Accessing a Continuing Care Home in Alberta: Supporting Transitions in Care

October 2023

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ahs.ca/continuingcare

Alberta Health

Seniors Health & Continuing Care

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References to continuing care (including home care, designated supportive living, long term care and hospice) may not reflect the updated language or terms found in the new Alberta *Continuing Care Act* which is anticipated to take effect April 1, 2024. Please refer to the definitions/glossary section of the document or website for updated terms.

Acknowledgements

This resource has been prepared by Alberta Health Services (AHS) Provincial Seniors Health and Continuing Care in partnership with the AHS Coordinated Access Working Group, Indigenous Wellness Core & the Indigenous Services Canada First Nations, and Inuit Health Branch (FNIHB), Alberta region.

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Introduction

The purpose of this document is to support health professionals to navigate access to a **Continuing Care Home (CCH)** for **clients** from another location in Alberta, including other zones and First Nations communities, and those wishing to move to a CCH in Alberta from another Canadian province or territory. This guide aligns with the principles and values of the provincial Alberta Health Services (AHS) Access to a Designated Living Option (ADLO) in Continuing Care Policy Suite.

Note: **The first reference to bolded terms that are used through the document (except titles) are defined terms that can be found in the Definitions section at the end of this document.**

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Key Principles

1. Continuing care clients are eligible to access services anywhere in the province, regardless of zone, community, or other geographical boundaries.

    - Options offered to clients may differ across the province based on availability of optimal services.

    - CCH's located in National Parks may be subject to residency requirements as per the *National Parks Lease and License of Occupation Regulations*; and,

    - The process for moving to a CCH in Lloydminster is primarily managed by the Saskatchewan Health Authority.

2. Decision-making regarding client access to a CCH is inclusive of client well-being, client choice, stewardship, fairness, and transparency.

3. Assessments are standardized and transferrable across the province of Alberta and some standardized assessments may transfer between provinces and territories.

4. Waitlists are managed using consistent provincial criteria.

5. Access to service is reasonable, timely, and appropriate.

6. Decisions regarding the level of care is based on the Designated Living Option Guide for Case Managers.

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Overview of Access and Case Management

In Alberta, AHS is organized into five geographic zones: North, Edmonton, Central, Calgary, and South. Each zone has a Continuing Care Access Centre (CCAC) team that can be contacted to begin the transition process (see Appendix A).

Requests to access continuing care services in Alberta can be initiated by anyone; however, the client and their health care team all play a key role in providing the required supporting documentation for a successful referral.

The referring **case manager** will collaborate with the CCAC team of the clients' desired location (zone). Case managers work with the client and their care team to review care needs using standardized Canadian assessment tools (e.g., **Resident Assessment Instrument-Home Care (RAI-HC)**), and additional assessments, to determine the client's needs. Assessments should be completed in the client's home whenever possible, to improve client experience and decrease delays for access to a CCH. An AHS case manager will discuss with you the level of care/CCH best suited to your client's assessed need.

In First Nations communities, RAI-HC assessments are typically completed by a home care nurse in the First Nation Home Care Program. This varies with each community depending on the availability of resources and home care provider. Additional information about home care in First Nations communities is available by contacting the First Nations and Inuit Health Branch (FNIHB) Alberta Home and Community Care team (see Appendix B).

AHS recognizes the importance of traditional wellness services and culturally appropriate practices in continuing care for Indigenous peoples. Indigenous clients should inform the CCAC team of cultural preferences during intake. Additional information about the AHS Indigenous Wellness Core and First Nations Community Health Centres is outlined in Appendix B.

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Clients with Alberta Health Care Insurance Plan (AHCIP)

Clients living in Alberta should contact their local CCAC for assessment and services. The local CCAC team will initiate a zone-to-zone transfer. For clients transferring from First Nations communities in Alberta, contact the FNIHB nursing team to coordinate a local transition package, including the required supporting documents, to be sent to the local CCAC.

Clients without Alberta Health Care Insurance Plan (AHCIP)

Once the client knows where they would like to live, the case manager or client and/or alternate decision-maker should contact the CCAC in that zone to begin the transition process (see Appendix A).

- Individuals can apply to be part of the AHCIP and be eligible to access publicly funded health care services up to three months after becoming a resident in Alberta.
- Medically necessary health services across Canada are covered in accordance with the *Canada Health Act* (https://www.canada.ca). Coverage for additional services, such as continuing care services (excluding auxiliary hospitals), ambulance, prescription medications, and other health services are not typically covered. It is important to understand what coverage your client has and whether they should consider purchasing additional private health insurance. For more information about provincial or territorial health insurance coverage while travelling across Canada and interprovincial reciprocal billing agreements, please contact your local government (Appendix C).

Note: **This guide does not include information for clients who are from out-of-country and do not qualify for the AHCIP. These applications tend to be more complex because of insurance coverage and residency requirements. The Continuing Care Access Centre team in the local/receiving zone can provide more information on federal and provincial requirements if your client is from out-of-country and does not qualify for the AHCIP.**

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The Moving to a new home in continuing care: An information and decision-making guide for clients and families is a helpful resource for clients and families about additional financial charges and what to expect when moving to a CCH.

Clients may wish to review sites listed on the continuing care facility directory.

Financial Considerations

- Health care services in CCHs are publicly funded at no cost to residents; however, residents are required to pay an accommodation charge to cover the cost of accommodation-related services (i.e., rent, meals, housekeeping, and routine building maintenance). More information about the maximum accommodation charge, set by the Alberta government each year, is publicly available at https://www.alberta.ca/continuing-care-accommodation-charges.
- Additional charges (e.g., laundry, medications, supplies etc.) will vary between Designated Supportive Living (DSL) and Long Term Care (LTC).
- Some facilities may require the resident to have their own bed, mattress and furniture.
- Moving costs are often significant and should be considered.
- An AHS case manager can help your client review their finances and determine if any financial assistance is available to them and provide additional information on charges. If a client requires a comprehensive financial assessment, has immediate financial concerns, or requires detailed advice or education, then a referral to a social worker, another appropriate team member or an appropriate community resource with additional expertise to assess the need, is advised.

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Referral Process

Referring Location Process

1. Contact the CCAC in the zone your client has requested to move to (Appendix A).

2. Complete and forward the Continuing Care Home Waitlist Referral Form along with the required supporting documentation, outlined in the form (where not available in a shared electronic medical record), to the receiving zone CCAC email (indicated on the bottom of the form).

3. Referring case manager is required to maintain supports and services while the client is on the waitlist in the receiving zone.

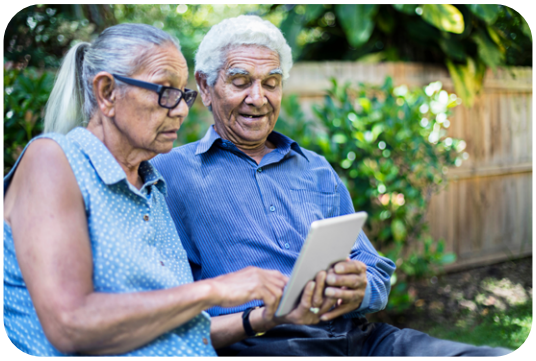
4. Referring case manager shall notify the receiving zone of the case manager/ designate contact information.

   - Receiving case manager may request additional information, clarification, updated assessments or supporting documents. Referring case manager should respond to requests promptly to prevent delays.

5. Inform the receiving zone case manager/transition coordinator of any significant change that would affect the client's status on the waitlist (e.g., health status, decision-making capacity, change in finances, change of site preference, request for removal from waitlist etc.).

   NOTE: *This should include notification of transitions to a different care setting (e.g., transfers from acute to a temporary CCH, acute care, sub-acute care, etc.) to inform on current location and any required changes to waitlist prioritization.*

6. Referring case manager provides the updated client assessment and **care plan** information to the receiving zone at the time of admission to a CCH in that zone.



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Receiving Zone Process

1. CCAC will accept the referral and notify the appropriate AHS team of the client's request to access a CCH.

2. Acknowledge receipt of the referral by phone, fax, or email to the referring case manager within two business days.

3. Notify the referring case manager of the receiving AHS case manager supporting the referral.

    - Clarify with the referring case manager for additional information as required to complete waitlisting process or for an admission to a CCH.

4. Contact the client/family to review process, explore most preferred and preferred CCH, and share accommodation fees and site specific costs (e.g., damage deposit).

    - Explore/negotiate with the client options available in their community of choice and review finances required.

5. Add the client's name to the appropriate waitlist according to their original assessed and approved date as per the Access to a Designated Living Option in Continuing Care policy and the Designated Living Option: Access and Waitlist Management procedure.

6. Contact the client by email, letter and/or phone to confirm the addition of the client's name to the waitlist.

7. Maintain contact and provide assistance to the referring case manager and client as needed while on the waitlist. Referring case manager is required to maintain supports and services while the client is on the waitlist in the receiving zone.

8. Inform the referring case manager/health professional whenever the client is

    a) added to or removed from any CCH waitlist

    b) accepts or declines any CCH offer

    c) admitted to any CCH.

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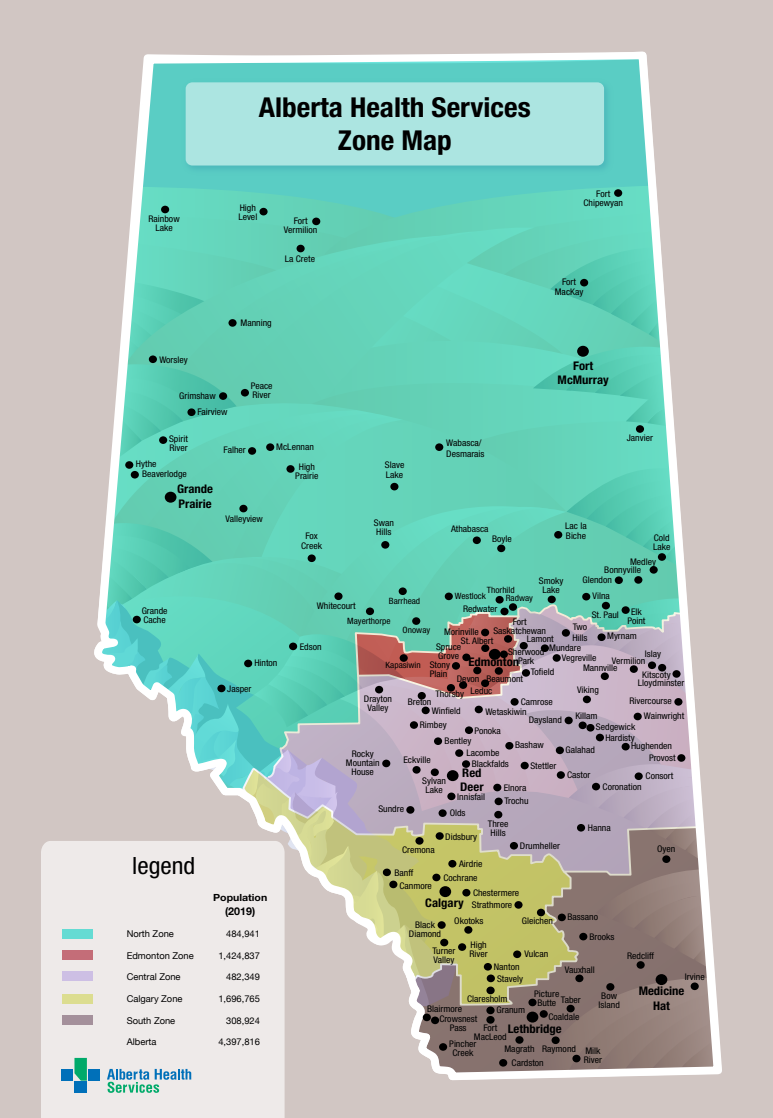
Appendix A: Zone Map and Access Contact Numbers by Zone



Zone Map is available online at ahs.ca/zone map

Additional information about continuing care services and a link to each zone's access page is available at ahs.ca/continuingcare

Continuing Care Access Centres	
North Zone	1-855-371-4122
Edmonton Zone	1-780-496-1300
Central Zone	1-855-371-4122
Calgary Zone	1-888-943-1920
South Zone	1-866-388-6380

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Appendix B: Indigenous Resources and Information

Availability of AHS CCHs on First Nations reserves and communities varies. Waitlists are managed collaboratively between the AHS zone, CCAC and the First Nations community. The CCAC in the zone where your client desires to live will be able to provide additional information about the availability of continuing care services that support indigenous people as they age and as their care needs change.

- AHS Indigenous Wellness Core, partners with Indigenous peoples, communities, and key stakeholders to provide accessible, culturally appropriate health services for First Nations, Métis, and Inuit people in Alberta. For more information email: indigenouswellnesscore@ahs.ca.
- First Nations and Inuit Health Branch, Alberta Region, Home, and Community Care. For more information email: sdmcregiondeab-abregionhcc@sac-isc.gc.ca.
- Contact information for First Nations Community Health Centres can be found at informalberta.ca by searching: First Nations Community Health Centres.
- Additional resources, services, and information for First Nations and Metis peoples in Alberta is available at: https://www.alberta.ca/first-nations-and-metis.aspx.
- Additional information about continuing care in Indigenous Communities is available in the Continuing Care in Indigenous Communities Guidebook located at: https://www.albertahealthservices.ca/assets/info/seniors/if-sen-ccic-guidebook.pdf.

Health care services on-reserve are delivered by a variety of health care professionals. These health care professionals are employed by the band/First Nation in most cases; however, can be employed by the FNIHB, or contracted through AHS. Reference to FNIHB nurse responsibilities throughout this resource is inclusive of the health care professionals employed by, or contracted with, the reserve/community where the individual lives. For those band members that live off-reserve, healthcare services are provided by AHS.

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Appendix C: Provincial and Territorial Health Care Web Resource

Located at: https://www.canada.ca/en/health-canada/services/health-care-system/canada-health-care-system-medicare/provincial-territorial-health-care-resources.html

Province/Territory	Website	Phone number
Alberta	https://www.alberta.ca/health.aspx	1-800-232-7215
British Columbia	https://www2.gov.bc.ca/gov/content/home	1-800-663-7100
Manitoba	https://www.gov.mb.ca/	1-800-392-1207
New Brunswick	https://www.gnb.ca/	(506) 457-4800
Newfoundland and Labrador	https://www.gov.nl.ca/	1-866-449-4459
Northwest Territories	https://www.gov.nt.ca/	1-800-661-0830
Nova Scotia	https://beta.novascotia.ca/	1-800-670-4357
Nunavut	https://www.gov.nu.ca/	1-867-975-5700
Ontario	https://www.ontario.ca/	1-866-532-3161
Prince Edward Island	https://www.princeedwardisland.ca/en	1-800-321-5492
Quebec	https://www.quebec.ca/	1-877-644-4545
Saskatchewan	https://www.saskatchewan.ca/government	1-800-667-7551
Yukon	https://yukon.ca/	1-800-661-0408

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Definitions/Terms

Care Plan – working document that includes the assessed health and social needs of the client, the agreed upon health outcomes and target dates for achievement, the specific interventions/treatments that shall be provided and who provides them, and review and evaluation dates and information.

Case Manager means the health professional that will help navigate the continuing care system. A case manager has the primary responsibility to work with clients to assess care needs and assist with service options. They may also be called a transition coordinator or discharge planner.

NOTE: *For the purposes of this document the term case manager includes health professionals involved in care coordination (e.g., FNIHB nurses, regulated health professionals from referring province).*

Client – means all persons; inclusive of residents and patients who receive or have requested healthcare or services from AHS and its health care providers. Client also means, where applicable: a co-decision-maker with the person; family/support person; or an alternate decision-maker on behalf of the person.

Continuing Care Home (CCH) – Continuing care home means a facility or part of a facility where facility-based care is provided to residents, some of whom must be eligible residents.

Designated Living Option (DLO) – publicly funded residential accommodation that provides health and support services appropriate to meet the resident's assessed unmet needs. The level of care is accessed through a standardized assessment and single point entry process and consists of Designated Supportive Living Level 3 (DSL3), Designated Supportive Living Level 4 (DSL4) and Designated Supportive Living Level 4 Dementia (DSL4D) and Long Term Care (LTC). DLO and CCH are used interchangeably during the transition period to the Alberta Continuing Care Act.

Resident Assessment Instrument- Home Care (RAI-HC): a standardized, minimal assessment and screening tool designed for clinical use.

NOTE: *Assessment tools may vary across jurisdictions. Appropriate interRAI instruments may be considered. A comprehensive assessment, using the appropriate interRAI instrument assessment tool, is used to determine the client's care needs. Results from the comprehensive assessment, in addition to information from the client's care team and secondary assessments regarding physical function, mental health, social abilities, and financial circumstances, all play a role in determining the client's needs.*