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Home Care Development

Provincial and Territorial Home Care Programs:

A Synthesis for Canada

June 1999

Canada

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Provincial and Territorial Home Care Programs:
A Synthesis for Canada
was prepared by Mireille Dumont-Lemasson, Carol Donovan
and Maggie Wylie at Health Canada with the assistance
of the Federal-Provincial-Territorial Advisory Committee
on Health Services Working Group on Continuing Care

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Preamble

This report represents phase three of a four-phase project. The phases were to: (1) draft the tables and synthesis report; (2) seek review, verification of the information, and comment from provincial-territorial representatives; (3) obtain home care funding and utilization data from provincial and territorial officials; and finally, (4) finalize the document for distribution.

Phase one started in May 1998 to expand on work done by the Canadian Home Care Association (CHCA) for the National Conference on Home Care held March 8-10, 1998. Carol Donovan, Mireille Dumont-Lemasson and Maggie Wylie of Health Canada developed the project framework, coordinated the information collection and prepared the draft synthesis report with tables.

Assistance in phase one was also provided by senior policy analysts in Health Canada Regional Offices who prepared updated descriptions of provincial and territorial home care programs by building on the work done by the CHCA and consulting with provincial and territorial representatives as needed. Maggie Wylie of the Regional Director General's Office in Edmonton coordinated this work and was assisted by Jasvinder Chana and David Muddle. These descriptions were used along with a variety of other sources to develop draft tables of comparison to be used for this report as appendices. The senior policy analysts who participated were Mary Fulton, Patricia-Anne Côté, Charlotte Johnson, Patrick Munoz, Aruna Sehgal, Denise Côté, Geneviève Félix, Judith Wood Bayne and Sandra Parkins.

Phase two commenced with presentation of the paper to the Federal-Provincial-Territorial (FPT) Advisory Committee on Health Services Working Group on Continuing Care at its meeting on October 30, 1998. Members were asked to review and comment on the document. All 12 jurisdictions responded and provided additional information and clarification of the content. Other provincial representatives who had contributed to the *Portrait of Canada: An Overview of Public Home Care Programs* for the National Conference on Home Care (March 1998) also provided comments. Based on these comments from members of the working group and others, the paper was revised. Draft #2 was distributed for review to the working group in December 1998. Once again, comments were received from all provinces and territories.

Phase three was conducted in response to FPT Advisory Committee on Health Services Working Group on Continuing Care members who requested that provincial/territorial funding and utilization data be obtained and included along with the other data sources in section 7.0. A table requesting this information was developed and distributed to provincial and territorial representatives on January 28, 1999. Draft #3 of the paper represented revisions to draft #2 and the expanded funding and utilization data in section 7.0 of the paper and appendix 7.0. Draft #3 was tabled at the meeting of the working group on April 15, 1999. **Phase four** allowed for a final round of revisions, French translation, production and distribution.

Members of the Advisory Committee on Health Services Working Group on Continuing Care and others who reviewed the paper and provided information on the various drafts are listed below. A thank you is extended to all those who assisted. This review process has allowed for constructive discussion on common characteristics and goals of home care programs across the country.

Comments and questions can be addressed to Carol Donovan at (613) 941-9966 (e-mail: Carol_Donovan@hc-sc.gc.ca). The facsimile number is (613) 957-3233.

Participants from the FPT Advisory Committee on Health Services Working Group on Continuing Care and other reviewers of the paper

FPT Advisory Committee on Health Services Working Group on Continuing Care

Newfoundland
Eleanor Gardner, Provincial Director, Continuing Care
Department of Health and Community Services

Ann Crowley, Continuing Care Consultant
Department of Health and Community Services

Prince Edward Island
Betty McNab, Home Care and Long Term Care Coordinator
Department of Health and Social Services

Nova Scotia
Dean Hirtle, Director, Long Term Care
Department of Health

Eleanor MacDougall, A/Provincial Director
Home Care Nova Scotia

New Brunswick
André Lépine, Coordinator of Long Term Care Services
Family and Community Social Services Division
Department of Health and Community Services

Quebec
Jeannine Auger, Chef de service
Santé physique et mentale
Ministère de la Santé et des Services sociaux

Réjean Hébert, Director
Centre de Recherche
Sherbrooke, Quebec

Ontario
Patrick Laverty, Director, Program Standards Branch
Ministry of Health

Manitoba
Linda Bakken, Director, Capital Planning
Manitoba Health

Marion Pringle, Director, Long Term Care
Manitoba Health

Saskatchewan
Jim Simmons, Executive Director
Community Care Branch
Saskatchewan Health

Alberta
Vivien Lai, Senior Policy Advisor
Alberta Health

British Columbia
Sally Hamilton, Consultant, Continuing Care
Ministry of Health

Northwest Territories
Mary Jane Stewart, Consultant, Home Care
Program Planning, Support and Evaluation
Department of Health and Social Services

Yukon
Cathy Morton-Bielz, Acting Manager, Continuing Care
Department of Health and Social Services

Health Canada
Barbara Ouellet (Chairperson)
Director, Quality Care Group

Myra Conway
Director of Policy
Home Care Development

Pauline Chartrand
Senior Policy Advisor
Home Care Development

Lucy Wynn, Senior Consultant
Health Systems Division

Other Reviewers

Lesley Larsen, Canadian Home Care Association
Sandra Tingley, Department of Health and Community Services, New Brunswick
Hervé Anctil, Ministry of Health and Social Services, Quebec
Jacinthe Normand, Association des CLSC et des CHSLD du Québec
Jean McCartney, Ministry of Health, Ontario
Frank Teal, Ministry of Health, Ontario
Calvin Hawley, Manitoba Health
Roger Carrière, Saskatchewan Health
Barbara Garding, Alberta Health
Madeleine Pichoir, Department of Health and Social Services, Yukon Territory
Judith Wood-Bayne, Health Canada
Julie Erwin, Home Care Development, Health Canada
Sue Morrison, Home Care Development, Health Canada
Heather Davis, Home Care Development, Health Canada
Margaret MacAdam, Health Canada and Baycrest Centre for Geriatric Care
Betty Havens, University of Manitoba, Winnipeg, Manitoba
Marcus Hollander, Hollander Analytical Services Ltd., Victoria, British Columbia
Evelyn Shapiro, University of Manitoba, Winnipeg, Manitoba

Background

Health Canada and the province of Nova Scotia jointly hosted the National Conference on Home Care in Halifax on March 8-10, 1998. At the conference, there was much discussion among the broad representation of Canadians who were present on what is needed to further develop the home care sector as part of the health care system across Canada.

As background information for the conference, the Canadian Home Care Association (CHCA) prepared a *Portrait of Canada: An Overview of Public Home Care Programs*. This *Overview* gave us snapshots of all provincial and territorial programs in one report. It has served to introduce people interested in home care to the various approaches used within each jurisdiction.

This project expands on the *Overview* work by making comparisons across provincial and territorial home care programs on individual descriptive factors in an effort to view where provinces and territories hold approaches and practices in common, as well as where they are different. Through these comparisons, a picture for the country emerges to show developments that have been achieved by all jurisdictions collectively. Specific models and approaches to services delivery are viewed within the context of the various practices across Canada.

This paper describes the status of home care from a national perspective. The paper is **not** looking to define a single national program. Rather, the intent is to provide current, accurate information within the parameters of the project, and also to make comparisons as to similarities, differences and unique practices emerging across jurisdictions. This may help the reader to find ideas to enhance individual programs while respecting diverse approaches and unique local needs for clients and providers.

Objectives of the Project

This project has three specific objectives which are addressed in this paper and appendices 1.0 to 8.0. The objectives are to:

1. update and provide more detailed information on the descriptions of provincial and territorial home care programs;
2. make comparisons across provincial and territorial programs on each of eight descriptive factors; and
3. describe a picture of home care programs for Canada by presenting how provinces and territories are similar and how they are different in their approaches and developments in home care.

First, updated information describing provincial and territorial home care programs was gathered on each province and territory. Second, it was then incorporated into a framework of eight factors that were used as the basis of descriptive comparison of provincial and territorial home care programs: organization and governance; legislation; programs and services; eligibility; assessment and case management; coverage; funding and utilization data and current initiatives.

This work is represented in the tables of descriptive summaries for each province and territory, done for each of the eight factors found in appendices 1.0 to 8.0 of this report. The information draws upon a variety of sources to update and add to that provided by provincial and territorial representatives who prepared the *Portrait of Canada: An Overview of Public Home Care Programs* (March 1998). This current paper involved provincial and territorial representatives in the review and clarification of the content where needed for each province and territory. A synthesis for Canada emerges as each of the eight factors is discussed and developments in the provinces and territories illustrate the status of the factor across the country.

Each home care program is unique within its provincial and territorial jurisdiction. Although public information is available on each, the aggregation of the data is difficult as national standards for terminology and statistical reporting in this sector do not currently exist. General observations are rarely true for all programs. However, efforts have been made to verify the accuracy of the information provided in the paper. For additional information on specific programs and practices, contact the ministry or department in the jurisdiction concerned.

Limitations

This description and discussion of home care in Canada is limited to programs funded by provincial and territorial governments. Private sector home care and supplementary services are not included in the report. Additional work is needed to understand the public-private mix of home and community care services that are available to people. Please note that the Nunavut government was not yet established when this document was prepared.

This paper focuses on the kind of services that are available. It does not present a complete picture of the “quantity” of services that are included for clients under home care programs and the ways this variable is controlled.

Due to the variety of terms used and the differing categories of services to which they refer in the various jurisdictions, it can be difficult to make inter-jurisdictional comparisons. Every effort has been made in this report to use terms that facilitate discussion of comparable services from one jurisdiction to the next. Additionally, there are limitations on the availability of data and certain figures are estimates.

Definition of Home Care

In Canada, home care has been generally defined as:

"an array of services which enables clients, incapacitated in whole or in part, to live at home, often with the effect of preventing, delaying, or substituting for long-term care or acute care alternatives."

"Home care may be delivered under numerous organizational structures, and similarly numerous funding and client payment mechanisms. It may address needs specifically associated with a medical diagnosis (e.g., diabetes therapy), and/or may compensate for functional deficits in the activities of daily living (e.g., bathing, cleaning, food preparation). Home care is a health program, with health broadly defined; to be effective it may have to provide services which in other contexts might be defined as social or educational services (e.g., home maintenance, volunteer visits)."

"Home care may be appropriate for people with minor health problems and disabilities, and for those who are acutely ill requiring intensive and sophisticated services and equipment. There are no upper or lower limits on the age at which home care may be required, although as in other segments of the health system, utilization tends to increase with age."[1]

Generally, the purpose of home care programs is to provide:

- a substitution function for services provided by hospitals and long-term care facilities;
- a maintenance function that allows clients to remain independent in their current environment rather than moving to a new and more costly venue; and
- a preventative function, which invests in client service and monitoring at additional short-run but lower long-run costs.[2]

All provinces and territories have developed definitions of home care specific to their home care programs. Due to the diversity in range and orientation (e.g. clinical approach and

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[1] Health Canada. *Report on Home Care* (prepared by the Federal/Provincial/Territorial Working Group on Home Care, a Working Group of the Federal/Provincial/Territorial Subcommittee on Long Term Care), 1990, p. 2.

[2] *Portrait of Canada: An Overview of Public Home Care Programs* (prepared by the Canadian Home Care Association in collaboration with *l'Association des CLSC et des CHSLD du Québec*). February, 1998, p. 1.

client profile) of services among programs, it is possible that persons, when referring to home care programs in their respective provinces and territories could be talking about different sets of services and clients. For example, home care programs, characterized by an acute care orientation are defined differently from those incorporating a broader range of services (i.e. post-acute, long-term health care and home support services, including personal care and homemaking) into one program (e.g. Saskatchewan, Manitoba, Quebec and Prince Edward Island).

In New Brunswick, two programs provide the major part of home care services. The Extra-Mural Program has both short- and long-term home care with a health services emphasis. The separate Long Term Care Program emphasizes long-term home support and long-term residential care services.

An understanding of each provincial and territorial home care program and its definitions is needed to have a common language for discussion of developments in this sector.

A final note is to mention the combined health and social support services orientation that is generally included in the definition of home care. In recent years, it appears that post-acute or hospital substitution services have taken on greater emphasis relative to maintenance and prevention services than was the case in the past. With hospital reforms such as consolidation, shorter lengths of hospital stays, day surgery, etc., the need for the provision of heavier acute care in the home and community has increased. Generally, acute home care is still regarded by provinces and territories as only one of several components of home care services. Diverse clients with diverse needs, including long-term home care clients such as the frail elderly, still have access to health care, personal care, homemaking and other social support services in the home setting (but not limited to this setting) to meet their needs and those of their family and volunteer caregivers.

Jurisdiction for Home Care Services

In Canada, the jurisdictional responsibility of providing home care services rests with the provinces and territories. Publicly funded home care programs exist in every province and territory in Canada. Since each program has undergone its own unique development in response to community needs, service delivery varies across the country.

This diversity of home care programs is both a strength and a limitation to development in this sector. While individual programs allow for specific and local responses to address needs, the lack of common terminology, standards for service delivery and information collection across jurisdictions has limited the ability of individual jurisdictions to benefit from the development of collective initiatives across the country. Some of the potential benefits for all jurisdictions of collective work include enhanced research activity, examination of the cost-effectiveness of

interventions, and enhanced information systems to support improved management and policy decision making.

Home care is included in the federal *Canada Health Act* as an "extended health care service." However, home care services are not publicly insured in the same way as hospital and physician services. Provinces and territories provide and publicly fund home care services at their own discretion.

The *Canada Health Act* sets out the conditions for federal transfer payments for health under the Canada Health and Social Transfer (CHST). By virtue of the mention of home care in the *Canada Health Act*, the federal government includes financial support for home care as part of CHST payments intended for health care services in provinces and territories.

From 1977 to 1996, under the previous Established Programs Financing arrangements, the federal government provided direct per capita cash transfers to the provinces and territories for extended health care services, one of which is home care. However, in recent years, the main focus of the federal approach has been assistance to home care consumers through tax credits and deductions (e.g. the Disability, Infirm Dependent, Medical Expense, and Care Giver tax credits).

The federal budget of February 1999 provided for increased funding under the CHST to provinces and territories for health. Additional funds were designated to invest in health research, health information systems, First Nations health services, rural and community health, prevention and other health initiatives, many of which have the potential to build on the strengths of medicare and contribute to the integration of home and community care services into the health care system.

Home care is a priority for targeted research funding through the existing three-year Health Transition Fund at Health Canada. Provincial and national home care research and other initiatives are currently under way in an effort to contribute to our understanding of the role of this important sector of the health system in maintaining the health of Canadians. Research results are expected to be released later in 1999 and in the following two years, thus contributing to the needed evidence base for decisions in the home and community care sector, as well as the health system as a whole.

On an ongoing basis, the federal government contributes to home care services provision through direct programs for specific clients. Veterans Affairs Canada offers home care services to clients with wartime or special-duty-area service when the service is not available to them through provincial and territorial programs. A limited home care program is offered jointly by the Department of Indian Affairs and Northern Development and Health Canada, which have joint responsibility for on-reserve First Nations home care.

Synthesis of Home Care Programs on Each of Eight Descriptive Factors

In this section, an interprovincial analysis for each of eight descriptive factors is presented. Based on the information provided in appendices 1.0 to 8.0, the analysis shows commonalities and differences among jurisdictions for each of eight descriptive factors.

Section 1.0: Organization and Governance

In all 12 jurisdictions, the ministries or departments of health and/or social/community services have maintained control over home care budgets and funding levels. Quebec, Prince Edward Island, Northwest Territories and Yukon have departments of Health and Social Services responsible for home care. Newfoundland and New Brunswick have departments of Health and Community Services which administer their home care programs. The remaining six provinces (i.e. British Columbia, Alberta, Saskatchewan, Manitoba, Ontario and Nova Scotia) include home care programs under the ministries or departments of Health.

Most provinces have delegated responsibility for funding allocation and service delivery to regional or local health authorities. However, in most cases the provincial and territorial departments set overall policy guidelines and standards for regional service delivery, reporting requirements and monitoring outcomes.

In recent years, there has been a trend for provinces to allocate health funds using a population needs-based funding model. Funding levels are determined by population needs-based characteristics rather than on past service use. Another trend that is just beginning is for provinces or regional health authorities to specify that community health budgets cannot be reduced, while hospital acute care and institutional supportive budgets can be decreased to provide additional funding for community budgets.

British Columbia, Alberta, Saskatchewan, Manitoba, Prince Edward Island, Newfoundland and Northwest Territories have, over the last seven years, devolved the delivery of home care services to local or regional health authorities. Across Canada, a total of 149 regional health boards/authorities, district health boards and non-profit corporations are present. In addition, Ontario delivers its home care services through 43 Community Care Access Centres (CCACs) and Quebec through its 146 Local Community Services Centres (CLSCs).

In New Brunswick, the Department of Health and Community Services has two programs which work in partnership to administer home care services in the province. The Extra-Mural Program (EMP) has regional service delivery units administered by eight Regional Hospital Corporations. Management of the EMP and its regional service delivery units falls under the Institutional Services Division of the department. A second program, the Long Term Care

Program (home support services and long-term residential care), is administered through the Family and Community Social Services (FCSS) Division.

The current home care program in Nova Scotia is administered by the Nova Scotia Department of Health through Regional Home Offices in four regions. Responsibility for the delivery of home care has not been delegated to the regional level.

The Social Services Branch of the Department of Health and Social Services administers the Yukon Home Care Program.

Section 2.0: Legislation

Six provinces have legislation related to home care services (i.e. British Columbia, Alberta, Saskatchewan, Ontario, New Brunswick, Nova Scotia). In British Columbia, the *Continuing Care Act* addresses home care and residential care, while other acts relate specifically to residential care. In Alberta, the *Coordinated Home Care Program Regulation 232, 1991* falls under the *Public Health Act* and provides the legislated mandate for Alberta's Home Care Program. Saskatchewan, Ontario, New Brunswick and Nova Scotia each have two pieces of legislation related to home care (see appendix 2.0 for names).

Manitoba and Prince Edward Island have Orders in Council establishing their home care programs. Quebec, Newfoundland, Yukon and Northwest Territories have guidelines or policies governing the delivery of home care services in their jurisdiction but do not have specific legislation governing home care.

Section 3.0: Services and Providers

All provinces have both acute and long-term home care services. Palliative care services may be included either under the acute home care program or as a separate program. Three provinces (i.e. British Columbia, Manitoba, Ontario) have identified specific pediatric programs. The Ontario and British Columbia programs include certain care services to children in the school setting. Pediatric services are available in other provinces as part of existing programs.

All provinces offer a similar range of basic services: client assessment; case coordination; case management; nursing services; and home support, including personal care, homemaking, Meals-On-Wheels and respite services. Other services, such as rehabilitation services (e.g. physiotherapy, occupational therapy), oxygen therapy, respirology and specialized nursing services are in development as part of home care in some provinces. Seven provinces have contracts for oxygen therapy services (i.e. British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick, Nova Scotia). Social work, speech therapy and dietician services are

offered as part of some home care programs. There is a greater emphasis placed on applying a multidisciplinary approach to care in some jurisdictions. Overall service delivery models are undergoing review and/or change in some provinces (e.g. British Columbia, Ontario, Quebec).

Four models appear to represent provincial and territorial home care programs:

1) Single-entry functions (i.e. assessment, case management, discharge planning) are delivered by public employees or staff of publicly funded community agencies, while professional services (e.g. nursing, occupational therapy) and home support are contracted out (e.g. Ontario). [Note that Ontario is currently undergoing a shift toward Model 1 from Model 2.]

2) Single-entry functions **plus some** professional services (e.g. nursing, occupational therapy, physiotherapy) are delivered by public employees. However, some nursing services and home support services are contracted out either province-wide or in certain regions (e.g. Nova Scotia; therapy services are contracted for the most part throughout Manitoba and, in Winnipeg, most nursing services and a small portion of home support services are contracted to an agency).

3) Single-entry functions **plus all** professional services are delivered by public employees (e.g. New Brunswick, Newfoundland, British Columbia, Alberta). Home support services are contracted out by agency or client in most instances.

4) Single-entry functions, professional and home support services are mainly delivered by public employees (e.g. Saskatchewan, Quebec, Prince Edward Island, Yukon, Northwest Territories).

Contracting out for home support services occurs in most of the provinces, the exceptions being those in Model 4 above. For Quebec, however, contracting out for home support is currently done in Montreal and likely to increase in the future with implementation by various agencies of the *économie sociale* (social economy) initiative and the changes in self-managed care. In British Columbia, amalgamation of home support agencies with local health authorities is encouraged.

Public agencies contracting out for nursing services from a private or a not-for-profit agency is practised to a differing extent in a few provinces. The practice is most prevalent in Ontario; however, private contractors are directly accountable to a publicly funded community agency (e.g. CCAC). In Alberta, nurses providing assessments and also those providing direct care to clients are employees of the Regional Health Authorities (RHAs). There are a few exceptions where the RHA contracts out for direct nursing services (but not for assessment services). However, the exceptions are not enough to warrant Alberta being regarded as using model 2 as opposed to model 3 where it is categorized above. The effects over the long term of

the various contracting options/models in terms of quality, cost and effectiveness of services have yet to be fully evaluated.

Most jurisdictions have developed some type of self-managed care program where persons with disabilities are funded to manage and pay for their own care requirements. The exceptions are Saskatchewan, Nova Scotia, Prince Edward Island (pilot project with plan to expand) and Yukon. Quebec has the largest number of self-managed care clients of all provinces (more than 6000). British Columbia, Alberta, Manitoba, Ontario, New Brunswick, Newfoundland and Northwest Territories also have self-managed care programs.

In Ontario, a self-managed care program is funded by the province with a voluntary sector organization (Centre for Independent Living in Toronto) serving persons with disabilities, determining eligible clients, conducting client needs assessments and assisting clients as needed to manage their own care. The program is not part of the provincial home care program.

For the self-managed care process in New Brunswick, the type and amount of authorized services is determined through a standardized assessment process. Some clients receive financial assistance from the provincial government to purchase their services directly from individuals and agencies. In other cases, the Department of Health and Community Services makes requisitions for services from various agencies for the client.

Case managers are generally registered nurses in four jurisdictions (British Columbia, Alberta, Ontario, Northwest Territories), although there may be some situations where other professionals conduct case management activities (e.g. social workers, occupational therapists, physiotherapists). In British Columbia, most case managers are registered nurses with a Bachelor of Science in nursing. In the other provinces and territories, the case manager role is generally regarded as one that can be carried out by a variety of health professionals and is not as limited to nurses for its performance.

Nursing services are delivered by nursing personnel with varying levels of educational preparation. In Saskatchewan, home care nursing services are delivered by Registered Nurses (RN), Registered Psychiatric Nurses (RPN) and Licensed Practical Nurses (LPN). RNs can have college or university preparation, while LPNs have a more limited scope of college preparation. The educational profile for LPNs can vary from one province to another, but when mentioned, it is usually one year of training through a community college program. RNs provide services in all provinces and territories. In several provinces (e.g. Saskatchewan, Manitoba, Ontario, Nova Scotia), LPNs are also involved in delivering nursing services.

In most provinces, personal care is being shifted from the nursing sector to workers whose positions hold a variety of names, such as Home Care Attendants, Home Care Aides, Home Health Aides, Personal Support Workers, Attendant Outreach Workers, *auxiliaire familiale et sociale* or Home Support Workers, Visiting Homemaker and Home Support Worker. While many

different personnel designations may be allowed to provide personal care depending on the province, LPNs are included among those who assume personal care in four provinces (i.e. Saskatchewan, Manitoba, Ontario, Nova Scotia). For example, in Saskatchewan all types of home care workers, including LPNs, are allowed to provide personal care; however, it is usually done by home care aides.

In British Columbia, LPNs are mostly employed in residential care settings. If they work as a line staff member for a home support agency, they are paid at a rate lower than the usual LPN rate. They do not have a designation as LPNs for home support services provision. However, LPNs may be employed as supervisors by the Home Support Agencies and be paid according to LPN rates.

Staff training is an important issue in home care. Examples of provinces with systematic training programs for Personal Care Workers (depending on the province, also referred to by several other titles, such as Home Support Worker, Home Care Worker, Home Care Aide, Personal Support Worker) include: British Columbia, 22 weeks at a community college program; Saskatchewan, pre-employment program and a two year on-the-job program for Home Care Aides; Manitoba, Home Care Attendant Certificate from a recognized community college or vocational school; Ontario, Personal Support Worker training by community colleges and private vocational schools; Quebec, 960 hours training from a community college; New Brunswick, completion of the Home Care Worker Program at N.B. Community College or a similar certified program; and Nova Scotia has a program under development. Since few programs have mandatory contractual training requirements for Personal Care Workers, many workers have little or no formal training in health or home care work.

In many provinces, homemaking and personal care are performed by the same workers (e.g. Saskatchewan, Quebec, New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland, Yukon, Northwest Territories). In British Columbia, Alberta, Saskatchewan and Ontario, this also applies for programs to persons who are physically disabled. For example, Ontario has attendant care workers who perform homemaking and personal care. Generally, the training requirement for homemakers is less than that of personal care workers. When homemaking and personal care are performed by the same worker, personal care is usually the priority for patient care over basic home cleaning.

Home care workers who are public employees are usually unionized. The situation varies greatly when the employers are not-for-profit organizations or for-profit businesses. Unionization appears to be increasing for not-for-profit and for-profit agencies (e.g. British Columbia, Alberta, Nova Scotia).

Among home care employees, the unregulated workers (i.e. home support, personal care workers, homemakers) are lower paid and have less training than other home care workers. In Ontario, homemakers whose homemaking services are purchased by CCACs have a protected

minimum wage. In British Columbia, the *Employment Standards Act* and collective agreements specify hours of work for home support workers. In Saskatchewan, collective agreements have a salary rate for employees completing the two-year on-the-job training program ("training rate"), and a "trained rate" for those employees who have been hired after completing the pre-employment training program for Home Care Aides. Both programs include components such as personal care skills, communication skills, meal preparation, special needs skills and other home support skills.

Generally, hospital or long-term institutional care workers are paid more than community health care workers. Historically, this is partially due to the longstanding public funding and/or subsidization of institutional care in Canada. Workers in home and community care have not traditionally been publicly funded to any comparable extent.

With the recent shift in provision of some hospital services (e.g. due to earlier discharge and increases in day surgery) to home and community health care services, there has been an impact on the workforce. For example, with more nurses required to work in community nursing, there appears to be an overall negative impact on nurses' wages and benefits. While wages and benefits for nurses working for any individual employer may not be decreasing, as more nurses are working in the community and becoming employed by for-profit companies rather than by government or hospitals (e.g. Ontario, Nova Scotia), overall salaries and benefits for nursing are decreasing.

The incentive for workers is to go to where the pay rates are higher, thus leading to difficulty in retaining workers in home and community care (and sometimes in the same province if adjacent provincial institutions require staff). In Quebec, this is partially addressed by the public policy that workers doing the same function are paid at the same rate regardless of the setting where that function is performed (i.e. hospital, long-term care facility or home).

Section 4.0: Eligibility

Provinces and territories have similar basic requirements for eligibility for home care services:

- proof of residence in the province (and/or Canada) is provided;
- a comprehensive needs assessment is conducted prior to any service being provided;
- the care is a response to unmet needs (e.g. sufficient help from family and friends is not available in the home);
- the home is safe and suitable for service delivery; and
- consent of the client or legal representative is obtained.

Proof of residence in the province providing the service is usually demonstrated by documents showing proof of address, and a valid health care insurance card. Eligibility is less straightforward for persons travelling through the province, persons referred for care from another province, and persons moving to the province who are in need of immediate home care services (i.e. cannot wait three months for new health insurance card). Provinces usually do provide needed services and insure them for these people. However, eligibility for home care for non-residents of the province is usually determined on a case-by-case basis at the discretion of the host province without obligation to do so. British Columbia has specified a residency requirement of 12 months for intermediate clients and three months for extended care clients before a person is eligible for these services.

For residents of most provinces, anyone may refer a client to the provincial or territorial home care program for assessment for eligibility. In New Brunswick, the Extra-Mural Program limits home care to individuals with a New Brunswick health insurance number, a physician referral (except for rehabilitation services), an evaluated specific health need, and an illness requiring home health care. For home support services and residential long-term care in New Brunswick, clients and others can prepare requests for services without a physician's referral.

Provinces and territories do not charge fees or apply an income test for professional nursing care included as part of the home care programs. This is also true for certain other health professionals such as physiotherapists and occupational therapists. Physician services are covered under the provincial or territorial health care insurance plans.

Seven provinces have client income assessment arrangements for **home support services**. Eligibility for services is primarily based on need; however, these provinces use an official income assessment to determine the financial contribution of the client (i.e. payment of fees) for home support services (e.g. British Columbia, Alberta, Saskatchewan, New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland). Quebec and Manitoba have no formal income assessment process and do not charge fees. Quebec does have a policy whereby priority in service delivery is given to low-income people or people with no other options for care. Manitoba gives priority to people with no other options for care. Ontario, Yukon and Northwest Territories are the remaining three of the five jurisdictions that do not have a formal income assessment process for home support services.

Upper limit cost maximums for home support (i.e. personal care and homemaking services) may apply to the individual care plan. They are usually based on the comparable cost to care for this person in a long-term care facility. Examples include: Alberta ($3,000 per month), Nova Scotia ($2,200 per month), New Brunswick ($2,040 per month) and Newfoundland ($2,268 - $3,240 per month).

A maximum number of home support hours is also used as a limit to services provision. Examples are: Quebec averaging 35-40 hours per week; Yukon at 35 hours per week; and

Prince Edward Island at 28 hours per week. In Ontario, maximum home support hours through CCACs are 80 in the first month and 60 per month thereafter. In addition, eligible clients can currently add 30 hours per week in attendant services if needed. British Columbia has a "guideline" of 30 hours a week at the highest level of care. However, certain clients may be assessed to require additional hours per week and the care is provided.

People under 18 years old are covered for acute home care, but may not always be eligible for long-term home care. Often family and social services programs have the responsibility for these people.

Section 5.0: Assessment and Case Management

Most provinces and territories are moving toward the development and use of standardized home care assessment mechanisms. In addition, they are working to more closely integrate assessment and case management functions to better respond to the complexity of the continuing care needs of clients. Provinces and territories appear to be focusing their public policy efforts on eligibility determination, assessment, care planning, case management, and resource allocation.

Most provincial and territorial home care programs have a single point of access system, where referrals of clients to receive services are made from a variety of sources (e.g. the client, the client's physician, a family member, a nurse). With a few exceptions, a physician's referral is not normally required; however, most provinces contact the client's physician once the client has been assessed as needing services, especially medical services.

The role of the single point of access varies. There appear to be three general models: (1) the single point of access provides referrals and admissions to programs/services (but no follow-up on progress); (2) the single point of access provides referrals, admissions **and** follow-up on progress of clients (keeping track of their care plan and progress), regardless of services needed by the client (e.g. home care, long-term residential care and other services), including reassessment from time to time; and (3) the single point of access does the referrals and admissions **and** case management, including providing the care.

The range of services to which access can be obtained through the single-entry system vary regardless of which of the models is used. The basic range of services includes assessment, care planning, admission to the home care program or to long-term care facilities (permanent or temporary) and referral to community services such as adult day-care, as needed. In some provinces, the basic range plus specialized programs, such as rehabilitation, geriatric services **and** specialized nursing services, are also accessible through single point of entry.

Most provinces and territories have moved toward a standardized assessment tool; however, the tools vary from one jurisdiction to the next. In Winnipeg, Manitoba, work is nearing completion on a trial run with the Screening, Assessment and Care Planning Automated Tool (SACPAT), an automated case management and client information system. It is proposed that this tool might be further developed with Home Care Nova Scotia, which is currently testing the SACPAT II.

Alberta has had the Alberta Assessment and Placement Instrument in place since 1988. A home care classification system for use with home care clients is also used in Alberta. Application of these assessments is at the regional level in Alberta's 17 RHAs. Work is under way to reconceptualize and update the assessment and classification process in Alberta. At the same time, the long-term care system in the province is undergoing review.

Quebec uses the tool *outil d'évaluation multiclientèle*. Ontario is currently testing a comprehensive standardized assessment tool called the Common Assessment Instrument (CAI). In New Brunswick, the type and amount of authorized services is determined through a standardized assessment process called the Single Assessor Model, which is currently being tested according to three aspects of the process: screening, assessment and automated format.

Prince Edward Island has Coordinated System Entry and the standardized assessment process and tool (SAT), both based in Home Care. Together, they assist with client assessment, planning, monitoring and access to a range of home care, regional and community services, including the assessment for eligibility and placement in long-term care facilities.

The common characteristics of the assessment process are an intake/screening phase, an assessment component using general/standard criteria, and then a specialized planning component, usually involving the client in the preparation of a care plan. The provinces and territories implement and emphasize different parts, with differing degrees of flexibility when it comes to individual cases.

Some jurisdictions add reassessment and discharge planning into the initial assessment process. In British Columbia, long-term patients receive a mandatory review every year or whenever their condition, and hence needs, change. For patients receiving post-acute home care following hospital discharge, Ontario, Nova Scotia and Prince Edward Island plan to set anticipated discharge dates from the home care program at the time of client intake into the home care program. This practice incorporates elements of discharge planning as early as possible in services provision so that adequate consideration is given to arrangements for the client following post-acute care in the home.

Every province and territory uses screening and assessment information emphasizing the care needs of the clients (i.e. needs-based assessment). The informal support available to the client is also factored into the assessment process by most provinces and territories. Available informal

support is generally regarded as important to assessing what client needs can be met by family caregivers and, also, the adequacy of both informal and formal services in assisting the client. For example, Saskatchewan and Quebec use a general formula in assessment where Need for Home Care Intervention equals (=) Functional Need minus (-) adequacy of Client's Informal Support. There is some variation among provinces in the method and weight put on these criteria.

Section 6.0: Coverage and Co-payment Charges

The client assessment and the consequent care plan determine services to be delivered and the extent of public funding in full or in part. The assessment process itself and nursing services are typically provided free of charge, while fees may apply to personal care and homemaking services. There may also be direct charges or income tested co-payments to the client for prescription drugs, medical supplies and/or adaptive equipment, particularly in long-term care in the community. Income/means testing is done in some provinces to determine what the client can contribute. If the client wants services beyond those assessed for public coverage, the client pays for them privately out-of-pocket or with private third-party insurance.

Provinces do not charge clients for professional nursing services. However, some provinces have service limits either in terms of the number of hours of service to be provided or they have set dollar maximums in public funds for these services. In some provinces, publicly funded nursing services are not available 24 hours a day or on weekends as a standard part of home care services. Clients requiring this level of care would remain in the hospital or other facility where these services are available.

Public coverage for services of other health professionals (e.g. occupational therapists, physiotherapists, social workers, speech therapists) varies with the province, but is usually limited. Due to a variety of factors, there may be waiting lists for these services. For example, in New Brunswick, all professional services (seven disciplines) provided by the EMP are insured health services.

Seven provinces have some arrangement for income assessment of client's ability to pay for home support, homemaking and other non-professional services, particularly for long-term care clients. At least two of these provinces (i.e. New Brunswick's long-term care program and Newfoundland) consider assets (excluding the client's home) as well as income in some way as part of their financial assessment arrangements. In Newfoundland, this consideration applies to home support and access to facility-based services, but does not apply to professional services in the community. Alberta charges $5 per hour for home support services and considers client income as well. British Columbia, New Brunswick and Nova Scotia apply any third-party insurance the client may have to cover a portion or all of the costs of needed home care services. Manitoba, Ontario, Quebec, Yukon and Northwest Territories do not have an official income/means assessment process for home support services.

Generally, there are charges, in whole or in part, for prescription drugs, medical supplies and equipment. In a few provinces, these services are covered in the acute care program and not necessarily in the long-term care program. At least two provinces, Ontario and New Brunswick, issue drug cards to home care clients under certain circumstances. Often, there are provincial drug programs for seniors and certain others which clients of the home care program can use for coverage. In Quebec, home care clients are covered through the provincial drug program, and as of 1998 specific supplies and equipment are covered for disabled people through a provincial program.

Section 7.0: Funding and Utilization Data

7.0.1: Sources

National funding and utilization data for the home care sector are not collected on a regular basis. The periodic publication by Health Canada, *National Health Expenditures in Canada*, does not include a specific expenditure category for home care as it does for physicians, hospital and other categories of health expenditures. Similarly, other sources for national health information, such as Statistics Canada, do not collect information specifically on the home care sector. Only recently have national organizations attempted to develop a picture of this sector by making efforts to obtain information in a consistent way for all provinces and territories so some comparisons can be made. To date, these estimates provide a picture for a point in time and no regular reporting on agreed upon definitions of service categories has been developed.

Recently, Health Canada, Statistics Canada and the CHCA have attempted to collect national information for the home care sector. Comparisons across the country remain preliminary because a variety of sources, which capture similar but not exactly the same set of services, must be used to develop the estimates. While it is important and useful to begin to learn what we can from the various sources we have, caution is necessary in making and viewing comparisons until a consistent national standardized data collection system is developed and maintained regularly so that trends can be reported over time.

In this section, currently available national sources of home care data are compared to learn more about home care in Canada. Having more than one data source providing data for the same year is a new opportunity in the home care sector to compare the consistency of information across sources. Where greater consistency in reported data exists for all or most of the sources, confidence in the accuracy of the data is increased. Such a comparison may contribute to developing better information and data collection to be used for decision making in the future.

To consider the status of national information available on home care sector funding and utilization, four sources were consulted and compared for this report, including those at Health Canada (which incorporate both home care expenditures and utilization data from the Canadian

Institute on Health Information and other sources), Statistics Canada (National Population Health Survey, 1996-97) and CHCA. During the spring of 1999, provincial and territorial officials also provided the most recent data available on provincial funding and utilization for use in this report.

Health Canada and the Government of Nova Scotia jointly sponsored the National Conference on Home Care in March 1998. At the time, Health Canada released fact sheets on *Public Home Care Expenditures in Canada, 1975-76 to 1997-98*, which provided preliminary estimates on public home care expenditures for Canada. Home care expenditures by provincial, territorial, municipal governments, Workers' Compensation Boards and the federal government (e.g. Health Canada's home care programs for First Nations and Veterans Affairs home care spending for veterans) were included. These expenditures included assessment, case management, nursing, personal care services, physiotherapy, occupational therapy, homemaker services, and meal programs. Excluded were home support services offered to individuals for reasons other than health problems (e.g. social services). Also, drugs, medical equipment and supplies (e.g. wheelchairs, assistive devices, hospital equipment for dialysis) were not included in the estimates.

In recent years, CHCA has been collecting data from provinces and territories on home care expenditures. Its data, prepared for the National Conference on Home Care, were also consulted for purposes of this report. To allow for comparisons, CHCA's provincial/territorial expenditure categories conforming most closely with Health Canada's expenditure categories were used.

In consultation with the Federal/Provincial/Territorial Working Group on Continuing Care, provincial and territorial jurisdictions provided their most recent data available on funding and utilization. The questionnaire used categories similar to those of the Health Canada data to allow comparisons of the sources. The expenditure categories included assessment, case management, nursing, personal care services, physiotherapy, occupational therapy, homemaker services, and meal programs. Excluded were home support services offered to individuals for reasons other than health problems (e.g. social services). Drugs, medical equipment and supplies (e.g. wheelchairs, assistive devices, hospital equipment for dialysis) were also not included in the estimates.

The series of tables in appendix 7.0 of this report present provincial and territorial funding and utilization data from the various sources referred to in this section.

7.0.2: Funding Data

According to Health Canada data, when provinces and territories are compared as to the portion of their public health expenditures allocated to home care (1997-98), including national funding sources for First Nations, veterans, provincial and municipal home care services, the data

show a range from 2% to 6% (Health Canada, 1997-98). The relative levels of proportional home care expenditures are shown according to clusters of provinces and territories below:

- Manitoba, Ontario, New Brunswick, Nova Scotia, Newfoundland invested more than 5% of their health budget in home care;
- Saskatchewan and British Columbia invested between 3% and 4%;
- Alberta, Quebec, Prince Edward Island and Northwest Territories invested between 2% and 3%; and
- Yukon invested less than 2%.

According to provincial and territorial sources, when provinces and territories are compared relative to the portion of their **provincial and territorial health expenditures** allocated to home care (excluding First Nations and other federal investments), the portrait changes slightly. The relative levels of proportional home care expenditures are shown according to clusters of provinces and territories below:

- British Columbia, Manitoba, New Brunswick and Ontario invested more than 6% of their health budget on home care;
- Saskatchewan and Nova Scotia invested between 4% and 6%;
- Alberta, Quebec (3.3% for 1996-97) and Prince Edward Island invested between 2% and 4% of their health budget;
- Northwest Territories and Yukon invested less than 2%; and
- Data were not available for Newfoundland

With the exception of the Northwest Territories, provincial and territorial data show that a higher percentage of their health budget is devoted to home care services for all provinces and territories than Health Canada data. The range of differences between provinces and territories is greater at from 1% to 8% than from 2% to 6% for the Health Canada data. Four provinces, representing large differences in population and wealth, spend more than 6% of health expenditures on home care.

Health Canada reports total public funding for home care has increased substantially over the last seven years (from $1.028 billion in 1990-91 to $2.096 billion in 1997-98), an average annual rate of increase of almost 11%.[3] Provincial and territorial data show that home care expenditures reached more than $2 billion in 1996-97.

When comparing the provinces and territories on groupings of level of per capita expenditures for home care in 1997-98, the following relative levels of per capita spending

[3] *Public Home Care Expenditures in Canada, 1975-1976 to 1997-98, Fact Sheets*. Health Canada, March 1998.

according to clusters of provinces and territories emerge, as shown below, for each of Health Canada and provincial and territorial data sources:

Health Canada data, 1997-98:

- Northwest Territories had the highest per capita spending at $216;
- New Brunswick, Newfoundland, Manitoba and Ontario showed per capita expenditures for home care from $90 to $94;
- Nova Scotia reported per capita spending at $80;
- Saskatchewan, Alberta and British Columbia ranged from $53 to $69 per capita expenditures;
- Quebec, Prince Edward Island and Yukon showed per capita expenditures of less than $37.

Provincial and territorial data, 1997-98:

- The first group showed Manitoba, New Brunswick and Ontario with per capita expenditures ranging from $98 to $124.
- The second group was British Columbia, Saskatchewan and Nova Scotia with a per capita range from $64 to $80.
- Northwest Territories, Alberta and Quebec allocated respectively a per capita of $61, $53 and $52 (only 1996-97 data were available for Quebec).
- Yukon and Prince Edward Island spent around $33-34 per capita.
- No data were available for Newfoundland.

The major differences between these two sources of data are the increase of per capita with provincial and territorial data and the relative position of the Northwest Territories and the province of Quebec. In the Northwest Territories, this is primarily due to the inclusion of federal allocations for First Nations in the Health Canada data. For Quebec, the department changed to a new methodology for evaluating home care funding.

7.0.3: Utilization Data

Four national sources of data are available to consider public home care service utilization. Utilization data estimates for home care are more difficult to obtain than funding data and are often incomplete. Note that the first three sources listed below are administrative data, while the

fourth is based on the self-reporting of survey respondents. Although the four sources have some different assumptions, they nonetheless represent the status of national utilization data available and are used to make some preliminary national comparisons. The sources are:

- Health Canada data (unpublished data, 1998).
- CHCA data prepared for the National Conference on Home Care, March 1998.
- Provincial and territorial data for 1996-97 and for some provinces for 1997-98.
- Statistics Canada: National Health Population Survey, 1996-97, which estimated the number of people aged 18 and over who received government-supported home care services (*Source: Statistics Canada, Catalogue 82-003, Summer 1998*).

The utilization rates are reported as the number of persons served by home care per 1000 inhabitants in the province or territory. The utilization rate can be used **as one of many pertinent indicators** in understanding the capacity of a program to provide home care services. Contextual, clinical and organizational factors should be taken into consideration for evaluating how home care programs do meet the needs of people in a given community.

Some provinces can offer more or fewer units of service for each client depending on the design of the program and the range of services. If the program is designed to respond to a narrow range of clients and needs, it is likely that more services per client will be required and fewer clients will use program services. If the program responds to a larger range of clients and needs (e.g. both acute and long-term care), usually there are more clients served and fewer services per client.

Where patients are charged co-payments (or fees) for certain services (e.g. home help, respite, personal care) which are counted in the utilization data, the number of clients recorded as served may appear to be greater than another program which pays the total cost of most services in the program. In actual fact, the utilization rates may be similar.

In *Table 1*, the utilization rates for provinces are grouped according to the four data sources. Refer to appendix 7.0 for expanded tables.

Table 1: Utilization rate levels of provincial and territorial home care programs: number of clients per 1000 residents by sources of reference, 1996-1997 (jurisdictions where data are available)

Number of clients per 1000 residents	Statistics Canada	Canadian Home Care Association	Health Canada	Province/ Territory
30 and over	Saskatchewan	*Quebec*	New Brunswick, *Quebec*	*Quebec* New Brunswick British Columbia
25 to 29	British Columbia Manitoba **Ontario** Nova Scotia	**Ontario** *Saskatchewan*	**Ontario** *Saskatchewan* British Columbia Manitoba	**Ontario** *Saskatchewan*
20 to 24	New Brunswick **Alberta**	Manitoba, **Alberta,** British Columbia	**Alberta**, P.E.I.	Manitoba **Alberta**
19 and less	Quebec	*Nova Scotia*	*Nova* Scotia, Yukon N.W.T.	*Nova Scotia* Yukon, P.E.I.

Similar rankings are shown among the four data sources above for Ontario and Alberta. Quebec, Nova Scotia and Saskatchewan are similar for three data sources. The exception is Statistics Canada data.

Disparities appear between data sources for New Brunswick and Quebec. However, data confirm that the number of clients served per 1000 inhabitants is consistent among all four data sources for Ontario and Alberta.

According to three of the four sources, the highest rate of utilization is reported for Quebec, Ontario and Saskatchewan. The lowest is reported for Nova Scotia.

Table 2 shows percentages of clients receiving acute, long-term and "other" services for provinces that have these data available.

Table 2: Percentage of acute, long-term, and other clients, 1996-97 (jurisdictions where data are available)

Province/ Territory	Acute Care Clients	Long-Term Care Clients	Others	Total
B.C.	56.4	34.5	N/A	90.9
Alta.	41.0	52.0	7.0	100.0
Sask.	22.9	70.5	6.6	100.0
Que.	21.1	63.7	15.2	100.0
N.B.	53.3	46.6	N/A	99.9
P.E.I.	20.0	75.0	5.0	100.0
Y.T.	16.6	73.7	9.6	99.9
Canada	33.0	58.0	8.7	99.7

Five provinces and territories did not have data available on clients by service category. British Columbia, Alberta, Saskatchewan, Quebec, New Brunswick, Prince Edward Island and Yukon reported data as closely as possible to the definitions provided; however, services included in each category may vary slightly (see notes with corresponding tables in appendix 7.0, table 6).

The percentage of long-term care clientele represents the majority of the case load for all provinces reporting except for British Columbia and New Brunswick. On a national basis, one third of the clientele has acute needs and two-thirds use long-term services.

Finally, according to data provided by six provinces (appendix 7.0, table 7), the number of clients served by type of service revealed that for Canada, 38.8% of the clientele received professional nursing services, 27.4 % home support services, 26.5% therapies services (i.e. occupational therapy, physiotherapy, speech therapy, social work and others), and 7.2% other type of services such as Meals on Wheels or transportation, depending on services included in the home care program.

Additional data are needed to assist decision makers to evaluate the capacity of a program to provide services. Decision making on the quantity and type of services needed in relation to assessed client needs and potential client outcomes measures are examples of applications that would be better informed if more data were available.

Table 3 combines data on per capita funding and utilization from jurisdictions where these data are available and reported.

Table 3: Levels of provincial and territorial per capita home care funding and utilization, 1997-98 (for jurisdictions where data are available)

Levels	Per capita	Utilization rate (Number of clients/1000 inhabitants)
Group 1 (highest)	($98-124) Manitoba, New Brunswick, Ontario	(30 and over) Quebec,[4] New Brunswick, Ontario, British Columbia
Group 2	($64-80) British Columbia, Saskatchewan, Nova Scotia	(25 to 29) Saskatchewan, Manitoba
Group 3	($61-52) Northwest Territories, Alberta, Quebec	(20 to 24) Alberta
Group 4 (lowest)	($33-34) Yukon, Prince Edward Island	(19 and less) Nova Scotia, Prince Edward Island, Yukon

The relationship between funding and utilization is consistent among data sources for provinces such as Saskatchewan, New Brunswick, Ontario, Yukon, Alberta and Prince Edward Island. Generally, there is a direct relationship between per capita spending and utilization rates. Lower per capita funding levels correspond to lower utilization rates. Medium per capita funding levels correspond to medium utilization rates, and so on. For Manitoba and Nova Scotia, the level of utilization rates is not as high as their funding levels relative to other provinces. Quebec shows the highest utilization rate and lower per capita funding.

These differences are dependent on many other factors that could be taken into consideration in funding and utilization, such as cost of service units, cost per client, range of services provided, provider (e.g. professional, non-professional or both), duration, intensity level of service delivery, and eligibility. Clearly, development of ongoing national information and data collection in the home care sector is needed if we are to better understand this aspect of the health care system.

[4] For Quebec, per capita for 1997-98 data were not available

Section 8.0: Current Initiatives

Within individual jurisdictions as opposed to nationally across jurisdictions, there appear to be five major trends emerging from current initiatives being undertaken by the provinces and territories with regard to home care:

1. Provinces are investing significant resources for the establishment of health information networks to facilitate the collection and transmission of timely accurate information (e.g. Alberta, Saskatchewan, New Brunswick, Newfoundland) for home care, and also between home care and other sectors.

2. Provinces and territories are developing and/or reviewing standardized provincial and territorial assessment instruments and care coordination tools (e.g. British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland, Northwest Territories).

3. Provinces are either in the process of developing an accountability framework for the health system including home care and/or they are attempting to apply accountability mechanisms to this sector through the development of performance measures and the evaluation of outcomes (e.g. British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick, Prince Edward Island, Newfoundland).

4. Within their respective jurisdictions, provinces and territories are making a concerted effort to develop standards for the services provided under their home care programs and for new classifications of workers who are charged with delivering these services (e.g. Saskatchewan, Ontario, New Brunswick, Nova Scotia, Northwest Territories)**.**

5. Provinces and territories, for the most part, are promoting the increased integration of direct services (e.g. British Columbia, Saskatchewan, Manitoba, Quebec, New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland, Yukon, Northwest Territories).

In addition, a number of specific initiatives in various jurisdictions are worthy of note. Although some of these initiatives may already exist in other jurisdictions, they either have recently been developed (within the last year or so) in the named jurisdiction or they are unique to that jurisdiction. The status of recent developments, influences and current priorities for activity are sometimes reflected in these current initiatives. Some examples are:

- Prince Edward Island has established a Provincial Geriatrician position. This position is being shared with Veterans' Affairs Canada (20%).

- Nova Scotia has developed a Program Risk Management Strategy.
- The New Brunswick long-term care program (FCSS) has developed standards for home support services, which are currently under revision.
- The New Brunswick Extra-Mural Program, in partnership with the New Brunswick Healthcare Association, is working on home health care standards.
- Quebec has developed the "social economy" not-for-profit enterprises in home care domestic support.
- Ontario is working with CCACs to identify best practices and improve accountability mechanisms.
- Ontario has had a new Personal Support Worker training program available through community colleges and private vocational schools since fall 1997.
- Manitoba has a new Supportive Housing Initiative.
- Saskatchewan is working with Saskatchewan Municipal Affairs, Culture and Housing to encourage collaborative relationships between housing authorities and District Health Boards.
- The CHOICE (Comprehensive Home Option of Integrated Care for the Elderly) Program has been implemented in Alberta.
- Alberta has implemented a project to determine outcome measures for continuing care, including home care.
- British Columbia has undertaken a strategic review of continuing care services. A report was released in early 1999.
- Newfoundland is implementing a computerized Client and Referral Management System.

Synthesis for Canada

The previous sections of this report gave detailed accounts of public home care program organization, funding and services delivery in the provinces and territories. This section highlights some overall similarities and differences identified through that analysis. Together, they provide a picture of home care programs and services for Canada.

Similarities

Home care programs in the provinces and territories reflect some important similarities:

- **Responsibility for home care** falls under jurisdiction of departments/ministries of Health. In some provinces and territories, responsibility for health is combined with social or community services. For example, in Quebec, Nova Scotia, Yukon and the Northwest Territories, it is the Department of Health and Social Services. In New Brunswick and Newfoundland, it is the Department of Health and Community Services.
- There is a **common base of services**, including nursing, personal care and homemaking services, available in all provinces and territories.
- A **diverse clientele** is served when factors such as age, health status, medical and social needs and duration of services are considered. Clients requiring long-term care services represent approximately two thirds of those served. In 1997-98, nearly one million Canadians or 3% of the population received home care services from provincial and territorial programs.
- There is a set of **similar basic requirements for eligibility** for home care services applied based on possession of provincial and territorial health insurance, residence in the jurisdiction, assessment of unmet needs, safety considerations in the home and obtaining client consent.
- Provisions are in place for **coordination and integration of services**, including single point of access, comprehensive needs assessment, case management and access to long-term institutional care, including for respite purposes. Single point of entry access is more comprehensive in British Columbia, Alberta, Saskatchewan and Manitoba in that admission to a broader range of services, such as adult day centre services, Meals on Wheels and special rehabilitation programs, can be arranged through this process in addition to the basic home care services.
- The **case management** functions are under the responsibility of public employees.
- There is increasing **standardization within individual jurisdictions** with respect to both the processing of demand (e.g. by a standardized assessment tool) and management of service information (e.g. by provincial information systems) in home care. British Columbia has gone a step further to implement management of a single data bank for both home and institutional care using the same functional classification system.
- **Professional nursing services are provided without charge to clients**; however, limitations may apply to client eligibility, intensity and duration of care provided. Most provinces have co-payments and/or some form of income assessment for home support services.
- **Provinces have invested in the home care sector** despite government fiscal constraints in recent years. Health Canada data show that public home care expenditures in Canada have more than doubled in the last seven years to over

$2 billion (1990-91 to 1997-98). The average annual rate of increase has been almost 11%. Eight of twelve jurisdictions have exceeded 3% of their health spending allocated to home care. According to provincial sources in British Columbia and Manitoba, the percentage reached more than 7% of total health spending in these provinces for 1997-98. During the past few years, provinces and territories have implemented controls on eligibility, services delivery and budget allocations in order to control the growth in expenditures and to manage growing expectations and demands for home care services from the hospital sector and the public.

- The **regionalization** process that has occurred in most provinces over the last several years has given more flexibility to regional or local authorities to decide upon funding and priorities for home care services. At the same time, it has contributed to diversity of regional programs within some jurisdictions.
- **Training** of unregulated workers, **division of tasks** between unregulated and regulated workers and **recruitment** of professional and other home care workers are issues in most provinces.
- Increased activity in innovation and **developmental initiatives** in the provinces and territories are responding to emerging issues and needs in the home care sector. In the medium to long term, this work will influence adjustments of the various programs to meet broader health system challenges. Examples include expansion of research activity in the sector; establishment of programs targeting the needs of specific client groups; development of standardized assessment instruments, databases and information systems; and expansion of the study and use of technology for service delivery, safety and security of clients at home.

Differences

- The **regulatory status** of home care programs varies from one jurisdiction to another. Professional home care and homemaker service categories often fall under different legislative, regulatory, administrative and/or policy arrangements. In most cases, there is no legislation specifically governing home care.
- There are differences among provinces and territories in the policies and **arrangements for charges to clients** and/or assessing client contributions for home support services (i.e. personal care and homemaking). Examples of differences (which may vary with the kind of home support services provided) include formal income testing (and certain assets in some cases), giving priority access to low-income clients (without formal income testing), charging a flat rate per hour, and applying any third-party insurance the client may have to cover a portion or all of the costs of needed home care services. More detailed information and study on this subject are needed.

- The **range of professional services** (i.e. nursing and therapy services) available varies among provinces and territories. These services are generally fewer in rural and isolated areas. Speech therapy, dietician and social work services are less available than other professional services in home care programs. Ontario's program has the broadest range of professional services included.
- The **models of service delivery** reflect a diverse mix of public and private sector workers in the provision of publicly funded services. Examples are Saskatchewan where home care workers are public employees, and Ontario where service delivery has changed over the past few years from a public and not-for-profit model to open competitive model where either for-profit and not-for-profit agencies can compete for contracts to deliver home care services.
- The variation among jurisdictions in the development of **databases and information systems** contributes to the difficulty in obtaining various kinds and levels of data on a national basis or for selected inter-provincial and -territorial comparisons. If such information is desirable, further consideration is needed to develop more consistent data across jurisdictions.
- Although **levels of funding** for home care have been increasing in most jurisdictions, the actual funding levels vary depending on the province or territory, ranging from $24 to $124 per capita. This may have implications for utilization in terms of access and range of services available. More data are needed to understand utilization and to determine ideal funding levels relative to client mix, service mix and integration with other sectors of the health system.
- Finally, it is worthy of note that there are variations in **policy in certain areas**, such as client access to services, equity in provision of services, service standards and quality, client obligation to pay for publicly funded services, obligation for family members to provide care, to name a few, and these issues remain a consideration in all provinces and territories.

Conclusion

While all provinces and territories have home care programs, there is considerable variation among them. Although variation is not necessarily undesirable in a country as diverse in population and geography as Canada, much can be learned from the experiences in other jurisdictions. This report provides a comparison of provincial and territorial home care programs on eight factors related to organization, funding and services delivery. A picture of the status of home care for Canada emerges.

While provincial and territorial home care programs have existed in some provinces since the early 1970s, this report shows that all programs are currently in a period of growth and new development relative to other sectors of the health system. This alone accounts for some of the

variation among jurisdictions that are described in the report. At the same time, it indicates that home care is responding to changing demands according to client need and overall health system change. A more in-depth understanding of home care programs across the country may assist in the policy, planning, programming and research developments which are under way. One of the important conditions to support this process toward accessible, comprehensive and integrated home care services is the development of systematic information and data collection in home care so that inter-provincial and -territorial comparisons can be made and included as part of decision making in the broader health system.

Appendices

Tables of Descriptive Information by Province and Territory

Appendix 1.0: Organization and Governance

B.C.	The home care program began in 1978 as part of the Continuing Care program. Devolution to the health authorities for the delivery services was implemented April 1, 1997 through the "Better Teamwork Better Care" initiative. The Ministry of Health, Acute and Continuing Care regional teams work to support each of the five macro regions of the province and to facilitate communication between the Ministry and the region. British Columbia has 11 Regional Health Boards, 34 Community Health Councils (CHCs) and 7 Community Health Service Societies (CHSSs), all of which are generally referred to as "health authorities." The Ministry of Health allocates funding for health services to the health authorities, but continues to set overall policy guidelines and standards for service provision. The Ministry continues to retain ultimate accountability for ensuring the highest standards of care by delegating authority and reporting requirements.
ALTA.	The Home Care Program was established by the Government of Alberta in 1978. Initially, only individuals with a medical condition requiring professional health services received assistance but, in 1984, the program was expanded to accommodate the increasing need for support services and palliative care. Community care and support services are financed by the department of Alberta Health; however, these programs and services are administered and delivered by the 17 Regional Health Authorities.
SASK.	A comprehensive program of home care was first introduced in Saskatchewan in 1978, and by 1984 all "home care districts" were operational. At that time, the program was the responsibility of the Department of Social Services; in 1983, it became the responsibility of the Department of Health. The program is currently the responsibility of the Community Care Branch of Saskatchewan Health. Until April 1, 1994 home care programs in the south of the province were delivered by 45 non-profit incorporated home care boards. Since then these services have been amalgamated with services for which District Health Boards (DHBs) are responsible. There are 32 District Health Boards in Saskatchewan comprising both elected and appointed members which serve different geographic areas. In the northern portion of the province, non-profit corporations provide home care services in collaboration with two DHBs and one health authority. The role of the health department's Community Care Branch with respect to the home care program is to provide overall direction by developing provincial objectives, policies, procedures and standards in consultation with DHBs; provide consultative/advisory services; monitor outcomes of home care programming; promote communication/liaison. Saskatchewan Health provides guidelines and standards for the delivery of services and allocates funding using a population needs-based funding formula that was implemented in 1994-95.

MAN.	The Manitoba Home Care Program was established in 1974. The Home Care Program provides comprehensive community care and also ensures coordination of admission to facility care when living in the community is not a viable alternative for a client. Manitoba Health is responsible for policy and overall program standards for home care. Responsibility for the delivery and operational management of home care services and for service delivery standards rests with 12 Regional Health Authorities (RHAs) throughout Manitoba. Home care is a core service which RHAs must deliver in their respective regions.
ONT.	The first home care demonstration program was funded in 1958. Following a series of pilots, home care was formally established by the Government of Ontario in 1970. The establishment of 43 Community Care Access Centres (CCACs) was completed in January 1998. These CCACs consolidated the services formerly provided by 38 home care programs and 36 placement coordination services. These CCACs act as a single point of access for a wide range of community services and programs, coordinate and plan delivery of services to support clients and caregivers, and coordinate and assist clients with applications and admissions to long-term care facilities. CCACs are governed by independent, incorporated, non-profit boards of directors. The boards are accountable through service agreements to the Ministry of Health. The Ministry of Health sets broad guidelines and policy for CCACs, including guidelines for Requests For Proposal for home care services, medical supplies and equipment.
QUE.	In Quebec, publicly funded home care services are the responsibility of the Local Community Services Centres (CLSCs) that were established in 1972. These CLSCs (146) are local public organizations managed by boards. The Ministry of Health and Social Services sets overall policy and plans for services in the province. Eighteen (18) Regional Health and Social Services Boards are responsible for the planning, budget allocations and coordination of health and social services, including the home care services, in their respective areas, but not for the delivery of these services. Note: 38% of the 146 CLSCs (55) are merged with other types of institutions.
N.B.	The New Brunswick Extra-Mural Hospital (NBEMH) was founded in 1981, and was Canada's first government funded home-hospital program. It was designated as a Hospital Corporation under the *New Brunswick Hospital Act* and its services were insured by the province. In 1996, the status of the NBEMH changed to that of the current Extra-Mural Program (EMP). Management of the existing service delivery units devolved to the remaining 8 Regional Hospital Corporations (RHCs). The 8 RHCs manage hospital facilities, community health care centres and the Extra-Mural Service Delivery Units. The Institutional Services Division of the Department of Health and Community Services sets overall policy, plans for and provides funding to eight hospital corporations which deliver programs and services. The EMP provides acute care substitution, some home support, and some long-term health care services. The Family and Community Social Services Division (FCSS) administers long-term home support services and also long-term residential care under the Long Term Care Program. The Nursing Home Division provides some of the long-term residential care.

N.S.	The comprehensive Home Care Nova Scotia program was implemented June 1, 1995, replacing the Coordinated Home Care Program which had been established in 1988. The current program is administered by the Nova Scotia Department of Health through Regional Home Care offices in the provinces four health regions. Four Regional Health Boards have been established, and service delivery in the areas of public health, mental health and drug dependency has been transferred to them but not home care. The date for transfer of this service has not been established.
P.E.I.	Prince Edward Island's home care program, the Home Care Support Program (HCSP), was implemented in 1986 and underwent a substantial review process in 1996. The Department of Health and Social Services is responsible for establishing the program's philosophy, mission, goals, objectives and policies, as well as program content and development, standards, evaluation and staff education. Five Regional Health Boards can tailor program content and development to the unique features and needs of each region. These boards are responsible for the financial management, strategic planning and operation of the program, as well as the delivery of home care services.
NFLD.	Home care services were introduced in 1975. Since then, they have been developed in various regions throughout the province. Home care service delivery is managed through Regional Health and Community Service Boards which have the flexibility to design the content of their programs to meet the unique needs of their region. The Department of Health and Community Services is responsible for policy direction, allocation of resources to the region and program monitoring.
Y.T.	The Social Services Branch of the Department of Health and Social Services administers the Yukon Home Care Program. It was implemented in 1988.
N.W.T.	The Coordinated Home Care program was first implemented in Yellowknife in 1978. Since then, it has been expanded to include the various communities throughout the region. The program is planned and delivered by Regional Health and Social Services Boards. The Department of Health and Social Services sets policy directions and transfers funds to three Community Services and Hospital Boards and 10 Regional Health Boards.

Appendix 2.0: Legislation

B.C.	***Continuing Care Act* (1992)** - residential care, home support, adult day centres, family care homes, group homes for disabled persons, short stay assessment and treatment centres. ***Hospital Act*** - professional and insured services, acute, rehabilitation, palliative and extended care services which are insured services under the provincial health care insurance plan. ***Community Care Facility Act*** - applies to licensing of community residential care facilities.
ALTA.	***Coordinated Home Care Program Regulation 232/91*** - provides legislated mandate for Alberta's Home Care Program. Falls under the ***Public Health Act.***
SASK.	***Health Districts Act* (1993)** - provides authority for not-for-profit district health boards to plan, administer and deliver home-based services. ***Home Care Act*** - (is expected to be repealed in the near future as it applied to former non-profit home care boards.) The District Health Boards (DHBS) act in accordance with these Acts and with provincial policies.
MAN.	The Home Care Program was established through an **Order-in-Council** of provincial Cabinet. There is no legislation governing the program.
ONT.	In 1995, changes were made to the regulations under the ***Health Insurance Act*** and the ***Homemakers and Nursing Services Act*** so that it is no longer necessary for a physician to authorize provision of home care. The recipient does, however, require medical supervision by a physician in some cases (e.g. medical orders).
QUE.	The guidelines for home care services are defined by the Ministry of Health and Social Services in two official documents: The ***Home Care Services* (1979)** document was replaced by ***Policy on Primary Home Care Services* (1994)**. The Ministry's focus on clients and its policy regarding health and wellness contribute equally to the objectives to reach certain population groups. The ***Act Respecting Health and Social Services (Section 80)*** gives the mission and service requirements at CLSCs. The specific home care services to be insured or paid for by public funds are not specified in legislation.
N.B.	**Bill 85, an Act to Amend the *Hospital Act* (1992), of April 16, 1996** pertains to the Extra-Mural Program. The specific home care services to be insured or paid for by public funds are not specified in the ***Hospital Act***, the health insurance legislation of the province. The ***Family Services Act*** also relates to home care.
N.S.	***Homemaker Services Act* (1981)** ***Coordinated Home Care Act* (1990)**
P.E.I.	The 1986 Home Care Support Program was implemented through an **Order-in-Executive-Council**. Currently, no Act or legislation governs the program.

NFLD.	There is no legislation for home care, but there is legislation governing licensed home support agencies.
Y.T.	There is no legislation governing the delivery of home care services. However, legislative authority for the home care program and its services is derived from the ***Yukon Health Act***. Home care program philosophies and policies reflect the principles of the Act.
N.W.T.	There is no legislation for home care.

Appendix 3.0: Services and Providers

3.1 Range of Services:

Legend:
✔: service available 0: service not available NA: information not available OT: occupational therapy PT: physiotherapy

3.1 RANGE OF SERVICES: PROVINCE/ TERRITORY	Assessment - Care coordination, Case management	Home support/ Personal care including meals programs and respite	Nursing[5]	Rehabilitation OT/ PT	Social work	Speech therapy	Respiratory services
B.C.	✔	✔	✔	Limited to home-bound clients only. Includes nutrition.	very limited	0	In some health authorities, but not through home support services.
ALTA.	✔	✔	✔	✔ plus nutrition	✔	0	✔
SASK.	✔	✔ including home maintenance program if safety issues[6]	✔ plus laboratory in some districts	OT; PT; mental health, dietician counselling in some districts	✔ in some districts	0	✔ in some districts

[5] Where mentioned, the range of services included under laboratory services was not specified.

[6] District Health Boards are responsible for establishing volunteer services (e.g. friendly visiting, security calls, transportation).

3.1 RANGE OF SERVICES: PROVINCE/ TERRITORY	**Assessment - Care coordination, Case management**	**Home support/ Personal care including meals programs and respite**	**Nursing**[5]	**Rehabilitation OT/ PT**	**Social work**	**Speech therapy**	**Respiratory services**
MAN.	✔	✔	✔	✔	✔ Social work needs are incorporated into care plans where appropriate to support the overall plan of care.	✔ On a very limited basis	✔ province-wide home oxygen concentrator services
ONT.	✔	✔ including referral to other community support services and health-related programs.	✔ plus laboratory	✔ plus dietician	✔	✔ in publicly funded schools and client's homes.	✔

3.1 RANGE OF SERVICES: PROVINCE/ TERRITORY	**Assessment - Care coordination, Case management**	**Home support/ Personal care including meals programs and respite**	**Nursing**[5]	**Rehabilitation OT/ PT**	**Social work**	**Speech therapy**	**Respiratory services**
QUE.	✔	✔ House cleaning mostly offered outside public program. Meals on Wheels[7]	✔ plus laboratory	✔ except in few CLSCs	✔ plus Community development[8]	0	✔ except in Montreal and Quebec where specialized hospitals ambulatory programs exist
N.B.	✔	✔	✔ both acute and long term	✔ OT and PT in acute and long-term care, plus dietician in acute care	✔ in Long Term Care Program (FCSS) and in EMP acute care	✔ in acute and long-term care program	✔ province wide in acute program and long term program. Sub-contracting of equipment only.
N.S.	✔	✔	✔	0	0	0	✔
P.E.I.	✔	✔	✔	OT in local programs; referral to regional programs for PT	referral to regional resources	referral to regional resources	0

[7] Free coverage for disabled persons, poor and frail elderly; other recipients referred to the 75 new government-supported enterprises giving this service with a fee per hour income tested. (*Entreprises d'économie sociale en aide domestique*.) Meals on Wheels are run by a non-profit organization outside the home care program. Referrals are made by the home care program. Adult day-care centres are administered by public nursing homes and a few CLSCs.

[8] Community organizers are part of home care programs and are supporting volunteer organizations, inter-sectoral initiatives and local concentration.

3.1 RANGE OF SERVICES: PROVINCE/ TERRITORY	**Assessment - Care coordination, Case management**	**Home support/ Personal care including meals programs and respite**	**Nursing**[5]	**Rehabilitation OT/ PT**	**Social work**	**Speech therapy**	**Respiratory services**
NFLD.	✔	✔	✔	✔ (limited)	✔	0	✔
Y.T.	✔	✔	✔	✔ OT and PT are part of the home care team in Whitehorse; referral to travelling team for outlying communities	✔ (A large part of program)	Referral to regional services	0
N.W.T.	✔	✔	✔	0 - (referral to regional services)	0 - referral	0 - referral	0

3.1 Range of Services continued:

Additional notes:

Saskatchewan: Volunteer services are part of home care program (e.g. visiting, security checks, transportation).

Ontario: Provides of enterostomal therapy, medical transportation under specified circumstances (provided by Ministry of Health), and arranges admission to long-term care facilities and admission to adult day programs (planned for 1999).

Manitoba: Program options or components include Self-Managed/Family-Managed Care, Group Shared Care, Community Intravenous Therapy Program, Home Oxygen Therapy Program, Dialysis Program and Terminal/Palliative Care. Home care provides assessment and referral to Adult Day Programs, supportive housing, chronic care and personal care homes. There is also a Medical Supplies and Equipment Program.

British Columbia: Adult day-care centres are funded through the continuing/acute care budget. British Columbia has a self-managed care program called "Choice in Support for Independent Living." Home support services include palliative care. Community home care nurses provide a limited IV program in some health authorities.

New Brunswick: New Brunswick manages adult day-care under the Family and Community Social Services Division Long Term Care Program.

Manitoba and Ontario (as of April 1999) manage adult day-care under the home care program.

3.2 Models of Service Delivery:

3.2 MODELS OF SERVICE DELIVERY: PROVINCE/ TERRITORY	Delivered by public employees (including employees of regional health authorities or publicly funded agencies)	Contracted out	Self-managed care
B.C.	All professional services	Home support services only (includes not-for-profit and for-profit organizations). Some home support agencies have amalgamated with the Health Authorities.	Yes. "Choice in Support for Independent Living" program since 1994
ALTA.	Always professionals doing assessment, reassessment and discharge planning; sometimes professional services	Mainly home support (personal care and homemaking). For professional services, there are a few exceptions where some RHAs contract out for direct nursing care (but not for assessment services).	Home support services only Yes, plus Guardian Managed Care (dependent adults or children who cannot manage their own care but have legal guardians)
SASK.	Usually professionals doing the assessment, reassessment, discharge planning and the majority of professional and non-professional services	While DHBs have the authority to contract out services, all services are directly delivered by the DHB except in a few exceptional circumstances.	No
MAN.	Professional and non-professional services (except for a portion of services in Winnipeg). All assessment and care planning.	Therapy services are contracted for the most part throughout Manitoba. In Winnipeg, most nursing services and a small portion of home support services are contracted to an agency. Back-up services are also contracted in Winnipeg.	Yes. Self-managed care and family-managed care for non-professional services only

3.2 MODELS OF SERVICE DELIVERY: PROVINCE/ TERRITORY	**Delivered by public employees (including employees of regional health authorities or publicly funded agencies)**	**Contracted out**	**Self-managed care**
ONT.	Some professional and non-professional services. In the year 2000, it is anticipated that only professionals doing assessment, reassessment and discharge planning will be employees of CCACs. CCACs are publicly funded, transfer payment agencies which contract with service providers to provide direct service through a Request For Proposal process.	A Request for Proposal process (RFP) was introduced in 1997 for all providers. The RFP requirements are based primarily on service quality. Price is a secondary factor. There is a 3-year time frame for implementation. It is open to all for-profit and not-for-profit organizations. Professional/homemaking/personal support services are contracted out. By the year 2000, only case managers will be CCAC employees. All nursing services, some home health allied services and all home support services will be contracted out.	Self-managed attendant care for adults with disabilities program is now available province wide. It is not funded by/or operated by the CCACs. The Centres for Independent Living assist with administration of the program and clients with self-managed care as needed.
QUE.	All professional services. Personal care and home support to high-risk clients (health and social services).	Contracting out for home support services for disabled persons in Montreal region and for respite hours (for profit and non-profit agencies) Contracting out for house cleaning, mostly for the elderly, under the Corporations d'économie sociale en aide domestique.	Yes (applies to around 7000 clients and/or legal representatives of physically, mentally disabled persons) Home support services financed Respite care: monetary allocation is offered to family

3.2 MODELS OF SERVICE DELIVERY: PROVINCE/ TERRITORY	**Delivered by public employees (including employees of regional health authorities or publicly funded agencies)**	**Contracted out**	**Self-managed care**
N.B.	All professionals services	Home support and Meals on Wheels are contracted.	In a number of cases, the client receives financial assistance from the government to purchase services directly from individuals or agencies. For alternative family living or adult foster care, clients may be eligible to receive up to $68 per day residential or $2,040 a month for home support services according to an assessment of their income, assets to the level of assistance needed (Provincial Long Term Care Program).
N.S.	Case management functions, including intake, assessment, service planning, resource allocation and authorization of service are performed by Home Care Nova Scotia staff. Approximately 25% of nursing services are delivered by public employees.	Approximately 75% of nursing services and 100% of home support services are provided through contracts with not-for-profit agencies. Home oxygen services are provided through contracted vendors.	No
P.E.I.	All professional and non-professional services	Physiotherapy, dietician therapy and speech therapy are arranged through regional resources or may be contracted out across regions.	No
NFLD.	Intake, assessment, care planning, case management, discharge planning by professional staff.	Home support services	Yes
Y.T.	All professional and non-professional services	None	No

3.2 MODELS OF SERVICE DELIVERY: PROVINCE/ TERRITORY	**Delivered by public employees (including employees of regional health authorities or publicly funded agencies)**	**Contracted out**	**Self-managed care**
N.W.T.	All professional and non-professional services	None	Yes

3.3 Types of Provider:

3.3 TYPES OF PROVIDER: PROVINCE/ TERRITORY	Case Management	Nursing care	Personal care	Homemaking
B.C.	Registered nurse, mostly B.Sc. prepared. Sometimes social workers, PTs or OTs	Registered nurse, many B.Sc. prepared.	Home support workers: No licencing requirement. 22-week community college program/provincial curriculum. Occasional: Licensed practical nurses (LPNs) who are paid as Home Support Workers. LPNs may act as Home Support Agency Supervisors. In B.C., home support includes personal care and homemaking.	Same as previous section on personal care.
ALTA.	Registered nurse	Registered nurse	Home support aide No requirement	Same as in previous section.
SASK.	Degree/diploma in health, social services, education or related area or considerable experience in assessment and interviewing techniques.	Registered nurse, registered psychiatric nurse, licensed practical nurse (Only registered nurses may perform nursing assessments and define nursing needs). Supervisor: Bachelor degree or diploma in public health nursing and 3 years' experience in community nursing.	Registered nurses, registered psychiatric nurses, licensed practical nurses can perform personal care; however, it is usually home care aides who do this. Training for Home Care Aides: Completion of home care core components of an approved training program is required within 2 years of employment.	Home care aides: training as in previous section. There are also training requirements for individuals preparing meals, performing home maintenance and providing volunteer services.

3.3 TYPES OF PROVIDER: PROVINCE/ TERRITORY	**Case Management**	**Nursing care**	**Personal care**	**Homemaking**
MAN.	Registered nurse, social worker, sometimes physician, occupational therapist or home economist	Licensed practical nurse	Licensed practical nurse	Home support worker (combination of training and/or experience)
ONT.	Mainly by registered nurses but other professional staff have been used successfully.	Registered nurse Licensed practical nurse	Personal support services are provided by homemakers for services accessed through CCACs. Personal support services are provided by attendants for services in supportive housing programs and attendant outreach services. A training program for personal support workers has now been implemented (510-520 hours, including 160 clinical hours).	Assistance with homemaking is provided by homemakers for services accessed through the CCACs. The primary tasks undertaken by attendants relate to the provision of personal support, but a limited amount of homemaking may be provided.
QUE.	Registered nurse, social worker, OT, depending on the client profile.	Registered nurse	*Auxiliaire familiale et sociale* or home support worker (960 hours of post-community college training). Not mandatory.	*Auxiliaire familiale et sociale* or home support worker *Aide ménagère* or domestic help (training on the job) in the *entreprises d'economie sociale*

3.3 TYPES OF PROVIDER: PROVINCE/ TERRITORY	**Case Management**	**Nursing care**	**Personal care**	**Homemaking**
N.B.	EMP: The primary service provider in any discipline may act as case manager. For home support (FCSS), usually social workers are case managers.	Registered nurse	Registered nursing assistant (one-year training through community college). Home support worker, personal care worker and visiting homemaker are equivalent workers. An individual who has completed either the Home Care Worker Training Program provided by N.B. Community College or a similar certified program is considered to have the minimum training requirements for a qualified home support services worker. Some clients under the age of 65 receive services from an attendant care worker.	Homemakers
N.S.	A degree in either Health or Social Science or an accepted and approved equivalent of training and experience, plus five years of related experience.	Registered nurse Licensed practical nurse	Registered nurse Licensed practical nurse Home support worker	Home support worker
P.E.I.	Registered nurses for post-acute care. Very limited case management for continuing care sector.	Registered nurse Licensed nursing assistants in two regions	Licensed nursing assistants in two regions. Also, certified visiting homemakers.	Licensed nursing assistants in two regions. Also, certified visiting homemakers.
NFLD.	Professional, multi-disciplinary	Registered nurse	Home support worker	Home support worker

3.3 TYPES OF PROVIDER: PROVINCE/ TERRITORY	**Case Management**	**Nursing care**	**Personal care**	**Homemaking**
Y.T.	Professional selected upon client's profile	Registered nurse	Home support worker	Home support worker
N.W.T.	Usually registered nurse or occupational therapist	Registered nurse or could be certified nursing assistant	Home support worker Certified nursing assistant (Personal care and provider requirements are defined differently according the regional board requirements)	Home support worker Certified nursing assistant Homemaker

Appendix 4.0: Eligibility

PROVINCE/ TERRITORY	**Eligibility requirements** **[The symbol (✓) refers to basic requirements common to all provinces and territories as follows. The client has:** **1. Proof of residence in province or territory and a valid health insurance card for the jurisdiction where services are being delivered** **2. Unmet needs from family and community** **3. A suitable home to provide care** **4. An assessment as needing care** **5. Consented to treatment]**	**Ages of clients accepted**	**Income testing and/or fees**	**Limits/Guidelines to services provision**
B.C.	✔ Residency: must be a landed immigrant or a Canadian citizen. Minimum of 12-month residency for intermediate care level clients and minimum 3-month residency for extended care clients to access home support, residential care, respite services, adult day centres. Access to Home Support Services: client has presence of a chronic illness for a minimum of 3 months. Access to Direct Care Services of community nurses requires a physician's order as part of hospital discharge. Hospital liaison staff may be employed by health authorities to facilitate discharge. Community home care nurses may make an assessment visit without a physician order.	For home support (must be age 19 or older) Nursing: all ages	Yes - for home support, respite and residential care.	Community home care nursing for acute care clients has a guideline of 2 weeks of service, including medical supplies. Home Support guidelines: 40 hrs/month Intermediate care-Level I: 46 hrs/month Intermediate care-Level 2: 64 hrs/month. Intermediate care-Level 3: 98 hrs/month. Extended care: 120 hours per month or 30 hours per week. **Guidelines are not maximum limits and clients may have care requirements that exceed the guideline.**

PROVINCE/ TERRITORY	**Eligibility requirements** **[The symbol (✓) refers to basic requirements common to all provinces and territories as follows. The client has:** **1. Proof of residence in province or territory and a valid health insurance card for the jurisdiction where services are being delivered** **2. Unmet needs from family and community** **3. A suitable home to provide care** **4. An assessment as needing care** **5. Consented to treatment]**	**Ages of clients accepted**	**Income testing and/or fees**	**Limits/Guidelines to services provision**
ALTA.	✔ Residency: Inter-provincial agreements exist for residents of British Columbia and Saskatchewan living in certain communities bordering on Alberta. Client does not require 24-hour services provision.	All	Yes - for home support according to the size of the family and the annual income	Services up to $3,000 per month (i.e. equivalent to facility placement rates). There are allowances for a higher dollar amount per month for people awaiting placement or receiving palliative care.
SASK.	✔ Residency: Inter-provincial agreements exist for residents of Manitoba and Alberta living in certain communities bordering on Saskatchewan.	All	Yes - for home support including personal care, respite, home maintenance and meals.	
MAN.	✔ All residents of Manitoba across the life span may access home care for assessment for eligibility for home care services. Anyone may refer a client to the Manitoba Home Care Program for assessment for eligibility. Home oxygen program: basic home care program criteria plus specific medical criteria.	All	No Priority is given to people with no other options for care.	Upper cost limit based on a formula for equivalent level of institutional care. Service limits based on client risk and safe-care. Exceptions can be made for clients waiting long-term care placement, short-term need and terminal care.

PROVINCE/ TERRITORY	**Eligibility requirements** **[The symbol (✓) refers to basic requirements common to all provinces and territories as follows. The client has:** **1. Proof of residence in province or territory and a valid health insurance card for the jurisdiction where services are being delivered** **2. Unmet needs from family and community** **3. A suitable home to provide care** **4. An assessment as needing care** **5. Consented to treatment]**	**Ages of clients accepted**	**Income testing and/or fees**	**Limits/Guidelines to services provision**
ONT.	✔ Residency: Eligible if living in the area of a CCAC. Eligible for professional services if needs are not met by a hospital outpatient service. Eligible for homemaking and personal care if there is a need for assistance with personal care and/or there is a risk that the person will require institutional care without the service.	All	No	Homemaking (includes personal support): Through CCACs, maximum of 80 hours per month in first month, 60 hours per month thereafter. Nursing: maximum of 4 visits per day or dollar equivalent up to 28 hours per month. Through Attendant Outreach for adults with disabilities, 120 hours per month. These can be combined for those who need high levels of assistance with personal support. For palliative or complex care, the dollar equivalent for the hour of nursing per day can be exchanged to purchase longer blocks of nursing.

PROVINCE/ TERRITORY	**Eligibility requirements** **[The symbol (✓) refers to basic requirements common to all provinces and territories as follows. The client has:** **1. Proof of residence in province or territory and a valid health insurance card for the jurisdiction where services are being delivered** **2. Unmet needs from family and community** **3. A suitable home to provide care** **4. An assessment as needing care** **5. Consented to treatment]**	**Ages of clients accepted**	**Income testing and/or fees**	**Limits/Guidelines to services provision**
QUE.	✔ Non-residents: pay full cost or are referred to private sector. Clients must use coverage from other public programs if applicable. Definition of "home": According to Ministry of Health and Social Services policy, home includes private long-term residential care facilities and also *résidence d'accueil* or foster home arrangements where supplementary services may be required.	All	For home support services, priority is given to low-income people and those with no other option for care. The exception is for disabled persons under 65 requiring long-term intensive supportive care, for whom no income priority is applied.	Priority given to emergency and crisis situations, including situations where family support is needed. Home support maximum is 40 hours per week. It can be more depending on client needs (e.g. certain disabled persons) and may vary from one region to another.

PROVINCE/ TERRITORY	**Eligibility requirements** **[The symbol (✓) refers to basic requirements common to all provinces and territories as follows. The client has:** **1. Proof of residence in province or territory and a valid health insurance card for the jurisdiction where services are being delivered** **2. Unmet needs from family and community** **3. A suitable home to provide care** **4. An assessment as needing care** **5. Consented to treatment]**	**Ages of clients accepted**	**Income testing and/or fees**	**Limits/Guidelines to services provision**
N.B.	✔ Specific criteria established for some services. Extra-Mural Program: Physician referral except for rehabilitation. Services are needed from one of the health professionals employed by the EMP (long- or short-term). Drugs covered if no private insurance. Long Term Program: Home support and long-term residential care. Health care if needed.	All	No charges for acute care or long-term health services. Long-term supportive and residential care is income tested according to income and assets, excluding the client's home.	$2,040 per month for home support (FCSS) Up to $68 per day for residential services.
P.E.I.	✔ Clients must be medically stable Non-residents pay the full cost of services excluding administrative costs	All	For home support services (i.e. personal care and respite)	Maximum of 4 hours/day up to 28 hours/week

PROVINCE/ TERRITORY	**Eligibility requirements** **[The symbol (✓) refers to basic requirements common to all provinces and territories as follows. The client has:** **1. Proof of residence in province or territory and a valid health insurance card for the jurisdiction where services are being delivered** **2. Unmet needs from family and community** **3. A suitable home to provide care** **4. An assessment as needing care** **5. Consented to treatment]**	**Ages of clients accepted**	**Income testing and/or fees**	**Limits/Guidelines to services provision**
N.S.	✔ Specific criteria for each level of service	All	There are no fees for nursing services. Based on the recipient's income and family size, there may be a minimal fee assessed for home support, personal care or home oxygen services.	Acute home care services: up to a maximum of $4,000 per month Chronic home care services: equivalent to facility placement cost ($2,200 per month)
NFLD.	✔	All	Income test for home support services (personal care, household management and respite).	Health care supplies provided free for acute care. Oxygen, health supplies, orthotics, equipment and medications for long-term care determined on means test. A maximum range of $2,268 to $3,240 monthly for home support services. Government is the payer of last resort for long-term home support services.
N.W.T.	✔	All	No	

PROVINCE/ TERRITORY	**Eligibility requirements** **[The symbol (✓) refers to basic requirements common to all provinces and territories as follows. The client has:** **1. Proof of residence in province or territory and a valid health insurance card for the jurisdiction where services are being delivered** **2. Unmet needs from family and community** **3. A suitable home to provide care** **4. An assessment as needing care** **5. Consented to treatment]**	**Ages of clients accepted**	**Income testing and/or fees**	**Limits/Guidelines to services provision**
Y.T.	✔ Criteria for admission to program: - physical and mental disabilities - acute care needs - terminal illness - frail elderly needing assistance in daily living	All	No	Acute care: for clients requiring less than 12 weeks of service Wound care: supplies provided for 2 weeks if no income or private insurance Maximum number of home support hours per client: 35 hours per week

Appendix 5.0: Assessment and Case Management

B.C.	**Case manager assessment for home support, respite, adult day centre services, meal programs and residential care:** A single-entry system allows access to all community support programs. Assessment activities include intake and screening, initial assessment, financial assessment of income, program planning, service authorization, monitoring, evaluation, follow-up and reassessment. Anyone can refer an individual for assessment, including self-referral. A physician referral is not required. Staff employed by the health authorities conduct the assessment and case management processes. Case managers (mostly nurses, but also social workers and rehabilitation staff) go out to the home to do the assessment. If the person is assessed to be eligible for services, a care plan is developed and the family physician is called to inform him or her of the care plan for the client. Services may include home support, respite at home or facility, adult day centre, meal programs and residential care. Assessment for respite care is done using the same single-entry system, through the community case manager. The assessment determines eligibility for home support, adult day care and facility placement services for respite. The assessment instrument, referred to as the LTC1, was first developed in 1978 and has had two major revisions since then. A mini mental status exam (MMSE) and a financial assessment (LTC1.6) are also included as complementary assessment instruments in the process. **There is a separate process for Direct Care Services of community home care nurses.** Direct Care Services of community home care nurses require a physician's order, but an initial assessment visit may be undertaken without a physician's order. Health authorities may have an employee responsible for hospital liaison discharge activities.
ALTA.	Entry to long-term care services in Alberta occurs through the single point of entry process through the Home Care Program. The Alberta Assessment and Placement Instrument (AAPI) was introduced in 1990 to standardize the documentation of assessment information. It was developed to guide health care professionals in assessing individuals requiring long-term care services. Each individual goes through an intake/screening process through which the initial indication of need and the urgency of need are assessed. Each individual then has an assessment completed. This is a process in which the individual and the case coordinator can identify patient needs together. This information is then documented on a standardized form. Once the needs are identified by the client, the caregiver and the case coordinator, a care plan is developed. This plan lays out which needs will be addressed, what the desired outcome is, and the plan of how and when the outcome will be reached. This care plan is followed by implementation. A reassessment is completed with each client. This is done yearly if the client needs are long term, or any time there is a significant change in the client's condition and/or situation creating a change in need. Finally, there is discharge which is planned for at the time of intake. It occurs when the client no longer needs or chooses to have services.

SASK.	Saskatchewan has a single-entry system through each District Health Board which provides assessment and care coordination for clients. The Saskatchewan Client Information Profile (SCIP) is a new assessment tool that provides better information about behavioural and emotional needs, along with the degree of informal support, than the former continuing care tool. Applicants are assessed by the home care program before service commences. Home care is provided on the basis of assessed need and degree of risk for illness, injury and institutionalization. Each health district has a case coordinator(s) who is responsible for assessment, care planning and case management for home care clients. The coordinator monitors each client and alters the services if necessary. Service is based on functional need. Need for Home Care Intervention = (equals) Functional Need - (minus) adequacy of Client's Informal Support.
MAN.	There is a single point of entry system for the Home Care Program. Referrals are received through a regional Home Care office. In Winnipeg and some RHAs, there are also Home Care referral and assessment staff in hospitals. Anyone (i.e. self, physician, family member) may make a referral for Home Care services. Home Care case coordinators in the RHAs are responsible for assessment, care planning and case management for Home Care clients. Assessment for placement in a long-term care facility is done by the Home Care representatives (usually case coordinators). Referrals are reviewed by a multi-disciplinary Assessment/Placement Panel. A standard application and assessment form is used in the assessment for placement process. An initial version of the Screening, Assessment and Care Planning Automated Tool (SACPAT) has been developed and planning is in process for its implementation across Winnipeg during 1999-2000.
ONT.	CCACs offer a single-entry service point and are responsible for placement in all long-term care facilities; coordinated service planning and monitoring, and case management. CCACs assess need, determine eligibility and purchase services. CCACs will purchase all services by the year 2000, except for assessment, case management, evaluation and monitoring. Following referral, a multidimensional assessment of needs and available informal supports is completed, treatment goals are set and a service plan is developed. Case managers are then assigned to coordinate the delivery of home health care and homemaking services by various providers according to the client's assessed need for these services. Adults with physical disabilities can access attendant services directly without going through the CCAC.
QUE.	Referrals for home care are made to the CLSC by physicians, individuals, families and other health providers. A CLSC staff member, usually a nurse or a social worker, will go to the person's home and conduct an assessment of the individual's functional ability and service needs using a standardized *Évaluation Multi-Clientèle* tool. The province is in the process of developing a new assessment tool which will integrate tools used for home care through to institutional care. Treatment goals and a plan are developed based on the assessment. The case manager will then arrange for and coordinate the various home health and social services needed by the patient according to the treatment plan.

N.B.	To be eligible for the Extra-Mural Program, the person must have a New Brunswick health insurance number, a referral from an attending physician (except for rehabilitation services), a specific health care need that has been identified, and an illness requiring home care services that can be appropriately delivered by the EMP. Patients must be "admitted" to the EMP by a physician in a similar way to a hospital admission; however, a hospital stay is not required. An EMP professional assesses the patient and develops a care plan in consultation with the patient and family. Appropriate referral is made to other members of the interdisciplinary team as needed. Persons discharged from hospital or the EMP, or other persons needing long term in-home support services, would access them through the Long Term Care Program of FCSS. All of the three community partners (EMP, FCSS and Mental Health) use the same criteria and standardized assessment tool/process (Single Assessor Model) to determine the type of care needed by the client for services outside of hospital services. They then refer or draw on the services available from all three partners as needed. The case manager is usually the professional who is most involved with the client and, although it is usually the FCSS worker, may be from any of the partner organizations.
N.S.	Home Care Nova Scotia provides single-entry access to home care services. The program's care coordination staff are responsible for all case management functions including intake, assessment, service planning, resource allocation and authorization of service. Care coordinators use a comprehensive, standardized assessment (SACPAT II) to identify the individual's unmet needs, in areas of clinical care, health functioning, social functioning and environmental support, which can be met by home care. Care coordinators determine a plan of care in consultation with the client and/or family. Care coordinators are located in communities throughout the province and in all general tertiary, regional and community hospitals in Nova Scotia.
P.E.I.	As admission criteria to Home Care Support, all clients are assessed as to need, what risks for personal breakdown or decline, what family or community support is in place, and what additional services/supports are required to safely maintain this individual at home or elsewhere. The standard tool (SAT) for eligibility and needs assessment covers function, cognition, risks and caregiver support. It is targeted that 85%-90% of all Home Care clients will require the standard assessment for eligibility and admission to Home Care Support. In addition, all nursing home applications and placements (public & private) go through the coordinated single-entry system, based in Home Care, and use the standard assessment process and tool (SAT). The Home Care Support Program has the responsibility for coordinating all home care needs and services with the client, through the care plan. This includes assessment, care planning, reassessment and discharge planning. The assessment is coordinated by the case coordinator who is responsible for facilitating the ongoing provision of the care plan. Discharge planning is part of the completion of the service. At present, self-managed care is not an option.

NFLD.	The single-entry system to Continuing Care is used in Newfoundland. Health and Community Service Board's core services include assessment and case management. A standardized assessment is used to access a broad range of community and facility-based services. The assessment is interdisciplinary and focuses on client need. The outcome of assessments inform changes to the care plan. Anyone can make a client referral to the single-entry system. Professional assessment, consultation and ongoing management are part of the government-funded continuing care service delivery system.
Y.T.	Yukon Home Care Program provides and coordinates an assessment of the individual requiring care. Referrals to the program are accepted from any source, including clients, family members, physicians and other health professionals. An assessor, often the social worker unless the referral is specifically for nursing or rehabilitation, will meet the client to review the individual situation, health status, social support and needs. The assessor will then determine the services required to best suit the individual's needs and personal goals. The assessor will include them in the care plan for the client and remain the case coordinator, or transfer the role of case coordination to another professional if this is indicated by the assessment as more appropriate for the client.
N.W.T.	Assessment and Case coordination is considered a home care program. The programs are managed by a home care coordinator who may also function as a case manager, assessor and/or health professional within the program. In hospital-based programs, the home care coordinator is a member of a multidisciplinary, inter-agency, discharge planning committee. In small communities, the coordinator's position is a regional one. Anyone can refer an individual for assessment. A physician referral is not required. When someone needs home care services, an assessor will determine need for the individual by reviewing the client's situation, health status, supports available, health care and social care needs. The assessor will then design a care plan outlining the services required to best suit the individual's needs and health goals. In 1997, the Department of Health and Social Services field tested the Alberta Assessment and Placement Instrument (AAPI). Using the input from the field test, a new Continuing Care Assessment Package (CCAP) has been developed for Northwest Territories. The CCAP consists of a screening tool, general assessment and a specialized assessment. The CCAP will be phased in over the next fiscal year.

Appendix 6.0: Coverage and Co-payment Charges

PROVINCE/ TERRITORY	Services and charges	In general: Charges to the client
B.C.	**Acute care:** No charges for Direct Care Professional Services, including nursing (acute, chronic and palliative), rehabilitation, social work, in-school health services, assessment and case coordination. **Supplies:** Supplies may be at no charge for the first two weeks and client generally pays for supplies after that. **Drugs:** Persons 65+ pay the drug dispensing fee up to a certain amount. Clients under 65 pay a deductible up to $2,000 per year for prescription drugs. **Long-term chronic care/home support:** A client pays for home support services according to a financial assessment.	No charge for professional Direct Care Services. Income test for home support. Deductible for drugs.
ALTA.	**Acute care and long-term/chronic care:** No charges for nursing, rehabilitation, personal care, assessment and case coordination. A client may pay for home support at $5 per hour to a maximum of about $300 per month. **Supplies, equipment and medication:** Mixed public/private pay.	No charge Mixed public/private pay.
SASK.	**Acute, palliative and long-term/chronic care:** There are no charges for professional services, including nursing, therapies and case management. However, homemaking, meals and home maintenance are chargeable services. Charges are based on income and number of service units required per month with maximums ranging from about $55 to around $335 per month. Palliative care clients who are in the end stage of the disease process, or who require acute care management of palliative symptoms, are not charged home care fees. Social assistance, seniors on income support are charged the minimum. Some District Health Boards have established a general guideline that home care services, including respite services, should not exceed $2,500 to $3,000 per client per month, the approximate cost of care in a special care home. There is no provincial policy that limits the amount of home care an individual can receive. **Supplies, equipment and medication:** Medications and certain nursing supplies, including home antibiotic IV medications, are covered by the District Health Board.	No charge for nursing, therapies and case management delivered by DHBs. Income-assessed fees for home support. Some medications and nursing supplies are covered.

PROVINCE/ TERRITORY	Services and charges	In general: Charges to the client
MAN.	**Acute and long-term/chronic care:** There are no charges for professional nursing services, personal care, home support and therapy services provided under a care plan to eligible clients. However, there are cost and service limit guidelines depending on the client assessment. For home support services to be provided under the Home Care Program, the client must be unable to access them from the community and they must prevent the person from having to live in an institution. **Supplies, equipment and medication:** An approved range of medical supplies and equipment is available where necessary to support a home care plan of care. This excludes clients who are self-care in the use of supplies. There is an equipment-lending program for high-cost equipment. The Pharmacare program assists many clients with drug costs.	No charge Mixed public/private pay
ONT.	**Acute and long-term/chronic care:** There is no charge for nursing, therapy, social work, personal support and homemaking services provided through CCACs for persons with assessed service needs up to specified maximums. Persons who wish more services than those for which they have been assessed may purchase them privately. **Supplies, equipment and medication:** Client is eligible for a drug card which covers drugs related to the admission to Home Care program according to provincial formulary. CCACs provide some specified supplies and equipment to support the service plan where appropriate. CCACs do not provide any supplies/equipment that can be made available through Ontario's Assistive Services Program.	No charges for needs assessed services up to service limits. •

PROVINCE/ TERRITORY	Services and charges	In general: Charges to the client
QUE.	**Acute care:** No charges. **Long-term/chronic care:** No charges. However, budget constraints at CLSCs are limiting capacity to respond to the needs of long-term care clients requiring ongoing home support services to live at home. Where services are available outside the home care plan, clients pay according to their ability to do so. **Supplies, equipment and medication:** Free for acute care with prescription. Province has drug plan for those without third-party medical insurance. Department of Health and Social Services issued a policy in 1998 to allow certain supplies and equipment for certain disabled persons.	No charge For long-term care, financial eligibility assessed (local criteria) Mixed public/private pay
N.B.	**Extra-Mural Program:** Professional services from the EMP are insured. There is a small budget for homemaker services for short-term needs, primarily palliative care. **Long-term/chronic care:** Long-term care clients may receive services and assistance through Family, Community and Social Services Division (FCSS) and are subject to a client contribution fee based on financial assessment. **Supplies, equipment and medication:** EMP-related supplies and equipment are insured. EMP clients are required to access third-party insurance for drugs where possible. If no insurance, an EMP drug card is issued to cover drugs directly related to the client condition. LTC, FCSS clients may receive assistance with drugs, supplies and equipment via social assistance, or through the Pharmacare program for seniors. **Financial Eligibility Assessment:** Assessment for the Long Term Care program (FCSS) is completed according to an income and asset assessment formula. Clients contribute according to their ability to pay.	No charge for EMP. For long-term care, income and assets assessed Third-party insurance applied Clients, except low income, pay for medications.

PROVINCE/ TERRITORY	Services and charges	In general: Charges to the client
N.S.	**Acute care:** Services include nursing, home support and home oxygen. Clients are required to have an attending physician who accepts medical management of the case. There is no charge to the client for medications or supplies used in the treatment of the acute condition. Acute level entitlement for services and medical supplies, excluding medications, is $4,000 per month. **Chronic care:** Services include nursing, home support and home oxygen. Clients receiving home oxygen services must meet medical eligibility criteria. There is no charge for nursing services. Minimal fees, to a monthly maximum, may be assessed for home support and home oxygen services. **Supplies, equipment and medication:** There is no charge to the client for supplies used during nursing visits. In chronic-level services, clients are responsible for supplies required between nursing visits.	No charges Fees may be assessed on a sliding scale determined by income and family size.
P.E.I.	**Health care services:** No charge for professional services. No 24-hour services. Weekend or evening coverage on an assessed basis. The maximum time guideline is 4 hours service per day, up to a total of 28 hours per week, to be planned into the family care plan. The average is 1-2 hours per day, with a very limited number of clients receiving the maximum. **Support services/Long-term care:** Income assessed for ability to pay. Charges apply to home support services, including homemaker, personal care, meals and respite. **Supplies, equipment and medication:** Charges apply. **Income assessment:** Assessment is completed with client to apply for public funding assistance. About 60% of clients receiving home support/personal care services contribute according to their ability to pay.	No charges Income assessed for ability to pay for home support

PROVINCE/ TERRITORY	Services and charges	In general: Charges to the client
NFLD.	**Acute care/home care program:** Professional services include acute home nursing visits, social work, rehabilitation, palliative care, and therapies such as oxygen. There are no specific service or dollar limits. **Long-term care/Home support:** Home support includes personal care, home management and respite. Client contribution is determined through a means test. **Supplies, equipment and medication:** Health care supplies are free for acute care. Medications are not. Long-term care services in the community are means tested to determine the client contribution. **Financial eligibility assessment:** Assessment is completed with client to determine level of client contributions toward home support. Liquid assets are considered in determining eligibility for home support.	No charge for the professional home care program Financial eligibility assessed to determine amount of client contribution for home support services
Y.T.	**Acute, long-term and palliative care services:** Includes some respite services. Home support services are available up to 35 hours per week per client depending on assessed need. There is no means testing. **Supplies, equipment and medication:** For wound care, the program covers dressing supplies for up to 2 weeks if the client has no third-party insurance or cannot pay. For some equipment, funding assistance can be requested from the Non-insured Health Benefits for First Nations, or from the Yukon Extended Care benefits for seniors and for persons with chronic diseases.	No charges except for certain supplies, equipment and medication
N.W.T.	Admission to the program is through assessment by the home care program staff or an admission committee. Services are covered according to the assessed need of the client.	No charges

Appendix 7.0: Funding and Utilization Data

Table 1: Public Home Care Expenditures in Dollars and Percentage of Public Health Expenditures by Province and Territory, 1996-97 and 1997-98 (in $000,000) by Source of Reference

PROVINCE/ TERRITORY	Province/ Territory 1996-97	Province/ Territory 1997-98	Health Canada 1997-98	CHCA 1997-98	% of public health expenditures Health Canada 1997-98	% of public health expenditures Province/Territory 1996-97/1997-98	
B.C.	276.6	313.9	244.1	236.9	3.1	N/A	8.0
ALTA.	102.6	148.8	149.3	131.6	2.8	(7)3.2	3.6
SASK.	(1)66.4	68.2	70.3	67.9	3.9	4.1	4.1
MAN.	129.4	142.5	103.6	(10)91.7	5.0	6.9	7.5
ONT. TOTAL (CCA CENTRES ONLY)	(2)946.1 (693.9)	1,119.1 (855.2)	1,038.9	832.7	5.3	5.3	6.1
QUE.	(3)384.3	N/A	277.2	(11)266.0	2.4	3.3	N/A
N.B.	(4)73.8	80.0	72.0	(12)30.0	5.8	5.8	6.2
N.S.	57.1	60.5	76.8	69.0	5.1	4.4	4.3
P.E.I.	3.4	4.6	4.7	4.4	2.3	(8)2.4	2.6
NFLD.	(5)N/A	N/A	52.0	41.0	5.1	N/A	N/A
Y.T.	(6)1.0	1.1	1.4	0.9	1.7	N/A	(9)1.1
N.W.T.	3.4	4.1	6.5	4.3	2.1	1.6	1.8
CANADA	2,044.1	1,942.8	2,096.0	1,776.4	4.0	4.1	4.5

In the following tables, N/A means not provided or not available.

Notes for Table 1

Provinces and Territories, 1996-97 and 1997-98

Definition of expenditures included direct and indirect public **provincial** spending. Direct services encompass assessment/case management, nursing services, home support services, home respite, therapies and volunteer services. For comparability with Health Canada data, the expenditures for adult day care centres, medical equipment, drugs and medical supplies are excluded.

1. Most therapies in Saskatchewan are not funded through Home Care but through other budgets except in the three largest Health Districts.
2. Ontario CCAC funding excludes approximately 5% for medical supplies and equipment. Among community programs which are excluded from expenditure data are adult day care programs and children's treatment centres.
3. Data for Quebec (Financial and Operational Information System - SIF) include all funding for selected activities delivered explicitly at home - **by all institutions** - (i.e. professional services [except physicians' services], home nursing services, Info Health Line weekends and out of CLSCs' hours of operation, intravenous nutritional support, social work services, specialized services and home support services).
4. In New Brunswick, Family, and Community Social Services data include some transportation, medical equipment, drugs and medical supplies but the amounts are not significant. Total health expenditures do not include capital expenditures in hospitals and special-purpose expenditures.
5. In Newfoundland and Labrador, funding for home care is consolidated with funding for other programs and services delivered by Health and Community Services Boards. These resources are allocated as block funding and administered/monitored at the board level. Currently, the province is developing a detailed management information system which will be used by local Boards and will provide standardized financial and utilization data to the Department of Health and Community Services.
6. The annual Yukon funding figures include $6,476 in 1996-97 and $8,000 in 1997-98 for program materials.
7. Alberta's per capita figures do not include expenditures of the provincial Department of Health in the annual expenditures.
8. Public Health expenditures in Prince Edward Island apply to home care, hospitals, physicians, residential care in manor houses, mental health services, seniors health services, public health, laboratory services, rehabilitation, pharmacy, dental health and environmental health.
9. In Yukon, home care and continuing care are part of the Department of Social Services; the hospitals and nursing stations are under the Department of Health. Health and Social Services also include family services, alcohol and drug services and social assistance programs.

Health Canada
Definition of expenditures included **provincial/municipal/federal** spending on home care and encompass the list of services mentioned above.

Canadian Home Care Association (CHCA)
Representatives of each province and territory produced a portrait of their home care programs edited by the Canadian Home Care Association (CHCA) in March 1998. Data on funding and utilization were collected as part of the process. Definition used are provided in the document.

10. Manitoba's funding figures include direct services only.
11. Quebec's funding include CLSCs' expenditures only. (CLSC: Community Local Services Centres)
12. New Brunswick's funding data and per capita expenditures for the Extra-Mural Program only.

Table 2: Revenues from Home Care Clients, 1996-97 and 1997-98 (Provincial/Territorial Data)

PROVINCE/TERRITORY	Revenues from home care clients	
	1996-1997	1997-98
B.C.	9,300,000	10,400,000
ALTA.	560,000	(1)540,000
SASK.	6,400,000	6,600,000
MAN.	0	0
ONT. TOTAL	24,700,000	(2)25,600,000
QUE.	0	0
N.B.	N/A	6,400,000
N.S.	N/A	0
P.E.I.	N/A	less than 45,000
NFLD.	N/A	N/A
Y.T.	N/A	N/A
N.W.T.	0	0
CANADA	40,960,000	less than 49,585,000

Notes on Table 2

1. Alberta's revenues are estimates.
2. In Ontario, CCAC clients are not charged. Nominal fees are charged for in other community services, such as Meals on Wheels, transportation and social/recreational programs. Revenues include amounts for user fees and agency fund raising.

Table 3: Public per Capita Expenditures by Sources of Reference (1996-97 and 1997-98)

PROVINCE/TERRITORY	Per capita Province/ Territory 1996-97	Per capita Province/ Territory 1997-98	Per capita Health Canada 1997-98 (estimate)	Per capita CHCA 1997-98
B.C.	71.8	79.6	61.6	60.2
ALTA.	36.8	52.7	53.0	66.3
SASK.	64.6	66.3	69.1	46.2
MAN.	113.2	124.1	90.2	80.1
ONT. **CCACS: CENTRES ONLY**	84.2 61.7	98.1 75.0	91.0	72.9
QUE.	51.7	N/A	37.4	35.8
N.B.	97.0	105.0	94.2	39.4
N.S.	60.6	63.9	80.3	72.8
P.E.I.	24.8	33.3	33.8	32.1
NFLD.	N/A	N/A	91.8	72.7
Y.T.	31.2	34.2	21.2	28.5
N.W.T.	51.4	61.1	216.1	63.7
CANADA	62.5	71.8	69.2	55.9

Table 4: Home Care Utilization Data: Number of Clients Served by Source of Reference (1996-97 and 1997-98)

PROVINCE/ TERRITORY	Province/ Territory 1996-97	Province/ Territory 1997-98	CHCA - data 1996-97	Health Canada 1996-97	Statistics Canada (estimated number of people aged 18 and over) 1996-97[11]
B.C.	[1]119,428	124,113	[7]79,000	[10]104,900	79,798
ALTA.	[2]64,854	66,881	65,199	67,750	46,574
SASK.	[3]28,513	29,033	27,410	27,339	24,190
MAN.	27,226	29,838	27,226	29,783	22,335
ONT.	[4]321,116	361,918	[8]325,116	324,699	224,787
QUE.	[5]339,051	N/A	[9]282,402	238,918	106,204
N.B.	[6]30,312	33,179	N/A	[10]25,323	13,649
N.S.	17,926	18,014	17,934	17,926	10,017
P.E.I.	2,200	2,212	N/A	2,941	N/A
NFLD.	N/A	N/A	N/A	N/A	N/A
Y.T.	301	295	361	301	N/A
N.W.T.	N/A	N/A	N/A	646	N/A
CANADA	950,927	665,483	824,648	840,526	527,554

Notes for Table 4

Provincial and Territorial Data, 1996-97 and 1997-98

1. British Columbia: Palliative care is included in acute care.
2. Alberta: Acute clients are classified as short-term clients (less than 3 months) or long-term clients (more than 3 months).
3. Saskatchewan: The province does not collect number of clients receiving assessment/case management or volunteer services.
4. Ontario: Only CCAC clients are included here. Therapies include occupational therapy, physiotherapy, speech therapy, social work, dietetics. In "other services" are included enterostomal therapy, laboratory, technology, paramedical, respiratory technology.
5. Quebec: Data on clients and services are collected through CLSC Information System Data. The data are an estimate based on 115 of 150 CLSCs. Acute care clients included post surgery, post-hospitalized clients; long-term clients included those with long-term diseases, physically and mentally handicapped. Others included social-related problems (*difficulté d'adaptation situationnelle*), terminal care, AIDS and others. According to the change in health status, a client can change profile during the same fiscal year and be counted accordingly. Data on services, therapies include specialized home services and social work, others represents home community services.
6. New Brunswick: Long-term clients consisted of 11 788 seniors, 1548 adults and 805 children with special needs. They received home support services, except children received mostly therapist services. Extra-Mural Program has no breakdown between acute and long-term care. All clients have been put in acute care. The program can provide data on client visits, time, direct and indirect services, and travel.

Canadian Home Care Association

7. British Columbia clientele do not include long-term care for children.
8. Ontario clientele include 27 658 children aged 18 and under.
9. Quebec clientele are an extrapolation based on 49% of all CLSCs' Home Care Programs.

Health Canada

10. Health Canada: Estimates

Statistics Canada

11. Estimated number of people served aged 18 and over. Data extracted from National Population Health Survey, 1996-97.

Table 5: Rate of Utilization - Number of Home Care Clients by 1000 Inhabitants by Source of Reference (1996-97 and 1997-98)

PROVINCE/ TERRITORY	Province/ Territory 1996-97	Province/ Territory data 1997-98	CHCA 1996-97	Health Canada 1996-97	Statistics Canada 1996-97
B.C.	31.0	31.0	20.0	27.0	28.0
ALTA.	23.0	24.0	23.0	24.0	23.0
SASK.	28.0	28.0	27.0	27.0	35.0
MAN.	24.0	26.0	24.0	26.0	27.0
ONT.	29.0	32.0	28.0	28.0	27.0
QUE.	46.0	N/A	38.0	32.0	19.0
N.B.	40.0	43.0	N/A	33.0	24.0
N.S.	19.0	19.0	19.0	19.0	27.0
P.E.I.	16.0	16.0	N/A	21.0	N/A
N.B.	N/A	N/A	N/A	11.0	N/A
Y.T.	9.5	9.2	N/A	10.0	N/A
N.W.T.	N/A	N/A	N/A	10.0	N/A
CANADA	25.0	25.0	26.0	23.0	26.0

Table 6: Number and Percentage of Acute, Long-Term and Other Clients in the Provinces and Territories (1996-97)[9]

PROVINCE/ TERRITORY	Acute Care Clients		Long-Term Clients		Others		Total
	Number	%	Number	%	Number	%	
B.C.(1)	67,428	56.4	52,000	34.5	N/A	N/A	119,428
ALTA.(2)	24,949	41.0	31,655	52.0	4,268	7.0	60,872
SASK.	6,541	22.9	20,094	70.5	1,878	6.6	28,513
MAN.	N/A	N/A	N/A	N/A	N/A	N/A	27,226
ONT.(3)	N/A	N/A	N/A	N/A	N/A	N/A	321,116
QUEBEC(4)	71,703	21.1	215,897	63.7	51,451	15.2	339,051
N.B.(5)	16,171	53.3	14,141	46.6	N/A	N/A	30,312
N.S.	N/A	N/A	N/A	N/A	N/A	N/A	17,926
P.E.I.(6)	440	20.0	1,650	75.0	110	5.0	N/A
NFLD.	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Y.T.	50	16.6	222	73.7	29	9.6	301
N.W.T.	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CANADA	188,282	33.0	335,659	58.0	57,736	8.7	946,945

[9] Data provided by provinces and territories.

Notes for Table 6

1. British Columbia: Palliative care is included in acute care.
2. Alberta: Acute clients are classified as either short-term (less than 3 months) or long-term (more than 3 months).
3. Ontario: Registered here only are CCAC clients.
4. Quebec: Data on clients and services are collected through Information System Data of the CLSCs. The data are an estimate based on 115 CISCs of 150. Acute care clients included are: post surgery, post-hospitalized clients; long-term clients included those with long-term diseases, physically and mentally handicapped persons. Others included social-related problems (difficulté d'adaptation situationnelle), terminal care, AIDS and others. According to the change in health status, a client can change profile during the same fiscal year and be counted accordingly. Data on therapies services include specialized home services and social work. Others services represent community intervention.
5. New Brunswick: Long-term clients consisted of 11 788 seniors, 1548 adults and 805 children with special needs. They received home support services with the exception of children who received mostly therapist services. The Extra Mural Program data do not distinguish between acute and long-term care. Data are available on client visits, time, direct and indirect services, and travel, etc.
6. Prince Edward Island: Provincial estimates.

Table 7: Number of Home Care Clients Served by Type of Service (1996-97) - Data Provided by Provinces/Territories

PROVINCE/ TERRITORY	Nursing services		Home support services		Therapies		Other		Total	
	Number	%	Number	%	Number	%	Number	%	Number	%
B.C.	44,342	37.1	52,000	43.5	23,086	19.3	NA	NA	119,428	99.9
ALTA.	44,566	25.4	38,274	21.9	21,287	12.2	70,786	40.50	174,913	100.0
SASK.(1)	19,501	47.8	16,117	39.5	N/A	N/A	5,206	12.80	40,824	100.0
MAN.(2)	4,922	28.0	12,155	69.1	501	2.8	N/A	N/A	17,578	99.9
ONT.(3)	177,964	37.8	126,276	26.8	159,965	34.0	6,237	1.30	470,442	99.9
QUE.	150,925	50.1	54,097	17.9	96,120	31.9	175	0.06	301,317	100.0
N.B.	N/A		13,336		805		N/A		14,141	
N.S.	N/A		N/A		N/A		N/A		N/A	
P.E.I.	N/A		N/A		N/A		N/A		N/A	
NFLD.	N/A		N/A		N/A		N/A		N/A	
Y.T.(4)	N/A		N/A		N/A		N/A		N/A	
N.W.T.	N/A		N/A		N/A		N/A		N/A	
CANADA	442,220	38.8	312,255	27.4	301,764	26.5	82,404	7.20	1,138,643	99.9

Notes for Table 7

1. Saskatchewan: Nursing services include personal care and respite when provided by a nurse or a psychiatric nurse. Home support services include personal care and home respite when provided by a homemaker. Other services include home maintenance and meal services. The province does not collect data on the number of clients receiving assessment, case management and volunteer services.
2. Manitoba: The number of clients served is a monthly average by type of service. It does not include block care and self-managed services.
3. Ontario. Only CCAC clientele are included. Therapies include occupational, physiotherapy, speech, social work, dietetics. Others services included are enterostomal therapy, laboratory, technology, paramedical, respiratory technology.
4. Yukon. Data are available for year 1997-98 only.

Table 8: Number of Self-Managed Care Clients (1996-97 and 1997-98). Data Provided by Provinces and Territories

Years	B.C.[1]	Alta.	Man.	Ont.	Que.	N.B.[2]	Total
1996-97	240	1,070	83	ND	approx. 6,000	approx. 500	7,893
1997-98	300	1,130	102	102	approx. 6,000	approx. 500	8,134

Notes for Table 8

Self-managed care refers to a model of care in which the client receives from the home care program a sum of money to purchase his or her own home support and personal care services. This model enables the client to decide by whom, when and how the services will be provided.

1. British Columbia: Approximately 6% of the home care hours are utilized by self-managed care.
2. New Brunswick: For the majority of cases, the services are paid directly by the Department. Some clients pay the full cost of services and a few receive a financial allocation from the Department to purchase services related to their home support.

Appendix 8.0: Current Initiatives

B.C.	A **health information system** & an **accountability framework** are being developed in cooperation with the Health Authorities. Implementation of the continuing care review recommendations (summer 1999). There are ongoing Health Authority initiatives examining service delivery, utilization and integration of services.
ALTA.	In November 1997, Alberta established the **Long Term Care Review Advisory Committee** to address four priority issues: home care, drug strategies, accommodation policies and health-related support programs. ***Wellnet*** is developing new information systems to provide timely, accurate information on health - finding the best ways to use technology to link and share health information while protecting privacy. In June 1997, Alberta Health released ***Achieving Accountability in Alberta's Health System***. This document outlines an overall accountability framework for the health system. The **Continuing Care System Outcomes Development Project** is to provide a provincial minimum data set and performance measures for continuing care services. This information will be used to assess and classify clients according to their needs, to plan services and to evaluate performance. The Comprehensive Home Option of Integrated Care for the Elderly **(CHOICE)** Program is a program for seniors who may be otherwise eligible for admission to a continuing care centre or who are frequently admitted to hospital, but who choose to live in their own home. The CHOICE Program offers a coordinated approach to health services and manages all the health requirements an eligible senior may have.
SASK.	The **Saskatchewan Client Information Profile (SCIP)** is a new assessment tool that provides more information, particularly concerning behavioural and emotional needs, and the degree of informal support. **Minimum Data Set/Resource Utilization Groups (MDS RUGS)** is being piloted to determine the level of care of residents in long-term care facilities, care planning needs and staffing needs in special care homes. This tool will be linked with SCIP. Saskatchewan Health is working with Saskatchewan Municipal Affairs, Culture and Housing to encourage collaboration between housing authorities and DHBs to develop creative social housing options. In some districts, transition beds exist in facilities to provide home care services to people who have been discharged from hospital but are not yet able to return home. The **Saskatchewan Health Information Network (SHIN)** is being designed to provide an integrated health information system. The **Health Services Utilization Commission** has completed a study on the cost-effectiveness of home care for individuals with acute care needs.

MAN.	Development and publication of a new client/public brochure entitled *Your Guide to the Manitoba Home Care Program.* An automated screening, assessment and care planning tool (**SACPAT**) has been developed and planning is in process for its implementation across Manitoba during 1999-2000. A **Supportive Housing Initiative** has been developed to provide additional community living options for people who otherwise would require Personal Care Home placement. There are currently four projects that have been approved.
ONT.	A new **Personal Support Worker Program** curriculum for the training of workers providing personal care and support to people living at home and in long-term care facilities has been implemented and available through community colleges and private vocational training facilities since the fall of 1997.
QUE.	Release of a revised information system of client and service data (***Système d'information - clientèle - CLSC***) software for the management of home care services (SISMAD) is expected in 2000. Quebec is in the process of revising its client evaluation tool that will integrate into one the tools presently being used to assess long-term care and home care clients. The development of **"social economy"** not-for-profit enterprises in domestic care support (6000 employees projected) with 75 such organizations operational at the end of 1998. They serve mostly non-priorized home care clients, usually the elderly. **SIPA** (a system of integrated care for the frail elderly) is a community-based primary care system based on a patient-focused model designed to meet the needs of the frail elderly and to assure comprehensive care, integration of all available services and continuity of care by all professionals and institutions involved. It is responsible for primary and secondary medical and social services, prevention, rehabilitation, medication, technical aids and long-term care. Integrated Palliative Care Pilot Project (5 CLSC and CHU McGill) Integrated Services for elderly in the region of Bois Francs (sub-regional case - management for CLSCs, residential care, hospitals, community resources)
N.B.	Development of provincial home care standards for the EMP and for FCSS residential services. The Provincial Long-Term Care Program, in partnership with Family and Community Social Services and Mental Health Services, provides comprehensive long-term care services to residents 19 years of age or older. The implementation of the **Rehabilitation Services Plan** (RSP) has resulted in the amalgamation of rehabilitation resources from Nursing Home Services, Family and Community Social Services, the Department of Education and the Extra-Mural Program into Community Rehabilitation Pools. Work began in February 1998 on a plan to implement the automated client charting system province-wide beginning in fiscal year 1998-99. This system forms part of a larger database of information and can be accessed by any of the three service delivery partners (i.e. EMP, Long Term Care/FCSS, and Rehabilitation Services. New Brunswick is currently testing three aspects of the Single Assessor Model: screening, assessment and automated format. An **Evaluation Framework** is being developed for the Extra-Mural Program.

N.S.	Home Care Nova Scotia is involved in the collaborative effort between Nova Scotia and Prince Edward Island to undertake a demonstration project addressing palliative services in rural settings and is improving services to palliative clients of the program. The program is an active participant in "care for the caregiver" projects being implemented in two of the province's health regions. Home Care Nova Scotia is working with the mental health sector to ensure existing home care services will be delivered to mental health clients in a safe and suitable way. Home Care is circulating, for discussion, a third edition of its "Standards for Quality Services." Standards are presented under the categories of Governance and Accountability, Provision of Care to Clients and Support Services. These bring the program closer to meeting the CCHSA accreditation standards. Updated standards and curriculum for home support worker training, developed collaboratively with providers and representative associations, will be implemented in January 1999. A **Provincial Risk Management Strategy** is under development to address and minimize the risks involved with delivering care in the home. The functions and tasks for service providers have been revised, in collaboration with providers and associations, to foster appropriate assignment of functions.
P.E.I.	All five regions are participating in the development of a *hospital-to-home protocol*, including strategy and funding to address the continuing demand for home care support to support hospital discharge planning and follow-up care. A **Provincial Geriatrician Position** has been newly developed. This position is being shared with Veterans' Affairs Canada (20%) and is a resource to seniors' services, home care and continuing care across regional and provincial services and programs. The home care component of the Prince Edward Island **System Evaluation Project** will be completed during 1998/99. It is evaluating care to those over 75 years of age, to look at services, integration and outcomes, as well as validating the **Continuing Care Screening Tool.**
NFLD.	The introduction of a Client and Referral Management Information System. Review of the standardized assessment instrument and minimum data set. Research project on the future delivery of long-term care services in St. John's and replication in all regions of the province. Integration of the Department of Health with components of the former Department of Social Services to make the Department of Health and Community Services.
Y.T.	Since October 1998, home care is no longer actively involved in the pilot project of an integrated care management computer system. However, home care is continuing to work on increasing the integration of the continuum of care by working with the hospital, continuing care facilities and community services groups. Home IV therapy is now being piloted in Whitehorse (from Nov. 1998 to Dec. 1999). A review of community needs assessment for outlying communities is under way. Home care program is preparing for accreditation in the spring of 1999.

N.W.T.	An **Assessment and Placement Instrument** has been field-tested and is being adapted to assess client's needs objectively. A Care Reform Team is reviewing existing care facilities, programs and services to better meet the needs of all people requiring long-term care services and improving linkages among all services for people needing long-term care. Standards are being developed for home care programs to establish a mechanism for accountability and evaluation. A **single point of entry** is being developed for entry into the continuum of care. The home care coordinator's position has been designated as the public guardian representative in the regions.