Ministry of Health

Transition Briefing Material

Overview Binder

July 2017

PARLIAMENTARY SECRETARY FOR SENIORS
Anne Kang

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BC Ministry of Health
Seniors Services

July 26, 2017

BRITISH COLUMBIA

Agenda

- BC Health System Overview
  - Governance/Funding
  - Legislative Framework
  - Public vs Private
- Key Reports on Seniors Care
- Home and Community Care Services
  - Accessing HCC Services
  - Home Health Services
  - Assisted Living Services
  - Residential Care Services
- Seniors Health Promotion and Support Services
  - Better at Home
  - Age Friendly
  - Elder Abuse Prevention
  - Aging Well
- Areas of Focus for Seniors Care
- Future of Seniors Services

BRITISH COLUMBIA

Ministry of Health Role

Overall responsibility for ensuring that quality, appropriate, cost-effective and timely health services are available for all British Columbians

Working in conjunction with health authorities, health care providers, agencies and other organizations, the Ministry guides and enhances the Province's health services to ensure that British Columbians are supported in their efforts to maintain and improve their health

Provides leadership, direction and support to health service delivery partners and sets province-wide priorities, goals, standards and expectations for health service delivery by health authorities

Leadership role is accomplished through development of province wide health system policy, legislation and professional regulation, funding decisions, negotiating and bargaining, and accountability framework for health authorities

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Health Services in BC

- *Canada Health Act* (federal) governs work of the Ministry and establishes conditions the provinces must meet in order to receive federal funding contributions towards provincial health insurance costs

- The Ministry oversees provincial legislation and regulations governing provision of health care in B.C. such as:
  - *Medicare Protection Act*, which provides the parameters for benefits under the Medical Services Plan and for enrollment and payment of practitioners
  - The *Health Professions Act*, which regulates 26 health professions in British Columbia

- The Ministry directly manages a number of provincial programs and services including:
  - Medical Services Plan, which covers most physician services
  - PharmaCare, which provides prescription drug insurance for British Columbians
  - BC Vital Statistics Agency, which registers and reports on vital events such as a birth, death or marriage

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Seven Provincial Health Authorities

- Organizations primarily responsible for health service delivery
- Five regional health authorities deliver a full continuum of health services to meet the needs of the population within their respective geographic regions:
  - Vancouver Island (Island Health)
  - Vancouver Coastal
  - Fraser
  - Interior
  - Northern
- Provincial Health Services Authority manages province-wide specialized health programs/services for cancer, disease control, renal, transplant, cardiac, ambulance
- The First Nations Health Authority provides services previously delivered by Health Canada's First Nations and Inuit Health Branch, Pacific Region, with a mandate to focus on improving wellness

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Regional Health Authorities

- Receive global funding from the Ministry
- Public health, hospital care, integrated primary and community care:
  - Mental health and substance use
  - Home and community care ($2.9B in 2015/16)
    - $1.089B community (home health and assisted living)
    - $1.860B residential care
  - Primary health care
- Deliver many services directly
- Also contract with not-for-profit and for-profit service providers for a wide variety of services
- Provide grant funding to many community organizations for partnerships
- Work collaboratively with physicians and surgeons

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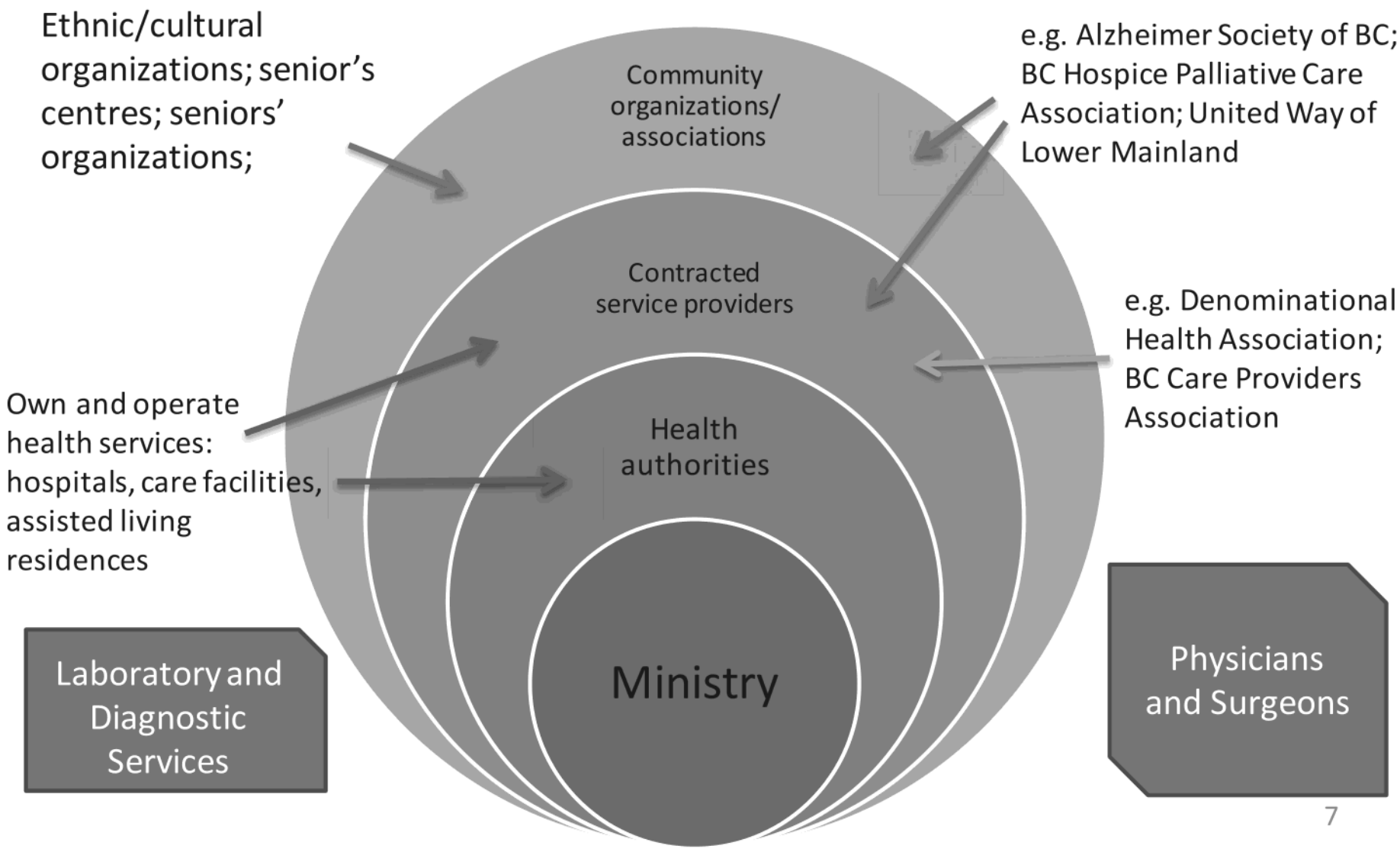
Other Partners in the Health System (seniors' services)



Legislation and Regulations

Prescribed programs and the fees to be assessed for services

- Continuing Care Act
  - Continuing Care Programs Regulation
  - Continuing Care Fees Regulation
    - Home Support
    - Assisted Living
    - Residential Care
- Hospital Insurance Act
  - Hospital Insurance Fees Regulation

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Other Relevant Legislation

- *Health Authorities Act*
- *Community Care and Assisted Living Act*
  - Community Care and Assisted Living Regulation (list of prescribed services)
  - Assisted Living Regulation (1 – 2 prescribed services)
  - Residential Care Regulation (3 or more prescribed services)
- *Hospital Act*
- *Health Care (Consent) and Care Facility (Admission) Act*

http://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/accountability/legislation-governing-seniors-care

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Publicly Subsidized or Private Pay Services

Publicly Subsidized Services:

- Are accessed through the health authority;
- Are accessed by the individual/representative who meets general provincial eligibility criteria and agrees to participate in a formal assessment that is conducted by their health authority and are assessed as having needs that can be met by the services;
- Are subsidized by the Ministry of Health and administered and delivered by the health authorities and other contracted providers; and
- While individual preference for service is considered, the individual's need as determined by a formal assessment is the primary consideration in determining which service is provided.

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Publicly Subsidized or Private Pay Services (cont'd)

Private Pay Services:

- Are accessed by the individual directly from the service provider;
- Each individual can shop and compare for services that best meet their needs and preferences;
- All aspects of service provision are agreed to by the individual and the service provider; and
- Government does not provide any financial assistance to individuals or service providers for the service.

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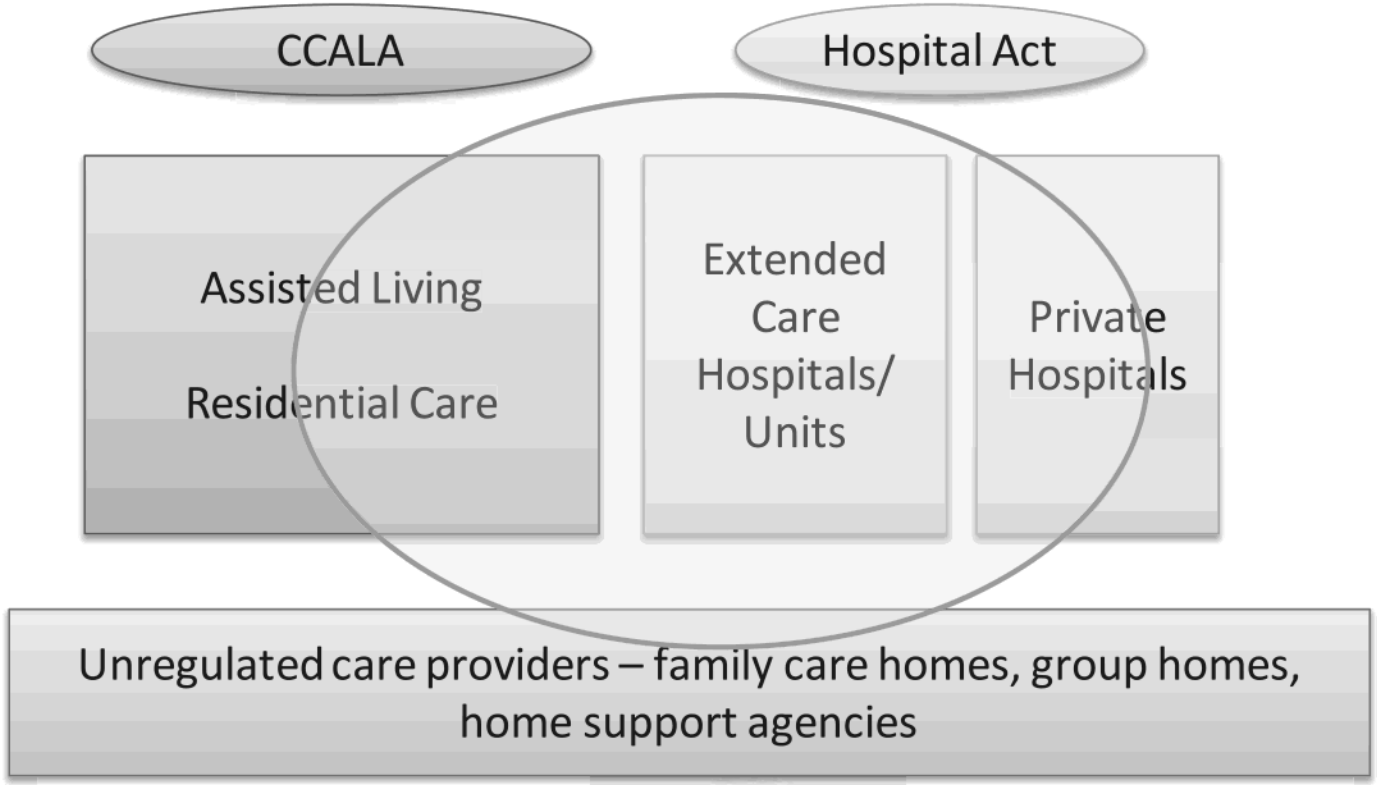
Home and Community Care Service Providers – Public/Private



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Key Reports on Seniors Care

- *Aging Well in British Columbia*, Premier's Council on Aging and Seniors' Issues, December 2006
- Ombudsperson's Report on Seniors Care: *Best of Care: Getting it Right for Seniors in British Columbia*", February 2012
  - Covered Home and Community Care in general, and home support, assisted living and residential care services
  - 149 findings and 176 recommendations
- Office of the Seniors Advocate – multiple reports on a wide range of issues related to seniors including care and information resources
- Other organizations such as the BC Care Providers Association and the BC Law Institute also publish reports on seniors care

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Home and Community Care Services

Purposes of HCC Services

- Post acute care
- Maintenance for stable clients
- Long term supportive care for less stable clients
- Functional rehabilitation and reactivation
- Palliative and End of Life care
- Respite for caregivers

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HCC Services

Home Setting Includes Supportive Housing and Group Homes	Assisted Living Setting	Residential Care Setting
Home Support Services Adult Day Programs Health Services for Community Living Choice in Supports for Independent Living	Personal Care Services 24/7 Emergency Response Meals, Laundry, Recreational/Social Activities and Housekeeping Support	24/7 Professional Supervision Nursing Care Medical Coordination Personal Care Services Rehabilitation Activities Programs Social Work Dietician Meals and Housekeeping
Services Across Community Settings Community Nursing Care Community Rehabilitation Social Work Pharmacy Quick Response Teams Home Oxygen Facility Access and Transition Dietician Services		
Services Across All Settings Palliative and End-of-Life Care, Case Management		

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HCC Services

- Home Health Services
  - Case Management
  - Community nursing and community rehabilitation
  - Home Support (including Choice in Supports for Independent Living - CSIL)
  - Adult Day Programs
- Assisted Living
- Residential Care
- Hospice
- Palliative Care and Benefits

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Accessing HCC Services

- Referrals through:
  - Physician, hospital or other agencies
  - Family or friend
  - Self
- Health authority case manager/health professional determines client's:
  - eligibility for services
  - health care needs through an interRAI Home Care assessment (for long-term clients)
  - amount of client rate towards cost of services (if a fee applies)

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Home Health Services

- Case Management
- Community nursing and community rehabilitation
- Home Support (including Choice in Supports for Independent Living - CSIL)
- Adult Day Programs

BRITISH COLUMBIA

Case Management

- Delivered by health authority staff - usually registered nurse, social worker, occupational therapist (sometimes physical therapist)
- Services include:
  - Assessment
  - Care planning
  - Determining eligibility for HCC services
  - Calculation of client rate
  - Coordination of services
  - Referrals - community nursing or rehab services, other community services
  - Caseloads of 100 – 150 clients
- Role is starting to shift with introduction of multi-disciplinary teams, proactive case finding, more specialization

About 49,000 clients and almost 210,000 visits in 2015/16

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Community Nursing and Community Rehabilitation

- Delivered by health authority registered nurse or rehab therapist (e.g. PT, OT, Nutritionist, Respiratory Therapist)
- Services include:
  - dressing changes
  - pain management
  - strengthening exercises
  - seating assessments
  - household adaptation
  - specialized diet management
- Care at home following discharge from acute care, to prevent hospitalization or for palliative/ end of life care
- No cost to client
- About 87,000 clients and over 1 million visits in 2015/16 (nursing, rehab and other professional services)

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Home Support

- Home support worker provides personal care services, such as assistance with:
  - bathing
  - dressing
  - transfers
- Services allow clients to remain in their own home as long as possible
- Delivered by:
  - health authority; or
  - under contract with agency
- About 42,000 clients (including CSIL) and over 11 million hours in 2015/16
- Average of 262 hours/year/client

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Home Support Client Fees

- No charge if client receiving:
  - Guaranteed Income Supplement (GIS)
  - BC Disability Assistance
  - War Veteran's Allowance
- If client required to pay, income-based fee calculation is applied
- About 68% of home support clients do not pay fees
- Hardship provision for all services that have fees (home support, assisted living and residential care)

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Home Support - CSIL

- CSIL = Choice in Supports for Independent Living
- A self-managed home support option:
  - Health authorities provide funding directly to eligible clients
  - Allows clients to purchase and supervise their own personal care services
  - Clients with a physical disability and high-intensity care needs
  - People who cannot manage CSIL on their own may be eligible if a client support group or an individual designated as a representative through a Representation Agreement is acting as the CSIL employer
- Funding based on assessed need (convert hours to dollars)
- About 956 clients currently use CSIL as of 2015/16
  - 2% of home support clients

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Adult Day Services

- Assists people to live in their own homes
- Provides a variety of supportive programs and activities in a community group setting
- Services may include:
  - personal assistance
  - health care services including nursing and/or rehabilitation services
  - nutrition and bathing, foot care, blood pressure clinics
  - meals, therapeutic social and recreational activities
  - caregiver support, including respite, activities such as caregiver support groups, information and education programs
- Minimal daily fee ($10) assists with cost of meals, transportation and craft supplies
- About 6,200 clients and about 259,000 days in 2015/16

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Assisted Living

- Assisted living provides:
  - private room with lockable door
  - hospitality services - meals, housekeeping, laundry, social and recreational activities, 24-hour emergency response system
  - personal care services such as assistance with bathing, grooming, transfers and taking medications
- Clients can direct own care but require assistance with activities of daily living
- Clients do not require 24-hour nursing care and supervision
- Scheduled and unscheduled personal care available to meet client needs
- About 6,000 clients and 1.8 million days in 2015/16
- 4,453 assisted living units reported by HA's as of March 2017

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Assisted Living

- Clients pay 70% of after-tax income
- Monthly costs range from $931.50 to about $3,400
- Assisted Living Registrar established in legislation to ensure health and safety of clients

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Residential Care Facility

- 24-hour professional nursing and supervision:
  - clients have complex care needs
  - can no longer be cared for in their own homes
- Services include:
  - nursing care and supervision
  - assisted meal service
  - medication supervision
  - personal assistance with daily activities – bathing/dressing/grooming
  - planned program of social/recreational activities
- May provide short-term care, respite care or hospice care
- Some may provide convalescent care
- About 40,000 clients and about 10 million days in 2015/16 (including convalescent care)
- 27,700 residential care beds reported by HA's as of March 2017 (excludes family care home and group home beds)
- Licensed under the CCALA or regulated under the *Hospital Act*

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Residential Client Fees

- Residential care rates are based on up to 80% of client income
- Clients are left with $325/month residual income
- Minimum monthly rate is $1,104.70
- Maximum monthly rate is $3,240.00
- Short-term rate is $36.30/day or $1,104.70/month
- Rates are adjusted annually, based on changes in the consumer price index

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Group Homes

- Private residences that enable adults with a physical disability to live as independently as possible in the community
- Services include:
  - short- and long-term living arrangements
  - affordable, safe housing
- Support the adult's responsibility in:
  - household management
  - vocational pursuits
  - social relationships
- Also receive assistance with:
  - meals
  - medications
  - activities of daily living – such as dressing/grooming
- Clients do not pay a fee but are responsible for all living costs such as shelter, food and utilities
- 90 Group Home Beds reported by HA's as of March 2017

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Family Care Homes

- Single family residence
- Supportive accommodation for up to two clients
- Alternate to a care facility for some clients
- A home-like atmosphere that provides:
  - meals
  - housekeeping
  - personal assistance for activities such as bathing, grooming and dressing
- More numerous in rural areas to allow clients to remain closer to their communities
- Pay a monthly fee same as clients in a residential care facility
- 65 FCH Beds reported by HA's as of March 2017

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Palliative/End-of-Life Care

- Supportive and compassionate care for both client and their care givers
- Approach to life limiting illness applicable early in the course and in conjunction with other therapies that are intended to prolong life
- Provided wherever the client is living, whether in home, hospice, assisted living, residential care or hospital
- Community services include palliative care co-ordination and consultation, professional nursing services, community rehabilitation services, home support and respite for the caregiver
- Palliative care services relieve, eliminate and/or control symptoms so those facing death, and their loved ones, can devote their energies to embracing the time they have together

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Palliative Care Benefits Program

- Available to BC residents of any age
- For people who have reached the end stage of a life-threatening disease or illness
- For those who wish to receive palliative care at home
  - meaning wherever the person is living, whether in their own home, with family or friends, in a supportive/assisted living residence, or in a hospice unit at a residential care facility

- Two components:
  - a ministry program that covers the cost of certain prescription drugs
  - a health authority program that provides certain medical equipment and supplies

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Hospice

- Residential, home-like setting
- Supportive and professional services for persons of any age who are in the end stages of an illness
- Services may include:
  - medical and nursing care
  - advance care planning
  - pain and symptom assessment and management
  - psychosocial, spiritual and bereavement support
  - access to specialized prescription medication, supplies and equipment
- Pay the same fee as short-term residential care client
- Short-term stay

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Seniors Health Promotion and Support Services

Seniors Health Promotion & Support Services

- Ministry provides to the Centre for Hip Health and Mobility for Active Aging BC of which delivers the Choose to Move program
- Ministry provides active aging grants through the United Way of the Lower Mainland (grants to community organizations that serve older British Columbians, focussed to support vulnerable seniors to be physically active, enable older adult's independence and enhance social connectedness). http://www.activeagingbc.ca/

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Seniors Health Promotion & Support Services

- Through Aging Well, BC Healthy Communities (BCHC) receive funding to work with several community-based seniors organizations to deliver workshops to help older people plan and prepare for aging in the areas of health, finances, housing, transportation and social connections.
  https://www.healthyfamiliesbc.ca/aging-well

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Serving seniors in the community

- Better at Home
  - Expands non-medical home support (such as light housekeeping, yard work, grocery shopping, transportation services and friendly visiting)
  - Managed by United Way of the Lower Mainland

s.13,s.17

  - 61 established programs + 6 rural/remote pilot sites, 4 of which are on First Nations reserves
  - Complements Home and Community Care

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Age-Friendly BC

- Age-friendly Communities Program:
  - Grants up to $20,000 awarded to local governments to support community planning and/or projects to enable seniors to age in place
- Age-friendly BC Recognition:
  - Awards local government for their commitment in supporting older residents to remain healthy and active in their communities
- Tools and Resources:
  - Dedicated website: www.gov.bc.ca/agefriendly
  - Age-friendly BC Toolkit (online resources to assist local government and business to become age-friendly)

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Information and resources

Information suite for seniors and families, including:

- Advance Care Planning
- B.C. Seniors Guide
- Enhanced websites
  - www.gov.bc.ca/hcc
  - www.SeniorsBC.ca
- Dementia support information
  - Alzheimer Society BC First Link® Program
- Elder Abuse information kits
- Online Facility & Residence Reports
  - Residential Care and Assisted Living

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Protection

- Expanded Community Response Networks (CRNs)
  - Network of individuals, groups and agencies from diverse sectors (e.g., First Nations, justice, health authorities, not-for-profit, and police) that work together at the community level to promote a coordinated community response to adult abuse and neglect
  - As of February 2017, there were 66 CRNs (including a provincial Francophone CRN) active in 157 BC communities and over 1,000 community organizations connected to CRNs, with new communities continually being added
  - Provided $1.4M in 2012 and $2.6 million in 2014/15 to coordinate local actions to prevent/respond to elder abuse and neglect over 3 years
- The Ministry invested to expand the capacity and hours of the Seniors Abuse and Information Line (SAIL), which is operated by Seniors First BC
- The Ministry produced and disseminated Elder Abuse Prevention Kits to over 600 organizations in B.C.

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Aging Well

- Online resource to support and motivate older British Columbians to plan and prepare for aging.
- Evidence-based content, tools and videos on health, finances, housing, transportation and social connections (including fall prevention, health eating, physical activity, mental wellness, protection from elder abuse and more).
- Workshops on Planning for Aging Well, managed by BC Healthy Communities Society, to engage seniors face-to-face. Five workshops have been delivered and more are planned. Includes an open-source workshop facilitation kit for seniors organizations and centres throughout BC.
- HealthyFamiliesBC.ca/Aging-Well

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Areas of Focus for Seniors Care

Areas of Focus for Seniors Care

- Improve home care services
- Strengthen seniors' centres around the province
- Ensure the staffing of public and private care homes meets government guidelines, and provide additional funding to address staffing levels in public facilities
- Develop an all-party Select Standing Committee on Seniors – refresh Council on Aging and Seniors' Issues 2006 report

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Future for Seniors Services

- Recommendations from Ombudsperson and Seniors Advocate
- Advocacy from Client Groups
- New Model of Care for Seniors with Complex Chronic Health Conditions
  - Multi-disciplinary teams
  - Different HA staff "authorizing" services
  - Policies need to be reviewed and revised

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QUESTIONS?

Further Resources

HCC Website:

http://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care

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Health System Seniors Services

OVERVIEW

Services provided to seniors fall into two main categories: 1) home and community care services which are managed and delivered by the regional health authorities; and 2) health promotion supports and services for seniors which are provided primarily through other organizations such as the United Way, community seniors' organizations and municipal governments.

The Seniors Services Branch is part of the Primary and Community Care Policy Division (see section below under Roles and Responsibilities). The role of the branch is to provide current, evidence informed policy in priority areas affecting seniors' services in BC, and is also responsible for monitoring performance of home and community care services, and regulatory oversight for both assisted living residences and licensed care facilities. There are a few health promotion activities in which the Branch is involved, but some of them are managed through other branches in the Ministry.

STRUCTURE

Home and Community Care Services

The home and community care services sector provides a range of clinical and support services focused on individuals living in their own homes, or in home like settings. Services include professional care such as nursing, rehabilitation therapy and social work; services unique to the community setting such as home support and adult day programs; and a variety of health services provided in specialized accommodations such as assisted living and residential care facilities.

People receiving home and community care services may have a short term need, due to an episode of illness, surgery or specialized treatment, or a long term need as a result of a chronic condition or life limiting illness. Although home and community care services are provided to adults of all ages, the majority of clients are seniors.

Because home and community care services are provided to those living in the community, the factors influencing the plan of care are much broader than in a controlled hospital setting. Health services in the community are provided to supplement the efforts of the client and their family to manage their own condition, which means understanding not just clinical needs, but also functional and psycho-social needs, cultural influences and a recognition that what defines quality of life is unique to the individual.

Home and community care has been described as "a complex terrain"[1]. Not contained by the physical structures of the hospital, and including care facilities but ranging beyond them and throughout the community, home and community care services may be combined into bundles or delivered individually to address specific needs. Clinical and service supports are linked to the medical assessment and treatment plan but often require a different focus to address functional abilities, activities of daily living, availability of informal support and the personal goals of the individual.

Home and community care services are generally designed to:

- Help individuals remain independent in their own homes for as long as possible;
- Provide short term care at home where possible to either avoid hospitalization or to minimize extended hospital stays;
- Provide alternate extended care options, like assisted living and residential care, when it is not possible to stay at home; and
- Support individuals at end of life.

[1] Williams, A. Paul. Canadian Research Network for Care in the Community, Building for Change, Integrated Services for Seniors. Keynote Presentation to North West LHIN, Thunder Bay.

Health System Seniors Services

Home and Community Care Clients: In 2015/16, home and community care services were provided to approximately 142,200 individual clients across the province, with roughly 87,300 receiving professional services; 42,200 receiving home support services; 6,200 receiving adult day programs; 6,000 receiving assisted living services and 40,200 receiving residential care services.[2]

Of the approximately 142,200 individuals receiving home and community care services in 2015/16, 83% were 65 or older. However, for those receiving residential care or assisted living services 91% were 65 and older.[3] Publicly subsidized residential care services are provided to approximately 5% of the total senior's population (65 and older).

Over the past decade, growing numbers of clients with urgent needs, and the need to reduce pressure on the acute care system has drawn community care disproportionately towards urgent and acute response, and residential care settings now manage clients with more complex care needs, as well as post- acute convalescence and palliative care. Clients discharged from hospital now have very high medical and/or rehabilitative care needs, and are much less stable than was the case when many of the current service models were designed.

The information provided below provides some indication of the complexity of care needs being addressed by home and community care services. While this data is from a 2007 extract of all initial assessments of HCC clients with the interRAI Home Care assessment instrument, the profile, if anything, has only become more complex[4]:

Clients

- 79% were aged 75 or older, with 18% aged 90 or older.
- 64% were widowed, divorced or single
- 45% had a primary caregiver living with them, 13% had a secondary caregiver living with them
- 61% were female, 39% male
- 48% of clients were alone for long periods of time

Caregivers

- More than 50% of primary caregivers indicated they could not increase the amount of emotional supports, or supports with Instrumental Activities of Daily Living, or Personal Activities of Daily Living
- 13% of caregivers indicated they were unable to continue providing care
- 20% expressed distress, anger or depression

Functional Abilities

- 63% of clients were assessed as in danger of falling due to an unsteady gait, and 37% limited outdoor activities due to a fear of falling
- 33% have pain that disrupts daily activity
- 52 % of all clients had a decline in their "Activities of Daily Living" abilities in the prior 90 days
- 55% have great difficulty preparing meals
- 76% do not think they can increase their functional ability

Medical Challenges

- 37% were taking nine or more medications in the previous seven days
- 58% had some impairment in making everyday decisions
- 30% had dementia (Alzheimer's and non-Alzheimer's)

[2] BC Ministry of Health (January 5, 2017). HCC Client Counts and Service Volumes by HSDA (2016-0684).
[3] BC Ministry of Health (January 5, 2017). HCC Client Counts and Service Volumes by HSDA (2016-0684).
[4] HCC Client Profiles RAI HC Analyses, 2008

- 40% had arthritis
- 47% had hypertension

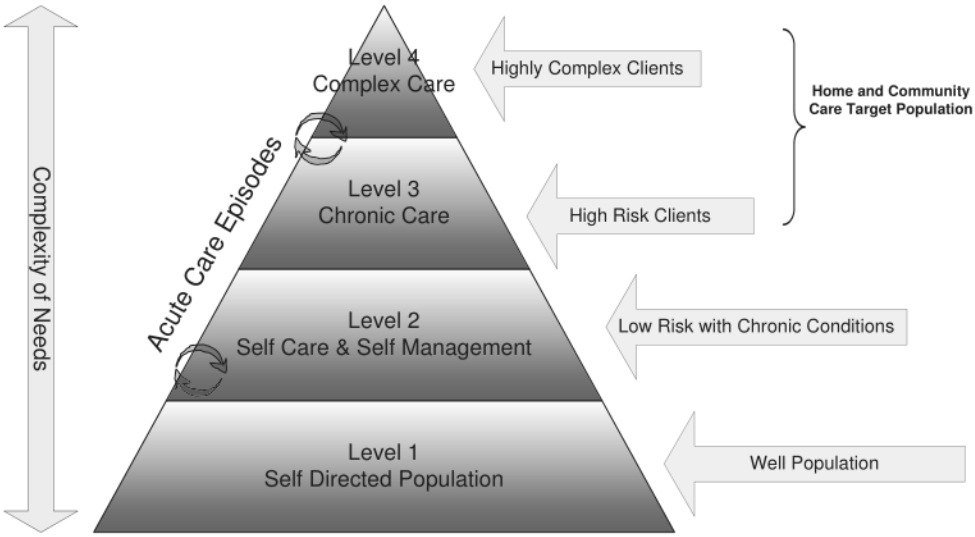
Choices

- 63% of clients and caregivers indicated that they do not feel the client would be better off in a different location
- 13% have advanced health care directives in place

Another way to portray home and community care clients is from a population lens. The "Home and Community Care Complexity of Needs Triangle" was developed based upon the "Kaiser Permanente Population Health Model"[5] and the National Health Service and Social Care Model, "Supporting People with Long Term Conditions"[6] as part of work on developing a care management strategy for home and community care (see Figure 1). The BC triangle is a generic model which can be applied to all client populations. The model recognizes that clients will have episodes of interaction with acute care services and provides a mechanism to ensure integration with both acute care and primary health care.

This version of the triangle shows a proposed change in focus for providing clinical and care management support to Level 3 and Level 4 populations, and is supported by additional documentation on a proposed care management service delivery model for home and community care services.

Figure 1: Home and Community Care Complexity of Needs Triangle



Range of Current HCC Services and Service Delivery: In BC, home and community care services are available from both private-pay and publicly subsidized providers:

Private pay services are accessed by clients directly from a service provider. Individuals can explore various options for services that best meet their needs and preferences. The individual and the service provider agree to all aspects of the service provision. Government does not provide any financial assistance to individuals or service providers for the service.

[5] University of Birmingham and NHS Institute for Innovation and Improvement (2006). *Improving care for people with long-term conditions: A review of UK and international frameworks*.

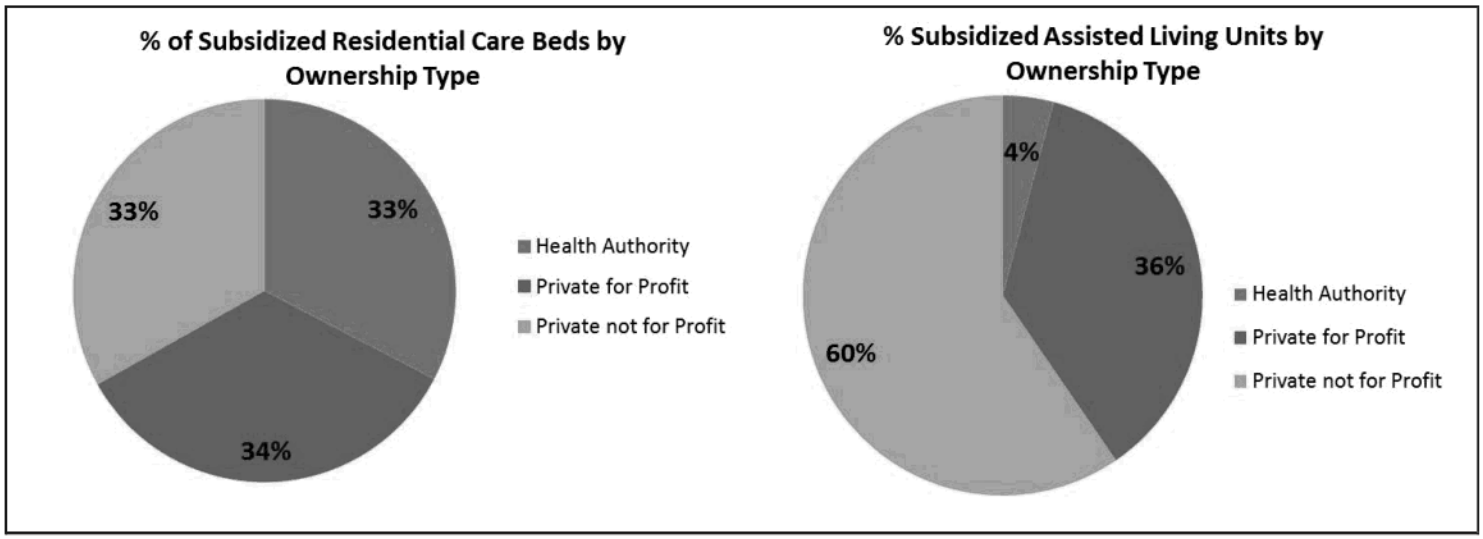
[6] Department of Health (January, 2005). *Supporting people with long-term conditions: An NHS and social care model to support local innovation and integration*. United Kingdom.

Health System Seniors Services

Publicly subsidized home and community care services are accessed through the health authorities, based on provincially set eligibility criteria. Services are subsidized by the Ministry of Health and administered and delivered by the health authorities and contracted providers. While individual preference for service is considered, the individual's need as determined by a formal assessment is the primary consideration in determining the type and mix of services that are provided. Health authorities may provide these services directly or through contracts with not-for-profit and for-profit service providers.

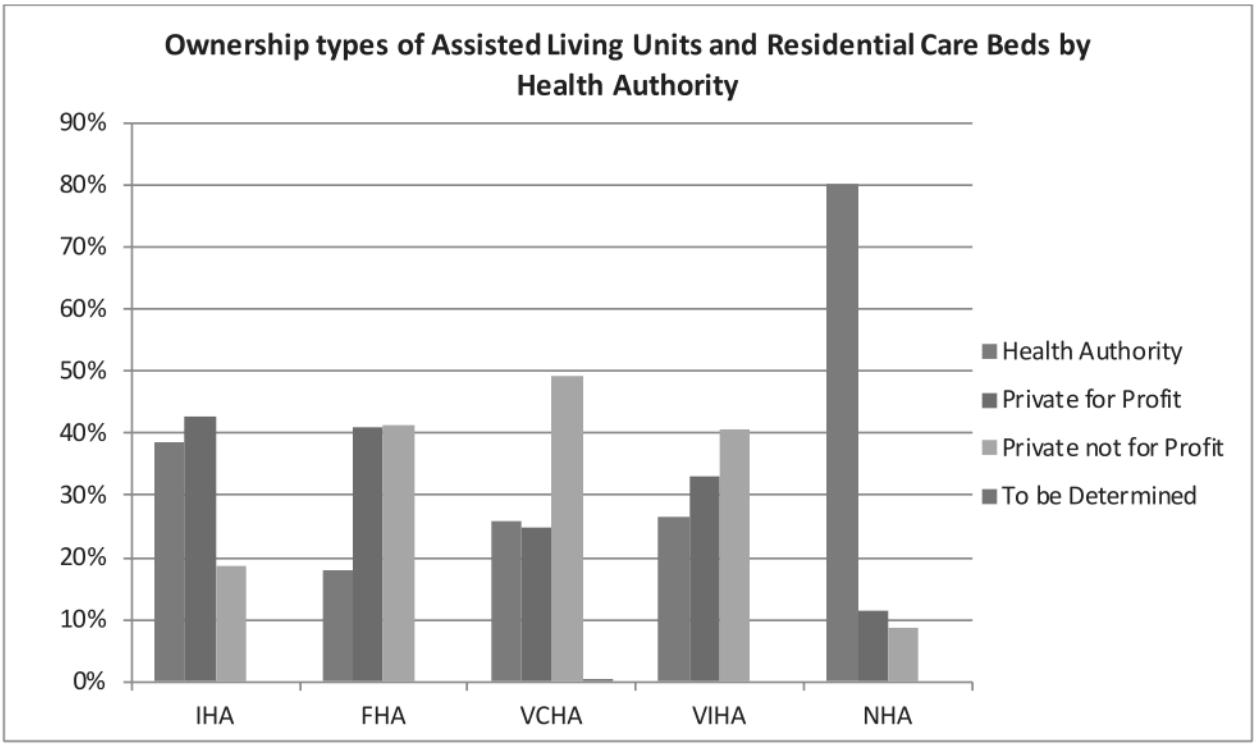
As of March 31, 2017, 34% of subsidized residential care beds and 36% of subsidized assisted living units were privately owned and operated; 33% of all subsidized residential care beds are owned and operated by health authorities directly, but only 4% of subsidized assisted living units are owned and operated by health authorities. Additionally, 60% of all publicly subsidized assisted living units are owned and operated by not-for-profit enterprises (see Figures 2).

Figure 2: Breakdown of Residential Care Ownership Type in BC as of March 31, 2017



Health authorities have contracts with service providers that establish deliverables based on compliance with policies and standards as well as reporting requirements. Each health authority has a mix of ownership types used to provide subsidized services, but there are notably a higher percentage of not-for-profit enterprises in the Vancouver Coastal Health Authority (49%), and less contracted (of either for profit or not-for-profit) service providers in Northern Health Authority where 80% of residential care and assisted living services are owned and operated by the health authority (see Figure 3).

Figure 3: Ownership types of Assisted Living Units and Residential Care Beds by Health Authority as of March 31, 2017



Publicly subsidized home and community care services are provided to people who are able to continue to live in their own homes and to people who require care in a supportive housing environment including family care homes, assisted living and residential care facilities (see Table 1).

Health System Seniors Services

Table 1: Publicly Subsidized Home and Community Care Services

<table>
<tr><th>Home Setting
Includes Supportive Housing</th><th>Housing and Health Services
Includes Group Homes, Family Care Homes and Assisted Living</th><th>Residential Care Setting</th></tr>
<tr><td>○ Home Support Services
○ Adult Day Services
○ Health Services for Community Living (HSCL)
○ Choice in Supports for Independent Living (CSIL)</td><td>○ Personal Care Services
○ 24/7 Emergency Response
○ Meals, Laundry, Housekeeping Support & Recreational/Social Activities</td><td rowspan="3">○ 24/7 Professional Supervision
○ Nursing Care
○ Medical Coordination
○ Personal Care Services
○ Rehabilitation
○ Activities Programs
○ Social Work
○ Dietician
○ Meals and Housekeeping</td></tr>
<tr><td colspan="2">Services Across Community Settings</td></tr>
<tr><td colspan="2">○ Community Nursing
○ Community Rehabilitation
○ Social Work
○ Pharmacy
○ Quick Response Teams
○ Home Oxygen
○ Facility Access and Transition
○ Dietician Services</td></tr>
<tr><td colspan="3">Services Across All Settings</td></tr>
<tr><td colspan="3">Hospice Palliative Care, Case Management, Respite Care</td></tr>
</table>

Services provided include:

Community Nursing Services: are provided by a licensed nursing professional to clients in the community who require acute, chronic, palliative or rehabilitative support. Services include assessment and nursing interventions such as education, wound care, medication management, chronic-disease management, care management, post-surgical care and palliative care. Generally, community-nursing services will be provided on a short-term basis and community nurses assist clients and their families to be confident in taking over care at home. Community nursing services may be provided in a variety of settings such as clinics, the client's home, assisted living residences, family care homes, group homes, or other community settings.

Community Rehabilitation Services: are provided by a licensed physical therapist or occupational therapist to clients who require acute, chronic, palliative or rehabilitative support. The main goals of rehabilitation therapy are to help improve or maintain physical and functional abilities and to provide assessment and treatment to ensure a client's home is suitably arranged for their needs and safety. Generally, community rehabilitation services will be provided on a short term basis and community rehabilitation therapists assist clients and their families to be confident in taking over care at home.
Community rehabilitation services may be provided in a variety of settings such as clinics, the client's home, assisted living residences, family care homes, group homes, or other community settings.

Adult Day Services: include an organized program of personal care, health care and therapeutic social and recreational activities in a group setting that meet client health care needs and/or caregiver needs for respite. In some cases transportation is provided, while in others clients are responsible for their own transportation to and from the program. Many adult day service programs are connected with residential care facilities, while others operate independently.

Health System Seniors Services

Home Support Services: are designed to help clients remain independent and in their own home as long as possible. Home support services are provided by community health workers to clients who require personal assistance with activities of daily living, such as mobilization, nutrition, lifts and transfers, bathing, cueing, grooming and toileting, and may include safety maintenance activities as a supplement to personal assistance when appropriate, as well as specific nursing and rehabilitation tasks delegated by health care professionals.

Choice in Supports for Independent Living (CSIL): provides eligible home support clients (clients living with physical disabilities and who have high-intensity care needs) more flexibility in managing their home support services. CSIL clients, or a designated representative or a client support group, receive funds directly for the purchase of home support services and assume full responsibility for arranging services, including recruiting, hiring, training, scheduling, supervising, and paying home support worker(s).

Palliative and End-of-Life Care Services: Palliative care[7] improves the quality of life for people and their families facing the problems associated with serious illness, through the prevention and relief of suffering. It is appropriate at any age and at any stage in a serious illness and can be provided together with any beneficial treatment. End-of-life care generally refers to formal and informal care provided during the final year of life and is associated with advanced, life-limiting illnesses. It focuses on comfort, quality of life, respect for personal health care treatment decisions, and support for the family, psychological, and spiritual concerns. It is provided whatever the age or wherever the client is living, whether in their home, in hospice, an assisted living residence or a residential care facility.

The BC Palliative Care Benefits Program supports home-based palliative care. It allows BC residents of any ages who have reached the end stage of a life-threatening illness and want to receive medically appropriate palliative care at home, rather than being admitted to hospital. The program gives palliative patients access to the same drug benefits they would receive in a hospital, and access to some medical supplies and equipment from their health authority. The program includes full coverage of approved medications and equipment and supplies (upon referral to, and assessment by the local health authority).

Palliative care services can be provided in a number of settings including people's homes, assisted living, residential care and hospitals.

Caregiver Respite/Relief Services: Many people receiving home and community care services are assisted by informal caregivers, often a friend or family member. Respite care can give the caregiver temporary relief from the emotional and physical demands of caring for a friend or family member. Respite may take the form of a service that is provided in an individual's home or a residential care facility, hospice or other community care setting such as an adult day centre.

Family Care Home Services: are provided in a single-family residence that accommodates clients with specialized care needs that cannot be optimally met in a residential care facility. Family care homes provide a home-like atmosphere, nutritious meals, laundry and housekeeping services and supervision, along with any required assistance with daily living activities, such as bathing, grooming and dressing. As they are unlicensed they cannot house more than two clients.

Assisted Living Services: provide housing, hospitality services and personal care services for adults who can live independently and make decisions on their own behalf but require a supportive environment due to physical and functional health challenges.

[7] Palliative care may be offered to children and teenagers with cancer. If a young person requires palliative care, it is specialized to focus on enhancing quality of life by addressing their unique physical, social, spiritual and emotional needs.

Short-Term Residential Care Services: are provided on a short-term basis (usually less than three months) and include convalescent care, residential hospice palliative care and respite care. Respite care provides a client's main caregiver a period of relief; it can also provide a client with a period of supported care to increase their independence. Convalescent care is provided to clients with defined and stable care needs who require a supervised environment for reactivation or recuperation prior to discharge home, most commonly following an acute episode of care. Residential hospice care is provided to clients who require support with comfort, dignity and quality of life in the final days or weeks of their lives, and is distinct from palliative care provided to residential care clients.

Long-Term Residential Care Services: are provided in facilities that provide 24-hour professional care and supervision in a protective, supportive environment for people who have complex care needs and can no longer be cared for in their own homes or in an assisted living residence.

Home and Community Care Funding: The Ministry of Health provides global funding to health authorities across British Columbia for the delivery of publicly subsidized home and community care services. Provision of home and community care services has changed significantly over the past few decades. Since the late 1980's, what began as 'homemaking' support and follow-up hospital care has expanded enormously. As British Columbia's population has changed and the demand for health care services has continued to grow, home and community care services have absorbed larger volumes of clients with increasingly complex health care needs. This impacts existing services structures, and creates significant challenges for the capacity of the system in all community settings.

Clients co-pay for publicly subsidized home and community care services, specifically residential care, assisted living, and home support services and a fixed rate of $10 or less is charged for receiving adult day services:

Income-Based Client Rates – Home Support: Clients receiving long-term home support services pay a daily rate based on their income (and the income of their spouse, if applicable) which is calculated by multiplying "remaining annual income" by 0.00138889. Clients in receipt of an income benefit pay no fee, and if a client or their spouse has earned income, they pay no more than $300 per month for home support services.

Income-Based Client Rates – Assisted living: Clients receiving assisted living or family care home services pay up to 70 % of their after-tax income towards the cost of their accommodation and hospitality services, subject to a minimum and maximum client rate. The maximum rate is based on a combination of the market rent for housing and other actual costs.

Income-Based Client Rates – Long-term residential care/ Family Care homes: Clients receiving long-term residential care or family care home services pay up to 80 % of their after-tax income towards the cost of their accommodation and hospitality services, subject to a minimum and maximum client rate per month. The maximum client rate is adjusted annually based on changes to the Consumer Price Index (CPI).

Minimum Residual Income: Client rates are calculated so that most clients receiving residential care services retain a minimum income amount to cover personal expenses, such as personal toiletry items or over-the-counter medications. On February 1, 2012, the Government of British Columbia increased the minimum residual income amount from $275 per month to $325 per month.[8] When implemented, this was the highest minimum residual income amount in Canada.

[8] The increase in the minimum residual income amount reflects the changes made to the OAS/GIS benefits on July 1, 2011 under which seniors may be eligible for additional benefits of up to $50 per month for a single senior. The increase in the minimum residual income amount ensures that the additional OAS/GIS benefits are not counted as income when assessing client rates.

Fixed Daily Client Rates: Clients receiving short-term residential care services for respite care, convalescent care, or hospice/end-of-life care, pay a fixed daily rate based on the minimum monthly client rate for residential care services.

Clients Receiving Income Benefits from MSD: There are unique arrangements for clients receiving income benefits from the Ministry of Social Development and Social Innovation (MSDSI). MSDSI fully subsidizes the cost of residential care services, Medical Service Plan (MSP) premiums and additional expenses such as optical, dental, and medical supplies and equipment for these clients. The Ministry of Health works with MSD to align the policies and processes for these clients.

Temporary Reduction of Client Rates: If payment of the assessed client rate would cause the client or their spouse/dependents serious financial hardship, the client can apply to their local health authority for a temporary reduction of their client rate. In 2013, the temporary rate reduction process was revised based on a standardized approach to ensure consistency across the province and to make the process more fair and transparent for clients, their family members and caregivers, and the public.

Information for Care and Planning is provided through InterRAI, developed though a collaborative network of researchers in over 30 countries who developed and maintain evidence-based clinical assessment tools tailored to people with chronic conditions, including frail seniors. British Columbia has implemented the InterRAI standardized assessment tools for both home care and residential care settings, giving the capacity to access reliable, validated assessment protocols, outcome measures, case-mix algorithms and quality indicators.

InterRAI data is an important component of the national Home Care and Continuing Care Reporting Systems, providing relevant information on which to compare client outcomes across national and international jurisdictions. This information, along with the data collected through the Minimum Reporting Requirements for home and community care services, provides a robust information source to aid understanding of needs, outcomes being achieved for clients, to inform research and performance accountability for overall health system improvement, and target planning to the needs of populations.

Analysis

Comprehensive Assessment

BC has mandated the use of two interRAI assessment tools for clients receiving long term services (home support, assisted living, adult day services, group homes, family care homes and residential care services). However, in most health authorities, there is no standardized assessment tool being used for many clients receiving short term acute care, short term rehabilitative care or palliative care. This represents a significant gap in the home health sector, and could be addressed through the introduction of other interRAI instruments, such as the Contact Assessment, which is being used in Vancouver Island Health Authority and Ontario, or the Community Health Assessment, also used in Ontario, to ensure standardized comprehensive assessments are carried out on all home health clients.

Service Models and System Coordination

Despite many changes over the past 20 years, home and community care services remain organized in large part around eligibility criteria and service guidelines that limit who may receive services and in what format. Clinical services such as community pharmacy, social work and dietician services are available in some communities, but not others. Other ministries or community agencies may share responsibility for services in some cases. As a result, home and community care services can be complex and restrictive in their coordination and delivery. This creates frustration for clients trying to navigate the health care system, for caregivers and for family physicians and other health providers needing to link with community based care.

Funding

s.13,s.17

s.13,s.17

Health Promotion Supports and Services

The following section provides some information about a number of supports and services provided in the province by a variety of organizations with the support of Ministry funding, or by the Population and Public Health Division or the Seniors Services Branch in the Ministry.

Better at Home

- The Ministry has provided $41 million in funding to the United Way of Lower Mainland since 2011.
- 67 core Better at Home program sites are operating in communities across BC; many serve more than one community. Of the 67, six sites are in rural/remote communities, four of which are on First Nations Reserves. The program helps seniors with simple day-to-day tasks so that they can continue to live independently in their own homes and remain connected to their communities.
- Services are delivered by local non-profit organizations with a mix of paid workers and volunteers, and may include grocery shopping, transportation to appointments, light housekeeping, yard work, snow shovelling, friendly visiting, and minor home repairs. Seniors are expected to pay for services on a sliding scale based on income.
- 6 sites received funding in April 2015, to pilot test new models for Better at Home service delivery in rural and remote communities. The United Way of the Lower Mainland's Better at Home Rural and Remote Pilot Project: Final Evaluation Report was released in March 2017.
- In August 2014, UWLM completed an operational evaluation of Better at Home, which suggested that the program is working well and that clients are generally satisfied, although more could be done to reach isolated seniors and keep clients connected to their communities.
- The Ministry of Health is partnering with the UWLM and the Michael Smith Foundation for Health Research on a research study that will look at longer-term outcomes and the program's impact on clients' quality of life, health care service use and cost effectiveness for the health care system.

Age Friendly BC

- The Government's 2013 election platform included a commitment to "ongoing funding of $500,000 to partner with communities to make their communities more age-friendly for senior residents, through the successful age-friendly community grant program."
- The Province works with the Union of BC Municipalities (UBCM) to provide local governments with age-friendly BC grants.
- In December 2014, in partnership with UBCM, 28 communities received age-friendly grants of up to $20,000 to help create programs or tools that address the needs of their older residents.
- For the 2015 round of age-friendly grants and local governments were encouraged to consider community planning and projects that focus on accessibility, dementia, elder abuse prevention and non-medical home supports.
- To date over 135 local governments in all areas of B.C. have received at least one grant and 225 projects have been funded.
- Local governments that complete basic steps on age-friendly community engagement, commitment, assessment and action may receive Age-friendly BC Recognition. A total of 25 local governments have received age-friendly recognition. Applications will be accepted until March 31, 2015 for the next round of recognition.
- Age-friendly BC also provides resources to assist communities and businesses to become more age friendly.

Health System Seniors Services

Seniors' Information and Resources

- Ministry of Health provides information about government programs, services and initiatives for seniors through a suite of print-based and web-based resources (including SeniorsBC website and e-newsletter, BC Seniors' Guide, BC Elders' Guide, Healthy Eating for Seniors handbook).
- The information and resources are designed to help seniors and those who care for them make informed decisions about care, to plan for healthy aging and to understand how to navigate the system of care and supports in B.C.

Aging Well

- Aging Well is an online resource to support and motivate older British Columbians to plan and prepare for changes that come with age, to help them better cope with changes and prevent the stress and associated health impacts of dealing with change in a crisis situation. It is available at: www.healthyfamiliesbc.ca/aging-well
- It includes evidence-based content, tools and videos to support older adults in planning and preparing for aging in the areas of health, finances, housing, transportation and social connections. Topics include fall prevention, financial planning, health and safety, health care, healthy eating, physical activity, leaving a legacy, advance care planning, mental wellness, protection from elder abuse and neglect, and volunteering.
- Seniors are also being supported with an offline component that includes engagement through community workshops. BC Healthy Communities Society has received funding to work with community and seniors' agencies in hosting local workshops on Planning for Aging Well to motivate seniors to think ahead and prepare for future changes. These have taken place in Abbotsford, Fraser Lake, Comox Valley, Kelowna and South Vancouver. They are currently developing a plan to deliver workshops in additional communities and create an open-source workshop facilitation kit that will be available to seniors organizations and centres throughout BC so that they can deliver Planning for Aging Well workshops.

CanAssist (University of Victoria)

- CanAssist's mandate is to improve the independence and quality of life of people representing the full spectrum of disabilities by developing and delivering innovative customized technologies and services where there are gaps in existing offerings. In March 2013, the Ministry provided CanAssist with $2 million to undertake technology initiatives with the five regional health authorities in 2013/14. Each health authority worked with CanAssist to complete the following project stages: identifying 10 to 15 individuals to represent its priority population; assessing project participants and providing each individual with up to three customized technologies; and identifying one to three platform technologies that will benefit larger groups of clients.
- Additional funding ($2 million) has also been provided in 2014 by the Ministry and this enables the expansion of CanFITT-BC. This funding enables CanAssist to undertake activities in three primary areas: expand work with B.C.'s 5 regional health authorities develop larger platform technologies for broad application and develop a suite of easy to use software apps for targeted populations.
- In 2017, the Ministry is providing $3 million in funding to expand CanAssist's services for seniors living with dementia. The $3 million will continue the CanStayHome initiative, which has two components: the development of new innovative technologies and the completion and launch of Ability411, a web-based assistive technology information service for seniors, their families and other caregivers.

Elder Abuse Prevention

- Government recognizes that elder abuse is a serious social, public health and legal issue that undermines seniors' independence, dignity and sense of security, and can seriously impact a senior's health. A coordinated and multi-sector approach to elder abuse prevention, both within government, and with individuals and community and provincial-level organizations has been utilized.
- Government released *Together to Reduce Elder Abuse – B.C.'s Strategy* (TREA Strategy) March 2013 to promote health, safety and independence for B.C. seniors.

- The Ministry coordinated implementation of the strategy across government and with multi-sector stakeholders, and funding was provided by Government for community-based efforts to prevent and respond to elder abuse.
- Every year since 2006, B.C. has proclaimed June 15th as World Elder Abuse Awareness Day.
- The Ministry of Health has provided multi-year funding to:
  - BC Association of Community Response Networks, which supports and trains Community Response Networks (CRN's). A CRN is a network of individuals, groups and agencies from diverse sectors that work together at the community level to promote a coordinated community response to elder abuse and neglect. There is CRN activity in 157 communities across B.C.
  - Seniors First BC, which hosts the Seniors Abuse and Information Line (SAIL). SAIL provides assistance, referrals and information on elder abuse to seniors, their caregivers and family, and the general public seven days per week, 12 hours per day. Translation and hearing-impaired assistance is also available.

ROLES AND RESPONSIBILITIES

MINISTER ROLES AND RESPONSIBILITIES

PARLIAMENTARY SECRETARY ROLES AND RESPONSIBILITIES

MINISTRY ROLES AND RESPONSIBILITIES

Seniors' Services, Primary and Community Care Policy Division

The Primary and Community Care Policy Division (PCCP) sets the foundation for the delivery of high quality health services by establishing patient centered health services policy for primary and community care services and undertaking activities to ensure quality care is delivered. The division works with regional health authorities and other key service providers to ensure service delivery models are aligned with the dimensions of quality health care and meet the needs of patients.

The primary accountabilities of PCCP are:

- the development and maintenance of health service policy;
- oversight of implementation of health service policy; and
- the ongoing monitoring of health service delivery based on a performance management framework.

Working with health authorities and stakeholder organizations, PCCP collaborates to set service delivery policy, standards and measures of compliance that are aligned with the five dimensions of quality linked to patient populations and health services.

PCCP has oversight for statutory and legislative mandates under the *Community Care and Assisted Living Act*, *Hospital Act*, *Continuing Care Act* and *Patient Care Quality Review Board Act,* and undertakes licensing, audit, inspection, and reporting activities to support continued improvement and high quality health care across the continuum.

In addition to the Seniors' Services Branch there are other branches in the Ministry, which have responsibility for some areas related to seniors' services.

Health System Structure and Governance

Population and Public Health Division

The Population and Public Health (PPH) Division in the Ministry of Health focuses on improving people's overall health and well-being by promoting health; preventing disease, disability and injury; protecting people from harm; and ensuring a particular focus on key populations including Aboriginal peoples, women and children, and seniors.

PPH is the lead on issues that relate to health promotion, population health and prevention, and has direct responsibility for:

- Serving as the primary support for the Parliamentary Secretary to the Minister of Health for Seniors;
- Creating and promoting policies, initiatives and opportunities for healthy, active, independent aging for British Columbians; and
- Coordinating priority healthy aging-related policies, programs and initiatives across ministries and with other partners.

Office of the Seniors Advocate Roles and Responsibilities

- Monitors and analyzes seniors' services and issues in BC, and makes recommendations to government and service providers to address systemic issues. The Office also provides information and referrals for individuals who are navigating seniors' services and tracks their concerns, which helps inform future work.
- The services which the Office monitors are in five key areas: health care, housing, income supports, personal supports and transportation.

HEALTH AUTHORITY GOVERNANCE

Health System Structure and Governance

KEY ORGANIZATIONS

COUNCILS, BOARDS & COMMISSIONS

- **BC Patient Safety and Quality Council –** The council works to enhance patient safety, reduce errors, promote transparency, and identify best practices to improve patient care. The Council may provide advice and recommendations to the Minister of Health on matters related to patient safety and the quality of health care in BC. The Council strives to bring a coordinated and consistent provincial approach to patient safety and quality improvement and will provide support to health authorities and other service delivery partners in their efforts to improve the safety and quality of care.
- **Patient Care Quality Review Boards** – There are six independent review boards created under the *Patient Care Quality Review Board Act* to receive and review care quality complaints that have first been addressed by a health authority's Patient Care Quality Office, and remain unresolved. They make recommendations to the Minister of Health and health authorities.

Effective April 1, 2017, responsibility for the following Boards has been transferred to the Ministry of Justice; however, they remain key components in the health care system:

- **Community Care and Assisted Living Appeal Board** – The board is a tribunal created under the *Community Care and Assisted Living Act* to hear and decide appeals from licensing, registration and certification decisions about community care facilities, assisted living residences, and early childhood educators.
- **Health Professions Review Board** – The board is an administrative tribunal created under the *Health Professions Act* to provide an independent review of certain decisions made by the self-governing colleges regarding the registration of their members, and the timeliness and disposition of complaints made against their registrants.

PROFESSIONAL COLLEGES

There are 26 regulated health professions in BC, of which 25 are self-regulating professions governed by 22 regulatory colleges under the Health Professionals Act two government-appointed licensing boards.

- The Colleges are in place to ensure practitioners meet expected standards of practice and conduct
- Regulation helps to protect the public by ensuring that professional care or service received by the public is competent, ethical and meets the standards that society views as acceptable.
- Regulatory functions may include:
  - establishing, monitoring and enforcing standards of practice
  - establishing the conditions or requirements for registration
  - establishing and employing registration, inquiry and discipline procedures

HEALTH SECTOR ADVOCATES, ASSOCIATIONS, UNIONS, SUPPLIERS

- **BC Care Providers Association, Denominational Health Association and the BC Seniors Living Association**
- **Ombudsperson's Office**
- **Office of the Seniors Advocate**
- **Association for CSIL Employers (ACE)**
- **Health Employers Association of British Columbia (HEABC) -** Accredited bargaining agent for most publicly funded health employers. HEABC negotiates five major provincial agreements covering more than 115,000 unionized health care employees, including nurses, health science professionals, physician residents, and support workers in both facilities and community settings.
- **Key Health Sector Unions -** Hospital Employees Union, BC Nurses' Union, Health Sciences Association of BC, Canadian Union of Public Employees.

Health System Structure and Governance

- **Patient Advisory Councils** (various established at health authority level) – patients/family-members provide advice to health care leaders. Participants share their health care experiences, and collaborate with care providers to improve quality care through providing the patient perspective and insights.
- **Patient Voices Network** – a community of patients, families and caregivers working together with health care partners to improve BC's health care system. Supported by the BCPSQC since December 2015.

Allied Health Service Providers

- Allied health professionals provide a range of health services to patients delivering preventive and continuous care toward the management of patients' health and include both regulated and unregulated professions

Physician Services

- **Doctors of BC (DoBC) –** The DoBC works to promote a social, economic, and political climate in which members can provide the citizens of BC with the highest standard of health care while achieving maximum professional satisfaction and fair economic reward. This is achieved through:
    - Collaborating with government on joint committees such as the General Practice Services Committee (GPSC), Specialist Services Committee (SSC), Shared Care Committee (SCC), and Joint Standing Committee on Rural Issues (JSC), all of which are dedicated to improving the quality of patient care in BC
    - Engaging with government on the development and implementation of policies and programs that promote the best standard of health care
    - Advocating for health promotion in a manner that influences positive change in population health

Pharmacare and Pharmacy Services

- **BC PharmaCare** - Helps BC residents with the cost of eligible prescription drugs, and certain medical supplies and pharmacy services. It provides assistance through several drug plans. The largest is the income-based Fair PharmaCare plan.
- **British Columbia Pharmacy Association (BCPhA) -** An organization that supports and advances the professional and economic interests of community pharmacists and pharmacies in the province. The BCPhA's membership includes more than 3,150 practicing pharmacists and nearly 1,000 pharmacies that are in communities large and small across the province.

Key partners and stakeholders

- Community Living BC
- Alzheimer's Society of BC
- BC Centre for Palliative Care

FACT SHEET

OMBUDSPERSON INVESTIGATION OF SENIORS' CARE

ISSUE

On February 14, 2012, the Ombudsperson publicly released her report on seniors' care, *The Best of Care: Getting it Right for Seniors in British Columbia* (Part 2), following an extensive three year investigation.

KEY FACTS

- In August 2008, the Ombudsperson publicly announced that she had launched investigation of seniors' care in BC based on complaints of administrative unfairness. The Ombudsperson indicated the Report would be released in two parts.
- The Ombudsperson released *The Best of Care: Getting it Right for Seniors in British Columbia* (Part 2) (the Report) on February 14, 2012. The *Part Two Report* is organized into four main subject areas - home and community care, home support, assisted living, and residential care. The Report contains 143 findings and 176 recommendations on seniors' care.[1]
- The findings and recommendations focus on administrative unfairness, protection for those who are vulnerable, access to services and information, consistent quality standards, complaints and concerns, and policy and regulatory changes for both publicly funded and private home and community care services.
- Since April 2012, the Ministry of Health (the Ministry) has provided annual updates each spring to the Ombudsperson on work completed related to the findings and recommendations, reporting on the progress made in various areas to improve seniors' care in the province.
- In April 2014, the Ministry developed a multi-year work plan going out to 2017/18 and a governance structure with clear accountabilities and achievable timelines that was aligned with existing public commitments, the Ministry's Health System Strategy and relevant policy work underway.
- In April 2016, senior leadership from the Ministry met with the Ombudsperson and noted that typically, after five annual progress reports, the on-going requirement to report out to the Office of the Ombudsperson stopped, and that the Ministry believed that it was time to review the requirement of continued annual reporting for this report.
- The Ministry informed the Ombudsperson that since starting on this work, a number of key changes had occurred to ensure a continued focus on seniors' services, including creating the Office of the Seniors Advocate, identifying seniors' services as one of five top priorities and creating a new branch dedicated to seniors' services.
- The Ministry provided a comprehensive response on May 6, 2016 to the Ombudsperson's Office annual request for an update on remaining recommendations, accompanied by a letter that reiterated the cessation of the annual reporting process and the rationale, and made a commitment to arrange another meeting after the Ministry's review of the remaining recommendations was completed.
- In June 2016, the Ombudsperson's Office released its annual report, which took a different approach than it has in past years. Annual reports typically provided commentary on a number of systemic investigation reports and also included assessment tables outlining evaluations of progress made in addressing individual report recommendations. In the 2015/16 annual report, systemic investigation reports did not receive commentary, and assessment tables were not published.

[1] Report found at www.bcombudsperson.ca/documents/best-care-getting-it-right-seniors-british-columbia-part-2

FACT SHEET

- In August 2016, the Ministry met with the Ombudsperson once again to provide a summary of the current status of all s.13,s.17 according to the ministry:
    - 80 recommendations: Complete;

s.13,s.17

    - *After discussion with the Ombudsperson's office, the Ministry's position on recommendation 122 is being re-visited and may result in it being categorized as something other than "not accepted".
- Many of the recommendations s.13,s.17

s.13,s.17

- Government has committed verbally to the Ombudsperson that the remaining work required to bring Part 3 into force will take place over the coming year, with a projected effective date of April 1, 2018. A more formal announcement is expected later in February.
- Ministry staff met with the Ombudsperson's office staff in January 2017 to provide further clarification on actions taken to address specific recommendations about which the Ombudsperson's office requested additional information to make a final assessment for their March report.
- The Ombudsperson's office has advised that after publishing their five year "anniversary" update in March, they intend to continue to monitor a small number of key recommendations that are not yet implemented.
- Ministry staff will continue to work with the Ombudsperson's office to provide further information that will allow the Ombudsperson's office to accurately reflect in their update the work that has been done to date.

s.13,s.17

FACT SHEET

Approved by:
Sharon Stewart obo Doug Hughes, ADM Primary and Community Care Policy; February 17, 2017

An Action Plan to Strengthen Home and Community Care for Seniors

March 2017

BRITISH COLUMBIA | Ministry of Health

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Community Care for Seniors

About 853,000 seniors lived in B.C. in 2016.

A population-based strategy for seniors' health care begins with supporting seniors to remain active in their daily life, keep well and live independently. This will remain the cornerstone of the Province's strategy to improve the lives of older British Columbians, along with a continued focus on health aging.

However, for those seniors who experience increasingly complex medical health-care needs and/or frailty, it is critical that they have access to well co-ordinated and integrated services across the continuum of care – from home health services through to residential care. This action plan addresses these needs.

These specialized services require more than a medical lens. They require shifting how the health system approaches seniors care – and partners with other support systems in seniors' lives – to add a greater focus on enhancing quality of life.[1] Many of the medical conditions experienced by seniors are more about how they live with their conditions, with the highest quality of life possible, rather than a cure. In some instances, particularly in terms of frailty, these conditions are linked to the realities of an aging body. People living and managing daily with complex chronic medical conditions, or experiencing frailty, are increasingly dependent on others to maintain their health and well-being, and want more than medical care. They want:

- As much freedom from the impact of their medical conditions as possible;
- To retain as much function as possible to engage in their community, with continued autonomy to shape their own life and story; and
- To be able to take part in meaningful activities, maintain social and family connections, and enjoy the here and now and the everyday pleasures of living.

While it is not government's role to provide for all quality of life considerations, there are many existing community supports that can and should be engaged to support the care of seniors from a holistic perspective along with health-care services. These supports include government programs, as well as non-profit organizations, volunteers, denominational or church-based services, and family caregivers, among others. This requires us to rethink some of our health-care practices, in a medical system concentrated on intervention and cure.

[1] See Atul Gawande's Being Mortal (2014)

There are a number of critical and difficult questions: When should we try to fix and when should we not? When should we stop intervening? When should we shift from pushing against limits to making the best of them? When is the right time to choose medical interventions that may be more intrusive or move to comfort care? The answer to these questions takes time, skill, and real engagement with the patient and usually their family. The answers are unique to the individual, and finding them requires discussion of the trade-offs and choices, useful information, promoting and allowing patient control, and giving thoughtful guidance as a therapeutic partner. Creating the space and time for these discussions is essential to our goal of making primary and community care person- and patient-centred.

B.C.'s population is aging, and a growing number of older British Columbians are living with illness, disability and/or frailty. As a result, there is increasing demand for both traditional home support services, including personal care, as well as other supports such as light housekeeping, transportation and shopping. Health authority programs support eligible B.C. seniors to remain living in their own homes as long as possible through publicly subsidized home health services. Community nursing, community rehabilitation, adult day programs, home support for assistance with activities of daily living, and at-home end-of-life care are examples of these services. Family caregivers, volunteers and community services are relied upon to provide other supports required.

Often the home health services being provided to the patient population are disconnected. Our objective is to re-think what services are needed, and how these services can be better aligned, integrated, and co-ordinated, with the person at the centre of the care. This includes identifying how to best link community-based specialist physician services. Consideration should be given to: how to better provide person-centred home care services; how to better use assisted living and long-term residential care resources for promoting social connectedness; and, whether adding specific home support services like laundry and meal preparation to existing home support services can be an effective contributor to avoiding premature entry into assisted living or residential care.

Current and Future Demand for Home and Community Care

Currently, over one-sixth of B.C.'s population is over 65 years old.[2] In 2015/16, the growth rate of the population aged 65 years and older was 3.5% – about three times the growth rate of the total population.[3] While the majority of seniors age well, with this growth in the number of older adults, the incidence of chronic illness and frailty will increase. Publicly subsidized home and community care services provide a range of health care and support services for people who have acute, chronic, palliative or rehabilitative health-care needs ranging from home care to assisted living to residential care services.

Primary care remains the cornerstone of health-care delivery for seniors. As reported by the B.C. seniors advocate[4], 92% of seniors report having a regular physician.

Home support services deliver personal supports and assistance with activities of daily living to about 20,000 seniors at any one time and is key to keeping seniors from requiring residential care. A 2016 survey by the B.C. seniors advocate showed that, overall, the majority of clients are satisfied with the quality of the home support services they receive (62%). However, many respondents identified that they want more services to be available to them, such as housekeeping (28%) and meal preparation (12%). Additional highlights included an overwhelming recognition that home support staff are caring and respectful (92%), but expressed concerns around the number of different workers (20% of clients say they get too many different regular workers) and the lack of skills and training of some home support workers (only 47% of clients think their workers have all the necessary skills to provide good care). The B.C. seniors advocate also reported[5] that in 2015/16 the average home support hours delivered per year per client decreased by about two percent from the previous year, while the number of clients increased by two percent – pointing to the challenge of keeping pace with increasing demand from an aging population.

Assisted living is a housing option that provides seniors with enhanced supports to maintain their independence. In B.C., there are currently 139 subsidized registered assisted living residences. As of March 2016, there were 4,408 subsidized registered assisted living units. Legislative changes to the *Community Care and Assisted Living Act* will offer more flexibility and choice for seniors in assisted living residences, while at the same time increasing protections. Bill 16, *Community Care and Assisted Living Amendment Act*, received Royal Assent by the Lieutenant Governor on May 19, 2016. It responds to concerns identified over the past several years in reports published by B.C.'s ombudsperson, B.C.'s seniors advocate and the B.C. Law Institute. Once put into force, the changes to the act will allow seniors to remain in assisted living longer when their care needs change and not have to move into a residential care facility as early as they would have previously– or may not have to move at all. It is anticipated that

[2] PEOPLE v2015. BC STATS. Ministry of Technology, Innovation and Citizens' Services.
[3] www.statcan.gc.ca/pub/91-215-x/2016000/part-partie2-eng.htm
[4] Monitoring Senior's Services, December 2016.
[5] Ibid.

as a result of these changes the oversight and monitoring of assisted living will increase. It is not clear what, if any, impacts the changes will have to staffing levels and skillsets.

Residential care facilities offer seniors 24-hour professional supervision and care in a safe and secure environment. About 4.4% of seniors live in residential care. The majority of people moving into residential care are over the age of 75 and make up 83% of all residential care clients. There are about 27,760 subsidized residential care beds in the province in 335 regulated facilities.[6] In 2015, there were 28,156 resident assessments completed using the standardized interRAI resident assessment tool.[7]

Based on the information from these assessments, the majority of residents are frail and have complex care needs:

- 93% of residential care clients had some level of cognitive impairment, with 65% having a diagnosis of dementia;
- 93% had some level of impairment with their ability to perform daily living activities, while 73% required moderate to significant assistance;
- 69% had bladder incontinence and 49% had bowel incontinence;
- Just over 21% had suffered a cerebral vascular accident and 12% had congestive heart failure; and
- 55% of residents had some indication of frailty and health instability, and 10% had a higher level of medical complexity and were at serious risk of decline.

It is not yet known what the full impact of the changes to *Community Care and Assisted Living Act* will be to the residential care sector. It is likely that the proportion of higher needs clients will increase in residential care facilities, which will impact staffing numbers and staffing mix. Also, as more people with lower care needs are able to be supported successfully at home or in an assisted living residence, it is likely that the average length of stay in residential care will decrease from the current average of 500 days. Increasing complexity and more rapid turnover will have affect the number of staff required, the staff mix and the training necessary to meet the higher care needs of residents.

There have been a number of actions taken over the past few years to optimize the scope of practice of all direct care staff. Licensed practical nurses have been added to the skill mix and perform clinical skills within their scope while registered nurses assume leadership and care co-ordination functions within the facilities. Efforts have been made to incorporate residential care aides more fully into the care team. The service model, based on the needs of residents, will influence the staffing levels and staffing mix required in a particular facility. Given the changing demand and after considering broader research findings, a key recommendation of the *Residential Care Staffing Review* and the B.C. seniors advocate is to ensure staffing levels provide for a health authority average of 3.36 direct care hours per resident day, supported by a standard funding and monitoring approach.

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[6] Ministry of Health bed inventory, September 2016.
[7] B.C. interRAI Minimum Data Set 2.0 and interRAI Home Care data, 2015.

Key Actions

1. Focus on healthy aging.

There are many factors that shape the way that people age, but much of it is influenced by behaviour, illness, disability and loss of independence are not inevitable consequences of aging. A focus on healthy living can prevent, minimize or even reverse frailty and poor physical and mental health in old age.

Through Age-Friendly BC, in partnership with the Union of British Columbia Municipalities, the ministry will continue to provide grants, support, tools and information to help communities meet the needs of an aging population. In an age-friendly community, seniors are able to enjoy good health and active social participation. The grants are targeted toward enhancing healthy living programs that focus on healthy lifestyles, fall prevention and social connectedness.

Hundreds of resources and services to seniors currently are available on HealthLinkBC. There are opportunities to further leverage this platform to support seniors to remain active, live healthy and stay well.

Next Steps:

- Through HealthLinkBC and in collaboration with the Office of the Seniors Advocate, develop both general and targeted messaging on healthy aging and self-care building to British Columbians at specific ages, building on B.C.'s Aging Well Strategy:
  - Aging Well In Your 60s – Key Actions You Can Take to Maintain Your Health and Independence
  - Aging Well In Retirement – Self Care and Services
  - Aging Well in Your 70s - Key Actions and Plans You Can Take to Maintain Your Health and Independence
  - Additionally, given growing number of seniors maintaining good health into their 80s and 90s, the need for targeted messaging on aging well past your 70s will need to be considered.
- The Office of the Provincial Dietitian (in collaboration with Dietitian and Physical Activity Services at HealthLinkBC and the Provincial Health Services Authority) is:
  - Updating the Healthy Eating for Seniors handbook. This includes developing a suite of standardized provincial training resources and tools for health professionals and community care workers to support healthy eating for seniors and improve nutrition care for those experiencing frailty.
  - Enhancing the healthy living content within the Healthy Families BC Aging Well platform.
  - Supporting older adults through the Farmers Market Nutrition Coupon program (one of the target populations = low income older adults) and Food Skills for Families program (Active Seniors curriculum).

- Ensuring patient centred care by exploring opportunities to improve nutrition care practices for B.C. seniors across the continuum of care, using recent evidence from the Canadian Malnutrition Task Force to highlight patient safety and quality of care concerns.

- Create a seniors section on HealthlinkBC.ca to showcase seniors' resources and services.

2. Provide better co-ordinated and integrated community care for seniors with complex medical needs and/or frailty.

There are 61 geographic health service areas across B.C. made up of metro, urban/rural, and rural/remote areas. Over the coming four years, health authorities will establish an integrated primary and community care service system in each of these areas that is easy to understand and navigate. This new model is intended to improve ease of access and co-ordination of services for seniors who have more complex medical needs, who are experiencing frailty and/or dementia, or who need palliative or end-of-life care. Each area will have a single **Specialized Community Services Program** for seniors that will link together the current suite of services and offer a number of **core health services**. These services will:

- Actively work with primary care practices to identify patients needing increased supports, and have an efficient intake and assessment process to provide these enhanced patient-centred supports.

- Provide comprehensive case management and co-ordination services. This includes: co-ordination of care across medical specialists, home nursing and home support services; pharmacist medication review and support services; facilitating access to day programming, respite care in assisted living, and residential care facilities for socializing, eating, laundry, bathing, and personal care as a community resource for people living at home; proactive planning for admission to assisted living and residential care to increase choice of residence and reduce wait times. This approach to supporting clients will provide better co-ordinated care, reduce hospitalizations and increase the length of time older adults can safely and appropriately remain at home.

- Increase home support services and hours, as well as leverage other health-care professionals (e.g., paramedics) and technology to increase home health monitoring and connectivity for patients and health-care providers.

- Effectively link and co-ordinate access to other health services in their geographical service areas – such as 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.

Next Steps:

- Refresh policy directions to better articulate and monitor quality service and outcomes (September 2017):
  - Policy on Service Attributes and Practice Expectations for Specialized Community Services Program for Seniors
  - Specific Policy HealthLinkBC and Aging Well
  - Specific Policy Home Nursing and Health Services
  - Specific Policy on Pharmacist Support Services for Seniors
  - Specific Policy Home Support Services for Seniors
  - Specific Policy Assisted Living in Support of Community Care and Assisted Living Act Modifications
  - Specific Policy Residential Care (including Quality and Funding Model)
  - Specific Policy Prioritized Access Diagnostic and Hospital Services for Patients Attached to Specialized Community Services Program for Seniors
- Develop a detailed geographic service area rollout plan for introducing Specialized Community Care Program for Seniors (September 2017).

3. Work with assisted living residences to implement the new *Community Care and Assisted Living Act* provisions.

The changes to the *Community Care and Assisted Living Act* will allow clients to remain in assisted living who have increased complexity and require more services than is currently permitted under the current model. The ministry worked with stakeholders to develop is develop elements for a new assisted living regulation that will set out the minimum health and safety requirements that an operator of an assisted living residence must meet. The new assisted living regulation will be brought into force at the same time the amendments *to Community Care and Assisted Living Act* are brought into force.

Next Steps:

- Complete the consultation process on the amendments to the *Community Care and Assisted Living Act* and use the information to inform the development of the new regulations.
- Complete modelling work with the Canadian Institute for Health Information to establish a clear understanding of the profile of assisted living clients within the revised model of care delivery.
- Implement an education strategy to inform service providers and health authorities about new regulatory requirements and their impact on operational service delivery.
- Develop policy and guidelines to support:
  - revised staffing levels;
  - skill mix; and
  - service delivery models to best meet the needs of the clients.

4. Strengthen role and quality of residential care.

A recent review of residential care in B.C. was undertaken by B.C.'s Parliamentary Secretary for Seniors to determine what, if any, improvements should be made in the residential care system. The review focused on opportunities to improve consistency, transparency and accountability across the province in meeting resident's needs, sustainability of the system, and alignment with the ministry's focus on patient-centered care in the community. *Residential Care Staffing Review – March 2017* identifies 16 actions in three areas: funding and staffing; quality of care; and accountability. Between 2017/18 and 2019/20, the ministry will complete the identified actions in collaboration with the Office of the Seniors Advocate, other provincial ministries (e.g., Advanced Education and Jobs, Tourism and Industry), health authorities, industry partners and other stakeholders.

Over the coming four years, health authorities will also establish enhanced services in some residential care facilities to provide a higher level of medical care on a short-term basis for frail, complex older patients to avoid hospital admissions or allow residents to return from hospital sooner. These services will be available to both patients who are living in the community and in the facility who would otherwise require a visit to the emergency department, with a possible hospital admission, or who has been hospitalized but their condition has stabilized. These beds will be supported by the health authority and dedicated staff on-site (nursing and allied health staff such as occupational therapists, physiotherapists, podiatrists, and dietitians), with appropriate access to specialist consultations and services in both planned and emergent situations. The services would be connected to the local area Specialized Community Services Program for Seniors and affiliated with local hospital sites.

Next Steps:

- Implement the *Residential Care Staffing Review* action plan. (see Appendix 1)
- Ensure short-term residential care services are integrated into detailed geographic service area rollout plan for introducing the Specialized Community Service Program for Seniors.

Health Human Resources

The Specialized Community Services Program for Seniors will consist of an interdisciplinary team (or teams for larger geographic service areas) of experts to provide appropriate person- and family-centered services and interventions for older adults. It is expected that existing health human resources will be used differently to improve coordination and continuity of care. This will mean that staff roles and functions may change to better meet the needs of the patients within the new system and that all staff work to their full range of competency with clearly defined roles.

Therefore, changes to how we approach and manage health human resources are required:

- A cultural shift needs to occur where all staff work to a full range of competency, in a team-based model of care, to support complex patients – including those with episodic, short-term and longer-term care needs.
- Community-based resources (nursing, allied health, social work) must be shifted from existing siloed programs and function as a system across home support, assisted living and residential care.
- Other unregulated disciplines should be examined for their contribution to the teams (i.e., life skill workers and rehabilitation assistants). This is in addition to the well-established health-care professional roles such as nurses (including nurse practitioners, registered nurses, registered psychiatric nurses, licensed practical nurses) and health-care assistants), physiotherapists, occupational therapists, social workers, etc.
- Roles of allied professionals (e.g., physiotherapists, occupational therapists, social workers) should be examined and revised to enable more efficient use of resources within teams.
- Closer working relationships with contracted services providers.

While a fulsome health human resource planning process across the home and community care sector is necessary, there also is a need for an enhanced focus on health human resources in the residential care sector specifically, linked to the *Residential Care Staffing Review*.

- Within residential care facilities, the ministry has estimated that an increase of about 1,500 FTEs (full-time equivalents) is required to meet a standard of an average of 3.36 direct care hours per resident day by health authority, as follows:
  - Registered nurses increasing by about 165 FTEs.
  - Licensed practical nurses increasing by about 300 FTEs.
  - Allied health-care professionals (physiotherapists, occupational therapists, social workers) increasing by about 50 FTEs.
  - Health-care assistants increasing by about 900 FTEs.
  - Other non-professional allied health-care workers increasing by about 100 FTEs.
- In some facilities, providing more advanced short-term in-patient medical care as an alternative to hospital will require additional access to medical and nursing staff resources. The ministry will work with health authorities and service providers to prioritize increased staffing levels in all categories to meet these needs. This will start with using the analyses being conducted by the Canadian Institute for Health Information, data within each health authority about their specific client populations in residential care, and the service models required to meet the planned adjustments to staffing mix and levels. This will be a continual process as service models evolve and changes in the community take effect, including expanded services in assisted living residences and greater capacity to manage clients with complex medical conditions and frailty in the community.

- A multi-pronged health human resource approach will be undertaken that will include:
  - **Regularization of Casual and Part-Time Staff** – Analysis to determine the percentage of casual and part-time positions that can potentially be converted to regular full-time positions will be undertaken to increase the productivity of the existing labour pool. This approach is expected to have an immediate impact in the short-term (i.e., year one), but diminishing impact as opportunities to convert casual and part-time staff to regular full-time positions are maximized over time.
  - **Targeted Recruitment** – The ministry, health authorities, HealthMatch BC and other partners will launch a targeted recruitment strategy for home, and community care staff, including residential care staff. The success of a targeted recruitment strategy will be constrained by factors such as the location of work (urban, rural, remote) and the availability of labour in a local geographic area, and the type of employment being offered (full time, part time, casual).
  - **Training Expansion** – The ministry will work with the Ministry of Advanced Education to determine the need, capacity and costs associated with targeted short-term expansion of education and training spaces.
- Ongoing in-service education and training for all direct care providers is necessary to improve staff capability to assess, problem solve, and identify appropriate care interventions for seniors with complex medical and/or frailty (including patients with cognitive impairment). The Ministry of Health will work with health authorities, service providers, colleges and unions to assess and then develop a framework for in-service staff development, including developing skill sets necessary to provide quality care for dementia and palliative/end-of-life clients.

Next Steps:

- Refresh policies for staffing deployment and productivity to support team-based program delivery of specialized services (September 2017).
- Complete analysis of the percent of casual and part-time positions in residential care that can potentially be converted to regular full-time positions.
- Complete a health human resource gap analysis for health authority-delivered and contracted home and community care services for seniors. Develop a three-year health human resources plan/budget plan (November 2017).
- Complete analysis of potential use of home monitoring and other technologies to support home care services (November 2017).
- The ministry's Nursing Policy Secretariat, will ensure policy is available for the optimal use of the nursing professions' (i.e., NPs, RNs, RPNs and LPNs) scope of practice to meet the patient needs of people living in community and in residential care (November 2017).

Monitoring and Evaluation

Monitoring and evaluation over the next four years will focus on whether quality, staffing, and funding policies and goals are being achieved. Specific actions will include:

- Develop reporting requirements for all of home and community care based upon established tools currently available in the system, and that are included in or extracted from the current minimum reporting requirements, Home Care Reporting System and Continuing Care Reporting System.
- Revise the current minimum reporting requirements so they align with the current service delivery model expectations and team-based care.
- Establish provincial performance metrics to monitor the specialized community services program that supports complex medical and/or frail older adults.

Next Steps:

- Develop a monitoring and evaluation plan (September 2017).

Funding

Over the coming four years the Ministry of Health will spend an additional $500M on home and community care. By 2020/21, net new annualized funding will reach $180M, starting with an additional $45 million being available for 2017/18, rising to $125 million in 2018/19, $150 million in 2019/20, and $180 million in 2020/21. Detailed spending plans for 2017/18 will be developed over the next three months, and actual expenditures will be reported at the end of each fiscal year as part of the monitoring and evaluation process.

In addition to the above, health authorities will continue to invest in expanding capacity to meet growing demand for home and community care services. This investment will be in the region of $200 million.

Appendix A

Category	Action	Proposed Timeline
Funding and Staffing	1. Finalize a report, in collaboration with the Canadian Institute for Health Information, to better understand the demand for home health, assisted living and residential care services (including the different profiles of clients using RAI assessment and service episode data) given the changes taking place in the home and community care system, and to inform required changes to existing residential care service models.	May 2017
	2. Confirm the definition of direct care hours per resident day.	July 2017
	3. Establish a baseline for: hours per resident day, client case mix, other identified residential care costs.	September 2017
	4. Work with health authorities and industry to create and implement an interim targeted process that would increase hours per resident day for areas with identified gaps until a costing review has been completed and the funding model has been updated to incorporate client complexity.	October 2017
	5. Move towards a province-wide standard residential care funding model, with a lens to incorporate resident complexity (using RUGs and case mix index from RAI assessments), quality of care and flexibility.	January 2018
	6. Complete an analysis of percentage of casual and part-time positions that can potentially be converted to regular full-time positions in residential care facilities.	June 2017
	7. Develop an interim strategy to address immediate high-priority vacancies in residential care facilities.	June 2017
	8. Develop a health human resources plan to ensure supply of staff will meet the needs of the residential care sector. The plan will include targeted recruitment activities and seat-planning in post-secondary programs.	November 2017

Category	1. Action	Proposed Timeline
Quality of Care	2. Prioritize key quality of care initiatives in residential care and facilitate a co-ordinated approach that promotes consistency and standardization, yet allows for flexibility given varying needs across facilities.	April 2018
	3. Bring into force Part 3 (care facility admission) of the *Health Care (Consent) and Care Facility (Admission) Act* to protect vulnerable adults. This work will include revising the residential care admission policy to be more person and family-centred.	April 2018
	4. Develop and implement palliative and dementia care policy including requirements and targets for staff education.	April 2018
Accountability	1. Incorporate the requirement to increase hours per resident day through annual bi-lateral agreements between the ministry and health authorities.	April 2017
	2. Monitor health authority progress on achieving the 3.36 hours per resident day and produce annual reports for Leadership Council.	April 2018
	3. Develop and implement a policy to mandate accreditation for all residential care facilities.	April 2018
	4. Develop and implement performance measures that support quality of care and quality of life outcomes using outputs from RAI assessment and survey data including quality indicators.	April 2018
	5. Develop and implement a process and policy for monitoring, reporting and evaluation processes related to resident need, funding, service delivery and operations, building on experience from other provinces such as Alberta and Ontario to assess whether quality, funding and staffing policies and goals are being achieved.	April 2019

FACT SHEET

Home and Community Care Expenditures and Client and Service Volumes

ISSUE

In 2015/16, there were approximately 40,181 clients receiving publicly subsidized residential 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 in Supports for Independent Living [CSIL] program).[1]

KEY FACTS

- Home and community care services include a range of home health services including community nursing, community rehabilitation, adult day services, home support services, assisted living services and residential care services.
- Publicly subsidized residential care services are provided to approximately 5 percent of the total seniors' population (65+).[2]
- More detailed information on client numbers and service volume is provided below:

HCC Clients by Service Type 2006/07 to 2015/16, All Ages

Type of Service	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	% Change 2006/07 to 2015/16
Residential Care (includes convalescent care)	36,287	36,869	38,056	38,766	37,695	38,056	38,462	38,554	39,795	40,181	11%
Convalescent Care[1]	2,082	1,992	2,603	3,054	2,597	2,662	2,804	2,951	2,982	3,441	not calculated[1]
Assisted Living[4]	3,721	4,646	5,253	5,473	5,656	5,706	5,770	5,878	6,000	6,062	5%
Adult Day Services	6,751	6,825	6,617	6,346	6,406	6,548	6,139	6,280	6,214	6,242	-8%
Home Support/CSIL	34,471	35,971	36,794	35,119	36,599	38,254	38,873	40,472	41,341	42,170	22%
Professional Services[2]	66,229	66,671	69,462	69,712	71,598	72,825	80,815	82,643	85,324	87,289	32%
Case Management[3,4]	3,922	3,605	8,629	13,331	17,388	19,147	40,437	42,593	45,523	48,810	21%

HCC Service Volumes by Service Type 2006/07 to 2015/16, All Ages

Type of Service	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	% Change 2006/07 to 2015/16
Residential Care (includes convalescent care) Days	8,646,773	8,883,170	9,059,774	9,306,760	9,392,023	9,553,191	9,562,520	9,738,755	9,960,034	10,130,555	17%
Convalescent Care Days[1]	102,089	104,299	115,831	134,711	152,928	187,558	185,096	225,254	297,017	340,608	not calculated[1]
Assisted Living Days[4]	868,554	1,222,289	1,419,014	1,548,735	1,632,552	1,674,655	1,686,783	1,727,109	1,765,811	1,797,632	7%
Adult Day Services Days	264,799	262,171	251,731	251,015	253,995	259,946	250,263	254,917	259,099	259,703	-2%
Home Support/CSIL Hours	8,383,447	8,590,745	8,794,890	8,792,364	9,587,546	9,784,432	10,384,951	11,006,501	11,099,203	11,089,553	32%
Professional Services Visits[2]	996,781	986,458	1,052,141	989,331	992,922	994,750	1,043,385	1,042,767	1,090,752	1,111,123	11%
Case Management Visits[3,4]	20,725	17,596	24,737	35,021	59,382	66,949	142,182	169,814	189,358	209,977	48%

Source2017-0208 HCC Annual Client Counts, Volumes, Rates 2015-2016.xlsx; Data extracted October 14, 2016.
Client Counts: Unique client counts from various service types cannot be summed as some clients may have received more than one type of service during the year.
[1] Percentage change not calculated for Convalescent Care because of inconsistent reporting.
[2] Professional services includes community nursing, community rehabilitation and other.
[3] Caution should be used when interpreting Case Management client counts and service volumes. An increase in client counts and visits over time does not necessarily mean that more case management clients are being provided with more services. Although Case Management Services were provided to clients prior to 2013/2014, this service type is only reported in the HCCMRR and 2012/2013 is the first year that all five Health Authorities reported to the HCCMRR.
[4] Percentage change is calculated from 2012/2013.

[1] 2017-0161 HCC Expenditures and Client Services Volumes Updated (From 2017-0208 HCC Annual Client Counts, Volumes, Rates 2015-2016.xlsx; Data extracted October 14, 2016).

[2] 2017-0161 HCC Expenditures and Client Services Volumes Updated (From 2017-0208 HCC Annual Client Counts, Volumes, Rates 2015-2016.xlsx; Data extracted October 14, 2016).

FACT SHEET

FINANCIAL IMPLICATIONS

- In 2015/16, health authorities reported spending over $2.9 billion on home and community care.
- The following table shows community and residential care expenditures, as reported by the health authorities, by fiscal year and health authority. Funding for these services is incorporated in the health authorities' global budgets.

Community Care and Residential Care - Gross Expenditures
Summary by Health Authority ($ millions)

	2007/08 (Actual)	2008/09 (Actual)	2009/10 (Actual)	2010/11 (Actual)	2011/12 (Actual)	2012/13 (Actual)	2013/14 (Actual)	2014/15 (Actual)	2015/16 (Actual)	2016/17 (Budget)
Fraser										
Community	203.4	213.4	221.3	230.8	235.3	258.6	280.1	289.1	296.2	325.0
Residential	410.6	440.9	452.4	456.9	501.8	521.5	535.9	544.8	553.6	584.5
Total	**614.0**	**654.3**	**673.7**	**687.6**	**737.1**	**780.1**	**816.0**	**833.9**	**849.8**	**909.5**
Interior										
Community	138.0	144.9	142.1	147.5	172.7	183.6	191.6	196.4	212.0	216.1
Residential	280.6	306.0	317.8	332.3	340.2	356.7	367.9	367.8	376.6	380.2
Total	**418.6**	**451.0**	**459.9**	**479.8**	**512.9**	**540.3**	**559.5**	**564.2**	**588.6**	**596.3**
Northern										
Community	32.0	35.1	38.9	40.7	44.8	49.2	52.2	75.9	82.9	118.6
Residential	63.2	66.8	73.6	76.8	91.7	95.9	97.4	99.2	106.9	104.2
Total	**95.2**	**101.9**	**112.6**	**117.5**	**136.4**	**145.1**	**149.6**	**175.1**	**189.8**	**222.8**
Vancouver Coastal										
Community	161.2	173.2	180.1	181.7	219.2	240.9	236.7	242.5	251.1	258.5
Residential	385.3	398.6	410.3	424.9	442.0	442.8	464.5	461.1	463.7	470.9
Total	**546.5**	**571.8**	**590.4**	**606.6**	**661.2**	**683.7**	**701.2**	**703.6**	**714.8**	**729.4**
Vancouver Island										
Community	172.3	182.8	189.5	194.9	213.4	227.1	233.7	231.5	247.1	255.9
Residential	283.2	313.4	322.6	334.5	341.8	343.4	352.3	358.2	360.1	362.9
Total	**455.5**	**496.2**	**512.0**	**529.5**	**555.2**	**570.5**	**586.0**	**589.7**	**607.2**	**618.8**
British Columbia										
Community	706.9	749.5	771.9	795.6	885.3	959.4	994.3	1,035.4	1,089.3	1,174.1
Residential	1,422.9	1,525.6	1,576.8	1,625.4	1,717.4	1,760.2	1,818.0	1,831.0	1,860.9	1,902.7
Total	**2,129.8**	**2,275.1**	**2,348.6**	**2,421.0**	**2,602.8**	**2,719.6**	**2,812.3**	**2,866.4**	**2,950.2**	**3,076.8**

1. HA sector information has been re-defined due to the implementation of Public Sector Accounting Standards.

2. 2015/16 actual and 2016/17 budget are as per HA Service Plans for 2016/17 - 2018/19.

- Community care totals include the following sub-categories: Adult day services, professional services (nursing and rehabilitation services), home support services, case management and assisted living services.
- Residential care totals include the following sub-sector categories: Family care homes, group homes, residential care facilities and extended care hospitals, and nursing/personal long term residential care.

Approved by:
Sharon Stewart obo Doug Hughes, Primary and Community Care Policy; March 15, 2017
Gordon Cross, obo Manjit Sidhu, ADM, Finance and Corporate Services; March 31, 2017
Christine Voggenreiter, obo Teri Collins, Health Sector Information, Analysis & Reporting Division; June 30, 2017

FACT SHEET

Home Health Services

ISSUE

- BC has a range of comprehensive home health services, including community nursing, community rehabilitation, adult day programs, home support for assistance with activities of daily living, and at-home end-of-life care. These services support seniors and people with disabilities of all ages to manage their health care needs and remain in the community.

KEY FACTS

- BC home health services, delivered by the health authorities, comprise three main services: professional clinical services; home support; and Choice in Supports for Independent Living (CSIL). These services are available to any eligible client aged 19 or older. In 2015/16:
  - 87,289 clients received professional at-home nursing, rehabilitation, and other services. [1]Community nursing is provided by a licensed nursing professional to clients in the community who require acute, chronic, palliative or rehabilitative support. Community rehabilitation services are delivered by a licensed physical therapist or occupational therapist to clients who require acute, chronic, palliative or rehabilitative support. All professional services are provided free of cost.
  - 41,282 clients received home support (excluding CSIL) services that help people remain independent, and in their own homes for as long as possible. [2] Clients are charged an income-tested fee ("the client rate") for these services.
  - 956 clients received at-home home support services through the CSIL program. [3] CSIL is a self-directed home support option for eligible clients with high-intensity care needs. CSIL clients receive funds directly from their local health authority to purchase their own home support services. CSIL clients become employers who manage all aspects of their home support.

FINANCIAL IMPLICATIONS

- In 2015/16, health authorities reported spending more than $1 billion on community care services, which include adult day services, professional services (nursing and rehabilitation services), home support, case management, and assisted living services.

Approved by:
Sharon Stewart obo Doug Hughes, ADM Primary and Community Care Policy; February 17, 2017
Gordon Cross obo Manjit Sidhu, ADM, Finance and Corporate Services; March 7, 2017
Christine Voggenreiter obo Teri Collins, ADM, Health Sector Information, Analysis and Reporting; March 8, 2017

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[1] 2017.0208 HCC Annual Clients Counts, Volumes, Rates 2015-2016, last updated March 3, 2017, Health Sector Information, Analysis, and Reporting Division, Ministry of Health.

[2] 2017.0208 HCC Annual Clients Counts, Volumes, Rates 2015-2016, last updated March 3, 2017, Health Sector Information, Analysis, and Reporting Division, Ministry of Health.

[3] 2017.0208 HCC Annual Clients Counts, Volumes, Rates 2015-2016, last updated March 3, 2017, Health Sector Information, Analysis, and Reporting Division, Ministry of Health.

FACT SHEET

Licensed Community Care Facilities

ISSUE

- Community care facilities are regulated under the *Community Care and Assisted Living Act* (CCALA) and are licensed through regional health authorities.
- The Ministry of Health Community Care Licensing program provides provincial stewardship for the operation of the health authority community care licensing programs, and is responsible for the development and implementation of legislation, policy and guidelines to protect the health and safety of people being cared for in licensed community care facilities.
- Licensed community care facilities include both publically subsidized and private pay models.
- It is important to note that there are several different types of licensed care under the CCALA, including child day care, child and youth residential care, and residential care for specialized populations including Hospice, Mental Health, Substance Use, Community Living, Acquired Injury and Long Term Care.
- Health authorities provide quarterly data[1] to the Ministry on the number of facilities under each service type described in the Act and its Regulations.

Residential Care

Spring 2017	Island	VCHA	FHA	IHA	NHA	BC
Facility Service Type						
Acquired Injury	3	4	16	10	1	**34**
Child and Youth Residential	18	18	19	7	23	**85**
Community Living	120	84	167	86	31	**488**
Hospice	3	6	5	4	3	**21**
Long Term Care	80	45	65	66	13	**269**
Mental Health	14	40	39	8	0	**101**
Substance Use	5	12	15	3	0	**35**
Mental Health and Substance Use	0	0	0	6	4	**10**
Hospital Act[2]	22	23	25	18	11	**99**
Total	***265***	***232***	***351***	***208***	***86***	***1142***

Child Care

Spring 2017	Island[3]	VCHA	FHA	IHA	NHA	BC
Facility Service Type						
Group Child Care < 36 months	132	165	284	115	40	**736**
Group Child Care > 30 months	289	295	474	207	80	**1345**
Group Child Care School Age	268	221	486	221	87	**1283**
Preschool	201	224	412	195	102	**1134**
Family Child Care	369	256	471	225	209	**1530**
Occasional Child Care	15	31	5	33	3	**87**
In-Home Multi Age Child Care	82	45	145	52	36	**360**
Multi Age Child Care	80	41	294	112	65	**592**
Child-minding	4	5	12	4	1	**26**
Total	***1440***	***1283***	***2583***	***1164***	***623***	***7093***

FINANCIAL IMPLICATIONS

N/A

Approved by:
Sharon Stewart obo Doug Hughes, Primary and Community Care Policy Division; February 17, 2017

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[1] Data current to February 15, 2017/ Licensed Facilities by Service Type Spring 2017 / Source: HA Community Care Licensing Programs.
[2] These facilities are designated as extended care or private hospitals under the *Hospital Act*, not licensed under CCALA.
[3] For Island Health this was counted by primary service type, some of these will have more than one service type but it is only counted in the most dominant service type

FACT SHEET

HOME AND COMMUNITY CARE
TEMPORARY RATE REDUCTIONS (HARDSHIP WAIVERS)

ISSUE

A revised Temporary Rate Reduction (TRR) process was implemented on April 1, 2013, in response to recommendations in the Ombudsperson's report, *"The Best of Care: Getting it Right for Seniors in BC."* The Ministry of Health (the Ministry) committed to monitoring TRR numbers under the revised process for a period of two years starting July 1, 2013, At the completion of the two years, the Ministry and health authorities commited to ongoing monitoring.

KEY FACTS

- A TRR is a time-limited, reduced rate for clients receiving publicly subsidized home and community care services, who would experience serious financial hardship if they were to pay their assessed client rate. Health authorities follow a standardized process, using the client's income and expenses for themselves, and their spouse and dependent children (if applicable) to calculate a reduced rate. If approved, the client may pay a nil or reduced client rate.
- Effective April 1, 2013 changes to the TRR process were made to ensure the process reflected the cost of living in BC at that time. These changes resulted in updates to the types of allowable expenses that could be claimed with the necessary supporting documentation. Changes also included the calculation of the temporary daily rate for home support clients to ensure the client's expenses are considered fair and consistent.
- TRRs are approved for the shortest time period possible, up to a maximum of twelve months.
- In response to a recommendation by the Office of the Ombudsperson, health authorities have been collecting and reporting data to the Ministry on the number of TRR applications approved/ denied and the number of TRR policy exceptions.
- The number of TRR applications approved province-wide in each quarter:

TRR approvals										
13/14 Q2	13/14 Q3	13/14 Q4	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2	15/16 Q3	Total
377	464	538	564	493	544	707	569	498	521	5275

- The number of TRR approvals over the period July 1, 2013 to December 31, 2015 per health authority:

Total number of TRR approvals by health authority	Interior	Fraser	Vancouver Coastal	Northern	Island	Total
	2489	648	822	144	1172	5275

- The number of TRR denials is low, as TRR applications are generally submitted only when the health authority knows it will most likely be approved. From July 1, 2013 to December 31, 2015, there were a total of 391 TRR applications denied.

FACT SHEET

- Most TRR approvals are for short-term residential care services. TRR approvals based on type of service:

Total number of TRR approvals July 1, 2013 to December 31, 2015 (all health authorities combined)	Long-Term Residential Care	Assisted Living	Home Support	Short-Term Residential Care	Total
	1306	319	1241	2409	5272

- 75 percent of all exceptions to TRR policy are for one of three administrative reasons: Non-standard income documentation, incomplete expense documentation, or an adjustment of the effective date of the TRR.

Exceptions to TRR policy July 1, 2013 to December 31, 2015 (all health authorities combined)	Ineligible Client (e.g. MSD client)	Non-Standard Income Docs.	Incomplete Expense Docs.	Adjusted Effective Date	Other	Total
	42	516	633	604	536	2331

FINANCIAL IMPLICATIONS

N/A

Approved by:
Sharon Stewart obo Doug Hughes, ADM Primary and Community Care Policy Division; February 17, 2017

The data source for the information referenced in this fact sheet is the TRR quarterly data reporting submitted by the health authorities to the Ministry of Health.

FACT SHEET: Pending ADM Approval

Choice in Supports for Independent Living (CSIL)

ISSUES

CSIL is a self-managed home support funding program that allows clients to receive funds directly for the purchase of home support services, and assumes full responsibility for the management, co-ordination and financial accountability of their services. Major issues relate to CSIL reimbursement rates, inconsistent application of policy, and program sustainability.

KEY FACTS

CSIL Assessment and Rates

- Provincial policy indicates that health authorities are responsible for determining eligibility for CSIL (Home and Community Care [HCC] Policy 4.C.3).
- The funding provided to CSIL clients was increased to $27.63 per hour, effective April 1, 2011, with subsequent increases to $28.63 per hour effective April 1, 2012 and $29.50 per hour effective April 1, 2013.
- In 2014, the Association for CSIL Employers (ACE) asked the Ministry of Health to increase CSIL funding to bring the rates into parity with the agency (health authority) home support rates.
- In December 2015 the Ministry responded by aligning the CSIL hourly rate increases with the wage rate increases negotiated through the Province's 2014 Economic Stability Mandate. The CSIL hourly rate is increasing 5.5% from January, 2016 – February, 2019. The breakdown of the increases are as follows:

s.13,s.17

CSIL Program Sustainability [1]

- On average, CSIL clients received 229 hours of home support per month compared to 17 hours per month for traditional home support clients. [1]
- Currently, the average CSIL client receives $6,856.26 per month in funding ($29.94 per hour x 229 hours[1]). The amount of CSIL funding is based on the number of home support hours, as determined through a clinical assessment (RAI-Home Care), multiplied by the hourly CSIL rate.
- In 2015/16, BC has 956 people who receive home support through CSIL, an increase of 77% since 2001/02. [2] Although the eligibility policy has not changed since April 2011, there is increased utilization of the program, by both clients and by number of service hours.

[1] 2016-0684 HCC Annual Clients Counts, Volumes, Rates 2015-2016, last updated January 7, 2017, Health Sector Information, Analysis, and Reporting Division, Ministry of Health.

- Other jurisdictions cap program funding with the option of capping funding equal to the cost of residential care.

Consistent Program Implementation and Portability

s.13,s.17

FINANCIAL IMPLICATIONS

Health authorities have absorbed the costs of increasing the hourly rate to CSIL clients implemented April 1, 2011, 2012, and 2013 and are responsible for the funding of health related programs and services within the available financial resources.

Approved by:

Sharon Stewart obo Doug Hughes, Primary and Community Care Policy Division; February 17, 2017
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; February 11, 2016
Christine Voggenreiter, obo Teri Collins, Health Sector Information Analysis & Reporting; March 3, 2017

[2] 2017-0155 HCC Annual Client Counts Volumes 2015-2016 – SUMMARY, last updated February 18, 2017, Health Sector Information, Analysis, and Reporting Division, Ministry of Health. NOTE: CSIL Client count # in 2001/02 = 540.

FACT SHEET

ASSISTED LIVING - SENIORS RESIDENCES

ISSUE

The government is committed to promoting health and safety for vulnerable adults receiving assisted living services under the *Community Care and Assisted Living Act* (CCALA). Seniors residences are one type of assisted living that is regulated by the CCALA.

KEY FACTS

- Assisted living is housing which supports adults by providing one or two prescribed services (i.e., medication management, daily living assistance) and five hospitality services (meals, house-keeping, laundry, recreation, emergency response system).
- Residences which meet the CCALA definition of assisted living are required to be registered with the provincial assisted living registrar, regardless of whether they are publicly subsidized.
- As of February 2017, 218 assisted living residences for seniors (both publicly subsidized and private pay) have been registered with a total of 8,017 registered publicly subsidized and private pay units (56 percent of these are publicly subsidized).[1]
- The total number of publicly subsidized assisted living units in BC as of February, 2017 was 4,464: 1,393 in Fraser Health Authority, 931 in Interior Health Authority, 993 in Vancouver Island Health Authority, 288 in Northern Health Authority, and 859 in Vancouver Coastal Health Authority.[2]
- Since September 2012, high level information from substantiated complaints has been posted on the Ministry of Health's (the Ministry) Assisted Living Registry (ALR) website.
- From January 1 to December 31, 2016, the ALR received 48 complaints about seniors' residences, with 115 different health and safety issues.
- Four of the 48 complaints were substantiated after investigation. Two reports have been posted and one will be posted on the ALR website.
- In 2016, the ALR conducted a total of 18 site inspections at seniors' assisted living residences. Fourteen inspections were related to a health and safety concern, 3 inspections were pre-registration, and 1 inspection was of a possible unregistered residence.[3]
- The ALR received and investigated 395 serious incident reports in seniors' assisted living residences in 2016.[4]
- As of February 3, 2017, the ALR has 19 complaints regarding seniors' assisted living residences under investigation.[5]

Background

- The CCALA, which came into force in 2004, established an Assisted Living Registrar to oversee registration and respond to concerns about health and safety in assisted living residences.
- In January 2012, the registry operations were moved into the Ministry to ensure alignment of the Registrar's work. The Assistant Deputy Minister of the Primary and Community Care Policy Division was appointed as the Assisted Living Registrar.
- The ALR is responsible for registering assisted living residences, and responding to complaints or other information that indicates residences are being operated in a way that does not ensure the health and safety of the residents, or that an unregistered assisted living residence is being operated. Anyone with a concern can complain to the registry. Registry staff conduct investigations that are remedial in nature.

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[1] Assisted Living Database, February 10, 2017
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Assisted Living Database, February 3, 2017

FACT SHEET

- In 2016, government amended the CCALA to increase flexibility and allow more than two prescribed services to be provided in assisted living. This change was made in response to recommendations by the Seniors Advocate and other stakeholder groups, who were of the opinion that people who could still live safely in assisted living were being moved into residential care prematurely.
- The amendments to the CCALA also included enhancements to the registrar's inspection and enforcement powers, and increased protections for residents. The amendments will be brought into force once assisted living regulations have been developed, and are ready to be implemented.

FINANCIAL IMPLICATIONS

- The monthly client rate for publicly subsidized assisted living units is set at 70 percent of the client's after-tax income, subject to the minimum and maximum rate. The maximum rate is based on a combination of market rent for housing and hospitality costs for that geographic area, plus the actual cost of personal care services for the client.
- As of January 1, 2017, the minimum monthly rate for publicly subsidized assisted living services is $931.50 per month for a single client, and $1501.80 per month for a couple.
- The minimum monthly rate is adjusted each year to reflect the changes in the federal supplements (OAS/GIS) as of July 1 of the previous year.
- Client rates are reviewed annually based on income information received from the Canada Revenue Agency. In the fall of each year, health authorities notify clients of their new client rate, effective January 1 of the following year.
- Clients that do not consent for the Canada Revenue Agency to release income information to the Ministry to establish the client rate are charged the maximum client rate for assisted living services.
- Clients who believe that payment of their client rate will cause them serious financial hardship can apply to their health authority for a temporary rate reduction of their client rate.
- Clients in publicly subsidized assisted living units are responsible for paying for certain costs, such as Medical Services Premiums, Fair PharmaCare coverage, personal telephone, and cable television. However, low-income clients pay nothing for Medical Services Premiums, and pay no more than $250 per year for their PharmaCare costs, depending on their income. In addition, there may be charges in different settings for other optional services or activities, such as transportation, or help with errands that are not considered hospitality or personal care services.

Approved by:
Sharon Stewart obo Doug Hughes, ADM Primary and Community Care; February 17, 2017
Gordon Cross obo Manjit Sidhu, ADM, Finance and Corporate Services, May 9, 2017
Christine Voggenreiter, obo Teri Collins, ADM Health Sector Information, Analysis and Reporting Division; February 23, 2017

BC Care Providers ASSOCIATION

Celebrating 40 Years | 1977 – 2017

Assisted Living Tenancy Task Force Review

A Report of Findings and Recommendations July 2017

Chaired by Tom Crump

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-Communique-

Meeting to Discuss Risk Assessment for BC Care Homes and Assisted Living Residences

February 28, 2014 (Vancouver, BC): Over 20 individuals representing key stakeholders (see below for complete list) that either work within or with the continuing care and assisted living sectors in British Columbia held a meeting on Wednesday, February 26th at the BC Care Provider's Association office in Vancouver to discuss the issue of fire safety within care homes.

The Ministry of Health provided attendees with an update on the current status of care homes and assisted living residences which have either no sprinklers or a partial system in place.

- All new residential care facilities and assisted living facilities are required to be built to the current B.C. Building Code standards.
- In fact, all licensed residential care facilities built since 1996 have been built with sprinkler systems and most of the older residential care facilities have been retrofitted.
- Only 6 per cent of B.C.'s residential care facilities do not have sprinklers – that's 10 of 361 facilities. Another 12 are partially sprinklered.
- In addition, only two percent of B.C's assisted living residences do not have sprinklers – that's five of 212 facilities. Another eight are partially sprinklered.
- This means the vast majority of both publicly funded and private pay residential and assisted living care facilities already have full sprinkler systems in place.
- The government updated the Building Code in December 2012 to require any new assisted living facilities to be built with sprinklers. All new buildings will be built to these standards.

The working group agreed that all efforts will be made over the coming weeks to initially focus on the care homes and assisted living residences identified on the official list released by the Ministry of Health.

One of the key outcomes of the meeting is that the Ministry of Health, in consultation with municipal fire officials and the working group, will immediately engage an external consultant to undertake a detailed risk analysis of the identified homes. The consultant will determine all possible risk factors that may exist and what can be done to mitigate them to ensure the continued safety of seniors in care.

During the two-hour roundtable discussion attendees also worked to identify possible gaps in data collection with a commitment to jointly producing an updated and comprehensive list that will be made available to the public in the coming weeks.

Other items discussed:

- Challenges facing volunteer rural fire departments in responding to fires in care homes
- What alternatives to sprinkler retrofits exist to reduce fire risk
- How BC compares to other jurisdictions and whether there are best practices from other jurisdictions that could be implemented

- The role that combustible materials within a care home (such as furniture and personal belongings) can play in fuelling the rapid spread of a fire
- Ensuring that residential care facility fire safety plans factor in lower staffing levels at fire halls and care homes during overnight periods
- Standards for fire prevention and protection vary within municipal jurisdictions

“Our meeting today was an excellent first step at ensuring we gather the data and develop a coordinated action plan moving forward,” says Daniel Fontaine, CEO for the BC Care Providers Association. “We want to assure the public that we are all working collaboratively and are making every effort to prevent the kind of tragedy we witnessed in Quebec.”

The working group has agreed to meet again in the coming weeks and will use that opportunity to receive a briefing on the status of the consultant’s report and map out possible next steps.

-30-

Organizations with representatives in attendance:

Ministry of Health
Ministry of Natural Gas Development and Responsible for Housing
Fraser Health Authority
Northern Health Authority
Island Health Authority
Vancouver Coastal Health Authority
Interior Health Authority
Union of BC Municipalities
BC Care Providers Association
Denominational Health Association
BC Seniors Living Association
Fire Chiefs’ Association of BC
National Fire Protection Association
Representatives from Vancouver, Langley and White Rock fire departments were in attendance representing provincial or national associations.

FACT SHEET

Residential Care Benefits

ISSUE

In October 2013, following reports of inconsistencies, the Ministry of Health (Ministry) conducted a provincial review of the application of chargeable extra fees in publicly subsidized residential care facilities throughout the province. In 2016, the Ministry implemented a new policy on basic wheelchair fees in all publicly subsidized residential care facilities, which extended the list of benefits available to residents.

KEY FACTS

- Residential care services fall under 1 of 2 categories: benefits or chargeable extras.
  - Benefits include standard accommodation, meals, standard hygiene supplies, routine laundry, development and maintenance of a care plan, and clinical support services. These services are included in the client rate and are provided at no additional charge.
  - Chargeable extras include personalized, exclusive-use mobility equipment such as walkers; personal transportation; preferred nutrition supplements; personal hygiene products; hearing aids and batteries, value-added items such as cable, telephones and newspapers, and other items identified in Chapter 6, Residential Care Services, F - Benefits and Allowable Charges of the Home and Community Care Policy Manual. Currently, the cost of these added services are the responsibility of the patient.
- In October 2013, following reports of inconsistencies, the Ministry and regional health authorities launched a provincial review of the application of chargeable extra fees in 308 publicly subsidized residential care facilities throughout the province.
- The provincial review indicated that:
  - Facilities are inconsistent in providing information to clients on the optional nature of chargeable extras and receiving client consent for charges.
  - Facilities have varied practices for situations where clients cannot afford extra fees.
  - Wheelchair fees are the most common non-discretionary, medically required chargeable extra in 247 of the facilities that responded.
- On January 1, 2016, the policy on basic wheelchairs was implemented in all health authority owned and operated residential care facilities. Contracted operators had until April 1, 2016 to become fully compliant with the policy.The policy provided for the following:
  - Basic wheelchairs for personal exclusive use, if they are medically required, are provided to residents as a benefit (i.e., at no charge).
  - Basic cleaning and maintenance of basic wheelchairs will also be provided as a benefit.
  - Residents requiring a specialized wheelchair continue to be responsible for the cost. Service providers are not expected to provide this service.
- The Ministry in collaboration with health authorities will continue to monitor and update the chargeable extras policy as issues arise.

FINANCIAL IMPLICATIONS

- In the case of financial hardship, health authorities may choose to waive fees, and individuals may apply for temporary rate reductions to help them accommodate any exceptional costs.
- Revenue from chargeable extras is assumed to be fairly significant and is one of the drivers behind facilities offering these optional services onsite. Between June 2013 and September 2014, Fraser Health Authority owned and operated facilities alone collected $67,762 in wheelchair rental fees. This does not account for the cost of wheelchair repairs, cleaning, and replacement cushions.

FACT SHEET

Approved by:
Sharon Stewart obo Doug Hughes, Primary and Community Care Policy Division; February 17, 2017

FACT SHEET
Residential Care Beds Inventory

ISSUE

The Government of BC has invested in the development of residential care and assisted living beds across the province. The Home and Community Care (HCC) Beds Inventory enables the Ministry of Health to provide semi-annual updates on publicly subsidized residential care beds and facilities in BC.

KEY FACTS

- As of September 30, 2016, the total capacity of publicly subsidized residential care beds in BC was 27,765[1]. Additional details are provided in Table 1, below.

Table 1: Publicly subsidized residential care beds in BC

Short-Term RC Beds				Long-Term RC Beds	Temporary Beds	Family Care Home Beds	Total RC Beds
Convalescent	End of Life	Respite	Flex Beds				
487	261	204	30	26,269	449	65	27,765

- Table 2 provides the total capacity of publicly subsidized residential care beds in BC by health authority and health service delivery area (HSDA), as of September 30, 2016.

Publicly subsidized residential care beds in BC by health authority and HSDA	Health Service Delivery Area (HSDA)	Short Term RC Beds	Long Term RC Beds	Temporary Beds	Family Care Home Beds	Total RC Beds
Interior Health Authority	East Kootenay	31	460	0	0	491
	Kootenay Boundary	22	561	0	0	583
	Okanagan	164	2,918	8	16	3,106
	Thompson Cariboo Shuswap	101	1,422	1	4	1,528
IHA Total		318	5,361	9	20	5,708
Fraser Health Authority	Fraser East	56	1,536	81	1	1,674
	Fraser North	52	3,116	29	0	3,197
	Fraser South	219	3,416	104	9	3,748
FHA Total		327	8,068	214	10	8,619
Vancouver Coastal Health Authority	North Shore/Coast Garibaldi	29	1,656	26	0	1,711
	Richmond	10	726	68	0	804
	Vancouver	87	4,171	10	0	4,268
VCHA Total		126	6,553	104	0	6,783
Vancouver Island Health Authority	Central Vancouver Island	70	1,843	46	12	1,971
	North Vancouver Island	11	594	51	3	659
	South Vancouver Island	69	2,738	18	16	2,841
VIHA Total		150	5,175	115	31	5,471
Northern Health Authority	Northeast	5	248	0	0	253
	Northern Interior	32	597	7	0	636
	Northwest	24	267	0	4	295
NHA Total		61	1,112	7	4	1,184
British Columbia Total		982	26,269	449	65[2]	27,765

- Approximately 61 percent of publicly subsidized residential care facilities in BC are regulated/licensed under the *Community Care and Assisted Living Act* (CCALA), and approximately 27 percent under the *Hospital Act*[1]. For more details, see Table 3.

[1] 2017-0162 HCC Residential Bed Inventory Updated (for September 30, 2016), Health Sector Information, Analysis, and Reporting Division, Ministry of Health.

[2] Family Care Homes are private residence homes where care is provided to a maximum of two people. As of September, 2016 survey, there were a total of 45 publicly subsidized family care homes in British Columbia providing 65 family care home residential care beds (Table 2).

- Health authorities own and operate approximately 33 percent of the publicly subsidized residential care facilities in BC, while private for-profit companies operate approximately 39 percent, and private not-for-profit organizations operate approximately 28 percent of publicly subsidized residential care facilities[3]. For more details, see Table 3 and 4.

Table 3 and 4: Proportion of publicly subsidized residential care and assisted living facilities in BC (includes family care homes) by regulation/legislation for facility and owner type.

Table 3: Percentage of Publicly Subsidized Facilities in BC with Residential Care Beds by Regulation/Legislation	Community Care & Assisted Living Act	Hospital Act	CCALA & Hospital Act	Missing*
Interior Health Authority	67%	19%		14%
	70	20		15
Fraser Health Authority	69%	30%		1%
	61	27		1
Vancouver Coastal Health Authority**	65%	29%	6%	
	45	20	4	
Vancouver Island Health Authority**	45%	26%	29%	
	40	23	26	
Northern Health Authority	57%	43%		
	16	12		
British Columbia	**61%**	**27%**	**8%**	**4%**
	232	**102**	**30**	**16**

** Missing- information not provided by health authorities*
***Vancouver Coastal Health Authority and Vancouver Island Health Authority have facilities to which both CCALA and the Hospital Act apply. For example: Licensed prior to "complex care" designation; extended care wing under the Hospital Act and other part of facility under CCALA.*

Table 4: Percentage of Publicly Subsidized Facilities in BC with Residential Care Beds by Owner Type	Health Authority Owned	Private for Profit Owned	Private Not for Profit Owned
Interior Health Authority	44%	47%	10%
	46	49	10
Fraser Health Authority	18%	44%	38%
	16	39	34
Vancouver Coastal Health Authority	28%	22%	51%
	19	15	35
Vancouver Island Health Authority	24%	51%	26%
	21	45	23
Northern Health Authority	79%	7%	14%
	22	2	4
British Columbia	**33%**	**39%**	**28%**
	124	**150**	**106**

[3] 2017-0162 HCC Residential Bed Inventory Updated (for September 30, 2016), Health Sector Information, Analysis, and Reporting Division, Ministry of Health.

FACT SHEET

Background

- Since 2001, the Government of BC has invested in the development of residential care and assisted living beds across the province. This increased bed capacity allows the care needs of seniors and people with disabilities to be met in a setting which supports their independence to the highest degree possible.
- The 5,000 Beds database was initially created to track the development of new beds. After the close of the project in March 2010, the Ministry and health authorities agreed there was a need to maintain a current and complete inventory of residential care and assisted living beds in the province.
- The provincial HCC Beds Inventory was developed and the five regional health authorities have been submitting data on publicly subsidized residential care and assisted living beds since September 2010. Health authorities update the HCC Beds Inventory twice annually in March and September.

FINANCIAL IMPLICATIONS

N/A

Approved by:
Sharon Stewart obo Doug Hughes, Primary and Community Care Policy Division; March 15, 2017
Heather Richards obo Teri Collins, ADM, Health Sector Information, Analysis & Reporting Division; March 22, 2017
Gordon Cross obo Manjit Sidhu, Finance and Corporate Services, April 3, 2017

FACT SHEET

Client Rates for Residential Care Services

ISSUE

Clients receiving subsidized long-term residential care services pay an income-based monthly rate. The rates are updated annually, based on the client's income information from the Canada Revenue Agency, subject to a minimum and maximum monthly rate. Clients receiving short-term residential care services pay a fixed daily rate.

KEY FACTS

Income-Based Client Rates

- Clients receiving long-term residential care or family care home services pay a monthly client rate based on 80 percent of their after tax income towards their housing and hospitality costs, subject to a minimum and maximum monthly rate.
- As of January 1, 2017, the minimum monthly client rate is $1,104.70. The minimum rate is adjusted annually based on changes to the Old Age Security/Guaranteed Income Supplement rate as of July 1 of the previous year.
- As of January 1, 2017, the maximum client rate is $3,240.00 per month. The maximum client rate is adjusted annually based on changes to the Consumer Price Index over the previous year.

Fixed Client Rates

- Clients receiving short-term residential care services for respite care, convalescent care, or hospice/end-of-life care are assessed at a fixed daily rate, based on the minimum monthly rate for long-term residential care services.
- As of January 1, 2017, the fixed daily rate for short-term residential care services is $36.30.

Minimum Residual Income

- Client rates are calculated so that most clients receiving residential care services retain a minimum residual income amount to cover personal expenses, such as personal toiletry items or over-the-counter medications. On February 1, 2012, the Government of BC increased the minimum residual income amount from $275 per month to $325 per month. The increase in the minimum residual income amount ensures that the additional Old Age Security/Guaranteed Income Supplement benefits are not counted as income when assessing client rates. When implemented, this was the highest minimum residual income amount in Canada.

Temporary Reduction of the Client Rate

- If payment of the assessed client rate would cause the client or their spouse/dependents serious financial hardship, the client can apply to their health authority for a temporary reduction of their client rate (cross-reference Hardship Waivers Fact Sheet).
- In 2013, the temporary rate reduction process was revised based on a standardized approach to ensure consistency across the province, and to make the process more fair and transparent for clients, their family members and caregivers, and the public.

Background

- On February 1, 2010, the Government of BC introduced a more equitable client rate structure which was phased in over the following two years. Prior to the rate restructuring, lower-income clients were paying a higher percentage of their income in relation to higher-income clients. The revised client rate structure ensures that clients who can least afford the cost of residential care services are not unreasonably charged.

FACT SHEET

- Client rates are intended to cover housing and hospitality costs, including meals, routine laundry and housekeeping. Health authorities cover the cost of care, such as nursing, in all publicly subsidized residential care facilities.
- The rate setting methodology for clients receiving residential care services is set out in the *Continuing Care Fees Regulation*, the *Hospital Insurance Act Regulations*, and the *Home and Community Care Policy Manual.*
- Client rates are updated annually by the automated Health Authority Rate System, using income information obtained from the Canada Revenue Agency with the client's prior consent.

FINANCIAL IMPLICATIONS

Health authorities reported revenues of approximately $177 million in 2015/16, related to health authority owned and operated residential care facilities. Based on this information, the estimated total amount of residential care client rate revenue is $485 million annually.

Approved by:
Sharon Stewart obo Doug Hughes, ADM Primary and Community Care Policy; February 17, 2017
Gordon Cross obo Manjit Sidhu, ADM Finance and Corporate Services; November 29, 2016

FACT SHEET

High Risk Residential Care Facilities

ISSUE

Health authorities are responsible for monitoring licensed residential care facilities licensed under the *Community Care and Assisted Living Act*). Using a standardized Risk Assessment Tool, facilities are categorized as low, medium or high risk rating based on compliance with the Act and the Residential Care Regulation, using information gathered during routine inspections, observations, interviews, examination of records, as well as facility history. When non-compliance is identified, that specific area of non-compliance is assessed using the Risk Assessment Tool to assess potential risk of harm to persons in care in the facility.

KEY FACTS

- The purpose of the Act and its regulations is to ensure that the health, safety, and well-being of persons in care are promoted and protected. The Act and regulations set the minimum standards for care that licensed operators must meet.
- The Community Care Facility Licensing program staff of health authorities regularly inspect and monitor all licensed care facilities to ensure compliance with legislative requirements, and work with the operators to meet these necessary requirements.
- A risk assessment is typically completed at least annually along with a comprehensive routine compliance inspection, and is completed using a standardized Risk Assessment Tool.
- Frequency of monitoring is based on the Risk Rating: Low risk facilities will receive their next comprehensive routine compliance inspection within 12 to 18 months, and high risk facilities will receive their next comprehensive routine compliance inspection within 3 to 6 months. Licensing officers may also visit a facility at any time for follow up inspections to ensure that identified non-compliance has been corrected, or to follow up on a complaint or incident report.

High Risk Facilities by Facility Type[1]

Health Authority	Long Term Care (Seniors)	Child & Youth	Community Living	Hospice	Mental Health	Substance Use	Acquired Injury
Fraser	4	0	1	0	0	1	1
Island	3	0	3	0	0	0	0
Interior	1	0	0	0	0	0	1
Northern	0	0	0	0	0	0	0
Vancouver Coastal	1	0	1	0	0	0	0
TOTALS:	**9**	**0**	**5**	**0**	**0**	**1**	**2**

- It is important to note that numbers of high risk facilities, without inspection information, is only a snapshot in time, and may change quickly based on response/actions of the operator. When facilities are rated high risk, health authorities implement enhanced monitoring, as noted above.

FINANCIAL IMPLICATIONS

N/A

Approved by:
Sharon Stewart, obo Doug Hughes, Primary and Community Care Policy Division; February 17, 2017

[1] Information has been provided by health authority Community Care Facility Licensing programs effective February 15, 2017.

FACT SHEET

Residential Care Staffing Review Report

ISSUE

- A number of events in BC, culminating in the posting of the Office of the Seniors Advocate's (OSA) *Residential Care Facilities Quick Facts Directory* in January 2016, which indicated that 81% of facilities were operating below 3.36 direct care hours per resident day (HPRD), have brought to light concerns about the progress in implementing the Ministry of Health staffing guideline in residential care facilities and the impact on quality of care and residents.
- The OSA released a 2017 version of their *Residential Care Facilities Quick Facts Directory* in January 2017, which shows the percentage of facilities operating below 3.36 HPRD has increased. Some of the change may be attributed to differences in reporting from one year to the next (e.g., 1 health authority included special care units (which have higher staffing levels) in the 2016 report, but not in the 2017 report.
- The Minister of Health asked Parliamentary Secretary Darryl Plecas to work with the OSA and Ministry staff to examine quality of care, staffing levels and funding in residential care facilities, and report back to him.
- Ministry staff worked in collaboration with key stakeholders to undertake: Key/Expert Interviews (including Alberta and Ontario); Document Acquisition and Review; Health Authority Current State Questionnaire; Literature Review; Data Analyses; and Application of the Residential Care Staffing Framework Staffing Model.
- A *Residential Care Staffing Review Report* was released on March 9, 2017, in conjunction with *An Action Plan to Strengthen Home and Community Care for Seniors*. The purpose of the Report was to determine what, if any, changes needed to be made in the residential care system to ensure consistency, transparency and accountability across the province in meeting resident's needs, sustainability and align with the Ministry's focus on patient-centered care in the community.
- A literature scan was conducted that involved a search for long-term care in conjunction with quality, staffing and budget. Similar to findings from a 2007/08 search, the literature review findings identified facility staffing decisions should be made based on evidence-based staffing frameworks that incorporate variables that positively affect resident and staff outcomes. Other articles reviewed indicated that, in general, staffing levels were predictors of care quality and increased staffing levels could improve care and resulted in better outcomes or decreased severity of deficiencies. Findings also indicated nursing staff affects the quality of care in facilities; staffing stability is associated with better patient outcomes and likewise, staffing instability with poorer outcomes; staffing challenges that negatively affect quality include director of nursing turnover, staff turnover, changes in staffing pattern (e.g., decrease in staffing levels or change in staffing mix), high levels of absenteeism; limited time available to train staff; and effectiveness of minimum staffing standards is unknown and staffing should be allocated according to particular resident needs.
- The Jurisdictional Review found that both Alberta and Ontario have standard province-wide funding models using interRAI organizational outputs (Resource Utilization Groups and Case Mix Index); Alberta talks about 2 measures - 3.02 worked hours or 3.67 paid hours; and Ontario does not have a target for HPRD, but rather monitors quality through inspections and using interRAI Quality Indicators.
- Input from health authorities and industry indicated health authority concerns about lack of clarity on contracted site operating costs, provincial policies being implemented without additional funding (e.g. basic wheelchairs), and the cost of collective agreement negotiations and generous entitlements for vacation and sick leave in collective agreements. Industry's concerns are about the need to increase funding for HPRD, lack in consistency between health authorities in

approaches to provision of services; differing definitions of direct care hours, challenges attracting and retaining staff, policies being implemented without additional funding (e.g. basic wheelchairs), and inconsistent interpretation of regulations and licensing.

- The Report action plan calls for the implementation of the 16 actions as follows:

Category	Action	Proposed Timeline
Funding and Staffing	1. Finalize a report, in collaboration with CIHI, to better understand the demand for home health, assisted living and residential care services (including the different profiles of clients using RAI assessment and service episode data) given the changes taking place in the home and community care system, and to inform required changes to existing residential care service models.	May 2017
	2. Confirm the definition of direct care hours per resident day.	July 2017
	3. Establish a baseline for: hours per resident day, client case mix, other identified residential care costs.	Sept. 2017
	4. Work with health authorities and industry to create and implement an interim targeted process that would increase hours per resident day for areas with identified gaps until a costing review has been completed and the funding model has been updated to incorporate client complexity.	Oct. 2017
	5. Move towards a province-wide standard residential care funding model, with a lens to incorporate resident complexity (using RUGs and case mix index from RAI assessments), quality of care and flexibility.	Jan. 2018
	6. Complete an analysis of percentage of casual and part-time positions that can potentially be converted to regular full-time positions in residential care facilities.	June 2017
	7. Develop an interim strategy to address immediate high-priority vacancies in residential care facilities.	June 2017
	8. Develop a health human resources plan to ensure supply of staff will meet the needs of the residential care sector. The plan will include targeted recruitment activities and seat-planning in post-secondary programs.	Nov. 2017
Quality of Care	1. Prioritize key quality of care initiatives in residential care and facilitate a coordinated approach that promotes consistency and standardization, yet allows for flexibility given varying needs across facilities.	April 2018
	2. Bring into force Part 3 (care facility admission) of the *Health Care (Consent) and Care Facility (Admission) Act* to protect vulnerable adults. This work will include revising the residential care admission policy to be more person and family-centred.	April 2018
	3. Develop and implement palliative and dementia care policy including requirements and targets for staff education.	April 2018
Accountability	1. Incorporate the requirement to increase hours per resident day through annual bi-lateral agreements between the Ministry and health authorities.	April 2017
	2. Monitor health authority progress on achieving the 3.36 hours per resident day and produce annual reports for Leadership Council.	April 2018
	3. Develop and implement a policy to mandate accreditation for all residential care facilities.	April 2018
	4. Develop and implement performance measures that support quality of care and quality of life outcomes using outputs from RAI assessment and survey data including quality indicators.	April 2018
	5. Develop and implement a process and policy for monitoring, reporting and evaluation processes related to resident need, funding, service delivery and operations, building on experience from other provinces such as Alberta and Ontario to assess whether quality, funding and staffing policies and goals are being achieved.	April 2019

FINANCIAL IMPLICATIONS

- In 2009, the incremental cost to achieve an average of 3.36 total direct care staffing levels for each health authority was estimated at about $215 million annually. By 2011/12, health authorities reported a total of $85.62 million being re-invested into residential care due to the change in the residential care client rate structure, of which $52.51 million was invested in increasing nursing, allied health, and care aide staffing levels. Health authorities have maintained that level of investment and reported small growth in the subsequent years. As of 2015/16, the health authorities reported the annual incremental investment had reached $90.60 million. In 2016, based on current staffing levels and costs, it was estimated that incremental annual funding of $113.7 million would be required to fully achieve an average of 3.36 hours per resident day by health authority, with an increase of approximately 1,511 FTEs (includes 886.7 care aides).

FACT SHEET

- On March 9, 2017, government announced a significant funding boost to strengthen care for BC seniors to support the actions identified in the review of residential care services, as well as other key action areas identified in the Home and Community Care Action Plan. The Province is investing $500 million over the next 4 years as part of a Ministry of Health action plan to improve home and community supports and quality of care for older British Columbians. Over the next 4 years, year-over-year funding increases from the Ministry will enable each health authority to reach an average of 3.36 direct-care hours per resident day across both publicly administered and contracted residential-care facilities. Increased staffing levels will also address a key recommendation from the Ombudsperson's Best of Care (Part 2) report on seniors' care.

Approved by:
Sharon Stewart, obo Doug Hughes, Primary and Community Care Policy Division; May 14, 2017
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; May 29, 2017

Residential Care Staffing Review

March 2017

BRITISH COLUMBIA | Ministry of Health

Table of Contents

Letter from Parliamentary Secretary Darryl Plecas

As Parliamentary Secretary for Seniors to the Minister of Health, ensuring high quality patient-centred care for seniors is a priority for both myself and our government. I also know that ensuring our seniors receive the best care we can provide is a priority for our service providers, their staff, families of seniors and seniors themselves. I know that because I have had the privilege of visiting many of our senior's care facilities around the province, and I have had the opportunity to meet and talk directly with seniors and seniors' groups, service providers, unions, associations and service groups to learn about the issues that matter most to them. All of these groups have truly helped me to identify strengths and challenges in the existing health system and opportunities to enhance quality of life for seniors in residential care facilities throughout British Columbia. Most significantly, their dedication, compassion and deep sense of concern has made my learning more about seniors care more heartfelt. They are truly inspirational.

I have also had the pleasure of working with the seniors advocate and Ministry of Health staff to examine the current state of residential care service delivery in B.C., with a focus on quality of care (including outcomes), staffing levels and funding. I have learned much from that work about the complexity in trying to establish what ought to be, and can be, an appropriate number of funded care hours for any one care facility. Indeed, as the findings of this review indicate that, in addition to staffing levels and staffing mix, there are multiple factors that contribute to quality of care, quality of life and resident outcomes. For example, meals, recreational activities, and opportunities for socialization are just some of the other ways that a resident's experience can be enriched, and we need to be attentive to these considerations as we continue with our efforts to get our funding and staffing models right.

We have learned a great deal through this review process and I am confident that moving forward with the actions in this report will help our province to meet current and future population needs for residential care services and improve the lives of seniors living in residential care.

Dr. Darryl Plecas
Parliamentary Secretary for Seniors to the Minister of Health

Acknowledgements

I would like to acknowledge and thank the following committees and organizations for their contributions to this report:

B.C. Ministry of Health – Primary and Community Care Policy Division; Finance and Corporate Services Division; Health Sector Information, Analysis and Reporting Division; and, Health Sector Workforce Division

Office of the Seniors Advocate

Regional Health Authorities

BC Care Providers Association

Denominational Health Association

Canadian Institute for Health Information

Hospital Employees' Union

Ontario Ministry of Health and Long Term Care

Alberta Health and Wellness

Alberta Health Services

RKL Health Informatics

Executive Summary

A number of events in B.C., culminating in the posting of the Office of the Seniors Advocate's 2016 *Residential Care Facilities Quick Facts Directory*, which indicated that 81% of facilities were operating below 3.36 direct care worked hours per resident day, have brought to light concerns about the progress in implementing the Ministry of Health staffing guideline in residential care facilities, and the impact on quality of care and residents.

Health Minister Terry Lake asked Parliamentary Secretary Darryl Plecas to work with Seniors Advocate Isobel Mackenzie and ministry staff to examine three core areas – quality of care, (including outcomes), staffing levels and funding in residential care facilities and report back to him. The intent was to determine what, if any, changes need to be made in the residential care system to ensure consistency, transparency and accountability across the province in meeting resident's needs, sustainability and alignment with the ministry's focus on patient-centered care in the community.

In 2008, the ministry's new provincial residential care staffing framework (described in Appendix C), was developed in response to growing concerns about the availability of appropriately educated, competent staff to adequately meet the complex care needs of clients in residential care, as well as the appropriate mix of professional and non-professional staff to meet these needs. The framework included a stated philosophy of care and describes the intended relationship between resident care needs, and staff leadership and direct care. The resulting staffing model was predicated on the basis that direct care hours align with the needs of the resident and are determined through a comprehensive assessment process involving the resident, their family and staff.

After considering the research findings, as well as current staffing levels within B.C., it was agreed in 2009 that a target be established where total direct care staffing levels for each health authority was to average 3.36 hours per resident day, comprised of 3.0 worked hours of nursing care (includes care aides) and 0.36 worked hours of allied health services. At that time, the cost of achieving this level was estimated at about $215 million of new incremental annual funding, which was about 14% of total reported expenditures of $1,525.6 million.[1]

[1] 2008/09 reported expenditures for residential care, prepared by Regional Grants and Decision Support, Ministry of Health.

Implementation of the framework was funded using incremental revenue generated by changes to the residential care client rate structure, where clients pay up to 80% of their after-tax income (subject to minimum and maximum rates), which took effect Feb. 1, 2010. The ministry estimated that $53.7 million in incremental annual client revenue would be available for reinvestment once the revised rate structure was fully implemented.[2] By 2011/12, health authorities reported a total of $85.62 million being re-invested into residential care due to the changes, of which $52.51 million was invested in increasing nursing, allied health and care aide staffing levels (leaving a gap of about $129 million needed to reach the 2009 estimated amount of $215 million). Health authorities have maintained that level of investment and reported small growth in the subsequent years, with $87.96 million being invested in 2014/15.

Provincially, hours per resident day improved from a baseline of 2.88 in 2009 to 3.06 in 2011/12 and 3.11[3] as of January 2016. Although some facilities have achieved 3.36 hours per resident day, no health authority has achieved the desired average set by the province.

As part of this review, the ministry conducted a literature search, as well as a jurisdictional review with Alberta and Ontario to look at current evidence/best practices for staffing hours and funding.

The jurisdictional review showed that both Alberta and Ontario have standard province-wide residential care funding models. However, when components of these models are examined, there are similarities and differences in the models and how they address staffing in their residential care facilities. For example, Alberta includes paid hours worked per resident day in their formula while Ontario does not factor hours per resident day into their calculations. Both jurisdictions consider client case mix index, a measure of resource intensity based on the client's needs, and have quality improvement outcome measures in their funding formulas.

The recent literature search findings showed that nursing staff affects the quality of care in facilities. Staffing stability is associated with better patient outcomes while staffing instability is associated with poorer patient outcomes. While there was no consistent evidence for a relationship between higher staffing levels and improved quality of care indicators, other articles reviewed indicated that, in general, staffing levels were predictors of care quality and increased staffing levels could improve care and resulted in better outcomes or decreased risk. Increased staffing was found to be a common intervention to improving quality of care and outcomes. However, it was noted that the effectiveness of minimum staffing standards is unknown and that staffing should also be allocated according to particular resident needs.

[2] For existing clients, 50% of the client rate increase was applied Feb. 1, 2010 and the remainder was applied on Jan. 1, 2011.
[3] Office of the Seniors Advocate (March 2016). *B.C. Residential Care Quick Facts Directory as of January 2016.*

Quality of care and safety of residents living in residential care facilities are absolute priorities for government. The ministry needs to ensure that services delivered by the health authorities in owned-and-operated facilities, as well as by contracted service providers, meet patients' needs, are aligned with its focus on patient-centred care in the community, and are sustainable. Although the literature is inconclusive about the effectiveness of defined minimum staffing standards, the ministry believes that achieving a minimum 3.36 hours per resident day average by health authority is required for safe, quality care in most facilities. It is recognized that some special populations, such as younger adults with behavioural and cognitive issues or small facilities in rural areas, would require specific consideration.

The seniors advocate has suggested that all facilities could be brought to a minimum average of 3.36 hours per resident day by health authority through the investment of $83.5 million based on $30/hour for care aides (assuming all the added staff are made up of care aides).[4] Using the current staffing framework and current labour costs provided by the Health Employers Association of B.C., the ministry calculates it could cost upwards of $113.7 million for an increase of 1,511 FTEs (includes 886.7 care aides) to meet a standard of an average of 3.36 hours per resident day by health authority. Even if new funding could be made available, the likelihood of increasing to 3.36 hours per resident day within a short timeframe is unlikely, given the challenges with the supply of health human resources required.

Achieving an average of 3.36 hours per resident day by health authority would best be supported by a standard funding and monitoring approach. The funding approach should incorporate variables that impact staffing level and mix such as changes in workload resulting from residents moving into and departing from facilities, and changing resident needs over time. This could be done in conjunction with defining a small number of province-wide priority quality of care initiatives.

The actions set out in the following table are grouped into one of three categories (funding and staffing, quality of care and accountability), and will be carried out in collaboration with the Office of the Seniors Advocate, other provincial ministries (e.g. ministries of Advanced Education and Jobs, Tourism and Industry), health authorities, industry partners and other stakeholders. The table includes the next steps required to move forward:

[4] 2015 labour costs provided by the Health Employers Association of B.C. cite $34.27/hour on average for care aides, and includes wages, premiums and benefits (source is data reported in the Health Sector Compensation Information System). Using this higher average cost, the estimate would increase to $95.3 million.

Category	Action	Proposed Timeline
Funding and Staffing	1. Finalize a report, in collaboration with the Canadian Institute for Health Information, to better understand the demand for home health, assisted living and residential care services (including the different profiles of clients using RAI assessment and service episode data) given the changes taking place in the home and community care system, and to inform required changes to existing residential care service models.	May 2017
	2. Confirm the definition of direct care hours per resident day.	July 2017
	3. Establish a baseline for: hours per resident day, client case mix, other identified residential care costs.	September 2017
	4. Work with health authorities and industry to create and implement an interim targeted process that would increase hours per resident day for areas with identified gaps until a costing review has been completed and the funding model has been updated to incorporate client complexity.	October 2017
	5. Move towards a province-wide standard residential care funding model, with a lens to incorporate resident complexity (using RUGs and case mix index from RAI assessments), quality of care and flexibility.	January 2018
	6. Complete an analysis of percentage of casual and part-time positions that can potentially be converted to regular full-time positions in residential care facilities.	June 2017
	7. Develop an interim strategy to address immediate high-priority vacancies in residential care facilities.	June 2017
	8. Develop a health human resources plan to ensure supply of staff will meet the needs of the residential care sector. The plan will include targeted recruitment activities and seat-planning in post-secondary programs.	November 2017

Category	Action	Proposed Timeline
Quality of Care	1. Prioritize key quality of care initiatives in residential care and facilitate a coordinated approach that promotes consistency and standardization, yet allows for flexibility given varying needs across facilities.	April 2018
	2. Bring into force Part 3 (care facility admission) of the *Health Care (Consent) and Care Facility (Admission) Act* to protect vulnerable adults. This work will include revising the residential care admission policy to be more person and family-centred.	April 2018
	3. Develop and implement palliative and dementia care policy including requirements and targets for staff education.	April 2018
Accountability	1. Incorporate the requirement to increase hours per resident day through annual bi-lateral agreements between the Ministry and health authorities.	April 2017
	2. Monitor health authority progress on achieving the 3.36 hours per resident day and produce annual reports for Leadership Council.	April 2018
	3. Develop and implement a policy to mandate accreditation for all residential care facilities.	April 2018
	4. Develop and implement performance measures that support quality of care and quality of life outcomes using outputs from RAI assessment and survey data including quality indicators.	April 2018
	5. Develop and implement a process and policy for monitoring, reporting and evaluation processes related to resident need, funding, service delivery and operations, building on experience from other provinces such as Alberta and Ontario to assess whether quality, funding and staffing policies and goals are being achieved.	April 2019

Introduction

In B.C., care and support are available from both publicly subsidized and private-pay providers for people having difficulty coping with activities of daily living because of health-related problems or a life-threatening illness. Publicly subsidized home and community care services in B.C. provide a range of health-care and support services for people who have acute, chronic, palliative or rehabilitative health-care needs. People receiving home and community care services may have a short-term need due to an episode of illness, surgery or specialized treatment, or a long-term need as a result of a chronic condition or life limiting illness.

Although home and community care services are provided to adults of all ages, the majority of clients are seniors. More information about B.C.'s publicly subsidized home and community care services is available at www.gov.bc.ca/hcc.

Residential care services are part of the continuum of care in B.C., and include both long-term and short-term services (see Appendix A). Long-term residential care services provide 24-hour professional supervision and care in a protective, supportive environment for people who have complex care needs and can no longer be cared for in their own homes or in an assisted living residence. Short-term residential care services include respite care, convalescent care and residential hospice care. Supportive and compassionate care is provided with the goal of preserving an individual's comfort, dignity and quality of life as their needs change, and to offer ongoing support for family and friends.

Similar services can also be purchased by individuals privately from a service provider, where aspects of service provision are agreed to by both parties. In these cases, government does not provide any financial assistance to individuals or service providers for the service. This report deals only with publicly subsidized residential care services.

Why are we doing this?

Moving into a residential care facility is a significant life change event for a person, their family and friends. There can be a lot of uncertainty and stress experienced during the transition period, and once in a residential care facility, residents and families alike want to be reassured that the services provided will meet not only the resident's care needs, but their emotional, psychological, social and spiritual needs as well, along with upholding their autonomy and dignity to the greatest degree possible.

Staffing levels and staffing mix are two key components that contribute to both quality of care and quality of life for residents, as well as improved resident outcomes. However, there are other components that can be just as important such as the programs offered in each facility, facility design, training and education for staff, availability of technology, models of care delivery, and organizational culture and leadership.

B.C. has had a staffing target of an average of 3.36 hours per resident day by health authority since 2009, which means that some facilities may have lower levels and some may have higher levels within a given health authority. However, no one health authority has yet reached the goal of an average of 3.36 hours per resident day.

A number of events in B.C., culminating in the posting of the Office of the Seniors Advocate's 2016 *Residential Care Facilities Quick Facts Directory*, which indicated that 81% of facilities were operating below 3.36 worked hours per resident day, have brought to light concerns about the ministry's staffing guideline in residential care facilities. The ministry has stated previously that 3.36 hours is a starting point for planning decisions that health authorities should be working toward, and that direct care hours are dependent on the individual's needs and are determined through a comprehensive assessment process involving the client, their family and staff. The ministry wants care providers to deliver high quality care at whatever level is most appropriate for an individual client. The average number of care hours and staffing mix in each facility will depend on the resident population in that facility.

Health Minister Terry Lake asked Parliamentary Secretary Darryl Plecas to work with Seniors Advocate Isobel Mackenzie and ministry staff to examine quality of care, staffing levels and funding and report back to him. The review is timely – providing services for medically complex and/or frail seniors (including dementia) is one of government's five strategic priorities in health care. Additionally, changes to the *Community Care and Assisted Living Act* are anticipated to increase the proportion of clients with complex care needs residing in residential care facilities.

The purpose of this review is to examine the current state of residential care service delivery in B.C., with a focus on quality of care (including outcomes, staffing levels and funding), and to determine what, if any, changes need to be made in the residential care system. These changes will ensure consistency, transparency and accountability across the province in meeting residents' needs, in remaining sustainable and in aligning with the ministry's focus on patient-centred care in the community.

The current state analysis included a document review, key/expert interviews with industry contacts and health authority staff, a literature search, a staffing model review, a health authority current state questionnaire and a jurisdictional scan with Alberta and Ontario to look at current evidence/best practices for staffing hours and funding (see Appendix F).

Background

How is residential care provided now?

Access to Services

In B.C., anyone can access publicly subsidized residential care services regardless of income, provided they meet the eligibility criteria set out by the province in the Home and Community Care Policy Manual.[5] All clients are assessed by a health authority professional to determine their care needs, using the interRAI Home Care Assessment instrument. If they are found eligible, they are offered a bed in a facility based on the urgency of their care needs and other factors such as their facility preference, clinical care needs, appropriateness of the facility, availability of caregivers and community supports, and potential risk from abuse, neglect or self-neglect in their present living situation arising from ability of the client and/or their caregiver to manage their health and daily living needs.

Health authorities try to accommodate individual needs and move clients into a facility that is their first choice. However, as the goal is to find a residential care facility that meets the care needs for a person at risk as quickly as possible, sometimes an individual is not placed in the facility that is their first choice. In these situations, health authorities facilitate a transfer to the client's preferred facility at a later date.

Provision of Residential Care Services

Currently in B.C., there are approximately 27,760 subsidized residential care beds in 335 regulated facilities.[6] The facilities are owned and operated either by health authorities, not-for-profit organizations, or for-profit companies. These care facilities are regulated under two different statutes – the *Hospital Act* (102 facilities or 31% of all publicly subsidized facilities) and the *Community Care and Assisted Living Act* (231 facilities or 69% of all publicly subsidized facilities). In addition, these acts also govern over 3,300 non-publicly subsidized (private-pay) beds, some of which are located in the same facilities as publicly subsidized beds.[7] In 2015/16,

[5] www.gov.bc.ca/hccpolicymanual
[6] Ministry of Health Home & Community Care Bed Inventory – September 2016.
[7] Ministry of Health bed inventory, March 2016.

health authorities reported spending over $1.8 billion on residential care services, an increase of just over 18% since 2009/10, and 60% since 2001.[8]

The *Continuing Care Act* and the Home and Community Care Policy Manual set out what services must be provided by health authorities and contracted service providers, and how fees will be charged. Residential care clients pay a monthly client rate of up to 80% of their after-tax income towards their housing and hospitality services subject to a minimum monthly client rate of $1,104.70 and a maximum monthly client rate of $3,240.00 (as of Jan. 1, 2017). However, the estimated actual cost of residential care as reported by the seniors advocate is close to $7,000 per month.[9] Health authorities cover the costs of care (e.g., nursing/care aides) in all publicly subsidized residential care facilities and residents receive coverage for most of their prescription medication, routine medical supplies and equipment, and some over the counter drugs.

For the most part, it is expected that publicly subsidized residential care facilities are able to provide services that can meet the needs of clients with complex care needs. This has not always been the case, which will be explained in the section, *Historical Context*.

Residential care residents live in a room, sometimes with one or more people, and have either a private or shared washroom. Meals are provided in a common dining area (some facilities have several such areas) and access in and out of the facility is secured and monitored. Some facilities have special units for residents with severe dementia that include an additional level of security, sometimes referred to as secure care units. Once a client has moved into a residential care facility, facility staff assess clients with the interRAI Minimum Data Set 2.0 assessment instrument. An individualized care plan is developed within two weeks of admission and re-assessed 90 days after admission and quarterly thereafter.

Clinical data from these assessments, which are completed electronically, generates other useful information for clinicians, facility managers and decision makers such as: clinical assessment protocols (used to determine areas of further assessment and develop a client's care plan); outcome scales (a series of outcome measures that assist clinicians to understand the characteristics of a client's health status); quality indicators (used to monitor quality of specific areas of clinical practice in a particular facility and can be used for comparison across facilities, health authorities and provinces) and resource utilization groups or RUGs (a case mix classification to categorize clients into groups based on similarity of resource use).

Average length of stay in residential care facilities in B.C. has either remained fairly constant or increased over the past five years across the five regional health authorities, contrary to

[8] 2015/16 actual expenditures are taken from health authority service plans for 2016/17 – 2018/19.
[9] Office of the Seniors Advocate. (May 2015). *Seniors' Housing in B.C.: Affordable, Appropriate, Available*.

anecdotal reports from health authorities and operators. For all of B.C., there was a 17.6% increase from 705 days in 2009/10 to 829 days in 2014/15, and a 4.7% increase from 2013/14 (791 days) to 2014/15.[10]

Who lives in Residential Care Facilities?

Currently, over one-sixth of B.C.'s population is over 65 years old.[11] The number of seniors is expected to rise from approximately 853,000 in 2016 to an estimated 1.47 million over the next 20 years.[12] It is important to realize that, while it is mainly seniors who live in residential care facilities, most seniors will not require residential care services. The total number of people who received services in 2015/16 was over 40,000, which represents less than 1% of B.C.'s total population, 4.4% of the seniors' population (those aged 65+) and 9.1% of the population over 75.[13]

Residential care facilities are home not only to seniors, but also to people with physical disabilities, acquired brain injuries or chronic conditions such as multiple sclerosis who cannot be cared for without access to an array of services, particularly unscheduled care provided by regulated professionals such as nurses.

In 2015 there were 28,156 resident assessments completed using the interRAI Minimum Data Set 2.0 resident assessment instrument.[14] Based on the information from these assessments, we can ascertain that the majority of the residents are frail and have complex care needs. For example, the assessments found 93% of residential care clients had some level of cognitive impairment, and 66% had moderate or higher cognitive impairment; 65% had a diagnosis of dementia; 93% had some level of impairment with their ability to perform activities of daily living while 73% required moderate to significant assistance; 69% had bladder incontinence and 47% had bowel incontinence; just over 21% had suffered a cerebral vascular accident and 12% had congestive heart failure. 55% of residents had some indication of frailty and health instability, and 10% had a higher level of medical complexity and were at serious risk of decline.

[10] 2016_0387 Home and Community Care Residential Care Average Length of Stay at Discharge.
[11] PEOPLE v2016. BC STATS. Ministry of Technology, Innovation and Citizens' Services.
[12] Ibid.
[13] Home and Community Care Annual Report - Client Counts and Service Volumes (PAS 2016_0684). Population Data: PEOPLE 2016 data. BC STATS. Ministry of Technology, Innovation and Citizens' Services.
[14] B.C. interRAI Minimum Data Set 2.0 and interRAI Home Care data, 2015.

How has residential care changed over the years?

Historical Context

In 2002, the government implemented a Home and Community Care Redesign Strategy to address seniors' and people with disabilities' need for more independent housing and care options that would allow them to remain in the community for as long as possible. A key component of this redesign was the government's commitment to make 5,000 net new residential care beds, assisted living units, and supportive housing units with home support available by December 2008. The 5,000 beds target was met in June 2008, with the majority of new beds/units built and operated by contracted for-profit and not-for-profit service providers.

As part of this redesign strategy, significant changes were made to the residential care system in the province to ensure sustainability and quality care. The provincial access policy was changed to one of priority based on urgency and need, rather than chronology. The criteria for access was amended to focus on clients with higher care needs and all facilities were expected to be able to provide care to clients with complex care needs rather than just extended care hospitals, private hospitals and what were known as "multi-level care" facilities.

2008 Provincial Residential Care Staffing Framework

Implementation of the Provincial Residential Care Staffing Framework

As a result of the changes described above, there was a significant shift in the care needs of clients living in care facilities. From 2002 on, concern grew about the availability of appropriately educated, competent staff to adequately meet the complex care needs of residential care clients, as well as the appropriate mix of professional and non-professional staff to meet client care needs. In 2007, the Ministry of Health and health authority representatives started work to develop a draft provincial staffing framework to:

- provide an evidence-based staffing framework for facilities;
- support the provision of quality services and care to facility residents;
- improve the health outcomes of facility residents; and
- support a consistent approach to making staffing decisions in all provincial facilities.

The literature review conducted in 2008 clearly identified that facility staffing decisions should be made based on evidence-based staffing frameworks that incorporate variables that positively affect resident and staff outcomes (Appendix B). It was noted that establishing provincial averages for direct care staffing levels and professional staff mix should only be one component of the staffing framework. Organizational structures, managerial practices, work environment and culture, education and experience of staff, clinical leadership, and resident needs all impact resident and staff outcomes.

It is also known that other factors such as facility design influence how well care can be provided to residents with complex care needs, including dementia.

Based upon best practice evidence, the final framework components included philosophy of care, resident care needs, structure (staff level and mix, structures to support care, leadership, culture and climate), process, outcomes and evaluation (see Appendix C).

After considering the research findings, as well as current staffing levels within B.C., it was agreed in 2009 that total direct care staffing levels for each health authority was to average 3.36 hours per resident day, comprised of 3.0 worked hours of nursing care (includes care aides) and 0.36 worked hours of allied health services. In order to meet the goal of a consistent approach to making staffing decisions in facilities across the province, the framework identified the number of registered nurses, licensed practical nurses and care aides based upon facility size and identified that no less than 20% of the direct care hours should be professional care (registered and licensed practical nurses) and that each facility was to have at least one registered nurse on duty at all times (see Appendix D).

On Feb. 27, 2009, the Minister of Health Services released a directive regarding Home and Community Care Quality and Performance Monitoring (see Appendix E). The directive covered four deliverables and outlined six objectives, including:

> *Achievement of average standard staffing levels, in worked hours per resident per day for direct care (Registered Nurse, Licensed Practical Nurse, Residential Care Attendant) and for clinical support services (Rehabilitation, Social Work, Activity and Pastoral Care) in residential care facilities.*

Health authorities were asked at that time to estimate the cost of implementing the framework of 3.36 direct care worked hours per resident day and determined the annual incremental cost to be about $215 million. Implementing the other components of the framework (leadership, culture and physician oversight to support care) was estimated at an additional $175 million annually. Initial implementation of the framework was to be funded using incremental revenue generated by rate changes to the residential care client rate structure, which took effect Feb. 1, 2010. The ministry estimated that $53.7 million in annual incremental revenue would be available for reinvestment once the revised rate structure was fully implemented. Therefore, it was recognized that the changes to the residential care client rate structure would fund only a portion of the costs required to achieve the 3.36 hours per resident day component of the framework.

Reinvestment Results

One of the commitments that government made when it introduced the new client rate structure, which was based on the principle that people should pay what they could afford toward the cost of their accommodation (housing and hospitality services), was to ensure that health authorities used the incremental revenue resulting from the rate changes to increase direct care staffing levels. Individual health authorities were allowed to direct some of the re-investment funding to other priority investment options that would improve care, such as staff education, specialized services and non-capital equipment, if their staffing levels were sufficiently high enough already to start with and if approved by the ministry. Interior Health, Island Health and Northern Health all had staffing levels above 3.0 hours per resident day when this process started. Vancouver Coastal Health and Fraser Health had levels below 3.0 hours per resident day. The latter two health authorities were required to direct almost all of their incremental revenue to increasing staffing levels.

In collaboration with an independent consultant and health authorities, the ministry developed and implemented a formal monitoring evaluation framework for the residential care rate reinvestment which spanned from 2010/11 to 2011/12.

Health authorities were required to submit a range of data to the ministry, including an initial detailed reinvestment plan, quarterly residential care client rate revenue monitoring reports and biannual health authority plan staffing, and reporting and management report updates. These health authority reports were reviewed and analyzed by both the ministry and independent consultants. In addition to analyses of these data, a series of informant interviews were conducted to assess processes and outcomes of implementation. While in both years the information available reflected inputs, outputs and process outcomes, the data required to be able to identify and reflect client (e.g., interRAI data) and staff outcomes were not available.

As mentioned above, the rate reinvestment was estimated to generate $53.7 million of additional funds over the initial two years. However, health authorities reported the total annual incremental residential care client rate revenue investment was $85.62 million after two years.[15] Each health authority was required to submit reinvestment plans, which were vetted and in some cases adjusted, then approved by the ministry. The majority of the expenditures ($64.95 million) were related to priority investments in contracted residential care facilities.

[15] B.C. Ministry of Health (May 2013). *Health Authority Investment of Revised Residential Care Client Rate Revenue: Summary Report for 2010/11 and 2011/12*.

The remaining $20.67 million was for investments in owned and operated facilities. The funds were distributed as follows across the five areas described below:

1. $52.51 million (61%) was invested in increased nursing, allied health and care aide staffing. These funds were primarily invested in contracted facilities with $47.67 million invested and the remaining $4.84 million going to health authority owned and operated facilities.
2. Education, clinical leadership evidence-based tools investments of $5.89 million (6.9 %) were distributed across health authority owned and operated facilities ($3.32 million) and contracted facilities ($2.56 million).
3. Specialized services and supports for distinct population's investments in owned and operated and contracted facilities were $1.81 million (2.1%).
4. Non-capital equipment investments of $17.78 million (20.8%) were distributed across contracted facilities ($9.68 million) and owned and operated facilities ($8.1 million). Health authority documentation provided shows equipment purchased included items such as beds, mattresses, resident lifts, bed and chair exit alarms and vital sign equipment.
5. Mitigating Preferred Accommodation Fees accounted for $7.63 million (8.9%) of the total invested, with $2.63 million being for owned and operated and $5 million for contracted facilities.

Changes in direct care worked hours per resident day were analyzed to determine the shift in full time equivalent positions (FTEs). From 2009/10 to 2011/12, there was an increase of 1,104 FTEs across the province. These included 932 direct care FTEs and 172 allied care FTEs.

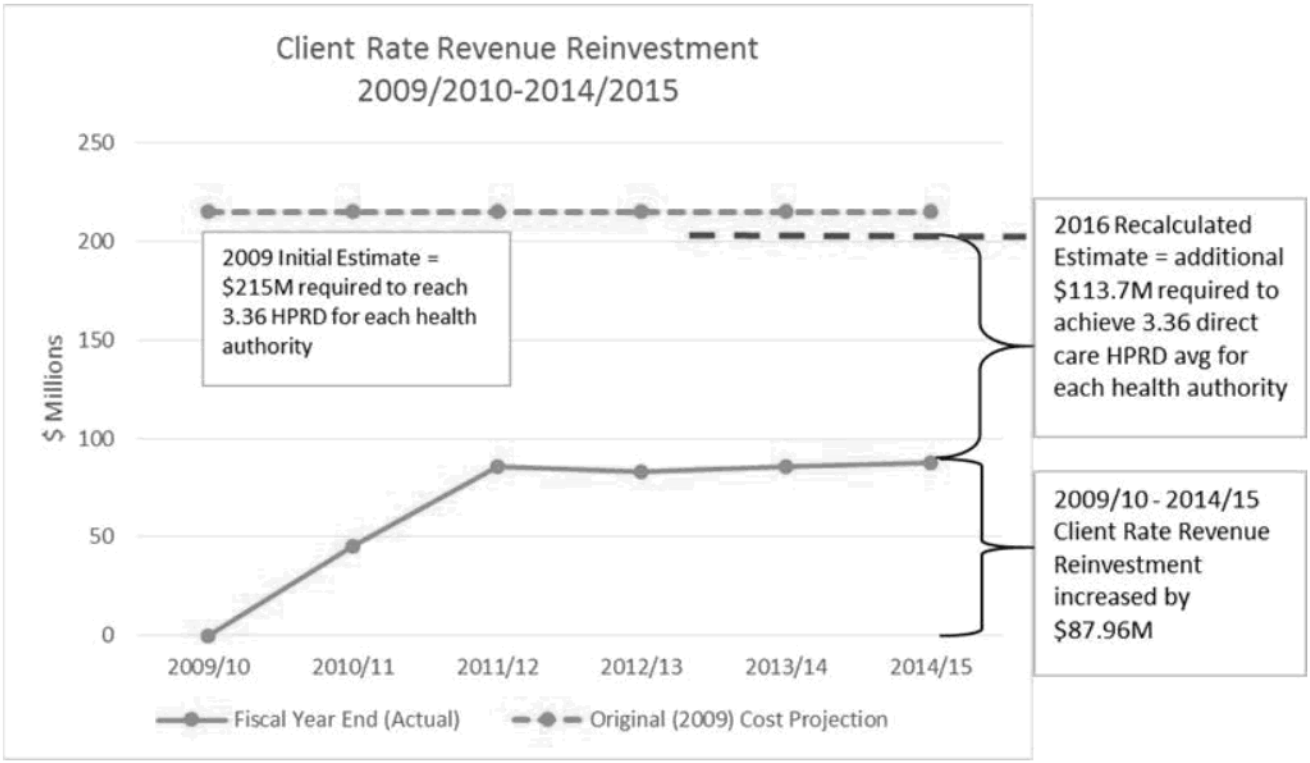
With the $52.51 million investment in increased nursing, allied health and care aide staffing, by the end of 2011/12 the average hours per resident day increased from the baseline 2009/10 hours per resident day in:

- Fraser Health – from 2.64 to 2.94 hours per resident day
- Vancouver Coastal Health – from 2.69 to 2.85 hours per resident day
- Vancouver Island Health – from 3.11 to 3.20 hours per resident day
- Interior Health – from 3.13 to 3.33 hours per resident day
- Northern Health – from 3.27 to 3.31 hours per resident day
- *Across British Columbia – from 2.88 to 3.06 hours per resident day*

After two years of intensive monitoring and evaluation, it was determined by ministry executive that this level of monitoring at the facility level was challenging to sustain for the ministry, health authorities and facility operators. Much of the reporting was manual, carried out at the facility level, and also involved health authority staff in both the program and financial areas.

A decision was made to instead communicate to health authorities a requirement to continue to invest the incremental fee revenues from the revised client rate structure to increase care hours and move towards full implementation of the staffing framework. Through funding letters to the health authorities in 2012/13, 2013/14, 2014/15, 2015/16 and 2016/17, the ministry has directed health authorities to sustain this investment. Health authorities have been able to maintain the annual incremental investment in resident direct care hours in subsequent years, along with having small growth over and above the $85.62 million. As of 2014/15, the health authorities reported the annual incremental investment had reached $87.96 million.

The figure below shows the change in client rate revenue reinvestment from 2009/10 to 2014/15. In 2009/10, it was estimated that $215 million was required to fully achieve the 3.36 hours per resident day. Over 2009/10 to 2014/15, the client rate revenue reinvestment reached $87.96 million. In 2016, based on current staffing levels and costs, it is estimated an annual additional $113.7 million is required to fully achieve the 3.36 hours per resident day average for each health authority, with an increase of 1,511 FTEs (includes 886.7 care aides).



It is important to note that the total amount of the client rate revenue reinvestment has not been all directed to increasing staffing. Health authorities have directed some of those additional funds to the other priority investment options (staff education, specialized services and non-capital equipment). Nevertheless, hours per resident day have improved provincially from a baseline of 2.88 in 2009 to 3.06 in 2011/2012 and 3.11[16] as of January 2016. Although some facilities have achieved 3.36 hours per resident day, no health authority has achieved the desired average set by the province.

The following table shows hours per resident day in both owned and operated and contracted facilities as of March 2016, and as reported by the health authorities. Owned and operated facilities tend to have higher direct care hours. Only two health authorities (Fraser Health and Northern Health) have achieved the average 3.36 hours in owned and operated facilities. Fraser Health and Vancouver Coastal Health have the lowest hours per resident day in contracted facilities (2.86 and 2.81 respectively).

Residential Care Beds and Ownership and Direct Care Hours per Resident Day – March 2016 as reported by health authorities

Health Authority	Owned/Operated	Contracted	Total
Fraser Health	**1,870**	**6,233**	**8,103**
Ownership%	23%	77%	100%
Hours per Resident Day (average)	**3.59**	**2.86**	
Interior Health	**2,548**	**3,014**	**5,562**
Ownership%	46%	54%	100%
Hours per Resident Day (average)	**3.22**	**3.15**	
Island Health	**1,713**	**3,721**	**5,434**
Ownership%	32%	68%	100%
Hours per Resident Day (average)	**3.16**	**3.12**	
Northern Health	**1,031**	**138**	**1,169**
Ownership%	88%	12%	100%
Hours per Resident Day (average)	**3.36**	**3.10**	
Vancouver Coastal Health	**2,532**	**4,258**	**6,790**
Ownership%	37%	63%	100%
Hours per Resident Day (average)	**3.14**	**2.81**	
Total Beds	**9,694**	**17,364**	**27,058**
Ownership %	36%	64%	100%

Source: Health authority combined hours per resident day submissions. June 2016. Regional Grants and Decision Support, Ministry of Health.

Notes: Fraser Health excludes hospice. Interior Health excludes hospice and family care home beds. Island Health excludes family care home beds. Northern Health excludes 10 hospice and two family care home beds. Vancouver Coastal Health excludes temporary and hospice beds.

[16] Office of the Seniors Advocate (2016, March). *B.C. Residential Care Quick Facts Directory as of January 2016*

2016 Literature Review

As B.C.'s staffing framework was based upon evidence compiled in 2007/08, the ministry conducted an extensive literature scan to identify any new evidence that would support a set level of hours per resident day. The 2007/08 review (see Appendix C for a summary) identified only three studies from the U.S.A. that provided recommendations for a range of total nursing staff levels needed for quality care, between 3.20 and 3.93 worked hours per resident day. A 2016 article references a study done in 2001 by the U.S. Centres for Medicaid and Medicare Services that cites 4.1 worked hours per resident day as a minimum target, and which was later confirmed in a 2004 observational study and in a reanalysis by Abt Associates in 2011.[17] A further article from the U.S.A. found that beyond 4.1 hours per resident day there was no further benefit of additional staffing with respect to quality.[18]

The 2016 literature scan involved a PubMed search for long-term care in conjunction with budget, quality and staffing. The search terms for long-term care included "long term care," "nursing home" and "residential care" (with qualifiers of "frail" or "elderly"). A total of 3,246 unique articles were identified, of which 2,581 were for quality, 630 were for staffing and 240 were for budget. As 3,246 abstracts were too numerous to be reviewed in a short period of time, the scan was limited to abstracts of articles published between 2013 and 2016, plus a handful of abstracts before 2013. The final literature scan includes 181 papers, a short summary of which is provided below.

Similar to the 2007/08 finding, the 2016 literature review findings identified that facility staffing decisions should be made based on evidence-based staffing frameworks that incorporate variables that positively affect resident and staff outcomes. Other articles reviewed indicated that in general, staffing levels were predictors of care quality, and that increased staffing levels could improve care and resulted in better outcomes or decreased severity of deficiencies.

The more recent findings showed that nursing staff affects the quality of care in facilities and that staffing stability is associated with better patient outcomes while staffing instability is associated with poorer patient outcomes. Staffing challenges that negatively affect quality include director of nursing turnover, staff turnover, changes in staffing pattern (e.g., decrease in staffing levels or change in staffing mix), high levels of absenteeism and limited time available to train staff.

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[17] Harrington, C., Schnelle, J. F., McGregor, M., & Simmons, S. F. (2016). The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes. Health Services Insights, 9, 13–19. http://doi.org/10.4137/HSI.S38994

[18] Abt Associates Inc. (2001). Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report To Congress: Phase II Final, Volume I. Center for Medicare and Medicaid Services. Baltimore, MD. www.allhealth.org/briefingmaterials/abt-nursestaffingratios%2812-01%29-999.pdf.

While increased staffing was a common intervention to improving quality of care and outcomes, it has been noted that the effectiveness of minimum staffing standards is unknown and that staffing should also be allocated according to particular resident needs.

Changes to the Community Care and Assisted Living Act

Government introduced amendments to the *Community Care and Assisted Living Act* in March 2016 to offer more flexibility and choice and to achieve a more person-centered approach for seniors in assisted living residences, while at the same time increasing protections. Bill 16, *Community Care and Assisted Living Amendment Act*, received Royal Assent by the Lieutenant Governor on May 19, 2016, and responds to concerns identified over the past several years in reports published by the ombudsperson, the seniors advocate and the B.C. Law Institute.

The changes mean that seniors may be able to remain in assisted living longer, and, if their care needs change, may not have to move into a residential care facility as early as they would have had to previously, or not at all. It is not yet known what the full impact of these changes will be to the residential care sector, but some have suggested that the proportion of higher needs clients will increase in care facilities, which will impact staffing. Whether or not the demand for residential care beds will decline is uncertain, as the growth in the proportion of people aged 75+ continues to significantly outpace the growth in new beds across the province. The ministry has plans to engage in predictive modeling that may assist in helping to answer some of these questions.

How does residential care in B.C. compare to other Canadian jurisdictions?

Residential care services provided in B.C. are fairly similar to services provided in other jurisdictions across Canada. Home and community care services are not governed under the *Canada Health Act*, but instead are regulated by each province or territory. There are probably more similarities between the services provided than differences. The clients who live in these facilities have similar care needs across the country.

As both Alberta and Ontario are often provinces referenced by our industry partners, as well as by unions, the ministry wanted to understand how B.C. compared to them in relation to population and expenditures on home and community care. In 2015, Ontario had the largest number of citizens aged 75+ at 0.974 million, B.C. was second largest at 0.354 million, followed by Alberta at 0.205 million.[19] When annual spending made in residential care was examined between the three provinces, B.C.'s overall spending in 2014/15 ($1.8 billion) was higher than

[19] Statistics Canada, Table 051-0001 Estimates of population, by age group and sex for July 1, Canada, provinces and territories www5.statcan.gc.ca/cansim.

Alberta's reported spending ($1.43 billion) but lower than Ontario's ($3.9 billion).[20] When distributed across all people 75 years and older, at $5,085 per person, B.C. spent more than Ontario ($4,003 per person) and less than Alberta ($6,976 per person). Both Alberta and Ontario have also announced increased funding over the next 3-5 years.[21]

Alberta and Ontario both have province-wide funding models for residential care. However, their approaches have similarities and differences as set out below:[22]

- Ontario's model is outcome-based and does not include hours per resident day (the Province has been lobbied by the Canadian Union of Public Employees for a legislated minimum average of four hours of nursing and personal care per resident per day in residential care facilities).
- In Ontario, there are four funding envelopes (Nursing and Personal Care, Program and Support Services, Raw Food, Other Accommodation) and full funding is based upon an annual occupancy of 97%. If occupancy rates drop below 97%, the service provider is funded at actual occupancy.
- Ontario service providers receive funding in their nursing and personal care envelope based on the assessed needs of their residents determined annually using RUGs (places clients into groups based on similarity of resource use) and the related Case Mix Index score based on the Resident Assessment Instrument assessments.
- According to Ontario's posted information, operators of residential care facilities in Ontario cannot make a profit on the provision of nursing and personal care, program and support services (e.g., therapeutic services, pastoral care, staff training) or raw food. The only envelope in which they can retain surplus funding is "other accommodation." Financial accountability is more stringent in the residential care sector than in any other sector within the health-care system in Ontario.
- Residential care facilities in Ontario are guided by the Local Health Integration Network Service Accountability agreement and the *Long Term Cares Home Act.* Residential care facilities are required to complete audited annual reports on their revenue and expenses in all envelopes. Any unspent funding in the specific areas is returned to government through a reconciliation process.

[20] B.C.: Community and Residential Care Spreadsheet prepared by Regional Grants and Decision Support, Ministry of Health, Jan. 12, 2016. Alberta: April 25, 2016 email from director, Continuing Care Branch, Alberta Health. Ontario: April 18, 2016 email from Office of the Hon. Dr. Eric Hoskins, Ontario's Minister of Health and Long-Term Care.

[21] Ontario: April 18, 2016 email from Office of the Hon. Dr. Eric Hoskins, Ontario's Minister of Health and Long-Term Care. Alberta: Budget 2016 Speech: The Alberta Jobs Plan.

[22] B.C. Ministry of Health received information about Alberta and Ontario through interviews and materials provided by both provinces.

- In 2009 Alberta Health Services adopted a patient/care-based funding model, with the key objective of aligning incentives within the health system so that the most appropriate services are delivered for the most efficient funding levels. Alberta Health Services identifies that patient/care-based funding is:
    - An output based allocation method that classifies residents/patients by clinical acuity and resource use to enable consistent and appropriate funding. The model provides funding based on care provided to residents/patients, recognizing needs and complexities as opposed to funding a specific type of bed.
- Alberta has incorporated the Resident Assessment Instrument Case Mix Index measure directly into its funding model, with the intent to reflect different resident complexity levels. The Case Mix Index is multiplied by the number of resident days to calculate a facility's "weighted resident days," which is the main determinant of variable patient/care-based funding for a facility.
- Alberta talks about two measures – 3.02 worked hours or 3.67 paid hours.
- The key objective of Alberta's model is to align incentives within the health system so that the most appropriate services are delivered for the most efficient funding levels. Alberta has stated a number of accountabilities that each provider must meet.

How is residential care funded and what is the model?

There is no agreed-upon province-wide standard funding methodology in B.C. for residential care services. Most health authorities report having a standard funding model, which is used annually to allocate annual increases to address cost changes such as increased wages due to collective agreements and other cost pressures. It is not clear whether these models also attempt to address variation in facility-base funding across facilities, which has existed historically and is reflected by the variation in direct care hours per resident day. Health authorities have indicated they have been making efforts to bring up the funding levels for the lowest funded providers.

In 2006, the ministry held an industry forum on residential care to discuss a number of topics, including moving toward a standardized residential care service agreement and the possible use of performance metrics in determining funding and overall funding levels.

As B.C. has moved to a regionalized health-care system, the Province no longer funds service providers directly, as it did prior to 1997. The ministry allocates funding to each health authority annually using a number of methodologies including targeted funding, consideration of past historical base funding and its Population Needs Based Funding model. This model is a funding methodology to determine how to divide a pre-determined pool of funds fairly and

equitably between the five regional health authorities. The model has a number of elements or inputs, which include population growth and demographics, expected use of services, complexity, remoteness and the inter-regional patient flows. The health authority then decides, based on its annual service plan, how to allocate the funding to various services and programs described as sectors, including the acute sector (e.g., services provided through hospitals), population health and wellness, mental health and substance use, residential care and community care. Within the community care sector, the five regional health authorities determine the amount of funding to be directed toward services such as home support, adult day programs, assisted living and residential care.

Within the residential care sector, health authorities are both the funder and owner/operator of their own residential care facilities, and the funder of contracted for-profit and not-for profit residential care providers. When considering residential care facility operations, the following standard cost categories exist across all facilities:

- Wages for direct care costs (hours provided by registered nurses, licensed practical nurses, and care aides are based upon a staff to resident ratio that factors in facility size. Funding for allied health staff is based on a block of time, dependent on the type of health care provided);
- Wages for supports (administration, office staff, dietary, housekeeping, laundry, facility maintenance, education, support labour funding);
- Non- wage costs (food costs, dietary supplies, housekeeping, laundry, administrative supplies, insurance, professional fees);
- Property operating costs (utilities and maintenance);
- Capital costs – rent/lease (property taxes, mortgage [interest and principal], building reserve, equipment reserve, rent/lease);
- Other add-on's or adjustments (facility size [less than 75 or 51 beds], pharmacy labour and drug costs in sites that operate under the *Hospital Act*, additional staff requirements).

While standard cost categories are similar, each health authority currently use different methods for determining priorities and assigning funds to residential care providers. As well, there is a range of approaches taken to monitor how these funds are implemented and the impact on direct care hours per resident day within each facility.

As with many other public services, government expects a public-private partnership approach to be used to develop new capacity for residential care beds. Health authorities are mandated by the ministry to plan for services that will meet the needs of their residents. When they decide that new beds are required in a given community, they engage in a competitive process

to procure those beds and then enter into a contract with the service provider to provide the necessary services and programs. One health authority has reported the cost of construction for one new residential care bed to be about $190,000. Operating funding for new beds comes from the health authority's annual funding allocation from the ministry.

While there is a lot of activity around the province in planning and development of new beds, many of those will be replacing older sites that can no longer adequately meet the needs of today's residents. For 2016/17, there are about 500 new beds that will open, and many more are planned for 2017/18 and 2018/19. Health authorities recognize how critical it is to either renovate or replace their older bed stock with improved facility design, including single rooms with a private washroom and shower, walking loops and smaller dining areas. Better design has a significant positive impact on the ability of service providers to care for residents, especially those with dementia as well as younger adults with behavioural and cognitive challenges.

Concerns and Issues: What we heard

As mentioned previously, there are a number of challenges and issues regarding the provision of residential care services in B.C., in particular related to staffing levels. Residents and their families, the public, media, the ombudsperson, the seniors advocate, individual service providers, industry associations and others have raised these concerns previously.

Ombudsperson

On Feb. 14, 2012 the ombudsperson released *The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)*. This comprehensive and in depth report included 143 findings and made 176 recommendations. Of these, recommendation 123 and 124 spoke specifically about new client rate reinvestment and meeting the guideline of providing 3.36 direct care hours per resident day.

> Recommendation 123: The Ministry of Health provide further and more detailed public information on how the additional revenue generated by the new residential care rate structure is being spent and what improvements to care have resulted in each facility.
>
> Recommendation 124: The Ministry of Health, together with Interior, Fraser, Vancouver Coastal and Vancouver Island health authorities ensure that each health authority, at a minimum, meets the ministry's guideline of providing 3.36 daily care hours by 2014/15.

Since 2012, the Ministry of Health has been actively addressing the recommendations from this report and has provided regular updates to the Office of the Ombudsperson, including the purpose of and findings from this review.

Seniors Advocate

Several reports released by the Office of the Seniors Advocate, including their reports on placement, drugs and therapy (April 2015), housing (May 2015) and resident to resident aggression (June 2016), have highlighted concerns about residential care such as the proportion of "light care needs" clients living in care facilities that could be living in assisted living or at home, the need for more private rooms and staffing levels. With the publishing of the *Residential Care Facilities Quick Facts Directory* in March of 2016, which includes a variety of information about each care facility, many questions were asked about the variation in the staffing levels between facilities and about the ministry's role in monitoring them. Ministry staff have been working with staff from the Office of the Seniors Advocate to better understand their data analysis and the concerns expressed in their reports.

As mentioned earlier, the seniors advocate has suggested that all facilities could be brought to a minimum average of 3.36 hours per resident day by health authority through the investment of $83.5 million based on $30/hour for care aides (assuming all added staff are care aides).[23]

Health Authorities

As part of this review process, the ministry asked health authorities a series of questions related to quality, staffing levels and budget. One question asked was, "Is the client rate reinvestment achieving identified outcomes?" Four health authorities answered the question and indicated that intended outcomes were achieved. Island Health prefaced the answer by affirming that "no one investment (staffing, education, equipment) is solely responsible for improving care and client outcomes."

- In Interior Health, there were improvements in nine of the ten interRAI quality indicators ranging from 8% to 36%. There was no change in one of the indicators (worsened pain).
- In Island Health, there were improvements in wound care, pain reduction and the reduced use of restraints.
- In Northern Health, there was an increase in hours per resident day levels to 2.8 hours and 3.5 hours in residential care facilities and designated special care units respectively.
- In Vancouver Coastal Health, there was an increase in hours per resident day levels across all owned and operated as well as contracted facilities.

An unintended consequence highlighted by Interior Health was that the principle of standardization resulted in higher workload costs at individual facilities when residents with high complex needs were admitted.

[23] 2015 labour costs provided by the Health Employers Association of B.C. cite $34.27/hour on average for care aides, and includes wages, premiums and benefits (source is data reported in the Health Sector Compensation Information System). Using this higher average cost, the estimate would increase to $95.3 million.

Health authorities concerns included:

- Lack of clarity on contracted site operating costs;
- Provincial policies are being implemented without additional funding (e.g., basic wheelchairs);
- Cost of collective agreement negotiations; and
- Generous entitlements for vacation and sick leave in collective agreements.

Industry Associations

In addition to discussions with operators while visiting facilities, a conference call was held with members from the B.C. Care Providers Association, the Denominational Health Association and the B.C. Seniors Living Association. Discussion points included: 1) what was working well in the existing system; 2) what innovations would assist in improving care; and, 3) if government could only make one change, what would have the greatest impact?

Concerns included:

- The majority of interviewees identified the need to increase funding for hours per resident day. Many noted that the complexity of clients is changing and that additional funding is not typically provided to address increased care requirements.
- There is a lack of consistency between health authorities in approaches to service provision including funding, staffing, training, policies and procedures, which impact contracted service providers that operate in more than one health authority.
- Direct care hours are defined differently – both within the same health authority and across health authorities.
- Funding is not keeping up with inflation/labour costs in negotiated collective agreements.
- Policies are being implemented without additional funding (e.g., basic wheelchairs).
- Challenges attracting and retaining staff.
- Wanting to operate as a campus of care, but policies can intervene (e.g., first appropriate bed).
- The lack of job readiness of new health-care graduates.
- "Rich" vacation and sick leave entitlements and impacts on staffing.
- Timing of notification on budget and unclear how annual lifts are calculated. Providing an interim budget was identified as a best practice.
- Cost of capital to increase private sector investment and residential care development.
- Inconsistent interpretation of regulations and licensing.

- Affiliates indicated challenges with being competitive with the for-profit providers in the request for proposal process for new beds as they have to pay union rates, the same as health authority owned and operated facilities.

In addition to consultation with the industry associations, it is important to note that in May 2016, the B.C. Care Providers Association issued two White Papers that explain the concerns of care providers and outline 32 options for review and consideration. Sixteen options are related to funding and 16 to new care models and innovation.[24] In January 2017, the B.C. Care Providers issued their final report, *Strengthening Seniors Care: A Made-in-BC-Roadmap*. While the papers and final report do not focus solely on residential care services, they offer food for thought in several areas that have been touched on in this report.

Finally, the ministry has heard concerns expressed about how the client rate structure for residential care services is not aligned with other home and community care services where the client rate is based on an individual's income. For clients receiving either home support or assisted living services, the maximum rate a client would pay (if their income is high enough to warrant being charged the maximum rate) is the full cost of the service, which means those individuals would be paying about the same amount as if they were to seek services from the private-pay sector. However, this is not the case for residential care services. Currently, the maximum rate is capped well below the actual cost of delivering the service.

Rethinking the Foundation

At the beginning of this report, three key areas were identified for examination – quality of care, staffing levels and funding – to determine what, if any, changes need to be made in the residential care system to ensure consistency, transparency and accountability across the province in meeting residents' needs, in remaining sustainable and in aligning with the ministry's focus on patient-centred care in the community. Based on all the information collected to date, it seems evident that action is required in a number of areas and on a number of levels.

Quality of Care

B.C. is now in a position to take advantage of the effort that has been invested in years past in implementing the interRAI Minimum Data Set 2.0 assessment instrument and to learn from the information generated from the clinical data to improve care. While most facilities are already

[24] Sustainability Through Innovation: Exploring Options for Improving B.C.'s Continuing Care Sector – White Paper on Funding Part 1, April 2016 (Report P1). Sustainability Through Innovation: Exploring Options for Improving B.C.'s Continuing Care Sector – White Paper on New Care Models and Innovation Part 2, April 2016 (Report P2).

using such information to monitor quality, there are opportunities for the ministry to take a leadership role in working collaboratively with service providers, including health authorities, to develop province-wide goals and focussed quality initiatives. Focusing on resident outcomes could be a key element in a new approach moving forward. Recent research indicates there are 13 main clinical areas to monitor.[25] B.C. could also look to Ontario to explore how they have incorporated monitoring of outcomes into their overall accountability mechanisms for care providers.

Health authorities have identified a number of quality of care initiatives being pursued, but there are few of these that are consistent across health authorities or the province. A co-ordinated approach would benefit all.

Quality of Life

Quality of life is another important factor that needs to be included in any quality improvement work. For those seniors who experience increasingly complex medical health care needs and/or frailty, it is critical that they have access to well-coordinated and integrated services. However, many of the medical conditions experienced by seniors are more about how they live with their conditions, with a focus on quality of life, rather than cure; and, in some instances, particularly in terms of frailty, are linked to the realities of an aging body.[26] People living and managing daily with complex chronic medical conditions, or experiencing frailty, are increasingly dependent on others to maintain their health and well-being, and want more than medical care. They want:

- As much freedom from the impact of their medical conditions as possible;
- To retain as much function as possible to engage in their community, with continued autonomy to shape their own life and story; and
- To be able to take part in meaningful activities, maintain social and family connections, and enjoy the here and now and the everyday pleasures of living.

Both the Office of the Seniors Advocate, in their April 2015 report *Placement, Drugs and Therapy… We Can Do Better*, and the BC Care Providers Association, in their 2017 report *Strengthening Seniors Care: A Made-in-BC-Roadmap,* identify the importance of increased access to programs provided by allied health professionals such as recreational therapy, physical therapy and occupational therapy, as a means to achieving quality of life expectations. The seniors advocate is currently engaged in a province-wide quality of life survey of residents and their most frequent visitor in residential care facilities, using the interRAI Self-Report

[25] Estabrooks CA, Knopp-Sihota JA, Norton PG. (2013). Practice sensitive quality indicators in RAI-MDS 2.0 nursing home data. BMC research notes, 6(n.i.), 460.
[26] See Atul Gawande's Being Mortal (2014)

Nursing Home Quality Of Life Survey, with results expected within the 2016/17 fiscal year.[27] This work offers another opportunity for learning more about what is important to residents and their families and could offer insight into how care providers could recognize and address the things that give joy and meaning in the day of a resident.

Staffing Levels and Staffing Mix

There are some basic actions that could take place that may resolve some issues, such as working with health authorities and service providers to confirm the definition of direct care hours per resident day as the standard across the province, and to collect supporting information. While this may seem challenging, consistency was maintained in the definition for over two years while the ministry was working closely with the health authorities monitoring and evaluating the impact of the residential care rate reinvestment. In addition, based on the review to date, the ministry's position is that it is appropriate to continue with B.C.'s original target of an average of 3.36 hours per resident day, at a minimum, by health authority. Work also needs to be done to explore if this standard should be revised to better reflect changing resident needs.

There will always be exceptions and variations may be necessary in some circumstances. For example, special populations, such as younger adults with behavioural and cognitive challenges, may require a different staffing mix with less nursing care time and more time from allied health workers. Facilities in rural settings may have different needs as well that must be accommodated.

Funding

There are a number of factors that would support consideration of moving toward a province-wide funding model for residential care facilities. The B.C. Care Providers Association has included this as an option in its white papers, and cited the models from both Ontario and Alberta. B.C. has been in discussions with both provinces and both seem willing to assist. The ministry, working in collaboration with the health authorities and service providers, could develop a made-in B.C. version of a comprehensive funding and monitoring model that incorporates variation in resident needs, promotes the principles of transparency and consistency, and aligns resources to meet not only the physical care needs of residents, but their emotional, social, psychological and spiritual care needs as well. As suggested by the B.C. Care Providers Association, funding model components could include client case mix and other cost categories. Building on this, the Province could explore a number of funding envelopes similar to what Ontario has established.

[27] Office of the Seniors Advocate (2016, June). *2015-16 Annual Report of the Office of the Seniors Advocate.*

B.C. may want to consider the key objectives of Alberta's patient/care-based funding model, which include:

- Achieve equity in funding allocation by focusing on the equitable access and quality of services for residents with similar needs.
- Support consistency in access to care, standards of care, and the amounts paid for care for residents with similar care needs.
- Provide transparent, predictable funding consistent with the quantity, complexity and quality of the services needed by residents.
- Enhance funding predictability for residents, operators, decision-makers and other stakeholders.
- Provide incentives for improving efficiency and quality in long term care service delivery.

Accountability

Accountability is a key foundational element as well when trying to ensure quality care is provided to residents of care facilities. Again, the province may want to look to Alberta and Ontario in the way they have structured their reporting, monitoring and evaluation processes related to resident need, funding, service delivery and operations across the residential care sector, which happen at the facility level. Accreditation is another mechanism for accountability and ensuring quality of care. As most facilities are accredited through a recognized accrediting body currently, B.C. may want to standardize the requirements for accreditation.

Way Forward

The Province is fully committed to ensuring the needs of residential care clients are met in a caring, holistic manner that respects their dignity and autonomy, and results in better client outcomes and promotes quality of life. Within the context of the current fiscal situation, challenges exist that influence how this work may move forward, including the estimated $113.7 million annual cost needed to fund a standard average of 3.36 hours per resident day, at a minimum, by health authority and how to recruit the additional 1,511 FTEs needed. While there is still much more work to be done, this review offers many avenues for further exploration and analysis.

Next Steps

Achieving a standard cross-province average of 3.36 hours per resident day (at a minimum) by health authority would best be supported by a standard funding and monitoring approach. The funding approach should incorporate variables that impact staffing level and mix such as

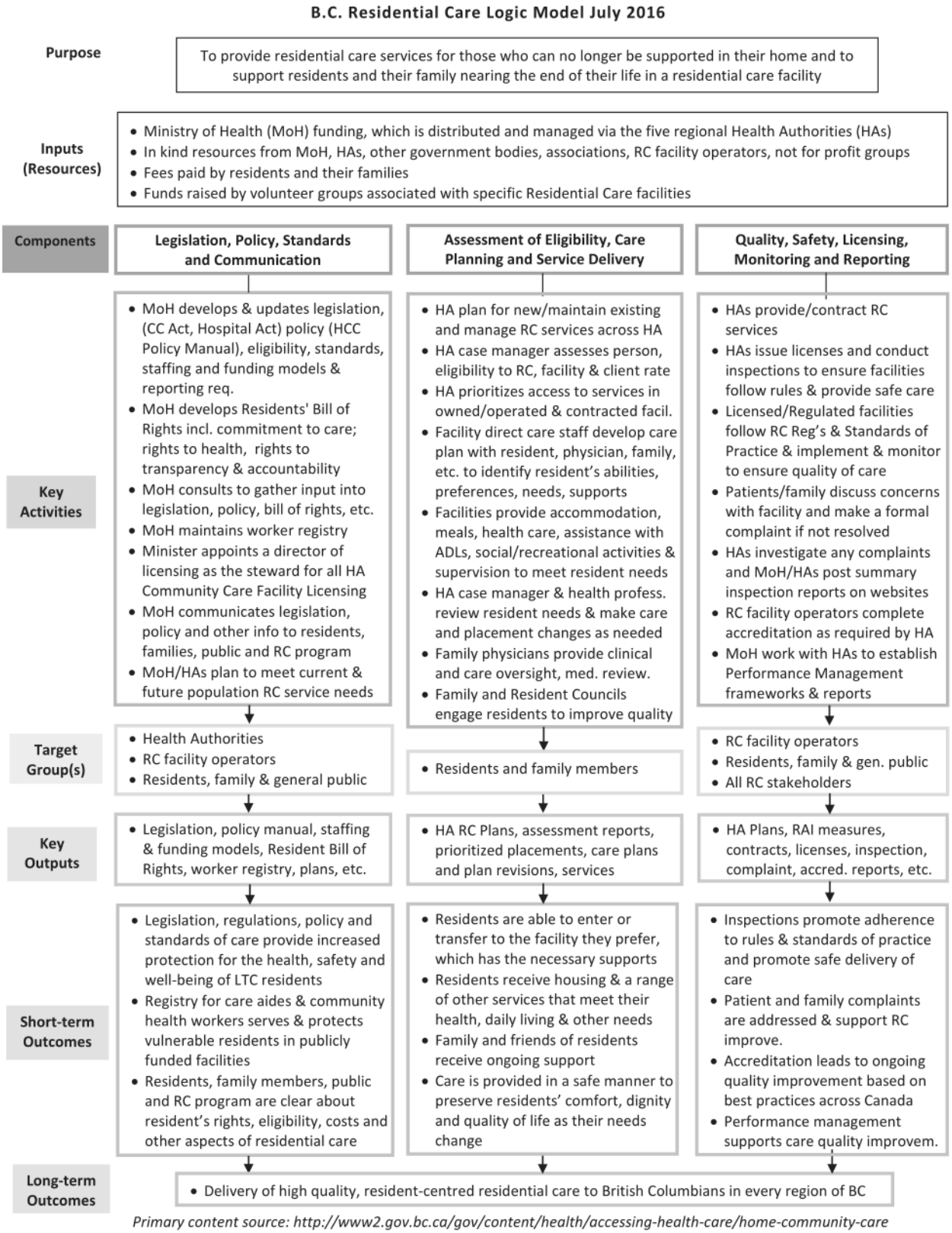
changes in workload resulting from residents moving into and departing from facilities, and changing resident needs over time. This work could be done in conjunction with defining a small number of province-wide priority quality of care initiatives.

The actions set out in the following table are grouped into one of three categories (funding and staffing, quality of care and accountability), and will be carried out in collaboration with the Office of the Seniors Advocate, other provincial ministries (e.g. ministries of Advanced Education and Jobs, Tourism and Industry), health authorities, industry partners and other stakeholders. The table includes the next steps required to move forward:

Category	Action	Proposed Timeline
Funding and Staffing	1. Finalize a report, in collaboration with the Canadian Institute for Health Information, to better understand the demand for home health, assisted living and residential care services (including the different profiles of clients using RAI assessment and service episode data) given the changes taking place in the home and community care system, and to inform required changes to existing residential care service models.	May 2017
	2. Confirm the definition of direct care hours per resident day.	July 2017
	3. Establish a baseline for: hours per resident day, client case mix, other identified residential care costs.	September 2017
	4. Work with health authorities and industry to create and implement an interim targeted process that would increase hours per resident day for areas with identified gaps until a costing review has been completed and the funding model has been updated to incorporate client complexity.	October 2017
	5. Move towards a province-wide standard residential care funding model, with a lens to incorporate resident complexity (using RUGs and case mix index from RAI assessments), quality of care and flexibility.	January 2018
	6. Complete an analysis of percentage of casual and part-time positions that can potentially be converted to regular full-time positions in residential care facilities.	June 2017
	7. Develop an interim strategy to address immediate high-priority vacancies in residential care facilities.	June 2017
	8. Develop a health human resources plan to ensure supply of staff will meet the needs of the residential care sector. The plan will include targeted recruitment activities and seat-planning in post-secondary programs.	November 2017

Category	Action	Proposed Timeline
Quality of Care	1. Prioritize key quality of care initiatives in residential care and facilitate a coordinated approach that promotes consistency and standardization, yet allows for flexibility given varying needs across facilities.	April 2018
	2. Bring into force Part 3 (care facility admission) of the *Health Care (Consent) and Care Facility (Admission) Act* to protect vulnerable adults. This work will include revising the residential care admission policy to be more person and family-centred.	April 2018
	3. Develop and implement palliative and dementia care policy including requirements and targets for staff education.	April 2018
Accountability	1. Incorporate the requirement to increase hours per resident day through annual bi-lateral agreements between the Ministry and health authorities.	April 2017
	2. Monitor health authority progress on achieving the 3.36 hours per resident day and produce annual reports for Leadership Council.	April 2018
	3. Develop and implement a policy to mandate accreditation for all residential care facilities.	April 2018
	4. Develop and implement performance measures that support quality of care and quality of life outcomes using outputs from RAI assessment and survey data including quality indicators.	April 2018
	5. Develop and implement a process and policy for monitoring, reporting and evaluation processes related to resident need, funding, service delivery and operations, building on experience from other provinces such as Alberta and Ontario to assess whether quality, funding and staffing policies and goals are being achieved.	April 2019

Appendix A: B.C. Residential Care Program Overview



Primary content source: http://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care

Appendix B: Summary of 2008 Research Findings

The following material is a summary of a review of the most recent and relevant research into residential care staffing practices (2008), which was undertaken to inform the development of an evidence-based staffing framework for residential care facilities. The review consisted of research pertaining to direct care nursing providers and allied health staff, leadership and education-related structures, and non-direct care services.

- Canadian researchers and professional organizations support the need for a broad focus on the factors impacting staff and resident outcomes, and reject the legislated focus on staffing ratios and hours of care adopted in some jurisdictions in the United States.
- Research in all jurisdictions emphasizes the complexity of making staffing decisions. Staffing decisions should be made following consideration of many variables and once made, they should be evaluated to ensure the level and mix of staff result in positive resident and staff outcomes.
- Research supports the development of staffing frameworks that are evidence-based and help those making staffing decisions to consider all important variables. An effective staffing plan requires an understanding of the complexity involved in matching human resources to resident needs, and appropriately skilled individuals to develop these plans.
- Staff mix is just one factor impacting resident outcomes and staff job satisfaction. Organizational structures, managerial practices, the work environment and culture, education and experience of staff, clinical leadership, and resident needs and complexity all have an impact on resident outcomes and staff satisfaction and turnover.
- Research in all jurisdictions consistently shows that higher levels of all types of staffing lead to better resident outcomes. Most research studies specify the levels of staffing required to avoid specific adverse events or improve specific quality of care outcomes. Only three US studies address total nursing staff levels needed for quality care in residential facilities; the recommended range is between 3.9 and 4.8 paid hours per resident day.
- Research suggests the higher the proportion of professional staff, particularly registered nurses, the better the quality of care as evidenced by resident and staff outcomes.
- Decisions about registered nurse and licensed practical nurses staff mix must consider their core competencies, the acuity and complexity of resident care needs, and the availability of supports such as other health-care staff.
- Some evidence supports the need for a shift in the way that organizations view cost. The emphasis should be on the cost of outputs, such as nurse absenteeism and the results of poor quality care, rather than the cost of inputs such as nurse to resident ratios and nurse skill level.

Appendix C: 2008 Staffing Framework Principles and Components

The following material is taken from 2008 planning documents that describe the framework to support residential care evidence-based staffing practice decisions and quality of care.

Framework Principles:

1. The delivery of safe, competent care is based on having the appropriate number and mix of multidisciplinary staff and the competencies required to provide the care.
2. Sufficient nursing competencies are required to address the highly complex, unpredictable care needs of residents in care and to avoid situations where subtle changes in status that are treatable are not identified until irreversible damage has occurred.
3. Sufficient allied health staff (regulated and non-regulated) are required as part of the multidisciplinary team to improve the functional status of residents and augment the direct care nursing staff.
4. All staff work to full scope of practice.
5. While cost efficiency is an essential element, achieving good resident outcomes through an evidence-based approach is central to making staffing decisions.
6. An evidence-based approach to staffing and resident outcome evaluation requires inclusion of structure and process indicators, not only staffing levels and mix.

Description of the Framework Components

Philosophy of Care

The philosophy of care specifies the values and beliefs about residents and care, and guides how resident care needs are identified, how staff resources are determined and how staff is organized to provide care.

Resident Care Needs

Staffing decisions must be based on a clear understanding of the unique needs of residents which in turn creates the demand for care by a multidisciplinary team. This includes resident characteristics such as age and sex, as well as common physical, social, emotional and cognitive problems; common acute and chronic medical diagnoses; admissions and discharges/deaths; end of life care; functional status; ethnicity; family relationships and the care required to meet basic human needs. Care needs vary in complexity, variability and acuity, thus affecting the amount of time required to meet them. Staffing levels, staff mix and care processes should be developed based on care needs, including at a minimum an RAI MDS 2.0 assessment.

Structure

Structure encompasses a broad range of variables that influence care processes and outcomes. They are divided into the following three categories:

1. *Staff level and mix* – Resident care needs is one factor that must be used to determine the level, mix and type of disciplines needed to provide care. Staff mix, staffing levels, multidisciplinary team members, full-time versus part-time status, competencies, education, experience and workload are other factors that must be considered before making staffing decisions. Access to primary care (physician or nurse practitioner) influences staff capacity to meet resident needs.
2. *Structures to support care* – There are many structure variables identified in the literature that impact care processes and outcomes. Examples include room size, physical layout of a site, the needs of specialized client populations, availability of technology, availability of clerical and support staff, unit geography/layout, availability of equipment and supplies, model of care delivery, contingency plans and availability of clinical practice guidelines. These must be considered in addition to resident care needs when making decisions about staffing levels and staff mix.
3. L*eadership, culture and climate to support care* – Organizational culture and climate, management strategies, communication, control, autonomy, span of control and governance are all variables that must be considered at the unit and facility levels when making staffing decisions, as these factors influence both care processes and staff and resident outcomes.

Process

Process pertains to activities undertaken by staff when delivering care, such as assessing residents; resident and family education; therapeutic communication; activities aimed at improving functional, physical and cognitive status; monitoring resident status; discipline specific and inter-professional practice; symptom management and avoiding predictable adverse events. Process examines actual services or activities provided to, or on behalf of, clients and is influenced by structure and resident care needs. Often clinical practice guidelines form the basis on which indicators are defined and monitored.

Outcomes

Outcomes are the relationships between structure, process and resident care needs that determine resident, staff and system outcomes. Outcomes are commonly separated into three areas: resident, staff and organization.

- Resident outcomes can be grouped as adverse events, symptom management, resident satisfaction with care and functional health outcomes (physical, social, and cognitive functioning, mental health and self-care ability).
- Staff outcomes include staff illness and injury, retention, turnover, autonomy, optimal use of competencies and job satisfaction.
- Organization outcomes include overtime, absenteeism, sustainable costs, continuity of care and recruitment.

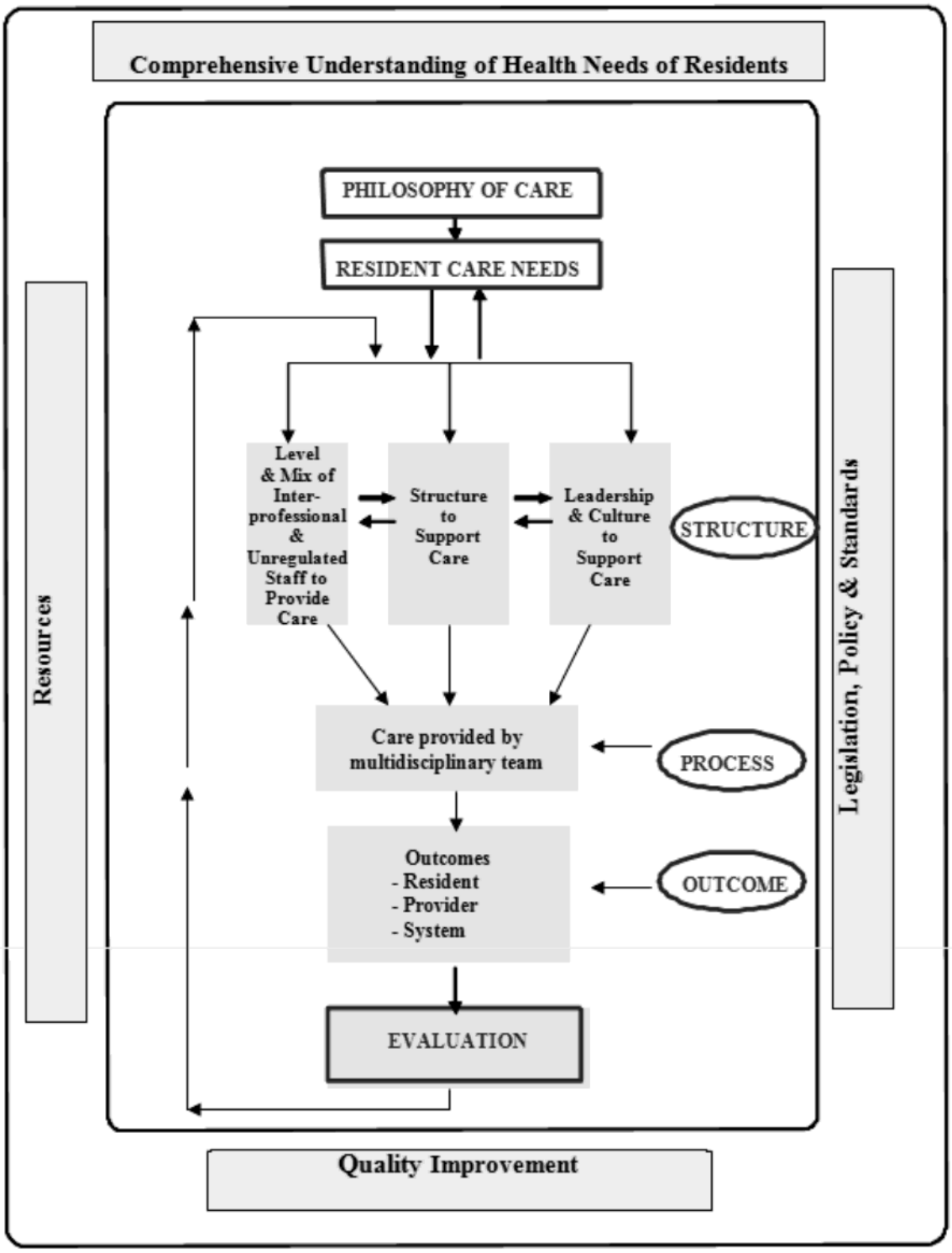
Evaluation

Evaluation involves:

- identifying indicators that reflect good care and positive health outcomes for residents;
- identifying indicators that reflect a culture and climate that retains staff;
- developing efficient systems for collecting and analysing data, and reporting progress; and,
- developing processes to manage change and achieve quality improvement.

The following diagram identifies the framework components that are essential to support evidence-based staffing decisions and are more likely to result in high quality, safe resident care and increased staff job satisfaction. It also identifies the contextual factors that have the potential to affect all components of the model. These factors include resources [such as financial, human, primary care (physician and nursing practitioner), physical plant, equipment and supplies], health needs of residents, and legislation, policy and standards. They also include a quality improvement process that seeks to meet residents' needs and expectations, and is achieved through a structured process that selectively identifies and improves all aspects of care and services on an ongoing basis.

2008 staffing framework components to support evidence-based staffing decisions:



Appendix D: 2008 Costing Assumptions – Assignment of Direct and Allied Health-Care Staff

The following information is taken from the 2008 Ministry of Health Costing Assumptions for the Proposed Staffing Framework for Residential Care Facilities. At that time, the Residential Care Standing Committee developed, as part of the costing assumptions, detailed staffing levels and staff mix to ensure consistency in costing the first phase of implementation of the framework.

The staffing levels and mix set out below are evidence-based. However, they are not indicative of actual staffing patterns to be used in each facility. Facilities will have the flexibility to develop their own staffing levels and mix, with the exception that they must at least one registered nurse for every 75 beds.

Direct Care

The total is 3.36 worked hours of care made up of direct and allied health care staff.

- Includes registered nurses, licensed practical nurses and care aides.
- *Registered nurses*: Should be one registered nurse 24 hours/day, seven days/week as set out in the table below.

Number of Beds	Number of Registered Nurses 24/7
0 – 75	1
76 – 150	2
151 – 225	3
226 - 300	4

- *Licensed practical nurses*: Should be one licensed practical nurse for every 25 residents on day and evening shifts, none for the night shift in facilities with 75 beds or less, and one for the night shift in facilities with more than 75 beds, as set out in the table below.

Number of Beds	Number of Licensed Practical Nurses 24/7		
	Days	Evenings	Nights
0 – 25	1	1	0
26 – 50	2	2	0
51 – 75	3	3	0
76 - 100	4	4	1
101 – 125	5	5	1
126 – 150	6	6	1
151 – 175	7	7	2
176 - 200	8	8	2
201 – 225	9	9	2
226 – 250	10	10	2
251 – 275	11	11	3
276 - 300	12	12	3

- *Care aides*: Should be one care aide for every six residents on day shifts, and one care aide for every eight residents on evening shifts – one to 37 residents on nights.
- Each resident should get 3.0 worked hours of direct care per day.
- Not less than 20 – 25% of the direct care hours should be professional (registered and licensed practical nurses) care.
- In a 75 bed facility, each resident would receive daily:
  - 19 minutes of registered nurse care (10%) based on a DC1 at the top step.
  - 57 minutes of licensed practical nurse care (32%) based on a PC11 at the top step.
  - 104 minutes of care from care aides (58%) based on a PC3 at the top step.
- In a 25 bed facility, each resident would receive daily:
  - 58 minutes of registered nurse care (32%).
  - 122 minutes of care from care aides (68%).

Allied Health Care

- Includes occupational therapists, physiotherapists, social workers, dietitians, recreational therapists, and activity workers.
- Each resident should get 0.36 worked hours (22 minutes) of allied health care per day based on a seven day work week comprised of:
  - 7 minutes of professional care based on an occupational therapist at the top step (equivalent to 8.8 hours/day for all residents in a 75 bed facility).
  - 15 minutes of care from activity workers based on a PC13 at the top step (equivalent to 18.75 hours/day for all residents in a 75 bed facility).
- Current occupational therapy/physiotherapy staffing levels would not be reduced if a facility has more than the target seven minutes/resident/day professional staffing level.

Benefits

- Includes sick, vacation, severance and shift differential - cost at 26%
- Relief factor is 26% based on 100% backfill

Appendix E: 2009 Ministerial Directive

On Feb. 27, 2009, the Minister of Health Services issued a ministerial directive to the health authority board chairs re: Home and Community Care Quality and Performance Monitoring, pursuant to the 2008/09 government letters of expectations. The directive included the following home and community care deliverables for health authorities:

A: Quality and Consistency – Assisted Living and Residential Care Services

B: Quality and Consistency – Home Health Services

C: Access to Information on Home and Community Care Services

D. Access to a Continuum of Home and Community Care Services

E. Minimum Reporting Requirements

Directive A included six areas related to assisted living and residential care including staffing, education, facility conditions and capital investments, quality and safety monitoring protocols, contract management process, and a monitoring and inspection process for extended care hospitals and private hospitals under the *Hospital Act*.

A.1, which focussed on staffing, stated:

> *Achievement of average standard staffing levels, in worked hours per resident per day for direct care (Registered Nurse, Licensed Practical Nurse, Residential Care Attendant) and for clinical support services (Rehabilitation, Social Work, Activity and Pastoral Care) in residential care facilities. (This is the initial focus of the implementation and evaluation.)*

Appendix F: Current State Analysis Methodology

Working closely with Ministry of Health and the Office of the Seniors Advocate, the residential care environmental scan included:

- **Key/Expert Interviews:** Semi-structured interviews were held with industry contacts, health authority staff and jurisdictional contacts in Alberta and Ontario to examine/discuss various aspects of residential care.
- **Document Acquisition and Review:** Numerous documents were gathered and reviewed in the course of the project. These included legislation, standards, policy, consultant reports, internal communications, draft materials, statistical summaries and other sources.
- **Health Authority Current State Questionnaire**: Each health authority provided a written response to the ministry. The results were analyzed and overview of the findings is presented in this report. The topics addressed include:
  - Ensuring quality of care for residential care clients;
  - Identifying/supporting staffing care models that enable quality and safe care;
  - Budgeted residential care funding; and
  - New models and innovation.
- **Literature Review:** A PubMed search was conducted for long-term care in conjunction with budget, quality and staffing. The search terms for long-term care included "long term care," "nursing home" and "residential care" (with qualifiers of "frail" or "elderly"). Of the 3,246 abstracts identified, 181 were selected and reviewed.
- **Data Analyses:** Data was provided by the ministry and the Office of the Seniors Advocate. The data was analyzed using primarily descriptive statistical approaches to address a range of questions.
- **Application of the Residential Care Staffing Framework Staffing Model**: The model was reviewed, applied to current state data and projected staffing requirements were estimated.

FACT SHEET: Pending ADM Approval

END OF LIFE CARE AND INITIATIVES

ISSUE

The planning and delivery of palliative and end-of-life care supports people's choice of receiving palliative and end-of-life care in their preferred location, including their own home or in a home-like setting[1].

KEY FACTS

- The Ministry of Health and health authorities provide a range of services to support people to receive palliative and end-of-life care in the care settings that best meet their needs, including at home, in hospital, in long-term care facilities, and in free-standing hospice residences.
- In BC, in 2014/15, there were 20,079 BC residents receiving some type of palliative care. Of those, 58 percent were users of Pharmacare Plan P, and 55 percent accessed home care services[2]. In 2013/14, the most recent data available, an estimated 12,726[3] people were not identified as palliative but may have benefited from a palliative approach to care.
- BC has been a leader in promoting integration of a palliative approach to care. For example, since 2012, 1,098 out of 5,624 General Practitioners in the province (20 percent) have participated in the General Practice Services Committee Practice Support Program End of Life Learning Module. The Module is designed to improve identification of those in their last year of life, and to integrate the palliative approach to care.
- On June 17, 2016, amendments were made to the *Criminal Code of Canada* to allow medical assistance in dying for capable adults in certain circumstances. The Government of Canada, through this legislation, committed to working with the provinces to facilitate access to palliative and end-of-life care[4].
- Palliative care will be an important component of the Ministry's development of primary care homes, linked with specialized services for people with complex medical conditions and frailty. Earlier provision of palliative care is linked with better patient outcomes, as well as better alignment of a person's treatment choices with their personal goals of care.
- A number of initiatives have been implemented in BC to improve palliative and end-of-life care:
  - The After-Hours Palliative Nursing Service, operating since 2012, is a provincial telephone service that provides palliative nursing support via telephone to palliative clients living at home, and their family members. From April 1, 2015 to March 31, 2016, the Service managed 544 calls, and forwarded 199 calls to the Palliative Response Nurse upon being assessed as requiring more specialized support.[5] The majority of calls forwarded to the Palliative Response Nurse resulted in patients remaining in their home (79 percent).
- In 2015/16, 1,400 general practitioners received $358,000 to help 3,568 patients with palliative care planning through the Conferencing Fee Initiative and the Palliative Care Incentive for family physicians.[6]
- Over 96,000 clients have received benefits through the BC Palliative Care Benefits Program since the program started in 2001. In 2015/16, $19.4 million was spent on medications and pharmacy[7].

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[1] Budget Speech 2015, pp.14-15
[2] Health System Matrix 7, Health Sector Information, Analysis and Reporting, Ministry of Health, April 2016
[3] End of Life Analysis, Matrix 6 2013/14 data, Health Sector Information, Analysis and Reporting, Ministry of Health, 2015.
[4] http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=E&Mode=1&DocId=8384014
[5] After-Hours Palliative Nursing Service, Year End Report, April 1, 2014 2015 – March 31, 2015 2016
[6] Workforce Analysed, Health Sector Information, Analysis and Reporting, Research and Evaluation 2015/16 data from October 1,2016
[7] PharmaNet Data, Health Sector Information, Analysis and Reporting, Ministry of Health, Retrieved October 2016, Health Ideas

- Established in 2013 by the Institute for Health System Transformation and Sustainability, the BC Centre for Palliative Care is a provincial hub to support palliative and end of life care practices based on evidence, education, and innovation to improve and support care for those living with and dying from serious illness and their families.

Provincial End-of-Life Care Action Plan Implementation

The Provincial Palliative Care Advisory Committee has made significant progress addressing the following three key priority actions:

1. A population needs-based approach to planning palliative and end of life care services, including by significantly expanding the availability of hospice spaces and supporting the Centre's efforts to raise the capacity of hospice societies to educate the public about advance care planning.
2. Improve the capacity to provide quality palliative and end-of-life care in residential care, and other housing and care settings. The Ministry, in collaboration with the Centre, is working to identify leading practices and opportunities for system improvements to integrate a palliative approach for all residents living in residential care facilities.
3. Improve access to BC Palliative Care Benefits by ensuring a consistent streamlined process that supports timely access to palliative care benefits for patients.

FINANCIAL IMPLICATIONS

- In 2014/15, the Institute for Health System Transformation and Sustainability was provided $2.125 million in support of the BC Centre for Palliative Care to advance best practice palliative care service delivery across the province.
- A further $5 million was provided to the Institute for Health System Transformation and Sustainability in support of the Centre to improve access to new hospice beds in communities across BC, make improvements to current spaces, and to support initiatives and partnerships to promote better end of life care throughout the province.[8]
- With the release of the End-of-Life Care Action Plan in 2013, the following funding was provided to support hospices in the province: $950,000 to Vancouver Hospice Society to allow the new hospice home to become fully operational; $3 million to the Peace Arch Hospital & Community Health Foundation to support the expansion of hospice services, including 15 hospice beds at Peace Arch Hospital; and $2 million for Canuck Place Children's Hospice.
- In 2013/14, $40,000 was provided to both the North Thompson Valley Hospice House Society and the Oceanside Hospice Society to help support end-of-life care services. In addition, $250,000 was provided to St. Joseph's Hospital Foundation to support four new hospice beds in Comox.
- Since 2001, the Province has provided more than $40 million to Canuck Place Children's Hospice.
- In 2014/15, $2.5 million was provided to Abbotsford Hospice Society.
- In 2016/17, $1.746 million was provided to support hospice and palliative locations in BC for palliative and hospice care, and an additional $4 million was provided to Canuck Place Children's Hospice.

Approved by:

Sharon Stewart, obo Doug Hughes, Primary and Community Care Policy Division; July 11, 2017
Christine Voggenreiter, obo Teri Collins, Health Sector Information, Analysis & Reporting Division;
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; July 13, 2017

[8] See Expansion of Hospice Spaces Fact Sheet

FACT SHEET

BC Centre for Palliative Care

ISSUE

The BC Centre for Palliative Care (the Centre) was established in 2013, by the Institute for Health System Transformation and Sustainability, through $2 million in funding provided by the Ministry of Health. The Centre is a provincial hub to support palliative and end-of-life care practices based on evidence, education and innovation to improve and support care for those living with and dying from serious illness and their families.

KEY FACTS

- Canada as a country is falling behind on the quality and availability of palliative care to adults, according to international indicators of the Quality of Death Index - from 9th place in 2010 to 11th place in 2015[1]. A palliative approach to care is often introduced too late, or not at all.
- The Centre's vision is for all British Columbians living with serious illness to have equitable access to compassionate, quality palliative care and resources from the time of diagnosis.
- In 2014, the Centre launched their strategic plan which focuses on three strategic priorities:
  1. Improving access to person-centred care for patients and families living with serious illness;
  2. Enabling excellence in integration of the palliative approach to care, and increasing capacity through innovation and evidence-based policy development; and
  3. Mobilizing citizen engagement in the development of quality person and family-centred outcomes within local communities and workplaces.

Centre Initiatives

Under the leadership of Dr. Doris Barwich, the Centre in 2016 is focusing on increasing capacity through education and support of leading practices associated with advance care planning, compassionate communities, and palliative education networks as described below.

Advance Care Planning

The Centre is developing a suite of tools and resources for advance care planning founded on best practices which will be designed to increase public awareness. Estimated date of completion of these tools and resources is September, 2017.

In addition, the Centre is promoting best practices for health-care providers around serious illness conversations, encouraging practitioners to have more, better, and earlier conversations with individuals facing serious illness to promote care that aligns with individuals' goals. As part of this work, on November 7, 2016, the Centre co-sponsored events featuring Dr. Rachelle Bernackie, Associate Director of the Serious Illness Care Program, at Ariadne Labs at Harvard Medical School, to discuss potential for system-wide improvements enabling conversations about serious illness with patients and their loved ones.

Compassionate Communities Initiative

Working closely with the BC Hospice Palliative Care Association and other key community organizations, the Centre is collaborating across the province to support and mobilize local community partnerships; raise public awareness about people who experience life-limiting illness and the shared responsibility to support them; and engage and empower local communities and citizens with the knowledge, skills and tools/resources that will help them provide care and support. In May 2015, the Centre hosted Dr. Allan Kellehear to mobilize public support for the creation of Compassionate Communities. The Centre is working closely with the national Compassionate Communities Initiative[2].

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[1] The Economist. (2015). *The 2015 Quality of Death Index.* [Report] Available at: http://www.economistinsights.com/healthcare/analysis/quality-death-index-2015/tab/0

[2] *Compassionate Communities*. (n.d.) Pallium Canada. [Website]. Available at: http://pallium.ca/compassionate-communities-2/

FACT SHEET

Integration of the Palliative Approach to Care

The Centre is supporting a broad community of practice to develop, implement and sustain a provincial strategy for education. Academic partners, educators and front-line providers are involved in crafting a strategy for uptake of the palliative approach to care throughout BC. This will be accomplished by using a competency framework to enable a consistent palliative approach in all care settings; creating an online provincial repository of education resources; supporting revision and uptake of evidence-informed practice guidelines for symptom management to be used throughout BC; and offering provincial education events.

Research and Innovation

The Centre is also an important partner in research that supports integration and knowledge translation of key research findings into practice. Current projects include: iGAP-improving advance care planning (ACP) in general practice; iDECIDE-ACP for hospitalized patients; Participatory Research study with young adults transitioning to the adult palliative care system; and support for knowledge translation activities for NCARE: Peer navigation in rural settings.

FINANCIAL IMPLICATIONS

In 2014/15, the government provided $7.125 million to the Institute for Health System and Transformation and Sustainability, in support of the BC Centre for Palliative Care to increase public awareness on advance care planning and to improve access to palliative care and to support integration of a palliative approach to care in communities across British Columbia.

The BC Centre for Palliative Care, in partnership with local hospice organizations, a hospital foundation and health authorities, distributed funding totalling $3.67 million toward 47 new hospice beds in 13 communities throughout the province.

$1.33 million is being used by the BC Centre for Palliative Care to fund provincial partnerships and community-based projects that promote compassionate care closer to home.

- The $1.33 million breaks down as follows:
  - Capital funds to support hospice spaces initiatives and improvements that will provide alternatives to hospice beds (e.g., day hospice, respite and supportive care centres - $440,000 (6 communities).
  - The Centre issued a call to BC's community hospice societies for 'seed grant' funding requests. Seed grants provide an opportunity for hospice societies to access up to $5,000 per project for innovative educational and/or outreach programs to improve public awareness of palliative care, and to further train palliative volunteers. Seed grant funding is being provided in three cycles, with the first and second cycle already allocated, and the third cycle will take place in 2017 for a total of $350,000.
  - $540,000 is directed towards partnerships in support of health care provider palliative care education, addressing the needs of people with serious and terminal illnesses in rural or remote settings, and supporting a palliative care community development model for First Nations' communities.
  - $2.125 million is supporting the BC Centre for Palliative Care's work to advance best practice palliative care service delivery across the province, including increasing public awareness on advance care planning.
  - Announcements for hospice expansion and the improvement and innovation grants occurred in January 2017.

Approved by: Sharon Stewart, obo Doug Hughes, Primary and Community Care Policy Division; February 17, 2017
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services; February 22, 2017

FACT SHEET: Pending ADM Approval

Provincial Expansion of Hospice Spaces

ISSUE

The previous Government committed to doubling hospice spaces in the province by 2020.

KEY FACTS

Hospice Spaces Baseline Measures

The baseline number of hospice beds is 375 beds[1] (as of March 2015, and consisted of 87 acute/tertiary palliative care unit beds and 288 community hospice beds).

New beds to end of June 2017:

70 new beds have been added, including 53 community hospice and 17 acute/tertiary beds, for a total number of 445 beds (currently 339 community beds and 106 acute/tertiary beds). Details regarding new beds are as follows:

- 19 beds in 2015/16:
  - Island Health opened 8 beds (4 beds in Comox and 4 beds in Parksville)
  - Northern Health Authority opened 1 hospice bed in each location: Fort St. James; McBride; Fort Nelson; Chetwynd; Mackenzie; Smithers; Kitimat; Massett; Queen Charlotte City; Fort St. John and Prince Rupert
- 35 beds in 2016/17:
  - Fraser Health Authority opened 10 beds in Abbotsford
  - Interior Health Authority added 14 hospice beds (8 beds in Kamloops, 4 beds in Kelowna, 2 beds in Salmon Arm)
  - Island Health added 6 hospices beds (4 in Campbell River, 2 in Sooke)
  - Vancouver Coastal Health added 5 hospice beds in North Vancouver
- 16 beds to date in 2017/18:
  - Interior Health Authority opened 8 beds (3 in West Kelowna, 2 in Trail, and 1 bed in Grand Forks, Nakusp, and Nelson)
  - Vancouver Coastal Health opened 8 beds in Vancouver

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[1] Government of BC. (2015). *BC Palliative Population Needs Assessment: Hospice Palliative Care Beds and Home Based Palliative Care Services*. Ministry of Health, Victoria BC [Report].

FACT SHEET: Pending ADM Approval

Summary

- Additional hospice spaces created, identified, and planned to date will result in a total of 533 beds provincially and represent a total increase of 45 percent over the baseline number of hospice beds.
- 533 hospice beds are projected to reach a bed to population ratio of 13 hospice beds per 100,000 adults in 2020, ranging from 11 beds per 100,000 in FHA and Island Health to 21 beds per 100,000 in IHA.
- International best practice is 8 beds per 100,000 as a target hospice bed to population ratio.
- 206 additional hospice beds are required to meet the commitment of 375 new beds.

FINANCIAL IMPLICATIONS

s.13,s.17

- The BC Centre for Palliative Care, in partnership with local hospice organizations, a hospital foundation and health authorities, distributed funding totalling $3.67 million toward 47 of the new beds above in 13 communities throughout the province.
- $1.33 million is being used by the BC Centre for Palliative Care to fund provincial partnerships and community-based projects that promote compassionate care closer to home.
- $2.125 million is supporting the BC Centre for Palliative Care's work to advance best practice palliative care service delivery across the province, including increasing public awareness on advance care planning.
- Announcements for hospice expansion and the improvement and innovation grants occurred in January 2017.

Approved by:
Sharon Stewart obo Doug Hughes, ADM, Health Services Policy Division;
Gordon Cross obo Manjit Sidhu, ADM, Finance and Corporate Services;

FACT SHEET

Better at Home Program

ISSUE

Better at Home, managed by the United Way, provides seniors with access to simple, non-medical home support services to help them remain independent in their own homes and connected to their communities for as long as possible. Better at Home uses a community development model and each program is tailored to meet the needs of local seniors, and is one of the pillars in the United Way's Provincial Healthy Aging Strategy.

KEY FACTS

- 67 core Better at Home program sites are operating in communities across BC; many serve more than one community; 4 of these communities are on First Nations Reserves.
- Program sites were identified based on criteria such as the overall proportion of seniors in the area and the number of seniors (e.g., isolated and vulnerable) likely to require Better at Home services. Seniors' organizations and other local and regional experts have helped guide the site selection process.
- Services may include light housekeeping, yard work, snow shoveling, grocery shopping, minor home repairs, transportation services and friendly visiting. Services are provided by local non-profit organizations and delivered by a mix of volunteers, contractors and paid staff.
- Seniors are charged a fee for service on a sliding scale based on income. Eligible low-income seniors are not charged for services. Local circumstances determine fee structures and services available. Currently, 10% of seniors accessing Better at Home pay a full fee for services. As of March 2017, Better at Home had delivered 394,605 services and 20,093 seniors and elders were enrolled.
- Many sites have now reached service delivery capacity, maximized program efficiencies, and will not be able to grow further without additional program funding. More than 40 community organizations and individuals across BC have contacted United Way to request Better at Home programs for their communities and more than 1,700 seniors are waitlisted for services across 46 program sites.
- United Way has indicated its interest in and readiness for further program expansion beginning in 2017/18, which would require an increase in the annual program budget.

<u>Program Oversight</u>

- Better at Home is guided by a provincial reference group comprising 14 subject matter experts and community partners/stakeholders from across the province including a Ministry of Health representative. The reference group acts as a consultative body to the Better at Home program.
- Each program site is guided by a local Advisory Committee, which provides advocacy and helps support the integration of the Better at Home program into the community.
- Program coordinators from each program site submit regular reports to the provincial office for performance monitoring.

<u>Rural and Remote Pilot Project and Evaluation</u>

- 6 sites received funding in April 2015, to pilot test new models for Better at Home service delivery in rural and remote communities. The *United Way of the Lower Mainland's Better at Home Rural and Remote Pilot Project: Final Evaluation Report* was released in March 2017. Findings state that:
  - The Better at Home program had positive impacts on seniors' ability to live safely alone, reduced social isolation and strengthened their connections with the community; and provided a safe avenue for seniors to express their needs and reduced the stigma in asking for help.
  - Some rural communities did not have the volunteer base required to run the program.

- Limited funding and resources presented challenges in offering a full basket of services in many rural and remote communities and also limited outreach efforts.
- There were more female than male clients, many of them lived alone and many received partial or full subsidies for services.
- Transportation and food security are the biggest challenges facing seniors living in remote communities. Lack of access to transportation was a contributing factor to increased social isolation among seniors in those communities.

Funded Program Sites by Health Authority

Fraser Health	Logan Lake	North Central B.C. (Fraser Lake, Fort St. James and Vanderhoof)*
Abbotsford	North Okanagan (Vernon)	
Burnaby	Penticton	Gitxsan First Nation
Chilliwack	Shuswap Region (Salmon Arm)	Granisle*
Delta	South Okanagan (Osoyoos)	Kitimat
Hope/Fraser Canyon	Williams Lake	Prince George
Langley	**Island Health**	Prince Rupert
Maple Ridge/Pitt Meadows	Campbell River	Quesnel
Mission	Comox Valley	Robson Valley (Valemount area)*
New Westminster	Cowichan Region (Duncan/Cowichan)	Terrace
Richmond	Cowichan Tribes (Cowichan First Nation)	**Vancouver Coastal Health**
South Surrey/White Rock	Nanaimo	North Shore (North Vancouver)
Stó:lō Territory (Stó:lō First Nation)	North Island (Port Hardy)	Sea to Sky (Pemberton/Whistler)
Surrey-Newton	Oceanside (Parksville)	Squamish Nation - Tsleil-Waututh Nation
Surrey-Whalley	Port Alberni	Sunshine Coast (Sechelt)
Tri-Cities	Powell River	Vancouver DTES/Strathcona/Chinatown
Interior Health	Salt Spring Island	Vancouver Hastings-Sunrise
Arrow Lakes (Nakusp area)*	Southern Gulf Islands*	Vancouver Kerrisdale/Oakridge/Marpole
Ashcroft/Cache Creek	Victoria Esquimalt	Vancouver Kitsilano
Castlegar	Victoria (James Bay)	Vancouver Mount Pleasant
Central Okanagan (Kelowna)	Victoria Saanich	Vancouver Renfrew-Collingwood
Cranbrook	Victoria West Shore	Vancouver South
Creston	**Northern Health**	Vancouver West End
Columbia Valley (Invermere area)*	Dawson Creek	
Kamloops	Fort St. John	

*Better at Home rural/remote pilot site

FINANCIAL IMPLICATIONS

- The Ministry has provided $41 million in funding to the United Way ($15 million in 2011/12, $5 million in 2012/13 through the Provincial Health Services Authority, $2 million in 2013/14, $4 million in 2014/15, $5 million in 2015/16, and $10 million in 2016/17) to expand and operate the Better at Home program.
- The platform commitment of $10 million annually to the United Way to manage Better at Home beginning in 2014/15[1] represents a cost pressure to the Ministry.

Approved by:
Sharon Stewart, obo Doug Hughes, Primary and Community Care Policy Division; July 7, 2017
Barb Lee, obo Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; July 11, 2017

[1] Strong Economy Secure Tomorrow, 2013 Platform, p. 65

FACT SHEET

SENIORS' INFORMATION

ISSUE

The Ministry of Health (the Ministry) develops and disseminates information about government programs, services and initiatives for seniors through a suite of print-based and web-based resources. The information is designed to help seniors and those who care for them make informed decisions about care, to plan for healthy aging, and to understand how to navigate the system of care and supports for seniors in BC.

KEY FACTS

- In 2012, 32 percent of Canadian Internet users aged 65 and over used social networking sites, and 25.5 percent used the Internet to make telephone calls online.[1]
- In 2012, 56 percent of British Columbians aged 65 and over reported having used the Internet for personal non-business use in the past twelve months from any location.[2]
- In 2012, 61.9 percent of Canadian Internet users aged 65 and over used the Internet to search for medical or health-related information.[3]

Background

The Ministry has made ensuring access to high quality information about programs and services for seniors a priority. However, this is also an ongoing challenge, and has been identified as a major need by many seniors and experts—for example, the Premiers' Council on Aging and Seniors' Issues (2006); the Ombudsperson's 2012 report on seniors' care; and the Office of the Seniors Advocate's March 2015 report, *B.C. Seniors Survey: Bridging the Gaps*, which indicates low awareness of seniors' programs, especially among low-income seniors, older seniors, and seniors in the north.

SeniorsBC.ca Website

- Seniors, families and caregivers can easily access information about government programs, services, supports and benefits for older adults by visiting www.SeniorsBC.ca. The website is updated regularly to ensure accuracy and timeliness of information.
- The website provides information about provincial and federal government programs, services and benefits for older adults, including the following:
  - Downloadable versions of resources such as the *BC Seniors' Guide, BC Elders' Guide, Healthy Eating for Seniors* handbook, the *My Voice* advance care planning guide and workbook and Elder Abuse Prevention Information kits;
  - Promotion of events such as World Elder Abuse Awareness Day (WEAAD), Seniors' Week and the International Day of Older Persons; and
  - Links to information and resources such as the Office of the Seniors Advocate website, the new Aging Well section of Healthy Families BC.ca, which encourages older adults to plan for a healthy older age, and Home and Community Care (e.g., care and support options; how to access health care services; criteria for publicly subsidized services; accountability for health, safety and quality of care; and how to have concerns and complaints addressed).

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[1] Statistics Canada. *Table358-0153 - Canadian Internet use survey, Internet use, by age group, Internet activity, sex, level of education and household income, occasional (percent),* CANSIM (database).

[2] Statistics Canada. *Table358-0152 - Canadian Internet use survey, Internet use, by age group and household income for Canada, provinces and census metropolitan areas (CMAs), occasional (percent),* CANSIM (database).

[3] *Ibid.*, 1

FACT SHEET

BC Seniors' Guide and other publications

Many older adults do not use the Internet to access information, and the Seniors' Health Promotion team and the Office of the Seniors Advocate continue to receive requests for print resources. Other seniors embrace technology and increasingly make use of devices such as laptops, tablets and e-readers. To reach as many seniors as possible, the Seniors' Health Promotion team produces both print and electronic versions of key publications such as the *BC Seniors' Guide,* the *Healthy Eating for Seniors* handbook and Elder Abuse Prevention Information kits, which are all available in English, French, Chinese and Punjabi.

An updated 11th edition of the *BC Seniors' Guide* was released earlier this year. In response to the Office of the Seniors Advocate's March 2015 *Bridging the Gaps* report, the 11th edition of the *BC Seniors' Guide* highlights programs and services of particular interest to seniors with lower incomes. In addition, a new free e-book version has been developed (in English only), and is compatible with e-readers such as Kobo and Kindle. E-books can also be read on tablets, laptops, desktop computers and other devices. Free individual print copies of the *BC Seniors' Guide* are available by calling the Office of the Seniors Advocate, toll-free at 1 877-952-3181, or 250 952-3181 in Greater Victoria. PDF and e-book versions can be downloaded at www.gov.bc.ca/seniorsguide.

Promotion and Distribution

In addition to the SeniorsBC.ca website and print material, information resources are promoted to seniors and the public in a variety of ways to increase access and awareness across the province. Those avenues include the following:

- HealthLinkBC.ca and 8-1-1;
- Office of the Seniors Advocate;
- Crown Publications Online Catalogue;
- HealthyFamiliesBC Twitter account;
- The Aging Well website (www.healthyfamiliesbc.ca/aging-well)
- BC Public Libraries;
- Community-based events such as the BC Elders Gathering; and
- Other government and non-government partners, including Service BC, Service Canada, MLA offices, health authorities, seniors' groups and community agencies.

FINANCIAL IMPLICATIONS

- In 2014/15, the cost to reprint the *BC Seniors' Guide* was approximately $65,000.
- The cost to complete the new (11th) edition of the *BC Seniors' Guide* in English, French, Chinese and Punjabi was approximately $580,000 (including updating, editing, translation, printing, and the e-book) in 2015/16.

Approved by:

Sharon Stewart obo Doug Hughes, ADM, Health Services Policy Division; October 30, 2016
Maria Furmek obo Manjit Sidhu, ADM, Finance and Corporate Services; November 2, 2016

FACT SHEET

PROVINCIAL APPROACH TO DEMENTIA CARE AND PRIORITIES

ISSUE

The Ministry of Health's *Provincial Guide to Dementia Care in British Columbia* (May 2016) represents a call to action for government, health authorities and community partners, identifying priorities and actions designed to improve the quality of life and quality of care for people living with dementia, including supports for families and caregivers.

KEY FACTS

- The *Provincial Guide to Dementia Care in British Columbia* (Guide) builds on the 2012 Provincial Dementia Action Plan and responds to needs of the estimated 62,000[1] people with dementia in BC.
- The impact of dementia will continue to grow as the proportion of seniors in BC increases. Within the next 15 years it is anticipated there will be fewer school age children than people over 65, and by 2022, it is expected one in five British Columbians will be over 65 years old.[2]

Provincial Guide to Dementia Care in British Columbia

- Development of the Guide was informed by a review of dementia plans from around the world. Input was sought from people living with dementia, their family and caregivers, the Alzheimer Society of BC, health care professionals including family physicians and geriatricians, and health authority representatives.
- The Guide is structured around the dementia journey travelled by people with dementia, their families and caregivers. This includes changes in the living environment (e.g., need for family and/or caregiver support to allow individuals to remain at home), and decisions about care such as a move to residential care, or receiving palliative and end-of-life care.
- A priority goal of the Ministry is to meet the needs of older adults with moderate to complex chronic conditions, including dementia. The Guide identifies actions that will assist the ministry and health authorities to redesign specialized services for this population.
- The Ministry will work with health authorities and community organizations, identifying opportunities to address the priorities contained in the Guide.
- Priorities identified in the Guide are as follows:
    1) Increase public awareness and early recognition of cognitive changes;
    2) Support people with dementia to live safely at home for as long as possible and support caregivers;
    3) Improve quality of dementia care in residential care including palliative and end-of-life care; and
    4) Increase system supports and adoption of best practices in dementia care.

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[1] The reported decrease in prevalence of Alzheimer's and other dementias from earlier years is primarily the result of a change in the definition and not in the number of cases. The definition used for cerebral degeneration is now specific to Alzheimer's and other dementias, and excludes other causes such as obstructive hydrocephalus which were previously included. The change in reported prevalence is also due to amendments to other reporting criteria which were made in order to standardize database sets and enable comparison across jurisdictions. Source: BC Ministry of Health, Chronic Disease Information Registries, 2014/2015, Alzheimer's Disease and Other Dementia Measures Report.

[2] BC Ministry of Health, Primary and Community Care in BC: A Strategic Policy Framework, 2015, p. 27.

- Work underway includes:
    - The Alzheimer Society of BC First Link® program is available throughout all health authorities. Availability in Interior Health Authority includes the North, South and Central Okanagan, Central Interior, and Similkameen regions, with expansion into the Kootenay region underway. The First Link® program connects people with dementia, family members and caregivers with support, education and information at any stage of the dementia journey (see Fact Sheet on First Link).

FINANCIAL IMPLICATIONS

- In March 2016, the Ministry renewed its license for the P.I.E.C.E.S.™ dementia education program for a second three year term (2016 – 2019), renewing the Ministry's existing 2013 – 2016 license purchased in March 2013 (at a cost of $91,956 for each three year term).
- In fiscal 2012/13, the Ministry provided funding of $25,000 to each regional health authority for P.I.E.C.E.S.™ dementia care training for health care providers, and a further $50,000 was provided in the 2013/14 and 2014/15 fiscal years.
- The Ministry and the Provincial Health Services Authority have provided a total of $13.4 million to the Alzheimer Society of BC's First Link® program to support individuals and families affected by Alzheimer's disease and dementia. (See Fact Sheet on First Link).

Approved by:
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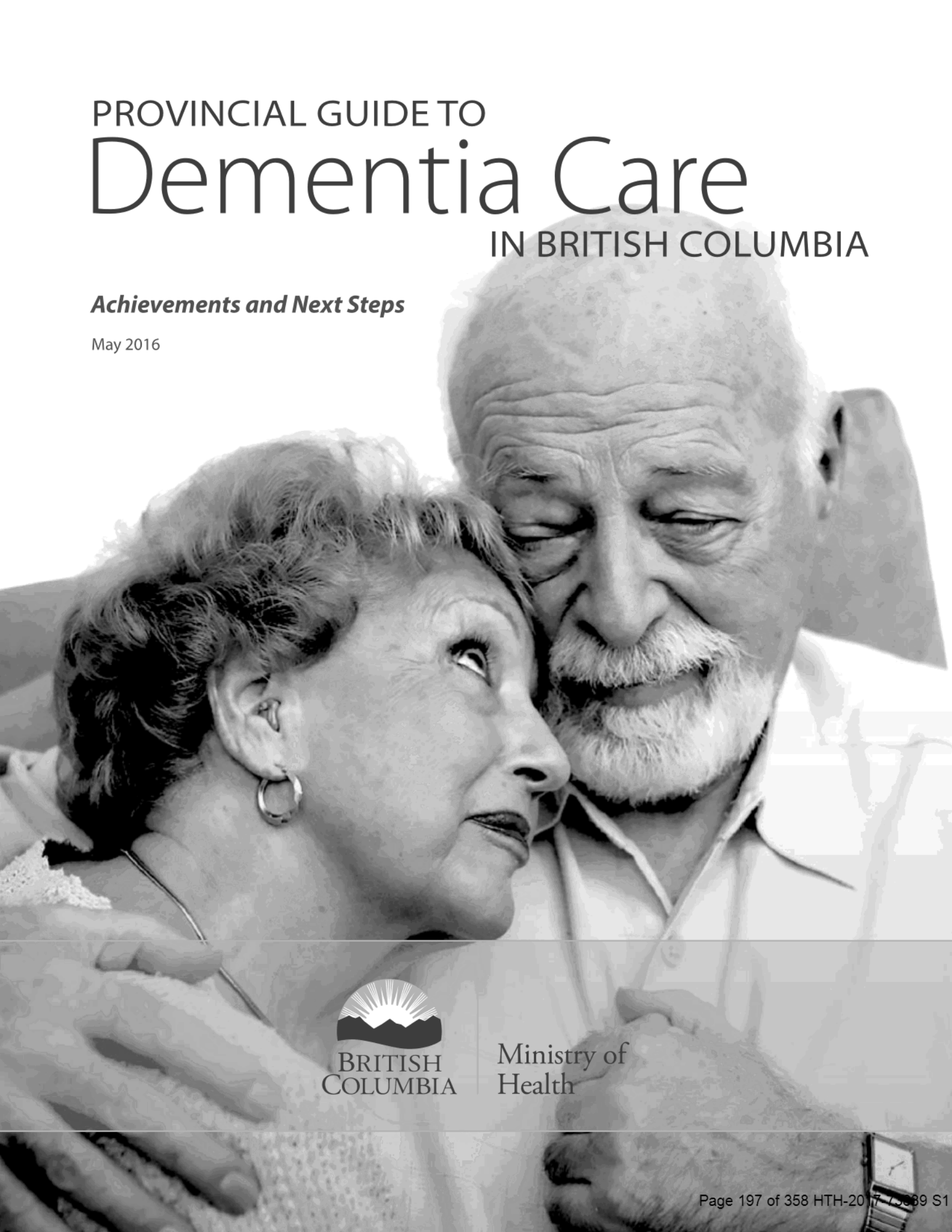
PROVINCIAL GUIDE TO Dementia Care IN BRITISH COLUMBIA

Achievements and Next Steps

May 2016



BRITISH COLUMBIA | Ministry of Health

Contents

Executive Summary

Although many seniors will remain healthy and active throughout their lives, the likelihood that a person will require health services (and the amount of those services), increases dramatically as we age – especially for those over age 85. Seniors may require health supports to manage increasing frailty or chronic disease, including dementia, which can profoundly impact their ability to maintain independence and remain at home.

In 2012, the Ministry of Health released The *Provincial Dementia Action Plan for British Columbia*[1] to demonstrate government's continued support for people with dementia (major neurocognitive disorder[2]) and their families. The plan committed to specific priorities designed to improve the health and quality of care for people with dementia – from prevention through to end of life. The 2012 action plan priorities included:

- PRIORITY 1: *Support Prevention and Early Intervention*
- PRIORITY 2: *Ensure Quality Person-Centred Dementia Care*
- PRIORITY 3: *Strengthen System Capacity and Accountability*

Built around a system-wide approach, the plan aimed to increase individual, family, community and health service capacity to provide early, safe and appropriate person-centred care. It supported people living with dementia in British Columbia to remain within their communities to the greatest extent possible – reducing or delaying transition to residential care – and recognized the important role of family caregivers. The plan also supported increased awareness of brain health strategies and provided early access to support and information to manage the physical, behavioural and psychological symptoms of dementia.

Notable achievements arising from the 2012 action plan include the following:[3]

- Updated HealthLink BC, SeniorsBC, and Home and Community Care websites and print resources with information on brain health, planning for healthy aging and living with dementia.
- Expansion of the Alzheimer Society of B.C.'s First Link® dementia support program which connects people with dementia and their care partners to support services, education and information at any stage of the journey.
- Health-care professionals are being provided with dementia care training through the P.I.E.C.E.S.™ Canada (**P**hysical, **I**ntellectual, **E**motional health, **C**apabilities, **E**nvironment, **S**ocial self) program, which provides a systematic framework for assessment and care planning using a person-centred approach.[4]
- The 48/6 Model of Care for hospitalized seniors, in use in hospitals and all acute inpatient care settings, focuses on screening and assessment in six key care areas and the development of a personalized care plan within 48 hours.

1 *www.health.gov.bc.ca/library/publications/year/2012/dementia-action-plan.pdf*

2 Dementia is not itself a disease but is caused by a variety of diseases including Alzheimer's disease. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) now uses the term "major neurocognitive disorder" instead of "dementia." As well, the DSM-5 recognizes a less severe type of cognitive impairment, "mild neurocognitive disorder."

3 See details in Appendix A.

4 *www.piecescanada.com*

- A funding partnership between the Michael Smith Foundation for Health Research, Brain Canada, the Pacific Alzheimer Research Foundation, and Genome BC supports a new British Columbia Alzheimer's Research Award and the Djavad Mowafaghian Centre for Brain Health.

Since release of the action plan, the Ministry of Health launched its current strategic plan, *Setting Priorities for the B.C. Health System* (2014).[5] This plan identifies the need for continued improvements to dementia care. This includes support and training for formal and informal caregivers, and a more adequate service framework for the different stages of dementia (linked to the expansion of home and residential care options). The accompanying policy paper, *Primary and Community Care in BC: A Strategic Policy Framework*,[6] identifies practical recommendations, including the need to integrate dementia care planning into all activities that support seniors care. This *Provincial Guide to Dementia Care in British Columbia* (guide), sets the direction for planning dementia care services and supports in the province.

To meet current and future population and patient health care needs, the guide provides a comprehensive approach to the dementia journey – from diagnosis to end of life. The aim is to reduce the risk of dementia, and to improve the lives of people living with dementia, their families and caregivers. The priorities and deliverables outlined in this guide are based on: consultation with interest groups, including people living with dementia and caregivers; best practices from research literature; analysis of population health and resource use data; and strategic guidance from *Setting Priorities for the B.C. Health System.*

The Priorities:

PRIORITY 1: *Increase public awareness and early recognition of cognitive changes.*

GOAL: *Increase healthy behaviours by promoting brain health and improve access to early diagnosis, intervention and community support programs.*

PRIORITY 2: *Support people with dementia to live safely at home for as long as possible, including caregiver support.*

GOAL: *Improve supports that allow people with dementia to remain at home and better support transition to residential care when needed.*

PRIORITY 3: *Improve quality of dementia care in residential care, including palliative and end-of-life care.*

GOAL: *Strengthen standards for dementia care in residential care to provide quality care for individuals who cannot live at home.*

PRIORITY 4: *Increase system supports and adoption of best practices in dementia care.*

GOAL: *Improve health-care professional and caregiver knowledge and ability to deliver safe, well-informed dementia care using best practices.*

One of the Ministry of Health's priorities is to better meet the needs of older adults with moderate to complex chronic conditions. This guide calls for services that allow people with dementia to live safely at home for as long as possible, with smooth transition to residential care when needed. This includes the ability to receive palliative and end-of-life care in their home. Responsive service delivery

5 *www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf*

6 *www.health.gov.bc.ca/library/publications/year/2015/primary-and-community-care-policy-paper.pdf*

and flexible care models are needed to support people with dementia to be cared for at home rather than in emergency departments and acute care in-patient beds.

As frailty is compounded by an increased prevalence of dementia and other forms of cognitive decline, this guide will support health authorities to meet the needs of frail seniors and people with complex chronic conditions.

The guide contains concrete actions for the ministry, health authority staff, and communities to include in their planning processes. Some actions will be led by the ministry (e.g., working with educational institutions to increase dementia care competency among future health-care professionals) and others by health authorities (e.g., incorporating dementia friendly design into residential care homes). Health authorities will be responsible for work plans with actions that have targets and measures aligned to the ministry policy papers (e.g., primary and community care policy paper[7]). The list of deliverables and implementation leads are provided in Appendix B. A framework identifying provincial measures and reporting requirements is being developed.

When implemented, the actions will help those affected – people with dementia, their families and caregivers – to live with continued meaning, enjoyment and quality of life.

7 *www.health.gov.bc.ca/library/publications/year/2015/primary-and-community-care-policy-paper.pdf*

Introduction

Dementia (major neurocognitive disorder[8]) is a broad term applied to a group of signs and symptoms seen in a variety of diseases affecting the brain. Dementia is not itself a disease but is caused by diseases such as Alzheimer's disease. Impairment of higher brain functions such as memory, thinking, orientation, comprehension, calculation, learning capacity, language, judgement and executive function (a mental process that helps us plan, organize, remember instructions and focus our attention) are all possible outcomes of dementia.[9] Changes in behaviour and mood are also common.

Dementia impacts roughly 62,000 British Columbians and is expected to rise to 87,000 by 2024.[10] This increase marks dementia as one of the biggest health challenges for B.C., elsewhere in Canada and around the world.

TABLE 1: PREVALENCE OF DEMENTIA IN B.C. BY AGE GROUP, 2014/15

Age Group (years)	40–64	65–84	85+	Total
Dementia Prevalence by Age Group	4,740	27,835	29,142	61,717
Dementia Prevalence Rate by Age Group	0.3%	3.9%	23.3%	2.4%
Distribution of Dementia Prevalence by Age Group	8%	45%	47%	100%

The rising number of people with dementia correlates to British Columbia's aging population. Although dementia is not a normal part of aging, the risk of developing dementia increases with age. In 2014/15, 47% of those with dementia were aged 85+, followed by 45% aged 65 to 84, and 8% had early onset under the age of 65 (See Table 1)

Nearly a third of British Columbia's population is over the age of 50.[11] By 2022, one in five British Columbians will be over 65 years old.[12] The impact of dementia will grow as the proportion of seniors in British Columbia's population increases over the next ten to fifteen years.[13]

The majority of care and support for people with dementia is provided by caregivers such as family members, friends and/or neighbours. In 2011, caregivers in Canada provided over 400 million unpaid hours looking after someone with dementia.[14] This support allows those living with dementia to remain safe at home for as long as possible. However, the demand placed on caregivers can affect their physical, emotional and financial well-being. It is critical that caregivers are supported to continue in their caring roles.

The 2012 dementia action plan recognized the important and unique needs of caregivers while working to improve care for people living with dementia. This guide carries forward that recognition and approach by promoting a person-centred philosophy of care. In dementia care, a person-centred philosophy of care means the person with

8 The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) now uses the term "major neurocognitive disorder" instead of "dementia." As well, the DSM-5 recognizes a less severe type of cognitive impairment, "mild neurocognitive disorder."

9 Adapted from the Dementia Service Framework, Ministry of Health (2007)

10 Population Health Surveillance and Epidemiology, Ministry of Health, Dementia (age 40+ years), data extracted December 2015

11 Ministry of Health (February 2014). Setting Priorities for the B.C. Health System. p 21.

12 Ibid.

13 Ministry of Health (November 2012). The Provincial Dementia Action Plan for British Columbia. p 5.

14 Alzheimer Society of Canada (September 2012). A new way of looking at the impact of dementia in Canada. *www.alzheimer.ca/en*

dementia is valued and treated as an individual with unique qualities, strengths and abilities. Health care is delivered in a culturally appropriate way that respects the individual's cultural, linguistic and spiritual needs. Person-centred care also respects the importance and value of family and friends. This approach creates a positive environment in which the person living with dementia can experience relative well-being.

Our goal is to better meet the needs of older adults with moderate to complex chronic conditions. The guide calls for services that allow people with dementia to live safely at home for as long as possible, with smooth transition to residential care when needed. This includes the ability to receive palliative and end-of-life care in their home environment.

Responsive service delivery and flexible care models are needed to allow this vulnerable population to be cared for at home rather than in emergency departments and acute care in-patient beds. The guide supports health authorities in achieving meaningful outcomes for people with dementia and their caregivers that are effective and sustainable.

Dementia Care, Achievements and Next Steps

The Provincial Dementia Action Plan for British Columbia (2012) and related provincial strategies have set us on the right course for improving the lives of people with dementia.

Since the release of the 2012 dementia action plan, the Ministry of Health launched its current strategic plan, *Setting Priorities for the B.C. Health System* (2014).[15] This plan identifies the need to improve dementia care. This includes support and training for formal and informal caregivers, and developing a more adequate service framework for the different stages of dementia linked to the expansion of home and residential care options. The accompanying policy paper, *Primary and Community Care in BC: A Strategic Policy Framework,*[16] identifies practical recommendations, including the need to update actions from the 2012 dementia action plan.

Over the last three years, we have seen more evidence-based information and resources made publicly available, as well as improved training of health-care professionals. This *Provincial Guide to Dementia Care in British Columbia* (guide), integrates dementia planning into all activities that support care for people with dementia.

To meet population and patient health needs moving forward, the guide provides a comprehensive approach to the dementia journey – from diagnosis to end of life. It places the needs of people with dementia, their families and caregivers first.

Method and Structure of the Guide to Dementia Care

Development of the guide was informed by a review of dementia plans from around the world. The review identified key elements for moving forward:

- The importance of including the person with dementia in decision making;
- The valuable role families and communities play in supporting people to live well with dementia;
- The need to strengthen and enable the health-care system to deliver person-centred dementia care through education and research; and,
- Inclusion of targets and measures to track progress.

These elements are fundamental to best practice approaches in care and education methods. B.C.'s guide combines these elements with the work being done in communities, with provincial expertise, and with the voices of people who live the experience of dementia.

During the development of this guide, we heard from:

- People living with dementia, their families and caregivers;
- Alzheimer Society of B.C.;
- Health-care professionals, including geriatricians and geriatric psychiatrists;
- Primary care providers, including family doctors and nurse practitioners; and,
- Health authority representatives.

15 *www.health.gov.bc.ca/library/publications/year/2014/Setting-priorities-BC-Health-Feb14.pdf*

16 *www.health.gov.bc.ca/library/publications/year/2015/primary-and-community-care-policy-paper.pdf*

We also received advice from an advisory committee.[17]

The guide is structured around the dementia journey travelled by people with dementia, their families and caregivers. This includes changes in the living environment (e.g., need for family and/or caregiver support to allow individuals to remain at home), and decisions about care such as a move to residential care or receiving palliative and end-of-life care. These transitions often call for additional health care and other support services. The functional decline caused by the disease can also prompt significant life and care-planning decisions, and decrease quality of life for people with dementia, their families and caregivers.

The guide's first three priorities touch on transitions along the journey. The fourth priority is focused on improving system supports in terms of a skilled, informed, collaborative and respectful health-care workforce.[18]

There are a total of fifteen deliverables whose achievement will require the collaboration of many stakeholders. The ministry will be accountable for leading some deliverables, health authorities others, and some deliverables will be jointly led by health authorities and the ministry. Deliverables and accountabilities are summarized in Appendix B.

17 Refer to Appendix C for complete list of Guide to Dementia Care Advisory Committee members.

18 Workforce refers to all people (e.g., volunteers, housekeeping, health-care professionals, etc.) involved in the provision of assistance, care, information or support services to people with dementia, their caregivers or families at home and in all health-care settings.

PRIORITY 1: *Increase public awareness and early recognition of cognitive changes.*

GOAL: *Increase healthy behaviours by promoting brain health and improve access to early diagnosis, intervention and community support programs.*

In national and international dementia plans reviewed, raising public and health-care professionals' awareness of dementia and reducing stigma came out as top priorities. People's lack of understanding about dementia can lead to the misconception that behavioural and psychological symptoms of dementia are a normal part of aging. People may not know that risk factors such as smoking, type 2 diabetes and hypertension (particularly in midlife) may increase the risk of developing dementia. In addition, because of the stigma attached to dementia, people may avoid their doctors if they fear diagnosis or they may delay accessing support in their communities.

Early diagnosis and intervention can improve the quality of life for individuals with dementia and their families and have been shown to be cost-effective for the health-care system.[19, 20] Yet, dementia remains underdiagnosed. Many health-care professionals lack the confidence and skills required to provide an accurate diagnosis.[21, 22, 23] Professionals may also be unaware of the resources available following diagnosis.[24] Information on the medical support and treatment available, along with earlier connection to appropriate resources, helps allow for a better quality of life for those diagnosed and their caregivers.

Community supports and awareness also positively affect quality of life. If people with cognitive changes or a diagnosis of dementia feel accepted in their communities, they are better able to continue the activities that give their life meaning. A diagnosis of dementia does not mean enjoyment and value in life are over. With early detection, connection to community supports and overall community awareness, people diagnosed with dementia can live fulfilling lives and be active members of the community.

Finally, quality of life can be enhanced by advance care planning. By planning early and continuously throughout the dementia journey, people with cognitive changes and their families can communicate wishes for their finances, health care and end-of-life care before the decision-making ability is lost. Planning will help ease the stress and discomfort at end of life when wishes and beliefs that have guided an individual through their life are discussed and decisions are documented.

19 Report by the Comptroller and Auditor General. (July 2007). Improving services and support for people with dementia. National Audit Office: pp 7, 9.

20 United Kingdom Department of Health. (February 2009). Living well with dementia: a national dementia strategy. *www.gov.uk/government/uploads/system/uploads/attachment_data/file/168220/dh_094051.pdf*

21 Turner, S, Iliffe, S, Downs, M, et al. (July 2004). General practitioners' knowledge, confidence and attitudes in the diagnosis and management of dementia. Age and Ageing 33(5): pp 461-467.

22 Pimlott, NJ, Persaud, M, Drummond, N, Cohen, CA, et al. (May 2009). Family physicians and dementia in Canada: part 2. Understanding the challenges of dementia care. Canadian Family Physician 55 (5): pp 508-509.e1-7. *www.cfp.ca/content/55/5/508.full.pdf*

23 Alzheimer Society of Ontario. (June 2014). People, partners & possibilities: transforming dementia care in the community. Pre-symposium survey: synthesis of feedback. *brainxchange.ca/Public/Files/Primary-Care/ASO_Symposium_Survey_Synthesis_June-2014.aspx*

24 Ibid.

DELIVERABLES:

1.1 *Increase understanding of dementia and continue to expand community information and support programs (e.g., dementia-friendly communities) for people with dementia and their caregivers.*

1.2 *Increase awareness of healthy behaviours associated with risk reduction for certain types of dementia, and promote brain health for all ages while targeting midlife individuals.*

1.3 *Enhance the ability of health-care professionals to detect and diagnose cognitive changes, provide appropriate and culturally sensitive treatment, and link people with dementia and their families to information and community supports such as First Link®.*

1.4 *Support and promote early advance care planning for people with major cognitive changes and their caregivers.*

PRIORITY 2: *Support people with dementia to live safely at home for as long as possible, including caregiver support.*

GOAL: *Improve supports that allow people with dementia to remain at home and better support transition to residential care when needed.*

Care at home[25] with appropriate supports can reduce or delay the need for unnecessary hospital and/or residential care admissions. People with dementia often stay longer in acute care (i.e., emergency departments and inpatient hospital care) and this can result in a decline in health.[26, 27] Thirty per cent of seniors admitted to acute care are discharged at a significantly reduced level of functional ability, and are unlikely to regain their previous level of independence.[28] In addition, an acute care stay may lead to premature admission to residential care.[29] Dementia-specific care guidelines and better management of existing conditions at the primary care level are needed to reduce the risks of unnecessary hospitalizations.[30] A focus on returning the person with dementia to live safely at home, with support if required, is essential.

Caregivers play a critical role in allowing people with dementia to remain safely at home. However, as the disease progresses and care needs increase, caregivers may feel overwhelmed. This is especially true if the person with dementia experiences behavioural and psychological symptoms such as agitation, sleep disturbance, psychosis or wandering. Caregivers need access to a range of supports, including flexible respite programs. Living well with dementia applies not only to people with dementia but also to their caregivers.

While the majority of people with dementia continue to live at home (approximately 60 per cent), the other roughly 40 per cent live in residential care,[31] with wandering a common trigger leading to this transition.[32] Changes in the brain can lead to confusion and disorientation, which may result in people with dementia becoming lost and putting their safety at risk. Risk reduction through appropriate home care services, support, education and awareness can alleviate the stress and safety concerns that accompany wandering.

25 "At home" refers to living with cognitive changes or major neurocognitive disorder and relying on caregiver support to remain at home. While residential care is home for those who live there, "at home" as used in this document means that residential care admission is deferred.

26 Donnelly, M, McElhaney, J, Carr, M. (November 2011). Improving BC's care for persons with dementia in emergency departments and acute care hospitals.

27 Canadian Institute for Health Information (November 2012). Analysis in brief: health system performance. Seniors and alternate level of care: building on our knowledge.

28 Fraser Health. 2010. 48/6 model of care. *https://bcpsqc.ca/clinical-improvement/48-6/resources/*

29 Donnelly, M, McElhaney, J, Carr, M. (November 2011). Improving BC's care for persons with dementia in emergency departments and acute care hospitals.

30 Ibid.

31 BC Ministry of Health, Chronic Disease Information Registries, 2013/14, Alzheimer's Disease and Other Dementia Measures Report.

32 Canadian Institute for Health Information (August 2010). Analysis in brief: types of care. Caring for seniors with Alzheimer's disease and other forms of dementia.

DELIVERABLES:

2.1 *Review, modify and/or expand home care services, including flexible respite programs and supports for people with dementia and their caregivers.*

2.2 *Review and enhance workplace policies for people with dementia and caregivers.*

2.3 *Develop and implement a strategy to address wandering that spans from prevention through to the safe return of the individual.*

2.4 *Develop a care pathway for the identification, management and care of people with dementia, starting with diagnosis and including transitions in care.*

PRIORITY 3: *Improve quality of dementia care in residential care, including palliative and end-of-life care.*

GOAL: *Strengthen standards for dementia care in residential care to provide quality care for individuals who cannot live at home.*

When living safely in the community with home support is no longer an option, people with dementia may need residential care or other supportive care models. Roughly 40 per cent of people with dementia in British Columbia are living in residential care.[33] Residential care models need to incorporate standards of care specific to the needs of residents with dementia. The model needs to focus on respecting and responding to the needs of the person in care, their families and their caregivers.

Many people with dementia experience behavioural and psychological symptoms such as agitation or aggression. These symptoms may be a person's way of responding to their surroundings or communicating an unmet need. Assessment and care planning approaches should look to leading practices to manage these complex health needs and behaviour changes, while reducing inappropriate use of antipsychotic drugs as treatment.

Physical design in residential care requires attention as well. People with dementia are sensitive to their psychosocial environment. Appropriate levels of stimulation are needed to prevent individuals from becoming more confused or agitated.[34, 35] Some research suggests that an inviting, home-like environment can help to engage people with dementia in household and social activities.[36] Designing the physical space with this in mind will improve their quality of life.

Quality of life when a person reaches end-stage dementia is as important as during the earlier progression of the disease. A "good death" sees the person with dementia treated with dignity and respect. However, people with end-stage dementia do not always receive effective palliative care and their pain is not always managed properly.[37] Palliative and end-of-life care for people with dementia should address their physical, emotional, social, psychological and spiritual needs as well as those of their families. Care should be responsive to distressing symptoms, with an emphasis on promoting dignity and quality of life.

DELIVERABLES:

3.1 *Incorporate dementia friendly design into new and, where appropriate, existing residential care homes to improve quality of life for people with dementia.*

3.2 *Review and improve dementia-specific standards of care in residential settings, with the desired result of spreading those standards to all health-care settings.*

3.3 *Promote a palliative approach to end-of-life care for people with dementia.*

3.4 *Increase the capacity of the residential care sector to provide appropriate assessment and care for persons experiencing behavioural and psychological symptoms of dementia, including reducing the inappropriate use of antipsychotic drugs as treatment.*

33 BC Ministry of Health, Chronic Disease Information Registries, 2013/14, Alzheimer's Disease and Other Dementia Measures Report.

34 Fleming, R, Purandare, N (November 2010). *Long-term care for people with dementia: environmental design guidelines*. International Psychogeriatric 22(7): pp 1084-1096.

35 Chatha, D, Wilkinson, SB. (May 2012). Fraser Health alternative care model-dementia (ACM-D) manual.

36 Ibid.

37 Sampson, EL, Gould, V, Lee, D, et al. (March 2006). Differences in care received by patients with and without dementia who died during acute hospital admission: a retrospective case note study. *Age and Ageing* 35(2): pp 187-189.

PRIORITY 4: *Increase system supports and adoption of best practices in dementia care.*

GOAL: *Improve health-care professional and caregiver knowledge and ability to deliver safe, well-informed dementia care using best practices.*

As their disease progresses, people with dementia touch many parts of the health system, including primary care (medical care from a physician or other health care professional who is the patient's first contact with the health system), the acute sector (emergency departments and inpatient hospital care), home care (services provided in the patient's home) and residential care. A competent workforce is required in all settings. However, focus groups comprised of people with dementia and caregivers identified a lack of training and understanding of dementia in acute care and residential care, and expressed concern about the quality of care received.

Practicing health-care professionals and future practitioners need training on the diagnosis and management of dementia. Cultural competency training needs to be a component of this instruction to promote respectful and responsive care. Training and education that is evidence-based, person-centred and integrated between care settings and health professionals will support people with dementia to get the care they need.

Participating in a national dementia strategy will foster the adoption and spread of best practices, helping to improve care to those living with dementia.

DELIVERABLES:

4.1 *Increase and sustain consistent dementia training for health-care professionals and caregivers – including cultural competency training – in all care settings.*

4.2 *Work with educational institutions to increase dementia care competency among future health-care professionals.*

4.3 *Participate in the development of a national strategy that will promote the spread and adoption of best practices in dementia care.*

Conclusion

The Ministry of Health worked with health authorities, health-care professionals and other partners to refresh priorities and actions around dementia care and to build on the progress already achieved. Aligning with the ministry's *Setting Priorities for the B.C. Health System*, the guide provides a comprehensive approach to dementia care. It aims to improve the lives of those affected by dementia throughout the dementia journey.

The guide has concrete actions for the ministry, health authority staff and communities to include in their own planning processes to improve the lives of people living with dementia across the province. Implementation by health authorities includes ensuring work plans contain actions with targets and measures aligned to the ministry's strategic direction.

The person-centred approach will address issues at transition points along the dementia journey:

- At diagnosis: through early recognition and interventions to improve quality of life for people with dementia and their caregivers;
- During early progression of the disease: through improved home care services to support safety and quality of life while living at home, and reduce and/or delay hospital and residential care admissions;
- During changes in the living environment: through quality care in all care settings, with emphasis on residential care; and,
- At end of life: through improved palliative and end-of-life care that responds to peoples' beliefs and wishes.

Actions in the guide will also increase public awareness and system supports. Education that reduces stigma in the community and strengthens health-care provider knowledge will help those affected by dementia to get the appropriate care and support they need earlier. In addition, increased public awareness of ways to promote brain health at all ages will help to reduce the risk of developing certain types of dementia.

In collaboration with stakeholders, the Province will continue to raise awareness of what it means to live with dementia. It will work to meet the challenges related to the increasing number of those affected. Government is committed to helping those with dementia, their families and their caregivers live with continued meaning, enjoyment and quality of life.

Glossary

ADVANCE CARE PLANNING: A process by which a capable adult considers their beliefs, values, and wishes for personal care and health care in advance of a time when they may be incapable of deciding for themselves. The advance care planning process includes ongoing conversations with close family/friend(s) and health care providers and is an essential element to ensuring health care treatments align with personal values and goals.

BEHAVIOURAL AND PSYCHOLOGICAL SYMPTOMS OF DEMENTIA: Behavioural and psychological symptoms of dementia include, but are not limited to, agitation, depression, apathy, repetitive questioning, psychosis, reactive behaviours, sleep problems and wandering. One or more of these symptoms will affect nearly all people with dementia over the course of their illness. These symptoms are among the most complex, stressful and costly aspects of care. They can lead to poor patient health outcomes, health-care problems and income loss for family caregivers.[38]

CAREGIVER: Refers to family members, friends and/or neighbours who provide unpaid care to people with dementia.

COGNITIVE CHANGES: Changes in the brain (e.g., memory, attention, planning, decision making, language) that are noticeable by the person experiencing them or to other people who know them well. The impact of the changes can be major (severe enough to interfere with daily life) or mild (not severe enough to interfere with daily life).

DEMENTIA: A broad term applied to a group of signs and symptoms seen in a variety of diseases affecting the brain. Dementia affects memory, thinking, orientation, comprehension, calculation, learning capacity, language, judgement and executive function (a mental process that helps us plan, organize, remember instructions and focus our attention).[39]

Dementia is not itself a disease but is caused by a variety of diseases, including Alzheimer's disease. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) now uses the term "major neurocognitive disorder" instead of "dementia." As well, the DSM-5 recognizes a less severe type of cognitive impairment, "mild neurocognitive disorder."

DEMENTIA JOURNEY: Refers to the journey people with dementia, their families and caregivers take as they progress through the stages of dementia to end of life.

END-OF-LIFE CARE: Care that is an important part of palliative care and usually refers to the care of a person living with a progressive condition during the last part of their life from the point at which it has become clear that the person is in a progressive state of decline.[40]

MAJOR NEUROCOGNITIVE DISORDER: The term now used by the Diagnostic and Statistical Manual of Mental Disorders instead of "dementia."

38 The BMJ 2015;350:h369

39 Adapted from the *Dementia Service Framework*, Ministry of Health (2007).

40 Adapted from AVERT (United Kingdom) definition. *www.avert.org/palliative-care.htm*

PALLIATIVE CARE: An approach that improves the quality of life of people facing a life-threatening illness, and their families, through the prevention and relief of suffering by means of early identification, assessment, treatment of pain and other problems (physical, psychosocial and spiritual).[41]

PERSON-CENTRED DEMENTIA CARE

Care that is centred on:

a. the whole person

b. remaining abilities, emotions and cognitive abilities

c. the person within the context of family, marriage, culture, ethnicity and gender; and,

Care that is centred within a wide society and its values.[42]

RESIDENTIAL CARE SERVICES: Occur in facilities that provide a secure, supervised physical environment, accommodation and care to clients who cannot have their care needs met at home or in an assisted living residence.[43]

RESPITE: Short-term services that allow the client's principal caregiver a period of relief or provide the client with a period of supported care to increase independence.[44]

WANDERING: Movement that is associated with confusion or disorientation when the person with dementia is at risk for becoming lost. Wandering is not the same as pacing, which is a common behaviour in dementia.

41 Adapted from the World Health Organization definition. *www.who.int/cancer/palliative/definition/en/*

42 Adapted from The Canadian Alzheimer Disease Review (April 2003). *Person-centred Dementia Care: A Vision to be Refined.*

43 Adapted from definition in the *BC Home and Community Care Policy Manual,* Chapter 8 (2014).

44 Ibid.

Appendix A – Status of Dementia Action Plan (2012) Commitments

ACTIONS	STATUS
PRIORITY: Support Prevention and Early Intervention	
Include information on brain health as an important element of healthy aging in all health promotion information – online (*SeniorsBC.ca*) and in print (BC Seniors Guide).	COMPLETE *SeniorsBC.ca* and BC Seniors Guide
Support the expansion of community support programs, such as the Alzheimer Society's First Link. Together with physicians, refer people with dementia and their families to these services as early as possible	COMPLETE *Ministry of Health funding for First Link*
Provide increased access to information on managing the condition and daily lives, including abuse prevention information online and in print.	COMPLETE *Protection from Elder Abuse/Neglect* *HealthLink BC* *Seniors Abuse and Information Line*
Promote advance care planning to support people with mild cognitive impairment and their families to plan ahead for future personal and health-care decisions	COMPLETE *My Voice Advance Care Planning Guide* *Speak Up BC* *Advance Care Planning Resources*
PRIORITY: Ensure Quality Person-Centred Dementia Care	
Implement evidence-based interdisciplinary dementia education, information, tools and resources for family physicians, clinicians and care providers.	COMPLETE *Behavioural and Psychological Symptoms of Dementia (BPSD) Algorithm* Purchase of P.I.E.C.E.S.™ Canada License
Develop and implement clinical guidelines for the effective use of medications to assist with the behavioural and psychological symptoms of dementia. Work to reduce the use of antipsychotic medications across all settings wherever possible.	COMPLETE *Best Practice Guideline for Accommodating and Managing Behavioural and Psychological Symptoms of Dementia in Residential Care* *Call for Less Antipsychotics in Residential Care (CLEAR)*
Provide people with dementia and their caregivers with an identified care co-ordinator linked to an integrated health-care team, which includes family physicians, caregivers and community health services.	IN PROGRESS
Ensure provincial end-of-life care strategies and priorities include the unique needs of people with dementia.	IN PROGRESS
PRIORITY: Strengthen System Capacity and Accountability	
Increase the flexibility and number of options in housing and care models to provide a broader range of living environments with supportive care for those who cannot live independently	IN PROGRESS
Work with health authorities to ensure hospitals and emergency departments have strategies for seniors' care that reflect best practice, and address the needs of people with dementia and their caregivers	COMPLETE *48/6 Model of Care*
Identify evidence-informed measures of quality dementia care and incorporate these in integrated health services planning and quality improvement activities, beginning with residential care services	IN PROGRESS
Support research to improve outcomes for people with dementia and their families in all care settings	COMPLETE *BC Alzheimers Research Award* *Centre for Brain Health*

2012 Achievements

The 2012 dementia action plan identified three priorities and corresponding actions. The plan provided a whole-system approach to improving care and support for individuals with dementia and their families. This section lists accomplishments to date.

PRIORITY 1: *Support Prevention and Early Intervention*

GOAL: *Increase awareness of self-care strategies for brain health and increase access to early support and information to manage the physical, behavioural and psychological symptoms of dementia.*

WHAT WE ACCOMPLISHED:

- Updated HealthLink BC, SeniorsBC, and Home and Community Care websites and print resources with information on brain health, planning for healthy aging and living with dementia.
  - » Information about dementia and a wide range of other related topics is available on HealthLink BC, including information about the condition and specific types of dementia, behaviour changes, caregiver support and living with dementia.
  - » Seniors BC (*www.seniorsbc.ca*) and the Ministry of Health's Home and Community Care (*www.gov.bc.ca/hcc*) websites offer user-friendly navigation, updated information and enhanced ability to search for relevant information.
  - » The British Columbia Seniors' Guide has been translated from English into French, Chinese and Punjabi. The new guide includes updated information about brain health, physical activity and wellness, how to access health services, information on the First Link® program and a range of other useful topics.
- The Ministry of Health developed and distributed an Elder Abuse Information Kit to increase awareness about elder abuse. The kit helps older adults learn how to prevent abuse, recognize abuse when it happens, know how to respond and know where to find assistance. The resource was sent to over 600 seniors, ethno cultural and First Nations organizations provincewide, and is available in English, French, Traditional Chinese and Punjabi.
- Government has provided $13.4 million to the Alzheimer Society of B.C. for First Link® since 2007. First Link® provides connections to learning, services and support to over 12,500 individuals diagnosed with dementia and their families throughout British Columbia.
- In April 2012, the ministry released *My Voice: Expressing My Wishes for Future Health Care Treatment*[45] a comprehensive advance care planning guide and workbook to help people prepare for their future health care. An online B.C. workbook, *Speak Up BC*, is also available. Advance care planning information, tips, brochures, videos and the My Voice guide (English, Punjabi, and Simplified Chinese Versions) are available at *www.gov.bc.ca/advancecare*.

45 *www.health.gov.bc.ca/library/publications/year/2013/MyVoice-AdvanceCarePlanningGuide.pdf*

PRIORITY 2: *Ensure Quality Person-Centred Dementia Care*

GOAL: *Improve health-care providers' knowledge and capacity to deliver timely, safe, person-centred care to individuals and their caregivers through evidence based information and interdisciplinary care team approaches across all care settings.*

WHAT WE ACCOMPLISHED:

- The *Best Practice Guideline for Accommodating and Managing Behavioural and Psychological Symptoms of Dementia in Residential Care*[46] was developed to support improved quality of care for people with dementia in residential care. The guideline focuses on the use of non-pharmacological interventions and the appropriate use of antipsychotic drugs in residential care settings. It offers evidence-based guidance to assist physicians, nurses, health-care professionals, family members and people with dementia in assessment, care planning and care decision making. An accompanying algorithm provides a practical, user friendly online decision support tool for health-care professionals and caregivers to support assessment, problem solving, care planning and evaluation. The online algorithm helps health-care professionals and caregivers provide dementia care that best meets the needs of the person receiving care.
- Health-care professionals in residential care are being trained with a dementia care program developed by P.I.E.C.E.S.™ Canada (**P**hysical, **I**ntellectual, **E**motional health, **C**apabilities, **E**nvironment, **S**ocial self)[47] through a joint project between the Ministry of Health and health authorities. P.I.E.C.E.S. ™ provides a systematic framework for detection, assessment and care planning using a person-centred approach. As more individuals are trained in P.I.E.C.E.S. ™ and related dementia care educational programs, public and contracted residential care sites in British Columbia will be better equipped to provide individualized, appropriate and evidence-based care to people who are experiencing the complex behavioural and psychological symptoms associated with dementia.

PRIORITY 3: *Strengthen System Capacity and Accountability*

GOAL: *Provide high-quality assessment and treatment services and access to flexible community care services and care options for individuals with dementia to reduce or delay the need for admission to residential care services.*

WHAT WE ACCOMPLISHED:

- The 48/6 Model of Care for hospitalized seniors is being used in hospitals and all acute inpatient care settings. The 48/6 model focuses on screening and assessment in six key care areas. Inter-professional teams develop and implement a personalized care plan within 48 hours of the decision to admit a senior, based on screening and assessment, and in collaboration with the senior. The 48/6 approach was developed by geriatric experts and representatives in each health authority, along with the Ministry of Health and the British Columbia Patient Safety & Quality Council, to address essential needs early in a senior's admission. The goal is to reduce the risk of functional decline and to support independence.
- In December 2013, a new $7.5-million fund to advance British Columbia's research into Alzheimer's disease was announced, with funding provided by the B.C. Government, Brain Canada, Michael Smith Foundation for Health Research, Genome B.C. and the Pacific Alzheimer's Research Foundation. Research is vital to preventing, treating and finding a cure for

46 *www.health.gov.bc.ca/library/publications/year/2012/bpsd-guideline.pdf*

47 *www.piecescanada.com*

Alzheimer's disease. The funding supports a new British Columbia Alzheimer's Research Award, which will contribute to international efforts to find a treatment or cure for the disease.

- On Feb. 27, 2014, the Djavad Mowafaghian Centre for Brain Health opened in Vancouver, uniting research and patient care under one roof. As a partnership between the University of British Columbia and Vancouver Coastal Health, the centre will accelerate research and discovery in neuroscience, psychiatry and neurology – translating new knowledge into better treatment and prevention strategies.

Much was accomplished within each priority of the 2012 *Provincial Dementia Action Plan for British Columbia*. This success was due to the collaboration between the Ministry of Health, clinical experts, health authorities and partners in dementia care improvement, as well as better integration of primary and community care services.

The Ministry of Health released *Improving Care for B.C. Seniors: An Action Plan in February 2012*.[48] The plan included concrete actions targeted at addressing concerns expressed by seniors, their families and care providers about seniors' care in British Columbia. It was informed by the findings and recommendations of the British Columbia Ombudsperson's report, *The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)*.[49]

Along with other strategies such as *Healthy Minds, Healthy People: A Ten-year Plan to Address Mental Health and Substance Use in British Columbia*[50] and *The Provincial End-of-Life Care Action Plan for British Columbia*,[51] we have built a solid foundation for system-wide change. Renewed overall leadership and integration of these programs and strategies has led to better alignment of actions and policy improvements, shared learnings and increased momentum to sustain change.

We have also benefitted from the concerted efforts of our partners in care. In order to continue to move ahead with health system and health care culture change, it is important that our communities and partner organizations are engaged and empowered to make differences that meet the needs of the people they serve and represent.

We have witnessed a range of activities from our partners and organizations involved in the lives of people with dementia, including:

- The British Columbia Care Providers Association's knowledge exchange *Care to Chat* speaker series which brings in experts and leaders to speak to the continuing care sector and other stakeholders about emerging topics relevant to seniors care. Their session titled "Debunking the Myths and Misconceptions of B.C.'s Continuing Care Sector" included a look at whether the vast majority of seniors moving into care were living with dementia.
- The British Columbia Care Providers Association's *Best Practices Guide for Safely Reducing Anti-Psychotic Drug Use in Residential Care*[52] shares stories of excellence from residential care settings across the province.
- The British Columbia Patient Safety & Quality Council's Call for Less Antipsychotics in Residential Care (CLeAR) is a quality improvement project designed to support interested teams from

48 *http://www2.gov.bc.ca/assets/gov/people/seniors/about-seniorsbc/pdf/seniorsactionplan.pdf*

49 *www.bcombudsperson.ca/images/pdf/seniors/Seniors_Report_Volume_2.pdf*

50 *www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf*

51 *www.health.gov.bc.ca/library/publications/year/2013/end-of-life-care-action-plan.pdf*

52 *www.bccare.ca/wp-content/uploads/Anti-Psychotics-Guide-hr-06-05-13.pdf*

residential care facilities in British Columbia in their efforts to manage the behavioural and psychological symptoms of dementia and reduce the inappropriate use of antipsychotics.

- The Alzheimer Society of B.C.'s website *www.alzheimerbc.org* offers a wandering package toolkit with information on wandering and locating devices, an identification kit and tips for police. Tools, education and information provide help for municipalities, professionals, corporations and the public to develop dementia-friendly communities. As well, the Alzheimer Society of Canada has partnered with the Canadian MedicAlert Foundation to improve the MedicAlert® Safely Home® program, which is designed to help identify the person who is lost and assist in a safe return home.

Local governments across British Columbia have taken steps to make their communities more age friendly, with support from the Province and the Union of British Columbia Municipalities. For example, the City of Vancouver developed *The Age-Friendly Action Plan: A Safe, Inclusive and Engaging City for Seniors*,[53] which includes dementia awareness training and information and active programming for people with dementia.

53 *vancouver.ca/files/cov/age-friendly-action-plan.pdf*

Appendix B – Guide to Dementia Care Deliverables, Implementation Leads

PRIORITY 1: Increase public awareness and early recognition of cognitive changes.		
		LEAD
1.1	Increase understanding of dementia and continue to expand community information and support programs (e.g., dementia-friendly communities) for people with dementia and their caregivers.	Ministry of Health
1.2	Increase awareness of healthy behaviours associated with risk reduction for certain types of dementia, and promote brain health for all ages while targeting midlife individuals.	Ministry of Health
1.3	Increase the ability of health-care professionals to detect and diagnose cognitive changes, provide appropriate and culturally sensitive treatment, and link people with dementia and their families to information and community supports such as First Link®.	Ministry of Health
1.4	Support and promote early advance care planning for people with major cognitive changes and their caregivers.	Health Authority
PRIORITY 2: Support people with dementia to live safely at home for as long as possible, including caregiver support.		
		LEAD
2.1	Review, modify and/or expand home care services, including flexible respite programs and supports for people with dementia and their caregivers.	Health Authority
2.2	Review and enhance workplace policies for people with dementia and caregivers.	Ministry of Health
2.3	Develop and implement a strategy to address wandering that spans from prevention through to the safe return of the individual.	Ministry of Health
2.4	Develop a care pathway for the identification, management and care of people with dementia, starting with diagnosis and including transitions in care.	Ministry of Health develop & Health Authorities implement
PRIORITY 3: Improve quality of dementia care in residential care including palliative and end-of-life care.		
		LEAD
3.1	Incorporate dementia friendly design into new and, where appropriate, existing residential care homes to improve quality of life for those with dementia.	Health Authority
3.2	Review and improve dementia-specific standards of care in residential settings, with the desired result of spreading those standards to all health care settings.	Ministry of Health develop & Health Authorities implement
3.3	Promote a palliative approach to end-of-life care for people with dementia.	Health Authority
3.4	Increase the capacity of the residential care sector to provide appropriate assessment and care for persons experiencing behavioural and psychological symptoms of dementia, including reducing the inappropriate use of antipsychotic drugs as treatment.	Health Authority
PRIORITY 4: Increase system supports and adoption of best practices in dementia care.		
		LEAD
4.1	Increase and sustain consistent dementia training for health-care professionals and caregivers – including cultural competency training – in all care settings.	Ministry of Health and Health Authority
4.2	Work with educational institutions to increase dementia care competency among future health-care professionals.	Ministry of Health
4.3	Participate in the development of a national strategy that will promote the spread and adoption of best practices in dementia care.	Ministry of Health

Appendix C – Guide to Dementia Care Advisory Committee Members

The Ministry of Health wishes to thank members for their time, contribution and dedication toward improving the health and quality of care for people with dementia.

Debbie Andersen, Seniors' Health Promotion Directorate, Ministry of Health
Elisabeth Antifeau, Interior Health
Simon Barton, Acute and Provincial Services, Ministry of Health
Monica Blais, Seniors' Health Promotion Directorate, Ministry of Health
Lisa Chu, Fraser Health
Brian Evernden, Policy and Planning for End of Life and Dementia Care, Ministry of Health
Fabio Feldman, Fraser Health
Chelsea Greczi, Fraser Health
Kelly Gunn, Northern Health
Maria Howard, Alzheimer Society of British Columbia
Dr. Suzanne Johnston, Northern Health
Jennifer Kennedy, Northern Health
Christina Krause, B.C. Patient Safety & Quality Council
Barbara Lindsay, Alzheimer Society of British Columbia
Deborah Lorimer, Vancouver Coastal Health
Dr. Katharine McKeen, Victoria Division of Family Practice
Marianne McLennan, Island Health
Sarah Metcalfe, Fraser Health
Rebecca Morris, Alzheimer Society of British Columbia
Carrie Murphy, Fraser Health
Shana Ooms, Primary Health Care Services, Ministry of Health
Maria Przydatek, Alzheimer Society of British Columbia
Nancy Rigg, Eaglevision Consulting Ltd.
Holly Romanow, Policy and Planning for End of Life and Dementia Care, Ministry of Health
Valerie Spurrell, Ridge Meadows Hospital
Jennifer Stewart, Alzheimer Society of British Columbia
Elizabeth Stanger, Vancouver Coastal Health
Dr. Carol Ward, Division of Geriatric Psychiatry, University of British Columbia; and Interior Health
Susanne Watson, Northern Health
Dr. Michael Wilkins-Ho, Vancouver Coastal Health
Gerrit Van Der Leer, Mental Health and Substance Use Policy and Program, Ministry of Health
James Watson, Quality Assurance, Ministry of Health
Janet Zaharia, Policy and Planning for End of Life and Dementia Care, Ministry of Health

BRITISH COLUMBIA

Ministry of Health

FACT SHEET : Pending ADM Approval

Elder Abuse Prevention Initiative

ISSUE

Elder abuse is a serious social, public health and legal issue that undermines seniors' independence, dignity and sense of security, and can seriously impact a senior's health. A coordinated and multi-sector approach to elder abuse prevention, both within government, and with individuals and community and provincial-level organizations has been utlilzed.

KEY FACTS

- Elder abuse (including neglect) is defined as a single or repeated act, or a lack of appropriate action, that causes harm or distress to an older person. It can take place in a senior's home, a care facility and in the community, and often involves a person in a position of trust or a situation of dependency. The abuse can be physical, emotional, verbal, financial, sexual, spiritual, or neglect.
- Between 4-10% of seniors in Canada (8% in BC[1]) experience some form of abuse.[2] However, research suggests that older adults are often reluctant to report abuse, and so the prevalence is likely much higher.
- As of July 1, 2016, 17.9% of BC's population is over the age of 65, compared to 16.5% nationally.[3] The proportion of people aged 85 years and older is 2.3%.
- Between 2011 and 2016, the number of people aged 85 and older grew by 19.4%.
- With BC's aging population, elder abuse is expected to rise and increase demands on the health, justice and financial systems, as well as on caregivers, families and communities.
- In *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia*, a commitment was made to implement "a coordinated provincial initiative to prevent elder abuse.".
- The paradigm underlying the approach to addressing elder abuse is one of multi-sector collaboration, awareness and engagement building, training and inspiring the public to take action to reduce elder abuse and effect a societal change in attitudes.
- A multi-sector Council to Reduce Elder Abuse (CREA), was established in 2013 to facilitate multi-sector collaboration in addressing elder abuse and to galvanize society to commit to taking action (collective and individual) to prevent elder abuse. CREA members include individual seniors and executive level representation from the health, legal, financial, policing, and caregiving sectors, as well as senior-serving organizations, and Aboriginal and ethnocultural communities.
- Within government, the Ministry of Health works with key ministries (partial list below), the health authorities and the Public Guardian and Trustee.
- The Ministry of Justice provides programs and services for victims of elder abuse (e.g., VictimLink BC helpline; *Understanding and Responding to Elder Abuse E-Book* and a webinar for support workers; information resources in multiple languages, and website); is responsible for some of the relevant legislation (e.g., *Adult Guardianship Act*); and, through the Public Guardian and Trustee, protects the legal, financial and personal care interests of adults who require assistance.
- The Ministry of Advanced Education developed and made publicly available, elder abuse prevention, identification and response modules for entry into practice in the health, legal, financial and social services areas and for continuing education / professional development.

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[1] Seniors First BC. *Fact Sheets on Abuse of Older Adults*
http://seniorsfirstbc.ca/resources/fact-sheets/fact-sheets-abuse-older-adults/

[2] National Seniors Council, *Report of the National Seniors Council on Elder Abuse*, 2007, p.5,
http://www.seniorscouncil.gc.ca/eng/research_publications/elder_abuse/2007/hs4_38/hs4_38.pdf

[3] B.C. and Other Provincial and Territorial Populations: 1971-2016 (July, 1)
http://www.bcstats.gov.bc.ca/StatisticsBySubject/Demography/PopulationEstimates.aspx

- Examples of Ministry of Health involvement to date include the following:
  - Provided secretariat support to CREA, and developed and disseminated information and awareness building initiatives to promote healthy, active aging.
  - Proclaimed World Elder Abuse Awareness Day on June 15 as the Province has done every year since 2006.
  - Printed and distributed 31,000 Elder Abuse Prevention Information kits in English, French, Punjabi and Traditional Chinese and distributed kits widely across the province (digital versions available at SeniorsBC.ca).
  - Significantly expanded the elder abuse resource section available online at SeniorsBC website.
  - Updated the Elder Abuse Prevention Series available online at HealthLink BC.
  - Implemented consistent, province-wide procedures for consent to care facility admission.
  - Worked with the BC health authorities, Community Living BC and Providence Health Care Society (the designated agencies), which have the mandate to receive and respond to reports of abuse or neglect of adults.
  - Supported BC Association of Community Response Networks initiatives to provide extra support for prevention and education activities, in collaboration with local stakeholders, to reduce elder abuse and neglect in the province. The Networks now exist in 157 communities around the province.
  - Developed an online interactive course for anyone who acts in a caregiving or service-providing capacity and is in contact with an adult (e.g., a meal provider, receptionist, health care assistant and physician), within any setting, to build awareness about recognizing, preventing and responding to the abuse of adults. This brief course covers key definitions and the different types of abuse, provides a scenario in a health care setting involving an adult with multiple vulnerabilities, advises how to respond to suspected abuse, and obtain more information, and offers a certificate upon successful completion.

FINANCIAL IMPLICATIONS

- The Ministry provided $4.7 million in funding to the BC Association of Community Response Networks to support practices to raise awareness and reduce or prevent elder abuse in communities.
- This funding included $ 650,000 for Community Capacity Building Grants, which provided up to a maximum of $50,000 per project, to support community-based awareness building, enhanced training, and improved response to elder abuse.
- The Provincial Health Services Authority provided a grant of $850,000 in 2012/13 to the BC Centre for Elder Advocacy and Support to expand the capacity and hours of its Seniors Abuse and Information Line (SAIL).
- In 2016/17, the Ministry provided $250,000 in funding to Seniors First BC (formerly the BC Centre for Elder Advocacy and Support) to support services related to the Council to Reduce Elder Abuse ($50,000) and to operate the SAIL line ($200,000).

Approved by:
Sharon Stewart, obo Doug Hughes, Primary and Community Care Policy Division; July 5, 2017
Gordon Cross obo Manjit Sidhu, Finance and Corporate Services Division; June 21, 2017

FACT SHEET

Community Response Networks

ISSUE

As part of its efforts to support and respond to elder abuse and neglect (see Fact Sheet-Elder Abuse Prevention Initiative), the Government of BC is investing in the operations and expansion across the province of Community Response Networks (CRNs).

KEY FACTS

- Based on available Canadian data, it is estimated between 4 and 10 percent of older adults in Canada experience some type of abuse.[1] One in every 12 seniors (8 percent) in BC experiences abuse.[2]
- A CRN is a network of individuals, groups and agencies from diverse sectors (e.g., First Nations, justice, health authorities, not-for-profit, and police) that work together at the community level to promote a coordinated community response to adult abuse and neglect. The CRNs jointly assist in identifying common themes, barriers and issues that require work at the regional, provincial and sometimes national levels.
- CRNs arose out of the *Adult Guardianship Act* (Part 3, Support and Assistance for Abused and Neglected Adults). Until 2003, communities were provided with modest funding from the adult guardianship implementation budget through the Public Guardian and Trustee of BC to support the development of CRNs.
- The BC Association of Community Response Networks (BCCRN), established in March 2003, is the provincial coordinating body for the provincial CRNs offering expert mentorship and ongoing support to the CRNs. It provides a support structure for local CRNs and small project funding, materials, training, and support personnel for the CRNs. It maintains a website (www.bccrns.ca), holds monthly provincial learning events by teleconference with the CRNs, and has been involved in numerous elder abuse awareness and prevention activities.
- In February 2012, as part of *Improving Care for BC Seniors: An Action Plan,* the Ministry of Health (the Ministry) allocated $1.4 million to BCCRN for the operations and expansion of CRNs across the province.[3] In 2015, BCCRN was provided with a further $2.6 million to continue expanding the CRNs' reach.[4]
- As of February 2017, there are 66 CRNs (including a provincial Francophone CRN) active in 157 BC communities and over 1,000 community organizations connected to CRNs, with new communities continually being added.[5] Every region of the province is being served, supported and assisted by a team of 15 Regional Mentors. The local CRNs are run by volunteers.
- Since 2012, grant funding from the Ministry is assisting BCCRN in developing the infrastructure to support the expansion of CRNs including: updating and expanding the BCCRN website (e.g., up-to-date information and contacts for each CRN, and lists of programs and services available in communities around the province); developing information management tools and governance policies; holding teleconferences and webinars for stakeholders; providing "It's Not Right – Neighbours, Friends and Families" bystander engagement workshops to prevent elder abuse and other workshops (to train volunteers and community members to help locate and identify high-risk seniors who are in need of assistance); developing First Nations Protocols; recruiting and training mentors; and evaluating the effectiveness of CRN activity.

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[1] National Seniors Council, *Report of the National Seniors Council on Elder Abuse*, 2007, p.5, link: http://www.seniorscouncil.gc.ca/eng/research_publications/elder_abuse/2007/hs4_38/hs4_38.pdf

[2] BC Centre for Elder Advocacy and Support, *Fact Sheets on Abuse of Older Adults: Fact Sheet #1* http://site.bcceas.ca/wp-content/uploads/FACT-SHEETS-ENGLISH-LONG.pdf

[3] Province of BC News Release 2012HLTH0019-000220 – March 2, 2012

[4] Province of BC News Release 2015HLTH0045-000896 – June 18, 2015

[5] BCRN Fact Sheet Accomplishments since March 2011 – Highlights dated October, 2016

- The work of the BCCRN and the CRNs supports the Ministry's priorities, including care for the frail elderly, response to the Ombudsperson's Report on seniors' care, and healthy, active aging in age-friendly communities.
- The BCCRN, through the CRNs, has helped communities to understand their role in preventing abuse and neglect, and ensuring the safety of seniors in their homes, residential care and neighbourhoods. Increasing the number of CRNs around the province, and supporting greater collaboration among organizations involved in addressing elder abuse is building local capacity for prevention, recognition and response.
- Additionally, enhancing BCCRN capacity complements the development of the provincial Better at Home and other non-medical home support programs, as the CRNs provide support and training to service providers, who are in seniors' homes and are well placed to detect possible elder abuse. The CRN mentors are participating in Better at Home activities, and are inviting Better at Home coordinators to participate on CRNs in their community.
- BCCRN developed a World Elder Abuse Awareness Day (WEAAD) Guide for the CRNs that includes information about WEAAD, how to build community support and raise awareness about WEAAD, including a focus on intergenerational activities. It has also posted elder abuse prevention awareness-building materials on its website for individuals and communities to use in support of local WEAAD events, and activities on June 15 of every year.
- It has chosen four additional campaigns to focus on: October 1, National Seniors Day; November, Crime Prevention Week; December 3 International Day of People with Disabilities; and March, National Fraud Prevention Month, and has developed awareness packages for these.
- BCCRN has hired a consultant to prepare intergenerational materials for use in CRN communities.
- More than 100,000 people attended CRN workshops, events and projects in 2015/16.[6]
- The Ministry provided grant funding of $350,000 in 2013/14, and again in 2014/15 (total $700,000) to BCCRN on behalf of the Council to Reduce Elder Abuse for a grant program to enhance elder abuse prevention, and response capacity in communities and provincial agencies.[7]

FINANCIAL IMPLICATIONS

Since 2011/12, the Ministry has provided BCCRN with $4.7 million: $1.4 million fiscal 2011/12; $350,000 in fiscal 2013/14; $350,000 in 2014/15; and, $2.6 million 2014/15.

Approved by:

Approved by Sharon Stewart obo Doug Hughes, ADM Primary and Community Care Policy; February 17, 2017
Maria Perri obo Manjit Sidhu, Finance and Corporate Services Division; July 6, 2017

[6] Ibid.

[7] Province of BC News Release 2015HLTH0045-000896 dated June 18, 2015.

Fire Safety
Assessment Report
for
Licensed Residential Care Facilities
and
Registered Assisted Living Residences

November 17, 2014

EXECUTIVE SUMMARY

Following a tragic fire at a seniors` residence in Quebec where thirty-two people were killed and fifteen others were injured, British Columbia (BC) is reviewing the fire safety provisions in residential care facilities and registered assisted living residences.

The Ministry of Health (the Ministry) established a Fire Safety Working Group with membership from the Ministry, the Office of the Fire Commissioner and the Office of Housing and Construction Standards to develop an inventory of facilities and residences without full sprinkler systems and to develop a methodology for the review of fire safety provisions in these buildings. The goal was to determine what additional protective measures are in place, as well as to assess the potential risks and the means by which any risks could be mitigated.

In March 2014, there were 359 residential long-term care facilities in BC. Of these, 12 had partial sprinkler systems and nine had no sprinkler systems. There were 209 registered seniors assisted living residences in BC. Of these, there are only five residences currently operating without full sprinkler systems. Five residences have partial sprinkler systems. The result of the initial review was that less than six percent of residential care facilities and less than six percent of assisted living residences in BC have partial or no sprinkler systems. During assessment one assisted living residence was determined to have full sprinklers. Since the completion of assessments, one residential care facility and one assisted living residence have ceased operating. These three were removed from the project.

The Ministry`s Capital Planning Branch contracted VFA Canada Corporation (VFA), which is a specialized agency for facility fire safety assessments, to conduct on-site assessments of all seniors residential care facilities and registered seniors assisted living residences that did not have full sprinkler systems.

The VFA assessments confirmed that many residential care facilities and assisted living residences have some fire safety deficiencies recommended for remediation. VFA recommended identifying the people at risk and documenting proper procedures on fire safety plans.

There were several recommendations for addressing deficiencies including having appropriate fire safety plans, installing full sprinkler systems, fire-rated doors, additional smoke detectors and visual alarms, and replacing outdated or aging fire safety equipment. It was also advised that night staffing levels be reviewed in residential care.

The Fire Safety Working Group developed an Action Plan to address the issues found during the assessments. The Ministry and the Office of the Fire Commissioner will write jointly signed letters to owner and operators of the assessed facilities and residences requiring them to provide a plan to address required fire safety deficiencies. The Ministry will monitor progress in the completion of the remediation actions.

BACKGROUND

Following the tragic fire at Résidence du Havre Seniors' Residence in L'Isle-Verte, Quebec in January 2014, where thirty-two people were killed and fifteen others were injured, BC is reviewing the fire safety provisions in residential long term care facilities and registered assisted living residences. The Résidence du Havre had a partial sprinkler system; however, in the section of the building that burned, there were no sprinklers. In Quebec, only buildings where residents have no mobility are currently required to have sprinklers. Sprinklers are not mandatory where residents are independent or semi-independent. It is not clear whether The Résidence du Havre would be considered to be a residential care facility or an assisted living residence under the BC definition in the *Community Care and Assisted Living Act* and the Residential Care Regulation.

For the purposes of this report, a person is considered ambulatory if the person does not require assistance to evacuate during an emergency and:

- is capable of independent mobility;
- does not require assistance to use or access a mobility aid;
- is capable of following directions under emergency conditions; and,
- is capable of self-evacuation without direction and within time frames considered necessary for safe evacuation in an emergency situation.

This report is a culmination of a cross-ministry review of all residential care facilities and assisted living residences without full sprinkler systems in place to determine fire safety status of these. A Fire Safety Working Group was established to provide advice on a risk assessment process for both private and publicly funded long-term care Residential Care Facilities and registered seniors Assisted Living residences in BC that have been identified by health authorities as having either no sprinkler system or a partial sprinkler systems as part of their fire safety plan, equipment and approach. The Fire Safety Working Group included representation from the Ministry, the Office of the Fire Commissioner and the Office of Housing and Construction Standards. The result of the initial review was that less than six percent of residential care facilities and less than six percent of assisted living residences in BC have partial or no sprinkler systems.

GUIDING LEGISLATION AND REGULATION FOR FIRE SAFETY:

The *Fire Services Act*

Under the *Fire Services Act* (FSA), the Fire Commissioner is responsible for the administration and enforcement of the FSA and the BC Fire Code. To assist the Fire Commissioner in the enforcement of this legislation, Local Assistants to the Fire Commissioner (LAFC) are appointed within each municipality and in unorganized areas. In most cases, the LAFC is the fire chief and other fire service members of that community.

The LAFC acts under provincial authority and is accountable to the Fire Commissioner rather than to local government. The LAFC is responsible to: investigate fires; report fires; create preliminary fire reports; and, enforce provincial fire safety legislation. The FSA empowers an LAFC to enter premises to inspect for fire hazards and conditions that would hinder escape from fire. For further information, please see Appendix 1.

BC Building Code

The BC Building Code (BCBC) applies to the construction of buildings; including extensions, substantial alterations, buildings undergoing a change for occupancy, "green" building specifications, and upgrading of buildings to remove an unacceptable hazard. It applies the core concepts of the National Building Code, combined with elements specific to BC's unique needs.

The BCBC is a provincial regulation for new construction, building alterations and change of use, establishing minimum standards for safety, health, accessibility, fire and structural protection of buildings but does not apply retroactively to existing buildings.

The BC Fire Code is a provincial regulation for the ongoing use of existing buildings and facilities, establishing minimum standards for health, safety, and fire protection.

Operators of residential care facilities and assisted living residences must comply with all applicable laws of BC and Canada, including the BCBC and the BC Fire Code.

Fire sprinklers are one of the many important fire safety features in buildings. Other fire safety features include: dividing buildings into fire resistant compartments to limit the spread of fire, fire alarms, smoke alarms or detectors, reduction of distances to exits and fire resistive construction.

Residential Care

The BCBC has required sprinkler systems in residential care facilities since 1998. Under the 2012 Building Code, residential care facilities are categorized as a Group B, Division 2 occupancy. Facilities with six or fewer persons in care, as determined by the *Community Care and Assisted Living Act* (CCALA), are categorized as Group C (Residential) provided the occupants are ambulatory; live as a single housekeeping unit in a dwelling unit with accommodation for not more than ten persons; there are interconnected smoke alarms installed in each sleeping room; emergency lighting is provided; and, the building has sprinklers throughout.

The 2012 BCBC introduced a middle ground between "care and treatment" (Group B Division 2) and residential (Group C) occupancies: "Treatment" is now Group B Division 2 and "Care" is Group B Division 3. All of the facilities assessed were constructed prior to the 2012 amendments to the BCBC. These facilities are assumed to be compliant with the Building Code which was in place at the time of construction, and are not legally required to upgrade to meet the requirements of the 2012 Building Code with respect to automatic sprinkler systems. The decision on whether or not a renovation, alteration or repair of a building requires upgrading the building to comply with the current BCBC (as per Div. A, Part 1, Article 1.1.1.1.) is normally the responsibility of the local building official.

For any new construction, the profile of the residents would determine which occupancy classification the Residential Care facilities would have. As per the 2012 BCBC, both Group B Division 2 and Group B Division 3 require automatic sprinkler systems.

In addition to meeting the requirements of the BCBC, residential care facilities must incorporate the specific design and construction provisions outlined in the Residential Care Regulation. The provisions related to fire safety include requirements for signalling devices, mobility and access, signage and fire safety requirements over and above what is required by the BCBC.

Assisted Living Residences

The 2012 BCBC requires that any new assisted living residence or any assisted living residence undergoing substantial renovation must comply with the 2012 Building Code. It is important to note that Building Codes are not retroactive and apply only to new construction and to major renovations.

The residences assessed for this project were all built prior to 2012. Prior to the 2012 changes, assisted living residences were considered as "Class C Residential Occupancy", which meant that sprinkler systems were not required. However, many assisted living residences were developed in partnership with BC Housing and have sprinkler systems as well as some additional protective features.

The *Community Care and Assisted Living Act*

The *Community Care and Assisted Living Act* (CCALA) provides the legislative authority for the Director of Licensing, the Assisted Living Registrar and Medical Health Officers to exercise certain powers and to carry out mandated duties and responsibilities. The Act also empowers the Lieutenant Governor in Council (Cabinet) to make regulations. These regulations include the Residential Care Regulation, Assisted Living Regulation, and the Community Care and Assisted Living Regulation.

The regulations, and associated policies and standards establish minimum health and safety standards for licensed residential care facilities and registered assisted living residences.

Residential Care Facilities

Most residential long-term care facilities are licensed under the *Community Care and Assisted Living Act* (CCALA) and the Residential Care Regulation and provide care and supervision to a person in care as defined in the Community Care and Assisted Living Regulation. Facilities that provide residential care to three or more persons must have a valid community care facility license, whether they receive funding from a health authority or other agency, or whether the client pays privately for their accommodation and care.

A number of the facilities which were assessed in this project are regulated under the *Hospital Act* and, therefore, not subject to the Residential Care Regulation. These are sometimes referred to as "private hospitals" or "extended care facilities".

Residential care facilities typically provide 24/7 professional care and supervision in a protective, supportive environment, for people with complex care needs who are not able to live independently. Complex care includes a mix of ambulatory and non-ambulatory persons.

Assisted Living Residences

Registered Assisted Living residences are also regulated under the CCALA. Residences are considered assisted living (AL) residences if they provide housing, hospitality services, and one or two prescribed services under the Community Care and Assisted Living Regulation to three or more adults. Prescribed services for seniors typically include regular assistance with activities of daily living and medication services. Both publicly subsidized and private-pay assisted living residences that meet the definition of an assisted living residence under the CCALA are required to be registered with the provincial assisted living registrar.

Assisted living is a semi-independent form of housing for people who need regular assistance in one or two areas of their daily living. Assisted living residents are expected to be able to make decisions on their own behalf and to function safely in a semi-independent environment. This includes the ability to recognize an emergency and summon help or to follow directions. In the context of fire safety, this means residents are expected to be able to evacuate independently, without requiring assistance from staff. When residents lose these abilities, it is

expected that planning will be initiated to relocate residents to settings which can safely meet their needs, such as licensed community care facilities.

ROLES AND RESPONSIBILITIES

Owners and Operators of Community Care Facilities

It is the role of the owner/operator to provide a safe environment for persons who are accommodated in community care facilities. The owner/operator must comply with the CCALA and its regulations, as well as with all other relevant statutes of BC and Canada.

Owners and operators are held accountable through routine inspections under the *Fire Service Act* (FSA) and the CCALA.

Ministry of Health

Residential Care

The Community Care Licensing team is part of the Quality Assurance Branch of the Health Services Policy and Quality Assurance Division responsible for the development and implementation of legislation, policy, and guidelines to protect the health and safety of people being cared for in licensed community care facilities. The Branch provides provincial stewardship for the operation of the community care licensing programs under the CCALA.

The Director of Licensing is appointed by the Minister to carry out specified duties, holds explicit powers under the CCALA, and has an overall stewardship role for the provincial community care licensing program.

Assisted Living

The Assisted Living Registrar is appointed by the Minister under the CCALA which outlines his or her authority, powers and duties. The Assisted Living Registry is part of the Quality Assurance Branch of the Health Services Policy and Quality Assurance Division responsible for protecting the health and safety of assisted living residents by:

- registering all assisted living residences in BC, whether they are publicly subsidized or private-pay;
- establishing and monitoring health and safety standards, policies and procedures;
- investigating complaints about the health and safety of residents living in assisted living residences and ensuring resolution of all substantiated complaints; and,
- inspecting residences if there is a concern about the health or safety of a resident.

Assisted Living Residences

An amendment to the BCBC that is applicable to assisted living residences was introduced in 2012. The BCBC now requires that any new assisted living residence or any assisted living residence undergoing substantial renovation must comply with the 2012 Building Code. It is important to note that Building Codes are not retroactive and apply only to new construction and to major renovations.

The residences assessed for this project were all built prior to 2012. Prior to the 2012 changes, assisted living residences were considered as "Class C Residential Occupancy", which meant that sprinkler systems were not required. However, many assisted living residences were developed in partnership with BC Housing and have sprinkler systems as well as some additional protective features.

Health Authorities

Medical Health Officers (MHOs) are employed by the regional health authorities and are appointed under the Public Health Act. MHOs have explicit duties under the CCALA such as issuing licenses, inspecting licensed facilities and investigating complaints that an unlicensed facility is being operated. The MHO delegates these duties to be carried out by Licensing Officers on a day-to-day basis.

Licensing Officers and Licensing Nutritionists inspect, license and monitor all licensed community care facilities in the province.

Office of the Fire Commissioner

The Office of the Fire Commissioner is the senior fire authority in the province with respect to fire safety and prevention. Services include administration and enforcement of fire safety legislation, training of Local Assistants to the Fire Commissioner, fire loss statistics collection, fire investigation, fire inspection, response to major fire emergencies, and advice to local governments on delivery of fire protection services, public fire safety education and fire fighter certification.

Office of Housing and Construction Standards

The Building and Safety Standards Branch of the Office of Housing and Construction Standards is responsible for governance of the regulatory system for the design, construction and occupancy of buildings in BC. This work includes the development and production of the BCBC and BC Fire Code, promoting BC's interests in national building and fire code standards, and working with stakeholders to balance safety, economic and social priorities.

METHODOLOGY

The Ministry established a Fire Safety Working Group with membership from the Ministry, the Office of the Fire Commissioner and the Office of Housing and Construction Standards which met weekly to develop an inventory of facilities and residences without full sprinkler systems and to develop a methodology for the review of fire safety provisions in these buildings. The goal was to determine what additional protective measures were in place, as well as to assess the potential risks and the means by which the risk could be mitigated.

VFA conducted site assessments which were provided to the Ministry. The Office of the Fire Commissioner and the Ministry reviewed the assessments. The result of the review is this summary report.

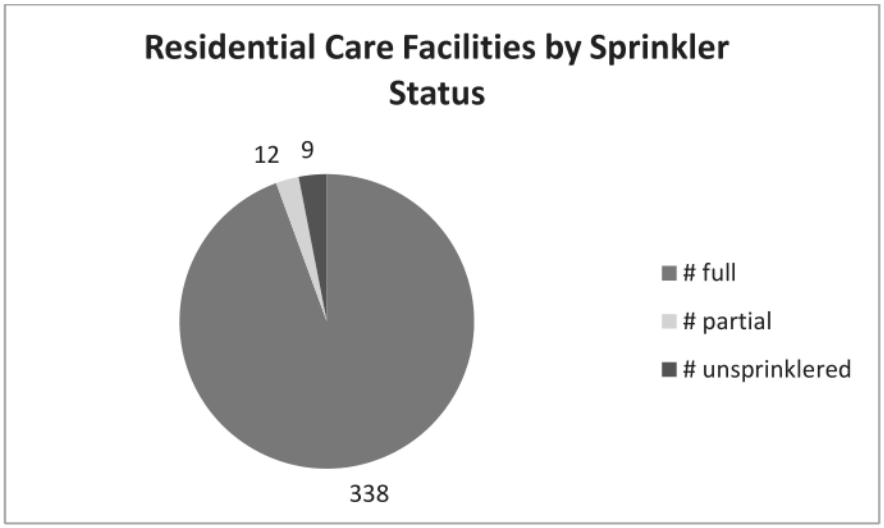
SPRINKLER STATUS

The Ministry collaborated with industry stakeholders, Health Authority Community Care Licensing programs and assisted living residence operators to develop an inventory of residential care facilities and assisted living residences to determine which of these had full, partial or no sprinkler systems. The vast majority, 94 percent, of residential care facilities and assisted living residences in BC have full sprinkler systems in place.

Residential Care Facilities by Sprinkler Status

In March 2014, there were 359 residential long-term care facilities in BC. Of the total number of residential care facilities assessed, 9 had no sprinkler systems and 12 had partial sprinkler systems. It is important to note that not having a full sprinkler system does not mean the facility is not in compliance with building codes and fire safety requirements, as noted previously. With the closure of one facility, there are currently only 11 long-term residential care facilities with no sprinkler systems in BC and nine residential care facilities with partial sprinkler systems.

Residential Care Facilities by Sprinkler Status as of May 2014

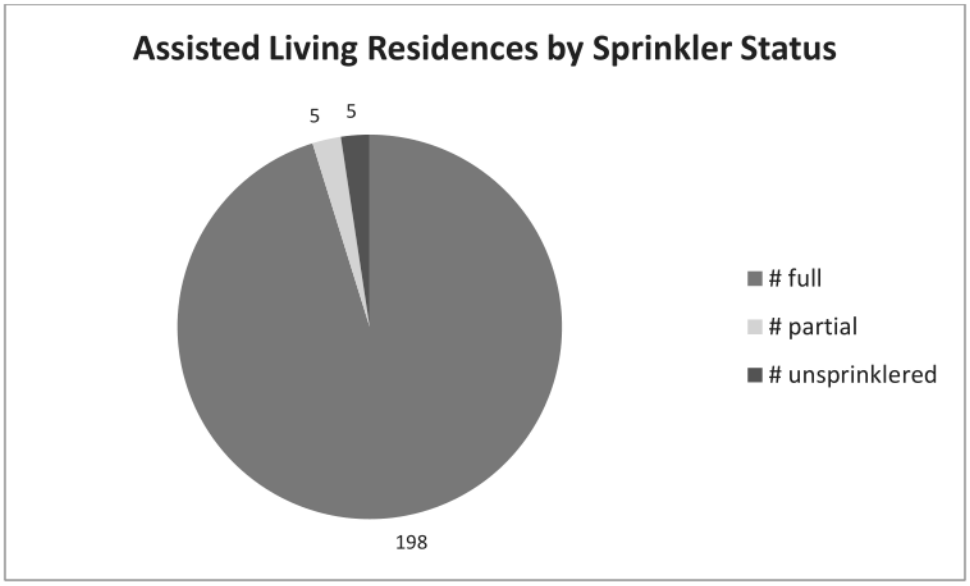


Note: One facility has closed since the inception of this project. The total number of facilities is now 358.

Assisted Living Residences by Sprinkler Status

As of March 2014, there were 209 registered seniors assisted living residences in BC. Of these, there are only five currently operating that do not have full sprinkler systems. Five residences have partial sprinkler systems. In addition, three of the five residences with partial sprinkler systems are in a campus of care, which means that there may also be licensed residential care beds and/or independent living units at the same address. As noted previously, it is important to note that not having a full sprinkler system does not mean the residence is not in compliance with building codes and fire safety requirements.

Assisted Living Residences by Sprinkler Status as of May 2014



Note: One residence has closed since the inception of this project. The total number of residences is now 208.

FACILITY AND RESIDENCE ASSESSMENTS

The Ministry`s Capital Planning Branch contracted VFA Canada Corporation (VFA), which is a specialized agency for facility fire safety assessments, to conduct on-site assessments of all seniors residential care facilities and registered seniors assisted living residences that did not have full sprinkler systems.

In total, VFA conducted site visits to 18 residential care and 12 assisted living residences. Their purpose was to conduct a fire safety assessment of each facility or residence and to report the results to the Fire Safety Working Group, including recommendations for upgrades. Three other residential care facilities were not assessed on site by VFA at the time of this review as they had been recently assessed by VFA for a previous project. A total of 21 residential care facilities and 12 assisted living residences were assessed during this project.

During assessment, one assisted living residence was determined to have a full sprinkler system. Since assessments were completed, one facility is no longer operating as a residential care facility and one residence is no longer operating as an assisted living residence. These three were removed from the assessment process.

The assessments of the residential care facilities were completed on April 1, 2014, and the assisted living residence assessments were completed on May 2, 2014. The terms of the contract required immediate notification of any urgent fire safety issues. No urgent fire safety issues were brought to the attention of the Ministry by VFA. In reviewing the VFA assessments the Ministry identified four issues in residential care facilities and two issues in assisted living residences that needed further follow up or clarification. These were related to storage of combustible materials, a blocked exit door, and bars on some service area windows of one facility. The Ministry contacted these facilities and residences or the local fire authority requesting that these issues be addressed. In these cases, the identified issues have been resolved or are in the process of being resolved.

KEY FINDINGS AND RECOMMENDATIONS

The assessments confirmed that the residential care facilities and assisted living residences had some fire safety deficiencies recommended for remediation. Identifying the people at risk and documenting proper procedures on fire safety plans were noted as paramount to fire safety. The installation of additional protective and preventative measures was recommended for implementation in the short term, and periodic assessments conducted by internal and external bodies were highly recommended.

It was noted that increased awareness for owners, operators and staff of high-risk areas (resident rooms, kitchens, boiler rooms, electrical and incoming gas areas) is needed to ensure the safety of seniors in care.

Fire Safety Plans

Many facilities and residences assessed did not have complete and/or up-to-date Fire Safety Plans (FSP) in place. FSP provide a thorough analysis and operations approach to meet the needs of residents and staff in the event of an emergency. As the fire safety plan details how a facility has assessed their risk and client population, and plans to manage operations/ evacuations in an emergency, the lack of a FSP prevents an accurate assessment of the risk level. Due to the great variation between jurisdictions in how fire inspections are conducted and recorded, it was not clear whether FSPs are routinely reviewed during annual fire inspections.

Residential care facilities and assisted living residences that are not located in municipalities receive their inspections under local bylaws, with the exception of Vancouver, which falls under the Vancouver Charter.

Out of 20 residential care facilities assessed:

- Seven had a current, complete FSP;
- 10 had either an incomplete, or outdated, FSP; and,
- Three had no FSP.

Of the 10 assisted living residences:

- Six had a current, complete FSP;
- Three had either an incomplete, or outdated, FSP; and,
- One had no FSP.

Key Findings: Residential Care

Most residential care facilities had lower staffing levels for night shifts than during day and evening shifts. It is recognized that routine activities such as meals, bathing, and recreation activities are not needed during the night shift, which will naturally result in a lower staffing component. It is also recognized that with lower staffing components there is less assistance available to non-ambulatory persons in the event of an emergency. Plans for emergency evacuation are to be described in facility FSPs.

Recommendations for Residential Care

It was recommended that staffing levels at night in residential care be reviewed.

In addition, there were several recurring deficiencies/issues noted (number of facilities with each in brackets):

- Install visual alarms at exit doors missing to assist people with hearing impairment (19)
- Replace electrical outlets in or near the kitchen that were not GFCI (ground fault circuit interrupter) (16)

- Repair inadequate fire stopping at floors/wall penetrations to maintain fire separation (12)
- Remove masking tape or paint covering fire ratings on doors and door frames, and ensure that fire rated doors are in place where required (12)
- Replace missing fire and smoke detectors in some areas (8)
- Install fire-rated doors in stairwells, water heater rooms or other doors (5)
- Ensure laundry room is contained within a fire compartment (3)
- Install missing fire dampers on door grille and/or machine room (3)
- Conduct periodic inspections on fire safety equipment (3)
- Ensure inspection tags on fire extinguishers are current (3)

Key Findings: Assisted Living

There were no key findings specific to Assisted Living; however, all Assisted Living Residences assessed had a low level of understanding regarding fire safety risk areas.

Recommendations for Assisted Living

There were several recurring deficiencies/issues noted (number of residences with each in brackets):

- Install visual alarms at exit doors to assist people with hearing impairment (7)
- Install missing fire and smoke detectors in some areas (6)
- Install fire-rated doors in stairwells, water heater rooms or other doors (6)
- Repair inadequate fire stopping at floors/wall penetrations to maintain fire separation (5)
- Ensure inspection tags on fire extinguishers are current (5)
- Remove masking tape or paint covering fire ratings on doors and door frames, and ensure that fire rated doors are in place where required (3)
- Install missing fire dampers on door grille and/or machine room (3)
- Ensure laundry room is contained within a fire compartment (2)
- Conduct periodic maintenance on fire safety equipment not performed (2)
- Replace aging alarm system or panel (2)

ACTION PLAN

The Ministry and the Office of the Fire Commissioner are committed to enhancing the safety of seniors in care and will undertake the following actions to address the findings of this review:

- A letter will be sent to all residential care facilities and assisted living residences providing them with a template for use in creating a comprehensive FSP in consultation with the local fire department or other regulatory authority.

- The Office of the Fire Commissioner will issue an Advisory Bulletin to local fire authorities regarding the requirements for, and importance of, FSPs.

- The Director of Licensing and the Office of the Fire Commissioner will write to the assessed residential care facility operators outlining findings of the assessment of their facility requesting that they work with the local fire authority to remedy the issues found. The letter will require the facility to report back to the Ministry within 30 days of the date of the letter with their plan to address the issues noted. The Ministry will monitor the progress of the facilities in completing required mitigations.

- The Ministry will follow up with facilities that do not currently have a FSP to request they complete a plan, and submit a copy so the Ministry can work with the OFC to assess the risk level.

- A jointly signed letter will also be sent to the local fire authority requesting that they work with the facility and the Office of the Fire Commissioner to reduce the risk to persons in care. The letter will request the fire authority to report back to the Ministry within 30 days of the date of the letter with their plan to address the issues noted.

- The Assisted Living Registrar and the Office of the Fire Commissioner will write to the assessed assisted living residence operators outlining findings of the assessment of their residence requesting that they work with the local fire authority to remedy the issues found. The letter will require the residence to report back to the Ministry within 30 days of the date of the letter with their plan to address the issues noted. The Ministry will monitor the progress of the facilities in completing required mitigations.

- A jointly signed letter will also be sent to the local fire authority requesting that they work with the residence and government to reduce the risk to residents. The letter will request that the fire authority report back to the Ministry within 30 days of the date of the letter with their plan to address the issues noted.

- The Director of Licensing and the Office of the Fire Commissioner will jointly write to residential care facilities that have been identified as having low night staffing and request that they review and remedy this situation.

- Stakeholders will be consulted to ensure transparency.

Some facilities and residences have taken action to address identified deficiencies:

- One residential care facility has completed the clean-up of items stored in the attic.
- One residential care facility has installed most of the needed sprinklers and will install those in remaining 4 rooms in 2015.
- One residential care facility re-installed missing fire doors.

- One local fire authority clarified that bars installed on lower level windows at a residential care facility were located in a service area where there were no persons in care and did not pose a risk to fire safety.

In addition:

- One residential care facility has ceased operation.
- One assisted living residence has ceased operation.

APPENDIX 1 BC FIRE SAFETY LEGISLATION

The British Columbia Fire Code (BCFC) applies to all existing buildings and facilities, and to building construction or demolition sites.

The BCFC contains references to the British Columbia Building Code (BCBC) for the design, construction and installation of many fire protection features. Some BCBC requirements are most readily applied to new buildings and their retroactive application to existing situations as prescribed by this Code could result in some difficulty in achieving compliance. It is the intent of the BCFC that an equivalent level of safety be achieved rather than necessarily achieving strict conformance to the BCBC. The application of the BCFC to the upgrading of existing facilities should be based on the judgment of the enforcement authority, who must deal with each case on its own merits.

The BCFC states that the owner or the owner's authorized agent is responsible for carrying out the provisions of the Code. However, the owner is expected to communicate with the authority having jurisdiction that is in a position to assess the relative significance of variances from the BCBC requirements. Such authority may then determine that upgrading measures are not necessary, on the basis that the existing arrangement represents an equivalent level of fire safety. The Fire Services Act (FSA) and BCFC allow discretionary judgment on the part of the enforcing officials, along with appropriate rights to appeal.

Under the FSA, the Fire Commissioner is responsible for the administration and enforcement of the FSA and pursuant BCFC. To assist the Fire Commissioner in the enforcement of this fire legislation, Local Assistants to the Fire Commissioner (LAFC) are appointed within each municipality and in unorganized areas. In most cases, the LAFC is the fire chief and other fire service members of that community.

The LAFC acts under Provincial Authority and is accountable to the Fire Commissioner not local government. The LAFC is responsible for:

- Investigating fires
- Reporting fires
- Creating preliminary fire reports
- Enforcing provincial fire safety legislation

The FSA empowers an LAFC to enter premises to inspect for fire hazards and conditions that would hinder escape from fire. The FSA [and BCFC] do not make the inspection of a property by a LAFC, Office of the Fire Commissioner Inspectors, or Fire Commissioner mandatory. The word "may", used in both the FSA [and BCFC] is defined in section 29 of the Interpretation Act as "is to be construed as permissive and empowering". The Fire Commissioner or inspectors have a duty or obligation to consider each complaint, but they do not have a requirement or obligation to enter and inspect every time they receive a complaint.

The FSA requires that a municipality provide for a regular system of inspection of hotels and public buildings. This does not apply to areas outside of a municipality. "Inspection" is not defined in the FSA and the requirement for the inspection to be "regular" is also undefined. The municipality has the authority to choose who carries out the inspection, such as a "municipal fire inspector" or "bylaw enforcement officer". The administration of the regular system of inspection stays at the municipal level which largely depends on the local resources and other local factors.

The FSA and BCFC place no obligation on a municipality to inspect for matters within the BCFC. The BCFC does not place an obligation on a municipality to enforce the BCFC.

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FACT SHEET

Resident to Resident Aggression

ISSUE

Residents with cognitive impairment, such as dementia, may exhibit physical aggression as part of their disease process, and this behaviour may be directed towards other residents.

KEY FACTS

- Over 60%[1] of people living in residential care settings have dementia, and approximately 90% of people with dementia experience behavioral and psychological symptoms of dementia, such as aggression, agitation, and psychosis (delusions and hallucinations)[2].
- Residential care facilities balance the need to keep people safe with the human need for social interaction, freedom of movement and the routine of everyday life, including recreational opportunity and shared meals.
- Community care facilities licensed under the *Community Care and Assisted Living Act* (CCALA) and designated extended care and private hospitals regulated under the *Hospital Act* are responsible for reporting instances of aggression between persons in care to health authorities. Under each Act, definitions and reporting requirements differ somewhat.
- The Ministry receives quarterly reports from the health authorities on a number of data elements, including aggression between persons in care in facilities licensed under CCALA.
- The data received is the number of confirmed incidents by type of care (i.e., child day care, child/youth residential, mental health and long term care). Only confirmed incidents in licensed adult community care facilities, and designated extended care and private hospitals are reported in the tables below.

CCALA - Long Term Care

On December 1, 2013, the Residential Care Regulation (CCALA) was amended to add a reportable incident of "aggression between persons in care." The amendment ensured that aggression between persons in care would be reported as a separate incident, as previously these were included under the broader category of "aggressive or unusual behaviour" (behavior by a person in care towards another person in care that causes an injury that requires first aid, emergency care by a medical practitioner or nurse practitioner, or transfer to a hospital).

Health Authority	# Confirmed Incidents	# of Facilities
Fraser	33	64
Island	423	217
Interior	31	26
Northern	7	2
Vancouver Coastal	117	47
TOTAL	**611**	**356**

All information has been provided by health authority Community Care Facility Licensing (CCFL) programs for calendar year 2015

Hospital Act – Extended Care and Private Hospitals

- Under the Hospital Act Regulation, extended care and private hospitals designated under the *Hospital Act*, facilities are required to report "serious adverse events" to the Minister. A "serious adverse event" means an incident that:
  a) Took place in a hospital or private hospital;
  b) was the likely cause of, or likely significantly contributed to, severe harm to or the death of a patient;

[1] https://www.cihi.ca/en/quick-stats
[2] https://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=1191

c) was not expected or intended to occur; and
d) was not caused by or related to an underlying medical condition of the patient.

Health Authority	# Confirmed Incidents	# of Facilities
Fraser	Not collected	26
Island	172*	22
Interior	6	5
Northern	2	2
Vancouver Coastal	3	21
TOTAL	**183 (30**)**	**76**

All information has been provided by health authority Community Care Facility Licensing (CCFL) programs for the period of January 1 to September 30, 2016* Island Health numbers include events with **no harm**, if excluded there are19.** This count reflects total events where no harm occurred.

- In October, 2012, the Ministry released the Best Practice Guideline for Accommodating and Managing Behavioural and Psychological Symptoms of Dementia in Residential Care, A Person-Centred Interdisciplinary Approach. This guideline supports interdisciplinary, evidence-based, person-centered care for those experiencing behavioural and psychological symptoms of dementia.
- Health authorities are increasing awareness and training for staff on the care of people with complex physical and cognitive/mental health needs, and behaviour changes. The P.I.E.C.E.S.™ training program, available across all health authorities, provides staff with strategies to manage the behavioral and psychological symptoms of dementia. The P.I.E.C.E.S.™ program works to reduce the risk of aggressive behaviours between patients. As of December, 2015, over 1,500 health care providers had received P.I.E.C.E.S.™ training across 226 facilities (residential care and tertiary mental health settings).
- The Ministry's recently released Provincial Guide to Dementia Care in BC, identifies priorities to improve the quality of dementia care in residential care facilities, as well as increasing system supports and best practices in dementia care. Priorities include:

    - Standards of care that will guide the transition to residential care, should it be needed.
    - Steps to enhance dementia-specific quality standards of care in residential care.
    - Increase and sustain consistent dementia care training for health care professionals and caregivers – including cultural competency training – in all care settings.

FINANCIAL IMPLICATIONS

N/A

Approved by:
Sharon Stewart obo Doug Hughes, Health Services Policy Division; November 4, 2016

FACT SHEET

Call for Less Antipsychotics in Residential Care (CLeAR)

ISSUE

The Call for Less Antipsychotics in Residential Care (CLeAR), led by the BC Patient Safety & Quality Council (the Council), is a voluntary, provincial quality improvement initiative aimed at reducing the inappropriate use of antipsychotic medications for residents with the behavioural and psychological symptoms of dementia (BPSD).

KEY FACTS

- According to the Canadian Institute for Health Information, 28.0% of long-term care residents in BC were prescribed potentially inappropriate antipsychotics in 2015/16. While the BC average continues to decline, it remains consistently higher than the national average, which is currently 23.9%.[1]
- CLeAR Wave 1 ran from October 2013 – December 2014, with 48 Action & Improvement teams participating. CLeAR Wave 2 supported 40 Action and Improvement teams from September 2015 to December 2016.[2]
- In addition to the Council's focused work with care homes, over 250 individuals and care home teams accessed CLeAR virtual learning sessions, communications and resources.

CLeAR: A Model for Improving the Quality of Care

Participating care homes received support from the Council to improve the quality of care through:

- Expert faculty support on the clinical issues related to BPSD;
- Improvement Advisors who provided coaching and guidance on quality improvement strategies to help sites identify and test new approaches to address BPSD;
- Interactive regional workshops to provide teams with quality improvement knowledge, skills and tools;
- Coaching and support with data collection and analysis; and
- Regular educational virtual learning sessions for all participating care homes.

Evaluation Findings[3]

Finding 1: Decreased Use of Antipsychotic Medication

A total of 1001 residents had their antipsychotics reduced or discontinued.

Finding 2: Positive System Level Impact

Through analyses of CIHI Inter-RAI data for all care homes in BC, CLeAR Wave 2 care homes showed a statistically significant decrease in the percentage of residents on antipsychotics without a diagnosis of psychosis. While both CLeAR and non-participating care homes both decreased their percentage of potentially inappropriate antipsychotics over the course of the initiative, the reduction was greater in the CLeAR group of care homes than the non-CLeAR group.

Finding 3: Improvements In Best-Practice Management For Residents With BPSD

To support the decrease in antipsychotic medications, CLeAR teams also focused on improving non-pharmacological approaches to address the needs of the residents with BPSD. CLeAR teams reported an increased inquiry into underlying causes of BPSD and increased use of recreation therapy.

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[1] Canadian Institute for Health Information. (2014). Your Health System. Retrieved February 2017, from https://yourhealthsystem.cihi.ca/hsp/indepth?lang=en#/indicator/008/2/C9001/

[2] Forty-four care homes joined CLeAR Wave 2 in the spring of 2015, including 19 health authority owned/operated sites and 25 contracted sites. Sites ranged in size from 34 to 260 residents, and were spread across five health authorities. Four of these care homes transitioned from Action and Improvement teams to Organizational Partners during the initiative, meaning they no longer reported data to the Council.

[3] Reichert & Associates was contracted to evaluate CLeAR Wave 2 at the end of the initiative.

Finding 4: Enhanced Teamwork And Communication In Workplace And Workflow

CLeAR care homes improved care by strengthening their teamwork, communication, and culture. CLeAR care home leads (N=51) reported:

- A positive change in care home's culture during the CLeAR initiative (88%);
- Respondents felt like they were more a part of a team (73%); and
- Communication between health care providers improved during CLeAR (69%).

Finding 5: Improved Resident Care Planning

CLeAR has increased team awareness and consideration of the residents' personal history and background when developing care plans:

- 56% of teams reported that residents/family members are more regularly involved in developing care plans;
- 75% reported using the care plans more often in their daily work.

Finding 6: Improved Quality of Life

76% of CLeAR team leads agreed that the quality of life for residents had improved.

Finding 7: Sustainability

- 96% of CLeAR teams indicated that the processes and outcomes of the CLeAR initiative would likely be sustained in their care homes.
- Building capacity for quality improvement was identified as the most valued impact of having support from the Council.

Building on CLeAR's Successes

10 CLeAR teams recently completed the Council's Action Series entitled *Improving Patient Outcomes through Effective Teamwork and Communication,* along with other care homes, clinical teams and care teams.[4]

- The Ministry of Health has signalled preliminary support for CLeAR Wave 3, and has provided direction to focus on the care homes with the highest rates of antipsychotics.
- The Council is actively engaging with stakeholders and planning for a launch in 2017.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Sharon Stewart, obo Doug Hughes, Primary and Community Care Policy Division; July 7, 2017
Christine Voggenreiter, obo Teri Collins, Health Sector Information, Analysis and Reporting Division, July 12, 2017

[4] Fifty teams, including 287 people, are participating in the Action Series from across the province.

FACT SHEET

Large Scale Staff Replacement

ISSUE

Local media reports have claimed that mass turnover through the change from one contracted service provider to another negatively influences the quality of services provided to residents in residential care facilities.

KEY FACTS

- The Ombudsperson launched an investigation of seniors' care in 2008, and publicly released The *Best of Care: Getting it Right for Seniors in British Columbia (Part 2)* on February 14, 2012. This report resulted in 176 recommendations on seniors' care.
- One of the recommendations outlined by the Ombudsperson's report is as follows: "The Ministry of Health works with the health authorities to develop safeguards to ensure that seniors in residential care are not adversely affected by large-scale staff replacement." (R170)
- To address this recommendation, the Ministry of Health developed a new policy (Policy 6.K, Large-Scale Staff Replacements) which is included in the Home and Community Care Policy Manual to ensure that the quality and safety of client care is maintained during a large scale staff replacement.
- Large scale staff replacement is defined in the policy as mass staff turnover through the change from one contracted service provider to another, or through a change in ownership.
- Health authorities must ensure service providers plan and manage the change process for clients where a service provider is planning a large scale staff replacement, consistent with the following requirements:
    - Ensure that maintenance of the quality and safety of the client's care is the priority throughout the process;
    - Provide the client with information about the upcoming change;
    - Offer clients and families an opportunity to meet with service provider staff to identify the key concerns in the changeover in staff; and
    - Ensure that the staff replacement does not happen until all clients are informed, and have had an opportunity to have their concerns heard.
- The policy was introduced on April 1, 2015 and applies to all publicly subsidized residential care facilities, both health authority owned and operated and contracted.
- To further enhance the reporting requirements set out by the above noted policy, an amendment was made to the Residential Care Regulation on July 18^{t}, 2016, requiring licensees of community care facilities licensed under the *Community Care and Assisted Living Act* to give written notice about operational suspensions, changes, reductions, expansions, sales, leases or transfers to:
    - A medical health officer,
    - The persons in care,
    - The contact persons of the persons in care, and
    - The parents or representatives of the persons in care.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Sharon Stewart, OBO Doug Hughes, Health Services Policy Division; October 30, 2016
Kevin Brown, Executive Director, Health Sector Workforce Division; November 17, 2016

FACT SHEET

Sale of Retirement Concepts

ISSUE

Retirement Concepts is a large provider of Residential Care, Assisted Living, and Independent Living services in British Columbia, many of which are provided in a Campus of Care environment. Retirement Concepts is in the process of selling its shares for most of these operations to a unique limited liability partnership. Retirement Concepts will continue to manage the affected residences and facilities on behalf of the new owner.

KEY FACTS

- Retirement Concepts (RC) owns and operates independent living, assisted living and complex care facilities in British Columbia (BC), Alberta and Quebec. In BC, 24 sites are operated in all regional health authorities (HAs), except Northern Health. Twenty-three sites are licensed/registered under the *Community Care and Assisted Living Act* (CCALA); one site is licensed under the *Hospital Act*.
  - Retirement Concepts operates 15 Registered Assisted Living Residences, 13 of which are part of the proposed sale.
  - Retirement Concepts operates 17 Residential Care Facilities, 16 of which are part of the proposed sale.
- Each of the residences and facilities will be owned by a unique limited liability partnership that will be operated by Retirement Concepts.
- The new ownership group has indicated there will be no changes to the management, staffing and operations of the residences as a result of the sale.
- The sale was completed February 15, 2017, and the applicable licenses/registrations certificates have been processed.

Approval of Sale to Foreign Investors

- The federal government has exclusive jurisdiction for matters of international trade, under various trade agreements entered into by Canada and under the Investment Canada Act.
- The People's Republic of China is a member of the World Trade Organization and is eligible to make larger investments in Canada, as provided in s. 14.1 of the Investment Canada Act. As the proposed sale was over the $600 million threshold set out in the Investment Canada Act, the proposed investment was reviewed by the Federal Minister.
- In making a determination as to whether a proposed investment "…is likely to be of net benefit to Canada….", the Federal Minister is obliged to consider the economic/financial factors set out in section 20 of the Investment Canada Act; any other considerations are not within the purview of the Federal Minister under the Investment Canada Act
- There is no statutory requirement for Canada to consult with a province respecting a proposed investment under the Investment Canada Act; as a matter of practice, good government, and courtesy, the federal government will consult with a province if a proposed sale to a foreign corporation or other legal entity could have a negative effect on, among other things, a health care program operated by that province.

FACT SHEET

Residential Care Regulations

- Section 9(3) of the Residential Care Regulations sets out the requirements for the sale of a facility. A licensee is unable to sell, lease or otherwise transfer control without providing the medical health officer at least 120 days' notice AND the medical health officer must be satisfied that operations will continue for at least 12 months from the date of sale, lease or transfer and that the new purchaser, lessee or transferee is qualified to be a licensee.

FINANCIAL IMPLICATIONS

- N/A

Approved by:
Sharon Stewart obo Doug Hughes, ADM Primary and Community Care Policy; February 17, 2017

ADVICE TO MINISTER

CONFIDENTIAL ISSUES NOTE **Ministry: Health** **Date: July 24, 2017** **Minister Responsible: Adrian Dix**	**Sale of Retirement Concepts**

BACKGROUND REGARDING THE ISSUE:

- On June 13, 2017, a Globe and Mail a reporter contacted the Ministry of Health to inform the ministry that Chinese media were reporting Anbang's chairman Wu Xiaohui had been detained by authorities.
- Anbang, a Chinese insurance-holding company, owns Cedar Tree who recently purchased 23 of 25 facilities owned by Retirement Concepts (20 in BC, 2 in AB and 1 in Quebec). The sale was subject to federal approval. Under the Investment Canada Act (ICA) it is the Federal Minister that is responsible to approve the sale to a non-Canadian if over $600m (increases to $800m in 2017).
- There is no statutory requirement for the Government of Canada to consult with a province respecting a proposed investment under the ICA; however, consultation is routinely conducted as a matter of policy.
- Factors are purely economic/financial considerations, any other considerations (e.g. care implications) are not within the purview of the Federal Minister.
- Through provincial Ministry of International Trade, Ministry of Health staff were contacted to provide an outline of the legislation and licensing process.
- B.C.'s Assisted Living and Residential Care regulations outline requirements of applicants for registration or licensing when there is a change in ownership. These regulations are in place to protect the health and safety of residents and persons in care irrespective of ownership.

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- Under the partnership agreement, Retirement Concepts retains a minority stake and will continue to manage the day-to-day operations of all of the facilities. Retirement Concepts committed that there is to be no change to staffing plans, the quality of care provided to residents, or to policies, procedures and other operating standards.
- The complete terms of the transaction are not available due to confidentiality agreements both at the federal level with Investment Canada and between Retirement Concepts and Cedar Tree.
- Retirement Concepts provides assisted living and residential care services through contract with the health authorities.

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- Following the approval of the sale, on March 1, Vancouver Coastal Health was given six-month's notice by Retirement Concepts to end their contract with us for 20 Assisted Living (AL) units (housing 21 residents) at the Terraces on 7th in Vancouver by September 30, 2017.
- The Terraces is one of two facilities that were not part of the federally approved sale and is still owned by Retirement Concepts.
- After significant media attention, Retirement Concepts rescinded their notice and worked with Vancouver Coastal Health to find a solution to allow residents to stay until the original agreement end date of March 2019.
- In response to concerns raised about Retirement Concepts and other providers suddenly ending contracts in the future the Board of Directors of the BC Care Providers struck an Assisted Living Tenancy Task Force to review this matter and provide recommendations to prevent future sudden terminations and evictions.

ADVICE AND RECOMMENDED RESPONSE:

- **The federal government has exclusive jurisdiction for matters of international trade.**
- **The ministry's role is the health and safety of persons in care – regardless of ownership. That is our number one focus and what we will work to ensure.**
- **Retirement Concepts continues to manage the day-to-day operations of all of the facilities. It is important to remember that this is a business that has been operating in B.C. for a number of years providing quality care to seniors.**
- **The company has assured residents that no changes are being made to the day-to-day operations, to staff or leadership team or the level and quality of care that residents are accustomed to receiving.**
- **The Seniors Advocate has said that we need to let the process transpire, and has also pointed out that we have legislation in place that allows the health authorities and the Registrar to continue to monitor these facilities.**
- **B.C.'s Assisted Living and Residential Care regulations outline requirements of applicants for registration or licensing when there is a change in ownership. These regulations are in place to protect the health and safety of residents and persons in care and to ensure that the purchasing company or individuals is able to meet the needs of patients and provide quality care.**
- **Medical Health Officers and the Assisted Living Registrar monitor care provided in these facilities and can require:**
    - **Reports on the operation of licensed facilities,**
    - **Results of any investigations, or investigations of complaints,**
    - **Inspection of books, records or premises in connection with the operation,**
    - **Require an audit of the operations of a community care facility, and**
    - **Specify policies and standards of practice.**

- **Health authorities have used these powers in situations where facilities have not been in compliance.**

- **Last year the ministry also took step to make amendments to the Act to allow provide better protections for seniors including which permit the inspection of a residence at any time it is felt there is a risk to the health and safety of a resident, and increased oversight protections for incidences of senior's abuse.**

Communications Contact: Reviewer:
Program Area Contact:
File Created:
File Updated:

Minister's Office	Program Area	Deputy	HLTH Communications

FACT SHEET

FIRST LINK®

ISSUE

The Alzheimer Society of BC's First Link®/ Premier lien® program connects individuals, families, and caregivers affected by Alzheimer's disease and other forms of dementia to community supports and services as soon as possible after diagnosis.

KEY FACTS

- In 2014/15, there were an estimated 62,000[1] people with dementia in BC. The impact of dementia will continue to grow as the proportion of seniors in BC increases over the next 10 to 15 years.
- In 2014/15, the prevalence of dementia in British Columbians aged 40+ was 2.40 percent, up from 2.35 percent in 2013/14.[2]
- The Alzheimer Society of BC (ASBC) provides education and support services for individuals, families, and caregivers affected by Alzheimer's disease and other forms of dementia. ASBC funds dementia-related research and training, and offers client services through resource centres across BC, a toll-free Dementia Helpline, and programs such as First Link®.
- First Link® is a proactive early intervention program. Physicians and other health care professionals refer patients and their families to First Link® to ensure that they are able to find and receive appropriate support as soon as possible after diagnosis. Self-referral is also available.
- ASBC provides First Link® clients with introductory and follow-up phone calls, information about dementia, dementia education programs and support groups, referrals to other community and health care services, a bi-monthly First Link® bulletin, and tips for both day-to-day living and planning for the future.
  (Source: Alzheimer Society of BC, 2015/16 annual First Link data, date received April 28, 2016)
  - There are currently over 12,500 people participating in the First Link® program.
  - In 2015/16, 1,927 people were referred to First Link® by a health care provider (an increase of 33 percent over the previous two years), and 1,937 self-referrals (individual/family) were received. Since beginning tracking of self-referrals in January 2015, ASBC reports 50 percent of First Link® referrals are made by an individual or family member (as opposed to a formal provider).
  - For formal referrals, the top three sources to First Link® are assessment clinics/specialists (73 percent), followed by GP/Primary Care (11 percent), and Home and Community Care (8 percent).
  - Close to 5,000 families receive regular outreach calls from First Link®, and the First Link® Bulletin is sent to 9,382 families and health care professionals every two months.
  - First Link® is available throughout all health authorities. Availability in Interior Health Authority includes the North, South and Central Okanagan, Central Interior, and Similkameen regions, with expansion into the Kootenay region underway.

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[1] The reported decrease in prevalence of Alzheimer's and other dementias from earlier years is primarily the result of a change in the definition and not in the number of cases. The definition used for cerebral degeneration is now specific to Alzheimer's and other dementias, and excludes other causes such as obstructive hydrocephalus which were previously included. The change in reported prevalence is also due to amendments to other reporting criteria which were made in order to standardize database sets and enable comparison across jurisdictions. Source: BC Ministry of Health, Chronic Disease Information Registries, 2014/2015, Alzheimer's Disease and Other Dementia Measures Report.

[2] Ibid.

FACT SHEET

- Support for First Link® is included in the Ministry of Health's *Provincial Guide to Dementia Care in British Columbia*, which calls for enhanced linkages between people with dementia and their families through information and community supports, such as First Link®. This deliverable builds on the 2012 Provincial Dementia Action Plan which called for expanded community support programs such as First Link®.
- Priorities identified in the Guide will be incorporated into design of specialized care services for people with complex medical conditions and frailty.
- Services provided under First Link® are consistent with the Ministry of Health's *2014 Setting Priorities for the BC Health System* (Priority 3, Implement a provincial system of primary and community care, which calls for improved dementia care including support and training for formal and informal caregivers).

FINANCIAL IMPLICATIONS

- The Ministry and the Provincial Health Services Authority have provided a total of $13.4 million to the Alzheimer Society of BC First Link® Program to support individuals and families affected by Alzheimer's disease and dementia.
  - In 2007, the Ministry provided $1 million to ASBC to pilot dementia care initiatives, including a prototype of First Link® in Greater Victoria.
  - The Ministry provided ASBC with funding of up to $1 million per year from 2010/11 to 2013/14 to expand First Link® to more communities across BC in all five regional health authorities. In 2013/14, the Ministry provided an additional $4 million to ASBC to further expand First Link®.
  - The Provincial Health Services Authority (PHSA) provided $2 million to ASBC in 2012/13 to support First Link®.
  - In 2015/16, the Ministry provided $2.7 million to ASBC to support First Link®.
- The Ministry and ASBC are discussing a sustainable funding model for the First Link® program to ensure its continued support to people with dementia and their caregivers throughout the dementia journey.

Approved by:
Sharon Stewart obo Doug Hughes, ADM Primary and Community Care Policy; February 17, 2017
Gordon Cross obo Manjit Sidhu, ADM, Finance and Corporate Services; November 16, 2016
Jack Shewchuk obo, Teri Collins, ADM, Health Sector Information, Analysis & Reporting Divison; November 10, 2016

FACT SHEET

ADULTS WITH DEVELOPMENTAL DISABILITIES

ISSUE

In December 2011, a committee of Deputy Ministers reviewed the operations of Community Living BC (CLBC), and related linkages to relevant government ministries to consider concerns expressed by individuals with developmental disabilities and their families.

KEY FACTS

- A cross-ministry team, that includes representatives from Social Development and Social Innovation, Children and Family Development, Education, Health and CLBC, has been tasked with developing an action plan for delivering on 12 recommendations provided by the Deputy Ministers. The goal of this team is to develop an integrated service delivery system that will provide a long term sustainable care system for individuals with developmental disabilities and their families.
- CLBC has primary responsibility for providing supportive community supports, personal care assistance and staffed residential settings for adults with developmental disabilities. Health authorities (HAs) provide home and community care services i.e. Health Services Community Living (HSCL), to this specialized population as outlined below:
    - Specialized nursing and rehabilitation services for assessment, care planning, caregiver training, and minor direct care;
    - Community nursing services for episodic and end-of-life care;
    - Medical consultant and clinical consultant services for expert advice on care needs and service planning;
    - Dental hygiene services, dietary, and in some cases, speech-language therapy;
    - In-hospital supports in a hospital setting unless this support is included within the provisions of the service provider's contract with CLBC;
    - Specialized assessment and care planning for behavioural and psychiatric needs, through Developmental Disabilities Mental Health Services (DDMHS); and
    - Access to added funding to support clients with high intensity health care needs.
- Health Authority clinical staff use a standardized assessment process (interRAI Home Care) to inform and guide comprehensive care and service planning. HAs work in partnership with CLBC to assess clients' health care needs, develop appropriate care plans, and provide teaching to caregivers.
- To improve understanding among organizations responsible for supporting this population, a Provincial Cross Ministry Working Group developed *Guidelines for Collaborative Service Delivery for Adults with Developmental Disabilities (GCSD,* released in 2010).
- The Ministry of Health (the Ministry) and HA leads were active participants in the working groups established by STADD from 2012/13-2013/14. In 2012/13, the business processes, and performance measures were developed for the early implementation sites, launched in late 2013 and early 2014.
- Four sites (Courtenay/Nanaimo, Surrey, Kamloops/Merritt and Prince George/Haida Gwaii) focused on supporting youth ages 16-24 years, while the fifth site (Burnaby) focused on aging adults with developmental disabilities. In the fall of 2015, a review of the Older Adult Site in Burnaby was conducted. As a result of the review, it was recommended that the older adult site close and that effective January 1, 2016, CLBC facilitators would take on the role of providing transition supports for older adults. CBLC was also asked to incrementally implement the navigator function throughout the province for older adults.

- The benefits of the early implementation sites include supporting youth transition to adulthood earlier than at the point of transition (age 19).
- In 2012/13, the Ministry, in collaboration with CLBC, developed a three year aging action plan for adults with developmental disabilities.. The action plan includes three major priorities/goals: provide access to early information and early planning; assess and redesign health services and supports as individuals move through the transitions associated with aging; and forecast future demand for services and supports for aging adults. The action plan deliverables for year one (2013/14) and year two (2014/15) have been completed. In 2017/18, the Ministry will work with CLBC to develop a forecast model to identify health care service requirements.
- In 2014/15 and 2015/16, the Ministry led the Added Care Funding (ACF) working group which included participation by HAs. The focus for this work was aimed at building a common understanding of the issues that arise related to achieving consistency in provincial practice through the GCSD.

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FINANCIAL IMPLICATIONS

- There could be significant resource implications associated with this work. Additionally, any new approach will require consultation and approval by senior executive in the Ministry and HAs.

Approved by:
Sharon Stewart obo Doug Hughes, ADM Primary and Community Care Policy; February 17, 2017

FACT SHEET

Monitoring Seniors' Services Report

ISSUE

Public reporting on seniors and seniors' issues is a key part of the Office of Seniors Advocate's mandate. *Monitoring Seniors' Services Report,* published January 27, 2016, was the first annual report to the public on key seniors' services. On December 13, 2016, an update to this report was released. The report presents 2015/16 data highlighting areas where seniors' needs were met, where improvements were needed, and where there were opportunities for improvement. The findings from the latest report are listed below.

KEY FACTS

REPORT FINDINGS FOR THE 2015/16 REPORT;

- A total of 92 percent of seniors report having a regular physician.
- Approximately 52,000 British Columbians are living with a diagnosis of Alzheimer's or another dementia, leaving 4 out of 5 seniors aged 85 and over with no diagnosis of dementia.
- There were 451 incidents of seniors missing or wandering from residential care facilities in 2015/16. All were found, with no fatalities occurring.
- The population over the age of 75 has increased by 4 percent in the past year, but the number of home support hours is trending down in 2 out of 5 health authorities (Island Health and Vancouver Coastal), while the number of clients has increased in 3 out of 5 (Interior Health, Fraser Health and Northern Health).
- The number of clients of all ages receiving professional home care services has increased 2.3 percent in the past year.
- There are 918 individuals on the waitlist for a total of 4,408 subsidized assisted living units.
- There has been less than a 1 percent increase in the number of subsidized assisted living units since 2012.
- The number of residential care beds in the province has increased by 3percent since 2012, but the population over 85 has increased 21 percent during that time.
- 74 percent reported residential care beds are in single rooms.
- The number of seniors placed within the 30-day target window has decreased from 64 percent to 57 percent in 2015/16.
- 16 percent of licensed residential care facilities did not have an annual inspection within the last year.
- In 2015/16, 418 incidents of aggression between residents were reported in licensed residential facilities in BC.
- In 2015/16, the Public Guardian and Trustee received 1,590 referrals regarding financial abuse, neglect, and self-neglect. Referrals increased over the last year by 7 percent.
- Between October and December 2016, low income single seniors received $1,491.92 per month in federal and provincial income supports, an increase of about 7 percent from the same quarter of 2015. The Seniors Abuse and Information Line received 1,463 calls related to elder abuse in 2015, and nearly 30 percent of these calls reported the abuse had been going on for 5 or more years.

Program Information

- Home support provides clients with specific help with daily personal care activities, such as bathing, dressing or toileting. Home support is part of the Home and Community Care Program, and is delivered by community health workers paid for by the health authority. Clients may pay a co-payment amount based on income.

  - The total number of home support clients in BC increased by 2 percent overall over 2014/15. Specifically, in 2015/16, the total number of clients increased in 3 health authorities Interior Health, Fraser Health and Northern Health) and decreased in 2(Island Health and Vancouver Coastal).
  - Note that all home support clients include Choice in Supports for Independent Living clients and clients receiving short-term home support.
- Home Care-Professional Services are provided on a short-term basis only, to address health issues post-discharge from hospital or an episodic illness or injury. Unlike home support, there is no client co-payment for professional services. These services include 1) Nursing (registered nurse); 2) Physical therapy; 3) Occupational therapy; 4) Nutritional services (registered dietician); and 5) Social work (registered social worker).
  - The total number of clients who received professional home care services in BC increased by 2.3 percent over 2014/15. Specifically, the number of clients increased in 4 health authorities (Island Health, Interior Health, Fraser Health and Vancouver Coastal) and decreased in 1 (Northern Health).
- Residential care facilities offer seniors 24-hour professional supervision and care in a safe and secure environment. Residential care facilities here refer to those that receive public funding, including those that are owned and operated by health authorities, and those that are operated by private for-profit and private not-for-profit organizations.
- Assisted living is a housing option that provides seniors with enhanced supports to maintain their independence. Assisted living residences are regulated rather than licensed as is the case for residential care facilities. In BC, three versions of assisted living exist: Subsidized registered assisted living, private pay registered assisted living, and private assisted living (non-registered).

FINANCIAL IMPLICATIONS

N/A

Approved by:
Approved by Sharon Stewart obo Doug Hughes, ADM; March 27, 2017
Heather Richards obo Teri Collins, ADM, Health Sector Information, Analysis and Reporting Division; March 20, 2017

FACT SHEET

Medical Assistance in Dying

ISSUE

Medical assistance in dying (MAiD) is legal in Canada, with federal legislation in place since June 17, 2016, when Bill C-14 *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* received royal assent, ending the prohibition on MAiD in Canada. The Federal legislation allows for both practitioner-administered (intravenous) and self-administered (oral) MAiD, when specific eligibility criteria are met and safeguards are followed.

KEY FACTS

Exemptions from Criminal Liability

- Physicians and nurse practitioners (NP) who assess persons for eligibility and provide MAiD.
- Pharmacists who dispense drugs for the purpose of MAiD.
- Persons (e.g., a registered nurse or social worker) who aid a physician/NP to provide MAiD.
- Persons (e.g., a family member or friend) who aid a patient to self-administer.

Eligibility for MAiD - Is limited to persons who meet all of the following criteria:

- Eligible for health services funded by a government in Canada.
- At least 18 years of age, and capable of making decisions with respect to their health.
- Have a grievous and irremediable medical condition (i.e., a serious and incurable illness/ disease/disability; advanced state of irreversible decline in capability; intolerable physical or psychological suffering that cannot be relieved by means that are acceptable to the person; and, natural death is reasonably foreseeable).
- Have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure.
- Give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.

Safeguards for MAiD - Before providing MAiD, the physician/NP must ensure the following:

- A written request must be signed and dated by the person (or their proxy, if person is unable to sign) before two independent witnesses, who must also sign and date the request.
- The person must be informed they may withdraw their request at any time, in any manner.
- Two independent physicians/NPs must assess the person's eligibility for MAiD, and confirm in writing that the person meets all of the eligibility criteria.
- There must be 10 clear days between the day of the signed request and the day on which MAiD is provided, unless death or loss of capacity to provide informed consent is imminent.
- Immediately before providing MAiD, the person must be given an opportunity to withdraw their request, and must provide express consent to receive MAiD.
- All necessary measures must be taken to provide a reliable means by which the person may understand the information provided to them, and communicate their decision.

Implementation of MAiD in BC

- The Minister of Health made amendments to the Medical Practitioners Regulation, Nurses (Registered) and Nurse Practitioners Regulation, and Pharmacists Regulation under the *Health Professions Act*, to give regulatory college Standards for MAiD the force of provincial law.
- BC's Additional Safeguards - in BC, the prescribing physician or NP must: 1) Receive the drugs directly from the dispensing pharmacist and return any unused drugs to the pharmacy; and 2) Be present with the patient for MAiD (including for self-administration) until death is confirmed. This approach ensures the patient is capable of providing consent, the management of any possible

adverse events, proper disposal of any unused medications, and emotional support for the patient and others present.

- Amendments were made to the Drug Schedules Regulation to allow NPs the ability to prescribe certain drugs which may be used for MAiD under BC's drug protocol.
- A provincial approach to privileging physicians for health authority-based MAiD was developed and implemented.
- A revised physician payment schedule was approved by the Medical Services Commission in June 2017, following development by the Section of General Practice and approvals from Tariff Committee and the Board of the Doctors of BC.
- Processes and policy were put in place to ensure individuals receiving MAiD are able to access required pharmaceuticals and supplies as insured benefits.
- The Provincial MAiD Working Group (Ministry of Health, Ministry of Justice, BC Coroners Service, health authorities, and regulatory colleges) meets regularly to provide advice and guidance related to the implementation of MAiD from a service delivery and operational perspective.
- Sub-committees of the MAiD Working Group have developed drug protocols (including the prescription form and guidance document), a nursing clinical decision support tool and education resources, standard provincial forms for data collection, and indicators for oversight/monitoring.
- On July 20, 2016, regulatory changes came into force to provide the BC Coroners Service with the authority and responsibility to collect and report on deaths resulting from MAiD. The role of the Coroners Service is to ensure compliance with federal/provincial laws and regulations, and to gather information about MAiD deaths for aggregate reporting.
- The Coroners Service chaired the first BC MAiD Review Panel on February 22, 2017; release of a report from the Panel to the Chief Coroner is pending.
- Health authorities have delivered education sessions for physicians, NPs, and registered nurses.
- The Ministry maintains an active role in federal/provincial/territorial discussions, including issues pertaining to reporting and oversight.
- In January 2017, the federal government initiated three independent reviews into complex issues currently excluded from MAiD: 1) mature minors; advance requests; and, 3) mental health as the sole underlying medical condition.

Access and Care Coordination of MAiD in BC

- MAiD Care Coordination Services are in each health authority to ensure reasonable access.
- The Ministry continues to assist health authorities and regulatory colleges with policy questions and working through issues as they arise, and is aware of areas of concern (i.e., resistance to MAiD in some hospice and palliative care settings, physician compensation, and patient transfers from denominational facilities). There continues to be media attention in these areas.
- Demand for MAiD in BC has been higher than expected. As of May 31, 2017, a total of 435[1] persons had received MAiD (Vancouver Island - 186; Vancouver Coastal - 115; Fraser - 54; Interior - 66; Northern - 14).

FINANCIAL IMPLICATIONS

N/A

Approved by:

Ian Rongve, Hospital, Diagnostic and Clinical Services Division; July 5, 2017

Nancy South, obo Teri Collins, Health Sector Information Analysis and Reporting Division; July 10, 2017

[1] Source – BC Coroner's Service

FACT SHEET

Polypharmacy

ISSUE

Polypharmacy is the use of multiple medications by an individual. It is a problem when the benefits of using multiple medications are outweighed by the negative effect of the sheer number of medications. It is more likely to occur in the elderly.

KEY FACTS

- Polypharmacy is rapidly increasing in affluent populations worldwide, posing an increasing challenge for patients, their families and care providers.[1,2]
- Polypharmacy is linked to heightened risks such as adverse drug reactions, non-adherence, functional and cognitive decline, and falls.[3]
- Although an identified specific threshold for the number of medications to define polypharmacy has not been validated, it is known the risk of drug-related problems increases with the number of medications used.[4]Five or more medications are often a prompt for a medication review.
- In a study conducted in 2008, 27% of Canadian seniors reported taking 5 or more medications on a regular basis; for people older than 85 years, 41% reported taking 5 or more medications.[5]
- On January 28, 2016, a representative from the Pharmaceutical Services Division attended the "2nd National Stakeholder Meeting to Increase Safe and Appropriate Medical Therapy for Older Men and Women Across Canada." The meeting was organized by a research group, Canadian Deprescribing Network (CaDeN), from Université de Montréal and was funded primarily by a Canadian Institutes of Health Research grant. CaDeN is composed of a core working group, and 5 sub-committees. Each is working toward 2 overarching goals:
  - Reduce harm by curbing the prescription of inappropriate medications by 50% by 2020.
  - Promote health by ensuring access to safer pharmacological or non-pharmacological therapies.
- The Ministry of Health supports activities aimed at optimizing the use of drugs. This includes healthcare professional education activities on polypharmacy provided by the Doctors of BC, the Therapeutics Initiative (TI), and the CLeAR initiative. The Ministry, through PharmaCare, also provides funding for pharmacists to conduct medication reviews.[6]
- The Doctors of BC's Shared Care Polypharmacy Risk Reduction Initiative aims to reduce risks of polypharmacy (confusion, falls, adverse drug reactions) in the elderly by providing physicians with tools and strategies to reduce medications for improved safety and quality of life.[7] It is being implemented in 3 phases, focusing on prescribing in the following care settings:
  1) residential care (currently underway);
  2) acute care and transitions (currently underway); and
  3) community-based/primary care (planned).

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[6] (see "Pharmacy Medication Management Services" Fact Sheet).

[7] http://www.sharedcarebc.ca/initiatives/polypharmacy

- In September 2014, TI published its 90th Therapeutics Letter on "Reducing polypharmacy: A logical approach"[8] [9] and describes 7 steps that health professionals, patients and their families can employ to become adept at de-prescribing. This work is funded by the Ministry.
- In June 2013, the BC Patient Safety and Quality Council invited residential care homes to join a "Call for Less Antipsychotics in Residential Care" (CLeAR) initiative[10]. This voluntary quality improvement initiative offered support through resources, improvement coaching, an opportunity to collectively learn and problem solve, as well as development of new strategies to improve care for residents and their families. From October 2013 to December 2014, many care homes achieved a steady decline in antipsychotic use that led to evidence of residents' improved health. Based on the success of CLeAR, the Council initiated a second wave for BC residential care homes in October 2015.
- PharmaCare Medication Review Services - PharmaCare reimburses pharmacists for conducting Medication Reviews, a one-on-one appointment between a patient and pharmacist where medication information is gathered, validated, summarized and reviewed.[11] Patients who have taken at least 5 different medications in the previous 6 months and demonstrate a clinical need for service are eligible for the service.

FINANCIAL IMPLICATIONS

N/A

Approved by:
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; October 7, 2014
Randi West, obo Carolyn Bell, Health Sector Planning and Innovation Division; October 9, 2014
Mitch Moneo, Pharmaceutical Services Division; July 5, 2017

[8] http://ti.ubc.ca/letter90
[9] TI also has a podcast on polypharmacy at: http://www.ti.ubc.ca/2014/09/02/therapeutics-letter-90-reducing-polypharmacy-logical-approach/# and polypharmacy is often included as a topic in the educational sessions they provide to physicians and pharmacists.
[10] A full report on CleAR is available in The Journey Towards Dignity & Resident-Centered Care: Summary Results from the Call for Less Antipsychotics in Residential Care .
[11] Factsheet - Pharmacy Medication Management Service, February 2017

FACT SHEET

Office of the Seniors Advocate

OVERVIEW

The Office of the Seniors Advocate (OSA) has been in place since March 31, 2014. Now in its third year of operation, the Advocate continues to travel the province widely to consult with seniors, their families, stakeholder groups and service providers. The focus for the office has been on monitoring seniors services, providing information and referral, analysing systemic issues and providing recommendations for improvements. The current staffing level is 14 FTEs.

ACTIVITIES

Snapshot of OSA Activities during 2015/16

Visited 45 communities to further OSA's Communication, Outreach and Engagement with seniors, their families, stakeholders, and service providers including:

- 99 Stakeholder meetings where the subject matter touched all 5 seniors service areas of the OSA mandate.
- 22 Site Visits that included residential care facilities, adult day programs, and hospitals around the province.
- 13 Town Hall meetings where the Advocate consulted with seniors and their families in various locations around BC.
- Promoting awareness of seniors services and connecting individuals with agencies to resolve complaints continues with over 9,000 incoming calls annually, and over 16,000 unique visits to the OSA website annually.

OSA Released 4 Reports and a Directory in 2015/16

- *Seniors Housing: Affordable, Appropriate, Available Report (May 2015)* - focuses on housing as a major determinant of seniors' health across a continuum from independent homes, assisted living and residential care. The report discusses a range of issues related to the cost to seniors of various forms of housing and how government impacts these costs as well as how available certain types of housing are to seniors. In addition, the report takes a deep look into how appropriately assisted living and residential care is being utilized. The report makes a number of recommendations designed to improve housing for seniors across the continuum.
- *Annual Report (August 2015)* - provides a detailed summary of the activities of the OSA for 2014/15 and includes a detailed breakdown of the contacts made by the public to the Advocates information and referral telephone line. This includes details on the annualized volume of 8,000 phone calls for information and referral and visits to the website.
- *Caregivers in Distress - More Respite Needed Report (September 2015)* - looks at the home and community care system in BC and analyzes data to find who the distressed caregivers are, why they are distressed, what supports are available to them and if they are accessing these supports.
- *Monitoring Seniors Services Report (January 2016)* – this report, published annually, fulfills the statutory obligation of the Advocate to monitor key services to seniors. The first report was issued in January and work will continue to update information for the next review period.
- *Residential Care Facility Directory (March 2016)* – this directory of all publicly subsidized residential care facilities in the province will be produced annually with updated information. It contains standard information on each facility in the province.

Looking Ahead

The OSA continues to have a strong public profile. The OSA website continues to attract approximately 2,500 to 3,000 unique visitors per month. The office also maintains its own Twitter and Facebook accounts with a sizeable collective social media presence which continues to steadily build.

FACT SHEET

The Advocate is continuously engaged in outreach activities and will continue a busy schedule of attending town halls, presentations, conferences and stakeholder meetings in the months ahead.

2016/17 Reports released to date and Reports in Development

- *Annual Report (06-2016)* - provides a detailed summary of the activities of the OSA for 2015/16 and includes a detailed breakdown of the contacts made by the public to the Advocates information and referral telephone line. This includes details on the annualized volume of over 9,000 phone calls for information and referral and visits to the website.
- *Resident to Resident Aggression Report (06-2016)* - examines the reported incidents of resident to resident aggression and discusses patterns and commonalities in incidents across health authorities. Factors such as facility size, type, configuration, location, resident RAI profile, use of physical restraints and drugs are among the factors examined.
- *Listening to your Voice: Home Support Survey (09-2016)* – presents results from the comprehensive home support survey conducted last year. This report provides a summary of the collective voice of almost 10,000 home support clients and their family members who responded.
- *Making Progress: Placement, Drugs and Therapy Update (11-2016):* The progress report highlights some improvements are being made in the provisions of rehabilitative therapies to seniors in residential care, as well as the use of antipsychotic medications. Data also shows the premature placement of seniors into residential care is also declining.
- *Monitoring Seniors Services Report (12-2016)* – this report, published annually, fulfills the statutory obligation of the Advocate to monitor key services to seniors. This is the second report issued and work will continue to update information for the next review period.
- *Moving in the Right Direction: HandyDART Survey Results (02-2017)* – this report highlights the results of a province-wide survey of almost 7,500 HandyDART users in the province. The survey highlights that, while 91% of users are satisfied with the service when they receive it, almost 1/3 of respondents say it is not meeting, or only moderately meeting, their transportation needs.
- *Residential Care Survey (ends early 2017)*: volunteers are currently surveying seniors living in over 300 residential care facilities across BC. The results of the survey will provide a road map for improvements of quality of care and services provided to residents and their families in residential care. Results of the survey will be posted publicly on the Office of the Seniors Advocate's website in 2017.
- *Home Support Review Report* - will review home support system and recommend changes to the home support program to better meet the needs of seniors to maintain their independence and prevent/divert emergency department admissions and acute care stays and prevent or delay admission to residential care. The results of the province-wide home support survey will be incorporated into the review.
- *Review of PharmaCare Report* - will focus on the gaps that exist in terms of coverage of listed drugs, i.e. excess dispensing fees and drug charges and the financial impact on seniors. The report will highlight the role that pharmacists and physicians play. Differences in formularies between the community/residential care and hospital sites will be examined as they affect the discharge of seniors from acute care to either residential care or the community.
- *Residential Care-the Residents Voice Report* - will use the results of the province-wide residential care survey of 27,000 residents in facilities that receive public funding to recommend changes to residential care. Surveys will be done between May 2016 and February 2017, with the results being incorporated into the review this fiscal.
- *Hospital Referral and Discharge* - will examine the process of the emergency department and look at what variations exist across the province. The focus will be on what patterns exist that indicate greater likelihood of discharge versus in-patient admission as well as re-admission. There is a

hypothesis that a more systematic approach to assessment, better training and awareness of community supports and a more rigorous and standardized discharge process will result in fewer admissions to acute care beds from the emergency department and fewer re-visits/admissions to the emergency department.

- *Transportation Report* - will look at the broad range of supports for seniors transportation also incorporating the results from the 2016 HandyDart survey.

In addition to the development of these reports, the OSA will continue to provide information and referral to seniors by phone, email and letter.

Approved by:
Isobel Mackenzie, Seniors Advocate; July 26, 2017

FACT SHEET

Home Health Monitoring

ISSUE

The Home Health Monitoring initiative, funded by the Strategic Investment Fund, will provide a common platform and operational services, based on clinical monitoring protocols developed by the Province, that can be used by health authorities in BC to deliver locally-administered Home Health Monitoring programs for at-risk individuals living with moderate to high complexity chronic and mental health conditions.

KEY FACTS

- The Strategic Investment Fund has allocated $52 million to the Home Health Monitoring (HHM) initiative. To date, approximately $34 million has been allocated to individual projects within the initiative.
- Under the terms of the Strategic Relationship Agreement between TELUS and the Province, the Strategic Investment Fund "is aimed at strategic, ambitious IT projects that hold the promise of making significant impacts in the lives of BC citizens".
- To date, 4 health authorities have been approved for funding:
    - Home Health Monitoring for Chronic Heart Failure Patients (Island and Interior Health)
    - Phase 2 of Home Health Monitoring (Island Health): The Island project has been expanded to include patients with COPD.
    - Tec4Home (Vancouver Coastal Health): To determine whether home health monitoring can improve outcomes health for destabilized heart failure/COPD patients who needed hospitalization and are now being sent home for convalescence and reduce healthcare utilization costs.
    - Paramedicine (BC Emergency Health Services/Provincial Health Services Authority): Community paramedics will provide home health monitoring support to 1,500 seniors living at home in rural and remote communities.
- Health authorities, the Ministry of Health, and TELUS are actively collaborating to develop clinical protocols and technology solutions to support the ongoing use of HHM to support patients in a home and/or community setting.
- The evaluation of the Chronic Heart Failure project in Island and Interior Health found improvements in client management of symptoms, reduced use of acute care resources, and significant levels of overall client and clinician satisfaction with HHM.
- The main actions/initiatives required to achieve the vision for HHM in BC are:
    - Development of additional clinical protocols;
    - Expansion of HHM to all health authorities;
    - Moving HHM from a project model to an operational model; and
    - Development of an appropriate funding model to support HHM in operational mode (Strategic Investment Funding is intended to be used to support project costs).
- The current authorization for accessing Strategic Investment Fund funds for HHM expires at the end of March 2018. The Ministry of Health is working with the participating health authorities and Telus to present a renewed plan for achieving the HHM vision and a request for an extension to the Strategic Management Committee of the Strategic Investment Fund. The presentation is scheduled for September 2017.

FINANCIAL IMPLICATIONS

N/A

FACT SHEET

Approved by:
Ian Rongve, Hospital, Diagnostic and Clinical Services Division; July 6, 2017

Raising the Profile Project

Building links between Community-Based Seniors' Services and the Health System

The MOH Funding for this Project

How can the Community-based Seniors' Services Sector be integrated with the MOH's strategic plan for seniors' care?

March 2017 Action Plan from the MOH

While it is not the governments role to provide for all quality of life considerations, there are many existing community supports that can and should be engaged to support the care of seniors from a holistic perspective along with health care services…This requires us to rethink some of our healthcare practices in the healthcare system concentrated on interventions and cures.

Challenges to Collaboration from the Health System Perspective

- Lack of awareness of the range of programs offered by Community-Based Seniors' Services (CBSS) sector and the increased focus on health prevention and promotion.
- CBSS can also be difficult to navigate in larger centres, and many services not available in smaller and even larger communities.
- These services are not part of the "core" mandate of health system and when the gov't expectation is to reduce costs these are often the first services to go.
- Uncertainty about the quality of the programming provided by the CBSS and their limited capacity to evaluate results.

Challenges to Collaboration from the CBSS Perspective

- Community-based seniors' services, particularly non-profits, increasingly see people with higher needs and are keen to develop innovative programs in response to changing needs…but lack of long term stable funding makes this challenging.
- Committed to working more closely with the health system…but have difficulties in establishing stable relationships, essential to building effective partnerships.
- CBSS are often expected to rely on volunteers to provide services in situations where there is not enough paid staff to support the volunteers and/or where the use of volunteers is not possible.

Why address these challenges? And why now?

- Rapid growth in the aging population and the evidence that healthcare costs and utilization can be better controlled with more attention on health promotion and prevention (i.e. upstream intervention to reduce downstream utilization)
- The tie to the "core" mandate of the health system is that these upstream interventions improve health outcomes for **older adults living with chronic conditions** and those at **risk of frailty.**

Looking at the Research Evidence

- *Longitudinal Study of Aging* in Beijing evaluated the impact of health deficits (e.g., diseases, cognitive function, etc.) and protective factors (e.g., marital status, socioeconomic status, social and recreational activities, etc.) on health status and mortality in Chinese seniors. The authors found that for seniors at risk of frailty, possessing more protective factors was associated with lower risk of decline in health and mortality of from 13 to 25 percent. (Wang et al. 2014)

- The relationship between health and income inequality is well established including in areas such as: diabetes, heart attacks, falls and self-reported mental health (CIHI, 2015)

Long Standing Partnership Between the City of Kamloops and Interior Health

- Began in 2008 and focused primary prevention for people at risk or with a chronic condition.
- Located at the municipal recreation centre, it is 10 - 12 week program: includes exercise, mental health support and nutritional counselling.
- Funding for staff from Interior Health(IH): facility space provided by the City.
- Physician referral needed to participate: clinical services provided by IH multi-disciplinary team and exercise program provided by City.
- Subsidy available to reduce costs to participants and many opportunities for people to stay connected after the program ends.
- Evidence of improvement in mental health and reports of reductions in emergency room visits.

A Newer Partnership in a Smaller Community

Port Alberni and surrounding area:

- *Echo Sunshine Club* is a seniors' club supported by Parks and Rec. staff offering twice weekly exercise classes for seniors with mobility problems.
- Integrated Community Services (an Island Health Outreach Program) provides seniors with free passes to these exercise classes.
- *Better at Home* provides transportation to seniors who need it to access the exercise program.

Goal of Partnership: To support low-income and rural seniors with chronic health and mobility challenges to access programming.

A Structured Wellness Model

TAPS (Therapeutic Activation Program for Seniors), Creston

- TAPS is a wellness program utilizing a model similar to an adult day program. It fills a gap in the health care continuum, serving seniors who are isolated and unable to independently access community programs, but who don't qualify for health authority adult day programming.

- Participants are interviewed prior to starting the program, provided with transportation, and usually attend 2 or 3 days a week. The typical day includes a nutritious lunch, a physical activity and an educational/recreation activity.

- Interior Health provided funding a number of these programs up until about 2005 when they were phased out. The Creston program is the only one to survive.

"Suddenly I have a life… I now know people…The exercises helped a great deal. I do activities I don't do at home, and I get hugs which is very important when you're alone." participant

An Emerging Model… but no Sustainable Funding

A number of newer programs for people with higher needs, who do not qualify for home and community care (HCC), but who require more structured programming.

- Mt. Waddington: combined community and HCC adult day program initiated by the Division of Family Practice…on-going funding not secured
- Parkgate Community Services: adult day care program for seniors with early dementia…referrals from case managers, long wait list
- Campbell River: volunteer run senior centre for higher needs seniors, supported by the city and with chair exercise provided by Parks and Recreation
- Richmond: 2 programs that don't have funding to continue: *Wellness Connection Program* funded by VCH from 2008 to 2014 at Minoru and *Music Work Program* where funding was provided to the West Richmond Community Centre for one year through New Horizons.

West Vancouver Activity Centre, *Keeping Connected Program* is the exception. It supports over 500 seniors, who are struggling with some kind of a loss who can't access programming on their own, with more than 15 different weekly programs, including telephone reminders, one to one support, various kinds of exercise options, transportation

A Fraser Health Authority Initiative

CARES, *Community Action and Resources Empowering Seniors*

- Family physician identifies patients who are at risk of frailty. A health care provider completes a Comprehensive Geriatric Assessment that generates a Frailty Index (FI).
- A wellness plan is developed that focuses on the goals the senior identifies as most important to their health and quality of life.
- A volunteer wellness coach from *Self-Management British Columbia* paired with the senior to help them achieve their goals by tracking their progress, providing encouragement and motivation, and connecting them with community resources.

Why Spread CARES?

Results reported are based on 39 CARES participants who completed the Comprehensive Geriatric Assessment at both the baseline and 6-month follow-up periods.

BASELINE 6 MONTH FOLLOW UP

30% increase
Walking independently
27 › 35

67% increase
Exercising frequently
15 › 25

29% increase
Balance within normal limits
21 › 27

19% increase
No supports needed
32 › 38

59% increase
Health attitude
17 › 27

11% increase
Socially engaged
28 › 31

There was a statistically significant **decrease in the frailty index (FI) score** in seniors participating in CARES.

0.032
decrease from baseline to 6 month follow up

EQUIVALENT TO 2 LESS HEALTH PROBLEMS AT FOLLOW UP

Examples of Successful Integration

A small regional health system in Germany invested in heavily in health promotion and prevention for people living with chronic health conditions, including funding to support seniors to access physical activity programming and connect to community-based services. Over five years, the region realized significant health improvements and cost savings.

Restorative care is a multi-disciplinary model for delivering home health services which includes educational and rehabilitation resources to support seniors to better manage their health challenges, improve their functional capacity and re-engage with community. Resulted in increased independence for seniors, reduced use of health services and lower costs overall costs.

What Would a More Connected Wellness-Oriented Future for Seniors Look Like?

- Access to services in the seven core areas in every community: (1) Nutritional Supports, (2) Wellness Programs, (3) Physical Activities, (4) Recreation, Education and Arts Programming; (5) Information and Referral; (6) Transportation and (7) Affordable Housing.
- Primary Care and Home and Community Care Staff would know about these services and "prescribe" them as appropriate.
- There would one person from health authority in each community whose primary responsibility would be the bridge between the health system with the CBSS sector.
- CBSS sector would be recognized as a sector provincially. There would have resources to support capacity building of programs and services that have a proven track record, are cost effective and result in health improvements.

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RESIDENTIAL CARE BEDS, ASSISTED LIVING UNITS AND HOME SUPPORT SERVICES

(Information provided by health authorities July 2017)

SUMMARY:

Number of current or anticipated Request for Proposals (RFPs) for residential care and/or assisted living:

- Fraser Health – one Request for Expressions of Interest for 35 new residential care beds to be awarded in August
- Interior Health – no RFPs
- Northern Health – no RFPs for residential care beds due to open in near future
- Island Health – three RFPs for total of 140 to 162 new residential care beds
- Vancouver Coastal Health – 11 Request for Quotations (RFQs) for residential care beds

Plans for Residential Care and Assisted Living bed stock:

- Fraser Health – 35 new residential care beds (via Request for Expressions of Interest mentioned above)
- Interior Health – no RFPs
- Northern Health – currently in planning process utilizing service delivery models and projections
- Island Health – three RFPs for total of 140 to 162 residential care new beds
- Vancouver Coastal Health – 279 net new residential care beds out of the 1,382 bed rejuvenation project

Proportion of home support services by health authority for contracted (including for-profit and not-for-profit) versus owned and operated:

- Fraser Health – estimate of 70% contracted and 30% owned and operated
- Interior Health – estimate of 18% contracted and 82% owned and operated
- Northern Health – 100% owned and operated, except occasional use of contracted service due to increased demand or staff shortages
- Island Health - 53% contracted and 47% owned and operated services
- Vancouver Coastal Health – 100% contracted within the Richmond and Vancouver Health Service Delivery Areas (HSDA) and 10-15% contracted and 85 – 90% owned and operated in the North Shore/Coastal Garibaldi HSDA

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BRITISH COLUMBIA | Ministry of Health

Report 2 - Facilities and Beds by Owner Type

Date: **May 12, 2017**

Client: **Ministry of Health & Health Authorities**

Author: **Community & Cross Sector Branch, Health Sector Information, Analysis and Reporting Division, Ministry of Health**

Project #: **2017_0213** *Please reference the project # when making inquiries about this report.*

Filename: ***Rpt 02 - Facilites and Beds by Owner Type- March 2017.xlsx***

Source: **March 2017 Submissions from Health Authorities**

Tabs:

Cover Page	
Owner Type	

Notes: ***Group Homes are excluded from the count***

Privacy Statement: *The information contained in this/these spreadsheet(s) is of a summary nature and may be released in its entirety (Cover Sheet and relevant Tabs) for the purpose for which it was provided. However, as it was prepared to address a specific question, other use or manipulation of the data is not permitted.*

Beds and Facilities by Owner Type Report (as of March 31, 2017)

Providers without bed number (0 or Null) are excluded

% Residential Care *Beds* by Owner Type as of March 31

% Assisted Living *Units* by Owner Type as of March 31

	Health Authority	Private for Profit	Private not for Profit	To Be Determined	Total
IHA	2605	2452	762	0	**5819**
	44.8%	42.1%	13.1%	0.0%	
FHA	1796	3450	3326	0	**8572**
	21.0%	40.2%	38.8%	0.0%	
VCHA	1951	1743	3114	8	**6816**
	28.6%	25.6%	45.7%	0.1%	
VIHA	1712	1769	2013	0	**5494**
	31.2%	32.2%	36.6%	0.0%	
NHA	1033	131	20	0	**1184**
	87.2%	11.1%	1.7%	0.0%	
BC	9097	9545	9235	8	**27885**
	32.6%	34.2%	33.1%	0.0%	

	Health Authority	Private for Profit	Private not for Profit	To Be Determined	Total
IHA	6	419	506	0	**931**
	0.6%	45.0%	54.4%	0.0%	
FHA	0	619	774	0	**1393**
	0.0%	44.4%	55.6%	0.0%	
VCHA	30	173	657	0	**860**
	3.5%	20.1%	76.4%	0.0%	
VIHA	0	371	608	0	**979**
	0.0%	37.9%	62.1%	0.0%	
NHA	147	35	108	0	**290**
	50.7%	12.1%	37.2%	0.0%	
BC	183	1617	2653	0	**4453**
	4.1%	36.3%	59.6%	0.0%	

Beds and Facilities by Owner Type Report (as of March 31, 2017)

Providers without bed number (0 or Null) are excluded

% *Facilities* with Residential Care Beds by Owner March 31

% *Facilities* with Assisted Living Units by Owner Type as of March 31

	Health Authority	Private for Profit	Private not for Profit	To Be Determined	Total
IHA	46	50	10	0	**106**
	43.4%	47.2%	9.4%	0.0%	
FHA	16	40	33	0	**89**
	18.0%	44.9%	37.1%	0.0%	
VCHA	19	15	35	1	**70**
	27.1%	21.4%	50.0%	1.4%	
VIHA	21	43	23	0	**87**
	24.1%	49.4%	26.4%	0.0%	
NHA	22	2	4	0	**28**
	78.6%	7.1%	14.3%	0.0%	
BC	124	150	105	1	**380**
	32.6%	39.5%	27.6%	0.3%	

	Health Authority	Private for Profit	Private not for Profit	To Be Determined	Total
IHA	1	23	16	0	**40**
	2.5%	57.5%	40.0%	0.0%	
FHA	0	16	16	0	**32**
	0.0%	50.0%	50.0%	0.0%	
VCHA	1	5	13	0	**19**
	5.3%	26.3%	68.4%	0.0%	
VIHA	0	13	19	0	**32**
	0.0%	40.6%	59.4%	0.0%	
NHA	6	1	10	0	**17**
	35.3%	5.9%	58.8%	0.0%	
BC	8	58	74	0	**140**
	5.7%	41.4%	52.9%	0.0%	

Residential Care Facilities by Category as of March 31, 2017

Percentage of Publicly Subsidized Facilities in BC with Residential Care Beds by Owner Type	Health Authority Owned	Private for Profit Owned	Private Not for Profit Owned
Interior Health Authority	43%	47%	10%
	46	50	10
Fraser Health Authority	18%	45%	37%
	16	40	33
Vancouver Coastal Health Authority	28%	22%	50%
	19	15	35
Vancouver Island Health Authority	24%	49%	26%
	21	43	23
Northern Health Authority	79%	7%	14%
	22	2	4
British Columbia	**33%**	**39%**	**28%**
	124	**150**	**105**

Planned Residential Care Net New Beds by Health Authority – Next 18 Months
(Information provided by health authorities November 2017)

	March 2018	September 2018	March 2019	Total
FHA	38 - Awarded to 4 proponents, 3 for-profit and 1 NFP	0	0	38
VCHA	0	0	0	0
IHA	0	83 (Kamloops and Penticton) – 18 with NFP, 65 with for-profit	160 (Salmon Arm, Williams Lake, Cranbrook) – all beds with for-profits	243
NHA	0	0	0	0
VIHA	0	0	0	0
TOTAL	**38**	**83**	**160**	**281**

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MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 1093465

PREPARED FOR: Honourable Ravi Kahlon, Parliamentary Secretary for Sport and Multiculturalism, and Honourable Anne Kang, Parliamentary Secretary for Seniors **- FOR INFORMATION**

TITLE: September 20, 2017 Meeting: Ethno-Cultural and Indigenous Seniors in British Columbia.

PURPOSE: To provide information for Parliamentary Secretaries Ravi Kahlon and Anne Kang in preparation for meeting with Mrs. Buncy Pagely and Mr. Raj Singh Pagely scheduled for September 20, 2017, to discuss the needs of ethno-cultural and indigenous seniors in BC.

BACKGROUND:
Mrs. Buncy Pagely, Chair of the Multicultural Working Group for the Office of the Seniors Advocate, requested a meeting with Parliamentary Secretary, Ravi Kahlon to discuss the needs of ethno-cultural and indigenous seniors in British Columbia. Given the nature of the request, it was suggested that Parliamentary Secretary Anne Kang also attend the meeting scheduled for September 20, 2017. Mrs. Buncy Pagely has been a very active volunteer, serving as a board member of the College of Dieticians of BC, the College of Registered Nurses of BC, as a member of the Aboriginal Advisory Panel in the Capital Health Region and is sole proprietor of Pagely Consulting-Coordinating. She was also the recipient of the Queen's Golden Jubilee Commemorative Medal for her work as a health care educator and has received the Women of Distinction Lifetime Achievement Award for her 45 years of community service.

Mr. Raj Singh Pagely (attending meeting) is a retired teacher and business person who served as a member of the Multicultural Advisory Council from 2005-2011. Mr. Pagely was a founder of the first Indian Field Hockey Team in Victoria, a former member with the Commonwealth Nations Multicultural Committee, the Smart Heart Educational Awareness Programs for the Multicultural Communities of BC and has served as the community health liaison with the Saanich Peninsula Health Association for the Peninsula First Nations. Mr. Pagely has been the recipient of the Honorary Citizen Award for the City of Victoria.

The Pagely's are very busy, community-minded people, both are founding members of the first Umbrella Association of Multiculturalism organizations in BC, AMSA, now called AMSSA (The Affiliation of Multicultural Societies and Service Agencies) and have become involved in establishing the Inter-Cultural Association of Victoria.

DISCUSSION:
The Office of the Seniors Advocate of British Columbia produced the report, Priorities for BC Seniors September 2016 which highlights the foundational richness of Canada's indigenous and ethno-cultural diversity of backgrounds reflected in the seniors' population. The report presents the following recommendations specific to culturally-sensitive care provision[1]:

[1] The Office of the Seniors Advocate. 2016. *Priorities for BC Seniors*. Accessed Electronically, https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2016/10/Council-Of-Advisors-Federal-Submission.pdf

- Through its mandate on multiculturalism, the Federal government should consider explicit expectations in its provision of Federal transfer payments to provinces.
- Initiatives include supporting the training of care providers in relation to different cultural norms, attitudes, beliefs and values.
- Governments must also work together to ensure that culturally appropriate patient-centred care across all sectors of the health system is the norm.
- Culturally sensitive care must consider food, religion, customs and cultural traditions that will improve patient well-being that, in turn, will lead to faster healing times and more optimal use of health care resources.

Section 3 of the BC Multiculturalism Act states that it is the policy of government to: "(g) recognize the inherent right of each British Columbian, regardless of race, cultural heritage, religion, ethnicity, ancestry or place of origin, to be treated with dignity, and (h) Generally, carry on government services and programs in a manner that is sensitive and responsive to the multicultural reality of British Columbia."

The ethnicity of British Columbians is widely varied. The scheduled release of the "Immigration and Ethno-cultural Diversity, Housing, Aboriginal Peoples' Report in October 2017, is highly anticipated as a significant source of current information about ethnicity and culture. Presently, the most accurate information which reflects the ethnicity of British Columbia's population is available from, The 2006 Mandatory Census – by selected ethnic origin, The 2011 Census by Metropolitan Area - By count, percentage distribution and relative ratio of total, immigrant and recent immigrant population by major city, and The 2011 Census by Metropolitan Area - Visible minority population and top three visible minority groups, selected census metropolitan areas, Canada.

Within BC, the Provincial Health Services Authority has developed an Indigenous Cultural Safety Training Program designed to increase knowledge, enhance self-awareness, and strengthen skills of those who work directly and indirectly with Indigenous people. Health authorities have made cultural safety training a priority for employees, physicians, contractors, students, community support professionals, and volunteers to complete the training. Health Authorities work in partnership with agencies and ethnic groups to deliver culturally appropriate care in areas of significant diversity, i.e. – China Town Care Center in Victoria, BC.

ADVICE:
Awareness of cultural diversity is an essential element in the design and delivery of seniors care across British Columbia. For diversity to bring strength, it must be valued and integrated into care practices and philosophy. The report recommendations support the need for education and policy leverage the diversity in the seniors' population in British Columbia.

Program ADM/Division: Sharon Stewart, Primary and Community Care Policy
Telephone:250 216-9748
Program Contact (for content): Kathy Chouinor, Ministry of Health
Drafter: Kathy Chouinor, Strategic Advisor, Seniors Services, Primary & Community Care Policy
Date: September 18, 2017

Singh, Jasmyn HLTH:EX

From: Kang, Anne s.17
Sent: Monday, September 18, 2017 3:35 PM
To: Singh, Jasmyn HLTH:EX
Subject: RE: Senior's Guide in Farsi

Hi Jasmyn,

Bowinn is the MLA of Vancouver Londsdale, which has a high population of Farl speakers. Do we have any Senior's Guide in Farsi? Or, would the ministry consider increasing the availability of translated guides?

Thanks for looking into this,
Anne Kang

From: Ma, Bowinn
Sent: Friday, September 15. 2017 5:56 PM
To: Kang, Anne s.17
Subject: Senior's Guide in Farsi

Hi Anne,

I'm wondering if the Senior's Guide can be translated to Farsi. Are you able to find out?

In your service,

Bowinn Ma, MLA
North Vancouver-Lonsdale
Sḵwx̱wú7mesh-ulh Temíxw & sallilwata?ł tamaxʷ

Office: 604-981-0033 | Direct: 604-981-0043 | 5-221 W. Esplanade Ave, North Vancouver, BC, V7M 3J3 | BowinnMaMLA.ca

Singh, Jasmyn HLTH:EX

From: Kang, Anne s.17
Sent: Saturday, July 22, 2017 3:05 PM
To: Singh, Jasmyn PREM:EX
Subject: Wednesday meeting

Hi Jasmyn,

Min. Dix has spoken to me about a possible Wednesday meeting and a schedule with the agenda. That way I can be better informed of which part of the meeting I should be part of and when to arrive in Victoria.

Keep in touch~
Thanks for setting up the meeting :)

Anne Kang

Sent from my iPhone

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