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HEALTH ASSOCIATION NOVA SCOTIA

An Interjurisdictional Comparison of Continuing Care Services in Canada

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An Interjurisdictional Comparison of Continuing Care Services in Canada

Key Messages

- Continuing care services do not fall within the Canada Health Act, and therefore have developed in the 13 jurisdictions in a piecemeal way, creating what is often referred to as a patchwork quilt of services.
- Most jurisdictions in Canada use a decentralized approach to planning, management and delivery of home care services with the exception of PEI and Yukon; Nova Scotia is currently devolving management and delivery of continuing care services from the provincial Department of Health and Wellness to district health authorities (DHAs).
- Regardless of the governance and delivery model of continuing care, inadequacies in these services have direct implications for acute care settings. For example, alternate levels of care (ALC) patients accounted for 14% of hospital days in Canada in 2007-08, 60% of ALC days were attributed to those awaiting long term care placement, and of all ALC patients, those awaiting long-term care placement had longest median length of stay of 15 days (CIHI 2009).
- When compared to other jurisdictions, continuing care services in Nova Scotia generally have poor to mediocre performance on a variety of measures. For example:
    - Despite having the highest proportion of seniors, NS had the fourth lowest number of nursing home beds at 42.6 per 1000 of the senior population in 2009 (Canadian Policy Research Network, 2009). Nova Scotia nursing homes also had the 3rd highest occupancy rate in the country at 96.6% (Statistics Canada, 2011).
    - Despite having the third highest per capita spending on home care ($103 per capita), Nova Scotia serves the third lowest percentage of seniors, aged 65+ with home care services at 8.4%, and has the highest number of services not provided through home care compared to other jurisdictions (Canadian Policy Research Network, 2009).
    - Spending on facility based care is substantially higher than home care. In 2010 NS spent $532 per capita on facility-based care; this ranged from $261 per capita in BC to $791 per capita in Yukon. Paid hours per resident day in nursing homes varied from 3.6 hours in BC to 7.4 in the territories; NS had the fourth highest at 5.9 hours per resident day. However, this measure is not exclusive to nursing or paraprofessional care.
    - In 2009-10 there were 3230 new clients added to the waitlist for long-term care placement in Nova Scotia. Of these clients, 36% were in the community with no publicly funded home care, and 27% of clients were waiting in the community with publicly funded home care (Nova Scotia Department of Health and Wellness, 2010).
    - Unlike acute care settings, Accreditation is not mandatory for continuing care services, with the exception of long-term care facilities in Quebec and Alberta. Very few home care agencies are accredited in Nova Scotia. Anecdotal evidence suggests that the costs and lack of government funding are barriers to achieving accreditation.
    - However, Nova Scotia is currently the only province where government has implemented an entry to practice policy with standardized educational requirements through the Continuing Care Assistant program.

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Continuing care services do not fall within the Canada Health Act, and therefore have developed in the 13 jurisdictions in a piecemeal way creating what is often referred to as a patchwork quilt of services. This has created significant variation between the jurisdictions with respect to the range of services available, governance, allocated resources, accessibility and quality.

Governance

The governance model of home care varies, with most jurisdictions using a decentralized approach to planning, management and delivery of home care services.

- In British Columbia, Saskatchewan, Manitoba, New Brunswick, Newfoundland, North West Territories and Nunavut, the regional health authorities (RHAs) are provided with global funding from provincial governments. In Ontario, the Local Health Integration Networks (LHINs) and the Community Care Access Centres work together and, in Quebec, the RHAs work the Health and Social Services Centres to deliver home care services (Canadian Home Care Association, 2008).
- In PEI, Yukon and Nova Scotia, this occurs at the provincial level. However Nova Scotia is working towards integrating continuing care services with the DHAs (Canadian Home Care Association, 2008)[1].

Resources

Beds

- The number of nursing home beds per 1000 of the senior population varies greatly from 31.3 in Quebec to 60.9 in Manitoba (see table 1). As of 2009, Nova Scotia had 42.6 beds per 1000 seniors; however as part of the provincial Continuing Care strategy, the province plans on building new beds. This intent was echoed from all jurisdictions with the exception of Ontario (Canadian Policy Research Network, 2009).
- All jurisdictions in the province experience occupancy rates which near maximum capacity. The 2009-10 occupancy rates of nursing home beds, based on beds staffed and in operation, ranged from 90.8% in PEI to 98.1% in Manitoba and Quebec (see table 1). Nova Scotia's occupancy rate was 96.6% (Statistics Canada, 2011).

Expenditures

- Per capita spending on both facility based care and home care also varied greatly within the jurisdictions.
- Home care spending in 2003-04 ranged from $46 per capita to$156 per capita (see table 2), and has been increasing with 2005-06 per capita spending ranging from $82 to $198, or 1.56% to 6.8% of provincial budgets. (Canadian Institute for Health Information, 2007, Canadian Home Care Association, 2008).
- Spending on facility-based care in 2009-10 ranged from $261 per capita in BC to $791 per capita in Yukon (see table 1). Nova Scotia spent $532 per capita on facility based care in 2009-10[2] (CIHI, 2011).
- Expenditures per resident day in 2009-10 in residential care facilities also varied from $134 in PEI, to $334 in the territories. Nova Scotia spent $178 per resident day in 2009-10 (Statistics Canada, 2011).

[1] At the time of report Alberta was still operating with RHAs which delivered home care services (Canadian Home Care Association, 2008).

[2] Data on facility based care comes from the "Other Institutions" category which includes residential care types of facilities such as homes for the aged (including nursing homes), facilities for persons with physical disabilities, developmental delays, psychiatric disabilities, alcohol and drug problems, and facilities for emotionally disturbed children.

- New Brunswick, which has been highly regarded for its home care program known as the Extra-Mural program, has the highest per capita spending on home care ($156) and has one of the lowest rates of per capita spending on facility based care ($453).
- Despite having the third highest per capita spending on home care ($103 per capita), Nova Scotia has the longest lists of services not provided through home care (see table 2).

Staffing

- It has been recommended that each resident should receive 4.55 hours of total nursing care per resident day (Canadian Healthcare Association, 2009). As of 2008, Ontario did not have minimum staffing ratios, and New Brunswick's model of funding is based on 3.1 hours of care per resident (Canadian Healthcare Association, 2009).
- Data from 2001 indicates that staffing ratios are well below this recommended standard as Ontario provided 2.04 hours per resident day of nursing care, Saskatchewan provided 3.06 hours and Manitoba provided 2.44, with the majority hours being provided by paraprofessional nurses in all three provinces (Canadian Healthcare Association, 2009).).
- Paid hours per resident day in 2009-10 ranged from 3.6 in BC to 7.4 in the Territories (see table 1). Nova Scotia averaged 5.9 paid hours per resident day, however these hours are not exclusive to nursing services (Statistics Canada, 2011).
- There even appears to be variation intra-provincially. For example in BC nursing hours per resident day was dependent on the type of facility. In 2006 for- profit facilities provided 2.13 hours, not-for-profit, non-government facilities provided 2.48 hours and not-for-profit region owned facilities provided 3.3 hours or nursing care (Statistics Canada, 2010).
- The Canadian Healthcare Association has recommended pan-Canadian minimum staffing standards for long term care (Canadian Healthcare Association, 2009a).

Access

- There is generally a wide variation with respect to services offered, fees attached and eligibility criteria for home and facility based care.
- The percentage of the senior population that is served by home care is also quite variable. Nova Scotia, Newfoundland and British Columbia all provide less than 10% of their senior population with home care services (see table 2) (Canadian Policy Research Network, 2009). Given that Nova Scotia has the highest percentage of seniors (16.5%) in the country (Statistics Canada, 2011), and a high prevalence of chronic illness, the need for home care services is presumably greater than what is currently being provided. This is corroborated by the addition of 3230 clients to the waitlist for long-term care placement in 2009-10. Of these clients, 36% were in the community with no publicly funded home care, and 27% of clients were waiting in the community with publicly funded home care (Nova Scotia Department of Health and Wellness, 2010).
- Most jurisdictions (8) have upper service limits which vary. These limits may be based on hours, number of visits, type of professional providing care, or a common limit was until the costs of home care approximate or exceed the cost of facility based care (see table 2) (Canadian Healthcare Association, 2009).

- Whether co-payments are applied and how fees are determined is also variable. Five jurisdictions report no co-payments for home care; however, many apply fees to home support services (see table 2) (Canadian Healthcare Association, 2009).

Quality

- Lack of standardized measurement and data collection mechanisms is an issue. While the Minimum Data Set Resident Assessment Instrument (MDS-RAI) is available for both long-term care and home care clients, the level of uptake across the country varies. As of 2008, 8 of 13 jurisdictions had implemented or were planning on implementing the MDS-RAI for home care (Canadian Home Care Association, 2008).
- As of 2008, 8 of 13 jurisdictions reported that their home care programs had achieved or were planning to achieve accreditation. Accreditation for home care is mandatory only in Quebec, Manitoba and Newfoundland (Canadian Home Care Association, 2008). Very few home care agencies are accredited in Nova Scotia. However, home support agencies serving provincial home care program clients are audited to provincial government standards.
- As of 2007 there were 2577 total long term care facilities in Canada (Canadian Healthcare Association, 2009). In 2008 124 long term care homes were surveyed by Accreditation Canada (Canadian Healthcare Association, 2009). Although surveys through Accreditation Canada occurs every three years, and some facilities may choose a different accrediting body, this number suggests there is room for improvement. Accreditation for long term care is mandatory only Quebec and Alberta. In Ontario, funding is linked to accreditation and approximately 50% of long term care facilities are accredited. In Atlantic Canada funding is not tied to accreditation resulting in a smaller proportion of private facilities being accredited (Canadian Healthcare Association, 2009, 2011). Anecdotal evidence in Nova Scotia suggests that the costs and lack of government funding are barriers to achieving accreditation.
- While all jurisdictions require publicly funded facilities to be licenced thereby guaranteeing a minimum standard, there are variations in these standards and various levels of rigor in monitoring performance and adherence to standards (Canadian Healthcare Association, 2009). Nursing Homes and Residential Care facilities funded by the Nova Scotia Department of Health and Wellness are audited to departmental standards but Department of Community Services funded Adult Residential Centres and Regional Rehabilitation Centres (ARC/RRCs) are not. Only one ARC/RRC is accredited by Accreditation Canada.
- Paraprofessional staff, such as Personal Care Workers (PCWs) generally lack standard educational and training requirements for these positions (Canadian Healthcare Association, 2009). For example Nova Scotia is currently the only province where government has implemented an entry to practice policy with standardized educational requirements through the Continuing Care Assistant program and BC is the first province to establish a registry for home support workers (Canadian Research Network for Care in the Community, 2010). Residential Care Workers in ARCs and RRCs are not required to go through the same CCA curriculum required of LTC and home care workers. Rates of pay tend to be lower in this sector than in long-term care.

Table 1: Interjurisdictional Comparison of Facility Based Care in Canada

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	YT	NWT	NU
Number of nursing home beds per 1000 of the 65+ population	47.9	38.7	58.0	60.9	45.0	31.3	40.5	42.6	50.0	38.2	NA	NA	NA
Occupancy rate (homes for the aged)(09/10)	95.1%	95.0%	95.1%	98.1%	95.7%	98.1%	94.0%	96.6%	90.8%	85.9%	95.9%		
Per capita spending on "Other institutions"[3]	$261	$339	$570	$559	$307	$503	$453	$532	$460	$721	$791	$529	$752
Expenditures per resident day (homes for the aged)	$167.7	$201.8	$216.7	$180.2	$155.3	$254.3	$142.2	$178.1	$134.1	$158.3	$333.7		
Paid hours per resident day (homes for the aged)	3.6	5.3	6.1	5.6	4.0	7.1	4.5	5.9	4.5	4.5	7.4		

[3] Data on facility based care comes from the "Other Institutions" category which includes residential care types of facilities such as homes for the aged (including nursing homes), facilities for persons with physical disabilities, developmental delays, psychiatric disabilities, alcohol and drug problems, and facilities for emotionally disturbed children.

Table 2: Interjurisdictional Comparison of Home Care in Canada

	BC	AB	SK	MB	ON	QC	NB	NS	PE	NL	YT	NWT	NU
Percentage of 65+ served by home care program	8.8%	15.5%	17.4%	16.8%	18.4%	12.9%	18.4%	8.4%	5.9%	NA	NA		
Per Capita spending on home care [4]	$82	$87	$80	$140	$99	$79	$156	$105	$46	NA	$66	$62	$65
Services not provided through homecare	Nurse Practitioner (NP), Physician, pharmacy, speech and language pathology (SLP)	NP, physician, pharmacy	NP, SLP, Physician, Social work, pharmacy, respiratory therapy (RT), dietetics	NP, SLP, physician, pharmacy, dietetics	Physician, pharmacy	All services appear to be funded	NP	NP, physiotherapy (PT), occupational therapy (OT), SLP, social work, dietetics, physician, pharmacy	SLP, RT, NP, physician	Physician, pharmacy	NP, RT, dietetics, physician, pharmacy, self-managed care (SMC)	RT, SMC	NP, physician, pharmacy, RT
Limits to Care Provision	None	NA	None	Until costs approximate costs of placement in long-term care	Up to 60 hrs/ month of personal support and or homemaking, (120 hours for adults with physical disabilities). Nursing services up to 28 visits/ week or up to 53 hrs/ week[5] (varies depending on type of nurse	Until costs approximate costs of placement in long-term care	215 hours of home support	Until costs approximate costs of placement in long-term care	3 visits or 28 hours/ week (unless special permission is granted for more)	No limits for professional services, home support max is $2702/ month for seniors and $3875/ adults with disabilities	35 hours of home support/ week with no more than 2 visits of a professional staff a day	NA	None

[4] CIHI data from 2003-04

[5] Varies depending on type of nurse. 53 hours are allowed for RPN, 48 for a combination of RN and RPN and 43 hours for an RN

Co-payments	Income testing, home support fees capped at $300 per month	Income testing, home support fees are $5 per hour up to $300 per month	$6.96 per unit[6] up to 10 units per months, after which fees are based on ability to pay	Fees for adult day care, meals on wheels and facility respite, otherwise no fees to home care services	No co-payments or income testing for those who have been assessed as needing home care	No co-payments or income testing for those who have been assessed as needing home care	Income testing, client contribution based on income	Income testing, below a certain income category no fees. The maximum fee is dependent on client income and family size	No co-payments for home support, clients must pay for medication supplies and equipment	No income testing for those in need of professional services, income testing is required for home support and supplies, medication and equipment	No income testing, no direct fees. Clients must pay for supplies and equipment unless palliative or over the age of 65 or registered in Chronic Disease program	No income testing and no charges. Supplies, equipment and medication paid for privately (e.g. user pays, private insurance or non-insured health benefits)

[6] One unit is equivalent to one hour of service or one meal.

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