REPORT OF CONTINUING CARE ORGANIZATION AND TERMINOLOGY

Prepared on behalf of the Federal/Provincial/Territorial Committee of Officials (Seniors) for the Minister Responsible for Seniors

by

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EXECUTIVE SUMMARY

This report on the organization and terminology of Continuing Care systems in Canada was prepared for the officials of the federal, provincial and territorial Ministers Responsible for Seniors in response to the Ministers' request that they propose a common vocabulary for describing Continuing Care systems and components across jurisdictions. The two primary objectives of the study were as follows:

- To provide an up-to-date brief description of the structure and components of Continuing Care in all provinces and territories.

- To develop an easy-to-grasp reference framework incorporating all current Continuing Care systems/components that would allow Ministers to readily understand how system or component features in another jurisdiction related to their own system.

Data for the study were collected through telephone interviews with key officials in each province and territory from mid-September to early December 1997. The officials interviewed also provided written documentation about their service delivery system, as appropriate. Representatives of two regional boards per province for Alberta, Saskatchewan and Newfoundland were also interviewed, given that most of the operational responsibility for the delivery of services has been delegated to the regional level in those three provinces. It was anticipated that there would be some degree of regional variation.

This report is organized in the following manner. Chapter two provides a brief overview of key terms and key service delivery and organizational variables. Chapter three provides a summary, across jurisdictions, of the major terms and service delivery models in each jurisdiction and definitions for the different Continuing Care services. A description of how services are organized, and what terminology is used, in each jurisdiction is presented in Appendix A.

This study found that six provinces and one territory (BC, Alberta, Manitoba, Nova Scotia, PEI, Newfoundland, and the Northwest Territories) use the term Continuing Care to describe the full range of care services for the elderly and disabled, although in most cases, the term is now used as a descriptive term or as a concept, or organizing framework, for providing a continuum of services, rather than as an administrative term to identify a branch or division of government. It is also used in the Saskatoon Regional Board and the two Newfoundland Boards. The term Long Term Care is used as an overall umbrella term in two jurisdictions (Ontario and New Brunswick). Saskatchewan uses the term Supportive Services as an umbrella term, and the Yukon and Quebec do not use a single umbrella term to describe the full array of services in their systems.

With regard to facility care, five provinces (Saskatchewan, Manitoba, Quebec, Nova Scotia, and PEI), and two of the six regional boards (Regina and Saskatoon) use the term Long Term Care to describe facility care. Four provinces (BC, Ontario, New

Brunswick, and Newfoundland) and one territory (NWT) may use the term Long Term Care descriptively to refer to Long Term Care facilities, but more generally use the name of the actual facility types (e.g., nursing home). The Yukon, Alberta Health, and the Capital Health Authority in Edmonton use the term Continuing Care to refer to facility services.

It should be noted that in Atlantic Canada, clients are income and asset tested and may have to pay up to the full cost of care, or an amount which is capped that is considerably more than the room and board costs of care. In the rest of Canada, clients may be income tested and may have to pay up to a fixed per diem to cover "room and board" costs.

Seven provinces, both territories and five of the six regional boards use the term Home Care to refer to professional home based care services. British Columbia uses the actual names of its nursing and rehabilitative services. Saskatchewan uses the term Home Based Services. New Brunswick uses the term Home Health Care for services provided through the Extra-Mural Program, and Prince Edward Island uses the term Home Care Support (i.e., Home Care and Home Support). The term Home Support, or the subset of Home Support services provided in the home, is subsumed under Home Care in seven provinces or territories (NWT, Yukon, Alberta, Manitoba, Ontario, Quebec, and Nova Scotia). Other jurisdictions (Saskatchewan, PEI) include Home Support in a re-named Home Care/Home Support service (e.g., Home Care Support in PEI), or use the term but restrict its usage to be the same as Homemaker services (e.g., BC). New Brunswick and Newfoundland use the term Home Support.

Currently, only Ontario and Prince Edward Island have Divisions of Long Term Care or Continuing Care which are responsible for the funding and administration of all residential and home and community services. British Columbia and Prince Edward Island are the only two jurisdictions with identical care level classification systems for residential and community based clients in which a care level is assigned for all clients when the initial care plan is developed. Other jurisdictions (e.g., Newfoundland) may also use their existing classification systems to designate a care level for higher needs clients who are community based. Alberta, and the two regional boards in Alberta, have Residential and Home Care classification systems which are fairly comparable in regard to the functional needs of clients, and Alberta is working on developing an integrated system. None of the other provinces, territories, or boards have a specific Home Care classification system based on functional needs.

In terms of single entry systems, seven provinces and five of the six regional boards have relatively fully developed single entry systems (BC, Alberta, Saskatchewan, Manitoba, New Brunswick, PEI, and Newfoundland). Other jurisdictions have partial single entry systems which cover many, but not all, of the services typically included in Continuing Care (Ontario), or they have parallel systems for facility care and Home Care (Yukon, Quebec, and Nova Scotia). However, Quebec is rapidly moving to a single entry system through their CLSCs

(community health centres). The Northwest Territories is currently developing a single entry system. Almost all jurisdictions have a standardized assessment tool for Home Care and residential care, or for residential care alone. All jurisdictions and boards have some form of case management. However, only in Continuing Care in British Columbia and in Social Services in Nova Scotia do community based case managers continue to be involved with the client even after the client is admitted to a facility.

With regard to specific services, survey respondents were provided with a generic set of names and definitions for most of the services which are generally included in a Continuing Care system of service delivery. They were asked whether or not the names and definitions were appropriate to their jurisdiction, and if not, to provide suggested changes. They were also asked to provide the specific names used in their jurisdiction for each type of service. We have tried to incorporate as many of the suggestions received as possible into a revised set of names and definitions which are presented in Appendix B of this report. Perhaps these new names and definitions can be a starting point for gaining greater consensus on terminology across jurisdictions.

ACKNOWLEDGEMENTS

The conduct of this study was only possible due to the cooperation of the survey respondents from each province, territory, and regional board, and for that we thank them.

We would also like to thank Ellen Leibovich, Louise Plouffe, Howard Bergman, and Terry Kaufman for their assistance with the Quebec portion of this study, and Anthony Beks, of Capital Stenographic Services in Victoria, for his unstinting assistance in typing and otherwise preparing this report.

Producing a report such as this is a complex task. The cooperation we received from across Canada was exceptional. The authors take responsibility for any errors or omissions in this report.

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1. INTRODUCTION

The federal, provincial and territorial Ministers Responsible for Seniors have mandated their officials to propose a common vocabulary to describe Continuing Care systems and system components across jurisdictions. In order to achieve this goal, staff of the Division of Aging and Seniors, Health Canada, engaged Hollander Analytical Services Ltd. to conduct a study of Continuing Care systems, system components, and definitions (the terminology used to describe services) for each province and territory. The two primary objectives of this study were as follows:

- To provide an up-to-date brief description of the structure and components of Continuing Care in all provinces and territories.

- To develop an easy-to-grasp reference framework incorporating all current Continuing Care systems/components that would allow Ministers to readily understand how system or component features in another jurisdiction related to their own system.

Data for this study were collected through telephone interviews with key officials in each province and territory from mid-September to early December 1997. The initial contacts for the study were members of the Federal/Provincial/Territorial Committee of Officials for Ministers for Seniors in each jurisdiction. These contacts identified the people who were the most appropriate to interview in each jurisdiction and facilitated our access to these officials. Between one and five telephone interviews were conducted in each jurisdiction. The officials we interviewed also provided comments on a set of definitions of Continuing Care services provided by the research team. This included providing the specific terms used in their jurisdiction for each component of Continuing Care. They also provided written documentation about their service delivery system, as appropriate. Representatives of two regional boards per province for Alberta, Saskatchewan and Newfoundland were also interviewed, given that most of the operational responsibility for the delivery of services has been delegated to the regional level in those three provinces. It was anticipated that there would be some degree of regional variation.

This report is organized as follows. Chapter two provides a brief overview of key terms and key service delivery and organizational variables. Chapter three provides a summary, across jurisdictions, of the major terms and service delivery models in each jurisdiction and definitions for the different Continuing Care services. Appendix A provides a description of the use of major terms, such as Continuing Care and Home Care, and an overview of how services are organized, for each jurisdiction. Appendix B provides original and revised definitions of Continuing Care service components. Appendix C lists additional Continuing Care services that were identified by respondents as being available in their jurisdictions.

2. OVERVIEW OF KEY TERMS AND CONCEPTS

Introduction

Survey respondents were asked how the major terms Continuing Care, Long Term Care, Home Care and Home Support were used in their respective jurisdictions. There are a number of potential definitions for these terms. To provide an initial basis for comparison, the following provides a discussion of how these terms have been used in Canada. This discussion is based on findings from a national study of Continuing Care conducted in 1993 for Statistics Canada.[1] The purpose of the 1993 study was to determine the feasibility of developing a national data base for Continuing Care services. It included a review of how Continuing Care services were organized in each province. The findings of that component of the study were briefly presented in the 1993 report. The findings were also presented, in a more comprehensive manner, in the report entitled, The Costs, and Cost-Effectiveness, of Continuing Care Services in Canada.[2] In Chapter three, we shall discuss the extent to which the use of terminology has changed from the formulation presented in this chapter.

Key Terms

Continuing Care

Continuing Care is a term that is generally used to describe a system of service delivery which includes all of the services provided by Long Term Care, Home Care and Home Support. This term reflects within it two complementary concepts: that care may "continue" over a long period of time, and that an integrated program of care "continues" across service components, that is, that there is a continuum of care from community services such as Meals-on-Wheels to care in geriatric units in acute care hospitals.

It is important to note that Continuing Care is, in fact, not a type of service, such as hospital care or physician services, but a complex "system" of service delivery. This system has a number of components and is integrated through a "continuum of care." The efficiency and effectiveness of the system depends not only on the efficiency and effectiveness of each component, but also on the way that the service delivery system, itself, is structured. This point has been made in the document Future Directions in Continuing Care which states:

> Continuing care is multifaceted and combines aspects of both health and social services. Unlike hospital care or physician services, varied as they may be, continuing care is an amalgamation of diverse categories of service. These categories are integrated by an overall "system" of service delivery. Thus ... it is important to remember that *continuing care is not a type of service, but a system of service delivery*. The efficiency and effectiveness of that system is based not only on its constituent parts, but also on the nature of the system itself.[3]

In a few instances, the term Continuing Care has also been used to refer to a set of services that include community based Long

Term Care services and Home Care services but exclude residential Long Term Care services. This definition was used in Manitoba until the early 1990s and has also been used in Newfoundland.

Long Term Care

One of the typical uses of the term Long Term Care is to refer to residential services. In this model, adult day care services operating in Long Term Care facilities may be considered to be part of residential "Long Term Care" services because they are provided in an institutional setting. In this type of system, Home Care services often expand from their core base of nursing services to include Home Support services, such as homemakers. Therefore, in a number of jurisdictions, there is a split between Long Term Care (defined as residential care) and Home Care (defined as home and community based care). The responsibility for community based services, such as adult day care centres and group homes, may vary across jurisdiction in this model (e.g., facility based adult day care centres may be in Long Term Care while stand-alone centres may be in Home Care). In some jurisdictions a clear distinction is made between Home Support and Home Care services.

The term Long Term Care also has a second, and very different, meaning. This term has come to refer to both residential and community based services and has come to have a meaning similar to the term Continuing Care. This usage was reflected in the establishment, in 1986, of the Federal/ Provincial/Territorial (F/P/T) Sub-Committee on Long Term which defined Long Term Care as follows:

> Long term care represents a range of services that address the health, social and personal care needs of individuals who, for one reason or another, have never developed or have lost some capacity for self-care. Services may be continuous or intermittent, but it is generally presumed that they will be delivered for the 'long term' that is, indefinitely to individuals who have demonstrated need, usually by some index of functional incapacity.[4]

This definition includes residential long term care services, community and home based long term care services (i.e., home support) and longer term home care services.

Home Support

Home and community based Long Term Care services, generally provided by persons other than professionals such as nurses or rehabilitation therapists (e.g., homemakers), are often referred to as "Home Support" services, even though some of these services are provided in the community. Adult day care and group home services are community based "Home Support" services. Going to adult day care centres provides support to people living at home by providing needed health services and the opportunity for socialization. It is believed that persons who attend such centres can continue to live at home for longer periods of time. In addition, adult day care services can provide a period of respite for family caregivers. In group homes, individuals typically pay for the room and board component of care in "their home" and only the care component of services is paid for by

government, thus providing "Home Support" for persons in group living situations.

Home Care

How have Home Care services been defined? A Working Group on Home Care was established under the F/P/T Sub-Committee on Long Term Care to review the major issues in home care. Their report recognized the conceptual confusion around the term "Home Care." The report stated that "... there is no precise and universally accepted definition ... home care therefore has different meanings in different places." [5]

The report goes on to clarify matters by noting that there are three distinct models of Home Care:

- The **maintenance and preventive model**, which serves people with health and/or functional deficits in the home setting, both maintaining their ability to live independently, and in many cases preventing health and functional breakdowns, and eventually institutionalization;
- The **long term care substitution model**, where home care meets the needs of people who would otherwise require institutionalization;
- The **acute-care substitution model**, where home care meets the needs of people who would otherwise have to remain in, or enter, acute care facilities.

The first model entails providing care to individuals in their own homes to help them maintain their independence. The second model is a substitute for placement in a Long Term Care facility. The third model refers to relatively short periods of care in which Home Care serves as a substitute for acute care. It is this third model which is distinct from the broadest definitions of Long Term Care. It is, however, included in the term Continuing Care, both for historical reasons (it is part of the overall approach to Home Care) and because it constitutes a clear continuum of care services from one setting to another.

The Organization of Service Delivery

Introduction

This study investigated how services are organized and delivered in Canadian jurisdictions. Respondents were asked to provide information on five major features of Continuing Care systems: single entry, assessment and placement, case management, client classification, and the organizational structure of the ministry or regional board responsible for the stewardship of the Continuing Care system. A brief discussion is presented below of each of these system components.[6]

Key System Characteristics

Single Entry

A single entry system for the accessing of Continuing Care services provides a consistent screening mechanism that ensures that only those with appropriate needs are provided services. This increases overall systems efficiencies because it minimizes the probability that unnecessary care may be provided. In addition, single entry provides a single focal point, in local communities, for "one stop shopping" for care services. This means that individuals do not have to speak to multiple sources to find out about

what services are available and how they can be accessed. This increases the level of accessibility to the care system. In systems without single entry, people may not obtain care, or the most appropriate care, because of a lack of knowledge about what is available to them.

Coordinated Assessment and Placement
Coordinated assessment and placement ensures that there is an appropriate determination of need and that an initial care plan is developed that is most closely suited to the needs of the client. Based on this care plan, the client is "placed" (i.e., provided access to care) in any of the components of the service delivery system, regardless of whether these services are provided in institutions, the community or the client's own home. Coordinated assessment and placement increases systems efficiencies because, during this process, consideration is given to whether or not clients can be cared for in the community as opposed to a facility. In most cases, community based care is less expensive. At a clinical level, the assessment and placement process maximizes the probability that the most appropriate services are provided based on the needs of the client. Finally, coordinated assessment allows for the collection of the same information for residential and community based clients on admission to the overall care system.

Coordinated Case Management
Coordinated case management coordinates the provision of necessary services across the service components of the overall system and ensures that there is regular monitoring and review of client needs. As needs change, care plans are adjusted to ensure that there is a continuing match between the needs of the client and the care provided. This again provides for good care and increases systems efficiencies by not allowing clients to deteriorate through lack of regular monitoring to the point where more costly services, such as a Long Term Care facility or an acute-care hospital, may be required.

Client Care Level Classification
Having a consistent care level classification system allows for the comparison of clients across service delivery components, by level of care, i.e., an "apples to apples" comparison. This, in turn, allows analysts to determine the extent to which greater efficiencies may be possible (e.g., to what extent are clients who could be treated appropriately at less cost in the community being admitted to residential care). It should be noted, however, that while community based care is typically less expensive, within each level of care, this is not always the case.

Without being able to compare levels of care, it is not readily possible to determine the extent to which similar types of clients are served across service components. Without this knowledge, one cannot plan for an efficient and effective mix of services, i.e., plan on a system-wide basis. For example, if all community and home based clients are at low levels of care and all facility clients are a high levels, providing more resources to community services, and reducing beds, may only result in having more clients at low levels of care in the community while depriving those with high care needs of the facility based care they require. Conversely, if a significant

proportion of community based clients are at higher levels of care, and a proportion of facility clients are at lower levels of care, the system may be capable of greater efficiencies because community and home based services have demonstrated their capacity to care for people who may be at an equivalent level of need as those in facility care. Without having comparable care levels, this type of analysis is much more difficult.

Administrative Arrangements

Having a single administration to provide oversight to all Continuing Care services has several positive aspects. Government funds can typically be more readily transferred between residential and community based services, to maximize systems efficiencies, if they are in one division rather than if they are split between two divisions or two ministries. Similarly, at a policy level, a single administration maximizes the probability that policy issues are viewed in the context of the total Continuing Care system. At the clinical level, a single administration maximizes the probability that care staff have a sense of the overall Continuing Care system, the roles that each of the service components play in the system, and, therefore, the way that the needs of the client can best be met within the system. At a planning level, a single administration maximizes the probability that planning and resource allocation will be done on an overall systems basis, rather than on a component by component basis.

3. THE USE OF MAJOR TERMS AND THE ORGANIZATION OF CONTINUING CARE SERVICES ACROSS JURISDICTIONS

There have been numerous changes in Continuing Care over the past five years. There seems to have been an enhancement of the clinical characteristics of single entry, standardized assessment, and case management within the Continuing Care sector. There does not seem to have been as much forward progress on adopting comparable care level classification systems across facility and community care. Such comparability can be quite helpful for planning initiatives to increase the efficiency and effectiveness of the system. There also seems to have been a decrease in the use of a single administrative structure for the management of Continuing Care services. In 1992/93, there were single administrative structures responsible for all residential and community based Continuing Care services within Ministries/Departments of Health in BC, Saskatchewan, Manitoba, Ontario, Quebec, and PEI. Currently, such structures now only exist in Ontario, PEI, and the NWT. However, good coordination can achieve many of the same benefits as a single administrative structure.

With regard to the terminology used, there are numerous similarities in how the terms Continuing Care, Long Term Care, Home Care, and Home Support are used today compared to 1992/93, except that the term Continuing Care is now used more as a descriptive than an administrative term. With regard to the term Continuing Care, two jurisdictions (Yukon and Quebec), and three of the six regional boards (Edmonton, Calgary, and Regina), do not have an umbrella term which covers the full range of services. Six provinces and one territory (BC, Alberta, Manitoba, Nova Scotia, PEI, Newfoundland, and the Northwest Territories) use the term Continuing Care to describe the full range of care services, although in most cases, the term is now used as a descriptive term or as a concept, or organizing framework, for providing a continuum of services. It is also used in the Saskatoon Regional Board and the two Newfoundland Boards. The term Long Term Care is used as an overall umbrella term in two jurisdictions (Ontario and New Brunswick). Saskatchewan uses the term Supportive Services as an umbrella term.

With regard to facility care, five provinces (Saskatchewan, Manitoba, Quebec, Nova Scotia, and PEI), and two of the six regional boards (Regina and Saskatoon), use the term Long Term Care to describe facility care. Four provinces (BC, Ontario, New Brunswick, and Newfoundland) and one territory (NWT) may use the term Long Term Care descriptively to refer to Long Term Care facilities, but more generally use the name of the actual facility types (e.g., nursing home). The Yukon, Alberta Health, and the Capital Health Authority (Edmonton) use the term Continuing Care to refer to facility services.

It should be noted that in Atlantic Canada, clients are income and asset tested and have to pay up to the full cost of care, or an amount which is capped that is considerably beyond the room and board costs of care. In the rest of Canada, clients may be income tested and may have to pay up to a fixed per diem to cover “room and board” type costs.

Seven provinces, both territories, and five of the six regional boards use the term Home Care to refer to professional home based care services. British Columbia uses the actual names of its nursing and rehabilitative services. Saskatchewan uses the term Home Based Services. New Brunswick uses the term Home Health Care for services provided through the Extra-Mural Program, and Prince Edward Island uses the term Home Care Support (i.e., Home Care and Home Support). The term Home Support, or the subset of Home Support services provided in the home, is subsumed under Home Care in seven provinces or territories (NWT, Yukon, Alberta, Manitoba, Ontario, Quebec, and Nova Scotia). Other jurisdictions (Saskatchewan, PEI) include it in a re-named Home Care/Home Support service (e.g., Home Care Support in PEI), or use the term but restrict its usage to be the same as Homemaker services (e.g., BC). New Brunswick and Newfoundland use the term Home Support.

Table two provides an overview of how services are organized. Ontario and Prince Edward Island have Divisions of Long Term Care and Continuing Care, respectively. British Columbia and Prince Edward Island are the only two jurisdictions with identical care level classification systems for residential and community based clients in which a care level is assigned for all clients when the initial care plan is developed. Other jurisdictions (e.g., Newfoundland) may also use their existing classification system to designate a care level for higher needs clients who are community based. Alberta (and the two regional boards in Alberta) have Residential and Home Care classification systems which are fairly comparable in regard to the functional needs of clients. None of the other provinces, territories, or boards have a specific Home Care classification system based on functional needs.

In terms of single entry, seven provinces and five of the six regional boards have relatively fully developed single entry systems (BC, Alberta, Saskatchewan, Manitoba, New Brunswick, PEI, and Newfoundland). Other jurisdictions have partial single entry systems which cover many, but not all, of the services typically included in Continuing Care (Ontario), or they have parallel systems for facility care and Home Care (Yukon, Quebec, and Nova Scotia). However, Quebec is rapidly moving to a single entry system through its CLSCs (community health centres). The Northwest Territories is currently developing a single entry system. Almost all jurisdictions have a standardized assessment tool for Home Care and residential care, or for residential care alone. All jurisdictions and boards have some form of case management. However, only in Continuing Care in British Columbia and Social Services in Nova Scotia do community based case managers continue to be involved with the client even after the client is admitted to a facility.

In terms of specific services, survey respondents were provided with a generic set of names and definitions for most of the services which are generally included in a Continuing Care system of service delivery. They were asked whether or not the names and definitions were appropriate to their jurisdiction, and if not, to provide suggested changes. They were also asked to provide the specific names used in their jurisdiction for each type of service. It is recognized that it is very difficult to reach consensus on definitions across jurisdictions. We do not

claim to have done so. However, we have tried to incorporate as many of the suggestions received as possible into a revised set of names and definitions. Perhaps these new names and definitions can be a starting point for gaining greater consensus on terminology across jurisdictions.

Appendix B provides a listing of the original names and definitions which were sent out to survey respondents. It also provides a listing of the revised names and definitions based on the input received from respondents.

Table three is a detailed table which presents, for each type of service (using the new names from Appendix B), information on whether or not the service is available in each jurisdiction, whether it is in that jurisdiction's Continuing Care system, and what name(s) is used to describe the service in that jurisdiction. It should be noted that this table does not provide one hundred percent accuracy. Given that Continuing Care is now more of a concept than an administrative reality, respondents may have used their own interpretation of what is in and out of their Continuing Care system. Some may have used funding as a criteria for inclusion, while others may have used the concept (i.e., it is in Continuing Care broadly defined). It is believed that the responses are relatively consistent, valid, and reliable, but much more work would be required to obtain responses on absolutely identical criteria. In some cases, it may not even be possible to do so as a given service may be included according to one key criterion but not another. For example, a service may be funded by a funder external to Continuing Care, but access may only be obtained by going through the single entry system. This was the case for Extended Care hospitals in British Columbia which were founded through Hospital Care but could only be accessed through Continuing Care.

It should also be noted that in most jurisdictions, Chronic Care is now part of Long Term Care, and a distinction is no longer made between Chronic Care beds and Long Term Care beds. In these cases, table three notes that Chronic Care is not available but is included in residential Long Term Care. The definition of Long Term Care Facilities in Appendix B has been adjusted accordingly.

Appendix C is a compilation of additional services (i.e., services not covered in table three) which were identified by our respondents as being offered in their respective jurisdictions.

TABLE 1: SUMMARY OF THE USE OF MAJOR TERMS ACROSS JURISDICTIONS

JURISDICTION	MAJOR TERMS			
	Umbrella term to refer to the overall system of care	**Term used for the full range of residential services**	**Term used for the range of professional health services provided in clients homes or in community settings**	**Term used for non-professional services provided in the home and for supportive community services**
Northwest Territories	• Use of terminology is in transition • Now use Continuing Care; formerly used Long Term Care	• Long Term Care	• Coordinated Home Care Program	• Use Home Support but generally included in Home Care (Coordinated Home Care Program)
Yukon	• No specific term	• Continuing Care is now used • Use of the term Long Term Care is fading	• Home Care	• Home Care
British Columbia	• Continuing Care was used in a descriptive and administrative way. With regionalization now used more as a descriptive term to denote a strategy of how to deliver services • Long Term Care was used to describe facilities and home and community services, excluding short term Home Care. Term is now fading away	• Names of types of facilities (e.g., intermediate care, extended care, multi-level care) • Residential Care	• Do not use Home Care, use: - Community Home Care Nursing - Community Rehabilitation	• Used to use the term Home Support. Now Home Support is coming to be synonymous with Homemaker services. Use actual name for community services (e.g., meal programs, group homes, adult day care) or refer to these services in aggregate as Community Support Programs
Alberta - Alberta Health	• Use of terminology in transition • Use Continuing Care as an umbrella term and as a concept and organizing framework	• Continuing Care Centres	• Home Care	• Home Care

JURISDICTION	MAJOR TERMS			
	Umbrella term to refer to the overall system of care	**Term used for the full range of residential services**	**Term used for the range of professional health services provided in clients homes or in community settings**	**Term used for non-professional services provided in the home and for supportive community services**
Alberta - Capital Health Region (Edmonton)	• No specific term	• Continuing Care Centres	• Home Care	• Home Care
Alberta - Calgary Regional Health Authority	• No specific term	• Supported Living	• Community Care and Support - Home Care	• Community Care and Support - Home Care
Saskatchewan - Saskatchewan Health	• Terminology is in a state of transition in Saskatchewan • Term used to be Continuing Care but has now changed to Supportive Services	• Long Term Care used to refer to residential services but this term is in decline	• Used to be Home Care, now Home Based Services	• Used to be Home Care, now term is Home Based Services
Saskatchewan - Regina Health District	• No specific term	• Long Term Care	• Home Care	• Home Care
Saskatchewan - Saskatoon District Health	• Terminology is in a state of transition in Saskatoon • Continuing Care can be used as umbrella term	• Long Term Care (more common) • Continuing Care (sometimes used)	• Home Care (including Home Support) • Home Care can also be used to refer to Home Nursing Care only	• Home Care (as umbrella term to include Home Support) • Home Support
Manitoba	• Continuing Care used in a descriptive way to denote overall system of care. Use of term is unofficial	• Long Term Care (includes personal care and chronic care facilities)	• Home Care	• Home Care

JURISDICTION	MAJOR TERMS			
	Umbrella term to refer to the overall system of care	**Term used for the full range of residential services**	**Term used for the range of professional health services provided in clients homes or in community settings**	**Term used for non-professional services provided in the home and for supportive community services**
Ontario	• Long Term Care	• Long Term Care may also be used to describe facility care (e.g., nursing homes and homes for the aged) • Chronic Care hospitals, or wards in hospitals, are <u>not</u> included in the Ontario Long Term Care system	• Home Care	• Home Care (for one-on-one care) • Community Support Services (for home/community services, e.g., meal programs, adult day care) • Group Homes are not included in the Ontario Long Term Care system
Québec	• No specific term	• Institutional Long Term Care (service d'hébergement et de soins de longue durée)	• Home Care (service à domicile de première ligne)	• Home Care
New Brunswick	• Long Term Care	• Use name of type of facility (e.g., nursing home, residential facility-1, residential facility-2 [RF1, RF2, etc])	• Home Care only used descriptively. Professional services delivered through Extra-Mural Programs and referred to as Home Health Care	• Home Support

JURISDICTION	MAJOR TERMS			
	Umbrella term to refer to the overall system of care	**Term used for the full range of residential services**	**Term used for the range of professional health services provided in clients homes or in community settings**	**Term used for non-professional services provided in the home and for supportive community services**
Nova Scotia	• Continuing Care used as a conceptual and strategic bridge, or framework, for integrating a wide range of services across the Departments of Health and Community Services	• Long Term Care (Homes for the Aged and Nursing Homes in the Department of Health) • Long Term Care (all clients who need care in a structured setting, i.e., facility, group home, community, in the Department of Community Social Services)	• Home Care (does not include physiotherapy and occupation therapy which are provided through hospital outreach)	• Home Care • There is a separate In-Home Program which provides Home Support services to adults with special needs through the municipalities
Prince Edward Island	• Continuing Care	• Long Term Care	• Home Care Support	• Home Care Support
Newfoundland - Department of Health and St. John's and Central Regions	• Continuing Care may be used descriptively, but administratively does not include Nursing Homes or Chronic Care	• Nursing Homes (for higher level care facilities) • Personal Care Homes (for lower level care facilities)	• Continuing Care (administrative term) in the Department of Health • Home Care (descriptive term)	• Continuing Care (administrative term) in the Department of Health • Home Support (descriptive term)

TABLE 2: SUMMARY OF KEY ASPECTS OF SERVICE DELIVERY AND ORGANIZATION ACROSS JURISDICTIONS

JURISDICTION	KEY COMPONENTS				
	Single Entry	**Standardized Assessment**	**Ongoing System Wide Case Management**	**Client Classification**	**Administrative Arrangements**
Northwest Territories	• Working on developing single point of entry	• Standardized assessment for facility care • Home Care General Assessment	• Case Management provided through Home Care and Home Support, also do hands on care • Transfer case management to facility staff when client admitted to facility	• Six level classification system (levels 5 and 6 for rehab and acute care, respectively) for facilities • Do not have classification system for Home Care	• All services come under the Manager of Programs and Services, in the Program, Planning, Support and Evaluation Division
Yukon	• Separate single entry systems for facility care and Home Care	• Standardized assessment for facility care • Do not have standardized assessment for Home Care, but have standardized process of handling clients	• Case Management for Home Care, and hands on delivery. • Transfer case management to facility staff when client admitted to a facility	• Five levels of care system for facilities • No classification system for Home Care but may informally classify clients for planning and statistical purposes using facility classification tool	• Separate administrative arms for Continuing Care (Residential) and Home Care (Community)

JURISDICTION	KEY COMPONENTS				
	Single Entry	**Standardized Assessment**	**Ongoing System Wide Case Management**	**Client Classification**	**Administrative Arrangements**
British Columbia	• Have single entry for all longer term clients including those needing professional home care services • Have single entry for Community Home Care Nursing and Community Rehabilitation	• Have standardized assessment for all longer term clients • Have standardized assessment for Community Home Care Nursing and Community Rehabilitation	• Have ongoing system wide case management for all longer term clients. Case Managers continue to coordinate services even after client is admitted to a facility • Have case management within Community Home Care Nursing and Community Rehabilitation	• Have standard classification system which is used for all longer term clients, irrespective of setting • Do not have classification system based on functional needs for Community Home Care Nursing and Community Rehabilitation	• Operational responsibility devolved to Regional level • At Ministry level have Regional Directors and Director of Operational Support for Acute and Continuing Care
Alberta - Alberta Health	• Have single entry system though Home Care	• Have standardized assessment, the Alberta Assessment and Placement Instrument (AAPI)	• Have ongoing case management through Home Care (which may also provide hands on care in some Regions) • Case management transferred to facility staff when client admitted to facility	• Have Residential Classification System (seven levels, A-G) • Have Home Care Classification System which includes assessment of available level of informal support • Some overlap between systems for functional needs component of classifications	• Administration devolved to regions, no staff with specific operational responsibilities for Continuing Care remain in Alberta Health

JURISDICTION	KEY COMPONENTS				
	Single Entry	**Standardized Assessment**	**Ongoing System Wide Case Management**	**Client Classification**	**Administrative Arrangements**
Alberta - Capital Health Region (Edmonton)	• Have single entry through Home Care • Continuing Care (residential) case managers can also do intake, assessment and case management and are cross-trained with Home Care staff	• Use own standardized assessment tool (based on the AAPI) • Use short version of this tool for short term Home Care clients	• Have case management through Home Care • Case management transferred to Continuing Care case managers when client admitted to facility	• Use Alberta Resident and Home Care Client Classification Systems	• Separate individuals responsible for Continuing Care and Home Care but both report to the same Vice-President
Alberta - Calgary Regional Health Authority	• Have single entry through Community Care and Support	• Have own standardized assessment (based on AAPI) but different from the one in Edmonton	• Have ongoing case management through Community Care and Support. • Case management transferred to facility staff when clients admitted to a facility	• Use Alberta Resident and Home Care Classification Systems	• Separate individuals responsible for facility and community services. Both report to the same Chief Operating Officer

JURISDICTION	KEY COMPONENTS				
	Single Entry	**Standardized Assessment**	**Ongoing System Wide Case Management**	**Client Classification**	**Administrative Arrangements**
Saskatchewan - Saskatchewan Health	• Have a single entry system through Home Based Services or stand alone assessment units	• Have standardized assessment tool (SCIP) • Plan to adopt MDS-2 for facility assessment • Will keep Saskatchewan Client Information Profile (SCIP) for Home Based Services	• Have ongoing case management through Home Based Services (in some areas hands on care is also provided) or stand alone assessment units • Case management is transferred to facility staff when a client is admitted to the facility	• Have 1-4 level classification system for residential services • Plan to adopt RUG III system for residential services • Do not have separate classification system for Home Based Services clients	• Operational responsibilities have been devolved to the district health boards • Same individual responsible for residential and home based services in Saskatchewan Health. Another individual responsible for program development. Both report to the Executive Director of Community Care

JURISDICTION	KEY COMPONENTS				
	Single Entry	**Standardized Assessment**	**Ongoing System Wide Case Management**	**Client Classification**	**Administrative Arrangements**
Saskatchewan - Regina Health District	• Have single entry system for facilities and Home Care	• Use SCIP as assessment tool for residential care and Home Care • Use short version of SCIP for acute short term Home Care clients	• Ongoing case management provided by System Wide Admission and Discharge • Case management transferred to facility staff when client admitted to a facility	• Use Saskatchewan's 1-4 level classification system for facilities • No separate assessment tool for Home Care but use own "risk indicators tool" to determine level of risk of client	• Separate individuals for residential and community services. Both report to the same Vice President • Client assessment and coordination for facility care and Home Care comes under the Vice-President for Medical Services
Saskatchewan - Saskatoon District Health	• Have single entry. Staff of Coordination and Assessment Units do entry, assessment and case management	• Use own standardized assessment tool	• Case management provided by Coordination and Assessment Units and is separate from Home Care • Case management functions transferred to facility staff when client admitted to facility	• Use Saskatchewan 1-4 level system for reporting • Use Alberta RCS as basis for funding facilities • No classification system for Home Care but use own "risk indicators tool"	• Have separate individuals responsible for residential and community services
Manitoba	• Have single entry	• Have standardized assessment tool	• Ongoing case management by Home Care staff but assessment and case management separate from provision of hands on care • Case management function transferred to facility staff when client admitted to facility	• Use 1-4 level of care classification system for facilities • No classification system for Home Care	• Separate individuals responsible for residential and community care

JURISDICTION	KEY COMPONENTS				
	Single Entry	**Standardized Assessment**	**Ongoing System Wide Case Management**	**Client Classification**	**Administrative Arrangements**
Ontario	• Single entry for Long Term Care facilities and Home Care through Community Care Access Centres (CCACs) • CCACs do not do single entry for Chronic Care hospital beds or Community Support Services	• Developing standardized tool for Long Term Care facilities and Home Care • Use MDS-2 for Chronic Care	• Case management for Long Term Care provided through CCACs. Case management responsibility is transferred to facility staff when client admitted to facility • Community Support Services coordinated by agencies where client receives care • Case management provided by Chronic Care facilities	• Long Term Care facilities use Alberta Resident Classification System (A-G) • Chronic Care hospitals use RUG III • No classification system for Home Care	• All Long Term Care services, (excluding chronic care hospitals and group homes) come under the responsibility of the Executive Director of Long Term Care
Québec	• In some areas, entry can be through hospital emergency departments or CLSCs (community health centres) • Québec is moving rapidly to a single entry system through the CLSCs	• Have standard tool for facility assessment • Have a variety of tools for Home Care	• CLSCs generally provide ongoing case management. Case management may also be provided by hospitals in areas with two points of entry (i.e., CLSC and hospital)	• No standard classification tool but have system for evaluating client needs for facilities • No standard classification tool for Home Care	• Administration delegated to Regional Boards • No specific administrative structure for Continuing Care with the Québec Ministry of Health and Social Services

JURISDICTION	KEY COMPONENTS				
	Single Entry	**Standardized Assessment**	**Ongoing System Wide Case Management**	**Client Classification**	**Administrative Arrangements**
New Brunswick	• Have a single entry process	• Have standard assessment tool (based on the Alberta tool, the AAPI) • Assessments generally done by two people. Social worker from Family and Community Social Services (FCSS) and a health care professional from the Extra-Mural Program or Mental Health, whichever is most appropriate • There is a planned change to a single assessor in 1998	• Case management generally provided by FCSS social workers • Extra-Mural Program and Mental Health Services provide case management to clients who are eligible for their respective programs • Case management functions are separated from hands on care (for FCSS) • Case management is transferred to facility staff when client is admitted to a nursing home but maintained by FCSS when client is admitted to other residential facilities	• Have 1-4 level classification system for facility care • Do not have classification system for Home Health Care or Home Support	• Have separate staff for Family and Community Social Services, Extra-Mural Programs and Mental Health. They report to Assistant Deputy Ministers of Family and Community Social Services, Institutional Services, and Mental Health Services, respectively

JURISDICTION	KEY COMPONENTS				
	Single Entry	**Standardized Assessment**	**Ongoing System Wide Case Management**	**Client Classification**	**Administrative Arrangements**
Nova Scotia	• There are two single entry systems. Home Care Nova Scotia does single entry for its clients. Municipalities provide single entry for all residential clients and community clients for social services • It is planned that on April 1, 1998 the province will take over single entry, assessment and case management from the municipalities	• Home Care Nova Scotia has standard assessment form • Municipalities have standard assessment form for facility care	• Home Care Nova Scotia provides case management for its clients. Case management is transferred to municipal/facility staff when a client is admitted to a facility • Municipalities provide case management services and continue as case managers even after clients are admitted to a facility	• Have 1-5 level of care system but generally only classify Long Term Care facility clients into two levels • No separate classification system for Home Care or Home Support	• There are separate staff for Home Care and residential care in the Department of Health but they report to the same Executive Director
Prince Edward Island	• Have single entry, called Coordinated System Entry, based in and coordinated by the Home Care Support Program	• Have standardized assessment form	• Provided by Home Care Support Program • Case management transferred to facility staff when client is admitted to a facility	• Have a 1-5 classification system that is used for Long Term Care and Home Care Support	• Separate individuals are responsible for residential and facility care but are both in Continuing Care which is a part of the Acute and Continuing Care Division

JURISDICTION	KEY COMPONENTS				
	Single Entry	**Standardized Assessment**	**Ongoing System Wide Case Management**	**Client Classification**	**Administrative Arrangements**
Newfoundland - Department of Health and St. John's and Central Regions	• Have single entry	• Have standardized provincial assessment instrument	• Have ongoing case management • Responsibility for case management transferred to facility staff when client is admitted to a facility	• Have a provincial system of client classification but are considering revisions to include a higher level of care in the system	• At the provincial level, separate individuals responsible for Continuing Care (community) and Nursing Homes[1]

[1]Continuing Care comes under an Assistant Executive Director in both the St. John's and Central Regional Community Health Boards.

TABLE 3: COMPARISON OF TERMINOLOGY USED TO DESCRIBE CONTINUING CARE SERVICE COMPONENTS

Province	Assessment & Case Management			Meals Program			Homemaker Services		
	Available	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**
Northwest Territories	Yes	Yes	• Assessment & Placement Record • Home Care Assessment & Care Planning	Yes	Yes	• Meals on Wheels • Wheels to Meals	Yes	Yes	• Personal Care Home Support • Community Living Worker or Services • Homemaker s.
Yukon	Yes	Yes	• Part of Home Care • Part of Facility Care	Yes[2]	Yes	Meals-on-Wheels	Yes	Yes	Home Support Services
British Columbia	Yes	Yes	Assessment & Case Management	Yes	Yes	• Meal Programs • Congregate Meals	Yes	Yes	Home Support Program
Alberta	Yes	Yes	• Single Point of Entry • Service Coordination	Yes	Yes	Meal Programs	Yes	Yes	Personal Supports
Alberta (Edmonton)	Yes	Yes	Case Coordination (Home Care)	Yes	No[3]	N/A	Yes	Yes	Support Services (in Home Care)
Alberta (Calgary)	Yes	Yes	• Single point of entry • Case coordination	Yes	Yes	Meals-on-Wheels	Yes	Yes	• Personal Care • Homemaker Services (in Home Care)
Saskatchewan	Yes	Yes	• Assessment & Case Coordination • Case Management • Single Point of Entry	Yes	Yes	• Meals-on-Wheels • Wheels-to-Meals	Yes	Yes	• Homemaking Services • Personal Care • Respite
Saskatchewan (Regina)	Yes	Yes	System Wide Admission and Discharge	Yes	Yes	Meals-on-Wheels	Yes	Yes	Home Care
Saskatchewan (Saskatoon)	Yes	Yes	Assessment & Case Management	Yes	Yes	Meals-on-Wheels	Yes	Yes	Homemaker Services

[2] In Whitehorse

[3] Voluntary Program

Province	Home Nursing Care			Community Physiotherapy & Occupational Therapy			Adult Day Support		
	Available	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**
Northwest Territories	Yes	Yes	• Home Nursing Care • Home Care	Yes	Yes	Home Care	Yes[4]	Yes	Adult Day Program
Yukon	Yes	Yes	Home Care	Yes	Yes	Community Physiotherapy & Occupational Therapy Services	No	No	N/A
British Columbia	Yes	Yes	Community Home Care Nursing	Yes	Yes	Community Rehabilitation	Yes	Yes	Adult Day Centre Program
Alberta	Yes	Yes	Home Care	Yes	Yes	Home Care	Yes	Yes	Adult Day Support
Alberta (Edmonton)	Yes	Yes	Home Care Program	Yes	Yes	Home Care Program	Yes	Yes	Adult Day Support
Alberta (Calgary)	Yes	Yes	Home Care	Yes	Yes	• Community Rehabilitation Services • Home Care Program	Yes	Yes	Adult Day Support
Saskatchewan	Yes	Yes	Home Nursing Services	Yes	Yes	Community Physiotherapy & Occupational Therapy Services, also include Speech/Language, Pathology, Audiology and Respiratory Therapy	Yes	Yes	Adult Day Programs

[4]Limited access, still under development

Province	Home Nursing Care			Community Physiotherapy & Occupational Therapy			Adult Day Support		
	Available	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**
Saskatchewan (Regina)	Yes	Yes	Home Care Nursing	Yes	Yes	Community Physiotherapy & Occupational Therapy Services	Yes	Yes	Adult Day Support
Saskatchewan (Saskatoon)	Yes	Yes	Home Nursing Care	Yes	Yes	Community Physiotherapy & Occupational Therapy Services	Yes	Yes	Adult Day Care Services

Province	Group Homes			Long Term Care Facilities			Chronic Care Units/Hospitals		
	Available	**In cont. Care**	**Name**	**Available**	**In cont. Care**	**Name**	**Available**	**In cont. Care**	**Name**
Northwest Territories	Yes	Yes	• Adult Group Homes • Children's Group Homes	Yes	Yes	Long Term Care Facilities	Yes	Yes	Extended Care Wards
Yukon	Yes	Yes	Part of Social Services but linked to Home c.	Yes	Yes	Continuing Care Facilities	No	No	Included in Continuing Care f.
British Columbia	Yes	Yes	Group Homes	Yes	Yes	• Residential Care Facilities • Multi-Level Care Facilities • Private Hospitals	Yes	Yes	• Extended Care Hospitals • Multi-Level Care f. • Private Hospitals
Alberta	Yes	Yes	• Adult Family Living • Group Homes	Yes	Yes	Continuing Care Centres	No	No	Included in Continuing Care Centres
Alberta (Edmonton)	Yes	Yes[5]	• Personal Care Homes • Family Care Homes (Licensed by Soc. Serv. if more than 4 cl)	Yes	Yes	Continuing Care Centres	No	No	Included in Continuing Care Centres
Alberta (Calgary)	Yes	Yes	• Licensed by Social Services, called Personal Care Homes • Companion Care	Yes	Yes	Care Centres	No	No	Included in Care Centres
Saskatchewan	Yes	No[6]	Group Homes	Yes	Yes	• Special Care Homes • Health Centres • Long Term Care Beds in Hospitals • Personal Care Homes • Nursing Homes	No	No	Included in Long Term Care facilities
Saskatchewan (Regina)	Yes	No[7]	Group Homes	Yes	Yes	• Special Care Homes • Extended Care	No	No	Included in Long Term Care facilities
Saskatchewan (Saskatoon)	Yes	Yes	Group Homes	Yes	Yes	Special Care Homes	Yes[8]		Included in Long Term Care facilities

[5]Provided through Continuing Care Centres
[6]Provided through Mental Health and Social Services
[7]Provided through Mental Health and Social Services
[8]One facility

Province	Assessment and Treatment Centres & Day Hospitals			Equipment & Supplies			Transportation Services		
	Available	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**
Northwest Territories	Yes	Yes	• Long Term Care Respite or Assessment Beds • Children's Treatment Centre	Yes	Yes	Equipment Loan	Partial[9]	Partial	• Transportation Service • Handivan
Yukon	Yes	Yes	Assessment of Treatment for Dementia Care only	Yes	Yes	Part of Chronic Care extended benefits and Pharmacare under Health Insurance Program. Also from Health Benefits fund for First Nations Clients	Partial	Partial	Facilities have own vehicles, Handibus in community
British Columbia	Yes	Yes	Assessment & Treatment Centres & Day Hospitals	Yes	Yes	Equipment & Supplies	Yes	Partial[10]	N/A
Alberta	Yes	Yes	• Geriatric Assessment and Rehabilitation • Adult Day Hospital	Yes	Yes	Alberta Aids to Daily Living Program	Yes	Partial	Transportation Services
Alberta (Edmonton)	Yes	Yes	Geriatric Assessment	Yes	Yes	Alberta Aids to Daily Living Program	Yes	No	N/A
Alberta (Calgary)	Yes	Yes	Seniors Health Acute Care	Yes	Yes	Alberta Aids to Daily Living Program	Yes	Partial[11]	• Some Facilities have own van • Handibus in Community

[9]Vans in facilities
[10]Some facilities or services have vans; services provided by volunteers
[11]Some facilities or services have vans

Province	Assessment and Treatment Centres & Day Hospitals			Equipment & Supplies			Transportation Services		
	Available	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**
Saskatchewan	Yes	Yes	• Geriatric Assessment • Multi-Purpose Beds	Yes	Yes	Saskatchewan Aids to Independent Living Program	Yes	Partial[12]	Transportation Services
Saskatchewan (Regina)	Yes	No[13]	N/A	Yes	Yes[14]	N/A	Yes	No	N/A
Saskatchewan (Saskatoon)	Yes	Yes	Geriatric Assessment Program	Yes	Yes	Equipment & Supplies	Yes	No[15]	N/A

[12]Through Municipalities
[13]In hospital Psychiatric Services
[14]For short-term loans
[15]Part of larger transport system

Province	Support Groups			Crisis Support			Life and Social Skills for Independent Living		
	Available	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**
Northwest Territories	Yes	Yes	Support Groups	Yes	Yes	Part of Respite Care	Yes	Yes	Community Living
Yukon	Yes	Yes	• Cancer Support Groups • Alzheimer Support Groups • Arthritis Society	Yes	Yes	Part of Respite Care and Assessment	Yes	No	Part of Independent Living
British Columbia	Yes	No	• Caregiver Support Networks • Disease Specific Support Groups	Yes	Yes	Crisis Support (through case management)	Yes	No	N/A
Alberta	Yes	Yes	Support Groups	Yes	Yes	No Consistent Term Used	Yes	Partial	No Consistent Term Used
Alberta (Edmonton)	Yes	Partially	Support Groups	Yes	Yes	• Emergency Holding Bed • CHOICE Treatment Bed/Respite	Yes	Yes	Community Integration Program
Alberta (Calgary)	Yes	Yes	Support Groups	Yes	Yes	Quick Response	Yes	No	N/A
Saskatchewan	Yes	No[16]	Support Groups	Yes	Yes	• Quick Response • Emergency Respite Bed	Yes	No[17]	N/A
Saskatchewan (Regina)	Yes	Yes	Support Groups	Yes	No[18]	Quick Response Unit (6 beds)	No	No	N/A
Saskatchewan (Saskatoon)	Yes	Yes	Support Groups	Yes	No[19]	Crisis Support	Yes	No[20]	Life & Social Skills for Independent Living

[16] By Volunteers
[17] Through Voluntary Groups
[18] Through Mental Health
[19] Through Mental Health
[20] Through Mental Health

Province	Respite Services			Palliative Care			Volunteers		
	Available	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**
Northwest Territories	Yes	Yes	Respite Services	Yes	Yes	Palliative Care	Yes	Yes	Volunteers
Yukon	Yes	Yes	Respite Services	Yes	Yes	Palliative Care	Yes	Yes	Volunteers
British Columbia	Yes	Yes	Respite Services	Yes	Yes	Palliative Care	Yes	Yes	Volunteers
Alberta	Yes	Yes	Respite Services	Yes	Yes	Palliative Care	Yes	Yes	Volunteers
Alberta (Edmonton)	Yes	Yes	Respite Services	Yes	Yes	Palliative Care	Yes	Yes	Volunteers
Alberta (Calgary)	Yes	Yes	Respite Services	Yes	Yes	Regional Palliative and Hospice Care Services	Yes	Yes	Volunteers
Saskatchewan	Yes	Yes	Respite Services	Yes	Yes	Palliative Care	Yes	Yes	Volunteers
Saskatchewan (Regina)	Yes	Yes	Respite Services	Yes	Yes	Palliative Care	Yes	Yes	Volunteers
Saskatchewan (Saskatoon)	Yes	Yes	Respite Care	Yes	Yes	Palliative Care	Yes	Yes	Volunteers

Province	Congregate Living Residences		
	Available	**In Cont. Care**	**Name**
Northwest Territories	No	Will be introduced	Supported Independent Living Facilities
Yukon	No	No	N/A
British Columbia	Yes	No	• Congregate Living Residences • Supportive Housing • Abbeyfield Housing
Alberta	Yes	No	• Senior Citizens Lodges and Apartments • Variety of private sector models/terms used
Alberta (Edmonton)	Yes	No	• Senior Citizens Lodges and Apartments • Assisted Living (in private sector)
Alberta (Calgary)	Yes	No	• Seniors Apartments • Retirement Apartments/Lodges
Saskatchewan	Yes	Through social housing	N/A
Saskatchewan (Regina)	Yes	Through social housing	Assisted Living
Saskatchewan (Saskatoon)	Yes	Through social housing	• Social Housing • Assisted Living

Province	Assessment & Case Management			Meals Programs			Homemaker Services		
	Available	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**
Manitoba	Yes	Yes	• Home Care • Manitoba Assessment and Placement Process	Yes	Yes	Meals-on-Wheels	Yes	Yes	• Home Support Services (cleaning, laundry, meal prep) • Personal Care Services (personal care tasks)
Ontario	Yes	Yes	• Community Care Access Centres, • Case Coordination • Case Management • Placement Coordination • Assessment	Yes	Yes	Meals-on-Wheels Wheels-to-Meals	Yes	Yes	• Home Care • Home Help • Homemaking Services (household activities) • Personal Support Attendant (personal care tasks)
Québec	Yes	Yes	Assessment and Case Management	Yes	No	Meals-on-Wheels	Yes	Yes	• Homemaker Services • Personal, domestic and community assistance
New Brunswick	Yes	Yes	• Single Entry Process • Assessment and Case Planning	Yes	Yes	Meals-on-Wheels Wheels-to-Meals	Yes	Yes	• Homemaking Services • Home Support Services • Attendant Care
Nova Scotia	Yes	Yes	• Case Coordination • Case Management • Placement Coordination	Yes	No	Meals-on-Wheels	Yes	Yes	Home Support
Prince Edward Island	Yes	Yes	• Assessment • Care Coordination • Case Management • Coordinated System Entry • Placement Coordination	Yes	Yes	Meals-on-Wheels	Yes	Yes	• Home Care Support Worker • Visiting Homemaker
Newfoundland - Department of Health and St. John's and Central Regions	Yes	Yes	Assessment & Placement	Yes	Yes	Meals-on-Wheels are available in some Community Health Regions	Yes	Yes	Home Support

Province	Home Nursing Care			Community Physiotherapy & Occupational Therapy			Adult Day Support		
	Available	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**
Manitoba	Yes	Yes	Home Nursing Care	Yes	Yes	Community Physiotherapy & Occupational Therapy Services	Yes	Yes	Adult Day Care
Ontario	Yes	Yes	Home Care Nursing (CACC)	Yes	Yes	Physiotherapy Occupational Therapy	Yes	Yes	Adult Day Services
Québec	Yes	Yes	Home Nursing Care	Yes	Yes	Home Rehabilitation Services	Yes	Yes	• Adult Day Centre • Activity Day Centre
New Brunswick	Yes	Yes	Home Health Care (through Extra-Mural Program)	Yes	Yes	Community Physiotherapy & Occupational Therapy Services (also includes other services, e.g. Speech Therapy). These services are provided through the Extra-Mural Program	Yes	Yes	Adult Day Programs
Nova Scotia	Yes	Yes	Home Nursing Care	No	No	N/A	Partial	No	Adult Day Care
Prince Edward Island	Yes	Yes	Home Care Nursing	Yes	Yes	Community Physiotherapy & Occupational Therapy Services	Yes	Yes	Adult Day Care Programs
Newfoundland - Department of Health and St. John's and Central Regions	Yes	Yes	• Home Nursing Care • Home Care Nursing • Community Health Nurse (in St. John's Region)	Yes, in varying degrees across province	Yes, where avail-able	Community Physiotherapy & Occupational Therapy Services	Yes, in varying degrees across province	Yes, where available	• Adult Day Support • Adult Day Enrichment

Province	Group Homes			Long Term Care Residential Facilities			Chronic Care Units/Hospitals		
	Available	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**
Manitoba	Yes	Yes	• Shared Care • Clustered Care • Block Care • Supportive Housing	Yes	Yes	Personal Care Homes	Yes	Yes	Provided in Acute Hospitals and in designated LTC hospitals and units
Ontario	Yes	No	• Group Homes (provided through various government programs) • Rest and retirement homes (non-funded)	Yes	Yes	• Nursing Homes • Homes for the Aged	Yes	No	• Chronic Care Hospitals (MoH, Institutions Branch) • Complex Continuing Care
Québec	Yes	Yes	• Adult Family Residences • Group Homes • Foster Homes	Yes	Yes	Long Term Residential Care Centre	Yes	Yes	Long Term Care Residential Centre
New Brunswick	Yes	No	N/A	Yes	Yes	• Adult Residential Facility (Levels 1-4) • Nursing Homes (Levels 3 & 4)	No	No	Included in Nursing Homes and Hospital Extended Care units
Nova Scotia	Yes	Yes	In Community Services	Yes	Yes	• Homes for the Aged • Nursing Homes	No	No	Included in Nursing Homes
Prince Edward Island	Yes	No[21]	Provincial Group Homes	Yes	Yes	• Community Care Facilities • Private Nursing Homes • Government Manors	No	No	Included in Long Term Care facilities
Newfoundland - Department of Health and St. John's and Central Regions	Yes[22]	No	Group Homes	Yes	Yes	• Personal Care Homes (Level 1 and some Level 2) • Nursing Homes (Levels 2 & 3 and some Level 4)	Yes	Yes	There are separately designated Chronic Care beds in some hospitals in the province

[21]Under Child and Family Services

[22]Group Homes in Family and Rehabilitative Services will all be phased out by year end. There will still be some Group Homes in Youth Corrections and Child Welfare.

Province	Assessment and Treatment Centres & Day Hospitals			Equipment & Supplies			Transportation Services		
	Available	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**
Manitoba	Yes	Yes	Long Term Rehabilitation (Assessment and Rehabilitation Units and Day Hospitals)	Yes	Yes	Equipment & Supplies	Yes	Partial[23]	Handi-transit (municipal)
Ontario	Yes	Yes	Geriatric Assessment Program	Yes	Yes	Assistive Devices Program & CCACs	Yes	Yes	Transportation Services
Québec	Yes	Yes	Geriatric Assessment Unit and Day Hospital	Yes	No	• Technical Aid Services • Material Aid Services	Yes	No	Adapted Transportation
New Brunswick	Partial	No	Part of Hospital Care	Yes	Yes	• Seniors Rehabilitation Equipment Program • Red Cross Loan Cupboard • Human Resources Development (social assistance for health card)	Yes	Yes	Access-a-Bus (Transport services, available through various organizations and nursing homes)
Nova Scotia	Partial	No	N/A	Yes	Yes	Equipment & Supplies	Yes	Yes	Varies across province
Prince Edward Island	No	No	N/A	Partial	No[24]	Equipment & Supplies	Yes	No	N/A
Newfoundland - Department of Health and St. John's and Central Regions	Yes, in St. John's only	Yes	Assessment and Treatment Unit	Yes, in some regions	Yes, where available	• Special Assistance • Equipment and Supplies	Yes	No	Transportation services come under the Department of Human Resources and Employment

[23]Some Facilities have vans
[24]In Facilities

Province	Support Groups			Crisis Support			Life and Social Skills for Independent Living		
	Available	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**
Manitoba	Yes	Partial	Support Groups	Yes	Yes	Part of Home Care	Yes	Yes	Life and Social Skills for Independent Living
Ontario	Yes	Yes	Caregiver Support	Yes	Yes	Intervention and Assistance Services for Seniors	Yes	Yes	Lifeskills Services (disabled)
Québec	Yes	Yes	Support Groups	Yes	Yes	• Short Term Residential Care • Day Centre Respite	Yes	Yes	No specific term
New Brunswick	Yes	No	Support Groups	Yes	Yes	• Crisis Bed Program • After Hours Emergency Social Services	Yes	No[25]	Life Skills
Nova Scotia	Yes	No	Support Groups	No	No	N/A	Yes	No	Life Skills
Prince Edward Island	Yes	Yes	Support Groups	No	No	N/A	Yes	No	N/A
Newfoundland - Department of Health and St. John's and Central Regions	Yes	Yes	• Support Groups • Friendly Visitation	Yes	Yes	Crisis Support	Yes	No[26]	N/A

[25] In Facilities
[26] Coordinate access to service in some areas

Province	Respite Services			Palliative Care			Volunteers		
	Available	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**	**Available**	**In Cont. Care**	**Name**
Manitoba	Yes	Yes	Respite Services	Yes	Yes	Palliative Care	Yes	Yes	Volunteers
Ontario	Yes	Yes	Respite Services	Yes	Yes	Palliative Care	Yes	Yes	Volunteers
Québec	Yes	Yes	• Home Respite • Short-Term Residential Care	Yes	Yes	Palliative Care	Yes	Yes	Volunteer Groups
New Brunswick	Yes	Yes	Respite Services	Yes	Yes	Palliative Care	Yes	Yes	Volunteers
Nova Scotia	Partial	Yes	Respite Services	Partial	Partial	Palliative Care	Yes	Yes	Volunteers
Prince Edward Island	Yes	Yes	Respite Services	Partial	Partial	Palliative Care	Yes	Yes	Volunteers
Newfoundland - Department of Health and St. John's and Central Regions	Yes	Yes	Respite Services	Yes	Yes	Palliative Care	Yes	Yes	Volunteers

Province	Congregate Living Residences		
	Available	**In Cont. Care**	**Name**
Manitoba	Yes	No	Residential Care Facilities and Elderly Persons' Housing
Ontario	Yes	No	• Seniors Housing • Supportive Living
Québec	No	No	N/A
New Brunswick	Yes	No	• Seniors Apartments • Subsidized Housing
Nova Scotia	Yes	Yes	• Seniors Apartments • Retirement Residences • Enriched Housing Units
Prince Edward Island	No	No	N/A
Newfoundland - Department of Health and St. John's and Central Regions	Yes, in some regions	Yes, where available	Congregate Living Arrangements

NOTES

1. Hollander, M.J. (1994). Report of the project to review the need for, and feasibility of, a national data base on Continuing Care. Ottawa: Statistics Canada (Ref No: 82F0012XPE).

2. Hollander, M.J. (1994). The costs, and cost-effectiveness, of Continuing Care services in Canada. Ottawa: Queen's-University of Ottawa Economic Projects - Working Paper No. 94-10.

3. Federal/Provincial/Territorial Subcommittee on Continuing Care. (1992). Future directions in Continuing Care. Ottawa: Health and Welfare Canada.

4. Subcommittee on Institutional Program Guidelines. (1988). Assessment and placement for adult long-term care: A single-entry model. Ottawa: Health and Welfare Canada.

5. Federal/Provincial/Territorial Subcommittee on Long Term Care. (1990). Report on Home Care. Ottawa: Health and Welfare Canada.

6. These five areas have been documented by Marcus Hollander (1994) in The costs, and cost-effectiveness, of Continuing Care services in Canada. Ottawa: Queen's-University of Ottawa Economic Projects - Working Paper No. 94-10. The author notes that when taken together, the five components of single entry, coordinated assessment and placement, coordinated case management, consistent care level classification, and a single administration represent a “best practices” model for organizing a Continuing Care service delivery system.

APPENDICES

APPENDIX A: SUMMARIES OF PROVINCIAL AND TERRITORIAL CONTINUING CARE SYSTEMS

NORTHWEST TERRITORIES

Introduction

The Northwest Territories (NWT) is a large and sparsely populated area. The way services are organized and delivered reflects the needs of this unique population. The NWT merged health and social services into one Department in 1994 and has been developing a regional model of service delivery. The two former Departments completed their amalgamation into the Department of Health and Social Services (DHSS) and were co-located as of April 1997. This was a comprehensive amalgamation in that all services were integrated, and there are no residual parallel administrative structures, for health and social services, within the new Department.

The process of regionalization is well under way. Some Regional and Community Boards have been in place for a period of years while others have been formed fairly recently. The DHSS has developed a list of core services and a series of protocols to guide its relationship with the Regional Boards. These protocols are documented in what is referred to as a series of Relationship Documents covering matters such as the partnership agreements, contribution agreement and accountability framework.

In terms of Continuing Care, the DHSS has developed a comprehensive Business Plan for 1997/1998 which outlines a series of key recommendations for action to improve the integration and coordination of Continuing Care services in the NWT.

Use of Major Terms

Formerly, the main term used in the NWT was Long Term Care. Through a recent change, Continuing Care is now the term used to cover the full range of facility, home and community based services for persons of all ages. The term Long Term Care is now used to refer only to residential facilities. Usage of the terms Home Care and Home Support varies to some degree across regions; however, both are seen as coming under the overall umbrella term of Continuing Care. Home Care is generally referred to as the Coordinated Home Care Program. It is used to describe community based home care services. There are 12 Boards which have Coordinated Home Care Programs. Home Support Services are generally also delivered by these programs. However, in some Regions only Home Support is provided. In these Regions, the term Home Care is also used, but it describes what is essentially Home Support. Nursing services in these Regions are provided through a health centre.

Service Delivery and Organization

The NWT does not currently have a single point of entry system for all Continuing Care services. However, it has been recommended that such a system be established in the 1997/98 Business Plan and work is underway to plan and develop a single entry system.

In terms of a standardized assessment instrument, there is a standardized instrument for use in Long Term Care called the Assessment and Placement Record. There is a separate form for Home Care clients. There are also other forms which may be used locally for the full range of home and community based services. The 1997/98 Business Plan calls for the development of an Assessment and Placement Instrument to be introduced into the NWT as a comprehensive

and standardized assessment tool which would be used for all Continuing Care services, except in those cases where persons require very low levels of service.

There is case management of community based clients through Home Care and Home Support services. The persons doing case management will also typically provide some hands-on care as well. Thus, case management and care provision are combined and are not two separate functions in the NWT. In order for a client to receive facility care, the case manager has to demonstrate that care is needed. Once admitted to a facility, facility staff take over case management functions.

In terms of classification, the Assessment and Placement Record has a classification system with six levels. Levels five and six are for intensive rehabilitation and acute care. Long Term Care facilities may care for a range of clients, but many would be at Level 3. Level 4 clients are closer to Extended Care. Extended or Chronic Care beds are part of Long Term Care and are generally provided through designated beds, or wards, in hospitals. There is not a standardized classification system for Home Care. However, general practice is to provide care in the community for clients who would be the equivalent of levels one or two if they were classified according to the six level system of the Assessment and Placement Record.

The key individuals responsible for Continuing Care services are the following: Consultant, Residential Care, Elderly and Handicapped; Consultant, Home Care; Consultant, Independent Living; Consultant, Rehabilitation Services; and Consultant, Residential Care for Children. There is also a Care Reform Working Group that includes in its mandate the development of an action plan for the reform of care facilities in the NWT. This Working Group is linked to the Mental Health Act and to Addictions Reform and Promotion Working Groups via the Project Teams and Board Support Unit, which also reports to the Assistant Deputy Minister of Health and Social Services.

Currently, within the transitional organization structure, there are three directors (Population Health, Financial and Management Services, and Policy and Planning) and an ADM/Director of Program Planning, Support and Evaluation. The ADM/Director of Program Planning, Support and Evaluation has two units in her Division, each with its own Manager. All the Continuing Care related consultants now report to the Manager of Programs and Services. The Project Teams and Board Support Unit is a new addition to the Department.

The Division named Program Planning, Support and Evaluation is expected to be integrated into the Population Health Division in the near future, in accordance with the preferred future scenario of having three Divisions.

YUKON

Introduction

In the Yukon, Continuing Care services come under the Department of Health and Social Services. Home Care programs have always been housed in the social services section of the Department. Responsibility for the facility component of Continuing Care was transferred from the health section of the Department to the social services section in 1996. Also, responsibility for the health services previously administered by Health Canada, on behalf of the Yukon Territory, were recently transferred to the Yukon Department of Health and Social Services.

Use of Major Terms

The two major terms used in the Yukon are Continuing Care and Home Care. The term Long Term Care has been used to describe residential services but the use of this term is fading. The term Continuing Care started to be actively used some four years ago and has been coming to be the term of choice rather than Long Term Care.

The term Continuing Care is used primarily to denote facility services. However, it also includes a number of outreach services to the community which are provided from facilities. These include therapy services, such as physiotherapy, speech therapy, and occupational therapy, and host home respite care. Continuing Care is not used as an umbrella term to cover Home Care in the Yukon. These are two different programs. There are, however, some practical linkages between these two programs. For example, Home Care has therapists (occupational therapy, physiotherapy) who operate as part of the Home Care program but are reimbursed and supervised through a Continuing Care facility, as administrative responsibility for rehabilitation rests with Continuing Care facilities.

The term Home Support is included under the term Home Care in the Yukon. The Home Care program provides intake and case management services and includes a range of community based practitioners such as nurses, social workers, therapists, and home support workers. There are three categories of service in Home Care: Acute, Palliative, and Long-Term. Home support workers and professional practitioners provide services in all three categories of Home Care. Home Care services are provided through a Home Care office in Whitehorse which does outreach support work across the Yukon. In addition, some First Nations Bands also have a capacity to provide the home management portion of Home Support services to their members.

Service Delivery and Organization

There are relatively few facilities in the Yukon, given its population. A high level Continuing Care facility was recently built and put into operation. This facility now also provides services to Chronic Care level clients. Thus, hospitals no longer provide Chronic Care services. There is a single entry system for facility clients in the Yukon which uses a placement committee. There is also a single point of entry system for Home Care clients.

Home Care provides a seniors outreach service (by a social worker) to target some of the people who may fall between the cracks of the two single point of entry systems. Initial assessments for Home Care are primarily done by social workers. These individuals also provide services directly to clients. For medical services such as the acute care replacement component of Home Care, services are provided by nurses and other health professionals (e.g., occupational therapists), as required. In communities across the Yukon, the social services offices function as the single point of entry to Home Care. However, now that responsibility for the nursing stations has been transferred from the federal government to the Yukon, nursing stations may also begin to serve as points of entry to the system.

In terms of assessment, the placement application which is used to document facility care need by the facility placement committee serves as the standardized assessment tool for Continuing Care facilities. There is also a standard classification system which has five levels of care. Home Care assists many of the clients who seek facility services to initiate the process of being considered for facility placement, i.e., clients may access facility

care through the Home Care program. However, other care providers may also refer clients to the placement committee and assist them as required.

In terms of assessment, Home Care has a standardized process for admitting and documenting new clients. However, there is no standard assessment tool used by all Home Care services at this time. Home Care is considering the development of a standard, computerized assessment instrument. Home Care staff provide care to clients and serve as case managers. However, once a client is admitted to a facility for ongoing care, the case management function is transferred to the facility. Home Care does not have a client classification system; however, it does informally classify clients using the same level of care designation as is used for facilities, for planning and statistical purposes. Continuing Care and Home Care services are available to persons of all ages including children.

In terms of administrative arrangements, there is a split with one individual being responsible for Continuing Care and one for Home Care. The individual responsible for Continuing Care reports to the Assistant Deputy Minister of Social Services. The person responsible for Home Care reports to a Director of Social Services who reports to the same Assistant Deputy Minister.

BRITISH COLUMBIA

Introduction

British Columbia has recently completed the process of regionalization, and the operational responsibility for Continuing Care services has now been passed on to Regional Health Boards (RHBs), Community Health Councils (CHCs), and Community Health Services Societies (CHSSs). The Continuing Care Division, which was previously responsible for the overall management of the Continuing Care system, has been phased out. Instead there is now an Assistant Deputy Minister who is responsible for Acute and Continuing Care Programs. Thus, British Columbia still has a focus on Continuing Care at the ministry level. Responsibility for Continuing Care services, provided through the RHBs, CHCs, and CHSSs, is vested in the Regional Directors and the Director of Operational Support who report to the Assistant Deputy Minister. While a number of jurisdictions did have a single administrative structure for Continuing Care in the early 1990s, they all maintained separate administrative streams for facility and community services. British Columbia, from the mid-1980s to the early 1990s, was the only province to fully integrate both facility and community services.

Another relatively unique feature of Continuing Care in British Columbia prior to regionalization was that it had a very strong Home Support sector which was separate from professional services such as nursing and rehabilitation. British Columbia did not use the term Home Care to describe these professional services. They were called Direct Care or Clinical Care. Home Support and professional community based services were descriptively referred to as Community Based Services. Given that services have been regionalized fairly recently, we did not conduct interviews with regional staff in British Columbia.

Use of Major Terms

While the term Continuing Care was used in both a descriptive and administrative sense in the past, with regionalization it is now used more as a descriptive term, or a term to denote a strategy of how to deliver services to the elderly and disabled. The Continuing Care Act is, however, still in force and lists the range of services which come under the umbrella term of Continuing Care. Long

Term Care was used as a descriptive term to denote facility care and the full range of Home Support and Home Care services, excluding short term professional nursing and rehabilitation therapy services. Long Term Care is coming to be seen as an archaic term in British Columbia and is being used more in relation to facility care, i.e., long term facility care. British Columbia has not used the term Home Care except in a descriptive sense when dealing with other jurisdictions. Currently the terms used are Community Home Care Nursing and Community Rehabilitation. The term Home Care may come to be used more in the RHBs, CHCs, and CHSSs, but it is too early to tell if this will be the case.

Previously, the term Home Support was used for a range of community based services including group homes and adult day care centres (now adult day centres). However, over the past five years the term Home Support has increasingly become synonymous with Homemaker services, now called Home Support Worker services. The other services which were previously under the Home Support umbrella are now more generally referred to by the name of the specific service, such as meal programs, group homes, and adult day centres, or they may be called Community Support Programs, in aggregate. Currently Continuing Care is seen as having three major components: assessment and case management, community care, and residential care.

Service Delivery and Organization

British Columbia continues to have a single entry system for all residential and community based Continuing Care services including professional nursing and rehabilitation therapy. Community Home Care Nursing and Community Rehabilitation also have a separate assessment form for their clients. There appears to have been a somewhat greater separation between Community Support Services and Community Home Care Nursing and Community Rehabilitation over the past few years. However, there is still good coordination between these services, and persons requiring longer term professional services could be clients of both the Community Support Program and Community Home Care Nursing and/or Community Rehabilitation.

There is a standardized province wide assessment instrument which is completed on all Continuing Care clients irrespective of what type of service they may require (residential or community). There is also a province wide assessment form for Community Home Care Nursing and Community Rehabilitation. Case Managers complete the Continuing Care assessment form and designate a level of care on a five point classification system (Personal Care, Intermediate Care 1-3, and Extended Care) for all clients. Clients are classified before they enter any given service or set of services.

The Case Managers are responsible for client intake and for developing a care plan in which the general volume and mix of services is determined. They determine which services should be provided, and to what degree, and then authorize the use of these services for clients. They contact service provider agencies on behalf of clients and arrange for the provision of all necessary services. The Case Managers also re-assess clients on a regular basis and maintain responsibility for overall case management even after clients are admitted to Residential Care. Extended Care is provided in acute hospitals, Extended Care facilities, Multi-Level care facilities (which provide services to both Intermediate and Extended Care level clients), and private hospitals (which also have Intermediate Care and Extended Care clients). However, entry to all these services is through the Continuing Care system. Therefore, Extended Care beds

are considered to be part of the Continuing Care system. The Case Managers continue to do re-assessments and determinations of the level of care for clients in all facilities. Thus, British Columbia has what could be described as a "systems level" entry, assessment, classification, and case management system. Individual agencies still develop service plans for clients, but Case Managers are responsible for the overall plan of care, which can include service from multiple providers, and are responsible for regularly re-assessing clients and revising the overall care plan. Community Home Care Nursing and Community Rehabilitation services provide hands-on care for clients residing in their own homes as well as clinical case management and regular re-assessments of their clients.

ALBERTA

Provincial System

Introduction

Alberta has regionalized most health services, although Mental Health and Alcohol and Drug Services continue to operate through separate commissions and remain centrally funded. As part of the regionalization process, there has been a significant reduction in staff at Alberta Health. Many former staff have been deployed out to the regions. Full time equivalent staff in Alberta Health have gone from a complement of some 2,200 before reforms to 600 after reforms. The staff who remain are involved primarily in policy development, planning, monitoring, standards, and project management.

Given that the operational responsibility for the delivery of Continuing Care services has been devolved, there are no positions in Alberta Health which are dedicated to Continuing Care *per se*. However, there are a number of Continuing Care projects which are being conducted by Alberta Health in partnership with the Regional Health Authorities. There are currently major projects related to revising the Alberta Assessment and Placement Instrument (AAPI) and the Resident and Home Care Classification Systems, and to developing performance indicators for Continuing Care. In addition, Alberta has recently launched a major Long Term Care Review.

The Alberta Continuing Care system has had strong leadership for many years which has resulted in the Regional Boards maintaining most of the components of the system and being willing to work with Alberta Health to revise and improve the system. Traditionally, residential care and Home Care were administered separately in Alberta, but there has generally been close coordination between these sectors. For a short period of time, starting in 1994, residential care, Home Care and aids to daily living were integrated into one administrative structure within Alberta Health. There is currently a recognition in Alberta that while Regional Boards have a reasonable degree of autonomy, provincial standards and policies are still important. Therefore, major issues are generally dealt with on a partnership basis.

Use of Major Terms

The use of terminology is to some extent in transition in Alberta. Continuing Care is used as a term to describe the full range of residential, community and home based services. Use of the term Long Term Care is in decline although it is still sometimes used to refer to facility care. The trend seems to be to use the term Continuing Care as a concept, and as an organizing framework, and to begin to use it in more operational terms as well. For example, there is increasing use of the term Continuing Care Centres to refer to what were previously called Long Term Care facilities.

The term Home Care has been in active use in Alberta for some time. Home Support is seen as falling under the Home Care umbrella while Home Care comes under the Continuing Care umbrella at least provincially (terminology varies somewhat between regional health authorities). Nevertheless, as noted, these terms are still in transition and some people still refer to Long Term Care facilities. In addition, the major review of this sector is called the Long Term Care Review.

Service Delivery and Organization

Alberta has a single entry system in which assessment, referral and ongoing case management are provided by Home Care staff. Alberta, at this time, does not have a separate assessment and case management structure. Home Care provides these functions and also provides hands-on care. In larger communities there may be a functional separation between assessment/case management and direct delivery, but in many smaller communities the same staff person provides all of these functions.

A standardized assessment form, the Alberta Assessment and Placement Instrument (AAPI), is used across the province for Continuing Care services. Some regions have streamlined the AAPI and, therefore, use AAPI derivatives, but the actual data collected are very similar. Once clients are admitted to facilities, the case management function is transferred to the facilities. All residential clients are classified on an annual basis using the Resident Classification System (RCS) which has seven categories (A-G). There is a separate Home Care Classification System which is similar to the RCS but also includes variables on social supports. The resulting Home Care classification system is, thus, a combination of functional need and existing social supports. There is reasonable comparability for the functional needs component of the two classification systems, so some comparisons can be made between the relative need distributions of facility and community based clients using a similar metric.

Given that Continuing Care services are provided through the Regions, we shall now provide an overview of the Capital Health Region in Edmonton and the Calgary Regional Health Authority.

Capital Health Region (Edmonton)

Continuing Care services, community health, public health, community rehabilitation, community hospitals and health centres, rehabilitation hospitals, and a number of speciality programs come under the responsibility of the Vice-President and Chief Operating Officer for Community Care and Public Health. The term Continuing Care has superseded the term Long Term Care as the designated term for facility care. The term Home Support is not used. Home Support functions are subsumed under Home Care. The term Home Care is used to designate short term clients, long term clients, and palliative clients. The majority of clients receive long term services, and this is referred to as the Long Term Care component of Home Care. Officials are aware of the usage of the term Continuing Care as an overall umbrella term for all residential and community services and may consider adopting this meaning of the term in the future. However, for now, the term Continuing Care is used to refer to residential services, including Chronic Care services. There are separate individuals responsible for Home Care and Continuing Care in the Capital Health Region who report to the Vice-President and Chief Operating Officer for Community Care and Public Health.

All home care clients, regardless of their needs, receive a comprehensive needs assessment. The Capital Health Region has a

single entry system and a standardized assessment instrument. Capital Health also uses the Alberta Resident and Home Care Client Classification Systems.

Home Care currently performs all client assessment and case management functions. Once a client is deemed to require long term care in a facility, he or she is referred to a facility based case manager (a Continuing Care Case Manager). A client's application for placement is then reviewed by a central assessment and placement team. Home Care staff have also been deployed to most community and rehabilitation hospitals in order to do assessments for individuals in these institutions. In addition, Continuing Care Case Managers (in facilities) and Home Care staff have been cross-trained so that each type of worker can handle the intake and assessment process. Once assessed, a client would either be maintained in the facility or in Home Care, if they were assessed as receiving the appropriate level of care, or they would be transferred to the program that was appropriate for their care needs. This process facilitates the admission of clients into the care system. Community based clients are assessed by Home Care. Placement to all Continuing Care facilities is still done through a central assessment and placement team. Waiting lists are also managed centrally.

Calgary Regional Health Authority

Until recently the Calgary Regional Health Authority had a Vice-President for Continuing Care, and Continuing Care services came under this person. This individual has now been given added responsibilities for public and community health. Her title now is Chief Operating Officer for Community Health Resources. With the integration of Public and Community Health with Continuing Care, there was a perceived need to change some of the terminology which was used. Thus, in Calgary the terms Continuing Care, Long Term Care and Home Care are no longer used. The term Supported Living is now used to refer to residential Long Term Care services including Chronic Care. The Home Care program has been subsumed under the title Community Care and Support. There is also a shift in emphasis to focus more on client needs and less on the setting in which services are provided. Community Care and Support is responsible for the assessment function and also contains a broader array of services than was the case under Home Care, including Adult Day Programs, Technical Supports (Aids for Activities of Daily Living), Community Rehabilitation, and Transition Services.

The Calgary Regional Health Authority has a single entry system. It also has a standardized assessment form based on the AAPI, but this form is different than the one developed in Edmonton. The Community Care and Support staff who are responsible for Home Care-type services still do intake, assessment and case management. Home Care maintains clients even though they may go to an acute hospital for a short period of time. Home Care staff also provide direct professional nursing care. If individuals are admitted to care centres, the case management function is handed off to staff in the facility. Transition Services maintains the facility waiting lists. Individuals who are discharged from hospitals and urgent admissions from the community are provided priority placement for facility care.

In terms of organization, one individual is responsible for facility care and housing options (Senior Operating Officer for Supported Living and Specialized Services), and one is responsible for community care (Senior Operating Officer for Community Care and Support). Both individuals report directly to the Chief Operating Officer for Community Health Resources.

SASKATCHEWAN

Provincial System

Introduction

Saskatchewan Health has developed and implemented a regional (district) model of health reform and has adopted an overall "wellness approach" to health services. As part of regionalization, there has been a major restructuring of Saskatchewan Health. On April 1, 1995, there was a transfer of some 1,400 staff, who had been delivering community based services as staff of Saskatchewan Health, to the District Health Boards. The Continuing Care Division of Saskatchewan Health was phased out as part of the regional reform process in 1993.

In terms of organization in Saskatchewan Health, one Associate Deputy Minister is responsible for all district health services and one Assistant Deputy Minister is responsible for services such as health insurance, physician services and prescription drug services which have not been regionalized. Saskatchewan also has a list of core health services which should be delivered by the districts. Staff in Saskatchewan Health are now more focused on the development of broad policy, standards, and legislation.

Use of Major Terms

Continuing Care terminology is in a state of transition in Saskatchewan. There is no tradition of using the term Home Support. These services were generally included as part of Home Care. Traditionally, the term Long Term Care was used to refer to facility based care (including Chronic Care), and the term Continuing Care was used as an umbrella term which included the full range of residential and community based services. Terminology has now changed. The term Home Care is still used, but Home Care is now also referred to as Home Based Services. The term Supportive Services has superseded the term Continuing Care to refer to the full range of residential and community services. The term Long Term Care has been in decline for some time.

Service Delivery and Organization

The operational responsibility for the delivery of Supportive Services has been passed to the districts. Overall, most districts still use a single point of entry model, and some regions have enhanced their approach to single entry. There is a standardized assessment instrument which is currently recommended for use for Supportive Services called the Saskatchewan Client Information Profile (SCIP). It is planned for Saskatchewan districts to adopt the Minimum Data Set (MDS-2) assessment tool for facilities and to adopt the Resource Utilization Groups (RUG III) method of classification for facility residents. At this time, a 1-4 classification system is used for facility clients. The use of the MDS-2 and RUG III instruments is being pilot tested in the Prince Albert District. The SCIP will continue to be used for Home Care/Home Based Services even after the adoption of MDS-2 and RUG III for residential care.

Some districts have a case management service that is separate from Home Based services, while in other districts, case management and hands-on care are provided through the Home Based Services program. In both cases, case managers arrange for the provision of appropriate services for their clients. They also facilitate the transfer of clients to facility care and transfer the case management function to facility staff when the client is admitted to a facility. There is no standardized classification system for Home Based Services clients.

In terms of organization it has been noted that Saskatchewan Health is no longer engaged in program operations. The two individuals who are most involved in what used to be

Continuing Care are Directors in the Community Care Branch. The Executive Director of this Branch (which also includes Mental Health and Addictions) reports to the Associate Deputy Minister responsible for the District Programs Division. All age groups are eligible for Home Based Services and institutional supportive care in the province.

The Regina Health District

The Regina Health District primarily uses the term Long Term Care to describe care in facilities and the term Home Care to describe home and community based services. The term Home Support is subsumed under Home Care, and the term Continuing Care is not actively used. Chronic Care is part of Long Term Care, and with regionalization, some other heavy care facilities such as those for rehabilitation also came to be included under Long Term Care. Regina has a system wide single entry, assessment and case management system for Home Care and for facility based clients, and staff are responsible for admission and discharge. They also provide admission and discharge services for acute care, mental health and alcohol and drug programs. This is an example of the greater integration of services across sectors since regionalization. Home Care also provides services to a wider range of clientele. For example, Home Care may now go into Mental Health group homes to provide needed services whereas they generally would not have done so prior to regionalization.

The Saskatchewan Client Information Profile (SCIP) is used as the assessment tool in Regina. It has both a long and short version. The longer version is used to assess clients going into facility care or clients requiring ongoing care in the community. The shorter version is used in Home Care for short term acute admissions. Home Care also relies on discipline specific tools for more in depth investigations of clients' needs.

There is no formal classification system for Home Care. A 1-4 level classification tool is used for Long Term Care facility clients. The Regina Health District has also developed a "risk indicators tool." This tool is used to determine the level of risk for clients and is used as a preventive tool. It is also used as part of the screening process at intake in Regina. This tool is different than the tool used in Saskatoon.

In terms of organization in the Regina Health District, there are two individuals responsible for Home Care and Long Term Care, respectively. They both report to the Vice-President of Integrated Community Clinical Services. The client assessment component and case coordination component of Long Term Care (i.e., facility care) and Home Care now come under the Vice-President of Medical Services.

Saskatoon District Health

The use of terminology is somewhat in flux in Saskatoon. The term Continuing Care can have a few different meanings. It can be used to describe the whole range of residential and community based services, but it can also be used to refer to heavier care residential services. The facility portfolio is named Continuing Care and Geriatric Services while Home Care services are provided through the Family Health portfolio.

The term Long Term Care is generally used to refer to heavy care facilities. Facility care can be referred to as Long Term Care or Continuing Care. The term Home Care, like Continuing Care, can have two different meanings. It can refer to the full range of home based services. It can also be used to describe Home Nursing Care only. The term Home Support is used in Saskatchewan to refer to non-professional services such as aides and homemakers and to community based services such as Adult Day Care.

Saskatoon has a single point of entry system. Staff of the Coordination and Assessment Unit do client assessment and case management. They are responsible for obtaining both Home Care and Long Term Care services for their clients. Thus, like in British Columbia, system level assessment and case management is distinct from the provision of hands-on care. Saskatoon District Health uses a standardized assessment tool. It uses the 1-4 level classification system for reporting to Saskatchewan Health. It also uses the Resident Classification System (RCS) from Alberta (a seven point scale from A to G) as a basis for funding. Saskatoon, like Regina, uses a "risk indicators" tool which has been tested for validity and reliability, but this tool is different from the one used in Regina.

In terms of facility services, there has been a significant reduction in funding clients at lighter levels of care (Levels 1 and 2) in facilities. Such clients are now cared for in the community whenever possible, and facilities only admit heavier care clients (levels 3 and 4). These may include Chronic Care, sub-acute and medically complex cases. There is a great deal of collaboration by Saskatoon District Health and facility providers, and provider representatives sit on advisory bodies to the District. In terms of the move to MDS-2 and RUG III, there is some concern that administering these instruments may take more time and resources than using the Alberta RCS tool for annual assessments. This is an important consideration as the District classifies some 1,700 clients on an annual basis.

In terms of organization, Saskatoon District Health has two CEOs who work together collaboratively. One CEO is responsible for the Catholic Hospital and one for all other District Health Services. There are five Vice-Presidents. Under the Vice Presidents are 12 general managers. Of these twelve, one is responsible for residential care (Continuing Care and Geriatrics), and one is responsible for Home Care and Home Support (Family Health Services). Home Care and Home Support services are provided by staff of the District. Long Term Residential care is provided through 17 Special Care Homes, one of which is wholly owned and operated by Saskatoon District Health. The other 16 facilities are operated on a contractual basis with Saskatoon District Health. Both residential services and community services are provided to persons of all ages.

MANITOBA

Introduction

Manitoba has a long tradition of providing Continuing Care services. The term Continuing Care was used in Manitoba to refer to Home Care and Home Support services from the mid-1970s to the early 1990s. In 1992, all services were combined under an Assistant Deputy Minister of Continuing Care. In 1994, this position was replaced by an Assistant Deputy Minister for Community and Mental Health Services. Manitoba started to move to a regional model of service delivery in two steps. In September 1995, the Minister of Health announced the establishment of 10 Regional Health Authorities in rural and northern Manitoba. These Authorities received operating funding starting April 1, 1997. More recently, regionalization was expanded to the rest of the province. Regional Boards will be operational in Brandon, and Winnipeg (two Boards), as of April 1998.

Use of Major Terms

As noted earlier, the term Continuing Care was used in Manitoba from the mid 1970s to the early 1990s to describe Home Care and Home Support services. In 1992, with the appointment of the Assistant Deputy Minister

for Continuing Care, the term came to be used for the full range of health services. Since 1994, the term has been in decline and is used more as a descriptor or to denote the concept of an overall system of care. The two terms which are currently in use are Long Term Care, which refers primarily to facility based services, and Home Care, which refers to home and community based services and includes Home Support. While Long Term Care is generally used to describe facility care, longer term clients in Home Care are referred to as being in the Long Term Care component of Home Care.

Service Delivery and Organization
As noted above, Manitoba Health is in the midst of its restructuring and reform process. As regionalization is completed, the regions will take over the responsibility for the operational delivery of all Continuing Care services. At present, Manitoba has a single point of entry system and a standardized assessment tool. Home Care serves as the single point of entry, and Home Care staff complete the standardized assessment and provide ongoing case management while the client remains in the community. In Manitoba, the assessment and case management process is separate from care provision, and Assessors/Case Managers do not provide hands-on care. Instead they facilitate access to a wide range of care services for their clients. They also facilitate entry into residential care through the Manitoba Assessment and Placement Process. Once clients are admitted to a facility, the case management function is transferred to facility staff.

Chronic Care beds come under Long Term Care. There is a 1-4 level classification system which is used in Manitoba for personal care services. Relatively few people at levels one and two are now in facilities. Home Care Assessors/Case Managers use the levels of care to identify the dependency level of the individual who requires facility care. There is no separate classification system for Home Care clients. However, the facility classification system is used for planning and for certain aspects of delivery. For example it is used to determine whether or not the costs of caring for someone in Home Care would exceed the costs of providing care for that person in a facility.

In terms of administrative arrangements, the senior staff person responsible for Long Term Care in Manitoba Health has just retired. Her replacement, and the director of Home Care, report to the Executive Director of the Health Programs Branch of Manitoba Health. This is a newly consolidated programs branch. The executive director of this branch reports to the Associate Deputy Minister for External Programs and Operations (formerly Community and Mental Health).

ONTARIO

Introduction
Ontario is also going through a major reform process. Ontario has not adopted regionalization; rather, the Ontario Ministry of Health is involved in projects related to new models of delivering Primary Care services and to the development of Integrated Health Systems. Ontario has been involved in a range of Continuing Care related reforms over the past years. These projects have now been integrated into a focus on instituting a process for a single point of entry through newly established Community Care Access Centres (CCACs).

Use of Major Terms
The term Continuing Care is not used in Ontario. Instead the term Long Term Care is used to describe the full range of facility, home and community based services, i.e., Ontario uses Long Term Care instead of

Continuing Care as an umbrella term. The term Long Term Care is also used by some to refer primarily to facility care. It should be noted that Chronic Care hospitals, or wards in hospitals, are not included in Long Term Care. They are seen to be part of the hospital system.

The term Home Care, as used in Ontario, includes the concept of one-on-one professional services and supportive services such as homemakers. However, there are also community based services such as meal programs, transportation, adult day services, friendly visiting and so on which are referred to as Community Support Services. Many of these services would be included in the term Home Support in other jurisdictions. There are two major roles for Home Care: the short-term acute hospital replacement component which is available to individuals of all ages, and the care of clients who need assistance over a longer period of time.

There are a number of different pieces of legislation which apply to the full range of Long Term Care services in Ontario. The Long Term Care Act provides a list of services that come under Long Term Care community based services. However, this Act is not yet fully operational.

Service Delivery and Organization

The newly established Community Care Access Centres provide single point of entry, assessment, and case management functions for Home Care clients. In addition, they determine eligibility and authorize access to Long Term Care facilities. Once a client is admitted to a facility, the case management function is transferred to facility staff. The CCACs do not, however, authorize access to Chronic Care hospitals or to Community Support Services, although they may refer clients to these services or serve as an access point by mutual agreement. The CCACs determine overall care requirements and act as the purchasers of service from the various Home Care providers in their areas. These providers can be for-profit or not-for-profit organizations. The CCACs will also make referrals and arrange linkages with providers of other services to benefit their clients as part of the case management function.

The process for accessing Long Term Care facilities is that staff of a CCAC determine eligibility for facility care by conducting an assessment. This may take place as part of a regular, ongoing reassessment process. If eligible, the individual would indicate his or her preference for a facility, and, generally, would go on a waiting list. CCAC staff are responsible for maintaining the waiting lists for the facilities in their areas.

Chronic Care hospitals use the American MDS-2 assessment form and the RUG III facility classification system. There is not a standardized assessment form for Long Term Care facilities although one is in the process of being developed. Long Term Care facilities have adopted the Alberta Resident Classification System (Levels A-G). All facility clients are assessed once per year by assessors who are external to the facility. Classification information is entered into a case mix type funding formula, and the appropriate rate of reimbursement is determined for each facility.

In terms of the organization of the Ontario Ministry of Health, all Long Term Care services (excluding Chronic Care hospitals and Group Homes) come under the responsibility of the Executive Director of Long Term Care.

QUEBEC

(Prepared by Ellen Leibovich,
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Introduction

The province of Quebec has had a regional model of service delivery for many years. Local CLSCs (community health centres) provide a range of community based services using a Primary Care Model. These CLSCs come under regional authorities which have received greater administrative responsibilities during the 1990s.

Like in other regionalized provinces, there have been a number of changes in the way the Quebec Ministry of Health and Social Services (MSSS) has organized itself to best deal with the needs of Continuing Care clients.

Ten years ago there were separate services for institutional and community care services for the elderly. These two services were merged to become one service for the elderly. Afterwards the "Direction de l'adaptation et l'intégration sociale" was created which included a service for the elderly and services for the handicapped. These services were combined into one division. Individual roles have changed, and the number of people working in each sector has been reduced.

With respect to institutionalization, the names of the organizations have evolved. What were once called "centres de soins prolongés," "centres d'accueil d'hébergement," and "centres hospitaliers de soins prolongés" are now all called "centres d'hébergement et de soins de longue durée." Home Care services provided through the CLCSs are now known as "services à domicile de première ligne." A small portion of highly specialized services are also provided in the home by other providers (e.g., hospital outreach).

At present, a division responsible solely for the elderly no longer exists in the MSSS. There is no unique administration for this clientele. The "Direction de la recherche et de l'évaluation" and the "Direction de la Santé publique" are each in part responsible for the elderly. However, they serve other clients as well (e.g., youth protection, drug addiction). The heads of each of these services are thus responsible, in part, for the elderly.

Use of Major Terms

In Quebec the terms Continuing Care and Long Term Care are not used. Instead, the term "service d'hébergement et de soins de longue durée" is used for facility care, and it includes all social and health care services and other services provided in institutional settings.

With regard to Home Care, the term "service à domicile de première ligne" is used to designate care and services offered in the community through CLSCs. Thus, in Quebec when one talks about services provided in the home, the general descriptive term "services à domicile" is used, and when one talks descriptively about long term institutional services, one refers to "services de soins en établissement de longue durée."

Home Care services are provided to assist people in their homes, or in a setting considered to be a home, and include nursing care, medical care, rehabilitation services, psychosocial services, personal aid and domestic services, and social support to family and other care givers. These services are intended to help maintain individuals in the community for as long as possible.

Service Delivery and Organization

While there has been a progressive, and rapid, movement to have single entry through the CLSCs, there are, in some areas, still two principal entry points into the system. One is the hospital, and the other is the CLSC. It is planned, however, that in the future access to Home Care services and institutional care will

be through the CLSCs only. Coordination mechanisms will be set up between the CLSCs and the hospitals. If a patient that is hospitalized needs to be placed in an institution, the CLSC will be involved in this decision. In Montréal, development of a single entry point system has recently been completed. As well, other organizational models of integrated service delivery are being pilot-tested.

The CTMSP ("Classification par type en milieu de soins et services prolongés") is the tool used in Quebec to assess persons who require institutionalization. However, this tool is not used for home care services. The CLSCs have a variety of tools (including the "Système de mesure de l'autonomie fonctionnelle" [SMAF] and modified SMAF) to evaluate patients requiring Home Care services. However, consideration is being given to revising this so that one single tool can be established and used for all patients who require either Home Care services or institutionalization. A group has been set up by the Quebec Ministry of Health and Social Services (MSSS) to work with service provider networks to establish a single tool.

In Quebec, institutional care and Home Care are generally managed separately, although some merged models do exist in rural areas. Presently, each case is managed by the system that offers the service. The shift to ambulatory care, called "virage ambulatoire," or more globally, the transformation of health and social services, tends to encourage greater coordination and communication between the hospitals and the CLSCs so that proper follow-up is possible, and it brings institutional care and Home Care closer together. There is presently a great deal of discussion concerning the implementation of individualized service plans which would permit a case management approach. Although this is among the objectives, very few organizations are currently equipped with the appropriate tools.

There is not a standard classification system in Quebec. Rather, there exists a system of evaluation of needs. Clients are evaluated, and services are then determined according to the patients' needs. When institutional care is deemed to be required by front line service providers, a complete bio-psycho-social assessment is done by means of a single standardized instrument, the CTMSP. Multidisciplinary teams then determine service needs, after which regional committees orient clients on the basis of their needs and of the resources available. This process is known as "mécanismes d'orientation et d'admission." The request for care can be initiated by the individual or a family member, the hospital, or a doctor who directs the individual patient to the CLSC.

The present tendency is to decentralize the management and administration of services to the regional health boards. The MSSS divides the budget into 18 smaller regional budgets. The MSSS creates an overall policy framework and system of follow-up and evaluation. Everything else is decided and administered by each of the regional boards.

NEW BRUNSWICK

Introduction

The New Brunswick Department of Health and Community Services conducted a major review of Continuing Care services which culminated in the publication, in 1993, of their Long Term Care Strategy document. This document contained a vision for a more inclusive, coordinated and client centred system of care.

New Brunswick completed the introduction of a single entry process in 1993. The Extra-Mural Hospital and the Family and Community Social Services Division both served as initial entry points, within a single process, to the system of care. In fact, the introduction of the single entry process allowed New Brunswick to have a major success in reducing facility waiting lists from 889 people in 1992 to 55 people in 1994. The Long Term Care Strategy expanded the partnership for the single entry process to include Mental Health Services. In 1996, the Extra-Mural Hospital was restructured and changed to the Extra-Mural Program. The organization is no longer a free standing program. The headquarters was dissolved, and service delivery units became the responsibility of the eight regional hospital corporations. The Program provides acute and long term health services. As a result, each hospital corporation now provides extra-mural health care services to its clientele. In addition, the former Mental Health Commission was integrated into the Department as a Division called Mental Health Services and is now a full partner in the LTC strategy.

Thus, in New Brunswick there is a three part team involved in the "Long Term Care Strategy" which is made up of the Extra-Mural Program (EMP), the Family and Community Social Services Division (FCSS) and Mental Health Services Division (MHS). FCSS is always involved in client assessment, and the Extra-Mural Program and Mental Health Services may also assess clients as appropriate. While FCSS involvement in Long Term Care is solely within the Long Term Care Strategy framework, EMP and MHS provide Long Term Care services to other client groups outside this framework. Mental Health Services Division provides psycho-social rehabilitation while the Extra-Mural Program provides physical health rehabilitation. Community Mental Health may also be provided to persons with Long Term Care needs, as required.

Use of Major Terms

The term Continuing Care is not used in New Brunswick. Rather, the term Long Term Care is used to describe the full range of residential, home and community based services. The term used for the residential portion of Long Term Care is the name of the type of facility, either Nursing Home for clients requiring nursing care in addition to substantial assistance with personal care, or Residential Facilities for lighter care clients. The terms Home Support or Homemaker are used to refer to non-professional services. The term Home Care may be used descriptively, but its functions come under the auspices of the Extra-Mural Program which uses the term Home Health Care. The Extra-Mural Program has two major components for Home Health Care. They are a short-term acute care substitution and palliative component, and a Long Term Care component. Individuals are considered to be in the Long Term Care component of the Extra-Mural Program once they have been in, or require, care for four to six weeks or longer. The short term program generally provides services for thirty days or less, although some individuals in acute care require services for longer than four weeks. Resource intensity, as well as length in the program, is considered when determining whether a client is acute or long term.

Service Delivery and Organization

As noted above, New Brunswick does have a single entry process. Assessments are generally done by two people, a social worker from FCSS and a health care professional from the Extra-Mural Program or from Mental Health Services. New Brunswick uses a slightly modified version of the Alberta Assessment and Placement Instrument

(AAPI) as its assessment form. Once the assessment is completed, the FCSS social worker will generally serve as the ongoing case manager unless, due to client needs, some other arrangement is more appropriate. For example, Extra-Mural Programs would provide case management for clients who only need their services. In general, the case management function is separate from care provision. The case manager will assist the client to obtain the range of services which are most appropriate to the client's needs. The case manager will also assist the client to obtain care in a residential setting. Each Region has a panel to review admissions to all residential facilities including Nursing Homes, and the panel may consult a range of professionals, as required. Clients can select up to three choices for facility care. Currently most clients are able to access their facility of choice rather quickly because there are almost no waiting lists for facility care. Once the client is admitted to a Nursing Home, facility staff take over the case management functions. The case managers will, however, remain involved if the client goes to an adult residential facility. New Brunswick has a 1-4 level classification system for residential placement. Individuals in Adult Residential Facilities are generally at levels one and two while those in Nursing Homes are at levels three and four. In New Brunswick clients are income and asset tested and may have to pay the full cost of facility care.

In terms of reporting relationships, there are Assistant Deputy Ministers for Family and Community Social Services, Institutional Services (which includes Nursing Homes and the Extra-Mural Program) and Mental Health Services.

NOVA SCOTIA

Introduction

In the past in Nova Scotia, much of what is generally referred to as Continuing Care was in the Department of Social Services (now the Department of Community Services). There has been a gradual transfer of responsibility for Home Care and facility care for the aged to the Department of Health. Given this historical background, there is still a strong working relationship between the two Departments, and efforts are being made to devise an overall system which can serve a wide range of clientele in both Departments including the elderly, children with special needs, and those who are mentally challenged.

On the health side, Nova Scotia has developed a regional model of service delivery with four regions. There are also four Non Designated Organizations (NDOs) which are essentially tertiary level facilities or major centres.

The Departments of Health and Community Services are actively discussing the concept of a comprehensive and integrated single point of entry system for a wide range of clients across both departments. A number of issues will need to be addressed in the development of a new system. Home Care, Nursing Homes, and Homes for the Aged (in Health) have not been transferred to the regions to date.

Home Care Nova Scotia was established in 1995. The program provides an array of professional and home support services in the community and acts as a referral linkage to other health and community services. Responsibility for a group of municipally based InHome Support programs that provide financial assistance to low income Nova Scotians with care needs was transferred to the Home Care Nova Scotia budget from Community Services. Community based support services that are provided in a structured setting, such as Group Homes, are

provided through the Department of Community Services. In addition, the Children's InHome Support program, a service for children with special needs, continues to operate as a separate entity in the Department of Community Services.

In terms of facility care, all facilities, whether for seniors, the disabled, or the mentally challenged, are operated through the municipalities. Municipalities own and operate 22 of the 69 nursing homes in the province. For clients requiring financial assistance, the point of entry to the system is generally through the municipalities.

Use of Major Terms

The term Continuing Care is used as a conceptual and strategic bridge to bring together the full range of Health and Community Services programs to constitute the future "Continuing Care" system. The term Long Term Care is used to include Homes for the Aged and Nursing Homes in Health. It is used in Community Services to describe all clients who need ongoing care in a structured setting, which could include facilities, group homes or community based options.

The term Home Care in Nova Scotia refers to the delivery of nursing care, personal care assistance, home support assistance, home oxygen service and case management services in the client's home. Currently, Home Care Nova Scotia's services are delivered through the Chronic Home Care and Acute Home Care categories. The program will enhance its service capacities over the next several years as resources permit. Development will occur in the areas of rehabilitation therapies (occupational therapy and physiotherapy), palliative care, pediatric care and direct funded care options. Adult Day Services are not a formalized part of the Continuing Care sector at this time.

Service Delivery and Organization

There are two parallel streams in Nova Scotia. Home Care Nova Scotia has a single entry point for its clientele. There is a standard assessment form, and ongoing case management is provided for clients. There is no separate client classification system. Case managers also assist in the process of obtaining facility care for clients but hand over case management responsibilities once the client is admitted.

For all other facility and related services (group homes, etc.), municipalities generally function as the single point of entry through their social services departments. There is a standard form which is filled out as an assessment for admission to facility care. Ongoing case management is provided to all clients. In addition, like British Columbia, case managers continue to assist clients even after they are admitted into facilities or related services. Prior to August 1995, municipalities served as the single point of entry for facilities such as the Homes for Special Care. Since that time, there has been a gradual transition of this function from a number of the municipalities to the Department of Community Services. This transition will be completed by April 1, 1998. The development of a single entry point to a range of Continuing Care services will continue to be examined by the Departments of Health and Community Services. No decisions have been made, to date, regarding the substance, process, or timing of the devolution of Continuing Care services to the regions.

In terms of facility care, prospective clients are both income and asset tested and can be charged up to the full cost of facility care. There have not been formal Chronic Care hospitals, or wards, in Nova Scotia hospitals, although individuals at the chronic level may have occupied beds in such hospitals. More

and more Chronic Care clients are now looked after in Nursing Homes. Nova Scotia uses a classification system with five levels of care for its facility clients although, in Nursing Homes and Homes for the Aged, clients are generally classified into only two of these five levels of care. While some facilities have historically only admitted the elderly (i.e., 65 years of age and over), Long Term Care facilities are now generally available to the entire adult population. However, one facility also exists for children up to 18 years of age.

PRINCE EDWARD ISLAND

Introduction

Prince Edward Island has a combined Department of Health and Social Services. Starting in 1988/89 a number of steps were taken to put into place a regionalized model of service delivery with five health and social services regions. The Health and Community Services Agency Board was established in 1993. It provided the oversight, and legislative basis, for the development of the five Regional Boards. The regions became operational in April 1994. In 1996, there was a change of government, and subsequently, the Health and Community Services Agency Board was re-integrated into the Department of Health and Social Services. Change is ongoing, but as of late 1997 the Regional Boards were still in place.

In terms of Continuing Care, a number of important initiatives have taken place since 1995. A coordinated (single) point of entry system was implemented in September 1996 across all five regions. A new assessment form and a process to identify needs and eligibility as well as referrals were also implemented for all five regions in 1996. The classification system of levels of care has been updated for compatibility with the assessment and referral process.

As of late 1997, there were seven senior directors who reported to the Deputy Minister of Health. One of these Directors is responsible for Acute and Continuing Care. Thus, like British Columbia, Continuing Care remains as an administrative entity in the department/ministry, even though a regional model of delivering services has been implemented. Continuing Care reports to the Director of the Acute and Continuing Care Division.

Use of Major Terms

The term Continuing Care is used to describe the overall system of facility, home and community based care services. The term Long Term Care is used primarily to describe residential care including Chronic Care delivered in Nursing Homes and Government Manors. The terms Home Care and Home Support have been combined to form a new term, Home Care Support, which includes a full range of professional and ancillary services provided in the home and community. In the Home Care Support Program, clients are grouped as follows: short term, intermediate, continuing care, and specialized care.

Service Delivery and Organization

Prince Edward Island has a single point of entry system called Coordinated System Entry. It is managed by the Home Care Support Program. This program screens clients and, as required, conducts a comprehensive assessment of their care needs using a newly developed, standardized assessment tool. Based on the assessment, clients are assigned to one of five levels of care. Clients at levels one and two are cared for in the community. Assessors/Case Managers facilitate entry to facility care, as appropriate, for level four and five clients. Level three clients are cared for in the community, or in facilities, whichever is most appropriate to their needs. Staff of the

Care Support Program provide assessment, care coordination, and hands-on care delivery functions. Once the client is admitted to residential care, case management responsibilities are transferred to facility staff. Clients are income and asset tested in Prince Edward Island and may have to pay up to the full cost of facility care.

It should be noted that Prince Edward Island is the only other jurisdiction, besides British Columbia, to have the same system-wide classification tool for both residential and community clients. Alberta has similar classification tools, at the level of functional needs, across both sectors.

NEWFOUNDLAND

Introduction

Newfoundland has a range of regional services. There are four Regional Community Health Boards which are responsible for Continuing Care, Drug Dependency, Mental Health, Health Promotion and Health Protection. These Boards use a Wellness framework to guide their work. There are also six Regional Institutional Boards which are responsible for acute care hospitals and Long Term Care facilities and two Regional Integrated Health Boards (in northern Newfoundland and in Labrador) which are responsible for Long Term Care, acute care, and community health. It is anticipated that on April 1, 1998 a separate board will be established for Long Term Care facilities in St. John's (the St. John's Nursing Home Board).

It is planned that the Department of Health will merge with the care provision components of the Department of Social Services (family services, rehabilitation and child welfare) in the 1998/99 fiscal year. This may bring an expanded clientele into the overall Continuing Care system such as those with developmental delays and physical disabilities. Responsibilities for these new services will be transferred to the Regional Community Health Boards, and these boards will come to be called Regional Health and Community Service Boards.

Use of Major Terms

The term Continuing Care may be used as a descriptive term to refer to the full range of services. Administratively, it refers to the Division responsible for Home Care and Home Support, and more recently, to Personal Care Homes for lower level care needs clients (levels 1 and 2; levels 3 and 4 are cared for in nursing homes). Continuing Care also provides the access point for admission to facility care. Administratively, Continuing Care does not include Nursing Homes or designated Chronic Care beds. Nursing Homes are included in the Institutions component of the Department of Health. The term Long Term Care is used to describe facility care and may also be used for a wider range of services provided over a longer period of time.

There is a distinction in Continuing Care between Acute Care Home Care (short term) and Long Term Home Care (longer term). The terms Home Care and Home Support are used descriptively to refer to professional and non-professional and community services, respectively.

Service Delivery and Organization

Newfoundland has a single entry system. The entry point is through the four Regional Community Health Boards and the two Regional Integrated Health Boards. There is also a standard assessment Instrument which is used across the province and is based on the Alberta tool, the AAPI. Case management (often referred to as service coordination) is provided by nurses and social workers through the Regional Boards. Case

management is not independent of direct care provision and is often done by the same professional. Newfoundland has a three level classification system for residential services. However, there is now some consideration being given to adding a fourth level for complex care. Newfoundland is also looking at developing a classification system for all of the services coming under Continuing Care (including nursing homes). While many higher level needs clients are being cared for in Nursing Homes, there are also some designated Chronic Care beds in hospitals. These beds are considered to be part of the hospital system and are not part of Long Term Care. Clients are tested for income and liquid assets in Newfoundland and may be required to pay up to $2,800 per month for care. However, this is less than the full cost of care, which is, on average, $4,000 per month per client.

Administratively, the Director responsible for Continuing Care in the Department of Health reports to the Assistant Deputy Minister for Community Services. Nursing Homes come under a Director for Hospital, Health Centre and Nursing Home Services, who reports to the Assistant Deputy Minister for Institutions.

Newfoundland has relatively well developed Regional Community Health Boards. While there is some variation to meet local needs, all Boards conform to the overall provincial framework for providing services. Thus, there is one consistent provincial program for the provision of Continuing Care services, and this program is carried out by the Regional Community Health Boards. The following provides examples of two such Boards, one for the St. John's Region and one for the Central Region.

Examples of Regional Boards

The **St. John's Region** uses the term Continuing Care to refer to the full range of facility, home and community based services. The term Home Care is used to describe professional nursing, social work, and rehabilitation services. The term Home Support is used to describe non-professional services such as homemakers and personal care attendants. The actual services are provided by staff who are referred to as community health staff. They may be nurses, social workers, or other professionals.

As in other regional models, Continuing Care has been combined with community and public health services. The overall model of care is moving to more of a Primary Care model with an emphasis on overall wellness and the use of multidisciplinary teams.

There is a single point of entry system in the St. John's Region. Introduction of single entry two years ago resulted in a considerable reduction of facility waiting lists. St. John's uses the provincial standardized assessment tool. There is also a 1-3 level classification system although a fourth level seems to be emerging based on the needs of the clientele. This system is used for facility care. There is no specific functionally-based classification system for home and community based clients. All community health services are provided by the staff of the St. John's Community Health Regional Board. Services are not contracted out. Continuing Care comes under one of three Assistant Executive Directors for the Region.

In the **Central Region**, Continuing Care refers to the full range of care services. Home Care refers primarily to Home Care Nursing, and Home Support refers to a range of non-professional services. The Central Regional Community Health Board has a single entry system. Case management, or service coordination, is part of Home Care. Home Care staff may do both case management and hands-on care. The provincial standard

assessment instrument is used. Work is under way to improve the existing classification system and the assessment instrument. Continuing Care services come under the responsibility of the Assistant Executive Director of Programs and Services who is also responsible for Mental Health and Addictions.

APPENDIX B: ORIGINAL AND REVISED DEFINITIONS OF CONTINUING CARE SERVICE COMPONENTS

Original definitions used for study	Revised definitions based on input from respondents
Community Based Services:	
Assessment and Case Management Services constitute a process of determining care needs, admitting clients into service and providing for the ongoing monitoring of care requirements, including the revision of care plans as necessary.	**Assessment and Case Management** constitutes a process of screening clients, conducting assessments, determining care needs, determining eligibility, making referrals to appropriate services, admitting clients into service(s) and providing for the ongoing monitoring of care requirements, including the revision of care plans, and discharge planning. Assessors/Case Managers may also conduct financial assessments, act as client advocates in facilitating care provision and manage facility waiting lists.
Meals-on-Wheels is a voluntary community service that provides and delivers a hot nutritious meal to the client's home. The goal of Meals-on-Wheels is to supplement a client's diet by delivering an attractive nourishing meal to help maintain or improve health.	**Meal Programs** are generally voluntary community services that deliver a nutritious hot, or frozen, meal to the homebound client (Meals-on-Wheels) or bring the client to a congregate setting to have a meal (Wheels-to-Meals). The goal of Meal Programs is to supplement a client's diet by delivering an attractive nourishing meal to help maintain or improve health. Governments may pay for some of the costs of this program, e.g., cost of meals, transportation subsidy.
Homemaker Services are provided to clients who require non-professional (lay) personal assistance with care needs or with essential housekeeping tasks. Personal assistance needs may include help with dressing, bathing, grooming, and transferring, whereas housekeeping tasks might include activities such as cleaning and meal preparation.	**Homemaker Services** are provided to clients who require non-professional (lay) personal assistance with care needs or with essential housekeeping tasks. Personal care needs may include help with dressing, bathing, grooming, and transferring, whereas housekeeping tasks might include activities such as cleaning, laundry, meal preparation, and other household tasks. Homemakers may have post secondary training to the same level as Aids and Care Attendants and may provide similar types of personal care services. Specific nursing and rehabilitation tasks may also be delegated to Homemakers. Homemaking can also be provided as a respite service.

Original definitions used for study	Revised definitions based on input from respondents
Home Nursing Care provides comprehensive nursing care to people in their homes. A home nursing care program coordinates a continuum of services designed to allow clients of all ages to remain in their homes during an acute or chronic illness. This community based program provides one-to-one nursing care in the client's own environment. Home nursing care encourages clients to be responsible for, and to actively participate in, their own care. Goals for nursing care can be curative, rehabilitative, or palliative.	**Home Care Nursing** provides comprehensive nursing care to people in their homes, generally by registered or psychiatric nurses. A home care nursing program coordinates a continuum of nursing services designed to support clients of all ages to remain in their homes during an acute, chronic, or terminal illness. This community based program provides nursing care in the client's own environment. Home care nursing encourages clients and their families to be responsible for, and to actively participate in, their own care. Thus, teaching and self-care are promoted. Goals for home care nursing can be curative, rehabilitative, palliative, or supportive.
Community Physiotherapy and Occupational Therapy Services provide direct treatment and consultative and preventative services to clients in their homes, arrange for the necessary equipment to cope with physical disability, and train family members to assist clients. Community physiotherapy and occupational therapy programs also typically provide consultative, follow-up, maintenance, and educational services to patients, families, physicians, public health staff, hospitals, and nursing homes.	**Community Physiotherapy and Occupational Therapy** provide direct assessment, treatment, consultative and preventative services to clients in their homes to monitor, rehabilitate, or augment function, or to relieve pain. Therapists may also arrange for the necessary equipment to manage the clients' physical disabilities and may train family members to assist clients. Community physiotherapy and occupational therapy programs also may provide consultative, follow-up, maintenance, and educational services to clients, families, physicians, other health providers, hospitals, and Long Term Care facilities.
Adult Day Care Services provide personal assistance, supervision and an organized program of health, social and recreational activities in a protective group setting. The program is designed to maintain persons with physical and/or mental disabilities, or restore them to their personal optimum capacity for self-care. Adult day care centres may be established within a residential care facility or may be located in a freestanding building.	**Adult Day Support** provides personal assistance, supervision and an organized program of health, social, educational and recreational activities in a supportive group setting. Nursing, rehabilitation, and a range of other professional and ancillary services may be provided. The program is designed to maintain persons with physical and/or mental disabilities, or restore them to their optimum capacity for self-care. It can also be used to provide respite care, training and informal support to family caregivers. Adult Day Support may be provided within a residential care facility or may be provided through organizations in the community.

Original definitions used for study	Revised definitions based on input from respondents
Group Homes are independent private residences which enable persons with physical or mental disabilities to increase their independence through a pooling of group resources. They must be able to participate in a cooperative living situation with other disabled individuals. This type of care is particularly suitable for disabled young adults who are working, enrolled in an educational program, or attending a sheltered workshop.	**Group Homes** are homes or home-like residences which enable persons with physical and/or mental disabilities to increase their level of independence through a pooling of group resources. They must be able to participate in a cooperative living situation with other challenged individuals. This type of care is particularly suited for disabled young adults who are working, enrolled in an educational program, or attending a sheltered workshop. It may also be provided to seniors and others who require an alternative to facility care.
Residential Services:	
Long Term Care Residential Facilities provide care for clients who can no longer safely live at home. Residential care services provide a protective, supportive environment and assistance with activities of daily living for clients who cannot remain at home due to their need for medication supervision, 24-hour surveillance, assisted meal service, professional nursing care and/or supervision. Clients may have moderate to fairly heavy care needs but are not at the highest level of care, i.e. chronic.	**Long Term Care Facilities** provide care for clients who can no longer live safely at home. Residential care services provide a safe, protective, supportive environment and assistance with activities of daily living for clients who cannot remain at home due to their need for medication supervision, 24-hour surveillance, assisted meal service, professional nursing care and/or supervision. Clients may have moderate to heavy care needs which can no longer be safely or consistently delivered in the community. They may suffer from a chronic disease, from a disability that reduces their independence and, generally, can not be adequately cared for in their homes. In some cases, all facility services, including chronic care, are provided in Long Term Care facilities.

Original definitions used for study	Revised definitions based on input from respondents
Chronic Care Units/Hospitals provide care to persons who, because of chronic illness and marked functional disability, require long term hospitalization but do not require all of the resources of an acute, rehabilitation or psychiatric hospital. Twenty-four hour coverage by professional nursing staff and on-call physicians is provided, as well as care by professional staff from a variety of other health and social specialities. Only people who have been properly assessed and who are under a physician's care are admitted to chronic care facilities. Care may be provided in designated Chronic Care Units in acute care hospitals or in stand alone Chronic Care Hospitals. Care requirements are typically 2.5 hours of professional nursing care per day or more.	**Chronic Care Units/Hospitals** provide care to persons who, because of chronic illness and marked functional disability, require long term institutional care but do not require all of the resources of an acute, rehabilitation or psychiatric hospital. Twenty-four hour coverage by professional nursing staff and on-call physicians is provided, as well as care by professional staff from a variety of other health and social specialities. Only people who have been properly assessed and who are under a physician's care are admitted to chronic care facilities. Care may be provided in designated Chronic Care Units in acute care hospitals or in stand alone Chronic Care Hospitals. Care requirements are typically 2.5 hours of professional nursing care per day or more.
Assessment and Treatment Centres and Day Hospitals provide short-term diagnostic and treatment services in a special unit within an acute care hospital. These centres provide intensive assessment services to ensure that elderly persons with complex physical and psychiatric disorders are correctly assessed and treated. The objective of the centres is to assist the client to achieve and maintain an optimal level of functioning and independence. Centres may have beds for inpatient assessment and treatment, a day hospital service, and/or an outreach capability that permits staff to assist clients in care facilities or in their homes.	**Assessment and Treatment Centres and Day Hospitals** provide short-term diagnostic, assessment and treatment services in a special unit within an acute care hospital or other health facility. These centres provide intensive short term assessment services to ensure that persons with complex physical mental and social needs are correctly assessed, diagnosed, and treated. The objective of the centres is to assist the client to achieve, regain, and maintain an optimal level of functioning and independence. Centres may have beds for short-term inpatient assessment and treatment, a day hospital service, and/or an outreach capability which permits staff to assist clients, who are in care facilities or in their homes, and their families.
Equipment and Supplies may be provided as required to maintain a person's health, e.g., medical gases or assisted-breathing apparatus, and to improve the opportunities for self-care and a better quality of life, e.g., wheelchairs, walkers, electronic aids, etc. Equipment may be loaned, purchased or donated.	**Equipment and Supplies** may be provided as required to maintain a person's health, e.g., medical gases or assisted-breathing apparatus, and to improve the opportunities for self-care and a better quality of life, e.g., wheelchairs, walkers, electronic aids, etc. Equipment may be loaned, purchased or donated.

Original definitions used for study	Revised definitions based on input from respondents
Transportation Services may be provided to the disabled to allow them to go shopping, keep appointments and attend social functions. Many vehicles are adapted for wheelchairs and other devices.	**Transportation Services** may be provided to persons with disabilities and others with mobility related limitations to allow them to go shopping, keep appointments and attend social functions. Some vehicles are adapted for wheelchairs and other devices.
Support Groups may be initiated by many sources, e.g., community and institutional services, friends and families of clients, and clients having similar disabilities. The groups provide psychological support and foster mutual aid.	**Support Groups** may be initiated by many sources, e.g., community and institutional health services, friends, families of clients, and individuals having similar needs. The groups provide peer support and foster mutual aid. Some groups may receive government subsidies.
Crisis Support may be available in the community to give emergency assistance when existing arrangements break down, e.g., illness of the spouse caring for a disabled person, which could include emergency admission to institutional care.	**Crisis Support** may be available in the community to give emergency assistance when existing arrangements break down, e.g., illness of the spouse or caring for a disabled person, which could include facilitation of emergency admission to institutional care, or the provision of enhanced Home Care.
Life and Social Skills for Independent Living may provide retraining and support for independent living, and for social and personal development, in group settings or on an individual basis.	**Life and Social Skills for Independent Living** may provide training and support for independent living, and for social and personal development and integration, in group settings or on an individual basis.
Respite Services may be provided to primary caregivers to give them temporary relief by providing a substitute for the caregiver in the home or by providing alternate accommodation to the client.	**Respite Services** may be provided to primary caregivers to give them temporary relief or support by providing a substitute for the caregiver in the home or by providing alternate accommodation to the client in a residential setting.
Palliative Care may be provided to dying persons in their homes or in residential settings.	**Palliative Care** is an interdisciplinary service that provides active, compassionate care to the terminally ill in their home, a hospital, or other health care facility. Palliative care is provided to individuals, and their families, where it has been determined that treatment to prolong life is no longer the primary objective.

Original definitions used for study	Revised definitions based on input from respondents
Volunteers may provide programs of volunteer help that are utilized in most aspects of Long Term Care.	**Volunteers** may provide programs of volunteer help that are utilized in addition to formal care services. Volunteer services may include, but are not limited to, friendly visiting, telephone reassurance and monitoring, doing errands and shopping, and other social and recreational activities.
Congregate Living Facilities are apartment complexes which offer amenities such as emergency response, social support and shared meals.	**Congregate Living Residences** are apartment complexes which offer amenities such as emergency response, social support and shared meals.

APPENDIX C: ADDITIONAL CONTINUING CARE SERVICES IDENTIFIED BY RESPONDENTS

Children's Group Homes are operated to meet the needs of children who are in the care and custody of Child Welfare. Group homes provide a normal home-like environment. Consumers are those children who can benefit from consistent structure, discipline, instruction and emotional support before returning to a more open community living arrangement. **Handicapped Group Homes** provide for the needs of children who have been assessed as having a physical disability or disorder, mental deficiency or disorder, or who are handicapped as a result of an injury. (NWT)
Social Workers are the primary intake workers for all long-term and palliative clients. Social Workers are involved in case management, counselling, and emotional support for clients and families. (Yukon)
Outreach Social Workers for Seniors provide services to street people who fall between the cracks or stay away from programs such as Home Care. Advocacy, housing, case management are some of the roles. (Yukon)
Choice in Supports for Independent Living (CSIL) is direct funding for Home Support Services only to clients or Client Support Groups (Societies). The client accepts all the responsibilities of being a legal employer in the hiring, firing, supervision and payment of their home support worker. (British Columbia)
Multilevel Care takes place at Residential Care Facilities which provide professional services to clients at the Intermediate and Extended levels of care. (British Columbia)
Discharge Planning Units/Transitional Care are special units in acute care hospitals which provide enhanced rehabilitation and assist the client to reach an optimal level of care in preparation for discharge to the community or residential care. In addition, social work and nursing services liaise with community contacts to facilitate a planned discharge from acute care. (British Columbia)
Quick Response Team or Quick Response Program is a health care program of services designed to prevent unnecessary hospital admissions and to facilitate the earlier discharge home of clients who no longer require acute care treatment. (British Columbia)
Subacute Care is for patients who have had surgery or hospital treatment and need extra time to recover before going home. Surgery and medical subacute care beds are available in continuing care centres in a region. (Edmonton)
Comprehensive Home Option Integrated Care of Elderly (CHOICE) is a comprehensive coordinated program for seniors eligible for admission to a continuing care centre. It includes CHOICE day centre with a full range of medical, social, and supportive services; transportation; home support services; 24 hour emergency response; and respite care. Individuals continue to live in their own homes. (Edmonton)

Seniors Health Line is a 24 hour telephone information line for seniors' services. (Edmonton)
Lamplighter Program is a community based volunteer program operated by Capital Health. Lamplighters are people in the community trained to watch for changes in a senior's condition which may signal a health or safety risk. Seniors Health Line is advised and follow up with the client occurs. (Edmonton)
Care Housing is a continuing care centre built to residential apartment standards where residents purchase a suite through a life lease arrangement. They can have a spouse/friend who does not qualify for continuing care live with them. (Edmonton)
Progressive Care Unit is a unit offering short term services to persons who no longer require acute care but do need services to maximize their physical and cognitive function. (Calgary)
Mentally Dysfunctioning Elderly Unit is a unit offering assessment and transitional services designed to meet the unique needs of individuals experiencing irreversible dementia. (Calgary)
Services for Healthy Living are public health services which are part of the Community Health resources portfolio but may not fit the definition of continuing care. (Calgary)
Quick Response is a 24 hour short stay unit to support clients who would otherwise access emergency rooms for non-acute reasons. (Regina)
Convalescent Care supports clients requiring an extended recuperation following acute care - primarily elderly high-risk clients. (Regina)
Supportive Living is an institutional service designed to support aging mental health clients. (Regina)
Community Social Work involves medical social workers assisting individuals/families in the community to cope with changing needs, bereavement counselling, and more. (Saskatoon)
Pediatric Respite Care includes respite services both in the community and in Specialized Residential LTC facilities for families of multiply handicapped, medically at-risk children (mostly by nurses in the community). (Saskatoon)
Security Calls are regular telephone contact by contracted individuals to elderly, at-risk clients in their homes at specified times. (Saskatoon)
Home Maintenance and Repair is a support service which provides or arranges for an individual worker or company to undertake a home maintenance and repair job. The job may be undertaken on a regular basis or may be undertaken occasionally or one time only. Generally, the job is beyond the client's capability to undertake or arrange by themselves. Examples of ongoing jobs include property maintenance such as snow shovelling, yard maintenance and outside window washing. One time jobs include helping the client to arrange home repairs and renovations such as decorating, plumbing, electrical, new furnaces, roofs, masonry repairs and structural modifications for personal safety, barrier free access to quality of life. (Ontario)

Friendly Visiting is a support service which matches a volunteer on a one to one basis to visit an isolated senior or physically disabled adult in their home on a regular basis. The visits will generally be to the client's home but the volunteer can also do shopping for the client, take the client on a shopping trip, banking or to a social or cultural event. (Ontario)

Security Checks or Reassurance Service is a support service designed to provide isolated persons with regular contact to reassure them that help is available if and when needed. This service may be provided by a person visiting the home, by telephone or other means. It is expected that regularly scheduled friendly visits, either to the home or by telephone, will be included under Friendly Visiting Service. Security visits or reassurance visits to the home will generally be on a one time or infrequent basis as part of a general security and safety program. A general security activity would include a short daily telephone call, for less than five minutes, that checks the health and safety of the client. Postal alert would also be an example of a security program. (Ontario)

Caregiver Support - Support and Counselling Service provides therapeutic counselling to a caregiver who has an emotional, behavioural or personality problem that is impeding their ability to provide care and support for the client. The service is provided to caregivers either in group or individual sessions on a time limited basis either by, or under the direction of, a professionally trained individual and/or one who has demonstrated knowledge and expertise in the client's area of need for support/counselling. The support/counselling should be time limited and goal directed in meeting the caregiver's social and emotional needs. (Ontario)

Caregiver Support - Training, Information and Education Service provides information and education about the disease as well as training and moral support that will assist the caregiver in providing physical care and emotional support to the client. The service is provided on a time limited goal directed basis either by or under the direction of a professionally trained individual and/or individual who has demonstrated knowledge and expertise in the client's area of need. The service is provided in group or individual sessions. (Ontario)

Caregiver Support - Volunteer Hospice Visiting Service is a support service where volunteers are recruited, trained and supported to provide support to individuals in receipt of palliative care. Generally, the client will be matched with one volunteer. More than one volunteer may be provided where a volunteer is required to stay with a palliative care client for long periods of time, and on occasion for 24 hour periods. The palliative care visitor will supplement the support of family and friends. In some situations, the palliative care visitor may be the only source of support for the client. (Ontario)

Foot Care is a service which arranges for a person trained in basic or advanced foot care to provide services, including trimming toe nails, monitoring the condition of feet, bathing feet, and massaging feet. (Ontario)

Emergency Response Systems is a service which provides an electronic device in a client's home so that the client can communicate, in an emergency, with a centre staffed 24 hours a day that can summon emergency help. (Ontario)

Nursing is the promotion of health, assessment, provision of care and treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function. (Ontario)
Physiotherapy is the assessment of physical function and the treatment, rehabilitation, and prevention or physical dysfunction, injury or pain to develop, maintain, rehabilitate or augment function or to relieve pain. (Ontario)
Occupational Therapy is the assessment of function and adaptive behaviour, and the treatment and prevention of disorders which affect function or adaptive behaviour to develop, maintain, rehabilitate or augment function in the areas of self care, productivity and leisure. (Ontario)
Social Work is the discipline of enabling persons and families to develop the skills and abilities necessary to optimize their functioning and thus reduce the risk of psycho-social breakdown. (Ontario)
Speech - Language Pathology Services are the assessment of speech and language functions and the treatment and prevention of speech and language dysfunctions or disorders to develop, maintain, rehabilitate or augment oral motor or communication function. (Ontario)
Dietetic Services are the assessment of nutrition and nutritional conditions and the treatment and prevention of nutrition related disorders by nutritional means. (Ontario)
Outpatient Psychogeriatric Services are specialized psychogeriatric services to assess, orient, and treat the person with a psychogeriatric problem. Information, training, and support for informal and formal caregivers are provided as well. (Quebec)
Intensive Functional Rehabilitation Services are interventions in cases of, for example, CVA, hip fracture or complicated fracture, to promote optimum functional restoration. Available services include medical services, nursing, and rehabilitation (physiotherapy, occupational therapy, social work, and psychological therapy). Services can be in-patient or out-patient. The duration of in-patient services is up to 2-3 months, and the duration of out-patient services is up to one year. (Quebec)
Personal Care Homes provide supportive care to persons requiring minimal supervision and support with activities of daily living. (Central Newfoundland)