

Integrated Adult Services Pilot Project Research Summary¹

Prepared by St.Amant Research Centre²

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1. SARC Research Summary Report, Part 1

Part 1 of this report summarizes the work done and findings shared by St. Amant Research Centre in response to direct requests from the Integrated Adult Services (IAS) Steering Committee over the period of 2023 through early 2025. This three-page executive summary relates to five topics and is followed by a series of appendices that correspond to the topics listed.

- 1) The IAS research team conducted a literature search examining intake methods for adult integrated care (Appendix 1.1A). This work identified a key review by the National Institute for Health and Care Excellence (NICE), titled *Adults with complex needs: social work interventions including assessment, care management, and support* (NICE, 2022).**

The NICE review sought to address two primary research questions: first, what is the effectiveness of social work approaches to assessing and reviewing complex care and support needs; and second, based on the views and experiences of all stakeholders, what aspects of social work assessment and review processes work well and what could be improved. Six studies were included in the review (Abendstern et al., 2013, 2014; Bolger, 2014; Darling & Derry, 2012; Symonds et al., 2018; Yeung et al., 2016). The key findings emphasized the importance of conducting individualized and tailored needs assessments and clearly communicating the purpose and process of assessment in advance. It was also recommended that information related to the assessment be provided in accessible, person-centred formats and that individuals be given sufficient time to prepare for and review relevant documentation. Furthermore, assessors were encouraged to employ flexible, clear, and plain-language approaches throughout the assessment process and to support the option of self-assessment where appropriate, with adequate guidance and information provided. Collectively, these findings underscored the need for assessment procedures that are collaborative, transparent, and responsive to individual preferences and circumstances.

- 2) The research direction then shifted to examining models of Self-Directed Care (SDC) across Canada (Appendix 1.1B). Findings from Kelly et al. (2020) were reviewed to understand how SDC programs are managed and implemented nationally.**

Across 20 SDC programs in Canada, program management structures varied, with care being directed by the user, family members or informal supports, legal representatives, or Microboards (groups of family and friends who assist an individual in designing personalized supports). Only four programs explicitly

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permitted funding to be used for equipment purchases. Eight programs operated under an Individualized Funding model, which provides flexibility for expenditures related to personal care, social participation, and individualized supports.

In Manitoba, In the Company of Friends represents an individualized funding option administered by Living in Friendship Everyday and funded by the Department of Family Services. Eligibility requires participants to be over 18 and supported by a Microboard. In 2018, the average funding amount was approximately \$9,300 per month, which could be allocated toward support worker wages, training, and equipment costs.

3) The steering committee then requested additional information in the form of a jurisdictional scan about how access to equipment is managed across the country.

Saskatchewan: Equipment access is primarily through the Saskatchewan Aids to Independent Living (SAIL) program, which provides no-cost equipment loans such as wheelchairs and hospital beds. Equipment is typically available within two weeks to three months following a requisition by an occupational or physiotherapist. Maintenance and repairs are included, and equipment may be kept as long as needed. Direct funding cannot be applied to equipment purchases. See Appendix 1.1C.

Alberta: The Alberta Aids to Daily Living (AADL) program provides partial funding for approved equipment. Clients contribute 25% of costs (up to \$500 annually), though exemptions exist for low-income individuals. Equipment is supplied through approved vendors and includes mobility aids and other assistive devices. The Residential Access Modification Program (RAMP) provides additional support for home modifications, offering up to \$7,500 per year or \$15,000 over ten years. Following administrative changes in 2022, AADL wait times were significantly reduced. See Appendix 1.1D

4) Next, the committee requested information about eligibility requirements for other provinces. This is in the context of Manitoba's Community Living disABILITY Services (CLdS) eligibility requirements, whose current reliance on IQ-based criteria may exclude some individuals with significant functional impairments (Appendix 1.1E).

A jurisdictional scan revealed that many provinces have similar practices to Manitoba, however two varied significantly. British Columbia provides supports for individuals with FASD or ASD who do not meet traditional IQ criteria. Nova Scotia offers services to individuals diagnosed with intellectual disability before age 18, or

those who have a long-term mental illness, physical disability, or acquired brain injury.

5) Finally, the committee requested information about accessible housing. Specifically, the Chalet Point Interim Report identified a need for cost-benefit and outcome analyses for improvements to community-based housing. The IAS research team conducted a literature search examining housing and health outcomes for persons with disabilities. This work identified a key systematic review by Sally Lindsay and colleagues at Bloorview Research Institute, titled, Accessible independent housing for people with disabilities: A scoping review of promising practices, policies and interventions (Appendix 1.1F).

The Lindsay (2024) scoping review included 60 studies from 18 different countries over 20 years. The key findings emphasized the importance of breaking down barriers to obtaining accessible housing, helpful policies to ensure buildings are accessible, as well as programs that support home modifications. The authors identified several benefits of accessible housing including: increased independence, improved safety, improved quality of life, better physical and mental health, and more opportunities to participate in community activities.

Appendix 1.1A: Integrated Health Review

- 1) We began our search by working with a research librarian to create a search strategy.
 - We landed on a search strategy yielding 436 results from PubMed.
 - Key search terms included adult, integrated care, community care, social care, and intake.
 - Upon reviewing titles and abstracts, the majority of these articles were inappropriate (focus was too medical for many of these articles)

- 2) We stumbled upon a review by the National Institute for Health Care and Excellence (NICE) titled Adults with complex needs: social work interventions including assessment, care management and support.
<https://www.nice.org.uk/guidance/ng216/documents/evidence-review>
 - The primary goal of this paper was to answer the questions: What is the effectiveness of social work approaches to assessing and reviewing complex care and support needs? And
 - Based on the views and experiences of everyone involved, what works well and what could be improved about social work assessment and review of complex care and support needs?
 - Six relevant studies were identified and used in this review paper (Abendstern et al., 2013, 2014; Bolger, 2014; Darling & Derry, 2012; Symonds et al., 2018; Yeung et al., 2016)

The general findings of the NICE paper were (pages 18-22):

- “Importance of taking a tailored, individualized approach to a needs assessment”
- “Recommendation to ensure that the process and purpose of an assessment are communicated [to the client] beforehand” and “any information regarding the assessment process should be provided to a person in an accessible format and in line with their needs and preferences to ensure it is person centred”
- “People should be given enough time to prepare and review documents [prior to the assessment meeting]”
- “Flexible approach [should be] taken during the assessment as well as explaining concepts using simple, clear language”
- The processes of scheduling the appointment and deciding who will accompany the individual should be as person centered as possible
- Self-assessment may not be appropriate for all people and may not address all needs, however those who prefer this option should be supported to do so and given appropriate information.

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Appendix 1.B: Self Directed Care Review

After meeting with the IAS Steering Committee this February (2024), some more information from the articles we shared was requested. As a reminder, the articles we shared were reviews of self-directed care (SDC) in Canada. SDC is a term used for when caregivers or individuals are given funds or budgeted hours and able to organize their own home services based on their unique needs.

Questions for further clarification were as follows:

1) In SDC, who is able to manage care?

Across Canada, SDC programs can be managed by one or more of three entities: the user, family members/informal supports, or legal representatives/other third parties.

- In 4/20 SDC programs in Canada, the user, family members, or another legal representative can manage care
- In 5/20 SDC programs in Canada only the user or family members can manage care
- In 4/20 SDC programs in Canada only the user or a legal representative can manage care (not family members)
- In 1/20 SDC programs in Canada only the family or a legal representative can manage care (not the individual)
- In 3/20 SDC programs in Canada only a legal representative can manage care
- In 2/20 programs, only the individual can manage care
- In 1/20 programs a Microboard manages care. A Microboard is a group of family and friends joining with a person with a disability to help design individualized and customized supports.

In some of these programs (8/20) funds can be used to hire family members to provide services to the individual, in other programs (12/20) you cannot.

2) Can money be used on equipment?

This varies by the program. Only 4/20 programs specified that money could be used for equipment.

3) 8 Programs used an Individualized Funding Model. Can you tell us more about that?

Individualized funding programs are broader in scope than home care or respite. Funds can be used for social participation (like a gym membership or bus pass) as well as personalized care. All provinces except for Quebec and Nova Scotia have Individualized Funding Programs.

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In Manitoba, we have In the Company of Friends as an individualized funding option. This program is funded through the Department of Family Services and administered through a non-profit organization, Living in Friendship Everyday.

To be eligible for this program, the individual must be over 18 and have a Microboard to help support them. In 2018, the average individual got \$9,300 per month that could be spent on wages for support workers, training staff, and equipment costs.

This information comes from Kelly et al. (2020). Questions 1 and 2 are summarized in the table below:

Table 2: Summative Overview of DF Care Programs in Canada

Jurisdiction	Program Name	Type			Background & Eligibility					Who Can Manage Care				
		Respite	Individualized Funding	Home Care	Inception (Including Pilot Pgms)	Clients	Approximate % of Home Care Users	Age Eligibility	Means-Tested Eligibility	Average Monthly Funding	User	Family, Informal Support	Legal Representative, Other 3rd Party	Hire Agency Workers?
AB	Family Managed Services (PDD)	●	●	●	2005	4,500	–	18+	–	●	●	●	Yes	No
AB	Self-Managed Care	●	●	●	1991	1,700	1.4%	None	\$3,277	●	●	●	Yes	No*
BC	Choices for Supports in Independent Living	●	●	●	1994	956	2.3%	19+	\$7,360	●	●	●	No	No
BC	Individualized Funding, Community Living BC	●	●	●	2005	4,068	–	19+	\$2,800	●	●	●	Yes	No*
CA	Veterans Independence Program	●	●	●	1981	90,854	–	None	\$3,855	●	●	●	Yes	No*
MB	In the Company of Friends	●	●	●	1993	66	–	18+	\$9,300	●	●	●	No	Yes*
MB	Self and Family Managed Care Program	●	●	●	1991	980	2.6%	None	\$3,800	●	●	●	Yes	No*
NB	Long Term Care Services for Seniors	●	●	●	1978	1,060	20.0%	65+	\$1,250	●	●	●	Yes	Yes*
NB	Self-Managed Support Disability Support Program	●	●	●	–	90	–	19-64	–	●	●	●	Yes	Yes*
NL	Self-Managed Home Support Services & Provincial Home Support Services Program	●	●	●	1988	3,680	40.0%	15+	\$1,500	●	●	●	No	Yes*
NS	Self-Managed Care Program	●	●	●	1994	216	0.8%	19+	\$3,100	●	●	●	No	No
NS	Supportive Care	●	●	●	2008	528	1.9%	65+	\$500	●	●	●	Yes	Yes
ON	Caregiver Support Project	●	●	●	2011	874	–	None	\$117	●	●	●	Yes	Yes
ON	Passport	●	●	●	2005	24,000	–	18+	\$833	●	●	●	Yes	Yes*
ON	Self-Managed Attendant Services	●	●	●	1994	980	0.4%	16+	\$4,035	●	●	●	No	No
ON	Wesway Family Directed Respite Services	●	●	●	1973	327	–	None	\$375	●	●	●	Yes	Yes*
PE	Home Care and/or Disability Support Program	●	●	●	2001	1,414	–	64-	\$833	●	●	●	Yes	Yes
QC	L'allocation Directe – Chèque Emploi-Service	●	●	●	<1997	10,219	7.8%	None	\$503	●	●	●	Yes	No*
SK	Community Living Self Directed Funding	●	●	●	2014	7	–	18+	\$6,250	●	●	●	Yes	Yes*
SK	Individualized Funding for Home Care	●	●	●	2002	154	0.3%	None	\$3,959	●	●	●	No	No
A	B	C	D	E	F	G	H	I	J	K	L			

No*: No with exceptions Yes*: Yes with restrictions

Source: Kelly, Jamal, Aubrecht, and Grenier, 2020. The information is presented alphabetically for ease of reference.

Appendix 1.C: Saskatchewan Jurisdictional Scan

May, 2024

The table below includes information collected in the Spring of 2024 by reviewing jurisdictional websites. In the absence of information publicly available online, follow-up via phone with staff at relevant organizations was completed as indicated below. The following information may therefore be out-of-date or incorrect.

<p>Primary and supplementary questions:</p>	<p>How do programs in Saskatchewan manage access to equipment for individuals with IDD? Who gets what equipment, when, and how?</p> <ul style="list-style-type: none"> • What equipment do programs cover? • How much money do they cover? (is it income based?) • What is the requisition process for equipment? • Is it a “single door” process or do individuals need to engage with multiple organizations? • Are there self-managed care options for accessing equipment? <p>Equipment of interest includes manual/power chairs, communication devices, home/vehicle modifications (ramps), feeding supplies, etc.</p>
<p>Search Results:</p> <p>Google search of terms related to disability equipment Saskatchewan</p>	<p>Saskatchewan Department of Health oversees disability programming. They offer a number of relevant services:</p> <ol style="list-style-type: none"> 1) Saskatchewan Aids to Independent Living (SAIL)³ <ul style="list-style-type: none"> • This program strives to “provide people with physical disabilities and certain chronic health conditions a basic level of coverage for disability related equipment, devices, products, and supplies in a cost effective and timely manner.” • To be eligible you must reside in Saskatchewan and be referred by a health care professional. You cannot access this program if you are receiving benefits from

³ <https://www.saskatchewan.ca/residents/health/accessing-health-care-services/health-services-for-people-with-disabilities/sail#eligibility>

	<p>Saskatchewan Government Insurance, Workers Compensation, Health Canada, or Department of Veteran's Affairs</p> <ul style="list-style-type: none"> • This program includes the following: prosthetics and orthotics program, mobility and assistive devices program (equipment loan described below), therapeutic nutritional products program, respiratory equipment program, home oxygen program, and compression garment program. <p>2) Equipment loan program (in partnership with SaskAbilities)⁴</p> <ul style="list-style-type: none"> • Residents may loan equipment including mobility and environmental equipment with a referral from an OT or PT • Equipment can be loaned for as long as necessary • Equipment includes mobility aids (wheelchairs, wheelchair cushions, folding walkers, walker gutter attachments, and more), environmental aids (bathroom accessories such as commodes and lifts), transfer assists, and hospital beds and accessories. • A 2016 audit⁵ indicated that the Council reviews trends each year to determine need for equipment and funding. Equipment can be readily transferred between 5 depots in the province. The program aims to provide wheelchairs within 2-3 months and other equipment within 2 weeks (although in 2016, 27% of clients did not receive their equipment within these targets). The program will help maintain and repair equipment. The 2016 audit revealed 87% of clients using the services were satisfied with wait times, and 88% thought it was an effective program.
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⁴ <https://www.saskabilities.ca/services/independent-living/special-needs-equipment#items-available-for-loan>

⁵ https://auditor.sk.ca/pub/publications/public_reports/2016/Volume_2/27_Health_Special%20Needs%20Equip.pdf

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	<p>Note: it does not appear that individualized funds can be used to access equipment in Saskatchewan⁶</p> <p>3) Adaptation for Independence (Funded by Saskatchewan Housing Corporation)⁷</p> <ul style="list-style-type: none"> • Provides financial assistance (forgivable loan to a maximum of \$23,000 based on income and assets) to improve accessibility of a home for families that rent or own and have a household member with a housing related disability.
<p>Phone Call: SaskAbilities, Saskatoon</p>	<p>I spoke with the manager of Saskatoon SaskAbilities branch, who confirmed above information and shared the following new information:</p> <ul style="list-style-type: none"> • Need for wheelchair must be longer than three months, need for hospital bed must be longer than 6 months. Must be living in their own apartment/home (not PCH or private care). • The program is meant to meet basic needs and recommended people to Kinsmen foundation for those who wanted to apply for funding to buy equipment. SAIL does provide a \$2,500 grant for an ultralight wheelchair.
<p>Search Results: Kinsmen Saskatchewan</p>	<p>The Kinsmen Foundation funds equipment (mobility equipment, vehicle conversions, outdoor lifts, adaptive technology, and home accessibility) and Medical Travel.⁸</p>

⁶ <https://www.saskatchewan.ca/residents/health/accessing-health-care-services/care-at-home-and-outside-the-hospital/individualized-funding-for-home-care>

⁷ <https://www.saskatchewan.ca/residents/housing-and-renting/home-repairs-and-renovations/adapt-a-home-for-a-person-with-a-disability>

⁸ <https://telemiracle.com/funding-info-application/>

	<ul style="list-style-type: none"> • They are a “funder of last resort” meaning that they encourage individuals to self-fund, utilize other funding programs or crowd source. • Individuals self-apply with a letter of recommendation from a medical professional and a request for a specific item of equipment.
Phone Call: Inclusion Saskatoon	<p>I inquired: Is there a gap in services for people who are unable to borrow equipment from SAIL (highly customized, very long term, etc.)? Where do they procure funding for equipment?</p> <p>Inclusion Saskatoon recommended that people look into the Cognitive Disability Strategy, which funds people with cognitive disabilities for unmet needs (income based), otherwise people usually use SaskAbilities.</p>
Search Results: Cognitive Disability Strategy	<p>The Cognitive Disability Strategy⁹ is a provincial service that provides services to address the unmet needs of people with cognitive disabilities and their families.</p> <ul style="list-style-type: none"> • To access this benefit, there must be an unmet need that cannot be supported by another system. • An income test and needs assessment is conducted to determine funding levels. • Medical equipment and supplies are NOT covered, but assistive technology is.
Summary:	<p>In Saskatchewan, the main way individuals with a disability access equipment is through the SAIL equipment loan program, which allows individuals to loan equipment such as wheelchairs, transfer assists, and hospital beds. To access this equipment, a physiotherapist or occupational therapist must submit a requisition. Once requested, equipment should be ready for the individual in 2 weeks – 3 months. The program will</p>

⁹ <https://www.saskatchewan.ca/residents/family-and-social-support/people-with-disabilities/financial-help-and-support-for-people-with-cognitive-disabilities>

	<p>help you maintain, and repair equipment as needed, and it can be kept for as long as necessary. It doesn't cost any money, and overall, people are satisfied with this service.</p> <p>If individuals need highly specialized equipment or want to buy their own equipment, they are responsible for financing it on their own or seeking support through non-profits, such as the Kinsmen foundation. Individuals can apply for income-based funding for assistive technology through the Cognitive Disability Strategy.</p> <p>If individuals need help modifying their home, they apply through a different program, Adaptation for Independence, which gives loans to help people do construction on their home to make it more accessible.</p> <p>Individuals cannot use direct funding on equipment in Saskatchewan.</p>
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Follow-Up Questions

<p>What transportation supports are available for individuals with disabilities in Saskatchewan?</p> <p>Answers obtained by Google Searching</p>	<p>The government of Saskatchewan funds a Transit Assistance for People with Disabilities program (TAPD). The government funds municipalities to offer paratransit services, a door-to-door service for individuals unable to use a fixed-route transit service.¹⁰</p> <p>You must register for paratransit with your municipality and have your application approved. There is some variation in procedures according to municipality. Once approved in Regina, for example, you can book your trip up to 7 days in advance. Fares are consistent with conventional transit.¹¹</p>
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¹⁰ <https://www.saskatchewan.ca/government/municipal-administration/funding-finances-and-asset-management/funding/funding-transit-for-people-with-disabilities#program-background>

¹¹ <https://www.regina.ca/transportation-roads-parking/transit/paratransit/>

	<p>SaskAbilities offers a similar program for individuals in Swift Current and Yorkton, although they have stricter eligibility criteria (in Regina, the TAPD program will cover individuals who cannot ride transit because they are a fall risk or easily confused; with SaskAbilities, the individual must have mobility issues or other permanent disabilities to be eligible).¹²</p>
<p>What does the equipment repair process look like for equipment loaned from the Equipment Loan Program?</p> <p>Answers obtained by Phone Conversation with staff from SaskAbilities</p>	<p>The individual can rent the equipment from vendors in town while their equipment is being repaired/undergoing maintenance. Unfortunately, they are responsible for covering the cost of the rented equipment during this time.</p>
<p>How often can new/different equipment be requested from the Equipment Loan Program?</p> <p>Answers obtained by Phone Conversation with staff from SaskAbilities</p>	<p>Individuals can access new equipment as frequently as they would like, as long as it is supported by a requisition. They must return equipment immediately that is no longer being used.</p>
<p>Is the \$2,500 SAIL wheelchair grant only once per lifetime.</p> <p>Answers obtained by Phone Conversation with staff from SaskAbilities</p>	<p>The grant is given by a committee and applications are reviewed on a case-by-case basis. It is for use only for hyperlite wheelchairs.</p>
<p>What is the best option for individuals needing highly specialized/individualized equipment.</p>	<p>The program provides a wide range of chairs that can suit most needs and is a really good option for the majority of people. Staff from SaskAbilities could not think of any examples of individuals</p>

¹² <https://www.saskabilities.ca/services/independent-living/access-transit/>

<p>Answers obtained by Phone Conversations with two staff from SaskAbilities</p>	<p>whose needs had not been met by the program.</p> <p>Staff asked for specific examples of specific chairs/accommodations I was inquiring about. At a later date I spoke with a different staff member who shared that SaskAbilities makes the frame of the chair and customized seating is taken care of by a specific seating department in Saskatchewan and Wascana Rehab in Regina. This is fully funded and covered by the program and includes components such as seatbelts, backrests, and customizable seating.</p>
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Appendix 1.D: Alberta Jurisdictional Scan

September, 2024

The table below includes information collected in the Fall of 2024 by reviewing jurisdictional websites. In the absence of information publicly available online, follow-up via phone with staff at relevant organizations was completed as indicated below. The following information may therefore be out-of-date or incorrect.

<p>Primary and supplementary questions:</p>	<p>How do programs in Alberta manage access to equipment for individuals with disabilities? Who gets what equipment, when, and how?</p> <ul style="list-style-type: none"> • What equipment do programs cover? • How much money do they cover? (is it income based?) • What is the requisition process for equipment? • Is it a “single door” process or do individuals need to engage with multiple organizations? • Are there self-managed care options for accessing equipment? • Why does Alberta have such a good reputation? <p>Equipment of interest includes manual/power chairs, communication devices, home/vehicle modifications (ramps), feeding supplies, etc.</p>
<p>Search Results: Google search of terms related to disability equipment Alberta</p> <p>Findings confirmed with age-well</p>	<p>The primary way to access equipment in Alberta is through the Alberta Aids to Daily Living (AADL) program¹³. This program is a provincial program overseen by the ministry of health.</p> <p><u>Program Overview</u></p> <ul style="list-style-type: none"> • In order to receive funding, you must be a resident of Alberta and have a long-term disability, chronic illness, or terminal illness. • You must be assessed by an AADL health care provider (nurse, occupational therapist, or physiotherapist) who determines your needs and acts as your guide through the program (AADL Authorizer).

¹³ <https://www.alberta.ca/alberta-aids-to-daily-living>

<p>jurisdictional scan</p> <p>Additional information provided by AADL program manager</p>	<ul style="list-style-type: none"> • Once approved for funding, an AADL-approved vendor will help provide the equipment and collect the cost-share portion for the equipment. <p><u>Cost-Sharing</u></p> <ul style="list-style-type: none"> • There are no income requirements to be eligible for AADL benefits. Albertans pay 25% of the equipment cost (maximum of \$500 per individual/family per year. Low-income individuals do not pay the cost-share portion (<\$20,970 for single person). Additionally, clients receiving supplemental benefits (income supports, assured income for severely handicapped, adult health benefits) may be exempt from cost-sharing. Individuals must apply for cost-exemption. • If clients choose an ungraded item, they must pay the additional cost of this item. Upgrades not covered by the program include specialty wheels for manual wheelchairs, high speed motors on power chairs, accessories such as cup holders, pouches, or covers. If desired equipment is more expensive than the products offered by the AADL, clients can also pay the difference. <p><u>Eligibility</u></p> <ul style="list-style-type: none"> • You are not eligible if you are eligible to receive benefits from another source including veterans affairs, workers compensation board, NIHB, a private insurance plan. <p><u>Equipment</u></p> <ul style="list-style-type: none"> • Once approved by a healthcare provider, you will be given a list of at least three vendors who have this equipment. You may also choose your own vendor from an approved list. The approved vendor will then provide you with the equipment and you pay your cost-share, if applicable. Large equipment, such as wheelchairs and hospital beds are purchased by AADL and delivered to an individual's residence. • The following equipment is covered: <ul style="list-style-type: none"> ○ Back and abdominal supports, bathing and toileting equipment, burn garments, compression garments, custom footwear, ocular prostheses,
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	<p>hearing aids, homecare beds, incontinence supplies, injection supplies (not for insulin injections), laryngectomy equipment, breast prostheses, orthotic braces (not foot orthotics), ostomy supplies, oxygen, lifts, pressures reduction overlays, prosthetic devices, respiratory equipment, shoe elevations, specialized pediatric equipment, specialized seating devices, communications devices, therapeutic shoes, transfer aids, walkers and walking aids, wheelchair cushions and accessories, manual and power wheelchairs, vision aids.</p> <ul style="list-style-type: none"> • Some equipment (beds, lifts, pediatric equipment and wheelchairs) is recycled and the AADL program retains full ownership. This equipment must be returned to the vendor if the equipment is no longer required, needs to be replaced by AADL, the individual using the equipment moves out of Alberta or the person becomes ineligible for the benefit. This is done to keep products out of the landfill and decrease the costs to the program. AADL is responsible for repair of these items, but the individual must pay the cost-share. Chairs can be refurbished and individualized (i.e. seating, controls) based on request and is covered by the program. • Clients are responsible for ensuring care and maintenance of equipment and they're responsible for replacing lost, stolen, or damaged (due to misuse) equipment. <p>Home Modifications are funded by the Residential Access Modification Program (RAMP), which helps low-income Albertans with Mobility challenges to modify their home.¹⁴</p> <ul style="list-style-type: none"> • Up to 7,500 per person each benefit year • Up to 15,000 per person within 10 years • Income based • Must provide quote from contractor with application
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¹⁴ <https://www.alberta.ca/residential-access-modification-program>

	<ul style="list-style-type: none"> • Modifications include curb guards, doors, landing pads, porch lift, ramp, sidewalk, stairlift, walkways, bathtub cut out, bathroom counter, bathroom fixtures, bath lift, bathroom enlargement, bathroom shelving, bathroom sink, ceiling track lifters, grab bars, handrails, landings, wheel-in shower, threshold ramp
<p>Additional Questions from the steering committee</p>	<p>What is the time process from start to finish? (are there enough authorizers?)</p> <p>Steve Crochetiere (director, Wheels of Change (an Alberta advocacy group)) shared in a 2021 news article¹⁵ that the AADL program is “inefficient and inhumane” and reported that individuals with physical disabilities are waiting months “or even up to a year” for access to support and equipment. Wheels of Change shared their opinion that the “program has inadequate staffing and a cumbersome approval (and sometimes re-approval) process for applicants.”</p> <p>Wheels of Change believed that a “backlog of paperwork” causes much of the delay and that the “administration of the program has become rigid and inflexible.”¹⁶</p> <p>A charity called The Lending Cupboard (based in Red Deer, Alberta)¹⁷ is often used to provide short term equipment loans to individuals waiting for services from AADL. The Lending Cupboard is a charity that has a warehouse of over 15,000 pieces of equipment (including wheelchairs, bathroom equipment, crutches, walkers, transport) that is available to anyone in central Alberta, free of charge.</p> <p>According to the AADL program manager, AADL switched to Blue Cross Authorizing in 2022. Prior to this, authorizers had to submit a referral to home care. Unfortunately, this wait time</p>

¹⁵ <https://www.reddeeradvocate.com/news/people-with-disabilities-deserve-more-timely-support-from-alberta-says-advocacy-group-6797639>

¹⁶ <https://globalnews.ca/news/7592350/advocacy-group-wait-times-specialized-mobility-aids-alberta/>

¹⁷ <https://www.lendingcupboard.ca/>

	<p>could be up to a year. This was managed by Alberta Health Services (AHS) which is a separate arm of Alberta Health, and AADL did not have direct operational control of staffing through AHS.</p> <p>Since AADL moved to Alberta Blue Cross managing authorizations and claims, the process for approval and payment is instantaneous. If any product needs prior approval this may take 1-2 weeks to complete.</p> <p>Once approved, the product is ordered through the client's vendor of choice and if they do not have the product in stock, it can take several weeks. So overall time, can be a few days to several months.</p> <p>Is it difficult to get insurance coverage for equipment?</p> <p>The AADL program manager recommended that all clients get insurance to cover lost, stolen, or damaged equipment, but did not indicate how difficult that might be.</p> <p>How often does an individual need to apply for cost-exemption?</p> <p>According to the AADL program manager, yearly, but for many clients the program gets notification if clients are in any Alberta programs like Assured Income for severely Handicapped (AISH) or seniors, where their status does not change so they don't need to reapply.</p> <p>Is it difficult for rural Albertans to access services? (Are there rural authorizers/vendors?)</p> <p>According to the AADL program manager, AADL has authorizers all over the province, but it can be challenging. There are vendors in Northern Alberta but many have to rely on Edmonton vendors. Wait times currently are longer in Edmonton and Calgary than it is rurally.</p>
Summary	<p>In Alberta, you can get help with equipment through the Alberta Aids to Daily Living (AADL) program, run by the health ministry. To qualify, you need to live in Alberta and have a long-term disability or serious illness. A health professional will assess</p>

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	<p>your needs and guide you through the program. This person is called an authorizer.</p> <p>Once approved, an AADL-approved vendor will provide the equipment, and you pay a part of the cost (25%, up to \$500 per year). Low-income individuals might not have to pay this cost-share, and some people can be fully exempt if they receive other benefits. If you choose more expensive upgrades or extra features, you will need to cover those costs yourself.</p> <p>You can't use AADL if you're getting benefits from other programs like veterans affairs or private insurance. Equipment like wheelchairs and hospital beds are covered, and some equipment is recycled to save costs and reduce waste. You need to take care of the equipment and replace it if it's lost or damaged.</p> <p>For home modifications, low-income Albertans can get up to \$7,500 per year or \$15,000 over ten years through the Residential Access Modification Program (RAMP). This includes changes like ramps, stairlifts, and bathroom adjustments. You need to submit a contractor's quote with your application.</p> <p>In 2021 there was backlash against AADL with individuals claiming wait times could take up to a year. Users would need to borrow equipment from other agencies while they waited for AADL approval. In 2022, AADL switched to have its claims authorized by Blue Cross and wait times shortened considerably.</p> <p>Some questions remain about the AADL program, such as is it difficult to get insurance? And are there situations where approved equipment cannot be found on the vendor list? Next steps include speaking to advocacy groups to answer these questions and learn about user experiences.</p>
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Appendix 1.E: IQ Requirements Jurisdictional Scan

February, 2025

The table below includes information collected in late 2024 and early 2025 by reviewing jurisdictional websites. The following information may therefore be out-of-date or incorrect.

Research Context/Question: Corroborated by participants, the current eligibility protocol for Manitoba’s adult disability services system, Community Living DisABILITY Services (CLdS), presents a barrier for persons with disabilities who do not meet the IQ criteria.

What criteria practices do other jurisdictions use—with success—across Canada? Which of these could be adapted/adopted in Manitoba?

Province	Program	Eligibility Criteria	Comments
Alberta	PDD (Persons with Developmental Disabilities Program). Includes home living supports, respite, community access supports, employment supports, caregiver training, specialized supports (behaviour, etc.)	Developmental disability diagnosed before age 18 (IQ 2 standard deviations below the mean, significant limitation in adaptive skills) ¹⁸	Identical criteria to MB
British Columbia	CLBC (Community Living British Columbia). Includes transition planning, community connection, job support,	Developmental disability diagnosed before age 18 (significantly impaired intellectual and adaptive functioning) ¹⁹	Identical criteria to MB for CLBC, but additional

¹⁸ <https://manuals.alberta.ca/pdd-policy-manual/tools-and-resources/developmental-disabilities-guidelines>

¹⁹ <https://www.communitylivingbc.ca/who-does-clbc-support/eligible-clbc-support/>

	living support (independent, shared, or staffed), support coordination, communication and behavioural support, family wellness support	If an adult does not meet criteria for a developmental disability but has a diagnosis of FASD or ASD (and limited adaptive functioning as evaluated by the Scales of Independent Behaviour, revised, Vineland Adaptive Behaviour Scales, or Adaptive Behaviour Assessment System) they are able to access some services through the personalized support initiative. These supports may include supported living, respite, employment support, homemaker services, and development of network supports. ²⁰	supports available for those who do not meet criteria
Ontario	DSO (Developmental Services Ontario). Includes specialized supports (case management, person-directed planning), community involvement support/respite, housing support	Developmental disability diagnosed before age 18. Must provide assessment with information about your cognitive and adaptive functioning. ²¹	Identical criteria to MB
Sask.	CLSD (Community Living Service Delivery). Includes individualized support, assessment of needs, home and family	Diagnosis of intellectual ability before age 18. Must provide assessment with description of	Identical criteria to MB

²⁰ <https://www.communitylivingbc.ca/wp-content/uploads/Personalized-Supports-Initiative-Brochure.pdf>

²¹ <https://www.dsontario.ca/how-to-access-services>

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	support, planning support, day programs.	individuals cognitive and adaptive functioning. ²²	
Nova Scotia	DSP (Disability Support Program). Includes day programs, independent living support, among others.	Intellectual disability diagnosed before age 18. (IQ at or below approximately 70, impairments in adaptive behaviour) OR Long term mental illness, physical disability (impairing activities of daily living), acquired brain injury ²³	Broadest inclusion criteria

²² <https://www.saskatchewan.ca/residents/family-and-social-support/people-with-disabilities/housing-and-support-for-people-with-intellectual-disabilities>

²³ https://novascotia.ca/coms/disabilities/documents/Disability_Support_Program_Policies.pdf

Appendix 1.F Housing Topic Overview

Housing Topic Overview

Our working topic statement was, “What are the findings of cost/benefit analyses of increasing or enhancing community-based housing options for persons with disabilities and/or complex medical needs? What are the outcomes of such programs generally? What is the social return on investment for them?”

We’ve conducted multiple independent searches to get an overview of the relevant literature and concepts, and to form questions to potentially improve further searches. The most promising single result is a 2024 systematic review by Sally Lindsay and colleagues at Bloorview Research Institute, published in PLOS ONE. The article is, “Accessible independent housing for people with disabilities: A scoping review of promising practices, policies and interventions.”

Some General Observations

- Notwithstanding that the Lindsay review found a sample of 60 articles, we found that not many studies substantively and directly addressed our topic statement.
- We found that it’s easy for searches on this topic to return work on deinstitutionalization, which we recognize as important but less relevant to IAS.
- A small but surprising number of studies were on smart home and technology topics.
- There is also a modest literature focusing on home modifications, typically for accessibility purposes.

Plain-Language Summary of Lindsay Scoping Review

The researchers looked at ways to help people with disabilities find and live in homes that meet their needs. They looked at 60 different studies from 18 countries over 20 years to understand what works best.

They found four main things:

- I. Breaking down barriers to getting accessible housing:
 - Having advocates speak up for better housing options
 - Encouraging builders to create more accessible homes
 - Providing financial help like housing vouchers
 - Making sure people with disabilities can easily communicate with housing providers
- II. Helpful policies:
 - Laws that require buildings to be accessible

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- Rules that protect the rights of people with disabilities in housing
- Programs that help pay for home modifications

III. Solutions that make homes more accessible:

- Home modifications like ramps, wider doorways, and accessible bathrooms
- Smart home technology to control lights and appliances
- Mobile apps that help find accessible housing
- New devices that make homes easier to use

IV. Benefits of accessible housing:

- More independence
- Better safety
- Improved quality of life
- Better physical and mental health
- More ability to participate in community activities

The researchers concluded that while there are some good solutions available, we urgently need more accessible housing options for people with disabilities. They recommend continuing to advocate for better housing and focusing on helping groups who face the biggest challenges in finding accessible homes.

Reference

Lindsay, S., Fuentes, K., Rangunathan, S., Li, Y., & Ross, T. (2024). Accessible independent housing for people with disabilities: A scoping review of promising practices, policies and interventions. PLOS ONE, 19(1), e0291228.
<https://doi.org/10.1371/journal.pone.0291228>

2. SARC Research Summary Report, Part 2

Part 2 of this report summarizes the work done and findings for topics prioritized by the Integrated Adult Services Steering Committee in 2025. An interim report and summary of recommendations prepared by Chalet Point (both dated September 23, 2024), included more than 15 recommendations that could be further explored by our research team. As an initial follow-up to these documents, we assessed the feasibility of the topics and identified areas within our expertise that we could respond to. Of the eight topics that were assessed as feasible candidates, the Steering Committee prioritized five topics.

The following sections of this report include executive summaries of both the peer reviewed research literature searches and grey literature²⁴ (e.g., jurisdictional scans) searches related to the five topics (sections 2.1 – 2.5). Each subsection includes a series of appendices related to the topics. The five topics explored in the next sections include:

- 2.1 Redressing Inadequate Income Supports
- 2.2 Family Caregivers
- 2.3 Transition Supports for Family Caregivers
- 2.4 Rural Service Delivery
- 2.5 Rural Staffing

²⁴ The grey literature results below (sections 2.1 – 2.5) include information collected between June – December, 2025 by reviewing jurisdictional websites and information publicly available online. The following information may therefore be out-of-date or incorrect.

2.1 Redressing Inadequate Income Supports

Response Outline and Approach

Question

What income support models for persons with disabilities are implemented across Canadian provinces and territories, and what are their eligibility criteria, benefit levels, and coverage of disability-related expenses (e.g. accessible housing, transportation, specialized diets, para-health services, and respite care)? What data is available regarding the outcomes of these models?

Method

Question Approach and Interpretation

We distinguish between income support **models** and support **programs**. A model is a general approach that jurisdictions could adopt, while a program is an actual service or agency one can access within a jurisdiction. Each program thus employs some kind of model; some programs may use the same model.

We also distinguish between program **outcomes** and program **outputs**. Outputs are the services provided (e.g. the funding dispersed), while outcomes are the benefits produced for those who receive the services.

Using these distinctions, we interpreted the question as follows.

1. What income support programs for persons with disabilities are implemented across Canadian provinces and territories?
 - a. What general model does each program use?
 - b. What are their eligibility criteria, benefit levels, and coverage of disability-related expenses?
 - c. What data is available regarding the outcomes of each program?
2. If outcome data is available, and if different models can be distinguished, do any models appear to produce better outcomes?

Search Terms and Tools

To locate peer-reviewed academic literature we conducted a Semantic Scholar search via Elicit.com, using the text of the question as the set of search terms.

To locate grey literature (open web) resources we searched the web (using Microsoft Bing) for a variety of related terms from the primary question. These terms included (but were not necessarily limited to):

- disability income support Canada comparison
- provinces disability assistance programs
- [province/territory name] disability assistance benefits
- [province/territory name] disability benefit amount
- [province/territory name] disability assistance rates [year]
- [province/territory name] disability program supplement
- [province/territory name] disability benefit update
- disability assistance models Canada
- disability income support program structure Canada
- disability benefit categorical vs general assistance
- disability assistance outcomes Canada study
- impact of disability benefits Canada
- disability income support poverty housing employment research
- [province/territory name] new disability benefit [year]
- [province/territory name] disability program reform
- [province/territory name] disability benefit increase [year]

Results

Peer-reviewed Literature

Nine studies examining income support programs for persons with disabilities across Canadian jurisdictions were identified (Appendix 2.1A). The design of the studies varied and included: descriptive analysis, policy analysis, qualitative analysis, systematic review, and database compilation. The program types examined in the studies varied and included: provincial disability support programs, social assistance programs, federal disability support programs, private disability programs, and long-term disability insurance. Detailed information about eligibility criteria, benefit levels, and coverage of disability-related expenses were **not** provided in detail in 6 out of the 9 studies.

We noted several key patterns across the Canadian disability support landscape.

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Eligibility frameworks were consistently described as rigid and complex, requiring medical certification and unemployability assessments that exclude individuals with episodic conditions like mental health disabilities, while means-testing criteria may be opaque and inconsistently applied. **Benefit adequacy** was a common concern, with multiple studies reporting benefit levels below the poverty line and rarely indexed to inflation. Coverage of **disability-related expenses** such as drug costs, transportation, and housing were uneven and can create “benefit traps” that discourage employment transitions ⁽¹³⁾. The Disability Tax Credit, despite serving as a gateway to other supports, remains inaccessible to many low-income individuals with only a 40% take-up rate. **Program access** is hindered by complex eligibility requirements, low awareness, administrative barriers, and confusing interactions between programs that can create exclusionary effects, while the absence of centralized data and coordination across programs further complicates both access and evaluation. **Special populations** face particular disadvantages: women with disabilities, especially single mothers, experience higher poverty rates due to earnings-based benefit calculations and restrictive eligibility; people with mental illnesses face subjective and inconsistent assessments using tools ill-suited to fluctuating conditions; and the binary employable/unemployable framework fails to accommodate part-time work or partial benefits, limiting flexibility and social inclusion for those with episodic disabilities.

Grey Literature

What income support programs for persons with disabilities are implemented across Canadian provinces and territories?

Every province and territory in Canada offers a basic income support program for adults with disabilities, although these programs vary in structure. In January 2025, the Kids Brain Health Network commissioned the “Disability Policy in Canada: Provincial and Territorial Report”, which includes information about income support programs across Canadian jurisdictions (Appendix 2.1B). Further, in July 2025, the National Educational Association of Disabled Students published a white paper titled “A Case for Decoupling Employment Income and Benefits for People Living With Disabilities,” which was funded by Employment and Social Development Canada, and includes information about income support programs in Canada (Appendix 2.1C). Given the availability of these recent jurisdictional surveys, we will not provide an additional listing of programs, but will rely upon these two reports and our own grey literature findings (Appendix 2.1D) in the following sections.

What general models do the programs use?

Across Canada, there are two types of provincial income support models for persons with disabilities, categorical disability programs (in BC⁽⁷⁾, SK⁽¹¹⁾), and integrated social assistance (in NB⁽³⁾, NS, PEI, NL⁽¹²⁾), as well as a hybrid of both types (MB⁽⁵⁾ and Quebec⁽¹⁰⁾). Categorical disability programs may be described as separate or enhanced disability benefits. Integrated social assistance may be described as general welfare with provisions for disabilities.

What are the eligibility criteria?

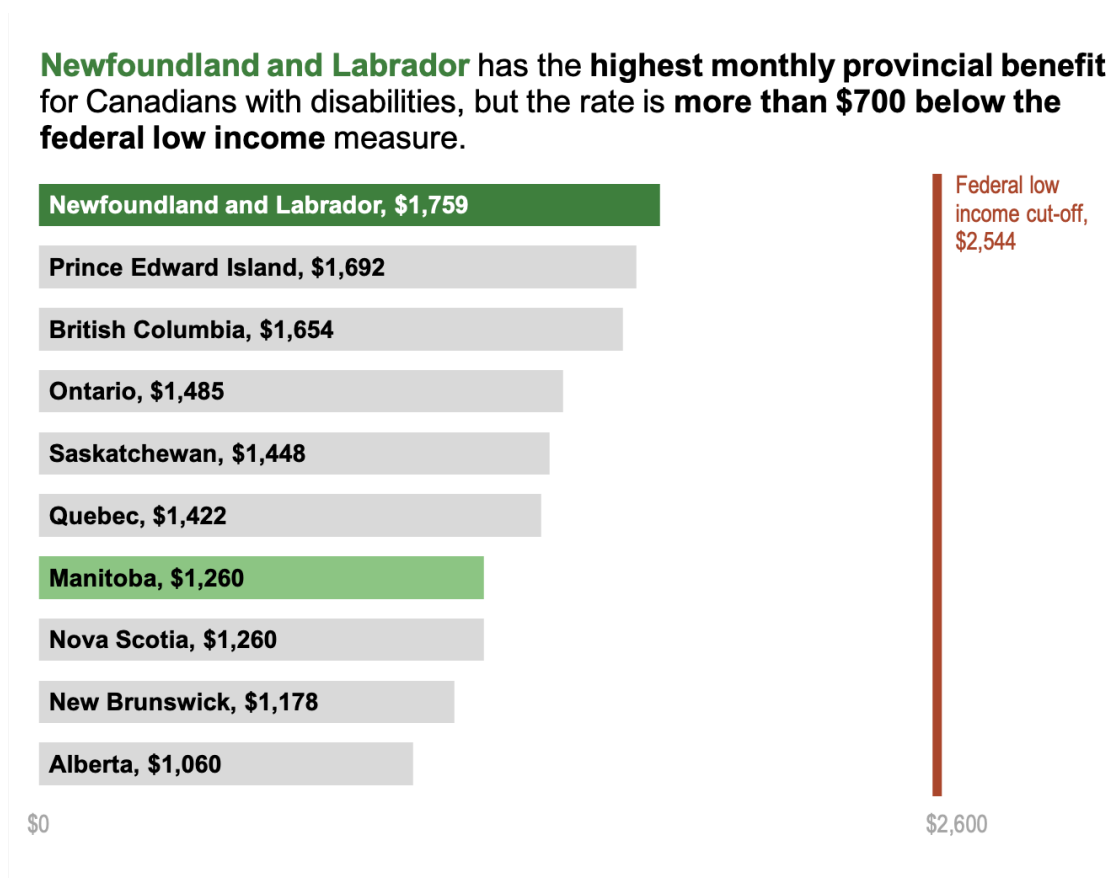
Eligibility criteria to access disability programs across Canadian jurisdictions was previously summarized. In general, applicants must demonstrate intellectual or developmental disability before the age of 18 years old although, there are some exceptions in some Canadian jurisdictions that consider other diagnoses (in BC) or physical disability impairing activities of daily living, acquired brain injury, or long-term mental illness (in NS). In addition, applicants must be 18 years old, maintain provincial or territorial residency, and be Canadian citizens or permanent residents to be eligible for disability income support programs. The medical assessment of disability varies across Canadian jurisdictions and includes different approaches:

- Restrictive: Medical Advisory Board certification is required in NS
- Stream-lined: One-time physician assessment form is permitted in MB
- Comprehensive: Assessment from various healthcare professionals is accepted in NWT

What are the benefit levels?

Depending on the program, benefit determination may be **flat-rate** (standard amount provided for basic needs) or **needs-based** (customized amount to actual expenses). Some programs allow some employment earnings or other income without reducing benefit amounts.

Figure 1 – Monthly disability benefit provided to adults with disabilities across Canadian provinces.



Note – Sources: 2024 Unattached single with disability welfare income ⁽⁵⁾, Federal low income cut-offs of census metropolitan area of 500,000 inhabitants or more comparator ⁽¹⁶⁾.

What is the coverage of disability-related expenses such as accessible housing, transportation, specialized diets, para-health services, and respite care?

The coverage of disability-related expenses depends on the program and differs across Canadian jurisdictions. Depending on the program, coverage may include prescription drug coverage, dental and vision care, specialized aids, nutritional supplements or food allowances, medical equipment or transportation, diabetes care supplies, emergency ambulance services, and home or vehicle modifications.

What data are available regarding the outcomes of these models?

There is limited publicly available outcome data of the impact of providing income support to Canadians with disabilities. In addition, there is a lack of transparent

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and consistent monitoring of outcome indicators. Available output data about socio-economic indicators reveal poverty, housing instability, unmet health care needs, food insecurity, and barriers to employment. Notably, there is no evaluation or outcome data about the direct impact of income support programs to quality of life.

Poverty

The poverty rate for Canadians with disabilities is twice as high as the rate for those without disabilities ⁽²⁾. Consequently, material deprivation and food insecurity have been reported in some jurisdictions. Manitoba has the smallest difference in income between people with and without disabilities ⁽⁴⁾, in part due to Manitobans with disabilities receiving a combination of disability benefits and general income supports including, rent assistance housing benefits. Notably, recipients of disability-related benefits are far below the poverty threshold in all Canadian provinces (see Figure 1) ⁽¹²⁾.

Housing instability

In jurisdictions across Canada where there is no housing support provided to adults with disabilities, a significant portion of income supports are spent on rent. Consequently, overcrowding and homelessness have been reported. In jurisdictions across Canada where housing supports exist, such as in Manitoba, homelessness risk has been reduced ⁽⁵⁾.

Unmet health care needs

Research findings indicate that Canadians with disabilities are four times more likely to experience unmet health care needs compared to Canadians without disabilities ⁽⁹⁾ and may not be able to afford dental care or mental health services.

Food insecurity

Food bank usage is high among Canadians with disabilities in some jurisdictions ⁽¹⁴⁾.

Barriers to employment

Increasing annual earnings exemptions without risking the loss or reduction of benefit amounts may increase employment opportunities ⁽¹⁵⁾.

What is the best income support model based on outcomes?

Based on available data, categorial disability programs (separate or enhanced disability benefits) provide higher incomes to adults with disabilities living in Canada. However, recipients are still well below the federal low income cut-offs.

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Further, a combination of flat-rate and needs-based benefit levels appear to provide Canadian adults with disabilities a higher income although, still below the poverty threshold. Finally, complementary supports such as health care services, housing assistance, and employment opportunities may also contribute to higher income for adults with disabilities across jurisdictions in Canada although, still below the poverty threshold. Research findings indicate that adequate and stable income support is positively associated with improved health and quality of life.

Appendix 2.1A: Academic Literature References

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Appendix 2.1B: Kids Brain Health Report

Disability Policy in Canada: Provincial and Territorial Report. (2025). Kids Brain Health Network - Réseau Pour La Santé Du Cerveau Des Enfants. Retrieved December 18, 2025, from <https://kidsbrainhealth.ca/disability-policy-in-canada-provincial-and-territorial-report/>

Appendix 2.1C: National Educational Association of Disabled Students Report

A Case for Decoupling Employment Income and Benefits for People Living With Disabilities. (2025, July 24). NEADS - Media.

<https://www.neads.ca/en/about/media/index.php?id=1461>

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Appendix 2.1D: Grey Literature References

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<https://www.canada.ca/en/employment-social-development/services/foreign-workers/caregiver/financial-ability.html>

2.2 Family Caregivers

Response Outline and Approach

Question

What formal support programs exist across Canadian jurisdictions to assist family caregivers of adults with disabilities living in community settings, including respite care services, home care supports, and caregiver training or education programs? What data are available regarding the outcomes of these programs?

Method

Question Approach and Interpretation

We interpreted, “including,” to mean, “including but not limited to.”

We also distinguished between program *outcomes* and program *outputs*. Outputs are the services provided (e.g. the number of people who accessed respite services), while outcomes are the benefits produced for those who receive the services.

Search Terms and Tools

To locate peer-reviewed academic literature we conducted a Semantic Scholar search via Elicit.com, using the text of the question as the set of search terms.

To locate grey literature (open web) resources we searched the web (using Microsoft Bing) for a variety of related terms from the primary question. Search terms included, but were not limited to:

Program Effectiveness & Outcomes

- Canadian family caregiver support programs adults disabilities evaluation outcomes
- respite care effectiveness research Canada adult disability
- home care support program evaluation Canada health outcomes longitudinal study
- Canadian caregiver training program effectiveness evaluation outcome measures

Economic & Cost Analysis

- cost effectiveness analysis caregiver support programs Canada health outcomes
- Canadian caregiver support SROI social return investment economic evaluation
- international best practices caregiver support programs Australia UK cost effectiveness

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Research Institutions & Policy Organizations

- Canadian health research institutes caregiver program evaluation (e.g., CIHI, IHE Alberta)
- Canadian policy organizations caregiver support analysis (e.g., CCPA, Conference Board, OECD)
- Canadian research universities caregiver support economic evaluation (e.g., McMaster, UBC, Toronto)

Federal Government Sources

- site:canada.ca family caregivers disability support programs benefits funding
- site:canada.ca federal budget parliamentary committee caregiver support disability

Provincial/Territorial Programs

- [Each province/territory] disability support programs family caregiver respite funding community living (Searches conducted individually for all 13 jurisdictions)

Program Implementation & Utilization

- Canadian caregiver training programs certification
- caregiver support utilization statistics wait times Canada
- innovative caregiver support programs pilot projects Canada

Results

Peer-reviewed Literature

We identified 10 of the most relevant studies examining formal support programs that exist across Canadian jurisdictions to assist family caregivers of adults with disabilities living in community settings (Appendix 2.2A). The design of the studies varied and included: descriptive analysis, systematic review, interventional, observational, survey data analysis, and qualitative data analysis. The program types examined in the studies varied and included: consumer-directed support, family support, home care support, direct funding home care, respite care, psychosocial interventions, caregiver training or education, community residential support, home mechanical ventilation services, acquired brain injury support, and transitional care. Different delivery models to implement programs were used and included: consumer-directed and family-managed, publicly-funded and formal service, group-based and community-delivered, institutional-based with caregiver training, and transitional care coordination. Funding models were either direct, self-managed, or agency-mediated.

Thematic analysis revealed a variety of findings. Program variations were observed in direct funding and transitional care, highlighting access or equity

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concerns. Consumer-directed support reportedly improved access to health care, improved mental health, reduced unmet needs, and lowered out-of-pocket expenses, especially among low-income families. Higher home care use and a reduced desire for institutionalization was reportedly associated with families accessing multicomponent interventions and formal respite programs. Enhanced caregiver competency and satisfaction was observed after receiving group-based training. The need for ongoing caregiver education and support was also identified.

Overall, **considerations for successful program implementation** included individualized, flexible, accessible, comprehensive, multi-component, and long-term supports; early or enhanced care; a sustainable and adequate workforce; an equitable policy design; family or participant involvement in program design; consumer-directed models; and financial support to low-income families. **Barriers to successful program implementation** were related to (lack of) sustainability, funding, workforce, equity, self-management, or rural-urban and socioeconomic disparities.

Grey Literature

Every province and territory in Canada offers formal support programs to assist family caregivers of adults with disabilities living in community settings such as home care services, respite services, and tax measures or cash benefits (Appendix 2.2B; 2.2C).

Across Canada, existing formal support programs to assist family caregivers of adults with disabilities living in community settings may be categorized as joint federal-provincial partnerships to provide home and community care, federal income support to provide employment insurance (EI) caregiver benefits, or federal tax measures.

In joint federal-provincial partnerships, federal funding is provided to create programs that are delivered at the provincial level. Examples of support programs include personal support, nursing, in-home respite care, and adult day programs.

Outcome data is limited to evaluations conducted at the systems level. In 2024, the Caring in Canada report was published by the Canadian Centre for Caregiving Excellence to share survey findings from more than 3,000 caregivers and care providers across Canada ⁽¹⁾. Main findings included:

- 1 in 4 caregivers report fair or poor mental health
- 1 in 5 caregivers are 65 years old or older
- 1 in 5 caregivers provide financial support to the care recipient
- 1 in 5 caregivers report spending \$1,000 per month on out-of-pocket expenses

Federal EI caregiver benefits include Family Caregiver Benefit for Adults (15 weeks maximum) and Compassionate Care Benefits (26 weeks maximum). These benefits are intended to act as a short-term income replacement while a caregiver

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is providing intensive care. **There is limited outcome data available** about the impact of these benefits on caregivers or care recipients.

Federal tax measures include the Canada Caregiver Credit and the Disability Tax Credit. These benefits are non-refundable credits that intend to reduce income tax for people with disabilities and the family members that support them. **There is no outcome data available** about the impact of these benefits on caregivers or care recipients.

There is limited structured training or education offered to family caregivers of adults with disabilities. What is available is typically part of home care training for caregivers to learn how to perform tasks or use equipment at home, or is provided by diagnosis-specific or caregiver non-profit organizations. **There is limited outcome data available** about the impact of caregiver training or education on caregivers or care recipients. In one study (n=81) conducted in Quebec, family caregivers shared that they felt a greater sense of empowerment related to their caregiving experience after participating in a stress management intervention ⁽²⁾. However, it is unknown whether these impacts are observed after receiving support from provincial programs.

Appendix 2.2A: Peer-Reviewed Literature

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[https://doi.org/10.1352/0047-6765\(2006\)44%255B405:csehas%255D2.0.co;2](https://doi.org/10.1352/0047-6765(2006)44%255B405:csehas%255D2.0.co;2)

Gallagher, E., & Hagen, B. (1996). Outcome evaluation of a group education and support program for family caregivers. *Gerontology & Geriatrics Education*, 17(1), 33–50. https://doi.org/10.1300/j021v17n01_03

Gan, C., Gargaro, J., Brandys, C., Gerber, G., & Boschen, K. (2010). Family caregivers' support needs after brain injury: A synthesis of perspectives from caregivers, programs, and researchers. *NeuroRehabilitation*, 27(1), 5–18.
<https://doi.org/10.3233/nre-2010-0577>

Heller, T., Miller, A. B., & Hsieh, K. (1999). Impact of a consumer-directed family support program on adults with developmental disabilities and their family caregivers. *Family Relations*, 48(4), 419. <https://doi.org/10.2307/585250>

Kelly, C., Jamal, A., Aubrecht, K., & Grenier, A. (2020). Emergent issues in directly-funded care: Canadian perspectives. *Journal of Aging & Social Policy*, 33(6), 626–646. <https://doi.org/10.1080/08959420.2020.1745736>

Martin, L., Ouellette-Kuntz, H., & McKenzie, K. (2017). Care in the community: Home care use among adults with intellectual and developmental disabilities over time. *Journal of Policy and Practice in Intellectual Disabilities*, 14(3), 251–254.
<https://doi.org/10.1111/jppi.12171>

Medical, A. S. (2008). Caregiver- and patient-directed interventions for dementia: An evidence-based analysis. *Ontario Health Technology Assessment Series*.

Rose, L., McKim, D. A., Katz, S. L., Leasa, D., Nonoyama, M., Pedersen, C., Goldstein, R. S., Road, J. D., Amin, R., Avendano, M., Goldstein, R., Dial, S., Fan, E., Fraser, I., Fowler, R., Rubinfeld, G., Katz, S., King, J., Leasa, D., ... Rose, L. (2015). Home mechanical ventilation in Canada: A national survey. *Respiratory Care*, 60(5), 695–704. <https://doi.org/10.4187/respcare.03609>

Stainton, T., Brown, J., Crawford, C., Hole, R., & Charles, G. (2011). Comparison of community residential supports on measures of information & planning; access to & delivery of supports; choice & control; community connections; satisfaction; and, overall perception of outcomes. *Journal of Intellectual Disability Research*, 55(8), 732–745. <https://doi.org/10.1111/j.1365-2788.2010.01378.x>

Weeks, L. E., Barber, B., MacDougall, E. S., Macdonald, M., Martin-Misener, R., & Warner, G. (2020). An exploration of Canadian transitional care programs for older

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adults. *Healthcare Management Forum*, 34(3), 163–168.
<https://doi.org/10.1177/0840470420974040>

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Appendix 2.2B: Grey Literature References

1. Caring in Canada: Survey insights from caregivers and care providers across Canada. (2024). Canadian Centre for Caregiving Excellence. Retrieved December 1, 2025, from https://canadiancaregiving.org/wp-content/uploads/2024/06/CCCE_Caring-in-Canada.pdf
2. Ducharme, F., Lebel, P., Lachance, L., & Trudeau, D. (2006). Implementation and effects of an individual stress management intervention for family caregivers of an elderly relative living at home: A mixed research design. *Research in Nursing & Health*, 29, 427-441. <https://doi.org/10.1002/nur.20152>

Appendix 2.2C: Canadian Caregiver Programs

Jurisdiction	Program Name	Program Type	Outcome Data	Evidence Summary
Federal	Canada Caregiver Credit	Financial	No	Tax expenditure data only; no caregiver outcome evaluation
Federal	EI Family Caregiver Benefit for Adults	Financial	No	2013-2017 program evaluation: 78% approval rate; awareness issues identified
Federal	EI Compassionate Care Benefits	Financial	No	Same evaluation as above; uptake and awareness challenges documented
National	National Recreational Respite	Respite	No	No outcome evaluation data identified
Ontario	Ontario Health atHome Respite Care	Respite	No	Operational outputs tracked only
Ontario	Passport Program (Respite Component)	Respite	No	2024 Carleton analysis noted 'little attention paid to outcomes'
Ontario	Developmental Services Caregiver Respite	Respite	No	No published outcome evaluations found
Ontario	Direct Funding Program (Self-Managed Attendant Services)	Home Care	No	No formal outcome evaluation found
Ontario	Attendant Outreach Services	Home Care	No	No outcome-specific data identified
Ontario	SCALE Program (Ontario Caregiver Organization)	Training	No	Uses evidence-based approaches but no published evaluation
Ontario	Caregiving Essentials Course (McMaster)	Training	Yes	RCT evidence: improved knowledge/confidence; burden reduction NOT significant
Ontario	Ontario Caregiver Helpline	Other	No	Call volumes tracked only

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Quebec	Baluchon Répit Long Terme	Respite	No	Won Prix d'excellence MSSS 2023; no published outcome studies
Quebec	Programme de soutien à la famille	Respite	No	No formal outcome evaluation found
Quebec	L'Appui Community Respite Projects	Respite	Yes	Satisfaction survey of 285 caregivers; not measuring burden outcomes
Quebec	Services de soutien à domicile CLSC	Home Care	No	No caregiver-specific outcome data found
Quebec	Allocation directe (Direct Allowance)	Home Care	No	No caregiver outcome evaluation found
Quebec	EÉSAD (Social Economy Home Care Enterprises)	Home Care	No	No caregiver-specific outcome data found
Quebec	Devenir aidant, ça s'apprend!	Training	No	Studies report increased confidence and self-efficacy; no burden reduction data
Quebec	Tax Credit for Specialized Respite Services	Financial	No	No outcome evaluation
Quebec	Volunteer Respite Tax Credit¹	Financial	No	No outcome evaluation
British Columbia	CLBC Individual and Family Wellness Services	Respite	Yes	Consumer satisfaction tracked (79-80%); no rigorous burden outcome studies
British Columbia	Health Authority Respite Services	Respite	No	No published outcome evaluations identified
British Columbia	Fraser Health BookABreak	Respite	No	No outcome evaluation data identified
British Columbia	Home Support Services	Home Care	No	No BC-specific outcome studies identified
British Columbia	Choice in Supports for Independent Living (CSIL)	Home Care	No	No outcome evaluation identified
British Columbia	Family Caregivers of BC Programs	Training	No	Self-reported: 89% more confident, 85% improved care recipient QoL; not controlled

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British Columbia	Family Support Institute of BC	Training	No	CARF accredited; no published outcome evaluation
Alberta	PDD Program Respite Services	Respite	No	Expenditure outputs tracked; no caregiver burden studies
Alberta	AHS Home & Community Care Respite	Respite	No	Warren et al. 2003: burden/QoL 'remained stable' with high satisfaction
Alberta	AHS Home & Community Care	Home Care	No	No specific caregiver outcome evaluations found
Alberta	Family Caregiver Centre (AHS Calgary)	Other	No	No published outcome data found
Alberta	COMPASS for the Caregiver	Training	No	2019 Gold Laurel Award; qualitative testimonials only
Alberta	Caregiver-Centered Care Education (U of A)	Training	Yes	BMC Health Services Research 2022: improved provider knowledge/attitudes
Saskatchewan	SHA Home Care Respite	Respite	No	No published outcome evaluation data identified
Saskatchewan	SHA Home Care Program	Home Care	No	No caregiver-specific outcome evaluation identified
Saskatchewan	Individualized Funding for Home Care	Home Care	No	No outcome evaluation identified
Saskatchewan	Self-Directed Funding (Ministry of Social Services)	Home Care	No	No outcome evaluation identified
Saskatchewan	Saskatoon Caregiver Information and Support Centre	Training	No	No outcome evaluation identified
Manitoba	CLDS Respite Services	Respite	No	No outcome evaluation identified
Manitoba	WRHA Respite Care Program	Respite	No	No outcome evaluation identified
Manitoba	St. Amant Respite Services	Respite	No	No outcome evaluation identified
Manitoba	Manitoba Home Care Program	Home Care	No	Provincial metrics in development via Shared Health; no published evaluations yet

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Manitoba	Primary Caregiver Tax Credit	Financial	No	No outcome evaluation
Manitoba	CLDS Clinical Services Training	Training	No	No outcome evaluation identified
Nova Scotia	Flex Individualized Funding Program	Respite	No	Funding increased 25%+ in 2025; no formal outcome evaluation
Nova Scotia	Caregiver Benefit	Financial	No	Referenced in research on caregiver financial well-being
Nova Scotia	Caregivers Nova Scotia Programs	Training	No	No formal outcome evaluations found
Nova Scotia	NS Centre on Aging CARERS Program	Training	No	Peer-reviewed: reduced emotion-based coping, enhanced mastery, reduced burden
New Brunswick	Disability Support Program Respite	Respite	No	No publicly available outcome data found
Prince Edward Island	AccessAbility Supports (AAS)	Respite	No	2,457 cases in 2023-24; program review underway; no outcome data yet
Prince Edward Island	At Home Caregiver Benefit	Financial	No	Launched July 2024; too new for outcome data
Prince Edward Island	Gardens of Hope Respite Cottage	Respite	No	No formal evaluation data
Newfoundland and Labrador	Provincial Home Support Program	Home Care	No	Deloitte program review conducted 2016
Newfoundland and Labrador	Paid Family Caregiving Option	Home Care	Yes	NL Centre for Health Information evaluation 2016 with recommendations
Yukon	Adult's Disability Services Respite Funding	Respite	No	No outcome evaluation data identified
Yukon	Yukon Home Care Program	Home Care	No	No outcome evaluation data identified
Yukon	YACL Respite Care Home	Respite	No	Pilot project; no outcome evaluation identified
Yukon	Inclusion Yukon Respite Matching Program	Other	No	Matching service only; no outcome evaluation

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Northwest Territories	Home and Community Care Program	Home Care	No	interRAI implementation referenced; no outcome data published
Northwest Territories	Facility-Based Respite	Respite	No	17 beds across territory; no outcome evaluation
Northwest Territories	NWT Caregivers Guide	Training	No	27-page educational resource; informational only
Nunavut	Home and Community Care Program	Home Care	No	interRAI planned; no outcome data published
Nunavut	Facility-Based Respite	Respite	No	5 respite/palliative beds; no outcome evaluation

Notes: ¹ This program was cancelled in 2021.

2.3 Transition Supports for Family Caregivers

Response Outline and Approach

Question

What formal transition planning programs and services do Canadian jurisdictions provide to support adults with disabilities whose primary family caregivers are aging or becoming unable to continue providing care, and what are the eligibility criteria and service pathways for these programs? What data are available regarding the outcomes of these programs?

Method

Question Approach and Interpretation

We noted that the programs identified would likely have a large degree of overlap with the programs from the Income Support and Family Support questions. Any program that supports individuals and families may be of benefit during care transitions. Our response to this question therefore focuses on programs or services that are specifically intended to support future care planning, or on programs that provide a range of supports, including one or more that explicitly include future care planning.

We also distinguished between program **outcomes** and program **outputs**. Outputs are the services provided (e.g. the number of people who accessed respite services, how many hours of homecare services a person received per month), while outcomes are the benefits produced for those who receive the services.

Using these distinctions, we interpreted the question as follows:

1. What programs or services do Canadian jurisdictions provide specifically to support adults with disabilities and/or families, when primary family caregivers are aging or becoming unable to continue providing care?
2. What are the eligibility criteria and service pathways for these programs?
3. What data are available regarding the outcomes of these programs?

Search Terms and Tools

To locate peer-reviewed academic literature we conducted a Semantic Scholar search via Elicit.com, using the text of the question as the set of search terms.

To locate grey literature (open web) resources we searched the web (using Microsoft Bing) for a variety of related terms from the primary question. Search terms included, but were not limited to:

Geographic Coverage

- [Each province/territory] aging caregiver transition planning disability future planning (*Searches conducted individually for all 13 jurisdictions*)

Provincial/Territorial Organizations

- Provincial inclusion/community living organizations + aging families + future planning (e.g., BCACL, NBACL, NLACL, Inclusion Alberta, Community Living Ontario)
- Provincial disability councils and advocacy bodies + supported living services adults

Based on the results of these searches, we followed up with additional more targeted searches, including:

National Organizations & Networks

- PLAN Planned Lifetime Advocacy Network Canada disability future planning
- Inclusion Canada / Canadian Association for Community Living aging caregivers report
- IRIS Institute Research Inclusion Society disability aging caregivers Canada

Provincial Programs & Initiatives

- LIGHTS program Ontario developmental disabilities
- Partners for Planning Ontario network future planning families
- Continuity Care Manitoba families disabilities future planning
- CLBC BC Strategy on Aging developmental disabilities

Government & Policy Sources

- Canada Senate committee disability aging parents caregivers report
- Ontario Ombudsman developmental services transition aging caregivers report
- Canada Law Commission disability aging legal capacity report
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Results

Peer-reviewed Literature

There is no Canadian research literature about formal transition planning programs and services to support adults with disabilities whose primary family caregivers are aging or becoming unable to continue providing care.

However, 3 studies conducted elsewhere were identified and are summarized in this section (Bigby et al., 2011; Brennan et al., 2020; Heller & Caldwell, 2006). The design of the studies varied and included: 1 intervention study, 1 qualitative study, and 1 systematic review. Findings from the systematic review indicated that structured programs are not widely implemented or evaluated. Some positive outcomes were reported for families after they engaged in a future planning process, but details were not provided.

The intervention study provided structured, peer-led training in small group workshops to families. Reported outcomes included increased family preparedness (i.e., completion of planning documents), reduced caregiver burden, and enhanced autonomy (i.e., increased daily choice-making by adults with disabilities).

Findings from the qualitative interview study revealed the absence of formal transition planning and processes and described support as informal and mostly managed by family members. Further, transitions were reportedly often crisis-driven and swift, which made family members feel powerless.

Limitations of the research studies included a lack of detail about eligibility or outcomes, and small sample sizes.

Grey Literature

At the national level, there are a limited number of formal transition planning programs and services to support adults with disabilities whose primary family caregivers are aging or becoming unable to continue providing care: Future Planning Tool ⁽¹⁾, PLAN/Plan Institute/Partners for Planning ^(2, 3, 4), AIDE Canada ⁽⁵⁾, and Siblings Canada ⁽⁶⁾. Resources are mostly educational and informational, and not service-based. All Canadians are eligible to use the resources, which are freely accessible online. There is no outcome data available for any of these programs.

All Canadians with a disability and their caregivers are eligible to use the Future Planning Tool, which is funded by Employment and Social Development Canada, and is accessible at the public website ⁽¹⁾. Resources include content about finances and housing, and a self-guided online tool that creates a customized plan for the future. There is no outcome data available.

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All Canadians with a disability and their caregivers are eligible to use resources provided by PLAN/Plan Institute, which are partially funded by government grants, and accessible for free online or for fee-for-service ^(2, 3). Resources include workshops and webinars about finances and housing, and customized planning support. There is no outcome data available.

All Canadians with a disability and their caregivers are eligible to use resources provided by AIDE Canada, which is funded by multiple sources including government and charitable organizations, and accessible for free online ⁽⁵⁾. Resources include learning modules, webinars, and evidence summaries about available support and future planning. There is no outcome data available.

All Canadian siblings of adults with disabilities are eligible to use resources provided by Siblings Canada, which is funded by the Canadian Centre for Caregiving Excellence, and accessible for free or at a low cost ⁽⁶⁾. Resources include online courses and webinars about finances, mental health, communication, and future planning. There is no outcome data available.

Across provincial and territorial jurisdictions in Canada, there are respite and home care services available for caregivers of adults with disabilities that are typically based on the needs of the care recipient rather than the age of the caregiver, nor for the purposes of proactive planning for the future. However, these services may be used reactively following a crisis or hospitalization, precipitating the transition of an adult with disabilities from primary family care to other caregivers/residences.

In Manitoba, the Continuity Care program is a non-profit organization founded by family members that is specifically designed to support family caregivers in planning for their loved one's future when they can no longer provide care ⁽⁷⁾. The main source of funding for this program is an endowment fund that is managed by The Winnipeg Foundation ⁽⁸⁾. Individuals and families may become a member for \$25 per year or \$250 for a lifetime membership. Agencies may become a member for \$50 per year. Resources include individual, sibling, and parent support; workshops; and future planning. There is no outcome data available.

Appendix 2.3A: Peer-Reviewed Literature

Bigby, C., Bowers, B., & Webber, R. (2011). Planning and decision making about the future care of older group home residents and transition to residential aged care. *Journal of Intellectual Disability Research*, 55(8), 777–789.
<https://doi.org/10.1111/j.1365-2788.2010.01297.x>

Brennan, D., McCausland, D., O'Donovan, M. A., Eustace-Cook, J., McCallion, P., & McCarron, M. (2020). Approaches to and outcomes of future planning for family carers of adults with an intellectual disability: A systematic review. *Journal of Applied Research in Intellectual Disabilities*, 33(6), 1221–1233.
<https://doi.org/10.1111/jar.12742>

Heller, T., & Caldwell, J. (2006). Supporting aging caregivers and adults with developmental disabilities in future planning. *Mental Retardation*, 44(3), 189–202.
[https://doi.org/10.1352/0047-6765\(2006\)44%255B189:sacaaw%255D2.0.co;2](https://doi.org/10.1352/0047-6765(2006)44%255B189:sacaaw%255D2.0.co;2)

Appendix 2.3B: Grey Literature References

1. Future Planning Tool. Plan Institute and Prosper Canada. Available at: <https://futureplanningtool.ca/>
2. Planned Lifetime Advocacy Network (PLAN). Available at: <https://plan.ca/>
3. Plan Institute. Available at: <https://planinstitute.ca/>
4. Partners for Planning. Planning Network. Available at: <https://www.planningnetwork.ca/>
5. AIDE Canada (Autism and/or Intellectual Disability Knowledge Exchange Network). Available at: <https://aidecanada.ca/>
6. Siblings Canada. Canadian Centre for Caregiving Excellence. Available at: <https://canadiancaregiving.org/siblingscanada/>
7. Continuity Care Inc. Available at: <https://continuitycare.ca/>
8. The Winnipeg Foundation. Organizations with Agency Funds. Available at: <https://www.wpgfdn.org/granting/agency-funds/organizations-with-agency-funds/>

2.4 Rural Service Delivery

Response Outline and Approach

Question

What service delivery models do Canadian jurisdictions use to provide homecare, nursing, and direct support services to persons with disabilities in rural and remote communities, including mobile services, telehealth applications, and regional service hubs?

Method

Question Approach and Interpretation

What service delivery models are used across Canadian jurisdictions to provide homecare, nursing, and direct support services to persons with disabilities in rural and remote communities? We distinguish between service **models** and service **programs**. A model is a general approach that jurisdictions could adopt, while a program is an actual service or agency one can access within a jurisdiction. Each program thus employs some kind of model; some programs may use the same model.

Search Terms and Tools

To locate peer-reviewed academic literature we conducted a Semantic Scholar search via Elicit.com, using the text of the question as the set of search terms.

To locate grey literature (open web) resources we searched the web (using Microsoft Bing) for a variety of related terms from the primary question. Search terms included, but were not limited to:

General overview searches:

- rural remote disability services Canada
- remote rehabilitation service delivery models
- Canadian rural healthcare delivery approaches
- disability services remote communities Canada

Telehealth/virtual care searches:

- rural telehealth infrastructure challenges Canada
- broadband internet rural remote Canada disability services
- virtual care nurse practitioner remote communities

Hub-and-spoke model searches:

- hub spoke rehabilitation model Canada
- regional rehabilitation networks Canada
- hub spoke disability services rural

Itinerant/mobile services searches:

- mobile health services rural Canada
- itinerant therapy services remote communities
- outreach rehabilitation services northern Canada

Comparative and implementation searches:

- comparing rural service delivery models Canada
- rural disability service best practices Canada
- remote healthcare equity access Canada
- provincial rural rehabilitation programs comparison
- barriers rural disability services Canada

Results

Peer-reviewed Literature

Ten studies examining rural service delivery models used to provide services to persons with disabilities in rural and remote communities across Canadian jurisdictions were identified (Appendix 2.4A). Most studies were descriptive, qualitative, or policy analyses. The study settings varied and included: rural or remote, rural and urban, Canada-wide, and province- or territory-based. The service types were varied and included: homecare, nursing, long-term care, dementia care, and chronic disease self-management. The service delivery models were varied and included: technology-enabled care, integrated interdisciplinary teams, hybrid (technology and in-person), government-funded, policy or sector-focused, community or home-based, and informal (family) care. Notably, all identified private sector service delivery models included public or community involvement.

Thematic analysis revealed several observations about the use of some service delivery models: integrated models reportedly facilitated resource allocation and coordination, hybrid models are frequently used among children with disabilities, and informal care provided by family and friends in rural areas to persons with disabilities addressed the gap in available formal services. Notably, while government-funded home care services are reportedly more accessible in rural areas, for-profit services are less available.

Among technology-enabled care service delivery models, studies reported that telehealth is used for chronic disease self-management and dementia care, and to provide nursing and direct support. A variety of technology platforms are also used

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to provide training, coaching, and support. Mobile services such as telehealth and telehomecare reportedly addressed geographic barriers. Notably, limited internet access is identified as a barrier for technology-enabled care. Overall, **barriers to implementing service delivery models included** those related to geography, workforce, resources, infrastructure, or availability of for-profit services.

There is limited outcome data available about the impact of service delivery models for persons with disabilities in rural communities. Among the study findings, reported positive outcomes among persons with disabilities and their families using different rural service delivery models to receive services included: improved self-efficacy and health, greater support, flexible or cost-effective access, positive family experiences, and reduced travel.

Grey Literature

Canadian provinces have developed several service delivery models specifically adapted to the challenges of providing disability and rehabilitation services across great distances and to isolated communities ⁽¹⁾. Three approaches have shown particular utility.

Telehealth and Virtual Care connects rural providers and patients with specialists and services through video and telephone technology. British Columbia's Real-Time Virtual Support Network exemplifies this approach: rural nurses and physicians can instantly connect via video with emergency physicians, pediatricians, or other specialists for real-time clinical guidance, while patients in remote communities can access primary care and mental health services without travelling ⁽²⁾. The network operates on the principle that virtual care should augment rather than replace local services, building capacity in communities rather than centralizing care elsewhere ⁽²⁾. Similar programs in Nunavut pair nurse practitioners with community health nurses to manage chronic conditions remotely ⁽³⁾. The primary limitation remains broadband infrastructure—many remote communities lack reliable internet connectivity ⁽⁴⁾.

Hub-and-Spoke Models extend specialized expertise to communities that lack the population base to support full-time specialists. A regional hub with interprofessional teams provides specialized assessment and treatment planning, while local "spoke" sites deliver ongoing care under the hub's guidance through virtual consultation ⁽⁵⁾. This model allows patients to receive most of their care close to home while maintaining access to specialized expertise for complex needs. Ontario's Rehabilitative Care Alliance has formalized this approach for populations such as acquired brain injury, spinal cord injury, and amputee care ⁽⁵⁾. In Newfoundland and Labrador, the Western Zone implemented a hub-and-spoke virtual care model across 25 of 28 primary care sites, successfully diverting over 26,000 visits from emergency departments while maintaining high patient satisfaction ⁽⁶⁾.

Traveling and Mobile Services bring providers and equipment directly to communities on scheduled rotations. In Yukon, rehabilitation therapists travel to nearly every community in the territory, building ongoing relationships that are essential to effective care in small communities ⁽¹⁾. Alberta Health Services operates mobile MRI and dialysis services for patients who cannot travel to urban centres ⁽⁷⁾. British Columbia's Mobile Medical Unit—a pair of tractor-trailers with clinical equipment—can deploy anywhere in the province within 24 hours for emergency response, public health clinics, or to maintain services during hospital renovations ⁽⁸⁾.

Each model addresses different aspects of the rural service gap, and most jurisdictions employ them in combination. The common thread is flexibility: adapting service delivery to geographic realities rather than expecting rural communities to conform to urban models.

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2.5 Rural Staffing

Response Outline and Approach

Question

What recruitment, retention, and training strategies have Canadian provinces and territories implemented to address shortages of qualified disability support workers, nurses, and homecare providers in rural areas, and what are the outcomes of these initiatives?

Method

Question Approach and Interpretation

We understand “strategies” to mean not specific programs, but rather approaches or solutions that might be applied within or across programs.

We distinguish between program **outcomes** and program **outputs**. Outputs are the services provided (e.g. the number of people who received services), while outcomes are the benefits produced for those who receive the services.

Search Terms and Tools

To locate peer-reviewed academic literature we conducted a Semantic Scholar search via Elicit.com, using the text of the question as the set of search terms.

To locate grey literature (open web) resources we searched the web (using Microsoft Bing) for a variety of related terms from the primary question. Terms used included, but were not limited to:

Provincial/Territorial Government Sources

- [jurisdiction] healthcare workforce rural recruitment nursing shortage homecare
- [jurisdiction] disability support worker training programs rural recruitment (Searches conducted individually for Atlantic, Central, Western, and Northern jurisdictions)

Program-Specific Searches

- “Learn and Stay Grant” Ontario outcomes data evaluation results
- “Tuition Support Program for Nurses” rural remote outcomes
- “International Educated Nurses” program Western Canada recruitment 2019–2024
- “community health representative” training territorial northern Canada

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Academic & Research Institution Sources

- Atlantic Canada healthcare workforce research “Memorial University” “Dalhousie University”
- Northern Ontario School Medicine rural physician recruitment
- academic research rural healthcare workforce Western Canada university studies

Workforce Statistics & Outcomes

- [jurisdiction] health workforce statistics 2024 outcomes data recruitment retention rural
- Atlantic Canada healthcare workforce statistics 2024 rural nurse retention rates
- territorial Canada health workforce research evaluation outcomes remote nursing

Specific Population & Service Focus

- “Indigenous nursing” workforce recruitment Western Canada First Nations health
- “home care” “homecare” workforce rural recruitment training Western Canada provinces
- Quebec rural health workforce strategy nurse recruitment

Results

Peer-reviewed Literature

Ten studies examining recruitment, retention, and training strategies that have been implemented to address shortages of qualified disability support workers, nurses, and homecare providers in rural areas across Canadian jurisdictions were identified (Appendix 2.5A). The design of the studies varied and included: qualitative, systematic review, mixed methods, and policy analysis. Most studies focused on nurses, some focused on homecare providers, and none focused on disability support workers. Overall, there is limited available outcome evaluation data.

Thematic analysis of **recruitment strategies** revealed communication technologies (telehealth, distance training), financial incentives, continuing professional education, work environment improvements, and targeted marketing (staff referrals, provider-community fit). Limited outcome evaluation data (Nowrouzi et al., 2015; Mbemba et al., 2013) indicated that work environment improvements led to increased job satisfaction and that financial incentives were effective to improve human resource distribution.

Thematic analysis of **retention strategies** revealed work environment improvements, stress management, continuing professional education, support, and financial incentives. Limited outcome evaluation data (Nowrouzi et al., 2015; Mbemba et al., 2013) indicated that stress management and improved work environments reduced burnout and increased retention among nurses. One study (Nowrouzi et al., 2015) also highlighted that supportive relationships among nurses was key for retention.

Thematic analysis of **training and education strategies** revealed continuing professional education, communication technologies (telehealth, distance training), mentorship, stress management, and a structured transition program for new graduate nurses. Limited outcome evaluation data (Nowrouzi et al., 2015; Mbemba et al., 2013) indicated that continuing professional development and stress management increased knowledge and reduced burnout among nurses.

Grey Literature

Recruitment

Multiple jurisdictions have used targeted financial incentives with return-of-service commitments. Saskatchewan's Rural and Remote Recruitment Incentive offers up to \$50,000 over three years for RNs, with scaled amounts for CCAs and LPNs ⁽¹⁾. PEI adds \$5,000 for placements outside Charlottetown ⁽²⁾. Nunavut provides \$3,000 sign-on bonuses plus up to \$15,000 retention over two years ⁽³⁾. International recruitment pipelines are also expanding—Newfoundland has 600+ internationally educated nurses in process ⁽¹¹⁾, and Nova Scotia's Kenya recruitment mission resulted in 65 continuing care assistants receiving conditional job offers ⁽¹²⁾.

Retention

BC's Provincial Rural Retention Incentive provides up to \$8,000/year across 74 communities ⁽⁴⁾. Permanent wage enhancements address churn in community care roles: Ontario implemented a permanent +\$3/hr increase for personal support workers and disability support workers ⁽⁵⁾, while Manitoba established a funded wage floor of approximately \$19/hr for Community Living disABILITY Services disability support workers ⁽⁶⁾. These wage measures specifically target the high turnover in community supports that has been particularly acute in rural areas.

Training

Paid "earn-while-you-learn" pipelines can help to expand the care workforce. BC's Health Career Access Program covers tuition and provides stipends for health care assistant training while employed ⁽⁷⁾. Nova Scotia's condensed 6-month continuing care assistant pilot graduated its first cohort in October 2024 ⁽⁸⁾. These pipeline models are directly transferable to disability home- and community-

support roles, though job titles vary across jurisdictions (disability support worker, continuing care assistant, health care assistant).

Outputs

Yukon reduced hospital nursing vacancies from 20.4% to 8.1% and reported no rural health-centre closures in 2024 ⁽⁹⁾. Saskatchewan placed 400+ professionals since 2022 with a 28% reduction in rural service disruptions ⁽¹⁰⁾.

Conclusions

The most effective approaches combine multiple strategies rather than relying on single interventions. Paid training pipelines address workforce supply while reducing financial barriers to entry. Targeted rural incentives with return-of-service requirements direct workers to underserved areas. Permanent wage increases instead of temporary bonuses appear critical for reducing turnover in community care roles. Finally, jurisdictions that publish transparent outputs metrics (vacancy rates, net hires, graduate retention) and outcomes are better positioned to track progress and adjust programming. Gaps remain as outputs and outcomes reporting is uneven and generally limited across provinces. Further, disability support worker recruitment lags behind nursing-focused initiatives.

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