

Strengthening Seniors Care Delivery in BC

September 2015

By Michael Kary



**BC CARE PROVIDERS
ASSOCIATION** www.bccare.ca

Advocating service excellence for seniors

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ABOUT BCCPA

The BC Care Providers Association (BCCPA) is the industry association for BC's long term care sector, which has been serving private and non-profit community care providers for over 35 years. Our growing membership base includes over 260 residential care, assisted living, home support and commercial members across British Columbia. Our members care for more than 16,000 seniors annually in residential care and assisted living, and over 10,000 each year through home support. They also create over 18,000 direct and indirect jobs in the continuing care sector.

1.0 EXECUTIVE SUMMARY

With the aging population and increased pressures facing the acute care system in British Columbia now is the time to explore new solutions and models to meet the challenges and strengthen seniors care in the province. In this regard, the intention of this paper is to:

- Articulate the BCCPA's positions in regards to the Policy Papers the Ministry of Health released earlier in February 2015 particularly the one on Primary and Community Care;
- Outline various recommendations to improve the continuing care system focusing on two critical priorities namely the redirection of acute care funding to home and community care as well as the development and funding of new long-term care (LTC) models (i.e. Continuing Care Hubs); and
- Outline a process for advancing these and other recommendations particularly through the creation of a new Continuing Care Collaborative.

SECTION 1: SUSTAINABILITY

As outlined in this paper, the BCCPA advocates that the Health Authorities better utilize the existing capacity and expertise amongst non-government operators to act as champions and drivers of system change in the continuing care sector. In particular, it is recommended that the Ministry of Health and Health Authorities work with the BCCPA and other stakeholders to develop strategies to better utilize the existing excess capacity in the continuing care sector to



reduce alternate level of care (ALC) beds and offset acute care pressures. At a minimum, strategies should include the creation of a new publicly accessible online registry to report on ALC and vacant residential care beds as well as the use of current vacant beds within residential care homes, assisted living units and home support to reduce acute care pressures.

This paper also recommends the establishment of a Continuing Care Collaborative comprised of the BCCPA, Health Authorities and BC Ministry of Health to support the long-term sustainability of the sector and improve seniors care across the province. This report also suggests a strategy that new designated funding be redirected to home and community care, such as perhaps a minimum of 1% of acute care funding annually by the Health Authorities. This funding could be allocated on annual basis over a five year period into the continuing care sector including residential care and home support. This redirected existing funding would amount to approximately \$320.8 million in the fifth year and would be used to

directly address some of the documented challenges facing current operators including minimal funding lifts but also support development of new long term care models particularly new Continuing Care Hubs.

Redirecting funding from acute care could go a far way in addressing current and future pressures facing the continuing care sector. For example, based on initial cost estimates \$320.8 million, directed to the continuing care sector could potentially fund the following services: the annual operation of 4,395 long term care beds;¹ or 12,832,000 care aide hours;² or 8,020,000 home support hours.³ Along with improving access new funding as well as development of new continuing care models will also help seniors to live in the most appropriate care setting.

As outlined also in the paper, the BCCPA believes some of the acute care funding that is re-directed to continuing care sector could be obtained with a reduction of alternate level of care (ALC) beds.⁴ For example, assuming a fifty percent of ALC days could be reduced by caring for patients in residential care homes (average daily cost of \$200) instead of a hospital (average daily cost of \$1,200) it could generate over \$200 million in annual cost savings (\$203.6M). These savings in turn could also be used to reduce wait times for existing elective surgeries. For example, based on initial estimates \$203.6 million in acute care savings could potentially fund the following surgeries:

- 13,196 Additional hip replacements; or
- 17,085 Additional knee replacements; or
- 65,471 Additional cataract surgeries; or
- 9,972 Additional Cardiac Bypass Graft (CABG) surgeries.⁵

SECTION 2: INNOVATION

Consistent with the BC Ministry of Health's cross health sector strategic priorities, the Continuing Care Collaborative should review as a priority options for new delivery models including, but not limited to the creation of continuing care hubs, geriatric centres of excellence, as well as Post-Acute, Specialized Stream, Integrated Care, Frail Elderly and Dementia Care Models in order to optimize ER utilization, reduce acute care congestion and better care for the frail elderly.

As outlined in the paper the focus should be the **development of new continuing care hubs, which can provide enhanced care for seniors, including additional services such as dialysis, IV, sub-acute care, wound care, etc...** A visual schematic of such a model is provided in Figure 1 below. The four key elements of the new continuing care hubs as outlined further in the paper include:

- 1) ***Integration of health professionals and family in seniors care*** (i.e. Integrating nurse practitioners, family physicians and physician assistants into long term care (LTC), use of health and emergency professionals, specialized training, etc...);

¹ The Best of Care: Getting It Right for Seniors in British Columbia (Part 2) at p. 216-17. Accessed at:

<https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2047%20The%20Best%20of%20Care-%20Volume%202.pdf>

² Assuming a wage of \$25 per hour, as quoted by Welcome BC: <http://www.welcomebc.ca/Work/fqr/Your-Qualifications-Intro/occupational-guides/Occupation/Health-Care-Assistant.aspx>

³ Assuming that each hour of subsidized home support costs the health authorities \$40, as reported in the Ombudsperson (2012) "Home Support Backgrounder". Accessed at: <https://www.bcombudsperson.ca/sites/default/files/BOC2%20-%20Health%20Sector%20Backgrounders.pdf>

⁴ ALC beds are those occupied by patients who no longer require acute care, but who continue to occupy a hospital bed because they are unable to access home and community care services.

⁵ Uses average cost data for surgeries for those 80+ years of age, as reported by CIHI's patient cost estimator. See:

<https://www.cihi.ca/en/spending-and-health-workforce/spending/patient-cost-estimator>

- 2) ***New roles for care providers*** (i.e. new Health Care Aide roles, multidisciplinary LTC team, education and training, integration of physicians and other allied health professionals);
- 3) ***New funding models*** (i.e. sustainable funding including redirection of acute expenditures to continuing care, outcome based funding that considers optimal staffing mix and care outcomes, integration of care and team based models); and
- 4) ***Expanded role and co-location of services*** (i.e. sub-acute care, paramedics and ambulatory care, wound care, dialysis, IV care, prevention and health promotion including frailty screening and chronic disease management, respite care, palliative care, pharmacy and medication management, mental health, diagnostic and laboratory services, rehab and recovery care, etc...).

Finally, this report also advocates that **the province redefine the existing eligibility criteria for complex care** as well as **undertake a review of Assisted Living to remove the restrictions relating to the number of prescribed services** (currently two) that may be provided in this care setting. By undertaking the recommendations outlined in this paper the BCCPA believes it will help accomplish following outcomes:

- Allow more seniors to live in their home (i.e. single family residence or apartment longer while ensuring a broader level of residential care and sub-acute services are available to them);
- Increase the ability of the health authorities to provide residential care beds closer to the senior's former single family home / apartment when they need it;
- Increase choice for seniors utilizing the current "First Appropriate Bed" policy;
- Improve overall quality of seniors care, including access and better health outcomes;
- Help reduce unnecessary hospitalizations and acute care / ER pressures;
- Reduce immediate and long-term pressures facing the system including ALC beds;
- Enhance and build upon existing capacity and expertise in the continuing care sector;
- Foster innovation and care through the development of new care models particularly new continuing care hubs and geriatric centres of excellence;
- Better meet the needs of a growing elderly population particularly those with high needs such as the frail elderly and dementia care;
- Expand role of continuing care including residential care, assisted living and home support to reduce overall health system costs;
- Foster greater collaboration in the sector through creation of a new Continuing Care Collaborative;
- Develop strategies to begin the redirection of funding from more costly acute to home and community care; and
- Remove unnecessary restrictions for Assisted Living including around number of prescribed services.

Figure 1: Components of the Current 24/7 Residential Care Model and New Continuing Care Hubs



Current 24/7 Residential Care Model

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



New Continuing Care Hub or Continuing Care Campus (C3)

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

New Services Offered

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

1.1 RECOMMENDATIONS

SUSTAINABILITY

Recommendations

1. That, as an immediate priority, the Ministry of Health and Health Authorities work with the BC Care Providers Association (BCCPA) and other stakeholders to develop strategies to better utilize the existing excess capacity in the continuing care sector to reduce alternate level of care (ALC) beds, offset acute care pressures as well as better care for frail elderly and seniors with Dementia. Strategies should include the creation of a public registry to report on ALC and vacant residential care beds as well as use of current vacant beds within residential care, assisted living units and home support services to reduce acute care pressures.
2. That the BC Ministry of Health, Health Authorities, and BCCPA establish by the end of 2015 a Continuing Care Collaborative in order to support the long-term sustainability of the sector and improve seniors care across the province.
3. Starting in fiscal year 2016/17, the Performance Agreements between British Columbia's Ministry of Health and Health Authorities should include a specific target for redirecting acute care expenditures such as a minimum of 1 percent annually over a five year period to the home and community care sector. Such expenditures would be directly reinvested into residential care and home care / support to deal with existing cost pressures facing service providers as well as support development of new continuing care models to reduce acute care pressures, improve access to care while also allowing seniors to receive services in the most appropriate setting. A thorough public reporting on the additional services provided to seniors on an annualized basis as result of investment should also be considered.

Intended Outcomes:

- Allow more seniors to live in their home (i.e. single family residence or apartment longer while ensuring a broader level of residential care and sub-acute services are available to them)
- Increase the ability of the health authorities to provide residential care beds closer to the senior's former single family home / apartment when they need it
- Increase choice for seniors utilizing the current "First Appropriate Bed" policy
- Reduced ALC days
- Reduce acute care pressures and ER utilization
- Better utilization of existing capacity in the continuing care sector
- Improved care for frail elderly and seniors with dementia
- Greater public reporting (i.e. ALC beds and vacant beds)
- Greater collaboration between government, Health Authorities and continuing care sector
- Reducing current pressures facing care operators

INNOVATION

Recommendations

4. That, consistent with the Ministry of Health's cross health sector strategic priorities to improve the effectiveness of primary and community care and access to care including rural health as well as provide seniors with improved access while residing in the most appropriate care setting, the Collaborative as a key priority review options for new delivery models. This includes, but not limited to the creation of Continuing Care Hubs, Geriatric Centres of Excellence / innovation, as well as Post-Acute, Specialized Stream, Integrated Care, Frail Elderly and Dementia Care Models to optimize ER utilization, reduce acute care congestion and better care for frail elderly.
5. That the Ministry of Health redefine the existing eligibility criteria for complex care and Assisted Living to allow seniors to remain at home longer or the most appropriate care setting in accordance with the recommendations from the Seniors Advocate to remove restrictions relating to the number of prescribed services (currently two) that may be provided in Assisted Living.

Intended Outcomes:

- Allow more seniors to live in their home (i.e. single family residence or apartment longer while ensuring a broader level of residential care and sub-acute services are available to them)
- Increase the ability of the health authorities to provide residential care beds closer to the senior's former single family home / apartment when they need it
- Increase choice for seniors utilizing the current "First Appropriate Bed" policy
- Reduced ALC beds
- Reduce acute care pressures and ER utilization
- Greater innovation with new Continuing Care Hubs and other care models such as geriatric centres of excellence
- Expanded scope and access to care for seniors
- Better utilization of existing capacity in the continuing care sector
- Improved care for frail elderly and seniors with dementia
- Reducing current pressures facing care operators
- Removing restrictions on prescribed services and expanded role for Assisted Living

2.0 Background

On February 18, 2015 the BC Ministry of Health released a series of papers covering five broad areas of the health system including: patient centered care, health human resources, rural health, surgical services as well as primary and community care. The Ministry also later released a paper on Information Management / Technology in June of 2015.⁶

The most relevant of the papers with respect to the continuing care sector and seniors is the report on primary and community care.⁷ As part of the roll out of these papers a consultation session with the Ministry of Health took place on March 25, 2015 in Vancouver with members from Denominational Health Association and BCCPA. The Ministry of Health also hosted a larger public primary and community care forum on June 1 and 2, 2015 in Vancouver.

Overall, the Ministry papers identify key population areas including caring for the frail elderly and chronically ill. As noted by the Ministry of Health the growth in demand for health care for frail elderly living in residential care, who already utilize about 25% of health services, is projected to increase by 120% by 2036.⁸ The papers also deal with significant populations including those with mental health issues particularly dementia. In addition, they cover for the most part the key areas of the health system namely primary and community care (including long-term care (LTC), home care and palliative care), rural health, surgical services, etc...



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

- Improving the effectiveness of primary, community care (including residential care), medical specialist and diagnostic and pharmacy services for patients with moderate to high complex chronic conditions, patients with cancer, patients with moderate to severe mental illness and substance use;
- To significantly reduce demand on emergency departments, medical in patient bed utilization, and residential care;⁹
- Significantly improving timely access to appropriate surgical treatments and procedures; and
- Establishing a coherent and sustainable approach to delivering rural health services.

⁶ The papers build on many of the themes and ideas outlined in its *Setting Priorities* document released in February of 2014. See: <http://www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf>

⁷ Primary and Community Care in BC: A Strategic Policy Framework. BC Ministry of Health. February 2015. Accessed at: <http://www.health.gov.bc.ca/library/publications/year/2015/primary-and-community-care-policy-paper.pdf>

⁸ Setting Priorities for BC's Health System. BC Ministry of Health. February 2014. Accessed at: <http://www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf>

⁹ The Ministry of Health Primary and Community Care paper outlines that a range of multidisciplinary practices will be developed across communities with the capacity to address longitudinal health care needs of older adults with chronic medical conditions, potentially requiring home support, cancer care, and/or palliative care. They will have ability to respond effectively to urgent and emergency care where required for short periods of time with effective linkages to higher levels of services. Second, these practices will be linked to residential care services that include bed capacity designated for short term acute medical care needs including short-term stays for respite, end-stage palliative care or more short stay interventions than can be provided through home physician and nursing care.

2.1 BCCPA Response to MOH Policy Papers

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

Following a review of the Ministry papers, the BCCPA agrees with a number of recommendations. In particular as outlined further in Appendix A of this paper, the BCCPA highlights areas where it is in agreement and additional areas it would like to put forward in part to meet some of the current challenges and pressures facing operators, particularly regarding:

- *Increased collaboration;*
- *Review of funding lifts and Direct Care Hours;*
- *Review of new funding models;*
- *Better Dementia and Palliative Care; and*
- *Improving Seniors Safety and Quality Care.*

3.0 SECTION 1: SUSTAINABILITY

3.1 Using existing expertise of the private sector

With less funding than their health authority counterparts, both private and non-profit care homes deliver quality care for seniors across the province. Through innovation and their entrepreneurial spirit, BCCPA members are finding creative ways to make BC the best place for seniors' care.¹⁰ As noted in the February 2012 report from the BC Ombudsperson, it identifies that on average, beds in non-government care homes can cost up to about 15% less than beds in public homes.

In 2011, the BC Ombudsperson reported that in the Vancouver Island Health Authority "it would be typical for a publicly funded [Health Authority operated] care home with 50 residential care beds to receive approximately \$44,000 more in funding each month than a non-government owned care home with the same number of subsidized residential care beds."¹¹ As also noted in the BCCPA Seniors Care for a Change report, the evidence shows that non-government operated care homes are operating efficiently and there could be cost savings in investing further in these service providers, particularly as demand for continuing care services increase.¹²

Overall there are a number of specific examples where non-government operators are leading the way with respect to fostering innovation and dealing with challenges facing the system including reducing alternate level of care (ALC) beds and hospitalization rates. One such example of an innovative leader is Retirement Concepts, the largest private provider of long-term care in BC, which as discussed later in the paper is making significant technological advances to improve the care of seniors.

¹⁰ BCCPA 2015 Budget Submission. Accessed at: <http://www.bccare.ca/file/BCCPA-Budget-Submission-2015-Final.pdf>

¹¹ *The Best of Care: Getting It Right for Seniors in British Columbia (Part 2)* at p. 216-17. Accessed at:

<https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2047%20The%20Best%20of%20Care-%20Volume%202.pdf>

¹² Seniors Care for a Change. BCCPA. Prepared by Izen Consulting. July 2014. Accessed at: <http://www.bccare.ca/file/Seniors-Care-for-a-Change-FC.pdf>

In order to make best use of limited tax dollars dedicated to health care, we recommend the government continue its efforts to capitalize on our members' innovation and entrepreneurial spirit by maintaining a priority on funding the residential care and home support provided in order to ensure BC seniors continue to have access to the best possible care. In particular, the BCCPA recommends that BC Health Authorities better utilize the existing capacity and expertise amongst non-government care operators to act as champions and drivers of system change in the continuing care sector. This includes the use of funded demonstration projects to reduce emergency room (ER) visits and ALC beds as well as better care for frail elderly and seniors with dementia.



Along with various demonstration projects and the use of technologies to improve seniors care, a more province-wide approach also needs to be taken to ensure the sharing of advances and best practices. In particular, this requires a more coordinated approach to research and innovation such as exploring the establishment of a provincial centre of excellence for aging. A provincial centre, for example, could link in a coordinated fashion with leaders in innovation such as Retirement Concepts but also other centres including newly established Geriatric Centres of Excellence / Innovation or programs such as the Comprehensive Home Option of Integrated Care for the Elderly (CHOICE) as outlined later in the paper.

3.2 Immediate Priorities: Reducing ALC and creation of a Registry

Along with exploring the development of new continuing care models it will be important as outlined in the paper to address some of the more immediate priorities facing service providers including existing cost pressures. In particular, a key priority will be to address the existing capacity in the continuing sector in order to reduce alternate level of care (ALC) beds and offset acute care pressures.

While a Continuing Care Collaborative could explore such solutions further through the creation of new continuing care models, steps should be undertaken immediately in the short term to address issues of existing capacity. For example, as outlined in this paper in BC ALC utilization is in excess of 10% of acute care capacity, though significant variation exists between HAs and hospitals.

As outlined in the table below, in 2010/11 there was a total of approximately 375,000 ALC days in BC, accounting for approximately 12.8% of total hospital days. In 2014/15 according to CIHI's latest data there were total of 407,255 reported ALC days in BC, accounting for 13% of total hospital days across the five regional health authorities.

Table 1: Alternate Level of Care Days as a Proportion of Total Hospital Days in BC Health Authorities, 2010/11 and 2014/15

Health Authority:		Interior Health	Fraser Health	Vancouver Coastal Health	Vancouver Island Health	Northern Health	Total
2010/11	Inpatient days	453,348	919,757	722,974	543,045	164,684	2,803,808
	ALC days	75,500	101,178	61,818	108,303	28,325	375,124
	ALC days as a % of all days	16.7%	11.0%	8.6%	19.9%	17.2%	13.4%
2014/15	In patient days	516,386	1,089,615	748,058	586,500	191,879	3,132,438
	ALC days	86,677	154,288	60,112	71,450	34,698	407,225
	ALC days as % of all days	16.8%	16.8%	8.0%	12.2%	18.1%	13.0%
Sources: Health Ideas, Total Acute Rehab and ALC days by HSDA 2010/11, extracted from the Hospital Workload by Governance Authority, Report Run ID 338462041 (Caring for BC's Aging Population Improving Health Care for All. Canadian Centre for Policy Alternatives (CCPA). Marcy Cohen. July 2012) CIHI Data 2015. pen year data for fiscal year 2014-2015 from eDAD							

As noted above, there are significant variations with respect to ALC rates across the Health Authorities from a low of 8% in Vancouver Coastal to 18.1% in Northern Health. When comparing current figures from 2010/11 the only noticeable drop in ALC days as percentage of all days is from Vancouver Island which was close to 20% in 2010/11 and in 2014/15 is 12.2%.

Using 2014/15 Canadian Institute for Health Information (CIHI) data, a 50% reduction in ALC days (from 407,255 to 203,613) could generate significant cost savings to the health system. For example, assuming 50% of ALC days could be reduced by caring for patients in residential care homes (average daily cost of \$200) instead of in a hospital (average daily cost of \$1,200) it could generate over \$200 million in cost savings (\$203.6M). These savings in turn could be used to reduce existing elective surgeries. For example, \$203.6 million in acute care savings could potentially fund the following surgeries: 13,196 Additional hip replacements; or 17,085 Additional knee replacements; or 65,471 Additional cataract surgeries; or 9,972 Additional Cardiac Bypass Graft (CABG) surgeries.¹³

To better address immediate issue of ALC and acute care pressures, the BCCPA recommends that short term and long term strategies must be developed. In the short-term strategies should include the immediate use of current vacant beds within residential care homes and assisted living units to reduce acute care pressures. In this regard, the BCCPA in 2014 surveyed its members in the Fraser Health Authority to better understand the extent of vacant residential care beds that could be potentially used to reduce ALC and acute care pressures.

¹³ Uses average cost data for surgeries for those 80+ years of age, as reported by CIHI's patient cost estimator. See: <https://www.cihi.ca/en/spending-and-health-workforce/spending/patient-cost-estimator>

The BCCPA has also surveyed all of its members in regards to the number of vacant residential care beds and assisted living units across BC. It is also considering publicly releasing on an annual basis how much private capacity exists within the continuing care system and where. While the new survey data will help create a picture of existing capacity that may be underutilized in residential care, more and better data will need to be available on an ongoing basis.

In this regard, the BCCPA recommends the creation of a registry to report on ALC and vacant residential care beds across the province. This registry should also be updated regularly, namely at minimum on a monthly basis as well as be available to the general public. In addition the registry should also list all private beds not currently within the publicly funded system to give a whole picture of capacity. A portion of new funding re-directed from acute care outlined later in this paper could be potentially used to support the creation and maintenance of such a registry.

RECOMMENDATION #1

That, as an immediate priority, the Ministry of Health and Health Authorities work with the BC Care Providers Association (BCCPA) and other stakeholders to develop strategies to better utilize the existing excess capacity in the continuing care sector to reduce ALC beds, offset acute care pressures as well as better care for frail elderly and seniors with Dementia. Strategies should include the creation of a public registry to report on ALC and vacant residential care beds as well as use of current vacant beds within residential care, assisted living units and home support services to reduce acute care pressures.

3.3 Continuing Care Collaborative

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

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

RECOMMENDATION #2

That the BC Ministry of Health, Health Authorities, and BCCPA establish by the end of 2015 a Continuing Care Collaborative in order to support the long-term sustainability of the sector and improve seniors care across the province.

Reallocation of Funding from Acute and development of New LTC models

Although the BCCPA has a number of areas it would like to put forward as part of an ongoing dialogue through a new Continuing Care Collaborative, we have focused this paper on two areas as part of the initial process. In particular, this includes finding solutions for reallocating funding from the acute sector to continuing care as well as developing new continuing care models. The redirection of acute funding is the focus of the first section of this paper.

3.4 PRIORITY 1: Reinvesting From Acute to Continuing Care

Currently, residential care homes and home support providers across BC's health authorities are facing critical fiscal challenges in order to meet existing cost pressures while also delivering high quality care for seniors. This is despite an aging population and increasing levels of acuity for residents.¹⁴

Despite multiple chronic conditions, particularly as new entrants are coming into residential care homes with higher levels of acuity, funding for residents and operators is often less than collective agreement increases, while cost of living increases are not recognizing inflationary pressures and/or enhanced service delivery requirements (see Appendix A for further information).

In order to make best use of limited tax dollars dedicated to health care and as outlined earlier, the BCCPA advocates that the government continue its efforts to capitalize on our members' innovation and entrepreneurial spirit by maintaining a priority on funding the residential care and home support we provide in order to ensure BC seniors continue to have access to the best possible care. In particular, this includes that all residential care homes, including public and private, are funded appropriately. Overall reinvesting in continuing care makes sense as costs are substantially lower as **the cost of treating a BC senior in hospital ranges from \$825 to \$1,968 per day**, whereas **the cost of residential care is approximately \$200 per day**.¹⁵ Not only will it reduce costs in more costly emergency and acute care it will improve the overall quality of seniors care in BC.

Results from a 2015 BC Care Providers Association (BCCPA) Commissioned Poll, conducted by Insights West, indicate that British Columbians also believe government should increase funding for long-term care. In particular, it found that:

- 62% believe that the health care system focuses too much on acute care and not on providing ongoing care needs, such as long term care or caring for the chronically ill elderly;
- 68% believe that the government does not provide adequate funding for residential care; and
- 84% believe that as seniors enter residential care homes with increased acuity or medical complexity, government funding should increase to meet these care needs.¹⁶

3.5 The Proposed 1% Example

One of the major themes of the BC Ministry of Health Primary and Community Care paper is that existing expenditures will be protected, while appropriate reallocations from the acute to the community services

¹⁴ Health Council of Canada Report – Seniors in Need, Caregivers in Distress (April 2012). Accessed at:

http://www.healthcouncilcanada.ca/rpt_det_gen.php?id=348

¹⁵ Caring for BC's Aging Population Improving Health Care for All. Canadian Centre for Policy Alternatives (CCPA). Marcy Cohen. July 2012. BC Ombudsperson, 2012, Volume 2:239. Accessed at:

<http://www.policyalternatives.ca/sites/default/files/uploads/publications/BC%20Office/2012/07/CCPABC-Caring-BC-Aging-Pop.pdf>

¹⁶ The results included from this poll are based on an online study conducted by Insights West among a representative sample of 814 British Columbian adults. The data has been statistically weighted according to Canadian census figures for British Columbia for age, gender and region. Results have a margin of error of ±3.5 percentage points, 19 times out of 20.

sector must become part of the forward health authority planning and a majority of new net funding must be assigned to developing primary and community services.¹⁷

The BCCPA is encouraged by the Ministry's commitment to reinvest from acute to continuing care. To ensure that this does occur, it is suggested that in the Performance Agreements between the Ministry of Health and the Health Authorities starting in fiscal 2016/17 outline a specific commitment to reinvest expenditures such as a target of 1% per year from acute care be relocated to the continuing care sector over a five year period.

In 2011/12, regional health authorities spent approximately \$5.7 billion on the acute care sector and over \$2.6 billion for home and community care. Currently, based on 2014/15 budget figures, expenditures by Health Authorities for acute care is even higher at over \$6.4 billion or between 55 to 59% of total regional budgets. A breakdown of the funding by each Health Authority is seen on the following page (Figure 2).

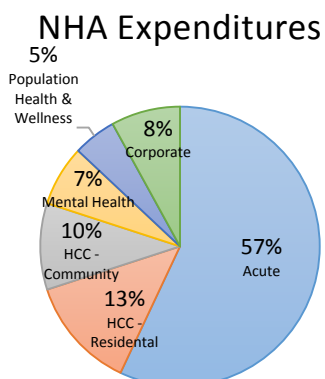
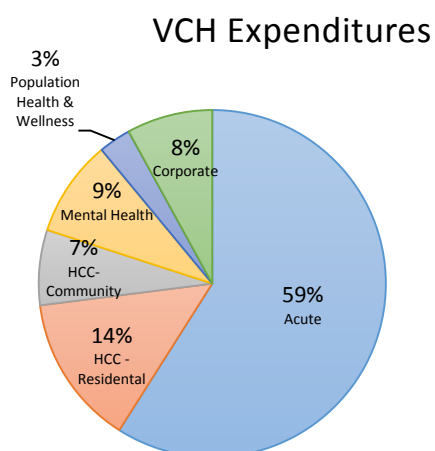
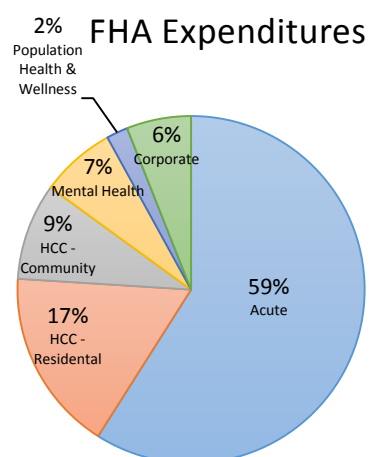
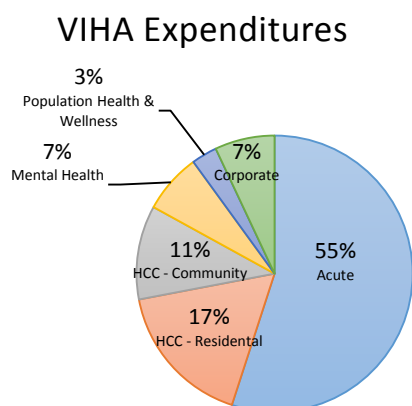
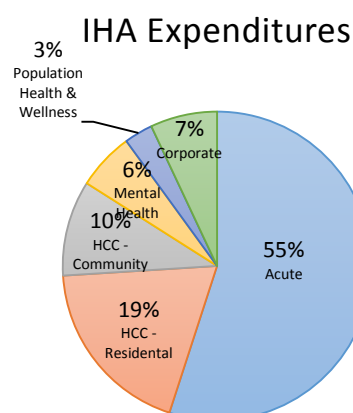
As outlined in table 2, using 2014/15 Health Authority budget figures a one percent re-allocation from acute to community care for the five regional health authorities would amount to approximately \$64 million in the first year. Excluding any annual funding increases to health authorities that would have occurred anyways this would equate to a five-year reinvestment from acute to home and community care including approximately \$320.8 million in the fifth year.

Table 2: Health Authority 1% Reinvestment from Acute to Home and Community Care						
	Dollars spent on Acute Care (2014/15)	First year	Second year	Third year	Fourth year	Fifth year
Vancouver Coastal Health	\$1,856,996,000	\$18,569,960	\$37,139,920	\$55,709,880	\$74,279,840	\$92,849,800
Vancouver Island Health	\$1,150,853,000	\$11,508,530	\$23,017,060	\$34,525,590	\$46,034,120	\$57,542,650
Interior Health	\$1,079,080,000	\$10,790,800	\$21,581,600	\$32,372,400	\$43,163,200	\$53,954,000
Fraser Health	\$1,893,608,000	\$18,936,080	\$37,872,160	\$56,808,240	\$75,744,320	\$94,680,400
Northern Health	\$435,760,000	\$4,357,600	\$8,715,200	\$13,072,800	\$17,430,400	\$21,788,000
Total	\$6,416,297,000	\$64,162,970	\$128,325,940	\$192,488,910	\$256,651,880	\$320,814,850
Sources: Financial Statements of Vancouver Coastal Health Authority, Vancouver Island Health Authority, Interior Health Authority, Fraser Health Authority, and Northern Health Authority (year ended March 31, 2015).						

Developing a systematic 5 year strategy to redirect funding from acute care could significantly help meet the current and future pressures facing the continuing care sector. In particular, the BCCPA believes it is critical to set targets regarding the level of funds to be redirected in order for this to occur. For example, based on initial cost estimates \$320.8 million in new funding directed to the continuing care sector could

¹⁷ Primary and Community Care in BC: A Strategic Policy Framework. BC Ministry of Health. February 2015.

Figure 2: Breakdown of Health Authority Expenditures (2014/15)



Sources: Financial Statements of Vancouver Coastal Health Authority, Vancouver Island Health Authority, Interior Health Authority, Fraser Health Authority, and Northern Health Authority (year ended March 31, 2015).

potentially fund the following services: the annual operation of 4,395 long term care beds;¹⁸ or 12,832,000 care aide hours;¹⁹ or 8,020,000 home support hours.²⁰

The BCCPA believes some of the acute care funding that is re-directed to continuing care sector could be obtained with a reduction of alternate level of care (ALC) beds.²¹ For example, assuming 50% of ALC days could be reduced by caring for patients in residential care homes (average daily cost of \$200) instead of in a hospital (average daily cost of \$1,200) it could generate over \$200 million in annual cost savings (\$203.6M). These savings in turn could also be used to reduce wait times for existing elective surgeries. Based on initial estimates \$203.6 million in acute care savings could potentially fund the following surgeries:

- 13,196 Additional hip replacements; or
- 17,085 Additional knee replacements; or
- 65,471 Additional cataract surgeries; or
- 9,972 Additional Cardiac Bypass Graft (CABG) surgeries.²²

In summary the BCCPA advocates that starting in fiscal year 2016/17, the Performance Agreements between BC's Ministry of Health and Health Authorities should include a specific target for redirecting acute care expenditures such as a minimum of 1% annually over a five year period to the home and community care sector. A thorough public reporting on the additional services provided to seniors on an annualized basis as result of this investment should also be considered.

RECOMMENDATION #3

Starting in fiscal year 2016/17, the Performance Agreements between British Columbia's Ministry of Health and Health Authorities should include a specific target for redirecting acute care expenditures such as a minimum of 1% annually over a five year period to the home and community care sector. Such expenditures would be directly reinvested into residential care and home care / support to deal with existing cost pressures facing service providers as well as support development of new continuing care models to reduce acute care pressures, improve access to care while also allowing seniors to receive services in the most appropriate setting. A thorough public reporting on the additional services provided to seniors on an annualized basis as result of investment should also be considered.

4.0 SECTION 2: INNOVATION

In February 2015, the BC Ministry of Health released a series of papers on its website covering five broad areas of the health system including: patient centered care, health human resources, rural health, surgical

¹⁸ The Best of Care: Getting It Right for Seniors in British Columbia (Part 2) at p. 216-17. Accessed at:

<https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2047%20The%20Best%20of%20Care-%20Volume%202.pdf>

¹⁹ Assuming a wage of \$25 per hour, as quoted by Welcome BC: <http://www.welcomebc.ca/Work/fqr/Your-Qualifications-Intro/occupational-guides/Occupation/Health-Care-Assistant.aspx>

²⁰ Assuming that each hour of subsidized home support costs the health authorities \$40, as reported in the Ombudsperson (2012) "Home Support Backgrounder". Accessed at: <https://www.bcombudsperson.ca/sites/default/files/BOC2%20-%20Health%20Sector%20Backgrounders.pdf>

²¹ ALC beds are those occupied by patients who no longer require acute care, but who continue to occupy a hospital bed because they are unable to access home and community care services.

²² Uses average cost data for surgeries for those 80+ years of age, as reported by CIHI's patient cost estimator. See: <https://www.cihi.ca/en/spending-and-health-workforce/spending/patient-cost-estimator>

services as well as primary and community care. The BC Ministry of Health papers also identify various cross sector health strategic service priorities that will result in substantive first steps to a repositioning of the BC health system over the coming five years to better position it to meet both increasing and changing patterns of demand, namely:

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

The BCCPA believes that by redirecting acute care funding to home and community care as outlined earlier in this paper, that it will help meet the strategic service priorities outlined above. Meeting these priorities, however, will also require development of new continuing care models to address some of the pressing challenges faced in the health system including dealing with seniors with increased levels of acuity and reducing acute care pressures (i.e. ALC beds, ER utilization, etc...). This is the focus of the next section of this paper.

4.1 PRIORITY 2: New Continuing Care Models

4.1.1 Rationale for exploring new Continuing Care models

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

One of the major reasons for establishing new continuing care models is to improve access to care as well as allowing seniors the opportunity to live in the most appropriate care setting. One of the priorities outlined by the Ministry of Health, for example, is to allow more seniors to live at home whether this is in a single family residence or apartment, assisted living or residential care. As noted by the BC Seniors Advocate, the vast majority of seniors in BC are living independently (93%) including approximately 90% who own their own home. In total, less than 2% of seniors in BC live in provincially subsidized Assisted Living (AL) setting while about 4% live in residential care.

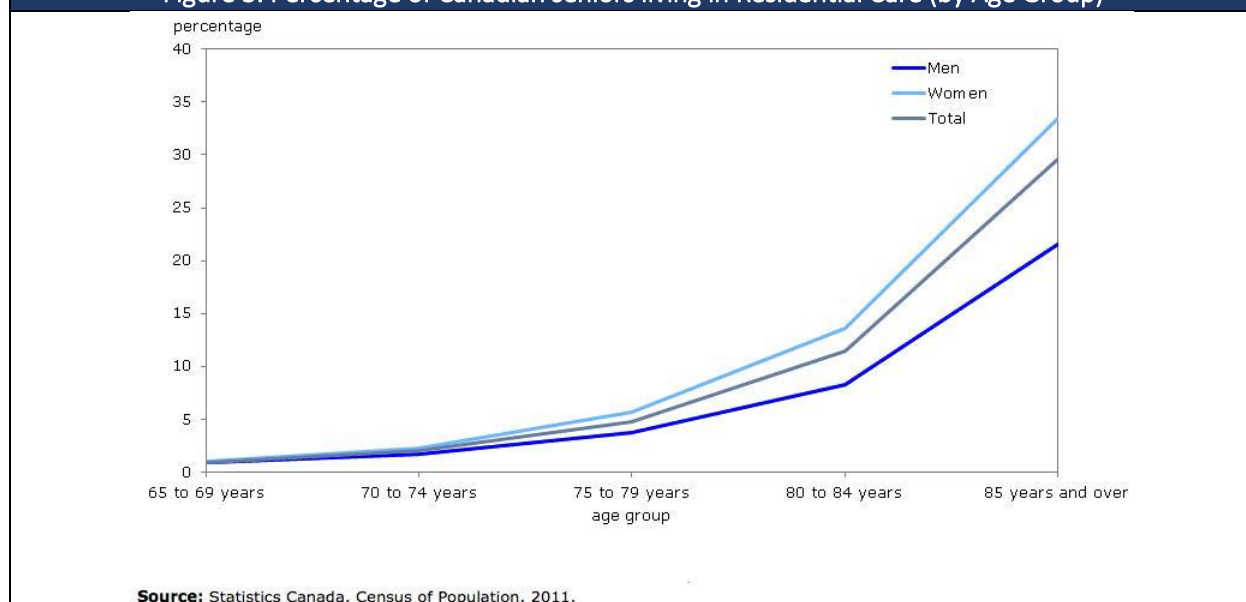
The figures with regards to residential care, however, increase with various older age populations including 9% of those over 75 and about 15% of those over 85.²³ In particular, the demand for residential care will also increase significantly in the future because the proportion of seniors living in long term care homes increases with age and the number of elderly seniors will grow as the aging of the population accelerates. As Figure 3 shows, about 1% of people between the age of 65 and 69 live in residential care homes in Canada, while the largest age group living in care-homes is 85 and older at 29.6%.²⁴

²³ Seniors' Housing in BC: Affordable, Appropriate, Available. BC Office of the Seniors Advocate. May 2015. Accessed at:

<https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2015/05/Seniors-Housing-in-B.C.-Affordable-Appropriate-Available.pdf>

²⁴ A Policy Framework to Guide a National Seniors Strategy for Canada. CMA. August 2015. Accessed at: https://www.cma.ca/Assets/assets-library/document/en/about-us/gc2015/policy-framework-to-guide-seniors_en.pdf

Figure 3: Percentage of Canadian seniors living in Residential Care (by Age Group)



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

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

In particular, one focus of the new continuing care hubs could also be the provision of respite care including for frail seniors. Respite care is the provision of short-term and/or temporary relief to those who are caring for family members or loved ones who might otherwise require permanent placement in a facility outside the home. As outlined in one report the level of demand for facility-based respite in British Columbia is quite high compared to most jurisdictions.²⁵

Along with increasing access to services and beds for seniors to allow them to live in the most appropriate care setting, the new LTC models, particularly the continuing care hub outlined later in this paper will also assist increasing choice for seniors utilizing the current BC "First Appropriate Bed" (FAB) policy. Under this policy adopted by all the health authorities, a senior who has been assessed as ready for a move to residential care must accept the first appropriate bed that becomes available in their chosen geographic catchment area. In particular, seniors have 48 hours to accept and move to the bed offered, or risk being removed from the priority list for a FAB. The FAB policy is designed to ensure that those who are the most in need of a residential care home bed secure that bed as quickly as possible.²⁶

²⁵ Respite for Family Caregivers: An Environmental Scan of Publicly-funded Programs in Canada" Prepared for Health Canada by Janet Dunbrack. February 2003. http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2003-respite-releve/2003-respite-releve-eng.pdf

²⁶ British Columbia. Ministry of Health. (2014). Home and community care: Policy manual.

Victoria: Ministry of Health. Retrieved from http://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/hcc-policy-manual/6_hcc_policy_manual_chapter_6.pdf

As outlined in the recent Seniors Advocate report it highlights the discrepancy between average wait times and median wait times showcasing the fact that some people are waiting a very long time for a residential care FAB.²⁷ In particular, wait times for placement are greater in the north than in the Lower Mainland and are greatest for those who require highly specialized care such as a secure dementia unit.²⁸ The BCCPA believes that adopting new models such as the continuing care hub outlined later will not only improve access to residential care and services for seniors in the community but will also increase choice for seniors utilizing the current FAB policy.

Dealing with higher levels of acuity

Another reason why it is crucial to explore the development of new continuing models is to deal with the growing levels of acuity facing the continuing care sector. Similar to BC, and as outlined in a 2015 report, new entrants into long-term care in Ontario are coming into residential care homes with much higher levels of impairment. In Ontario, for example, in the 4th quarter of 2009/10, 76% of new admissions had high to very high levels of impairment (35% high and 41% very high). At the end of 2013/14 this figure for new admissions increased to 83%, with most of the growth in the very high category representing 47% of new admissions and growing at 3.9% per year.²⁹ **In BC the growth in demand for health care for frail elderly living in residential care, who already utilize about 25% of health services, is projected to increase by 120% by 2036.**³⁰

Along with increasing levels of acuity with a growing and aging population, a large percentage (41%) of Canadian seniors are dealing with two or more select chronic conditions, such as diabetes, respiratory issues, heart disease, and depression, and many are experiencing a decline in physical and/or cognitive functioning.³¹ Mental health challenges will also become more prevalent as it is estimated the number of BC residents with dementia is expected rise from 70,000 to 110,000 by 2025.³²

Alternate Level of Care (ALC) Beds

Along with increasing levels of acuity, another major reason to explore the development of new continuing care models is to reduce the pressures faced in more costly acute and emergency care, particularly reducing alternate level of care (ALC) beds. ALC beds are those occupied by patients who no longer require acute care, but who continue to occupy a hospital bed because they are unable to access

²⁷ Seniors' Housing in BC: Affordable, Appropriate, Available. BC Office of the Seniors Advocate. May 2015. Accessed at:

<https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2015/05/Seniors-Housing-in-B.C.-Affordable-Appropriate-Available.pdf>

²⁸ As outlined in the Seniors Advocate Affordable, Appropriate, Available report: 67% of clients move to a FAB within 30 days; this ranges from a high of 80% in Vancouver Coastal to a low of 27% in Northern Health Authority; The average length of time waiting for residential care is 36 days and this ranges from a low of 25 days in Vancouver Coastal to a high of 122 days in Northern; The median waiting time is 15 days ranging from a low of 9 days in Vancouver Coastal to 96 days in Northern; Seniors get their preferred bed at time of the FAB move anywhere from 23% to 45% of the time; Seniors get to their preferred bed *after* moving to a FAB anywhere from 4% to 22% of the time; And Overall, residents end up in their facility of choice anywhere from 34% to 67% of the time.

²⁹ OANHSS Submission to the Ontario Standing Committee on Finance and Economic Affairs. The Need Is Now: Addressing Understaffing in Long Term Care Ontario Association of Non-Profit Homes and Services for Seniors. January 2015.

³⁰ Setting Priorities for BC's Health System. BC Ministry of Health. February 2014. Accessed at:

<http://www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf>

³¹ Health Council of Canada Report – Seniors in Need, Caregivers in Distress (April 2012). Accessed at:

http://www.healthcouncilcanada.ca/rpt_det_gen.php?id=348

³² Workforce Analysis, Health Sector Workforce Division, Ministry of Health, Dementia (age 45+ years) March 24, 2014, project 2014_010 PHC

home and community care services. According to one report, **the cost of treating a BC senior in hospital ranges from \$825 to \$1,968 per day**, whereas **the cost of residential care is approximately \$200 per day**.³³ Currently, approximately 14% of Canadian hospital beds are filled with patients who are ready to be discharged but for whom there is no appropriate place to go. Over a single year, these patients' use of acute hospital beds exceeds 2.4 million days, which equates to over 7,500 acute care beds each day.³⁴

According to recent data from Alberta, on a daily basis approximately 822 people in that province are in an acute care facility who could be cared for less expensively in the community. If these patients were in more appropriate care setting such as a nursing home as opposed to a hospital, which is about four times as expensive, it could result in savings of over \$170 million per year. The data shows that over a 33-month period through December 2014, the number of alternative level of care (ALC) days doubled and on average about 11 per cent of Alberta's acute care capacity was occupied by ALC patients.³⁵



As outlined earlier in the paper, the ALC rate has not improved much over past several years. In 2011/12, there was a total of approximately 375,000 ALC days in BC, accounting for approximately 12.8% of total hospital days; while in 2014/15 there were a total of 407,255 reported ALC days in BC, accounting for 13% of total hospital days across the five regional health authorities.³⁶ In BC, ALC utilization is in excess of 10% of acute care capacity, though significant variation exists between HAs and hospitals. BC's health authorities report that approximately one-half of ALC patients are awaiting discharge into long-term care; while others are waiting for home care, assisted living, rehabilitation or are residing in acute care due to inefficient transfer processes.³⁷

³³ Caring for BC's Aging Population Improving Health Care for All. Canadian Centre for Policy Alternatives (CCPA). Marcy Cohen. July 2012. BC Ombudsperson, 2012, Volume 2:239. Accessed at:

<http://www.policyalternatives.ca/sites/default/files/uploads/publications/BC%20Office/2012/07/CCPABC-Caring-BC-Aging-Pop.pdf>

³⁴ Exploring alternative level of care (ALC) and the role of funding policies: An evolving evidence base for Canada. Canadian Health Services Research Foundation. September 2011. Accessed at: http://www.cfhi-fcass.ca/sf-docs/default-source/commissioned-research-reports/0666-HC-Report-SUTHERLAND_final.pdf

³⁵ Seniors stuck in hospital wastes \$170 million a year, Liberals say. Matt McClure. Calgary Herald. April 1, 2015. Accessed at:

<http://calgaryherald.com/news/politics/seniors-stuck-in-hospital-wastes-170-million-a-year-liberals-say>

³⁶ Between 2005/06 and 2010/11, there was a 35.5 per cent increase in the number of hospital beds across BC occupied by people classified as ALC patients. Source: Caring for BC's Aging Population Improving Health Care for All. Canadian Centre for Policy Alternatives (CCPA). Marcy Cohen. July 2012. BC Ombudsperson, 2012, Volume 2:239. Accessed at:

<http://www.policyalternatives.ca/sites/default/files/uploads/publications/BC%20Office/2012/07/CCPABC-Caring-BC-Aging-Pop.pdf>

³⁷ Exploring alternative level of care (ALC) and the role of funding policies: An evolving evidence base for Canada. Canadian Health Services Research Foundation. September 2011. Accessed at: http://www.cfhi-fcass.ca/sf-docs/default-source/commissioned-research-reports/0666-HC-Report-SUTHERLAND_final.pdf

Reducing hospitalizations

As also outlined in the 2014 BC Ministry of Health Setting Priorities document one large driver of total cost occurs in the year prior to, and the year of, entry into residential care - with high rates of hospitalization via emergency departments en route to residential care. For example, more than seven out of every 10 new entrants to residential care have at least one inpatient hospitalization in the year. In particular, more than 60 per cent of people entering residential care have been identified as having a high complexity chronic condition in the previous year and it is likely that many will also have fallen into the “frail in community” category as well.³⁸

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

Table 3: ER Visits for Seniors for 2014/15 (65+)			
Health Authority	Number ER Visits (Patients Aged 65+)	Total # of ER Visits	Proportion (%) of ER Visits for Patients Aged 65+
Interior	32,612	133,580	24%
Fraser	148,749	652,779	23%
Vancouver Coastal	80,115	332,334	24%
Vancouver Island	78,168	269,745	29%
Northern	7,176	44,528	16%
Source: CIHI 2015 data - Report contains open year data for fiscal year 2014-2015 from eNACRS			

As outlined in various studies, once residents are in long-term care there is a significant reduction in hospitalizations. A recent study from Alberta, for example, found that the incidence of hospital admission was about 3 times higher among Assisted Living (AL) residents than among long-term care residents (14%). In particular, nearly 40% of AL residents in Alberta were admitted to hospital over 1 year, a rate substantially higher than that for long-term care residents.³⁹

According to a 2014 report from the Canadian Institute for Health Information (CIHI) seniors in long term care homes make up less than 1% of ER visits in Canada. The data, however, shows that one-third of these visits are potentially avoidable as they could have been addressed in the care home itself. Common avoidable reasons for visits to ER for seniors in care were urinary tract infections, pneumonia and falls.⁴⁰ As outlined by CIHI, with earlier diagnosis and improved access to on-site treatment, some of these conditions could be managed at the care home and such a visit could be avoided altogether.



³⁸ Setting Priorities for BC's Health System. BC Ministry of Health. February 2014. Accessed at: <http://www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf>

³⁹ High rates of hospital admission among older residents in assisted living facilities: opportunities for intervention and impact on acute care. David Hogan et al. Open Medicine, Vol 8, No 1 (2014). Accessed at: <http://www.openmedicine.ca/article/view/622/541>

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

Although ER visits are relatively low for seniors and decrease once a resident is admitted to residential care, there is still a need to also look at ways to reduce such visits particularly during the first year of residential care. Although data is limited in this regard one of the reasons for a high number of visits during the initial stay in residential care is due to care staff who want to minimize any potential health risks for the resident. To deal with this a number of solutions should be explored, including:

- Greater involvement from the family with staff in overall care and planning;
- Co-location of ambulatory and sub-acute care with residential care;
- Development of integrated programs such as the Comprehensive Home Options of Integrated Care for the Elderly (CHOICE) model (see Appendix E);
- Work with municipal governments to determine feasibility of co-location and enhanced training of other first-responders such as fire and police;
- Greater use of physicians including possibly Physician Assistants and Nurse Practitioners in long term care settings; and
- Earlier diagnosis as well as better management and preventative care for seniors within care homes including improved resident safety measures, chronic disease management and dementia care.

By adopting these and the measures outlined later in this paper, the BCCPA believes ER visits could be lowered among those living in residential care and the senior's population at large particularly through the development of new and enhanced care models (i.e. continuing care hubs). Based on initial estimates even a 10% reduction in seniors ER visits (35,000) could amount to savings of approximately \$13,510,000.⁴¹ The need to reduce more expensive and unnecessary hospitalizations such as ALC days and ER visits by seniors through new continuing care models is the focus of remainder of this paper.

4.2 Enhancing the Role of Continuing Care: New Continuing Care Models

In 2010, the Ontario Long Term Care Association (OLTCA) commissioned the Conference Board of Canada to investigate the innovation potential of Ontario's long-term care homes. The result was *Why not now?* A five-year strategy published in 2012 by the expert panel, co-chaired by William Dillane, President, The Response Group, and Dr. William Reichman, President and CEO of Baycrest. The panel envisions long-term care homes as hubs of innovation that work closely with hospitals, ensuring accessibility, and handling all sorts of short-term, long-term, and cyclical care.⁴²

As outlined in OLTCA paper with the development of new models, highly integrated care teams would require new roles and a different mix of skills. Staffing models would also have to be developed to allow the same service providers to provide care in and out of hospital. The main background and expert panel recommendations of the OLTCA paper are outlined in Appendix B. In particular, it identifies a number of new continuing care models such as the post-acute care model, specialized steam model, integrated care model, and the Hub Model.

4.3 Continuing Care Hubs

While each of the models outlined in Appendix B merits further consideration in the context of BC, the BCCPA particularly supports the development of a new Continuing Care Hub model. This is a network of individual care homes [or home care providers] sharing services, specializing in care etc... potentially over

⁴¹ Assuming the average cost of a seniors ER visit is \$386 per visit, as quoted for Ontario 2007-08:

https://secure.cihi.ca/free_products/seniors_ed_e.pdf

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

a large geographical area but are formally networked. In this model the residential care home could be a centre for the delivery of a wide range of seniors' services; some of which could be co-located such as in a Campus of Care and/or others potentially managed by a network of care homes.

Although not exhaustive, services that could be delivered by a new Continuing Care Hub could include: primary care, chronic disease management, rehabilitation, sub-acute, dialysis, oral care, foot care, adult day/night programs, and satellite specialized geriatric services collaboratively delivered with hospital and community partners. This model would also invest in physical infrastructure and existing continuing programs and services by centralizing care and expertise.

4.3.1. Four Key Features of new Continuing Care Hubs

Although the exact features of Continuing Care Hubs will differ depending on location and needs of the community, some of the common features could potentially involve:

Integration of health professionals and family in seniors care

- Physically and virtually integrating the practice of nurse practitioners, family physicians and physician assistants into the continuing care hub or campus.
- Use of other health and emergency professionals including but not limited to paramedics and firefighters with enhanced training.
- Increasing the proportion of LTC nurses with advanced or specialized training, particularly in areas such as behavior as well as pain and symptom management.
- Self-regulated professions work to full scope of practice, which includes delegation of acts to other health professionals and unregulated staff.
- Directly integrate the family into the care team and overall care of the resident as a strategy to potentially reduce unnecessary hospitalizations.



New roles for care providers

- Creation of new Health Care Aide roles that enable nursing staff to focus on clinical care and leadership rather than routine tasks that can be safely delegated.
- Creation of a multidisciplinary LTC team core competencies task force to examine the composition, skill set and level of interdisciplinary integration required to support the delivery of safe, high-quality care and other models of care delivery.
- A comprehensive review and update to college and university curricula to better prepare front-line workers for the emerging long-term care environment.
- Develop an on-going foreign worker recruitment or relocation incentive program to ensure access to adequate clinical staff willing to work in rural and remote areas.

New funding models (outcome-based funding)

- Performance-based funding that considers optimal staffing mix for different groups of residents, along with care outcomes.
- Empower Continuing Care Collaborative to develop a model which better links funding to outcomes.
- In collaboration with private-sector service providers, develop mutually agreed upon quality indicators in continuing care including incentives to encourage integration of care and team based models (i.e. paramedics, rehabilitation, pharmacy, etc...).
- Development of alternate LTC physician and nurse practitioner reimbursement models which provide incentives for mentoring LTC staff and students and achieving key care outcome targets such as reducing hospital transfers.

Expanded role and co-location of services

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



Overall, as noted one of the key features of such a Continuing Care Hub model is the provision of procedures or services that may be commonly performed in alternative care settings such as a hospital or

in primary care setting including dialysis, rehabilitation, frailty screening, seniors health promotion, and other potentially non-complicated surgical or treatments. Such services would be based on existing expertise of providers as well as the needs of the community.

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

Integration of health providers into new Continuing Care Hubs

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

One crucial aspect will be to better integrate physicians into any new long term care models or Continuing Care Hubs. In the last 10 years, while the number of community-based family physicians has increased by about 10%, the number of family physicians delivering residential care services has dropped by about 13%. While this downward trend is occurring it is anticipated that there will be a 120% growth in the residential care population in the next 20 years.⁴³

As outlined further in Appendix C, it highlights examples of initiatives which have attempted to better integrate physicians and other health professionals into long term care. This includes programs such in Nova Scotia's Care by Design, which attempts to address issues such as the reduction of family physician services and on-call coverage for LTC home residents, and high rates of ambulance transports to emergency departments (EDs). It also discusses the recent Residential Care Initiative in BC being undertaken by the General Practice Services Committee.

Appendix C also discusses other innovative models include Ontario's Long-Term Care Nurse-Led Outreach Teams (NLOTs) as well as the need to look at the role of new health professionals such as nurse practitioners and physician assistants. Likewise, it also outlines examples such as Teaching Nursing Homes, which attempt to better integrate teaching, training and education within long-term care homes. Going forward with the development of new models, particularly the new Continuing Care Hub, such integration will be critical.

⁴³ General Practice Services Committee (GPSC). Residential Care Initiative. Accessed at: <http://www.gpscbc.ca/family-practice-incentive/residential-care>.

Rural Considerations

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

- Providing multidisciplinary health care team members with access to up-to-date patient health information at the point of care;
- Enabling multidisciplinary health care teams to contribute to the residents' health care plan;
- Improving the quality of health data;
- Standardizing and expanding use of telehealth, including use of videoconferencing technologies; and
- Support telehealth policy recommendations to ensure emerging technologies are leveraged for key populations including the frail senior population living in residential care as well as potentially for on-going foreign worker recruitment or relocation incentive program to ensure access to adequate clinical staff willing to work in rural and remote areas.⁴⁴

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

4.4 Geriatric Centres of Excellence / Innovation

Related to creation of Continuing Care Hubs is the concept of geriatric centres of excellence, in which residential care homes, including care hubs could lead development of research and innovation within the sector. An example of a current research leader and innovator in the BC context is Retirement Concepts, the largest private provider of LTC in BC, which as part of its Innovation Centre is looking to

technology advances and innovative processes to personalize and improve care in a cost effective manner. Further details of Retirement Concepts Innovation Centre, including its proposed framework proposal for BC's frail older adult population can be found in Appendix D of this paper.



Along with fostering innovation and new models of care, innovation centers such as Retirement Concepts or new geriatric centers

of excellence could link with a new provincial center for excellence in aging. Working in conjunction with care providers such a center for excellence in aging could facilitate research and sharing of best practices and technological advances to support seniors across the province, including facilitating use of non-government operator's expertise and capacity through the trialing of demonstration projects.

⁴⁴ BC Ministry of Health. Enabling Effective, Quality Population and Patient-Centred Care: A Provincial Strategy for Health Information Management and Technology. June 2015. Accessed at: <http://www.health.gov.bc.ca/library/publications/year/2015/IMIT-policy-paper.pdf>

Likewise, such a provincial centre could link nationally with organizations such as AGE-WELL, a pan-Canadian network of industry, non-profit organizations, government, care providers, caregivers, end-users, and academic partners working together using high-quality research to drive innovation and create technologies and services that benefit older adults. Launched in 2015, through the federally funded Networks of Centres of Excellence program, AGE-WELL addresses a wide range of complex issues in technology and aging through receptor-driven transdisciplinary research, training programs, partnerships, knowledge mobilization and the commercial development of technologies.⁴⁵

4.5 Financing the creation of Continuing Care Hubs / Other models

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

Using 2014/15 Health Authority budget figures a one percent re-allocation from acute to community care for the five regional health authorities would amount to approximately \$64 million in the first year. Excluding any annual funding increases to health authorities that would have occurred anyways this would equate to a five year reinvestment from acute to home and community care including approximately \$320 million in the fifth year.

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

4.6 New Home Care Models/ Innovations

Along with exploring the development of new Care Hubs it will also be important to look at new models for home care and home support within the continuing care sector. In BC, home support provides assistance with the tasks of daily living for people with chronic illnesses, disabilities or progressive medical conditions. Home support workers provide personal assistance with daily activities, such as bathing, dressing, grooming, and light household tasks, that allow patients to stay in their homes for as long as possible. Access to publicly subsidized home support services is based on an assessment by Health Authorities. Eligible patients using publicly funded home support services are charged a daily rate based on their after-tax income. These services may also be purchased privately. About 73% of people receiving home support services pay no fee due to their low incomes.

As outlined further in Appendix E of this paper it highlights a number of innovative home care models from Ontario including its Seniors Managing Independent Living Easily (SMILE) and Integrated Comprehensive Care Program (ICC) programs as well as Alberta's Comprehensive Home Options of Integrated Care for the Elderly (CHOICE). CHOICE, which is modelled on the Program of All-Inclusive Care for the Elderly (PACE) program from United States is essentially a one-stop health-care and recreational centre for the elderly with chronic medical conditions and has been quite successful in keeping the frail

⁴⁵ Canada's Technology and Aging Network. Accessed at: <http://www.agewell-nce.ca>

elderly out of hospital. For example, one study shows that in the six months after joining the program emergency department visits dropped 30 per cent. CHOICE has been effective at keeping the elderly healthy and delaying their admission into long-term homes because medical staff get to know the patients and can quickly detect any change in their condition.⁴⁶

Overall, much like long term care, the appropriate home care model will depend also on the capacity and expertise of service providers as well as the needs of the community. While this paper does not advocate a specific home care / support model, one potential alternative similar in concept to the Continuing Care Hub is for various home support service providers to join together as part of an affiliated network to provide seniors care for a particular geographical area. For example, two or more home care / support service providers could potentially work together as part of a formal affiliated network with each providing different home support services. Likewise, it is also possible that such a home support network could be affiliated with a specific Continuing Care hub and/or even contract with them to provide services to seniors in the community.

4.7 Funding for Home Support

Overall, the BCCPA believes that home support is a critical area of the health system and that government and health authorities where possible should support a re-allocation of funding away from more costly acute care to less expensive areas of the system including home care. Similar to residential care, BCCPA home support members are also facing challenges to remain fiscally sustainable due to an identified shortage of funding to cover inflationary costs. In particular, for BCCPA home care members these can be attributed to a lack of recognition and compensation for travel time, increasing levels of acuity for seniors as well as higher compensation and benefits costs. Furthermore, many of BCCPA's home care members



Home Support

have not seen funding increases for several years.

As outlined earlier, a one percent re-allocation from acute to community care would amount to approximately \$64 million in the first year.

Excluding any annual funding increases to health authorities this would equate to a five year reinvestment from acute to home and community care including approximately \$320 million in the fifth year. While it would be ultimately up to Health Authorities to reinvest how they deem appropriate, the BCCPA suggests that along with residential care some of this funding be used to support the creation and development of new home care or home support models, such as the CHOICE model outlined earlier.

In summary, consistent with the Ministry of Health's cross sector health sector strategic priorities to improve effectiveness of primary and community care as well as access to care including rural health, the BCCPA believes that the Continuing Care Collaborative should review options for new delivery models including, but not limited to the creation of Continuing Care Hubs, geriatric centres of excellence /

⁴⁶ Integrated care benefits seniors and cash-strapped government. Globe and Mail. July 12, 2011. Accessed at: <http://www.theglobeandmail.com/news/national/time-to-lead/integrated-care-benefits-seniors-and-cash-strapped-government/article586634/>

innovation, as well as Post-Acute, Specialized Stream, Integrated Care, Frail Elderly and Dementia Care Models to optimize ER utilization, reduce acute care congestion and better care for frail elderly.

RECCOMENDATION #4

That, consistent with the Ministry of Health's cross health sector strategic priorities to improve the effectiveness of primary and community care and access to care including rural health as well as provide seniors with improved access while residing in the most appropriate care setting, the Collaborative as a key priority review options for new delivery models. This includes, but not limited to the creation of continuing care hubs, geriatric centres of excellence / innovation, as well as Post-Acute, Specialized Stream, Integrated Care, Frail Elderly and Dementia Care Models to optimize ER utilization, reduce acute care congestion and better care for frail elderly.

4.8 Review of Prescribed Services for Assisted Living in British Columbia

Assisted Living (AL) is a relatively new form of care in British Columbia and is a middle option between independent living (with some limited support) in one's own home, and living in a residential care home. Established in 2002, AL is a care setting that combines publicly subsidized apartments with support services for frail seniors and people with disabilities who can no longer live at home, yet do not require the 24-hour professional care and supervision provided in residential care homes.

AL residences can range from a unit in a high rise apartment complex to a private home. Units can vary from one room to private, self-contained apartments. Residents pay an inclusive fee for which they receive room, board, meals, weekly laundry and housekeeping and only one or two prescribed personal care services to assist with the activities of daily living. Additional services are paid for out of pocket by the residents or their families. Nursing care is not provided but there is a 24-hour emergency response system in place. In BC, residents pay 70 percent of their after-tax income for publicly-funded AL services and are responsible for cost of other services they would normally pay for if they lived in own home.⁴⁷

According to a 2012 study, half of AL residents are 85 or over, three-quarters are female, and about half subsequently move on to residential care. Approximately a quarter of people leave AL after less than one year.⁴⁸ Only one-third of people who die do so in AL, suggesting a possible need for more attention to end of life care in this type of care setting.⁴⁹

BC was the first province in Canada to regulate AL residences. By law, AL operators must offer five hospitality services: one to three meals a day plus snacks; light housekeeping once a week; laundering of flat linens once a week; social and recreational opportunities; and a 24-hour emergency response system. They must also provide at least one, and not more than two, of six "prescribed services", which as outlined in the *Community Care and Assisted Living Act* include: regular assistance with activities of daily living (i.e. eating; mobility, dressing, etc...); medication management; personal financial management;

⁴⁷ Centre for Health Services and Policy Research. Home Health Services in BC: A Portrait of Users and Trends Over Time. Kim McGrail et al. October 2008. Accessed at: http://www.chspr.ubc.ca/sites/default/files/publication_files/chspr08-15.pdf

⁴⁸ Just over one-half (51%) of all Assisted Living residents eventually move to residential care facilities. One-half of those move directly from Assisted Living to residential care, while the other half seem to be triggered to move to residential care following a hospital stay. Another 34% of Assisted Living clients die: 11% die in Assisted Living, 22% die after being admitted to hospital, and 1% die within 30 days of admission to residential care. A full 15% of Assisted Living residents appear to move back to the community: one-third of those with community based home health services, and two-thirds without any publicly-funded services.

⁴⁹ Centre for Health Services and Policy Research. Who uses Assisted Living in BC: An Initial Exploration. April 2012. Kim McGrail et al. Accessed at: http://www.chspr.ubc.ca/sites/default/files/publication_files/assistedliving.pdf

monitoring of food intake; structured behaviour management and intervention; and psychosocial rehabilitative therapy or intensive physical rehabilitative.⁵⁰

According to a May 2015 report from the Seniors Advocate BC entitled *Seniors Housing in BC: Affordable, Appropriate, Available*⁵¹ as of March 2014, BC has about 23,000 AL units including 4,400 that are subsidized while the remaining are private registered (3,200) or private non-registered (15,200). As also outlined in the Seniors Advocate report it recommends that registered AL be fundamentally redesigned and regulations changed, to allow for a greater range of seniors to be accommodated and age in place as much as possible including palliative care. The BCCPA would be willing to explore a review of AL including expanding the scope of registered services. In particular, the BCCPA suggests reviewing the list of six prescribed services to allow greater flexibility for AL operators.

As outlined under the *Community Care and Assisted Living Act* registered AL operators must nominate two of six prescribed services that will be offered to residents. The two most commonly prescribed services offered by AL operators are: assistance with the activities of daily living, and central storage / distribution of medications. If a resident needs one or more of the other four prescribed services, their care will be deemed as too complex for registered AL and a discharge plan will be implemented or, in the case of a senior attempting to move in, the move will not occur.

In addition, if a senior requires two prescribed services or needs only one prescribed service, but it is not the prescribed service offered by that operator, then they will not be admitted to Registered AL and may be referred directly to residential care. As noted by the BC Seniors Advocate, the decision is based not on what assistance senior needs but on what two prescribed services the operator has selected to provide.⁵²

A major report on AL in British Columbia released in September 2013 also notes that the cap on two prescribed services were created to establish a boundary between AL and residential care. Despite this, however, the cap fails to take into account the reality that the care needs of individual residents are not static and the resources of the care system do not always allow for an immediate solution when those needs change. The report, which outlines 50 recommendations, advocates amendments to the CCALA to not only delete references to prescribed services but to require AL sites to provide services including assistance with daily activities, medication management, psychosocial rehabilitative therapy and other personal care services that can be safely provided without 24 hour professional nursing supervision.⁵³

The BCCPA supports an approach that is consistent with the recommendations from the Seniors Advocate in which the BC government removes the restrictions relating to the number of prescribed services (currently two) that may be provided in AL. In the same regard, the Ministry of Health should also work with the BCCPA to redefine the existing eligibility criteria for complex care to allow seniors to remain at home longer and the most appropriate care setting particularly AL or at home if appropriate. As defined by the Ministry of Health, complex care refers to care and support for people who are moderately or severely cognitively impaired; are physically dependent (their medical needs require professional nursing care, and they need a planned program to retain or improve their functional ability); have multiple

⁵⁰ Ibid.

⁵¹ Seniors' Housing in BC: Affordable, Appropriate, Available. BC Office of the Seniors Advocate. May 2015. Accessed at: <https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2015/05/Seniors-Housing-in-B.C.-Affordable-Appropriate-Available.pdf>

⁵² Ibid.

⁵³ Report on Assisted Living in British Columbia. British Columbia Law Institute and Canadian Centre for Elder Law – Members of the Assisted Living Project Committee. September 2013. Accessed at: http://www.bccare.ca/file/report_72_assisted-living-in-BC.pdf

disabilities and/or complex medical conditions that require professional nursing care, monitoring and/or specialized skilled care; or have severe behavioral problems on a continuous basis.⁵⁴

By removing the restrictions relating to number of AL services or expanding role of AL it will be important to ensure that there are no adverse effects such as an increase in ER or acute care. As noted earlier, a recent study from Alberta shows the incidence of hospital admission was about 3 times higher among AL residents than among LTC residents (14%) and that many of the admissions could have been prevented.⁵⁵

To ensure no increase in ER visits and ultimately reduce such utilization, where feasible AL should also be linked to new models of continuing care as outlined earlier such as but not limited to Continuing Care Hubs, geriatric centres of excellence / innovation in order optimize ER utilization, reduce congestion in acute care and better care for frail elderly.

RECOMMENDATION #5

That the Ministry of Health redefine the existing eligibility criteria for complex care and Assisted Living to allow seniors to remain at home longer or the most appropriate care setting in accordance with the recommendations from the Seniors Advocate to remove restrictions relating to the number of prescribed services (currently two) that may be provided in Assisted Living.

⁵⁴ Ministry of Health Home and Community Care Policy Manual, Chapter: 6 Residential Care Services (Section 6.D : Access to Services (October, 15, 2012)

⁵⁵ In particular, nearly 40% of Assisted Living residents in Alberta were admitted to hospital over 1 year, a rate substantially higher than that for long-term care residents. High rates of hospital admission among older residents in assisted living facilities: opportunities for intervention and impact on acute care. David Hogan et al. Open Medicine, Vol 8, No 1 (2014). Accessed at: <http://www.openmedicine.ca/article/view/622/541>

5.0 CONCLUSION

With the aging population and increased pressures facing the acute care system in British Columbia now is the time to explore new solutions and models to meet the challenges and improve seniors care in the province. In this regard, the intention of this paper was to:

- Articulate the BCCPA's positions in regards to the Policy Papers the Ministry of Health released earlier in February 2015 particularly the one on Primary and Community Care;
- Outline various recommendations to improve the continuing care system focusing on two critical priorities namely the redirection of acute care funding to home and community care as well as the development and funding of new long-term care models (i.e. Continuing Care Hubs); and
- Outline a process for advancing these and other recommendations particularly through the creation of a new Continuing Care Collaborative.

SUSTAINABILITY

As outlined in this paper, the BCCPA advocates that the Health Authorities better utilize the existing capacity and expertise amongst non-government care operators to act as champions and drivers of system change in the continuing care sector. In particular, it is recommended that the Ministry of Health and Health Authorities work with the BCCPA and other stakeholders to develop strategies to better utilize the existing excess capacity in the continuing care sector to **reduce ALC beds and offset acute care pressures**. At a minimum, strategies should include the creation of a new publicly accessible online registry to report on ALC and vacant residential care beds as well as the use of current vacant beds within residential care homes, assisted living units and home support to reduce acute care pressures.

This paper also recommends the establishment of a Continuing Care Collaborative comprised of the BCCPA, Health Authorities and BC Ministry of Health to support the long-term sustainability of the sector and improve seniors care across the province. This report also suggests a strategy that new designated funding be redirected to home and community care, such as perhaps a minimum of 1% of acute care funding annually by the Health Authorities. This funding could be allocated on an annual basis over a five year period into the continuing care sector including residential care and home support. This redirected existing funding would amount to approximately \$320.8 million in the fifth year and would be used to directly address some of the documented challenges facing current operators including minimal funding lifts but also support the development of new care models particularly Continuing Care Hubs.

Redirecting funding from acute care could go a far way in addressing current and future pressures facing the continuing care sector. The BCCPA believes some of the acute care funding that is re-directed to the continuing care sector could be obtained with a reduction of alternate level of care (ALC) beds; savings which could also be used to reduce pressures on the acute care system as well as provide better access to care and allow seniors to live in most appropriate care setting.

INNOVATION

Consistent with the BC Ministry of Health's cross health sector strategic priorities, the Continuing Care Collaborative should review as a priority options for new delivery models including, but not limited to the creation of Continuing Care Hubs, geriatric centres of excellence, as well as Post-Acute, Specialized Stream, Integrated Care, Frail Elderly and Dementia Care Models in order to optimize ER utilization, reduce acute care congestion and better care for the frail elderly.

As outlined in the paper the focus should be the **development of new Continuing Care Hubs, which can provide enhanced care for seniors, including additional services such as dialysis, IV, sub-acute care, wound care, etc...** The four key elements of the new continuing care hubs as outlined further in the paper include:

- 1) ***Integration of health professionals and family in seniors care*** (i.e. Integrating nurse practitioners, family physicians and physician assistants into long term care (LTC), use of health and emergency professionals, specialized training, etc...);
- 2) ***New roles for care providers*** (i.e. new Health Care Aide roles, multidisciplinary LTC team, education and training, integration of physicians and other allied health professionals);
- 3) ***New funding models*** (i.e. sustainable funding including redirection of acute expenditures to continuing care, outcome based funding that considers optimal staffing mix and care outcomes, integration of care and team based models); and
- 4) ***Expanded role and co-location of services*** (i.e. sub-acute care, paramedics and ambulatory care, wound care, dialysis, IV care, prevention and health promotion including frailty screening and chronic disease management, respite care, palliative care, pharmacy and medication management, mental health, diagnostic and laboratory services, rehab and recovery care, etc...).

Finally, this report also advocates that **the province redefine the existing eligibility criteria for complex care** as well as **undertake a review of Assisted Living to remove the restrictions relating to the number of prescribed services** (currently two) that may be provided in this care setting. By undertaking the recommendations outlined in this paper the BCCPA believes it will help accomplish the following outcomes:

- Allow more seniors to live in their home (i.e. single family residence or apartment longer while ensuring a broader level of residential care and sub-acute services are available to them);
- Increase the ability of the health authorities to provide residential care beds closer to the senior's former single family home / apartment when they need it;
- Increase choice for seniors utilizing the current "First Appropriate Bed" policy;
- Improve overall quality of seniors care, including access and better health outcomes;
- Help reduce unnecessary hospitalizations and acute care / ER pressures;
- Reduce immediate and long-term pressures facing the system including ALC beds;
- Enhance and build upon existing capacity and expertise in the continuing care sector;
- Foster innovation and care through the development of new care models particularly new Continuing Care Hubs and geriatric centres of excellence;
- Better meet the needs of a growing elderly population particularly those with high needs such as the frail elderly and dementia care;
- Expand role of continuing care including residential care, assisted living and home support to reduce overall health system costs;
- Foster greater collaboration in the sector through creation of a new Continuing Care Collaborative;
- Develop strategies to begin the redirection of funding from more costly acute to home and community care; and
- Remove unnecessary restrictions for Assisted Living including around number of prescribed services.

RECOMMENDATIONS

SUSTAINABILITY

Recommendations

1. That, as an immediate priority, the Ministry of Health and Health Authorities work with the BC Care Providers Association (BCCPA) and other stakeholders to develop strategies to better utilize the existing excess capacity in the continuing care sector to reduce ALC beds, offset acute care pressures as well as better care for frail elderly and seniors with Dementia. Strategies should include the creation of a public registry to report on ALC and vacant residential care beds as well as use of current vacant beds within residential care, assisted living units and home support services to reduce acute care pressures.
2. That the BC Ministry of Health, Health Authorities, and BCCPA establish by the end of 2015 a Continuing Care Collaborative in order to support the long-term sustainability of the sector and improve seniors care across the province.
3. Starting in fiscal year 2016/17, the Performance Agreements between British Columbia's Ministry of Health and Health Authorities should include a specific target for redirecting acute care expenditures such as a minimum of 1% annually over a five year period to the home and community care sector. Such expenditures would be directly reinvested into residential care and home care / support to deal with existing cost pressures facing service providers as well as support development of new continuing care models to reduce acute care pressures, improve access to care while also allowing seniors to receive services in the most appropriate setting. A thorough public reporting on the additional services provided to seniors on an annualized basis as result of investment should also be considered.

Intended Outcomes:

- Allow more seniors to live in their home (i.e. single family residence or apartment longer while ensuring a broader level of residential care and sub-acute services are available to them)
- Increase the ability of the health authorities to provide residential care beds closer to the senior's former single family home / apartment when they need it
- Increase choice for seniors utilizing the current "First Appropriate Bed" policy
- Reduced ALC days
- Reduce acute care pressures and ER utilization
- Better utilization of existing capacity in the continuing care sector
- Improved care for frail elderly and seniors with dementia
- Greater public reporting (i.e. ALC beds and vacant beds)
- Greater collaboration between government, Health Authorities and continuing care sector
- Reducing current pressures facing care operators

INNOVATION

Recommendations

4. That, consistent with the Ministry of Health's cross health sector strategic priorities to improve the effectiveness of primary and community care and access to care including rural health as well as provide seniors with improved access while residing in the most appropriate care setting, the Collaborative as a key priority review options for new delivery models. This includes, but not limited to the creation of continuing care hubs, geriatric centres of excellence / innovation, as well as Post-Acute, Specialized Stream, Integrated Care, Frail Elderly and Dementia Care Models to optimize ER utilization, reduce acute care congestion and better care for frail elderly.
5. That the Ministry of Health redefine the existing eligibility criteria for complex care and Assisted Living to allow seniors to remain at home longer or the most appropriate care setting in accordance with the recommendations from the Seniors Advocate to remove restrictions relating to the number of prescribed services (currently two) that may be provided in Assisted Living.

Intended Outcomes:

- Allow more seniors to live in their home (i.e. single family residence or apartment longer while ensuring a broader level of residential care and sub-acute services are available to them)
- Increase the ability of the health authorities to provide residential care beds closer to the senior's former single family home / apartment when they need it
- Increase choice for seniors utilizing the current "First Appropriate Available Bed" policy
- Reduced ALC beds
- Reduce acute care pressures and ER utilization
- Greater innovation with new Continuing Care Hubs and other care models such as geriatric centres of excellence
- Expanded scope and access to care for seniors
- Better utilization of existing capacity in the continuing care sector
- Improved care for frail elderly and seniors with dementia
- Reducing current pressures facing care operators
- Removing restrictions on prescribed services and expanded role for Assisted Living

APPENDIXES

Appendix A: BCCPA Response to Ministry of Health Policy Paper

Re: BC Care Providers Association (BCCPA) response to Ministry of Health Policy Papers

The BC Care Providers Association (BCCPA) would like to thank the Ministry of Health once again for hosting an important dialogue with service providers on March 25, 2015. The BCCPA believes this constructive dialogue must also continue particularly through the establishment of a new Continuing Care Collaborative. Likewise, the BCCPA also looks forward to participating in the Primary and Community Care Forum organized by the Ministry of Health on June 1st and 2nd in Vancouver.

Overall the papers do a good job in identifying key population areas including caring for the frail elderly and chronically ill. They also deal with significant other populations including those with mental health issues particularly dementia. Following a review of the Ministry papers, the BCCPA agrees with a number of recommendations. In particular, some of the potential positive points and/or opportunities as outlined in the papers include:

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

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

Although younger seniors may prefer to age in place this may change as they get older. As a result, the BCCPA suggests undertaking a research project to review how a senior's preference for aging in place or at home may change over time depending on their specific age and/or level of acuity. In addition, there should be further studies on the costs of home care versus long-term care for seniors as their levels of acuity rise. Along with the earlier concerns about ensuring seniors with higher levels of acuity are cared for appropriately, it will be important that stakeholders including BCCPA are involved in any process or assessment with respect to changing the delivery of rural health services for seniors. Other positions, although not specifically outlined in the papers, that the BCCPA would like to put forward for consideration include:

Increased collaboration

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

Review of funding lifts and Direct Care Hours

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

Review of new funding models

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

Better Dementia and Palliative Care

- Development of a program to better integrate residential care homes as part of any age friendly community approaches, including Dementia Friendly Communities with funding to retrofit existing care homes to support such an approach.
- Development of a dementia friendly care home program in which a specific designation could be provided to care homes that have made specific redesign changes to accommodate dementia patients and/or where specific dementia training has been provided to staff.

- Endorsement of a National Dementia Strategy with federal participation which should include investing in research and ensuring capacity and appropriate funding in the continuing care sector.
- Adoption of new palliative care models including where necessary providing funding to improve the integration between long-term and end-of-life care, including new long-term care models with expanded roles in caring for seniors.

Improving Seniors Safety and Quality Care

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

Appendix B: Review of OLTC report on Long Term Care

BACKGROUND

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

Post-Acute Model

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

Specialized Stream Model

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

Integrated Care Model

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

Hub Model

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

Designated Assisted Living Model

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

Culture Change Model

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

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

Appendix C: Integrating Health Care Providers into Long Term Care

Integrating Physicians into LTC

Nova Scotia – Care by Design

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

The core of CBD is dedicated family physician coverage for each care home floor, with regular on-site visits; on-call coverage, 24 hours a day, 7 days a week; and standing orders and protocols. Other key aspects of CBD include an extended care paramedic (ECP) program, providing on-site acute care and facilitating coordinated transfers to the ED; a new comprehensive geriatric assessment (CGA) tool; performance measurements; and interdisciplinary education.⁵⁶ Care by Design improves on-site care for long-term care home residents and improves family physicians' experiences of providing care in several ways, including:

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

Preliminary results from CDB include that the initiative has improved clinical efficiency by reducing travel time to visit residents in multiple long-term care homes and that continuity and quality of care has improved for residents. In particular, data also shows that there has been a 36 per cent reduction in transfers from LTC homes to Emergency Department over six month period.⁵⁷

British Columbia General Practice Services Committee – Residential Care Initiative

To deal with the issue of physicians providing LTC, BC government and Doctors of BC through the General Practice Services Committee (GPSC) is supporting physicians through its residential care initiative. With the GPSC's commitment of up to \$12 million annually, the initiative is attempting to meet the needs of residential care patients in 104 communities across BC. The initiative also includes the establishment of new fee codes for seniors care. Starting on July 1, 2015, divisions / self-organizing groups can potentially access a quarterly lump sum incentive, calculated for equity at an annual \$400 per residential care bed, to implement local solutions.⁵⁸

⁵⁶ Nova Scotia Capital District Health Authority. Care by Design. <http://www.cdha.nshealth.ca/care-by-design>

⁵⁷ Evaluating "Care by Design" – a New Model of Long-term Care from Physicians Perspectives. Emily Marshall et al. Accessed at: <http://www.cdha.nshealth.ca/system/files/sites/12558/documents/evaluating-%E2%80%9Ccare-design%E2%80%9D-new-model-long-term-care.pdf>

⁵⁸ General Practice Services Committee (GPSC). Residential Care Initiative. Accessed at: <http://www.gpscbc.ca/family-practice-incentive/residential-care>.

Physician Assistants

Physician Assistants (PAs) are essentially healthcare professionals educated in the medical model to practice medicine under the direction of a physician. In a formal practice arrangement with a physician, PAs practice medicine which includes obtaining medical histories and performing physical exams, ordering and interpreting laboratory and diagnostic tests, providing therapeutic procedures, prescribing medications, and educating and counselling patients.⁵⁹

Recent studies have highlighted the benefits of PAs including that they can increase access to medical care for seniors. In particular, having a full-time PA on staff at a nursing home or long-term care home can translate into patients being evaluated sooner and can prevent transfers to the hospital in many cases. A study from the US, shows that PAs in long-term care settings have decreased hospital admission rates by 38% for seniors. PAs can also have an important preventive role in care of geriatric patients.⁶⁰

While relatively new in the Canadian health care setting, PAs have been practicing in the Canadian Armed Forces for over 50 years and have been instrumental in providing a high level of care to soldiers on the front lines. PAs also practice in a variety of specialties including emergency rooms, primary care, orthopedics, psychiatry, neurosurgery in a number of provinces including Alberta, Manitoba, Ontario and New Brunswick.⁶¹

Integrating Nurses into LTC

Integrated Nursing Teams – Ontario LTC Nurse-Led Outreach Teams

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

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

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

⁵⁹ University of Manitoba. What is a Physician Assistant? Accessed at:

http://umanitoba.ca/faculties/health_sciences/medicine/education/paep/whatisapa.html

⁶⁰ Hooker, Cawley and Asprey. (2010). Physician Assistant Specialization: Nonprimary care. PA Specialty Care. Ch. 7. p.p. 235. Accessed at:

http://capa-acam.ca/wp-content/uploads/2013/09/PA-FACT-SHEET-2013_FINALcopy.pdf

⁶¹ CAPA. New Study Shows Canadians Want Physician Assistants to Play a Greater Role in Their Health Care. October 24, 2014. Accessed at:

<http://www.newswire.ca/en/story/1433470/new-study-shows-canadians-want-physician-assistants-to-play-a-greater-role-in-their-health-care>.

follow-up, and to build the clinical capacity of long-term care providers with knowledge around the management of urgent and palliative issues.⁶²

INTERventions to avoid Acute Care Transfers: (INTERACT) II initiative

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

Nurse Practitioners

In addition to physicians, new LTC models should also better utilize or integrate nurse practitioners (NPs).⁶³ Overall, progress in implementing NPs has lagged behind other provinces including Ontario and Alberta. One of the major problems, however, has been that insufficient funding has left many NPs unable to obtain employment.⁶⁴ Although in 2012 the BC government announced \$22.2 million to pay for 190 positions over the next three years, it is not clear whether some commitments will continue in the future.⁶⁵ As of January 2014 there were only 287 NPs registered in BC. Another survey also shows that less than 10% NPs who responded (8% or 7 in total) identified residential care as a practice setting.⁶⁶

There is evidence that shows NPs improve family satisfaction and staff confidence. They also reduce transfers to the emergency department, hospital admissions and length of stay, and workload for long term care physicians.⁶⁷

Teaching Long Term Care Homes

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

Teaching Nursing Homes in the United States: Early Lessons

A U.S. TNH initiative was funded by the Robert Wood Johnson Foundation and was later implemented by the National Institute on Aging between 1982 and 1987. Eleven schools and twelve nursing homes participated in the early phases of this project which aimed to increase the quality of care; to increase the

⁶² Living Well, Living longer. Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on recommendations to Inform a Seniors Strategy for Ontario. December 2012. Accessed at http://www.health.gov.on.ca/en/common/ministry/publications/reports/seniors_strategy/docs/seniors_strategy_report.pdf

⁶³ In BC a NP is a Registered Nurse with a Master's Degree, advanced knowledge and skills who provides health care services. NPs are able to diagnose, consult, order interpret tests, prescribe, and treat health conditions. They also work independently and collaboratively to provide British Columbians with Primary and Specialized Health Care using a team-based approach. Since 2005, BC began graduating and regulating NPs, with about 45 students per year.

⁶⁴ Are nurse practitioners the cure for B.C.'s family doctor shortage? Globe and Mail. Rod Mickelburgh. January 5, 2013. Accessed at <http://www.theglobeandmail.com/news/british-columbia/are-nurse-practitioners-the-cure-for-bcs-family-doctor-shortage/article6970838/>

⁶⁵ BC funds more Nurse Practitioner positions. Ministry of Health media release. May 31, 2012. Accessed at: <http://www.newsroom.gov.bc.ca/2012/05/bc-funds-more-nurse-practitioner-positions.html>

⁶⁶ A Survey of Nurse Practitioner Practice Patterns in British Columbia. University of Victoria and Michael Smith Foundation for Health Research. January 2014. Accessed at: <http://www.uvic.ca/research/projects/nursepractitioners/assets/docs/NP%20Practice%20Patterns%20Report.pdf>

⁶⁷ WHY NOT NOW? A Bold, Five-Year Strategy for Innovating Ontario's System of Care for Older Adults. LTC Innovation Expert Panel. March 2012. Accessed at: http://www.olta.com/olta/Documents/Reports/WhyNotNowFULL_March2012.pdf

interest in geriatrics in the school of nursing; to improve staff development; and to ensure independent financial survival for the program.

While the initiative achieved some good results, the program ended in the late 1980s due to insufficient funding. As TNH homes take some years to produce measurable success, and many stakeholders and state governments were impatient for results, additional funding and support was not available after the Foundation's resources were depleted. Despite its challenges, the U.S. initiative produced some positive outcomes. For instance, at one participating school (Rutgers University in New Jersey) patient care and conditions significantly improved within the first year, including:

- A 50 per cent decrease in bedsores;
- A 23 per cent decrease in the use of physical restraints in one unit;
- A 25 per cent decrease in the use of enemas;
- An 18 per cent fewer acute care transfers than previous years; and
- A 7 per cent drop in hospitalization rates during the first three months.

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

Teaching Nursing Homes in Norway: A Model Initiative

The Norwegian TNH program differs significantly from the U.S. model, as it is was designed in collaboration with, and is funded by, the Norwegian government. The TNH program aims to improve the competence of staff, enhance the prestige of working with older people, stimulate the development of services, facilitate research on the care of older persons, and develop strong learning environments for students. Norwegian TNHs were established on a permanent basis as of 2004 with funding from the Department of Health and Social Services. Design and development of the Norwegian program was more gradual and strategic than the U.S. initiative.⁶⁸

⁶⁸ Elements of an Effective Innovation Strategy for Long Term Care in Ontario. Prepared for OLTCa by Conference Board of Canada. January 2011. Accessed at: http://seniorshhealthknowledge network.ca/sites/seniorshhealthknowledge network.ca/files/march11_cboc_report.pdf

Appendix D: Retirement Concepts Innovation Centre

Retirement Concepts is the largest private provider of LTC care in BC. As part of its Innovation Centre it is looking to technology advances and innovative processes to personalize and improve care in a cost effective manner. In particular, as part of the Retirement Concepts Innovation Centre (RCIC) partnership, members are being brought together to direct technology development.

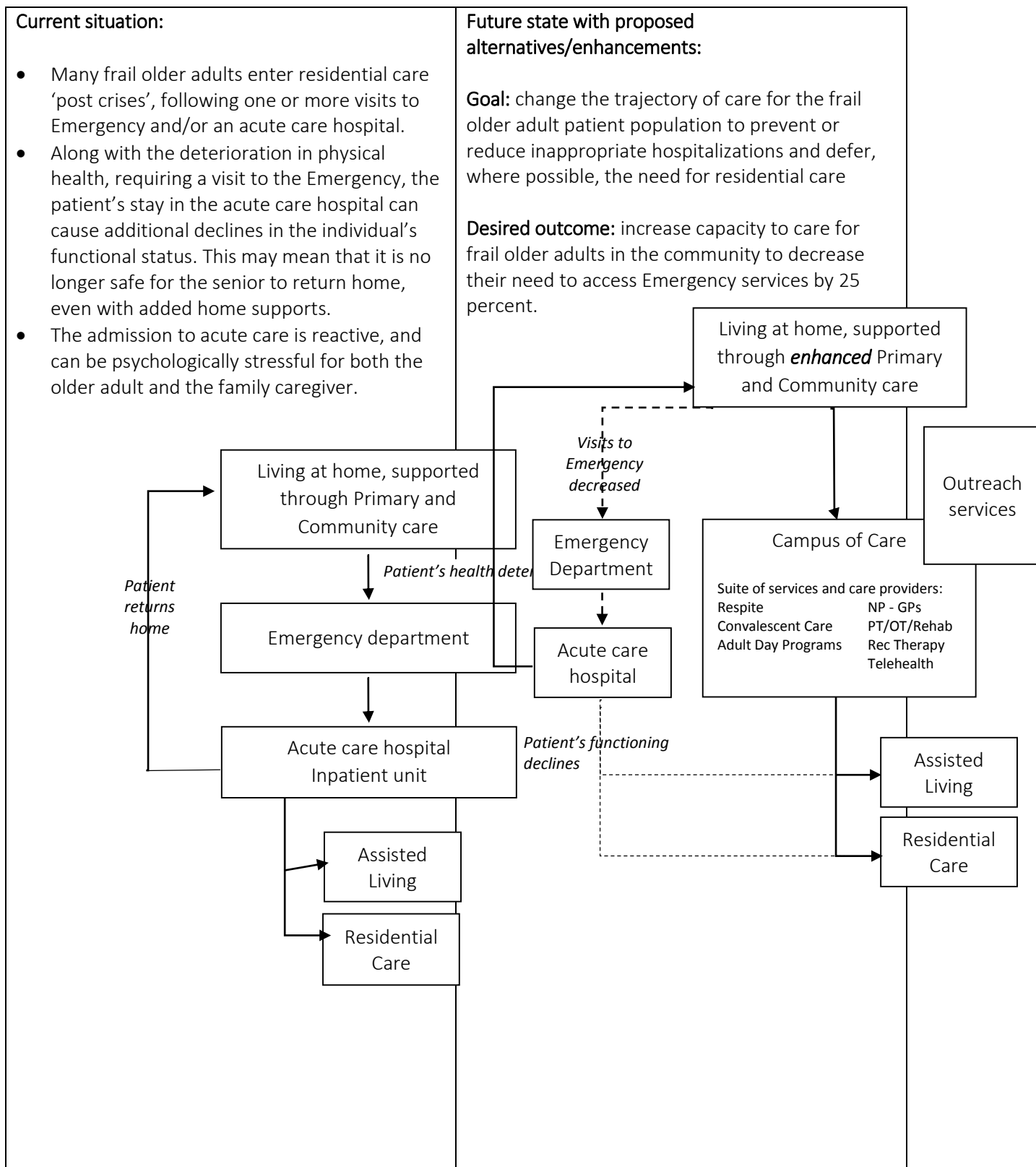
The three key objectives of this initiative include: 1) maximizing innovations in client care, 2) embedding research in the care environment and 3) getting products and services to market. Although only a year old, RCIC has multiple projects underway including the testing and development of a wheelchair airbag in partnership with MobiSafe Systems Inc, the development and implementation of a brain vital sign system for dementia care, and the integration of video surveillance in the analysis and care provider training of falls and aggression in long term care.

Retirement Concepts' is also developing a framework proposal to change health care utilization patterns for BC's frail older adult population. This model, similar in concept to the Continuing Care Hub proposed earlier, is designed to change the overall trajectory of care for the frail older adult patient population as well as prevent or reduce inappropriate hospitalizations. As outlined in Retirement Concept's example (see visual schematic below), some of the proposed enhancements to seniors care include:

- Integrated Primary and Community Care teams, with links to network of community services;⁶⁹
- Improved Home Health monitoring technologies (e.g. Integrated Home System);
- Campus of Care Amenities – activity/dining/bathing/respite/short stay;
- Adult Day Program options;
- 'Outreach' services to keep seniors safe at home and avoid acute care (e.g. Home Visits);
- Community services - Navigator;
- 24/7 Interdisciplinary care providers to meet the episodic needs (i.e. pharmacy, OT/PT, dining, bathing, dressing, IVT, psycho social); and
- Hospital at Home team` to provide short-term acute medical care to seniors at home as used in UK.

⁶⁹ Bellows, J., Young, S., and Chase, A. (2014). Person-focused care at Kaiser Permanente. *The Permanente Journal*, 18(1). Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3951036/pdf/permj18_1p0090.pdf. Oxford Health NHS Foundation Trust. Hospital at Home. Retrieved from http://www.oxfordhealth.nhs.uk/?service_description=hospital-at-home

Retirement Concepts' Frail Elderly Care Model: A proposal to change health care utilization patterns for BC's frail older adult population



<p>Patient and health system outcomes and supporting evidence:</p> <ul style="list-style-type: none"> • In Canada, over 55% of acute care hospital beds are currently occupied by seniors on any particular day⁷⁰ • Thirty percent of seniors admitted to acute care will be discharged at a significantly reduced level of functional ability and most will never recover to their previous level of independence⁷¹ • Health care costs, especially hospitalization expenditures, rise in the year before a patient enters residential care⁷² • Inappropriate use of acute care resources, as evidenced by a high Alternative Level of Care rate, particularly in Fraser Health⁷³ 	<p>Value proposition</p> <ul style="list-style-type: none"> • Prevent inappropriate use of Emergency services and acute care admissions • Flexible range of services in the community to meet the individualized person centered needs of seniors • Enable frail seniors to remain safely at home longer and/or indefinitely where appropriate • Optimize existing human and capital resources (e.g. Municipal Resources & Community Campus of Care®) • Support proactive and planned community-based admissions to Residential Care when required. <p>Proposed enhancements:</p> <ul style="list-style-type: none"> • Integrated Primary and Community Care teams, with links to strengthened network of community services⁷⁴ • Improved Home Health monitoring technologies (e.g. Integrated Home System®) • Campus of Care Amenities – activity/dining/bathing/respite/short stay • Adult Day Program options • ‘Outreach’ services to keep seniors safe at home and avoid acute care –Home Visits • Community services - Navigator • 24/7 Interdisciplinary care providers to meet the episodic needs – i.e. pharmacy, OT/PT, dining, bathing, dressing, IVT, Psycho social • Hospital at Home team` to provide short-term acute medical care to seniors at home, similar to UK model
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⁷⁰ BC Patient Safety and Quality Council (Nov 2014). Hospital Care for Seniors Clinical Care Management Guideline: 48/6 Model of Care. Retrieved from <https://bcpsqc.ca/clinical-improvement/48-6/practice-statements/>

⁷¹ Ibid

⁷² BC Ministry of Health (2015). Primary and Community Care in BC: A Strategic Policy Framework. Retrieved from <http://www.health.gov.bc.ca/library/publications/year/2015/primary-and-community-care-policy-paper.pdf>

⁷³ Fraser Health Feb 2015 Report Card. Retrieved from http://www.fraserhealth.ca/media/022415_Overall_Report_Card.pdf

⁷⁴ Bellows, J., Young, S., and Chase, A. (2014). Person-focused care at Kaiser Permanente. The Permanente Journal, 18(1). Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3951036/pdf/permj18_1p0090.pdf Oxford Health NHS Foundation Trust. Hospital at Home. Retrieved from http://www.oxfordhealth.nhs.uk/?service_description=hospital-at-home

Appendix E: Innovative Home Care Models

ONTARIO

Seniors Managing Independent Living Easily (SMILE) program

The Seniors Managing Independent Living Easily (SMILE) program was implemented in 2008 as a pilot project by the South East Local Health Integration Network (LHIN), as part of the *Aging at Home strategy* of the Ontario Ministry of Health and Long-Term Care. The Southeast LHIN, is one of 14 agencies put in place by Ontario to provide regional-decision making and accountability for the following healthcare services: homecare, long-term care, mental health and hospital services.⁷⁵

The primary goal of the LHIN is to provide patient centred care within their designated regions. At the same time LHIN's develop innovative and collaborative initiatives to increase access to care for patients, they are the only organizations that bring together various sectors (hospitals, community care, long-term care, etc.) in order to provide care to citizens.⁷⁶ The SMILE program was initiated by the LHIN, through consultation with seniors and healthcare providers and emphasizes the need to provide care to frail seniors at home who are at risk of losing their independence. The project funds services such as: housekeeping, shopping, laundry, seasonal chores, and transportation to healthcare appointments.⁷⁷ Such support services cost \$80 per day.

The SMILE program offers seniors a chance at managing their own care where seniors can choose what kinds of services they need, when they need them and who will provide these services, such as funded organizations (by the LHIN) or non-traditional service providers (family, friends, third party etc.).⁷⁸ The philosophy behind the program is based on the belief that attending to senior care is more than just about their medical needs but allowing them to stay in an environment that is beneficial to their well-being, that home is a good place to live, and that dignity and choice go hand in hand.⁷⁹ Based on a February 2012 survey, the majority of clients enlisted in the program reported satisfaction with SMILE services, with 49% expressing that their physical health had improved since being on the program⁸⁰.

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

CHATS is a non-for-profit organization which offers services to seniors such as: meals on wheels, transportation, diversity outreach programs, home care and caregiver support/education.⁸¹ CHATS provides services to over 7,600 York Region and South Simcoe seniors and caregivers each year where services are provided through dedicated volunteers, 220 staff and a Board of Directors.⁸² CHATS envisions

⁷⁵ Quick Facts about the South East Local Health Integration Network, accessed at: <http://southeastlhin.on.ca/Page.aspx?id=1302>

⁷⁶ Our Mission, Vision & Values, accessed at: <http://southeastlhin.on.ca/AboutUs/MissionVisionValues.aspx>

⁷⁷ Donner G., McReynolds, J., Smith, K., Fooks, C., Sinha, S., & Thomson, D. (2015) "Bringing Care Home: Report of the Expert Group on Home & Community Care". Accessed at: http://www.osot.on.ca/imis15/TAGGED/News/Bringing_Care_Home_-_Report_of_Expert_Group_on_Home_Community_Care_Released.aspx

⁷⁸ SMILE Program Information. Accessed at: http://www.von.ca/smile/programs_info.aspx

⁷⁹ South East Local Health Integration Network (2008) "A Plan to help seniors stay at Home".

⁸⁰ Accreditation Canada (2013) "Seniors Managing Independent Living Easily (SMILE)". Accessed at: <https://www.accreditation.ca/seniors-managing-independent-living-easily-smile>

⁸¹ Donner G., McReynolds, J., Smith, K., Fooks, C., Sinha, S., & Thomson, D. (2015) "Bringing Care Home: Report of the Expert Group on Home & Community Care". Accessed at: http://www.osot.on.ca/imis15/TAGGED/News/Bringing_Care_Home_-_Report_of_Expert_Group_on_Home_Community_Care_Released.aspx

⁸² About CHATS. Accessed at: <http://www.chats.on.ca/about-chats>

to provide innovative leadership in order to promote the wellness of seniors and caregivers in Ontario.⁸³ Since its launch in 1980, CHATS has provided a continuum of care services to over 700 culturally, economically, and geographically diverse seniors.⁸⁴ CHATS was also accredited with exemplary standing by Accreditation Canada and met 100 percent of the 852 standards during its evaluation period.

Integrated Comprehensive Care Program (ICC)

The Integrated Comprehensive Care Program (ICC) was undertaken at St. Joseph's Health System in Ontario, the pilot project ran for a year and integrated case management between hospital and community based care.⁸⁵ The idea behind ICC was that after patients undergo surgery and leave to their home, they would receive access to the same care team on a 24/7 basis, if the need be. In order to deliver care services, ICC requires technology such as a computer/ telephone so patients can access their care team via skype or phone and maintain an electronic health record.⁸⁶ Dedicated care coordinators keep track of complex care patients, from the moment they are admitted to the hospital, to when they are discharged. The use of technology to connect with patients ensures that there will be reduced duplications, shorter hospital stays and fewer re-admissions.⁸⁷

Important features of the program include having one contact number so the patient can direct their needs to one individual on the team, a shared electronic health record, flexibility in communications by using the latest technology to connect and community partner support.⁸⁸ So far, the project has reduced length of hospital stay by 24 percent and has seen a 15% drop in hospital re-admissions after surgery.⁸⁹

ALBERTA

Comprehensive Home Options of Integrated Care for the Elderly (CHOICE)

Developed in 1996, the Comprehensive Home Options of Integrated Care for the Elderly (CHOICE) program in Edmonton, Alberta has become a recognized delivery model for homecare to elderly adults. In partnership with Capital Care and the Good Samaritan Society, the CHOICE program provides adults over the age of 60 options for care at home and at the same time operates itself like a day clinic. The program also offers a variety of services to seniors throughout the week and is run by a multi-disciplinary team of physicians, nurses, pharmacists, dieticians, occupational and physiotherapists and social workers.⁹⁰ Under CHOICE, seniors are delivered all basic health services, this includes personal care (bathing, dressing, etc...), dental care, respite care, meals and snacks, medication and home care services.⁹¹

The program offers care to seniors who have complex long-term care issues and live at home. Clients must be willing to change their health care provider and should be able to use transportation provided by

⁸³ CHATS: Community and home Assistance to seniors (2009-2010) "Annual Report: A Year to Grow".

⁸⁴ CHATS: Community and home assistance to seniors (2-13-2014) "Annual Report".

⁸⁵ Donner G., McReynolds, J., Smith, K., Fooks, C., Sinha, S., & Thomson, D. (2015) "Bringing Care Home: Report of the Expert Group on Home & Community Care". Accessed at: http://www.osot.on.ca/imis15/TAGGED/News/Bringing_Care_Home_-_Report_of_Expert_Group_on_Home_Community_Care_Released.aspx

⁸⁶ Integrated Comprehensive Care Project. Accessed at: <http://www.sjhs.ca/integrated-comprehensive-care-project.aspx>

⁸⁷ St. Mary's General Hospital (2013) Successful model for complex care patients expands to St. Mary's. Accessed at: <http://www.smgh.ca/successful-model-for-complex-care-patients-expands-to-st-marys/>

⁸⁸ Ministry of health and long-term care (2013) "Integrated Comprehensive Care Project". Accessed at: <http://news.ontario.ca/mohltc/en/2013/09/integrated-comprehensive-care-project.html>

⁸⁹ Ministry of health and long-term care (2013) "Ontario Helping More Patients to Benefit from New Model of Care".

⁹⁰ DeSantis, B. (2014) "CHOICE Edmonton Day Program: An outlet for social seniors". Senior Care Canada. Accessed at: http://seniorcarecanada.com/articles/choice_edmonton_day_program#sthash.nxuSwoyF.C8bmbATx.dpuf

⁹¹ Hollander Analytical Services Ltd. (2006). Home care program review: Final report. Accessed at: http://www.health.gov.sk.ca/HomeCareReview2006_FinalReport.pdf

the program.⁹² Two examples of the CHOICE Program is the independent living complex of the Good Samaritan Place and onsite at the continuing care centre / auxiliary hospital of Dr. Gerald Zetter Care Centre in Edmonton.⁹³ According to Alberta Health Services, six months after joining the program, all CHOICE clients saw a drop in emergency visits by 30 percent.⁹⁴ BC also had a similar program to CHOICE at the University Hospital in Shaughnessy, which was originally built to house veterans returning from World War I and was closed in 1993.

Program of All-inclusive Care for the Elderly (California)

The CHOICE program in Edmonton was modeled off of the Program of All-inclusive Care for the Elderly (PACE). Developed in the early 1970s, the PACE model first emerged in Northern California, where it was co-founded by dentist Dr. William L. Gee and Social Worker Marie-Louise Ansak.⁹⁵ The idea developed to address the needs of elders immigrated from Italy, China and the Philippines whom required long-term care services, in order to create a “community hub” where seniors, medical, emotional and physical needs could all be met in one place. Gee and Ansak formed a non-profit corporation called On Lok Senior Health Services, to provide community care to elders.⁹⁶

Similar to the CHOICE program, On Lok Lifeway care providers work in interdisciplinary teams to offer similar services at a specific location or center. The PACE model’s key features include, flexibility – coordinate care based on individual needs, all inclusive care (preventive, primary, acute and long-term care), interdisciplinary teams and capitation funding.⁹⁷ Unlike CHOICE, the PACE program offers community care to seniors aged 55 and up, as CHOICE offers the program to anyone 60 or older.

⁹² Choice© Program. The Good Samaritan Society, accessed at: <https://www.gss.org/find-housing-support-services/community-care/choice/>

⁹³ For more information on the Good Samaritan Place & Dr. Gerald Zetter Care Centre, see: <https://www.gss.org/find-housing-support-services/community-care/choice/>

⁹⁴ Alberta Health Services. Accessed at: <http://www.albertahealthservices.ca/1362.asp>

⁹⁵ McGregor Pace. “History of Pace”. Accessed at: [HTTP://WWW.MCGREGORPACE.ORG/ABOUT/HISTORY/](http://WWW.MCGREGORPACE.ORG/ABOUT/HISTORY/)

⁹⁶ Wong, J. (2013) “For Chinese Speaking Seniors, Better Service in San Francisco and Toronto”. The Tyee. Accessed at: <http://thetyee.ca/News/2013/04/04/Chinese-Speaking-Seniors/print.html>

⁹⁷ What is PACE? On Lok PACEpartners, accessed at: <http://pacepartners.net/what-is-pace/>

Appendix F: Glossary of Terms

Term	Definition
Adult Day Services	Adult day services assist seniors and adults with disabilities to continue to live in their own homes by providing supportive group programs and activities in the community. Clients receiving adult day services travel to a location in their community usually 1-2 days per week where they may receive a variety of services, including: personal assistance; health care services including nursing and/or rehabilitation services; an organized program of therapeutic social and recreational activities in a protective group setting; health education and promotion, nutrition and bathing programs, blood pressure and podiatry clinics, telephone checking, and counselling; and caregiver support, including respite, activities such as caregiver support groups, information and education programs.
Alternative Level of Care (ALC)	Alternative Level of Care (ALC) refers to when a patient is occupying a bed in a hospital and does not require the intensity of resources / services provided in this care setting, and is thus waiting to be discharged to a more appropriate care setting. Often refers to a patient occupying an acute care bed, and is waiting for placement in a residential care bed or assisted living unit.
Assisted Living (AL)	Assisted living services provide housing, hospitality services, and personal care services for adults who can live independently and make decisions on their own behalf but require a supportive environment due to physical and functional health challenges. Assisted Living represents a middle option between independent living (with some limited support) in one's own home, and living in a residential care home. Specifically in British Columbia, Assisted Living provides housing, hospitality, and two prescribed services .
Campus of Care	A campus of care is a group of residences or buildings in which more than one level of housing and care is provided – often a combination of supportive housing, assisted living, and/or residential care. The campus of care is meant to allow people to stay in one place even as their care needs change. This promotes greater continuity of care and social networks, as well as reducing stress and other health risks.
Comprehensive Home Options of Integrated Care for the Elderly (CHOICE) Program	The Comprehensive Home Options of Integrated Care for the Elderly (CHOICE) program in Edmonton provides adults over the age of 60 options for care at home and at the same time operates itself like a day clinic. The program also offers a variety of services to seniors throughout the week, and is run by a multi-disciplinary team of physicians, nurses, pharmacists, dietitians, occupational and physiotherapists and social workers. Seniors are delivered all basic health services, including person care, dental care, respite care, meals and snacks, medication and home care services.
Complex Care	As defined by the Ministry of Health, complex care refers to care and support for people who: are moderately or severely cognitively impaired; are physically dependent (their medical needs require professional nursing care, and they need a planned program to retain or improve their functional ability); have multiple disabilities and/or complex medical conditions that require professional nursing care, monitoring and/or

	specialized skilled care (“clinically complex”); or have severe behavioural problems on a continuous basis.
Continuing Care Hub	A Continuing Care Hub is a network of individual care homes (or home care providers) that share services, potentially over a large geographic area. In this model, the residential care home could be a centre for the delivery of a wide range of seniors’ services; some of which could be co-located such as in a Campus of Care and/or others potentially managed by a network of care homes. Services that could be delivered by a new Continuing Care Hub could include: primary care, chronic disease management, rehabilitation, sub-acute, dialysis, oral care, foot care, adult day/night programs, satellite specialized geriatric services collaboratively delivered with hospital and community partners, etc.
Direct Care Hours (DCH)	Direct Care Hours (DCH) generally refers to the number of hours of care provided to residents by care staff. What constitutes care staff under direct care hours varies by health authority, though it generally includes registered nurses, LPNs, RNs, care aides, occupational therapists, physiotherapists, among others.
First Appropriate Bed Policy	The Ministry of Health’s Residential Care Access Policy sets in place a process where seniors who are eligible for subsidized residential care must accept the first appropriate bed they are offered. This policy is intended to reduce wait times for residential care, and eliminate vacancies. Residents are expected to occupy their bed within 48 hours of being notified of its availability.
General Practice Services Committee	The General Practice Services Committee (GPSC), composed of representatives from Doctors of BC and the BC Ministry of Health, is a committee devoted to improving patient care and family-physician satisfaction in BC.
Geriatric Centres of Excellence	Geriatric Centres of Excellence are leaders in areas of care such as dementia, mental illness, end-of-life, as well as leaders in the development of research and innovation within the continuing care sector.
Health Care Aide / Residential Care Aide	Health Care / Residential Care Aides provide basic resident care, assisting residents with the activities of daily living such as bathing, dressing, grooming - and often serve meal trays and feed residents. They are also known as care attendants or care assistants.
Integrated Care Model	As outlined in the Ontario Long-Term Care Association (OLTCA) paper Why Not Now? an Integrated Care model integrates housing and home and community care to support a certain challenging population of seniors as their care and housing needs change over time. Can refer to providers of continuums with an enrolled population, or a variety of integrated home and community support services within a defined geographic area.
Nurse Practitioner (NP)	In British Columbia, a Nurse Practitioner (NP) is a Registered Nurse with a Master’s Degree, advanced knowledge, and skills who provides high quality health care. NPs are able to diagnose, consult order & interpret tests, prescribe, and treat health conditions. They work independently and collaboratively to provide British Columbians with Primary and Specialized Health Care using a team-based approach. Nurse Practitioners work in

	multiple settings including acute care, specialty clinics, long term care settings and Primary Care Clinics.
Physician Assistant (PA)	Physician Assistants are skilled health professionals who support physicians in all health care settings. Within a formal Physician/Physician Assistant relationship, PAs deal with medical emergencies, specialty practice environments, as well as everyday health care needs. Depending on the agreement between the physician and the PA, activities may include conducting patient interviews, histories, physical examinations; performing selected diagnostic and therapeutic interventions; and counseling on preventive health care. The PA is a physician extender and not an independent practitioner; they work under the direction of supervising physicians within the client/patient-centered care team.
Prescribed Services	As outlined in BC's Community Care and Assisted Living Act (CCALA), prescribed services with respect to assisted living include: regular assistance with activities of daily living (i.e. eating; mobility, dressing, etc...); medication management; personal financial management; monitoring of food intake; structured behaviour management and intervention; and psychosocial rehabilitative therapy or intensive physical rehabilitative.
Non-Government Care Operators	Refers to care operators in the home and continuing care sector that are not owned or operated by a health authority. Includes both private for-profit and non-profit care operators.
Residential Care	In British Columbia, Residential Care refers to what the public commonly calls nursing homes, care homes, care centres, long-term care homes, extended care, or geriatric care facilities. Residential care refers to a place where a person can receive health care services, accommodation, and support on a regular basis. The BC Ministry of Health defines residential care as being for adults with complex health care needs, who required 24 hour professional care due to physical disability or mental or behavioural conditions, including brain injuries or dementia. Specifically, residential care provides three or more prescribed services .
Respite Care	Respite care is the provision of short-term accommodation in a care setting outside the home in which a loved one may be placed. This provides temporary relief to those who are caring for family members, who might otherwise require permanent placement in a facility outside the home.
Specialized Stream	As outlined in the OLTCA paper Why Not Now?, the Specialized Stream Model provides a higher level of care for special needs populations including persons with late stage dementia, severe mental illness and addictions, and those at end of life. The model blends social and medical models of care with an emphasis on specialized care, pain and symptom management, quality of life and family support.
Sub-acute Care	Subacute rehabilitation is less intensive than acute rehabilitation. Patients in a subacute facility generally only receive one or two hours of therapy per day, and it is usually a combination of physical, occupational and speech therapy. Patients are seen by their attending physician on a monthly basis.

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