Building Consensus on Winnipeg's Personal Care Home Paneling Criteria

by

Megan Campbell

A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

in partial fulfilment of the requirements of the degree of

MASTER OF SCIENCE

Department of Community Health Sciences

University of Manitoba

Winnipeg

Abstract

Background: It is important to ensure that the right criteria are used to admit (panel) older Manitobans into personal care homes (PCHs), so that only people who must exclusively be cared for in this setting are admitted, while all others remain supported in the community. However, research shows that 10.4% of people admitted into Winnipeg PCHs are less clinically burdened, and that Manitoba has the second highest supply of PCH beds per capita age 85 and older. This study examines the kinds of need factors (e.g., cognitive impairment), by their severity level, that community representatives believe should be used to admit people into a Winnipeg PCH (unconditionally or pending the types of community supports available).

Methods: Guided by the Anderson-Newman Behavioural Model of Health Services Utilization, a Delphi survey method was utilized to determine how need factors (both physical and psychosocial), by their severity level, should be used to make PCH admission decisions (i.e., independently or pending available community supports). The research was conducted in three sequential phases. A literature review was conducted in phase 1 to gather information to be used in the Delphi survey. Phase 2 involved creating and piloting the survey. Phase 3 involved applying the Delphi survey to a group of community representatives with experience as an informal caregiver for someone during a PCH paneling process in Winnipeg.

Results: With one exception (i.e., someone who has severe cognitive impairment or has been diagnosed with dementia/Alzheimer's), community representatives did not agree that people with severe need challenges should be admitted to a PCH unconditionally. Participants most commonly agreed on scenarios where people should almost never be admitted to a PCH, or where this admission depends on the kinds of supports available in the community.

Conclusion: With one exception, across multiple factors and severity levels, community representatives report that PCH admission decisions should consider need factors combined with the kinds of community support available, rather than need factors alone. These findings have implications on the kinds of community-based supports that should be offered in Winnipeg to prevent or delay admission to a PCH.

Acknowledgements

This thesis would not be possible without the support and valuable contribution of my committee members, Dr. Tara Stewart, Dr. Verena Menec, and Ms. Gina Trinidad. I would like to say a special thanks to my supervisor Dr. Malcolm Doupe for his guidance through this research, as well as for providing me with incredible research opportunities and experiences which have undoubtedly increased the value of my education. I am also extremely grateful to have had this research funded by the Manitoba Training Program for Health Services Research and the Research Manitoba Master's Studentship.

Thanks to the staff and students of MCHP who were there to support me, both in person and through Zoom check-ins. I would also like to acknowledge the participants in this study for taking the time to share their knowledge with me, especially during the early days of the pandemic.

Finally, to my friends and family who helped keep me sane through this process, I truly would not have been able to complete this thesis without your never-ending encouragement and support.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction

The province of Manitoba, along with the rest of the world, is experiencing a significant shift in population aging. While 6.7% of Manitoba's population is presently age 75 years and older, it is anticipated by 2037 the number of people in this age group will double (Canadian Institute for Health Information, 2017; Manitoba Health Seniors and Active Living, 2018b). This demographic shift heightens the need to ensure that health care policies, programs, and services are best aligned to meet the needs of older adults. One area that requires attention is the paneling process used to admit people into personal care homes (PCH).[1] Winnipeg's PCH system can be improved by developing clear and up to date admission criteria and by enhancing the supports that enable older adults to remain safely in the community, thereby avoiding the need for premature transition to this highest level of care (PCH).

The World Health Organization (WHO) recently published a global strategy and action plan on aging and health, which emphasizes the importance of ensuring that health systems support older adults to successfully age in place (i.e., to live independently at home or in the community, with necessary supports and services) (Federal/ Provincial/ Territorial Ministers responsible for Seniors, 2019; World Health Organization, 2017). One of the key goals of this plan is to develop sustainable and equitable systems for long term care (World Health Organization, 2017). The WHO argues people have a right to receive care in a way that maintains or preserves their highest level of function, and that health systems require re-alignment to better help older adults age in a place that best fits their needs (World Health Organization, 2017). This strategy aligns with Manitoba's mission to ensure that Manitobans

[1] In this study, the term 'PCH' will be used to refer to nursing homes, long term care facilities, continuing care facilities and any other government funded, older adult housing with 24/7 nursing care.

receive the right care, at the right time, and in the right place. According to the WHO, governments play an important role in overseeing partnerships and building consensus on the most appropriate system for providing PCH-level care (World Health Organization, 2017), which includes, in this research, determining consensus on the factors used to admit people into PCHs.

Canadian provinces are looking for cost-effective strategies to alleviate the rising costs associated with older adult care (Sinha, S. Dunning, J. Wong, I. Nici, M., 2019). It is estimated that Canada spent $20 billion in public funds on PCH care in 2018, compared to just $4 billion on community-based programs and services for older adults. Furthermore, there are approximately 40,000 Canadians on PCH waitlists, largely due to a lack of programs or services available in the community to support them (Sinha, S. Dunning, J. Wong, I. Nici, M., 2019). In some cases, people are being recommended to go on a waitlist for a PCH bed, not because of current need, but rather in an effort to plan ahead for anticipated future need (Fancey and Keefe, 2014). This suggests Canada's current care continuum for older adults is not as effective as it could be. In response, all Canadian provinces, including Manitoba, have begun enacting policies to ensure that older adults are able to thrive in the community for as long as safely possible (Alberta Health and Wellness, 2008; Cohen, 2012; Ontario Association of Community Care Access Centres, 2014), and research shows that aging in place initiatives enhance the dignity, independence, and feelings of security amongst older people (Black, Dobbs, & Young, 2012; Wiles, Leibing, Guberman, Reeve, & Allen, 2012).

Consistent with the initiatives developed by other provinces, in 2004, Manitoba Health, Seniors and Active Living (MHSAL) implemented supportive housing as a community-based congregate housing option to, in part, help avoid premature admissions to PCHs (Doupe et al.,

2011). Despite this and other expansions of services, the paneling criteria used to admit people into PCHs has not changed much since its inception (Doupe et al., 2011). While the paneling process can be viewed as the 'gatekeeper' between community and institutional care for older adults, it is unclear how well this process is working. Some evidence suggests that people are frequently being admitted to a PCH with a level and type of need that could be cared for in community-based settings – provided the appropriate services existed and were available. The Canadian Institute for Health Information (CIHI), recently published a new national indicator that demonstrates that 1 in 9 newly admitted PCH residents could potentially be cared for in the community if they had the proper supports (Canadian Institute for Health Information, 2020). Manitoba is also the province with the highest proportion of institutional admissions for people with low MAPLe scores (i.e., the Method for Assigning Priority Levels, a score used as part of the inter-RAI assessment, to prioritize service need) (Nuernberger, Atkinson, & MacDonald, 2018). Additionally, a Winnipeg based study showed that 10.4% of newly admitted PCH residents have a similar functional, cognitive, and behavioural profile to older adults residing in the community (Doupe et al., 2016). In another Winnipeg-based study that looked at PCH admission reasons for residents with care needs similar to community residing older adults, breakdowns in both community and health care and avoiding a safety crisis, were found to be largely responsible for the seemingly premature admissions (Campbell-Enns, Campbell, Rieger, Thompson, & Doupe, 2020). The results of these research studies demonstrate that more attention must be paid to the types of community supports available as alternatives to PCH care.

The need to study and update the PCH paneling criteria to more strongly consider the community services that are available, is consistent with the healthcare transformation process underway in Manitoba, to help ensure that all residents receive the right care, at the right time, in

the right place (Manitoba Health Seniors and Active Living, 2019). Implementing any major changes to the healthcare system will undoubtedly have an effect on how people transition into PCHs, therefore, it is essential to ensure that the criteria being used for admission considers the current array of community-based and PCH-level services that are available in Winnipeg, as well as what additional services are needed to prevent or delay premature PCH admission.

Following the WHO's recommendation, and in light of the changes to Manitoba's healthcare system, Winnipeg PCH paneling process should be updated, *first* to help ensure that only people requiring institutional care are admitted into these facilities, and *second* to help determine the appropriate supports that all other people require to successfully remain in the community. In determining which criteria should be used in the admission process, it is important not only to consult those who work in, and plan our healthcare system, but also the caregivers who are supporting older adults in the community. While there is an abundance of literature on risk factors for PCH admission, there is less literature that examines the perspectives of community members regarding what should be included in the PCH paneling criteria.

Guided by the Anderson-Newman Behavioural Model of Health Services Utilization (ANBM), this study utilized a Delphi method with representatives from the community who have experience with the paneling process.[2] The objective of this study was to identify, among these participants, perceptions of how need (i.e., conditions that require a need for care) and enabling (i.e., the availability of resources) factors can influence PCH admission criteria in Winnipeg. The following research question was posed:

[2] The original study plan included recruiting a second panel of participants made up of healthcare stakeholders who had experience working with the paneling process. Recruiting this latter group was not feasible given COVID-19.

To what extent can community representatives reach consensus on the need factors that (i) independently warrant PCH admission, and (ii) warrant PCH admission depending on a person's enabling factors (e.g., access to formal supports)?

It was hypothesized that respondents' degree of consensus on PCH admission decisions (i.e., always admit, never admit, admission depends) would vary pending the severity level of need factors (e.g., lowest, moderate and highest need). Respondents would concur that people with the (a) highest need severity should almost always be admitted into a PCH, (b) lowest need severity should almost never be admitted into a PCH, and (c) moderate need severity should be admitted depending on the availability of certain enabling factors (e.g., access to formal supports). The knowledge gained from this research provides insights into the types of PCH care levels and community-based services required to help Manitobans successfully age in an environment best suited to their needs. It also emphasizes that the admission criteria should not be developed devoid of discussions about the types of community-based supports available to help people.

Chapter 2: Literature Review

2.1 The Manitoba Context

In order to determine what factors should be considered when paneling for PCH admission, it is essential to first be aware of the main programs and services that are available to help support older adults as they move through Manitoba's continuing care system. For people who live in Winnipeg, there are a variety of publicly available options (see Table 1).

Table 1 - *Continuing Care Services Publicly Available in Winnipeg*

Home Care	Supportive Housing	Personal Care Home	Chronic Care Facilities
Purpose: Home Care coordinates and provides a range of services such as personal care, nursing care, household assistance, assessments and referrals etc., to help people remain living in the community. **Target Population**: People who require assistance (i.e., health services, assistance with activities of daily living etc.) and cannot receive the appropriate support from other community resources. e.g., People who need help with medication management, bathing and dressing. **Examples**: WRHA Home Care Program, Priority Home	**Purpose**: Supportive Housing is an option for people who can no longer manage to live independently, but don't yet require the level of care of a personal care home. People have their own rooms and share a living space with access to 24/7 support. Services include meals, laundry and housekeeping services, social and recreational activities. Access to supportive housing is based on a WRHA assessment process. **Target Population**: People who are physically frail and require access to supervision 24-7, but do not require 24-7 health care. e.g., Individuals with some degree of cognitive impairment and have family involved in their care. **Examples**: Rosewood Village, Harmony Court at Riverwood Square	**Purpose**: A personal care home provides personal care services to individuals who can no longer manage independently, with options such as home care or supportive housing. People are admitted into PCHs using a process where a home care case coordinator works with the individual, their family, and their health care team to complete a PCH panel assessment form. **Target Population**: People who require access to 24-7 nursing care. e.g., Individuals with physical impairments affecting ability to perform activities of daily living. **Examples**: Charleswood Care Centre, River Park Gardens	**Purpose**: Chronic care facilities help people who show little to no potential for improvement and need more care than a personal care home can provide. It offers specialized care and equipment for chronic health conditions. **Target Population**: People who require ongoing medical management and/or extensive nursing care. e.g., Individuals with traumatic brain injuries or who require complex wound care **Examples**: Riverview Health Centre, Deer Lodge Centre

One of the community-based options is the home care program. In Winnipeg there are several forms of home care, including the Winnipeg Regional Health Authority (WRHA) home care and Priority Home programs. Home care provides health care services to people living in their own homes, in an effort to keep individuals as independent as possible and subsequently delay admission into a PCH (Winnipeg Regional Health Authority, 2020b). There are a variety of programs offered under home care in Winnipeg including short and long-term care, dialysis and ostomy care, community intravenous therapy and other speciality services (Winnipeg Regional Health Authority, 2020b). Home care provides different services depending on the client's needs. Services range from personal care or nursing care, to assessment and referrals for other agencies or services (Winnipeg Regional Health Authority, 2020b). Home care also coordinates and assesses clients for PCH and supportive housing, among other speciality services

(Winnipeg Regional Health Authority, 2020b). In order to receive home care, individuals must require either health services or assistance with activities of daily living (ADLs). Between 2013-2015, 3.3% of Manitobans received home care services (Cui, Zinnick, Henderson, & Dunne, 2019). Provincial data employing a user-based analysis, also shows that use of home care is higher among low income residents (Cui et al., 2019).

In 2017, the WRHA introduced a new home care service called Priority Home, which was developed to help individuals remain in the community and prevent premature admission into PCHs (Cui et al., 2019). This intensive and short term (90 day maximum) program serves to reduce the number of patients paneled directly to a PCH from hospital (Winnipeg Regional Health Authority, 2017). The program has served over 700 clients, 85% of which were referred directly from hospital (Cui et al., 2019). This program, in addition to other community-based supports, has been credited with helping to decrease the number of older adults paneled into PCHs in recent years (Cui et al., 2019).

Next along the continuum is supportive housing. Supportive housing is a government regulated housing option that provides care to those who can no longer reside safely in their own homes, even with informal support or home care (Doupe et al., 2016). Supportive housing tenants receive services including meals, laundry, light housekeeping, 24-hour on-site assistance with personal tasks, (not including nursing care), and access to additional support services through the home care program (Doupe et al., 2016). While supportive housing has existed in Manitoba since 2004, to date MHSAL has not formally developed admission guidelines for this care option or investigated how the PCH admission criteria should be changed to reflect the expanded community-based services in Manitoba (Doupe et al., 2016).

PCHs are defined as “residential facilities which are predominately intended for adults age 75 and older that may have a chronic condition, disability or can no longer live independently” (Manitoba Health Seniors and Active Living, 2018a). In Winnipeg, PCHs are regulated and licensed by the Manitoba government (Winnipeg Regional Health Authority, 2013). The process of paneling or admitting people into a PCH is coordinated by a home care case coordinator, who works with the individual, their family, and their health care team to complete the Application/Assessment for Long Term Care Placement form (Winnipeg Regional Health Authority, 2012). This form addresses factors such as people’s physical health, functional ability, and behavioural issues (Manitoba Health Seniors and Active Living, 2010). The application is then presented to the Long Term Care Access Centre Panel Review Board which consists of physicians, Home Care, and Long Term Care Access Centre staff (Winnipeg Regional Health Authority, 2012). Once the application has been approved the individual is put on a wait list for PCH admission. If the application is rejected, community-based options are discussed with the individual and their family (Winnipeg Regional Health Authority, 2012).

Manitoba currently has 125 PCHs comprising about 10,000 beds (Chateau et al., 2012; Manitoba Health Seniors and Active Living, 2018a), with 38 of these facilities (5,549 beds) located in Winnipeg (Manitoba Health Seniors and Active Living, 2018a). Approximately 2,600 Manitoban’s aged 75+ years old are admitted to a PCH annually (Manitoba Health Seniors and Active Living, 2018a). In Winnipeg, people wait a median of four weeks for admission into a PCH, and most people (64.3%) spend this time waiting in hospital (Manitoba Health Seniors and Active Living, 2018a). The median length of stay in Manitoba PCHs has been decreasing in recent years and is now only 2 years (Manitoba Health Seniors and Active Living, 2018a),

however, evidence also shows that PCH residents in Manitoba have longer and more stable lengths of stay relative to other provinces such as Alberta (Hoben et al., 2019).

Manitoba is unique in its supply of PCH beds compared to the rest of the country. While the current Manitoba government has proposed building over 1,000 new PCH beds (CBC News Manitoba, Sept. 8, 2017), Sivananthan, Doupe, and McGregor (2014) show that Manitoba has one of the largest supplies of PCH beds in Canada, second only to Prince Edward Island. This evidence highlights the importance of ensuring Manitoba has sufficient community supports, so that older Manitobans can receive the appropriate level of care based on their needs.

On the far end of the older adult care continuum is Chronic Care, intended for those whose care needs exceed what PCHs can provide, for example, specialized wound care, and tracheostomy or gastrostomy management. Winnipeg has two chronic care facilities that care for people with specialized care needs or chronic conditions that cannot be managed in a PCH (Winnipeg Regional Health Authority, 2020a).

While there are many options to support older adults as they age, access to these care options also have to be considered. Some of the previously mentioned services (e.g., supportive housing, Priority Home etc.) have been introduced since the PCH paneling criteria were last updated, signaling the need to re-examine the current criteria in light of these new services. In addition, Manitoba's healthcare system is currently going through a significant transformation which will no doubt have repercussions on the health system as a whole. The goal of this research is to help support a small but important aspect of this transformation, by examining the kinds of guidelines that should be used to admit people into PCHs.

2.2 Theoretical Framework

This research was guided by the Andersen-Newman Behavioral Model of Health Services Utilization (ANBM) (Andersen & Newman, 1973), which was developed to measure the determinants of health services use. Since its inception as a doctoral dissertation in 1968, there have been many subsequent variations and adaptations of the model to consider both individual and societal determinants of health services use (Andersen, 2006; Andersen & Newman, 1973). The original version of the model – focusing on individual determinants – was used in this study to help develop the Delphi survey. According to the original model, health care service use can be influenced by a person's need, enabling, and predisposing characteristics (Andersen & Newman, 1973). Need factors are the most immediate cause of health service use, while enabling and predisposing factors can mediate how people with a given level of care need utilize healthcare services (Andersen & Newman, 1973).

Originally referred to as illness level, the now termed "need component" was defined as the most significant driver of health care use (Andersen, 2006; Andersen & Newman, 1973). There are two different types of needs that influence use; perceived need and evaluated need (Andersen & Newman, 1973). Perceived need occurs when an individual believes they need help and begins seeking or adhering to medical care (Andersen, 2006). Evaluated need occurs once a professional has determined the need for care, and administers medical treatment (Andersen, 2006). Perceived need includes factors such as self-rated health while evaluated need includes diagnosed medical conditions and their treatments (Andersen, 2006). While need factors are often considered to be the most relevant component of health care use, predisposing and enabling factors affect health care use in various ways, depending on the type of health service (Andersen, 2006; Luppa et al., 2009).

Enabling factors influence the extent to which someone can access or use services (Andersen & Newman, 1973). Health care service use requires both personal and community enabling resources to be present; for example, health care resources must be available in a community and people must have the ability to access them (Andersen, 2006). Predisposing factors consist of the characteristics that increase people's propensity to use health services (Andersen & Newman, 1973). These include demographic measures, social structure and health beliefs (Andersen & Newman, 1973). Enabling and predisposing factors may increase the likelihood of healthcare use, however, by themselves, they do not directly result in the use of health services (Andersen & Newman, 1973).

This study examines perspectives on how need and enabling factors determine PCH use. While predisposing factors are a significant part of the ANBM and several predisposing factors are considered important predictors of PCH admission, these are mostly unmodifiable individual characteristics. Issues of ageism, sexism or racism may arise with the use of demographic factors as admission criteria. Consequently, although things like age, sex and race may be related to the likelihood of admission, these factors along with education level, were not be included in the Delphi survey.

A more recent version of the Andersen-Newman Behavioral Model of Health Services Utilization, sometimes referred to as Phase 4, takes into account access to health care and the external environment, in addition to the individual determinants (Andersen, 1995). According to Andersen (1995), a main goal of any healthcare system is to maintain and improve the health of a population, meaning that the external environment is important for understanding how people use healthcare services. This includes the access an individual has to health services and their satisfaction with them (Andersen, 1995). The physical, social and economic environment can

also affect the health of a community. Aday (2004) states that predisposing and need factors determine the health care services that are accessible, while inequitable health care use is more strongly influenced by enabling factors (Aday, 2004). The revised version of the model also includes feedback loops to highlight how health outcomes, predisposing factors, perceived need and health behaviours can subsequently influence health services use (Andersen, 1995).

The ANBM has been used extensively in health services research (Babitsch, Gohl, & von Lengerke, 2012). It has also frequently been applied to the health care use patterns of older adults (Hajek, Bock, & König, 2017; Lo, Parkinson, Cunich, & Byles, 2016; Miller & Weissert, 2000; Vyas et al., 2017; Wolinsky & Johnson, 1991; Yang et al., 2018). While the ANBM model was created to help guide the understanding of health care use, many authors have used it only to select or categorize study variables (Carter, Yang, Davenport, & Kabel, 2019; Vyas et al., 2017), and not to guide analysis plans (e.g., understanding how enabling and predisposing factors interact with need measures to influence healthcare use).

In addition to the model being used to explain the use of health care services in general, it has also been specifically applied to study factors leading to PCH admission (Liu & Tinker, 2001; Luppa et al., 2009; Mui & Burnette, 1994). In this study, the model has been used to structure the types of factors that may influence PCH use, and also to understand how the results from the Delphi method can be applied to Winnipeg's paneling criteria. Similar to the approach used by others (Babitsch et al., 2012; Liu & Tinker, 2001; Luppa et al., 2009), an overall list of PCH admission risk factors was first generated and categorized into need and enabling measures. During the Delphi method, respondents were asked to identify the types and severity of need factors (e.g., degree of assistance to complete activities of daily living tasks) that (i) independently warrant PCH admission, or (ii) should be considered pending a person's enabling

factors (e.g., access to formal supports). This approach provides a rich understanding of how need and enabling factors could be used to guide PCH admission criteria, and also to examine the kinds of supports needed to help older adults live successfully in the community. While the approach to the survey was based on the earlier ANBM, incorporating the results within the local context aligns with the more recent version of the model.

In addition to the use of the Andersen-Newman Model, need factors can be organized into the physical and psychosocial dimensions of health. Physical factors include anything that affects the physical condition and/or use of the body. Psychosocial factors affect a person's mental or emotional state, or how they interact with others. Physical health is often the focal point for determining whether someone is considered healthy. However, health is a multifaceted concept which requires consideration of many different dimensions, therefore, it is important the PCH admission criteria reflect all aspects of health, not just physical (Greenberg, 1985). For this reason, psychosocial aspects of health were also taken into consideration. The use of these health dimensions provides further insight into (perspectives about) when people should be admitted into PCHs, and alternatively individuals who would best benefit from enabling factors in the community.

2.3 State of the Literature on PCH Admissions

Numerous authors have examined the risk factors for PCH admission over the last several decades. This literature comes from a variety of different countries around the world including Canada, the United States, the United Kingdom, Taiwan, Australia and more. Overall, the quality of the literature in this area is very good with several systematic reviews summarizing the findings (Gaugler, Duval, Anderson, & Kane, 2007; Luppa et al., 2009; Toot, Swinson, Devine, Challis, & Orrell, 2017). Many authors have used longitudinal study designs (Bharucha, Pandav,

Shen, Dodge, & Ganguli, 2004; Castora-Binkley, Meng, & Hyer, 2014; McCallum, Simons, Simons, & Friedlander, 2005), and/or have used data from national surveys (Castora-Binkley et al., 2014; Hanratty, Stow, Moore, Valtorta, & Matthews, 2018; Newman, Struyk, Wright, & Rice, 1990), and to lesser extent, administrative data (Betini et al., 2017; Jamieson et al., 2019; Maxwell et al., 2013). Most studies have large sample sizes, and use data focusing on community-dwelling older adults (Bharucha et al., 2004; Castora-Binkley et al., 2014; Freedman, Berkman, Rapp, & Ostfeld, 1994; McCallum et al., 2005). These findings, along with the actual PCH admission criteria used across three Western Canada provinces, were used to create the Delphi survey in the present study.

2.4 Literature on Risk Factors for PCH Admission

In order to determine how need and enabling factors influence PCH admission criteria it is important to determine the main risk factors that lead to admission. As has been previously noted, the literature in this area is abundant. The conditions and illnesses that are most likely to lead to PCH admission, were categorized based on the ANBM for subsequent use in the Delphi survey.

2.4.1 Need

Most of the PCH admission risk factors in the literature fall into the need category in the ANBM. Some of the most frequently described risk factors for PCH admission include declines in functional ability. Several authors have shown that challenges in conducting activities of daily living (ADL) tasks and instrumental activities of daily living (IADL) tasks, can predict PCH placement (Bharucha et al., 2004; Castora-Binkley et al., 2014; Liu & Tinker, 2001; Maxwell et al., 2013; Mui & Burnette, 1994). Impairments in physical or functional ability are also associated with placement (Luppa et al., 2009; McCallum et al., 2005). In addition, frail and pre-

frail older adults, who experience weight loss, exhaustion, weakness, slow walking speed and low physical activity, are shown to have a much greater likelihood of being admitted to a PCH than non-frail older adults (Kojima, 2016). Authors have also demonstrated that cognitive impairment is associated with admission (Luppa et al., 2009; Maxwell et al., 2013; Mui & Burnette, 1994).

The presence of chronic conditions and diagnosed disorders are often noted as risk factors for admission in the literature. Medical conditions found to be associated with PCH admission include neurological disorders, skeletal muscular disease, and impaired peak respiratory flow (Castora-Binkley et al., 2014; Liu & Tinker, 2001; McCallum et al., 2005). While there is evidence that cardiovascular disease is associated with PCH admission (Liu & Tinker, 2001), the evidence is slightly mixed, as Castora-Binkley et al. (2014), found that cardiovascular disease's association with admission became non-significant when controlling for other forms of mortality. Dementia is one of the most common diagnoses associated with PCH admission (Bharucha et al., 2004; Luppa et al., 2009). In a 12-year longitudinal by Bharucha et al. (2004), dementia was found to be the strongest predictor of PCH admission. A meta-analysis by Toot, Swinson, Devine, Challis, and Orrell (2017) also shows that having multiple comorbidities may be a risk factor for admission, although the findings are inconsistent. Two research groups have shown that people with poor or no bladder continence are at a higher risk of PCH placement, versus those who are usually or completely continent (Maxwell et al., 2013; McCallum et al., 2005).

Psychosocial risk factors are also strongly associated with PCH admission. Mental health (e.g., depression) and behavioural (e.g., aggression) challenges have been shown to predict PCH admission (Maxwell et al., 2013; McCallum et al., 2005). In addition, general health instability is

also a predictor of PCH placement (Maxwell et al., 2013). Similarly, evidence also shows that low self-rated health is a significant predictor of PCH admission (Castora-Binkley et al., 2014; Luppa et al., 2009; Miller & Weissert, 2000).

Previous health care use is also a risk factor for PCH admission. Evidence shows that older adults who have previously resided in a PCH (e.g., short-stay respite), are at high risk of re-admission (Castora-Binkley et al., 2014; Luppa et al., 2009; Miller & Weissert, 2000). Likewise, recent hospitalizations or emergency department visits may also lead to placement (Maxwell et al., 2013), although it is has been well established that many PCH admissions start from hospital (Manitoba Health Seniors and Active Living, 2018a), and hence these findings may be tautological. Taking a large number of prescription medications has been found to be a risk factor for admission (Castora-Binkley et al., 2014; Luppa et al., 2009; Miller & Weissert, 2000). Bharucha et al. (2004) showed that the interaction between dementia and number of prescription drugs statistically influenced PCH admission.

2.4.2 Enabling

Enabling factors associated with PCH admission include social relationships, living situation and availability of appropriate care either through formal or informal caregivers. One of the most common such factors found in the literature concerns social relationships. Older adults with poor social support are considered to be at a higher risk of PCH admission (Bharucha et al., 2004; Luppa et al., 2009; Maxwell et al., 2013). According to a study by Freedman, Berkman, Rapp, and Ostfeld (1994), the absence of regular contact with a spouse is associated with increased PCH admission for men, while women were more likely to be admitted if they had a small social network. In addition, feelings of loneliness were found to lead to admission, independent of actual social isolation (Hanratty et al., 2018).

Living alone has also been associated with PCH admission (Jamieson et al., 2019; Miller & Weissert, 2000). Several authors have also shown that not owning a home increases the risk of admission, (Luppa et al., 2009; Miller & Weissert, 2000). According to Newman, Struyk, Wright, and Rice (1990), home ownership can protect against admission because it leads to the use of formal supports, although this could also be reflective of one's financial situation.

The presence of caregiving is also associated with PCH admission. The use of paid or formal caregiving has been associated with an increased risk of PCH admission (Newman et al., 1990). A synthesis done by Miller and Weissert, (2000) supports this finding. This synthesis also showed that the presence of an informal caregiver can increase the risk of PCH placement (Miller & Weissert, 2000). According to a Canadian study by Betini et al. (2017), people receiving care from a spouse or other non-child caregiver were more likely to be admitted than those being cared for by a co-residing child. The presence of caregiving may indicate that an individual's health is rapidly declining, making them more likely to require PCH care. Additionally, caregiver distress has been found to predict PCH admission (Betini et al., 2017; Jamieson et al., 2019). If a caregiver becomes too burdened or overwhelmed to manage the care requirements, admission may be the only option.

2.4.3 Predisposing Characteristics

Several predisposing factors (e.g., age, sex, race) are associated with PCH admission. Most studies that examine risk factors leading to PCH admission recognize the significance of increasing age on likeliness of admission (Betini et al., 2017; Bharucha et al., 2004; Castora-Binkley et al., 2014; Liu & Tinker, 2001; Luppa et al., 2009; Maxwell et al., 2013; McCallum et al., 2005). There have been some studies that link sex to the likelihood of PCH admission, with women being more likely to enter a PCH than men (Castora-Binkley et al., 2014; Liu & Tinker,

2001). This latter evidence is inconsistent, with some studies showing a non-significant relationship between PCH admission and sex (Bharucha et al., 2004). Ethnicity can also influence the likelihood of PCH admission, however, the evidence is also slightly mixed. A United States based study by Castora-Binkley et al. (2014) found that Black race increases the risk of long term PCH placement in men. Conversely, a number of studies have shown that being White significantly increases the risk of PCH admission (Luppa et al., 2009; Mui & Burnette, 1994).

Social structural factors such as education may also influence likelihood of admission. Several studies have found that higher level of education are associated with an increased risk of PCH admission (Castora-Binkley et al., 2014; Liu & Tinker, 2001).

Chapter 3: Methods

This research occurred in three phases. The first phase involved gathering the information to be used in the Delphi method. The second phase involved creating the Delphi survey questionnaire using evidence from the literature combined with the actual admission criteria used in three Canadian provinces. The third phase involved applying the Delphi survey to a group of community representatives to reach consensus on the ways in which need and enabling factors interact to influence PCH admission.

3.1 The Delphi Method

This study used a modified Delphi method to determine consensus on need factors that either independently warrant PCH admission, or warrant admission pending enabling factors. A Delphi is a type of survey that uses expert opinion to determine consensus on a topic through a series of questionnaires and feedback processes (Keeney, Hasson, & McKenna, 2011). This

method has been adopted for use across a variety of disciplines including health research (Keeney et al., 2011). The Delphi method relies on the premise that group opinion is more reliable and valid than individual option (F. J. Gill, Leslie, Grech, & Latour, 2013). It is an appropriate study design to use when the goal is to develop consensus based guidelines or criteria (Page, Potter, Clifford, McLachlan, & Etherton-Beer, 2015).

There are a few ways in which this Delphi study differs from the classical Delphi method. In a classical Delphi method, the first survey round would ask participants to identify an initial list of factors for use in later rounds (e.g., to document all factors they believe are important to consider during the PCH panel process) (Keeney et al., 2011). In the present study, however, this initial list of factors was determined based on a review of the literature and the current paneling criteria used across Manitoba, Alberta and British Columbia. This modified method lessened the workload on the participants and ensured the factors used in the questionnaire were supported by evidence. In Delphi round one, expert participants were asked to first determine whether various need factors warranted PCH admission, and second to provide additional factors they felt were missing. In the following survey rounds, participants were asked to compare their responses to those made by their peers and were given the opportunity to adjust their 'round one' responses if necessary. This process occurred three times, after which the final respondent consensus was determined.

Another way this study differs from the classical method is with the use of a web-based Delphi (e-Delphi). In this study, the questionnaires were administered through SimpleSurvey (Outsidesoft Solutions Inc, 2020), a commercially available online survey tool, instead of pen and paper (F. J. Gill et al., 2013; Helms, Gardner, & McInnes, 2017). There are a number of benefits to using an e-Delphi method. Not only is it more time-efficient than postal distribution,

but it also can assist with data analysis and panel feedback, as the results can be downloaded directly into an excel file (Gill et al., 2013).

3.2 Phase One: Literature Search for Admission Risk Factors

Phase one involved gathering the information to be used in the Delphi method. This consisted of a review of the related literature and the identification of the admission criteria currently used in Manitoba, Alberta and British Columbia.

Given the substantial amount of literature regarding risk factors for PCH admission, certain search criteria were used to identify studies for inclusion in this phase. Studies using multivariable modeling to determine the unique effect of risk factors were included, as well as systematic reviews and meta-analyses of multivariable studies. The academic databases searched included MEDLINE, Cochrane Library, PsychINFO, CINAHL and PubMed. Key search terms used included “Institutionalization” OR “nursing home placement” OR “nursing home admission” AND “older adults” OR “seniors” OR “elderly” AND “admission” OR “risk” OR “risk factor” OR “predictor” OR “criteria”. The review of the literature concluded once the identification of risk factors reached saturation, meaning that no new risk factors were found by reading additional articles. Any risk factor that was reported to be statistically significant for admission to a PCH in two or more studies were extracted from the included articles. Risk factors were then categorized as either predisposing, enabling or need factors, however, only the enabling and need factors were used in the Delphi survey.

In addition to the risk factors found in the literature, the PCH admission criteria was also obtained from Manitoba, Alberta and British Columbia, with more emphasis placed on Manitoba’s criteria. The criteria used to admit people in these provinces was compared to the

results of the literature review. Additional factors not included in literature, were added to the list of need and enabling factors.

3.3 Phase Two: Survey Creation

The final Delphi survey questionnaire used in this study is provided in Appendix A. The questionnaire starts with an introductory page that explains the purpose of the study and provides general instructions. Participants were then provided a reminder about the study context including the types of formal continuing care services that are offered in Winnipeg and who they are intended for (see Table 1). This section provides participants with baseline knowledge about the care continuum in Manitoba, hence ensuring that they were well-informed to discuss factors warranting PCH admission.

Next, participants were provided directions on how to fill out the survey based on the scoring system. Participants were asked to consider each need factor, independent of any other conditions a person may have, based on three severity levels; for example, a) requires verbal prompting or limited assistance with at least one ADL, b) requires weight-bearing help to complete at least one ADL, c) fully dependent on others to complete at least one ADL. A short description of each factor was provided to ensure everyone was using the same definitions. For each level of need severity, participants had the option of selecting:

a) *almost never warrants admission* (i.e., the issue by itself does not warrant care in a PCH);

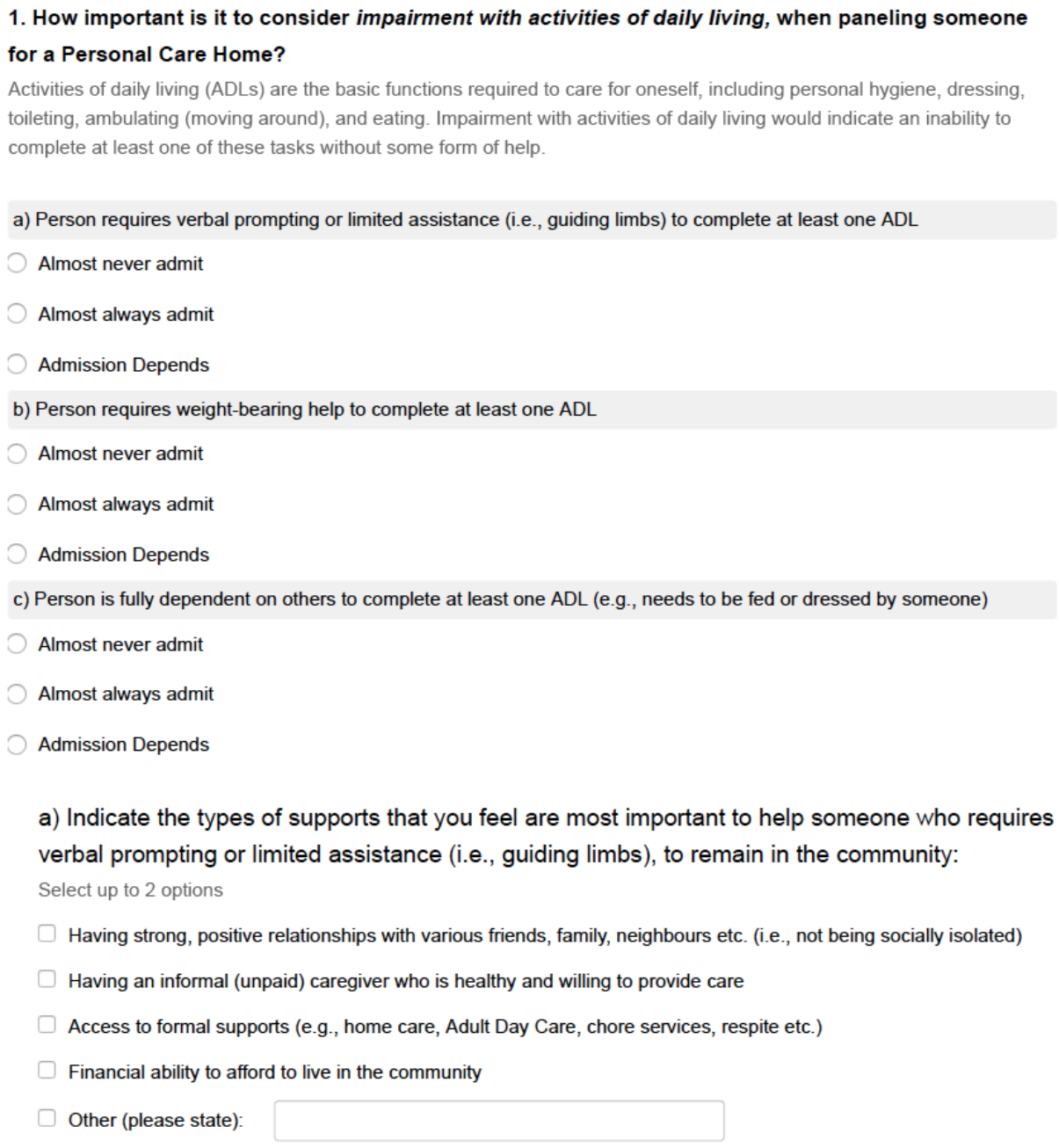
b) *almost always warrants admission* (i.e., the issue requires admission, independent of the type of supports people have in the community); or

c) *admission depends on the types of supports people have in the community*

If the last option was chosen, participants were then asked to select up to two types of supports that could help someone with this level of need to remain in the community (e.g., having an informal caregiver who is healthy and willing to provide care, access for formal supports etc.). The list of supports for admission depends came from the literature on enabling factors for PCH admission.

Participants were also provided an opportunity to leave a comment explaining each of their responses. These comments were provided anonymously in subsequent rounds to help others think about rescoring their responses. An example of a survey question is provided in Figure 1.

Figure 1 - Example of Survey Question Format



1. How important is it to consider *impairment with activities of daily living,* when paneling someone for a Personal Care Home?

Activities of daily living (ADLs) are the basic functions required to care for oneself, including personal hygiene, dressing, toileting, ambulating (moving around), and eating. Impairment with activities of daily living would indicate an inability to complete at least one of these tasks without some form of help.

a) Person requires verbal prompting or limited assistance (i.e., guiding limbs) to complete at least one ADL

- Almost never admit
- Almost always admit
- Admission Depends

b) Person requires weight-bearing help to complete at least one ADL

- Almost never admit
- Almost always admit
- Admission Depends

c) Person is fully dependent on others to complete at least one ADL (e.g., needs to be fed or dressed by someone)

- Almost never admit
- Almost always admit
- Admission Depends

a) Indicate the types of supports that you feel are most important to help someone who requires verbal prompting or limited assistance (i.e., guiding limbs), to remain in the community:

Select up to 2 options

- Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- Having an informal (unpaid) caregiver who is healthy and willing to provide care
- Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- Financial ability to afford to live in the community
- Other (please state):

Next was the consent section. Participants were required to consent to have their results included in the study, to have subsequent survey rounds sent to them and to be involved for the

duration of the study. Participants had to provide consent in order to access the actual Delphi survey.

Respondents were next asked to provide some basic characteristics including their age, sex, and PCH paneling experience. Participants were asked whether they had ever been involved in the paneling process, for how many people and how long ago, or if they had ever been paneled themselves. In addition, participants were asked to write a few sentences describing their experience with the paneling process. This text was summarized to present the varying types of experiences people had with the paneling process and to better inform the results of the survey.

The final section of the questionnaire consists of the actual survey questions. The need factors used in the questionnaire came from the results of the literature search, the actual admission criteria used in Manitoba, Alberta and British Columbia, and from participant suggestions provided in the first survey round. Severity level categories (e.g., cut-points) were created based on the RAI-MDS 2.0, Manitoba's current paneling criteria, and other commonly accepted scales in the literature. Further details about these severity levels are presented in the Results Chapter.

3.3.1 Piloting the survey

Once a draft of the questionnaire was created, it was reviewed by the academic supervisory committee, and as a result, question format, wording and content were revised. The survey was then transferred to the online survey platform, SimpleSurvey (Outsidesoft Solutions Inc, 2020). Two community representatives piloted the survey. The piloting process ensured that the general format, survey directions, and explanation of factors were understandable and clear. This process has been shown to improve participant response rates (Fan & Yan, 2010). The feedback from the piloting process was positive, and the questionnaire was thought to be

straightforward and easy to complete. Changes made as a result of the piloting process included clarifying the definitions of the care continuum options, streamlining survey directions, and fixing typographic errors. The final version of the Delphi survey questionnaire was approved by the thesis committee.

3.4 Phase Three: Conducting the Delphi Survey

3.4.1 Study Sample and Recruitment

The Delphi method requires experts to participate in the survey process (Keeney et al., 2011). The appropriate sample size to use with the Delphi method varies in the literature and can range anywhere from 3 to 418 participants (Boulkedid, Abdoul, Loustau, Sibony, & Alberti, 2011), but it is generally accepted that somewhere between 10 and 18 experts should be chosen for survey panels (Baines & Regan de Bere, 2018). As inclusion criteria, participants were selected for the study if they had been an informal caregiver for someone paneled to a Winnipeg PCH. Anyone who was unable to give consent, for example, due to cognitive impairment, was excluded from participating in the study. Cognitive impairment was established through self-declaration, and all participant's eligibility was confirmed through a phone conversation with the primary investigator (PI).

Recruitment of study participants occurred between February and March 2020, and occurred in four main ways. First, a recruitment poster was distributed on social media (Facebook and Twitter) by the Centre on Aging at the University of Manitoba, as well as in their bi-weekly email updates. Second, the Manitoba SPOR PIHCI Network's (MPN) Patient/Public Research Partnership Network sent the recruitment information to their patient partners. Participants were also identified using the social and professional networks of the PI and supervisors (Baines & Regan de Bere, 2018). Lastly, a significant number of participants were

recruited through snowball sampling, whereby recruited participants were asked to share the recruitment information with anyone else they knew who had experience with the paneling process (Sudore et al., 2017).

Once the expert panel was formed, the PI held individual phone calls with each participant to ensure that everyone adequately understood the continuing care service options in Winnipeg. A table highlighting the formal continuing care services available in Winnipeg was provided to all participants prior to the scheduled one-on-one calls (see Table 1). To start the discussion, all participants were first made aware of the purpose and design of the study and were provided an opportunity to ask any questions they had about the survey process. The remainder of the call focused on going through the options provided on the table. All participants were aware of, and understood, the purpose of home care and PCHs, consequently, more time was spent discussing supportive housing and chronic care. Assisted living, as opposed to supportive housing, was described as private services that are not part of the array of publicly operated continuing care services (e.g., there is no formal admission process with entry and exit criteria). The differences between PCHs and chronic care facilities were also clarified for participants. All participants were able to ask questions and the PI ensured everyone properly understood and felt comfortable with the various continuing care options available in Winnipeg, before the survey officially began.

3.4.2 Data Collection and Analysis

Data were collected over three survey rounds conducted between April and June 2020. Data collection occurred using a series of online questionnaires with the SimpleSurvey platform (Outsidesoft Solutions Inc, 2020). Most study participants were emailed a link to round one of the online questionnaire. The PI also facilitated the survey over the phone for one participant

who was not able to complete the survey online. All participants were given two weeks to complete the survey and were provided a reminder with one-week left and one-day left.

During each survey round, participants were asked to rate whether the type and severity of each need factor (e.g., impairment with activities of daily living tasks) should be considered during the PCH paneling process. Participants were initially given a list of 13 need factors, each broken into three severity levels (e.g., ADL impairment severity levels - requires verbal prompting or limited assistance, requires weight-bearing help and full dependence). Participants were then asked to choose whether each need factor severity level should:

a) *almost never warrant admission*;

b) *almost always warrant admission*; or

c) *admission depends on the types of supports that people have in the community*. If this latter option was selected, participants were asked to define the type of enabling factor that should be considered (e.g., having an informal caregiver who is healthy and willing to provide care, access for formal supports, etc.).

Participants were also asked to provide comments rationalizing their score and were given the opportunity to add any additional factors they felt were missing from the first round.

During round two, participants received individualized feedback comprised of their own round one results compared with the aggregate scores of all other participants. They were also provided with an anonymized list of the comments written by their peers in round one. Participants were then asked to critically review this information and re-complete the questionnaire with this additional knowledge. This same process occurred for round three of the survey.

Need factors were accepted based on the level of consensus reached. There is no standard approach for determining consensus opinions using the Delphi method (Keeney et al., 2011), and commonly used approaches include percentages; measures of central tendency such as mean, median or mode; and levels of dispersion, such as standard deviation or inter-quartile range (Annear et al., 2015). When using percentage to establish consensus, a cut point between 75-80% has been recommended (Annear et al., 2015). Consensus in this study was determined a priori using a variation of the method established by Van Der Steen et al. (2014), whereby high consensus was defined as >80%, moderate consensus was defined between 60-79.9% agreement, and no consensus was defined as <59.9%. Any need factor that reached a high level of consensus for all three of the severity levels was removed from subsequent survey rounds.

Chapter 4: Results

4.1 Defining Need Factors for the Delphi Survey

This study examines the extent to which community representatives can reach consensus on the need factors that (i) independently warrant PCH admission, and (ii) warrant PCH admission conditional on enabling factors. Need factors were developed from reviewing the relevant literature; by examining paneling criteria in Manitoba, Alberta and British Columbia; and from suggestions made by participants in round one of the Delphi survey. Seventeen (17) factors were included in this study; 9 of these factors were derived from the literature, four were selected from provincial paneling criteria, and four were developed from round one survey results. This section describes how need factors were selected, and also defines how the severity levels for each factor were determined.

4.1.1 Factors from the Literature

Over 700 titles and abstracts were scanned from the literature search, 33 articles were reviewed in full, and data were extracted from 12 articles. A description of each risk factor (e.g., references to the academic literature, findings reported by other researchers) is presented in Table 2. Details about the severity levels for each risk factor are provided in Table 3.

Impairment with activities of daily living was a risk factor for PCH admission in several studies (Castora-Binkley et al., 2014; Gaugler et al., 2007; Liu & Tinker, 2001; Maxwell et al., 2013; Miller & Weissert, 2000; Mui & Burnette, 1994; Toot et al., 2017). In the present study, severity levels were created based on collapsing the six original categories of the RAI-MDS 2.0 Hierarchical ADL outcomes scales, into three categories (Canadian Institute for Health Information, 2006).

Similarly, authors frequently identified impairment with instrumental activities of daily living as a risk factor for PCH admission (Bharucha et al., 2004; Castora-Binkley et al., 2014; Gaugler et al., 2007; Luppa et al., 2009; Miller & Weissert, 2000; Toot et al., 2017). The severity levels for this factor were created by examining the Lawton Instrumental Activities of Daily Living Scale (Graf, 2008).

Several authors have reported that people taking more prescription medications are more likely to be admitted into a PCH (Bharucha et al., 2004; Luppa et al., 2009; Miller & Weissert, 2000). Categories for this factor (i.e., counts of prescription medications) were determined from a CIHI report on older adult drug use (The Canadian Institute for Health Information, 2018).

Independent of all other risk factors, people with multiple comorbidities are at increased risk of PCH admission (Miller & Weissert, 2000; Toot et al., 2017). The severity levels for this

factor were created from a study by Huang et al. (2014), which used the Charlson Comorbidity Index (Charlson, M.E., Pompei, P., Ales, K.L., MacKenzie, 1987).

Bladder incontinence is another risk factor for PCH admission (Maxwell et al., 2013; McCallum et al., 2005). The severity levels for this factor were created by collapsing the continence self-control categories reported in the RAI-MDS 2.0 tool (Canadian Institute for Health Information, 2006).

Several authors have reported that cognitive impairment is a significant risk factor for PCH admission (Bharucha et al., 2004; Gaugler et al., 2007; Luppa et al., 2009; Maxwell et al., 2013; Miller & Weissert, 2000; Mui & Burnette, 1994; Toot et al., 2017). The severity levels for this factor were created by collapsing the original six categories of Cognitive Performance Scale in the RAI-MDS 2.0, to three categories. (Canadian Institute for Health Information, 2006).

Psychological symptoms such as anxiety, depression or hallucinations can increase the risk of PCH admission (McCallum et al., 2005; Miller & Weissert, 2000; Toot et al., 2017). The severity levels for this factor were developed based on the incidence of mental health symptoms, with the most common symptoms being used as the lowest severity level (e.g., the 3-year incidence rate for major depressive disorders in older adults is 3.38% compared to 0.54% for bipolar disorder) (Chou, Mackenzie, Liang, & Sareen, 2011).

Certain problematic behaviours, such as wandering and aggression, can also increase the risk of PCH admission (Maxwell et al., 2013; Miller & Weissert, 2000; Toot et al., 2017). The issues listed in this factor are based on the behaviour symptoms scale in the RAI-MDS 2.0 (Canadian Institute for Health Information, 2006), and the order of severity was adapted based on the Cohen-Mansfield Agitation Inventory (Cohen-Mansfield, 1986) .

Poor self-rated health has been frequently associated with PCH use (Castora-Binkley et al., 2014; Luppa et al., 2009). The severity levels of this factor were based on cut points used by others in the academic literature (Benyamini & Idler, 1999).

4.1.2 Factors from the Paneling Criteria

Need factors were also added based on a review of the actual PCH paneling forms used in Manitoba, Alberta and British Colombia. This review added an additional four factors.

The complexity of people's care needs is included as part of Manitoba and Alberta's PCH paneling criteria. The severity levels of this factor were based on the professional intervention section reported in Manitoba's PCH paneling form (Alberta Health Services, 2010; Manitoba Health Seniors and Active Living, 2010).

Specific medical conditions are considered when making PCH admission decisions in Manitoba (Manitoba Health Seniors and Active Living, 2010), and severity levels for this factor were based on the severity and control of these conditions.

Bowel incontinence is included in the admission criteria in all three provinces (Alberta Health Services, 2010; British Columbia Ministry of Health, 2019; Manitoba Health Seniors and Active Living, 2010). Bowel incontinence severity levels were created by collapsing the incontinence outcome scales in the RAI-MDS 2.0 from five to three categories (Canadian Institute for Health Information, 2006).

Manitoba's paneling assessment form asks questions about smoking and substance abuse (e.g., alcoholism). Severity levels for this factor are based on the extent to which people use these substances according to the literature, with the most common substances being used as the lowest severity level. For example, the 3-year incidence rate for nicotine dependence in older

adults is 3.38% compared to 0.40% for alcohol dependence and 0.29% for other drug dependence (Chou et al., 2011).

4.1.3 Additional Factors from Survey Participants

Participants suggested including 21 additional factors during round one of the survey (several participants suggested the same factor). New factors were added if they could be categorized as a need or enabling factor, and if there was some basis, either in the literature or in the provincial paneling criteria, to support their inclusion. One new enabling factor (i.e., having a safe home environment) and four new need factors (i.e., loneliness, mobility, vision loss, hearing loss) were added to the Delphi questionnaire based on this information. Further information about these factors, and their severity levels, is provided in Tables 2 and 3, respectively.

Table 2 Need Factors for PCH Admission Found in the Literature

Factor	Article	Types of Methodology[1]	Study Finding[2]	Statistical Significance	Type of Variable
Impairment with ADLs	Toot, 2016	Review	Varies by Study	Significance varies between p = 0.27 and p = 0.001	Varies by study
	Castora-Blinkley, 2014	Multivariate Analysis	Increased Risk	Hazard Ratio 1.12 95% CI (1.02-1.22) for women	Continuous
	Maxwell, 2013	Multivariate Analysis	Increased Risk	Adjusted Hazard Ratio 1.52 95% CI (1.03–2.22) for Extensive Assistance required	Categorical
	Luppa, 2010	Review	Increased Risk	Strong evidence	Varies by study
	Gaugler, 2007	Review	Increased Risk	Odds Ratio 3.25, 95% CI (2.56-4.09)	Varies by study
	McCallum, 2005	Multivariate Analysis	Increased Risk	Hazard Ratio 1.59 95% CI (1.07-2.35) for Severely Impaired	Categorical
	Lui, 2001	Multivariate Analysis	Increased Risk	Adjusted Odds Ratio 3.0, 95% CI (2.8-3.3)	Continuous
	Miller, 2000	Review	Increased Risk	Positive significance[+]	Varies by study
	Mui, 1994	Multivariate Analysis	Increased Risk	Odds Ratio, 1.22, p = < .01	Categorical
Impairment with IADLs	Toot, 2016	Review	Increased Risk	Significance varies between p = 0.05 and p = 0.001	Varies by study
	Castora-Blinkley, 2014	Multivariate Analysis	Increased Risk	Hazard Ratio 1.2 95% CI (1.09-1.31) for women	Continuous
	Luppa, 2010	Review	Increased Risk	Strong evidence	Varies by study
	Gaugler, 2007	Review	No Relationship	Odds Ratio .98, 95% CI (.71-1.36)	Varies by study
	Bharucha, 2004	Multivariate Analysis	Increased Risk	Hazard Ratio 1.31, 95% CI (1.15-1.50)	Continuous
	Miller, 2000	Review	Increased Risk	Positive significance[+]	Varies by study

Table 2 – Continued

Factor	Article	Types of Methodology[1]	Study Finding[2]	Statistical Significance	Type of Variable
Number of prescription medications	Luppa, 2010	Review	Increased Risk	Strong evidence	Varies by study
	Bharucha, 2004	Multivariate Analysis	Increased Risk	Hazard Ratio 1.21 95% CI (1.11-1.32)	Continuous
	Miller, 2000	Review	Increased Risk	Positive significance[+]	Varies by study
Complexity of care needs	From Provincial PCH Assessments	N/A	N/A	N/A	N/A
Stage of diagnosed medical condition	From Provincial PCH Assessments	N/A	N/A	N/A	N/A
Number of comorbidities	Toot, 2016	Review	Increased Risk	Not provided	Varies by study
	Miller, 2000	Review	Increased Risk	Positive significance[+]	Varies by study
Bladder continence	Maxwell, 2013	Multivariate Analysis	Increased Risk	Adjusted Hazard Ratio 1.58 95% CI (1.15–2.19) for no control	Categorical
	McCallum, 2005	Multivariate Analysis	Increased Risk	Hazard Ratio 1.66 95% CI (1.13-2.44)	Categorical
Bowel continence	From Provincial PCH Assessments	N/A	N/A	N/A	N/A

Table 2 – Continued

Factor	Article	Types of Methodology[1]	Study Finding[2]	Statistical Significance	Type of Variable
Cognitive impairment	Toot, 2016	Review	Varies by Study	Significance varies between p = 0.094 and p = < 0.001	Varies by study
	Maxwell, 2013	Multivariate Analysis	Increased Risk	Adjusted Hazard Ratio 2.66 95% CI (1.56–4.53) for Mod, Severe and Very Severe Impairment	Categorical
	Luppa, 2010	Review	Increased Risk	Strong evidence	Varies by study
	Gaugler, 2007	Review	Increased Risk	Odds Ratio 2.54, 95% CI (1.44 - 4.51)	Varies by study
	Bharucha, 2004	Multivariate Analysis	Inconsistent Results	Hazard ratio 1.05, 95% CI (0.97-1.13) for Cognitive Functioning; Hazard ratio 5.09, 95% CI (2.92-8.84) for Dementia diagnosis	Continuous
	Miller, 2000	Review	Increased Risk	Positive significance[+]	Varies by study
	Mui, 1994	Multivariate Analysis	Increased Risk	Odds Ratio 1.21, p < .05	Categorical
Psychological symptoms	Toot, 2016	Review	Increased Risk	Not provided	Varies by study
	McCallum, 2005	Multivariate Analysis	Increased Risk	Hazard Ratio 1.85 95% CI (1.22-2.82) for Tertile 3	Categorical
	Bharucha, 2004	Multivariate Analysis	No Relationship	Hazard Ratio 0.80, 95% CI (0.48-1.34)	Categorical
	Miller, 2000	Review	Increased Risk	Positive significance[+]	Varies by study

Table 2 – Continued

Factor	Article	Types of Methodology[1]	Study Finding[2]	Statistical Significance	Type of Variable
Substance use	From Provincial PCH Assessments	N/A	N/A	N/A	N/A
Problematic behaviours	Toot, 2016	Review	Increased Risk	Significance varies between p = 0.004 and p = < 0.001	Varies by study
	Maxwell, 2013	Multivariate Analysis	No Relationship	Adjusted Hazard Ratio 1.93 95% CI (0.91–4.08) for very severe	Categorical
	Miller, 2000	Review	Increased Risk	Positive significance[+]	Varies by study
Self-rated health	Castora-Binkley, 2014	Multivariate Analysis	Increased Risk	Hazard Ratio 1.09 95% CI (1.00-1.19)	Categorical
	Luppa, 2010	Review	Increased Risk	Strong evidence	Varies by study
	Gaugler, 2007	Review	No Relationship	Odds Ratio .90, 95% CI (.58 - 1.39)	Varies by study
Feelings of Loneliness*	Jamieson, 2019	Multivariate Analysis	Increased Risk	Adjusted Risk Regression Hazard Ratio 1.18, 95% CI (1.13 - 1.24)	Categorical
	Hanratty, 2018	Multivariate Analysis	Increased Risk	Significance varies between p = 0.05 and p = 0.0002	Continuous

Table 2 – Continued

Factor	Article	Types of Methodology[1]	Study Finding[2]	Statistical Significance	Type of Variable
Mobility*	Toot, 2016	Review	Increased Risk	Significance varies by study from not significant to p = 0.007	Varies by study
	Maxwell, 2013	Multivariate Analysis	No Relationship	Not provided	Categorical
	Miller, 2000	Review	Increased Risk	Positive significance[+]	Varies by study
Vision loss*	From Provincial PCH Assessments and Participant Feedback	N/A	N/A	N/A	N/A
Hearing loss*	From Provincial PCH Assessments and Participant Feedback	N/A	N/A	N/A	N/A

Note:

[1] Types of Methodologies can include: (1) Reviews (e.g., Systematic reviews, meta-analyses, syntheses), (2) Multivariate Analysis

[2] Study Findings can show: (1) No relationship, (2) Factor increases risk of admission, (3) Factor decreases risk of admission, (4) Inconsistent results

[+] Positive Significance: the number of positive significant results was greater than 85 percent of all significant results

* Factor was added by participants after round one

Abbreviations: ADL – Activities of Daily Living, IADL – Instrumental Activities of Daily Living, CI – Confidence Interval

Table 3 - Full List of Survey Factors and Severity Levels

Factor	Factor Severity Levels		
	Lowest Severity	**Moderate Severity**	**Highest Severity**
Impairment with activities of daily living	Person requires verbal prompting or limited assistance (i.e., guiding limbs) with at least one ADL	Person requires weight-bearing help to complete at least one ADL	Person is fully dependent on others to complete at least one ADL (e.g., needs to be fed or dressed by someone)
	Based on: RAI-MDS 2.0, (Canadian Institute for Health Information, 2006)		
Impairment with instrumental activities of daily living	Person requires supervision or limited assistance (i.e., prompting) to complete on at least one IADL	Person requires extensive assistance to complete instrumental activities of daily living (e.g., needs to be accompanied on shopping trips)	Person is fully dependent on help to complete instrumental activities of daily living (e.g., requires someone to prepare and serve their meals)
	Based on: Lawton Instrumental Activities of Daily Living Scale, (Graf, 2008)		
The number of prescription medications a person is taking	Person takes 5 or fewer different prescription medications	Person takes 6-14 different prescription medications	Person takes 15 or more different prescription medications
	Based on: Drug Use Among Seniors in Canada, (2016 Canadian Institute for Health Information, 2018)		
The complexity of care needs	Person is independent or requires infrequent care throughout the day (e.g., medication distribution in morning and evening)	Person requires interventions every few hours (e.g., application of ointments every 2-4 hours)	Person requires frequent (i.e., constant to hourly) and/or complicated interventions (e.g., oxygen therapy)
	Based on: Application/Assessment for Long Term Care Placement, (Manitoba Health Seniors and Active Living, 2010)		
The stage of diagnosed medical conditions	Condition is controlled through medication or treatments but may cause instability in mood, behaviours etc.	Condition has acute episodes or flair-ups (e.g., frequent episodes of swelling and pain from Arthritis)	Person suffers daily from condition (e.g., Parkinson's tremors)
	Based on: Application/Assessment for Long Term Care Placement, (Manitoba Health Seniors and Active Living, 2010)		

Table 3 – Continued

Factor	Lowest Severity	Moderate Severity	Highest Severity
The number of comorbidities a person has	Person has 2 or less chronic conditions	Person has 3-4 chronic conditions	Person has 5 or more chronic conditions
	Based on: Charlson Comorbidity Index, (Charlson, 1987)		
Bladder continence	Usually Bladder Continent (Bladder incontinent 2 or less times a week)	Occasionally to Frequently Bladder Incontinent (Bladder incontinent daily, although some control is present)	Bladder Incontinent (Bladder incontinent multiple times daily)
	Based on: RAI-MDS 2.0, (Canadian Institute for Health Information, 2006)		
Bowel continence	Usually Bowel Continent (Bowel incontinent less than weekly)	Occasionally to Frequently Bowel Incontinent (Bowel incontinent up to 2 or 3 times a week)	Bowel Incontinent (Bowel incontinent almost all the time)
	Based on: RAI-MDS 2.0, (Canadian Institute for Health Information, 2006)		
Cognitive impairment	Person has mild cognitive impairment (i.e., experiences some trouble with cognitive skills and sometimes has trouble making themselves understood)	Person has moderate cognitive impairment (i.e., experiences moderate impairment with cognitive skills for daily decision-making (e.g., can't remember the day of the week), has trouble making themselves understood)	Person has severe cognitive impairment or has been diagnosed with Dementia/Alzheimer's (i.e., severe impairment with cognitive skills and depends on help for activities (e.g., eating))
	Based on: RAI-MDS 2.0, (Canadian Institute for Health Information, 2006)		
Psychological symptoms	Person frequently experiences anxiety or depression	Person has a diagnosed mental health disorder (e.g., bipolar disorder)	Person experiences periods of psychosis and/or hallucinations
	Based on: Three-year incidence of psychiatric disorders among older adults aged 60 and older (Chou et al., 2011)		

Table 3 – Continued

Factor	Lowest Severity	Moderate Severity	Highest Severity
Substance use	Regularly smokes (e.g., cigarettes, cannabis)	Alcohol dependency or abuse (i.e., regularly consumes more than 3 drinks per day)	Illicit drug dependency or abuse
	Based on: Three-year incidence of psychiatric disorders among older adults aged 60 and older (Chou et al., 2011)		
Problematic behaviours	Wandering	Displays socially inappropriate or disruptive behaviour (e.g., yelling, inappropriate sexual behaviour, hoarding)	Verbally or Physically abusive to self/others
	Based on: the Cohen-Mansfield Agitation Inventory (Cohen-Mansfield, 1986)		
Self-rated health	Person believes they are very healthy	Person believes their health is fine	Person believes their health is poor
	Based on: Community Studies Reporting Association Between Self-Rated Health and Mortality, (Benyamini & Idler, 1999)		
Feelings of Loneliness*	Rarely feels lonely (e.g., feels alone no more than once a month, may wish for more meaningful social relationships)	Sometimes feels lonely (e.g., feels lonely once a week, lacks companionship)	Often feels lonely (e.g., feels completely alone daily, even if around people, may lead to depression)
	Based on: UCLA Loneliness scale, (Russell, 1978)		
Mobility*	Someone who is able to move around independently e.g., go for walks in neighbourhood) with the help of an assistive device (i.e., walker, cane etc.)	Someone who relies on personal assistance, in addition to an assistive device (e.g., needs help going up or down steps etc.,)	Someone who relies entirely on personal assistance to move around their own living space (e.g., needs to be lifted out of bed)
	Based on: RAI-MDS 2.0, (Canadian Institute for Health Information, 2006)		

Table 3 – Continued

Factor	Lowest Severity	Moderate Severity	Highest Severity
Vision Loss*	Someone who has limited visual impairment (e.g., able to read large print but not small print)	Someone who has moderate visual impairment (e.g., not able to read, but can identify objects)	Someone who has severe visual impairment (e.g., legally blind)
	Based on: RAI-MDS 2.0, (Canadian Institute for Health Information, 2006)		
Hearing Loss*	Someone who has limited hearing impairment (e.g., may have trouble hearing when not in a quiet setting)	Someone who has moderate hearing impairment (e.g., can hear in certain circumstances only – quiet settings when others speak in a loud voice etc.)	Someone who has severe hearing impairment (e.g., deaf with and without hearing aids)
	Based on: RAI-MDS 2.0, (Canadian Institute for Health Information, 2006)		

Note: *Factor was added by participants after round one

4.2 Survey Participant Characteristics

The Delphi survey was completed by 12 community representatives. Each round had a 100% response rate. The study participant characteristics are provided in Table 4. Overall, 58% of participants were female and the average age across participants was 67 years (SD=10 years). The majority of participants (54.5%) had participated in one PCH paneling process as an informal caregiver, while 9.1% had participated in 3 or more panels.

Table 4 - Participant Characteristics

Count	12
Profile	
Participant Sex (% Female)	58%
Average Age in Years (SD)	67 (10)
Expertise*	
Number of panels attended	
1	54.5%
2	36.4%
3+	9.1%

Note: *Data based on 11 participants only
SD = Standard Deviation

Participants were also asked to describe their experience with the PCH paneling process (see Appendix A for survey questions). Participants overall experiences with this process varied. Some participants expressed a generally positive experience, stating that the "process itself has been fine and all involved have been very caring and understanding," while others stated that it was "difficult to initiate." Several people highlighted the emotional difficulty involved in paneling a loved one.

Participant's perceived level of involvement in their loved one's previous PCH paneling processes also varied. While some people stated they participated closely in the process, others stated that they were either not given many options or did not feel their family's preferences

were taken into account. One participant reported, “we saw the need, but our choices were not taken into consideration.” Another participant talked about the need to “advocate” to ensure things went smoothly, while another participant reported that the PCH paneling process was “very confusing. By that I mean, there seems to be several departments involved and one doesn't seem to know what the other is doing. Information, therefore, is not consistent.”

Seven of the participants emphasized that the support they received from the home care case coordinator was essential for the paneling process. Case coordinators provided emotional support, advocacy and a continual contact for participants as they navigated their way through the process. One participant noted that the involvement of the case coordinator was “crucial,” but that it all depended on the individual coordinator. This person stated, “There has been a lot of responsibility placed on the home care coordinator and there are individual differences, and some aren't as proactive as others.” Several participants also mentioned the key role that the family doctor played in initiating the paneling process.

Several participants also mentioned that they had experience with other services or programs such as supportive housing, transitional care and the Geriatric Program Assessment Team (GPAT). Two participants reported their loved one had been hospitalized prior to PCH paneling. Participants also noted that their loved one had numerous transitions through the healthcare system, were paneled multiple times, and experienced long wait times for PCH admission.

4.3 Overall Delphi Results

This study hypothesized that respondents should agree people with the (a) highest need severity should almost always be admitted, (b) lowest need severity should almost never be admitted, and (c) moderate need severity should be admitted depending on the availability of

certain enabling factors (i.e., community-based supports). Study results demonstrate partial agreement with these hypotheses (Table 5, see Appendix B for full study results). Responses to each hypothesis are provided in subsequent text.

Table 5 - Round Three Results by Severity Level and Admission Decision

		Options for PCH Admission Decision		
Survey Question	**Severity Level**	**Almost Never Admit**	**Admission Depends**	**Almost Always Admit**
How important is it to consider impairment with activities of daily living, when paneling someone for a Personal Care Home?	a) Person requires verbal prompting or limited assistance with at least one ADL	50%	42%	8%
	b) Person requires weight-bearing help to complete at least one ADL	0%	83% High Consensus	17%
	c) Person is fully dependent on others to complete at least one ADL	0%	42%	58%
How important is it to consider impairment with instrumental activities of daily living when paneling someone for a Personal Care Home?	a) Person requires supervision or limited assistance on at least one IADL	42%	58%	0%
	b) Person requires extensive assistance to complete instrumental activities of daily living	8%	67% Moderate Consensus	25%
	c) Person is fully dependent on help to complete instrumental activities of daily living	0%	42%	58%
How important is it to consider the number of prescription medications a person is taking when paneling someone for a Personal Care Home?	a) Person takes 5 or fewer different prescription medications	83% High Consensus	17%	0%
	b) Person takes 6-14 different prescription medications	50%	42%	8%
	c) Person takes 15 or more different prescription medications	33%	50%	17%

Table 5 - Continued Survey Question	Severity Level	Almost Never Admit	Admission Depends	Almost Always Admit
How important is it to consider the complexity of care needs when paneling someone for a Personal Care Home?	a) Person is independent or requires infrequent care throughout the day	75% Moderate Consensus	25%	0%
	b) Person requires interventions every few hours	17%	83% High Consensus	0%
	c) Person requires frequent (i.e., constant to hourly) and/or complicated interventions	0%	42%	58%
How important is it to consider the stage of diagnosed medical conditions when paneling someone for a Personal Care Home?	a) Condition is controlled through medication or treatments but may cause instability in mood, behaviours etc.	58%	42%	0%
	b) Condition has acute episodes or flair-ups	42%	50%	8%
	c) Person suffers daily from condition	17%	75% Moderate Consensus	8%
How important is it to consider the number of comorbidities a person has when paneling someone for a Personal Care Home?	a) Person has 2 or less chronic conditions	50%	50%	0%
	b) Person has 3-4 chronic conditions	25%	75% Moderate Consensus	0%
	c) Person has 5 or more chronic conditions	8%	75% Moderate Consensus	17%
How important is it to consider bladder continence when paneling someone for a Personal Care Home?	a) Usually Bladder Continent (Bladder incontinent 2 or less times a week)	83% High Consensus	17%	0%
	b) Occasionally to Frequently Bladder Incontinent	42%	58%	0%
	c) Bladder Incontinent	8%	50%	42%
How important is it to consider bowel continence when paneling someone for a Personal Care Home?	a) Usually Bowel Continent	67% Moderate Consensus	33%	0%
	b) Occasionally to Frequently Bowel Incontinent	25%	67% Moderate Consensus	8%
	c) Bowel Incontinent	8%	33%	58%

Table 5 - Continued Survey Question	Severity Level	Almost Never Admit	Admission Depends	Almost Always Admit
How important is it to consider cognitive impairment when paneling someone for a Personal Care Home?	a) Person has mild cognitive impairment	50%	50%	0%
	b) Person has moderate cognitive impairment	8%	83% High Consensus	8%
	c) Person has severe cognitive impairment or has been diagnosed with Dementia/Alzheimer's	0%	25%	75% Moderate Consensus
How important is it to consider psychological symptoms when paneling someone for a Personal Care Home?	a) Person frequently experiences anxiety or depression	58%	42%	0%
	b) Person has a diagnosed mental health disorder	33%	67% Moderate Consensus	0%
	c) Person experiences periods of psychosis and/or hallucinations	17%	50%	33%
How important is it to consider substance use when paneling someone for a Personal Care Home?	a) Regularly smokes	67% Moderate Consensus	33%	0%
	b) Alcohol dependency or abuse	67% Moderate Consensus	33%	0%
	c) Illicit drug dependency or abuse	50%	33%	17%
How important is it to consider problematic behaviours when paneling someone for a Personal Care Home?	a) Wandering	42%	58%	0%
	b) Displays socially inappropriate or disruptive behaviour	17%	75% Moderate Consensus	8%
	c) Verbally or Physically abusive to self/others	17%	33%	50%
How important is it to consider self-rated health when paneling someone for a Personal Care Home?	a) Person believes they are very healthy	33%	67% Moderate Consensus	0%
	b) Person believes their health is fine	33%	67% Moderate Consensus	0%
	c) Person believes their health is poor	0%	100% High Consensus	0%

Table 5 - Continued Survey Question	Severity Level	Almost Never Admit	Admission Depends	Almost Always Admit
How important is it to consider Feelings of Loneliness, when paneling someone for a Personal Care Home?	a) Rarely feels lonely	100% High Consensus	0%	0%
	b) Sometimes feels lonely	92% High Consensus	8%	0%
	c) Often feels lonely	58%	42%	0%
How important is it to consider Mobility, when paneling someone for a Personal Care Home?	a) Someone who is able to move around independently with the help of an assistive device	92% High Consensus	8%	0%
	b) Someone who relies on personal assistance, in addition to an assistive device	33%	67% Moderate Consensus	0%
	c) Someone who relies entirely on personal assistance to move around their own living space	8%	50%	42%
How important is it to consider Vision Loss, when paneling someone for a Personal Care Home?	a) Someone who has limited visual impairment	83% High Consensus	17%	0%
	b) Someone who has moderate visual impairment	58%	42%	0%
	c) Someone who has severe visual impairment	17%	75% Moderate Consensus	8%
How important is it to consider Hearing Loss, when paneling someone for a Personal Care Home?	a) Someone who has limited hearing impairment	92% High Consensus	8%	0%
	b) Someone who has moderate hearing impairment	75% Moderate Consensus	25%	0%
	c) Someone who has severe hearing impairment	33%	50%	17%

Note: High Consensus = 80%
Moderate Consensus = 60–79.9%

4.3.1 Hypothesis A - Results at the Highest Severity Level

This hypothesis states that people with the highest need severity levels should almost always be admitted to a PCH. Based on the results presented in Table 5, across all results combined, this hypothesis was not supported. As one exception, 75% of participants responded that a person who has severe cognitive impairment or has been diagnosed with Dementia/ Alzheimer's, should almost always be admitted to a PCH. Consensus was close to being reached for some other risk factors; 58% of participants reported that people who experienced extreme challenges in each of ADL impairment, IADL impairment, complexity of care needs, and bowel continence should be considered for PCH admission irrespective of their community supports.

Conversely, participants did not come close to reaching consensus on many other need factors. For example, no participants thought someone who believes their health is poor, or who often feels lonely should be admitted to a PCH. Further, only 8% of respondents reported that someone who suffers daily from a diagnosed medical condition should almost always be admitted to a PCH.

4.3.2 Hypothesis B - Results at the Lowest Severity Level

This hypothesis states that people with the lowest need severity levels should almost never warrant PCH admission, and across all need factors combined this hypothesis was supported. On 9 of the 17 factors, participants reached consensus that people with these lowest severity needs should never be admitted to a PCH (Table 5). As examples, all participants (100% consensus) agreed that someone who rarely feels lonely should almost never be admitted to a PCH. Likewise, 92% of participants agreed that people who are able to move around independently with the help of an assistive device, and who have limited hearing impairment should almost never be admitted to a PCH. Eighty-three percent (83%) of respondents reported

someone who takes 5 or fewer prescription medications, someone who is usually bladder continent, and someone who has limited visual impairment should almost never be admitted to a PCH. Similarly, 75% of respondents reported that someone with complex needs but who infrequently requires help throughout the day should almost never be admitted to a PCH. Sixty-seven percent (67%) of participants responded that someone who is usually bowel continent, and someone who regularly smokes should almost never be admitted to a PCH.

Participants came close to reaching consensus on two additional factors where need severity levels were low; 58% of participants agreed that someone whose medical condition is controlled through medication or treatments, and someone who frequently experiences anxiety or depression should almost never be admitted to a PCH.

There were three instances where this hypothesis was extended to scenarios involving the moderate severity categories. Sixty-seven percent (67%) of respondents thought that someone with alcohol dependency or abuse should almost never be admitted to a PCH, and similarly, 75% of participants responded that someone with moderate hearing impairment should almost never be admitted to a PCH. Lastly, 92% of respondents reported that someone who sometimes feels lonely should almost never be admitted into a PCH.

4.3.3 Hypothesis C - Results at the Moderate Severity Level

This hypothesis states that people with moderate need severity levels should be admitted to a PCH conditional on the supports available in the community. Participants reached some level of consensus on this statement for 10 of the 17 factors (Table 5), and hence this hypothesis was supported. Eighty-three percent (83%) of participants agreed that PCH admission should depend on enabling factors for people who require weight-bearing help to complete at least one

ADL; for someone who requires interventions every few hours to support their complex care needs; and for someone who has moderate cognitive impairment.

People also reached moderate consensus on an additional 7 need factors (Table 5). Seventy-five percent (75%) of respondents agreed that PCH admission should depend on enabling factors for people with 3-4 chronic conditions, and also for someone who displays socially inappropriate or disruptive behaviour. Similarly, 67% of respondents agreed that PCH admission should depend on enabling factors for people who require extensive assistance to complete IADLs; for someone who is occasionally to frequently bowel incontinent; for someone who has a diagnosed mental health disorder; for someone whose self-rated health is fine; and for someone who relies on personal assistance to be mobile.

Participants came close to reaching consensus on one additional factor. Fifty-eight percent (58%) of respondents agree that someone who is occasionally to frequently bladder incontinent should almost never be admitted.

There were also instances where the results for this hypothesis were extended to scenarios involving the highest severity levels. For example, 75% of participants agreed that admission depends on enabling factors for a person who suffers daily from a chronic medical condition, for someone one who has five or more chronic conditions, and for someone who has severe visual impairment. One hundred percent (100%) of participants thought that admission to a PCH should depend on enabling factors, for people whose self-rated health is poor.

4.3.4 Supports Chosen when the *Admission Depends* Option was Selected

This study also defines the kinds of community supports participants felt were most important to help people remain in the community. Upon selecting ‘admission depends’, participants were asked to identify up to two supports (i.e., enabling factors) required to help

someone remain in the community. Table 6 highlights how frequently participants selected these various enabling factors in round three of the Delphi survey.

Across all risk factors combined, participants most frequently identified access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.) as the most important enabling factor. In round three of the Delphi survey, participants identified that community supports were important 200 times (i.e., participants 'checked-off' these supports 200 times after deciding that 'admission depends' based on need severity), and access to formal supports was selected by participants 38.7% of the time. Having an informal (unpaid) caregiver who is healthy and willing to provide care, was the second most commonly selected factor (N= 127), (i.e., this factor was selected 24.6% of the time), followed closely by financial ability to stay in the community (selected 23.4% of the time). Having strong positive relationships with family, friends and neighbours (selected 21 times), as well as having a safe home environment (selected 21 times) were not deemed to be as important. Participants could also choose the 'other' option (selected 26 times) and provide their own response to what support was most important to help delay PCH admission.

There was only one exception (i.e., substance use), where access to formal supports was not the most frequently chosen enabling factor. For this factor, financial ability was selected most frequently (33.3% of the time).

Table 6 - Consensus Results for Types of Supports Selected when Admission Depends

		Percent that selected each type of support					
Factor	**Total number of responses for each factor***	**Having strong, positive relationships with various friends, family, neighbours etc.**	**Having an informal (unpaid) caregiver who is healthy and willing to provide care**	**Access to formal supports**	**Financial ability to afford to live in the community**	**Having a safe home environment**	**Other**
Total supports selected across all factors*	N= 516	N= 21	N= 127	N= 200	N= 121	N= 21	N= 26
Impairment with activities of daily living	37	8.1%	24.3%	37.8%	18.9%	10.8%	0.0%
Instrumental activities of daily living	34	8.8%	29.4%	35.3%	17.6%	2.9%	5.9%
Number of Prescription Medications	23	0.0%	30.4%	39.1%	30.4%	0.0%	0.0%
Complexity of care needs	34	0.0%	32.4%	44.1%	20.6%	2.9%	0.0%
Stage of diagnosed medical condition	37	5.4%	21.6%	45.9%	24.3%	2.7%	0.0%
Number of comorbidities	42	0.0%	21.4%	42.9%	26.2%	2.4%	7.1%
Bladder Continence	24	0.0%	25.0%	41.7%	25.0%	0.0%	8.3%
Bowel Continence	27	0.0%	22.2%	33.3%	29.6%	3.7%	11.1%
Cognitive Impairment	35	2.9%	28.6%	45.7%	22.9%	0.0%	0.0%
Psychological Symptoms	34	0.0%	20.6%	44.1%	23.5%	0.0%	11.8%

Table 6 – Continued

Factor	Total number of responses for each factor*	Having strong, positive relationships with various friends, family, neighbours etc.	Having an informal (unpaid) caregiver who is healthy and willing to provide care	Access to formal supports	Financial ability to afford to live in the community	Having a safe home environment	Other
Substance Use	21	0.0%	23.8%	19.0%	33.3%	9.5%	14.3%
Problematic behaviours	35	2.9%	25.7%	42.9%	25.7%	0.0%	2.9%
Self-rated health	49	16.3%	24.5%	30.6%	16.3%	4.1%	8.2%
Loneliness	12	25.0%	16.7%	33.3%	25.0%	0.0%	0.0%
Mobility	27	0.0%	25.9%	40.7%	22.2%	11.1%	0.0%
Vision Loss	27	0.0%	14.8%	37.0%	25.9%	11.1%	11.1%
Hearing Loss	18	0.0%	27.8%	33.3%	22.2%	11.1%	5.6%

Note: * Each participant was asked to select up to two responses per factor. Percentage values represent the number of times a factor was selected (and not the number of people who selected the factor).

Chapter 5: Discussion

Two main findings emerge from this study. First, with one exception (i.e., someone who has severe cognitive impairment or has been diagnosed with Dementia/Alzheimer's), participants in this study did not identify scenarios where people should almost always be admitted to a PCH, irrespective of enabling factors. Instead, study participants often agreed that, across need severity levels, people in many instances should either never be admitted to a PCH or should be admitted to a PCH pending the kinds of community-based factors available to them.

Second, in the instances where enabling factors were identified as being important to determine admission, formal supports appeared to be the most important mediating factor to consider, in order to prevent or delay PCH admission. This result is consistent across all need factors. These findings emphasize the importance of considering a person's context and community environment during the PCH admission process. Therefore, based on the consensus reached for 'almost never admit' and 'admission depends' response options, it is necessary to ensure that there are sufficient community-based supports available to address these factors.

5.1 Contribution to the Literature

This study confirms findings from the current academic literature; based on the 17 factors identified as strongly influencing PCH use, participants in this study agreed that 12 of these factors were in some way (either directly or pending access to supports) important to consider during the PCH paneling process. This study also contributes to the current state of the academic literature first by highlighting the importance of considering interactions between need and enabling factors, and second by providing the perspectives of community representatives with real lived experience of the paneling process. Further details are provided in the following text.

5.1.2 Application of the Andersen Newman Behavioural Model

Based on the factors that reached consensus, results from the study demonstrate that according to the perspectives of community representatives, need factors alone are not responsible for admission to a PCH, and that in fact, admission may be conditional on the presence of enabling factors, such as access to formal supports. With only one exception, participants did not identify any scenarios where need factors should independently warrant admission. While need factors are an important component of PCH use, in almost all instances enabling factors are also critical to consider.

This study emphasizes the need to further research the conditional relationship between need and enabling factors in large scale epidemiological studies. This is in contrast to the vast majority of studies that consider main effect study results only (e.g., assessing the effect of need factors while adjusting for the main effect of various other measures) (Liu & Tinker, 2001; Steinbeisser, Grill, Holle, Peters, & Seidl, 2018). Including interaction terms between need and enabling factors, especially in longitudinal epidemiological studies, will help to further understand the ways in which enabling factors moderate how various need factors influence PCH use. Only one study included in the review for this research incorporated any interactions, and, it only focused on the interaction between need variables, not need and enabling variables (Bharucha et al., 2004).

Additionally, this contributes to the literature on the importance of enabling factors. The list of enabling factors used in this study was determined based on the academic literature. Each enabling factor used was determined to be important to help delay or prevent PCH admission, which implies the right enabling factors were included. In addition, this study is able to rank

order the importance of each type of enabling support, which is a fairly novel contribution to the literature.

5.1.3 Examining the Community Representative Perspective

While many researchers have investigated the risk factors for PCH admission, this study uniquely identifies these factors from the perspective of community caregivers with real-life experience with the paneling process. In addition to providing their opinion on what factors should be considered for PCH admission, participants were also asked to share their overall experiences with the paneling process. While accounts varied there were some common themes that arose, including frequent use of the health care system, such as emergency department visits and hospitalizations, a lack of information available to help make decisions, and multiple paneling's. These findings closely align with the results of a study by Campbell-Enns et al. (2020) who looked at resident and family member perspectives influencing PCH admission and barriers to use of community supports.

In addition, the results can also contribute to the literature on the importance of community perspectives. There is existing literature that examines the importance of community member and patient perspectives (Doupe, 2017; Wu, A., Snyder, C., Clancy, C., Steinwachs, 2010). Research in this area emphasizes that including system-users in studies can empower the participants and can provide researchers with a better understanding of their topic (Brett, J., Staniszewska, S., Mockford, C., Herron-Marx, S., Hughs, J., Tysall, C., Suleman, 2014). This study contributes to this literature by highlighting the disparity between what caregivers say they require and what is available to support them. Participants noted the lack of options or consideration of family preferences prior to placement. One participant even recognized the limits of the paneling current system stating, "there was no apparent ability for the system to

account for the client's specific and unique needs." Results from Table 6, however, indicate that in many cases, support from informal caregivers can be important in mitigating PCH admission. Therefore, more extensive involvement of caregivers in the paneling process, as well as in research in general, may be critical.

5.2 Policy and Care Practice Implications, and Areas for Future Research

5.2.1 Alignment with Winnipeg's Current PCH Admission Criteria

The PCH paneling form in Winnipeg is effective in addressing the need factors used in the survey, however it does not necessarily specify severity levels, and it does not explicitly consider enabling factors. While many of the survey need factors were mentioned multiple times throughout the PCH paneling form (e.g., mobility, behavioural issues etc.), several need factors, including IADL impairment, loneliness, and self-rated health were not specifically addressed in this form. While these factors and others may be considered during the paneling process, they are not included explicitly as criteria on the form.

Conditional on replication with a larger sample, the study findings point to the need for a revision of the Manitoba PCH paneling form to include a dedicated section that explicitly asks about enabling factors such as the social health of the individual (e.g., family support, social networks etc.), and impact of community-based supports. While potentially already taken into consideration during the paneling process, attention to these factors should be explicitly built into the panelling form so that the documentation is consistent with the practice. Moving forward, the paneling process should not be considered independent from community resources. Furthermore, improvements to the paneling system will not work without first addressing the needs in the community.

5.2.2 Community-based Interventions

The current paneling process should include a discussion of the community-based supports available, when deciding whether someone needs a PCH level of care. Since the presence of enabling factors may impact the need for admission, community-based supports are clearly integral. There is already an extensive amount of literature on the types of supports and interventions that exist to help older adults remain living in the community. Implementing supports such as these may ensure that only those who need a PCH-level of care are admitted.

Across nine factors, Delphi participants agreed that people with the lowest need severity levels should almost never be admitted to a PCH. Examples of these factors include taking 5 or fewer different prescription medications or being able to move around independently with the help of an assistive device. Participants also reached some level of consensus on 12 factors where admission depends, such as requiring weight-bearing help to complete at least one ADL or having moderate cognitive impairment. These results suggest that people with these specific challenges do not necessarily belong in a PCH, therefore, supports or programs must be available to address these issues in the community. This is also supported by the participants' overwhelming response to the importance of formal supports (e.g., home care, Adult Day Care, chore services, respite etc.), when it comes to preventing PCH admission.

There are several interventions in the literature that could be used to help support people in the community, including the use of multifactorial interventions such as case management, single focus interventions including those that specifically address dementia, as well as caregiver supports. According to Dawson et al. (2015) the use of multifactorial interventions is important in helping older adults to remain living in the community. This was also supported by Luker et al. (2019) who state that complex interventions (i.e., interventions that take a multifactorial

approach to preventing admission, such as case management) have been found to be effective at delaying PCH admission.

For those with functional impairments or chronic conditions, interventions such as case management has been shown, with varying degrees of benefit, to delay PCH admission (Duan-Porter et al., 2020). Case management is a process of assessing, planning, facilitating and advocating for a person's health needs through the coordination of services, which can reduce PCH admissions and improve one's function, medication management, and use of community services. This intervention has shown to be effective at helping older adults avoid PCH admission (Low, Yap, & Brodaty, 2011). Duan-Porter et al. (2020), also credit case management as being potentially the most beneficial type of community-based support, contingent upon ensuring high-frequency contact, early initiation and the extension of support for several years. For those with functional impairments or chronic conditions, interventions such as case management have been shown, with varying degrees of benefit, to delay PCH admission (Duan-Porter et al., 2020). In Winnipeg, home care case coordinators are essential to the paneling process, and their importance was highlighted by the community representatives when reiterating their paneling experiences.

While single focus interventions may be less effective in their ability to prevent admission (Dawson et al., 2015), there are still single focus interventions that can be used to help with issues such as dementia, use of prescription medications or mobility challenges. Community-based services can be essential sources of support for people with dementia or cognitive impairment (Warrick, Prorok, & Seitz, 2018), and dementia-specific programs have been shown to significantly reduce the risk of admission (Luker et al., 2019). For example, using non-pharmacological interventions for dementia has been shown to significantly reduce the odds

of PCH admission (Spijker et al., 2008). There are also interventions that specifically address mobility issues or impairments of daily living. For example, Gill et al. (2002), developed an intervention where individuals were assessed by a physical therapist and provided a recommended intervention, tailored to the individual and their environment. This intervention resulted in participants experiencing less functional decline (Gill et al., 2002).

According to the survey, having an informal (unpaid) caregiver who is healthy and willing to provide care, was the second most commonly selected participant response when 'admission depends'. According to Duan-Porter et al. (2020), many community-based supports or interventions will only be effective in meeting the needs of older adults with impairments, if they also have adequate caregiver support. Warrick et al. (2018), have also shown that education and training for caregivers, as well as respite, can delay PCH admission. Therefore, the combined involvement of both informal and formal care is essential to support people in the community and delay PCH admission.

One area that will need to be examined further is the uptake and availability of these supports in Winnipeg. The literature identifies several barriers that older adults face when trying to remain in the community and delay admission to a PCH. One of the biggest obstacles comes from a lack of knowledge or awareness of the supports that are available, either in the community or in the healthcare system (Brown, McWilliam, & Mai, 1997). When supports do exist, they are often focused on medical conditions and not the everyday issues that can hinder an older adult's ability to be independent (Brown et al., 1997). For example, it can be difficult to find support for house maintenance or home repairs (Cao, Guo, Yu, Chen, & Mcdonald, 2014; Grimmer, Kay, Foot, & Pastakia, 2015). Even accessing the appropriate community support (e.g., home care), can be a significant challenge for people (Cao et al., 2014). System rigidity and

the strict criteria required to access certain community-based programs can limit the services available to some older adults (Brown et al., 1997). Overall, the study results identify the factors that should be managed in the community, and existing research has shown that community-based interventions in these areas are generally effective. However, the extent to which these supports are used and available in Winnipeg will require further examination.

5.2.3 Areas for Future Research

The next step for future research would be to conduct this same Delphi survey using a larger cohort of people to validate the findings. In addition, this study could be replicated with a group of healthcare stakeholders so that the system-users perspective be compared to the system planner's perspective. Having these results would also strengthen the impact of the recommendations for improving the paneling criteria and can lay the groundwork for an evaluation and possible update of the paneling process in Winnipeg.

This research also points to the need for more large-scale epidemiological studies that make use of interactions to understand how need and enabling factors impact PCH admission.

5.3 Benefits of the Delphi Method

The Delphi method is a good way to draw together existing knowledge on a topic and determine areas of agreement and disagreement (Iqbal & Pipon-Young, 2009). It is an especially applicable methodology to use when trying to develop criteria for something such as PCH admission (Page et al., 2015). A strength of the Delphi technique compared to other group consensus methodologies, such as focus groups, is that the participants are anonymous to each other, allowing for people to freely express their opinions (Keeney et al., 2011). This method also ensures that no one individual's opinion dominates (Page et al., 2015).

In this study, the group was able to reach some level of consensus on all 17 of the need factors. Throughout the rounds, consensus generally increased for most factors, despite many not reaching the level of moderate or high consensus. Agreement often moved away from the response option of ‘almost always admit’, towards either ‘admission depends’ or ‘almost never admit’. This demonstrates that the consensus building process was effective, and that people were taking into consideration the way their peers scored, and the comments provided to rationalize their scores, when they completed each subsequent round.

5.4 Study Limitations

One of the main limitations of this study was the small sample size, despite this, the response rate was 100% and there was a good mix of male and female participants. With such a small sample size, one person’s change in opinion can result in a significant change in group consensus. The small sample size was due, in part, to recruitment occurring in the early days of the Covid-19 pandemic.

The pandemic also resulted in the health-care stakeholders not participating as planned, therefore, the results from the community representative participants cannot be compared to people who work in the health care system. Since the admission criteria are created and implemented by policy makers, including both groups in the study would have allowed both perspectives to be taken into consideration, therefore, the resulting recommendations for change would have been stronger.

There were also limitations in how the survey was completed. Each need factor had to be considered independently, when in reality, the admission process considers the individual’s physical, psychological and social challenges together when making a decision. Consequently, the factors may have resulted in different admission decisions if considered in combination.

There is also the possibility that the Covid-19 pandemic may have impacted people's survey results (i.e., scoring towards almost never admit or admission depends), due to the perceived risk of outbreaks in PCHs.

Limitations in the survey creation include the lack of a formal literature review and the subjectivity of some of the need factor severity levels. While a structured process was used to select and evaluate the literature on PCH admission risk factors, an exhaustive search for all the literature on the topic was not conducted, and articles were not excluded due to poor quality. Therefore, some influential studies may have been omitted. In addition, while most severity levels were based on evidence (i.e., literature, RAI-MDS 2.0), there were some severity levels that were determined more subjectively, instead of using an existing scale (i.e., stage of diagnosed medical condition, psychological symptoms, problematic behaviours and substance use). In other cases, since only three severity levels were selected for each factor, existing scales, (e.g., in the RAI-MDS 2.0), had to be adapted to fit the survey. Additionally, considering the participant population, in some cases understandability of the severity level was favoured over rigour (i.e., severity levels were adapted from their original form, both to fit the format of the questionnaire and to be understandable to a lay audience). Consequently, there is a possibility that the results would have differed with the use of different cut-points in the scales.

Finally, these results are only specific to Winnipeg and cannot be applied in other jurisdictions. Furthermore, this study focused only on the publicly available components of Winnipeg's older adult continuum of care (see Table 1). For those who can afford it, private care options are also available including assisted living facilities which, in some cases, can provide care levels similar to a PCH, and private home care. However, the cost of these services may be prohibitive for many people, which is why private care was not included in this study.

5.5 Knowledge Translation

The study aligns well with the Manitoba government's current health care reform strategies, and therefore, should provide evidence to improve decision making during the PCH admission process. Results of this study will be disseminated to MHSAL, WRHA and Shared Health decision-makers. These organizations are the target audience for this research as they have control over the paneling criteria and process. This will provide the organizations with evidence to inform the ways in which PCH paneling criteria could potentially be updated. In addition, study results will be published in a peer reviewed journal and presented at both local and national conferences. Both stakeholders (i.e., health care decision-makers) and knowledge users (older adults and caregivers) were consulted during the study process through meetings. This was to ensure the study results are relevant to the end users.

5.6 Conclusions

This study identified, among community representatives who had experience with the paneling process, the ways in which need and enabling factors can guide the criteria for PCH admission in Winnipeg. The results showed consensus on need factors that do not warrant admission, and on factors where admission depends on the presence of enabling factors that can mediate the impact of requiring admission. Only one factor reached consensus for almost always warranting admission. These findings have implications on the kinds of community-based supports that should be offered in Winnipeg to prevent or delay admission to a PCH. In addition, in order to provide a full physical and psychosocial evaluation of the individual, changes should be made to the PCH paneling form to consider the individual's enabling factors and the use and impact of community-based supports, but more importantly, the appropriate supports must be made available in the community. In conclusion, since access to formal supports appears to be a

mediating factor for PCH admission, it is critical that community-based supports are available and accessible, and that Winnipeg's PCH admission criteria take these supports into account, during the paneling process.

References

Aday, L. A. (2004). *Evaluating the healthcare system: Effectiveness, efficiency and equity* (3rd ed.). Chicago: Health Administration Press.

Alberta Health and Wellness. (2008). Continuing Care Strategy. Aging in the Right Place, 1–24. https://doi.org/10.1136/adc.85.5.354

Alberta Health Services. (2010). *Admission Guidelines for Publicly Funded Continuing Care Living Options*. Edmonton, AB.

Andersen, R. M. (1995). Revisiting the behavioral model and access to medical care: Does it really matter? *Journal of Health and Social Behavior*, *36 (March)*, 1–10.

Andersen, R. M. (2006). Revisiting the Behavioral Model and Access to Medical Care: Does it Matter? *Journal of Health and Social Behavior*, *36*(1), 1. https://doi.org/10.2307/2137284

Andersen, R. M., & Newman, J. F. (1973). Societal and Individual Determinants of Medical Care Utilization in the United States. *The Milbank Memorial Fund Quarterly*, *51*(1), 95–124.

Annear, M. J., Toye, C., McInerney, F., Eccleston, C., Tranter, B., Elliott, K. E., & Robinson, A. (2015). What should we know about dementia in the 21st century? A Delphi consensus study. *BMC Geriatrics*, *15*(1), 1–13. https://doi.org/10.1186/s12877-015-0008-1

Babitsch, B., Gohl, D., & von Lengerke, T. (2012). Re-revisiting Andersen's Behavioral Model of Health Services Use: a systematic review of studies from 1998-2011. *Psycho-Social Medicine*, *9*, Doc11. https://doi.org/10.3205/psm000089

Baines, R. L., & Regan de Bere, S. (2018). Optimizing patient and public involvement (PPI): Identifying its "essential" and "desirable" principles using a systematic review and modified

Delphi methodology. *Health Expectations*, *21*(1), 327–335. https://doi.org/10.1111/hex.12618

Benyamini, Y., & Idler, E. (1999). Community Studies Reporting Association Between Self-Rated Health and Mortality. *Research on Aging*, *21*(3), 392–401.

Betini, R. S. D., Hirdes, J. P., Lero, D. S., Cadell, S., Poss, J., & Heckman, G. (2017). A longitudinal study looking at and beyond care recipient health as a predictor of long term care home admission. *BMC Health Services Research*, *17*(1), 1–11. https://doi.org/10.1186/s12913-017-2671-8

Bharucha, A. J., Pandav, R., Shen, C., Dodge, H. H., & Ganguli, M. (2004). Predictors of Nursing Facility Admission: A 12-Year Epidemiological Study in the United States. *Journal of the American Geriatrics Society*, *52*(3), 434–439. https://doi.org/10.1111/j.1532-5415.2004.52118.x

Black, K., Dobbs, D., & Young, T. L. (2012). Aging in Community. *Journal of Applied Gerontology*, *34*(2), 219–243. https://doi.org/10.1177/0733464812463984

Boulkedid, R., Abdoul, H., Loustau, M., Sibony, O., & Alberti, C. (2011). Using and reporting the Delphi method for selecting healthcare quality indicators: A systematic review. *PLoS ONE*, *6*(6). https://doi.org/10.1371/journal.pone.0020476

Brett, J., Staniszewska, S., Mockford, C., Herron-Marx, S., Hughs, J., Tysall, C., Suleman, R. (2014). A Systematic Review of the Impact of Patient and Public Involvement on Service Users, Researchers and Communities. *The Patient - Patient-Centred Outcomes Research*, *7*, 387–395.

British Columbia Ministry of Health. Home and Community Care Policy Manual, Pub. L. No.

6.C (2019). British Columbia.

Brown, J. B., McWilliam, C. L., & Mai, V. (1997). Barriers and facilitators to seniors' independence: Perceptions of seniors, caregivers, and health care providers. *Canadian Family Physician*, *43*(MAR.), 469–475.

Campbell-Enns, H. J., Campbell, M., Rieger, K. L., Thompson, G. N., & Doupe, M. B. (2020). No Other Safe Care Option: Nursing Home Admission as a Last Resort Strategy. *The Gerontologist*, *XX*(Xx), 1–11. https://doi.org/10.1093/geront/gnaa077

Canadian Institute for Health Information. (2006). *Continuing Care Reporting System Specifications Manual*. Ottawa, Ontario.

Canadian Institute for Health Information. (2017). Infographic: Canada's seniors population outlook: Uncharted territory. Retrieved December 21, 2020, from https://www.cihi.ca/en/infographic-canadas-seniors-population-outlook-uncharted-territory

Canadian Institute for Health Information. (2018). *Drug Use Among Seniors in Canada, 2016*. Ottawa, ON. Retrieved from www.cihi.cacopyright@cihi.caISBN978-1-77109-705

Canadian Institute for Health Information. (2020). *Common Challenges, Shared Priorities: Measuring Access to Home and Community Care and to Mental Health and Addictions Services in Canada - Volume 2, August 2020*. Ottawa, ON.

Cao, M. J., Guo, X. L., Yu, H., Chen, L. Y., & Mcdonald, T. A. (2014). Chinese community-dwelling elders' needs: Promoting ageing in place. *International Nursing Review*, *61*(3), 327–335. https://doi.org/10.1111/inr.12119

Carter, M. W., Yang, B. K., Davenport, M., & Kabel, A. (2019). Increasing Rates of Opioid Misuse Among Older Adults Visiting Emergency Departments. *Innovation in Aging*, *3*(1),

1–13. https://doi.org/10.1093/geroni/igz002

Castora-Binkley, M., Meng, H., & Hyer, K. (2014). Predictors of long-term nursing home placement under competing risk: Evidence from the health and retirement study. *Journal of the American Geriatrics Society*, *62*(5), 913–918. https://doi.org/10.1111/jgs.12781

CBC News Manitoba. (2017, September 8). 258 new personal care home beds promised in Winnipeg, Steinbach, Carman. *Canadian Broadcasting Corportation*.

Charlson, M.E., Pompei, P., Ales, K.L., MacKenzie, C. (1987). A new method of classifying prognostic comorbidity in longitudinal studies: development and validation. *Journal of Chronic Disease*, *40*(5), 373–383. Retrieved from doi:10.1016/0021-9681(87)90171-8

Chateau, D., Doupe, M., Walld, R., Soodeen, R. A., Ouelette, C. A., & Rajotte, L. (2012). *Projecting Personal Care Home Equivalent Needs In Manitoba Through 2036*. Winnipeg, MB. Retrieved from http://mchp-appserv.cpe.umanitoba.ca/reference/MCHP_pch_days_report_WEB.pdf

Chou, K. L., Mackenzie, C. S., Liang, K., & Sareen, J. (2011). Three-year incidence and predictors of first-onset of DSM-IV mood, anxiety, and substance use disorders in older adults: Results from wave 2 of the national epidemiologic survey on alcohol and related conditions. *Journal of Clinical Psychiatry*, *72*(2), 144–155. https://doi.org/10.4088/JCP.09m05618gry

Cohen-Mansfield, J. (1986). Agitated behavior in the elderly: II. Preliminary results in the cognitively deteriorated. *Journal of the American Geriatrics Society*, *34*, 722–727.

Cohen, M. B. H. C. and C. (2012). *Caring for BC's aging population: Improving health care for all*. *Canadian Centre for Policy Alternatives BC Office* (Vol. 159).

https://doi.org/10.3928/00989134-20091103-04

Cui, Y., Zinnick, S., Henderson, A., & Dunne, L. (2019). *Winnipeg Health Region Community Health Assessment 2019*. *Winnipeg Regional Health Authority*. Winnipeg, MB.

Dawson, A., Bowes, A., Kelly, F., Velzke, K., & Ward, R. (2015). Evidence of what works to support and sustain care at home for people with dementia: A literature review with a systematic approach. *BMC Geriatrics*, *15*(1). https://doi.org/10.1186/s12877-015-0053-9

Doupe, M. (2017). More than just Measurement. *Healthcare Papers*, *17*(2), 46–49. https://doi.org/10.12927/hcpap.2017.25410

Doupe, M., Finlayson, G., Khan, S., Yogendran, M., Schultz, J., McDougall, C., & Kulbaba, C. (2016). *Supportive Housing for Seniors: Reform Implications for Manitoba's Older Adult Continuum of Care*. Winnipeg, MB.

Doupe, M., Fransoo, R., Chateau, D., Dik, N., Burchill, C., Soodeen, R., & Bozat-emre, S. (2011). *Population aging and the continuum of older adult care in Manitoba*. Winnipeg. Retrieved from http://mchp-appserv.cpe.umanitoba.ca/reference/LOC_Report_WEB.pdf

Duan-Porter, W., Ullman, K., Rosebush, C., McKenzie, L., Ensrud, K. E., Ratner, E., … Wilt, T. J. (2020). Interventions to Prevent or Delay Long-Term Nursing Home Placement for Adults with Impairments—a Systematic Review of Reviews. *Journal of General Internal Medicine*, *35*(7), 2118–2129. https://doi.org/10.1007/s11606-019-05568-5

Fan, W., & Yan, Z. (2010). Factors affecting response rates of the web survey: A systematic review. *Computers in Human Behavior*, *26*(2), 132–139. https://doi.org/10.1016/j.chb.2009.10.015

Federal/ Provincial/ Territorial Ministers responsible for Seniors. (2019). *Core Community*

Supports to Age in Community. Ottawa, ON.

Freedman, V., Berkman, L. F., Rapp, S. R., & Ostfeld, A. M. (1994). Public Health Briefs Family Networks : Predictors of Nursing Home Entry. *American Journal of Public Health*, *84*(5), 843–845.

Gaugler, J. E., Duval, S., Anderson, K. A., & Kane, R. L. (2007). Predicting nursing home admission in the U.S: a meta-analysis. *BMC Geriatr.*, *7*, 13.

Gill, F. J., Leslie, G. D., Grech, C., & Latour, J. M. (2013). Using a web-based survey tool to undertake a Delphi study: Application for nurse education research. *Nurse Education Today*, *33*(11), 1322–1328. https://doi.org/10.1016/j.nedt.2013.02.016

Gill, T. M., Baker, D. I., Gottschalk, M., Peduzzi, P. N., Allore, H., & Byers, A. (2002). A program to prevent functional decline in physically frail, elderly persons who live at home. *New England Journal of Medicine*, *347*(14), 1068–1074. Retrieved from http://www.embase.com/search/results?subaction=viewrecord&from=export&id=L35093794%0Ahttp://dx.doi.org/10.1056/NEJMoa020423

Graf, C. (2008). The Lawton Instrumental Activities of Daily Living (IADL) Scale. *American Journal of Nursing*, *108*(4). https://doi.org/10.1097/00000446-199901000-00026

Greenberg. (1985). Health and Wellness: A Conceptual. *Journal of School Health*, *55*(10), 403–406.

Grimmer, K., Kay, D., Foot, J., & Pastakia, K. (2015). Consumer views about aging-in-place. *Clinical Interventions in Aging*, *10*, 1803–1811. https://doi.org/10.2147/CIA.S90672

Hajek, A., Bock, J. O., & König, H. H. (2017). Which factors affect health care use among older Germans? Results of the German ageing survey. *BMC Health Services Research*, *17*(1), 1–

8. https://doi.org/10.1186/s12913-017-1982-0

Hanratty, B., Stow, D., Moore, D. C., Valtorta, N. K., & Matthews, F. (2018). Loneliness as a risk factor for care home admission in the english longitudinal study of ageing. *Age and Ageing*, *47*(6), 896–900. https://doi.org/10.1093/ageing/afy095

Helms, C., Gardner, A., & McInnes, E. (2017). The use of advanced web-based survey design in Delphi research. *Journal of Advanced Nursing*, *73*(12), 3168–3177. https://doi.org/10.1111/jan.13381

Hoben, M., Chamberlain, S. A., Gruneir, A., Knopp-Sihota, J. A., Sutherland, J. M., Poss, J. W., … Estabrooks, C. A. (2019). Nursing Home Length of Stay in 3 Canadian Health Regions: Temporal Trends, Jurisdictional Differences, and Associated Factors. *Journal of the American Medical Directors Association*, *20*(9), 1121–1128. https://doi.org/10.1016/j.jamda.2019.01.144

Huang, Y. Q., Gou, R., Diao, Y. S., Yin, Q. H., Fan, W. X., Liang, Y. P., … Liu, F. (2014). Charlson comorbidity index helps predict the risk of mortality for patients with type 2 diabetic nephropathy. *Journal of Zhejiang University: Science B*, *15*(1), 58–66. https://doi.org/10.1631/jzus.B1300109

Iqbal, S., & Pipon-Young, L. (2009). The Delphi Method. *Psychologist*, *22*(7), 598–600. https://doi.org/10.1142/S0219877009001686

Jamieson, H., Abey-Nesbit, R., Bergler, U., Keeling, S., Schluter, P. J., Scrase, R., & Lacey, C. (2019). Evaluating the Influence of Social Factors on Aged Residential Care Admission in a National Home Care Assessment Database of Older Adults. *Journal of the American Medical Directors Association*, 1–6. https://doi.org/10.1016/j.jamda.2019.02.005

Keeney, S., Hasson, F., & McKenna, H. (2011). *The Delphi Technique in Nursing and Health Research*. Chicherster, United Kingdom: Wiley-Blackwell.

Kojima, G. (2016). Frailty as a Predictor of Nursing Home Placement Among Community-Dwelling Older Adults. *Journal of Geriatric Physical Therapy*, *41*(1), 42–48. https://doi.org/10.1519/jpt.0000000000000097

Lenaghan, E., Holland, R., & Brooks, A. (2007). Home-based medication review in a high risk elderly population in primary care - The POLYMED randomised controlled trial. *Age and Ageing*, *36*(3), 292–297. https://doi.org/10.1093/ageing/afm036

Liu, L. F., & Tinker, A. (2001). Factors associated with nursing home entry for older people in Taiwan, Republic of China. *Journal of Interprofessional Care*, *15*(3), 245–255. https://doi.org/10.1080/13561820120063138

Lo, T. K. T., Parkinson, L., Cunich, M., & Byles, J. (2016). Factors associated with the health care cost in older Australian women with arthritis: An application of the Andersen's Behavioural Model of Health Services Use. *Public Health*, *134*, 64–71. https://doi.org/10.1016/j.puhe.2015.11.018

Low, L. F., Yap, M., & Brodaty, H. (2011). A systematic review of different models of home and community care services for older persons. *BMC Health Services Research*, *11*. https://doi.org/10.1186/1472-6963-11-93

Luker, J. A., Worley, A., Stanley, M., Uy, J., Watt, A. M., & Hillier, S. L. (2019). The evidence for services to avoid or delay residential aged care admission: A systematic review. *BMC Geriatrics*, *19*(1), 1–20. https://doi.org/10.1186/s12877-019-1210-3

Luppa, M., Luck, T., Weyerer, S., König, H. H., Brähler, E., & Riedel-Heller, S. G. (2009).

Prediction of institutionalization in the elderly. A systematic review. *Age and Ageing*, *39*(1), 31–38. https://doi.org/10.1093/ageing/afp202

Manitoba Health Seniors and Active Living. Application/Assessment for Long Term Care (2010). Winnipeg, MB.

Manitoba Health Seniors and Active Living. (2018a). *Annual Statistics 2017-2018*. Retrieved from https://www.gov.mb.ca/health/annstats/as1718.pdf

Manitoba Health Seniors and Active Living. (2018b). Manitoba Population Report June 1, 2018, 1–91. Retrieved from https://www.gov.mb.ca/health/population/pr2018.pdf

Manitoba Health Seniors and Active Living. (2019). Health System Transformation. Retrieved from https://www.gov.mb.ca/health/hst/

Maxwell, C. J., Soo, A., Hogan, D. B., Wodchis, W. P., Gilbart, E., Amuah, J., … Strain, L. A. (2013). Predictors of nursing home placement from assisted living settings in Canada. *Canadian Journal on Aging*, *32*(4), 333–348. https://doi.org/10.1017/S0714980813000469

McCallum, J., Simons, L. A., Simons, J., & Friedlander, Y. (2005). Patterns and predictors of nursing home placement over 14 years: Dubbo study of elderly Australians. *Australasian Journal on Ageing*, *24*(3), 169–173. https://doi.org/10.1111/j.1741-6612.2005.00116.x

Miller, E. A., & Weissert, W. G. (2000). Predicting elderly people's risk for nursing home placement, hospitalization, functional impairment, and mortality: A synthesis. *Medical Care Research and Review*, *57*(3), 259–297. https://doi.org/10.1177/107755870005700301

Mui, A., & Burnette, D. (1994). Long-term care service use by frail elders: is ethnicity a factor? *Gerontologist*, *34*(2), 190–198. https://doi.org/10.1093/geront/34.2.190

Newman, S. J., Struyk, R., Wright, P., & Rice, M. (1990). Overwhelming odds: Caregiving and

the risk of institutionalization. *Journals of Gerontology*, *45*(5). https://doi.org/10.1093/geronj/45.5.S173

Nuernberger, K., Atkinson, S., & MacDonald, G. (2018). *Seniors in Transition: Exploring Pathways Across the Care Continuum*. *Healthcare quarterly (Toronto, Ont.)* (Vol. 21). https://doi.org/10.12927/hcq.2018.25529

Ontario Association of Community Care Access Centres. (2014). Making way for change: Transforming home and community care for Ontarians. Retrieved from http://healthcareathome.ca/southwest/en/news/Documents/OACCAC-Whitepaper-FINAL.pdf

Outsidesoft Solutions Inc. (2020). SimpleSurvey. Retrieved September 23, 2020, from https://simplesurvey.com

Page, A., Potter, K., Clifford, R., McLachlan, A., & Etherton-Beer, C. (2015). Prescribing for Australians living with dementia: Study protocol using the Delphi technique. *BMJ Open*, *5*(8), 1–7. https://doi.org/10.1136/bmjopen-2015-008048

Sinha, S. Dunning, J. Wong, I. Nici, M., N. S. (2019). *Enabling the Future Provision of Long-Term Care in Canada*. Toronto, ON.

Sivananthan, S. N., Doupe, M., & McGregor, M. J. (2014). Exploring the ecology of Canada's publicly funded residential long-term care bed supply. *Canadian Journal on Aging*, *34*(1), 60–74. https://doi.org/10.1017/S071498081400052X

Spijker, A., Vernooij-Dassen, M., Vasse, E., Adang, E., Wollersheim, H., Grol, R., & Verhey, F. (2008). Effectiveness of nonpharmacological interventions in delaying the institutionalization of patients with dementia: A meta-analysis. *Journal of the American*

Geriatrics Society, *56*(6), 1116–1128. https://doi.org/10.1111/j.1532-5415.2008.01705.x

Steinbeisser, K., Grill, E., Holle, R., Peters, A., & Seidl, H. (2018). Determinants for utilization and transitions of long-term care in adults 65+ in Germany: results from the longitudinal KORA-Age study. *BMC Geriatrics*, *18*(1), 1–11. https://doi.org/10.1186/s12877-018-0860-x

Sudore, R. L., Lum, H. D., You, J. J., Hanson, L. C., Meier, D. E., Pantilat, S. Z., … Heyland, D. K. (2017). Defining Advance Care Planning for Adults: A Consensus Definition From a Multidisciplinary Delphi Panel. *Journal of Pain and Symptom Management*, *53*(5), 821-832.e1. https://doi.org/10.1016/j.jpainsymman.2016.12.331

Toot, S., Swinson, T., Devine, M., Challis, D., & Orrell, M. (2017). Causes of nursing home placement for older people with dementia: A systematic review and meta-analysis. *International Psychogeriatrics*, *29*(2), 195–208. https://doi.org/10.1017/S1041610216001654

Van Der Steen, J. T., Radbruch, L., Hertogh, C. M., De Boer, M. E., Hughes, J. C., Larkin, P., … Volicer, L. (2014). White paper defining optimal palliative care in older people with dementia: A Delphi study and recommendations from the European Association for Palliative Care. *Palliative Medicine*, *28*(3), 197–209. https://doi.org/10.1177/0269216313493685

Vyas, A., Madhaven, S., Sambamoorthi, U., Pan, X., Regier, M., Hazard, H., & Kalidindi, S. (2017). Healthcare utilization and costs during the intial phase of care among elderly women with breast cancer. *Journal of the National Comprehensive Cancer Network*, *15*(11), 1401–1409. https://doi.org/10.1177/0333102415576222.Is

Warrick, N., Prorok, J. C., & Seitz, D. (2018). Care of community-dwelling older adults with dementia and their caregivers. *Cmaj*, *190*(26), E794–E799. https://doi.org/10.1503/cmaj.170920

Wiles, J. L., Leibing, A., Guberman, N., Reeve, J., & Allen, R. E. S. (2012). The meaning of "aging in place" to older people. *Gerontologist*, *52*(3), 357–366. https://doi.org/10.1093/geront/gnr098

Winnipeg Regional Health Authority. (2012). Personal Care Home Program: Paneling Process. Retrieved from http://www.wrha.mb.ca/ltc/pch/paneling.php

Winnipeg Regional Health Authority. (2013). Personal Care Home Standards. Retrieved from http://www.wrha.mb.ca/ltc/pch/files/MBHealthStandards.pdf

Winnipeg Regional Health Authority. (2017). WRHA announces Priority Home. Retrieved March 30, 2020, from https://wrha.mb.ca/2017/09/20/wrha-announces-priority-home/

Winnipeg Regional Health Authority. (2020a). Chronic Care. Retrieved March 30, 2020, from https://wrha.mb.ca/long-term-care/chronic-care/

Winnipeg Regional Health Authority. (2020b). Home Care. Retrieved March 30, 2020, from https://wrha.mb.ca/home-care/

Wolinsky, F. D., & Johnson, R. J. (1991). The use of health services by older adults. *Journals of Gerontology*, *46*(6), 345–357. https://doi.org/10.1093/geronj/46.6.S345

World Health Organization. (2017). *Global strategy and action plan on ageing and health*. Geneva: World Health Organization. Retrieved from http://www.who.int/ageing/WHO-GSAP-2017.pdf?ua=1

Wu, A., Snyder, C., Clancy, C., Steinwachs, D. (2010). Adding The Patient Perspective To

Comparative Effectiveness Research. *Health Affairs*, *29*(10), 1863–1871.

Yang, Y., Yang, G., Wan, J., Wang, Y., Jiang, M., & Fang, L. (2018). Factors associated with healthcare utilization among community-dwelling elderly in Shanghai, China. *Plos One*, *13*(12), e0207646. https://doi.org/10.1371/journal.pone.0207646

Appendix A: Delphi Survey Round One

Study Context

The actual personal care home (PCH) paneling process takes into account a combination of factors, however, in this study we are just interested in a few select biological, psychological and social factors that may warrant admission into a personal care home. **While we recognize that people have multiple issues that may result in a PCH admission, we are asking you to please consider each factor independently.**

The purpose of this research is to identify factors that should be used to accept people into PCHs in Winnipeg. In this survey we are asking to you to (1) identify the kinds of factors (e.g., cognitive impairment, the ability to complete daily physical tasks etc.) that are important to consider when admitting someone to a PCH, and (2) decide if this depends on the type of informal supports that a person has in the community.

As background information, we have provided in Table 1, the types of continuing care services that are offered in Winnipeg, and the kinds of people that these options were designed to serve. This information is provided to help you consider who should be admitted into a PCH versus who could be supported elsewhere.

Please review this information before completing the survey and contact Megan at [redacted] if you have follow-up questions about this table.

Table 1 - Continuing Care Services in Winnipeg

Home Care	Supportive Housing	Personal Care Home	Chronic Care Facilities
Purpose: Home Care coordinates and provides a range of services such as personal care, nursing care, household assistance, assessments and referrals etc., to help people remain living in the community. **Target Population**: People who require assistance (i.e., health services, assistance with activities of daily living etc.) and cannot receive the appropriate support from other community resources. e.g., People who need help with medication management, bathing and dressing. **Examples**: WRHA Home Care Program, Priority Home	**Purpose**: Supportive Housing is an option for people who can no longer manage to live independently, but don't yet require the level of care of a personal care home. People have their own rooms and share a living space with access to 24/7 support. Services include meals, laundry and housekeeping services, social and recreational activities. Access to supportive housing is based on a WRHA assessment process. **Target Population**: People who are physically frail and require access to supervision 24-7, but do not require 24-7 health care. e.g., Individuals with some degree of cognitive impairment and have family involved in their care. **Examples**: Rosewood Village, Harmony Court at Riverwood Square	**Purpose**: A personal care home provides personal care services to individuals who can no longer manage independently, with options such as home care or supportive housing. People are admitted into PCHs using a process where a home care case coordinator works with the individual, their family, and their health care team to complete a PCH panel assessment form. **Target Population**: People who require access to 24-7 nursing care. e.g., Individuals with physical impairments affecting ability to perform activities of daily living. **Examples**: Charleswood Care Centre, River Park Gardens	**Purpose**: Chronic care facilities help people who show little to no potential for improvement and need more care than a personal care home can provide. It offers specialized care and equipment for chronic health conditions. **Target Population**: People who require ongoing medical management and/or extensive nursing care. e.g., Individuals with traumatic brain injuries or who require complex wound care **Examples**: Riverview Health Centre, Deer Lodge Centre

Directions to Complete the Survey

1. Please complete the consent and participant information sections of the survey.
2. The survey consists of 13 factors (e.g., cognitive ability) that may be important when considering PCH admission. We have also divided each factor into sub-groups based on severity (e.g., people with mild cognitive impairment versus severe cognitive impairment). For each factor sub-group, we are asking you if the PCH panel should:
    a. ***Almost never admit*** **someone with the issue into a PCH** (i.e., The issue by itself does not warrant care in a PCH)
    b. **A*lmost always admit*** **someone with the issue into a PCH** (i.e., independent of the type of supports that people have in the community)
    c. **If admission into a PCH *depends* on the types of supports that people have in the community**. If you choose this response, we will ask you to identify the types of supports that are most important to help someone remain in the community, including (select up to 2 options):

- Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- Having an informal (unpaid) caregiver who is healthy and willing to provide care
- Access to formal supports (e.g. home care, Adult Day Care, chore services, respite etc.)
- Financial ability to afford to live in the community
- Other (please state):

3. We have included a space after each factor so that you can explain your response. While you do not have to provide a written comment for every factor, we would like you to do so for those that you feel most strongly about. Your and other people's comments will be summarized in the next round, anonymously, but for others to see.
4. At the end of the survey please provide us with additional factors that you feel should be considered when admitting someone into a PCH.

Things to Keep in Mind:

- If you do not provide a score for a factor, it will be rated as *Almost never admit*

Consent

All people who wish to complete the survey MUST complete this section.

Your participation in this research study is completely voluntary and confidential (no other participants will see your individual responses). There are no risks or benefits to participating in this study. All survey data will be de-identified (i.e., prior to storing study results, your name will be separated from your survey responses) and stored on a password protected computer.

You may decide to withdraw from the study at any time. To withdraw from this study, please contact Megan by email at [redacted]

This research was funded by Research Manitoba and the Manitoba Training Program for Health Services Research. Permission to conduct this research has been given by the University of Manitoba Health Research Ethics Board and the Winnipeg Regional Health Authority.

* Important: Please only check this box if you consent to participate in this study. Your consent indicates that you agree to the following:

- I can include your results in the study
- I can send subsequent survey rounds to you
- You will be involved for the duration of the study (note the anticipated end date is May 2020)

☐ I Consent

Community Representative Questions

1. Age (years):

2. Sex

- [ ] Male
- [ ] Female

3. Have you previously been involved in the process of paneling someone into a Winnipeg Personal Care Home?

- ○ Yes
- ○ No

a) How many people's paneling were you involved with?

b) How long ago was the paneling? ℹ

4. Have *you* ever been paneled for admission into a Winnipeg Personal Care Home?

- ○ Yes
- ○ No

5. Please describe your experience with the PCH paneling process in Winnipeg.

Questions

1. How important is it to consider *impairment with activities of daily living,* when paneling someone for a Personal Care Home?

Activities of daily living (ADLs) are the basic functions required to care for oneself, including personal hygiene, dressing, toileting, ambulating (moving around), and eating. Impairment with activities of daily living would indicate an inability to complete at least one of these tasks without some form of help.

a) Person requires verbal prompting or limited assistance (i.e., guiding limbs) to complete at least one ADL

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

b) Person requires weight-bearing help to complete at least one ADL

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

c) Person is fully dependent on others to complete at least one ADL (e.g., needs to be fed or dressed by someone)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

a) Indicate the types of supports that you feel are most important to help someone who requires verbal prompting or limited assistance (i.e., guiding limbs), to remain in the community:

Select up to 2 options

- ☐ Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- ☐ Having an informal (unpaid) caregiver who is healthy and willing to provide care
- ☐ Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- ☐ Financial ability to afford to live in the community
- ☐ Other (please state): _____

b) Indicate the types of supports that you feel are most important to help someone who requires weight-bearing help, to remain in the community:

Select up to 2 options

- ☐ Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- ☐ Having an informal (unpaid) caregiver who is healthy and willing to provide care

- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

c) Indicate the types of supports that you feel are most important to help someone who is fully dependent on others (e.g., needs to be fed or dressed by someone), to remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

Comments

2. How important is it to consider *impairment with instrumental activities of daily living* when paneling someone for a Personal Care Home?

Instrumental activities of daily living (IADLs) are the more complex functions required to care for oneself, including managing finances, transportation, shopping, meal preparation, house cleaning or maintenance, communication (i.e., phone, mail etc.) or medications. Impairment with instrumental activities of daily living would indicate an inability to complete at least one of these tasks without some form of help.

a) Person requires supervision or limited assistance (i.e., prompting) to complete instrumental activities of daily living

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

b) Person requires extensive assistance to complete instrumental activities of daily living (e.g., needs to be accompanied on shopping trips)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

c) Person is fully dependent on help to complete instrumental activities of daily living (e.g., requires someone to prepare and serve their meals)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

a) Indicate the types of supports that you feel are most important to help someone who requires supervision or limited assistance (i.e., prompting), to remain in the community:

Select up to 2 options

- ☐ Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- ☐ Having an informal (unpaid) caregiver who is healthy and willing to provide care
- ☐ Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- ☐ Financial ability to afford to live in the community
- ☐ Other (please state): _____

b) Indicate the types of supports that you feel are most important to help someone who requires extensive assistance to complete IADLs (e.g., needs to be accompanied on shopping trips), remain in the community:

Select up to 2 options

- ☐ Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- ☐ Having an informal (unpaid) caregiver who is healthy and willing to provide care

- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

c) Indicate the types of supports that you feel are most important to help someone who is fully dependent on help to complete IADLs, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

Comments

3. How important is it to consider *the number of prescription medications a person is taking* when paneling someone for a Personal Care Home?

The number of prescription medications a person is taking refers to the total number of prescription medications that have been perscribed to an individual (e.g., high cholesterol, high blood pressure etc.). This does not refer to the number of pills taken or the frequency of doses.

a) Person takes 5 or fewer different prescription medications

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

b) Person takes 6-14 different prescription medications

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

c) Person takes 15 or more different prescription medications

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

a) Indicate the types of supports that you feel are most important to help someone who takes 5 or fewer different medications, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

b) Indicate the types of supports that you feel are most important to help someone who takes 6-14 different medications, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

c) Indicate the types of supports that you feel are most important to help someone who takes 15 or more different medications, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

Comments

4. How important is it to consider *the complexity of care needs* when paneling someone for a Personal Care Home?

Complexity of care needs refers to the type and frequency of care a person requires. The more complex or unpredictable the care needs, the harder it becomes to care for a person. Complex care is often provided by a professional, and can be provided by a non-professional caregiver under a professional's direction or supervision.

a) Person is independent or requires infrequent care throughout the day (e.g., medication distribution in morning and evening)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

b) Person requires interventions every few hours (e.g., application of ointments every 2-4 hours)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

c) Person requires frequent (i.e., constant to hourly) and/or complicated interventions (e.g., oxygen therapy)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

a) Indicate the types of supports that you feel are most important to help someone who is independent or requires infrequent care, remain in the community:

Select up to 2 options

- ☐ Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- ☐ Having an informal (unpaid) caregiver who is healthy and willing to provide care
- ☐ Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- ☐ Financial ability to afford to live in the community
- ☐ Other (please state): _____

b) Indicate the types of supports that you feel are most important to help someone who requires interventions every few hours, remain in the community:

Select up to 2 options

- ☐ Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- ☐ Having an informal (unpaid) caregiver who is healthy and willing to provide care
- ☐ Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- ☐ Financial ability to afford to live in the community

- [ ] Other (please state): _____

c) Indicate the types of supports that you feel are most important to help someone who requires frequent or complicated interventions, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state): _____

Comments

5. How important is it to consider *the stage of diagnosed medical conditions* when paneling someone for a Personal Care Home?

A diagnosed medical condition is a condition or disease that has been diagnosed by a physician and is currently being treated. This could include cardiovascular diseases such as congestive heart failure or hypertension; neurological diseases such as Alzheimer's, or Parkinson's; pulmonary diseases like COPD; Endocrine, Metabolic or Nutritional diseases such as diabetes; musculoskeletal diseases like Arthritis; or any other disease such as Cancer.

a) Condition is controlled through medication or treatments but may cause instability in mood, behaviours etc.

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

b) Condition has acute episodes or flair-ups (e.g., frequent episodes of swelling and pain from Arthritis)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

c) Person suffers daily from condition (e.g., Parkinson's tremors)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

a) Indicate the types of supports that you feel are most important to help someone whose condition is controlled through medications or treatments, remain in the community:

Select up to 2 options

- ☐ Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- ☐ Having an informal (unpaid) caregiver who is healthy and willing to provide care
- ☐ Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- ☐ Financial ability to afford to live in the community
- ☐ Other (please state): _____

b) Indicate the types of supports that you feel are most important to help someone whose condition has acute episodes or flair-ups, remain in the community:

Select up to 2 options

- ☐ Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- ☐ Having an informal (unpaid) caregiver who is healthy and willing to provide care
- ☐ Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- ☐ Financial ability to afford to live in the community

☐ Other (please state):

c) Indicate the types of supports that you feel are most important to help someone who suffers daily from a condition, remain in the community:

Select up to 2 options

☐ Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)

☐ Having an informal (unpaid) caregiver who is healthy and willing to provide care

☐ Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)

☐ Financial ability to afford to live in the community

☐ Other (please state):

Comments

6. How important is it to consider *the number of comorbidities a person has* when paneling someone for a Personal Care Home?

A comorbidity is the presence of more than one chronic disease at the same time. For example, a person who has diabetes and hypertension.

a) Person has 2 or less chronic conditions

○ Almost never admit

○ Almost always admit

○ Admission Depends

b) Person has 3-4 chronic conditions

○ Almost never admit

○ Almost always admit

○ Admission Depends

c) Person has 5 or more chronic conditions

○ Almost never admit

○ Almost always admit

○ Admission Depends

a) Indicate the types of supports that you feel are most important to help someone who has 2 or less chronic conditions, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

b) Indicate the types of supports that you feel are most important to help someone who has 3-4 chronic conditions, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

c) Indicate the types of supports that you feel are most important to help someone who has 5 or more chronic conditions, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

Comments

7. How important is it to consider *bladder continence* when paneling someone for a Personal Care Home?

Bladder continence is the ability to control the bladder. Incontinence is the lack of control over the bladder.

a) Usually Bladder Continent (Bladder incontinent 2 or less times a week)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

b) Occasionally to Frequently Bladder Incontinent (Bladder incontinent daily, although some control is present)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

c) Bladder Incontinent (Bladder incontinent multiple times daily)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

a) Indicate the types of supports that you feel are most important to help someone who is usually bladder continent, remain in the community:

Select up to 2 options

- ☐ Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- ☐ Having an informal (unpaid) caregiver who is healthy and willing to provide care
- ☐ Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- ☐ Financial ability to afford to live in the community
- ☐ Other (please state): _____

b) Indicate the types of supports that you feel are most important to help someone who is occasionally to frequently bladder incontinent, remain in the community:

Select up to 2 options

- ☐ Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- ☐ Having an informal (unpaid) caregiver who is healthy and willing to provide care
- ☐ Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- ☐ Financial ability to afford to live in the community
- ☐ Other (please state): _____

c) Indicate the types of supports that you feel are most important to help someone who is bladder incontinent, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

Comments

8. How important is it to consider *bowel continence* when paneling someone for a Personal Care Home?

Bowel continence is the ability to control the bowel. Incontinence is the lack of control over the bowel.

a) Usually Bowel Continent (Bowel incontinent less than weekly)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

b) Occasionally to Frequently Bowel Incontinent (Bowel incontinent up to 2 or 3 times a week)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

c) Bowel Incontinent (Bowel incontinent almost all the time)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

a) Indicate the types of supports that you feel are most important to help someone who is usually bowel continent, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

b) Indicate the types of supports that you feel are most important to help someone who is occasionally to frequently bowel incontinent, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

c) Indicate the types of supports that you feel are most important to help someone who is bowel incontinent, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

Comments

9. How important is it to consider *cognitive impairment* when paneling someone for a Personal Care Home?

Cognitive impairment is a decline in cognitive ability, such as memory.

a) Person has mild cognitive impairment (i.e., experiences some trouble with cognitive skills and sometimes has trouble making themselves understood)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

b) Person has moderate cognitive impairment (i.e., experiences moderate impairment with cognitive skills for daily decision-making (e.g., can't remember the day of the week), has trouble making themselves understood)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

c) Person has severe cognitive impairement or has been diagnosed with Dementia/Alzheimer's (i.e., severe impairment with cognitive skills and depends on help for activities (e.g., eating))

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

a) Indicate the types of supports that you feel are most important to help someone who has mild cognitive impairment, remain in the community:

Select up to 2 options

- ☐ Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- ☐ Having an informal (unpaid) caregiver who is healthy and willing to provide care
- ☐ Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- ☐ Financial ability to afford to live in the community
- ☐ Other (please state): _____

b) Indicate the types of supports that you feel are most important to help someone who has moderate cognitive impairment, remain in the community:

Select up to 2 options

- ☐ Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- ☐ Having an informal (unpaid) caregiver who is healthy and willing to provide care
- ☐ Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)

- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

c) Indicate the types of supports that you feel are most important to help someone who has severe cognitive impairment, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

Comments

10. How important is it to consider *psychological symptoms* when paneling someone for a Personal Care Home?

Psychological symptoms refer to issues regarding mental health that negatively affect quality of life.

a) Person frequently experiences anxiety or depression

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

b) Person has a diagnosed mental health disorder (e.g., bipolar disorder)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

c) Person experiences periods of psychosis and/or hallucinations

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

a) Indicate the types of supports that you feel are most important to help someone who experiences anxiety or depression, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

b) Indicate the types of supports that you feel are most important to help someone who has a diagnosed mental health disorder, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

c) Indicate the types of supports that you feel are most important to help someone who experinces periods of psychosis and/or hallucinations, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

Comments

11. How important is it to consider *substance use* when paneling someone for a Personal Care Home?

a) Regularly smokes (e.g., cigarettes, cannabis)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

b) Alcohol dependency or abuse (i.e., regularly consumes more than 3 drinks per day)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

c) Illicit drug dependency or abuse

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

a) Indicate the types of supports that you feel are most important to help someone who regularly smokes, remain in the community:

Select up to 2 options

- ☐ Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- ☐ Having an informal (unpaid) caregiver who is healthy and willing to provide care
- ☐ Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- ☐ Financial ability to afford to live in the community
- ☐ Other (please state):

b) Indicate the types of supports that you feel are most important to help someone who depends on or abuses alcohol, remain in the community:

Select up to 2 options

- ☐ Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- ☐ Having an informal (unpaid) caregiver who is healthy and willing to provide care
- ☐ Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- ☐ Financial ability to afford to live in the community
- ☐ Other (please state):

c) Indicate the types of supports that you feel are most important to help someone who

depends on or abuses illicit drugs, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

Comments

12. How important is it to consider *problematic behaviours* when paneling someone for a Personal Care Home?

Problematic behaviours include any behaviours displayed by an individual that are harmful or disruptive to themselves or others. These behaviours may be a result of cognitive impairment, mental illness, personality, etc.

a) Wandering

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

b) Displays socially inappropriate or disruptive behaviour (e.g., yelling, inappropriate sexual behaviour, hoarding)

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

c) Verbally or Physically abusive to self/others

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

a) Indicate the types of supports that you feel are most important to help someone who wanders, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

b) Indicate the types of supports that you feel are most important to help someone who displays socially inappropriate or disruptive behaviours, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

c) Indicate the types of supports that you feel are most important to help someone who is verbally or physically abusive, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

Comments

13. How important is it to consider *self-rated health* when paneling someone for a Personal Care Home?

Self-rated health refers to how healthy a person believes they are, regardless of their actual health status. Having poor self-rated health has been shown to be a strong predictor of mortality.

a) Person believes their health is poor

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

b) Person believes their health is fine

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

c) Person believes they are very healthy

- ○ Almost never admit
- ○ Almost always admit
- ○ Admission Depends

a) Indicate the types of supports that you feel are most important to help someone who believes their health is poor, remain in the community:

Select up to 2 options

- ☐ Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- ☐ Having an informal (unpaid) caregiver who is healthy and willing to provide care
- ☐ Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- ☐ Financial ability to afford to live in the community
- ☐ Other (please state): _____

b) Indicate the types of supports that you feel are most important to help someone who believes their health is fine, remain in the community:

Select up to 2 options

- ☐ Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- ☐ Having an informal (unpaid) caregiver who is healthy and willing to provide care
- ☐ Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- ☐ Financial ability to afford to live in the community

- [ ] Other (please state):

c) Indicate the types of supports that you feel are most important to help someone who believes they are very healthy, remain in the community:

Select up to 2 options

- [ ] Having strong, positive relationships with various friends, family, neighbours etc. (i.e., not being socially isolated)
- [ ] Having an informal (unpaid) caregiver who is healthy and willing to provide care
- [ ] Access to formal supports (e.g., home care, Adult Day Care, chore services, respite etc.)
- [ ] Financial ability to afford to live in the community
- [ ] Other (please state):

Comments

Additional Factors

Please list any additional factors that you feel are important to consider when paneling someone into a PCH.

1.
2.
3.

Appendix B: Full Survey Results

Survey Question	Rounds	Severity Level	Almost Never Admit	Admission Depends	Almost Always Admit
How important is it to consider impairment with activities of daily living, when paneling someone for a Personal Care Home?	Round 1	a) Person requires verbal prompting or limited assistance with at least one ADL	17%	0%	83%
		b) Person requires weight-bearing help to complete at least one ADL	8%	17%	75%
		c) Person is fully dependent on others to complete at least one ADL	8%	50%	42%
	Round 2	a) Person requires verbal prompting or limited assistance with at least one ADL	25%	0%	75%
		b) Person requires weight-bearing help to complete at least one ADL	0%	25%	75%
		c) Person is fully dependent on others to complete at least one ADL	0%	67%	33%
	Round 3	a) Person requires verbal prompting or limited assistance with at least one ADL	50%	42%	8%
		b) Person requires weight-bearing help to complete at least one ADL	0%	83%	17%
		c) Person is fully dependent on others to complete at least one ADL	0%	42%	58%
How important is it to consider impairment with instrumental activities of daily living when paneling someone for a Personal Care Home?	Round 1	a) Person requires supervision or limited assistance on at least one IADL	25.0%	8.3%	66.7%
		b) Person requires extensive assistance to complete instrumental activities of daily living	16.7%	25.0%	58.3%
		c) Person is fully dependent on help to complete instrumental activities of daily living	8.3%	50.0%	41.7%
	Round 2	a) Person requires supervision or limited assistance on at least one IADL	17%	8%	75%
		b) Person requires extensive assistance to complete instrumental activities of daily living	8%	25%	67%
		c) Person is fully dependent on help to complete instrumental activities of daily living	8%	58%	33%
	Round 3	a) Person requires supervision or limited assistance on at least one IADL	42%	58%	0%
		b) Person requires extensive assistance to complete instrumental activities of daily living	8%	67%	25%
		c) Person is fully dependent on help to complete instrumental activities of daily living	0%	42%	58%

How important is it to consider the number of prescription medications a person is taking when paneling someone for a Personal Care Home?	Round 1	a) Person takes 5 or fewer different prescription medications	42%	0%	58%
		b) Person takes 6-14 different prescription medications	25%	17%	58%
		c) Person takes 15 or more different prescription medications	17%	33%	50%
	Round 2	a) Person takes 5 or fewer different prescription medications	58%	0%	42%
		b) Person takes 6-14 different prescription medications	33%	8%	58%
		c) Person takes 15 or more different prescription medications	33%	8%	58%
	Round 3	a) Person takes 5 or fewer different prescription medications	83%	17%	0%
		b) Person takes 6-14 different prescription medications	50%	42%	8%
		c) Person takes 15 or more different prescription medications	33%	50%	17%
How important is it to consider the complexity of care needs when paneling someone for a Personal Care Home?	Round 1	a) Person is independent or requires infrequent care throughout the day	42%	0%	58%
		b) Person requires interventions every few hours	8%	25%	67%
		c) Person requires frequent (i.e., constant to hourly) and/or complicated interventions	0%	75%	25%
	Round 2	a) Person is independent or requires infrequent care throughout the day	58%	0%	42%
		b) Person requires interventions every few hours	8%	0%	92%
		c) Person requires frequent (i.e., constant to hourly) and/or complicated interventions	8%	42%	50%
	Round 3	a) Person is independent or requires infrequent care throughout the day	75%	25%	0%
		b) Person requires interventions every few hours	17%	83%	0%
		c) Person requires frequent (i.e., constant to hourly) and/or complicated interventions	0%	42%	58%
How important is it to consider the stage of diagnosed medical conditions when paneling someone for a Personal Care Home?	Round 1	a) Condition is controlled through medication or treatments but may cause instability in mood, behaviours etc.	25%	8%	67%
		b) Condition has acute episodes or flair-ups	42%	17%	42%
		c) Person suffers daily from condition	8%	25%	67%
	Round 2	a) Condition is controlled through medication or treatments but may cause instability in mood, behaviours etc.	41.7%	0.0%	58.3%
		b) Condition has acute episodes or flair-ups	50.0%	8.3%	41.7%
		c) Person suffers daily from condition	25.0%	8.3%	66.7%
	Round 3	a) Condition is controlled through medication or treatments but may cause instability in mood, behaviours etc.	58%	42%	0%
		b) Condition has acute episodes or flair-ups	42%	50%	8%
		c) Person suffers daily from condition	17%	75%	8%

How important is it to consider the number of comorbidities a person has when paneling someone for a Personal Care Home?	Round 1	a) Person has 2 or less chronic conditions	25%	0%	75%
		b) Person has 3-4 chronic conditions	17%	25%	58%
		c) Person has 5 or more chronic conditions	0%	50%	50%
	Round 2	a) Person has 2 or less chronic conditions	41.7%	0%	58%
		b) Person has 3-4 chronic conditions	41.7%	0.0%	58.3%
		c) Person has 5 or more chronic conditions	8.3%	16.7%	75.0%
	Round 3	a) Person has 2 or less chronic conditions	50%	50%	0%
		b) Person has 3-4 chronic conditions	25%	75%	0%
		c) Person has 5 or more chronic conditions	8%	75%	17%
How important is it to consider bladder continence when paneling someone for a Personal Care Home?	Round 1	a) Usually Bladder Continent (Bladder incontinent 2 or less times a week)	67%	0%	33%
		b) Occasionally to Frequently Bladder Incontinent	33%	8%	58%
		c) Bladder Incontinent	0%	50%	50%
	Round 2	a) Usually Bladder Continent (Bladder incontinent 2 or less times a week)	75%	0%	25%
		b) Occasionally to Frequently Bladder Incontinent	33%	0%	67%
		c) Bladder Incontinent	17%	42%	42%
	Round 3	a) Usually Bladder Continent (Bladder incontinent 2 or less times a week)	83%	17%	0%
		b) Occasionally to Frequently Bladder Incontinent	42%	58%	0%
		c) Bladder Incontinent	8%	50%	42%
How important is it to consider bowel continence when paneling someone for a Personal Care Home?	Round 1	a) Usually Bowel Continent	58%	0%	42%
		b) Occasionally to Frequently Bowel Incontinent	25%	25%	50%
		c) Bowel Incontinent	17%	67%	17%
	Round 2	a) Usually Bowel Continent	58%	0%	42%
		b) Occasionally to Frequently Bowel Incontinent	17%	17%	67%
		c) Bowel Incontinent	8%	75%	17%
	Round 3	a) Usually Bowel Continent	67%	33%	0%
		b) Occasionally to Frequently Bowel Incontinent	25%	67%	8%
		c) Bowel Incontinent	8%	33%	58%
How important is it to consider cognitive impairment when paneling someone for a Personal Care Home?	Round 1	a) Person has mild cognitive impairment	25%	17%	58%
		b) Person has moderate cognitive impairment	25%	25%	50%
		c) Person has severe cognitive impairment or has been diagnosed with Dementia/Alzheimer's	0%	67%	33%
	Round 2	a) Person has mild cognitive impairment	42%	0%	58%
		b) Person has moderate cognitive impairment	8%	8%	83%
		c) Person has severe cognitive impairment or has been diagnosed with Dementia/Alzheimer's	0%	83%	17%
	Round 3	a) Person has mild cognitive impairment	50%	50%	0%
		b) Person has moderate cognitive impairment	8%	83%	8%
		c) Person has severe cognitive impairment or has been diagnosed with Dementia/Alzheimer's	0%	25%	75%

How important is it to consider psychological symptoms when paneling someone for a Personal Care Home?	Round 1	a) Person frequently experiences anxiety or depression	33%	0%	67%
		b) Person has a diagnosed mental health disorder	17%	8%	75%
		c) Person experiences periods of psychosis and/or hallucinations	8%	42%	50%
	Round 2	a) Person frequently experiences anxiety or depression	50%	0%	50%
		b) Person has a diagnosed mental health disorder	42%	0%	58%
		c) Person experiences periods of psychosis and/or hallucinations	8%	42%	50%
	Round 3	a) Person frequently experiences anxiety or depression	58%	42%	0%
		b) Person has a diagnosed mental health disorder	33%	67%	0%
		c) Person experiences periods of psychosis and/or hallucinations	17%	50%	33%
How important is it to consider substance use when paneling someone for a Personal Care Home?	Round 1	a) Regularly smokes	58%	0%	42%
		b) Alcohol dependency or abuse	42%	0%	58%
		c) Illicit drug dependency or abuse	33%	8%	58%
	Round 2	a) Regularly smokes	75%	0%	25%
		b) Alcohol dependency or abuse	67%	8%	25%
		c) Illicit drug dependency or abuse	42%	8%	50%
	Round 3	a) Regularly smokes	67%	33%	0%
		b) Alcohol dependency or abuse	67%	33%	0%
		c) Illicit drug dependency or abuse	50%	33%	17%
How important is it to consider problematic behaviours when paneling someone for a Personal Care Home?	Round 1	a) Wandering	25%	33%	42%
		b) Displays socially inappropriate or disruptive behaviour	0%	33%	67%
		c) Verbally or Physically abusive to self/others	0%	67%	33%
	Round 2	a) Wandering	17%	8%	75%
		b) Displays socially inappropriate or disruptive behaviour	8%	25%	67%
		c) Verbally or Physically abusive to self/others	8%	67%	25%
	Round 3	a) Wandering	42%	58%	0%
		b) Displays socially inappropriate or disruptive behaviour	17%	75%	8%
		c) Verbally or Physically abusive to self/others	17%	33%	50%
How important is it to consider self-rated health when paneling someone for a Personal Care Home?	Round 1	a) Person believes they are very healthy	42%	0%	58%
		b) Person believes their health is fine	42%	0%	58%
		c) Person believes their health is poor	0%	0%	100%
	Round 2	a) Person believes they are very healthy	33%	0%	67%
		b) Person believes their health is fine	33%	0%	67%
		c) Person believes their health is poor	0%	0%	100%
	Round 3	a) Person believes they are very healthy	33%	67%	0%
		b) Person believes their health is fine	33%	67%	0%
		c) Person believes their health is poor	0%	100%	0%

How important is it to consider Feelings of Loneliness, when paneling someone for a Personal Care Home?	Round 2	a) Rarely feels lonely	92%	0%	8%
		b) Sometimes feels lonely	83%	0%	17%
		c) Often feels lonely	42%	0%	58%
	Round 3	a) Rarely feels lonely	100%	0%	0%
		b) Sometimes feels lonely	92%	8%	0%
		c) Often feels lonely	58%	42%	0%
How important is it to consider Mobility, when paneling someone for a Personal Care Home?	Round 2	a) Someone who is able to move around independently with the help of an assistive device	92%	0%	8%
		b) Someone who relies on personal assistance, in addition to an assistive device	42%	0%	58%
		c) Someone who relies entirely on personal assistance to move around their own living space	8%	42%	50%
	Round 3	a) Someone who is able to move around independently with the help of an assistive device	92%	8%	0%
		b) Someone who relies on personal assistance, in addition to an assistive device	33%	67%	0%
		c) Someone who relies entirely on personal assistance to move around their own living space	8%	50%	42%
How important is it to consider Vision Loss, when paneling someone for a Personal Care Home?	Round 2	a) Someone who has limited visual impairment	83.3%	0.0%	16.7%
		b) Someone who has moderate visual impairment	50.0%	0.0%	50.0%
		c) Someone who has severe visual impairment	16.7%	8.3%	75.0%
	Round 3	a) Someone who has limited visual impairment	83%	17%	0%
		b) Someone who has moderate visual impairment	58%	42%	0%
		c) Someone who has severe visual impairment	17%	75%	8%
How important is it to consider Hearing Loss, when paneling someone for a Personal Care Home?	Round 2	a) Someone who has limited hearing impairment	83%	0%	17%
		b) Someone who has moderate hearing impairment	75%	0%	25%
		c) Someone who has severe hearing impairment,	33%	8%	58%
	Round 3	a) Someone who has limited hearing impairment	92%	8%	0%
		b) Someone who has moderate hearing impairment	75%	25%	0%
		c) Someone who has severe hearing impairment,	33%	50%	17%