

Facility-Based Long-term Care in Canada:
Examining the Potential for a Federal Role in
Improving Quality and Consistency of Access

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EXECUTIVE SUMMARY

The federal government has oversight capacity to ensure quality, sustainability, and accessibility of the facility-based long-term care (LTC) system, by promoting federal-provincial-territorial discussion and planning. The delivery of facility-based LTC falls under the jurisdictional authority of health departments and ministries in provincial and territorial governments. In some jurisdictions, governments have further delegated the authority to deliver facility-based LTC to regional health authorities. Provinces and territories put in place respective policies, legislation and guidelines to determine how to fund, design, and manage the service (Health Canada, 2010a; Berta, Laporte, Zarnett, Valdmanis & Anderson). As a result, there are differences across the country in the terminology, facility ownership patterns, and levels of access to public not-for-profit facility-based LTC. There is also variation in education, training, and staffing standards for human resources. Given the demographic pressures experienced in many jurisdictions, provincial and territorial governments must strategize and make decisions on how to address the needs of aging populations, through facility-based and other LTC options.

This project is geared towards the information and research needs of the Chronic and Continuing Care Division (CCCD) of Health Canada. The scope of this paper is limited to the oversight role of Health Canada in facility-based LTC. The objective of this report is to examine how Health Canada can liaise and facilitate discussion with provincial and territorial health departments and ministries, to promote greater quality and accessibility in facility-based LTC.

Summary of Methods

The data sources used to inform the report were a literature review, jurisdictional scan, and survey interview. The aim of the literature review was to identify perspectives as to how various factors impact quality and accessibility in facility-based LTC, and to gain an understanding of how recent trends in the LTC landscape have impacted facility-based LTC. Information from the jurisdictions was reviewed with the aim of making broad comparisons in facility-based LTC across Canada, specific to identifying quality and accessibility issues. Survey interviews were conducted to substantiate the results and findings from the literature review and jurisdictional scan, rather than to inform new results. The names of organizations were not used within this report, as per the Ethics parameters that were negotiated prior to commencement of the project.

Results

Based on the literature review, the following areas have a significant impact on quality and accessibility of facility-based LTC:

- Standards
- Accreditation
- Human Resources
- Reciprocity/Portability

- Research

The jurisdictional scan indicated that certain quality and accessibility issues are common across provincial-territorial jurisdictions. There is uneven access to facility-based LTC across Canada, and challenges in accessibility are more pronounced in northern and rural areas. There are uneven levels of training and education for paraprofessional workforce across jurisdictions. Staffing levels and staffing mix are often inadequate, and do not reflect the higher and more complex care needs of the average resident. Recruitment and retention of the LTC workforce is a significant challenge faced across the sector. Many provincial and territorial LTC strategies have increased emphasis on LTC services received in the home and the community, to alleviate demand on facility-based LTC. Interviews with respondents helped to substantiate the findings of the literature review and jurisdictional scan. The results of survey interviews with respondents were consistent with the findings of the jurisdictional scan. Both the survey interviews and jurisdictional scan found certain challenges to be commonly experienced in the sector, such as increased resident acuity, lack of research, inadequate staffing levels, recruitment and retention, and training and education of the workforce. Both the literature review and the survey interviews highlighted that residents experience difficulty when they relocate across jurisdictions, because there are different admission requirements in each jurisdiction. As well, personal support workers (PSWs) who work in facility-based LTC staff are faced with barriers if they wish to migrate across jurisdictional borders. There is not a pan-Canadian standardized curriculum for PSWs, and education and training requirements differ across jurisdictions.

Recommendations

Four recommendations were developed to improve quality and accessibility of facility-based LTC:

- Establish mandatory accreditation for LTC facilities
- Develop pan-Canadian staffing models
- Develop a pan-Canadian curriculum for Personal Support Workers (PSWs)
- Promote discussion and research on dementia
- Promote portability and reciprocity of services among the provinces and territories

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INTRODUCTION

While provincial and territorial governments are responsible for the delivery of facility-based long-term care (LTC), the federal government has the oversight capacity to ensure quality, sustainability, and accessibility of the system. Facility-based LTC is provided to those in need of high levels of personal care including 24-hour professional nursing care or supervision, assistance with activities of daily living, and a secure environment (Berta, Laporte, Zarnett, Valdmanis & Anderson). This report will use the term quality to refer to excellence in clinical outcomes for facility-based LTC residents, as well as to quality of life for residents and staff, as determined by resident and staff satisfaction. This definition was developed in alignment with discussions of quality in national reports by the Canadian Healthcare Association (2009), Canadian Union of Public Employees (2009), and in the literature by Mor (2005) and Levenson (2009). Increasingly, it has been recognized that resident and staff satisfaction are significant determinants of quality, and should be taken into consideration (A Report of the Independent Review, 2008; LeRoy, Treanor & Art, 2010). Accessibility refers to the degree to which clients can access publicly-funded facility-based LTC, including users of the system who require specialized care. Specialized care includes culturally-sensitive care, or care for residents with Alzheimer's disease and other forms of dementia. Accessibility is impacted by factors including admission requirements, geographic location, availability of publicly-funded beds versus demand, and cost (CHA, 2009).

Given that provinces, territories, and health authorities administer health services, the federal government is removed from the service delivery aspect of facility-based LTC. An exception to this rule is specific components of the Canadian populations, for which the federal government retains jurisdictional responsibility to administer LTC. This includes current members and veterans of the Armed Forces, First Nations and Inuit communities on reserves, members of the Royal Canadian Mounted Police, and individuals in correctional institutions (SSCA, 2009; Commission on the Future of Health Care in Canada, 2002). The Government of Canada has made significant progress in its objectives regarding LTC for specific populations under its jurisdictional authority, through Veterans Affairs Canada, Health Canada, and Indian and Northern Affairs Canada. This aspect of the federal role is not in the direct scope of this research. This paper will examine the federal government's role (and specifically, the role of the Chronic and Continuing Care Division of Health Canada) in initiating partnerships and promoting discussion with provincial and territorial jurisdictions. Through these actions, the federal government can encourage the development and implementation of policies by the provinces and territories that will promote greater consistency in accessibility and quality of facility-based LTC across Canada.

There is not a single national plan that governs facility-based LTC, since provinces and territories develop their own facility-based LTC strategies, legislative frameworks, and guidelines to determine the design and administration of the service in the given jurisdiction. As a result, there is little consistency across Canada in facility-based LTC. The LTC system has evolved into what has been referred to as a "patchwork quilt" of provincial and territorial systems (CHA, 2009; NUPGE, 2007; Levine, Halper, Peist & Gould, 2010; Sholzberg-Gray, 2008). These differences are significant, because they have an impact on the accessibility and comparability of quality of facility-based LTC across Canadian jurisdictions. Provincial and

territorial governments require flexibility to deliver health care services in a way that reflects regional realities, and unique challenges faced by specific jurisdictions (CHA, 2009). There are differences across the country in the terminology used to describe 24-hour, professional care administered in long-term care facilities, which makes it difficult for industry stakeholders, researchers, LTC clients, and the public to identify comparable services across jurisdictions. There is variation in almost all aspects of the facility-based LTC system across the country. This includes the level and type of care that is offered in facilities. Level 1-2 refers to care that entails minimal assistance with the activities of daily living, and the provision of professional health care services when required. Level 3-4 denotes higher and more complex care requirements, which may include significant cognitive or physical impairment, including 24-hour professional care, and significant assistance required with activities of daily living. This type of care is usually provided in facility-based LTC. It also extends to how standards of care are measured, how facilities are governed, and facility ownership patterns (facilities may be not-for-profit, government-owned and/or operated, private not-for-profit, and private for-profit) (Health Canada, 2004; Canadian Healthcare Association (CHA), 2009).

Further, there are inconsistencies in levels of access to public not-for-profit facility-based LTC, because of differences in capacity across jurisdictions versus demand for services. Also, there is a wide range in resident fees and admission requirements (Berta et al., 2006; CHA, 2009; Canadian Union of Public Employees (CUPE), 2009; National Union of Public and General Employees (NUPGE), 2007). These include physical eligibility requirements that a client must meet in order to be assessed as eligible for facility-based LTC, as well as provincial or territorial residency requirements. Physical eligibility requirements refers to the requirement that an individual have care needs that are high and complex enough to warrant admission to facility-based LTC, and which could not be met by another lower-level LTC service. There are differences in access to end-of-life care across the country. There are often limited and uncoordinated end-of-life services available to residents within the facility-based LTC system when they require it, and access to end-of-life services varies as a result of uneven capacity across jurisdictions (Wilson et al., 2008).

Lastly, widespread differences are apparent across jurisdictions regarding education, training, and staffing standards for human resources in facility-based LTC (CHA, 2009; Special Senate Committee on Aging (SSCA), 2009; Canadian Nurses Association, 2008). The facility-based LTC workforce is composed of professional and paraprofessional workers. Professional workers in facility-based LTC setting are: registered nurses (RNs), physiotherapists, physicians, occupational therapists, dieticians, and licensed practical nurses (LPNs). Paraprofessional workers are: nurse aides and health care aides (HCAs), who are sometimes referred to as personal support workers (PSWs), depending on the jurisdiction, and will be referred to as such for the purposes of this paper. Increasingly, the paraprofessional workforce is providing more care to residents, under the supervision of RNs and LPNs, as opposed to this care being provided by the professional workforce (CHA, 2009). For this reason, it is particularly relevant to focus attention to training and education for the paraprofessional component of the workforce. In the long-term care environment, the term paraprofessional encapsulates personal support workers (PSWs), health care aides, long-term care aides, nurse aides, personal aides, and personal care attendants (Stone, 2000).

This paper focuses on LTC that is administered in publicly-owned facilities that provide 24-hour care, including on-site professional care, seven days a week to frail seniors and to other individuals who cannot remain in other living accommodations by virtue of their high care needs. This type of care is referred to by various nomenclature across Canada, including nursing homes, residential care facilities, continuing care facilities, special care homes, personal care homes, and long-term care homes. This report will use the term *facility-based long-term care* to refer to all of these. Provinces and territories often categorize facility-based LTC into accommodation, hospitality, and health services (CHA, 2009). Accommodation, (which is also referred to as *lodging, hotel services, or room and board*) includes the provision of meals and other food, laundry, housekeeping, and maintenance (CHA, 2009; Ministry of Health and Long-term Care (MHLTC), 2010a). Personal clothing, personal items, and special off-site transportation are generally excluded from the accommodation component of care (CHA, 2009), and in most cases, residents pay extra fees to receive these services. *Hospitality services* include recreation programs and social activities that are administered by the facility (CHA, 2009). *Health services* are composed of on-site, 24-hour professional nursing services and assistance with the activities of daily living including eating, personal hygiene, ambulating, and the provision of basic safety (CHA, 2009). What is encapsulated under *health services* has implications for resident co-payments, since, in many jurisdictions, the provincial or territorial government covers the cost of health services, while the resident must pay for the accommodation portion of their care. Facility-based LTC is divided differently across jurisdictions, which affects which services are covered under the given provincial or territorial plan and which are excluded.

An increased demand for facility-based LTC has been observed across Canada (National Advisory Council on Aging, 2006; Canadian Nurses Association, 2008; CUPE, 2009; CHA, 2009; Berta et al., 2005; Health Review Steering Committee, 2008; Manitoba Nurses Union, 2006; Ontario Health Coalition, 2008; Auditor General of Alberta, 2005). Given the demographic pressures experienced in many jurisdictions, provincial and territorial governments must strategize and make decisions on how to address the needs of aging populations through facility-based LTC and the broader continuing care continuum. Information gleaned from review of Canadian jurisdictions reveals a policy shift, increasingly, towards receiving LTC services in the home and community, as opposed to in a facility-based setting. This was observed by the prevalence of *aging in place* philosophies across jurisdictions (Alberta Health and Wellness, 2008a; BC Ministry of Health Services, 2005; Manitoba Health, 2009a; MHLTC, 2007; PEI Health and Wellness, 2009a).

Residents in LTC facilities are increasingly characterized by more complex physical and mental health issues (Laporte & Valdmanis, 2005; Wilson & Truman, 2004; CHA, 2009), which has implications across the sector. Increasingly, there is delayed admission to facility-based LTC until individuals are nearing the end of their lives (CHA, 2009). Increased resident acuity in facility-based LTC may be attributed, in part, to individuals with increasingly complex and heavy care needs being directed from health settings such as mental health facilities and hospitals to facility-based LTC (Ontario Health Coalition, 2008). In some situations, younger people with disabilities are moved to LTC facilities because they do not have access to adequate home care and community supports (Ontario Health Coalition, 2008). Increased resident acuity means the workforce is faced with a higher workload, because staff

must spend more hours providing care to each resident (Manitoba Nurses Union, 2006). Some provincial funding requirements allocate funds to facilities based on a resident's care needs; the higher the care needs, the more money that is allocated. As a result, higher resident acuity requires increased funding from provincial and territorial governments to subsidize health care costs per resident (CHA, 2009; NUPGE, 2007; Ontario Health Coalition, 2008).

Certain national health organizations, service organizations, and researchers have expressed concern about the desirability and implications of the significant differences in facility-based LTC across jurisdictions (CHA, 2009; Berta et al., 2006; CUPE, 2009; NUPGE, 2007). Researchers, national organizations, and LTC associations have expressed support for an increased federal role in LTC, through supporting and collaborating with provincial and territorial governments. In their 2009 report, *Canada's Aging Population: Seizing the Opportunity*, the Special Senate Committee on Aging stated that the Government of Canada has the potential to act as a catalyst and motivator to realize progress in the facility-based LTC system. In their 2009 report, *New Directions for Facility-Based Long Term Care*, (henceforth referred to as *New Directions*) the Canadian Healthcare Association (CHA) supported a greater federal role in facility-based LTC, in supporting provincial-territorial jurisdictions in ensuring that the system is equipped to address the needs of an aging Canadian population (CHA, 2009). As well, in *New Directions*, the CHA expressed a desire for a federal role in promoting and encouraging provincial-territorial discussion to formulate a national vision for facility-based LTC (CHA, 2009). The recommendations formulated by the CHA in *New Directions* were broadly supported in other pan-Canadian LTC research. As well, the National Advisory Council on Aging (2006), CUPE (2009), and the National Union of Public and General Employees (NUPGE) (2007) expressed support for the CHA recommendations. The expiration of the Government of Canada's Ten-year Plan on health care renewal in 2013-2014, combined with demographic pressure make it timely and relevant for Health Canada to re-open federal-provincial-territorial dialogue on LTC in upcoming years, and to consider new commitments to improve facility-based LTC.

Health Canada has an interest in ensuring that high quality, accessible, facility-based LTC is provided consistently across Canada. This paper focuses on the oversight capacity of Health Canada in facility-based LTC, and examines how Health Canada can facilitate federal-provincial-territorial discussion on facility-based LTC, and encourage policies that support quality and accessibility of facility-based LTC in Canada.

This report identifies trends, strengths, and challenges in facility-based LTC to gain an understanding of current policy issues faced by the Canadian sector. The report draws on research and literature produced on the sector, information available from Canadian jurisdictions, and survey interviews with individuals from provincial and territorial government, service organizations, LTC associations and national health organizations. This report focuses on publicly-funded facility-based LTC (care that includes 24-hour professional nursing and personal care), but other types of LTC are discussed to a lesser extent, because they have an impact on facility-based LTC.

This project presents recommendations for a greater federal role in facility-based LTC, in accordance with the jurisdictional authority of the provinces and territories in LTC and the capacity of the federal government to adopt policy in this area. For purposes of this report it is

assumed that LTC should be delivered in a manner consistent with the five principles of Medicare:

- Universality
- Accessibility
- Comprehensiveness
- Portability
- Public administration

As well, this report will consider quality as a sixth principle to be considered for facility-based LTC.

The implications of these principles for the facility-based LTC system are as follows:

- The system should be accessible to all individuals who are assessed as requiring a facility-based LTC level of care, regardless of where they reside.
- Individuals should experience comparable access to public facility-based LTC services regardless of the jurisdiction in which they reside, and should have access to the service without facing a significant wait time.
- Provincial or territorial governments should offer comprehensive not-for-profit facility-based LTC services, that include all medically necessary services, and should provide subsidies to cover all necessary health care services when it is determined that a subsidy is required.
- Individuals should be able to relocate from one jurisdiction to another, without experiencing significant barriers in receiving facility-based LTC in a new jurisdiction.
- The facility-based LTC workforce should be able to relocate across jurisdictions without experiencing reduced access to job opportunities because of differences in training and education standards.
- The facility-based LTC system of a province or territory should be administered and operated in a not-for-profit basis by a public authority that is responsible to the provincial or territorial government, or where services are administered by a for-profit entity, they should be of the same quality as not-for-profit facilities and should continue to be subject to provincial or territorial quality standards.
- There is a high quality of publicly funded facility-based LTC available, regardless of where it is provided in Canada or within a jurisdiction.

Recommendations developed as part of this report were oriented to the above criteria.

Client Background

This project is geared towards the research and information needs of the Chronic and Continuing Care Division (CCCD) of Health Canada. The CCCD provides analytical and policy leadership on primary health care, continuing care, and e-Health (Health Canada, 2009). The Division monitors the health care system in these areas, identifies policy issues, and provides policy analysis and strategic advice as to federal or federal-provincial-territorial implications and action (Health Canada, 2009). The Division has the capacity to contribute to the advancement of federal-provincial-territorial policy priorities through a range of mechanisms, such as through Federal-provincial-territorial Advisory Committees (Health Canada, 2009). Division staff participate in national initiatives in policy development, in collaboration with other governments and partners (Health Canada, 2009). Health Canada is engaged in research and policy analysis pertaining to facility-based LTC, regarding issues such as population aging, service delivery models of facility-based LTC, quality of care and quality of life, access and affordability of care, and human resources issues (Health Canada, 2004).

Report Structure

This paper presents findings from the literature review, a jurisdictional scan, and key informant interviews. The report reviews literature that has been produced on facility-based LTC to examine how various factors impact quality, provides an overview of trends and challenges, and discusses policy implications in order to make recommendations to the client, the CCCD of Health Canada.

BACKGROUND

Two kinds of background information provide the foundation for this study. The first is an overview of the recent evolution of facility-based long-term care (LTC) in Canada, noting the effect of recent national health care reforms. The second identifies trends and themes that have shaped the LTC landscape in Canada.

The Evolution of Long-term Care in Canada

Legislative Framework

Health is not a single area assigned exclusively to one level of government under the *Constitution Act* of 1867 (Privy Council Office, 2010). Health traverses levels of government, and may be addressed by federal or provincial legislation, depending on the health issue involved (Privy Council Office, 2010). However, jurisdiction to deliver health care services to individuals lies primarily with the provinces (Privy Council Office, 2010). Most provinces and territories have delegated service delivery to administer facility-based LTC to local service providers or regional health authorities (Berta et al., 2006). Health authorities develop policies on facility-based LTC in their own regions. The *Canada Health Act* delineates two types of health services, *insured health services*, which refer to hospital, physician, and surgical-dental services, and *extended health services*, which include nursing home intermediate care, adult facility-based LTC, home care, and ambulatory health care services (Canada Health Act, 1985,

s. 2). The *Canada Health Act* reiterates the five principles of Medicare (Canada Health Act, 1985, s. 7), adherence to which is a precondition to receiving federal transfers for insured services; however as LTC is not an insured service, the five principles do not (under the CHA) apply to LTC. The federal government provides funding for LTC through block funding to the provinces and territories for health care sectors, including LTC (Berta et al., 2006). Individuals who require facility-based LTC pay a portion of the cost of LTC themselves, to supplement the provincial or territorial health insurance plan. This out-of-pocket fee, commonly referred to as a *co-payment*, varies across the country based on the given provincial and territorial plan (CHA, 2009). The rationale for this co-payment (in most provinces/territories) is that residents, if living independently, would pay for their basic cost of living (food, shelter, clothing, personal items); therefore public funding is usually intended to cover just the portion of LTC costs that relates to health care, not the portion that relates to basic costs of living.

Recent Health Care Reform

In September 2000, First Ministers¹ agreed on a shared vision, principles and an action plan for health care renewal (Health Canada, 2003). This was followed by the establishment of priorities and setting an agenda for health system renewal in the 2003 First Ministers' Health Accord on Health Care Renewal (henceforth referred to as *the Accord*). The priorities for reform, as identified through the 2000 First Ministers' agreement, were primary health care, home care, catastrophic drug coverage, access to diagnostic/medical equipment, information technology and establishment of electronic health records (Health Canada, 2003). The Accord reaffirmed the Government's commitment to the five principles of health insurance: universality, accessibility, portability, comprehensiveness and public administration. Based on the 2003 Accord, investments have been made across jurisdictions to enhance the responsiveness, accessibility and sustainability of the health system. Moreover, federal, provincial and territorial governments have commissioned numerous task forces and studies that reflect the need for reform, as acknowledged through the Accord.

The 2003 First Ministers' Accord was followed by a First Ministers Meeting in 2004, which informed the development of the *Government of Canada's Ten-year Plan to Strengthen Health Care*. The plan covers the period from 2004/2005-2013/2014 (Health Canada, 2003). The plan provides first-dollar coverage for the following specific home care services: case management, intravenous medications related to the discharge diagnosis, nursing and personal care for short-term acute home care (two weeks), case management and crisis response services for short-term acute community mental health home care (two weeks), and; end-of-life care for case management, nursing, palliative-specific pharmaceuticals and personal care at the end-of-life. Federal, provincial and territorial governments agreed to increase the supply of health professionals including development of targets for training, recruitment, and retention of professionals. A five-year \$16 million Health Reform Fund was established to further initiatives identified through the Accord, and to transfer targeted resources to the provinces and territories towards for various initiatives. The initiatives are as follows: increasing the supply of health professionals, community-based services including home care, a national

¹ The term first ministers refers to the prime minister of Canada and the 13 premiers of the provinces and territories of Canada. The term is used frequently when the prime minister and the premiers meet on issues of national importance with an impact on both federal and provincial jurisdictions, such as health care reform.

pharmaceuticals strategy, health promotion and disease prevention, and catastrophic drug coverage. The design of the Health Reform Fund ensures provincial and territorial leaders have the resources required to achieve common objectives, while ensuring they have the necessary flexibility and discretion to utilize the funds for any program described within the parameters of the Fund (Health Canada, 2003). Federal, provincial, and territorial governments have made headway in implementing the commitments under the 2004 Accord. Completed commitments include: establishment and implementation of a diagnostic/medical equipment fund to improve access to publicly funded diagnostic services and to reduce waiting times, and the development of the Health Council, which will monitor and make public reports on the implementation of the Accord. With federal funding, governments have launched initiatives to improve recruitment and retention of health care professionals, by integrating more internationally educated health care graduates into Canada's health care system. Governments are developing a framework for pan-Canadian health workforce planning. Outstanding commitments which have not yet been implemented in the provinces and territories include realizing first-dollar coverage for a basket of home care services and catastrophic drug coverage (Health Canada, 2006).

Though the First Ministers' Accord and Ten-year Plan did not make commitments towards facility-based LTC, the Accord evidenced the capacity of the federal government to initiate federal-provincial-territorial action in health care by facilitating discussion among jurisdictions, agreeing on shared principles, and promoting policies through the transfer of resources. There has been minimal movement on the federal-provincial-territorial LTC partnership outside of the 2003 Accord and the 2003/2004 Ten-year Plan. Given that the Ten-year Plan will expire in 2014, it is timely for the Government to consider a long-term commitment to facility-based LTC.

There have been comprehensive national reports published in the last decade on health care in Canada. In 2002, the Commission on the Future of Health Care in Canada published their final report, *Building on Values: the Future of Health Care in Canada* (hereon in referred to as *the Romanow Report*). The Commission, led by Roy J. Romanow, was established by Order-in-Council to recommend federal policies that ensured the sustainability and accessibility of the publicly-funded health system. The Romanow Commission did not make recommendations in the area of facility-based LTC, although it touched on other aspects of the LTC system, such as provision of support to informal caregivers and home care programs (Commission on the Future Health Care, 2002). The Report recommended expansion of insured health services under the *Canada Health Act* to include federal coverage for post-acute and palliative home care services (Commission on the Future Health Care, 2002). The Report drew from previous research and expressed support for enhancing co-ordination and linkages between home care providers and other health care providers in the primary and LTC sectors (Commission on the Future of Health Care, 2002). The Report recommended review of education and training programs for health care providers in the primary health care sector, and the use of the Rural and Remote Access Fund to address recruitment and retention challenges among health care providers (Commission on the Future Health Care, 2002). The Report helped set the agenda for the 2003 First Ministers' Health Accord and the consequent Ten-year Plan on health care renewal (Health Canada, 2003).

The 2002 Report of the Standing Senate Committee on Social Affairs, Science and Technology, *the Health of Canadians- The Federal Role: The Final Report on the State of the Health Care System in Canada* (commonly referred to as the Kirby Report), made recommendations for health system renewal. The Kirby Report noted the need to address further federal attention to a national palliative care strategy and expansion of home care coverage, but omitted any specific mention of facility-based LTC.

The Oncoming Cohort of Seniors

The cohort of seniors² in the Canadian population is growing at a significant rate. Individuals 65 and over made up nearly 14% of Canada's population in 2006 (Statistics Canada, 2007). Women continue to constitute the majority of the senior population in Canada, as 56% of Canadians aged 65 and over in 2006 were females (Statistics Canada, 2007). Baby-boomers, people born between 1946 and 1965, remained the largest population cohort in Canada as of 2006 (Statistics Canada, 2007). It is expected that baby-boomers will live longer than previous generations and will have different and higher expectations about the publicly-funded LTC system (CHA, 2009). It is anticipated that baby-boomers will be less accepting of an institutional setting, structured schedules, limited dining hours, and long waitlists for care; and will have high expectations about quality of care (CHA, 2009; Denton & Zeytinoglu, 2010). An growing demographic of seniors has implications for future LTC demand, service delivery models, and system cost projections. In their recent study, the Alzheimer Society of Canada concluded that based on historical trends, the total number of LTC beds in Canada is forecast to grow from approximately 280,000 beds in 2008 to 690,000 in 2038 (Alzheimer Society of Canada, 2010). This shortfall may be offset by increased demand for community-based services (Alzheimer Society of Canada, 2010). A degree of uncertainty pervades the literature as to the exact impact the baby boomers will exert on the long-term sector in Canada (Berta et al., 2006).

Demographic pressure has potential repercussions for access to facility-based LTC. If provinces and territories have insufficient capacity to meet the demands of their aging populations, users of the system will face significant wait times before they are able to access the care they require. National health care associations, service organizations, and seniors' organizations see access as a significant challenge experienced in many jurisdictions in Canada because of increased demand and a limited supply of facility-based LTC (CHA, 2009; CUPE, 2009; NUPGE, 2007; National Advisory Council on Aging, 2006). It is difficult to procure exact or current information on wait lists for facility-based LTC, but based on provincial and territorial estimates, it can be deduced that there is a significant gap between supply of public facility-based LTC beds and demand (NUPGE, 2007). The CHA noted that a capacity shortage is experienced in both urban and rural regions of Canada (CHA, 2009).

The Federal Role in Long-term Care

The Government of Canada provides facility-based LTC for qualifying veterans through Veterans Affairs Canada (VAC). However, the role of VAC primarily consists of monitoring

² For the purposes of this paper, the term senior refers to individuals aged 65 and older. This is based on a general consensus in Canadian literature and in government documents.

and oversight, because in the large majority of cases, the federal government does not directly provide services. In fact, there remains only one facility still under direct administration of the federal government, Ste. Anne's Hospital, in Quebec (Veterans Affairs Canada, 2010). Outside of this exception, VAC enters into purchase-of-service agreements or transfer agreements with health care facilities or regional health organizations that are administered and funded by the provinces.

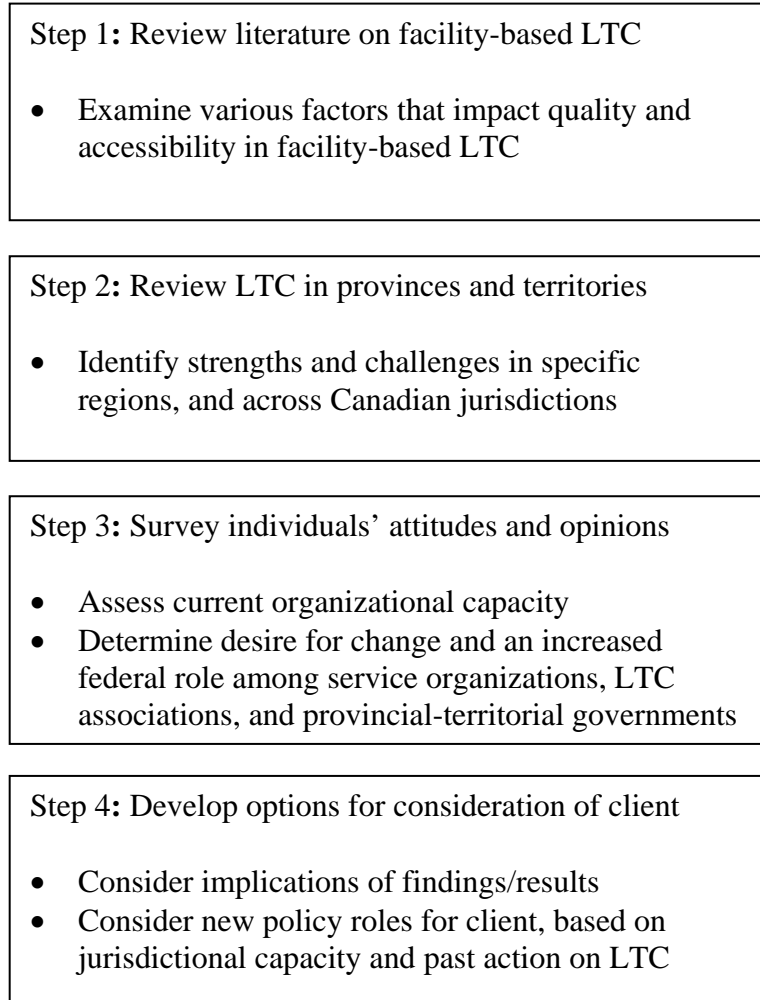
Indian and Northern Affairs Canada (INAC) funds lower-level LTC (levels 1 and 2) for First Nations and Inuit communities on reserves through the First Nations and Inuit Home and Community Care (FNIHCC) program of Health Canada (Health Canada, 2005). The intent of the FNIHCC is to provide First Nations and Inuit communities with quality care in their own homes and communities that reflects the cultural values and individual needs of First Nations and Inuit communities (Health Canada, 2005). The federal government collaborates with local service providers by entering into contribution agreements, and transferring funds to partner organizations that provide services on the government's behalf (Health Canada, 2005). The federal government does not have the authority to deliver higher-level (levels 3 and 4) facility-based LTC services to Aboriginals, as this authority is considered the responsibility of provincial and territorial governments or health authorities (Indian and Northern Affairs Canada, 2008; Assembly of First Nations, 2007). Provinces (with the exceptions of Québec and Newfoundland Labrador) generally do not provide on-reserve services to First Nations, noting that this is a federal responsibility. Individuals requiring higher levels of care may leave their communities to obtain necessary care in provincial/territorial or private institutions outside of their communities. Alternatively, they may remain in their communities where services may not be sufficient to fully meet their care needs (Health Canada, 2008b).

In addition to having direct service responsibility to the specific, abovementioned populations of Canadians, the federal government has the capacity to promote policy in facility-based LTC by facilitating federal-provincial-territorial partnerships. The oversight and leadership facet of the federal role is the focus of this report.

METHODS

This section describes the methodology used for the literature review, jurisdictional scan and survey interviews. As Figure 1 shows, this research draws on data from three sources: literature, publicly-available information from federal-provincial-territorial jurisdictions, and survey interviews.

Figure 1. Project Methods and Objectives



Literature Review

The methodology used for the literature review was to focus on high-level topics within the scope of the project, with a particular strategy of focusing on areas where Health Canada has the potential to formulate policy. Taking into consideration this guideline, certain topics that undoubtedly impact quality and accessibility of facility-based LTC were omitted, including a discussion of cultural change models, physical design of LTC facilities, resident-family councils, and wait list policies. Academic literature was found in the following way. Initially, pan-Canadian research on facility-based LTC was identified and reviewed. Because there is limited pan-Canadian data on LTC, other relevant research was used as well, even if it was particular to a certain jurisdiction. In order to procure pan-Canadian LTC articles, search words such as “LTC in Canada,” “facility-based LTC in Canada,” and “pan-Canadian LTC” were used. The search engines were accessed through the University of Victoria online library website; predominantly through EBSCO. More specific articles were used towards the end of the research, after more general, high-level research on LTC in Canada had been completed. For example, specific research on accreditation was sought after it had been shown in prior research that accreditation was a relevant topic in association with quality assurance. The sources used included literature by researchers in the field, including from the following journals: *Canadian Journal on Aging*, *the Milbank Quarterly: A Journal of Public Health and Health Care Policy*, and the *Canadian Medical Association Journal*. Articles from research centers such as the *Canadian Centre for Policy Alternatives* were used.

In addition to academic research, the literature review drew on national research on facility-based LTC, and national health care and seniors’ organizations such as the CHA, the Alzheimer Society of Canada, and Canadian Institute for Health Information (CIHI). These sources helped to gain a pan-Canadian view of facility-based LTC and overarching strengths and challenges experienced across jurisdictions. In certain cases, the literature review referred to sources from the jurisdictions to support that a particular issue was experienced across the country. These sources were found by identifying relevant organizations and searching their web site to check for recent and relevant publications. These web sites also gave links to related web sites, which was useful in gaining access to further information.

Jurisdictional Scan

The purpose of the jurisdictional scan was to understand how the administration of facility-based LTC differs across jurisdictions, and specifically to understand how these differences impact quality and accessibility. Public documents were used. Provincial and territorial LTC strategies, available from government websites, were used as a starting point. In addition, the jurisdictional scan drew on reports, media releases, and position papers from provincial LTC associations and employees’ unions. These sources were useful in gaining an understanding of stakeholders’ viewpoints of the strengths and challenges of facility-based LTC in each jurisdiction. In certain jurisdictions, provincial governments commissioned research on LTC to identify strengths and weaknesses of the system. These reports were valuable and informative sources. Reports from provincial Auditors General, and from Ombuds offices were used, in cases where relevant reports were available.

Survey Interviews

Interviews were conducted to obtain evidence from credible sources to help substantiate the findings of the literature review, and to appraise the attitudes and positions of individuals with knowledge and expertise in facility-based LTC in their region, and/or across Canada. Interviews helped to understand the perspectives of diverse organizations, including provincial/territorial governments, on prominent pan-Canadian policy issues in the facility-based LTC sector. The interviews were used to support and confirm the results from public data sources. In a few cases, information from interviews was used to help demonstrate that a policy issue was prevalent in a certain region. The same five pre-set questions were administered to respondents. The questions were designed by the researcher and reviewed by the client. The interviews took place over the phone, with two exceptions, where respondents stated that as a result of time constraints, they were unable to schedule a phone interview but were willing to respond to the five interview questions via email. These answers were considered acceptable as part of the interview responses. The research received ethics approval from the University of Victoria. The survey questions are included in Appendix A. A copy of the ethics approval obtained is included in Appendix B.

Recruiting Participants

An initial contact list was assembled by the client. The researcher added organizations to this list, which were approved by the client. Contact information was located using online searches. Searches were performed for job titles under relevant branches of provincial-territorial ministries/departments using provincial-territorial online government employee directories. A complete list of organizations that were contacted and interviewed is included in Appendix C.

Government respondents were selected from the department, ministry, or secretariat responsible for administering facility-based LTC. Respondents were selected from national health organizations where the associations were directly related to facility-based LTC. Respondents held senior positions in LTC organizations, such as President, Director of Policy, Executive Director, Chief Executive Officer, CEO, and gerontologist. Individuals contacted from government ministries, departments, or secretariats included Senior Policy Analysts and LTC consultants. One Assistant Deputy Minister of Operations was contacted, because it was not possible to speak to an individual who worked in a policy and planning position. Attempts were made to contact all Provincial/Territorial LTC associations where they existed. The Saskatchewan Association of Hospital Organizations was contacted because Saskatchewan had no LTC organization. In circumstances where individuals from governments refused to participate, other organizations were contacted to ascertain the regional perspective. This was the case in Quebec, where the Counsel on Aging was contacted.

Once potential respondents and organizations had been identified, email was sent to a specific individual (where one could be identified) or to an organization. In either case, the initial email sent to potential respondents provided an explanation of the project, described research aims, and the purpose of the interviews. A script of the five survey questions was included. This email constituted a consent script, as it included instructions as to how to proceed and give

consent, if the individuals agreed to participate. In the initial email, individuals were informed how to proceed if they had any questions about the research.

A snowball sampling technique was used. Respondents (but not refusers) were asked whether there was anyone in their region or in Canada that they would suggest as an informant, because of demonstrated knowledge and expertise in facility-based LTC. These contacts were added to the list of respondents, in cases where similar contacts had not already been interviewed, and when the suggestion was relevant to the study. Follow-up phone calls were made two weeks after the initial email, in cases where no response was received.

Table 1 shows the success rate of recruiting respondents based on the two methods used. A much higher success rate was achieved in contacting individuals who had been recommended by other respondents. When a response was never received, or in the one case where an interview could not be arranged, this was considered a “No.” In cases when an initial reply was received, but then the individual stopped replying to emails so interviews could not be arranged, this is also considered a “No.” The first method - cold calls - refers to cases when the researcher selected individuals based on a list assembled by the researcher with input from the client. The second heading describes respondents who were contacted as a result of the snowball sampling; other respondents recommended that the researcher contact these individuals.

Table 1. Recruiting Interview Respondents

Participated?	Cold Calls	Referred	Total
No	16	1	17
Yes	6	7	13
Total	22	8	30
Success Rate (No. of Yes/ Total)	27.3%	87.5%	43.3%

FINDINGS

This section presents findings from the literature review, jurisdictional scan, and survey interviews. The implications, and an analysis of these findings, are discussed in the following section.

Literature Review

Based on a review of the literature, the following factors were found to impact quality of and accessibility to facility-based LTC:

- Standards
- Accreditation
- Research
- Human Resources
- Reciprocity/Portability

The literature brought to light trends that have emerged in the LTC sector, and which have an impact on the delivery of facility-based LTC across Canada. These trends included increased acuity of residents, significant expansion of home and community care and an emergence of privatization in certain jurisdictions. These trends provide context to the results.

Setting the Context: Trends and Themes Shaping the Long-term Care Landscape

Increased Resident Acuity

Increasingly, residents admitted to facility-based LTC have higher and more complex care needs than in the past, which has sector-wide implications. Increased resident acuity was a challenge observed across Canadian jurisdictions (CHA, 2009; Auditor General of Alberta, 2005; Manitoba Nurses Union, 2006; Ontario Health Coalition, 2008; Berta et al., 2005; Health Review Steering Committee, 2008; SSCA, 2009; NUPGE, 2007). Residents are admitted to facility-based LTC when they are older and frailer, and hence have higher needs upon entry to the system (CHA, 2009). Modern LTC facilities have been likened to “mini-hospitals,” underlining the higher level of care that is now typical in most facilities (CUPE, 2009). As well, there has been an increase in the proportion of residents with Alzheimer’s disease and other dementias.³ Fifty-three per cent of residents in a sample of LTC facilities in Ontario were affected by dementia, according to a 2001 study (Price Waterhouse Coopers, 2001). This is reflective of the prevalence of Alzheimer’s and other dementias in the Canadian population, as, in their recent report, the Alzheimer Society estimated that 500,000 Canadians are affected by Alzheimer’s disease or a related dementia (Alzheimer Society, 2010). In *New Directions*, the CHA identified dementia as a specific issue that contributes to challenges for the LTC workforce, since the care needs of residents have become increasingly complex (CHA, 2009).

³ The Alzheimer Society of Canada notes that dementias related to Alzheimer’s include: Frontotemporal Dementia, dementia with Lewy bodies and Creutzfeldt-Jakob Disease. These dementias occur in combination with various chronic non-dementia conditions such as Parkinson’s disease and Huntington’s disease. (Alzheimer Society, p. 11, 2010)

There are sub-populations of residents in the facility-based LTC system who require specialized care for numerous reasons, such as because they have serious mental health issues, or because they exhibit behavioural symptoms such as verbal or physical abuse, social inappropriateness, resistance to care, or wandering (CIHI, 2008). In certain situations, young adults with serious mental health issues enter the facility-based LTC system. This may be attributed to a single entry system where individuals assessed as having the highest care needs are eligible for admission. In *New Directions*, the CHA expressed the concern that facilities may not have adequate social programming and resources to address the specific needs of this younger resident population. According to the CHA, in certain cases, individuals with serious mental health issues and significant cognitive impairment are placed in facility-based LTC because of a lack of viable alternatives, rather than because it is the most appropriate setting (CHA, personal communication, June 14, 2010).

LTC residents who display aggressive behaviours can be a source of stress to themselves, to other residents, and to staff members (CIHI, 2008). Many residents with major cognitive emotional or behavioural problems have never been appropriately diagnosed and have not received comprehensive therapy (King, 2005). In situations where LTC facilities are inadequately resourced, the needs of these special populations of residents are often unmet (ASG, 2008; Corpus Sanchez International (CSI), 2008). There is an over reliance on psychotropic medications, deployed for the reason of behavioural management, in some facilities, which has adverse affects for residents, as observed in the American context (Travis, 2005). Adequate resources are required to address the increasingly high and complex needs of LTC residents, and to ensure the health and safety of these subpopulations of residents (MHLTC, 2008a; NUPGE, 2007; Canadian Nurses Association, 2008; ASG, 2008). Adequate resources refers to staffing levels and mix, appropriate staff training and education, and sufficient funding to take into account higher care needs of clients.

Expansion of Home and Community Care

Based on the literature, there has been a policy shift towards services received in the home and the community, as opposed to in a facility-based setting. Home care has long been emphasized in Manitoba's LTC strategy, and has been expanded as part of the LTC strategies of Nova Scotia, PEI, Quebec and Ontario, to supplement the facility-based LTC system. Manitoba's emphasis on home care is reflective of client preference and past utilization trends. In its 2002 study, the Manitoba Centre for Health Policy found the rates of facility-based LTC had decreased, while utilization of home care had increased (Manitoba Centre for Health Policy, 2002). The Romanow Report cited home care to be the fastest growing component of the health care system (Commission on the Future of Health Care in Canada, 2002). The literature showed that investing in home care can be more economical than facility-based LTC, and can improve quality of life for those who would otherwise be hospitalized or placed in LTC facilities (ASG, 2009; CHA, 2009; CIHI, 2007a). Typical outcomes of home care include: reduction of emergency hospitalization, improved client health status, decreased caregiver burden, improved disease management, avoidance of institutionalization, and client satisfaction (Canadian Home Care Association, 2005). Based on prominent national research conducted on the program, *the National Evaluation of the Cost-Effectiveness of Home Care*, led by Chappell

and Hollander, home care can be deployed for numerous purposes. Home care may be used as a preventative and maintenance model, designed to reduce the rate of deterioration for persons with relatively low level care needs. It may also be used as an acute care substitution model whereby home care is substituted for hospital care, and as a substitute for facility-based LTC (National Evaluation of the Cost-Effectiveness of Home Care (National Evaluation), 2001). The National Evaluation determined that the overall health care costs to government for home care clients are about one half to three quarters of the costs for clients in facility-based LTC (National Evaluation, 2001).

The amount of home care available in a given jurisdiction has implications for facility-based LTC in the region, since one of the purported functions of home care is to reduce demand on facility-based services (ASG, 2008). The result of higher resident acuity is that individuals need to have higher care needs to be admitted to facility-based LTC than they did in the past. This has implications on other areas of the system. Increasingly, home care services are being used to provide care to individuals with relatively high and complex care needs, yet who do not qualify for admission to facility-based LTC. In certain jurisdictions, the service is no longer provided as a preventative service for individuals who require basic assistance such as food preparation and housekeeping, because it is focused on providing care to these higher needs clients. Such a shift has been observed in BC (ASG, 2008; Cohen et al., 2005).

Integration of Long-Term Care Services

Increasing linkages among facility-based LTC and other home and community care services (such as home care, supportive/assisted living) is a trend that has emerged in jurisdictions such as BC and Alberta (BC Ministry of Health Services, 2005; ASG, 2008). Integrating care options has been prioritized in national dialogues on LTC such as the Annual Premiers' Conference in 2002, and by the Special Senate Committee on Aging, in 2009. The goal of integrated models of care is to improve coordination of care for individuals who rely on various specialized medical, community, and social services (Alzheimer Society of Canada, 2010). Organized provider networks are amalgamated by standardized procedures, services agreements, joint training, and shared information, resulting in greater client satisfaction and cost-effectiveness (Alzheimer Society of Canada, 2010). *Campus of Care* locations illustrate this type of linkage among services. Campus of Care locations are housing options that include many levels of care for the elderly, including apartment style complexes without health services, apartment complexes with or without home care, residential care units with 24-hour care, and special care units (SCUs). Integrating services has been supported in the literature and by other stakeholders, for the following reasons. Integrated models of care make it easier for residents and caregivers to navigate the system (Alzheimer Society of Canada, 2010). The Campus of Care model has been praised, because it enables seniors to progress from one type of care to another, while minimizing transition (BC Ministry of Housing and Social Development, 2009).

Informal Care giving

A family or informal caregiver in Canada is defined as an individual who provides care and support to a family member, friend, or neighbour who has a physical or mental disability, is

chronically ill, or is frail (Health Canada, 2010b). Families of facility-based LTC client also play an important role in their care. Research showed that informal caregivers play an important role in facility-based long-term care, and should be increasingly incorporated and involved in the resident's care (Levine, Halper, Peist & al., 2010). Informal care, received in the home, is a major source of care for frail seniors and younger individuals with physical or mental health issues who require assistance with the activities of daily living. Even when a family or loved one makes a decision to admit an individual into facility-based LTC, informal caregivers continue to play an important role in the residents' care. In recent years, there has been increased demand placed on family care giving, with an estimated two million family and informal caregivers in Canada (Health Canada, 2010b; NUPGE, 2007). Respective jurisdictions offer various form of support to eligible informal caregivers (SSCA, 2009). Canadian government uses tax deductions and credits to help offset the cost of informal caregiving at home, through the Compassionate Care Benefits tenet of the Employment Insurance program (SSCA, 2009). Canadians who act as informal caregivers for elderly parents often simultaneously work in their own job, while also caring for their own children (Special Committee on Aging, 2009), and for this reason are often referred to as the *sandwich generation*. Many jurisdictions have encouraged the establishment of family councils to promote further engagement of residents' families in the care of their loved ones. The literature showed the importance of establishing positive rapports, based on open communication and trust, with residents' families and loved ones, which points to a need to ensure employees receive adequate training to build these types of relationships (Gilton, Guruge, Librad, Bloch & Boscard, 2008). Training and education can help build positive relationships between formal and informal caregivers, as is examined later in this report. Resident and family councils have been established to various degrees across jurisdictions as a way to engage informal caregivers in the care of their loved ones. These councils, though undoubtedly important, are outside the scope of this project.

Facility Characteristics

Facility Ownership

The facility-based LTC sector has increasingly opened up to the private sector in certain Canadian jurisdictions. For example, in BC, there has been a six-fold increase in corporate investment in facility-based LTC (Cohen et al., 2005). Growing prominence of the private sector in the delivery of facility-based LTC has potential implications for quality and accessibility of the service. Private facilities may or may not be subject to provincial licensing requirements, as is discussed further in the jurisdictional scan. Data from the Statistics Canada 2005-2006 Residential Care Facilities Survey evidences that 53.7 % of Canadian LTC facilities were privately owned (Statistics Canada, 2007, p. 13).⁴ Based on the same dataset, the not-for-profit and government sectors constitute almost equal proportions of the remainder of facilities.⁵

⁴This figure is based on an assumption of relative equivalency between "homes for the aged" as defined by Statistics Canada and public LTC facilities. Quebec is excluded in this statistic.

⁵ A degree of caution should be exercised in interpreting these numbers, since 32 of the total 1,873 operating facilities were composites; comprised of several smaller facilities.

Based on the literature, privatization may have an impact on quality and accessibility of facility-based LTC. Deber (2002) noted that for-profit delivery of health services tends to be inferior than not-for-profit entities, because the latter are less sensitive to bottom line incentives. Private ownership is associated with lower staffing levels. In a study on facility-based LTC in BC, McGregor et al. (2005) found that the mean number of hours per resident per day was higher in the not-for-profit facilities than in the for-profit facilities, for both direct care and support staff and for all levels of care.⁶ McGrail et al. comment that the tendency towards lower staffing levels may be common across private facilities, given that for-profit facilities inherently divert some of their funding towards profits. Since staffing accounts for a significant portion of total budget expenditures, it is a natural area in which to realize cost savings (McGrail, McGregor, Cohen, Tate & Ronald, 2007). The findings of McGregor et al. were supported by Statistics Canada data, which reported lower employee-per-bed and hours-per-bed ratios and wages-per-bed ratios in privately-owned facilities as compared to in government-owned and not-for-profit facilities (Statistics Canada, 2007, p. 13).⁷ Fewer employees mean that less time is spent with residents. Nonetheless, it is worth remarking that there may be other factors to consider in an interpretation of this data. Helfrich (2005) considers the limitations of the analysis conducted by McGregor et al., on the basis that it examines staffing as a structural indicator of quality of care, without taking into consideration other factors such as outcomes for residents, and family and resident satisfaction levels. Experience, training, productivity, and innovation should be factored in as other significant indicators in quality of care, according to Helfrich.

Concern about privatization of LTC has been expressed by LTC associations, unions and other organizations (CHA, 2001; Ontario Federation of Labour, 2005; Rubin, 2003). Concerns pertaining to accessibility are due to the high financial cost of care in these facilities. The average cost of care in a private facility ranges from \$44,000 to \$67,000 per year, and as such, this option is not affordable to the majority of seniors in the province (Cohen et al., 2005). Many seniors receive only Old Age Security (OAS) and Guaranteed Income Supplement (GIS), and the combined income from both of these programs is approximately \$1,079 per month, placing private facilities out of financial reach for many seniors without another source of income (Service Canada, 2010b). As well, in most cases, clients are required to pay the full cost of services in private facilities, unless they are also licensed and receive government funding. Nonetheless, privatization is integral to the industry, because it contributes to the total stock of LTC and the range of options available to clients. Government sources acknowledge that demographic pressure will require an increase in the supply of both privately and publicly-owned facility-based LTC (Statistics Canada, 2007).

Facility Size

⁶ The study examined mean number of hours per resident per day provided by direct care staff (RNs, LPNs, and HCAs) and support staff (housekeeping, dietary, and laundry staff) in publicly-funded and not-for-profit LTC facilities in BC, after adjustments for facility size and level of care.

⁷ These numbers can be partially explained by examining the level of care administered in privately-owned facilities. Government-owned facilities had a much higher proportion of residents who received higher levels of care, thus necessitating more staff hours, higher skilled workers, and larger operating budgets for wages.

Berta et al. (2005) theorized an association between facility size and quality of care, based on a statistical analysis of data collected via the Residential Care Facilities Survey from LTC facilities in Ontario. The observations are summarized as follows. Government-owned facilities were generally larger than for-profit or not-for-profit facilities. The prevalence of larger facilities is partially attributed to the regulatory environment in Ontario, which was asserted to favour for-profit operators, because of the ability of these larger facilities to realize economies of scale.

Factors that Impact Quality and Accessibility in Facility-based Long-Term Care

1. Standards

Standards are necessary to measure and enforce quality of care, to ensure the safety of residents and staff in LTC facilities, and to ensure a consistent standard of care is provided to residents across facilities (Manitoba Nurses Union, 2006). Without clear and enforceable standards, it is difficult to maintain an effective monitoring and enforcement regime (Smith, 2004). Based on a review of the literature, there are no national standards for facility-based LTC, and federal funding for LTC is not linked to pan-Canadian standards. Numerous stakeholders have pointed to inadequate or absent standards in areas such as staffing ratios, hours of care provided by staff per residents, and education and training for staff (CHA, 2009; SSCA, 2009; Smith, 2004; CUPE, 2009; NUPGE, 2007; CSI, 2008). It is difficult to guarantee that the quality of care administered to a senior in PEI is comparable to the care that a senior receives in BC, for example, since quality is measured and monitored by two different regulatory and policy frameworks.

There is room to improve existing measures of quality in facility-based LTC, based on a review of the literature and from concern expressed by stakeholders. The CHA stated that staff are often focused on adhering to specific regulatory requirements, which makes work increasingly task-oriented and less resident-focused. As well, quality indicators do not sufficiently factor in quality of life for residents (CHA, 2009). The 2008 Report of the Independent Review of Staffing and Care Standards for Long-term Care Homes in Ontario (*the Sharkey Report*) called for the development of indicators that linked funding to resident-focused outcomes, such as resident and staff satisfaction and engagement. Smith (2004) supported using staff and resident satisfaction surveys as focuses for quality indicators.

Accreditation

Most LTC facilities must meet standards set by provincial licensing departments, but facilities may also meet standards set by accrediting entities. Accreditation is an internationally recognized evaluation process used to assess quality of health services, and to recognize that a health care organization has met a standard of quality set by a national accrediting entity (Accreditation Canada, 2008). The Government of Canada does not provide input to the standards developed by accrediting bodies. Accreditation may be voluntary or a provincially-legislated requirement for facilities, depending on the jurisdiction. There are various levels of support for accreditation of LTC facilities by federal, provincial and territorial governments. In Newfoundland, all LTC facilities are required to be accredited by Accreditation Canada. There

is also mandatory accreditation of public LTC facilities in Quebec and Alberta (CHA, 2009). It appears based on review of government information that the three existing LTC facilities in the Yukon are accredited (Yukon Health and Social Services, 2009c). Certain provincial governments offer incentives for LTC facilities to seek accreditation. There is partial subsidization for LTC facilities seeking accreditation in Saskatchewan and Ontario (MHLTC, 2010a; Saskatchewan Health, 2007). The Government of Canada funds accreditation for all Aboriginal health organizations and organizations that provide services to Aboriginal, through the Aboriginal Health Services Accreditation (Health Canada, 2008b). The CHA noted that BC health authorities draw on standards derived by Accreditation Canada to develop regional standards (CHA, 2009). In BC, government public consultation revealed that the public has a desire for mandatory accreditation for LTC facilities, as a way to promote greater consistency in standards and quality of care across the province (BC Ministry of Health Services, 2007).

It is useful to briefly examine the process of accreditation, as there are strengths and limitations associated with the process. The process of accreditation entails a peer review process and self-assessment based on a given set of standards and an on-site survey. Based on the assessment, a report is issued to identify areas for improvement and to formulate recommendations. There is follow-up on these recommendations (Accreditation Canada, 2010b). The process enables organizations and teams to establish benchmarks and share best practices (Touati & Pomey, 2009). Accreditation Canada accredited 124 LTC facilities as of 2008 (CHA, 2009).⁸ Accreditation Canada develops standards that incorporate input from experts from the field, are evidence-based, and have been demonstrated to be effective in practice (Accreditation Canada, 2010a). Accreditation status lasts for three years and, depending on the rating that an organization receives, follow-up may be required by the organization during this period (MHLTC, 2010c; Accreditation, 2010a). The Commission on Accreditation of Rehabilitation Facilities (CARF), which was established in 1996, has recently gained prominence as an accreditation body for Canadian LTC facilities (CHA, 2009).

Advantages of Accreditation

Information from government sources, accrediting entities and the literature was used to ascertain that there are numerous advantages to accreditation on quality in facility-based LTC. The literature showed that accreditation improves quality, efficiency, and effectiveness in health care organizations, and promotes a culture of continuous quality improvement (MacRae, Menger & Prada, 2003; Greenfield & Braithwaite, 2008). The theory underlying accreditation is that adherence to evidence-based standards produces a higher quality of services and a safer environment compared to the organization's performance in the absence of these standards (Accreditation Canada, 2008). Accreditation may have a positive effect on specific health and safety resident outcomes. CARF stated that accreditation is associated with a decrease in the administration of psychotropic drugs for residents and a decrease in medication administration errors (CARF, 2006).

The purported advantages of accreditation included the following positive organizational outcomes for staff engagement: knowledge transfer, capacity building, and organizational learning (CHA, 2009; Ministry of Health and Long-term Care (MHLTC), 2008a; Accreditation

⁸ Accreditation Canada was formerly the Canadian Council on Health Services Accreditation.

Canada, 2008). The CHA supported accreditation because it give staff a higher sense of purpose, and provides front-line staff with recognition and the opportunity to provide input (CHA, 2009). Accreditation Canada encourages LTC staff to become actively engaged during the process, thereby promoting staff engagement and professional development (Accreditation Canada, 2008). The literature showed that as a result of the accreditation process and at being nationally recognized, employees feel greater pride in their institution (Touati & Pomey, 2009). Further, accreditation gives staff an opportunity to reflect on organizational practices (Greenfield & Braithwaite, 2008).

Limitations of Accreditation

There are limitations of accreditation that should be taken into consideration. Resource constraints impede access to facilities seeking accreditation, as it is perceived as labour-intensive for staff and requires a significant amount of resources (Greenfield & Braithwaite, 2008). Touati and Pomey (2009) offer valuable criticism in a discussion on accreditation, which is summarized below. There is a lack of research that confirms a positive association between accreditation and client outcomes. The process of accreditation entails periodic rather than continuous assessments. As a result, there can be a focus on addressing quality deficiencies or adverse events, which can lead to a reactive, rather than proactive focus. Accreditation has a tendency to value uniformity and adherence to standards as opposed to individual organizations' performance and innovation. Drawing on the example of France, Touati and Pomey (2009) suggest that nation-wide mandatory accreditation of health care organizations may be an overly bureaucratic and inflexible approach, and can be perceived as less legitimate if it is not the result of an open process that invites input from stakeholders. When national standards developed by accrediting bodies are open to comment and based on professional consensus (as exemplified by Accreditation Canada), there may be a greater perception of legitimacy among health care organizations who are obliged to adhered to these standards.

2. Human Resources

The literature conclusively showed an association between human resources and quality in facility-based care. Human resources refers to staffing levels and mix, staff training and education, and recruitment and retention for both the professional and paraprofessional workforce.

Staffing Levels/Mix

Long-term care associations, service organizations, and researchers substantiated that inadequate staffing in facility-based LTC is a challenge experienced across Canadian jurisdictions (CUPE, 2009; Armstrong, 2009; Canadian Nurses Association, 2008; CHA, 2009; NUPGE, 2007). Staffing ratios refers to the number of direct care hours that are administered by professional and paraprofessional staff in LTC facilities. Staffing in LTC facilities has not been adjusted to reflect the increased acuity of the average resident (CHA, 2009; SSCA, 2009), resulting in a gap between the staffing level and skills required, and those that exist. Staffing mix refers to the portion of staff that are professional health care workers, versus members of

the paraprofessional workforce since these individuals vary in the amount of training and education they possess. Increasingly, the care administered to residents in LTC facilities is provided by the paraprofessional workforce, (PSWs, LTC aides, nurse aides, personal aides, and personal care attendants) (Canadian Nurses Association, 2005; Wilson & Truman, 2004; Brazil, Royle, Montemuro, Blythe & Church, 2004; SSCA, 2009). Shifting of the LTC workload to the paraprofessional workforce has been referred to as the *casualization* of the workforce (Smith, 2004), and has similarly been observed in the American LTC context (LeRoy, Treanor & Art, 2010). Research has attributed the trend to a shortage of professional health care workers, and inadequate funding for the sector (CHA, 2009; Smith, 2004; NUPGE, 2007; Canadian Nurses Association, 2008).

Staffing levels are a significant determinant of quality of care. Higher staffing levels and an appropriate staff mix results in better resident outcomes, in terms of quality of life and clinical care (Smith, 2004; CUPE, 2009; Canadian Nurses Association, 2008). In contrast, lower staffing levels lead to worse outcomes for residents. Adverse outcomes in clinical care include falls, fractures, infections, weight loss, dehydration, pressure ulcers, incontinence, agitated behaviour, and hospitalizations (CHA, 2009). Quality of life for residents is associated with the type of care they receive from staff. Understaffing can result in residents spending more time remaining in bed (CHA, 2009). Staff in under-resourced facilities have less time to fulfill auxiliary tasks, such as taking time to interact with residents, helping a resident apply make-up, or taking a resident for a walk (CHA, 2009). In understaffed scenarios where staff face heavy workloads, the social and emotional aspects of care are often first to be eliminated because addressing the clinical needs of residents takes the majority of staffing time (CHA, 2009). In some cases, residents or their families may opt to pay for additional services to supplement the basic clinical care provided (CHA, 2009). Inadequate staffing hinders the ability of staff at LTC facilities to provide specialized care, such as for residents who display aggressive behaviours and behavioural symptoms (CHA, 2009). Residents who display behavioural symptoms and aggressive behaviours, such as verbal/physical abuse, social inappropriateness, resistance to care and wandering, often face complex health issues such as delirium, depression, and insomnia (CIHI, 2008). The literature has suggested that increasing the ratio of staff, particularly on evenings and weekends, and focusing social programming on these times, is an effective way to address resident boredom and frustration, and decrease the occurrence of aggression among residents (CHA, 2009).

The results of staffing shortages are widespread, as they impact both staff and residents. Inadequate staffing results in increased levels of stress for facility-based LTC staff, which contributes to a poor work environment. Nelson (2009) describes the occurrence of moral distress and ethical uncertainty in health care organizations, noting that a specific type of moral distress may occur when a health care professional is unable to take the ethically appropriate course of action because of an organizational obstacle such as lack of staffing time. Ethical uncertainty of staff has detrimental effects to the organizational culture of health care organizations, as it results in low morale, staff turnover, and diminished quality of care. In *New Directions*, the CHA reinforced that working understaffed with heavy workloads, coupled with physical exhaustion and low morale, contributes to high turnover in the sector. Inadequate staffing is associated with increased incidence of workplace injury and violence exhibited by residents towards care providers for all types of staff in LTC facilities (Banerjee, Daly,

Armstrong, Armstrong et al., 2008; Armstrong, 2009; CHA, 2009; ASG, 2008; Canadian Nurses Association, 2008). Residents often become frustrated with health care providers when they receive a lack of care, are rushed through their daily activities, or wait prolonged periods of time for assistance because staff cannot respond to call bells in a timely fashion (Armstrong, 2009).

There is growing consensus in the literature on optimal standards that guarantee an optimal quality of care (the Independent Review 2008; Berta et al., 2005). The 2007 Sharkey Report identified an optimal staffing range of 3.5 hours of care per resident per day which includes care provided by professional and personal support staff (MHLTC, 2007). Certain Canadian jurisdictions have staffing standards in place for LTC facilities, as is the case in New Brunswick, while others have staffing targets, such as in BC. Even when a staffing standard is in place, facilities may not be adequately resourced to ensure that it is consistently met (CHA, 2009). As well, in certain provinces, staffing standards are difficult to enforce and not adequately monitoring by provincial licensing departments, or are out-of-date and may not be taken into consideration higher care needs of the average resident (CHA, 2009). Certain associations have called for the development and implementation of a pan-Canadian staffing standard (CHA, 2009), while other national dialogues have expressed support for general improvement in staffing levels and competencies in Canadian LTC (SSCA, 2009).

Training and Education

The increased and more complex care requirements of residents highlight the need for adequate training and education for all types of facility-based LTC staff. Adequacy in this area means ensuring that the workforce has specialized knowledge and skills tailored to geriatric care. This includes education and training for paraprofessionals, professionals, and management. Education and training of the LTC workforce is an area where further attention is required, based on concern expressed by the public, by service organizations, and by provincial LTC organizations (BC Ministry of Health Services, 2007; Government of New Brunswick, 2008a; Ontario Health Coalition, 2008; CHA, 2009; SSCA, 2009; Canadian Nurses Association, 2008; MHLTC, 2008a; Ontario Human Rights Commission, 2001; Price Waterhouse Coopers, 2001). There are no educational standards in place for HCAs or PSWs, while certain front-line workers have minimal, or no formal training at all (Smith, 2004). There is a need to improve post-secondary training to become more specific to seniors, taking into consideration the higher care needs of the average care needs, as well as the specific care needs of residents with dementia (Ontario Human Rights Commission, 2001; Ontario Health Quality Council; Price Waterhouse Coopers, 2001; Smith, 2004).

Enhancing training for LTC staff strengthens the existing workforce, as an alternative to recruiting and training new personnel (Levenson, 2009). As well, training ensures ongoing evolution and improvement of the sector, because it ensures staff are receptive to new ideas (Edwards et al., 2003). Training and education improves the quality of care administered to residents (Canadian Nurses Association, 2008; CHA, 2009; Edwards et al., 2003). In their 2009 report, *Residential Long-term Care in Canada: Our Vision for Better Seniors' Care*, CUPE stated that training and education has direct and indirect links to quality of care. To exemplify this point, an education program on nutrition for residents has a direct link to

improving quality of care, but may also have indirect benefits, such as improving retention for staff. Research has identified decreased violence exhibited by residents as a result of educational interventions (Guss, McCann, Edelman & Farran, 2004).⁹ Training may assist staff in developing appropriate ways to address and manage residents who display aggressive behaviours (CHA, 2009), which may reduce utilization of chemical restraints.¹⁰ This includes training in communication and conflict de-escalation techniques that have been demonstrated to reduce resident frustration (Ontario Health Quality Council, 2010). Given that many pharmaceuticals deployed as chemical restraints have potentially serious side effects, health organizations have noted they should be avoided where possible (Ontario Health Quality Council, 2010). Most jurisdictions have clear policies in place regarding the use of any type of restraint. For example, in Ontario, provincial legislation requires LTC facilities to document the rationale for the use of a restraint (Ontario Long-term Care Homes Act, 2007). Some health organizations have suggested that there may be an over reliance on restraints in certain facilities, and anti-psychotics may be prescribed in some cases with no clear reason (Ontario Health Quality Council, 2010; CHA, 2009). This suggests that the improper use of restraints may be an issue in facility-based LTC. Training and support for paraprofessional staff can increase their skills in handling minor emergencies, reducing the need to transfer to emergency departments in certain scenarios (Ontario Health Quality Council, 2010). As well, training can be deployed to assist staff in delivering LTC services that are culturally sensitive and reflective of the diverse and multicultural needs of the resident population (MHLTC, 2008a).

While the literature established numerous advantages to training in theory, there are also certain real-world challenges experienced in the sector that impede the effectiveness of training. The CHA stated listed the following challenges to affect efficacy of training: poor staff coverage, heavy workloads, lack of incentive to upgrade knowledge and skills, and lack of educational opportunities (CHA, 2009). As well, the Canadian Nurses Association (2009) commented that there is less access to on-site training opportunities for staff in LTC facilities than for their counterparts in acute care.

Researchers asserted that training can be deployed to improve family engagement practices in LTC facilities (Gladstone, Dupuis & Wexler, 2007; Levine, Halper, Peist et al., 2010). A study focusing on family engagement with LTC staff by Gladstone, Dupuis & Wexler (2007) suggests that communication skills training and workshops potentially involving the family could improve staff knowledge of conflict resolution, problem-solving methods, empathic and non-defensive attitudes, validation, and openness. This could have an indirect benefit for staff, because it fosters a cooperative and supportive relationship with residents' families and caregivers, potentially preventing conflict in the future between staff and residents' families. Training can equip management staff with knowledge on how to motivate and retain front-line staff, reducing employee turnover (CHA, 2009). Effective training for management staff ensures that these individuals are skilled in promoting effective teamwork and coordinated approaches to daily care (Edwards et al., 2003).

⁹ The outcome described was the result of educational intervention, in combination with other factors such as the establishment of special care units.

¹⁰ A chemical restraint is a medication that is administered to an individual in care, to subdue and in certain cases, to sedate a resident.

Maximizing the Effectiveness of Training and Education Programs

The literature points to certain factors that impact the accessibility and effectiveness of staff training programs. Beer et al. (2009) note that educational interventions for facility-based LTC staff should be flexible, locally relevant, and focused on practical strategies (Beer et al., 2009). Training should be administered frequently, given the high turnover of employees in the sector (CHA, 2009). Staff training programs are ineffective unless learning is consistently integrated into practice (CHA, 2009). Training is more successful when educational strategies are diverse and flexible enough to take into consideration the needs of a heterogeneous and multicultural paraprofessional workforce, who may have low levels of education, or who may speak English as a second language (Brazil et al., 2004; Beer et al., 2009). An independent consultant was hired by the Alberta government to review LTC in the province. Roulston (2009) identified the following factors as barriers to receiving training in the jurisdiction: transportation to training sessions, lack of substitutes in facilities resulting in difficulty providing in-service education because of staff shortages, and lack of subsidization for training. As well, Roulston noted that it was unclear what the repercussions were if staff did not attend the training sessions. Accessibility of training remains a barrier experienced in the sector, and as such, effective training should provide staff with a continuum of educational opportunities including off-site training, home study, distance learning and online seminars, and in-service education sessions (CHA, 2009).

Based on a review of the literature, there are no national standards, or a standardized pan-Canadian curriculum, for unregulated health professionals. Each jurisdiction has various standards and programs in place to prepare unregulated health workers for work in the sector. The result is inconsistencies in the levels of basic training required for PSWs (CHA, 2009). As previously noted, there has been a transfer of workload from the professionals to the paraprofessional workforce; a trend observed across the Canadian LTC sector. However, the specific tasks that they are performing are not clearly defined in the literature. Many paraprofessional health care positions require minimal formal training or education (SSCA, 2009). Education standards for unregulated health professionals vary significantly, depending on the jurisdiction. There are limited existing programs that focus specifically on care of the elderly. Only Alberta, Nova Scotia, and Ontario were noted to offer specific diploma programs in LTC for PSWs (SSCA, 2009). Education is a strategy used to equip the facility-based LTC workforce with tools to provide specialized care for residents with Alzheimer's, dementia, and mental health issues (CHA, 2009; CUPE, 2007; Canadian Nurses Association, 2008).

Concern about training and education was also observed pertaining to the professional LTC workforce. Government, health organizations and service organizations expressed concern about the adequacy of education for the professional LTC workforce (MHLTC, 2008a; Canadian Nurses Association; 2008; CHA, 2009). The CHA (2009) stated that there is a lack of focus on geriatrics in medical school. As well, the CHA suggested that gerontological health care profession are not generally promoted in Canadian training programs, as rotations in geriatric medicine are not a mandatory aspect of training (CHA, 2009). Work in the LTC sector requires less preparation for nurses than work in acute care (Edwards et al., 2003). Generally, health care professionals often lack specific preparation in gerontological care (King, 2005). In response to the abovementioned concerns, the CHA expressed a desire to

develop and implement pan-Canadian training and education standards for the paraprofessional workforce in *New Directions*. This option was also put forward by the Special Senate Committee on Aging in 2009. A precondition to development of a standardized curriculum would be establishing and codifying leading practices (CHA, 2009).

Recruitment and Retention

Recruitment and retention of the professionals and paraprofessionals workforce is a challenge faced across Canada (CHA, 2009; CIHI, 2007b; National Advisory Council on Aging, 2006; NUPGE, 2007; SSCA, 2009; CSI, 2008; Ontario Health Coalition, 2008; the Independent Review, 2008; Auditor General of Alberta, 2005; Roulston, 2008; Government of New Brunswick, 2008a). Workforce shortages can be partially attributed to an aging workforce of health care professionals such as doctors and nurses (SSCA, 2009; Canadian Nurses Association, 2005). Wage disparities between the LTC sector and the acute sector, high workload, and poor working conditions have an impact on recruitment and retention (SSCA, 2009; Armstrong, 2009; CHA, 2009). These challenges are not specific to the Canadian context. Low wages and benefits, a lack of advancement opportunities, high risk of work-related injuries, high emotional stress, and a negative societal perception of the sector were noted to contribute to recruitment and retention challenges in the American LTC sector (LeRoy, Treanor & Art, 2010; Kane & Kane, 2001). McIntosh, Torgerson and Wortsman (2009) stated that human resource planning is generally done on an ad-hoc basis, with little coordination across Canada. As a result, the same theorists suggested a need for greater intergovernmental coordination, to develop a pan-Canadian, multi-professional, human health resource planning mechanism that takes into consideration the full spectrum of health services for Canadians.

A negative perception of the sector contributes to difficulty recruiting health care workers to LTC. There is a view among health care workers and in society that posits working in seniors' care as less favourable than working in the acute care sector (King, 2005; Canadian Nurses Association, 2008; MHLTC, 2008). The underlying rationale may be that seniors are already close to death (Edwards et al., 2003). The perception that LTC recipients are on a downward trajectory, and full recovery is unlikely, pervades the sector, and as such, LTC lacks the heroic, "rescue" aspect associated with medical care (Feldman & Kane, 2003). A generally unfavourable view of the sector may contribute to poor moral, high staff turnover, and an unhealthy workplace environment (Canadian Nurses Association, 2008). A lack of understanding of gerontological care among health care professionals, residents, and families, may also exacerbate difficulties in recruitment (King, 2005).

3. Reciprocity/ Portability of Services

In *New Directions*, the CHA pointed to reciprocity as a challenge, because individuals may face significant obstacles if they wish to receive facility-based LTC outside of their jurisdiction. Funding received for LTC within one jurisdiction does not follow the resident when they relocate outside of jurisdictional borders. As such, when a senior relocates out of jurisdictional borders, they are subject to a new set of admission requirements. This can mean they will not receive any provincial subsidy for LTC until they satisfy the admission

requirements of the given jurisdiction. This can cause stress for seniors who relocate out-of-province to be closer to their families and friends. Further, the CHA notes that jurisdictions that experience high rates of in-migration of seniors may face significant costs for LTC should these individuals increase demand for facility-based LTC system.

4. Research

There is a shortage of comprehensive, pan-Canadian research on LTC (National Advisory Council on Aging, 2006; the Independent Review, 2008; Price Waterhouse Coopers, 2001; CHA, 2009), including national data on quality and accessibility of the service. Limited funding was cited as a contributing factor to explain sparse research on aging and LTC in Canada (CHA, 2009). Past funding for research in this area has come from Health Canada, the Canadian Patient Safety Institute, and the Canadian Health Services Research Foundation (CHA, 2009).

Benefits of Research to the Long-term Care Sector

Denton & Zeytinoglu, (2010) discussed numerous strengths of the role of research in the LTC sector, as summarized here. Research plays an instrumental role in providing evidence that change in LTC is required. It enables governments to make projections for future capacity requirements based on current trends, and to develop policy solutions to address care of an aging population. As well, research describes the context of aging adults, and develops and evaluates new models of care. Feldman and Kane (2003) built on these points, stating that research helps to refine the long-term practice agenda, give way to paradigmatic changes, and help design practical tools that document problems. Berta et al. (2006) reaffirm that given the emergence of care of the aging population as a public policy priority, research that explores the sources and complexities of performance variation in LTC is critical to improving industry effectiveness and efficiency.

Lack of Comparable Data across Jurisdictions

Most data collected by provinces and territories is region-specific. It is often complex to draw comparisons across jurisdictions, because of varying policies and legislation in place in respective regions (Price Waterhouse Coopers, 2001; Mor, 2005). The interRAI MDS is a standardized assessment tool that determines eligibility and placement for all continuing care services, including facility-based LTC. The system classifies residents based on their health services requirements and their functional status (interRAI, 2010). As of 2009, the interRAI MDS 2.0 was implemented, or implementation was underway, in seven provinces and one territory (CHA, 2009). This particular tool is only used in the home care sector. The interRAI Long Term Care Facility (interRAI LTCF) is a similar tool applied in LTC facilities. The interRAI LTCF consists of a core screening and assessment instrument, known as the Minimum Data Set (MDS), and 18 Resident Assessment Protocols (RAPs), which provide a standardized approach to assessing the health, functional and psychosocial needs and strengths of residents in facility-based LTC. The interRAI has been implemented to a limited number of long-term care facilities across Canada (interRAI, 2009).

Limitations of the interRAI-MDS 2.0 have included that direct resident interviews are often absent from the assessment process, and that it is labour intensive for front-line workers (CHA, 2009). To this end, a revised model has been developed by US researchers, taking into consideration criticisms of the former model (US Centre for Medicare & Medicaid Services, 2010). Based on a review of the information available from jurisdictions, this version of the assessment tool has not been implemented in the Canadian context. The Canadian Institute of Health Information (CIHI) collects data from publicly-funded LTC facilities through the Continuing Care Reporting System (CIHI, 200). This data is obtained via the RAI-MDS 2.0 resident classification system. CIHI also collects information regarding facility size, location, and type. In the future, CIHI stated its long-term objective to expand the scope of data that it collects, to examine safety and quality of care (CIHI, 2002). It is difficult to use data from Statistics Canada or CIHI to draw cross jurisdictional comparisons, to conduct pan-Canadian analysis, or to establish benchmarks because the data categorizes LTC in different ways (CHA, 2009). Moreover, the information that is collected from facilities varies across jurisdictions (CHA, 2009).

Provincial LTC organizations and health quality councils hold significant research potential, and have recently emerged in many jurisdictions. The Saskatchewan Health Quality Council, the Health Quality Council of Alberta, the BC Patient Safety & Quality Council, the Commission of Health and Wellbeing in Quebec (*Commissaire à la santé et au bien-être Québec*), Manitoba Institute for Patient Safety, Ontario Health Quality Council, and New Brunswick Health Council, are examples of such councils. Yet, information generated from these sources is region-specific and cannot necessarily be generalized to LTC practices in the rest of Canada (CHA, 2009). As well, based on a review of information available on health quality councils' websites, a large part of research conducts focuses on acute care.

Existence of Research Networks in Canada

There are a lack of formal associations between research centers and LTC homes. The literature supported the potential of these alliances to link researchers and policy makers with caregivers, and to facilitate information sharing and dissemination of best practices (Feldman & Kane, 2003; Smith, 2004). An example of a practitioner-researcher alliance is the Seniors Health Research Transfer Network (SHRTN), in Ontario. The SHRTN is a province-wide knowledge exchange network that links caregivers with researchers and policy makers (eHealthOntario.ca, 2010). The SHRTN develops communities of practice, which are groups of people who collaborate to identify innovations, translate evidence into practice, and assist in implementing changes to improve seniors' care (eHealthOntario.ca, 2010).¹¹ Nineteen communities of practices were established in Ontario as of 2009, including in the following areas: Alzheimer and Related Dementias, End-of-Life Care, Mental Health, Addictions, and Behavioural Issues, and Support for Personal Support Workers (eHealthOntario.ca, 2010). Sharing of best practices through the network was noted to be a mechanism in achieving

¹¹ Community of practice refers to the process of social learning that occurs when people who have a common interest in some subject or problem collaborate over an extended period to share ideas, find solutions, and build innovations (eHealthOntario.ca, 2010).

quality improvement (MHLTC, 2008a). Best practice resource centers operate under a contracted service model in Ontario (Brazil et al., 2004).

Brazil, Royle, Montemuro, Blythe and Church (2004) wrote on the objectives and purported advantages of a best practice resource centers, as summarized below. Best practice resource centers provide access to literature for LTC staff, improve the information management skills of health care providers, and support research and the integration of best practices in LTC organizations. The center centralizes LTC resources in one location and builds a collection of key resources, to facilitate information sharing across LTC agencies and organizations. This allows for the development of expertise, with the objective of applying best practice literature into practice. Brazil et al. identified establishment of the centers as an innovative capacity-building strategy, to increase evidence-based practice in a health care environment. Advantages of the center were also advertised by the Ontario government The Ontario Ministry of Health and Long-term Care, in collaboration with the Seniors' Health Research Transfer Network, stated that establishing community partnerships between LTC facilities and the community (including colleges and universities) was a potential strategy in countering negative public perception of the LTC sector and of LTC facilities, and increasing community interest in the elderly (MHLTC, 2008a).

Jurisdictional Scan

The following information presents the findings from the jurisdictional scan. Information from provincial-territorial jurisdictions was reviewed to gain an understanding of how facility-based LTC differs across jurisdictions, with a specific interest in learning how this impacts quality and accessibility.

Provincial/Territorial Long-term Care Strategies: Emphasis on Aging in Place

In order to address demographic pressures and to reduce pressure on facility-based LTC, government LTC strategies have emphasized “aging in place” philosophies. Practically, this entails an expansion of services received in the home and in the community, such as home care, community programs, and assisted/supportive living arrangements. These programs are deployed to supplement facility-based LTC, and take the primary emphasis away from facility-based services. Similar aging in place strategies have been adopted in Alberta, BC, Manitoba, Newfoundland, Ontario, and Quebec (Alberta Health and Wellness, 2008a; BC Housing, 2007; Manitoba Health, 2010; Newfoundland Health and Community Services, 2008; MHLTC, 2007; Ontario Association of Non-profit Homes and Services for Seniors (OANHSS), 2010; Quebec Finances, 2007). Aging in place strategies aim to provide seniors with a range of alternatives to facility-based LTC, and reduce dependence on the more costly, facility-based LTC component of the system. Nonetheless, review of provincial and territorial strategies demonstrated an ongoing need to focus attention on the facility-based LTC component of the system, as shown in the inclusion of facility-based LTC in the following government strategies. Appendix E provides an overview of provincial and territorial LTC strategies, and discusses strengths and challenges of facility-based LTC in each jurisdiction.

New Brunswick's ten-year LTC strategy, *Be Independent Longer*, increased focus on home and community services but also committed \$400 million to replace and renew facility-based LTC infrastructure (Government of New Brunswick, 2008a; New Brunswick Social Development, 2010a). The Newfoundland and Labrador 2010 Budget committed to significant investments in LTC infrastructure and creation of new LTC beds, including \$27.3 million in the development of LTC facilities to accommodate 460 residents (Marshall, 2010). Quebec's 2002 Health and Social Services Plan, *Making the Right Choices*, made significant investment in the LTC sector, through the creation of 2,200 new facility-based LTC beds while simultaneously committing \$133.5 million to the expansion of home care services (Quebec Health and Social Services, 2002).

Some governments have placed greater emphasis on certain components of the LTC system. Based on a review of information from BC, Assisted Living (AL) has assumed an important place in the province's LTC system. The 2002 *Independent Living BC* strategy included a significant expansion of supportive living and Assisted Living units (BC Housing, 2007). BC reduced its facility-based LTC capacity by a net reduction of 2,529 residential care beds across the province, while adding 1,065 publicly-subsidized AL units (ASG, 2008; CHA, 2009). On the other hand, Manitoba has emphasized its home care program. The Manitoba Home Care Program is the oldest comprehensive, province-wide, universal home care program in Canada, and administers care to an estimated 39,000 clients per year; the majority of whom are seniors (Manitoba Health, 2010). The focus on home care in the province is evidenced by Manitoba's expenditures on home care, which were higher than nearly every other province (CIHI, 2007a).

Unique Challenges Experienced in Northern Jurisdictions

Nunavut faces certain unique challenges in the delivery of facility-based LTC. A challenge faced in the territory is increasing the stock of facility-based LTC that is culturally-specific. The Department of Health and Social Services' *Closer to Home* strategy, initiated in 2004 to be implemented over five to ten years, aims to strengthen continuing care through increasing the care and services delivered to Nunavummiut in their own communities, using their own language, and in the proper cultural setting (Irniq, 2004). Nursing education programs have been established in both the Northwest Territories (NWT) and Nunavut with the aim of reducing dependence on southern recruits to staff positions in the north (NWT Registered Nurses Association, 2006). Similar objectives were expressed in the Yukon, where recruitment and retention challenges result in dependence on recruits from southern Canada. The Yukon Health Care Review suggested providing local training opportunities for professional staff, to allow RNs to upgrade to Nurse Practitioners (Health Care Review Steering Committee (HCRSC), 2008).

Government Consultation on Long-term Care

Through consultation, many provinces and territorial governments have engaged the public (current and future users of the LTC system), and other relevant LTC stakeholders from the industry and from service organizations. This has enabled governments to obtain feedback and

input to inform the development of their respective LTC strategies. To illustrate this point, consultations held in 2007 by the New Brunswick provincial government, and in 2006 by the Government of Newfoundland, respectively, revealed a desire of many participants to remain at home for as long as possible (Government of New Brunswick, 2008a; New Brunswick Family and Community Services, 2007; Newfoundland and Labrador Health and Community Services, 2006; Newfoundland Health and Community Services, 2007).

Based on a review of information from the jurisdictions, the provinces and territories are making headway in facility-based LTC through a range of diverse strategies and initiatives. The Independent Review of Staffing and Care Standards for Long-term Care Homes in Ontario (the Independent Review), established by the Ministry of Health and Long-term Care in September 2007, helped inform the development of regulations under the new *Long-term Care Homes Act* (the Independent Review, 2008). In Saskatchewan, the Commission on Medicare, appointed by Premier Romanow in June, 2000, identified a relatively high rate of dependence on facility-based LTC homes in the province, and an insufficient utilization of less costly alternatives (Commission on Medicare, 2001). The province of Saskatchewan held consultations in 2009 to identify gaps and challenges in LTC (Saskatchewan Ministry of Health, 2010b). Many provincial governments have funded reviews of the LTC sector in their jurisdictions, which has helped pave the way for new and innovative approaches to addressing challenges in existing LTC systems. In April, 2008, the government of Yukon commissioned the Health Care Review Steering Committee (HCRSC), to review the territory's health care system (HCRSC, 2008). The Committee recommended that the government investment in home care, community support and supportive and assisted living, to keep individuals out of the acute care and facility-based LTC system to address burgeoning health care costs (HCRSC, 2008). The Report also recommended that the government develop a long-term plan to increase residential long-term beds ensure plans are in place for future capacity requirements, and suggested allowing private or not-for-profit suppliers of long-term beds enter the market (HCRSC, 2008). The government of PEI called on the efforts of Corpus Sanchez International (CSI), an independent consultancy group, to review LTC in the province. CSI's final report suggested there was an over reliance on facility-based component of the LTC system, pointing to a need to bolster investment in health care services received in the home and community (CSI, 2008). In accordance with this finding, expansion of the home care system was identified as a pillar of the province's 2009 *Healthy Aging Strategy* (PEI Health, 2009a). Similar findings resulted from the HCRSC in the Yukon.

Fiscal Pressures

Based on information available from the jurisdictions, provincial and territorial governments are faced with fiscal pressures, which require them to address facility-based LTC in an economic and realistic way. As a result of fiscal pressures, the Manitoba government proposed a two-year wage freeze for the province's nurses (Turenne & Romaniuk, 2010). The 2004 Throne Speech for the Legislative Assembly in Nunavut included an acknowledgement that fiscal challenges are a continuing challenge, impacting the delivery of LTC (Irnig, 2004). The Auditor General of Nova Scotia suggested that as a result of fiscal pressures experienced by the government, there was a need to address seniors' health care requirements in a cost-effective manner (Auditor General of Nova Scotia, 2007). Large jurisdictions with aging demographics

experience significant fiscal pressures, as a result of a high population of facility-based LTC residents. For example, there are more than 76,000 residents in public and private LTC homes in Ontario (Statistics Canada, 2008;¹² Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS), 2010), with the large majority of these residents having complex care needs, and more than two thirds of residents suffered from some type of dementia (OANHSS, 2010). Given the size of the Ontarian LTC sector, any system-wide improvement to the LTC system has large-scale resource implications (OANHSS, personal communication, June 30, 2010). Effective July 1, 2010, a new regulatory scheme for LTC, the *Long-term Care Homes Act*, will come into force in Ontario (MHLTC, 2010c). The province's 2008 Budget allocated \$23.3 million to help offset the cost of increased regulatory requirements (Ontario Ministry of Finance, 2008). The OANHSS expressed a concern that this funding is not enough for facilities are able to meet the ongoing requirements of the new regulations (OANHSS, 2010b).

Facility Ownership

Review of government information evidenced that, in certain jurisdictions, the private sector is playing an increasingly large role in facility-based LTC, through ownership and operation of LTC facilities. As of 2008, the Alberta Health and Wellness long-term care plan encouraged private as well as not-for-profit investment in the development and operation of facilities, through outside partnerships and cost-sharing agreements (Alberta Health and Wellness, 2008a). In 2008, the province of New Brunswick entered into a pilot public-private partnership with Shannex New Brunswick, to construct 700 new nursing home beds over ten years (New Brunswick Social Development/Seniors and Healthy Aging Secretariat, 2010a). The private sector company, Shannex, has assumed responsibility for the development of the facility and its day-to-day operations (New Brunswick Social Development/Seniors and Healthy Aging Secretariat, 2010a). In Ontario, there has been an increase in privatization of LTC and contracting-out of LTC services (ASG, 2008; Ontario Health Coalition, 2002).

The balance of private versus public ownership of facility varies across jurisdictions. This has an impact on access to publicly-funded LTC beds. Manitoba has one of the highest rates of not-for-profit ownership of facilities in Canada, with the large majority (75 %) of LTC facilities being not-for-profit (Manitoba Nurses Union, 2006). In New Brunswick, facility-based LTC (referred to as *nursing homes* in the province) constitute privately owned, not-for-profit organizations, funded 85 % by the provincial government (New Brunswick Association of Nursing Homes, 2010; Government of New Brunswick, 2008a). Although the term “nursing home” may be used generically in the Canadian LTC sector, it denotes a specific type of LTC facility found in New Brunswick, Nova Scotia, Newfoundland and Labrador (CHA, 2009). In Saskatchewan, personal care homes provide another care facility-based LTC option for individuals to access, but while they are licensed and monitored by Saskatchewan Health, they remain outside of the publicly-funded system (Saskatchewan Health, 2007c). This is in contrast to the majority of private facility-based LTC, which is not subject to provincial licensing requirements. In PEI, effective January, 2007, the provincial government initiated subsidization of facility-based LTC in both public nursing facilities and private nursing homes

¹² Statistics Canada uses the term “long-term care home” to denote “nursing homes, homes for the aged, and other facilities providing services and care for the aged. Not included are homes for senior citizens or lodges where no care is provided.

(PEI Health, 2009b). This is not the case in most jurisdictions, where individuals do not receive government subsidy unless they receive care in a public facility.

Resident Cost of Care

The cost of facility-based LTC care to residents varies a significant degree, depending on the jurisdiction. Residents are charged \$54.25 per day in public facility-based LTC in Alberta, which ranks among the lowest cost in the country (Alberta Continuing Care Association, 2008). In the NWT, the resident co-payment for a public LTC bed is \$23.40 per day (NWT Health and Social Services (HSS), 2009d). This is a stark difference from the rate charged in other jurisdictions, such as in Nova Scotia where the cost of facility-based LTC is \$94.75 per day (Nova Scotia Health, 2010). Resident fees also vary within the same jurisdiction. In BC, the cost of public facility-based LTC varied from \$30 to \$95 per day (BC Ombudsperson, 2009). Further details on cost of facility-based LTC across jurisdictions is provided in Appendix D. Appendix D also outlines the eligibility requirements for admission, as well as nomenclature used to describe facility-based LTC in each province and territory. Appendix D also uses provincial and territorial information to show the demographic pressure that will be exerted by seniors in each jurisdiction.

There is variation in the degree to which provincial or territorial governments subsidize care, as shown in Appendix E. Many provinces and territories apply a financial assessment to determine the cost of facility-based LTC residents. In New Brunswick, individuals are responsible for the full cost and provision of LTC services for their family members through a standardized assessment criterion, the Standard Family Contribution Policy (SFCP), and the government is payer of last resort (New Brunswick Social Development, 2009a). The SFCP takes into consideration all personal or the net income of the family unit through intergenerational transfers (New Brunswick Social Development, 2009a). A limited number of provincial policies take into consideration assets as well as income, in determining cost of care and accommodation for the client, as is the case in Newfoundland (Newfoundland Health and Community Services, 2010a) and Quebec (Manulife, 2009). Provincial and territorial jurisdictions have a cap or ceiling in place to determine the maximum fees that a resident is responsible to pay (CHA, 2009). This amount varies across jurisdictions.

Based on information from the jurisdictions, most provinces have adopted an income-testing model, thereby omitting personal assets from the financial assessment that determines resident cost of care. In the majority of jurisdictions, the provincial government covers the cost of health services, while the resident is charged with the accommodation component. Nova Scotia recently adopted this policy, reflecting an alignment with the policies of most of Canada (ASG, 2008; Auditor General Nova Scotia, 2007). A unique case was observed in the Yukon and in Nunavut, where the government covers the total cost of facility-based LTC for residents (Manulife, 2009).

Admission Requirements

Admission requirements were found to be generally consistent across jurisdictions. Jurisdictions employ a single-entry tool to determine admission to facility-based LTC. In all

jurisdictions, the individual must be assessed as requiring complex medical and nursing care. Further comparison on admission requirements between jurisdictions is included in Appendix D.

Generally, individuals must be of a certain age (usually 18 or 19 years of age), a resident of the jurisdiction, and a Canadian citizen or permanent resident. Age requirements differ in the NWT and in PEI, where individuals must be 60 years of age or older to be eligible, or have met exceptional requirements (NWT HSS, 2009b; PEI Health, 2009b). In the NWT, prospective clients must be deemed eligibility by a Territorial Admissions Committee (TAC) whose mandate is to ensure quality and accessibility of the continuing care system (NWT HSS, 2009a). The Committee utilizes a standard assessment tool in determining eligibility. Similarly, in Nunavut, Manitoba and Saskatchewan, admission to facility-based LTC is determined by a panel or committee (Manulife, 2009).

The majority of provinces and territories have residency requirements in place in order to be eligible for subsidized facility-based LTC. Jurisdictions vary in how residency is determined (Manulife, 2009). An exception is Nunavut, where there are no territorial residency requirements (CHA, 2009). Across jurisdictions, if an individual does not meet the given admission requirements, they will be admitted to a LTC facility, but will be responsible to pay the full cost of their care, until they are eligible for a subsidy (Manulife, 2009). All jurisdictions specify that an individual must qualify for care by having been assessed as requiring the level of care provided in facility-based LTC, as shown conclusively in Appendix D. For example, the Residential Care Access Policy, in place in BC since 2002, is a needs-based access policy for facility-based LTC (BC Ministry of Health Services, 2002). This policy restricts admission to facility-based LTC to individuals who require complex care.

All provinces and territories provide financial subsidies to those who require it, to a varying extent. In Alberta, a sliding scale is used to determine level of subsidy based on a needs-assessment, up to a maximum of \$8,880 per year (Manulife, 2009). Provincial and territorial jurisdictions also have policies in place to determine levels of “comfort allowances” or “personal allowances.” This refers to the amount that a resident is allowed to retain in disposable income per month, after paying accommodation charges (Manulife, 2009). This amount was \$265 in Alberta, for example, but may be higher or lower based on the jurisdiction (Alberta Seniors and Community Supports, n.d).

Accessibility

There has been increased demand for services in many jurisdictions, which may be attributed to a steady growth in the senior population and a high utilization rate (ASG, 2008). In this context, LTC capacity refers specifically to the availability of publicly-funded LTC beds that provide a high level (level 3 or 4) care to residents. Inadequate facility-based LTC capacity results in increased pressure on the acute care sector (Alberta Health and Wellness, 2008a; CHA, 2009; New Brunswick Senior and Healthy Aging Secretariat, 2010; Ontario Health Quality Council, 2010; Quebec Health and Social Services, 2002). Longer wait times for facility-based LTC means that many seniors are left in the community while they await admission, which can cause significant stress on their informal caregivers at home. This may

also result in emergency hospitalizations when individuals require immediate treatment, contributing to wait times in the acute care sector.

Uneven Access across Canada

Accessibility of facility-based LTC varies between provinces or territories, and even within the same jurisdiction. Information from jurisdictions reflected that PEI and Manitoba had relatively high level of access to care. In their final 2008 report on LTC in PEI, the Ascent Strategy Group (ASG) determined that 9.2 % of PEI's over 65 population had access to facility-based LTC; a figure that is twice as high as the national average. The Manitoba Nurses Union (2006) stated that Manitoba had the highest rate of residential care beds per 1,000 individuals over 75 in Canada. On the other hand, challenges in access to facility-based LTC were experienced in Ontario, as a result of a gap between capacity and demand (OANHSS, 2010c; Ontario Federation of Community Mental Health and Addiction Programs et al., 2009). The waitlist for LTC beds in Ontario was estimated at over 25,000 individuals as of June, 2010, with the greatest demand being for the not-for-profit sector (OANHSS, 2010a). BC government-initiated consultation revealed public perception of a shortage of publicly-funded beds, particularly among low-income earners (BC Ministry of Health Services, 2007). Uneven access across jurisdictions and health authorities was a challenge also experienced in the NWT, Ontario, and PEI (NWT HSS, 2009c; Price Waterhouse Coopers, 2001; CSI, 2008). Differences in accessibility within jurisdictions may be the result of uneven distribution of LTC beds across health authorities, uneven government funding for health authorities or specific barriers faced in rural areas, such as transportation (Price Waterhouse Coopers, 2001).

Challenges in Accessibility in Rural/Northern Regions

Issues of access are particularly pronounced in rural and northern regions, and in large service delivery areas, where inadequate transportation can impede the delivery of community-based programs (National Advisory Council on Aging, 2006; Federal/Provincial/Territorial Committee for the Ministers Responsible for Seniors, 1999). They may be forced to leave their communities, families, and friends to re-locate to communities where facilities are available, causing stress (National Advisory Council on Aging, 2006). Difficulties in access are experienced in rural areas of the Atlantic provinces (CSI, 2008; Federal/Provincial/Territorial Ministers Responsible for Seniors, 2007). Accessibility to LTC services is particularly pronounced for seniors in rural areas, because of unique geographical issues that were not experienced in urban areas. This was observed in jurisdictions such as Alberta, Newfoundland, NWT, Saskatchewan, Yukon and Nunavut (Alberta Continuing Care Association, 2009; NWT HSS, 2009c; Commission on Medicare, 2001; Health Canada, 2005; Health Review Steering Committee, 2008). In Newfoundland, as a result of the "first available bed" policy, facility-based LTC clients may have to accept placement at a facility that is located far from their families and communities (Newfoundland Health and Community Services, 2007). Further, seniors who reside in regions that are geographically isolated may have a lack of sufficient support systems that enable them to remain in the community (Health Review Steering Committee, 2008). This may cause them to enter facility-based LTC sooner than if the necessary supports to remain in their own homes were available. In Saskatchewan, the literature shows that it is difficult to deliver required services to Aboriginal people across the

province, specifically people who live on reserve (Commission on Medicare, 2001). These people travel or relocate to urban centres to seek health services including LTC (Commission on Medicare, 2001). Accessibility is a challenge in Aboriginal communities, as individuals in these communities may experience geographic, cultural, social, and financial barriers to accessing care (Minister's Advisory Committee on Health, 2010; Roulston, 2008).

Access to Specialized Care

Access to culturally-specific within LTC facilities was cited as a concern among stakeholders (BC Ministry of Health Services, 2007). The Ontario Human Rights Commission determined that there was a lack of French-language LTC facilities, impeding access for francophone communities (Ontario Human Rights Commission, 2001). The Commission observed more broadly that there are not enough homes that serve specific cultural or linguistic sub-populations, which results in longer wait lists for individuals who desire placements at these facilities (Ontario Human Rights Commission, 2001).

Obtaining specialized care for residents with Alzheimer's disease in a facility-based care setting was identified as a challenge experienced in the sector (CHA, 2009; Canadian Institute of Health Information, 2008). Facilities encounter difficulty in meeting basic care needs of existing residents while simultaneously addressing more complex situations such as mental health issues and aggressive behaviours (OANHSS, 2010c). Meeting the specific needs of subpopulations of residents was identified as an issue in Ontario, including adequately addressing the needs of residents with dementia, and individuals who have complex care requirements but are much younger than the typical resident population (ASG, 2008; CSI, 2008). LTC facilities experience difficulty offering specific programming to these individuals, and staff are not appropriately trained to respond to the needs of younger residents who are placed alongside seniors (ASG, 2008).

There are certain options available to cater to the specialized needs of residents with dementia. Specially designed units, referred to as *special care units* (SCUs), take into consideration the specific needs of these residents who have dementia in their architectural design, such as the tendency of individuals with dementia to wander (Ascent Strategy Group (ASG), 2008). SCU's may be built as smaller-scale pods within larger facilities, or as separate, smaller, residential units (ASG, 2008). The availability of special care units is one way that specialized care is provided in facility-based LTC.

In many jurisdictions, publicly available information evidenced that individuals have access to palliative care through the provincial home care program as well as through facility-based LTC, as was the case in New Brunswick, Newfoundland (Government of New Brunswick, 2008a; Newfoundland Ministry of Health and Community Services, 2005). However, it was difficult to ascertain the availability of, and accessibility to end-of-life care within facility-based LTC.

Education and Training

Objectives pertaining to training and education of the LTC workforce were less commonly mentioned as part of provincial LTC strategies. An exception to this was Manitoba's *Aging in Place* plan which included a plan to strengthen work environment for staff, and to provide dementia education to both staff and families (Government of Manitoba, 2007). Alberta constituted a unique jurisdiction in the area of education, as the province has a province-wide education curriculum in place for PSWs. However, completion of this curriculum was not mandatory (Auditor General of Alberta, 2005). Review of information on Alberta revealed concerns that the current education program is underused, and does not provide an adequate number of prospective employees (Roulston, 2008; Auditor General of Alberta, 2005). The provincial Auditor General also identified uneven levels of training received by the paraprofessional workforce as a challenge in Alberta.

In 2008, the government of Alberta hired an HR consultant, Roulston, to examine issues faced by the long-term and continuing care sector in recruiting and retaining HCAs. Roulston's 2008 report, *Labour Market Study: Recruitment and Retention of Health Care Aides in Long-term Care* made the following observations. Securing adequate funding to ensure adherence to new province-wide education requirements for HCAs, implemented as of 2007, was a challenge. As well, education programs were noted to have become the responsibility of the employer, because colleges were not able to attract a significant number of applicants to programs. Cost of training was identified as a discouraging factor, because of the relatively low salary one could expect to earn upon graduation. Other barriers to seeking training in the sector included: transportation, lack of substitutes to cover roles in facilities, and a lack of enforcement measures for staff who did not attend. Although these observations were made on the basis of review of Alberta, Roulston's conclusions may be helpful in understanding similar challenges that may be experienced in other Canadian rural and northern jurisdictions.

Staffing Levels/Mix

Certain jurisdictions have mandatory staffing standards or targets in place. As of 2008, the staffing standard in New Brunswick was 3.0 hours of direct care per resident per day, with an eventual commitment to increase the level to 3.5 hours of care per resident per day (Government of New Brunswick, 2008a; New Brunswick Senior and Health Aging Secretariat, 2009). The standard guarantees a certain staffing mix ratio, meaning that a set number of hours must be provided by RNs, LPNs, and PSWs, respectively. The staffing target in place in BC was 2.6 – 2.7 hours of direct care per resident per day, as of 2009 (CHA, 2009). In Nova Scotia, the Department of Health sets guidelines for resident care staffing levels and ratios, including RNs, LPNs, and PSWs (Auditor General of Nova Scotia, 2007). Although it is expected that nursing homes maintain approved standards, it was noted that there may be a lack of monitoring and oversight in this area as staffing levels were not ensured as part of provincial licensing inspections (Auditor General of Nova Scotia, 2007). Ontario's new *Long-term Care Homes Act* puts in place a staffing target of 3.26 for the average paid hours of direct daily care per resident for nursing, personal support, and programming (MHLTC, 2008b). Staffing levels in PEI were generally higher than in other provinces as they ranged from 3.69 to 4.25 direct care hours per resident per day in public LTC facilities (CSI, 2008).

Review of the literature exposed inadequate and inconsistent staffing levels to be a challenge across provincial and territorial jurisdictions. Based on the interpretation and views of the researchers, inadequate staffing means that there is not enough staff to provide a high quality of care to residents, thereby resulting in poorer clinical outcomes, and a decrease in resident and staff satisfaction and quality of life. The challenge of inadequate staffing was commonly identified by independent organizations, LTC reviews conducted at the request of governments, LTC associations and other health organizations (Auditor General of Alberta, 2005; Roulston, 2008; 2004; BC Ombudsperson, 2009; British Columbia Care Providers Associations (BCCPA), 2010; Ontario Health Coalition, 2008; Ontario Health Quality Council, 2009; Smith, 2004; OANHSS, 2010c; CSI, 2008). Such sources noted staffing levels to be deficient to enable staff to provide a sufficient number of hours of direct care for residents, who, as it has been noted, have higher and more complex care needs than in the past.

In recognition of staffing levels as a prevalent concern in the sector, many provincial and territorial strategies have focuses LTC strategies in this area. For example, a 2009-2011 objective of the NWT territorial government was to standardize models of care, direct care hours, and staffing, to promote greater consistency in staffing across the territory (NWT HSS, 2009c). In PEI, the Health Recruitment and Retention Secretariat was created within the Department of Health to provide health human resource planning, and to undertake recruitment and retention efforts to meet current and future needs for physicians, nurses, and allied health professionals (PEI Health Recruitment and Retention Secretariat, 2010). A stated objective of the Manitoba LTC plan was to target investments to increase staffing levels across the province to ensure 3.6 hours of direct care per resident per day from registered nurses, registered psychiatric nurses, licensed practical nurses, and health care aides (Government of Manitoba, 2007).

Recruitment/Retention

Many Canadian jurisdictions are experiencing difficulties in recruitment and retention in LTC. For the unregulated or paraprofessional component of the facility-based LTC workforce, the literature shows that these challenges are faced across the Canadian facility-based LTC sector (Auditor General of Alberta, 2005; Alberta Continuing Care Association, 2009; BCCPA, 2010; Roulston, 2008; Ministers Advisory Committee on Health, 2010; Government of New Brunswick, 2008a; Newfoundland Health and Community Services, 2007; Ontario Health Coalition, 2008; the Independent Review, 2008; Smith, 2004; CSI, 2008). This has been attributed to numerous factors, including the demographic of the workforce and upcoming retirements, high job stress, low wages for paraprofessional staff, and low wages for professional staff relative to their counterparts in the acute care (BCCPA, 2010; Government of New Brunswick, 2008a; Ontario Health Coalition, 2008; Smith, 2004). The literature exposed recruitment and retention as an area where further attention is required, to formulate recruitment and retention strategies across types of LTC health care staff (Ontario Health Coalition, 2008; the Independent Review, 2008). Recruitment and retention issues were particularly pronounced in rural and remote geographic regions, such as in Nunavut, as was addressed in the 2005 Throne Speech delivered in the territory (Hanson, 2005).

Recruitment and retention challenges were also attributed, in part, to a poor societal perception of the sector as physically and mentally demanding, characterized by increasingly frail seniors, aging infrastructure, staff shortages, poor working conditions for unregulated health care workers, heavy workloads and uncompetitive wages and benefits (Auditor General of Alberta, 2005; Roulston, 2008; MHLTC, 2008a). A negative view of the sector contributes to difficulty attracting university students to health care programs that are focused on seniors' care (Newfoundland Health and Community Services, 2007).

Retention and recruitment challenges were also observed for the professional workforce, such as physicians and nurses across Canada (Newfoundland Health and Community Services, 2007; Saskatchewan Association of Health Organizations (SAHO), 2010; Saskatchewan Union of Nurses, 2010; CHA, 2009). Wage levels for LTC professionals vary across the province, which may impact recruitment of professional LTC staff to given jurisdictions. As was evident in the literature, Alberta has the lowest wages for HCAs in the country as of 2008, while the province simultaneously has the highest wages for RNs in Canada (Roulston, 2008). In 2006, the Registered Nurses Association of the NWT and Nunavut observed that the NWT is facing a shortage of RNs, as a result of an aging workforce of baby boomers, inadequate health funding, and poor recruitment of new graduates to fill vacancies. The Association stated that the nursing shortage, though experienced across Canada, is more acute in the NWT and in Nunavut because of the higher cost of living, isolation, and increased expectations of nurses (NWT Registered Nurses Association, 2006).

Recruitment challenge may be exacerbated by difficulties in recruiting LTC personnel from outside jurisdictional borders, due to lack of reciprocity provision. Roulston commented on the absence of assessment tools to determine equivalences or assess whether educational qualifications received outside of the province meet in-province standard for LTC workers. Difficulties are particularly pronounced for potential employees who receive training and education outside of Canada (MHLTC, 2008a). In the absence of a streamlined process to attract foreign workers, it can be up to two years to grant a visa, adhere to the existing immigration process and be placed in a LTC vacancy (Roulston, 2008). It may be possible to streamline this process to reduce unnecessary delay and facilitate the process for LTC workers.

Many provincial and territorial governments have initiated strategies to address these workforce challenges. The Alberta government in collaboration with the LTC industry established a strategy to provide PSWs with greater recognition and enhance team-building activities in LTC facilities (Alberta Continuing Care Association, 2009). The NWT government's strategic plan included an aim to develop new ways to recruit and retain staff, indicating that this remains an area of concern (NWT HSS, 2009c). Manitoba Department of Health's 2007 *Aging in Place* strategy allocated \$40 million dollars to improving quality of LTC, for objectives including to hire 250 nurses, 100 personal health care aides and 50 allied health care professionals, and to increase direct care hours for residents (Government of Manitoba, 2007). The plan included a recruitment strategy including return-of-service grants for nurses and health care aides in LTC facilities (Government of Manitoba, 2007). This means that financial assistance, in the form of a conditional grant, is given to nurse and HCAs in LTC facilities. Roulston (2008) proposed providing assistance with staff burn out, implementing a supervisory training program for leaders, developing of a performance management system,

and improving access to education opportunities as strategies to address retention challenges in the province.

The New Brunswick provincial government invested \$1.2 million in community services, including the development and implementation of a recruitment and retention strategy for LTC workers (Government of New Brunswick, 2008b). The province's LTC strategy, *Be independent. Longer* aims to address recruitment and retention by enhancing the availability and affordability of training opportunities in the province's post-secondary education system; ensuring seniors-specific training in curricula for all formal caregivers and establishing a standardized training across the LTC sector (Government of New Brunswick, 2008a). As well, a four-year contract was negotiated between the New Brunswick Nursing Home Association and the Canadian Union of Public Employees (CUPE), to give 4,000 LTC workers parity of wage with counterpart employees in the hospital sector (New Brunswick Association of Nursing Homes, 2010). Nova Scotia's 2006 10-year plan for LTC, *Continuing Care Strategy for Nova Scotia: Shaping the Future of Continuing Care* noted that short- and long-term approaches are required to address staffing shortages, recruitment, retention, education, and training in the province (Nova Scotia Health, 2006a). Regarding recruitment and retention efforts are a slow process, and it takes ongoing long-term efforts to realize progress in the area (Government of Manitoba, personal communications, July 13, 2010).

Provincial/Territorial Funding for Facility-based LTC

Many stakeholders expressed concern that current funding from the provinces for facility-based LTC was inadequate to address the much higher care needs of residents (Quebec Health and Social Services, 2002; CHA, 2009). There are different levels of funding for various health authorities, which may result in inconsistencies in quality of care across the province. This was noted to be a challenge in Alberta and in BC (Auditor General of Alberta, 2005; Roulston, 2008; BCCPA, 2009). In certain jurisdictions, there was concern that the existing classification system is losing relevance, because the large majority of residents in facilities are older and sicker (Manitoba Nurses Union, 2006). In Manitoba, where care is classified from a 1-4 level of care, it was cited that only 0.4 % of admissions to LTC facilities were residents who were classified as Level 1 of care (Manitoba Nurses Union, 2006). In certain jurisdictions such as PEI, there is no formal resident classification tool in place to allocate resources based on resident needs (CSI, 2008). This means that the province allocates funds based on a per capita distribution formula, that does not take into consideration the health status of residents across facilities and therefore the amount of care that one resident requires compared to another.

Standards

In certain jurisdictions, it was noted that there are out-of-date or absent standards in place for LTC facilities. In Alberta, out-of-date standards for facility-based LTC led the health authorities to develop supplementary standards that varied across the jurisdiction (Auditor General of Alberta, 2005). Certain organizations reflected the view that standards were inconsistent across the provinces (Auditor General of Alberta, 2005; Manitoba Nurses Union, 2006). In 2006, the Manitoba Nurses Union asserted that standards for levels of care and staffing models were out-of-date. In the majority of jurisdictions, facility-based LTC is subject

to standards set by provincial or territorial legislation. Exceptions to this include Nunavut, the Yukon and Newfoundland, where there are no legislated requirements governing the administration of facility-based LTC (CBC, 2010).

Survey Interviews

Survey interviews were conducted with respondents from provincial-territorial government, national health organizations, and long-term care associations. The survey questions are included in Appendix A. This section summarizes the findings from the interviews.

Strengths of Facility-Based Long-term Care in Provincial/Territorial Jurisdictions

Two responses indicated that a strength of the system is that every province and territory offers facility-based LTC, albeit to a varying degree. This allows seniors, and other individuals with physical and mental disabilities, to access high-level care when they require it. The emergence of new aging-in-place models was identified as a strength by two respondents. This was seen as increasing choice for clients. Based on one survey response, universal eligibility was a strength, in that anyone who requires facility-based LTC is able to access it, assuming they meet residency requirements of the given jurisdiction. The admission process was noted to be a strength by one respondent, in that only clients with the highest needs are eligible to receive facility-based LTC. The existence of various service delivery models (private, non-for-profit, and administered by health authorities) was cited as a strength by one respondent, who noted that each delivery model has particular advantages and brings specific expertise to the delivery of the service.

Weaknesses and Challenges Experienced in the Sector

The predominant themes that emerged from respondents' answers are summarized as follows:

- Inconsistent terminology across Canada
- Inadequate staffing level/mix
- Recruitment and retention
- Inadequate training/education for Workforce
- Inadequate funding
- Inadequate capacity and long waits for admission
- Lack of research in the sector
- Inconsistent quality care across/within jurisdictions
- Increased resident acuity
- Negative societal view of the sector

Inconsistent LTC nomenclature or terminology across jurisdictions makes it difficult to determine equivalencies and commonalities among provincial and territorial plans, to engage in a pan-Canadian discussion on facility-based LTC, and to engage in information-sharing, according to respondents. Staffing has not been modified to reflect a clientele with higher care needs, noted one respondent. In addition to general workforce shortages, certain respondents specified that a lack of physicians and nurses with specialized geriatric care was a challenge.

Demographic challenges, and the resulting increased demand, are being felt throughout the sector in many jurisdictions, according to many interview responses. Long wait times for admission to LTC homes was identified as an obstacle or barrier in certain jurisdictions. Two respondents noted that a significant challenge was to reduce reliance on facility-based LTC system and to increase investment in prevention and alternatives to facility-based LTC. One respondent commented that a high level of reliance on facility-based LTC is indicative that other components of the system have been ineffective.

Increased resident acuity was experienced across jurisdictions, including an increase in residents with Alzheimer's disease and other dementias, and residents with significant behavioural and mental health issues. It was noted that it was a challenge to provide a high quality of care, given the increased proportion of residents who have dementia.

Respondents' Views of Policy Priorities for Facility-based Long-term Care in Canada

Certain respondents noted a need to procure more exact demographic forecasting to determine, with more precision, the extent and implications of demographic pressure on the facility-based LTC system.

Assessing Respondents' Views on the Federal Role in Facility-based Long-term Care

Many respondents were unclear as to the role of the federal government in facility-based LTC. When asked whether they would like to see the federal government expand its role in this area, most respondents responded affirmatively, noting a desire for the federal government to support the development of a common terminology and to work with provincial-territorial governments to develop national standards. A limited number of respondents commented that the federal government does not have a role to play in facility-based LTC, as it is solely the responsibility of the provinces and territories.

Certain respondents suggested a need for the federal government to develop a comprehensive mental health strategy. Certain respondents suggested that the federal government should address facility-based LTC by helping to determine, in partnership with the provinces, the needs and service preferences of the future generation of seniors and potential users of the system. Another respondent commented that the federal government should ensure provincial-territorial jurisdictions are equipped to address the needs of their aging populations. It was suggested by several respondents that there is a need for federal-provincial-territorial governments to engage in conversation about facility-based LTC and to share best-practices in a national forum.

LIMITATIONS

This section notes the limitations associated with this research, which should be considered when interpreting conclusions and results.

Literature Review

There was a shortage of information that focused on facility-based LTC from a pan-Canadian perspective; a limitation of the review. In certain areas, there was only information available for one or few provinces, which limits generalizability. A level of bias was apparent in certain sources, specifically during review of jurisdictional literature. As such, they were either omitted from the report or in some cases, were used to a lesser extent. This includes biases that favoured a particular regional perspective, or biases that reflected the particular views of the organization. In order to address the challenge of biased work, the research attempted to draw information from numerous sources to balance bias and gain a comprehensive picture of challenges, strengths, trends and issues in facility-based LTC across regions.

Jurisdictional Scan

There was a shortage of information and a lack of clear and comprehensive information available, on facility-based LTC in Nunavut and Quebec. In jurisdictions where there was a shortage of publicly available information, other types of sources were used to gain an overview of facility-based LTC in the region. For example, Hansard reports and Budget and Throne speeches were used to identify recent government commitments in LTC. As well, online local newspaper articles, and online newsletters issued by provincial LTC associations were used to substantiate the existence of issues and challenges prevalent in specific jurisdictions. In cases where there was limited information available, survey interviews with stakeholders were used to help substantiate the prevalence of regional trends and issues.

While a plethora of research was available on certain jurisdictions, research in other jurisdictions was sparse, resulting in a potentially uneven balance of information. In some cases, it was difficult to gain a picture of progress made on challenges in certain jurisdictions. For example, workforce recruitment and retention was commonly identified as a challenge, and provincial-territorial governments stated there were strategies in place to address this issue. It was difficult to determine the effectiveness of the policies in place, given that there was a lack of information available on whether workplace shortages and high workplace turnovers had been reduced since the implementation of the given recruitment and retention strategy.

It was difficult to gain information as to the current level of education and training for LTC staff, including professional and paraprofessional staff, across jurisdictions, and to examine how education and training standards differ across Canada. Information regarding reciprocity, and recognition of foreign or out-of-jurisdiction education credentials for the paraprofessional workforce. This was largely unavailable, except for general information about the issue provided within broader pan-Canadian LTC reports. This information would have been of use to this study, as it would have enabled an assessment of current mechanisms to promote

transferability of education credentials for the LTC workforce, to determine if the federal government could promote or coordinate policy in this area.

Survey Interviews

There are limitations associated with the interviews conducted. Initially, the research plan anticipated interviewing approximately 20 – 30 individuals. The actual number of interviews conducted was 14; about 10 less than anticipated. It was understood that individuals facing high workloads might not be willing to make the necessary time available. The time required to follow up and arrange times with individuals was more than anticipated and a lack of timely responses made it difficult to make arrangements with many individuals. Given the relatively small sample size of individuals who were interviewed, personal opinions and viewpoints were not taken into consideration.

Although it was stated to individuals in verbal conversations that the researcher was seeking the views of the organizations, in certain cases the individual may have offered personal opinions in response to the interview questions. The sample is not representative as it was not randomly chosen. Not all jurisdictions are represented, and a national Aboriginal organization was unwilling to participate. It was more difficult to obtain responses from provincial-territorial governments and as such, there were more interviews conducted with individuals from non-government organizations. The interviews took approximately 15-25 minutes. In some cases, the interviews were longer than 30 minutes. This may be considered a weakness in the study, as there was much more information given with regards to some organizations relative to others. In one case, the individual was not available to speak for longer than five minutes, and as such, the answers may have been too brief to be considered valid and meaningful responses. Certain respondents noted that they were not able to speak to LTC across Canada, and could only comment on obstacles and challenges in facility-based LTC in their region. This meant that they were only able to respond to part of the questions that were being asked.

DISCUSSION

The following section discusses and analyzes findings and results from the literature review, jurisdictional scan, and survey interviews. The discussion section will form the basis for the development of recommendations.

Implications of the Expansion of the Home and Community Care Sector

Based on the literature review and jurisdictional scan, certain trends have emerged on the LTC landscape and provide valuable context for understanding the evolving role of facility-based LTC in broader government LTC strategy. However, these trends were noted primarily to give context to the discussion on facility-based LTC. As such, an in-depth discussion of the implications of trends is not within the scope of this report; quality and accessibility of facility-based LTC. However, it is useful to give a brief analysis of the implications that the expanded role of home and community care has on facility-based LTC. A review of provincial and territorial LTC strategies showed that increasing AL, home care, and supportive living were integral to LTC strategies. No provinces are focusing solely on facility-based LTC. (A more primary focus on facility-based LTC was seen in the case of the territories, which may be due to the transportation issues associated with delivering home and community care services in large, northern jurisdictions). Survey interviews, especially from individuals in government, reinforced that it is not a favourable policy to rely heavily on facility-based LTC. It is difficult to discuss facility-based LTC without engaging in a discussion of other types of LTC. It appears that good policies in this area will continue to establish innovative linkages between facility-based LTC and AL, home care, and supportive living, given the support for integrated services by stakeholders and in the literature.

Yet, it is important to note that the provinces and territories continue to make significant investments in facility-based LTC in conjunction with expansion of the home and community care sector. This suggests that while home and community care plays a role in prevention and increasing client choice, there is no evidence that it negates or decreases the need for facility-based LTC. Based on the literature, there is uncertainty regarding to what degree home and community services can be substituted for facility-based LTC. This point of ambiguity was also raised in interviews with respondents. Further research and more precise forecasting would be useful to enable provincial and territorial governments to determine the actual facility-based LTC capacity required to respond to demographic pressure. For example, focused research in this area could track clients' utilization of home and community care programs, following the client as they progress from lower-level care to higher-level care options, to ascertain the degree to which these services reduce the need for facility-based LTC options.

Expansion of the private sector has potential implications for quality and accessibility, based on the literature. The literature review showed that private facilities are associated with lower staffing levels, because profit-driven facilities inherently divert a portion of their resources towards profit, which may lead to cost-cutting in the area of staffing. Yet, the literature review also expressed the importance of looking at factors outside of staffing to measure quality such as resident and staff satisfaction levels and innovative strategies. The jurisdictional scan

demonstrated that, in many jurisdictions where the private sector has emerged in the sector, private facilities are subject to the same provincial licensing requirements as public LTC facilities. This is a strength of the system in these jurisdictions, because this means that there is greater consistency in the quality of private and public facilities. On the other hand, in terms of accessibility, based on information from the jurisdictions, private facilities are largely out of reach of most individuals because they are more expensive than public facilities. What's more, clients are required to pay the full cost of services in these facilities. This means that although private facilities provide more options for seniors, but realistically only a small contingent of seniors are able to access private facility options. The majority of seniors are only able to afford publicly-subsidized care. This underlines the importance of ensuring adequate capacity of public, facility-based LTC.

Accessibility

Accessibility of facility-based LTC is affected by numerous factors including admission requirements, geographic location, availability of publicly-funded beds versus demand, and cost, based on the views of the researcher. Based on the jurisdictional scan, all jurisdictions have provisions in place to provide financial support for facility-based LTC. Provision of financial compensation for those who require it is considered a strength of the system, as was noted by numerous interview respondents. There were significant variations in the level of government subsidy that was provided, and in the test applied to determine eligibility for subsidy. In certain jurisdictions, assets are still taken into consideration, while most jurisdictions have aligned themselves with the income-based testing model. Imposing a standardized income-based test for facility-based care clients would promote greater consistency in the system, from a financial point of view. Despite these differences in administration, there is no evidence from the literature review that supports that accessibility is an issue from a financial point of view.

While issues of access in urban areas arise primarily from long wait list times, issues in rural and Northern areas are related to very limited capacity. Another issue specific to rural areas was that home and community care programs are less prevalent, and this may cause individuals to enter the facility-based system before they have high care needs. Accessibility issues are also prevalent for Aboriginal communities. Based on the jurisdictional scan, there appears to be substantial gaps in the continuum of services being provided to First Nations and Inuit individuals, particularly for those in institutional settings who require higher levels of care (Health Canada, 2008b). These challenges require unique solutions that are not within the scope of this paper.

It is persuasive based on information from the jurisdictional scan that issues of access emerge because of significant waitlists. Only certain jurisdictions had policies in place to monitor, track, and reduce wait times, as was the case in BC. Maintaining adequate data on wait times would give insight as to the demand for in certain jurisdictions. It would also allow for a more accurate comparison in wait times across jurisdictions, to monitor progress in the area of accessibility and make cross-jurisdictional comparisons.

Standards

Through the literature review, jurisdictional scan, and the survey interviews, it was determined that there are no national standards in facility-based LTC. This contributes to inconsistency in quality of care across Canada. The assumption literature review supported that standards have a viable association with quality of care. Based on information from the jurisdictions, standards are inconsistent among and within jurisdictions. Standards would help to promote greater consistency in quality, as supported by certain interview respondents. There are certain downsides to mandatory standards. They would impose a degree of uniformity on the sector. This might be met by opposition by some LTC stakeholders and by governments, where large-scale efforts to implement standards have already been newly implemented, as is the case in Ontario. As well, significant funding would be required to adhere to new standards.

Based on the literature, accreditation has positive effects on quality and organizational culture and is a way to promote greater consistency in standards of facility-based LTC across facilities and jurisdictions. The jurisdictional scan revealed varying levels of support for accreditation across jurisdictions. General support for accreditation was evidenced from the jurisdictional scan, as provinces had varying levels of support for LTC facilities seeking accreditation. It was surprising that none of the respondents who were surveyed mentioned accreditation as either a strength of LTC in their jurisdiction, or as an area where future improvements are required.

Accreditation is a mechanism to adhere to current standards in the sector without duplication of research on quality (at the provincial and territorial level) that is already being undertaken by organizations such as Accreditation Canada. The development of national standards by Accreditation Canada has no association with the development of standards by the federal government. However, the federal government could assume a role in promotion of accreditation by funding the provinces and territories in seeking accreditation for their LTC facilities. This was supported in the literature, as certain national reports showed that the federal government could take a greater role in encouraging the provinces and territories to accredit LTC facilities.

It is noteworthy that accreditation of LTC facilities would help to promote greater consistency of standards in the sector, but other challenges identified in the sector such as inadequate funding and understaffing would not be addressed through a recommendation of national accreditation. The accreditation process also requires a high level of time commitments from facility staff, which may be a challenge because of already high workloads faced in the sector.

Human Resources

Difficulties in recruitment and retention were identified as a common challenge facing progress in facility-based LTC across jurisdictions. Based on a review of the literature, the jurisdictional scan and the survey interviews, a negative societal view of the sector, relatively low wages, high workload and high stress levels contribute to recruitment and retention challenges. These results demonstrate that there are numerous factors underlying recruitment and retention challenges. Progress in this area is largely the responsibility of the provinces and territories. There seems to be an inclusion of recruitment strategies in current government LTC strategies,

based on the jurisdictional scan. However, it was difficult to gauge success in this area. It would be useful to gain more information as to whether any existing recruitment initiatives to combat recruitment have been successful, in order to engage in sharing of best practices across similar jurisdictions.

Certain national reports expressed a desire for the federal government to promote the development and implementation of pan-Canadian staffing standards in facility-based LTC. There were limited national LTC reports that recommended the establishment and implementation of national staffing standards for facility-based LTC. Although many respondents observed that low staffing levels was a challenge in their jurisdictions, none of the survey respondents cited national staffing standards as a potential policy to improve LTC across jurisdictions. It is unclear why this area was omitted. However, this may be in acknowledgement that, in many cases, current resources are inadequate set and meet staffing standards. The development of a national staffing target, rather than a mandatory ratio, with input from key stakeholders, may be a more realistic and flexible measure to guide the development and implementation of staffing ratios and targets by provincial and territorial jurisdictions. In addition to financial pressures, workforce shortages faced in many jurisdictions may complicate realization of this objective. Further discussion may be required among federal-provincial-territorial government, in collaboration with industry stakeholders, to identify a staffing target (rather than a staffing standard) that could be used as a model in all jurisdictions. A target would enable provinces and territories to set long-term goals in the area of staffing, and would help provinces and territories establish recruitment strategies in accordance with these long-term objectives.

The literature review revealed that education has a positive effect on quality in facility-based LTC. The jurisdiction scans showed that most jurisdictions have incorporated improvement to education for PSWs into their LTC strategies. Two interview respondents cited inadequate education as an obstacles faced by sector. Standardizing the education curriculum for PSWs would respond to certain challenges observed through the literature and jurisdictional scan; specifically, that there is uneven and inadequate education received by the paraprofessional workforce, given the higher acuity of residents in facility-based LTC. A standardized curriculum would benefit the sector, by ensuring consistency in the preparation that workers receive before entering the workforce, which may, in turn, improve consistency in the care that is administered. Moreover, standardization of education standards across the country may assist in recruiting members of the workforce from different Canadian jurisdictions, as well as from outside of Canada. Currently, there is a lack of reciprocity agreements for PSWs between provinces and territories to recognize training and education awarded in other Canadian or international jurisdictions.

The development of a pan-Canadian curriculum could draw on best practices from existing models of curriculum in Canadian jurisdictions, while ensuring that training and education is adequately specific to prepare the paraprofessional workforce to respond to specific challenges faced in the sector. The education of the paraprofessional workforce was also expressed as a concern through the literature review. However, given that the paraprofessional workforce plays an increasing role in providing care to residents, it seems particularly important to focus attention for this contingent of the workforce. As well, greater standardization in this area

would facilitate transferability of PSW credentials and certifications from one jurisdiction to another. The jurisdictional scan showed a lack of processes in place to recognize education and training received in other jurisdictions when a PSW seeks work in a different province or territory. This was also mentioned in a limited number of survey interviews. This may exacerbate difficulties for members of the paraprofessional workforce who attempt to relocate and seek similar work. A risk to bolstering education for the paraprofessional workforce may be that it could have an impact on recruitment; some paraprofessional workers may be attracted to the sector because of the low education requirements. This could be particularly relevant for low-wage earners who do not have adequate resources to pay for education programs. If education programs are not made widely accessible and are not subsidized, they may not be accessible for many individuals in the paraprofessional workforce and may discourage these individuals from working in the sector.

The literature showed that training helps support a higher level of quality in facility-based LTC. Two respondents mentioned inadequate training and education as an obstacle that prevents progress in the sector. The jurisdictional scan also revealed that, in certain regions, accessibility of training programs is a barrier to employees receiving training. It seems likely that any improvement in training programs should be accompanied by an incentive system. This could entail ensuring that all employees are paid for their time while receiving training. Further research could be undertaken to gain a more comprehensive view as to current incentive systems in place across jurisdictions, and attendance rates at current training programs. In embarking on any modifications to current training programs, it would be useful to consult with current personal support worker staff to ensure responsiveness of training to current needs and desires of the workforce.

RECOMMENDATIONS

Based on this research, the following four recommendations are made to the Chronic and Continuing Care Division of Health Canada:

Recommendation 1: Establish Mandatory Accreditation for Long-term Care Facilities

The federal government could support the mandatory accreditation of long-term care facilities by allocating transitional funding to the jurisdictions, taking into consideration the considerable resources that are required to complete the three-year accreditation process.

As a precondition before adopting this option, the federal government should conduct further research into the outcomes of accredited facilities versus non-accredited facilities. This study should include an examination of quality, as measured by the following: clinical outcomes and quality of life outcomes for residents; resident and staff satisfaction; and staff engagement, morale, and retention levels.

Recommendation 2: Develop pan-Canadian Staffing Models

Given the significant differences in staffing models and standards across jurisdictions, Health Canada could assume a leadership position in the development of general pan-Canadian objectives and guidelines in this area.

In order to establish appropriate benchmarks or targets for staffing, multi-stakeholder consultation should be conducted. This consultation should include: provincial and territorial stakeholders, industry stakeholders, unions, long term care associations, researchers in the field, and staff representatives.

The purpose of this deliberation would be for the federal government to demonstrate leadership in advocating and supporting a specific staffing target. It would be the responsibility of the provinces and territories to adopt this target, either through the establishment of a new staffing targets or standards, or modifications of existing targets and standards.

New staffing standards might also be adopted as part of amended accreditation requirements.

Recommendation 3: Develop a pan-Canadian Curriculum for Personal Support Workers

Personal support workers, also referred to as personal care aides and special care aides, receive different levels of training and education. The federal government could support the development of a standardized personal support worker curriculum, based on leading practices from current curriculum already in place, in post-secondary institutions.

This would involve allocating funding to a working group, which would be charged with taking a leadership role and overseeing the developing of a new curriculum with input and consultation with relevant provincial and territorial authorities, industry stakeholders and members of the workforce.

This policy would facilitate hiring of long-term care workers from outside jurisdictions, as it would be easier to recognize the qualifications and credentials from an out-of-province or out-of-territory worker.

New training requirements might also be adopted as part of amended accreditation requirements.

Recommendation 4: Promote Discussion and Research on Dementia

Given the increased prevalence of long-term care residents with Alzheimer's and other dementias in clients of the facility-based long-term care system, it is important to ensure that the current system has the capacity to address the special and specific needs of these residents. There is evidence that in many cases, the physical design of facilities, social programming, training and education of staff, and funding levels, are inadequate to address the needs of residents with dementia.

The federal government could allocate new funding for specific national research to be conducted in this area. This research could examine the ability of the current facility-based LTC system to address the needs of residents with dementia. This could include looking at the availability and efficacy of special care units across the country. Research could assess the adequacy of current training and education to prepare the professional and paraprofessional workforce to address the needs of residents with. Research should identify gaps in the current system, and identify potential policies to address deficiencies.

Recommendation 5: Promote portability and reciprocity of services among the provinces and territories

The federal government could encourage discussion among provinces and territories, to promote the development of reciprocity agreements. This would assist clients of the facility-based LTC system when they wish to cross jurisdictional borders to be closer to family and/or friends.

There are varying residency requirements in order to be eligible for financial subsidy for long-term care, and residents are often responsible to pay for the full cost of their care in new jurisdictions before they are insured under the given jurisdictional plan.

Reciprocity agreements might allow funding to "follow" residents when they relocate from one jurisdiction to another, until they are eligible for coverage by the new jurisdiction.

CONCLUSION

This project sought to provide an overview of quality and access issues for facility-based long-term care in Canada. A literature review was undertaken to obtain an understanding of various factors that impact quality and accessibility. A scan of provincial-territorial jurisdictions was completed to understand how facility-based LTC differs across jurisdictions, and how this impacts quality and accessibility. Survey interviews with respondents helped substantiate the findings of the literature review and jurisdictional scan. The objective of the project was to make recommendations about federal government policy in the area of facility-based LTC.

Based on based on the findings from the literature review and jurisdictional scan, this project proposed four recommendations for consideration by Health Canada. These recommendations take into consideration that the federal government is removed from the service delivery aspect of facility-based LTC, but may promote and facilitate certain policies among provincial-territorial jurisdictions. This report may be used by the client to identify further actions and strategies that will be taken in short-term and long-term, on facility-based LTC.

Given the considerable scope of this project, certain areas were omitted from research parameters but are of interest to the final recommendations proposed in the study. Further research may be required as a necessary precondition to inform potential federal action. This research should be conducted in the areas of accreditation, to determine the impact of accreditation on quality of care for residents, and on resident and staff satisfaction and quality of life in long-term care facilities. Further, research may be required specifically in the area of mental health, to determine how the facility-based LTC system could be amended to better suit the specialized needs of residents with mental health issues.

The federal government has made significant headway and progress in its commitments to LTC access and quality for specific populations for which it has direct service responsibility. Health Canada has the capacity to enhance its role in facilitating and coordinating provincial-territorial action on facility-based LTC for the entire population. Further steps are required to enhance accessibility and quality in the system and ensure an optimal (not minimum) level of care for current and future facility-based LTC clients.

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Appendix A: Consent Script/Interview Questions

Appendix A contains the consent script, including the five survey interview questions, which was distributed to individuals via email.

As a Masters student at the University of Victoria, I am required to conduct research as a prerequisite for my degree in Public Administration. The purpose of this research is to conduct an analysis of pan-Canadian issues in facility-based long-term care and identify jurisdictional variations and commonalities. I will identify areas for learning and improvement and, as appropriate, policy recommendations for federal government consideration.

You are being asked to participate in an interview because of your expertise in policy issues pertaining to facility-based long term care. I would like to ask you five open-ended questions, and I expect the interview will take 15-20 minutes.

The questions are:

1. What are the strengths of the current system of facility-based long term care in your region specifically, and across Canadian jurisdictions?
2. What do you think are the weaknesses or challenges for long term care in your region, and more broadly, in Canada?
3. My research is examining medium and long term planning in long term care, and identifying policy priorities. Based on your knowledge and experience, what do you think are the most prominent policy issues in facility-based long term care in Canada?
4. What do you think the federal government role is in addressing the issues faced in the provincial/territorial delivery of facility-based long term care? Would you like to see it change in any way?
5. Is there anyone else in Canada that you would suggest I interview?

You may answer only some of my questions, or all. After agreeing to participate and starting the interview, you may withdraw at any time, and in that case I will not use your answers in my research. If you agree to participate, the ideas and information you share will be used to supplement the information I have obtained from publicly-available documents and academic literature. Your name will not be used anywhere in my report. If you do not wish that the name of your organization be cited in my report, it will not be mentioned by name. My report will not be published for commercial purposes. I will document our conversation by taking written notes, which I will shred after the completion of my report.

You may verify the ethical approval for this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca). It is being conducted under the supervision of Dr. Rebecca Warburton. You may contact my supervisor if you have further questions by phone at 250-721-8066, or by email at rnwarbur@uvic.ca. This research is being funded by Students Providing Aligned Research and Knowledge (SPARK), a program under the Canada School of Public Service.

If you are willing to participate, please reply to this email saying “Yes” or “I agree to participate.” In that case, please provide me with the phone number you would like me to use

in contacting you. If you do not wish to participate, please reply saying “No” or “I do not wish to participate.” In that case, I will not contact you again. If I have not heard from you within a week or two, I will call to ask whether you wish to participate, and/or answer any questions you may have about this research.

Appendix B: Ethics Certificate



University
of Victoria

Human Research Ethics Board
Office of Research Services
University of Victoria
Administrative Services Building B202
Tel (250) 472-4545 Fax (250) 721-8960
Email ethics@uvic.ca Web www.research.uvic.ca


Human Research Ethics Board Modification of an Approved Protocol

<u>Principal Investigator</u>	<u>Department/School</u>	<u>Supervisor</u>
Natalie Desimini Master's Student	PADM	Rebecca Warburton
<u>Co-Investigator(s):</u>		
<u>Project Title:</u> A Policy Analysis of Solutions for Facility-Based Long Term Care in Canada		
<u>Protocol No.</u> 10-170	<u>Date</u> 03-Jun-10	
<i>For modifications to an Approved Protocol, your protocol approval period remains the same as your original certificate of approval.</i>		

Certification

This certifies that the UVic Human Research Ethics Board has examined this research protocol and concluded that, in all respects, the proposed research meets the appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Participants.

This Certificate of Approval is valid for the above term provided there is no change in the protocol. Extensions and/or amendments may be approved with the submission of a "Request for Annual Renewal or Modification" form.



Dr. Afzal Suleman
Associate Vice-President, Research

Appendix C: Organizations and Governments Represented by Survey Respondents

Below is a list of the organizations that participated in survey interviews. The names of the respondents are not given, as per the parameters outlined in Application for Ethics Approval for Human Participant Research which was submitted prior to the interview process.

Alberta Continuing Care Association
 BC Care Providers Association
 BC Ministry of Health Services
 Canadian Association on Gerontology
 Canadian Healthcare Association
 Council on Aging (*Conseil des aînés*)
 Government of New Brunswick
 Long-term & Continuing Care Association of Manitoba
 Manitoba Department of Health
 New Brunswick Senior and Healthy Aging Secretariat
 Newfoundland and Labrador Health Boards Association
 Nova Scotia Department of Health
 Nunavut Department of Health and Social Services
 Ontario Long-term Care Association

Below is a list of other organizations who were invited to participate in a survey interview.

National Initiative for the Care of the Elderly
Regroupement Québécois des Résidences pour aînés
 National Aboriginal Health Organization
 Northwest Territories Health and Social Services
 Ontario Ministry of Health and Long-term Care
 Saskatchewan Ministry of Health
 Ministère de la Famille et des Aînés Québec

Appendix D: Provincial/Territorial Cost and Eligibility Requirements for Facility-Based Long-term Care

Jurisdiction	Nomenclature	Demographics	Fees/Subsidies	Admission Requirements
Alberta	nursing homes	20% seniors by 2031 ¹³	<ul style="list-style-type: none"> • government covers health care costs of facility-based LTC • accommodation costs are \$54.25 per day¹⁴ 	<ul style="list-style-type: none"> • residency requirement • must be covered under the provincial health care plan • must be assessed as requiring 24-hour professional care¹⁵
BC	residential care	22.6% seniors by 2031 ¹⁶	<ul style="list-style-type: none"> • province covers cost of health care in publicly-funded facility-based LTC • clients pay a monthly charge of up to 80 % of after-tax income to a maximum of \$2,932 per month¹⁷ 	<ul style="list-style-type: none"> • age requirement, 19 years of age or older • must have lived in BC for three months • must be a Canadian citizen or have permanent resident status • must have been assessed as unable to function independently because of chronic, health-related problems, or an end stage illness
Manitoba	personal care homes	22 % seniors by 2031 ¹⁸	<ul style="list-style-type: none"> • government pays majority of cost for care • resident fees determined by income-based test¹⁹ 	<ul style="list-style-type: none"> • must have lived in province for two years, or have resided in Manitoba for 30 years and returned within less than 10 years • eligibility for facility-based LTC determined by provincial panel²⁰

¹³ Minister's Advisory Committee on Health, 2010.

¹⁴ Alberta Continuing Care Association, 2008.

¹⁵ Alberta Seniors and Community Supports, n.d

¹⁶ BC Stats, 2004.

¹⁷ BC Ministry of Health Services. Fees for Services. (n.d.)

¹⁸ Manitoba Nurses Union, 2006.

¹⁹ Manitoba Health. 2009b.

²⁰ Finlayson et al., 2007; CHA, 2009

Jurisdiction	Nomenclature	Demographics	Fees/Subsidies	Admission Requirements
New Brunswick	nursing homes	provincial population of seniors forecast to double by 2030 ²¹	<ul style="list-style-type: none"> • income-best test to determine resident fees • New Brunswickers are responsible for the full cost of LTC services for their family members • government will assist if family is unable to cover cost²² 	<ul style="list-style-type: none"> • Canadian citizens are eligible immediately upon entering New Brunswick • must be 19 years of age or older • must have been assessed as requiring services by a standardized assessment criteria²³
Newfoundland	nursing homes, long-term care homes	20 % senior population by 2017 ²⁴	<ul style="list-style-type: none"> • health services costs bundled together with accommodation fees • max. fee for resident is \$2,800 per month • if client is unable to cover cost of care, income and asset-based test is applied to determine how much the resident pays²⁵ 	<ul style="list-style-type: none"> • individual must be a citizen or permanent resident of Canada, and a resident of Newfoundland and Labrador • must have been assessed as requiring 24-hour professional care²⁶

²¹ Senior and Healthy Aging Secretariat, 2010

²² New Brunswick Social Development, 2009a

²³ New Brunswick Social Development, 2010b; Manulife, 2009

²⁴ Newfoundland and Labrador Health and Community Services, 2007

²⁵ Newfoundland Health and Community Services, 2010a

²⁶ Manulife, 2009

Jurisdiction	Nomenclature	Demographics	Fees/Subsidies	Admission Requirements
Nova Scotia	nursing homes, homes for the aged	population of seniors will increase by 86.3% in 2033, from 2007 level ²⁷	<ul style="list-style-type: none"> • provincial government is payer of last resort • accommodation charge for clients is \$94.75 per day²⁸ • province recently divided costs of care into accommodation and health care²⁹ <ul style="list-style-type: none"> • province subsidizes health care portion of LTC, resident covers accommodation component • province offers subsidy based on an income-based financial test • resident fee is \$23.40 per day • financial subsidy available where client is unable to pay³² 	<ul style="list-style-type: none"> • single entry access system • 18 years of age or older • citizens or permanent residents of Canada • residents of Nova Scotia must have a Nova Scotia Medical Service Insurance health card must have been assessed as having health care needs beyond what can be adequately managed by family, home care, and community services³⁰
NWT	LTC facilities	seniors projected to double (reaching 7,000) by 2020, but are still only a small contingent of territorial population ³¹		<ul style="list-style-type: none"> • single point-of-entry policy • applicant must be approved by Territorial Admissions Committee • must be a resident of the NWT • must meet eligibility requirements of the territory's Health Insurance Plan • must be 60 years of age or older or meet exceptional requirements

²⁷ Nova Scotia Department of Seniors, 2009.

²⁸ Rate was \$94.75 as of November, 2009. Nova Scotia Health, 2010.

²⁹ "Health care costs" includes nursing and personal care, social work services, physical, occupational, recreation, and other therapies. "Accommodation costs" include salaries, benefits, costs of dietary services, housekeeping, management, etc. Nova Scotia Health, 2010.

³⁰ Nova Scotia Health, 2006b

³¹ NWT Health and Social Services, 2002; NWT Health and Social Services, 2003

³² NWT Department of Health and Social Services, 2009d

Jurisdiction	Nomenclature	Demographics	Fees/Subsidies	Admission Requirements
Nunavut	continuing care facilities	only 1,000 of the 32,200 residents of Nunavut are 65 and older	<ul style="list-style-type: none"> territorial governments covers full cost of care³³ 	<ul style="list-style-type: none"> no territorial residency requirements must be a citizen or permanent resident of Canada client must be approved by a board of professionals before entry into a nursing home³⁴
Ontario	long-term care homes	more than 76,000 LTC LTC residents in Ontario ³⁵	<ul style="list-style-type: none"> residents pay accommodation part of care co-pay rate is \$53.07 for basic accommodation, \$71.07 for preferred accommodation³⁶ 	<ul style="list-style-type: none"> 18 years of age or older insured person under the <i>Health Insurance Act</i> Canadian citizen, or posse permanent/ principal home in Ontario, and physically present in Ontario for at least 153 days of any 12-month period³⁷

³³ CHA, 2009

³⁴ Manulife, 2009; CHA, 2009

³⁵ This is based on the Statistics Canada (2008) which uses the term “homes for the aged” to refer to “nursing homes, homes for the aged, and other facilities providing services and care for the aged.”

³⁶ There are basic or preferred types of facility accommodation. Preferred accommodation refers to private or semi-private rooms with special features, while basic or standard rooms are less expensive, and vary based on what the regular room is in the given facility. Long-term care homes offer short-stay (respite) and long-stay programs. MHLTC, 2010a

³⁷ CHA, 2009

Jurisdiction	Nomenclature	Demographics	Fees/Subsidies	Admission Requirements
PEI	nursing homes, government manors, public nursing facilities, or public nursing manors, private nursing homes (privately-owned, provincially regulated)	population over 75 projected to increase by 67% over 20 years, and to double over 30 years ³⁸	<ul style="list-style-type: none"> • effective 2007, government subsidizes care in both public nursing facilities and private nursing homes • subsidy covers health care costs of care, resident pays for accommodation costs • eligibility for subsidy determined by income-based test • cost of LTC with subsidy was \$69.30³⁹ 	<ul style="list-style-type: none"> • 60 years of age or older, or requires 24-hour professional care and no other alternatives exist • Canadian citizen or landed immigrant, valid Provincial Health Card⁴⁰
Quebec	nursing homes, residential and extended care centres (<i>centres d'hébergement et de soins de longue durée</i>)	over a million seniors in 2006, or 14 % of Quebec's population. By 2020, seniors will surpass 1.65 million, or 21 % of Quebec's population ⁴¹	<ul style="list-style-type: none"> • social and health services associated with facility-based LTC are covered by government co-payment determined by the Health Insurance Board of Quebec, takes into consideration the clients' and their spouses' assets and all revenue • accommodation cost in a private room is \$54⁴² 	<ul style="list-style-type: none"> • 18 years or older • resident of Quebec • citizen or permanent resident of Canada must have been assessed as having diminished autonomy as a result of physical or mental handicap⁴³

³⁸ PEI Health and Wellness, 2009a

³⁹ PEI Health and Wellness, 2009b

⁴⁰ PEI Health, 2009b

⁴¹ Quebec Finance, 2007

⁴² Manulife, 2009

⁴³ Manulife, 2009

Jurisdiction	Nomenclature	Demographics	Fees/Subsidies	Admission Requirements
Saskatchewan	special care homes	in 2021, about one in six persons in the province will be seniors ⁴⁴	<ul style="list-style-type: none"> • income-based test determines resident fee • resident fee varies from \$982-\$1,866 • fee depends on client income⁴⁵ 	<ul style="list-style-type: none"> • regional committee reviews a report of the assessment and determines acceptance to facility-based LTC • must be a Canadian citizen or a permanent resident, be over 18 years of age, and hold a valid Saskatchewan Health services card • no provincial residency requirements, the individual only needs to be assessed as requiring the care to receive provincial subsidy or to be admitted⁴⁶
Yukon ⁴⁷	continuing care facilities		<ul style="list-style-type: none"> • cost was \$18-21 per day, rate has been unchanged for 15 years⁴⁸ • no income/asset test to determine fee⁴⁹ 	<ul style="list-style-type: none"> • client must be a citizen or permanent resident of Canada, and must have been a resident of Yukon for a minimum of one year • must have been assessed as requiring the level of care as provided by a LTC facility⁵⁰

⁴⁴ Hollander Analytical, 2006; Government of Saskatchewan, 2001

⁴⁵ Saskatchewan Health, 2007d

⁴⁶ CHA, 2009; Manulife, 2009

⁴⁷ Info on senior demographic was unavailable from publicly available government information

⁴⁸ HCRSC, 2008

⁴⁹ Manulife, 2009

⁵⁰ HCRSC, 2008

Appendix E: Strengths and Challenges in Facility-based LTC across Jurisdictions

Jurisdiction	LTC Strategy	Strengths	Challenges
Alberta	2009-2012 Continuing Care Strategy: <i>Aging in the Right Place</i> <ul style="list-style-type: none"> • expansion of community-based services and supportive-living • provision to provide support to informal caregivers increase in AL program ⁵¹	<ul style="list-style-type: none"> • low resident fees compared to other jurisdictions • mandatory accreditation for LTC facilities • province offers specific diploma programs and courses in LTC for PSWs⁵² 	<ul style="list-style-type: none"> • inadequate capacity • accessibility a challenge in rural areas and for Aboriginal communities • completion of standardised province-wide curriculum for LTC staff is not mandatory • inadequate staffing levels • recruitment and retention of paraprofessionals • lack of standardized funding formula results in different funding for H.A.s • out-of-date, inconsistent standards across the province⁵³
BC	2002 <i>Independent Living BC</i> strategy: <ul style="list-style-type: none"> • expansion of AL/supportive living, reduction in facility-based LTC 2002 <i>A Provincial Framework for End-of-Life Care</i> : <ul style="list-style-type: none"> • supplements end-of-life services 	<ul style="list-style-type: none"> • wide range of options for seniors through home and community care options • financial assistance available to eligible seniors • reduction in wait times to average 90 days or less⁵⁴ • implementation of BC Care Aide & Community Health Worker Registry, a centralized data base for health care 	<ul style="list-style-type: none"> • concern among public, other stakeholder regarding inadequate staffing standards and inadequate training for LTC staff • lack of planning for potential workforce shortages (LPNs, PSWs) uneven access to care based across health authorities (HAs)⁵⁶

⁵¹ Alberta Health and Wellness, 2008a

⁵² Special Senate Committee on Aging, 2009,

⁵³ Alberta Health and Wellness, 2008a

⁵⁴ Ministry of Health Services, 2009

	provided in LTC facilities	workers ⁵⁵	
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⁵⁶ BC Ombudsperson, 2009; Cohen et al., 2005; BC Care Providers Association, 2009; Auditor General of BC, 2008

⁵⁵ BC Care Aid & Community Health Worker Registry, n.d; Cohen et al., 2005; Ministry of Health Services, 2007

Jurisdiction	LTC Strategy	Strengths	Challenges
Manitoba	<p><i>Aging in Place</i> strategy:</p> <ul style="list-style-type: none"> • explores options other than personal care homes (PCHs) such as supportive housing, group living, and community housing • \$40 million allocated in 2007 towards hiring of LTC staff, staffing levels, and quality of care of PCHs⁵⁷ 	<ul style="list-style-type: none"> • Manitoba is likely to have sufficient facility-based LTC capacity to address projected needs of province in 2020 • broad continuum of LTC services available • Home Care Program provides services 39,000 clients per year, supplements care available in facility-based LTC⁵⁸ 	<ul style="list-style-type: none"> • provincial government fiscal pressures have contributed to two-year wage freeze for nurses • out-of-date, inconsistent standards for levels of care and staffing⁵⁹ • recruitment of professional workforce • accessibility of care
New Brunswick	<p>10-year LTC Strategy, <i>Be Independent Longer</i>:</p> <ul style="list-style-type: none"> • greater emphasis on home and community services • commitment to nearly 300 new beds by 2017⁶⁰ <p>Health Plan 2008-2012: \$1.2 million investment in community services, recruitment/retention strategy for LTC workers, standardized sector training, increased access to and adequacy of training for formal caregivers</p>	<ul style="list-style-type: none"> • province-wide staffing standard of 3.0 hours of care per resident per day • New Brunswick Nursing Home Association, in collaboration with CUPE, arranged parity of wage for 4,000 LTC workers with acute sector counterparts⁶¹ 	<ul style="list-style-type: none"> • estimated 800 seniors were waiting for LTC in the province as of 2010, placing pressure on acute care sector • recruitment and retention of staff⁶²

Government of Manitoba, 2007

⁵⁸ Manitoba Health, 2010; Manitoba Centre for Health Policy, 2002

⁵⁹ Turenne & Romaniuk, 2010; Manitoba Nurses Union, 2006

⁶⁰ New Brunswick Social Development, 2010a

⁶¹ Government of New Brunswick, 2008a

⁶² Senior and Healthy Aging Secretariat, 2010; Government of New Brunswick, 2008a

Jurisdiction	LTC Strategy	Strengths	Challenges
Newfoundland	Department of Health and Community's 2008- 2011 Strategic Plan <ul style="list-style-type: none"> • aims to increase client choice, increase availability of community support options 2010 Budget allocated \$27.3 million to development of LTC facilities to fit 460 residents ⁶³	<ul style="list-style-type: none"> • increase in the personal allowance given to LTC clients to \$150 per month • raise in exemption of liquid assets for clients⁶⁴ 	<ul style="list-style-type: none"> • recruitment of professional workforce • accessibility of facility-based LTC
Northwest Territories (NWT)	<i>A Foundation for Change- Building a Healthy Future for the NWT</i> (2009) <ul style="list-style-type: none"> • addresses accessibility, sustainability or system • addresses recruitment and retention efforts of health care providers stated objective to standardize models of care, direct care hours, staffing levels	<ul style="list-style-type: none"> • financial subsidy available to those who require it • 	<ul style="list-style-type: none"> • accessibility to health care services is an issue, including access to home care services • inadequate staffing levels • shortage of RNs⁶⁵
Nova Scotia	2006 10-year Continuing Care Strategy for Nova Scotia, <i>Shaping the Future of Continuing Care</i> : <ul style="list-style-type: none"> • 1,320 new LTC spaces by 2016 • expansion of home care • commitment to increase support for eligible caregivers • initiatives to address LTC staff recruitment, retention, education, and training • commitment to develop province-wide palliative care program⁶⁶ 	<ul style="list-style-type: none"> • province assumes cost for health care services via the Cost of Care Initiative⁶⁷ • facility-based LTC specific diploma programs and courses in place for PSWs • province-wide staffing standard 	<ul style="list-style-type: none"> • staffing shortages • recruitment/retention • challenge to care for residents with special requirements (such as residents with Alzheimer's disease) • increased demand resulted in higher wait list times • lack of consistency and efficiency in funding formula⁶⁸

⁶³ Marshall, 2010

⁶⁴ Kennedy, 2009

⁶⁵ Northwest Territories Health and Social Services, 2009c; Registered Nurses Association of the Northwest Territories and Nunavut, 2006

Jurisdiction	LTC Strategy	Strengths	Challenges
Nunavut	<p>Department of Health and Social Services' 2004 <i>Closer to Home</i> strategy:</p> <ul style="list-style-type: none"> • increases the care and services delivered to Nunavummiut in their own communities, using their own language, and in the proper cultural setting • territorial government committed to two continuing care facilities in the territory, in the communities of Igloodik and Gjoa Haven, to open in July, 2007 • facilities were in the process of being implemented as of 2010⁶⁹ 	<ul style="list-style-type: none"> • territory covers the full cost of LTC services for residents • two new facilities will provide 24-hour high level (level 3 and 4) care to individuals who require it, including palliative care services • facilities will enable citizens to receive care that is more culturally relevant • fewer residents will have to travel out of territory to receive care • staff in facilities will be trained within the community, to delivery services by Inuit to Inuit, and reduce dependence on human resources from the south of Canada⁷⁰ 	<ul style="list-style-type: none"> • recruitment and retention of health care professionals • increased reliance on contracted employees and casual employees to offset unfilled vacancies • dependence on LTC workers from outside of the territory • before the establishment of these two new facilities, individuals must leave territory to receive facility-based LTC services, which is costly for government⁷¹

⁶⁶ Nova Scotia Health, 2006

⁶⁷ Special Senate Committee on Aging, 2009

⁶⁸ Ascent Strategy Group, 2008; Auditor General of Nova Scotia, 2007; CIHI, 2008; Auditor General of Nova Scotia, 2007

⁶⁹ Irniq, 2004; Legislative Assembly of Nunavut, 2007.

⁷⁰ Legislative Assembly of Nunavut, 2007; "Round the Clock Health Care," 2005; Irniq, 2004; Hanson, 2005; NWT Registered Nurses Association, 2006

⁷¹ Auditor General of Canada, 2010; NWT Registered Nurses Association, 2006

Jurisdiction	LTC Strategy	Strengths	Challenges
Ontario	<p>2007 <i>Aging at Home</i> strategy:</p> <ul style="list-style-type: none"> • expands services received in the home and community <p><i>Long-term Care Homes Act</i> (effective July, 2010)</p> <ul style="list-style-type: none"> • 2008 Budget allocated \$23.3 million to support the creation of 873 PSW positions in LTC homes, and to help offset the cost of increased regulatory requirements^{72 73} 	<ul style="list-style-type: none"> • Act supports greater resident/family input • significant research has been focused on LTC in the province • public consultations helped inform new regulations⁷⁴ • new regulatory scheme increases average hours of direct daily care per resident to 3.26 hours for nursing, personal support and programming 	<ul style="list-style-type: none"> • current funding may be inadequate for facilities to meet the ongoing requirements of updated regulations • Recruitment and retention • no province-wide educational standards in place for paraprofessional staff⁷⁵ • post-secondary training/education not adequately specialized in seniors' care⁷⁶
Prince Edward Island	<p>2009 <i>Healthy Aging Strategy</i>:</p> <ul style="list-style-type: none"> • expands home care • aim to reduce dependence on facility-based LTC, as per recommendations of the CSI Report • LTC infrastructure replacement and renovation⁷⁷ 	<ul style="list-style-type: none"> • significant research on LTC conducted in province (Ascent Strategy Group, Corpus Sanchez International in 2008) • 9.2 % of the province's over-65 population had access to facility-based LTC; figure is twice as high as the national average • staffing levels generally higher than in other provinces, as they ranged from 3.69 to 4.25 direct care hours per resident per day in public nursing homes^{78 79} 	<ul style="list-style-type: none"> • relatively high level of dependence on the facility-based LTC system • no formal resident classification tool in place to allocate resources based on resident needs • uneven access throughout province • inadequate staff training and specialized facility programming to meet needs of residents with dementia • recruitment/retention^{80 81}

⁷² MHLTC, 2008b

⁷³ MHLTC, 2010c; Ontario Ministry of Finance, 2008

⁷⁴ Strutzenberger, 2010

⁷⁵ Ontario Health Coalition, 2008; the Independent Review, 2008; Smith, 2004; OANHSS, 2010b

⁷⁶ Ontario Human Rights Commission, 2001; Price Waterhouse Coopers, 2001; Smith, 2004; Ontario Health Coalition, 2008; Ontario Health Quality Council, 2009

⁷⁷ PEI Health and Wellness, 2009a

⁷⁸ Ascent Strategy Group, 2008

⁷⁹ Corpus Sanchez International, 2008

⁸⁰ Ascent Strategy Group, 2008; Corpus Sanchez International, 2008

⁸¹ Corpus Sanchez International, 2008

Jurisdiction	LTC Strategy	Strengths	Challenges
Quebec	<p>2007 plan: <i>Action Strategy for the Elderly, Improving their Living Situation and Encouraging their Participation</i>:</p> <ul style="list-style-type: none"> • provides seniors with alternatives to facility-based LTC • increases support for informal caregivers • \$133.5 million expansion to home care program⁸² <p>2002 Health and Social Services Plan, <i>Making the Right Choices</i>:</p> <ul style="list-style-type: none"> • 2,200 new facility-based LTC beds 	<ul style="list-style-type: none"> • mandatory accreditation for LTC facilities • cost of facility-based LTC is relatively low compared to other provinces⁸³ 	<ul style="list-style-type: none"> • long wait times for facility-based LTC places pressure on the acute care sector • funding inadequate to address the much higher care needs of residents • shortage of physicians⁸⁴
Saskatchewan	<p>2008-2009 <i>Ready for Growth</i> plan:</p> <ul style="list-style-type: none"> • \$152.8 million to construct 13 new LTC facilities 	<ul style="list-style-type: none"> • research has been done on LTC in the province (Commission on Medicare appointed in 2000, Patient First Review in 2008), and consultations were held in 2009 to identify gaps and challenges in LTC • range of options by availability of both PCHs (mostly publicly-funded) and SCHs (privately funded by licensed under provincial Department of Health)⁸⁵ 	<ul style="list-style-type: none"> • recruitment and retention, especially of nurses • service delivery is a challenge in a sparsely populated, predominantly rural province⁸⁶

⁸² Quebec Finances, 2007

⁸³ CHA, 2009

⁸⁴ Quebec Health and Social Services, 2002

⁸⁵ Saskatchewan Ministry of Health, 2010b

⁸⁶ Commission on Medicare, 2001; Saskatchewan Union of Nurses, 2010

Jurisdiction	LTC Strategy	Strengths	Challenges
Yukon	<ul style="list-style-type: none"> • three LTC facilities in the Yukon, constituting a total of 152 beds <p><i>Health Human Resources Strategy:</i></p> <ul style="list-style-type: none"> • improve recruitment and retention, including sending nurses to receive training/education in Yellowknife, and initiated expansion of nurse mentorship program to include LPNs • 	<ul style="list-style-type: none"> • Health Care Review Steering Committee, established in 2008, to review health care • demand in Yukon will surpass capacity by 2018 • Continuing Care branch of Health and Social Services received national accreditation from Accreditation Canada • “Telehomecare Project” initiated in March, 2009 to improve service delivery to home care clients⁸⁷ 	<ul style="list-style-type: none"> • workforce shortages, anticipated to be a long-term challenge faced in the territory • shortage of local training opportunities for staff • accessibility is an issue, because of geographical isolation, and a lack of sufficient support systems that enable seniors to remain in the community⁸⁸

⁸⁷ Yukon Health and Social Services, 2009a; Health Care Review Steering Committee, 2008

⁸⁸ HCRSC, 2008

Appendix F: Report Abbreviations

ADL	Activity of Daily Living
AHHI	Aboriginal Health Human Resources Initiative
ASG	Ascent Strategy Group (Consultancy)
BCCPA	British Columbia Care Providers Association
CARF	Commission on Accreditation of Rehabilitation Facilities
CCCD	Chronic and Continuing Care Division (Health Canada)
CHA	Canadian Healthcare Association
CICS	Canadian Intergovernmental Conference Secretariat
CSI	Corpus Sanchez International (Consultancy)
CIHI	Canadian Institute for Health Information
CUPE	Canadian Union of Public Employees
FNIHCC	First Nations and Inuit Home and Community Care
GIS	Guaranteed Income Supplement
HCA	Health Care Aide
HCRSC	Health Care Review Steering Committee (Yukon)
HHRIS	Health Human Resource Strategy
INAC	Indian and Northern Affairs Canada
LHIN	Local Health Integration Networks (Ontario)
LPN	Licensed Practical Nurse
LTC	Long-term Care
MOHLTC	Ontario Ministry of Health and Long-Term Care
NUPGE	National Union of Public and General Employees
NWT	Northwest Territories
OLTCA	Ontario Long-Term Care Association
PCH	Personal Care Home
PCW	Personal Care Workers
PEI	Prince Edward Island
RN	Registered Nurse
SAHO	Saskatchewan Association of Health Organizations
SCCA	the Special Senate Committee on Aging
SCH	Special Care Home
SHRTN	Seniors Health Research Transfer Network
SCU	Special Care Unit
TAC	Territorial Admissions Committee (Northwest Territories)