# Planning Model for The Health and Care of the Elderly

November 2005

Alzheimer Society
ONTARIO

This survey identifies some of the planning models or frameworks that have been proposed by Ontario's former District Health Councils as well as some other Canadian and international jurisdictions. The focus is on services for seniors in general but includes specific proposals for people affected by Alzheimer Disease and related dementias (ADRD) and for seniors in rural and remote communities.

It is a selective not exhaustive list and, as a result, not all DHCs are represented. Omitted, for example, are the proposals of some DHCs that are either broader than the population of seniors (such as proposals for the health care system as a whole) or narrower than the continuum of services for people affected by ADRD (such as supportive housing).

This document takes the form of an annotated bibliography. The reports themselves can be accessed through the link provided or, in the case of the DHC models, through www.dhcarchives.com.

*Prepared by*
*Anne Anderson*
*November 2005*

# Table of Contents

## Ontario DHC Models

**TORONTO REGION**

**Toronto DHC**

***The CACHET Model***

*Full title* - Coordinated, Accessible Community Healthcare for Elders in Toronto: The CACHET Model (December 2004)
Developed at the request of MOHLTC, this document proposes a model to address system fragmentation. The model recommends a single agency responsible for intake, assessment, care coordination/case management, information & referral, outcome monitoring, and suggests using the model as a pilot for how best to implement a case management coordinated approach for seniors. Françoise Hébert, Alzheimer Society of Toronto, was one of the Committee Chairs.

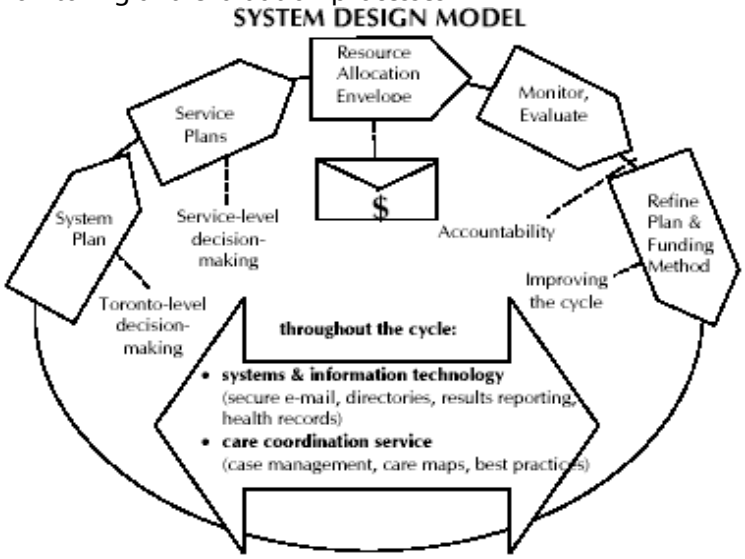
*Link to report:*
http://www.dhcarchives.com/protected/uploaded/publication/Senior%20Integration%20Final%20Report%20December%202004.pdf

***Toronto Health System Framework***

The Toronto Health System Framework (June 2004) is a plan to develop system-wide health services to 2008 and beyond. It is based on the concepts of population health, urban health, and system integration, and draws on work of task forces on care coordination, system alignment and systems and IT (whose reports are also available).

Four key components of the framework:

(i) system-level plan for coordinated care delivery;
(ii) local health service plans to identify needs and priorities associated with population change to 2016;
(iii) resource allocation/reallocation processes; and
(iv) monitoring and evaluation processes.




*Source: Toronto Health System Framework, Figure 1, p. 17*

The framework is designed to be applicable to either population-based or disease-based models of care. One example of population-based planning is the Seniors' Integration Model which is "a person-focused service delivery model, founded on the need to identify the individual care requirements of seniors and to provide appropriate care as these needs change." It focuses on the development of Seniors Care Coordination Agencies located in areas where a large number of seniors live. See pages 24-27 for more details. Also referenced is the consultation document - Senior's Care Coordination: An Integrated Service Delivery Model for Seniors.

*Link to report:*
http://www.dhcarchives.com/protected/uploaded/publication/Toronto%20Health%20System%20Framework%20June%202004.pdf

**CENTRAL EAST REGION**

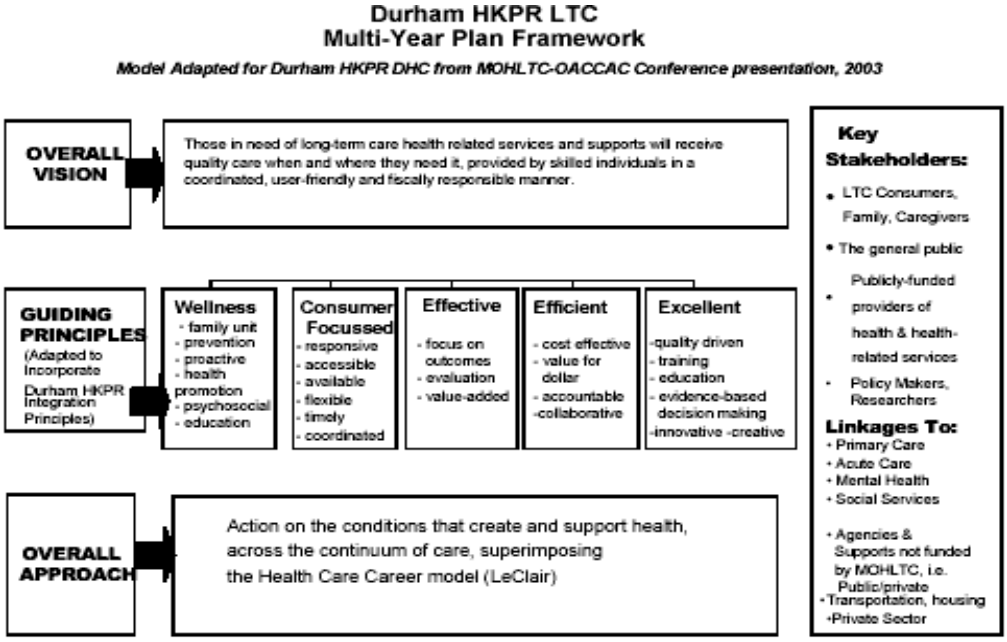
**Durham Haliburton Kawartha and Pine Ridge DHC**

***LTC Multi-Year Plan 2004-2009: Ten System Enablers***

Full title - *Long Term Care Multi-Year Plan 2004-2009: Ten Health System Enablers for the Continuous Care of Long-Term Care Consumers and Caregivers*

The plan is a population-based approach to LTC planning across the continuum of care. The ten recommendations and implementation strategies include many of the factors relevant to ADRD such as:

- education and training for care coordinators, frontline staff, volunteers;
- continuum of housing options;
- single health support plan for each LTC consumer;
- specialized testing and assessment; and
- respite care.




*Source: LTC Multi-Year Plan 2004-2009, Figure 4, p. 6.*

*Link to report:*

http://www.dhcarchives.com/protected/uploaded/publication/LTC%20MYP%20FINAL_Web%20version.pdf

**Simcoe York DHC**

***Long-Term Care Multi-Year Plan 2004-2009***

Identifies ten key features of the health care system that enable continuous care of long-term care populations, a ten-point strategy, and planning frameworks for identifying LTC consumer service and support needs.

*Link to the report's Table of Contents:*
http://www.dhcarchives.com/protected/uploaded/publication/Long%20Term%20Care%20Multi-Year%20Plan%202004-2009.pdf

**CENTRAL SOUTH REGION**

**Grand River DHC**

***LTC Multi-Year Plan 2003/04***

*Full title – Long-term Care Multi-Year Plan 2003/04: Where We Are, Where We are Going, Where We Need To Be*

The plan includes both short-term recommendations, most of which are to expand specific services, and long-term recommendations of issues for further study, e.g. the impact of limited transportation services. One conclusion is that the potential for integration and amalgamation is limited.

*Link to report:*
*http://www.dhcarchives.com/protected/uploaded/publication/ltcmyp.pdf*

**Hamilton DHC**

***Seniors Health and Well-Being: A Picture of Community Planning***

This 2004 report describes an intersectoral approach to planning for seniors, which is designed to plan and influence factors beyond health care, e.g. housing or income.

It assumes that an effective inter-connected series of networks is required to coordinate planning and champion solutions. The aim is to build a community system of planning for seniors by connecting organizations to organizations, networks to networks and sector to sector. The intent is to combine system planning with the energy and enthusiasm of local coalitions and networks rather than establish a separate, parallel planning process.

The planning framework on which the Seniors' Health and Well-Being Project was developed was drawn from the determinants of health described by the WHO in *Active Aging: A Policy Framework* (2002).

Table 1: The Determinants of Seniors' Health and Well-Being in Hamilton – A Framework for Planning

| Health Determinant | Critical Components |
|---|---|
| 1. Economic Determinants | ▪ Income<br>▪ Social Protection |
| 2. Social Determinants | ▪ Social Support<br>▪ Safety and Security<br>▪ Social Inclusion |
| 3. Physical Environment | ▪ Land Use Planning<br>▪ Transportation<br>▪ Housing |
| 4. Personal Health Determinants | ▪ Physical Factors (Food Security and Nutrition; Exercise)<br>▪ Emotional and Spiritual Factors (Coping Skills, Community Participation, Mental Health) |
| 5. Health Services | ▪ Access to Information<br>▪ Health Promotion/Disease Prevention<br>▪ Treatment/Healing<br>▪ Rehabilitative<br>▪ Support to Activities of Daily Living |

Source: World Health Organization. Active Ageing: A Policy Framework, 2002

*Source: Seniors' Health and Well-Being, p. 2.*

*Link to report:*
*http://www.dhcarchives.com/protected/uploaded/publication/SeniorsHealthandWellBeingJune2004.pdf*

***Long-Term Care Community Support Services***

*Full title – Long-Term Care Community Support Services in Hamilton: Capacity and Coordination in a Changing Environment (2004)*

The report is more analysis than framework, but the concept of dividing population into clusters may be of interest. On that topic, the reports says that there is no single way in which clients enter the system, nor is there a single pathway to other required services. Client pathways are often unique, but similarities in entry and movement can be linked at times to a particular 'cluster' of organizations – and the report illustrates the different pathways for each cluster. These 'clusters', in turn, can be best understood in relation to geographic or population factors. Types of clusters are rural, fixed neigbhourhood/urban, marginalized/hard-to-serve, specialized, and general population.

Implications of the report's findings:

- Community support services should be planned using the best information available on health risks and needs on a neighborhood basis, to guide allocation of resources.
- Coordination and capacity building strategies should be championed through a cluster based approach rather than service based approach.
- Shared infrastructure for common administrative activities e.g. integrated information collection, should be explored for system efficiencies.
- Local strategies for system development and growth should be guided by a provincial policy framework for community support services.

*Link to report:*
*http://www.dhcarchives.com/protected/uploaded/publication/LTCCommunitySuppServinHam%20March2004ReportMainBody.pdf*

**Niagara DHC**

***Community-Based Long-Term Care System Plan***
The 2004 report includes diagrams that illustrate the context of community-based LTC services within the Niagara health system - both the current scenario and the potential future scenario following further development of community-based long-term care services (see pages 8 and 9 of Executive Summary).
The supporting Technical Reference Report includes a section profiling Persons with Dementia (s. 2.4.1).

*Link to reports:*
Executive Summary:
http://www.dhcarchives.com/protected/uploaded/publication/CBLTC%20System%20Plan%20-%20Exec%20Sum.pdf

Technical Reference Report:
http://www.dhcarchives.com/protected/uploaded/publication/Community%20Based%20Long-Term%20Care%20System%20Plan%20-%20Full%20Technical%20Report.pdf

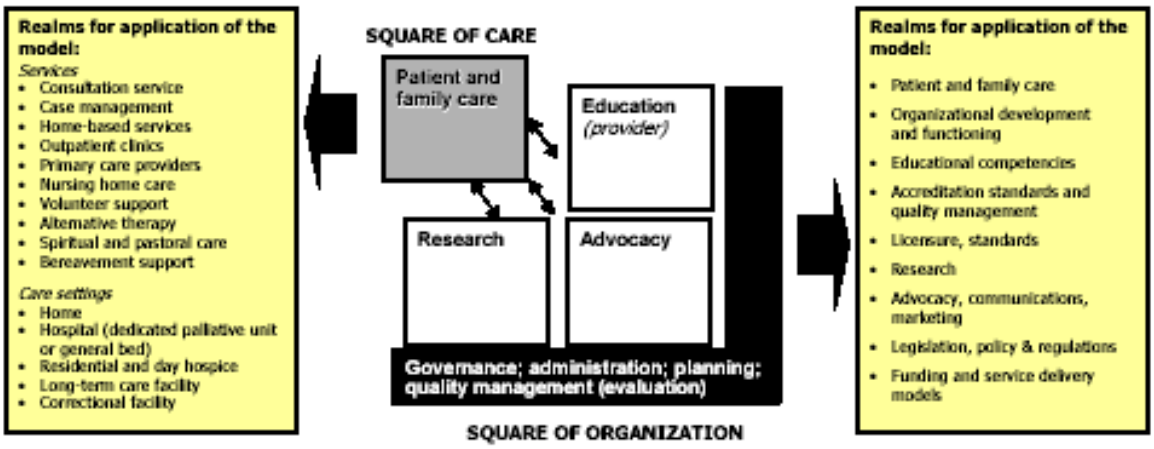
**Central West Region**

**Halton Peel DHC**

***Regional Framework for Palliative Care in Halton-Peel***

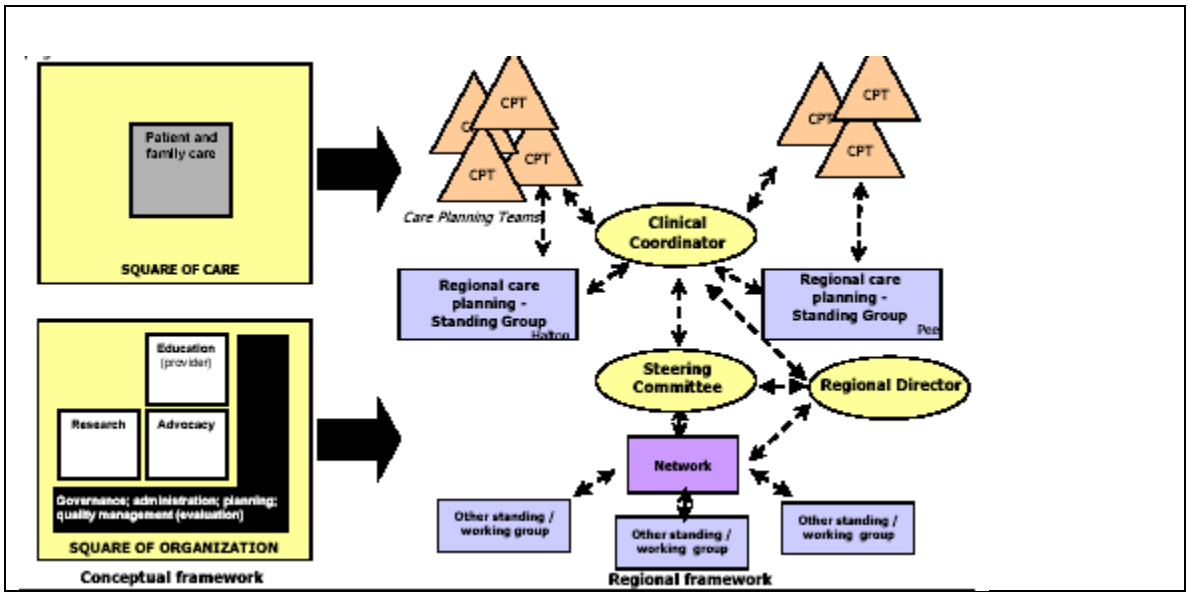
The 2004 report is based on the principles of two conceptual frameworks developed by the Canadian Hospice Palliative Care Association, which are:

- the square of care which concentrates on the delivery of client and family care; and
- the square of organization which focuses on the development and function of an organization.



*Source: Regional Framework for Palliative Care, p. 7.*

The following diagram illustrates how these principles have been adapted to a regional framework for palliative care in Halton-Peel; each component as well as implementation factors are described in some detail in the report.




*Source: Regional Framework for Palliative Care, p.23.*

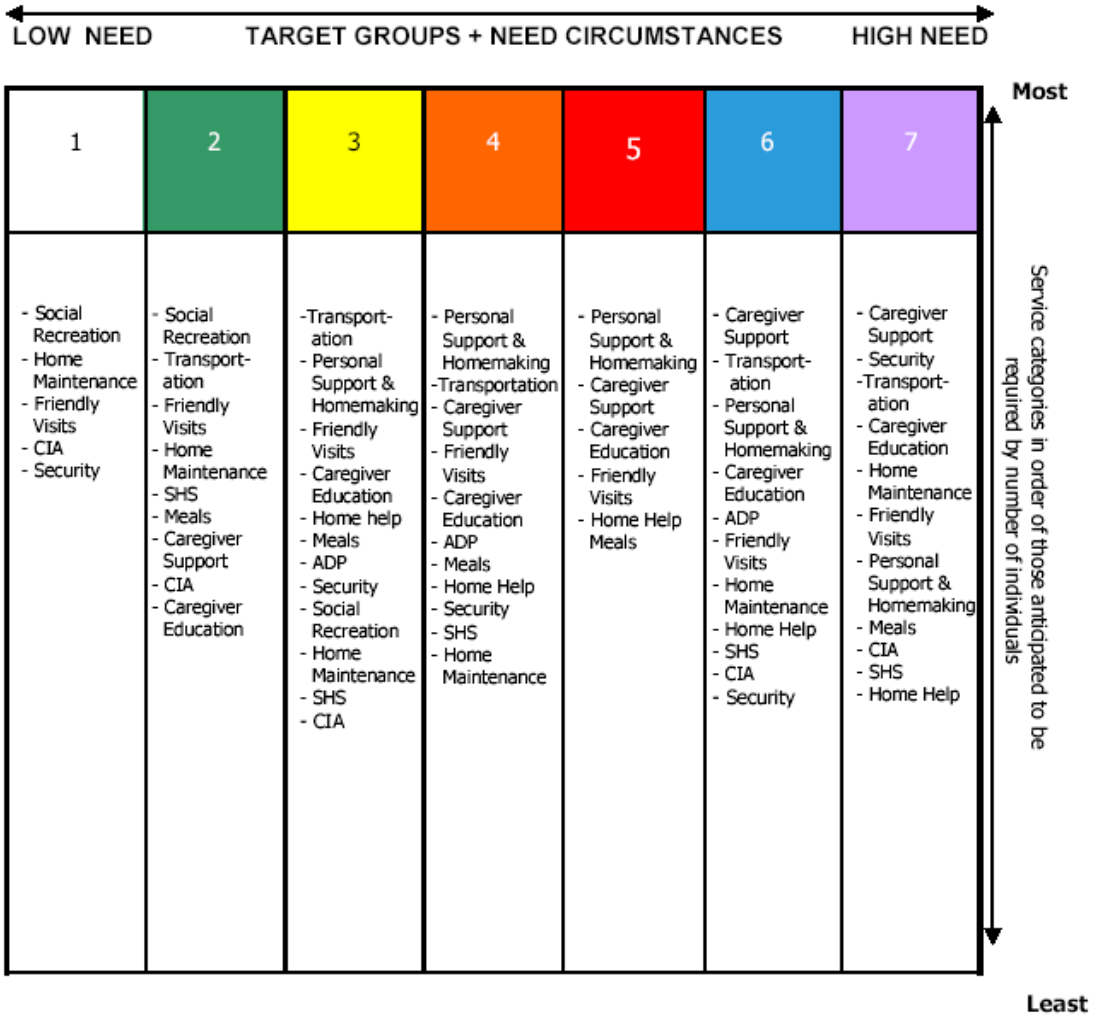
*Link to report:*
*http://www.dhcarchives.com/protected/uploaded/publication/Palliative%20Care%20FINAL%20Report.pdf*

***Future Vision of Community Support for Older Adults***

Full title - *Future Vision of Community Support for Older Adults: A Needs-Based Planning Framework for Halton-Peel (2004).*

The report is Phase III of four phases towards developing the framework. Phase III translates projected population growth and changing demographics (Phases I and II) into the need for services (CCAC, CCS etc.).
The diagrams below illustrate firstly a planning model of the needs of different groups of older adults and secondly the impact that the planning model might have on system design.

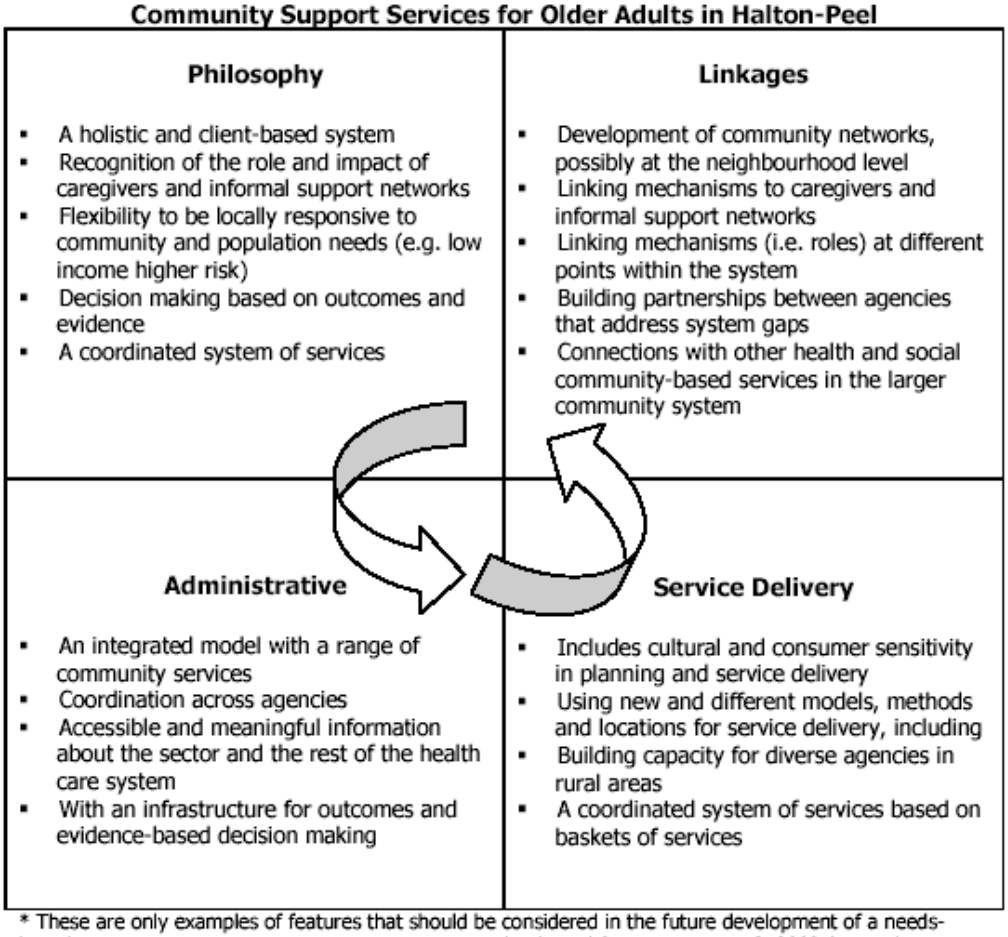
**Figure 8. Community Support Services Planning Model for Older Adults in Halton-Peel***




CIA= Client Intervention and Assistance SHS = Supportive Housing ADP = Adult Day Program

*Source: Future Vision for Community Support for Older Adults, p. 27*

**Figure 9. System Features* Framework**
**Community Support Services for Older Adults in Halton-Peel**




* These are only examples of features that should be considered in the future development of a needs-based community support services system. Framework adapted from Toronto DHC, 2002 (original adaptation of the Best Practices Framework in Hollander, M. & Prince, M. 2002)

*Source: Future Vision for Community Support for Older Adults, p. 28*

*Link to report:*
*http://www.dhcarchives.com/protected/uploaded/publication/CSS%20report.FINAL.%20May%202004.pdf*

***Planning Mental Health Services for an Aging Population***

This 2002 report includes a comparison of four approaches to organizing human services. The first two approaches are 'structuralist' in that they prescribe structures to organize relationships on a hierarchical basis. The latter two approaches are 'relationship oriented' by focusing on complex inter-provider and inter-organizational relationships in a nonhierarchical model.

- integrated delivery system/program
- lead agency
- managed network
- decentralized collaborative network

The Advisory Committee concluded that the preferred approach to organizing mental health services for older adults with mental illness is to move from decentralized collaboration towards a managed network. The critical issue in a managed network is to

establish cross-sector assessment, clinical treatment and specialized support in a range of environments to both clients and other service providers.

*Link to report:*
*http://www.dhcarchives.com/protected/uploaded/publication/Psychogeriatrics%20report%20-%20FINAL.pdf*

**Waterloo Wellington DHC**

***Strengthening Services for People with ADRD***

Full title - *Strengthening Services for People with ADRD in Waterloo … : Building a Dementia Network in Waterloo* Region, Building a Dementia Network in Wellington and Dufferin Counties (2004).

The networks were launched in 2003 and 2002 respectively. The documents include recommendations to support their ongoing activities and to develop linkages between them.

*Link to report:*
http://www.dhcarchives.com/protected/uploaded/publication/Dementia%20Report%20-%20Jan%202004.pdf

***Toward 2006: Directions for Community LTC Services***

In 2002 Waterloo Region's Specialized Geriatric Services Steering Committee used a logic model to develop a planning framework and implementation structure.

Recommendations in Chapter 8: Directions towards 2006 are presented in three categories:

- implementation planning for identified needs/gaps in service;
- areas for further research and documentation of need; and
- monitoring and documenting the implications of changes across the health system.

*Link to report:*
*http://www.dhcarchives.com/protected/uploaded/publication/Twrd%202006%20title%20pg.pdf%20full%20report.pdf*

**East Region**

**Champlain DHC**

***Specialized Geriatric Services in the Eastern Counties***
This 2000 document contains two reports - (i) needs assessment and (ii) options for models of service delivery - for specialized geriatric services in the Eastern Counties based on the situation in 2000 (Alzheimer Society of Cornwall and District was a member of the Advisory Committee.) It recommends developing a Specialized Geriatric Services Network with central intake and referral as the preferred model.

*Link to report:*
*http://www.dhcarchives.com/protected/uploaded/publication/specializedgeriatricservicesneedsassessmentreporteng.pdf*

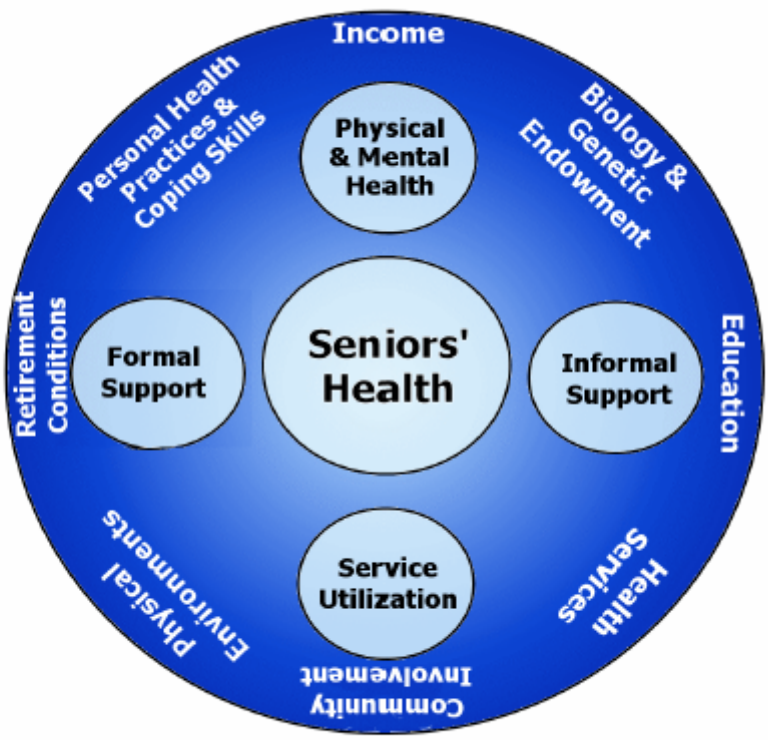
**Southeastern DHC**

***Healthy Aging in Southeast Ontario***

The goal of the Healthy Aging Project in 2004 was to provide the DHC with an understanding of the determinants of healthy aging and to support community capacity to address the needs of seniors in the area. The report makes ten recommendations.

Underlying the project's work was an adaptation of Health Canada's model population health with its determinants and their interplay. The basic model is applicable to the general population: this adaptation by Rosenberg may be more appropriate to seniors.

**Conceptual Framework of Seniors' Determinants of Health**

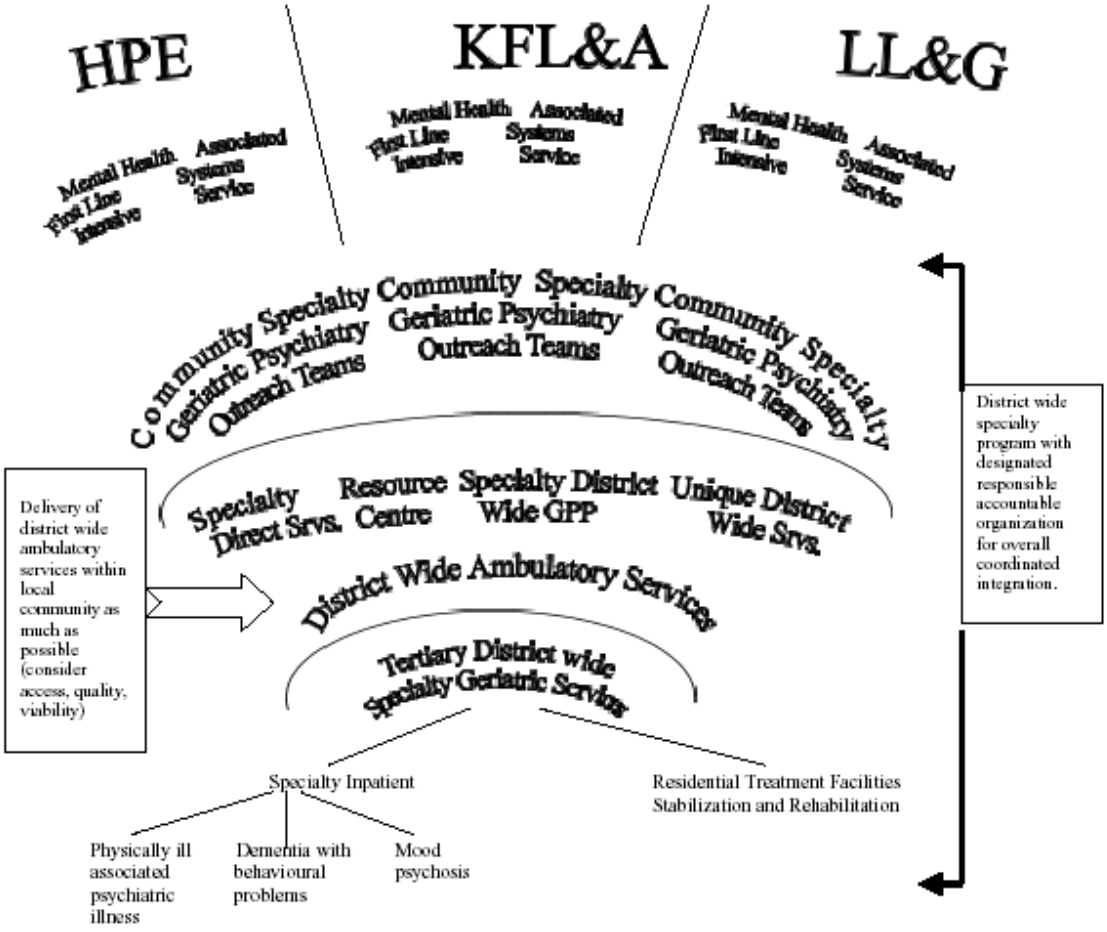



*Source: Healthy Aging in Southeast Ontario, Appendix B, p. 28*

*Link to report:*
http://www.dhcarchives.com/protected/uploaded/publication/64_SEODHC_Nov2004_HealthyAginginSEO.pdf

A Plan and Model for Meeting the Needs of Older Individuals with Mental Health Problems
The 2002 report provides advice on developing a district system that meets the needs of older people with mental health problems. It notes that the population of seniors served is diverse with complex and changing needs that go beyond mental health, e.g. the effects of aging.

The Model for Services for Seniors with Mental Health Needs




*Source: A Plan and Model for Meeting the Needs of Older Individuals with Mental Health Problems, p. 24*

*Link to report:*
*http://www.dhcarchives.com/protected/uploaded/publication/55_MeetingTheNeedsOfOlderIndividuals.PDF*

**NORTH REGION**

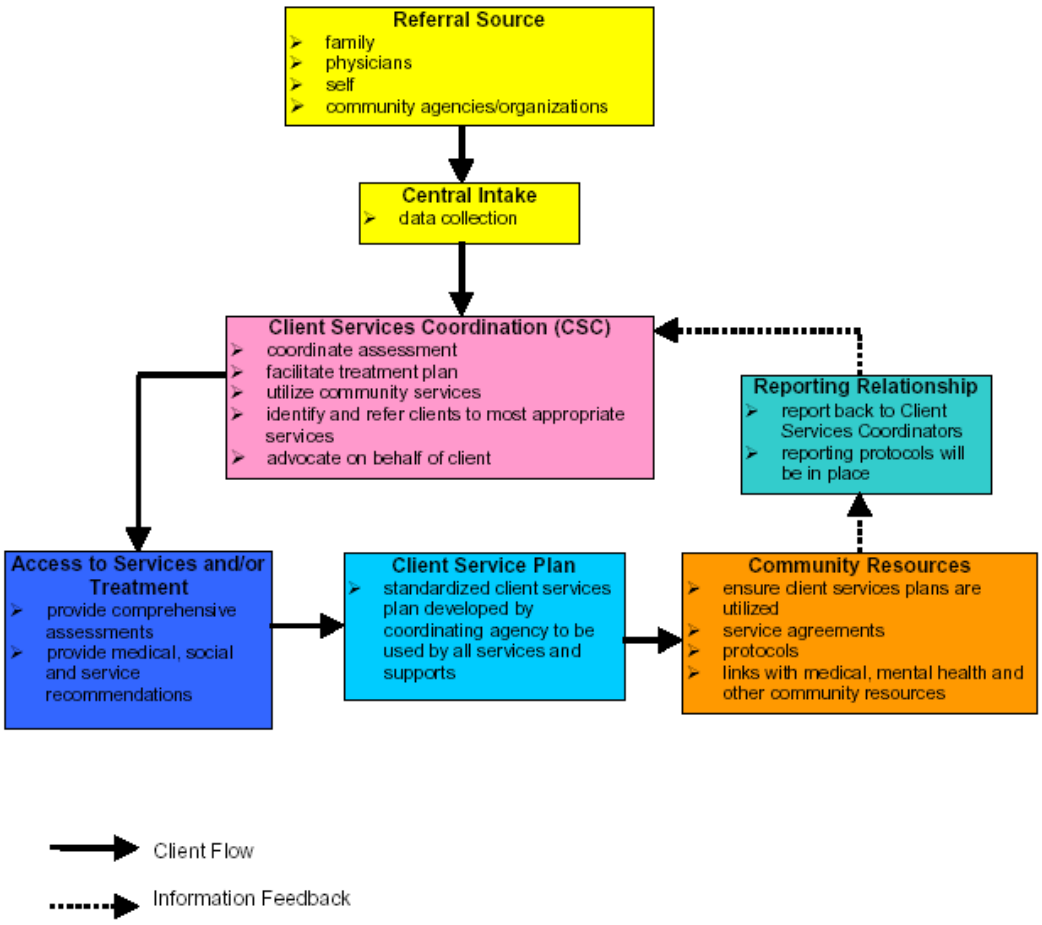
***Muskoka DHC***

***Plan for Continuum of Care for ADR***

The proposed plan (2002-03) for a continuum of care for people with ADRD has three interdependent components:

- Entry to system
  - Referral source, central intake
  - Client services coordination
  - Access to services and/or treatment
- Services and supports
  - Psychogeriatric teams
  - Specialist consultations
  - Highly specialized regional geriatric resources
  - Local hospital resources
  - Long-term care facilities
  - Retirement/supportive housing
  - Community resources
- System level functions
  - Planning/coordination/administration
  - Monitoring and evaluation
  - Community and professional awareness

**Proposed Serviced Delivery Model**




*Source: Plan for Continuum of Care for ADRD, p. 7-6*

*Link to 7 - Proposed Continuum of Care (each chapter has its own file):*
*http://www.dhcarchives.com/protected/uploaded/publication/A%20Plan%20for%20the%20Continuum%20of%20Care%20for%20Alzheimer%20Disease%20and%20Related%20Dementia7[1].a_Proposed_System.PDF*

*Figure 7.1:*
*http://www.dhcarchives.com/protected/uploaded/publication/A%20Plan%20for%20the%20Continuum%20of%20Care%20for%20Alzheimer%20Disease%20and%20Related%20Dementi7[1].b__Proposed_System.PDF*

## OTHER CANADIAN MODELS

### Canada

### Federal/Provincial/Territorial

***Planning for Canada's Aging Population: A Framework (2005)***

Prepared for the Committee of Officials for Federal/Provincial/Territorial Ministers Responsible for Seniors, April 2005, the plan takes a holistic view of senior's health and wellness. It organizes the factors affecting senior's wellness into three overarching pillars:

- Health, Wellness and Security
- Continuous Learning, Work and Participation in Society
- Supporting and Caring in the Community

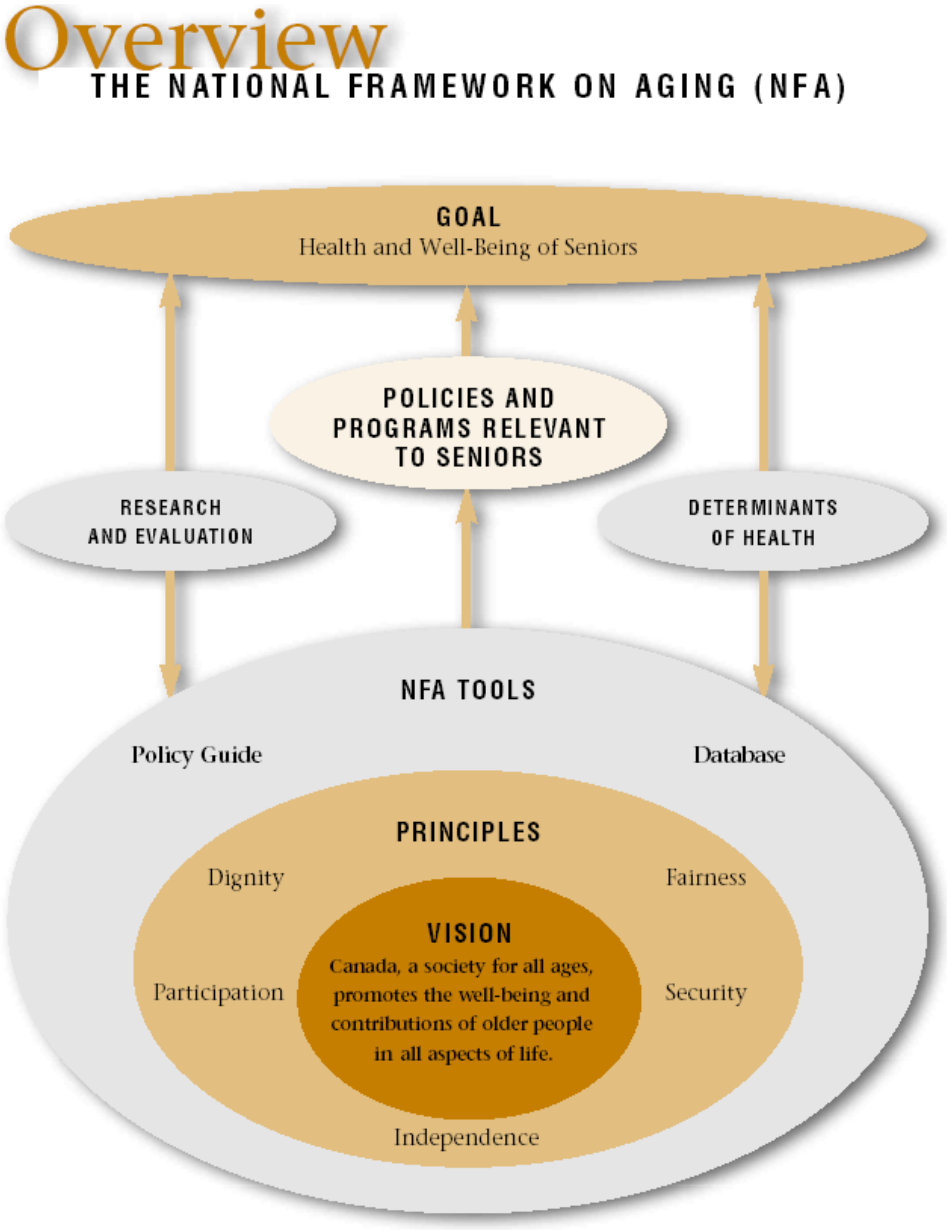
*PLANNING FOR CANADA'S AGING POPULATION*

Vision: "Canada, a society for all ages, promotes the well-being and contributions of older people in all aspects of life"


*Source: Planning for Canada's Aging Population, p. 6.*

***National Framework for Aging: A Policy Guide (1998)***

Developed for the F/P/T Ministers Responsible for Seniors for the International Year of Older Persons 1999, this framework is based on five principles: dignity, independence, participation, fairness, and security.



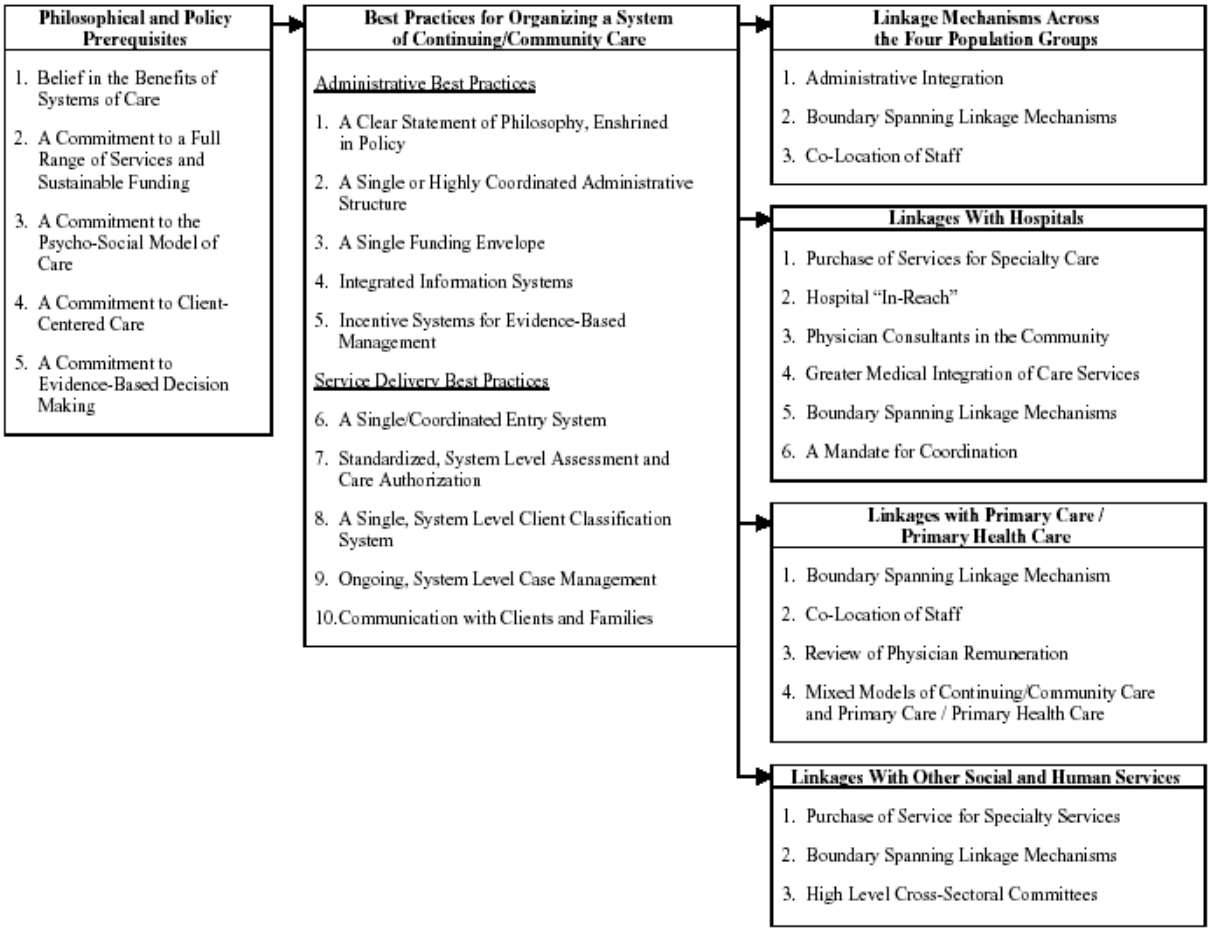

*Link to guide:*
*http://www.phac-aspc.gc.ca/seniors-aines/nfa-cnv/index_e.htm*
*or*
*http://www.phac-aspc.gc.ca/seniors-aines/nfa-cnv/pdf/aging_e.pdf*

**Hollander (for Health Canada)**

***The Third Way***

*Full title - "The Third Way": A Framework for Organizing Health Related Services for Individuals with Ongoing Care Needs and Their Families. Prepared by Hollander Analytical Services for Health Canada, February 2002*.

The paper reports on research commissioned by Health Canada on the continuum of care for four population groups: seniors 65 years of age or older, adults with physical disabilities, persons requiring mental health services, and children with special needs. The report brings together the results of six technical reports and provides a new conceptual framework for "a continuum of integrated home and community care, with adequate links to hospitals and primary care." The framework can be used as the basis for discussion about the required linkages between sectors and supporting policy options.
Section 3 (p. 33) discusses a Best Practices Framework for Organizing Systems of Continuing/Community Care Services.




*Link to report:*
http://www.hollanderanalytical.com/downloads/continuum-final.pdf

**ALBERTA**

**Capital Health**

***CHOICE - Model of Integrated Home Care***

The Comprehensive Home Option of Integrated Care for the Elderly (CHOICE) was initiated in 1996 in Edmonton by Alberta's Capital Health Authority, Good Samaritan Society and Capital Care Group. It is similar to the U.S. PACE program described below.

The program is designed to help seniors live independently in the community. All participants are brought to a day centre one to five days a week where a inter-disciplinary team provides a full range of medical, psychological, social and support services.

Services include:

- Medical monitoring and treatment by CHOICE physicians, psychiatrists and nurses
- Foot care, dental and eye care screening
- Physical, occupational and recreation therapy
- Personal care (help with dressing, bathing, nail, foot and hair care)
- Social work, spiritual care and help from a team of volunteers
- Health education
- Assistance with meals and snacks
- Assistance with nutrition
- Support and encouragement of participant and families
- Opportunities to make friends and take part in social activities
- Assistance with meals and personal care provided at home as needed
- Loan of equipment such as walkers and railings if required
- Transportation is provided to and from the CHOICE Programs
- Clients may stay overnight at one of the centres while they receive treatment for short term illness
- Respite care is available so home caregivers can receive a break while the person they care for stays at one of the centres for a few days

In partnership with the Alberta Mental Health Board, one of Capital Care's day centres serves frail elderly people who experience persistent mental health problems.

*More information:*

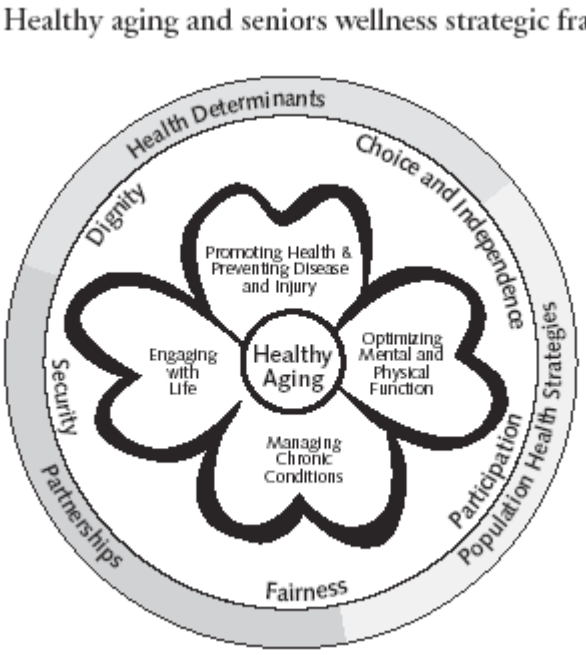
*Capital Health:*
*http://www.capitalhealth.ca/ProgramsAndServices/BrowseServicesByAlpha/Content.htm?IA_ID=1001469*

*Capital Care:*
*http://www.capitalcare.net/Programs/choice.htm*

**Alberta Health and Wellness**

**Healthy Aging and Seniors Wellness Strategic Framework**

Full title - *Alberta's Healthy Aging and Seniors Wellness Strategic Framework 2002-2012*
Prepared for Alberta Health and Wellness by KPMG Consulting, the framework is based on a health promotion approach.




*Source: Healthy Aging and Seniors Wellness Strategic Framework, p. 18*

*Link to report:*
*http://www.health.gov.ab.ca/resources/publications/pdf/HealthAgingJune31.pdf*

***Strategic Directions in Healthy Aging and Continuing Care: ADRD***

Full title - *Strategic Directions in Healthy Aging and Continuing Care in Alberta: Alzheimer Disease and Other Dementias (2002)*

A reference document developed by Alberta Health and Wellness to help regional health authorities in the preparation of their ten-year continuing care strategic service plans. The working task group developed themes for quality dementia care and strategies for achieving the desired outcomes. These fell into six key priority areas:

- Public awareness
- Guidelines for the care of clients with ADRD should be in place in all service areas
- Support for informal caregivers
- Service delivery across the continuum of care
- Supportive environments
- Education and training

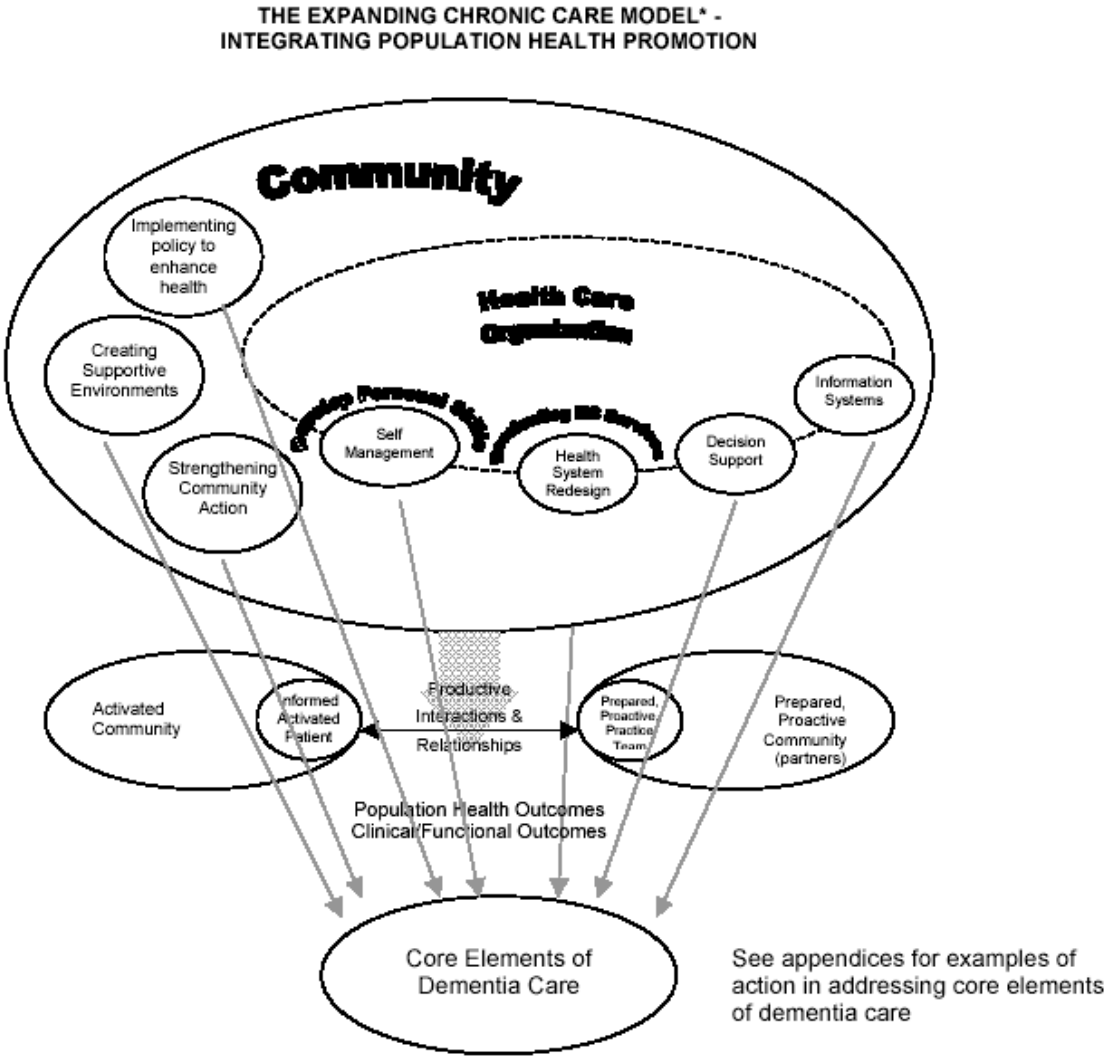
*Link to report:*
*http://www.health.gov.ab.ca/resources/publications/pdf/AlzheimerReprt.pdf*

**BRITISH COLUMBIA**

**Interior Health**

**Dementia Care Service Framework**

The dementia care service framework of 2004 was developed by Interior Health's Dementia Care Working Group. The framework is based on a population health chronic disease management model.



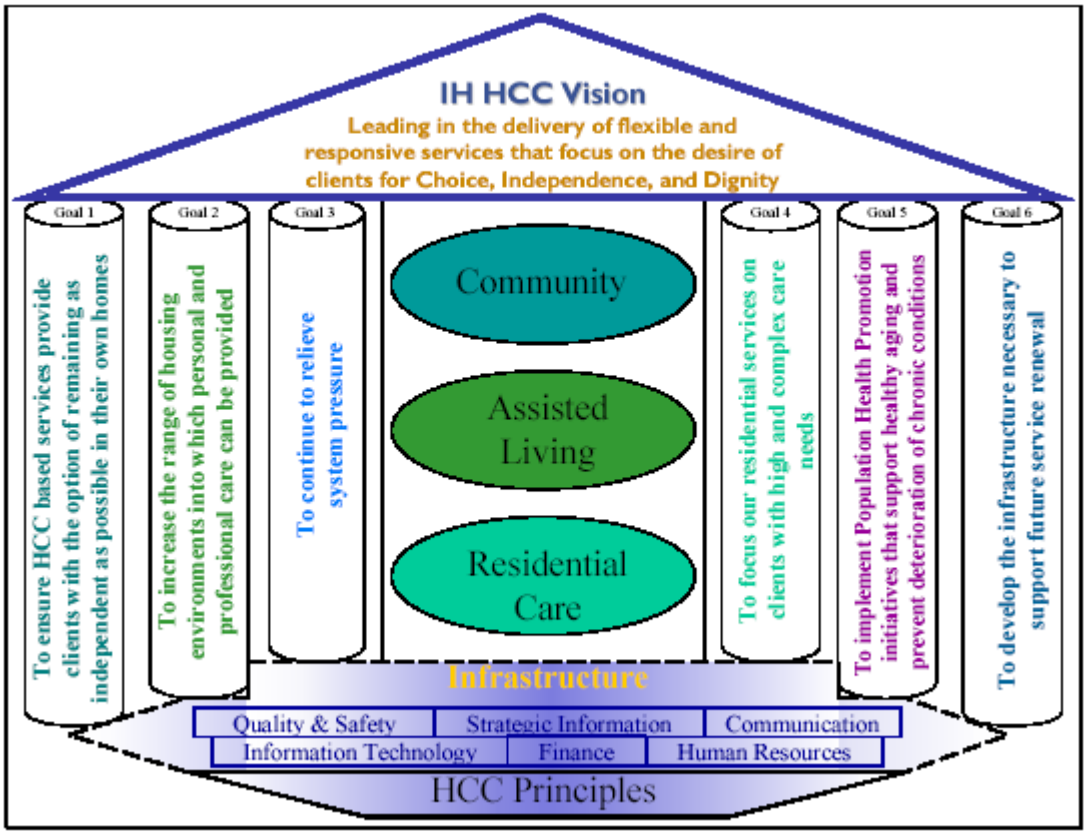

**Adapted from: Victoria Barr, Anita Dotts, Brenda Marin-Link, Darlene Ravensdale, Sylvia Robinson, Lisa Underhill (2002)**
*Adapted from the Chronic Care Model: Glasgow, R., Orleans, C., Wagner, E., Curry, S. Solberg, L. Does the Chronic Care Model Serve Also as a Template for Improving Prevention? The Milbank Quarterly, 79(4), 2001. Also the World Health Organization, Health and Welfare Canada, Canadian Public Health Association. Ottawa Charter of Health Promotion. WHO, Copenhagen. 1986

*Source: Dementia Care Service Framework, p. 16*

The document has been moved from Interior Health's public website to its intranet. for more information contact Lila-Mae Soleski at 250-870-4661.

Home and Community Care: Service Plan 2004-2007
Interior Health's Home and Community Care Service Plan is intended to support its strategic objective:
To provide a network of facilities, services and staff resources required to meet the needs of persons with acute, chronic, palliative, or rehabilitative health care needs through a range of caring, responsive home care, assisted living and residential care programs.

Diagram 1




*Source: Home and Community Care Service Plan, p. 5*

*Link to report:*
http://www.interiorhealth.ca/NR/rdonlyres/B87A65A1-5D2D-4414-BEB8-0954835FF259/2359/HCCPlanMay2005wps.pdf

**MANITOBA**

**Seniors and Healthy Aging Secretariat**

***Advancing Age: Promoting Older Manitobans***

In 2003 the Manitoba government implemented a new seniors' strategy through the Seniors and Healthy Aging Secretariat titled *Advancing Age: Promoting Older Manitobans*. It will address issues under three themes: health care, community living, and security. Policy forums were to be convened to support long-term planning on different issues.

*Link to report:*
http://www.gov.mb.ca/shas/advancingage.html

**SASKATCHEWAN**

**Provincial Advisory Committee for Older Persons**

***Provincial Policy Framework and Action Plan for Older Persons***

Saskatchewan's 2003 report includes recommendations to support six goals:
Ensure provision of and access to affordable and supportive housing and services for older persons.

- Provide safe and affordable transportation for older persons.
- Ensure the access and availability to the continuum of quality and appropriate health care services for all older persons.
- Promote active living and lifelong learning.
- Enhance the recognition of contributions of older persons.
- Ensure the safety and security of all older persons.

*Link to report:*
http://www.health.gov.sk.ca/ic_prpolicyfrwk.pdf

**QUEBEC**

**Solidage Research Group**

**SIPA**

**SIPA** was a demonstration and evaluation project in Quebec based on a model of integrated care for the frail elderly. The model includes a clinical aspect, a management structure and a funding-by-capitation system. The project was developed by the Solidage Research Group of McGill University-University of Montreal and carried out in the Island of Montreal over 22 months between 1999 and 2001.
Its goals were to:

- respond appropriately to the needs of older persons with disabilities
- maintain and promote the independence and capacity of older persons to make choices, while respecting their dignity
- optimize the use of community, hospital and institutional resources

The SIPA model is an integrated system of social, medical and short- and long-term hospital services offered in both the community and institutions to vulnerable elderly persons.

Elderly persons eligible for SIPA have functional disabilities or cognitive problems that limit their ability to perform the usual tasks related to activities of daily living and upkeep of their immediate environment.
The SIPA model falls within the range of activities promoted by the Quebec Ministry of Health and Social Services, and involves significant changes in the way health services are organized, delivered and funded.
The results as given in a 2004 presentation indicate this model has the potential to change the utilization of services from hospital to community in a cost-effective manner. The presentation gives more details including the conditions that would be required for successful implementation.

*More information:*
SIPA Research Program, Solidage Research Group: http://www.solidage.ca/e/sipa.htm

Presentation on SIPA – Results of a 22 month Randomized Control Trial on an Integrated System of Care for Frail Older Persons by Dr. Howard Bergman, McGill:
http://www.departmentofmedicine.ualberta.ca/rounds/slides/mgr_09-24-04.pdf
Béland F., Bergman H., Lebel P., et al. A System of Integrated Care for Frail Older Persons (SIPA) in Canada: Results from a Randomized Controlled Trial. J of Gerontol A Biol Sc, Med Sci. (In Press)

## ATLANTIC CANADA

### Nova Scotia and PEI

#### *Nova Scotia and PEI Rural Palliative Home Care Model*

Full title - *A Rural Palliative Home Care Model: The Development and Evaluation of an Integrated Palliative Care Program in Nova Scotia and Prince Edward Island. A report for the Health Transition Fund, Health Canada (2001).*

The project was an interprovincial initiative to develop, implement and evaluate a palliative care program in three rural communities. Key elements of the integrated palliative care program were:

- Access and referral through a regional single entry point.
- A common assessment tool and home chart used with all agencies and interdisciplinary team members.
- Coordination through an identified case manager for each client and family and weekly palliative care rounds.
- Care delivery by an interdisciplinary team in consultation with the palliative care resource/consult team and the patient/family. One demonstration site provided enhancements in nursing, respite and medication coverage.
- Consultation/resources teams included physicians and nurses and, in some sites, social workers and pharmacists.
- Community resource linkages to provide support in palliative care volunteerism, acquisition of equipment and public awareness.

The report provides details of the integrated care program as well as its evaluation and further recommendations.
*Link to:*
http://www.gov.ns.ca/health/downloads/Palliative%20Care.pdf

## INTERNATIONAL MODELS

### United States

### Federal

### PACE

PACE (Program of All-Inclusive Care for the Elderly) is an American model of care for the elderly. It features a comprehensive service delivery system and integrated Medicare and Medicaid financing (all seniors are eligible for Medicare). The program is modeled on the system of acute and long term care services developed in 1986 by On Lok Senior Health Services in San Francisco. The Balanced Budget Act of 1997 established the PACE model of care as a permanent entity within the Medicare program and enables States to provide PACE services to Medicaid beneficiaries as a State option.
Participants must be at least 55 years old, live in the PACE service area, and be certified as eligible for nursing home care by the appropriate State agency. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees.
An interdisciplinary team, consisting of professional and paraprofessional staff, assesses participants' needs, develops care plans, and delivers all services (including acute care services and when necessary, nursing facility services) which are integrated for a seamless provision of total care. PACE programs provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs. The PACE service package must include all Medicare and Medicaid covered services, and other services determined necessary by the multidisciplinary team for the care of the PACE participant.
Services include:

- Delivering all needed medical and supportive services, the program is able to provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as possible. Care and services include:
- Adult day care that offers nursing; physical, occupational and recreational therapies; meals; nutritional counseling; social work and personal care
- Medical care provided by a PACE physician familiar with the history, needs and preferences of each participant
- Home health care and personal care
- All necessary prescription drugs
- Social services
- Medical specialists from fields such as audiology, dentistry, optometry, podiatry, and speech therapy
- Respite care
- Hospital and nursing home care when necessary

*More information:*
http://www.cms.hhs.gov/pace/

National Pace Association: www.npaonline.org

**Pennsylvania**

***Adult Day Services in Rural Pennyslvania***

Full title - *Adult Day Services in Rural Pennsylvania* by Janet Melnick, Heather Shanks-McElroy, and Doris Chectotka-McQuade, 2004
Published by the Center for Rural Pennsylvania (a legislative agency advising on rural policy) and based on research and a review of rural Adult Day Services (ADS) practices in the U.S. and Canada, this report identified several key elements concerning the potential success of ADS in rural communities. Noteworthy are:

- The role of community support for developing and sustaining a program. The community from which clients will be drawn must not only see the need for ADS, but also be part of the planning and resource pool. This necessitates the cooperation of multiple localities, and possibly counties, as well as professional service providers in the aging and mental health networks.
- Transportation. An effective and reliable transportation network that prioritizes ADS equally with medical appointments and trains drivers to assist ADS clients appropriately is needed.
- Consistent annual funding that is not tied to a monthly head count.
- Leadership skills and knowledge. The lead person or ADS center director must be knowledgeable of the client population, possess programming expertise, and have the requisite financial and marketing skills to successfully energize an interdisciplinary staff.

Included in the report are characteristics of two programs considered to be successful.

Link to report:
http://www.ruralpa.org/Adult_Day_Services_Melnick04.pdf

**UNITED KINGDOM**

**Department of Health**

**National Service Framework for Older People**

Full title - *U.K. Department of Health, National Service Framework for Older People, Executive Summary, March 2001*

The U.K.'s National Service Framework for Older People sets standards and service models of care across health and social services for all older people, whether they live at home, in residential care or are being looked after in hospital.
There are eight standards:

1. Rooting out age discrimination
2. Person-centred care
3. Intermediate care
4. General hospital care
5. Stroke
6. Falls
7. Mental health in older people (includes dementia)

8. Promotion of health and active life in older age
The Alzheimer Society has welcomed standard 7 for mental health in older people but is disappointed that there is not more detail about standards in dementia care.

*More information:*

*Executive Summary*
http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/OlderPeopleArticle/fs/en?CONTENT_ID=4073597&chk=4wRxm%2B

*Standard Seven – including section on dementia*
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPAmpGBrowsableDocument/fs/en?CONTENT_ID=4096710&MULTIPAGE_ID=4901983&chk=UshevM

**AUSTRALIA**

**Federal**

**Joint National Framework for Action on Dementia Consultation Paper**
In January 2005 Australia's health ministers jointly agreed to develop a National Framework for Action on Dementia. The development process has included a public consultation process in June and July from which a draft framework will be prepared for consideration by the health ministers, expected in November 2005.
*Consultation paper:*
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-dementia-nfad.htm

**New South Wales**

***Framework for Integrated Support and Management of Older People***

Full title - *Framework for Integrated Support and Management of Older People in the NSW Health Care System 2004-2006*
The model documents how care and support should be provided in a systematic way to older people with the NSW public health system. It is built on a multidisciplinary approach and a key feature is that assessment and management is offered, not imposed. The model works from the broader context of health promotion and prevention activities through to training, education and research to inform practice.
The steps in the framework are:

- Identify and triage or prioritize the potential aged care client on presentation at an NSW health care entry point.
- Proceed with urgent treatment, support or intervention as appropriate.
- Offer the potential aged care client or their representative specialized multidisciplinary assessment and management.
- Commence specialized multidisciplinary assessment and management.
- Develop and implement a multidisciplinary care plan for continuing management in partnership with the aged care client and families/carers and relevant care and service providers.

The framework model is described in more detail in Appendix 3 (p. 52).

*More information:*

http://www.health.nsw.gov.au/pubs/2004/pdf/fw_older.pdf

**Victoria**

***Dementia Framework***

Full title - *Dementia Framework for Victoria, 2005 and beyond: A consultation paper.*
As part of the process of considering a framework for dementia care in Victoria, the state government issued a consultation paper. As input to the paper, the Victoria Dementia Reference Group and Working Party have suggested four main areas with proposed strategies:

- Risk reduction and prevention of dementia
- Early stages on the dementia pathway
- Middle stages on the dementia pathway
- Late stages on the dementia pathway.

See Appendix 4 for lifecourse approach to services.

*Consultation paper:*
http://www.health.vic.gov.au/agedcare/publications/dem_framework_05.htm