations, it appears it may be financially unsustainable for the industry to have 95 percent of all residents in private and non-profit facilities in single-occupancy rooms. This can be illustrated by the fact that some Health

36 This regulation states: "A licensee must ensure that all bathrooms have (a) a door, equipped with a lock that can be opened from the outside in the case of an emergency."
37 Alzheimer's Society of Canada, p.24
38 National Institute on Aging, "Caregiver Guide: Tips for caregivers of people with Alzheimer's Disease," *Alzheimer's Disease Education and Referral Center,* October 17, 2013, p.13
39 National Institute on Aging, p.13
40 Alzheimer's Society of Canada, p.24
41 BC Government, "Residential Care Regulation, BC Reg 96/2009"
42 Accent on Seniors, California's Senior Living Experts, "Assisted Living Facilities: Five reasons to consider a roommate"

authority residences have only six percent of their rooms as single-occupancy rooms (for example, this is the case at Banfield Pavilion in the Vancouver Coastal Health authority), while the rest are multiple-occupancy rooms.[43]

According to an interviewee, construction costs are approximately $250,000 per bed in a single-occupancy (single) room and $140,000 per bed in a double-occupancy (double) room. Currently, a facility with 100 beds that must have at least 95 percent of the rooms as single rooms would cost a minimum of $24,500,000 to build. If instead 75 percent of the beds were single rooms, a facility with 100 beds would cost $22,250,000 to build. This is a savings of $2,250,000 in construction costs per care home, or a savings of almost 10 percent of current construction costs.

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

Funeral Planning

3d: Clarify *Regulation 5(1)* of the *Cremation, Interment, and Funeral Services Act*

When a resident of a care home passes away, the care home legally cannot send the body to the deceased's chosen funeral home until the funeral home receives authorization to do so from a person with a specific relation to the deceased, as prescribed by *Regulation 5(1)* of the *Cremation, Interment, and Funeral Services Act*.[44]

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

This presents a serious issue: some residents may not have any contactable relations, or any relations at all, as defined in *Regulation 5(1)*. *Regulation 5(1)(j)* states that a minister, or the official administrator of the estate (understood to be the Public Guardian and Trustee) can give approval in this case. However, there is a problem if they cannot be reached promptly, as could be the case in the evening or on the weekend.[45] In this situation, a care provider would be required to keep a body at a care home until the funeral home has contacted someone who can approve the transfer. It is perceivable that this could take several days over the weekend.

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

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

- Nurse

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43 See <www.vch.ca/Banfield_Pavilion>

44 BC Government, "Cremation, Interment and Funeral Services Act, [SBC 2004] Chapter 35," March 18, 2013, states:

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

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

Privacy Legislation

3e: Implement legislation that allows patient information to flow through the health care system with the resident.

Nursing Charts

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

When a resident moves from a privately funded bed to a publicly funded bed, the legislation that protects the privacy of their medical information changes from the *Personal Information Protection Act*[46] to the *Freedom of Information and Protection of Privacy Act*.[47] Since the privacy legislation changes, the nursing chart cannot be continued even if the resident stays in the same care home with the same staff. This is an inefficient use of nursing time.

It costs care homes $80 to create a nursing chart from scratch.[48] If every care home had four clients a year in every care home transfer from a public to a private bed, this could cost the industry $787,200 over 10 years.[49] This accounts for 19,680 hours across the industry over 10 years that are spent duplicating clinical activities rather than providing care to clients because of the lack of legislation that allows for the continuation of existing charts when funding sources change.[50]

Besides the entering of initial nursing information, nutritional, physiotherapy, recreational and physical assessments also have to be done. It has been estimated by some care providers that this all inclusive cost can be up to $200.

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

Return from a Hospital Stay

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

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

- Nurse

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)*[51] which stipulates that this personal medical information that is owned by the hospital cannot be acquired by a third party.

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.

46 BC Government, "Personal Information Protection Act, [SB 2003], Chapter 63," October 23, 2003.
47 BC Government, "Freedom of Information and Protection of Privacy Act, [RSBC 1996], Chapter 165"
48 According to interviewees, it takes 2 hours to create a new nursing chart. Nurses who create these charts are paid $40/hour
49 (($80 * 4 moves)* 246 care homes)*10 years = $787,200
50 ((2 hours * 4 moves)*246 care homes)*10 years = 19,680 hours
51 BC Government, "Freedom of Information and Protection of Privacy Act, [RSBC 1996], Chapter 165"

It should also be noted that it can be difficult to gather information from clients with dementia, adding to the risk of error.

It costs care homes $23 every time a client returns from hospital to gather new medical information.[52] One study 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.[53]

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

4. Reduce overlap with the investigation and inspection process

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

Positive steps have been taken in the past to improve investigation and inspection processes in BC. For example, FHA recognized that it is problematic to have Licensing Officers with backgrounds in childcare inspect or investigate care homes. In response, they recently underwent a reorganization such that only specialists in residential care will inspect and investigate care homes.[55]

Furthermore, care providers feel that the process that has been set up by the BC Government and the Health authorities for clients to make complaints is generally functioning well. For example, the Patient Care Quality Review Board (PCQRB) will only get involved after the Patient Care Quality Office (PCQO) has attempted to handle the issue. This means that overlapping investigations and responsibilities are minimized between these groups.

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

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

Consolidating Investigations

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

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

When there is an allegation of abuse, many different bodies may perform their own independent investigation of the same event. The care provider

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

- Care Home Administrator

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

53 (($23 * 0.36 clients)*246 care homes)*10 years=$20,369

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

55 Fraser Health Authority, "Restructuring of Program Services, Bulletin to Licensees of Licensed Community Care Facilities in Fraser Health," Dec. 2013, p.1

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

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

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

Consider the case that PCQO only investigated if the Licensing investigation was complete and if the outcome of that investigation were unsatisfactory to the resident or their family. This would give the family and resident a chance to decide whether they were satisfied with the outcome. In the event that the family decided they were satisfied with the Licensing investigation when they had been planning on contacting PCQO, the health authorities could save an estimated $1,200 on a single investigation.[56] Over time, these costs could be substantial. For example, if this happened 4 times a year, the health authorities could save $48,000 over 10 years in wage costs for investigations.[57]

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

The Care Aide Registry

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

Care providers commend the Government on establishing the Registry and support its mandate to protect vulnerable clients in the continuing care sector;[58] however, care providers suggest that there are concerns with the way the Registry operates. BCCPA is currently undertaking a research project that will be released later this year to identify a sustainable model for the Registry that supports a "zero-tolerance" approach to elder abuse. This report will contain detailed recommendations; here the issues with the Registry that are particularly relevant to the Core Review are outlined.

Registry Investigations

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

Furthermore, the Registry seems to often have conflicting findings to the other investigations. Since the Registry's conception in 2010 and as of January 2014, 139 employees were reported to the Registry as being terminated or suspended for abuse. This means that the internal investigation and external investigation conducted by Licensing found that abuse occurred, and that the employee was no longer suitable to be working in that home. Of these reported employees, the Registry investigated 73 cases because the employee contested their employment termination or suspension, and seven investigations were currently underway.[59]

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

57 There were 2 reports in our sample of 68 of investigations in the past year where both licensing and PQCO were involved. Extrapolating this figure to all private care homes in BC (246), this would suggest a total of 7.2 in the past year [(2/68)*246=7.24]. Consider that in just over half of these cases (4), the resident or family was satisfied with the outcome of the Licensing investigation even though they would have asked PCQO to investigate if the two organizations could investigate at the same time. In this case, the health authorities would $4,800 annually in wage costs for investigators (4*1200=4,800), or $48,000 over 10 years, by requiring PCQO to investigate only after the Licensing investigation is complete.

58 BC Care Aide & Community Worker Registry, "Role and Mandate"

59 Numbers obtained in care providers' correspondence with the Denominational Health authority (DHA) and the Health Employers Association of BC (HEABC). Confidential

Of the 66 investigations that were completed, 54 employees were reinstated to the Registry after certain requirements were fulfilled such as further education. That is, only 12 employees were removed from the Registry. This means that in over 80 percent of the cases where abuse was substantiated by Licensing and the employer, the employee is still eligible to work in the industry.[60] Furthermore, there is no documentation for future employers to inform them that a care aide had their employment terminated in the past for abuse. This is an enormous concern for residents, families and care providers.

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

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

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

Considering these issues with Registry investigations, care providers do not see the value added in the investigations especially considering they must pay for half of the investigation costs, which normally range from $5,000 to $15,000.[61]

This concern is avoided in Ontario because the Registry directs complaints about care aides to other appropriate investigation bodies rather than conducting the investigation themselves. That is, in Ontario the Registry is simply a registry of care aides rather than a registry and an investigatory body, as is currently the case in BC.[62]

Privacy Concerns During Registry Investigations

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

Inspections and Audits

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

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

Inspections are conducted by Accreditation Canada every four years and are intended to ensure that the care home is meeting a shared set of standards concerning all aspects of the quality of care.[63] The Health authority also conducts its own quality review, as does WorkSafeBC and Licensing. This creates duplication because several different bodies inspect similar factors. Based on the consultations, it appears as though the same standards could be monitored more efficiently by consolidating inspections.

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

60 (54/66)*100=81.8%
61 Investigation costs were reported by a number of different care providers who were interviewed.
62 PSW Registry Ontario, "General Public, Complaint(s) about a PSW"
63 Accreditation Canada, "Accreditation Basics"

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

If criteria such as sufficient controls on chemicals were the responsibility of one body, such as Licensing, a half hour, for example, could be saved on the Quality Review inspection and the same amount of time could be saved on the WorkSafeBC inspection. This could save an estimated total of $30 per WorkSafeBC and Quality Review inspection, or $73,800 over 10 years in health inspector time across the province.[64]

Saving a total of an hour of inspection time could also save care homes 2,460 hours over 10 years across BC that could be spent providing care to residents rather than duplicating processes.[65] Equivalently, saving one hour of inspection time could save care providers $55 per inspection, or $135,300 over 10 years in care providers' time across the province.[66]

This amounts to a total savings of $209,100 from reducing WorkSafeBC and Licensing inspections by a half hour each.[67]

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

5. Streamline and standardize reporting and data collection.

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

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

Reports Across Health Authorities

5a: Standardize reports across health authorities.

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

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

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

The implementation of this recommendation also could save time at the care home-level since care providers would no longer have to re-group the same information in different ways to satisfy different reports. The time saved could be redirected to caring for clients.[68]

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

65 ((1 hour*246 care homes)*10 years)=2,460 hours

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

67 $73,800+$135,300=$209,100

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

Provincial Performance Management Framework Reports

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

Only some health authorities require the Provincial Performance Management Framework Reports.[69] This framework was designed to help support health outcomes at care homes. In reference to the Provincial Performance Management Framework, some care providers are unclear regarding the benefit the sector is gaining from these reports, especially if some health authorities no longer require this report. However, a number of care providers have identified some value in these reports as a standardized accountability tool.

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

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

Health Sector Compensation Information System (HSCIS) Reporting

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

Care providers must complete two types of financial reports: the Quarterly Financial Reports to the health authorities, and semi-annual financial reports to the Health Employers Association of BC (HEABC),[70] through the Health Sector Compensation Information System (HSCIS).[71] Both reports include payroll information.

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

The purpose of HSCIS is to gather data on workers in the BC health system. This data is used for collective bargaining strategies, calculating required funding adjustments and for pay equity adjustments.[72] A representative sample of the industry, rather than a census, could suffice for these objectives. This is because an informed estimate of variables of interest provides a relatively accurate picture of the industry; an exact figure may not be necessary for HEABC's purposes.[73] Compliance costs of data reporting are high, and reducing the cost burden on the industry may increase efficiency since more time could be spent providing quality care rather than providing data in excess to HEABC's needs.

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

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

Higher Compliance Costs for Smaller Operators

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

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

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

70 HEABC coordinates the human resource and labour relations interests of publicly funded health care employers in BC, including the Health authorities, non-profit and private health employers.

71 All care homes that are members of HEABC or that receive funding from the Ministry of Health must complete HSCIS. This covers most care homes in BC. See HEABC.

72 Health Employers Association of British Columbia, "HSCIS"

73 A representative sample is a subset of individuals of the population of interest, with a similar distribution of characteristics as the entire population, which is used to predict characteristics of the entire population of interest. A census is where data is collected on the entire population of interest.

with 100-499 employees ($313 versus $74). That is, organizations with 1-4 employees spend almost 9 times more on regulatory compliance costs per employee than organizations with 100-499 employees.[74] Hence compliance costs per employee decrease as the number of employees increase, or there are economies of scale in compliance costs.

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

The provision of high quality data from all care homes is an important resource that can be used to improve seniors' care through research and supervision. Therefore it is recommended that the Government acknowledges the substantially higher compliance costs for small facilities by providing support and funding accordingly. For example, the Government could provide data collection officers and/or provide extra funding for reporting duties based on the size of the organization. This could allow smaller operators to provide high quality data and it could reduce the financial burden of complying with HSCIS and interRAI requirements. The implementation of this recommendation could allow small facilities to direct more of their limited resources toward caring for clients rather than toward administrative tasks.[75]

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

Conclusion

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

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

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

74 Government of Canada, p. 3

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

Appendix A: The BC Care Providers Association[76]

About Us

230+ MEMBERS

The BC Care Providers Association (BCCPA) is the industry association for BC's long term care sector.

We are a non-profit society that has been serving private and non-profit community care providers for **over 35 years**. Our growing membership base includes over **230 members across British Columbia**.

35+
YEARS OF SERVING A GROWING MEMBERSHIP BASE

Scope & Size

21,000+ SENIORS CARED FOR

Membership in our association is voluntary. We are BC's largest industry representative of the long term care sector.

Our members care for more than **11,000 seniors** each day in residential care and assisted living, and **over 10,000** each year through home care.

10,000+
BC SENIORS CARED FOR EACH YEAR IN HOME CARE

What We Do

The BCCPA focuses its efforts in three key areas:

1. **Foster Standards and Quality of Care:** Advocate & enhance quality of life for seniors
2. **Advocacy:** Ensure adequate funding to enhance quality care
3. **Relationship Building:** Focus on government, health authorities and key stakeholders

We host a number of key events throughout the year, including:

- Annual Conference *(over 250 attendees each year)*
- Minister of Health Annual Luncheon *(Over 350 people attend)*
- Care to Chat Speaker Series *(Over 300 attendees for first two events in November 2013 and January 2014)*
- B.C. Care Awards

Supporting the Economy

$2 [illegible]lion HOME & C[illegible]NITY

15,000+ DIRECT AND INDIRECT JOBS CREATED

$1.4 billion+ CAPITAL INVESTMENTS IN COMMUNITIES

Our members:

- create over **15,000 direct and indirect jobs** in the continuing care sector
- have made more than **$1.4 billion in capital investments** in communities across the province

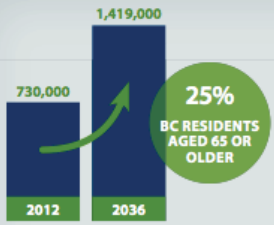
Many of our members have been in operation for over 20 years.

BC's Home and Community Care budget exceeds $2.0 billion, which is on par with the fifth largest Ministry.

A Proactive Approach

- We take a **"zero-tolerance"** approach to elder abuse.
- Our Association pro-actively developed:
  - → **Best Practices Guide** to help reduce the inappropriate use of anti-psychotic medication
  - → **Intergenerational toolkit** for schools, care homes and community groups
  - → **Residential care health and safety guidelines**
  - → **Easy-to-read guide** to assist establishing resident/ family councils
- We initiated the:
  - → **BC Cares project** which included a special "Thank You" campaign for care aides
  - → **Establishment of SafeCare BC** – the new health and safety association for BC's continuing care sector

B.C.'s Growing Continuing Care Sector



In B.C. the number of people aged 65+ is estimated to grow from 730,500 in 2012 to 1,419,900 by 2036

By 2036, almost 25% of B.C. residents will be aged 65 or older

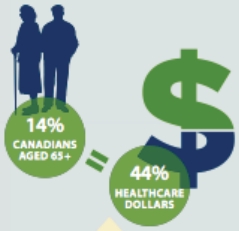
(BC Stats)

The share of government health care dollars spent on Canadian seniors has not changed much—from 43.6% in 1998 to 43.8% in 2008

(Canadian Institute for Health Information)

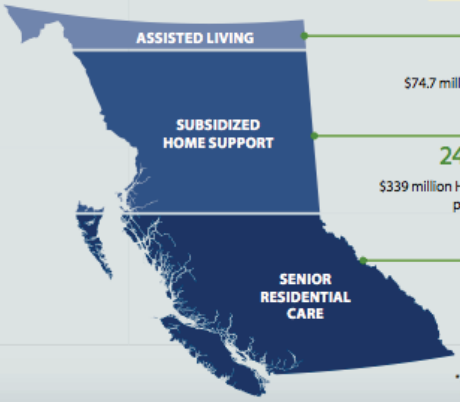
70,000 British Columbians are living with Alzheimer's disease and other dementias. This number is expected to double within the next 25 years.

(Alzheimer Society of BC)



Canadians age 65+ account for less than 14% of the population, and consume nearly 44% of provincial and territorial government health care dollars

(Canadian Institute for Health Information)



6,832 units* *(2011)*
$74.7 million provided by Health Authorities

24,724+ seniors *(2009/10)*
$339 million Health Authorities spent in 2009/10 providing subsidized home support

28,992 beds *(2010/11)*
$2 billion + to operate per year

** AL Registrar doesn't track whether unit is single or double occupancy, includes younger adults.*

76 BC Care Providers Association

Appendix B: Core Review Terms of Reference[77]

Purpose:

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

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

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

Scope:

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

Role of the Cabinet Working Group on Core Review:

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

Objectives:

The objectives for core review are to:

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

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

Timelines:

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

Appendix C: Minister of Health Mandate Letter [77]

77 Honourable Terry Lake, Minister of Health Mandate Letter

June 10, 2013

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

Dear Colleague:

Congratulations on your new appointment as Minister of Health.

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

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

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

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

To that end our first priorities across government are:

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Complete laboratory reform initiative and achieve required savings.

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

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

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

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

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

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

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

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

I look forward to working with you.

Sincerely,

Christy Clark
Premier

Attachments (2)

Seniors Care for a Change
Stories of how reducing red tape can enhance frontline service delivery