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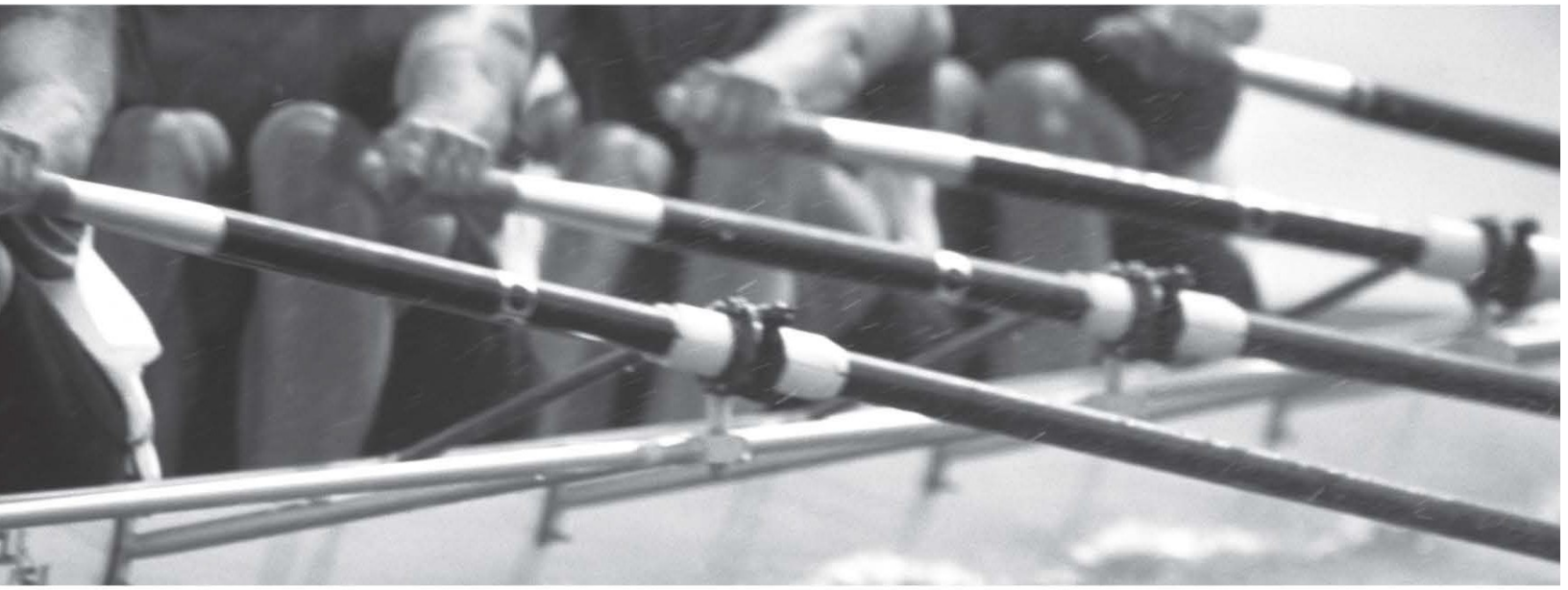

Review of Community Living BC
Efficacy and Progress to 2011

November 2011

Executive Summary

In 2005, government devolved responsibility for the delivery of services for adults with developmental disabilities to a new crown corporation, Community Living British Columbia (CLBC). CLBC has undergone (and undertaken) a number of reviews of its operations since then, focusing on the appropriateness of its new service delivery system, attempts to develop and introduce efficiencies in its work, and supporting policies and procedures.

This review was commissioned by the Ministry of Social Development (MSD), CLBC's main funder, and the Ministry of Finance, with a mandate to look at three broad topics:

1. The efficacy of CLBC's service delivery system and operations, with particular consideration of:
   a) Caseload data and forecasting methodology;
   b) The Request for Service List;
   c) Efficiencies that CLBC has introduced as well as opportunities for additional efficiencies; and
   d) Performance monitoring metrics;
2. Progress made by CLBC in implementing 27 recommendations from a 2008 review of its service delivery system; and
3. The wider service delivery system for people with developmental disabilities in BC, through consideration of:
   a) Service delivery systems and supports in selected comparator jurisdictions;
   b) The range of services that are available through British Columbia's various government sources; and
   c) Options for consideration in moving forward with improvements to the service delivery system.

The overall objective of the review was to provide government with a sense of CLBC's progress on these key topics, and to present some wider context for the service delivery system that serves people with developmental disabilities in BC. It was designed as a means of providing options for future consideration about CLBC's direction, rather than as a review that would result in clear recommendations for proceeding on the above matters.

During the course of this review, a concurrent review was commenced by the Internal Audit and Advisory (IA) Branch of the Ministry of Finance, which altered the focus of this review. In particular, the IA review took an examination of CLBC's operations, with a thorough and comprehensive analysis of CLBC caseload and RFSL systems and processes. Accordingly, this review provides an overview of those two items, but these are considered in greater detail in the IA report, which provides recommendations for proceeding on those points.

In addition, during the course of the review its sponsors requested that a more focused inquiry be made with respect to the various needs assessment tools that are used across jurisdictions to evaluate individuals' disability-related needs and assign appropriate resources to meet those needs. While much work must still be done to fully understand these tools, this report provides an initial assessment of the main characteristics of the leading assessment tools.

Over 100 documents were considered in the course of this review, including internal CLBC data summaries, policies and procedures; and public documents from BC and around the world. In addition, individual interviews were held with leading individuals from CLBC, MSD, and other organizations to obtain their input on the topics of inquiry.

Key findings set out in this review include the following:

1. Efficacy of CLBC

Caseload

Caseload growth has caused concern both within CLBC and among wider stakeholders. Growth is based on two factors: higher numbers of younger people coming to CLBC on turning 19; and larger numbers of older clients coming to CLBC throughout their lifetimes. The first of these factors is highly predictably and CLBC's projections are very accurate in this respect. While the second is less predictable, with unknown factors affecting caseload projections, CLBC has reasonably used data from the last three to five years to try to predict future growth in this area.

Linking caseload projections to cost projections is extremely challenging under the current service delivery model, which is built around assessing needs and allocating appropriate resources at a very specific, individual level. Over time, it is likely that cost estimates will be more accurate, as CLBC has better data to draw on for an understanding of how individual-based need translates into financial support. Until then it will continue to be challenging to estimate both the number of older clients who will present for service in the course of a year, and the cost of serving each year's new cohort.

Request for Service List

Managing and communicating information about the RFSL has been an intense challenge for CLBC. While challenging and at times unclear, CLBC's RFSL is an important first step in trying to rationalize, prioritize, and provide services to the people that need them most in a context of budget restrictions. It is a sound tool conceptually, if the conceptual starting point is to provide services based on the highest established need, within a fixed budget cap. Work remains with respect to clarifying processes and methodologies and communicating the function of RFSL. The concurrent IA review will provide more guidance in these areas.

Efficiencies realized and anticipated

CLBC has made significant progress in terms of identifying and capitalizing on potential efficiencies, including its contract review process resulting in the identification of $24.87M in contract efficiencies. This has been re-invested in the organization, allowing CLBC to expand the reach of its services and address the needs of people on its Request for Service List even within its budget restrictions. This work will continue, as CLBC continues to implement its contract management system, automate contract monitoring business processes to enhance reporting compliance, automate service providers' periodic reporting of individual participation in services to provide data to support individual resource utilization, and automate its payment interface.

Work remains to be done in some areas, particularly with respect CLBC's communications strategy and processes, an increased emphasis on employment services and the use of community and natural supports.

Performance Metrics

CLBC has implemented significant improvements to the MIS, performance measures and reporting capabilities it inherited from MCFD upon devolution in 2005. Overall MIS and performance metrics have been developed and implemented in five areas (service delivery, financial, innovation and communications, quality of life and safety, and human resources). Although measuring clear outcomes is not equally robust at this point, CLBC is the process of integrating this into its performance metrics.

Each ministry or agency that serves people with developmental disabilities appears to have its own performance measures. These inter-ministry metrics are not generally linked and there is an opportunity improve alignments in order to more accurately measure need, service delivery options and most importantly, outcomes.

2. Progress on 2008 Recommendations

CLBC has completed implementation of the vast majority of the 27 recommendations that were made in the 2008 review of its service delivery system, policy framework and tools, guardianship policies and procedures, and sustainability. Twenty-five of 27 recommendations are assessed as either *complete* (if the recommendation contemplated an action that was finite) or *ongoing* (if the recommendation was for a more ongoing, systemic action).

Two recommendations still require attention or clarification. Recommendation 4 is *in progress*, but still requires implementation with respect to part of the expansion of the role of facilitator. With respect to recommendation 5, CLBC notes that the expansion of facilitators' ability to more efficiently provide direct-funded respite (within set limits) has been "indefinitely delayed." It is therefore noted as *partly complete*.

3. Wider service delivery considerations

Comparison with other jurisdictions

The service delivery systems and specific levels of supports for people with developmental disabilities in BC was compared with those in Alberta, Ontario, Manitoba, Western Australia and New Zealand. In addition, the State of Washington was compared with respect to its employment programs. These jurisdictions were selected at the outset of the review for their leading practices and/or similarities in demographics.

Services in five general areas were considered: facilitation and referral, residential supports, individual and family supports, employment supports, and income support. Although data was not consistently available across all jurisdictions to make this comparison possible in all categories, overall BC provides a comparable range of individual and family support services, with a moderately high degree of funding per client served, compared with the other jurisdictions considered in this review. BC also provides greater flexibility for a growing number of families through individualized funding models.

In addition, BC spends less per capita on income and employment supports for people with disabilities than Alberta and Ontario (for very comparable results). While BC spends more per capita on individual and family supports, supports which typically help to enable inclusive societies, BC spent less than Alberta and Western Australia on residential supports for people with developmental disabilities

Assessment tools

Currently, the various ministries that provide services to people with developmental disabilities (and disabilities generally) use different assessment tools. This is inefficient and inhibits a standardized comparison and understanding of individuals' needs over time and across service systems.

Most of the comparator jurisdictions use some form of assessment to determine disability-related need and, in some cases, to link resource allocation to that need. The following were considered: the Guide to Support Allocation (CLBC); interRAI's assessment tool (Ministry of Health and part of Ontario); the Support Intensity Scale (SIS) (26 American states, including Washington); and the Estimate of Requirement for Staff Support Instrument (ERSSI) and the Inventory for Client and Agency Planning (ICAP), used in Western Australia and other jurisdictions. All of these have advantages and disadvantages, with SIS being the most widely-used assessment tool.

The Guide to Support Allocation, developed and used by CLBC, presents some strong benefits, including a clear link to resource allocation and minimal implementation and operational costs. The interRAI tool, used by the Ministry of Heath, shows initial promise as a cross-ministry tool, and has been strongly welcomed where it has been implemented. It does not appear to provide a clear linkage to resource allocation however, which could serve as a drawback for adoption as the cornerstone of a more systemic approach to needs assessment.

Services for people with developmental disabilities in BC

The cost of serving people with developmental disabilities is an ongoing concern, for families, CLBC and government more broadly. One of the key questions is that of equity and comparability of services, both with in CLBC and between CLBC-eligible and non-eligible people with disabilities. A first step in bringing greater service level equity across disability categories (so that services are based on need, not category or diagnosis), is to identify how service levels differ.

Consideration of this question is new, and obtaining the relevant data is challenging, but initial analysis suggests that CLBC clients are supported at a much higher level than people who have similar disability challenges but who do not qualify as eligible for CLBC service.

Future considerations

Finally, a number of areas were identified as warranting greater government consideration going forward. These are options that could provide greater equity, predictability, and sustainability of both CLBC services and services for people with developmental disabilities more generally. Key considerations include the following:

Employment services
CLBC is one partner in what could be a much broader shift in the focus of public education to include more vocational and practical life skills training so that people with developmental disabilities have greater opportunities for employment.

Transitioning to adulthood
Despite progress in this area, transition from youth to adult services continues to be an area that requires greater attention from CLBC and MCFD, and coordination from government more broadly. A more integrated approach to transitions planning is now newly underway in some parts of the system, which could be expanded to benefit from earlier expectations management.

Assessment tools and processes
There is a very wide range in the tools and processes that various programs and agencies of government use to assess eligibility and allocate resources. As a result, systemic planning is extremely challenging and fractured and individuals may end with very different assessment outcomes depending on what tool is used. Initial steps are underway to identify options for assessment tools that would have a wider application, and this work must consider the challenges not only of assessing needs in a standardized and appropriate way, but also making resource allocations that are linked to needs assessments.

Disparity in service levels
Much more work is required to fully identify and assess how adults with comparable levels of severe and very severe disabilities, developmental and otherwise, are served by British Columbia's system(s). The approach of Western Australia, which organizes, assesses, and resources services for all people with severe and very severe disabilities, may provide valuable guidance in future inquiries.

Rationalizing the approach to developmental disabilities
Government may also benefit from more fully examining a different approach to developmental disabilities and work towards a system that provides much more predictability and stability, perhaps through the automatic granting of set levels of funding. This would be a long-term shift in public policy, requiring much fuller consideration and inquiry.

Cultural challenges
One of the ongoing challenges with addressing service and funding pressures for adults with developmental disabilities is a sense of entitlement among families in this sector that is often stronger than other sectors. This expectation may be linked to the commitments of various governments to support community inclusion following the de-institutionalization in the 1990s. Addressing this culture should be at the core of any directions that government takes towards the service delivery system for people with developmental disabilities.

Communication
CLBC has experienced considerable challenges with respect to its communications with individuals, families, service providers, government and the general public. Going forward, greater linkages in the communications between CLBC and government could provide each with a better basis for engaging clients, agencies, and the public.

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1.0 Introduction

Community Living British Columbia (CLBC) is a crown agency mandated under the provincial *Community Living Authority Act* with responsibility for delivering supports and services for two groups of adults in British Columbia:

- Adults with a developmental disability, with limitations in intellectual functioning and adaptive behaviour; and
- Adults with fetal alcohol spectrum disorder (FASD) or autism spectrum disorder (ASD) who have significant limitations in adaptive functioning.

Over 3,000 non-profit agencies, private service providers and individual contractors are funded through CLBC, which has an operating budget of almost $710 million (2011-12). These service providers deliver a range of services that include residential supports (with varied models), community inclusion programs and supports, and skills development and employment services. Respite services are also funded, as part of CLBC's efforts to enhance families' abilities to manage and to enhance the quality of life of CLBC clients and families.

CLBC's work also extends to developing and enhancing relationships with other community and generic service providers, all of which form a part of the web of services that people with developmental disabilities can access in British Columbia.

CLBC currently has open files for 13,696 adults with a developmental disability and 181 adults with FASD or ASD. The agency carries out its work through two basic operational areas: planning and community development is undertaken by facilitators; while analysts are responsible for contract development and monitoring. Staff are organized within four service regions, which correspond to health authority boundaries: Vancouver Island, Vancouver Coastal and the North, Frasers, and the Interior. Work in these regions is coordinated by Directors of Regional Operations, to whom both work streams (facilitators and analysts) report.

CLBC came into existence in 2005, when services were devolved from the Ministry of Children and Family Development (MCFD), and since 2008 it has reported to the Ministry of Social Development. The creation of CLBC was part of an evolution in this sector, which started with the closure of BC's three large institutions in the 1980s and '90s. After deinstitutionalization services for people with developmental disabilities were administered directly by government through MCFD (although then, as now, many services are also provided through the Ministry of Health, the Ministry of Education, and other sources).

By further devolving services to CLBC, British Columbia has moved further towards a system where individuals determine their own services and make decisions about their own lives. CLBC's service model is built on identifying disability-related needs that affect specific life goals, then working with clients to secure supports and services to help

address those needs. This is a work in progress – the system that was inherited focused on providing services such as group homes and centre-based day programs, which do not necessarily match need to service, are relatively costly and were not necessarily based on fostering a better quality of life for clients

This report provides an assessment of CLBC's progress as the leader in BC's evolution from institutions to a service delivery system that is based on principles of effectiveness, efficiency, and equity. It is not a comprehensive review of the agency, but rather examines three specific areas:

1. Efficacy of specific components of the service delivery systems (caseload projection, waitlist processes, system efficiencies and performance metrics);
2. Implementation of twenty-seven recommendations arising from the 2008 review of the service delivery system; and
3. Consideration of the overall system for people with developmental disabilities in light of comparisons to other selected jurisdictions.

As this review was commencing, a concurrent review was also undertaken by the Internal Audit and Advisory (IA) Branch of the Ministry of Finance. That review focused on conducting a review of the following:

1. Accountability and Decision-Making;
2. Linkages and Coordination (between branches and ministries);
3. Workload and Cost Drivers;
4. Performance Measures;
5. Contract Management;
6. Operational and Financial Controls; and
7. Cost Analysis.

In addition, the concurrent IA review also examines factors such as CLBC executives' compensation structures; expenses; organizational and regional structures; forecasting methodologies for the transition into adult care; costs and comparisons for services between ministries. Although the IA review was separate from this review, the two processes were collaborative in the sense of sharing documents and information in order to ensure as efficient a process as possible. Commencement of the IA review also resulted in some shifts to the emphasis of this review, as outlined in section 3.0.

Finally, during the course of this review a Deputy Ministers' Committee was established to provide oversight and direction to these reviews and to overall efforts to address challenges in the service delivery structures for adults with developmental disabilities in BC. The advice and direction of this Committee was also considered with respect to the identification and examination of key issues associated with CLBC as set out in this report.

2.0 Methodology

After confirmation of the terms of reference (included as Appendix 1) for this review in late August, interviews were conducted with 16 individuals over the course of September

(participants are included as Appendix 2). Interviews focused on identifying key points of progress at CLBC, outstanding hurdles, and options for moving forward with respect to each of the items identified in the terms of reference. Follow-up questions were put to relevant individuals throughout September and October, to ensure that the information used in this report was current and accurate.

In addition to individual interviews, Queenswood Consulting Group (QCG) participated in key information sessions that were held with CLBC and the Ministry of Finance. These were held in part to answer detailed questions and provide demonstrations of CLBC's processes, procedures and systems to the team from the Ministry's Internal Audit and Advisory Service Branch. Sessions were held regarding CLBC's waitlist policies and processes on October 12, and regarding the assessment tools on October 18.

In September and early October, research was conducted to obtain and analyze information relating to service delivery in the jurisdictions of Alberta, Manitoba, Ontario, Western Australia, New Zealand and Washington state. Considerable documentation was also provided by CLBC, Ministry of Social Development (MSD), Ministry of Children and Family Development (MCFD) and the Ministry of Finance. More than 100 sources of information, including reports, reviews, policies, and financial audits were examined and inform the findings in this report.

In light of the concurrent review being conducted by the Ministry of Finance (see below), emphasis was placed on the elements of this review that examined other jurisdictions' approaches to supporting people with developmental disabilities, efficiencies realized and planned by CLBC, and options for better aligning services within CLBC and across government. As well, this review and report was not aimed at providing actionable recommendations for government, but rather at reporting on progress and identifying areas that look promising for future inquiry.

3.0 Scope

The terms of reference for this review sets out three broad areas of inquiry:

1. Reviewing, assessing and making recommendations related to the efficacy of the CLBC model;
2. Reviewing and assessing CLBC's progress in implementing the recommendations contained in the 2008 *Review of Community Living British Columbia's (CLBC) Service Delivery Model and Policy Tools*; and
3. Reviewing and commenting on government's role in funding and supporting the health and safety of people with developmental disabilities.

For the first area of inquiry, four topics are specified for examination: the efficacy of CLBC's caseload data and forecasts; the efficacy of its Request for Service list; identifying efficiencies that have been realized as well as opportunities for further efficiencies; and the performance metrics that CLBC uses and could use to enhance accountability and efficiency.

During the course of this review, government initiated a second review of CLBC, through the Internal Audit and Advisory Service Branch of the Ministry of Finance. The IA Review takes an analysis of a number of factors that have some overlap with this

review, including workload and cost drivers, and contract management processes and practices. Because of the overlap and in light of the tight timelines for both reviews, MSD approved an alteration with respect to the first two items of inquiry under the Efficacy heading. Rather than undertake a detailed review of CLBC's caseload and Request for Service list, the scope of this review is limited to a description of relevant processes and a discussion of key changes and anticipated future enhancements. While consideration of implications for families, services and finances is still included, more analysis is provided in the IA Report.

Under the second area of inquiry, scope was limited to identifying the key measures that have been implemented in order to implement twenty-seven recommendations that were made in a 2008 review of CLBC's service delivery model. This review was the first comprehensive examination of the fundamental design of the service delivery system and included recommendations with respect to CLBC's policy tools and processes, guardianship functions, and efforts and sustainability, as well as the service delivery model itself. For each recommendation, current status was also identified as part the assessment overall progress.

The third area of this review was to examine the overall service system for people with developmental disabilities in British Columbia. Two primary areas of inquiry were included: comparing how selected jurisdictions allocate resources to support people with developmental disabilities, and identifying the full range of supports that people with developmental disabilities receive in BC from CLBC and other sources.

Five jurisdictions were included in the extra-jurisdictional review, as set out in the terms of reference: Alberta, Ontario, Manitoba, Western Australia, and New Zealand. In addition, the State of Washington was considered with respect to its skills development and employment programs for people with developmental disabilities. Recognizing that it is extremely challenging to draw comparisons because of very different funding models, eligibilities, governance and operational structures, comparisons are made at a high level. Where appropriate, areas meriting further inquiry are specifically noted.

Scope was expanded in this section, to include consideration of CLBC's needs assessment tools and processes, and identifying assessment tools that are used in other jurisdictions. As assessment plays an important role in the process of identifying and obtaining required services, this discussion is included in the chapter that compares and contrasts the service delivery systems in selected jurisdictions (section 6).

Finally, drawing on information from other jurisdictions and from developments within government, this review discusses options for providing services to people with developmental disabilities in BC in a more efficient and rationalized way. The scope of this review did not include a detailed examination of these options, but was limited to identifying and commenting on promising areas for further inquiry and consideration.

4.0 Assessment of CLBC's efficacy

The first of the three broad areas of inquiry in this review looks at CLBC's efforts, successes and challenges in terms of efficacy. As set out in the terms of reference for this review, there are four aspects to this examination of efficacy: caseload data and forecasts, the request for service list, effort at increasing efficiency, and performance metrics. As noted above, efficacy is one of the primary areas of focus of the concurrent IA review, which analyzes the CLBC caseload data and forecasts in greater detail than in this review.

4.1 Caseload

CLBC currently carries a caseload of 13,696 individuals with a developmental disability and 181 individuals with FASD or ASD (September 2011). Concern about CLBC's caseload information has focussed on two issues: 1) the methodology for counting an individual as part of the caseload (i.e. who makes up the caseload?); and 2) the methodology for predicting changes in the caseload (i.e. how is the caseload likely to grow?). Both of these factors are important as building blocks in predicting CLBC's current and projected costs.

In 2009, the Internal Audit and Advisory Branch of the Ministry of Finance conducted a review of CLBC's caseload composition and growth prediction methodology. It reviewed client information including electronic and paper files, relevant policies and processes, and other information regarding CLBC's caseload methodology. It found that the overall methodology was adequate, and made four recommendations:

Definition of "client" in caseload

An ongoing point of confusion with respect to CLBC has been what constitutes its caseload. As noted in the 2009 IA review, while one might expect caseload to include clients who are eligible and receiving CLBC-funded services, the reality is that CLBC's caseload includes people who are both currently receiving eligible and:

1. Receiving CLBC-funded services;
2. Receiving community and generic services; and
3. Not yet in receipt of any services, but on the Request for Service list.

People who are not receiving CLBC-funded services are included for two reasons. First, while CLBC does not directly fund community and generic services, individuals using those services access CLBC support through planning and ongoing ad-hoc issue resolution. For these clients, involvement with CLBC may be minimal after initial planning, but CLBC retains them as a "client" because CLBC provides life-long supports to the individuals they serve. They remain clients in the sense that they are eligible for CLBC supports and have had an assessment that may one day require reassessment and the provision of different services.

Secondly, those who are not in receipt of either CLBC or generic services but are on the waitlist are included as "clients" because they have gone through CLBC planning, have an ongoing relationship with CLBC, and are simply waiting for funding to be available to meet their needs.

These factors have not changed since the 2009 IA review was undertaken.

IA recommended that CLBC work with MSD to come to a shared understanding of "client" for planning and reporting purposes. CLBC indicates that this has been accomplished, although it has perhaps not been effectively communicated, as there continues to be some ambiguity and misunderstanding around what CLBC's caseload is comprised of. Some further communication is still required to confirm that CLBC's caseload consists of 13,696 clients who include eligible individuals that have:

1. Met with a facilitator in order to develop a plan, but are not yet funded for services;
2. Met with a facilitator who has helped the individual obtain community and generic services, but not CLBC-funded services;
3. Obtained and are actively using CLBC-funded services.

It should be noted that in all three categories, people may be on CLBC's waitlist (the Request for Service List, or RFSL), either for new or augmented funded services.

Data quality assurance

The 2009 IA review highlighted some challenges with the caseload data, including human errors in data entry, eligibility errors for children turning 19, and outstanding verification needs for files inherited from government on devolution. There was some concern that these issues may contribute to an overstatement of the caseload numbers.

IA also recognized CLBC ongoing efforts to address data quality, and recommended that CLBC work with MSD to design a data quality assurance program. Towards this end, CLBC has now implemented data quality improvements in its PARIS client information system, including a business rule that requires all active adult clients to have recorded eligibility for CLBC services in the system. On a bi-weekly basis, CLBC extracts any records that do not conform to this rule and forwards them to the relevant regional Community Planning and Development Manager for resolution. The goal is to ensure that CLBC has accurate data for all active clients at the end of each month. This appears to be functioning well, and the current month identified on individual in the system in violation of the business rule – this has since been resolved.

Management reporting

At the time of the IA review, CLBC systems could not provide expenditure reports at the client level, except for some clients receiving residential services. This was due to the inherited practice of contracts being provided at the agency level, not the individual level, and the lack of the collection of individual-level information in contract reporting.

CLBC has been working towards client-level reporting, which will allow for the compilation of better management information, inform decision-making, and support funding requests. This is in line with the IA recommendation that MSD continue to support CLBC's implementation of its contract management system improvements. Efforts in this respect are described earlier in this report (see also section 4.3 regarding implemented and planned efficiencies, and section 5.0 regarding CLBC's progress on implementing recommendations from 2008).

Projections and assumptions

Caseload projections are made up of two key components. One of these is very predictable and accurate, while the other has challenges. Both feed into CLBC's analysis to arrive at each year's caseload projection rates.

The first component of growth is the cohort of individuals who will turn 19 over the course of the year and become eligible for CLBC services. Over the past four years this has been a very reliable predictor, with the number of eligible 19-year olds registering with CLBC approaching the provincial average of 0.95% of the total population of 19-year olds. That is, almost all eligible individuals will come to CLBC in the year they turn 19.

Determining the number of older adults projected to register with CLBC is less predictable, with an unknown number of unserved people in the general population who would be eligible for services. There is no way to predict why or how they apply to CLBC for service, and without an obvious trigger like the end of secondary schooling and/or turning a specific age, people may come to CLBC for different reasons at different times of their lives. A 35-year old who has lived without funded supports may find, with aging parents or a change in their own health, that they now require greater supports, while another individuals may live their entire life relying on family supports and may never come to CLBC for assistance.

The best information that CLBC has in this respect is the evidence of previous years' numbers of new post-19-year old clients. The following table illustrates new post-19 clients over the past five years, in addition to children turning 19 and the total amount of the annual actual caseload growth[1]:

Year	New CLBC clients, "older" adults	New clients, children turning 19	Total new clients
2006/07	181	388	569
2007/08	514	560	1,074
2008/09	316	534	850
2009/10	303	577	880
2010/11	279	631	910

The first year's lower number is likely due to a lack of public knowledge about CLBC as it had only come into being the previous year. 2007/08 saw a considerable increase, in large part due to the *Fahlman* decision and the publicity that surrounded it. Over the past three years, the number of new "older" clients has been relatively stable, and slowly declining. Using this information, CLBC has assumed an average growth about 310 "older" individuals per year when tabulating its annual caseload growth projections.

The IA review examined how CLBC's caseload data linked to its projects and concluded that "current projection methodology is generally appropriate for CLBC's estimation needs." IA pointed out that CLBC's 2008/09 projection was accurate, with projected growth of 6.8% and actual of 5.8%, with the discrepancy due the difficulty in determining client mortality rates.

Subsequent projections have been within a similar range of accuracy: in 2009/10 CLBC forecast a growth of 6.2% while the actual growth was 5.8%; in 2010/2011 the

[1] CLBC: CLBC Caseload, comparison of Forecast and Actual, Sep 11

forecast was 5.5% versus an actual of 6.0%. Current year growth is projected to be 5.1%, and mid-year pro-rated data suggests that it will be about 5.6%.

The overall methodology that CLBC uses to estimate caseload growth is sound. Particularly with respect the larger source of this growth – individuals turning 19 over the course of the coming year – the numbers are highly predictable. For the second component, the approach of using previous years' data as a predictor for the future seems to be the best option available. This indicates a stable but slowly declining growth of about 300 individuals per year.

Taking all of the above into account, there does not appear to be major areas of unreliability with CLBC's current caseload data, nor with the methodology it uses to project future caseload growth. Although the latter is not 100% precise, this is largely due to the difficulty in predicting what might trigger potentially eligible people in BC who have not come forward to ask for service, to do so. Factors such as an aging population (leading to increased health-related needs), and the aging/mortality of custodial parents who have cared for their children without assistance but can no longer do so, may lead to a growth in older individuals. This may be counterbalanced by the overall decline of this cohort as a proportion of CLBC's potential clientele: every year a higher proportion of the caseload will be made up of the predictable component of children turning 19, while the number of "older" adults will decline through natural attrition.

While caseload forecasting is relatively sound and predictable, assessing the financial implications of caseload growth is more challenging. While caseload projections provide a sense of the basic numbers of new clients, it is also necessary to assess what services they need, how much those services are likely to cost, and how their needs will change over time in order to arrive at a financial estimate.

Again, the evidence provided by past trends is the primary way CLBC arrives at these estimates. Residential services are more easily analyzed because the agency's Management Information System (MIS) and contracting systems now record information at the individual level. For other services, there is not yet the ability to track costs back at the individual level, so that coming up with an overall average cost per client is not yet possible.

One option to address this would be to apply an American model, exemplified by the Support Intensity Score (SIS), which essentially assigns a fee charge per service and is described in detail later in this report. CLBC has considered this, but there are significant implications for CLBC's accounting processes in addition to overall processes for assessing need and resource allocation. This approach is also not favoured because it tends to discount individual needs and circumstances, approaching people as service units without considering the range of needs they may actually have.

Instead, CLBC is working to implement a cost allocation process that will include a service provider portal to allow for retrospective reporting on all individuals who accessed a CLBC program or service. Reporting on actual use at an individual level will allow for the calculation of a "per unit" cost, allowing CLBC to estimate costs based on a range of individual characteristics (age, assessed needs, location). CLBC estimates that it will take another two years for this system to be operational.

4.1.2 Summary: Caseload

In summary, while CLBC's caseload growth causes concern among stakeholders, both internal and external, this growth does appear to be based on two key factors: the higher proportion of younger people who are meet eligibility requirements and grow up expecting full services and supports; and the aging population which brings more previously independently-supported people to CLBC each year. The first of these factors is highly predictably and CLBC's projections are very accurate. The second is less predictable, with unknown factors affecting caseload projection.

In addition, linking caseload projections to cost projections is extremely challenging under the current service delivery model, which is built around assessing needs and allocating appropriate resources at a very specific, individual level. This requires an inquiry with each person as they identify themselves as a client. Costs per person vary widely and need to factor in individual needs in addition to alternative support situations, locations, and demographic factors.

Over time, it is likely that cost estimates will be more accurate, as CLBC has better data to draw on for an understanding of how individual-based need translates into financial support. Until then, issues are likely to continue, both with estimating the number of older clients who will present for service in the course of a year, and the cost of serving each year's new cohort.

4.2 CLBC's Request for Service List

CLBC has a budget of $710 million for fiscal 2011/12 to provide a range of community living supports and services to eligible adults, to assist them to live as fully and independently as possible. These services include (for a full explanation of each, see Appendix 3):

Community inclusion
- employment
- skill development
- community-based
- home-based

Residential support
- supported living
- shared living
- staffed residential

Respite
- direct-funded
- contracted

Support for individuals and families
- psychological
- behavioural
- home-maker
- support coordination
- individual planning support

The Request for Service List (RFSL) is CLBC's primary means of managing demand for services that exceeds available funding, by capturing information about services that have been requested by individuals but not yet delivered. The RFSL includes both new clients and individuals who are already receiving services (whether generic community services or CLBC-funded services) but who have requested additional services.

The composition and use of the RFSL has been a main focus of concern about CLBC, due in part to a lack of understanding about the RFSL's scope and the process for individuals who are on the list. An analysis of the RFSL is one of the primary topics of the concurrent IA review. This section provides a summary of the RFSL process with an analysis of CLBC's progress in addressing issues related to the list.

4.2.1 Process

The main purpose of the RFSL is to identify the relative need of individuals, so that those with the most urgent needs undergo planning and resource allocation first. When vacancies or funding become available, analysts look to the RFSL to identify who should be contacted for individual planning, application of the Guide to Support Allocation (GSA), and distribution of appropriate resources.

There are currently 13,696 individuals registered with CLBC in British Columbia, which includes:

- 10,856 individuals who are receiving services and supports appropriate to their needs.
- 2,126 individuals who are currently receiving services but who have also requested additional services.
- 832 individuals who are currently not receiving services.

For those 2,958 individuals who are waiting for new or additional services, urgency of need determines the priority of service delivery. In order to ensure that people with the greatest needs obtain services ahead of those whose needs are not as severe, CLBC relies on a three-step process:

1. Confirmation that the individual meets health and safety criteria
2. Completing of the Priority Ranking Tool
3. Review of the relative ranking of the individual compared to others in the region.

CLBC has no statutory authority to exceed the budget allocated by government. Its budget has not increased proportionate to caseload growth, and maintaining services for existing clients consumes most of the budget. Because of the current funding allocation, only individuals with health and safety needs are considered for new services. This means that the facilitator determines that there is significant risk of harm to the individual due to:

- Abuse or neglect;
- Death or incapacity of the individual's current (unfunded) caregiver;
- The individuals is a child in care turning 19 who will need residential support;
- Homelessness; or
- Disability-related needs, behaviour or health that places them at serious risk.

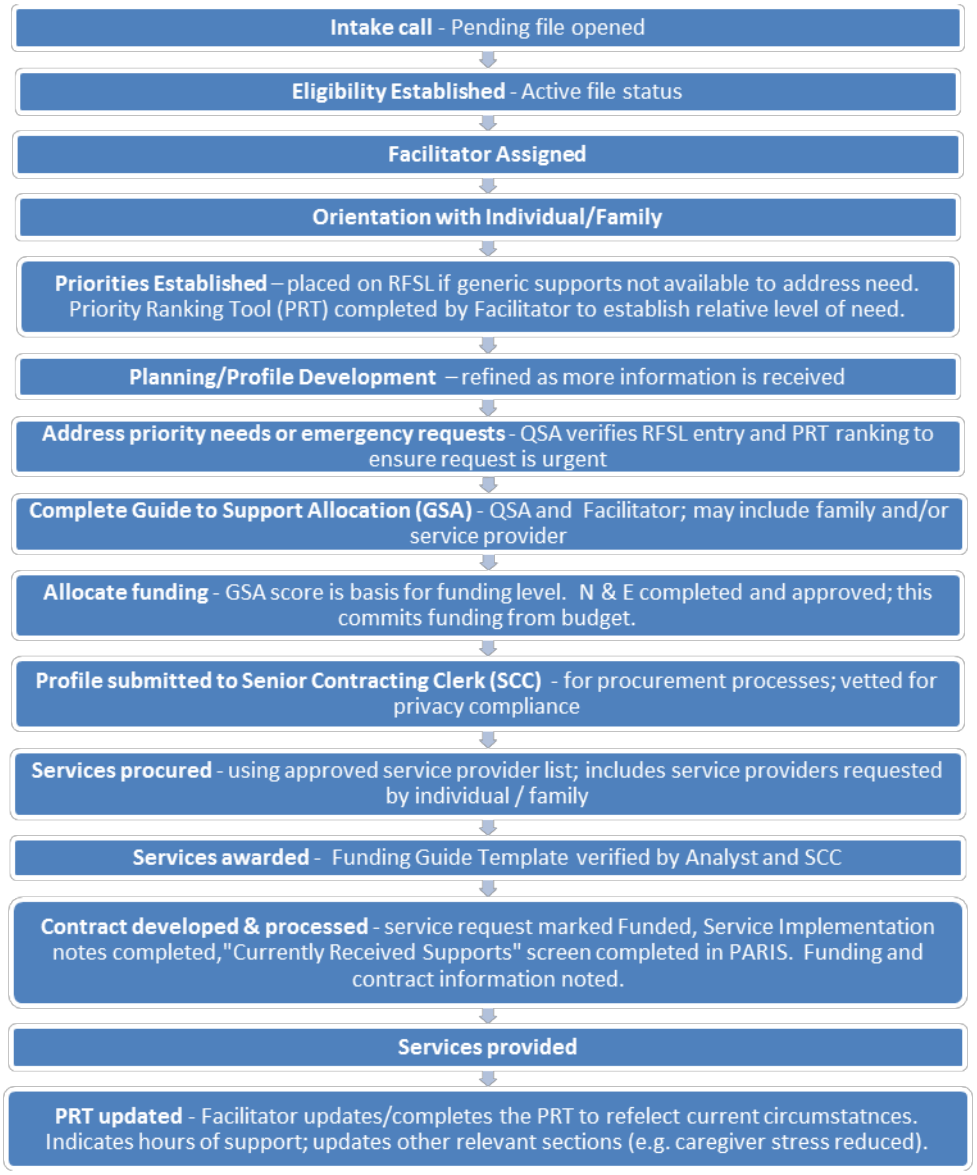
If the individual meets these criteria, the facilitator applies a ranking method called the Priority Ranking Tool (the PRT). The PRT includes questions in 11 categories, each of which is scored from zero (lowest urgency) to five (highest urgency), resulting in a maximum score of 110. Policy guidelines define each category and provide guidance on scoring, indicating circumstances that would correspond to a score of zero or five in each category. The categories are:

1. Housing availability
2. Housing suitability
3. Abuse/neglect
4. Caregiver health
5. Caregiver stress
6. Environmental accessibility
7. Supports (intensity)
8. Supports (impact)
9. Personal financial management
10. Community inclusion and supports
11. Other considerations

When funding becomes available, analysts and facilitators work together to review data for their community and determine which support requests should be funded, based on the individual's position on the RFSL, their PRT ranking relative to others in the region, and whether the request is for new or enhanced services (with new requests having a higher priority). CLBC has indicated that its policy is to provide services within six months for individuals with a PRT over 50. It is also CLBC policy to provide services for emergency requests within 48 hours of notification, where the individual faces:

- Imminent and significant risk of serious harm;
- Death, incapacity or loss of sole caregiver; or
- Statutory or legal requirement.

To put the RFSL within context of the overall process for obtaining services, the following illustrates the general course for individuals who are new clients of CLBC, from initial inquiry to the securing of services:



All eligible individuals who request CLBC services and meet health and safety criteria are added to the list and those with immediate health and safety needs are provided with supports. Individuals already receiving services from CLBC may request additional services, such as respite, residential, community inclusion and/or employment and they would also be added to the RFSL. The list is reviewed on an ongoing basis.

For people not receiving service, the most frequently requested service is community inclusion such as skill development or employment. The most frequently requested residential service is shared living such as home sharing or live in support. The most frequent family support is respite care.

4.2.2 Challenges

There are a number of issues with the Request for Service List. Key challenges include:

Confusion about who is included on the RFSL

As explained above, the RFSL includes people who are currently receiving no services, people who are receiving unfunded generic community services, and people who are receiving CLBC-funded services and have requested additional or enhanced services. Without understanding that the RFSL includes a significant proportion of people who are already receiving service of some kind, many assume that all 2,958 on the list (as at September 30, 2011) are currently going without any services. The result is an exaggerated sense of urgency.

While the demand for services is certainly growing and outstripping available resources (the RFSL included 2,327 individuals one year ago and 1,895 individuals two years ago), the bare numbers do not provide any sense of the more nuanced context. As summarized on the table below, 72% of people on the RFSL currently receive services and are waiting for more. Only 16% have been without any services for more than six months.

September 30, 2011	
Currently Receiving:	**Individuals**
No service, less than 6 months	363
No service, more than 6 months	469
Services equivalent to one day/week or less	593
Services equivalent to more than one day/week	979
Residential Service	554
Total	**2,958**

This is not to say the level of unmet need is not significant. Rather, the issue is one of clearly understanding and articulating what the level of that need is, and how the composition of the RFSL is more complex than simply being a unique number of individuals not receiving any service through CLBC.

Understanding the use of the RFSL

The RFSL is often referred to as a waitlist, although this is not accurate because the list does not track specific individuals who are waiting for specific services. Rather, it simply indicates the number of people who have requested a service, and the relative need of that person. Being on the RFSL does not mean the individual is waiting for a specific services; it includes individuals who have requested services that may not necessarily be provided as an appropriate response to the individual's needs. Instead of a waitlist for specific services, it is more of queue to determine when the individual can have their needs assessed and addressed. This is because CLBC no longer undertakes planning unless funding is first available.

Full assessment of individuals' needs (i.e. individual service planning and the application of the Guide to Support Allocation) only takes place once funding is

available. At that point, appropriate services will be identified, approved and funded, and only then will it be clear what service the individual will actually receive. In this way, the RFSL is more of a queue that prioritizes who should get assessment and allocation of appropriate services first, rather than a waitlist for specific services.

Understanding Priority Ranking methodology

While CLBC has indicated that is policy is to provide services within six months to people with a PRT score of 50 or more, it is difficult to communicate and understand what "50 or more" means for a real individual. The abstract number is challenging to understand and, importantly, to communicate to individuals, families and the general public. In addition, the PRT score is not meant to be a stand-alone determinant, but rather an indicator of *relative need* in the region.

However, even in CLBC's own policy the mandate to provide services for individuals with a score of over 50 indicates an objective requirement rather than a relative need. This further confuses the meaning of the PRT score, the overall RFSL rank, and how these are applied when funding decisions are made.

Linking RFSL to funding requirements

Because the RFSL is applied at the individual level rather than the service request level (i.e. ranking is applied to the individual as a whole rather than to the specific service(s) he or she requires), the list cannot be used as a predictor or funding requirements. Instead, the RFSL is meant to identify an individuals' overall priority of need relative to other individuals in the region, and give guidance on who should be funded first.

This does not allow for cost prediction. In a waitlist such as for health services, once a person is on the list it is clear what their service will be and what it will cost. For those on CLBC's RFSL, all that is indicated is the person's relative level of need, not the actual service they are waiting for (because this has not yet been assessed or approved). So while an individual may have a high rank on the RFSL, it will not be clear how that need will be met. High need does not necessarily translate into higher costs, and the RFSL does not capture that level of information.

CLBC has attempted to bring some linkage to the RFSL's composition and the ultimate cost of meeting those individuals' needs, by applying the lowest cost item as an estimate of what it will cost to serve that individual. This only results in a best case scenario, however, because the lowest cost item may not be the service that the individual needs most, and the estimate can only be based on the average cost of those particular services.

The resulting cost estimates are very broad. For example, over the past two years the most frequently requested services were community inclusion and respite supports, which has significantly reduced the average cost per individual for support. In 2010/11 CLBC implemented 2,231 new services for 1361 people at an average cost of $23,100 per person. On this basis, CLBC estimates it would cost about $19.2 million to provide supports and services for the 832 individuals who currently have no service. Again, this is very broad and does not (and cannot) take into account actual needs.

Application of the GSA in the process

It is current practice for facilitators to apply the Priority Ranking Tool, and to get a sense of what supports and services are being requested from a preliminary review and discussion with the individual and family. Facilitators do not apply the GSA or do detailed planning at that time. As a result, whatever the family requests is added to the RFSL as the requested service, without any assessment of the validity of that request.

This often leads to inflated expectations amongst individuals and families, who believe they are on the list for the specific service they requested. When the GSA is later applied, they may be approved for something quite different and, in their view, insufficient. In this way, the current process leads to both unreasonable expectations from families and an RFSL that may be overstated and may not accurately reflect what CLBC's actual support response will be.

CLBC is considering changing the process, so that the facilitator applies the GSA, and does so at the time the individual is placed on the RFSL. This will allow a request to be pre-screened for appropriateness, through earlier application of the GSA. Because facilitators do not have budget accountability, there is a risk that they will approve higher/more expensive services than analysts might do. However, CLBC is aware of this risk, and managing it is part of the current piloting of the new process. If successful, this will be implemented throughout CLBC within 12 months.

Quality of RFSL data

Current data capture and recording processes are not optimal and do not link well to CLBC's business processes. This is due in large part because information is entered and removed manually from the RFSL, information is sometimes put in the system without full analysis, and there is a lack of linkages between CLBC's various systems.

The system overall is characterized by manual entries, which are vulnerable to human error and inconsistency of application. Manual entry includes:

- Entering a request for service into the PARIS management information system;
- Entering "currently received" services when adding the request for service into PARIS;
- Removing a request for service when it has been funded;
- Adding a request for service as a "currently received" service once it is funded; and
- Re-performing the PRT scoring when a request has been funded.

A particular area of concern is that there are currently no processes to record individual's entry and exit from globally-funded programs like community inclusion and respite. This means the agency cannot track and report on services that are provided under those headings, and cannot assess whether an individual is currently receiving those services on their request for service.

To address these concerns, CLBC has implemented short term measures to improve data quality through retrospective auditing and reporting. Examples include running reports to see if appropriate RFSL adjustments have been made and conducting a

one-by-one review of all requests for service that are on the RFSL for longer than 12 months.

In the medium term, CLBC will develop a process in PARIS that links RFSL requests with new services and required support increases (NSRIs), which are new services implemented by CLBC in the course of a year. Requiring NRSIs to be created in PARIS and will result in automatic updates to the "currently received" services data, and will tag the request for service as funded. Business requirements for this change are currently being defined and refined, and will be implemented in first half of 2012/13.

In the long term, CLBC will address the accuracy of data regarding "currently received" services to account for individuals'' movement in and out of globally-funded services. This will occur by requiring service providers to report retrospectively on individuals accessing programs/services during a given period. Reporting will take place through a contract management system portal, providing information on resource consumption by each individual. CLBC anticipates having to address challenges from service providers in implementing this change, which is planned for 2013/14.

4.2.3 Summary: Request for Service List

Managing and communicating information about the RFSL has been an intense challenge for CLBC. It has also been problematic for families whose sons and daughters are entering into adult care or requiring new service(s). These challenges are heightened when the individual is transitioning from youth to adult services, in part because the service level children and youth is more comprehensive than what is available for adults.

While challenging and at times unclear, CLBC's RFSL is an important first step in trying to rationalize, prioritize, and provide services to the people that need them most in a context of budget restrictions. It is a sound tool conceptually, if the conceptual starting point is to provide services based on the highest established need, within a fixed budget cap. Work remains with respect to clarifying processes and methodologies and communicating the function of RFSL. The concurrent IA review will provide more guidance in these areas.

4.3 Efficiencies realized and anticipated

The next area of inquiry with respect to CLBC's efficacy is an identification of efficiencies that have been realized by CLBC, as well as opportunities for further efficiencies within CLBC's current service delivery model and budget. This section provides a high level description of the means CLBC has used to enhance the use of existing resources, and sets out a number of measures that CLBC indicates it will capitalize on for further service delivery and budget efficiencies.

4.3.1 Efficiencies undertaken

CLBC was founded in 2005 with a number of goals, including a desire to provide services to people with developmental disabilities in a more responsive manner; to provide a stronger voice to community in developing and providing supports and services; and to provide services in a more efficient manner. The 2008 service delivery model review identified a number of areas where the model was not working as efficiently as possible and, since that time, the organization has implemented a number of means to improve the efficiency of its operations. This section outlines a number of the important efficiencies that arose from the 2008 review and from CLBC's general efforts to review and improve its work on an ongoing basis.

Procurement and Contracting

CLBC inherited a system of contracting and procurement from government that was based on a lack of competitive procurement, and a reliance on individually-negotiated contracts with service providers. As a result, the terms, conditions and amounts of contracts varied widely and an inordinate amount of time was spent developing, physically producing, tracking, and re-negotiating contracts with service providers.

The procurement process was time consuming and inefficient. The annual process of individual negotiation, along with a paper-based contract development and amendment process, meant a considerable amount of staff time was spent meeting with service providers, discussing and bargaining about contract details, then writing, approving, signing and filing paper contracts.

Efficiencies were further compromised because contracts were based on block provision of funds to service providers, rather than contracts for services for specific individuals. As a result, it was impossible to track progress and outcomes and the individual level, and it was not even possible to definitively know how many people were served by a given contract.

A number of changes to contracting and procurement policies and procedures has increased CLBC's operations in this area.

First, the "unbundling" of service contracts for residential programs, which is now largely complete, means that CLBC can identify, monitor, and assess the outcomes of the contract for each individual's housing service. Rather than being service/program and location based, contracts are now individual-based, allowing for better tracking, monitoring and outcomes assessment. This is also a fundamental improvement in terms of financial predictability, allowing for stronger forecasting and the identification of opportunities for better efficiencies.

Contracts are now also based on a standardized amount for each particular service. Consistent and fixed funding rates for the inputs required to deliver services are based on industry standards and data, introducing standardization and encouraging service providers to operate as efficiently as possible to realize the best value for their funding.

Reaching agreement with service providers on this point means that there is now a given compensation rate for every category of service CLBC funds, dramatically reducing the amount of time that is required for contract development with service providers. This also allows for better financial predictability and forecasting at a more global level. Further, it enhances fairness and equity as the contracting procedures between CLBC and service providers are more standardized, therefore less influenced by a strong negotiator or previous relationship.

Following on the above, standardized funding templates have now been developed and are used by all providers, reducing the amount of time spent developing, negotiating, and recording service provision contracts.

Overall procurement and contracting practices that fit CLBC's business model and are consistent with government procurement practices have now been implemented. CLBC's Procurement and Contracting Policy, finalized in July 2011, in based on key principles of person-centered planning, transparency, fairness and integrity, value for money, competition and environmental sustainability. Important facets of the policy include:

- Enhanced use of direct-award contracts of under $50,000, with appropriate guidelines for those awards;
- Increased use of pre-qualified vendors lists for program and non-program expenditures, with appropriate guidelines for establishing and using the list
- Clear guidelines for contract solicitation, awarding, and administration procedures; and
- Expedited procedures for contract modification

The new Policy is accompanied by a comprehensive Procurement and Contracting Procedures Guide, with principles, descriptions, direction and key responsibilities for all steps in the procurement process (planning, pre-award and solicitation, contract award and administration, monitoring and vendor relationship management).

The effect of these changes is to improve and streamline contracting and procurement practices, and to align those processes with CLBC's business practices. The support of service providers in developing and implementing standardized service terms, processes and templates is also a key improvement in terms of agency-based efficiencies, as well as overall CLBC-based standardization and financial predictability.

Contract review

In April 2010, CLBC committed to undertaking a one-time initiative to review all contracts managed by the organization, in order to ensure that individuals received appropriate service levels and modalities, and to review the costing set out in all contracts for services. An overarching goal of the initiative is to examine each contract to identify areas where savings could be realized and applied to address the needs of individuals who are not currently receiving services.

This review is now underway, and a standard manner for regions to implement and report on the initiative is outlined in CLBC's Savings Initiatives Tracking Template (SITT), which was distributed to CLBC offices in April 2011. The goal of the SITT tool was to develop a master list of all contracts, track progress in their review, and identify outcomes. This process has allowed regions to a) identify and review all the contracts applicable in their regions and b) review and record contracting processes for each contract. After completion of this initial review, it is anticipated that ongoing contract review will take place as part of the normal course of operations at times of contract modification and renewal. These will then be recorded in CLBC's management information system on an ongoing basis.

The contract review process applies to all contracts except direct home share, individualized funding and microboards. As of August 2011, 696 reviews of staffed residential and community inclusion program contracts had been completed, with another 888 contract reviews still in process. The total amount of savings identified in completed reviews stood at $24.87M (on contracts with a total value of $145.45M), which CLBC will use to apply to caseload growth and addressing the needs of people who are on the RFSL.

As a result of contract reviews, 64 homes have closed in staffed residential services, with 169 people moving into different residential arrangements. In community inclusion service contracts, 33 locations have closed. Where the existing service continued, 166 contracts had no reduction in funding, while 301 had funding reduced. In addition, 17 contracts had an outcome of "additional persons added", 15 had an outcome of "service modality changed", 10 had an outcome of "change in person(s) served", and 45 had an outcome of "funding increased". None of the reviews resulted in people no longer receiving services.

Along with the 888 reviews still underway (estimated savings: $16.05 M on total contract values of $234.63), the contract review process will include an additional 1,303 contracts where reviews have not yet started. There is not yet an estimate of potential savings with respect to the 1,303 reviews that are still pending.

CLBC's contract review process has resulted in considerable savings realized, which have been reinvested to expand services to other CLBC clients. However, this is a one-time process and the savings are not infinite. It is also likely that the most significant savings have already been realized, as CLBC managers focused initial attention on those contracts that were most likely to yield the best returns.

Contract Management system

CLBC's introduction and implementation of a new contract management system is another efficiency, both in terms of administration and staff time, and in improving the organization's ability to identify, analyze, and capitalize on opportunities for service efficiencies.

The Upside CMS system went into production in May 2011, with training for all regional Quality Service staff (i.e. analysts), which has been well received. As of the end of August, 1,440 contracts have been entered into the Upside system, which is

replacing the inefficient, cumbersome, and inconsistent paper-based system that was previously in place for contract management at CLBC.

Implementation will continue over the coming months. By the end of November 2011, CLBC anticipates having fully implemented the Upside CMS, with all staff in Quality Service achieving acceptable competencies. During this time the organization will also build on the contract review initiative, renegotiate all contracts, and convert contracts to the new format with a Funding Guide template where required.

In addition to its contract management system, CLBC has also made significant improvements to its service delivery and client management system. CLBC inherited a system that did not allow for the identification of individual clients, so it could not say who it was serving either at the individual level, or even at the agency level. Since 2008, CLBC has introduced the PARIS system, which provides work assignment management and monitoring of field staff activity and processes. It is also the system repository for individual data, including all service encounter information.

CLBC continues to define all work processes associated with resource allocation and will begin a detailed system design for automating all the various components associated with how it currently allocates resources to individuals and families. Despite advances in this area and the full implementation of PARIS, further development is required to incorporated other business processes into the application, including resource allocation processes and new service approvals.

Resource Allocation Tools

CLBC's development, implementation, and integration into its planning process of resource allocation tools such as the Guide to Support Allocation and Catalogue of Services are positive steps forward in providing for greater consistency in resource allocation based on disability related need. Prior to the introduction of these tools, there was no way to objectively assess what individuals actually required in terms of supports and services, and no way to rationally connect resource allocation to that need.

As noted in an earlier section, use of these tools in tandem with the Priority Ranking Tool and Request for Service List provide and overall framework for identifying who should be served in what order, ensuring that those with the most acute needs receive services first as they become available.

Use of these ranking and assessment tools have allowed CLBC to move from the previous model, where funding was provided to agencies and little consideration was made to the specific needs of individuals, to a system that focuses on accurately identifying actual individual need and then linking funding to that need. These are all steps in the right direction in terms of increasing efficiencies thanks to the availability of better data. It is not perfect, in part because individual-level contract monitoring is not yet available for community inclusion contracts, and also because longitudinal data is required to predict how people's needs change over time. However, these are clear improvements and are built on a framework that is conceptually sound.

While the adoption of the GSA and related tools and processes has allowed for more standardization, predictability, and equity in service provision across the province, this

is only within the CLBC system specifically. Families are still required to deal with multiple assessment processes and procedures, depending on which ministry or agency they seek services from. This is a matter that is considered in a subsequent section of this report.

Functions of facilitators and analysts

At the time of the original review, a major concern with CLBC's service delivery system was the strict division of duties between facilitators and analysts. At its inception in 2005, CLBC divided planning and community development work from contracting services, with physical separation through creation of separate offices. This was widely criticized as contributing to confusion and inefficiencies in how needs were assessed and services allocated to meet need.

In response to recommendations in 2008, CLBC implemented a number of significant changes to the duties of the two positions. Facilitators and analysts now work much more closely together, and function as a team with complementary roles allowing better service for clients. Workers themselves are now clearer about their duties and how they interact with each other, and the more integrated system has been fully adopted. While facilitators still focus on relationships with families and analysts still focus on contracting procedures, there are now clear linkages between the two, and the system as a whole functions more efficiently.

Despite increased collaboration between the two roles, there are changes that still need to be made. For example, it was previously recommended that having facilitators rather than analysts apply the Guide to Support Allocation would increase efficiency and seamlessness. This would allow planning to take place with a full understanding of the realm of financial aid available at the end of the day; seamlessly incorporating facilitators' planning efforts with financial realities. This process has been piloted in one region with positive results, and CLBC is now in the process of expanding it more widely across the province.

Personal Supports Initiative program

The Personal Supports Initiative (PSI) was launched in February 2010, with a mandate to provide services to eligible clients with Pervasive Developmental Disorder (PDD) or Fetal Alcohol Spectrum Disorder (FASD). Funding for the program is restricted, so the program operates distinctly from CLBC's other programs and services.

Since its inception on February 1, 2010, 304 individuals have been confirmed as eligible for PSI services. The majority of these (90%) are 25 years and younger; in the last year 41% were under 19 when determined as eligible, providing a more seamless transition into adult services from children's services. About 28% of services are residential, 48% community inclusion, and 9% respite, with the remaining 15% consisting of individual and family supports such as the development of support networks, behavioural consultation and coordination of supports.

Because the PSI program was developed as a new, stand-alone program, CLBC was able to structure in set funding amounts for residential supports and community supports. This standardization from the outset means there is less of an "entitlement" mentality amongst service providers and clients, and time and resources are not spent negotiating with families about levels of funding. For many, fixed service funding

levels is the key not only to this program's success, but also to bringing cost rationalization and greater efficiency to the service delivery system as a whole.

Relationships and agreements with service providers

CLBC has invested considerable time and resources to engaging and improving its relationships with service providers. This relationship has been at time acrimonious, as CLBC attempted to introduce a new service delivery system that included increased contracting structure, monitoring, and overall vigour. The support of service providers was necessary for some facets of this new system – for example, the introduction of a costing guide for services that will introduce greater standardization and predictability to contracts and budgets.

As of October 2011, CLBC's working relationships with service providers, particularly through engagement with the CLAN-CEO Network, resulted in a number of important agreements that will contribute to a higher degree of operational and contracting efficiency. This is especially so with respect to contract development and funding processes, a summary of the applicable agreements for which is included as Appendix 4.

4.3.2 Potential additional efficiencies

In addition to the measures that have already been implemented to increase efficiencies, a number of areas have been identified that provide promise in further increasing the efficiency of CLBC. This is by no means an exhaustive list, providing a sense of some of the key ideas that arose in the course of this review.

Better Alignments

Currently, a significant area of inefficiency surrounds the different processes and systems that people with developmental disabilities access from government, and the different levels of service expectations that comes with each. This is particularly so for children transitioning into CLBC's adult service system. There are significant differences in funding and processes between social services and health sectors, where, for example, home and community care does not started until age 19 leaving a gap for individuals between 18 and 19.

There is also a lack of transition planning between MCFD and CLBC, although this is improving. While a transition protocol (see below) calls for transition planning to begin at age 14, MCFD does not have the data base to identify who these youth are and ensure that a plan is started, and many parents are not properly prepared. In the education system there is little focus on employment preparation and life skills development, so much so that when individuals graduate from school, they are not well prepared for that organization's growing emphasis on employment readiness and support.

Alignments have improved between CLBC and the health sector, with the development and implementation of *Guidelines for Collaborative Service Delivery for Adults with Developmental Disabilities*. This provides, broadly, that the Ministry of Health is responsible for paying health-related costs of individuals, while CLBC is responsible for other costs. Determining the details of this agreement and fully operationalizing it are a work in progress: while the intent was to clarify roles and funding, there are still

significant gaps in coming to agreement as to who should fund what. Nevertheless, this it is an important area of focus for a more efficient service system overall.

For youth transitioning into adulthood, a similar arrangement exists between CLBC and MCFD, through the *Services for Transitioning Youth Operating Agreement*, which has been in place since December 2009. This agreement establishes practices and procedures to promote integrated practice, ensure sound planning and continuity of services, and clarify the roles and responsibilities of CLBC and MCFD.

Transition from children's services is challenging, in part because families are relatively richly served through MCFD and the education system. There is a wide perception that children and families come to CLBC with expectations that far exceed the ability of CLBC to financially meet, partly because they have become accustomed to special education and MCFD-supported services that are not as vigorously tested for relevance to disability-related need. Particularly with respect to the education system, there are clear opportunities to streamline service provision, rationalize approaches, and address discrepancies in family expectations versus government and public resources.

Youth transition is a challenging time, requiring considerable energy and attention from all sides of government. This is an area where CLBC is focussing more of its attention, and where better efficiencies both in terms of administration and of client services and outcomes are possible.

Community Inclusion contracts

As noted elsewhere in this report, community inclusion contract remain largely under the same rubric as when they were inherited from MCFD: block contracts are provided to service providing agencies to provide given services, but there is no tracking of service provision, service levels, or outcomes at the individual level. It is likely that a review of community inclusion contracts will identify and illuminate opportunities for efficiencies, as has taken place with residential contracts.

CLBC is now going through these contracts to assess whether services, supports and staffing levels are appropriate. Where discrepancies are identified, contract will be re-negotiated. Regions will be encouraged to identify efficiencies, because any savings that are identified will remain in the regions to be applied to other services, to address waitlists and meet unmet needs.

This process will lead to CLBC using government resourcing in the best way possible within current budgets and service delivery structures. It will lead to the best use of resources, but it will not result in a reduction of overall resource consumption unless there is a larger decision about the appropriate level of funding for specific services.

Focus on employment

A service and support area that holds promise, and one that leading jurisdictions are paying increasing attention to, is that of employment services for people with developmental disabilities. This is sometimes seen as a natural evolution in society's treatment of this group, from custodial institutionalization, to structured integration, and now to full integration that includes employment where possible.

CLBC estimates (very roughly) that about 50% of its current clientele is employable, but have grown up in a system that assumes they will not work, and fails them by not teaching relevant skills and abilities. CLBC, looking to jurisdictions like Washington State, is at the start of a process to put much more emphasis on employment supports and services. There is recognition that it will be challenging and require significant investments to shift individuals and families from a fully supported, service-dependant environment to an approach that emphasizes employment readiness, as it must be based (at least initially) on a very individualized approach. However, there is a growing consensus in jurisdictions like Washington, Alberta, and the Australian State of Victoria that this approach is both the most efficient and the most aligned with the ultimate goal of full integration and inclusion.

Full implementation of employment as a priority will require significant partnership with the education system. Many feel that the current education system is a missed opportunity to provide people with developmental disabilities with meaningful, applicable skills and to put them on a sound grounding for employment when they transition to adulthood. CLBC and government have an opportunity to build on the experience of places like Washington, which is piloting the use of the school system to support employment readiness, as a way of promoting employment readiness for youth with developmental disabilities.

CLBC is now exploring ways of promoting employment readiness and employment support services. Options under consideration include the recognition and fostering of agencies who are committed to employment first programs over those who retain community inclusion/day programs, with financial incentives to shift approaches in order to foster employability and more meaningful independence for individuals with developmental disabilities.

Communications approach

Communications has been an area of considerable challenge for CLBC. There is an opportunity for improvements and increased efficiencies for how CLBC communicates to stakeholders, especially to the media. Over the past five years, considerable efforts have been made in trying to manage and respond to issues as they arise in the media and from stakeholders. Often, this response has been reactive and defensive, and has taken staff from their work to respond to issues only after they become crises.

CLBC has recognized that this is an area where improvements must be made, which will result in greater operational efficiencies for the organization as a whole. It has adopted a new approach of responding more quickly to issues as they arise and being more proactive in communicating the positive actions and initiatives of the agency. and an opportunity for CLBC. Part of this approach must also be to acknowledge mistakes and areas where CLBC must work to improve its service delivery.

Communications must also consider how to address larger issues of entitlement and expectation, both from families and from service providers. Traditionally, these groups have directly or indirectly determined how services are provided. If CLBC and government more generally is to bring about a more efficient and rationalized service approach, considerable efforts must be made to address this traditional presumption.

Use of community and natural supports

Finally, although less straightforward than some of the other measures that have been introduced to increase efficiencies, CLBC is also promoting a conceptual shift towards meeting disability related needs by ensuring that family, community, and other "natural" supports remain in place and are not supplanted by funded services. This is consistent with its foundational goal of ensuring that community and generic supports are inherently part of planning to meet the disability-related needs of individuals with developmental disabilities. It expands this approach, though, to make families and support systems a more considered, active, and identified part of supports and services. The hope is that this will foster a greater shared understanding that, within current financial restraints, government alone cannot be responsible for serving people with disabilities.

This is largely a conceptual shift, although initiatives like the South Island region's One-to-One review actively includes the concept at the heart of its design. Overall, this is a fundamental shift that, while requiring significant planning, implementation, and coordination across agencies and government, holds promise for substantial and structural efficiencies.

4.3.3 Summary: Efficiencies Realized and Anticipated

Since its inception in 2005, and particularly since 2008, CLBC has made significant progress in terms of identifying and capitalizing on potential efficiencies. The contract review process resulting in the identification of $24.87M in contract efficiencies, focus on employment as a priority, relationships with service providers are examples of CLBC's movement to a more efficient system of support. Financial savings have been re-invested in the organization, allowing CLBC to expand the reach of its services and address the needs of people on its Request for Service List even within its budget restrictions.

Increasing financial efficiencies will continue, as CLBC continues to implement its contract management system, automate contract monitoring business processes to enhance reporting compliance, automate service providers' periodic reporting of individual participation in services to provide data to support individual resource utilization, and automate its payment interface from CMS to Oracle.

Work remains to be done in some areas, particularly with respect CLBC's communications strategy and processes. In this area, as with an increased emphasis on employment services and community/natural supports, CLBC has identified its overall challenges and is the process of addressing them through new strategies and processes.

4.4 Performance Metrics

As an organization responsible for managing a budget of $710 million, it is important that CLBC be in a position to measure and report on its performance. As an organization responsible for the well-being of people with developmental disabilities, who are often vulnerable and highly reliant on the services CLBC funds, performance measuring and reporting is also important in terms of understanding and demonstrating the effectiveness of such a considerable financial investment.

When CLBC came into being in 2005, it inherited an MIS that did not easily allow for performance monitoring and assessment. At the outset, the MIS collected only the most rudimentary client and contracting information. It was not even possible to say with certainty how many clients were served through CLBC supports and services. This was in part the product of inheriting a system of block or "bundled" contracts whereby an agency would be funded for a program but not required to report on how many clients were being served or how well they were being served.

Over time, CLBC's systems have improved dramatically, building on a comprehensive contracting system, contract monitoring processes, standardized funding levels, and the "unbundling" of all residential contracts. This has allowed CLBC to define and collect an increasingly, intricate and sophisticated set of key performance indicators

In 2006/07, CLBC could only report on the total number of clients served (10,400), how that total list changed from the previous year (an addition of 454, or 4.6%), the total amount of new services forecast ($18.5M) and actually funded ($26.27M) in the year and the number of clients who received new services during the year (1,229). The focus on new clients was due to CLBC's ability to apply new systems to clients as they came into CLBC services, and was important both for tracking contract performance and for building a more reliable means of estimating future caseloads.

By 2008/09, the current structure for performance indicators was established, built on five key domains:

1. Service Delivery
2. Financial
3. Innovation and Communications
4. Quality of Life and Safety
5. Human Resources.

This has remained the basic structure of CLBC's performance monitoring framework, although in 2009/10 separate data reporting was added for CLBC's PSI program, in the service delivery (number of individuals supported, amount of new funding and number of new individuals served annually) and financial (average annual cost per file) domains.

4.4.1 Current Indicators:

Currently, performance indicators are collected and reported quarterly and annually in the five domains noted above. Each area has a number of indicators, and each indicator collects and reports on a number of specific metrics. There are a total of twelve indicators and forty specific metrics as set out in the tables that follow.

The first performance domain is Service Delivery, which considers four indicators. Data to support the four indicators is collected on a total of seventeen metrics:

Area: Service Delivery		
Indicator	**Metric**	**Explanation**
Supported Individuals	Total number of clients supported	Total of all clients registered, eligible, resident in BC and receiving OR requested DD-related services. Does not include PSI clients.
	Change over the previous period	Change in number of total clients since last quarter or year
	Percentage change	As above
	Individuals in PSI program	Total number of clients receiving PSI services
Request for Service List	Millions $	Estimate of the annual cost for the least expensive services requested by people on the EFSL with a Priority Tool score of more than 50.
	Individuals on list	All individuals on the RFSL, including those who currently have no services, and those who have services but are waiting for additional services.
	Average months on list	May include people who have some services but are awaiting others.
	Individuals without any services for more than six months	Individuals on the RFSL with a PT score of more than 50 but have not had CLBC-funded services for more than six months.
New Services	Committed annual funding for new services (DD)	Total cost of new (and additional, where there has been a service increase for a client already in receipt of services) services within the fiscal year. Does not include PSI services.
	Individuals provided with new services (DD)	Number of individuals benefitting from those services (excluding PSI)
	Percentage new services that were emergency (DD)	Percentage of new/additional services that were approved as an emergency response (therefore short-term, pending development of a plan) (excludes PSI)
	Forecast annual funding for new services (DD)	Annualized, ongoing cost of new service commitments implemented during the fiscal year (excluding PSI)
	Committed annual funding for new services (PSI)	Total cost of new (and additional, where there has been a service increase for a client already in receipt of services) PSI services within the fiscal year.
	Individuals provided with new services (PSI)	Number of individuals benefitting from those new PSI services
	Forecast annual funding for new services (PSI)	Annualized, ongoing cost of new PSI service commitments implemented during the fiscal year
Complaints	Number of complaints (funding)	Complaints related to funding that have advanced beyond the informal level (through facilitator or analyst)
	Number of complaints (other)	Other complaints that have advanced beyond the informal level (through facilitator or analyst)

Figure 1: Service Delivery Performance Indicators, CLBC (internal)

The Financial domain examines two indicators with a total of eight metrics:

Area: Financial		
Indicator	**Metric**	**Explanation**
Forecast Financial Position	Surplus or Deficit	Total budget surplus or deficit for the current fiscal year
	Annualization Impact	Cost of annualizing new services made in the current fiscal year. The metric presents the amount by which annualization of current year commitments will exceed or be less that the amount budgeted for that purpose at the beginning of the year.
Cost Profile/ Efficiency	Percentage of budget spent on services	Percentage of total CLBC expenditures that went to DD, PSI and Provincial Assessment Centre services for individuals.
	Committed contract savings	Total amount of savings for the fiscal year, including savings related to mortalities and discharges.
	Average annual cost per file (DD)	Total expenditures divided by total clients (DD) – includes those in receipt of CLBC-funded services, those receiving community services, and those on the RFSL but not yet receiving any services.
	Average annual cost per file (PSI)	As above, but for PSI clients
	Average annual cost for residential services (new)	Average cost for individuals newly admitted to residential services during the year.
	Average annual cost for residential services (all)	Average cost for all people receiving residential services.

Figure 2: Financial Performance Indicators, CLBC (internal)

CLBC's performance in the domain of Innovation and Communications is considered through three indicators, with a total of ten separate metrics:

Area: Innovation and Communications		
Indicator	**Metric**	**Explanation**
Individualization	Number of clients receiving Direct Funding	Total individuals who directly control their own funding
	Number of clients with a Host Agency	Total individuals whose direct funding is administered by a host agency
	Number of clients with a Microboard	Total individuals whose direct funding is administered by a microboard
	Number of clients with Direct Funded Respite	Total individuals receiving direct funded respite
Innovation	Percentage of new admissions NOT in group homes	Percentage of individuals newly entering into residence who do not go to staffed group homes
	Number of admissions	Total individuals newly entering into residential services this year
	Number of clients moved	Number of individuals who started the fiscal

Area: Innovation and Communications		
Indicator	**Metric**	**Explanation**
	from group homes to other	year in group home, but moved to another setting
	Percentage of smaller, individualized residential arrangements	Percentage of all individuals in CLBC-funded residential services who are living in locations with one or two beds.
Communications	Number of people visiting website	Unique visitors (not visits) in the fiscal year
	Number of people receiving newsletter	Number requesting receipt of the newsletter

Figure 3: Innovation and Communications Performance Indicators, CLBC (internal)

CLBC assesses its performance in terms of Human Resources through two indicators, which are informed by a total of four separate metrics:

Area: Human Resources		
Indicator	**Metric**	**Explanation**
Learning and Growth	Average training days	Average of training days per FTE, annualized
Recruitment and Retention	Staff turnover	Resignations (excluding retirement) in the period, annualized as percentage of total FTEs
	Sick time	Sick days per FTE in the period, annualized
	Qualified applicants	Number of pre-qualified applicants for facilitator and analyst positions within CLBC

Figure 4: Human Resources Performance Indicators, CLBC (internal)

Finally, the area of Quality of Life and Safety is measured through one indicator:

Area: Quality of Life and Safety		
Indicator	**Metric**	**Explanation**
Mortality	Mortality	Total number of individuals deceased in the reporting period

Figure 5: Quality of Life Performance Indicators, CLBC (internal)

The obvious conclusion from the above is that while CLBC spends a considerable amount of effort collecting information on and analyzing its performance in terms of the number of services it provides and the financial impact of its work, the organization's measurement framework is much less robust when it comes to considering the outcomes of those services. This is not surprising, as one of CLBC's primary areas of focus since coming into being in 2005 has been on providing services in a rights-based context, within strict financial parameters. Its main area of consideration, therefore, has been establishing and measuring how many people are served in the context of growing demands and static resources.

However, one of the founding principles of CLBC was to improve the quality of lives of the people it serves; to move beyond merely facilitating people living safely in their communities (traditionally, through group homes and day programs) and help people become active, integrated members of their communities. The positive quality of life measurements that should be performance indicators for this part of CLBC's work are currently absent from the performance measurement framework. So while it is possible to assess the quantity of CLBC's services, there is little to allow for an assessment of the quality of those services.

CLBC has made efforts towards qualitative measurement and assessment through its Satisfaction Survey, first introduced in 2006. This looked at how well individuals and families felt supported by their services providers, with measures including:

- The degree that individual and family concerns were being listened to;
- The degree that concerns were addressed in a timely manner; and
- The extent that individuals and families felt that they were provided with useful referrals and resources.

These performance measures have been included in CLBC's Service Plan for 2009/10-2011/12, which includes a combination of qualitative and quantitative measures under three goals: Service Excellence, Organizational Responsiveness, and Operational Efficiency, with annual surveys providing the source of data for measures 1, 4, 5 and 6. Non-qualitative measures (measures 2, 3, 7 and 8) focus on CLBC's success in moving towards more direct funding, and increasing the percentage of clients who are in residential settings other than expensive staffed group homes.

Full Service Plan Goals and performance measures are as follows:

Goal 1: Service Excellence	
Measure 1	Percentage of individuals and families who believe they are well supported by their service providers
Measure 2	Number of individuals and families who purchase supports and services using individualized funding
Measure 3	Number of families who receive direct payments for adult respite
Goal 2: Organizational Responsiveness	
Measure 4	Percentage of individuals and families who believe their concerns were listened to
Measure 5	Percentage of individuals and families who feel their concerns were addressed in a timely manner
Measure 6	Percentage of individuals and families who feel they were provided with useful referrals and resources
Goal 3: Operational Efficiency	
Measure 7	Percentage of annual budget used for direct service delivery
Measure 8	Percentage of individuals receiving residential services that live in smaller, individualized arrangements

Figure 6: Performance Measures, CLBC Service Plan

Each of these measures includes baseline levels (based on 2008 survey responses) and annual targets up to 2013/14.

4.4.3 Additional Metrics

CLBC recognizes that moving to a more holistic performance measurement model is part of their development as an organization, and an integral element of assessing outcomes. CLBC is now in the process of piloting a new component of its overall monitoring framework which will assess clients' quality of life outcomes in the areas of independence, social participation, and well-being.

For agencies such as CLBC, which are aimed at supporting and assisting individuals, it is increasingly important to establish and report on measureable client outcomes. In a time of fiscal restraint, it is doubly important that the organization be able to demonstrate that its publically funded services make a positive difference in the clients that CLBC supports.

Recognizing the need for an outcomes measurement framework, CLBC is now in the process of adapting and implementing a client survey tool to measure quality of life outcomes in its clients. A number of possibilities were considered for this purpose, including developing its own measurement framework, using accreditation-based approaches and adopting the American National Core Indicators. Each of these had important limitations, though, and CLBC has opted to use a quality of life (QoL) framework known as *My Life: Personal Outcomes Index*™.

This tool, developed by Dr. Michael Schalock and implemented in Alberta by the Persons with Developmental Disabilities Edmonton Region Community Board, focuses on measuring quality of life in three eight domains:

Emotional well-being	Personal development	Social Inclusion
Material well-being	Interpersonal relations	Rights
Physical well-being	Self-determination	

A number of questions seek client views on each of the above domains, with a 0 to 10 point scale. This results in average scores for each of the domains, with results report on an agency, not an individual, level.

From November 2010 to March 2011, CLBC trialed the *My Life* QoL framework in a demonstration project, with interviews conducted by trained self-advocate volunteers. The trial identified a number of implementation challenges, but was overall considered to be a success. CLBC has now included the *My Life* QoL framework in its contracting terms with the service agencies it funds, and is in the process of expanding application of the framework throughout the agency.

Adoption of the *My Life* QoL framework will allow CLBC to implement a system of data collection and analysis that will help assess what gets positive results and what does not, where improvements should be made and how. This can help determine the efficacy of particular program models, and help inform policy and practice decisions.

Taking all of the foregoing into consideration, CLBC now has a number of key components of a comprehensive performance monitoring framework in place. These include:

1. Internal performance indicators, in five domains (service delivery, financial, innovation and communications, quality of life and safety, and human resources), built on twelve indicators and forty metrics. This provides strong assessment of CLBC's quantitative service delivery and financial performance, but does not address qualitative performance very well. The primary source for this information is data from PARIS, CLBC's MIS system.
2. The performance framework included in CLBC's Service Plan, which reports on three goals (service excellence, organizational responsiveness and operational efficiency) through consideration of eight measures. These are a mix of quantitative and qualitative measures, with data derived from the PARIS system as well as annual client surveys. This provides basic qualitative data mostly related to the sense of responsiveness that clients have of CLBC-funded agencies but does not consider client outcomes as part of its framework.
3. The *My Life* QoL framework, which assesses the outcomes of CLBC-funded programs and services in terms of the impacts on clients' well-being and quality of life. This is in the early stages of implementation, but provides a promising way of assessing how CLBC-funded programs make a difference in the lives of the clients it serves, This will in turn allow for policy, practice, and funding decisions that support services and approaches that make positive differences in the lives of individuals and families.

4.4.4 Summary: Performance Metrics

CLBC has implemented significant improvements to the MIS, performance measures and reporting capabilities it inherited from MCFD upon devolution in 2005. Key improvements include the ability to:

- unbundle non-community inclusion contracts, allowing CLBC to be able to analyze contracts and an individual level, assess trends and outliers, and identify areas to reassess or reallocate resources; and
- forecast the magnitude and – to some degree – the financial impact of new clients, although significant challenges remain in this area.

Overall MIS and performance metrics has been developed and implemented in five areas (service delivery, financial, innovation and communications, quality of life and safety, and human resources). Although measuring clear outcomes is not equally robust at this point, CLBC is the process of integrating this into its performance metrics.

It should be noted that each ministry or agency that serves people with developmental disabilities appears to have its own performance measures – each with varying degrees of sophistication and value. These inter-ministry metrics are not generally linked in any holistic manner, and there is an opportunity to enhance and align linkages between performance metrics to more accurately measure need, service delivery options and most importantly, outcomes.

5.0 Assessment of CLBC's progress

5.1 Implementation of recommendations of the *2008 Report*

In 2008, the (then) Ministry of Housing and Social Development sponsored a review of CLBC, to assess its initial progress since becoming a Crown Corporation in 2005. The review had three key focuses: CLBC's service delivery model itself, the policy tools and processes that support the service delivery model, and the guardianship responsibilities and functions of CLBC. These three factors were examined with two key lenses in mind: the vision and mandate of CLBC, and longer-term cost certainty and sustainability.

The primary deliverable of the 2008 review was a report that set out twenty-seven recommendations, covering CLBC's service delivery model, guardianship functions, policy tools and sustainability. These recommendations were reviewed and accepted by government and CLBC, which shortly thereafter began a process of planning and implementation to carry out the recommended actions.

Beginning in the spring of 2009, CLBC began reporting progress on these recommendations, with regular reports being submitted to MSD every two to three months. Implementation of some of the recommendations was prompt, with workplans for many of the measures in place by June 2009. The first fully recommended recommendation was reported in May 2009. By May 24, 2011, all 27 recommendations were reported as fully implemented and had become part of CLBC's ongoing operations.

Our review confirms that the vast majority of these recommendations have been substantively implemented, and this is summarized in Figure 7, below. Where the recommendation called for an specific action and that has been implemented, the status is *complete*. Where the recommendation was for an ongoing action (for example, foster partnerships) and the recommendation has been implemented and continues to be performed, it is noted as *ongoing*.

Two recommendations still require attention. Recommendation 4 is *in progress*, but still requires implementation with respect to part of the expansion of the role of facilitator. With respect to recommendation 5, CLBC notes that the expansion of facilitators' ability to more efficiently provide direct-funded respite (within set limits) has been "indefinitely delayed." It is therefore noted as *partly complete*.

Progress Status: Implementation of 2008 Recommendations		
No.	**Recommendation**	**Status**
1.	Improve collaboration between facilitators and analysts	Complete
2.	Joint reporting for the Community Planning and Development and Quality Service streams	Complete
3.	Introduce a constant point of contact	Complete
4.	Expand role of facilitators to include application of the Guide to Support Allocation and discussion of waitlist	Waitlist: complete GSA: In progress
5.	Expand role of facilitator to include ability to directly approve limited services	Partly complete

Progress Status: Implementation of 2008 Recommendations		
No.	**Recommendation**	**Status**
6.	Clarify role of facilitators to include community development as well as planning	Complete
7.	Clarify role of analysts to emphasize teamwork	Complete
8.	Focus the role of Community Councils	Complete
9.	Improve communications about the service delivery model	Ongoing
10.	Maintain designated agency status and functions under the *Adult Guardianship Act*	Complete
11.	Enhance the proactivity of facilitators	Complete
12.	Involve analysts in guardianship matters	Complete
13.	Enhance orientation to guardianship responsibilities	Complete
14.	Develop and implement clear guidelines for informal supports	Complete
15.	Rationalize planning processes	Complete
16.	Query use of Guide to Support Allocation	Complete
17.	Provide consistent, comprehensive training for staff	Ongoing
18.	Attention to performance management	Ongoing
19.	Clarify potential integration with government systems	Complete
20.	Clarify government oversight of policy	Complete
21.	Undertake ongoing assessment	Ongoing
22.	Foster partnerships	Ongoing
23.	Manage expectations and clarify mandate	Ongoing
24.	Foster inclusive practice and the use of generic services	Ongoing
25.	Promote innovation	Ongoing
26.	Engage service providers more effectively	Ongoing
27.	Maintain focus on contract reform and contract management	Ongoing

Figure 7: Status, implementation of 2008 recommendations

A review of all recommendations and the steps taken to implement them is as follows:

5.2 Service Delivery Model Recommendations

Nine recommendations were made for improvements to CLBC's service delivery model, focusing on clarifying and improving the roles of facilitators and analysts, and improving relationships with clients and families. These measures were made in order to address concerns that CLBC was overly focused on planning rather than implementing services, and that clients and families often had expectations raised through the planning process that could not be met through the financial resources and programs/services that CLBC was able to provide.

A lack of clarity and communication between the roles of facilitators and analysts contributed to this situation: broadly speaking facilitators tended to plan for services and supports without any reference to the resources that analysts would be in a position to provide, and the process itself was time consuming and confusing for families.

Recommendation 1: Improve collaboration between facilitators and analysts

This recommendation was aimed at addressing the gap that occurred once a facilitator completed the planning process with a client and the plan was handed off to analysts

without further communication. Improved collaboration was aimed at ensuring that facilitators remained an ongoing resource for families, and that families knew who to turn to for help with questions and other concerns.

Progress: Based on focus groups with front line staff, new work flows and practices, including training curriculum, were developed by October 2009. Training for CLBC field staff took place in November and December 2009, with full regional implementation completed by the end of December 2009. Recommendations 3 and 7, below, were grouped with this recommendation, and underwent the same implementation process. All three recommendations are now part of CLBC's service delivery procedures. **Complete.**

Recommendation 2: Joint reporting for the Community Planning and Development and Quality Service streams

When CLBC set up its service delivery system, facilitators (CPD) and analysts (QS) reported up through separate management and reporting streams. The only place where both sides of the service delivery system reported together was to the CEO. IN order to address the troublesome disconnect, it was recommended that joint reporting occur at a lower level, to facilitate better coordination of services.

Progress: CLBC hired four Directors of Regional Operations (DROs) to introduce joint reporting at the regional level, with regions organized to align with those of MSD, Health and MCFD. These were in place by May 2009. DROs have since created regional teams where CPD and QS managers work more closely together to implement organizational objectives, fundamentally altering the reporting structure of CLBC and bringing a more consistent approach to the agency's efforts. **Complete.**

Recommendation 3: Introduce a constant point of contact

One of the challenges of the original service delivery system was that families were confused about how to communicated with CLBC. While understanding CLBC's move away from a mandated, social worker approach to contact with families, the review identified a sense among many clients and families that they had no clear "point of entry" into the system. CLBC's desire to introduce a system where any analyst or facilitator could theoretically address the concerns of any client meant resulted instead in a sense of disconnect for those families who wanted or needed some degree of ongoing support. Accordingly, it was recommended that a single point of contact – preferably a facilitator – be identified for those families who wanted this.

Progress: see Recommendation 1. **Complete.**

Recommendation 4: Expand role of facilitators to include application of the Guide to Support Allocation and discussion of waitlist.

One of the results of CLBC's initially strict separation of planning (carried out by facilitators) and contracting (carried out by analysts) functions was that client planning tended to take place without sufficient consideration of what funding would be available to meet the client's needs. This led to great frustration with clients and families, who spent a lot of time establishing their disability related needs and planning goals, only to wait for funding and services to come available, often without a sufficient explanation of how the system worked.

Accordingly, recommendation 4 was that the facilitator role be expanded to include application of the Guide to Support Allocation (or whatever assessment tool that CLBC might use), and discussion of waitlist procedures and processes with clients for whom supports and services were not immediately available.

Progress: The waitlist policy was revised and facilitators were identified as the communication point for families on waitlist issues starting in September 2009. This was posted to the CLBC website in November 2010, and has been fully implemented throughout CLBC, consistent with the general focus on facilitators as being the primary ongoing client contact. **Complete.**

Progress has been slower with respect to facilitators applying Guide to Support Allocation. Starting in February 2010, facilitator responsibility for assessment was piloted in the Personalized Support Initiative (PSI). This pilot will be fully evaluated in December 2011, but early indications are that the shift in responsibilities is successful within PSI. Although CLBC has reported that this recommendation is now "complete" it is unclear how the shift in facilitator application of the GSA will be expanded beyond the PSI, and CLBC has indicated that a decision on this has been deferred to allow for completion of service redesign, implementation of the new contracting systems, and to allow for appropriate training and fiscal controls. **In progress.**

Recommendation 5: Expand role of facilitator to include ability to directly approve limited services

In order to provide more efficient and responsive service to families, it was recommended that CLBC expand the ability of facilitators to approve services without completing a full plan, and without seeking the approval of an analyst. This was meant to allow for a faster provision of smaller-scale services without excessive bureaucratic process, in appropriate situations.

Progress: By November 2009, CLBC began implementing the ability of facilitators to directly allocate life skills, supported employment, behaviour consultation, respite and homemaker support services with a total value of less than $6,000 per year. Full implementation was delayed because of challenges related to the request for service list. Although noted as completed, the latest indication is that "limited implementation" began in the summer of 2010.

For direct-funded respite services, a similar threshold was also contemplated, but implementation has been indefinitely delayed. Instead, CLBC's practice is now that facilitators and analysts work together to identify appropriate services for requests that are under $6,000 per year. **Partly complete.**

Recommendation 6: Clarify role of facilitators to include community development as well as planning

In order to address a perceived over-emphasis on planning as well as an imbalance in the workloads of facilitators and analysts, it was recommended that CLBC expand the role of facilitators to include a greater emphasis on community development. The goal was that facilitators' expanded roles would help clients identify ways to incorporate generic community services into their individual web of supports and services.

Progress: CLBC now distinguishes between planning (encompassing a range of activities) and formal written plans, with the latter only undertaken when funding or services are available. The organization has increased its emphasis on short term work with families to help them solve issues and access generic community services, using a one page agreement to summarize the process. CLBC now more clearly emphasized that non-CLBC funded services are part of families' service options.

CLBC began working with municipal representatives in 2009 to identify better ways to support community inclusion. A discussion paper on community engagement was completed in the spring of 2010, resulting in a Community Engagement strategy to increase inclusion and participation. The strategy paper was circulated and discussed with all CLBC staff, and it was identified that it was necessary to engage service providers in the discussion as well.

At the same time, CLBC was engaged in negotiations with service providers regarding contract management and funding. These have taken priority, and CLBC's community engagement efforts have since been limited to specific areas such as employment. **Complete.**

Recommendation 7: Clarify role of analysts to emphasize teamwork

Although there was greater clarity with the role of analysts than facilitators, analysts were originally directed to make financial decisions about clients' services largely in isolation, leading to problematic messaging when analysts approached facilitators or families with questions about completed plans. It was recommended that CLBC address this by implementing a team approach to funding assessment, in which the analyst, facilitator and family worked more collaboratively to discuss and apply funding decisions.

Progress: see Recommendation 1. **Complete.**

Recommendation 8: Focus the role of Community Councils

Community Councils were developed by CLBC as community-level organizations where self-advocates, families, community members and service providers could have a more meaningful involvement in how their services are delivered and outcomes achieved. The role of Community Councils was initially unclear, however, and there was a lack of consistency across the province with respect to their roles and functions.

To address this challenges, it was recommended that the roles, responsibilities and functions of Community Councils be reviewed and clarified, to move away from advocating for funding and focus more on supporting strategic initiatives. It was also recommended that training be provided to CLBC managers to help them effectively engage Councils in a more meaningful way.

Progress: A review of all Community Councils took place in the spring of 2009, and CLBC worked with Councils to redefine roles and responsibilities based on the outcomes of the review. The Community Council manual was re-written to reflect revised Terms of Reference, with orientation and implementation completed by June 2010. **Complete.**

Recommendation 9: Improve communications about the service delivery model

A recurring theme of the original review of CLBC was that, while the organization was making progress in terms of implementing positive operational changes, these changes were not well communicated. It was recommended that CLBC develop and implement a comprehensive communications plan to ensure that families, community partners, funders, advocates, service providers, and other partners are all aware of changes CLBC makes, and the reasons for those changes.

Progress: A communications plan was developed an shared with MSD and PAB in June 2009, with ongoing communications to inform CLBC stakeholders of service delivery changes. In November 2009, MLAs' constituency offices were briefed on CLBC changes, and CLBC participated in the 2009 UBCM annual general meeting. Although noted as "fully implemented" in CLBC's progress reports, communications has remained an ongoing challenge at the organization, as noted elsewhere in this report. CLBC has recently taken additional steps to address communications challenges, focusing on a more positive, active approach rather than reacting to issues and challenges when they arise. **Ongoing.**

5.3 Adult Guardianship Recommendations

Five recommendations were made with respect to CLBC's adult guardianship functions, focusing on clarifying the relevant roles of facilitators and analysts, and generally confirming and communicating the agency's appropriate roles in guardianship matters.

CLBC's service delivery model resulted in some confusion in the implementation of the guardianship duties that it inherited. Previously, social workers with long-standing client relationships were mandated with guardianship duties where necessary. The division of the previous social work functions between facilitators and analysts, neither of whom had a mandated ongoing relationship with individuals, created some confusion about how guardianship functions should be applied under the new model. The following recommendations were made in order to address these concerns.

Recommendation 10: Maintain designated agency status and functions under the Adult Guardianship Act

One of the options that was considered at the time of the original review was that an agency other than CLBC could be designated as the point of responsibility for adult guardianship concerns. However, it was recommended that CLBC continue in this role, building on the meaningful steps it had taken to address issues and implement appropriate standards and practices.

Progress: In May 2009 CLBC completed staff training on adult guardianship issues, with involvement from the Ministry of Health and the Office of the Public Trustee and Guardian (OPTG). CLBC has continued to work with the OPTG on an ongoing basis to ensure that any issues are identified and appropriately addressed. **Complete.**

Recommendation 11: Enhance the proactivity of facilitators

It was recommended that the facilitator's role regarding adult guardianship be clarified and enhanced to encourage a more active approach to inquiry and investigations into situations where an individual may be vulnerable to abuse or neglect. As the ongoing point of contact for families (although not mandated as social workers had been

previously), facilitators were considered as the more natural locus for guardianship-related functions.

Progress: In May 2009 CLBC completed staff training on adult guardianship issues, including clarifying the predominant role of facilitators in the process. CLBC has continued to work with the OPTG on an ongoing basis to ensure that any issues related to facilitators' roles in guardianship matters are identified and appropriately addressed. **Complete.**

Recommendation 12: Involve analysts in guardianship matters

Although facilitators were recommended as the primary point of contact for guardianship matters, it was also recommended that analysts should include monitoring for abuse and neglect as part of their regular contract and performance monitoring activities.

Progress: An enhanced role for analysts was included in CLBC's implementation plan for contract monitoring, although implementation was delayed until fall 2010 due to the transfer of children's services to MCFD and to account for the overall timelines of the contract monitoring project. This issue was addressed as part of the monitoring training for all analysis which took place between January and March 2011. **Complete.**

Recommendation 13: Enhance orientation to guardianship responsibilities

In order to clarify roles and responsibilities, it was recommended that CLBC provide a full orientation to adult guardianship policies, procedures, roles and responsibilities to all staff, including analysts. It was also recommended that staff be encouraged to participate in joint initiatives with the OGPT to enhance understanding of adult guardianship issues.

Progress: Analysts were included in May 2009 adult guardianship training, and regional leads for adult guardianship were established in November 2009. Adult guardianship orientation is now standard for all CLBC staff. **Completed.**

Recommendation 14: Develop and implement clear guidelines for informal supports.

At the time of the original review, there was some concern that while CLBC-supported service providers play an important role in providing informal supports to clients, there was a lack of supporting policy and guidelines in areas that involve potential conflict such as finances or health. Accordingly, it was recommended that CLBC develop and implement clear guidelines to assist service providers in these circumstances.

Progress: While there was a shared sense that the role of accredited agencies was clear, CLBC recognized the need to develop guidelines for smaller, non-accredited service providers. This was originally conceived of as being included as part of CLBC's contract monitoring initiative, although CLBC has now developed guidelines as part of its standards for unaccredited service provider. This requires a written procedure to define and ensure appropriate financial processes are in place, and includes guidance on how the service provider can ensure the requirements are met. **Complete.**

5.4 Recommendations regarding policy tools to support service delivery

The initial review of CLBC's policy tools and framework found that organization had taken considerable steps towards a more equitable and predictable system of needs assessment and service/support provision. After inheriting a system that was characterized by non-standardized assessment of need and non-rationalized linkage to resource allocation, CLBC's system of individual service planning, application of the Guide to Support Allocation, and needs ranking on the Request for Service list were all clear steps in the right direction. These policy tools were meant to support a significant shift in the way services are delivered and it was recognized that it would take time for the effects of the new policy tools and service delivery model to take hold.

Seven recommendations were made in order to facilitate the development of a strong policy tool framework. Progress on each is reported below.

Recommendation 15: Rationalize planning processes

Although CLBC introduced greater predictability and standardization through its policy and planning tools, the initial review found that there was a disconnect in the emphasis placed on funded services versus CLBC's rhetoric of employing generic community services. Accordingly, it was recommended that planning processes be rationalized to account for this discrepancy, and also that CLBC continue to revisit the necessity and appropriateness of extensive planning for situations where that is not required.

Progress: In 2009, the annual CLBC staff conference focused on the importance of non-CLBC funded elements in planning and support. All facilitators received training, in Discovery Based Planning, which focuses on identifying a broader range of options beyond funded services for meeting peoples' needs. Ongoing monitoring and use of informal and generic community supports has been built into the PARIS system.

As noted under recommendation 6, CLBC We now distinguishes between "planning" (encompassing a broad range of activities) and formal written plans, with the latter undertaken only when funding or services are available. Planning now includes an increased emphasis on short term work with families to help them solve issues and access generic community resources, with a summary agreement that sets out the family's concerns and describes what the family and facilitator will do to resolve those concerns. Typically this work does not involve the provision of CLBC services – rather there is a focus on using non-CLBC funded community resources in community. **Complete.**

Recommendation 16: Query use of Guide to Support Allocation

One of the fundamental policy tools that CLBC uses for planning and resource allocation is the Guide to Support Allocation. This tool provides guidance to analysts with respect to the amount of funded support that should be provided to an adult with a developmental disability, based on their disability related need. Analysts apply a 5-point score in ten functional areas (communications, hygiene, relationships, etc.), using information from the individuals' support plan. The GSA also includes "flags" to account for extreme circumstances that may drive costs higher than the developmental disability alone would indicate, such as mental health issues or physical disabilities

When all ten areas are reviewed and a determination of need made in each, the analyst adds the total score and divides by the number of areas where scores were recorded.

This is then used by the analyst to determine the maximum amount of support that CLBC could provide, based on reference to its Catalogue of Services.

The GSA was considered to be a useful policy tool and a step in the right direction, being based on sound research and best practices, but still leaving room for professional judgment. However, it was recommended that CLBC review use of the tool in light of other, more widely used tools such as the Support Intensity Scale (SIS), particularly in light of the recommendation that facilitators, not analysts, should play a role in applying the GSA.

Progress: In spring 2009, CLBC investigated use of the SIS and conducted a review of other jurisdictions' experience with alternative assessment tools. This built on the considerable time and resources that CLBC dedicated to consideration of the SIS at the outset of its service delivery development.

In March 2010, testing and feedback indicated that the a revised version of the GSA had greater reliability than the previous version. It was recognized that further enhancements would continue to enhance the tool's efficacy and CLBC decided not to adopt another planning tool. The GSA remains in place as the primary tool for assessing need and allocation appropriate resources. **Complete.**

Recommendation 17: Provide consistent, comprehensive training for staff

Although the GSA and related tools were found to be promising, a key requirement for their fully efficacy is consistent application. The initial review indicated that staff was inconsistently trained, and that the tools were not being applied in a consistent manner across the province. It was therefore recommended that CLBC implement a comprehensive round of training and education to all facilitators and analysts with respect to the proper application of assessment tools, and that analysts and facilitators (presuming they would assume responsibility for application of the tools, as recommended earlier) be mandated to participate in training and refresher sessions to ensure ongoing equity, fairness and predictability.

Progress: Joint training on resource allocation practices (including the use of the GSA) was provided to all facilitators and analysts in November / December of 2010. Since that time, regional GSA leads have continued to participate in bi-monthly conference calls with the provincial lead. To further reinforce best practices that were introduced during joint training, a Resource Allocation Practice Guide was developed and distributed to analysts and facilitators in April 2011.

On an ongoing basis, new staff are invited to participate in a 1-hour introductory webinar on resource allocation as part of their initial orientation. The 6-hour session that was delivered throughout the regions at the end of 2010, is being developed as an on-line course that staff will be able to take at any time. This course will be available through CLBC's on-line learning site shortly.

CLBC continues to explore the possibility of having facilitators (instead of analysts) complete the GSA. A pilot project is scheduled to commence in its South Island region this fall and, should the pilot prove successful, it is expected that the transition of this piece of work to facilitators in other parts of the province would commence in the spring of 2012. **Ongoing.**

Recommendation 18: Attention to performance management

At the time of the original review, CLBC recognized that performance management was an area that required greater attention and was largely absent from its contract management system. This was due in part to the system that was inherited upon devolution from MCFD, but was also an overarching characteristic of the sector which has not traditionally put an emphasis on monitoring and management. To address this, is was recommended that CLBC focus on performance management in its contracting procedures and processes. Changes to technology and systems, in particular, were highlighted as opportunities to build performance management into CLBC's processes and procedures.

Progress: A initial draft contract monitoring framework was completed in spring 2009, focusing on effective contracting processes and including outcomes and outputs monitoring. In early 2010 the framework was revised to specify monitoring at the contract, service and agency levels, with appropriate monitoring for each level. The implementation plan was further adjusted during the 2010-11 year to better align with the release of other Contract Management components that were also being introduced to the field and service providers. The revised implementation plan is as follows:

Phase 1 – monitoring service levels and management information plus on-site visits
Phase 2 – monitoring personal outcomes of individuals served
Phase 3 – monitoring standards compliance for unaccredited service providers
Phase 4 – monitoring standards compliance and alignment of outcomes for accredited provider
Phase 5 – monitoring agency alignment with CLBC vision and goals

Phase 1 has been implemented. This included the development of a policy and practice guide for staff. It also included comprehensive training for staff and a detailed orientation for service providers.

The implementation of phase 2 is in process. This began with the completion of a successful pilot project during the 2010 fiscal year that involved interviewing 330 individuals supported by seven service providers In CLBC's Fraser region. The next step of implementation involves surveying 750 individuals in the Vancouver-Coastal and Fraser regions. An RFP has been issued to select a survey company to oversee this piece of work and BC is currently in negotiations with Alberta to issue a joint RFP for data analysis. Surveys are scheduled to begin in January 2012. Over the next 3-4 years, CLBC will invite more individuals from all regions to participate in this process.

The standards and resource guide required for a successful implementation of phase 3 have been developed. Training for CLBC staff and for service providers will begin in 2012. These standards come into effect on April 1, 2012.

CLBC has been working with service providers and a consultant to develop the resources required to support the implementation of phase 4. While the requirements related to standards compliance are simple, those related to outcomes alignment are more complex. Development on this phase will continue throughout the 2011-12 year.

Finally, CLBC anticipates that phase 5 will be introduced during the 2012-13 year. **Ongoing.**

Recommendation 19: Clarify potential integration with government systems

Given the general move towards greater systems integration at the time of the review (particularly in respect of the social services sector with government's Integrated Case Management (ICM) system project), it was recommended that CLBC work closely with government partners to examine, clarify and, where appropriate, implement greater systems integration.

Progress: In early 2009, CLBC confirmed that its contract management system would interface with the Corporate Accounting System. The organization was also represented on the ICM working group until the project was indefinitely postponed in early 2010. Since recommencement of the ICM project, Since recommencement of the ICM project, CLBC has been advised by MSD that it is not involved in the current phase of the project. The future scope and timeline for CLBC's potential involvement is not known at this point. **Complete**.

Recommendation 20: Clarify government oversight of policy

Although the overall roles and responsibilities of CLBC and the Ministry were clear at the time of the original review (i.e. government sets broad policy direction while CLBC is responsible for developing and implementing the strategies that are consistent with that direction), the relationship between the two organizations was still uncertain and there was a degree of disagreement about governance and authority. It was accordingly recommended that CLBC and the Ministry work together to implement a formal review and approval process for the development of appropriate policy.

Progress: CLBC developed and submitted draft policy development and roles clarifications in spring 2009, and these were approved by the Ministry that summer. The *Policy Development and Implementation* policy, which specifies that CLBC's role is to develop and implement policy in response to the broad direction provided in MSD's annual Shareholder's Letter of Expectations. It also provides that CLBC policy must be linked with those of other social service and health ministries, especially when policies may affect individuals and families involved in multiple service systems. **Complete.**

Recommendation 21: Undertake ongoing assessment

While CLBC's policy tools showed promise at the time of the initial review, they were newly developed and implemented and had not yet been fully assessed. For this reason, it was recommended that CLBC undertake ongoing assessment of the efficacy of its policy tools, including regular reporting to government, the Board of Directors, and to the public.

Progress: In early 2009, CLBC implemented an ongoing responsibility for the Director of Quality Assurance to undertake a review of policy tool and report to government and the public. CLBC now undertakes a minimum of 3 policy compliance reviews each fiscal year, all of which are conducted by external consultants. Each report provides recommendations for action which are reviewed by Senior Management and the Board as indicated and lead to the development of an 'action plan'. These plans include a timetable for implementation of changes or modifications to policy, procedures and practice and may involve operational working groups, statutory reviews, technology adjustments, etc.. Amended policies are posted on the CLBC website for public access. **Ongoing**.

5.5 Recommendations regarding sustainability

One of the key motivations behind the devolution of service delivery from MCFD to CLBC was a belief that the proposed system would offer more predictability and overall sustainability than the historic model. There was a belief that a cost-effective model would be possible by utilizing options like individualized funding, increased role of families, and an increased use of generic and community services.

In light of factors such as demographic shifts that increase the number and complexity of CLBC clients, financial limitations, and increased family expectations for services, the long-term sustainability of CLBC was identified as an area of concern in the original review. With this in mind, six recommendations were made to foster the ongoing sustainability of CLBC. Progress on each is reported below.

Recommendation 22: Foster partnerships

At the time of the original review, there was a growing understanding that CLBC-funded services was only one part of the service and support web for people with developmental disabilities, and that CLBC alone could not provide all services that people want. IT was recommended that CLBC take leadership in fostering relationships within and amongst the community living sector, other government ministries, other community resources, and the private sector to expand both the range of services and supports that clients could look to, as well as the general awareness that government-funded services are not the sole means of support for this sector.

Progress: Beginning in spring 2009, CLBC established working groups with government bodies and agencies such as MSD, the Ministry of Health, the Ministry of Education, BC Housing, Municipalities and Health Authorities to more effectively support and coordinate services for people with developmental disabilities. Community members, individuals, families and service providers also played an ongoing role in these working groups, and specific partnership initiatives were established to address issues related to housing and homelessness, mental health and addictions, employment, and youth transitioning out of the school system and into adulthood.

The PSI initiative provided an opportunity to start a new program that included considerable partnership input from the outset. In early 2010, CLBC developed and implemented a practice framework and staff training that emphasized regional multi-disciplinary planning and service delivery. CLBC has also worked closed with MCFD to both transfer children's services back to government, and to develop and implement protocols to ensure more effective transitions for youth.

Fostering partnerships is an area of ongoing effort at CLBC. As budget and service demand pressures have grown, so has the necessity that CLBC continue to work with partners to help meet the needs of people with developmental disabilities. A key component of this strategy going forward will be to more effectively communicate that the service delivery model for people in British Columbia is comprised of many parts, and that government-funded services are only one part of this support system. Effective communication remains an ongoing challenge. **Ongoing.**

Recommendation 23: Manage expectations and clarify mandate

Managing the expectations of the community living sector has been an ongoing challenge for CLBC. At the time of the review, this largely focused on the disconnect between CLBC's promotion of what was widely seen as an unrealistic message around increasing choice without offering a counterbalancing realistic message about the financial constraints. In addition, there was a lack of clarity about CLBC's role as a government agency rather than an advocate.

To address the concerns, it was recommended that CLBC clarify and clearly communicate that its role is to appropriately and competently allocate resources, not to act as an advocate. This was part of an overall recommendation to better communicate with the sector, in order to manage expectations and reduce frustration amongst clients, partners, and stakeholders.

Progress: Beginning in the summer of 2009, CLBC started specific effort to clarify its role, and this was part of its message during September 2009 regional and provincial meetings with service providers. As noted elsewhere, effective communications has been an ongoing challenge for CLBC. It is anticipated that increased efforts to manage and address unrealistic client and stakeholder expectations will be a focus of communications going forward. **Ongoing.**

Recommendation 24: Foster inclusive practice and the use of generic services

At the time of the original review, there was a sense among some that there had been a decline in the openness and inclusiveness of community services like recreation centers. As the use of community and generic services was – and remains – a key component of the long-term sustainability of CLBC and the community living sector generally, it was recommended that CLBC play a stronger role in bringing together federal, provincial, and municipal-level partners to identify, foster, and make better use of generic community services.

Progress: CLBC annually conducts public awareness initiatives to raise awareness of the importance of inclusive communities and the work that CLBC does. The Start with Hi' initiative is now in its third year, and aims to increase understanding about the importance of safeguards and inclusive communities. This initiative is promoted through social media which includes a "Start with Hi'" Facebook page that currently has over 2,700 fans.

With the RCMP, CLBC has developed icanbesafeonline.com, the first website of its kind in Canada dedicated to educating adults with developmental disabilities about how to stay safe while using the internet. The site recognizes the role the internet and social media play in connecting people to their communities, and helps adults know what information to share online and what to do if they feel at risk.

For the last two years, the Globe and Mail has partnered with CLBC for Community Living Month. This year, London Drugs joined the Globe and Mail as a corporate sponsor for Community Living Month. The focus was I Can Be Safe Online, with an invitation to the general public to be aware of safeguarding vulnerable people online and in community.

For the last two years, CLBC has contributed articles, ads and content to the quarterly disability focused publication, PossABILITIES Now, published by the Surrey Now

newspaper. The publication is circulated throughout the Lower Mainland and on the Surrey Now website.

In 2010/11, 39 Ageing Forums were held throughout the Province with 1275 participants. Many of these forums were held in community facilities, from libraries to senior centres to community recreation facilities. A number of the participants were people from Health Services, community agencies like senior and recreation centres, libraries and local disability clubs and groups like Stroke Clubs and Alzheimer's support groups. Forums allowed for input and ideas on how to best approach and address the needs of Ageing Individuals with Disabilities and their families.

An Ageing Parents Planning Pamphlet was developed and explained to a number of community agencies, including mayors, community colleges, police departments, health services, hospitals and first emergency responders, and recreation and seniors centres.

CLBC has also developed and fostered a number of inter-ministerial relationships, committees and other forums to engage other funding partners in expanding access to generic services. CLBC works closely with MSD and MCFD to promote employment opportunities, in particular youth employment (most recent example is an inter-ministerial policy forum on youth employment occurring in Victoria October 25), provincial and regional work with MOH and the Health Authorities on accessing health services, and connections with other partners such as BC Housing to raise awareness and enhance access to generic services. **Ongoing.**

Recommendation 25: Promote innovation

Innovation was one of the original motivations for the creation of CLBC, and this has only grown more important as financial resources have become tighter across government and throughout the province. It was recognized that ongoing innovation would require working with the business community, health services and other sectors to bring new solutions to the challenges CLBC faces. For this reason, it was recommended that CLBC adopt a specific focus on promoting innovation, including the creation of a specific innovation unit with a dedicated budget and a clear mandate to identify and develop creative options to address issues and challenges.

Progress: Innovation funding was increased from $300,000 to $1 million in 2009-10, with dedicated staff and a more robust evaluation and review process. Initial solicitation for proposals focused on building capacity and moving towards sustainability in the community living sector.

Four innovation projects, focusing on building the capacity of self-advocates, families, and the sector, were commenced in fiscal 2009-10 and continued through the subsequent year. In 2010, CLBC also participated in a number of projects that promoted innovation, including a dialogue table with MSD that discussed longer term sustainability options for the sector; establishing a community living social innovation fund in partnership with 2010 Legacies Now; co-chairing a service provider group that is aimed at re-thinking approaches to service delivery; and exploring ways to better communicate innovative practices. **Ongoing.**

Recommendation 26: Engage service providers more effectively

At the time of the original review, there was a widespread sense that CLBC's relationship with many services providers was strained, affecting the ability to work together to support clients within systemic budget restraints, and potentially compromising the overall sustainability of CLBC. It was therefore recommended that CLBC make specific efforts to engage service providers more effectively, to improve relationships and the ability to work together to put into place an efficient, effective and sustainable service delivery system. In particular it was recommended that CLBC work with service providers to move forward with expanded individualized funding, which was a key component of the original vision for CLBC, but which formed a relatively minor proportion of actual service contracts.

Progress: In the spring of 2009, CLBC finalized its Individual Funding policy, with related communication plan and community engagement plan. This was accompanied by a focused effort to increase dialogue with service providers, including the establishment of 18 "tables" across BC to facilitate information sharing with local service providers.

In addition, in the fall of 2009 CLBC undertook meetings with the newly-formed CEO Network and CLAN to discuss major areas of CLBC policy including costing guidelines, procurement and contracting policies, and a new monitoring framework. These talks continued through the summer of 2010 and resulted in a comprehensive agreement on the above sustainability-related matters.

Finally, as IF is implemented over time across the province, CLBC will include training, incentives and support for service providers to participate. **Ongoing.**

Recommendation 27: Maintain focus on contract reform and contract management

At the time of the initial review, CLBC was at the beginning of its contract management and monitoring initiative. This sought to implement more rigorous contract design and monitoring practices and procedures, allowing CLBC to address major weaknesses in the system it inherited from MCFD. This initiative was also aimed at putting into place a system that would support better contract design, tracking, and evaluation, thereby contributing to the ongoing sustainability of the agency. It was recommended that CLBC continue to focus on designing and implementing this reform initiative.

Progress: By the spring of 2010, CLBC began implementing all phases of reforming contracting processes and systems, including the Supply Registry, Funding Guidelines, New Supplier Agreements, Standards, Outcomes, Monitoring, and the Contract Management System. Release 1 of the Contract Management System and Vendor Document Library was operational by March 31, 2011. Implementation began in May of 2011 with training for all Quality Service staff concluded in mid-July 2011.

Currently regions are converting existing contracts in the new contract formats and using Upside to author contracts. The goal is to have Funding Guide templates completed for all contracts which require them by November 30, 2011. All contracts for which CLBC has developed Upside formats will be in Upside by March 31, 2012 (excluding microboard, IF and PSI contracts). **Ongoing.**

5.6 Summary

CLBC has undertaken significant work to clarify and refocus the roles of the facilitator and analyst. Given the fiscal pressures facing the organization it may be time to re-assess these roles and identify if there are any opportunities to combine and retain the key functions of these positions, and thereby shift resources to direct service to families.

In addition, significant progress has been made on contract reform, particularly regarding the unbundling of global contracts to identify opportunities to shift from residential to home share options. The quality of CLBC's data collection and management has also improved significantly, providing the organization with a more robust system for information analysis.

6.0 BC's service system for people with developmental disabilities

The third area of inquiry for this review is a broad analysis of the overall system for services for people with developmental disabilities in British Columbia, with a focus on three considerations:

1. A high-level comparison of how people in BC are served by CLBC with the systems that serve people with developmental disabilities in other selected jurisdictions;
2. Consideration of the full range of supports and services that people with developmental disabilities receive in BC, from CLBC and other sources; and
3. Identification of options for government to consider with respect to BC's service delivery system for people with developmental disabilities.

The information that follows is not presented at a detailed level. Comprehensive analysis was not possible in the course of this review, due to the timeframes and resource availability. Accordingly, the sections that follow are provided as an initial guide for further consideration.

6.1 Jurisdictional comparison

In order to assess the relative merits and challenges of the system that British Columbia uses to serve and support people with developmental disabilities, a high-level comparison of service delivery systems in other relevant jurisdictions was conducted. The jurisdictions that were included Alberta, Ontario, Manitoba, Western Australia, and New Zealand. Washington State was also added during the course of the review as a comparator on the specific issue of employment supports. These jurisdictions were identified in advance and selected due to similarities in demographics and/or recognition as using leading practices in the field developmental disabilities.

Making comparisons amongst the jurisdictions is challenging, due to differences in service delivery structures, divided responsibilities, and variances in how information is collected and reported. Despite these challenges, this section provides a high-level comparison of the levels of resourcing in the various jurisdictions and how resources are allocated to support services for people with developmental disabilities.

In addition, this section identifies and draws some initial comparisons of the various disability-related needs and resource allocation assessment tools and processes that are used in the comparator jurisdictions. This additional factor was added during the course of the review, in response to specific requests from the review sponsors.

6.1.1 Demographics

In order to establish a comparative framework, key demographic information about the selected jurisdictions was identified. Identifying the number of people with disabilities, as well as the severity and types of disabilities in a population, provides important contextual information for assessing the disability supports available.

Across the jurisdictions reviewed, slightly more than one in six people had a disability (ranging from 16%-21%) and approximately one in a hundred had a developmental

disability (ranging from 0.5% to 1%). People with developmental disabilities make up only a small proportion of people with disabilities within these jurisdictions: on average, 4%.

As this review encompassed international jurisdictions, the way disability was defined differed slightly across national borders, which may account for some of the difference in the reported proportions of the populations with disabilities. In all of these definitions, disability is a self-reported measure of activity limitation, so answers are greatly influenced by the person's perception of what constitute a disability, and his or her willingness to report the limitation.

Three key surveys were reviewed[1], all based on the World Health Organization framework of disability provided by the International Classification of Functioning. This defines disability as the relationship between body structures and functions, daily activities and social participation, while recognizing the role of environmental factors. Each survey acknowledges that there may be some underreporting due to the sensitive nature of the condition or a lack of awareness of the presence of the condition on the part of the person[2].

In Australia and New Zealand, developmental disabilities are referred to as intellectual disabilities, but have the same general definition: people who have significantly greater difficulty than most people with intellectual and adaptive functioning and have had such difficulties from a very early age (adaptive functioning means carrying out everyday activities).[3] Other key aspects of how developmental disabilities are understood are that they originate before 18 years of age and are likely to be life-long in nature.

Although there is general consensus with the definition of developmental disability, there are some variations in the way this is applied and assessed for eligibility of specific services in each jurisdiction. These differences are addressed in section 6.2, below.

A second contextual factor is that the proportion of the population with disabilities in Canada is increasing, although the growth is primarily amongst people with mild and moderate degrees of disability. Across the Canadian jurisdictions, between 2001 and 2006, there were slight increases in all jurisdictions in the numbers of people with disabilities. This differs from the recent trend in Australia, where there has been a slight decline in the number of people with disabilities, attributed to a decline in the population with physical health problems due to asthma and breathing issues.[4]

The Canadian increase in the population of people with disabilities is attributed both to the ageing population and an effect called the "period effect." The period effect is the combination of societal and medical changes that occur over time and can affect the way disability is self-reported by respondents. These changes may include less stigmatization of persons with disabilities, higher expectations of personal functioning, better detection and treatment of disease or injury, better assistive technologies and devices, and the way individuals interact with their environment.

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[1] *Participation and Activity Limitation Survey (PALS*) (Canada); Survey of Disability, *Ageing and Carers* (Australia); *Disability Survey* (New Zealand).

[2] See Appendix 9 for a table summarizing the definitions of disability used.

[3] E.g. National Coalition on Dual Diagnosis, *Dual Diagnosis Glossary*, 2008

[4] Australian Bureau of Statistics. *Disability, Ageing and Carers: A Summary of Findings*, 2009

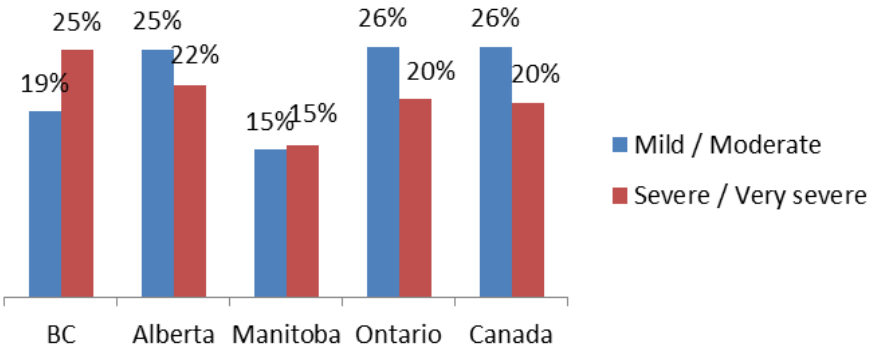

Figure 8: Percent growth in numbers of people with differing levels of severity of disability, 2001-2006[5]

The number of Canadians with disabilities is expected to continue to rise as Canada's baby boomer generation ages, with projections that by 2026, the number of people with disabilities over 65 years of age will be almost double those reported in 2001.[6] While the overall increase in the percent of the population with disabilities augurs a potential increase in demand for funding for disability supports, it is worth noting that the percent of the population who require the most support may not be changing at the same rate. The chart above shows that the increase in disabilities is primarily in mild and moderate forms, and less in severe or very severe.

In British Columbia, the number of people with developmental disabilities is growing faster than numbers of people with disabilities overall. As set out in Figure 3, BC had a significantly higher growth than other Canadian jurisdictions of people with developmental disabilities versus disabilities overall from 2001 to 2006. If the same percent of growth were to have occurred in BC between 2006 and 2011, the number of people with developmental disabilities would have increased by 8,600 to 35,910. CLBC's caseload has grown at a similar rate, with a growth of 35.5% between 2005/06 and 2010/11 (on average 5.8% a year).

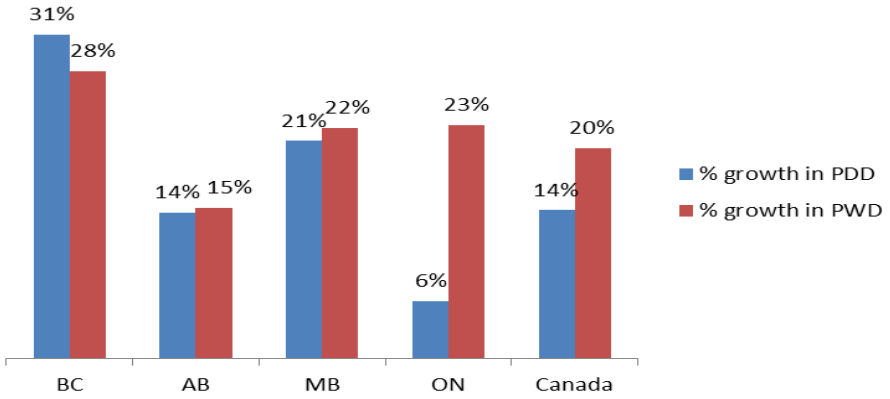

Figure 9: Percent change in population of all people with developmental disabilities compared to change in population of all people with disabilities, 2001-2006[7]

[5] Statistics Canada, *Participation Activity Limitation Survey 2006 Tables*
[6] HRSDC, *Addressing the Challenges and Opportunities of Ageing in Canada*, 2007
[7] Statistics Canada, *Participation Activity Limitation Survey 2006 Tables;* Please note that this table includes all people, not just adults, with developmental disabilities for greater data reliability.

This growth does not appear to be due to more children being born or diagnosed with developmental disabilities, but rather to an increase in "older" adults with developmental disabilities identifying a need for services. Other Canadian jurisdictions reviewed, and Canada as a whole, had a markedly different trend. It is unclear why this increase has occurred, or if this is an aberration as data was not available for earlier years. However, it clearly indicates a potential increase in demand for services for people with developmental disabilities.

In addition to a higher growth rate amongst people with developmental disabilities than other provinces, BC can expect a greater increase in the numbers of people with more severe disabilities than other Canadian jurisdictions.

As set out in Figure 10, below, people with developmental disabilities tend to have more severe disabilities than people with disabilities overall. The increase of numbers of people with developmental disabilities in BC suggests that while across Canada, the increase in numbers of people with disabilities will be primarily in those with mild and moderate disabilities, in BC the increase may be more concentrated in people with more severe disabilities. Therefore, strategies adopted by other provinces may be responding to different demographics and may not be as relevant to BC's situation.

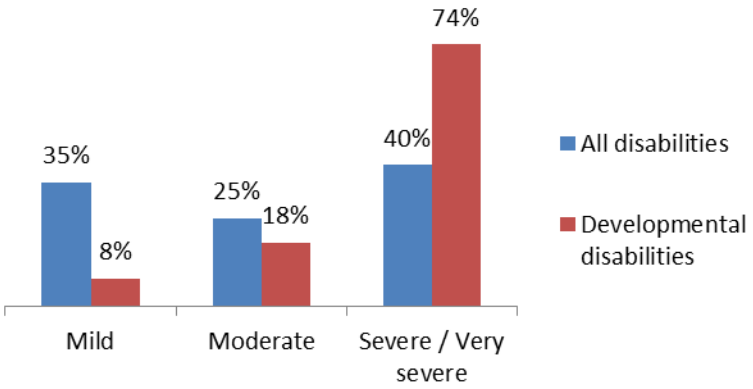

Figure 10: Comparison of distribution of severity of disability, between all people with disabilities and people with developmental disabilities, in Canada, 2006[8]

6.1.2 Funding and Service Delivery Structures

It is a trend amongst jurisdictions to move toward service delivery through a centralized agency. However, even in those jurisdictions where a central agency delivers most disability supports, some supports are delivered by one or more additional agencies. The effect is that, in each of the surveyed jurisdiction, disability support services are funded and delivered by multiple agencies.

In jurisdictions that have moved to a more centralized approach, there is either a central agency for people with all disabilities, or one that has a specific mandate to serve for people with developmental disabilities. The agency also often plays a coordinating role, developing, monitoring and reporting on a comprehensive strategy to increase the inclusion of people with disabilities. However, even where these central agencies exist, some supports for people with disabilities are delivered through other agencies.

[8] Statistics Canada, *Participation Activity Limitation Survey 2006 Tables*

The basic structures for the surveyed jurisdictions are set out in the following table:

	BC	W.A.	AB	MB[9]	ON	NZ
Central agency for people with disabilities		x				x
Central agency for people with developmental disabilities	x		x		x	
Some or all services distributed amongst multiple ministries or agencies	x	x	x	x	x	x

Figure 11: Service Delivery Structure, by jurisdiction

Within their overall structure, every jurisdiction has mixed responsibilities for the delivery of specific services for people with developmental disabilities and disabilities in general. Five categories of supports have been identified, which are explained in greater detail in section 6.4. The specific responsibilities for each jurisdiction is included as Appendix 5, and these are summarized in the table that follows:

Support category →	Facilitation & Referral	Accommodation	Individual & Family Support	Income Support	Employment Support
British Columbia	Ministry of Social Development (MSD) – Community Living BC (CLBC) MSD	MSD (CLBC) MSD (BC Housing)	MSD (CLBC) Ministry of Health Ministry of Advanced Education	MSD Government of Canada[10]	MSD CLBC
Western Australia	Disability Services Commission (DSC) FHCSIA	DSC	DSC Families, Housing, community Services and Indigenous Affairs (FHCSIA) - federal	Human Services (HS) - federal	HS FHSCIA
Alberta	Ministry of Seniors and Community Supports (MSCS) PDD Program	MSCS Persons with Developmental Disabilities (PDD) Program	MSCS PDD Program	MSCS Government of Canada	MSCS
Manitoba	Ministry of Family Services and Consumer Affairs (MFSCA)	MFSCA	MFSCA Ministry of Health (MOH)	MEIA Government of Canada	Ministry of Employment and Income Assistance (MEIA)
Ontario	Ministry of Community and Social Services (MCSS) – Developmental Services Ontario (DSO)	MCSS (DSO) Ministry of Municipal Affairs and Housing	MCSS (DSO) Ministry of Health and Long-Term Care	MCSS – Ontario Disability Support Program (ODSP) Government of Canada	MCSS (ODSP)

[9] In Manitoba, Community Living disABILITY Services serves more as a program than an agency. Some service funding flows through this program, but some is also contracted directly by government, making it dissimilar to the focused, clearly defined mandates of CLBC and PDD.

[10] Canada Pension Plan – Disability

New Zealand	MOH – Disability Support Services (DSS)	MOH (DSS) MSD – Office for Disability Issues (ODI)	MOH (ODI)	MSD (DSS) Min. of Labour – Accident Comp. Corp.	MSD

Figure 12: Service Delivery Structure, by jurisdiction

In addition to all of the specific governmental responsibilities for service delivery streams as outlined above, almost all of the jurisdictions under review have a coordinating strategy to improve accessibility and inclusion for people with disabilities. While the scope and status of each of these is difficult to determine, the respective strategies are set out in the following table:

	BC	W.A.	AB	MB	ON	NZ
Disability Strategy	Provincial Disability Strategy, 2008	Count Me In: Disability Future Directions, 2009 National Disability Strategy, 2011	Premier's Council Strategic Plan, 2009	Opening Doors: Manitoba's Commitment to Persons with Disabilities, 2009	N/A	New Zealand Disability Strategy, 2009
Who monitors?	MSD	DSC FHCSIA	Premier's Council on the Status of Persons with Disabilities	Disabilities Issues Office	N/A	Office for Disability Issues
Annual public progress report	No	Yes	No	Yes	N/A	Yes

Figure 13: Disability Strategies, Monitoring and Reporting, by jurisdiction

As set out above, Ontario does not have a comprehensive disability strategy, though they have been reviewing and implementing new legislation in the past few years to improve supports for people with disabilities. In Western Australia, both the state and national governments have disability strategies, though these complement and intersect with each other.

In all of these jurisdictions, non-profit community based organizations play an important role in informing and monitoring government strategies for people with disabilities, and many of these agencies are funded by government for this role, among others. The development, implementation, monitoring and reporting on disability strategy also requires resources.

6.2 Needs Assessment Tools

All jurisdictions surveyed use some sort of formalized assessment tool and process to try to identify the specific disability-related need(s) of individuals who are eligible for services and, in the best case scenario, to allocate appropriate resources to meet that need.

Regardless of the specific methodology used to calculate budgets based on individual support needs, most funding models can be classified as either 'prospective' or 'retrospective'. The difference is the stage at which, in the process of assessing, planning and monitoring, an individual's budget allocation is determined.

- Prospective methods determine individuals' funding allocations prior to the development of their support plan. These methods use statistical modelling to determine the contribution of multiple variables in predicting the level of funding required to meet need. While prospective models work well to ensure that existing resources are fairly and equitably distributed, the cost data are based on overall fixed funding amounts for disability supports and so the sufficiency of each individual's allocation is dependent on the size and proportional adequacy of the overall existing funding.
- Developmental or retrospective methods wait until the person-centered planning process is complete and then an individual budget is calculated that is sufficient to purchase the planned supports. These methods might have fixed hourly or unit rates determined through fiscal analysis, but the hours of support needed are negotiated as part of the planning process. These accounting-based methods are good for assuring that an individual budget amount is adequate to meet a given person's needs. However, they do not work well in assuring that the total resources available are necessarily distributed in an equitable or fair manner.

Amongst the comparator jurisdictions, assessment tools that are used include the Support Intensity Scale (SIS), used in Ontario, Alberta and Washington (and 25 additional American states); CLBC's Guide to Support Allocation (GSA) and related tools; and the Estimate of Requirement for Staff Support Instrument (ERSSI) and the Inventory for Client and Agency Planning (ICAP), which are used in Western Australia. Washington also uses ICAP along with the SIS.

Although the SIS is the most widely used assessment tool, it was not adopted in BC when CLBC came into being in 2005. This was largely because of the distinct separation between the planning and costing roles (facilitators and analysts) in BC: the SIS model requires that the analyst have a direct relationship to the individual in order to complete the complicated and intricate assessment process. In BC, it was considered that this would impact the ability of the analyst to remain impartial to the determination of benefit allotments, and the CLBC facilitator currently has the primary relationship with the person requesting service.

Current assessment tool use for people with developmental disabilities is summarized below, and a description of each follows. In addition, an initial summary of the key characteristics of each of these tools is included as Appendix 6.

	BC	W.A.	AB	ON	Washington
Assessment Tool used	Guide to Support Allocation	Estimate of Requirement for Staff Support Instrument (ERSSI) Inventory for Client and Agency Planning (ICAP)	Support Intensity Scale	Support Intensity Scale	Support Intensity Scale Inventory for Client and Agency Planning (ICAP)

Figure 14: Needs Assessment Tools, by jurisdiction

6.3.1 Guide to Support Allocation

The CLBC Service Delivery Model is supported by policy tools in three key areas: individualized planning guidelines (Discovery Goal Based Planning; guide to creating an Individual Service Plan); assessment of disability-related need (Priority Ranking Tool, Guide to Support Allocation) and resource allocation (Catalogue of Services).

The Guide to Support Allocation (GSA) was a first attempt in BC to provide an objective assessment of the disability-related need of the individual. When initially adopted, challenges were identified in term of application: the information that is provided in plans was sometimes insufficient for analysts to make assessments, requiring them to contact families or facilitators for more information. There was also a misperception that going through the GSA process was akin to approval of the plan, but this is not the funding step. CLBC's Guide to Support Allocation tool (GSA) used the Resource Allocation System model developed in the UK as a primary template.

The Guide to Support Allocation is intended to support Quality Service Analysts to make a professional judgement about the level of support a person requires based upon "individual disability related need" as outlined in an Individual's Support Plan. It applies a numerical level of disability-related need (0 to 5 points based on ascending need) to the individual in ten areas of everyday life:

1. Communication
2. Routine personal care needs*
3. Creating/maintaining relationships*
4. Making day-to-day decisions
5. Making important life decisions
6. Safety within community*
7. Work and learning
8. Community participation
9. Complex health needs (including mental health)*
10. Complex risks and actions*

In those areas marked with asterisks, "flags" can be included to identify specific, extreme situations that are considered critical in determining the support needs of the individual. Where there is a flag, CLBC uses its discretion to ensure that needs are met, either though engaging specific supports are providing additional funding. Approval from a QS Manager is required, and temporary flags are reviewed at least once per year.

When all ten areas are reviewed and a numerical determination of need is made in each, the analyst adds up the total score, which is then divided by the number of areas where scores were recorded. Flags are not scored and therefore the areas that they fall into

are excluded from determining the average score as related to the disability related needs of the individual. This is all reviewed against the individual's service plan, to confirm the appropriateness of supports and services to be funded by CLBC – the question being: is the request reasonable and relevant given the disability related need of the individual?

Once the average score is determined and approved, the numerical level is cross-referenced with the *Catalogue of Services* and Resource Allocation Schedule to determine the maximum level of service and/or funding for which the individual is eligible. QS Manager approval is required for funding allocation in excess of those outlined in the Resource Allocation Schedule.

The GSA and its related tools have not been adopted by other jurisdictions. The tools are specifically designed for CLBC's target population: adults with developmental disabilities, although a version for children's services was drafted but never finalized due to the transfer of children's services back to MCFD. It has not been tested against a wider group or adapted to assess the needs of people with other disabilities or needs

There are no costs associated with the GSA – it was developed in-house at CLBC, and is now regularly used as part of staff duties, with application for clients in both the developmental disabilities stream and the PSI stream.

In terms of feedback, some service user advocates have expressed concern that the analysts interpreting the results of the "Guide to Support Allocation" do not necessarily have to have any experience working with people with disabilities. In addition, the inclusion of flags is seen by some as a fundamental flaw, compromising the attempt to provide overall objectivity because flags can essentially overwrite the entire points-based analysis. Others see this as a key requirement for the flexibility that the target population requires, and a significant advantage over more strict systems such as the Supports Intensity Scale.

The GSA is seen by CLBC as an appropriately objective tool, and internal reviews have demonstrated that staff applies it in a sufficiently standardized manner so that disability-related needs are consistently assessed across the province. It has not been peer reviewed or rigorously validated, although it is modeled on the Contact 4, which is used in the United Kingdom and which has been fully reviewed and validated. A key advantage of the GSA is that it is clearly linked to and provides a sound basis for resource allocation based on the assessment of individual need.

6.3.2 Support Intensity Scale

The Support Intensity Scale (SIS) is an assessment tool that evaluates practical support requirements of a person with an intellectual disability. Available in print and electronic formats, SIS consists of an 8-page Interview and profile form that tests support needs in 87 areas, and a 128-page user's manual. The scale ranks each activity according to *frequency*, *amount* and *type* of support required. A Supports Intensity Level is determined based on the Total Support Needs Index, which is a standard score generated from scores on all the items tested by the Scale.

The SIS measures support requirements in 57 life activities and 28 behavioural and medical areas. SIS measures support needs in the areas of home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. Traditionally, a person's level of developmental disability has been measured by the skills the individual lacks. SIS shifts the focus from lacks to *needs.* The SIS is not directly comparable to tools such as the ICAP (following).

The SIS has been widely adopted: in addition to approximately 26 American states, another 14 countries also use the SIS. Like CLBC's GSA, the SIS is designed for people with intellectual disabilities, and its application has thus far been limited to that population. It was normed for people with "mental retardation", and it is not clear that the SIS could be applied to CLBC's PSI clientele. It's use has been limited to adults, although a children's version was field tested in 2009 and will be available for use in 2013.

SIS assessment is done through an interview with the client, ideally by someone who knows the person well (most states use case managers to conduct the interview). It typically takes two interviews of two hours each, and interviews may be conducted individually or in small group settings, interviewing two or more respondents at the same time.

The interview process is key with the SIS assessment and there is significant emphasis placed on closely following the user guide for administering the assessment tool. In the USA, it is administered by trained interviewers with extensive experience in supporting people with disabilities and/or a bachelor's degree in an appropriate human service field. The main purposes of the SIS is the formulation a good individual service plan.

The SIS is described by some stakeholders as an extremely complex and intensive analysis requiring the use of an approximately 100 page detailed users' manual and interpretation guide. Research has indicated that SIS scores contribute significantly to a model that predicts greater levels of support need.

SIS measures the intensity of support that a person needs along several dimensions of everyday living, including both a total index score and standard scores for each of identified six life activity areas. SIS also provides an additional dimension by assessing whether a person has extraordinary medical or behavioural support needs. When employing SIS in a funding application, all of these parts of SIS should be taken into account. For example, some people have low support needs but have extraordinary behavioural support needs that require extensive staffing. Basing funding solely on the total index score would fail to take into account the other key medical and behavioural support needs that a person might have.[11]

Jurisdictions who have implemented SIS have found that SIS alone explains only about 30% of the difference in funding among individuals. The remaining variance can be attributed to factors that SIS itself does not measure such as the extent of unpaid support that is available to a person or whether a person requires close supervision due to involvement in the criminal justice system. For the purposes of resource allocation, additional data is also obtained per participant such as expenditure on billings and paid

[11] National Disability Authority (2011) *The Introduction of Individual Budgets as a Resource Allocation System for Disability Services in Ireland: A Contemporary Developments in Disability Services Paper*

claims from state mainframe data systems, information on living arrangements, risk assessment data etc. In Washington State, where SIS is used as a funding model, the process is as follows:

1. First, assessment responses are used to determine how frequently an individual needed support, within six categories from weekly or less, to those with extensive behavioural support needs. Typically, the majority of people with developmental disabilities will be appropriately classified within such a model, however, that those with severe and complicated disabilities will not be covered by the SIS model.
2. Next, assessment responses are used to determine the number of Base support hours needed in various life areas presuming that the residential provider would deliver all of an individual's support hours and that none of these support hours would be shared with other clients.
3. The Base Hours represent the average support time required in each life area for persons who responded to the assessment questions in a similar manner. However, averages do not necessarily present an accurate picture of the appropriate residential rate for a particular individual. The purpose of the Economies of Scale is to make adjustments to the statistically predicted individual rate based on personal and environmental factors that may not have been adequately taken into account, such as whether the client refuses support or has access to support elsewhere.
4. Once the number of hours that the residential provider is going to offer is determined, the resource manager and the residential agency discuss how many of these hours must be reserved specifically for this individual and how many support hours can be shared with others living in the household or cluster,
5. Once the direct care service hours have been determined, the resource manager generates the administrative rate component. The sum of the calculated direct care hours multiplied by the benchmark plus the additional administrative rate components becomes the final rate that the residential provider will be paid to support the client.[12]

A recent study identified a number of strengths and weaknesses of the SIS:

SIS: Strengths and Weaknesses	
Strengths	**Weaknesses**
• Provides useful information about the supports needed and the intensity of those supports taking into account the frequency or intensity of the support required. • Positive feedback that instrument contributes to effective individual service plan development. • Directly assesses support need. Contrasts with tools such as the ICAP, which provide information from which the level and intensity of support needs must be deduced.	• The tool is best administered by individuals who are skilled interviewers, placing a high premium on training personnel in the administration of the tool. • The baseline SIS instrument must be supplemented to secure additional pertinent information about the person. • Inter-rater reliability is less strong than other tools. This stems in part from the

[12] Weber, Lisa and Stern, John (2008). "Washington's Residential Resource on Intellectual and Developmental Disabilities.

• The employment part of the tool is especially strong. The SIS is the only tool that includes a focus on employment-related supports. • The tool exhibits acceptable psychometric properties. • By securing information from multiple informants, the tool potentially yields a more informed assessment of the person.	nature of the tool and how it is administered. Inter-rater reliability is improved when personnel receive extensive and thorough training and when the tool is administered by a small number of individuals. It also is expected to improve through further refinement by AAMR of training materials.

Figure 15: Strengths and Weaknesses, SIS[13]

6.3.3 Estimate of Requirement for Staff Support Instrument

The Estimate of Requirement for Staff Support Instrument (ERSSI) is an instrument developed and used by the Western Australia Disability Services Commission to allocate funding to individuals with disability by determining the support needs of those individuals. ERSSI is designed to be applied to people with all disabilities, although people with complex needs will be assessed with ICAP (following). It is used for adults sixteen and older.

ESRRI consists of a 30 question interview administered by contracted service providers, which takes between fifteen and thirty minutes to complete, and another twenty minutes for the Disability Services Commission to score and analyse. Contracted service providers are not compensated for this time. The topics included in the interview are:

ERSSI: Domains of Inquiry		
Adaptive Skills Domain	**Behaviour Domain**	**Medical Domain**
• Eating • Toileting • Tooth Brushing • Bathing and Showering • Dressing • Mobility • Transfer • Receptive Communication • Expressive Communication • Community Mobility • Purchasing Skills	• Endangering Behaviour • Staying at Home Alone • Aggressive Behaviour • Destructive Behaviour • Threatening Behaviour • Disruptive Behaviour • Stereotypic Behaviour • Self-injurious Behaviour • Illegal Behaviours • Petty offences - minor • Criminal behaviour - serious	Diagnoses and conditions

Figure 16: ESRRI Domains

[13] Colorado Department of Human Services , Division for Developmental Disabilities, "Assessment Instruments and Community Services Rate Determination", 2008

The ERSSI provides an estimate of the number of direct care hours required for a given individual(s) in group settings of two to eight people. The result is also used as a maximum funding benchmark for other service models, such as individual options.

The funding rate is based on an amount per staff support hour and a percentage for Program Support. The rate is standardised for all service providers to ensure equity for consumers and service providers. The ERSSI rate is set for clients at the time of initial assessment, indexed at at least 2% per annum. The 2011 pricing rate is:

Support Staff cost per hour + Program Support cost (15%) + Other costs (6%) = Total $45.10

There are some variations on the benchmark rate, such as:

- For services that involve consumer management, the program support is capped at 10% (instead of 15%).
- For new Community Support services that operate exclusively on weekends, the maximum funding rate may include an additional 8% on top of the standard hourly rate (which already includes a proportion of the weekend and evening penalties).

As well as a standardized hourly rate, there are also some maximum benchmarks for different types of services.

- The Community Living Support Funding strategy has a maximum of $20,000 per individual.
- Funding for accommodation services is capped at $30,000 per year, based on the costs of one quarter of the predicted total funding for a four person group home. However, additional support is available through Accommodation Support Funding, in the following situations:
    - Shared care or individual arrangements that aim to enable people with a disability to live in the community in a home environment as close as possible to that enjoyed by other community members;
    - Individualised accommodation options where the person lives in their family's home and support costs are more than the designated benchmark per annum ($30,000); and
    - Foster care options where the child spends 50% or more time away from their family of origin.

A higher hourly rate is also available for those who have been assessed as having significant challenging behaviour. To qualify for the higher significant challenging behaviour rate, an independent assessment is conducted using the Inventory for Client and Agency Planning (ICAP).

Disability Services Commission policy acknowledges that there are cases where the assessed need underestimates actual need, especially in the initial stages of the

establishment of an accommodation option. In this case, the Board of the Commission has the discretion to allocate above the estimated amount.

The Disability Services Commission has found that the ERSSI is not a strong predictor of support hours and costs for a person moving into an individualized option. Individual needs analysis or assessment is often required to provide a better and more comprehensive estimate of support hours and costs. Specifics on the individual needs assessment process, which is additional to the ERSSI and ICAP, were not available.

The normal process adopted by the DSC in assessing funding levels follows (this is illustrated in Appendix 7):

- The service provider submits a funding plan to the Commission;
- It assesses the plan and determines whether it is capable of delivering the required services and is within acceptable pricing limits and policy parameters;
- In order to determine whether the requested funds are within acceptable limits, the DSC uses the ERSSI to benchmark the required support hours for that group of individuals; and
- It then applies its benchmark hourly rate along with the 6% "Other Costs" component to determine the maximum funding available.

Concerns about the ERSSI and related funding model include:

- Some service providers have described the fluctuating nature of some people's behaviour which means they may have long periods of stability with services working well and times of instability where increased resources are required.
- A 2009 review found that the standard rate provided unequal service to people with disabilities who accessed service through small or medium service providers, or regional only providers. These organizations experienced higher percentages of funding for travel, administration and training costs. Small and medium providers lacked administrative support structures, and often had older and more costly transportation infrastructure, and had smaller numbers of staff to provide backup when others accessed training.
- Past criticisms of the ERSSI include that it does not adequately identify the support requirements of people whose behaviour is seen as challenging. This can result in service funding that may not adequately match the best service design option. However, this critique has been addressed with the introduction of the use of ICAP to confirm high support needs, which then allows a higher hourly rate to be used in calculating funding.

6.3.4 Inventory for Client and Agency Planning

The Inventory for Client and Agency Planning (ICAP) is designed as a structured assessment of an individual's: (a) adaptive behaviour and (b) problem behaviours (maladaptive behaviour). ICAP is used to assist service providers, regional authorities, and state agencies in compiling standardized profile information about individuals who receive services.

The stated purpose of the ICAP is to "aid in screening, monitoring, managing, planning and evaluating services." The instrument was not developed principally to support rate determination or resource allocation strategies, although it has been employed by

several states for such purposes. The ICAP is intended for use with adults and children who are at least three years of age. It is applicable to people with all types of disabilities.

The *Inventory for Client and Agency Planning* is a 16 page booklet that, in addition to measuring adaptive and maladaptive behaviour, also gathers a compact but comprehensive set of information about an individual's demographic characteristics, diagnoses, support services needed and received, and social/leisure activities. ICAP is composed of 185 items related to an individual's adaptive behaviour (i.e., a person's skills); problem behaviours; diagnostic information; demographics; functional limitations; required assistance; services received and recommended changes in services.

The ICAP is designed to be administered by a parent, teacher, care provider or professional who has known the person for at least three-months and sees the person on a day-to-day basis. As a consequence, the ICAP often is frequently administered by service providers. However, in some states, case managers are tasked with administering the ICAP or reviewing provider-administered ICAPs. Alternative approaches to administration include contracting with third-parties to administer the tool with the third party examiner consulting with up to three key-informants who know the individual.

Tool administrators (examiners) must be trained. There is a complete, well-designed examiner manual that supports training. Specialized clinical skills are not required to administer the ICAP. Scoring the results is straightforward and is built into the instrument. Training to administer the tool should require no more than one day.

The ICAP's adaptive and maladaptive behaviour sections contain items selected from the Scales of Independent Behaviour (SIB-R), with norms for infants through adults. The ICAP yields a Service Score, a combined measure of adaptive and maladaptive behaviour indicative of overall need for care, supervision, or training.

In Western Australia the ICAP is used to assess problem behaviour if deemed by an ERSSI assessment to be out-of-scope. If an independent assessment using the ICAP confirms that the person has problem behaviour at the very serious level, they are eligible for a higher form of funding.

ICAP was not designed for resource allocation, though it is used this way by several US states.

During the development of ICAP as a model to assist in resource allocation, jurisdictions would typically compile information from a large sample of service users and the services they have received (in dollars) over the last year, and develop correlations between ICAP scores and service utilization patterns using multiple regression analyses. These correlations are converted to "ICAP formulas" which can be used to assign future public funds to individuals. Recent funding levels are used to establish a financial baseline to calibrate the ICAP scores.

The relationship between the number and cost of service units and the ICAP functional assessment scores is analyzed, and funding formulas for residential and day programs are developed. The formulas and processes using ICAP to determine or assess adequacy of resource allocation differ across jurisdictions,. The following example shows how Texas uses the ICAP for rate setting: depending on the Service Score, there are scales of hourly rates for each service category.

ICAP Service Score	Texas Level of Need	Foster Home Scale	Group Home Scale	Day Support Scale
70-100	Intermittent to Limited	42.23 to 45.51	100.73 to 110.30	14.52 to 18.15
40-69	Limited to Extensive	45.51 to 61.95	110.30 to 124.64	18.15 to 24.20
20-39	Extensive to Pervasive	61.95 to 84.97	124.64 to 148.54	24.20 to 36.30
1-19	Pervasive	84.97	148.54	36.30
Note "a"	Pervasive Plus	111.27	196.35	145.22
"a" Certification that self-injurious, disruptive or aggressive behaviour constitutes a clear and present danger to the individual or others with constant one on one supervision needed to ensure health and safety.				

Figure 17: Texas use of ICAP

With respect to feedback, a recent report assessed the following strengths and weaknesses:

ICAP: Strengths and Weaknesses	
Strengths	**Weaknesses**
• Reliable tool for measuring adaptive and problem behaviour. • Acceptably differentiates among individuals with respect to extent of their adaptive and maladaptive behaviours. • May be applied to both children and adults. • Exhibits acceptable psychometric properties. • Supports compiling robust information concerning people receiving services. • Tool is relatively compact, given its intended purpose. • Instrument scoring is relatively straightforward. • The tool is in relatively wide-use, with various applications.	• Collects relatively minimal information about individual health status; health status is not considered in calculating the Service Level Index score. • Not widely employed to support the development of individual service plans. While on face the instrument speaks to services needed, this part of the instrument is underdeveloped and especially subject to administrator judgment. • Does not directly measure the frequency or intensity of the support necessary to assist a person; instead, inferences must be made about support needs. • Does not take collected information about the extent to which non-paid caregivers are available to meet needs. • Does not contain sufficient elements related to vocational/employment supports. • Sometimes characterized as a "deficit-based" rather than a "strengths-based" instrument. • Anecdotal evidence that ICAP scoring is influenced by the type of individual who administers the tool. • The most common error in ICAP administration is the multiple rating of the same behaviour in several of the ICAP maladaptive categories, resulting in an over scoring of a person's problem behaviours.

Figure 18: Strengths and Weaknesses, ICAP[14]

In Western Australia, ICAP is used in tandem with the Estimate of Requirement for Staff Support Instrument. Generally speaking, it appears that the ERSSI is applied first and if

[14] Colorado Department of Human Services , Division for Developmental Disabilities, "Assessment Instruments and Community Services Rate Determination", 2008

there is an indication that the individuals will have higher support needs, they are assessed again with the ICAP. This then links to a higher resource allocation.

6.3.5 InterRAI Assessment Tool

In addition to the above developmental disability-focussed tools, the interRAI needs assessment tool also has some applicability for people with developmental disabilities as well as people with other disabilities.

The interRAI assessment tool, developed by an international consortium of researchers and originally focussing on identifying the needs of geriatric patients in a standardized way, is currently used by BC's Ministry of Health. Its current application includes the Ministry of Health's Home, Community and Integrated Care Branch.

interRAI has also developed an assessment module for people with intellectual disabilities. This is a comprehensive, holistic approach that assesses individuals' needs, strengths and preferences in the following domains:

- Education, employment and recreation
- Psychological well-being & social supports
- Lifestyle
- Environmental assessment
- Communication and vision
- Cognition
- Health conditions
- Functional status
- Oral and nutritional status
- Mood and behaviour
- Medications
- Service utilization and interventions
- Diagnostic information

In addition to these assessment domains, the tool gathers identification information about the individual, as well as their intake and initial history. There are multiple questions in all domains, which is collected and entered into a database in a standardized way. Items are based on best-practice; both the items and tools have been evaluated using published research studies which ensures consistency in assessments between assessors and assessment instruments. The assessment has internal consistency and imbedded algorithms calculate scales which have been extensively researched and validated against industry gold standards.

A copy of the interRAI assessment tool for intellectual disabilities is included as Appendix 8.

Acquisition and licensing costs for interRAI are minimal, with a nominal licensing fee of $1. However, there are significant implementation costs associated with the necessary hardware, requiring a business decision on how the tool will be used (e.g. desktops, tablets, or laptops). There are also costs associated with training and vendor costs for development of the required software (including consideration of what reports to build into the system, for example). The Ministry of Health is unable at this time to provide an estimate of the cost to implement interRAI in Home, Community and Integrated Care, but suggests it is "in the millions". These are largely one-time costs, however.

The interRAI tool can be applied by a wide range of staff. Although a background in assessment is helpful, training is available so that in Ontario, for example, interRAI is applied by staff with one-year diplomas.

The interRAI tool is considered to be highly objective because it is fully standardized and people are trained to apply questions and code responses in a particular way. Data

analysis is also standardized. While the tool does not assess outcomes specifically, it allows for the tracking and analysis individuals over time, which in turn allows for analysis about the effectiveness of specific interventions or supports.

Although there is no link to resource allocation at the individual level through the interRAI tool, it can be used to predict future need at an aggregate level. Health authorities, for example, use information from interRAI to get a sense of workload distribution and make decisions about staffing and client location based in part on this information. At the individual level, the tool is does not prescribe a set course of action but rather is used to inform professional judgement and resource allocation decisions.

6.3.6 Summary: Needs Assessment Tools

Currently, the various ministries that provide services to people with developmental disabilities (and disabilities generally) use different assessment tools. This is inefficient and inhibits a standardized comparison and understanding of individuals' needs over time and across service systems. Government has expressed interest in moving towards an assessment approach that is consistent across ministries and agencies, in order to provide more predictability and standardization both for individuals seeking assistance, and government as a whole.

As set out above, most of the comparator jurisdictions use some form of assessment to determine disability-related need and, in some cases, to link resource allocation to that need. All of these have advantages and disadvantages, with SIS being the most widely-used assessment tool.

The Guide to Support Allocation, developed and used by CLBC, presents some strong benefits, including a clear link to resource allocation and minimal implementation and operational costs. It is also based on a validated UK approach, has been well received by staff, and is applied to both the developmental disability and PSI clientele at CLBC.

The interRAI tool, used by the Ministry of Heath, shows initial promise as a cross-ministry tool, and has been strongly welcomed where it has been implemented. It does not appear to provide a clear linkage to resource allocation however, which could serve as a drawback for adoption as the cornerstone of a more systemic approach to needs assessment.

6.4 Developmental disabilities supports and services

Although it is very challenging to draw direct comparisons between the jurisdictions with respect to the kinds of services that are provided and the level of resourcing that is dedicated to relevant supports, five categories of disability supports and services were identified in the course of this review. These five categories form the basis for comparisons in the sections that follow:

- Facilitation and referral;
- Residential supports;
- Individual and family supports;
- Employment supports;
- Income supports.

The types of services included within each of these categories differed somewhat between jurisdictions, and the section which follows provides a comparison across jurisdictions for the type of supports, degree of funding and numbers served within each category. Excluded from these five categories are traditional health services including drug, dental and medical treatment costs. British Columbia was able to provide an estimate of some of these costs, but all other jurisdictions did not report on health costs for people with disabilities separately from the broader population.

Information was not consistently available across jurisdiction for each category, and, as a result, there are gaps in the information below. The funding reports that follow are, at best, minimum funding for a type of support, as there may have been additional programs or grants that we were unable to locate. Nevertheless each support category section includes a summary table which presents, at minimum, whether the type of support is offered in each jurisdiction.

Eligibility requirements for services for people with developmental disabilities are similar across jurisdictions: all require demonstration of significantly impaired functioning accompanied by impaired adaptive behaviour, which has existed prior to adulthood. Eligibility requirements are summarized on the following table:

Eligibility Requirement ↓	BC	WA[15]	AB	MB	ON	NZ
Age	19 +	If 65+, disability onset = pre-65	18+	18 +		
Diagnostic	DSM IV Mental retardation (IQ 70 or below), FASD or ASD plus	More than two standard deviations below the mean on a recent (within 3 years) intellectual functioning assessment	Full scale IQ score 2 or more SDs below the mean,		Overall score of 2 or more standard deviations (SDs) below the mean on standardized IQ test	

[15] Disability Services Commission, Eligibility Policy for Specialist Disability Services, 2010

Eligibility Requirement ↓	BC	WA[15]	AB	MB	ON	NZ
Adaptive functioning	3 standard deviations below the norm	More than two standard deviations below the mean on a measure of adaptive functioning. Deficits in 2 or more of the following: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work.	2 standard deviations below the norm The inability to perform 6 or more adaptive skills without the assistance of another person, and at a level comparable to a peer without a disability	Must manifest significantly impaired functioning accompanied by impaired adaptive behavior.	Score of 2 or more SDs below the mean on 2 subscales of the IQ test and a history of habilitative support needs OR Significant limitations in cognitive functioning based on a clinical determination by a psychologist or psychological associate and a history of habilitative support needs	
Residency requirement	Yes	Yes	Yes	Yes	Yes	Yes
Citizenship	No	Yes	No	Yes / perm. resident	No	Yes

Figure 19: Eligibility requirements for services for people with developmental disabilities

In Alberta, the PDD program has developed an additional test, based on twenty-four identified adaptive skill areas. A significant limitation in adaptive skills is the inability to perform six or more adaptive skills without the assistance of another person and at a level comparable to a peer without a disability.

6.4.1 Facilitation and Referral

Across the jurisdictions reviewed, there were a range of levels of service available to assist people with disabilities to navigate support systems, develop personalized care plans, and access supports:

- On the low end of services, Manitoba appears to have no service with this as a central function, though likely many providers offer information and referral services.
- On the high end is Western Australia, who fund Local Area Coordinators to assist people with disabilities to plan, organise and access supports and services which enhance their participation in and contribution to their local community.
- With similar services to Western Australia, CLBC offers a coordinating/planning function through its facilitator position.
- New Zealand is piloting a Local Area Coordination model this year, with the intent of expanding across the country next year.
- Alberta assesses an individual's need for support by a Persons with Developmental Disability Client Service Coordinator (CSC).

- Ontario has recently undergone a service transformation and Developmental Services Ontario will be a single point for information, needs and eligibility assessment and connection to services.

Within Canada, these coordination and assessment services for people with developmental disabilities are separate from services for people with other forms of disability. In Western Australia and New Zealand, coordination and assessment services are together for all forms of disability.

Costs for these services are variously reported within non-residential services (e.g. individual and family supports), administrative services or, in the case of Western Australia, separated as a unique service.

- In 2009-2010, Western Australia's DSC provided 8,726 people with Local Area Coordination services at an average cost of $2,614 per client.
- In Alberta, where Client Service Coordinators are reported as an administrative function, a 2011 review of the PDD program found that administration services were high, with average administration costs of $3,340 per individual.
- In BC, CLBC reported total administrative costs of $16.8 million, or $1,246 per client served.
- Ontario and New Zealand's models are new, and do not have public information on administrative costs.

As can best be determined, the following summarizes comparative average costs for facilitation and referral services in the selected jurisdictions:

	BC[16]	WA[17]	AB[18]	MB[19]
Total known facilitation and referral users		8,726		
Avg facilitation and referral/user	$1,256	$2,614	$3,340	
Total known facilitation and referral cost ($millions)	$16.8	$22.8	$31.06	$0.547

Figure 20: Facilitation and Referral costs, by available jurisdiction

Individualized Funding

In addition to Local Area Coordination facilitation services, many of these jurisdictions also offer an individualized funding model, whereby families and clients can administer funds directly. Individualized funding where funds are managed by the family are still a very small portion of service delivery models in all jurisdictions, including Western Australia which has had an individualized funding system in place the longest of all jurisdictions reviewed.

- In Western Australia, 1,428 people accessed direct consumer funding (6% of clients served in 2009-10).

[16] Community Living BC. Financial Statements 2010-11
[17] Disability Services Commission, Annual Report, 2009-10.
[18] KPMG, Administrative Review of the Persons with Developmental Disabilities (PDD) Program, 2011
[19] Government of Manitoba. Budget 2011-12, Estimates of Expenditure and Revenue.

- At CLBC, individualized funding use is growing. In 2010-11, 287 individualized funding contracts amounted to $11.6 million, up from $5.1 million in 2008-09. However, this is still only 2% of clients served and less than 2% of the annual budget.
- In Alberta individualized funding is through Family Managed Services, which oriented 85 families to the program in 2009-10.
- In the Manitoba program, In the Company of Friends (ICOF), program served 60 individuals throughout Manitoba in 2009-10.
- Direct funding will be implemented in Ontario In 2012. No information was available for New Zealand's pilot.

	BC[20]	WA[21]	AB[22]	MB[23]
Total known individualized funding users	287	1,428	85	60
Avg individualized funding /service user	$40,418	$7,128		
Total known individualized funding cost ($millions)	$11.6	$10.1		

Figure 21: Individualized funding costs, by available jurisdictions

Western Australia and BC also have a host agency funding model of individualized funding. Funds are allocated by the DSC or CLBC respectively for the purchase of individualized supports and services are paid to a Host Agency that has been approved by the DSC / CLBC and selected by the individual and family. The Host Agency administers the funds and works with the individual and family to arrange and manage the supports required. This option provides the benefits of Individualized Funding, but with less responsibility for paperwork and record-keeping.

Summarizing the available information, overall BC has a service lower service cost per individual than comparable jurisdictions with respect to facilitation and referral services, as illustrated on the chart below:

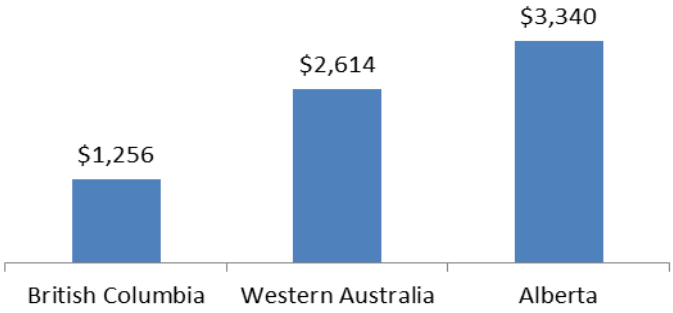

Figure 22: Facilitation and referral costs, by available jurisdictions

[20] Community Living BC. Financial Statements 2010-11.
[21] Disability Services Commission, Annual Report, 2009-10.
[22] Number of families oriented to Family Managed Services in 2009-10
[23] Government of Manitoba, Government of Manitoba Family Services and Consumer Affairs Annual Report

6.4.2 Residential Supports

As a general observation, all reviewed jurisdictions are moving away from institutional housing for people with disabilities towards models of supported community living, building on contemporary approaches to disability housing support that demonstrate the positive effects for people with disabilities of living in the community rather than in institutional care. However, larger scale residential institutions still exist in Western Australia, Alberta and Manitoba, though the size and number of these institutions has been decreasing.

- In Alberta, an Administrative Review of Persons with Developmental Disabilities indicated the government's direct operations (institutions) supported less than 7% of the individuals.
- Analysis of disability housing support arrangements in Australia has shown a slow but consistent decline in the proportion of people housed in large residential settings; a gradual increase in the number of people in community group homes; and a more rapid growth in home-based drop in services to support semi-independent housing.[24]
- BC and Ontario have eliminated large scale institutions. In 1996, BC led other Canadian provinces by closing their large scale jurisdictions. Ontario closed the last three of its large scale-government operated institutions in 2009.

Though there has been a noticeable movement away from large scale institutional housing, in many cases community homes for people with developmental disabilities have replicated the institutional practices they were meant to replace, through fully-staffed group homes. Emerging trends in show a growth in demand for supported independent living models, for example, of the 1,175 people with developmental disabilities on the CLBC waitlist, 69% are waiting to access home-sharing.

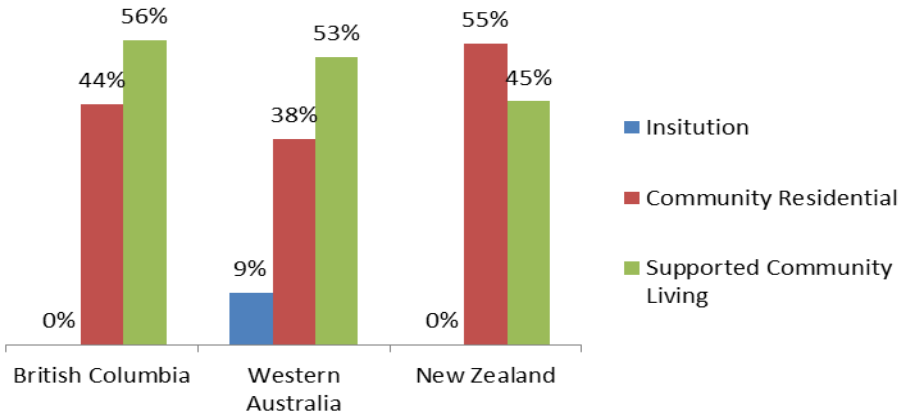

Figure 23: Percent of people receiving different type of residential supports, for available jurisdictions

[24] Parker, Susan and Fisher, Karen. "Facilitators and Barriers in Australian Disability Housing Support Policies: Using a Human Rights Framework", Disability Studies Quarterly, Vol 30, No ¾, 2010.

The approaches of the various jurisdictions towards residential services, and the number of clients within the included categories for each (where available) are summarized in the following table:

Residential services ↓	BC[25]	WA[26]	AB[27]	MB[28]	ON[29]	NZ[30]
Hostel / Institution		✓ 365	✓	✓ 492		
Community Residential Group homes, duplexes	✓ 2,508	✓ 1,451	✓	✓ 1,486	✓	✓ 2,600
Supported Community Living	✓ 3,176		✓		✓	✓ 800
Shared Care		✓ 1,923		✓ 3,408		
Family placements	✓				✓	✓ 250
Foster arrangements						✓ 75
Co-residency	✓					
Personal in-home support	✓					✓ 975
Attendant care						
Community Living Support Funding	✓	✓ 104				

Figure 24: Types of Residential Supports, including numbers served (where available)

In terms of average cost for residential services for people with developmental disabilities, BC ranks highest amongst Canadian provinces, but lower than Western Australia. CLBC's average costs per individual for residential services is also declining. Both factors are due to the inheritance of a large proportion of clients who were in fully staffed residential services, and the slow process of moving towards home share and smaller residential settings. Overall average costs for residential services are summarized in Figure 15.

[25] Community Living BC. Financial Statements 2010-11.
[26] Disability Services Commission, Annual Report, 2009-10.
[27] Persons with Developmental Disabilities www.seniors.alberta.ca/PDD/
[28] Government of Manitoba, Disability Issues Office, Action in 2009-10; Government of Manitoba Family Services and Consumer Affairs Annual Report
[29] Developmental Services Ontario, www.dsontario.ca
[30] IHC Annual Report, 2010-11.

	BC[31]	WA[32]	AB[33]	MB[34]	ON[35]	NZ[36]
Total known residential cost ($ millions)	$427.447	$295.48	$333.808	$256.771	$1,052	n/a
Total known residential service users	5,684	3,574	6,450	5,386	17,000	4,700
Average cost per service user	$75,202	$82,673	$51,750	$47,674	$61,888	n/a

Figure 25: Residential services, known funding and service users

The following chart summarizes the relative average costs per client for residential services across the jurisdictions, based on the available information.

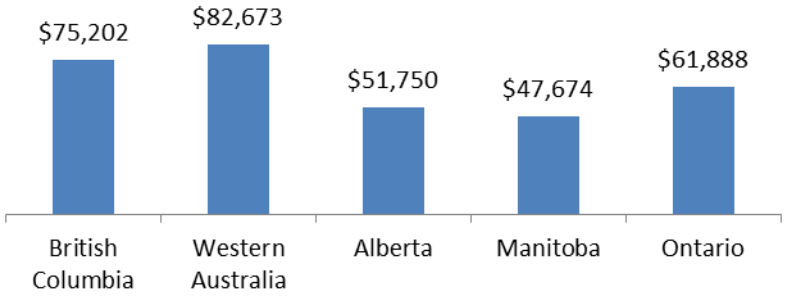

Figure 26: Residential costs, by available jurisdictions

6.4.3 Individual and Family Supports

Drawing comparisons amongst the jurisdictions' individual and family supports services is particularly challenging. Individual and family supports, along with residential supports, form the bulk of services that most jurisdictions provide for people with developmental disabilities. Individual and family supports take many forms. In BC, this category includes psychological, behavioural, home-maker and support coordination supports, but other jurisdictions also include day programs, an community aid programs that BC is more accustomed to categorizing as "community inclusion" services.

Throughout the selected jurisdictions, respite is considered and counted as both an accommodation and an individual and family support. The focus of respite is to provide temporary relief to carers, which enables supported independent living models. Respite may include in or out-of-home respite. Most jurisdictions tend to consider respite as a family support, so it is included here for comparison.

[31] Community Living BC. Financial Statements 2010-11.
[32] Disability Services Commission, Annual Report, 2009-10.
[33] Government of Alberta. Budget 2011-12: Detailed Budget Statement, Ministry of Seniors and Community Services; Government of Alberta. Budget 2011-12: Service Plan, Ministry of Seniors and Community Services.
[34] Government of Manitoba. Budget 2011-12, Estimates of Expenditure and Revenue; Government of Manitoba, Disability Issues Office, Action in 2009-10.
[35] Ontario 2010/11 budget information
[36] IHC Annual Report, 2010-11.

The following table summarizes the jurisdictions' approaches to individual and family supports. Where the information is available, the number of people served in each category annually is noted:

Individual and Family support services ↓	BC[37]	WA[38]	AB[39]	MB[40]	ON[41]	NZ[42]
Therapy services	✓	✓ 7,114	✓		✓	✓
Day options (skill development, recreation)	✓	✓ 3,983	✓	✓		✓ 3,450
Respite	✓	✓ 2,808	✓	✓	✓	✓ 120
Family Support	✓	✓ 2,368	✓	✓	✓	
Community aids and equipment	✓	✓ 8,046	✓	✓	✓	✓

Figure 27: Individual and Family Supports by Jurisdiction, including numbers served (where available)

In addition to differences in the naming and classification of relevant services, comparisons are further challenging because jurisdictions have not traditionally counted individuals served in day program services – rather these have often been resourced through service contracts with agencies, with broad service expectations but little data collection or analysis at the individual level. This is the case with BC, for example, which is now beginning a process to move to individual-level costing analysis for formerly block-funded supports and services like community inclusion programs.

With that caveat, the following table summarizes, at a high level, the overall cost per individual for individual and family support services.

	BC[43]	WA[44]	AB[45]	MB[46]	ON[47]	NZ[48]
Total known support cost ($M)	$213.996	$140.26	$91.716	$230.454	$571.4	
Total known individual and family support users	7,797	17,983	4,500	5,094	23,800	3,450
Average support cost/service user	$27,445	$7,800	$20,380	$45,240	$24,000	

Figure 28: Individual and Family supports, known funding and service users

[37] Community Living BC www.communitylivingbc.ca
[38] Disability Services Commission, Annual Report, 2009-10.
[39] Persons with Developmental Disabilities www.seniors.alberta.ca/PDD/
[40] Disability Issues Office, Action in 2009-10; Family Services and Consumer Affairs Annual Report
[41] Developmental Services Ontario, www.dsontario.ca
[42] IHC Annual Report, 2010-11.
[43] Community Living BC. Financial Statements 2010-11.
[44] Disability Services Commission, Annual Report, 2009-10.
[45] Government of Alberta. Budget 2011-12: Detailed Budget Statement, Ministry of Seniors and Community Services; Government of Alberta. Budget 2011-12: Service Plan, Ministry of Seniors and Community Services.
[46] Government of Manitoba. Budget 2011-12, Estimates of Expenditure and Revenue; Government of Manitoba, Government of Manitoba Family Services and Consumer Affairs Annual Report
[47] Ontario 2010/11 budget information
[48] IHC Annual Report, 2010-11.

Expressed as a chart, the average levels of individual and family supports is as follows:

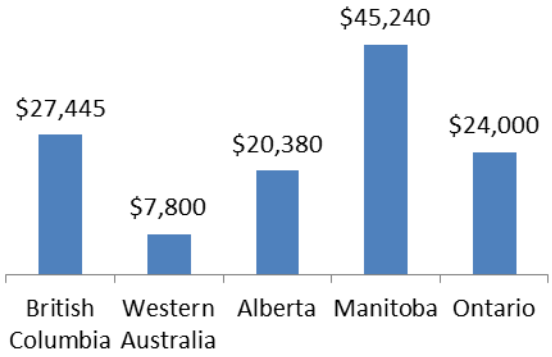

Figure 29: Individual and Family supports, by jurisdiction

6.4.4 Employment Supports

Participation in the labour force is a common measure of success of integration and independence for people with disabilities, though almost half of people with disabilities are not working or looking for work. This percentage of labour force participants is smaller still for people with developmental disabilities. Across Canada, while 56% of all people with disabilities participate in the labour force, only 31% of people with developmental disabilities do.[49]

A new comparator jurisdiction, Washington State, is Included in this category of supports because their employment programs for people with developmental disabilities is highly regarded and widely seen as successful. In Washington the integrated employment rate for people with developmental disabilities is 26%% compared to 24% across the US (integrated employment includes competitive employment, individual supported employment, and certain forms of group supported employment (e.g., mobile work crews) but excludes sheltered workshops or employment in other isolated, non-integrated settings). In Washington 59% of people with developmental disabilities who accessed employment supports through the Division of Developmental Disabilities found paid work.[50] Alberta has had even better employment results from its employment supports for people with developmental disabilities program, yielding a success rate of 64%.

[49] Galarneau, Diane and Radulescu, Marian, *Employment Among the Disabled*, Statistics Canada, Participation and Activity Limitation Survey

[50] Institute for Community Inclusion (2011) State Data: The National Report on Disability Outcomes

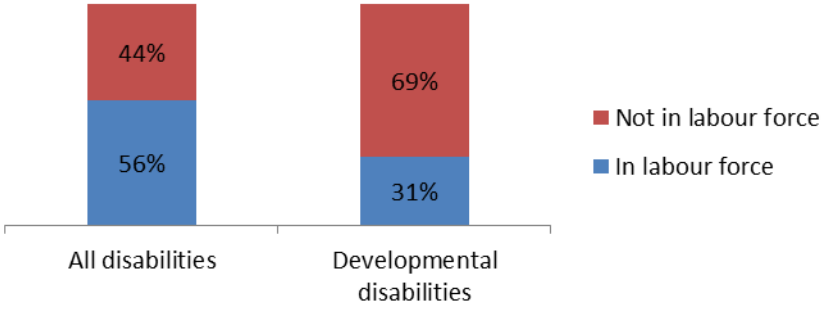

Figure 30: Labour force participation rates between people with developmental disabilities and all forms of disability, Canada, 2006

All jurisdictions have some form of employment supports for people with disabilities, though there is variation between the levels of services received. Employment services provide ongoing support services and training for eligible persons with paid jobs in a variety of settings and work sites. Supports may include assessment services, vocational supports, direct employment supports, and assistance with addressing disability-related barriers. Settings include individual supported employment, group supported employment, and prevocational services. These may be individual or group options in the community and specialized industry settings.

The following chart sets out the various forms of employment support offered in the comparator jurisdictions and, where known, the number of clients that participate in each. It also indicates each jurisdiction's annual employment support budget and, where possible, the average annual cost per client.

	BC[51]	WA[52]	AB[53]	MB[54]	ON[55]	NZ[56]	Washington[57]
Employment Supports	✓	✓	✓ 4,462	✓	✓	✓	✓ 5,867
Group Supported Employment							✓ 1,107
Sheltered Workshops		✓		✓		✓ 22,000	✓ 642
Earnings Exemptions for Disability Benefits	✓	✓	✓	✓	✓		✓
Total known employment supports cost ($millions)	$24	$210.9	$39.745	$10.177	$50.057	$87.585	$31.5

[51] BC Ministry of Social Development; CLBC Annual Report 2009-10
[52] Disability Services Commission, Annual Report, 2009-10.
[53] Government of Alberta. Budget 2011-12: Detailed Budget Statement, Ministry of Seniors and Community Services; Government of Alberta. Budget 2011-12: Service Plan, Ministry of Seniors and Community Services.
[54] Government of Manitoba. Budget 2011-12, Estimates of Expenditure and Revenue
[55] Government of Ontario. Budget 2011-12, Expenditure Estimates of the Province of Ontario for the fiscal year ending March 31, 2012 VOLUME 1, Ministry of Community and Social Services
[56] Government of New Zealand, Ministry of Social Development, Annual Report 2010-11
[57] Washington State. Department of Social and Health Services. Proposed Policy: County Employment Program. Legislative Proviso Report, 2008; Communication between Jane Boone, Manager of Employment Partnership Program, Washington State DDS, and Barb Penner, CLBC

	BC[51]	WA[52]	AB[53]	MB[54]	ON[55]	NZ[56]	Washington[57]
Total known employment service users	1,534 [58]	20,000	4,690			22,000	4,114
Average employment cost per service user	**$4,563** [59]	**$10,545**	**$8,475**			**$3,981**	**$7,657**

Figure 31: Types of Employment Services, known funding and service users, by jurisdiction

The following chart shows relative funding levels per individual:

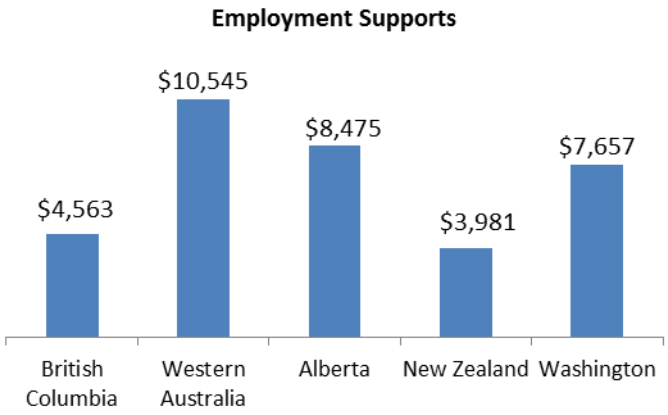

Figure 32: Employment Services funding, by jurisdiction

In Washington, one key factor cited as contributing to its higher employment rates is the time that workers spend with clients: the current average support level of 6.1 hours per client per week supports an average work week of 10.4 hours for clients. Research suggests that 9.2 hours of support would yield the state's target of 20 hours of week per client. No other jurisdiction documents time per client supported, but experience with BC's system suggests Washington's rate is much higher than what other programs provide.

The second factor is that Washington, offers group supported employment, which includes many of the basic employment supports as well as ongoing supervised employment for groups of no more than 8 workers with disabilities in the same setting. Examples include enclaves, mobile crews, and other business models employing small groups of workers with disabilities in integrated employment in community settings. This is a step along the pathway to fully integrated employment. In recent years, Washington has begun to focus on integrated employment and move away from sheltered workshops.

While there has also been a move away from sheltered workshops in Alberta, these still exist and in part account for that province's high employment rate. In addition, Alberta's Disability Related Employment Services provides funding for individuals, including up to $35,000 for initial, not ongoing, workplace supports and workplace modifications. These two factors - an incentive to employers to employ people with disabilities below minimum wage, and the provision of good disability supports in the workplace – result in Alberta's relatively high employment rate for people with developmental disabilities.

[58]Based on CLBC data only; BC EDPP 2010-11 Budget $17M but no service user numbers available

BC's known employment supports for people with disabilities are currently among the lowest funding per capita of jurisdictions reviewed. However, as Figure 23 below shows, in 2006, BC had a similarly small gap between the employment rates for people with disabilities and people without disabilities as Alberta (it is not known how employment rates for people with disabilities might have changed since 2006). Alberta and Washington, both known as successful employment programs, provide almost twice as much employment support funding per service user than does BC for very similar outcomes.

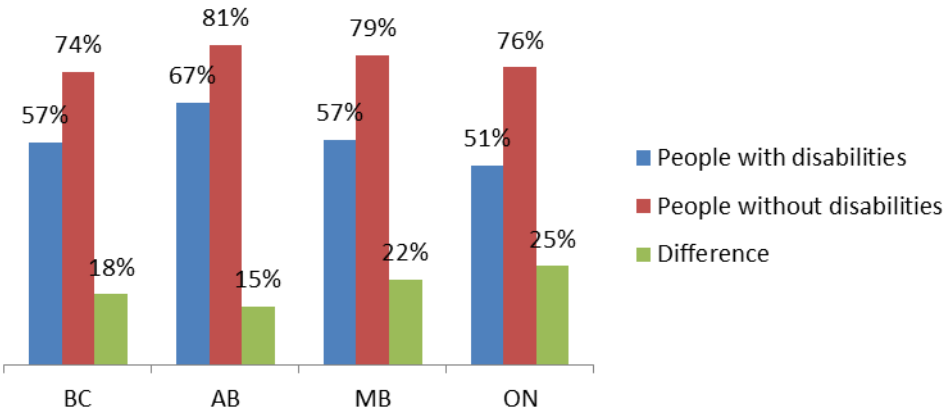

Figure 33: Comparison and difference between employment rates for people with and without disabilities, by jurisdiction, 2006[60]

6.4.5 Income Supports

Finally, although not provided specifically by agencies responsible for developmental disabilities, income supports serve as a fifth general area of supports and services for people with disabilities across the jurisdictions surveyed. Every jurisdiction provides a basic income supplement or benefit to people who qualify as having a disability within that jurisdiction and who meet income limitations. The relative amounts in each of the comparator jurisdictions are set out below:

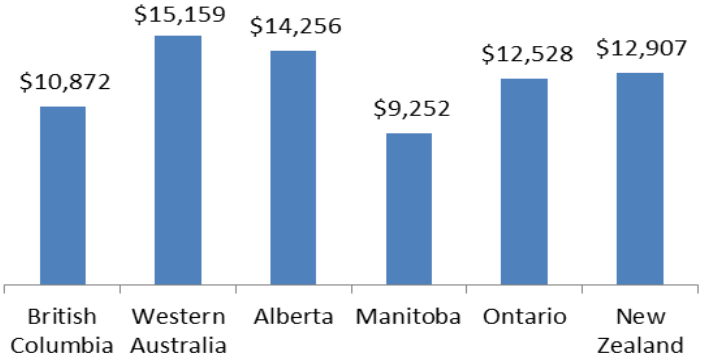

Figure 34: Disability Support Benefits, in Canadian dollars, by jurisdiction[61]

[60] Statistics Canada, *Participation Activity Limitation Survey 2006 Tables*

[61] Australia and New Zealand rates converted to Canadian dollars based on October 2011 exchange rate.

In addition to basic income supports, each jurisdiction has a variety of targeted income supports, including telephone allowances (for medical reasons), mobility allowances for people who cannot use public transportation without substantial assistance, and disability supplements for ongoing costs related to seeing a doctor, extra clothing or travel. Most of these would not be accessed by all people receiving income support.

Additional targeted income supports are all classified and funded very differently amongst the jurisdictions, making direct comparisons extremely challenging. They share the characteristic, though, of being provided for specific disability-related needs in addition to the general income supplement, and the requirement that people meet specific eligibilities or requirements in order to access the additional funding. These targeting supplements are set out on the table below, with monthly rates noted where applicable and identified:

	BC[62]	WA[63]	AB[64]	MB[65]	ON[66]	NZ[67]
Telephone Allowance		✓		✓		
Mobility Allowance		✓ $83-$116				
Disability Supplement						✓ $57
Dietary Allowance	✓			✓	✓	
Rent / Accommodation Assistance		✓ $119		✓		✓ $75 - 225
Medical costs / Health benefits	✓	✓	✓	✓	✓	✓
Volunteer Supplement	✓ Up to $100			✓		

Figure 35: Other Income Supports for Adults with Disabilities, including amount (where available)

BC's basic income support for people with disabilities is lowest of all six jurisdictions under review. Though BC does provide additional optional support for people disabilities it is unlikely to make up the gap. As Figure 26 shows below, BC also has one of the highest percent people with disabilities living on low income, among Canadian jurisdictions reviewed, though they also have the highest percent of people living in poverty overall. BC and Alberta have some of the smallest differences between poverty rates for people with disabilities and for the population overall.

[62] BC Ministry of Social Development http://www.gov.bc.ca/hsd/
[63] Government of Australia, Department of Human Services, Centrelink. http://www.centrelink.gov.au
[64] Government of Alberta, Persons with Developmental Disabilities www.seniors.alberta.ca/PDD/
[65] Government of Manitoba, Family Services and Community Affairs, http://www.gov.mb.ca/fs/pwd/iapd.html
[66] Government of Ontario, Ministry of Community and Social Services, http://www.mcss.gov.on.ca/en/mcss/programs/social/odsp/
[67] Government of New Zealand, Work and Income http://www.workandincome.govt.nz/individuals/a-z-benefits/invalids-benefit.html

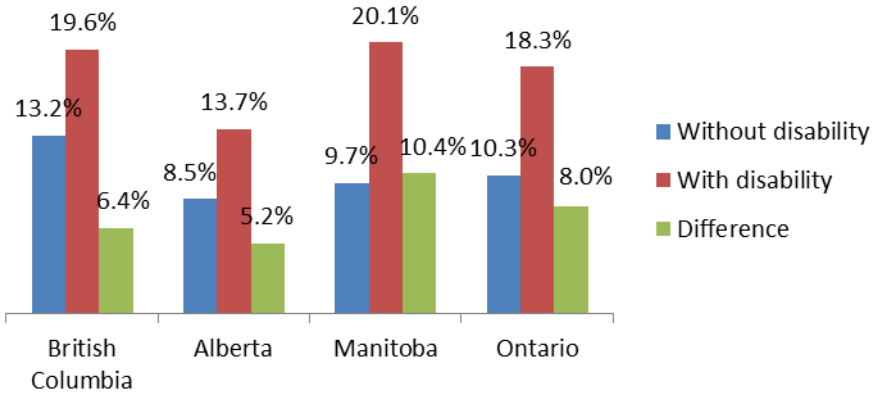

Figure 36: Percent of population below after-tax low income rate, for people with disabilities and people without disabilities, by Canadian jurisdiction[68]

6.4.6 Summary of Jurisdictional Comparison

Overall, BC provides a comparable range of individual and family support services, with a moderately high degree of funding per client served, compared with the other jurisdictions considered in this review. BC also provides greater flexibility for a growing number of families through individualized funding models. In this way, BC is a leader in meeting the demands of families of people with developmental disabilities.

When funding per client for type of service provided is considered, British Columbia provides services for people with developmental disabilities on the mid- to low-range of costs. Although data was not consistently available across all jurisdictions to make this comparison possible in all categories, the following table, which summarizes the funding per individual detailed in the sections above, sets out the overall per-client costs in each of the five service categories for BC and the comparator jurisdictions.

[68] Crawford, Cameron. *Disabling Poverty and Enabling Citizenship: Understanding the Poverty and Exclusion of Canadians with Disabilities*, Council of Canadians with Disabilities and University of Victoria

	BC[69]	WA[70]	AB[71]	MB[72]	ON[73]	NZ[74]
Facilitation and Referral	$1,256	$2,614	$3,340			
Residential Support	$75,202	$82,673	$51,750	$47,674	$61,888	
Individual and Family Support	$27,445	$7,800	$20,380	$45,240	$24,000	
Employment Supports	$4,563	$10,545	$8,475		$3,981	$7,657
Income Support	$10,872	$15,159	$14,256	$9,252	$12,528	$12,907

Figure 37: Comparison of average cost per client with disability served, by jurisdiction

This is not to say that there is not room for improvement in BC supports for people with disabilities. BC spends noticeably less per capita on income and employment supports for people with disabilities than Alberta and Ontario. While BC spends more per capita on individual and family supports, supports which typically help to enable inclusive societies, BC spent less than Alberta and Western Australia on residential supports for people with disabilities.

When compared by costs for the central agency serving people with developmental disabilities, BC ranks in the middle of costs for the three jurisdictions where this information was available. Comparisons are challenging: Western Australia's Disability Services Commission serves all people with disabilities in that state, and so may have a different set of challenges and business practices than agencies who specifically serve people with developmental disabilities such as in Alberta and BC. The DSC has identified that services for people with developmental disabilities tends to be approximately 20% higher in cost than services for other forms of disability.

	BC	WA	AB
Total known funding ($millions)	$695.3	$486.42	$592
Total known service users	13,650	21,652	9,300
Average cost/service user	$50,937	$22,469	$63,655

Figure 38: Comparison of per client cost between Community Living BC (BC), the Disabilities Services Commission (Western Australia) and the Persons with Developmental Disabilities Program (Alberta)

[69] CLBC Annual Report 2009-10; Community Living BC. Financial Statements 2010-11; BC Ministry of Social Development

[70] Disability Services Commission, Annual Report, 2009-10; Government of Australia, Department of Human Services, Centrelink. http://www.centrelink.gov.au

[71] Government of Alberta. Budget 2011-12: Detailed Budget Statement, Ministry of Seniors and Community Services; Government of Alberta. Budget 2011-12: Service Plan, Ministry of Seniors and Community Services. Government of Alberta, Persons with Developmental Disabilities www.seniors.alberta.ca/PDD/

[72] Disability Issues Office, Action in 2009-10; Government of Manitoba. Budget 2011-12, Estimates of Expenditure and Revenue; Government of Manitoba, Government of Manitoba Family Services and Consumer Affairs Annual Report

[73] Government of Ontario. Budget 2011-12, Expenditure Estimates of the Province of Ontario for the fiscal year ending March 31, 2012 VOLUME 1, Ministry of Community and Social Services

[74] Government of New Zealand, Ministry of Social Development, Annual Report 2010-11

Funding levels, of course, are not the measurements of success of a service - client satisfaction and positive outcomes are also key indicators, for example. Although there are challenges in the availability of comparator data, it is fair to say that BC has been a leader within Canada in instituting individual planning and service coordination, individualized funding and integrated employment. BC's employment rate for people with disabilities and self-reports by people with disabilities as to their access to the help they need were comparable to other jurisdictions.[75] While CLBC has been the source of much public criticism of late, over three quarters reported they were well supported by their service providers.

Though it should be interpreted with caution, as the information is now over five years old, data from the Statistics Canada Participation Activity Limitation Survey on unmet needs provides an interesting perspective on outcomes of funding for disability supports; that is, that people with disabilities are receiving the support they need. As illustrated in Figure 29, across Canadian jurisdictions more than half of people with disabilities self-reported receiving all the help they need; but one in sixteen are receiving no help and reported needing some.

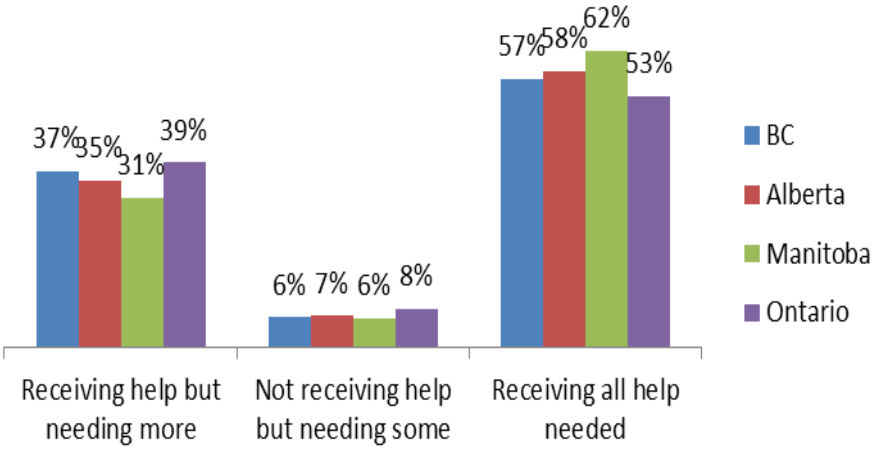

Figure 39: Percent of people with disabilities reporting needs met for disability supports, 2006[76]

There are only slight differences between the jurisdictions, despite funding differences noted in this report. However, Manitoba had the highest percent of people reporting they received all the help they needed. This is particularly interesting as Manitoba is not the highest funding per service user overall. There is little significant difference between unmet needs in disability types across Canada; however, people with psychological disabilities are least likely to have their needs met. The same percent of people with developmental disabilities self-report having their needs met as the average across all types of disability. As all four jurisdictions have undergone significant disability support service changes since 2006, it would be useful to review the 2012 updated data when it is released.

[75] In 2006, the last date such information was available.

[76] Source: Participation and Activity Limitations Survey, 2006. Comparable questions were not available for Western Australia and New Zealand.

Finally, another aspect of satisfaction with individual and family supports is autonomy to select and access supports which meet individual needs. The desire for access to a range of flexible supports to meet a person-centred plan has inspired all four Canadian jurisdictions reviewed to implement individualized funding programs, though BC's is the oldest and therefore, the most widely used.

Some direct customer satisfaction measures are available from jurisdictions included in this review, however, as the questions differ comparisons should be made with caution.

BC	WA	AB
78% of individuals and families believe they are well supported by their service providers	84% of people who used individual and family support service were happy with the support they received.	85% of families/guardians reported overall satisfaction with the PDD-funded services received by the person to whom they provided guardianship

Figure 40: A comparison of consumer satisfaction at CLBC, the Disability Services Commission and the Persons with Developmental Disabilities program

All of the key characteristics of service delivery models across the comparator jurisdictions are summarized on the following table.

Summary of Key Characteristics,
British Columbia and Comparator Jurisdictions

Jurisdiction	Agency or program focused on DD?	Eligibility (criteria including age)	Supports Delivery (listing and agency that provides them)	Costs (average costs of each support)	Assessments (tools used)
BRITISH COLUMBIA	Yes - CLBC	**Age:** Adults only **DD criteria:** DSM IV Mental retardation (IQ 70 or below) & adaptive functioning 3 standard deviations below the norm **PSI criteria:** FASD or ASD and significant limitations in adaptive functioning.	**Facilitation:** CLBC **Residential:** CLBC, non-profit housing providers **Individual/family**: CLBC **Income:** Ministry of Social Development **Employment:** CLBC, Ministry of Social Development	**Facilitation:** $1,256 **Residential:** $75,202 **Individual/family**: $27,445 **Income:** $10,872 **Employment:** $4,563	Guide to Supports allocation (GSA)
ALBERTA	Yes - Persons with Developmental Disabilities Program	**Age:** Adults only **DD criteria:** 2 standard deviations below the norm and the inability to perform 6 or more adaptive skills without the assistance of another person, and at a level comparable to a peer without a disability. FASD or ASD also eligible with significant limitations in adaptive functioning.	**Facilitation:** PDD (Client Service Coordinators) **Residential:** PDD **Individual/family:** PDD **Income:** Ministry of Seniors and Community **Employment:** PDD	**Facilitation:** $3,340 **Residential:** $51,750 **Individual/family:** $20,380 **Income:** $8,475 **Employment:** $14,256	Supports Intensity Scale (SIS)
ONTARIO	Yes - Developmental Services Ontario	**Age:** Adults only **DD criteria:** Overall score of 2 or more standard deviations (SDs) below the mean on standardized IQ test. Significant limitations in cognitive functioning based on a clinical determination by a psychologist or psychological associate and a history of habilitative support needs.	**Facilitation:** **Residential:** DSO **Individual/family:** DSO **Income:** Ministry of Community and Social Services **Employment:** Ministry of Community and Social Services	**Facilitation:** **Residential:** $61,888 **Individual/family:** $24,000 **Income:** $3,981 **Employment:** $12,528	Supports Intensity Scale (SIS)

Jurisdiction	Agency or program focused on DD?	Eligibility (criteria including age)	Supports Delivery (listing and agency that provides them)	Costs (average costs of each support)	Assessments (tools used)
MANITOBA	Yes - Community Living disAbilities Program	**Age:** Adults only **DD criteria:** A mental disability (significantly impaired intellectual functioning existing concurrently with impaired adaptive behaviour) and in need of assistance to meet basic needs with regard to personal care or management of property. Excludes mental disability due exclusively to a mental disorder as defined in section 1 of The Mental Health Act.	**Facilitation: Residential:** CLdP, **Individual/family:** CLdP**Income:** Ministry of Family Services and Community Affairs**Employment:** Ministry of Family Services and Community Affairs	**Facilitation: Residential:** $47,674**Individual/family:** $45,240**Income:** $9,252**Employment:**	unknown
W. AUSTRALIA	No - but Disability Services Commission serves people with all forms of disabilities	More than two standard deviations below the mean on a recent (within 3 years) intellectual functioning assessment and below the mean adaptive functioning.	**Facilitation:** DSC **Residential:** DSC **Individual/family: DSC** **Income:** Ministry of Human Services **Employment:** DSC	**Facilitation: $**2,614 **Residential:** $82,673 **Individual/family:** $7,800 **Income:** $10,545 **Employment:** $15,159	Estimate of Requirement for Staff Support Instrument (ERSSI) & Inventory for Client and Agency Planning (ICAP)
NEW ZEALAND	No - Disability Support Services serves people with all forms of disabilities	unknown	**Facilitation:** DSS **Residential:** DSS, Office for Disability Issues **Individual/family:** Office for Disability Issues **Income:** Disability Support Services **Employment:** Ministry of Social Development	**Facilitation: Residential: Individual/family: Income:** $12,907 **Employment:** $7,657	Support Allocation Tool (SPA tool)

6.5 BC: funding for developmental disabilities and other disabilities

The cost of serving people with developmental disabilities is an ongoing concern, both for CLBC and for government more broadly. One of the key questions is that of equity and comparability of services. In order to bring more equity to its service provision, CLBC has invested a considerable amount of resources to the development of systems that more fairly assess need and assign appropriate resources based on that need. While historical inequities still exist, the groundwork has been laid to bring more rational, predictable and equitable service provision over time.

A related question is the equity of service levels for people with developmental disabilities who are served by CLBC, and people who have similar levels of disability-related challenges but who are not eligible for CLBC service because they have other disabilities than a developmental disability. A first step in bringing greater service level equity across disability categories (so that services are based on need, not category or diagnosis), is to identify how service levels differ.

Consideration of this question is new, and obtaining the relevant data is challenging, but an early estimate of service levels for CLBC clients compared to other people other disabilities is set out in figure 41, below. This summarizes what a CLBC client may receive on an annual basis on Disability Assistance (DA) and off DA, compared to a person with a disability (PWD) who is not CLBC-eligible. While there are strong caveats to this data, initial analysis suggests that CLBC clients are supported at a much higher level than people who have other disabilities than a developmental disability.

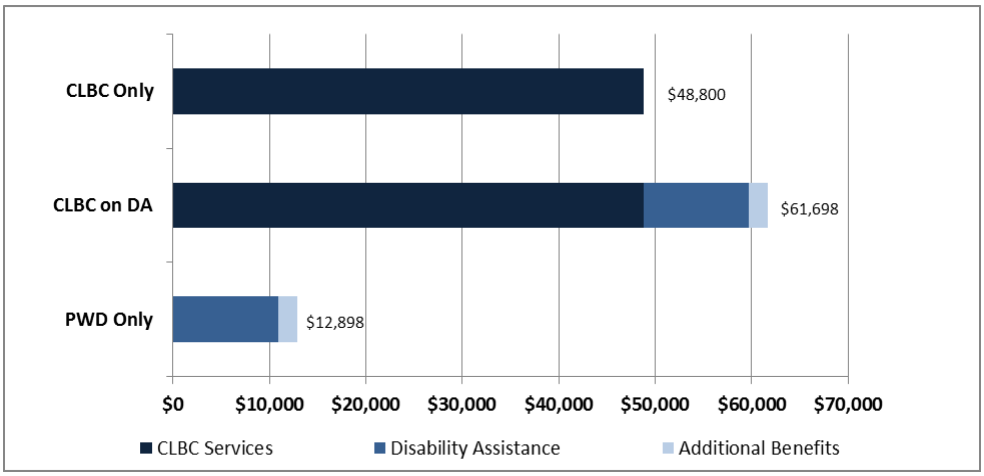

Figure 41: Supports to CLBC and PWD clients, annual maximums

The composition of the supports is set out in figure 42. Here, "CLBC services" indicates the average cost per client for all CLBC services. This amount could not be separated by CLBC clients of DA versus those who are not on DA. "Disability Assistance" indicates the maximum annual rate for a single PWD, assuming full support and shelter and no deductions. Actual amounts will vary depending in family size, shelter costs, income.

"Additional Benefits" includes Community Volunteer Supplement ($1,200), Bus Pass and Special Transportation Subsidy ($790.56), and Christmas Supplement ($35). This is a maximum, and not all PWD client receive all these benefits. Finally, "Supplementary Assistance" includes additional allowances (e.g. nutritional supplement, diet), medical

equipment, medical supplies, dental and optical. The amount spent on Supplementary Assistance varies by client – not all clients receive all or any of these benefits.

Supports	CLBC	CLBC on DA	PWD
CLBC Services	$48,800	$48,800	$0
Disability Assistance	$0	$10,872	$10,872
Additional Benefits	$0	$2,026	$2,026
Supplementary Assistance	$0	Varies	Varies
Total	**$48,800**	**$61,698 +**	**$12,898 +**

Figure 42: Supports to CLBC and PWD clients, annual maximum composition

The level of financial support is one indicator of service equity. However, people with disabilities may not use disability support services because they do not need them, or because they are unable to access them for a variety of reasons. Another consideration is whether or not people are receiving all the help they need, or whether they have support needs that are not being met. Figure 43 illustrates self-reported levels of met and unmet need in Canada, by type of disability, in 2006 (the most recent year for which data was available).

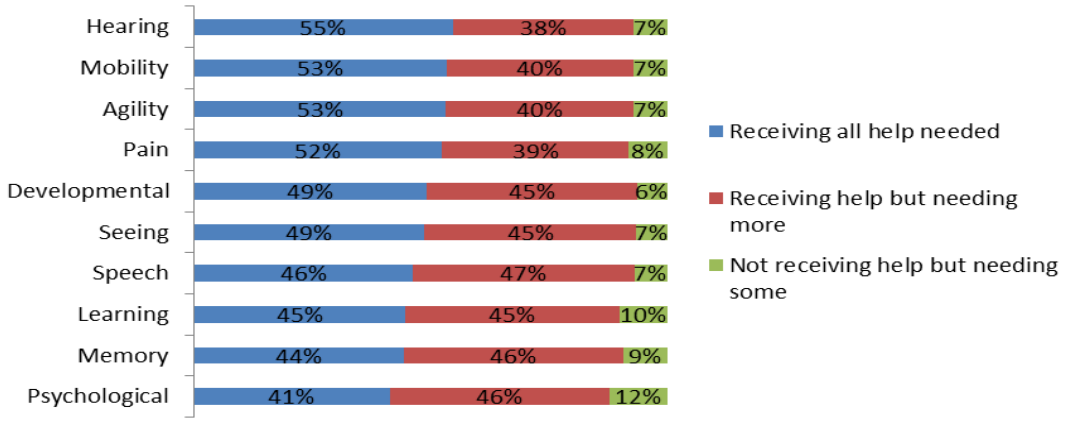

Figure 43: Reported levels of met and unmet need, by disability (Canada)

People with developmental disabilities reported average amount of access to help, with just under half (49%) reporting receiving all the help they needed. Though this data is for Canada, it suggests that across disability types and at a very broad level, people with disabilities have generally comparable access to the help they need, with learning, memory and psychological disabilities reporting the highest levels of unmet need.

Much work remains to be done in order to fully understand the differences between services provided to CLBC clients versus people with other disabilities but similar levels of need. Initial indications, however, suggest that there are significant inequities in the amount of funding that is available between these groups and that those with developmental disabilities feel relatively more well-served than those in other disability groups.

7.0 Future Directions

Taking all of the foregoing into consideration, this chapter presents a number of options for government to consider with respect to the future direction of Community Living British Columbia. The topics that are presented arose from discussions carried out in the course of this review, consideration of the documentation presented by CLBC, and independent research. These are not recommended actions but rather options that merit further thought, attention, and analysis.

1. The emphasis on paid supports

Many participants in this review shared a sense of one of the key pressure points and flaws with the CLBC service delivery system: what is seen as an over-emphasis on paid supports. Although community and generic supports were at the heart of CLBC's conceptual basis when it came into being, much of its system is actually predicated on paid services being the end goal for individuals and families. This is likely the overwhelming view of consumers themselves and much of the recent publically-expressed frustration revolves around challenges in obtaining paid supports and services.

Many participants in this review characterized CLBC (and the developmental disabilities sector in general) as being over-professionalized and overly focused on assessing need for paid care in its service delivery approach. This is not out of the norm with other jurisdictions, who also tend to emphasize paid supports. However, there is a growing recognition that, in the context of increasing demands and scarce resources, governments must address daunting financial restraints in a different manner.

People's supports are sometimes characterized as concentric "rings" surrounding them in a decreasing order of support intensity. For many people, these rings are composed of family, then friends, followed by commercial contacts and then finally paid supports. A number of participants in this review suggested that the population CLBC serves – and its service delivery model – does not fully utilize the first three rings and instead moves directly to paid supports, which in this province are most often unionized, highly formalized, and costly.

CLBC itself recognizes the flaw in this approach, and its leadership increasingly talks about shifting emphasis to the more informal, "natural" and unfunded supports that families, friends and communities can provide. The potential for a larger role for these supports is something that is increasingly emphasized in jurisdictions like Australia, and merits more study, consideration and promotion in British Columbia.

2. Individualized Funding

Individualized funding was another concept that was originally at the core of CLBC's service delivery and operational model. It was promoted not only as a way to reduce administrative costs and bureaucratic controls over service decision making, but also a key component in promoting and encouraging individual and family self-determination. Individual funding as a payment mechanism was viewed as an important part of an

overall approach for individuals and families to create services that met individual need.

While the opportunities to capitalize on individual funding have not been fully realized by CLBC, this is part due to the considerable operational challenges it has faced in introducing a payment mechanism attached to a new model and approach to the province. Efforts have also been hampered by a general resistance to individual funding amongst CLBC's front-line staff, whom many feel have failed to appropriately promote the option with the families they work with. There has also been a reluctance among families to assume the role of employer, which CLBC has attempted to mitigate by providing the ability for host agencies to take on this role. In addition, efforts have also suffered from a lack of leadership and support at the governance and political levels to strongly move families towards this option.

Individual funding is playing a larger role in jurisdictions such as Australia, where federal government along with the states of Western Australia and Victoria appear to have put significant effort into promoting, developing and implementing its wider use. The United Kingdom also places a growing emphasis on individual funding, with a decreasing role for government being the arbitrator of what services and supports will and will not be funded. These models should be more fully examined and reviewed for approaches that could apply to CLBC to help move towards a greater adoption of individualized funding.

3. Employment services

Over the past few years, CLBC has been placing a greater emphasis on employment supports and services as part of its community inclusion programming. This is an important shift away from the more traditional, custodial and somewhat patronizing approach of day programs that focus on recreation and socializing activities.

While this is a positive shift that should be encouraged by government, it is also only one part of what could be a more rationalized and integrated focus on employment readiness and skills development, to allow individuals to find and maintain work when they become adults. The approach of other jurisdictions such as Washington is to not only emphasize employment supports in the developmental disabilities service sector, but also to work with the education system to include this emphasis as part of individuals' schooling.

An option for British Columbia is to consider a more integrated, government-wide shift from the current approach, which many believe does not adequately prepare individuals for an independent life. This would enhance the employment opportunities for the significant numbers of people with disabilities who have the capacity and desire to participate in the social workforce.

CLBC is one partner in what could be a much broader shift in the focus of public education to include more vocational and practical life skills training so that they have greater opportunities for employment. Many believe the current system, from MCFD and Ministry of Education, prepares people to expect paid supports, and to specifically not consider the option of employment. The Ministry of Social Development, too, could potentially play a greater role in supporting employment readiness and employment support programs, and there are likely measures that government as a whole could

take to facilitate this change (for example, tax incentives and job strategies might serve as positive catalysts).

4. Transitioning to adulthood

Despite recognition of the challenges for individuals with developmental disabilities who transition from children's and youth services into adulthood, youth transition continues to be an area that requires better attention from CLBC and coordination from government more broadly. The MCFD/CLBC *Operating Agreement on Services for Transitioning Youth* provides a strong procedural and operational guide for helping to facilitate this transition, but there is a wider challenge with the very different levels of service and approaches that children and youth have available versus those that are available for adults. While youth transition protocol address service processes, they do not consider the fundamental inequities that exist between services for adults and children with developmental disabilities.

Youth transition has been improved through better communications between MCFD and CLBC, so CLBC is now aware of the vast majority of youths coming into service from MCFD on turning 19. While this information is now provided approximately 18 months in advance, many believe it should begin earlier and that joint planning could help facilitate a more seamless transition to adulthood. In addition, there remain concerns with the fullness of information flow between the education system and CLBC, which has knowledge of a larger range of children with developmental disabilities than MCFD.

At a more systemic level, there is a widely shared sense that the level of service that children and youth obtain from MCFD and the education system is so full compared to what is available to them as adults that they are inevitably disappointed when they come to CLBC for assistance. Many believe that these systems result in a sense of dependency and an automatic presumption of paid services and supports, which then must be re-aligned when the adult system is encountered, with its stricter funding restrictions.

There is also a sense that the lack of inter-ministry planning and rationalization of service systems contributes to the difficulty in making the transition into adulthood. The lack of integration and alignment across government in planning for individual's lives is a key contributing factor to many families' experience of disjointed processes, inflated expectations and unmet needs. Earlier, more integrated communications to families – even if the message is only that there will be far fewer services to draw from when youths turn 19 – can only help to reduce conflict and smooth the transition to the adult service delivery system. This needs to happen both when children and families are in both the Ministry of Children and Families service system and the school system.

A more integrated approach to transitions planning is now newly underway in some parts of the system such as the *Protocol for Transition* from the Children with Special Needs Program to the Persons with Disabilities system at the Ministry of Social Development and the *MCFD/CLBC Operating Agreement*. This could be expanded to included government more broadly, and benefit from earlier expectations management at the MCFD and MED level.

Effective October 2009, the nine signatories involved in the Youth Transition Protocol have been working to understand what services are currently available and what the gaps are, and this effort is beginning to improve coordination between adult services and children's services.

5. Assessment tools and processes

Currently, there is a very wide range in the tools and processes that various programs and agencies of government use to assess eligibility and allocate resources. This provides challenges not only for individuals and families who must tell their stories over and over again. It also challenges government, which cannot rely on an ongoing, standardized assessment process that applies to people throughout their lives and across the various services they are trying to access. As a result, systemic planning is extremely challenging and fractured and individuals may end with very different assessment outcomes depending on what tool is used.

Initial steps are underway to identify options for assessment tools that would have a wider application, with the goal of identifying and implementing a standardized tool for assessing disability related needs for individuals with developmental. This work will include identifying the issues and options associated with implementing cross-ministry tools to enhance consistency of decision making, resource allocation and service fairness. Appendix 6 presents the early findings of this work.

Going forward, this work must consider the challenges not only of assessing needs in a standardized and appropriate way, but also resource allocations to needs assessments. This is challenging, particularly when funding comes from different sources, which may have different focuses and desired outcomes. The costs of assessment options must also be considered, including:

- Capital costs (e.g. appropriate technology and licensing)
- System capacity (accommodating the assessment tool within the various systems each ministry currently uses);
- Change management to address existing cultural differences across the ministries. This has been a significant issue, for example, in the Ministry of Health's adoption of the interRAI tool;
- Training and education; and
- Implementation costs, which in the case of the interRAI experience at the Ministry of Health, can be significant.

6. Disparity between services for developmental disabilities and other disabilities of comparable severity

As set out earlier in this report, initial analysis suggests that the average amount of funding that is available for an adult with a developmental disability far exceeds that of adults with other disabilities who have similar levels of impairment In some cases, adults with developmental disabilities have an extremely difficult combination of physical, intellectual and social challenges that is simply more costly to support.

However, it is likely that other factors affect the disparity in available funding. It is partly due, for example, to the relatively rich funding contracts that accompanied the closure of the institutions, and the legacy of contracts awarded when adult services

were provided by MCFD and there was little standardization or linkage to an objective assessment of need. CLBC has made efforts to address these historical disparities and introduce more equity in new contracts going forward, but the sector remains characterized by a well-organized advocacy arm that is vigilant against any attempts to structure lower level services into the system.

Much more work is required to fully identify and assess how adults with comparable levels of severe and very severe disabilities, developmental and otherwise, are served by British Columbia's system(s). The children's sector has undergone such a review through the Children and Youth with Special Needs initiative, resulting in a more rationalized and standardized approach across the system. Adult services for adults with severe and very severe disabilities could benefit from a similar review process, and an overall movement towards better system integration and rationalization. A step in the right direction is the introduction of the PSI program at CLBC.

The approach of Western Australia, which organizes, assesses, and resources services for all people with severe and very severe disabilities, may provide valuable guidance in future inquiries, which might also consider how these services for people with severe disabilities, including those with developmental disabilities, might be better coordinated. It will be important to consider how these services can be more effectively provided and coordinated in an equitable and predictable way throughout the lifespan of the individual.

7. Rationalizing the approach to developmental disabilities

Government may also benefit from more fully examining a different approach to developmental disabilities. Currently, individuals must establish and demonstrate needs through the assessment process, then look to government to fund the means to meet those needs. This results in a low level of predictability both for individuals and families, particularly through transition times like moving into adulthood; and for government which cannot accurately predict individual needs until individuals assessments are undertaken.

A different option would be to work towards a system that provides much more predictability and stability, perhaps through the automatic granting of set levels of funding. Different funding levels could be based on key factors such as the individual's age and broad level of need (high, medium, low, for example). This would approach developmental disabilities in a manner akin to the seniors' policy, with a guaranteed supplement, a reduced level of government intervention, and an increase in the autonomy and decision making of families to decide their own priorities and needs. Such an approach could provide a predictable course of supports throughout an individual's life, allowing them to more fully plan for their futures

This approach would shift the general approach from one of focusing on establishing and assessing need, leading to obtaining funding for specific services, to one that provides individuals and families with a predictable base around which they could base their own planning. Set, capped levels of funding would also provide government with much more predictability for financial planning.

This would be a long-term shift in public policy, requiring much fuller consideration and inquiry. However, conceptually it might provide a good basis around which to

organize other systemic changes, such as a standardized assessment approach, and the rationalizing of funding for people with developmental disabilities and other disabilities. It could be linked as well to the expansion of peoples' circles of supports, and provided certainty in the state's responsibility so that families would no longer have to undergo duplicative processes to establish their specific needs for specific services.

8. Cultural challenges

One of the ongoing challenges with addressing service and funding pressures for adults with developmental disabilities is a difficulty in identifying and addressing some cultural and philosophical characteristics of the sector.

Many participants in this review spoke of a sense of entitlement among families in this sector that is stronger than other sectors. Perhaps in response to the history of institutionalizing people with developmental disabilities, this sector is now characterized by a much richer per capita funding level when compared to other disabilities and considerations and a reluctance among government and service providers to examine and address this discrepancy.

In addition, many of the families that lead advocacy in the sector are highly skilled, resourced, and committed to increasing the level of funding that individuals receive, rather than considering alternative support methods including an expanded custodial and care role for families themselves. Many families in this sector have high expectations for supporting their sons and daughters, and the sector has a demonstrated history of political sophistication to advance its goals. This is a fundamental contributing factor to the difficulty in making meaningful changes to the service delivery system as evidenced, for example, in the challenges that CLBC experiences when trying to shift individuals living in group homes whose needs do not match the need for this level of service to living in community.

Addressing this culture should be at the core of any directions that government takes towards the service delivery system for people with developmental disabilities. Changing attitudes and expectations is an extremely difficult challenge, but it will be required if there are to be meaningful changes to the system as a whole.

9. Communication

As noted elsewhere in this report, CLBC has experienced considerable challenges with respect to its communications with individuals, families, service providers, government and the general public. While many of the changes it has brought the service delivery system for people with developmental disabilities in BC are positive, that message has often been lost through ineffective communications.

Going forward, greater linkages in the communications between CLBC and government could provide each with a better basis for engaging clients, agencies, and the public. Rather than being reactive to issues and crises, attention could be paid to proactively communicating the positive changes that have been implemented and are underway.

Without a renewed emphasis on proactive, positive communications, the constructive and positive work of CLBC, of which there is much to profile, risks being subsumed by the strong voices of advocates, and the inevitable challenges that come with serving this population. Government can play a role in supporting this communication and linking CLBC's work into a larger approach towards serving people with disabilities in a better way.

Appendices

Appendix 1: Terms of Reference

Review of Community Living British Columbia's Efficacy and Progress

TERMS OF REFERENCE

The Ministry of Social Development (MSD) and the Ministry of Finance (MF) have initiated an independent, third party review of the efficacy and progress of Community Living British Columbia (CLBC). The review will also consider the overall model for services for people with developmental disabilities in the province. It will be conducted by Queenswood Consulting Group, led by Rene Peloquin and Ted Matthews in accordance with the following terms of reference.

Purpose

1. The purpose of the review is to:
   a) Review, assess and make recommendations related to the efficacy of the CLBC model, focussing on the specific factors outlined in these Terms of Reference;
   b) Review and assess CLBC's progress in implementing the recommendations contained in the 2008 *Review of Community Living British Columbia's (CLBC) Service Delivery Model and Policy Tools* (the *2008 Report*); and
   c) Review and comment on government's role in funding and supporting the health and safety of people with developmental disabilities, with reference to the models used in key selected jurisdictions.

Sponsors

2. The review is jointly sponsored by MSD and MF.
   a) MSD and MF will provide general direction and oversight to the review, with input from CLBC.
   b) The Deputy Ministers of MSD and MF will serve as executive sponsors of the initiative.
   c) The MSD,MF and CLBC executives will identify and assign appropriate resources within each of their organizations to provide information and support to QCG in conducting the review

Method

3. The third party will undertake the following tasks during the course of the review:
   a) Assessment of CLBC's efficacy:
      i. Assess the efficacy of CLBC's caseload data and forecasts;
      ii. Assess the efficacy of CLBC's Request for Service list, identifying key issues and options, and making recommendations for means to manage and communicate about service requests and demands;
      iii. Identify efficiencies realized by CLBC, as well as opportunities for further efficiencies within CLBC's current service delivery model and budget; and

iv. Recommend performance metrics such as a balanced scorecard that can be integrated into CLBC operations, to enhance accountability and commitment to an effective and efficient service delivery model.

b) Assessment of CLBC's progress:
   i. Review and assess CLBC's progress in implementing the recommendations of the *2008 Report*;

c) Assessment of the British Columbian service system/model for people with developmental disabilities:
   i. Undertake a high level comparative analysis across selected jurisdictions (Alberta, Ontario, Manitoba, Western Australia, and New Zealand) to identify the level of resourcing and how resources are allocated to support services for people with developmental disabilities;
   ii. Identify and describe the range of supports that persons with developmental disabilities may receive in British Columbia, both from CLBC as well as from other sources and government agencies/programs; and
   iii. Comment on the options available to government in providing services for people with developmental disabilities.

Deliverables

4. The primary deliverable of this review will be a report that reflects the information obtained during the review's consultations, analysis of processes and data, and the experience in selected jurisdictions. The review will also provide recommendations regarding each of the tasks set out in section 3.

Timing

5. The review will consist of three parts:
   a) Phase 1(August, 2011)
      Development and confirmation of the project's scope and Terms of Reference
   b) Phase 2 (September-October, 2011)
      Conducting the key tasks as outlined in section 3, above.
   c) Phase 3 (November, 2011)
      Submission of the final report, with recommendations for consideration and response by MSD and MF

Agreed this ____day of _____, 2011

Mark Sieben Deputy Minister, Ministry of Social Development	Peter Milburn Deputy Minister, Ministry of Finance

Appendix 2: Participants in Review

Review Participants	
Ministry of Social Development	
Mark Sieben	Deputy Minister
Molly Harrington	Assistant Deputy Minister, Policy and Research Division
Harb Sihota	Executive Director, Disability Services Branch
Odette Dantzer	Director, Disability Services Branch
Ian Brethour	Director, Disability Services Branch
Andrew Wharton	Special Advisor, Disability Services
Internal Audit and Advisory Services, Ministry of Finance	
Chris Brown	A/Executive Director, Internal Audit and Advisory Services
Lisa Haas	Business Advisor, Internal Audit and Advisory Services
Ken Worthy	Business Advisor, Internal Audit and Advisory Services
Community Living British Columbia	
Rick Mowles	Chief Executive Officer (former)
Doug Woollard	Chief Executive Officer (interim)
Richard Hunter	Chief Financial Officer
Carol Goozh	Vice President, Policy
Brian Salisbury	Vice President, Strategic Planning
Other	
Peter Batini	Executive Director, Service Contracting & Development Disability Services Commission Western Australia
Colleen Watters	Policy Analyst, Manitoba Disabilities Issues Office

Appendix 3: CLBC supports and services

Types of CLBC Supports and Services Community Inclusion

CLBC funds a variety of community inclusion options. These services are designed to support individuals to be contributing members of their community. The amount of funding and type of support provided depend upon the individual's current disability-related needs, support preferences, and goals for inclusion.

Employment

This service uses a variety of methods to ensure that individuals achieve employment with an employer in the community. This option includes supported employment, customized employment, and / or self-employment options. Employment is a first priority for individuals served by CLBC.

Skill Development

This service provides individuals with support to develop skills that are required for healthy, independent living. Support may be provided to individuals through one-on-one or group arrangements. Services are goal-based and time-limited.

Community-Based

This service is designed for individuals who require ongoing support to participate in community in a meaningful way. The service operates outside the individual participants' homes and is usually offered according to an established schedule that allows individuals to participate on a part-time or full-time basis. This service may have a vocational focus, social /recreational focus, or some combination of the two.

Home-Based

This service is designed for individuals who require ongoing support to participate in community in a meaningful way. The service operates within the individual participants' homes and is usually offered according to an established schedule that allows individuals to participate on a part-time or full-time
basis. This service is typically associated with staffed residential and may have a vocational focus, social / recreational focus, or some combination of the two.

Residential

Community Living BC supports eligible adults to live as fully and independently as possible in the community. Funding and the type of support provided depend upon the individual's current disability-related needs, support preferences, and preferred home environment.

Supported Living

Supported living is a residential option that provides individuals living independently in the community with assistance in daily living. This service is available to individuals who own, lease, or rent their own homes. Supported Living services include outreach support and cluster living. Outreach support provides targeted hourly support to individuals through one-on-one or group arrangements. Within cluster living, an on-site contractor provides ongoing support to a group of individuals who have homes close to one another (typically within the same apartment building).

Shared Living

Shared living is a residential option in which an adult with a developmental disability shares a home with someone who is contracted to provide ongoing support. The home is the primary residence of both the individual being supported and the person offering support.

Shared living includes home sharing and live-in support.

- Within home sharing, the contractor controls the home through ownership, lease, or rental.
- Within live-in support, the individual controls the home.

Staffed Residential

Within staffed residential, support for daily living is provided to an individual or group of individuals by a team of staff who rotate through the home according to an established schedule that includes overnight hours.

Respite

Respite provides families with a break from the challenges of caregiving. Families can use this service in the manner that best suits their unique circumstances. The service may be delivered in the family home, the home of a respite provider, or within the community.

Direct-Funded

Direct-funded respite is coordinated by families. The family recruits, screens, monitors, and pays for the delivery of respite services.

Contracted

Contracted respite is coordinated by a community-based agency. The agency recruits, screens, monitors, and pays for the delivery of respite services.

Support for Individuals and Families

CLBC funds a range of services for those who support an adult family member with a developmental disability. Services are designed to enhance the individual's overall quality of life and to strengthen the family's ability to manage. Services are typically goal-focused and time-limited.

Psychological

CLBC contracts with a licensed psychologist to provide assessment and consultation services for people served by CLBC.

Behavioural

CLBC contracts with a licensed psychologist or qualified counsellor on behalf of a person served by CLBC with emotional or behavioural support needs. The service includes consultation, assessment, and therapy.

Home-Maker

Home-maker services are available to individuals who require basic housekeeping services or temporary personal care to successfully live in the community. The service may also be accessed by those who provide ongoing, unpaid residential support to an adult with a developmental disability.

Support Coordination

This service is tailored to the unique needs of the individual or family. It may involve counselling, resource / referral, education / training, scheduling, or connecting people with peers in the community. The service is typically delivered through a community-based agency that is contracted by CLBC to oversee the service. Support may be offered to an individual, a specific family member, an entire family, or family groups with similar needs.

Individual Planning Support

CLBC provides planning support for individuals and their families. This may include support in accessing community services, problem solving or a formal plan to request CLBC funded services.

Appendix 4: Summary of CLBC-CLAN/CEO Agreements, October 2011

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Summary of Agreements with the BC CEO Network and CLAN
October 2011

Collaborative Working Relationships

a. Agreement on principles for service providers and CLBC to work together.

b. GSA use - CLBC staff, indiYiduals, families and service providers will complete the GSA together, when a plan has not been completed; sharing the complete results v..ith families and servic• provicil•rs; cutd, f".xplai.J.ti.ng the rationalo.•for recolllme•mk•d se•rvice IL•vl'ls.

Funding

a. j\1PP - Funding approved by government for tvPP. CLBC lo develop specif.ic requirements for docuutl'ntation by s•rvicc provider; d.IId contrdd dlli.'Ilduwllt process.

b. CLI:C will t'l"t'dt uHion and nuH-tuti.on service providers eduitably when providi.J.tg fumling for the Municipal Pension Plan beginning in the 2010-11 fiscal year.

c. The DC CEO :\etwork and CLAN accept the concept of negotiating and reporti.J1g Service T P.vt•l s in p1·inciplP..

d. SPrvicl' h'YPs d't IPlmin<'d u<;ing Il w Ill'W Ftmding C:uidP TPmpl all">.

e. CLI:C costing guideli.J1es will be renamed "hmdi.J1g Guidelines".

f. CLBC will change the Funding Guidelines to say "up to 10% administration".

g. CLBC will fund 1 supervisor to 8 PTE' s supervisory ratio v.'ith the supervisory positions not in the service level.

h. CLI3C, I3C CEO Network and CLAN agreed upon $26.57 per hour plus benefits as an all iw.:lusivc• rate• fur !>Upervi :ors fund•d under the• 1-8 rdtio. (&e• dppl'Hdix 1.)

1. Agreement that ti.J.ue for staff meeti.J.tg will be included in ervice leveb.

j. Cnlculntion of cost impacts for senior workers providing lectdership as pnrt of the 1-8 supervisor ratio - Two options will be available in the Funding Template. l11e preferred option will be to cost online hours of supervisors or staff providing leadership at the line workf>r ritiP. wlh it noiP. in Cl:llllllP.nls Ihal IhP. work is bP.ing d01w by a supf>rvisnr.

k. Cilining darily on which posilinns iliP hackfillPd. This nl aiP'i lo Pmpl oynwnl prngrilms whe•n• une fur one backfill has not typically l>l'L'11 pruvidl•d - CLBC may dtooc• nut to purdme full backfill in sU!Ilt' en•ice e.g. employment ur kill dt>velupment. ervice providers may also i11dicate that they do not require full backfill. CLBC agrees to negotiate the amowu of backfill required.

1. Cnsl or dily shirls O1 slals in slafff>d l"f'SidP.nlial - CJ.BC hils iiKnrpnraif>cl cosls itlld Sf>rvi:'P. h'vcls lor dily-tinHfunding i11 stilrl,,d 1Psidenliill nn si,111J ioly hoidays. To.mpl ai!' formulC s

designed and agreed upon. CLI3C has deferred any contract modif ication as a result of this w1til annual service level reporting.

m. Agreement on principles that will guide CLBC staff and service providers who arc either tmder or over the service levels at the end of a contract term or year.

n. Increases in ftmding as a result of the application of the founding Guide Template will only occtu wheH ::,avings are found within the service providers existing CLBC fumliHg.

o. CLBC will develop regional program cost guidelines based on existing negotiated contracts by June 30, 2011. We will use a minimtm1 of 10 final FGT per region and have separate averages by con tracl type e.g. staffed residential and commtmity inclusion. Once completed the regioHal \.lata will be shared at the provim:ial taule with the CEO Network ;u1cl CT.AN. Futl1rP <iirPction rf'g;miing rf'gionfl l versus provindfll g11idf'linf's will hP df'ciciP<i and the process for how the averages are calculated will be described.

p. '!he next step wiiJ be to share these average program costs with regional service providers. Adjushlll'Hts will be mttde l>a.scd oii datd as more FCT are completed. The iutent is that if a provi df>f's proposil l fits wi th thP ovf'rfl ll fltnolmt of tlw guiclPlilws Pflch lilw "'ri ll not })f' negotiated. ·where the total is over the average, items which are above the average will be negotiated. The intention is to provide prudent and reasonable amotmts for program costs while reducing the time it takes to negotiate these items.

C) Surw rior hPnf'fiK will hf' rPcogni zf'd wlwn tlwy ilrf' pmt of il collfctivP ilgt'f'Pnwnt ind11cling local agreements which are part of the collective agreement.

r. This issue relates lo providers where WCH has assessed all programs a l the higher r0sicl rntia1 rilte. For Communi ty Tnch1sion thr r◁te is lower in the Fun cling \.uicl0. trmpl nt0.. This may present a challenge for a provider. The agreement for the VVCB rate was that CLDC would fund a reasonable base rate. Service providers were responsible for managing their safely program and CLHC would nol cover increased premiums d ue lo increased inj11ry. Thf'rP flff' il vn rif'ty of dflssificntions for thf' work in thf' Sf'Ctor ;md som f' provi<iPrs have lower rates than others. It is agreed that if WCB assesses a base rate across all programs based on the residential rate that the provider appeals that decision. If the provider is Hot successful CLJ)C will take the increased cost for the vase rate intu accouut when recouping undelivered service level hours. T11is is the same arrangement made for Home based Community Inclusion contracts whicll were agreed to prior to the change of lhe Funding Guide templale. When i t is cl1allenging lo support a person and staff are being injured, CLBC and the service provider will work together to address the situation. Similar to otlwr rmploy0r costs, <Jmol mts pn id hy CT .RC for \VCR costs ◁re su bj0.ct to twgotiiltion betvreen CU3C, the *DC* CEO Network and CLAN.

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s. It is agreed that the CSSEA data collection, in preparation for Collective Bargaining in 2012, be used as a basis for reviewing the existing funding Guide rates. It is anticipated that negotiations between CLBC, the BC CEO Network and CLAN can begin in the fall and be concluded for December 31, 2011. Implementation is a separate conversation based on the environment at that time.

t. Prior to any reduction of cost pressures to for FY, MSP, minimum wage etc., service providers must go through an alignment of steps with CLBC:

- Negotiate service levels using Funding Guide templates.
- Attempt to find savings in the existing contracts. Agencies and CLBC agree that once services have been reviewed and appropriate models of service confirmed, they will not be reviewed again for more savings.
- For non-union providers if savings are found they will first be applied to fund actual costs then the CLBC - CLAN agreement will apply.
- For unionized providers additional savings will be shared between the provider and CLBC to assist the provider to reach the FCT rates and to assist CLBC to serve new individuals on the CLBC Request for Service list.
- Providers who are not at FGT rates will maintain increased costs until the new rates are set. Undelivered service hours will be recaptured.

u. For providers who are not at the FGT rates and where no additional savings can be found, the difference between the FGT rates and the actual funding will not be recaptured by CLBC when reconciling service levels at the end of the first year of the contract.

v. CLBC has agreed to move towards funding services in existing contracts at the Funding Guide rates over time as savings are found in existing contracts. The BC CEO Network and CLAN members have agreed to communicate in a timely way with CLBC during the term of a contract when the need for service changes.

w. Service providers who are unable to deliver the contracted service levels should advise CLBC as soon as possible. The provider and CLBC will examine all options to resolve the issue.

Terms and Conditions- Contracts

n. CLBC negotiated that the Dispute resolution process in contracts can be applied to terminations.

h. The dispute resolution portion of the Terms and Conditions provides a short-form process for resolving disputes. We have agreed not to change the T and C at this time. In addition to the dispute resolution process, CLBC agrees that a service provider can bring with them a member of the BC CEO Network, CLAN or a colleague. If the provider chooses to bring legal counsel CLBC should be advised in advance. The dispute resolution process is for

business matters related to the contract. Service providers should avoid bringing families or individuals ns tlw (·1.B<::complaints procf'ss is availahlf' for familiPs ancl individlunls. Both parties to a potential dispute agree that a timely response is essential and may mutually agree to shorten the time frame to less than 60 days.

Reporting by Service Providers

a. Agreement on reporting as outlined in Schedule of the Terms and Conditions.
b. Changes were made to the materials prior to the orientation session for service providers which have begun. Service providers have agreed to follow the Y1onitorir1g Framework requirements as described in the Terms and Conditions and Schedule D.
c. Neither party will support requireuteHts from local CLBC offices that are outside of the Monitoring framework "list of requirements" that we have illready agreed to In other ·words, we v.;ill not support additional expectations being imposed on service providers to complete "new" forms.
d. CLBC retains the right under the terms and conditions to review service provider documeittatiun whell issues or coucents are raised about tlte service (SectiUit 11 Verification).

Reviewing Contracts -Service Redesign

a. The BC CEO Network and CLAN v.,ill support the participation of their members in service redesign and reHegotiation of contracts to assist CLBC irt freeing up fumls to reirtvest fur additional services.
b. 'l hf' KC CEO Nf'twork fln◁ Cl .AN wou lcl Pncourflgf' thf'ir mf'tnhf'rs to 0f'VPiop thPir own Service Redesign plans, rather than have CLBC representatives develop a Service Redesign plan on their behalf.
c. Where appropriate the BC CEO Network and CLAN members '"ould recommend individuals who might benefit from service redesign.
d. 'l lw KC Cl-:O Nf'twork *rmcl* CI.A N flgrPPd th At it woulcl hP in thP hf'st intPrf'sts of thf' pPoplf' we support to collaborate with CLBC on the comnnmication going out, i.e.: letters, and/or meeting with people.
e. The BC CEO Nenvork would ask Network members to v.-ork collaboratively with CLBC representatives to ensure that lhe d10ices of people and their families a1·e, or will continue lo hf' hon ourf'cl, ami th tlt tllf'Sf' choicPs flrP rf'spmldf'd to appropristf'ly.
f. Both parties to the negotiation seek to understand the others point of view. CLBC to revise the draft "negotiations with service providers" to reflect:
   - Service providers will present Fundir1g Guide Templates (FGT) for all contracted servie s in a timely way.

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- CLBC will not present altered FCT's to service providers.
- CLBC will make counter proposals to the costs presented by service providers in writing.
- Once agreement iachieved the en·ice yrovider will make the 11ece sary dJauges to the l!G1'so lhat il reUecls the agreement.
- The issue of the Level of support provided by staff funded through contracts will be negotiated based on the disability related needs of the people served. Specific job diJs.sificFJtions will 11ot hE" clisrllss!"cl in any SE"rvi re area.
- Dming nPgotintions C:T.RC: staff nnd servirf' provic!P.rs will trf>ilt f>ilch othf'r rPspectf11lly following the Guiding Principles fOI Working Together.

g. CLBC, the person aml their family working with the ser vice yrovitler would reach agreement on service redesign.

h. Service l edesign- Enhance conununicalion between CL!::lC and service providers:

- Increase local conunw1ication ·with service prO\iders.
- CLBC will explain the Service Redesign initiative to people and their families.
- F.nsurf' diflogtlf> nhout issues occurs.
- Issues and concems from service providers go directly to QS manager or DRO.
- CLBC and the BC CEO Network leadership meet together with service providers who are struggling.
- CLBC provide positive communication about what is working.
- CLl3C coordinate service redesign plans by community so service providers work together to solve problems they cannot solve on their own.

i. In establishing a common understanding of how negotiations occur on all the issues in this documf>nt Sf>rvir.P providf>l'S il grf>f> to work rollflhorativPly fine! inn timf>ly wny \"Vith C:T.RC: to find whatever savings possible to assist individuals and families.

l· DRO's will coordinate the various managers involved to meet with a service provider who serves more than one CLBC area or region, to develop a plan for how they should work together. Providers should contact the DRO where they du the most l!uiiH!SS to iHitiate this process.

k. The DC CEO Network and CLAN commit to working with their members to implement the above agreement. DC CEO 1'\etv\'ork and CLAN continue to support member's understanding.

1. VVf> would inform famil if'S fine! inclivicimlls who Wf'rf> not heil1g ilPlWoflr.h f'd nho1lt Sf'rvi rf> redesign that their services would not be changing.

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Administration

a. The BC CEO Network and CLAN accept the 1997 Contract Reform administration guidelines as the basis for administration funding in the Funding Guidelines.

b. CLBC agrees to work with the BC CEO Network, CLAN and other Ministries to establish a process to review administration funding, programs through (;N 1 1.

Non-Union Service Providers

a. See page 11 for a summary of the agreement regarding non-Union service providers represented by CLAN and the BC CEO Network.

Home Sharing

a. Home Sharing Agreement (see page 9 for details).

b. Home Share Coordinator - Agreement that Home Sharing Coordinator will not be included in service levels.

c. Home Share rates – Joint project to review Shared Living/respite rates.

d. To encourage the BC CEO Network members to consider offering, and Overseeing Home Sharing as a residential option in their communities (if they are not already) to ensure we are providing as many residential choices as possible.

e. Agreed that issues will be identified by the Home Sharing working groups for resolution at the provincial table. Issues include recruitment process and liability concerns.

Facilities

a. CLBC will use market rent as the basis for all new contracts. CLBC will create a project to review historical circumstances.

b. CLBC, the BC CEO Network and CLAN will establish a small working group of 5-7 people with staff support to research and examine the impact of paying Fair Market rent for facilities which are already funded. The purpose would be:

- To understand the costs associated with implementation.
- Complete analysis of the current situation looking at real circumstances.
- To clearly define Fair market rent and how it may be applied to existing contracts.

c. Once we know the implications we can make decisions about whether to proceed and how. The working group will report out by October 31, 2011.

d. The BC CEO Network and CLAN agree that their members will not delay negotiations due to issues related to facilities costs and CLBC will apply the Interim Guidance for Facilities costs while we are engaged in this process.

e. Until a decision has been taken abou l .lail· market rent CLJ:C will pay act ual cosls as described in the previously circulated presentation or read1 mutually acceptable agreement on a fair markf>t r?nt.

f. If there is a dispute about the fair market rent value an independent professional assessor will he usP<i to rlPfinf' thf' rf'ntal value in that com m11ni ty. ( ] .RC anrl the servi r:e provider will share in lhe costs.

g. If the provider docs not want to usc an independent assessor and mutual agreement cannot be achieved CLIlC ,.vill pay actual costs based on documentation provided by the service provider.

Payments

a. Payment Date change - CLBC is moving to one system for payment effective April I, 2011. All con tm cts will n ow hP pilid on tht> Siltnf' Oilt▷ prior to th ▷ mirldl ▷ of the mon th. CT.RC will adjust the payment dale for those service providers lhal experience a hardship.

b. Partial month payments - Partial month calculator adopted.

Appendix 5: Responsibilities for the delivery of services, by category

This appendix sets out the various responsibilities that the governments in the selected comparator jurisdictions have with respect to people with developmental disabilities, tracking responsibilities according to the broad categories of services and supports identified in this report.

British Columbia

In BC, the central government ministry responsible for disability supports is the Ministry of Social Development (MSD). The MSD is responsible for developing and coordinating the Provincial Disability Strategy, and their budget includes the funding for Community Living BC (the central agency who delivers services to adults with developmental disabilities) as well facilitation (disability support centres), employment and income assistance for people with disabilities, and accommodation support (BC Housing).

The Ministry of Advanced Education provides some disability specific education programs, and the Ministry of Health provides some disability supports through home support. The Ministry of Children and Families provides support for children with disabilities, as does the Ministry of Education. As in all Canadian jurisdictions, the province is responsible for most disability supports, with the exceptions of a federal disability tax credit and the Canada Pension Plan Disability Benefits.

Support category →	Facilitation & Referral	Accommodation	Individual & Family Support	Income Support	Employment Support
Responsibility →	MSD (CLBC) MSD	MSD (CLBC) MSD (BC Housing)	MSD (CLBC) Ministry of Health Ministry of Advanced Ed.	MSD Government of Canada	MSD

Figure 44: BC funding & service delivery responsibilities, by type of service

Western Australia

Both the federal and the state governments have a joint responsibility for funding disability services in Western Australia. Western Australia administers accommodation, community support and respite services, while the Australian government administers disability employment programs and income supports. Advocacy, print disability and information services are jointly administered by both state and federal governments. A series of Commonwealth-State/Territory Disability Agreements have clarified the roles and responsibilities of the respective governments, with an aim to reduce duplication and administration in the funding and service arrangements.

In 1993, the *Western Australian Disability Services Act* created the Disability Services Commission (DSC) as a unified and streamlined formal service for Western Australians with all disabilities. The creation of a new department specifically for disability services with its own Minister was an Australian first. The Minister for Mental Health and Disability Services directly funds the Disability Services Commission to deliver accommodation, individual and family supports, facilitation and referral and strategy development.

Despite this centralization in Western Australia, responsibility for most of the service areas is shared with the Federal Departments of Families, Housing, Community Services and Indigenous Affairs (FHCSIA), and Human Services (HS), as set out on the table below:

Support category →	Facilitation & Referral	Accommodation	Individual & Family Support	Income Support	Employment Support
Responsibility →	DSC FHCSIA	DSC	DSC FHCSIA	HS	HS FHSCIA

Figure 45: W. Australia funding & service delivery responsibilities, by type of service

Alberta

Alberta has one Ministry who is primarily responsible for funding disability support services, as the Ministry of Seniors and Community Supports (MSCS) funds all five categories of services. One of the services that the MSCS funds, sets the strategic direction and goals for, and evaluating results of, is the Persons with Developmental Disabilities Program (PDD).

The PDD program is a key service provider for adults with developmental disabilities in Alberta. The PDD Program consists of six Community Boards, which are agents of the Crown and are responsible for developing, implementing and evaluating plans for the provision of services in their respective regions. The Board is appointed by the Minister of Seniors and Community Supports and is accountable to the Minister through the Deputy Minister. The Chief Executive Officer of each Community Board reports to and is accountable to their Community Board through the Board Chair, and to the Minister through the Assistant Deputy Minister.

The Ministry also works with Alberta Health Services, and the ministries of Health and Wellness, Solicitor General and Public Security, Education, Advanced Education and Technology, and Employment and Immigration to develop a cross-ministry policy framework and an implementation plan to enhance the coordination and integration of services for adults with complex service needs. The Ministry of Children and Youth Services provides services for children with disabilities, as does the Ministry of Education.

Alberta's governmental responsibilities are set out in the following table. As in all Canadian jurisdictions, the province is responsible for most disability supports, with the exceptions of a federal disability tax credit and the Canada Pension Plan Disability Benefits.

Support category →	Facilitation & Referral	Accommodation	Individual & Family Support	Income Support	Employment Support
Responsibility →	MSCS PDD Program	MSCS PDD Program	MSCS PDD Program	MSCS Gov. of Canada	MSCS

Figure 46: Alberta funding & service delivery responsibilities, by type of service

Manitoba

Three Manitoba ministries share responsibility for funding supports for adults with disabilities. The Ministry of Family Services and Consumer Affairs (MFSCA) has the central responsibility for disability supports, including the Disabilities Issues Office (DIO). In addition to MFSCA's responsibility for the DIO, Manitoba's Ministry of Health (MOH) and the health authorities support self- and family-managed home care options. The Ministry of Employment and Income Assistance (MEIA) manages disability benefits, while the Ministry of Family Services and Consumer Affairs (MFSCA) also serves children with disabilities, as does the Ministry of Education.

The various governmental responsibilities are set out in the following table. As in all Canadian jurisdictions, the province is responsible for most disability supports, with the exceptions of a federal disability tax credit and the Canada Pension Plan Disability Benefits.

Support category →	Facilitation & Referral	Accommodation	Individual & Family Support	Income Support	Employment Support
Responsibility →	MFSCA	MFSCA	MFSCA MoH	MEIA Gov. of Canada	MEIA

Figure 47: Manitoba funding & service delivery responsibilities, by type of service

Ontario

In Ontario as in Manitoba, three ministries provide services to adults with disabilities. The Ministry of Community and Social Services (MCSS) manages the Ontario Disability Support Program (ODSP), which includes income and employment assistance for people with disabilities, as well as Developmental Services Ontario (DSO). As of July 2011, services for people with developmental disabilities are delivered through Developmental Services Ontario, which financially assists with developmental services and programs that support inclusion for adults with a developmental disability and their families. Community agencies deliver most of the available accommodation, individual, and family services and supports.

In addition, Ontario's Ministry of Health and Long-Term Care (MHLTC) delivers the Assistive Devices Program to provide consumer-centered support and funding to Ontario residents who have long-term physical disabilities and to provide access to personalized assistive devices appropriate for the individual's basic needs. The Ministry of Municipal Affairs and Housing (MMAH) helps to improve access to affordable housing, including housing for people with disabilities. Services for children and youth under the age of 18 who have a developmental disability are offered through the Ministry of Children and Youth Services and the Ministry of Education.

As in all Canadian jurisdictions, the province is responsible for most disability supports, with the exceptions of a federal disability tax credit and the Canada Pension Plan Disability Benefits.

Support category →	Facilitation & Referral	Accommodation	Individual & Family Support	Income Support	Employment Support
Responsibility →	MCSS (DSO)	MCSS (DSO) MMAH	MCSS (DSO) MHLTC	MCSS (ODSP) Gov. of Canada	MCSS (ODSP)

Figure 48: Ontario funding & service delivery responsibilities, by type of service

New Zealand

Two central New Zealand ministries provide the majority of funding for people with disabilities: the Ministry of Health and the Ministry of Social Development. The Ministry of Health (MOH) generally funds facilitation and referral, accommodation and individual and family support services. Within the Ministry of Health, Disability Support Services (DSS) is responsible for the planning and funding of disability support services, administers the *Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003* and provides policy advice to the Minister of Health.

The Ministry of Social Development (MSD) funds employment and income supports, as well as the Office for Disability Issues (ODI), which acts as the focal point within government on disability issues. The ODI promotes and monitors implementation of the New Zealand Disability Strategy. There is some overlap between the two ministries, often funding different aspects of the same program, most commonly within accommodation.

Following a recommendation from an inter-ministerial committee on disability, the Disability Support Services at the Ministry of Health has developed a new model for disability support services. The new model is now being piloted in some parts of New Zealand – as such there is very limited information available as to services and related costs of the model. The stated intent is that the costs will remain within those established under the old model, yet improving quality of life for people with disabilities.

In addition to the above, the Ministry of Education provides support for children with disabilities, as does the Ministry of Social Development. The governmental responsibilities in New Zealand are set out in the following table:

Support category →	Facilitation & Referral	Accommodation	Individual & Family Support	Income Support	Employment Support
Responsibility →	MOH (DSS)	MOH (DSS) MSD	MOH	MSD ACC	MSD

Figure 49: New Zealand funding & service delivery responsibilities, by type of service

In addition to all of the specific governmental responsibilities for service delivery streams as outlined above, almost all of the jurisdictions under review have a coordinating strategy to improve accessibility and inclusion for people with disabilities. While the scope and status of each of these is difficult to determine, the respective strategies are set out in the following table:

	BC	W.A.	AB	MB	ON	NZ
Disability Strategy	Provincial Disability Strategy, 2008	Count Me In: Disability Future Directions, 2009 National Disability Strategy, 2011	Premier's Council Strategic Plan, 2009	Opening Doors: Manitoba's Commitment to Persons with Disabilities, 2009	N/A	New Zealand Disability Strategy, 2009
Who monitors?	MSD	DSC FHCSIA	Premier's Council on the Status of Persons with Disabilities	Disabilities Issues Office	N/A	Office for Disability Issues

	BC	W.A.	AB	MB	ON	NZ
Annual public progress report	No	Yes	No	Yes	N/A	Yes

Figure 50: Disability Strategies, Monitoring and Reporting, by jurisdiction

As shown in the chart above, Ontario does not have a public comprehensive disability strategy, though they have been reviewing and implementing new legislation in the past few years to improve supports for people with disabilities. In Western Australia, both the state and national governments have disability strategies, though these complement and intersect with each other.

Appendix 6: Key Characteristics: Needs Assessment Tools

The following table summarizes key characteristics of three important needs assessment tools outlined in this report (GSA, SIS and interRAI). It is a work in progress and will include information about the Australian tools (ERSSI and ICAP) as information about them becomes better known.

	INTERRAI (INT)	GUIDE TO SUPPORT ALLOCATION (GSA)	Support intensity scale (SIS)
Initial Cost	Licensing fees with interRAI are nominal. Manuals & education for coders and receivers of information. Identify # of assessors/skills level to quantify training hrs/backfill. Hardware & physical infrastructure. Decide if data entry will be point of care to eliminate double data entry (e.g. require tablets/laptops) Vendor costs for software development are unknown though opportunity to negotiate exists. The Intellectual Disability (ID) assessment system is being developed by interRAI for use with both community-based and facility based settings. Cost to develop and implement could be in the millions.	No cost - tool has been developed and is currently in use	Licensing fees; cost of tool and manual; hardware and software; IT; training; coordinator support; communication and change mgmt costs, Estimated one-time costs need to be determined.
Ongoing Cost	Capital costs re: hardware maintenance & replacement. Ongoing assessment of clinical coding accuracy, education - support of learning needs at all levels in organization. Communication structure for coding updates. Technical support for data extract to interRAI. Vendor fees unknown.	No cost - tool has been developed and is currently in use and completed by staff part of their regular duties	Coordination and Support costs, training and use of tool to assess individuals, interview time (on average 2 -3 hours), online fees, purchase of SIS tool, re-testing costs. Capital costs re: hardware maintenance and replacement. Ongoing costs would need to be determined.
Knowledge, Skills, and Abilities Required	Any healthcare/social services worker may receive education to ensure coding accuracy is attained. Basic education for those with clinical assessment skills & knowledge of RAI is 2 days. For those without that base or	Tool is relatively straight-forward. CLBC staff who apply the tool are required to be familiar with relevant policies and practice guidelines. CLBC staff must complete specific in-house training and are mentored by provincial /	Resource intensive – highly skilled trained interviewers with extensive experience in supporting people with disabilities and/or a bachelor's degree in an appropriate human services field.

	INTERRAI (INT)	GUIDE TO SUPPORT ALLOCATION (GSA)	Support intensity scale (SIS)
	requiring assessment or technical skill building, training needs may increase up to 4 days	regional leads	Training is required to ensure assessors have the knowledge and skills to complete the SIS tool
Objectivity	Ensures objective results by using a standardized instrument. The individual who is coding the assessment receives training to answer every item according to standardized intents. The coding manual supports & reinforces this common frame of reference. Input and interpretation of assessment information is therefore consistent.	GSA appears to provide a good means to objectively review the disability-related needs of individuals based on input of individuals, families, and those who know the person (either through plans submitted by the individual or through an interview process)	Ensures objective results by using a standardized instrument. By securing information from multiple informants, the tool potentially yields a more informed assessment of the person. SIS shifts focus from deficits or lacking to what is needed and provides an objective measure to discuss and quantify medical, behavioural, and daily support needs.
Inter-Rater Reliability and Validity	Items are based on best-practice; both the items and tools have been evaluated using published research studies; ensures consistency in assessments between assessors and assessment instruments. The assessment has internal consistency (edit checks assess for conflicting responses). Imbedded algorithms calculate scales which have been extensively researched and validated against industry gold standards.	Internal testing indicates that the current version of the GSA has good inter-rater reliability as well as good test-retest reliability / the tool is loosely based on a system in the UK called Contact 4 (the validity of this tool has been verified). The basic construct validity of the GSA was also confirmed by independent consultants with expertise in this area (although not scientifically verified)	Solid psychometric techniques were used to develop the tool and iteratively refine it. Low inter-rater reliability is often a reflection of inadequate training
Comparability	Consistent interpretation of the tool allows comparison of the client over time. At an aggregate level, comparative analysis between local communities, regions, other provinces - countries is also supported. At the caseload or team levels this information is especially helpful in setting priorities.	Initial analysis indicates that the tool can be used provincially	Using trained interviewers allows for consistent interpretation of individual client needs and aggregate needs of all clients to understand overall support needs.
Comprehensive-ness	The interRAI tools are functional assessments intended to assess the needs, strengths and preferences of individuals. The tool uses the least quantity of items to provide the greatest quality of information	Focus is on current disability-related support needs in 10 areas of daily living (communication, decision-making, etc.) It also allows for identification of "exceptional" support needs in 5 of the 10 areas (personal	The SIS measures support requirements in 57 life activities and 28 behavioural and medical areas; home living, community living, lifelong learning, employment, health and

	INTERRAI (INT)	GUIDE TO SUPPORT ALLOCATION (GSA)	Support intensity scale (SIS)
	(least number of items necessary to create a comprehensive screening assessment).	care needs, creating / maintaining relationships, safety in community, complex health, complex risks and actions)	safety, social activities, and protection and advocacy. The Scale ranks each activity according to frequency (none, at least once a month), amount (none, less than 30 minutes), and type of support (monitoring, verbal gesturing). Finally, a SIS level is determined based on the Total Support Needs Index, which is a standard score generated from scores on all the items tested by the Scale. The SIS aligns with CLBC's outcomes framework.
Outcome Based	Using standardized outcomes and quality measures to track client status over time supports: improvement-focused client/caregiver centred care, increased awareness of client characteristics creates opportunities to plan, implement and evaluate effectiveness of interventions, services or programs, identify service needs/gaps as well as establish accountability for services.	information achieved through completion of the GSA provides valuable information to support the implementation of services (funded and generic) for individuals as specific areas of support needs are clearly identified ... tool can be completed again at any time when an individual's support needs change	SIS contributes to effective individual service plan development.
Integration	The interRAI ID tool is compatible with other interRAI assessment instruments. This commonality of language thereby advances continuity of care through a seamless assessment system across multiple settings. Creates opportunities for collaborative care planning and enhanced client outcomes due to efficiencies.	GSA is loosely based on a system in the UK called Contact 4 ... The GSA is aligned with other CLBC tools / practices (funding guide templates, resource allocation schedule, etc.)	The SIS has acceptable reliability/validity. Inter-rater reliability problems can stem from issues in interpretation and consistency in administration. Reliability studies have revealed that exceptionally good inter-rater reliability can be achieved through intensive training and by employing experienced examiners. SIS has been independently judged to have construct validity.

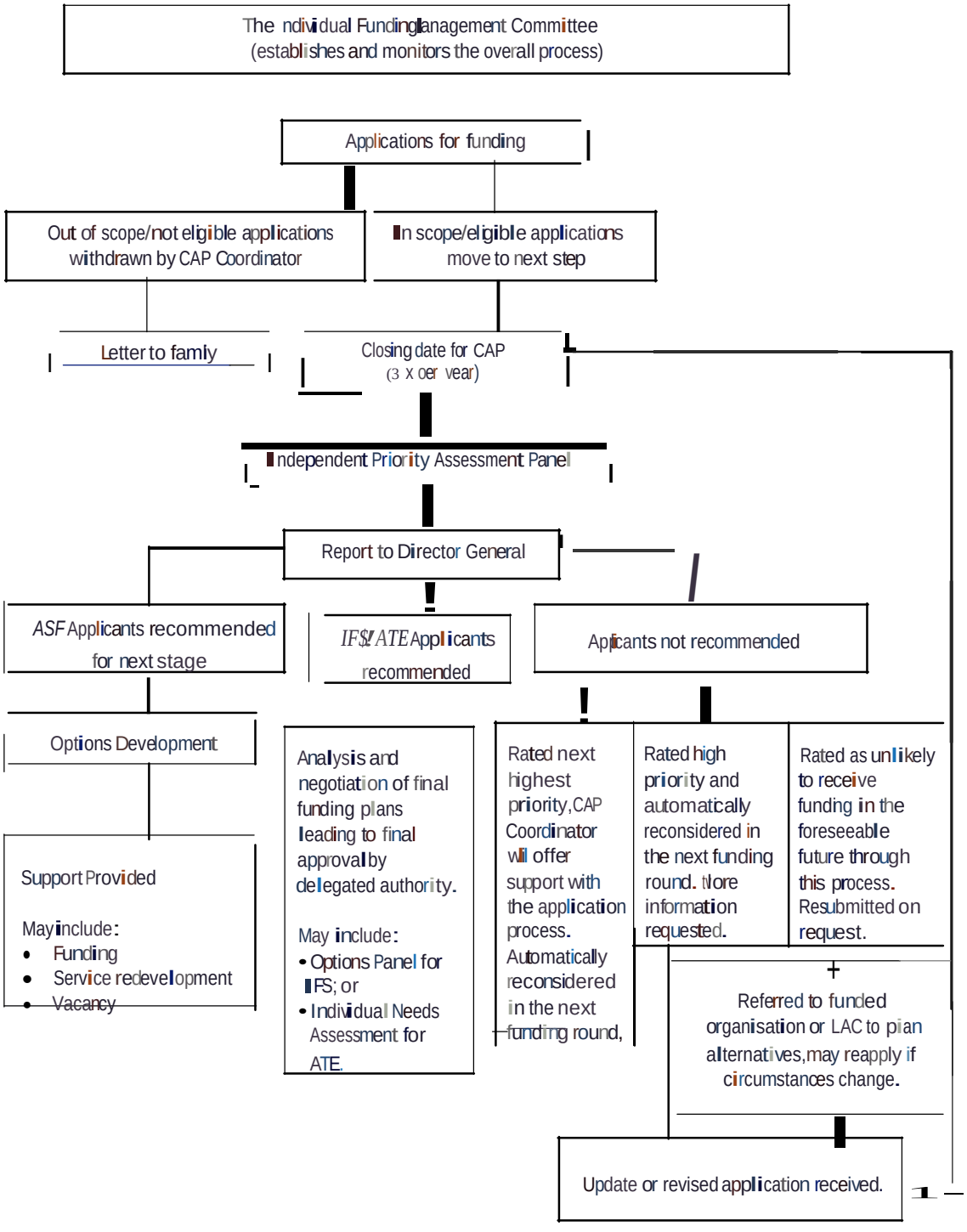
	INTERRAI (INT)	GUIDE TO SUPPORT ALLOCATION (GSA)	Support intensity scale (SIS)
Scalability	Can be implemented across a number of organizations in an efficient and consistent manner.	Unsure – the GSA was developed for use specifically within CLBC. Focus is specifically on support needs that relate to an individual's developmental disability.	The scope of activities addressed in the SIS is broad and range from ability to perform a host of everyday activities to the ability to advocate and protect one's self-interests. The SIS measures a person's support requirements in 57 life activities across 28 behavioural and medical areas. The SIS includes a focus on employment related supports.
Predictability	Can be used to predict future needs for decision making, resource allocation, planning at the personal, organizational and system levels	GSA is a reflection of an individual's current disability-related needs and can be applied anytime an individual's support needs change. It is designed to focus on current needs rather than past needs or to anticipate future needs. Internal testing indicates that the tool has good test-retest reliability.	The SIS was designed to be congruent with and support a person-centered approach to service delivery and to change the focus of assessment from measuring deficit to directly measuring support needs.
Benchmarking	Standardized outputs facilitate benchmarking that can be used for performance accountability, quality improvement and comparisons between organizations (service providers, regions, provinces, countries)	GSA provides opportunities for internal benchmarking across the province. Opportunities for benchmarking beyond CLBC are uncertain.	Once assessors are trained, there is a high rate of inter-rater reliability which allows for consistency in understanding support needs across province. Unsure if comparisons can be made to other jurisdictions.
Transparency	Assessment completion and review with client/caregiver/ family supports collaborative development of a mutually agreed upon plan of care.	GSA provides opportunity for high transparency. It is completed using information submitted by individual (and their family / support network) in an Individual Support Plan or completed through interviews with the individual and those who know him / her well. Individuals / families have the opportunity to meet with a CLBC facilitator to debrief the results of the GSA application.	The SIS interview engages a variety of stakeholders, including the person's family members, friends, and professionals, and the process fosters a spirit of cooperation with an emphasis on community resources.
Evaluation of Tool	Across the interRAI suite of tools, there is about a 50-70% commonality of assessment items. All outputs have been extensively researched and validated against industry	GSA has been in use since 2007. The version that was released in Nov 2010 incorporates results of an internal research project (conducted in the 2008-09 fiscal year) to assess	The tool Has received research-supported validation and the tool exhibits acceptable psychometric properties.

	INTERRAI (INT)	GUIDE TO SUPPORT ALLOCATION (GSA)	Support intensity scale (SIS)
	gold standards e.g. the Depression Rating Scale has been validated against the Hamilton and Cornell scales. There is an opportunity to work directly with the interRAI researchers in their efforts to continually improve the tools.	the tool's reliability. The current version of the GSA has good reliability.	
Web-Based	Due to privacy and security of information, caution would be recommended in exploration of this option. There is alternate functionality (e.g. store forward or access via a secure network) that supports information security for completion at point of assessment.	CLBC's intent is to make the GSA publically available through its public website. Consultation process is underway.	SIS is available in a web based format called SISOnline. SISOnline makes it easy to share assessment data between various stakeholders. SIS is also available in CD-ROM format with the provision to store optional questions about the person being assessed.
Resource Allocation	Using RAI data to increase awareness of client characteristics supports link to resource allocation. Client needs can be predicted and resources planned. As mentioned under *comparability*, allows for setting priorities.	Used as a starting point in resource allocation and provides some benchmarks for staff who are required to make funding and other allocation decisions. Tool aligns with other CLBC tools / practices (funding guide templates, resource allocation schedule, etc.)	Proven use in allocating resources in other jurisdictions. SIS for funding allocations in BC would need development.
Portability	The interRAI ID tool was researched and is being developed for the client population with intellectual disabilities.	The GSA is currently used across the province for both of CLBC's eligibility groups - individuals with a developmental disability as well as those who meet our criteria for the Personalized Supports Initiative	The SIS has been normed on a population of over 1,200 persons with mental retardation and related intellectual disabilities in the U.S. and Canada. It is not normed for the PSI cohort at CLBC
Age	The interRAI ID tool targeted for all adults aged 18 and over with intellectual disabilities (e.g., Down's Syndrome, Autism) has not yet been released. The manuals are scheduled for publishing this winter. InterRAI allows for up to 5% of changes to be made to the tool. This provides a tremendous opportunity to lead the country in application, implementation of the tool	GSA is designed for adults (19 years and older) who are eligible for CLBC services	The tool has been developed for individuals 16 – 72 years. There is a version of the Supports Intensity Scale for children (age 5-15) with developmental disabilities that is currently being normed and standardized in North Carolina

	INTERRAI (INT)	GUIDE TO SUPPORT ALLOCATION (GSA)	Support intensity scale (SIS)
Uptake Used In Other Jurisdictions?	The Intellectual Disability (ID) assessment system is being developed by interRAI for use with both community-based and facility based settings. With electronic completion of the tool, there are increased efficiencies related to decreased repetition of data entry, enhanced communication across settings, & embedded algorithms that generate outputs for decision support which benefit client/caregiver/family, care service providers, organizations and jurisdictions. It is important to incorporate knowledge based on full environmental scan and to consider change management strategies, and to plan from implementation through to integration which will address initially identified needs.	Use of the GSA is exclusive to CLBC.	In North America several states are using the SIS along with ON and AB in Canada. SIS has been translated into Dutch and complex Chinese, and is in use in the Netherlands and Belgium.
Implementation	The Intellectual Disability (ID) assessment system has not been developed or implemented in any jurisdiction. Cost to develop and implement could be in the millions.	No cost - tool has been developed and is currently in use and is completed by staff part of their regular duties.	The SIS is designed to be administered by a trained interviewer who has extensive experience in supporting people with disabilities and/or a bachelor's degree in an appropriate human service field. The ability to interview well and thoroughly is central to the examiner's skill set for successful administration of the tool. The baseline SIS instrument does not capture certain types of information about the individual (e.g., type(s) of disability, presence of certain conditions, and other demographic/situational information).

	INTERRAI (INT)	GUIDE TO SUPPORT ALLOCATION (GSA)	Support intensity scale (SIS)
Stakeholders	Client perception of title of the tool - may feel it does not apply to them.	Because this was a tool that was developed by CLBC without the rigorous scientific process that is used in the development of psychometric instruments, stakeholders have expressed concerns about the tool's reliability and validity.	May be viewed as a strategy for analyzing and reducing supports. With start-up costs required, may be viewed as an inefficient use of money – stakeholders may want to see money used for services

Appendix 7: W. Australia- DSC Combined Application Process



Appendix 7: InterRAI Assessment Tool (Intellectual Disabilities)

interRAI Intellectual Disability (ID)

[CODE FOR LAST 3 DAYS UNLESS OTHERWISE SPECIFIED]

SECTION A IDENTIFICATION INFORMATION

1. NAME
a. First b. (Middle Initial) c. (Last) d. (Jr/Sr)

2. GENDER
1. Male 2. Female

3. BIRTHDATE
Year Month Day

MARITAL STATUS
1 Never married 4 Widowed
2. Married 5. Separated
3 Partner/Significant other 0 Divorced

NUMERIC IDENTIFIERS [EXAMPLE - CANADA]
a. Health Card Number
b. Case Record Number

13. PROVINCE OR TERRITORY OF USUAL LIVING ARRANGEMENT AND AGENCY IDENTIFIERS [EXAMPLE - CANADA]
a. Province or Territory
b. Agency Number

CURRENT PAYMENT SOURCES [EXAMPLE - CANADA]
0. No 1. Yes
a. Provincial or territorial government plan (this province or territory)
b. Provincial or territorial government plan (other province or territory)
c. Federal government — Veterans Affairs Canada (VAC)
d. Federal government — First Nations and Inuit Health Branch (FNIHB)
e. Federal government — Other
f. Worker's Compensation Board (WCB/WSIB)
g. Canadian resident insurance pay
h. Canadian resident, public trustee pay
i. Canadian resident, self-pay
j. Other country resident; self pay
k. Responsibility for payment unknown or unavailable

8. REASON FOR ASSESSMENT
1. First assessment 5. Discharge
2. Routine reassessment covering last 3 days of service
3. Return assessment 0. Discharge tracking only
4 Significant change in status reassessment

9. ASSESSMENT REFERENCE DATE
2 0
Year Month Day

10. PERSON'S EXPRESSED GOALS
Enter person's own words in boxes

11. RESPONSIBILITY/LEGAL GUARDIAN [EXAMPLE - CANADA]
0. No 1. Yes
a. Legal guardian
b. Other legal oversight
c. Durable power of attorney (health care)
d. Durable power of attorney (financial)
e. Family member responsible
f. Person responsible for self

12. ADMITTED FROM AND USUAL RESIDENCE
1. Private home/apartment/rented room
2. Board and care
3. Assisted living or semi-independent living
4. Mental health residence — e.g. psychiatric group home
5. Group home for persons with physical disability
6. Setting for persons with intellectual disability
7. Psychiatric hospital or unit
8. Homeless (with or without shelter)
9. Long-term care facility (nursing home)
10. Rehabilitation hospital/unit
11. Hospice facility/palliative care unit
12. Acute care hospital
13. Correctional facility
14. Other

a. Usual residential status
b. Admitted from

13. POSTAL CODE OF USUAL LIVING ARRANGEMENT [EXAMPLE - CANADA]

14. LIVING ARRANGEMENT
1. Alone 5. With parent(s) or guardian(s)
2. With spouse/partner only 6. With sibling(s)
3. With spouse/partner and other(s) 7. With other relative(s)
4. With child(ren) (not spouse/partner) 8. With non-relative(s)

SECTION B. INTAKE AND INITIAL HISTORY

NOTE: Complete Section B at Admission/First Assessment only

1. DATE CASE OPENED
Year Month Day

2. ORIGIN IS INUIT, METIS, OR FIRST NATIONS [EXAMPLE - CANADA]
0. No 1. Yes

3. PRIMARY LANGUAGE [EXAMPLE - CANADA]
01 English
02 French
(See manual for additional codes)

4. NATURE OF INTELLECTUAL IMPAIRMENT
1 Down syndrome
2. Other
3. Autism or Autistic spectrum disorder
Other (see manual for additional codes)

DOCUMENTED SEVERITY OF INTELLECTUAL DISABILITY
0. No intellectual impairment 4. Severe
1. Borderline 5. Profound
2. Mild 8. Not documented
3. Moderate

6. AGE AT WHICH PERSON LEFT FAMILY HOME
Code "00" if not applicable (i.e., person never left family home). Code "99" if unknown.

7. NUMBER OF YEARS (LIFETIME) SPENT IN AN INSTITUTIONAL SETTING FOR PERSONS WITH INTELLECTUAL DISABILITY

interRAIIntellectual Disability (ID)!)

8. RESDENTIAL HБ TORY OVER LAST 5 YEARS
Code for allsetiJ/Jgs perscn lived i:> during 5 YEARS prior to date c.н ѕ orf:JnPcl [fiPIH J-i1}
0. No 1. Y;
a. Semi-Independent living (SILI
b. Board and care
c. Grollp home
d. Institutional setting for persons with Intellectual disabi ity
a. Long-term care facility (nursng hme)
t P!lych atric hospital or un t

SECTION C. EDUCATION, EMPLOYMENT, AND RECREATION

1. EMPLOYMENT STATUS
t-wpov:<l
2. Unemployed, seek ng emp oyment
3. Unemploya j , not •eeking employment

EMPLOYMENT ARRANGEMENTS-EXCLUDE VOLUNTEERING
1. Compe1itive e11ployment 3. Vocat onol rehebilit9tion
2. Supported employment 0. Nol applicable

3. INVOLVEMENT IN STRUCTURED ACTI VITIES
0. No 1. Y s
.. Formal educat on progmm
ii. Volunteerism— t<. .• (fJf <:Ji/IlfiWiifr ::tetK:es
c. Day program

4. NUMBER OF DAYS OF PARTICIPATION IN PREFERRED RECREATI ON AND LEISURE ACTIVITIES IN LAST 7 DAYS

SENSE OF INVOLVEMENT
0 Not pr-r:.f.:nt
1. Present but not exhibited in lost 3 doys
2. D<h bited on 1–2 of last J days
3. Exhili cd daily i1llaJ 3 taY'>
t. At eRsei nterAct ng with others
0. At ease doi ng planned or structured activities
c. Pursues in Yolvement i n activities of residential setting or comr1ut1 ty— *a makA<> or kAP.p.c: frtRtk1.c;; 1nvoJvHrl m group activitJs: rt>spond's posifflo&ly to nel-' activllies; ri Jhf.c; fiT fPIIGlOiJ.C:J:AlVlC'R.<O'*

6. PERSON PREFERS CHANGE (when asked)
0. lo B. Could nol (woulJ m; respond
1. Ye•
.:t Paid employ nent P.!], *typ, h:-Jur.. p;1)/*
b. Recreat onal activities - 6.g, *f!'P:J. rwmber, or,'eve/ of pur (rcfj.XJliou*
r; Living arrangements fJ, *fcr-nhnn. typn, wnn /tvc:r; \\'Jfh*
d Daily routine *t. U 1!mf, .!:rNfJ ;dmdu o. doimm Jo vmnr*

SYCHOSOCIAL WELI ... PORTS

0. No 1. Ye;

L STRENGTHS
.:t Consistent positive outlook
u. Finds meanin g n day-to-day life
c. Reports having a conf dant
d Strong and supportive relationship witl family
o. Reports strong sense of involvement i n commLntiy

SOCIAL RELATIONSHIPS
{Note: <Alen.w.>r possibJe, ask person]
0 Nc:vm :1 4 to / ctav.NJO
t. M01t lllt-.1 30 duv:-;.:-!-Jd 4. Ill ltrj13 dtl
2. 0 toJO days ago 0. Unab e to de armine
a. Participation in social act vi1i Ss of long-stand ng i nter &t h V:::; t with a ong-standi ng social relation or fami ly member
G. Other interact on 'Nith l ong-standi ng 60ci al relation or fami ly member c.y., *lvlophom.J, v mali*
d. OVernight stay of 1 or more nights at home of fami y member or l ong-standing social relation

INFORMAL HELP GIVEN TO OTHERS
J:i>:!UufiufvuuaI lwJpqh'f:ll b}- lhu J.J(•l..:(Jl/ lU rAhwu. (exduo'fng vofumeer actiL•ities)
0 r.J() YF!
a Emot onal support/compani onship
h IAOL
r ADL

UNSETTLED RELATI ONSHIPS
0. No I. Yes
a. Conflict with or repeated cttclsm of family or fr ends
b. Confl ct w th or repeated criticism of other clients
r; Confl ct with or repealed crit cism of staff
d. Family or cl ose friends are pers stently hosti e tow::ud person

TWO KEY INFORMAL HELPERS
a Relationship to person — Helper 1 2
1. Chid or cld-in-law 6. Other ra ive
/' Spou t-oondl
3. Paner significant olher 8. NeiJhbour
4. Parent/guardian 9. No infmnal helper
Sclt1lq
Areas of informal help during last 3 d.R{s:
0 No 8 No informal helper — Helper 1 2
b. General oversight or cuei ng
c. IADL
d. ADL
e. Diisto support

HOURS OF INFORMAL HELP AND ACTIVE MONITORING DURING LAST 3 DAYS
o1 iu:.twuu. miaJ :mt.J JX..W<m:Jl ::.Jc!iJ(ir.)-11 tJf duil-y Jivmr.J iu ihe LAST 3 DAY.S. indicate fhe tc.taJ number of hours of tr r.o rec.:i\'ed from ALL tamif., inends, and naJg/iiJovrs

INFORMAL HELPER STATUS
0. No 1. Y;
a. Informal helper(• ll• unable to continue l n cari ng *t/Uu.ull fo c.ontmm* activities— e.g., *declitte in the !u::alth of the helper makes it*
b. Primary Informal helper expresses feelings of distress, anger, or depression
c. Family or cl ose friends report feel nD overwhelmed by person's support needs

PLANS FOR FUTURE NEEDS
J-lmrt)fl 01 mlwm:l! lu:lpm(';) lt:!.'i pln.om im alwmnfl'ltlitlum :suppwt o1 f;'ll1lJ Jllt111 9 mr:mt. if rt.'qu;Jl!C! (.y., if o.."urtf informal>Jiper is nol" nger able ro prowl<> supp,rl)
0 Alh:rm; rvc) l•lar1; 11lJl (:\JJISKIIrcil ()H 1101 rc;qu d
1. Alternative plans not made, but under consideration
2. Alternative plans made

interRAI

interRAI Intellectual Disability (ID)e

LIFE EVENTS

(;wJo iN m:;i fC'f:fNi/ IIIfHof fWWII

0. Never
1. More than'l year ago
2. 3f duy.s 1 Y tlt ▮ U
3. 3 – 30days ago
1. ·1 – 7 day• ago
5. lr1 lu l3U: s

H. Serious acddent or physical im pair ment

b. Di stress about health of another person

c. D&ath of cl ose family momber or friond

d. Vi ct m of sexual assault or abuse

e. Vl ct m of physleal assault or

abuM f. Vi ot m of emotional abuse

g. Vi ct m of bullying

10. DESCRIBES ONE OR MORE OF THESE LIFE EVENTS (D9) AS INVOKING A SENSE OF HORROR OR INTENSE FEAR

H No, or 11olapplk:ahc
L Yes
H CDI IC N I(Wo IIII WJI) respond

D

SECTION E LIFESTYLE

CAFFEINE USE

H;ghesz number oj ceffejnated bewemges *C))Swned in !WY single day of rile IAST 3* DA YS

H No :.Jt: t:or c;;ttc1mn:1h<:vr:mgr; ,
1. ·1 – 2 cups of coffee or 1 – 4 coffe;neted bevemge-s
2. 3 – 5 cups of coffee or 5 – 9 caffe-nated beverages
:1 til)l lflllfCIIPSCl r OII(:ll OI 1[] Cli iiU)f(;C;'11(liJ1ai(IJ ilOVIEfl!)(;

SMOKES TOBACCO DAILY

0. No
1. Not in last 3 days, but is usua y a daily smoker
:J Y s

:{ ALCOHOL

H;gheSI.number o jdfinks in en}' s;ndle sittf?g" in LAST 14 DAYS

0. None 1. 1 3. 5 or more

SECTION F. ENVIRON TAL ASSESSMENT

1. HOME ENVIRONM...

(:o.i 9 tnr Any of fhtoiJowmg tlmf m<-lkP home m11rcnmnt luu.tm/o;_t:;r'll uuin!wf.JiH.IJft;; (iJ !t:Hil{JU:tm/y irt jr;lilu!Jou, bt,St:' ssessrrem *OtJ l?on'/e v1s.'t)*

tl No
1. Yeo;
3. Unknown. home not visited or no information

a. Di&ropair of tho homo-e.g. . hazardous clutter: nadeQuate ur rnu lil rliul-J 11 ivinl-J IOUIII, ., (...'Cpinruu111. kilth.m, loilcl, corridors; holes in floor :leking p pes

b. Squal id conditon— e.g., extreom€ffy dirty illfestz ion by rat& or htlg.:

c. Inadequate heatlng or eoollng--€g., too hot in summer, to:J cold in winter

d Lack of personal safety r.g . t11r ot v o cn(t" , :w;tty f)lUbl.; uirt!Jdiq!-J Lt. lllt ll.Jox:01 vi. Unr-t urJiJrbouk>, lr.:-iVY traffic in sil'eet

e. Limi ted access to home or roomsin 1lome----e.g., diff cul ' tmlcrinu lct-vug h:nnu:, unsillulodinu :IBrk, nJirficuH• m.£ noeuvrintJ within rooms. no milings olthollgh ooeded

COMMUNICATI ON METHODS

ClJ.it• f01 f-l';'m11y IYIP-ofV;<J:H'-lJWvk c." '1ITIUffJ.:<lIh;,

0. Verbsl--i.e., :ijeech
-. *Non-verllsl--€.g., gesillfes.s n language, sounds, writing*

:> MAKING SELF UNDERSTOOD (Expression)

xpu:;m!J IIlfmm;J(HIII t:oulc:ul luH!' Vf Ix!! mu:r n:Ht 1i!Jul

0. Understood---expressesideas WJthout c'ifficulty
1. *Usually* unc/orsroo<— Difficult,' finding words or fri•t:ing Uod-Jil<i BUT irqi-; rr time, lilli! u• ItO PK•IIIJJlin14uited
2. *Ofren* underntood--Difficulty finding words or finishing thooghls AND pronpng usually r"quired
Sometimes understood /\t.Jhty r. mrtt!rltn mk1ng concrete reques:s
4. *R•Y* or *never understood*

D

3. ABILITY TO UNDERSTAND OTHERS !Comprehension)

flml:mfomflmT vr:IIJOJ! mJmumi:Jn umltmJ (lKH'(:1iw allit? \JN;f, hearing:Jppliance normafty used)

0. *Unclorsranas*— C ear compraUansion
1. *U3d.ally* understll'nds— Mis>t'> o11fIII:! pw Lirrll:!•l Jr message BUT comprehends most conversation
2. *Ofron* un<lOf-sllin<ls— Nlsse•some part/intent of mt:!" .y : Hl l l w h rq')('trton nr crcp'lnl'ltlon r.'"n nttr:r comprehend conversotion
3. Sometimes *undersr•nds-Responds* adeQuately to Slf1lph,! IJ(CI C! IIHIIIIII:in:rr o11ly
4. *Rarely* or *never Hnderstands*

D

4. HEARING

r. Ability *to* hear wl h hFimng Apfi rAinnmmlly us)

0. *Adequate-No* difficulty in normal conversation, social interactjon, listening to TV
Minimal difficulty I) tir.t1 ty rn ,nmnnvrron mnt, {e.g.,'A'hen person speaks softly or is more than 2 metres [6 feet] away)
Modemte *difficulty* 1-lJhl< m u;al rrl lrHHfllal cun.,.uo;aiorr, 1cquire5quicl <elli1q lo hem W(1
1
3. Severe diffioufty-Difficulty in a l s tuations (e.g., speaker has to ta k lou-jt or speak VBry sk:rwty; or pei"SUil lt!;J.lUi IS ltl uiJ 'jpet:!clr Wllilt t..led)
4. No *hearing*

D

b. Hearing old uoed

0. No 1. Ye•

D

VISION

:; Ablity to see in adequOJte light (wtl lr nla;: .m wlh ol t• visual appliance normally used)

0. Adequa Sees fine data l, including r>gular print m llCwall<iJ(I ;t JOClk ;.
1. *Minims/ difftctrlty*— S.e-3 CU!-Jt!p1i1rt, Uul 1rul ru lur p rntin nawspepersbooks
Moder-at•difficulty— ! rmrtf!rlv•rn ;not ahiA t.;,!=.f!A nev-3p£lper headl nes, but ron k.entify objects
3. Severe dlfffcufty-Object identiticat Oil in question, but YA::tp(>Ar lrJ tniiO\l' ohl.;,c.t; t=.AS. nnly h!)ht, c:orurr, sl iiJ)(;
4. No *vision*

D

b. Visual appliallco used

D. No 1. Yes

D

SECTION H COGNmON

COGNITIVE SKILLS FOR DAILY DECISION-MAK NG

Mal<;f!-1 tlvci.&..;UIIS f('!-J::lldiil-J hwf.:ur c.iaJy fire t.'.Q., wilt.!/!! tJ get up or flave meats, wh;ch cJothes to we:Jr or acti'ilJes to do

II *Independent* l C)< rsrou.c:.u;r lwr .masonHtrlc. arrti "Xfe
1. *Modified* ;ndependenc&-Some dfficulty in new s1hrt ons. only
2. *MlnlmBlly lm/)IIIred--In* specfic recurring stuaons. decisions become poor or uns(lfe :cuesisupervision nA00S..._...ry ;;, fh0S.Fl tmnA
Moderately impaired l >m:r;um: ; c ousrl! lf ly pom O1 unsafe; cues supen ision required at al times
·1. Severelyimpaired--Never or rarely makes decis ons
!i Nv *discernible* consciousness. com.:J

D

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2_ MEMORY/RECALL ABILITY
Code for recl:i/1 of w.Jat was teemed or known

0_ Yes, memor)'OK   1_ Memory probfGm

a. Short-term nH:mory OK— Seerns lap 9ars to reca after mnutes.

b. Procedura l memory OK Cau1Jefuuu till alrnu: ll -stps in a mult tMk sequence wlhout cue>

c. Sii\Jat onaJ m<>mory OK— Dotll: Recognizes caregivers' names faces frequenty encountered AND knows location tlf p-u:n ;rcjJulmly vis]c:l (hl: tlrt HI l, d irrir rlJ (Offr ;u: ivilv

PERIODIC DISORDERED THINKING OR AWARENESS
{Note: Accurate assessment requres cOJlW::rsations wnh siaff, family or o'hers wiJO />ave dtroct knew/edge ol rl9 pers01l S

0. Behaviour not pre"S.ent
1. Behaviour present, consistent with usual functoning
2. Behaviour present, appears. difftrent from usual tnnchomng (A g , nAw .-:. A(nr worsAflrrg ; 11HAr-t from

a. Easil distracted U-l-1-- VJ.isoJe:; ur dirficult fXy uq attenti, n ;9ets '>idetrocked

b. Ep sodes of disorganiucl speech-e.g., speech is nonsens cal, irrslevant, or rambling from subject to subject; lot(!S hain<:r lil i!J •l

c. Mental funct on \laries over the course of the day <q J., someUmes bejer, sometimes worse

4_ ACUTE CHANGE IN MENTAL STATUS FROM PERSON'S USUAL FUNCTIONING-"</ . 1<-'lluu•Y. riiffiml] *to arous. arrerttd errlironmenlaf perception*

0 No   1 YAs.

5. CHANGE IN DECISION-MAKING AS COMPARE'D TO 90 DAYS AGO (OR S NCE LAST ASSESSMENT)

0. Improved   2. Declined
1. No change   U. Uncertain

SECT ON I HEALTH CONDITIONS

1_ SELF-REPORTED HEALTH
Ask: *"In genell, llo 'V 'Nould you rate your health?"*

L Good   S_ Could not 1woui:J not)

0_ E:<cellent   3_ Poor

2_ PROBLEM FREQUENCY
CorJ9 tnr-fN eo nrm lrn :t11)

0_ Jot present
1_ Present but not €Xhibited in lost 3 days.
2. Exhibit-ad on 1 of la&t 3 days
J. Eshlbit9d on L ot la&t J days
4. Exhibit(udailv iu l:):13 d i y:>

BALANCE

a. Diff cutt or unable to move self to standing positon unassiste-d

b. Difficult or unable to turn u lf around and face the oppo::ite direct on vhen standing

c. Dizziness

d. Unsteady gait

PSYCHIATRIC

e. Abnormal thought prc.ces&-e.g., loosen ng ot essocie ions, bocking, filgt of idea>, tangentialify, circumstant al ty

Deltlsions Fixed r;;buUl icf.

Hallucinations— Ftb!:! stl l':iory f-.lr cepiu l 'j

GI STATUS

h. Acid reflux-Regurgitation of acid fwn stomach to tllroat

i. Const pation----No bowel movement in 3 days or difficut pessage of har:l stooll

j. Diarrhea

k. Dry mouth

Hypersal vation or drooling

m. Increase or decrease n normal appetite

n. Vomiting

OTHER

o. Aspirat on

p. Dayt me drowsiness or sedation

q. Headache

r. Peripheral edema

s. Seizures

3_ DYSPNEA (Shortness of breath)

0 1\tr,nnaof :'.ympt(Jm
1_ Absent at rest, but present when performed moderate activities
2. !\bsent at rest, but present when performed normal day-to-day activities
3. rnf:"jf:'r-t :t rt:'>L

FATIGUE

!rJrbiii' iu t.:'(0J1(.1dt:: rrormtJ! dtJify tJdil-ilie: <: J. , ADG, iADL:s

0_ *None*
1. Minimal-Diminished energy but completes nom1al day-hr davadtvlin;
2. Moderate-Due o dirrri lsl rtJ Cle14'i, UtABLE TO riNISI I normal day-to-day activities
3. sv Due to dninished energy, UNAOLr:TO SIIl\k I SOMt- ll!lIIItlIclay lo <ay utMI n; *Unable to commence any normill day-to-day 0ciivities*
— Due oodriinished energy

5. EXTRAPYRAMIDAL SYMPTOMS DURING LAST 3 DAYS

Akathisia Sl h!0Or.n trchng t tr,t(. nn=. r nc:H1tor

0_ No   1_ Yes

mo"ement

b. Dyokine<l &---€.9. • chewing, pueker nQ movements of mouth; abnormol irregular moveman: ;oflips;rocking or writhing of lJunk

c. Tremor— -hvulutl tuyfl rhl il c ııı Vt ltn 'jor lhe frıqer, limbs, head, mouth, tongue

d. Bradykinesia— Decreased in spontaneous movements (e.g., 1n1hn:t:\lholly rnovmtnll, u p! Jmt y ol la1ral • xpns>llm, tJ:ShHt •. spt:l:t h)

e. Rigidity-Resistance to flexton and extension of musck!s (e.g., continuous or cog< heeling ridity)

Dystonia— Mw;.r!;j hypfH1:tll1r.lty {t=0 .mu.lA J<lmnr sll l U)i . pmlrmfiiiUmUD,upw:ml ! CWi lOllUlltJ<:C)(i.l

g. Slow shuffling gait— Reduc ion in speed and tride 1en9th, usually with a decrease in pendulor mm mov&ment

6. FALLS

0. No tall ast 9U days
1. Nu r-ill ir1 30 d 't'-, lJ11fcl 31 00 <:l:iy'_aqu
2. One oll n last 30 davs
3. Two or more falls in last J0 days

7. RECENT FALLS

[Skip if last assassed morn than 30 days ago or rt this is trst asses5ment]

0. Nu
1. Yes
[blank[Not applicabe l first assessment, :>r more han JO days •n0(; kt-t ;;:=n: .mntJ

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PAIN SYMPTOMS

[Note: Always ask the person about pam frequenay, mtcmSJty, and control. UC>s<tve person and ask ot/1ersw/10 are" co11tact wrth the person.]

a. Frequency with v1hich pa-rson complains or shows evidence of pain (including gri macing, teeth clenching, moaning, Vithdrawal when touched, or other non-verbal signs suggesting pain)

0 ND pi-l II
1 Pm ..:ulbull Jlol <:KhitMk din la;l dav;
-• txhrbrted on 1-ot last 3 day;;
'J. Lxhrb<ted dar y rn last J days

O

h Intensity of highest level of pain present

o ND p:-till
1. M11d
2. Moderate
St:V(!ID
4. 1in1es'Nhen pain IS horrible or excruciating

O

(; Consistency of pain

0. No parn
1. Single episode curing last 3 days
:1 In armttent
J. Ccnstan:

D

d. Pain contro — AdO<J<tacy of cun-ent tiJ&rapeuba regrmeo to control pain (from perscn's point of view)

0 No issue of pein
·1. rain intensitv acceptable to person; n0 tre a ment rc;oimn nr chmgo in m!J mr.:n mqiirM
<'. Controlled adequate' by therapeutc reg1men
- Controlled whGn therepeu rc regn11Gn tollowed, but not always followed as orderej
4. Tr-,erapeutic reqimen followed. bit pain control not ul1:qua e
5 ND Ihm<-I KI Ii : 14:[JHH:Il1;(iil!J roll JW<d ror piiil ,p<in uol adequately controlled

D

fl SCHEDULED TOILETING

0 ND

D

0. Conl/nenr – Complete con:rot; DOES NOT USE en-

10. BLADDER CONTINENCE

O

IYf <:11f1<IIH m O1 o u:11ni1H1Y 4:4 1c)<: ionc 1:vi >)
Centro/ 'Vith any c<Jtheter or ostomy ovH 1t;I 9, d:-ty;
2. *Infrequently ;ncontinent-Not* Incontinent over last J days, but does have incontinent episodes
3. *Occasionally* nconrlnenr-Less than daily
4. *Frequently Incontinent–Daily*, but some control present
- *Incontinent— No* control prtsent
- *Did no! occur—No* unne Ctrtput trom blojd6r'" last days

tt. BOWEL CONTINENCE

0. Contiflenr-Compete control; DOES NOT USE any type ct os.tomy dev1cra
1. *Control •vitll ostomy*— Control wIth o;tony devrce ovar last :J davs
2. *Infrequently Inconllnenr-Not* incontnent over lasl3 d;;y;..twl docs H1\'1tu on1n(n Inp! ood!;
:'t *Occasionally incontinent* I<!-; lhm daily
4. *Frequently* incontinent–Uar y but some control present
5. *Incontinnt— No* control present
8. *Did* nor *occur— No* bowel movement n last 3 davs

D

MOST SEVERE PRESSURE ULCER

0. No pressure ulcer
1. A.ny m&of per'3i'Stent skin redness
2. rart al loss of skin evers
3. Doop Gl''''' in 111skin
'1. treaks III skm axpos1I-g muse e or bone
5. Not codeable, e.Q. ,oocrotc eschar pred00Jinant

D

H PRESENCE OF SKIN ULCER OTHER THAN PR ESSURE ULCER 9g. venous ulcar. art9nal ulloer, mixad vanous-artenal ulcer. d1abet1c too: ucer

0. No ·1. Yes

O

'14. MAJOR SKIN PROBLEMS-e.g.. *lesions, ?"'- or :J"-egr;,e bums, heaimg surgicai 'AOlmds*

0. No 1. Yes

D

15 OTHESKIN CONDITIONS OCHANGES IN SKIN CONDITION— e.g. *,brutses,* rasIlf>S *lrGilllJg, motIllllQ, /leipes* zoster *mteJtngo. ecz&ma*

0. No 1. Yes

D

1U. FOOT PRO6LEMS-•>.Q *bumons,11ammettoes. overtappmg toes, structural problems, mtecttons, u!cers*

0. No foot problems
1. Foot problems, no limitation in wolkinQ
2. Foot problems li'll t wellm!J
:\ FooI pwhlt:r1l!. r)fm Lii lwalkifi4J
4 Foo I p10hl)rl .dous 1111 walk fm uiiID wa iOII>

D

SECTION J. FUNCTIONAL STATUS

1. IADL SELF-PERFORMANCE AND CAPACITY

()ode lor 1-'ti-<1-UI-iMANC/:::m rouhoe ecv1Pes eroaod tile home *grin the comnwnitv dminq the LAST 3 DA'{S*

1-'cxi'e lor <:AI-'AC/1Y based 01l presumed ab!Ity tocarw out actJvJty as mdependantl;' as posstble. Ih:s Will r9qwre "specc.JJstion" by theassessor.

0. *Independenr—No* help, set-up. or supeovi$ion
1 *Set-up help only*
2. Supe1vision— Ovarsighcueing
3. *L;m;ted assistancua*p on some occasions
4. *£xrensivu sisrance-Ilelp* throughout task, but pertorms 50% or more o f ask *on* O'A'n
fi *M:JXimal asstance* HDio IIu:Juulurnllask. b11l (Hrror111. lc!.sI hm!iOQh of 1:4k m1nw11
li. *Total* depenclenc&-rul pertormenca by others ·junng tntrre penod
8. *AcIlvlty did nor* occur— Drr n entire period *(DO* NOT USE THIS CODE IN SCORING CArACTY)

P Pndormm:1:(; C.apac:i p r.

y a. Meal preparat on— How meals are prGparoo (e.g., piann ng meas, assembling rngredrent>, oook ing, setting Olfood and utensils)

rn

hru;ri;pDt foll I(I(d U,c!dilJ dishD. du;lnu, making

rn

b. Ordinary housewortc— Ilow ordinary W<lrk around the hn:, lidyiuu up, I;1uml1y)

rn

c. Managing finances-How bill are pard, chequebook1s ba anc&d, h.usGhofd expense are budgeted, credrt card accountis monitored

d. Manag ng medcatlon9— Haw medicat ons me mana9ed (< U, u:ul(fIlh! riuJIolako rTlGll iifrw;s, op nil!J boiiiD, L•k11g cul IicIUkuy Ua>;cty.,;, yiviny injdium; ly1ly dintments)

rn

e. Phone use- loVJ teleph:>re calls are made or received (with assistive de• ices stlch (IS lar9e numbers on ld<ldK:r(l ,amtl liic ;-I clllas •<:c:th:d)

rn

I. Stairs— How managas ui Hrgtl ct starrs (1:!-H starr;

g. Sl O.lping— How >hopprng rs pertormed tor tood and household items (e !J., select n! items, pavinq money) – EXCLUDE TRII.NSPOIHATION

EB

h. Transportat on— How traves ty public transportation (ml\'i[JHiill!_l ;y. W. f,yinu(; :}01 lhj:iiLJ;clr (U1cud

rn

2. iIJ

y<l liny uut ufl ruu><J, n w1d uuluf v<Jhid>)

WORK

Ih;;uu llrr1;;mit! cudiny m;iu.If, cmk! pmfcHtrr.Jm:rami c:Jf1'rr.lly mgmtiiug jniJ mfafvvl :w:/liiiirm, im;lwiu:u IJofIl conitfve (e.g. pIannmg_ sequencing of iasks, adherence to scllI'dlIi?s} and pf/YSical aspecrs (e. g., strength. rxoraimaiJOJJ, siEiminll) – EXCLUDE Tr<ANSf'ORTATION

rn

interRAI Consulting Group

interRAI Intellectual Disability (ID)©

AD SELF-PERFORMANCE

(;cm;irhr 011! npi<ocim; ONN :1 11ny pmiod

Jf aiJ I!pi tuk m mn1u:dmmwl at lhn ::mitlvd, Hitxun Ani nl JII-II lrwd

II any eprsodes at /ele/ ;; aod otlle•s less d&p&fldMI, score AL!/ jJ1 .., :i

()Jhr:n-ioc, to1:un em Jim Jilmn munl fk:f'r:mJml(Cf'i .tu.k:; [01 aJI epls:x:ses d pe11ormed fewer tlwn 3 tJmesj.

It n10st dependent flmsode rs 1, scoro AULas 1. It not, score AUL as least dependent ot mose ep1sodes In rang2–0.

U. Ind8p8ndent—No phySical m;;,,;,tance, set-up,or supe!Yision in any episoce

1. Indpnd nt. sr-up hlp only— Artide or de'Jce prov ded or placed within reach, no physiCa assistanc-a or supervision in any episOCe

2. Suprvi.sion— Oversight/c ueing physical giidance 'Aiihout taking v1eight

3. UmJted t.sslstsnce-Guided manoeuvrng of limbs,

4. Exrenlve a slstsnce-Weight-beari support (ncludinQ liftinq limbs) by I helper where person s il pDi DIFIi f0% O IUID(nf ;ubl;; J;

5. Ma)(;mal assistance V\uiqIII iJ '=lrir!-j -.;u.purt (i11duLitl'J lif il ltJ lind! lby ?+ llo p(;J i OR V'tDigh l htuii!J !Bppw I (H Jfl(:rn lhau 0%nf sublak!

U. rota/ depenaem;....-1-ull pertormance by o hers dunng all episoce

Adivity did not occur during entire ptiod

a. 6athing— Hovtakes a tull-dy ba h stiOwar. ncludes hov1 tr-nsttr> mand ou ot tubor 5h01"" .ANUhov1eachpart oi bo<f)• is bathec: arms. upper andlo'A' legs.chesl abdomen,perinea area-CXCLUDC WASHING or DACK AND [.<IJR

b. Prsonal hygi n— I!:>w manages personal hygiene, inc udin9 combing hair. brushin tee h, shang, ap;>lying make-up, wmhing and dry ng face anc hands-EXCLUDE D.A.T IS AND SHOWCRS

c. Dressing upper l>ody— How dresses oM undresses(street clothes,underwear) 9bo'.e llle waist, indudinprosthses, nrllmiK:;, pullo\'i: t. de

d. Dressing lower body How [illegible] root [illegible]

e. Wolking—1 ow waWs betv een loca ioos on same ftoor indoors

f. Locomotion— ow moves between ocations on same floor (wa kinQ or wheeing). If in wheelchair,seK-sutficiency once in choir

g. Transfer Tcilet How [illegible] and urileiid [illegible]

h. Toilet Us&-How uses the toilet room commocte, bedpan, unnal), cltanses. 5elt at:ar toilet usa or 1noontmant episode(s),chanes be-j pad, manages ostomy or catheter, acjusts clothes-CXCLUDC TRANSFER ON AND orr TOI CT

i. lled mobility— I ovn:wes " and from lying p:.sitin. t rns fromside to sde, and positions body while in bed

Eat ng— How eats and drinks (reqmdless of skill). Incude-; intake of nonrishment bv other mens (e.q., tube eeding, total parentemlnmmion)

PRIMARY MOOE OF LOCOMOTION

0. \N1lkinlu, no i-t s ;livc:dcvir:t!

1. Nolking, uses assistive devce-e_q_, cane,wa ker, crutch, pushinQ wheelchair

2. \t,JM!c lr;hair, [illegible]

3. Rndbound

D STANCE WHEELEO SELF

Farihesi distance wheeled seif at one rime in lhe LAST J DAYS (includes indep:mden(use of motodzed whee.Jchair)

0. Wheeled by others

1. Usee motorized wheelchair / scooter

2. \Vheelec self ess than 5 meues (uncer 15 feet)

3. Wheeled self 5–49 meues ("15–149 feeO

4. 'N|r<!r:1>l self so nn'"''''''';(1fi0 ?!!0 fed)

5. Wheeled seU 100+ m e rt!'j (300+ ret)

f; Oi1luolu;r:whee dd l; ir

n. TOTAL HOURS OF EXERCISE OR PHYSICAL ACTIVITY IN LAST 3 OAYSo--e. g., wal/ung

0. None
1. ess than 1 hour
2. 1–2 hours
3. 3–4 hours
4. More than 4 hours

/. PHYSICAL FUNCTION IMPROVEMENT POTENTIAL

U. No 1. Yes

a. Person b lievu h e s his eapabof improv d performance In physi Ml function

b. Care professional believes person is capable of Improved performance in physical function

0. CHANGE IN AOL STATUS AS COMPARED TO 90 OAYS AGO, OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO

0. Improved 2. Declinec
1. No change 0. Uncertain

SECTION K. ORAL AND NUTRITIONAL STATUS

1. HE GHT AND WEIGHT [EXAMPLE – CANADA]

Recoro (a.) Jeght m cent1:1>.:tres ami (b.) w;;lgl!t m1<1/ograms. Dase WBight on most recent measure in LAST JO DAYS.

a. HT (cm) b WT (kg)

NUTRITIONAL ISSUES

U. No 1. Yes

a. Weight oss of 5% or more In LAST 30 DAYS, or 10% or more In LAST 180 DAYS

b. Weight gain of 6% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS

c. Fluid intake less than 1,000 cc per day (less than foll r e-oz cups/day)

3 CHEWING PROBLEM

U. No 1. Yes

MODE OF NUTRITIONAL INTAKE

0. Normal-Swallows all types of foods

1. Modified independent—e.g., liquid is s pped, takes limitec soM foo.:l, need for modification ma'i be unknown

2. Requires dler mod/fleet/on to s.vel/ow solid lood-- e.g., mechanical diet (e.q, purl!€, minced) or only abe to ingest specific foods

Requires modification to swallow liquids — thickened liquids

4 Can s'vallow only pureed solids AND thickened liquids

5. Combined oral and parenteral or tube feeding

U. Nasogastric tube feeding only

7. Abdominal tube feeding—e.g., PEG tube

8. Parenteral feeding only-Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)

9. Activity did not occur— During entire period

5. DENTAL OR ORAL

0. No 1. Yes

a. Wears a denture (removable prosthesis)

b. Has broken, fragmented, loose, or otherwise non-intact natural teeth

c. Presents with gum (soft tissue) inflammation or bleeding adjacent to natural teeth or tooth fragments

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SECTION L **MOOD AND BEHAVIOUR**

1. INDICATORS OF POSSIBLE DEPRESSED, ANXIOUS, OR SAD MOOD

c;mk: IWIIH/IC:ollom otmmvr:d m f;ml 3 c#ty;, IfHNi/If.'f:!rv(• rJII/m assumed Cltuse (fJme: V1111enever possible, (Isk person1

(Not prAftifl

1. resent but not exhibited in last 3 days

/ h :hrhlh c1on 1–')of <1sf: Irlr1y

3. Exhibited ddh last 3 days

MODO

a. Cheerful, happy facial expressions—e.g., smiles or laughs, appears relaxed

b. Sad, pai11N, or worried facial expressions--e.g., r IIII'Md blOW, (:!Jil ;);H I hovm I !!

c. Crying, tearfulneu

d. Made positive statements-e.g., "I have a lot to look tonwm1 tty Inm hpry; IAIIICf)'wh IIIIm nang•

q Made negative statemetlt&–A g , Nothlll[I In;:ltRCS.; \Nnuol wlhr IIt:! dt.U, \Nhul'◇ lh!:! u:;;e, 11:rel ll ;vimJ li0i:ld '9.1 lonl-J, Let me de"

f. Hyper-arousal — Mo or e'citation; unusually hh activity; rnr:n;.;;)S.At1 r r.1nnty

g Irritab ty Mmkcr! Ina.n 111 hc;ln!J .hort t0.1npc:rc;I1 or easy upset

h. Pressured speech or Racing tl1oughts— napid speech. rapid transition from opc to topic

i. Labile affect— Affec: fuctuates frequen ly 1\ith or without an nx-f:m "!I t xpli:!nflhnn

Flat or blunted affect Im11Imm:..11111 Hx:n 'JWi; hard to get to smile, etc.

ANXIETY

k. Repetitive anxious complaints/concerns (non-hMith r lated)—e.g., persistently seeks attention/reassurance regarding schedules, meals, laundr; clothing, relationships Express ons. including non-ver00 , of wlIOlt appear to be

unrealistic fears n U, mil oltlc I !J allHmkuK! , tx 11g111 olone, b.enq with others; ntense fefIr of specific obiect'S or situntions.

m. Obsessive thoughts— Unwanted ideas or thoughts that cannot be eliminated

u Compulsive l>ehaviour I) u . lm11tlN;-t;IIIIILI, WImII lvn chn1:ki11q n(ODIU, C(Nffl inq

0. Epl oodE>0 oparic-Cascade olsymptoms of fear, nxiety, loss of control

NEGATISYMPTOMS

p. Expr&&sion&, including non-verb4\ , of alack of pleasurt in life (anhedon a......, g., "I don't enjoy anything an)more"

q Withdraw3l from activit es of nterest o U, lml!J .1;m<llll!J ii(:ivii1 s ,hc!ii iO vilhEmlilv.'r1mld!i

r. Lack ofmotivation--A.bsence of s:x>nteneous gooi<Jirected ocivity

s. Reduced sociRl Inferactl<>ns

OTHER JHOICATORS

Repetitive health complaints-e.g., persistently seeks medical attention, incessant concern with body functions

11 Recurrent statements that something terrible is about to happen c!J, mltc w·tm or he 1.ahmJt torf1le, he vc; n heart ottock

v. Persistent anger with self or others---e.g., easi y onooyed, anger at care received

w. Unu&\lalor abnonnal physical movements— Unusual lat <tli:XJH:SSIOIinr rmtr(!tl >Ill;, p :tiil'l 111001 h! : HVlCl Jl or bod\' posturin(.]. eq. stereot\•pie-s. W8"Y0J' flexibilit.r

x. Hygiene-Unusually poor hygiene. unkempt, di>hevelled

y. Difficulty falling asleep or staying asleep; waking uptoo early; rKt essnKs; non-restful sleep

z. Too much sleep (lXJ:esoNl : arnoun o ; (:()p111:-ti iiJim iDH! ; Wih JU! {I;lOIIIIi"ll fIIIIInlll!I

2. SELF-REPORTED MOOD

0. Not in la>t 3 days

1 Nnl 11lil ;{ Ifay!;, lJHI olh)I IIOOI i 111 Wty lo 1 or la,; da s

3. Daily in the last 3 dG\'S

8. Could not (would not) respond

Asl<: ''In the lesi J deys, how ofren heve you felL ''

a. Little Interest or pleasure In things you normally enjoy?

b. Anxious, re-stle-ss, or une-asy?

c. Sad, depressed, or hopeless?

3. ADJUSTED EASILY TO CHANGES N ROUTINES IN LAST 50 OAYS

0. No 1. y.,.

4. BEHAVIOURAL SYMPTOMS

Ctl(ff01 irx.Jt..:tIIUJ:> tJbsr / /, iHs.rJtH..'lilie. of IiiB&Jwne<lt":J:JUd

0. h t present

1. Present but no'e ' bited in last J days

I-xhlhltn1on f 'Jot I1-1.t { f'l<-:tf•

I-xh1htndf1ally 1n li. :, t:{ fk!y.

Wandering–11.t1VAd with nor Mon l ptnpoq . AAming y oblivious lu ueetl•01 '].tJ n;

b. Verbal abuse-e.g., others were threatened, screamed at, cursed at

1: Physic3l 3buse <U ,11hn1iw;mtul, ; fi(J-m,, ! itH lt: hcJ, ;m:!l: ill-; J HI j(X i

d. Socially inappropriate or disruptive behaviour— eg., maj e disruptiv9 sourKls or noises., s.cr&amed ou: smeared or thffiVl food or feces. hoarded. rummaged f hl tII! h d 01"; tH)UII JIlq;

e. Inappropriate public sexual behaviour or public disrobing

Resists car&-4=1g , t:tkng rnAl1c-:;.tlonlnJ L.tlnn. AIII il..J .tR ncx:;, eating

· Self in]ur1ous behaviour—6.q. ,b nqinq heed on wsll; pinching, biting, scratching, hitting, or punching self; pulling ovn hair

Destructive behaviour r: g Ihi OWlIIJOhJr(I; , hi11IiiU over beds or table'S. vendtlI31I

1. Outburst of anger—I ntense nare-up of anger in reactio11(O a spacific action or &ven: la.g., upset wi1h deCISIOns olothers)

j. Echolalia--Rar>sats tha worn spoken by others

k. Seft-1alk— Talks to se f

Fica Ing0:.lon ot non tonrJ n :rn . (g . .oap dirt, tecn.r)

m Rumination Ih"JilrJifrttlnn fln-1 c:h('.YJin!) nt prl:'Jinu, y SWiiiOV'/CI li X III

n Polydips a h1iflpmm.-tc; 1r:)(fr:!":;ve thirl c:r,t=.umpflon (t!.!..J-, th rlks rlu b IIItilly times dUiiII-1 tile Uuy, dr ub huge amOlint at a time, refuses to stop drinking, drinks "Secret v from unusual sources)

5. VIOLENCE

(.'x/rormo.1-.t nf tn rlnr:

() NDvt:r :1 H :1q ti-J f0 auo

1. More than 1 veer 0<IO 4. 4 –7 days aqo

2. 31 ooys — 1 year 0(10 5. In la t3 ooys

a. Intimidation of others or threatened violence-e.• :hreatening gestures or stance vith no physical contact, shouting angrily, throwing furnure, exploit threats of

h Violence to others Act. w1th pnrpo.1tu , m>'llr;0JJ.nr vicious intent, reSllti in physical hmm to another--6.• stabbing, chokin. beating

11lAii-<A IID p

interRAI

interRAI Intellectual Disability (ID)

u EXTREME BEHAVIOUR DISTURBANCE
Hfsiory oi extreme belmwour(s) that suggests srmoi.ls nsk of llmm Jo u: fl (ny , :u,vmc:m lf rwJIII;J!Km) or olm.w (v y . iac: tfmg. hanur.,:JA)
0 Na
1 YD;, H I11D1I I)XIilil<!4 I 11 la;I 7 ty;
2. Yes, exhinited in last 7 doys

O

SECTION M. MEDICATIONS

1. LIST OF ALL MEDICATIONS
()m:JJJUW if IIUXfil:<JfWt.'l oii /;u;f tJ<lrJC.' in !jflJ/.r;,J1ff1VicfncJ

:! ALLERGY TO ANY DRUG
0 ND known druui-tlmuics 1 Yt!;

. PHYSICIAN REVIEWED PERSON'S MEDICATIONS AS A WHOLE IN LAST 1M DAYS OR SINCE LAST ASSESSMENT

0 bIS(d!:;i(!!IYJIlil I1(!!4IlUllnpi ICIHil{(Il 11 I IIO(IC:il:IJI ikl>Il)
Nb sin!J<pi Jy;ie onI1(:\it'!Md all i HxI itl<nJ-;

1. ADHERENT WITH MEDICATIONS PRESCRIBED BY PHYSICIAN
0 Alwa'r..iidhclcrtl
1. Adherent 80% of time or more
2. /'l.diUICIII t:;<; Uit-lll SG% or lime, iw...luding fd luw to ptlrchase prescr bed medications
8. No medications prescribed

SECTION N. SERVICE UTILIZATION AND INTERVENTIONS

1. PREVENTION
0 ND Yt.
a. Complete physl""lexamIn>tlon In LAST YEAR
b. Dentalexam In LAST YEAR
c. Eye exam in LAST YEAR
d. Huringe anin LAST TWO YEARS
e. Influenza vaccine in LAST YEAR

FORMAL SERVICE PROVIDERS
(;iiulm:f vJIf;n {mma! f:4JHpuwidm iH lm;(30 dny:;(w ;;r; ICf w.lmj$sitllr if LESS THAN j0 DAVE.)
0. Nu con<etin :-:e130Lklrs
1. No C) ntoc: in ast 7 days, but contact 8–30 days Elf.lO
2. Contact in last 7 davs but not deil ii
J. Daily contacin ast 7 days
a. Devellopmental Serv ces Worker or direct care staff
b Oc[:upaticnal Therapist, Phsical Therapist, or Speech Thel'apist
r.;. Recrem:ion Therapist
d. Nurse

FOCUS OF SUPPORTS
Cede for tpes of issoes t!ltli were a major focus of formAl 1\IK.: !.,l.;l;J<i (ruirJifiJ.I prowwus in LAST 30 DAYS()(l:i:lJt.t1. Admission if les rl1n 30days ago
0. No service or proqmm of this type
1. Offered. b<Jt refused
2. Not received, bu: schedule1to s:an.,1hin next 30 days
J. Received C – JO da]S ego
'1. Kecauvec1 1n la5t / jays
a. Self-care skills–e.g., dressing, eaing, hYl)iene
b Community skills oU, vncalicmal cil hil lal oll, transportat on, shoppriq
c. Social skills–e.g., interpersona sils. etiqueHe
d. Cognltlve skills--e.g., readin, leHers. cdlour recognuon
l:!. Educati on on spec tltopic.s-t::.!-J ,'.it.lfLittl v, unt!:l-t
Behaviour management c9 r.mgmm to rr:f1l1c:t: lHJwo rlh d ur inap!HOpJ;1h:h0havMnn
!J Sensory stimulation 4:l! .<(i llal tl apy , lKIt /nktl room, music tho9rap/

D

§

1. PHYSICALLY RESTRAINED—Jmbs *reslfamed, used bed rar/s, restromed to chmr w/J9n Slltmg*
0 Nh 1 y.,,;

D

HOSPITAL USE, EMERGENCY ROOM USE, PHYSICIAN VISIT
Code for number of Umes during rhe LAST 90 DAYS (or since la.t:.fA$>i9.'=':mt:mt tt/1.SS IHAN JHIMYSA(())
a. Inpatient acute hospital Yith overnight stay
b. Emergency room vi•H (not counting overnigh: stay)
c. Visit with physician {or authorized assistant or practi:ionsr}
tJ Visit wi h licensed mental heal th professional ({U, t.J'.;'cIli:lJi-.l, IJ";\'cl\J)[cl!-j-.l, <;0<;itd YJIIkCI I

6. TIME SINCE LAST HOSPITAL STAY
Gode tor most recant mslane>ii m LA:il !!UVA y:;;
fJ Nn hti;; Hiillintlior1 wi liin !fl day.; :i R ID 14 4ti-lf-HtJ>
I :I IIHI!days:i1)(1 4 IIlliil:)lel I / d;;ys
2. 15lu 30 U/ tIJ!-l(J 5. NrYA'illliu..il:; :-

D

SECTION O. DIAGNOSTIC INFORMATION

1. MEDICAL DIAGNOSES
0 Nul pH iWJI
1. Piri<:uvrJitl!.)Jl0<.;i-;/di<i)llO J>;; rol cuIIUII•.;l.a
? Oin!JIU!s ;pu:;nul, H!(:4 i\•1JO active luallii()JJI
3. Oi9nosis pre$erlt, monitored but no actr e treatment
H Asthma
h C&nilbralpalsy
•: Di(Jbetes melus
d. Epilepsy or Seizure disorder
() Hypothyroidism
f. Traumatic brAi nInjury

D

otl1er med:caJ diagnoses	Disease Code	IGU-1UGode [l::xamp!.rU9nada]
g		
h.		

(Add lines as necessary for other disease diagnoses)

interRA/ ID (Intellectual Disability)°

[COIlE FOR LIST 1 DYS UtiLESS OTHERWISE SPECIFIED]

SECTION M.MEDICATIONS (continued from page 7)

1. LIST OF ALL MEDICATIONS

J i:;/ all m:f1wprdfpfimm. and :my mm pHmf.tiMHI (ovm111! r;wmlw) mru!ir.'iiiml:>lalwn in ffm f /1ST 3 Dt, Y.S
[NO Ir - U>t-; r;ompnf,-;n7t;rI mt":.CJ«Ir:1/ JlO"tUhfr;, fL-11fl c:.nfr:r cmly wlwn,-,br.!11ufc;1;!Jl";('C::>1ryj

For each drug, record:

a. Name

b. Dose-A *number such as 0.5, 5, 150. 300. [Note: Nerer wrlre a zero by ifsef <Jl'ter a decimal point (X mg) All1!D}'S use a zero before a decimal point ro.x mg)j*

c. Unii— Code *u.sing the following list:*

gtto	(Drops)	meg	(Microgram)	ml	(Millilitre)	%	(Percent)
gm	(Cram)	mEq	(Milli-equivalen)	oz	(Ounce)	Units	
L	(Litres)	mg	(Milligram)	Putf9		OTH	

d. Route of administration *Lod1: u;iuu lf m fo!fuwing Ji:;*

PO	(By mouth oral)	Sub-Q	(Subcutaneous)	NAS	(Nosal)	EYE	(Eye)
SL	(Subl rqutd)	REC	(Redt l)	ET	(Enterul lui.N!.,	OTH	
IM	(Intramuscllar)	TOP	(Topical)	TO	(Tronsdermwl)		
IV	(Intravens)	IH	(Inhalation)				

e. Frequency *(';:Hin l:Ju: murrlH:r of limen pvr dJY, '''cdc, w mouJ!r Jiw rrnHfi:;-, fiwr i:::uJmini;lmmJ u::inu Jim fnlfrJltimJ li;:l*

Q1H	(Every huur)	Dfliily		SD	(Sii11e;;. daly)	4W	(4 Limes wet!kl'/)
Q2H	(Fvtrv 2 rows)	BED	(1\1 tmdlirru:)	020	(Fvc:ry olhcr, I I<iy)	6W	U, I mn;wcHIkl-()
Q3H	(Every 3 hours)	BID	(2 times dDily)	030	(E erv 3 days)	6W	(6 times weekl'/1
Q4H	(Every 4 hours)		(ncludes everl• -12 hrs)	Weekly		1M	(Monthly)
Q6H	(Every 6 hours)	TID	(3 times dai y)	2W	(2 t mes weekly)	2M	(Twice every month)
QSH	([very 6 hours)			QID	(4 times daily)	3W	(3 t mes weekly) OTH
PRN	0 Ntr						

g. Computer-onteriKl drug code [Example canada – DIN]

a. NAme	b. Dose	c. Unit	d. Route	e. Freq.	f. PRN	g. Computer-entered dru code
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10						
11.						
12.						

{Nore. Add ac!drliO.>81fl.>es as nece9>!lfV. ror other drucj teken/
{Abbreviafi()()S are Count'J Specific for Unit. Roufe, Frequency]

SECnON P ASSESSMENT INFORMATION

SIGNATURE OF PERSON COORDINATING/COMPLETING THE ASSESSMENT

1. Signature (sign on above line)
2. Date assessment signed "" complete |2|0|__1-ITJ-ITJ

Year Month Day

Appendix 8: Definitions of Disability in Canada, W. Australia and New Zealand

Canadian jurisdictions[77]	Western Australia	New Zealand
Participation and Activity Limitation Survey (PALS) Questions include: 1. Do you have any difficulty hearing, seeing, communicating, walking, climbing stairs, bending, learning or doing any similar activities? 2. Does a physical condition or mental condition or health problem reduce the amount or the kind of activity you can do a) at home? b) at work or at school? c) in other activities, for example, transportation or leisure? Followed by PALS filter questions used to identify all 10 major disability categories; that is, hearing, seeing, communication, mobility, agility, pain, learning, memory, developmental and emotional disabilities.	Survey of Disability, Ageing and Carers Disability is defined as any limitation, restriction or impairment which restricts everyday activities and has lasted or is likely to last for at least six months. To identify whether a person has a particular type of limitation or restriction, the SDAC collects information on need for assistance, difficulty experienced, or use of aids or equipment to perform selected tasks. Types of limitations include: Core activity limitations: • Communication • Mobility • Self-care Schooling or employment: • Schooling • Employment Other: • Health care • Reading or writing • Transport • Household chores • Property Maintenance • Meal preparation • Cognition or emotion	Disability Survey Disability is defined as any self-perceived limitation in activity resulting from a long-term condition or health problem; lasting longer or expected to last longer than six months or more and not completely eliminated by an assistive device. Participants in the survey are initially selected using information from the Census of Population and Dwellings, which contained two short questions designed to identify whether people thought they had a disability. 1. Does a health problem, or a condition you have (lasting six months or more) cause you difficulty with, or stop you doing: • everyday activities that people your age can usually do • communicating, mixing with others or socialising • any other activity that people your age can usually do • no difficulty with any of these. 2. Do you have any disability or handicap that is long-term (lasting six months or more)? Disability was further determined by responses to a series of questions that assessed difficulties performing certain day-to-day activities.

[77] MacKenzie, Andrew, Hurst, Matt and Crompton, Susan. *Defining disability in the Participation and Activity Limitation Survey*, Statistics Canada, Living with disability series