ALBERTA ASSOCIATION ON GERONTOLOGY

Older Albertans Living Well:

A Call to Action to Enhance Care and Services

September 2020

FORWARD

On behalf of the Alberta Association on Gerontology (AAG), I am pleased to submit this policy recommendation document, ***Older Albertans Living Well: A Call to Action to Enhance Care and Services,*** to government Ministers, policy makers, health and social service agency leaders. This document provides important information for consideration in developing long range directional policies and immediate actions to improve seniors care and services in Alberta.

2020 is an important time for Alberta to reflect on a new vision for seniors care and services for the next decade. Not only are we are experiencing a demographic surge of older adults with different lifestyles and choices compared to previous generations, but we have the opportunity to learn from the COVID-19 pandemic.

AAG started the process of future planning by holding Vision 2030 for Seniors Services Symposium in November 2019. The overwhelming consensus of participants for a new vision was: ***A future in which older Albertans are engaged, empowered and enabled to achieve quality of life through financial security, social connectedness and access to health care in inclusive communities*****.**

This document contains Directional Policy Recommendations as well as Immediate Actions Recommendations. Directional policies are broad policy objectives used to guide future initiatives and activities towards achieving the goal of the new vision, in this case, the seniors care and services sector in Alberta. Immediate actions are actions to be undertaken in the coming fiscal year (2021/22) to initiate changes towards the new vision.

The unexpected occurrence of the COVID-19 pandemic and its impact on older adults, is also discussed. The vulnerability of older persons and the subsequent number of deaths due to COVID-19, highlighted the shortcomings in Alberta's health and social service systems. This situation reinforces the need for all policy makers, professionals and citizens of Alberta to collaborate on their collective learnings to provide better and safer care to older Albertans in the future.

Although AAG doesn't have all of the solutions, we expect this document to stimulate discussion on what needs to be done to improve the seniors care and services system. We look forward to partnering and collaborating to champion necessary changes.

Respectfully Submitted,

Linda Stanger,
President, Alberta Association on Gerontology

ACKNOWLEDGEMENTS

Many Albertans have made the production of this policy recommendation document a reality. First and foremost, it is the result of the Pre-Symposium Consultation Sessions and Round Table Discussions of participants in the AAG Vision 2030 for Seniors Services Symposium held in November 2019. The goals for seniors care and services for Alberta, expressed as the vision, as well as the Directional Policies and Immediate Actions Recommendations in this policy document were based on the collective views of those who participated in the Symposium.

The document was developed and written by a group of experts with special knowledge in the field of aging policies, research and education. They include:

- Vivien Lai, Past President of AAG and Chairperson of the Collaborative Planning Committee.
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- Dr. Sharon Anderson, Research Coordinator, Family Medicine, Faculty of Medicine and Dentistry, University of Alberta.
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- Dr. Susan Slaughter, Associate Professor, Faculty of Nursing, University of Alberta.
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Sections of the report were also reviewed by a variety of experts, in particular, Safia Khalfan, Beth Mansell, Jennifer Chan, Mollie Cole, Ann Madeline Toohey, Dr. David Hogan, Beth Gorchynski, Dr. Haidong Liang, Carol Anderson, Carleen Brenneis, Dr. Konrad Fassbender, and Dr. James Silvius and Michelle Peterson-Fraser.

The AAG extends its sincere thanks to the writers and reviewers of this report for giving their time, as volunteers, and sharing their expertise in helping to develop the policy recommendations and immediate actions presented in this report. The AAG is grateful for their individual and collective contributions.

Note to Readers: The terms client, resident and patient are used throughout the report to reflect the use of each term in a particular context, whether Home Care, Supportive Living, Long Term Care, Acute and Medical Care.

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1 EXECUTIVE SUMMARY

1.1 WHY A NEW VISION IS NEEDED FOR SENIORS CARE AND SERVICES IN ALBERTA

Alberta's senior population is aging. The number of seniors is expected to reach a million by 2035. One in five Albertans in 2046 will be 65 or older. Persons over 80 years of age are expected to experience the most rapid growth. This age group is expected to place major demands on health care, Home Care, and Long-term Care (LTC) services.

The future population of seniors will have different characteristics than the current generation of older adults. They will be more educated, have higher incomes, desire choice and independence, and want to be active and engaged in the community. They are expected to contribute more in volunteer work, and have a higher labour force participation rate. More cultural diversity and a better knowledge of technology are also apparent. This new generation of seniors will have different lifestyle and service preferences and their choices will influence the future seniors services to be provided.

At the Vision 2030 Symposium, the Alberta Association of Gerontology consulted with Alberta seniors, their caregivers, health and social service professionals, educators and researchers on the kind of seniors services expected in the future. They advised AAG that their vision of seniors care and services was: ***A future in which older Albertans are engaged, empowered and enabled to achieve quality of life through financial security, social connectedness and access to health care in inclusive communities.***

1.2 HOW TO ACHIEVE THE PREFERRED FUTURE

The delivery of seniors care and services in all sectors needs to be improved and transformed to achieve the preferred future. This document sets out two types of recommendations for moving towards the vision: Directional Policy and Immediate Actions.

Directional Policy Recommendations are listed in **red**. Directional policies are broad policy objectives used to guide future initiatives and activities towards achieving the goal of the new vision, in this case, the seniors care and services sector in Alberta. **Immediate Actions Recommendations,** identified in **blue,** are actions to be undertaken in the coming fiscal year (2021/22) as short-term implementation steps to start moving towards the new vision.

1.3 SUMMARY OF DIRECTIONAL POLICY RECOMMENDATIONS AND IMMEDIATE ACTION RECOMMENDATIONS

Tables, beginning on the next page, provide a summary of the seven Directional Policy Recommendations and their associated Immediate Actions Recommendations.

1.0 Living Well in the Community

Home and Community Care is a priority and must be transformed to provide flexible and integrated packages of home and social services as part of an "integrated community care sector" to empower more seniors to receive services at home.

Alberta seniors value living at home and aging in the community as long as possible. The design and range of services need to be enhanced in all communities to enable this to happen.

DIRECTIONAL POLICY RECOMMENDATION

1.0 Improve the coordination and integration of care between primary care, Home Care and community services to help seniors live as independently as possible in the community.

IMMEDIATE ACTIONS RECOMMENDED FOR 2021/22

1.1 The Government of Alberta to increase the proportion of spending on Home Care and community-based service to approach 35% of LTC expenditures, the OECD average,[1] by reallocating funds from reducing emergency use/hospital admissions, keeping alternative levels of care beds constant, and reducing the proportion of LTC admission of people whose needs can be met in the community.

1.2 Alberta Health and Alberta Seniors and Housing to continue to support development of an Alberta-wide "Community-based Seniors Serving Sector".

1.3 To prepare for future waves of COVID-19 and future pandemics, the seniors serving sector, develop plans to meet the needs of vulnerable seniors to reduce social isolation, assist with transportation, and ensure access to basic needs/ food security.

1.4 Ensure Primary Care Networks are age-friendly health homes where a full interdisciplinary team works with Home Care teams to coordinate seniors' health and support services.

1.5 Improve care coordination by developing a standardized process for collaboration and referrals between Home Care case managers, primary care, and seniors serving agencies.

1.6 Promote the development of innovative design and delivery of services to ensure that seniors can age well.

1.7 Implement innovative Home Care projects that cut red tape and give seniors and their family caregivers choice and control over service delivery (e.g. Home Care Invoicing Model).

1.8 Enhance access to and evaluate home-based technologies using a value-based approach.

2.0 Living Well in Supportive Living

All innovative accommodation and housing options, including lodges, private and public assisted living and Designated Supportive Living (SL3, SL4 and SL4D), must be explored and expanded to address the increased need for supportive housing by an aging society.

DIRECTIONAL POLICY RECOMMENDATION

2.0 Enhance the ability of the supportive housing sector to facilitate aging in the community by promoting a person-centred model of care, supporting the ability of couples to age together, fostering a consistent, stable and capable workforce, and effectively employing technology to promote resident independence and staff effectiveness.

IMMEDIATE ACTIONS RECOMMENDED FOR 2021/22

2.1 Re-introduce a capital grant program to promote the redevelopment of aging senior citizen lodges and development of new supportive housing projects that blend independent supportive housing and Designated Supportive Living suites in a flexible model that promotes aging in place and helps couples age together, while eligible individuals receive assessed publicly funded health and personal support services.

2.2 Create mechanisms to promote workforce stability and continuity of care in supportive housing settings. Ideas include:

- **Appropriate compensation (wages and benefits) for Health Care Aides (HCAs) and other support staff in designated supportive living settings**
- **Increased hours for individual HCAs to enable them to be employed in a single continuing care site and avoid the need for employment across multiple continuing care sites**
- **Support for in-service training and professional development to maintain and improve competencies and provide opportunities for advancement**

2.3 Promote the implementation of assistive technologies in supportive housing and Designated Supportive Living settings to enhance the well-being of residents and improve the efficiency and effectiveness of staff.

2.4 Require all supportive housing and Designated Supportive Living projects to develop and implement a Pandemic Outbreak Plan, appropriate to the setting, in collaboration with Alberta Health Services and in consultation with residents and family members. The plan must provide ways in which select family and friends can provide support and essential care to residents as key care partners, while respecting the principles of outbreak prevention.

3.0 Living Well in Long-term Care Centres

Care in Long-term Care centres must be enhanced to provide safe and competent care to persons with complex health needs.

People who require a higher level of care that cannot be provided in the community will continue to require Long-term Care facilities in the future. The population served in Long-term Care facilities by 2030 will have much more complex needs than the current population and most will have dementia.

DIRECTIONAL POLICY RECOMMENDATION

3.0 Transform the Long-term Care facility system so that it provides person (resident)-centred, safe, quality services by competent staff, for residents who live in an environment that provides and promotes their quality of life.

IMMEDIATE ACTIONS RECOMMENDED FOR 2021/22

3.1 Implement resident-focused rounds on a weekly basis.

3.2 Mandate a minimum of 4.1 worked hours of direct care for 100 Case Mix Index (CMI) for Long-term Care facilities.

3.3 Build essential leadership capabilities in Long-term Care administrators for today's and tomorrow's leaders.

3.4 Create mechanisms to ensure a consistent, dedicated, and educated workforce.

3.5 Increase the use of consistent resident assignments.

3.6 Mandate annual continuing competency requirements for health care aides.

3.7 Develop a post-education course specific to health care aides and other frontline workers, focused on the needs of older residents in Long-term Care facilities; followed by an increase in compensation salary after successful completion of the course.

3.8 Support innovation in health care and evidence-based decisions through ensuring that each unit in a Long-term Care facility has a high-speed Internet computer, with electronic decision-making resources, and that all staff are trained in its use.

3.9 Implement lessons learned from the COVID-19 experience into a comprehensive provincial plan, with coordination and cooperation from all Long-term Care facilities in Alberta, to prevent and address infectious outbreaks.

3.10 Address the challenge of social isolation and loneliness caused by quarantine-imposed isolation.

3.11 Ensure an individual who has completed an endorsed infection and prevention control course[2], and is certified in infection control procedures, manages each facility's infection control program, with a central reporting system to Alberta Health Services.

3.12 Ensure every Long-term Care facility has a minimum of six weeks personal protective equipment supply for all staff and two visitors per resident.

3.13 Eliminate all three and four bed wards as an urgent priority.

3.14 Allocate capital funding to renovate old nursing homes to avoid over-crowding situation for residents.

3.15 Amend the *Design Guidelines for Continuing Care Facilities in Alberta* [3] to:

- **Ensure that all rooms are capable of being single isolation units**
- **Design groupings for smaller numbers of residents per household (12 to 14 residents) in Long-term Care facilities to facilitate social distancing and circulation of clean air**

4.0 Living Well with Restorative Care

Wellness and restorative care should be the philosophical approach for all services for seniors.

Physical activity and healthy lifestyles are well known as drivers for wellness. Recent research indicates that such activity is important across the lifespan, including older adults. It is not too late to start an exercise routine even at 80 years of age and beyond. Alberta studies have demonstrated the success of restorative care and exercise for older adults living in supportive housing and long-term care. Denmark has endorsed the Wellness, Restorative and Re-enablement Strategy as an essential element of their Seniors Strategy.

DIRECTIONAL POLICY RECOMMENDATION

4.0 All health services in Alberta implement a restorative care philosophy across the care continuum and all seniors' community services in Alberta promote active living and programs to mitigate sedentary behaviour. Special attention should be given to addressing the impact of social isolation imposed during outbreaks on activity levels of older adults.

IMMEDIATE ACTIONS RECOMMENDED FOR 2021/22

4.1 Government of Alberta assign leadership to establish a provincial multi-sector taskforce inclusive of, but not limited to, educational institutions, health care and community agencies to develop and implement a provincial restorative care policy and provincial strategy that will promote the active living of older adults.

5.0 Living Well with Dementia

Persons living with dementia must be provided with supports to enable them to live well in the most appropriate setting of their choice.

People with dementia live in the community, supportive housing and Long-term Care centres. Their needs for support change as their condition progresses. More than 45,800 Albertans were living with some form of dementia as of March 31, 2018. That number is expected to increase to 155,000 Albertans with dementia within 30 years. The enhancement of dementia services in the community, technology support, and support for caregivers will help more people with dementia to live well in the community.

Further, COVID-19 has led to loneliness and fear for people with dementia. Technology support and innovative communication mechanisms with caregivers and family members must be enhanced as a priority.

DIRECTIONAL POLICY RECOMMENDATION

5.0 The work of the Alberta Dementia Strategy and Work Plan be sustained and extended through continued funding that will support individuals living with dementia and their caregivers across the range of living situations.

IMMEDIATE ACTIONS RECOMMENDED FOR 2021/22

5.1 Provide additional resources for flexible respite to caregivers of individuals living with dementia.

5.2 Create a process relevant to both current and future pandemic situations, that while acknowledging the need for infection prevention and control still allows for appropriately trained Designated Care Partners to continue to visit in care environments.

5.3 Provide access to technology that assists caregivers in remaining engaged with their loved ones when restricted visiting and physical distancing are being enforced. In addition, safety technology (e.g. locator devices, stove monitoring, fall monitoring) are important. This could be administered through the Alberta Aids to Daily Living program.

5.4 Provide ongoing funding to programs such as First Link.

5.5 Enhance dementia content for the public on accessible, virtual educational platforms such as CoreAlberta, and Mental Health First Aid for Seniors.

5.6 Support primary care physicians and other health care practitioners in the accurate and timely diagnosis of people experiencing a dementia and their management.

5.7 Support restorative care for individuals living with dementia.

6.0 Supporting Wellness for Family Caregivers

Family caregivers must receive education, support and services to enable them to live well as they care.

Family caregivers are an important part of the health system, providing 70 to 90% of care for Canadians living with complex health conditions in the community, and 30% of the total care delivered in Long-term Care facilities, lodges and supportive housing. Yet, the needs of family caregivers often go unnoticed within the health system. They need support, education, and understanding to minimize the stress they undergo while supporting their partners or family members.

DIRECTIONAL POLICY RECOMMENDATION

6.0 Primary care, community care, Home Care, supportive housing and Long-term Care policies be revised to support family caregivers as well as older adults. All health and community providers must be trained to recognize the essential work of family caregivers, assess family caregivers' support needs to provide care and maintain their own well-being, and assist family caregivers in accessing the supports and services they require.

IMMEDIATE ACTIONS RECOMMENDED FOR 2021/22

6.1 Support person-centered, Caregiver-Centered Care education for the health and community workforce.

6.2 Recognize family caregivers as core health team members in all health organizations and support them in their care role and to maintain their own well-being.

6.3 Extend and scale essential family caregiver infection control training so that family caregivers are prepared for this COVID-19 pandemic and future epidemics.

7.0 Living Well at the End of Life

Albertans must be assisted to achieve quality of life at the end of life

End of life is a journey every human being will experience. Seniors and their families have stated they value independence, connection and choice and that "living well at end of life" is their goal. Alberta has long been recognized as a leader in providing an integrated and innovative range of End-of-Life Care programs and services. However, it is important to continue to invest in services that will ensure care is consistently available and of the highest quality possible. The COVID-19 pandemic shone a light on the experience of Albertans and their families at the end of life and the need to make improvements. For example, public health pandemic visitor directives in congregate settings were initially very restrictive, resulting in isolation and loneliness but they are now being revised based on feedback from residents, families and staff. The opportunity exists now to strengthen and improve end-of-life care throughout the continuum.

DIRECTIONAL POLICY RECOMMENDATION

7.0 Strengthen and fully implement a comprehensive and integrated range of Palliative and End of Life Care (PEOLC) services across the province to ensure that Albertans experience optimal quality of life at the end of life, wherever they wish to be.

IMMEDIATE ACTIONS RECOMMENDED FOR 2021/22

7.1 Improve the quality of the end-of-life experience for seniors, families and staff by:

- **Reducing the severity of burdensome symptoms by increasing staff awareness and referrals to specialized consultation services**
- **Enhancing access to technology through funding for devices and adequate Internet service across the continuum and province**
- **Adding staff resources at end of life in congregate settings as needed**

7.2 Increase public awareness of Advanced Care Planning and Goals of Care

7.3 Increase the proportion of deaths at home or hospice and reduce unnecessary transfers to acute care by increasing community-based service capacity.

7.4 Develop and implement standardized competency-based staff and student education for all care providers using easily accessible technology.

7.5 Increase the engagement of Primary Health Care Providers (Physicians and Nurse Practitioners).

1.4 TAKING THE NEXT STEP IN DEVELOPING ALBERTA'S SENIORS SERVICES SYSTEM

In 1999, the Broda Report (*Healthy Aging: New Directions for Care*) introduced the "Supportive Living Stream" adding a new stream of services to the existing Home Care and Long-term Care

streams in the continuing care system. The Broda Report vision and directions led to transformations in the continuing care system spanning the last twenty years. Now it's time to create an "integrated community care sector" including primary health care and community services working with Home Care as the foundation to assist Albertans to age in the community.

A new opportunity for continuing transformation has arrived. To support this, changes are needed in all living streams. The Alberta government needs to assess the financial, operational and implementation considerations related to the above recommendations in order to develop an implementation plan. While some recommendations will incur financial costs, others will generate savings or cost avoidance; for example, investment in home and community care services to substitute for institutional costs and use of technology and assistive devices to substitute for labour costs. Many recommendations involve the design and delivery of services in different ways that will not incur additional costs; for example, use of a Home Care Invoicing Model or Self-Directed Care Model for Home Care as a replacement for traditional Home Care or nursing home care.

The Alberta Association on Gerontology looks forward to working with Alberta Health, Alberta Seniors and Housing, Alberta Health Services and all other health and social service agencies to achieve the next transformation in the province's continuing care system. Alberta seniors made important contributions in building Alberta's legacy and now, it's time to respond to their inspiration, hard work, and desires in designing a meaningful seniors care and services system to enable them to experience a high quality of life.

1.5 FOR FURTHER CONSIDERATION: RECOMMENDATIONS ADDRESSING THE IMPACT OF COVID-19

Alberta is currently dealing with the COVID-19 pandemic that affects the lives of every Albertan, in particular seniors, one of the most vulnerable groups in society. Consequently, the short-term actions must also address the impact of this continuing health crisis.

While recommendations in this report are based on discussions at the AAG Symposium, the COVID-19 pandemic gave rise to additional recommendations to highlight two significant issues exacerbated by the pandemic:

1) The health, well-being and safety issues for seniors related to the pandemic

2) The need for a robust workforce strategy

1. Health, well-being and safety of seniors. Analyses show that older adults both in Alberta and Canada are groups most adversely affected by the COVID-19 pandemic. Seniors living in Long-term Care centres represented more than 80% of the deaths attributed to COVID-19 in Canada**.** The impact of COVID-19 on seniors is devastating.

Recommendation: Canadians, as a society, and Alberta, provincially, must develop more proactive strategies to protect seniors and the vulnerable in future pandemics and other infectious disease outbreaks, as well as to cushion the social, physical and mental health impact on their victims.

2. Robust workforce. The workforce serving seniors, particularly in the personal care area, is subject to supply shortages and considerable disruption of services. This may be due to unstable working conditions, gaps in the supply of personnel and the need for enhanced training, particularly in the areas of infection prevention and control.

Recommendation: The Alberta Government must develop a provincial workforce strategy to ensure there is a sufficient, stable, trained workforce (of all professional groups) to address the health needs of aging Albertans in the coming decade.

2 BACKGROUND: THE NEED FOR CHANGE WITH A FUTURE FOCUS

Alberta's senior population is aging. In 2016, 12% of the population was over 65 years. It will increase to 20% in 2041 with the peak expected by 2030. The number of seniors is expected to reach a million by 2035. By 2046, one in five Albertans will be 65 or older. Persons over 80 years of age are expected to experience the most rapid growth, a 204% increase between 2016 and 2041.[4] This age group is expected to place a major demand on acute and continuing care.

The emerging population of seniors has different characteristics than the current generation of older adults. On average, they tend to be more educated, have higher incomes, desire choice and independence, and want to be active and engaged in the community. They contribute more volunteer work, and have a higher labour force participation rate. They are also characterized by more cultural diversity and a better knowledge of technology.[5,6,7,8] With different lifestyles, service preferences and choices, the new seniors generation will have an influence on the future provision of seniors care and services.

In 2019, the AAG Board decided the time had arrived to start planning a new vision for seniors services for 203*0*. A *Vision 2030 for Seniors Services Symposium* was held in November 2019. More than 250 educators, researchers, health and social service deliverers, seniors, and their caregivers attended. Symposium participants all agreed that the Vision for Seniors Services was:

A future in which older Albertans are engaged, empowered and enabled to achieve quality of life through financial security, social connectedness and access to health care in inclusive communities.[9]

To achieve this vision, the emphasis and priority of current services need to change. New structures and models of care need to be found and/or created. The emphasis on services must give priority to those service themes that were repeatedly articulated by seniors. While many of the themes have been articulated in previous policy documents, seniors are saying that implementation has not progressed sufficiently to achieve real outcomes. Consequently, more work is needed to achieve the vision put forth by the seniors. The following themes were identified by Symposium participants:

- Person-centred care
- Choice, independence and empowerment
- Wellness, living well and happy
- Integration of health and social services, continuity of care
- Shifting services from institutions to community
- Enhancing community capacity
- Respecting cultural diversity

Appendix A contains a summary of the Symposium findings.

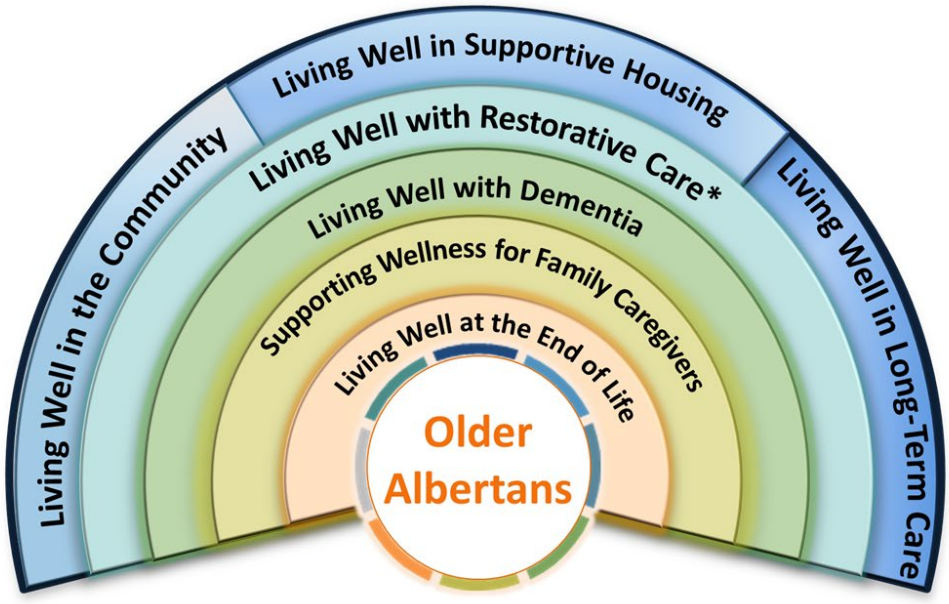
Another unexpected development also affected the seniors care and services sector. During the last year, COVID-19 has impacted the lives of all Albertans. Seniors are particularly vulnerable due to their age, frailty and/or other health conditions. The congregate living

situation in Long-term Care facilities has been particularly susceptible to the rapid spread of COVID- 19. To date, 80% of the deaths relating to COVID-19 have occurred in Long-term Care facilities. This situation is a "call to action" to all professionals working in the health and social services sector to be diligent in learning from the experiences of the pandemic and to prevent the impact resulting from the pandemic happening in the future.

Despite the challenges, Alberta is well positioned to transition into a more responsive and flexible system of care and services for future generations of older adults. Its current system has many strengths that will facilitate the transformation, including:

- A single health authority enabling the transfer of funding from one part of the system to another
- Advanced information technology tools such as MyHealth Records and ConnectCare to help transition to a more standardized and virtual delivery of health care
- Strong voluntary non-profit service sector that works together as partners, particularly in the delivery of seniors services
- Strong academic and health research institutions and facilities that can assist in system innovation
- Internationally reputable clinicians and experts in health and social service delivery who can lead the transformation into a new system of care

The purpose of this policy document is to describe how seniors care and services can be enhanced by committing to new policy directions and taking immediate actions during the next fiscal year to begin the change process. The following schematic shows the areas to be addressed in enhancing the system of seniors care and services in Alberta.



Enhancing Seniors' Care and Services

*with access to Senior Friendly acute and emergent care when required.

The schematic, Enhancing Seniors Care and Services, shows the seven policy areas discussed in this report. Three living situations for older Albertans are shown in the outer ring, and the priority themes across all living situations are shown in the inner rings. Older Albertans are the focus for attention and care so they are shown in the centre of the rings.

The report addresses all aspects of health and social services. The recommendations describe the **Directional Policy Recommendations** to be implemented in each area, as well as the **Immediate Actions Recommendations** to be undertaken in the next fiscal year to begin the change process.

3 LIVING SITUATIONS

3.1 LIVING WELL IN THE COMMUNITY

A. CURRENT STATE

Most Canadians (87%) want to live in their community homes for as long as possible.[10] Little wonder that the Symposium priorities for policies and services focused on services to enable Albertans to age in their communities, including support for family caregivers, enhanced community and home care support and age-friendly inclusive communities. However, the goal of living in the community is threatened by chronic conditions, frailty, increasing physical limitations, insufficient finances, and family caregiver capacity.

Improving community environments and integrating health and community services can enable older Albertans to age in their communities and reduce health care costs.[11,12,13] About 30% of the people admitted to Long-term Care have needs that could be met in the community with the support of family caregivers, primary care, and home care.[14,15] COVID-19 has also demonstrated that living in their community homes is much safer than residential care.[16]

Community living is the less expensive policy option. In 2017, the Conference Board of Canada estimated that one LTC bed cost about $320,000 to build and $75,000 per year for care. The provincial government noted that new Alberta LTC beds were more costly, up to $600,000 to $1 million per unit.[17]

Alberta's Seniors and Housing Business Plan[18] articulates a goal to *make life better for Alberta seniors and caregivers* along with three objectives designed to strengthen communities:

- *1.1 Provide individual and community-based programs and services that support seniors to participate in their communities, and for their communities to support seniors' independence.*
- *1.3 Explore approaches that support the needs of diverse populations of seniors who reside and contribute to the province, and implement initiatives to address retirement planning, ageism, elder abuse, social inclusion, transportation, caregiver supports, and aging in communities.*
- *1.4 Explore innovative approaches to partner with civil society organizations to improve cross-sector collaboration in the planning and delivery of programs and services, including programs focused on prevention and healthy aging.*

Alberta's Ministry of Health[19] articulates four objectives relevant to ensuring older Albertans have a real choice to remain in their community homes:

- *1.2 Support continuing care in the community so that patients can remain in their communities and ensure timely transition of inpatients out of hospital to an appropriate community setting.*
- *1.4 Strengthen home care and supports for caregivers that keep Albertans in their homes, including access to self-directed funding models in order to support*

Albertans with disabilities and chronic conditions (including people living with dementia).

2.4 Work with independent providers to develop long-term care and supportive living spaces in community and modernize the continuing care legislative framework to enable more integrated care."

3.2 Develop and implement modernized, fiscally-sustainable distribution and funding models for health providers that support high quality care and collaborative practice within interdisciplinary team-based environments, including implementing provisions related to practitioner identification numbers to ensure the right number and distribution of physicians across the province.

The AAG policy recommendations align with the above Ministry objectives.

B. RECOMMENDATIONS

DIRECTIONAL POLICY RECOMMENDATION

1.0 Improve the coordination and integration of care between primary care, Home Care and community services to help seniors live as independently as possible in the community.

Rationale: Navigating health and community systems is a nightmare for older adults with complex health conditions, their family caregivers, and health and community professionals.[20] Family caregivers of older adults are now spending 15-50% of their time finding the services they need and then trying to gain timely access rather than providing care.[21] In Alberta two-thirds of health care expenses are being used by only 5% of the population.[22,23] Frail older people without family caregivers to coordinate care are often the high health care users.[24,25] High users of health care receive complex and costly care in uncoordinated "siloed" ways in hospital emergency departments and lengthy inpatient stays rather than receiving care from community-based services, primary care, and Home Care.[26,27] They are less likely to have a family doctor, currently a primary resource for health care coordination.[28] The lack of coordination and integration between health and community providers results in health providers referring older people to costlier health services (hospitals, LTC) rather than more economical community services.[29,30,31]

IMMEDIATE ACTIONS RECOMMENDATION

1.1 The Government of Alberta increase the proportion of spending on Home Care and community-based services to approach 35% of LTC expenditures, the OECD average,[32] by reallocating funds from reducing emergency use/hospital admissions, keeping alternative level of care beds constant, and reducing the proportion of LTC admissions of people whose needs can be met in the community.

Rationale: Reallocation of funds to community should ensure that Albertans with needs that can be met in the home or community will receive the support they need to age well in the community. In the COVID-19 pandemic, seniors have been safer in OECD countries that spend 35% or more of their seniors care funding on community care.[33] While overall, Canada is

directing 90% of seniors' care funding to institutional care and only 10% to home and community-based care, Alberta has been very successful at giving Albertans choice to remain in their community homes longer. Alberta has one of the lowest ratios of residential care beds per 1000 population over 85 years of age (#2 of 10; 267 beds/1000 population over 85 years compared to the Canadian mean of 294/1000 population over 85 years).[34]

Moreover, Hoben and colleagues' longitudinal analysis of Translating Research in Elder Care [TREC] data demonstrates that Albertans moving into Long-term Care have complex care needs that cannot be met in the community.[35] See Hoben's Figure 1 Comparing Median Length of LTC Stay in Alberta to Manitoba.[36] While Hoben's research demonstrates Alberta is doing well, only 10% of Canadian seniors' care funding has been directed to home and community base care and 90% to institutional care.[37] About 42% of Canadians over 80 years of age reside in residential care compared to 30% in Switzerland, the US, New Zealand, Norway, Germany and Denmark.[38] An innovative approach to enabling Albertans who qualify for LTC but want to remain at home, might be to increase their home care support to the DSL4 level of funding. People might be willing to cost contribute to the funding required.

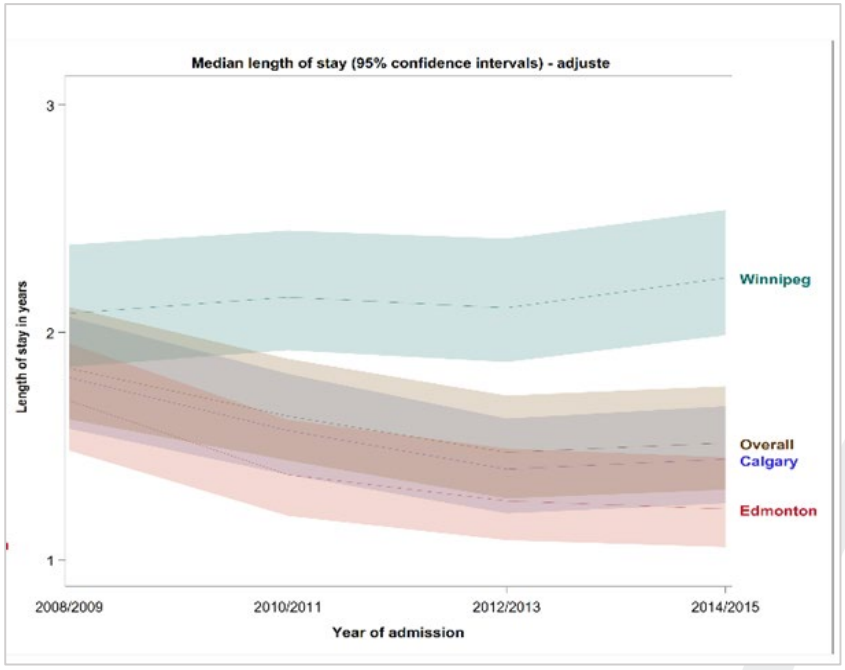


Figure 1. Comparing Median Length of LTC Stay in Alberta

(267 beds/ 1000 rank 2/10) to Manitoba (338 beds/1000 pop, rank 8/10).

IMMEDIATE ACTIONS RECOMMENDATION

1.2 Alberta Health and Alberta Seniors and Housing continue to support development of an Alberta-wide "Community-based Seniors Serving Sector".

Rationale: Alberta has been an early adopter in community planning for a growing population of older people.[39] As frailty and chronic conditions advance, older people need many types of care, in different settings, and from different providers. Integrating health and community service improves older people's health and well-being and increases satisfaction with care.[40,41] Integrated care will be a paradigm shift from a health and community system that currently

prioritizes short-term interventions to one that supports long-term, comprehensive, continuity of care.

Notably, nine in ten Canadians agree that a seniors services strategy needs coordinated health and community services that will address older adults' diverse needs along the full continuum of care.[42] Following BC's lead, which the Blue Ribbon Panel recognizes has a more cost-efficient health system, the **CORE Healthy Aging Collaborative Online Resources and Education** platform has been launched to connect community-based seniors serving organizations and allied agencies and individuals in Alberta.[43,44] Alberta needs to investigate what type of care coordination is needed to assist older adults to navigate community and health care systems. Does Alberta require a new community-based social prescribing model in which care is coordinated by a community link worker as BC[45] and Ontario[46] are exploring, or should navigation and care coordination be the role of primary care or Home Care case management?

IMMEDIATE ACTIONS RECOMMENDATION

1.3 To prepare for future waves of COVID-19 and other pandemics, the seniors serving sector develop plans to meet the needs of vulnerable seniors to reduce social isolation, assist with transportation, and ensure access to basic needs/food security.

Rationale: In general, Albertans are well served by health-related supports. However, pre-COVID-19, community supports were less consistent, especially for vulnerable seniors.[47] Seniors Centers were serving about 7% of the seniors population, mainly those who could access the seniors centre on their own.[48] Although COVID-19 has increased seniors social isolation, some seniors services have used innovative approaches to ensure availability and access to services. The seniors serving sectors need to plan how to harness community networks (friendly visitors, volunteers, technology) to reach vulnerable seniors consistently.

IMMEDIATE ACTIONS RECOMMENDATION

1.4 Ensure Primary Care Networks are age-friendly health homes where a full interdisciplinary team works with Home Care teams to coordinate seniors' health and support services.

Rationale: A primary health care home for every Albertan is integral to Alberta's Primary Health Care Strategy.[49] An evolution is expected in which Alberta Primary Care Networks serve as a health home and provide a full interdisciplinary team to coordinate patient's health and support services. The increasing number of older people with frailty and dementia requires that primary care is as senior friendly as possible. *The Seniors' Community Hub* (Oliver Primary Care Network)[50] and *Primary Health care Integrated Geriatric Services Initiative* (Central Zone) demonstrate that integrated, interprofessional, shared-care geriatric and primary care programs increase patients and family caregiver satisfaction with care and reduce use of emergency and hospital services. The time has come for primary care, Home Care, and the community-based seniors serving sector to work towards integrating seniors' services.

IMMEDIATE ACTIONS RECOMMENDATION

1.5 Improve care coordination by developing a standardized process for collaboration and referrals between Home Care case managers, primary care, and seniors serving agencies.

Rationale: Seniors who have complex health and social needs benefit from care coordination. Case management can significantly improve the effectiveness and efficiency of health care delivery at the individual and population health levels.[51,52,53] Care coordination occurs in silos. Currently, nurses or social workers in primary care and Home Care case managers coordinate health care services. Some seniors centres have outreach workers who will coordinate community services.

Denmark's integrated system of care for older adults and those with disabilities is cost-effective in focusing on integration of primary and Home Care. In the 12-year period from 1985 to 1997, when the United States experienced a 67% increase in per capital expenditures for continuing care, including both community and institutional care, Denmark experienced an 8% increase. During this time, Denmark decreased nursing home beds by 30%, while the United States increased theirs by 12%.[54] In the Netherlands the Buurtzorg Model of District Community Teams reduced Home Care management and bureaucracy.[55]

IMMEDIATE ACTIONS RECOMMENDATION

1.6 Promote the development of innovative design and delivery of services to ensure that seniors can age well.

Rationale: As Albertans live longer, the demand for community and health care support services will increase. Reallocation of funds will not work with a continued focus on budgeting separately at the level of 'one fee' per service procedure, provider, program, or site of care. As the science of health and community care has evolved, multiple layers of organizational structure have been added without a meaningful organizational strategy for person- and family-centered care delivery. Seniors care becomes more and more complex. The overall quality of care cannot be measured by treating outcomes by each provider separately. Budgeting by program also limits reallocation of funds to lower cost community services such as home and community care. This is an ideal time to implement a long-term comprehensive strategic plan and value-based seniors care. Value-based care is patient-centred care in which outcomes that matter to patients and costs to achieve them are accurately measured over the entire cycle of care for the condition rather than as a single service at one point in the trajectory.[56,57] Value-based care encourages integration, working together to produce value and discourages transferring costs to another department.

IMMEDIATE ACTIONS RECOMMENDATION

1.7 Implement innovative Home Care projects that cut red tape and give seniors and their family caregivers choice and control over service delivery (e.g. Home Care Invoicing Model, Self-Managed Care).

Rationale: Initially piloted for in-home palliative care, and now also in the Edmonton Zone, the Home Care Invoicing Model is an alternative method of providing Home Care support services including personal care support services, respite, and Instrumental Activities of Daily Living (IADL), to clients who meet the general eligibility criteria for Home Care. The invoicing model gives Home Care clients the choice and control of providers in the self-managed care model

with less administrative burden. Evaluation results show that clients are pleased with being able to have consistent frontline providers with fewer changes in care scheduling.

IMMEDIATE ACTIONS RECOMMENDATION

1.8 Enhance access to and evaluate home-based technologies using a value-based approach.

Rationale: COVID-19 has demonstrated the importance of technology to support older Albertans in the community. The impact of virtual primary care visits has been positive. Older adults do not need to travel to appointments, pay for parking, and generally, are more relaxed in their own homes. However, COVID-19 has also exposed the gaps in access to technology and the Internet. In the pandemic, many older adults could not access the Internet when public access at libraries or seniors centres was restricted. Technology such as smart homes, enhanced mobility equipment, wandering monitoring, medication reminders, virtual care can support seniors to remain in the community. Wandering monitoring can enable wanderers to traverse their communities with reduced risk and significantly reduce the costs to police services should they get lost.[58,59]

Appendix B gives a listing of innovative community programs in Alberta and internationally.

3.2 LIVING WELL IN SUPPORTIVE HOUSING

A. CURRENT STATE

Supportive housing has played an important role in providing safe and healthy living options for older Albertans since the late 1950s with the advent of the Seniors Lodge Program. Over many decades growth in the supportive housing sector was largely unregulated and involved a combination of government funded projects and private developments by for-profit and non-profit organizations. This has led to a wide variety of ownership types, available services, eligibility rules and terminologies that have created a confusing landscape for seniors to navigate.

Over the past twenty years the Alberta government has promoted the development of supportive housing projects through a series of capital grant programs such as the Affordable Supportive Living Initiative (ASLI). These programs provided a portion (generally up to 50 percent) of the funding for development or upgrading of projects through conditional grants.

In recent years the provincial government has endeavoured to bring some order to the supportive housing sector by creating legislation governing the licensing, accommodation standards and inspection of all supportive housing projects that house four or more adults (*Supportive Living Accommodation and Licensing Act, 2009*). In keeping with the growing trend of providing continuing care health services in community versus Long-term Care settings Alberta Health Services funds and oversees the provision of health and personal support services in select supportive housing settings referred to as Designated Supportive Living (DSL) and provides publicly funded Home Care services to residents in other supportive housing settings like seniors lodges.

Currently, Alberta has 32,754 licensed supportive living spaces, which include 9,438 Seniors Lodge Program spaces, 11,999 private supportive housing spaces and 11,317 Designated Supportive Living spaces (Alberta Health, 2020).

B. RECOMMENDATIONS

If properly guided and supported, the supportive housing sector has the potential to address many of the housing, personal support and health care needs of Alberta's aging population in the decades ahead. However, as it is currently structured, a number of gaps are apparent between the needs of older Albertans and the availability of appropriate settings and services.

DIRECTIONAL POLICY RECOMMENDATION

2.0 Enhance the ability of the supportive housing sector to facilitate aging in the community by promoting a person-centred model of care, supporting the ability of couples to age together, fostering a consistent, stable and capable workforce, and effectively employing technology to promote resident independence and staff effectiveness.

IMMEDIATE ACTIONS RECOMMENDATION

2.1 Re-introduce a capital grant program to promote the redevelopment of aging senior citizen lodges and new supportive housing projects that blend independent supportive housing and Designated Supportive Living suites in a flexible model that promotes aging in place and helps couples age together, while eligible individuals receive assessed publicly funded health and personal support services.

Rationale: Recommendation 2.1 addresses three important needs.

Modernizing senior citizen lodges. The Seniors Lodge Program was designed at a time when residents were expected to move to Long-term Care as their health and personal support needs became more complex. Alberta has adopted a model that promotes aging in the community, but the design and services offered in many seniors lodges, especially older settings, do not support this model. Seniors lodges need to be modernized or rebuilt with an adjustment to the program model to provide the necessary health and personal support services to support aging in the community.

Couples aging together. Much of Alberta's supportive housing portfolio, including seniors lodges, was developed with the expectation that residents' rooms would be occupied by a single person or shared by unrelated individuals, often single or widowed females. This is less frequently the case as male spouses are living longer and same sex marriages or adult interdependent relationships are becoming more common. Couples desire to age together, even if one partner does not have complex health and personal support needs. Current guidelines for the design of continuing care facilities call for a portion of resident rooms to be connected by a lockable door or moveable solid divider (Alberta Design Guidelines for Continuing Care Facilities, 2018). The percentage of such convertible rooms needs to increase, and some purpose-built couples' suites need to be included in future supportive housing designs.

Multi-level supportive housing projects. Alberta's supportive living model usually places people who require 24-hour monitoring and support, but who do not have complex health care needs, into a Designated Supportive Living setting. This often requires moving from one's current accommodation to another setting, possibly to another community and possibly apart from a spouse or partner. One alternative would be to promote the development of multi-level supportive housing projects in which a portion of the suites would be contracted DSL and a portion would be private supportive housing. Residents whose care needs are assessed at a DSL level could move into a rent-controlled DSL space or remain in their own suite and pay market rent but receive publicly funded DSL services based on assessed need. Examples of this model are already in place, but they need to be expanded to other sites.

IMMEDIATE ACTIONS RECOMMENDATION

2.2 Create mechanisms to promote workforce stability and continuity of care in supportive housing settings. Ideas include:

- **Appropriate compensation (wages and benefits) for Health care Aides (HCAs) and other support staff in Designated Supportive Living settings**
- **Increased hours for individual HCAs to enable them to be employed in a single continuing care site and avoid the need for employment across multiple continuing care sites**
- **Support for in-service training and professional development to maintain and improve competencies and provide opportunities for advancement**

Rationale: Health care Aides provide the majority of health and personal support services in DSL settings. It has long been reported that these key care providers face challenges of low pay, irregular working hours, inadequate benefits, physically challenging working conditions and few opportunities for in-service training and professional development. The COVID-19 pandemic highlighted the critical role these workers play and the obstacles they face in performing their duties. The training, pay and working conditions of Health Care Aides and other support staff in DSL settings needs to be reassessed now.

IMMEDIATE ACTIONS RECOMMENDATION

2.3 Promote the implementation of assistive technologies in supportive housing and Designated Supportive Living settings to enhance the well-being of residents and improve the efficiency and effectiveness of staff.

Rationale: Jurisdictions, such as Denmark, have actively employed technological solutions to improve the quality of life of continuing care clients and ease the workload of care providers (*Assisted Living: A Dignified Elderly Care in Denmark, 2019*). Alberta has undertaken a number of pilot projects to explore the benefits of employing new technologies in community-based care settings. Examples include wander management systems, personal medical response programs and medication management systems. While many of these projects have demonstrated benefits, few have moved past the pilot project stage. Alberta needs to take steps to support the use of assistive technologies in supportive housing.

IMMEDIATE ACTIONS RECOMMENDATION

2.4 Require all supportive housing and Designated Supportive Living projects to develop and implement a Pandemic Outbreak Plan, appropriate to the setting, in collaboration with Alberta Health Services and in consultation with residents and family members. The plan must provide ways in which select family and friends can provide support and essential care to residents as key care partners, while respecting the principles of outbreak prevention.

Rationale: While all continuing care providers are required to establish policies and procedures for outbreak prevention, identification, management and control, the COVID-19 pandemic has highlighted the vulnerability of continuing care residents to such infectious diseases. In future, all continuing care settings serving vulnerable people need to have an approved plan for responding to pandemic level outbreaks, including COVID-19. In developing the plan residents and their families must be consulted. While protecting the health of residents must be paramount, any plan must also consider their quality of life. Family and friends play a key role in providing emotional support and comfort to residents, advocating on their behalf and often lessening the burden on paid staff by providing essential personal care. The outbreak plan must incorporate ways of involving such key care partners in each resident's care while respecting the principles of outbreak prevention.

3.3 LIVING WELL IN LONG-TERM CARE CENTRES

A. CURRENT STATE

Older Albertans living in Long-term Care facilities are a unique group, often they are not acutely ill. However, they do require substantial assistance due to their functional and/or cognitive decline and number of chronic conditions. The proportion of residents aged 85 years and older has increased. At the same time, newly admitted residents are more likely to be at an advanced age with complex medical conditions and care needs.[60,61,62,63] For all older Albertans**,** admittance to a Long-term Care facility is often accompanied by a reduction in many activities of daily life that had provided meaning and purpose.

An extensive review of the literature identified that many families continue to visit and provide various forms of assistance to family members in care facilities. The outcome is often enhanced resident well-being. All these factors influence the care needs of older residents. It requires staff who have the appropriate attitudes, knowledge, and skills required to deal with the complex health and social needs of these residents. How care is delivered is as important as what care is given. Kale et al (2019) in their study of residents' perspectives on their relationships with others reported that the cultivation of social relationships is central to promoting well-being in nursing homes.[64] These relationships encourage residents, family members, and staff to be valued as unique persons and empowered as partners in care.

In addition, the COVID-19 epidemic has taken a tremendous toll on seniors residing in Long-term Care facilities in this province. In Alberta, as of May 22nd, 2020, the number of deaths from COVID-19 was 132, of which 98 (74%) were residents of Long-term Care facilities.[65]

The issues arising from within Long-term Care facilities are not new for many Albertans. It is recognized that some temporary changes to provide better care for older residents will become permanent as of August 15th, 2020. However, the COVID-19 pandemic has raised these issues to the forefront of public perception.

Five key issues are identified as priority for government action:

#1: Need for Resident-Centred Care
#2: Restructuring of the Long-term Care Facility
#3: Preparation for the Work Roles
#4: Preventing and Managing Infections Safely
#5: Physical Environment of the Facility

B. RECOMMENDATIONS

DIRECTIONAL POLICY RECOMMENDATION

3.0 Transform the Long-term Care facility system so that it provides person (resident)-centred, safe, quality services by competent staff, for residents who live in an environment that provides and promotes their quality of life.

#1: The Need for Resident-Centred Care

The needs of Long-term Care residents are increasingly complex, reflected in complex care and treatment plans that span a range of needs from those requiring assistance with activities of daily living to those who may be technology dependent.[66,67] In Alberta, this is clearly identified in the 2018 Long-term Care resident profile report prepared by Alberta Health Continuing Care.[68] In addition, the complexities of dementia (e.g., type and speed of progression) and limitations on family caregiving supports result in reliance on Long-term Care facilities.[69] About one-third of seniors younger than 80 diagnosed with dementia live in Long-term Care homes. The proportion increases to 42% for those 80 and older according to an analysis by the Canadian Institute for Health Information.[70] Consequently, the health and social needs of older adults, residing in Long-term Care are multifaceted, diverse and, often unmet. Duan et al (2020) reported that residents with higher depressive symptoms and poorer physical and sensory function were more likely to report unmet preference needs.[71] Similar findings about resident needs being unmet have been found in other studies including Chamberlain et al.[72], Brink and colleagues[73] and Olsen and associates.[74]

Emergent solutions such as person-(resident) centred care are helping staff accommodate the full complexity of the residents they serve. A report by the National Academies of Sciences, Engineering, and Medicine (2018) proposed a paradigm shift, specifically the integration of social care and medical care.[75,76]

IMMEDIATE ACTIONS RECOMMENDATION

3.1 Implement resident-focused rounds on a weekly basis.

Rationale: Resident-focused rounds is purposeful rounding by staff, at regular intervals, on Long-term Care units. The rounds consist of addressing any unmet care needs, assessing the

environment for safety concerns, and listening to the voice of the resident. The goals of these rounds include: to deliver proactive rather than reactive care, to enhance the resident experience, and to increase staff satisfaction in care delivery.

IMMEDIATE ACTIONS RECOMMENDATION

3.2 Mandate a minimum of 4.1 hours worked hours[77] for 100 Case Mix Index (CMI) for Long-term Care facilities.

Rationale: Older adults living in Long-term Care facilities increasingly have multimorbidity.[78] Residents frequently experience deteriorations due to their advanced age, multiple chronic illnesses, and high levels of dependency.[79]

In addition, the rapid spread of COVID-19 in Canadian nursing facilities have shown the weaknesses of most nursing facilities including staff shortages to provide sufficient care and infection control. Nursing staff is an important contributor to resident care and well-being. Despite this, the relationship between staff coverage, care hours, and quality of resident care in Long-term Care facilities is not well understood. The United States Centres for Medicare and Medicaid Services in a 2001 study concluded that staffing levels below 4.1 direct hours per resident day could have adverse consequences.[80] This has been substantiated in numerous other documents.[81,82,83,84,85,86,87,88]

#2: Restructuring of the Long-term Care Facility Culture

Long-term Care facilities face two competing forces:

1) Ensuring resources are used as efficiently as possible while providing good resident care outcomes
2) Developing a culture of care that is person (resident)-centred and home-like, acknowledging that Long-term Care facilities are places where older Albertans reside and receive care

Nursing staff must provide safe, competent, compassionate, and ethical care. Making long-term care a career of choice is necessary to meet the current and future demand for high quality Long-term Care services. Chronic under staffing, stress, burnout, and less than ideal working conditions are barriers to recruitment and retention.[89,90,91]

IMMEDIATE ACTIONS RECOMMENDATION

3.3 Build essential leadership capabilities in Long-term Care for today's and tomorrow's leaders.

Rationale: Engagement of leaders is essential to the success of culture change and innovation. Evidence identifies a close connection between leadership style and culture change processes toward person-centred care.[92,93] Values underlying such care include respect for other persons, developing relationships and community, individualized residential care, and quality of work life for staff. These leadership traits transform the values of the Long-term Care facility culture and affect the quality of resident life in a profound way. Supportive supervisory practices HCAs have been shown to positively affect quality of work life and quality of care.[94]

IMMEDIATE ACTIONS RECOMMENDATION

3.4 Create mechanisms to ensure a consistent, dedicated, and educated workforce.

Rationale: Health care aides comprise the largest group of formal providers delivering care in Long-term Care facilities. However, a failure to acknowledge them as members of the care team is prevalent.[95] Studies show that incorporating health care aides into care teams has a direct positive effect on quality of care for residents[96,97] and reduces staff turnover.[98]

IMMEDIATE ACTIONS RECOMMENDATION

3.5 Increase the use of consistent resident assignments.

Rationale: The goal is to have the same staff member taking care of the same resident each time the former is on shift. This promotes person (resident)-centred care as missed nursing care is often related to not knowing the resident.[99] Morgan, Kosteniuk, O'Connell, Dal Bello-Haas, Stewart, and Karunanayake reported that nurses/case managers were significantly more likely than aides to regularly perform eleven activities of daily care while aides more likely assisted with only two activities.[100] Consistent resident assignments also provide the family with a point of contact who knows their family member best.

#3: Preparation for the Work Roles

Barriers to implementing quality care include health care providers' limited knowledge and lack of training[101], poor morale among care staff[102], low pay[103] and inadequate staffing[104]. Aging-related stigma acts as an obstacle to the well-being and quality of life of residents in Long-term Care facilities, as it may interfere with access to care, and how care is provided. Health care aides are a critical part of the Long-term Care facility as they provide the vast majority of care to older residents.[105] The need for health care aide education has been well documented relating to their involvement with significant daily direct care of residents.

IMMEDIATE ACTIONS RECOMMENDATION

3.6 Mandate an annual continuing competency requirement for health care aides.

Rationale: Continuing competence is the ongoing ability of a health care aide to integrate and apply the personal traits, knowledge, skills, and clinical reasoning required to practice safely and ethically in a Long-term Care facility. The need for education of staff was also recognized in the Broda Report.[106]

IMMEDIATE ACTIONS RECOMMENDATION

3.7 Develop a post-education course specific to health care aides and other frontline workers, focused on the needs of older residents in Long-term Care facilities; followed by an increase in compensation salary after successful completion of the course.

Rationale: Caring for older residents is complex, requiring a strong knowledge and skills foundation.[107] The program could include a paid Long-term Care facility work experience, with an evidence-based Long-term Care nursing focused curriculum. Required content includes: dementia and delirium care, end of life and palliative care, and infection

control protocols. Skilled facility staff members can provide effective role models for positive attitudes towards and quality care for older residents.

IMMEDIATE ACTIONS RECOMMENDATION

3.8 Support innovation in health care and evidence-based decisions through ensuring that each unit in a Long-term Care facility has a high-speed Internet computer, with electronic decision-making resources, and all staff trained in its use.

Rationale: Emphasis on innovation will produce exponential change in significant areas including enhanced resident-centred care[108], alternative integrated and comprehensive delivery organizational designs, and creative technology-enabled options for effective health relationships (e.g. resident to family, resident to physician).

#4: Preventing and Managing Infections Safely

Given their congregate nature and the resident population served (e.g. older Albertans often with underlying chronic medical conditions), Long-term Care populations are at high risk for being affected by respiratory pathogens such as COVID-19 and other pathogens, including multidrug-resistant organisms (e.g., *Candida auris*).[109,110] As demonstrated by the COVID-19 pandemic, a strong infection prevention and control program is critical to protect residents, their families, and facility personnel. The lack of personal protective equipment places the resident, their family members, and facility staff at high risk of both contracting and transferring potentially harmful and infectious organisms.

IMMEDIATE ACTIONS RECOMMENDATIONS

3.9 Implement lessons learned from the COVID-19 experience into a comprehensive provincial plan, with coordination and cooperation from all Long-term Care facilities in Alberta, to prevent and address infectious outbreaks.

3.10 Address the challenge of social isolation and loneliness caused by quarantine-imposed isolation.

Rationale: COVID-19-imposed restrictions on physical connections have had an unforeseen impact on the well-being of older residents.[111] Quarantine measures have never before been implemented at this scale. Individuals may experience unfamiliar challenges in receiving social support, as they are not able to gather in person. Rates of social isolation and loneliness have increased dramatically.

IMMEDIATE ACTIONS RECOMMENDATION

3.11 Ensure an individual who has completed an endorsed infection prevention and control course[112] and is certified in infection control procedures manages each facility's infection control program.

Rationale: The needs of Long-term Care facilities are increasingly complex, reflected in complex care and treatment plans, and with a range of residents from those requiring assistance with activities of daily living to those who may be technology dependent. Staff identified in the infection control role includes: recognizing and isolating outbreaks of infectious diseases in long-term care facilities; designing action plans for the prevention of outbreaks; collecting and analyzing data on the incidence of infections and the success of prevention strategies; investigating of possible outbreaks; and the assembling of appropriate resources in response to confirmed outbreak(s).

IMMEDIATE ACTIONS RECOMMENDATION

3.12 Ensure every Long-term Care facility has a minimum of six weeks personal protective equipment supply for all staff and two visitors per resident.

Rationale: Residents and staff will benefit from increased safety from the transfer of infectious organisms. Long-term Care facilities have been documented as having high transmission rates for infectious diseases for a range of reasons including lack of adequate PPE, crowding, sharing of bathroom facilities, and gathering in common areas, as well as insufficient preparedness for infection control.[113,114]

#5: Physical Environment of the Facility[115]

Long-term Care facilities need to be reconceptualized.[116,117,118] The core building blocks of Long-term Care: housing, basic personal care, and medical care, must be re-imagined in various and innovative ways to meet the needs and preferences of older residents. Facilities must not be viewed as impersonal health care institutions, but rather as person-centred homes offering Long-term Care services. Designs of private and public space in Long-term Care homes impact residents' sense of home by meeting their needs primarily for privacy and social interaction. Wada et al (2019),[119] in a Canadian located study, reported the physical environment features are foundational for the emergence of social and personal meanings associated with a sense of home. In addition, the reduced size of facilities promotes the well-being of daily life for older adults with dementia.[120] Over-crowding in Long-term Care facilities must be avoided to prevent the rapid spread of infectious disease, and smaller number of resident units per household (e.g. 12 to 14 resident units) should be designed to ensure privacy and the circulation of clean air, and quality of life.

IMMEDIATE ACTIONS RECOMMENDATIONS

3.13 Eliminate all three and four bed wards as an urgent priority.

3.14 Allocate capital funding to renovate old nursing homes to avoid over-crowding situations for residents.

3.15 Amend the *Design Guidelines for Continuing Care Facilities in Alberta* [121] to:

- **Ensure that all rooms are capable of being single isolation units.**
- **Design groupings for smaller number of residents per household (12 to 14 residents) in Long-term Care facilities to facilitate social distancing and circulation of clean air.**

Rationale: These recommendations were also made in the Broda Report[122], but they have not been implemented. Residents and staff benefit from increased safety from the transfer of infectious organisms. Crowded nursing homes are the "petri dish" for infection. Recent studies from University of Toronto, McMaster University, and Public Health Ontario show that residents of crowded Ontario nursing homes are twice as likely to die of COVID-19 compared to the general population.[123] In addition to the consideration for infection control issues, the above recommendations on facility design will also help to improve the privacy and quality of life for Long-term Care residents and provide a more "home-like environment" for its residents.

4 LIVING WELL WITH RESTORATIVE CARE

A. CURRENT STATE

Physical Inactivity Challenges

Physical inactivity has been associated with significant increases in disease morbidity and mortality. Woolcott et al. (2010)[124] assessed the association between physical activity and (1) health resource use; and, (2) health resource use costs:

- Physical inactivity was associated with statistically significant increases to hospitalizations, lengths of stay and health care visits ($p<0.01$).
- Average health care costs (based on the 2007 value of the Canadian dollar) for the physically inactive were $C1214.15 higher than the health care costs of the physically active ($C2005.27 vs $C791.12, $p<0.01$).
- Better mobility status and leisure activity were also associated with mental well-being among older adults based on factors including depressive symptoms, anxiety, loneliness, self-rated mental vigour and life meaning[125].

Up to 65% of older adults, independent in walking will lose their ability to walk during a typical hospital stay.[126] Without mobilization, older adults:

- Can lose up to 5% of their muscle strength due to bed rest[127]
- One third may develop a new disability in an activity of daily living during hospitalization[128]
- Half are unable to recover previous function resulting in a loss of independence, medical complications, caregiver burden, increased mortality and premature institutionalization[129]

Given the growing body of evidence that supports an increased focus on physical activity as essential for long-term independence, health, wellness, quality of life and reduced use of health care services, a range of mobility strategies for older adults are recommended for community-based agencies, congregate living situations, Long-term Care, acute care and post-acute care. In the current COVID-19 pandemic, social isolation, a necessary measure to combat the spread of the infection, has the potential to increase sedentary behavior in older adults and the potential for contributing to deteriorating health in those who are more prone to sarcopenia, frailty and cardiometabolic abnormalities.

Potential of Restorative Care

Optimal wellness for older adults includes physical activity, encompassing a restorative care approach. Restorative care is a philosophical approach to care that focuses on preventing functional decline and restoring and maintaining optimal functional and physical status[130]. This philosophy supports a care approach that prevents or minimizes a decline in activities of daily living, and maximizes physical abilities.

In a Restorative Care bedded program (e.g. hospital, post-acute, continuing care) the focus is on an individualized, goal-oriented plan of care to improve mobility, physical function and

Activities of Daily Living while normalizing daily routines, helping individuals "do for themselves" and maximizing their abilities rather than their disabilities.

A restorative care philosophy can be implemented wherever the person is situated. In addition to tertiary rehabilitation, a restorative care approach has been demonstrated to be effective with older people living at home in the community[131], in assisted [supportive] living,[132,133] in Long-term Care,[134,135] in hospital,[136] and in post-acute transitional care (DeSantis, 2014).[137]

While the desire is to minimize the need for acute hospital care, those services are required for older adults on an episodic basis to address exacerbation of chronic illness, an acute medical event, acute functional decline or traumatic injury. Acute hospital care may be followed by rehabilitation in a tertiary setting, so it is also crucial to include a restorative care philosophy in hospital settings.

Restorative Care Worldwide and Local Experience

Several Restorative Care examples can be found across the world. Denmark was one of the first countries to adopt a Restorative Care model to address the needs of an aging population.[138] An Alberta example is the Restorative Care Unit operated by Capital Care, which in the initial evaluation, showed an 88% improvement in functional gains.[139]

Global initiatives such as "*#endpjparalysis*" started by the National Health Service in the UK, have saved over 710,000 hospital days.[140] An evaluation shows improvements in patients' experience of hospital care, as well as a reduction in falls and pressure ulcers. This initiative has now spread to Europe, Australia, New Zealand, the US and Canada[141] and has been adopted sporadically but not universally across Alberta.

Implementing a Restorative Care Approach

- All health care providers, students and volunteers, can support increased mobility in older adults. The integration of restorative care practices into the education of direct care providers offers a strong foundation for use of these practices in day-to-day person-centred care.
- Adoption of best practices including initiatives such as "*#endpjparalysis"* home exercise programs and Restorative Care across the continuum of care and in the community; building on and spreading learnings from successful pilots and initiatives.
- Organizational incentives to support this care approach in health care, continuing care and community care are also needed. This may require a review of resources since supporting activity and independence often takes more time than simply "doing for" the older adult.

B. RECOMMENDATIONS

DIRECTIONAL POLICY RECOMMENDATION

4.0 All health services in Alberta implement a restorative care philosophy across the care continuum and all seniors community services in Alberta promote active living and programs to mitigate sedentary behaviour. Special attention must be given to

addressing the impact of social isolation imposed during outbreaks on activity levels of older adults.

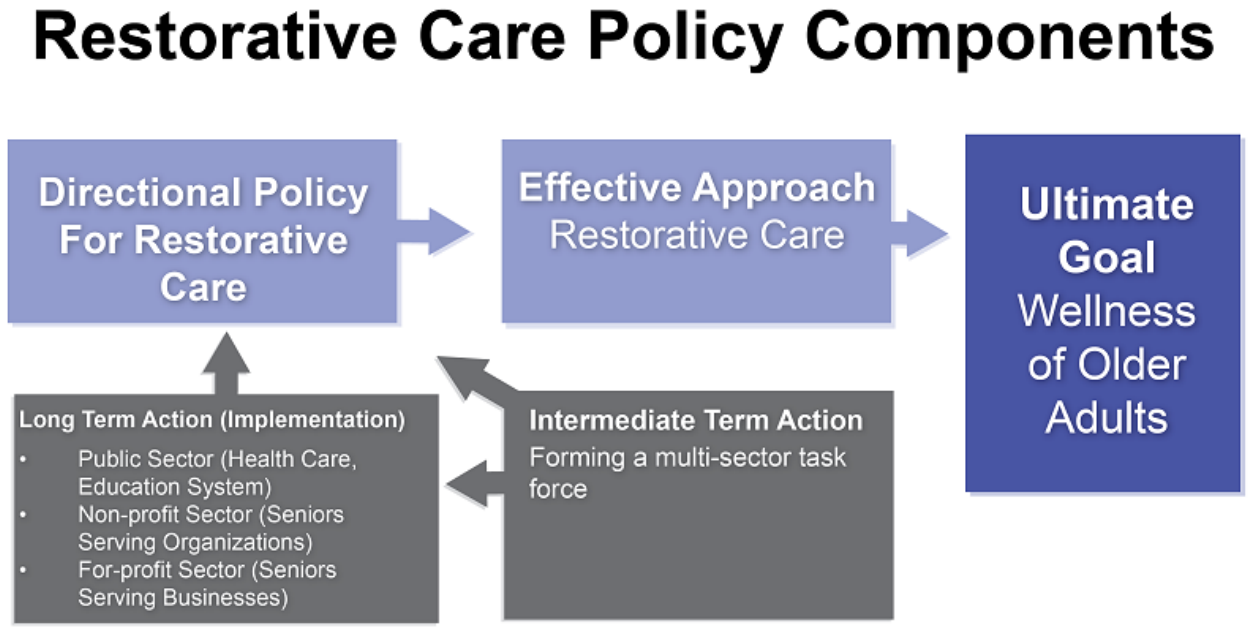
Rationale: While there are small pockets of excellence across Alberta related to restorative care initiatives, a greater focus and support are needed for scale and to extend these proven initiatives. Implementing a restorative care philosophy will contribute to well-being for older adults and mitigate functional decline with associated sequelae of the need for emergency visits, hospitalization and potential institutionalization.

IMMEDIATE ACTIONS RECOMMENDATION

4.1 Government of Alberta assign leadership to establish a provincial multi-sector taskforce inclusive of, but not limited to, educational institutions, health care and community agencies to develop and implement a provincial restorative care policy and provincial strategy that will promote the active living of older adults.

Rationale: A provincial strategy is required, involving key stakeholders, to successfully scale and spread across the continuum. Key outputs from the taskforce would include a restorative care framework that addresses education, equipment, and creative strategies to mitigate the potential negative effects of sedentary behaviour and social isolation in order to maintain muscle health and functionality.

The following schematic illustrates the components of the restorative care policy recommendation.



5 LIVING WELL WITH DEMENTIA

A. CURRENT STATE

As the Alberta population ages, the prevalence and impact of dementia on society will increase. Delays in proactive efforts to address dementia are due to a number of factors, including:

- Lack of awareness of the early signs
- Ageism
- Memory loss viewed as a normal component of aging
- Stigma of dementia
- Belief there is little that can be done

However, research has shown much can be done to improve the lives of individuals living with this progressive disease, all of which can delay or slow the onset of dementia, including:

- Physical activity
- Keeping an active mind
- Addressing underlying health issues
- Meaningful socialization
- Healthy diet

Caregivers are integral to the well-being of those living with dementia. They make it possible for individuals to remain in their homes and to continue to engage in everyday activities. Without them, health and social systems would have to step in. Supporting caregivers and addressing their unique needs is important to the success of a dementia strategy.

Individual response to the disease will vary according to age, marital status, ethnicity, education, economic status, and gender identity, to name but a few. Services to individuals living with dementia and their caregivers must also recognize the need for inclusivity in this diverse population.

The system of services for older Albertans, addressed in this document, impact the quality of lived experience for people living with a dementia. Generally speaking, people living with a dementia experience significant periods of boredom, lethargy, task-based care and other features of institutionalization where the individual's need for meaningful occupation and engagement and “busyness” are not addressed.

Awareness is growing within the system of services about the importance of love, warmth, human interactions, people's individual needs and realities, relational person-centred care, occupation and the quality of daily lives experienced by people living with a dementia. However, the focus of the system of services' requirements and expectations often remains on physical care and safety.

Opportunities for Improvement

Fifteen years ago, the Alberta Government released its dementia strategy *Alzheimer Disease and Other Dementias: Strategic Directions in Healthy Aging and Continuing Care*.[142] This document gave the then health regions guidance in developing their own dementia strategies

as part of overall regional service plans. While successful for its time, the intervening years have seen a growth in the number of persons living with dementia and an increasing desire by them and their caregivers for enhanced support in the community. In March 2017 the Alberta government tabled a revised five-year plan, *The Alberta Dementia Strategy and Action Plan,* representing years of dialogue with experts in the field, individuals living with dementia and their families.[143]

The over-riding vision was a future where: *Albertans are committed to optimizing brain health and valuing and supporting individuals impacted by dementia from its onset through to end of life.* The principles for the framework to guide this work were: 1) person- and family-centred; 2) collaborative and integrated; and, 3) flexible and adaptive care and services.

Expected outcomes of the strategy and action plan were that:

1. *Albertans understand the impact of dementia and actively work towards optimal brain health.*
2. *Albertans living with dementia and their caregivers are supported in community.*
3. *Albertans living with dementia and their caregivers receive timely recognition, diagnosis and clinical management through primary health care supported by specialized services.*
4. *Albertans living with dementia and their caregivers experience timely, accessible, integrated and high-quality care and services.*

System enablers to achieve these outcomes included:

1. *Research, technology and knowledge transfer (the aim was to position Alberta as a leader in dementia research, the development of supportive technologies and translating research into practice).*
2. *Trained and supported workforce (ensure Alberta has a trained and supported workforce to provide dementia care and services).*
3. *Monitoring and reporting (implement a comprehensive measurement, monitoring and reporting framework to the implementation of the Strategy).*

The Strategy identified 26 actions with proposed timeframes. According to the 2019 Progress Report the Alberta government had invested $12.8 million dollars in the dementia strategy and action plan through grants to both health and community partners up to that date (*Alberta Dementia Strategy and Action Plan Progress Report, March 2019*).[144]

Still much must be done to carry through with the recommended actions of the Dementia Strategy and spread successful initiatives across the province. The *Appropriate Use of Antipsychotics* project provides an excellent example of how to promote sustainable long-term change.[145]

Pressing needs continue:

- Individuals living with dementia must be supported where they are, recognizing and respecting their unique situations.
- Caregivers must be supported and recognized as equal partners in the care process.

- Stigma of the disease must be reduced and dementia friendly Albertan communities developed.
- Research into dementia and brain health must be supported.

The Alberta Dementia Strategy and Action Plan provide the blueprint for continuing to move forward.

B. RECOMMENDATIONS

DIRECTIONAL POLICY RECOMMENDATION

5.0 The work of the Alberta Dementia Strategy and Work Plan be sustained and extended through continued funding that will support individuals living with dementia and their caregivers across the range of living situations.

IMMEDIATE ACTIONS RECOMMENDATIONS

To further the Strategy in light of the additional stress arising from COVID-19, the following recommendations for immediate action are made:

5.1 Provide additional resources for flexible respite to caregivers of individuals living with dementia.

Rationale: Respite is whatever the caregiver deems it to be. Policies around what can and cannot be done to provide respite (e.g. home visiting, virtual day programing, and facility stays) need to be flexible to cover individual and unique situations. Once an individual is diagnosed with dementia, caregiver respite must become part of the service package provided.

5.2 Create a process, relevant to both current and future pandemic situations, that while acknowledging the need for infection prevention and control, still allows for appropriately trained Designated Care Partners to continue to visit in care environments.

Rationale: The presence of familiar family and friends reduces isolation and psychological distress of those living with dementia and also assists care providers.

5.3 Provide access to technology that assists caregivers in remaining engaged with their loved ones when restricted visiting and physical distancing are being enforced. In addition, safety technology (e.g. locator devices, stove monitoring, fall monitoring) are important. This could be administered through the Alberta Aids to Daily Living program.

Rationale: Technology adds to the supports already in place across living situations.

5.4 Provide ongoing funding to programs such as First Link.

Rationale: Grant funding is presently in place. However, these programs need assurance of ongoing secured funding to continue to support their clients.

5.5 Enhance dementia content for the public on accessible, virtual educational platforms such as CoreAlberta, and Mental First Aid for Seniors.

Rationale: This will increase the public's understanding of dementia and provide a resource for creating dementia-friendly communities.

5.6 Support primary care physicians and other health care practitioners in the accurate and timely diagnosis of people experiencing a dementia and their management.

Rationale: Primary health care is often the first source of advice to persons living with dementia and their caregivers. Examples of this work in primary care networks include, distributing the dementia curriculum developed for primary care networks in the Central Zone and/or implementing novel approaches to dementia care such the MINT Memory Clinics[146] developed by Dr. Linda Lee and colleagues in Ontario.

5.7 Support restorative care for individuals living with dementia.

Rationale: Programs that effectively promote physical activity and enhance the quality of life of those living with dementia and their caregivers need to be part of core services offered to individuals living with dementia and their families. These core services need to receive sustainable funding and be implemented across Alberta, including rural areas.

6 SUPPORTING WELLNESS FOR FAMILY CAREGIVERS

A. CURRENT STATE

Aging in place in communities is not possible without the contributions of family caregivers. In this document, family caregiver (carer, care partner) is defined broadly as any person who takes on a generally unpaid caring role providing emotional, physical, or practical support in response to an illness, disability or age-related needs. The objectives in the Ministry of Health Business Plan for 2020-23,[147] recognize that family caregivers also need support:

1.3 Support Albertans in accessing appropriate and timely palliative and end of life care by increasing awareness of how and when to access palliative care options, shift from hospital to community-based home and hospice care, expand effective caregiver supports in their homes and communities, and establish education, training and standards for health care professionals;

1.4 Strengthen home care and supports for caregivers that keep Albertans in their homes, including access to self-directed funding models in order to support Albertans with disabilities and chronic conditions (including people living with dementia)

Family caregivers (FCGs) provide 70-90% of the care for older Canadians living with complex conditions, frailty, and impairments in the community. Pre-COVID-19, family caregivers were providing 30% of the care in congregated living (lodges, supportive living, LTC). In 2002, the Commission on the Future of Health Care in Canada, headed by Roy Romanow, recognized that without the work of family caregivers, the Canadian health system was unsustainable.[148] In 2018, Dr. Janet Fast estimated that FCGs unpaid care work contributes about $66.5 Billion yearly to the health system.[149]

Yet, the needs of FCGs often go unnoticed within the health system. Despite some teaching, Alberta health care providers are not well prepared to assess FCGs' well-being, their willingness or ability to care, nor the problems they experience as care providers. Throughout the care trajectory, health professionals discount the amount of work FCGs do and underestimate FCGs' distress. A population health approach to maintaining FCGs' well-being and sustaining the care they provide, requires that health providers:

- Identify FCGs
- Assess the support FCGs need to provide care and maintain their own well-being
- Assist FCGs to navigate and access needed supports

Furthermore, ensuring the workforce is trained to support FCGs is also given as Enabler B in the Alberta Dementia Strategy and Action Plan, *Ensure Alberta has a trained and supported workforce to provide dementia care and services.*[150]

B. RECOMMENDATIONS

DIRECTIONAL POLICY RECOMMENDATION

6.0 Primary care, community care, Home Care, supportive living and Long-term Care policies be revised to support family caregivers as well as patients/clients. All health and community providers must be trained to recognize the essential work of family caregivers, assess family caregivers' support needs to provide care and maintain their own well-being, and assist family caregivers in accessing the supports and services they require.

Rationale. Mandating health and community providers to identify all family caregivers requires small changes in practice. The United Kingdom enacted caregiver support policies in 2004 and in the United States in 2018, the President signed the Recognize, Assist, Include, Support, and Engage [RAISE] Act directing the Secretary of the Department of Health and Human Services to develop and maintain a strategy for health care providers to recognize and support FCGs.[151] In Alberta, Dr. Jasneet Parmar and multilevel interdisciplinary Alberta stakeholders validated a Caregiver Centered Care Competency Framework.[152,153.] Online education is in development.

IMMEDIATE ACTIONS RECOMMENDATIONS

6.1 Support person-centered, Caregiver-Centered Care education for the health and community workforce.

Rationale: Family caregivers need person-centered care from all health and community providers. While support from community organizations such as seniors' centers, Caregivers Alberta, The Alzheimer's Society, Parkinson's Society is important, social care is not a substitute for consistent health promotion, care, and support from health care professionals.

6.2 Recognize family caregivers as core health team members in all health organizations and support them in their care role and to maintain their own well-being.

Rationale: COIVD-19 exposed how undefined the family caregiver role is. While importance of family presence has previously been endorsed by many health care organizations, growing recognition of family caregivers is essential. However, inconsistency is a concern in the application of family caregiver policy at the care level.

6.3 Extend and scale essential family caregiver infection control training so that family caregivers are prepared for this COVID19 pandemic and future epidemics.

Rationale: One third of family caregivers already carry out technical aspects of care such as changing bandages, monitoring or administering medications, while 18% carry out medical procedures such as changing gastric tubes and giving injections.[154] Essential family caregivers have the capacity to learn and carry out infection control procedures and are highly motivated to do so meticulously. Family caregivers should participate in organizational health and social care pandemic preparation, rehearsal, and response as well as their inclusion in ongoing and emergent care planning activities.

7 LIVING WELL AT THE END OF LIFE

A. CURRENT STATE

Palliative and End-of-Life Care (PEOLC) is both a philosophy and an approach to care. Palliative care aims to improve the quality of life of individuals and their families facing the problems associated with a life-limiting illness through the prevention and relief of suffering. PEOLC experts agree that programs and services should be integrated and available across the health system from home to acute care, continuing care and hospice; and from early diagnosis to bereavement.

Alberta has been recognized nationally as a leader in providing an integrated and innovative range of PEOLC programs and services, including.

- In 2014, the Palliative and End-of-Life Care Alberta Provincial Framework was launched to improve PEOLC across Alberta.[155] It recommended 36 initiatives, over half of which have been implemented, including websites with resources for providers and the public, the EMS PEOLC Assess, Treat and Refer Program and a province-wide 24/7 Physician On-Call support program.
- One of the key objectives of the Alberta Government 2020-23 Health Ministry Business Plan, is to *support Albertans in accessing appropriate and timely palliative and end-of-life care by increasing awareness of how and when to access palliative care options, shift from hospital to community-based home and hospice care, expand effective caregiver supports in their homes and communities, and establish education, training and standards for health care professionals*. Five million dollars was budgeted for 2020-21.[156]
- The Provincial Palliative and End-of-Life Innovations Steering Committee (PPAL/EOL ISC) is currently completing an Addendum to the 2014 Framework to capture the current state and identify and prioritize remaining gaps in services and supports.
- In 2018, PPAL/EOL ISC, in collaboration with Alberta Health, University of Alberta and University of Calgary, conducted a Health Technology Assessment that led to a number of recommendations; these have been incorporated into the Framework Addendum.

Other Alberta groups have also provided leadership in PEOLC, including:

- The Alberta Hospice and Palliative Care Association which provides support to caregivers and has led innovations such as sponsorship of a provincial Resource Directory, Death Cafés and a Cree Tea Dance.[157]
- The Covenant Health Palliative Institute, established in 2012, advocates for robust PEOLC services.[158] Through the national Palliative Care Matters initiative, the Institute developed a consensus statement with many recommendations, including incorporating PEOLC services as part of the Canada Health Act.
- The College and Association of Registered Nurses of Alberta (CARNA) has developed a position statement promoting person and family-centered care and quality of life at end of life in all practice settings.[159]

As Alberta's population ages and the prevalence of chronic diseases increases, the need for quality PEOLC increases dramatically. The COVID-19 pandemic demonstrated that people over 80 years of age are the most vulnerable to negative outcomes and death. Compared to many other provinces, Alberta has been successful in minimizing the total number of outbreaks and deaths. However, approximately three quarters of all COVID-19 deaths in Alberta and Canada were elderly residents of congregate care settings.[160] The COVID-19 pandemic has highlighted several key areas for improvement with the need to fully implement the PEOLC Alberta Provincial Framework.

B. RECOMMENDATIONS

DIRECTIONAL POLICY RECOMMENDATION

7.0 Strengthen and fully implement a comprehensive and integrated range of Palliative and End of Life Care services across the province to ensure that Albertans experience optimal quality of life at the end of life, wherever they wish to be.

IMMEDIATE ACTIONS RECOMMENDATION

7.1 Improve the quality of the end-of-life experience for seniors, families and staff by:

- **Reducing the severity of burdensome symptoms by increasing staff awareness and referrals to specialized consultation services**
- **Enhancing access to technology through funding for devices and adequate Internet service across the continuum and province**
- **Adding staff resources at end of life in congregate settings as needed**

Rationale: Research has shown that the prevalence of burdensome symptoms could be alleviated, such as pain, delirium, depression, dyspnea and challenging behaviours [expressions of feelings/challenges being experienced by people living with dementia] goes up in the months before death in LTC.[161] Although data is lacking, this is likely the case in other settings. In Alberta, 24/7 access to on-call palliative specialists is available, but not all providers or programs refer to them. In addition, the primary care provider has the option to accept or reject the recommendations of the specialist. Increased awareness and education are required on burdensome symptoms and the benefits of palliative consultation to reduce intractable symptoms.

Alberta Health Services is currently leading a project in Long-term Care to address risk factors that contribute to worsening or unresolved pain and depression by looking at trends and triggers of pain, social engagement, sleep patterns, and depression in the comprehensive electronic assessment, Resident Assessment Instrument (RAI 2.0), and implementing interventions. The learnings from the evaluation of this project will be important in making necessary improvements.

COVID-19 has not only revealed the vulnerability of older seniors to the virus, it has also shown the negative effects of physical and social isolation on people at the end of their lives and their families, whether they live in their own homes, congregate living settings or hospices. According to Dr. Carole Estabrooks, "they are not just dying – they are dying alone. They are

dying without family; they are dying afraid".[162] Although the visitation policy for the first three months of this pandemic allowed a visitor in during the last two weeks of life (which can be difficult to predict), families felt acute anxiety and guilt if they were not able to be present to comfort their family member or provide supplementary care.

Staff are doing their best in a difficult time, but may be off work due to quarantine. A balance is needed between protecting vulnerable seniors from infection and the negative effects of social isolation. Many sites have been creative in the use of technology to enhance communication between residents and families. This experience can be built upon by adding more virtual consultations, spiritual care visits and palliative volunteer visits and by helping families to say goodbye.[163]

Added Care is available but is not often utilized in Long-term Care. Additional staff time to spend with the client/resident at the end of life would be beneficial. A review of staffing resources, the effects of visitation restrictions and enhanced access to technology across the province is required; solutions should be sought in collaboration with seniors, families and staff. An evaluation of the impact of COVID-19 on PEOLC, including electronic health record data and an online survey for health care providers, is underway.

IMMEDIATE ACTIONS RECOMMENDATION

7.2 Increase public awareness of Advanced Care Planning and Goals of Care

Rationale: Advance Care Planning (ACP) is intended for individuals to document their personal wishes for health care in the event they become incapable of determining their own treatment or other care.[164] Goals of Care Designation (GCD) is the medical order used to describe the aim and preferred location of care. In 2013, building from a successful program in Calgary Zone, Alberta Health Services implemented the "Green Sleeve" strategy that helps to ensure people's wishes are readily available in a recognizable form in the home or health care facility when needed. Awareness of ACP/GCD is even more important during a pandemic.[165] Ideally, conversations should be held with family members and/or primary health care providers before a health crisis occurs, and not between strangers during an urgent health care situation. Since most people would prefer to die in a familiar environment, and not in an intensive care unit, ACP/GCD is of crucial importance before COVID-19 is diagnosed, using open and sympathetic communication.[166] A request has been put forward to the provincial government for a public awareness campaign but it has been paused during the COVID-19 pandemic.

IMMEDIATE ACTIONS RECOMMENDATION

7.3 Increase the proportion of deaths at home or hospice and reduce unnecessary transfers to acute care by increasing community-based service capacity.

Rationale:

More support for home deaths. Research indicates that unnecessary transfers to acute care at the end of life are still occurring in Alberta[167], although some transfers will always be needed. To meet the increased need for palliative services across the care continuum, more services and infrastructure need to be put into place to support home deaths. In Alberta, there is access to

personnel who have palliative care expertise 24 hours a day in person, via telephone, or by teleconference. However, a number of other barriers prevent a home death and lead to unnecessary acute care admissions. Barriers include:

- Availability of prompt unscheduled access to competent front line staff with palliative care expertise
- Access to ready to use, injectable medications for symptom management
- Equipment availability

By addressing each of the barriers that prevent family members being able to confidently care for a person with a life-limiting illness, transfers to acute care could be prevented in the final days or hours before death. Geographic inequity is also a factor in-home palliative support between urban and rural centres regarding symptom management and timely access to unscheduled expertise when concerns related to care arise unexpectedly.

More hospice beds and overall PEOLC capacity needed. Despite adding a number of hospice beds over the last 10 years, additional hospice beds are needed. An expert panel determined a need for 7.7 hospice beds per 100,000 needs adjusted population; the number of hospice beds in Alberta is still below that target. Even if additional supports were to be put in place to facilitate more home deaths, not all palliative patients have family members who are able to provide care in the home and some patients suffer from refractory symptoms that cannot be managed in the home setting. Since the outbreak of COVID-19, an overall decrease in hospice occupancy of 20% (from March – May, 2020) has been experienced, likely due to a combination of fear, visitation policies and outbreak precautions at some sites.

In 2017/18, an expert panel projected a need for a 50% increase in PEOLC capacity (from 2015/16 to 2035/36) integrated across hospice/community supported PEOLC beds, palliative home care and designated PEOLC beds in acute care. The expert panel also proposed increasing the proportion of PEOLC service days provided in Home Care and in hospice. Studies have indicated that compared to acute care, hospital-based hospice palliative care may save the health care system $7,000 to $8,000 per patient and according to an Ontario study, shifting 10% of patients who are nearing end of life from acute to hospice palliative care (home or hospice) could save their health care system $9 million. Specific research on the savings due to use of palliative home care alone compared to acute care is not yet available.[168]

Grief and bereavement services needed. After a person has died in the community, family members need to know where to access affordable grief and bereavement resources in the days and months after the death. Families may not be aware of the Alberta Bereavement Directory on Inform Alberta.[169] Follow-up grief support is not consistent across geographic areas and it would be helpful for providers to know what electronic grief resources are available that can be provided to family members.

IMMEDIATE ACTIONS RECOMMENDATION

7.4 Develop and implement standardized competency-based staff and student education for all care providers using easily accessible technology.

Rationale: Over the years, a variety of different educational courses in end-of-life care have been implemented in different programs across the province. Under the auspices of the PPAL/EOL ISC, the Covenant Health Palliative Institute is in the process of finalizing and publishing PEOLC competencies for each of 14 disciplines for both generalist and specialist roles. The next step will be assessing all current educational programs and making recommendations to fill gaps. Collaboration between all educational and program stakeholders is needed to agree on one set of curricula for implementation in order to leverage the work on competencies to the next level.

Consideration should be given to on-line education methods, especially for existing staff, including volunteers. The education content should include how to hold serious conversations about end-of-life care and choices. According to a survey noted in Canada's National Seniors Strategy,[170] only 24% of family doctors and 18% of primary health care nurses felt experienced and comfortable in having these conversations. A proposal has been submitted to the provincial government for Serious Illness Conversation Guide training for all disciplines and needs to be supported as part of current and future pandemic preparation.

IMMEDIATE ACTIONS RECOMMENDATION

7.5 Increase the engagement of Primary Health Care Providers (Physicians and Nurse Practitioners)

Rationale: An opportunity exists to create stronger linkages between primary health care providers and continuing care programs. Currently, no consistent formal mechanism is in place to notify primary care providers when home care clients are in hospital or are requiring significant amounts of home care services and supports.

The clinical information system (CIS), Connect Care, is viewed as an opportunity to facilitate greater information sharing between providers and, thereby, improve the patient experience across the continuum of care. The CIS will provide the technology and infrastructure but this needs to be supported by education and other processes to enable providers to offer increased services to end-of-life patients. This person-centred approach could decrease institutionalization and hospitalizations of patients in home settings who require increased amounts of care. Increased engagement of primary health care providers could also lead to more proactive conversations with patients and families about their wishes and more in-person or virtual home visits near end of life.

8 CONCLUSION

Alberta has a strong foundation underpinning its current system of care and services to seniors. While much progress has been made over the last 30 years, changing socio-demographics and advances in continuing care highlight the need for another evolution of the system. With the unexpected development of the COVID-19 pandemic, the shortcomings in seniors care and services were heightened, reinforcing the urgency of addressing the areas needing improvement.

The Alberta Association on Gerontology is a leader in the gerontology field, guided by a wide range of experts with extensive knowledge and experience in the seniors services system in Alberta and around the world. The Association's mission is to *enhance the lives of older adults in Alberta by supporting research, influencing policy and promoting the exchange of knowledge and best practice among the public, experts, service providers and government.*

In November 2019, the Association undertook, in collaboration with its vast array of stakeholders, a Symposium on *Vision 2030 for Seniors Services in Alberta*. The findings arising from the Symposium and the passion exhibited, paved the way for this policy document.

This policy document is intended to be a roadmap to begin the important process of system transformation to more effectively serve seniors in the future. Major recommendations are made regarding the policy directions and implementation actions to be initiated in the next fiscal year, 2021-2022. Recommendations are supported by extensive research and knowledge of advances in seniors care and services around the world as well as current experience in Alberta's system. The Alberta Association on Gerontology is committed to working with the Government of Alberta and all health and social organizations involved in the seniors services sector, in moving Alberta's seniors care and services system forward.

Alberta has the opportunity now to realize an important vision articulated by participants in the Symposium: ***A future in which older Albertans are engaged, empowered and enabled to achieve quality of life through financial security, social connectedness and access to health care in inclusive communities.*** With everyone working together, this vision can be achieved.

APPENDICES

APPENDIX A: ALBERTA ASSOCIATION ON GERONTOLOGY: VISION 2030 FOR SENIORS SERVICES SYMPOSIUM, SUMMARY OF FINDINGS

BACKGROUND

Alberta's population, like the rest of Canada, is aging. In 2019, 13% of the population was over 65 years of age. This cohort is expected to more than double by 2041, representing 19% of the population. The oldest component of the senior population, those over 80 years of age, is expected to show a significant surge, increasing from 3% of Albertans in 2012 to 6.4% in 2041. This age group is expected to place a major demand on health care, home care and assisted living services.

This upcoming group of older adults, the baby boomers, is expected to have different lifestyle preferences than the current generation of elderly Albertans. Independence and choice is important to them, and their expectations of these features in health and social services will be different.

For this reason, the Alberta Association on Gerontology (AAG), together with 16 other organizations as collaborators, decided to host a ***Vision 2030 for Seniors Services Symposium*** to discuss the future vision for seniors services. They felt it is important that we plan for these future changes, and that health and social services professionals, the public and gerontologists have an opportunity to discuss the future service needs of seniors and express their ideas on the changes required to achieve a preferred vision.

EMERGING INTERNATIONAL POLICY TRENDS

Prior to planning the Symposium program experts and members of the Collaborative Planning Committee discussed and reviewed policy trends that are being implemented around the world to meet the future needs of this new generation of elderly. They identified the following six emerging international trends:

1. ***Emphasizing wellness and independence for seniors***
2. ***Enhancing community capacity***
3. ***Integrating health and social care***
4. ***Shifting priorities of services in continuing care from institutional care to home and community care***
5. ***Transforming the health system to meet future needs of older adults***
6. ***Addressing the cultural diversity of the future population***

The Collaborative Planning Committee planned the Symposium program around these trends.

EVIDENCE-BASED FINDINGS

The findings of the Symposium are based on a three-part evidence-based process:

1. Regional consultations with seniors and other Albertans were conducted at six sites in Alberta to understand the views and needs of Albertans for future seniors' services.
2. Literature review was conducted on grey literature that document demonstration projects, evaluations and briefings from projects that are of relevance to the Symposium planning.
3. A Discussion Symposium was held on November 12-14, 2019 starting with presentations by national and international experts on future needs for seniors services and concluding with participants' group discussions and recommendations. More than 300 health and social services clinicians, policy planners from government departments, voluntary, private and public agencies, seniors and caregivers attended the Symposium and joined in the Discussion Groups on the future vision, and policy and services priorities for Alberta seniors in 2030.

THE 2030 VISION FOR SENIORS SERVICES IN ALBERTA

The Symposium participants' Vision for Seniors Services for 2030: ***A future in which older Albertans are engaged, empowered and enabled to achieve quality of life through financial security, social connectedness and access to health care in inclusive communities****.*

[Please note that after the Symposium Summary Report was published in March 2020, some further wording changes were made to the vision.]

PRIORITY POLICIES TO ACHIEVE BEFORE 2030

The three priority policies recommended to be achieved before 2030 by Symposium participants are as follows:

1. **Support for family caregivers**
2. **Provide community supports and financial security for seniors**
3. **Provide accessible information and health care services**

Other additional priority policies recommended are as follows:

- Provide equitable access to services for all in both rural and urban areas
- Address needs of marginalized seniors
- Acknowledge government accountability
- Enhance primary care, continuing care, dementia/Alzheimer's care, mental health
- Address social isolation
- Improve transportation

Participants suggested that when designing policies, the following features be addressed:

- Provide engaged, enhanced and integrated community care

- Develop adaptable, flexible, responsive policies and care options
- Provide appropriate, sufficient and sustainable funding
- Provide accessible and affordable services that respect personal choice and autonomy
- Design affordable and accessible living communities that bring people together
- Use a team-based approach for client care

PRIORITY SERVICES TO ACHIEVE BEFORE 2030

The three priority services recommended to be achieved before 2030 by Symposium participants are as follows:

1. **Enhance system navigation**
2. **Enhance home care and support services**
3. **Support active and healthy aging, enable technology financial support, support family caregivers, and develop age-friendly and inclusive communities**

Other additional priority services recommended are as follows:

- Enhance respite care
- Enhance dementia and mental health services
- Develop companion program
- Enhance end of life care

Participants suggested that when designing services, the following features be addressed:

- Provide coordinated, integrated, cross-sectoral partnerships, especially between health and social service providers
- Provide convenient, accessible, inclusive, timely and sustainable services
- Design inclusive and intergenerational communities
- Focus on personalized, person-centred services incorporating personal choices and sensitive to cultural and linguistic needs

CONCLUSION

The Alberta Association on Gerontology and Collaborative Planning Committee believe that planning for services to meet the future needs of seniors is important. The number of seniors in Alberta will more than double between 2018 and 2046. The urgency for planning requires us to act now. We urge that policy makers in government departments, organizations and agencies address the above- mentioned findings of the ***AAG Vision 2030 for Seniors Services Symposium*** as a priority. We are available to meet and dialogue with policy makers to plan collaboratively to make this vision a reality before 2030.

March 19, 2020

APPENDIX B: INNOVATIVE PROGRAMS IN ALBERTA AND INTERNATIONALLY

ALBERTA PROGRAMS

The Seniors' Community Hub (Oliver Primary Care Network) is an integrated, interprofessional, shared-care geriatric and primary care program.[27] The model fosters active patient and caregiver engagement with primary care network physician and teams which promotes continuity of care and self-management that are critical to aging in place.

Primary Health Care Integrated Geriatric Services Initiative (Central Zone):This initiative links primary care with specialty care in the management of older people with geriatric syndromes such as frailty and cognitive impairment. Built on the concept of a Health Neighborhood which fosters integration of health and community-based services, it aimed to improve the diagnostic and management skills in the primary care networks in Central Zone. The project is in evaluation phase with limited expansion to other areas in Alberta.

Destination Home targets community-based clients at risk for institutionalization to maximize their potential in the familiar surroundings of their home if safely able to do so. Projects facilitated, 1) safe discharge of patients from hospital with comprehensive home care and community supports, and 2) provided intensive case management for home care clients with complex chronic conditions at high risk of residential admission (e.g., Congestive Heart Failure, COPD). Evaluation demonstrated significant decreases in emergency department visits and in-patient admissions, as well as significant cost avoidance in the Edmonton Zone. Hoben's comparison of lengths of stay in Edmonton and Calgary suggest the model should be expanded.

Self-managed care [SMC], an alternate method of service provision, provides the resources to home care clients to directly pay for and manage needed home care services. SMC enables home care clients and their family choice and control in terms of the care provider who's coming in to work with them.[37] The client or a legal representative of the client must be willing and able to assume the responsibilities and risks associated with contracting personal or home care support services and managing the finances (including CPP, EI, Income tax) and reporting. SMC was designed for younger people with disabilities. This may be an appropriate time to promote SMC for older people.

The Invoicing Model (initially piloted for in-home palliative care, and now used more widely in the Edmonton Zone) is an alternative method of providing Home Care support services including personal care support services, respite, and Instrumental Activities of Daily Living (IADL) to clients who meet the general eligibility criteria for Home Care. Clients have the option to utilize the AHS-contracted agency providers or in-house health care aides and provides a less administratively burdensome option than the Self-Managed Care Program. Instead of Home Care contracting with an agency or providing these services clients or their legal representatives can direct their own services by choosing their own agency provider. Clients and families are responsible to direct and purchase their own care the cost of which is then reimbursed for, up to a pre-authorized number of hours. The invoicing model gives home care clients the choice and control of providers in the self-managed care model with less administrative burden. Evaluation demonstrates clients are pleased with being able to have consistent frontline

providers with fewer changes in care scheduling. This model could be evaluated further and then based on this evaluation expanded provincially.

INTERNATIONAL PROGRAMS

Denmark Comprehensive Community & Long-term Care System

The success of this system is attributed to adoption of an "integrated care system" that involves extensive systems of home-based care facilities and hospitals throughout the country. Denmark's policy priority is homebased care. Danish municipalities must conduct annual home visits for all adults over 75 to identify those at risk for frailty in need of home care services and a reablement training program. Reablement, preventive home visits, and home care (personal, e.g., bathing, shaving and practical assistance e.g., chores, meal preparation are provided free of charge to Danish citizens regardless of dwelling.

Denmark has not constructed a conventional nursing home since 1987. About 3.4% of adults aged 65 or older live in Denmark's conventional nursing homes and typically represent the oldest segment of the population (i.e., aged 90 and older). Instead of nursing homes, Denmark built a wide range of close-care dwellings for older adults. Close-care dwellings are small individual apartments that are physically connected with a shared common-room and garden. Residents of close-care dwellings maintain autonomy and privacy; however, individuals also indicate the level of care and services they desire.

Netherlands Home Care Community Teams

The Netherlands Buurtzorg Model of district community teams reduces home care management and bureaucracy.[32] A team of 12 work in a neighbourhood, taking care of people needing support as well managing the team's work. A new team will find its own office in the neighbourhood, spend time introducing themselves to the local community and getting to know GPs and therapists and other professionals. The team decides how they organize the work, share responsibilities and make decisions, through word of mouth and referrals the team build-up a caseload. https://www.buurtzorg.com/about-us/buurtzorgmodel/

Western Sydney Integrated Care Program (WSICP) Primary Care

WSICP supports "team-based" medical home model. It features a care coordinator (registered nurses employed by the Western Sydney Local Health District) to smooth transitions between hospital and primary care settings. Care coordinators conduct comprehensive assessments of patient's health and social care needs, provide care plan enhancement and supervision, monitor patient care during hospitalization, encourage self-care interventions, and coordinate care team activities. Health and social care workers help patients navigate between primary and acute care settings. Care plans are accessible to the care team through Linked EHR, a shared care repository. Health Pathways, an online clinical decision-support tool and referral information portal, is used by health and social care workers.

New Zealand Te Whiringa Ora (TWO)

The integrated community-based care service provides comprehensive care to high users of hospital services with complex, long-term health needs. The program area has high

unemployment, low incomes, and poor educational outcomes. The population is bi-cultural, with 48% identifying as Māori (national average is 14%). The goal is to provide responsive, coordinated, and seamless delivery of services for patients and families incorporating traditional Whānau Ora principles across primary care practices, hospital, community service providers and iwi providers. The multidisciplinary team uses assessment, case management, home visits, telemonitoring, self-management support, care planning and integrated information technology records system. It has reduced the use of inpatient services, the number of bed days, and avoidable hospital admissions. Improved patient quality of life over time has also been shown.

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