

Shaping the Future of Continuing Care in Nova Scotia

To have every Nova Scotian live well in a place they can call home.



Continuing Care Strategy
Report from the Provincial Steering Committee

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Foreword

Creating a continuing care system that provides Nova Scotians with the supports they need to live well in a place they can call home is an ambitious but worthwhile project. While our current system boasts some of the most caring professionals found anywhere, many excellent programs and services, and numerous agencies, facilities, and homes dedicated to the well-being of Nova Scotians, there is always more that can be done.

The Continuing Care Strategic Framework Project was started to identify possibilities – better ways to provide support to all Nova Scotians and to make our continuing care system the best it can be. The recommendations it proposes apply to all areas of the sector.

As with any project, this could not have been successfully accomplished in isolation. The Provincial Steering Committee, the Department of Health, and the Province of Nova Scotia extend our gratitude to the District Level Committees, the Provincial Pediatric Committee, the Trends Analysis Working Group, the consultants, and Department of Health staff. Each of these groups was instrumental in arriving at the findings presented in this report.

Most importantly, the steering committee would like to thank the Nova Scotians who participated in this project. Over a 14-month period, the Continuing Care Provincial Steering Committee heard from 1,400 people from all over the province. With their help, we identified challenges that we believe we can meet. Together, we developed a clear vision for the future of continuing care in our province.

Nova Scotians told us they want a continuing care system that allows each of us to live well in a place we can call home. The steering committee has adopted this vision as our goal. And, as with any goal, its realization is not something an individual or organization can achieve single-handedly.

This report contains recommended ideas for improved and expanded continuing care services. While government has an important role to play, it is critical that everyone play a part to achieve the vision for continuing care. While some services can best be delivered or licensed by government, the continuing care sector must also embrace a leadership role. The no-cost and low-cost recommendations included in this report will provide the sector with a springboard from which it can move forward.

In May 2006, the government announced a Continuing Care Strategy informed by this report. The strategy is a 10-year plan to enhance and expand Nova Scotia's continuing care system. Government has committed to moving forward and has implemented a number of programs, including palliative home care services and improved access to home oxygen. Work is well under way to build 1320 new long-term care beds over the next 10 years. Other initiatives are in various stages of planning and implementation.

While the goals in this report are ambitious, the steering committee is confident that solutions exist. Working together, we can create the caring and effective system we all envision.

Sincerely,

A handwritten signature in black ink, appearing to read "K. Menzies". The signature is fluid and cursive, with a large initial "K" and a long, sweeping underline.

Keith Menzies

Executive Director, Continuing Care Branch, Nova Scotia Department of Health
Member, Provincial Steering Committee, Continuing Care Strategic Framework Project

Executive Summary

The Nova Scotia government initiated the Continuing Care Strategic Framework Project to improve the continuing care system so it is able to better meet the needs of our aging population and to better support all Nova Scotians in their communities. The findings and recommendations stemming from this 14-month project informed the development of the Continuing Care Strategy – government’s plan to transform the continuing care system over the next 5 to 10 years, which was released in the spring of 2006.

The Provincial Steering Committee’s work was informed by numerous committees and by public consultations that involved more than 1400 Nova Scotians. Their input helped to identify priorities for the future of continuing care.

This report contains the vision and recommendations developed by the steering committee as part of the Continuing Care Strategic Framework Project. Throughout the project, Nova Scotians expressed a desire to remain as independent as possible for as long as possible. As their health status changes, they may require support to do so. Nova Scotians expect the right care, in the right place, at the right time, provided in the right way. They want support to be delivered in the environment in which they live – their homes, supportive housing, or long-term care facilities.

Regardless of the level of support required, Nova Scotians want to make their own choices about their lifestyle and health-care options.

Based on input from Nova Scotians, the steering committee developed a statement that reflects the vision Nova Scotians have for continuing care in our province:

To have every Nova Scotian live well in a place they can call home.

Following this, the steering committee developed recommendations in six key areas aimed at achieving the vision (Figure 1).

1. Support Individuals and Families

Skills, knowledge building, and support to help Nova Scotians as they take responsibility for their own health and participate in their community

2. Support Community Solutions

Recommendations to promote and support sustainable community-based initiatives that help Nova Scotians remain in their homes for as long as possible

3. Strengthen Continuing Care Services

Ways to enhance and expand existing continuing care services and implement innovative, new programming

4. Invest in Providers

Ways to ensure that enough of the right health-care providers, with the right skills, are available to implement a revitalized continuing care system

5. Invest in Infrastructure

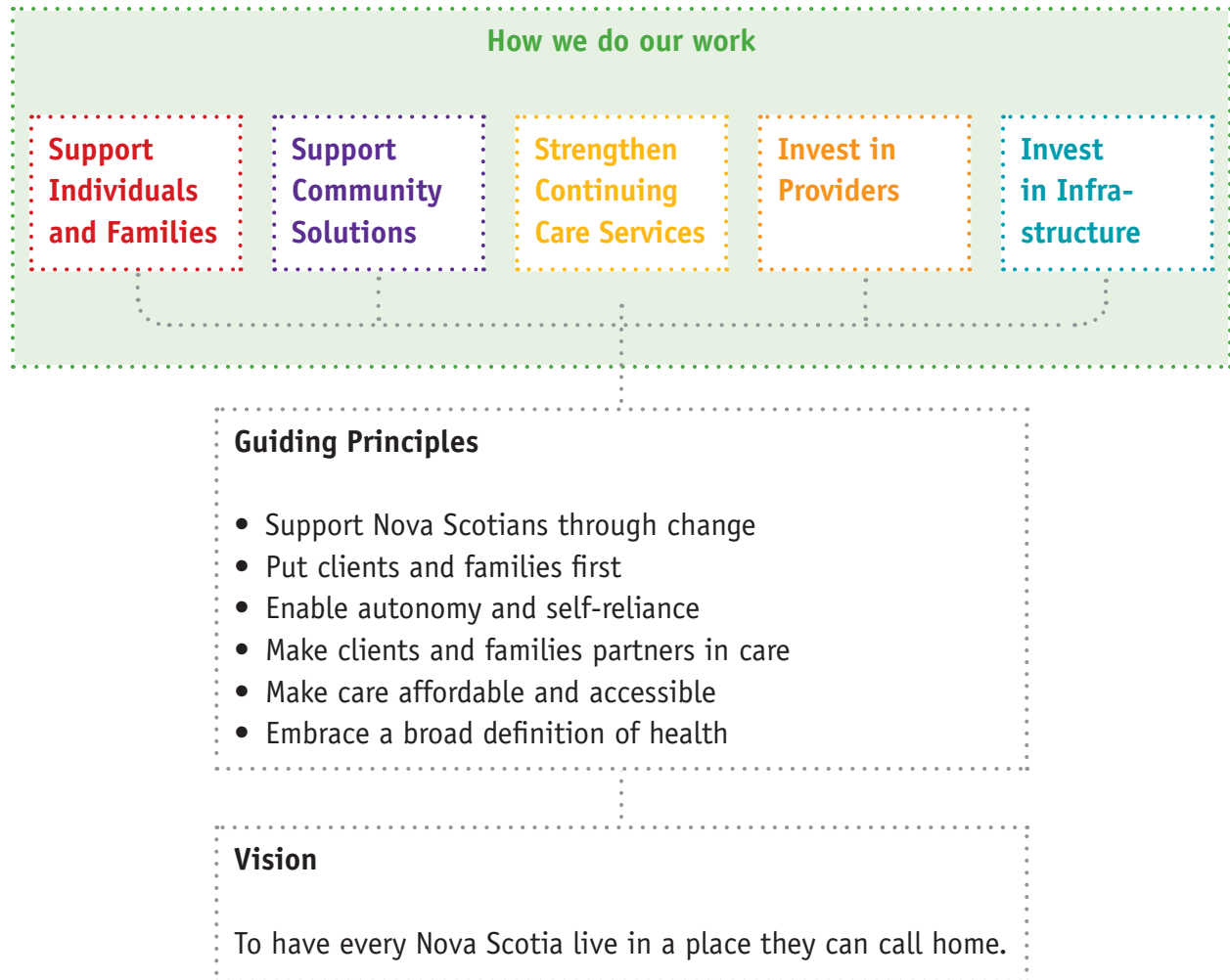
Physical space, information systems, and processes that will improve access to and delivery of high-quality services that support the needs of Nova Scotians

6. How we do our work

Philosophies and principles that Nova Scotia must embrace to ensure that we work co-operatively to bring the vision for continuing care to life

Under each of these six areas, the steering committee made a number of recommendations. Many of these are related to service areas traditionally within the sphere of continuing care, such as home care, long-term care, adult day programs, respite services, and care coordination. The steering committee also made recommendations in areas not traditionally associated with continuing care, such as community capacity building, transportation, diversity, and housing. The steering committee consistently heard that additional supports/services and new ways of working together at the community level and throughout the health-care system are needed in to be effective in realizing the vision.

Figure 1



It is the belief of the Provincial Steering Committee that the issues highlighted in this report belong to all Nova Scotians. These recommendations extend beyond the purview of the Department of Health’s Continuing Care Branch. To realize the new vision for continuing care, changes are needed at every level. The involvement of partners, stakeholders, and the sector at large is critical to success.

The issues facing Nova Scotia’s continuing care system are complex. The recommendations presented in this report are intended to affect the greatest number of Nova Scotians. Acting on these recommendations will allow Nova Scotians to remain as independent as possible, for as long as possible. It will create a system that allows Nova Scotians to make decisions about their own care.

Background

Project Mandate

Recently the province has recognized that over the next decade a plan will be needed to respond to the health system pressures resulting from Nova Scotia's aging demographics and health status. Resources will need to be realigned, new dollars invested, and partners and stakeholders consulted.

Nova Scotia has the oldest population in Atlantic Canada and the third oldest in Canada.¹ With those aged 65 and over making up the fastest-growing segment of the population, this trend will continue for the foreseeable future.

Nova Scotians are also living longer. By 2021, the life expectancy for the average Nova Scotian is projected to increase to 78.2 years for men and 83.9 years for women.²

The health of our population is also a concern. Nova Scotia has the second-highest rate of diabetes in the country and the highest death rates in Canada from cancer and respiratory disease.³ Statistics Canada reports that 52.6 per cent of Nova Scotians over the age of 12 do not participate in sufficient activity to obtain optimal health benefits.⁴ We are not consuming enough fruits and vegetables, and a significant number of us are above our optimum weight. Many of us continue to smoke. These factors are adding pressure and cost to the health system. More importantly, they have a negative impact on families, volunteer organizations, communities, work places, and overall quality of life.

To respond to these challenges, the government called for the development of a Continuing Care Strategy. A Continuing Care Provincial Steering Committee was struck to gather information and develop recommendations to improve and expand Nova Scotia's continuing care system.

The mandate of the Strategic Framework project was as follows:

1. Consult with district health authorities, community health boards, stakeholders and partners, service providers, and the public.
2. Facilitate development of a shared vision for continuing care.
3. Develop recommendations for achieving the vision.
4. Provide the Department of Health Continuing Care Branch with recommendations for strategic and business planning over the next 5 to 10 years.

To achieve its mandate, the steering committee determined that it would use a collaborative and integrated approach to the project. Shared values and purpose, concrete objectives, and joint leadership would be established.

Project Overview

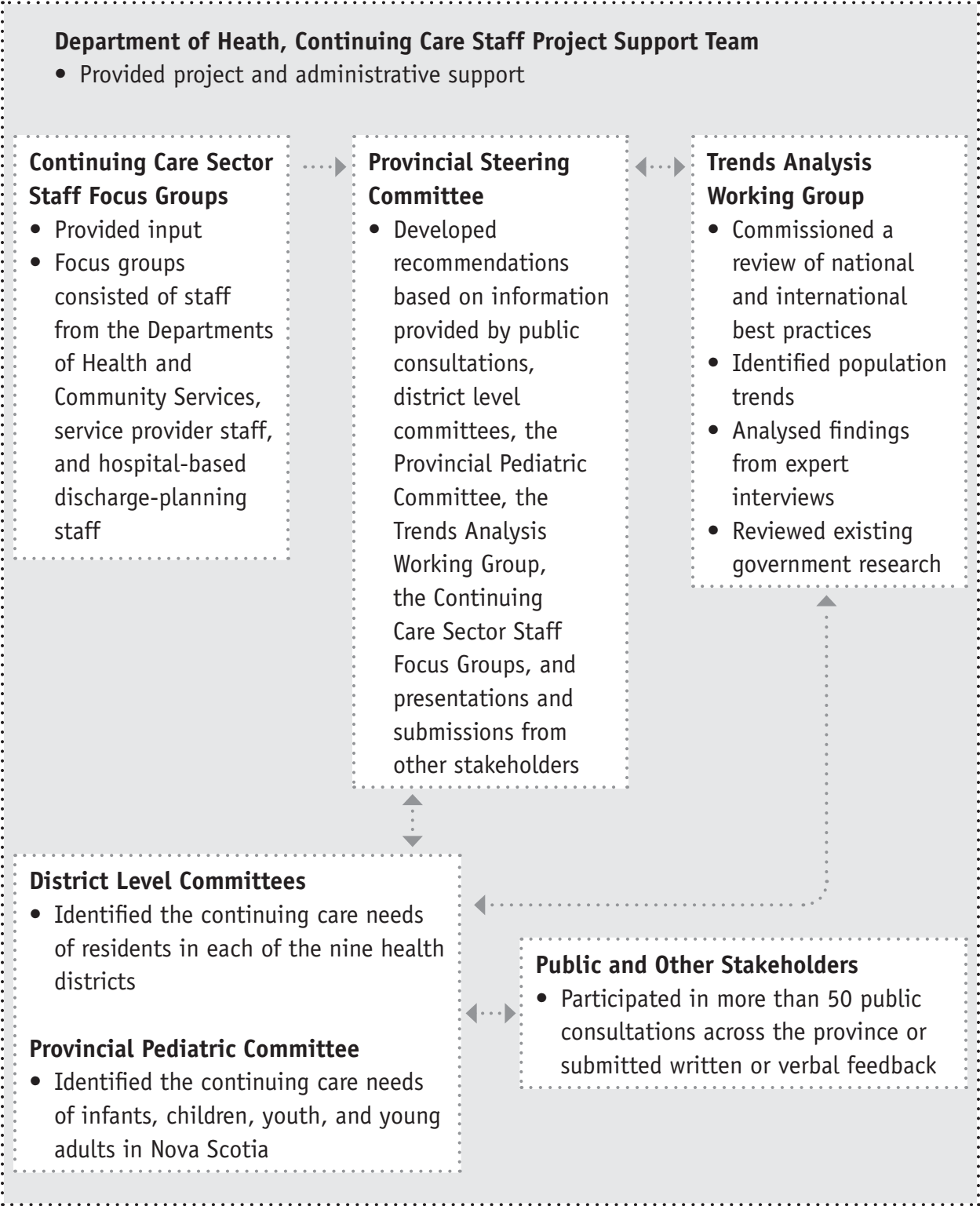
Nova Scotians, subject matter experts, Department of Health staff, and the province's district health authorities all contributed to this project. The project was based largely on consultation – with the public, professionals, and stakeholders. Throughout the project, some issues were heard repeatedly and consistently, while others were brought forward less often but were viewed to be good ideas. The information and advice gathered was used to inform the Provincial Steering Committee's recommendations. The steering committee recognizes that additional research will need to be conducted to determine how to move forward the ideas presented in this report.

Figure 2 outlines the contributions of each group that participated in the project.

For More Information

Reports prepared by the committees can be found on the Department of Health website at <http://www.gov.ns.ca/health/ccs/vision.htm>

Figure 2: Team Structure



Department of Health staff and members of the various committees involved in the project are listed in Appendix A.

Project Timeline

Spring through Summer 2005

- Public consultations were held across the province. Findings were shared with the district level committees and the Provincial Pediatric Committee.

Spring through Fall 2005

- The Trends Analysis Working Group commissioned research on demographic trends, interviewed subject matter experts, reviewed previous government studies and recommendations, and conducted a cross-jurisdictional review.

November 2005

- The Provincial Steering Committee received reports from the nine district level committees and the Provincial Pediatric Committee.
- Information from focus groups with continuing care sector staff was compiled in a report that was presented to the Provincial Steering Committee

December 2005

- A report synthesizing findings from the 52 community consultations was completed and presented to the Provincial Steering Committee.
- The Council of Chairs, the nine district level committees, and the Provincial Pediatric Committee presented their findings to the steering committee.
- A report containing the findings of the Trends Analysis Working Group was submitted to the steering committee.

January to March 2006

- Presentations and submissions from stakeholder organizations were delivered to the Provincial Steering Committee.
- The Provincial Steering Committee developed recommendations.
- The Provincial Steering Committee submitted draft recommendations to the Minister of Health on March 31, 2006.

April to May 2006

- Government reviewed the recommendations and developed priorities for action as outlined in Nova Scotia's 10-year Continuing Care Strategy.

Understanding Continuing Care

Continuing Care in Canada Today

To improve continuing care, we must first understand what it is and what services are currently included. According to Health Canada, continuing care encompasses “a wide range of health services delivered at home and throughout the community to recovering, disabled, chronically or terminally ill persons in need of medical, nursing, social or therapeutic treatment and/or assistance with the essential activities of daily living. Continuing care also includes supportive housing and long-term facility based care.”⁵ In most cases, the need for care and support is for the longer term.

Unlike hospital and physician services, continuing care services are not insured under the Canada Health Act. Therefore, the provinces have developed unique systems, terminology and service options. However, in general, continuing care services include the following:

- assessment and case management
- long-term care facilities, including chronic care facilities
- home care nursing
- homemaker and personal care services
- community rehabilitation services such as physiotherapy and occupational therapy
- palliative care
- respite care

Other commonly provided continuing care services include:

- meal programs
- adult day support
- group homes
- equipment and supplies
- quick response teams

Continuing Care in Nova Scotia Today

The Continuing Care Branch, Department of Health, provides a number of services:

- **Home Care**

Nova Scotians of all ages who need care in their homes and communities to remain independent receive support through provincial home care services. Home care services include home support (such as personal care, respite, and light housekeeping), nursing care (such as dressing changes, catheter care, and intravenous therapy), and home oxygen.

Continuing Care Branch staff provide intake, referrals and care coordination through assessments of the clients' care needs, development of service plans, and authorization of service providers to provide the required care. Direct services in the home care program are primarily provided by contracted agencies, although in some areas of the province, Department of Health employees provide some nursing services.

- **Long Term Care**

The Department of Health licenses or approves several types of long-term care facilities:

- Nursing homes serve clients who have more intense personal care needs and require the care of professional nursing staff to be on site at all times.
- Residential care facilities (RCFs) serve clients who need supervision or personal care and do not require on-site professional nursing services.
- Community based options (CBOs) serve three residents or less and provide a similar level of care to that available in an RCF.

Long-term care beds primarily serve seniors. Health-care costs at long-term care facilities are funded by the Department of Health. Residents are responsible for the accommodation cost associated with living in a long-term care facility. Depending on the resident's income, this cost may be subsidized by the province.

- **Respite**

Respite care is intended to support the client and their family by allowing caregivers time for needed rest and relief. The Continuing Care Branch of the Department of Health offers up to 40 hours of in-home respite services per month. It also provides up to 28 days of respite per year in long-term care facilities.

- **Self Managed Care**

The Self Managed Care program was introduced as a new Continuing Care program option in December 2005. The program helps many Nova Scotians with physical disabilities to increase control over their lives. The province provides eligible individuals with funding that can be used to directly employ the people who attend to their home support and personal care needs.

- **Adult Protection**

The Department of Health offers support for people age 16 or older who are abused or neglected and who cannot physically or mentally protect or care for themselves. This work is guided by the Adult Protection Act (1985).

In Nova Scotia, the delivery of continuing care is the responsibility of many individuals, companies, groups, and organizations. Other government departments and non-government organizations, as well as family and friends, play a critical role in providing needed services and supports generally considered to be “continuing care.”

The foundation of continuing care is made up of family and friend caregivers who provide a wide range of supports to seniors and those with disabilities; they are reported to provide as much as 80 per cent of the required care in the home.⁶

Other government departments, such as the Department of Community Services, offer essential programs. The Services for Persons with Disabilities Program provides a range of in-home, residential, and day program support services to eligible persons with a diagnosis of one or more of the following: intellectual disability, long-term mental illness, or physical disability. The Department of Community Services, Housing Services, offers a number of programs to help lower-income households to maintain, acquire, or rent safe, adequate, and affordable housing.

Non-government organizations provide much-needed supports such as meal programs and transportation services that allow seniors and those with disabilities to remain in their own homes. Private housing options such as assisted living units provide options between home and long-term care.

Appendix B gives a graphical overview of continuing care programs and services in Nova Scotia today.

Nova Scotia System Strengths

Much of this report explores opportunities for improvement in Nova Scotia's continuing care system. However, it should be noted that the existing system has significant strengths on which to build.

It is encouraging that the majority of services included in most continuing care systems across Canada are currently available in Nova Scotia. Also encouraging are several initiatives already implemented by the province.

For example, the Department of Health has implemented significant changes to the way long-term care in Nova Scotia is funded and how residents pay for long-term care. Under the Cost of Care Initiative – launched on January 1, 2005 – residents of nursing homes, residential care facilities, and community-based options under the Department of Health's mandate are no longer required to pay for their health-care costs. In addition, residents no longer have to use their assets to pay for their accommodation costs.

The Self Managed Care Program is now broadly available. Introduced as a new Continuing Care program option in December 2005, it helps Nova Scotians with physical disabilities to increase control over their lives by providing funds so that they may directly employ the people who provide home support and personal care needs.

Exemplary programs such as the Challenging Behaviours Program, which provides education to front-line staff and managers on how to work together in new ways to better address the needs of clients with challenging behaviours, have also been identified as system strengths.

We have a good system on which to build. The commitment to system change, consultation, and collaboration that served as the basis of the process used to develop the Continuing Care Strategy will serve as a strong foundation for moving forward.

The continuing care program, while it may not be perfect, is working.

I've been involved with community health care for 20 years. I was here when we didn't have any government support and it was terrible. The Home Support Workers then were doing cleaning and meal preparation and that was about it. Now they're there for personal care, family support, respite care, and so on.

Now we do have a continuing care program.

Public consultation participant

Changing to Meet Nova Scotia's Needs

Research clearly indicates that Nova Scotia's demographics are changing. Along with that so too are our needs. The strengths present in today's continuing care system must be built on to meet those changing needs.

Based on consultations with Nova Scotians and on the work of the sub-committees involved in this project, the Provincial Steering Committee believes a broad vision of health that includes physical, mental, social, economic, and spiritual well-being for individuals of all ages and life circumstances is required.

A revitalized continuing care system should permit individuals to bear a portion of the responsibility for maintaining and managing their health. It must allow Nova Scotians to retain their autonomy, self-reliance, and independence as long as safely possible – even as their circumstances change.

Nova Scotians should not be required to move far from their communities to secure support services as their needs change. In addition, services should be individually matched to the client's needs. Therefore, flexibility must be an inherent part of the system.

The steering committee envisions continuing care as being provided in the right place – a place that Nova Scotians can call home. It sees Nova Scotians able to access the right services, delivered in the right way, at the right time.

Based on research and consultations with Nova Scotians and subject matter experts, the Provincial Steering Committee has recommended that Nova Scotia move toward a community care – based system. The literature supports community-based care as being more cost-effective than facility-based care. This will ensure that Nova Scotians receive the care they need in a place they can call home.

To guide its work, the Provincial Steering Committee adopted the following definition of continuing care:

Continuing care is a range of services for individuals of all ages and their families that provide support and allow people to remain in their homes and communities throughout their lifetimes.

The nature and cost of the changes needed to revitalize the continuing care system make the process complex. Change must be fundamental – new learning must lead to new ways of thinking, and new capacity in the system. Governments and organizations must find new ways of building capacity within the system. Decisions will need to be based on evidence, and funding must be sustainable.

Creating the right conditions for change will take time. It is therefore likely that it could take more than a decade to fully transform the province’s continuing care system. Ultimately, however, a revitalized system will allow more Nova Scotians to participate in their communities and live well in a place they can call home.

In the interim, commitments by government, continuing care sector leadership, and communities will help promote changes that reduce the number of people in facilities, prevent or reduce frailty, and encourage community participation.

Therefore, the steering committee concludes that the recommendations in this report are about providing better care, not necessarily by spending more, but by spending better.

The Vision for the Future

Over the course of the 14-month continuing care strategy project, more than 1,400 Nova Scotians participated in the project. Their input helped to identify priorities for the future of continuing care.

Nova Scotians expressed a desire to remain as independent as possible for as long as possible. As their health status changes – and they require support to maintain their independence – they expect the right care, in the right place, at the right time, provided in the right way. They want the care they need to be delivered in the environment in which they live – their homes, supportive housing, or long-term care facilities.

Regardless of the level of support required, Nova Scotians want to make their own choices about their lifestyle and health-care options.

Vision

Based on this input, the steering committee developed a statement that reflects the vision Nova Scotians have for continuing care in our province:

To have every Nova Scotian live well in a place they can call home.

Guiding Principles

Nova Scotians identified key factors that will help create an environment in which the system they envision can come to life. The steering committee used these factors to guide the project, and it recommends that they become the province's guiding principles as it implements its chosen priorities:

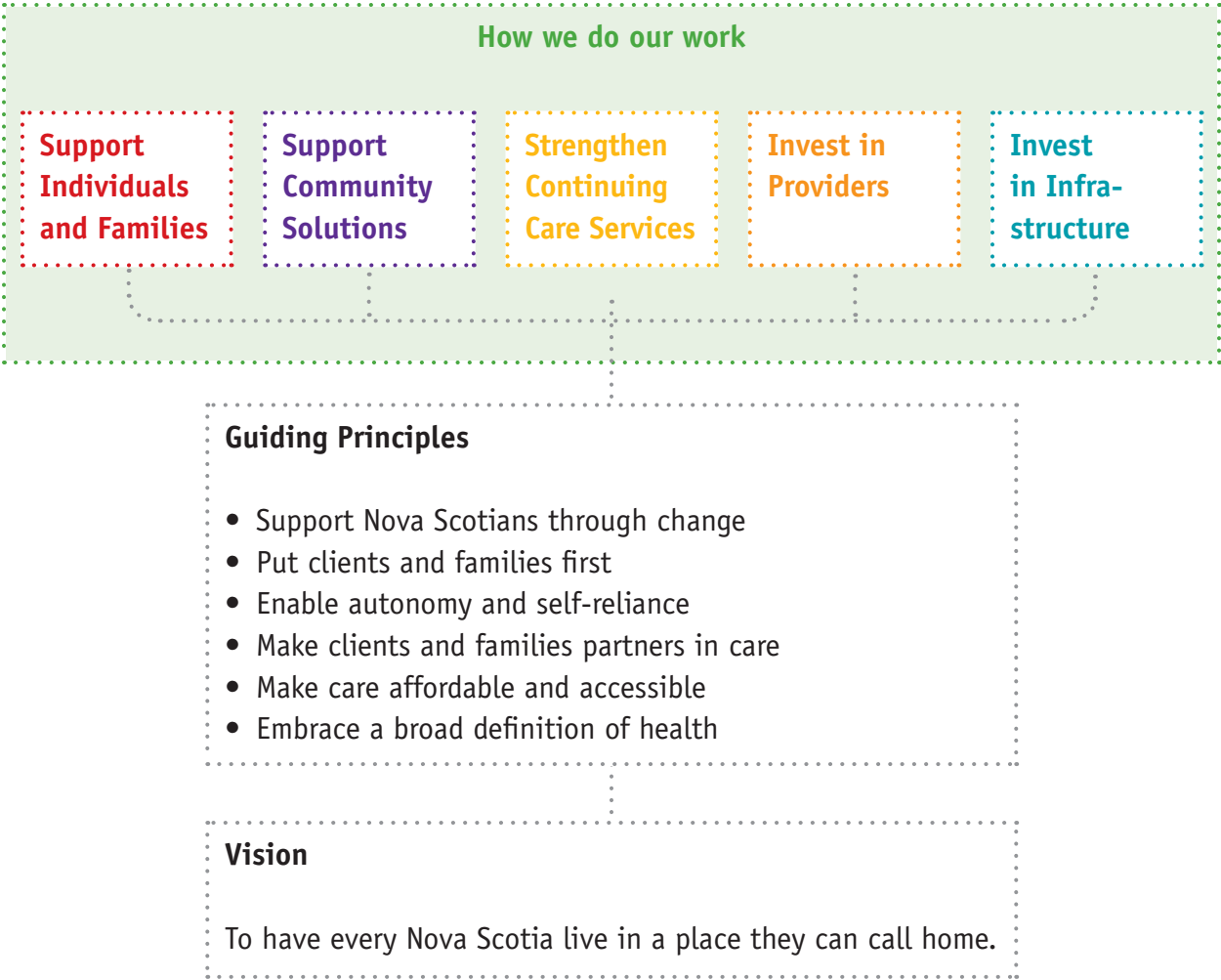
- **Support Nova Scotians through change.** Enable Nova Scotians to remain in their communities of choice and secure support services as their needs change.
- **Put clients and families first.** Build services and supports to meet individual needs. Flexibility must be part of the system.
- **Enable autonomy and self-reliance.** Find ways to help Nova Scotians stay as independent as possible even as their circumstances change. Individuals should bear some responsibility for maintaining and managing their health.
- **Make clients and families partners in care.** Allow clients and their loved ones to help choose the care options best suited to their needs.
- **Make care affordable and accessible.** Access to appropriate and affordable care, regardless of an individual's geography, age, income, gender, cultural background, or sexual orientation is imperative. The system should be easily accessed, understood, and navigated by all clients and their families.
- **Embrace a broad definition of health.** Physical, mental, social, economic, and spiritual well-being should be achievable for Nova Scotians of all ages and life circumstance.

Throughout the consultations, Nova Scotians expressed their belief that change in the continuing care system is possible. They advise that an effective continuing care system should:

- be innovative and creative and seek new ways of looking at old problems
- use the best available evidence when making decisions
- be provided in a manner that is sustainable
- be accountable and transparent and maintain open communications

The Continuing Care Strategy

The continuing care strategy should aim *to have every Nova Scotian live well in a place they can call home*. Ultimately, we want more Nova Scotians in their homes and participating in their communities. We want to see fewer people in facilities; we want to do a better job at preventing and delaying frailty and to see fewer individuals suffering from loneliness and isolation.



Nova Scotians want to be able to access the *right services*. Those services should be delivered in the *right way*, at the *right time*. To do this, the steering committee recommends changes to areas traditionally associated with continuing care – those designed to improve existing continuing care services, fill gaps, and ensure that Nova Scotians have reasonable access to quality services across the health system when needed.

The steering committee also believes that changes in areas beyond those traditionally associated with continuing care are needed to support this vision. Nova Scotians explicitly identified service needs that are usually not included as part of a continuing care system. Transportation, primary care, and housing directly affect both the ability of clients to remain in their own homes and their care needs. The absence of services in these areas can increase demand for care.

Those who rely on services delivered by other parts of the health-care system or other areas of government may encounter difficulties with silos and gaps. Gaps and silos are created when departments or programs are not closely connected to others delivering different but inter-related services. The silo approach to health care is outdated. When it occurs, it can foster feelings of disconnection and frustration. Many of the recommendations in this report are intended to build stronger connections within the continuum of care – it's not just the quality of the services, but also how we do our work that counts.

This report also outlines actions to transform the system and achieve the proposed new vision for continuing care. Suggestions for moving forward often accompany recommendations. These are activities that will assist in reaching our vision.

The recommendations of the Provincial Steering Committee have been divided into the following six categories. The steering committee believes that investment is required in all of these areas to bring the vision for the future of continuing care to life.

1. Support Individuals and Families

Skills, knowledge building, and support to help Nova Scotians as they take responsibility for their own health and participate in their community

2. Support Community Solutions

Recommendations to promote and support sustainable community-based initiatives that help Nova Scotians remain in their homes for as long as possible

3. Strengthen Continuing Care Services

Ways to enhance and expand existing continuing care services and implement innovative, new programming

4. Invest in Providers

Ways to ensure that enough of the right health-care providers, with the right skills, are available to implement a revitalized continuing care system

5. Invest in Infrastructure

Physical space, information systems, and processes that will improve access to and delivery of high-quality services that support the needs of Nova Scotians

6. How we do our work

Philosophies and principles that Nova Scotia must embrace to ensure that we work co-operatively to bring the vision for continuing care to life

The recommendations in this report are based on information gathered through public consultations, the experiences of people working in the continuing care system, and subject matter experts. The health challenges facing Nova Scotia are complex and will take a number of years and a phased implementation plan to resolve. The Provincial Steering Committee contends that the government is best able to identify actionable and achievable priorities. To do so, additional research is needed to determine which recommendations will have the most impact on the continuing care system. The steering committee acknowledges that not all recommendations put forth in this report will be acted on immediately and that additional planning is required.

In May 2006, the government announced a Continuing Care Strategy informed by this report. Since that time, new initiatives have been implemented by government, including palliative home care services and improved access to home oxygen. In addition, work is under way to build 1320 new long-term care beds over the next 10 years. Other initiatives are at various stages of planning and implementation. While, government will continue to play a significant role in implementation of the strategy, this report contains additional recommendations that require leadership from the continuing care sector and others. These additional recommendations, many of which can be achieved at no cost or low cost, will provide the sector with a springboard from which it can move forward.

Support Individuals and Families

Nova Scotians want to remain in their own homes, to do as much for themselves as possible, and to make choices about their lifestyles and health care. They are mindful that family and friend caregivers, and volunteers are supporting individuals in their homes across the province. While they believe this support is essential and will continue, they said that many caregivers are overburdened, with some near burnout, and in need of support. Enabling individuals to engage in their communities by improving accessibility and social opportunities was also discussed. As well, there is a shared belief that improving opportunities for health promotion and illness prevention would play a major role in increasing the capacity of individuals and the communities they live in.

Based on the information they received, the steering committee recommends the following:

Caregivers

Recommendation 1:

Recognize caregivers as partners in care and as clients in their own right.

Recommendation 2:

Implement a comprehensive caregiver strategy that will include caregiver assessment and a menu of supports/services that offer choice and meet social, economic, and health needs.

Suggestions for moving forward

- Recognize the diversity of caregivers when developing policy and programs. Raise awareness of the role that caregivers play in enabling Nova Scotians to remain in a place they can call home.
- Support caregivers by increasing home care and respite entitlements and investing in adult day programs.
- Examine financial support and compensation approaches for caregivers.
- Consider expanding the Self Managed Care Program to allow family members to manage all aspects of care.
- Encourage family-friendly workplace policies that offer flexibility and support services to assist caregivers both while caregiving and after caregiving responsibilities have ended.
- Improve access to information on government programs and local community supports, as well as education and training opportunities for caregivers.
- Improve integration of caregivers' needs in care plan development. Consider use of a caregiver assessment tool as part of a care coordinator assessment process.

It will cost the government a fortune to keep clients in hospitals once family caregivers and volunteers are burnt out.

Public consultation participant

Frailty

Recommendation 3:

Develop a better understanding of the impact of frailty and a system-wide approach to prevention.

Suggestions for moving forward

- Recognize that frailty, not age, determines service needs.
- Reduce frailty by increasing opportunities for positive personal health practices for all Nova Scotians.
- Consider the increasing frailty of the long-term care client population when planning for the delivery of long-term care services, including staff-to-client ratios.
- Invest in education, training, and supports, such as equipment, to help frail clients with complex needs in home and long-term care settings.

Health Promotion and Illness Prevention

Recommendation 4:

Support health promotion and illness prevention across the lifespan.

Suggestions for moving forward

- Apply a population health approach to the development of continuing care services.
- Collaborate with the Department of Health Promotion and Protection on health promotion activities.
- Support efforts to
 - create more affordable physical activity options
 - develop incentives to participate in health promotion activities
 - make regular physical education mandatory at all grade levels in all schools
 - implement workplace wellness programs
- Ensure that the Wellness in the Community grants program is accessible and user-friendly.
- Endorse and implement the recommendations contained in the Falls Prevention Strategy.
- Support community recreational programming in long-term care facilities.
- Provide smoking-cessation programs to continuing care clients.

Senior-Friendly Environments

Recommendation 5:

Develop senior-friendly environments that celebrate aging, encourage independence, and facilitate community involvement.

Suggestions for moving forward

- Endorse the Seniors' Secretariat Strategy for Positive Aging in Nova Scotia. Consider the recommendations it outlines when developing new policies, programs, and services.
- Educate the business sector about seniors and their contributions. Encourage them to help older employees remain active later in life.
- Encourage seniors to volunteer and remain in the workplace.
- Invest in seniors' health promotion and illness prevention activities.

Support Community Solutions

Nova Scotians are known to have a strong sense of family and community. They want to build on what is already in their communities and to further develop local solutions to meet their distinct needs.

When Nova Scotians were asked what additional supports could help individuals remain in their homes and communities, transportation and housing were mentioned consistently around the province. Access to equipment, supplies, and medication were other common themes.

To address these needs, the steering committee recommends the following:

Community Capacity

Recommendation 6:

Promote and support sustainable community capacity building.

Suggestions for moving forward

- Encourage government to strengthen commitment to a philosophy of community capacity building and increase the Department of Health's contributions in this area.
- Engage in dialogue with district health authorities and community health boards to identify how the Continuing Care Branch can contribute to building community capacity.
- Encourage the development of local champions committed to building community capacity.
- Recognize the roles communities play in supporting their residents to remain in their own homes as their care needs change.
- Maximize the use of available community resources.

We need to learn how to listen differently to communities, to think differently about how we communicate, to do community development that empowers them to be part of their own solutions.

Public consultation participant

Equipment and Supplies

Recommendation 7:

Develop a multi-faceted approach to respond to equipment and supply needs.

Suggestions for moving forward

- Expand the home oxygen program to include portable oxygen.
- Evaluate the provincial Long-Term Care Equipment Program. Consider expansion of this program to home care, schools, and the broader community.
- Develop a coordinated approach to providing affordable equipment to clients in need. Consider the role of community and private agencies.
- Consider options for providing additional care-related supplies to home care clients.
- Provide caregivers and staff with training on the proper use of equipment.
- Support the increased use of monitoring and checking services for seniors at home.

The lack of funding for access to portable equipment runs counter to aspirations for clients to engage in their communities.

**District Level
Committee 1
Report**

Housing Policies and Programs

Recommendation 8:

Support housing policy and programs that meet the needs of all Nova Scotians.

Suggestions for moving forward

- Ensure that low-income Nova Scotians, including the working poor, have access to affordable housing and can remain in their communities as they grow older.
- Ensure that future housing plans consider the needs of people with physical and intellectual disabilities, youth, and people with mental health issues, dementias, and challenging behaviours. Housing policies and programs should consider options to
 - improve access
 - reduce social isolation
 - provide emergency housing
 - provide supportive living opportunities
 - establish standards for safety and maintenance

Access to affordable, safe housing options for a range of housing types, and the availability of resources to have people to remain in their home, have been identified as issues.

District Level Committee 1 Report

- Develop a comprehensive plan to improve access to health services for clients currently using Department of Community services housing programs.
- Provide more funding and simplify processes to improve access to the Department of Community Services' programs that provide funds for home adaptation and repairs.
- Develop a roster of reliable, skilled people available to do small home-repair jobs and modifications to improve accessibility.
- Review policies to eliminate disincentives and promote opportunities for clients to remain in their own homes.

Housing Options

Recommendation 9:

Create a wider range of housing options for all Nova Scotians.

Suggestions for moving forward

- Offer a wider array of housing options including
 - enriched housing
 - seniors' apartments
 - emergency housing
 - assisted living
 - congregate housing
 - co-op housing
 - campuses of care
 - life-lease programs, such as not-for-profit condominiums
- Ensure that the development of new housing options includes
 - incentives for development in rural and remote areas
 - affordable options for low- and middle-income Nova Scotians
 - education about licensing requirements and care standards
 - design to meet complex health-care needs
- Examine government's role in licensing and monitoring housing standards.
- Engage private-sector partners in a dialogue about developing alternative housing options for all Nova Scotians.
- Revise legislation to reflect the current and future direction of housing options.
- Encourage municipalities to make changes to zoning bylaws and create areas for alternative housing options.

Rural and Remote Areas

Recommendation 10:

Use innovative models and approaches to improve access to services in rural and remote areas.

Suggestions for moving forward

- Collaborate with key stakeholders to address transportation challenges in rural and remote communities.
- Improve access to primary health care and health-care specialists.
- Design policies and programs that consider the unique needs of rural and remote communities. Facilitate equitable access to services.
- Use technology, such as telehealth, to improve access to services that are not available locally.

We shouldn't treat rural areas the same ways we treat metropolitan areas. They are different.

Public consultation participant

Transportation

Recommendation 11:

Launch a government-supported, community-based approach to developing a sustainable, multi-faceted provincial transportation system.

Suggestions for moving forward

- Base Nova Scotia's transportation solutions on national and international best practices.
- Ensure that community differences are addressed in a provincial transportation strategy.
- Develop affordable transportation solutions and determine how government will support these solutions over the long term.
- Work with partners to improve access to affordable liability insurance for volunteer-based and staff-provided transportation.
- Review the costs associated with emergency versus non-emergency ambulance trips. Consider alternative fee structures for non-emergency transports that do not require a paramedic and consider other transportation options for transfers.
- Work with long-term care facilities to develop district-wide, shared service models for client transportation.

Transportation is the number one problem in our system.

Public consultation participant

Volunteers

Recommendation 12:

Support the voluntary sector in improving quality of life and health outcomes of Nova Scotians.

Suggestions for moving forward

- Value volunteerism across the lifespan.
- Recognize volunteers as a vital part of continuing care. Support essential services provided by volunteers at the community level.
- Promote access to training and education to support volunteers.
- Explore best practices in volunteer recruitment and retention.
- Consider developing a provincial process to help reduce duplication in volunteer screening.

A youth volunteer program is needed to link community youth with those who need assistance.

Public
consultation
participant

Strengthen Continuing Care Services

Nova Scotians are generally complimentary about the continuing care service options currently available. They also believe it would be beneficial to have more services that can be tailored to the specific needs of individuals. They indicated a desire to expand and/or improve home care, self-managed care, respite, and palliative care. We also heard that they need access to restorative care so that they can regain their health and independence after an illness or injury.

Access to other parts of the health system and programs is critical to remaining healthy. Nova Scotians, including those who are continuing care clients, indicated that they need greater access to primary care services and that clinics providing ambulatory care services in their communities are also needed as a part of the health system.

Nova Scotians were clear in expressing their desire to stay in their communities when entering long-term care. They also shared their ideas about how to improve access to long-term care services and the policies and processes that support long-term care.

The steering committee recommended strengthening continuing care and related health services in the following ways.

Acquired Brain Injury

Recommendation 13:

Provide for the unique needs of persons with acquired brain injuries.

Suggestions for moving forward

- Inventory programs already in place to support individuals with acquired brain injuries.
- Adopt a common definition of acquired brain injury to help clarify which services appropriately address the needs of these clients.
- Incorporate the needs of clients with acquired brain injury into continuing care services.

Addiction Services

Recommendation 14:

Improve access to addiction services for continuing care clients.

Suggestions for moving forward

- Determine how continuing care can contribute to improved client outcomes.
- Educate continuing care providers on how to access addiction services for clients of all ages across their lifespans.

Adult Day Programs

Recommendation 15:

Work with partners and stakeholders to design and implement a provincial adult day program that considers the needs of both clients and caregivers.

Suggestions for moving forward

- Develop common definitions of adult day programs and identify target populations.
- Develop standards for operating an adult day program.
- Provide access for more complex clients.
- Determine if access to adult day programs should be through a single point of entry.
- Address barriers to use, including transportation, cost, availability across the province, physical environments, and hours of operation.

Adult day programs just make sense. Participants' lives are far more enriched and it helps everyone stay sane.

Public consultation participant

Adults with Disabilities and/or Chronic Illness

Recommendation 16:

Improve integration of services for clients with physical disabilities, intellectual disabilities, and chronic illnesses.

Suggestions for moving forward

- Promote policies and programs that enable individuals with disabilities to fully participate in community life, including barrier-free access to services.
- Identify barriers to educational and employment opportunities for clients with disabilities and/or chronic illnesses.
- Develop strategies for improved service delivery to small and geographically widespread client groups with unique needs. Consider
 - increasing access to specially trained staff
 - developing networks to help clients access centres of expertise
 - providing support for families and caregivers
 - developing client support groups/networks
- Work with municipalities to ensure that building codes and municipal by-laws consider accessibility.

Ambulatory Care

Recommendation 17:

Develop a provincial plan to improve ambulatory care services for continuing care clients.

Suggestions for moving forward

- Explore best-practice multidisciplinary delivery models for ambulatory care.
- Support district-level geriatric health networks.
- Develop a province-wide ambulatory wound management program.

Ambulatory clinics need to be developed within the community and be accessible to all.

**District Level 2
Committee Report**

Challenging Behaviours

Recommendation 18:

Expand strategies to respond to challenging behaviours.

Suggestions for moving forward

- Continue to execute Phase 1 of the Continuing Care Branch's Challenging Behaviour Program; implement Phases 2 and 3.
- Develop incentives to encourage and support professionals participating in the Continuing Care Branch's Challenging Behaviours Program.
- Explore models that address challenging behaviours in individuals under the age of 65.
- Increase collaboration and communication among all parties involved in the care and treatment of clients with challenging behaviours.
- Provide education, support, and respite to caregivers of those with challenging behaviours.

Complex Health Care Needs

Recommendation 19:

Increase the capacity of the continuing care sector to respond to clients with complex health-care needs across all ages of the lifespan.

Suggestions for moving forward

- Research best-practice models for delivering services to clients with complex health-care needs. Staffing requirements, environmental needs, equipment needs, and education for workers should be considered.
- Use a team approach to provide care to clients with complex health needs.
- Invest in technology to facilitate communication with, and monitoring of, clients with complex health needs.
- Use community-based solutions to assist geographically widespread client groups.
- Formalize access to geriatric assessment services and other relevant expertise.
- Provide expertise and resources to support clients in non-traditional, long-term care environments.
- Improve communication with facilities and agencies to meet the needs of clients with complex needs.

Diversity

Recommendation 20:

Ensure that continuing care services, programs, and policies recognize ethnicity, culture, language, sexual orientation, and personal beliefs.

The desired continuing care system has policies and service delivery models that recognize clients' sexual orientation, ethnicity, culture and personal beliefs in the vision of continuing care services.

Trend Analysis Working Group Final Report

Suggestions for moving forward

- Seek leadership and input from Nova Scotia's diverse communities including African Nova Scotians, First Nations, Acadian and francophone populations, and gay, lesbian, bi-sexual, and trans-gender groups when planning continuing care services.
- Increase cultural diversity among care providers.
- Increase the cultural and linguistic competency of health-care workers through communication and education.
- Revise the long-term care placement policy to allow for more choice and flexibility in placement to meet client needs.
- Ensure that information about continuing care services is sensitive to the needs of different cultures.
- Conduct a cultural and linguistic impact analysis when introducing all new policies.
- Working with Primary Health Care and First Nations communities, develop a plan to deliver accessible chronic home care nursing on reserves.

Gender

Recommendation 21:

Design, develop, and implement policies and programs that account for gender and its impact on the social determinants of health.

Suggestions for moving forward

- Consult and collaborate with key partners and stakeholders to address gender issues that affect continuing care.
- Ensure that policies consider income inequity and its impact on women.
- Review current policies to ensure that they do not unintentionally promote gender inequity. Look for assumptions about gender roles and responsibilities.

Home Care

Recommendation 22:

Revise current home care policy and programs to increase the ability of Nova Scotians to remain in a place they can call home.

Recommendation 23:

Identify opportunities for new delivery models and services.

Suggestions for moving forward

- Develop home care legislation.
- Invest in education to ensure that policy is applied consistently across the province.
- Develop and implement a standard client home record.
- Ensure that the home care program is family centred.
- Increase involvement in discharge planning. Ensure that transition through the system is client centred.
- Design a holistic home care program that is comprehensive, innovative, coordinated, accessible, and sustainable. It should include both new and existing services such as
 - professional services such social work and mental health services
 - household maintenance
 - housekeeping
 - meals and nutrition
 - social support
 - respite
 - transportation
 - equipment and medication funding
 - emergency and crisis support
 - 24/7 service entitlements
 - restorative/rehabilitative services for all ages across the lifespan
 - pediatric home care

**I counted back
and I've had 49
different people
trot in and out
of my house
already ... 49
guided tours:
this is how you
work the stove,
this is where the
supplies are ...**

**Public
consultation
participant**

- Develop service agreements for home care service providers. These should include standards around
 - services offered
 - scheduling
 - continuity of care providers
 - response times
 - cultural competency
 - scope of practice
 - responding to evolving client needs
 - performance-based reporting requirements
- Make home care services available to clients in any place they call home. Expand the definition of “home” to allow for provision of home care services in Department of Health community-based options and residential care facilities and in Department of Community Services facilities.

Infant, Child, and Youth Populations

Recommendation 24:

Expand the role of continuing care in the delivery of services to infants, children, and youth and improve access for those in need of home care services.

Suggestions for moving forward

- Explore ways to provide age-appropriate pediatric programs and services including long-term care, home care, and mental health, rehabilitation, and outreach services.
- Work with the Department of Education and school boards to support children with care needs in the school system. Approve the South Shore District Health Authority’s pilot program.
- Identify ways in which the continuing care system can support the IWK in their work with medically complex children requiring long-term stays.
- Strengthen relationships with youth advocacy groups such as the Child and Youth Action Committee (CAYAC).
- Improve the transitions from pediatric services to adult services.
- Train continuing care assistants to meet the needs of the pediatric population.
- Develop a human resources strategy to help sustain pediatric care in the community.

There are gaps for children returning to their communities from the hospital. Continuing Care should make a greater effort to ensure the transition from hospital to home and home to school is much smoother, safer, and more successful.

Public consultation participant

Long-Term Care Policy

Recommendation 25:

Review long-term care policies and procedures to ensure a client-centred approach. Policies and procedures should encourage integration and be flexible to accommodate diverse needs.

Suggestions for moving forward

- Ensure that the long-term care placement system is flexible and considers the needs of clients and caregivers.
- Evaluate the potential impact of eliminating or changing the 100-km rule.
- Study the financial impact of current long-term care policy on spouses who remain in the community.
- Determine if long-term care beds are fully utilized.
- Develop a transition plan that responds to immediate pressures on long-term care.

Seniors are not given adequate choice in where they access nursing home care. The current system often results in seniors being placed far from their families and loved ones, adding unnecessary stress to an already stressful time.

Public consultation participant

Long-Term Care: Innovative Approaches

Recommendation 26:

Encourage innovation in long-term care planning and service delivery.

Suggestions for moving forward

- Expand available long-term care options and consider creative solutions across the lifespan for clients of all ages.
- Ensure that complex-needs clients have access to appropriate long-term care.
- Develop home-like environments in long-term care. Work with facilities to identify needed resource and support requirements for achieving this goal.
- Encourage leaders to promote a client-centred philosophy in long-term care facilities.
- Improve public perception of the long-term care system through strategic communications.

There are caregivers at their breaking points, even with the maximum supports that the system provides. It is taking far too long for people to get into a long-term care facility.

Public consultation participant

- Set and maintain a population-based provincial target ratio for long-term care beds. Consider current and future needs and understand that flexibility is needed to respond to unique circumstances. Consider how the Health Services Steering Committee (Phase 2) report, *Making Better Health Care Decisions for Senior Citizens of Nova Scotia* can support this work.
- When increasing long-term care capacity, consider building smaller facilities to enable Nova Scotians to remain closer to home.
- Develop facility design standards that reflect future demands on long-term care.
- Research staffing standards in long-term care. Ensure that care teams and resources respond to the changing needs of clients.
- Explore opportunities to share resources between long-term care facilities and community-based agencies.

Long-Term Care: Unlicensed/Unfunded Facilities

Recommendation 27:

Develop a strategy to better understand the current and future role of unlicensed or unfunded facilities in the continuing care system.

Suggestions for moving forward

- Research the care needs being met by unlicensed facilities.
- Formalize standards for community-based options environments.
- Research licensing and standards-of-care practices in other jurisdictions.
- Use fair, equitable, and transparent processes to expand community-based options.
- Provide the public with the tools they need to make informed choices about care provision.

Medication Access

Recommendation 28:

Address medication access issues and understand how gaps affect the well-being of Nova Scotians.

Suggestions for moving forward

- Examine issues affecting access to medications and medical foods for clients living at home and in long-term care facilities. Issues may include transportation, cost, and differences in services available in rural and urban areas.
- Expand coverage for palliative medications to clients in all continuing care settings in the province.
- Allow exception drug costs for a period of time to cover gaps created when clients move from one care environment to another in the health-care system.
- Develop and implement a universal drug registry for all Nova Scotians.
- Explore opportunities for joint medication access and distribution in acute and continuing care settings. Move toward a district-wide supply chain.
- Develop a medication management program that encompasses facility, home, and community environments. The program should support information sharing, facilitate safety and compliance, and help prevent the occurrence of side effects and interactions.

As a result of the financial burden, people go without medication or end up in the hospital sooner. Some clients take only half of their medication in order to make it last longer, or don't take it for two weeks because they ran out, or don't eat because they need to spend their money on medication.

Public consultation participant

Mental Health Services

Recommendation 29:

Identify and analyse gaps in mental health services for continuing care clients. Increase the continuing care system's capacity to respond to the mental health-care needs.

People with mental illness require safe, affordable housing options as well as a range of responsive and individualized supports in order to continue to live in their own homes.

District Level Committee 8 Report

Suggestions for moving forward

- Support provincial mental health service plans and their integration in the continuing care system.
- Improve the availability of, and access to, mental health expertise in communities.
- Invest in mental health education for continuing care providers.
- Heighten awareness of depression in seniors.
- Use a holistic approach that considers both mental and physical health-care needs when assessing and classifying patients.

Oral, Hearing, and Vision Services

Recommendation 30:

Improve access to oral, hearing, and vision health services for continuing care clients.

Oral health needs to be recognized as an essential part of overall health. Poor oral health contributes to a variety of illnesses and increases costs to the health-care system. There are limited preventative services available to seniors.

District Level Committee 6 Report

Suggestions for moving forward

- In consultation with experts and continuing care clients, develop a plan to enhance access to oral, hearing, and vision health services.
- Develop standards to support equitable access to oral, hearing, and vision services in all continuing care practice settings.
- Allocate space in new facilities for dental and eye exams that is accessible to all continuing care clients, including those participating in adult day programs.
- Look at the potential role of dental hygienists in the continuing care oral health system.
- Educate Nova Scotians about the importance of maintaining oral, hearing, and vision health.
- Improve assessment screening for oral, hearing, and vision health.

Palliative Care Services

Recommendation 31:

Develop and implement a comprehensive provincial palliative care program. The program should be available in multiple settings to all Nova Scotians of all ages.

Suggestions for moving forward

- Extend home care authorization policies used in the Northern Region to the entire province.
- Prioritize long-term care placement and home support waitlists to support palliative care clients and their families.
- Revise policy to better support palliative clients remaining in their homes.
- Ensure that palliative care services include
 - case management and assistance with system navigation
 - standardized assessment, care planning, and charting
 - consult teams that include physicians, nurses, social workers, and pharmacists with specialized training in palliative care
 - training for primary health-care teams, volunteers, caregivers, and family members
 - a bereavement program that expands end-of-life care.
- Provide access to palliative care medications and equipment that improves client comfort and safety.
- Expand home oxygen program entitlements for palliative care clients.
- Identify and address reimbursement issues for physicians providing palliative care.
- Continue to develop designated nursing expertise in palliative care.
- Provide access to palliative resources and expertise through a 24-hour hotline.

Multiple agencies are providing palliative care with minimal coordination or patient follow up. There is a need for a holistic approach to care and collaboration on delivery.

District Level
Committee 7
Report

Primary Care

Recommendation 32: Ensure that primary health-care services are accessible to continuing care clients where they live.

Suggestions for moving forward

- Ensure that continuing care providers are regarded as an important part of the primary health-care team.
- Allow primary health-care teams to follow the client through the health-care system.
- Use technology, such as telehealth, to improve access and continuity of care for continuing care clients.

Respite

Recommendation 33:

Provide a wide range of respite options for all Nova Scotians. Consult with partners and encourage expansion of respite options that help build community capacity.

Suggestions for moving forward

- Adopt a broad, inclusive definition of respite as part of a comprehensive approach to providing respite.
- Recognize emergency respite as emergency care. Provide emergency care options in circumstances where caregivers are unexpectedly unable to provide care due to physical, mental, and/or emotional circumstances.
- Ensure that planning for new respite care options considers the following:
 - self-managed care
 - day programs
 - overnight respite
 - providing respite in a way that meets caregivers' needs and provides relief
 - increasing service entitlements
 - flexibility
 - infants, children, and youth with special needs
 - ways to “normalize” use of respite opportunities
 - strategies for increasing awareness of available services
 - diversity of caregivers
 - barriers to access
- Determine if current respite policy and processes have an impact on the use of existing respite services.

As family members and other volunteers take on more responsibility for home-based care, systems need to be put into place to make respite care something that a caregiver/family can count on when needed.

District Level Committee 7 Report

Restorative, Rehabilitative, and Convalescent Programs

Recommendation 34:

Meet the restorative, rehabilitative, and convalescent needs of Nova Scotians of all ages.

Suggestions for moving forward

- Use alternative level of care (ALC) beds as short-term convalescent beds not “holding beds.”
- Offer restorative, rehabilitative, and convalescent services in home, community and long-term care settings. Services should include
 - physiotherapy
 - occupational therapy
 - nutrition
 - oral health, vision, and hearing care
 - social work
 - case management
 - mental health
- Establish system-wide definitions, population targets, performance measures, and expected outcomes for restorative, rehabilitative, and convalescent programs.

There is a step missing between acute care and the home. It’s convalescent care. There are nurses, but most of the care is provided by occupational therapists, physiotherapists and social workers ... guiding these people back through rehabilitation to be able to go home.

Public consultation participant

Self-Managed Care

Recommendation 35:

Expand the Self Managed Care program.

Suggestions for moving forward

- Consult with stakeholders, partners, and researchers to determine the appropriateness of allowing clients in the Self Managed Care program to use funds to pay family members providing care.
- Incorporate a third-party manager role into the program to provide better access for the pediatric population and for persons with mental health-care needs, intellectual disabilities, chronic illnesses, and cognitive-impairment issues. Ensure that this addition complements, not duplicates, services available through the Department of Community Services.
- Evaluate the current Self Managed Care program and ensure that it fulfils its purpose.
- Improve audit mechanisms to minimize the risk of misuse of funds.

Create opportunities for people to self-manage and make decisions about their care.

District Level
Committee 9
Report

Vulnerable Adults

Recommendation 36:

Work with partners to ensure that appropriate programs and resources are in place to support vulnerable adults.

Suggestions for moving forward

- Complete evaluation and review of Adult Protection Services and legislation.
- Educate care providers about adult protection, particularly as it relates to roles, responsibilities, procedures, the impact of being declared incompetent, and how these services can be used more appropriately.
- Review policies and procedures and standard response times for after-hours access to Adult Protection Services.
- Build a better understanding among the public and care providers around competency, power of attorney, and guardianship issues.

The Adult Protection Act provides well for those adults who are in a vulnerable position.

Public consultation participant

Invest in Providers

To attain the new vision for continuing care in Nova Scotia, a number of building blocks are required. Nova Scotians discussed shortages of workers in all health professions that help people to remain independent in their homes. Nova Scotians told us that a team approach to service delivery should be considered a key element in any improvements to the health system.

Ultimately, the new vision for continuing care recommends a new approach to delivering services. To achieve this, we will require leaders in the sector who can support this change in philosophy. Nova Scotians clearly identified that focused attention on recruitment and retention are necessary across all areas of the continuing care system. They felt it should contain short- and long-term approaches to address staff shortages and outline strategies related to recruitment, retention, education, and training. In addition, many felt it was important to find additional opportunities to share information and best practices among providers.

To support our providers, the steering committee recommends the following.

Care Teams

Recommendation 37:

Implement a client-centred team approach that facilitates transition through the system, improves access to expertise and resources, and advances integration.

Suggestions for moving forward

- Determine the composition of a core care team. Recognize the need for flexibility and build in the ability to tailor the team to meet client needs. Team members may include social workers, physicians, occupational therapists, physiotherapists, registered nurses, continuing care assistants, dieticians, nurse practitioners, clerical support, care coordinators, family and friend caregivers, and volunteers.
- Remove barriers to collaboration.
- Recognize that continuing care is an integral part of the care team.
- Use technology to facilitate communication and increase the ability of the team to work together from a distance.
- Investigate a hospital in-reach approach. This will allow primary care teams to improve communication with clients as well as follow them through the system.

Teamwork among healthcare professionals is seen as a positive aspect of Continuing Care.

Public consultation participant

Education and Training

Recommendation 38:

Increase investment in education and training for continuing care providers.

Suggestions for moving forward

- Evaluate the Continuing Care Assistant program. Determine if graduates are appropriately prepared for work in facility and home care settings.
- Promote and support continuing education for care providers. Identify and address any gaps in care-provider skills. Additional training may benefit care providers assisting clients with
 - mental health-care needs
 - palliative care needs
 - pediatric care needs
 - unique cultural needs
 - cognitive impairments
- Address barriers to education in rural and remote settings by promoting technology such as telehealth.
- Work with educational institutions to expand or include continuing care in health program curricula and practicums.

Increased opportunities for training and promotion for all frontline staff would be a benefit. We need to communicate the ways we value continuing care workers.

District Level Committee 1 Report

Human Resource Strategy

Recommendation 39:

Introduce a comprehensive human resource strategy with short- and long-term strategies to address continuing care staff shortages. Collaborate with other health human resources strategies already under way.

Suggestions for moving forward

- Address human resource issues, including workforce planning, replacement time, hiring freezes, use of casual staff, and working conditions.
- Capitalize on available human resources and identify ways to reduce duplication, improve collaboration, and clarify roles.
- Define the government's role in developing and monitoring standards for care providers, professional services, and support staff.
- Implement marketing strategies to promote continuing care as a dynamic and worthwhile career.
- Clarify the role of nurse practitioners in the continuing care system – particularly in rural areas.
- Include service providers delivering non-professional services such as household and yard maintenance in the continuing care system.
- Use the principles of learning organizations to create attractive work environments and improve quality of care and the effectiveness of the health system.
- Increase the number of certified continuing care assistants (CCAs) in the system by continuing to provide bursaries, implementing strategies such as prior learning assessment and recognition (PLAR), and executing marketing programs such as the continuing care assistant recruitment initiative.
- Invest in staff skill development and training, higher staff levels, and solutions to the environmental challenges care workers face, to enable care providers to deliver quality care.
- Make care-provider compensation packages fair and equitable.

Home care workers are a system strength, but there just aren't enough of them ...

Public consultation participant

Primary Care: Medical Input

Recommendation 40:

Increase medical input into the continuing care system.

Suggestions for moving forward

- Encourage increased communication and collaboration between physicians, specialists, and long-term care staff.
- Facilitate access to specialists for continuing care clients.
- Include primary care physicians in a team approach to care.
- Expand physician services beyond long-term care to include the continuing care system. Invest in physician leaders to improve collaboration and coordination between continuing care and other areas of the health system.
- Consider the role of nurse practitioners in long-term care facilities.

Invest in Infrastructure

During the course of this project, a number of building blocks were identified as foundations for system change. These building blocks are the infrastructure that supports our clients and include not just buildings, but also tools, knowledge, policies, and processes. This infrastructure ensures that we understand our clients and have their needs in mind when we design and implement services. It also ensures that we have the resources required to deliver sustainable services and that we have the supports in place to provide services that help Nova Scotians remain at home for as long as safely possible.

Many Nova Scotians identified that adequate facility-based services are critical to move the system forward and called for increasing the number of long-term care beds. They also identified the need for investment in other areas of infrastructure, such as accessing and navigating the system, expanding the role of long-term care facilities in communities, and better management of information to enable sharing and reduce duplication.

To address these needs, the steering committee makes the following recommendations:

Assessment and Classification

Recommendation 41:

Ensure that assessment and classification systems are integrated, holistic, and needs based.

Suggestions for moving forward

- Evaluate classification procedures and levels of care in Nova Scotia.
- Develop a shared intake process for the Departments of Health and Community Services.
- Standardize assessment tools across government departments. Tools should be flexible and empower staff to address client needs.
- Avoid a task-oriented system; focus on providing the right level and type of services to enable independence.
- Involve families and caregivers in assessments to ensure an accurate understanding of care needs.
- Consider a client’s social well-being as well as the social determinants of health in assessments.
- Enable sharing of client files across services to reduce duplication and improve service delivery.
- Enhance use of the information gathered through the RAI-HC assessment tool to improve client care plans.

The processes to access Continuing Care services should be made less intimidating and less medically oriented.

Public consultation participant

Case Management

Recommendation 42:

Develop and implement an integrated provincial case management model that spans the health system.

Suggestions for moving forward

- Working with key partners, develop a common vision for case management across the health-care and continuing care systems. The vision should be supported by clear goals and objectives, processes, and tools to allow for smooth transitions through the system.
- Ensure that those responsible for client intake are also responsible for assisting clients and families with preliminary system navigation.
- Invest in education and skills development in the areas of case management, team building, and negotiation.
- Facilitate dialogue around coordination issues, tools, and mechanisms. Clarify staff roles and responsibilities and create a culture that puts client and family needs first.
- Empower care coordinators with the ability to develop tailored care plans.
- Examine Nova Scotia's current case management model. Identify areas where resources could be better used. Determine how a system navigation role should be included in a case management model.
- Identify system navigation as a key component of the care coordinator role.
- Develop training and provide information to support staff responsible for helping clients and families navigate the system. Raise awareness of how the system functions and what resources are available.

Provide more discretion and flexibility for care coordinators to access and develop care plans tailored to individual needs.

District Level Committee 5 Report

Continuing Care Funding

Recommendation 43:

Develop and implement provincial funding models for continuing care services to ensure equity across the province.

Suggestions for moving forward

- Address funding differences between for-profit and not-for-profit homes.
- Ensure comparable staffing complements at all long-term care facilities that allow for a health-care team approach.
- Separate funding for care and operational issues in long-term care facilities from building construction and maintenance.
- Develop minimum standards, performance measures, and reporting requirements for continuing care services.
- Build on existing incentives for efficiency. Permit facilities and agencies to reinvest budget surpluses in client service.
- Sufficient and sustainable funding for continuing care services should consider client acuity level and the needs of unique populations.

Information Management

Recommendation 44:

Develop an information management strategy, designed collaboratively with stakeholders and partners, to support decision making.

Suggestions for moving forward

- Identify data requirements and support data collection. Consider information technology and related human resource needs.
- Develop systems for research, data collection, data analysis, and evaluation.
- Support the appropriate use of the InterRAI suite of assessment tools e.g., RAI-HC, RAI 2.0. Ensure that information gathered is used to improve decision-making processes.
- Explore best practices for integrated information systems.
- Research and implement best practices for sharing information throughout the continuing care system.
- Determine government's role in investing in information technology and data-gathering mechanisms for the continuing care sector.
- Consider expanding the province's health information technology strategy to include continuing care.

Long-Term Care Infrastructure

Recommendation 45:

Develop a long-range capital investment plan for long-term care facilities.

Suggestions for moving forward

- Continue to assess long-term care facilities to identify required structural and functional upgrades and project future facility need.
- Develop standards for new construction and renovations that consider acuity of clients and program and service needs. Minimum standards should include
 - program space for both residents and the broader community
 - single-room accommodations
 - minimum square footage per client
 - single-level living
 - equipment and technology requirements
- Work with sectors in and outside of health care to review and assess minimum standards for long-term care facilities.

The care requirements of nursing home residents today present many challenges based on the functionality of these aging facilities. Aging infrastructure often increases workloads because buildings and systems are outdated.

District Level Committee 3 Report

Public Awareness

Recommendation 46:

Increase public awareness of available continuing care programs in Nova Scotia.

Suggestions for moving forward

- Provide information to the public about available continuing care services and how to access them. Information sources should be easy to understand.
- Communicate more information on the system and available resources to Continuing Care staff.
- Simplify and streamline information. Create a clearly written and easy-to-use multilingual service directory for clients and their families. Provide guidance to families making choices about how best to help loved ones.
- Improve the accessibility of Continuing Care branch offices and the website. Office locations should be in easy-to-access public venues and designed to support walk-in traffic. The locations should be advertised, and the website should include information about all available continuing care services. Provide a live voice at the end of the line.

There exists a tremendous lack of understanding of what services are available and what exactly continuing care is.

District Level
Committee 2
Report

System Access

Recommendation 47:

Help clients and their families easily access the continuing care system.

Recommendation 48:

Develop one point of entry to access the full range of continuing care services.

Suggestions for moving forward

- Work with other government departments to create a seamless system easily understood by clients.
- Expand the range of service options that can be accessed through Single Entry Access.
- Use a single entry access system for all services offered by the Departments of Health and Community Services.
- Provide continuing care staff with comprehensive information on the full range of services available in continuing care system, including in other departments and in the community.
- Improve access to services through an after-hours system.

The experience in finding your way around the system is absolutely overwhelming.

Public
consultation
participant

How We Do Our Work

Through the course of this project, we have looked toward exemplary continuing care systems in other jurisdictions. What we have learned is that these systems work well, not only because of the *types* of services they provide, but also because of *how* they provide these services and how continuing care partners work together.

Many of the recommendations outlined in the previous sections call for investment in new or expanded services, investment in human resources, or investment in infrastructure.

However, the steering committee also recognizes that new investment will have maximum impact only when coupled with changes in how we do our work. Government, service providers, and other stakeholders need to develop new kinds of relationships and processes for moving the vision for the future

of continuing care forward. This means new ways of thinking about our clients, of working together, and of delivering services. These elements will serve as the building blocks for successful transformation of the continuing care system as a whole.

Based on input from project participants, the Provincial Steering Committee identified characteristics necessary to building and sustaining a successful continuing care system.

Our committee supports innovative approaches where issues are addressed, not only by investing more resources in the system, but also by combining or realigning existing resources to make them more effective.

District Level Committee 4 Report

1. Commitment to Accountability for System Change

During consultations in communities throughout Nova Scotia, participants – not confident that changes to continuing care will be forthcoming – voiced skepticism. Identifying priorities from the recommendations presented in this report and then taking action will be critical if Nova Scotians are to embrace changes in continuing care.

As a key characteristic of a revitalized continuing care system, accountability ensures that the change process is governed by a solid philosophy and a disciplined approach. Those responsible for enacting the priorities must be accountable for implementing and managing change and for preserving the vision for continuing care.

The Provincial Steering Committee makes the following recommendations to support the commitment to accountability and system change:

- Seek change management expertise. The province must take a leadership role in facilitating cultural shifts across the system. Advice on how best to manage the required changes will be imperative.
- Use professional project management to ensure a comprehensive, disciplined approach to implementation.
- Consider incentives in implementation plans where appropriate.
- Explore new opportunities, such as use of service agreements.
- Identify leaders to champion system change.
- Share best practices broadly to support system stakeholders in bringing about change.
- Use pilot programs only as a part of a larger implementation plan. The ultimate goal should be province-wide implementation.
- Recognize that some changes must happen before others. Pay careful attention to sequencing and phasing.
- Develop an accountability framework to ensure transparency. Report progress toward goals, objectives, and performance targets.
- Measure client outcomes, satisfaction, and outputs and use this information to inform future change.

2. Commitment to Communication

Communication will play a vital role in the realization of the vision for continuing care. Communication builds trust and co-operation. It supports transparency and knowledge sharing. It ensures accountability.

The implementation plan must allow adequate time to gain support through communication and to build relationships among those who must work together more closely. Those affected by change must be part of this process, and communication must take place with these groups before and throughout the implementation process.

The Provincial Steering Committee makes the following recommendations:

- Embrace communication as a key component of implementation planning, project management, and execution processes.
- Ensure that a comprehensive communication strategy considers the needs of all partners and stakeholders.
- Create opportunities for front-line staff to contribute to change and move towards a more integrated system.
- Lead by example.

3. Commitment to a Holistic, Client-Centred Approach to Care

In order to effectively use our resources and deliver services that meet the needs of clients, decision makers and administrators should adopt a client-centred approach when developing policies, programs, and processes. In addition, those responsible for assessing clients' needs and authorizing services should focus on identifying the best possible care response to clients, within available resources, and to support clients throughout the system. This requires an investment in understanding the unique context and circumstances of each client and their family.

In order to meet clients' needs, the approach to care must also be holistic. While clinical services, such as nursing, are a key component of continuing care, clients often need a broader range of ongoing and long-term care supports. These supports allow people to remain at home and live as independently as possible for as long as possible, reducing the demand for more-costly services in hospitals and long-term care facilities.

To meet this commitment the steering committee makes the following recommendations:

- Encourage leaders to promote a client-centred philosophy.
- Recognize that flexibility is required to respond to unique client circumstances.
- Make services available to clients in any place they call home.
- Solve client issues through an integrated approach.
- Design a holistic home care program that delivers services to best meet client needs.
- Allow for client choice in service delivery.

4. Commitment to Evidence-Informed Decision Making

The recommendations in this report call for an ambitious strategy of change and investment in continuing care in Nova Scotia. Given the demands throughout the health-care system for new investment, it is critical that investment in continuing care is done wisely. In order to make decisions so that our limited resources will have maximum positive impact on clients, we need to build systems and skills that allow for evidence-informed decision making. This includes systems that allow for data collection in areas such as service need, utilization, and satisfaction, for data analysis, and for consultation with clients and stakeholders.

There is also a need for a broad sharing of information throughout the sector. By sharing information about best practices and about system challenges, we can work better together to develop solutions. Access to information will also allow us to be innovative in our approaches while remaining grounded in solid information. We must support decision makers and stakeholders to constantly look for ways to further improve and enhance services. We need to support a “culture of inquiry.”⁷

To meet this commitment, the steering committee recommends the following:

- Build data collection, data analysis, and research capacity in the Continuing Care Branch and the continuing care sector.
- Support development of an integrated information system.
- Support ongoing evaluation of continuing care services to improve service delivery and ensure the most effective use of health resources.
- Develop evidence-based standards for new programs and attach performance measures to new programs.
- Collaborate with the private sector and academic researchers to design policies and programs.
- Develop quality improvement activities in the Continuing Care Branch and sector.
- Explore new research methods that allow for better understanding of client experiences, needs, and outcomes.
- Empower front-line staff to make decisions in line with the vision for continuing care and its intended outcomes.

5. Commitment to System Integration and Coordination

An integrated continuing care system will create system efficiencies and service improvements. Clients will be able to move through the system seamlessly, allowing “admission” to the next service needed before being “discharged” from the service no longer required. A client in the hospital could be admitted to home care before being discharged from hospital to avoid service disruption during transitions.

An integrated system should include more than shared services. All components should work together to meet client needs and to better manage client transitions. It should also be flexible and able to respond to change.

Those responsible for facilitating the implementation of the Provincial Steering Committee’s recommendations must cultivate a common vision and scope for integration. The vision must focus first and foremost on the needs of clients. If successful, partners and stakeholders will accept a philosophy of shared responsibility. Opportunities for shared service delivery will be explored early and often.

There is a lack of communication between government departments and there is a need to eliminate barriers and gaps that exist for clients when they move from one department to another.

District Level Committee 6 Report

To achieve integration and coordination, the steering committee recommends the following:

- Engage a multi-disciplinary committee to develop a shared vision, goals, and strategies for a fully integrated and coordinated system.
- Support planning and policy development at the system level to increase opportunities for integration.
- Develop a full range of services, with sustainable funding, including wellness and preventative health measures, chronic disease management, home and long-term care, and palliative care. An appropriate full range of services should be available to individuals across the lifespan.
- Build linkages to span boundaries between components of the health-care system, including primary care, acute care, mental health, continuing care, and other services that support continuing care clients. This will ensure that clients get the right care at the right time and will help support transfers from one component of the system to another.
- Continue to establish close ties between the Departments of Health and Community Services, as well as other government departments and agencies to improve coordination and foster collaboration. Support current joint initiatives, regional networks, and the Continuum of Care Working Group.
- Encourage increased collaboration between the Department of Health, the district health authorities and community health boards, and community agencies.

- Support joint planning initiatives between the province and federal departments responsible for continuing care and related services, such as Veteran's Affairs and Health Canada's First Nations and Inuit Health Branch (FNIHB), to ensure service equity, resolve gaps, reduce duplication, coordinate policy, and deliver a seamless continuum of continuing care services.
- Empower front-line staff from different sectors of the continuing care system to develop networks to help clients through the system.
- Develop effective partnerships with the private sector that help deliver a full range of continuing care services.
- Advocate for the development of a national continuing care strategy, including standards.

Moving Forward

An aging population, increases in chronic illness, and evolving expectations mean that changes to Nova Scotia's continuing care system are necessary. Without change, health-care spending will continue to grow at an unprecedented rate. Difficult decisions regarding service provision will need to be made.

The continuing care sector must respond to today's concerns while preparing for the pressures of tomorrow. The recommendations outlined in this report are designed to facilitate change and ultimately produce a responsive system that supports Nova Scotians as they live well in a place that they can call home.

Success will require innovative approaches and new ways of thinking about clients and delivering services.

It will also require collaboration.

It is therefore the belief of the Provincial Steering Committee that the issues highlighted in this report belong to all Nova Scotians.

The recommendations extend beyond the purview of the Department of Health's Continuing Care Branch. To realize the new vision for continuing care, changes are needed at every level. The involvement of partners, stakeholders, and the sector at large is critical to success.

The Continuing Care Branch must play a central role, working with and supporting its partners. Transformation will hinge on using new and innovative forms of leadership and collaboration across many boundaries.

Recommended Priorities

The priority areas below reflect the voices of Nova Scotians, extend beyond traditional continuing care services, and address current pressures on the health system. Many of the recommendations require a multi-faceted approach to action.

A new continuing care system requires a shift in the way we do our work, make decisions, and report on progress. This will require time, effort, and leadership. This kind of change will require investment in relationship building, skills development, and communication. This is the foundation of a continuing care system that supports integration, collaboration, and coordination to ensure seamless service delivery for clients and cost-effectiveness for the system. With this new way of working together in place, investments in new programs and improved services will lead to improved client outcomes. Given that this change is required for the overall success of the strategy, it has been identified by the steering committee as the primary priority.

In addition, the steering committee has identified the following priority areas for investment:

Support Individuals and Families

Caregiver Strategy

Implement a comprehensive caregiver strategy that will include caregiver assessment and a menu of supports that offer choice and meet social, economic, and health needs.

Support Community Solutions

Transportation Strategy

Participate in a government-supported, community-based approach to developing a sustainable, multi-faceted provincial transportation system.

Strengthen Continuing Care Services

Home Care Services

Provide a comprehensive, innovative, coordinated, accessible, and sustainable network of home care services.

Respite Options

Provide a wide range of respite options for all Nova Scotians. Consult with partners and encourage expansion of respite options that help build community capacity.

Invest in Providers

Human Resource Strategy

Introduce a comprehensive human resource strategy with short- and long-term strategies to address continuing care staff shortages. Collaborate with other health human resources strategies already under way.

Invest in Infrastructure

Public Awareness

Increase public awareness of available continuing care programs in Nova Scotia.

Long-Term Care Infrastructure

Develop a long-range capital investment plan for long-term care facilities.

Next Steps

The issues facing Nova Scotia's continuing care system are complex. Deciding where to start will present tough decisions. It is anticipated that consensus on all priorities will be elusive.

The recommendations presented in this report are intended to affect the greatest number of Nova Scotians. They focus on creating a system that provides the right care, at the right time, in the right way, in the right place. Acting on these recommendations, or on a selection of these recommendations, will allow Nova Scotians to remain as independent as possible, for as long as possible. It will create a system that allows Nova Scotians to make decisions about their own care.

Consider this:

Nova Scotians expressed a strong desire for action, not for more consultations.

Appendices and References

Appendix A: Project Structure and Team Members

Project Mandate/Terms of Reference

Develop a shared vision for continuing care and recommendations on how to achieve this vision. Recommendations to be based on consultations with district health authorities, community health boards, stakeholders, service providers, and the public.

Provincial Steering Committee

Purpose

To develop a strategic framework to support the design and development of continuing care services.

Membership

Pat Bates	Public Representative
Donna Dill	Director, Monitoring and Evaluation, Continuing Care Branch, Nova Scotia Department of Health
Geri Frager	Medical Director, Pediatric Palliative Care, IWK Health Centre
Norine Heselton	Public Representative
Rick Kelly	Chief Executive Officer, Northwood Inc.
Susan Logue	Executive Director, Strategic Social Policy Initiative, Nova Scotia Department of Community Services
Menna MacIsaac	Executive Director, Alzheimer Society of Nova Scotia
David MacIver	Vice President, Population Health & Continuing Care, Cape Breton District Health Authority
Karen McDuff	Director of Finance, Programs, Nova Scotia Department of Health
Keith Menzies	Executive Director, Continuing Care, Nova Scotia Department of Health
Ruth Morrison	Agency Director, Victoria County Home Support Services
Bob Mullan	Medical Director Kings Regional Rehabilitation Centre and Past President, Doctors Nova Scotia
Colin Nordqvist	Owner/Operator, Community Based Options

Sheila Peck	Administrator, Townsview Estates
Jill Robbins	Health Services Director, Nova Scotia Rehab Centre, Capital Health
Janet Simm (Chair)	Director, System Planning and Liaison, Continuing Care Nova Scotia Department of Health
Donna Smith	Patient Navigation Community Liaison, Cancer Care Nova Scotia
Terri-Lynn Smith	Director of Social Work, Cumberland Regional Health Care Center
Barb Stonehouse	Director of Children's Medical Care, IWK Health Centre
Valerie White	Chief Executive Officer, Seniors' Secretariat
Sue Ellen Wilson	Provincial Executive Director, Victorian Order of Nurses (VON), Nova Scotia

Trends Analysis Working Group

Purpose

Inform the steering committee of promising strategies in other jurisdictions and other relevant findings. Such strategies and findings should support the implementation of cost-effective and high-quality continuing care services that support individuals to remain in their homes and communities.

Membership

Larry Baxter	Nova Scotia Advisory Commission on AIDS
Barry Clarke	Associate Chief Family Medicine Continuing Care, QEII Health Science Centre, and Medical Director, Camp Hill Veterans Memorial, Long Term Care Program, QEII
Marie Earl	Atlantic Health and Wellness Institute/School of Physiotherapy, Dalhousie University
Monika Harvey	Care Coordinator, Continuing Care Branch, Department of Health
Janice Keefe	Canada Research Chair in Aging and Caregiving Policy, Mount Saint Vincent University
Carolyn Kelly	Nova Scotia Society of Occupational Therapists
Judy LaPierre	Senior Policy Analyst, Strategic Social Policy, Nova Scotia Department of Community Services
Andrea Leonard	Director of Clinical Care, Northwood Homecare
Ann McKim	Palliative Care Nurse, Colchester East Hants Health Authority
Sharon Reashore	Executive Director, Caregivers Nova Scotia
Jason Shannon	Chief Operating Officer, Shannex Inc.
Susan Weagle (Chair)	Director, Standards and Policy Development, Continuing Care, Nova Scotia Department of Health

District Level Committees

Purpose

To compile a report to inform the Provincial Steering Committee of issues related to continuing care in each health district. The reports included demographic and health trends information and an overview of existing health services. The reports also included information from the public consultations and local initiatives that support continuing care. The District Level Committees used the information gathered to develop recommendations to the steering committee for continuing care services required to respond to unmet local needs.



Membership

DHA 1: South Shore Health District Level Committee

David Baker	Volunteer, Shizophrenia Society of Nova Scotia
Cynthia Baker	Supervisor, Continuing Care Branch, Nova Scotia Department of Health
Tammy Ballard (Co-Chair)	Coordinator, Geriatric Clinic, Fishermen's Memorial Hospital, South Shore District Health Authority
Lyn Cash	Lunenburg County Community Health Board
Carla Malay	Nova Scotia Heart and Stroke Foundation
KJ Rumboldt (Co-Chair)	Discharge Planner, South Shore Regional Hospital, South Shore District Health Authority
Margo Walsh-Leaman	Coordinator of Community Support/Volunteer Services, Victorian Order of Nurses (VON) Queens County Branch
Ruth Smith	Region of Queens Home Support
Diane Warner	Child Help Initiative Program, Native Council of Nova Scotia, Liverpool Regional Office
Joan Watson	Seniors' Secretariat

DHA 2: South West Health District Level Committee

Debbie Boudreau	District Manager, Continuing Care Branch, Nova Scotia Department of Health
Bertha Brannen	Administrator, Nakille Home for Special Care
Donna Coggins	Agency Director, Digby/Clare Home Support
Suzanne d'Entremont	Director, Victorian Order of Nurses (VON), Tri-County Branch
Louise Delisle	Member, Shelburne Community Health Board
Cindy Dunnet	Pastoral Care Committee, Roseway Hospital, Shelburne
Debra Foote-Browett (Chair)	Yarmouth Stroke Project
Gail Jarvis	Digby and Area Community Health Board
Crissy Sollows	Coordinator of Community Support/Volunteer Services, Victorian Order of Nurses (VON), Tri-County Branch
Art Surette	District Manager, Nova Scotia Department of Community Services
Cheryl Wallace	Acute Care, Yarmouth Regional Hospital

DHA 3: Annapolis Valley Health District Level Committee

Scott Anderson (Vice Chair)	Coordinator of Community Support/Volunteer Services, Victorian Order of Nurses (VON) Annapolis Valley
Sylvester Atkinson	Public Representative
Judy Balcolm	Seniors Lincs Program, Soldiers Memorial Hospital, Annapolis Valley Health Authority
Daphne Carroll	Social Worker, Nova Scotia Department of Community Services
Fran Duggan	Director of Health Programs and Site Manager, Annapolis Community Health Centre, Annapolis Valley Health Authority
Graham Hardy (Chair)	Administrator, Grandview Manor
Jake MacDonald	Community Health Board, Brain Injury Association of Nova Scotia
Kimberly Smolenaars	Occupational Therapist, AVH Chipman, Annapolis Valley Health Authority
Helen Walsh	Administrator, New Vision Special Care Homes Ltd.
Sharon Whelton	Supervisor, Continuing Care Branch, Nova Scotia Department of Health

DHA 4: Colchester East Hants Health District Level Committee

Jerry Amirault	North Shore Area Community Health Board
Paul Bolivar	Colchester East Hants Seniors Council Board
Della Boyle	Administrator, Westside Villa
Rhonda Claes	Representative, Native Council of Nova Scotia
Carol Curley	Director, Victorian Order of Nurses (VON), Colchester East Hants
Margaret Johnson	East Hants Community Health Board
Jimi Kaye (Chair)	Community Health Planner/Developer, Colchester East Hants Health Authority
Ruby Knowles	District Manager, Continuing Care Branch, Nova Scotia Department of Health
Kevin McInnes	Nova Scotia Department of Community Services
Kim Power	Administrator, Cedarstone Enhanced Care
Linda Russell	Discharge Planner, Colchester Regional Hospital, Colchester East Hants Health Authority
Heather Wood	Yarmouth, Digby, Shelburne Branch, Nova Scotia Division, Canadian Mental Health Association

DHA 5: Cumberland Health District Level Committee

Patricia Burke	North Shore Area Community Health Board
Rosemary Donkin	Administrator, East Cumberland Lodge
Ruth Gould	Director, Victorian Order of Nurses (VON) Cumberland Branch
Monika Harvey	Care Coordinator, Continuing Care, Nova Scotia Department of Health
Gerry Helm	Cumberland Hospice Palliative Care Society
Conrad LeBlanc (Chair)	Administrator, High Crest Springhill Home for Special Care
Fran McMillan	Vice President, Community Health, Cumberland Health Authority
R. B. Minocha	Vice-President, Operations, Cumberland Health Authority
Patricia Moore	District Manager, Nova Scotia Department of Community Services
Veronica Richards	Manager, Cumberland Mental Health Services
Will Rodd	Member, Springhill, Oxford, Amherst & Region Community Health Board
Terri-Lynn Smith	Director of Social Work, Cumberland Regional Health Care Center

DHA 6: Pictou County Health District Level Committee

Glen Alexander	Royal Canadian Legion Branch #028
Hilary Amit	Executive Director, Highland Community Residential Services
Anne Baxter	District Manager, Nova Scotia Department of Community Services
Rev. Rhonda Britton	New Glasgow African Nova Scotian Community
Brenda Butler	Central/East Pictou Community Health Board
Wilma Hahnen (Chair)	Nurse Manager Restorative Care Unit/Veterans Unit Pictou County Health Authority
Jane Jordon	Supervisor, Continuing Care Branch, Nova Scotia Department of Health
Geri MacDonald	District Manager, Nova Scotia Department of Community Services
Wendy MacDonald	Director, VON Pictou Branch
Mary MacLellan	Central/East Pictou Community Health Board

Debbie Murray	Community Health Nurse, Pictou Landing First Nations
Sharon Purvus	Coordinator, Seniors Outreach, Pictou County Health Authority
Allison Smith	Recreation Director, Maritime Odd Fellows Home
Joan Steward	Heart and Stroke Foundation of Nova Scotia
Linda Tapp	Pictou County Health Authority
Debbie Williams	Interim Palliative Care Coordinator, Pictou County Health Authority

DHA 7: Guysborough Antigonish Strait Health District Level Committee

Mary Beaver	Administrator, Highland Crest Residential Care Facility
Andrea Boyd White	Facility Manager, Straight Richmond Hospital, Guysborough Antigonish Strait Health Authority
Lorna Crocker	Administrator, RK MacDonald Nursing Home
Wendy DeCoste	Nurse Manager, Victorian Order of Nurses (VON), Antigonish
Venus Doucette	Occupational Therapy, Guysborough Antigonish Strait Health Authority
George Kyte	Strait Richmond Community Health Board
Beth MacDonald	Supervisor, Continuing Care Branch, Nova Scotia Department of Health
Madonna MacDonald (Chair)	Vice President, Community Health, Guysborough Antigonish Strait Health Authority
Muriel Present	Straight Richmond Community Health Board
Carol Rhynold	RN Supervisor, Guysborough County Home Support Agency
Harold Roberts	Manager, Guysborough District Office, Nova Scotia Department of Community Services

DHA 8: Cape Breton Health District Level Committee

Pat Bates (Chair)	Public Representative
Francis Butler	Director, Medical Social Work, Cape Breton District Health Authority
Sharon Crane	Executive Director, Cape Breton County Homemakers Agency
Bev Gabriel	Educator, Continuing Care Branch, Nova Scotia Department of Health
Eleanor Gillis	North Inverness Community Health Board
Charmaine Jesty	SARSET Facilitator, Native Council of Nova Scotia
Stephen Leadlay	Sydney Central Community Health Board
Cyril LeBlanc	Regional Administrator, Nova Scotia Department of Community Services
Elizabeth MacDonald	Nurse Manager, Victorian Order of Nurses (VON)
Sherry MacNeil	Owner/Operator, My Cape Breton Home for Seniors Residential Care Facility
Camille Mailett	Seniors Representative, Acadian Population
Paula McMullin Beaton	Canadian Paraplegic Association
Darlene Moulard	Home Care Nurse, Eskasoni Health Centre
Susan Plath	Coordinator, Dementia Network of Cape Breton, Alzheimer Society of Nova Scotia
Catherine Power	Administrator, Seaview Manor
Patricia Swan	Services for Persons with Disabilities Program Specialist, Nova Scotia Department of Community Services
Sharon Sheppard	Director Continuing Care, Cape Breton District Health Authority
Peter Stevens	Consultant, Eskasoni Health Centre
Carolyn Toomey	Academic Chair, School of Health & Human Services & School of Access, Marconi Campus, Nova Scotia Community College

DHA 9: Capital Health District Level Committee

Sandra Bauld	Senior Director, Northwood Homecare Limited
Patricia Bland	Chebucto West Community Health Board
Ken Brown	Dartmouth Community Health Board
Cathy Crouse	Executive Director, Metro Community Housing Association
Carol Evans	Past Executive Director, Metro Community Housing Association
Beth Floyd	Program Manager Special Services, Mental Health Program
Bonnie Kay-Griffin	Administrator, Glades Lodge
Marilyn MacDonald	Manager, Social Work Department, Capital Health
Morah MacEachern	Branch Director, Victorian Order of Nurses (VON) Greater Halifax
Wendy McVeigh	Supervisor, Continuing Care Branch, Nova Scotia Department of Health
John Melanson	Executive Director, MINDS – Moving In New Directions Society (Aiseirigh House)
Dion Mouland	Administrator, Ocean View Manor
Rosemarie Sampson (Chair)	Cobequid Community Health Board
Carol Sheppard-Conrad	Nova Scotia Department of Community Services
Shari Volger	Hospice Society

Provincial Pediatric Committee

Purpose

To compile a report to inform the steering committee of issues related to continuing care for the pediatric population. The report included demographic and health trends information and an overview of existing health services. The report also included information from the public consultations and initiatives that support continuing care for this client population. The committee used the information gathered to develop recommendations to the steering committee for continuing care services required to respond to unmet need of the pediatric population.

Membership

Margie Beck	Coordinator, Student Services, Chignecto-Central Regional School Board
Debbie Dicks	Director of Nursing, Children's Centre, Evergreen Home for Special Care
Art Dukeshire	Care Coordinator, Services for Persons with Disabilities, Nova Scotia Department of Community Services
Caroline Gallop	Early Intervention Nova Scotia
Pat Hamilton	Supervisor of Assessments, Continuing Care, Department of Health
Dawn LeBlanc	Social Worker, IWK Health Centre
Lorna MacPherson	Community Supports for Adults, Nova Scotia Department of Community Services
Anne Matheson (Co-Chair)	Discharge Planning Coordinator, Neonatal Patient Care Team, IWK Health Centre
Patti McEwan	Colchester-East Hants Health Authority
Sue Mercer	Senior Director, IWK Mental Health and Addictions Program, IWK Health Centre
Karen Slaunwhite	Executive Director, Home Support Association of Nova Scotia
Barb Stonehouse	Director of Children's Medical Care, IWK Health Centre
Trisha Towne	Nurse Manager, VON Annapolis Valley Victoria Order of Nurses (VON)
Anne Vaughan	Social Worker, IWK Health Centre
Mary Wile (Co-Chair)	We Care Home Health Services

Department of Health Project Management Team

Janet Simm	Director, System Delivery and Liaison
Beth Rajnovich	Project Manager
Shawna Elliott	Senior Policy Analyst
Karen Andrea	Planner/Developer
Susan Pringle	Planner/Developer
Peter Zwicker	Planner/Developer

Additional Department of Health Support Staff

Marlene Boss

Jo Burt

Margaret Douglas

Diana Drysdale

Anne Erly

Sheri Fitzgerald

Robert Graham

Kate Hemeon

Natalie MacKay

Ardith MacPhee

CJ Malton

Sharon Marchand

Carolyn Maxwell

Ken Rehman

Wade Were

Kim Williams

Appendix B: Continuing Care Services in Nova Scotia

Table 1: Continuing Care Services Delivered in Nova Scotia

Services	Funded by the Department of Health	Funded by the Department of Community Services	Other
Home and Community-Based Services	<ul style="list-style-type: none"> • Home Care (acute and chronic) <ul style="list-style-type: none"> – Home Support – Home Nursing – Home Oxygen • Adult Protection Services • Self Managed Care* • Community Rehabilitation* • Adult Day Programs* • Quick Response Team* 	<ul style="list-style-type: none"> • Services for Persons with Disabilities Program <ul style="list-style-type: none"> – Direct Family Support (children and adults) – Independent Living Support (adults) – Alternative Family Support (adults) – Group Homes (adults) – Developmental Residences (adults) – Residential Care Facilities (adults) – Small Options (children and adults) • Adult Service Centres • Housing Services <ul style="list-style-type: none"> – Rental Housing – Assistance for Minor and Major Repairs to Housing Units – Assistance for Adaptations to Housing Units – Affordable Housing Program – Provincial Loan and Mortgage Programs 	<ul style="list-style-type: none"> • Transportation Services • Meals Programs • Assisted Living Facilities • Home Care, Chronic Care or Long-Term Care Services to Veterans • Community Care Services to First Nations on Reserve

Services	Funded by the Department of Health	Funded by the Department of Community Services	Other
Facility-Based Services	<ul style="list-style-type: none"> • Assessment and treatment centres and day hospitals* • Restorative care* • Alternative level of care in hospital • Nursing homes • Residential care facilities • Small options • Specialized equipment program for residents of LTC facilities 	<ul style="list-style-type: none"> • Services for Persons with Disabilities Program <ul style="list-style-type: none"> – Regional rehabilitation centres – Adult residential centres – Group homes 	
System-Level Services	<ul style="list-style-type: none"> • Assessment and Case Management to DOH Services • Caregiver Respite Services (home and facility) • Palliative Care* 	<ul style="list-style-type: none"> • Services for Persons with Disabilities Program <ul style="list-style-type: none"> – Assessment and Case Management Department of Community Services – Caregiver Respite Services 	

* Partial availability; not a province-wide program

Appendix C: Key Health Statistics

Life Expectancy

A female born in 1997 might expect to live 81.4 years on average, while her male counterpart would reach 75.8 years. By 2021, life expectancy is anticipated to reach 83.9 years for Nova Scotian women and 78.2 years for men.⁸ Despite this increase, life expectancy for Nova Scotians continues to be below the national average.⁹

Today, many more Nova Scotians are living past the age of 85. The largest proportion of this group continue to live in their own homes.¹⁰

Aging and Disability

Hayward and Colman¹¹ report that Nova Scotia has

- the highest death rates in Canada from cancer and respiratory disease
- the highest rate of arthritis and rheumatism
- the second-highest rate of diabetes.

Ninety-one per cent of Nova Scotians aged 65 and over report having a chronic condition.¹² We have a higher incidence of seniors most commonly reporting health issues such as arthritis and rheumatism, high blood pressure, allergies, back problems, chronic heart problems, cataracts, and diabetes.^{13, 14, 15}

Inactivity

According to Statistics Canada, 52.6 per cent of Nova Scotians over the age of 12 report levels of activity too low to achieve optimal health benefits.¹⁶

Those with chronic disability are also likely to have high levels of inactivity.¹⁷

Youth and Chronic Conditions

Almost half (49 per cent) of 12- to 19-year-old Nova Scotians report having a chronic condition.¹⁸ Females (73 per cent) show a significantly higher prevalence than males (63 per cent).¹⁹

Disability and Impairment

Research on under-served populations is limited, but the average disability rate for all groups in Nova Scotia (17.1 per cent) has remained consistently higher over the past three decades than the national average (12.4 per cent).²⁰ Mobility (23 per cent) is the most commonly reported type of disability.²¹

Almost 4 per cent (3.75 per cent) of Nova Scotia's population 15 years and under are reportedly disabled. Male children comprise 64 per cent and female children 36 per cent of this population.²²

Cognitive impairment and dementias are on the rise. Individuals with brain injuries are reportedly under-served in Nova Scotia.

Consider this:

**Nova Scotia
has the lowest
disability-free
life expectancy in
the country.**

Appendix E: Project Glossary

Adult Day Programs

Designed to maintain persons with physical and/or mental disabilities or to restore them to their optimum capacity for self-care. Adult day programs provide personal assistance; supervision; and health, social, and recreational activities in a supportive group setting. Nursing, rehabilitation, and other professional services may also be provided. It can also be used to provide respite care, training, and informal support to family caregivers. (*Glossary of Continuing Care Terms*, Strategic Framework Initiative, Department of Health, 2005)

Adult Protection Services

Offer help and support for people aged 16 years or older who are abused or neglected and who cannot physically or mentally care for themselves. (Adapted from http://gov.ns.ca/health/ccs/adult_protection_services.htm)

Aging in Place

A diverse range of programs and housing options needed to ensure that seniors maintain personal dignity and functional independence in their homes, neighbourhoods, or communities for as long as possible. (Adapted from the *Strategy for Positive Aging*, Seniors' Secretariat, 2005)

Ambulatory Care

Encompasses all health services provided to clients who are not residing in health-care institutions at the time that care is given. Ambulatory care includes emergency services, day/night care, specialty clinics, non-specialty clinics, community clinics, day surgery, private practice, and home care. (Canadian Institute for Health Information [CIHI]. (1998). *National Ambulatory Care Reporting System Project Report*)

Assisted Living Facilities

Privately owned facilities designed to meet the needs of independent seniors who require accommodations and access to services such as meals, housekeeping, laundry services, care assistance, recreation programs, and fitness facilities. The homes are not licensed to provide care. Accommodation and service fees vary. (Adapted from the Seniors' Secretariat, 2005)

Best Practices

Processes, practices, or systems developed through experience and research that improve the performance and efficiency of organizations in a target area, such as continuing care. A commitment to using best practices in any field is a commitment to use all the knowledge and technology available to ensure success. Knowledge about best practices is used to demonstrate what works and what does not and to accumulate and apply knowledge about how and why they work in different situations and contexts. (Adapted from <http://www.unfpa.org/monitoring/toolkit/glossary.pdf>, <http://www.healthyagingprograms.com/content.asp?sectionid=31>, and http://searchvb.techtarget.com/sDefinition/0,,sid8_gci498678,00.html)

Case Management

A collaborative, client-driven strategy for the provision of quality health and support services through the effective and efficient use of available resources that support the client's achievement of goals related to healthy life and living in the context of the person and their ability. (Adapted from the Canadian Home Care Association, Home Care Case Management Invitational Roundtable, March 2005, http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2005-cas-mgmt-gest/2005-cas-mgmt-gest_e.pdf)

Caregiver

An individual who gives care and assistance to a family member or friend who requires such assistance due to a chronic physical or mental health condition. (Adapted by the Trends Analysis Working Group, Strategic Framework Initiative, Department of Health, June 2005, and advocated by Caregivers Nova Scotia)

Care Provider

A paid person who provides assistance and support to an individual in a community or institutional setting. A care provider can refer to an individual or an agency/organization that provides care services. (Adapted by the Trends Analysis Working Group, Strategic Framework Initiative, Department of Health, June 2005, and advocated by Caregivers Nova Scotia)

Care Team

A team made up of staff, physicians, other health-care professionals, partners, and volunteers, as appropriate, who together are responsible to make, put in place, and review a care plan that meets the needs of a patient and their family. The team may, at times, address administrative issues and quality improvement. (Adapted from <http://www.iwk.nshealth.ca/helpfulinformation/glossary.cfm>)

Client-Centred Care

In a client-centred care approach, individual client needs are identified and a plan is developed that outlines how best to provide assistance. This assistance may be provided directly through government-funded sources or through coordination of government-funded and community resources. Case managers work with clients to meet their needs, over and above determining the clients' eligibility for services and benefits. (Adapted from Veterans Affairs Canada, <http://www.vac-acc.gc.ca/providers/sub.cfm?source=approach/implement>)

Client-Centred Care Plan

The purpose of the client-centred care plan is to develop strategies directed at meeting identified unmet needs and validating the client/caregiver's contributions to the goal of improving their quality of life. The effectiveness of these strategies is monitored on an ongoing basis to determine if the final outcomes are effectively meeting the client's unmet needs and stated goals. (Veterans Affairs Canada, <http://www.vac-acc.gc.ca/providers/sub.cfm?source=approach/careplan>)

Cluster Housing

A cluster housing development generally holds multiple dwelling units placed in close proximity (closely spaced or attached) on smaller parcels of land. The additional land that would have been allocated to individual lots is converted to common shared space for the subdivision residents. In some cases, cluster housing developments share common utilities and infrastructure.

Community Capacity

Community capacity is a community's ability to define and solve their own problems. The more skills, assets, and strengths that a community group has, the better prepared they are to achieve their goals. Communities that are able to understand issues, develop solutions, and create change are better able to build healthier and safer environments. (<http://www.communitycapacity.org>)

Continuing Care

A range of services for individuals of all ages, and their families, that provides support, allowing people to remain in their homes and communities throughout their lifetimes. (As defined by the Provincial Steering Committee)

Co-operative Housing

Housing co-operatives are incorporated, non-profit organizations whose members jointly own their own housing. Co-operatives may be government funded or resident funded. Persons who live in a government-funded co-operatives do not own their own units but share in the ownership of the building. They also share responsibility for managing and operating the building. Rather than paying rent, members pay monthly housing and maintenance fees. Housing costs are usually lower than in private rentals. (*More Than Shelter Housing Policy Kit for Seniors in Atlantic Canada*, Atlantic Seniors Health Promotion Network, 2004)

Community Based Options

Small, home-like, safe, and supportive environments that may be a rented or purchased unit or a family home. When home care is not appropriate and nursing home care is not required, a community based option can provide people with personal care, supervision and accommodation. In Nova Scotia, community based options operate under the jurisdiction of either the Department of Health or the Department of Community Services. Those under the Department of Health provide care mainly to seniors and are inspected by departmental staff to ensure that they are operating in compliance with the requirements of the Interim Standards for Community Based Options. These standards were implemented in 1996, as the basis for determining the establishment and operation of community based options.

Emergency Care

Provides the caregiver or family security in the event of an emergency that the special needs person will be well cared for. Emergency care is considered an important component of the continuum of care and follows the same principles as planned respite care (i.e., a desirable result of relief from care-giving responsibilities) (Adapted from <http://www.respiteconnections.com/whatIsRespiteCare.htm> and <http://www.cvcsb.org/Services/RespiteEmergencyCare.htm>)

Evidence-Based Decision Making

Aims to ensure that decisions about health and health care are based on the best available knowledge. To use evidence-based decision making, one must first assess what constitutes evidence, both in relation to health-enhancing interventions and to organizational or policy-level decision making. One also needs to explore the availability and accessibility of reliable information and knowledge that identifies how interventions, practices, and programs affect health outcomes. A second use of evidence-based decision making is to explore what is preventing change from taking place in the health system (in practice and policy) when there is clear evidence that change is necessary and desirable. An evidence-based decision-making framework also examines the length of time the health system takes to adopt existing information about the interventions that work, and their degree of success. (Adapted from <http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/index.htm> and the National Forum on Health's summary report *Evidence-Based Decision Making A Dialogue on Health Information*, 1995)

Family-Centred Care

A way of caring for clients that recognizes and respects the essential role of their families in their lives. Family-centred care strives to support families in their caregiving role and promotes a partnership of mutual respect and support among families and staff. (Adapted from <http://www.iwk.nshealth.ca/helpfulinformation/glossary.cfm>)

Home Care Services

Designed to complement the help people can receive from others such as family, community, or friends. Home care will help people remain as independent as possible in the community. It is always the first option considered for care in the community. Services are offered on both a short-term (acute) and longer-term basis by qualified professionals and include home support (such as personal care, respite, and light housekeeping), nursing (such as dressing changes, catheter care, and intravenous therapy), and home oxygen.

Holistic Care

An approach to health care that emphasizes the whole person, including physical, psychological, social, economic, and cultural factors that may influence health. It fosters a collaborative relationship among those involved in a care, leading towards optimal attainment of physical, mental emotional, social, and spiritual aspects of health. (Adapted from Canadian Holistic Medical Association and <http://www.holisticmed.com/whatis.html>)

Integrated Model of Delivery

A recommended shift in Canadian health-care policy from a focus on home care on its own to a broader integrated model of continuing care in which cost-effective substitutions of home care for residential care and acute care services can be facilitated. This model of delivery recommends that home care, in order to more readily make the types of substitutions required to achieve greater effectiveness, needs to be part of a broader, integrated system of home care and residential care. (Adapted from *Synthesis Report of the National Evaluation of the Cost Effectiveness on Home Care*, Hollander and Chappell, 2002)

Navigation Function

A client-centred outcome-focused case-management approach put in place for clients and their families to effectively navigate the complexities of the continuing care system. Additionally, those in a navigator role provide an added source of expertise for health professionals in the community and promote teamwork and communication among health-care providers.

Primary Health Care

An approach to health and a spectrum of services beyond the traditional health-care system. It includes all services that play a part in health, such as income, housing, education, and environment. Primary care is the element within primary health care that focuses on health-care services, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury. (Health Canada [http://www.hc-sc.gc.ca/hcs-sss/prim/about-
apropos/index_e.html#1](http://www.hc-sc.gc.ca/hcs-sss/prim/about-
apropos/index_e.html#1))

Prior Learning Assessment and Recognition (PLAR)

A systematic process that involves the identification, documentation, and recognition of learning (i.e., skills, knowledge, and values). This learning may be acquired through formal and informal study, including work and life experiences, training, independent study, volunteer work, travel, hobbies, and family experiences. (Canadian Association for Prior Learning Assessment and Recognition)

Respite

A desirable result of relief from caregiving responsibilities. It is a mental state resulting in feeling of freedom from responsibility and worry. It is the emotional, psychological, spiritual, physical, and/or social relief or renewal experienced by the caregiver as a result of access to services or other strategies intended to help maintain their own health and achieve greater balance in their lives. (Adapted from VON, Respite Policy Lens)

Restorative Care Services

Services to assist functionally impaired older persons to achieve maximum independence, continue to live in their communities, and avoid re-admission to hospital. Patients are provided with intense interdisciplinary therapies to help recover function following an injury or illness and to help prevent secondary injury or loss of independence.

Residential Care Facility

Can provide people with personal care, supervision, and accommodation in a safe and supportive environment. Residential care facilities serve clients who need supervision or personal care that can be provided by personal care workers and do not require on-site professional nursing services. In Nova Scotia, residential care facilities operate under the jurisdiction of either the Department of Health or the Department of Community Services.

Rural

This report adopts Statistics Canada's Rural and Small Town definition, which considers any community of 10,000 or fewer people and distanced from major centres to be rural. (Canadian Rural Secretariat, http://www.rural.gc.ca/programs/mrди_e.phtml?content=faq#faq1)

Single Entry Access

Department of Health continuing care services may be accessed through a single point of entry that ensures that care needs are identified through the use of a consistent assessment process. By contacting 1-800-225-7225, anyone can begin the process from anywhere in the province. Care coordinators conduct assessments and coordinate access to home care and long-term care facility services. Where appropriate, adult protection workers conduct assessments and coordinate access to services to meet the needs of adults in need of protection as defined by the Adult Protection Act.

SEAScape

SEAScape (Single Entry Access Simultaneous Client Assessment Placement Evaluation) is the automated tool used by continuing care staff to carry out the single entry access process for continuing care in Nova Scotia.

Unlicensed/unfunded facilities

Community-based housing options that are operating but are not in compliance with the requirements of the Interim Standards for Community Based Options. These standards were implemented in 1996, as the basis for determining the establishment and operation of Community Based Options.

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