February 12, 2021

Ms. Carol Blair,

Thank you for the opportunity to provide feedback to the Continuing Care Legislation review. Our submission is based on feedback from our stakeholders including people living with dementia and their family caregivers, academic researchers, health care professionals and public, private and non-profit organizations. While our submission is focused on people impacted with dementia, our recommendations are applicable to all recipients of care. However, some issues, such as consistent care assignments are critical for people living with dementia and their caregivers because of the nature of the disease and its progression.

We are not experts in legislation and as such, our recommendations may be outside the Act and Regulation components of the governance framework. We rely on the expertise of policy makers and legislators to ensure that changes to legislation will enable and support these recommendations.

Dementia Network Calgary works collaboratively with stakeholders to make life better for people impacted by dementia. Changes to legislation that will enable a person-centered (relational) model of care; support care givers; improve system navigation; enforce excellent standards of care; enable a competent and fairly compensated workforce; and support people to live in the community as long as possible will make life better for people impacted by dementia. Thank you again for the opportunity to participate in this review and we welcome further involvement.

Sincerely,

Kim Brundrit
Collective Impact Lead, Dementia Network Calgary

cc. Honourable Tyler Shandro, Minister of Health
    Honourable Josephine Pon, Minister of Seniors and Housing
    Richard Gotfried, MLA for Calgary-Fish Creek
    John Cabral, Assistant Deputy Minister of Health, Health Service Delivery
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Continuing Care Review Submission: Dementia Network Calgary

OVERVIEW:

Dementia Network Calgary is a growing multi-stakeholder group of knowledgeable, capable, and passionate individuals from across public, private, and non-profit sectors in Calgary and area that is taking a cross sector, collaborative approach to tackling the complex challenge of dementia.

This submission is a response to the request from the Government of Alberta to provide perspectives and recommendations for new continuing care legislation on behalf of our stakeholders. We have framed our input in the context of a holistic view of the continuum of services for people living with dementia and their families. Our submission addresses both cross-cutting issues that affect all areas of care as well as individual elements pertaining to specific components of this continuum in order to avoid repeating the same cross-cutting issues under each service area. We hope our document will identify areas of the legislative framework that we believe require amendment to address the challenges experienced by people living with dementia and their families now and into the future.

The continuing care review is an opportunity for the Government of Alberta to take a proactive approach to the growing needs of people living with cognitive impairment (including dementia). They now represent the majority (87%) of people living in continuing care¹. While the prevalence of dementia in older persons (i.e., number per 100 persons 65+) is decreasing in economically developed countries like Canada, the total number of people living with dementia in Alberta will continue to grow as our population both expands and ages (i.e., the risk of dementia increases with age). It is expected to triple by 2046².

The experience of living in continuing care facilities or having a loved one who lives in a continuing care facility in Canada during the pandemic was frightening for all and deadly for many. Canada experienced a far higher proportion of total COVID-19 related deaths in continuing care than comparable countries (81% in Canada, 28% in Australia, 31% in the US and 66% in Spain)³. In Alberta, 73% of LTC operations have had outbreaks, the highest percentage in Canada compared to 39% in BC and 62% in Ontario⁴. This highlights the necessity for change and the need to rebuild trust in the continuing care system.

This submission was informed by people with lived experience including families, caregivers, and professionals who work with people with dementia as well as the results of recent research conducted in Alberta.

⁴ https://ltc-covid19-tracker.ca/.
A. CROSS-CUTTING ISSUES

A.1. Person-Centered Care

Issue:

People living with dementia deserve dignity, respect and appropriate care throughout their dementia journey. Studies have shown that for people living with dementia this can be best accomplished through a relational model of care, rather than the predominantly task-based model of care that currently exists. A relational model of care recognizes the importance of the relationships/interactions between caregivers and the individual receiving care. Success is defined by meeting the needs of the individual receiving care, which cannot be simply reduced to addressing a list of commonly prescribed tasks. This is particularly important for people living with dementia, their families and the staff who care for them because it provides a familiar face and a shared understanding of the person’s needs even if they cannot be expressed verbally. Relational models of care including consistent staff assignments have been proven to decrease injuries for staff and residents, decrease infection rates, lessen weight loss, decrease the use of anti-psychotic medication, and lead to both greater job satisfaction and reduced staff sick time and turnover\(^5\).

The relational model of care is important for home care as well as facility-based care for people impacted by dementia. A consistent home care provider allows for increased trust by the family/friend caregiver, recognition by the person living with dementia and greater understanding of the needs of the person living with dementia and their family/friend caregivers by the home care provider. A different home care provider every week is confusing to the person living with dementia and increases the burden on family/friend caregivers who need to repeatedly introduce new care providers to the person living with dementia and familiarize these care providers about their family member. As a result, family caregivers will often forego the service rather than see their loved one distressed by this turnover.

By providing the right care in the right place, Albertans will have the support they need to remain at home as long as possible and live their lives as fully as possible.

Recommendations:

1. That the Government of Alberta review all care provided to Albertans through the lens of relational care instead of task-based care and adopt funding models to enable/facilitate the implementation of relational care throughout the continuum of services.
2. That Alberta Health Services implement a relational model of care approach throughout the care continuum.

A.2 Support for Family/Friend Caregivers (FC)

Issue:

Family/Friend Caregiver (FC): A person who gives unpaid care to someone who has a physical or mental health condition, or who is chronically ill or frail, either at home or in a facility. Caregivers may be spouses, adult children or in-laws, parents, siblings, youth, extended family members, friends, neighbours, or family of choice.

FCs for people living with dementia provide more hours of care and experience higher levels of distress than those caring for other older persons. The Alberta Dementia Strategy and Action Plan states, “Supporting caregivers and addressing their needs is vital to our success.”

People living with dementia receive a high level of support from unpaid FCs throughout their journey with dementia. This support enables many people with dementia to continue living at home, participate in their community and sustain employment in some situations.

The pandemic created a crisis for FCs caring for a person with dementia at home. This crisis continues ten months later. In a study commissioned by the Alzheimer Society of Calgary in 2020, researchers found that during the pandemic services for people living with dementia in the community decreased while needs increased. Almost 50% of FCs provided more than 40 hours per week of care to their loved one with dementia. The pre-pandemic average was 26 hours per week. FCs were emphatic about their need for respite, with one FC sharing the comment that, “… if you don’t come and help, I’m done, I cannot do this anymore.” Some FCs reported having to leave their job and assume more caregiving responsibilities. In 2021, we continue to hear from FCs who are continuing to prematurely admit loved ones to long-term care due to lack of home care and respite support.

Family/friend caregiver support for people living with dementia often continues after the person with dementia transitions into residential care settings. While many FCs are charged with being the substitute decision maker or having power of attorney for their loved one, they are also the main social, emotional and physical support person. This unpaid workforce has a level of commitment and expertise that is invaluable and is a backbone of our health system. This investment of time and resources by FCs benefit the person living with dementia as well as the health care system. These are not “visitors”, as they are often in the facility every day providing supports such as feeding, toileting, dressing, emotional support and personal hygiene and they are essential partners in health care decisions for their loved one. Being separated from their loved ones during the initial

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6 https://caregiversns.org/who-we-are/caregiving-language/
8 http://www.dementianetworkcalgary.ca/news
months of the pandemic caused anxiety and trauma for FCs. Alberta was a leader in recognizing the importance of FCs access to loved ones living in continuing care facilities in July 2020.

Unfortunately, the health and wellness of these unpaid FCs is routinely overlooked by the Alberta health system. **FCs are not well supported in their role or acknowledged by the health care system.**

**Recommendations:**

1. That the role of FCs is formally acknowledged by all Alberta health systems as members of the core health team for their loved one, and the FC has the opportunity to be included in decision-making and care planning at all stages in continuing care.
2. That the Carer Support Needs Assessment Tool\(^\text{10}\) (CSNAT) is used by health care professionals and by family/friend caregivers themselves to assess needs.
3. That health care professionals are trained in the assessment, support and inclusion of FC (www.caregivercare.ca).
4. FCs are provided with appropriate training in how to use personal protective equipment (PPE) and infection control procedures and supplies of PPE in order that they may continue to care for their loved one in times of disease outbreak.
5. FCs are given priority access to Covid19 vaccines in recognition of their essential care role, as has been instituted in some other provinces.

**A.3 System Navigation:**

**Issue:**

There are a wide array of services and programs available to assist persons living with dementia and their caregivers; however, one of the most frequently voiced issues is the difficulty experienced in identifying and navigating the options for care and support through the health and community services system. It is a challenge that people experience from the point of diagnosis through the various transitions as the disease progresses.

In the absence of a coordinated system of care that responds to the various and changing needs of persons living with dementia, they and their caregivers too often find themselves trying to figure out what services are available, how to access them and what are the options. The organizational silos between health, social or community-based services present unnecessary hurdles to be overcome.

The lack of adequate facilitation through a complex and fragmented system places an additional burden on the individuals living with dementia and their caregivers. It is estimated that family caregivers spend 15-50% of their time finding the services they need and trying to get access to them\(^\text{11}\). That is time taken away from caregiving and

\(^{10}\) http://csnat.org

\(^{11}\) https://www.ncbi.nlm.nih.gov/books/NBK396398/
taking care of themselves, placing greater stress on the caregiver. The consequences are often a reduced quality of life for the person with dementia, burn-out for caregivers and increased use of acute care facilities when community-based or home care services would have been more appropriate and more cost effective.

Coordinated system navigation for persons with other diseases such as cancer or ALS, demonstrates the effectiveness of this approach for the individual and the health care system. A similar commitment to a coordinated system navigation for persons living with dementia, from diagnosis through end of life is required.

**Recommendations:**

1. That Alberta funds one consistent point of contact for persons living with dementia and their caregivers from the date of diagnosis to end of life. Based on the values, preferences, goals and needs of the person living with dementia and their caregivers, this contact will help them navigate the intersections between Primary Care, Long-Term Care, Acute Care, Hospice and Palliative Care, and community-based social support organizations. This will improve access to needed services and diminish both fragmentation and gaps in its delivery.

2. That programs, such as First Link, that connect individuals and their family members directly to key supports at the time of diagnosis or as soon as possible thereafter receive on-going funding as essential services.

3. That primary care physicians are well aware of services, such as First Link and system navigation, so they can direct individuals and their family members to these services immediately upon the diagnosis of the disease, providing a path forward at a time when people often feel overwhelmed, fearful and grief-stricken.

**A.4 Standards of Care:**

**Issue:**

Current standards and regulations are intended to ensure the safety and health of people receiving care which is vitally important. Standards should be expanded to include person-centered programming and measure quality of life indicators. Quality of life indicators that incorporate addressing social, emotional, physical and recreational needs must be **mandated, measured and audited** in all care situations (home care, residential care, respite, adult day programs, etc.). Continuous improvement and incentives for implementing evidence-based improvements are important to elevate the quality of care in Alberta.

**Unscheduled, rigorous audits** must be in place for all care providers and facilities. In order to instill trust in the continuing care system, standards should be consistent, transparent, applied to all service providers equally and results of audits should be publicly available.
Recommendations:

1. That person-centered, evidence-based, best practice standards for all service providers (i.e., public, private, non-profit) include quality of life indicators such as addressing social, recreational, emotional and physical needs.
2. That standards are reviewed regularly and adjusted to reflect changing understanding of best care practices.
3. That care providers are required to strive for continuous improvement, with incentives for implementing best-practices.
4. That audit/inspection results are made publicly available in a timely manner.

A.5 Workforce:

Issue:

We are facing a global healthcare workforce shortage and an aging population in Alberta. The experience of people who are supported by the continuing care system since the start of the pandemic has highlighted the essential services provided by health care aides (HCAs) both in the community and continuing care settings.

The majority of care hours in the continuing care system are provided by HCAs. They often work for many employers both within the formal health system and in private homes. They receive the lowest wages in the healthcare sector, are given variable and minimal formal training in long-term care and are rarely part of decision-making about care for residents. Studies have shown that they often have insufficient time to complete essential care and are at high risk for burnout and injury. A lack of full-time positions with benefits contributes to the need for HCAs to hold several jobs. In addition, the discrepancy in pay for HCAs between acute care and other situations means that HCAs are incentivized to decline full time work, or to call in sick to continuing care positions in favour of “hospital hours” that pay more.

The single site policy put in place for the pandemic allowed facilities to move toward a more relational model by enabling consistent staffing assignments. As mentioned above, relational models of care including consistent staff assignments have been proven to decrease injuries for staff and residents, decrease infection rates, lessen weight loss, decrease the use of anti-psychotic medication and resulted in increased job satisfaction and a reduction in staff sick time and turnover.

A knowledgeable workforce with dementia-specific skills and understanding is essential to provide high quality care. It is greatly appreciated that Alberta recently introduced an eight-month training requirement for a HCA certificate and a requirement that HCAs be regulated by the College of Licensed Practical Nurses of Alberta. Additionally, continuous learning that features regular face-to-face, small group, on-the-job training with an emphasis on relational care led by a qualified leader and supported by all levels

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of management is critical. Education alone, though, does not change practice. It is important that organizational changes also occur that will reinforce improved work-related practices.

Recommendations:

1. That all paid staff working with people living with dementia need a minimal level of dementia-specific training (e.g. Best Friends Approach™, Gentle Persuasive Approach™).
2. That HCAs be compensated for additional training, rather than paying out of pocket for upgrading their training.
3. That the AHS funding model is transparent and provides for appropriate and consistent compensation for HCAs across the care continuum and across all care situations.
4. That the continuing care funding model supports the creation and filling of full-time positions that will help in achieving improved relational care through permitting consistent staff assignments.
5. That staff ratios are increased to ensure high quality, relational care in continuing care.
6. That on-the-job mentorship and continuous improvement are measured and incentivized.
7. That training standards must be met by all care providers in continuing care including those brought in from external, private staffing agencies.

B. CONTINUUM OF SERVICES

B.1 Community Supports:

Issue:

The pandemic highlighted the importance of community supports for people living at home with dementia. Without these supports, caregivers experienced burnout, increased stress, physical and mental health breakdowns. These stresses led some caregivers to report pursuing early placement of loved ones into facility-based care because of a lack of support in the community.

The media reports of horrific conditions and calls for the military intervention in other parts of the country have left the public with fear and distrust of facility-based continuing care. The number of Covid-19 infections and deaths in people living in continuing care facilities in Canada was one of the highest of the OECD countries. It will take time to rebuild trust in the system. This will lead to an increased number of people choosing, wherever possible, to remain in their homes. If we do not provide adequate community

14 http://www.dementianetworkcalgary.ca/news
supports, caregivers’ health will fail leaving them unable to fulfil their role as unpaid care partners and the cost to the system will increase exponentially.

Recommendations:
1. That adult day programs are expanded to provide more days per week for each participant as well as more spaces to eliminate wait lists.
2. That there is choice in location and flexible respite opportunities including occasional, emergency and overnight respite in appropriate settings (other than continuing care facilities) where staff are appropriately trained not only in dementia, but in respite care for people living with dementia.
3. That family members are provided with opportunities to be paid to provide respite care.
4. That short-term employment leave be available to family members who need to provide emergency respite care.
5. That personnel of recreation, social, government and community organizations are trained to adapt their services to be inclusive for people living with dementia. These programs might be considered respite care. For example, a facilitated art program that a person with dementia can attend would provide a family/friend caregiver with short respite.
6. That dementia awareness programs are implemented in all Alberta communities to reduce the stigma associated with dementia.

B.2 Home Care:

Issue:
80% of people living with dementia live at home, in the community. They receive varying levels of support from formal systems like home care and informal systems like family and friends. Home care is essential in supporting people to retain their independence so they can remain living in the community and age in place. As described above, this support must be person-centered and designed to meet the specific needs of the individual living with dementia. If family/friend caregivers are involved, their needs and health must also be assessed and monitored. The goal is to support people safely at home, where they want to stay, for as long as possible.

The pause in provision of home care services during the pandemic highlighted the critical need for these services and continues to be a stressful challenge 9 months later. The definition of “essential care” varied greatly from one case manager to another and families were at times left with the choice of either hiring private care (which many could not afford even if they could find somebody) or prematurely admitting their loved one to acute or long-term care.

Consistent care assignments are critical for people living with dementia. An understanding of the individual needs and preferences of the person with dementia makes caring easier for the carer and life better for the care recipient. A consistent, appropriately trained home care provider allows for building trust with the family/friend caregiver, improved recognition and comfort with the provider by the person living with dementia and greater understanding of the needs of the person living with dementia by the provider. A different home care provider every week is confusing to the person living dementia and family/friend caregivers will often forego the service rather than see their loved one in distress.

Rehabilitation services for people living with dementia are often not considered indicated or are unavailable. Every person, regardless of health status or ability to pay has the right to access public health care. This includes services such as mental health care, palliative resources, physical therapists, occupational therapists, speech/language therapists, recreation therapists, dietitians, pharmacists, podiatrists, pastoral care, psychologists, podiatry, dental, hearing and vision care. These services may need to be delivered to people at home or made more easily accessible by offering a “one-stop shop” for people living with dementia.

**Recommendations:**

1. **That one designated contact** point is available to people living with dementia and their care partners. This service must have experience working with people with dementia and will provide navigation support both within and outside AHS.
2. That consistent care assignments are prioritized for people living with dementia (the same home care provider wherever possible).
3. That home care assessment assesses and addresses the unique needs of the person living with dementia and, where applicable, the family/friend caregiver(s). This assessment must include para-medical needs such as podiatry, eye care, etc. If there are needs outside of those provided by public health care, the designated contact will work with other community providers to ensure services are in place (i.e. snow shovelling, meal preparation, small home repairs).
4. That assessment of both the person living with dementia and the family/friend caregiver (FC) occurs at least bi-annually using a standardized tool (e.g., CSNAT for FCs) available to healthcare professionals including family physicians and transition teams.
5. That the self-managed care program be immediately available (after assessment), easy to understand, and easy to administer with user support available (or replace this program for people impacted by dementia with the “Edmonton Invoicing Model”).
6. That health care workers understand the benefits of rehabilitation services for people living with dementia and these services are always made available.

**B.3 Supportive Living/Long-term Care:**
The majority of people living in continuing care facilities are impacted by dementia. Staff training, mentorship and compensation (all covered in other areas of this submission) are imperative to the ability to offer a relational model of care in this setting. Consistent care assignments have been proven to improve the quality of life for residents, family members and staff. It also provides the family with a point of contact who knows their family member best. They should be empowered to make meaningfully contributions to care planning for residents living with dementia. The single site rule that came into effect as a result of the pandemic has accelerated the move to consistent care assignment in many facilities. Policies, education and funding model changes are needed to support operators to sustain a permanent transition to consistent care assignments.

Continuing care facilities for people living with dementia must be purpose-built and utilize technology that allow residents to walk freely, participate in recreation activities and engage in activities they enjoy while ensuring their safety and security. Small, community-based facilities and purpose-built facilities for people with dementia offer distinct advantages to residents, families and staff. The design of continuing care facilities contributed to the spread of infection during the pandemic. A move to single rooms with private bathrooms is important for infection control. However, accommodations must be available for couples who choose to live together.

An increased number of small, community-based homes (similar to community-based group homes for people with disabilities) would allow people to continue to live in a community they know, reduce travel time and expense for friends and family members and allow staff to provide person-centered care for every resident. An example of this type of housing is the Green House Project.

The families of people living in continuing care are frequently approached to provide basic items such as toilet paper and diapers for their loved one. These supplies can certainly be bulk purchased by AHS at a lower price and should be included in any residential care situation. The accommodation fees must be high enough to ensure that basic needs including appetizing, nutritious meals and personal hygiene supplies are included for all Albertans. Increases in support staff, food and accommodation costs have been faster than the increases in accommodation fees.

Funding contracts to support resident care in facility-based continuing care should provide a consistent and equitable level of public funding support per resident for all operators whether they are public, private or non-profit. Funding models must incentivize consistent staff assignments and full-time positions in order to promote a relational model of care which is so important for people living with dementia, their families and the staff who care for them. Allied health professionals (e.g. physiotherapists, social workers, podiatrists, sight and vision specialists) must be

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18 https://www.thegreenhouseproject.org/
available to all people living in continuing care within a reasonable time frame (days not months).

Prescriptive staffing models imposed on care operators prohibits them from optimizing care assignments for their residents. Increased flexibility would allow operators to provide relational care based on the needs of each resident with the appropriate staff mix. However, with increased flexibility, oversight is essential and regular, unscheduled audits must be in place for all care providers.

Family/friend caregivers provide 30% of the care in facilities including feeding, washing, toileting, social, emotional and memory support, and mobilization. These care partners are an unpaid workforce that is integral to the functioning of continuing care in Alberta and they must be recognized and supported in their role as a partner in the care team of their loved one. In addition, continuing care facilities where family/friend caregivers spend the majority of their time, have a role to play in ensuring the health and well-being of family/friend caregivers.

Recommendations:
1. That funding models support the single-site rule, consistent care assignments (the same staff member caring for the same resident every time they are on shift) and incentivize full-time positions with benefits.
2. That the accommodation fee be increased and indexed to cost-of-living and allow for dealing with the basic needs (hygiene supplies, appetizing, nutritional meals, etc.) of all.
3. Public funds provided to operators for residential care should be the same for every resident no matter who is providing the service (public, private, non-profit).
4. That staff ratios are increased and that the staffing mix is flexible to ensure high quality, relational care for all residents.
5. That up to two family/friend caregivers are recognized as essential members of the care team with a role to play in care planning.
6. That all continuing care facilities be funded to provide one point of contact for essential family caregivers. This person would be responsible for:
   - Ensuring smooth and effective coordination of the essential caregiver responsibilities;
   - Providing supportive education with information regarding infection prevention and control measures (and source other education as desired/required);
   - Liaising with staff to ensure they are aware of the essential caregivers
   - Highlighting relevant policies (ex. Fire drill procedure);
   - Providing guidance in the case of any conflicts; and.

• Assessing (periodically) the needs of essential care partners and refers caregiver to Caregivers Alberta, AHS or other community supports.

7. That incentives are provided to build provide small, community-based care homes.

8. That facilities provide opportunities for couples to live together, including LBGTQ2S+ couples.

B.4 Palliative Care

Issue:
The inevitable final stage of the continuing care continuum for many is end of life care. Alberta provides an integrated range of end of life programs and services; however, there are gaps in the services and concerns that persons with dementia do not the same access to palliative care (which focuses on providing relief from pain and other distressing symptoms of a serious illness, no matter the diagnosis or stage of disease) as other Albertans. The consequences are significant for both the individuals affected and their family members, ranging from unrelieved pain or other distressing symptoms during the time preceding death, isolation, fear, dying alone and grief to anguish experienced by family members.

The experiences of the Covid-19 pandemic has highlighted these issues and their impact regardless of whether people at this stage of life are living in their own homes, long-term care or other facilities, or hospices. While many facilities have been inventive in trying to address this need, unfortunately not all care providers make use of the round-the-clock on-line palliative care specialist services. Nor is it common for long-term care facilities to have additional staffing available to provide extra time with residents at the end of life.

An effective continuing care plan needs to ensure that dying patients are treated humanely with access to palliative care if required and other support during this time. Doing so will also relieve families from the long-term grief of knowing their loved ones suffered unnecessarily. Factors that prevent delivering this level of care need to be addressed, whether it is access to readily injectable medications, reluctance to access available specialized palliative expertise, funding models that may influence decisions to transfer patients, or inadequate knowledge in addressing end of life care needs by those providing care.

Recommendations:
1. That persons living with dementia and their family/friend caregivers understand the palliative care options at all stages of the disease, not only at end-of-life.
2. That people living with dementia have access to the same range of services as other Albertans, whether dying at home or in a care facility to allow them to die with dignity.
3. That protocols are mandated for all health care and continuing/long-term care facilities to enable designated family members to be with dying loved ones, and that those protocols balance the need to protect vulnerable individuals with the need for
humane care and comfort when dying. These protocols must recognize the needs of family members to be present and provide support through this final stage of life.

4. That the Province continue to inform caregivers, care facilities and primary care physicians about the existing specialized palliative care support available on-line 24/7 and encourage them to make use of this expertise in their care plans.

5. That the Province promote public awareness of, and make use of, the Advance Care Planning and Goals of Care tools to document personal wishes for their treatment and care, and to make these readily available at home or in facilities when needed.

CONCLUSION

The pandemic has pulled back the curtain on long-standing and well-documented issues in long-term care in Canada and elsewhere around the world. The losses of people living with dementia and those to who care for them during the pandemic has focussed attention on the need for systemic change. We applaud the Alberta government for consulting with Albertans to discuss the changes necessary to support all Albertans receiving continuing care. We hope this consultation process will result in necessary policy changes and actions, ensuring that all Albertans receive the quality care required to live out their lives with dignity and respect, now and in the future.

We would like to sincerely thank the people living with dementia, family/friend caregivers, researchers, community support workers, home care operators, facility operators and health care workers for their contribution to this submission.

Dementia Network Calgary Strategic Council Members

Katherine van Kooy, Chair
Dr. David Hogan, University of Calgary, Faculty of Medicine
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