Recommendations for Improvements to Healthcare Services for Seniors

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EXECUTIVE SUMMARY:

The purpose of this report is to present topics, explanations and solutions to the healthcare services for seniors. The primary focus revolves around services received in Residential Care facilities but extends in some areas to include the full continuum of services for seniors.

The governing principles that have been considered in assembling these proposed solutions stem from the following beliefs:

- A consumer belief that the power to choose – including the choice of location, choice of service and of service provider – is the most meaningful component to maintaining and improving health as it ensures independence & dignity, creates an inner sense of strength and instills a quality focus into all aspects of the system;

- An economic belief that a dynamic health system will find an optimal blend of private and Government-subsidized services that compliment each other and jointly deliver quality services while creating a robust sector which benefits all; and

- An operating belief that a clearly defined and broadly communicated future vision is the critical first step to improving and changing the direction of healthcare. In particular, it is important to announce that growing old is not a disease (that should be covered by healthcare) but simply another part of our life cycle that requires the same diligence in planning and preparation as required in all other stages of life.

With these principles in mind, the following recommendations are submitted for consideration:

- Create a clear, well communicated future vision for Healthcare Services for Seniors;

- Implement a performance management system that drives behaviors based on client satisfaction and a social model of care (complimented with the traditional and somewhat existing medical monitoring and measures);
• Consider and implement an alternative funding model for the sector that better aligns with the future vision; and
• Modify the system for client contribution (user fees) to better blend into the cost of private pay services and to better recognize the differences in capital costs related to the accommodation component of the fee.

This report is intended to provoke thought and present concepts that warrant further exploration and discussion and as such, it does not comprehensively present all of the details for each of the topics. If additional information is required to clarify or explain any of the content, the author is pleased to provide that information.

It should be noted that the personal motivation for making this submission stems from a heartfelt interest to improve the Healthcare System in BC and through that, to improve the quality of life for our seniors.

(Due to the required structure of the submission, certain information applies to separate topics and therefore, it has been repeated.)
TOPIC #1:
The Future Vision of Healthcare Services for Seniors

EXPLANATION for Topic #1:

The future vision and direction for healthcare services relating to seniors is unclear to the public and does not ‘paint a picture’ of how the system functions, what the benefits are, and what users can individually expect. By looking to the current operating practices, assumptions can be made (as actions and implementation are the true translation of what direction is intended) and would suggest the intended future vision should be one that:

- **Measures numbers – not satisfaction.** It monitors and tracks indicators that are predominantly (if not exclusively) based on tangible, quantitative measures (such as physical corridor widths or number of falls) as opposed to the more meaningful measures of qualitative performance (such as quality of relationships and an overall feeling of satisfaction with services). Refer to Topic #2;

- **Controls choice.** Under the existing operating policies and parameters, it restricts the powerful force known as “client choice” from benefiting and augmenting the system thereby ensuring both quality and meaningful services are delivered. Refer to Topic #3;

- **Discourages private pay.** It limits the expansion of services by creating funding structures, legal contracts and client entitlement expectations that prevent and discourage the development of private pay services. Refer to Topic #4;

- **Undervalues existing infrastructure.** It promotes expensive (and potentially unnecessary) capital redevelopment as the effectiveness of facilities is measured solely on physical, quantitative comparators and fails to recognize the quality of life indicators that can exist regardless of the surroundings. Refer to Topic #4;

- **Establishes Government paid services at an extremely high standard and further discourages private pay.** The ‘base service’ that is funded by the Government is creating a very high expectation of what clients can expect and thereby, it diminishes the interest and/or desire for any alternative private pay options. The system is driving towards an unlimited suite of services together
with the baseline expectation of receiving a private room. Despite the fact that it is extremely difficult for a private pay operator to compete on that platform, it is very expensive to Government. Refer to Topic #3;

- **Gives lip-service to the concept of a Social Model for Residential Care.** As the system has been predominantly managed by numbers (quantitative) and is now further evolving into tracking performance based on the number of ‘direct care hours’ provided, the current system is becoming more and more “hospitalized” (i.e. a medical model). The value of activities, recreation, meals, socialization, relationships and overall satisfaction are only being given lip-service as priority since the true tracking of performance does not align with the messaging. Refer to Topic #2; and

- **Promotes entitlement mentalities.** Specifically, the current system limits society’s progression towards individual acceptance of responsibility for one’s health and living needs as being simply a natural part of aging. Instead, it breeds an entitlement mindset and a perspective that aging is a social responsibility that needs both to be managed as well as paid for collectively. Refer to Topic #3.

**SOLUTIONS for Topic #1:**

As suggested above, a clearly defined and articulated future vision of healthcare for seniors is needed. At a minimum, the disclosure of any vision, despite what it might contain, would be an improvement over the existing situation. But, by stretching further and looking to some of the social and economic principles that have been learned and are clearly valued in many world class organizations, a future system would:

- **Measure satisfaction first and medical indicators second.** By mandating and monitoring measures that first look to satisfaction or quality of life indicators (qualitative) and are balanced by quantitative indicators, a more meaningful assessment of ‘value’ would be obtained. Refer to Topic #2;

- **Promote choice.** By actively engaging the power of client choice and the ability to make ‘buying’ decisions, a mentality of customer service is created which
Drives to ensure service quality as well as being responsive and adaptive to new and changing needs. Refer to Topic #3;

- **Encourage options to funded health services:** The future system will seek out a means of promoting options to funded health services by establishing Government systems and practices that minimize the disruption on ‘natural market forces’. By considering new approaches to funding and labour cost management combined with proactively supporting operators that deliver creative service options, a dynamic, integrated and complimentary system will evolve between private pay and the funded system. Refer to Topic #4;

- **Value the existing infrastructure.** As the wave of environmental responsibility continues to gain momentum, it is prudent that the future vision incorporate a new perspective on valuing the existing infrastructure. In particular, it will seek to find meaningful ways to utilize older structures that can continue to benefit the system by responding to niche services and/or social needs. It creates a healthcare and social culture that strives to find ways of working with existing structures and discourages delisting their purpose based solely on quantitative measures. Refer to Topic #4;

- **Establish and educate on the ‘Government guaranteed system’ – a very modest minimum that individuals can expect.** In the future, the services received under the Government paid system will be modest and reflect a minimum acceptable level of service while providing the ability for individuals to supplement those levels, if they so choose. Through the process of establishing clearly defined services, the future system would incorporate education and communication to ensure individuals proactively assume responsibility for planning their later years. (As part of the message, it should be communicated that the Canada Health Act does not mandate any subsidy to this sector and therefore, any involvement by Government is voluntary and optional.). Refer to Topic #3;

- **Deliver a social model of service.** A future system that consciously moves away from a medical model and works to truly prioritize the meaningful social contributions made to health would be demonstrated through measuring client satisfaction. Particularly, it would elevate and respect the fact that one’s quality
of life stems primarily from the living experience and far less from physical surroundings and enhancements. Refer to Topic #2; and

- **Initiate a social shift.** A future vision would spark a social shift in the view of and response to aging. It would message that growing old is simply a natural and predictable part of living and therefore it actively requires forethought, education, planning and personal responsibility to prepare for its eventual arrival and to embrace it as yet another stage of life. It is not a disease or a medical condition that mandates Government support. Refer to Topic #3.
TOPIC #2:
Performance Management Systems

EXPLANATION for Topic #2:

*Performance measures are predominantly quantitative and lack important qualitative measures.* Over the past few years, there has been significant progress towards the implementation of performance measures as a means to monitor the quality of services delivered within Residential Care. The intention of this direction is appreciated and supported but the focus has become one-sided. In particular, the general nature of these discussions has revolved almost exclusively around physical measures that can be objectively assessed and reported and compared to benchmarks. For example, number of falls, skin conditions, medications, etc. as well as the size of corridors, door widths, room square footage, etc. In most cases, the numbers reported are based on a definition of the physical condition and they do not take into account the desire of the client to live at risk, the overall satisfaction of the client and/or staff nor the client mix/acute at a site (i.e. facilities with specialized or niche populations.) There has been reference in a recent performance measures task force document of the need to incorporate satisfaction levels of clients and staff into a program but progress in this area has been very limited.

*Technology tools reinforce the quantitative tracking.* In more recent times with the direction to implement the MDS InterRAI client assessment and tracking tool, there has been a further digression into electronically tracking the quality of healthcare services through this system and according to a very similar number of physical indicators (as referenced above) without any regard to the other important qualitative factors. It is well known that a balanced scorecard includes all areas of performance management and without that balanced approach, conclusions can be drawn and decisions made that do not properly reflect the desired future direction.

*Measures are becoming more prescriptive and reinforce a medical model.* Specifically, performance monitoring have become even more prescriptive in nature as can been seen...
in the direction of Health Authorities to stipulate the minimum number of direct care hours by facility without any specific acknowledgement of client mix and/or acuity levels. As there is a lack of any other accurate and reliable measure for quality, it is suggested that closer controls are needed to be intimately managing the output. The result is a system that is micromanaged using expensive resources (people, technology, etc.) without any confirmed assurance that the quality of healthcare services, as received by the clients, is even close to satisfactory. As well, by driving a system that tracks professional healthcare hours in a model that strives to value residential living and a social model of care is inconsistent. The message delivered is that direct care hours are what matter and that the enjoyment of meals, activities, and personal interests lie completely secondary, if even having any importance, relative to that dominant focus.

**SOLUTIONS for Topic #2:**

*Implement a robust Performance Management System that prioritizes and focuses strongly on Satisfaction.* In particular, it would align with the evidence that one’s quality of life is measured by our mental experience and not the physical state: In world class organizations, a simple system that tracks an organization’s ‘net promoter index’ is used to establish the best in class companies. It is a tool that asks if the client/customer would ‘enthusiastically refer’ the services to another person and on a similar level, would the staff ‘enthusiastically refer’ this employment to others. The intention is to get to the heart of satisfaction and drive systems and behaviors to be equally focused on the same. In a time of shrinking labour resources, a system that proactively seeks to understand and respond to staff interests will prove to be the successful ingredient to ensuring a robust health service sector. A further added benefit would be the encouraged evolution of niche service areas as service providers would be motivated to respond to specialized needs without risking assessments that are skewed relative to their peer group. To be clear, a performance management system that has only qualitative measures would be equally deficient and therefore, a blended approach is needed.
**Expand monitoring measures to drive a social model of care.** By simply expanding the driving focus on direct care hours to include a measure for social programming and the overall number of facility hours, the message moves away from a medical focus and onto a balanced service approach. Ideally, a dominant focus on social measures (activities, meals, etc.) paired with tracking care hours and overall facility hours sends a consistent message of priorities (i.e. a Social Model is expected.) An added benefit to monitoring total hours is that it can normalize different operating models (i.e. dedicated skills workers versus multi-skilled workers, etc.) and creates more comparable and meaningful information. Clearly, the missing indicator is an assessment of acuity or mix but on the surface there would be better alignment to the overall direction as residential and social in nature.

**Align funding and incentives with the performance management system.** By pairing the monitoring focus with money and/or recognition, there is a clear direction for behaviors to follow. This solution is age-old and well proven: we motivate what we measure and recognize.
TOPIC #3:
Government Funding Structures & Relations with Service Providers

EXPLANATION for Topic #3:

**Government funds a ‘global amount’ for a broadly stated service known as ‘complex care’**. Currently, the system for funding residential care is based on a ‘global budget’ model wherein operators receive a lump sum amount and are expected to deliver the services within the contract terms. Effectively, the Government funds the bed with the clients being allocated among the available spots by the Case Managers. There are service provider contracts in place but the terms do not stipulate the specific services that must be provided nor do they include the contract funds. These elements are at the sole discretion of the Health Authority and this structure creates an ‘interesting’ agreement as neither the detailed services nor the fees are formally disclosed in the contract.

**Service Providers effectively operate as ‘dependent contractors’**. Specifically, operators are generally expected to openly and fully respond to client’s needs as directed by the Health Authorities – regardless of increasing demands (unless the operator needs to limit their risk by referencing the terms of the license) and have no ability to impact fees (i.e. the contract terms prevent dispute resolution on funding). Acuity levels, which were once recognized as being a basis for modifying funding levels, have been eliminated as has the system for monitoring acuity. In many cases, operators are mandated (via HEABC membership) to pay Facilities Sub-sector Master Collective Agreement labour costs which accounts for over 50% of operating costs and in the few exceptions to HEABC membership, the Health Authorities require approval of any sub-contractor that is engaged by a service provider. In addition, the terms of the arrangement require full disclosure of all financials. In short, the Health Authorities control the revenues, control the costs, have full financial disclosure and are intimately involved in key decisions. Paired with those elements is the conflicting interest structure that occurs as the Health Authority acts as both funder and operator in many settings. The Government has suggested that the relationship between the parties is a business partnership (or at
minimum, an independent service provider arrangement) but the nature of the relations and the manner in which negotiations are conducted suggest that the operators are actually ‘dependent contractors’ and simply an extension of the existing Health Authority operations.

_A funding model is being compiled by Health Authorities that targets a minimum level of direct care hours._ There is currently work in progress that is seeking to establish a funding model that would create transparency and equity between providers (the concept of which is strongly supported). The existing system has a wide variety of rates and is based on a combination of historical calculations, site-specific negotiations and varied annual increases which results in significant inconsistency between operators that can not be explained. It is the industry understanding that the new model will reflect the expectation by the Health Authorities to mandate staffing at a minimum prescribed level. At this time, there is little information on how the system will be presented and what the implications will be for operators. However, the indications are such that there will be more prescriptive requirements and a further progression towards the independent service providers simply becoming a ‘division’ of the Health Authorities.

_The Government’s funding strategy has been to manage costs by controlling labour strategy._ The cost of operations varies significantly between operators depending on two key elements – the cost of labour and the cost of capital. In the case of labour, facilities may be certified or uncertified; they may be part of the Facilities Sub-sector Master Collective Agreement or have independent agreements; and/or they may have contracted service providers with certified or uncertified labour. The diversity of labour options is equally representative of the diversity in costs and in all cases labour costs are lower for facilities that are not part of the Government’s labour strategy. Further, there have been significant discussions arising from Bill 29, Bill 94, the recent Supreme Court of Canada and the review of HEABC membership which makes the Government’s future labour strategy for this sector very unclear and uncertain. In short, the ceiling for labour costs for this sector has historically been established by the Government through its decision to collectively negotiate for Facilities. In the recent past, some ‘tools’ were available to
operators enabling them more influence on their labour costs. However, it is not known what the future direction will be in these areas and, more importantly, how it will align into the funding model. Of particular interest is the question around Government’s need to have a ‘hand’ in managing labour versus setting the funding and allowing market forces to drive the costs. (The cost of capital is addressed separately in Topic #4.)

The ‘base service’ as funded by Government is not clearly defined. There have been on-going working committees challenged with better defining the permitted ‘chargeable extras’ within a funded facility. This work remains incomplete. As well, there are a number of ‘grandfathered facilities’ that are permitted to charge a room differential for private occupancy and/or a larger room. These sites are older and it is therefore inconsistent that an older site can charge a client top-up amount for space which a newer facility is restricted from doing. (Effectively, a client is paying more for older accommodation than what would be required for a new state-of-the-art location – simply due to policies.) In addition, while the work on chargeable extras has had numerous starts and stops, the committee purpose has not been to define and articulate the included services but rather to address items that are permitted for additional charge. This approach avoids the challenging exercise of establishing what qualifies as funded which by default, would permit charges on items that were not listed.

The ‘base services’ set an extremely high standard and further discourages private pay. As the service provider contracts require the delivery of ‘complex care’ (which is a very wide band of services) and the definition of these services are not clearly defined publicly, there is tremendous upward pressure to continuously find new ways to respond to increasing demands without additional funds to do so. Through the vague description of service and a limit on what can be an additional charge, clients expect that all needs are met by the system and it works to reinforce the entitlement mentality. In addition, there is an extremely high base-line set for accommodations which stems from the construction and licensing requirements for developing a new facility. As an example, a maximum of 5% double occupancy rooms are permitted in new developments. This compares to a much higher maximum in other provinces, such as 80% in Ontario, which
is far less costly to build. It would suggest that the BC Government’s ‘base-line’ service mandates that single rooms (not shared) are required. Through this message, it indirectly devalues existing double or multiple occupancy spaces as well as undervalues the social component gained by community or personal connections from shared spaces. But by far the most challenging result is that it creates a ‘bar’ that is extremely difficult for private pay services to exceed in order to attract potential clients away from wanting Government subsidy.

*Alternative funding models have been considered but the industry has not been involved in assessing the merits of a new system.* Alternative models have been explored at various times in the past but there has been limited progress towards aligning a future model with the future vision. Some examples of systems include a client voucher system or an envelope funding system. What is known is that the current funding system is creating a future direction as outlined in ‘Explanation for Topic #1’.

**SOLUTIONS for Topic #3:**

*Establish and communicate the Government’s ‘guaranteed’ services:* Healthcare should consider defining clearly what is part of the ‘Government guaranteed services’ for Residential Care and by default, the industry would be able to establish ‘optional extras’ that could be purchased privately outside of that guarantee. It should look carefully at the expectation as well as the social messages being created by establishing private rooms as the base Government service. This would respond to and further promote choice for clients as well as encourage the creation of private pay services as a means to augment operations and enhance overall client satisfaction with the system.

*Confirm and declare the desired relationship with Independent Service Providers through an assessment of the service delivery options for the sector.* The clarification of this arrangement would greatly assist operators in knowing what to expect from doing business with Government. It would be prudent to review the operating/service delivery
model to ensure that a combined system of Health Authority and Independent providers optimally achieves the desired outputs. In the past, the reason that such a review has been avoided is due to the explanation that Health Authority operations are complex and true costing is not possible. Having had experience with large international companies who fully know the costs associated with their divisions, it is curious that such costing analysis can not be preformed. At a minimum, a review of the objectives for a combined system should be articulated to the parties together with a declaration of the relationship that can be expected. And, ideally, this conclusion would be supported by qualitative and quantitative analysis to support the decision. As an adjunct to this solution, there should be clarity sought as part of the relationship definition that would determine the nature of funding model and labour strategy. Specifically, if the decision is confirmed that independent operators are being engaged and managed under clear qualitative and quantitative performance measures, then a funding model that establishes the ‘purchase price’ should be considered with a conscious commitment to allowing operators to truly manage their affairs. This would modify and/or eliminate the historical direction for collective bargaining and HEABC membership.

*Explore a system of ‘care credits’ as an alternative funding model that better aligns with the future vision.* To promote maximum choice and decision-making, encourage private investment in additional services, and ensure living costs are paid by the user, a system that distributes ‘care credits’ (or client vouchers) could evolve. Specifically, the client would direct their ‘care credits’ (i.e. designated/qualified funds) towards specified organizations – depending on a wide variety of choices. For example, they could consider home support, adult day programs, or community living options. As a means to control costs and limit an “entitlement explosion” as well as to protect current owners and investors in the existing system, only a limited number of service providers would be designated as ‘qualified’. Effectively, there would be a quota allocated, very similar to today’s numbers for facilities, home support, etc., and individual care credits could only be applied to one of those certified providers. The objective would be to promote and support clients to select their preferred method of healthcare delivery while ensuring that funds would only be allocated to certified organizations (the numbers of which are
controlled by the Health Authorities). Clearly there are challenges to this model but it strives to direct the cost of health services to be separate and distinct from hospitality and accommodation costs while seeking to deliver maximum choice to the users.

**Consider an envelope funding system as an interim measure between today’s model and a future state model.** As an interim step to the above proposed solution, there is merit to exploring an envelope funding model (similar to other provinces) as a means to separate hospitality and accommodation costs from the cost of healthcare services. Establishing funding parameters for each envelope ensures comparability between sites and seeks to build efficiencies into the services while fully appreciating the increasing costs associated with new development. However, it does not promote efficiency unless the operator is able to maintain funds based on achieving performance measure in spite of costs. This solution is viewed only as an interim measure.
TOPIC #4:
Client Contribution (Client User Fee)

EXPLANATION for Topic #4:

_The current Client User Fee system does not ‘blend’ into the private pay system which creates a large gap in costs and therefore, encourages individuals to seek out Government subsidy._ Currently, client user fees for Residential Care services are based on a model that establishes the client’s hospitality and accommodation contribution to ranges from $28 per diem to $65 per diem, depending on income levels (relative a total service cost that ranges between $160-$200 per diem.) In contrast, the equivalent private pay rate for Residential Care ranges between $140 per diem to $180 per diem depending on client needs. (Private rates are slightly lower in cost as the individuals who opt to pay privately for their services tend to be lower in acuity than their Government funded counterparts.)

As a result of this cost range, there is a significant gap between the client’s cost under the Government system (i.e. a maximum of $65 per diem) and the equivalent rate if someone pays privately. With an annual cost spread of approximately $27,000 ($140-$65 x 365), individuals are certainly motivated to seek the methods for obtaining Government funding – regardless of their ability to pay.

_The current Client User Fee system does not encourage the growth of private pay facilities nor does it encourage individuals (who have the means) to consider private pay as an alternate to Government subsidy._ In addition, as the majority of private pay bed stock is situated within facilities that also host the Government funded services (i.e. contracted service providers), there is the stated expectation by the Health Authorities and Government that individuals within the facility receive comparable and similar services (i.e. no segregation or service differences relative to source of payment). As such, there is little again that would motivate or encourage individuals to consider paying privately, despite their financial means, as there is no difference in the service received.
The current Client User Fee rates do not adequately reflect the cost of hospitality and accommodation services in new facilities and the system of placing individuals does not reflect the cost differences associated with capital differences (i.e. new versus older locations). As the cost of new construction continues to escalate, the cost of Residential Care services has continued to climb. The private pay rates have been modified to reflect these increases simply based on the increased cost of accommodation in new facilities. However, the client user fee component has remained relatively constant and does not appropriately recognize the increases nor does it recognize (or value) the differences in capital contribution that are required to stay in a new facility as compared to an older building. In certain urban areas of the province and under the costing associated with new construction, the client user fee maximum of $65 per diem is insufficient for hospitality and accommodation costs. For some older facilities, the rate may be appropriate but when the system strives to be equal (not equitable) to all, differences continue to exist.

The current Client User Fee system does not honor or respect the economic realities of life and the resulting choices we all need to make. The client contribution is determined solely based on their income and bears no reference to the cost of the housing and accommodation service received. In contrast, at all other times of life, people make choices to pay for accommodation that they can afford and accept the options available to them. This system does not acknowledge nor incorporate that fact. The policy of placement in the first available bed strives for equality but is not equitable if one considers that the same user fee contribution can result in new or old surroundings, simply by the “luck of the draw”. Effectively, the only motivation created is for an individual whose placement opportunity comes up with a facility that they do not prefer, can then opt to pay privately elsewhere. However, if they have ‘good’ luck and are placed into one of their preferred options, the Government has signed up for an ongoing subsidy. As the demographics continue to increase, the absolute number of individuals that will qualify for services under the current system also increases as do the hopes of ‘lucking’ into the preferred place. In its current structure, the system strives heavily for
equality without acknowledging the ‘realities’ that exists at all other stages of a person’s life (i.e. you live where you can afford).

SOLUTIONS for Topic #4:

*Create a Client User Fee model that better blends the cost of funded services into the cost of private services.* It is recommended that the client user fee model should extend such that there is marginal difference between a person paying privately and the least subsidized level of Government care (i.e. the maximum user fee). The objective is to create a blended system that inspires individuals to consider private pay as well as motivating private investment in the creation of alternative healthcare services. In order to promote innovation towards reducing the capital costs associated with licensed care facilities, there will need to be support from licensing and specifically within the prescriptive and costly requirements for buildings. It would then be possible for service providers to become more innovative and find a means of further reducing the costs of private pay services – which could indirectly benefit the Government. As well, this solution seeks to create a social shift by promoting private pay and reduces the drive towards Government subsidy (as the expanded client user fee would cause clients to consider private options as a natural part of and alternative to fully funded services.)

*Create a client user fee model that better reflects the true cost of accommodation and introduces choice for the client.* It should be reasonable that a newer facility would have an accommodation cost that is higher than its older counterpart. In the new Client User Fee model, a client would still qualify for a particular user fee rate based on income. However, that level would align with various designated facilities that have a corresponding cost of accommodation (within that predetermined range). The first available bed policy would continue to apply for the facilities within that range and in the event that the client could obtain supplementary assistance from other means (i.e. family), they could consider another accommodation option accordingly. Alternatively, the Government may decide to place a client in a higher accommodation cost facility and
subsidize the difference (depending on the circumstances). This approach is an extension of the envelope funding concept that is referenced in Topic #3. Specifically, the accommodation & hospitality costs of a facility are set and the client is able to ‘select’ within the range of their affordability. The added benefit to this model change is that there is an increased ‘value’ to older facilities as their inherent capital costs are significantly lower making them attractive affordable options. It is known that many of these older sites deliver exceptional care services despite a so-called compromised physical state (relative to ‘current standards’ only) and would become very attractive options for affordability. It simply promotes using the existing infrastructure as optimally as possible. As well, the newer developments would need to ensure the hospitality and accommodation costs are also affordable to clients (or work accordingly with the Ministry of Housing) and therefore, prevent our healthcare system costs from needing to subsidize housing.
REFERENCES:

Recommendations are based on the following sources:

- 7 years hands-on operations experience in the capacity as CEO of a large private seniors housing & services company that offered campuses of care as well as independent, assisted and residential care housing & service options. Locations were dispersed throughout 4 health regional areas within British Columbia;
- 5 years board experience and a member of the executive (including the President for most of those years) for BC Care Providers Association; and
- 2 years as one of two British Columbia representatives with the Canadian Association for Long Term Care (a national consortium representing long term care operators in Alberta, Saskatchewan, Manitoba, Ontario and Nova Scotia).