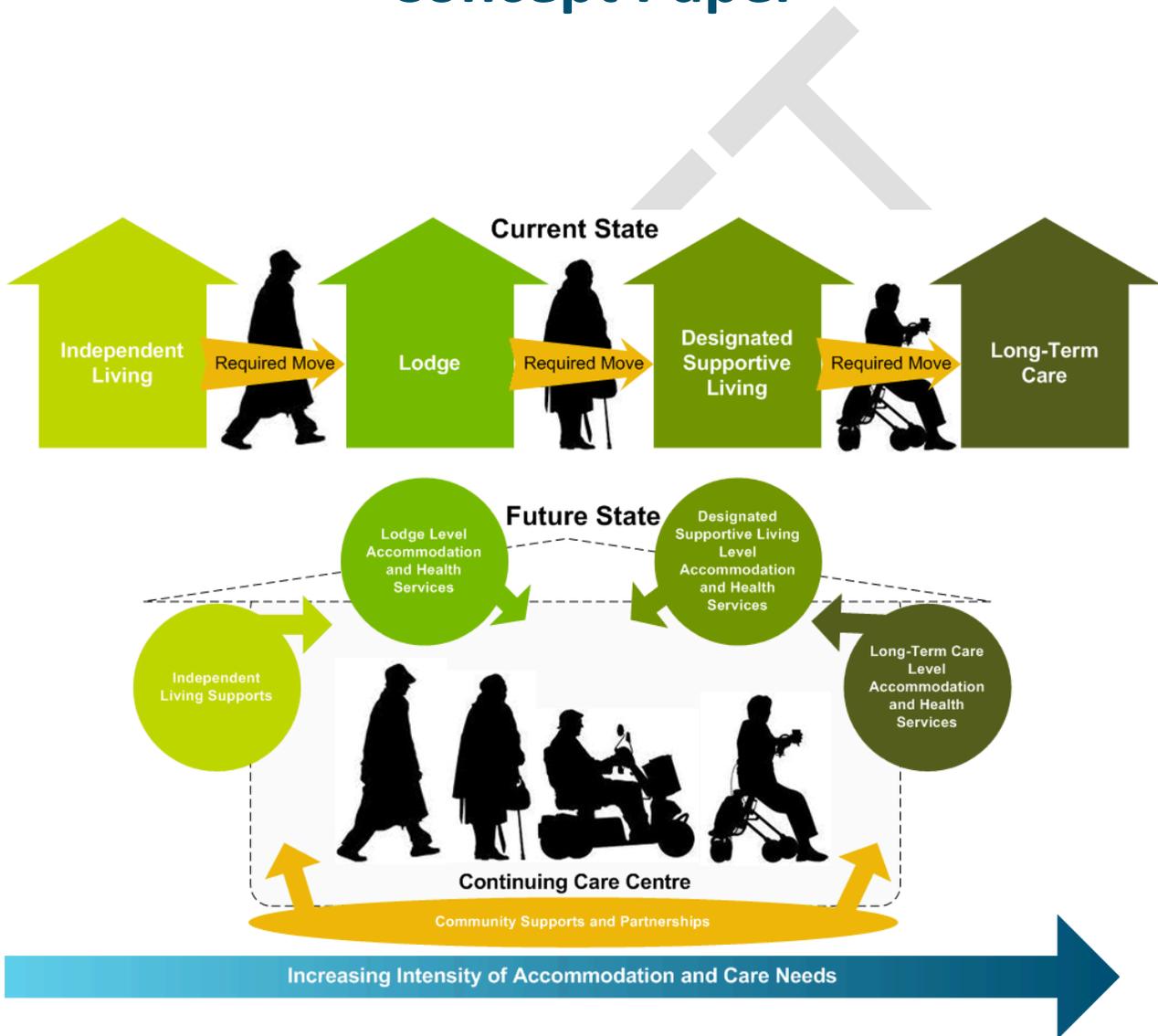


Moving Continuing Care Centres Forward: Concept Paper



Alberta Health

Draft – June 20, 2012

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Purpose of Document

The purpose of this document is to define the Continuing Care Centre concept, by establishing the overarching vision, high-level goals and key elements for their implementation in Alberta. This document will outline the Continuing Care Centres concept which will be validated through consultation and implemented through demonstration projects.

In addition, future work will include a gap analysis and the identification of operational requirements including barriers and options required to fully implement Continuing Care Centres.

Background

In December 2008, the Government of Alberta released the *Continuing Care Strategy: Aging in the Right Place*, which included strategies that build infrastructure to provide more options and improve choice and availability as to where Albertans receive services, as well as fund individuals based on needs.

Continuing Care Centres are a key component to further implementation of the Continuing Care Strategy and are a natural extension of this work. The implementation of Continuing Care Centres will address three issues which currently require individuals (including seniors and persons with disabilities) to move between continuing care settings:

- Access - appropriate service provision is not available in the individual's place of residence and/or community as health care needs change.
- Appropriateness - the site is not designed, functionally or physically, to support the care of individuals with increased needs.
- Resources - the continuing care provider identifies a lack of sufficient resources to deliver the required increase in health care services.

A number of Alberta's continuing care operators have developed innovative service delivery approaches that enable residents to remain in the same facility or on the same site with their family and friends as their care needs increase, but face barriers related to operational and directional policies and legislation. There are also operators who are well-positioned to support their residents to age in place but lack the supports required to do so. In order to support Albertans to age in place, this work will identify challenges limiting the implementation of Continuing Care Centres and develop the provincial policy and operational processes required for successful implementation.

Continuing Care Centres will operate within the continuing care system alongside other existing supports, services and accommodations. Continuing care services will continue to be provided in a variety of settings, including, but not limited to Continuing Care Centres.

Link to Ongoing Work

Alberta Health directs the building and expansion of the continuing care system in Alberta. Alberta Health Services and other continuing care service providers and facility operators are essential partners in the delivery of continuing care. In addition, Alberta Health Services is an integral partner in the implementation of continuing care strategies. In completing the task of defining Continuing Care Centres, Alberta Infrastructure and Alberta Municipal Affairs were also approached to collaborate on the Continuing Care Centres initiative.

Through this collaborative process, a number of current initiatives were identified which are expected to run parallel to this work and which are key to the achievement of the Continuing Care Centre mandate.

Alberta Health, Alberta Infrastructure, Alberta Municipal Affairs and Alberta Health Services are working together to:

- Discuss the next steps for the completion of the Continuing Care Strategy implementation.
- Finalize the continuing care capacity demand planning model which enables the projection of continuing care capacity demands.
- Ensure the appropriate building codes and standards are applied and developed for the Continuing Care Centres.

In addition, the following initiatives, which are currently underway within various ministries and Alberta Health Services, are central to the development of Continuing Care Centres:

Alberta Health

- Provision of capital funding for affordable supportive living (ASLI).
- Review and update of Alberta Aids to Daily Living program.
- Continued implementation of the Alberta Continuing Care Information System and the interRAI tools (MDS 2.0 and RAI-HC).
- Review and update of the Home Care Regulations.
- Revision of the Continuing Care Health Service Standards.
- A review of the inspections and compliance processes for standards in continuing care facilities was undertaken in early 2012. The purpose of this review was to provide recommendations to simplify or consolidate the inspection process.

Alberta Health and Alberta Health Services

- Implementation and utilization of the interRAI suite of tools (Contact Assessment, MDS 2.0 and RAI-HC) including client assessment protocols, care planning, quality indicators and Resource Utilization Groups (RUGs).
- Development and implementation of Patient Based Funding linked to assessed health care need.
- Examination of the provision of continuing care services, including Home Care service redesign, supportive living and long-term care capacity and end-of-life/palliative services.
- Implementation of the “Coordinated Access to Publicly Funded Continuing Care Health Services: Directional and Operational Policy” to support an integrated, streamlined continuing care system.

Alberta Municipal Affairs

- Implementation of the five year regeneration and renewal plan for government owned social housing, including lodge and seniors self-contained units.

Alberta Infrastructure

- Provision of advice and guidance in the procurement, design and construction of health facilities.
- Guidance in the revision and implementation of design guidelines for continuing care.

Vision

It is recognized that the term “continuing care centre” has been previously used in Alberta to describe a variety of different settings or models. For the purpose of this mandated initiative and its implementation, Continuing Care Centres:

- provide an integrated and seamless approach to the provision of continuing care services;
- promote independence and offer choice through the provision of an array of health, personal care and accommodation services in one location (a single building or a cluster of buildings on the same site);
- bring services and care to the client and adjust as needs change rather than the client having to move to another setting, as appropriate;
- enable seniors and persons with disabilities to maintain wellness and improve their quality of life;
- are supported by a comprehensive and robust home care program; and
- have strong community linkages.

Principles

In November 2010, the Government of Alberta released the *Aging Population Policy Framework* which outlines the following principles for the development of policies, programs and services that meet the changing needs of Alberta's aging population. These principles are the basis for the Continuing Care Centre model:

- *Fair and equitable to future generations.*
 - Addressing the needs and priorities of Alberta's aging population should be done in ways that are fair and equitable to future generations of Albertans; and should not place a disproportionate tax burden on future generations.
- *Collaborative with communities.*
 - Communities are key partners in addressing the needs of Albertans as they age. The Alberta government should seek to collaborate in appropriate ways with the private sector, non-profit and voluntary sector, municipal governments, and other community partners, to identify and respond to the needs and priorities of an aging population.
- *Respectful of individual choice.*
 - The Alberta government should respect the choices of aging Albertans and their families, facilitate and support the ability of Albertans to make decisions and individual choices as they age, and encourage and inform Albertans in planning and preparing for their future needs.
- *Aimed at encouraging the independence of Albertans.*
 - The Alberta government should encourage and support independence, self-reliance and self-determination among Albertans throughout their lives, facilitate and support individual responsibility, and support families in helping aging Albertans maintain their independence.
- *Proactive and flexible to changing circumstances.*
 - The Alberta government should examine, review and adapt to the changing needs and priorities of Alberta's aging population on an ongoing basis, and assess policies, programs and services to determine if they have sufficient flexibility and capacity to respond to these changing circumstances.
- *Aligned towards achieving outcomes.*
 - Ministries should collaborate effectively to address the needs of Alberta's aging population in a coordinated fashion, and align their policies and programs towards achieving Alberta's desired outcomes in preparing for an aging population.
- *Affordable to taxpayers.*
 - Policies, programs and services aimed at meeting the needs and priorities of Alberta's aging population must be sustainable and affordable to taxpayers over the long term.
- *Effective and efficient at achieving intended objectives.*

- The Alberta government should strive to design and deliver programs and services in ways that make efficient and effective use of resources, and that have a meaningful impact in achieving outcomes for Alberta's aging population.
- *Structured to assist Albertans most in need.*
 - Alberta government-funded programs, services and mechanisms should be designed to focus on assisting disadvantaged and vulnerable Alberta seniors so that they can meet their basic needs and remain safe and secure.
- *Informed by evidence and input.*
 - The development of policies, programs and services should be informed by evidence to effectively reflect changing demographic and socio-economic factors. The input of Albertans and those involved in addressing the needs of aging Albertans should also help to inform the development of Alberta government actions concerning the aging population.

In addition to the above principles, publicly funded continuing care health services will continue to be provided to all Albertans based on assessed need.

Goals

Continuing Care Centres will support individuals to age in place by:

- Allowing individuals to remain in one location when their health and personal care needs change minimizing the need to move to a new physical setting.
- Providing the opportunity to continue to live as a couple and with or nearby family/friends, if they wish, even when their types or amount of health care needs differ, as appropriate.
- Supporting independence and encouraging participation in social and spiritual activities including those in the larger community.
- Respecting their well-being, dignity and privacy at every stage of life.
- Enabling flexible responses to their needs and wishes.

Continuing Care Centres provide holistic, quality, person-centred services by:

- Establishing and maintaining supportive relationships with individuals and families.
- Ensuring that team members know their roles and responsibilities and work to support one another in delivering the best possible accommodation and care supports to the people they serve.
- Working together with individuals and their families to develop and implement a collaborative service plan that meets the individuals' needs and preferences.

- Offering long-term residency within or as close to the client's community as possible.
- Addressing expectations by providing greater choice.

Continuing Care Centres will engage with the community by:

- Involving Continuing Care Centres and their residents as part of community development and planning.
- Encouraging the use of an integrated approach to planning community programs.
- Establishing partnerships in order to accommodate increasing needs within the site or community. Such inter-agency collaboration will strengthen opportunities for community or geographically based support networks and establish the Continuing Care Centre within community hubs.

Continuing Care Centre Core Elements

Continuing Care Centres will provide a range of co-located housing options and provide access to accommodation, hospitality services, professional health, personal care and community living support services. In order to meet the goals outlined above, Continuing Care Centres will have the following core elements:

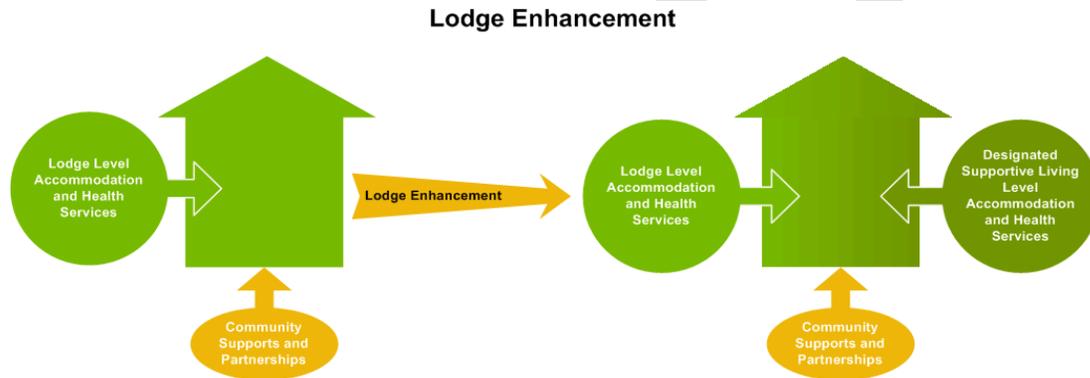
- A physical structure that is flexible in order to meet the range of service delivery needs.
- A wide array of services within safe and secure accommodations.
- Enhanced choice in living environments and the option to obtain additional amenities or services beyond those funded by government.
- A flexible and integrated approach to service delivery allowing clients to age in place with services coming to the individual when care needs change.
- The ability to provide services to individuals with complex health care needs.
- A strategy to maximize individual and family engagement.
- A plan for community engagement and partnerships.

Appendix A provides additional details on the elements of a Continuing Care Centre. Appendix B presents future state scenarios illustrating the benefits of Continuing Care Centres.

Continuing Care Centre Models

Although the core elements must exist in order for a site to be considered a Continuing Care Centre, the actual physical environments and configurations of Continuing Care Centres may vary. Within existing continuing care capacity there is opportunity for different delivery in the demonstrations and implementation of Continuing Care Centres. These include:

1. Lodge Enhancement - Enhancing accommodation and health services within lodges to a designated supportive living level of care in order to allow existing residents to receive enhanced services as their health and accommodation needs change, minimizing moves to other settings or communities.

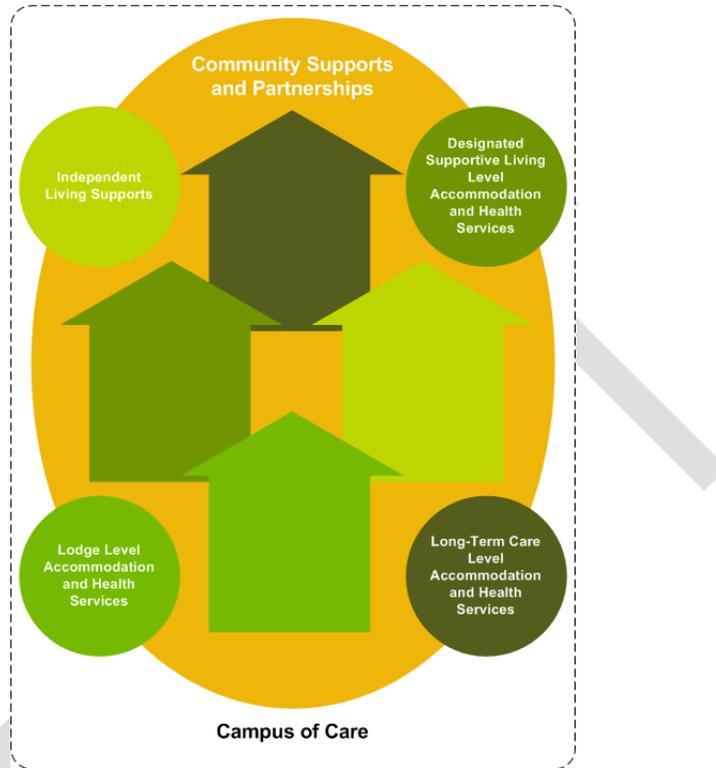


2. Single Building – A single building Continuing Care Centre would provide a range of accommodation and care options within one building, allowing residents to receive a range of services on-site, minimizing moves to other settings or communities.

Single Building Continuing Care Centre



3. Campus of Care – A campus of care Continuing Care Centre would consist of a cluster of buildings on the same physical footprint or parcel of land which, together, provide an array of continuing care accommodation and care options, supporting couples to remain together and clients to age in place.



All of these models would have linkages to community supports and partnerships with community programs and organizations and whenever possible are co-located with a residential community services such as shopping centres, recreational facilities, schools and churches.

Multiple demonstration projects for Continuing Care Centres will identify and validate the appropriateness of creating Continuing Care Centres using existing and new capacity to test and develop operational policies for the delivery of care and accommodation services in the Centres. There is value in testing a variety of delivery models for Continuing Care Centres to reflect opportunities based on the population in the catchment area, the setting and the needs of individual residents. For that reason, it is important to test Continuing Care Centres in both rural and urban communities.

Appendix A: Continuing Care Centre Core Elements

Continuing Care Centres will provide the following:

<p>A physical structure that is flexible in order to meet the range of service delivery needs.</p>	<ul style="list-style-type: none"> ▪ Allow for the delivery of the range of accommodation and care options necessary. ▪ Apply and develop appropriate building codes and standards. ▪ The design of the structure will be developed to reflect the service delivery plan and the needs of each community.
<p>A wide array of services within safe and secure accommodations</p>	<ul style="list-style-type: none"> ▪ Provides access to an array of health and support services to a range of individuals, from those who are independent to those with complex health needs including: <ul style="list-style-type: none"> □ Accommodation/Hospitality services: safe and secure environment, building operations, food services, housekeeping and recreational and social opportunities within the site and the surrounding community. □ Community living support services: assistance with shopping, transportation and personal finances. □ Personal support services: assistance with eating, personal grooming, bathing, dressing, mobility, toileting and medication management. □ Professional health services: physician services, professional nursing services, allied health professionals and other health services (e.g., palliative supports). □ Case management services ▪ Assist the individual in self-management of chronic disease and promote wellness with supportive responses to unplanned health and personal support needs.
<p>Enhanced choice in living environment and the option to obtain additional amenities or services beyond those funded by government.</p>	<ul style="list-style-type: none"> ▪ Residents will have enhanced choice in the living environment in which they receive supports and services. ▪ Health services based on assessed need will be publicly funded. Additional services may be included as part of the person's accommodation fees or purchased at an additional charge. The funded and unfunded services must be standardized, clearly described and information will be shared with individuals prior to moving into the centre. ▪ All individuals in the continuing care centre will be subject to the same basic accommodation costs. Individuals will have the option to pay for enhanced accommodation, hospitality services, community living support services, personal support services or professional health services beyond those funded by government.
<p>A flexible and integrated approach to service delivery allowing clients to age in place with services coming to the individual when care needs change</p>	<ul style="list-style-type: none"> ▪ Shared/cooperative governance model, in the case of multiple operators and care providers. ▪ Collaboration among housing, support and health providers to coordinate care and services and to optimize efficiencies under a shared accountability model. ▪ Services may be provided or managed through an integrated relationship between the: <ul style="list-style-type: none"> □ Publicly funded health system. □ Operator: provides services within contract. □ Community: services provided external to the operator or those publicly funded. □ Individual: self-directed care. □ Family or the individual's personal support network. ▪ Service providers work together under a shared management agreement. ▪ Health services are provided by a multi-disciplinary team of health professionals working to their full scope of practice. ▪ Care and services provided to the client minimizing moves to different settings/communities as care needs change. ▪ Unregulated providers (hospitality, community living and personal supports) are trained and supervised accordingly.

The ability to provide services to individuals with complex health care needs	<ul style="list-style-type: none"> ▪ Where there is value added, utilize technology to enhance and support care delivery, for the potential benefit of the individual, family/friend caregiver and formal caregiver. Technologies will also allow for better use of the multi-disciplinary team’s resources.
A strategy to maximize individual and family engagement	<ul style="list-style-type: none"> ▪ Involvement of family members and volunteers as active participants. ▪ Support couples/families to remain together.
A plan for community engagement and partnerships	<ul style="list-style-type: none"> ▪ Active integration and involvement with the surrounding community. ▪ Co-location of community health services and programs (e.g., day programs, caregiver support programs, etc.) or services such as community centre, educational centre, library, indoor and outdoor recreation facilities, child care, shopping and dining establishments, where appropriate.

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Appendix B: Scenarios of the Future – Continuing Care Centres

Scenario 1 – Sophie & May

Sophie and May are sisters who never married and do not have children. They have lived in the same apartment building most of their adult lives.

May, who is 59 years old, has Multiple Sclerosis. May has been able to live in her apartment with the support of home care and her sister. However, May's disease has progressed to the point that she requires 24/7 unscheduled care and home care is no longer able to provide the necessary health care services and supports required. Sophie, at 68 years of age, is independent and capable of remaining in her apartment, although she has fallen twice at home and is cautious about leaving her building. Sophie does not drive, has difficulty getting around via public transportation and is unable to afford regular taxi rides. If May moves to a care facility without her, Sophie will have great difficulty visiting May regularly. The possibility of May and Sophie being separated is causing them great stress.

However, May and Sophie discover that they can both move into a Continuing Care Centre. In this facility, May is able to receive the assistance she requires and Sophie is able to live in the same building even though she is receiving no health care services or supports. May chooses to purchase an additional two baths per week, in addition to those provided as part of her assessed needs. Sophie is able to cook meals in her suite for them to share or they meet in the main dining room for a prepared meal. They are able to participate in recreational activities together and visit whenever they like.

This example illustrates that benefits achieved through Continuing Care Centres include:

- families/friends with differing care needs are able to remain together; and
- individuals experience flexible responses to their needs and wishes.

Scenario 2 – Paul

Paul is a 79 year old man who has a long history of chronic obstructive pulmonary disease. A few years ago, Paul's wife passed away which prompted him to move from the family farm to the Continuing Care Centre in a nearby rural community. Paul felt that he was unable to cook and clean for himself and chose to move to the Centre for assistance with these tasks, the ability to socialize with others and for medical oversight. Paul is on oxygen 24 hours per day and has to use inhalers four times a day. As Paul's disease progresses, he is no longer able to wheel himself to meals without becoming too tired to eat. His case manager suggests he receive additional supports, including assistance getting to the dining room for meals, transfer support when he is tired, and regular monitoring and support with his symptom management from the LPN. Because Paul lives in a Continuing Care Centre he is able to receive these additional supports without moving. In addition, an Arco rail is installed beside his bed to assist him with getting in and out of bed.

Paul's shortness of breath increases, so the health care aides in the facility begin to help him to wash and dress in the morning and he receives scheduled nebulizer treatments from the LPN and uses intermittent treatments as needed. A respiratory therapist and the community

pharmacist are regularly consulted as part of the multi-disciplinary care team. Paul goes out with his scooter in the summer around the block and he goes over to the seniors centre about once a month to play cards. As there is no public transportation in Paul's community, the Continuing Care Centre has partnered with the town to establish a handi-bus program for residents at the Centre and for seniors living in their own homes. The handi-bus drives Paul to the seniors centre and the Continuing Care Centre plans regular shopping trips for the residents using the handi-bus.

Paul now gets more frequent chest infections but is able to manage most of these with medications the doctor prescribes and which the LPN, Amy, delivers to him. Amy works with the RN who comes to check on any health or function changes and makes recommendations or refers Paul to the doctor. Paul's appetite declines so the dietician, who is part of the care team, makes changes to Paul's meal plan to address this.

As Paul's disease continues to progress, the services he receives are adjusted to meet his changing needs. Paul is experiencing increased chest infections resulting in multiple hospitalizations. His breathing is increasingly labored and eating is proving difficult. As a result, Paul has lost weight and is very lethargic. Based on Paul's pre-discussed goals of care, Paul's care team determine that he is approaching the end-of-life and, in consultation with Paul and his family members, begin to provide palliative care measures. Paul's chronic disease specialist and a palliative care team are consulted for symptom management when Paul's dyspnea becomes severe. The Nurse Practitioner is on-call for palliative emergencies. Ultimately, Paul passes away in the Continuing Care Centre.

This example illustrates that benefits achieved through Continuing Care Centres include:

- those with increasing care needs are able to age in place;
- linkages with the surrounding community are encouraged and supported;
- individuals with complex care needs are able to be supported, including the provision of end-of-life care; and
- individuals with complex symptoms can remain in their home environment with specialist consultation.

Scenario 3 – Lily & John

Lily and John live together in a two bedroom suite at a Continuing Care Centre. They chose a two-bedroom so their out-of-town children can stay with them when they visit. Lily and John moved to the Centre when John had a major stroke 1 year ago. John also has Type I diabetes and while in hospital developed an ulcer on his leg. He has no function on his left side and requires full assistance with a mechanical lift to transfer him from bed to chair. He is given medications by the LPN or RN on duty. The RN monitors his ulcer and recommends treatments which the LPN provides. The LPN checks his blood sugar as ordered by the doctor. There are health care aides who help with all transfers and personal care. The RN visits daily or as needed and the doctor visits once a month. The physical therapist regularly assesses John, and through the use of a physical therapy aide, has developed a program aimed at increasing John's strength post-stroke. John's swallowing was affected by the stroke and there have been times when he has choked on his pureed diet and required suctioning and immediate treatment. John is regularly seen by an occupational therapist to address his swallowing difficulties. When they

moved into the facility, Lily did not require assistance, but ate meals in the dining room with John and was able to assist John with some tasks, like grooming.

Over time the facility staff noticed that Lily was exhibiting some memory and cognitive deficits. She was getting lost in the building, forgetting to take her medications and was forgetting how to perform some daily activities, like dressing. Lily's doctor diagnosed her with dementia and the care staff at the facility began to provide assistance with some of her daily tasks. As Lily's disease progressed, Lily's care team and her children determined that she should move into the dementia care unit for her safety and specialized dementia care. Volunteers wheel John over to Lily's unit daily for a visit. Their children are able to visit both parents when they come to the facility.

This example illustrates that benefits achieved through Continuing Care Centres include:

- couples with differing care needs are able to remain together;
- those with increasing care needs are able to age in place; and
- individuals with complex care needs are able to be supported, including the provision of dementia care.