



**BC Care
Providers**
ASSOCIATION



When a **Hub** Becomes **Home**: Placing Seniors at the Heart of B.C.'s Communities

December 2019

By Michael Kary

MESSAGE FROM THE CEO

Too often, we see seniors in our cities and towns across British Columbia who are cut off from the heart of our communities, with limited access to family members or companions, and deprived of life-enhancing activities and services. What if they were instead connected to both medical and non-medical services by a network of distinct service providers that serves as a “Care Hub” within that community?

These networks, or hubs, would be designed to alleviate social isolation, would help create stronger connections back to the community by helping to enhance mobility, while at the same time bolstering and making more efficient our health services.

Through this scoping paper, entitled ***When a Hub Becomes Home: Placing Seniors at the Heart of B.C.'s Communities***, BC Care Providers Association (BCCPA) outlines the concept of Continuing Care Hubs, where older adults are better connected, and therefore less isolated, more healthy and happier.



Soon one-in-four Canadians will be above retirement age, and due to that aging demographic, it is possible to see today how provincial healthcare budgets will be severely strained by the needs of the population. It is critical therefore to commit to finding innovative and cost-effective ideas that enhance our continuum of care for seniors.

As far back as 2015, through its paper titled *Quality-Innovation-Collaboration*, BCCPA has championed new care models such as connecting services via a community hub. In this scoping paper, we explore the Continuing Care Hub concept so that it may kickstart a conversation among our provincial and local government leadership, health professionals, and those who design our cities and transportation services.

Beginning with a discussion of the basic tenets of Care Hubs, the scoping paper then discusses the operational hurdles around issues such as funding, human resources, information technology, regulatory reforms and physical infrastructure.

Overcoming these challenges will be critical to strengthening the continuing care sector.

Finally, the paper explores the operationalization of a Continuing Care Hub, using the example of the community non-medical services model. As with all of our policy work, our aim is to strike an important and necessary conversation about creating a sustainable system of care, that promotes quality of life for all of B.C.'s seniors.

A handwritten signature in black ink, appearing to read 'Daniel Fontaine'. The signature is fluid and cursive, written on a white background.

Daniel Fontaine, CEO

ACKNOWLEDGEMENTS

BC Care Providers Association (BCCPA) is the leading industry association for B.C.'s continuing care sector. We have been serving non-government care providers for over 40 years. Our growing membership includes over 350 long-term care, assisted living, independent living, home support and commercial members across BC. Over 23,000 vulnerable adults—primarily seniors—receive their care from our members each day.

Special Recognition

We would like to acknowledge its Board of Directors, and its Emerging Issues and Policy Committee (EIPC) for supporting the development of this report, and dedicating the necessary resources to make it happen. The report's author is **Michael Kary**, BCCPA's Director of Policy and Research.

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Table of Contents

MESSAGE FROM THE CEO	2
ACKNOWLEDGEMENTS	3
EXECUTIVE SUMMARY.....	5
<i>BCCPA Continuing Care Hub Research</i>	5
INTRODUCTION	8
PART I: OVERVIEW OF CONTINUING CARE HUBS	13
BACKGROUND.....	13
RATIONALE FOR NEW CONTINUING CARE HUBS	23
<i>Improved access & allowing seniors to live in most appropriate care setting</i>	23
IMPROVING ACCESS TO HOME HEALTH CARE AND ASSISTED LIVING.....	31
PART II: OPERATIONALIZING THE CONTINUING CARE HUB	46
SECTION 1: IDENTIFYING THE FIVE CARE HUB MODELS.....	48
<i>Current long-term care model</i>	48
<i>Integrated Home and Long-Term Care Model</i>	48
<i>Enhanced Specialized Services Model</i>	50
<i>Enhanced Community Health Services Model</i>	51
<i>Community Non-Medical Services Model</i>	52
<i>Hypothetical Care Hub: Victoria Continuing Care Hub Group</i>	54
SECTION 2: CASE STUDY ON COMMUNITY NON-MEDICAL SERVICES MODEL	61
<i>Kelowna Forum: Creating Communities of Care</i>	62
<i>Howegroup Consultations with Stakeholders</i>	64
CONCLUSION	66
<i>Benefits of implementing Continuing Care Hubs</i>	66
APPENDICES	71
<i>Appendix A: Overview of BC's home and community care system</i>	71
<i>Appendix B: Review of OLTC report on Long Term Care</i>	72
<i>Appendix C: Comprehensive Home Options of Integrated Care for the Elderly</i>	74
REFERENCES.....	75

EXECUTIVE SUMMARY

Purpose of Paper / Project

The purpose of this paper or project is to outline the idea of the Continuing Care Hub, including what BC Care Providers Association (BCCPA) has discussed in previous policy papers.

While the ideas outlined are primarily for information or discussion purposes, they by no means represent the entirety of issues that need to be addressed with the development of new Continuing Care Hubs across the province.

Along with highlighting some of the reasons for establishing new Care Hubs – such as increasing access to care and ensuring seniors are cared for in most appropriate setting – this paper will highlight different models or aspects of service delivery. These include four areas that build on the existing long-term care model: the integrated home and long-term care model; enhanced specialized services model; enhanced community health services model, and community non-medical services model.

Although this paper will discuss some of the aspects of these various models, it is not intended to discuss all the key features or how to implement new Continuing Care Hubs as this is beyond the paper's scope. However, the paper does examine the community non-medical services model – including highlighting some of the discussions from a Forum event hosted in September 2018 in Kelowna, as well as stakeholder interviews and several focus group discussions that were undertaken externally by Howegroup. The paper also outlines a hypothetical Continuing Care Hub that has been established to meet needs of a specific community (Victoria, B.C.), and is person-centred.

While obtaining government support, including funding, will assist with the development of Care Hubs, it will also be important to advance the models by looking at other means to support their development. For example, partnerships with business and community stakeholders, as well as further private pay and/or public revenues generated through various amenities or events.

This paper is intended to begin a broader discussion that will involve further work and stakeholder work on developing Continuing Care Hubs in B.C., and may lead to the creation of a blueprint for the creation of Care Hubs throughout the province.

BCCPA Continuing Care Hub Research

BCCPA in various policy papers has advocated for the development of what is referred to as the Continuing Care Hub. These “hubs” may provide an expanded level of services (i.e. sub-acute, respite, IV, wound care, health promotion, etc.) to seniors living in long-term care or assisted living, as well as those living at home, whether they be receiving formal home health services, or not.

This paper will explore further the development of a Continuing Care Hub model, including what it would consist of and how it could be potentially operationalized in the B.C. context. As outlined by BCCPA in the

2015 paper *Quality-Innovation-Collaboration*, the four key elements of the new continuing care hubs include:

- 1) *Integration of health professionals and family in seniors care;*
- 2) *New roles for care providers;*
- 3) *New funding models;* and
- 4) *Expanded role and co-location of services.*

Essentially, the Continuing Care Hub is a network of individual care homes sharing services, specializing in care or providing services potentially over a geographical area, but are formally networked. In the Hub setting, the long-term 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. While care providers would be encouraged to join Continuing Care Hubs, that decision would be voluntary.

Although not exhaustive, the 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 as well as existing continuing programs and services by centralizing care and expertise.

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 virtual network of care homes. These care homes would have decided to work collaboratively to provide care amongst themselves as part of a cluster or network arrangement. For example, two or more care homes could potentially join 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. Likewise, it will particularly important that any new additional services that are provided including sub-acute care be funded appropriately and commensurate with any additional work.

Different Care Hub Models (including community non-medical services model)

While the first part of this paper will discuss the rationale behind establishing new Continuing Care Hubs particularly focusing on several areas (i.e. improving access, reducing pressures in the health system, enhancing seniors' quality of life, and integrating seniors care with the community), the second part of this paper will look at the different possible models of the Care Hubs, including:

1. **Today's long-term care model in B.C.;**
2. **An Integrated Home and Long-Term Care Model** (where care homes or hubs provide home health care services, including home support to seniors in the community);
3. **An Enhanced Specialized Services Model** (where care homes or hubs with commensurate or appropriate funding provide enhanced specialized medical services to seniors in long-term care and the community, such as sub-acute care);
4. **An Enhanced Community Health Services Model** (where care homes provide community health services to seniors in the community such as primary care, health promotion, mental health, screening);

5. **A Community Non-Medical Services Model** (where care homes or hubs provide non-medical services to seniors in the community such as adult day programs).

Part II of the paper also looks at some of the operational features to make these models a reality in B.C.'s continuing care sector including: funding, health human resources (HHR) / staffing, information systems, regulation / legislative changes, municipal and rural considerations, and physical infrastructure, etc.). In particular, the **community non-medical services model** is explored in greater detail. BCCPA in September 2018, for example, hosted an event entitled *Creating Communities of Care* in Kelowna¹ to discuss the Continuing Care Hub model.

The Kelowna forum which largely focused on the **community non-medical services model** brought together a diverse group of 35 stakeholders representing local government, non-profit and social housing, public transportation, health care, First Nations, finance, planning and engineering, utility companies, and seniors care providers. In particular, it was a timely dialogue focusing on how communities can better integrate seniors care among complementary services and amenities — the aim being to establish “care hubs” that improve quality of life for people in care, support care workers by providing housing options and child care, and reduce the health impacts of social isolation by building stronger networks and mobility among families.² One of the key themes from the forum was fostering the integration of long-term care homes with the broader community and vice-versa. This is also one of the key reasons for the Continuing Care Hubs as discussed later on in this paper.

Following the Kelowna event, BCCPA enlisted consultants the Howegroup to engage further with various stakeholders as part of interviews and focus groups to look further at the community non-medical services model. This and the Kelowna Forum event are discussed in further detail in Part II of this paper.

¹ BCCPA. Wrap Up Report: Communities of Care Kelowna Forum. September 19, 2018. Accessed at: <https://bccare.ca/2018/09/wrap-up-report-communities-of-care-kelowna-forum/>

² BCCPA. Wrap Up Report: Communities of Care Kelowna Forum. September 19, 2018. Accessed at: <https://bccare.ca/2018/09/wrap-up-report-communities-of-care-kelowna-forum/>

INTRODUCTION

Continuing Care Sector Profile

B.C.'s Home and Community Care budget is close to \$3 billion, which if it stood alone would make it the provincial government's fifth largest Ministry. Over one-third of all care delivered to seniors in British Columbia is provided by the private sector – which includes both for-profit and non-profit operators. The majority of B.C.'s non-government (private) care providers are funded directly by the regional health authorities to deliver seniors care services.

Seniors care is seeing the fastest growth in the province's economy. In B.C. alone, the seniors care sector is anticipated to create over 36,000 jobs over the next ten years,³ and will remain the fastest growing employment sector here until 2025.⁴

Background

In 2015/16, there were approximately 40,000 (40,181) clients receiving publicly subsidized long-term care services; 6,062 clients receiving publicly subsidized assisted living services; and 42,170 clients receiving publicly subsidized home support services (including clients receiving services through the Choice Supports for Independent Living program).⁵ In 2015/16, health authorities reported spending over \$2.9 billion on home and community care (see Appendix A for an overview or summary of BC's home and community care system).

BCCPA in various policy papers has advocated for the development of what is referred to as the Continuing Care Hub which could potentially provide an expanded level of services (i.e. sub-acute, respite, IV, wound care, health promotion, etc.) to seniors living in long-term care and those in the broader community.

This paper will explore further the development of a Continuing Care Hub model, including what it would consist of and how it could be potentially operationalized in the B.C. context. When this model was first proposed by BCCPA in a paper titled *Quality-Innovation-Collaboration* (2015), the **four key elements** of the new continuing care hubs included:

- 1) **Integration of health professionals and family in seniors care** (integrating nurse practitioners, family physicians and physician assistants into long-term care (LTC), use of health and emergency professionals, specialized training);
- 2) **New roles for care providers** (new Health Care Aide roles, multidisciplinary LTC team, education and training, integration of physicians and other allied health professionals);
- 3) **New funding models** (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

³ WorkBC, 2017. Labour Market Outlook, 2017 Edition.

⁴ WorkBC, 2015. British Columbia 2025 Labour Market Outlook.

⁵ BC Government. Open Information FOI Request. Copies of the transition briefing material prepared for the new Minister who was sworn in on July 18, 2017. Date Range for Record Search: From 07/01/2017 To 07/19/2017. Ministry of Health. Accessed at: http://docs.openinfo.gov.bc.ca/Response_Package_HTH-2017-72410.pdf

- 4) **Expanded role and co-location of services** (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, pharmacy and medication management, mental health, diagnostic and laboratory services, rehab and recovery care).

Essentially, the Continuing Care Hub is a network of individual care homes sharing services, specializing in care or providing services potentially over a geographical area, but are formally networked. In the Hub setting, the long-term 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. While care providers would be encouraged to join Continuing Care Hubs, the decision to do so would be voluntary.



Although not exhaustive, the 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 as well as existing continuing programs and services by centralizing care and expertise.

One of the key features of such a 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. One size will not fit all communities.

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 virtual network of care homes. These care homes would have decided to work collaboratively to provide care amongst themselves as part of a cluster or network arrangement. Two or more care homes could potentially join within a formal affiliated network, for example, 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 fiscal and other 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.

Finally, as outlined later in this paper, many of these Care Hubs could provide services to seniors in the community such as home health care (including home support), adult day programs or even primary care. Such services could also be provided to seniors in the community by private home health care companies who are affiliated with the Care Hub network.

Different types of Continuing Care Hubs (including community non-medical services model)

While Part I of this paper will discuss the rationale behind establishing new Continuing Care Hubs – particularly focusing on several areas (i.e. improving access, reducing pressures in the health system, enhancing seniors quality of life and better integrating seniors care to the community) as outlined in earlier BCCPA documents – Part II of this document will look more at how to operationalize this model in the context of B.C.'s continuing care sector. It focuses on five models including:

1. **Today's long-term care model in B.C.;**
2. **An Integrated Home and Long-Term Care Model** (where care homes or hubs provide home health care services, including home support to seniors in the community);
3. **An Enhanced Specialized Services Model** (where care homes or hubs with commensurate or appropriate funding provide enhanced specialized medical services to seniors in long-term care and the community, such as sub-acute care);
4. **An Enhanced Community Health Services Model** (where care homes provide community health services to seniors in the community such as primary care, health promotion, mental health, screening);
5. **A Community Non-Medical Services Model** (where care homes or hubs provide non-medical services to seniors in the community such as adult day programs).

Part II of the paper also looks at some of the operational features to make these models a reality in B.C.'s continuing care sector, including: funding, health human resources (HHR) staffing, information systems, regulation / legislative changes, municipal and rural considerations, and physical infrastructure, etc.). In particular from the operational perspective, the **community non-medical services model** is explored in greater detail throughout this paper and in the Howegroup report (see below).

Kelowna Forum and Howegroup Consultations

In September 2018, BCCPA hosted an event entitled *Creating Communities of Care* in Kelowna to discuss the Continuing Care Hub model.⁶ This forum, which largely focused on the **community non-medical services model**, brought together a diverse group of 35 stakeholders representing local government, non-profit and social housing, public transportation, health care, First Nations, finance, planning and engineering, utility companies, and seniors care providers. In particular, it was a timely dialogue focusing on how communities can better integrate seniors care among complementary services and amenities — the aim being to establish “care hubs” that improve quality of life for people in care, support care workers by providing housing options and childcare, and reduce the health impacts of social isolation by building stronger networks and mobility among families.⁷

One of the key themes from the forum was fostering the integration of long-term care homes with the broader community and vice-versa. This is also one of the key reasons for the Continuing Care Hubs as discussed later on in this paper. Following the Kelowna event, BCCPA, through the Howegroup, has also engaged further with various stakeholders as part of interviews and focus groups to look further at the

⁶ BCCPA. Wrap Up Report: Communities of Care Kelowna Forum. September 19, 2018. Accessed at: <https://bccare.ca/2018/09/wrap-up-report-communities-of-care-kelowna-forum/>

⁷ BCCPA. Wrap Up Report: Communities of Care Kelowna Forum. September 19, 2018. Accessed at: <https://bccare.ca/2018/09/wrap-up-report-communities-of-care-kelowna-forum/>

community non-medical services model. This and the Kelowna Forum event are discussed in further detail in part II of this paper.

Care Hub Key Tenets

The following table below attempts to depict the key tenets of a Continuing Care Hub. As mentioned, it is important to note that **one size does not fit all and the type of Care Hub will ultimately depend on the needs of the community**. Likewise, the models below are not distinct or stand-alone models as a Care Hub could provide services or supports under each of the models.

Continuing Care Hub: Key Tenets				
Current Model Current long-term care model (i.e. existing long-term care model in BC)	Enhanced Models			
	Integrated Home and Long-Term Care Model (i.e. care homes or hubs provide home health care services, including home support to seniors in the community)	Enhanced Specialized Services Model (i.e. care homes or hubs with commensurate or appropriate funding provide enhanced specialized medical services to seniors in long-term care and the community, such as sub-acute care, etc.)	Enhanced Community Health Services Model (i.e. care homes or hubs provide community health services to seniors in the community such as primary health care, health promotion, screening, etc.)	Community non-medical services model (i.e. care homes or hubs provide non-medical services to seniors in the community such as adult day or night programs, etc.)
Operational Considerations				
<ul style="list-style-type: none"> Funding: How the new models or networks will be funded both at macro and micro-level including annual funding lift formulas. Definition or criteria: Determining criteria for what defines a Continuing Care Hub in BC for operational or program purposes. Services: Establishing list of services (medical / non-medical) that could be provided under each model. HHR / Staffing: Developing appropriate staffing and HHR plans. Equipment considerations 		<ul style="list-style-type: none"> Legislative or other changes: Revising regulations, legislation or other changes. Information / IT systems: Development of appropriate information / IT systems. Municipal and Rural considerations (i.e. property zoning bylaws & property taxes). Physical infrastructure (i.e. infrastructure investments, etc.). 		
Benefits				
<ul style="list-style-type: none"> Increase access to care and ensure seniors are cared in most appropriate setting; Reduce health system pressures (i.e. reducing unnecessary hospitalizations, ER visits, ALC days, etc.); Improve seniors quality of care and quality of life for seniors, including those with dementia; and Better integrating seniors care with the community. 				

Hypothetical Care Hub Model

A hypothetical care hub model placed in the Victoria, BC region is outlined later in this paper. In this example, five care homes have established a Care Hub which provides a wide array of services and supports to seniors living in long-term care and in the community. The paper includes a scenario where a fictional senior named Betty, who lives at home, receives numerous services and programs through the Victoria Continuing Care Hub Group.



PART I: OVERVIEW OF CONTINUING CARE HUBS

BACKGROUND

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.⁸

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. In particular, it identifies a number of new continuing care models such as the post-acute care model, specialized stream model, integrated care model, and the Hub Model. These models are outlined further in appendix B of this paper while below we focus one of them in particular - the Care Hub.

Continuing Care Hubs

BCCPA believes the six models outlined in the Ontario paper – including the post-acute, specialized stream, and integrated models of care – should be explored further in the context of British Columbia. In particular, BCCPA supports the development of a hub model where the continuing care home could be a centre for the delivery of a wide range of seniors' services; some co-located and others managed by the care home. While care providers would be encouraged to join Continuing Care Hubs, that decision to do so would be voluntary.

Although not exhaustive, services that could be delivered by a Continuing Care Hub could include primary care, chronic disease management, rehabilitation, sub-acute, dialysis, oral care, foot care, adult day / night programs, meals on wheels, as well as caregiver support such as home monitoring and satellite specialized geriatric services collaboratively delivered with hospital and community partners. This model takes advantage of investments in physical infrastructure and existing long-term care programs and services by centralizing care and expertise.

Although each Continuing Care Hub would be developed in alignment with the needs of the community, the four fundamental principles underlying Care Hubs are outlined in the table below.

Table 1: Four Key Features of new Continuing Care Hubs

Integration of health professionals and family in seniors care

- Physically and virtually integrating 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 long-term care nurses with advanced or specialized training, particularly in areas such as behavior as well as pain and symptom management.

⁸ 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

- 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 elsewhere.
- Creation of a multidisciplinary long-term care 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 including in areas such as gerontology education, occupational health and safety training.
- Strengthen health human resource (HHR) recruitment including developing 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 or outcome-based funding that considers optimal staffing mix for different groups of residents, along with care outcomes.
- Develop a funding 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 long-term care physician and nurse practitioner reimbursement models which provide incentives for mentoring staff and students as well as 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) including expanded provision of Adult Day or related programs.
- Physical co-location of urgent care centres or sub-acute care centres 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.
- Health care worker housing and/or supportive living arrangements.

Source: BCCPA. Strengthening Seniors Care: A Made-in-BC Roadmap. January 2017. Accessed at: http://bccare.ca/wp-content/uploads/2017/01/BCCPA_Roadmap_Full_Jan2017.pdf



Current 24/7 Long-Term 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 long term 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

- Expanded adult day programs
- 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 as well as palliative / hospice 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)

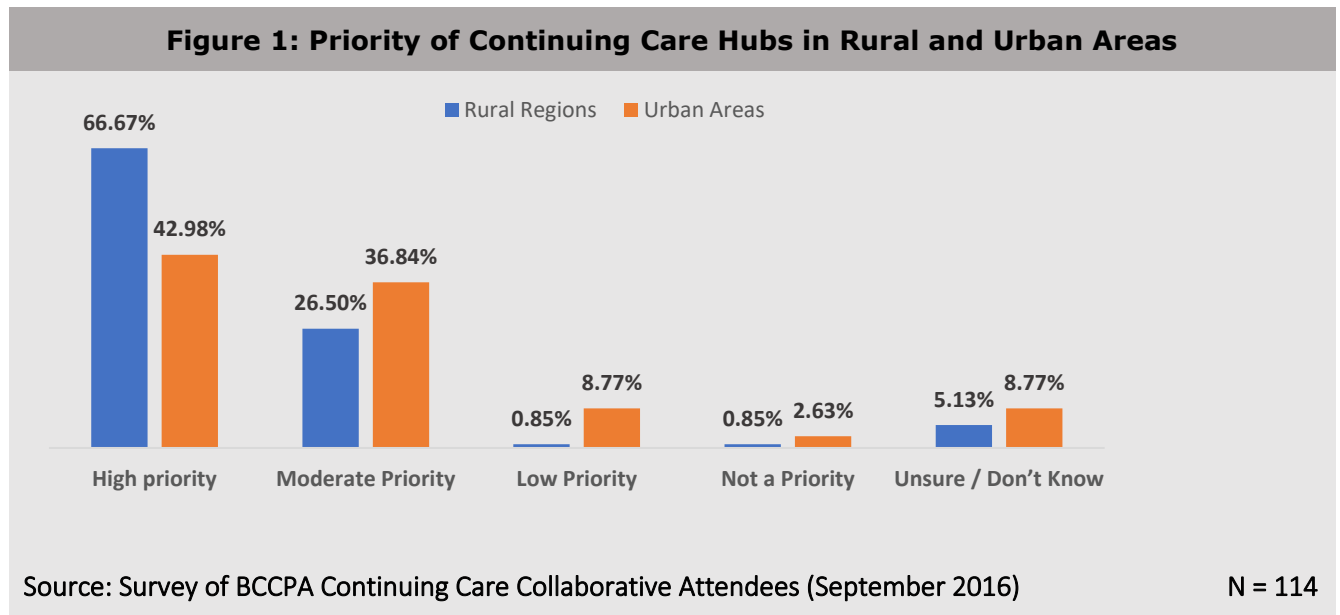
Overall, as noted above in the earlier table and figure, one of the key features of such a Continuing Care Hub model is the provision of procedures or services that may be commonly performed in alternative care settings (such as a hospital or in primary care setting), including dialysis, rehabilitation, frailty screening, seniors health promotion, and other potentially non-complicated surgical treatments. The types of services would be based on needs of the community – one size would not fit all communities.

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

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

Support for Continuing Care Hub Models

As outlined in a survey conducted at the September 20, 2016 BCCPA/Ministry of Health Continuing Care Collaborative event, there was considerable support for Continuing Care Hubs. Close to 80% identified them as a moderate or high priority in urban areas, while the numbers were even higher for rural areas (over 90%).



Rural Considerations

The Continuing Care Hub model would function well in urban centres given their larger and centralized senior populations. There is the potential, however, 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 2015 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' 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.⁹

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.

The Care Hub concept also has significant potential in rural areas to act in particular as a community hub or meeting point. An example of this is seen in Niverville, Manitoba which is discussed later in this paper.

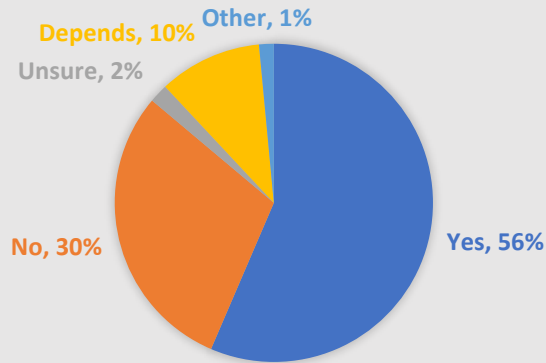
Additional Onsite Services

In an earlier BCCPA survey, respondents were asked to indicate their support or opposition for long-term care homes offering additional onsite services in the community, such as sub-acute care services or community care services (e.g. day care). This policy option received good support, with 56% of survey respondents indicating support, and an additional 10% indicating depends.¹⁰ Thirty percent of survey respondents indicated that they did not support this option.

⁹ 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>

¹⁰ Of those survey respondents that indicated depends, common themes were that it would depend on the type of services being provided (i.e. many support sub-acute care services but not childcare); appropriate funding and staffing levels; the availability of these services in the community; an whether those accessing services would pay a small fee.

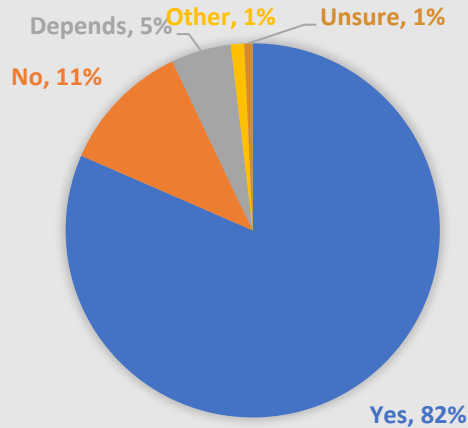
Figure 2: Do you think long-term care homes should be offering additional onsite services in your local community such as IV therapy, dialysis, childcare?



N=735

Survey respondents were also asked to indicate their support or opposition for long-term care homes offering additional offsite services, such as adult day programs, recreational therapy and occupational therapy programs. This policy option received overall very good support from survey respondents, with over 80% supporting, and an additional 5 per cent indicating depends.

Figure 3: Do you think Long Term Care Homes should be providing services to seniors who actually live off site in the community?



N=744

NEW HEALTH CARE TEAMS

As outlined in the OLTCA Why Not Now? paper, turning continuing care homes into hubs of innovation in aging care will also require new roles, a different skill mix and well-integrated care teams. One such example being used in Ontario are Long-Term Care Nurse-Led Outreach Teams (NLOTs), which the Ontario Ministry of Health established in 2008 in each Local Health Integration Network (LHIN) as one of several projects implemented under its Emergency Room and Alternate Level of Care (ER/ALC) Strategy. NLOTs bring together a dedicated team of nursing professionals to provide continuing care residents and their care provider's access to timely, high quality urgent care support within the comfort of their own homes.¹¹

Nurse Practitioners

New integrated care teams and long-term care models could also utilize nurse practitioners (NPs) into care homes.¹² Overall, progress in implementing NPs in B.C. has lagged behind other provinces including Ontario and Alberta. One of the major problems has been that insufficient funding has left many NPs unable to obtain employment.¹³ 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 these commitments will continue in the future.¹⁴ As of January 2014, there were only 287 NPs registered in B.C. Another survey also shows that less than 10% NPs who responded (8% or 7 in total) identified long-term care as a practice setting.¹⁵

As outlined in the literature, there is evidence that shows NPs can enhance quality of care in long-term care including improving family satisfaction and staff confidence. They also reduce transfers to the emergency department, hospital admissions as well as length of stay and workload for continuing care physicians. Physician competence and engagement are also associated with lower hospitalization rates, higher functional status as well as resident satisfaction and reduced rates of regulatory non-compliance.¹⁶ With the decrease in numbers of physicians providing long-term care, NPs represent one way to enhance the provision of medical services in such care environments.

Integration of physicians into new continuing care models

Going forward, better integrating physicians into new long-term care models, including new Care Hubs will also be critical, particularly in an attempt to reduce unnecessary hospitalizations and ER visits. In the last 10 years, while the number of community-based family physicians in B.C. has increased by about 10%, the number of family physicians delivering long-term care services dropped by about 13%. This downward trend is occurring at the same time as it is anticipated that there will be significant growth in the long-term care population in the next 20 years. To deal with this issue the B.C. government and

¹¹ 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

¹² 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.

¹³ 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/>

¹⁴ 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>

¹⁵ 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>

¹⁶ 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

Doctors of BC through the General Practice Services Committee (GPSC) is supporting physicians through its residential care initiative.¹⁷

With the GPSC's commitment of up to at least \$12 million annually, the initiative is attempting to meet the needs of long-term care clients in over 100 communities across British Columbia. The initiative also includes the establishment of new fee codes for seniors care. Starting in July 1, 2015, divisions / self-organizing groups can access a quarterly lump sum incentive, calculated at an annual \$400 per long-term care bed, to implement local solutions.¹⁸

Along with programs such as the GPSC residential care initiative, new models of continuing care should look at alternative approaches to integrating physicians. One such model was implemented in Nova Scotia's Capital District Health Authority is Care by Design (CBD), which attempted to address concerns of a previously uncoordinated care system in long-term care homes, reduction of family physician services and on-call coverage for care home residents, and high rates of ambulance transports to emergency departments (EDs). The core of CBD is dedicated family physician coverage for each long-term 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 program, providing on-site acute care and facilitating coordinated transfers to the ED; a new comprehensive geriatric assessment tool; performance measurements; and interdisciplinary education.¹⁹



Preliminary results from CBD include that the initiative has improved clinical efficiency by reducing travel time to visit residents in multiple long-term care homes and that continuity and quality of care has improved for residents. The data also shows that there was a 36 per cent reduction in transfers from care homes to ED over a six-month period.²⁰

Physician Assistants

Along with integrating physicians better into long-term care, continuing care hubs may also require looking at new health providers, particularly physician assistants. Physician Assistants (PAs) are healthcare professionals educated in the medical model to practice medicine under the direction of a physician.²¹ Recent studies have highlighted the benefits of PAs including that they help increase access to medical care for seniors. In particular, having a full-time PA on staff at a care home can translate into residents being evaluated sooner and can prevent transfers to the hospital in many cases. A study from the United

¹⁷ General Practice Services Committee (GPSC). Longitudinal Residential Care. Accessed at: <http://www.gpsc.bc.ca/what-we-do/longitudinal-care/residential-care>

¹⁸ General Practice Services Committee (GPSC). Residential Care Initiative. Accessed at: <http://www.gpsc.bc.ca/family-practice-incentive/residential-care>.

¹⁹ Nova Scotia Capital District Health Authority. Care by Design. <http://www.cdha.nshealth.ca/care-by-design>

²⁰ 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>

²¹ In a formal practice arrangement with a physician, PAs practice medicine which includes obtaining medical histories and performing physical exams, ordering and interpreting laboratory and diagnostic tests, providing therapeutic procedures, prescribing medications, and educating and counselling patients. University of Manitoba. What is a Physician Assistant? Accessed at: http://umanitoba.ca/faculties/health_sciences/medicine/education/paep/whatisapa.html

States 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.²²

Integration of long-term care / assisted living and home care

Most recently, the idea of the Continuing Care Hub model is explored in BCCPA paper on home health care, entitled *Health Begins at Home* (2018). As outlined in that and earlier BCCPA papers, the new Continuing Care Hub could be a centre for the delivery of a wide range of seniors' services some of which could be co-located within a Campus of Care or managed by a virtual network of care homes.

The Continuing Care Hubs could also offer care or other quality of life programs to seniors in the community including those receiving home health care. For example, the Continuing Care Hub (long-term care and/or assisted living) could contract with health authorities or private home health care operators to provide services directly to the senior's home or in the community. This includes, for example, various rehabilitation or restorative health therapies, which are vital to the overall health and well-being of seniors.



The Care Hub model could facilitate the provision of home health care including home support services to seniors living in the community along with providing existing long-term care services. This is discussed further as part of the integrated home and long-term care model. Likewise, the Care Hub could also function as a community non-medical services model providing seniors with services such as adult day programs, music concerts or even recreational therapy as also outlined further in part II of this paper.

While this paper generally focuses on integration of long term and home care, the same principles could also apply with assisted living. In particular, there are also opportunities to integrate assisted living operators who could contract with the health authorities to provide home health care services to seniors in the community. Likewise, along with being part of any Care Hub network, home health care operators could also continue, where appropriate, to provide home health services to those living in assisted living

²² 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

RATIONALE FOR NEW CONTINUING CARE HUBS

As outlined in the 2017 BCCPA paper *Strengthening Seniors Care*, one of the main reasons for establishing the new Care Hub model is to improve access to care and services as well as allow seniors to live in most appropriate care setting. Other rationales for establishing new Continuing Care Hubs include:

- addressing system pressures, including dealing with higher levels of acuity, reducing unnecessary hospitalizations ER visits and Alternate Level of Care (ALC) days;
- improving quality of life for B.C. seniors including those with dementia; and
- better integrating seniors care with the broader community.

Improved access & 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. In 2012, for example, it was reported that 461,000 Canadians were not getting the home care they thought they required, while wait times for access to long-term care in Canada also ranged anywhere from 27 to 230 days.²³

One of the priorities outlined by the B.C. 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 long-term care. As noted by the B.C. Seniors Advocate, most 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 long-term care.

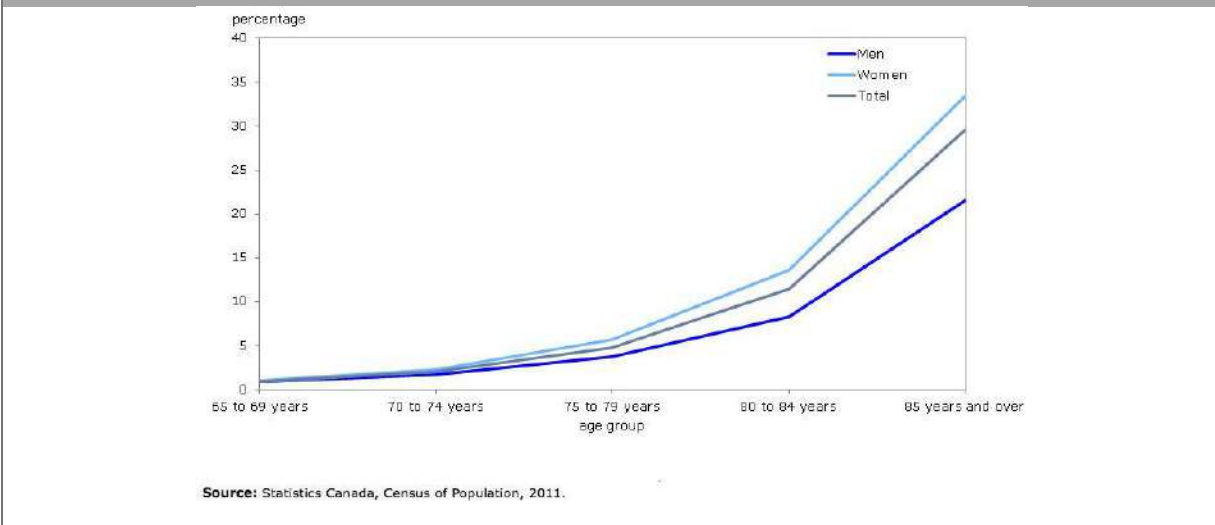
The figures with regards to long-term care, however, are higher among older age populations, including 9% of those over 75 and about 15% of those over 85.²⁴ In particular, the demand for long-term care will increase significantly in the future because the proportion of seniors living in care homes increases with age and the number of elderly seniors will grow as the aging of the population accelerates. As the figure below shows, about 1% of people between the age of 65 and 69 live in long-term care homes in Canada, while the largest age group living in care-homes is 85 and older at 29.6%.²⁵

²³ Canadian Medical Association. Doctors to leaders: Canadians want a Seniors Care Plan in election. August 2, 2015. Accessed at: <http://www.newswire.ca/news-releases/doctors-to-leaders-canadians-want-a-seniors-care-plan-in-election-520419582.html>

²⁴ 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>

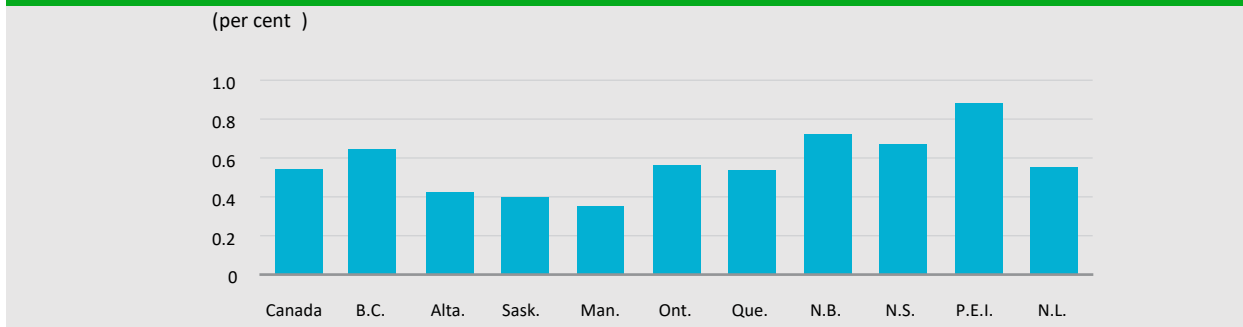
²⁵ A Policy Framework to Guide a National Seniors Strategy for Canada. CMA. August 2015. Accessed at: https://www.cma.ca/Assets/assets-library/document/en/about-us/gc2015/policy-framework-to-guide-seniors_en.pdf

Figure 4: Percentage of Canadian seniors living in Long Term Care (by Age Group)



In B.C., the Ministry of Health has outlined that the growth in demand for health care for frail elderly living in long-term care, who already utilize about 25% of health services, is projected to increase by 120% by 2036.²⁶ More recent data highlights that the number of frail elderly living annually in residential or long-term care in B.C. is expected to almost triple (from 38,000 to over 106,000) by 2042.²⁷ This will require a substantial new number of long-term care beds. For example, according to a 2017 Conference Board report, Canada requires an additional 199,000 long-term care beds by 2035 (30,900 in B.C.), nearly doubling current long-term care capacity.²⁸ B.C. also ranks above the Canadian average of new bed demand by 2035 (see figure below).

Figure 5: New Bed Demand Per Current Population (percent)



Source: Sizing Up the Challenge: Meeting the Demand for Long-Term Care in Canada. Ottawa: The Conference Board of Canada, 2017.

Using data projections provided by in 2018 by the Conference Board of Canada, B.C. is already short on

²⁶ 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>

²⁷ BCCPA. Bedlam in BC's Continuing Care Sector: Projecting Future Long Term Care Needs. May 2019. Accessed at: https://bccare.ca/wp-content/uploads/2019/05/Bedlam_in_BC_Continuing_Care_Sector.pdf

²⁸ Gibbard, Robyn. Sizing Up the Challenge: Meeting the Demand for Long-Term Care in Canada. Ottawa: The Conference Board of Canada, 2017.

the optimal number of beds. In particular, as of 2016, the Conference Board projects current bed demand in BC is approximately 33,300 which is higher than existing levels (i.e. about 30,000 if include publicly subsidized and private pay beds).²⁹ The Conference Board of Canada also projects that B.C. requires an additional 31,000 (30,900) new long-term care beds by 2035 to meet demand.

As also outlined in the report *Bedlam in BC's Continuing Care Sector* (May 2019) BCCPA believes some of this demand for new care beds can be addressed through the development or creation of new Continuing Care Hubs.³⁰ While these Care Hubs are envisioned to care primarily for the current and future seniors in long-term 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. The new Care Hubs could also offset demand for more costly long-term care beds by allowing seniors to remain at home longer as well as provide additional services (medical and non-medical) to seniors residing at home in the community to prevent hospitalizations and delay entry, if required, to long-term care.

Along with providing a wide array of care services for seniors, the new Continuing Care Hubs with appropriate funding, would also increase the ability of the health authorities to provide long-term 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 long-term care beds, sub-acute beds as well as end-of-life and respite beds. As outlined in previous policy papers, BCCPA believes some of these costs to establish new Care Hubs could be offset by reallocating health authority acute care funding to home and community care.

Determining New Types of Long-Term Care Beds

With the increase of resources and perhaps new Continuing Care Hubs, it will important also to determine specifically what types of long-term care beds are required to meet the needs of an aging population. For example, there are various types of long-term care beds including complex continuing care, transitional, respite, etc. As outlined in the November 2018 Facilities report, a breakdown of publicly subsidized beds is provided below showing that the vast majority are regular long-term care beds (26,628) followed by convalescent (464) and end of life (292). Within the different long-term care beds, however, these are different levels of resident needs including more complex care.

Residential or Long-Term Care Beds (as of November 2018)						
Short Term RC Beds				Long Term RC Beds	Temporary Beds	Total RC Beds
Convalescent	End of Life	Respite	Flex Beds			
464	292	214	32	26,628	199	27,829

²⁹ For 2018, estimated long term care bed demand based on earlier projections is approximately 36,500.

³⁰ BCCPA. *Bedlam in BC's Continuing Care Sector: Projecting Future Long Term Care Needs*. May 2019. Accessed at: https://bccare.ca/wp-content/uploads/2019/05/Bedlam_in_BC_Continuing_Care_Sector.pdf

Going forward it will be important to outline as part of any new long-term care beds strategy to get a further breakdown on what types of beds are required. Along with complex continuing care, for example, one area that has been identified as needing further support is respite care.

Respite Care

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 long-term care outside the home. Respite beds allow seniors to leave home and stay in a care home for up to 30 days in a one-year period. A typical long-term care home may allocate a small percentage of their total beds to short-term respite care and may decrease the number of short-term beds if additional beds are needed to provide long-term care.

As outlined in one report, the level of demand for long-term care based respite in British Columbia is quite high compared to most jurisdictions.³¹ In a 2015 report entitled *Caregivers in Distress: More Respite Needed*, the B.C. Office of the Seniors Advocate (OSA) notes that the number of respite beds in the province fell by 12% between 2012 and 2015. As the following table demonstrates, there has been little increase since 2015 as the number of respite beds has remained relatively constant over last five years.

Health Authority	2014	2015	2016	2017	2018
IHA	63	61	62	62	60
FHA	40	41	45	43	43
VCHA	24	25	26	27	29
VIHA	41	39	38	38	38
NHA	32	34	34	34	33
B.C.	200	200	205	204	203

Source: BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

First Appropriate Bed policy (new Access Policy)

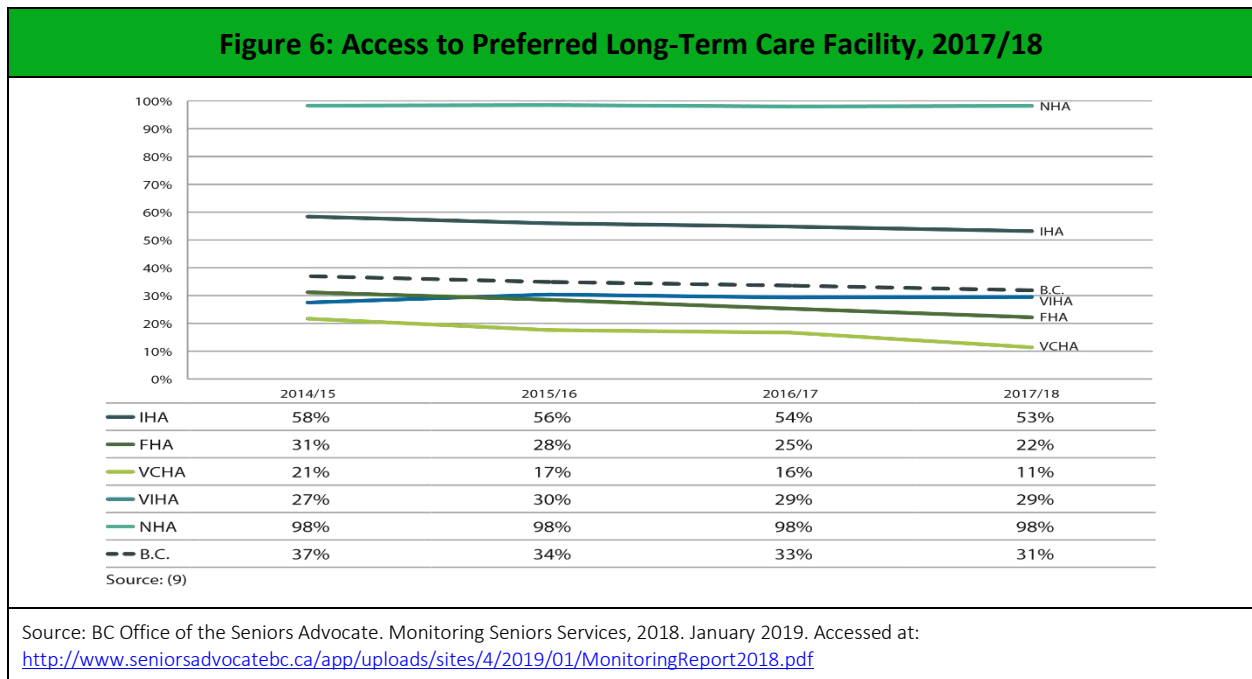
Under the previous “First Appropriate Bed” (FAB) policy adopted by all the health authorities, a senior who had been assessed as ready for a move to long-term care must have accepted the first appropriate bed that becomes available in their chosen geographic catchment area. They had 48 hours to accept and move to the bed offered, or risk being removed from the priority list for a FAB. The FAB policy was essentially designed to ensure that those who are the most in need of a long-term care home bed secure that bed as quickly as possible.³² In July of 2019, the FAB policy was replaced with a new access policy in which seniors and their families are able to review their options and choose up to three preferred care

³¹ 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

³² 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

homes. As such people no longer have to accept the first available bed and can make more informed choices about where to live.³³ The changes seems warranted as a 2015 OSA report 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 or long-term care FAB.³⁴ 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.³⁵

In its latest analysis, the OSA reports that in most health authorities clients are not receiving their preferred bed at initial admission. In B.C., only about a third of clients (32%) achieved their preferred placement at initial admission – a rate which has declined over the past four years in Interior, Fraser Health and Vancouver Coastal (see figure below).



As outlined in a July 2019 media release, BCCPA also supports these changes and the new access policy to allow increased choice.³⁶ In the 2019 Bedlam report, BCCPA supports that adopting new models, such as the Continuing Care Hub, may not only improve access to long-term care and services for seniors in the community, but could also increase choice for seniors as part of any new access policy.³⁷

³³ BC Ministry of Health. More choice, a stronger voice help seniors make long-term care decisions. July 3, 2019. Accessed at: <https://news.gov.bc.ca/releases/2019HLTH0098-001385>

³⁴ 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>

³⁵ 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.

³⁶ BCCPA. Media Release: BCCPA applauds Ministry of Health decision to amend long-term care access policy. July 2019. Accessed at: <https://bccare.ca/2019/07/media-release-bccpa-applauds-ministry-of-health-decision-to-amend-long-term-care-access-policy/>

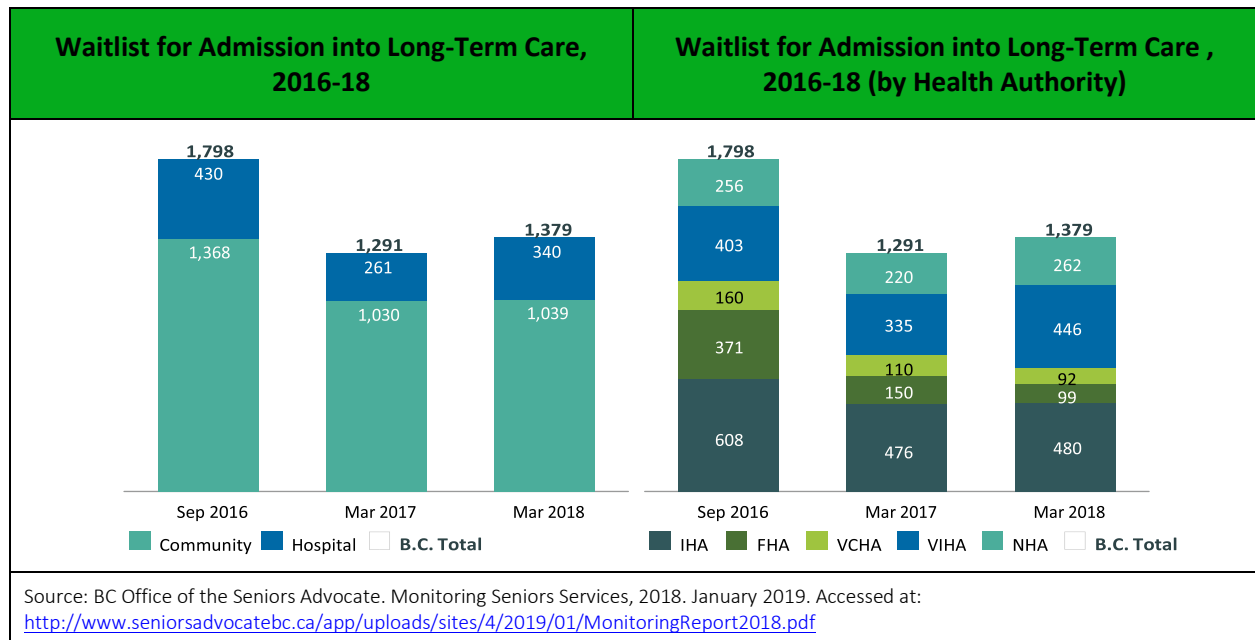
³⁷ BCCPA. Bedlam in BC's Continuing Care Sector: Projecting Future Long Term Care Needs. May 2019. Accessed at: https://bccare.ca/wp-content/uploads/2019/05/Bedlam_in_BC_Continuing_Care_Sector.pdf

Waitlists into long-term care

A December 2016 OSA report also highlighted that wait times for long-term care are getting longer. The report notes that the average and median wait times for long-term care increased in three of five regional health authorities, and the proportion of residents admitted to long-term care within the target window of 30 days decreased from 64% in 2014/15 to 57% in 2015/16.³⁸

With a rapidly aging population, the demand for long-term care in B.C. and Canada is growing. The B.C. Office of the Seniors Advocate (OSA) reported in 2016, for example, that average wait times for long-term care grew in three of five regional health authorities between January 2016 and September 2016.³⁹

The table below shows as of March 2018 there were about 1,400 (1,379) persons waiting for admission into long-term care – about a 7 percent increase from previous year. The majority or about 75 percent of those waiting for admission into long-term care (1,039 of 1,379) were those living in the community compared to rest who were waiting in hospital (i.e. alternate level of care or ALC patients).



The graph shows there are also differences in wait lists among the different health authorities. While the waitlist in Fraser Health decreased 34% (150 to 99), it increased 33% in Island Health (335 to 446).⁴⁰

Comparatively, wait lists in B.C. are not as severe as other jurisdictions. For example, OSA data as of August 2017 indicates there were only about 1,500 people waiting for long-term care bed. This compares favorably to other jurisdictions such as Ontario, which as of October 2017, had nearly 34,000 people waiting for a bed.⁴¹

³⁸ Office of the Seniors Advocate. Monitoring Seniors' Services (2016). December 2016. Accessed at: <https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2016/12/OSA-MonitoringReport2016.pdf>

³⁹ Office of the Seniors Advocate. Monitoring Seniors Services 2016. Accessed at: <https://www.seniorsadvocatebc.ca/osa-reports/report-monitoring-seniors-services-2016/>

⁴⁰ On average, clients still on the waitlist have been waiting longer than those already admitted to a facility had to wait. The average wait time for people on the waitlist on March 31, 2018 was 138 days ranging between 41 days in Fraser Health and 282 days in Northern Health. The median wait times ranged from 14 days in Vancouver Coastal to 147 days in Northern Health.

⁴¹ Ontario Ministry of Health and Long-Term Care. Long-Term Care System Reports. October 2017.

Unlike other jurisdictions such as Ontario, B.C. also seems to be doing better with respect to the length of wait for long-term care. As the table below shows, clients admitted during 2017/18 waited an average of 34 days and a median of 12 days. This compares favorably to other provinces such as Ontario which has an average wait time for placement of about 140 days.⁴²

Table 3: Wait Times for Clients on the Waitlist for Long-Term Care, on March 31, 2018				
Health Authority	Number on the Waitlist	Average Wait Time (Days)	Median Wait Time (Days)	Maximum Wait Time (Days)
IHA	480	134	55	1,196
FHA	99	41	22	632
VCHA	92	50	14	1,041
VIHA	446	99	63	648
NHA	262	282	147	2,627

Average Wait Time for Clients Admitted to Long-Term Care, 2013/14-2017/18		Median Wait Time for Clients Admitted to Long-Term Care, 2013/14-2017/18			
IHA	29	38	45	56	38
FHA	3	43	49	42	20
VCHA	25	28	25	17	14
VIHA	42	42	62	61	63
NHA	122	85	68	73	68
B.C.	36	40	46	45	34

	2013/14	2014/15	2015/16	2016/17	2017/18
IHA	29	38	45	56	38
FHA	3	43	49	42	20
VCHA	25	28	25	17	14
VIHA	42	42	62	61	63
NHA	122	85	68	73	68
B.C.	36	40	46	45	34

	2013/14	2014/15	2015/16	2016/17	2017/18
IHA	13	18	22	27	15
FHA	21	25	29	18	10
VCHA	8	8	8	6	5
VIHA	18	17	42	38	37
NHA	96	57	39	44	29
B.C.	15	18	23	17	12

Source: (20)

Source: BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

⁴² Ontario Ministry of Health and Long-Term Care. Long-Term Care System Reports. October 2017.

Table 4: Percent of Seniors Admitted to Long-Term Care within 30 Days, 2013/14-2017/18					
Health Authority	2013/14	2014/15	2015/16	2016/17	2017/18
IHA	73%	63%	58%	53%	67%
FHA	62%	57%	52%	63%	82%
VCHA	80%	80%	82%	88%	90%
VIHA	60%	62%	40%	45%	45%
NHA	27%	36%	44%	45%	50%
B.C.	67%	64%	57%	61%	71%

Source: BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

The above table shows that of the seniors who went into long-term care in 2017/18, 71% were admitted within the Ministry of Health’s target window of 30 days. This is a major improvement over 2016/17 where the proportion of new admissions within 30 days was 61%. In Vancouver Coastal, 90% of new admissions were admitted within 30 days, while Island and Northern Health had the lowest proportion of clients admitted within the target window at 45% and 50% respectively. The lower numbers for these health authorities may be in part due to a lack of available care beds particularly in more rural and remote locations.⁴³

⁴³ BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

IMPROVING ACCESS TO HOME HEALTH CARE AND ASSISTED LIVING

In the early 2000s, it became apparent that the demand for long-term care needed careful management due to a combination of factors, including rising costs, significant growth in the number of seniors and recognition that seniors value their independence highly, preferring to remain in the community for as long as possible. In response, many jurisdictions like B.C. began introducing new types of care in an effort to redirect people with less complex needs away from long-term care.⁴⁴ These services (such as assisted living and supportive housing) allow individuals to enjoy the benefits of living more independently in the community but typically cost less to provide than long-term care, in part because they do not provide costlier 24-hour nursing support.⁴⁵

Access to home health care

Accessing home health care in B.C. also poses barriers to care for seniors here. Between 2000/01 and 2015/16, the rate of home care client visits in B.C. declined by 15 per cent, in all but one health authority.⁴⁶ B.C. Ministry of Health data also shows that between 2000/01 and 2015/16, access to home support, measured by number of home support clients per 1,000 seniors aged 75 and older, fell by 30 per cent.⁴⁷ Along with a decline in access, the scope of home support services being provided has also diminished. For example, housekeeping and related tasks are now excluded.

Access issues to home health care are highlighted in an August 2017 report by the B.C. Office of the Seniors Advocate (OSA). The OSA, for example, notes that despite the increase in complexity of home support clients, the number of home support hours for clients 65 or older increased by 2 per cent, while the average hours per day per client decreased by 5, signaling less intensive service. Access limitations appeared to extend beyond the home support realm, into other areas of the community care sector. In fact, the number of home support clients accessing adult day programs (ADP) also decreased by 5 per cent and the number of days delivered to these clients declined by 2 per cent.⁴⁸

In the latest OSA Monitoring Services report we see that in 2017/18 there of the 43,831 clients receiving publicly subsidized home support services; approximately 88% were 65 or older and 73% were 75 or older. The number of home support clients, however, declined in Fraser, Island, and Northern health authorities in 2017/18 and remained essentially the same in Interior and Vancouver Coastal while the seniors population grew across the province (3.5% for 65 or older and 2.4% for 80 or older).⁴⁹

⁴⁴ Canadian Centre for Elder Law. *Discussion Paper on Assisted Living: Past, Present and Future Legal Trends in Canada*. 2008. (FN – 23)

⁴⁵ Canadian Institute for Health Information. *Seniors in Transition: Exploring Pathways Across the Care Continuum*. Ottawa, ON: CIHI; 2017. Accessed at: <https://www.cihi.ca/sites/default/files/document/seniors-in-transition-report-2017-en.pdf>

⁴⁶ Whereas access decreased in Northern Health (–59 per cent), Vancouver Coastal Health (–25 per cent), Fraser Health (–23 per cent) and Interior Health (–1 per cent), the client visit access rate increased by 9 per cent in Vancouver Island Health.

⁴⁷ Home support access declined in all health authorities: Northern Health (–54 per cent), Vancouver Coastal Health (–49 per cent), Interior Health (–25 per cent), Vancouver Island Health (–19 per cent) and Fraser Health (–16 per cent).

⁴⁸ Office of the Seniors Advocate. *Caregivers in Distress: A Growing Problem*. August 2017. Accessed at: <https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2017/08/Caregivers-in-Distress-A-Growing-Problem-Final.pdf>

⁴⁹ BC Office of the Seniors Advocate. *Monitoring Seniors Services*, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

Table 5: Number of Clients Receiving Home Support, 2013/14-2017/18						
Health Authority	2013/14	2014/15	2015/16	2016/17	2017/18	% Change in Last Year
IHA	8,361	8,797	9,291	9,460	9,471	0.1%
FHA	12,225	12,934	13,691	14,408	14,166	-1.7%
VCHA	9,318	8,937	8,674	9,457	9,449	-0.1%
VIHA¹	9,470	9,492	9,335	9,553	9,286	-2.8%
NHA	1,545	1,598	1,696	1,744	1,670	-4.2%
B.C.¹	40,624	41,603	42,465	44,442	43,831	-1.4%

Source: BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

In 2017/18, 93,651 clients received professional home care services in B.C., 72% of whom were 65 or older, and 52% were 75 or older. While the number of professional services clients increased 1.5% this was largely due to an increase of 10.2% in Interior Health. There were decreases in Fraser Health (3.5%), Island Health (3.3%) and Northern Health (9.3%). Likewise, the number of visits increased 9.6% in Interior Health but decreased in all other health authorities so that the overall change was very small (-0.1%).

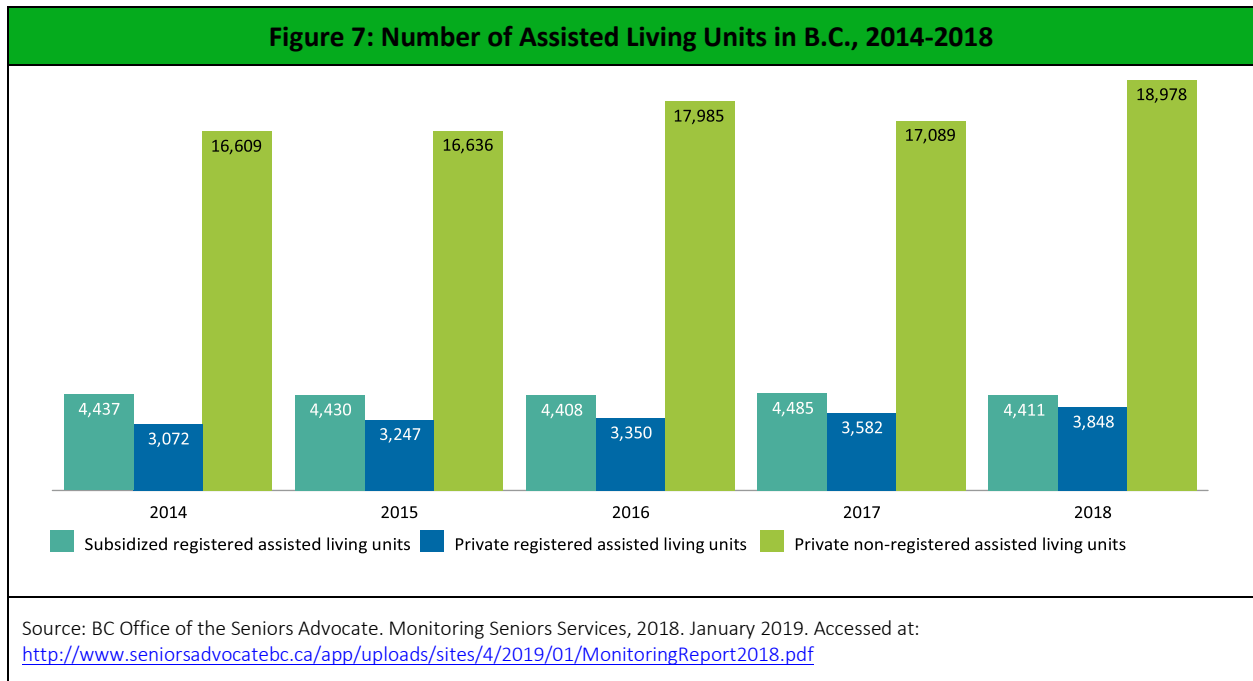
Table 6: Home Care Clients, 2013/14-2017/18						
Health Authority	2013/14	2014/15	2015/16	2016/17	2017/18	% Change in Last Year
IHA	22,204	24,431	26,063	27,591	30,407	10.2%
FHA	20,652	20,786	21,246	22,616	21,819	-3.5%
VCHA	18,358	19,066	19,114	19,809	20,137	1.7%
VIHA	17,946	17,811	17,823	19,067	18,444	-3.3%
NHA	3,882	3,673	3,508	3,653	3,315	-9.3%
B.C.	82,650	85,333	87,315	92,262	93,651	1.5%

Source: BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

Access to Assisted Living

Like home health care, the assisted living sector in B.C. is in high demand. As of March 31, 2017, 750 individuals were on the waitlist for a subsidized registered assisted living unit in B.C.⁵⁰ Province-wide, 141 registered assisted living buildings contain subsidized assisted living units.

As of March 31, 2018, there were 4,411 subsidized registered assisted living units – a 2% decrease over last year, and 3,848 private registered assisted living units – a 7% increase over 2017.⁵¹ A breakdown is seen in the following figure below.

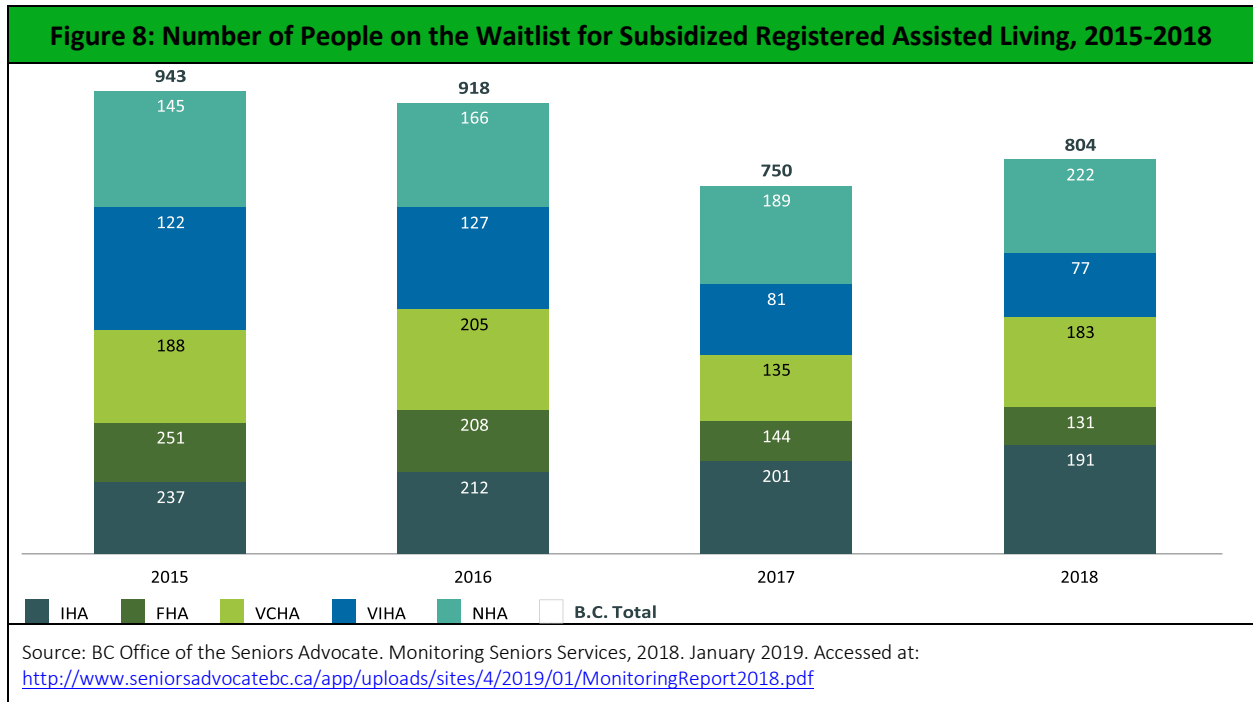


Despite relatively small numbers compared to long-term care (one sixth that of number of LTC beds), the number on such wait lists is quite high relative to long-term care. For example, while about 1,400 persons were waiting for long-term care in March of 2018, there were 804 individuals waiting for subsidized registered assisted living units.⁵²

⁵⁰ BC Office of the Seniors Advocate. Monitoring Seniors Services, 2017. December 2017. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2017/12/MonitoringReport2017.pdf>

⁵¹ BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>

⁵² BC Office of the Seniors Advocate. Monitoring Seniors Services, 2018. January 2019. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2019/01/MonitoringReport2018.pdf>



Waits in Assisted Living

BCCPA attempted to obtain specific wait time data for AL from the B.C. Ministry of Health. In response, however, the Ministry stated that because clients have the ability to choose an assisted living home and may be willing to wait longer for their preferred location, they do not calculate wait times.

With changes to Assisted Living with Bill 16 (2016) coming into effect in December 2019, unless capacity is significantly expanded it is anticipated that the number of people on wait lists and perhaps wait times may increase substantially. Currently, registered assisted living regulated under the *Community Care and Assisted Living Act (CCALA)* allows operators to provide residents up to two out of six prescribed services; typically, assistance with activities of daily living (e.g. dressing) and the administration of medication. Private non-registered assisted living residences, however, are not limited to two of the six prescribed services. Legislative changes to the CCALA have been approved that will eliminate the restriction to two prescribed services with regulations in effect as of December 2019.⁵³

Similar to long-term care there is limited choice also in assisted living. In Fraser Health, Interior Health, and Vancouver Coastal Health, for example, individuals may only be placed on one assisted living residence waitlist; however, they may choose which residence to apply. In Island Health and Northern Health, individuals may place themselves on waitlists for multiple assisted living residences. While there is

⁵³ As outlined in the following news release the new assisted living regulations will come into effect December 1, 2019 (BC Ministry of Health. More choices, stronger protection for people in assisted living. August 21, 2019. Accessed at: <https://news.gov.bc.ca/releases/2019HLTH0097-001627>). For link to new AL regulations see: http://www.bclaws.ca/civix/document/id/oic/oic_cur/0466_2019

availability in some Island Health residences, seniors may choose to wait for a unit to become available in their preferred residence.⁵⁴

BCCPA, in a separate policy paper released in January 2019, addressed many of the key issues related to Bill 16 and the future of assisted living including improving access and quality of care.⁵⁵ BCCPA believes that adopting new models, such as the Continuing Care Hub will not only improve access to assisted living, long-term care and services for seniors in the community (including home health care), but will also increase choice for seniors. In May of 2019, BCCPA also released a separate policy paper entitled *Bedlam in BC's Continuing Care Sector*, which discusses many of these access issues in long-term care including increasing number of beds but also offsetting or mitigating demand through various approaches, including assisted living, home care and new care models (i.e. Care Hubs).⁵⁶

1. Addressing Health System Pressures

Dealing with Higher Levels of Acuity

Along with improving access, another reason for exploring new models including the Continuing Care Hub is to deal with the increasing levels of acuity (including levels of chronic disease) within the continuing care sector. Like B.C., and as outlined in a 2015 report, new entrants into long-term care in Ontario have much higher levels of impairment. In Ontario, for example, in the 4th quarter of 2009/10, 76% of new admissions had high to very high levels of impairment (35% high and 41% very high). At the end of 2013/14, this figure for new admissions increased to 83%, with most of the growth in the very high category representing 47% of new admissions and growing at 3.9% per year.⁵⁷

In B.C., the growth in demand for health care for frail elderly living in long-term care, who already utilize about 25% of health services, is projected to increase by 120% by 2036.⁵⁸ More recent data shows the number of frail living annually in residential or long-term care in BC is expected to almost triple (from 38,000 to over 106,000) by 2042.⁵⁹ Acuity levels in B.C.'s care homes are also high and increasing. Using data from the Canadian Institute for Health Information (CIHI) the BC OSA that 30% of residents in long-term care are completely dependent in their activities of daily living (ADL 5+). Furthermore, 63% of residents have dementia, with 30% having severe cognitive impairment (CPS 4+). The average CMI in B.C. is 0.575, which ranges from a low of 0.40 to a high of 0.90.⁶⁰

⁵⁴ BC Office of the Seniors Advocate. Monitoring Seniors Services, 2017. December 2017. Accessed at: <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2017/12/MonitoringReport2017.pdf>

⁵⁵ BCCPA. A Report on Bill 16 (2016) and the Future of Assisted Living. January 2019. Accessed at: <https://bccare.ca/wp-content/uploads/2019/01/BCCPA-Report-Bill-16-AL-2019.pdf>

⁵⁶ BCCPA. *Bedlam in BC's Continuing Care Sector: Projecting Future Long Term Care Needs*. May 2019. Accessed at: https://bccare.ca/wp-content/uploads/2019/05/Bedlam_in_BC_Continuing_Care_Sector.pdf

⁵⁷ 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.

⁵⁸ *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>

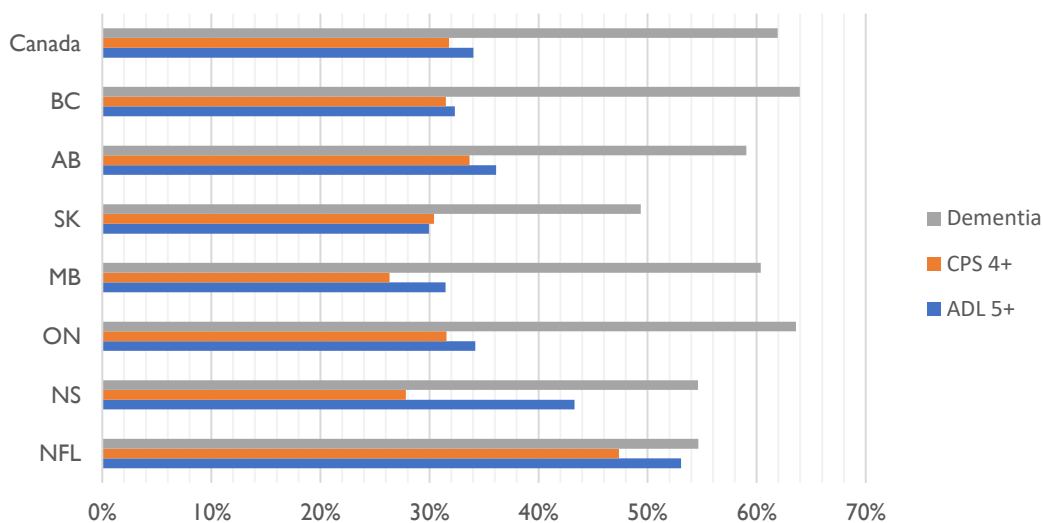
⁵⁹ BCCPA. *Bedlam in BC's Continuing Care Sector: Projecting Future Long Term Care Needs*. May 2019. Accessed at: https://bccare.ca/wp-content/uploads/2019/05/Bedlam_in_BC_Continuing_Care_Sector.pdf

⁶⁰ The CMI calculation uses the old methodology by CIHI. The methodology of calculating CMI has since been changed so new numbers are likely much higher.

Table 7 – Acuity Levels in B.C. Long Term Care Homes			
	B.C.	HA	Affiliate
Average Case Mix Index (CMI)	0.575	0.596	0.565
% of residents dependent in activities of daily living (ADL 5+)	30%	34%	28%
% of residents with severe cognitive impairment (CPS 4+)	30%	31%	29%
% of residents with dementia	63%	59%	65%

Source: Office of the Seniors Advocate, Residential Care Quick Facts Directory, Summary, 2018.

Figure 9 – Acuity Levels of Long Term Care Residents by Province, 2016-17



Source: CIHI, CCRS 2016-17

High acuity levels are an issue that is facing many provinces – according to data from CIHI, the acuity level of residents in care homes across Canada are fairly consistent. In particular, the figure above highlights that B.C. has the highest proportions of residents with dementia (64% versus Canadian average of 62%). Similarly, B.C. is very similar to the Canadian average in terms of portions of residents that have severe cognitive impairment (CPS 4+) and are completely dependent in their activities of daily living (ADL 5+).

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.⁶¹ Mental health challenges will also become more prevalent, as it is estimated the number of B.C. residents with dementia is expected rise from 70,000 to 110,000 by 2025.⁶²

Alternate Level of Care (ALC) Beds

Along with increasing levels of acuity, another major reason to explore the development of new care models, particularly the Continuing Care Hub, is to reduce the pressures faced in the costlier acute and emergency care system, including reducing alternate level of care (ALC) beds. ALC beds are those occupied by patients who no longer require acute care but continue to occupy a hospital bed as they are unable to access home and community care services. In B.C., the cost of treating a senior in hospital ranges from \$825 to \$1,968 per day, whereas the cost of long-term care is approximately \$200 per day.⁶³

Currently, approximately 14% of Canadian hospital beds are filled with patients (85% of which are over 65) who are ready to be discharged but for whom there is no appropriate place to go. Over a single year, these patients' use of acute hospital beds exceeds 2.4 million days, which equates to over 7,500 acute care beds each day.⁶⁴ A conservative national estimate of resulting costs to provincial governments from ALC days is approximately \$3 billion per year.⁶⁵

As outlined in the 2015 BCCPA *Quality-Innovation-Collaboration* (QIC) paper, there were over 400,000 reported ALC days in B.C. in 2014/15, accounting for 13% of total hospital days across the five regional health authorities.

There were also significant variations across the Health Authorities from a low of 8% in Vancouver Coastal to 18.1% in Northern Health.⁶⁶ B.C.'s health authorities also report that about one-half of ALC patients are awaiting discharge into long-term care, while others are waiting for home care, assisted living, rehabilitation or are residing in acute care due to an inefficient transfer processes.⁶⁷



⁶¹ 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

⁶² Workforce Analysis, Health Sector Workforce Division, Ministry of Health, Dementia (age 45+ years) March 24, 2014, project 2014_010 PHC

⁶³ 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>

⁶⁴ 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

⁶⁵ CD Howe Institute. Commentary No. 443. Shifting Towards Autonomy: A Continuing Care Model for Canada. Ake Blomqvist and Colin Busby. As noted in one report from the Canadian Life Health Insurance Association (CLHIA), 7,550 acute care beds are taken up by individuals who should be in home and community care or in rehabilitation. This represents about 7% of all hospital beds in Canada. The report also notes that if systemic reform were able to transition all those in a hospital setting to a more appropriate continuing care setting, the savings to the system would be about \$77 billion over the time period examined (35 years). Source: Improving the accessibility, quality and sustainability of long-term care in Canada. CLHIA Report on Long-Term Care Policy. June 2012)

⁶⁶ Quality-Innovation-Collaboration: Strengthening Seniors Care Delivery in BC. BC Care Providers Association. September 2015. Accessed at: <http://www.bccare.ca/wp-content/uploads/BCCPA-White-Paper-QiC-FINAL-2015.pdf>

⁶⁷ 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

As highlighted in the 2015 BCCPA QIC paper, a 50% reduction in ALC days could generate significant cost savings to the health system. For example, assuming 50% of ALC days could be reduced by caring for patients in long-term 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 that could be used to fund other needed and/or backlogged services.⁶⁸ The problem of ALC beds not only creates fiscal challenges, but quality of care and access issues as well. The Wait Time Alliance (WTA), for example, has noted that the ALC issue represents the single biggest challenge to improving wait times across the health care system.⁶⁹

There are many reasons for the high rates of ALC patients, including the lack of appropriate community supports to prevent hospitalizations, as well as to return patients to a more appropriate setting after they receive hospital care.⁷⁰ The ALC issue is also one that is closely tied to dementia – a common diagnosis among ALC patients. In particular, a dementia diagnosis often results in at least once instance of hospitalization and escalates ALC rates when persons with dementia have other chronic diseases (i.e. 90% of community-dwelling persons with dementia have two or more chronic diseases). A study in New Brunswick found that one third of the hospital beds in two hospitals were occupied by ALC patients, of whom 63% had been diagnosed with dementia. It also found their mean length of stay was 380 days, with 86% of these patients waiting for a bed in a long-term care home while their health declined.⁷¹

As outlined by the WTA, adequate attention to seniors' care – such as having the necessary health human resources, treating seniors where they live thereby preventing unnecessary emergency department visits and hospitalizations, as well as collaborative care models - are key to reducing the numbers of ALC patients.⁷² In particular, one critical area for improving the ALC situation is the better reporting of such data. The U.K.'s National Health Service, for example, reports monthly ALC rates as delayed transfers of care including outlining the causes of delay by region and facility.⁷³

While BCCPA believes the development of the Continuing Care Hub model may help address issue of ALC, we also believe as a medium-term goal the Ministry of Health should work to set as a target by the year 2024 to have no more than 5% of acute care beds occupied each day by seniors who have been assessed as capable of being transferred into a more appropriate long-term care or home care setting.⁷⁴ BCCPA believes the creation of new Care Hubs may help assist in meeting this ALC target.

Reducing Unnecessary Hospitalizations

As outlined in various studies, once residents are in long-term care there is a significant reduction in hospitalizations. A 2014 study from Alberta found that that the incidence of hospital admission was about 3 times higher among assisted (or supportive) living residents than among long-term care residents

⁶⁸ Quality-Innovation-Collaboration: Strengthening Seniors Care Delivery in BC. BC Care Providers Association. September 2015. Accessed at: <http://www.bccare.ca/wp-content/uploads/BCCPA-White-Paper-QulC-FINAL-2015.pdf>

⁶⁹ Wait Time Alliance. 2015. Eliminating Code Gridlock in Canada's Health Care System: 2015. Wait Time Alliance Report Card Accessed at: <http://www.waittimealliance.ca/wp-content/uploads/2015/12/EN-FINAL-2015-WTA-Report-Card.pdf>

⁷⁰ Wait Time Alliance. 2015. Eliminating Code Gridlock in Canada's Health Care System: 2015. Wait Time Alliance Report Card Accessed at: <http://www.waittimealliance.ca/wp-content/uploads/2015/12/EN-FINAL-2015-WTA-Report-Card.pdf>

⁷¹ McCloskey R, Jarrett P, Stewart C, Nicholson P. Alternate level of care patients in hospitals: What does dementia have to do with this? *Can Geriatr J* 2014;17(3):88–94.

⁷² Wait Time Alliance. 2015. Eliminating Code Gridlock in Canada's Health Care System: 2015. Wait Time Alliance Report Card Accessed at: <http://www.waittimealliance.ca/wp-content/uploads/2015/12/EN-FINAL-2015-WTA-Report-Card.pdf>

⁷³ NHS England. Delayed transfers of care statistics for England 2014/15. 2014/15 annual report. London: NHS England; 2015 May 29. Available: www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/2014-15-Delayed-Transfers-of-Care-Annual-Report.pdf

⁷⁴ BCCPA. Bedlam in BC's Continuing Care Sector: Projecting Future Long Term Care Needs. May 2019. Accessed at: https://bccare.ca/wp-content/uploads/2019/05/Bedlam_in_BC_Continuing_Care_Sector.pdf

(14%). In particular, nearly 40% of assisted living (AL) residents in Alberta were admitted to hospital over 1 year - a rate substantially higher than that for long-term care residents.⁷⁵

As outlined in the 2015 B.C. Ministry of Health Setting Priorities paper, one large driver of total cost occurs in the year prior to, and the year of, entry into long-term care - with high rates of hospitalization via emergency departments en route to long-term care. For example, more than seven out of every ten new entrants to long-term care have at least one inpatient hospitalization in the first year. More than 60 per cent of people entering long-term 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.⁷⁶ As outlined in the table below, the use of emergency rooms (ERs) by seniors overall is quite high with close to one quarter of ER visits (24%) being for patients over age 65. In total in B.C., there were close to 350,000 ER visits (346,820) by seniors for 2014/15.

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

Overall, according to a 2014 report from the Canadian Institute for Health Information (CIHI) seniors in long-term care homes make up less than 1% of emergency room visits in Canada, with 1 of 3 of these visits being potentially avoidable as they could have been addressed in the care home itself. Common avoidable reasons for visits to ER for seniors in care were urinary tract infections, pneumonia, and falls.⁷⁷ In B.C., residents in care homes who visited the ER twice or more only made up 1% of ER visits.⁷⁸ As outlined by CIHI, with earlier diagnosis and improved access to on-site treatment, some of these conditions could be managed at the care home and a visit to the ER avoided altogether.

Although ER visits are relatively low for seniors and decrease once a resident is admitted to long-term care, there is still a need to look at ways to reduce such visits, particularly during the first year in long-term care. Although data is limited in this regard, one of the reasons that has been outlined for a high number of visits during the initial stay in long-term care is due to care staff wanting to minimize any potential health risks for the resident. To deal with this, along with the creation of Continuing Care Hubs, various solutions need to be explored such as:

⁷⁵ 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>

⁷⁶ 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>

⁷⁷ 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>

⁷⁸ Canadian Institute for Health Information (CIHI). “Quick Stats”. Accessed at: <https://www.cihi.ca/en/quick-stats?xQSType=Interactive%2520Data&pageNumber=2&resultCount=10&filterTypeBy=2&filterTopicBy=undefined&autorefresh=1>

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



In summary, there is a critical need to reduce more expensive and unnecessary hospitalizations including ALC days. To accomplish this, it will require enhancing the role of continuing care as well as looking at new care models. Reinvesting in continuing care makes sense, as costs are substantially lower – the cost of treating a B.C. senior in hospital ranges from \$825 to \$1,968 per day (average is about \$1,200), whereas the cost of long-term care is approximately \$200 per day or less than \$50 for home care.⁷⁹

BCCPA believes that re-directing funding from acute care to continuing care could also be achieved partially through a reduction of alternate level of care (ALC) beds. BCCPA also advocates as outlined in earlier papers that some of this re-direction in acute care funding be used to support the development of Care Hubs including the different models as outlined earlier.

2. Quality of Seniors Care and Quality of Life

While improving staffing levels and increasing home visit times will enhance seniors care over the long term, further initiatives will need to be undertaken to improve the overall quality of life for seniors in long-term care and living at home. Today's seniors face critical challenges such as having multiple chronic conditions, increasing levels of dementia and mental health concerns, high rates of falls, as well as escalating levels of social isolation and depression, to name a few. These are detrimental to quality of life and strategies to address these areas will be critical going forward.

As over twenty-five per cent of B.C.'s population will be 65 years or older by 2036, it is clear the current health system is not prepared to meet the challenges of an aging population, including managing the rising number of mental health and chronic diseases. As discussed in previous BCCPA papers, the health system is still largely acute care oriented and not optimally designed to provide care for those with ongoing care needs, such as the chronically ill or frail elderly.⁸⁰

The B.C. Office of the Seniors Advocate (OSA), for example, has addressed some of these issues in a report highlighting the need for greater supports in the community particularly Adult Day Programs

⁷⁹ According to the Home Care Ontario (2011) estimated the daily cost of care at home at \$42, of a long term care bed at \$126 and of a hospital bed at \$842. The Ombudsperson also notes it costs Health Authorities only about \$30 to \$40 for each hour of subsidized home support.

⁸⁰ National Health Leadership Conference. The Great Canadian Healthcare Debate. Issue Briefs: Top 5 motions. Second Edition. June 2016. Accessed at: <http://www.nhlc-cnls.ca/assets/2016%20Ottawa/E-Issues%20Brief%20Booklet.pdf>

(ADPs). A 2015 OSA report, notes that ADPs provide important benefits to both clients and their informal caregivers, yet they face a number of challenges and limitations. In particular, the OSA indicates that the capacity of ADPs in BC has not kept pace with the aging demographics. The report indicates that in real terms, the number of ADP clients decreased 20 per cent, and the number of days utilized had decreased 18 per cent between 2011 and 2014.⁸¹ Since 2015/16, there has also been an 8 per cent decrease in the number of funded ADP days offered and a 4 per cent decrease in clients.⁸²

Like the OSA, BCCPA believes ADPs are vital to the overall health and well-being of seniors. As such they should be one of key areas of a Seniors Quality of Life Fund as outlined in detail below.

Seniors Quality of Life Fund (SQLF)

Quality of life refers to activities that take place beyond basic shelter, food, and medical needs. These activities enrich lives and have been proven to improve the mental and physical health, as well as the productive longevity, of participants.⁸³ To help meet these goals and address the aforementioned gaps in quality of life programming, BCCPA has previously recommended new funding for the creation of a *Seniors Quality of Life Fund (SQLF)* to support quality of life for seniors, focusing on person-centered care that improves their physical, spiritual, mental, and psychosocial well-being.

The SQLF would also address some of the challenges seniors face in receiving culturally appropriate care and appropriate supports including Recreational Therapy (RT), Occupational Therapy (OT) and Physical Therapy (PT). Additional areas that should also be addressed as part of any intervention to improve the quality of life include increasing the number of, and access to ADPs, and other initiatives to deal with issues of seniors' isolation.

According to a 2012 study of the National Academy of Sciences, social isolation and loneliness are associated with a higher risk of mortality in older adults.⁸⁴ One study, for example, notes isolation is as strong a factor in early death as smoking 15 cigarettes a day,⁸⁵ while another notes it can be twice as unhealthy as obesity, increasing chances of early death by 14 per cent.⁸⁶

While a review of all the relevant research to improve seniors quality of life goes beyond the scope of this paper, BCCPA has outlined some of this in its 2017 paper *Strengthening Seniors Care: A Made-in-BC Roadmap*. This 2017 report recommended that the BC government establish a new annual \$22 million SQLF for three years to support quality of life for seniors in long-term care and in the community. Since the release of that paper, BCCPA has developed and submitted a more formal proposal to the BC government for a \$25 million SQLF, which includes the \$22 million proposed fund outlined in *Strengthening Seniors Care* and a \$3 million component geared towards specialized province-wide programs. These programs, which would be managed by BCCPA directly, would improve the health and well-being of seniors in BC, such as the *Concerts in Care* and a new pilot program, *Collaborating Artists in Residence (CAiR)*.

⁸¹ BC Office of the Seniors Advocate. Caregivers in distress: More respite needed. September 2015. Accessed at: <http://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2015/09/CaregiversReport.pdf>

⁸² BC Office of the Seniors Advocate. December 2017. Monitoring Seniors' Services 2017 <http://www.seniorsadvocatebc.ca/app/uploads/sites/4/2017/12/MonitoringReport2017.pdf>

⁸³ Measured Outcome. Wellness & Quality-of-life Programs for Low-income Seniors. Rebecca Thomas. 2017. Accessed at: http://measuredoutcome.org/wp-content/uploads/2017/03/MO_Seniors-Wellness-Programs_Updated-Version_WEB.pdf

⁸⁴ Social isolation, loneliness, and all-cause mortality in older men and women. Proceedings of the National Academy of Sciences of the United States of America. Andrew Steptoe et al. February 15, 2013. Accessed at: <http://www.pnas.org/content/110/15/5797.full>

⁸⁵ Holt-Lundstedt, J., Smith, T.B., and Layton, B.L. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Medicine*, p. 12. Retrieved from <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000316>

⁸⁶ Loneliness twice as unhealthy as obesity for older people, study finds. *The Guardian*. Ian Sample. February 16, 2014. Accessed at: <http://www.theguardian.com/science/2014/feb/16/loneliness-twice-as-unhealthy-as-obesity-older-people>.

As outlined in the earlier \$25 million proposal, along with providing services to community, the SQLF would provide up to \$100 per month per senior living in a non-government operated long-term care setting. Up to \$22 million per year would be provided to care homes based on the fact there are approximately 18,300 non-government operated care beds that receive public funding.⁸⁷

Care providers would apply for funding based on the number of publicly subsidized beds in their homes and would be eligible to receive funding provided they follow the parameters outlined in BCCPA's SQLF proposal. While the \$22 million fund would largely be allocated to long-term care operators, care providers applying for funding must demonstrate how the seniors living at home would also benefit. This includes provisions to help increase transportation for seniors to and from the care home to attend programs or receive care including ADPs. Overall, one of the major benefits of a proposed SQLF is creating a catchment and care hub model that enables care providers to work more collaboratively with each other. Other such benefits include:

- Increasing access to RT, OT, and PT for seniors living at home;
- Increasing access to a broad array of music programs such as Concerts in Care in the community;
- Reducing seniors' isolation through increased Adult Day and similar programs;
- Reducing the impact on seniors transitioning across the continuum of care; and
- Providing care and access to programs that are culturally appropriate.

As outlined most recently in the 2018 BCCPA paper entitled *Health Begins at Home*, BCCPA recommends that a new Seniors Quality of Life Fund (SQLF) be established by the BC government with designated funding to support seniors living at home and in congregate settings by:

- Increasing access to recreational therapy, occupational therapy, physiotherapy, nutrition, culturally appropriate care, music and art programs;
- Reducing seniors' isolation through increased Adult Day and similar programs; and
- Enabling Care Hubs to work more collaboratively with local home health providers.⁸⁸

To support the funding of the new SQLF, along with redirecting acute care expenditures new federal funding could be allocated to home care. The federal government plans to provide targeted funding of about \$7 billion over 10 years to provinces and territories to improve access to home care services.⁸⁹ As such, BCCPA suggests that potentially as part of any redirected funding or new federal funds, the BC government provide \$25 million annually to establish a SQLF to improve the quality of life and well-being of seniors in the province.

In its 2018 Budget submission, BCCPA also recommended that BC government provide \$25 million in annual funding to support models such as the Continuing Care Hub to reduce acute care congestion and ER visits as well as better care for frail elderly and seniors with chronic conditions including dementia.

More recently, BCCPA has recommended that the province government invest up to \$28M per year over the next five years to support the introduction and/or expansion of the Care Hub concept throughout B.C.

⁸⁷ According to March 2016 Facilities report, in BC there were approximately 27,422 long term care beds in BC including 18,338 non-government and 9,084 government operated. To determine SQLF it equates to number of non-government operated care beds (18,338) x \$100 x 12 months.

⁸⁸ BCCPA. *Health Begins at Home: Strengthening BC's Home Health Care Sector*. February 2018. Accessed at: <https://bccare.ca/wp-content/uploads/2018/02/BCCPA-Home-Health-Care-Paper-2018.pdf>

⁸⁹ Government of Canada. Minister Philpott highlights significant investments to improve access to home care. April 11, 2017. Accessed at: https://www.canada.ca/en/health-canada/news/2017/04/minister_philpott_highlights_significant_investments_to_improve_access.html

The BCCPA in its 2019 *Bedlam in BC's Continuing Care Sector* paper dealing with future demand for long-term care also recommended that:

- *The B.C. government invest up to \$50 million per year over the next four years to support the introduction of new models or approaches of care such as the Continuing Care Hub to improve access to seniors' care. Where appropriate, investments from this funding should be provided to initiatives or programs across the continuing sector including assisted living and home health care that can mitigate and/or reduce future demand for long-term care.*⁹⁰

BCCPA believes that the Care Hub Model if implemented across the province in conjunction with any SQLF could play a major role in enhancing the quality of life for BC seniors living in long-term care and in the community. Along with advocating for the implementation of the Care Hub model over the course of the next year, in June of 2019 BCCPA also released a new *Seniors Quality of Life Framework* entitled the Best Day Possible.⁹¹ This Framework, which outlines a set of actions within four domains (Supportive Environments, Meaningful Relationships, Fulfilling Activities, and Cultural Diversity) has been a focal area of by BCCPA's Quality Committee which was established earlier to provide programs and resources to improve the quality of care and quality of life in relation to services provided by members.⁹²

Improved Dementia Care

Improving dementia care is also a significant priority for the province. B.C.'s Dementia Guide (2016) notes dementia impacts roughly 62,000 British Columbians and is expected to rise to 87,000 by 2024.⁹³ With



the aging population dementia levels are likely to increase. In 2014/15, 47% of those with dementia were aged 85 or older, followed by 45% aged 65 to 84, and 8% with early onset under the age of 65. While the majority of people with dementia continue to live at home (approximately 60 per cent), the other roughly 40 per cent live in long-term care.

In B.C. over 60% of residents in long-term care have some level of dementia. According to the USC Leonard D. Schaeffer Centre for Health Policy and Economics the annual per-person cost

of the disease (including direct and indirect costs) was \$71,000 (US) in 2010 and is expected to double by 2050.⁹⁴

BCCPA believes the new Continuing Care Hubs have the potential to improve quality of care and quality of life for those with dementia in a number of ways including:

⁹⁰ BCCPA. *Bedlam in BC's Continuing Care Sector: Projecting Future Long Term Care Needs*. May 2019. Accessed at: https://bccare.ca/wp-content/uploads/2019/05/Bedlam_in_BC_Continuing_Care_Sector.pdf

⁹¹ BCCPA. *Quality of Life Framework for B.C. seniors promotes "new vision" for care*. June 2019. Accessed at: <https://bccare.ca/2019/06/quality-of-life-framework-for-b-c-seniors-promotes-new-vision-for-care/>

⁹² BCCPA. *New BCCPA Committee Aims to Improve Quality of Life for BC Seniors*. October 19, 2016 Accessed at: <http://bccare.ca/2016/10/new-bccpa-committee-aims-improve-quality-life-bc-seniors/>

⁹³ BC Ministry of Health. *Provincial Guide to Dementia Care in British Columbia*. May 2016. Accessed at: <http://www.health.gov.bc.ca/library/publications/year/2016/bc-dementia-care-guide.pdf>

⁹⁴ Press Room. *Study: Baby Boomers Will Drive Explosion in Alzheimer's-Related Costs in Coming Decades*. November 11, 2014. Accessed at: <https://pressroom.usc.edu/study-baby-boomers-will-drive-explosion-in-alzheimers-related-costs-in-coming-decades/>

- Improving access to care including reducing ALC days which affects many dementia patients;
- Improved access to dementia care in the community including home health care;
- Provision of enhanced specialized or community services for those with dementia;
- Increased quality of care including life enhancing therapies or programs for those with dementia (i.e. concerts in care, recreational therapy, etc.)
- Improved access to adult days programs for those with dementia;
- Improved preventative and health promotion activities; and
- Improved dementia training and education for health care workers.

3. Better Integrating Seniors Care with the Community

In towns and cities across British Columbia, long-term care homes are often located on the fringes of communities, apart from other amenities and services which might be used by seniors in care and other members of the public. This has real impacts on how we think about care homes and seniors who need care and can have the following detrimental effects including:

- It can result in social isolation, as many seniors in care have limited ability to travel;
- It can also be a barrier for family members and friends who would want to visit; and
- It creates systemic inefficiencies, as services which are vital to many segments of the population, not just seniors in care, are too far apart.

As our population ages it is imperative that we change that, and better integrate care into the heart of our communities. It is important that we create a place where health and non-health services for seniors are not set on the edge of town but integrated into the heart of a bustling community. In addition to being efficient and affordable, these communities can help to reduce social isolation faced by seniors, while bolstering existing health services. Furthermore, they can attract family members and others from the community by providing a range of services and amenities.



One key aspect of the Continuing Care Hub is that seniors and seniors care are better integrated with the community. In some cases, the seniors care home acts as the centre for the delivery of a wide range of seniors' services. As discussed earlier, Care Hub services may include variety of medical / health services – such as primary care, chronic disease management, rehabilitation, sub-acute care, dialysis, oral care, foot care, home health care services, and specialized geriatric services.

Likewise, as seen with the **community non-medical services** model and as discussed in part II of this paper, it could also involve providing various other supports such as adult day/night programs, non-profit services and amenities available to the general public such as restaurants, daycare, theaters, pubs, senior-friendly transit options and senior drop-in centres. Some models may even integrate on-site housing for workers. One excellent example of a seniors care home in Canada which is better integrated with the community, is that of Niverville in Manitoba (see below).

A CANADIAN EXAMPLE: NIVERVILLE



Niverville is a small town of approximately 4,500 people located 25 kilometers south of Winnipeg, Manitoba. Opened in 2013, the 80-bed Heritage Life Personal Care Home included Canada's first special-care 20-bed unit designed specifically for patients with aggressive and overactive Alzheimer's or suffering from dementia. It was also Manitoba's first personal-care home funded entirely by the community. What also makes Niverville unique from most care homes is that it adjoins the town's Heritage Centre (NHC) which includes a large event centre and even a restaurant tavern. Along with this, the care home is adjacent to an assisted-living and supportive-care residence as well as a primary health-care centre.⁹⁵

The Niverville Heritage Centre (NHC) is not only a residential or long-term care home, it has quickly become the heart of the community with intergenerational living that cultivates meaningful connections between family members, children, and seniors. NHC describes itself as "a community owned, not for profit corporation that is focused on social enterprise." At over 300 employees, the NHC is now one of the largest employers in the community. On site are a number of services that you would not normally associate with long-term care including two large community banquet halls, full service restaurants open to the public, a children's daycare, a primary care clinic and a dental clinic.

Although NHC is technically a non-profit, they use many for-profit principles and have developed similar business units to help generate additional revenue. For example, all net revenues generated from Hespeler's Cookhouse and Tavern, a business unit run by NHC, goes back to support the delivery of care. They have also leased out office space to a number of tenants which also produces a steady revenue stream to the Society.

⁹⁵ Manitoba Co-operator. Niverville unveils new state-of-the-art personal-care home. Lorraine Stevenson. September 6, 2013. Accessed at: <https://www.manitobacooperator.ca/2013/09/06/niverville-unveils-new-state-of-the-art-personal-care-home/>

PART II: OPERATIONALIZING THE CONTINUING CARE HUB

While Part I of this paper provides further background on the Continuing Care Hub as advocated by BCCPA, the remainder of this scoping paper will look at more at how to operationalize this model in the context of B.C.'s continuing care sector. As outlined below, this section focuses on five potential models for the Continuing Care Hub, which include:

1. **Today's long-term care model in B.C.;**
2. **An Integrated Home and Long-Term Care Model** (where care homes or hubs provide home health care services, including home support to seniors in the community);
3. **An Enhanced Specialized Services Model** (where care homes or hubs with commensurate or appropriate funding provide enhanced specialized medical services to seniors in long-term care and the community, such as sub-acute care);
4. **An Enhanced Community Health Services Model** (where care homes provide community health services to seniors in the community such as primary care, health promotion, mental health, screening);
5. **A Community Non-Medical Services Model** (where care homes or hubs provide non-medical services to seniors in the community such as adult day programs).

As mentioned earlier, the models identified above are not distinct or stand-alone ones as a Care Hub could provide services or supports under each of the models. BCCPA also believes these models would tie in very well also to the work that the B.C. Ministry of Health is undertaking to establish specialized care programs. For example, significant policy work has been completed with the health sector ready to establish Specialized Care Programs across all of B.C.'s 80 Local Health Service Delivery areas. In this example, focus areas over the coming years for the frail elderly population include increasing service integration, coordination, and access to both home care, assisted living, and long-term care.⁹⁶ As outlined by the Ministry of Health, health authorities will establish a Specialized Community Services Program for Seniors in each of these areas that will link together the current range of services and offer several core health services, such as:



- Actively work with primary care practices to identify patients needing increased supports with patient-centred and efficient intake and assessment services to provide enhanced supports;

⁹⁶ BC Government. Open Information FOI Request. Copies of the transition briefing material prepared for the new Minister who was sworn in on July 18, 2017. Date Range for Record Search: From 07/01/2017 To 07/19/2017. Ministry of Health. Accessed at: http://docs.openinfo.gov.bc.ca/Response_Package_HTH-2017-72410.pdf

- Provide case management and coordination services across medical specialists, home nursing and support services; pharmacist medication review and support services;
- Increase access to day programming, assisted living, and long-term care services for socializing, eating, laundry, bathing, and personal care as a community resource for people living at home;
- Pro-active planning for admission to assisted living and long-term care to increase choice of residence and reduce wait times; provide better coordinated care, and reduce hospitalizations;
- Increase home support services and hours as well as leverage technology to increase home health monitoring and connectivity for patients and providers; and
- Effective linkages and access to local diagnostic and hospital care, specialized regional services and specialized provincial services to provide optimal and rapid care in meeting more complex patient health care needs.⁹⁷

⁹⁷ Ibid.

Section 1: Identifying the Five Care Hub Models

Current long-term care model

The services below are those provided to seniors currently living in long-term care or the existing model (i.e. current long-term care model):

- Accommodation / housing for seniors
- 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; and
- Any other specialized services

Long-term care homes offer seniors 24-hour professional supervision (i.e. by a health care professional including nurses or health care aides) and care in a safe and secure environment. For the small portion of seniors who live in care homes (approximately 4% in B.C.) care homes also provide primary housing. Approximately 4% of seniors live in long-term care with most people moving into long-term care over the age of 75 - making up over 80% (83%) of all long-term care clients. There are approximately 27,760 subsidized long-term care beds in the province. With over 300 care homes in B.C., there is an opportunity for many of these to establish formal networks to expand the level of service they are currently providing. This is the focus of the four models of the Care Hub as outlined below.

Four New Continuing Care Hub Models (in addition to current Long Term Care Model)			
Integrated Home and Long-Term Care Model	Enhanced Specialized Services Model	Enhanced Community Health Services Model	Community non-medical services model

Integrated Home and Long-Term Care Model

The integrated home and long-term care model builds upon the first model, but where the long-term care home (or network of care homes) could contract directly with the health authorities to provide home health care (including home support) services to seniors living in the community. Alternatively, home health care providers could sub-contract to a long-term care home (or network) to deliver such services.

Hypothetically, under such a model staff who work in the long-term care home (particularly care aides or nurses) could also provide care to seniors living in the community. As part of this model the services would include those provided in model 1 (current residential or long-term care model) but also contracted home health care including home support services provided to seniors in the community. Such services could also be provided to seniors in the community by private home health care companies who are affiliated with the Care Hub network.

The model is most like the Integrated Care Model as outlined in earlier OLTCA paper and Appendix B, which integrates housing and home and community care to support a certain population of seniors as their care and housing needs change over time. This model could provide incentives for effectively managing chronic conditions, reducing emergency department visits and avoiding hospital admissions, as well as managing long-term care admissions within the continuum. Likewise, it could be modified to support residents discharged from hospital or short-stay beds that require further follow-up or intensive but intermittent care.

While this paper generally focuses on integration of long term and home care, the same principles could also apply with assisted living. In particular, there are also opportunities to integrate assisted living operators who could contract with the health authorities to provide home health care services to seniors in the community. Likewise, home health care operators could also continue, where appropriate, to provide home health services to those living in assisted living.

Preventative Home Care Visits



One other area that this model could be involved in is the provision of preventative home care visits as discussed in the 2018 BCCPA paper, *Health Begins at Home*. Denmark's Ministry of Social Affairs, for example, passed a law in 1998 obliging municipalities to offer professionally delivered home visits twice a year to all citizens 75 and older. One of the reasons for this is that older and frail people often wait too long to ask for care or are unaware these services exist, by which point their health has severely declined. As noted in the literature, these preventative home health care visits serve multiple purposes including:

- Initiate contact or facilitate encounters with older persons who may not request medical attention as expeditiously as they should to increase their overall health and well-being;
- Help older people with the aim of remaining well and independent for as long as possible;
- Identify safety issues in the home to prevent such things as falls;
- Raise awareness of community services and programs; and
- Facilitate adjustment of home care arrangements as needed.⁹⁸

Denmark has found that these visits quite successful as seen by the reduction in hospital admissions by 19 per cent, while admissions to long-term care homes declined by 31 per cent.⁹⁹ In 2015, this Danish program was modified slightly as municipalities were required to offer at least one preventative home care visits to seniors once they reach 75 years and at least one visit per year for seniors 80 or older.¹⁰⁰ In the Danish program, nurses with specialized training particularly in preventative health are largely responsible for providing such visits. While the percentage of seniors receiving home support in Denmark has increased, overall health spending on seniors over 80 years of age has decreased. This reduction appears to be the result of funds being diverted from more institutional care to a more cost-effective home support program.¹⁰¹

While BCCPA in *Health Begins at Home* recommends the provision of preventative home health care visits to people 75 and older on a proactive basis to prevent pre-mature frailty and ensure that seniors are provided with the necessary care as soon as possible; it is possible that if implemented appropriately the new Care Hub or particularly the Integrated Home and Long-Term Care model could play a prominent role in this regard.

Enhanced Specialized Services Model

As discussed earlier, one of the key features of 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. Services would be based on the existing expertise of providers as well as the community needs.

Under the Enhanced Specialized Services Model, a care home or network of care homes in addition to providing regular long-term care services (i.e. model 1) could provide more specialized services such as sub-acute care, dialysis, PICC line,¹⁰² etc. The exact suite of services will need to be determined and may vary from community to community. While applicable to all models it will be particularly important that any new additional services that are provided, including sub-acute care, be funded appropriately and commensurate with any additional work.

⁹⁸ BCCPA. *Health Begins at Home: Strengthening BC's home health care sector*. February 2018. Accessed at: <https://bccare.ca/wp-content/uploads/2018/02/BCCPA-Home-Health-Care-Paper-2018.pdf>

⁹⁹ Home Care in Canada: From the Margins to the Mainstream. Canadian Health Care Association. 2009. Accessed at http://www.healthcarecan.ca/wp-content/uploads/2012/11/Home_Care_in_Canada_From_the_Margins_to_the_Mainstream_web.pdf

¹⁰⁰ Eva Pedersen. The Ideal Home Care Model: Experience from Denmark. Presentation to the Alberta Continuing Care Association. IQ 2107 Conference: A World of Caring. September 27, 2017.

¹⁰¹ BC Ombudsperson. *The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)*. February 2012. Accessed at: <https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2047%20The%20Best%20of%20Care-%20Volume%201.pdf>

¹⁰² A peripherally inserted central catheter (PICC or PIC line), less commonly called a percutaneous indwelling central catheter, is a form of intravenous access that can be used for a prolonged period of time (e.g., for long chemotherapy regimens, extended antibiotic therapy, or total parenteral nutrition) or for administration of substances that should not be done peripherally (e.g., antihypertensive agents a.k.a. pressors).

As part of this model, the services would include those provided in model 1 (current long-term care model), but also any additional services that have been contracted to provide from the health authorities of a more specialized nature. The Enhanced Specialized Services Model is most like the Specialized Stream Models outlined in earlier OLTC paper and Appendix B. As outlined, this 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. It also combines specialized medical care, including pain and symptom management, with social supports to maintain residents' quality of life and support other caregivers.

Enhanced Community Health Services Model

While similar in concept to the above model (model #3), the Enhanced Community Health Services Model would provide more basic or less specialized care services including primary or preventative care. This could, for example, include primary care, mental health, health promotion or frailty screening. The exact suite of services will need to be determined and may vary from community to community. As part of this model, the services would include those provided in model 1 (current long-term care model) but also any additional community health services (i.e. primary care, health promotion, screening, etc.) that have been contracted to provide from the health authorities of a more general nature. This model is also most like the Post-Acute or Hub models as outlined in the OLTC report and Appendix B.

As outlined, the 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). Under this model, 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. The Care Hub model meanwhile integrates long-term care with other services for seniors (i.e. primary care, chronic disease management, oral care, community support services, specialized geriatric services, mental health, etc.).

Preventative / Pro-Active Care (including Dementia Care)

As outlined in the 2019 BCCPA *Bedlam* paper, an example of an initiative that a Continuing Care Hub could potentially oversee is a preventative program related to dementia care similar to one that has been developed at the University of California, Los Angeles (UCLA). A 2018 research study from the United States, for example, shows that a comprehensive, coordinated care program for people with dementia and their caregivers can potentially decrease the likelihood that individuals may need to enter a nursing or long-term care home.¹⁰³

The research, published in the December 2018 JAMA Internal Medicine,¹⁰⁴ analysing the UCLA Alzheimer's and Dementia Care Program, found that patients enrolled in the program reduced their risk of entering a nursing home by about 40 percent.¹⁰⁵ As part of this program people with dementia and their caregivers meet with a nurse practitioner (NP) specializing in dementia care for a 90-minute in-person assessment and then receive a personalized dementia care plan that addresses the medical, mental health and social needs of both people. The NPs also work collaboratively with the patient's

¹⁰³ Medical Xpress. Study shows dementia care program delays nursing home admissions, cuts Medicare costs. December 2018. Accessed at: <https://medicalxpress.com/news/2018-12-dementia-nursing-home-admissions-medicare.html>

¹⁰⁴JAMA Internal Medicine. Health Care Utilization and Cost Outcomes of a Comprehensive Dementia Care Program for Medicare Beneficiaries. December 2018. Accessed at: <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2719196>

¹⁰⁵ A total of 1,083 Medicare beneficiaries with dementia were enrolled in the program and were followed for three years. The study compared them to a similar group of patients living in the same ZIP codes who did not participate in the program.

primary care provider and specialist physicians to implement the care plan, including adjustments as needs change over time.¹⁰⁶ A follow-up study also found that while the UCLA program did not slow the progression of dementia, it did improve mental health by reducing patients' behavioral problems and depression, as well as lowering the distress of caregivers.¹⁰⁷ A similar program should be explored for adoption in BC particularly if able to reduce the demand or overall numbers of those with dementia who need to enter long-term care. Likewise, it is an example of a program that a Continuing Care Hub could be funded to oversee to not only improve care for those with dementia but also reduce or mitigate future demand for long-term care. Along with improving dementia care, such a model could also take a proactive approach to improve not only the physical care needs of seniors, but their mental health as well – an area that can often be neglected particularly for those who are feeling isolated and/or alone.

Community Non-Medical Services Model

Though it resembles the Integrated Home and Long-Term Care Model, the Community Non-Medical Services Model would provide other services to seniors living in the community. These services, however, would be more non-medical in nature and would largely be provided on-site at the Continuing Care Hub location. Examples of such services include but are not limited to adult day programs (ADPs) or similar night programs, Concerts in Care, recreational therapy or various activities, as well as possibly social supports or programs (i.e. social work, meals on wheels, Better at Home, social work and transportation services).



This model incorporates elements of the various models outlined in the OLTCA paper (*Why Not Now!*) particularly the Hub Model that integrates long-term care with other services for seniors (i.e. primary care, chronic disease management /prevention, oral care, community support services, specialized geriatric services, etc.). One other potential aspect of the community non-medical services model could be to also provide housing or supportive living arrangements to health care workers. The availability, for example, of affordable housing arrangements for health care workers could also be a key aspect in recruiting and retaining such workers. This model is explored in further detail later in this paper as part of the Kelowna Event (September 2018) and the consultations that were undertaken by the Howe Group.

BCCPA's Addendum: Note on Assisted Living

While the above models focus on long-term care, BCCPA believes many of the same tenets underlying these models could apply to assisted living as well. In B.C., there are 139 subsidized registered assisted living residences and (as of March 2016) there were 4,408 subsidized registered assisted living units. Legislative changes to the *Community Care and Assisted Living Act* (CCALA) in March 2016, and recent

¹⁰⁶ Medical Xpress. Study shows dementia care program delays nursing home admissions, cuts Medicare costs. December 2018. Accessed at: <https://medicalxpress.com/news/2018-12-dementia-nursing-home-admissions-medicare.html>

¹⁰⁷ UCLA Newsroom. Dementia care program improves mental health of patients, caregivers. August 13, 2019. Accessed at: <http://newsroom.ucla.edu/releases/dementia-care-program-improves-mental-health-patients-caregivers>

regulatory changes will offer more flexibility and choice for seniors in assisted living residences, while at the same time increasing protections.

It is not yet known what the full impact of the changes to CCALA will be to the long-term care sector, but it is likely that the proportion of higher needs clients will increase in care homes, which will impact not only staffing numbers but staffing mix as well. In addition, as more individuals with lower care needs can be supported successfully at home or in assisted living residences, it is likely that their length of stay in long-term care will decrease from the current average of 500 days.¹⁰⁸ The 2019 BCCPA Bedlam in BC's Continuing Care Sector paper discusses further how demand for assisted living could potentially increase considerably over the next number of years. As such, BCCPA believes that assisted living and even independent living should also be considered as integral components of any future vision for Continuing Care Hubs in B.C. The next section below outlines such a vision.

¹⁰⁸ BC Government. Open Information FOI Request. Copies of the transition briefing material prepared for the new Minister who was sworn in on July 18, 2017. Date Range for Record Search: From 07/01/2017 To 07/19/2017. Ministry of Health. Accessed at: http://docs.openinfo.gov.bc.ca/Response_Package_HTH-2017-72410.pdf

Hypothetical Care Hub: Victoria Continuing Care Hub Group

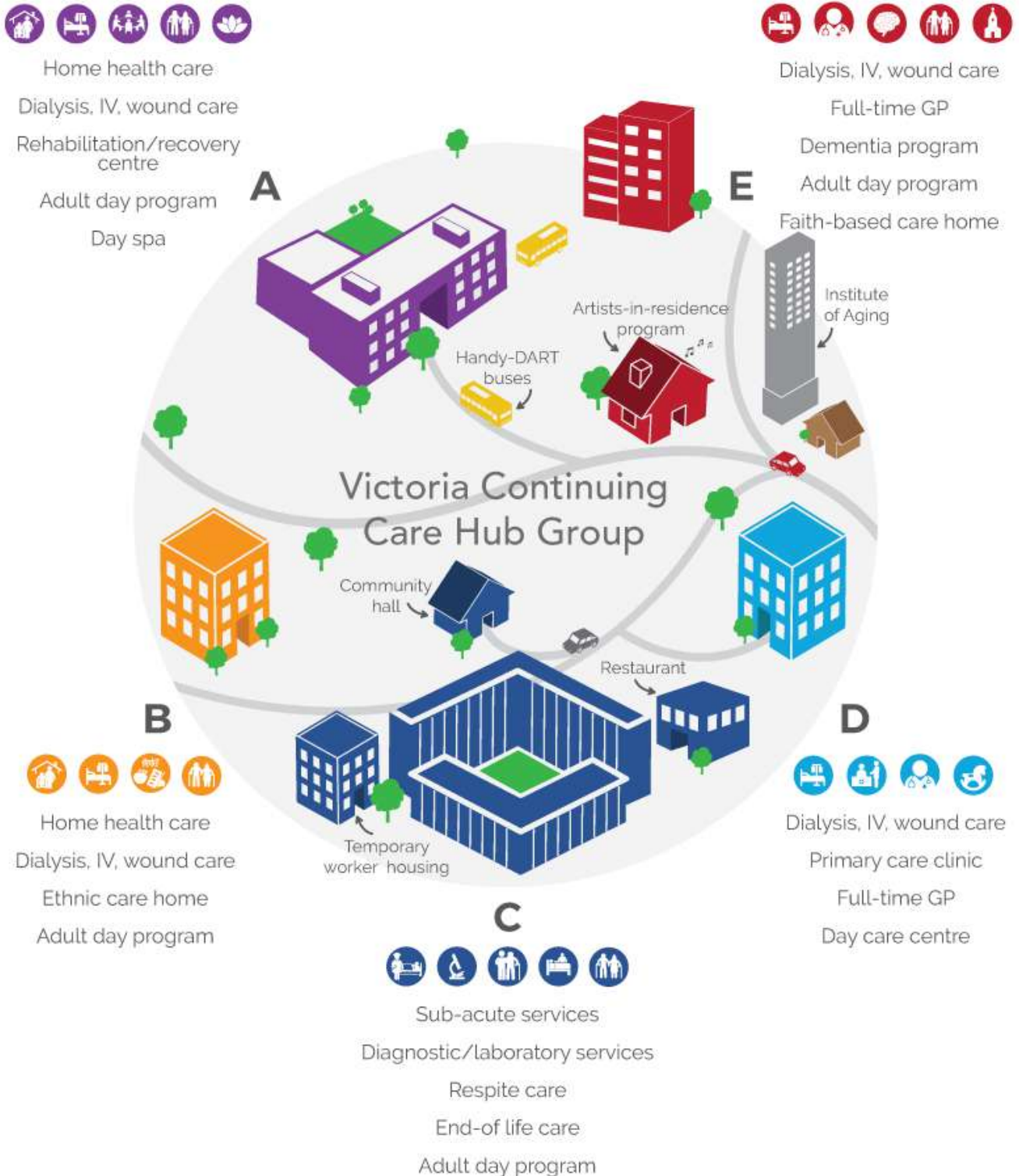
As outlined earlier, no “one size fits all” as the development of the Continuing Care Hub will depend largely on the needs of the community as well as what services operators decide to provide. In this section, we have outlined a hypothetical care hub model located in the area of Victoria, B.C., as seen in the following table and infographic.

Hypothetical Continuing Care Hub Model (Victoria Continuing Care Hub Group)

- In 2025, the Victoria Continuing Care Hub Group (VCCHG) was formally established.
- The VCCHG consists of five care homes (three private for-profit and two non-profit) that have agreed to collaborate to provide services and supports to a catchment of seniors living in the Victoria area. In total, the five care homes have close to 600 long-term care beds.
- Along with providing traditional long-term care services in each of the care homes, the five homes provide a variety of other services.
- Care Homes A and B, for example, provide home health care services to about 500 seniors in the Victoria area (i.e. integrated home and long-term care model). They have contracted with the local health authority (Island Health) to provide these services. Some of the same staff who also work in their care homes also provide home health care services.
- The largest of the care homes (Care home C) within the VCCHG, which has close to 200 long-term care beds, also provides a variety of sub-acute services that traditionally would have been provided by the local hospitals (i.e. Enhanced Specialized Services Model).
 - Care Home C is also compensated fully for such services through an arrangement with the local hospital and health authority. All seniors who reside in the five care homes have ready access to these services. As part of its sub-acute services program, Care Home C is also in the process of expanding the provision of diagnostic and laboratory services.
- While the other care homes do not provide sub-acute services, all of them provide services including dialysis, IV and wound care. The health authority also fully compensates these care homes for such services through financial arrangements.
- Care Homes D and E have also hired two full time general practitioners who visit the other residents in other care homes (i.e. Enhanced Community Health Services Model). This initiative has been supported through the local Division of Family Practice in Victoria. A primary care clinic has also been established in Care Home D where local seniors in the area can also visit.
 - This primary care clinic also provides greater preventative and health promotion services including frailty screening, mental health, etc. The primary care centre is also in the process of expanding into a community health centre which could include dentistry and oral care.

- With the collaboration of a non-profit dementia organization, Care Home E has established a dementia program where people and their caregivers can attend an in-person assessment and receive a personalized dementia care plan that addresses the medical, mental health and social needs of both people. All residents in the VCCHG as well as seniors living in the surrounding community who have been diagnosed with dementia can access this program.
- Care Home C has also established a respite program with 10 respite beds that seniors (and their caregivers) in the community can use. Likewise, Care Home C has also 5 end of life care beds.
- Care Home A has also established a rehabilitation and recovery centre. Residents from the other care homes are also able to use the centre when appropriate.
- Care Homes A, C and E have also established Adult Day Programs in which residents in the other two care homes can also access (i.e. Community Non-Medical Services Model). Seniors living in the community particularly those receiving home health care services can also access the ADPs. As part of this initiative 2 full time (and one part time) recreational therapists are shared amongst the care homes. They also attempt to coordinate their recreational therapy programs together.
- Care Home A also has a day spa program which provides services to its resident population but also seniors from other care homes and those living in the community.
- The VCCHG also has employed 2 full time social workers who rotate their time between all five care homes and provide support also for some of their home health care clients.
- Care Home B is also an ethnically based care home serving residents primarily of Asian descent. It also provides various events and services for Asian populations living in other care homes within the VCCHG as well as some of its home health care clients.
- Care Home D has also added a children's day care where seniors in the residence (and some from other care homes) participate in joint activities as part of an intergenerational initiative.
- Care Home E is also faith-based catholic care home with a large chapel and full-time pastor on-site. The bus service (see below) also provides transportation on Sundays to residents in the other care homes who want to attend the Sunday morning service at Care Home E.
- The VCCHG has also partnered with Translink BC and has a Handy-DART bus, which it is able to use 24/7. The bus assists in transporting residents between care homes particularly to access adult day programs. Likewise, it can also transport seniors who are receiving home health care services to the various care homes to access services, etc. The VCCHG has also received funding and support from Ministry of Health and Translink to add a second bus given high demand.
- Care Home C, which is located on a Campus of Care that has assisted and independent living has also added worker housing where health care aides and other workers from the VCCHG can live in on a temporary basis.
 - On occasion students from the University of Victoria will also live there as part of another intergenerational program where students volunteer their time at the various care homes.

- Care Home C, which is close to the downtown area, also has a large community space which hosts various events (i.e. weddings, festivals, etc.) and a relatively large tavern / restaurant which is open to the public.
- Along with hosting various music events through a partnership with Concerts in Care, the VCCHG also has an artists-in-residence program. Many of the larger events are held in the community events centre space located at care home C.
- The VCCHG has also established a partnership agreement with University of Victoria including working with its Institute on Aging and a non-profit organization to undertake research and test new technologies in the area of long term and home health care.
- The VCCHG has also partnered with local colleges on the Island to provide training and work experience for health care aides.
- The VCCHG has also entered into a funding arrangement which allows care homes greater flexibility in meeting an hours per resident day (i.e. direct care hours) target, in particular, allowing them to meet a specified average among all care homes as opposed to a specific target for each care home.
- Along with health authority and provincial government funding, the group also obtains revenues through other sources such as partnerships and sponsorships with businesses and community stakeholders as well as further private pay and/or public revenues generated through various amenities, events, etc.



- 600 LTC beds
- Home health care for 500 clients
- Assisted living/independent living
- Recreation therapists
- Social workers
- Partnership with local colleges for HCA training
- Partnership with UVic for research

Focus on Person-Centred Care: VCCHG and Betty

Along with meeting the needs of the community (i.e. one size does not fit all), the impetus of the Care Home models must be around putting the resident or senior in the community first through the provision of person-centred care. Using the example above we show below how the Continuing Care Hub model established in the Victoria region could also benefit a fictional senior – in this case Betty (see below).

Resident profile (Betty)

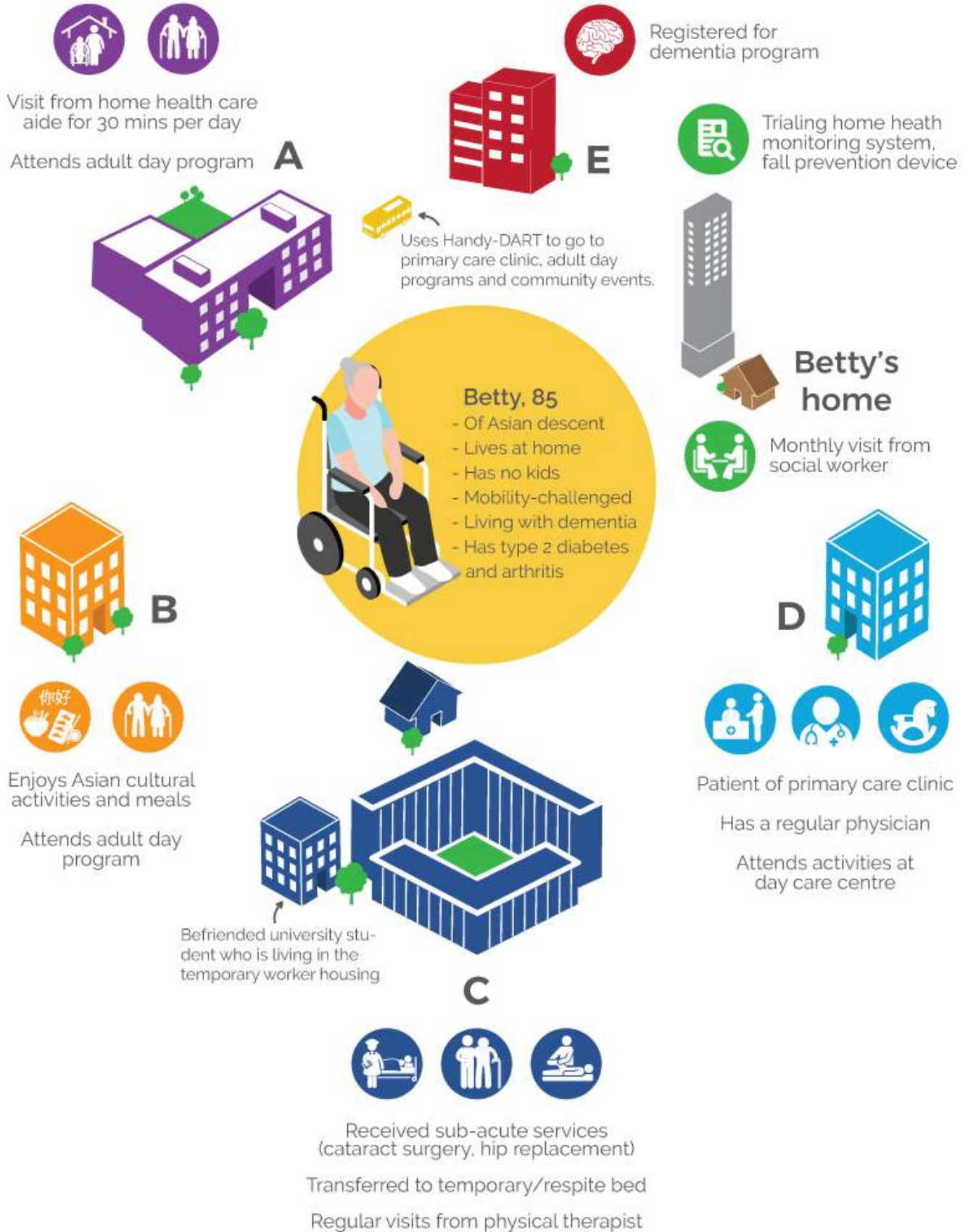
- 85-year-old female widow of Asian descent with no children
- Lacks mobility and is confined to a wheelchair to move around
- Was diagnosed with dementia about one year ago – the dementia is still in its early stages
- Has multiple chronic conditions including type 2 diabetes and arthritis
- Currently Betty lives at home as per her preference

Services and benefits of the VCCHG that Betty receives

- Care Home A provides Betty with home health care services as a health care aide / community health worker visits her on a daily basis for at least 30 minutes.
- Over the past two years, Betty has received sub-acute care services including cataract surgery and hip replacement at Care Home C.
- After her regular general practitioner or family physician retired, she became a client at the primary care clinic (Care Home D) where she now has a regular physician. Here she has also received preventative and promotion services to better manage her diabetes as well as arthritis. She has also received frailty screening and mental health services at the clinic.
- After being diagnosed with dementia, she registered for the dementia program (Care Home E) where they have developed a personalized dementia care plan to address her medical, mental and social needs.
- Last year after suffering a bad fall down the stairs and being hospitalized for brief period of time, she was transferred to a temporary / respite bed in Care Home C where she resided before going back to home where she continues to live. While residing in the temporary bed, a physical therapist who worked full time for VCCHG would visit her on regular basis.
- Betty participates in a couple of Adult Day Programs per week, which provide various social and recreational therapy activities. One of the more physical oriented recreational programs also assists in mitigating the pain associated with her arthritis.
- Once per week Betty also attends Care Home B to participate in Asian culture activities including an Asian dinner. Likewise, once every week or two weeks she will also sit in on activities at the children's day care centre (Care Home D), as part of their intergenerational program.

- Betty is able to access the VCCHG Handy-DART bus service on regular basis in order to attend various adult day programs as well as visit the primary care clinic and on occasion attend events particularly in the community event centre space at Care Home C. While visiting the community event centre she has also established close friendship with one of the university students who is living in Care Home C's temporary worker housing as part of its intergenerational program.
- Through the VCCHG and in partnership with a non-profit organization, Betty is also trialing various technologies including home health monitoring system, falls prevention device, etc.
- In addition to receiving home health care services, a social worker from the VCCHG also visits Betty once per month.
- Betty is assessed regularly to determine her level of care needs. Although she has indicated preference to remain at home, if required she has indicated willingness to move into one of three care homes (as per the Ministry of Health new access policy) all of which are part of the VCCHG. Her preference would be Care Home B given its ethnic Asian focus.

When a Hub Becomes Home: Putting Seniors at the Heart of B.C.'s Communities



SECTION 2: CASE STUDY ON COMMUNITY NON-MEDICAL SERVICES MODEL

To operationalize the envisioned Continuing Care Hub, it will require addressing various issues and challenges. While not entirely exhaustive some of these issues or challenges include:

1. How the new models or networks will be funded both at a macro and micro-level, including funding lift model and ensuring that any new additional services that are provided including sub-acute care be funded appropriately and commensurate with any additional work;
2. Determining criteria for what defines a Continuing Care Hub in British Columbia for operational or program purposes;
3. Establishing the list of services (medical / non-medical) that could be provided under each model;
4. Developing appropriate staffing and health human resource plans;
5. Revising as necessary regulations, legislation or other changes;
6. Development of appropriate information / IT systems;
7. Municipal considerations (zoning, building, etc.);
8. Rural considerations (access to transportation and other services);
9. Physical infrastructure (including equipment considerations); and
10. Revised contractual or other agreements.

As with any major transformational health system change, addressing various factors to operationalize or implement the change will be critical. The following are only some of the issues which BCCPA believes will need to be addressed over time. It is beyond the scope of this paper or project to go into depth or attempt to address the issues identified above or as noted earlier to discuss all the key features and/or how to implement new Continuing Care Hubs in the B.C. context.

These would likely be issues that would need to be addressed following extensive consultations with stakeholders, and best addressed through a committee that would be established consisting of representatives from the Ministry of Health, Health Authorities, BCCPA and other stakeholders.

Given the scope of this project, particularly with the amount of potential new care hub models, BCCPA will be first exploring the operationalization of one of the models particularly the **community non-medical services model**. Focusing on this model initially also makes sense given the BC Ministry of Health's recent indication to look further at Residential Care Design for Community Supports particularly exploring how to leverage existing community resources / supports with long-term care. Subsequent models, however, may be explored in future BCCPA papers.

Case Study: Community Non-Medical Services Model

Kelowna Forum: Creating Communities of Care



On September 13, 2018, the BC Care Providers Association (BCCPA) gathered a diverse set of stakeholder partners together to envision how we better integrate care into our cities and towns that promotes connectedness between families and neighbors, improves health outcomes, supports workers, and makes efficient use of financial resources. Participants included local government staff, elected officials, managers of assisted living and care homes, academia, transportation providers, and health authorities, and others involved in providing care, housing, and community infrastructure.

In towns and cities across British Columbia, the traditional model of seniors' care homes are often located on the fringes of communities, apart from other amenities and services which might be used by seniors in care and other members of the public. Such design has real impacts on how we think about care homes and seniors who need care. The consequences can be social isolation, as many seniors in care have limited ability to travel, and it can be a barrier for family members and friends who would want to visit. It creates systemic inefficiencies, as services which are vital to many segments of the population, not just seniors in care, are too far apart. As our population ages it is imperative that we change that, and better integrate care into the heart of our communities.

The alternative is for health and non-health services (i.e. Community non-medical services model) for seniors to be integrated into the heart of a bustling community. The central facet to a 'Care Hub' is a seniors care home acts as the centre for the delivery of a wide range of seniors' services. The Care Hub may exist as a Campus of Care or be managed in collaboration by a network of care homes. In some cases, services are co-located, but in other instances they may exist separately as part of a formal integrated network.



The Communities of Care Workshop held in Kelowna was designed to explore the Care Hub model by:

- raising awareness among participants about best practices in creating these hubs in other communities;
- defining the conceptual framework for establishing care hubs in both urban and rural contexts;
- confirming the potential risks and opportunities in creating continuing care hubs throughout B.C., and;
- identifying a set of next steps to accelerate the implementation of continuing care hubs in B.C.

The Workshop was held in Kelowna, British Columbia at the Four Points Sheraton Hotel, and lasted from 8:30am to 4pm. Workshop participants were engaged and animated throughout. The appended [“What We Heard” Kelowna Forum report by Urban Matters](#) summarizes the exercises and discussions over the course of the workshop.



Howegroup Consultations with Stakeholders

Following the Kelowna Forum, in 2018 BCCPA also contracted with the Howegroup to do further consultations and focused discussions on the Continuing Care Hub particularly exploring the operationalization of the community non-medical services model, as outlined earlier in this paper. Input was sought from stakeholders inclusive of seniors, municipalities, health authorities, care providers, community partners, transit and developers on barriers and factors that would support the practical design and delivery of continuing care with community based non-medical services.

The approach for this work consisted of meetings with BCCPA leadership, including the Emerging Issues and Policy Committee (EIPC), 21 interviews, two focus groups with community stakeholders and three focus groups with seniors. In addition to seeking input from stakeholders on the operationalization of a non-medical community hub model, interviewees shaped the design of the engagement, including the selection of the communities (Creston, Saanich and New Westminster).

Conceptual components of the model were explored to understand the implications through the practical lens of stakeholders and seniors. The findings shed light on what it would mean to offer services in a community non-medical hub in the following areas:

Hub specific services: Services most important in a Care Hub include medical services (i.e. access to primary care and specialist services), a mix of housing, expanded home health care, transportation, shopping (including groceries), adult day programs and recreation.

Communication and coordination of services: A Care Hub needs formalized structures for action planning and building community capacity with existing community services as well as assisting seniors to access the right services at the right point and transitioning between levels of care.

Transportation: Operationalizing a Care Hub is dependent upon effective transportation to improve access to custom and conventional transportation as well as maximize underutilized transit (i.e. long-term care buses). This is achieved through community input in planning and by providing education to seniors to make better use of existing transit.

Sufficient long-term care: Sufficient long-term care is needed to support the transition between appropriate levels care and to alleviate pressures on the acute care system. With the general trend of increasing acuity among seniors, the transition from Assisted Living to Long Term Care is an ongoing challenge that is placing additional strains on the acute care system. The insufficient number of long-term care beds in some communities across BC is making it such that seniors are being cared for in hospital rather than in a long-term care setting. This is particularly challenging when seniors progress quickly to needing long-term care. It was noted that Interior Health has a higher than average proportion of seniors population and that there is a need for more long-term care beds in the Kootenays.

Expanded home health care: There is a need for additional home health care, including social and physical services to support seniors' desire to live at home.

Municipal planning: A hub needs flat topography (walkable), the physical infrastructure of purpose-built affordable housing, a seniors' recreation centre and a transit hub.

Housing mix: A varied housing mix enables seniors to age in their own community. Affordable housing also considers seniors health workers and their families. The seniors' living mix includes affordable rental, adult day support, expanded home health care, assisted living and long-term care.

Rural considerations: Operationalizing a rural Care Hub may consider challenges faced by seniors such as accessing specialized services (which may require travel outside of their community), limited frequency and large geographic spread between transit stops and limited housing mix. Development may, however, be streamlined as the cost of land tends to be lower with less competition for permit approvals.

Family support: Locating consumer services in close proximity to seniors' living helps both the senior and the family member by saving time, reducing stress and improving access and awareness to existing services. For example, a family may be able to complete errands for themselves and a senior on their way to a visit.

Volunteerism: A great number of community programs rely on volunteers, many of which are seniors themselves, who enjoy the rewarding opportunity to participate in meaningful activities in their communities.

This engagement highlighted four specific opportunities for collaboration as the non-medical community services model is further developed:

1. **BC Healthy Communities (Age Friendly Community Initiatives / designation):** The concept of a Continuing Care Hub aligns closely with the existing Healthy Communities initiative and may provide opportunities for exploratory funding for communities and neighborhoods. There are also opportunities to leverage a proven framework for developing neighborhoods that are safe and accessible for seniors and their families.
2. **BC Housing:** BC Housing has two initiatives that align with the outcomes of the Care Hub model: Shelter Aid for Elderly Renters (SAFER) and BC Housing Financing. The SAFER programs provide monthly rent subsidies for seniors with low to moderate incomes. BC Housing Financing provides access to construction financing for non-profit organizations building assisted living and long-term care. These two programs align with the Care Hub model by supporting seniors to stay in their community and increasing living options in communities where seniors are already located.
3. **Alzheimer Society of BC:** The Alzheimer Society of BC provides education and support to communities throughout BC. There are four possible areas for collaboration with the Care Hubs model – supporting Alzheimer Resource Centres (including the First Link Dementia Helpline), Dementia Friendly Action Plans, Alzheimer Society Support Groups and Minds in Motion. With the increasing impact of dementia on seniors, their families and service providers, collaborating with the Alzheimer Society will be critical to ensuring communities are safe and supportive.
4. **BC Divisions of Family Practice:** An integrated system of care would enable further collaboration with health authority services, community health services, specialized services and acute care. There may be opportunities to align with provincial goals of moving away from episodic and siloed care toward an integrated system that increases access to services as well as coordinates care and services.

CONCLUSION

While Continuing Care Hubs are yet to be widely adopted in B.C.'s cities and towns, the demands of Canada's aging demographic on our healthcare system will necessitate new policies to connect older adults to the services they need. Care Hubs are part of the answer.

It is beyond the scope of this paper or project to go into depth or attempt to address the issues identified in the numbered list below or, as noted earlier, to discuss all the key features and/or how to implement new Continuing Care Hubs. These also would likely be issues that would need to be addressed following extensive consultations with various stakeholders and probably best addressed through a committee that would be established of representatives from the BC Ministry of Health, Health Authorities, BCCPA and others.

Challenges and opportunities for Continuing Care Hubs

Some of these issues or challenges of implementing Care Hubs, as discussed earlier in this paper, include:

1. How the new models or networks will be funded both at macro and micro-level, including funding lift model and ensuring that any new additional services that are provided including sub-acute care be funded appropriately and commensurate with any additional work;
2. Determining criteria for what defines a Continuing Care Hub in British Columbia for operational or program purposes;
3. Establishing the list of services (medical / non-medical) that could be provided under each model;
4. Developing appropriate staffing and health human resource plans;
5. Revising as necessary regulations, legislation or other changes;
6. Development of appropriate information / IT systems;
7. Municipal considerations (zoning, building, etc.);
8. Rural considerations (access to transportation and other services);
9. Physical infrastructure (including equipment considerations); and
10. Revised contractual or other agreements.

Benefits of implementing Continuing Care Hubs

Better Access and Most Appropriate Care Setting

If implemented appropriately, the Continuing Care Hub has the potential to improve access to seniors care in B.C. In particular, the models could improve access to home health care services (including home support) provided to seniors in the community. Likewise, it could provide seniors with increased access to specialized or community health services regardless of whether living in long-term care or the broader community. Finally, with respect to access, the model could facilitate access to community non-medical services such as adult day programs (ADPs), recreational therapy, or even transportation services. In particular, Care Hubs could also allow seniors to remain in the most appropriate care setting while receiving necessary care or services.

Reducing Health System Pressures, Improving Quality and Integrating Seniors Care with Community

Care Hubs also have the potential to reduce health system pressures, such as better addressing growing levels of acuity as well as reducing alternate level of care (ALC) days and emergency room visits. They also have the potential to improve quality of care and quality of life for seniors. With respect to quality of care the models have the potential to not only increase access to a variety of services but also provide greater health promotion, as well as preventative care including chronic disease management and primary care.

The models also have the potential to increase access to life enhancing therapies such as recreational, occupational and physical therapy. Likewise, they could provide greater access to important non-medical services that enhance quality of care such as ADPs to reduce seniors isolation but also transportation options. Care Hubs, particularly the community non-medical services model, also has the potential to better integrate the current long-term care sector with the broader community, much like the Niverville model as discussed earlier. Finally, as also discussed in the 2019 BCCPA Bedlam paper, Continuing Care Hubs have the potential to reduce or mitigate some of the future demand for long-term care.

Now is the time to act and develop new care models, particularly the Continuing Care Hub in B.C., to improve the quality of seniors care. If implemented properly with appropriate resources, the Care Hub model could achieve the following outcomes or benefits as summarized in detail from the table below.



Potential Benefits of the Continuing Care Hub Model

- Better integrating seniors care with the broader community;
- Improving access for seniors to long-term care, home health care and other health areas;
- Ensuring seniors remain in most appropriate care setting;
- Improving the overall quality of seniors' life and care, including physical, spiritual, psychosocial and mental well-being in their remaining years through targeted initiatives (i.e. Recreational Therapy, Occupational therapy, Physical therapy, music therapy, food and nutrition, etc.);
- Ensuring the necessary resources, including human and physical infrastructure are available, particularly in rural and remote communities to provide appropriate care and living for seniors;
- Keeping seniors in the community healthier including reducing levels of chronic disease and achieving better health outcomes;
- Reducing unnecessary hospitalizations including seniors who occupy a more-costly acute care bed;
- Minimizing the deterioration in physical and mental functioning that can occur among seniors from prolonged stays in acute care;
- Improving social engagement and reducing levels of seniors' isolation;

- Better meeting the needs of a growing elderly population particularly those with high needs such as the frail elderly and dementia care;
- Strengthening the role and sustainability of the continuing care including long-term care, assisted living and home support to reduce overall health system costs;
- Better integrating the continuing care sector particularly long term and home health care;
- Providing affordable housing arrangements for care workers to recruit and retain such workers;
- Improving collaboration and working relationships with the continuing care sector;
- Reducing or mitigating some of the future demand for long-term care;
- Development of more pro-active approaches to seniors care including dementia; and
- Redirecting funding from more-costly acute to home and community care.

While this specific report makes no new recommendations, BCCPA encourages the provincial government to review and reconsider earlier ones that have been made on the Continuing Care Hub as outlined below with at least an initial focus on the community non-medical services model as outlined in this paper. This should also be done following extensive consultations with stakeholders and perhaps through a committee that would be established consisting of representatives from the Ministry of Health, Health Authorities, BCCPA and other stakeholders. In conclusion, BCCPA strongly encourages the BC Ministry of Health to consider the implementation of new Continuing Care Hubs as it moves forward reforming the health system to improve quality of care and quality of life for BC seniors.

Previous BCCPA Recommendations on the Continuing Care Hub	
<p>Bedlam in BC's Continuing Care Sector (2019)</p> 	<ul style="list-style-type: none"> • <i>That the BC government invest up to \$50 million per year over the next four years to support the introduction of new models or approaches of care such as the Continuing Care Hub to improve access to seniors care. Where appropriate, investments from this funding should be provided to initiatives or programs across the continuing sector including assisted living and home health care that can mitigate and/or reduce future demand for long-term care.</i>
<p>Health Begins at Home (2018)</p> 	<ul style="list-style-type: none"> • <i>That a new Seniors Quality of Life Fund (SQLF) be established by the BC government with designated funding to support seniors living at home and in congregate settings by:</i> <ul style="list-style-type: none"> ○ <i>Increasing access to recreational therapy, occupational therapy, physiotherapy, nutrition, culturally appropriate care, music and art programs;</i> ○ <i>Reducing seniors' isolation through increased Adult Day and similar programs; and</i> ○ <i>Enabling care hubs to work more collaboratively with local home health providers.</i>
<p>2018 Budget Submission (2017)</p>	<ul style="list-style-type: none"> • <i>That the BC government provide \$25 million in annual funding to support models such as the Continuing Care Hub to reduce acute care congestion and ER visits as well as better care for frail elderly and seniors with chronic conditions including dementia.</i>
<p>Strengthening Seniors Care (2017)</p>	<ul style="list-style-type: none"> • <i>That as a key priority any future BC Continuing Care Collaborative review options for new delivery models such as the Continuing Care Hub to reduce acute care congestion and ER visits as well as better care for frail elderly and seniors with chronic conditions and dementia. In particular, the BC government and Health Authorities should expand and/or introduce the Continuing Care Hub model in rural areas to increase the</i>

 <p>Strengthening Seniors Care: A Made-in-BC Roadmap #CanCareHere January 2017</p>	<p><i>level of medical and social services provided to seniors in the community.</i></p>
<p>Quality-Innovation-Collaboration (2015)</p>  <p>Quality • Innovation • Collaboration</p> <p>Strengthening Seniors Care Delivery in BC September 2015 BC CARE PROVIDERS ASSOCIATION</p>	<ul style="list-style-type: none"><i>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.</i>

APPENDICES

Appendix A: Overview of BC's home and community care system

Types of Home and Community Care Support	
Type of Support	Services / Supports Provided
Home Support	Home support , like home care services, are intended to support an individual's independence by supporting the person in their own home or in a care setting. Such services help seniors with bathing, personal care and meal preparation. In BC, home support workers, also referred to as Community Health Workers (CHWs), help seniors with daily activities such as getting up and around, changing clothes, using the bathroom, preparing meals and taking medications. In addition to these services, home support may include safety maintenance activities and specific nursing and rehabilitation tasks that have been delegated by regulated health professionals. ¹⁰⁹
Choice in Supports for Independent Living	Clients receive funds, either directly or through a client support group, to purchase and manage their own home support services. Home care programs support citizens of all ages by providing an array of services including health promotion, treatment, end of life care and rehabilitation. According to CIHI, home care includes professional services such as nursing care, physiotherapy, occupational therapy, speech therapy, respiratory therapy, nutrition, counselling, and social services. While not exhaustive, some of the services generally undertaken by nurses or other regulated health professionals include:
Home Care	<ul style="list-style-type: none"> • Prevention, screening and service intake; • Assessment of health status and/or medical condition; • Performing treatments and procedures; • Rehabilitation; • Medication administration / pharmaceutical assistance; • End of life care; and • Health promotion and fostering greater self-care.¹¹⁰
Adult Day centres	Supportive group programs for seniors and adults with disabilities living at home. May include bathing programs, personal care, social activities, meals, and transportation.
Caregiver relief / respite	Temporary relief to informal caregivers in either the client's home, or the client may be admitted temporarily to a care home.
Assisted Living	Publicly subsidized apartments with support services for frail seniors and people with disabilities. Housing, meals, laundry, housekeeping, and some personal care services are provided. Nursing care is not provided but is a 24-hour emergency response system in place.
Long term care home	24-hour professional nursing care and supervision in a care home.
Family Care Homes	Single-family residences that provide supportive accommodation for up to two residents.

¹⁰⁹ BC Ombudsperson. The Best of Care: Getting it Right for Seniors in British Columbia (Part 2). February 2012. Accessed at: <https://www.bcombudsperson.ca/documents/best-care-getting-it-right-seniors-british-columbia-part-2>

¹¹⁰ Review of Quality Assurance in Continuing Care Health Services in Alberta. Health Quality Council of Alberta. April 2014. Accessed at: https://d10k7k7mywg42z.cloudfront.net/assets/538f500bd6af685f2a000136/Continuing_Care_FINAL_Report.pdf

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.

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 long-term 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: Comprehensive Home Options of Integrated Care for the Elderly

Developed in 1996, the Comprehensive Home Options of Integrated Care for the Elderly (CHOICE) program in Edmonton, Alberta has become a recognized delivery model for home care 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.¹¹¹ Under CHOICE, seniors are delivered all basic health services – this includes personal care (bathing, etc.), dental care, respite care, meals and snacks, medication and home care services.¹¹²

The program offers care to seniors who have complex long-term care issues and live at home. Clients must be willing to change their health care provider and should be able to use transportation provided by the program.¹¹³ Two examples of the CHOICE Program are the independent living complex of the Good Samaritan Place and onsite at the continuing care centre / auxiliary hospital of Dr. Gerald Zetter Care Centre in Edmonton.¹¹⁴ According to Alberta Health Services, six months after joining the program, all CHOICE clients saw a reduction in emergency visits by 30 per cent.¹¹⁵

The CHOICE program in Edmonton was modeled after 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.¹¹⁶ The idea developed to address the needs of elders that had immigrated from Italy, China, and the Philippines whom required continuing care services, 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.¹¹⁷ On Lok Lifeway care providers work in interdisciplinary teams to offer similar services at a specific location or centre.

Similar to the CHOICE program, the PACE model's key features include flexibility (i.e. coordinating care based on individual needs), all-inclusive care preventive, primary, acute and continuing care, interdisciplinary teams, and capitation funding.¹¹⁸ The PACE program offers community care to seniors aged 55 and up, where CHOICE offers the program to anyone 60 or older. One disadvantage of both the PACE and CHOICE programs are that they do not include frailer portions of society, as one of the program requirements is that seniors must be certified by government to require home care.

¹¹¹ 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

¹¹² Hollander Analytical Services Ltd. (2006). Home care program review: Final report. Accessed at: http://www.health.gov.sk.ca/HomeCareReview2006_FinalReport.pdf

¹¹³ Choice© Program. The Good Samaritan Society, accessed at: <https://www.gss.org/find-housing-support-services/community-care/choice/>

¹¹⁴ 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/>

¹¹⁵ Alberta Health Services. Accessed at: <http://www.albertahealthservices.ca/1362.asp>

¹¹⁶ McGregor Pace. “History of Pace”. Accessed at: [HTTP://WWW.MCGREGORPACE.ORG/ABOUT/HISTORY/](http://WWW.MCGREGORPACE.ORG/ABOUT/HISTORY/)

¹¹⁷ 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>

¹¹⁸ What is PACE? On Lok PACEpartners, accessed at: <http://pacepartners.net/what-is-pace/>

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