There's No Place Like Home:

Why Canada Must Prioritize Small Care Home Models in its Provision of Long-Term Care

January 2025

AGEING IN THE *RIGHT* PLACE

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The National Institute on Ageing (NIA) improves the lives of older adults and the systems that support them by convening stakeholders, conducting research, advancing policy solutions and practice innovations, sharing information and shifting attitudes. Our vision is a Canada where older adults feel valued, included, supported and better prepared to age with confidence.

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Table of Contents

Acronyms

BSTN
Behavioural Support Transition Neighbourhood

CCA
Continuing Care Assistant

CCS
Continuing Care Strategy

DLA
Daily Living Assistant

FBCC
Facility-Based Continuing Care

GHP
Green House Project

HSO
Health Standards Organization

HCA
Healthcare Aid

L/RPN
Licensed/Registered Practical Nurses

LTC
Long-Term Care

MA
Maisons Alternatives

MDA
Maisons Des Aînés

NIA
National Institute on Ageing

OECD
Organization for Economic Cooperation and Development

PSW
Personal Support Worker

PEAK
Promoting Excellent Alternatives in Kansas

PCH
Personal Care Home

RN
Registered Nurse

US
United States

Introduction

Canada's provincial and territorial long-term care (LTC) systems are increasingly struggling to meet the rapidly growing needs of their ageing populations. The roots of its current problems extend back decades due to a history chronic underfunding by governments on the provision of LTC services.[1,2]

Canada's current challenges around its ability to deliver safe and high-quality LTC services likely also stem from a uniquely North American phenomenon that, unlike much of the rest of the world, prioritizes care for its mostly older and frail citizens in large institutional and hospital-like care settings.

Ironically, other forms of LTC services, such as caring for adults with disabilities and hospice care, has been, by and large, provided in small household settings, yet the approach to caring for often frail older adults living with dementia has been described as "warehousing" older people in often poorly staffed and large institutional settings.[3]

The recent COVID-19 pandemic demonstrated both the longstanding challenges facing Canada's LTC systems and homes and their ability to safely manage the care of some of our most vulnerable persons through a public health emergency. Indeed, after the first wave of the COVID-19 pandemic, a National Institute on Ageing (NIA) analysis demonstrated that, among other major Organization for Economic Cooperation and Development (OECD) nations, Canada had the highest mortality ratio when comparing COVID-19-related deaths among LTC and retirement home residents with those of community-dwelling older persons (73.7 vs. the OECD 12-country average of 25.5). Overall, Canada's COVID-19-related deaths occurring within its 6,029 LTC and retirement homes accounted for a very high relative percentage of its overall deaths (78.4%) compared to the OECD 12 country average of 47.3% by the middle of 2020.[4]

Within two years, the NIA's LTC COVID-19 Tracker had recorded 17,177 resident and 32 staff deaths across Canada's LTC and retirement home settings, representing 43% of Canada's overall deaths attributed to COVID-19, despite this group representing less than 1% of its population.[5]

Several subsequent public inquiries and reports have highlighted how longstanding operational and structural factors significantly impacted the ability of Canada's LTC systems to appropriately protect and care for LTC home residents during the pandemic.

Collectively, their findings called for the more immediate provision of adequate staffing levels and improved working conditions, the reduction of crowded living conditions in these environments through the elimination of three- and four-bed ward style rooms — which were still common in some jurisdictions — as well as the creation of more private rooms with their own dedicated bathrooms.[6]

Compared with its peer OECD countries, the pandemic also made it clear that Canada had fallen behind in its investments in the provision of publicly funded LTC services, despite the continued ageing of its population. This is evident by how even though Canada's LTC spending is greater than the OECD average as a share of its GDP (2.3% versus 1.8%), there are still nine countries that spend more on LTC than Canada.[7] Furthermore, Canada's universal health care system — known as Medicare — has never included, nor guaranteed, the provision of LTC services such as home and community care or care in LTC homes. Indeed, this remains the largest form of hands-on care not currently covered under the Canada Health Act. Thus, Canada's provinces and territories have been left to determine what LTC services they will provide, along with their associated qualifying criteria, coverage levels and design standards, which continue to vary significantly across the country. Furthermore, in its first comprehensive review of the provision of LTC services across Canada, the NIA concluded that significant changes were long overdue to better enable Canada's overburdened LTC sector.[8]

In the NIA's post-pandemic review of LTC services across Canada, it identified several challenges currently facing its provision of LTC services, including the rapid expansion of both its LTC home and home and community care waitlists, a continued long-standing legacy of government underfunding, growing care quality inconsistencies, ongoing and worsening staffing shortages, and a continued preference to provide LTC services in large institutional care settings that make it harder to provide safe and high-quality care. Therefore, the NIA's latest report, *Enabling a More Promising Future for Long-Term Care in Canada*, drew attention to the need for a "paradigm shift" to support a more promising future for delivery of LTC services in Canada. The report also provided a road map towards improving the delivery of care in LTC homes that emphasizes the provision of truly resident-centred care (focusing on the needs, goals and preferences of each resident) in adequately staffed and smaller home-like LTC settings.[9]

While the need for care in LTC settings has continued to increase, so has the desire by the public to avoid being admitted into LTC homes.

A survey conducted by the NIA in 2021 found that nearly 100% of older Canadians reported that they would "do everything they could" to prevent themselves and their family members from being admitted to LTC homes.[10]

Additionally, it has recently been found that the public perceives LTC homes as large, and often inhospitable, institutional settings where people are largely being "warehoused" rather than having their care needs being appropriately met.[11] These findings have made it clear that current government priorities that are principally focused on funding construction of LTC home infrastructure are not entirely aligned with now well-established

public preferences of how LTC homes should look and feel.

In the wake of the significant quality of life and care issues faced by residents and staff associated with large and traditional LTC settings both leading up to and during the COVID-19 pandemic,[12,13] increased attention has been given to understanding what alternative and more effective models and methods of delivering LTC home services should entail. In the fall of 2020, the federal government announced its desire to see the creation of new national LTC standards to better support the future design, operation and more consistent delivery of safe and high-quality care in LTC homes across Canada. Canada's Health Standards Organization (HSO) and the CSA Group were thus tasked by the Standards Council of Canada with developing these new standards over the next two years.

The two complementary standards developed by HSO and the CSA Group were based on established evidence and best practices, along with feedback through consultations and surveys with over 20,000 LTC home residents, staff, families and caregivers, leaders and the members of the public.[14]

In January 2023, HSO released its new National Long-Term Care Services Standard, which outlined 113 recommendations for providing safe and high-quality resident-centred, team-based care within a home-like environment.[15] The standard also specifically recommended that LTC homes be adequately funded and staffed to support the provision of at least 4.1 hours of direct care per LTC home resident per day. While Nunavut now requires all LTC homes to provide a minimum of 4.1 hours of direct care per LTC home resident per day,[16] Manitoba, Nova Scotia and Ontario have also committed to do the same within the next few years.

In December 2022, the CSA Group released its new standard, which focused on providing criteria that could support the design and operation of LTC homes. It also specifically recommended the greater implementation of a smaller format LTC home. According to the CSA Group, an LTC home should ideally support no more than 10-12 residents within a shared household space, with each resident having the option of either a private room or a two-person/adjoining bedroom in the case of residents who are siblings, spouses, or friends.[17]

According to Canada's new national LTC standards, supporting the greater provision of LTC in small care home settings could be best be achieved by focusing on: creating small household and "home-like" living environments as opposed to traditionally large and more institutional settings; providing adequate staffing levels; and enabling staffing models and the necessary training, which — together — can better enable the provision of more resident-centred care.

These three "pillars" or overall concepts thus represent a useful encapsulation of the types of improvements and reforms that are increasingly being supported by a growing body of evidence and experience to establish a useful framework to envision care provision in LTC homes that more closely aligns with the needs and desires of residents, their care providers and their families and caregivers.

In addition to Canada's new national LTC standards, the United States (US) National

Academies of Sciences,[18] and the Australian government,[19] have also recently called for their future LTC homes to adopt smaller physical formats that offer single bedrooms and bathrooms, and for the adoption of better ways to provide more resident centred/directed care. It is important to note that while similar concepts are coming to increasingly underlie the development of Small Care Homes, there currently is no one accepted model supporting their implementation.

Beyond Canada, there are numerous examples of Small Care Homes for older adults including individuals living with dementia that have adopted smaller household physical formats and are focused on delivering aspects of resident centred care in Australia, the United States, the United Kingdom, and European countries.[20,21,22,23] The most robust evidence in support of Small Care Home models comes from the US-based Green House Project (GHP), which has supported the development of more than four hundred small care homes across the US over the past two decades, and more recently Australia and Canada. Interestingly, some of the earliest examples of Small Care Home models originated in Canada.

This report reviews the efficacy of Small Care Home models, outlines key learnings from their adoption by a variety of jurisdictions over the past few decades and highlights important relevant considerations as governments across North America, and especially Canada, are increasingly showing greater interest in implementing these models to achieve better resident, staff and system outcomes. To develop this report, in addition to reviewing scholarly articles and reports on Small Care Home models, expert informant interviews were conducted with the leads of the Green House Project in the US and the leaders of existing Small Care LTC Homes across Canada, Australia and the United Kingdom.[i]

i These experts have been noted as part of the list of Contributors and Reviewers on page four, as well as within the section associated to their respective initiatives.

Canada's Current LTC Home Landscape

While nearly 100% of older Canadians have reported that they would "do everything they could" to prevent themselves and their family members from being admitted to an LTC home,[24] the reality is that some will eventually require care in such a setting.

A 2017 analysis by the Conference Board of Canada demonstrated that on top of Canada's current complement of nearly 200,000 LTC beds, it would need an additional 199,000 new LTC beds to be built by 2035 to meet the anticipated and growing LTC needs of its ageing population.[25]

52,000 Canadians were estimated to be on LTC home waitlists in 2021,[26] however, the current number is now likely higher as Ontario alone reported that more than 44,000 individuals were on its LTC home waitlists as of December 2023.[27]

There are numerous examples of Canadian jurisdictions making large commitments towards the development and redevelopment of LTC beds. For example, British Columbia has allocated $1.6 billion to support the development and redevelopment of close to 1,700 LTC beds to modern standards.[28] The Government of Nova Scotia also recently announced its plans to develop or redevelop a total of 5,700 LTC beds by 2032.[29]

Ontario has committed to developing an ambitious 58,000 LTC beds (30,000 new beds and 28,000 redeveloped beds) by 2028.[30,31] The initial estimated cost of approximately $240K per bed or $14B overall (in 2020 dollars) through its related capital infrastructure construction funding subsidies made Ontario's commitment the largest LTC home development program ever launched in Canada.

With rapidly growing construction cost estimates and long-term borrowing rates, Ontario and other jurisdictions have faced significant delays around the development of LTC beds.[32,33] For several planned homes whose estimated construction began to far exceed the Government of Ontario's originally proposed construction funding subsidies, the government recently more than doubled its proposed construction funding subsidies from an average of $240 to $560K per bed, or $14 to $34B overall, to help further incentivize and accelerate the building of new and redeveloped LTC beds to meet its 2028 goal.[34] However, it remains uncertain how this government's goals will be met as on March 2024 it was reported that just over 4,500 beds or 8% of the government's proposed target of 58,000 new and redeveloped LTC beds have been opened since 2018.[35] Furthermore, LTC home developers and operators have noted that the types of homes that are being built in Ontario to the government's pre-pandemic design standards, and with their current construction funding subsidy levels, still makes it hard for them to not build large, institutional-style homes in order to achieve construction cost economies of scale.

Nevertheless, the majority of Canada's provincial and territorial jurisdictions have been becoming increasingly focused at some level in ensuring that current or new LTC homes that are being developed or redeveloped prioritize Small Care Home design formats, via individual standalone projects and even province/territory-wide initiatives (see Table 1).

Table 1: Canadian Provincial and Territorial Government Achievements Towards the Development of Small Care Home Models of Long-Term Care

Canadian Jurisdiction	Small Care Home Achievements by Government
Alberta	Alberta's Continuing Care Capital Program, includes the Small Care Home Stream that was launched in 2023 to fund the development of Small Care Home projects (incl. LTC homes).[36,37] For continuing care homes larger than 14 bedrooms, mandatory design guidelines require household sizes that do not exceed 14 bedrooms.[38] For continuing care homes between 4 to 14 bedrooms, there exist separate mandatory design guidelines.[39]
British Columbia	Certain LTC homes have applied Small Care Home design principles like the two new homes that were opened over the last year.[40,41,42] These design principles will also be applied within six new LTC homes.[43,44,45,46,47,48]
Manitoba	Manitoba Personal Care Homes (PCHs) follow PCH Building Design Guidelines that emphasizes Small Care Home design principles that have been applied in new homes that were opened over the last few years.[49,50,51]
New Brunswick	A new LTC home that is currently under development will be built according to Small Care Home design principles.[52]
Newfoundland and Labrador	Recently constructed LTC homes have applied Small Care Home design principles, with small households of 15 bedrooms.[53]
Northwest Territories	The government has adopted Small Care Home design principles, with the most recent LTC home opened this year having households of 15 to 20 residents. These design principles will also be applied within all of the four new LTC homes, aiming to have households of 10 to 12 residents.[54,55,56]
Nova Scotia	Nova Scotia has required that its new LTC homes be composed of small households of between 14-16 bedrooms.[57] However, its LTC home design requirements are currently being updated.[58]
Nunavut	All LTC homes in Nunavut are required to use Small Care Home design principles, including three new LTC homes that are currently under development.[59,60]

Ontario	No current initiatives have been identified supporting the development of Small Care Homes.
Prince Edward Island	Many of PEI's publicly owned LTC homes have been designed using Small Care Home design principles, with small households of around 12 bedrooms, like the most recent one opened in 2019.[61,62] A current request for proposal exists for the development of 175 LTC beds prioritizing Small Care Home design principles.[63]
Quebec	Quebec recently committed to developing 49 new LTC homes and alternative homes, renovate 18 former LTC homes and redevelop four existing LTC homes, using the Small Care Home design principles and composed of small households with no more than 12 bedrooms. As of March 2024, 30 new LTC homes and alternative Small Care Homes, along with the redevelopment of one existing LTC home using Small Care Home design principles have been completed.[64]
Saskatchewan	Certain LTC homes have applied Small Care Home design principles, like ones that were opened as far back as 1999 as well as 2005,[65] and more recently in 2014 and 2015.[66,67,68] No current initiatives have been identified supporting the development of Small Care Homes.
Yukon	All LTC homes have applied Small Care Home design principles.[69] No current initiatives have been identified supporting the development of Small Care Homes.

Overall, the following five Canadian jurisdictions have been involved over the past few decades in various capacities (e.g., funding, contracts and requests for proposals) in the development of some Small Care Home projects: British Columbia, New Brunswick, Newfoundland and Labrador, Saskatchewan and Yukon. In one of BC's new Small Care Homes, Providence Living in the Views, a multi-year evaluation is currently being conducted to understand the impact of this new home's physical design and model of care on its residents and staff.[70]

The following seven Canadian jurisdictions have in the past or are currently supporting the mass development of Small Care Homes: Alberta, Manitoba, Northwest Territories, Nova Scotia, Nunavut, Prince Edward Island and Quebec. For example, Nova Scotia was the first Canadian jurisdiction to embrace Small Care Home design principles as part of its 2006 Continuing Care Strategy (CCS).[71] In Alberta, Manitoba, Nunavut and Prince Edward Island, design guidelines or requirements exist to support the development of Small Care Homes. In Quebec and Alberta, there have been recently implemented and announced large province-wide initiatives to further the development of Small Care Homes.

In 2021, the Government of Quebec promised to begin the construction of 46 LTC homes (called maisons des aînés" [MDAs]) and homes for adults with special needs (called maisons alternatives [MAs]) following Small Care Home design principles, composed of households of 12 residents. These homes can be together or

separate, based on the needs of the region.[72,73] The budget announced for this initiative was $2.8 billion to support the development and redevelopment of 3,480 beds including the development of almost 3,000 new beds.[74] However, numerous delays were experienced around building and opening these new homes, from construction-related delays to a lack of available care providers to staff these new Small Care Homes.[75] As a result, only 30 of the originally promised new Small Care Homes have been opened as of June 2024.[76] Additionally, costs have risen drastically, with one MDA expected to cost $200 million alone, doubling that project's initial cost estimation.[77] Escalating costs have thus resulted in the development of certain MDAs being stopped or re-evaluated.[78,79] Regardless, the Government of Quebec's 2024-2034 Infrastructure Plan has committed to open a total of 49 MDAs and MAs. This initiative has also been accompanied by an additional commitment of over $2.3 billion to modify 22 facilities to incorporate Small Care Home design principles.[80,81] Overall, this current plan estimates that this will result in a total of over 6,300 beds for older adults and adults with special needs within Small Care Homes across Quebec.[82]

In 2023, the Government of Alberta committed $310 million in new LTC home capital infrastructure funding through its Continuing Care Capital Program, including to support a new Small Care Home Stream to specifically fund the development of standalone Small Care Homes that would house between 4 and 14 residents each.[83] In the 2024 provincial budget, the government has increased the investment for the Continuing Care Capital program to $654 million.[84]

Overall, while it has been encouraging to see governments across Canada respond to the growing need to invest in the creation of new and renovated LTC homes; collectively, these overall investments will still likely fall short of meeting even the current existing demands for care in LTC homes across Canada,[85,86] let alone an anticipated and unprecedented demand for this level of care over the coming decades.[87]

Furthermore, in provinces like Ontario, while governments continue to support the development of large traditional institutional format LTC homes, the needs of rural and remote communities, that neither need nor could support such large LTC care settings, continue to be overlooked.

The Origins and Rise of the "Culture Change" Movement Redefining Traditional North American LTC Home Models of Care

Over the past few decades, significant innovations designed to improve the provision of care across LTC settings have been piloted and implemented across North America. Much of this has reflected an emerging "culture change" movement aimed at countering traditional, institutional care home models that have become well-entrenched as a standard of care across North American LTC homes, which were not prioritizing resident-centred care.

In both the US and Canada, licensed LTC home operators derive their funding by receiving a standardized per-diem for every resident for which they care. The growing discomfort with this model and realization that LTC homes were increasingly becoming designed to provide efficient, task-focused care in ever larger and less personal settings spurred a growing desire to fundamentally deliver care differently in these settings, in ways that could deliver better resident, staff and system outcomes. "Culture Change" has been defined by Pioneer Network, a group working to infuse person-directed care practices into eldercare settings across the US,[88] as "the common name given to the national movement for the transformation of older adult services, based on person-directed values and practices where the voices of elders and those working with them are considered and respected."[89]

The person-directed values that are core to the "culture change" movement are choice, dignity, respect, self-determination and purposeful living.[90]

Although the "culture change" movement can trace its origins to 1991, with the launch of the Eden Alternative care model, the movement is generally thought to have gathered momentum when several proponents of the "culture change" movement formally met in 1997. They went on to form the Pioneer Network, through which they officially coined the term "culture change."[91] The Pioneer Network has since gone on to establish coalitions across 20 US States, where it aims to share information and resources for the purpose of advancing culture change.[92]

The culture change umbrella has come to encompass a range of LTC home models and care practices that are centred around the provision of resident-centred/ directed care and practices such as the Eden Alternative, The Pioneer Network, and the Green House Project (GHP).

The movement's key goals are summarized by Calkins (2002) as follows:[93]

1. Respecting the individual needs and desires of each person.
2. Honouring the life patterns and accomplishments of every person within the setting, residents and staff alike.
3. Supporting opportunities for continued growth.

4. Enabling continued productive contributions to their community.
5. Encouraging meaningful connections with family and the community.
6. Restructuring of staffing roles and relationships between staff and residents.

Broadly speaking, culture change activities in North American LTC settings have sought to shift care delivery away from the more traditional institutional model of care that has remained dominant in the development and operation of LTC homes over the past 50 years in both the US and Canada.[94] This traditional model has been considered "institutional" due to the fact that care is essentially provided in a manner similar to that of a simplified hospital.[95] Traditional LTC home models were felt to encourage their residents to spend most of their time in bed within highly sterile environments that lack, most if not all, of the amenities they would otherwise be able to access at home.[96] They have also been designed in a manner that prioritize the ability of LTC home staff to carry out their daily tasks quickly and efficiently over meeting or addressing the potential care preferences of residents.[97]

Culture change in LTC settings, therefore, occurs through the development of a holistic plan targeting decision-making, the physical environment, organizational design and leadership practices.[98] Alternative models to the traditional model of LTC homes proposed by culture change proponents have broadly emphasized a person-centred or resident-centred approach to care, which represents a core philosophy of the movement.[99] The Eden Alternative and the subsequent GHP are emblematic examples of this philosophy at the core of the culture change movement in practice, seeking to meet the goals outlined above through the application of innovative care practices.

The Eden Alternative

First described in 1991, the Eden Alternative represents the earliest major iteration of the "culture change" movement in LTC settings, designed to address what were referred to as the "three plagues" for residents in traditional LTC homes: loneliness, helplessness and boredom.[100] The Eden Alternative model seeks to accomplish its goals through the following 10 principles:

1. Loneliness, helplessness and boredom are painful and destructive to our health and well-being.
2. A caring, inclusive and vibrant community enables all of us, regardless of age or ability, to experience well-being.
3. We thrive when we have easy access to the companionship we desire. This is the antidote to loneliness.
4. We thrive when we have purpose and the opportunity to give, as well as receive. This is the antidote to helplessness.
5. We thrive when we have variety, spontaneity and unexpected happenings in our lives. This is the antidote to boredom.
6. Meaningless activity corrodes the human spirit. Meaning is unique to each of us and is essential to health and well-being.
7. We are more than our medical diagnoses. Medical treatment should support and empower us to experience a life worth living.

8 Decision-making must involve those most impacted by the decision. Empowerment activates choice, autonomy and influence.

9 Building a collaborative and resilient culture is a never-ending process. We need to keep learning, developing and adapting.

10 Wise leadership is the key to meaningful and lasting change. For it, there can be no substitute.

There are currently 36 Eden Alternative member organizations across Canada, which are provided with education, resources, networking and support to aid them in adopting its principles and practices.

Of these 36 organizations in Canada, 16 organizations have earned higher levels of membership based on their commitment to implement a certain number of practices related to this model of care on an annual basis.[101,102]

The Green House Project

The most comprehensive "culture change" approach that has emerged over the last two decades has been the Green House Project (GHP), which largely developed as a subsequent evolution of the Eden Alternative.[103] The GHP works to further apply the Eden Alternative's ideals related to delivery of resident-centred/directed care by specifically promoting the use of a universal care provider staffing model and a series of changes to the traditional institutional physical environment of an LTC home that would see this care delivered in small home-like or household living environments.[104]

Indeed, the Green House model has emerged as the most holistic manifestation of the culture change movement in the provision of LTC services, which best attempts to create smaller and more home-like living environments, along with improvements to staffing levels, training, support, and retention, in order to better enable the provision of resident-centred care.

Though limited data exists on the relative success of some alternative approaches to delivery of care in LTC homes that have been attempted as part of a broader "culture change" movement, the little that has emerged has been promising. As the next part of this report will demonstrate, the GHP has produced the most robust evidence to date that clearly demonstrates the ability of this Small Care Home model to deliver better resident, staff and system outcomes as compared to traditional institutional LTC care models. Research on LTC home physical environments has demonstrated how design can substantially impact patterns of social behaviour and the overall quality of life for their residents.[105,106,107,108] These findings have helped to further spur more efforts to create more "home-like" care environments, with LTC organizations increasingly implementing changes like providing more private bedrooms and bathrooms, natural sunlight, home-like furnishings and décor, access to outdoor spaces, and the removal of "hospital-like" corridors, nursing stations, and staff uniforms and public address systems in their homes.[109]

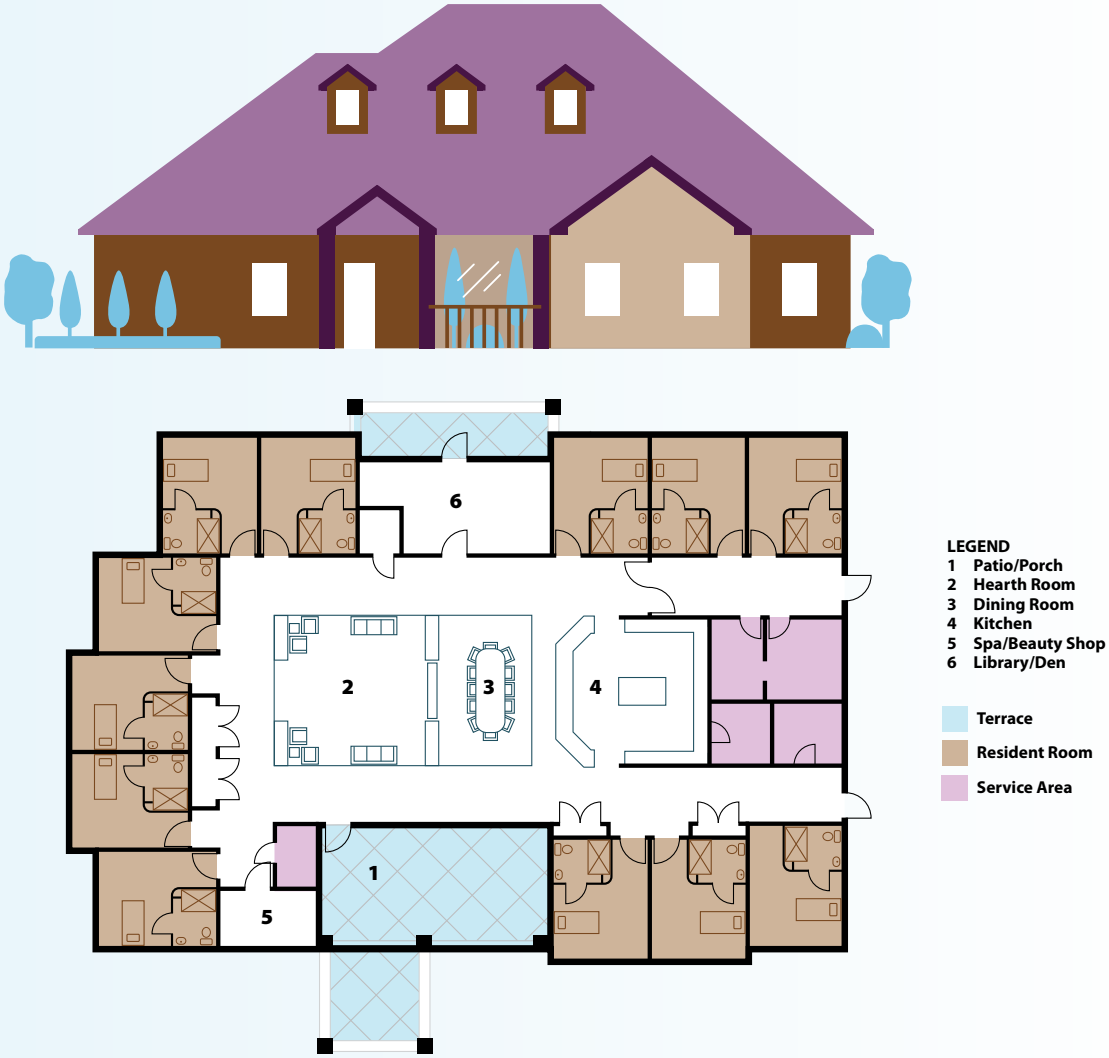
The Green House Model of Care

The Green House model is a now well-established approach to the operation of LTC homes made up of philosophical, structural, and procedural elements built on upholding three core values:[110]

- Meaningful Life (emphasizing autonomy and engagement)
- Empowered Staff (emphasizing a collaborative, shared decision-making design)
- Real Home (emphasizing de-institutionalized living and "convivium," i.e. the sharing of good food in good company)

In the Green House model, these values are implemented via the construction of smaller residential-style houses located in community neighbourhoods (see Figure 1). Households within this model are typically constructed to provide a home-like environment that feels familiar to residents and includes features such as private bedrooms and bathrooms, open kitchens and common living areas, and unrestricted access to outdoor nature areas. Multiple Green House homes, however, can be designed to exist within a single building hosting multiple households as well, especially in urban or other settings where there may not be enough land to build standalone physical household structures (see Figure 2).

Figure 1: Outside Picture and Floor Plan of the Green House Cottages of Poplar Grove in Little Rock, Arkansas, United States[111]



Adapted from photos and diagrams provided by The Green House Project.

Figure 2: Outside Picture and Floor Plan of the Leonard Florence Center for Living in Chelsea, Massachusetts, United States[112]

* Contains 10 Green House homes.
Adapted from photos and diagrams by DiMella Shaffer (n.d.) provided by The Green House Project.

Many Green House communities have been developed by LTC home operators that may have originally developed and operated traditional LTC homes but are now adding more capacity with the addition of Green House homes potentially as a first step to completing an eventual transition to a complete Green House model of LTC provision. As a result, it is not uncommon to see traditional older LTC homes operating alongside newer Green House homes that are also operated by the same LTC provider. Operationally the Green House model has been particularly revolutionary in its attempt to deconstruct staff roles found within traditional LTC homes while further avoiding the use of their related terminology (such as "resident" and "care aide or personal support worker").

The Green House model of care provision further involves the employment of a consistent, empowered work team of paid care providers – called *Shahbaz* ("*Shahbazim*" plural) – with shared responsibilities. Shahbazim, who may have been traditionally trained as care aides or Personal Support Workers (PSWs), are responsible for the range of personal, clinical and home care activities that are to be provided within Green House homes, as

well as cooking, cleaning, laundry, ordering, scheduling arranging activities and other tasks typically associated with a variety of different paid care providers in traditional LTC homes. As the description suggests, the *Shahbazim* staffing model represents what is referred to as a "universal care provider" staffing model that is increasingly being adapted within other Small Care Home models.

The provision of care in this model is fundamentally different than what is employed in more traditional LTC settings, as it creates household level self-managed care teams who are collectively responsible for the well-being of their residents and, as such, share duties that include meal preparation, housekeeping, organizing and running activities and spending time with residents.[113]

Green House homes typically house 10 to 12 residents—called *elders*—who each have their own private room and bathroom. Green House residents share a central living space with an open kitchen, dining and living area, as well as having access to outdoor space. Nursing stations, public address systems and medication carts that are standard inclusions in traditional LTC homes are eliminated to aid in creating a more home-like environment.[114] Meals are jointly prepared in the household by the *Shahbazim*, residents, and family members in the open kitchen and meals are shared at a common dining table in the spirit of convivium, recognizing how mealtimes are not only important for their nutritional and social aspects, but also for their role in affecting a person's quality of life.[115]

In the Green House model of care, *Shahbazim* work within a non-hierarchical staffing structure and rotate the primary responsibility of their shared duties. Rather than reporting to a director of nursing or clinical supervisor, they are supported by a *Guide*, who coaches and supervises them. Clinical staff such as nurses, social workers, occupational therapists, physiotherapists, dieticians, pharmacists and physicians are not based in a particular Green House home but make visits to Green House homes on a campus as needed. For example, a nurse is often required to be available 24 hours a day to meet the evolving needs of Green House residents with each nurse typically supporting two homes during a day shift, and three homes at night; and like other professionals, is likely to be serving several Green House homes as is reasonable to make effective use of their skills and time.

The widespread uptake of the Green House model of care over the last two decades – mainly across the US – has been aided with the ongoing support of the Centre for Innovation, which organizes national meetings, webinars, a peer support network and other knowledge exchange platforms. Care within Green House homes is intended to be person or resident-centred, with *elders* dictating their daily schedules, activities and meals. Normalized daily activities are promoted and intended to be organized with spontaneity by the residents and *Shahbazim*.[116,117]

Though capital costs associated with building Green House homes have tended to be higher than the building of traditional LTC homes, research has demonstrated that this LTC model can, at the same time, achieve meaningful downstream cost savings which can help offset their potentially higher

initial capital costs. A study of Green House LTC home residents that were comparable to traditional LTC home residents at admission, found that Green House residents tended to experience lowered rates of hospitalization and thus hospital expenditures. Furthermore, as Green House residents were also able to maintain better overall functional levels, this resulted in their lower daily care costs. The overall combined cost-per-resident savings that were observed over 12 months on the basis of these two factors were demonstrated to range from approximately $1,300 to $2,300 USD ($1,975-$3,140 CDN) per Green House LTC home resident when compared with traditional LTC home resident-related health care costs in the US.[118]

These findings suggest that, though the building of Green House homes may represent a higher level of initial construction costs, these costs should not be considered in a vacuum, as they could possibly be offset in the long-term due to the observed improvements in care and system outcomes that have been found to be associated with the Green House model.

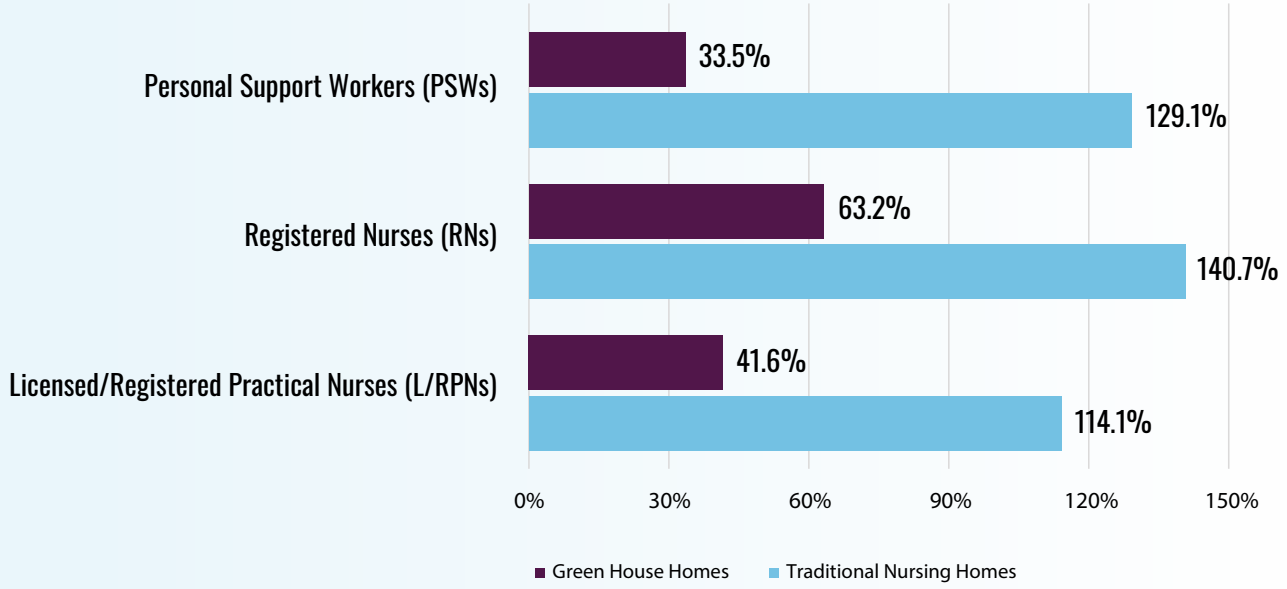
Another important improvement that the Green House model has demonstrated in comparison to more traditional LTC home models is their reported ability to deliver higher levels of quality of life and care for their residents.

According to longitudinal research, statistically Green House residents reported higher scores on multiple quality of life scales when compared with traditional LTC home residents. This study also assessed 11 quality of care measures in Green House LTC homes that included the domains of comfort, functional competence, privacy, dignity, meaningful activity, relationship, autonomy, food enjoyment, spiritual well-being, security and individuality and found that they at least equalled and — with respect to reported changes in functional status — exceeded care outcome measures achieved in traditional LTC homes.[119] Families of Green House residents also reported greater satisfaction with the meals, housekeeping, physical environment, privacy, autonomy, care and general amenities provided in Green House homes in comparison with traditional LTC homes.[120]

Staff within Green House homes have reported greater rates of job satisfaction and were found to spend more time providing direct care to residents than their counterparts in traditional LTC homes. For example, it was specifically reported that Green House direct care staff spent 23-31 more minutes per resident per day providing direct care activities than those working in traditional LTC homes and more than four times as much staff engagement with residents outside of providing direct care activities without any increase to overall staffing work hours.[121] Also, it was similarly found that the Green House universal care provider staffing model allowed direct care staff to spend approximately 30 more minutes per resident per day.[122] The Green House Project reported that direct care staff in Green House homes experience less job-related stress.[123] Perhaps not surprisingly, given the above, Green House models also report better staff retention rates.

LTC home staff recruitment and retention have been a longstanding challenge in the LTC sector for a variety of reasons that were further exacerbated with the pandemic across both Canada and the US.[124,125]

Figure 3: Care Staff Turnover Rates in 2020 Among Green House Homes vs Traditional LTC Homes[126]



From *The Green House Difference: By The Numbers*, by The Green House Project, n.d. (https://thegreenhouseproject.org/wp-content/uploads/The-Green-House-Difference-2022.pdf). Copyright 2023 by The Green House Project.

Green House homes have performed significantly better than traditional LTC homes when it comes to staff turnover, with their reported staff turnover rates being consistently over 70% lower than those of traditional LTC homes for PSWs, Registered Nurses (RNs) and Licensed/Registered Practical Nurses (L/RPNs) (see Figure 3).

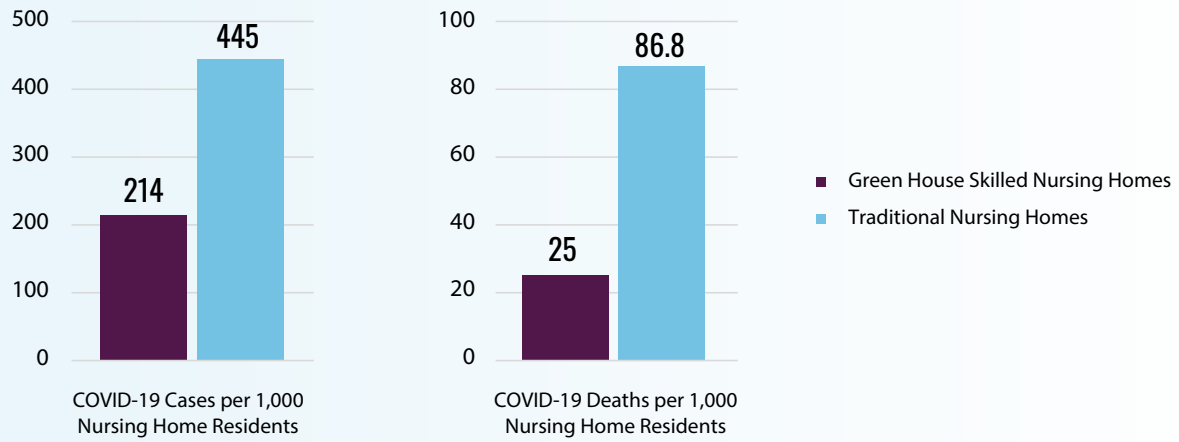
While there are now 401 Green House homes on 89 campuses in 33 US States serving 4,472 residents and eight Green House homes, on one campus in Australia, the Green House model of care has yet to be formally adopted into any of Canada's provincial or territorial LTC systems, despite a longstanding and growing interest by LTC home operators in doing so. However, recently Silver Services, a not-for-profit organization offering care, access, support and education to older adults, opened Canada's first certified Green House home providing assisted-living services in Hamilton, Ontario.[127]

Part of the difficulty associated with assessing the overall effectiveness of the Green House model of care has been the variability in the degree to which the model has been implemented and adhered to in some settings. An analysis of the Green House model of care found that Green House homes often varied in the degree to which they have implemented the universal care provider staffing model, with some providers adjusting it to utilize more specialized workers to take on specific tasks (like scheduling and cooking). It was noted that the use of such specialized workers requires further study to determine the associated benefits and limitations of this approach to staffing in contrast with the originally conceived universal care provider staffing model.[128]

Some of the most compelling recent data in support of the Green House model, which has renewed significant interest in it and Small Care Homes in general, related to its overall

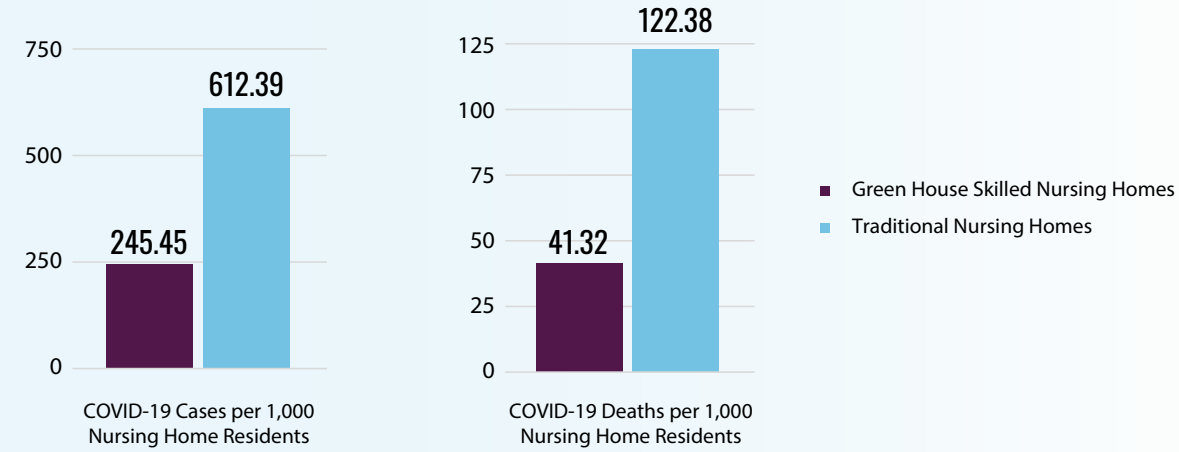
performance outcomes compared to those of traditional LTC homes with respect to their COVID-19 performance. The Green House model was shown to significantly outperform traditional US LTC homes when it came to reducing the spread of COVID-19 infections and the incidence of related deaths in the first two years of the pandemic. To this effect, Green House homes reported 52% fewer COVID-19 cases of infection and 79% fewer COVID-19-related deaths than traditional US LTC homes in 2020, 60% fewer COVID-19 cases of infection and 66% fewer COVID-19-related deaths in 2021 (see Figures 4 and 5).

Figure 4: Green House Home vs Traditional LTC Home COVID-19 Cases and Deaths per 1,000 Residents in 2020[129]



From *Green House Homes and COVID: More Than Just Design*, by The Green House Project, n.d. (https://thegreenhouseproject.org/wp-content/uploads/Green-House-Homes-and-COVID-1.pdf). Copyright 2023 by The Green House Project.

Figure 5: Green House Home vs Traditional LTC Home COVID-19 Cases and Deaths per 1,000 Residents in 2021[130]



From *Green House Homes and COVID: More Than Just Design*, by The Green House Project, n.d. (https://thegreenhouseproject.org/wp-content/uploads/Green-House-Homes-and-COVID-1.pdf). Copyright 2023 by The Green House Project.

The main factors recognized as contributing to these results across US Green House homes were one of their principle physical design attributes, namely the provision of private rooms and bathrooms for each of their residents, as well as their unique staffing model.

In Green House homes, most direct care staff in these models work on a full-time basis supporting a single household of 10-12 residents. Thus, the Green House universal care provider staffing model (and the reduced fragmented staffing and turnover rates associated with it) limits the number of staff residents interact with, and therefore, decreases the means by which staff could unwittingly introduce COVID-19 infections within the home. Overall, the US COVID-19 performance data related to the Green House model of care has demonstrated the value of this within the context of managing public health emergencies and infectious disease outbreaks. Internationally, a meta-analysis of the data from 41 articles across 11 countries, including Canada and the United States further found that care homes that operated as smaller and detached buildings versus standalone single buildings experienced significantly lower rates of COVID-19 infections amongst their residents.[131]

Developing International Collaborations to Advance Small Care Home Models

To influence the promotion of Small Care Home models internationally, the GHP joined with HammondCare (Australia) and Belong (United Kingdom) to become founding members of the Household Model International Consortium in June 2023. This initiative aims to advocate for the greater adoption of small household models within residential care settings for older adults. This would be done through deciding on areas of strategic focus, having a shared research agenda, developing joint papers and position statements. Additionally, members will share learning materials and create avenues for staff exchanges. Similar to the GHP, HammondCare and Belong have also been early adopters of Small Care Home models for older persons and individuals with dementia within their respective countries.[132,133]

Given the current evidence that exists in support of the Green House model of care, there is also a strong case for further advancing this model of care in Canada as well. As the next section of this report demonstrates, some examples of Small LTC, retirement and assisted living homes exists, that have been able to implement many of the same approaches to care that underlie the Green House model of care and also seen improvements in resident and family satisfaction, quality of care and staff retention.

Examples of Established Small Care Homes in Canada

As noted earlier, the Small Care Home model of LTC has been implemented at various levels across Canadian jurisdictions (see Table 1). While some jurisdictions thus far have or are currently been involved in the development of some smaller-format LTC home projects (like British Columbia, New Brunswick, Newfoundland and Labrador, Saskatchewan and Yukon), the following seven jurisdictions have implemented the wider scale development of smaller-format LTC homes or households: Alberta, Manitoba, Northwest Territories, Nova Scotia, Nunavut, Prince Edward Island and Quebec.

In this next section, we will profile three particular examples across three provinces that have helped to demonstrate that not only can Small Care Home models of LTC be created, but like the Green House model, they have the ability to deliver better resident, staff and system outcomes than the more longstanding, traditional and institutional approaches to delivering care in LTC homes.

The Sherbrooke Community Centre and Village in Saskatoon, Saskatchewan

Canada's best of example of an LTC setting that has been long considered at the forefront of its "culture change" movement is the Sherbrooke Community Centre and Village in Saskatoon, Saskatchewan, which has been credited with inspiring the conceptualization and subsequent development of the Green House model of care.

The Sherbrooke Community Centre was originally established as a traditional LTC home when it was built in 1966, and designed to house four residents per ward-style room in larger units of at least 60 people. In 1993, the home was rebuilt to introduce private rooms and bathrooms, but this "traditional hospital-like setting" was causing increasing numbers of eligible residents to not want to move into these settings due to their stated preference to live in smaller homes with fewer residents and consistent staff.[134] The CEO of the Sherbrooke Community Centre, Suellen Beatty, then launched a series of community consultations and trials of alternative approaches towards providing LTC home services to help inform the development of a new Small Care Home model.[135]

The new Sherbrooke Village opened in June of 1999, alongside its more traditional LTC home equivalent, and created a series of 11 smaller homes. Each house is home to either nine or 10 residents each, that are all connected to allow for the building of a greater community as well as to support more consistent and flexible staffing models to aid in the delivery of resident-directed care. This form of care looks to have residents make their own decisions, compared to resident-centred care, which looks to simply consider resident preferences and choices.[136] While most of the rooms in the 11 houses are private rooms, shared rooms exist as well.

Sherbrooke Village residents have easy access, through an internal street, to various services and amenities in the broader Sherbrooke Community Centre including an art studio, therapy area, aviary, community gathering area, community day program, gift shop and childcare centre.[137]

Similar to the subsequent Green House model, the Sherbrooke Village implemented a "universal care provider" staffing model where all staff participate in performing multiple tasks or roles based on the needs of the residents within the Village. This approach also aligned with its early and continued incorporation of the Eden Alternative philosophy of care across both the Sherbrooke Community Centre and Village. It is currently an Eden Alternative member home.

Currently, two Daily Living Assistants (DLAs) are always assigned to each home of 9-10 residents and are expected to perform a variety of care and support tasks. DLAs are PSWs who are also trained in housekeeping, medication assistance and food safety. An example of their tasks includes planning and cooking meals according to the preferences of the household residents. Additionally, two professional nurses are assigned to the broader village during the day, moving between the homes as needed, with two being available on an on-call basis overnight. Though they are required by provincial regulations to perform the more medical tasks in the villages, the nurses also assist as able with other household tasks such as cooking, cleaning, and other forms of assistance for the residents. This universal care provider staffing model has generally appeared to have been embraced by workers at the Sherbrooke Village. Furthermore, its reported annual staff retention rates have continued to range between 90-95% for its permanent staff.[138]

The Sherbrooke Community Centre and Village was previously found to have the highest rate of staff engagement across the Saskatchewan Health System at 82%, and it has been declared a "Best Employer" organization.[139]

More recently, the Centre and Village noted that it continued to report consistently strong employee well-being survey results throughout the pandemic. In addition, its overall mortality rate in its homes didn't change throughout the pandemic, even though they experienced multiple outbreaks.[140]

The Sherbrooke Village has been found to create both operational and capital savings. The former is evident through the DLA-focused staffing model within each home, creating less work duplication and less need for time spent on coordination with other professionals. Also, operational savings have been reportedly achieved through lower food costs created by the reduced wastage created from offering more personalized food choices. Capital savings have also reportedly been found through not needing to have certain care infrastructure that is required in a transitional institutional setting.[141]

The Sherbrooke Community Centre additionally hosts a Learning Centre that shares the journey and experiences of the organization.[142] For example, the centre offers tailor-made visits that can touch on various aspects including organizational culture, the Sherbrooke Village Model and the Eden Alternative philosophy.[143]

The Tideview Terrace in Digby, Nova Scotia

In 2006, the Nova Scotia government began implementing its new Continuing Care Strategy (CCS) per the recommendations of a provincial steering committee. The strategy represented a 10-year plan for the government to improve the supports available to help Nova Scotians both live at home and in LTC settings. It further resulted in an

overhaul in the requirements for the design and operation of future LTC homes which would be reflected in the construction of 11 new LTC home communities in the province.[144] The resulting LTC reforms that would influence the design and operation of these new homes focused on establishing practices that supported "home-likeness" and relational care based on the understanding that these practices would contribute to enhanced resident quality of life.[145]

As a result, Nova Scotia became the first Canadian jurisdiction to actively promote a "household" model of care over traditional LTC home design and operations by establishing a requirement for the development of residential "clusters," "pods," or "neighbourhoods," under the province's *Homes for Special Care Act* to be composed of small "households" of 9-16 residents each.[146,147] Additional clauses requiring the provision of private bedrooms and bathrooms for each resident were further introduced and new LTC homes being built would be required "to create small group living environments for residents" with architecture required to "reflect residential scale and detail, appearing as home-like as possible."[148] To further support this household model, the government also adopted two new staffing models that could support the provision of more resident-centred care. New LTC homes would be eligible for funding for a "full-scope" staffing model that could provide residents with 3.33-4.17 hours of direct care per day, while refurbished homes would be eligible for funding for an "augmented-traditional" staffing model that could provide residents with three hours of direct care per day. Traditional homes would receive funding to provide residents with 2.45 hours of direct care per day (see Table 2).[149] This worked to ensure that the gap between new LTC homes and refurbished LTC homes in terms of the direct care received by residents was limited. Table 1 summarizes the different staffing ratios funded within the traditional, augmented-traditional and full-scope models.

One key benefit of maintaining three different staffing models for the delivery of care in Nova Scotia's LTC homes is that it allowed for a comparison of performance across the various service models under Nova Scotia's new CCS to be evaluated. Indeed, a 2015 report by Keefe and her colleagues found that increased "home-likeness" and positive relationships between residents and staff members – which represented core objectives of the full-scope model – were "significant predictors" of improved resident quality of life.[150]

Table 2: Direct Care Staffing Ratios for Traditional, Augmented-Traditional and Full-Scope LTC Homes in Nova Scotia[151]

Staffing Model	Per Resident/Per Day	Per Day/Per Household
Traditional	2.45 hours	N/A
Augmented-traditional	3.00 hours	40 hours
Full-scope	3.33-4.17 hours	50 hours

From "Examining a "household" model of residential long-term care in Nova Scotia," by J. Keefe, D. Dill, R. Ogilvie, and P. Fancey, 2017, *Health Reform Observer - Observatoire Des Réformes de Santé, 5*(1), 6 (https://doi.org/10.13162/hro-ors.v5i1.2748). Copyright 2023 by J. Keefe, D. Dill, R. Ogilvie, and P. Fancey.

According to frontline staff within one LTC home that had embraced the household model, this perception of feeling at home while working was also experienced by care providers within these care settings. This, in turn, led to care staff reportedly feeling more empowered in their work roles and having a deeper understanding of the importance of their roles in the day-to-day lives of the residents they interacted with.[152]

These findings demonstrate that this "household" approach to LTC in Nova Scotia was proving to be beneficial for both LTC home residents and their care providers.

Perhaps the most intriguing takeaway from Nova Scotia's experiment with LTC home reforms in its CCS was the government's willingness to experiment with sector-wide reforms at all. The government's CCS was driven by a number of factors, including a recognition that Nova Scotia's population was rapidly ageing, the possibility of future consumers of LTC services having higher expectations of support, and that Nova Scotia's more than 80 LTC homes were ageing, and that there was a growing consensus that care provision within them needed to change.[153]

None of these factors were unique to Nova Scotia at the time; however, what was unique was the willingness of the province to test a policy intervention with its LTC home reforms, as there was limited evidence to support the adoption of LTC 'household' models of care at the time.[154] Even internationally, apart from research lauding the benefits of providing a home-like environment with private rooms and decentralized bathrooms, dining and leisure spaces, little evidence for the benefits of household models of care existed.[155] Despite this, the notion of a LTC delivery model emphasizing a home-like design aesthetic was appealing to Nova Scotia policymakers and decision-makers, and supported their vision at the time to allow Nova Scotians to live "in a place they [could] call home."[156]

One example that stands out of Nova Scotia's CCS in practice was the Tideview Terrace LTC Home in Digby, Nova Scotia. Originally selected as one of the CCS's 11 new LTC home projects announced by the government, its leaders were pioneers among their peers in pushing for additional measures that went above and beyond the baseline goals established by the CCS. With an awareness of what had been developed with the Sherbrooke Village and increasingly in the US under the emerging GHP, Tideview Terrace chose to embrace the Eden Alternative philosophy of care in 2008.

In partnership with both the Town and the Municipality of Digby, Tideview Terrace convinced the Nova Scotia government to allow it to construct an LTC home that would be comprised of 10 interconnected, but separate, buildings – referred to as 'neighbourhoods' – that would each house no more than nine residents who would each have their own private rooms and bathrooms with a shared kitchen and common living area. Their logic behind a nine-bed household model, as their CEO Debra Boudreau later explained, was that it would create a more intimate human experience, where neighbourhood staff would be able to build

closer relationships and better connections with residents, as well as have more flexibility to match residents with similar lifestyles within a single household neighbourhood.[157] The current home with the nine-bed household model was constructed in 2011. Tideview Terrace, like the Sherbrooke Village, has also been an early adopter of the Eden Alternative philosophy of care and remains a regional champion of this approach to care in Atlantic Canada.

Each nine-resident neighbourhood at Tideview Terrace is assigned a Continuing Care Assistant (CCA) or PSW and a Support Service Care Partner during the daytime, with a CCA remaining assigned throughout the night. Four RNs or L/RPNs are on duty to monitor care across the 10 houses from 7 AM to 11 PM. During the night (11 PM to 7 AM), there is one RN and one L/RPN. Tideview Terrace also employs a rotating group of nurses and CCAs to serve as relief labour. The original staffing model at Tideview Terrace did not adopt a universal care provider staffing model, where tasks are assigned based on what needs to be done rather than by pre-determined worker roles. However, the Vivage Neighbourhood Guide training for staff, which is focused on self-directed teams working together within a household, influenced the implementation of cross-training staff. This meant that nurses, CCAs and Support Service Care Partners alike all began sharing tasks like cooking, cleaning and meeting basic resident requests.[158] Overall, having better care provider to resident staffing ratios than one would find in traditional LTC homes and having CCAs and PSWs take on a broader set of resident support roles have enabled staff to have more interactions with, and time to support, residents, allowing Tideview Terrace to ensure its residents receive four hours of direct care per resident per day.[159]

While the early proponents of the Tideview Terrace LTC Home indicated that they wanted to implement the Green House model of care at the outset, they noted that they were unable to convince the Nova Scotian government at the time to support its implementation due to the perceived high costs associated with formally implementing this model. Nevertheless, although Tideview Terrace is not a certified Green House, its nine-bed neighbourhood household structures, its growing adoption of a universal care provider staffing model, and its resident-directed approach to care that is embedded in the Eden Alternative philosophy have helped to demonstrate that the Small Care Home model could be implemented within LTC homes in Nova Scotia.

Indeed, Tideview Terrace's CEO, Debra Boudreau, has noted that, of the 11 new LTC home approved to be built under the implementation of Nova Scotia's CCS, only Tideview Terrace LTC Home and the Windsor Elms Village LTC Home in Falmouth, Nova Scotia have deliberately built their homes as a collection of smaller households and implemented the Eden Alternative philosophy of care in their homes. The other LTC homes that were subsequently built as part of the CCS chose to adhere more closely to the government's design recommendations which called for households of 12-16 residents, and did not implement the Eden Alternative philosophy in their settings. Part of this was likely reflected in the perceived extra construction costs associated with building smaller households, and the fact that the costs associated with training a care home's staff to adapt to Eden Alternative's approach had to be taken on by the provider.[160]

Nevertheless, Boudreau and their team at Tideview Terrace have suggested that their choosing to build the smaller nine-bed

household neighbourhoods has proven to be the right choice, as they feel it has created more intimate human experiences, allowing their staff to build closer relationships and better connections with their residents, as well as have more flexibility to match residents with similar lifestyles in living together. According to Boudreau, "the more people you have, the less it feels like a household and more like an institutional trapping."[161] Meanwhile, the Nova Scotian government has further entrenched its building standards to encourage the building of LTC homes with larger households of between 14-16 residents each, and sharing a dining room between 2 households, which can ultimately undermine the creation of a more "home-like" atmosphere.

While there exists limited empirical data on the impact of Tideview Terrace's Small Care Home model of LTC, like the Green House model, their CEO has noted its superior performance during the COVID-19 pandemic was likely influenced by its easier ability to isolate residents due to its model. With its resident rooms being private and each household neighbourhood being situated in separate buildings, individual rooms or entire households could be isolated and have the movement of their residents and staff restricted within them to prevent the spread of infection. Part-time and full-time staff were also kept to a specific household, further limiting the potential for spreading infections between household neighbourhoods. As a result, Tideview Terrace reported only experiencing two COVID-19 outbreaks throughout the pandemic — the first with no deaths, and the second with three.

Despite the promise of Nova Scotia's CCS that was the first in Canada to promote the concept of Small Care Homes that could provide more resident-centred care, Tideview Terrace, which was ahead of its time and more aligned with current best care practices, remains more of an outlier both physically and in its approach to providing resident-centre care in both Nova Scotia and Atlantic Canada.

With the Nova Scotia government recently announcing its intent to both redevelop and build thousands of new LTC beds by 2032, there exists an opportunity to promote the development of more Small Care Home models of LTC, like Tideview Terrace.

The Czorny Centre in Surrey, BC

Originally opened in 2007, the Czorny Centre was started as a philanthropic initiative by a family who wished to see the better provision of LTC for people living with Alzheimer's and other dementias. The Stewart family donated both land and the costs of construction over two phases that allowed for the construction of an LTC home designed specifically for the needs of people living with Alzheimer's and other dementias that would be "home-like and non-institutional." They further funded staff training and the costs associated with adopting a resident-centred care philosophy.

The Czorny Centre is comprised of six cottages or households each with 12 single-resident rooms for a total capacity of 72 occupants. Currently, of the 72 total residents, 25 are

classified as Behavioural Support Transition Neighbourhood (BSTN)[ii] residents who are characterized as living with "challenging" behaviours that would not be able to be cared for in other LTC homes. Ideally, no more than four of such residents are assigned to any one cottage, as going above that number has historically led to an increased risk of experiencing patient and staff injuries.[162]

Staff working at the Czorny Centre operate within very individualized resident care routines. There are no set wake-up times for residents and all residents can potentially have breakfast prepared for them, if they so desire. Breakfast is the sole meal that is prepared by care providers within the cottages themselves, while other meals are prepared within a central kitchen on site but served within each cottage.

Each cottage has one L/RPN and one Healthcare Aid (HCA) or PWS assigned to work in it during the day, and one L/RPN assigned to work overnight. RNs play a supervisory role for care across the cottages. Generally, there is a lot of "role immersion" among care providers, with no strict division of work between staff, particularly when it comes to managing typical household tasks. Nurses are not limited to the medical scope of their work and are expected to participate in some of the care tasks associated with typical HCA or PSW roles, similar to the universal care provider philosophy. However, there are also dedicated housekeeping and food service staff on site that perform more of the task-driven work related to meals, though housekeepers were recently repatriated by the provinces and now operate as "in-house" workers for the Czorny Centre, employed by the Fraser Health Authority.[163]

Due to its historical focus on Alzheimer's patients, Czorny also stands out from the rest of British Columbia on its resident profile statistics related to dementia, with 83.3% of residents having mild to severe dementia compared to a provincial average of 63.3%, and 48.7% of residents living with severe cognitive impairment, including severe dementia compared to a provincial average of 27.9%.[164]

Despite having a higher than average amount of residents with mild to severe dementia and severe cognitive impairment, the Czorny Centre stands out in contrast with the provincial average for its average length of stay (1,331 days compared to the provincial average of 855), percent of residents diagnosed with depression (8.4% compared to the provincial average of 23.3%), percent of residents in a wheelchair (24% compared to the provincial average of 52.8%). Furthermore, like other Small Care Homes, the Czorny Centre performed well during the COVID-19 pandemic, experiencing only one outbreak of COVID-19 that led to the closure of the entire centre during the pandemic. Due to each cottage being spaced apart and operating as its own household, intra-cottage transmission of infections ended up being relatively easy to prevent.[165]

Overall, what is clear is that the Czorny Centre has demonstrated the impact of what a purpose-built Small Care Home and publicly funded model of LTC can deliver, especially for people living with dementia.

ii Behavioural Support Transition Neighbourhoods are separate neighbourhoods within Fraser Health care homes specifically for residents living with a dementia who have responsive behaviours (e.g. hitting, cursing or kicking) that are a safety concern for fellow residents, staff or others.

New and Emerging Provincial Small Care Homes Initiatives

The growing success of the GHP in the US has become increasingly apparent to Canadian jurisdictions over the years. In response, the most prominent recent initiatives embracing a greater emphasis on the development of Small Care Homes have occurred in the provinces of Quebec and Alberta.

Québec's "Maisons Des Aînés" Initiative

While Nova Scotia was Canada's first jurisdiction to promote the development of smaller home-like LTC settings, the most ambitious and recent Small Care Homes initiative in Canada has been Québec's decision to invest in developing smaller-format LTC homes (called maisons des aînés" [MDAs]) and homes for adults with special needs (called maisons alternatives [MAs]).[166],[167] Additionally, the government plans to modify facilities to incorporate this smaller format design,[168] which was inspired by the Green House model.[169] This initiative currently has a budget of over $5.1 billion CDN,[170] with an additional $472.7 million recently being provided by the Quebec Infrastructure Plan 2024-2034.[171]

Quebec's goal is to create over 6,300 beds, with around 3,600 beds from the construction of 49 MDAs and MAs, along with around 2,700 beds from modifying 22 facilities to incorporate Small Care Home design principles.[172]

The government of Quebec aims to leverage these investments to allow older adults to live in smaller, self-contained household environments with no more than 12 other residents, each of whom will have their own private bedroom and bathroom.[173]

Though the project was originally unveiled in 2019, the COVID-19 pandemic demonstrated the urgent need for Quebec's planned efforts to improve its traditional LTC home models of care. Indeed, the province experienced the highest rate of COVID-19-related deaths in its LTC homes in Canada during the first wave of the pandemic.[174] These deaths occurred in the midst of numerous challenges Quebec's LTC home system faced prior to the pandemic such as suboptimal funding, chronic understaffing issues and aging infrastructure. Quebec was truly ill-equipped to handle the spread of COVID-19 infections through its LTC homes.[175]

The basic elements of the MDA — called "maisonnées," which is French for "households" — are independent units of 12 residents, each having their own private bedrooms and bathrooms. Some design elements are specific to the Quebec approach. For example, instead of rooms surrounding a common area, MDAs typically use an L-shaped floor plan, with the elbow of the L containing the kitchen and dining room. Medical and administrative services are provided by a separate wing for every two maisonnées. This design approach represents a compromise for MDAs, which haven't gone as far as the Green House model that required the removal of nursing stations.[176]

Many documents pertaining to the MDA plan are publicly available on the government of Québec's Ministry of Social Services website, making it possible to gain insight on projects related to it. One example is a 96-bed home constructed in Montmagny, down the St. Lawrence River from Québec City. Originally projected to cost $40 million before taxes, the project would build eight separate maisonnées in one building. The residents of the home were expected to be either older adults or those "with a geriatric profile," 80% of whom were anticipated to have severe cognitive disorders.[177]

Once the COVID-19 pandemic began in 2020, the design for MDAs had to be altered to provide better support for infection prevention and control measures. These changes – alongside the inflationary pressures facing the construction sector as the pandemic continued related to labour shortages and higher prices for building materials – resulted in increased costs for these projects. Labour shortages have long plagued the LTC sector, and the Quebec government has also aimed to address this issue with another $2.9 billion plan to hire additional LTC staff and provide a more personalized level of care. The province went on to develop and are now testing a "balanced" staffing model that attempts to provide a more tailored response to the needs of older adults.[178] The province has provided organizations voluntary guidelines on how to implement "balanced" staffing model.[179]

Accordingly, LTC care settings typically have more staff on hand during the day than overnight. MDAs in Quebec have, therefore, been designed to utilize a staffing plan that schedules more employees when residents are typically expected to be awake, between 7 a.m. and 9 p.m. As seen below, the health care professional per number of resident rate is lower for RNs, L/RPNs and PSWs during the daytime compared to evening or overnight (see Table 3).[180]

MDAs are also being encouraged to use "vertical staffing" methods to ensure that mobility among care providers can occur in relation to the needs of residents across multiple units. Vertical staffing encourages the creation of positions that are not only

Table 3: Number of LTC Home Residents for Each Health Care Professional During Different Periods of the Day[181]

Health Care Professional	Professional Per Number of Residents
1 RN	25-32 residents (daytime) 50-64 residents (evening) 75-96 residents (overnight)
1 L/RPN	25-32 residents (daytime) 32-40 residents (overnight)
1 PSW	6-7 residents (daytime) 10-15 residents (evening) 32-50 residents (overnight)

designed to be "horizontal" (i.e., attached to a particular home-like unit) but also vertical, with care providers expected to move between units depending on the time of day and the needs of the residents. Vertical staffing allows for LTC settings to better respond to residents' needs and habits in terms of the scheduling of their daily activities.

Similarly, "dynamic staffing" methods also aim to enable staff to be flexible in terms of their mobility and/or placement in relation to the fluctuating needs of the residents. It is specifically designed to encourage mutual support among care providers, allowing for continuous re-evaluation of units to assess residents' needs in recognition of the various challenges that can emerge in LTC living spaces that require a temporary re-allocation of resources.

Evolving or adaptive staffing further builds on the concepts underlying vertical and dynamic staffing principles by recognizing that it is the environment and staff that should adapt to the changing needs of LTC residents, rather than the residents that must adapt, as their care needs change. It mandates the regular monitoring and assessment of residents' functional autonomy and other parameters, with the data collected from such efforts expected to inform care and staffing adaptations as needs evolve. The main goal with evolving staffing is, therefore, to limit the relocation of residents as much as possible out of recognition of the benefits that come from ageing in place.

The staffing subtypes identified above that have been adopted in MDAs have been inspired by those used in Green House homes and Dementia Villages.[182] These are based upon the ideals of resident-centred care, and attempt to approximate a staffing model similar to the Shahbazim of Green Houses or iterations of the universal care provider staffing model used in other small care homes. With that said, it remains to be seen whether the staffing model of MDAs can be implemented at scale, considering negotiations that are taking place with unions on the expansion of the responsibilities of orderlies.[183] Also, as of May 2023, the province was short 11,000 orderlies (the Quebec equivalent of PSWs) and aiming to recruit 5,000 orderlies by the end of the year.[184] It is not yet clear whether such a staffing model will allow Quebec to achieve the HSO goal of four hours of direct care per patient per day within its MDAs. Indeed, worker retention continues to be a key concern in the LTC sector across Canada. Therefore, to invest so heavily in such a significant sector-wide policy change, without introducing improved human resource policies, would be a wasted opportunity. Indeed, Québec's recent difficulties with recruiting the staff necessary to meet the caregiving demands within its new MDAs have led to significant gaps between the time when the construction of homes has been completed and when doors open to residents.

Alberta's Small Care Homes Province-Wide Initiative

The shift towards Small Care Homes models of LTC has been gradually taking place in Alberta over the past few years. From 2010, continuing care homes were required to group residents into households, that did not exceed 18 residents.[185] This number has recently been reduced to a maximum of 14 residents per household.[186] The impetus for this change was the Facility-Based Continuing Care (FBCC) Review conducted

by the provincial government in 2021. The FBCC Review provided 42 recommendations to improve the continuing care system, with certain recommendations specifically mentioning small home models. In addition to revising design requirements, the FBCC review recommended refocussing capital grant programs to emphasize resident-centred care.[187] This initiated the Small Care Home Stream (launched in 2023) within the provincial Continuing Care Capital Program.

Alberta's Small Care Home Stream has been specifically designed to fund the development of smaller format supportive living and LTC homes that would house between four and 14 residents each.[188]

For these Small Care Homes, the government specifically developed design guidelines, titled the "Small Care Home Design Requirements Checklist," that must be followed.[189]

Prior to this, Alberta's only examples of Small Care Homes were those developed by private sector operators delivering residential assisted living services in smaller format residences. Alberta's leading developer of small care homes has been ExquisiCare, which was recently acquired by SE Health. ExquisiCare was founded by Dawn Harsch (Owner/CEO) and arose out of this nurse's vision to provide assisted living and LTC services in a smaller care home environment. Harsch's overall goal was to develop an affordable form of LTC, beginning with a private model. Without government support, she was able to work with the municipality of Edmonton to construct her first Small Care Home for 10 residents, which blended in with the other homes in the neighbourhood. ExquisiCare was able to demonstrate that a Small Care Home could be integrated within residential neighbourhoods while meeting municipal building standards. In particular, ExquisiCare has been able to demonstrate that such builds can be less expensive to construct than traditional larger scale LTC homes in terms of per-bed construction costs due to the fact that they often are not required to use the same commercial grade building materials that are needed when building large scale care settings.[190] Furthermore, similar to residential home construction, ExquisiCare has been able to demonstrate its ability to construct a Small Care Home within a shorter period of time than it can take to build a much larger traditional LTC home.

Like Green Houses, ExquisiCare Homes also employ a universal care provider staffing model. During the day, an PSW and L/RPN work together to provide the direct care their residents require. From 3 p.m. to 7 a.m., two PSWs provide all aspects of care. There is always a regulated health care provider available on call, as well as a recreation coordinator that also supports residents to engage in purposeful activities during the day. For example, encouraging residents to assist with preparing their home-made meals has become one of the many activities that helps keep them engaged in their homes.

Despite currently only being a private care option in Alberta that can cost a typical resident upwards of $10,000 a month for their overall care costs, ExquisiCare's model of care has proved to be attractive, allowing it to currently care for approximately 30 residents across three Small Care Homes in and around Edmonton. Similar to Green Houses and other Small Care Homes across North America, none of the ExquisiCare homes experienced a COVID-19 death during the pandemic –

which is notable, given that Alberta's LTC and retirement homes were some of the worst affected in Canada during the pandemic.[191] Harsch credits her care model's success to its ability to provide better working conditions for staff, which naturally translates into higher quality resident-centred care. It has been noted that ExquisiCare's staff turnover rate is low within its homes. Further, findings from its yearly client satisfaction surveys have noted its achievement of a high degree of satisfaction with the care, as well as quality of life, for its residents. With the government of Alberta's more recent call for proposals to support the development of new small care homes, SE Health and ExquisiCare have proposed to expand this care model with the development of multiple new publicly funded Small Care Homes serving 10-12 residents each across Alberta, which could help make this model of care more accessible to more Albertans.

Barriers and Facilitators to Making More Small Care Homes a Reality Across Canada

When it comes to the design and operation of LTC homes, North America has emerged as an outlier in its preference to provide LTC in large institutional care settings that resemble lower acuity hospitals rather than home-like settings.

In the UK these care settings trace their origins to that of the Victorian era institutional "workhouse," which would provide food and shelter to older people and others who could not do so on their own, with the expectation that if a person was able, they needed to work in order to receive support. Workhouses, however, often operated with prison-like conditions, with people living in cramped quarters and with little light where diseases often spread like wildfire. Despite their originating formats, in the UK and Europe, modern day LTC homes now tend to be much smaller settings and more home-like as well.[192,193] Across North America, there has been a shift to provide other forms of long-term community-based care from institutional settings to smaller home-like settings, as is the case with the development of group homes for adults living with disabilities or mental health issues, as well as hospices, which are also often integrated into residential neighbourhoods.

Small Care Homes for older people needing assisted living or LTC services are not only preferred,[194] but also appear to be able to deliver safer, more resident-centred care, better staff working conditions and retention rates compared to traditional LTC homes. Further research is required to determine if these models are indeed more cost-effective than traditional LTC homes, but the initial studies are promising.

It's clear that there are necessary enablers that need to be supported to deliver an effective Small Care Home Model of Care, which include appropriate staffing, support for the development of appropriate care environments and the enablement of a universal care provider staffing model, coupled with the necessary training — which, together, can deliver better resident and staff outcomes.

In both the US and Canada, publicly funded LTC homes were rarely funded until recently to provide more than three hours of direct care per resident each day. This likely spurred a response to build large institutional care settings that emphasized providing task-based care as efficiently as possible with the limited staffing resources that would be provided. Ironically, the universal care provider staffing model became a later response that has been associated with enabling staff to provide up to 30 more minutes of direct care per resident per day and lower staff turnover rates.[195,196] There are now several examples of universal care provider staffing models that have been established in both unionized and non-unionized working environments, as well.

After the pandemic, the US established a three hours of direct care per day minimum staffing standard in keeping with the National Academies of Sciences report on improving nursing home quality.[197] In Canada, provinces and territories are increasingly pledging to align with the 4.1 hours of direct care per day minimum staffing standard established in the new national LTC Services standard. These latest developments could better enable a universal care provider staffing model with more full-time employment opportunities and allow front-line care workers to have more time to deliver resident-centred care.

The greatest enablers to providing better resident-centred care, however, will be both the recruitment and retention of care providers in LTC settings, the appropriate training of these staff to deliver more resident-centred rather than task-based care and a more flexible regulatory environment that can allow LTC home operators to embrace a universal care provider staffing model and the delivery of more resident-centred care. Nevertheless, what should particularly motivate the increased adoption of a universal care provider staffing model and its resident-centred approach to care by jurisdictions and their LTC operators, is the demonstrated consistent association of Small Care Homes with better staff outcomes (e.g., greater engagement and retention and reduced turnover) compared to traditional LTC homes. With that said, if improvements to human resource practices are not made central to the implementation of a Small Care Homes approach, achieving its potential to improve outcomes for residents and staff may be challenging. Indeed, the Green House Project's own Workforce Task Force's first key finding was that improving worker pay is critical to recruiting and retaining the necessary work force the LTC sector needs.[198]

Developing more appropriate small and home-like care environments will also require a change from the deeply engrained approaches to building LTC and other residential care settings in North America.

Similar to the more institutional task-based staffing paradigms that characterize the vast majority of care being provided in LTC settings, the lack of government funding available to build these smaller care settings, and the lack of requirements or incentives to build smaller home-like settings have resulted in the continued development of larger institutional care settings that maximize economies of scale in care provision and minimize construction costs. Building at these large scales also tends to require more time and, in many cases, a requirement to follow more commercial and industrial standards and use building materials, as opposed to more residential ones that can be applied towards the zoning and construction of smaller care settings.

The construction and provision of care in large institutional settings significantly disadvantage smaller and more rural and remote communities, which often do not have the population required to maintain a large traditional LTC setting and these communities thus often find themselves unable to provide a continuum of LTC services to older adults within their own communities. As a result, it is often the case that older adults in rural communities have to leave their communities to receive care elsewhere in a larger, more institutionalized setting. This can worsen their overall quality of life by limiting the ability of their family and friends to remain connected and support their social wellbeing and overall

care needs. This was one of the key drivers behind the government of Alberta's Small Care Homes initiative which specifically seeks to establish smaller footprint LTC homes to deliver residential care across rural and remote communities.

The benefits of the US GHP and the various Canadian case studies outlined in this report have made it clear that "culture change" and system change can only occur when it is appropriately incentivized.

Over the last few years, there have been numerous examples of Canadian jurisdictions investing in Small Care Homes. Some jurisdictions (e.g., British Columbia, New Brunswick) have only supported the development of a few Small Care Homes, whereas other jurisdictions (e.g., Manitoba, Nunavut, Prince Edward Island, Quebec and Alberta) have looked to implement this model of care widely across their province or territory (see Table 1).

Among most jurisdictions, there have been recent announcements on their intentions to build new LTC homes and beds. In Ontario, where its government is currently trying to fulfil its commitment of building 58,000 LTC beds (30,000 new beds and 28,000 upgraded beds) by 2028,[199,200] its efforts have not produced anywhere near the results for which it was hoping.[201] Even with more than doubling the government of Ontario's proposed construction funding subsidies of operators to support the development or redevelopment of large traditional LTC homes according to pre-pandemic design standards, LTC operators are struggling to find a financially viable path to develop these large format homes.

Some of the most significant factors that are holding back the development of new beds and the redevelopment of others have been skyrocketing costs of construction and long-term borrowing rates.[202] As of March 2024, the government reported just over 4,500 beds have been opened, around 8% of the of the proposed target of 58,000 beds by 2028.[203] At the same time, the province is grappling with the announcement that several LTC home operators are planning to close their homes rather than redevelop them which could further fuel the ongoing shortage of LTC beds in Ontario. This has already been seen in Toronto, with six LTC homes announcing closure, which means a total of 650 LTC beds will no longer be available.[204]

A growing number of municipalities and private for profit and non-profit providers are actively lobbying Ontario's Ministry of Long-Term Care to support them to develop smaller format LTC homes but, to date, have only seemingly met with resistance.[205] Although developing smaller format LTC homes may require more upfront construction funding subsidies from the government, these homes could allow a greater number of smaller, rural and remote communities to provide LTC home services to their communities.

It should also be noted that the development of small care homes should not just be seen as a preferred care option for smaller rural and remote communities, but also something that can work well and potentially be a more feasible option to support the development of in urban communities as well.

The experience of the development of SE Health's private assisted living Small Care

Homes in and around Edmonton, Alberta are an example of how multiple Small Care Homes can be built on smaller and easier to acquire parcels of land in residential neighbourhoods and still be run efficiently by adopting cluster care staffing methods across a defined geography.[206] Further, according to SE Health, Small Care Homes housing 10 or fewer residents tend to fit more naturally into municipal residential, rather than commercial, zoning and design requirements, which can, ultimately, impact the construction costs that can come with developing larger care settings.[207]

In the US, the benefits of the GHP in certain US States has also demonstrated the impact that State level policies and incentives associated with operational funding envelopes for publicly funded LTC home providers can have in supporting the creation of more small LTC homes. An example includes the government of Arkansas provision of Medicaid rate add-ons for operators of household-model homes since 2009, recently expanded to encompass all private rooms, which led to the establishment of a number of Green Houses across the state by a single provider.[208]

Additionally, the Kansas Department for Aging and Disability Services established the Promoting Excellent Alternatives in Kansas (PEAK) program which is a Medicaid pay-for-performance initiative offered to LTC homes that achieve various person-centered care improvements, including changes to the physical space and operations.[209] This is different to other states' "pay-for-performance" programs, which only consider care outcomes (such as reduced rehospitalization rates).[210]

Perhaps the best example of a successful small LTC home incentive program has been the State of Ohio's recent change to its Medicaid insurance payment rates for low income individuals that increase LTC payments to homes that provide private rooms, with extra reimbursements for rooms with private baths.[211] The change came as a result of lobbying efforts by Otterbein, an Ohio-based LTC home provider that operates 47 Green Houses within 10 communities that typically host five 12-person Green Houses based in residential neighbourhoods across central and western Ohio. In doing so, Otterbein was able to turn its increasing LTC home payer deficit into a financial surplus, further allowing it to achieve a 38% higher care quality rating than the state average.[212]

Policy Recommendations

The benefits of delivering LTC in Small Care Home settings are increasingly being recognized as potentially the best way to provide care that collectively benefits residents, their care providers and their families. As a growing number of national bodies (e.g., Canada, US, and Australia) are recommending that future LTC home design and care delivery models embrace Small Care Home principles, well-established in the Green House model of care, the uptake of these approaches across North America still remains the exception rather than the norm.

The NIA thus proposes three recommendations to support policymakers and decision-makers and leaders working across Canada's LTC sector to further advance the wider adoption and development of Small Care Homes across Canada.

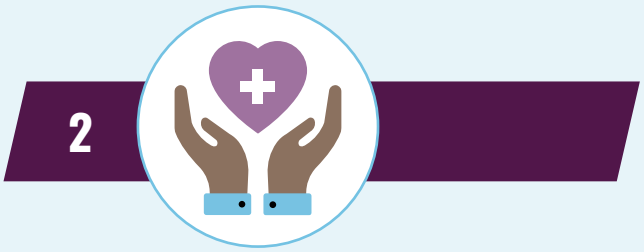
Canadian jurisdictions should prioritize the adoption of well-established Small Care Home design principles in the development and redevelopment of LTC homes.

With growing evidence supporting the multiple benefits that Small Care Home design principles can deliver, Canadian provincial/territorial governments can significantly influence the widespread future adoption of this superior approach to designing LTC settings. At a minimum, individual Small Care Homes or households co-located in a larger building should be deliberately designed to be home-like, house no more than 10-12 residents — each with access to their own private bedroom and bathroom, an open kitchen and common living areas and provide unrestricted access to outdoor nature areas.

This report's 10-12 residents-per-home or household limit recommendation, which can include couples, is being specifically recommended as it aligns with Canada's CSA Group's new national LTC standard concerning the design and operation of LTC homes. In caring for an increasingly complex population of residents usually living with dementia, it must be noted that when households begin to house more than 10-12 residents, their ability to create an actual "home-like" environment for both residents, their families and care providers becomes even more challenging. Additionally, all of the operators we interviewed for this report noted that having even smaller resident households appear to allow for more optimal care provider to resident ratios, and supports greater family and caregiver involvement in the life of a household as well.

Canada's provincial and territorial jurisdictions, which often wholly finance or heavily subsidize the building and operation of LTC homes, are well-positioned to support and incentivize the transition to adopting the latest Canadian, American and Australian evidence-informed design standards guidance around LTC homes. The fact that the development of Small Care Homes could support better access to LTC home supports

in rural and remote communities, support the greater integration of LTC homes into urban neighbourhoods and allow for care to be customized at the level of an individual household will enable the future provision of care in these settings to be more resident-centred and adaptable to the diverse and evolving needs of the communities they serve.



To further enable the best care outcomes that Small Care Homes can deliver, Canada's provinces and territories should support the ability of LTC homes to implement a universal care provider model, focused on delivering more resident-centred care.

The Green House Project and this report's Canadian case studies have demonstrated the significant benefits that a universal care provider staffing model of care can help provide for both residents and care providers alike.

This staffing approach has been successfully implemented in both unionized and non-unionized care environments and more effectively leverages both PSWs and Nurses in providing a broader range of care tasks like preparing meals, providing meal time assistance, cleaning and doing laundry in the same way that millions of family caregivers do on a daily basis. This re-orientation of care provision has been associated with residents receiving up to 30 minutes of additional direct care per resident per day and allowing for residents and their care providers to develop stronger relationships with each other.[213,214] This likely helps explain why this universal care provider staffing approach has also become a preferable working model for frontline care providers, where it has been implemented.[215,216,217,218] As was demonstrated earlier in in this report, care provider turnover rates appear to be significantly lower in LTC homes that utilize a universal care provider staffing model than homes with a more traditional, hierarchical and task-oriented staffing structure.[219] Nevertheless, governments need to ensure LTC home operators are appropriately funded to be able to hire sufficient numbers of appropriately compensated care providers with greater access to full-time employment and training opportunities that can better the recruitment and retention of LTC home care providers. This will better allow them to provide resident-centred and culturally safe and appropriate care.

Much of the evidence to date demonstrating the success of the universal care provider staffing model has been achieved across American and Canadian LTC homes that have been funded to provide less than the currently recommended 4.1 hours of direct care per resident per day. Furthermore, as more Canadian jurisdictions follow Ontario, Manitoba, Nova Scotia and Nunavut in supporting this recommended level of staffing, the universal care provider staffing model may be able to demonstrate its ability to deliver even greater resident, care provider and health care system outcomes.

3

Greater support for research and evaluation of Small Care Home models will be necessary to further establish the evidence and best practices that can further enable superior models of LTC in Canada.

While the evidence that has thus far emerged around Small Care Home models is both compelling and promising, more robust evaluations of this care model and its different iterations will help to provide more definitive evidence that can better inform our overall approaches to the future provision of LTC services in Canada.

It has been encouraging to witness how, over the past two decades, several Canadian provincial and territorial jurisdictions have become increasingly supportive of the development of individual Small Care Homes or households co-located in a larger building, especially post-pandemic. With that said, their approaches and guidance still vary considerably. There may be missed opportunities to deliver even better ways to provide care that collectively benefits residents, their care providers and their families. Also, governments and LTC operators have developed deeply engrained views over the past several decades that continue to largely support the development of large and traditional LTC homes. Thus, more compelling evidence will be necessary to make a more definitive case as for why future LTC home design and care delivery models should embrace Small Care Home principles in the delivery of care that our ageing population both needs and deserves.

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