INNOVATIONS IN BEST-PRACTICE MODELS OF CONTINUING CARE FOR SENIORS

Report prepared on behalf of the
Federal/Provincial/Territorial Committee (Seniors)
for the Ministers Responsible for Seniors

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Executive Summary

Introduction

In recent years, in part due to Canada's aging population, there has been a growing recognition across the country of the need to provide appropriate and affordable health care services for seniors. In addition, there has been an increasing emphasis placed on the provision of innovative health care services for the elderly.

For the purposes of this study, "continuing care" represents the whole system or continuum of services that address, over an indefinite and long-term period, the health, social and personal care needs of seniors. These services include facility-based care as well as community-based or home-based care delivered to individuals with demonstrated need. These services may be delivered for a short term or over a relatively long and indeterminate period.

The objectives of this study were to:

1. gather documentation on recent initiatives in community-based and facility-based continuing care for seniors in all provinces and territories

2. identify the features of best-practice models of continuing care

3. review information on recent initiatives to document the elements of best practice that have been adopted

Methodology

Information was gathered using a comprehensive five-page mailed questionnaire. This questionnaire was designed and administered for the purposes of collecting descriptive information regarding continuing care initiatives. It asked for a description of the program, its model, approach and any formal and informal evaluation that may have been done. Also, opinions on the key features which constitute a best-practice model were solicited. Approximately, 1,000 questionnaires were distributed to the different regions based on 1996 population data from Statistics Canada. Of the questionnaires mailed, 151 responses were received.

The report includes information only on agencies or programs who responded to the survey. The qualitative responses express the views of the respondents and do not necessarily reflect provincial or territorial policy or actual developments in a particular jurisdiction.

Features of Best-Practice Models

Six common features of best-practice models of continuing care identified by respondents are, in ranked order:

- **Consumer/Client Focus:** the degree to which the client's right to provide input into service planning is recognized and the extent to which services are relevant to the client's needs

- **Coordination and Integration**: the ability to provide uninterrupted, coordinated service across programs, practitioners, organizations and levels of service, over time

- **Efficiency and Flexibility**: achieving the desired results with the most cost-effective use of resources as well as the degree to which the program, service, or organization is capable and flexible

- **Program Assessment and Evaluation**: a measure of outcomes consisting of collecting information to inform decision-making and assess the effectiveness of strategies and programs

- **Education**: the level of staff competence and ensuring that the knowledge and skills of the service provider are appropriate to the service being provided for the delivery of quality care

- **Access**: the ability of the individual to obtain services at the right place and at the right time, based on respective needs

These features have been adopted or are in the process of being implemented by a majority of respondents. Other features were identified by a low number of respondents.

Evaluation

The report also includes an analysis of evaluation methods. Over half (62%) of respondents reported to have some method of assessment or evaluation in place. Three types of evaluation were identified:

- Client Satisfaction
- Overall Services Evaluation
- Efficiency and Effectiveness Measurement

Program Challenges

In the questionnaire, organizations were asked to identify the greatest difficulties and challenges facing their programs. Seven challenges identified by respondents are, in ranked order:

- **Resource Limitations** were identified including lack of funding, staff and other program resources. Over half of the respondents identified resource limitations as one of the major challenges facing program development and delivery.

- **Public Expectations** are often greater than the program is capable of meeting. Clients often have a very different perception of "entitlement" versus "need" which makes reductions in hours or program services difficult to implement.

- **Geographical factors** were most often identified by the rural programs as a challenge to program delivery. Weather conditions, large service delivery areas, and inadequate transportation options make the delivery of programs difficult and impede the cost-effectiveness of programs.

- **Lack of Understanding Regarding Continuing Care** can result in inadequate funding support and a small client base. A lack of public awareness regarding continuing care choices can make it difficult for some programs to attract a large client base.

- **Increased Complexity of Needs** and higher acuity levels were identified by questionnaire respondents as a challenge to program development and delivery requiring programs to be more complex and usually more costly.

- **Resistance to Change** is an added challenge in program delivery that must be addressed.

- **Political Environment and Provincial Control of Programs and Services** was identified as well. Programs and services are subject to the changes in health and social services budget pressures. Changes at the government level affect organizations and consequently, the clients.

This is the final report of the Identification of Innovative Best-Practice Models of Continuing Care for Seniors project. The information should be of assistance to planners, practitioners, researchers and policy makers regarding innovative best-practice models of continuing care for seniors. It is hoped that this report will aid seniors in achieving increased independence and a better quality of life.

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1.0 Introduction

1.1 Background

For the purposes of this study, “continuing care” represents the whole system or continuum of services that address, over an indefinite and long-term period, the health, social and personal care needs of seniors. These services include facility-based care as well as community-based or home-based care delivered to individuals with demonstrated need. These services may be delivered for a short term or over a relatively long and indeterminate period.

In recent years, because of Canada’s aging population, there has been a growing recognition across the country of the need to provide appropriate and affordable health care services for seniors. In addition, there has been an increasing emphasis placed on the provision of innovative health care services for the elderly.

The Canadian Home Care Association (CHCA) has been contracted by Health Canada to review initiatives in various models of continuing care for seniors across the country and to identify best-practice models for delivering high quality continuing care services for seniors in a cost-effective manner.

1.2 Objectives

The objectives of this report are threefold:

1. To gather documentation on recent initiatives in community-based and facility-based continuing care for seniors in all provinces and territories. These initiatives include new approaches to the delivery of health and social care, as well as initiatives that offer a multi-sectoral approach to support and care, addressing needs in the area of health care, social support, housing and transportation.

2. To identify the features of best-practice models of continuing care.

3. To review information on recent initiatives to document the elements of best practice that have been adopted.

The focus of the report is on models and programs of care rather than innovations regarding specific procedures. The report includes a description and contact information for the initiatives identified through the research as well as a description of the features of best-practice models of continuing care for seniors.

1.3 Methodology

A comprehensive five-page mailed questionnaire was designed and administered for the purposes of collecting descriptive information regarding continuing care initiatives (see Appendix I for a sample). It asked for a description of the program, its model, approach and any formal and informal evaluation that may have been done. Also, opinions on the key features which constitute a best-practice model were solicited. Where available, documentation was requested. The questionnaire was approved by the Federal/Provincial/Territorial Seniors Working Group on Continuing Care prior to being administered. Due to the nature of questionnaires, it should be stressed that the information included in this report is based on provider self-report, rather than a critical third party review.

The names of key contacts in continuing care were suggested by experts in all provinces and territories. These contacts include:

- Provincial and Territorial Ministries of Health and Social Services
- Home Care Programs
- Home Care Provider Agencies
- Long-Term Care Facilities and Nursing Homes
- Geriatric Centres

A list of respondents may be found in Appendix II.

The questionnaire was translated into French and the French version was sent to Quebec organizations. All other organizations were advised that the questionnaire was available in French.

The questionnaire was pre-tested, sampling fifteen organizations representing home care programs, regional health boards/authorities and long-term care facilities to ensure clarity of the questions. Follow-up calls were made to these organizations to determine any difficulties in understanding the questions as well as to predetermine the length of time required for questionnaire completion. Final minor revisions were made to the questionnaire based on this follow-up. The responses to the pre-test formed the basis of the first draft of this report. Roughly one-third of the pre-test questionnaires were returned, which was acceptable considering the length and complexity of the questionnaire. However, almost all organizations commented that they required significantly more time then was initially allotted to complete the questionnaire.

Following the pre-test, approximately 1,000 questionnaires were distributed by mail and fax. Distribution was split by regions based on 1996 population data from Statistics Canada. Table 1-1 shows the distribution of questionnaires mailed to the various regions.

Province/Territory	Provincial Population (thousands)	% of Canada's Population	Distribution of Questionnaires
Newfoundland	563.6	1.86	19
PEI	137.2	0.45	5
Nova Scotia	947.9	3.13	31
New Brunswick	762.0	2.52	25
Quebec	7, 419.9	24.40	244
Ontario	11, 407.7	37.67	377
Manitoba	1, 145.2	3.78	38
Saskatchewan	1, 023.5	3.38	34
Alberta	2, 847.0	9.40	94
British Columbia	3, 933.3	12.99	130
Yukon	31.6	0.10	1
NWT	67.5	0.22	2

Table 1-1: Distribution of Questionnaires by Population

In addition, assistance was received from New Brunswick to distribute additional questionnaires beyond the budget limitations. As well, further funding was received from Health Canada to collect additional responses. These responses have been added to this report. Of the questionnaires mailed, 151 responses were received. Roughly 15% of the questionnaires mailed were returned, which is understandable given the comprehensiveness of the survey and the length of time required for its completion.

Data is tabulated in this report using one of two presentation methods: when data is quoted as: "percentage of respondents" or "percentage of those surveyed", then it is the fraction out of the total number of surveys. When it is quoted as "percentage of responses" then it is the fraction out of the total number of responses. Due to multiple responses to some questions, the total number of responses may be much greater than the total number of surveys.

Also note that some of the respondents submitted more than one survey; these respondents are only listed once in Appendix II although the additional numbers are reflected in the tables.

The Federal/Provincial/Territorial Seniors Working Group on Continuing Care reviewed the first and second drafts of this document and their comments have been incorporated into this final report.

The report is intended to assist planners, practitioners, researchers and policy makers regarding innovative best-practice models for continuing care for seniors. It is hoped that this report will aid seniors in obtaining increased independence and a better quality of life.

The report includes information only on agencies or programs who responded to the survey. The qualitative responses express the views of the respondents and do not necessarily reflect provincial or territorial policy or actual developments in a particular jurisdiction.

1.4 Respondent Statistics

This section breaks down the distribution of the respondents to the questionnaire. Information has been tabulated on two criteria: provider type and regional representation. Further information on all the respondents may be found in Appendix I. Table 1-2 summarizes the distribution of respondents according to the type of provider.

Type of Provider	Number of Respondents
Regional Health Authority	38
Provincial/Territorial Ministries of Health and Social Services	7
Home Care Program	23
Home/Continuing Care and Facility Provider	83
Total	***151***

Table 1-2: Distribution of Questionnaire Respondents by Type of Provider

Table 1-3 summarizes the distribution of respondents over the various regions targeted in the questionnaire mailing (see Table 1-1 above). The table also breaks down the distribution between organizations which service primarily urban or primarily rural areas.

Region	Number of Respondents			
	Urban	Rural	Urban/Rural Mix	***Total***
Newfoundland	4	4		***8***
Prince Edward Island	1	1	1	***3***
Nova Scotia	7			***7***
New Brunswick	4	7	1	***12***
Quebec	9			***9***
Ontario	15	3		***18***
Manitoba	6	11		***17***
Saskatchewan	3	3	3	***9***
Alberta	22	7		***29***
British Columbia	32	4		***36***
Yukon	1			***1***
Northwest Territories		2		***2***

Table 1-3: Regional Distribution of Questionnaire Respondents

When classifying the respondents according to their regional distribution, the geographical area of the respondent was also examined. If the program served predominantly a rural or urban area, it was classified accordingly. However, as the provincial Ministries of Health and Social services for PEI, New Brunswick, and Saskatchewan provide services to the entire province, they could not be classified as primarily urban or rural but were instead classified as a mix of both geographical areas.

Note that respondents from both British Columbia, Alberta and Ontario were predominantly urban based. Manitoba, on the other hand, is more strongly represented by rural regions.

2.0 Best-Practice Models: Key Features

This section summarizes the key features that were identified by the questionnaire respondents. The questionnaire was structured so as not to guide the respondents with prompted responses. Instead, the questions were open-ended and responses were in their own words. Wherever possible, in this and in following sections, the respondent's wording has been maintained in the text of the report.

Common themes emerged across the questionnaires and these have been grouped into the key features included below. The degree of implementation of these concepts varied by organization and by resources available. A section has also been provided that summarizes the distribution of features identified by provider type, by per capita budget, by region, and by geographical area.

2.1 Consumer/Client Focus

The best-practice feature of Consumer/Client Focus is defined as the degree to which the client's right to provide input into service planning is recognized and the extent to which services are relevant to the client's needs. The goals and objectives for a client should include both his/her desired outcomes as well as those of the professional.

This was stressed as the single-most significant best-practice feature with 60% of respondents identifying consumer/client focus as a best-practice feature of continuing care services.

The respondents interpreted this feature as the requirement of the organization to respond to client needs and feedback. This may occur either through an individual's input into a care service plan, or by the implementation of entire new programs in response to community needs and demands. Without this focus, services may become outdated, redundant or ineffective. The incorporation of this feature results in more compliance and satisfaction on the part of the client and the family. Quality of care is usually enhanced by client involvement and empowerment. Furthermore, several organizations have stressed the need for culturally sensitive service provision and have also had to hire or train staff to acquire a sufficiently diverse linguistic background for the organization.

Implementing this feature requires some form of collecting and evaluating client feedback. This can range from casual feedback such as listening to unsolicited verbal comments to more structured methods such as formal questionnaires, quantitative evaluations, and focus groups. To be effective, the evaluation program must be ongoing and the organization must be flexible enough to respond to changes. More information on program evaluation is included in section 3.0.

2.2 Coordination and Integration

Coordination and integration is defined as the ability to provide uninterrupted, coordinated service across programs, practitioners, organizations and levels of care, over time. Of the respondents 26% identified coordination and integration as a best-practice feature.

Some organizations have adopted this feature by increasing the number of "in-house" services they provide. Most, however, prefer to specialize in an area and establish links to other professionals for care that falls outside their capabilities. This may also allow for cost-sharing between the disciplines in some cases. This feature is often measured by the reduction of duplication among organizations and the degree of coordination of services with other health organizations. If one organization is incapable of providing all services, it may make transdisciplinary or multisectoral alliances to ensure seamless provision of services.
Coordination and integration allow services to be more consistent across regions and require good communication between the different levels and disciplines of the health care sector.

2.3 Efficiency and Flexibility

Efficiency and flexibility were identified as a key feature of a best-practice model by 21% of respondents. These respondents interpreted efficiency as a quantitative measurement of cost against various performance indicators. Ongoing monitoring of these indices allowed for program planning, adjustments, and improvements. Some organizations did not use a specific index but instead implemented a streamlined administration, such as a single management system.

Efficiency is defined as achieving the desired results with the most cost-effective use of resources. It also involves the degree to which the program, service, or organization is capable and flexible. In general terms, this is the overall goal of a best-practice model.

Flexibility in the organization was also stressed, and was taken to be the ability to respond to changing client demographics and needs; changing government policy and funding; and changes in the health care sector. The system implemented has to be capable of responding to new program demands or requirements in a timely fashion.

2.4 Program Assessment and Evaluation

Program assessment and evaluation is defined as a measure of outcomes against stated objectives. This consists of collecting information to inform decision-making and assess the effectiveness of strategies and programs. After the data is collected, it must be analyzed and assessed to be put into an useful format.

Program assessment and evaluation were identified by 19% of respondents as a best-practice feature and were interpreted in two ways by the respondents. Some respondents interpreted

program assessment as the means through which consistent indicators for service, support, risk and placement are achieved. Program assessment ensures that there is an appropriate determination of need and that the services which are provided are most suited to those needs. The majority of respondents, however, defined this feature in terms of the measurement of outcomes relative to the resources consumed in order to make the best use of resources. Respondents also stated that the overall program and the services provided should be regularly evaluated.

Assessment methods vary according to the resources available from very casual and sporadic to highly quantified and formalized procedures. The most effective processes are usually found when evaluations are formalized and scheduled. Some areas that are included in the evaluation and program assessment are the services provided; client satisfaction; program efficacy; and skills and abilities of staff. Program assessment and evaluation were seen to be important to ensure consistency and quality of services.

2.5 Education

Education is defined as the level of staff competence and ensuring that the knowledge and skills of the service provider are appropriate to the service being provided for the delivery of quality care.

Education was identified by 11% of respondents as a best-practice feature. In addition to the required skill level of providers, respondents included the necessary provision of ongoing education and support by supervisors as integral to the best-practice feature. Staff competence also assists in the avoidance of risks.

In addition to ensuring that the staff is competent, there are additional aspects that may require training such as language and cultural skills; ensuring providers are familiar with the goals and services offered by the program; and ensuring that the public is aware of the range of services offered by the organization.

2.6 Access

Access is defined as the ability of the individual to obtain services at the right place and at the right time, based on respective needs.

Access was identified by 11% of respondents as a best-practice feature. Respondents felt that this feature requires complete accessibility of services and, specifically, single-point entry to the services provided by the organization. Single-point entry is, in effect, “one-stop shopping” to the services provided by the organization. It was identified as important in coordinating the efficient and effective utilization of services and also for pre-screening cases. Efficiency is improved by eliminating duplication and unnecessary care. Note that single-point entry does not imply *single-method* entry: there may be a variety of ways to enter the system, but they are all managed through

a single conduit. Other comments included the need to provide services at the right time and place. Therefore, this feature includes timely access to services and the portability of some services. Further, access to services should be based on identified need and the potential for a positive outcome. Access to services must provide for a comprehensive range of services that are coordinated and are allocated based on consistent criteria.

2.7 Other Identified Best-Practice Features

A very low number of respondents identified the following additional best-practice features:

- *Communication:* It is important that effective communication exist between providers and recipients, between government and the private sector, and within organizations.

- *Respite for Caregivers*: Without funding for respite, family caregivers burn out and clients are placed in higher cost facilities. If the client is to be cared for at home, it is essential to provide structured respite for caregivers.

- *Consistency*: Organizations must be consistent in terms of application of policies as well as in the provision of care.

- *Information Management System:* Such a system is necessary to assist with the management of clients and resources.

- *Level of Care Classification*: Having a consistent care level classification allows for the comparison of clients across service delivery components, by level of care.

- *Case Management*: Case management ensures that there is regular monitoring and review of client needs and that, as needs change, care plans are adjusted to ensure that there is a continuing match between the needs of the client and the care provided.

- *Marketplace Competition*: Respondents felt that a certain amount of marketplace competition ensures the best quality of service at the best price. However, respondents felt that this competition should be kept to a minimum.

- *Research-Based Programs:* Programs and projects should be research and evidence based. Prior to a program's implementation, research should be conducted to examine activities in other communities and other methods of service delivery. The choices made by professional practitioners in continuing care must be based on research-based principles.

- *Equity:* Resources must be distributed fairly among the community and among the program's clients.

- *Innovation:* As resources become increasingly limited in the face of rising demands, continuing care programs need to be increasingly innovative in their methods of service delivery.

- "*De-institutionalization" of facilities:* Long-term care providers must work to counter the perception of institutional living: a sterile cold environment where residents have no choices, freedoms, liberties or enjoyment of life. Institutions should be made more "home-like".

2.8 Summary of Responses

Table 2-1 shows the distribution of key features as identified by type of provider.
Most respondents identified only those best-practice features that had already been implemented as part of their program.

Key Feature	**Provider Type**				
	Regional Health Authority	Provincial/Territorial Ministries of Health and Social Services	Home Care Program	Home/ Continuing Care and Facility Provider	***Total***
Consumer/ Client Focus	21 (40%)	5 (28%)	12 (41%)	52 (42%)	***90***
Coordination/ Integration	9 (17%)	4 (22%)	8 (28%)	19 (15%)	***40***
Efficiency/ Flexibility	8 (15%)	1 (6%)	3 (10%)	20 (16%)	***32***
Assessment/ Evaluation	9 (17%)	2 (11%)	4 (14%)	13 (11%)	***28***
Education	2 (4%)	2 (11%)		12 (8%)	***16***
Access	3 (6%)	4 (22%)	2 (7%)	7 (6%)	***16***
Total	***52*** (100%)	***18*** (100%)	***29*** (100%)	***123*** (100%)	***222***

Table 2-1: Key Features by Provider Type

This table indicates that consumer/client focus is the most frequently identified best-practice feature by all types of providers. It is almost always followed by coordination/integration. Access was identified as a best-practice feature most often by the Provincial/Territorial Ministries of Health and Social Services.

Table 2-2 shows the distribution of key features by per capita budgets.

Key Feature	**Per Capita Budget**					
	$500-$1,000	$1,001-$2,500	$2,501-$5,000	$5,001-$10,000	$10,000+	***Total***
Consumer/ Client Focus	14 (45%)	8 (35%)	10 (34%)	5 (28%)	17 (41%)	***54***
Coordination/ Integration/	7 (23%)	4 (17%)	6 (21%)	2 (11%)	5 (12%)	***24***
Efficiency/ Flexibility	4 (13%)	4 (17%)	5 (17%)	4 (22%)	5 (12%)	***22***
Assessment/ Evaluation	4 (13%)	3 (13%)	4 (14%)	5 (28%)	7 (17%)	***23***
Education	1 (3%)	1 (4%)	1 (3%)	1 (6%)	5 (12%)	***9***
Access	1 (3%)	3 (13%)	3 (10%)	1 (6%)	2 (5%)	***10***
Total	***31*** (100%)	***23*** (100%)	***29*** (100%)	***18*** (100%)	***41*** (100%)	***142***

Table 2-2: Key Features by Per Capita Budget

Many of the respondents were unable to provide a per capita budget figure. This was partly due to insufficient data systems which prevented the separation of budget figures for the continuing care program from the total organizational operating budget.

Client and consumer focus was the most frequently identified best-practice feature across all budget ranges.

Education was only rated strongly as a best-practice feature by organizations in the upper budget range.

Table 2-3 shows the distribution of key features identified by region.

Region	**Key Feature**						
	Consumer/ Client Focus	Coordination/ Integration	Efficiency/ Flexibility	Assessment/ Evaluation	Education	Access	***Total***
NF	4 (21%)	5 (26%)	3 (16%)	5 (26%)	1 (5%)	1 (5%)	***19*** (100%)
PEI	2 (29%)	1 (14%)	1 (14%)	2 (29%)		1 (14%)	***7*** (100%)
NS	6 (50%)	3 (25%)	1 (8%)		2 (17%)		***12*** (100%)
NB	5 (29%)	1 (6%)	2 (12%)	3 (18%)	5 (29%)	1 (6%)	***17*** (100%)
QC	5 (63%)	3 (38%)					***8*** (100%)
ON	9 (32%)	6 (21%)	5 (18%)	4 (14%)	2 (7%)	2 (7%)	***28***(100%)
MB	11 (42%)	5 (19%)	5 (18%)	2 (8%)		3 (12%)	***26*** (100%)
SK	2 (50%)		1 (25%)			1 (25%)	***4*** (100%)
AB		7 (16%)	7 (16%)	5 (11%)	1 (2%)	3 (7%)	***44*** (100%)
BC	23 (46%)	7 (14%)	6 (12%)	7 (14%)	4 (8%)	3 (6%)	***50*** (100%)
YK	1 (33%)	1 (33%)			1 (33%)		***3*** (100%)
NWT	1 (25%)	1 (25%)	1 (25%)			1 (25%)	***4*** (100%)
Total	***90***	***40***	***32***	***28***	***16***	***16***	***222***

Table 2-3: Key Features by Region

While still scattered, it is apparent that client/consumer focus is considered the most significant factor in almost all regions.

The key features of coordination and integration and program assessment and evaluation were also highly ranked.

Table 2-4 shows the identification of key features by respondents according to the geographical area served.

Key Feature	Geographical Area			
	Urban	**Rural**	**Urban/Rural Mix**	***Total***
Consumer/Client Focus	62 (42%)	26 (40%)	2 (20%)	***90***
Coordination/Integration	27 (18%)	12 (18%)	1 (10%)	***40***
Efficiency/Flexibility	20 (14%)	11 (17%)	1 (10%)	***32***
Assessment/Evaluation	20 (14%)	6 (9%)	2 (20%)	***28***
Education	12 (8%)	3 (5%)	1 (10%)	***16***
Access	6 (4%)	7 (11%)	3 (30%)	***16***
Total	***147 (100%)***	***65 (100%)***	***10 (100%)***	***222***

Table 2-4: Key Features by Geographical Area

The best-practice features of client/consumer focus and coordination and integration were both seen to be important in roughly the same proportion in urban or rural settings. The urban/rural mix responses were more scattered.

The top two responses split with approximately the same ratio between urban and rural organizations.

Urban areas identified education as a best-practice feature more often than the rural areas. It may be that education is emphasized more in urban areas, as a significant proportion of the education recommended was cultural or language training.

3.0 Program Evaluation

As discussed previously, over half (62%) of the respondents reported to have some method of assessment or evaluation in place. These methods ranged from infrequent or very casual (i.e. waiting to hear a complaint from a client before acting) to detailed and quantitative evaluations (i.e. outcome measurement). The following sections examine these methods more closely. In general, three methods of evaluation were identified by respondents.

3.1 Client Satisfaction

Client satisfaction is perhaps the most valued measure. Of those respondents using an evaluation method, 84% measure client satisfaction. Some systems are very informal with client satisfaction measured by the number of complaints received over a given period. A large number of smaller organizations determine client satisfaction by "talking to the clients". More often, client satisfaction is measured through questionnaires. Some methods are more rigorous, encompassing random polling and focus groups. Some respondents attempt to gauge this with quantitative data such as the number of client transfers to other facilities or weighted formulas combining complaints, compliments and licensing non-compliance reports.

3.2 Overall Services Evaluation

Of those respondents using an evaluation method, 12% seek accreditation with provincially or nationally recognized bodies and agencies in order to obtain a third-party evaluation of programs. As part of the accreditation, some ongoing evaluation may also be required. Other organizations (26%) stated that they have implemented a quality improvement program and use this formalized structure to monitor the effectiveness of their programs. Several respondents (52%) use yearly program reviews and evaluations, occasionally combined with internal or external audits, in their evaluation process. These reviews also determine whether the programs and services meet all currently applicable licensing, quality assurance and accreditation standards.

3.3 Efficiency and Effectiveness Measurement

Efficiency and effectiveness usually require some quantitative measures of performance which are most often derived from some type of cost per unit of service formula that has significance to the area of operation of the organization. The four most common measures identified were chart audits (18%), readmission to hospitals (16%), length of stay (15%) and admission to long-term or acute care facilities (14%). Other measures reported were costs per patient day, staff-to-client ratios, and the number of problems (eg. number of issues raised in geriatric assessment). The measures of interest seem to be dependent upon the focus of the organization. Not all organizations seek to quantify the effects of their programs, whereas some have a far more structured and regular system

for reporting these indices. Annual reviews and reporting are common methods (52%) for most of these measures.

3.4 Summary of Evaluation Methods

Table 3-1 shows the proportion of respondents who have evaluation procedures in place, broken down by region. Table 3-2 summarizes the proportion of organizations using evaluation methods by provider type.

Province or Territory	Percentage of Respondents Using an Evaluation Method
Newfoundland	2 (25%)
PEI	2 (67%)
Nova Scotia	4 (57%)
New Brunswick	4 (33%)
Quebec	3 (33%)
Ontario	13 (72%)
Manitoba	7 (41%)
Saskatchewan	4 (44%)
Alberta	22 (76%)
British Columbia	31 (86%)
Yukon	0 (0%)
NWT	1 (50%)
Total	***93*** (62%)

Table 3-1: Regional Distribution of Respondents Using an Evaluation Method

Type of Provider	Percentage of Organizations Using an Evaluation Method
Regional Health Authority	19 (50%)
Provincial/Territorial Ministries of Health and Social Services	4 (57%)
Home Care Program	13 (57%)
Home/Continuing Care and Facility Providers	57 (69%)
Total	***93*** (62%)

Table 3-2: Distribution of Organizations Using an Evaluation Method by Type of Provider

British Columbia, Alberta, PEI, and Ontario respondents have largely implemented formal evaluation methods. Home/Continuing Care and Facility Providers were the most likely to have implemented a formal evaluation program.

4.0 Program Challenges

In the questionnaire, respondents were asked to identify the greatest difficulties and challenges facing their programs. From the questionnaires received, seven challenges emerged as the most commonly identified.

4.1 Resource Limitations

More than half (62%) of the questionnaire respondents identified resource limitations as one of the major challenges facing program development and delivery.

Inadequate funding was the most common form of resource limitation identified. As a result of inadequate funding for continuing care services, a great deal of effort is expended by programs and organizations in fighting for current and future funds. Establishing and operating programs during health care cutbacks has been challenging in promoting the credibility and justifying the program's need. Limitations in terms of available staff to administer and deliver the program as well as shortages of other program resources ranging from medical equipment to office supplies were also cited as difficulties. Staff resources that are available are often stretched to the limit and many programs are forced to rely on volunteers who are not always available.

4.2 Public Expectations

Of the respondents, 21% identified public expectations as a program challenge.

Increased public awareness and increased consumer activism, most notably in the seniors' lobby and the demands by the disabled, are putting pressure on continuing care for increased service delivery and the delivery of more complex services. A number of the organizations identified public expectations as a challenge to program delivery. Often the public expects a level of service which the program is not capable of meeting. For organizations serving a diverse population, such as Scarborough Community Care Access Centre, they not only have to face large demands for service, but they must meet the demands of an extremely varied and multicultural population which adds increased service pressures on the program.

When program cutbacks or changes to traditional service delivery are implemented, programs often face consumer resistance. Clients often have a very different perception of "entitlement" versus "need" which makes reductions in hours or program services that much harder to implement. Community perception that the program is not doing enough, coupled with a lack of alternative programs in the community, is a challenge to many providers of continuing care services.

Not only are consumers demanding more services, but they are demanding more involvement in the planning and delivery of services. In turn, continuing care must also become more accountable to consumers.

4.3 Geography

Geography was identified as a program challenge by 20% of respondents.

Geographical factors were most often identified as a challenge to program delivery by the rural programs. Service delivery areas are often extremely large making the delivery of programs difficult, as well as impeding the cost effectiveness of the program. These large geographical areas can be very stressful to the workers who cover them. Weather conditions, poorly maintained roads and long travel times are very stressful to providers. Many providers who deliver services in remote areas often suffer from feelings of isolation and a lack of peer support. The large area for supervisors to cover often means that staff are not adequately supervised which increases the requirement for well-trained and educated staff. Such staff are often difficult to obtain in rural, remote areas particularly when pay rates remain low and thus can not act as an incentive to attract highly skilled workers to the rural program. As well, transportation, both for staff and for clients, is often a difficulty in the smaller communities.

4.4 Lack of Understanding of Continuing Care

Of the respondents surveyed, 19% felt that lack of understanding regarding continuing care constituted a program challenge.

There is a lack of understanding about what continuing care is on the part of Canadians and a lack of public awareness regarding continuing care choices. This lack of understanding is seen at the government level as well as at the program level. Many of the Community Care Access Centres (CCACs) in Ontario that responded felt that care in the community was undervalued. It is not understood and is thus very under funded. Further, it was felt that there is a lack of government support for the role of the CCACs whereas hospitals are still favored by both private and public funding sources.

Respondents felt that there is a lack of understanding regarding community services on the part of clients as well. For example, many seniors still seek nursing home placement prior to trying community-based options for care. Participation in programs is difficult as clients often have a preference towards accessing a program or service offered in a facility rather than in the community.

One respondent from the private sector went one step further and identified a lack of understanding of the private sector providers as a program challenge. This respondent felt that the private sector

was often perceived negatively in the area of health care. It was felt that the government and other funding sources had a preference for public providers rather than private providers of services.

4.5 Increased Complexity of Needs

The increased complexity of client care needs as well as the higher acuity levels of clients were identified by 19% of questionnaire respondents as a challenge to program development and delivery.

As clients require increasingly complex and more intense levels of care, the programs to meet those needs become more complex and also more costly. People are now being discharged from the hospital sooner which means that the care required is more complex, for a longer period of time and thus, is more costly to provide. As well, people are living longer with multiple chronic illnesses.

New and improved technology is having an impact on the role of continuing care by making increasingly complex care possible. The complexity of services now delivered by continuing care has implications for workers as well as for the growing cost and risks entailed. As increasingly complex tasks are undertaken, the required knowledge of the continuing care workers must also increase. This impacts not only the cost of continuing care but also the need to educate and provide educational training programs for workers.

4.6 Resistance to Change

Dealing with resistance to change was identified as a program challenge by 16% of the respondents. This resistance is felt both by clients as well as other organizations in the health care system. When the continuing care program is required to make a change, often as a result of one of the aforementioned challenges, the clients are often very resistant to what they see as a decrease in service or a change in the delivery model. Clients are also resistant to the implementation of program user fees. Consequently, the program or organization is often impeded from undertaking new and innovative approaches to service delivery.

In addition, many community programs are now being required to form partnerships with new, often powerful organizations and groups who have traditionally not viewed the continuing care sector as an equal partner. The lack of understanding about the nature of continuing care services in the community on the part of hospitals and other facilities makes the formation of partnerships very difficult. Facilities can be reluctant to give up control to the community care sector and resist the change of service focus from the facility to the community level.

4.7 Political Environment/Provincial Control of Programs and Services

The political environment in which continuing care operates is also a difficulty. Of the respondents, 13% felt that program delivery was made more difficult by this factor.

Changes made to government legislation and regulations are only in effect for as long as the initiating government stays in power. This impedes the ability of continuing care to become a fully functioning and integral part of the health system. As a result, the programs and services are subject to the fluctuations of health and social budget pressures. Changes at the government level affect the organizations and consequently, the clients. Many organizations felt that governments did not always consider the impact that their policies had on clients. This continuing process is often difficult to manage successfully.

The provincial control of continuing care was also identified as a challenge for program development and delivery. Some respondents from the private provider agencies in New Brunswick felt that the provincial control of home care has resulted in a preference for the provision of services by public providers. This preference is reflected in a lack of funding and lack of cooperation from funding sources.

In addition, regional managers of both continuing care and home care programs, who sometimes want to develop their programs in different ways, felt that trying to implement provincial programs through regional structures was frustrating. It is more difficult to respond to regional needs when programs are developed provincially. It is also more difficult to get consumer involvement other than from special interest groups.

4.8 Summary of Program Challenges

Table 4-1 below shows the program challenges identified by region. Percentages are based on the number of program challenges identified. Many respondents identified more than one program challenge.

Region	Program Challenge							
	Resources	Geography	Public Expectations	Understanding of Continuing Care	Complexity of Needs	Change	Political Environment	***Total***
NF	4 (29%)	1 (7%)	3 (21%)	2 (14%)	2 (14%)		2 (14%)	***14*** (100%)
PEI	3 (50%)	1 (17%)	1 (17%)		1 (17%)			***6*** (100%)
NS	4 (33%)	2 (18%)	1 (9%)	2 (18%)	1 (9%)		1 (9%)	***11*** (100%)
NB	7 (39%)	6 (33%)				2 (11%)	3 (17%)	***18*** (100%)
QC	6 (43%)	1 (7%)	3 (21%)	1 (7%)	2 (14%)		1 (7%)	***14*** (100%)
ON	14 (52%)	1 (4%)	3 (11%)	2 (7%)	3 (11%)	3 (11%)	1 (4%)	***27*** (100%)
MB	9 (39%)		4 (17%)	7 (30%)	1 (4%)	1 (4%)	1 (4%)	***23*** (100%)
SK	4 (29%)	3 (21%)	1 (7%)	2 (14%)		2 (14%)	2 (14%)	***14*** (100%)
AB	11 (21%)	8 (15%)	7 (13%)	10 (19%)	6 (12%)	9 (17%)	1 (2%)	***52*** (100%)
BC	30 (44%)	5 (7%)	7 (10%)	2 (3%)	12 (18%)	7 (10%)	5 (7%)	***68*** (100%)
YK	1 (50%)						1 (50%)	***2*** (100%)
NWT	1 (20%)	2 (40%)	1 (20%)				1 (20%)	***5*** (100%)
Total	***94***	***30***	***31***	***28***	***28***	***24***	***19***	***254***

Table 4-1: Program Challenges By Region

With the exception of the Northwest Territories, a lack of resources was identified most frequently as a program challenge faced by respondents. Respondents identified the lack of resources in terms of funding, qualified staff and infrastructure.

A number of the respondents from British Columbia operating continuing care programs, many of which are located within a hospital, identified physical inadequacies with the building as a challenge to the program's operation. A lack of resources prevented upgrades of the infrastructure or the movement of the program to a new environment.

Respondents from British Columbia also identified a lack of resources on the part of the client as a program challenge. As clients can often not afford to pay privately for a continuing care facility, they experience the "trauma of not having the choice of facility placement suitable to the individual."

Many of the Community Care Access Centres (CCACs) in Ontario also identified the lack of funding as a difficulty in terms of a lack of transfer of funds from the hospital to the community care envelope. These respondents felt that adequate funds have not been shifted completely to the community setting despite the restructuring and cutbacks to the facility setting which have occurred in Ontario. In addition, respondents reported that adequate funding has not been given to other community services in Ontario which would have helped to relieve the pressure on the CCACs. The problem has been further exacerbated by unanticipated costs which have occurred related to the creation of the CCACs. Resource allocation is not meeting shifting demands.

A number of the respondents from smaller programs, many of which can be found in New Brunswick and Manitoba, also felt that the long wait between proposal submittal and funding approval made program development and delivery very difficult.

New Brunswick, Saskatchewan, and Northwest Territories felt that geography was a major challenge. Interestingly, Manitoba, the region with the most rural respondents (who might be thought to be more affected by geography) did not mention this as a challenge.

Respondents in Manitoba, Alberta and Nova Scotia felt most often that a lack of understanding existed in regards to the nature of continuing care. One respondent from Alberta felt that the community does not see the continuing care unit as a place in which they would choose to live. This continuing care program is working hard at changing the program's image, de-institutionalizing the facility, and making it more "home-like".

The increased levels of client acuity and complexity of client needs was most often identified by respondents from PEI and British Columbia. Some respondents in British Columbia linked this difficulty to the challenge of the political environment of continuing care. Respondents felt that the long-term care criteria for admission in British Columbia emphasized an illness versus a wellness model. It was reported that admission to continuing care requires that clients in British Columbia have a chronic health illness. People are therefore not admitted in a proactive, health promotional approach and continuing care clients often have very complex health needs.

5.0 Recent Initiatives

A number of continuing care programs and services for seniors are the result of new, often innovative, initiatives. This section highlights some of the more unique programs and delivery models on a provincial/territorial basis. Contact information for these programs appears in Appendix II.

5.1 Alberta

Assisted Living - Frail Elderly
The Good Samaritan Society

The Assisted Living - Frail Elderly program was designed to provide a residential care replacement model for traditional, facility-based continuing care facilities. The Good Samaritan Society's Assisted Living Model is based on the Oregon Model developed by Karen Brown Wilson. Wilson's assisted living is based on the premise of "normalization" in environmental and social settings. The principles of choice, independence, privacy, dignity and individuality in a "homelike" environment drive the program's operations. Three concepts guide delivery of assisted living: shared responsibility, bounded choice, and managed risk.

Shared responsibility requires that the individual participates in determining care needs and how those needs should be met. Everyone involved in the support and care for the person, including the person himself, is responsible for realistically contributing to meeting the identified needs according to their own resources.

Bounded choice recognizes that individual wishes and wants may be beyond available resources, may not be in keeping with the social milieu of the community, or may place the individual or others at risk. Therefore, residents in assisted living are made aware of the expectations and resource limits to their new community before agreeing to move in.

Managed risk recognizes the individual's right to live at risk and the importance of negotiation. A managed risk agreement is discussed and completed when the individual's behavior or choices are considered not to be in his best interests or when someone else may be harmed because of them. The intent of the managed risk agreement is to determine if there is a risk, the degree of the risk, and to whom, and then to modify the behavior or the context of the situation in the least restrictive means possible.

The program has proved to be very successful in translating principles and philosophy into a physical structure and program delivery as well as in the development of a Canadian program from an American model.

Carewest Day Hospital Program
Carewest Day Hospital

The Carewest Day Hospital provides a unique service in the Capital Region Health Authority. As an integral link in the continuum of care, the Day Hospital serves older adults living in private dwellings, group homes or lodges. The Day Hospital's mandate is to provide short-term, comprehensive assessment, and rehabilitation and treatment services by an interdisciplinary team.

The goal of the program is to improve client functional ability and level of independence and to support caregivers through counseling, education and access to resource information. Every attempt is made by the Day Hospital to ensure that supportive links are established to ongoing community services prior to discharge. When gaps in service or lack of services for clients are noted, the Day Hospital works to either stimulate development of the needed service or develops the service.

Carewest Regional Seating Services Program
Carewest Regional Seating Services

This program provides specialized wheelchair seating assessments and fabrication of components where required. The program is based on the belief that appropriate seating can promote quality of life by enabling optimal independence, skin integrity, respiratory efficiency, and comfort. The program uses a team approach with clients therapists, technologists, vendors, the care provider and the family all involved in the decision making about the seating system. Services are provided to those over the age of 18 with a physical disability requiring a specialized seating system.

Capable Seniors
Carewest Planning Centre

Serving seniors who have chronic diseases and/or disabilities but are not cognitively impaired, this program recognizes the individuality and competencies of clients. The program provides ongoing continuing care, housing and hospitality to seniors whose needs can not be met in their existing location. Services include both personal care and professional services. The program has been successful in increasing input from both residents and families and has led to the development of a "care team" concept and model.

Companion Care
Carewest

The goal of Companion Care is to provide alternate options to living in a traditional, institutional care centre. The program was developed to provide a care option for individuals who are no longer able to remain independent in the community even with good utilization of available service. Persons in this situation who do not require high levels of professional service or supervision have the opportunity as Companion Care clients to live in family-type environments in private homes. Companion care homes are operated by individuals who will serve as primary care providers providing 24 hour a day physical, emotional, and social support.

The program increases the range of choices available to continuing care consumers. The care options it provides are more flexible and focus on promoting client independence, autonomy and life-satisfaction at a cost that is significantly below that of institutional care.

Companion Care has been designed to:

- provide a program that is more flexible and responsive in appropriately matching care consumers and care providers in the areas of values, expectations, interests, needs and capabilities
- provide a quality service that:
  - supports care consumer independence and autonomy
  - enhances care consumer well-being, self-esteem and life-satisfaction; and
  - protects care consumer safety, security and privacy
- promote more efficient, effective use of existing acute and continuing care facilities and community support services
- reduces the demand for government supported continuing care facilities
- providing these services at a public cost that is less than institutional continuing care.

Companion Care recognizes and seeks to strengthen the rights and abilities of continuing care consumers to exercise their autonomy and independence to the highest level of which they are capable. It acknowledges their right to access care, environments and services that:

- enhance their well-being, self-esteem and life-satisfaction
- enable them to make informed choices and accept the associated risks
- protect their safety, security, and privacy; and
- are based on a commitment to quality teamwork, open communication and personal and professional integrity and accountability.

These program principles, philosophy, goals, and strategies form the basis of the Program Logic Model which guides the Companion Care program. The program has received very positive client satisfaction ratings and has been seen to be a good alternative choice for those who are able to participate in this option.

Continuing Care Counsellor Program
Red Deer Community Health Centre

Implemented in 1996, the Continuing Care Counsellor works in both the facility and community settings to provide counseling services to clients and/or families and caregivers in the continuing care system, using a collaborative approach with members of the health team. Areas of responsibility include client interventions, communication and liaison, and evaluation. The Continuing Care Counsellor has been found to be extremely effective in dealing with client/family related issues and is an effective part of the care team. The Counsellor has also been very effective in reducing the workloads of other care team staff (i.e. home care case coordinators, long-term care staff) by dealing with difficult family/client issues.

Fall Prevention Program
Mistahia Health Region

The Fall Prevention Program is a short term initiative by Mistahia Health Region. Operating until March 31, 1998, the program was initiated in October, 1997 to increase the knowledge and strength base of seniors regarding ways to prevent falls. The client base has been small, but enthusiastic and the program has had success in focussing attention on the importance of prevention.

Holistic Model of Care
Beverly Centre for Long Term Care, Father Lacombe Adult Day Support Program

Both of these organizations use a holistic model of care which provides compassionate and holistic care focusing on the quality of life as defined by the client. This model views the client as having rights, responsibilities, and, above all, choices. Both organizations emphasize the independence of the client and care plans are determined based on the perceived needs of the client. Focus is also placed on the caregiver.

Maximum Access
Cold Lake Health Centre

Maximum Access is part of a demonstration project with Alberta Health, New Horizons and the Federal Government. The purpose of the program has been to increase access to services and programs for seniors by choices. Using a social model of care, rather than a medical model, the program is aimed at allowing seniors to identify their own service needs as opposed to the health care provider defining the senior's needs.

Native Heritage/Enrichment
Rosefield Centre

The Native Heritage/Enrichment program is aimed at allowing aboriginal medicinal treatments/customs within the long-term care setting. All aboriginal seniors whose condition warranted admission into the facility for twenty-four hour care are eligible to participate in the program. Services provided include medicine man visits, sweet grass ceremonies, cultural cuisine, cultural decor and an annual pow-wow. The program is based on the philosophy that healing occurs in an environment that accepts and supports an individual's culture and belief systems, allowing inner peace and holistic health.

The program has resulted in greater cohesiveness within the entire community and between the cultures. The residents are happier in their surroundings and native elders have felt honoured by the opportunity to teach staff members their culture.

Provost Alternate Housing Project.
East Central Regional Health Authority 7

This project is based on a pilot project initiated in 1996 to explore alternative housing options to meet needs of clients with lighter care requirements who could no longer be accommodated in the decreasing numbers of long-term care beds. The proposal for the Alternate Housing Pilot Project was based on the belief that the client must be free to exercise independence of choice and decision making in the delivery of his/her health services and housing needs. The client's health requirements and housing choices should be met in such a way as to reflect the individualized needs and to allow for responsible, negotiated risk-taking, as well as promoting the privacy and dignity of the individual. Services are delivered within a group living environment, utilizing other community programs to enhance quality of life and health status as well as maintaining and promoting client independence.

Independence and choice are emphasized. Clients, who are able, are encouraged to make their own beds and help out in the kitchen. Services are planned with the client and the family and when, where, and how they are delivered is discussed and agreed upon. Clients participate in recreation activities when they choose and are not pressured to do so if they decline. Meals are offered with some flexibility and nursing visits and treatments are arranged based on the client's preference.

Both clients and families are very satisfied with the services received and with their opportunity for input and choice. The project was successful in contributing to the downsizing of long-term care beds and in the overall reduction of costs in the health care system. Although the number of clients involved in the project to date are small, there are indicators of reduced reliance on institutional living; delay or prevention of institutional placement; facilitation of discharge from hospital; and assessment and referral to other community resources as a result of the program.

Self Care Model
Population Health, East Central Regional Health Authority 7

The Seniors Wellness Program is a new program which was implemented in May, 1997. This program is aimed at strengthening the community and improving the well being of seniors. The strategy behind the program was to shift from a medical model which emphasizes "care of seniors" to a self care model which encourages seniors to take control. Consequently, the seniors are developing some innovative ways to address needs identified by their own community including a safety program for seniors and a community kitchen.

Short Term Assessment and Rehabilitation (S.T.A.R.) Program
Peace Health Region

The S.T.A.R. program was developed in 1996 to provide a comprehensive interdisciplinary assessment, and rehabilitation services in a continuing care setting for those individuals who no longer require acute care services or permanent continuing care residency, but have short term needs that exceed existing resources available through the Home Care program. The program focuses on individuals who require convalescence from surgery or acute illness such as cardiac rehabilitation or orthopaedic rehabilitation. It is also inclusive of individuals in an emotional, financial or housing crisis. However, the program is available only to individuals aged 18 or older.

The program is intended to serve those individuals who are "almost home" and is based on the model of:

- increasing time to provide a comprehensive and individual-centred assessment using an interdisciplinary approach
- identification and utilization of resources to meet an individual's needs while in the program
- promoting the effective and efficient use of acute and long-term care facility resources
- enabling individuals and families to make informed choices which promote quality of life
- managing services effectively and demonstrating accountability for the use of public funds

The program has proved successful both in terms of client satisfaction, but also in terms of improved collaborative relationships and communication with other health disciplines involved in the program. Marked cost savings have also been noted.

Social Care Model - Cognitive Support Unit
Extendicare, St. Paul

Established within Westview Home, the Cognitive Support Unit provides an enhanced therapeutic milieu for seniors in the facility with cognitive impairment. Implemented in 1996, this program is based upon a social model of care and incorporates the philosophy that elderly, cognitively impaired clients function best in a smaller, unstructured environment with individuals with similar needs. The strategies and approach of the program are focussed on de-emphasizing structure and providing an atmosphere of free-flowing activities. Emphasis is placed on tasks in which the resident is both interested and capable of participating. Although the program did not make any significant differences in the cognitive status of clients, staff have reported a decrease in aggressive episodes between residents and towards staff, longer attention spans and less anxiety on the part of clients, as well as improvements in overall client satisfaction levels.

Supportive Pathways Program
Carewest

This program is aimed at providing a client-centred approach to dementia care that includes adapted living environments, focussed education for staff, and ongoing support for families. Ongoing long-term services for clients with Alzheimer's disease and other related dementias are provided. Although the program managers have found it difficult to find good care models from which to work, the program has been moving from a medical model to a more social model. As well, both staff and family have reported satisfaction with the program.

Transitional Care
Allen Gray Continuing Care Centre

The transitional care program is designed to provide services to clients in the community who require more services than Home Care can provide, but do not require acute care admission. The target population for this program are the frail elderly with chronic conditions in acute exacerbation such as Parkinson's Disease, diabetes, pneumonia and those requiring wound management.

The Transitional Care program is a demonstration project which focuses on the provision of services to seniors in a home-like atmosphere allowing them to recuperate and return to living in the community. The majority of clients have expressed satisfaction with this program. The program has also been successful in terms of cost avoidance as the provision of 24 hour care to deal with the seniors' health crises has proven to be more cost-effective than admission to a higher cost acute care bed.

Wedman Village Homes
The Good Samaritan Society

The purpose of Wedman Village Homes is to provide residential continuing care services to individuals with Alzheimer's Disease or similar dementia as a replacement for facility-based continuing care. The approach to care is a social model; the major premise being that the more familiar the environment, the easier it is for someone with cognitive impairment to manage.

Wedman Village Homes was conceived as a non-institutional approach to Alzheimer's care. This residential care model "normalizes" the environment of individuals who have difficulty in interpreting their world. The principles of care at Wedman Village Homes build upon an individual's remaining life skills by encouraging them to perform familiar tasks in the home (eg. setting the table, doing laundry, etc.). The low stress, familiar environment of a house setting allows for a blend of privacy and socialization. The focus is on experiencing life as much as possible in the same manner as it had been experienced prior to the onset of the disease. The small environment and consistent staff allow the person to be "known" as an individual.

Care practices are tailored to the individual's skills and personality. Within the approach to care, activities are spontaneous and fitting the rhythm of a "normal" day. Assistance is given as needed; the approach individualized to the person's situation at the time. There are no structured therapeutic programs, but there are normal everyday and spontaneous activities supported by creative staff to help the people who live there stay engaged with themselves, each other, and the community around them. Trained staff pick up cues to problems and ask for help from experts across the organization as the need arises.

5.2 British Columbia

Adult Day Program
Rocky Mountain Lodge

This program provides an opportunity for adults and seniors to participate in a social, health-related program and provides respite to family caregivers. However, an additional goal of the Adult Day Program is to introduce seniors to facility life. It is thought that this introduction helps with an easier transition from home to facility placement should this move be planned for the future. Some of the programs and activities provided include social events, educational programs, trips, bingo, exercise, arts and crafts, family counseling, banking services, nutrition counseling, and medical arrangements.

The program has been successful at allowing the individual to choose the degree of care they receive while remaining independent in their own home.

Community Busy Bus
Pleasant View Housing Society

This program is intended to provide transportation options to seniors and the physically disabled for social recreation opportunities. The operation of this program has required a partnership model to establish relationships with various groups and agencies who require transportation and who can in turn assist with the operating costs.

Continuous Ambulatory Peritoneal Dialysis (CAPD)
Hawthorne Care Centre

This program was initiated in 1997 to provide facility placement for CAPD clients who are unable to return to their homes following hospitalization. The program's objectives are to reduce hospital bed utilization through earlier discharge, to enhance facility service utilization by broadening skills and education of R.N.s, to demonstrate positive client health outcomes by enabling the client to be maintained on his/her treatment of choice, and to provide alternative living arrangements to CAPD clients.

Although still in its early stages of development, the program has demonstrated significant cost savings.

Foot Care
Durend Manor

A foot care program was recently initiated at Durend Manor to address the foot care needs of seniors in the community. This program is based on the philosophy that prevention and health promotion are major components of health care. Programs resulting in positive changes in health habits play an essential role in enhancing functional health.

Grandfriends/Seniors Assisting and Guiding the Education of Students (S.A.G.E.S.)
Nelson & District Home Support

This program is intended to increase intergenerational program opportunities while providing an appropriate volunteer program for seniors through which they can share their talents in the community. Seniors work in seven different schools assisting students with school activities including reading, math, baking, and crafts. The project provides an opportunity for younger and older people to come together in a common bond of friendship.

Heritage Village
Fraser Valley Health Region

Heritage Village provides residential and professional nursing care for seniors. The Multilevel Care Facility Advisory Committee, formed as part of the planning process for Heritage Village, researched the reasons behind seniors' reluctance to be placed in a "nursing home". It was concluded that nursing homes were perceived as representing the worst aspects of institutional living and resulted in a loss of liberty, choices, freedom and enjoyment of life by residents. The vision of Heritage Village is that the resident is the centre of the healing circle and is thus the most important person in the facility. All residents' needs and choices are to be known and met by an empowered staff, to the extent that this is possible within resources. All care and services are resident-focussed and resident-directed. For those residents who can no longer speak for themselves, the family or significant other is asked to be the "voice" in planning care and activities. Values of respect, service, fun, cooperation, learning, integrity, and innovation are key.

The strategy undertaken by Heritage Village to achieve that philosophy began with a reevaluation of the traditional organizational chart. It was noted that the client/resident did not even appear on the chart but rather traditional organizational charts were headed by the Board and CEO who, in fact, are farthest from the resident. Heritage Village redesigned its organizational chart into a circle with the client at the centre and the Board in the outermost circle.

Dedicated teams were developed to work in specific "neighbourhoods" (units consisting of resident rooms, bathing rooms, a utility room, kitchen, dining and activity area, courtyards, and decks). Permanent lists of residents were assigned to providers to make the environment similar to a typical family structure. Consequently, residents and their families quickly get to know their care providers.

Implementation of Reviews and Outcome Indicators
Capital Health Region

Although the program offered by Capital Health Region is still developing, program reviews and outcome indicators are being implemented to improve efficiency and effectiveness. Standardized reviews of client satisfaction are also being developed. Currently, client and community input is gathered through questionnaires and feedback from clients and families, providers, and partner agencies. Methods of improving the functionality of the placement system are also being examined.

Implementation of an Information System
Continuing Care - Okanagan Similkameen Health Region

The Continuing Care Division (CCD) of Okanagan Similkameen Health Region has recently been able to work in partnership with the Kelowna General Hospital (KGH) to establish an integrated information system. Three MEDITECH terminals were installed allowing linkage with the hospital information system. Access to the MEDITECH system has allowed KGH staff to complete on-line referrals to CCD; has enabled CCD nurses to reduce the amount of time spent on hospital liaison tasks; has provided more timely and easier access to patient information; and has allowed e-mail access to all staff. CCD now has access to client information on-line. Referrals are also performed on-line. Movement is now being made towards having clinical charts on-line.

The implementation of this project has greatly enhanced the timeliness and accuracy of the client information being passed between the home and the hospital. This project has proven to be a successful, innovative effort to link up health service organizations.

Mobile Outreach to Caregivers
Trillium Lodge

The aim of this project is to support informal caregivers in the community. Ongoing services include counseling, home visits, a resource library, support groups and volunteer services. Episodic services provided include educational workshops, guest speakers, and an annual trade fair. The program has been very successful with caregivers in the area.

Seniors One-Stop Information and Referral Centre
Nelson and District Home Support

This centre was designed by seniors, for seniors, and is intended to assist seniors in remaining in their own homes with a variety of referral, information, and assistance services. Services include telephone and information referral, a handy person's registry, support group information, pension information, income tax clinics and podiatry clinics. The program has been a success in saving resources in the health care system by providing non-direct health care assistance and by acting as a single source of information.

Spiritual Model of Care
Tabor Home Society

The Intermediate Care Home offered by Tabor Home Society is unique in that it is very strongly based on a spiritual model of care. The program was driven by the needs of local Mennonite Brethren (although people of all faiths are now served) and is based on the recognition of God as the source of all life and hope. The program has been a success in that there have been many

quality of life successes wherein residents became happier, more active and embraced their faith to help them cope with life changes.

Therapeutic Activation Program
Senior's Therapeutic Activation Program

The purpose of this program is to provide a recreational focus program for senior clients with mental health problems. It is designed to facilitate the achievement of optimal improvement and maintenance of health well-being and personal independence by enhancing cognitive, social, emotional, and physical aspects of daily living.

The program has been successful in allowing clients to function at their maximum ability while providing freedom of choice for participation in programs in a very cost-effective manner.

Transitional Care
Northcrest Care Centre

This program was initiated in 1998 to provide a cost effective, short term alternative to acute care hospitalization that better meets the needs of the client target group. The program is aimed at seniors who are medically stable and no longer require acute care services but do need further short term care and intervention to regain function and return to their pre-hospital setting. The Transitional Care Unit (TCU) provides a multidisciplinary assessment and ongoing treatment for patients who meet admission criteria. These patients may be waiting placement or require longer term rehabilitation with a goal of returning home. The TCU is also expected to reduce readmission to acute care, to decrease the number of clients who are placed in Intermediate Care facilities or Extended Care beds because of premature assessment of their long term care needs, and to demonstrate an integrated model of care that involves the family physician, community and allied health care professionals in decision making and case management for the individuals who are referred to the TCU.

The program is based on a co-management model which ensures effective collaboration in the interest of optimal client care and ensures an efficient system which avoids duplication of roles or activities. Initial feedback indicates a high level of client satisfaction; however, the program is still quite new and will continue to be evaluated.

VISTA
Victoria Innovative Seniors Treatment Agency (VISTA)

VISTA is an innovative program for older adults experiencing day-to-day problems with the misuse of alcohol and/or prescription drugs and elder abuse issues. VISTA believes that physical, social, behavioral and spiritual factors interact in the experience of wellness. VISTA provides a senior

specific rehabilitation service delivered with dignity and respect through the maintenance of a holistic perspective, support of a variety of therapeutic methods, and a commitment to self-determination, personal responsibility, and confidentiality.

VISTA promotes wellness within a threefold service mandate:

Outreach - VISTA counsellors will visit clients at home to provide a comprehensive assessment of problems and strengths including elder abuse concerns and development of a personalized treatment plan which will include counseling, advocacy, information, problem solving and client specific support.

Residential Component - VISTA offers a limited residential component to complement the outreach service.

Community Development - VISTA counsellors provide consultative services, conduct educational workshops, and cooperate with prevention and self-help initiatives.

The length of both the outreach and residential components are determined by individual client needs.

Young and Elderly Sharing School Project
Slocan Community Hospital and Health Care Centre

Young and Elderly Sharing School Project is an intergenerational project. As part of this project a grade 5/6/7 class from a local elementary school attended regular school classes three days per week in the intermediate/extended care wing of the Slocan Community Hospital and Health Care Centre. The objectives of this project were:

- to encourage long-lasting, significant relationships between seniors and students by providing opportunities for the two groups to interact in meaningful ways;
- to link the school and health systems in a way that is beneficial to the people in both the systems;
- to impact positively on the residents' health by providing opportunities to participate in an empowering way through storytelling, assisting students with schoolwork, and by participating in any or all of the students' activities.

The major findings from this project were that the seniors and students became one community and valued each other for the difference each person made in each other's life.

5.3 Manitoba

Block Care
Parkland Regional Health Authority

The purpose of block care is better client care in conjunction with more efficient use of resources. The program is based on the approach that by grouping individuals requiring care, a greater number of people can be serviced with the same resource base. This method of care has been found to have greater efficiency in the deployment of the work force and greater cost savings. Clients benefit because the workers are in the area for a longer period of time than if they served only one individual and are therefore able to respond to needs as they arise. Service is also more flexible for individuals.

Continence Promotion Program
Riverview Health Centre

A new program initiated in 1998, the Continence Promotion Program is a two phase-project. Initially, the purpose of the project was to develop and implement a program, focusing on the promotion and management of urinary and fecal incontinence for all clients of Riverview Health Centre. The purpose of the second phase will be to extend continence promotion services to clients living throughout Winnipeg.

The specific objectives of the project include all of the following:

- to provide continence rehabilitative services to all inpatients and day hospital clients at Riverview Health Centre;
- to develop a continence resource library accessible to both the staff of Riverview Health Centre and the general public;
- to provide education on continence promotion and management to clients, families, health care professionals, and students;
- to conduct and support research initiatives regarding continence promotion and management;
- to develop a continence support group(s) for clients and families living with urinary and/or fecal incontinence.

This program meets the Centre's philosophy of patient focused care.

Night Respite Program
Riverview Health Centre

The Night Respite Program is to be initiated in April, 1998 to provide relief for caregivers living in the community whose family members have difficulty sleeping and/or require care during the night. The Night Respite Program will provide professional care for eight clients three nights per week between the hours of 8:00 pm to 8:00 am. The program offers all of the following services:

- initial assessment of the client
- assistance with limited personal care activities
- development of an individualized care plan in collaboration with each client, family, and Continuing Care Coordinator
- ongoing evaluation and monitoring of the client and care plan
- provision of an evening snack and light breakfast
- provision of quiet activities and socialization opportunities
- coordination of transportation to and from the program
- daily phone call reminders to each client and caregiver
- referral to other agencies and services as required
- family and primary caregiver support and referral
- intervention aimed at facilitating rest and sleep
- education for clients, family and the larger community
- dispensing medication for clients as required.

The program will continue to be evaluated through research to determine its effectiveness.

Supportive Housing
Lions Club of Winnipeg

Offered by the Lions Club of Winnipeg, Rimmer House is a new concept in supportive housing for seniors with early to middle stage Alzheimer Disease and other memory disorders. This twelve unit supportive housing option is the first demonstration project of Manitoba Health's Supportive Housing Services.

Rimmer House was developed in response to a number of needs in the community. Its purpose is to provide alternative housing for twelve individuals who were previously maintained in hospitals; or were living in the community at risk, in private residences with home care assistance; or were residents in inappropriate housing facilities with inappropriate or inadequate services.

The objective of this project is to create a viable community alternative to institutions and people's own homes in order to provide increased access to needed quality care services while encouraging greater participation and control in service provision, and ensuring respect for the individual in a stable, safe environment that promotes independence. Residents participate in meal service, laundry, cleaning and other homemaking skills, as well as in specialized programming that provides mental, physical, social, spiritual, music, and art activities.

Rimmer House is based on a social model rather than a medical model. Although cost savings are still being evaluated, successes have been noted in terms of high satisfaction from staff, families and clients, as well as providing more opportunity for clients to be as independent as possible.

5.4 New Brunswick

McAdam Outreach for Seniors
Wauklehegan Manor Inc.

McAdam Outreach for Seniors, originally known as Project Outreach, began as a seven month program designed to initiate and develop a program of services to assist area seniors and disabled adults to maintain themselves in their own homes as long and as safely as possible. The main goal of the program was to enlist and train a force of volunteers, under the direction of a paid coordinator, to carry out the various services. Built on a philosophy of community care and ongoing training, the program currently offers homemaker services, meals on wheels, wheels to meals, whirlpool baths, telephone reassurance, a Lifeline emergency response system, a Red Cross Equipment Loan Cupboard, foot care clinics and a nutrition program.

Positive Aging
Harvey Outreach for Seniors

Harvey Outreach for Seniors is a home support group which has been recognized for its innovative approach. Harvey Outreach focuses on “positive aging”--a philosophy which encourages seniors to look at what they can do as opposed to what they can not do. By focusing on activities to keep the frail elderly active, these seniors are able to stay in their own homes as independently and for as long as possible.

Harvey Outreach provides innovative services for seniors in a rural community, as well as a number of outlying communities. Harvey Outreach believes that loneliness is one of the biggest issues facing the senior population and one of the factors which inhibits seniors’ ability to “think young”. To combat this, Harvey Outreach has implemented the Wheels to Meals program. Seniors are taken to a central location in the community for a noon meal one day a week. Every other week, some form of entertainment or activity is planned after the meal. Harvey Outreach is working to develop innovative, cost effective programs to make the lives of seniors more active and independent.

Psychogeriatric Team
Fredericton Mental Health Centre

The aim of the psychogeriatric team is to address the mental health needs of seniors through counseling, education, therapy, further referral and other appropriate interventions. This program is unique in that it uses a team approach. The team leader (a part-time psychologist) does minimal management and case conferencing and acts as a liaison with the Mental Health Centre's Executive Director. For the most part, there is team collaboration on education, case assignments, intervention issues and priorities. Team building days are a new initiative being implemented as well. The team has also begun to use computers which are helping to manage the information better.

Staff Pay Incentives
Maritime Riley Home Care Inc.

Maritime Riley Home Care Inc. believes that the key to the successful provision of home care services rests with the competence of the staff providing the care. Consequently, Maritime Riley Home Care Inc. believes that challenging, motivating and rewarding employees is important. Not only is extensive staff education and training provided, but staff are also rewarded for performance and achievements. As a result, both staff and clients are satisfied.

5.5 Newfoundland

Continuing Care Service Coordination - Single Entry Model
Health and Community Services - Central, Eastern, St. John's and Western Regions. Health Labrador Corporation.

These organizations coordinate the continuing care services that they offer. Programs are organized under a single philosophy and assessment and placement process. This process provides for entry to a delineated range of services from a single coordinating point for assessment and placement in the continuing care system. The focus is placed on the needs of the client rather than on the needs of the service providers. Under this model, clients are placed in the appropriate service consistent with assessed needs and along the continuum of care using a standardized assessment. This process also emphasizes:

- the rights of individuals and their families to be responsible for their own decisions, to participate in their care plan and to accept or refuse any service
- the right of individuals receiving services to have their physical, psychosocial and spiritual needs considered when decisions are being made which will affect them directly or indirectly
- the right of individual agencies to ensure that the needs of an individual appropriately match the services and resources that can be made available through their agency

5.6 Northwest Territories

Senior Citizens' Home Repair Program
Department of Health and Social Services

This program is designed to assist senior citizens who own and occupy their home to repair and/or improve the condition of their present dwelling. The objective is to improve the living conditions of senior citizens so they can remain independent in their own homes as they age. The assistance comes in the form of a grant not exceeding $7,500.

Seniors' Independent Living Strategy
Department of Health and Social Services

This strategy was developed to assist seniors in accessing affordable housing. It recognizes that while housing shortages affect people of all ages, seniors, in particular, require special attention. This strategy enhances the commitment to support individuals staying in their own communities as they age and to promote the independence of seniors through the utilization of other support programs such as home care. Under this strategy, subsidized rental housing is constructed for senior citizens with the rent set at zero.

Seniors' 1 800 Information Line
Department of Health and Social Services

This line is intended to provide access for seniors to get information and have questions and concerns answered. The information line is intended to be a one-stop point for seniors, elders, families, care providers, and community workers to access information and obtain needed referrals. In the Northwest Territories, seniors are 60 years of age and over and elders are 50 years of age and older.

5.7 Nova Scotia

Alternative Living Programs
Cape Breton Community Housing Association

The mandate of the Cape Breton Community Housing Association is to provide quality, community based support and outreach programs for adult mental health services consumers in a non-institutional environment. There are two alternative living programs operated by Cape Breton Community Housing Association: 1) Supervised Apartments in which 1-2 residents share a home and 2) Small Options in which 3 residents share a home. Hours of supervision can range from 2 hours a day in a Supervised Apartment to 8 to 24 hours a day in a Small Option Home.

Community Outreach
Cape Breton Community Housing Association

Community outreach, which includes home care and a life skills program, is based on the belief that a continuum of care aids in the prevention of the “revolving door syndrome” from the community to a facility. Client-centred planning with outcome measurements is also conducted to achieve optimum levels of independence. Each resident has an individual plan of care developed to meet his or her needs in the rehabilitation process.

Development of Standards
Shannex Health Care Management

One of the major recent initiatives undertaken by Shannex Health Care Management has been the development of standards including the first complete set of Shannex Manuals to guide the work processes. Many of the programs participated in national accreditation with the Canadian Council on Health Services Accreditation (CCHSA). As well, Shannex redesigned its performance appraisal process with a focus on performance evaluation based on CCHSA standards and behaviourial aspects of the job.

Eden Alternative
Scotia Nursing Homes Ltd.

The aim of this program is to promote a quality environment for clients and continuing education for staff in a more client-focused facility. Eden Alternatives strives for a more home-like atmosphere through pet therapy programs, horticultural therapy, the promotion of personalized living space, as well as promoting and maintaining interaction among the client, staff, family, and community. The promotion of spiritual well-being is also a large component of this program.

Group Homes
Cape Breton Community Housing Association

The aim of these homes is to provide a home environment for adults living with chronic mental illness. By living in a group home, independent living and community integration are encouraged. Ongoing care is provided in the areas of physical and mental health, supervision of medications, social and spiritual well being, community integration, daily living skills development, independence, counseling, encouragement, and support. The group homes are licensed to provide services for up to nine residents in a caring learning environment and are staffed on a 24 hour basis.

Medication Assistance Program
Northwood Homecare

In 1996, Northwood Homecare developed a Medication Assistance program in response to the reduction in the hours of professional-level home care covered by the provincial plan. This reduction left many seniors to administer their own medication. Northwood Homecare now contracts the Northwood pharmacy to dispense client medication in weekly batches of clearly labeled bubble packs that guide the person through their medication administration hour by hour, day by day. This program costs the client and the system much less than daily in-home nursing assistance.

Sheltered Workshop
Skyline Enterprises

The Sheltered Workshop program is designed to provide meaningful employment for physically and mentally challenged adults of all ages who are residents of the Adult Residential Centre. The program includes classes in ceramics, knitting, and other crafts, as well as the operation of a thrift shop and craft store which sells the products produced by the program participants. The program concentrates on being client centred and on promoting independence and choices.

Staff Training Programs
Northwood Homecare

Northwood Homecare has developed a certificate home support worker course for all its employees to ensure that it meets the growing need for home support with the highest possible level of service. The three-step course is free of charge and is extremely comprehensive including training in body mechanics and lifting techniques, precautions regarding HIV, disposal of needles, food preparation, and safety.

In addition, Northwood Homecare supports its staff members with ongoing courses and 24-hour on-call access to case managers and nursing supervisors. Northwood Homecare also conducts quality circle meetings with staff, and is creating a home care workers' support network. In addition to providing educational and peer support to employees, Northwood Homecare instituted a new pay scale in 1996 that makes its workers among the highest paid in such a traditionally underpaid industry. By improving the quality of life for staff and compensating them well, there has been a significant decrease in staff turnover. The resulting continuity of care means clients receive high quality care.

5.8 Ontario

Community Link/Aging in Place
VHA Health and Home Support Services

The purpose of the Community Link/Aging in Place program is to promote wellness, quality of life, and aging in place for tenants in seniors' apartment buildings. The services provided by this program include ongoing information and referral, advocacy, supportive visiting, resource centre services, and health promotion programming.

Under this program, a Services Coordinator, hired to work on-site in a large Hamilton Wentworth Housing Authority building, works with both a team of homemakers assigned to the building as well as a multidisciplinary team of other service providers. All residents are welcome to access the services of the coordinator for information, referral, visiting, social and safety programs. This enhanced community-linked homemaking service with an on-site coordinator recognizes the interdependence of biological, social, psychosocial, and functional factors which place the frail elderly at risk.

This program is broader than supportive housing which limits services to specific clients in a building. The advantages of this model of service delivery are that all tenants are eligible to access the program; the program provides an anticipatory model of care which is the cornerstone of maintaining optimal health for seniors in the community and reduces the need for the more expensive health care system; the program removes the silos of existing funding by pooling them to provide the program; the program effectively links existing resources rather than adding another layer of administration; and it provides for both paid and volunteer services within the building, utilizing tenants as volunteers. This model is operating successfully in four seniors' housing authority buildings in Hamilton-Wentworth.

Fit to "Really" Live
Institute for Positive Health for Seniors Inc.

Fit to "Really" Live is an education and training workshop developed by the Institute for Positive Health for Seniors Inc. (IPHS) for people who work to assist older, inactive adults in their daily living. This program is aimed at training caregivers to motivate and help frail senior adults to regain strength and flexibility though physical activities.

As a new program initiated in 1998, Fit to "Really" Live is still facing the challenges of inadequate funding. However, this program has encouraged other community groups to launch similar projects.

Information and Referral Services
Toronto Community Care Access Centre, Community Care Access Centre Niagara, Scarborough Community Care Access Centre

Resource Centres have been established to house information and referral centres. Reference material, information packages, pamphlets and computerized resources are offered to all residents, regardless of whether they are admitted to the Home Care program or not. These services are designed to assist in the development and enhancement of community access.

Partnerships
Community Care Access Centre of Waterloo Region, Community Care Access Centre of Peel, Community Care Access Centre London Middlesex

The initiative to form partnerships is a common theme in Ontario. For example, Scarborough Community Care Access Centre (CCAC) has moved to develop partnerships with other community agencies and hospitals to participate in joint planning and shared service initiatives. The CCAC in Peel has established partnerships with hospitals through its involvement with Quick Response Teams, Respite Care programs and Hospital to Home initiatives.

Physical Activity Programs
Centre for Activity and Aging

The Centre for Activity and Aging (CAA) was established in 1989 as a research institution. The mandate of the CAA is to investigate the interrelationship of physical activity and aging. CAA is also mandated to translate research findings into strategies to maintain the aging population in independent lifestyles and to maintain or improve the functional levels for those living in a more dependent environment.

The CAA offers 16 in-house physical activity programs for its 400 participants. Most programs are held three times a week and run for the entire year. The CAA has assisted with the development of other community physical activity programs in low income housing, in urban and rural communities, and in First Nation Communities.

Some of the training and education programs include:

The Senior's Fitness Instructors Course (SFIC), a leadership course designed to teach adults to become fitness instructors, has had over 500 participants to date with the majority of these participants over 55 years of age.

The Long-Term Care Physical Activity Workshop is an education training program for people working with the frail elderly whether it be in a facility or at home.

The Home Support Exercise Program (HSEP) promotes specific exercises for the frail, homebound elderly and introduces home care personnel to the implementation and maintenance of an exercise program for their clients.

The Restorative Aides Education and Training Intervention was developed with the input and direction of two local long-term care facilities. Components of this 36 hour course include transfer and mobility training, a safe and effective eating program, and a communication and aging module for both staff and residents.

Physical activity programs offered at the CAA include strength training, power walking, an arthritis exercise program, an osteoporosis exercise program, and a T'ai Chi program.

Despite a lack of core funding, the CAA has successfully worked with communities to provide self-sufficient physical activities programs for independent older adults and has successfully implemented physical activity programs in long-term care facilities.

Request for Proposal
Ontario Community Care Access Centres

A recent initiative common to all Community Care Access Centres (CCACs) is the Request for Proposal (RFP) system. Although the home care programs contracted for services in the past, the province is moving towards a more open competition model for best quality and best price. In three years, all direct services, except for case management, must be awarded through a RFP process. Exemption is made if only one provider exists in the area and meets the requirements. RFPs with similar guidelines are also required to contract for medical supplies and equipment.

This year and in the next two years, only a percentage of contracted services will be open to tender so that those providers with a long history of service will have time to adjust to the increased competition. Providers will be competing on new volumes as well as a portion of the current market share.

RFPs will be used in order to purchase best quality of service delivery at best price. They help to provide a standardized process for contracting services by the CCACs as well as for ensuring quality requirements for service delivery.

Shared Care
Community Care Access Centre of District of Thunder Bay, Community Care Access Centre for the Eastern Counties

Shared Care is designed to provide flexible, frequent homemaking support in the most efficient manner possible. Shared Care is offered in residences with a high proportion of seniors and provides ongoing homemaking services through full-time homemakers available in the building at all times. With this program, homemaking services are scheduled around the time required for specific needs (i.e. one hour allotted to get up, dress and have breakfast, one-half hour required later in the day for cleaning). In this manner, homemaking can be scheduled in blocks as short as 15 minute periods. This increases the frequency that the client can be seen. Clients can now be seen for 15 minutes in the morning for help with a small task and still have time left for personal care and laundry later in the day. Shared Care is a very efficient, cost-effective and flexible means of delivering services.

5.9 Prince Edward Island

Seniors Assessment Program
PEI Health and Community Services Agency

The Seniors Assessment Program was developed and carried out in concert with a provincial review and restructuring of services to seniors. The overall goal of the program is to enhance and coordinate the assessment and delivery of services to seniors in PEI. This tool is intended to identify the needs for service, support, or linking across the regional services. It identifies personal risks that could impact on the health and well being of the client and provides discussion regarding opinions and interventions. This program is proactive in that it identifies risks to prevent problems before they occur. There are six components to the Seniors Assessment Program: geriatric assessment, seniors assessment, healthy aging, health reform, cost effective and accountable planning, and partnerships.

PEI Adult Day Care Program Needs Review
PEI Health and Community Services Agency

In order to help informal caregivers in their role, three main types of respite care have developed: institutional respite, in-home respite, and centre-based respite care. To date, centre-based respite care programs, better known as adult day care programs (ADCP), have received limited attention compared to institutional and in-home respite care programs. Adult day care programs, however, may be a viable alternative for both the dependent elders and their families who are caring for them while living in a small community. Adult day care programs are cost-effective programs which allow the informal caregiver a day off to rest or complete tasks they have not been able to do, and at the same time allow a day of activity and socialization for the dependent elder participant.

Although there are four models of adult day care programs, it has been identified that small communities generally extract different parts of each model to form a more general "mixed model" in an effort to care for a variety of individual needs in the community. During the development stage of an adult day care program, a variety of issues need to be taken into account, including: the facility, staffing, services to be provided, criteria for entrance, and the cost to be bourn to the participant.

A student in the Masters in Health Administration Program at Dalhousie University has completed a study of the types of Adult Day Care Programs across Canada, and has developed a "how to" manual for small community groups preparing a proposal or for researching such a need for P.E.I. This work will be distributed to the P.E.I. Regional Home Care offices and any interested community development groups in P.E.I.

PEI Integrated Mental Health Response for Seniors
PEI Health and Community Services Agency

The goal of this project is to provide a protocol for early assessment, diagnosis and intervention to seniors in order to earlier identify and diagnose depression and dementia, including Alzheimer's Disease and other related disorders that negatively affect cognition in seniors. This will help to determine the care and support needs; and to direct seniors and families to the education, planning and support resources in their region and across the province.

This proposal is the result of the development and implementation of a screening and assessment process for the P.E.I. Health and Community Services Home Care and Long Term Care sectors. The implementation of a single or coordinated system entry, using the SAST[1] Community/Continuing Care 1997 (copyright), has identified a need to develop additional specialized screening and diagnostic protocol.

The incidence of depression, polypharmacy confusion, and dementia (including vascular, frontal lobe, multiple drug use and interactions as well as Alzheimer's Disease), has been targeted as a large area of focus that requires a concerted effort from many sectors to earlier identify, diagnose, and assist seniors, families, and caregivers (both formal and informal) to provide earlier support, education and care planning.

The outcome clearly hoped for is early identification of seniors in need of assessment, diagnosis and intervention, and to work collaboratively with these seniors, their families, and related organizations to provide a responsive, integrated, and coordinated approach between government, voluntary and private sectors.

[1] ***Seniors Assessment Screening Tool, Seniors Assessment Program, 1994-97, Veterans Affairs Canada and P.E.I. Dept. of Health and Social Services.***

5.10 Quebec

Caregiver Support
CLSC Frontenac

A mutual support and assistance group for caregivers has been established. The lack of help for caregivers had been a difficulty identified by the CLSC respondent. Family and volunteer caregivers, and health providers, are imperative to the effective delivery of services for seniors.

Day Centre (Centre de Jour)
Henri Bradet Day Centre

The Henri Bradet Day Centre is targeted to seniors who have lost some autonomy due to physical, cognitive, psychological and/or social reasons. The primary purpose of the program is to enhance the client's and family's quality of life through an interdisciplinary, therapeutic approach using preventative and educational activities.

The Henri Bradet Day Centre is not based on a medical model but rather is based on the belief that seniors are generally happier, more self-fulfilled and more content in the home environment. They have the right to receive support services within the limits of available resources which enable them to live at home as long as possible.

Further, the program is based on the philosophy of mutual respect between individuals, be it staff, clients, or students/volunteers. Programs and services are organized to meet individual needs, maintain dignity, and have the objective of fostering a sense of self-esteem, self-worth and the healthy acceptance of limitations. The Day Centre recognizes the demands made on caregivers and seeks to collaborate with them and other community resources to provide support and a sense of community, and to provide the best possible quality of life for both the client and the caregiver.

5.11 Saskatchewan

Adult Day Program
Anderson Lodge

The Adult Day Program operated by Anderson Lodge was established in 1991 to provide services for adults that will prolong and enhance their ability to remain as well and as independent as possible. Aimed at mobile adults, this program focuses on the provision of emotional and spiritual care in addition to physical care, the provision of nourishment, and the provision of relief to the caregiver. Although still facing the challenges of limited space and a lack of washroom facilities, the program has been successful in both providing relief to the caregiver and in preventing/delaying institutionalization.

Multidisciplinary Care Planning
Parkland Health District, East Central Health District

A common theme in the questionnaires received from Saskatchewan was multidisciplinary care planning. By using this approach to the provision of services for seniors, better placement for long-term care has resulted. Accessibility to services has increased and there has been a decrease in waiting lists. Overall, client satisfaction has also improved.

Seniors Health and Continuing Care Program
East Central Health District

The Seniors Health and Continuing Care program was initiated in November, 1997. The purpose of this program is to provide a client-centered, team approach to the provision of care coordination, long-term care, home-based services and support services. Although still in the initial stages of development, a leadership team has been organized with representation from various community groups and clients. As well, a senior staff committee with representation from all areas of the program has been established.

Single Point of Entry
Battlefords Health District

A major initiative of Battlefords Health District has been to combine all the continuing care services (home care, long term care facilities, coordinated assessment units) into one program area to ensure a single point of entry for consumers. In addition, this combination of services facilitates service integration and promotes intersectoral involvement.

Some of the resulting benefits from this movement to a single point of entry have included a more efficient use of institutional beds, some reduction in acute care bed utilization, and better coordination of continuing care services.

5.12 Yukon

Social Model of Service Delivery
Department of Health and Social Services

The Yukon Home Care Program attempts a multi-disciplinary, team approach in its delivery of Home Care Services. This approach allows all components to be part of one program. Rather than using a model which is primarily medically based, the program is based on more of a social model. One of the unique features of the Yukon Home Care Program is its use of social workers to their fullest potential. Social workers act as intake workers for all long-term and palliative care. By using this structure, social workers can get involved before a crisis situation arises rather than after the fact.

6.0 Summary

This is the final report of the Identification of Innovative Best-Practice Models of Continuing Care for Seniors Project. Revisions have been made to the report as requested by the Federal/Provincial/Territorial Seniors Working Group on Continuing Care. Based on the information obtained, the report should be of assistance to planners, practitioners, researchers and policy makers regarding innovative best-practice models for continuing care for seniors. It is hoped that it will aid seniors in obtaining increased independence and a better quality of life.

Responses to the questionnaire have revealed six major themes as features of best-practice models of continuing care: consumer and client focus, coordination and integration, efficiency and flexibility, education, assessment and evaluation, and access. These elements have been found to have commonality across organizations and either have been adopted or are in the process of being implemented.

Respondents have identified seven major challenges to program development and delivery: a lack of resources, the lack of understanding of continuing care, public expectations, geography, the impact of the political environment, increasing complexity of needs, and resistance to change.

Appendices

I Sample Questionnaire

INNOVATIVE BEST-PRACTICE MODELS OF CONTINUING CARE FOR SENIORS

The Canadian Home Care Association (CHCA) has been contracted by Health Canada to review initiatives in various models of continuing care for seniors across the country and to identify best-practice models for delivering high quality continuing care services for seniors in a cost-effective manner.

For the purposes of this study, “continuing care” represents the whole system or continuum of services that address, over an indefinite and long-term period, the health, social and personal care needs of seniors. These services include facility-based care as well as community-based or home-based care delivered to individuals with demonstrated need for care, for a short term or over a relatively long and indeterminate period.

Please take the time to fill out this questionnaire which has been designed to gather documentation on recent initiatives in community-based and facility-based continuing care for seniors in all provinces and territories. These initiatives include new approaches to the delivery of health and social care, as well as initiatives that offer a multi-sectoral approach to support and care, addressing needs in the area of health care, social support, housing and transportation. We are interested in models and programs of care rather than innovations regarding specific procedures. We also want your opinions about the features of best-practice models of continuing care (e.g. quality, client focus, cost effectiveness, etc.)

The final report will include a description and contact information for the initiatives identified in the research, as well as a description of the features of best-practice models of continuing care for seniors. We encourage you to participate and to share this questionnaire with your colleagues so that innovative programs and models are not overlooked.

Please answer the following questions and return the questionnaire, along with any additional material you may wish to send, to Pamela Martin, CHCA, either by fax or by mail. If you would prefer to receive this questionnaire in electronic format, please contact the CHCA. If you have more than one program that you wish to highlight, please complete one questionnaire per program, photocopying the original questionnaire as many times as required.

Thank you very much for your contribution to this project.

Aussi disponible en français.

1. Your organization, its address, phone and fax numbers, e-mail address, and a contact person for your continuing care program(s):

   Organization: _____
   Contact Person for Continuing Care Program(s): _____

   Address: _____

   _____

   Phone #: _____ Fax#: _____

   E-mail Address: _____

2. Name of your continuing care program for seniors:_____

3. Brief description of your continuing care program for seniors:

   A) Starting date:_____

   B) Purpose of the program: _____

   _____

   C) Target population (age, condition, etc.): _____

   _____

   D) Services provided (Note: please indicate if the services are ongoing or episodic):

   _____

   _____

   E) Funding sources (e.g. Client pay/government subsidy):

   _____

4. Please provide the following information regarding resources and clients served by your continuing care program:

   A) Annual budget for the program: _____

   B) Number of seniors served by your program in a twelve-month period:

   _____

   _____

   C) Resources required annually to deliver the program (staff, equipment, etc):

   _____

5. How did you determine the need for the program?

   _____

   _____

6. Describe the model (philosophy, values) upon which the program is based:

   _____

   _____

   _____

7. Describe the approach (strategies, organizational structure) taken by the program to achieve this philosophy:

   _____

   _____

   _____

8. Who was involved in planning your program?

_____

_____

9. Describe the successes in the program's development (successes may include such achievements as client/community involvement, multidisciplinary/multisectoral involvement, creative ways to obtain funding, etc.):

_____

_____

_____

10. Describe the difficulties (difficulties may include the lack of client/community involvement, lack of support from other organizations/sectors, etc.) in the program's development:

_____

_____

_____

11. Describe the successes (successes may include such achievements as client satisfaction, cost savings, etc.) in the program's delivery:

_____

_____

_____

12. Describe the difficulties (difficulties may include client dissatisfaction, unforeseen hurdles in the program's implementation, etc.) in the program's delivery:

_____

_____

13. How do you evaluate program outcomes against stated objectives?

_____

_____

14. How do you obtain client/community input into ongoing program development?

_____

_____

15. Based on your experience, what do you feel are the key features of best-practice models in continuing care? For each feature, please briefly explain why it is important to the model.

_____

_____

_____

_____

_____

16. How does your program reflect the features of “best-practice” models in continuing care?

_____

_____

_____

_____

17. Please provide any documentation you are able to share regarding your program, including any evaluations that have been done as well as program objectives, descriptions, etc.

Thank you for taking the time to complete the questionnaire. Please return it, along with any materials about your program that you wish to share, by fax or mail to:

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