

Creating Outstanding Practices in Continuing Care

Submitted to Marten Van Huizen and Charis Village

By

Elden Wiebe, PhD
George Watts, MBA, MIB

July 25, 2011

Executive Summary

Charis Village Housing Society was formed in 2008 in response to the need to provide a faith-based seniors' housing facility in Central Alberta. This facility is to be based on Christian principles and values that will provide the basis for and "guide our future goals and plans." They envision their efforts will create a "village of care" that will allow seniors to 'age in place' within a "very specific and deliberate Christian context." Charis Village Housing Society is currently "working on becoming more familiar with other senior's complexes to give us some ground work as far as how the development would look." (Charis Village website).

To assist this endeavor, Charis Village Housing Society commissioned this report, which seeks to address the issue of best practices in continuing care. To do so, this report focuses on the following:

1. In Section 1 we address the issue of what is a 'best practice', contrasting the idea of best practices with what business researchers have called 'signature practices.' The combination of best practices and signature practices has been linked to the provision of excellence in work processes and outcomes.
2. In Section 2 we examine the trajectory of the Government of Alberta's development of continuing care as a 'continuum of care' as well as the minimum best practice standards established by the Government of Alberta in both provision of health care and accommodation. This is augmented by a review of best practices in continuing care in studies done at the national level.
3. In Section 3 we examine best practice models of continuing care developed in the last 20 years which reflect profound dissatisfaction with the typical nursing home model. The models examined are the Eden Alternative and its 'Green House' prototype, the Planetree model including the Wesley Village working example, and the Pioneer Network and Culture Change Movement.
4. Finally, in Section 4 we raise several research results that anticipate important developments in continuing care now and in the future. Among these is the quality of life as defined by seniors themselves, the social vs the medical model of care, the importance of socialization and social engagement, the care trajectory of seniors, the place of spirituality in continuing care, and the campus model of aging in place.

SECTION 1

Best Practices and Signature Practices

Adoption of best practices—that is, benchmarking practices of the best-in-class competitor within a market segment or industry—is an important management tool in the for-profit world. It assures the adopter of improvement of operational efficiency and it assures the adopter of not becoming a laggard in their industry. However, benchmarking also assures that margins for all competitors will diminish to a minimum as each firm seeks to occupy essentially the same strategic space. Moreover, what was once a best practice relatively quickly becomes a common practice performed by most if not all players (Nattermann, 2000; Gratton and Ghoshal, 2005). The result is sobering. As Collins (2005: 1) points out, “When you compare great companies with good ones, many widely practiced business norms turn out to correlate with mediocrity, not greatness.”

Gratton and Ghoshal (2005) contrast best practices with what they refer to as ‘signature practices.’ Signature practices are unique, idiosyncratic practices found in high performing organizations that develop out of the beliefs, passions, and interests of the organization. What is more, they can be (and perhaps often are) opposite to what is considered best practice in an industry. For example, Gratton and Ghoshal (2005:50) found one outstanding company requires business unit heads to support peers in other business units which are underperforming, tying significant compensation to the results of the underperforming business unit. This flies in the face of received best practice that executive compensation should not be tied to performance outside the executive’s control.

The presence of signature practices, however, does not preclude the adoption of other best practices. Rather, the two sets of practices should be seen as complementary, enabling an organization to compete at very high levels and to achieve outstanding results.

Delineating signature practices and best practices further, we can get a better understanding of how they may enhance an organization’s performance. Fundamental differences are evident in the origin, development, and foundation (or core) of these practices. Signature practices are “processes that have evolved internally” (Gratton and Ghoshal, 2005: 50) and are linked to the organization’s core values. Within their respective organizations, signature practices “are believed to serve as one of the crucial links between the processes of the organization and the vision, values, and behaviors of top management. They are imbued with energy and passion” (p. 50), and embody the organization’s history. This source (development from within), foundation (the core values and history of the organization), and development (championed by upper management) gives signature practices incredible power and vitality. Gratton and Ghoshal (2005: 56) observed:

We saw that, when people are participating in the signature processes..., they are ‘in the flow.’ The energy they exhibit is palpable, and they are oblivious to time. When people participate in the signature processes, they feel good precisely because, deep down, the process expresses something they believe in. They feel that what they are doing deeply resonates with who they are and what they value.

In addition, linked as they are to the heart of the organization, signature practices remain largely idiosyncratic to the organization—that is, they are very difficult, if not impossible, to adopt and replicate in other organizations, even when those practices appear relatively straight-forward.

Best practices, on the other hand, originate outside of the organization and at their core represent shared knowledge. This shared knowledge can come from books, conferences, consultants (who deal with particular issues using a few templates), and personal meetings with executives from comparable organizations. By its very nature, shared knowledge is explicit (rather than tacit) knowledge, and becomes abstracted from its context. In a very real sense it becomes generic. As such, best practices are representative of practices that are becoming increasingly common across an industry. They level the playing field for all competitors utilizing them (Gratton and Ghoshal, 2005: 51).

Nevertheless, while generic in nature, best practices must still be adapted to the organization adopting them. Processes and practices must be learned as they enter a new, already established context. The specific context within which they are implemented will demand recontextualization of those practices. ‘Context’ may be as broad as the national culture (Hope and Muehleman, 2001) or as narrow as another division or business unit within the same organization (Brown and Eisenhardt, 1997). The interaction between (external) best practice and (internal) context may reshape the best practice (e.g. strategic planning models restructured for a high-velocity industry), make the best practice untenable (e.g. the introduction and abandonment of quality circles), or profoundly change the organization’s context and culture (e.g. ISO certification).

The problem of contextualization leads to an important impediment in the adoption of best practices. That impediment is the knowing—doing gap. While an organization may be able to observe what is considered best practice in an industry, it may not have the organizational context needed to implement the practice in any meaningful way. This is true for even documented evidence-based best practices and best practices enshrined in the regulatory framework. Thus, the source of best practices (external), their foundation (explicit/generic shared knowledge), and their implementation (recontextualization requiring careful and sometimes difficult adaptation) can make adoption of best practices much less effective than we might assume.

Best Practices and Signature Practices in Non-Profit Settings

In the non-profit world, best practices are often “exemplary” practices which are then shared with other organizations within a sector either through reports, consulting, or conferences. For example, Hollander (2007: 1) “conducted a series of case studies of exemplary continuing care service delivery systems” in order to discern best practices of such systems. But sometimes best practices are merely the common practices of most organizations in a sector (e.g. 1999 Federal report on Innovations in best-practice models of continuing care for seniors). This latter group—common practices—can hardly be labeled ‘best practice’, and are susceptible to Collins’ (2005) observation of mediocrity. The former group—exemplary practices—are more likely signature practices that are carefully developed within a particular organizational context. As such, the implementation of exemplary practices is almost doomed to failure given the inability of organizations to adapt practices that are by definition idiosyncratic, being linked to an organization’s values and history, and championed by committed upper management. That non-

profit settings are not competitive in the same way as for-profit settings does not detract from the reality of the difficulty of implementing practices developed in other organizations. Those barriers remain. Moreover, competition still exists in the non-profit sector between non-profit organizations (e.g. in terms of fundraising), and thus there remains a reluctance to disclose exemplary processes. In fact, more extensive market competition is somewhat greater in the area of continuing care, which has a mixture of facilities operated by government, non-profits, and for-profit organizations.

The Way Forward

The way forward, then, is three-fold. First, an organization must pay attention to the regulatory environment. Within continuing care in Alberta are important regulations and standards that must be adhered. For example, Alberta Health and Wellness requires adherence to medical standards and procedures. Alberta Seniors and Community Supports requires adherence to standards for various types of housing/facilities. The standards developed by the province are best practices in that they represent in general the best of widely shared knowledge. As will be shown below, these practices have developed over time, and as new insights are uncovered, the practices eventually change to incorporate those insights.

Second, exemplary practices developed by other organizations can be adopted either as a whole or in a modified form. That is, exemplary practices might be distilled into a more generalized abstract framework or process which allows the adopting organization to more easily re-contextualize the practice into their own organization. For example, Hollander (2007: 1) examined exemplary continuing care delivery systems in order to facilitate the development of “a best practices framework for organizing continuing care service delivery systems” (my emphasis). He refers to the framework as a ‘third way’ which

represents a slightly higher level of abstraction than a model and is an approach that allows, within an agreed set of principles or parameters, for a number of variations to address unique circumstances. The framework is sufficiently flexible to be applicable.... Based on this framework, more specific models...could be developed (p.79).

Third, an organization must pay attention to its own values, beliefs, and history and do the hard work of developing its own signature practices. Executive leadership must commit to their organization’s history, values, and beliefs as well as bringing their own passion, values, and beliefs to bear. For example, Gratton and Ghoshal (2005:53-57) describe a signature practice at the Royal Bank of Scotland which dated back to 1727. This practice was daily morning meetings of the executives. This practice flies in the face of common practices today. However, this practice has deep roots in the bank’s early banking practices, and is based on the core values of respect and accountability. Gratton and Ghoshal (pp55-56) observed:

These values, which executives see as emanating from the company’s Scottish Presbyterian roots, emphasize the virtues of pragmatism, honesty and a respectful egalitarianism that is practical, down-to-earth, straightforward and action-oriented. The morning meetings provide an opportunity for these historical values to become a day-to-day reality.

Another example is the Good Samaritan Society in Alberta which has established its own process of moving research results into practice (Elm and Johnson, 2000: 324). This 'signature process' is described as follows:

First, a need to determine best practice in a particular area is identified. Second, research is reviewed by best practice consultants who then present findings and recommendations to the Best Practice Council. The council is a group of leaders representative of service providers and decision makers across the organization. Council members approve the recommendations as appropriate, and then decision trees, process maps, and policies and procedures reflective of a critical analysis of the research findings are developed. Dissemination of best practice takes place by education. Monitoring of best practice is then done by the council.

The values and beliefs of an organization, typically expressed in its mission, are foundational to its identity and operation. As these connect with day-to-day tasks and routines through signature practices, the power and passion of those values and beliefs actually touch everyday reality, and the organization experiences a sense of purposefulness, wholeness, and overall well-being.

Together, legislated best practices and adapted exemplary practices place an organization in good standing with regulators and on an even playing ground with the best competitors. Internally developed signature practices, however, are a powerful way of expressing one's mission and core values in the concrete day-to-day actions of employees as they interact with elders, and as such become a powerful source of competitive advantage.

SECTION 2

Regulatory Environment

Introduction

We now address the regulatory environment of health care and accommodation in Alberta. The three fundamental objectives for this section are to discern the ongoing policy direction of the Government of Alberta in continuing care, to highlight some of the key government regulatory documents and requirements, and to uncover where additional leeway exists to go beyond, while remaining within, the regulatory regime. We also examine the state of continuing care at the national level, through several key national studies conducted over the last 12 years.

In examining the key documents concerning continuing care within the regulatory environment in Alberta, it is evident that the Government of Alberta continues to affirm and support the central direction of continuing care established in 1999. Client centered care, client and family involvement, integrated care-giving, equitable funding for seniors regardless of accommodation type, and committed funding for increasing community supports as well as the building/renovating of accommodations reflect the ongoing commitment to the new model of continuing care established in 1999. The creation of the ministry of Seniors and Community Supports and its close collaboration with Alberta Health and Wellness is a welcome development in the provision of continuing care since it recognizes the importance of the social component of continuing care.

We also find further refinement and ongoing development of best practices. This is evident, for example, in the clarification and development of broader housing/health options (especially in supportive living) and the refinement of ‘aging in place’ to ‘aging in the right place.’ The addition of minimum standards and licensing of all continuing care accommodation providers—whether private or publically funded—also reflects growing clarity at the government level of how continuing care should be provided in Alberta within the new ‘continuum of care.’

Finally, we also note that the Alberta government has not only sought to unbundle health care and housing, but it encourages providers to go beyond the minimal standards to create many more options for seniors in continuing care. We begin to point the way forward here, which culminates in Section 4.

Best Practices: Alberta

We begin with the legislative requirements for providing continuing care in the Province of Alberta. These requirements effectively establish a baseline for best practices beyond which the adoption of exemplary practices of other organizations and development of internal signature practices can be undertaken.

Foundations for the Provision of Continuing Care in Alberta

The change in the provision of long term care toward continuing care in Alberta began in 1995 with an announcement by then Minister of Health Shirley McClellan that Alberta would be

participating in a multi-level Federal, Provincial, and local initiative supporting six continuing care demonstration projects on 12 sites. Key issues were already surfacing with this announcement (Alberta Health News Release, August 31, 1995):

- provid[ing] clients with increased choice, independence, and decision-making
- enhanc[ing] the ability of Albertans to live independently in the community
- avoid or delay institutionalization

This was followed by a formal review of long term care services by Health Minister Halvar Jonson begun in 1997, spurred by the realization that the baby boomer demographic would soon begin to put tremendous strain on the present, and inadequate, long term care system. A province wide consultation was undertaken, consisting of a review of current long term care services followed by an extensive consultation with seniors, interested Albertans, health care professionals, experts in the field, and members of various organizations and government departments.

The consultation culminated in the report, Healthy Aging: New Directions for Care (Nov. 1999), which was comprehensively adopted by the Government of Alberta. The recommended shift in continuing care was described as a paradigm shift—a fundamental change in the way the government thought about and financed continuing care (see Table 1, below, p. 9). At the heart of this change was (1) the provision of more choices for seniors for the type of care and the location where they received care, (2) a focus on prevention of health problems, and (3) co-ordination of care between informal caregivers (e.g. family, friends, and community members), care providers (e.g. supportive housing providers) and health care professionals across sectors. The report outlined six guiding principles based on this new vision for continuing care (see Table 2, below, p. 10). In effect, these principles became the basis for continuing care best practices in Alberta in 2000. Regional Health Authorities throughout the province were instructed to begin implementing these principles at that time.

Further Development of Continuing Care in Alberta

Continuing care policies in Alberta have been regularly refined since 2000. A second province-wide, cross-sectoral consultation took place, which included seniors receiving care/services, family members, health service providers, supportive living and long-term care housing operators, industry and professional associations, educational institutions, and unions. In November 2005, the MLA Task Force on Continuing Care Health Service and Accommodation Standards released their final report, Achieving Excellence in Continuing Care.

A particular strength of this document is the inclusion of comments from the broad group of stakeholders who participated in the consultation. The document sheds light on what could become best practice in the industry, given that client centered care has been at the heart of the provision of continuing care in Alberta since 1999 and is reaffirmed as central in subsequent documents, including the Alberta Health Act currently being debated in the Alberta Legislature.

Table 1
Changes in Long-Term Care Articulated by the Alberta Government, 1999

Continuing Care Today (1999)	Continuing Care in the Future
Few Choices—stay home if help is available, otherwise move to long term care facility	More Choices, within prescribed sequence of home care, supportive housing, and finally facility care, moving from one to the other as level of care required increases
Some Home Services	Extensive Home Services
Supportive Housing is beginning	Major Expansion of Supportive Housing
Long-term Care is common option	Continuing Care for “complex and chronic” health needs only
Focus on treating illness	Focus on prevention (“stay healthy and well”)
People go to medical services; services are attached to place; services not well coordinated	Services come to people; they are mobile and unbundled (only what is needed); services fully coordinated by case managers
Lack of coordination of services for older people; difficult to navigate the system	Provide Coordinated Access to the full range of continuing care services through initial assessment and case coordination
Old facilities; too many people to a room	New care centers to be developed and services expanded (e.g. palliative and respite care); 4 person rooms to be phased out
Lack of training in geriatric medicine and not enough trained health care providers meeting needs of seniors	More and mandatory training programs for health care professionals coordinated with the needs of care providers; also focus on attracting health care workers for continuing care
Family and Friends carry much responsibility with increasing stress	Informal caregivers added to the team providing care, as well as day programs and respite programs
<p>“This new direction for continuing care represents a fundamental departure from today’s situation. We believe it is the right direction for Alberta—a direction that reflects the changing expectations and needs of a new generation of aging Albertans, and a direction that will result in better care—better coordinated care—for an aging population.” (p. 20)</p>	

Source: Adapted from Alberta Health and Wellness, Healthy Aging: New Directions for Care. Part One: Overview, Nov. 1999.

Table 2
Guiding Principles for a New Direction in Continuing Care

Guiding Principles	Description
Wellness and prevention	<ul style="list-style-type: none"> • Support healthy aging for all Albertans • Emphasize promotion of health and prevention of illness, injury and disease • Help Albertans to cope effectively with chronic conditions and function to the best to their abilities
Client centered	<ul style="list-style-type: none"> • Endeavour to understand and meet client and family needs, work in partnership with clients, and ensure client choice where possible • Acknowledge the client's right to dignity and self-determination • Have reasonable access to a variety of affordable services and have their needs met in a flexible, timely and responsive manner • Respect the clients right to privacy of space and person • Recognize and respond to the physical, psychological, spiritual, and social aspects of health
Information	<ul style="list-style-type: none"> • Provide clients with access to information required to make informed choices and decisions regarding care and services • Ensure confidentiality of personal information, however, allow appropriate sharing of information to support the highest quality of services and best possible outcomes
Individual and shared responsibility	<ul style="list-style-type: none"> • Encourage independence by assisting Albertans to reach their greatest potential, recognizing that clients and families have the primary responsibility for their own health • Recognize the concept of interdependence and facilitate collaboration between Albertans, community and government
Effectiveness and efficiency	<ul style="list-style-type: none"> • Make decisions based, as much as possible, on the values of the consumer, on evidence provided through research, evaluation and technology assessment, and available resources
Intersectoral approach	<ul style="list-style-type: none"> • Recognize that, by working together, Albertans, government, regional and provincial authorities, non-government organizations, and the voluntary and private sectors all have an active role in contributing to the health of Albertans

Source: Taken from Alberta Health and Wellness, Healthy Aging: New Directions for Care, Pt One: Overview, Nov. 1999, pp 13-15.

While the MLA Task Force final report (2005) offered 45 recommendations in twelve areas of concern¹, especially pertinent to the issue of housing are the recommendations and stakeholder comments for:

- Staffing—adequate level and mix of trained staff for the various care levels
- Food services—the need for on-site preparation of quality foods by trained cooks/chefs
- Access to services—ensuring appropriate types of housing and levels of care where people wish to live; keeping couples together if they wish; and developing alternatives to the ‘first available bed’ placement process
- Resident/family satisfaction and concerns resolution—utilize a hospitality/customer-centered approach including using concerns as avenues of improvement; provide respite care; and involve family, residents, staff and volunteers in contributing to care and improving services
- Standards and legislation—updating all standards and legislation; standards to be applicable to all facilities providing seniors’ care, whether publically funded or not; regular monitoring and enforcement required
- Monitoring, compliance and enforcement—that all long term care facilities be accredited by the Canadian Council on Health Services Accreditation (CCHSA) which has a nationally recognized set of standards for organizations; that all public or private continuing care health service providers (including supportive housing) be held accountable to a basic set of accommodation standards and monitored on a regular basis (e.g. yearly); that there should be a coordinated approach to health and housing; that providers should be assisted in developing a plan to remedy any failures to meet standards; and that supportive living and long term care providers should be rated for quality of life and care provision
- Funding the system, funding individuals—current funding models can hamper ‘aging in the right place’ by disincentivizing moves from long term care to supportive living; thus, it is important to explore funding that incentivizes maintaining or increasing client functionality, including the possibility of having funding follow the client and reviewing funding limits for home care
- Health benefit and income support programs—AISH (Assured Income for the Severely Handicapped) and ASB (Alberta Seniors Benefit) funding should not change in relation to the location from which those services are accessed (e.g. home vs supportive living vs long term care)
- Building design and infrastructure—business case for new long term care facilities must present evidence of local need and preference for planned mix of private and shared

¹ For the specific details of the twelve areas of concern, we refer readers to the document, [Achieving Excellence in Continuing Care](#), 2005 published by the Government of Alberta.

rooms; development of basic design standards for publicly funded supportive living and long term care facilities; update building codes in view of new health care models which include the more complex ‘campus’ model

- Achieving, promoting, and recognizing excellence—establishing a network of excellence in the provision of care and accommodation for seniors and persons with disabilities; need to recognize both the medical and social model of care; need to assist health and housing providers to achieve excellence beyond the set standards
- Public awareness and communication—develop and adopt province-wide the Seniors’ Supportive Living Framework; adopt and distribute the Long-Term Care Facilities Information Package; share information on the general public’s rights and responsibilities as they relate to health and accommodation services in continuing care

Enactment of the Recommendations of the MLA Task Force on Continuing Care Health Services and Accommodation Standards

The recommendations of the MLA Task Force were addressed in several ways. The Government of Alberta, through Alberta Health and Wellness and the Ministry of Seniors and Community Supports, established two frameworks to guide the delivery of continuing care. The pairing of these two ministries recognizes the need for health services and accommodation services to work together. We will now turn to the frameworks and other documents that have resulted from the MLA Task Force study.

Supportive Living Framework

The first framework is the Supportive Living Framework (March 2007), which outlines four levels of supportive living and four dimensions cross-cutting the levels that can be used to match housing and health services.

Supportive living addresses a greater range of services and care than the original concept of ‘supportive housing.’ Supportive living now encompasses:

- Level 1: Residential living
- Level 2: Lodge living
- Level 3: Assisted living
- Level 4: Enhanced Assisted living (includes Designated Assisted living)

(Note: a diagram of supportive living within the overall continuing care system is provided in Appendix 1.)

The four dimensions that cross-cut the levels of supportive living are (1) *resident needs*, (2) *building features*, (3) *hospitality services*, and (4) *health and wellness services*. (See Appendix 2 for a chart taken from the Supportive Living Framework [March 2007], which details each of these dimensions by level of care.) This framework provides a guideline that can be used by

residents and their families to decide the appropriate level of care (building features, hospitality services, and health/wellness services) for the resident's needs at any point in time.

It is important to note that the prescription of standards among the different supportive living levels for building features and hospitality services is the minimum expected (see p. 5 of the Supportive Living Framework). The document actually suggests that a wide range of housing and service options are available:

Given that the nature of supportive living is to respond to individual needs and maximize choice, it is not possible to describe all of the possible combinations of housing, support services and care that exist now or that will exist in the future. This framework will need to be updated as the supportive living concept continues to evolve and mature. (p. 1)

Thus, while the Supportive Living Framework (March 2007) outlines essential differences between the various levels of housing, within the document there is latitude to provide a higher level, and perhaps even unique combinations, of housing and services beyond the minimum.

Fundamental to the variety that is possible, however, is the adherence to the basic principles that guide supportive living.

1. One central principle is that of “unbundling health and housing services,” allowing for a wider range of options and greater choice for residents so that they are able to ‘age in place.’ (pp 2, 4, 7). Unbundled services points to the commitment to provide needed services in a variety of settings, rather than having the setting determine the available health services. This means that it is possible to have several levels of resident care available in the same supportive living facilities. Thus, as residents’ needs change, services can be further enhanced to allow residents the choice of remaining in that particular facility. It is also possible that a resident will choose to remain in a particular facility even though their needs are beyond the available resources (see p. 4). Evident in this observation, however, is the recognition that housing and health are still linked to some degree, and that any particular residential option may not adequately address all health needs within a supportive housing definition.
2. The second central principle is ‘unmet needs.’ This refers to health needs, not hospitality needs. Unmet needs are those health needs that cannot be met by the individual given the individual’s personal, familial, and community supports. Unmet needs, however, may diminish where greater hospitality services are available (see Section 4 below; it is important to note that hospitality services do not include personal care services [activities of daily living and therapeutic regimes], which are covered by health services). The Supportive Living Framework (March 2007) outlines basic services that are either available or must be provided at each level of supportive living, but it is possible for a housing provider to supply greater levels of hospitality services and increase the family and community supports residents are able to access. Increased supports reduce unmet needs and hence the health services required.

3. The third central principle is the possible contracting of some supportive living spaces by the health authority (i.e. Alberta Health Services). These spaces are referred to as ‘designated supportive living’ spaces. Importantly for accommodation providers, these spaces are under the control of the health authority in collaboration with the housing provider, and provide a particular level of health and support services based on assessed need for the geographic area. Admission and discharge are determined by the health authority in collaboration with the housing provider.

The Supportive Living Framework (March 2007) also outlines seven general principles to guide the ongoing development of supportive housing in subsequent years (pp 2-3). These principles underscore the importance of collaboration between housing providers, the government, the health authority, social service providers, and the residents/families to develop the best supportive living arrangements possible. The principles are the following:

1. Supportive living options recognize the individuality of each resident and his or her changing needs.
2. Communities will strive to have a range of supportive living options that can meet the service and affordability needs for local residents wanting to stay in or near their own communities.
3. All orders of government, regional health authorities, housing operators, and other stakeholders will work collaboratively to develop and deliver supportive living options.
4. To maximize choice and flexibility, health, housing and social service providers will work together and with residents and/or their families when coordinating and collaborating on a person’s housing, care and service options.
5. To the extent they are able, Albertans are responsible for the costs associated with their supportive living accommodation. Provincial accommodation assistance will be targeted to those who need it most.
6. Regional health authorities [Note: now Alberta Health Services] are responsible for funding professional health services and personal care services to address individuals’ assessed unmet needs.
7. The provincial government is responsible for setting overall policies and strategies, legislation, and funding in areas of its responsibility, while operational decisions will be made at the local level, consistent with provincial priorities and accountability requirements.

Continuing Care Strategy: Aging in the Right Place

The second framework of importance is found in the document, Continuing Care Strategy: Aging in the Right Place (December, 2008). This document builds on the Supportive Living Framework, but refines the original concept of ‘aging in place.’ Alberta’s continuing care

strategy seeks to expand the options available and thereby offer more choices to seniors, so that they are able to ‘age in the right place’ for them; that is, “the right level of service is provided in the right setting, supporting Albertans’ preference to choose their own accommodations” (p. 3). Within this framework, ‘supportive living’ is now explicitly conceptualized as a “bridge between home living and facility living” (p. 19).

Strategies the government is using to achieve ‘aging in the right place’ are five-fold (note also that in the government document each strategy is linked to a timeline for implementation):

1. Investing in community supports:
Developing initiatives which increase the ability of seniors to remain in their own homes or in supportive living. It will also allow some seniors to return to their homes or to supportive living accommodations from nursing facility care. This strategy recognizes that many families are highly involved in the care of their loved ones, and thus seeks to provide for respite and other forms of support for families, as well as increased home care funding for health professionals. It also recognizes that communities can and do contribute to the well-being of seniors and others who need care, and therefore encourages the creation and development of volunteer organizations that will provide social supports. Together, the initiatives allow much wider variety of combinations of adequate health care and accommodations.
2. Building infrastructure to support the ‘aging in the right place’ vision:
Utilize capital funding to increase seniors’ options for quality accommodations that meet their life-style and care needs. This is addressed through replacement/refurbishment of older accommodations, new private investment in long-term care and supportive living accommodations, and cost-sharing arrangements to develop new accommodations.
3. Changing payment for long-term care accommodations:
Allowing for a new fee framework to support the provision of more long-term care beds by providers who are willing to offer more services/amenities for those who are willing and able to pay for them.
4. Options to fund individuals based on needs and/or funding providers:
Allocating funding to the person rather than a facility, allowing more choice regarding where a senior receives services.
5. Providing equitable drug coverage for people wherever they live:
This strategy allows equal drug coverage wherever seniors choose to live, rather than only in facility care.

Implementation of the Recommendations of the MLA Task Force on Continuing Care Health Service and Accommodation Standards

Health Care Services

Recommendations pertaining to *health care services* were enacted by the Government of Alberta in 2006 and updated in 2008 through Alberta Health and Wellness. The key document, Continuing Care Health Services Standards (July, 2008), indentified “standards for the provision of quality continuing care health services [defined as care exceeding three months] that take into consideration the individual needs, preferences and abilities of each client” (p. 2). The principles on which this document is based (see Table 3, below) affirm the original principles outlined in 1999 (see Table 2, above, p. 10), though it recognizes that quality of care is a phenomenon that requires ongoing monitoring and improvement. Responsibilities at the operational, regional (now Alberta Health Services), and provincial level are delineated. Especially pertinent for supportive living and long term care operators are the operational and regional/operational responsibilities (see document for details).

Table 3
Principles for the Continuing Care Health Service Standards, 2008

Guiding Principles	Description
Client Centered Care	<ul style="list-style-type: none"> • The client and their unique needs and preferences are at the heart of care planning, coordination and delivery of health service • The client participates in the decision making concerning their health care
Integrated Care Teams	<ul style="list-style-type: none"> • Care plans require many individuals working together to develop and provide the needed care. Members of the team know their role/responsibility within the team and support one another in providing the best possible care.
Client and Family Involvement	<ul style="list-style-type: none"> • Clients and their families are part of the integrated team. • They know their roles/responsibilities and are supported in making informed decisions about their care.
Wellness and Safety	<ul style="list-style-type: none"> • Provide health services for assessed needs and promote/maintain well-being in a such a way as to ensure safety
Quality Assurance	<ul style="list-style-type: none"> • Ensure compliance with standards in order to provide a minimum level of quality in care provision
Quality Improvement	<ul style="list-style-type: none"> • Using evident based practices to improve the quality of care • This requires supporting innovation and creativity, as well as cultivating a culture of quality • Based on the 6 dimensions of quality in the Alberta Quality Matrix for Health

Source: Adapted from Alberta Health and Wellness, Continuing Care Health Service Standards, July 2008, p. 2.

Accommodations

Recommendations pertaining to *accommodation* were enacted in 2006 by the Government of Alberta and administered through the Ministry of Seniors and Community Supports. This ministry works in conjunction with Alberta Health and Wellness to deliver continuing care in a more coordinated and seamless manner.

Of particular interest for supportive living and long term care operators is that the document, Achieving Excellence in Continuing Care (November, 2005), suggests recommended accommodation standards be equally applicable to sites which are not publicly funded as those that are (p. 2). This suggestion has been adopted and is currently enacted (1) through the requirement of licensing all continuing care operators, and (2) through legislated mandatory adherence to accommodation standards developed by the Ministry of Seniors and Community Supports. The document Long-Term Care Accommodation Standards (April 2010) outlines 30 standards that private, voluntary, and public operators must meet and maintain in addition to health care service standards. The document Supportive Living Accommodation Standards (April 2010) outlines 32 standards that, again, all operators must adhere to and maintain. Health care and personal care service standards must also be met by supportive living providers if those services are publically funded.

The accommodation standards for long-term care and supportive living represent minimum standards. The stated purpose for these standards is “to ensure that all supportive living [and long-term care] accommodations maintain a high quality of accommodation services that promote the safety, security and quality of life for Albertans living in those accommodations” (Supportive Living Accommodation Standards, April 2010, p. 4). Their intent is to provide accreditation for operating and confidence among the public as they access continuing care services for themselves or family members.

Conclusion

From our survey of the key Alberta Government documents pertaining to continuing care, we can see that the decade-long initiative in continuing care has not been reversed in the subsequent years since inception. In fact we have seen that initiative strengthened and further refined. This is critically important for developing new continuing care facilities since it suggests stability in policy at the provincial level. We certainly expect ongoing learning and refinement to continue, but that that refinement will be within the present fundamental direction.

From the perspective of best practice, the current development of continuing care standards represents the minimum expected practice in Alberta. In the words of one continuing care operator—an executive of a faith-based continuing care provider in Alberta—these standards are considered the best practices in the industry. However, at best they are minimum standards which will become common to all operators. And as we will see in Section 3, these minimum standards may in fact pose barriers to implementing practices that produce excellence.

It is our contention, then, that the current government standards alone will not produce excellence in the provision of continuing care. They are a baseline against which the government

will hold continuing care providers accountable, and in that sense are important. But there remains considerable scope in going beyond these basic standards. In fact, the government itself is encouraging greater levels of service in several ways. First, they are seeking to broaden services particularly in supportive living and long term care facilities by (modestly) increasing the fees for those types of accommodation. Also, the government is supportive of private investment into these types of accommodations, which assumes that private providers will supply a level of services beyond that which the government can supply. Finally, it is clear from government documents that the established (minimum) standards can be developed further in new and creative ways by operators willing and able to do so. For example, a campus model, very briefly referenced in government documents, is an innovation that has the potential to truly offer both community supports and ‘aging in the right place’ that is much more effective than what could be achieved in a more distributed network of services. Another example is that the client centered model of care can flourish within a context that is driven more by the social orientation rather than the medical orientation. In other words, the focus of care could more strongly emphasize living (social) rather than being dominated by a healthcare model that medicalizes the situation. These are discussed further in Section 4, below.

Best Practices: Canada

At the federal level, the Health Canada has commissioned two key studies to assess best practices in continuing care. This section examines the development of national ‘best practices’, and the ongoing effort to discern new best practices.

Baseline ‘Best Practices’

In 1999, the Division of Aging and Seniors at Health Canada published a report prepared for the federal, provincial and territorial Ministers entitled Innovation in Best-Practice Models of Continuing Care for Seniors. As with other jurisdictions, the impetus for the study was the need to address the growing needs of Canada’s aging population in an appropriate and affordable manner. The report methodology utilized a survey of open-ended questions that allowed respondents to provide their in their own words the description of their continuing care program (response rate of 151 out of 1000 surveys sent). Note that at this point in time, continuing care referred to home- or community-based care or facility care (i.e. nursing homes); supportive housing as presently understood did not exist. The report outlines the common themes that emerged from the questionnaires. These are perhaps better identified as ‘common (good) practices’ rather than ‘best practices.’ Nevertheless, there is still value in examining the identified practices to establish a baseline for the development of future best practices for continuing care.

The report offered a ranked listing of the most common features of ‘best-practice models’ for continuing care (p. 2):

1. Consumer/Client Focus: the degree to which the client’s right to provide input into service planning is recognized and the extent to which services are relevant to the client’s needs.

2. **Coordination and Integration:** the ability to provide uninterrupted, coordinated service across programs, practitioners, organizations and levels of service, over time.
3. **Efficiency and Flexibility:** achieving the desired results with the most cost-effective use of resources as well as the degree to which the program, service, or organization is capable and flexible.
4. **Program Assessment and Evaluation:** a measure of outcomes against stated objectives consisting of collecting information to inform decision-making and assess the effectiveness of strategies and programs
5. **Education:** the level of staff competence and ensuring that the knowledge and skills of the service provider are appropriate to the service being provided for the delivery of quality care
6. **Access:** the ability of the individual to obtain services at the right place and at the right time, based on their respective needs

The report highlights additional ‘best-practice’ features of continuing care delivery that a “very low number of respondents identified” (p.14). These are the following (pp14-15):

- **Communication:** It is important that effective communication exist between providers and recipients, between government and the private sector, and within organizations.
- **Respite for Caregivers:** Without funding for respite, family caregivers burn out and clients are placed in higher cost facilities. If the client is to be cared for at home, it is essential to provide structured respite for caregivers.
- **Consistency:** Organizations must be consistent in terms of application of policies as well as in the provision of care.
- **Information Management System:** Such a system is necessary to assist with the management of clients and resources.
- **Level of Care Classification:** Having a consistent care level classification allows for the comparison of clients across service delivery components, by level of care.
- **Case Management:** Case management ensures that there is regular monitoring and review of client needs and that, as needs change, care plans are adjusted to ensure that there is a continuing match between the needs of the client and the care provided.
- **Marketplace Competition:** Respondents felt that a certain amount of marketplace competition ensures the best quality of service at the best price. However, respondents felt that this competition should be kept to a minimum.

- **Research-Based Programs:** Programs and projects should be research and evidence based. Prior to a program’s implementation, research should be conducted to examine activities in other communities and other methods of service delivery. The choices made by professional practitioners in continuing care must be based on research-based principles.
- **Equity:** Resources must be distributed fairly among the community and among the program’s clients.
- **Innovation:** As resources become increasingly limited in the face of rising demands, continuing care programs need to be increasingly innovative in their methods of service delivery.
- **“De-institutionalization” of facilities:** Long-term care providers must work to counter the perception of institutional living: a sterile cold environment where residents have no choices, freedoms, liberties or enjoyment of life. Institutions should be made more “home-like”.

It is instructive that over the last 12 years, the ranked order list has been adopted as best practices by those responsible for delivering continuing care (e.g. the Government of Alberta). As instructive, however, is how these ‘best practices’ might be implemented differently by individual operators. For example, Heritage Village in British Columbia became very innovative by deliberately placing the client at the center of their organizational chart. They emphasized that the client—not the board, not the executive, not the staff, not the physicians—is the most important person in the facility and must be the focus of all its activities (p. 37). While this supports the best practice of consumer/client focus, it does so in a highly innovative fashion that allows that best practice to be better implemented into the everyday activities of the organization. In other words, this has the potential of becoming a signature practice in this setting—a core organizational value implemented in everyday activities that creates noticeable differentiation from that of other providers.

We also noted, however, that some of the ‘best-practices’ mentioned by very few respondents in the federal study (and therefore not given much standing) have also become best practices in the industry. For example, the de-institutionalization of facilities has come to the forefront today. The Good Samaritan Society in Alberta had decided as early as 1999 that the ‘normalization’ of the “environment and social settings” to produce a home-like atmosphere would assist them in giving their clients “choice, independence, privacy, dignity and individuality” (p. 28). These principles led to the development of three key concepts to guide the program: (1) shared responsibility which includes the client, (2) bounded choice which recognizes limits to resources, and (3) managed risk which recognizes risk as a reasonable part of everyday life. The model has also been extended in an innovative way to provide a non-institutional, social model of care for those suffering from Alzheimer’s (p. 35).

Finally, two examples of a practice which is not on the ‘additional best practice’ list but clearly meets key needs of clients is the inclusion of spiritual practices in continuing care. The first example is the Tabor Home Society in British Columbia, established by the Mennonite Brethren. They operate their Intermediate Care Home in a way that is “very strongly based on a

spiritual model of care” (p. 38). It bases its programs on the “recognition of God as the source of all life and hope.” This has led to residents becoming “happier, more active and embrac[ing] their faith to help them cope with life changes” (p. 38). Second, the Rosefield Center in Alberta has implemented a Native Heritage/Enrichment program to serve its aboriginal clients that is both cultural and deeply spiritual:

Services provided include medicine man visits, sweet grass ceremonies, cultural cuisine, cultural décor and an annual pow-wow. The program is based on the philosophy that healing occurs in an environment that accepts and supports an individual’s culture and belief systems, allowing inner peace and holistic health. The program has resulted in greater cohesiveness within the entire community and between the cultures. The residents are happier in their surroundings and native elders have felt honored by the opportunity to teach staff members their culture. (p. 32)

While a spiritual focus still remains largely outside of common practice, it may in fact represent, in some contexts and for some constituencies, an essential best practice. Since spirituality has many manifestations, incorporating spirituality and/or basing continuing care at the operational level on a spiritual system we suggest may become a signature practice for those organizations that do so.

Best Practices Framework for Continuing Care Delivery

Hollander and associates conducted a national program of research examining care delivery systems for four population groups: seniors, persons with disabilities, persons with chronic mental health issues, and children with special needs. In 2008 Hollander and Prince published an overall synthesis of this research in which they develop a detailed and sophisticated best practices framework for the delivery of care to those persons with ongoing care needs. (See www.hollanderanalytical.com for more details, as well as for their extensive literature review and sub-studies.)

The best practices framework is predicated on the complexity of care required. Hollander and Prince (2008: 45) make these observations concerning that complexity:

1. Care must be coordinated and provided over long periods of time, often measured in years and even decades.
2. Care needs may require services from all levels of the healthcare and human services systems.
3. Many of the appropriate responses to organizing services for such persons often go beyond strictly medical or professional health services to supportive and family care.

The chronic nature of health needs for the four population groups demands a different approach than would normally be taken in an acute care setting (McAdam, 2008:1). Hollander and Prince (2008) contend that this complexity can be best dealt with through the best practices framework.

There are three components that comprise the best practices framework. The first component describes the fundamental prerequisites needed for actually being able to implement the aspects

of the other two components. At its heart the first component deals with philosophical and policy issues. We list them here, and direct the readers to the paper by Hollander and Prince (2008: 48-49) for further details (as also with the items in the second and third components):

1. Belief in the benefits of a system of care delivery
2. A commitment to a full range of services and sufficient, sustainable funding—this will allow a system of care to function effectively, and it is important for them to be ‘enshrined in policy’
3. A commitment to the psychosocial model of care—a clear recognition of the importance of non-medical services that allow people to stay in their own environment
4. A commitment to client-centered care—providers need to ask ‘How does what I am doing, or what I am proposing, benefit the client or consumer of service?’ Also important here is not shifting fiscal responsibility to the front-line employee.
5. A commitment to analysis and evidence-based decision-making

The second component consists of ten best practices for organizing the delivery of care. Five of these practices relate to administration; the other five relate to service delivery. These are the following (2008: 48-50):

Administrative:

1. A clear statement of philosophy enshrined in policy.
2. A single or highly coordinated administrative structure.
3. A single funding envelope [which] is critical to maximizing the efficiency, effectiveness and quality of care provided.
4. Integrated electronic information systems.
5. Rewards and incentives for evidence-based management.

Service Delivery:

6. A single- or coordinated-entry system [which] provides for a consistent screening mechanism that ensures only those with appropriate needs are provided services.
7. Standardized system-level assessment and care authorization.
8. A single system-level client classification system.
9. Ongoing system-level case management.
10. Involvement of clients and families.

The third component of the best practices framework consists of coordination/linkage mechanisms. Given the system-level coordination required, it is imperative that linkages be made to services across and between the four population groups as well as development of linkages with hospitals, primary healthcare, and other social and human services (2008: 50-52).

We stress the value of this framework since it is a recent distillation of a significant program of research. We also recognize that the framework may be more fully applicable at the provincial level and/or the regional level where these exist. Nevertheless, as Hollander and Prince (2008) note, the framework can be used to develop a variety of more specific models dealing with the unique circumstances present even at the local level. For example, a facility (supportive or long-term care facility) could develop a very clear statement of philosophy and develop policies that make sure that philosophy is lived out day-to-day. A facility could also develop a highly coordinated administrative structure, such that the care provided is indeed seamless rather than a series of silos.

Review of Integrated Care Frameworks

MacAdam (2008) conducted a study of integrated care frameworks from several countries, including the Hollander-Prince framework outlined above, for the Canadian Policy Research Network. She found the Hollander-Prince framework most comprehensive. When compared to other integrated frameworks, MacAdam found four key elements (p. 24):

1. Umbrella organizational structures to (a) guide integration of strategic, managerial and service delivery levels; (b) encourage and support effective joint/collaborative working; (c) ensure efficient operations; and (d) maintain overall accountability for service, quality and cost outcomes
2. Multidisciplinary case management for effective evaluation and planning of client needs, providing a single entry point into the health care system, and packaging and coordinating services
3. Organized provider networks joined together by standardized procedures, service agreements, joint training, shared information systems and even common ownership of resources to enhance access to services, provide seamless care and maintain quality.
4. Financial incentives to promote prevention, rehabilitation and the downward substitution of services, as well as to enable service integration and efficiency

It is important to note that MacAdam found that the success of integrated models of care did not rest with any single feature. This underscores the systemic nature of successful continuing care delivery—many elements which are congruent with each other to produce a holistic approach and delivery of care. It also underscores that individual ‘best practices’ in themselves are not sufficient for producing excellent outcomes.

Further Development

A potentially useful development at the national level is the formation of the Canadian Institute for Health Information (CIHI). This is an independent, not-for-profit corporation funded by the Canadian, provincial and territorial governments. Its mandate is to improve Canada's health system through the collection, analysis and dissemination of high quality information. One CIHI initiative is the Continuing Care Reporting System (CCRS) through which CIHI collects data pertaining to clinical, administrative, and policy issues. Facilities that share their data through the continuing care reporting system are able to receive reports comparing their organization to others locally, regionally, nationally, and even internationally. They are also able to benefit from reports of evidence based best practices.

Conclusion

The baseline 'best practices' established by Health Canada in 1999 have become standard practice in continuing care. However, even some nascent practices reported at that time have since also been adopted as best practices. This suggests that it is important to keep an eye on developments in continuing care. Aiding this is the new Continuing Care Reporting System (CCRS) administered by CIHI. The CCRS may also be a source of practices that are relatively idiosyncratic to the industry. In other words, the system may reveal relatively rare practices (e.g. integrated spirituality) that in fact may be signature practices in those organizations using them.

When drawing on CIHI data (as well as any other source) for best practices, it is important to heed the observation of Hollander and Prince as well as MacAdam who show how best practice in continuing care is not predicated on singular best practices, nor even on a series of best practices, but rather the integration of best practices. The systemic nature of continuing care requires coherent integration. This means that adoption of a best practice may not make any significant difference. It will be important to develop an integrating philosophy and administrative structure through which continuing care can be delivered with excellence.

SECTION 3

Exemplary Practices Models of Continuing Care

Introduction

Several integrated innovative models of continuing care delivery currently exist. In particular, we will examine the Eden Alternative and its ‘Green House’ concept, the Planetree model including its Wesley Village working example, and the Pioneer Network and the Culture Change Movement. These models go well beyond the minimum standards in the regulatory environment described above and therefore have run into difficulty, “swimming against the tide of regulation, limited resources, and established practices” (Rahman and Schnelle, 2008: 143). Each of these models is effectively a signature practice model developed by their respective founders. For other organizations looking in from the outside, these models represent exemplary practices. There is a desire to disseminate these models and each parent organization provides help in doing so. For example, each model offers tools to help other organizations adopt their philosophy and implement the practices supporting their philosophy.

Nevertheless, dissemination remains difficult to do. As *models* rather than *frameworks* of care, their implementation demands full integration for those organizations adopting the model, meaning that the adopting organization will be transformed substantially both in operations and culture. On the other hand, there are gradients of adoption available. The adoption of various aspects of these models (rather than the whole model) is less intrusive to the adopting organization. However, the trade-off is that the beneficial effects of the adopted practices might not be experienced. This could result from several issues: the adopted practice being poorly implemented, the incompatibility of the adopted practice with current practices, the strength of the current culture of practice, and that individual best practices are often not sufficient for achieving excellent results. As a result, the adopted practices may eventually be abandoned, producing further difficulties and frustration.

Three Exemplary Models of Continuing Care

1. The Eden Alternative

The Eden Alternative (EA) is an innovative model founded in 1991 in upper New York State by Dr. William Thomas, who sought to transform the culture of long-term care facilities from places to die to places to live. At its core, the Eden Alternative is not a program nor a project, but rather an overarching philosophy which strives to provide quality of life for the elderly, whom they refer to as Elders (a term deliberately used to signify their dignity). Aging is considered a “continued stage of development and growth rather than a period of decline” (EA website). Thomas asserts that the elderly suffer not so much from disease related issues as from the three plagues of loneliness, boredom, and helplessness—plagues which also affect society at large. These ‘plagues’ are addressed through “de-institutionalizing the culture and environment” of long term care facilities, making them human habitations rather than “sterile medical institutions” (EA website). The Eden Alternative strives to provide Elders with:

- a) Companionship (with staff, family, friends, other Elders, children)

- b) Opportunities to care for other living things (e.g. plants, animals) and to create things (e.g. artwork)
- c) Variety and spontaneity in their interactions.

Fundamentally, the Eden Alternative seeks to replace the medical model of care with a social model of care. This is a profound paradigm shift in the provision of continuing care since it focuses on living rather than on medical conditions. See Appendix 3 for the Ten Principles of the Eden Alternative that drive their day-to-day activities.

The Eden Alternative is now international in scope, with care homes in the US, Canada, Australia, New Zealand, Japan, Denmark, Switzerland, and England. In addition, the Eden Alternative is seeking to apply their principles within community settings, so that Elders who remain in their own homes are able to experience higher quality of life.

Green Houses

A specific implementation of the Eden Alternative philosophy is known as the Green House concept. William Thomas noted that nursing home facilities that had taken the Eden Alternative training were having difficulty “making permanent far-reaching changes that influence the quality of life” (Rabig, Thomas, Kane, Cutler, McAlilly, 2006: 534). He proposed the building of ‘Green Houses,’ newly built structures that conform the material environment to the social model of care of the Eden Alternative. Please see the Green House Mission, Vision, Goals and Philosophy in Appendix 4

The Green House model is described by Rabig et al. (2006) from which the following material is taken. The model addresses three central dimensions: the physical, philosophical/cultural, and the organizational. The physical dimension may be characterized as providing a home-like atmosphere for elders, which contributes to positive quality of life outcomes. The philosophical and cultural dimension builds exclusively on the social model of care. The emphasis is on living and control over quality of life, not on being sick and unable to perform usual daily tasks. The organizational dimension conforms to the regulatory environment but within the philosophy of the Green House concept. Thus, while meeting regulatory requirements, the goal is to decrease bureaucracy and to re-create the role of the front-line staff and thus empower them to be able to take greater responsibility for overall care and support. See Appendix 5 for greater detail of each of these dimensions, and Appendix 6 for a brief description of the Green House model implementation in Tupelo, Mississippi.

2. Planetree Model

The Planetree model is fundamentally based on a holistic patient-centered focus (physical, mental, emotional, social, and spiritual needs), and the recognition that patients come to health professionals not only for medical care but for caring (Frampton, 2003: xxvi). It began in 1978 with the vision of Angelica Thieriot for a more humane health care experience. The Planetree Model takes its name from the tree under which Hippocrates taught his students in healing.

Besides being patient-centered and holistic in its approach, the Planetree model strives to provide patients and families with information so that they are able to participate with caregivers in the caring and healing process. Planetree also pays attention to the built environment and seeks to incorporate art and nature into its facilities to enhance the healing process. Three key words that capture the Planetree model are the “personalizing, humanizing and demystifying” of health care (Planetree website). See Appendix 7 for Planetree’s Vision, Mission, and Beliefs.

While beginning with a focus on hospitals, Planetree has since expanded to include continuing care. The central focus of the continuing care model is the relationships that develop within care facilities. It “emphasizes the relationships that sustain a healthy and meaningful life. It celebrates the uniqueness of each individual, and responds to the physical, mental, emotional, social, and spiritual needs of residents and staff” (<http://www.planetree.org/PCC.html>). The ten principles of the Planetree continuing care model are:

- a. Recognizing the primary importance of human interaction
- b. Enhancing each individual’s life journey
- c. Supporting independence, dignity, and choice
- d. Incorporating family, friends, and social support networks in the life of the community
- e. Supporting spirituality as a source of inner strength
- f. Promoting paths to well-being
- g. Empowering individuals through information and education
- h. Recognizing the nutritional and nurturing aspects of food
- i. Offering meaningful arts, activities, and entertainment
- j. Providing an environment conducive to quality living (physical environment)

Each of these principles is detailed in Appendix 8.

Wesley Village

Wesley Village is a Planetree continuing care demonstration site that incorporates retirement living, assisted living, and skilled nursing (nursing homes). Wesley Village was spurred on to adopt and adapt the Planetree model (at that point it had only been applied to acute care) because of the isolation between the various levels of care. Their central need was to create culture change in the organization. To do so, they engaged all staff, volunteers, residents, and families in identifying improvements in the ten components of continuing care with the overall goal of creating “relationship-centered care.” As they began to implement various programs to achieve the identified improvements, they noticed that caregivers and residents responded very positively,

to the extent that changes were being initiated by them ‘from below.’ The changes have “led to enhance clinical, financial, and operational outcomes as well as increased resident and staff satisfaction” (<http://www.planetree.org/Assets/PDF/Wesley%20Village%20Case%20Study.pdf>). For more detail, see the description of the Wesley Village implementation in Appendix 9.

Further information

Detailed descriptions of long-term care and the key elements of Planetree patient-centered care can be found in the book by Frampton, S. B., Gilpin, L., and Charmel, P. A. (eds), Putting Patients First: Designing and Practicing Patient-Centered Care. San Francisco: Jossey-Bass. The editors are all executives of the Planetree Model. The authors of the chapters are associated with Planetree in managerial capacities, or people with significant medical background who have had extensive interaction with the Planetree model.

3. The Pioneer Network and the Culture Change Movement

The Pioneer Network (PN) is an umbrella organization that began in 1997 by a group of prominent professionals involved in long term care (PN website; Rahman and Schnelle, 2008). It links stakeholders in aging and long term care (policy, consumers, academia/education, providers and owners, and partners/collaborators) as well as advocating for the elderly (PN website). Their aim is to radically change the culture of nursing homes and other community based settings by “delivering resident-directed care and empowering staff” (Rahman and Schnelle, 2008: 142) so that residents are able to thrive rather than decline (PN website). Efforts are made to move “away from institutional provider-driven models to more humane consumer-driven models that embrace flexibility and self-determination” (PN website). At its heart PN is striving for development of a supportive community and relationships characterized by respect for each person as an individual, “regardless of age, medical condition or limitations” and regardless of the elder’s particular living option (PN website). It seeks a culture in which “individual voices are heard and individual choices are respected” (PN website). For further information on the Pioneer Network’s Mission, Vision, and Values please see Appendix 10, and for their Declaration of Interdependence please see Appendix 11.

As the Pioneer Network has developed over time, it attracted the support of regulatory agencies, namely, the Centers for Medicare and Medicaid Services and State Survey and Certification Agencies. It also gained the support of significant funders, in particular The Commonwealth Fund (Rahman and Schnelle 2008). This has given the movement higher profile. The development of the Pioneer Network has also lead to increasingly specified policies that impact day-to-day routines. For example, Rahman and Schnelle (2008) observed:

Once content to exhort each [nursing home] to ‘choose for itself what works best in its own unique environment. . .some culture-change reformers are now issuing what amount to instructions for achieving culture change.

Rahman and Schnelle (1008: 144) point out that while this might be inevitable, the ‘best practices’ being suggested may not actually stand up to scrutiny. For example, the consistent assignment of nurses to the same resident is being held up as a best practice within the Pioneer

Network. Research, however, is inconclusive on this matter. Some studies suggest rotating assignment results in the same levels of quality-of-care outcomes. It seems, then, that the implementation of core values and principles in the pursuit of the mission should in fact be left to the particular care site. Further, as Rahman and Schnelle (2008) advocate, it is important for researchers to begin building a body of research on various practices (e.g. perception of quality of life, resident choice of daily activities, choice by cognitively impaired residents, staffing costs and workloads in implementing culture change) that will strengthen the culture-change movement.

Innovative Care Models Website

The three models delineated above are certainly not the only innovative models currently being applied to long-term care. The Innovative Care Models website details 24 innovative models of care delivery in three broad categories: acute care, bridge continuum (transitional care from hospital to home or long-term care facilities), and comprehensive care. Each model of care includes “a detailed description, impetus for its development, results, considerations for implementation and replication, and selected tools” (Innovative Care Models website). The intention of this research into innovative care models is to be a starting point that provides information, inspiration, and initiative for organizations seeking to improve their own patient care.

The continuing care models on the website useful for the purposes of this report are: Evercare Care Model, Living Independently for Elders, Care Transitions Intervention, Chronic Care Coordination, Home Healthcare Telemedicine, and Transitional Care Model. For detailed information on these models please visit their website at <http://www.innovativecaremodels.com/>.

Conclusion

The three exemplary models outlined above provide insight into new models of continuing care that are based on the social model of care rather than the medical model of care. Each represents an integrated system of care based on radically new philosophy. However, each model also reflects the difficulty in implementing the model, especially within already existing facilities. Hence the ‘Green House’ alternative developed by the Eden Alternative which seeks to develop the model in a greenfield site.

In spite of difficulties in implementation, each of these models (and others not detailed here) is an important source of ideas regarding the delivery of continuing care that move beyond basic government standards toward excellence in care. Also, the presence of these new models is beginning to radically change the continuing care landscape, not only in the U.S. but also Canada and other parts of the world. In spite of difficulties, the models are being adopted. Presently, research is only now catching up to these phenomena, but we expect that as more results become available, we will see substantiation of these philosophies and their practices and more movement toward them by continuing care providers.

SECTION 4

Quality of Life Issues for Seniors: Insights for Developing Signature Practices

Introduction

In this section we seek to delineate some of the research undertaken in continuing care that points toward better care provision for elders. Some of the research substantiates what was perhaps intuitively grasped in the models outlined above (e.g. the value of the social model of care over the medical model of care). Other research challenges current thinking of how continuing care should be delivered (e.g. the idea of supportive housing being transitional). Together, the material in this section points toward the future of continuing care provision, and provides pointers for developing excellence in the provision of care for seniors.

Quality of Life: Going Beyond Health Care to Living Meaningful Lives

Rosalie Kane, a leading researcher in long-term care, in 2001 noted that most nursing home models (in the U.S., but we can extrapolate to Canada as well) offered high quality in terms of technical care, but scored very poorly in terms of quality of life—consisting of “security, comfort, meaningful activity, relationships, enjoyment, dignity, autonomy, privacy, individuality, spiritual well-being, and functional competence” (Kane, 2001: 293). It is quality of life that must become the focal point for the provision of long-term care. This does not mean that quality health care is ignored; rather, that it becomes a part—but only a part—of the overall quality of life within a continuing care arrangement (home care, assisted living, and nursing home care). This will require a profound shift in our thinking:

Embedded in most of our rules and regulations is the idea that LTC should aspire to the best possible quality of life *as is consistent with health and safety*. But ordinary people may prefer the best health and safety outcomes possible *that are consistent with a meaningful quality of life*. (Kane, 2001: 296; her emphasis).

Forbes-Thompson and Gessert (2006) provide examples of the lack of quality of life even in nursing homes designated as free of deficiencies. From numerous interviews with residents, the researchers chose two representative examples (Debra and Lilly [note: not their real names]). These are poignant, moving accounts of two people who are becoming utterly despondent in day-to-day life because of losses of all kinds that largely stem from lack of attention to quality of life—loss of self-determined routines, of self-efficacy, of personal effects, of friends and relationships both inside and outside of the facility, of good care workers who leave, of good food, of privacy, of respect, of dignity, of information/knowledge, of participation in faith events (e.g. communion), and even of the future which now seems utterly hopeless and futile. In both cases, the residents lost something very precious—their sense of personhood—and in time both actually preferred death to remaining in the ‘care’ of the nursing home. What becomes painfully evident in these accounts is that people want to live meaningful and fulfilling lives to the end, and that lack of care concerning life issues in continuing care facilities often prevents that from happening.

Kane's (2001) observation that decisions concerning long-term care are decisions about the meaning of life in the last decade or so of life further substantiate the importance of attention to quality of life. It is not trivial; it is in fact foundational.

For many people, LTC decisions dictate the last chapter of their biographies—the chapter that should make sense of the story. LTC shapes where people live, how they live, whom they see, what they do, and the relationships transpiring within families and communities. How we choose to view LTC as a society, therefore, entails considering subjects as profound as the meaning of life. LTC is intimate care, and how it is given, when it is given, and by whom it is given shapes the biography of the LTC consumer and, by extension, the biography of the family caregivers and the collective biography of the whole family. (Kane, 2001: 294).

Quality of life as a priority needs to come down to the level of the mundane, day-to-day tasks and the way we think about and talk about residents and their needs:

...LTC is a mixture of concrete tasks that enable a person with a disability to flourish as much as possible despite that disability; these tasks are sometimes arduous, sometimes time-consuming, sometimes tedious, and often unpredictable and inimical to scheduling. Gerontologists use the shorthand jargon ADLs (activities of daily living) and IADLs (instrumental activities of daily living) to refer to the areas of functioning for which the LTC consumer requires assistance. These terms, while useful, tend to distance us from the phenomenon of the person whose life may sometimes be sustained by the care, whose aspirations might be made possible because of care received, and whose life is too often made more than necessarily miserable by the circumstances and conditions of LTC.... Assisted living, at its best, offers an opportunity for older LTC consumers to combine getting the services they need with continuing their lives in the most natural, normal, and meaningful way possible for them. (Kane, 2001: 295, 296).

In addressing quality of life, it is important to recognize that, while the intention in continuing care is to care for the elderly, the institutional mindset often found in continuing care militates against that:

Although we strive for institutions that 'do not harm' and have created processes to monitor institutional performance through surveys, harm is systematically embedded in institutions where elders are stripped of personhood and meaning. Harm is done when care practices, routinized for economic efficiency and to meet federal regulations, are more important than individual resident's personhood. The most profound suffering is rooted in the loss of personal meaning exacerbated by efficient, systematic, institutional practices focused on meeting regulatory guidelines. Institutional practices were evident in the cases of Debra and Lilly, where simple personal freedoms such as having coffee at breakfast, sleeping in, taking a bath, engaging in meaningful activities, or getting to the toilet were lost. (Forbes-Thompson and Gessert, 2006: 246).

Adopting quality of life as the central focus for a continuing care complex in Alberta is already well on the way to being established. Several things assisting the adoption of quality of

life are already in place (each of these is identified by Kane, 2001). First, consumer-centered or consumer-directed care can begin to move continuing care toward quality of life. We have noted above that this is a foundational best practice at both the provincial and national levels in Canada. Second, the provision of assisted living as well as the unbundling of health and housing aids the focus on quality of life. We have seen that both of these are fundamental to the direction of continuing care under Alberta Health and Wellness. In fact, the Alberta Government openly encourages a myriad of combinations of housing and health that unbundling provides. Third, culture change in nursing homes and attention to physical environments are reshaping the central focus toward quality of life. We have seen that these elements are central to the exemplary models noted in the previous section above as well as to the direction established by the Alberta Government. There is wide-spread recognition that fundamentally new values must be established and enacted for continuing care to truly begin to address the need for quality of life for seniors. Finally, an area not mentioned in the Alberta government documentation but implicit in several of their continuing care standards are resident rights. In the U.S., Medicare has established a list of resident rights for seniors in nursing homes (Komarek, 2003: 269-272). These rights were drawn up explicitly to counter abuses found at all levels within nursing homes. Such rights help turn the focus in nursing homes to quality of life rather than only quality of (health) care.

It is important to point out that each of the items above reflects the fundamental shift away from the medical model of care to the social model of care. As Forbes-Thompson and Gessert (2006: 247) note, “the medical model that most nursing homes operate within does little to address the psychosocial needs of most residents.” Echoing Kane’s (2001) sentiment mentioned above, Forbes-Thompson and Gessert (2006: 248) suggest, “maybe it is time to shift the emphasis focus of the regulatory oversight [from physical care and safety concerns] to one of ensuring that elders have more meaningful lives with the best possible health outcomes.”

We can see, then, that the direction of continuing care in Alberta and at the national level in Canada is highly conducive to refocusing continuing care on quality of life. Health care is important but must not be the definition of quality in continuing care. It is just a part of the overall life being lived out by residents in the continuing care context.

Measuring Quality of Life

We often hear that what is measured is what gets done. Fundamental to measuring quality of life in continuing care is the need for attentiveness to the individual. Research done by Degenholtz, Kane, Kane, Bershadsky and Kling (2006) shows that resident self-report on quality of life measures is the best way of improving quality of life in care facilities. ‘Objective’ measures do not adequately account for how well people are able to lead meaningful lives in care facilities. This means that surveys and mandated government measures are not able to adequately capture quality of life, which is a different and distinct aspect of the performance of care facilities (Degenholtz, et al., 2006: 350). It is important then to include subjective quality of life measures in the overall assessment of how well a facility is performing (note: Kane, Kling, Bershadsky, Kane, Giles, Degenholtz, Liu, and Cutler, 2003 provide a valid measure for quality of life for nursing home residents).

Forbes-Thompson and Gessert (2006: 248) provide support for using subjective quality of life measures by pointing to the need for attention to the individual. For example, they note that exemplary care facilities (such as those described in the previous section) typically seek to address the individual and their concerns on several levels:

Homes that are engaged in culture change espouse attention to resident choice on a daily basis; to empowerment of front-line workers, who know the resident best, to engage in creative care strategies; to foster human relationships with consistent staff assignments; to the alleviation of boredom with a wider array of activities; the fostering of meaning and purpose through the care of animals; and to creating more home-like environments with structural changes to living arrangements.

While much of the research noted above has focused on seniors without cognitive impairment, quality of life for those with dementia also has been increasingly addressed in the research community. Dröes, Boelens-Van Der Knoop, Bos, Meihuizen, Ettema, Gerritsen, Hoogeveen, De Lange and Schölzel-Dorenbos (2006) undertook a comparison of quality of life indicators for persons with dementia as (1) found in the literature (current theoretical models), (2) expressed by people with dementia living in community, (3) expressed by people with dementia living in nursing homes, (4) expressed by professional care givers, and (5) instruments for assessing QOL in dementia. Many of the indicators mentioned by people with dementia were also mentioned by care givers and the literature, but others were not. Quality of life for persons with dementia includes affect (expressing feelings of cheerfulness and/or sadness), self-esteem/self-image (being accepted, respected, autonomy, achieving something, continuity of self-image), attachment (being involved in things around you, continuing to live with partner, being understood), social contact (relationships, love, intimacy, friends, contact with nurse assistants), enjoyment of activities (doing things together with others, hobbies, going outside, work, sociability), sense of aesthetics in living environment (nature, listening to music, pleasant surroundings), physical and mental health, financial situation (no poverty), security and privacy (safe environment and privacy), self-determination and freedom (being able to make choices), being useful/giving meaning to life (being of use to others, having sense of purpose), and spirituality. (Note: These are further detailed in the article.)

Effectiveness vs. Efficiency

It becomes apparent that individual attention and quality of life is not in the service of ‘efficiency.’ Indeed, ‘efficiency’ as a fundamental value in continuing care will in fact detract from quality of life (e.g. witness the use of feeding stations, long hallways, shared bathrooms, nursing stations, and other current institutional approaches to care). ‘Efficiency’ is a machine and industrial concept that is not particularly conducive to handling the variation in human relationships, and hence is not particularly appropriate for care settings (Stein, 2002).

Better is the value of effectiveness. At the heart of providing continuing care are the issues of relationships, community, and meaningful living, not merely saving money. Yet, as the central issues of relationship, community, and meaningful living are attended to, monetary savings are realized through such things as decreased use of drugs, higher levels of experienced well being (and therefore less medical care needed), lower turnover of staff, and other practical savings

(Charmel, 2003; also see Appendices 6 and 9) There are many differences in quality of life for residents between a facility envisioned to be effective (a place where people can age in place with dignity and respect, getting the support they need) as opposed to a facility that has been designed (and measured) primarily for efficiency (getting the greatest financial outcome with the least possible inputs).

A concrete example of attending to effectiveness over efficiency is evident in dealing with chronic illness within the patient-doctor relationship. Doctors seeking to understand illness in the context of living a life are beginning to use what is known as narrative-based medicine. This approach is increasingly being recognized for its effectiveness in dealing with chronic illness. Ban (2003), himself a doctor, notes that physicians are becoming more aware of the importance of the “interpretive paradigm” in dealing with chronic illness, that is, the meaning that chronic illness has in the life of the elder. Quoting Ian McWhinney, Ban (2003) observes:

It is not easy for us to attend to our patients’ experience. To do so requires us to step out of our usual way of attending to a person’s illness. We are trained to see illness as a set of signs and symptoms defining a disease state—as a case of diabetes or peptic ulcer or schizophrenia. The patient, on the other hand, sees illness in terms of its effects on his or her life. The physician therefore must learn to see illness as it is lived through, before it has been categorized and interpreted in scientific terms.

Further, Ban (2003) notes that without attending to the person’s life—that is, without developing a relationship with the chronically ill person and hearing their story so that they, and their treatment, are known within the context of their story—even the best evidence-based knowledge will not be applied. Thus, narrative-based medicine, which begins with the social aspect of care, is as fundamental to quality of care as to quality of life. And this, while not initially seen as ‘efficient’ becomes both effective and efficient in the end.

Resident vs. Profession Focused

Continuing care occurs within the confluence of daily living on the part of residents and the day-to-day job on the part of caregivers. From the perspective of the medical model, continuing care is about the provision of health care. Here the precedence is on the caregiver and their work; elderly people needing help are entering a health care work-space. While this works relatively well with acute care, where specific health issues and their remedy are central (e.g. hospitals), this situation is inadequate for continuing care. Continuing care is about chronic illness which needs to be managed in the midst of life. This situation is better addressed from the perspective of the social model where the focus is on living one’s life. Here the precedence is on the elderly person and their life. Health care workers are entering people’s homes, and in doing so need to be respectful that they are not in a health care setting.

This difference creates distinctions on many levels between continuing care facilities that,

- on the one hand, are designed, managed, funded, and controlled with the primary focus on health care work carried out by the people who are employed and for whom it is their workplace and

- on the other hand, those facilities where the primary focus has been placed on the people who actually live there and for whom it is their home.

In addition, it is perhaps surprising but still very important to note that even ‘client centered’ approaches, while an improvement over the focus on health care providers, are still conceptualizing the relationship as a work relationship and the continuing care environment as a work environment. This is established by using the word ‘client’. A better word is ‘resident’ which places primacy on the person living in a facility who then receives services in their home (not a workplace!) as may be needed.

Socialization and Social Engagement: Fundamental to Living and Quality of Life

Research is demonstrating that social relationships are consistently linked to positive well-being in assisted living (Street, Burge, Quadagno, and Barrett, 2007). These relationships include family and friends developed while still in one’s own home, developing friendships with other residents in assisted living, and positive relationships with staff. Perhaps surprisingly, Street et al. (2007: S133) found that

internal social relationships, as measured by friendships within the facility and positive feelings toward staff, was the most consistently important predictor of resident well-being...[expressed as] life satisfaction, stable or improved quality of life, and a sense of feeling at home in assisted living.

In fact, “satisfaction with care staff can have a favorable effect on all other aspects of resident satisfaction” (Street et al., 2007: S130).

A second highly salient issue is food quality. Street et al (2007) found that food quality was very important to a sense of well-being, which is consistent with other studies.

Both findings are substantiated by the work of Park (2009: 474-475), who notes that “perceived friendliness of residents and staff and enjoyment at mealtime appeared to have greater influence on psychological well-being than did perceived social support, social activities, and relationship reciprocity.”

What becomes apparent in these studies is that internal relationships are especially important because of their day-to-day proximity and interaction, and likewise, quality of food and mealtime enjoyment is critical because it is such an important aspect of everyday life. These are important foundations for providing excellent quality of life in continuing care.

Adding to the importance of these research results is the sobering demonstrated link between social relationships and risk of death. In an analysis of 148 studies linking individual’s mortality with social relationships, Holt-Lunstad, Smith, and Layton (2010: 14) found that people with “adequate social relationships have a 50% greater likelihood of survival compared to those with poor or insufficient social relationships. The link is as strong as smoking and alcohol consumption, and even stronger than obesity and lack of physical activity. The authors recommend that the health care community take this link as seriously as they do smoking, etc.:

Individuals do not exist in isolation; social factors influence individuals' health through cognitive, affective, and behavioral pathways. Efforts to reduce mortality via social relationship factors will require innovation, yet innovation already characterizes many medical interventions that extend life at the expense of quality of life. Social relationship-based interventions represent a major opportunity to enhance not only the quality of life but also survival. (Holt-Lunstad, et al., 2010: 15).

Seniors' Care Trajectories: Challenging the Idea of Transitions in Continuing Care

The above considerations lead us to another important component shaping best practices in continuing care, namely, the idea of a care trajectory for seniors. At the provincial level in Alberta this idea of a trajectory, or movement, of seniors through the continuing care system is shaping how continuing care is conceptualized and set up. For example, in one of the Alberta government's core documents for continuing care, Continuing Care Strategy: Aging in the Right Place (December, 2008), supportive living is conceptualized as a "bridge between home living and facility living" (p. 19). This stems from the common assumption that seniors will enter the system at the low end of care and systematically progress through a few levels of assessment, requiring a move from independent care to supportive housing and eventually to placement in a long term care facility, where finally they reach end of life.

However, a major study done in 2001 covering 10 years of data (6384 clients in the continuing care system in British Columbia, 1987/88 to 1996/97) found that, contrary to these expectations/assumptions, seniors' care showed (1) a wide variety of trajectories, none having a large majority of clients, and (2) that the most common pattern of movement was entering at some level of care and remaining there with no change to level or type of care (Uyeno & Hollander, 2001). For example, those who entered care in the community tended to remain in the community and at the same level of care until death (or to the end of the research period—10 years). The same held for those who entered facility care. Even the small percentage of people whose *care level* increased remained in their initial *type of care* (e. g. community). Only a small percentage of seniors moved from community care into facility care.

The full implications of these findings are not clear at this point, and certainly more work will need to be done (Uyeno & Hollander, 2001). However, it seems prudent to suggest that the majority of seniors who enter a supportive living facility will remain there until their death. Supportive living is not necessarily a transitional living arrangement, and should not be organized and arranged exclusively in this way. Kane (2001: 302) provides an appropriate alternative orientation:

it would be helpful to stop confounding the place of care with the intensity or level of care. Professionals should desist from making hierarchical decisions about 'appropriate levels.' Ideals of continuum should give way to ideals of a repertoire of choices with recognition that choices are plausible based on consumer's values and circumstances.

Supportive living, then, should be provided in such a way as to enhance quality of life and dignity in aging. In fact, it is probable that with attention to quality of life—especially good social relationships with staff/other residents and good food—seniors will even thrive within their

particular setting until they pass away. Finally, given that seniors may well live out their lives in supportive living, appropriate measures for end of life care that enhance dignity and grace in that context should be established.

Spirituality: The Individual and Beyond

Spirituality, especially one based in a historic faith community such as Christianity, is an important source of well-being in continuing care. Research has shown, first, that spirituality is an important aspect of quality of life in continuing care (Kane, 2001; Katsuno, 2003; Snyder, 2003). Second, spirituality has been shown to be an important resource for healing and for dealing with disease for the individual person. Research has pointed to three links between spirituality and health (Handzo and Wilson, 2003; see also Daaleman and Dobbs, 2010):

- a. Spirituality gives meaning to what people are experiencing as they face disease and illness. This places the disease/illness within the context of their lives and their life journey.
- b. Spirituality provides connection to a community, and with it, support and caring. This is especially the case if the spirituality is linked to a vibrant faith community which is able to come alongside those who are ill.
- c. Spirituality provides resources for self-efficacy in relation to their disease/illness (i.e. how people respond to the disease/illness). Those who have a sense of self-efficacy are better able to deal with the issues they face.

We will now develop these further. Historic spiritual/faith communities are rich in resources for the elderly since these resources are grounded in deliberation and reflection over millennia. One such resource is narrative, which helps people gain meaning in the face of loss and difficulty in old age. Narrative assists those who are aging and/or chronically ill to place their illness within not only their life story but, more importantly, that of their faith life story. Brueggemann (1977) shows how individual life stories of Christians fit into the larger faith story of God's work with humanity in this world as delineated in the biblical text. Elders' life stories thereby become part of God's story, and God's story becomes part of the elder's story. Moreover, the link of one's personal story to that of the faith story provides strength as the power and authority of the faith story, demonstrated in a myriad of ways both in the biblical text and in the faith community, is appropriated at a community and at a personal level.

Related to narrative is the provision of futurity (Hancock, 2010). Futurity refers to having a future beyond the grave. Hancock (2010) examined the work of Richard Baxter (1615-1691), a Puritan pastor and prolific writer who himself lived and wrote reflexively on his life journey to the age of 76. Hancock (2010: 3) notes:

Baxter presents life as an introduction to a much larger story of the individual person than can be experienced within the bounds of mortal existence...the individual is assured of a future, with the persistence of the person as an entity-before-God envisioned not merely in a continuation of life, but in a perfected and transformed wholeness.

Community is another central source of meaning and value for elders even while facing inevitable death. Community is not only about a supportive network of care. Baxter delineates fifteen “special duties of the aged” which “assumes several things not always associated with the aged: their inclusion in a community; their specific responsibilities within that community; and their ability to will and to carry out such responsibilities, despite and within limitations and constraint....What is implied is a highly active and engaged old age, lived within a supportive community” (Hancock, 2010: 3-4). Even in advanced old age, the elderly can demonstrate ‘passive obedience’ and ‘patient suffering.’ Such a role in community also assumes that elders are upheld as valuable within the community, as is the case in historic faith communities. For example, communicating their experience with God over a lifetime presupposes a listener who is learning from those farther along in the journey. If and when life changes in terms of cognitive and/or bodily function, the community continues to nurture the elder. Fundamental to this stance is the assessment of personhood not on the basis of cognitive ability and productivity (a utilitarian and economic perspective), but, more fundamentally, on the basis of being loved, both by God and by the community, a central message of the biblical text. Thus, cognitive impairment (e.g. Alzheimer’s) does not diminish personhood because it does not diminish being loved.

Third, having duties in the community provides elders with vitality in the community. In other words, they have self-efficacy. They do not need to be passive, nor should they be passive. Hancock (2010) refers to this quality of elders within the faith community as ‘fecundity.’ Those reaching the end of life on earth are able to demonstrate vitality through long held beliefs as well as through facing and overcoming new challenges and temptations in this stage of life.

Besides these benefits to the elderly individual, spirituality provides important resources for caregivers. Tirrito and Choi (2006) show that:

Caregivers who are supported by their religion and spirituality are more likely to provide care at home than seek placement in a nursing home. Those caregivers who practiced more spiritual behaviors were able to maintain family members at home for longer periods and were able to cope better with the stress of caregiving.

Spirituality is also an important resource for spiritually oriented caregivers in facilities. For example, as a source of signature practices, Christian faith and spirituality can be implemented both in policy and practice. Signature practices are developed in-house and evolve internally—they are part of the fabric of the organization. They also have the ability to link policy with day-to-day activities that reflect core values. As noted at the beginning of this report, Gratton and Ghoshal (2005:56) observed that those working in organizations with signature practices were empowered and felt they were doing meaningful work:

When people participate in the signature processes, they feel good precisely because, deep down, the process expresses something they believe in. They feel that what they are doing deeply resonates with who they are and what they value.

In this way, spiritually oriented caregivers working in facilities are supported by spirituality in their workplace. But through that spirituality, they also become sustainers and enhancers of

spirituality for those in their care. Especially through signature practices, caregivers themselves become motivated and sustained by values which are deeply held, thereby providing a foundation for excellent care. This echoes the observation of those involved in the Planetree model (Komarek 2003: 275):

‘If a spiritual climate is to be created and maintained in any of the long-term care settings, the leadership must be attentive to the soul and spirit of the organization, providing opportunities that help staff members be aware of their own spiritual power.’ Many nursing homes invite ministers, rabbis, and other spiritual leaders to provide services for the residents, but it is the staff members who must continue to create an environment in which each resident feels that connectedness [with creation, oneself, others, and God]....

The social environment of the facility, especially as it relates to resident/caregiver interaction, is vitally important to the resident’s well-being and quality of life. As caregivers are more engaged and less stressed because of their connectedness to their faith and values through spirituality fostered in the workplace, their interaction with and care for residents becomes more effective, leading to higher quality of life and greater resilience for residents.

Aging in the Right Place

Alberta’s Continuing Care strategy (2008) refined their direction with an emphasis on “Aging in the Right Place.” This new strategy for the entire provincial system was based on intentions of making available to Albertans “...more community living support so seniors and those with disabilities can receive care in their homes and communities, where they are the healthiest and the most comfortable.”

Given the considerations raised above, however, we suggest further refinement on ‘aging in the right place.’ In particular, aging in the right place is not defined by a combination of housing and health, which is still evident in Alberta Government documentation (see pp. 12-15 above, and Appendix 2), but rather on quality of life based in the social model of care. The right place is in large part defined by where the elder has friends and is treated well; that is, where the elder has quality of life defined socially, not medically. If the elder is in a facility, then at least some of the residents must become friends and/or be friendly, and staff members need to interact positively with the elder and treat them well. Indeed, if these are present, further health issues may not require any change in place, only a change in accessed services.

Living at Home

Alberta’s ‘Aging in the Right Place’ strategy assumes that seniors are most comfortable within their own homes and communities. This assumption may not be warranted however. As seniors age, they may find that their houses are too large, and that they are unable to keep up with the maintenance. Often they also find that the home is not well designed for older individuals (laundry facilities in basement, etc). Moreover, the community in which they reside often no longer resembles the community they once knew. The demographics may have changed significantly, and many friends and people their own age no longer live there (and even if they do

there is little opportunity for interaction). This is the reality of many seniors who end up isolated while still in their own homes and in their own communities where they have spent the majority of their lives. Thus, home and community may not be where they are most comfortable and healthy.

According to the provincial strategy, however, seniors should remain in their homes *until they are no longer able to do so* (defined by unmet health needs). The tendency then is to remain in this type of home care longer than is optimal. When seniors finally do move, it is very stressful for them and their family since it is akin to a forced move. They are not really choosing to move to a place that will suit them well now and for the future, but they are being forced to move due to health problems into an available facility (perhaps far from family) that is capable of dealing with them in their now more deteriorated condition. These individuals will spend their last years in a place that more often resembles an institution to them. Thrust into this setting, they may further deteriorate with little quality of life or sense of community, especially if they are unable to interact with others who reside there.

Campus Model

The campus model creates a much stronger possibility for individuals to actually age in the right place, defined by the social model of care. The strength of the campus model is twofold. First, it allows the creation of a stable community, consisting of people at similar stages of life, while seniors are still living independently. Individuals move into the continuing care campus while still independent and are able to make friends internally while still cultivating old friendships externally. As they age, their external contacts may diminish, but their internal connections remain and in fact may have grown.

Second, if their health deteriorates, seniors may still be able to access additional services without moving. In this way, the campus model better deals with people whose changing health issues might place them in danger of slipping between the cracks (Alcock, Gallagher, Diem, Angus, and Medves (2000: 20). But even if the senior is required to move to another facility on the campus with higher health care capability, they remain within their campus community. The move is not alienating. Spouses need not be separated; family and friends who are still independent are easily able to visit. Managers and staff remain familiar. And the administration of care, if highly coordinated across the various levels available on the campus (Hollander and Prince, 2008), can provide a more seamless transition. In this way seniors have the opportunity to remain truly at home, in a community of friends and friendly faces, regardless of what type of care requirements may be necessary later in life.

Proximity to the Familiar (and Family)

Moving into a campus facility that accommodates independent living allows for better choice of facility. Being able to choose (rather than being forced to move in the face of deteriorated health) allows seniors to remain in closer proximity to things familiar (e.g. their local community). Patterns of living, including the involvement of family, are not as disrupted as is often the case in forced moves. Alcock, et al. (2000: 31) reported the following on the impact of proximity and family:

Living near or far from aging parents or relatives affects the nature of the care giving relationships which are formed and maintained. Living nearby certainly has its obvious advantages. Mixed housing complexes afford a range of living options. For instance, a case manager described the advantages for people living in a lodge next door to the nursing home where their spouses are living. Proximity enables frequent visits. Families living far apart have their unique struggles. Families that can only visit on holidays *want to fix everything over the holidays*. It is difficult when adult children want to uproot their aging parents and move them closer to where they are living, as one family was quoted as saying *just so we can keep an eye on them*. A case manager states: *Time and again I have seen this to be an absolute disaster...I have tried hard to talk to the kids, so that they're aware that quite often this isn't in their parents best interest*. However, in some families, such arrangements have worked out. (their emphasis)

Conclusion

Recent research is providing substantiation of new ways of providing continuing care (e.g. the exemplary models described in Section 3 above) and direction for continuing care in the future. Central to the new philosophy of care is the elderly person themselves, who is being recognized as the definitive stakeholder in continuing care. Refocusing on the elder within a model of social oriented care will inevitably inform and transform how personal care and even medical procedures are carried out (Rahman and Schnelle 2008: 144).

Grappling with the exemplary models of care as well as the burgeoning research in continuing care will require perseverance and commitment, but the result is worth pursuing. Excellence is not achieved by meeting minimum standards (Collins, 2005). Nor is excellence achieved in adopting singular exemplary practices. Rather, both of these, together with signature practices that develop out of deeply held convictions and values, will produce excellence in continuing care delivery.

The work will not be easy, but it is worth doing for the sake of our seniors.

REFERENCES

Government Documents

Alberta Health and Wellness. 1999. Healthy Aging: New Directions for Care. Edmonton: Communications Branch, Alberta Health and Wellness. November. (This document, in three parts, is also known as the Broda Report.)

Alberta Health and Wellness. 2008 (July). Continuing care health services standards. Edmonton: Communications Branch, Alberta Health and Wellness.

Alberta Health and Wellness. 2008 (December). Continuing care strategy: Aging in the right place. Edmonton: Communications Branch.

Alberta Health News Release. 1995 (August 31). Innovative projects challenge traditional approaches to continuing care. Edmonton: Communications Branch, Alberta Health.

Alberta Seniors and Community Supports. 2010 (April). Long-term care accommodation standards. Edmonton: Communications Branch.

Alberta Seniors and Community Supports. 2010 (April). Supportive living accommodation standards. Edmonton: Communications Branch.

Alberta Seniors and Community Supports. 2007 (March). Supportive living framework. Edmonton: Communications Branch.

Canadian Institute for Health Information. www.cihi.ca

Division of Aging and Seniors, Health Canada. 1999 (March). Innovations in best-practice models of continuing care for seniors. Ottawa: Minister of Public Works and Government Services Canada. From: <http://www.phac-aspc.gc.ca/seniors-aines/publications/pro/caregiving-soins/innovations/index-eng.php> accessed June, 2010.

Government of Alberta. 2005 (November). Achieving excellence in continuing care: Final report of the MLA task force on continuing care health services and accommodation standards. Edmonton: Communications Branch.

General References

- Alcock, D., Gallagher, E., Diem, D., Angus, D., and Medves, J. 2000. Decision-making: Home care of long term care facility. Substudy 6. National Evaluation of the Cost-Effectiveness of Home Care. Health Canada: Health Transition Fund.
- Ban, N. 2003. Continuing care of chronic illness: Evidence-base medicine and narrative-based medicine as competencies for patient-centered care. Asia Pacific Family Medicine, 2: 74-76.
- Brown, S.L. & Eisenhardt, K.M. 1997. The art of continuous change: Linking complexity theory and time-paced evolution in relentlessly shifting organizations. Administrative Science Quarterly, 42: 1-34.
- Brueggemann, W. 1977. *The Bible Makes Sense*. Atlanta: John Knox Press.
- Charis Village. <http://www.charisvillage.ca/> Accessed March 18, 2011.
- Charmel, P. A. 2003. Building the business case for patient-centered care. In S. B. Frampton, L. Gilpin, and P. A. Charmel (eds), Putting Patients First: Designing and Practicing Patient-Centered Care. pp 193-204. San Francisco: Jossey-Bass.
- Collins, J. 2005. Good to Great and the Social Sectors. New York: HarperCollins Publishers Inc.
- Daaleman, T. P. and Dobbs, D. 2010. Religiosity, spirituality, and death attitudes in chronically ill older adults. Research on Aging, 32 (2): 224-243.
- Degenholtz, H. B., Kane, R. A., Kane, R. L., Bershadsky, B., and Kling, K. C. 2006. Predicting nursing facility residents' quality of life using external indicators. Health Services Research, 42 (2): 335-356.
- Dröes, R-M., Boelens-Van Der Knoop, E. C. C., Bos, J., Meihuizen, L., Ettema, T. P., Gerritsen, D. L., Hoogeveen, F., De Lange, J., and Schölzel-Dorenbos, C. J. M. 2006. Quality of life in dementia in perspective: An exploratory study of variations in opinions among people with dementia and their professional caregivers, and in literature. Dementia, 5 (4): 533-558.
- Eden Alternative. <http://www.edenalt.org/> Accessed Dec 23, 2010.
- Elm, D. F. and Johnson, J. 2000. Educational Gerontology, 26: 317-330.
- Forbes-Thompson, S. and Gessert, C. E. 2006. Nursing homes and suffering: Part of the problem or part of the solution? Journal of Applied Gerontology, 25 (3): 234-251.
- Frampton, S. B. 2003. Introduction: The emergence of patient-centered care and the Planetree Model. In S. B. Frampton, L. Gilpin, and P. A. Charmel (eds), Putting Patients First: Designing and Practicing Patient-Centered Care. pp xxv-xxxix. San Francisco: Jossey-Bass.

Frampton, S. B., Gilpin, L., and Charmel, P. A. (eds), Putting Patients First: Designing and Practicing Patient-Centered Care. San Francisco: Jossey-Bass.

Gratton, L. & Ghoshal S. 2005. Beyond best practice. MIT Sloan Management Review, 46 (3): 49-57.

Green House Project. <http://www.thegreenhouseproject.org/> Accessed March 1, 2011.

Hancock, M. 2010. Consolation, injunction & self-reflection: Richard Baxter's framing of ageing in three major works. Paper presented at the Sixth International Conference of the International John Bunyan Society, Keele University, July 26-28, 2010.

Handzo, G. and Wilson, J. C. 2003. Spirituality: Inner resources for healing. In S. B. Frampton, L. Gilpin, and P. A. Charmel (eds), Putting Patients First: Designing and Practicing Patient-Centered Care. pp 89-104. San Francisco: Jossey-Bass.

Hollander, M. J., (Ed.) 2007. Development of a strategic framework for continuing care services: Continuing care service delivery systems—Case studies of current models (revised). Halifax: Nova Scotia Department of Health, Continuing Care Branch.

Hollander, M. J. and Prince, M. J. 2008. Organizing healthcare delivery systems for persons with ongoing care needs and their families: A best practices framework. Healthcare Quarterly, 11 (1): 44-54.

Holt-Lunstad, J., Smith, T. B., and Layton, J. B. 2010. Social relationships and mortality risk: A meta-analytic review. PLoS Med, 7 (7): e1000316. doi:10.1371/journal.pmed.1000316.

Hope, C. A. and Muehlemann, A. P. 2001. The impact of culture on best-practice production/operations management. International Journal of Management Reviews, 3 (3): 199-217.

Innovative Care Models Website: <http://www.innovativecaremodels.com/> Accessed July 18, 2011.

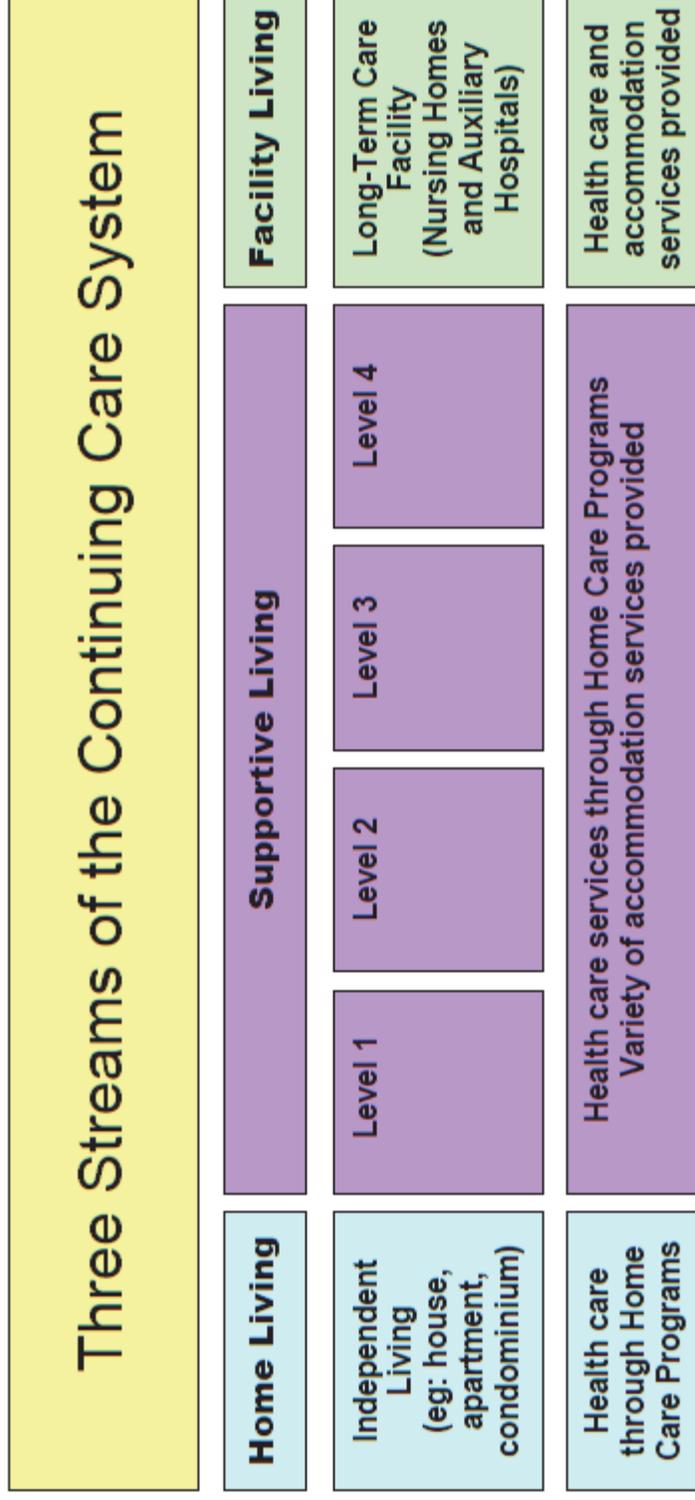
Kane, R. A. 2001. Long-term care and a good quality of life: Bringing them closer together. The Gerontologist, 41 (3): 293-304.

Kane, R. A., K. C. Kling, B. Bershadsky, R. L. Kane, K. Giles, H. B. Degenholtz, J. Liu, and L. J. Cutler. 2003. Quality of life measures for nursing home residents. Journals of Gerontology: Biological Science and Medical Science 58 (3): 240–8.

Katsuno, T. 2003. Personal spirituality of persons with early stage dementia. Is it related to perceived quality of life? Dementia: The International Journal of Social Research and Practice, 2 (3): 315-335.

- Komarek, A. 2003. Adapting patient-centered care to the long-term care environment. In S. B. Frampton, L. Gilpin, and P. A. Charmel (eds), Putting Patients First: Designing and Practicing Patient-Centered Care. pp 265-292. San Francisco: Jossey-Bass.
- Lum, T. Y., Kane, R. A., Cutler, L. J., and Yu, T-C. 2008. Effects of Green House nursing homes on residents' families. Health Care Financing Review, 30 (2): 35-51.
- MacAdam, M. 2008. Frameworks of integrated care for the elderly: A systematic review. Canadian Policy Research Networks Inc.
- Nattermann, P. M. 2000. Best practice does not equal best strategy. McKinsey & Company. https://www.mckinseyquarterly.com/Best_practice_does_not_equal_best_strategy_809
- Park, N. S. 2009. The relationship of social engagement to psychological well-being of older adults in assisted living facilities. Journal of Applied Gerontology, 28 (4): 461-481.
- Pioneer Network. <http://www.pioneernetwork.net/> Accessed February 26, 2011.
- Planetree. <http://www.planetree.org/index.html> Accessed March 1, 2011.
- Rabig, J., Thomas, W., Kane, R. A., Cutler, L. J., McAlilly, S. 2006. Radical redesign of nursing homes: Applying the green house concept in Tupelo, Mississippi. The Gerontologist, 46 (4): 533-539.
- Rahman, A. N. and Schnelle, J. F. 2008. The nursing home culture-change movement: Recent past, present, and future directions for research. The Gerontologist, 48 (2): 142-148.
- Snyder, L. 2003. Satisfactions and challenges in spiritual faith and practice for persons with dementia. Dementia: The International Journal of Social Research and Practice, 2 (3): 299-313.
- Stein, J.G. 2002. The cult of efficiency. Toronto: House of Anansi Press.
- Street, D., Burge, S., Quadagno, J., and Barrett, A. 2007. The salience of social relationships for resident well-being in assisted living. Journal of Gerontology: Social Sciences, 62B (2): S129-S134.
- Tirrito, T. and Choi, G. 2006. The caregiver's spirituality can serve as a buffer for stress and burden in care for person's with Alzheimer's disease and related disorders. Alzheimer's and Dementia, 2 (3), Supplement 1, July 2006, p. S584.
- Uyeno, D. & Hollander, M. J. 2001. Care trajectories: The natural history of clients moving through the continuing care system. Sub-study 2, National Evaluation of the Cost-Effectiveness of Home Care. Ottawa: Health Transition Fund, Health Canada.
- Wesley Village. <http://www.planetree.org/Assets/PDF/Wesley%20Village%20Case%20Study.pdf> Accessed July 10, 2011

Appendix 1



Taken from: Alberta Health and Wellness. 2008 (July). Continuing care health services standards: p 1. Edmonton: Communications Branch, Alberta Health and Wellness.

LEVELS OF SUPPORTIVE LIVING IN ALBERTA

Residential Living - Level 1	Lodge Living - Level 2	Assisted Living - Level 3	Enhanced Assisted Living - Level 4
RESIDENT NEEDS			
<ul style="list-style-type: none"> - Can arrange, manage and direct own care and is responsible for decisions about day-to-day activities. - Can manage most daily tasks independently. - Some supports/services are required. - All personal assistance can be scheduled. - Primarily needs housing for safety, security and socialization 	<ul style="list-style-type: none"> - Can arrange, manage and direct own care and is responsible for decisions about day-to-day activities. - Can manage some daily tasks independently. - A basic set of supports/services is required. - All or most personal assistance can be scheduled. - May require some assistance/encouragement to participate in social, recreational and rehabilitation programs. 	<ul style="list-style-type: none"> - Has choices but may need assistance in making some decisions about day-to-day activities. - Requires assistance with many daily tasks. - Most personal assistance can be scheduled. The need for unscheduled personal assistance is infrequent. - May require increased assistance to participate in social, recreational and rehabilitation programs. 	<ul style="list-style-type: none"> - Needs assistance in making decisions about day-to-day activities, but should still be given as many choices as possible. - Requires assistance with most/all daily tasks. - The need for unscheduled personal assistance is frequent. - Requires enhanced assistance to participate in social, recreational and rehabilitation programs.
BUILDING FEATURES			
<p>All Levels - Building safety and design features are appropriate for residents' needs</p> <p>Ideally, each suite is private, includes a lockable door, a bedroom, sitting area, bathroom and a kitchenette. Suites for residents with Residential Living - Level 1 needs may also include a full kitchen.</p> <p>Except for Residential Living - Level 1, that might only contain a common area for dining, all other levels of supportive living are expected to have common areas for dining and social/recreational activities.</p>			
HOSPITALITY SERVICES			
<p>Meal Services</p> <p>At least one main meal per day is available</p> <p>Housekeeping Services</p> <p>Services are available</p> <p>Personal Laundry</p> <p>Personal laundry equipment is available</p> <p>Personal laundry services may be available</p> <p>Laundry and Linen Services</p> <p>Laundry and linen services may be available.</p> <p>Safety & Security</p> <p>24 hour security is provided</p> <p>Social, Leisure & Recreational Opportunities</p> <p>Services may be available</p> <p>Coordination and Referral Services to Community Supports</p> <p>Guidance/Advocacy/Advisory role may be available</p> <p>Assistance with accessing community services may be available</p> <p>May be Available- Housing operators may or may not have the ability or capacity to co-ordinate this service or provide it to residents.</p> <p>Is/Are Available - The housing operator has the capacity to provide the service directly or arrange for its delivery by another source, if the resident needs or wants the service.</p> <p>Provided - These are the services that housing operators supply to meet residents' needs.</p>	<p>Meal Services</p> <p>Full meal services are available (2 meals / kitchenette in suite)</p> <p>Housekeeping Services</p> <p>Weekly services are available</p> <p>Personal Laundry</p> <p>Personal laundry equipment is available</p> <p>Personal laundry services may be available</p> <p>Laundry and Linen Services</p> <p>Weekly laundry and linen services are available</p> <p>Safety & Security</p> <p>24 hour staff on site</p> <p>Social, Leisure & Recreational Opportunities</p> <p>Services are available</p> <p>Coordination and Referral Services to Community Supports</p> <p>Guidance/Advocacy/Advisory role is available</p> <p>Assistance with accessing community services is available</p>	<p>Meal Services</p> <p>Full meal services are available</p> <p>Some special dietary requirements can be met</p> <p>Housekeeping Services</p> <p>More than weekly services are available</p> <p>Additional sanitization as required</p> <p>Personal Laundry</p> <p>Personal laundry equipment is available</p> <p>Personal laundry services are available</p> <p>Laundry and Linen Services</p> <p>Weekly laundry and linen services are available</p> <p>Safety & Security</p> <p>24 hour staff on site</p> <p>Social, Leisure & Recreational Opportunities</p> <p>Services are available</p> <p>Coordination and Referral Services to Community Supports</p> <p>Guidance/Advocacy/Advisory role is provided</p> <p>Assistance with accessing community services is provided</p>	<p>Meal Services</p> <p>Full meal services are provided</p> <p>Most special dietary requirements can be met</p> <p>Food/nutrition intake monitored</p> <p>Housekeeping Services</p> <p>Daily services are provided</p> <p>Additional sanitization as required</p> <p>Personal Laundry</p> <p>Personal laundry equipment is available</p> <p>Personal laundry services are available</p> <p>Laundry and Linen Services</p> <p>Weekly/daily laundry and linen services are provided</p> <p>Safety & Security</p> <p>24 hour staff on site</p> <p>Routine checking of residents as required</p> <p>Personal response system is provided</p> <p>Social, Leisure & Recreational Opportunities</p> <p>Services are provided</p> <p>Coordination and Referral Services to Community Supports</p> <p>Guidance/Advocacy/Advisory role is provided</p> <p>Assistance with accessing community services is provided</p>
HEALTH AND WELLNESS SERVICES			
<p>All Levels: General Service Needs</p> <ul style="list-style-type: none"> - Cause management by RHAs for publicly funded services - Assessment for publicly funded health and personal care services completed by the RHA based on unmet need. - Other health services, services of health professionals are available as arranged locally and on an as needed basis. - Personal assistance and/or professional services may be provided to residents by: the RHA directly, the operator on contract to the RHA, the operator privately, or private pay by an alternate vendor. <p>All Levels: Medication Support</p> <ul style="list-style-type: none"> - Support will be provided by RHA's based on assessed unmet need. Support can also be purchased privately. Residents are responsible for the costs of their medications including dispensing fees. 			
<p>Staff</p> <p>Scheduled visits by RHA staff and other community supports.</p> <p>No health staff on site on a 24-hour basis.</p>	<p>Staff</p> <p>Scheduled visits by RHA staff and other community supports.</p> <p>No health staff on site on a 24-hour basis.</p>	<p>Staff</p> <p>Scheduled visits by RHA staff and other community supports.</p> <p>Suitably qualified, certified or trained staff on site - on a 24-hour basis</p>	<p>Staff</p> <p>Scheduled visits by RHA staff and other community supports.</p> <p>Suitably qualified, certified or trained staff on site - on a 24-hour basis</p> <p>Regulated professional staff on site - on a 24-hour basis</p>

Taken from: Alberta Seniors and Community Supports. 2007 (March). Supportive living framework: p. 6. Edmonton: Communications Branch.

Appendix 3

Eden Alternative: The Ten Principles

1. The three plagues of loneliness, helplessness, and boredom account for the bulk of suffering among our Elders.
2. An Elder-centered community commits to creating a human habitat where life revolves around close and continuing contact with plants, animals, and children. It is these relationships that provide the young and old alike with a pathway to a life worth living.
3. Loving companionship is the antidote to loneliness. Elders deserve easy access to human and animal companionship.
4. An Elder-centered community creates opportunity to give as well as receive care. This is the antidote to helplessness.
5. An Elder-centered community imbues daily life with variety and spontaneity by creating an environment in which unexpected and unpredictable interactions and happenings can take place. This is the antidote to boredom.
6. Meaningless activity corrodes the human spirit. The opportunity to do things that we find meaningful is essential to human health.
7. Medical treatment should be the servant of genuine human caring, never its master.
8. An Elder-centered community honors its Elders by de-emphasizing top-down bureaucratic authority, seeking instead to place the maximum possible decision-making authority into the hands of the Elders or into the hands of those closest to them.
9. Creating an Elder-centered community is a never-ending process. Human growth must never be separated from human life.
10. Wise leadership is the lifeblood of any struggle against the three plagues. For it, there can be no substitute.

Source: Taken from the Eden Alternative Website (<http://www.edenalt.org/our-10-principles>)

Appendix 4

Green House Mission, Vision, Goals and Philosophy

Vision

We envision homes in every community where elders and others enjoy excellent quality of life and quality of care; where they, their families, and the staff engage in meaningful relationships built on equality, empowerment, and mutual respect; where people want to live and work; and where all are protected, sustained, and nurtured without regard to the ability to pay.

Mission

We partner with organizations, advocates, and communities to lead the transformation of institutional long-term care by creating viable homes that spread THE GREEN HOUSE® Project vision – demonstrating more powerful, meaningful, and satisfying lives, work, and relationships.

Goals

The Green House model is a de-institutionalization effort designed to restore individuals to a home in the community by combining small homes with the full range of personal care and clinical services expected in high-quality nursing homes.

Philosophy

The philosophy of The Green House long-term care model is to enhance elders' quality of life by:

- Creating small homes that offer intentional communities and high levels of care
- Recognizing and valuing individuality of elders and staff
- Supporting elders' dignity
- Honoring autonomy and choice
- Providing privacy
- Creating an atmosphere of security
- Promoting maximum functional abilities
- Facilitating physical comfort
- Offering opportunities for reciprocal relationships between elders and staff
- Fostering enjoyment by offering meaningful activities
- Fostering emotional and spiritual well-being

Source: Taken from The Green House Project Website
(<http://www.thegreenhouseproject.org/mission>)

Appendix 5

The Green House Model: The Physical, Philosophical/Cultural, and Organizational Dimensions

Physical Dimension

The physical dimension may be characterized as providing a home-like atmosphere for elders. Thus, a Green House is relatively small (7-10 elders) and looks like other homes in the neighbourhood. The layout is also homelike: living rooms, kitchens, family dining room, hearth, laundry area, porch, and easy accessibility to the outdoors. Each elder has a private room with their own full bathroom. Institutional and medical signs and symbols are deliberately removed. The small size and non-institutional orientation are linked with research-supported positive quality of life outcomes.

Philosophical/Cultural Dimension

The philosophical and cultural dimension builds exclusively on the social model of care. The emphasis is on living, not on being sick and unable to perform usual daily tasks. Quality of life issues are primary: sense of security, physical comfort, enjoyment, meaningful activity, relationships, functional competence, dignity, privacy, individuality, autonomy, and spiritual well-being. The model seeks to increase personal control rather than doing everything for the elder, which leads to learned helplessness. Elders are encouraged to make decisions (when to eat, sleep, get up, receive personal care) and to be involved in various activities (all aspects of meals, gardening, laundry, caring for household pets, cleaning, etc). Relationships are encouraged; building relationships happens with eating together, playing games together, working together, and making decisions together. This is also broadened out to include the larger community who can be involved in ways other than being a formal volunteer. Finally, the language used also reflects the social model of care (e.g. certified nursing assistants are now called a shahbaz, meals are not nutrition).

Organizational Dimension

The organizational dimension conforms to the regulatory environment but within the philosophy of the Green House concept. Thus, while meeting regulatory requirements, the goal is to decrease bureaucracy and to re-create the role of the front-line staff. The direct care worker is given higher levels of training to be more of a generalist (able to do many tasks) and hence is also given improved salary and benefits. These workers (called Shahbazim, a word without any baggage) are supervised by an administrator; they are not under the control of medical personnel (e.g. nurses). Clinical support teams consisting of all the necessary and required medical personnel are part of each Green House. They are not situated in the house but make regular visits as required by law and by need. Importantly, they are expected to behave as they would entering a private home, and they have no supervisory role outside of treatment. Finally, central administration still undertakes administrative tasks (e.g. accounting, billing, maintaining the medical record system, maintaining the physical plant, and procurement).

Appendix 6

Tupelo, Mississippi Green House Model Implementation

Rabig, et al. 2006 describe the implementation of the Green House model in Tupelo, Mississippi, in a faith-based non-profit organization that utilizes a campus model (see also Lum, Kane, Cutler, and Yu, 2008). The four Green Houses were designed and built according to the Green House philosophy. In its implementation, other issues came to light leading to some modifications (e.g. more training for both the care attendants [referred to as Shabazim] and professionals whose training and long-time practice was significantly challenged). Lum et al. (2008: 49) subsequently noted that the Green House model proved to be “measurably effective” for residents and for their family members. They also noted the importance of those responsible for social services and activities. In particular these authors suggest it is important to train those assisting elders and providing activities with communication and social well-being skills (e.g. in this faith-based context surprisingly very little if anything was done to arrange for in-house worship services or transportation to community worship services).

Rabig and her colleagues (2006: 539) provide an overall assessment of the Green House model as implemented in Tupelo:

The Tupelo experience shows that it was possible to put a well-argued theoretical concept into practice and further refine its parameters without doing violence to its major principles. This accomplishment was assisted by many factors: a corporation that needed to rebuild; a chief executive officer and corporate staff committed to the vision and willing to persevere to test the model; technical assistance from the Green House Project; and foundation financial support that allowed for the technical assistance and research. The first implementation provided feedback to the Green House Project for further implementation.

Appendix 7

Planetree Vision, Mission, and Beliefs

Vision

As a global catalyst and leader Planetree promotes the development and implementation of innovative models of healthcare that focus on healing and nurturing body, mind and spirit.

Mission

Planetree is a non-profit organization that provides education and information in a collaborative community of healthcare organizations, facilitating efforts to create patient centered care in healing environments.

Beliefs

We believe...

- that we are human beings, caring for other human beings
- we are all caregivers
- care giving is best achieved through kindness and compassion
- safe, accessible, high quality care is fundamental to patient-centered care
- in a holistic approach to meeting people's needs of body, mind and spirit
- families, friends and loved ones are vital to the healing process
- access to understandable health information can empower individuals to participate in their health care
- the opportunity for individuals to make personal choices related to their care is essential
- physical environments can enhance healing, health and wellbeing
- illness can be a transformational experience for patients, families and caregivers

Source: Taken from Planetree Website. <http://www.planetree.org/about.html>

Appendix 8

Planetree Model's Ten Continuing Care Components

Recognizing the Primary Importance of Human Interactions

Planetree is about human beings caring for one another. A Planetree continuing care community fosters caring relationships among residents, families, employees, and volunteers by emphasizing self-awareness and personal accountability. Staff retreats provide an understanding of the needs of older adults and sensitize staff to life from the resident's perspective, while building team relationship skills through experiential exercises. Ongoing seminars for residents and staff offer tools for communicating positively, maintaining authentic relationships, and managing conflicts in a dignified manner.

Enhancing Each Individual's Life's Journey

A Planetree continuing care community offers opportunities for personal growth, self-expression, and the fulfillment of individual dreams. Planetree supports individuals who provide volunteer service to the communities where they live and work. Through group discussions, journal writing and a life stories program, individuals have opportunities to review their life, clarify what they value, and determine personal goals. In a life stories program, a trained volunteer interviews a resident and writes a short story that captures some of the pivotal events in that resident's life. These short stories are shared with caregivers, enabling them to see each resident as a whole person rather than primarily as "someone needing services," and creating bonds between individuals that deepen mutual respect, trust, and concern.

Supporting Independence, Dignity, and Choice

A Planetree continuing care community offers a range of options that support an individual's autonomy, lifestyle, and interests. Residents direct their care and their decisions are respected. A Planetree community provides consistent caregiving teams in an effort to strengthen relationships and ensure that personal preferences are understood and met. Staff members and volunteers actively participate in the creative process of individualizing care and services that are offered to residents. Staff training emphasizes respect for privacy and personal space.

Incorporating Family, Friends, and Social Support Networks in the Life of the Community

Social support and loving relationships are vital to good health. A Planetree continuing care community surrounds residents with people whom they can depend on and encourages individuals to actively build trusting relationships. It enables residents to maintain their connections to family and friends by providing unrestricted visiting hours, flexible schedules, and convenient access to telephone and e-mail. There is a process to match residents with their neighbors, and staff with their peers, especially during times of need. Support groups help

individuals cope with transitions, illness, loss, grief, and stress. A care partner program actively involves family members and friends in planning and providing care.

Supporting Spirituality as a Source of Inner Strength

Planetree recognizes that spirituality is essential to a fulfilling life. A Planetree community provides opportunities to strengthen the relationship with one's faith and inner resources. Residents and staff have opportunities for worship, prayer, meditation, and ceremonies such as an annual Blessing of the Hands that celebrates the caring spirit of the staff. In addition, there are educational programs about spirituality and opportunities to discuss, both privately with clergy and in groups, the meaning and spiritual dimensions of life and one's personal beliefs and values. Pastoral care is available for residents and staff for routine needs as well as for times of stress such as illness or the death of a loved one.

Promoting Paths to Well-Being

A Planetree continuing care community provides innovative programs for residents and staff that maintain health and fitness and that complement western scientific medical care. Wellness programs include prevention and management of chronic diseases and convenient access to vision, hearing, dental, and other specialized services. There are exercise facilities with equipment designed for seniors and personalized programs for strength, balance and fitness training based on individual assessments and benchmarks. Naturopathic medicine, aromatherapy, guided imagery, massage, yoga, and meditation classes are offered.

Empowering Individuals Through Information and Education

A Planetree continuing care community gives residents and staff the information necessary to understand their situation and maximize their physical, psychological, and financial well-being. There are educational programs about preventing and coping with diseases, a resource library, and computers with Internet access. A Continuous Quality Improvement process throughout the organization encourages staff at all levels, residents, and family members to work together to solve problems and exceed quality standards. Staff are trained to take the initiative in resolving issues that arise with resident services.

Recognizing the Nutritional and Nurturing Aspects of Food

Planetree recognizes that eating is not only essential to physical health, but is also a source of pleasure, comfort, and fellowship. A Planetree dining program enhances the social aspects of meals while serving delicious fresh food that is attractively presented in a pleasant environment. A full-service dining program offers changing, nutritionally-balanced menus with choices of entrees and side dishes, including heart-healthy choices, that are responsive to individual preferences. Mealtimes are flexible and healthy snacks are available at all times. The dining program includes special events, holiday meals, parties, and picnics for residents and staff.

Offering Meaningful Arts, Activities and Entertainment

Planetree recognizes that people need opportunities for camaraderie, laughter, and creativity. A Planetree continuing care community offers a variety of activities that include classes, discussions, concerts, parties, outings, intergenerational programs, and family events. To broaden the relationships between staff and residents, staff participate in special resident activities. Transportation accommodates residents who wish to attend off-site events and to volunteer for local organizations. For animal lovers, pets visit regularly. An employee committee plans activities that enliven the workplace and encourage fellowship.

Providing an Environment Conducive to Quality Living

Planetree recognizes that the physical environment has a tremendous effect on the well-being of residents and staff. The design of a Planetree continuing care community incorporates public and private space, residential décor, natural light, and views of nature. An uncluttered environment facilitates movement and communication, creating a feeling of “safe shelter.” There is a library, and space for group activities, social gatherings, and worship. Common areas feature artwork, music, plants, and fish tanks. Flower gardens, fountains, labyrinths, and outdoor sitting areas allow individuals to experience the relaxing, invigorating, and meditative aspects of nature. The design and operations provide for the safety and security of residents, staff, and visitors while enhancing the quality of life.

Source: Taken from Planetree Website. <http://www.planetree.org/PCC.html>

Appendix 9

Wesley Village – Shelton, Connecticut Planetree Implementation Leads to Significant Changes Greater Staff Retention and Patient Safety Indicators Cut Operational Costs

Owned by the non-profit United Methodist Homes, Wesley Village provides independent, assisted living, and skilled nursing care to more than 600 residents annually. In 2002, each of the three communities on campus (as well as the individual departments within those communities) had high satisfaction scores, strong reputations, and longevity in staffing, but they were all operating in isolation. Resident-directed efforts did occur at the behest of the caring staff, but without the benefit of any deep-rooted systems change, they lacked focus and the ability to sustain those improvements.

Taking the First Step

Wesley Village noted the transformational change occurring at nearby Griffin Hospital in Derby, Connecticut and realized that Planetree concepts were very applicable to long-term care. They also noted the vast potential for improving the patient transition experience by connecting the Planetree philosophy across the continuum of care. To this end, Wesley Village began implementing and testing a set of components based on the Planetree acute care components. Some remained the same, while others were modified to meet the needs of individuals served in continuing care environments.

One of the most important first steps was educating staff on culture change and engaging them in the vision of community-building and relationship-centered care. At a farmhouse in the country, all staff participated in two days of experiential exercises on the aging process, teamwork, relationshipbuilding, as well as their role in the process of implementation. Residents, families, staff, and volunteers became an integral part of the process by setting goals and identifying improvements in each of the ten continuing care components. The goals were then prioritized by a committee comprised of managers, line staff from all departments, residents and family. The goals were posted along with quality improvement indicators to raise awareness and promote transparency of an environment that strives to exceed quality standards.

Taking Action

The community began implementing programs to achieve these goals. In many situations, the results far exceeded expectations and were fueled by the impetus of the line staff. At the nursing home on campus, for example, they began implementing consistent staff assignment and explored other ways to ensure that resident routines and preferences were honored and that those residents determined the pace of care and services. As changes were made to improve flexibility of meal times, for example, a domino effect took place, affecting the rhythms and routines of all departments. At first, it was simply a breakfast buffet for short-term rehabilitation residents to enhance flexibility for waking and rehabilitation times and to provide a separate dining experience from our long-term residents. Staff and residents responded so positively to the changes (the smell and aroma of food, hot toast, expanded choices, fewer call-downs to the kitchen, the bonding of residents with each other and with dietary staff, increased resident consumption of food, and an atmosphere of normalcy), that within 9 months, every resident

benefited from a trayless buffet system during all meals. The administrator notes that, for one pavilion of the nursing home, the shift occurred on a day that she was out of the building, a testament to the decentralization of leadership in the community.

For many staff members, it involved a new way of looking at their jobs, and at excellence in providing services. In the activities department, employees have long been evaluated by how many residents attend a program rather than the active engagement of the residents attending. Through Planetree, the focus has now changed from the quantity of programs and the numbers served to the quality of programs and resident-directed programs that support teaching, mentoring, sharing, and the building of skills and talents. For maintenance and housekeeping departments, an Earth-friendly cleaning program has been implemented with the use of all non-toxic cleaning supplies.

Far-reaching Results

Ultimately, the implementation of Planetree Continuing Care led to enhanced clinical, financial, and operational outcomes as well as increased resident and staff satisfaction. Since implementing Planetree at Wesley Village, staff turnover has remained 40 percent below the industry average. In addition, just two years after implementing the model, the nursing home reported that no certified nursing aides had left due to dissatisfaction with their jobs. Compared to a national average of 70 percent, all turnover was involuntary at a rate of 18 percent. Since 2003, a 42 percent decrease in the amount of CNA turnover has resulted in a savings of more than \$40,000. There has been a 36 percent increase in volunteers since 2003, with the hours volunteers logging at Wesley Village in 2008 valued at \$209,732 (Independent Sector). One quarter of the volunteer corps is comprised of residents (13%) and staff (11%).

At Bishop Wicke Health Center admissions have increased by 42 percent since 2005. Because of the trayless dining and improvements to the dietary system, weekly supplement use has decreased by 70 percent, resulting in a savings of \$26,000 annually. Bishop Wicke accomplished a 90 percent reduction in restraints, a reduction of safety alarms by 50 percent, and the installation of a wanderguard system to allow walking throughout the facility as opposed to a locked pavilion all without an increase in falls. Leaders attribute this improvement to Planetree initiatives including consistent assignment, information and empowerment of residents, the implementation of an incontinence program that minimizes late night wake-ups, and the redesign of an ambulation program to involve the primary caregiver (family member). Significantly, in 2008 there were no falls on the rehab unit on the 11 p.m. to 7 a.m. shift. In addition, agency use decreased by 50 percent from 2007 to 2008.

In the end, Wesley Village realized that transformation is not about implementing a laundry list of programs; instead it is about awakening passion, creating a strong sense of purpose, and engaging everyone in the process of improvement. Through the interactive and supportive environment, caregivers have reawakened their inner passion and remembered what brought them to healthcare in the first place.

Source: Taken from Planetree Website

<http://www.planetree.org/Assets/PDF/Wesley%20Village%20Case%20Study.pdf>

Appendix 10

Pioneer Networks Mission, Vision, and Values

OUR VISION

A Culture of Aging that is Life-Affirming, Satisfying, Humane and Meaningful

We recognize our need to create ways of living and working together different from the traditional models. The Pioneer Network supports models where elders live in open, diverse, caring communities. Pioneers are working for deep system change by both evolutionary and revolutionary means, using Pioneer values and principles as the foundations for change. In-depth change in systems requires change in governmental policy and regulation; change in the individual's and society's attitudes toward aging and elders; change in elders' attitudes towards themselves and their aging; and change in the attitudes and behavior of caregivers toward those for whom they care. We refer to this work as culture change. Our aim is nothing less than transforming the culture of aging in America.

OUR MISSION

The Pioneer Network advocates and facilitates deep system change and transformation in our culture of aging. To achieve this, we:

- Create communication, networking and learning opportunities
- Build and support relationships and community
- Identify and promote transformations in practice, services, public policy and research
- Develop and provide access to resources and leadership

VALUES AND PRINCIPLES

- Know each person
- Each person can and does make a difference
- Relationship is the fundamental building block of a transformed culture
- Respond to spirit, as well as mind and body
- Risk taking is a normal part of life
- Put person before task
- All elders are entitled to self-determination wherever they live
- Community is the antidote to institutionalization
- Do unto others as you would have them do unto you
- Promote the growth and development of all
- Shape and use the potential of the environment in all its aspects: physical, organizational, psycho/social/spiritual
- Practice self-examination, searching for new creativity and opportunities for doing better
- Recognize that culture change and transformation are not destinations but a journey, always a work in progress

Source: Taken from Pioneer Networks Website
(<http://www.pioneernetwork.net/AboutUs/Values/>)

Appendix 11

The Pioneer Network DECLARATION OF INTERDEPENDENCE The Spirit of '06

We began years ago as a movement to affirm the fundamental rights of those living and working in long-term care settings. We learned that where individuals are empowered and honoring of relationships, the process of *creating home and community* rekindles the human spirit and mends our frayed social fabric. Our collective journey of transformational change is inspired by a spirit of openness.

- It is an openness *to see* those who live and work with us with an honest reckoning of the present, and a progressive vision of the future.
- It is an openness *to hear* the voices of those who have been too often silenced in the decisionmaking process, and *to listen* to their self-directed preferences.
- It is an openness *to speak* from the heart and *to act* through a respectful awareness of community life and teamwork.

Openness to change and new possibility sustains us through inevitable periods of conflict and disruption. It helps us overcome the real world hurdles on our path toward de-institutionalized services and individualized care. It creates the energy for us to realize our leadership potential in our organizations and in our broader communities.

Today we invoke a spirit of openness to usher in a new era of aging in community. We declare our *interdependence*, and we invite each other into a dialogue about how to make interdependence our true way of being and living in community.

Interdependence: Reliance on one another for mutual support or sustenance.

Each of us has our own unique passions, capacities and strengths. We recognize these gifts as self-evident. And yet interdependence is not self-evident — it requires acts of intention.

As human beings, we live by and through cooperation with others — it is our destiny. In spite of the emphasis placed on being independent, in reality we are all interdependent. The nature of our cooperation with and relationship to others changes as we grow, mature, and age. These relationships form the basis of all true communities. Therefore, we seek to understand and possess the skills necessary to be interdependent in healthy, productive ways.

In declaring our interdependence, we recognize that when we are united, we have endless possibilities; when we are partners, we build community; when we are proactive together, we reduce our fear of change, and when we cultivate the common ground, we grow individually and collectively.

Source: Taken from Pioneer Networks Website
(<http://www.pioneernetwork.net/AboutUs/Declaration/>)