CARING FOR OUR SENIORS

PEI review of the continuum of care for Island seniors

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HEALTHHRGROUP

Hollander Analytical Services Ltd.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Seniors are the fastest growing segment of the population in Prince Edward Island. As in other Canadian jurisdictions, the growing number of older Islanders presents new challenges such as an increase in the prevalence of chronic diseases and increasing life expectancy accompanied by longer periods of morbidity and disability. The impact of these chronic conditions on health care costs will become more substantial for government, stakeholder groups and the general population. Governments across Canada are realizing that not addressing these realities will lead to escalating and uncontrollable costs which will ultimately affect the quality of care provided to seniors. The time for action is now.

Recognizing that the current system is not sustainable, the Government of Prince Edward Island commissioned a review of the continuum of care for Island seniors. The goal of the project was to support the development of an integrated policy and program framework for delivering the best possible home, supportive residential and long term care services for seniors in Prince Edward Island within the context of a fiscally sustainable health care system.

The objectives of the project were to: examine the current continuum of services and linkages between operations and their financial implications provided by the public and private sectors; explore the current and future needs of seniors and providers; identify the areas of successes and gaps pertaining to the current services provided and the future needs of seniors and providers; examine the trends in other Canadian jurisdictions in relation to services provided as well as legislation and regulation; identify the opportunities and challenges for system-wide improvements to achieve a more efficient approach to service delivery including a review of best practices/models existing in other jurisdictions; and reach consensus on the recommendations and strategies to guide the development of a policy and program framework.

The project included three approaches to data/information gathering: a literature scan; consultations with more than 74 key stakeholders through interviews and focus groups; and a roundtable session with key stakeholders. An Advisory Committee provided support and guidance throughout the project. Health HR Group, in collaboration with Hollander Analytical Services Ltd., was retained to complete the work.

The consultations revealed several opportunities to leverage and address the challenges and realities in Prince Edward Island. Public and private providers are cognizant and concerned about the impact of future demands associated with an aging population. Their participation in this initiative was perceived as a willingness to commence discussions regarding the current and future environment and demands. Stakeholders indicated that there are pockets of services that are successfully meeting the needs of seniors. In addition, the Island's small population size was seen as an opportunity to pilot different models of care and lead the country, as well as to be a model for high quality sustainable care for seniors.

Stakeholders also identified several gaps and challenges. The lack of a seniors' strategy was frequently cited as were the inequities existing between private and public providers across the continuum of care. Inconsistent means testing of seniors' and families' ability to afford care was identified as creating disincentives to consider supportive residential/community care facilities and encouraging a search for loopholes to access public home care and long term care programs. Recruitment issues and disparities in compensation between public and private providers present human resource challenges that will need to be addressed moving forward.

Stakeholders envisioned an environment where integrated and comprehensive care is designed to keep people as healthy as possible, for as long as possible, living independently in their own home. **Developing a strategic plan** for seniors and the frail elderly is critical to realizing this desired state and is the foundation for a policy and program framework. Seniors and their families need to be at the centre of the strategy. By setting priorities that are needs based rather than systems based, the strategic plan will outline directions, outcomes and ongoing evaluation methods as well as a budget process that will result in the delivery of quality and sustainable care. The "Home First" model currently implemented in New Brunswick supplemented by a housing strategy is recommended for consideration. Adopting this or part of the model will necessitate increasing the capacity and investment for home and community based care and services. A significant investment is required to bring home care spending closer to or at least that of the national average to support seniors living at home.

Targeted research that will provide more comprehensive information and data to inform decisions needs to be part of the strategic plan. One area of focus revealed in the current review is the need to understand the costs associated with the operations of public and private providers across the continuum of care. New financial data will need to be collected, particularly from private providers, and more up-to-date data will be required from public operators. This will help address the inequities between public and private providers identified by stakeholders.

A **funding model** will need to be incorporated into the strategic plan. The model should be outcomes based and should prioritize investments based on evidence and best return. Determining the funding model will require: reviewing and re-assessing the *Long Term Care Subsidization Act*; reviewing and revising components of the Physician Master Agreement; determining the acceptable level of compensation for physicians and/or Nurse Practitioners to conduct home visits; exploring the purchase of insurance for home care services; and exploring a self and family managed care model to ensure funding can follow seniors throughout their journey.

Key to realizing the desired state for Island seniors and a cornerstone of the strategic plan is the creation of a **Seniors Health Care Network**. Modeled after Prince Edward Island's Primary Health Care Unit, the Network will co-locate all care for seniors system wide. Services and care will be delivered to seniors across the Island and will not be located in just one place. Establishing such a centre will require revamping the current structures and systems already in place and building on

programs that are currently successful. The Seniors Health Care Network will focus on person and family-centred care and will ensure continuity of care for seniors through continuous monitoring and assessment processes to ensure their needs are being met.
Multi-disciplinary health care teams will be integral to achieving this goal. Current human resource gaps and challenges will need to be addressed in order to put senior health care teams in place.

Creating **one government portfolio for seniors** is a second key component of the strategic plan. There is a need to co-locate all functions and systems related to seniors in one area to improve care delivery in a fiscally sustainable environment. This approach will address the current lack of coordinated and streamlined services and programs, fragmented services and programs, and limited collaboration between public and private providers despite increasing demand and limited resources. The single government portfolio for seniors will collaborate with the Seniors Health Care Network to effectively provide financially sustainable programs, services and support for seniors and their families. Formal public and private sector partnerships will need to be established by removing the inequities, improving the sharing of information and expertise, and building relationships that focus on providing sustainable quality care to seniors.

A Seniors Health Care Network that collaborates closely with one government portfolio for seniors will be more conducive to ensuring **early health and financial assessments of seniors**. This will involve one point of access for financial assessments. It will also require reviewing and changing the current means testing approach to remove disparities across the continuum of care and creating a more consistent assessment process for seniors. Seniors will be subjected to a consistent means test whether accessing private or government funded home care, long term care or supportive residential/community care programs. A more coordinated and unified system realized by a Seniors Health Care Centre and government portfolio will enable the establishment of continuing care **navigators** who will be responsible for supporting and assisting seniors and their families to navigate the system, services and programs. The cancer treatment centre and home care's intake process are best practices to build upon.

Improving the communication and **dissemination of information** to seniors and their families, among health care providers, and to the general public will be facilitated by the collaboration between the Seniors Health Care Network and the government portfolio for seniors. Existing technology, such as telehealth, can be improved and communication tools will need to be developed, and consistently applied, across the continuum of care.

This review presents the building blocks for the development of a policy and program framework for Prince Edward Island's seniors. It sheds light on the opportunities and challenges currently existing in the province and presents evidence and best practices piloted and implemented in other jurisdictions for consideration. The dialogue about the immediate and long term future of our seniors has commenced. While several stakeholders were skeptical of any change resulting from the

review, others agreed that this review presents a willingness to start addressing the needs of seniors and their families and the impact of those needs on the health care system.

1.0 INTRODUCTION

The Government of Prince Edward Island (PEI) commissioned a review of the continuum of care for Island seniors in March 2016. The goal of the project was to support the development of an integrated policy and program framework for delivering the best possible home, supportive residential, and long term care services for seniors in Prince Edward Island within the context of a fiscally sustainable health care system. The objectives of the project were to:

- examine the current continuum of services and linkages between operations and their financial implications provided by the public and private sectors;
- explore the current and future needs of seniors and providers;
- identify the areas of successes and gaps pertaining to the current services provided and the future needs of seniors and providers;
- examine the trends in other Canadian jurisdictions in relation to services provided as well as legislation and regulation;
- identify the opportunities and challenges for system wide improvements to achieve a more efficient approach to service delivery, including a review of best practices/models existing in other jurisdictions; and
- reach a consensus on the recommendations and strategies to guide the development of a policy and program framework.

Health HR Group, in collaboration with Hollander Analytical Services Ltd., was retained to complete the research and facilitate the development of the framework.

This report provides:

- an overview of health and aging in Prince Edward Island;
- highlights from a cross jurisdictional scan of continuing care in Canada;
- a summary of consultations with key stakeholders regarding the strengths and challenges of the current continuum of care in Prince Edward Island;
- examples of best practices, person centred models of care and service delivery which may be adapted to the PEI context; and
- recommendations to guide the Government of Prince Edward Island's development of a policy and program framework based on the literature scan, consultations with stakeholders, and the research team's expertise.

Section 2 of the report presents the approach and methods used to collect data and information for the project while section 3 provides an overview of health and aging in Prince Edward Island. Section 4 briefly summarizes home care, supportive residential care, and long term care from the cross jurisdiction scan; section 5 presents a summary of the findings from consultations with key

stakeholders. Sections 6 and 7 discuss integrated health systems and present examples of person centred models of care and service delivery, while the final section 8, summarizes the strategic directions recommended for consideration by the Government of Prince Edward Island as it moves forward with a policy and program framework.

The term "client" refers to an individual (or their designated representative), families and groups. The term "senior" refers to seniors and frail elderly throughout the report. In some cases, the term "frail elderly" is identified for emphasis.

2.0 APPROACH AND METHODS

The project included three approaches to data/information gathering: a literature scan; interviews and focus groups with key stakeholders; and a roundtable session with key stakeholders. An Advisory Committee provided support and guidance.

2.1 Literature Scan

The literature scan was conducted during the spring of 2016 and focused on Canadian documents pertaining to an aging population; health and social supports, especially for seniors; and integrated systems of care. Published and grey literature and data were collected from the project's Advisory Committee, interview and focus group participants, multiple targeted web searches, references identified in documents reviewed for the project and relevant documents developed by members of the research team. An internal report summarized the findings from the literature scan and was used to inform the stakeholder roundtable.

2.2 Consultations

A total of 74 individuals participated in either an interview or focus group. About 20 telephone and in-person interviews and nine focus groups were conducted with representatives of public and private home care, supportive residential/community care and long term care providers, administrators, seniors' organizations, as well as seniors and their families.

Participants were asked to comment on successful programs or services (what is working well), identify gaps and potential gaps, identify potential solutions to address the gaps and/or identify additional supports required to maintain current strengths.

2.3 Stakeholder Roundtable

A discussion paper summarizing the findings from the literature scan was distributed to the stakeholders in advance of a full-day roundtable session. This session was designed to identify strategic directions for delivering the best possible services for Island seniors in the context of a fiscally sustainable health care system. A total of 17 participants discussed questions aimed at identifying the desired state for services and programs for Island seniors and how opportunities can be leveraged and challenges can be addressed to achieve the desired state. Stakeholders were selected to represent public and private home and long term care and supportive

residential/community care, as well as seniors and other relevant organizations. The invited stakeholders were knowledgeable about PEI's health care system and were key to moving the agenda forward.

2.4 Advisory Committee

An eight member Advisory Committee was established to support and guide the project (see Appendix A for a list of members). Three meetings were convened with the Advisory Committee over the course of the project.

2.5 Limitations

Budget and time constraints prohibited a more in-depth review and analysis of the issues, including greater financial background and analysis for each of the services in both the private and public sectors, with recommendations on how costs can be better sustained.

Although a number of stakeholder groups were consulted, a limited number of health professionals who work directly with seniors and families were included. A survey of front line staff across the continuum will benefit future analyses and discussions with respect to new and/or improved services and programs.

Input from seniors and their families was limited despite efforts to identify consumers of care. Information from other consultations with seniors and their families, provided by stakeholder groups, were reviewed to augment input from the two focus groups with seniors and families that were completed for this project.

3.0 AN OVERVIEW OF HEALTH AND AGING IN PRINCE EDWARD ISLAND

Seniors are one of the fastest growing populations in Prince Edward Island (Seniors' Secretariat of Prince Edward Island, 2015). In 2015, it was estimated that there were 27,180 individuals over the age of 65, and that seniors represented 18.6% of the population. By 2055, it is estimated that 27.3% of the population will be 65 years of age or older as presented in Table 1.

TABLE 1: Population Estimates for Individuals 65 Years of Age and Older, 2015-2055

	65 to 74 Years		75 to 84 Years		85 & Over		Total 65 & over		Total
	#	%	#	%	#	%	#	%	Population
2015	16,314	11.1	7,819	5.3	3,047	2.1	27,180	18.6	146,447
2025	20,479	13.1	12,980	8.3	3,646	2.3	37,105	23.8	156,042
2035	21,406	13.3	16,324	10.2	6,204	3.9	43,934	27.3	160,763
2045	19,669	12.2	17,082	10.6	7,976	4.9	44,727	27.7	161,687
2055	19,902	12.3	15,939	9.9	8,388	5.2	44,229	27.3	161,792

Source: Prince Edward Island Statistics Bureau, 2016

A comparison of Prince Edward Island with other jurisdictions in Canada indicated that in 2015, PEI had the third highest percentage of the population 65 years of age and over, (after New Brunswick and Nova Scotia) and the fourth highest rate of growth (after Newfoundland and Labrador, New Brunswick and Nova Scotia; Statistics Canada, 2011, 2015a).

In Prince Edward Island, females outnumber males in the population 65 and over, as illustrated in Tables 2 and 3. This may have implications for the planning of programs and services to support aging in place, as well as the planning of health services in general (Seniors' Secretariat of Prince Edward Island, 2014).

TABLE 2: Total Population by Age and Gender (65 and Over)

	2011		2012		2013		2014		2015	
	#	%	#	%	#	%	#	%	#	%
Males	10,177	44.4	10,794	44.9	11,362	45.2	11,902	45.4	12,378	45.5
Females	12,732	55.6	13,232	55.1	13,757	54.8	14,307	54.6	14,802	54.5
Total Population[1]	22,909	100	24,026	100	25,119	100	26,209	100	27,180	100

Source: Statistics Canada, 2015b

TABLE 3: Population by Age Group for Individuals (65 and Over)

		2011		2012		2013		2014		2015	
		#	%	#	%	#	%	#	%	#	%
65-74	Males	6,148	26.8	6,669	27.8	7,117	28.3	7,552	28.8	7,902	29.1
	Females	6,526	28.5	6,997	29.1	7,510	29.9	8,003	30.5	8,412	30.9
75-84	Males	3,127	13.6	3,203	13.3	3,297	13.1	3,390	12.9	3,490	12.8
	Females	4,100	17.9	4,119	17.1	4,139	16.5	4,215	16.1	4,329	15.9
85 & Over	Males	902	3.9	922	3.8	948	3.8	960	3.7	986	3.6
	Females	2,106	9.2	2,116	8.8	2,108	8.4	2,089	8.0	2,061	7.6
Total Population[1]		22,909	100	24,026	100	25,119	100	26,209	100	27,180	100

Source: Statistics Canada, 2015b

3.1 Health and Aging

The Chief Public Health Officer in Prince Edward Island has stated that, "the growing number of seniors in Canada and Prince Edward Island has …led to challenges such as an increase in the prevalence of chronic disease. Increasing life expectancy has been accompanied by longer periods of morbidity and disability…" (2014).

PEI has a high prevalence of several types of cancer, diabetes, cardiovascular disease and arthritis (Government of Prince Edward Island, Department of Health, 2009a). As the population ages, the impact of these chronic conditions on health care costs will be substantial (Government of Prince Edward Island, Department of Health, 2009a).

Frailty, which has been defined as, "a state of vulnerability that can lead to poor health," has been associated with increased health care utilization (and thus, increased costs).

> *Many factors contribute to an individual's level of frailty including nutritional status, physical activity, social relations and mental health. Frailty may be a better predictor of health than age alone. Seniors who are frail for their age are more likely to experience illness, decreased quality of life and premature death. (Chief Public Health Officer, 2014)*

Using data from the 2011/2012 Canadian Community Health Survey, the Chief Public Health Officer found that 43% of individuals 65 years of age and older in Prince Edward Island were considered to be frail (2014). There were no significant differences between males and females.

3.2 The Importance of Healthy Aging

The Chief Public Health Officer in Prince Edward Island has stated that, "Healthy aging slows the onset and decreases the severity of chronic disease and disability. This saves health care costs and decreases the need for long term and home care resources," (2014).

Prince Edward Island's Healthy Aging Strategy is intended to correct the, "imbalance between community and institutional care [in order to] improve integration of services for individuals and families. The ultimate objective is to support individuals to remain in their home, in their community and live as independently as possible for as long as possible," (Government of Prince Edward Island, Department of Health, 2009a).

While the Chief Public Health Officer (2014) has emphasized avoiding or delaying the onset of chronic disease, the Healthy Aging Strategy has recognized that when chronic conditions are present, being able to live in the community as independently as possible is the preferred choice. Both approaches are likely to result in lower health care costs and higher quality of life (Government of Prince Edward Island, Department of Health, 2009a).

4.0 CONTINUING CARE AND THE CONTINUUM OF CARE

Continuing care is not a type of service, but a "complex 'system' of service delivery," (Hollander, 2001). The system consists of several components which are integrated conceptually and in practice through a continuum of care (Hollander, 2001). The term continuing care is generally used to describe a service delivery system which includes all home care, home support and long term care services.

"The term reflects within it two complementary concepts, that care may 'continue' over a period of time and that an integrated program of care 'continues' across service components, that is, that there is a continuum of care," (Hollander, 2001). Hollander (2001) noted that, "The efficiency and effectiveness of the [continuing care] system depends not only on the efficiency and effectiveness of each component, but also on the way that the service delivery system itself is structured."

This chapter examines three key components of a continuing care system (namely home care, supportive residential care and long term care) from a Canadian perspective and within Prince Edward Island.

4.1 Home Care

The Canadian Home Care Association (2013; see also Accreditation Canada & Canadian Home Care Association, 2015) defines home care as, "an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for family caregivers."

Home care is a critical part of the health care system (Accreditation Canada & Canadian Home Care Association, 2015; Canadian Home Care Association, 2013; CSI Consultancy, 2015). As the majority of Canadian seniors prefer to stay in their own homes for as long as possible, home care has become an important option for managing seniors' health needs (Accreditation Canada & Canadian Home Care Association, 2015). The definition of what constitutes home care - that is, the set of services included under home care - varies across jurisdictions.

Seniors are the largest users of home care services. In 2011, one in six individuals (16.7%) 65 years of age and older received home care services (Accreditation Canada & Canadian Home Care Association, 2015). Home care services may be provided by public and/or private organizations, and there is generally a limit on the number of hours of service provided (CSI Consultancy, 2015). Home care services in Manitoba, Prince Edward Island, Saskatchewan, Northwest Territories, Nunavut and Yukon are provided by public organizations; in other jurisdictions, they are provided through a mixture of public and private organizations (CSI Consultancy, 2015). With the exception of Alberta, British Columbia, Northwest Territories, Nunavut, and Saskatchewan, the amount of home care is generally limited. Limits may be based on funding, number of hours, or number of visits (CSI Consultancy, 2015).

4.1.1 Assessment for Home Care

Individuals, family members, and health care providers can make referrals to most home care programs. Hospitals provide the majority of referrals (Accreditation Canada & Canadian Home Care Association, 2015). Home care services include professional health care services (e.g., nursing care), personal care services (e.g., assistance with bathing and dressing), and home support services (e.g., assistance with meal preparation, light housekeeping). Supportive services, such as assistance with household tasks, account for a substantial proportion of home care expenditures (Hollander, 2015).

Most jurisdictions (e.g., Alberta, British Columbia, Manitoba, Newfoundland and Labrador, Nova Scotia, Ontario, Saskatchewan, and Yukon) use the interRAI to assess individuals' need for home support services (Canadian Institute for Health Information (CIHI), 2016; CSI Consultancy, 2015).[1]

In the Northwest Territories, a continuing care assessment package is used, and in Nunavut, a home and community care assessment tool is employed. Québec uses a multi-client assessment tool, and Prince Edward Island applies the Seniors Assessment Screening Tool, as well as other resources (CSI Consultancy, 2015). New Brunswick uses a program application (CSI Consultancy, 2015).

In Prince Edward Island, the home care program is managed by the Community Health Division of Health PEI. Referrals may be made by the individual requiring care, or on behalf of the individual requiring care (e.g., by a family member, friend or health professional).

An intake coordinator conducts an assessment to determine an individual's eligibility and need for service. The intake coordinator will also assess all new home care clients for their intensity of need for coordination, and will assign the individual to the most appropriate primary coordinator (i.e., care coordinator).

Home care services are provided based on assessed need and available resources. There is no income or asset test (Sykes Assistance Services Corporation, 2015). Priority is given to individuals with the highest needs.

4.1.2 Funding of Home Care Services

Governments provide public funding for home care services. Although some jurisdictions have user fees for home support services, others do not (Hollander, 2015). In addition, individuals can purchase home care services privately. Home care accounts for more than 5% of the total health budget in New Brunswick, Manitoba, Newfoundland and Labrador, Nova Scotia and Québec (refer to Appendix B). Based on 2010/2011 figures, (most recent data available) per capita home care spending ranged from a low of $90.86 in Prince Edward Island, to a high of $266.47 in Newfoundland and Labrador (CSI Consultancy, 2015).

In some jurisdictions (e.g., Alberta, British Columbia, New Brunswick, Newfoundland and Labrador, Nova Scotia, Québec and Saskatchewan), home care clients are required to pay fees, at least for some services (CSI Consultancy, 2015). Home care clients in Manitoba, Ontario, Prince Edward Island, Northwest Territories, Nunavut and Yukon do not pay fees (CSI Consultancy, 2015).

All public home care services in Prince Edward Island are provided free of charge (Seniors' Secretariat of Prince Edward Island, 2015). However, individuals are responsible for providing any medications, materials, supplies and equipment required for their care (Seniors' Secretariat of Prince Edward Island, 2015).

[1] New Brunswick implemented the interRAI long-term care tool in 2015. However, the province does not appear to be using the interRAI home care tool (CIHI, 2015).

In addition to care coordination, publicly funded home care services include:

- nursing services such as health supervision, medication monitoring, dressing changes, ostomy care and health education;
- home support services such as assistance with bathing and dressing, and respite;
- occupational therapy services, which may include recommendations regarding special devices, equipment or changes to enable individuals to live safely and independently at home;
- physiotherapy services which emphasize independence, function and mobility;
- nutrition services which may include assessment and information on a healthy diet to meet the individual's needs;
- enterostomal therapy which includes care and support for people who have wounds, ostomies or incontinence;
- social work services which may include counseling to help individuals and families cope with illness, loss or end of life issues; and
- peritoneal dialysis services which may include support from home care nurses for dressing and tubing changes as well as education for individuals and their families (Seniors' Secretariat of Prince Edward Island, 2015).

In addition to the professional, consultative and support services noted above, home care also provides several specific programs and services including:

- assessment for, and coordination of, nursing home admissions to ensure that all options to enable an individual to remain in the community as long as possible have been explored;
- administration of the provincial integrated palliative care program, provision of care coordination for individuals requiring palliative care and the delivery of services to individuals who wish to receive palliative care in their homes;
- designated adult protection workers who are responsible for receiving and investigating referrals of neglect or abuse in accordance with the Adult Protection Act;
- management of five adult day programs; and
- an expert collaborative team which supports frail seniors in their home.

As publicly funded home care services are limited, individuals may need to obtain additional home care services through private for-profit and/or private not-for-profit organizations in order to receive sufficient care. Private for-profit home care providers in Prince Edward Island include: Bayshore HealthCare, Home Instead Senior Care, and We Care Home Health Services (Seniors' Secretariat of Prince Edward Island, 2015).

Bayshore HealthCare is a national community health care provider. The Prince Edward Island branch provides nursing, pharmacy, foot care, personal support and home support services to clients 24 hours a day, 7 days a week. Home Instead Seniors Care is an international provider of non-medical in-home care services for seniors. In Prince Edward Island, Home Instead is a locally-owned franchise

which provides skilled non-medical care and support to seniors, including those with Alzheimer's disease or other forms of dementia. We Care Home Health Services is a national provider. The Prince Edward Island location offers personal care, home support, companion services, foot care, escorts for appointments, wellness and immunization clinics, and drug and alcohol testing.

As shown in Table 4, private home care services may include a range of services, including but not limited to, companionship, home support, personal support, specialized (e.g., dementia) care and a variety of professional services.

TABLE 4: Private Home Support, Personal Support and Professional Services Available in PEI

Home Support	Personal Support	Professional Services
➢ Meal preparation	➢ Complex/specialized care	➢ Nursing care[a, b]
➢ Medication reminders	➢ Assistance with activities of daily living	➢ Pharmacist[a]
➢ Transitional care	➢ Bathing	➢ Foot care[a,b]
➢ Discharge assistance	➢ Dressing	➢ Drug testing[a,b]
➢ Accompany to medical appointments	➢ Incontinence care/toileting	➢ Childprotection services[b]
➢ Transportation	➢ Transfers and lifts	➢ Immunization and wellness clinics[a,b]
➢ Grocery shopping and errands	➢ Mobility assistance	
➢ Laundry and linens	➢ Safety	
➢ Light housekeeping		
➢ Respite		
➢ Companionship		
➢ Supplemental support services (in hospitals & other facility settings)		

[a] Bayshore HealthCare [b] We Care
Source: Home Instead Senior Care & Bayshore HealthCare, 2013

Private home care services are primarily paid for by individuals and/or their families and to a lesser extent (based on client eligibility criteria established by funders) by insurance providers, Veterans Affairs Canada, and the Workers Compensation Board. Individuals receiving private home care services are charged HST unless they are also receiving government funded services (e.g., through the provincial home care program or Veterans Affairs Canada). Services are also disability tax credit eligible (Seniors' Secretariat of Prince Edward Island, 2015). Table 5 presents the cost of several private home care services in Prince Edward Island.

TABLE 5: Cost of Private Home Care Services

Type of Service	Provincial Range	Provincial Median
Meal delivery (per meal)	$3.00 - $5.00	$4.00
In home meal preparation (per hour)	$18.75 - $21.75	$20.25
Laundry/housekeeping (per hour)	$18.75 - $22.50	$21.75
Personal care (e.g., bathing, dressing) (per hour)	$21.25 - $23.50	$22.75
Companionship/supervision (per hour)	$19.75 - $22.50	$19.75
Skilled nursing[2] (per hour)	$45.00 - $55.00	$51.00
In home respite (per hour)	$19.75 - $24.00	$22.75
Palliative care (per hour)	$21.25 - $55.00	$24.00

Source: Sykes Assistance Services Corporation, 2015

There is a growing demand for home care services in the province (CSI Consultancy, 2015). As there is a finite amount of funding available for home care, it is anticipated that the number of individuals receiving home care services will decline, or at best, remain the same (CSI Consultancy, 2015).

4.1.3 Community Care Programs and Services

Community care programs and services include adult day programs, mental health services, and educational programs such as the *Living a Healthy Life Program*.

Adult day programs provide adults with special needs (e.g., those with memory loss, communication disorders, or physical disabilities or those experiencing social isolation) with a safe group setting when family members are not available to care for them. The day programs enhance individuals' wellbeing and provide support and/or respite for family members. Adult day programs are accessed, managed and operated by Health PEI. Individuals pay $5.00 to $6.00 per day to cover part of the cost of meals and activities; transportation costs are extra (Sykes Assistance Services Corporation, 2015). There are five day programs in the province within Health PEI.

The community mental health system in PEI includes centres that offer: assessment; consultation; treatment; crisis intervention; medication assistance; and outreach and ongoing support for individuals with mild to moderate mental health problems (Seniors' Secretariat of Prince Edward Island, 2015).

Living a Healthy Life Program assists individuals with ongoing health conditions to address daily challenges and maintain active lives. The program, which is also open to caregivers, consists of six sessions. Topics include: managing symptoms; healthy eating; exercise; better communication; and making daily tasks easier (Seniors' Secretariat of Prince Edward Island, 2015).

[2] Fees are based on rates for RNs. Fees may vary depending on the type of nurse delivering the care (e.g., RN, LPN).

4.2 Supportive Residential Care

The Canadian Centre for Elder Law Studies (2005) defined supportive residential care as follows:

> *'Supportive housing'[3] is an umbrella term that covers a range of housing options designed to accommodate the needs of older adults through building design features, housing management and access to support services. At one end of the range, supportive housing refers to congregate housing with supportive features and services such as monitoring and emergency response, meals, housekeeping, laundry and recreational activities. At the other end of the supportive housing range (referred to in most North American jurisdictions as, "assisted living") personal care services are provided for frailer seniors with more significant support needs in addition to monitoring and hospitality services. Professional services may also be provided on a "home-care" basis in a supportive housing setting as they would be if the resident were living in a different kind of (non-supportive) residential setting.*

Several different terms are used to refer to primary supportive residential care settings across Canada as outlined in Appendix C.[4] Despite the differences in terminology, the concept of (primary) supportive residential care appears to be quite similar across jurisdictions and generally involves three components: 1) accommodation (private units/apartments, private bedrooms, or a combination of private units and bedrooms); 2) hospitality services (e.g., light housekeeping, laundry services, 24-hour safety/security measures); and 3) care services (e.g., assistance with meals, activities of daily living, medications).[5]

The Canadian Centre for Elder Law Studies (2005) has indicated that the role of supportive residential care will become increasingly important as both an appropriate and sustainable housing option, as the population continues to age. They also note that a key challenge for supportive residential care settings will be determining when it is no longer appropriate (generally because of health and/or safety concerns) for individuals to live there. In Alberta, British Columbia, New Brunswick, Nova Scotia, Prince Edward Island and Québec, supportive residential care settings are designed for adults (18 or 19 years of age or older).[6] Several jurisdictions (i.e., Manitoba, Newfoundland and Labrador, Ontario and Saskatchewan) specifically target older adults and seniors.

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[3] The Canadian Centre for Elder Law Studies (2005) noted that in their report, the term supportive housing was used to "refer to housing with services for seniors regardless of government involvement and independent of any specific government program referring to "supportive housing" in its title or description."

[4] In their review of supportive residential care settings in Canada, Miller and Cherry (2016a) noted that in most jurisdictions in Canada, there appeared to be a primary supportive residential care setting as well as one or more other types of housing options. The primary supportive residential care setting was often well documented (e.g., there was generally information available regarding eligibility criteria, relevant legislation and funding). In contrast, there was relatively little information available regarding other types of supportive housing options.

[5] It is cautioned that, given the various terms used within and across jurisdictions in Canada (and elsewhere), it is *absolutely essential* to determine how each jurisdiction labels and defines (primary) supportive residential care in order to ensure one is comparing similar types of settings.

[6] In some jurisdictions (e.g., Alberta and British Columbia) the majority of individuals in supportive residential care settings may be seniors (Office of the Seniors Advocate, 2015b; Strain, Maxwell, Wanless&Gilbart, 2011).

Appendix D presents information regarding the number of supportive residential care settings and units/beds in each jurisdiction, as well as information on who owns and/or operates the facilities.

4.2.1 Government Responsibility for Supportive Residential Care

Responsibility for supportive residential care settings falls under the Ministry/Department of Health in British Columbia, Alberta, Saskatchewan, Manitoba, Québec, Newfoundland and Labrador, and Prince Edward Island.[7] In general, in these jurisdictions, provincial departments are responsible for developing legislation, regulations, policies and standards related to the provision of services in supportive residential care settings, and monitoring compliance with legislation and standards (Miller & Cherry, 2016a). In British Columbia, Alberta, Saskatchewan, Manitoba, and Newfoundland and Labrador, regional health authorities are responsible for conducting assessments to determine an individual's eligibility for different types of living environments, and providing subsidies for eligible individuals (Miller & Cherry, 2016a).

In three jurisdictions (New Brunswick, Nova Scotia and Ontario), responsibility for supportive residential care settings is the responsibility of an organization other than a Ministry/Department of Health, or is a shared responsibility with the Ministry of Health (Miller & Cherry, 2016a). In New Brunswick, the Department of Social Development is responsible for inspecting and licensing special care homes.[8] In Nova Scotia, responsibility for residential care facilities falls within the mandate of both the Ministry of Community Services and the Ministry of Health. The Ministry of Community Services is responsible for establishing the per diem rate for residential care facilities or homes for the disabled, while the Ministry of Health is responsible for establishing the per diem rate for homes for the aged and nursing homes (Government of Nova Scotia, 1989). Both ministries are responsible for licensing residential care facilities (Government of Nova Scotia, 1989).

In Ontario, the Retirement Homes Regulatory Authority, which was created relatively recently under the *Retirement Homes Act*, is responsible for supportive residential care settings (i.e., retirement homes; Ontario Retirement Communities Association, 2013b). The Authority is not part of the Ontario government nor is it a crown organization. Rather, it is an independent not-for-profit organization that is responsible for administering the *Retirement Homes Act* (St. Andrew's Residence, 2016). The Retirement Homes Regulatory Authority is accountable to the Ontario government through a Memorandum of Understanding (St. Andrew's Residence, 2016).

In Prince Edward Island, community care facilities are privately owned and operated supportive residential care facilities which provide services to five or more residents (Government of Prince Edward Island, 2016b). Community care facilities provide accommodation, meals, housekeeping, help and supervision with activities of daily living and personal care, and regular monitoring of health and

[7] In Manitoba, the role of Manitoba Health, Healthy Living and Seniors, with respect to supportive residential care settings is unclear; however regional health authorities are responsible for some key activities (Miller & Cherry, 2016a).
[8] The terms are those used for supportive residential care settings in the jurisdiction as outlined in Appendix C.

personal welfare; 24-hour nursing care is not provided (Community Legal Information Association of Prince Edward Island, 2014; Government of Prince Edward Island, Legislative Counsel Office, 2010a).

As of May 2016, there were 39 community care facilities in PEI with a total of 1,289 units/beds (Government of Prince Edward Island, personal communication, May 2016). However, not all of the community care facilities are designed specifically for seniors. Seven community care facilities provide both community care and long term care services (Government of Prince Edward Island, 2015). Collectively, these dual facilities have 262 community care beds. As of October 2015, 27.5% of the community care beds were subsidized beds for individuals 65 and older (Government of Prince Edward Island, 2015).

4.2.2 Regulation and Licensing of Supportive Residential Care Settings

Some jurisdictions (e.g., Alberta, Nova Scotia, Ontario and Saskatchewan) have developed legislation specifically for supportive residential care settings. Others (e.g., British Columbia, Newfoundland and Labrador and Prince Edward Island) have developed legislation for multiple components in the continuum of care. For example, in Prince Edward Island, legislation governing supportive residential care settings is combined with legislation governing long term care facilities. In two jurisdictions, (New Brunswick and Québec) legislation governing supportive residential care settings is incorporated into general acts related to the provision of health and/or social services. Neither Manitoba nor Yukon appear to have legislation related to supportive residential care settings (Miller & Cherry, 2016a). All jurisdictions (except Manitoba and Yukon) have developed regulations specifically for supportive residential care settings.

In all jurisdictions (except Manitoba and Yukon, and possibly Québec), supportive residential care settings must be licensed to operate.[9] To maintain their license, the facilities must be compliant with all applicable legislation, regulations, standards, etc., as well as the terms and conditions of their licenses. It is not clear whether intermediate resources in Québec need to be licensed to operate. They do, however, need to be compliant with relevant legislation and must have signed an agreement with a CISSS or CIUSSS[10] (Miller & Cherry, 2016a).

In British Columbia, Saskatchewan, New Brunswick, Nova Scotia, and Prince Edward Island licenses are valid for one year. In Alberta and Newfoundland and Labrador, licenses may be good for up to three years. It is not known how long licenses are valid for in Ontario or Québec. (Miller & Cherry, 2016a).

In most jurisdictions, (i.e., Alberta, Newfoundland and Labrador, Nova Scotia, Ontario, Prince Edward Island and Saskatchewan), licenses are location specific and/or non-transferable. In British Columbia, assisted-living residences must be registered with the Assisted Living Registrar. It is reasonable to

[9] In British Columbia, operators of assisted-living residences must be registered with the Assisted Living Registrar (Government of British Columbia, no date, a). The process is similar to being licensed.

[10] CISSS = Centre Intégré de Santé et de Services Sociaux; CIUSSS = Centre Intégré Universitaire de Santé et de Services Sociaux.

presume that the registration is location specific. It is not clear if licenses for special care homes in New Brunswick are location specific and non-transferable (Miller & Cherry, 2016a).

In Prince Edward Island, community care facilities are regulated under the *Community Care Facilities and Nursing Homes Act* and the *Community Care Facilities and Nursing Homes Act Regulations* (Government of Prince Edward Island, Legislative Counsel Office, 2005, 2010a).

The Community Care Facilities and Nursing Homes Board, which was incorporated under the *Community Care Facilities and Nursing Homes Act* is responsible for:

- licensing community care facilities and private nursing homes;
- advising on standards for facilities and the care and services provided in them;
- monitoring facilities and ensuring compliance with prescribed standards;
- providing guidance on the assessment and placement of individuals; and
- providing guidance with respect to charges for care and nursing services (Government of Prince Edward Island, Legislative Counsel Office, 2010a).

Community care facilities must be licensed to operate (Government of Prince Edward Island, Legislative Counsel Office, 2010a, s. 7). Licenses are specific to each facility, are non-transferable and are usually good for one year (Government of Prince Edward Island, 2005, ss. 3 (1), 3 (2), and 6 (1)). The Community Care Facilities and Nursing Homes Board may refuse, refuse to renew, revoke, suspend or impose conditions on a license if it feels a facility would not, or is not, operating in accordance with the standards or terms of its license (Government of Prince Edward Island, Legislative Counsel Office, 2010a, s. 10).

The Community Care Facilities and Nursing Homes Board is responsible for the inspection of community care facilities under the *Community Care Facilities and Nursing Homes Act* (Government of Prince Edward Island, 2016a). Inspections are conducted annually to ensure community care facilities are in compliance with regulatory requirements (Government of Prince Edward Island, 2016c). Inspections may be unannounced and may take several days to complete depending on the size of the facility (Government of Prince Edward Island, 2016c). If the board deems it necessary, facilities may be subject to more frequent inspections (Government of Prince Edward Island, 2016c). Inspection findings are reviewed with the operators, and reported to the Community Care Facilities and Nursing Homes Board (Government of Prince Edward Island, 2016c).

4.2.3 Eligibility, Assessment and Care Plans

Eligibility criteria for supportive residential care settings vary considerably from jurisdiction to jurisdiction in Canada. In general, it appears that eligible individuals must require some assistance (with hospitality and/or care services) to remain independent and must be able to live safely in a supportive residential care setting (e.g., are ambulatory; Miller & Cherry, 2016a).

In many jurisdictions (i.e., British Columbia, Manitoba, New Brunswick, Newfoundland and Labrador, Nova Scotia, Prince Edward Island and Québec), individuals considering moving into a supportive

residential care setting undergo an assessment to determine whether they meet the eligibility criteria for supportive residential care and whether that is the best option for them based on their current and anticipated future needs. In many cases, the assessments are conducted by health authority staff (usually nurses or social workers). If supportive residential care is determined to be the best option, individuals may be responsible for contacting supportive residential care settings directly (Miller & Cherry, 2016a).[11]

In some jurisdictions (such as Alberta, New Brunswick, Newfoundland and Labrador, Nova Scotia, Prince Edward Island, Québec and Saskatchewan), operators of supportive residential care settings are responsible for ensuring that a comprehensive care plan is developed for each individual shortly after he/she is admitted to the supportive residential care setting. In addition, individuals need to be reassessed on a regular basis (usually annually) and when their needs change (Miller & Cherry, 2016a).

In Prince Edward Island, individuals admitted to a community care facility must be assessed as requiring Level 1, 2, or 3 care based on the Seniors Assessment Screening Tool (Government of Prince Edward Island, Department of Health, 2009b, s. 4.1). In general, facilities conduct their own assessments. However, when home care has worked with individuals who are transitioning to community care, assessments and care plans are shared with community care facilities with the individual's permission (Health PEI, personal communication, June 2016). If an individual's assessed care requirements can be met by moving to a community care facility, the individual is free to decide which facility is right for them (Community Legal Information Association of Prince Edward Island, 2014).

An initial care plan must be developed within 24 hours of an individual's admission to the continuing care facility (Government of Prince Edward Island, Department of Health, 2009b, s. 4.2). The plan must contain sufficient information (e.g., regarding: assistance required with activities of daily living; safety risks; medication, treatment and diet orders; and allergies) to enable safe care to be provided. A comprehensive care plan needs to be developed within four to six weeks of admission (Government of Prince Edward Island, Department of Health, 2009b, s. 4.2). This plan needs to provide staff with clear direction on addressing: an individual's need for assistance with activities of daily living; safety issues; nutrition issues; social activities; religious/spiritual activities; access to treatment; and any special or unusual care requirements (Government of Prince Edward Island, Department of Health, 2009b, s. 4.2).

Each individual's care, services, and outcomes need to be monitored and evaluated on an ongoing basis. Care and services need to be documented in the individual's record by a direct care provider on at least a monthly basis (Government of Prince Edward Island, Department of Health, 2009b, s. 4.5). Reassessments of the individual's care and/or services needs must be conducted every 12

[11] In at least two jurisdictions (British Columbia and Manitoba), regional health authority staff refer individuals to supportive residential care settings (Miller & Cherry, 2016a).

months or if there is a change in the individual's condition (Government of Prince Edward Island, Department of Health, 2009b, s. 4.2).

If an individual currently residing in a community care facility requires more care than the facility can provide, the facility is required to have an assessment done to determine the level of care required. A request is made to home care to proceed with the long term care admission process, which is an intake, assessment and decision-making mechanism within Health PEI. The process provides for a structured, orderly admission of clients to long term care once they have been assessed at either Level 4 or Level 5, based on the Seniors Assessment Screening Tool (Health PEI, personal communication, June 2016).

4.2.4 Funding for Supportive Residential Care

With the exception of Manitoba, Nova Scotia and Québec, government funding for supportive residential care may be limited to subsidies for individuals with low incomes. In Manitoba, the support component of supportive housing is funded through the regional health authorities (Long Term Care and Continuing Care Association of Manitoba, 2016). In Nova Scotia, the provincial government covers health care costs which include:

- salaries, benefits and operational costs of nursing and personal care, social work services and various therapies;
- patient transportation for dialysis treatment; and
- costs associated with the loan of specialized equipment (Government of Nova Scotia, Department of Health and Wellness, no date; Government of Nova Scotia, Department of Health and Wellness, 2015a).

In Québec, the CISSS (or CIUSS) pays intermediate resource operators a daily rate for each resident. The rate is based on the resident's level of care as determined at the time of admission (Comité patronal de négociation du secteur de la santé et des services sociaux, 2016). Rates range from $34.88 to $78.47 per day depending on the level of care required.[12] The operator also receives funding for operational costs.

In all jurisdictions except Ontario, the provincial government may provide subsidies to individuals with low incomes (Miller & Cherry, 2016a). In Ontario, individuals living in retirement homes are responsible for paying for their own accommodation, care and services – government subsidies are not available (Ontario Retirement Communities Association, 2013a).

Resident fees are used to cover the cost of accommodation (i.e., room and board) in supportive residential care settings. As shown in Table 6, resident fees may vary considerably within a jurisdiction and do vary substantially across jurisdictions. Resident fees may be based on the type of accommodation provided, the resident's characteristics, the resident's income, or a set rate.

[12] There are six care levels (Government of Québec, 2016). For the first 60 days following the arrival of a resident, intermediate resource operators are funded $47.88 per day regardless of the resident's level of care (Comité patronal de négociation du secteur de la santé et des services sociaux, 2016).

In Newfoundland and Labrador, Ontario, Prince Edward Island and Saskatchewan, resident fees are established by each supportive residential care setting. This is also the case for some non-designated supportive living facilities in Alberta (Miller & Cherry, 2016a).[13]

TABLE 6: Monthly Resident Fees for Supportive Residential Care

Jurisdiction	Resident Fee	Resident Fee Based On
Northwest Territories	unknown[14]	• unknown
Yukon	$2,400[15]	• set rate[16]
Nunavut	unknown[17]	• unknown
British Columbia	$921.40[18]	• set rate
Alberta	$1,554 - $1,893[19]	• type of accommodation
Saskatchewan	$1,000 - $4,000[20]	• rate established by each personal care home
Manitoba	$1,295 – $2,495[21]	• set rate
Ontario	$1,500 - $6,000[22]	• rate established by each retirement home
Québec	$1,198.80[23]	• resident characteristics[24]
New Brunswick	$2,296[25]	• set rate
Nova Scotia	$1,954[26]	• set rate
Prince Edward Island	**Unknown**	• **rate established by each continuing care facility**[27]
Newfoundland and Labrador	Unknown	• rate established by each personal care home

Source: Miller & Cherry, 2016a

[13] In some supportive living facilities in Alberta, Albert Health Services controls access to a specified number of supportive living spaces through an agreement with the operator; these are known as designated supportive living facilities (Government of Alberta, 2014). In non-designated supportive living facilities, access to the supportive living beds is not controlled by Alberta Health Services.

[14] The Northwest Territories currently have three elders' centres (Government of Northwest Territories, 2016).

[15] Anticipated (Dolphin, 2014).

[16] Anticipated (Dolphin, 2014).

[17] Nunavut currently has one elders home for individuals with low care needs (Nunatsiaq Online, 2016).

[18] 2016 minimum rate; maximum monthly rate is based on market rent for housing and hospitality services where the individual lives as well as the actual cost of the personal care services received (Government of British Columbia, 2016). Maximum 2015 rates for single individuals ranged from $2,350 - $5,552 (Office of the Seniors Advocate, 2015b).

[19] 2015 rates (Alberta Health, 2015). The rates are expected to increase to $1,601 - $1,950 per month July 1, 2016 (Alberta Health, 2015).

[20] 2012 rates (Provincial Auditor Saskatchewan, 2012).

[21] 2016 rates (Long Term Care and Continuing Care Association of Manitoba, 2016).

[22] 2015 rates (Government of Ontario, 2015a).

[23] 2016 maximum rate (RAMQ information centre, personal communication, February 2016). The maximum rate is based on an estimated stay of two years or longer for individuals who are not recipients of last resort funding. The amount is indexed every year on January 1st.

[24] The resident accommodation amount is based on three factors: whether or not the individual is a recipient of last resort financial assistance; the estimated time the individual will stay in the intermediate resource (less than 2 years/more than 2 years); and the individual's age (under/over 65 years of age)

[25] 2012 rate (Coalition for Seniors and Nursing Home Residents Rights, 2012).

[26] 2015 rate (Government of Nova Scotia (2015a).

[27] It is believed that each community care facility in Prince Edward Island sets its own rate as all community care facilities are privately owned. However, no rate information was obtained.

In Prince Edward Island, residents are responsible for paying the cost of accommodation, although limited financial assistance may be available (Seniors' Secretariat of Prince Edward Island, 2015). Individuals are expected to pay for care to whatever extent they can. If assets (income and savings or investments) are insufficient to cover the cost of care, the province may provide a subsidy under the *Social Assistance Act* (Community Legal Information Association of Prince Edward Island, 2014).

If an individual needs to apply for a subsidy, it is important to find out the costs of the community care facility first (each community care facility sets its own resident accommodation fee). Although many community care facilities accept individuals who are subsidized, not all rooms in a community care facility may be available for those receiving a subsidy. In addition, there is an upper limit to the subsidy which may affect which community care facility an individual is able to go to (Community Legal Information Association of Prince Edward Island, 2014).

The amount of financial assistance provided by the government (through the Department of Family and Human Services) is the difference between the amount a subsidized individual contributes towards his/her cost of care and the established rate for care services in a continuing care facility. The established rate as of June 1, 2016 was $72.37 per day (Government of Prince Edward Island, personal communication, May 2016).[28]

Individuals wishing to obtain financial assistance need to undergo a financial assessment which includes providing information regarding their assets, income, liabilities and debts (Community Legal Information Association of Prince Edward Island, 2014). Assets include one's home (if no family members are living in it), property that can be converted to cash (including house and land), RRSPs, life insurance, pensions, bonds, an inheritance or a benefit received from a trust (Community Legal Information Association of Prince Edward Island, 2014).

4.3 Long Term Care

Several different terms are used for long term care facilities across Canada as illustrated in Appendix E. Although the terms differ across jurisdictions, the concept of what constitutes long term care is relatively consistent:

> *Long term care involves the provision of care and support 24 hours a day to individuals with complex care needs[29] who can no longer live safely at home or in a supportive residential care setting despite support from family, friends and neighbors and/or home and community support services (Miller & Cherry, 2016b).*

Long term care facilities are intended to support individuals with complex care needs who can no longer be safely cared for in other types of settings. In the majority of jurisdictions, adults (18 or 19 years of age or older) may be admitted into long term care facilities.

[28] This rate will be in effect until May 31, 2017 (Government of Prince Edward Island, personal communication, May 2016).
[29] Complex care needs may include physical and/or mental health conditions.

Nevertheless, in some jurisdictions (British Columbia, Manitoba, Newfoundland and Labrador and Saskatchewan), a substantial majority of long term care residents are seniors.[30] Alberta, Northwest Territories and Prince Edward Island specifically target seniors for long term care facilities (Alberta Health, personal communication, November 2015;[31] Government of Northwest Territories, no date; Government of Prince Edward Island, Health PEI, 2012).

In Prince Edward Island, nursing homes provide accommodation, supervisory care, nursing and personal care, and medical services 24 hours a day for individuals with complex care needs who can no longer be cared for in their own homes (see e.g., Government of Prince Edward Island, Department of Health, 2007a). Nursing homes provide care for five or more individuals (Government of Prince Edward Island, Legislative Counsel Office, 2010a, s. 1 (j)).

Saskatchewan has the largest number of long-term care beds for individuals 75 years of age and older; Manitoba and Prince Edward Island have the second and third largest number of beds, respectively, as outlined in Table 7.

*TABLE 7: Number of Long Term Care Facility Beds Per 1000 Individuals 75 Years and Older**

Jurisdiction	Number of Long Term Care Beds	Number of Individuals 75 Years of Age and Older	Number of Beds Per 1000 Individuals 75 Years of Age and Older
British Columbia	25,768	353,852	72.8
Alberta	14,523	204,991	70.8
Saskatchewan	8,857	78,115	113.4
Manitoba	9,714	84,886	114.4
Ontario	78,120	974,184	80.2
New Brunswick	4,455	59,329	75.1
Nova Scotia	6,923	73,230	94.5
Prince Edward Island	**1,141**	**10,866**	**105.1**
Newfoundland and Labrador	2,880	36,812	78.2
Canada	152,381	1,876,265	81.2

*Data not available for Québec, Northwest Territories, Yukon and Nunavut.
Source: Government of Prince Edward Island, 2015

Nursing homes in Prince Edward Island include publicly funded manors as well as licensed private nursing homes (Sykes Assistance Services Corporation, 2015).

[30] In British Columbia, over 95% of residents in long term care facilities are seniors (Office of the Seniors Advocate, 2015a). In Newfoundland and Labrador and Saskatchewan, over 90% of residents are seniors (Newfoundland and Labrador Department of Health and Community Services, personal communication, February 2016; Saskatchewan Ministry of Health, personal communication, February 2016). In Manitoba, over 70% of long term care residents are seniors (Manitoba Health, Healthy Living and Seniors, personal communication, February 2016).
[31] In Alberta, not all long term care residents are seniors, but the emphasis is on meeting the needs of seniors (Alberta Health, personal communication, November 2015).

As shown in Table 8, until July 2016 there were nine publicly funded manors and ten[32]privately owned and operated nursing homes in Prince Edward Island. As noted previously, seven of these facilities provide both continuing care and long term facility care services. Collectively, the nursing homes have 1,141 long term care beds, 12 respite beds and 13 restorative care beds.

TABLE 8: Number of Long Term Care Facilities and Beds in Prince Edward Island

		Public Manors	Private Nursing Homes	Total
Number of Facilities		9	10[33]	19
Number of Long Term Care Beds	Private Rooms	462	178	641
	Semi-Private Beds	133	368	501
	Total	**595**	**546**	**1,141**
Number of Designated Safety Beds		107	62	169
Number of Respite Beds		12	0	12
Number of Restorative Beds[34]		12	1	13

Source: Government of Prince Edward Island, 2015; Seniors' Secretariat of Prince Edward Island, 2015.

The majority of private rooms are located in public manors. All of the respite beds are in private rooms (Government of Prince Edward Island, 2015). There are a total of 169 beds in four manors and four private nursing homes designated for individuals with moderate to severe dementia with challenging behaviors who require a small group environment and a specialized care program. Referred to as designated safety beds, these beds are included within the long term care bed count (Government of Prince Edward Island, 2015).

Between 2007 and 2015, the number of long term care beds in Prince Edward Island increased from 996 in 2007 to 1,141 in 2015 (a 14.6% increase; Health PEI, 2015a). CSI Consultancy (2015) has noted that there appears to be an over reliance on nursing home beds in Prince Edward Island; the province uses 14% more long term care beds than the national average.

The number of long term care beds in Prince Edward Island for individuals 75 years of age and older is about 29% higher than the Canadian average and approximately 11% higher than the number in Nova Scotia as illustrated in Table 7 above.

[32] In July 2016, one private nursing home closed, although all beds were moved to another private nursing home. Thus, while the total number of facilities has declined, the number of beds has remained the same.
[33] Ibid.
[34] The one WCB funded bed located at the Mount Community of Care has been aggregated with the 12 restorative beds located at Prince Edward Home.

4.3.1 Government Responsibility for Long Term Care in Canada

In Canada, provincial/territorial responsibility for long term facility care generally falls within the mandate of the Ministry/Department of Health.[35] Provincial/territorial responsibility tends to focus on:

- strategy development;
- the development of legislation, regulations, and standards;
- overseeing the continuing care/integrated care system;
- providing funding to regional health authorities for long term care (where applicable); and
- establishing fees for long term care (Miller & Cherry, 2016b).

In general, health authorities in each jurisdiction are responsible for:[36]

- planning and managing long term care programs, services and facilities within their boundaries;
- delivering long term care services directly and/or through contracts with not-for-profit and for-profit organizations;
- ensuring that long term care facilities are compliant with relevant legislation, regulations, standards, licensing requirements, etc.;
- determining individuals' eligibility for long term care, conducting assessments, and coordinating admissions to long term care facilities; and
- providing funding to long term care facilities for health care services and individuals who are eligible for a reduction in the resident accommodation fee (Miller & Cherry, 2016b).

4.3.2 Regulation and Licensing of Long Term Care Facilities

All jurisdictions have developed legislation and regulations related to the operation of long term care facilities. In all provinces (except Newfoundland and Labrador and Saskatchewan), long term care facilities must be licensed to operate (Miller & Cherry, 2016b). In Alberta and Québec, all long term care facilities must be accredited as well as licensed (Auditor General of Alberta, 2014; Québec Ministère de la santé et des services sociaux, personal communication, October 2015). In Newfoundland and Labrador, all nursing homes are accredited but not licensed (Newfoundland and Labrador Department of Health and Community Services, personal communication, February 2016). In Saskatchewan, special care homes are not licensed (Saskatchewan Ministry of Health, personal communication, February 2016). In Prince Edward Island, public manors are accredited and private nursing homes are licensed.

4.3.3 Assessment for Long Term Care

Most jurisdictions in Canada emphasize keeping individuals at home/in the community with appropriate supports for as long as possible. There are many reasons for this including: supporting

[35] In Prince Edward Island, the Community Care Facilities and Nursing Homes Board (which reports to the Minster of Health and Wellness) plays a major role in the licensing and monitoring of nursing homes.

[36] Québec has integrated health and social service centres located throughout the province but does not have health authorities per se.

individuals' desire to remain at home; maximizing an individual's quality of life and independence for as long as possible; a desire to keep the family unit (e.g., spouses) together for as long as possible; and using limited resources (e.g., financial, space) as efficiently as possible (Miller & Cherry, 2016b).

Every jurisdiction in Canada uses an assessment process to determine an individual's eligibility for long term care. The assessments are generally conducted by health professionals (e.g., nurses, social workers, client care coordinators) from the health authority.[37] They may include input from other individuals (such as the person's family physician and/or family members). Eligibility requirements across jurisdictions include: the presence of physical and/or mental health conditions (including dementia) which require 24-hour care; and information which indicates the individual can no longer be cared for safely at home or in a supportive residential care setting (Miller & Cherry, 2016b).

In Prince Edward Island, admission to a nursing home is available to individuals who: meet the eligibility criteria; are assessed as requiring Level 4 or Level 5 nursing care which cannot be provided in the individual's place of residence; and wish to be admitted to a nursing home (Government of Prince Edward Island, Department of Health, 2007a).

To be eligible for admission to either a public or private nursing home in Prince Edward Island, an individual must be:

- a citizen or permanent resident of Canada;
- a resident of Prince Edward Island for six months or more (in a year);
- in possession of a valid Prince Edward Island health card; and
- assessed as needing a nursing home level of care (Government of Prince Edward Island, Health PEI, 2012).

Individuals who do not meet these criteria may be eligible for admission to a nursing home if they apply for exceptional status designation (Government of Prince Edward Island, Department of Health, 2007a).

Admission to a nursing home in Prince Edward Island is normally limited to individuals 60 years of age or older (Government of Prince Edward Island, Department of Health, 2007a). Individuals under 60 may be considered for nursing home placement when no appropriate alternative exists to meet their needs (Government of Prince Edward Island, Department of Health, 2007a).

Health PEI manages admissions to public and private nursing homes through a single point of entry in each region. Within each region, all individuals wishing to be admitted to a long term care facility need to be assessed by a designated Health PEI staff member (Health PEI, 2015b).

Assessments must include, but are not limited to, use of the Seniors Assessment Screening Tool (Government of Prince Edward Island, Department of Health, 2007a). Individuals admitted to nursing

[37] In Québec, assessments are conducted by a social worker or nurse from the local community service centre.

homes must be assessed as requiring Level 4 or Level 5 care based on the Seniors Assessment Screening Tool.

The Home Care Admissions Coordinator is responsible for processing applications, ensuring assessments are completed, determining eligibility and establishing priority for admission to a long-term care facility (Health PEI, 2015b). An Admission Committee or Admission Coordinator is responsible for offering an available long term care bed to the individual who has priority for admission to the long term care facility (Health PEI, 2015b).

Individuals who are medically discharged from acute care and approved for admission to a long term care facility are required to accept the first available bed that meets their assessed care needs (Health PEI, 2011).

The Health PEI Admission Committee is responsible for the waiting lists to nursing homes. Private nursing homes are responsible for their admission process and only accept individuals who have been assessed as requiring nursing home level of care by the Health PEI Admission Committee (Sun Life Assurance Company of Canada, 2014).

Efforts are made to accommodate individuals' location preferences. Individuals can and do request to be placed on a transfer list. Transfers from private to public long term care facilities often occur because the public facilities are less expensive and generally newer with access to private rooms at no additional cost (PEI Private Nursing Home Association, personal communication, June 2016).

Most individuals admitted into a nursing home have multiple complex diagnoses, usually a chronic condition with some form of cognitive impairment (Government of Prince Edward Island, Health PEI, 2015).

Table 9 presents the number of individuals admitted to long term care facilities in Prince Edward Island as well as the average length of stay over a five-year period. The data indicates that things have remained relatively stable over this period of time, and that public and private long term care facilities are very similar with respect to these characteristics.

TABLE 9: Number of Admissions to Long Term Care Facilities and Average Length of Stay for a Five-Year Period

		2010/ 2011	**2011/ 2012**	**2012/ 2013**	**2013/ 2014**	**2014/ 2015**	**Total/ Average**
Number of Admissions	Public Manors	206	225	206	256	251	1,336
	Private Nursing Homes	238	202	233	221	272	1,380
	Total	444	427	439	477	523	2,716
Average Age	Public Manors	81.8	82.6	82.7	82.5	82.8	82.1
	Private Nursing Homes	81.7	82.5	81.6	84.6	83.6	82.9
	Total	81.7	82.5	82.1	83.3	83.2	82.5

Average Length of Stay	Public Manors	2.70	2.70	2.80	2.90	2.60	2.74
	Private Nursing Homes	2.90	2.60	2.90	2.70	2.60	2.74
	Total	2.80	2.65	2.85	2.80	2.60	2.74

Source: Government of Prince Edward Island, 2015

Although the number of seniors requiring long term care has increased, the number of people on a waitlist for long term care decreased from 195 people in October 2012 to 110 people in October 2015 (a 44% decrease; Health PEI, 2015b). Table 10 indicates where people on the waiting list were living as of October 2015.

TABLE 10: Location of People on the Wait List for Long Term Care

# Waiting from Home	# Waiting from Community Care	# Waiting from Hospital	# Waiting from Other Locations	Total # Waiting
55	14	36	5	110

Source: Health PEI, 2015b

4.3.4 Funding of Long Term Care Facilities

In all jurisdictions in Canada except Nunavut, funding for long-term care facilities is provided by provincial and territorial governments, as well as through resident accommodation fees. In general, funding provided by government covers the majority of long term care costs. In several jurisdictions (e.g., Alberta, British Columbia, New Brunswick and Saskatchewan) government funding covers about 80% of long term care costs. In Nunavut, 100% of long term care costs are covered by the territorial government. Funding provided by government typically covers salaries and benefits, equipment, and supplies associated with resident care. In some jurisdictions (e.g., New Brunswick, Saskatchewan, and Nunavut), government funding may also cover insurance, taxes, renovations, mortgages and loan repayments (Miller & Cherry, 2016b). In all jurisdictions (except Alberta, Ontario and Québec),[38] provincial/territorial governments provide global funding to health authorities who are then responsible for administering it (Miller & Cherry, 2016b).

Resident accommodation fees are used to cover the cost of accommodation (i.e., room and board). As shown in Table 11, resident accommodation fees may be based on the type of accommodation provided, the resident's income, or a set rate. In general, individuals who are unable to afford the accommodation fee may be eligible for a subsidy or a reduction in the fee (Miller & Cherry, 2016b).

TABLE 11: Resident Accommodation Fees – All Provinces and Territories

[38] In Alberta, funding from the provincial government is distributed using a patient care based funding model (Auditor General of Alberta, 2014; Sutherland, Repin & Crump, 2013). In Ontario, funding from the provincial government is provided through an envelope funding system (Government of Ontario, 2013). In Québec, funding for privately owned, privately operated and publicly funded health care facilities (Private Institutions Under Agreement; Établissements privés conventionnés – EPCs) is comprised of two components: a clinical component and an operating component (Ministère de la santé et des services sociaux, personal communication, October 2015).

Jurisdiction	Monthly Resident Accommodation Fee (2015 Rates)	Accommodation Fee Based on
Northwest Territories	$772[39]	set rate
Yukon	$1,065[40]	set rate
Nunavut	not applicable[41]	not applicable
British Columbia	$991 - $3,158[42]	resident's income
Alberta	$1,554 - $1,893[43]	type of accommodation (basic, semi-private, private room)
Saskatchewan	$1,061 - $2,017[44]	set rate and income
Manitoba	$1,049 – $2,452[45]	resident's income
Ontario	$1,775 - $2, 535[46]	type of accommodation (basic, semi-private, private room)
Québec	$1,112 - $1,790[47]	type of accommodation (basic, semi-private, private room)
Nova Scotia	$1,992 - $3,346[48]	type of accommodation (residential care, nursing home)
New Brunswick	$3,437[49]	set rate
Prince Edward Island	**$2,505[50]**	**set rate**
Newfoundland and Labrador	$2,800[51]	set rate

Source: Miller & Cherry, 2016b

In Prince Edward Island, Health PEI provides both public and private nursing operators with a fixed dollar amount per bed per day to cover costs associated with basic health care services and supplies. Basic health care services and supplies include: nursing and personal care services; assistance with activities of daily living; medication administration; supplies and equipment necessary for the care of individuals (e.g., blood glucose monitoring supplies, dressings, and incontinence supplies); basic supplies for personal hygiene and grooming; and equipment for general use (e.g., mechanical lifts, shower chairs; Government of Prince Edward Island, Department of Health, 2007b; Government of Prince Edward Island, Health PEI, 2014; Sykes Assistance Services Corporation, 2015).

The December 2015 amount provided by Health PEI to nursing home operators for health care (not accommodation) was $99.06 per day per resident. In addition, Health PEI paid an additional $10 per

[39] Government of Northwest Territories (no date).
[40] Minimum rate (Taking Care Inc, 2014).
[41] Nunavut government covers all costs.
[42] Government of British Columbia (2015).
[43] Government of Alberta (2015).
[44] Government of Saskatchewan (2015).
[45] Government of Manitoba (2015).
[46] Government of Ontario (2015a).
[47] Régie de l'Assurance maladie du Québec (2015).
[48] Government of Nova Scotia, Department of Health and Wellness (2015b).
[49] Government of New Brunswick, Department of Social Development (2015).
[50] Sykes Assistance Services Corporation (2015).
[51] Government of Newfoundland and Labrador (2015c)

day for each dementia care bed identified in the license (Health PEI, Corporate Services and Long Term Care, personal communication, January 2016).

According to the *Long Term Care Subsidization Act*, Health PEI may assist individuals who cannot pay the full resident accommodation fee (see below; Government of Prince Edward Island, Legislative Counsel Office, 2010b, s. 1c). The resident must apply for the subsidy and undergo a financial assessment. As per the *Long Term Care Subsidization Act Regulations*, Health PEI may also provide a comfort allowance to subsidized residents to cover the purchase of items for residents' personal use and special needs (Government of Prince Edward Island, Health PEI, 2014). The 2015 comfort allowance amount was $103 per month (Sun Life Assurance Company of Canada, 2014).

Based on 2014/2015 numbers, approximately 81% of individuals living in public manors received partial or complete subsidies, while approximately 73% of individuals living in private nursing homes were subsidized (see Table 12).

TABLE 12: Percentage of Subsidized Individuals Living in Nursing Homes

Funding Source	Public Manors	Private Nursing Homes
Individual/Family Covers All Costs	13.1%	18.9%
Individual Receives Partial or Full Subsidy	81.1%	73.1%
Costs Covered by Veterans Affairs Canada	5.3%	7.0%
Costs Covered by Another Source	0.4%	1.1%

Source: Government of Prince Edward Island, 2015

In 2015/2016 Health PEI provided a $150,000 Capital Replacement Fund to assist private nursing homes with the purchase of needed equipment and/or the replacement or repair of infrastructure (Government of Prince Edward Island, no date) in addition to the funding noted above.[52] Private nursing homes must apply for funding from the fund. At present, there is no government funding available to cover the cost of new construction.

The combined allocations for public manor budgets and private nursing home grants have increased by 56.7% over the past 9 years (from $52.7 million in 2007/2008 to $82.6 million in 2015/2016) (Health PEI, 2015a).

Private nursing homes are responsible for establishing their own admissions procedures and fees.[53] The Department of Health and Wellness will pay up to $82.34 per day for accommodation costs and $99.06 per day for health care costs (PEI Private Nursing Home Association, personal communication, June 2016). Individuals who wish to live in a private nursing home are responsible for covering the resident accommodation fee, although they may be eligible for a subsidy (PEI Private Nursing Home

[52] This is the total amount available for all of the private nursing homes.

[53] Long Term Care Admission Committees (there are four across the province) manage waitlists for all long term care facilities.

Association, personal communication, June 2016). The cost of a private nursing home varies throughout the province. The rate ranges from $2,698 to $5,369 per month; the median is $3,532 per month (Sykes Assistance Services Corporation, 2015).[54]

Private nursing home residents who require financial assistance for drug coverage only, and who are unable to obtain assistance from other sources (e.g., Veterans Affairs Canada), may be eligible for assistance through the Private Nursing Home Program (Government of Prince Edward Island, Department of Health, 2007e). Drugs are provided to residents in public manors free of charge (PEI Private Nursing Home Association, personal communication, June 2016).

RESIDENT ACCOMMODATION FEE

The resident accommodation fee covers: room and board; laundry services; housekeeping and maintenance services; social/recreational activities; and basic trust account expenses (Government of Prince Edward Island, Health PEI, 2014).

Resident accommodation fees for publicly funded manors are established by the Prince Edward Island Department of Health and Wellness. The current cost is $82.34 per day ($2,505 per month) (Sykes Assistance Services Corporation, 2015). Private nursing home owners may charge different rates based on the type of accommodation an individual chooses.

According to the *Long Term Care Subsidization Act Regulations*, a resident whose assessed income is less than the resident accommodation fee can apply for a government funded subsidy (Government of Prince Edward Island, Legislative Counsel Office, 2007, s. 6). Subsidization is based on an individual's actual income from all sources as per the Net Income line on his/her previous year's income tax return (Government of Prince Edward Island, Department of Health, 2007b).

Individuals (and their spouse, if applicable) must apply for the maximum level of income for which they are eligible, including, but not limited to, Old Age Security, Guaranteed Income Supplement, and Canada Pension Plan benefits (Government of Prince Edward Island, Department of Health, 2007b). Individuals must apply all of their actual income received towards the cost of accommodation, subject to any income splitting or exemptions approved in accordance with the *Long Term Care Subsidization Act Regulations* (Government of Prince Edward Island, Department of Health, 2007b).

[54] The Sykes rates may be underestimated. The current rates are probably closer to $5,518 per month per resident (i.e., current rate of $99.06 per day for health care ($99.06x365=$36,157 per annum) + $82.34 per day for accommodation ($82.34x365=$30,054 per annum) based on the current subsidy rates. Some facilities may charge more for private rooms and self-paying residents. This equals a total cost of $66,211($36,157 + $30,054) per annum. The total per month (divided by 12) is $5,518 per month. This is the gross cost and is offset by payment towards accommodation costs from own source income such as Canadian Pension Plan, Old Age Security, Guaranteed Income Supplement and investment/pension income to the extent that any apply (Personal communication, PEI Private Nursing Homes Association, September 2016).

The amount of the subsidy is the difference between the individual's actual contribution towards the cost of accommodation and the cost of accommodation, plus an amount provided as a comfort allowance (Government of Prince Edward Island, Department of Health, 2007b). The $103 monthly comfort allowance[55] is intended to be used by individuals to purchase items for their personal use, comfort and recreation. It may also be used to purchase special needs items such as glasses, hearing aids, dentures, orthopedic shoes, and customized walkers (Government of Prince Edward Island, Department of Health, 2007c, 2007d). The comfort allowance is non-transferable (Government of Prince Edward Island, Department of Health, 2007c). An individual's eligibility for subsidization is reviewed annually (Government of Prince Edward Island, Department of Health, 2007b).

Individuals who do not apply for a subsidy do not need to undergo an income test, but are responsible for paying the resident accommodation fee (Government of Prince Edward Island, Department of Health, 2007b).

PAYER OF LAST RESORT

The Department of Health and Wellness is the payer of last resort for basic health care services and accommodation costs for individuals who are eligible for funding from other sources including, but not limited to: Veterans Affairs Canada; Workers Compensation Board; Court Award or Settlement; Federal Government Act; or Medical/Health Insurance (Government of Prince Edward Island, Department of Health, 2007b).

4.4 Other Components Related to the Continuum of Care

4.4.1 Respite Care

Respite care is provided for individuals whose primary caregiver is assessed as needing short term relief from providing ongoing care (Government of Prince Edward Island, Department of Health, 2007f). Requests for respite may be made by individuals, family caregivers or health service providers (Government of Prince Edward Island, Department of Health, 2007f). Assessment and coordination of respite care is managed by Health PEI's home care program in partnership with long term care (Health PEI, personal communication, June 2016). Referrals are made through the local home care office and processed by the Long Term Care Admissions Coordinator (Health PEI, personal communication, June 2016).

Respite beds are available in publicly funded manors. In general, an individual may be admitted to a respite bed for no more than 30 days in a 12-month period (Government of Prince Edward Island, Department of Health, 2007f). The cost of respite care is income based and is applied towards the cost of accommodations (Government of Prince Edward Island, Department of Health, 2007f).

Other costs (e.g., medication, personal supplies) are the individual's responsibility (Government of Prince Edward Island, Department of Health, 2007f).

[55] This rate has not been adjusted since 2007.

4.4.2 Restorative Care

Restorative care is available for individuals who need to recover after an illness, accident or surgery and who are expected to return to the community. Restorative care is offered at the Prince Edward Home in Charlottetown and Prince County Hospital in Summerside. Souris Hospital and Community Hospital O'Leary (in Souris and O'Leary, respectively) also provide restorative care within their limited resources.

4.4.3 Alternative Level of Care

Alternative Level of Care (ALC) patients are individuals who are using a hospital bed, but who require less intensive services and resources (Health PEI, 2015c). The number of ALC individuals appears to have declined between 2012/2013 and 2014/2015:

2012/2013	65
2013/2014	62
2014/2015	54.5 (Health PEI, 2015c)

In 2014/2015, the average wait time from a hospital bed to a nursing home (either private or public) was 41.3 days (Health PEI, 2015a).

5.0 SUMMARY OF CONSULTATONS

This section discusses the opportunities, challenges and gaps identified through the interviews, focus groups and stakeholder roundtable session. Participants were asked what was working well and where there were gaps and/or challenges for seniors and their families across the continuum of care. The common themes that emerged from the consultations are presented below.

5.1 Opportunities

Participants identified a number of successes that can be expanded or modeled to achieve the desired future state of care for seniors in PEI. There are pockets of services provided that are meeting the needs of seniors and it was generally believed that most health care providers and administrators understood the concept and value of person/family-centred care. Its implementation has remained a challenge.

A number of participants perceived the small size of the province as an opportunity to lead the country and be a model for high quality sustainable care for seniors. The small population and geographic size permits the province to pilot different models of care that can be expanded to the rest of Canada.

Public and private providers are cognizant and concerned about the impact of future demands of an aging population. The fact that the province and key stakeholders participated in this initiative was viewed as demonstrating the seriousness of the current and future environment and the importance of dialogue with regards to addressing the demands.

Publicly funded home care has assisted more seniors to remain and receive care at home. The centralized intake process has been successful in assessing and administering the right home care to seniors. It provides an opportunity to expand the role of case management across the continuum of care.

Supportive residential/community care enables seniors to live independently while enjoying access to social events and supportive-living assistance. Demand for supportive residential/community care living is being met.

The new public long term care facilities constructed in the last few years are smaller and modern yet "warmer" and with a more personal feeling. Some existing facilities have been renovated to provide a similar atmosphere. Continuation of the joint long term care committee that formerly existed, will improve upon the information exchange and communication between provincial and private long term care providers.

Several existing programs, including the restorative care program in long term care, were cited as examples of successful initiatives and identified as models to expand or build upon. The following initiatives were frequently cited – they are listed in no particular order:

Integrated Palliative Care Program

- community based program involving inter-disciplinary teams;
- referrals for the program are coordinated by the home care program through a care coordinator;
- program has been successful in respecting the wishes and keeping the client in the manor or home rather than in acute care;
- has also educated and raised awareness of end of life care for health care providers; and
- program has been expanded to include paramedics. The "Paramedics Providing Palliative Care at Home" program implemented in December 2015, allows paramedics to provide pain and symptom management care to clients in their home after hours. The first of its kind in Canada, all Island paramedics receive specialized clinical training and education to provide end of life care (CBC News, 2015).

SMART/SMHRT *(Senior's Mental Health Resource Team)*

- part of Health PEI's Mental Health and Addictions program based at McGill Community Mental Health;
- aim of the program is to reduce the incidents and impacts of psychiatric symptoms, maintain or improve the quality of life of clients and their caregivers, and assist in maintaining independent living (Health PEI, 2016);
- The program, which provides clinic based services as well as community outreach to clients living at home, in community care housing and consultation to long term care facilities, was initiated in Queens county and subsequently expanded to Prince and Kings counties (Government of Prince Edward Island, 2016d);
- multi-disciplinary team provides specialized mental health services to seniors experiencing complex mental health problems and to their caregivers; and
- team includes RNs and LPNs, social work, psychiatry and consulting psychology staff and collaborates with home care, the Provincial Geriatrician Program, inpatient psychiatric units and family physicians.

COACH *(Caring for Older Adults in Community and at Home)*

- program was created to improve access to care for frail seniors with complex needs and to address the issues of seniors' high use of services including emergency department visits, acute care inpatient days and appointments with primary care providers (McCardle, 2016);
- objectives are to: support seniors to remain at home longer and return home sooner; optimize existing resources across three partner programs (home care, geriatric program and primary care physicians); reduce duplication and repetition for seniors through sharing of information between partner programs; and increase awareness and expertise about complex geriatric syndromes (Coach Team, no date);
- involves an integrated, interdisciplinary expert team with the client at the centre, created through strong collaboration of existing resources in the three partner programs;
- was piloted in Montague, PEI in February, 2015 and has since been expanded to Souris, PEI.
- Geriatric Program nurse practitioner plays a key role on the team, acting as the interconnecting "glue" between various sectors of the healthcare system;
- the Geriatric Program nurse practitioner, a family physician and the care coordinator from home care are the core members of the team. Other team members are dependent on the client's needs and can include primary care staff such as Nurse Practitioners (NPs), Registered Nurses (RNs), Licensed Practical Nurses (LPNs), a geriatrician, and allied health or other health care providers;
- care is generally provided in the client's home;
- the pilot program was successful in keeping clients at home and providing opportunities for clients to self-manage and make informed decisions regarding their quality of care and life; and
- steering committee recommended expanding COACH into a provincial program.

Nurse Practitioner (NP) pilot program:

- program piloted in long term care facility to address the need for 24-hour medical coverage;
- NP collaborates with primary care physicians and geriatricians;
- provides education and information support to other staff members; and
- has been successful in addressing the gap of physician services.

PEI Cancer Treatment Centre

- person-centred approach to cancer care;
- multi-disciplinary cancer care team follows the client; and
- cancer care patient navigator available.

Participants commented that, despite challenges, Electronic Health Records (EHR) offer a positive solution for information sharing. Similarly, the social infrastructure support provided to seniors by churches, families, and community organizations relying on volunteers, provides an opportunity to address the issue of social isolation among seniors.

The capacity of family physicians in rural communities was cited as a benefit and opportunity to engage with seniors and their families. Some participants commented that family physicians assumed a different role in small and more remote communities because of their location.

5.2 Gaps and Challenges

Several current and anticipated challenges and gaps were discussed by participants in the interviews, focus groups and stakeholder roundtable session. The majority of the stakeholders consulted were aware of the 2010 Healthy Aging strategy for PEI but did not know how well the strategy was implemented, its impact and whether it had achieved its anticipated outcomes.

The **lack of a seniors' strategy** in PEI was identified by the majority of participants. They noted that the strategy should be client and family-centred and should address continuity of care and care planning including advanced care. The majority of stakeholders consulted were skeptical of any changes resulting from the review perceiving a resistance to change by decision makers. Many commented about the number of studies already completed with little action resulting.

A lack of coordinated and streamlined services and programs, fragmented services and programs, and limited collaboration between public and private providers were cited by the majority of participants. Stakeholders felt that there was little effort to streamline services provided by public and private providers despite increasing demand and limited resources.

Some raised the issue of inefficiencies resulting from a public system operating in silos and felt that the system was complicated. Time and focus is detracted from seniors and their families because of the inability to transfer funds from one department to another, complicated legislation and excessive paperwork.

The lack of information sharing and dialogue between public and private home care has resulted in duplication rather than integration of services for the same client. Other similar examples were identified across the continuum of care, stifling innovative and creative thinking by public providers. Participants commented that existing technology can be better integrated and used for information and data sharing, although inconsistent software and information privacy issues were identified as challenges.

A lack of coordinated **transitional care** was identified as an area requiring change. Several participants pointed out that seniors not suited for long term care are referred to nursing homes because there is nowhere else to send them. Quite often these seniors require rehabilitation but access and availability of these services is limited.

Communication and provision and **exchange of information** were identified by all stakeholder groups as a gap. While there was little communication and information sharing among providers, clarity and knowing what information was available and how to access it was cited as a challenge for seniors and their families. Many lacked awareness of the system, crippling families in their efforts to navigate the system at an emotional and stressful time.

Gaps in the **continuity of care** across the continuum were discussed. Integration of services and continuity of the family physician was limited, affecting the senior's care plan. Several stakeholders raised issues with the care plan, pointing out that there was very little to no follow up throughout the client's journey across the continuum and that discharge planning, particularly for speciality services off Island, is lacking altogether.

Human resource issues were identified across the continuum of care for seniors. Gaps in access to and the availability of social workers, occupational therapists, physiotherapists, pharmacists and mental health specialists such as psychiatrists and psychologists, as well as psychogeriatricians, was repeatedly discussed. The need for more nurse practitioners was raised, particularly with the success of the nurse practitioner pilot in one of the nursing homes. Expanding this pilot to other long term care centres will require recruiting from an already limited supply. The potential increase of nursing home beds in the future will also strain the numbers of Licensed Practical Nurses (LPNs) and Residential Care Workers (RCWs) available. Similarly, the change in staff ratios increasing the RN and LPN numbers will present further recruitment challenges to private providers in the future (ratios have already changed in public long term care).

A majority of private providers were challenged recruiting and retaining staff. Inequities in salaries and benefits between public and private employers were at the heart of the issue. Recruiting staff in rural areas continues to be an issue for all health care employers. Some employers employ independent caregivers[56] and/or unregulated care providers[57]to meet the demands. This practice is

[56] For the purposes of this report, independent caregivers are defined as caregivers who may be licensed and working independent of any organization. For example, a RN may be providing foot care nursing services to clients operating as an independent service.

common across the continuum, but was identified as an issue in private home care. While public and private employers are responsible for accountability and oversight of all employees, the same is not true of the care provided by independent caregivers or unregulated care providers who are retained directly by seniors and family members.

It was felt that seniors and their families do not know or understand that the person providing the care may not be licensed and that standards of practice are not overseen. These families presume that oversight is provided given that hospitals provide a list of home care providers that includes unregulated care providers. Moreover, families may not be aware of liability issues as some unregulated care providers may not be insured or bonded. Families who retain the services of unregulated care providers are not entitled to claim insurance for care (they can do so if the care is provided by licensed providers).

Equity issues pertaining to staffing levels were identified between public and private long term care. Acuity levels impacted staffing levels, which challenged private providers to meet the legislated requirements with limited or no recognized funding for additional staff resources. The impending changes to staffing ratios requiring more RNs and LPNs were felt to have been imposed with no regard to the implications of costs to private nursing homes.

Several participants identified the need for more and better training and education in mental health and seniors' care. Stakeholders commented that more mental health training and education of health care providers is necessary to equip the current workforce with the skills and knowledge to work with seniors with dementia. In addition, many felt that there was a lack of knowledge in caring for seniors and that there was a need to expand the curriculum to better train staff working with seniors.

Funding and costing issues were identified. Stakeholders commented that the increment in funding provided in long term care was not realized in supportive residential/community care. Data on operating costs of facilities was limited. The reliability and validity of available data is questionable. Supplies are an additional expense in home care which increases the costs for seniors and potentially hinders access to care. Equity issues related to drug costs and coverage was an ongoing challenge for seniors in private long term care. Inequities in funding levels between public and private providers were reported by several participants. Stakeholders pointed out that the recent funding provided to provincial long term care facilities was not matched for private providers.

The different assessment of a senior's **financial needs** across the continuum was identified as an issue in almost every consultation. This has resulted in what many participants feel is a disincentive for families to consider moving a loved one to supportive residential/community care. Income and assets are assessed if someone is seeking a government subsidy to live in a supportive residential/community care facility. Only income is assessed for long term care and there is no

[57] Unregulated providers are "unregulated workers who perform a variety of tasks, some of which may traditionally have been performed by regulated health care professionals (RHCPs)," (Gill, D., 1996).

income or assets assessment for home care. This discrepancy has resulted in what many participants feel is a "failed system" presenting loopholes for clients and families to manipulate. For example, families of medically discharged seniors chose to leave loved ones in the hospital to wait for a nursing bed or until provincial home care could provide the necessary services in the home. This approach was less expensive and less work for the family compared to bringing the family member home. While social assistance is available as required, the majority of participants commented that the client's financial needs should be assessed consistently across the continuum. Loopholes in existing financial assistance programs have created inequities between public and private home care providers. For example, clients are often referred to provincial home care to access the benefits from the Canada Revenue Agency's rule that states a person is exempt from taxes charged on private home care services if the person is also receiving services from a federal or provincial program (i.e., Veterans Independence Program, Provincial Disability Support Program, Provincial Home Care Program).

Inconsistencies in licensing between public and private facilities were frequently raised in the consultations. Public long term care facilities are subject to an accreditation review every three or four years while private facilities are licensed and inspected annually by government officials. Licensing standards differ with some participants arguing private long term care facilities are held to higher standards than public facilities. Although some improvement was noted, the rationale for issuing and removing provisional licenses continues to be inconsistent including the removal of negative inspection report comments from the public record that have been addressed and corrected by the facility.

Community care facilities, which are also licensed annually, reported similar challenges. Balancing government "asks" resulting from the annual review with limited funding was an issue identified by several stakeholders. While licensing of home care is non-existent, common standards between public and private home care providers are also lacking.

Gaps in the existing **services and programs** provided to seniors in PEI were identified. A lack of access to mental health and addictions care was raised by all participants and was linked to the lack of available and accessible mental health care providers. A lack of support for families with seniors in long term care was also discussed. Stakeholders recognized that the demand for home care services will continue to increase and challenge employers to meet demands. The following gaps were identified:

- lack of respite care. While participants acknowledged that there are several adult day programs available, a majority identified the need for more. Some suggested that these programs should consider integrating rehabilitative activities to help seniors;
- lack of wound care;
- need more home support hours and services; and
- lack of overnight care provided by public home care.

A few stakeholders discussed the healthy seniors who require home support services and "consulting" to monitor their health. These seniors live at home independently and are "not sick enough" to access public home care services. Family members are seeking "peace of mind" knowing that someone is checking in on their loved ones.

Transportation was identified as an issue for seniors irrespective of where they live. Furthermore, transportation "door to door" is limited if it exists at all. Transporting seniors and ensuring that they are settled back in their residence is important.

Transportation challenges are prevalent in rural communities where there is a lack of **infrastructure** for seniors. In some cases, seniors who were no longer able to live at home had to find a new home outside of their community.

The need for a **navigator** to help seniors and their families navigate the system was repeatedly cited by the majority of stakeholders. The referral process was identified as confusing with little to no direction provided with respect to "what is next". All participants recognized the importance of, "getting people the right care at the right time," but acknowledged that this was not happening.

Outcome measurement is lacking across the continuum. A number of participants noted that outcomes rather than inputs should be measured. The lack of data and performance indicators, particularly in home care, is a challenge. While all participants were weary from the number of studies completed, all agreed that further research to provide the data required for outcome measurement was necessary.

The Seniors Assessment Screening Tool (SAST) which is currently used to assess a senior's eligibility to receive care was identified by most participants as outdated. In addition, the SAST does not reflect the true time spent with the client and the increased acuity of the client's care and requirements. All participants suggested the province consider replacing the SAST with interRAI tools, recognizing the significant implementation costs (including technology, staff training and education) associated with the interRAI instruments. The instruments are standardized, reliable, and validated tools which offer several benefits, including helping clinicians identify important health issues among patients, developing appropriate care plans, and monitoring patient progress (Heckman, Gray & Hirdes, 2013). The instruments provide a standardized and common language that is compatible with electronic medical records thus facilitating greater integration of the health care system.

InterRAI instruments also provide quality indicators to assess care quality, and case-mix classification algorithms to facilitate funding of health services. Some of the challenges associated with implementing these instruments include providing adequate investments to facilitate their implementation (including ongoing training for clinicians focused on clinical applications), and developing robust and standardized electronic medical records. Challenges to fully realizing the clinical potential of these instruments include clinician unfamiliarity, privacy concerns that limit

information exchange between organizations that use interRAI instruments, and existing care processes that need to be reorganized in order to make efficient use of the instruments and eliminate the collection of redundant clinical data.

Cultural and language gaps are an ongoing challenge and will become more prevalent given the rise of immigrant populations in PEI. There are pockets of French language services provided to seniors but the system has limited capacity to respond to requests for these services. Cultural awareness is lacking among providers caring for aboriginal elders. There are efforts to educate health care staff, particularly on the topic of the aboriginal residential abuse that marked a large percentage of the elder population. Changing family dynamics was also identified as a cultural shift that will impact the system. Adult children are no longer residing near parents but are managing their elderly parents from a distance. A focus group of families of seniors in care noted that adult children who are aging while one or both of their parents are still living, may experience considerable financial stress.

6.0 INTEGRATED HEALTH SYSTEMS

Corpus Sanchez (2010) stated that:

> *Any time an individual receives care or services across the continuum, they are transitioning... Transition Management reflects planned and coordinated movement between sectors, within a sector and within units of a sector enabling individuals to receive the right care, in the right environment/location, at the right time. The result: increased patient safety; reduced risk; enhanced patient, family and provider satisfaction; and improved capacity to ensure people and physical resources are effectively and efficiently utilized.*
>
> *In the literature, integrated care is a more familiar term which captures the concepts inherent in transition management. The Canadian Home Care Association (2012) defined integrated care as, "a process or strategy for improving the coordination of health services to better meet the needs of patients and providers."*

Between the mid-1970s and the mid-1990s, province-wide integrated systems of care delivery (generally referred to as continuing care systems) were developed throughout Canada (Hollander, 2001). Although they evolved in different ways, the types of needs addressed and the types of health and supportive care services provided, were similar across jurisdictions (Chappell & Hollander, 2011a). In more recent years, national policy has focused more on short term home care that relies on professional services, rather than on the broader concept of continuing care (Hollander, Chappell, Prince & Shapiro, 2007). Supportive services provided over a long period of time are considered to be the responsibility of the individual and his/her family members, community voluntary agencies and social services (Hollander et al., 2007).

Hollander et al. (2007) have argued that policy and resources should shift to formally recognize the importance of long term home care and home support. They state that, "the advantages of this approach would be to restore and enhance services to those who are weak, vulnerable, and in need of ongoing care services, thereby reducing or delaying their need for institutional care," (Hollander et al., 2007).

Chappell and Hollander (2011a) stated that without integrated systems of care delivery, seniors and individuals with disabilities receive suboptimal care and greater costs are incurred by the health care system. Chappell and Hollander (2011b) have argued that:

> *...an integrated system needs to be broad and combine a wide range of health and supportive services, including case management, home care and home support services, supportive housing and residential care, and geriatric assessment units in hospitals. It should also have a single administrative authority and a single funding envelope that allows leaders in that system to increase value for money by making proactive trade-offs to substitute lower-cost care for higher-cost care, while maintaining the same, or better, quality of care.*

6.1 Key Elements of - and Barriers to - the Implementation of Integrated Systems

There are a range of different models and approaches to integration across Canada. However, there are several key elements that make some models more effective than others. These elements include:

- defined populations which enable health care teams to target individuals who would benefit most from a coordinated approach to the management of their care;
- multidisciplinary teams of health and social care professionals in which generalists and specialists work together to deliver integrated care;
- a culture that emphasizes collaborative team work and the delivery of highly coordinated patient-centred care;
- patient engagement in making decisions about their own care and support in enabling self-management;
- effective leadership at all levels with a focus on continuous quality improvement;
- the use of guidelines that promote best practices, support care coordination across care pathways, and reduce gaps in care;
- the use of information technology that supports the delivery of integrated care (e.g., electronic medical records and tools to identify and target 'at risk' individuals);
- shared accountability for performance through the use of data to improve quality and accountability to stakeholders through public reporting; and
- aligned financial incentives that support providers to work collaboratively (Canadian Home Care Association, 2012).

The Canadian Home Care Association (2012) identified several barriers to the successful integration of health systems:

- absence of a clearly articulated person-centred vision for integration;
- limited understanding of the roles and value of each team member in the patient care experience;
- lack of trust and limited communication among health care team members with no shared accountability for patient outcomes;
- fragmented and/or no technology systems to support the timely sharing of information, communication and evaluation;
- policies and funding that discourage collaboration by supporting episodic, silo-based care;
- governance models and leadership that support a hierarchical approach and reject flexible, adaptive models of care; and
- unrealistic expectations regarding the time it takes to build trusting relationships, the need to support a systemic change process, and the resources required to sustain the change.

The Canadian Home Care Association (2012) made several recommendations for overcoming barriers to integration:

- articulate a vision and philosophy for an integrated person-centred health care system;
- provide clear policy direction and funding models that incent, promote integration and enable providers to achieve the vision;
- design care delivery models based on population health needs that incorporate health promotion and disease prevention strategies;
- redesign primary health care services and build partnerships with home care, outreach to community support, acute care and supported living;
- leverage clinical partnerships and the home care capacity to provide case management as a strategy for health systems integration;
- invest in technology solutions to enable improved communication and collaboration across professions and health sectors;
- adopt new leadership competencies and operational structures that reinforce shared accountability and flexibility to foster and sustain integration.
- adopt an accountability framework that embraces a Triple Aim approach to measuring integrated system goals:
    - enhance the individual experience of care (including quality, access and reliability);
    - improve the health of patient populations; and
    - reduce or at least control the per capita cost of care for populations.

The Canadian Home Care Association (2012) has stated that:

> *Appropriate and sustained investment in…integrated strategies must be a priority in the evolution of the health care system. Integrating health systems is complex and multi-faceted – it is impossible to move to a new seamless, unified system of health care overnight. The transition takes time and investment for people and systems to work together differently.*

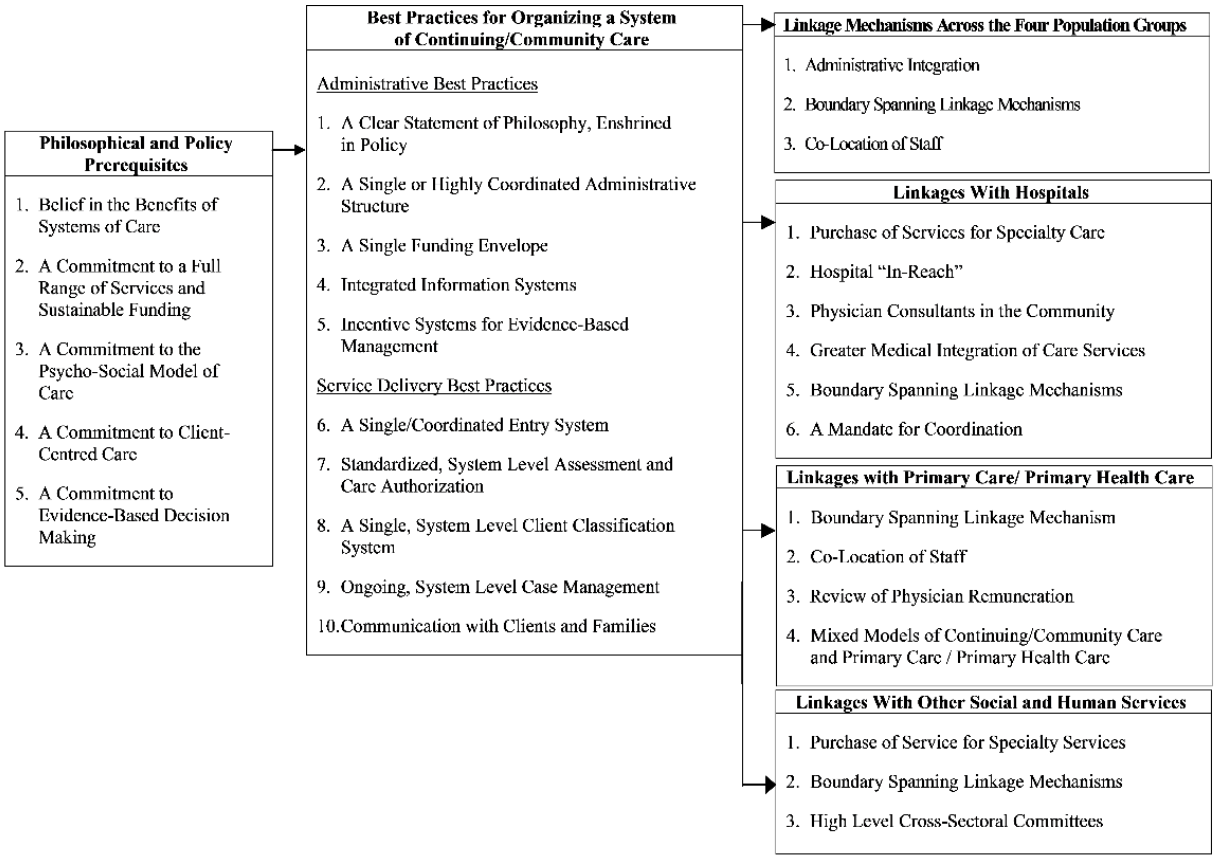
6.2 A Framework for Organizing Continuing Care Systems for Individuals with Ongoing Care Needs

In an independent review of international frameworks for developing systems of care for the elderly, MacAdam (2008) concluded that the Hollander and Prince (2008) Enhanced Continuing Care Framework was the most comprehensive.

As shown in Figure 1, there are three major components to the framework:

- philosophical and policy prerequisites – principles and commitments which are critical for the successful adoption of the framework;
- administrative and clinical best practices – for organizing service delivery systems; and
- coordination/linkage mechanisms – linkages to hospitals, primary care and other social and human services to ensure the best possible care response to meet client needs.

FIGURE 1: A Best Practices Framework for Organizing Continuing Care Systems for individuals with Ongoing Care Needs

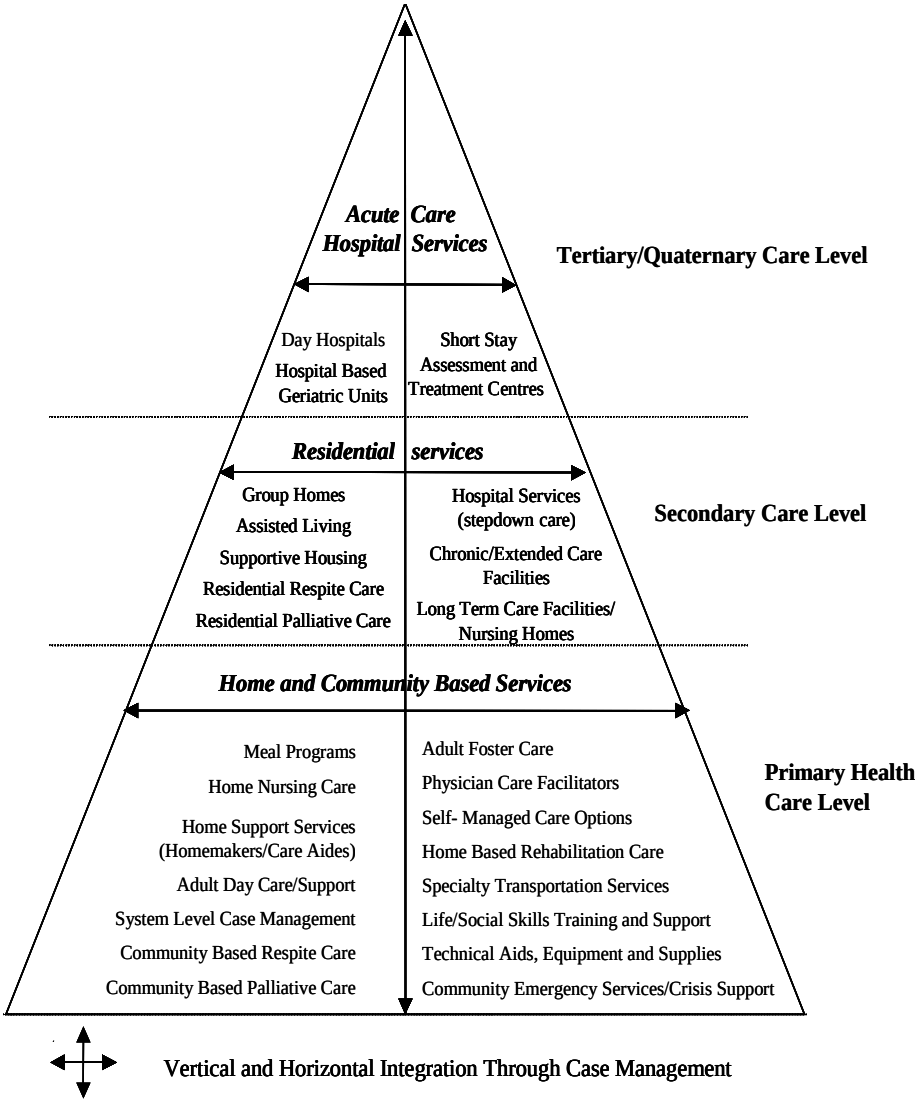


Source: Hollander & Prince, 2008.

One of the key aspects of the framework is the presence of system level case management to ensure that, as an individual's care needs change, there is a continuing match between the individual's needs and the range of services provided.

Hollander and Prince (2008) noted that their proposed framework links aspects of primary, secondary and tertiary/quaternary care both horizontally and vertically through case management. Figure 2 illustrates how the framework could be applied to seniors (Hollander & Prince, 2008).

FIGURE 2: Application of the Best Practices Framework to Seniors



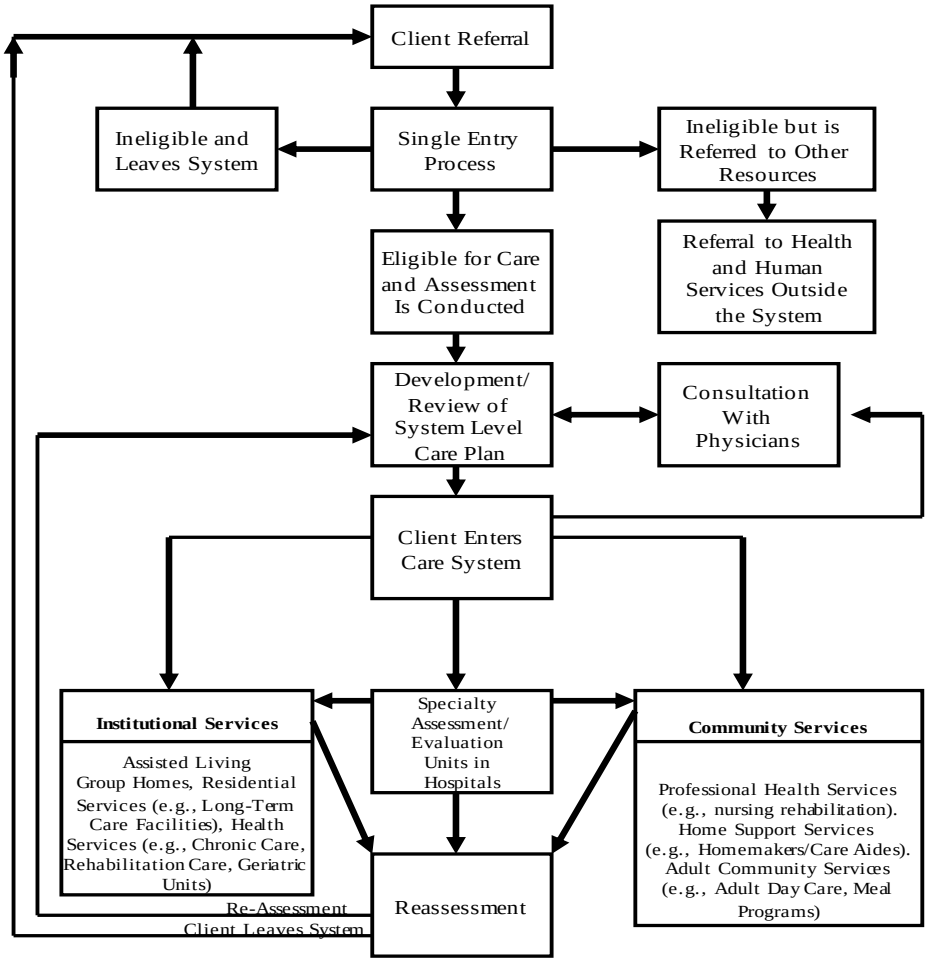
Source: Hollander & Prince, 2008.

Figure 3 illustrates how seniors would flow through a continuing care system (Hollander & Prince, 2008). Individuals could refer themselves to the system or be referred by family members, professionals, or other concerned individuals. The referral would be made through the local organization that serves as the single point of entry. A preliminary screening is conducted to determine if the individual is potentially eligible for services. If the individual appears to be eligible, he/she is assessed using a system level assessment tool (preferably with a built-in classification system). A care plan is then developed based on the assessment, a discussion with the individual and his/her family and discussions with the individual's family physician and/or specialist.

The individual then enters the care system, and may receive home and community based services, residential care services or specialty services. Individuals are reassessed by system level case managers on a regular basis and their care plan is revised as necessary. Individuals may also leave the system but can be referred back to it at any time.

In Figure 3, Health and Human Services Outside of the System could include financial assistance to purchase equipment and/or supplies for home renovations, Home and Community Services could include meal programs, day care, palliative care, and transportation services, and Residential Services could include community care facilities, nursing homes and hospital services (Hollander & Prince, 2008).

FIGURE 3: Flow of Individuals through a Continuing Care System



Source: Hollander & Prince, 2008.

6.3 The Role of Case Managers in Integrated Care Models

The Canadian Home Care Association (2007) has indicated that case management is a necessary component for health system integration. They defined case management as, "a collaborative strategy undertaken by health care professionals and clients to maximize the client's ability and autonomy through advocacy, communication, education, identification of and access to requisite resources, and service coordination," (Canadian Home Care Association, 2007).

Within the health care system, case managers[58] are often responsible for navigating the system and allocating resources. The Canadian Home Care Association (2007) noted that, "Within a chronic disease context, case management improves care by reducing fragmentation, increasing the coordination of complex care, and providing the necessary monitoring, screening and evaluation of clients using a holistic perspective and linkages to the broader care community."

As noted above, one of the key aspects of the Hollander and Prince (2008) best practices framework for continuing care is the presence of system level case management to ensure that, on an ongoing basis, there is a continuing match between the individual's needs and the range of services provided. Hollander and Prince (2008) have noted that system efficiencies are realized if individuals do not deteriorate to the point where more costly services are required due to a lack of regular monitoring.

In addition, individuals may be best served if they have the same case manager over time and across all components of the system (Hollander & Prince, 2008). Hollander and Prince (2008) have noted that, in addition to coordinating care across service components within an individual's system of care, system level case managers should be responsible for ensuring linkages between the individual's system of care and other health, social and human services.

6.4 Cost Effectiveness of Integrated Health Systems

As noted previously, national policy has focused on home care rather than the broader concept of continuing care. Chappell and Hollander (2011a) have argued that a focus on home care alone will generally only result in added costs:

> *…current policy appears to lead to an increasing cost spiral. Hospitals lobby for, and receive, additional funding. Governments reduce funding for long term home support services in the community (because they are not perceived to be "real health services"). People living in the community find it difficult to maintain their independence due to cuts to supportive services and are thus admitted to residential care or hospital. This, in turn, leads to greater cost pressures on hospitals, and the same cycle of using more costly services (i.e., hospital beds) to substitute for less costly services (home support) is repeated, over and over again, resulting in an ongoing spiral of increasing costs. (Chappell & Hollander, 2011a).*

[58] Case managers may also be referred to as care coordinators or system navigators (Canadian Home Care Association, 2007).

Chappell and Hollander (2011a) have also stated that, "Value for money in the broader healthcare system can only be achieved if home care is part of a larger integrated system of care delivery that allows for cost-effective trade-offs."

How care delivery systems are organized and structured can have a substantial impact on their efficiency and cost-effectiveness as well as on the quality of care provided to individuals (Hollander, et al., 2007; Hollander & Prince, 2008). Hollander and Chappell (2002; see also Hollander 2001) have argued that it is only possible to make cost-effective substitutions between home care and residential care if there is:

- a single or highly coordinated administration system;
- a single funding envelope;
- coordinated case management across all service components in the system;
- a standardized assessment; and
- one care level classification system that is the same regardless of the site of care.

7.0 BEST PRACTICE PERSON-CENTRED MODELS OF CARE AND SERVICE DELIVERY

"The goal of person and family-centred care is to use collaborative partnerships between health care providers, patients and their families to make informed and respectful decisions regarding care," (Health PEI, 2015c).

The literature scan identified several Canadian person-centred models of care and service delivery for individuals with continuing care needs: Veterans Independence Program; Self and Family Management of Home Care Services; Quality and Value in Home Care; Bundled Care; Home at Last; Home First; and Strategy for Meeting Increased Demands for Home Care in Nova Scotia. These are presented in this section.

7.1 Veterans Independence Program

The Veterans Independence Program (VIP) is a national, community based home and residential care program funded by Veterans Affairs Canada. The program complements local and provincial home care programs and is intended to assist individuals (primarily veterans) to remain independent and self-sufficient in their home and community (Veterans Affairs Canada, 2014). Eligible individuals are provided with financial assistance to enable them to obtain a range of services including:

- housekeeping and nutritional services;
- health and support services;
- personal care;
- grounds maintenance;
- home adaptations;
- ambulatory healthcare; and
- transportation (Veterans Affairs Canada, 2014).

Clients manage the funds they receive through the program. For example, they can choose to use their funding to pay for home support services or respite care. Clients may also access intermediate care beds in a long term care facility. Several research studies have indicated that the program is an effective way to support eligible individuals (e.g., Hollander, Miller, MacAdam, Chappell &Pedlar, 2009; Miller, Hollander & MacAdam, 2008).

7.2 Self and Family Management of Home Care Services

As part of its home care program, the Winnipeg Regional Health Authority offers the Self/Family Managed Care Program. The program consists of two components. Under the Self Managed Care component, individuals with long term disabilities become responsible for coordinating, managing, and directing the non-professional services they need to remain living at home and in the community. Under the Family Managed Care component, families of individuals with stable, chronic disabilities can accept responsibility for coordinating, managing and directing the non-professional services their family member needs to remain at home (Winnipeg Regional Health Authority, no date).[59]

To qualify for the program, individuals need to be eligible for attendant/homemaker services under the home care program. Individuals/families will be provided with funding from the regional health authority and are expected to use the funds to hire staff[60] to meet the individual's assessed needs. Funding adjustments may be made based on reassessments conducted on a regular basis by home care case coordinators from the Regional Health Authority. Self/Family Managed Care funds are subject to semi-annual reports and audit reviews by the Winnipeg Regional Health Authority (Winnipeg Regional Health Authority, no date).

Individuals who choose the Self/Family Managed Care program no longer receive home care attendant/homemaker services through the regional health authority. However, they remain eligible for professional services (e.g., visiting nurse and community therapy services) through the home care program (Winnipeg Regional Health Authority, no date).

7.3 Quality and Value in Home Care

Quality and Value in Home Care is a collaborative initiative which involves Community Care Access Centres and service provider organizations in Ontario working together to improve home and community care services. The initiative benefits individuals by ensuring that:

- there is a coordinated and consistent care team that knows an individual's specific needs and is prepared to provide his/her care;

[59] Individuals/families may employ staff directly (in which case they take on the full responsibilities of an employer), or they may hire a personal care agency to provide the care (Winnipeg Regional Health Authority, no date).

[60] Individuals or an agency may be hired to provide services. Family members generally cannot be hired to provide the services (Winnipeg Regional Health Authority, no date).

- there is one care team leader who serves as a knowledgeable point of contact for the individual;[61]
- information is shared with the care team to ensure that individuals only have to tell their story once;
- individuals are receiving the right care, in the right order, by the right person, based on best practices and evidence;
- individuals have access to flexible care (e.g., diverse health care providers, tele-homecare visits, e-mail support);
- individuals are able to transition smoothly between care settings (e.g., between hospital and home); and
- the initiative is consistently measured and reported on to improve the quality of care provided (Ontario Association of Community Care Access Centres, 2013).

The initiative involves:

- the use of electronic tools and technologies to share health information;
- Community Care Access Centre care coordinators sharing information with family physicians and nurse practitioners;
- consistent information gathering regarding the quality of care;
- the implementation of evidence-based, standardized care pathways;[62] and
- outcome-based reimbursement (Ontario Association of Community Care Access Centres, 2013).

7.4 Bundled Care

In 2011, a bundled care approach to transitioning individuals between hospital and their homes was successfully piloted in Hamilton, Ontario (Government of Ontario, 2015b). The approach has recently been expanded to five more communities in Ontario (Government of Ontario, 2015c).

In the bundled care model (also known as an integrated funding model), a group of health care providers is given a single payment to cover all the care needs of an individual's hospital and home care (Government of Ontario, 2015c). When an individual moves from the hospital back to their home, the majority of their health care team remains the same (Government of Ontario, 2015b). The team is responsible for ensuring individuals receive appropriate coordinated short term home care services (Government of Ontario, 2015b). The approach has been shown to result in fewer emergency room visits and a decreased risk of individuals being readmitted to hospital (Government of Ontario, 2015b).

[61] Care team members include patients and caregivers, a Community Care Access Centre care coordinator, service providers, family physicians, specialists and nurse practitioners (Ontario Association of Community Care Access Centres, 2013).

[62] Outcome-based pathways have been developed to address the needs of individuals requiring wound care, recovering from hip or knee surgery or requiring palliative care. It is anticipated that additional outcome-based pathways will be developed (Ontario Association of Community Care Access Centres, 2013).

Currently, the bundled care approach is available for individuals who require care for chronic obstructive pulmonary disease, congestive heart failure, stroke or cardiac surgery recovery, or nursing interventions for conditions such as urinary tract infections and cellulitis. It is anticipated that additional bundled care teams will be supported in the future (Government of Ontario, 2015b, 2015c).

7.5 Home at Last (Ontario)

The Home at Last program in Ontario is intended to assist seniors who are leaving hospital emergency departments or inpatient units to settle back into their homes safely and comfortably. Eligible individuals do not have support from friends or family upon discharge, but are able to direct their own care. Home at Last staff may: provide transportation home; pick up prescriptions or groceries; provide a meal; and/or follow-up with the senior (Toronto Central CCAC, no date; Victorian Order of Nurses Middlesex Elgin, no date).

7.6 Home First

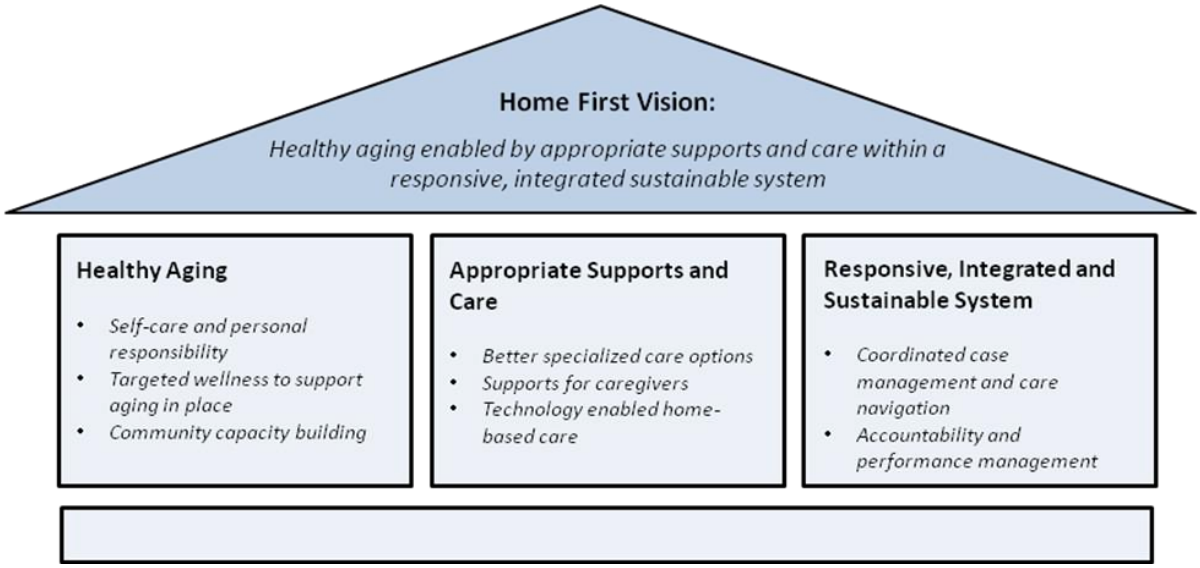
Home First is a three-year strategy in New Brunswick which recognizes seniors' desire to remain at home and in their communities for as long as possible. The strategy (which was developed collaboratively by the departments of Social Development, Health, and Healthy and Inclusive Communities as well as the Horizon and Vitalité health networks), focuses on the full continuum of care and better integration across the health and social service systems (Government of New Brunswick, 2016).

The strategy, "is the foundation of an integrated system of health and social care…[and] represents a fundamental change in philosophy and practice…" (Government of New Brunswick, 2015). Home First shifts the focus of senior care from nursing home care to healthy, active aging and home and community based care integrated across sectors and services. "The underlying principle of Home First is that by providing enhanced supports at the community level now, the need for more costly forms of care services can be delayed or avoided in the future," (Government of New Brunswick, 2016).

As shown in Figure 4, the Home First vision of, "Healthy aging enabled by appropriate supports and care within a responsive, integrated and sustainable system," is supported by three pillars – healthy aging, appropriate supports and care, and a responsive, integrated and sustainable system.

Each pillar contains strategic themes that support the vision (Government of New Brunswick, 2015). Appendix F expands on each of the strategic themes and identifies several initiatives which will be put in place to make the Home First strategy a reality.

FIGURE 4: Home First Vision



Source: Government of New Brunswick, 2015.

7.7 Strategy for Meeting Increased Demands for Home Care in Nova Scotia

As in other jurisdictions, enhancing the delivery of home care services and supporting individuals to live well at home is a strategic priority for the Nova Scotia Department of Health and Wellness (Health Association Nova Scotia, 2014). Although home support agencies support this focus, they are concerned about their capacity to provide services in a timely manner, both now and in the future (Health Association Nova Scotia, 2014). In addition, although the government has increased the home care budget, wait lists for home care services persist (Health Association Nova Scotia, 2014).

The provincial Home Care Network, which is composed of operators of home support agencies, developed a working group with representation from the Home Care Network, District Health Authority Vice Presidents of Community Services, and the Continuing Care branch of the Department of Health and Wellness to identify current and future challenges and make recommendations for increasing the capacity of the home care sector (Health Association Nova Scotia, 2014). The working group made several recommendations designed to enable people to remain at home safely and enable home care to meet current and projected future demands for care (see Table 13). The recommendations and proposed actions are provided, in part, to illustrate the range of activities key stakeholders may need to consider to expand a home care program.

TABLE 13: Recommendations Related to Meeting Increased Demands for Home Care in Nova Scotia

RECOMMENDATION	PROPOSED ACTIONS
Build human resource capacity in the home care sector to meet client care needs	Improve data on the supply of Continuing Care Assistants in the health care system, particularly in home care.
	Explore development of an alternate level of worker position which could be responsible for activities such as: meal preparation, housekeeping, laundry, banking, accompanying individuals to appointments, yard maintenance and similar types of tasks.
	Develop a recruitment strategy designed to increase the number of Continuing Care Assistants working in home care.
	Promote staff retention and workforce stability by supporting income stability and flexibility through a mix of staffing options (e.g., full time, part time, and casual).
Expand array of services, increase flexibility to access services, and examine current funding approach	Expand array of services offered through the home care program to include, for example, shopping/assistance with errands, assistance with accessing public transportation, grounds maintenance, and minor home repairs. Increase flexibility of funding so people can access a broader array of services, programs, housing options, etc.
	Re-examine existing funding model for home support agencies to ensure the system is sustainable and reflects actual cost of providing care.
	Increase understanding of process for obtaining funding increases.
Better utilize evidence for system planning, improved wait list measurement and management	Define data needs and gather evidence to inform planning and decision making.
	Develop common definitions for, and improve measurement of, wait list data.
	Develop response time standards.
	Improve management of the wait list.
Improve communication and use of technology to support better sector-wide system planning and service delivery	Establish opportunities for ongoing sector-wide planning and dialogue among home support agencies, District Health Authorities and the Department of Health and Wellness.
	Make better use of technology by, for example: enabling electronic exchange of client related information between District Health Authority care coordinators and home support agencies; continuing to use software and mobile phone technology to achieve efficiencies and enhance safety for home care staff; and exploring innovative ways individuals could use technology to monitor and manage their health at home.
	Better inform clients of available services through print materials and/or discussion of needs and program eligibility requirements, and support to access services.
Improve case/care management	Enable care coordinators to provide more intensive case management for individuals with multiple providers and/or greater complexity.

RECOMMENDATION	PROPOSED ACTIONS
	Allow home support agencies to change service hours within certain parameters (with notice to care coordinators) to better meet clients' needs.
	Allow home support agencies to change care plans/authorize additional services beyond current scope of home care services to meet client needs.
	Build relationships and enhance communication between the District Health Authorities and home support agencies at the local level to build interagency relationships, identify and resolve issues and clarify expectations.
	Joint orientation of new staff of home support agencies and District Health Authority Continuing Care Coordinators so there is better understanding of each other's roles and challenges.
Develop and implement a change management strategy	Develop a change management strategy to inform stakeholders (e.g., individuals and their families, managers, and health care providers) of the shift to a "home first" philosophy and to develop successful implementation strategies.
Develop a caregiver strategy	Through a collaboration of the Department of Health and Wellness, Caregivers Nova Scotia, the Home Care Network and other interested parties, develop a caregiver strategy which addresses the physical, financial and emotional aspects of caregiving.

Source: Health Association Nova Scotia, 2014.

8.0 STRATEGIC DIRECTIONS FOR CONSIDERATION

This section describes the desired future for seniors in Prince Edward Island and outlines the strategic directions government should consider in developing a policy framework to meet anticipated needs. Stakeholders who participated in interviews and focus groups were asked to propose recommended directions to address identified gaps and challenges. This input informed the discussion at the roundtable session. Roundtable participants were asked to identify the desired future for Prince Edward Island's seniors over the next five to 10 years and how this could be achieved. Participants were specifically asked to consider how the opportunities can be leveraged and how the gaps and/or challenges can be addressed to reach the desired future state. Results from the roundtable session, focus groups and interviews were further refined by the Advisory Committee.

8.1 Desired Future for Prince Edward Island Seniors

It is well documented that seniors prefer to live and die at home if they are able to. The ideal future for seniors in Prince Edward Island provides this opportunity.

The desired future state for Island seniors is an environment where individuals are able to live as independently as possible in their own home for as long as possible. When support is required, seniors will be provided with integrated and comprehensive care. Health and financial assessments

will be conducted early on so appropriate care plans can be designed and the means to finance them can be determined prospectively.

A "one stop care centre for seniors" will achieve this desired state. Seniors and their families are the central focal point. Government functions related to seniors' programs, services and policies will be centralized in one location rather than spread out across departments. Silos will be replaced with integrated units. Central to the "one stop care centre" model is an interdisciplinary collaborative care approach that integrates public and private care providers irrespective of where the senior lives. The "one stop care centre" will employ health care providers who are knowledgeable about caring for seniors, including the frail elderly. This will include: geriatricians; nurses with specialized training in geriatric care; allied health professions, especially physiotherapists, occupational therapists, and social workers; case managers; and health care providers with specialized training in mental health and additions. Providers of support services (such as housecleaning and assistance with daily living activities) as well as complementary therapists (such as those providing relaxation, spiritual wellness, and acupuncture) will also be part of the "one stop care centre".

The "one stop care centre" will enable all seniors and their families to benefit from education and communication on a range of topics, including wills, insurance, powers of attorney and health care directives. From an information sharing perspective, the goal will be to equip Prince Edward Islanders with the knowledge required to better plan for and invest in their senior years. Steps to achieve this can include partnering with the education community to educate youth, and with health care providers to educate the public about healthy aging.

For seniors requiring care and support, the "one stop care centre" will serve as a central hub of coordinated and integrated care across the continuum of care. A central intake process and case managers will be instrumental in collaborating with seniors and their families to develop sustainable care plans. Seniors' needs will be reassessed regularly across the continuum using input from a variety of sources including seniors and their families. Follow up and case management will occur continuously throughout the journey and across the full continuum of care. Funding for care will follow the senior.

8.2 Strategic Directions for Developing a Policy Framework

A **strategic plan** is necessary to provide the foundation for a policy framework. It is recommended that the Hollander and Prince (2008) best practices framework for an integrated continuing care system be used in developing the strategic plan. This framework will enable public and private home care, supportive residential care and long term care to be incorporated into the strategic plan. Seniors and their families are at the centre of the strategy, and the overall goal is the delivery of quality and sustainable care.

The "Home First" model currently implemented in New Brunswick, supplemented by a housing strategy, is recommended for consideration. Adopting this or part of this model will necessitate increasing the capacity and investment for home and community based care and services.

Government will need to recognize that a significant investment is required to bring home care spending closer to, or at least that of, the national average to support seniors living at home.

The strategic plan will establish priorities that are needs based as opposed to systems based. It will also outline directions, outcomes and ongoing evaluation methods. A budget process implementing "0" based budgeting (i.e., reinvestment of savings realized) will be part of the planning process. The challenges of financially-based decisions for access to care will need to be addressed.

While the current review of the continuing care system in Prince Edward Island is a first step, more comprehensive information and data is required. **Targeted research** focusing on costs associated with the operations of public and private providers across the continuum of care will be conducted. New financial data will need to be collected, particularly from private providers, and more up-to-date data will be required from public operators. Additional research will be necessary to explore:

- the costs of services (e.g., drug programs, housing);
- existing resources to support programs and services (e.g., Alzheimer's and Heart and Stroke Societies);
- seniors' views and assessment of accessing and receiving;
- providers' input regarding strengths, gaps and challenges;
- the services and programs needed in the next five years; and
- the feasibility of employing individuals including seniors seeking part-time employment (e.g., retired nurses, RCWs) to address recruitment and retention issues.

Sustaining the strategic plan will require **a funding model**. The funding model will be outcomes based and investments will be prioritized based on evidence and the best return. This will mean moving away from the medical model to reallocate funds from acute care and alternative level of care beds to home and community care. Determining the funding model will require:

- reviewing and reassessing the *Long Term Care Subsidization Act*;
- reviewing and revising components of the Physician Master Agreement to pave the way for more physician care in the home, in community care facilities and in long term care facilities, making referrals to the one stop seniors' care centre and/or funding Nurse Practitioners to provide care;
- determining the acceptable level of compensation for physicians and/or Nurse Practitioners to conduct home visits;
- exploring the purchase of insurance for home care services to help offset the increasing costs of public home care; and
- considering a self and family managed care model where funding is provided to seniors and their family members and they are responsible for accessing and paying for the necessary care.

A cornerstone of the strategic plan is the creation of a **Seniors' Health Care Network** which will involve locating all information, services and programs in one place that is senior centred. Modeled after, and potentially co-existing with, Prince Edward Island's Primary Health Care Unit, the Network will co-locate all care for seniors system wide and will provide services Island wide. Achieving this strategic direction will require revamping current structures and systems already in place and building on programs that are currently working well. This includes extending the integrated palliative care program to permit seniors to die at home. The Network will need to leverage and integrate existing resources such as the Alzheimer's and Heart and Stroke Societies to enhance programs and services. It will also need to provide 24-hour services similar to walk-in clinics or clinics with expanded hours, as well as a geriatric clinic education centre to support seniors and their families.

As part of the strategy, the Seniors' Health Care Network will focus on person and family-centred care and will ensure continuity of care for seniors through continuous monitoring and assessment processes to ensure their needs are being met. Seniors and their families will be consulted and their input will be integrated into the senior's care plan. A *self-managed care model* similar to what is used in Manitoba, will be incorporated into the strategic plan so that available funding can be used to follow the senior.

Multi-disciplinary health care teams involving RNs, LPNs, Nurse Practitioners, Physicians, Residential Care Workers, Occupational Therapists, Physiotherapists, Social Workers and other professionals will be integral to the success of the Seniors' Health Care Network. Continuity of care will also be achieved by involving physicians consistently across the continuum of care. Addressing the human resource challenges will be necessary. This will include reviewing current contract agreements.

Creating one government portfolio for seniors is also a key component of the strategic plan. This is consistent with the actions of other governments in Canada recognizing the need to co-locate all seniors' services in one area in order to improve care delivery in a fiscally sustainable environment. Coordination of supports and systems together with co-location of all government services and programs available to and accessed by seniors and their families will enhance the quality of the care provided, improve the allocation of limited funding and increase reinvestment of savings. The single government portfolio will work with the Seniors' Health Care Network to provide effective and financially sustainable programs, services and support for seniors and their families.

As with the Seniors' Health Care Network, a collaborative team approach to the creation of the seniors' portfolio is necessary. This will mean establishing formal public and private sector partnerships by removing the inequities, improving the sharing of information and expertise, and building relationships that focus on providing quality care to seniors that is sustainable.

A Seniors' Health Care Network that collaborates closely with one government portfolio for seniors will be more conducive to ensuring **early health and financial assessments of seniors**. This will involve one point of access for financial assessments currently followed in the Veterans Affairs Canada model. It will also require reviewing and changing the current means testing approach to remove disparities across the continuum and create a more consistent assessment process for seniors. A senior's and family's ability to pay for programs will be assessed in order to direct government subsidies to where they are truly needed. Legislative barriers will need to be identified and addressed.

Creating a navigator role will assist a senior and their family in navigating the system that includes the Seniors' Health Care Network and the government portfolio for seniors. Hollander and Prince's (2008) best practices framework acknowledges the importance of the navigator role. Typically carried out by case managers, navigators provide seniors and families with information and support to inform their decisions and journey. The cancer treatment centre and home care's intake process are successful examples of facilitating a client's navigation through the system. A successful navigator role will tie into ongoing care coordination by:

- reassessing individuals throughout the continuum;
- utilizing more rehabilitation/restorative care;
- providing rehabilitation at home with support;
- providing rehabilitation and re-enablement;
- providing resources to the family directly;
- managing and improving the transition from acute care utilizing options to care "outside the hospital" such as: respite, restorative care, assistance in the home (to avoid re-admittance); and
- allowing long term care facilities to take in "temporary residents."

Improving the communication and **dissemination of information** to seniors and their families, among health care providers, and to the general public will assist in ensuring the right care is provided at the right time. Existing technology such as telehealth can be improved to deliver care and to share client information among providers. Challenges associated with sharing information (such as privacy issues) will need to be addressed. New communication tools will need to be developed and consistently applied and used across the continuum of care. The Seniors' Network and the government portfolio for seniors could collaborate with the post-secondary education system to better educate youth and the public about healthy aging and managing well in one's later years.

9.0 CONCLUSION

This review demonstrates a willingness to commence discussions about the sustainability, quality and system of care for Island seniors today and the coming years. It is a first step and lays the foundation to develop a policy and program framework. Evidence of best practices across Canada that may

apply to Prince Edward Island is presented together with a detailed description and comparison of the components of the continuum of care across Canada to inform stakeholder groups and decision-makers. Consultations with stakeholders across the province, including seniors and families, identified several opportunities that can be leveraged to address the barriers and challenges discussed. Stakeholders recognized that the current system is not sustainable and will not meet the demands and needs of seniors in the future.

A senior centred strategy is integral to moving forward with action. A "one stop" centre for seniors that integrates all components of the system and delivers care to seniors Island wide will achieve the desired future which senior stakeholders described. Prince Edward Island's small population and size presents an opportunity to pilot models of care and lead the country as well as be a model for high quality sustainable care for seniors. Governments across Canada realize that change is inevitable. Not acting is not an option in the face of a growing number of seniors presenting new demands and challenges that will result in escalating and uncontrollable costs. The time for action is now.

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APPENDIX A
Advisory Committee Members

Cecil Villard, *Chair*	Health and Wellness PEI
Diane McQuaid	Association of Licensed Community Care Facilities
Wayne McMillan	PEI Private Nursing Homes Association
Mary McDonald	PEI Home Care Association
Mary Sullivan	Community Health, Home Care, Palliative Care and Geriatric Care, Health PEI
Cynthia Bryanton	Corporate Services and Long-Term Care, Long-Term Care, Health PEI
Rick Adams	Corporate Services and Long-Term Care, Health PEI
Deanna Estabrooks	Finance, Treasury Board Secretariat, Corporate Finance, Family and Human Services

APPENDIX B

Home Care Budgets and Per Capita Home Care Spending Across Canada[63]

Jurisdiction	Home Care Budget as Percentage of Total Health Care Budget	Per Capita Home Care Spending
Yukon	2.2	$129.94
Northwest Territories	1.6	$104.85
Nunavut	2.8	$237.64
British Columbia	4.5	$159.19
Alberta	2.4	$108.06
Saskatchewan	3.0	$123.33
Manitoba	5.8	$241.25
Ontario	4.4	$150.48
Québec	5.4	$177.94
New Brunswick	6.4	$248.64
Nova Scotia	5.4	$207.48
Prince Edward Island	**2.3**	**$ 90.86**
Newfoundland and Labrador	5.6	$266.47
Canada	N/A	$172.78

Source: CSI Consultancy, 2015

[63] Based on 2010/2011 information (CSI Consultancy, 2015). Inclusion/exclusion criteria for expenditures is not consistent across jurisdictions (CSI Consultancy, 2015).

APPENDIX C

Labels for Primary Supportive Residential Care Settings and Other Supportive Residential Care Settings Across Canada

Jurisdiction	Primary Supportive Residential Care Setting	Other Supportive Residential Care Settings
Yukon	• supportive independent living[64]	• not applicable
British Columbia	• assisted living	• supportive housing
Alberta	• supportive living	• seniors' lodges
Saskatchewan	• personal care homes	• Abbeyfield housing • assisted living
Manitoba	• supportive housing	• assisted living or independent living with tenant services • supports to seniors in group living
Ontario	• retirement homes	• supportive housing
Québec	• intermediate resources	• family type resources • private seniors' residences • Société d'habitation du Québec (SHQ)
New Brunswick	• special care homes	• community residences • specialized care bed homes
Nova Scotia	• residential care facilities	• approved/licensed facilities • assisted living • boarding homes
Prince Edward Island	• **community care facilities**	• **not applicable**
Newfoundland and Labrador	• personal care homes	• assisted living • congregate housing • protective community residences

Source: Miller, J.A. & Cherry, L. (2016a)

[64] The Yukon currently does not have any supportive residential care settings, although plans are underway to develop a supportive independent living facility (see for example, Sarin, 2014).

APPENDIX D
Description of Supportive Residential Care Settings

Jurisdiction	Number of Facilities	Number of Units/Beds	Notes
Northwest Territories	3	unknown	• Independent supportive living facilities provide a variety of services for seniors.
Yukon	1[65]	75	• The supportive independent housing facility currently being planned for the Yukon is designed to support seniors who can live independently with some assistance (Sarin, 2014).
Nunavut	1	unknown	• This facility provides services for seniors with low care needs.
British Columbia	unknown	7,635[66]	• Assisted living facilities provide services to 3 or more adults (Government of British Columbia, 2002, s. 1).
Alberta	789[67]	28,600[68]	• Supportive living settings provide services to 4 or more individuals (Government of Alberta, 2014). • Supportive living settings may be operated by private for profit, private not for profit or public operators (Government of Alberta, 2014). • In some cases, Alberta Health Services controls access to a specified number of supportive living spaces through an agreement with the operator (Government of Alberta, 2014).[69]
Saskatchewan	245[70]	3,200[71]	• Personal care homes are privately owned and operated businesses which are regulated by the Ministry of Health (Provincial Auditor Saskatchewan, 2012).
Manitoba	14[72]	628[73]	
Ontario	unknown	unknown	• Retirement homes are privately owned and operated facilities designed for seniors (Ontario Retirement Communities Association, 2013a). • Retirement homes provide services for 6 or more individuals.

[65] The Yukon currently does not have any supportive independent living facilities. The number of units/beds is an anticipated number (Sarin, 2014).
[66] These were registered assisted living units/beds as of March 2014 (Office of the Seniors Advocate, 2015b). Of these, 4,422 (58%) are publicly subsidized. The remaining 3,213 are private, non-subsidized assisted living units/beds (Office of the Seniors Advocate, 2015b).
[67] December 2014 numbers (Government of Alberta, 2014).
[68] December 2014 numbers (Government of Alberta, 2014).
[69] Such spaces are referred to as designated supportive living spaces.
[70] 2012 numbers (Provincial Auditor Saskatchewan, 2012).
[71] 2012 numbers (Provincial Auditor Saskatchewan, 2012).
[72] Number of supportive housing facilities that are members of the Long Term Care and Continuing Care Association of Manitoba (Long Term Care and Continuing Care Association of Manitoba, 2016). It is not clear how many additional supportive housing facilities may exist in the province.
[73] This includes 563 supportive housing suites as well as 65 units in an intermediate care centre in Winnipeg (Long Term Care and Continuing Care Association of Manitoba, 2016).

Jurisdiction	Number of Facilities	Number of Units/Beds	Notes
Québec	393[74]	8,034[75]	• Intermediate resources are privately owned and operated, but partially government subsidized (Santé et Services sociaux Québec, 2015).
New Brunswick	396[76]	unknown	• Special care homes are privately owned and operated (SeniorsZen, no date)
Nova Scotia	57[77]	928	• Residential care facilities provide services to 3 or more people, usually 65 years of age or older (Government of Nova Scotia, 2015b).
Prince Edward Island	**39[78]**	**1,289[79]**	• **Community care facilities are privately owned and operated (Community Legal Information Association of Prince Edward Island, 2014, Government of Prince Edward Island, 2016b)**
Newfoundland and Labrador	86[80]	Unknown	• Personal care homes are privately owned and operated (Ennis, 2012; Government of Newfoundland and Labrador, 2015a).

Source: Miller & Cherry (2016a)

[74] 2015 numbers (Montréal Economic Institute, 2015).
[75] 2015 numbers (Montréal Economic Institute, 2015).
[76] Government of New Brunswick, Department of Social Development (2016).
[77] These are Single Entry Access (SEA) residential care facilities meaning that admission is determined through the Nova Scotia Department of Health's single entry system, eligible residents pay an authorized accommodation charge and have the health care portion covered by the Department of Health (Government of Nova Scotia, 2016). There are also two non-SEA residential care facilities with a total of 38 beds (Government of Nova Scotia, 2016). For these facilities, individuals pay the facility directly and are not eligible for a government subsidy (Government of Nova Scotia, 2016).
[78] Government of Prince Edward Island, personal communication, May 2016.
[79] Government of Prince Edward Island, personal communication, May 2016.
[80] Government of Newfoundland and Labrador (2015b).

APPENDIX E

Labels for Long Term Care Facilities Across Canada

Jurisdiction	Label for Long Term Care Facility
Northwest Territories	long term care facilities
Yukon	continuing care facilities
Nunavut	continuing care facilities
British Columbia	long term residential care facilities
Alberta	nursing homes; auxiliary hospitals
Saskatchewan	special care homes
Manitoba	personal care homes
Ontario	long term care homes
Québec	residential and long term care centres (Centre d'hébergement et de soins de longue durée (CHSLD))
New Brunswick	nursing homes
Nova Scotia	nursing homes; residential care facilities
Prince Edward Island	**nursing homes**
Newfoundland and Labrador	long term care facilities

Source: Miller & Cherry (2016b)

APPENDIX F
Home First Strategic Themes and Initiatives

Pillar	Strategic Theme	Explanation	Proposed Initiatives
HEALTHY AGING	Self-care and personal responsibility	Provide seniors with the tools they need to make healthy choices and be active participants in the maintenance of their personal health &wellness.	• Establish seniors resource centres • Promote the Wellness Movement to seniors
	Targeted wellness to support aging in place	Support seniors to age in place by promoting wellness.	• Implement wellness clinics for seniors • Implement renewed Wellness Strategy
	Community capacity building	Focus on collaborating with community partners and service providers for the prevention of illness and injury by creating age-friendly communities, improving the availability and safety of seniors' housing options and providing timely access to necessary health equipment and information.	• Develop a seniors' health, well-being and home safety assessment • Develop age-friendly communities • Develop a province-wide affordable housing plan for seniors • Improve access to home-based medical equipment • Collaborate on the toll-free seniors' informationline • Explore the role of paramedics in delivering community-based care • Renew the Senior Goodwill Ambassador Program
APPROPRIATE SUPPORTS AND CARE	Better specialized care options	Broaden and improve the range of specialized care services for seniors who have significant health care needs, with a focus on managing chronic disease, providing rehabilitation and reablement services, and delivering effective health and social care services.	• Enhance rapid rehabilitation and reablement services for seniors • Develop a neighbourhood based model of home support services • Enhance the Extra-Mural Program home-based stroke care • Enhance the Extra-Mural Program home-based geriatric assessment and management service • Develop community based dementia care • Develop a provincial palliative care strategy

Pillar	Strategic Theme	Explanation	Proposed Initiatives
			• Roll-out the drug information system • Implement family health teams • Establish a community-based allied health professional team
	Supports for caregivers	Improve supports for both informal and formal caregivers, so they can provide optimal care to seniors in the home setting.	• Enhance supports for caregivers • Develop and implement a human service model for senior care workers
	Technology enabled home-based care	Ensure effective use of technology to improve access to services, enhance the care experience and provide reassurance to seniors and their caregivers.	• Develop an electronic health records system for the Extra-Mural Program • Expand the Extra-Mural Program Telehomecare Service • Expand the use of CareLink
RESPONSIVE, INTEGRATED AND SUSTAINABLE SYSTEM	Coordinated case management and care navigation	Focus on integrating care services to provide easy access and seamless delivery of both health and social care services.	• Design a model for integrated health and social services • Improve integration of health and social services • Improve the hospital discharge process • Improve the process for long term care assessment • Expand the Quick Response Home Care program to the community • Enable paramedics to refer seniors to the Extra Mural Program • Strengthen leadership for the Extra-Mural Program • Modernize the nursing home system
	Accountability and performance management	Ensure seniors receive high quality care and support by developing policy and legislation that supports the Home First vision and through ongoing monitoring of the Home First initiatives.	• Develop new legislation for the long term care continuum • Implement a Home First accountability framework • Develop a seniors' charter

Source: Government of New Brunswick