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LONG-TERM CARE FOR THE ELDERLY IN QUEBEC: CONSIDERATIONS OF APPROPRIATENESS AND QUALITY OF CARE

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Introduction

Since the 1970s, Quebec has managed health and social services, including services for seniors, within the same ministry and under the same principal law. One of the longest established loci of private and public social and health care in Quebec is its residences for the elderly. Quebec's residences for the elderly range from low rent housing with residential services for the elderly to full-fledged nursing homes (*centres d'hébergement et de soins de longue durée* —CHSLDS) with comprehensive nursing and medical supervision and care. Between these extremes are family-type lodging and intermediate resources, the latter consisting of lodging whose services exceed those offered by family-type housing but are less comprehensive than the services offered in at-home care. In CHSLDs, the provincial government pays for care but not for the costs of accommodations, meals and other services to the residents.

Admission to CHSLDs and private nursing homes with subsidized beds are managed through local community service centers or *Centres Locaux de Service Communautaire* (CLSCs). The needs assess-

ment tool that is usually used is filed electronically. At the CLSC, a social worker or nurse conducts an assessment of the client's physical and mental capabilities. Also, the client's physician undertakes a medical evaluation. To be eligible for admission to a CHSLD, an individual must be 18 years of age or older, a resident of Canada, a Canadian citizen or a person with permanent resident status and have diminished autonomy because of age or physical or mental limitations. While an income/asset test is not a standard part of the assessment performed by the CLSC if a client cannot afford the costs of nursing care, they may fill out a form called a *Demande d'exonération ou de réévaluation* and the *Régie de l'assurance maladie du Québec* or RAMQ will make a decision based on the evaluation form in order to determine the amount that the client will need to pay for CHSLD. The province of Quebec also provides subsidized home support services designed to help clients remain independent and in their own home for as long as possible. Home support services provide personal assistance with daily activities, such as bathing, dressing, grooming and light housekeeping. Also, some medical care such as skilled nursing care and occupational therapy is provided. Application and

assessment is again through the local CLSC. Services provided are free except for housekeeping, meal delivery, home repairs and assistive equipment such as bathtub bars. Housekeeping services such as laundry and home cleaning are charged based on an assessment of income. CLSC resources are limited and provided to those deemed neediest. Thus, many clients receive inadequate amounts of CLSC resources and often such individuals must rely on the private commercial sector for care services.

A breakdown of the costs of long-term care services for fiscal year 2006 was provided by Quebec's Ministry of Health and Social Services (*Ministère de la Santé et des Services Sociaux*, 2006). Public subsidies for public nursing homes and private, but publicly subsidized, homes was C\$1.474 billion. The cost of administering such services was C\$594 million. Intermediate care and family subsidies amounted to C\$116 million. Other services such as day care centers and elderly care centers amounted to C\$177 million. Professional and other services in the home amounted to C\$299 million and subsidies for domestic aides was \$21 million. Other services such as transportation and coordination of care amounted to C\$24 million. The overall total of these costs was C\$ 2.701 billion. A 2011 report by a group representing hospitals, long-term care and community health centers in Quebec, *Association Québécoise d'Établissements de Santé et de Services Sociaux* (AQESSS), noted that Quebec currently spends a modest amount on home care — C\$418 million as compared to C\$1.7 billion on long-term care facilities and intermediated care resources (Quebec Releases \$200 M Aging at Home Plan 2011). In Fiscal Year 2009, 44.4 percent of Quebec's budget was dispensed for health and social services (*Ministère de la Santé et des Services Sociaux*, 2008). Demographic trends indicate that the organization and delivery of services to the elderly may be of concern for future public policy in Quebec (*Institute de la Statistique du Québec*, 2003). In 2008, an estimated 14.7 percent of Quebec's population was 65 years of age or older and

6.8 percent was 75 years of age or older. For 2038, it is estimated that 28 percent of Quebec's population will be 65 years of age and older and 16.1 percent will be 75 years of age and older.

The Scope of Long Term Care Services and the Establishment of Quality Standards

Because the demand for public long-term care had outstripped supply, a climate of "quiet acquiescence" has prevailed under which private commercial nursing homes and residences for the elderly were allowed to proliferate without government oversight or quality control. In such facilities standards of care and the training of persons caring for the elderly were often below standard (Bravo et al. 1998, Shapiro 1998). This situation has changed in recent years, and any facility that offers services to the elderly are must now obtain a license from a regional health and social service agency that is certified by Quebec's accreditation body, the *Conseil québécois d'agrément*. The standards regarding resident safety and health care services are set out in "An Act Respecting Health Services and Social Services" (Canadian Legal Information Institute 2011). Thus the principal of public accountability has been established at the provincial level in Quebec (Minow 2003, Romanow 2002). However, the maintenance of accountability in Quebec is limited. Quebec has a Ministerial website that tracks inspections. However, there is no requirement of annual inspections, so that CHSLD residences are only inspected every few years (McKie 2007). For such residences, there was a significant backlog of inspection (*Ministère de la Santé et des Services Sociaux* 2011). As of Fiscal Year 2010 the Capitale Nationale area, 9 such residences had not been inspected since Fiscal Years 2004 and 2005; for the Montréal area, 18 such residences had not been inspected since Fiscal Years 2004 and 2005 and in the Montérégie region 12 such residences had not been inspected since Fiscal Years 2004 and

2005 (*Ministère des Santé et Services Sociaux* 2011).

In 1990, almost 100,000 accommodations for the elderly were available in private unlicensed residences for the elderly. This represented almost 75 percent of accommodations for the needy elderly (Charpentier 2002). In these residences, which were actually designed for residents who could care for themselves, 64 percent of inhabitants had experienced a loss of autonomy. This situation reveals the extent to which the province had delegated to the private commercial sector its responsibility to supply the needy elderly and persons experiencing a loss of autonomy with the housing and care that they needed. Indeed, this delegation of responsibility had taken place in the absence of any support or structure to ensure the quality of these residences. It was not until October 2003 that Quebec's Ministry of Health and Social Services published guidelines entitled "Quality Living Environments for People in Long-Term Care Hospital Center"[sic] and began visiting such residences to monitor the quality of services (*Ministère de la Santé et des Services Sociaux* 2004). Private, usually commercial, facilities for the elderly have been part of the Quebec landscape for so long that when the issue of private commercial facilities in health services began to surface, such facilities were "out of the searchlight."

In response to the growing demand for community care for the elderly, in the early 2000s the number of elderly homes and private services for the elderly began to grow. In 2005-2006, 55 percent or 72,006 of Quebec's 130,929 accommodations for elderly people experiencing a loss of autonomy were in private, for-profit residences; 28.9 percent were in CHSLD¹-type residences. 22.7 percent or 29,668 accommodations in public residences, 4.3 percent or 5589 accommodations in private residences with agreements with the public system, and 1.9 percent or 2467 accommodations in private residences without such agreements; a little over 10 percent were managed by private non-profit entities (6.7 percent

1 CHSLDs (centres d'hébergement et de soins de longue durée) refer to public nursing homes that provide medical and nursing care and supervision.

or 8819 accommodations in non-profit housing, 0.1 percent or 124 accommodations in housing cooperatives, and 3.4 percent or 4432 accommodations in religious communities); almost 5 percent were in a non-institutional milieu (1.9 percent or 2538 accommodations in intermediate resources)² and 3 percent or 3913 accommodations in family-type lodging; 0.7 percent or 960 were in low-rent housing facilities with services for the elderly; and 0.3 percent or 413 were in “innovative facilities”³.

With respect to nursing home care, a higher proportion of nursing home facilities are publicly owned, although there are many private for-profit nursing homes (*privé conventionne*). However, the *privé conventionne* must follow strict regulatory mandates with respect to admission criteria and procedures, entitlement and out of pocket spending levels. These criteria are identical with those required of publicly operated nursing homes (Béland 2003).

Also, the standards of care in residences for the frail elderly has been slow to be implemented. In 2005, the Charest government promised that it would improve supervision of the care of the elderly in such public and private residences for the frail elderly. It set a deadline of June, 2009 for the certification of all private residences for the elderly by government inspectors. Nevertheless, by March, 2010, only 20 percent of Quebec’s 2,200 private residential homes for seniors had been certified following an inspection. Also, the criteria for such residences are less rigorous than for licensed long-term care facilities and such licensing will be categorized according to the care needs of residents (Quebec is Planning to Tighten Up the Certification Process... 2010).

Also, no nursing homes in Montreal had had its certification revoked even in the wake of some serious complaints (Quebec’s Elderly Deserve Much Better

2010). According to the Quebec ombudsman Raymonde Saint-Germain in her 2009-2010 report, Quebec has not yet developed a workable system of insuring safety in Quebec’s nursing homes. Some situations that have arisen are residents left in diapers because there was insufficient staff to accompany needy residence to the toilet; some residents are bathed at 5:30 A.M. because that is convenient for the employees; in some nursing homes, meals are rushed to accommodate staff and violent ambulatory residents are not separated from those who are frail and have limited mobility. According to Saint-Germain’s report in one nursing home: “The resident’s were awoken at 5:30 A.M. The orderlies quickly dispensed personal care, in order to stay within a specific schedule. As a result, it sometimes happened that the users’ hygiene and clothing was neglected. Meals were then rushed in 30 to 40 minutes” (Séguin 2010). Complaints regarding nursing homes had increased by 38 percent over the previous year, mostly with regard to inadequate assistance with respect to proper hygiene services, meals and personal care (Séguin 2010). Saint-Germain indicated that inspection of nursing homes needed to be more rigorous and more systematic (Séguin 2010). Nevertheless, Quebec’s government indicated that it intended to trim its annual inspection rated of nursing homes from 12 percent of such centers to a 10 percent rate (Quebec’s Elderly Deserve Much Better 2010).

Integrating Health and Social Services

Also, in the late 1960s and the 1970s, Quebec established a network of integrated health and social service organizations. In 1968, this system consisted 160 nonprofit, community operated health and social service organizations that, as we have previously noted, are known as *Centres Locaux des Services*

Communitaires (CLSCs). Further increases in the number of CLSCs took place particularly in the early 1970s and again in the 1980s (Gaumer and Fleury 2009). The CLSCs provided at the primary care level, basic health and social services of both a preventive and curative nature as well as rehabilitation and reintegration services to the population in the areas served by the CLSC. Such services fell under the provincial governments oversight and assessment (Palley and Forest 2004, Soderstam and Bozzini 1994). Agreements entered into by CLSCs have varied. Some CLSCs contracted out services to both private nursing homes and home care agencies — both for-profit and non-profit agencies. Fifty percent of the CLSC budget involves the provision of home care. Also, with the closing of hospitals, CLSCs retrained formerly hospital-based nurses for community care functions (Soderstam, Tousignant and Kaufman 1999). CLSCs are involved in integrated care projects but their involvement has varied in the different *Centres de Santé et des Services Sociaux* (CSSSs) of which there are 95 throughout Quebec in Quebec’s 18 regions. In 2008, there were 90 CLSCs of which two were unattached and 88 were integrated in CSSSs.

CLSCs increasingly became involved in key community-based long-term care programs such a PRISMA (Program for Integrated Services for the Maintenance of Autonomy) in the Sherbrooke and Bois Francs areas (Archambault and Bonin 2001). The PRISMA model which we will examine in more detail has become the main focus in Quebec for an emphasis on community-based long-term care that hopefully will reduce the need for institutional nursing home care.

Quebec has experimented with two models of integrated long-term care services (one of which is the aforementioned PRISMA) with the goal of sustaining independent living in the community for as long as is appropriate.

2 In Quebec, intermediate resources refer to lodging whose services exceed those offered by family-type lodging but are less comprehensive than those offered by an institution.

3 These projects were financed through an invitation to tender entitled: “A new partnership in the service of the elderly: Innovative projects” [translation ours], explanatory document 2004-2005, 2005b — of the Ministry of Health and Social Services. The clientele targeted by the projects was anyone experiencing simultaneous physiological, psychological, social and/or functional difficulties that compromised his/her autonomy and caused him/her to need specialized professional services and an assisted living environment that could be furnished outside a CHSLD.

Both of these models have been semi-independent nonprofit ventures. The goal of these ventures has been to establish an integrated continuum of care services that would be provided in the care most appropriate to the needs of the predominantly elderly clientele (Palley 2003, Deber 2002; for an additional perspective on appropriateness see Redberg, 2011). In some ways, the precursor of these initiatives has been the U.S. PACE Program (Program for All-Inclusive Care for the Elderly).

The PACE Initiative

The PACE model is a U.S. federal government option under the Medicare Program (for the elderly and the disabled) and a state option under the means-tested Medicaid Program. Enrollment is primarily targeted on the community dwelling frail elderly, aged 55 and older who are eligible for admission to a nursing home and who are dually eligible for both the Medicare program and the means-tested Medicaid Program. It provides full funding of necessary care and is administered by the U.S. Centers for Medicare and Medicaid Services (Béland, et al. 2007).

The PACE model for achieving integration of services has been summarized by Kodner as:

1. Financing through the pooling of Medicare and Medicaid revenues along with the total control over all programme expenditures and the authority to use these prepaid, capitated funds flexibly.
2. Service delivery largely provided by the staff of the adult day health centre with outside contracts for specialty medical services, acute hospitalization and nursing home care.
3. Case management by a multidisciplinary team responsible for comprehensive assessment, service provision and arrangement, care coordination and clinical monitoring.
4. A focus on prevention, rehabilitation and other clinical efficiencies driven by consolidated service delivery and risk-based capitation." (Kodner 2009, 70)

The range of services provided by the program may include both housing as well as a number of in-home and community-based service alternatives to nursing home care. Where appropriate nursing home care will also be provided. The program makes use of gerontological teams including physicians, nurses, social workers, occupational and physical therapists, nutritionists, as well as clients and family members, in making assessments on service delivery and developing service plans (Centers for Medicare and Medicaid Services, 2008). PACE serves individuals who are certified by their states to be nursing home eligible, are living safely in their community at the time of enrolment and live in a PACE service area. Although certified as nursing home eligible, only about 7 percent of PACE participants are residents of nursing homes (National PACE Association 2008). In 2007, 42 PACE sites were in operation in 22 states. These sites were all not-for-profit organizations. The PACE model is one that develops a long-term care program with vertical integration with respect to appropriate levels of care and continuity of care without the barrier of vertical silos (Palley 2003). Moreover, it integrates the health needs of the frail elderly with their social needs. The role of the U.S. state in securing a PACE program is as follows:

"For a health plan to be approved as a PACE program, the state must elect PACE as a voluntary State option under its Medicaid plan. In addition, the prospective PACE organization and the State must work together in the development of a PACE provider application. On behalf of the prospective provider, the state submits the application to the Centers for Medicare and Medicaid Services (CMS) with the assurance of the state's support of the application and its contents. Each approved state program receives a fixed amount of money per PACE recipient regardless of the services the participant utilizes." (NREEP 2007)

PACE differs from the Quebec initiatives as most services are provided

within a single organization and the funding is centralized within PACE. Also, it operates under national policy parameters from the federal Centers for Medicare and Medicaid Services. In addition, health care providers are salaried — including physicians and it services only the section of the older community that is eligible for the means-tested Medicaid Program as well as the insurance-based Medicare program.

The SIPA and PRISMA Programs

Quebec's SIPA Program (*Système de Soins Intégré pour Personnes Âgées*) was also a fully integrated model of care. SIPA was a community-based, primary care focused, case-managed health care system that targeted the frail elderly (Bergman et al. 1997).

SIPA was a model developed by the McGill University/Université de Montréal Research Group on Integrated Care for the Frail Elderly. The SIPA project was implemented at two Montreal CLSCs for a 22 month period between June 1999 and March 2001. As we have previously noted, the CLSC is a local, publicly run community-focused clinic that until recently has been responsible of community-based health care and home care in Quebec (Gaumer and Fleury 2009). Two CLSC-based SIPA groups each with their own budget and staff were responsible for implementing the integration of community health and social services, as well as the coordination of hospital and nursing home care for about 160 patients per site (Béland, Bergman and Lebel et al. 2006). Enrollment in the program was limited to community resident elderly persons 64 years of age and older who resided in the two CLSC demonstration areas — and who had moderate disabilities and caregivers who were willing participants. The CLSCs provided most health care and community-based social services. The more specialized services needed were provided by hospitals, nursing homes and other contracted providers (Béland, Bergman, Lebel et al. 2006). While SIPA had a

single point of entry and a single assessment team, it was involved in coordinating services that were within the community but not under a single administrative roof.

Other aspects of the demonstration were:

1. A multidisciplinary team consisting of participants' personal physicians, nurses or social workers (acting as case managers), therapists, home care workers and sometimes nutritionists and pharmacists, assume total clinical responsibility in all settings.
2. A battery of evidence-based geriatric techniques, including multidisciplinary clinical protocols, intensive home care, 24-hour on call availability and rapid team mobilization (were) used to minimize functional decline, reduce inappropriate institutionalization and maintain community living for as long as possible.
3. Payment based on prepaid capitation [was] designed to insure responsibility for a full range of health and social services covered by the programme... (this part of the design was never implemented)." (Kodner, 2009)

The results of the SIPA demonstration were reported by Béland et al. in 2006. Some of these results were as follows: the program was effective in increasing access to community-based health and social services and in reducing acute hospitalizations by 50 percent for patients that could be appropriately care for in the community — thereby greatly reducing "bed blockers." While positive patterns were indicated in eliminating unnecessary use of hospitals and nursing homes, no significant differences between the experimental and control groups were found with respect to utilization of emergency rooms, hospitals or nursing home stays or overall costs of care. Neither were there significant differences between health outcomes of total costs between the SIPA experimental or control groups. While the SIPA experiment was temporary and therefore was not expanded, the elements of deinstitutionalization and community

care noted were seen both in SIPA and OECD (Organization for Economic Cooperation and Development) settings as having the potential for impacting inappropriate institutionalization and in other settings for reducing the level of health care costs (Johri et al. 2003).

A second model in Quebec for integrating health and social services which has proven to be more successful in terms of benefits for the experimental group is, as we have earlier noted, PRISMA (Program of Research to Integrate the Services for the Maintenance of Autonomy). PRISMA is a project of the province of Quebec that provides "virtual integration" through the provision of a single entry point for services for the frail elderly and coordination between a variety of agencies (rather than integration within a single organization). PRISMA represents an operationalization of Quebec's commitment to the development of Individualized Service Plans (IPs) as a key element for the provision of services to the frail elderly (Ministère de la Santé et des Services Sociaux [MSS], 2001).

As Réjean Hébert and his colleagues (2003) have note PRISMA is characterized by

1. coordination between decision-makers and managers at the regional and local level,
2. a single entry point for assessment of service need,
3. a case management process,
4. The development of individualized service plans.

The mechanisms for implementation are:

1. A single assessment instrument combined with a client management system based on an assessment of the clients' functional autonomy, A computerized clinical chart for coordination between institutions and clinicians in order to monitor the client,

These tools both facilitate:

1. The delivery of services adopted to client needs,
2. The monitoring of resources and the management of the supply of services — focusing on effectiveness and efficiency.

As this model was developed for a publicly funded system, the funding of the system was negotiated between the public partners and capitation funding was neither essential or required. Also, physician providers were resistant to the idea of capitation arrangements.

Procedurally in the PRISMA system, a single entry point can be accessed by an older person or family caregivers or professionals by telephone or written referrals. A link connects to the Health Info Line available to the general population of Quebec for 7 days a week and 24 hours a day. Clients are referred to the Integrated Service Delivery (ISD) system after a brief needs assessment that insures that they meet eligibility criteria for PRISMA. The criteria are that the individual must be over 65 years of age; present moderate to severe disabilities; show good potential for staying at home and need two or more health care and social service needs. Clients are assigned a case manager whose functions include:

- Evaluating client needs
- Planning necessary services
- Arranging to admit the client to such services
- Providing the organization and coordination of support
- Directing the multidisciplinary team of practitioners involved in the case, and
- Monitoring and reevaluation of the client.

The case manager is not only responsible for coordination of services but also plays an active role delivery of services to the client in his or her area of professional expertise and also has the function of intervening when nec-

essary with involved institutions and services. The organization of services is based on the findings of the assessment instrument. This instrument is the SMAF (*Systeme de Mesure De l'autonomie fonctionnelle* — Functional Autonomy Measurement System). The SMAF is a WHO 29 item scale to measure degree and area of disability.

In addition to the degree of disability, resources available to compensate for the disability are also assessed and both a needs score and budget estimate are developed. Furthermore, as of the second PRISMA demonstration program, implementation of the PRISMA system has been facilitated by the use of a continuous information system and the use of computerized tools to facilitate communication and insure continuity of services. All professional practitioners have quick access to a computerized clinical chart (CCC) which provides complete and continuous updated information with respect to the client's status and changes in the intervention plan.

The initial PRISMA pilot was implemented in two of Quebec's CLSCs in the Victoriaville region's Bois Francs section. Preliminary findings from the pilot involved an experimental group of 272 clients and a control group (nonexperimental) of 210. The study took place over a three year period; its findings were that:

"There were fewer clients who experienced a functional decline in the experimental group whose status was moderate to severe disability — but no discernable differences for those with only a mild disability. (This effect was significant at 12 months and remained at 24 months.)" Also, a desire to be institutionalized showed a significant decrease in the experimental group at 12 and 24 months. In addition, caregiver burden was significantly lower in the experimental and than in the control group at 12 and 24 months. While the utilization pattern of acute hospital was similar in both groups, a return to the

emergency room within 10 days of first visit after discharge was significantly greater for the control groups. Also, the risk of institutionalization was greater in the control group.

After the preliminary study, the PRISMA model was extended to three other areas in the Eastern Townships region of Quebec:

- Sherbrooke, an urban setting with a large university regional hospital and a high number of health and social organizations
- The Coatacook region, a rural area with no local hospital
- The Granit region, a rural area with a local hospital.

The impact of the PRISMA model as revealed by further studies in the three above settings showed clear benefits for the frail elderly (Hébert, Dubois, Raïche, Dubuc, et al. 2008). These benefits include a decreased frequency of functional decline, improved levels of client satisfaction and client empowerment. For the health care system, PRISMA resulted in fewer visits to emergency rooms and fewer hospitalizations. They also produced a system focused more in community-based care without significant extra costs.

The PRISMA model is embedded in the health system. It requires a level of reorganization of health and related social care systems. Sufficient availability of home care services and integrated service delivery essential elements of PRISMA are requirements for shifting a hospital centered system, appropriate for dealing with acute diseases to a home-centered system focused on dealing with an older population with chronic diseases. On the negative side, the studies showed an increase in caregiver burden in the experimental group and a corresponding need to develop more home-based services for the program. Nevertheless, PRISMA has been adopted by the provincial government as a model for integrative long-term care in

Quebec. By April 2010, all Quebec regions had computerized clinical charts and client case managers.

SIPA, when operative, followed a Full Integration Model similar to PACE although it did not provide necessary housing as some PACE centers do. Also PACE is a centrally financed prepaid system while SIPA and PRISMA models are not. In PRISMA the case manager works with the existing professional teams in various services while in SIPA the case manager was an essential part of the multidisciplinary team. In PRISMA the unique assessment tool's results with respect to clients and a computerized clinical chart are shared with all partners and services while in SIPA it was utilized for internal purposes only (Hébert et al. 2003).

Some Conclusions

This review has addressed some aspects of both institutional and community-based care for the frail elderly in Quebec. It emphasizes the need for care to be appropriate in terms of the meeting the needs of the elderly with various levels of disability and/or social isolation from in-home care to nursing home care. It also is concerned with care meeting a quality standard and being assessed in terms of public accountability that reflects the most appropriate use of public funds both for institutional and for community-based care. In terms of funding, the far greater share of public revenues is still committed to institutional care. There is a need for greater public accountability for the quality of care delivered in such institutions. Nevertheless, Quebec is seeking to emphasize increased use of community-based and home care in those instances where such care is most appropriate in terms of meeting client needs and it has developed a number of tools to see that appropriateness of care is assessed and care based on such assessment is provided. Also, the infrastructure necessary to support such home and community-based services needs further development.

REFERENCES

- Archambault, Claudine and Lucie Bonin. 2001, October. Réseau de services intègres aux Aînés des Bois-Francs, presentation to the région régionale, Sherbrooke, Quebec.
- Béland, François. 2003, November 25. Professor, Department of Health Administration, University of Montreal. *Personal Communication*. Montreal, Quebec.
- Béland, François, Howard Bergman, Paule Lebel, et al. 2006. Des services intégrés pour les personnes âgées fragiles (SIPA) Expérimentation pour le Canada. *Canadian Medical Association Journal*, 157: 116-1121.
- Béland, François, Howard Bergman, Paule Lebel, et al. 2006. A system of integrated care for older persons with disabilities in Canada: Results of a randomized control trial. *Journal of Gerontology: Medical Sciences*, 61: 367-373.
- Béland, François, Howard Bergman, Paule Lebel and Silvia Hummel. 2007. Des services intégrés: une expérience québécoise, 219-243. In Marie-Josée Fleury, M. Remblay, Paule Lebel and Silvia Hummel, eds., *Le Système Sociosanitaire au Québec: Régulation, Gouvernance et Participation*. Montreal: Gaëtan Morin.
- Bergman, Howard, François Béland, Paule Lebel, et al. 1997. Care for Canada's frail elderly population: Fragmentation or integration. *Canadian Journal of Aging*, 61 (4): 367-373.
- Centers for Medicare and Medicaid Services (CMS). 2008, December 20. *Program for All Inclusive Care for the Elderly (PACE)*. Accessed at www.cms.hhs.gov/PACE.
- Bravo, Gina, Michele Charpentier, Marie-France Dubois, Philippe DeWals and Aline Éline. 1988. Profile of residents in unlicensed homes for the aged in the eastern townships of Quebec. *Canadian Medical Association Journal*, 159 (2): 143-148.
- Canadian Legal Information Institute. 2011, March 11. *An Act Respecting Health Services and Social Services*, R.S.Q. c. S-4.2. March 11, 2011, Ottawa, Ontario.
- Deber, Raisa B. *Delivering Health Care Services: Public, Not-for-Profit or Private? Discussion Paper Number 17*. Saskatoon, SK: Commission on the Future of Health Care in Canada, 2002.
- Demers, Louis and André Tourigny. 2009. Peut-on importer le modèle d'intégration des services aux aînés en perte d'autonomie à la santé mentale. *Santé Mentale au Québec*. 34 (1): 239-244.
- Gaumer, Benoît and Marie-Josée, Fleury. 2009. CLSCs in Quebec: Thirty years of community action, 87-103. In Howard A. Palley, ed., *Community-Based Programs and Policies: Contributions to Social Policy Development in Health Care and Health-Related Services*. Abingdon, U.K. and New York: Routledge.
- Hébert, Réjean, Marie-France Dubois, Michel Raïche, Nicole Dubuc, et al. 2008, February. The effectiveness of the PRISMA integrated service delivery network: Preliminary report on methods and baseline data. *International Journal of Integrated Care*, 8: 1-15.
- Hébert, Réjean, Pierre J. Durand, Nicole Dubuc, André Tourigny, et al. 2003, March. A new model of integrated service delivery for the frail older people in Canada. *International Journal of Integrated Care*, 3: 1-8.
- Institute de la Statistique du Québec. 2003. *Perspectives Démographiques, Québec et Régions, 2001-2051*. Québec du Ville (QC).
- Kodner, Dennis. 2009. Integrated service models: An exploration of North American models and lessons, 68-80. In Jon Glasby and Helen Dickinson, eds., *International Perspectives on Health and Social Care: Partnership Working in Action*. West Sussex, U.K. and Ames, Iowa: Wiley-Blackwell.
- McKie, David. "Beaten Down: Fear and Violence in Canada's Nursing Homes." 2007, October 22. *CBC News*.
- Ministère de la Santé et des Services Sociaux. 2011. *Rapports d'Appréciation des CHSLD Visités par Région*. Gouvernement du Québec. Le Ministère, Québec, Québec.
- Ministère de la Santé et des Services Sociaux. 2008, Mars. *Budget de Dépenses, Secrétariat du Conseil du Trésor du Québec MSSS, SDI*. Gouvernement du Québec. Le Ministère, Québec, Québec.
- Ministère de la Santé et des Services Sociaux. 2006. *Coûts des Programmes du MSSS Courant*
- La Perte d'Autonomie, 2005-2006 (en Millions de Dollars)*. Gouvernement du Québec. Le Ministère, Québec, Québec.
- Ministère de la Santé et des Services Sociaux. 2001. *Orientations Ministérielles sur les Services Offerts aux Personnes Âgées en Perte d'Autonomie*. Gouvernement du Québec, Le Ministère, Québec, Québec.
- Minow, Martha. 2003. Public and private partnerships: Accounting for the new religion." *Harvard Law Review*, 116 (March): 1229-1270.
- National PACE Association. 2008. What is PACE. Arlington, Virginia.
- NREEP. 2007, June. *SAMHA's National Registry of Evidence-Based Programs and Practices: Program for All-Inclusive Care for the Frail Elderly (PACE)*. Accessed at www.nreep.smahsa.gov/prgramfull_details.asp. February 3, 2009.
- Palley, Howard A. and Pierre-Gerlier Forest. 2004. Canadian fiscal federalism, regionalization, and the development of Quebec's health care delivery system. *New Global Development: Journal of International and Comparative Social Welfare*, 20 (2): 87-96.
- Palley, Howard A. 2003. Long-term care for the elderly: Building a continuum of care. *Journal of Health and Social Policy*, 16 (3): 7-18
- Quebec is planning to tighten up the certification process for private residential homes for seniors. 2010, November 12. *Health Edition*, 14(44):3.
- Quebec releases \$200M aging at home plan. 2011, March 11. *Health Edition*, 15(10) <http://www.healthedition.com/article.cfm?articleID=9095>. Accessed May 12, 2011.
- Quebec's elderly deserve much better." 2010, October 8. *The Montreal Gazette*, A20.
- Redberg, Rita F. 2011, May 26. Squandering Medicare's money. *The New York Times*, A27.
- Romanow, Roy. 2002, April 16. Romanow speech to the Truro Chamber of Commerce." Truro, Nova Scotia.
- Séguin, Rhéal. 2010, October 1. Ombudsman says province must act on unacceptable practices in nursing homes. *The Globe and Mail*, A16
- Shapiro, Evelyn. Market forces and vulnerable elderly people: Who cares?
- Canadian Medical Society Journal* at <http://www.cmaj.ca/cgw/reprint/159/2/151.pdf>. Accessed March 2, 2010.
- Soderstam, Lee, Pierre Tousignant and Terry Kaufman. 1999, April 20. The health and cost effects of substituting home care for inpatient care: A review of the evidence. *Canadian Medical Association Journal*, 160: 11.

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