



# Improving Quality of Life for Residents in Facility-Based Continuing Care

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Alberta Facility-Based Continuing Care Review Recommendations  
Final Report – April 30, 2021

Prepared for Alberta Department of Health

**MNP**

## Acknowledgements

We extend our thanks to Alberta Health team members for their tremendous support and dedication, without which this project could not have been so well executed. Thanks go also to the members of the Expert Panel for their thoughtful inputs and sage advice along the way, and to the many individuals and organizations who participated in virtual interviews. We also extend appreciation to the organizations and individuals too numerous to mention here, for special briefings prepared for the MNP Team. Lastly, we extend a heartfelt thank you to the residents and family members who so openly shared their stories in the hope that their input would lead to improvements in facility-based continuing care in Alberta.

# Executive Summary

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Alberta's continuing care system provides Albertans with the health, personal care, and accommodation services they need to support their independence and quality of life. Any Albertan can receive continuing care services, no matter their age, diagnosis, or the length of time they need support. Eligibility is based entirely on a professional assessment of a person's unmet need for continuing care services and supports.

Continuing care services may be provided in different settings including individuals' homes, community-based service locations, such as adult day programs, supportive living facilities and facility-based continuing care (FBCC) which include designated supportive living (DSL) and long-term care (LTC). Long-term care is provided for people with complex medical needs who are unable to remain safely at home or in a supportive living setting, and residents receive accommodation, meals and 24-hour on-site professional nursing and personal care. Designated supportive living provides the highest level of care out of all supportive living settings needs across a range of care and services including DSL4D, DSL4 and DSL3, and includes access to 24-hour personal and professional nursing care.

A person's physical surroundings play an important role in creating a sense of meaning and organization in their lives and is closely tied to a sense of who they are. A person's "home" is the place where they feel in control and properly oriented in space and time<sup>1</sup>. Accordingly, it is important for one to feel at "home" wherever they may live, including in FBCC. The Facility-Based Continuing Care Review ("the Review") was commissioned by Alberta Health to identify systemic changes required to improve the lives of continuing care residents and their families, the satisfaction and quality of work environment for staff and operators, and also what changes can be made to modernize the overall FBCC service delivery model.

Information and data informing the analyses and ultimately the development of the report was collected from four distinct sources, including stakeholder engagement, expert panel advice, literature/jurisdictional review, and analysis of FBCC information/data. MNP received survey feedback from over 7,000 Albertans and completed over 90 interviews/groups interviews with key informants.

The review highlights several strengths in FBCC that can be built upon to improve the delivery of services including:

- A highly skilled and dedicated workforce that has strong and trusted relationships with residents and their family members
- Residents and family members who feel they are treated with dignity and respect at FBCC sites
- Well established and valid clinical assessment tools
- Robust financial management tools and performance monitoring systems

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McAndrew, F. Home is Where the Heart Is, but Where is "Home"? Psychology Today <https://www.psychologytoday.com/us/blog/out-the-ooze/201508/home-is-where-the-heart-is-where-is-home>

- A solid baseline of operating standards
- A centralized health authority to administer FBCC services, and
- A diversity of ownership types which uniquely contribute to the diversity, efficiency, and effectiveness of the Alberta continuing care system

Further, there was significant evidence that Alberta Health, Alberta Health Services (AHS), and FBCC operators worked collaboratively to respond to the COVID-19 pandemic, and made many adjustments over the last 12 months based on lessons learned to improve the response to the pandemic that can be carried forward for future pandemic planning.

The review also found that there were several challenges and issues existing in FBCC prior to the COVID-19 pandemic, that were amplified by the pandemic itself. These issues identified many opportunities for improvement including:

- An increased focus on quality of life and person-centered care for all FBCC residents
- Improving the provision of culturally appropriate services and inclusion at FBCC sites
- Improving the quality of care provided to those living with dementia
- Increasing client choices for care and the use of self-directed care models
- Improving the coordination of FBCC services with other health and social services, making continuing care services easier to navigate
- Increasing the direct hours of care for nurses, health care aides (HCAs), and therapy staff (e.g. occupational therapy, physical therapy, recreational therapy, etc.)
- Improving mental health and wellness supports for staff
- Increasing the level of full-time employment opportunities for some positions
- Enhancing working conditions for staff (e.g. wages, benefits, workplace supports, training opportunities, empowerment)
- Improving coordination for monitoring and inspections, changing the focus of audits from tasks/processes to outcomes
- Optimizing the use of technology in FBCC
- Applying learning from the COVID-19 pandemic experience to prevent the future spread of infectious diseases
- Replacing aged facilities that no longer meet current design standards
- Eliminating shared rooms and funding the development of new types of spaces (e.g. smaller congregate settings, campuses of care, etc.)

## Recommendations and Policy Directions

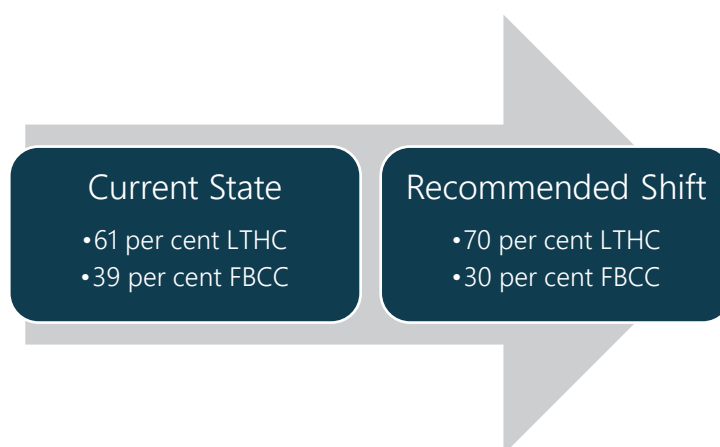
The improvement opportunities identified informed the development of 42 recommendations that were grouped into 11 policy directions.

<b>Policy Direction 1:</b> Establish Quality of Life as the number one priority goal for Alberta's continuing care system. <b>Recommendations 1 - 7</b>	<b>Policy Direction 2:</b> Enhance overall Quality of Care with emphasis on residents living with dementia. <b>Recommendations 8 &amp; 9</b>	<b>Policy Direction 3:</b> Improve the provision of culturally appropriate continuing care services. <b>Recommendations 10 &amp; 11</b>
<b>Policy Direction 4:</b> Improve coordination in the continuing care system, making it easier to navigate for the client and better integrated with other health, community, and social services. <b>Recommendations 12 - 15</b>	<b>Policy Direction 5:</b> Increase staffing hours and consistency of staffing to improve quality of care. <b>Recommendations 16 - 19</b>	<b>Policy Direction 6:</b> Develop a Workplace Improvement Action Plan to enhance working conditions for staff working in both FBCC and home care. <b>Recommendations 20 - 22</b>
<b>Policy Direction 7:</b> Expand the choices available to Albertans who require continuing care services. <b>Recommendations 23 - 25</b>	<b>Policy Direction 8:</b> Consolidate monitoring processes and improve the coordination of inspections, while enhancing accountability and public reporting. <b>Recommendations 26 - 29</b>	<b>Policy Direction 9:</b> Optimize the use of technology, research, and innovation in transforming FBCC. <b>Recommendation 30</b>
<b>Policy Direction 10:</b> Ensure sustainability and affordability for the future of continuing care. <b>Recommendations 31 - 35</b>	<b>Policy Direction 11:</b> Learn from the COVID-19 experience to prevent the spread of infectious diseases in FBCC sites and improve resident quality of life and care. <b>Recommendations 36 - 42</b>	<b>Total Number of Recommendations: 42</b>

## Demand for Continuing Care Services and Recommended Shift in Distribution of Services

The Review projects that the demand for continuing care services will grow by 62 per cent by the year 2030. To meet this growing demand, while ensuring suitability and affordability of the system, a significant shift is required such that a greater portion of continuing care services are delivered in the home/community through long-term home care (LTHC) services rather than through FBCC. This shift is also consistent with recommended improvements related to quality of life, client choices and the ability to live at home/community longer and increasing the use of self-directed care.

Accordingly, it is recommended that Alberta consider shifting its current distribution of continuing care services from 61 per cent LTHC and 39 per cent FBCC, to a ratio of 70 per cent LTHC and 30 per cent FBCC services.



The projected economic impact of shifting to a ratio of 70 per cent LTHC and 30 per cent FBCC by the year 2030 is:

- A reduction in annual operating costs of \$452 million
- Cumulative capital cost savings of \$1.7 billion

The annual operating cost reduction of \$452 million is slightly lower than the added costs of \$498 million that result from increasing direct hours of care to an average of 4.5 hours per resident day for LTC, 4.0 hours per resident day for DSL4D, and 3.5 hours per resident.

To keep the momentum established by the FBCC Review, the next important activity will be to develop action plans for implementing each of the 42 recommendations outlined in the report. Action planning will include the development of implementation working groups, including members from across stakeholder groups who informed the Review recommendations.

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# Purpose of the Review

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# 1 Purpose of the Review

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## 1.1 Purpose and Objectives of Review

Alberta's continuing care system provides Albertans with the health, personal care, and accommodation services they need to support their independence and quality of life. Any Albertan can receive continuing care services, no matter their age, diagnosis, or the length of time they need support. Eligibility is based entirely on a professional assessment of a person's unmet need for continuing care services and supports.

Continuing care services include assistance with dressing, eating and bathing, meal preparation, respite, wound care, medication administration, and various other health care and support services. These services and supports may be provided in different settings including individuals' homes, community-based service locations, such as adult day programs, supportive living facilities and facility-based continuing care (FBCC) which include designated supportive living (DSL) and long-term care (LTC).

Long-term care is provided for people with complex medical needs who are unable to remain safely at home or in a supportive living setting. In LTC, residents receive accommodation, meals and 24-hour on-site professional nursing and personal care.

Designated supportive living is unique to Alberta. It provides the highest level of care out of all supportive living settings and includes access to 24-hour personal and professional nursing care. Alberta Health Services (AHS) assesses individuals for their health and personal care needs and coordinates access to the designated spaces according to those needs across a range of care and services including DSL4D, DSL4 and DSL3. Residents of DSL receive 24-hour on-site, scheduled and unscheduled, personal care and support services from health care aides and/or licensed practical nurses.

A person's physical surroundings play an important role in creating a sense of meaning and organization in their lives and is closely tied to a sense of who they are. A person's "home" is the place where they feel in control and properly oriented in space and time<sup>1</sup>. Accordingly, it is important for one to feel at "home" wherever they may live, including in FBCC.

The Facility-Based Continuing Care Review ("the Review") was commissioned by Alberta Health to identify systemic changes required to improve the lives of continuing care residents and their families, the satisfaction and quality of work environment for staff and operators, and also what changes can be made to modernize the overall FBCC service delivery model.

This Review aimed to assess the existing FBCC model in Alberta and provide recommendations for improving residents' quality of life and care, while enhancing transparency, accountability, and efficiency<sup>2</sup> within the system. Further, considerations were made regarding how best to prevent and manage episodes of transmittable illnesses that affect residents such as influenzas, the annual flu season, Norwalk virus, and pandemics. Though DSL and LTC facilities were the focus of the Review, recommendations were made within the context of the overall continuing care system including hospitals and home care, as well as other concurrent and related initiatives that were taking place

during the Review (i.e., the development of a new continuing care legislative framework, home care redesign, and COVID-19 learnings).

The focus of the Review was to develop recommendations for improvement to address long-lasting systemic issues that existed prior to the COVID-19 pandemic, which were subsequently magnified by the pandemic. However, the Review captured feedback from Albertans regarding their experiences with FBCC during the pandemic as well.

The objectives and scope of the Review included:

- Evaluating existing FBCC model against leading or best practices
- Assessing and articulating opportunities for improvement regarding:
  - Quality of life for residents
  - Quality of care provided
  - Staffing mix and models
  - Workforce conditions
  - Cost effectiveness of FBCC service delivery and outcomes
  - Enhanced accountability
  - Enhanced resident, family, and public communication
- Producing identifiable and implementable recommendations and associated actions to improve FBCC
- Informing new continuing care legislation

## 1.2 Background and Context for Review

A major challenge for FBCC services in Alberta moving forward will be to both absorb ever-increasing demands for continuing care services and adjust to changing expectations. Accordingly, Alberta will need to consider adjusting the types and mixture of continuing care services provided in the future to meet these challenges.

Alberta's senior population is aging. In 2019, 13 per cent of the population was over 65 years of age. This proportion is expected to increase to 20 per cent by 2046, when one in five Albertans will be aged 65 and older. Persons over 80 years of age are expected to experience the highest growth with an expected increase of around 225 per cent<sup>3,4</sup>. This age group will be the highest user of health services, placing a major demand on acute care and continuing care services.

The emerging population of seniors has characteristics different from those of the current generation and includes the baby boomers. On average, future seniors are expected to be more educated, have higher incomes, desire increased choice and independence, and want to be active and engaged in the community. They are also characterized by more cultural diversity and a better knowledge of technology. They desire to "age in place" and stay in the community to receive care. They expect a higher quality of services, and their care needs will tend to be more complex when moved to FBCC (e.g. dementia care, palliative care). With different lifestyles, service preferences, and demand for choices, they will significantly impact the types of continuing care services provided in the coming decade<sup>5,6,7,8</sup>.

# Approach and Methodology

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## 2 Approach and Methodology

Information and data informing the analyses and ultimately the development of the report was collected through four unique sources, including stakeholder engagement, expert panel advice, literature/jurisdictional review, and analysis of FBCC information/data. Further details regarding each method are provided in the sections that follow.

*Figure 1: Data/Information Sources Informing the FBCC Review*



### 2.1 Stakeholder Engagement

Figure 2 provides a summary of the stakeholder engagement activities completed to inform the Review. A total of 7,098 survey responses were completed through nine online surveys which were active from January 4 to February 1, 2021. A total 94 virtual interviews/group interviews were completed with representatives from different stakeholder groups from October 26, 2020 to February 12, 2021.

*Figure 2: Summary of Stakeholder Engagement Activities*

Stakeholder Group	Survey Responses	Interviews/ Group Interviews
Public	1,512	0
Residents	179	3
Families/Caregivers	3,821	14
FBCC Administrators	233	6
FBCC Staff - HCA	267	0
FBCC Staff - Nurses	309	0
FBCC Staff - Prof Therapy	306	0
FBCC Staff All Other	352	0
External Organizations	119	35

Stakeholder Group	Survey Responses	Interviews/ Group Interviews
Indigenous Groups*	N/A	6
Government of Alberta/ Alberta Health Services (AHS)*	N/A	30
<b>Total</b>	<b>7,098</b>	<b>94</b>

\*Note, dedicated survey tools were not developed for Indigenous Groups or Government of Alberta/AHS representatives, and the number of surveys completed by these individuals was not tracked as survey responses were kept anonymous.

## 2.2 Expert Panel Advice

The Minister of Health appointed an Expert Panel to discuss issues relating to the FBCC Review. MNP facilitated a total of eight sessions with the Expert Panel. The Panel provided advice and improvement suggestions for many of the areas reviewed, as well as feedback and comments on the stakeholder engagement strategy, preliminary recommendations, and the draft report. The Panel was chaired by the MLA of Calgary-Fish Creek, Richard Gotfried, with the membership consisting of 15 experts from a variety of areas, including academics, clinicians, administrators, facilities operators, a FBCC resident and resident family members, and one Indigenous representative.

## 2.3 Literature Review of National and International Leading Practices

Relevant national, international and Alberta literature, reports and articles were reviewed to help inform improvement recommendations. Particular attention was paid to leading-edge practices in many countries such as the United States of America, United Kingdom, Australia, Denmark, Netherlands, Germany, and Japan, as well as other provinces from across Canada. Overall, MNP reviewed over 150 documents/articles/reports, many of which are cited in Appendix 4.

## 2.4 Data Analyses

MNP analyzed data sets provided by Alberta Health, AHS and Alberta Seniors and Housing. Key data sets analyzed included:

- Financial Information Reporting Management System (FIRMS) data
- Alberta Continuing Care Information System (ACCIS) data
  - Admissions
  - Discharges
  - Case Mix Index (CMI) and Resource Utilization Group (RUG)-III data
  - Outcome data sets including:
    - Depression rating scale (DRS) data
    - Changes in health, end-stage disease, and signs and symptom data (CHESS)
    - Pain scale data (PAIN)

- Activities of daily living (ADL) data sets
  - Index of social behaviour data (RISE)
  - Cognitive Performance Scale (CPS) data
  - Pressure Ulcer Risk Scale (PURS) data
  - Aggressive Behaviour Scale (ABS) data
- Quality indicators
- AHS data sets including:
  - CMI and RUG-III data
  - Outcome data sets including:
    - DRS data
    - CHESS data
    - PAIN data
    - ADL data sets
    - RISE data
    - CPS data
    - PURS data
    - ABS data
  - FBCC length of stay data
  - Hospital admission rate data (inpatient and emergency department) for FBCC residents
  - Health system planning scenario data and reports
    - Custom scenarios for continuing care service levels in the year 2030
- Alberta Seniors and Housing – supplementary accommodation benefit data

## 2.5 Dynamic Financial Model Development

MNP developed an integrated dynamic financial model in Microsoft Excel that allowed a multitude of variables to be modified in real time to support decision making for recommendation development. The integrated dynamic financial model quantified the relative financial impacts of implementing changes identified by the FBCC Review which included but was not limited to:

- **Distribution of Care Across Environments** - Level of service delivery and associated operating costs for LTC, DSL and home care for the status quo, low, medium, and high change scenarios, including a comparison of the projected total costs for each scenario
  - MNP examined long-term home care (LTHC) costs from the perspective of caring for higher acuity clients in the community
- **Increasing Direct Hours of Care** - Increasing direct hours of care and the impacts this will have on facility operating costs. Scenarios examined included:
  - Impacts of changing the proportions of Registered Nurse (RN), Licensed Practical Nurse (LPN) and Health Care Aide (HCA) staffing levels in the staffing mix
  - Impacts of adding professional therapy services into the staffing mix for direct hours of care



- **Capital Spending Requirements** - Impacts related to capital spending requirements associated with different care scenarios including:
  - Adding new beds to meet expected capacity increases for FBCC under each change scenario (status quo through high change)
  - Replacing/refurbishing existing aged infrastructure (30 years or older), including shared accommodations
- **Implementing a Self-Directed Care System** - Impacts related to incorporating a self-directed care system were determined. To do so, assumptions were made related to:
  - Proportion of residents receiving care under the self-directed care model, including by stream
  - The costs per day under the self-directed care model (including by stream)
  - The costs of administering the self-directed care model

## 2.6 Report Limitations

MNP has relied upon the completeness, accuracy, and fair presentation of all information and data obtained through the various stakeholder consultations completed, along with documents and data sets that were made available by March 31, 2021. The accuracy and reliability of the findings and opinions expressed in this report are conditional upon the quality of this same information.

Additionally, the findings and expressed opinions constitute judgments as of the date of the report and are subject to change without notice. MNP is under no obligation to advise of any such change brought to its attention which would alter those findings or opinions.

Further, the Review findings were limited by the following factors:

- **Limitations in Interviewing FBCC Residents and Caregivers/Families** – Due to the stress created by the COVID-19 pandemic, Alberta Health and MNP made a conscious decision to not actively pursue interviews with FBCC residents and caregivers/families. Instead, residents and caregivers were given the option to contact MNP directly for an interview based on communication through the FBCC operators. This resulted in a total of 17 virtual interviews, a significant reduction to the original stakeholder engagement plan.
  - To mitigate this limitation, MNP developed separate online surveys for residents and caregivers and received a total of 4,000 completed responses. The surveys provided respondents with the opportunity to provide quantitative feedback and qualitative feedback through comment boxes.
- **Limitations in Interviewing FBCC Staff** - Due to the stress created by the COVID-19 pandemic, Alberta Health and MNP made a conscious decision to not conduct any interviews with FBCC staff.
  - To mitigate this limitation, MNP developed four (4) separate online surveys for different groups of staff including HCAs, nurses, professional therapy, and all other staff, and received a total 1,234 completed responses. The surveys provided respondents with the opportunity to provide quantitative feedback and qualitative feedback through comment boxes.

# Review Findings

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## 3 Review Findings

The findings and recommendations (Section 4) for the FBCC review have been organized by 11 policy direction themes (Figure 3).

Figure 3: Report Policy Direction Themes

<b>Policy Direction 1:</b> Establish Quality of Life as the number one priority goal for Alberta's continuing care system.	<b>Policy Direction 2:</b> Enhance overall Quality of Care with emphasis on residents living with dementia.	<b>Policy Direction 3:</b> Improve the provision of culturally appropriate continuing care services.
<b>Policy Direction 4:</b> Improve coordination in the continuing care system, making it easier to navigate for the client and better integrated with other health, community, and social services.	<b>Policy Direction 5:</b> Increase staffing hours and consistency of staffing to improve quality of care.	<b>Policy Direction 6:</b> Develop a Workplace Improvement Action Plan to enhance working conditions for staff working in both FBCC and home care.
<b>Policy Direction 7:</b> Expand the choices available to Albertans who require continuing care services.	<b>Policy Direction 8:</b> Consolidate monitoring processes and improve the coordination of inspections, while enhancing accountability and public reporting.	<b>Policy Direction 9:</b> Optimize the use of technology, research, and innovation in transforming FBCC.
<b>Policy Direction 10:</b> Ensure sustainability and affordability for the future of continuing care.	<b>Policy Direction 11:</b> Learn from the COVID-19 experience to prevent the spread of infectious diseases in FBCC sites and improve resident quality of life and care.	<b>Federal Funding and Standards (Findings Only)</b>

The findings for Policy Direction themes 1 and 2 have been presented together, and the findings related to federal funding and standards have been presented independently of any policy direction.

MNP has organized the findings for each theme into four sub-sections including:

- Current context (including strengths and areas of opportunity)
- What we heard from the stakeholder engagement
- Leading practices/other jurisdictional research
- Policy directions and recommendations (except for federal funding and standards)

### 3.1 Quality of Life and Quality of Care



The findings for quality of life and quality of care have been presented together because quality of care was considered a significant contributor to quality of life.

#### 3.1.1 Current Context

Alberta Health currently funds FBCC services under two streams of services: LTC and DSL. Alberta is the only province in Canada that formally funds a DSL stream. Both are delivered through a traditional residential care model.

Many new models of care have been introduced in Alberta such as:

- The Assisted Living Model in Wedman House
- The Life Lease Model in Laurier House, CapitalCare McConnell Place (Dementia Homes), and Shepherd's Care Kensington Village
- The Butterfly Household Model of Care (as designed by Dr. David Sheard, *UK Dementia Matters*) in various locations<sup>9</sup>

These models value the quality of life of residents and person-centred care; and have special facility designs. Person-centred care is a philosophy that recognizes that individuals have unique values, personal history, and personality and that each person has an equal right to dignity, respect, and to participate fully in their environment<sup>10</sup>.

### 3.1.1.1 Strengths

Health Quality Council of Alberta (HQCA) survey data has found that FBCC residents and family members overall are satisfied with the services provided at FBCC sites as evidenced by: 93 per cent of LTC family members, 90 per cent of DSL residents, and 94 per cent of DSL families having a willingness to recommend their facilities to others.

Many FBCC sites, on their own initiative, have advocated for person-centred care and participated in training programs such as the Eden philosophy training, and the *"7 Key elements of person-centred care for people with dementia in long-term care homes"* by the Alzheimer Society of Canada.

In 2018, Alberta Health held discussions with operators and relevant associations' representatives in its Minister's Annual Continuing Care Forum regarding the future vision for continuing care. As a result of these consultations, four features were identified as the future continuing care vision and outcomes:

1. Person-Centred Care
2. Quality and Safety
3. Access
4. Sustainability

### 3.1.1.2 Areas of Opportunity

#### Modify Acts and Standards to Focus More on Quality of Life

The focus of the *Continuing Care Health Services Standards*, the *Nursing Homes Act*, and other related legislation is to support the delivery of quality health care to Albertans. There is an opportunity to modify existing legislation to be more focused on resident quality of life moving forward.

#### Recognize Importance of Primary Caregivers

With an intimate understanding of FBCC residents, primary caregivers can play many roles in the care and supports of residents. Examples include:

- Companionship and emotional support for residents
- Assisting in the provision of care activities such as eating, assistance in toileting, mobility (if residents prefer)

- Providing input into the development of care plan

It is estimated that primary caregivers provide between 30 to 40 per cent of the care provided in FBCC<sup>11</sup>. As the focus for FBCC shifts more towards person-centered care, with more options and choices of how and where residents receive services, primary caregivers will have greater responsibilities. It is important to recognize the role that primary caregivers play in FBCC, and to provide them with the necessary supports to reduce caregiver burnout.

## 3.1.2 What We Heard

### 3.1.2.1 Expert Panel

The Expert Panel members reported that the quality of life for residents could be improved through:

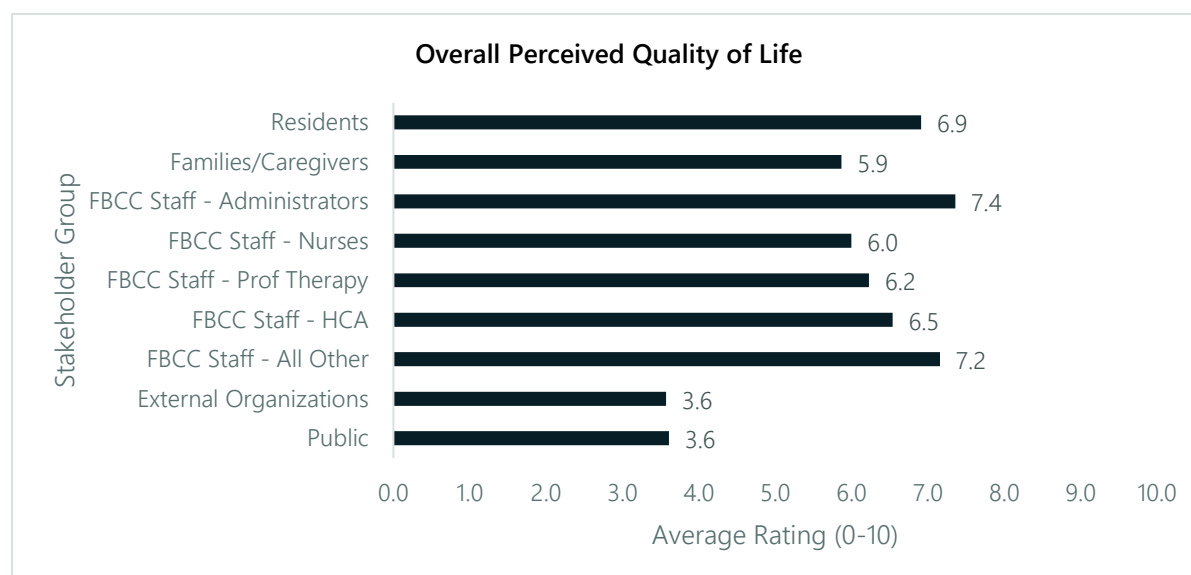
- Having more resident centred models of care
  - Supporting residents to age in place – care should come to the resident instead of the resident moving
- Improving food and meal quality
- Improving the physical environment for FBCC residents – having spaces that are conducive to walking and moving and no shared rooms
- Improving social interaction for clients
  - Improving the ability to interact with family members, friends, and caregivers
- Enhancing family involvement in care
- Improving meaning for FBCC residents
  - Creating opportunities for meaningful contribution to the community (e.g. helping set the table, growing vegetables, etc.)
  - Increasing opportunities for volunteerism by residents
  - Increasing diversity of cultural choices
- Staffing models
  - Decreasing the number of different staff that care for residents
  - Increasing the number of front-line staff available to provide care

### 3.1.2.2 Surveys and Interviews/Focus Groups

#### Quality of Life

Overall, respondents to the resident, family/caregiver, FBCC staff, and FBCC administrator surveys rated the overall quality of life for FBCC residents at 5.9 to 7.4 out of 10 (Figure 4). This was about 2.3 – 3.8 points higher than the ratings provided by respondents to the public and external stakeholder surveys.

Figure 4: Perceived Overall Quality of Life Ratings by Survey Respondents<sup>2</sup>



Survey respondents further rated the quality of life for multiple attributes on a scale of 0 (area for improvement) to 10 (strength). A summary of these ratings by stakeholder group is provided in Figure 5. The attributes with the highest ratings by residents and families/caregivers included security and safety, relationships with staff, resident autonomy, and resident dignity. The attributes with the lowest ratings included quality of meals, access to internet/technology, recreational activities, and physical facilities.

Figure 5: Summary of Ratings for Different Dimensions of Quality of Life

Quality of Life Attribute - Scale of 0 to 10 - 0 – Needs Improvement to 10 Strength										
Stakeholder Group	Physical Facilities	Quality of Meals	Security and Safety	Support for Families/Friends	Supporting Connections with Families/Friends	Relationships with Staff	Recreational Activities	Resident Dignity	Resident Autonomy	Access to Internet/Technology
Residents	6.3	5.3	7.5	7.1	6.9	7.4	5.9	7.1	7.3	5.5
Families /Caregivers	6.6	6.2	7.7	6.3	6.0	7.3	5.7	7.0	6.4	6.3
FBCC Staff - Administrators	6.7	7.5	8.1	7.5	7.7	8.3	7.5	8.0	7.4	5.9
FBCC Staff - Nurses	5.8	5.6	6.9	6.5	6.5	7.5	5.9	6.8	6.1	4.9
FBCC Staff - Prof Therapy	5.4	6.1	7.6	6.7	6.9	7.4	7.2	6.6	5.7	6.0

<sup>2</sup> FBCC Staff – All Other refers to all staff positions not included in the categories of administrators, nurses, professional therapies, and HCAs and includes positions such as non-professional therapy staff, food services staff, clerical support staff, education staff, housekeeping staff, laundry/linen staff, and maintenance and operation staff.

Quality of Life Attribute - Scale of 0 to 10 - 0 – Needs Improvement to 10 Strength										
Stakeholder Group	Physical Facilities	Quality of Meals	Security and Safety	Support for Families/Friends	Supporting Connections with Families/Friends	Relationships with Staff	Recreational Activities	Resident Dignity	Resident Autonomy	Access to Internet/Technology
FBCC Staff - HCA	6.1	6.0	7.1	6.9	7.0	7.7	6.1	7.3	6.5	4.9
FBCC Staff All Other	6.8	6.8	8.1	7.4	7.4	8.0	7.1	7.7	7.1	3.7
External Organizations	3.5	4.3	5.0	4.6	4.2	5.6	4.5	3.9	3.7	6.8
Public	3.8	3.9	4.8	4.2	4.1	5.0	4.4	3.7	3.6	6.8

Residents, caregivers, nurses and HCAs were further asked to rate quality for 43 measures along 10 dimensions of comfort, security, meaningful activity, relationships, functional competence, enjoyment, privacy, dignity, autonomy, and spiritual well-being, based on the assessment tool developed by Dr. Rosalie Kane<sup>12</sup>. Dimensions scoring well included comfort (except for pain management), security, relationships, functional competence, privacy, dignity, autonomy, and spiritual wellbeing. Dimensions with lower scores and opportunities for improvement included pain management, meaningful activities, and enjoyment (related to food and meals).

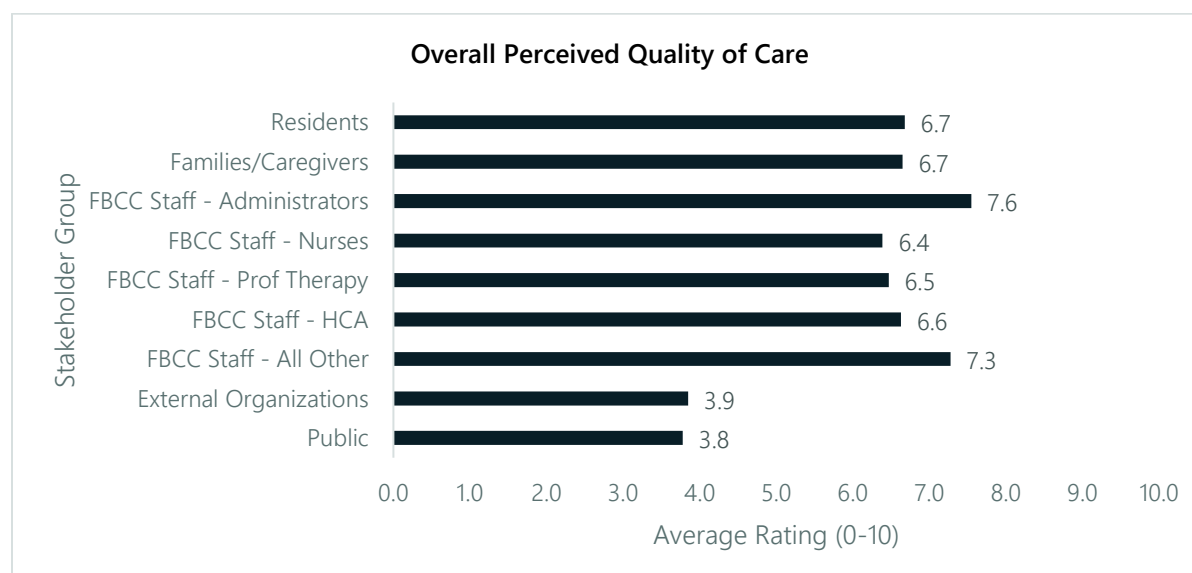
When asked about opportunities to improve FBCC resident quality of life, the following themes were identified from the surveys and interviews:

- Shift the culture for FBCC care from a clinical task-orientated medical model toward a holistic, relational, person-centered model of care which considers one's social, emotional, and behavioral sides
- Provide supports that allow Albertans to age in place as long as possible, and delay admission into FBCC if it is safe to do so
  - Include home care more deliberately in the continuing care model and provide the right level of care in the individual's home before moving to FBCC
- Increase recreation opportunities for FBCC residents
- Increase the quality and variety of food provided
- Improve the design of facilities to provide more space for activities, dementia-friendly features, and eliminate shared rooms
- Increase opportunities for visitations and social interactions for FBCC residents to reduce social isolation
- Improve access to technology and internet
- Improve cultural sensitivity to ensure that FBCC programs and services are provided in a culturally safe environment

## Quality of Care

Overall, respondents to the resident, family/caregiver, FBCC staff, and FBCC administrator surveys rated the overall quality of care provided to FBCC residents at 6.4 to 7.6 out of 10 (Figure 6). This was about 2.6 – 3.8 points higher than the ratings provided by respondents to the public and external stakeholder surveys.

Figure 6: Perceived Quality of Care Ratings by Survey Respondents



Survey respondents further rated the quality of different FBCC supports on a scale of 0 (area for improvement) to 10 (strength). A summary of the scores provided by survey respondents is provided in Figure 7. The supports receiving the lowest ratings by residents and families/caregivers included mental wellness supports, recreational activities, physical therapy, occupational therapy, and spiritual care. The supports with the highest ratings included access to physician/Nurse Practitioner (NP) services, clinical pharmacy, and personal care services.

Figure 7: Summary of Ratings for Different Types of Supports

Type of Support - Scale of 0 to 10 - 0 – Needs Improvement to 10 Strength								
Stakeholder Group	Recreational Activities	Mental Wellness	Personal Care	Spiritual Care	Access to Physician/NP	Occupational Therapy	Physical Therapy	Clinical Pharmacy
Residents	5.1	4.8	7.1	5.5	7.7	5.4	5.1	7.5
Families/Caregivers	5.3	4.4	7.2	5.4	7.0	5.6	5.2	7.8
FBCC Staff - Administrators	7.2	5.5	7.0	6.6	7.4	6.5	6.1	7.3
FBCC Staff - Nurses	5.5	4.3	5.6	5.1	6.8	6.2	5.7	6.9
FBCC Staff - Prof Therapy	6.8	4.6	5.9	5.7	6.8	7.1	6.4	7.3
FBCC Staff - HCA	5.8	5.3	6.8	5.9	6.7	6.0	5.7	6.7



Type of Support - Scale of 0 to 10 - 0 – Needs Improvement to 10 Strength								
Stakeholder Group	Recreational Activities	Mental Wellness	Personal Care	Spiritual Care	Access to Physician/NP	Occupational Therapy	Physical Therapy	Clinical Pharmacy
FBCC Staff All Other	6.6	5.7	6.9	6.6	7.5	6.9	6.6	7.7
External Organizations	4.1	2.8	3.7	4.0	4.5	3.6	3.4	5.1

When asked about opportunities to improve care supports, the following themes were identified from the surveys and interviews:

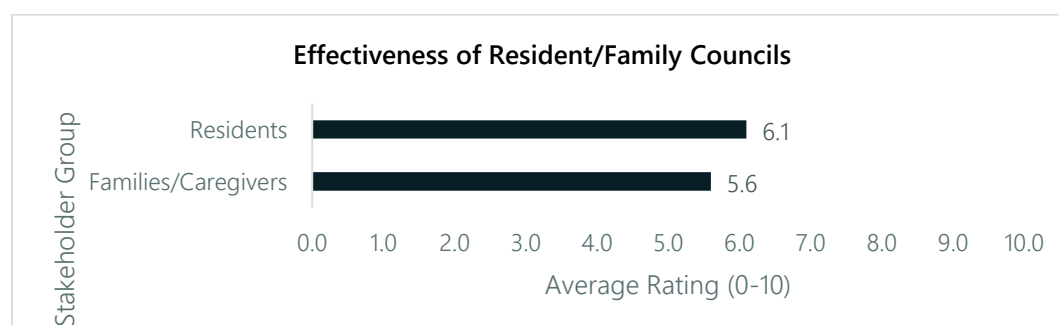
- Increase staffing numbers and access to front line staff
- Improve the continuity of staffing assignments
- Increase access to therapies such as occupational therapy and physical therapy
- Increase access to mental health supports
- Increase the availability of recreational activities
- Improve communication regarding resident care status with caregivers when appropriate
- Increase resident and caregiver involvement in care plan development
- Improve access to FBCC spaces closer to home for Indigenous and rural communities

### Resident/Family Councils

Overall, 51 per cent of residents and 44 per cent of family/caregiver survey respondents indicated that their facility had a resident/family council, while 22 per cent of residents and 49 per cent of family/caregiver respondents were not sure if their facility had a council, indicating a low level of awareness. Of the respondents reporting that their facility had a council:

- 51 per cent of residents and 23 per cent of family/caregiver respondents indicated that they participated in the council
- Resident survey respondents rated the effectiveness of their council at 6.1 out of 10, and family/caregiver respondents rated quality at 5.6 out of 10 (Figure 8).

Figure 8: Effectiveness Ratings of Resident/Family Councils



When asked about opportunities to improve resident/family councils, the following themes were identified from the surveys and interviews:

- Ensure that concerns brought forward by residents and families/caregivers at council meetings are addressed by FBCC sites
  - There is a perception by residents and families/caregivers that sites do not listen or implement the resolutions provided by the councils
- Resume the operation of resident/family councils once restrictions for the COVID-19 pandemic are relaxed

### 3.1.3 Leading Practices/Other Jurisdictional Research

Internationally, person-centred care is part of a culture-change movement that began to come to prominence in the early 1980s. The movement was led by consumer advocacy groups. The culture-change movement is focused on achieving the following features:

- Resident direction
- Homelike atmosphere
- Close relationships
- Staff empowerment
- Collaborative decision-making (staff, residents, and families/caregivers)
- Quality-improvement processes

This movement culminated in the Nursing Home Reform Act in the USA, incorporated into the Omnibus Budget Reconciliation Act (OBRA) of 1987. The Act required that each nursing home resident “be provided with services sufficient to attain and maintain his or her highest practicable physical, mental and psychosocial well-being.”<sup>13</sup> The law made nursing homes the only sector of the entire health care industry to have an explicit statutory requirement for providing what is now called “person-centered care”.

Many demonstration projects were implemented in the world as part of this culture change, including the Eden Alternative and what are known as Green Houses. The Eden Alternative<sup>14</sup> believes that care is not to be provided unilaterally, but rather a collaborative partnership, whereby all caregivers and care receivers are “care partners”. It uses environmental and social enrichment to overcome boredom, helplessness, and loneliness among residents.

The Green House Projects use small group home settings, where residents are cared for by a consistent group of direct care staff with much expanded work responsibilities, such as organizing and conducting recreational activities, light housekeeping and meal preparation, in addition to personal care. Evaluation studies have found that residents’ quality of life in Green Houses surpassed that of residents of larger traditional LTC homes owned by the same operator. In addition, Green House staff were more satisfied, and turnover rates had dropped in the evaluation period.<sup>13,15</sup>

For persons with dementia, the Butterfly Household Model of Care developed by Dr. David Sheard (*Dementia Care Matters*) in the UK has been proven to have positive impacts on improving the quality of care for people experiencing different stages of dementia including:

- Increased well-being
- Decreased falls
- Improved safeguarding alerts
- Improved weight gain

Another key benefit of the model included reduced staff turnover, sickness, and absenteeism.

The Butterfly Model of Care rests on the belief that feelings matter most for people experiencing dementia, that emotional intelligence is the core competency, and that “people living with a dementia can thrive well in a nurturing environment where those living and working together know how to be person centred together”<sup>16</sup>. Currently, Alberta has many demonstration projects using the Butterfly Household Model of Care, including homes from Lifestyle Options, Choices in Community Living, the Journey Club and Intercare.

A fundamental culture shift will be needed to change from the current practice of FBCC to one focused on achieving quality of life for all FBCC residents. Facilities must shift from a task-oriented, scheduled model of care to a relational, person-centred model of care. Internationally, many research studies identified the following steps as essential to achieving success<sup>17,18,19</sup>:

**A. Emphasize the leadership role of political, administrative, and medical professionals in fostering culture change.**

- The vision for change must be endorsed as the values and principles of the organization, and the declaration for change must come from the highest leadership level such as the CEO of the organization.
- All levels of management, including the medical and clinical leaders of the facility organizations, must champion the change.
- Staff and front-line staff must be trained on the benefits and approach for the change. Many front-line staff in FBCC sites are in fact already committed to delivering services to achieve an optimum quality of life for their residents. These staff could be “change agents” and leaders in their organizations to champion the change.

**B. Redesigning the structure, process, and outcomes of the organization is needed to achieve culture change.**

Dr. A. Donabedian (2005)<sup>20,21</sup>, creator of the model for evaluating the quality of medical care, indicated that “structure, process, and outcome” are the foundations for achieving quality medical care. Examples of ways of changing current practice include:

- Structure:
  - Facility designs should be reviewed to ensure that they achieve resident quality of life
  - Staff are trained to implement a person-centred care approach to care
  - Staff are encouraged to increase social interaction and enhance relationships with residents
  - Recreational programs are enhanced to add features that will improve resident quality of life: e.g. inclusions of music, pets, and gardening as recreational activities

- Facility schedules should be reviewed to see how they can be made more flexible to accommodate resident choices
- Food and meals should be reviewed to enable wider selections and cater to resident cultural diversity
- Process:
  - Legislation and standards should focus more on improving resident Quality of Life
  - Demonstration projects and evaluation should be introduced to assess the outcomes of specific care practices designed to enhance quality of life
  - FBCC sites that implement practices to improve quality of life should be profiled in presentation sessions, with quality of life awards being given to top performing FBCC sites annually to recognize their contributions
- Outcome:
  - Outcome indicators measuring quality of life should be developed
  - Facilities should report on the quality of life outcome measures

### **C. Redesign the workforce.**

In traditional FBCC sites, the management model is top-down. There is a “chain of command” in which all care staff must follow. Cultural change promotes a redesign of the workforce where the goal is to “flatten” the hierarchy. This levelling can be done by creating self-managed work teams (e.g. a group of HCAs responsible for providing care to a specific group of FBCC residents).

Team members are encouraged to plan for the care of residents around their total needs, respecting their choice, and foregoing some of the regular schedules if necessary. For example, if a resident wants to “sleep in” in the morning, that would be respected, and they can make their breakfast later in a nook designed for flexible snacking. Research studies have shown that self-managed work teams are associated with higher job satisfaction, improved self-esteem for workers, increased efficiency, and reduced staff turnover<sup>22</sup>.

### **D. Restructuring the physical design of facilities<sup>23, 24, 25</sup>.**

Physical design is extremely important in influencing the ability of a facility to achieve quality of life for residents. Research has shown that FBCC residents prefer privacy in a home-like environment. Residents living with dementia become more responsive when they live in environmental designs that remind them of their past life.

Privacy and dignity are important features of person-centred care. Thus, where possible, semi-private and four-bed rooms should be eliminated. Private one-person rooms for all residents (except for couples’ rooms) are the preferred accommodation to achieve privacy for residents. In addition, smaller dining spaces, recreational spaces for social events, and availability of green spaces contribute to fostering a home-like environment and improving resident quality of life.

## Supports for Primary Caregivers

Currently, it is estimated that there are more than eight million primary caregivers in Canada – more than one in four adults. If all the care provided by these caregivers is replaced by paid staff, it would cost \$66 billion per year<sup>26</sup>.

Many studies have documented various negative impacts on caregivers.

- In a 2012 Labour Force study, 2.4 million employed Canadians reported that they had arrived at work late, left early, or taken time off during the day to care for their ill family or friend. On average, caregivers were absent for eight to nine days, accounting for 9.7 million days of absenteeism in Canada per year in 2014<sup>27</sup>.
- Fifteen per cent of employed caregivers stated that they cut back their work hours because of caregiving responsibilities, often changing from full to part-time employment.
- Ten per cent of employed caregivers reported that they had retired early, quit, or been fired from a job because of caregiving during the previous 12 months.
- Caregiving responsibilities affect caregivers' physical and mental well-being, as in disturbed sleeping patterns, reduced social activities, disrupted holiday plans, and engendering psychological dysfunctions such as depression, guilt, worry/anxiety, loneliness, and emotional distress.
- It was documented that many caregivers are burnt out. They require support from the government and social agencies to continue with their role.
- Studies indicate that it is not sustainable for the health system to rely on family caregivers to supplement the care provided by formal caregivers unless services and programs are developed to support family caregivers<sup>28</sup>.

### 3.1.4 Policy Direction and Recommendations

Based on the findings articulated above related to resident quality of life and quality of care, nine recommendations were developed under two policy directions.

#### **Policy Direction 1: Establish Quality of Life as the number one priority goal for Alberta's continuing care system.**

- **Recommendation 1:** Declare that "Quality of Life is the number one priority for the continuing care system" and establish a Quality of Life Task Force to plan for and implement steps to achieve this.
- **Recommendation 2:** Develop new Quality of Life Standards to be included in FBCC standards.
- **Recommendation 3:** Develop quality of life outcome measures for FBCC and mandate the public reporting of these measures.
- **Recommendation 4:** Support couples<sup>3</sup>/loved ones to remain living together, if they choose, in continuing care facilities.

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<sup>3</sup> Couples defined as married, common-law, etc.

- **Recommendation 5:** Include primary caregiver(s) of FBCC residents as essential members of the Care Team and provide supports to reduce burnout.
- **Recommendation 6:** Improve the overall quality of meals (e.g. nutrition, menu selection, taste, presentation, and dining experience) at FBCC facilities.
- **Recommendation 7:** Refocus capital grant programs to prioritize a greater variety of client centred models of care (such as smaller homes/households and campuses of care).

### Policy Direction 2: Enhance overall Quality of Care with emphasis on residents living with dementia.

- **Recommendation 8:** Enhance the overall quality of care provided to FBCC residents by strengthening the relevant standards and updating/redesigning continuing care information systems and care indicators. Promote research, education, and evaluation activities on quality of care.
- **Recommendation 9:** Improve the quality of life for FBCC residents living with dementia, including quality of care, and the physical, mental, and emotional health of these residents.

Further details regarding these recommendations can be found in Sections 4.2.1 and 4.2.2 below.

## 3.2 Cultural Sensitivity and Inclusion



### 3.2.1 Current Context

Across Canada, including Alberta, FBCC sites are currently challenged to recognize and support the cultures of their residents at a time when their health and mental capacity are declining.

Based on interviews with DSL residents, HQCA found that most positive experiences in FBCC were created when residents felt their personal interests, lifestyles, and expectations were preserved. The residents also reported that maintaining, as much as possible, an individual's sense of identity is crucial to a more positive experience when transitioning to FBCC.

### 3.2.2 What We Heard

#### Expert Panel

Expert Panel members reported a need to provide cultural diversity at FBCC sites including:

- Meals
- Recreational activities
- Delivery language
- Facility design

#### Indigenous Perspectives

##### Quality of Life

The following comments and feedback were provided by First Nations and Métis participants to improve the quality of care and quality of life for Indigenous residents:

- Improve access to FBCC spaces closer to home for First Nations, Métis, and Inuit people
  - Increase development of facilities in First Nation communities and Métis Settlements to the degree possible
- Improve cultural sensitivity and acknowledgement of the importance of the land and the community with which Indigenous peoples have strong kinship ties
  - Reduce language barriers to the degree possible
  - Improve access to traditional foods for Indigenous residents
  - Ensure that staff working with Indigenous residents are trained in cultural sensitivity, traditional practices, and have a good understanding of trauma informed care
  - Provide appropriate physical spaces that allow for connection with the land and traditional ceremonies
  - Provide access to culturally appropriate First Nations, Métis, and Inuit programs and recreational activities
- Improve home care support in First Nation communities and Métis Settlements, to allow Elders to age in their communities as long as possible
  - Funding for home and community care services on-reserve is very limited
- Reduce wait times and improve admission process for Indigenous residents

#### Resident Choice

The following comments and feedback were provided by First Nations and Métis participants to improve choices for Indigenous people:

- Empower residents to make their own decisions and offering them the ability to choose when it comes to:
  - Food
  - Recreation and activities
  - Room layout (e.g. ability to customize a room with pieces of furniture from home)
  - Care planning, including involving a resident's family member in the process
- Have client liaisons who can ensure that Elders are heard and properly informed to ensure their choices are taken into consideration

#### Service Integration

The following comments and feedback were provided by First Nations and Métis participants to improve service integration for Indigenous residents:

- Build mutual trust with Indigenous leadership and communities
  - Alberta Health, AHS, and Indigenous Services Canada (ISC) need to build relationships with each other and Indigenous leadership to work better together

- Alberta Health, AHS and ISC need to trust that Indigenous leaders and communities can build and administer programs
- Help Indigenous communities build the capacity to administer their own programming with out stepping in and imposing a non-Indigenous model for care
- Develop a “Community Hub” in First Nation communities and Métis Settlements that has a collection of resources with an Indigenous focus that could branch out to the community to provide services
- Improve communication and information sharing between the community from which an elder/resident comes from and FBCC
  - Have a more centralized model that shows people how to access services close to home
  - Offer onsite wrap-around services for community members

### Navigation

The following comments and feedback were provided by First Nations and Métis participants to improve navigation for Indigenous stakeholders:

- Create one point of contact for individuals seeking assistance with care navigation
  - Utilize navigators or liaisons to help Elders navigate the system
- Ensure information is translated into different languages
  - Communication should be visual
  - Communication should be in their own language
  - Simplify terminology
- Increase awareness on how to navigate the system
- Strengthen connections with the community physicians and NPs to continuing care facilities

### Funding

The following comments and feedback were provided by First Nations and Métis participants to improve funding for Indigenous stakeholders:

- There is a need for better partnerships by the provincial and federal governments related to capital and operational funding for Elder’s lodges and FBCC facilities, including better coordination by all parties
  - There needs to be better continuity and consistency with the funding process for Indigenous communities
  - There needs to be stable, consistent, and adequate funding for Indigenous run facilities
    - Currently, funding is grant based and there is no specific stream of funding available
    - Facilities need to apply for funding every year which limits their capacity to plan for the future
    - Inconsistent funding is perceived to lead to more turnover in staff



- There needs to be flexibility in how funding is used
  - Other than a few capital grants, most grants do not allow funds to be used for renovations
  - More flexibility for program-based funding
- Funding for Indigenous facility planning needs to consider contingencies, feasibility studies, and cultural nuances (e.g. translators)
- Indigenous communities need access to more (Indigenous based) facilities equipped with culturally relevant services

### 3.2.3 Leading Practices/Other Jurisdictional Research

The National Institute on Aging (NIA) recently reported a growing need for inclusive care and support that acknowledges and affirms the immense diversity that exists among LTC residents across Canada including race, culture, gender, and sexual orientation<sup>29</sup>. It was noted that quality of life for all residents could be improved by making relevant changes in LTC facilities that ensures programs, policies, and practices contribute to inclusive, welcoming, and affirming environments for all members of the diverse populations who live, work, and visit in LTC homes.

A needs assessment performed specific to Indigenous culture for Ontario's LTC homes in 2017-2018 found that Indigenous people have unique cultural requirements that must be supported by all health care streams including LTC<sup>30</sup>. Levels of acuity for residents and demand for LTC is increasing across-the-board and under these stressors, continuing care homes are challenged to pay appropriate attention to, recognize, and support the culture of their residents. Through the work of three groups (Centres for Learning, Research, and Innovation in LTC [CLRIs]), it was identified that support for Indigenous culture in LTC was a key area in which innovation and capacity-building is needed. This group (in collaboration with Indigenous organizations and sector Associations) identified the following types of support opportunities to address these identified challenges:

- Cultural safety training for all staff whereby Indigenous organizations are the primary content creators for training materials
- Ways to connect to community care providers to ease the transition from community services to those provided within LTC
- Tips and ideas for helping residents stay in touch with their families and community more generally
- Information about ways for homes to work with Indigenous community organizations, Friendship Centres, Healing Lodges etc. to connect residents to their services; traditional medicines; navigating jurisdictional issues and different payment sources; cultural values, traditions and beliefs in a general way; and ways other organizations support smudging, fires and tobacco burning
- Promotion of culture specific information about dementia care, palliative care, and end-of-life practices
- Recipes for traditional foods, and menu ideas for incorporating them along with ideas for sourcing traditional foods

- Tips for engaging and working with interpreters
- The creation and sharing of printable cards with pictures and words in the language of the resident for activities of daily living and other important words
- Tips for training and engaging Indigenous care staff, supervisors, board of directors' members and volunteers, including visiting Elders

In 2018, the Standing Committee on Indigenous and Northern Affairs (the Committee) held eight public hearings and heard 48 witnesses, including representatives of the federal government, First Nation communities and organizations, tribal councils, service providers, health authorities and independent experts. The purpose of the study was to consider the main barriers that seniors and those with chronic illness face in obtaining continuing care on reserve (including care provided in LTC facilities on- or off-reserve). The study also addressed palliative care and the need for programs and practices adapted to First Nations' cultures and values<sup>31</sup>.

Over the course of its study, the House of Commons Standing Committee on Indigenous and Northern Affairs learned that the barriers associated with continuing care services on-reserve are partly due to the complexity of overlapping responsibilities and current policies between levels of government. Currently, the responsibility to provide health care on-reserve is unclear. The provision of those services is currently shared among the federal and provincial governments, First Nations organizations and communities, and third-party services providers resulting in a complicated and ambiguous framework. Because both levels of government have not fully assumed accountability, First Nation communities have trouble obtaining the support they need to offer health care services on- and off-reserve.

Current resources for home and community care cannot meet the growing demand for these services on-reserve; there are very few LTC facilities on or near reserves; and the services provided in off-reserve LTC facilities are often very far from First Nation communities or do not provide the required level of culturally appropriate care.

Recommendations related to this study are listed below.

1. That Indigenous Services Canada (ISC) provide increased funding to the First Nations and Inuit Home and Community Care Program (FNIHCC) to include palliative care as a service eligible for funding under the program
2. That ISC evaluate the current needs regarding in-home respite care under the FNIHCC Program and report publicly on it; and that ISC review the funding allocated for the FNIHCC Program to ensure that in-home respite care on-reserve is accessible and adequate
3. That ISC:
  - Establish a funding formula that provides stable, predictable, and long-term funding to projects to build or maintain LTC facilities on-reserve, and that the new formula considers factors such as First Nation population growth, inflation, and the remoteness of communities
  - Facilitate and support partnership initiatives to build LTC facilities
  - Work with First Nations and the provinces and territories, in accordance with the priorities that First Nations set for LTC services on-reserve, to develop and implement

pilot projects in various regions of Canada to build and maintain LTC facilities on-reserve

4. That ISC work with First Nations and the provinces and territories to take immediate measures to encourage the implementation of culturally appropriate programming and service delivery including traditional foods in LTC facilities and as part of home care and community care on-reserve
5. That ISC work with First Nations and provincial and territorial partners to develop and implement a mandatory training program for Indigenous and non-Indigenous health professionals providing continuing care on-reserve about the values, culture, and history of Indigenous peoples
6. That, in implementing Call to Action 22 of the Truth and Reconciliation Commission of Canada, ISC work with First Nations, provinces and territories and health authorities to recognize, fund and provide access to First Nation traditional healing practices in the delivery of continuing care
7. That ISC, in partnership with First Nations and other relevant federal departments, improve access to post-secondary health education and occupational training for First Nations learners to provide more opportunities for First Nations people to deliver health care on-reserve
8. That ISC co-ordinate with First Nations and the provinces and territories to clarify their respective roles and responsibilities for continuing care on-reserve
9. That the Minister of ISC facilitate tripartite meetings between the federal government, provinces and territories and First Nations representatives to address the jurisdictional challenges that exist regarding the delivery of home and community care, palliative care, and LTC services on-reserve
10. Based on the principles of OCAP® (ownership, control, access and possession) of the First Nations Information and Governance Centre, that ISC work with First Nations and provinces and territories to develop and implement an integrated data collection protocol specific to the health and well-being of First Nations; and that this data be used to inform the provision of evidence-based health services on-reserve

### 3.2.4 Policy Direction and Recommendations

Based on the findings articulated above, two recommendations were developed.

#### **Policy Direction 3: Improve the provision of culturally appropriate continuing care services.**

- **Recommendation 10:** Strengthen relationships and the level of collaboration with Indigenous leadership/organizations to provide more culturally appropriate continuing care services, closer to home and integrated with other community services, for Indigenous stakeholders.
- **Recommendation 11:** Improve cultural sensitivity, and diversity and inclusion at FBCC sites.

Further details regarding these two recommendations can be found in Section 4.2.3 below.



## 3.3 System Integration and Navigation

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### 3.3.1 Current Context

#### System Integration

System integration refers to how services in different sectors of the health and social system are coordinated, to prevent operating in silos (i.e., having limited inter-communication or interface in terms of process/procedures, etc.). Strong system integration is important to ensure that there is continuity of care between service providers and to make transitions from one sector of health services to another seamless from the perspective of the “user”. Because continuing care operates as one component of the health and social system, it is important that continuing care services are coordinated with other parts of the health and social system, particularly with primary health care, mental health care, acute care hospitals, and emergency departments of hospitals.

Integration of continuing care services in Alberta began with the implementation of the Single Point of Entry System in 1990 where assessment and case management for continuing care services were coordinated through home care assessors and case managers. This model provided referral, assessment, service placements, and coordination for individuals seeking continuing care. At that time, LTC and home care were the only two major streams of continuing care.

In 2000, the Single Point of Entry System was expanded to a Co-ordinated Access System for continuing care, whereby the entry system was broadened from LTC facilities and home care to include referrals to a variety of community services and DSL sites. Subsequently, various attempts were made to improve case management services in continuing care. Training for case managers was enhanced by the hiring of McMaster University to provide case management training to enhance this function throughout the province.

With the continual evolution of health and social services in the last 20 years and ever-changing demographics/needs of continuing care clients, the integration of systems providing care and support for this population needs to be re-envisioned beyond a Single-Point Entry and Coordinated Access System.

#### Transitions between FBCC and Hospitals

A key area of integration needed, from the perspective of FBCC residents and caregivers/families, are transitions between FBCC sites and acute care. Based on data provided by AHS, the rate of inpatient visits per 1,000 residents increased for LTC facilities in the South, Central and North zones between 2015/16 to 2019/20, and decreased for Calgary and Edmonton zones. Overall, the rates for LTC ranged from 0.71 to 1.06 inpatient visits per 1,000 resident days over the five-year period.

For DSL, the rate of inpatient visits per 1,000 resident days decreased in each AHS zone between 2015/16 to 2019/20. The rate of inpatient visits for DSL ranged from 1.18 to 1.89 inpatient visits per 1,000 resident days, which is higher than the rate observed for LTC facilities in Alberta.

The rate of emergency department (ED) visits per 1,000 resident days for LTC increased in South zone, remained stable in Edmonton, Calgary and Central zones, and fluctuated up and down in the North zone between 2015/16 to 2019/20; and ranged from 1.73 to 3.13 ED visits per resident day. The rate of ED visits for DSL decreased in all zones except for Edmonton zone (which was flat) between 2015/16 to 2019/20 and ranged from 2.49 to 6.52 ED visits per 1,000 resident days.

## Navigation

The continuing care system in Alberta is seen as confusing with different categories of services, facilities, and eligibility criteria. Users of FBCC services have expressed concerns about the difficulty of accessing these services. One issue is a lack of awareness the AHS Continuing Care Facility directory that was recently developed to help Albertans navigate the continuing care system. Also, there is currently no publicly available information on whether a FBCC site has violated any provincial health standards.

The navigation function in continuing care in Alberta sits with the case management and case coordination function of the Home Care/Community Care Case Managers. These case managers are responsible for assessing the continuing care needs of individuals and referring them to a range of continuing/community care services. Once a resident is moved into LTC, the case management function is provided by the site itself.

The most common responsibilities of navigators are to provide care facilitation and coordination, assist with appointment scheduling and other logistical support, assist with health literacy, provide patient education and psychosocial support, and connect patients and families with resources and services. Alberta has specialized navigators as part of cancer programs. Health Link and 211 are other examples of health system navigation in Alberta.

### 3.3.1.1 Strengths

#### System Integration and Navigation

The Single Entry and Coordinated Access System provided a good foundation for continuing care system integration in Alberta, as case managers are well accepted as coordinators of community care services within the health system.

At present, AHS divides the province into five zones and uses case managers to assess the needs of Albertans requiring publicly funded home care and community care services. Case managers will also refer clients to other community services, as necessary. As such, these case managers assist continuing care clients in accessing a wide array of community care supports and services available in Alberta.

The AHS Continuing Care Facility directory, Health Link and 211 are tools and services that can assist with improving the communication of and navigation of FBCC services in the future.

### 3.3.1.2 Areas of Opportunity

#### System Integration

##### The need to integrate health and social services

The health and social services systems have been changing in the last decade. Evaluation studies have demonstrated the importance of integrating health, social services, and community services to assist

older adults and people with disabilities to “age in the right place”<sup>32,33,34</sup>. Coordinated networks of health and social services should be put in place to enable the effective access to services as needed in an efficient manner.

The use, or misuse, of hospital EDs is an example of the need for a closely integrated health and social services system. It has been reported that patients who present to the hospital ED often disclose social problems<sup>35</sup> (e.g., lack of housing, financial insecurity, family violence, and transportation issues) which acute care facilities alone cannot address. In these kinds of circumstances, a close-knit network of all human services is required to resolve these issues including the underlying problems.

Primary health care is now regarded as the first point of contact for health services. There is a recognition that primary health care must be integrated and coordinated with continuing care and community services to be effective. Some Primary Health Care Networks (PCNs) in Alberta have developed multi-disciplinary teams, including physicians, to address the health needs of the patients.

There is a need to establish collaborative alliances amongst health and social agencies as well as age- and dementia-friendly neighbourhoods to assist individuals to remain in their community to receive services. CORE Alberta<sup>36</sup> (Healthy Aging Collaborative Online Resources and Education), funded by Alberta Seniors and Housing, is a good first step towards developing such integrated community networks of services with the assistance of technology. Additional funding to strengthen community networks and capacity to enable more seniors to age in the community is a good investment for an aging society.

Future planning for FBCC needs to be placed within the context of an integrated health system with coordinated health and social services serving as supports for all individuals.

### **Home-care case management and transformed community care services**

For individuals requiring publicly funded home and community care services, home care case management remains the appropriate program to provide assessment and referrals to these services. Case managers in the AHS home care program are knowledgeable, trained service coordinators who are skilled in assessing clients and assisting them to receive a variety of home and community care services.

During the past decade, many efforts have been made in Alberta to strengthen and improve the home care program such as the province-wide Destination Home Program and the self-directed invoicing home care program in the Edmonton Zone.

Moving forward, Alberta should consider the innovations already underway in home care and the potential role home and community care services could serve as alternatives to FBCC.

### **FBCC case management**

In FBCC, case management for residents in LTC facilities is the responsibility of LTC operators, whereas case management of DSL residents is the responsibility of AHS. This difference in case management was identified by operators and staff as a major issue in service delivery. One of the problems with the current approach for DSL is that while AHS case managers are responsible for assessing DSL residents and preparing their care plans, they are only present during regular office hours on weekdays, and their approval is required for off-hour health and emergency services. This anomaly has led to delays in the

provision of emergency services. In addition, the assessments and care plans are prepared by AHS case managers without the involvement of DSL care staff, who sometimes do not have access to the plans developed by AHS case managers.

## Navigation

To address current issues relating to navigation and information, Alberta Health should consider devising an information and communication plan to improve the navigation of continuing care service options in Alberta.

- The plan could include paper and digitalized information on the details of options of care under the FBCC system.
- The plan could provide a user-friendly description of services.
- The plan could be linked to facility-specific information sources that outline programs and services provided by each FBCC facility. The information package should also indicate whether the facilities have violated provincial regulations and health standards.
- The plan could provide the opportunity for the user to access navigators in person via actual or virtual means to discuss options for care and options to age in place in the community if necessary.
- A pilot project to explore ways of developing a strengthened navigation system for continuing care with navigators could also be considered.

The navigation system should include linkages to all health system services including primary care, mental health care, hospitals, social services, and community resources.

## 3.3.2 What We Heard

### 3.3.2.1 Expert Panels

#### System integration

The Expert Panel members reported that integration of FBCC with other health and social services could be improved through:

- Reducing the number of transitions through different levels of FBCC
- Simplifying the overall continuing care system in Alberta, as the current system is complicated with too many different levels of care
- Allowing individuals to remain in one facility
  - Bring care to the client, rather than moving the client to the care
- Providing more information and education to service providers and users about FBCC because there is confusion about how the current system works
- Improving access to health clinics, transportation programs and outreach services for seniors and people with disabilities with a prevention focus to support aging in place in the community
  - This could potentially be achieved with a “Community Hub” model that includes:
    - Physicians

- Public health nurses/district nurses
  - Outreach and day programs
  - Transportation programs
  - Collaborative care teams managing hubs to better integrate home care and FBCC services
- Having accurate assessments to ensure individuals receive appropriate services

## Navigation

Expert Panel members reported the following challenges with navigating FBCC services, and opportunities for improvement:

- The current continuing care system is difficult to navigate and there is a need to develop “journey maps” for different types of clients who may go through the system to help potential future clients navigate what their journey could look like through continuing care
- Providing good public education about FBCC because people do not understand how the system currently works
- Having a FBCC liaison or navigator and some sort of FAQ sheet or infographic to help people navigate the system especially as they are oftentimes trying to do so while in “crisis”
- Having primary care providers more involved in providing information to individuals looking for continuing care services
- Reducing the number of levels of care (LTC, DSL 3, DSL4 etc.) would help simplify the system

### 3.3.2.2 Surveys and Interviews/Focus Groups

#### System Integration

Overall, the majority of respondents to the FBCC administrator and FBCC staff surveys perceived the level of coordination between FBCC and home care, other levels of FBCC, hospital services, primary care services, occupational and physical therapy, and private health providers to be very well or somewhat coordinated. The level of coordination for mental wellness services and other community health services was perceived to be lower. In addition, approximately 40 per cent of respondents to the FBCC administrator and FBCC staff surveys perceived the level of coordination with private health services to be low or not coordinated at all.

Many respondents to the resident and family/caregiver surveys perceived access to hospital services, primary care, occupational and physical therapy to be easy or somewhat easy. Many respondents to each survey answered “I Don’t Know/Not Applicable” regarding the level of access to mental wellness and other community services, with 15-20 per cent of respondents indicating that each service is not easy to access.

When asked about opportunities to improve the integration of FBCC with other health/social services, the following themes were identified from the surveys and interviews:

- Improve communication between all service providers

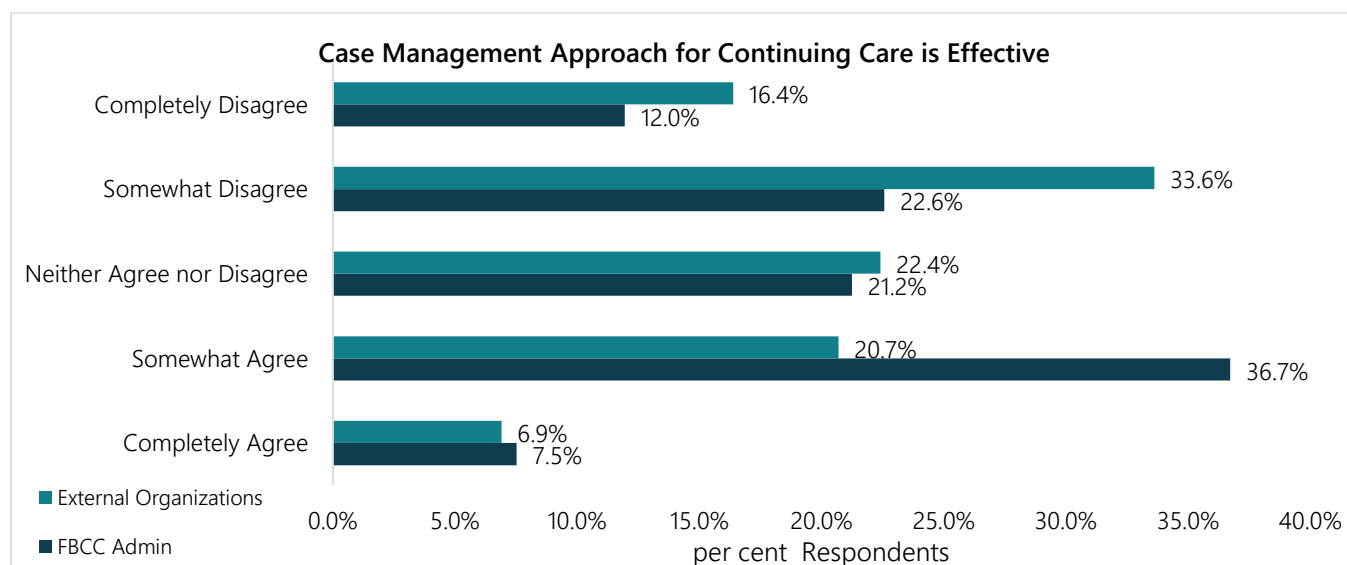


- Establishing a standardized system like Connect Care for sharing information and medical records across the system would help improve communication
- Increase the frequency of physician visits for FBCC residents
  - Incorporating the use of Nurse Practitioners would also improve the level of care provided to FBCC residents
- Increase the provision of continuing care to seniors and people with disabilities in the community if it is safe to do so, and enhance services to support the ability to receive care in the community if possible
  - Improve the coordination of Primary Care Networks with all continuing care services
  - Improve the coordination between continuing care and community/social support services (i.e. transportation services, assistance with errands, recreational services etc.)
  - Create campuses of care that offer multiple types of living environments and care options
- Increase access to on-site and mobile services for FBCC residents
  - Improve access and coordination with mental wellness and dental services
- Improve case management to be more seamless for continuing care clients/residents through different levels of care
- Reduce the complexity of the current continuing care system by eliminating the titles attached to the different levels of care (i.e. LTC, DSL4D, DSL4, DSL3)

## Case Management

Approximately 50 per cent of respondents to the external organization survey and 35 per cent of respondents to the FBCC administrator survey somewhat or completely disagreed that the current approach to case management was effective (Figure 9). Less than half of the respondents to each survey completely or somewhat agreed that the approach was effective.

Figure 9: Perceived Effectiveness of Case Management System



When asked about opportunities to improve case management for FBCC services, the following themes were identified from the surveys and interviews:

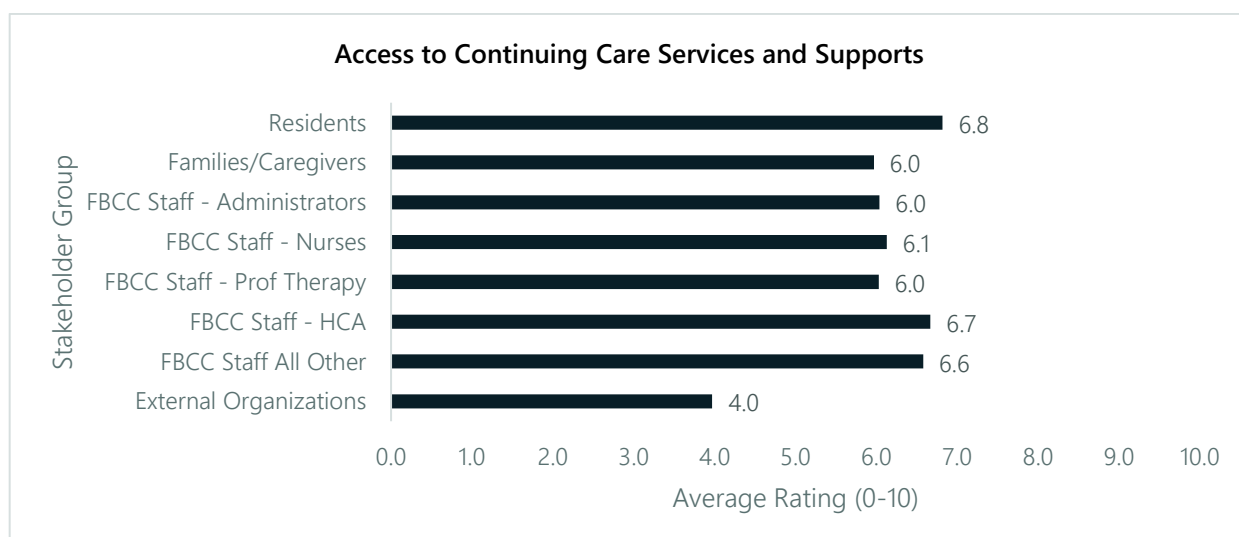
- Most stakeholders responding to this question perceived a need to increase the number of case managers
  - Some operators would like increased staffing and funding support for case management from AHS
- Improve the integration of the case management function across continuing care, as AHS currently manages case management for DSL and home care, and the operators manage case management for LTC
  - Respondents were split on who should be responsible for case management
    - Some operators, AHS and external organization respondents felt that AHS should be responsible for case management
    - Some operators felt that the operators should be responsible for case management in FBCC facilities
    - Some operators felt that the case management approach should remain as is
    - Some would like an improved partnership between AHS and operators to manage case management
  - Standardize the tools, processes, and technology used for case management

## Navigation

Many respondents (71.5 per cent) perceived that it is currently difficult to access FBCC services. Many respondents also perceived that these challenges were due to long-wait times (85.3 per cent), limited availability of care options in one's home community (78.0 per cent), high cost of services (68.5 per cent), unnecessary system complexity (53.4 per cent), and not sure where to get information from (45.6 per cent).

Respondents to the resident, family/caregiver, FBCC administrator, and FBCC staff surveys rated a resident's ability to access continuing care services and supports at 6.0 to 6.8 out of 10, while respondents from external organizations rated this ability at 4.0 out of 10 (Figure 10).

Figure 10: Perceived Ability of Residents to Access Continuing Care Services and Supports



The biggest challenges identified by FBCC administrator, FBCC staff and external organization respondents included:

- Not being sure where to get information from (49.4 per cent to 71.7 per cent of respondents)
- Unnecessary system complexity (35.6 per cent to 62.8 per cent of respondents)
- Limited availability of options in one's home community (58.7 per cent to 78.8 per cent)
- Long wait times (35.8 per cent to 62.8 per cent)

The types of information that would be of most help to assisting residents and family members make decisions when first accessing FBCC included:

- A listing and description of the services available in facility-based continuing care
- Compliance information for facility accommodation and care standards
- Information regarding ratings of facilities from residents and family
- The fees paid by residents for services
- A description of which services are regulated/audited to ensure quality
- Information regarding specific facilities including age, layout, and room types
- A description of private pay versus publicly funded services
- The process for accessing different types of services

Other supports that would be helpful to better navigate the system included:

- Funding a navigator position to help client/residents and caregivers navigate the continuing care system
- A listing of facility programming and services
- A central location for accessing all information (rather than different websites and service providers)
  - Create one webpage for easy comparison across sites and levels of care

- Having primary care providers and/or clinical pharmacists provide more information to patients regarding continuing care options
- Providing information in clear simple language
- Providing a mix of online and print information

### 3.3.3 Leading Practices/Other Jurisdictional Research

#### Increasing Access to Home Care Services

The Canadian Home Care Association's (CHCA) vision of health care is an integrated system that provides accessible, responsive services that enable people to stay safely in their homes with dignity, independence, and quality of life<sup>37</sup>.

- Within this integrated system, home and community-based care provide health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the family caregiver
- An integrated health system provides seamless patient- and family-centred care and supports for older adults living with frailty, individuals with complex, chronic disabling conditions, and individuals who require palliative care. Integrated home and community-based care enables the following:
  - Clients access the care and support services they need, when, they need them and where they choose to have them provided
  - Client and health care team members work together, communicate, and share health information
  - Caregivers are recognized as partners in care, are involved in care provision when they choose and know where and how to access resources and support
  - Individuals' health care wishes are shared, understood, respected, and acted upon
- Effective integrated home and community care models require:
  - Changing health system planning and funding from an episodic and acute care focus to long-term community-based care
  - Identification of vulnerable populations that will benefit from integrated care
  - Patient and family engagement in the co-creation of integrated models and shared decision making about care planning and delivery
  - Alignment of financial incentives to support collaboration and ensure resources (financial and human) are available in the home and community
  - Multidisciplinary teams of health care providers (e.g., generalists and specialists, regulated and unregulated)
  - Care pathways and clinical guidelines that promote best practice and facilitate clinical decision making among providers
  - Engaged leadership that understands resource needs and the ongoing process of integrated care

- A collaborative culture that emphasizes and rewards teamwork and measures coordinated patient-centred care
- Shared performance accountability of providers and patients supported by data collection, analysis, and reporting
- User-friendly information technology that supports information sharing between health care providers, patients and their caregivers, and system planners

Many jurisdictions have created very innovative programs to reduce early admission to LTC by providing outreach home care and community services. For example, New York State since 1988 has implemented a “Nursing Home Without Walls Program”<sup>38</sup> offering alternative high-level home and community care services to individuals assessed as requiring LTC. This program had the flexibility to provide an array of services to maintain an individual at home although they were assessed as eligible for LTC.

In New Brunswick in 2019, four LTC facilities participated in the \$1.5 million “Nursing Home Without Walls Program”<sup>39</sup>, with the goal to help seniors in rural communities stay in their own homes without going to LTC sites to seek services. “Seniors Navigators” were hired by the project to visit homes of seniors who require assistance, with staff and equipment provided by the LTC sites.

Seamless Transitions: Hospital to Home is a Mississauga Halton LHIN-funded, partnership initiative with Trillium Health Partners (THP) to improve patient and carer experiences through the development of a consistent, integrated, person-centered approach for hospital to home transitions<sup>40</sup>.

- The enhanced coordination and communication between providers and patients in this new approach enabled patients to remain at home and out of hospital, helping to improve patient experience, hospital flow/capacity and relationships between hospital and community providers.
- Using insights from patients, families, staff, THP staff, physicians, community providers and a leading practice review, a dedicated team of interdisciplinary professionals from both organizations developed a new approach to hospital transitions. It was tested for nine months in the THP-Credit Valley Hospital (CVH) Medicine program, following patients from admission through to discharge and recovery at home.
- Findings from the test phase indicate a significant reduction (52 per cent) in readmission rates for patients discharged using the Seamless Transitions approach, compared to all other patients in the THP-CVH Medicine program, saving 0.9 bed days for every patient. Patient experience improved measurably as well, with many patients commenting they felt better prepared to leave hospital.

Key components of Seamless Transitions approach include:

- Integrated, mobile care team
- Transition planning starting on admission (patients streamed into pathways based on post-hospital care coordination needs)
- Enhanced care coordination (Transition Coordinator role) - one person as key contact between patient and care team who oversees transition plan

- Individualized, comprehensive, written transition plan (My Story and My Care Guide for patients; Plan of Care for providers)
- Daily discharge rounds
- Post-discharge phone calls and/or visits
- Timely, accurate information flow from community providers, amongst hospital teams, and back to community providers

### Self-management and digital entry to the continuing care system

With advancing technology, a common trend in the health care sector is that consumers would prefer to manage their own care by utilizing relevant computerized tools. An example of this trend is the United Kingdom National Health Services' Long-Term Plan<sup>41</sup> which calls for "digital entry" to health services, with substantial investments in integrated primary and community health services. Within this system, health service clients can access their own health records and specific information related to their health and treatment needs and are then able to arrange for required services online. The Plan also addresses prevention programs, such as smoking cessation, obesity reduction, and prevention of alcohol-related hospital admissions.

### Navigation

In other jurisdictions, health navigation systems have been developed to address fragmentation in the health and social system<sup>42</sup>. The focus is on navigation at points of transition, as clients move from one provider to another<sup>43</sup>. Many navigation programs<sup>44, 45</sup> have been created to assist patients with complex needs such as oncology patients, disability groups, persons with mental health problems and addictions, and ethno-cultural groups.

In a 2019 study by Laura Funk, it is argued that navigation problems are rooted in the structures and operations of existing care systems, as well as the downloading of administrative and coordination tasks to individual patients and their families. In Funk's view, navigation work must be transformed from a private struggle into a public responsibility. This paper proposes three policy directions to alleviate the problems families face in navigating care access:

1. Providing better information about available services
2. Creating more formal navigation supports
3. Improving service integration

Ensuring easier access to services can increase the well-being of seniors, people living with disabilities, and caregivers. Furthermore, advocating for governments to bear some of the costs of barriers to access by instituting formal navigator programs may generate broader benefits. It might lead to greater recognition among decision-makers of the obstacles associated with accessing care for seniors and people living with disabilities and provide the impetus to better integrate services. Although the goal should be to improve the system so that navigators are no longer needed, in the short run this may be unrealistic given the complexity of needs for seniors and people living with disabilities across social and health domains<sup>46</sup>.

### 3.3.4 Policy Direction and Recommendations

Based on the findings articulated above related to system integration and navigation, four recommendations were developed.

**Policy Direction 4: Improve coordination in the continuing care system, making it easier to navigate for the client and better integrated with other health, community, and social services.**

- **Recommendation 12:** Make easily understandable information about continuing care services available to all Albertans to assist with navigation.
- **Recommendation 13:** Pilot the use of a continuing care navigator function to improve the coordination of services between continuing care, primary care, acute care, mental health care and community/social service providers.
- **Recommendation 14:** Pilot the use of some FBCC sites to function as the “resource hub” in communities where this approach would better meet community needs.
- **Recommendation 15:** Improve case management in continuing care including consideration of responsibilities and functions, with a particular focus on DSL facilities.

Additional details regarding these recommendations can be found in Section 4.2.4 below.

## 3.4 Staffing Mix and Models



### 3.4.1 Current Context

#### Funded Staffing Hours - LTC

Since 2014, the average level of funded worked and paid hours provided to LTC operators through the Patient-Care Based Funding (PCBF) system has remained at 3.37 worked hours per resident day (those hours actually worked by an employee while delivering FBCC services) and 4.08 paid hours per resident day (includes worked hours plus benefit hours that are paid but not worked) for nursing, personal care and therapy services based on an average Case Mix Index (CMI) of 100 (Figure 11).

*Figure 11: Average Level of Funded and Worked and Paid Hours for LTC*

Staffing Type	Worked Hours	Paid Hours	per cent Worked Hours
RN	0.52	0.64	15.3 per cent
LPN	0.37	0.45	11.0 per cent
HCA	2.13	2.58	63.4 per cent
Professional Therapies	0.19	0.23	5.6 per cent
Non-Professional Therapies	0.16	0.19	4.7 per cent
<b>Total</b>	<b>3.37</b>	<b>4.08</b>	<b>100 per cent</b>

Based on data provided by AHS, the level of funded worked hours in LTC varied by ownership type in 2018/19, with AHS and Covenant Care<sup>4</sup> being funded for a higher level of RN hours than all other operator types, and a lower level of LPN, HCA, professional therapy and non-professional therapy hours (Figure 12). Overall, AHS sites provided a higher level of actual hours than funded hours for all staffing types (except for RN hours). In addition, all sites provided a lower level of RN hours than funded for, and a higher level of LPN hours and HCA hours (except Covenant Care) than funded for. The level of actual professional therapy hours was also lower for most operator types except for AHS and Covenant Care. PCBF provides some flexibility for skill mix substitutions such that a minimum of 75 per cent of RN, LPN, HCA, Professional Therapist and Non-Professional Therapist funded worked hours must be provided by LTC operators.

Figure 12: Level of Funded Versus Actual Provided Hours in LTC by Operator Type for 2018/19

Operator Type	Worked Hours									
	RN		LPN		HCA		Professional Therapist		Non Pro Therapist	
	Funded	Provided	Funded	Provided	Funded	Provided	Funded	Provided	Funded	Provided
AHS	0.65	0.60	0.22	0.39	1.88	2.22	0.17	0.22	0.14	0.22
Private-for-Profit Operator	0.51	0.40	0.36	0.38	2.08	2.19	0.18	0.15	0.16	0.17
AHS Subsidiary	0.52	0.45	0.37	0.40	2.16	2.52	0.19	0.17	0.16	0.16
Voluntary (Not-For-Profit)	0.51	0.44	0.36	0.41	2.09	2.17	0.19	0.14	0.16	0.20
Covenant Health	0.56	0.37	0.32	0.57	2.06	2.24	0.19	0.17	0.16	0.17
Covenant Care	0.64	0.40	0.22	0.51	1.58	1.34	0.14	0.14	0.12	0.02
<b>Provincial</b>	<b>0.54</b>	<b>0.45</b>	<b>0.33</b>	<b>0.41</b>	<b>2.05</b>	<b>2.23</b>	<b>0.18</b>	<b>0.16</b>	<b>0.15</b>	<b>0.18</b>

## Funded Staffing Hours - DSL

In 2019/20, the average level of funded worked and paid hours provided to DSL was 2.66 worked hours and 3.12 paid hours per resident day for nursing, personal care and therapy services (Figure 13).

Figure 13: Average Level of Funded and Worked and Paid Hours for DSL

Staffing Type	Worked Hours	Paid Hours	per cent Worked Hours
RN	0.00	0.00	0.0 per cent
LPN	0.59	0.70	22.0 per cent
HCA	2.02	2.36	75.9 per cent
Professional Therapies	0.03	0.04	1.2 per cent
Non-Professional Therapies	0.02	0.03	0.8 per cent
<b>Total</b>	<b>2.66</b>	<b>3.12</b>	<b>100 per cent</b>

<sup>4</sup> Covenant Care and Covenant Health are funded by AHS through a services agreement to provide FBCC services. AHS reports data separately for Covenant Health and Covenant Care.



AHS subsidiary operators had the highest level of worked hours for RNs, LPNs, HCAs, and non-professional therapies (Figure 14).

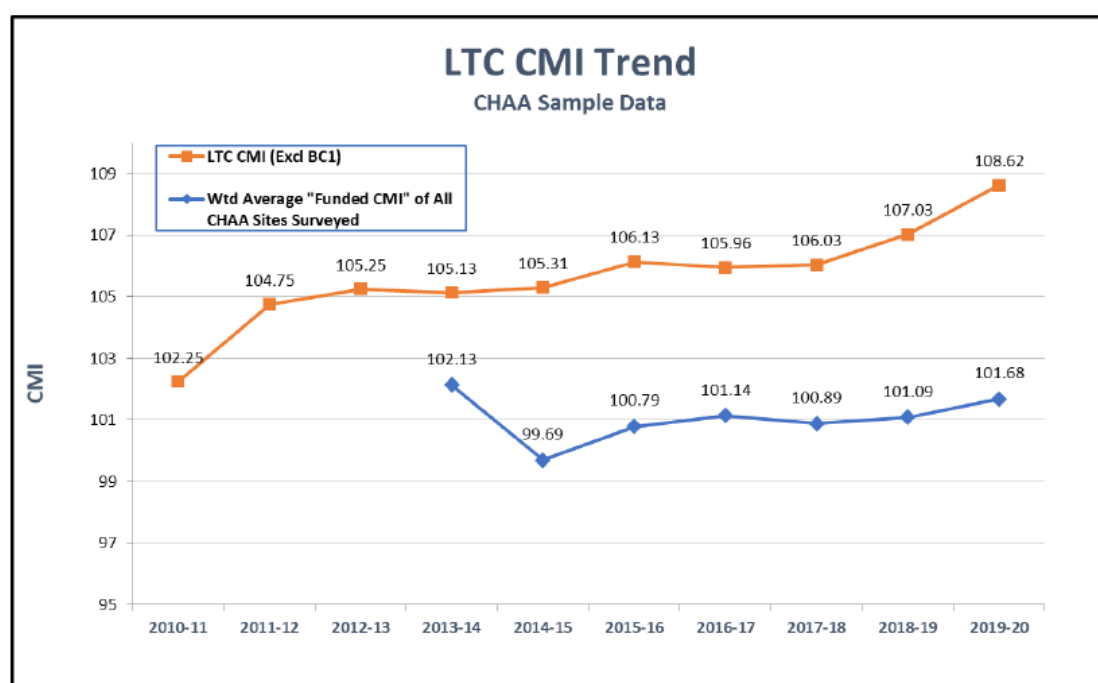
Figure 14: Level of Actual Worked Hours in DSL by Ownership Type for 2019/20

Operator Type	RN	LPN	HCA	Professional Therapist	Non Pro Therapist
AHS Operator	0.04	0.50	2.22	0.08	0.11
AHS Subsidiary	0.09	1.00	2.77	0.02	0.15
Private-for-Profit	0.02	0.56	1.90	0.04	0.10
Voluntary (Not-for-Profit)	0.01	0.55	2.11	0.02	0.10
<b>Provincial Worked</b>	<b>0.01</b>	<b>0.56</b>	<b>1.97</b>	<b>0.03</b>	<b>0.10</b>
Provincial Funded	0.00	0.59	2.02	0.03	0.02

## Increasing Acuity in LTC

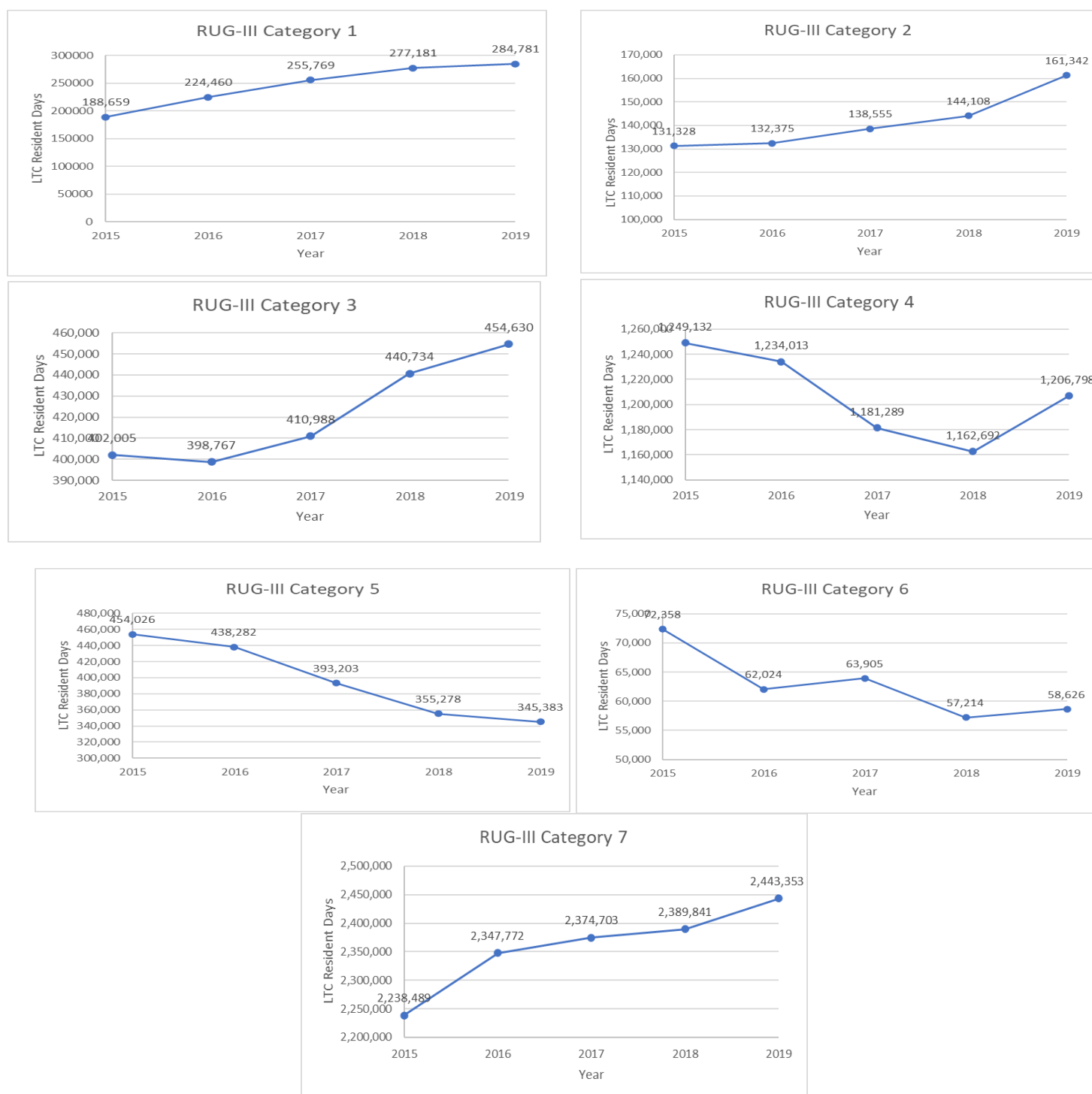
The Christian Health Association of Alberta (CHAA) recently published a report<sup>47</sup> that demonstrates the actual CMI for the not-for-profit operators they represent has increased from 102.3 in 2010/11 to 108.6 in 2019/20 (Figure 15).

Figure 15: CMI Trend for CHAA LTC Site Operators



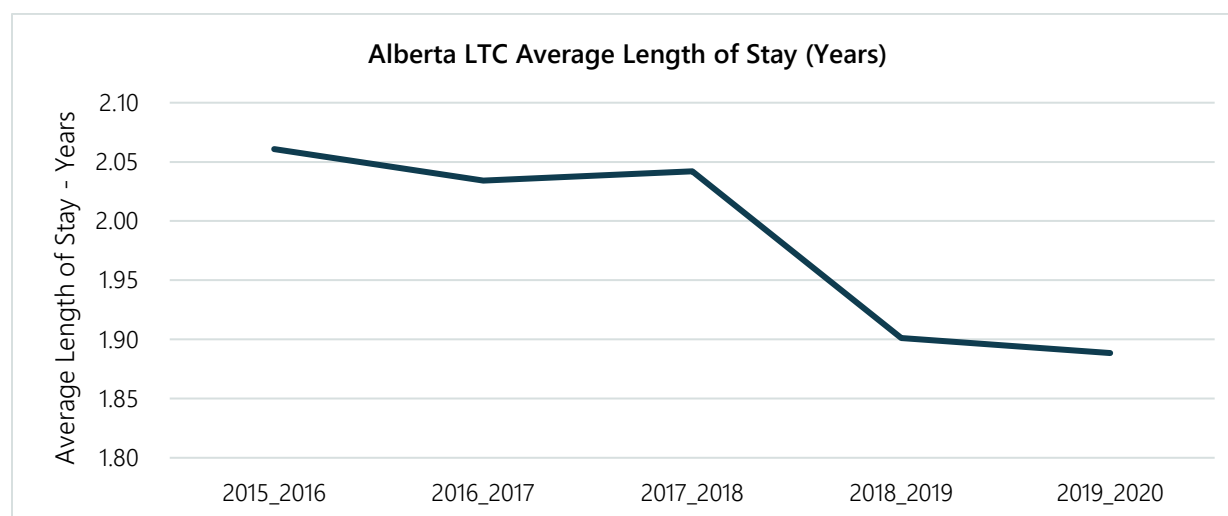
These findings are consistent with CMI data provided by AHS which demonstrate an increase in the number of resident days in Resource Utilization Group III (RUG-III) categories with higher CMI ratings (categories 1, 2 and 3) between 2015 to 2019, and decreases in the number of resident days in RUG-III categories with lower CMI ratings (categories 4, 5 and 6) with the exception of category 7 (Figure 16). A listing of CMI ratings by RUG-III category is included in Appendix 3.

Figure 16: Resident Day Trends by RUG-III Category for Alberta LTC Facilities – 2015 to 2019



Overall, the average length of stay for LTC residents in Alberta has decreased from 2.1 years in 2015/16, to 1.9 years in 2019/20 (Figure 17) based on data provide by AHS. This is consistent with a study by Hoben, *et al* which also showed that the average length of stay in LTC facilities has decreased from 1.8 years in 2008 to 1.3 years in 2015 in Calgary and from 1.9 years to 1.1 years in Edmonton<sup>48</sup>. The shortened average length of stay suggests that residents are being admitted with higher acuity.

Figure 17: Average Length of Stay of Alberta LTC Residents



### 3.4.1.1 Areas of Opportunity

A shortage of FBCC staff was reported by many survey respondents (see Section 3.4.2.2 below) as an issue in FBCC. The HQCA LTC Family Experience Survey of 2017 also reported that family members' top recommendation for improvement was to ensure enough staff were available to meet residents' care needs and the staff job responsibilities. Only 18 per cent of families said there were always enough nurses and HCAs<sup>49</sup>.

Inadequate direct care hours are a major concern in LTC as many research studies have confirmed that there is a direct relationship between adequacy staffing levels and quality of care in LTC homes<sup>50,51,52,53,54</sup>. The resident conditions most affected by staffing levels were found to be functional ability, pressure ulcers, and weight loss.

Alberta Health has recently explored options for increasing direct hours of care for LTC and DSL. As part of the review, MNP worked collaboratively with Alberta Health to examine options for increasing the average direct hours of care for nursing, personal care, and therapy hours. MNP suggests increasing direct hours of care as follows in FBCC:

- Increasing the average direct worked hours of care for LTC from 3.4 hours to 4.5 hours
- Increasing the average direct worked hours of care for DSL4D from 3.0 hours to 4.0 hours
- Increasing the average direct worked hours of care for DSL4 from 2.7 hours to 3.5 hours

### Staffing Model

There is an opportunity to provide greater flexibility within the staffing model for FBCC such that operators should be able to substitute professional care hours between nurses and professional therapies to meet the changing needs of FBCC residents.

There is also an opportunity to change staffing levels with the development of new models of care such as the use of smaller home-like settings. In these houses, leading-edge projects had developed very different staffing patterns than those of traditional LTC facilities. For example, one project used a consistent group of direct care staff with much expanded work responsibilities, such as suitable daily

activities, light housekeeping, and meal preparation, in addition to personal care. Teamwork and the absence of hierarchy were the features of the staffing model<sup>55,56</sup>.

The principle of adjusting staffing patterns to match clients' needs should also be used in the future to assist individuals to "age in the right place". Currently, DSL sites are staffed with a lower level of worked hours and professional nursing coverage than LTC sites. In the future, as DSL residents have higher acuity levels of care, it may be more cost-effective to increase the staffing levels of a particular DSL unit than moving these residents to LTC. This arrangement will enable DSL residents to "age in the right place".

### 3.4.2 What We Heard

#### 3.4.2.1 Expert Panels

The Expert Panel members reported that FBCC staffing could be improved through:

- Improving training offered to staff to meet the growing demands associated with increasing resident acuity
- Increasing the flexibility of the staff model to have an appropriate staffing mix that meets the differing needs of FBCC residents
- Having RNs focus more on leadership and less on assessments, although assessments are very important for ensuring proper quality of care
- Having HCAs be more involved in decision-making and formally included on the care team as a whole
- Implementing outcome-based staffing models (i.e. ensuring the best client outcomes) rather than task-based models
- Improving the balance of the flexibility needs of operators with income stability for staff
- Maintaining a mix of full-time and part-time positions based on staffing desires
  - Look at cohorting facilities or job-sharing options to support part-time positions as desired

#### 3.4.2.2 Surveys and Interviews/Focus Groups

Survey and interview respondents were asked to describe the strengths and challenges of the current staffing model. The following strengths were identified:

- Great teamwork and communication
- Staff are dedicated and qualified
- Great relationships between residents and staff

Survey and interview respondents reported the following challenges with the FBCC staffing model:

- A lack of available staff to meet workload demands and increasing resident complexity
- Over reliance on part-time hours
- A lack of training provided to staff

- A lack of flexibility in the staffing model to meet the different needs of FBCC residents
- Not involving HCAs in the care planning for residents, or including them as part of the care team
- Not enough primary care involvement (physicians and NPs) in FBCC

Respondents to the FBCC administrator, FBCC staff, and external organization surveys were asked to rate six different proposed changes to the staffing model for FBCC. The three options with the highest ratings included increasing direct hours of care to residents, putting in place minimum staffing ratios, and adding more flexibility to adjust staffing models based on resident need (Figure 18).

Figure 18: Ratings for Proposed Changes to Staffing Models

Stakeholder Group	Level of Support – 0 no support to 10 strong support					
	Adjusting Overall Staffing Mix	Having Minimum Staffing Ratios	Increasing Direct Hours of Care	Flexibility to Adjust Staffing Model	More Competency-Based Staffing	Adjusting Mix of Professional Therapies
FBCC Staff - Administrators	6.9	8.1	9.0	8.3	7.6	7.7
FBCC Staff - Nurses	7.6	9.0	9.0	8.1	7.6	7.1
FBCC Staff - Prof Therapy	6.6	8.9	9.0	8.2	7.6	7.4
FBCC Staff - HCA	7.6	8.6	8.3	8.4	7.7	7.4
FBCC Staff All Other	7.0	8.3	8.3	8.0	7.7	7.2
External Organizations	8.5	9.0	9.2	8.2	8.7	8.0

Other opportunities identified for improving the staffing model for FBCC included:

- Increase recreational therapy staff
- Increase mental health staff
- Increase spiritual care staff
- Better acknowledgement of all support staff

### 3.4.3 Leading Practices/Other Jurisdictional Research

#### Centre for Medicare and Medicaid Services Study

In 2000, a United States-based phase II study<sup>57</sup> conducted by the Centers for Medicare and Medicaid Services (CMS) examined the relationship between nurse staffing and quality of care at more than 5,000 LTC facilities in 10 states. The study revealed that among LTC residents: nurse staffing levels below 4.1 hours per resident day (below 1.3 hours per resident day for licensed nurses and below 2.8 hours per resident day for nurse aides and assistants) could have adverse consequences.

The study used a simulation model to determine the number of direct-care staff members necessary to provide five important "care processes" to residents including facilitating independence in dressing and grooming, assisting with feeding, facilitating exercise, and providing incontinence care or toileting assistance with repositioning.

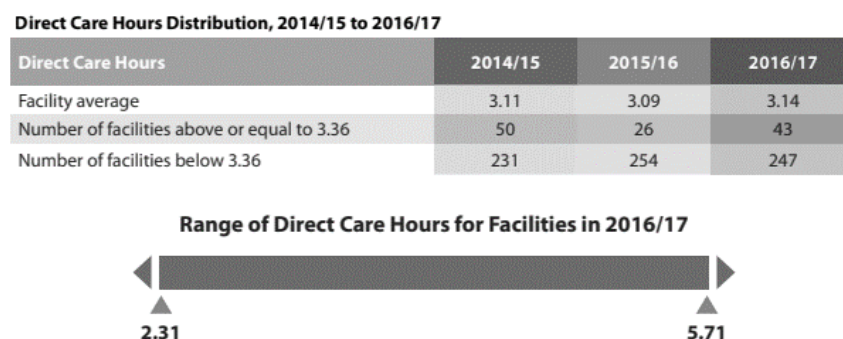
In 2000, 91 per cent of U.S. LTC facilities had nurse staffing levels below minimum thresholds based on the level of resident need for direct-care nursing.

### British Columbia Studies

In 2017, the BC Ministry of Health conducted a Residential Care Staffing Review<sup>58</sup> which included a literature review and jurisdictional research of the Alberta and Ontario staffing systems. Although the literature was inconclusive about the effectiveness of defined minimum staffing standards, the Ministry believed that achieving a minimum 3.36 hours per resident day average is required for safe, quality care in most facilities.

In BC, subsidized residential care facilities receive funding from health authorities to provide residential care. The Ministry of Health has set a guideline that residents should receive 3.36 hours of direct care daily [comprised of 3.0 worked hours of nursing care (includes care aides) and 0.36 worked hours of allied health services]<sup>59</sup>. Direct care hours may be delivered by nursing staff, care aides, or allied health care workers, such as physical, occupational, or recreational therapists, speech language pathologists, social workers or dietitians. Overall, 85 per cent of facilities are below the provincial guideline of 3.36 direct care hours per resident, per day. This was an improvement over the previous year, when the Office of the Seniors Advocate found that 91 per cent were not meeting the provincial standard (Figure 19).

Figure 19: Direct Care Hour Distribution in BC Facilities



### Ontario Study

The Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) is the provincial association representing not-for-profit providers of LTC services and housing for seniors. Members include not-for-profit LTC homes (municipal, charitable, and non-profit nursing homes) seniors' housing, supportive housing, and community service agencies. In 2014, this entity submitted recommendations based on input from the non-profit LTC sector's perspective on how the system could be improved through public investments and policy changes and enhancements. Specifically, one recommendation regarding staffing levels and service quality concluded that the Ministry of Health and

Long-Term Care set and fund over the next three fiscal years a system target of 4.0 paid hours of direct care per resident day for LTC.

Additional information on leading practices in other jurisdictions regarding staffing and workforce can be found in Section 3.5.3.

### 3.4.4 Policy Direction and Recommendations

Based on the findings articulated above related to staffing mix and models, four recommendations were developed.

#### Policy Direction 5: Increase staffing hours and consistency of staffing to improve quality of care.

- **Recommendation 16:** Increase direct care hours (includes nursing, personal care and therapeutic) at FBCC sites to an average of 4.5 worked hours per resident day for LTC and up to an average of 4.0 worked hours per resident day for DSL within a four-year period.
- **Recommendation 17:** Increase the level of professional care hours (nursing and therapeutic) for FBCC residents.
- **Recommendation 18:** Increase the level of mental health professional supports for FBCC residents.
- **Recommendation 19:** Support FBCC operators to implement consistent staffing assignments.

Additional detail regarding these recommendations can be found in Section 4.2.5 below.

## 3.5 Workforce



### 3.5.1 Current Context

Meeting the needs of the workforce for FBCC is a major consideration moving forward. This issue was amplified by the COVID-19 pandemic. The root causes of workforce concerns and challenges need to be identified and addressed to improve satisfaction, morale, and wellbeing (see opportunities for improvement below).

The current FBCC workforce includes HCAs, nursing staff, professional therapy staff, non-professional therapy staff, administration/management, food services staff, clerical support staff, education staff, housekeeping staff, laundry/linen staff, and maintenance and operation staff. Key features of the nursing and HCA workforce providing direct care includes but is not limited to:

- HCAs make up the majority of the FBCC workforce. As of September 2020, there were approximately 16,861 HCAs working in FBCC in Alberta. The current funded level of full-time equivalent (FTE) positions for HCAs is 11,610 (average complement is 0.69 FTE), and approximately 60 per cent of HCAs currently work part-time or in casual positions.
  - The single-site staffing order revealed that many HCAs had been working in multiple positions at more than one site.
- In 2019, there were 2,285 registered nurses working in FBCC.
  - 46 per cent of the total RN workforce worked full time.
  - There was a 2.8 per cent growth in the RN workforce between 2015 and 2019.

- In 2019, there were 3,808 licensed practical nurses working in FBCC.
  - 38 per cent of the total LPN workforce worked full time.
  - There was a 24 per cent growth in LPN workforce between 2015 and 2019.
- Based on the Single-staffing Database,
  - 45 per cent of staff work part-time, 33 per cent full-time, and 22 per cent casual/other.

### 3.5.1.1 Strengths

Continual efforts are being made by the Alberta Government to improve the training and competencies of HCAs. To ensure there is consistent training of HCAs, the Government of Alberta Health Care Aide Provincial Curriculum was developed and first used in 2005 and then updated in 2010 and 2013. In 2018, Alberta Health approved a new HCA competency profile. In 2019, Alberta Health introduced a new Provincial Health Care Aide Curriculum, along with a provincial final exam. Post-secondary institutions applied to use this curriculum and underwent a comprehensive review. All HCA programs are required to use this curriculum.

The *Continuing Care Health Services Standards*<sup>60</sup>, issued in March 2007, requires that HCAs providing publicly funded continuing care services have demonstrated the competencies required to provide safe, quality care as set out in the Provincial Curriculum for HCAs.

With Bill-46 (the Health Statutes Amendment Act)<sup>61</sup>, proposed in November 2020, HCAs have been placed under the College of Licensed Practical Nurses of Alberta for regulatory purposes. With this legislation, HCAs will soon become a regulated profession in Alberta.

It is expected that the combination of these latest regulatory efforts will continue to improve the training and competencies of HCAs to provide appropriate services to continuing care clients. The proposed regulation of the HCA profession will provide oversight supervision and increase the standard of care.

### 3.5.1.2 Areas of Opportunity

#### **Rising resident acuity and the gap between training/educational experience and the work environment**

Health care aides provide about 70 per cent of personal care at FBCC facilities in Alberta. Quality of care can only be achieved if staff are trained to deliver the appropriate care. The provision of quality care requires certified training with a uniform core curriculum, standardized staff competencies, and effective supervision of care practices.

The characteristics of LTC residents have changed substantially in the last twenty years. The once relatively mobile population has changed to one with high health care needs. It is estimated that 70 to 90 per cent of the current LTC population is living with dementia. The length of stay for LTC residents is also decreasing, suggesting higher acuity levels. FBCC staff will require proper training to provide proper care to higher acuity residents.



## **Demanding work and employment conditions for staff**

Increasing workload issues for nursing and personal care staff is another area of concern for FBCC, as the acuity of residents continues to increase. This demand has intensified the stressful working conditions in FBCC.

FBCC sites incur some of the highest work-related injury rates in Alberta and Canada. Personal care includes physically lifting and moving residents which often results in staff injuries due to either accidents or improper application of techniques. In addition, residents living with dementia can pose challenging behaviours for staff to address. In some of the worst instances, staff may even experience violence and abuse from residents. Many HCAs working in Alberta are immigrants and predominantly women, with language barriers and coming from low-income families. These conditions can lead to many obstacles in articulating their concerns on workplace issues and having their problems addressed.

Another issue with FBCC workplaces is a shortage of full-time employment with related benefits such as sick time, vacation, and other fringe and pension benefits. Part-time employment is created by the need to have enough staff at peak activity periods in FBCC (e.g. mealtime). Some employers prefer to provide part-time employment as it lowers the facilities' operating costs by reducing fringe and pension benefits. Many employees in FBCC require full-time employment to support the financial needs of their families. Thus, it is not unusual for them to work at two or three facilities concurrently. Some employees prefer part-time employment due to improved flexibility and the need for child-care, and other family commitments.

COVID-19 demonstrated the adverse impact that part-time employment had in FBCC. From the organizational health perspective, an excess use of part-time personnel in a facility creates instability in the organization. From the person-centred care perspective, part-time employment of nursing and personal care staff makes it impossible to provide consistency of care providers which is requested often by residents. Prior to COVID-19, many HCAs, LPNs, and RNs worked part-time or casual hours. The high percentage of part-time employment in FBCC should be reduced to improve continuity of care for FBCC residents.

Public Health Order 10-2020 came into effect in 2020 and will remain in effect throughout the course of the COVID-19 pandemic. This Order mandates that staff work at only one FBCC site, with some exemptions granted for special occasions. At present, more than 95 per cent of the workforce has been allocated to single sites.

## **Labour Supply and staff shortages**

Alberta is expected to experience a drastic increase of persons over 75 years in the population from 2020 to 2030. In response, there is an urgent need to project the types and quantities of labour force required to address the needs of the aging population and to develop a provincial human resources strategy to meet these needs. Ways of attracting and retaining workers such as HCAs, LPNs, RNs, and professional therapy staff in FBCC will be an important element of this strategy. An increase in home care staff to address the expansion of home and community services also needs to be evaluated.

## Insufficient funding for staff wages and hours of care

The funded wage rate for different FBCC positions is based on the average wage rates of all FBCC sites in Alberta. However, each operator negotiates its own wage rates with the corresponding unions. Some facilities indicate that the funded wage rates provided by AHS are below the actual wage rates they pay their staff.

## Culture of FBCC

The existing culture of FBCC is one in which staff become overly focused on regulated tasks and schedules, sometimes at the expense of positive resident outcomes. HCAs, who very often know the residents best, are not always involved in the care planning of residents. HCA positions are perceived as low-valued jobs, and few see any opportunity for advancement.

To better meet the needs of FBCC residents and build a high-performing workforce, the culture of FBCC needs to change. A continuous quality improvement approach that places residents at the centre of care should be adopted. Staff should be encouraged to participate in in-service education courses and continuous improvement activities. A “learning culture” should be cultivated, and opportunities for “career laddering” should be provided to all front-line staff to provide opportunities for advancement.

## 3.5.2 What We Heard

### 3.5.2.1 Expert Panels

The Expert Panel members reported that FBCC workplaces could be improved through:

- Reducing staff burnout, as care staff and managers experience high levels of burnout which can reduce quality of care and ability to retain experienced staff
- Building strong culture, as happy staff lead to happy residents and families which creates a culture of supporting staff
- Developing a formal Human Resources plan for FBCC keeping in mind what is needed for the future, competencies of staff and how to evaluate the effectiveness of the plan
- Reducing the administrative burden on front line staff so they have more time to spend with residents
- Improving the use of IT or management of health data to free up staff time for resident care
- Having a collective team focus, as the entire care team from cleaning staff to care staff should be looked at as a collective group and each member of the team should be working towards the same goal

### 3.5.2.2 Surveys and Interviews/Focus Groups

Respondents to the FBCC administrator and staff surveys rated the level of staff morale at FBCC sites from 5.0 to 6.3 out of 10 (Figure 20). FBCC staff survey respondents rated their level of satisfaction from 5.8 to 7.0 out of 10 (Figure 21).

Figure 20: Perceived Level of Staff Morale at FBCC Sites

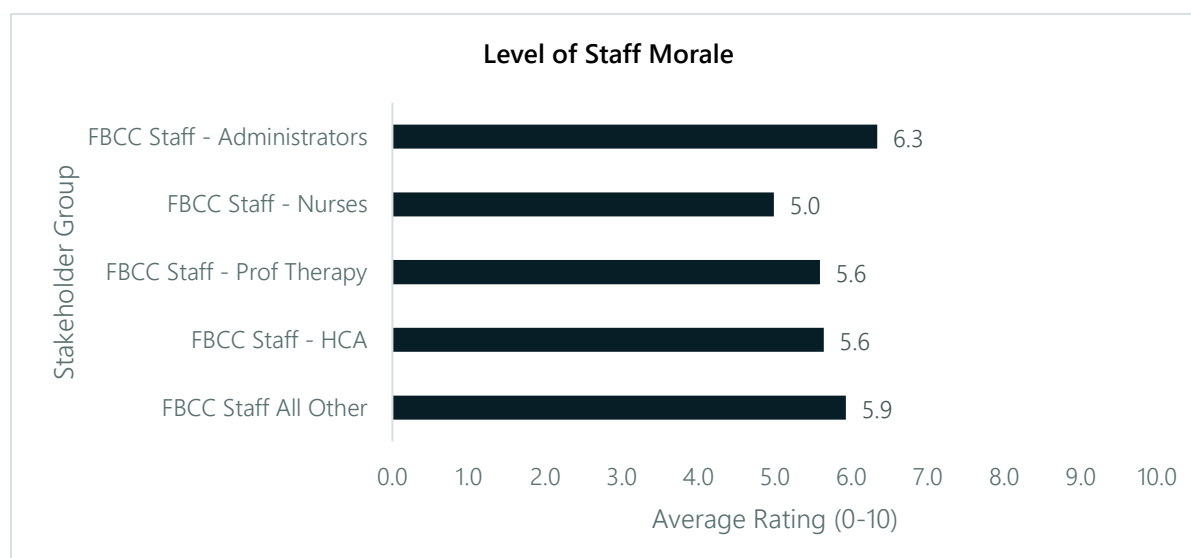


Figure 21: Perceived Level of Staff Satisfaction



Respondents to the FBCC administrator, FBCC staff and external organizations surveys were asked to rate six different proposed workplace improvements for FBCC. The three options with the highest ratings (Figure 22) included supports for staff wellbeing, increasing staff wages, and increasing staff benefits.

Figure 22: Ratings for Proposed Workplace Improvements

Stakeholder Group	Workplace Improvement Level of Support – 0 no support to 10 strong support					
	Supports for Staff Well-Being	Training to Improve Competencies	Training for Career Development	Increasing Staff Wages	Increasing Staff Benefits	Increasing Full-Time Positions
FBCC Staff - Administrators	7.9	7.7	7.4	7.6	7.0	7.3
FBCC Staff - Nurses	8.5	8.2	8.0	8.2	8.3	6.5
FBCC Staff - Prof Therapy	7.8	7.9	7.3	7.9	7.7	7.4
FBCC Staff - HCA	8.4	8.1	8.2	9.0	8.9	7.6
FBCC Staff All Other	8.3	8.1	8.2	8.4	8.4	7.6
External Organizations	8.5	9.0	8.3	8.2	8.2	8.4

Other opportunities identified for improving the workplace for FBCC staff included:

- Ensure that staff who only want to work part-time, still have the option to do so if there is a shift towards increasing full-time staffing complements
  - Ensure a proper balance of full-time and part-time hours
- Increase use of collaborative care teams in FBCC
- Improve recognition of staff contributions
- Improve communication between management and staff, and make sure that staff are supported properly by management

### 3.5.3 Leading Practices/Other Jurisdictional Research

Numerous studies have been conducted on workforce issues in LTC recently. Two prominent studies in this area are: the Ontario Long-Term Care Staffing Study, July 2020, by the Long-Term Care Staffing Study Advisory Group, Ontario Ministry of Long-Term Care; and Restoring Trust, COVID-19 and The Future of Long-Term Care June 2020, by the Royal Society of Canada<sup>62,63</sup>. There was consensus on major issues facing the LTC workforce including:

- Rising resident acuity
- Gap between training/educational experience and the work environment
- Challenging working/employment conditions for staff
- Labour supply and staff shortage
- Insufficient funding for staff wages and hours of care
- Workplace culture.

## Labor Supply and Staff Shortages

Following Ontario Premier Doug Ford's pledge that the Ontario government was "totally committed" to the provision of four (4.0) hours of care per resident per day in LTC homes, the government announced that it would invest up to \$1.9 billion annually by 2024-25 to create more than 27,000 new positions for personal support workers (PSWs, which are the equivalent to HCAs in Alberta), RNs, and LPNs in LTC within a four-year period<sup>64</sup>. The study also found that residents would benefit from more involvement by allied health and other professionals such as occupational therapists, physiotherapists, social workers, and recreation therapists.

In Ontario, the 2020 LTC staffing study provided several recommendations. Specific recommendations included:

1. The number of staff working in LTC needs to increase and more funding will be required to achieve that goal
  - Minimum daily average of four hours of direct care per resident
  - Guidelines for improving staffing ratios and skill mix for PSWs, nursing staff, and allied health professionals, with variance to address specific circumstances
2. The culture of LTC needs to change – at both the system and individual home level
  - Regulatory modernization
  - A quality improvement approach to sector oversight
  - Renewed performance measurements
  - A strong coherent philosophy of care
  - Recognition of the critical role of PSWs
  - Respectful team environment
3. Workload and working conditions must get better, to retain staff and improve the conditions for care
  - Compensation
  - Full-time and part-time employment
  - Protection from physical, mental, and emotional risk
  - Charting and documentation
  - Medication management
4. Excellence in LTC requires effective leadership and access to specialized expertise
  - Clarifying the role and accountability of the Medical Director
  - Expanding the use of Nurse Practitioners
  - Ensuring access to strong Infection Prevention and Control (IPAC) expertise
  - Accessing specialists
5. Attract and prepare the right people for employment in LTC, and provide opportunities for learning and growth

- Attracting people with the right personal attributes through:
  - Improved public perception
  - Stronger relationships with secondary schools
  - Enhanced supports for new graduates
  - Expanding the labour pool
- Aligning the number of graduates with needs across the health care sector
- Addressing educational requirements for the LTC sector by:
  - Increasing onsite experiences for students
  - Promoting preceptorships
- Supporting staff to stay current, gain new skills and develop specialized expertise, including:
  - Continuing education
  - Micro-credentialing and job laddering

## Workforce Culture

There is a growing body of evidence demonstrating that staff empowerment and collaborative decision-making has a significant effect on the overall quality of resident care such as those practices outlined in the Feasible and Sustainable Culture Change Initiative (FASCCI) Model<sup>65</sup>. Highlights of this model include:

- Creating an environment within which care staff experience being on a team that is positive, supportive, and inclusive is foundational to increasing their engagement in any practice change initiative aimed at improving resident care
- Research shows that there is a significant positive relationship between team inclusion and staff empowerment in LTC facilities
- Leadership training included in the FASCCI model assists supervisors to create such an environment
- Care-workers in the LTC sector frequently experience low job-satisfaction combined with high levels of burnout and high turnover, all of which has negative implications for the quality of resident care
- A cohesive work climate that provides more autonomy and clarity has been found to lead to a higher level of job satisfaction in the LTC sector

Further, existing research demonstrates that interventions aimed at increasing the provision of person-centred care most often fail if they do not address contextual and system issues<sup>66</sup>. Therefore, a multilevel systems approach is required. The following organizational factors have the greatest influence on improving person-centred care in practice:

- Leaders and managers who embrace a leadership style of 'supporting and valuing staff' combined with 'responsive to staff needs' and offering 'solution-focused approaches' to care decisions
- Empowered workforce practices that enable and encourage collaborative decision-making and increase staff's autonomy and self-determination

- The development of effective, supportive, and trusting teams

The FASCCI model incorporates the above factors and supports the successful implementation of person-centred care principles into everyday care practices in LTC homes.

### 3.5.4 Policy Direction and Recommendations

Based on the findings articulated above related to workplace, three recommendations were developed.

#### **Policy Direction 6: Develop a Workplace Improvement Action Plan to enhance working conditions for staff working in both FBCC and home care.**

- **Recommendation 20:** Develop a provincial Human Resource Strategy for continuing care (taking into consideration FBCC, home care, etc.).
- **Recommendation 21:** Establish a full-time employment benchmark for nursing, therapeutic and health care aide staff for FBCC and include the benchmark as one of the quality indicators for monitoring FBCC.
- **Recommendation 22:** Form a Workforce Improvement Task Force to assess ways of improving workforce design, workforce culture and working conditions for staff working in FBCC.

Additional detail regarding these recommendations can be found in Section 4.2.6.

## 3.6 Client / Resident Choice



### 3.6.1 Current Context

#### **Health Charter**

The values and philosophy of the Alberta health system were outlined by the 2014 *Alberta Health Act*. In tandem, a Health Charter was adopted in March 2014<sup>67</sup> which set out key values and aims of Alberta's health system and the roles and responsibilities of patients and providers within the health system.

The Health Charter (Appendix 1) outlines that, when someone interacts with the health system, the individual:

- Can expect that his/her health status, social and economic circumstances, and personal beliefs and values are acknowledged
- Be treated with respect and dignity
- Has access to team-based primary care services
- Has the confidentiality and privacy of his/her health information respected
- Be informed in ways that the person understands so that he/she may make informed decisions about his/her health, health care and treatment
- Be able to participate fully in his/her health and health care
- Be supported through his/her care journey and helped to find and access the health services and care that he/she requires

- Receives information on the health system and education about healthy living and wellness
- Has timely and reasonable access to safe, high quality health services and care
- Has timely and reasonable access to the individual's personal health information
- Has the opportunity to raise concerns and receive a timely response to his/her concerns, without fear of retribution or an impact on his/her health services and care

Implicit in the Health Charter is the belief that individuals should be given information on services and treatment provided in the Alberta health system to enable them to “make informed choice” and decision on services to be delivered.

### **Privately Funded Care and Services**

In Alberta, both publicly and privately funded health and personal care services are available. Albertans can access publicly funded services by working with an AHS case manager; private services are arranged and paid for by the individual. It is also possible to arrange a combination of public and private services to ensure all the client's needs are met.

Publicly funded services include FBCC and home care. An AHS case manager works with the client to assess their health needs and arranges for the publicly funded continuing care services appropriate to meet their needs. Publicly funded FBCC is provided by private for-profit and private not-for-profit FBCC operators contracted by AHS, as well as directly by AHS and its subsidiaries.

Private care facilities can be accessed without working with an AHS case manager. Individuals apply directly to the independent housing operators, and all fees for health and personal care services and accommodation are paid for by the individual. Fees are set by the housing operators.

Individuals may choose to supplement the publicly funded services they receive by paying for additional private home care services. They may also choose not to be moved to any of the publicly funded FBCC sites and to pay for privately funded sites and care instead.

#### **3.6.1.1 Strengths**

Alberta is one of a few jurisdictions in the world that has proclaimed a Health Charter for its citizens. The Health Charter embodies the values and principles governing the Alberta health system. These same values and principles also apply to the delivery of continuing care services in Alberta.

#### **3.6.1.2 Areas of Opportunity**

The principle of choice applies in two levels in continuing care, at the system level and the individual level.

##### **Application of the principle of choice at the system level**

Continuing care currently has three streams of services: LTC, DSL and home care. When applying for these continuing care services, the client is assessed for eligibility by means of the InterRAI Assessment Tools. If assessed as requiring FBCC, the person will be referred for admission. Individuals are not given a choice of providers or options to receive care outside of a facility setting (e.g. their own home, smaller congregate home settings etc.). If the individual selects a site in which there is a waiting list, the applicant can state three preferences of sites to live in. Those waiting in a hospital for placement begin



paying for FBCC accommodation fees after being assessed as needing FBCC. The applicant is then offered a space on a first-available basis within the three sites selected. If they choose to accept the space offered, they can remain on the waitlist for their most preferred option. If a FBCC space is offered and refused, the applicant goes back to the bottom of the waiting list. The applicant may also look for alternatives outside of the publicly funded system.

This system of assessment and referral to FBCC is generally used by all provinces, with some provincial variations.

### **Application of the principle of choice at the individual level**

At the individual level, choice is important to the resident regarding the way services are delivered. As seen in Section 3.6.2.2 below, interview and survey respondents feel that FBCC residents should have more choices with regards to bedtimes, meal selections and mealtimes, bathing times and frequency, clothing choices, recreation choices, visiting options, and accommodation choices (e.g. the ability to receive services in smaller congregate home settings, and the ability to continuing living with spouses and loved ones).

A self-directed system of care (see Section 3.6.3 below) could allow individuals who require high levels of support to choose to live outside of FBCC in a variety of settings such as their own home, private assisted-living, smaller congregate homes and shared and cooperative housing. It could also allow relatives (except direct family members and spouses) to receive government support for providing care for these individuals. The existing self-managed care program is utilized successfully in Alberta but does not get offered consistently across the province and is not available to people assessed as requiring FBCC.

### **Monitoring the self-directed care system**

One challenge of the self-directed care model is to ensure that there is sufficient oversight for self-directed care options. The monitoring mechanism should be simple and not pose a barrier to the provision of services. It should be effective in reviewing key aspects of self-directed care options such as proper use of funds based on assessed need, the quality of services provided (e.g. 2-3 assessments per year to monitor client outcomes), and licensing status of providers.

### **Privately paying for additional amenities at FBCC sites**

Another option that is already occurring across Alberta is to allow flexibility for residents to pay for additional services and amenities in publicly funded FBCC sites. This allowance would provide the choice and variety for the services delivered.

## **3.6.2 What We Heard**

### **3.6.2.1 Expert Panels**

The Expert Panel members reported that choices for FBCC residents could be improved through:

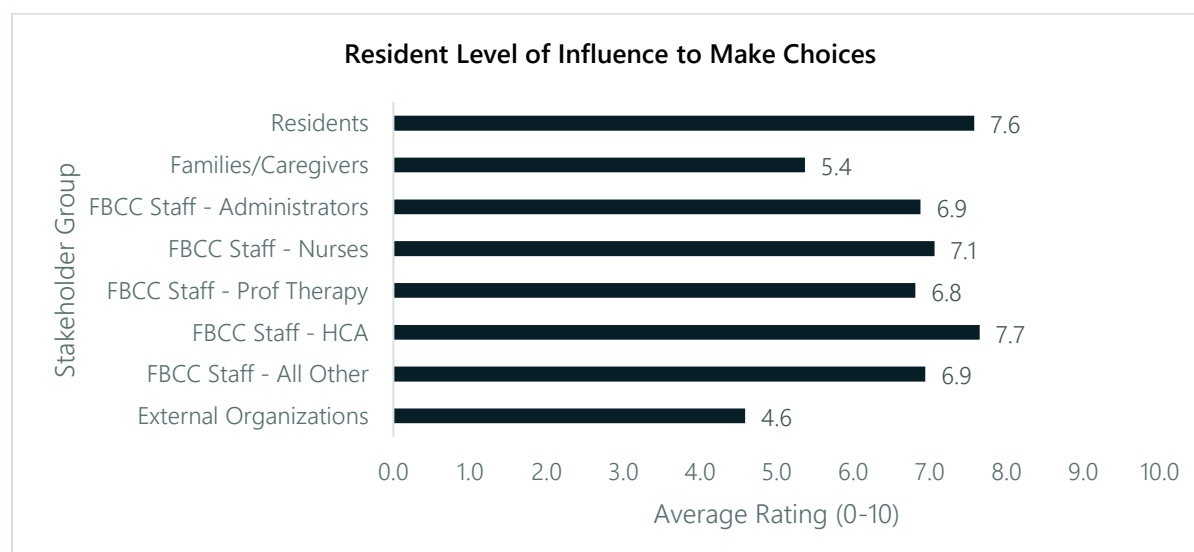
- Increasing focus on person centered models of care, by ensuring that the resident is at the centre of all choice, including care planning
  - Ensure care plans meet the goals chosen by residents

- Provide more choice with regards to where Albertans want to receive care
- Offer more choices with regards to living spaces such as smaller home options, and options that provide the ability to live in the community longer
- Removing barriers to receiving home care services, and broaden the basket of home care services
- Increasing access to self-directed care options both at home in the community as well as in other living environments such as smaller congregate living facilities and supportive living facilities
  - Implement income testing to support self-directed care models
  - Have monitoring mechanisms in place to assess the quality of services provided through self-directed care options
- Providing residents with the choice to live at risk
- Increasing resident choice on meals, menu choices and mealtimes
  - Provide opportunities to submit feedback to nutritionists and food staff
- Providing more choice with regards to daily schedules for FBCC residents
  - Increase resident choice about bedtimes and wake up times
  - Increasing resident choice for recreational services

### 3.6.2.2 Surveys and Interviews/Focus Groups

Overall, respondents to the resident, FBCC administrator, and the FBCC staff surveys ranked a resident's level of influence in making informed choices/decisions about their own continuing care services at 6.8 to 7.7 out of 10 (Figure 23). This was about 2.3 to 3.1 points out of 10 higher than the rankings provided by families/caregivers and external organizations.

Figure 23: Perceived Resident Level of Influence on Make Informed Choices



Respondents perceived that residents and caregivers/families have a relatively high level of influence on health care decisions, but a low level of influence on decisions related to food and accommodations. Respondents also reported that the level of influence over health care decisions is limited by constraints associated with staffing levels/flexibility and care funding.

Survey respondents were asked to rank their level of support for four different options regarding choices for continuing care clients to use public funding to pay for care in different settings including:

- **Option 1:** Choosing between receiving care in the home versus in a facility if the person is willing to pay for additional services to supplement what home care can provide
- **Option 2:** The ability to choose to use public funding (based on assessed need) to subsidize care at a private pay facility that is not contracted by Alberta Health Services (i.e., residents would make up the difference in cost themselves)
- **Option 3:** The ability to choose to use public funding (based on assessed need) to purchase private pay in-home care from a provider chosen by the client
- **Option 4:** The ability to choose to use public funding (based on assessed need) to pay a family caregiver instead of moving to a facility

The option receiving the greatest support was option 1, and the option with the lowest support was option 2 (Figure 24).

Figure 24: Level of Support for Public Funding Choices Outside of FBCC

Level of Support – 0 no support to 10 strong support				
Stakeholder Group	Option 1	Option 2	Option 3	Option 4
Residents	5.8	4.5	5.6	5.7
Families/Caregivers	6.3	5.8	6.4	6.6
FBCC Staff - Administrators	8.3	6.9	6.9	6.8
FBCC Staff - Nurses	8.3	7.0	7.3	7.6
FBCC Staff - Prof Therapy	8.6	6.9	7.8	7.8
FBCC Staff - HCA	8.3	7.1	7.4	7.8
FBCC Staff - All Other	7.8	6.5	6.9	7.4
External Organizations	7.8	6.2	7.5	7.3
Public	6.8	5.2	6.6	7.4

When asked to describe their answers in more detail, respondents provide the following:

- Respondents do not want to see public funds provided to private-for-profit facilities
- Respondents support the use of public funds to provide seniors and people with disabilities with more choices to receive care in the home/community
- Respondents felt that it was important to provide proper oversight and monitoring for publicly funded services in the community

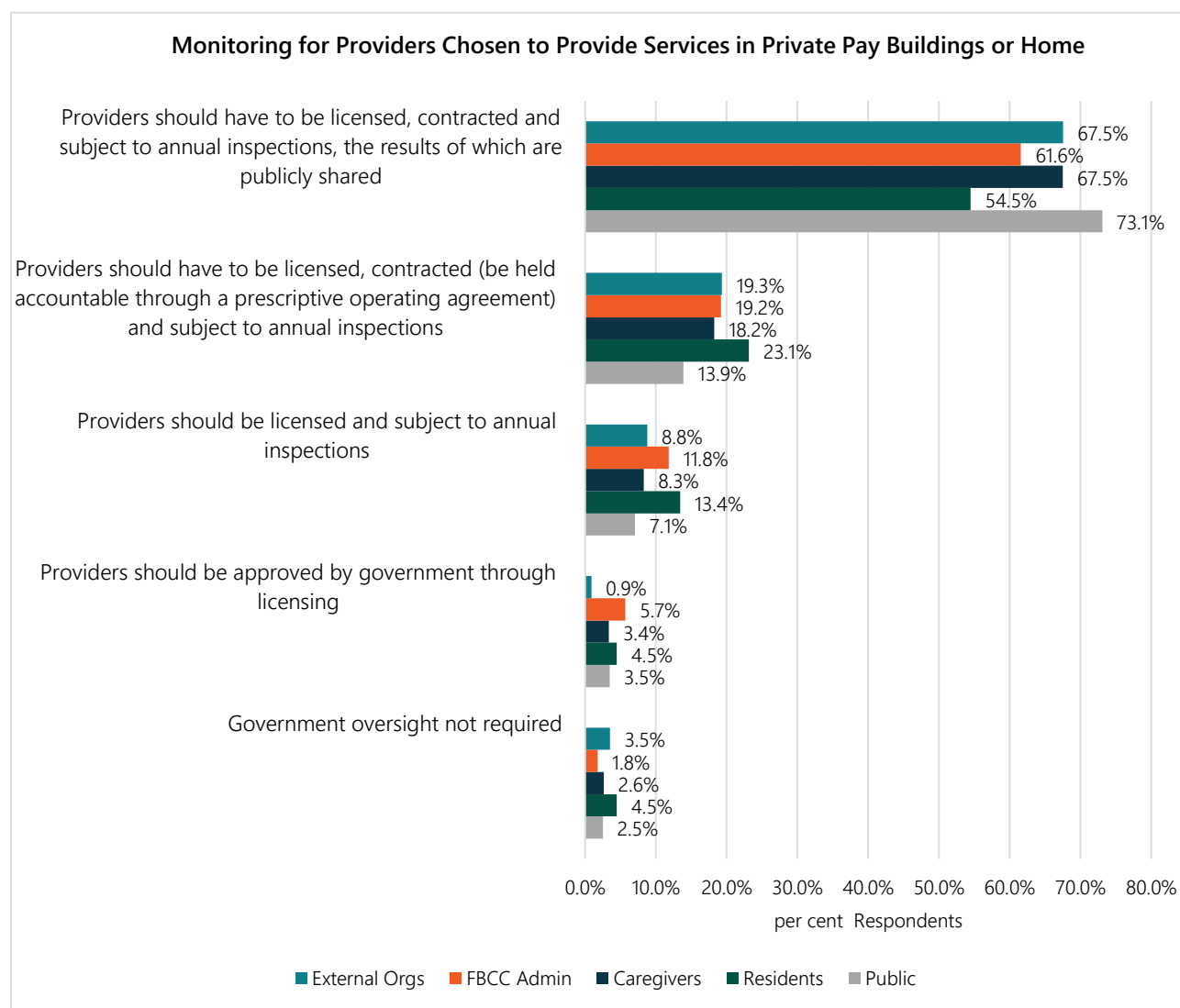
When asked about opportunities to improve client choice, the following themes were identified from the surveys and interviews:

- Need greater focus on aging in place
  - Provide options that enable individuals to receive care at home or in the community, versus in a FBCC space
  - Explore options for self-directed care models, and allow the opportunity to use public funds for this purpose
- Change the focus of FBCC to provide person-centered care to improve resident quality of life rather than task-focused care
- Involve clients and their caregivers in collaborative care and decisions related to care planning
  - Allow clients to choose their goals for care
- Increase choices related to facility types for residents to choose from
  - Need greater focus on aging in place such as having smaller, more personalized living environments
  - Support the development of smaller congregate care settings
  - Have facilities that provide different services levels under the same roof
  - Provide options that allow couples and loved ones to live together
- Provide FBCC residents with more choices related to lifestyle including:
  - Food choices
  - Mealtime choices
  - The choice of when to go to bed and when to wake up
  - The choice of when they have baths
  - Clothing/attire choices
  - Furnishings/decor
  - The choice of what activities they want to engage in socially (e.g. religious, cultural, gardening, creative)
  - Choices of when to communicate with family/friends

When asked about the level of oversight they would like to see for self-directed care options, most survey respondents selected the option with highest level of oversight (Figure 25) which was:

- Providers should have to be licensed, contracted and subject to annual inspections, the results of which are publicly shared

Figure 25: Preferences for Level of Oversight of Self-Directed Care Options



Respondents to the resident, family/caregiver, public, FBCC administrator, and external organization surveys were also asked about their level of support for FBCC residents accessing and paying extra out-of-pocket costs for different types of additional services and amenities. Residents, family/caregivers and public respondents had low to moderate support for all the options presented, while FBCC administrator and external organization respondents had higher support for each option (Figure 26).

Figure 26: Level of Support for FBCC Residents Having the Choice to Pay Extra for Additional Services

Additional Service Option Level of Support – 0 no support to 10 strong support								
Stakeholder Group	Better Meals	Larger Room / Better Amenities	1 on 1 Companion Support	Transportation (Errands / Family Outings)	Recreational Activities	Personal Care Services Beyond Assessed Need	Therapy (OT, PT) Beyond Assessed Needs	Facilities with More Updated Amenities
Residents	4.6	3.5	3.2	5.5	4.0	3.6	4.4	4.0
Families/Caregivers	4.5	3.7	5.4	4.8	4.7	5.3	4.9	4.3
FBCC Staff - Administrators	5.7	6.3	8.1	7.4	7.1	7.9	7.5	6.9
External Organizations	5.9	6.5	6.7	6.8	6.2	6.6	6.2	6.3
Public	4.6	5.4	4.9	5.5	5.0	5.4	5.2	5.0

Comments provided by survey respondents related to FBCC residents having the choice to pay extra for services included:

- The ability to pay extra for services will only benefit affluent residents with means to do so and would create an unfair multi-tiered system that erodes that basic care structure for the majority of FBCC residents
  - It was reported that most residents do not have the means to pay for extra services
- Respondents also perceived that many of the options presented should be included in a resident's basic level of care, and not something they have to pay extra for
  - Some respondents commented that if this option was supported, there would be a need to establish standards on what is the basic level of care
- Some respondents perceived this option as a move towards supporting a private healthcare system that only benefits those with money
- Respondents who supported this option felt that being able to pay for the following extra services would be helpful:
  - Additional mental health supports
  - 1 on 1 companionship
  - Additional recreational and exercise options
  - Additional foot care support
  - Spiritual and emotional supports
  - Television services
  - PT and OT
  - Esthetic services

### 3.6.3 Leading Practices/Other Jurisdictional Research

#### Self-Directed Care

The C.D. Howe Institute reviewed the manner provinces delivered their continuing care services in their research report, *Shifting Towards Autonomy: A Continuing Care Model for Canada (2016)*<sup>68</sup>, and concluded that “Canadian provinces’ one-size-fits-all approach to helping seniors continues to steer individuals towards institution-based care even when they would prefer to receive it elsewhere. Going forward, Canada must encourage a greater role for patients in choosing their care paths and doing so means expanding access to a more self-directed system.”

A proposed self-directed system is endorsed by many other evaluation studies and already implemented in countries like Japan, Australia, Germany, and France<sup>69</sup>. In fact, many advanced nations have moved towards continuing-care models that give clients a much larger say in the suite of services that they receive.

In 2020, Blomqvist and Wyonch drafted a memorandum addressed to Merrilee Fullerton, Ontario Minister of Long-Term Care regarding a self-directed care option for patients eligible for LTC. It suggests that Canada can learn from, adapt and implement LTC related innovations by other nations (e.g. France, Germany, Australia) that have designed flexible and efficient model for LTC and continuing care, and that a good starting place would be the implementation of a self-directed care option for patients eligible for LTC<sup>70</sup>.

Models that allow the clients to choose between care in-kind or a cash subsidy (or restricted cash transfers), have become a widely accepted feature in most developed nations as they seek to promote more independent living. For example, an eligible client could choose to wait for a LTC space in a subsidized licensed LTC home, or opt for a cash subsidy to be used to pay for care in an unsubsidized LTC facility (only those inspected and approved by government can be accepted). A client is free to choose any such facility, but there are no restrictions on fees. Some argue that the subsidy amounts could be roughly equivalent to the in-kind cost to government. Any difference between the value of the subsidy and the provider’s charges would be paid by the client.

The rationale for introducing a greater reliance on cash-based, self-directed models vary. They include:

- Increased recognition of diversity in care needs and the slow responsiveness of publicly managed care to these needs
- Home care substitution and preference over institutional care
- The need to put health costs on a more sustainable path
- The need to ensure choice
- The desire to improve the consistency of care for all people with similar needs
- The desire to better incorporate informal caregiving into care plans
- The desire to introduce more competition into care markets
- Job growth in caregiver services
- The importance of promoting independence among the elderly

- The desire to remove the distinction between age-related disabilities from overall policy toward those with disabilities<sup>71</sup>

Self-directed care models could also help free up beds in acute-care hospitals where many are occupied by patients that could be cared for in a LTC facility. Some patients could be accommodated in approved private facilities even if no public LTC spaces are available.

In Hong Kong, the Social Welfare Department (SWD) launched the Pilot Scheme on Residential Care Service Voucher (RCSV) for the Elderly in March 2017 with a total of 3,000 RCSVs to be issued within a period of three years. The Pilot Scheme, adopting the 'money-following-the-user' principle, provides an additional choice for people in need of residential care services (assessed to be of moderate level of impairment) and are wait-listed for care-and-attention places on the Central Waiting List (CWL). This pilot scheme has been extended for 3 years (March 2020 to March 2023)<sup>72</sup>.

Features of the Pilot Scheme include:

- 'Money-following-the-user' provides greater flexibility and choice: people can freely choose and switch residential care homes for the elderly (RCHes) under the Pilot Scheme according to their needs.
- 'Users pay in accordance with affordability' allows those who can afford less to receive more subsidy from the Government: the co-payment level is determined based on the asset and income of the person on an individual basis. People under Level zero (the lowest level) do not have to pay for the 'standard service package' included in the monthly voucher value. For the income test, the monthly income of the voucher applicants is benchmarked against the latest Median Monthly Domestic Household Income (MMDHI) for singleton households.
- Waiting time is shortened: people can receive subsidised residential care services in a shorter period of time.
- Six-month trial period: People can consider admitting to RCHes and try to adapt to life in RCHes.
- The Pilot Scheme allows voucher holders to make top-up payment up to an amount of 150 per cent of the voucher value to purchase enhanced or value-added services which are outside the standard service package. Examples of top-up services include additional physiotherapy/occupational therapy sessions, upgraded dormitory, acupuncture, Chinese medicine and massage service.

### Person-Centered Care and Choice

In the UK, the Health Foundation concluded that person-centred care is a relationship in which health care professionals and patients work together to: understand what is important to the person, make decisions about their care and treatment, identify and achieve their goals. The following positive outcomes of person-centred care were further described:

- Supporting patients with long-term conditions to manage their health and care can improve clinical outcomes. When people play a more collaborative role in managing their health and care, they are less likely to use emergency hospital services. They are also more likely to stick to their treatment plans and take their medicine correctly.



- Patients who have the opportunity and support to make decisions about their care and treatment in partnership with health professionals are more satisfied with their care, are more likely to choose treatments based on their values and preferences rather than those of their clinician, and tend to choose less invasive and costly treatments.
- Individuals who have more knowledge, skills and confidence to manage their health and health care are more likely to engage in positive health behaviours and to have better health outcomes.
- Person-centred care is good for health care professionals too. As patient engagement increases, staff performance and morale see a corresponding increase<sup>73</sup>.

### 3.6.4 Policy Direction and Recommendations

Based on the findings articulated above related to client/resident choice, three recommendations were developed.

#### Policy Direction 7: Expand the choices available to Albertans who require continuing care services.

- **Recommendation 23:** Introduce self-directed care as an option for people assessed as needing continuing care (expanding the option within home care and introducing FBCC options), to provide greater choice regarding locations, types, and providers of services.
- **Recommendation 24:** Develop a monitoring mechanism for the self-directed system of care.
- **Recommendation 25:** Enhance client choice by supporting a greater percentage of continuing care clients in the community rather than FBCC sites.

Additional details regarding these recommendations can be found in Section 4.2.7 below.

## 3.7 Governance, Accountability, and Transparency



### 3.7.1 Current Context<sup>74</sup>

#### Governance

AHS is Canada's first and largest province-wide, fully integrated health system, responsible for delivering health services to nearly 4.4 million Albertans. It is a single provincial health authority operating under the *Regional Health Authorities Act* of Alberta, RSA 2000, c. R-10 (RHAA)<sup>75</sup>. The governance of the Alberta health care system involves both AHS and Alberta Health, each with different roles and responsibilities.

Alberta Health is responsible for the developments of province-wide health services strategies, legislation and regulations pertaining to health services, and service standards. It also has an evaluative function in overseeing and reporting on the overall performance of the health system.

Under the *Regional Health Authorities Act*, AHS is charged with the following responsibilities:

- Promoting and protecting the health of Albertans and working towards the prevention of disease and injury
- Assessing the health needs of Albertans on an ongoing basis
- Determining priorities in the provision of health services in Alberta and allocating resources accordingly
- Ensuring reasonable access to quality health services for Albertans
- Promoting the provision of health services in a manner that is responsive to the needs of individuals and communities and supporting the integration of services and facilities in Alberta

AHS reports to the Minister of Health via the Alberta Health Services Board. Key features of AHS include:

- More than 103,000 direct employees (excluding contracted service providers) with almost 11,800 of whom work in AHS' wholly owned subsidiaries such as Alberta Precision Laboratories, Carewest and CapitalCare Group
- Programs and services offered at over 850 facilities throughout the province, including hospitals, clinics, continuing care facilities, cancer centres, mental health facilities and community health sites

The annual operating budget of AHS in the 2019-20 fiscal year was \$15.365 billion<sup>76</sup>.

## Ownership

There are three types of ownership for FBCC in Alberta (AHS/public, private-for-profit, and private not-for-profit). According to the AHS 2019 Bed Survey, the relative LTC bed capacities of these three ownership types were 29.5 per cent AHS/public, 33.2 per cent private not-for-profit, and 36.6 per cent private-for-profit. In terms of DSL spaces, the proportional distributions were 6.5 per cent AHS/public, 40.1 per cent private not-for-profit, and 53.4 per cent private-for-profit.

Figure 27: Number of LTC and DSL Spaces by Ownership Type in Alberta<sup>77</sup>.

Owner Type	LTC Spaces	Per Cent LTC Spaces	DSL Spaces	Per Cent DSL Spaces
AHS/Public	4,604	29.5 per cent	739	6.5 per cent
Private Not-For-Profit	5,176	33.2 per cent	4,542	40.1 per cent
Private-For-Profit	5,707	36.6 per cent	6,036	53.4 per cent
SHA Operated	110	0.7 per cent	0	0.0 per cent
<b>Total</b>	<b>15,597</b>	<b>100 per cent</b>	<b>11,317</b>	<b>100 per cent</b>

During the last few years, ownership of continuing care facilities has become an emerging issue for discussion, with some stakeholders believing there is a need to eliminate private-for-profit ownership.

### Public ownership of FBCC facilities (by AHS)

AHS operates FBCC spaces and also audits, monitors, inspects, and enforces compliance of these FBCC spaces as well as FBCC spaces owned and operated by private-for-profit and private not-for-profit operators. Many operators and stakeholders perceive AHS to be in a conflict-of-interest as the funder, operator, and auditor of its own FBCC spaces. This concern was expressed in survey responses (see below). In the AHS Performance Review, Ernst & Young recommended that “AHS should reconsider LTC facility ownership in cases where private delivery may be more efficient and appropriate.”<sup>78</sup>

### Private Ownership of FBCC facilities

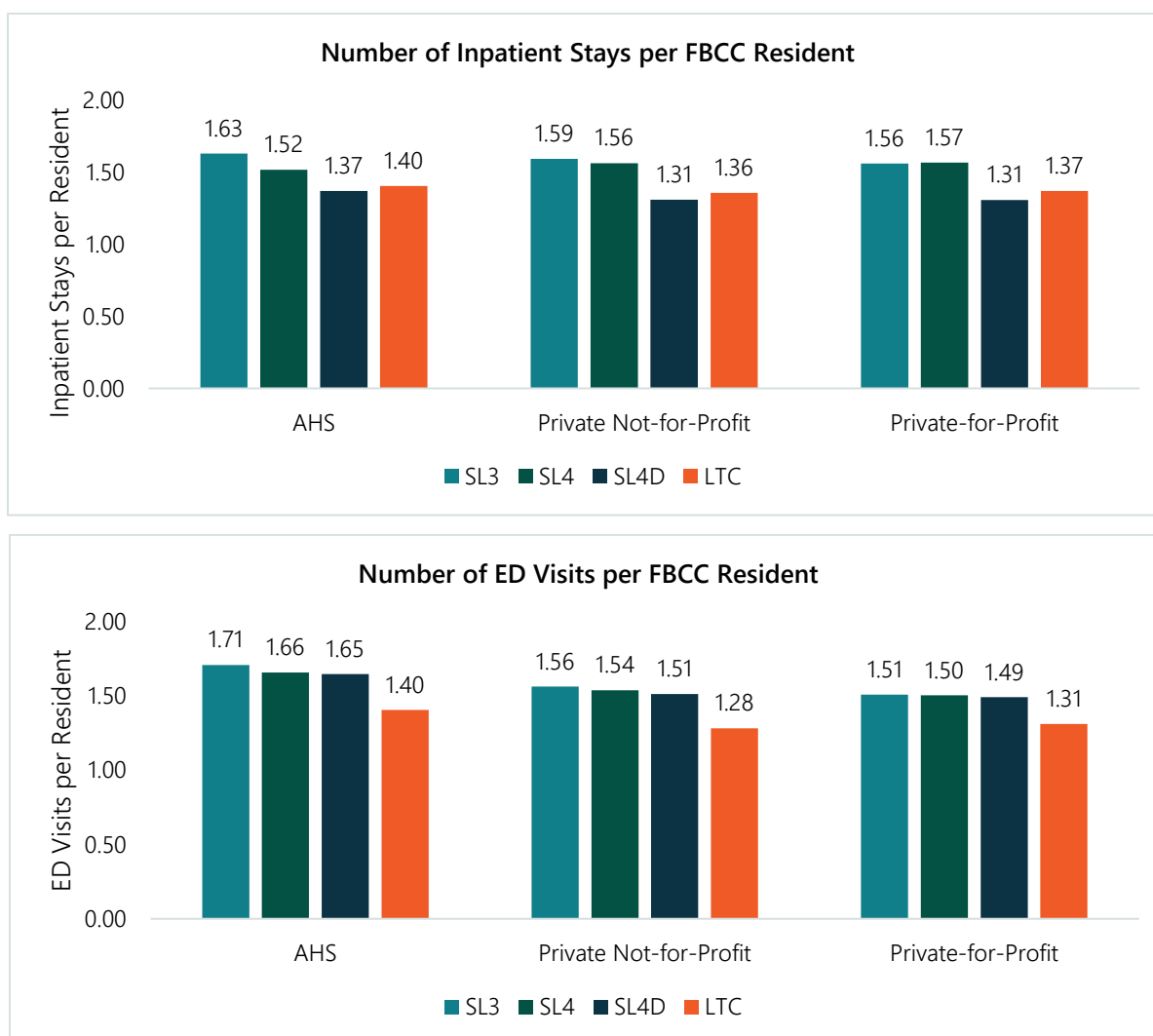
Across Canada, private ownership of LTC facilities has become a major concern during the COVID-19 pandemic. In many provinces, private LTC facilities have a higher proportion of outbreaks and fatalities than non-private facilities. This discrepancy has raised serious concerns about proper infection prevention and control protocols and care safety in private facilities. FBCC review survey respondents expressed similar concerns.

### Comparison of FBCC Site Data by Ownership Type

There is currently a perception in Alberta that private-for-profit FBCC sites perform worse than the other ownership types. However, this is not the case based on FBCC outcome data.

Hospital stay data for FBCC residents by ownership type was provided by AHS. The data shows that the average number of inpatient stays per FBCC resident for all three ownership types is similar, with AHS facility residents having the highest rate of inpatient stays per resident. The data also shows the average number of ED visits per resident is similar for all three ownership types, with AHS residents also having the highest rate of ED visits per resident (Figure 28).

Figure 28: Rate of Acute Care Visits per Resident by Ownership Type and Level of Care



An analysis of FBCC resident CPS scores (evaluates the level of cognitive impairment affecting a FBCC resident) and ADL long-form scores (evaluates a resident's ability to perform activities of daily living such as mobility in bed, transfers, locomotion, dressing, eating, toilet use and personal hygiene) also show similar outcomes from AHS, private not-for-profit, and private-for-profit operated sites for LTC and DSL (Figure 29 and Figure 30).

Figure 29: Comparison of LTC Outcomes by Operator Ownership Type

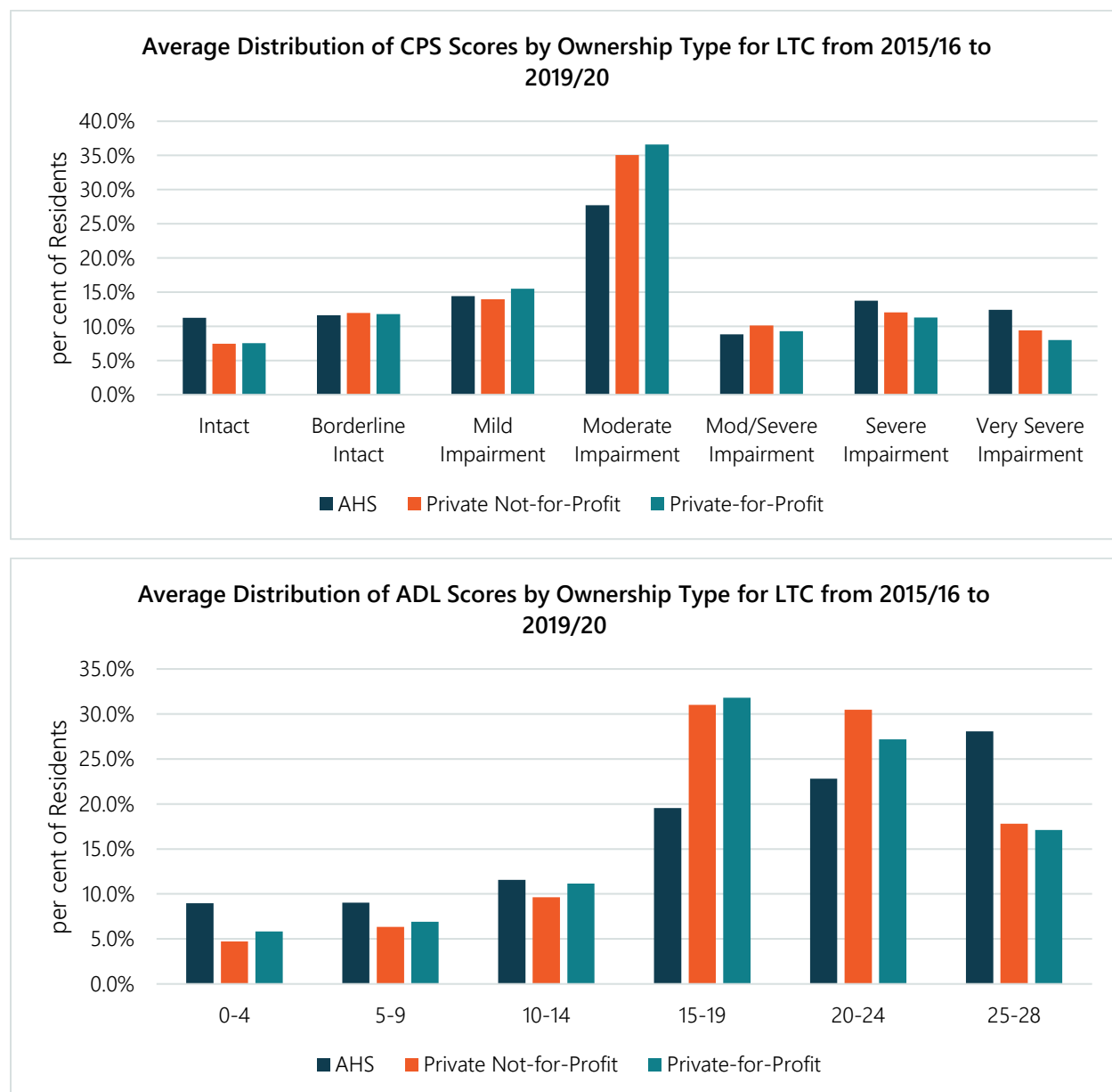
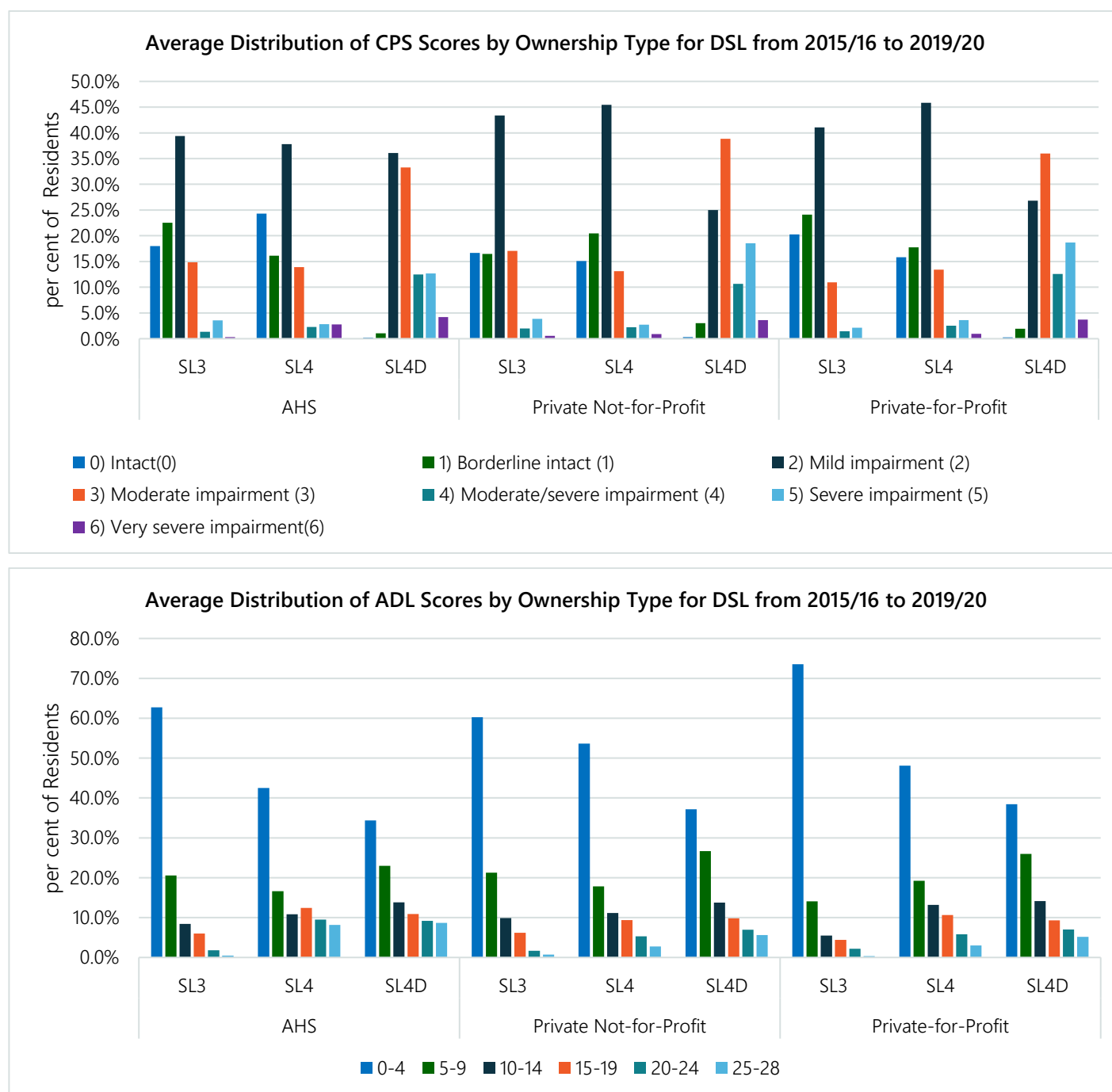


Figure 30: Comparison of DSL Outcomes by Operator Ownership Type



## Monitoring

The Minister of Health is ultimately responsible for assuring the public of the integrity of Alberta's continuing care system. Alberta Health has an oversight responsibility for the system and provides strategic and directional policy, legislation, and standards for public assurance and licenses DSL/certifies LTC accommodations and monitors compliance to the standards.

AHS, as the provincial health authority, is responsible for ensuring delivery of quality publicly funded services in FBCC (including publicly funded home care) throughout Alberta. In these settings, operators must comply with the Continuing Care Health Service Standards (CCHSS) as well as the Accommodation Standards.

Over the last 15 years, the quality assurance approach for Alberta's continuing care system has significantly evolved to better meet citizen expectations of service quality, safety and care in home care, DSL and LTC settings. It involves multiple Government of Alberta ministries, AHS programs/divisions, contracted providers, stakeholders, multiple standards, and quality assurance mechanisms.

### Continuing Care Compliance Monitoring

Since 2010, all accommodations serving four or more individuals where the operator provides or arranges for 24/7 safety and security measures and provides or arranges for either one meal per day or housekeeping services, must be licensed by Alberta Health under the *Supportive Living Accommodation Licensing Act (SLALA)* and comply with 32 Supportive Living Accommodation Standards. Similarly, LTC accommodations are certified by Alberta Health and monitored to their compliance with 30 LTC Accommodation Standards, pursuant to the *Nursing Homes General Regulation*.

All FBCC accommodations are monitored for compliance with Accommodation Standards, to ensure the provision of high-quality accommodation services that promote the safety, security, and quality of life for Albertans living in those facilities. Alberta Health's licensing inspectors, complaints officers and investigators conduct monitoring visits, inspections and investigations to determine compliance with legislation, regulations and standards; as well as compliance to the *Resident and Family Councils Act* which gives residents and their families the right to establish self-governing councils at any FBCC site. Where there are collateral authorities and funders, results of monitoring visits are shared to support the operator in achieving compliance.

Ministerial Directive D1-2018 requires AHS and its contracted third-party providers to comply with the CCHSS. The CCHSS set the minimum requirements that operators in the continuing care system must comply with in the provision of publicly funded continuing care services. These standards guide staff in providing safe, quality, standardized and individualized care based on assessed unmet needs of each resident/client. The CCHSS apply to publicly funded home care offices and contracted providers in the Co-ordinated Home Care Program, DSL sites, nursing homes and auxiliary hospital LTC facilities.

Currently, Alberta Health's health compliance officers (HCOs) and the AHS Continuing Care Provincial Audit Team (an independent team within AHS to audit FBCC services) collaborate on CCHSS compliance monitoring activities, including audits to the CCHSS, to support the health, safety and well-being of continuing care clients. Alberta Health provides oversight and monitors processes established by AHS and audit outcomes. The AHS audit team conducts routine audits, and AHS and Alberta Health jointly conduct high priority audits, which may be triggered by complaints and incidents that have direct and immediate impact on client care and safety. Alberta Health also conducts independent CCHSS audits as required.

AHS creates and shares two additional reports regarding compliance and monitoring including the Quality Management Report (QMR) and the Risk Assessment Report (RAR).

- The QMR enables operators to understand site performance, to identify quality improvement opportunities, and to measure progress towards quality goals in support of quality improvement.
- The RAR flags problems at a site/operator level based on minimum levels of acceptable performance for use by Zones/AHS leadership.

During the COVID-19 pandemic, monitoring has changed because of emergent needs to ensure compliance with the Chief Medical Officer of Health orders.

### Accreditation

In 2008, Alberta Health issued a directive that all publicly funded health care service providers require health system accreditation. In the context of continuing care, this is applicable to home care, DSL, and LTC service providers. Accreditation provides evidence that health service provider organizations have met established accreditation standards and have mechanisms in place to improve the quality of care they provide, manage risk, and assess performance.

Generally, accreditation drives best practice while legislation and standards outline minimum expectations to which operators are held accountable through regular monitoring. Accreditation standards are evidence-based and outline best practices that typically exceed minimum requirements. Accreditation standards focus on building quality and safety throughout the organization and on being client centered and responsive to customer needs. In Alberta, there is flexibility for organizations to select the accrediting body, as well as the types of standards that are applied to meet the requirement. The extent to which accreditation standards address the same organizational and care/service delivery requirements are different depending on the accreditation applied.

### Auditor General Report and Recommendations on Monitoring, 2014:

In 2014, the Auditor General of Alberta conducted a follow-up audit on LTC facilities in Alberta. The overarching objective was to “conclude whether improvements made by the department and AHS resulted in a system that provides adequate provincial oversight for health service delivery in LTC facilities.”<sup>79</sup>

The Auditor General made three recommendations regarding monitoring in Alberta:

#### Auditor General Recommendation 11: Monitoring care at the resident level

- Develop a system to verify that facilities provide residents with an adequate number and level of staff, every day of their operation
- Develop a system to verify that facilities deliver the right care every day by implementing individual resident care plans and meeting basic needs of residents

#### Auditor General Recommendation 12: Managing performance of LTC facilities

- Define clearly which program areas within AHS are responsible for managing the performance of individual facilities
- Establish a formal mechanism to use compliance data to review periodically the overall performance of each facility, and then initiate proactive compliance action with facilities based on the level of risk to health and safety of residents



- Establish a formal mechanism to escalate compliance action for higher risk facilities

### **Auditor General Recommendation 13: Oversight at the provincial level**

- Alberta Health define and separate its role and responsibilities from those of AHS in monitoring
- Improve public reporting on what results the provincial LTC system is expected to achieve and whether it is achieving them
- Finish the review of the continuing care health service standards
- Implement a mechanism for timely analysis and action on the accommodation cost data

In response to the AG recommendations:

- The Continuing Care Quality Management Framework was released by AHS in 2014<sup>80</sup>
- AHS produced the Alberta Long Term Care Quality Indicators Report in 2016-2017<sup>81</sup>, comparing Alberta's performance of the RAI QI indicators with those of other provinces
  - Alberta performed well in comparison with other provinces in quality indicators reported by CIHI
- AHS developed an independent audit team to monitor FBCC sites
- Alberta Health and AHS have refined processes to improve the coordination of Continuing Care Health Service Standards monitoring activities

### **Quality Monitoring Results**

Data provided by AHS shows that quality at FBCC sites in most AHS zones has improved or stayed relatively consistent from 2018/19 to 2019/20 based on the quality indicators of depression, presence of pain, pain worsened, and mid-loss ADL functioning (Figure 31). With that said, there are differences in the level of assessed quality across zones for all indicators, suggesting inconsistencies in the actual levels of care or the method for assessing quality across zones.

The results for safety indicators, including antipsychotic use, restraints, falls, and pressure ulcers were also relatively consistent within zones (Figure 32). However, assessed quality does differ across zones as well.

Figure 31: CIHI Release of Quality Indicators for Alberta Continuing Care – 2018/19 to 2019/20

## CIHI Public Release of 5 Quality Indicators

### Depression, Presence of Pain, Pain Worsened, Mid-loss ADL Functioning (Independent and Dependent)

Fiscal Year and Quarter

(Multiple values)

Fiscal Year and Quarter	MOD4A - Residents whose mood from symptoms of depression worsened				
	1) South	2) Calgary	3) Central	4) Edmonton	5) North
2018/19 Q1	29.1%	23.7%	28.3%	25.3%	29.2%
2018/19 Q2	29.9%	23.5%	28.4%	25.8%	28.5%
2018/19 Q3	29.8%	23.7%	28.6%	25.8%	28.4%
2018/19 Q4	28.5%	24.2%	27.6%	25.8%	29.0%
2019/20 Q1	28.0%	24.3%	27.3%	26.4%	28.5%
2019/20 Q2	26.6%	24.9%	27.0%	26.5%	28.9%
2019/20 Q3	26.8%	24.7%	26.4%	26.7%	29.1%
2019/20 Q4	26.9%	24.0%	26.6%	26.5%	27.8%

CIHI Adjusted QI (Lower percent is better)

23.5%  29.9%


Fiscal Year and Quarter	PAIOX - Residents with pain				
	1) South	2) Calgary	3) Central	4) Edmonton	5) North
2018/19 Q1	16.4%	5.7%	11.7%	5.0%	12.8%
2018/19 Q2	16.4%	5.4%	12.0%	5.0%	12.9%
2018/19 Q3	15.7%	5.2%	12.1%	4.8%	13.0%
2018/19 Q4	14.5%	5.2%	12.4%	4.8%	13.5%
2019/20 Q1	13.0%	5.3%	12.8%	4.6%	14.2%
2019/20 Q2	12.7%	5.2%	13.0%	4.6%	15.1%
2019/20 Q3	12.5%	5.2%	13.0%	4.6%	16.7%
2019/20 Q4	12.1%	5.1%	12.8%	4.8%	16.9%

CIHI Adjusted QI (Lower percent is better)

4.6%  16.9%


Fiscal Year and Quarter	PAN01 - Residents whose pain worsened				
	1) South	2) Calgary	3) Central	4) Edmonton	5) North
2018/19 Q1	15.4%	11.8%	16.4%	12.9%	16.2%
2018/19 Q2	15.6%	11.7%	16.2%	12.8%	16.4%
2018/19 Q3	14.6%	11.8%	16.4%	12.6%	16.6%
2018/19 Q4	14.2%	12.4%	16.2%	12.7%	17.7%
2019/20 Q1	14.6%	12.5%	16.0%	12.7%	17.2%
2019/20 Q2	14.4%	12.6%	16.1%	12.7%	17.8%
2019/20 Q3	13.8%	12.9%	15.7%	12.9%	18.2%
2019/20 Q4	14.0%	12.7%	15.3%	12.6%	17.6%

CIHI Adjusted QI (Lower percent is better)

11.7%  18.2%

Fiscal Year and Quarter	ADL05 - Residents whose status improved on mid-loss ADL functioning (transfer and locomotion) or remained completely independent in mid-loss ADLs				
	1) South	2) Calgary	3) Central	4) Edmonton	5) North
2018/19 Q1	33.4%	29.1%	35.6%	29.8%	37.7%
2018/19 Q2	33.0%	29.3%	34.9%	29.3%	38.2%
2018/19 Q3	32.4%	29.3%	34.5%	28.9%	37.3%
2018/19 Q4	33.3%	29.3%	35.1%	29.3%	37.9%
2019/20 Q1	33.4%	29.3%	35.4%	29.3%	37.5%
2019/20 Q2	33.8%	29.2%	35.6%	29.7%	36.7%
2019/20 Q3	33.6%	29.3%	35.8%	29.7%	36.7%
2019/20 Q4	33.6%	29.3%	35.7%	29.4%	36.1%

CIHI Adjusted QI (Higher percent is better)

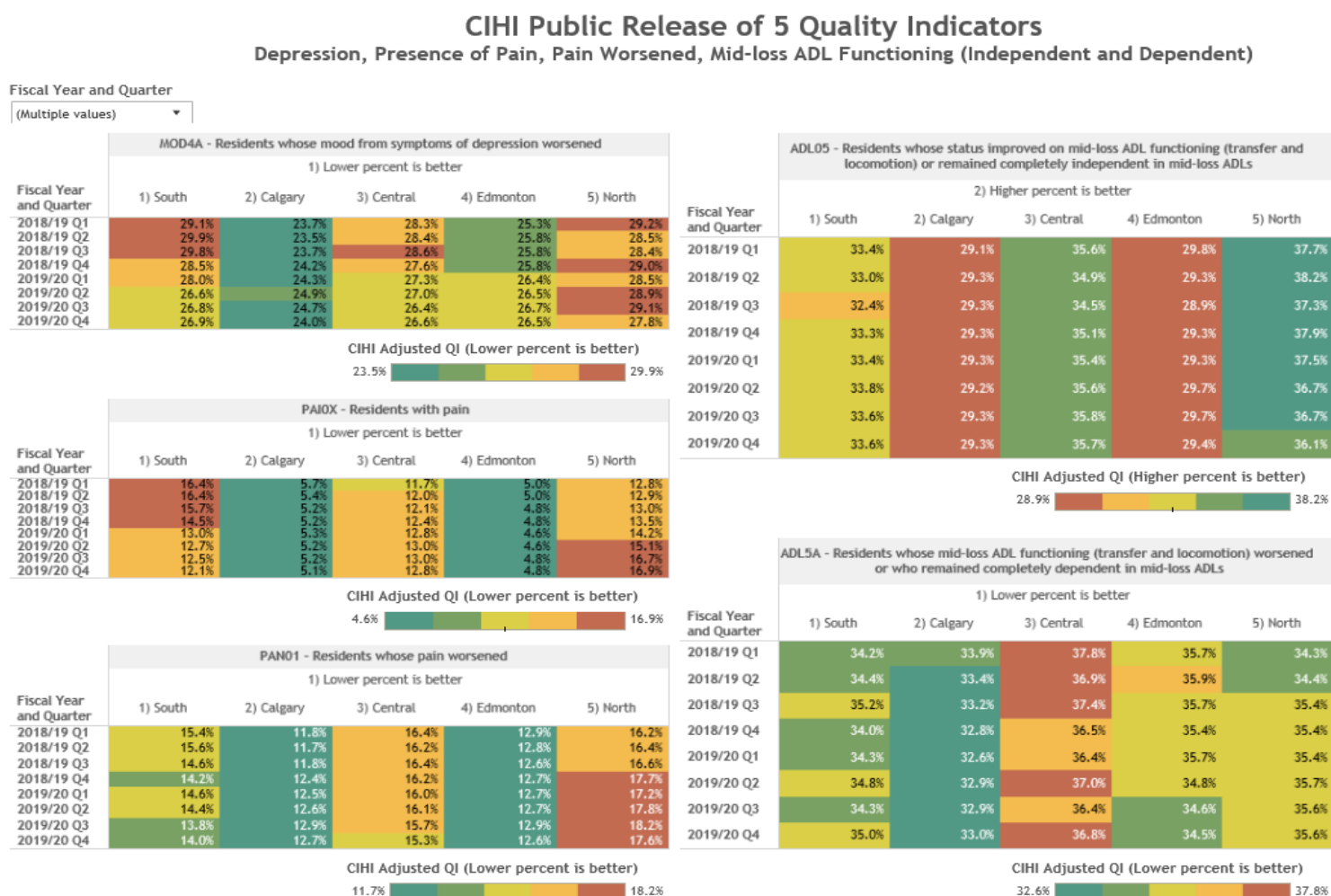
28.9%  38.2%

Fiscal Year and Quarter	ADL5A - Residents whose mid-loss ADL functioning (transfer and locomotion) worsened or who remained completely dependent in mid-loss ADLs				
	1) South	2) Calgary	3) Central	4) Edmonton	5) North
2018/19 Q1	34.2%	33.9%	37.8%	35.7%	34.3%
2018/19 Q2	34.4%	33.4%	36.9%	35.9%	34.4%
2018/19 Q3	35.2%	33.2%	37.4%	35.7%	35.4%
2018/19 Q4	34.0%	32.8%	36.5%	35.4%	35.4%
2019/20 Q1	34.3%	32.6%	36.4%	35.7%	35.4%
2019/20 Q2	34.8%	32.9%	37.0%	34.8%	35.7%
2019/20 Q3	34.3%	32.9%	36.4%	34.6%	35.6%
2019/20 Q4	35.0%	33.0%	36.8%	34.5%	35.6%

CIHI Adjusted QI (Lower percent is better)

32.6%  37.8%

Figure 32: CIHI Release of Safety Indicators for Alberta Continuing Care – 2018/19 to 2019/20

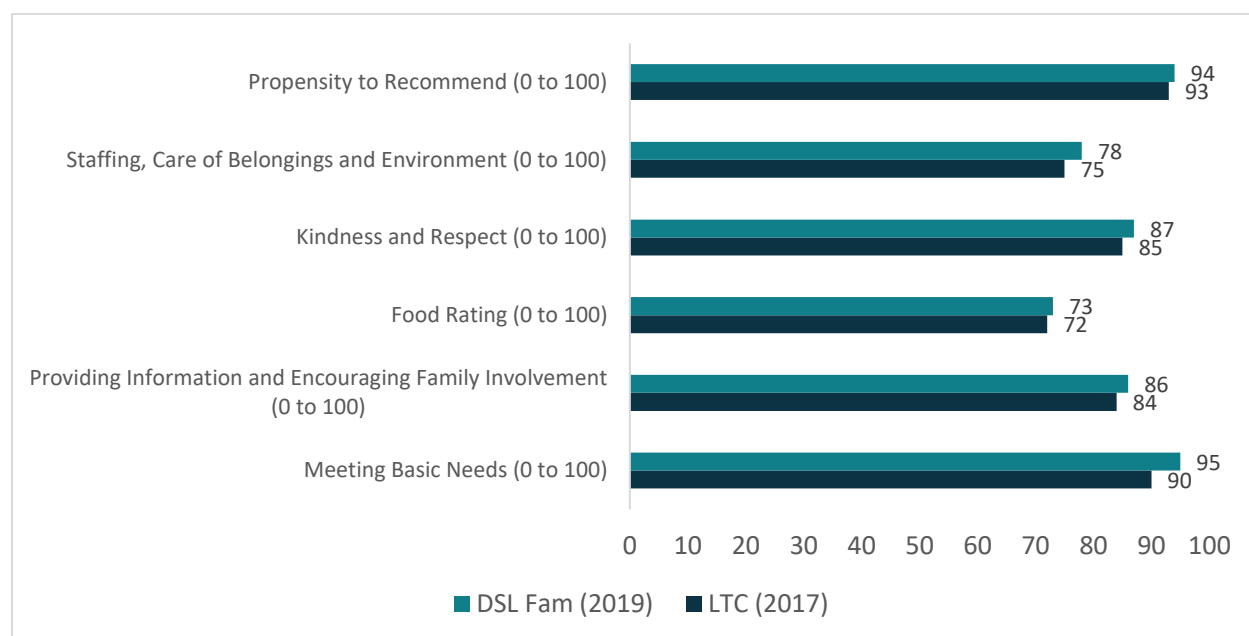


## Health Quality Council Reporting

The purpose of the HQCA is to bring an objective perspective to Alberta's health system, pursuing opportunities to improve patient safety, person-centred care, and health service quality for Albertans. HQCA regularly conducts surveys of FBCC residents and their families on their perception of the quality of care delivered in FBCC sites.

In these surveys, in general, residents and families were satisfied with their facilities and staff. However, residents and families have expressed concerns about inadequate staffing levels. For LTC, family members rated the overall quality of care at their facilities at an average of 8.4 out of 10, and 93 per cent would recommend their facility to others<sup>82</sup>. For DSL, residents' overall rating of their facility was 7.8 out of 10 (8.4 by family members). Ninety per cent of residents, and 94 per cent of family members would recommend their facilities to others (Figure 33)<sup>83,84</sup>.

Figure 33: Summary of HQCA Family Experience Survey Results



### 3.7.1.1 Strengths

#### Governance

Alberta has had a long history of policy development and innovations in FBCC in Alberta, with the support of research and expert panels. Examples of these developments include the successful implementation of the recommendations of the Mirosh Report, *A New Vision for Long-term Care, 1988*; the Broda Report, *Healthy Aging and New Directions for Care, 1999*; and *the Continuing Care Strategy, 2008*.

Furthermore, there has been a well-established continuing care system with historical partnership amongst government, industry, and AHS.

The consolidation of the planning and delivery of health services into one single authority enables AHS to:

- Acquire equipment and supplies for the entire health system, thus enabling economy of scale
- Transfer funding and resources from one service sector to another within AHS to address immediate demands
- Plan for the utilization of spaces and the delivery of all health services from a provincial, regional, and/or zonal perspectives as necessary, with the ability to remove and transfer spaces across the province as needed

The advantages of these strengths were evident in the acquisition of PPE and other pandemic-related equipment, and in the flexible management of spaces and staff resources during the COVID-19 pandemic crisis.

## Ownership

All three FBCC ownership types have been partners in the delivery of continuing care services since its inception. Outcome measures for each ownership type have been similar between 2015/16 to 2019/20. Each has its unique strengths and contributions to the diversity, efficiency, and effectiveness of the Alberta continuing care system. It is beneficial for Alberta to have the continued contribution of these ownership types.

## Monitoring

Alberta Health has a long history of creating tools and measurement indicators and using them for monitoring care. Many advanced health information systems were initiated, e.g. Patient Portal, Connect Care, the Alberta Continuing Care Information System (ACCIS) automating the InterRAI suite of care planning tools, and the Financial Information Reporting and Management System (FIRMS).

The expertise embodied in these initiatives will assist greatly in the monitoring of FBCC services.

### 3.7.1.2 Areas of Opportunity

#### Governance

With respect to FBCC, three ongoing governance issues have been raised by stakeholders including:

- The need for better role clarity between Alberta Health and AHS, especially with regards to monitoring and inspections.
- AHS funds and administers the entire continuing care system, and owns and operates FBCC spaces. This is perceived as a conflict of interest as AHS is the owner, funder, auditor, and inspector of its own facilities.
- AHS has a direct clinical role in assessing the care needs and designing care plans for individual residents in all DSL facilities, which coexists with its role as an overall funder, administrator, and inspector of continuing care services.
  - Since AHS is responsible for the overall management of FBCC, it is perceived as inappropriate for it to maintain the role of individual client assessment and care planning at the facility level.

#### Public ownership of FBCC sites (by AHS)

AHS ownership should be continued as one of the three FBCC ownership types. Public facilities have unique strengths and contributions. They play a unique role in addressing the needs of very complex cases, in providing restorative and sub-acute care, and in linking to acute care hospitals. In addition, some AHS rural facilities are very small and managed as combined facilities with acute care hospitals. It would be economically infeasible to operate a small FBCC site independent of acute hospitals in these circumstances.

To avoid the perceived conflict of interest as described above, several actions need to be considered. There should be transparency that AHS-owned-and-operated FBCC sites are subject to the same funding policies as other FBCC operators. These AHS-owned FBCC sites should also provide independent financial statements apart from overall AHS operations. Using independent inspectors and

auditors (such as Alberta Health) should also be considered for monitoring AHS-owned-and-operated FBCC sites if it is felt that there is insufficient independence with the current Audit Team structure in AHS.

### Private Ownership of FBCC sites

The Public Health and Emergency Measures Working Group of the CD Howe Institute researched the incidence of COVID-19 outbreaks in public and private-for-profit nursing homes. The study concluded that many factors could have significant effects on the severity of outbreaks. These factors included staffing levels, size and configuration of rooms, facility layout, and patient complexity. It recommended that “all provincial governments should work to address the ongoing challenges in the residential care sector and seniors’ care more generally”<sup>85</sup>.

Descriptive data provided by Alberta Health suggest that private-for-profit LTC/DSL facilities have a higher incidence of COVID-19 outbreaks than other ownership types. However, a higher incidence of outbreaks is largely correlated with rates of community transmission near a facility and facility size and facility age which could explain the difference<sup>86</sup>.

Finally, respondents to the 2018 LTC Family Experience and 2019 DSL Family Experience HQCA surveys provide similar care ratings for AHS, private-for profit, and private-not-for-profit operators for LTC and DSL:

- The overall care rating was 8.6 for AHS facilities, 8.2 for private-for-profit facilities, and 8.2 for private-not-for-profit facilities on the 2018 LTC Family Experience survey
- The overall care rating was 8.5 for AHS facilities, 8.2 for private-for-profit facilities, and 8.6 for private-not-for-profit facilities on the 2019 DSL Family Experience survey

Given that the overall outcomes for private-for-profit facilities are similar to those of AHS and private not-for-profit facilities, Alberta should continue to utilize all three FBCC ownership types.

### Monitoring

Alberta is facing many challenges related to monitoring FBCC services.

- Due to the impact of COVID-19 on FBCC, families and the public are asking for stronger monitoring, inspection, reporting, and enforcement measures. This trend is national in scope, not only in Alberta.
- Evaluative studies in other jurisdictions have cited monitoring, enforcement, compliance and reporting as important factors for improving quality of care in LTC (e.g. Ontario COVID-19 Commission Interim Reports<sup>87,88</sup>, Commonwealth Fund Report<sup>89</sup>).
- Operators are requesting for more coordinated auditing and monitoring to reduce the administrative demands associated with inspections and allow more time for nurses to provide resident care.
- Operators are in support of unannounced visits to ensure transparency of the system.

One strategy to address these challenges is for all monitoring agencies to meet and coordinate their monitoring methodology and schedules to eliminate duplicate efforts. A coordinated team visit may in fact improve the data obtained for the inspection. This approach would not take away the option of

each individual agency being able to conduct their own inspection, unannounced visits, or in-depth reviews in special circumstances.

## 3.7.2 What We Heard

### 3.7.2.1 Expert Panel

The Expert Panel members reported that monitoring and accountability for FBCC could be improved through:

- Coordinated and combined audits from AHS and Alberta Health to reduce duplication and administrative burden for site operators
  - The effectiveness of unannounced audits should be examined
- Monitoring and accountability should focus on outcomes-based measures rather than task-based measures
- Audits should be publicly available and easy to find in one place/simple to navigate in order to hold operators more accountable and to enable the public to make informed decisions about their, or a family members', care
  - Ensure that outcomes are reported in plain language to improve transparency
- Information sharing between different levels of the health system needs to be improved (i.e. patient information from acute care to FBCC facilities and lodges)

### 3.7.2.2 Surveys and Interviews/Focus Groups

#### Governance

Respondents to the FBCC administrator and external organization surveys were asked to comment on the ideal role of each stakeholder in FBCC. A summary of the distribution of responses is provided in Figure 34. Most respondents see the role as Alberta Health as a policymaker and funder, with approximately 48-50 per cent of respondents perceiving AHS having these same roles as well. Respondents also see an equal role for Alberta Health and AHS as auditors.

FBCC operators and external organizations had different views on the role of AHS as an operator. The FBCC operators perceived that AHS should not be involved in operations, while external organizations perceived AHS should be involved in operations of facilities.

Interview respondents felt there is a need for more clarity regarding the role of Alberta Health and AHS related to conducting FBCC audits. It was also felt that there is role for AHS in operator FBCC sites, as they provide care to complex high needs residents as well as residents in more rural settings that otherwise might not receive services. However, it was also felt that AHS should not audit its own facility operations, and these facilities should be audited by an independent party.

Figure 34: Perceived Role of Stakeholders in FBCC

Group	Policymaker		Funder		Auditor		Operator		Advocate	
	Per Cent FBCC Admin Responses	Per Cent External Orgs Responses	Per Cent FBCC Admin Responses	Per Cent External Orgs Responses	Per Cent FBCC Admin Responses	Per Cent External Orgs Responses	Per Cent FBCC Admin Responses	Per Cent External Orgs Responses	Per Cent FBCC Admin Responses	Per Cent External Orgs Responses
Alberta Health	57.4 per cent	78.6 per cent	74.8 per cent	74.6 per cent	52.9 per cent	58.2 per cent	7.1 per cent	14.7 per cent	33.2 per cent	27.9 per cent
AHS	47.9 per cent	50.0 per cent	48.6 per cent	50.0 per cent	59.5 per cent	52.7 per cent	29.7 per cent	64.2 per cent	41.6 per cent	37.8 per cent
FBCC Operators	47.4 per cent	29.5 per cent	17.6 per cent	18.2 per cent	25.2 per cent	19.1 per cent	83.5 per cent	65.1 per cent	60.8 per cent	36.9 per cent
Associations	14.7 per cent	25.0 per cent	11.9 per cent	7.3 per cent	20.0 per cent	28.2 per cent	17.0 per cent	10.1 per cent	75.7 per cent	91.0 per cent

## Ownership

Although the topic of ownership was not specifically asked in the surveys or the interviews, stakeholders did provide feedback regarding ownership when responding to other topics. There are varying views amongst different stakeholders regarding the effectiveness of private-for-profit operators as well as AHS as an operator. The following is a summary of those views:

- Multiple stakeholder groups perceive that the quality of care provided by private-for-profit facilities is lower than facilities run by AHS and private-not-for-profit operators
- AHS is perceived by some to have higher operating costs than private-for-profit and private not-for-profit operators, as well as an unfair advantage of subsidizing FBCC costs on top of funded levels to pay staff higher wages and benefits
- There were some respondents that commented that they would like to see all three FBCC ownership types (AHS, private-for-profit and private not-for-profit) continue to be funded in the future

## Current System for Monitoring FBCC Services

Over 60 per cent of respondents to the FBCC administrator survey either completely agreed or somewhat agreed that the current system for monitoring the quality of FBCC accommodation services was effective; and over 50 per cent agreed or somewhat agreed that the current system for monitoring the quality of health services was effective. In contrast, over 60 per cent of respondents to the external organization survey either completely disagreed or somewhat disagreed that the current monitoring systems for accommodations and health services was effective.

One key area for improvement identified by respondents to the surveys and interviews/group interviews was the need to better coordinate audits by Alberta Health and AHS to reduce duplication. This observation was noted by operators as well as representatives from associations, Alberta Health and



AHS. Operators found the duplication to be time-consuming and to take time away from nursing staff that could be better utilized providing care to FBCC residents. In addition, it was identified that there are inconsistencies between Alberta Health and AHS staff conducting the audits on what passes and what fails, which creates confusion for operators. Some respondents did indicate that Alberta Health and AHS had improved the coordination of audits during the COVID-19 pandemic, and that this could be carried forward to improving the coordination of audits for the future.

Survey and interview respondents also identified a need for improving role clarity for audits between Alberta Health and AHS. A wide variety of opinions were provided with this regard, with no agreed-upon option, including:

- Have Alberta Health conduct the audits related to health services and accommodations, and AHS focus on assisting sites with implementing quality improvement efforts to address audit results
- Have AHS focus on the health services audits, and Alberta Health focus on the accommodation audits
- Have a separate party (i.e. separate from AHS) audit AHS operated sites
  - Although AHS has worked on creating distance between its audit function and FBCC site operations, multiple stakeholder groups perceived there still to be a conflict of interest to have AHS audit their own sites
- Consolidate the audit function completely under one entity, including the possibility of creating a new entity for this purpose

In addition to reducing duplication, the following improvements to FBCC monitoring and compliance were identified by interview and survey respondents:

- Shift the focus of compliance audits from tasks and processes to more of a focus of outcomes and resident quality of life
  - Some operator associations note that Accreditation Canada audits have a greater focus on quality of life than Alberta Health/AHS audits
- Have a consolidated system level audit for sites, rather than separate functionally orientated audits
  - For example, operators found there to be repetitiveness between health services and accommodation audits
- Shift the focus of compliance audits from being punitive in nature to supporting quality improvement at sites
- Better coordinate unannounced audits by Alberta Health/AHS
  - Unannounced audits were perceived to be effective, and should continue
- Improve training for auditors to ensure audits are completed more consistently
- Increase the transparency of audit results to the public

### 3.7.3 Policy Direction and Recommendations

Based on the findings articulated above, four recommendations were developed:

#### Policy Direction 8: Consolidate monitoring processes and improve the coordination of inspections, while enhancing accountability and public reporting.

- **Recommendation 26:** Develop and implement a more coordinated and integrated system of monitoring where oversight bodies consolidate and integrate their efforts where possible when inspecting FBCC sites.
- **Recommendation 27:** Enhance the evaluation of, and public reporting on, the performance of all ownership types in FBCC.
- **Recommendation 28:** Enhance enforcement procedures for facilities violating government regulations, standards, and/or public health orders.
- **Recommendation 29:** Introduce added transparency for the funding and reporting of AHS owned and operated FBCC sites by requiring independent audited site-specific financial statements for its FBCC operations, as is required of other FBCC operators.

Additional details regarding these recommendations can be found in Section 4.2.8 below.

## 3.8 Technology and Innovation



### 3.8.1 Current Context

#### 3.8.1.1 Strengths

The current implementation of MyHealth Records and ConnectCare systems are good examples of digital transformations of the health system in Alberta. ConnectCare is a common provincial clinical information system that is currently in the process of being implemented by AHS. It is expected that the implementation of ConnectCare in FBCC sites will start in 2022 and end in 2023.

#### 3.8.1.2 Areas of Improvement

In addition to digitizing clinical information, the digitization of information for continuing care could include facility features (e.g. programs and services), and inspection results including any violations for FBCC sites. This information would allow users to review FBCC sites and make their own choice of which is suitable for themselves or their loved ones.

Some FBCC operators are exploring the use of innovative technologies to improve resident quality or care and quality of life as well as to improve the workplace for staff. Examples of technologies include using assistive technology for vital signs and medication monitoring, and electronic charting. However, the implementation of innovative technologies in the delivery of FBCC services is currently not funded by PCBF, which limits the ability of FBCC operators to implement technology in providing services.

The importance of technology in all aspects of FBCC should be recognized in planning for future continuing care services.

### 3.8.2 Leading Practices/Other Jurisdictional Research

In February of 2021, the McMaster Health Forum developed an Evidence Brief that mobilized both global and local research evidence to support and inform deliberations for improving LTC homes in Canada through the use of technology<sup>90</sup>. This Evidence Brief also provided several system-level factors that made it historically difficult to identify and harness the potential of technology in LTC settings as well as three elements that may address these challenges.

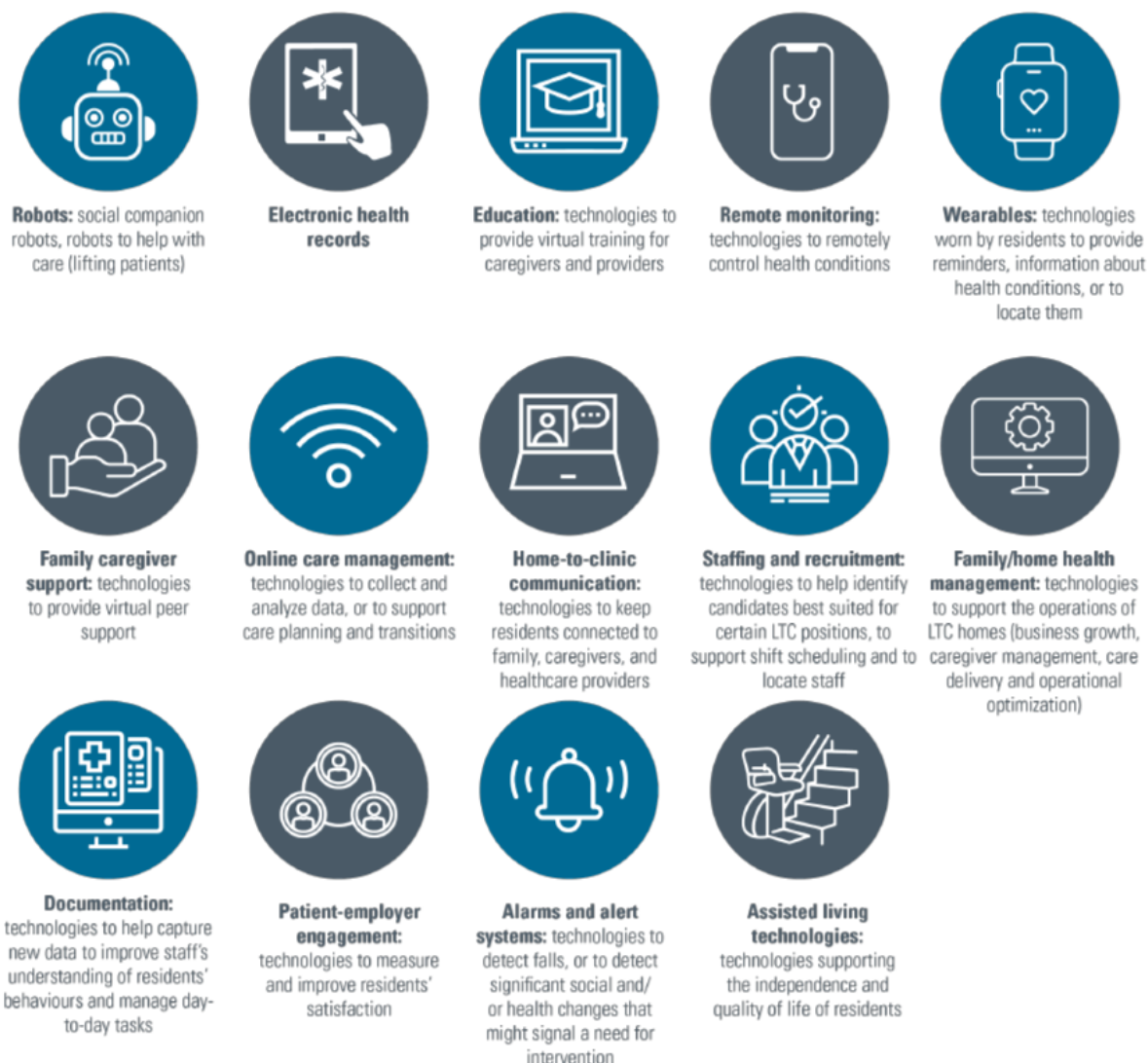
It was noted that the COVID-19 pandemic created a catalyst for change and a directed a sharp focus on LTC home residents who were disproportionately and negatively impacted by the infectious disease. This led to the development of several recommendations for strengthening the sector including the use of technology for helping address fundamental problems in LTC and ultimately optimize physical health and well-being, as well as improving communications (e.g., via remote visits with health care teams and caregivers, family and friends, etc.) through:

- Interdisciplinary and inter-facility communication (e.g., electronic health record systems)
- Safety monitoring (e.g., location tracking or GPS for wandering residents, health monitors, emergency response, and monitoring usage of appliances)
- Touchless hardware and voice activated devices (e.g., asking “Google” or “Alexa” to call the nurse and/or front desk staff; and activate features in rooms such as lights, blinds, heating and air-conditioning, ventilation, and entertainment)
- Artificial intelligence which can support implementation and enhance functionality and usability

The adoption of specific technologies needs to be done with respect to enhancing person-centered approaches for residents, caregivers, and family and friends, rather than only for enhancing efficiency and cost reduction, which can lead to de-personalized care and potentially exacerbating many of the fundamental issues that are present in LTC (i.e., using technology as a substitute for human interaction as opposed to using it to free up staff to have more interaction with residents).

There are a tremendous number of new advancements and technologies targeted towards LTC. Figure 35 articulates 14 different types/groupings of technologies that could be further developed and implemented in LTC.

Figure 35: Taxonomy of Technologies in LTC Homes



### 3.8.3 Policy Direction and Recommendations

Based on the findings articulated above, one recommendation was developed.

#### Policy Direction 9: Optimize the use of technology, research, and innovation in transforming FBCC

- **Recommendation 30:** Develop and implement a “Research, Innovation and Technology Strategy for Continuing Care” in Alberta

Details regarding this recommendation can be found in Section 4.2.9.

## 3.9 Sustainability and Affordability

### 3.9.1 Current Context

In 2019/20, Alberta spent \$1.8 billion on funding FBCC services, or an average of \$66,251 per person. This lower than the average cost of \$80,873 per person for LTC in BC<sup>91</sup>, and 68,286 per person for LTC in Ontario<sup>92</sup>.

#### Care Funding for LTC Facilities

All LTC facilities in Alberta are funded by AHS through the Patient Care Based Funding (PCBF) system. PCBF consists of three components: a variable component, a fixed component, and a quality incentive component.

The variable component provides funding for nursing, personal care, and therapy hours. PCBF assesses the worked hours and paid hours for a facility based on its Case-Mix as measured by the RUG-III system using the InterRAI suite of tools. Care staffing percentages are determined by PCBF, and the hourly paid rates for care staff are determined by AHS based on the average wage of care staff working in LTC. Some operators report that the average wage rates paid by AHS are higher than the funded rates which they have to pay their employees. Some operators also perceive that the PCBF rates do not cover fringe benefits and pension benefits<sup>93</sup>. Other variable component items include site-specific adjusted Care Related Supplies (CRS), and the client turnover costs.

The fixed component includes resident care management (funding for the Director of Nursing, Nursing Administration, therapeutic administration, Medical Director etc.), and care related administration (funding for In-Service Education, General Administration, Contracting of General Administration, and Management Fees). The cost per space for these services are set by AHS annually. Some operators perceive that wage rates set by PCBF for these positions do not match the actual market rates.

There is also a quality incentive component that provides a small percentage of funding used to reward operators with good performance as measured by quality indicators. This component has a separate funding pool.

PCBF has taken the philosophy that it is an “allocation model” and distributes funds from a finite pool of funding. “PCBF does not control the overall amount of provincial funding to be applied; rather, it is an allocation methodology used to determine the most optimal distribution of such funding”<sup>94</sup>.

As shown in Section 3.4.1, the average worked hours funded by PCBF for nursing and personal care are 3.02, which translates to 3.67 paid hours for 100 CMI. This funded number of care hours has not increased since 2014/15. During this same period, the level of acuity of LTC residents has increased. The CHAA showed that the actual CMI for the not-for-profit operators they represent has increased from 102.3 in 2010/11 to 108.6 in 2019/20 (Figure 15). These findings are consistent with system wide CMI data provided by AHS which demonstrate an increase in the number of resident days in RUG-III categories with higher CMI ratings (categories 1, 2 and 3) between 2015 to 2019, and decreases in the number of resident days in RUG-III categories with lower CMI ratings (categories 4, 5 and 6, Figure 16). The average length of stay in LTC facilities has also decreased (Figure 17 in Section 3.4.1), suggesting that residents

are being admitted closer to their last years of life with higher acuity, thereby requiring more complex and intensive care.

The level of funding for care hours for LTC through PCBF is a concern to operators, staff, and residents. The need to increase staffing hours in FBCC was a major theme identified from stakeholder engagement (Section 3.4.2.2). Accordingly, options for increasing direct hours of care for LTC have been considered in this report (Section 3.4.1.1 and Recommendation #16).

Operators and industry associations have submitted numerous briefs raising concerns about the PCBF funding system. Some examples of these submissions are: Letter by Alberta Continuing Care Association on Continuing Care Review, funding models, May, 2020; and a brief submitted by the Christian Health Association of Alberta on the Economic and Operational Impact of Patient Care Based Funding on Not-for-Profit (Voluntary) Operators of LTC Spaces, January 2021. Concerns include:

- Insufficient staffing hours provided to match the acuity increase of residents
- Lack of flexibility in the accountability measures of the funding system
- Adverse impacts of the funded average wage rates on some operator types
- Lack of responsiveness of the funding system to the needs of smaller facilities

### Care Funding for DSL

Currently in Alberta, there is no standard funding methodology for DSL. AHS Zones fund DSL based on historical experience or negotiation with individual facilities. AHS intends to replace the existing methods of funding DSL with the PCBF funding model in the future, but many operators have indicated that this change should not happen until the weaknesses of PCBF are addressed.

Like LTC, a key area of concern of DSL operators, staff and residents is the need to increase the funded level of direct care hours. Accordingly, options for increasing direct hours of care for DSL have also been considered in this report (Section 3.4.1.1 and Recommendation #16).

### Accommodation Fees

FBCC residents pay for their room and board expenses in the form of an accommodation fee. This fee ranges from \$69.70 a day for a private room (\$2,120 per month), to \$60.30 a day for a semi-private room (\$1,834 per month), and \$57.30 a day (\$1,743 per month) for a standard room (as of January 2021). The average accommodation fee in Alberta increases annually based on the core inflation rate in Alberta.

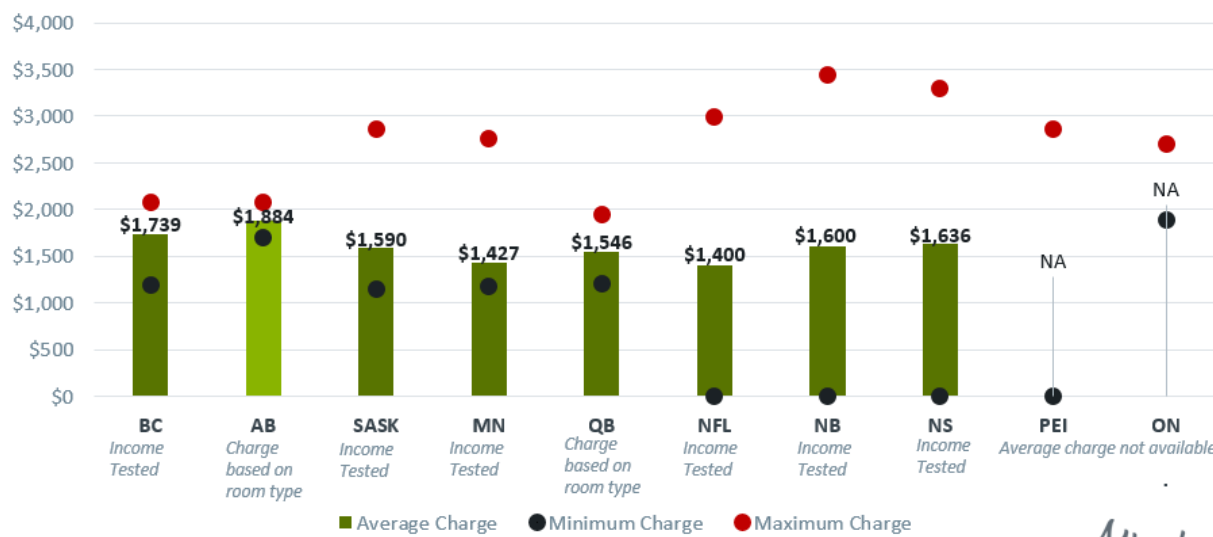
Alberta uses a different approach than other provinces for charging accommodation fees to residents. Most provinces adopt an income test for their accommodation charge with a minimum and maximum payment. Their accommodation charges are set at a much higher rate than those in Alberta. Alberta uses a flat rate accommodation charge for all residents and is the only jurisdiction in Canada that does not use a formal income test to set the accommodation fee for residents. However, Alberta Seniors and Housing does conduct an income testing process to identify residents who require a subsidy to pay for their accommodation fee.

In 2019/20, a total of 13,296 FBCC residents received the Supplementary Accommodation Benefit (SAB) from Alberta Seniors and Housing, resulting in total payments of \$86 million. The number of SAB

recipients has continued to increase annually since 2015/16, which had 11,958 recipients and total of \$72 million.

Currently, Alberta has the highest average actual FBCC accommodation fee in Canada (Figure 36). However, the maximum accommodation fee charged in Alberta is one of the lowest in Canada.

Figure 36: Average and Maximum Accommodation Charge Across Canada



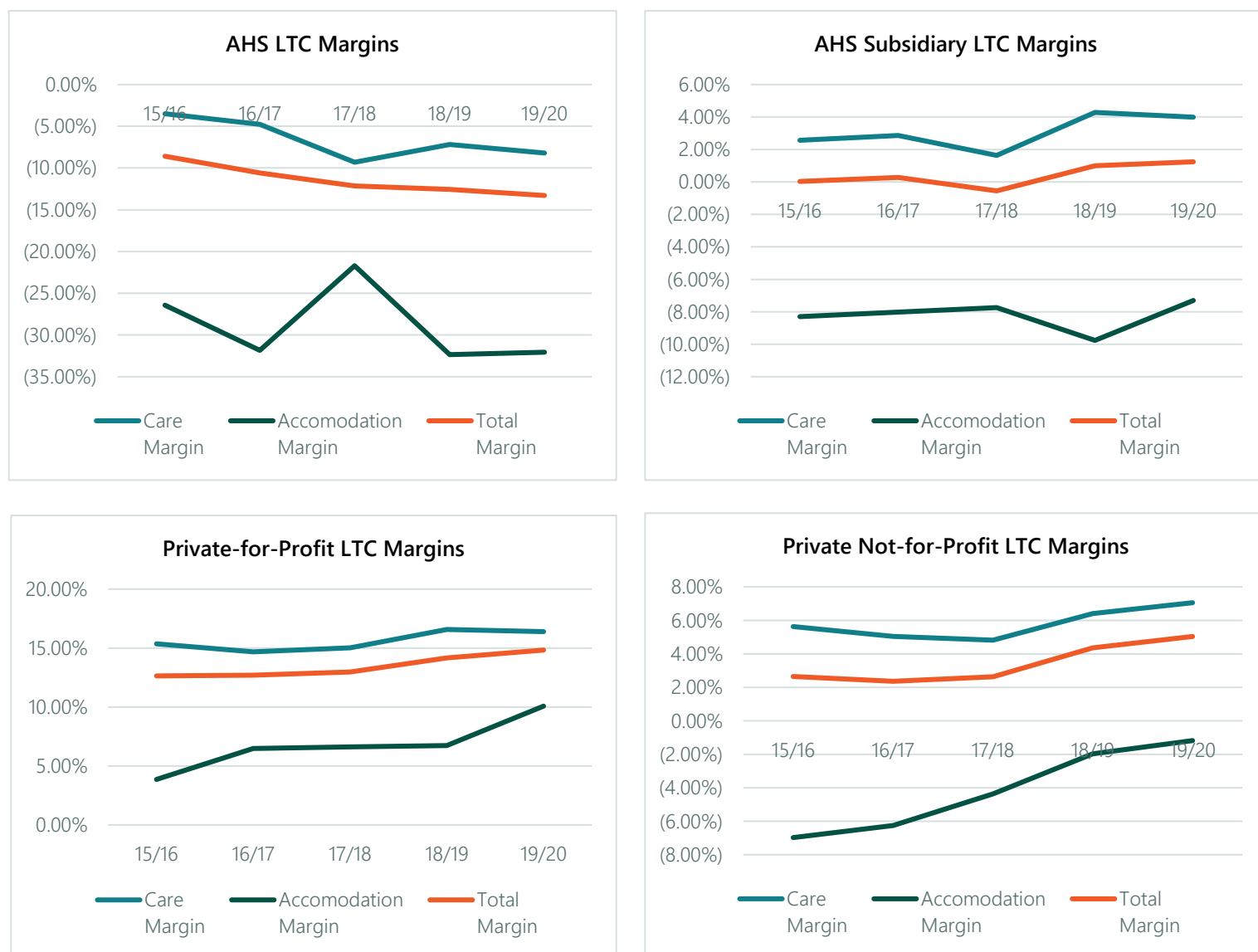
Operators have expressed concern that the current accommodation fee structure does not cover the full cost of room and board for residents, nor the costs of maintenance, upgrades, and regeneration. In addition, the current accommodation funding structure for FBCC does not include a stream of funding to cover the debt-service costs associated with the replacement of aged facilities and developing new FBCC spaces. As seen below, the current accommodation fee margins for DSL operators is higher than that of LTC operators, and there are LTC operators that need to subsidize their accommodation operations with other sources of funding.

## Financial Performance Trends

### LTC Operators

Over the last five years (2015/16 to 2019/20), the total operating margin for many LTC operators (except for AHS facilities) has improved slightly by 1 to 2 per cent. The increase was driven by very small increases in the care margin and larger increases in the accommodation fee margin, especially for private-for-profit and private not-for-profit operators (Figure 37). This suggests that the current approach to increasing accommodations fees in Alberta has been improving accommodation margins for LTC operators. However, the accommodation margin for private not-for-profit operators remains negative, and the current accommodation margin for all LTC operators is not sufficient to cover debt-service costs for capital replacement/development.

Figure 37: Trends in Operating Margins for LTC Operators, 2015/16 to 2019/20



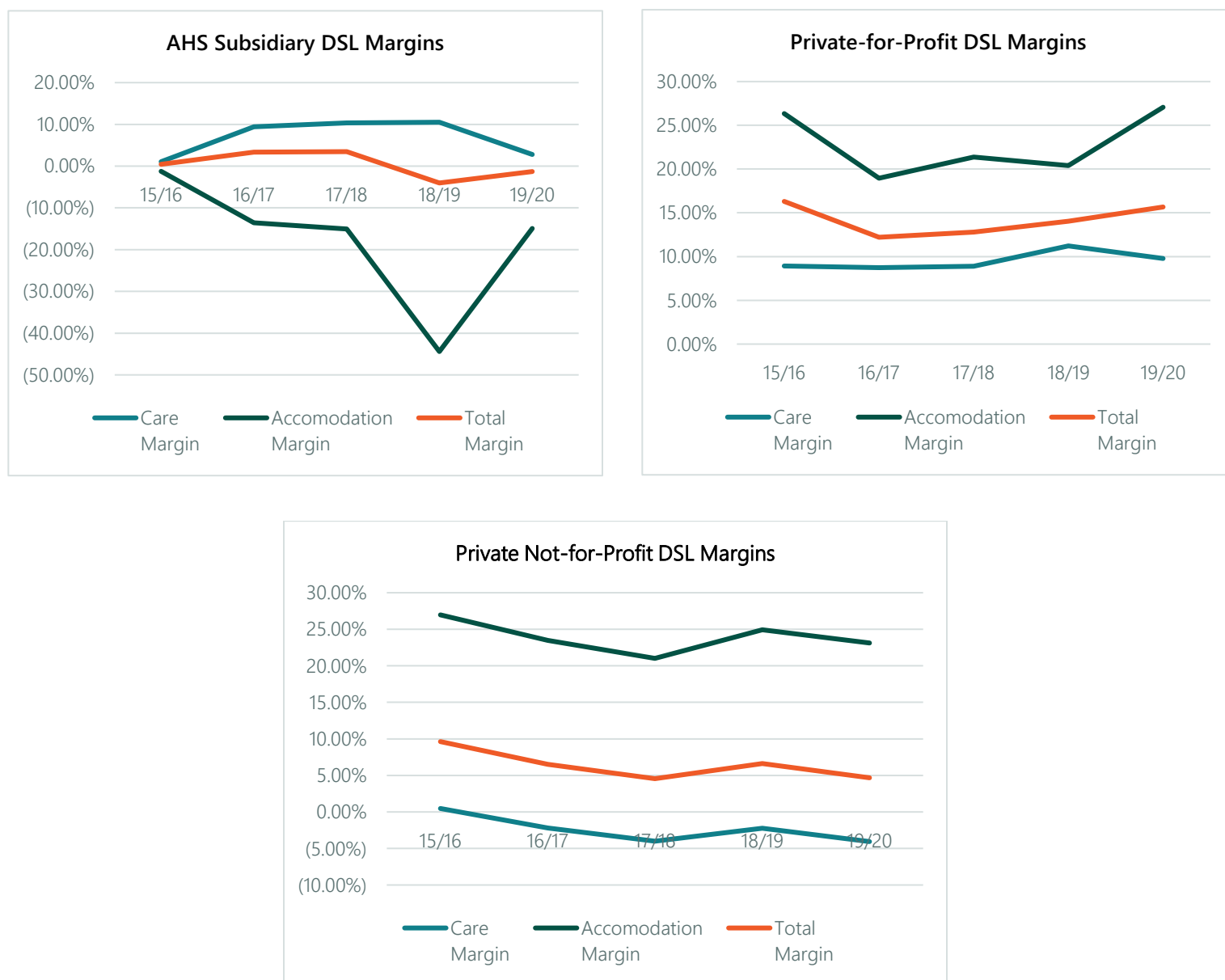
## DSL Operators

Over the last five years (2015/16 to 2019/20), the total operating margin for DSL operators has decreased slightly by 1 to 5 per cent (Figure 38). The decrease was driven by decreases in care margins for private-for-profit and private not-for-profit operators, with the care margin for private not-for-profit operators reaching -4 per cent in 2019/20. However, in contrast to LTC operators, the accommodation fee margin for private-for-profit and private not-for-profit operators ranges from 19 – 27 per cent and is sufficient to cover debt-service costs for capital replacement/development.

Another difference reported by DSL operators is the requirement to pay property taxes (which are included in the accommodation margins), which is currently not charged to LTC operators because they are tax exempt.



Figure 38: Trends in Operating Margins for DSL Operators, 2015/16 to 2019/20



## Fees and Charges for FBCC Residents

Other costs for DSL and LTC services beyond the accommodation fee are treated differently for FBCC residents. For example, medication and all health care service costs are covered for LTC residents. However, DSL residents must pay for additional expenses such as co-payments for pharmaceuticals, medical supplies and equipment, incontinence supplies, and ambulance transfers. It has been reported anecdotally that some individuals had to move from DSL to LTC facilities as they could not afford the additional costs associated with DSL. This inequity creates an incentive to seek LTC instead of DSL and should be removed to create an equitable system to ensure that the right services can be provided to the right people at the right time.

## Capital Development Considerations

Currently, there are 107 FBCC sites that are 40 years or older and do not meet current standards, and another 33 will be in this category by the year 2030, resulting in the need to replace 140 sites (approximately 10,475 FBCC spaces) over the next 10 years. Many of these spaces are shared accommodations in LTC facilities. There are also an additional 720 shared accommodation spaces that require replacement in facilities less than 30 years of age.

The cost of developing a FBCC space varies significantly by ownership type as follows:

- AHS/public facility - \$575,000 per space
- Private not-for-profit: \$337,400 per space
- Private-for-profit: \$250,000 per space

The total estimated cost to redevelop these FBCC spaces is approximately \$3.2 billion (in 2020 dollars), based on the current ownership structure of these spaces. The allocation of these development costs between the Government of Alberta and operators will be dependent on the structure of capital grant programs moving forward (see below).

## Capital Funding Considerations

Alberta Health has provided capital funding for FBCC spaces through capital grants. However, funding is limited and is only available through a competitive Request for Grants (RFG) process for the development of new FBCC spaces. Thus, some operators may struggle to upgrade old facilities if they cannot access this funding.

The average level of funding for successful grant applications has been the same to develop new LTC and DSL spaces. The average levels of funding awarded include:

- 39 per cent of the development cost per FBCC space for private not-for-profit operators
- 28 per cent of the development cost per FBCC space for private-for-profit operators

Given the current challenges for LTC operators related to funding capital replacement and development projects through debt-financing, combined with the pressing need to replace aging FBCC infrastructure (many of which are in LTC) over the next 10 years, it is recommended that an approach that encourages owners/operators of aging/obsolete facilities to replace or upgrade their buildings to meet current design requirements be developed. The approach should be competitive while at the same time acknowledging the relationship that has existed with the community and AHS in the operation of their facility. A process can be developed to approach current operators/owners to determine the future of their facilities. If an affirmative and competitive response is not provided by the operator/owner, then an RFG can be initiated to replace the specific facility in a community.

### 3.9.1.1 Strengths

There is general support for the principle of funding by case-mixes in Alberta through PCBF. The support is for the principle that care hours should match the care needs of the residents. The Alberta Auditor General's audit report on seniors' care in 2014 also supported the use of the case-mix funding approach.

Although there are concerns with the current funding model for FBCC, operators are still interested in service contracts for providing care, even if they are responsible for paying for capital development costs on their own.

### 3.9.1.2 Areas of Opportunity

#### Care Funding Model

Ensuring that the funding system for FBCC compensates facilities properly for delivering the right kind of care to residents based on their needs will be important moving forward. The funding system should be fair, equitable, and transparent to operators as well as residents and families. Considering the concerns expressed about PCBF, Alberta Health should consider a thorough assessment of the underlying assumptions/principles/objectives, and associated impacts of the funding model.

#### Growing Demand for Continuing Care Services

A key challenge related to sustainability will be the ability to meet the growing demand for all continuing care services in the future.

Based on data provided by AHS, the demand for continuing care services in 2020, including LTC, DSL (3, 4 and 4D), and long-term home care (LTHC) services was 69,732 spaces (Figure 39). Currently, LTC accounts for 22 per cent of continuing care spaces, DSL accounts for 17 per cent of continuing care spaces, and LTHC accounts for 61 per cent of continuing care spaces. The cost per day for services is highest in LTC, followed by DSL4D, DSL4, DSL3 and LTHC.

Figure 39: Current Distribution of Continuing Care Services

Continuing Care Service	Current Capacity	Per Cent of Current Capacity	Cost per Space per Day	Projected Capacity in 2030 (based on current distribution of services)	Future Proposed Model for 2030 (Increase LTHC)	Per Cent Capacity of Proposed Model in 2030
LTC	14,076	20.2 per cent	\$202.46	22,802	14,076	12.5 per cent
LTC - Special Programs <sup>5</sup>	1,589	2.3 per cent	\$272.11	2,574	1,589	1.4 per cent
DSL4D	3,500	5.0 per cent	\$159.29	5,670	5,648	5.0 per cent
DSL4	6,840	9.8 per cent	\$146.73	11,080	10,912	9.7 per cent
DSL3	1,513	2.2 per cent	\$100.08	2,451	1,663	1.5 per cent
LTHC	42,214	60.5 per cent	\$35.00	68,383	79,072	70 per cent
Total	<b>69,732</b>			<b>112,960</b>	<b>112,960</b>	

By 2030, the demand for continuing care services is expected to grow to 112,960 spaces (does not include ALC spaces). If Alberta were to continue to meet future demand with the same distribution of

<sup>5</sup> Includes approximately 80 programs with specialized care, which are different than basic LTC services.

services, there would be a need for 9,711 additional LTC spaces, 7,348 additional DSL spaces, and 26,169 additional LTHC “spaces”. The annual operating cost for continuing care services is projected to be \$4.2 billion by 2030 under this current model, an increase of \$1.8 billion. In addition, the total capital costs to develop an additional 17,059 FBCC spaces is estimated to be \$4.9 billion (Appendix 2).

The challenge facing Alberta is to choose a continuing care model to meet future demand that maintains sustainability while at the same time meeting the needs of Albertans. Based on the findings of this Review, a continuing care model that increases the proportion of services provided in the community and reduces the proportion of services in FBCC, would both improve quality of life for residents, while at the same time, reducing annual cost increases moving forward, thereby improving the sustainability of the system. This model would also reduce the need to build new LTC capacity and focus capital investment on replacing existing aged infrastructure and new DSL spaces, further improving sustainability.

Shifting the allocation of continuing care services in 2030, such that 13.9 per cent of demand is met by LTC, 16.1 per cent by DSL, and 70 per cent by LTHC, could result in annual operating cost savings of \$452 million per year, and cumulative capital cost savings of \$1.7 billion (Figure 40 and Appendix 2). Further, if the direct hours of care are increased in the new model as proposed in Recommendation 16, the total annual cost increase for the new model compared to the current model (with no direct hours of care increase) is \$46 million. Accordingly, shifting the allocation of services in 2030 covers most of the cost increase of \$498 million associated with increasing direct hours of care.

*Figure 40: Summary of Cost Implications of New Model*

	Current Model	Proposed Model	Cost Difference (Proposed – Current)
Projected Cost of Providing Continuing Care Services in 2030	\$4,207,017,382	\$3,755,435,827	-\$451,581,555
Projected Cost of Increasing Direct Hours of Care in 2030	\$0	\$497,512,375	\$497,512,375
Total Annual Operating Costs	<b>\$4,207,017,382</b>	<b>\$4,252,948,202</b>	<b>\$45,930,820</b>
Projected Cumulative Capital Costs (2021 – 2030)	<b>\$4,923,651,851</b>	<b>\$3,262,161,278</b>	<b>-\$1,661,490,574</b>

### Zero-Capital Options for Capital Replacement

Another option for the redevelopment of aged FBCC infrastructure is to use and convert existing private operated living spaces into FBCC spaces. Recently, AHS issued an expression of interest to gauge interest in this option and received many responses from facilities to convert some of their spaces into FBCC spaces at no cost to the Government of Alberta.

## 3.9.2 What We Heard

### 3.9.2.1 Expert Panels

The Expert Panel reported that the funding for FBCC and continuing care services more broadly could be improved through the following approaches:

- Shifting the focus from providing care to Albertans in FBCC facilities to enhancing continuing care options in the community to allow individuals to remain in the home/community longer
  - There is a preference for Albertans to receive care in their own homes/communities versus in a facility
  - There is a need to enhance caregiver supports to support this shift
  - There is a need to increase health and social service supports in the community
  - Consider the use of mobile diagnostic services and paramedics to keep people in the community longer
  - Increase choices of service and accommodation options for seniors and people with disabilities
    - Have more living options in one location such as continuing care campus developments to keep couples and loved ones together as long as possible
- Ensuring equity regarding the types of care costs covered by government in each level of continuing care, so that residents choose where they want to live and receive services based on personal preference rather than affordability and cost considerations
  - Individuals should not be choosing LTC over DSL or home care because the costs of pharmaceuticals are fully covered only in LTC
  - Define what services will be covered by Government for all Albertans receiving continuing care services
- Increasing the use of self-directed care options for home care and supportive living
  - Implement income testing to ensure sustainability of this option
  - Targeted care options through self-directed care will provide individuals more choices to receive services in the community longer
  - Provide oversight for self-directed care to ensure the quality of services provided, and the proper use of public funds
  - Support self-directed care with a strong assessment process, to ensure users receive the appropriate level of funding
- Focusing capital infrastructure investments to support a shift towards increasing care in the community versus in a facility
  - Focus on replacing older LTC spaces versus building new capacity
  - Eliminating shared accommodations in FBCC
  - Developing smaller congregate facilities located in communities/campuses of care

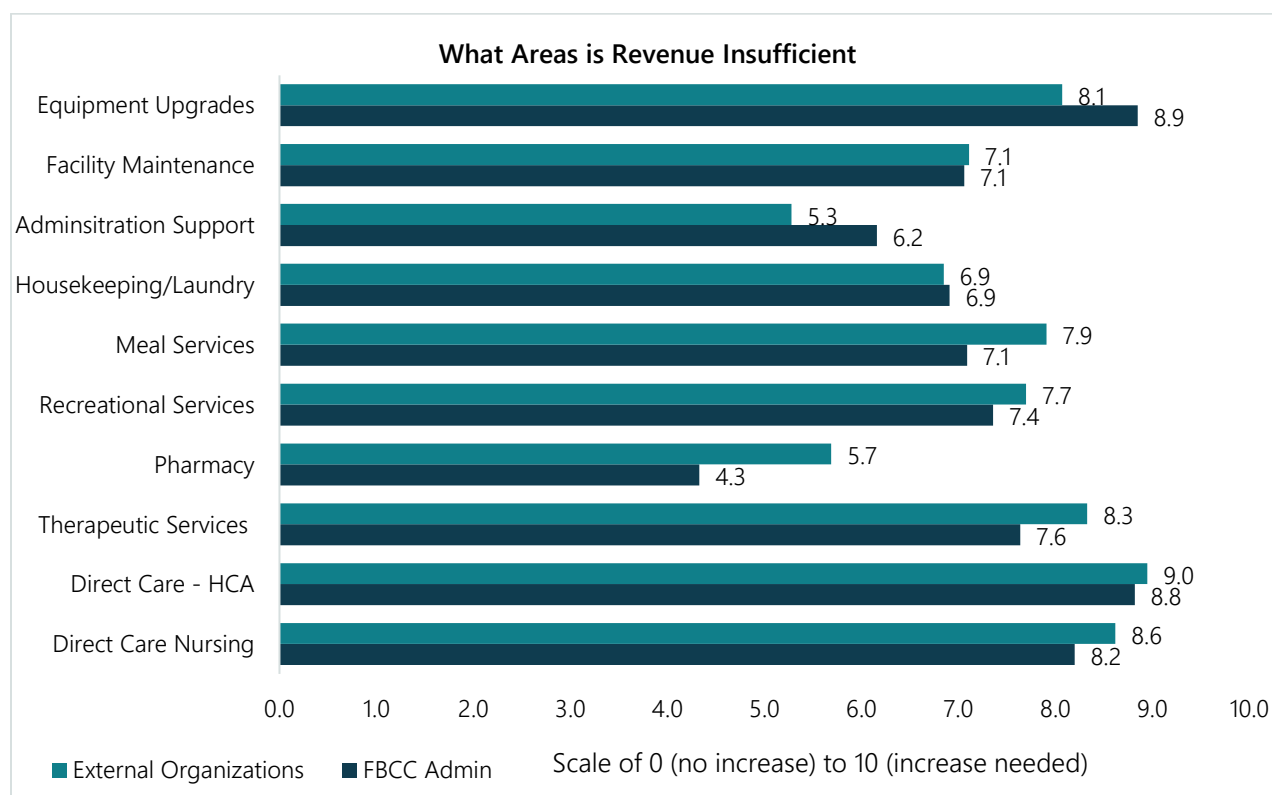
- Balance the need of having accommodation fees appropriately support capital development/maintenance versus maintain an affordable cost of living for FBCC residents
  - Continue to support all Albertans who cannot afford the accommodation fee schedule for FBCC, to ensure equity across the system
- Provide a funding and capital grant structure that attracts private investors while maintaining a high quality of care/life for FBCC residents
  - Consider development models that incorporate life leases

### 3.9.2.2 Surveys and Interviews/Focus Groups

#### Operational Costs

Overall, 46.7 per cent of respondents to the FBCC administrator and 54.7 per cent respondents to external organization surveys perceived that the current level of revenue received by continuing care facilities was insufficient to provide appropriate care and services to residents. Only 19.4 per cent of FBCC administrator respondents and 6.8 per cent of external organization respondents perceived the current level of revenue as being enough. According to survey respondents, the five areas where revenue is the most insufficient include direct care HCA, direct care nursing, equipment upgrades, therapeutic services, and meal services (Figure 41).

Figure 41: Perceived Areas of Operation That Revenue is Insufficient



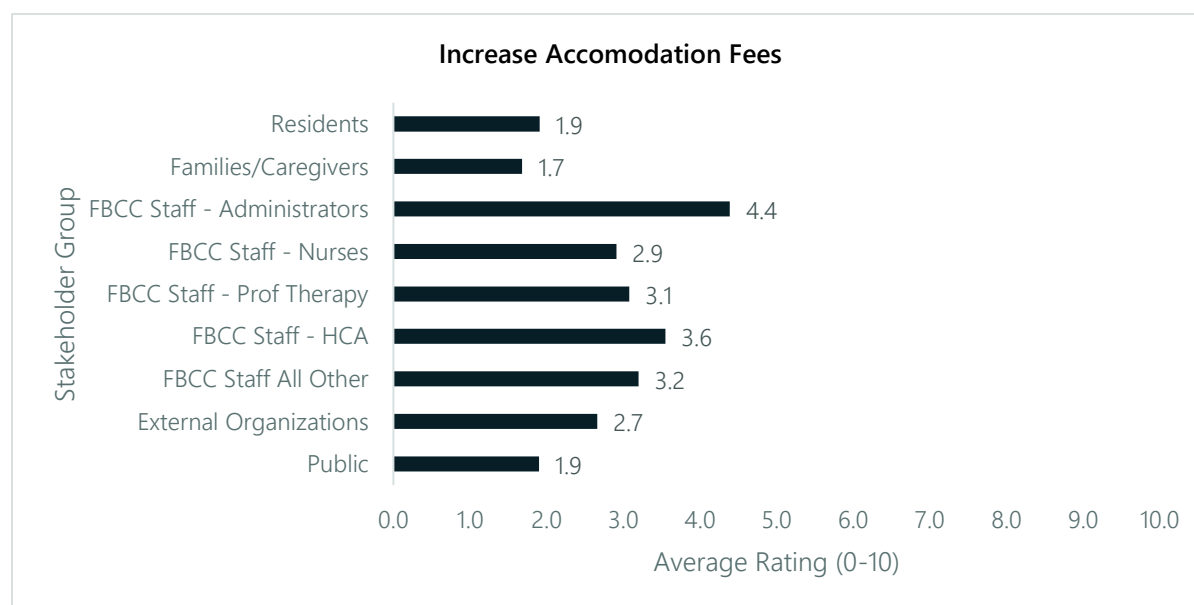
Survey and interview respondents provided the following opportunities for improving funding for FBCC services:

- Improve funding and supports for expanding home care services so that seniors and people with disabilities can receive care at home or in the community longer
- Allow for more flexibility in the FBCC funding model to shift staff requirements based on the needs of the resident
- Have equity across all continuing care streams with respect to what is funded by government and what the client/resident is responsible for
  - Review the damage deposit rules for DSL versus LTC
- Have equity across LTC and DSL for the payment of property taxes
- Increase accommodation fees so that providers don't have to subsidize accommodation costs with care funding
- Improve funding for supporting Elders in Indigenous communities
- Review the effectiveness of the current PCBF funding model
  - Examine if an outcome-based funding model could be introduced
  - There is a need for a comprehensive funding model that optimizes services based on resident need
  - Look into implementing the RUG-III plus methodology
  - Improve the consistency of case management and assessments
  - Include funding for medical leadership to have a medical director and clearly defined roles and responsibilities for this position
  - Funding needs to reflect the true acuity level of residents, to ensure their needs are being met
- Enhance the use of self-directed care models to support client choice

### **Accommodation Fee Increases**

All survey respondents were asked their opinion about increasing accommodation fees to better fund facility upgrades and replacement. As seen below (Figure 42), the level of support for increasing accommodation fees ranged from 1.7 to 4.4 out of 10, demonstrating very little support for increasing accommodation fees at this time.

Figure 42: Level of Support for Increasing Accommodation Fees



Overall, many respondents reported that they felt the level of accommodation fees was high already, and that capital upgrades should be covered by the government or FBCC owners.

### Capital Upgrades

Respondents to the surveys and interviews identified the following capital upgrade opportunities to improve FBCC:

- Replace or update aging infrastructure and equipment, and eliminate all shared accommodations in FBCC facilities
  - Bathrooms at some sites need to be renovated and made larger
  - Ensure that all rooms have closet space
  - Improve ventilation systems in older facilities
  - Upgrade furniture in common areas and bedrooms
  - Ensure that all rooms have adequate lifts
- Develop more flexible living options for residents such as:
  - Smaller facilities
  - Develop campuses/communities to accommodate multiple level of care at one site
    - Develop spaces that allow couples and loved ones to stay together
- Improve financial support for operators to fund the cost of capital upgrades/development through increasing accommodation fees, or enhancing capital grant funding
- Enhance technological equipment and internet connectivity



### 3.9.3 Leading Practices/Other Jurisdictional Research

Many other countries in the world have an older population than Alberta. The province can learn from these countries on ways of developing a continuing care system that is sustainable and can provide high quality care.

Denmark has been widely recognized as a leader in the care for its elderly population and is often cited by experts as a model of elder care. In the 1980s, Denmark faced demographic trends not unlike those facing Canada today with increasing numbers of elderly people and a declining work force. At that time, Denmark relied heavily on an institutional system of care. About 29 per cent of the elderly population were receiving some form of LTC, and 19 per cent were receiving home help.

In the early 1980s, Denmark's national government took a policy direction of expanding 24-hour home care services as an alternative to LTC homes. Services included home help (e.g. assistance with domestic tasks such as housecleaning) as well as nursing care. After-hours service for acute needs was provided in addition to regularly scheduled visits.

In 1988, legislation was passed limiting the construction of new LTC homes, and the remaining LTC homes were converted to housing units with single-occupancy rooms only. New housing for elders were constructed, where everyone must have at least one bedroom, sitting room, kitchen, and bath. Individuals pay for housing and the government pays for the necessary health and social services, regardless of the setting in which care is received. Some converted LTC homes became hubs for community support services that include a senior centre, day care, rehabilitation, 24-hour home care, and assisted living.

Between 1985 and 1997, the number of LTC beds in Denmark decreased by 30 per cent. This reduction was accompanied by an increase in adapted dwellings for elders and in the use of home help. Between 1985 and 1998, the number of sheltered housing and other adapted dwellings in Denmark increased by 331 per cent, and the proportion of people aged 67 and older receiving home help increased from 19 to 25 per cent. The number of people receiving 13 or more hours of home care per week increased by 196 per cent, reflecting the greater level of need in the community due to the shift in housing policy. This shift in policy resulted in the total LTC expenditures as a percentage of the Danish GDP decreasing from 2.4 to 2.2 per cent <sup>95</sup>.

#### Value for Money in Long Term Care

Value for Money in LTC, as outlined in 2011 by Colombo<sup>96</sup>, relates to a) cost efficiency (maximizing output) and b) cost-effectiveness (maximizing outcomes) for a given amount of resources. At the time of this study, it was suggested that many Organization of Economic Co-operation and Development (OECD) countries did not have operational concepts, measures, or indicators of efficiency in LTC systems. As such, there was little ability to evaluate the impact of such policies, making it difficult to determine or improve value in LTC. That said, the following is a summarized list of what OECD countries were doing under the broad umbrella of policies to improve efficiency in LTC:

- Important measures to improve efficiency in LTC have focused on 3 main areas:
  - Choice of settings – Nearly all OECD countries have been encouraging “Aging in Place” policies (as opposed to institutional care). In 2008, 60 per cent of total LTC costs were

spent on institutional care which is disproportionate to the number of those that received institutional care (only 3/10) in OECD countries.

- Incentives facing providers (payment mechanisms and incentives for provider competition):
  - Linking payments to quality and efficiency in “pay for performance” funding schemes. Little data was available at the time of the report regarding effectiveness. Some evaluations in Iowa indicate improvements in resident satisfaction, employee retention rates, and nursing hours.
  - Providing users with choice over the carer they prefer can stimulate competition and encourage providers to deliver better care/at a lower cost. For example, the use of vouchers for LTC in Nordic countries enabled users to choose the provider that best meets their needs, leading to higher user satisfaction, and improvements in quality and cost effectiveness. However, higher administration costs are associated with implementing a voucher system which can be reduced with technology.
- Impact of technology and productivity.
  - Technological solutions could assist in reducing the workload and stress of carers and improve work co-ordination, allowing carers to allocate their time more effectively.
- Key measures aimed at improving efficiency at the “interface” between LTC/health care include:
  - Incentives for appropriate use of LTC vis-à-vis acute care settings.
    - In order to prevent misuse or inappropriate referrals to acute care, some countries implement Health system support measures (e.g. higher involvement of primary care providers/GPs in placement), incorporate financial measures to limit acute care services use for LTC (e.g., Ireland imposes additional charges for those who remain in acute hospitals when their acute care phase is over), make changes in administrative responsibilities for care (e.g. In Sweden a new act transferred the responsibilities for LTC to municipalities who became financially responsible for older people remaining in hospitals), and the use of Information and communications technology (e.g. using electronic transfer sheets or referrals).
  - Healthy aging and prevention to reduce costs in LTC systems by reducing potential dependence later in life through lifelong health promotion.

### 3.9.4 Policy Direction and Recommendations

Based on the findings articulated above related to funding, the following five recommendations were developed.

## Policy Direction 12: Ensure sustainability and affordability for the future of continuing care.

- **Recommendation 31:** Focus government capital investments on the regeneration or replacement of existing FBCC spaces, with some funding ear-marked for the development of new spaces where needed.
- **Recommendation 32:** Continue to increase accommodation fees for FBCC annually and provide flexibility to increase fees beyond the core inflation rate for Alberta if required.
- **Recommendation 33:** Evaluate the PCBF funding model, its underlying assumptions / principles / objectives, and associated impacts on FBCC.
- **Recommendation 34:** Examine methods for funding the operation of smaller homes to facilitate their implementation.
- **Recommendation 35:** Review and standardize the types of fees and charges in all streams of continuing care, including long-term care, designated supportive living, and home care, to improve consistency and equity.

Details regarding these recommendations are provided in Section 4.2.10.

## 3.10 COVID-19 Responses and Learnings



### 3.10.1 Current Context

The COVID-19 pandemic is one of the most impactful events that has happened in LTC in Canada. The CIHI report shows that Canada has the highest proportion of deaths from COVID-19 in LTC settings among 14 OECD countries. Eighty-one per cent of Canada's COVID-19 deaths have been in LTC, compared with an average of 42 per cent in other OECD countries.<sup>97</sup>

The first COVID-19 outbreak at a continuing care site in Alberta was recorded on March 11, 2020.

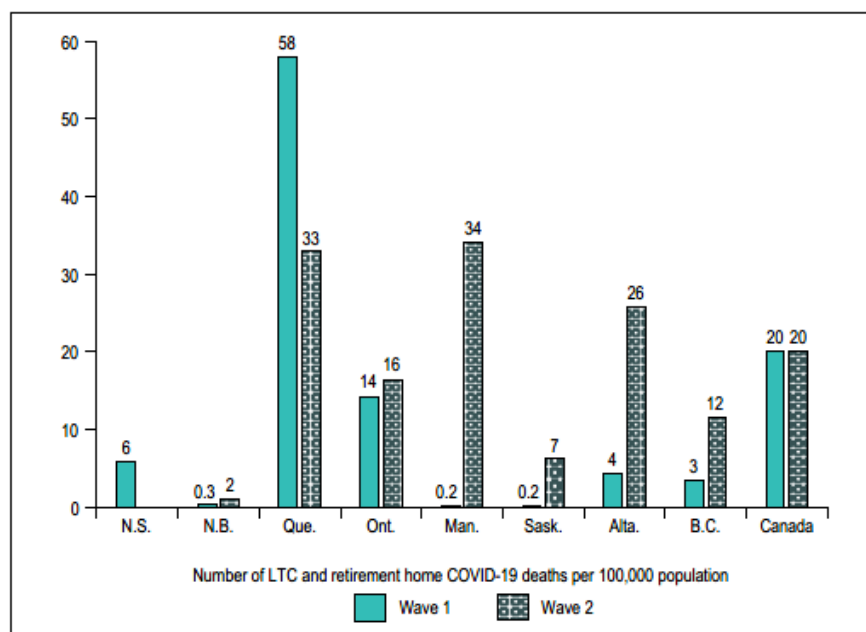
The number of COVID-19 cases in Alberta FBCC sites during the first wave of COVID placed Alberta in the middle of the pack when compared with other provinces. However, in the second wave, the number of COVID-19 cases and outbreaks in FBCC sites increased substantially.

Figure 43 shows the number of COVID-19 outbreaks and deaths in Alberta FBCC sites as of September 2020 ("first wave"), as per data provided by Alberta Health. Figure 44 shows data tracked by CIHI for wave 1 and wave 2 of COVID-19<sup>98</sup>.

Figure 43: LTC residents COVID-19 cases and deaths, Ontario, B.C., and Alberta, September 2020

	Ontario	BC	Alberta
No. of facility outbreaks	436	72	81
Cumulative no. of resident cases	5,965	466	511
Resident infection rate, per cent	7.6	1.7	2.4
Cumulative no. of resident deaths	1,817	156	158
Resident case fatality rate, per cent	30.5	33.5	30.9

Figure 44: CIHI COVID-19 Data for Waves 1 and 2



Alberta Health and AHS acted consistently in many areas to mitigate the spread of COVID-19 in FBCC. Below is a record of some of the actions taken by Alberta Health and AHS during this period.

### Communication

- A one-page information sheet on COVID-19 was distributed to operators on February 24, 2020 before any confirmed cases were found in Alberta
- A coordinated communication approach was rolled out, and by April 2020, about 95 per cent of congregate living operators, with a total of 1,600 sites province-wide (seniors lodges, adult group homes, FBCC sites) were contacted by AHS Safe Healthy Environments
- Alberta Health and AHS maintained regular contact with representatives of the four main associations representing FBCC operators
- Seven webinars and town halls were held with thousands of Albertans in attendance to answer questions and gather input from operators and families regarding the interpretation of Public Health Orders affecting FBCC sites

### Workforce

- Workforce supply became the most important issue to be addressed, especially during outbreaks
  - Some facilities reported that staffing decreased between 20 to 50 per cent in the first 24 hours after an outbreak

- Additional staff time was required to rearrange meal schedules for residents in smaller groups and for those in isolation and quarantine, to clean and sanitize the facilities, and to communicate with family members
- Increased funding was provided by Alberta Health for \$2 hourly wage top-up for HCAs, for increased HCA staffing levels, and for 1,000 paid student practicum positions
- Additional funding was provided by Alberta Health for increased worked hours by FBCC staff
- FBCC staff were provided with a one-time payment of \$1,200 through the Critical Worker Benefit
- The single-site staffing policy was implemented by Chief Medical Officer of Health Order 10-2020. Prior to COVID-19, 72 per cent of HCAs and 76 per cent of RNs worked part time or casual hours and many worked at multiple sites due to the lack of full-time positions in many facilities
- A new data system was developed to collect staffing payroll data to support the single-site staffing policy
- After implementation of the new policy, 95 per cent of the workforce was limited to working at a single site
- The scope of practice for Nurse Practitioners and other professionals in LTC was expanded
- AHS contracted a central hiring agency to recruit, train and deploy (according to provincial priority needs) Comfort Care Aides, a new pandemic-specific role developed to address workforce shortages arising from the pandemic
- AHS also provided staffing support on site to facilities with outbreaks if such assistance was necessary

### Infection prevention and control (IPC)

- IPC measures have always existed in the CCHSS, and since late March 2020, Alberta's Chief Medical Officer of Health issued additional guidelines and expectations to support continuing care operators in their defence against the introduction and spread of COVID-19 in their facilities including:
  - Screening for staff, residents, designated family/support people and visitors
  - Isolation and quarantine protocols
  - Continuous masking
- Visitor restrictions, masking and IPC requirements, and changes to routine life and activities, had significant negative impacts, despite the need for these restrictions to protect the lives of those who were most vulnerable to infection and death.
  - The restrictions also had a greater impact on people living with dementia and other cognitive impairments (it is estimated that 80 per cent of LTC residents and 100 per cent of DSL4D residents live with dementia)
- Shared rooms and shared bathrooms in older facilities were a challenge for implementing isolation and quarantine measures

- Where possible, facilities were encouraged to cohort infected residents and the staff serving them to prevent the spread of the disease

### Testing and contact tracing

- As of September 29, 2020, more than 1,350,800 tests for COVID-19 had been completed in Alberta, with 13,618 on-site tests in LTC and 8,688 on-site tests in DSL settings (this does not include staff or residents who may have been tested off-site)
- Testing is offered to all residents and staff at a site where a positive case has been identified, in an effort to identify and isolate any asymptomatic individuals who might be unknowingly infected
- Continuing care residents were offered tests upon admission and transitions between settings (e.g. transfers from hospitals, etc.)
- Rapid COVID-19 testing was introduced in Alberta in November 2020, piloted in some FBCC sites in December, and then expanded in February 2021 to all FBCC sites

### Personal protective equipment (PPE)

- Alberta Health, AHS and facility staff monitored, reinforced, and trained/coached staff in the proper use of PPE
- A continuous masking policy was implemented on April 10, 2020, when eye protection was introduced in continuing care
- PPE was and continues to be provided to all FBCC sites free of charge by Government of Alberta
  - Masks were also provided free of charge to all private facilities, home care agencies and Alberta residents during the period of the pandemic when the supply was limited in the private commercial market
- Alberta was the only province in Canada able to provide free masks to all its citizens during the period of short supply or non-availability commercially

### Visitor policy and the role of families

- Family members are estimated to provide a significant portion of total care given to FBCC residents
- Initial visitor policies put in place to protect continuing care residents from COVID-19 (CMOH Orders 03-, 09-, and 14-2020), had unintended, negative impacts on residents' mental and physical wellbeing and on the family caregivers who support them
  - Initial visitor policies limited the ability for families and support people to provide care to their residents at a time when more support would have been useful
  - This sudden reduction of family supports was detrimental for all FBCC residents, especially those living with dementia or at end of life
- The visitor policy was revised in July 2020 after extensive consultation with over 6,000 residents, families, operators, and staff, through town halls and surveys

- The new CMOH Order 29-2020, effective July 23, 2020, moved from a restricted to a safe visiting approach, and the policy changed as follows:
  - Two designated family/support people are to be supported per resident, no matter the reason
  - Up to four social visitors are supported per resident outdoors; and non-designated visitors are also supported indoors in extenuating circumstances (end of life, change in health status, pressing circumstances) or in the case of indoor social visits, if the site's risk tolerance assessment allows
- One major lesson from the COVID-19 pandemic is the essential role played by family members and support people in the care and support for FBCC residents
  - Family caregivers must be regarded as essential members of the care team in FBCC and should not be cut off from their contacts with their family members in care

### Impact on residents' and family caregivers' overall health and well-being

- The pandemic, and the policies put in place to combat it, have had many adverse effects on seniors and people with disabilities, whether they are living in FBCC, supportive housing settings, or at home alone, including physical and mental decline
- Family caregivers have also experienced increased stress and guilt and are mostly unaware of what is happening to their loved ones in FBCC
- In the summer of 2020, the Calgary Dementia Network published a report on the Impact of COVID-19 on Family Caregivers for Persons Living with Dementia<sup>99</sup> and found that:
  - Family caregivers were "overburdened" in their caregiving responsibility, and many of the residents living with dementia had experienced a decline in their well-being and functionality because of pandemic-related restrictive measures
  - Family caregivers also expressed a great need for increasing support in their role as caregivers for their dementia family members in care
  - The report made three recommendations to the Government of Alberta:
    - That consistent resources be made available to family caregivers so that they can deliver effective care
    - That clear, correct, and concise information on public health protocols be communicated to family caregivers via multiple media sources
    - That family caregivers be granted continued access to care recipients, as these caregivers are considered as "essential care partners", and not just visitors

### Infrastructure

- Recent studies by Public Health Ontario, researchers from the University of Toronto, and key researchers from Ontario hospitals and Research Institutes<sup>100</sup> indicate that residents living in overcrowded LTC facilities (e.g. homes with 2- to 4-bed rooms, shared bathrooms) are twice as likely to die from COVID-19 than in other settings
- Infrastructure issues include shared rooms and bathrooms, the age of facilities, the number of spaces in a building, and the use of ineffective ventilation systems

- Infrastructure guidelines should be modified for future new or regenerated FBCC sites based on lessons learned from the COVID-19 pandemic
- A plan needs to be developed to regenerate older facilities to conform with new guidelines and meet public health expectations

### Oversight, monitoring and compliance

- The Ontario Long-Term Care COVID-19 Commission<sup>101</sup> identified focused inspection, monitoring, and enforcement as important steps to stop the spread of COVID-19 in LTC facilities
- In normal practice, both AHS and Alberta Health have inspectors visit contracted FBCC sites to ensure that they follow the provincial health and accommodation standards
- As a result of the pandemic, some Alberta Health licensing inspectors and health compliance officers were additionally delegated as Executive Officers under the *Public Health Act* and tasked to inspect facilities against the Chief Medical Officer of Health COVID-19 Orders
  - All non-compliances with respect to COVID-19 Orders are followed up by Alberta Health to ensure they are rectified
  - This action typically happens within 48 hours and processes are in place when escalation is necessary
- A COVID-19 Inquiry Response Team (CIRT) was created by Alberta Health to work with complaints officers to ensure that potential non-compliance with the Orders are investigated by an Executive Officer in a timely manner
  - Complaints officers are also mandated to receive and respond to inquiries directly from the public
- As of the end of October 2020, CIRT had responded to over 900 inquiries and concerns from residents, operators, family members and visitors relating to the Orders issued by the Chief Medical Officer of Health

### Increased funding support

- \$260.1 million in pandemic funding was approved by the Departments of Health, and Seniors and Housing to support residents and staff of FBCC and seniors' lodges, including \$35.4 million from the Seniors and Housing budget
- Funding was provided to cover expenses for HCA wage top-up and extra hours, equipment and supplies, loss in accommodation revenue and reduced occupancy of FBCC spaces

### Vaccination

- All LTC and DSL residents and staff were ranked in the first priority group to receive vaccines in Alberta, due to their risk of adverse outcomes
- Full immunization with two doses offered to all residents and staff was completed in February 2021, the first amongst all provinces and territories
- Between February and March 2021, all residents in private supportive living, and seniors over 75 years living independently became eligible to receive vaccines



- Vaccination has dramatically decreased outbreaks in FBCC

### 3.10.1.1 Strengths

It should be noted that staff and operators from FBCC sites as well as Alberta Health and AHS staff demonstrated extraordinary and consistent efforts in managing the pandemic and providing care and services to residents.

### 3.10.1.2 Areas of Opportunity

The pandemic presented many challenges to Alberta Health, AHS, and operators and staff of FBCC sites. Early on, a major challenge was a lack of detailed knowledge on the spread of the COVID-19 virus, and the management and treatment of the disease. A reported lack of PPE supplies and a need for enhanced IPC training were also identified as issues initially. In addition, FBCC had many pervasive weaknesses which existed prior to the outbreak such as a lack of adequate staffing capacity, increasing resident acuity levels, and outdated facility infrastructure which generated operational challenges. The arrival of COVID-19 brought these existing deficiencies to a breaking point.

Moving forward, the following systemic issues should be addressed to prevent future challenges during outbreaks and pandemics including:

- Increasing staffing levels
- Improving staff training to deal with the increasing acuity of residents
- Improving working conditions for staff
- Replacing outdated infrastructure and eliminating shared living accommodations
- Improving preparedness and planning for handling future pandemics

Many key lessons were learned in the response to the pandemic such as:

- The need to enhance IPC training regularly for staff, including the proper use of PPE
- The need to have proactive labour-force contingency plans to acquire emergency staffing required by the pandemic
- The need to create a stable, healthy workplace culture
- The need to have efficient communication and consultation avenues between Alberta Health and families, residents, facility staff, and operators
- The need to value the emotional and physical support provided by family caregivers to residents and to design policies to enable and support their continued contact with FBCC residents as essential, especially, but not only, during a pandemic

## 3.10.2 What We Heard

### 3.10.2.1 Expert Panels

The Expert Panel members reported that the COVID-19 pandemic exposed several challenges with FBCC including:

- A need for increased staffing levels at FBCC sites
- A need to reduce part-time positions for HCAs and provide more full-time employment
- The need to replace aged infrastructure and eliminate shared rooms

Panel members also thought that the public health orders put in place to respond to the COVID-19 pandemic resulted in social isolation, and declining mental wellness and physical mobility.

Finally, panel members reported that operators felt that they were well supported by Alberta Health and AHS during the Pandemic.

### 3.10.2.2 Surveys and Interviews/Focus Groups

#### Impacts to Resident Quality of Life

Respondents to the resident and family/caregiver surveys perceived that resident quality of life decreased during the COVID-19 pandemic (Figure 45). This was consistent with public perception (Figure 46).

Other respondents to the surveys and interviews also perceived that COVID-19 negatively impacted the quality of life of residents due to increased social isolation, reduced physical activity, reduced social activities, and overall decline in physical and mental health.

Figure 45: Perceived Resident Quality of Life Before and During COVID-19 – Resident and Family Ratings

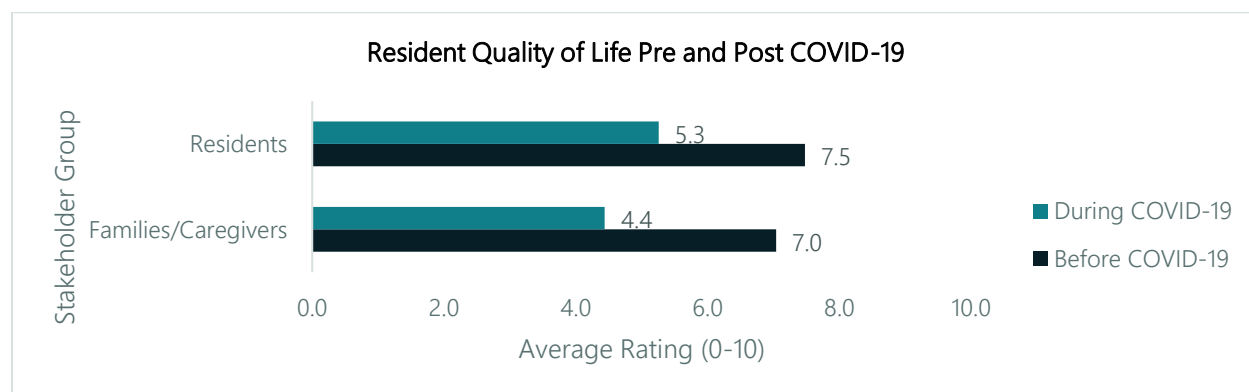
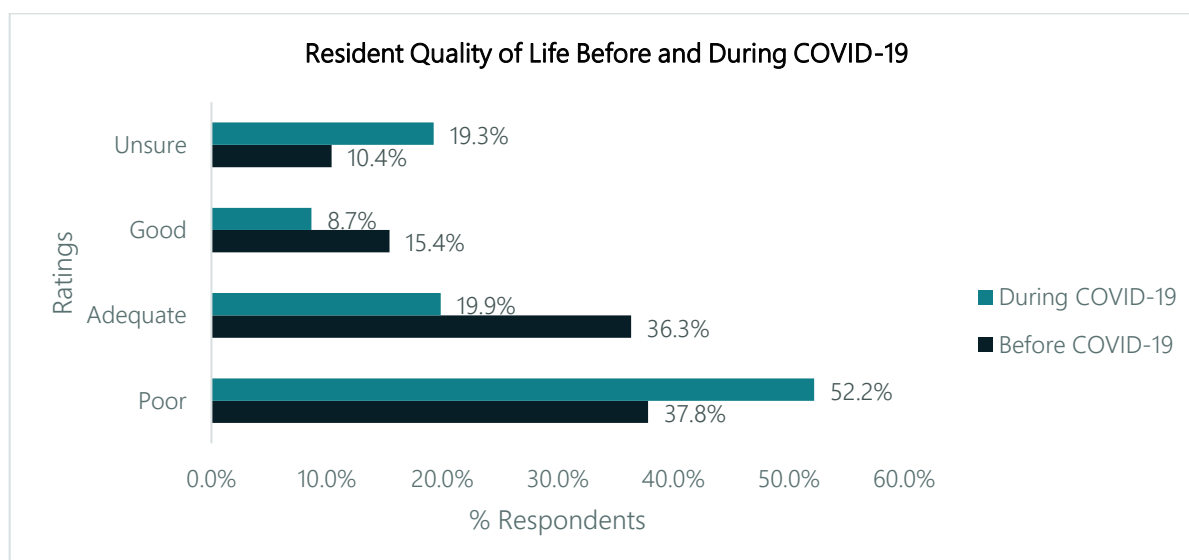


Figure 46: Perceived Resident Quality of Life Before and During COVID-19 – Public Ratings



### Perceived Opportunities for Improvements for Future Pandemics

The following improvements were suggested by respondents to the surveys and interviews to improve care and resident quality of life during a pandemic/outbreak:

- Increase staffing levels and availability of relief resources
  - Increase full-time staffing complements
- Increase quality and consistency of training related to understanding of pandemic policies, and use of personal protective equipment (PPE)
- Improve communication of orders, policies, procedures, and protocols during pandemic/outbreak
- Eliminate all shared rooms in continuing care facilities
- Ensure proper supply of PPE throughout the outbreak/pandemic
- Increase mental health supports for FBCC residents and staff
- Increase visitation opportunities to the degree possible
  - Create safe visitation spaces for residents and visitors and also enable family/support people to support residents in their rooms and shared care areas as needed
  - Increase access to technology to increase use of virtual visits for residents
- Increase opportunities for physical and recreation activities

Operators also expressed concerns about the reconciliation process for additional COVID-19 funding and are afraid that many operators will be left with a cash flow deficiency during this process.

### 3.10.3 Leading Practices/Other Jurisdictional Research

## Communication and System Integration

Recommendations coming out of Ontario's LTC COVID-19 Commission (for Ontario)<sup>102</sup> include:

- In the short term, where there are LTC homes that are likely to have difficulties, a collaboration model should be mandated immediately. These relationships between LTC homes, local hospitals and public health units must be based on trust, collaboration, and respect on all sides for the expertise that all parties bring to the priority of ensuring the health, safety, and well-being of residents.
- The Ministry of Long-Term Care should work with the Ministry of Health to formalize these relationships proactively – there is no need to wait until an outbreak has occurred before a local hospital assists or is compelled to assist a LTC home. Clearly defined supports and surge capacity for each LTC home must be in place and quickly mobilized when an emergency arises.

According to Revera Inc's Expert Advisory Pandemic Report<sup>103</sup>, each Canadian province should establish a regional network for its LTC sector with established relationships between the region's hospitals and LTC homes. This is less of an issue in Alberta, where there is one provincial health authority.

## Workforce

Recommendations coming out of Ontario's LTC COVID-19 Commission (for Ontario)<sup>104</sup> include:

- In addition to increasing the supply of PSWs, ensure that LTC staff recruitment efforts address the requirement for an appropriate staff mix to meet the increasing acuity and complex care needs of residents
- While staffing flexibility is needed given the 24/7 nature of homes' operations, more full-time positions must be created to ensure staffing stability and retention, and resident continuity of care
- Identify the permanent investments required to develop and implement a comprehensive human resources strategy that addresses the full range of staffing issues in the sector
- Mandate a minimum daily average of 4.0 hours of direct care per resident
  - The government needs to increase permanent funding for more nurses and support staff, to enable homes to increase their staff to resident ratio, and provide more hours of care, based on residents' needs.

## Infection Prevention and Control (IPAC)

Recommendations coming out of Ontario's LTC COVID-19 Commission (for Ontario)<sup>105</sup> include:

- Ensure every LTC home has a dedicated IPAC lead who can monitor, evaluate, and ensure compliance with proper protocols; support and provide basic training for all staff, and access the local IPAC centre of expertise, as required
- Enhance LTC ministry resources and capacity to provide compliance support immediately
  - In the short term, inspection staff from the Ministry of Long Term Care and others who can be trained, as well as from the local Public Health Unit, should be sent into homes to conduct timely, focused inspections to ensure homes are properly implementing proactive IPAC measures, and are responding effectively to their assessment results

- These inspections should prioritize visits to homes based on the same risk measures as those used for the first recommendation under Relationships and Collaboration
- Given LTC residents are a highly vulnerable population and to date have suffered the highest COVID-19 death rates, provide highest priority access to testing and quick turn-around of results for residents and staff
  - The government should also prioritize LTC homes for point of care and less invasive tests as they become available
- Residents who are COVID-positive, especially in older homes, should be given the option to transfer to alternate settings to avoid further transmission of the virus and to help them recover
  - Given that many LTC homes cannot effectively cohort and isolate because of physical infrastructure limitations, each home should work with its hospital, public health partners and others to put plans in place to quickly decant residents to other facilities, if it is appropriate and safe to do so, and the plan should identify these facilities in advance

According to Revera Inc's Expert Advisory Pandemic Report<sup>106</sup>, staff should be trained in how to obtain various samples for testing.

- Until routine testing of asymptomatic residents and staff is available, homes should continue regular testing with Polymerase Chain Reaction detection of viral RNA
- Management should familiarize itself with the residential areas of staff members and monitor community spread in those neighbourhoods to determine when there is a higher likelihood of staff becoming infected

### **Staff training and Personal Protective Equipment (PPE)**

According to Revera Inc's Expert Advisory Pandemic Report<sup>107</sup>, a several-day supply of PPE must be maintained at every LTC home. Central regional inventories should be established to provide supplementary supplies for homes that require extra supplies during an outbreak.

Standards involving IPAC in LTC must be brought to the levels expected in hospitals. This must include, at a minimum, training in hand hygiene; hand hygiene auditing; and the safe, effective use of PPE, including donning and doffing, and a focus on appropriate cleaning methods.

### **Visitor policy and the role of families**

In late 2020, in a Special Report provided by the Royal Commission of Aged Care Quality and Safety, it was recommended that the Australian Government should fund providers to ensure there are adequate staff available to deal with external visitors during COVID-19 to enable a greater number of more meaningful visits between people receiving care and their loved ones<sup>108</sup>.

According to Revera Inc's Expert Advisory Pandemic Report<sup>109</sup>, designated family members and/or friends should be recognized as "essential caregivers" with the same virus screening protocols and testing used for staff. These essential caregivers must also receive IPAC (infection prevention and control) training.

Recommendations coming out of Ontario's LTC COVID-19 Commission (for Ontario)<sup>110</sup> include:

- Given the essential role of families and caregivers in supporting not just physical care needs but the psycho-social well-being of residents, ensure that families and caregivers have ongoing, safe, and managed access to LTC residents

### **Impact on residents' and family caregivers' overall health and well-being**

In late 2020, in a Special Report provided by the Royal Commission of Aged Care Quality and Safety, it was recommended that Australian Government increase the provision of allied health and mental health services to people living in residential aged care during the pandemic to prevent deterioration in their physical and mental health. Any barriers, whether real or perceived, to allied health and mental health professionals being able to enter residential aged care facilities should be removed unless justified on genuine public health grounds<sup>111</sup>.

### **Infrastructure**

Recent studies by Public Health Ontario, researchers from the University of Toronto, and key researchers from Ontario hospitals and Research Institutes<sup>112</sup> indicate that residents living in overcrowded LTC homes (e.g. homes with 2 to 4-bed rooms, shared bathrooms) are twice as likely to die from COVID-19 (2.7 per cent vs. 1.3 per cent) than in other settings.

Infrastructure issues include shared rooms and bathrooms, the age of the facilities and the number of spaces in a building, and the use of ineffective ventilation systems.

### **Oversight, monitoring and compliance**

The Ontario Long-term care COVID-19 Commission<sup>113</sup> identified focused inspection, monitoring, and enforcement as important steps to stop the spread of COVID-19 in LTC facilities.

### **Increased funding support**

According to CD Howe Institute's 2020 expert working group<sup>114</sup>, among OECD countries for which recent data are available, Canada has fewer nurses and personal support workers per senior citizen than most (i.e. Canada only ranks above Korea, Hungary, and Portugal but below Austria, Germany, Estonia, United States, Japan, Australia, New Zealand, Luxembourg, Netherlands, Denmark, Switzerland, and Israel).

- Rather than blame LTC operators, group members noted that contract rates paid to these providers by government have not kept pace with increases in case complexity and inflation
- Group members pointed out that LTC operators have been unable to increase staffing levels and augment staff mix sufficiently given the limited funding increases they have received

The expert working group also noted that provinces should increase investment in home and community care and develop policies that increase the freedom of choice for Canadians with respect to where and how they receive care services. Incentives should be designed to encourage those who can receive appropriate care in a non-institutional setting to do so.

- OECD countries spent 35 per cent on community care and 65 per cent on institutional care, whereas Canada spent 10 per cent on community care and 90 per cent on institutional care
  - As such, reallocation from institutional care to community care can be supported.

- As already noted, France, Germany, and Australia, for example, have implemented self-directed models of care delivery that support greater independence among the elderly while improving patient satisfaction (Blomqvist and Busby 2014)

### 3.10.4 Policy Direction and Recommendations

Six recommendations presented earlier in the report, if implemented, would aid in preventing the future spread of infectious diseases in FBCC sites and also improve resident quality of care.

- **Recommendation 16:** Increase direct care hours (includes nursing, personal care and therapeutic) at FBCC sites to an average of 4.5 worked hours per resident day for LTC and up to an average of 4.0 worked hours per resident day for DSL within a four-year period.
- **Recommendation 17:** Increase the level of professional care hours (nursing and therapeutic) for FBCC residents.
- **Recommendation 18:** Increase the level of mental health professional supports for FBCC residents.
- **Recommendation 21:** Establish a full-time employment benchmark for nursing, therapeutic and health care aide staff for FBCC and include the benchmark as one of the quality indicators for monitoring facility care.
- **Recommendation 30:** Develop and implement a “Research, Innovation and Technology Strategy for Continuing Care” in Alberta.
- **Recommendation 31:** Focus government capital investments on the regeneration or replacement of existing FBCC spaces, with some funding ear-marked for the development of new spaces where needed.

Further, we developed seven additional recommendations that would aid in preventing the future spread of infectious diseases in FBCC sites and also improve resident quality of care.

#### Policy Direction 13: Learn from COVID-19 experience to prevent future spread of infectious diseases in FBCC sites and improve resident quality of life and care.

- **Recommendation 36:** Immediately halt new admissions to rooms that already have two residents. Permanently phase out shared rooms by April 1, 2027.
- **Recommendation 37:** Revise the design guidelines for continuing care facilities to incorporate findings regarding the spread of COVID-19 in FBCC.
- **Recommendation 38:** Ensure that there is an on-site leader in each facility who has the expertise or access to expertise to devise an early pandemic management and prevention plan and has the authority to implement that plan to improve issues related to infection prevention and control.
- **Recommendation 39:** Resolve labour force issues proactively to maintain needed staffing levels at FBCC sites during pandemics and outbreaks.
- **Recommendation 40:** Maintain an open communication channel with all FBCC sites and industry associations during emergency situations such as pandemics.
- **Recommendation 41:** Ensure that FBCC operators and staff always have appropriate access to personal protective equipment and other equipment/supplies for future outbreaks/pandemics.

- **Recommendation 42:** Reduce social isolation for residents and caregivers during an outbreak/pandemic.

Details regarding these recommendations are provided in Section 4.2.11.



## 3.11 Federal Funding and Standards

### 3.11.1 Current Context

The COVID-19 pandemic has highlighted two key issues related to LTC nationally: the financing of these services and standards of care.

The pandemic has exposed significant shortcomings in Canada's LTC sector. The Canadian Institute for Health Information (CIHI) reported in late June 2020 that LTC residents accounted for 81 per cent of COVID-19 deaths in Canada, more than double the average of 38 per cent across the 14 countries in the OECD<sup>115</sup>. Other reports have described extremely poor care services and practices in some provinces<sup>116, 117, 118</sup>. These problems with LTC services have become a national concern.

One of the root causes of these outcomes was identified as the chronic underfunding and understaffing of continuing care and LTC services across Canada. While health care service delivery is within provincial jurisdiction, the federal government assists provinces and territories by providing health transfer funding.

The *Canada Health Act* (CHA) sets out the criteria and conditions that provincial insurance plans must meet in order to receive these federal transfers. The CHA requires that "medically necessary" or "medically required" hospital and physician services be insured by the provincial or territorial plan. LTC and home care are not included in this provision. These services are governed by provincial legislation. All provinces have their own continuing care programs and services and a variety of housing options for clients. Details and options of continuing care programs and services vary by province.

Based on an online survey conducted by Ipsos:

- 86 per cent of Canadians believed that LTC should be considered an integrated part of the Canadian health system to be funded and administered accordingly<sup>119</sup>
- 47 per cent ranked improving the standards of LTC homes across Canada as one of their top five priorities
- 63 per cent of Canadians aged 65 years and older ranked improving the standards of LTC homes as their most important priority

Many organizations, researchers and clinicians argue for the development of national standards as a method of addressing current issues in LTC<sup>120,121</sup>.

Responding to public concern on deaths in LTC facilities due to the COVID-19 pandemic, The Government of Canada Speech from the Throne (September 23, 2020) indicated that the Government will also:



- Work with the provinces and territories to set new, national standards for LTC so that seniors get the best support possible
- And take additional action to help people stay in their homes longer<sup>122</sup>

On December 10, 2020, Prime Minister Justin Trudeau wrapped up his 23<sup>rd</sup> meeting with Canada's premiers by promising to increase health care funding to the provinces, but not before the immediate pressure of the pandemic subsidies<sup>123</sup>.

### 3.11.1.1 Areas of Opportunity

One challenge is for the federal and provincial/territorial governments to find common ground and a shared pathway to proceed harmoniously towards the mutual goal of rejuvenating the continuing care sector across the country.

The following comments below are offered from a financing and planning perspective.

#### **The financing perspective: the projected cost burden of the LTC system in Canada**

The impact of the aging population on the future health care costs in Canada is substantial. The population of people over 65 years of age in Canada is projected to increase from 18 to nearly 25 per cent of the population by 2040. This increase is driven in large part by the baby-boom generation who are now between the ages of 55 and 74 years. They will be entering the 75 plus age group who will be the highest users of the health system.

The 2020 Conference Board of Canada report on *Health Care Cost Drivers in Canada*<sup>124</sup> indicates that, without the impact of COVID-19, health care expenditures are estimated to increase at an average annual pace of 5.4 per cent out to 2030-31. Of the 5.4 per cent average annual growth, about 46 per cent of the increase is due to inflation, 18 per cent is due to population growth, and 19 per cent is due to population aging.

In addition, it estimates that because of the COVID-19 pandemic, additional health care funds are needed for testing, treatment, recovery, medical supplies, pharmaceuticals, and acquirement of vaccines. The report suggests that the additional health costs due to COVID-19 will range from \$20.1 to \$26.9 billion in 2020-21, and the total amount between 2020/21 and 2030/31 will range from \$80 billion to \$161 billion. Accounting for the COVID-19 pandemic, total health care expenditures for governments are projected to increase by between 20.9 and 27.5 per cent from 2019-20 to 2022-23, or by an average annual pace of between 6.5 and 8.4 per cent.

As health is a provincial jurisdiction, these projected additional health cost expenditures will weigh heavily upon the health care budgets of all provinces. For this reason, the premiers requested the federal government to increase the current 22 per cent of the federal share of provincial government health spending to 35 per cent, which would represent an increase in the Canada Health Transfer of \$28 billion annually next year<sup>125</sup>.

#### **The planning perspective: integrated system planning for seniors' care**

As the adverse impact of the COVID-19 pandemic is most visible in LTC facilities, there is a tendency to focus the discussion on developing national standards for LTC only. Other countries with aging populations have shown that there are more effective ways of managing the continuing care system

beyond only focusing on LTC. The C.D. Howe research report on *Shifting Towards Autonomy: A Continuing Care Model for Canada*<sup>126</sup>, observed that “other OECD countries, on average, spend a much larger share of their health and LTC budgets on home care services than Canada (OECD Stats 2012), as they have shifted large shares of their health budgets towards delivering care to the frail elderly in their homes.” Thus, what is needed in Canada is a national discussion on the bigger policy question on an appropriate integrated continuing care system in the future. Discussion of national standards, common elements, and outcome measures of the future system should be part of the discussion.

# Detailed Recommendations

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## 4 Detailed Recommendations

### 4.1 Future Vision for FBCC Services in Alberta

The findings from Section 3 above identified several opportunities to improve FBCC service delivery in Alberta. The findings also identified many strengths to build upon, including a unified health authority, good collaboration between the government and industry, use of proven assessment tools, history of successful policy development and innovations, and the availability of renowned experts and dedicated clinicians.

Moving forward, future users of FBCC services may have different life-style preferences from the residents of today, and their vision for healthy aging may also change. Accordingly, it will be important to develop a vision that reflects these differences and addresses the changing needs of residents.

Trending studies<sup>127,128</sup> and comments by gerontology experts<sup>129,130</sup> show that the preferred vision for aging consists of healthy and active lifestyles, an improved quality of life, and living in age-friendly communities close to their friends and support groups. People with disabilities have similar goals, to be able to live full lives supported by a network of services in the community<sup>131</sup>.

In November 2019, the Alberta Association on Gerontology hosted a Symposium on Vision 2030<sup>132</sup> for Seniors Services in Alberta. More than 250 participants including clinicians, gerontologists, researchers, health care planners, seniors and their family members attended.

#### Healthy Aging Vision for Alberta

Based on the above considerations, a Healthy Aging Vision for Alberta was developed, and utilized to articulate the desired end-state for healthy aging in Alberta.

*Albertans are supported to be healthy and active in their community, with an improved quality of life, and they are engaged, empowered, and enabled to live in inclusive communities with social connectedness and healthcare access.*

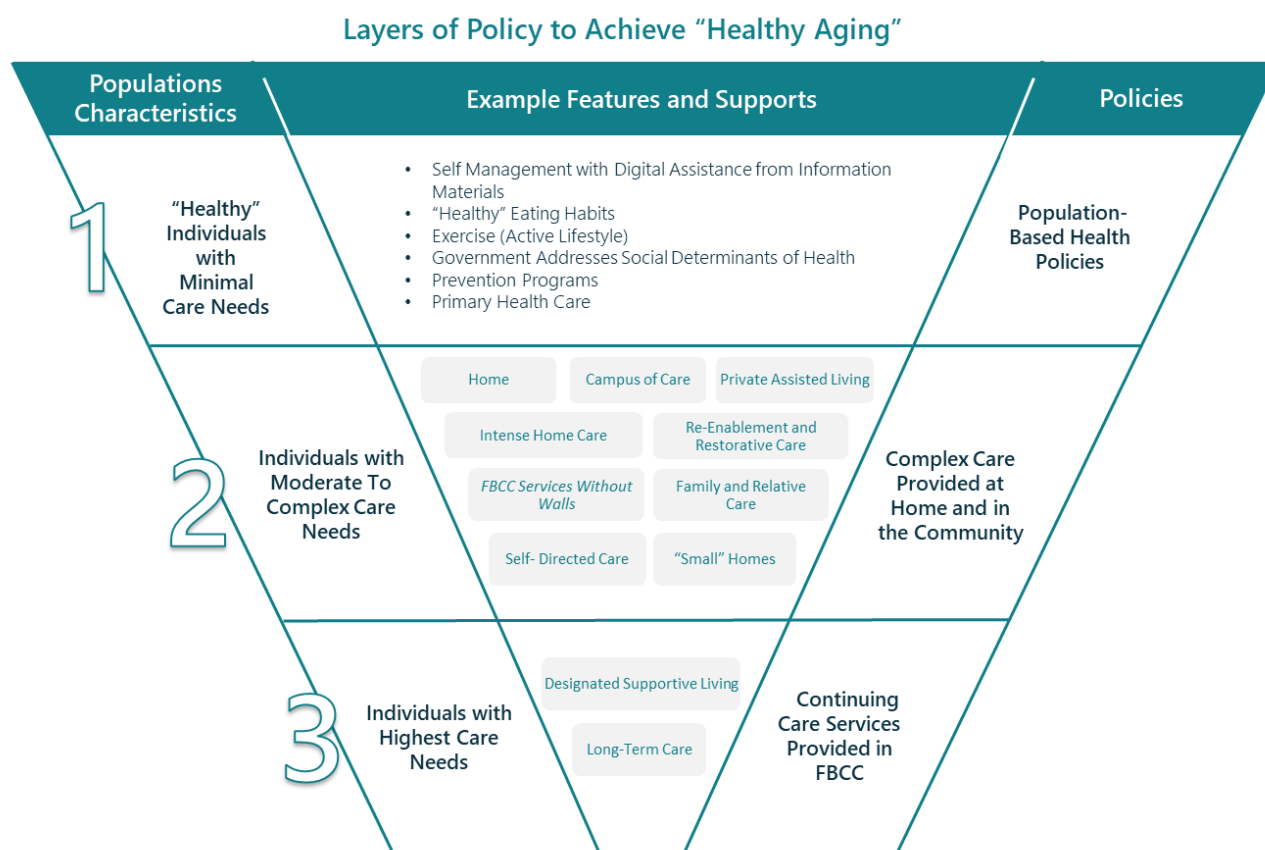
In thinking about how to achieve this vision, MNP developed a proposed policy structure that reflects key elements including population characteristics, features and support, and policies (Figure 47).

#### Goals for Healthy Aging and Transforming FBCC

The goal of the Healthy Aging Vision is to enable as much of the senior population and people with disabilities to live in Layer 1 (minimum care needs) as possible. For Layer 2, home care, community care, and supportive housing services should be augmented, aiming to have a moderate proportion of seniors and people with disabilities in this group. With these actions, the percentage of seniors and people with disabilities in FBCC (Layer 3) should decrease over time

Currently, 22.5 per cent of continuing care clients are in LTC, and 17 per cent are in DSL (39.5 per cent total), with 60.5 per cent served by LTHC. The target for continuing care services is to reduce the proportion of clients in LTC to 13.9 per cent and the proportion of clients in DSL to 16.1 per cent, with 70 per cent of clients served in LTHC.

Figure 47: Healthy Aging Vision - Policy Structure for Alberta



### Layer 1: For Individuals with Minimal Health Care Needs:

#### Required: Population-based Health Policies and Services

For Albertans with minimal health care needs, the priority is to implement population-based health policies that encourage individuals to practice healthy eating and active lifestyle habits. All government departments need to collaborate to improve the social determinants of health for seniors and people with disabilities including elimination of abuse, social isolation, and loneliness, improving financial security, and enabling accessible transportation. The health system should be enhanced whereby primary health care, community health programs, and community/home-care services are seamlessly coordinated. Programs and supports should be available to reduce unnecessary early movement into FBCC.

### Layer 2: For Individuals with Moderate to Complex Care Needs (Living at Home or in the Community):

#### Required: Services and Supports to Deliver Complex Care at Home and in the Community

For this group of individuals and people with disabilities, complex services and innovative programs supporting them in their community are needed. Such supports could include:

- New models of supportive housing, such as: “small” or cottage-like homes; housing designed specifically for delivering dementia care services; assisted living; campus of care villages; co-

operative housing; shared housing between students and seniors/people with disabilities; and specially adapted homes for aging living

- New models of services, such as: FBCC Services Without Walls <sup>133, 134</sup>; self-directed care; intense long-term home care <sup>135</sup>; family and relative care options; and re-enablement and restorative care <sup>136, 137</sup>

### **Layer 3: For Individuals with Highest Care Needs Living in FBCC:**

Based on the findings of the Review, a vision for transforming FBCC was developed.

*Facility-Based Continuing Care sites provide safe, affordable, inclusive, person-centred care to individuals in need, respecting their dignity, choice, and individual preferences, covering their holistic service needs including physical health, mental health, spiritual needs, cultural needs, and relational needs. The goal is to provide high quality care and services that support resident quality of life and happiness. Sites strive to be a joyous place for residents to live, for staff to work, and for family/caregivers to visit.*

### **Required: A Transformed Integrated FBCC System Delivering “Intense” Continuing Care Services**

The following changes are required to support the vision for FBCC:

- The culture of care is transformed from rigidly scheduled care to person-centred individualized care with quality of life being valued as a priority
- The culture of working life for staff is transformed from a poor working environment to one with pride, respect, continuous quality improvement, and healthy working conditions that stimulates high morale amongst staff
- Staffing hours of care and training are enhanced
- Family caregivers are treated as essential team members for care
- Couples and loved ones are not separated when moving to FBCC
- Individuals have a choice of their providers, locations, and options for continuing care services
- An easily accessible information system is designed to enable users to select appropriate service options or facilities for care

## 4.2 Detailed Recommendations for Change

A total of 42 recommendations for improvement were developed, and organized into 11 policy directions. Each recommendation includes:

A description of the recommendation	The supporting rationale for making the recommendation
The expected benefits of implementing the recommendation	The key actions required to implement the recommendation
The proposed timing for the recommendation	The financial considerations of the recommendation

An integrated dynamic financial model was developed to assess the financial implications of key recommended changes to the system. Detailed assumptions for the model are provided in Appendix 2. The model determined the projected costs of meeting future demand for continuing care services based on the current distribution of LTC, DSL and LTHC services, as well as proposed changes to the system based on the future vision for LTC, DSL and LTHC services. Key areas of change in the integrated dynamic financial model included:

- The implications of increasing the proportion of LTHC spaces from 60.5 per cent to 70.0 per cent and decreasing the proportion of FBCC services from 39.5 per cent to 30.0 per cent to meet demand in 2030. This included:
  - Annual operating cost implications
  - Cumulative capital cost implications from 2021 to 2030
- The implications of increasing the direct hours of care for:
  - LTC from an average of 3.4 worked hours per resident day to 4.5
  - DSL4D from an average of 3.0 worked hours per resident day to 4.0
  - DSL4 from an average of 2.7 worked hours per resident day to 3.5
- The implications of providing a self-directed care model, with 6.3 per cent of all continuing care clients receiving services through this option by 2030
- The implications of adjusting capital grant levels for LTC and DSL space development
- The implications of developing small homes to replace a portion of aged facilities, as well as for new DSL capacity
- The implications of replacing a portion of aged facilities with zero-capital options
- The implications of adding new FBCC capacity specifically in Indigenous communities, in addition to the projected demand for FBCC spaces

Implementing the proposed recommendations below, are projected to result in moderate operating cost increases and significant cumulative capital cost savings by the year 2030 in comparison to meeting demand and providing services with the current distribution of continuing care services with no increases in direct care hours for LTC or DSL. This includes:

- A projected cost increase of \$68 million per year (in 2020 dollars) in annual operating costs by 2030.
- Cumulative capital cost savings of \$1.7 billion (in 2020 dollars) by 2030.

## 4.2.1 Policy Direction 1: Establish Quality of Life as the number one priority goal for Alberta's continuing care system.



**Recommendation #1:** Declare that "Quality of Life is the number one priority for the continuing care system" and establish a Quality of Life Task Force to plan for and implement steps to achieve this.

### Supporting Rationale

- Quality of life and person-centred care are not a key area of focus in the *"Continuing Care Health Services Standards"* or the *Nursing Homes Act* or other related legislation
- Most public survey respondents perceived that resident quality of life in FBCC was poor (38 per cent of respondents) to adequate (36 per cent of respondents) prior to COVID-19, and that the quality of care decreased during COVID-19 (poor rating increased to 52 per cent of respondents and adequate rating decreased to 20 per cent of respondents)
- Residents in FBCC and their caregivers also perceived that quality of life decreased since COVID-19 started and requires improvement
  - Residents rated their quality of life at 7.5 out of 10 prior to COVID-19, and 5.3 out of 10 during COVID-19
  - Families/caregivers rated resident quality of life at 7.0 out of 10 prior to COVID-19, and 4.4 out of 10 during COVID-19
- Internationally, person-centred care is part of a culture-change movement. The culture-change movement includes features such as:
  - Resident direction
  - Home-like atmosphere
  - Smaller homes/facilities
  - Close relationships
  - Staff empowerment
  - Collaborative decision-making (resident and caregivers, and collaborative care team members)
  - Quality-improvement processes
- Many demonstration projects have been implemented in the world as part of this culture change, including the development of specific models such as the Green House Model, the Butterfly Household Model, and Eden Alternative
  - Although additional research on the Green House Model's quantifiable impacts to quality of life is required, it achieves the creation of a family-type/real home setting<sup>138</sup> where implemented
  - For persons with dementia, the Butterfly Household Model of Care developed by Dr. David Sheard (of Dementia Care Matters) in the UK has been shown to have positive impacts on improving the quality of care for people experiencing different stages of dementia



<ul style="list-style-type: none"> <li>◦ Likewise, the Eden Alternative has been successfully shown to reduce fall rates, resident-initiated assaults (on staff), and resident depression<sup>139</sup></li> </ul>
<p><b>Expected Benefits</b></p> <ul style="list-style-type: none"> <li>• This declaration will continue to shift the culture of care delivery in FBCC towards person-centred care, where relational care is valued, client's choice and dignity are respected, and cultural diversity and values are observed</li> </ul>
<p><b>Key Actions Required</b></p> <ul style="list-style-type: none"> <li>• Declaration by Government of Alberta that Quality of Life is the number one priority for the continuing care system</li> <li>• Formation of Quality of Life Task Force to implement Quality of Life Declaration:             <ul style="list-style-type: none"> <li>◦ Identify changes required to care protocols and approaches to inform the development of Quality of Life Standards</li> <li>◦ Oversee work of the Quality of Life Outcome Measures Expert Group, and provide guidance for the development of quality of life outcome measures</li> </ul> </li> <li>• Many research studies identify the following steps as essential to achieving culture change with a focus on quality of life:             <ul style="list-style-type: none"> <li>◦ Emphasize the leadership role of elected officials, administration, medical professionals, and front-line staff in fostering culture change</li> <li>◦ Redesign the "structure, process and outcome" of the organization to achieve culture change (see Recommendation #2)</li> <li>◦ Redesign the workforce where the goal is to "flatten" the hierarchy</li> <li>◦ Restructure the physical design of facilities to provide more privacy in a home-like environment</li> </ul> </li> </ul>
<p><b>Timing</b></p> <ul style="list-style-type: none"> <li>• Next 24 months</li> </ul>
<p><b>Financial Considerations</b></p> <ul style="list-style-type: none"> <li>• Time commitments from Quality of Life Task Force members and Government of Alberta staff</li> </ul>



**Recommendation #2:** Develop new Quality of Life Standards to be included in FBCC standards.

### Supporting Rationale

- Quality improvement experts recommend that, to be successful in improving and transforming any existing system, a formalized way of changing the “structure, process and outcomes” of the existing system should take place
- The new standards should become the new values and culture for FBCC service delivery

### Expected Benefits

- A change in focus from tasked-based care to person-centred care and quality of life for FBCC, which should address the choices and preferences of FBCC residents
  - This includes moving towards a more holistic model of care to address spiritual, social, emotional, intellectual, financial, environmental, mental, and physical needs
  - For example, providing residents with the choice to observe their cultural ceremonies, religion, and practices (including food choices) during their stay in FBCC

### Key Actions Required

- The Quality of Life Task Force should design an implementation plan for mandating the achievement of quality of life standards for all FBCC residents
  - The implementation plan should consider existing services, meals, facility design, staff work schedules and workplace practices, and work cultures that may need to be adjusted to achieve quality of life for all FBCC residents
- Identify changes required in care protocols, approaches, and relationships with residents in the above areas and formulate new approaches
- Pilot and evaluate these new approaches
  - One key aspect of the evaluation will be to assess the impact on the quality of life as well as the satisfaction of residents and their families
- Champions and leaders of the new approach should provide in-service training to all FBCC staff
- Identify the successful approaches and include them as the new Quality of Life Standards

### Timing

- Next 24 months.

### Financial Considerations

- Time commitments from staff involved in developing new Quality of Life Standards



**Recommendation #3:** Develop quality of life outcome measures for FBCC and mandate the public reporting of these measures.

### Supporting Rationale

- Quality improvement research indicates that the measurement of outcomes, and the public reporting of the same, is a way to achieve greater transparency and ensure facilities are accountable for their actions
- There have been vigorous research efforts to develop quality of life outcome measures by many countries in the world over the last ten years. Alberta can learn from the experiences of these countries
- Facility operators and external stakeholders perceive that the focus of audits should shift to assessing outcomes

### Expected Benefits

- Measurement of quality of life outcomes in FBCC and public reporting of the same will foster a culture of continuous improvement relating to FBCC residents' quality of life

### Key Actions Required

- Identify experts with knowledge and experience with developing quality of life outcome measures
- Form a Quality of Life Outcome Measures Expert Group or leverage existing groups/projects to select/develop quality of life outcome measures for Alberta, as well as to develop a reporting process for these indicators
- Mandate the public reporting of these quality of life outcome measures

### Timing

- Next 24 months

### Financial Considerations

- Time commitments from staff and expert group members involved in developing new quality of life outcome measures
- Time commitments from Government of Alberta to introduce and implement the quality of life outcome measures
- Consultant costs
- Time commitments to track data and report on quality of life outcome measures
- Information systems and infrastructure needed to measure/report on quality of life outcomes, as well as the time commitments of staff required for beta testing



**Recommendation #4:** Support couples\*/loved ones to remain living together, if they choose, in continuing care facilities.

### Supporting Rationale

- It has long been the complaint of residents that existing policies often separate couples/loved ones with different care needs, by moving them to different facilities
  - In some cases, these facilities are quite far apart or even in different towns
- The separation of couples/loved ones has, in many instances, led to poor physical and mental health outcomes
  - The Nova Scotia Legislature recently passed a law called *Life Partners in Long-Term Care Act*, mandating that, effective 01 March 2021, couples who require different levels of care in LTC must be admitted to the same facility
- Keeping couples/loved ones together was an opportunity for improvement identified by residents and caregivers
- In furtherance to the prioritization of quality of life of residents, it is recommended that “keeping couples/loved ones together” be a policy principle respected in the admission of FBCC residents, and that this principle override other policies of FBCC
  - Couples/loved ones requiring FBCC should be admitted to the same facility, in the same or connecting rooms (if they prefer) at the highest level of care required, provided that at least one individual is assessed as requiring FBCC services

### Expected Benefits

- This proposed policy will avoid further instances of couples/loved ones being separated while living at FBCC sites

### Key Actions Required

- Amend any access, admission, wait-list management or other policies to support “couples/loved ones to stay together”

### Timing

- Immediate

### Financial Considerations

- Availability of suites to house couples/loved ones
- Time commitments by Government of Alberta to identify and modify all applicable policies/regulations
- Determining how to apply accommodation rates for couples/loved ones who live together

\*Couples defined as married, common-law, etc.



**Recommendation #5:** Include primary caregiver(s) of FBCC residents as essential members of the Care Team and provide them with supports to reduce burnout.

### Supporting Rationale

- With an intimate understanding of FBCC residents, primary caregivers can play many roles in the care and supports of residents including:
  - Companionship and emotional support for residents
  - Assisting in the provision of care activities such as eating, assistance in toileting, mobility (if residents prefer)
  - Providing input into the development of care plans, etc.
- Survey and interview respondents identified a need for increasing caregiver involvement in care plan development and decisions
- For this reason, it is recommended that the resident's primary caregiver(s) have a larger role in care planning and decision making both during and following the COVID-19 pandemic
  - In addition, in relevant continuing care policies, it is recommended that the role of primary caregivers be recognized as an essential Collaborator of the Care Team
- Multiple studies<sup>140,141</sup> have documented various negative impacts on primary caregivers including:
  - Caregiving responsibilities affect caregivers' physical and mental well-being, as in disturbed sleeping patterns, reduced social activities, and engendering psychological dysfunctions such as depression, guilt, worry/anxiety, loneliness, and emotional distress
  - Studies have found that caregivers are burnt out and require support from the government and social agencies to continue with their role

### Expected Benefits

- This inclusion of primary caregivers will formally recognize their special role and empower them to participate in the planning and delivery of care for their resident family members/friends

### Key Actions Required

- Amend policies to recognize primary caregivers as collaborators of care (e.g. in standards; in legislation; in care assessment documents etc.)
- Provide training for FBCC staff on how to engage and include primary caregivers in care plan development and decision making
- Provide primary caregivers with mental health and social supports as needed to help alleviate caregiver distress

### Timing

- Immediate

### Financial Considerations

- Time commitments by Government of Alberta to identify and modify all applicable policies/regulations
- Staff training and change management



**Recommendation #6:** Improve the overall quality of meals (e.g. nutrition, menu selection, taste, presentation, and dining experience) at FBCC facilities.

### Supporting Rationale

- Food was consistently ranked as one of the most important dimensions of quality of life for LTC residents based on previous research studies<sup>142</sup>
- Malnutrition is a concern for individuals living in LTC and prevalence of this condition is high; recent estimates suggest that 44 to 58 per cent of residents are malnourished which can be attributable to poor consumption and menus not providing the appropriate levels of micronutrients, vitamins, and minerals<sup>143</sup>
- The FBCC residents and caregivers who completed the review survey ranked “increase the quality and variety of the meals” as one of top areas for improvement in FBCC sites. Quality of meals was also identified as an area of improvement by FBCC staff and the public
- The provincial facility average for the Food Rating Scale on the 2017 HQCA Survey was 71 out of 100, and facility results ranged from 47 to 88 out of 100
- In response to the Health Quality Council of Alberta Long Term Care Family Experience Survey conducted in 2018, family members said that the quality, temperature, taste, variety, nutritional value, preparation, and serving of meals to residents could be improved
  - Some said the meals could be more “home-like”, better reflecting what residents grew up eating and that tableware similar to a family dinner table should be used
  - Many family members said that nutritious options were not always available, as food was processed, ready-made, or canned. In general, they felt not enough fresh whole fruits and vegetables were used
  - Some said that meals were not always suitable for residents’ dietary needs. Care plans that detailed meal requirements were not always followed or accommodated
  - Regarding meal preparation, many said meals lacked variety (meals rotated through a schedule). Many said meal preparation could be improved with innovative and qualified chefs

### Expected Benefits

- The quality of meals and dining experience provided to FBCC residents is improved

### Key Actions Required

- Bring together nutritionists, chefs, and representatives of the restaurant business to assess the quality and variety of meals provided, including the preparation, serving and presentation, and nutritional value of meals
- Form a Task Group comprised of FBCC operators and representatives from Alberta Health and AHS to implement the recommendations to improve the quality and variety of meals provided in FBCC

### Timing

- Immediate

### Financial Considerations

- Resources to bring together experts
- Time and effort of Task Force members to implement the recommendations
- Potential for higher cost of food services



**Recommendation #7:** Refocus capital grant programs to prioritize a greater variety of client centred models of care (such as smaller homes/households and campuses of care).

### Supporting Rationale

- Capital grant programs were created originally to fund supportive living spaces as recommended by the Broda Report
- To respond to changing needs of the aging population, many other models of care have since emerged; examples of these models include:
  - **Smaller Homes.** Over the past thirty years, many models of care have been developed based on the smaller home concept such as Green House Model, Eden Alternative, and Dementia Butterfly Homes. All these models had received favourable evaluation results
    - These homes usually have 10 to 12 residents, and multi-skilled workers who provide consistent care including nursing care, personal care, daily activities, light housekeeping, and meal preparation
    - Usually, residents are included in household activities as a form of therapy to support clients to be more independent in activities of daily living
    - The design of these homes better suits the needs of residents (e.g. no dead ends with hallways) and generally provides a more residential feel
  - **Campus of Care Villages.** Campus of care villages have also been developed that include FBCC
    - These villages are usually comprised of multi-level facilities and may include spaces for LTC, private and publicly funded supportive living, and independent living, including affordable accommodation options for low-income residents
    - Some villages also include a few smaller homes
    - These villages may function as the “hub” of the community with commercial activities such as coffee shops, beauty salons, and medical clinics for the community housed in village buildings
  - Some sites may establish links with Universities and function as research and education centres for seniors’ services as well
  - Examples of campus of care villages in Alberta include:

- Shepherd's Care Kensington Village in Edmonton
  - Brenda Strafford Foundation Cambridge Manor/BSF Centre on Aging Campus in Calgary which is associated with the O'Brien Institute for Public Health, University of Calgary
- It is recommended that the mandate of capital grant funding be expanded to provide funding to a variety of models of care to allow a much greater choice of living options for FBCC residents
  - New funding mechanisms such as cost-sharing funding with sponsors, private donors, universities, industries, corporations, and private funding should be explored
- Smaller homes are more suitable for some rural areas and Indigenous communities, where the population is too small to support the building of a larger FBCC site

### Expected Benefits

- Greater choice of living options available to Albertans needing continuing care services
- Improved access to FBCC sites in Indigenous and rural communities
- A spectrum of accommodation and care options on one campus site may enable smoother transition between levels of care and keep couples closer together when one partner's care needs change

### Key Actions Required

- Amend the mandate and scope of capital grant funding to include the development of a range of models such as smaller homes and campus of care villages as part of the approach for replacing existing aged FBCC spaces and developing new FBCC spaces (see Recommendation 31)
  - The Government should set a target to develop approximately 1,600 small home FBCC spaces by 2030 as part of the replacement and new development of FBCC spaces in Recommendation 31
  - Set a target of developing some of the replacement/new FBCC spaces in Recommendation 31 in approximately 12 campus of care type of environments across AB (this could include the incorporation of small homes)
  - Include affordable independent living options within the campus (e.g. lodge settings or self-contained apartments)

### Timing

- Next 36 months

### Financial Considerations

- Capital funding from Government of Alberta
- Other sources of funding from cost-sharing parties
- Funding to evaluate resident outcomes in the new models of care



## 4.2.2 Policy Direction 2: Enhance overall Quality of Care with emphasis on residents living with dementia.



**Recommendation #8:** Enhance the overall quality of care provided to FBCC residents by strengthening the relevant services standards, and updating/redesigning continuing care information systems and care indicators. Promote research, education, and evaluation activities on quality of care.

### Supporting Rationale

- Quality of care is critical to quality of life but is only one aspect that contributes to quality of life
- The quality of care that FBCC residents receive is most often reported in terms of clinical quality indicators (QIs)
- Alberta has had a strong focus on improving quality of care over the past ten years:
  - In 2014, the Continuing Care Quality Management Framework was released by AHS
  - The *Continuing Care Health Services Standards* have been updated regularly since 2007, latest amendment in 2018
  - Alberta performs well in comparison with other Canadian provinces in terms of quality indicators reported by CIHI, using information from RAI tools
  - Alberta has chosen the reduction of antipsychotic drugs in LTC homes as a quality initiative since 2011. In 2011/12, the proportion of residents on antipsychotic drugs in LTC homes without a diagnosis of psychosis was 26.8 per cent. In 2019/20, this percentage had decreased to 18.1 per cent, the lowest in Canada
  - Alberta is now rolling out a similar initiative province-wide that focuses on reducing pain and depressive symptoms
  - The HQCA regularly conducts surveys of FBCC residents and their families on their perception of the quality of care delivered in LTC and DSL facilities
    - In these surveys, residents and families expressed concerns about the inadequate staffing levels of these sites. However, in general, residents and families were satisfied with their facilities and staff
    - For LTC, family members rated overall care at their facilities at an average of 8.4 out of 10, and 93 per cent would recommend their facility to others
    - For DSL, residents' overall rating of their facility was 7.8 out of 10 (8.4 by family members). Ninety per cent of residents, and 94 per cent of family members would recommend their facilities to others
  - The Institute for Continuing Care Education and Research (ICCER) is a network of post-secondary institutions, continuing care provider organizations, and regulatory bodies collaborating to improve continuing care in Alberta by encouraging research, translating knowledge into better practice, enhancing education and informing policy
- The RAI-MDS 2.0 tool and RUG III system currently used in LTC in most provinces of Canada is scheduled to be converted to a new system, the InterRAI LTC Facility assessment tool and RUG-III Plus over the next few years

- CIHI requires the reporting, by all applicable jurisdictions, of data generated by these new tools to its information systems
  - Funding is required to develop a new provincial information system to collect the data from these assessments, report these data to CIHI, and to enable analytics required to monitor quality, provide data for public reporting, and support policy development of these new tools and for the monitoring of the new indicators
- Quality of care in LTC is receiving a tremendous amount of attention as a result of the fatalities resulting from the ongoing COVID-19 pandemic
  - Many indicate that the current issues with LTC in Canada are chronic and strongly related to the culture of LTC
  - A transformational cultural change is needed that embodies learning and continuous improvement
  - An environment that promotes continuing education and training in the light of new research findings is critical to the delivery of leading practices
- It is recommended that additional funding be made available to provide support for activities promoting learning, research, education, and evaluation for continuing care in the province
  - Examples include organizing Think Tank Discussion Sessions for the improvement of the system, presentations by experts on leading-edge practices, mentoring experiences for front-line care staff, and implementation and evaluation of innovation projects pertaining to quality of care strategies

#### **Expected Benefits**

- The recommended activities will assist in continuously improving the quality of care in FBCC

#### **Key Actions Required**

- Develop an action plan to enhance the quality of care, taking into consideration the factors mentioned above
  - Modify relevant standards to support monitoring of quality of care indicators over task-based measures
- Develop a plan to assist in the implementation of the InterRAI LTC Facility and Home Care assessment tools and RUG-III Plus, and develop a new information system (e.g. replacing or updating ACCIS, continuing work on Connect Care system) to support the implementation including training, reporting, and trending of new indicators
- Develop a plan to promote research, education, implementation, and evaluation of innovation projects in FBCC

**Timing:** Next 24 months

#### **Financial Consideration**

- Time commitments by Government of Alberta to identify and modify all applicable policies/regulations
- Funding for future new information system and indicator development

- Funding for research, education, and evaluation projects in FBCC



**Recommendation #9:** Improve the quality of life for FBCC residents living with dementia, including quality of care, and the physical, mental, and emotional health of these residents.

### Supporting Rationale

- Experience has shown that activities aimed at improving the quality of care are more likely to be successful if they are very focused, carried out with concerted efforts of the care staff, and perceived as important, and measurable by indicators
- Rationale for this recommendation includes:
  - Residents living with dementia are estimated to represent 70 per cent to 90 per cent of the population of FBCC and it is estimated this proportion will continue to increase in decades to come
  - Residents living with dementia very often are unable to express their needs in both the Quality of Care and Quality of Life domains
  - Alberta Health is currently implementing the five-year Alberta Dementia Strategy and Action Plan, and this recommendation can build upon and leverage the expertise, knowledge base and momentum gained from the Dementia Strategy
  - Alberta can learn from demonstration projects focused on dementia care delivery
  - Evaluation studies ( e.g. CADTH Issues in Emerging Health Technologies: Dementia Villages: Innovative Residential Care for People with Dementia, 2019) have concluded that “rather than adopting a single model, adopting best practices from each to suit local needs may be a more reasonable approach”

### Expected Benefits

- Improved quality of care for residents living with dementia
- Improved quality of life for all FBCC residents, including residents living with dementia

### Key Actions Required

- Develop a Dementia Quality of Care initiative
  - It is recommended that both care delivery methods and physical design features be jointly considered as part of this initiative. Certain physical environmental conditions such as design features, colour, and lighting etc. contribute significantly to quality of life
- Develop a measurement approach for quality of care and life for residents living with dementia
- Establish trend data for reporting and multi-year targets

### Timing

- Next 36 months

### Financial Consideration

- Project expenses, including contracting expenses for indicator development and reporting tools, FBCC staff time, and evaluation activities

### 4.2.3 Policy Direction 3: Improve the provision of culturally appropriate continuing care services.



**Recommendation #10:** Strengthen relationships and the level of collaboration with Indigenous leadership/organizations to provide more culturally appropriate continuing care services, closer to home and integrated with other community services, for Indigenous stakeholders.

#### Supporting Rationale

- Feedback provided by Indigenous Albertans included:
  - Indigenous communities need access to more Indigenous-based facilities equipped with culturally relevant services
  - There is a need to improve the delivery of home care services on-reserve and -settlement
  - Indigenous communities would like help from the Government of Alberta with building internal capacity to provide FBCC services without having to give up authority
    - They would like to implement a culture-based model rather than a western model that is imposed on them
  - There is a need to build mutual trust between all partners (Indigenous, federal, and provincial)
  - There is a need for better partnerships around funding (provincial and federal) and better coordination among Alberta Health and AHS
  - There is a need for more consistency in support and communication from Alberta Health/AHS. Many Indigenous groups are unclear of the process for initiating discussions about establishing continuing care services in their communities

#### Expected Benefits

- Improved access to continuing care services closer to home for Indigenous clients/stakeholders
- Improved quality of care and quality of life for Indigenous clients/stakeholders

#### Key Actions Required

- Assign a dedicated team from Alberta Health/AHS to work collaboratively with Indigenous leaders/organizations and, as appropriate, representatives from First Nations and Inuit Health Branch (FNIHB) at Indigenous Services Canada (ISC)
- Have this team work collaboratively with Indigenous leaders/organizations and, as appropriate, representatives from FNIHB to establish a process for developing and funding continuing care services in Indigenous communities
- Have this team communicate with the Leaders/Health Directors in Indigenous communities the process for developing and operating FBCC services

- Coordinate consistent communication messaging with FNIHB on this process
- Provide supports to, and work collaboratively with, communities interested in trying to bring FBCC services closer to home. This includes working with representatives from FNIHB and helping to bring them to the table for these initiatives
- Pilot the “resource hub” model concept (see Recommendation 14) in some Indigenous communities

### Timing

- Immediately

### Financial Considerations

- Time and resource requirements of the team dedicated to support Indigenous organizations
- Funding for culturally appropriate Indigenous services, including capital funding



**Recommendation #11:** Improve cultural sensitivity, and diversity and inclusion at FBCC sites.

### Supporting Rationale

- Expert Panel members reported a need to provide cultural diversity in meals, and delivery language at FBCC sites
- Indigenous stakeholders reported a lack of consideration for Indigenous peoples’ needs and cultural safety in continuing care facilities in Alberta including:
  - A lack of cultural sensitivity and acknowledgement of the importance of the land and the community, with which Indigenous peoples have kinship ties
  - Language barriers can be a challenge off reserve
  - Facilities lack of access to traditional foods and do not allow family members to bring in traditional foods
- LTC homes in Canada are challenged to recognize and support the cultures of their residents at a time when their health and mental capacity are declining<sup>144</sup>
- The NIA recently reported a growing need for inclusive care and support that acknowledge and affirm the immense diversity that exists among LTC residents across Canada including race, culture, gender, and sexual orientation<sup>145</sup>

### Expected Benefits

- Improved quality of care and quality of life for all FBCC clients

### Key Actions Required

- Establish a task force to focus on improving cultural sensitivity, and diversity and inclusion in FBCC. Have the task force consider implementing the following actions for improving cultural sensitivity, and diversity and inclusion at FBCC sites:

- Provide a method for addressing and resolving conflicts related to inter-cultural and diversity issues among FBCC residents, caregivers, and staff
- Provide training related to cultural competence and cultural sensitivity, and diversity and inclusion for FBCC staff
- Support individuality and culture within the standardized environment of regulation and compliance
- Ensure that sites meet accreditation standards for diversity and inclusion
- Implement leadership training that includes diversity and inclusion, both in academic and in-service settings
- Include admission questions that ask about an individual's needs and preferences and integrate that information into care planning
- Provide traditional foods and sourcing traditional ingredients if possible
- Engage and work with interpreters when needed
- Engage and retain diversity at all levels with FBCC organizations including care staff, supervisors, board of directors' members and volunteers
- Identify languages spoken by staff and assigning shifts to ensure language support


#### **Timing**

- Next 24 months

#### **Financial Considerations**

- Time and resource requirements for developing task force
- Support to provide training for cultural sensitivity, and diversity and inclusion

#### 4.2.4 Policy Direction 4: Improve coordination in the continuing care system, making it easier to navigate for the client and better integrated with other health, community, and social services.

	<b>Recommendation #12:</b> Make easily understandable information about continuing care services available to all Albertans to assist with navigation.
<b>Supporting Rationale</b> <ul style="list-style-type: none"> <li>• Most respondents to the public survey indicated that residents and caregivers have difficulty in accessing FBCC services</li> <li>• Over 50 per cent of respondents to the public, facility operator and external organization surveys perceived that “unnecessary system complexity” was a challenge experienced by FBCC residents and caregivers</li> <li>• Alberta Health and AHS recently launched the AHS Continuing Care Facility Directory. This could be used as a starting point for improving information sharing</li> <li>• Clear and easily understandable information should be developed to explain the variety of available continuing care services; this information should be available online for people who prefer or can do self-navigation             <ul style="list-style-type: none"> <li>◦ However, navigators should be available to support individuals with more complex needs (see Recommendation 13)</li> </ul> </li> <li>• Consideration should also be given to providing educational materials to Albertans on diseases related to aging (such as dementia, physical impairments, etc.)</li> </ul>	
<b>Expected Benefits</b> <ul style="list-style-type: none"> <li>• Improved communication and access to information on continuing care programs and services</li> <li>• A better understanding by clients and caregivers on how to navigate continuing care services in Alberta</li> <li>• Improved attitudes towards the continuing care system by all system stakeholders</li> </ul>	
<b>Key Actions Required</b> <ul style="list-style-type: none"> <li>• Create information materials that are understandable and easily accessible to improve the navigation of continuing care service options in Alberta</li> <li>• The materials would be developed to share information more clearly with clients, potential residents, family members, community members, providers etc.             <ul style="list-style-type: none"> <li>◦ Materials could include paper and electronic web-based media</li> <li>◦ Materials should provide a user-friendly description of services</li> <li>◦ Materials should be easy to find and supported by navigators to guide Albertans in the use of continuing care services</li> </ul> </li> <li>• Align the information with communications materials of AHS and government departments, such as the AHS Continuing Care Facility Directory</li> </ul>	

**Timing**

- Next 12 months

**Financial Considerations**

- Staff and resource support to develop and implement the Information Sharing and Communications Plan
- Cost of developing website content and print materials
- Cost of translating materials to other languages



**Recommendation #13:** Pilot the use of a continuing care navigator function to improve the coordination of services between continuing care, primary care, acute care, mental health care and community/social service providers.

**Supporting Rationale**

- The navigation function in continuing care in Alberta sits with the case management and case coordination function of the Home Care/Community Care Case Managers
  - These case managers are responsible for assessing the continuing care needs of individuals and referring them to a range of continuing/community care services
- Existing navigation supports provided by non-profits and government agencies vary widely across regions and locations of care in Canada and tend to be for specific situations or health conditions
  - To mitigate this, some families are reaching out to private advocates and navigators, which creates inequity between those who can afford to hire these services and those who cannot<sup>146</sup>
- Navigators have been found to be uniquely positioned to play an integral role in the changing environment of health care delivery by facilitating access to care, as well as addressing language and cultural barriers<sup>147</sup>
- Most respondents to the public survey indicated that residents and caregivers have difficulty accessing FBCC services
- Over 50 per cent of respondents to the public, facility operator and external organization surveys perceived that “unnecessary system complexity” was a challenge experienced by FBCC residents and caregivers
- Indigenous stakeholders indicated that utilizing navigators would help Elders navigate the continuing care system in Alberta
  - In addition, professional therapists and external stakeholders who responded to the survey identified the use of navigators as an option for improving resident/caregiver navigation

**Expected Benefits**

- More support for clients and caregivers who need to access health social service supports and alternative senior/special needs accommodation options in Alberta, thereby reducing frustration



**Key Actions Required**

- Pilot the Navigator function at the primary care, acute care or social/community service levels in a few urban settings and a few rural settings
  - The Navigator function would be separate from case management but would work collaboratively with case managers
  - Also pilot the Navigator function specifically with Indigenous stakeholders
- Have the Navigator establish contacts with primary care physicians, home care case managers, FBCC sites, hospital emergency departments and admission/discharge offices, senior and special needs housing providers and community care and social services agencies
  - Indigenous Navigators would also establish connections with representatives from FNIHB, First Nation and Métis Settlement home care staff, and Métis Nation of Alberta representatives
- Assess the effectiveness of the function at different levels (i.e. primary care, acute care, social/community service levels) to determine if this function should be implemented province wide or not

**Timing**

- Next 24 months

**Financial Considerations**

- Additional funding to pilot new Navigator positions
  - Fund up to 10 positions to test the effectiveness of the role in different settings
  - The expected cost to pilot these 10 positions is \$650,000 per year, including salaries and benefits



**Recommendation #14:** Pilot the use of some FBCC sites to function as the “resource hub” in communities where this approach would better meet community needs.

### Supporting Rationale

- Research has shown that strong community support services are needed to support seniors and persons with disabilities to receive care in the community
- FBCC sites are positioned to play the role as the “community hub” providing such community support services, particularly in cultural communities as well as more rural settings where there are typically less community and social supports available
  - A lack of services available in small, rural, and northern communities was identified as a challenge to accessing continuing care services by FBCC staff
  - Indigenous stakeholders indicated that having a “community hub” could improve the coordination of continuing care services in their community
- FBCC sites have physical space, equipment, catering, and recreational spaces which could be shared with the community (this includes cultural, Indigenous and rural communities)
- FBCC sites could also provide respite and meal supports (including offering cultural meals) as well as home care services (on an outreach basis) to the community by drawing on its staffing pool
- Senior Lodge sites offer similar benefits in rural and remote communities where FBCC is not available and become “community hubs” to expand the reach of services

### Expected Benefits

- FBCC and Seniors Lodge sites and their surrounding communities will support each other to provide stronger neighbourhoods to enhance the goal of “aging in place”, particularly in rural, cultural, and Indigenous communities
- FBCC would be able to broaden its role in the community, in areas such as day programs, support services, and respite care
- These communities would have better and stronger social networks to prevent isolation and loneliness of its seniors/elders

### Key Actions Required

- Determine the features of resource hub role. Options include:
  - Providing home care services to residents of the surrounding areas on an outreach basis
    - Determine what additional staffing capacity is required to provide outreach home care services
    - Work with AHS to coordinate home care service delivery
  - Serving as the resource for the community, providing educational and support-group services, as well as providing physical space for community development activities
    - This undertaking could also include a partnership in the “age friendly” and “dementia friendly” initiatives

- Determine which FBCC sites are positioned to act as a test site in their communities (consider sites in multiple settings such as cultural, Indigenous and rural communities), including Senior Lodges in rural and remote areas and where Lodge Partnership Programs for joint Lodge/FBCC spaces already exist
  - A formal endorsement of this role by the Government of Alberta would be useful to provide support of, and recognition for this role

#### **Timing**

- Next 24 months

#### **Financial Considerations**

- Providing pilot sites with the financial flexibility to act as resource hubs
- Determining the additional staffing requirements to provide outreach home care services



**Recommendation #15:** Improve case management in continuing care including consideration of responsibilities and functions, with a particular focus on DSL facilities.

### Supporting Rationale

- Currently, the case management function for LTC residents is the responsibility of LTC operators, but the case management function for DSL residents is the responsibility of AHS
- For DSL sites, operators are expected to provide working space for AHS case managers who are responsible for preparing the RAI assessment and care plans as well as the approval for transfers of DSL residents
  - Very often the assessment and care plans devised by the AHS case managers are prepared without the involvement of the DSL care staff
- AHS case managers are only at DSL sites during office hours on weekdays
  - If DSL staff need to send their residents to emergency departments or make an urgent transfer to another location of service, they have to locate the AHS case managers to obtain the latter's approval before they can complete the transfer
- Survey and interview respondents identified a need to improve the integration of case management services across continuing care
  - DSL operators indicated that it would improve continuity of care for residents and be more cost effective for their staff to provide case management functions as staff are already located in the same site
- The dichotomy of assessment/care planning functions being undertaken by AHS case managers and care delivery functions by DSL staff has created many problems in the delivery of services in DSL including miscommunication, service gaps, and lack of continuity of care

### Expected Benefits

- Improved communication in the care planning of FBCC residents
- Delays incurred by the need to obtain untimely approval for transfer of DSL residents to emergency departments and other services could be avoided

### Key Actions Required

- Form a task force comprised of FBCC operators and representatives from Alberta Health and AHS to review the function, roles, and responsibilities of case management for FBCC residents
  - Identify opportunities to improve the case management function in FBCC, to ensure better care planning and improved transitions throughout the health and social systems
  - Develop measures to monitor the effectiveness of the case management system

### Timing

- Next 24 months

### Financial Considerations

- Time and effort of Task Force members to develop and implement recommendations

## 4.2.5 Policy Direction 5: Increase staffing hours and consistency of staffing to improve quality of care.



**Recommendation #16:** Increase direct care hours (includes nursing, personal care and therapeutic) at FBCC sites to an average of 4.5 worked hours per resident day for LTC and up to an average of 4.0 worked hours per resident day for DSL within a four-year period.

### Supporting Rationale

- The availability of staff in FBCC sites (LTC and DSL) was a key area for improvement identified by respondents to all surveys
  - A need to increase staffing levels for HCAs, nursing staff, professional therapy staff, and non-professional therapy staff was identified through survey and interview feedback
- FBCC staff reported high workload was an issue leading to decreased staff morale at their sites
- According to the HQCA, a predominant concern across multiple survey iterations for LTC and DSL was related to understaffing and high staff turnover
  - The Health Quality Council of Alberta LTC Family Experience Survey of 2017 stated that family members' top recommendation for improvement was to ensure enough staff were available to meet residents' care needs and staff's job responsibilities
    - Only 18 per cent of families said there were always enough nurses and health care aides
    - Fifty-three per cent of respondents indicated that, in the previous six months, they had to help their family member with toileting because the nurses or aides either didn't help or made them wait too long
  - The 2019 DSL Resident and Family Experience Family survey found that 43 per cent of residents and 23 per cent of family members felt there were always enough nurses and aides in the site
- The US Centers for Medicare and Medicaid Services (CMS) report to the US Congress, *"Appropriateness of minimum nurse staffing ratios in nursing homes"* in 2001, recommended 4.1 direct nursing and personal care hours per resident per day as the minimum for facilities, without which there could have adverse consequences
  - The recommended minimum hours were endorsed by many Canadian and international organizations
  - In December 2020, the Ontario government indicated that it would invest up to \$1.9 billion annually to implement 4.0 hours of direct care daily for each LTC resident in Ontario within a four-year period
  - Manitoba is proposing 3.6 hours of care per resident day in legislation
  - Nova Scotia has 3.5-4.3 hours of direct care per resident day with minimum one hour provided by a RN
  - PEI has 3.0-3.8 minimum hours per resident day depending on level of care

- AHS currently funds an average of 3.4 direct hours of care per day for nursing, personal care, and professional and non-professional therapies for LTC residents; and an average of 2.7 – 3.0 direct hours of care per day for nursing, personal care, and professional and non-professional therapies for DSL4 and DSL4D residents
  - This funding level was implemented in 2014/15 and has not changed for six years while at the same time, the acuity of Alberta FBCC residents has increased over this time span
  - The Christian Health Association of Alberta (CHAA) found that the actual LTC case mix index (CMI) for voluntary not-for-profit LTC operators increased from 105.3 in 2014/15 to 108.6 in 2019/20
  - An analysis of RUG and CMI data for LTC facilities in Alberta provided by AHS shows that:
    - There has been an increase in the number of resident days for RUG categories with higher CMI scores (RUG-III Category 1, 2 and 3) from 2014/15 to 2018/19
    - The analysis also showed a decrease in resident days for RUG categories with lower CMI scores (RUG-III Category 4, 5, and 6) over the same time frame
    - This suggests there could be an increase in acuity of FBCC residents over this time frame
- The length of stay of Edmonton LTC residents decreased from 1.9 years in 2008 to 1.1 years in 2015, and for Calgary, it decreased from 1.8 years in 2008 to 1.3 in 2015, indicating that residents entering LTC are now frailer than they were in the past
- The Ontario LTC staffing study found that residents would benefit from more involvement by allied health and other professionals such as occupational therapists, physiotherapists, social workers, and recreation therapists
- Based on stakeholder feedback, HQCA findings, and a review of studies and reports it is recommended that the direct hours of care in LTC and DSL be increased for nursing, personal care, and therapy staff to improve the quality of care provided to FBCC residents

#### **Expected Benefits**

- The proposed increase in direct care hours may enable FBCC staff to provide a higher quality of care to residents while at the same time reducing staff stress and burnout
- There is expected to be less care incidents such as pressure sores, skin trauma, and weight loss and increased functional improvement for the residents as they receive more therapeutic support
- Resident and family satisfaction should also increase

#### **Key Actions Required**

- The average nursing, therapeutic (e.g. physiotherapy, occupational therapy, mental health counseling, recreation supports etc.) and personal support direct care worked hours in LTC should be increased to 3.7 hours for year 1 (2022/23), 4.0 hours year 2 (2023/24), and 4.3 hours for year 3 (2024/25)
  - After year 3, the funded hours should be reassessed against the acuity of the residents as well as the performance of quality indicators

- The projected increase in care hours for year 4 (2025/26) could be 4.5 hours but it may be adjusted based on evaluation results
- The average nursing, therapeutic and personal support worked hours should be increased over four years as follows for DSL:
  - DSL4 – 2.7 hours to 3.5 hours
  - DSL4D – 3.0 to 4.0 hours

### Timing

- Next 4 years

### Financial Considerations

- The total projected cost for increasing the direct hours of care in FBCC based on 2020 service levels is \$410 million
  - The preliminary estimated annual cost of increasing the direct hours of care from 3.4 to 4.5 for LTC is \$266 million, once fully implemented (see Appendix 2)
  - The preliminary estimated annual cost of increasing the direct hours of care for DSL (see 4-year targets listed above) is \$144 million per year once fully implemented (see Appendix 2)

Continuing Care Stream	Current State Cost	Future State Cost	Cost Difference	Average Annual Increase per Resident
LTC	\$800,577,101	\$1,066,590,534	\$266,013,432	\$18,898
DSL4D	\$144,133,856	\$204,430,212	\$60,296,357	\$17,228
DSL4	\$260,833,145	\$344,953,259	\$84,120,114	\$12,298
DSL3	\$34,253,904	\$34,253,904	\$0	\$0
<b>Total</b>	<b>\$1,239,798,007</b>	<b>\$1,650,227,910</b>	<b>\$410,429,903</b>	



**Recommendation #17:** Increase the level of professional care hours (nursing and therapeutic) for FBCC residents.

### Supporting Rationale

- Evaluation studies on staffing patterns show that different types of staff are appropriate for different types of FBCC residents, e.g., in place of RNs or LPNs, therapists may be more suitable to assist in the mobility of residents, or mental health professionals in the mental wellbeing of residents
- Many research studies have shown that higher direct nursing care hours lead to less restraint use, fewer pressure ulcers, decreased probability of hospitalization, decreased mortality, and decreased urinary tract infections in LTC facilities
- The CMS study which proposed 4.1 direct nursing and personal care hours for LTC facilities also proposed a minimum 0.75 RN hours per resident day, and 0.55 LPN hours per resident day
- AHS data show that DSL (which does not have RN coverage) has a higher rate of transfer of residents to hospital emergency departments
- Increasing the availability of professional therapy supports was reported as an area for improvement in the stakeholder engagement surveys, and there needs to be flexibility in the staffing pattern to address these needs

### Expected Benefits

- Better quality outcomes should be achieved if more appropriate staff types are used for care
- Reduced adverse outcomes in FBCC sites such as pressure ulcers, urinary tract infections, and lessen the need for transfer to hospital emergency departments
- Increased flexibility by FBCC operators to use care hours to provide therapeutic supports (recreation, mental health, etc.) when appropriate
- Improved quality of care and quality of life for FBCC residents

### Key Actions Required

- Amend accountability requirements for staffing for FBCC sites
- Regularly review data regarding changes of length of stay, and acuity of the FBCC population
- Assess the need for the proportionate increase of professional care staffing funded annually as the acuity of FBCC population changes

### Timing

- Next 4 years

### Financial Considerations

- Funding increases to support increased professional care, which have been included in the cost estimates in Recommendation 16





**Recommendation #18** Increase the level of mental health professional supports for FBCC residents.

### Supporting Rationale

- Increasing the availability of mental health wellness supports was reported as an area for improvement in the resident/caregiver, FBCC staff, FBCC administrator, and external stakeholder surveys, and there needs to be flexibility in the staffing pattern to address these needs
- The National Institute of Aging found that COVID-19 has significantly increased Canadians' feelings of social isolation and loneliness
- The 2019/20 Alberta LTC Resident Profile shows that 36 per cent of residents have depression

### Expected Benefits

- Improved mental wellness supports for FBCC residents

### Key Actions Required

- Assess the need for additional mental wellness supports for FBCC residents
- Ensure that the increase in direct care hours from Recommendation 16 includes staffing considerations for enhancing mental wellness supports
- Provide FBCC staff with education/resources to understand mental wellness

### Timing

- Next 4 years

### Financial Considerations

- Provide flexibility in direct hours of care and staffing mix to provide additional mental health supports
  - This includes increasing direct hours of care allocated for this purpose



### Recommendation #19: Support FBCC operators to implement consistent staffing assignments.

#### Supporting Rationale

- Interview and survey respondents reported that improving the consistency\* of staffing assignments could improve the quality of care provided to FBCC residents
  - Consistency of staffing could provide better knowledge of care needs, better relationships between staff and residents, and limit the potential for miscommunication between staffing shifts

#### Expected Benefits

- An expectation that better care outcomes for FBCC residents can be achieved
- The potential to improve workplace satisfaction and engagement for FBCC staff

#### Key Actions Required

- Facility management leadership to assign consistent staffing assignments for each FBCC resident
  - Recommendations 16, 17 and 21 should provide operators with supports to implement more consistent staffing assignments
- Alberta Health and AHS can support this recommendation by communicating the importance of consistent staffing assignments and providing examples of how to do it
  - Alberta Health and AHS can also explore ways in which to make this a requirement of operators by changing standards

#### Timing

- Next 12 Months

#### Financial Considerations

- None

\*Assigning the same staff members to care for a resident to the degree it is possible

## 4.2.6 Policy Direction 6: Develop a Workplace Improvement Action Plan to enhance working conditions for staff working in both FBCC and home care.



**Recommendation #20:** Develop a provincial Human Resource Strategy for continuing care (taking into consideration FBCC, home care, etc.).

### Supporting Rationale

- Alberta will have the fastest growing aging population in Canada over the next ten years and will need a workforce with special training and understanding in continuing care and geriatric services
  - Knowledge of the aging process, dementia, chronic disease management, and palliative care will also be necessary in the delivery of continuing care services for all types of roles including administration and management, through to front-line and support staff
- COVID-19 has demonstrated the instability of the supply of the workforce in FBCC particularly with respect to HCAs
  - Special attention must be paid to ways to attract potential HCAs, to enhance their training, and then to retain them to work in FBCC
- Cultural change and leadership were identified by many reports as key in transforming the current system
- The Human Resource Strategy needs to identify ways of attracting qualified leaders and enhancing their training to enrich the future delivery of continuing care services

### Expected Benefits

- This plan should enable the training and provision of qualified staff to address the health care needs of Alberta's aging population through the continuing care system

### Key Actions Required

- The Human Resource Strategy should address the future human resource requirements needed to reform the continuing care system as per the recommendations in this report
- Key steps to develop the plan include:
  - Develop a forecasting methodology for the demand and supply of staff to meet the needs of the continuing care system
    - The model should specify the types and numbers of health care providers such as physicians, geriatricians, nurse practitioners, registered nurses, licensed practical nurses, therapists, and health care aides
    - The model should address the staffing requirements needed to meet the increase in direct care hours proposed in Recommendation 16
- Collaborate with post secondary institutions to ensure sufficient training spaces are created

- Market this area of work to potential students

### Timing

- Next 36 months

### Financial Considerations

- Staff time (multiple stakeholders and organizations) and investments to support the development of the forecasting model and the Human Resource Strategy



**Recommendation #21:** Establish a full-time employment benchmark for nursing, therapeutic and health care aide staff for FBCC and include the benchmark as one of the quality indicators for monitoring facility care.

### Supporting Rationale

- Having a high percentage of care staff with part-time employment is not beneficial to the consistency of care provided to FBCC residents
- Prior to COVID-19, 69 per cent of HCAs and 74 per cent of RNs in FBCC sites worked part-time or casual hours
- HCAs and professional therapy staff both expressed an interest in increasing the number of full-time positions at their facilities in the respective surveys
- Nursing staff expressed an interest in having a more balanced mix of full-time and part-time positions
- The high use of part-time positions creates instability and an unhealthy working environment in FBCC
  - In critical times such as the flu season and during pandemics, this instability is extremely detrimental to the normal functioning of FBCC sites
- The current Public Health Order in response to the COVID-19 pandemic mandates all care staff of FBCC sites work in a single facility
  - Alberta Health established a data base on single-site policy and worked with AHS to allocate staff to single sites
    - More than 95 per cent of existing staff have now been deployed to work in single sites
  - Prior to the single site policy, part-time staff often worked at more than one facility
    - It is expected that the employment situation will revert to the pre-COVID situation after the expiration of the Public Health Order, if there is no further government intervention
- The COVID-19 pandemic has exposed the danger of having a high percentage of part-time workers in FBCC sites

### Expected Benefits

- An expected increase in organizational and labour force stability in FBCC sites in times of high sick time, pandemic, and high staff turnover
- The quality and consistency of care provided to residents should improve
- Expected improvements in the working conditions for care staff and overall job satisfaction

### Key Actions Required

- Alberta to establish a full-time employment benchmark for nursing, professional and non-professional therapy and HCA positions in FBCC sites in consultation with industry associations, labour groups, operators, and AHS
  - The benchmark can be expressed as a percentage or proportion of the workforce
  - The goal of the benchmark is to safeguard the organizational stability of FBCC sites to ensure quality of care
- Implement the benchmark and establish it as one of the care indicators for monitoring FBCC

### Timing

- Next 24 months

### Financial Considerations

- Increasing the number of full-time employees may have financial implications for some employers related to additional benefits cost



**Recommendation #22:** Form a Workforce Improvement Task Force to assess ways of improving workforce design, workforce culture and working conditions for staff working in FBCC.

### Supporting Rationale

- Workforce issues were identified as significant problem in FBCC sites by multiple studies<sup>148,149,150</sup>
  - One specific problem relates to the non-regulated and insufficient training of HCAs who provide 70 per cent to 90 per cent of care in FBCC
  - The Government of Alberta has recently announced Bill 46: Health Statutes Amendment Act Bill 46, which introduces the regulation of HCAs under the College of Licensed Practical Nurses of Alberta, which if passed, will enhance the regulation of care provided by HCAs and could lead to higher standards of training and service
- All FBCC staff responding to the FBCC surveys reported a need to improve workplace supports, training, and recognition for FBCC staff, as well as a desire to increase the use of collaborative care teams to provide care and have improved communication between management and staff
- The University of Alberta's TREC project (Translating Research in Elder Care) has identified ways of improving working conditions for HCAs as well

### Expected Benefits

- Improving working conditions and workplace culture should improve employee engagement and satisfaction for FBCC staff
- Empowered and engaged staff should enhance the quality of care and life of FBCC residents

### Key Actions Required

- The Workforce Improvement Task Force should develop strategies to:
  - Improve workforce culture in FBCC
  - Emphasize team planning
  - Provide opportunities for and empower all team members to be leaders
  - Cultivate a learning culture by encouraging continuing education and career-laddering
  - Collaborate with universities, colleges/certificate programs, educators, and researchers to enable continuing care staff to participate in research and education opportunities
- The Task Force should develop specific actions to promote more stable, full-time positions in FBCC, to enhance sick pay and fringe benefits, and improve wage parity for FBCC workers
- A team concept in care planning should be used, and HCAs should be accepted as team members and included in care conferences for residents

### Timing

- Next 24 months

### Financial Considerations

- Staff time (multiple stakeholders and organizations) and investments to support the development and implementation of the Workforce Improvement Task Force

## 4.2.7 Policy Direction 7: Expand the choices available to Albertans who require continuing care services.



**Recommendation #23:** Introduce self-directed care as an option for people assessed as needing continuing care (expanding the option within home care and introducing FBCC options), to provide greater choice regarding locations, types, and providers of services.

### Supporting Rationale

- Users of the continuing care system indicated that current services are provided in an overly restrictive manner prohibiting resident choice on the types, locations, and providers of services
  - A self-directed system of care enables continuing care clients to have this choice
  - This type of self-directed care system is already implemented in countries like Japan, Australia, Germany, and France
  - Self-directed care will permit clients to use an approved level of public funding to purchase services from a provider of choice
- A self-directed system of care would allow individuals who require high levels of support to choose to live outside of FBCC, and allow relatives (except direct family members and spouses) to receive government support for providing care for these individuals
- Survey respondents were open to using public funding to receive care in the home but were less receptive to using public funding to receive care in private pay facilities
- The existing self-managed care funding option through home care is utilized successfully in Alberta but does not get offered consistently across the province and is not available to people assessed as requiring FBCC
- Income testing should be considered to ensure fairness and sustainability of the system

### Expected Benefits

- More choice is provided to continuing care clients regarding the location, types, and providers of services
  - It will allow clients to have more choice in the type of accommodation they live in while still receiving publicly funded care
- It will broaden the delivery of the “FBCC types” of services to include a variety of non-publicly built sites, thus reducing public funds needed to build more FBCC spaces
- It will encourage innovation in the design of models of care, as well as provide the impetus for the development of a variety of supportive housing options including campuses of care, shared housing, co-operative housing, cottage type smaller homes, intergenerational housing, student/older adults shared housing etc.

### Key Actions Required

- Develop a self-directed care program that allows clients to choose to access services through FBCC or receive direct care funding to provide them with the choice of their own provider of services

- Implement income testing to support the model
- Develop a consistent and reliable method for assessing self-directed care clients, and a methodology for costing assessed services
- Pilot and evaluate the new self-directed system model
- Develop associated legislation, regulations, directives, policies etc. to provide authority for the funding of the model
- Develop a new monitoring and enforcement system to support the model (Recommendation 24)

#### **Timing**

- Planning and piloting to take place over the next 12 months (2022 to 2023)
- Implementation to take place over the following 24 months (2023 to 2025)

#### **Financial Considerations**

- It is expected that up to 5 to 10 per cent of clients would use this model once it is fully implemented
- It is expected that self-directed care services will be funded at 80 per cent of the costs to provide the same service in a continuing care facility or through AHS home care
- Administrative costs are estimated to be 10 per cent of funded service costs
- Overall, the projected annual cost savings to the system by 2030 for self-directed care is approximately \$23 million (see Appendix 2), assuming 6.3 per cent utilization of the program





## **Recommendation #24:** Develop a monitoring mechanism for the self-directed system of care.

### **Supporting Rationale**

- A new self-directed system of care is recommended to give more choice to individuals with respect to the types of providers and location of care. If this new type of care is to proceed, a new monitoring mechanism must be developed for the following reasons:
  - Protection of the recipients of care who may be vulnerable, frail, and receiving care at home or in private pay settings
  - Unregulated service-providers are not currently held to the same standards or inspected in the same manner as FBCC sites, and thus oversight by a third party is needed
  - A need to ensure that public funds are being used as intended based on the assessments provided to clients
- Survey respondents all identified a need to properly monitor self-directed care

### **Expected Benefits**

- Upholding quality and safety for clients who choose to access self-directed care at home or in private pay settings

### **Key Actions Required**

- Design a new monitoring mechanism for the self-directed system of care
- Determine who will have the authority and responsibility for monitoring self-directed care services
  - The monitoring mechanism should be simple and not pose a barrier to the provision of services
  - The monitoring mechanism should have the credibility to gain the confidence of the public
  - Based on survey feedback, stakeholders would like to see regular inspections, with the results shared publicly

### **Timing**

- Development and piloting to commence the next 12 months (2022/23) with implementation to follow the next 12 months (2023/24)

### **Financial Considerations**

- Staff time and resources to design and implement the monitoring system
- The projected cost for administering and monitoring the self-directed care program is 10 per cent of funded service costs (Appendix 2)



Recommendation #25: Enhance client choice by supporting a greater percentage of continuing care clients in the community rather than FBCC sites.

### Supporting Rationale

- Survey respondents all showed a preference for options where clients could receive publicly funded care at home versus in a private-pay facility
- Seniors have repeatedly stated their preference to “age in place” at home; however, the current system of continuing care does not provide individuals with many choices if they need higher levels of care
- CIHI has shown that one in nine residents currently admitted to LTC in Canada could have been looked after at home
- In comparison with other countries, “about 90 per cent of funding for seniors’ care in Canada is directed to institutional care with only 10 per cent directed to home- and community-based long-term care
  - Canada falls well below the OECD average of 35 per cent of LTC expenditures being directed to home and community care<sup>151</sup>
  - In Alberta, home care costs represent 23 per cent of total continuing care costs
- This report recommends increasing home care and social supports in the community as well as introducing a client-directed system of delivery of continuing care in Alberta with an accelerated increase in a variety of supportive living and home-based options to be provided to individuals as alternatives to institutional care
  - Many jurisdictions (such as New York, New Brunswick) have successfully developed projects to delay or avoid admitting seniors to LTC
- The average care cost per day for a LTC facility space is \$202, for DSL-4D \$159, for DSL-4 \$147, for DSL-3 \$100, and for long-term home care (LTHC) \$35
  - It is estimated that, for complex care home care clients, the care cost per day would be \$112, approximately half the cost of care provided in a LTC setting
- Policy leadership in shifting funds from institutional expenses to supportive housing and home-based services is needed

### Expected Benefits

- Seniors, and people living with disabilities can “age in the right place” and receive continuing care services at home or at their location of their choice

### Key Actions Required

- Government of Alberta support the development of multiple options and multiple streams in the delivery of continuing care services
- It is recommended that a target of shifting from FBCC spaces to community-services be set annually

- The shift should be evaluated by measuring its impact on client satisfaction and quality of life, and the quality of care provided
- Under this system, the “assessed continuing care needs” of clients would be determined by trained assessors using the scientifically tested RAI-tools
  - The “assessed continuing care needs” will be publicly funded and provided
  - This transformational change should take place over a three-year period from 2022-2025
  - Self-directed care options will also be made available, as per Recommendation 23
- Consideration for innovative approaches to increase community supports for continuing care clients should be examined to delay and prevent admission of high-needs clients to FBCC sites
- Government of Alberta to provide legislative framework and monitoring mechanisms for these new options

### Timing

- Next 3 years, 2022-2025

### Financial Considerations

- If the Government of Alberta continues to provide care with the same distribution of services across LTC, DSL (3, 4 and 4D), and LTHC, the projected annual cost for continuing care services to meet demand in 2030 is \$4.21 billion, \$1.84 billion more than the cost of services today
- By shifting care to a model where the percentage of continuing care clients receiving LTHC services increases from 61 per cent (current) to 70 per cent (desired), the projected annual cost for continuing care services increases to \$3.76 billion in 2030, an increase of \$1.39 billion compared to the cost of services today, but a reduction of \$452 million per year compared to providing care with the same distribution of services (Appendix 2)

Projected Operating Cost of Current Model of Care (61 per cent LTHC/39 per cent FBCC) in 2030	Projected Operating Cost of New Model (Shift to 70 per cent LTHC/30 per cent FBCC) in 2030	Cost Difference in 2030 New Model – Current Model
\$4,207,017,382	\$3,755,435,827	-\$451,581,555

## 4.2.8 Policy Direction 8: Consolidate monitoring processes and improve the coordination of inspections, while enhancing accountability and public reporting.



**Recommendation #26:** Develop and implement a more coordinated and integrated system of monitoring where oversight bodies consolidate and integrate their efforts where possible when inspecting FBCC sites.

### Supporting Rationale

- Alberta Health and AHS are both involved in monitoring and inspecting FBCC sites. Historically, Alberta Health and AHS had done separate site visits to inspect facilities, creating a layer of duplication with inspections
  - Operators expressed concerns about the amount of time taken by multiple inspections, with inspectors sometimes asking similar questions
  - Visits are perceived as not being coordinated and can sometimes be disruptive to care
  - The issue of duplication in monitoring and inspecting FBCC sites has been looked at multiple times historically, further demonstrating a need to change the way that monitoring is carried out
  - Survey and interview respondents reported that Alberta Health and AHS had improved the coordination of audits during the COVID-19 pandemic, and that this could be carried forward to improving the coordination of audits in the future
- Respondents to the resident, families/caregivers, public, and FBCC administration surveys all support the importance of audits, including those that are unannounced to uphold accountability

### Expected Benefits

- Minimize the duplication and sometimes inconsistency of reviews by improving the coordination of monitoring between oversight bodies and consolidating the inspection protocols used by all oversight bodies
- Save the time of facility staff in dealing with multiple individuals from a variety of agencies

### Key Actions Required

- It is recommended that the monitoring agencies design a coordinated review process and try to conduct reviews as a team if possible. In addition, timing for the reviews of the same facility should be coordinated to avoid disruption to the facility
- Individual agencies should still have the authority to conduct specialized and independent inspections when necessary

### Timing

- Next 24 months

### Financial Considerations

- Time commitments from Alberta Health and AHS staff to work together and improve the coordination of monitoring activities



**Recommendation #27:** Enhance the evaluation of, and public reporting on, the performance of all ownership types in FBCC.

### Supporting Rationale

- The survey results demonstrated that public and external organization respondents had a much lower perception of the quality of care at FBCC sites, than residents, families/caregivers and FBCC staff and management
  - Given that public perception is currently not aligned with the perception of residents and staff at FBCC sites, there is a need for improving transparency and public reporting on the performance of all FBCC sites
- Some public stakeholders are advocating that private-for-profit-owned FBCC sites should not be funded going forward
- Ownership of LTC facilities has become a matter of public interest, particularly in view of the devastating impact of COVID-19 on LTC facilities
  - Private-for-profit LTC facilities in some cases have experienced higher COVID-19 outbreaks and fatalities, which has led to calls for the review of private-for-profit ownership of LTC facilities
- The Public Health and Emergency Measures Working Group of the CD Howe Institute researched the incidence of COVID-19 outbreaks in public and private-for-profit LTC and concluded that many factors could have significant effects on the severity of outbreaks including staffing levels, size and configuration of rooms, facility layout, and patient complexity
  - It recommended that “all provincial governments should work to address the ongoing challenges in the residential care sector and seniors’ care more generally”
- Descriptive statistics suggest that private-for-profit LTC/DSL facilities have a higher incidence of outbreaks in Alberta; however, the incidence of COVID-19 outbreaks is largely correlated with rates of community transmission near the facility and facility size, which could explain this difference
  - The spread of COVID-19 in all these facilities showed the importance of improving the monitoring and enforcement mechanisms of FBCC sites in the future
- The HQCA measures the quality of care of the three ownership types of FBCC sites in Alberta regularly in its survey reports
  - Its latest LTC Family Experience Survey Report of April 2018 indicated that there were no statistically significant differences in family experiences with the overall care rating across operator types (AHS, private-for-profit and not-for-profit)
    - The overall care rating was 8.6 for AHS facilities, 8.2 for private-for-profit facilities, and 8.2 for not-for-profit facilities

- Similarly, the overall care ratings for DSL facilities in the 2019 DSL Family Experience Report were also similar with 8.5 for AHS facilities, 8.2 for private-for-profit facilities and 8.6 for not-for-profit facilities
  - The overall care ratings provided by residents were also similar with 7.7 for AHS facilities, 7.7 for private-for-profit facilities, and 8.0 for not-for-profit facilities
- Each FBCC ownership type has its unique strengths and contributes to the diversity, efficiency, and effectiveness of the Alberta continuing care system
  - It is beneficial for Alberta to have the continued contribution of these ownership types
- In the U.S.A. and many other countries, inspection reports of LTC facilities, their staffing patterns, worked hours of care, services provided, performance on outcome indicators are posted on their respective web sites for residents and families to be able to review
  - Alberta should strive to make public reporting on indicators relating to FBCC sites a priority
- Enhanced evaluation and reporting of outcomes for all ownership types is needed to inform the public of the strengths and weaknesses of all FBCC sites to better inform decisions and public opinion

#### **Expected Benefits**

- Enhanced transparency and accountability for Albertans on the quality of care provided by facilities operating under all ownership types
- The ability for FBCC residents and caregivers to make more informed choices about which type of facility (i.e. private-for-profit, not-for-profit, AHS) they want to receive care from

#### **Key Actions Required**

- Support the continuation of the three ownership types (public, not-for-profit, and private-for-profit) of FBCC sites in Alberta
- Improve the monitoring and enforcement mechanisms for the review of these FBCC sites (as per Recommendations 3, 25, 26 and 28).
- Enhance the evaluation of, and public reporting on, the operational and quality performance of these three ownership types, including any violation of regulations/standards (Recommendation 27).

#### **Timing**

- Immediate

#### **Financial Considerations**

- Ongoing staffing and resource support for monitoring all sites by Government of Alberta.



**Recommendation #28:** Enhance enforcement procedures for facilities violating government regulations, standards, and/or public health orders.

### Supporting Rationale

- Many studies in other jurisdictions have cited monitoring, enforcement, compliance and reporting as important vehicles for improving quality of care in LTC (e.g. Ontario COVID-19 Commission Interim Reports, Commonwealth Fund Research Report)
- Respondents to the facility operator and external stakeholder surveys noted a need to shift the focus of audits from processes to facility outcomes
- Alberta recently started publicly reporting the results of accommodation standards audits and are moving to do the same for health service standards audits which could be used as a starting point to improve the reporting of results
- Continuous quality improvement activities are needed as a follow-up of any review
- Alberta Health, training institutions, and professional bodies can all play a role in providing training and educational materials in areas identified as common care challenges in Alberta based on inspection reports

### Expected Benefits

- Continuous quality improvement, enhanced accountability for facilities, and increased transparency for end-users of FBCC services

### Key Actions Required

- Post inspection reports on FBCC sites on appropriate web sites
- Identify the important indicators pertaining to FBCC sites for public reporting and plan to report these indicators to the public on a regular basis. Include Alberta Health, AHS, FBCC operators and other impacted or key stakeholders in this process
  - Identify process and timelines for developing and implementing improvement plans
  - Determine enforcement penalty options, should implementation of improvement plans be unsuccessful
- Focus reporting on resident outcomes, rather than outputs and processes
- Provide facilities that violate standards with the opportunity to address deficiencies by developing improvement plans
  - Alberta Health should provide quality improvement staff supports as required to develop improvement plans
  - Have operators report on progress on implementing improvement plans
  - Enforce penalty options, should implementation of improvement plans be unsuccessful
- Provide an update on the progress that sites have made to address deficiencies on appropriate websites

**Timing**

- Next 24 months

**Financial Considerations**

- Staff time and resources to support enhanced enforcement and reporting



**Recommendation #29:** Introduce added transparency for the funding and reporting of AHS owned and operated FBCC sites by requiring independent audited site-specific financial statements for its FBCC operations, as is required of other FBCC operators.

**Supporting Rationale**

- Private-for-profit and private not-for-profit operators produce audited financial statements and provide annual financial reports for FIRMS
- Some concerns have been expressed regarding the ownership of FBCC sites by AHS
  - The perceived problem relates to the fact that the funding amount for these facilities is not transparent, leading to the suspicion that they may be more highly funded than other FBCC sites
  - In addition, it is seen by some as a conflict of interest that AHS staff inspect and audit their own facilities
- The FBCC Review recommends AHS ownership be continued as one of the three ownership types of facilities because public facilities have unique strengths and contributions in the Alberta system
  - In addition, some AHS rural facilities are of smaller size, managed as combined facilities with acute care hospitals, and it would be difficult to find another operator in this kind of circumstance
- AHS-owned-and-operated facilities should be subject to the same funding policies as other FBCC sites

**Expected Benefits**

- Improved transparency related to the performance of AHS owned and operated FBCC sites in Alberta

**Key Actions Required**

- AHS-owned-and-operated FBCC sites should provide independent audited financial statements to Alberta Health for its FBCC operations (AHS owned and subsidiaries) apart from overall AHS operations

**Timing**

- Next 12 months

**Financial Considerations**

- Additional staff time from AHS to develop separate financial reports for each site



## 4.2.9 Policy Direction 9: Optimize the use of technology, research, and innovation in transforming FBCC.



**Recommendation #30:** Develop and implement a “Research, Innovation and Technology Strategy for Continuing Care” in Alberta.

### Supporting Rationale

- Seniors have indicated their desire to use alternative models of care, different from the design and care delivery method of current FBCC
- The McMaster Health Forum developed an evidence brief that shows technology has a significant role to play in addressing fundamental problems that currently exist in FBCC as well as for improving resident quality of care and quality of life
  - Technology can improve the delivery of care through improving clinical and personal care tasks/processes, information management, education, communication with staff and family members/friends, and supporting primary caregivers
- Innovation in FBCC could be supported through two approaches:
  - The first component is to develop an Innovation Funding envelope for FBCC operators to utilize technology in the delivery of care
  - Second, the Government of Alberta could empower the collaboration of a number of government departments (e.g. Alberta Health, Alberta Innovates, and Jobs, Economy and Innovation Department) to work with the industry sector and sponsors to develop a long-term investment strategy for the development of innovations for FBCC

### Expected Benefits

- The innovative services and technology developed could broaden the range and variety of continuing care options available to Albertans
- Partnerships with industry could bring economic and commercial activity in this area linking technology development with services to seniors

### Key Actions Required

- Develop an Innovation Funding envelope for FBCC operators to fund the use of technology in the delivery of FBCC services
  - Funding should be made available to support the purchase of new equipment as well as ongoing annual operating costs
- Examples of the use of technology in care delivery include: use of assistive and robotic technology for care delivery; medication monitoring, monitoring of falls, health incidences and wandering, and SMART condo-living
  - Operators should demonstrate the benefits (outcomes and financial) of these technologies after they are in operation
- Develop a long-range partnership with industry and sponsors to invest in innovations such as:

- Digital transformation of FBCC systems: Design digital entry to continuing care where individuals can view and assess facility sites, assess suitability of individual home for their own needs and view service options
- Facility Design: Campus of Care; Dementia Villages; Intergenerational Housing; Co-operative Housing; Student/Older Adults Companion Care Shared Housing; laneway homes
- Develop forums for exploratory discussions and planning amongst innovative technology planners, design engineers, architects, aging experts, and university researchers on new ways of providing continuing care
  - Establish partnerships with universities and colleges for research and education in the area of continuing care
- Create a Task Force to plan for the development of a long-range Research, Innovation and Technology Strategy for Continuing Care
- Schedule Think Tank sessions and forums with national and international experts regarding new technology, innovation and facility design enhancements for future transformation of continuing care


#### **Timing**

- Next 10 years, 2021 to 2031

#### **Financial Considerations**

- Development of an innovation fund to support FBCC operators with the cost of purchasing and implementing technology into their day-to-day operations
- Government of Alberta staff time and resources needed to support the development of a task force and innovation fund

## 4.2.10 Policy Direction 10: Ensure sustainability and affordability for the future of continuing care.

	<p><b>Recommendation #31:</b> Focus government capital investments on the regeneration or replacement of existing FBCC spaces, with some funding ear-marked for the development of new spaces where needed.</p>
<p><b>Supporting Rationale</b></p> <ul style="list-style-type: none"> <li>AHS estimates that there are over 8,000 FBCC spaces in facilities that are over 40 years of age which no longer meet current design standards, and an additional 800 to 1000 spaces need to be developed each fiscal year to replace the 8,000 spaces at end of useful life             <ul style="list-style-type: none"> <li>In addition, it is estimated that there will be another 2,475 spaces that will be 40 years or older by 2030 which will also require replacement, bringing the total requirement for replacement to 10,475 spaces</li> <li>Approximately 6,800 FBCC spaces are in shared accommodations; most of these spaces are in older LTC facilities                 <ul style="list-style-type: none"> <li>However, 720 of these spaces are in sites less than 30 years of age</li> </ul> </li> </ul> </li> <li>Past capital grant funding programs were focused on the development of new spaces to increase capacity in the system, and going forward, consideration should be given to provide funding to replacing existing aged facility spaces             <ul style="list-style-type: none"> <li>The levels of grant funding should also be examined with consideration for increasing grant levels for LTC spaces versus DSL spaces</li> <li>An analysis of the accommodation fee margins for private-for-profit and private not-for-profit LTC operators revealed little margin is available to fund debt-service obligations for capital development (see Appendix 2)</li> <li>However, the margin for private-for-profit and private not-for-profit DSL operators could support a higher debt structure to fund capital development projects with the same level of government capital grant funding (see Appendix 2)</li> </ul> </li> <li>The average capital construction cost for a FBCC space in 2018/19 currency is \$250,000 for private-for-profit operators, \$337,400 for not-for-profit operators, and \$575,000 for public operators</li> </ul>	
<p><b>Expected Benefits</b></p> <ul style="list-style-type: none"> <li>Improved quality of life for residents by replacing aged infrastructure with more modern and safe facilities</li> <li>Improvements to infection prevention and control</li> <li>The potential to improve sustainability for the Alberta continuing care system, by providing opportunities to attract more private development to replace aged infrastructure versus the full cost to replace an AHS space</li> </ul>	
<p><b>Key Actions Required</b></p>	

- Re-examine the approach to providing capital grant funding to replace aged infrastructure over the next 10 years
- Focus capital construction investments in Year 1 and Year 2 (2022/23 and 2023-24) on the regeneration of existing FBCC spaces to improve the living environments of FBCC residents, with some funding for the development of new spaces
  - The focus should continue to be on providing private rooms for residents
  - Options for replacing aged FBCC spaces should include the development of spaces to support a variety of models of care such as smaller homes and campus of care concepts
    - It is assumed that 1,120 replacement spaces and 637 new spaces will be developed in smaller home settings
  - Options for replacing aged FBCC spaces with zero capital options should also be considered, and 10 per cent of the needed replacement spaces (1,120 spaces) is assumed to be covered by this option
- In year 3, 2024/25, further models of care and home/community-based services would be expanded, while continuing to replace aged infrastructure
- It is projected that a total of 17,565 spaces (11,195 for replacement and 6,370 new FBCC spaces) will be developed to support the shift proposed in Recommendation 25 above
  - It is projected that an additional 1,930 new FBCC spaces will be developed to meet the needs of Indigenous communities (Appendix 2)
- Form an Implementation Team to strategize the development and implementation of policies, staffing, and service options required

### Timing

- Next 10 years
- Begin the shift to replace aged spaces versus build new capacity immediately over the next 12 months

### Financial Considerations

- The projected cost of replacing aged infrastructure, developing spaces to support a variety of models of care, and adding new DSL spaces as part of the shift to care in the community (thereby not needing to increase LTC capacity), is \$2.74 billion (in 2020 dollars) by the year 2030
  - This is approximately \$2.19 billion lower than costs associated with increasing capacity by 2030 to meet demand while maintaining the current distribution of services in 2030 (see Appendix 2)
  - Note, the projected savings from replacing 10 per cent of aged FBCC spaces with zero cap options will result in savings of \$335.5 million that could be used for capital upgrades at other sites. These savings have already been included in the total costs

Projected Cumulative Capital Cost to Implement Current Model in 2030 (Costs from 2021 – 2030)	Projected Cumulative Capital Costs to Implement New Shift Model in 2030 (Costs from 2021 – 2030)	Cost Difference in 2030 New Model – Current Model
\$4,923,651,851	\$2,738,289,278	-\$2,185,362,574



**Recommendation #32:** Continue to increase accommodation fees for FBCC annually and provide flexibility to increase fees beyond the core inflation rate for Alberta if required.

### Supporting Rationale

- FBCC residents pay for their housing costs through an accommodation fee
  - Alberta has the highest average actual FBCC accommodation fee in Canada
  - The maximum accommodation charge in Alberta has been increasing over the last five years based on the core inflation rate in Alberta
    - This practice has been improving the margin for operators, but the accommodation margin is still not sufficient to cover debt-service costs for capital replacement/development for LTC operators
    - Alberta should continue the practice of increasing accommodation fees annually based on the core inflation rate in Alberta
- The accommodation fee in Alberta does not cover the full cost of room and board for private-not-for profit LTC operators and for AHS operated FBCC spaces
  - Many operators need to subsidize the accommodation costs of their facilities with care funding
- All survey respondents (including a majority of facility operators) showed a strong preference for not increasing the accommodation fees in Alberta
  - There is a concern that the fee is already too high for FBCC residents, and that increasing the fees would make FBCC more unaffordable for Albertans
- The current practice of having Alberta Seniors and Housing subsidize the accommodation fee for low-income residents should continue to remain in place

### Expected Benefits

- Increased funding to support accommodation operations for FBCC operators over time
- Predictable increases to accommodation fees for FBCC residents and operators, based on established practices and regulations

### Key Actions Required

- Modify the regulations governing FBCC accommodation fees to provide Alberta Health with the flexibility to increase accommodation fees beyond the core inflation rate in Alberta
  - Any increases beyond the core inflation rate in any given year should be explained, with the explanation posted on the Alberta Health website
- Maintain the current practice of having Alberta Seniors and Housing subsidize the accommodation fee for low-income FBCC residents but change the process for flowing subsidy funding such that Alberta Seniors and Housing flows the subsidy directly to the FBCC operators to eliminate the need for residents to have to transfer the subsidy to operators

**Timing**

- Immediately

**Financial Considerations**

- The accommodation fee margin for operators should continue to improve over time, freeing up funds to support capital upgrades and replacement of aged infrastructure



**Recommendation #33:** Evaluate the PCBF funding model, its underlying assumptions/principles/objectives, and associated impacts on FBCC.

**Supporting Rationale**

- PCBF was implemented in Alberta in 2010 as a method for funding LTC operations (DSL sites are not funded by this model)
- While there is general support for the case-mix funding methodology, there have been concerns expressed about the funding level and funding policies of PCBF including: insufficient funding for hours of care; lack of appropriate consideration of rising acuity; inequitable compensation of wages between the three LTC facility ownership types; lack of compensation for fringe and pension benefits for staff; insufficient funding for facilities with smaller space sizes; and rigid accountability measures
- These concerns are documented in the Christian Health Association of Alberta (CHAA) study on the *"Economic and Operational Impact Patient Care Based Funding on Not-for-Profit Operators of Long-Term Care Spaces January 2021"*
  - Alberta Continuing Care Association operators also have expressed similar concerns
- Although the mandate of the current FBCC Review does not include an in-depth review of the PCBF funding system, it is recommended that a separate in-depth study of the PCBF system be conducted as soon as possible to address these concerns

**Expected Benefits**

- A more equitable and adequate funding system to address the needs of all FBCC residents

**Key Actions Required**

- Conduct an in-depth study to evaluate the underlying assumptions/principles/objectives of the PCBF funding model and the associated impacts on Alberta FBCC sites to improve funding for FBCC services
  - Revise the PCBF model based on the recommendations of the study, and communicate the changes to government, AHS and FBCC operators
- Ensure that decisions on appropriate funded hours of care are based on evidence-based research

**Timing**

- Next 12 months (2022-2023)

### Financial Considerations

- Funding to conduct an in-depth review of PCBF funding model
- Significant investment of time of Alberta Health, AHS, operators to support the review



**Recommendation #34:** Examine methods for funding the operation of smaller homes to facilitate their implementation.

### Supporting Rationale

- Research shows that a smaller, home-like setting is more suitable for the care of some residents, (such as individuals living with dementia), resulting in improved quality of life and care outcomes for residents
- Smaller homes are more suitable for some rural areas and Indigenous communities, where the population is too small to support the building of a larger FBCC site
- These homes need multi-skilled workers (including specialized training to support those living with dementia) to handle all aspects of personal care for the residents, including activities of daily living, personal care, light housekeeping, and meal preparation
- The current funding formula was designed for sites with high space counts and isn't seen as appropriate for smaller homes

### Expected Benefits

- Better care outcomes, and increased resident choice

### Key Actions Required

- Develop a new funding method for the staffing and operation of smaller homes
  - Examine approaches to improve efficiencies with operating smaller homes, for example clustering them in campus of care settings to share services (i.e. laundry, food services etc.)

### Timing

- Next 12 months

### Financial Considerations

- Time requirements of Government of Alberta and AHS to explore how to appropriately fund small facilities
- There may be funding implications associated with implementing a small home funding mode



**Recommendation #35:** Review and standardize the types of fees and charges in all streams of continuing care, including long-term care, designated supportive living, and home care, to improve consistency and equity.

### Supporting Rationale

- Currently, medication, equipment, and medical supplies are provided to LTC facility residents free of charge as are ambulance and medical transfers, while conversely, residents of DSL and home care clients are responsible for these costs (although programs exist to subsidize low income individuals and individuals over the age of 65 for some expenses)
- In addition, residents of DSL are sometimes asked to pay other charges (such as damage deposits or charges for toiletries) that LTC residents are not required to pay
- It has been reported anecdotally that some DSL residents choose to move to LTC facilities as they cannot afford the additional costs associated with DSL
  - This inequity creates an incentive to seek LTC which has the highest cost per day in comparison with other continuing care services

### Expected Benefits

- Individuals receiving continuing care services from different streams of services would have similar out-of-pocket expenses irrespective of the location of services
  - The elimination of the inequity would negate the incentive to seek the highest public cost alternative
- Individuals would choose the type of continuing care services most appropriate to their need

### Key Actions Required

- Review the types of costs in each stream of continuing care, and which are the responsibility of the client/resident
- Collaborate with Blue Cross, Aids to Daily Living, Alberta Seniors and Housing, AHS, and FBCC operators to plan and determine what types of care services/expenditures will be covered by the Government of Alberta across all continuing care streams, and what care services/expenditures will be the responsibility of the client/resident
  - The aim is to ensure a level playing field for all the recipients of continuing care services
  - The charges to be reviewed would include, but not be limited to, drugs and medication, equipment and supplies, ambulance and transportation, and damage deposits
  - Any additional fees to be introduced to ensure equity of payments for all users would only apply to new admissions, not to existing residents.
- Align with income testing for self-directed care
- Make changes to regulations to support changes
- Communicate changes to charges to clients, residents, families, and operators

### Timing

- Planning: next 3 years



- Implementation date: March 2025

#### **Financial Considerations**

- From the resident/client perspective, this could result in decreased out-of-pocket care costs for DSL residents and home care clients, and/or increases in out-of-pocket care costs for LTC residents, depending on how the system is changed to be made consistent
- From the operator perspective, there could be lost revenue from residents not paying for damage deposits

## 4.2.11 Policy Direction 11: Learn from COVID-19 experience to prevent future spread of infectious diseases in FBCC sites and improve resident quality of life and care.

There are many recommendations provided in the earlier policy directions which if implemented will also prevent the future spread of infectious diseases in FBCC facilities and improve resident quality of care during infectious disease outbreaks. These include:

- **Recommendation 16:** Increase direct care hours (includes nursing, personal care and therapeutic) at FBCC sites to an average of 4.5 worked hours per resident day for LTC and up to an average of 4.0 worked hours per resident day for DSL within a four-year period.
- **Recommendation 17:** Increase the level of professional care hours (nursing and therapeutic) for FBCC residents.
- **Recommendation 18:** Increase the level of mental health professional supports for FBCC residents.
- **Recommendation 21:** Establish a full-time employment benchmark for nursing, therapeutic and health care aide staff for FBCC and include the benchmark as one of the quality indicators for monitoring facility care.
- **Recommendation 30:** Develop and implement a “Research, Innovation and Technology Strategy for Continuing Care” in Alberta.
- **Recommendation 31:** Focus government capital investments on the regeneration or replacement of existing FBCC spaces, with some funding ear-marked for the development of new spaces where needed.

In addition to the above recommendations, we provide the following recommendations for preventing the future spread of infectious diseases in FBCC facilities and improving resident quality of care based on learnings from the ongoing COVID-19 pandemic.



**Recommendation #36:** Immediately halt new admissions to rooms that already have two residents. Permanently phase out shared rooms by April 1, 2027.

### Supporting Rationale

- Recent studies by Public Health Ontario, researchers from University of Toronto, and key researchers from Ontario hospitals and Research Institutes indicate that residents living in overcrowded LTC facilities (e.g. two- to four-bed rooms, shared bathrooms) are twice as likely to die from COVID-19 than those in private rooms
  - Upon release of this study, Ontario’s Chief Medical Officer of Health issued a directive in June 2020, immediately banning residents from being admitted into rooms with more than one resident already living in them, effectively banning three- and four-bed rooms going forward
  - However, residents who already live in those rooms are not affected
- Alberta currently has 80 three- or four-bed rooms in the LTC and DSL system, representing 0.3 per cent of the total spaces

- Alberta has 6,820 semi-private spaces (rooms with two beds) in FBCC, representing approximately 25 per cent of total spaces

#### Expected Benefits

- Increased privacy for residents, which will improve resident quality of life
- The fatality rate of residents in FBCC sites is expected to be lower during future instances of infectious disease outbreaks

#### Key Actions Required

- Immediately halt new admissions to rooms that already have two residents
- Permanently phase out three- and four-bed rooms from FBCC effective April 1, 2022
- Phase out semi-private rooms by April 1, 2027, with the exception of couples' suites to be reserved for couples and loved ones etc.
- Convert some existing capital grant funding into funds for the regeneration of FBCC sites (see Recommendation 31)

#### Timing

- Phase out three- and four-bed rooms in the next year
- Phase out semi-private rooms over the next five years

#### Financial Considerations

- The financial impacts have been articulated in Recommendation 31



**Recommendation #37:** Revise the design guidelines for continuing care facilities to incorporate findings regarding the spread of COVID-19 in FBCC.

#### Supporting Rationale

- Public Health infection control and pandemic guidelines have strict protocols regarding social distancing, isolation of sick patients, and grouping of residents in less crowded rooms in congregate settings
- The current design guidelines were updated in 2018 prior to COVID-19, and provide recommendations for developers, but are not mandatory
- Infectious diseases were named one of the top 10 risks in terms of adverse impact in the world for the next 10 years by the 2020 Global Risks Report. The occurrence of pandemics is expected to increase in the future in light of globalization and more frequent travel

#### Expected Benefits

- Increased privacy for residents, which will improve resident quality of life
- Smaller pods are more amenable to residents with cognitive challenges
- The fatality rate of FBCC residents during future outbreaks of infectious diseases will be lowered

- Improved clarity for operators regarding expectations

### Key Actions Required

- Amend Design Guidelines and issue new guidelines as mandatory requirements for future FBCC projects including renovations and new developments
- Adjustments should include the following:
  - All newly constructed rooms to be private rooms, except for eight couple suites per 100 units
  - Lowering the number of units in each household in continuing care facilities from 18 to 14
  - Increasing the number of smaller dining rooms and recreational spaces to enable physical distancing
  - Creating isolation rooms for sick residents or visitors if isolation cannot be safely met in the resident's room
  - Increasing more outdoor green spaces
  - Providing culturally appropriate spaces
  - Upgrading the ventilation systems of old facilities to provide clean air

### Timing

- Next 12 months

### Financial Considerations

- Staffing time commitments from Government of Alberta and AHS to review and modify the design guidelines
- Capital development implications



**Recommendation #38:** Ensure that there is an on-site leader in each facility who has the expertise or access to expertise to devise an early pandemic management and prevention plan and has the authority to implement that plan to improve issues related to infection prevention and control.

### Supporting Rationale

- Many studies in Canada and the USA have documented lessons that can be learnt from the first wave of COVID-19 to prevent the future spread of infectious diseases in continuing care facilities
  - Amongst these studies, one common factor that seems to contribute greatly to their success is the presence of a proactive Senior Management Leader with the expertise to develop and implement a suitable pandemic prevention and control plan, as well as the authority to affect such a plan

### Expected Benefits

- Proactive leadership in planning for and managing pandemics will improve the preparedness of facility staff to respond to a pandemic crisis in a more proficient manner
- More effective responses to future pandemics

### Key Actions Required

- Below are the key strategic actions that could contribute to a successful response plan:
  1. Ensure that there is a proactive leader with authority to manage crises, with an early management and prevention plan
  2. Ensure there is regular training on infection and control protocols and proper use of PPE, such training to be refreshed quarterly
  3. Identify an infection prevention and control lead responsible for staff training and managing the clinical issues relating to the prevention and isolation of infectious diseases
  4. Develop a means of communicating with family members and a method of allowing family support in a considerate and humane way
- Identify and train leaders in the continuing care system
  - Recognize them as mentors and facilitate the development of in-service training courses

### Timing

- Next 12 months

### Financial Considerations

- Staff and management time investment at the facility level



**Recommendation #39:** Resolve labour force issues proactively to maintain needed staffing levels at FBCC sites during pandemics and outbreaks.

### Supporting Rationale

- The pandemic has affected the labour force in FBCC sites in a major way
- Very often, labour force issues are the major factor affecting outbreak management of a FBCC site
- Sites should have a proactive plan to address problems of worker absence due to sickness and isolation, and the need for additional staffing to meet increased resident care needs during an outbreak
  - Some sites have reported that staffing decreased between 20 to 50 per cent in the first 24 hours after an outbreak
- Wages, overtime pay, and sick pay are important issues to be addressed quickly to retain staff

### Expected Benefits

- Improved ability to staff FBCC sites during the time of a pandemic

### Key Actions Required

- FBCC sites should always have contingency plans for filling vacancies
  - The contingencies could include making use of casual staff or even residents' family and friends
- A single site staffing policy is necessary to prevent the spread of the diseases from site to site similar to what the Government of Alberta enacted for COVID-19
- AHS should maintain province-wide lists of potential helpers and be prepared to shift staff from other sites or other sectors of the health system to continuing care
  - The fact that Alberta has a single health authority is an advantage in the deployment of the labour pool from a central perspective
- Leadership at FBCC sites should address labour issues proactively

### Timing

- Immediately

### Financial Considerations

- Staff time to develop plans for Government of Alberta, AHS, and facility operators



**Recommendation #40:** Maintain an open communication channel with all FBCC sites and industry associations during emergency situations such as pandemics.

#### Supporting Rationale

- To ensure the communication of quick and consistent response policies, it is important that there is a central vehicle which provides information regularly to FBCC operators, industry associations, families, and staff
- Public Health personnel must be involved to ensure consistent sharing of information between all groups

#### Expected Benefits

- Improved consistency to responding to a pandemic across the province of Alberta

#### Key Actions Required

- Implement and maintain ongoing communications with FBCC sites, AHS, and associations, including regular meetings and email communications and consultation on changes to orders

#### Timing

- Immediately

#### Financial Considerations

- Time commitments from operators, AHS and Government of Alberta to participate in the process



**Recommendation #41:** Ensure that FBCC operators and staff always have appropriate access to personal protective equipment and other equipment/supplies for future outbreaks/pandemics.

#### Supporting Rationale

- Increasing the supply and quality of the PPE for future pandemics and outbreaks was identified as an area for improvement by survey respondents, to reduce uncertainty

#### Expected Benefits

- Improved safety for FBCC residents and staff by reducing the spread of infection during an outbreak

#### Key Actions Required

- Ensure that congregate living and congregate care facilities always have the ability to access up to date and quality PPE and other equipment/supplies during for future outbreaks or pandemics to the degree that it is possible

#### Timing

- Immediately

#### Financial Considerations

- Providing facilities with the resources to procure PPE and other equipment/supplies during an outbreak/pandemic
- Partner with Seniors and Housing to coordinate training and support for Senior Lodges





**Recommendation #42:** Reduce social isolation for residents and caregivers during an outbreak/pandemic.

### Supporting Rationale

- Increasing access to in-person visits and social interactions was identified as a key area for improving the quality of life during an outbreak/pandemic by respondents to the public, resident/caregiver, FBCC staff and external stakeholder surveys
- The National Institute on Aging found that COVID-19 has significantly increased Canadians' feelings of social isolation and loneliness

### Expected Benefits

- Improved quality of life for residents and caregivers/families

### Key Actions Required

- Increase and enable in-person visits in a safe manner for FBCC residents during outbreaks/pandemics, especially for family care partners, who provide essential care for residents
  - Increase access to technology to facilitate virtual social interactions
- Increase social interactions and activities in a safe manner between residents and between residents and staff during outbreaks/pandemics

### Timing

- Immediately

### Financial Considerations

- Potential need for investments in technology to improve virtual interactions

# Next Steps

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## 5 Next Steps

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To keep the momentum established by the FBCC Review, the next important activity will be to develop action plans for implementing each of the 42 recommendations outlined in the report. Action planning will include the development of implementation working groups, including members from across stakeholder groups who informed the Review recommendations.

The action plans are expected to include:

- An articulation of the level of system change required, including change management requirements
- A prioritization of timing for implementing recommendations
- The key activities needed to implement recommendations, including opportunities to leverage existing projects/initiatives
- Detailed resource requirements (human and financial resources) to implement recommendations
- Timeframes for implementing recommendations, including key milestones
- Accountabilities and responsibilities for implementing recommendations
- Interdependencies and risks associated with implementing recommendations

The Action Planning Phase is estimated to be completed by October 31, 2021.

# Appendices

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# Appendix 1: Alberta Health Charter

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## Overview

Alberta's Health Charter was adopted in March 2014.

The *Alberta Health Act* requires the Government of Alberta to have a Health Charter. Alberta's Health Charter sets out key values and aims for Alberta's health system and the roles and responsibilities of patients and providers within the health system.

It is intended to guide the actions of health service organizations, providers, patients and government in the broader health system, both publicly funded and those services purchased through insurance or directly.

The Alberta Health Advocate Offices use the Health Charter as a lens to consider concerns and complaints brought to its attention by Albertans. The Health Advocate also provides education about the Health Charter and how it applies to Alberta's health service system.

## Health Charter

When I interact with the health system, I expect that I will:

- have my health status, social and economic circumstances, and personal beliefs and values acknowledged
- be treated with respect and dignity
- have access to team-based primary care services
- have the confidentiality and privacy of my health information respected
- be informed in ways that I understand so that I may make informed decisions about my health, health care and treatment
- be able to participate fully in my health and health care
- be supported through my care journey and helped to find and access the health services and care that I require
- receive information on the health system and education about healthy living and wellness
- have timely and reasonable access to safe, high quality health services and care
- have timely and reasonable access to my personal health information

- have the opportunity to raise concerns and receive a timely response to my concerns, without fear of retribution or an impact on my health services and care

Taking my circumstances into account and to the best of my abilities, when I interact with the health system, I understand that I will be asked to:

- respect the rights of other patients and health providers
- ask questions and work with providers to understand the information I am being provided
- demonstrate that I, or my guardian and / or caregivers, understand the care plan we have developed together and that steps are being taken to follow the plan
- treat health services as a valuable public resource
- learn how to better access health services
- make healthy choices in my life

As I work to be a healthy citizen within Alberta, I expect that:

- when economic, fiscal, and social policies are being developed by the Alberta government, the impact of those policies on public health, wellness and prevention will be considered and steps taken to ensure that public policy is healthy policy

# Appendix 2: Financial Model Detailed Assumptions

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## Financial Model Components

An integrated dynamic financial model was developed to assess the financial implications of key recommended changes to the system. Detailed assumptions for the model are provided below. The model determined the projected costs of meeting future demand for continuing care services based on the current distribution of LTC, DSL and LTHC services, as well as proposed changes to the system based on the future vision for LTC, DSL and LTHC services. Key areas of change included in the integrated dynamic financial model included:

- The implications of increasing the proportion of LTHC spaces from 60.5 per cent to 70.0 per cent and decreasing the proportion of FBCC services from 39.5 per cent to 30.0 per cent to meet demand in 2030. This included:
  - Annual operating cost implications
  - Cumulative capital cost implications from 2021 to 2030
- The implications of increasing the direct hours of care for:
  - LTC from an average of 3.4 worked hours per resident day to 4.5
  - DSL4D from an average of 3.0 worked hours per resident day to 4.0
  - DSL4 from an average of 2.7 worked hours per resident day to 3.5
- The implications of providing a self-directed care model, with 6.3 per cent of all continuing care clients receiving services through this option by 2030
- The implications of adjusting capital grant levels for LTC and DSL space development
- The implications of developing small homes to replace a portion of aged facilities, as well as for new DSL capacity
- The implications of replacing a portion of aged facilities with zero-capital options
- The implications of adding new FBCC capacity specifically in Indigenous communities, in addition to the projected demand for FBCC spaces

## Comparison Model Descriptions

**Current Proportion Model** - This model is the base case comparator for the proposed model. It represents the how the continuing care system in Alberta will meet future demand for continuing care spaces in 2030, as projected by AHS, by increasing capacity in each continuing care stream (LTC, DSL4D, DSL4, DSL3, LTHC) to maintain the same proportions of spaces in 2020. For example, if LTC represents 22.5 per cent of spaces in 2020, then the system will add LTC spaces to maintain the same 22.5 per cent distribution in 2030. Accordingly, the proportional mix of LTC, DSL and LTHC spaces will remain the same in 2030, and capacity will be increased in each stream to maintain this mix.

New Proposed Recommended Model - This model represents the proposed changes to the distribution of continuing care spaces in Alberta in the future, based on the findings of the FBCC Review. It represents the desired end state for the mix of continuing care spaces in 2030. The financial impacts of these proposed changes are provided from both a capital cost and operating cost perspective and compared to the costs of providing continuing care services in the future in the base case scenario (i.e. the current proportion model) above. It is also assumed that increases to direct hours of care, self-directed care services, and capacity for Indigenous communities will only be implemented in the new proposed model.

### Key Common Assumptions in Both Models

For both the current proportion model, and the new proposed model, it is assumed:

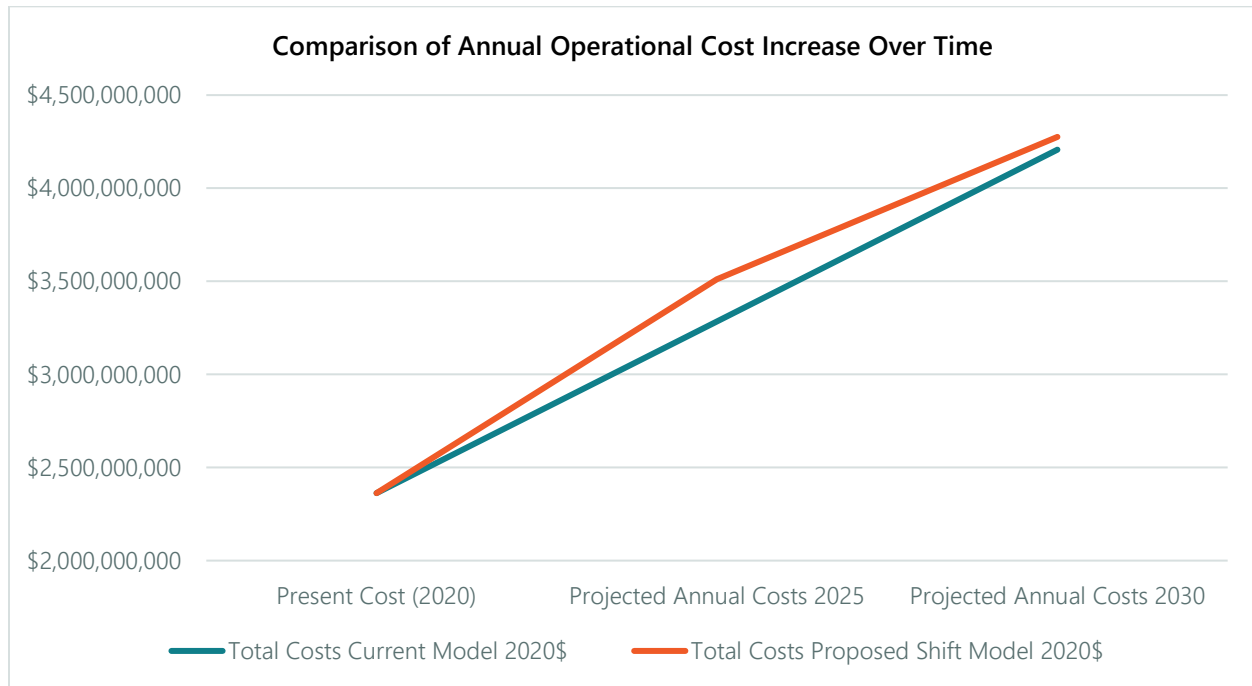
- That all FBCC spaces requiring replacement (i.e. will be 40 years or older by 2030), will be replaced over the next 10 years.
- Grant funding contribution levels for supporting capital development will remain the same for both models.

### Summary Comparison of Annual Operating Costs in 2030

The estimated annual operating costs (in 2020 dollars) to meet the projected demand for continuing care services in 2030 for each model is summarized below. Overall, the projected annual operating cost to meet the demand for continuing care services in 2030 under the current proportion model is \$1.8 billion higher than present costs in 2020 dollars. The projected annual operating cost to meet the demand for continuing care services in 2030 under the new proposed model is \$1.9 billion higher than present costs in 2020 dollars. Overall, the estimated annual operating costs of providing services in 2030 with the new proposed model are approximately \$68 million higher (in 2020 dollars) than meeting demand with the current proportion model in 2030. Accordingly, shifting the allocation of services in 2030 covers 83 per cent of the cost increases associated with increasing the direct hours of care and providing additional FBCC services to Indigenous communities.

Operational Cost Area	Recommendation	Current Model (61% LTHC/39% FBCC)			New Model (Shift to 70% LTHC/30% FBCC)		
		Present Cost (2020)	Projected Annual Costs 2030	Annual Change Compared to Present Cost	Projected Annual Costs for New Model in 2030	Change Compared to Present Cost	Annual Change Compared to Current Model in 2030
Mix of LTC, DSL, and LTHC Services	25	\$2,362,380,288	\$4,207,017,382	\$1,844,637,095	\$3,755,435,827	\$1,393,055,540	-\$451,581,555
Increased Direct Hours of Care	16	\$0	\$0	\$0	\$497,512,375	\$497,512,375	\$497,512,375
Additional Indigenous Facility Operating Costs	31	\$0	\$0	\$0	\$45,693,171	\$45,693,171	\$45,693,171
Cost Increase/Reduction from Self-Directed Care Model	23	\$0	\$0	\$0	-\$23,016,827	-\$23,016,827	-\$23,016,827
<b>Total FBCC System Annual Cost Impacts</b>		<b>\$2,362,380,288</b>	<b>\$4,207,017,382</b>	<b>\$1,844,637,095</b>	<b>\$4,275,624,546</b>	<b>\$1,913,244,259</b>	<b>\$68,607,164</b>

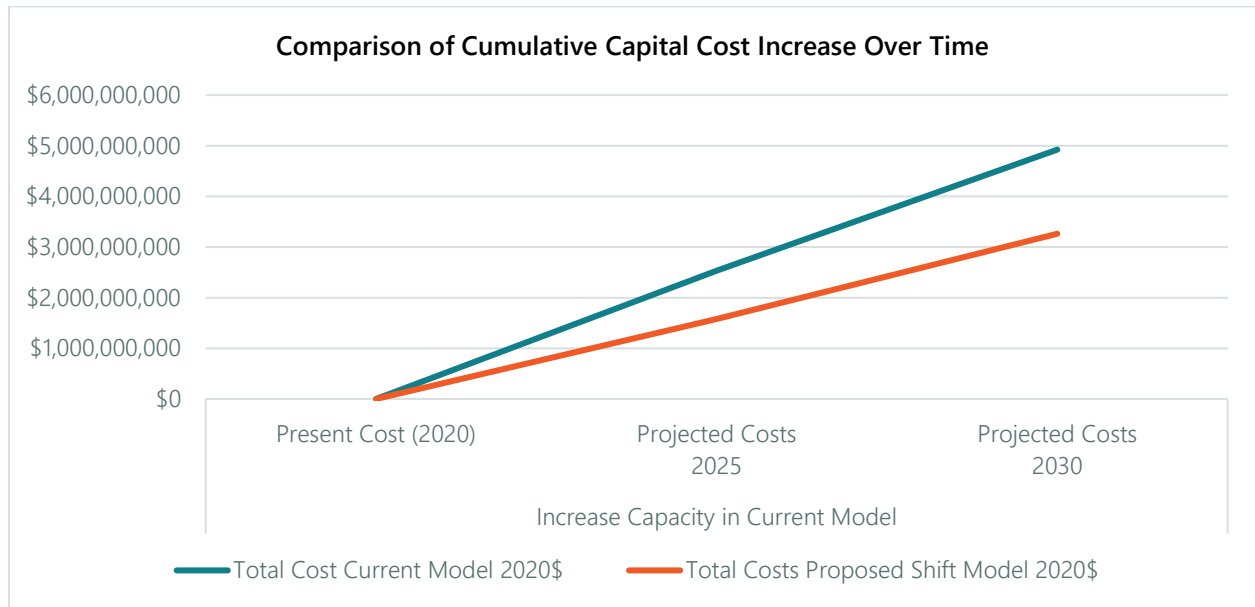




### Summary Comparison of Cumulative Capital Costs in 2030

The estimated cumulative capital cost requirements to meet the projected demand for continuing care services in 2030 for each model is summarized below. Overall, the projected cumulative capital costs required to meet the demand for continuing care services in 2030 under the current proportion model is \$4.9 billion in 2020 dollars. The projected cumulative capital costs required to meet the demand for continuing care services in 2030 under the new proposed model is \$2.7 billion in 2020 dollars. Overall, the cumulative capital costs required to provide services in 2030 with the new proposed model are approximately \$1.7 billion lower (in 2020 dollars) than meeting demand with the current proportion model.

Capital Cost Area	Current Model (61% LTHC/39% FBCC)		New Model (Shift to 70% LTHC/30% FBCC)	
	Present Cost (2020)	Projected Costs 2030	Projected Costs for New Model in 2030	Change Compared to Current Model in 2030
Cumulative Capital Costs for Replacement and Capacity Increases	\$0	\$4,923,651,851	\$2,738,289,278	-\$2,185,362,574
Additional Cumulative Capital Investment Indigenous Communities	\$0	\$0	\$523,872,000	\$523,872,000
<b>Total FBCC System Cost Impact</b>	<b>\$0</b>	<b>\$4,923,651,851</b>	<b>\$3,262,161,278</b>	<b>-\$1,661,490,574</b>



## Detailed Assumptions Regarding Service Levels by Stream

Based on data provided by AHS, the projected demand for continuing care spaces will be 112,960 by 2030, an increase of 43,228 ‘spaces’ (including FBCC spaces and the number of long-term home care clients) compared to current capacity of 69,732 “spaces”. The graphic below summarizes the differences in capacity by continuing care stream for the current proportion model and proposed model in 2030. Compared to 2020, LTC capacity does not increase in the proposed model (it remains at the current 2020 levels), DSL capacity increases by 6,370 spaces, and LTHC capacity increases by 36,858 “spaces”. Compared to the current proportion model in 2030, there will be a reduction of 9,711 LTC spaces and 978 DSL spaces, and an increase in 10,689 LTHC “spaces”.

Service Stream	Current Capacity (2020)	% of Capacity Current	Current Model Capacity by Stream in 2030	New Proposed Model Capacity by Stream in 2030	% of Proposed Model Capacity in 2030	Change from Current Capacity to Proposed Model in 2030	Change from Current Model to Proposed Model in 2030
LTC	14,076	20.2%	22,802	14,076	12.5%	0	-8,726
LTC - Special Programs	1,589	2.3%	2,574	1,589	1.4%	0	-985
DSL4D	3,500	5.0%	5,670	5,648	5.0%	2,148	-22
DSL4	6,840	9.8%	11,080	10,912	9.7%	4,072	-168
DSL3	1,513	2.2%	2,451	1,663	1.5%	150	-788
LTHC	42,214	60.5%	68,383	79,072	70.0%	36,858	10,689
<b>Total</b>	<b>69,732</b>	<b>100.0%</b>	<b>112,960</b>	<b>112,960</b>	<b>100.0%</b>	<b>43,228</b>	<b>0</b>

Of the 79,072 LTHC ‘spaces’ in the proposed model, it is assumed that 44,900 will remain at current complexity levels, 17,086 will have a moderate complexity level, and 17,086 will have complex care needs.

	Distribution of LTHC Clients Current Model 2030	Distribution of LTHC Clients Proposed Model 2030
Number of LTHC Clients with Current Complexity	42,214	44,900
Number of LTHC Clients with Moderate Complexity	15,701	17,086
Number of LTHC Clients with Complex Care	10,468	17,086
<b>Total</b>	<b>68,383</b>	<b>79,072</b>

Assumptions regarding the average cost/per day of operations for each service stream are summarized below. Note, these costs do not account for proposed increases to hours of care (see below) and are based on current hours of care levels.

Service Stream	Cost per space per day	Annual costs per space
LTC	\$202.46	\$73,898
LTC Special Programs	\$272.11	\$99,321
DSL4D	\$159.29	\$58,141
DSL4	\$146.73	\$53,556
DSL3	\$100.08	\$36,529
LTHC - Current/Basic	\$35.00	\$12,775
LTHC Future - Moderate	\$50.00	\$18,250
LTHC Future - Complex	\$112.00	\$40,880

Overall, the estimated annual costs of meeting the demand for continuing care services in 2030 with the new proposed model (not including the costs for increased hours of care) are \$452 million lower than the current proportions model.

Service Stream	Current Annual Costs (2020)	Future Costs in 2030 - Current Model	Future Costs in 2030 - Proposed Model	10 Year Change from Current Costs - Proposed Model	Annual Change in 2030 - Proposed Model Compared to Current Model
LTC	\$1,040,186,840	\$1,685,015,567	\$1,040,186,840	\$0	-\$644,828,726
LTC Special Programs	\$157,821,825	\$255,658,138	\$157,821,825	\$0	-\$97,836,314
DSL4D	\$203,492,975	\$329,641,577	\$328,379,521	\$124,886,546	-\$1,262,056
DSL4	\$366,326,118	\$593,417,632	\$584,404,555	\$218,078,437	-\$9,013,077
DSL3	\$55,268,680	\$89,530,632	\$60,748,060	\$5,479,380	-\$28,782,573
LTHC - Current/Basic	\$539,283,850	\$539,283,850	\$573,595,714	\$34,311,864	\$34,311,864
LTHC - Moderate	\$0	\$286,552,133	\$311,820,776	\$311,820,776	\$25,268,642
LTHC - Complex	\$0	\$427,917,853	\$698,478,537	\$698,478,537	\$270,560,685
<b>Total Costs</b>	<b>\$2,362,380,288</b>	<b>\$4,207,017,382</b>	<b>\$3,755,435,827</b>	<b>\$1,393,055,540</b>	<b>-\$451,581,555</b>

## Detailed Assumptions Regarding Increasing Direct Hours of Care – Current (2020)

### LTC

Currently, the average hours of care for typical LTC services is 3.4 worked hours per weighted resident day.

LTC - Current State Direct Hours of Care in 2020								
Staffing Type	Direct Worked Hours Per Weighted Day	Worked to Paid Ratio (WTP)	Direct Paid Hours per Weighted Day	Paid Hours	Paid Rate	Total Cost	Paid Hours Per FTE Year	FTE
RN	0.52	1.23	0.64	3,263,307	\$62.16	\$202,858,872	1,921	1,699
LPN	0.37	1.21	0.45	2,311,983	\$40.88	\$94,524,904	2,023	1,143
HCA	2.13	1.21	2.58	13,259,955	\$31.21	\$413,872,403	2,023	6,555
Professional Therapies	0.19	1.21	0.23	1,165,503	\$53.36	\$62,191,240	2,023	576
Non-Professional Therapies	0.16	1.21	0.19	976,239	\$27.79	\$27,129,682	2,023	483
<b>Total</b>	<b>3.37</b>		<b>4.08</b>	<b>20,976,987</b>		<b>\$800,577,101</b>		

Based on the findings of the review, it is proposed that the direct hours of care for typical LTC services increase to 4.5 worked hours per day as follows:

LTC - Future End State Direct Hours of Care in 2020								
Staffing Type	Direct Worked Hours Per Weighted Day	Worked to Paid Ratio (WTP)	Direct Paid Hours per Weighted Day	Paid Hours	Paid Rate	Total Cost	Paid Hours Per FTE Year	FTE
RN	0.67	1.23	0.82	4,234,012	\$62.16	\$263,201,336	1,921	2,204
LPN	0.50	1.21	0.61	3,108,333	\$40.88	\$127,083,483	2,023	1,537
HCA	2.88	1.21	3.48	17,903,996	\$31.21	\$558,823,172	2,023	8,851
Professional Therapies	0.25	1.21	0.30	1,554,166	\$53.36	\$82,930,316	2,023	768
Non-Professional Therapies	0.20	1.21	0.24	1,243,333	\$27.79	\$34,552,226	2,023	615
<b>Total</b>	<b>4.50</b>		<b>5.46</b>	<b>28,043,840</b>		<b>\$1,066,590,534</b>		

This will result in an estimated annual operating increase of \$266 million, and the requirement for 3,519 additional full-time equivalent staff (FTE) in LTC.

### Change in Direct Worked Hours/Costs

Staffing Type	Direct Hours Per Day	% Change Direct Hours	Paid Hours	FTE Change	Total Cost Change
RN	0.15	29.7%	970,704	505	\$60,342,464
LPN	0.13	34.4%	796,350	394	\$32,558,578
HCA	0.75	35.0%	4,644,042	2,296	\$144,950,769
Professional Therapies	0.06	33.3%	388,663	192	\$20,739,076
Non-Professional Therapies	0.04	27.4%	267,094	132	\$7,422,544
<b>Total</b>	<b>1.13</b>	<b>33.7%</b>	<b>7,066,853</b>	<b>3,519</b>	<b>\$266,013,432</b>

## DSL4D

Currently, the average hours of care for DSL4D is 3.0 worked hours per weighted resident day.

DSL4D - Current State Direct Hours of Care in 2020								
Staffing Type	Direct Worked Hours Per Weighted Day	Worked to Paid Ratio (WTP)	Direct Paid Hours per Weighted Day	Paid Hours	Paid Rate	Total Cost	Paid Hours Per FTE Year	FTE
RN	0.00	1.21	0.00	0	\$62.16	\$0	1,921	0
LPN	0.72	1.19	0.86	1,094,562	\$39.55	\$43,289,927	2,023	541
HCA	2.24	1.17	2.62	3,348,072	\$30.12	\$100,843,929	2,023	1,655
Professional Therapies	0.00	1.19	0.00	0	\$53.36	\$0	2,023	0
Non-Professional Therapies	0.00	1.17	0.00	0	\$27.79	\$0	2,023	0
<b>Total</b>	<b>2.96</b>		<b>3.48</b>	<b>4,442,634</b>		<b>\$144,133,856</b>		

Based on the findings of the review, it is proposed that the direct hours of care for DSL4D services increase to 4.0 worked hours per day as follows:

DSL4D - Future End State Direct Hours of Care in 2020								
Staffing Type	Direct Worked Hours Per Weighted Day	Worked to Paid Ratio (WTP)	Direct Paid Hours per Weighted Day	Paid Hours	Paid Rate	Total Cost	Paid Hours Per FTE Year	FTE
RN	0.20	1.21	0.24	309,155	\$62.16	\$19,218,183	1,921	161
LPN	0.72	1.19	0.86	1,094,562	\$39.55	\$43,289,927	2,023	541
HCA	2.88	1.17	3.37	4,304,664	\$30.12	\$129,656,480	2,023	2,128
Professional Therapies	0.10	1.19	0.12	152,023	\$53.36	\$8,111,921	2,023	75
Non-Professional Therapies	0.10	1.17	0.12	149,468	\$27.79	\$4,153,702	2,023	74
<b>Total</b>	<b>4.00</b>		<b>4.70</b>	<b>6,009,871</b>		<b>\$204,430,212</b>		

This will result in an estimated annual operating increase of \$60 million, and the requirement for 783 additional FTE staff for DSL4D.

### Change in Direct Worked Hours/Costs

Staffing Type	Direct Hours Per Day	% Change Direct Hours	Paid Hours	FTE Change	Total Cost Change
RN	0.20		309,155	161	\$19,218,183
LPN	0.00	0.0%	0	0	\$0
HCA	0.64	28.6%	956,592	473	\$28,812,551
Professional Therapies	0.10		152,023	75	\$8,111,921
Non-Professional Therapies	0.10		149,468	74	\$4,153,702
<b>Total</b>	<b>1.04</b>	<b>35.1%</b>	<b>1,567,237</b>	<b>783</b>	<b>\$60,296,357</b>

## DSL4

Currently, the average hours of care for DSL4 is 2.7 worked hours per weighted resident day.

DSL4 - Current State Direct Hours of Care in 2020								
Staffing Type	Direct Worked Hours Per Weighted Day	Worked to Paid Ratio (WTP)	Direct Paid Hours per Weighted Day	Paid Hours	Paid Rate	Total Cost	Paid Hours Per FTE Year	FTE
RN	0.00	1.21	0.00	0	\$62.16	\$0	1,921	0
LPN	0.65	1.19	0.77	1,919,236	\$39.55	\$75,905,795	2,023	949
HCA	2.00	1.17	2.34	5,842,044	\$30.12	\$175,962,365	2,023	2,888
Professional Therapies	0.05	1.19	0.06	138,205	\$53.36	\$7,374,619	2,023	68
Non-Professional Therapies	0.02	1.17	0.02	57,228	\$27.79	\$1,590,366	2,023	28
<b>Total</b>	<b>2.71</b>		<b>3.19</b>	<b>7,956,713</b>		<b>\$260,833,145</b>		

Based on the findings of the review, it is proposed that the direct hours of care for DSL4 services increase to 3.5 worked hours per day as follows:

DSL4 - Future End State Direct Hours of Care in 2020								
Staffing Type	Direct Worked Hours Per Weighted Day	Worked to Paid Ratio (WTP)	Direct Paid Hours per Weighted Day	Paid Hours	Paid Rate	Total Cost	Paid Hours Per FTE Year	FTE
RN	0.10	1.21	0.12	302,089	\$62.16	\$18,778,910	1,921	157
LPN	0.70	1.19	0.83	2,079,668	\$39.55	\$82,250,861	2,023	1,028
HCA	2.50	1.17	2.93	7,302,555	\$30.12	\$219,952,957	2,023	3,610
Professional Therapies	0.10	1.19	0.12	297,095	\$53.36	\$15,853,011	2,023	147
Non-Professional Therapies	0.10	1.17	0.12	292,102	\$27.79	\$8,117,520	2,023	144
<b>Total</b>	<b>3.50</b>		<b>4.12</b>	<b>10,273,509</b>		<b>\$344,953,259</b>		

This will result in an estimated annual operating increase of \$84 million, and the requirement for 1,250 additional FTE staff for DSL4.

### Change in Direct Worked Hours/Costs

Staffing Type	Direct Hours Per Day	% Change Direct Hours	Paid Hours	FTE Change	Total Cost Change
RN	0.10		302,089	157	\$18,778,910
LPN	0.05	8.4%	160,432	79	\$6,345,066
HCA	0.50	25.0%	1,460,511	722	\$43,990,591
Professional Therapies	0.05	115.0%	158,890	147	\$8,478,392
Non-Professional Therapies	0.08	410.4%	234,874	144	\$6,527,154
<b>Total</b>	<b>0.79</b>	<b>29.1%</b>	<b>2,316,796</b>	<b>1,250</b>	<b>\$84,120,114</b>

## Overall Impact Increasing Direct Hours of Care – Current (2020)

The combined overall impact of increasing direct hours of care under current service levels includes an estimated annual operating cost increase of \$410 million, and the total requirement for 5,552 additional FTE staff for FBCC.

### Summary Comparison of Current State to Future State Staffing Model in 2020

Continuing Care Stream	Current State Cost	Future State Cost	Cost Difference	Average Annual Increase per Resident
LTC	\$800,577,101	\$1,066,590,534	\$266,013,432	\$18,898
DSL4D	\$144,133,856	\$204,430,212	\$60,296,357	\$17,228
DSL4	\$260,833,145	\$344,953,259	\$84,120,114	\$12,298
DSL3	\$34,253,904	\$34,253,904	\$0	\$0
<b>Total</b>	<b>\$1,239,798,007</b>	<b>\$1,650,227,910</b>	<b>\$410,429,903</b>	

### Staffing Requirements in 2020

Position	FTE with Current Direct Hours of Care	Additional FTE Now with Direct Hour of Care Increase	Number of Staff Members	Current Average FTE/Staff Member	Average FTE for Additional Staff	Additional People to Recruit
RN	1,699	824	2,285	0.74	0.74	1,113
LPN	2,633	473	3,808	0.69	0.69	686
HCA	11,610	3,491	16,861	0.69	0.80	4,364
Professional Therapies	660	414			0.80	518
Non-Professional Therapies	537	350			0.80	438
<b>Total</b>	<b>17,139</b>	<b>5,552</b>				<b>7,118</b>



## Detailed Assumptions Regarding Special LTC Staffing Levels – Current (2020)

Currently, there are approximately 1,589 LTC spaces used for approximately 100 different types of special programs and services. It is assumed that the hours of care for these spaces will remain the same.

Special LTC - Current State Direct Hours of Care in 2020								
Staffing Type	Direct Worked Hours Per Weighted Day	Worked to Paid Ratio (WTP)	Direct Paid Hours per Weighted Day	Paid Hours	Paid Rate	Total Cost	Paid Hours Per FTE Year	FTE
RN	0.91	1.23	1.12	652,428	\$60.81	\$39,672,046	1,921	340
LPN	0.92	1.21	1.11	646,518	\$42.60	\$27,540,278	2,023	320
HCA	2.82	1.21	3.41	1,980,552	\$31.94	\$63,265,274	2,023	979
Professional Therapies	0.48	1.21	0.58	335,285	\$58.86	\$19,733,920	2,023	166
Non-Professional Therapies	0.33	1.21	0.40	231,079	\$32.93	\$7,610,306	2,023	114
<b>Total</b>	<b>5.47</b>		<b>6.63</b>	<b>3,845,861</b>		<b>\$157,821,825</b>		

## Impacts of Increasing Direct Hours of Care – Future (2030)

The projected annual cost increases related to increasing direct hours of care in 2030 for the current proportion model and new proposed model are articulated below. The projected annual cost in 2030 related to direct care hour increases, as proposed above for LTC and DSL, are \$498 million for the new proposed model. This is \$167 million lower compared to increasing direct hours of care for the current proportions model in 2030.

Service Stream	2030 Projected Costs					
	Projected Cost 2030 - Current Model & Current Hours	Projected Cost 2030 - Current Model & Increased Hours	Change - Current Model & Increased Hours	Projected Cost 2030 - Proposed Model & Current Hours	Projected Cost 2030 - Proposed Model & Increased Hours	Change -Proposed Model & Increased Hours
LTC	\$1,685,015,567	\$2,115,935,048	\$430,919,482	\$1,040,186,840	\$1,306,200,273	\$266,013,432
LTC - Special Programs	\$255,658,138	\$255,658,138	\$0	\$157,821,825	\$157,821,825	\$0
DSL4D	\$329,641,577	\$427,316,625	\$97,675,048	\$328,379,521	\$425,680,613	\$97,301,092
DSL4	\$593,417,632	\$729,685,171	\$136,267,540	\$584,404,555	\$718,602,406	\$134,197,851
DSL3	\$89,530,632	\$89,530,632	\$0	\$60,748,060	\$60,748,060	\$0
LTHC Current/Basic	\$539,283,850	\$539,283,850	\$0	\$573,595,714	\$573,595,714	\$0
LTHC Moderate	\$286,552,133	\$286,552,133	\$0	\$311,820,776	\$311,820,776	\$0
LTHC - Complex	\$427,917,853	\$427,917,853	\$0	\$698,478,537	\$698,478,537	\$0
<b>Total</b>	<b>\$4,207,017,382</b>	<b>\$4,871,879,451</b>	<b>\$664,862,069</b>	<b>\$3,755,435,827</b>	<b>\$4,252,948,202</b>	<b>\$497,512,375</b>

The estimated additional FTE staff requirements for the new proposed model will be 6,776 by the year 2030.

### Additional FTE Requirements

Position	FTE 2030 (Proposed Model)	Additional Staff 2030
RN	1,016	1,373
LPN	520	754
HCA	4,211	5,264
Professional Therapies	548	685
Non-Professional Therapies	482	602
<b>Total</b>	<b>6,776</b>	<b>8,677</b>

## Detailed Capital Cost Assumptions

Based on discussions and data provided by Alberta Health and AHS, there will be a need to replace approximately 10,475 FBCC spaces that will be 40 years or older by 2030, and an additional 720 FBCC spaces in shared accommodations, resulting in a total requirement of 11,195 FBCC spaces. It is assumed that these spaces will be replaced in both the current proportions model as well as the new proposed model. The graphic below summarizes the key assumptions related to the timing of replacement, as well as the breakdown of spaces between LTC and DSL.

Type of Space	Number of Sites	Estimated Number of Spaces To Replace by 2030	% Replaced by 2021 - 2025	% Replaced 2026 - 2030	% of Sites LTC	% of Sites DSL
FBCC Sites 40 years or older	107	8,000	60%	40%	79%	21%
Additional Sites 35-39 years (replace in 2025)	23	1,725	30%	70%	87%	13%
Additional Sites 30-34 years (replace in 2030)	10	750	0%	100%	90%	10%
Shared Spaces in sites < 30 years old	28	720	100%	0%	99%	1%
<b>Total Spaces to Replace</b>		<b>11,195</b>				

Based on the assumptions above related to service levels by stream, it is estimated that there will be a requirement to develop 5,445 additional new FBCC spaces (all DSL) for the new proposed model, and a need to develop 17,059 additional new FBCC spaces for the current proportion model. It should be noted that the number of new FBCC spaces required for the new proposed model will be reduced by the number of self-directed care clients assessed as requiring DSL level services. Based on the current assumptions, a total of 1,540 self-directed care clients are projected to require DSL level services (see below) and will not require a DSL space.

Type of Space	Number of New Spaces Developed from 2021 - 2025 Current Model	Number of New Spaces Developed from 2026 - 2030 Current Model	Total New Spaces Current Model (2021 - 2030)	Number of New Spaces Developed from 2021 - 2025 Proposed Model	Number of New Spaces Developed from 2026 - 2030 Proposed Model	Total New Spaces Proposed Model (2021 - 2030)
LTC	4,855	4,855	9,711	0	0	0
DSL	3,674	3,674	7,348	2,570	2,874	5,445
<b>Total</b>	<b>8,529</b>	<b>8,529</b>	<b>17,059</b>	<b>2,570</b>	<b>2,874</b>	<b>5,445</b>

Assumptions regarding the cost of developing a space by ownership type or other development type, the distribution of developing replacement and new capacity FBCC spaces by type, and grant funding levels by type are provided in the table below. Note that small facility spaces and zero capital options each represent 10 per cent of replacement spaces.

Ownership Type	Current Ownership breakdown	Replacement Ownership Type Distribution	Cost/Space To Develop	Government Contribution LTC Spaces	Government Contribution DSL Spaces	New Development Ownership Type Distribution
AHS/Public	21.0%	13%	\$575,000	100%	100%	17%
Private Not-For Profit	37.0%	30%	\$337,400	50%	39%	33%
Private For-Profit	42.0%	37%	\$250,000	28%	28%	40%
Small Facility Development	0.0%	10%	\$175,000	50%	50%	10%
Zero Cap Options	0.0%	10%	\$0	0%	0%	0%
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>				<b>100.0%</b>

It is proposed that capital grants be extended to cover replacement and new space development for LTC and DSL space development, and that private not-for-profit LTC operators receive higher grant

funding levels to fund the development of spaces than DSL operators, given the current differences in accommodation fee margins between each ownership type (see below).

The total projected cumulative capital cost requirements for the Government of Alberta to the year 2030 (based on the assumptions above) is \$2.7 billion for the proposed new model, approximately \$2.2 billion less than the projected capital cost requirement for the current proportion model.

Capital Cost Estimates - GoA Portion				Current Model			New Proposed Model			Change in Costs Proposed Model versus Current Model by 2030
Type of Space Developed	Projected Cost 2021 - 2025	Projected Cost 2026 - 2030	Total Projected Capital Costs (2021 - 2030)	Projected Cost 2021 - 2025	Projected Cost 2026 - 2030	Total Projected Capital Costs (2021 - 2030)	Projected Cost 2021 - 2025	Projected Cost 2026 - 2030	Total Projected Capital Costs (2021 - 2030)	
Capital Replacement - AHS	\$451,303,125	\$385,523,125	\$836,826,250	\$451,303,125	\$385,523,125	\$836,826,250	\$451,303,125	\$385,523,125	\$836,826,250	\$0
Capital Replacement - Private Not-for-Profit	\$293,706,456	\$251,106,694	\$544,813,150	\$293,706,456	\$251,106,694	\$544,813,150	\$293,706,456	\$251,106,694	\$544,813,150	\$0
Capital Replacement - Private-for-Profit	\$156,371,250	\$133,579,250	\$289,950,500	\$156,371,250	\$133,579,250	\$289,950,500	\$156,371,250	\$133,579,250	\$289,950,500	\$0
Capital Replacement - Small Facility Style	\$52,828,125	\$45,128,125	\$97,956,250	\$52,828,125	\$45,128,125	\$97,956,250	\$52,828,125	\$45,128,125	\$97,956,250	\$0
Capital Replacement - Zero Cap Options	\$0	\$0	\$0	0%	\$0	\$0	0%	\$0	\$0	\$0
<b>Total Replacement Costs</b>	<b>\$954,208,956</b>	<b>\$815,337,194</b>	<b>\$1,769,546,150</b>	<b>\$954,208,956</b>	<b>\$815,337,194</b>	<b>\$1,769,546,150</b>	<b>\$954,208,956</b>	<b>\$815,337,194</b>	<b>\$1,769,546,150</b>	<b>\$0</b>
New Spaces - AHS	\$833,751,557	\$833,751,557	\$1,667,503,114	\$251,245,808	\$280,975,650	\$532,221,458	\$251,245,808	\$280,975,650	\$532,221,458	-\$1,135,281,656
New Spaces - Private Not-for-Profit	\$429,844,826	\$429,844,826	\$859,689,652	\$111,610,662	\$124,817,518	\$236,428,180	\$111,610,662	\$124,817,518	\$236,428,180	-\$623,261,471
New Spaces - Private for Profit	\$238,823,975	\$238,823,975	\$477,647,951	\$71,968,109	\$80,484,074	\$152,452,182	\$71,968,109	\$80,484,074	\$152,452,182	-\$325,195,768
New Spaces - Small Facility Style	\$74,632,492	\$74,632,492	\$149,264,985	\$22,490,034	\$25,151,273	\$47,641,307	\$22,490,034	\$25,151,273	\$47,641,307	-\$101,623,678
<b>Total New Development</b>	<b>\$1,577,052,851</b>	<b>\$1,577,052,851</b>	<b>\$3,154,105,701</b>	<b>\$434,824,579</b>	<b>\$486,277,242</b>	<b>\$968,743,128</b>	<b>\$434,824,579</b>	<b>\$486,277,242</b>	<b>\$968,743,128</b>	<b>-\$2,185,362,574</b>
<b>Total Project Capital Costs</b>	<b>\$2,531,261,806</b>	<b>\$2,392,390,045</b>	<b>\$4,923,651,851</b>	<b>\$1,389,033,535</b>	<b>\$1,301,614,436</b>	<b>\$2,738,289,278</b>	<b>\$1,389,033,535</b>	<b>\$1,301,614,436</b>	<b>\$2,738,289,278</b>	<b>-\$2,185,362,574</b>

## Self-Directed Care Cost Assumptions

It is assumed that self-directed care will only be provided as part of the new proposed model. It is estimated that 7,075 continuing care clients (6.3 per cent of total clients) will access services through the self-directed care model by 2030. It is assumed that self-directed care clients will be funded up to 80 per cent of the assessed cost to receive care in typical setting, and that the costs of administering and monitoring these services will be an additional 10 per cent of funded service costs.

Stream	% of Clients in SDC Model 2025	% of Clients in SDC Model 2035	Number of SDC Clients in 2025 Proposed Model	Number of SDC Clients in 2030 Proposed Model	Annual Projected Service Cost Per Client	Annual Projected Admin Cost Per Client	Annual Total Projected Cost per Client	Projected Cost SDC Clients 2025	Projected Costs SDC Clients 2030	Rate of Service Funding Provided	Admin/Monitoring Costs as % of Service Costs
LTC	0%	0%	0	0	\$59,118	\$5,912	\$65,030	\$0	\$0	80%	10%
DSL4D	2%	5%	91	282	\$46,513	\$4,651	\$51,164	\$4,680,478	\$14,448,699	80%	10%
DSL 4	5%	10%	444	1,091	\$42,845	\$4,285	\$47,130	\$20,916,075	\$51,427,601	80%	10%
DSL3	5%	10%	79	166	\$29,223	\$2,922	\$32,146	\$2,552,368	\$5,345,829	80%	10%
LTHC - Current/Basic	3%	7%	1,318	3,143	\$10,220	\$1,022	\$11,242	\$14,814,854	\$35,333,496	80%	10%
LTHC Future - Moderate	3%	7%	251	1,196	\$14,600	\$1,460	\$16,060	\$4,026,860	\$19,208,160	80%	10%
LTHC Future - Complex	3%	7%	251	1,196	\$32,704	\$3,270	\$35,974	\$9,020,166	\$43,026,278	80%	10%
<b>Total</b>			<b>2,434</b>	<b>7,075</b>				<b>\$56,010,802</b>	<b>\$168,790,063</b>		
<b>% of All Clients</b>			<b>2.7%</b>	<b>6.3%</b>							

Based on these assumptions, the annual costs of funding and monitoring self-directed care for these 7,075 clients is estimated to be \$23 million lower than if they received similar care in typical settings.

### Projected Cost Difference for SDC Clients

Stream	Projected Costs For Clients in Not in SDC 2025	Cost Difference 2025 SDC versus Not in SDC	Projected Costs For Clients in Not in SDC 2030	Cost Difference 2030 SDC versus Not in SDC
LTC	\$0	\$0	\$0	\$0
DSL4D	\$5,318,725	-\$638,247	\$16,418,976	-\$1,970,277
DSL 4	\$23,768,267	-\$2,852,192	\$58,440,455	-\$7,012,855
DSL3	\$2,900,418	-\$348,050	\$6,074,806	-\$728,977
LTHC - Current/Basic	\$16,835,062	-\$2,020,207	\$40,151,700	-\$4,818,204
LTHC Future - Moderate	\$4,575,977	-\$549,117	\$21,827,454	-\$2,619,295
LTHC Future - Complex	\$10,250,189	-\$1,230,023	\$48,893,498	-\$5,867,220
<b>Total</b>	<b>\$63,648,638</b>	<b>-\$7,637,837</b>	<b>\$191,806,889</b>	<b>-\$23,016,827</b>

## Indigenous FBCC Space and Service Assumptions

According to Indigenous Services Canada (ISC) there were 6,996 registered First Nations over the age of 60 years old living on-reserve in Alberta in 2019. The population in this demographic is expected to grow to 11,552 in 2030. Based on recent submission requests for FBCC services from 12 First Nations, the ratio of people aged 60 years and older per FBCC space is 7.6. Applying this ratio to the projected population of First Nations 60 years and older in 2030 results in a projected need for 1,528 FBCC spaces by the year 2030. Assuming that 72 per cent<sup>6</sup> of those requiring FBCC services choose to receive services on-reserve, there will be a need for 1,100 FBCC spaces by 2030.

<b>First Nation Community Requirements</b>	<b>2025</b>	<b>2030</b>
Projected 60+ Population	9,196	11,552
60+ Population/Space	7.6	7.6
Projected Spaces	1,217	1,528
% that will prefer to stay on-reserve	72%	72%
<b>Number of Spaces Required First Nations</b>	<b>876</b>	<b>1,100</b>

Based on data provided in the Metis Settlement and First Nations in Alberta Community Profiles (January 2021 update), the total population for Metis settlements is 5,632. Based on 2016 Census data, it is assumed that 6.1 per cent of the population, or 344 people, are 65 years or older, and that the population of this age group will grow to 1,371 by the year 2030. Assuming that the ratio of people aged 65 years and older per FBCC space is 7.6, results in a need for 181 FBCC spaces by the year 2030. If 72 per cent of those requiring FBCC services choose to receive services on-settlement, there will be a need for 130 FBCC spaces by 2030.

<b>Metis Settlement Requirements</b>	<b>2025</b>	<b>2030</b>
Population 65+	687	1,371
65+ Population/Space	7.6	7.6
Projected Spaces	91	181
% that will prefer to stay in settlement	72%	72%
<b>Number of Spaces Required Metis Settlements</b>	<b>66</b>	<b>130</b>

Based on the above analysis, it is estimated that there is a need for 1,230 FBCC spaces by the year 2030 to better meet the needs of Indigenous people in Alberta. Given that there are currently 142 existing FBCC spaces specific for Indigenous communities in Alberta, the total need for new FBCC spaces is 1,088. The total estimated capital costs to develop these 1,088 FBCC spaces is \$524 million. The projected annual operating costs for these spaces by the year 2030 is approximately \$46 million if 744 of the 1,088 FBCC spaces are developed and are in operation.

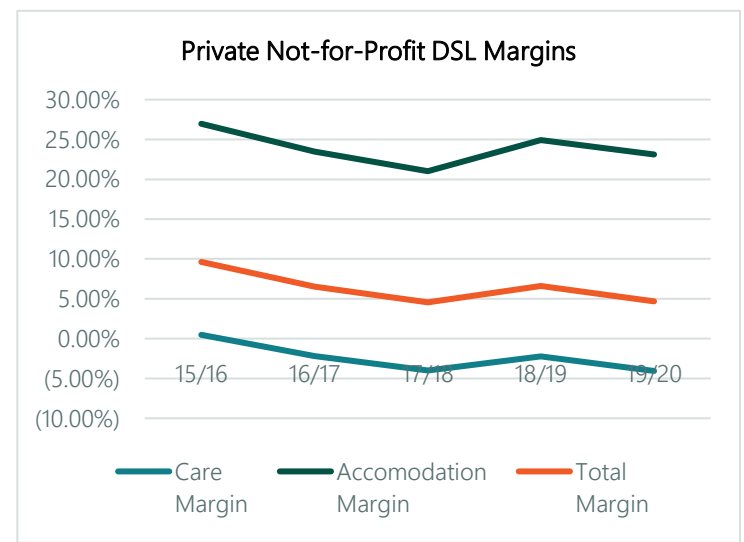
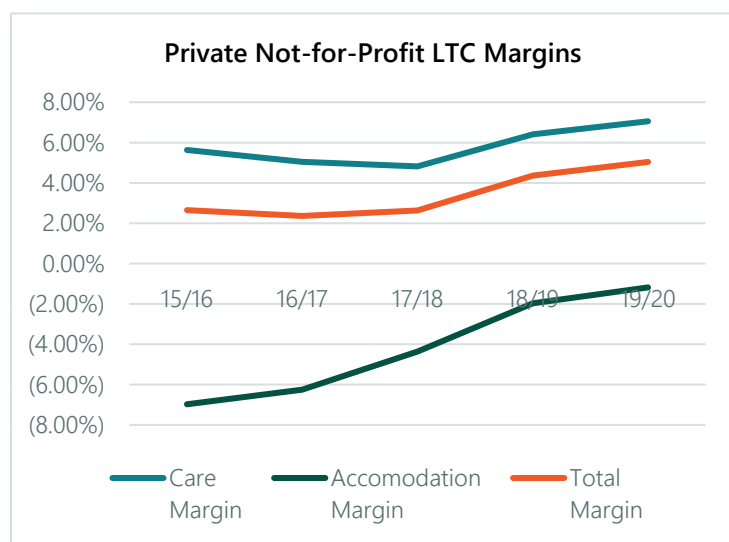
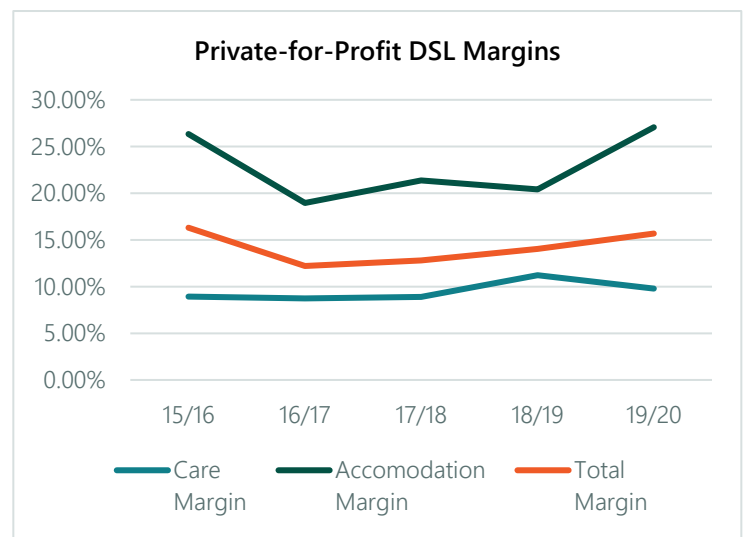
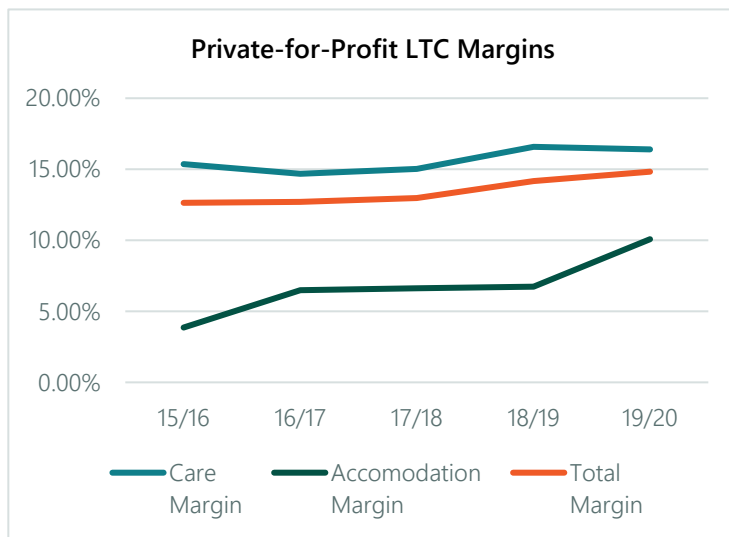
<sup>6</sup> Based on other recent planning projects with Ontario First Nations.

Variable	2021 - 2025	2026-2030	Cumulative 2030
Number of Spaces Developed	400	688	1,088
Cost per Space to Develop	\$481,500	\$481,500	
% of Costs Paid by GoA	100%	100%	
<b>Total Development Costs</b>	<b>\$192,600,000</b>	<b>\$331,272,000</b>	<b>\$523,872,000</b>
Percent of Spaces LTC	20%	20%	
Percent of Spaces DSL4/4D	40%	40%	
Percent of Spaces DSL3	40%	40%	
Number of LTC Spaces	80	138	
Number of Spaces DSL4/4D	160	275	
Number of Spaces DSL3	160	275	
Operating Cost/LTC Space (Includes increased hours)	\$92,796	\$92,796	
Operating Cost/DSL4/4D Space (Includes increased hours)	\$70,612	\$70,612	
Operating Cost/DSL3 Space (Includes increased hours)	\$36,529	\$36,529	
<b>Projected Operating Costs</b>	<b>2025</b>	<b>2030</b>	
Percent of New Spaces in Operation	50%	50%	
Number of Spaces in Operation LTC	40	149	
Number of Spaces in Operation DSL4/4D	80	298	
Number of Spaces in Operation DSL3	80	298	
<b>Total in Operation</b>	<b>200</b>	<b>744</b>	
<b>Total Projected Annual Operating Costs</b>	<b>\$12,283,110</b>	<b>\$45,693,171</b>	

## Accommodation Fee Analysis

The final component of the financial model was the analysis of accommodation fee margins for private-for-profit DSL and LTC operators as well as private not-for-profit DSL and LTC operators. The purpose of the analysis was to examine potential debt-service structures that operators could support for future FBCC space replacement and development, based on continuing with the current approach of increasing accommodation fees based the core inflation rate in Alberta over the next 10 years. The analysis assumes that all debt-service costs should be covered by the accommodation fee margin only and assumes that care margins should not be used for the purpose of covering debt-service expenses and used for funding care only.

Trends for the accommodation margins, care margins, and total margins for private-for-profit and private not-for-profit FBCC operators is provided below.





Assuming that accommodation fees increase by an average of 1.8 per cent per year over the next 10 years, based on the average core inflation rate in Alberta (previous 5 years), it is estimated that private-for-profit LTC operators could sustain a financing structure for developing LTC spaces whereby 50 per cent of their portion of development costs are financed through debt (assuming 35 years amortization, and an interest rate of 2.45 per cent) by the year 2027 (as measured by the ability to maintain a debt-service coverage ratio (DSCR) of 1.25 or higher). However, private not-for-profit LTC operators will not achieve a DSCR of 1.25 by the year 2030 under the same conditions, suggesting for the need to provide higher up-front capital grant funding to these operators to fund capital development costs.

<b>Operator Debt Calculation Assumptions</b>	<b>Private-For Profit LTC</b>	<b>Private Not-For Profit LTC</b>
Average Development Cost per Space (operator portion)	\$180,000	\$168,700
% of Development Cost Debt Financed	50.0%	50.0%
<b>Average Debt per Developed Space</b>	<b>\$90,000</b>	<b>\$84,350</b>
Term (years) on Debt	35	35
Rate of Borrowing	2.45%	2.45%
<b>Annual Debt Payment per Space</b>	<b>\$3,832</b>	<b>\$3,591</b>
Annual Debt Payment per Space per Day	\$10.50	\$9.84

Bank will require debt-service coverage ratio (DSCR) of 1.25

<b>Marginal Analysis (LTC Sites)</b>	<b>Private-For Profit Accommodation Margin</b>	<b>DSCR Private-for Profit</b>	<b>Private Not-For Profit Accommodation Margin</b>	<b>DSCR Private Not-for Profit</b>
Average Daily Accommodation Margin (Current)	\$6.35	0.60	-\$0.76	-0.08
Projected Margin 2021	\$6.86	0.65	-\$0.25	-0.03
Projected Margin 2022	\$8.02	0.76	\$0.91	0.09
Projected Margin 2023	\$9.20	0.88	\$2.09	0.21
Projected Margin 2024	\$10.40	0.99	\$3.30	0.34
Projected Margin 2025	\$11.63	1.11	\$4.52	0.46
Projected Margin 2026	\$12.87	1.23	\$5.77	0.59
Projected Margin 2027	\$14.14	1.35	\$7.04	0.72
Projected Margin 2028	\$15.43	1.47	\$8.33	0.85
Projected Margin 2029	\$16.75	1.60	\$9.65	0.98
Projected Margin 2030	\$18.09	1.72	\$10.99	1.12

The same analysis for private-for-profit DSL operators shows that the accommodation fee margin is already sufficient to support debt-financing to fund 50 per cent of their portion of development costs for a DSL space, and private-not-for-profit DSL operators could support the same level of debt financing by the year 2022.

<b>Operator Debt Calculation Assumptions</b>	<b>Private-For Profit DSL</b>	<b>Private Not-For Profit DSL</b>
Average Development Cost per Space (operator portion)	\$180,000	\$205,814
% of Development Cost Debt Financed	50.0%	50.0%
<b>Average Debt per Developed Space</b>	<b>\$90,000</b>	<b>\$102,907</b>
Term (years) on Debt	35	35
Rate of Borrowing	2.45%	2.45%
<b>Annual Debt Payment per Space</b>	<b>\$3,832</b>	<b>\$4,382</b>
Annual Debt Payment per Space per Day	\$10.50	\$12.00

Bank will require debt-service coverage ratio (DSCR) of 1.25

<b>Marginal Analysis (DSL Sites)</b>	<b>Private-For Profit Accommodation Margin</b>	<b>DSCR Private-for Profit</b>	<b>Private Not- For Profit Accommodation Margin</b>	<b>DSCR Private Not- for Profit</b>
Average Daily Accommodation Margin (Current)	\$16.51	1.57	\$13.95	1.16
Projected Margin 2021	\$17.00	1.62	\$14.43	1.20
Projected Margin 2022	\$18.10	1.72	\$15.53	1.29
Projected Margin 2023	\$19.23	1.83	\$16.64	1.39
Projected Margin 2024	\$20.38	1.94	\$17.77	1.48
Projected Margin 2025	\$21.55	2.05	\$18.93	1.58
Projected Margin 2026	\$22.73	2.17	\$20.10	1.67
Projected Margin 2027	\$23.94	2.28	\$21.30	1.77
Projected Margin 2028	\$25.18	2.40	\$22.52	1.88
Projected Margin 2029	\$26.43	2.52	\$23.76	1.98
Projected Margin 2030	\$27.71	2.64	\$25.02	2.08

# Appendix 3: RUG-III Categories and CMI

## 2020/21 Long-Term Care Alberta CMI Values

Based on Calendar Year 2019 LTC Data

Thursday, March 12, 2020

Province	RUG Rank	RUG Major Category	RUG Category	RUG Category	Year	CMI
AB	1	Ultra High Rehabilitation	Ultra high rehabilitation ADL 16-18	RUC	2020	2.1846
AB	2	Ultra High Rehabilitation	Ultra high rehabilitation ADL 9-15	RUB	2020	1.7840
AB	3	Ultra High Rehabilitation	Ultra high rehabilitation ADL 4-8	RUA	2020	1.5716
AB	4	Very High Rehabilitation	Very high rehabilitation ADL 16-18	RVC	2020	1.7271
AB	5	Very High Rehabilitation	Very high rehabilitation ADL 9-15	RVB	2020	1.6237
AB	6	Very High Rehabilitation	Very high rehabilitation ADL 4-8	RVA	2020	1.3639
AB	7	High Rehabilitation	High rehabilitation ADL 13-18	RHC	2020	1.7212
AB	8	High Rehabilitation	High rehabilitation ADL 8-12	RHB	2020	1.4969
AB	9	High Rehabilitation	High rehabilitation ADL 4-7	RHA	2020	1.2818
AB	10	Medium Rehabilitation	Medium rehabilitation ADL 15-18	RMC	2020	1.7719
AB	11	Medium Rehabilitation	Medium rehabilitation ADL 8-14	RMB	2020	1.4891
AB	12	Medium Rehabilitation	Medium rehabilitation ADL 4-7	RMA	2020	1.3385
AB	13	Low Rehabilitation	Low rehabilitation ADL 14-18	RLB	2020	1.4281
AB	14	Low Rehabilitation	Low rehabilitation ADL 4-13	RLA	2020	1.0529
AB	15	Extensive Care Services	Extensive care # of services 4-5	SE3	2020	1.8979
AB	16	Extensive Care Services	Extensive care # of services 2-3	SE2	2020	1.5540
AB	17	Extensive Care Services	Extensive care # of services 0-1	SE1	2020	1.3475
AB	18	Special Care	Special care ADL 17-18	SSC	2020	1.2983
AB	19	Special Care	Special care ADL 15-16	SSB	2020	1.2108
AB	20	Special Care	Special care ADL 4-14	SSA	2020	1.1543
AB	21	Clinically Complex	Clinically complex ADL 17-18 Depression	CC2	2020	1.3075
AB	22	Clinically Complex	Clinically complex ADL 17-18 No Depression	CC1	2020	1.1410
AB	23	Clinically Complex	Clinically complex ADL 12-16 Depression	CB2	2020	1.0557
AB	24	Clinically Complex	Clinically complex ADL 12-16 No Depression	CB1	2020	0.9803
AB	25	Clinically Complex	Clinically complex ADL 4-11 Depression	CA2	2020	0.9549
AB	26	Clinically Complex	Clinically complex ADL 4-11 No Depression	CA1	2020	0.8523
AB	27	Cognitively Impaired	Cognitively impaired ADL 6-10 Nursing 2	IB2	2020	0.8125
AB	28	Cognitively Impaired	Cognitively impaired ADL 6-10 Nursing 0-1	IB1	2020	0.7836
AB	29	Cognitively Impaired	Cognitively impaired ADL 4-5 Nursing 2	IA2	2020	0.6626
AB	30	Cognitively Impaired	Cognitively impaired ADL 4-5 Nursing 0-1	IA1	2020	0.6147
AB	31	Behaviour Problems	Behaviour problems ADL 6-10 Nursing 2	BB2	2020	0.8005
AB	32	Behaviour Problems	Behaviour problems ADL 6-10 Nursing 0-1	BB1	2020	0.7609
AB	33	Behaviour Problems	Behaviour problems ADL 4-5 Nursing 2	BA2	2020	0.6436
AB	34	Behaviour Problems	Behaviour problems ADL 4-5 Nursing 0-1	BA1	2020	0.5462
AB	35	Reduced Physical Function	Reduced physical function ADL 16-18 Nursing 2	PE2	2020	0.9432
AB	36	Reduced Physical Function	Reduced physical function ADL 16-18 Nursing 0-1	PE1	2020	0.9224
AB	37	Reduced Physical Function	Reduced physical function ADL 11-15 Nursing 2	PD2	2020	0.8617
AB	38	Reduced Physical Function	Reduced physical function ADL 11-15 Nursing 0-1	PD1	2020	0.8410
AB	39	Reduced Physical Function	Reduced physical function ADL 9-10 Nursing 2	PC2	2020	0.7797
AB	40	Reduced Physical Function	Reduced physical function ADL 9-10 Nursing 0-1	PC1	2020	0.7567
AB	41	Reduced Physical Function	Reduced physical function ADL 6-8 Nursing 2	PB2	2020	0.5795
AB	42	Reduced Physical Function	Reduced physical function ADL 6-8 Nursing 0-1	PB1	2020	0.5807
AB	43	Reduced Physical Function	Reduced physical function ADL 4-5 Nursing 2	PA2	2020	0.5542
AB	44	Reduced Physical Function	Reduced physical function ADL 4-5 Nursing 0-1	PA1	2020	0.5275
AB		BC1	Not elsewhere classified	BC1	2020	0.5275
AB		BC2	Not elsewhere classified within 14 days	BC2	2020	1.1264

## Appendix 4: References

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