



**DSL 101: UNDERSTANDING
DESIGNATED SUPPORTIVE LIVING
WORKSHOP**

WORKSHOP PROCEEDINGS

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1 DSL 101: UNDERSTANDING DESIGNATED SUPPORTIVE LIVING WORKSHOP

1.1 BACKGROUND

The Alberta Continuing Care Association (ACCA) is a non-profit voluntary organization that advocates for the private, voluntary and public sector providers of long term care (LTC) and designated assisted living (DAL) facilities and providers of home care and home support services.

Alberta's Continuing Care Strategy (2008) calls for most of the growth in facility-based continuing care to be focused on supportive living settings in which operators enter into a contract with Alberta Health Services to provide publicly funded health and personal support services. These settings have various names such as Designated Assisted Living (DAL) or Designated Supportive Living (DSL). The term DSL will be used in this document.

Many existing continuing care providers operate either seniors housing or long term care and are unfamiliar with requirements for operating DSL projects. As well, DSL is undergoing changes arising from the amalgamation of the nine former health regions into a single entity as standardized provincial funding and accountability mechanisms are being introduced. ACCA's members and other providers who are currently operating DSL projects, who have been approved to develop new projects, or who are contemplating responding to future proposal calls have expressed a need for current information on all aspects of developing and operating DSL projects.

To meet this need, a one day DSL 101: Understanding Designated Supportive Living workshop was held in Calgary on June 2, 2011.

Invitations to the workshop were sent to members of:

- Alberta Continuing Care Association (ACCA)
- Alberta Senior Citizens' Housing Association (ASCHA)
- Seniors Housing Society of Alberta (SHSA)
- Other providers

Experts from Alberta Health Services (AHS) and Alberta Seniors and Community Supports (ASCS) were invited to present and respond to comments and questions raised by providers. DSL providers from ASCHA and ACCA with a background in senior citizen lodges, private supportive living and long term care were also invited to relate their first hand experiences with delivering DSL.

1.2 WORKSHOP PURPOSE AND OBJECTIVES

The purpose of the DSL 101 workshop was to provide current and prospective operators of DSL projects the information they require in order to effectively develop and/or operate their projects. A key component was to provide consistent and accurate information. The workshop was also a forum to respond to questions raised by ACCA members and other providers.

Three specific objectives set the direction for the workshop:

- Move towards a common understanding of DSL
- Provide information on:
 - Past developments leading to Designated Supportive Living
 - The current state of and experiences in developing and operating Designated Supportive Living
 - The future direction for Designated Supportive Living
- Network with other providers and with AHS Zone representatives involved in Designated Supportive Living

1.3 WORKSHOP DEVELOPMENTAL PROCESS

Several tasks were undertaken to plan the workshop. A survey of ACCA members was conducted to determine topics to be addressed in the workshop. Topics included:

- Share operator experiences with DSL
- Definitions
- Assessment and placement models
- Staffing model
- Funding model
- Care model
- Accountabilities
- Responsibilities
- Design guidelines
- Standards and Regulations
- Accommodation fees

A Project Steering Committee with representation from ACCA, ASCHA and AHS guided the general direction of the project, discussed and finalized the workshop details. Carol Blair and Associates Inc. was retained to assist with workshop planning, facilitation and documentation of the proceedings. Proceedings of, and materials from, the DSL 101 workshop are available on the ACCA website: www.ab-cca.ca

The workshop agenda is given in Appendix A. The evaluation form and summary of the evaluations are given in Appendix B.

2 MORNING SESSION

2.1 WELCOME AND OPENING REMARKS

Bruce West, Executive Director of the Alberta Continuing Care Association (ACCA) opened the workshop and welcomed participants. He reinforced that the intent of the workshop was to clarify key aspects of Designated Supportive Living (DSL) including terminology, design, staffing and funding models, share experiences on how DSL is currently being implemented and learn about the future of DSL in Alberta.

Carol Blair, Workshop Facilitator, welcomed everyone and summarized housekeeping items. She introduced the presenters for each session and facilitated the question and answer sessions. The morning session focused on the background leading to the development of the Continuing Care Strategy as well as DSL policies and processes implemented by AHS. The afternoon session featured presentations by DSL providers on their experiences working in the field and concluded with a presentation by AHS on the future direction for DSL.

2.2 DESIGNATED SUPPORTIVE LIVING: WHAT ARE ITS ORIGINS?

Presentation Summary. Bruce West, Executive Director of the ACCA, provided background information on the key reports and studies that influenced the origins of DSL. The following reports were reviewed:

- *Alberta For All Ages: Directions for the Future (2000)* looked at trends impacting Albertans and government programs in light of an aging Alberta population. Key aspects of the report focused on the health system and actions to encourage healthy aging.
- *Healthy Aging: New Directions for Care (1999)* a.k.a. *The Broda Report* was a comprehensive report on Alberta's health system and the impact of the aging population on the system. The report developed a vision, principles and a framework of change for the Continuing Care Sector. Key concepts discussed by the report included: the importance of quality of living, unbundling of services, creation of three streams in Continuing Care, bringing services to the people who need them, healthy aging, and building senior-friendly communities. The report recommended: people should age in place (mostly at home and in the community), only people with complex needs should be placed in long term care (LTC), services should be unbundled, coordinated access should be used, comprehensive care for the elderly should be developed, and acute hospital services, emergency services and continuing care should be integrated.
- *A Future Scenarios for Continuing Care* study showed the impact of shifting from facility to community-based services. The scenarios considered demographics as well as resident classifications to calculate the number of people who would be receive care in their home, the community and in LTC.
- The *Provincial Service Optimization Review (2008)* also looked at the cost effects of shifting services to the community. The report suggested that by 2020 additional LTC will be needed, but a significant number of people can age in the community. The cost reduction to the health system as a result of this shift was estimated at \$60 million annually.
- *Implementing the New Vision: A Three Year Plan (1999)* was developed to look at funding distribution to enhance home care, renew LTC infrastructure, and develop supportive living. The plan stressed the importance of collaboration with stakeholders when developing new models of service.

2.3 ALBERTA HEALTH SERVICES AND GOVERNMENT OF ALBERTA PROGRAM GUIDELINES: CURRENT STATE

Presentation Summary. Cheryl Knight, Executive Director, Continuing Care Integrated Services, Alberta Health Services (AHS) outlined the current state of DSL addressing terms/definitions being used, resident attributes, assessment & placement models, staffing models, operating funding models, and AHS and Operator accountabilities.

- **AHS DSL Organization.** Two parts of Alberta Health Services are responsible for DSL in Alberta:
 - Provincial Portfolio integrates the work being done across the province, determines activity-based funding, creates and audits the framework, communicates issues, and is responsible for strategic implementation.
 - Zone teams are responsible for Zone operations and health services operations across continuing care settings either through contracted arrangements or direct care delivery. Zones also lead service provider contract activities at the Zone level as well as Zone Provider accountability audit activities.
- **Stakeholders.** DSL is provided with the help of numerous stakeholders:
 - Client and Family - DSL is a community service so the services are similar to what would be provided in the client's home. The intent is to assess unmet needs, so collaboration between the client, family, operator and AHS is integral.
 - Physician support - All Albertans are required to have access to a physician, but nurse practitioners may be a way to meet some of the need in the future.
 - Case management - Involves balancing needs of the system and the client.
 - Site Clinical Leadership - Supervise non-regulated staff, contribute to service planning, note client changes, and observe quality and safety.
 - Pharmacy services - Medication management requires collaboration with the client, site physician, community pharmacist, case management and direct care staff. AHS is looking at medication administration and how it may be organized to reduce medication errors.
 - Consultants (e.g., occupational therapists, physiotherapists, speech therapists, etc.,) - AHS is aware of the shortage of individuals who perform these services for seniors.
 - Direct care providers - Health Care Aides are the backbone of DSL, they communicate client concerns and observations. Certification and on the job training are being considered as models to increase the number of health care aides in response to demand. Innovative ways are being sought to utilize fully the skill sets of these individuals. There is also a growing demand for Licensed Practical Nurses who are the on-site professional staff in DSL settings.
- **DSL definitions used, resident attributes, and staffing models.** DSL refers to spaces contracted from an operator by AHS; AHS has control over the spaces, independent of the operator. When placing clients, AHS considers: predictability of condition, stability of change, complexity, and risk of adverse outcomes due to the change. Clients may be placed into one of three levels of DSL:

- A DSL3 client is predictable, stable, with a low risk of adverse outcomes, has scheduled care needs and the need for unscheduled assistance, and can select their own engagement activities. The staffing model includes health care aides on site, with an AHS RN on call 24/7.
- A DSL4 client is predictable, stable or unstable, with a low risk of adverse outcomes, has scheduled and unscheduled health status needs, and can manage care with predictive and anticipatory care plans. The staffing model includes LPNs for decision-making, assessment and intervention, health care aides on site and an AHS RN on call 24/7.
- A DSL4 Dementia client is predictable, stable or unstable, and has low risk of adverse outcomes, needs 24/7 support to carry out their daily activities. The staffing model includes team members that understand dementia. LPNs and health care aides are onsite and an AHS RN is on call. 24/7. The setting is a small and secure environment. Residents may be at risk of elopement.
- **Assessment and Placement Models.** Placement into DSL requires coordinated access, which follows a specific process: client screening, managing the waitlist, and attempting to match person's needs to services and spaces. Coordinated access is supported by case management and an integrated case management system.
- **Service contracts.** Contracts must meet the needs of the client and the community, so contracts are only tendered in communities that need DSL as per the Zone Teams and AHS demographic model. AHS is in the process of standardizing contract language and expectations across Alberta.
- **Activity Based Funding (ABF)** is coming to DSL. Three components are considered in the funding: variable components (e.g., client Resource Utilization Grouping (RUG) from InterRAI and staff components), fixed components (e.g., equipment), and quality components (e.g., exceeding quality outcomes). The process for collecting activity information is being developed. ABF has already been implemented in LTC.
- **Accountability** for operators is linked to standards (Continuing Care Health Service Standards and Accommodation Standards), the AHS Quality Framework, an auditing process, and adverse event reporting. AHS is working with other monitoring bodies to build collaborative auditing processes.
- **Issues still being addressed by AHS:** getting the right staff and enough staff, accommodation fees, capital and equipment costs, pharmacy services, client co-payments, collaborative relationships and system case management, and special cases.

Presentation Summary. Ralph Hubele, Manager, Supportive Living Programs, Alberta Seniors and Community Supports provided a presentation on the current state of capital grants, income supports, and accommodation fees.

- **Current state of Affordable Supportive Living Initiative (ASLI) capital grant.** The grant funds up to 50% of capital costs with a focus on facilities providing services to low-income residents in targeted communities. Mixed funding sources are allowed but only 70% of total development cost can come from ASCS and other government grant programs (e.g., Affordable Housing). Both new builds and modernization of existing builds are eligible for the grant.
 - **To apply** for a grant, the operator must provide SL3, SL4 or SL4D; be willing to enter into a designated supportive living agreement with AHS; have appropriate experience; charge affordable accommodation rates; provide a proposal that is feasible, appropriately designed, appropriately

financed within appropriate timelines (9 months to break ground and 2 years to open doors), and provide a component for community inclusion.

- **Design guidelines** are being created. The intent is to educate and promote best practices for design in supportive living. New buildings must comply with the Building Code B2 (Institutional) Occupancy.
- **Income supports** - AISH clients living in DSL or LTC can get \$315 plus the accommodation rate. Clients over 65 living in DSL or LTC will receive sufficient funds from federal and provincial programs and other income sources to pay the maximum accommodation fee in a long-term care private room (\$1,700/month) and be left with \$265 disposable income.
- **Future direction.** Future considerations for operators include re-profiling buildings to support aging in place, designing new flexible facilities to accommodate various resident needs, alternate funding arrangements (life lease, co-op housing, condo ownerships, and investor consortiums), other funding grants (other municipalities and other federal programs), conducting community assessments to ensure services are meeting resident needs, and looking at resource programs and services in the community.

Questions from the Audience

- **Q:** When is the next round of ASLI grants and have you identified priority areas in the province? **Ralph:** The next ASLI RFPs will be posted on <http://www.seniors.alberta.ca> in the next two weeks. The RFPs will be specific to geographic areas.
- **Q:** How much time is available to respond to the RFP? **Ralph:** Responses will be due in mid-September.
- **Q:** What does B2 Occupancy in the Building Code refer to? **Ralph:** B2 Occupancy is specific to buildings housing people who cannot evacuate on their own. Consequently, it has greater requirements for floors, rafters and joists than C Occupancy Building Code (code for apartment buildings).
- **Q:** Have the ASLI Building Guidelines been cross-walked with the Building Code and AHS design standards? **Jerri Taylor, AHS:** The Building Guidelines are not requirements; they provide best practices for providers to consider. Alberta Infrastructure has been cross-walking the guidelines against the standards.
- **Q:** B3 Building Code, specific to senior housing, will come into effect in January, how will it affect those who applied for ASLI grants before January? **Ralph:** The Building Code in effect when the building is being built is the code that must be followed.
- **Q:** Of the ASLI grants allocated, how many have been for upgrades to existing builds? **Ralph:** A few years ago, the grant allocated 31 million dollars into accessibility and safety upgrades to lodges. The ASLI grant has also been provided to for-profit and not-for-profit projects.
- **Q:** If a project is accepted for the ASLI grant but cannot meet the building time obligation, is the funding withdrawn? **Ralph:** If the timeline is reasonably delayed, proponents are encouraged to write to the Minister requesting an extension; it is likely that the extension will be approved. **Comment by Jerri Taylor, AHS:** AHS will be working with providers selected for ASLI grants to ensure AHS DSL contracts are in place 18 months prior to facility opening. As things may change within the 18 month period, AHS will meet with the operator again in three to six months before opening to finalize staffing mixes, client mixes, etc.

- **Q:** Is the type of unit, as per the Building Code, considered when placing a client in a setting? **Cheryl Knight:** This is not something that clinical case managers are considering, but it will be included in the future. Currently, this should be partially addressed through the conversation and collaboration between the case manager and the operator. **Comment by Caroline Clark, AHS:** This can be challenging when trying to move a unit to DSL4, especially when the environment was built to take on lighter care clients.
- **Q:** How can operators gain access to Netcare? **Answer:** AHW has submitted a Privacy Impact Assessment (PIA) to make Netcare accessible to operators; the resulting ruling will be posted on the Office of the Privacy Commissioner website.

3 AFTERNOON SESSION

3.1 SHARING OPERATOR EXPERIENCES: LESSONS LEARNED

Presentation Summary. Three DSL operators shared information on best/leading practices and lessons learned. Each of the following speakers gave a presentation followed by a question and answer period:

- Kathy Daly, Director of Professional Practice and Development, The Good Samaritan Society (GSS)
- Jeanette Leafloor, Lodge Manager, Aspen Ridge Lodge
- Doug Mills, Director, Points West Living

Kathy Daly, The Good Samaritan Society - Transition to from LTC to DSL

Kathy discussed the transition from long term care to DSL.

- Out of date and older LTC facilities are being closed and residents are being transferred to DSL. The hope is that in the future as people age, they will be able to be placed in settings that meet their needs.
- In 1995, the GSS opened the first “assisted living” project (Wedman House) that was designed to meet the needs of seniors living in lodges who needed additional care but were not ready or needing LTC.
- The GSS currently operates 900 funded assisted living beds [supportive living beds] in urban and rural communities throughout Alberta.
- New projects and developments are being planned and traditional nursing home beds are being converted to supportive living as part of closing outdated facilities.
- GSS is also developing combined nursing home and supportive living facilities and converting supportive housing to assisted living [designated supportive living].

Challenges in Transition:

- Some transitions go very well; some have many challenges.
- Seniors are happy to get new buildings, but may have negative feelings about a new transition model. It is important for them to know exactly what they are coming to in terms of costs and staffing. Providing only reassurance is not enough - seniors and their families need a great deal of information that often must be repeated.
- Inconsistencies occur with seniors being assessed for designated supportive living.
- Challenges exist for seniors who need LTC, but no facility is available. How will they supported in DSL4?
- Use of the term "unscheduled RN care" for admission is not well defined. Providing required scheduled care is a challenge if there are no available LTC beds or no facility is available in the community.
- **Role of RNs:**
 - A difficult transition piece for staff and residents and families is the role of the RN. In LTC, a RN is available, on-site 24/7. In DSL, they deal with a case manager, who may or may not live in the community. The RN and case manager play a crucial role in the program and consistency is vital. Poor communication and fragmentation of client care result when consistency does not occur. A solution is

to have regular meetings that include case managers and regular communication with case managers for each resident.

- Staff need clarity around who owns resident medical information and how it should be shared to ensure safe care for residents.
- Need clear guidelines on what policies are in play - the provider's or AHS's, e.g., how does client choice and autonomy interact with operator responsibility to provide safe care, e.g., staff trying to manoeuvre lifts when there is an abundance of furniture in the room?

- **Therapeutic services:**

- OT and PT are not on staff, but access to assessments can be arranged. However, this takes time and is variable and unpredictable. Residents coming from LTC will be used to having as-needed access to OT and PT and may complain about the lack of access in DSL.

- **Workforce/Occupational Health and Safety-** residents are more complex and have heavier care needs, which challenge multipurpose workers that are mainly HCAs. HCAs are trained to provide care and do so for heavier care clients, but that takes their time away from providing other services such as food services, housekeeping and laundry. It can be difficult for seniors to accept the multipurpose worker role, when they are used to dealing with HCAs for personal care only. This can also create difficulties for LPNs who must oversee staff and residents, rather than just providing patient care as in facility settings.

- **Environmental Occupational Health and Safety issues** - residents may come with nothing except their clothes, especially if they have been in LTC for a significant period of time. It may be difficult for them to furnish their rooms, and finances may be lacking to purchase furniture such as a bed.

- **Equipment** must be purchased by the resident/family and cost is an issue. Families must also purchase medical/surgical supplies, e.g., wound care. A challenge is to ensure consistency in what is purchased and that it is the same as those products with which care workers are familiar.

- **Medications** - another challenge is consistency in pharmaceutical provision.

- **Funding model** - in DSL, residents must pay accommodation fees, plus a number of other expenses, e.g. supplies, furniture, medication. In LTC, residents were only required to pay the accommodation fee. Even if the cost is the same, there is a perception by residents that services have been reduced, e.g., no on-site RN 24/7. A discrepancy still exists across the province in how SL4/SL4D is funded. Funding for additional services that are required in the short term is also lacking.

Jeanette Leafloor, Aspen Ridge Lodge - Sharing Lodge Operator Experiences in DSL

- Aspen Ridge Lodge provides services from Level 2 to Level 4 and 4D
- Residents wish to reside in one home for the rest of their lives. They want to live in a lodge (home), not a health care facility.
- Two philosophies are apparent among lodges. Some do not want to provide any health services and some embrace the concept of increasing services to allow residents to stay in their communities.
- Residents prefer a one-bedroom suite. They do not want to share a room or have a bachelor suite. However, when meals and snacks are provided, a kitchen table may not be needed or used.

- **Couples suites** - if one of the partners moves out, where does the remaining person go? It may be challenging to fill a couples unit if there are no couples, which means a loss of revenue.
- **Doors and flooring** are considerations - doors must be wide enough for palliative care beds. Carpets make it difficult to move equipment. This detracts from the “home-like” appearance of buildings.
- **Funding pressures:**
 - All AHS contracts are not equal. It is difficult to manage settings when funding varies.
 - Municipalities do not want to be involved with requisitions and are requesting that lodges become self sufficient for funding.
 - A perception exists among operators that AHS is downloading health services and associated costs to lodges.
 - Residents with high care needs create the most damage to suites, but they cannot be charged a damage deposit.
- **Increasing standards of practice:**
 - For small operators, the cost of accreditation is challenging and they must be accredited to provide DSL services.
 - Increased reporting and administration expectations result in increased costs in providing higher care level services.
 - Rural and remote facilities may find it difficult to have a physician in the area who can visit residents in their rooms.
 - Consistency of case management is vital.
 - Staffing shortages are ongoing.
 - Having a recreation therapist provides great benefits to residents, but it can be difficult to fund these positions.
 - Aspen Ridge has been more successful in hiring their own staff rather than having contract staff.
 - Many LPNs are new graduates and lack assessment skills.
- **Other issues:**
 - Skill shortages in mental health and psychogeriatric teams exist in rural areas. Wait times for mental health assessments may be over two months. When behaviour issues occur, a two-month wait is formidable for the staff having to deal with the issue.
 - Use one local pharmacy, rather than several for medication dispensing.
 - Families, residents, and AHS have difficulty understanding waitlists and supportive living options.
 - Residents who transfer back from LTC have difficulty understanding why they must now pay for some things, e.g., medications and wound care supplies
- Aging in the right place has been a good philosophy for Aspen Ridge to embrace. Transition can be done.

Doug Mills - Connecting Care and Points West

- Connecting Care manages 1,414 SL suites with 325 SL3, SL4 and SL4D suites. Points West manages 370 SL3, SL4 and SL4 suites.
- Small and medium size communities do not understand what DSL is. Much time is spent in education for seniors, families, AHS and home care.
- Local involvement in development and management is vital.
- Development is always slower than you plan.
- The development permit process can be difficult.
- Finding and developing appropriate land is difficult.
- Property taxes vary across the province.
- A graduation celebration is held for HCAs who complete their certification.
- A good working relationship with AHS is vital.
- The cottage design is efficient with many staff multi-tasking, including having meals with residents.

However, it is extremely gratifying when a new building is opened and families, residents and staff are happy.

Lessons learned:

- The design of the facility is key to operational efficiencies and a 60 suite minimum is required for financial viability.
- Use a single pharmacy provider and use Pouch Paks. Use RFP process to select the pharmacy.
- Residents in SL4 are more frail and their needs more acute than they used to be.
- Staffing in rural areas is more expensive than urban, despite lower cost of housing.
- Rules continue to change and administrative costs increase.
- Connecting care is not a medical model - resident quality of life is their goal.

Challenges;

- Keeping “medical model creep” from changing operational focus in which the resident is the centre.
- AHS funding model can be challenging at times.

Questions from the Audience

- **Q:** Is anyone turned down because there is no RN on site? **A:** A home care case manager, who is an RN, is on site. Having an RN onsite allows for more thorough assessments and allows the RN to get to know the residents on a day-to-day basis. **Audience member comment:** It would be useful to share the learning about how having an RN as an onsite case manager and how successful that model is.
- **Q:** How are on-site RNs funded? **A:** In the Calgary Zone, case managers are RNs and are assigned to sites and visit every day. Added Care grants from Alberta Health Services allow for funding for RNs for short-term increased care. Nurse practitioners are also being utilized.

- **Q:** Why isn't there more SL4D? **A:** Ratios are blended more, as there are complexities between SL4 and SL4D.
- **Comment from Jeanette Leafloor:** Good collaboration with health zones is vital when additional funding is needed, e.g., for palliative care.
- **Q:** What are the criteria for going into a rural community? **A:** Communities must be a certain size to have a viable operation. There is excellent support in smaller communities, as residents do not want to move to other areas.

3.2 LOOKING AHEAD TO THE NEXT FIVE YEARS

Presentation Summary. Cheryl Knight, Executive Director, Continuing Care Integrated Services, Alberta Health Services presented the AHS vision, expectations and plans for the next five years.

A focus for the future includes:

- Standardizing language around SL3, SL4 and SL4D so all stakeholders, AHS, the public, residents and families have a common understanding of the language.
- Expand the number and types of continuing care sites. The Minister has announced that 5,300 new continuing care spaces will be built over the next several years.
- Spaces need to be built on population need. AHS has done population projections; community needs assessments and is reviewing gaps in services.
- AHS is reviewing target capacity, which, in the past, was set at a target of 120 spaces per 1000 individuals over age 75. Current utilization and waitlist data have been reviewed. Number of individuals under age 75 has also been factored in. As a result the targets have shifted to 5.8 (rural) and 5.5 (urban) spaces for 1000 overall population. These numbers are validated annually.
- Solutions - the issues are known. However, the issues are very complex and will take time to solve. Strategies include:
 - Working towards implementation of Activity Based Funding.
 - Examining the feasibility of a standard accommodation rate for supportive living.
 - Working with ASCS to support access and acquisition of equipment and medical supplies.
 - Working with AHS and AHW Pharmacy on medication access and acquisition.
 - Working with physicians across the province to identify roles and responsibilities in supportive living environments.
 - Standardizing home care service packages which in turn will influence other parts of the housing and continuing care system.

Continuing Care Strategy and DSL

- Providing education for case managers to ensure consistency across the province.

- Completion of the Alberta Continuing Care Information System (ACCIS) database.
- End of life support will be defined.
- Populations who may need specific types of supportive living services, e.g., mental health, will have better access to those services.
- A dementia care and cognitive impairment strategy is under development.
- Working towards medication management consistency across continuing care settings.
- Fall risk management and mobility enhancement strategies are being implemented.

Questions from the Audience

- **Q:** Activity based funding will occur. How will AHS ensure that funding for continuing care is equitable with other health sectors? **A: David O'Brien:** Activity Based Funding is a methodology to determine how to divide the pie, not how big the pie will be. The size of the pie is being looked at. Activity Based Funding will help AHS determine inputs and outputs.
- **Comment from Jerri Taylor, AHS -** It is recognized that contracts across the province are not the same, but AHS is working to standardize contracts. There may be site-specific pieces, but overall, there will be consistency. Currently, there are over 1,000 contracts across the province.
- **Q:** DSL designation is based on AHS determination of health needs. Low income and health needs are not always the same. How can buildings built under ASLI meet both health and low income needs? **A: Ralph Hubele:** This hasn't been fully addressed but operators will not be asked to give funding back if not fully meeting criteria due to population changes.

3.3 ACKNOWLEDGEMENTS AND WRAP-UP

Bruce West, Executive Director, ACCA, thanked the presenters and workshop participants, briefly summarized the day's proceedings and requested that participants complete and hand in the evaluation forms included in their kits.

The workshop adjourned at 3:00 p.m.

APPENDIX 1

ACCA DSL WORKSHOP AGENDA

DSL 101: Understanding Designated Supportive Living Workshop Agenda

Date: June 2, 2011

Time: 9:30 – 3:00 pm

Location: Greenwood Inn and Suites, Calgary

Workshop Objectives:

- Move towards a common understanding of DSL
- Provide information on:
 - Past developments leading to Designated Supportive Living
 - The current state of and experiences in developing and operating Designated Supportive Living
 - The future direction for Designated Supportive Living
- Network with Operator and Zone representatives involved in Designated Supportive Living

Time	Item	Speakers
9:30	Registration and Refreshments	
10:00	Welcome and Opening Remarks <ul style="list-style-type: none"> • Workshop Objectives • Introduction of Facilitator 	Bruce West , Executive Director, ACCA
10:15	Designated Supportive Living: What are its Origins? Focus: Past development leading to DSL	Bruce West , Executive Director, ACCA
10:45	Alberta Health Services and Government of Alberta Program Guidelines: Current State Focus: Part 1: Current state of DSL addressing terms/definitions being used, resident attributes, assessment & placement models, staffing models, operating funding models, AHS and Operator accountabilities Part 2: Current state of capital grants, income supports, and accommodation fees	Cheryl Knight , Executive Director, Continuing Care Integrated Services, Alberta Health Services Ralph Hubele , Manager, Supportive Living Programs, Alberta Seniors and Community Supports
12:30	NETWORKING LUNCH	
1:15	Sharing Operator Experiences: Lessons Learned Focus: Sharing of information on best /leading practices, lessons learned by operators developing / operating DSL projects	Kathy Daly , Director of Professional Practice and Development, The Good Samaritan Society Jeannette Leafloor , Lodge Manager, Aspen Ridge Lodge Doug Mills , Director, Points West Living
2:30	Looking Ahead to the Next Five Years Focus: Vision, expectations and plans for the next five years	Cheryl Knight , Executive Director, Continuing Care Integrated Services, Alberta Health Services
2:55	Acknowledgements and Wrap-up Evaluation Forms	Bruce West , Executive Director, ACCA
3:00	Adjournment	

APPENDIX 2

**DSL WORKSHOP EVALUATION FORM AND
EVALUATION RESULTS**

A. EVALUATION FORM

Introduction

This is the first workshop that ACCA has provided to the Continuing Care Sector. Your feedback is important in helping us review and make any adjustments that may be necessary to strengthen future workshops / educational opportunities. Please take a few minutes to complete this form and hand it in to ACCA before you leave

How would you rate the following (place a checkmark in the appropriate column)?

Poor	Fair	Good	Very Good	Excellent
1	2	3	4	5

Workshop Component	1	2	3	4	5
Advertising, Registration, Location					
(Comments to add? Please refer to the back of the page.)					
Advertising and promotion					
Registration procedure					
Suitability of location					
Space/facilities					
Workshop Content					
(Comments to add? Please refer to the back of the page.)					
Overall rating of the workshop					
Achievement of the workshop objectives:					
1. Moved towards a common understanding of DSL					
2. Provided information on past developments leading to Designated Supportive Living					
3. Provided information on current state of and experiences in developing and operating Designated Supportive Living					
4. Provided information on the future direction for Designated Supportive Living					
5. Networked with Operator and Zone representatives involved in Designated Supportive Living					
Value of the workshop in meeting your needs					
Expertise / experience of the presenter					
Use of practical information and examples					

PLEASE TURN OVER AND ANSWER QUESTIONS ON THE BACK →

What were the overall strengths of the DSL workshop?
What areas need to be improved if similar workshops are offered in the future?
What did you learn today that you are most likely to use?
<p>Would you be interested in more educational / informational opportunities that further explore DSL? Yes ___ No ___ If yes:</p> <ul style="list-style-type: none"> • What specific areas would interest you? • What format would you prefer: workshop, website, other approaches? • Other suggestions (Note that focus would be on educational needs, not policy issues)?
Please provide any other comments that you may have.

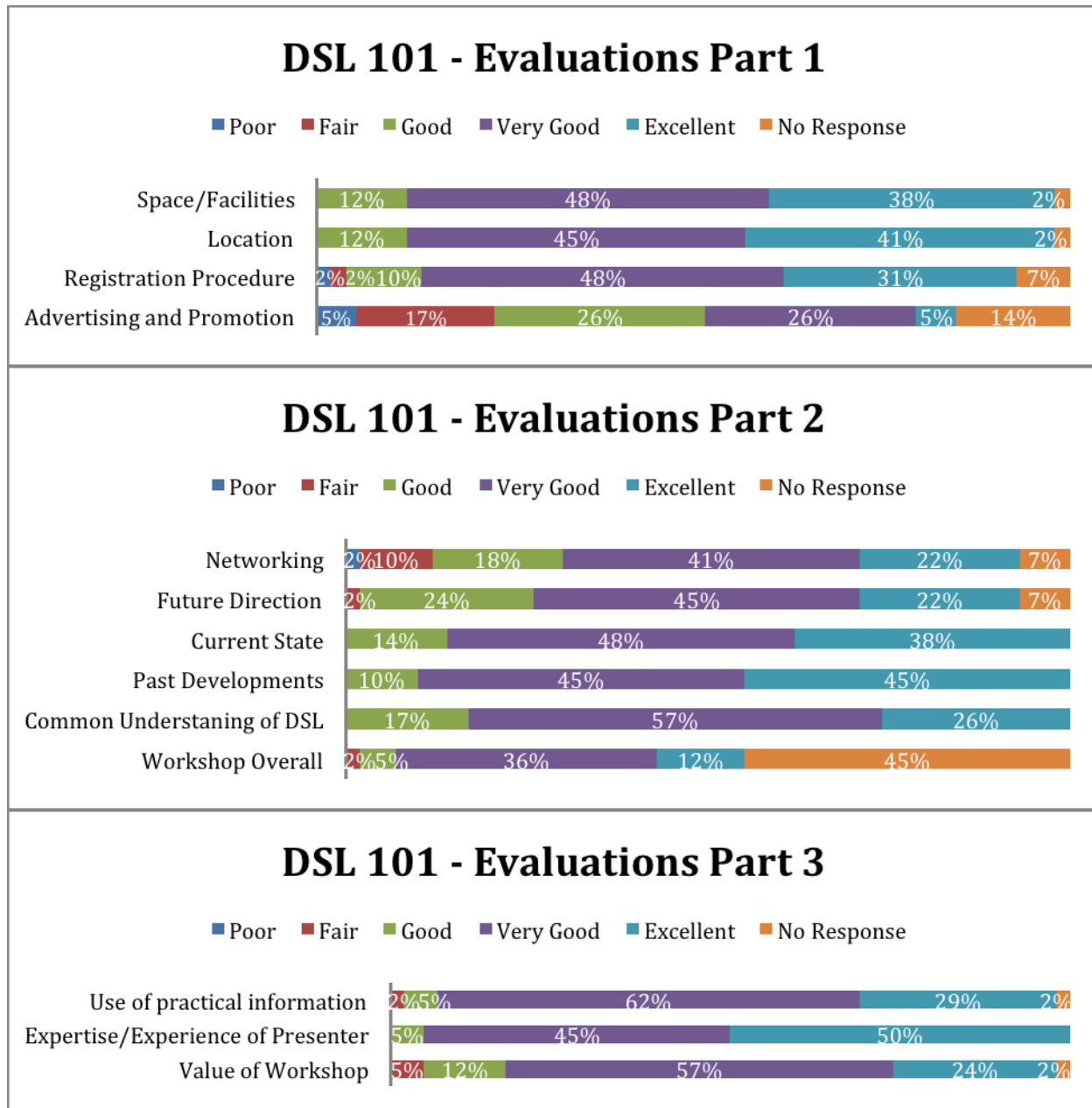
<p>To help us better understand the type of participants today and their needs, please check the boxes below that best describe your position:</p> <p><input type="checkbox"/> Provider. If a provider, please indicate the nature of the position you hold:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Leadership (i.e., CEO / CAO) <input type="checkbox"/> Support (i.e., Finance, Human Resources, Communications, Research) <input type="checkbox"/> Direct Services (i.e., Supervisors, care staff) <p><input type="checkbox"/> Alberta Health Services</p> <p><input type="checkbox"/> Government</p>

We may wish to contact you for more information on your responses. If you are agreeable to this contact, would you please provide the following information:	
Name:	Position:
Organization:	Email address:

THANK YOU FOR YOUR FEEDBACK!

B. EVALUATION RESULTS

The DSL workshop was attended by 70 participants with a total of 42 completing the evaluations; a response rate of 60%. The first series of questions asked participants to rate the preparation and content of the workshop using the scale 1 to 5, one being Poor and five being Excellent. The following three charts depict the responses received.



The next section of the Evaluations form consisted of open-ended questions to allow participants the chance to provide feedback on concerns not previously addressed.

What were the overall strengths of the DSL workshop?

- Expertise and experience of the presenters & variety of speakers; from AHS, ASCS, and a panel of operators
- Very informative and provided comprehensive information.

What areas need to be improved if similar workshops are offered in the future?

- Make the workshop more interactive and possibly break out into small groups
- Provide more concrete information around models as well as logistics (i.e., more comfortable chairs).

What did you learn today that you are most likely to use?

- Experience and diversity of panel and speakers
- Importance of relationships (family, community, government, providers)
- Understanding levels of DSL and ASLI program
- Awareness of transitions and “what’s in the works” along with commonalities and similar challenges experienced

Would you be interested in more educational/informational opportunities that further explore DSL?

- Yes = 74% (31)
- No = 2% (1)
- No response = 24% (10)

What specific areas would interest you?

- ABF funding
- Operational model
- Staffing model
- Contracting process
- Building guidelines
- Transition services

What format would you prefer: workshop, website, other approaches?

- Workshop = 40% (17)
- Website = 5% (2)
- Other = 2% (1) – Summit or Symposium
- No response = 53% (23)

Type of Participants attending DSL 101: Understanding Designated Supportive Living Workshop

