Continuing Care

2006 Strategy Evaluation

Executive Summary

June 2015

Introduction

In May 2006, the Department of Health and Wellness (DHW) released the Continuing Care Strategy entitled “Shaping the Future of Continuing Care.” This strategy has served as a 10-year action plan to improve and expand the province’s continuing care system. A cumulative total of $262 million of new funding has been invested to date in supporting the expansion of programs and services in Continuing Care under this strategy. Additionally, capital investment in new and replacement bed construction is estimated at $450 million, over the life of the 2006 strategy.

This summary evaluation report fulfills the Minister’s request for an evaluation of the 2006 Continuing Care Strategy following the recommendations proposed at a Roundtable hosted by the DHW Continuing Care Branch, in January 2014. It provides an overview of the performance of home care and long-term care, four program area evaluations, and an update on initiatives detailed in the strategy.

The DHW quality framework was used to develop performance measures to track client, health system, and population health outcomes. This framework comprises three levels of outcomes: service, system, and population health. Service-level outcomes focus on equity, access, and quality and safety. System-level outcomes represent effectiveness, efficiency, appropriate resourced, and integration. The evaluation focused on the strategy time period: fiscal years 2006–07 to 2013–14. In some instances, where data permitted, data for the fiscal year 2014–15 were included.

This executive summary provides an overview of the key strategy initiatives and the findings and recommendations made in the technical reports. Detailed analysis and discussion is available in the Final Report and underlying technical reports produced for the Strategy Evaluation.

Strategy Initiatives

There were five priority areas identified in the 2006 strategy:

1) Supporting Individuals and Families

The evaluation found that individuals and families benefited from increased support through the implementation of the Caregiver Benefit Program, expansion of the Adult Day Program, increased respite access, increased funding to Caregivers Nova Scotia, and increased public awareness of Continuing Care through a public awareness campaign and redesign of Continuing Care's website.

2) Investing in Providers

The evaluation found that government has invested in providers through several human resources initiatives, enhanced primary care in long-term care, and provider capacity building through the Challenging Behaviour Program.

3) Supporting Community Solutions

The evaluation found that additional community supports were introduced over the strategy period by providing funding to the home repair/adaptation and the equipment loan programs, expanding the Home Oxygen Services Program, and providing home-care nursing in residential care facilities.

4) Strengthening Continuing Care Services

The evaluation found that Continuing Care services were strengthened through the expansion of services such as home care, self-managed care, supportive care, and occupational therapy and physiotherapy, Instrumental Activities of Daily Living (IADL) funding, restorative-care beds, and the establishment of new programs such as palliative care and extended paramedic care.

5) Investing in Infrastructure

The evaluation found that significant investments were made in infrastructure through the opening of new and replacement beds in long-term care.

Long-Term Care

How much have we invested?

- Since the introduction of the Continuing Care Strategy, health-system spending on long-term care (LTC) from 2006–07 to 2014–15 grew by 71 per cent, to a projected high of $566 million in 2015–16, accounting for 70 per cent of the total Continuing Care budget of $808 million.
- Capital investment in new and replacement bed construction is estimated at $450 million, with 1,018 new beds built and 898 beds replaced. An additional 79 replacement beds are forecast to open in fiscal year 2015–16.
- Nova Scotia is ranked second among provinces for number of long-term care beds per 1,000 population age 75 or more. The national average was 86 beds. As of February 2015, the Nova Scotia figure is 115.

What difference has this investment made to the health system?

- The number of clients placed annually into long-term care increased by 18 per cent over the strategy period, with 2,955 individuals placed in 2013–14.
- There was an increasing trend in the number of clients receiving home care at the time of wait list registration for long-term care, from 52 per cent in 2006–07 to 68 per cent in 2013–14.
- The number of people on the wait list for long-term care ranged consistently between 2,000 and 2,500 individuals, despite the introduction of new beds.
- The average waiting period from registration on the wait list to acceptance of a bed offer was 169 days in 2006–07 and 333 days in 2014–15, a growth rate over 97 per cent.
- During the strategy time period, 69 per cent of the total length of stay for those discharged to long-term care was spent in an alternate level of care (ALC). There was no significant change in this number over the strategy period.
- During the strategy time period, the number of people placed into long-term care from home or a community-based setting has increased, while the number of placements from hospital has remained relatively stable at about 271 individuals annually
- Capital District has reported a 9.7 per cent reduction in the number of individuals waiting placement in a long term care facility, and a 17 per cent reduction in the percentage of admissions to long term care from hospital versus from community, since the adoption of a home first discharge planning philosophy.

How has the investment impacted the target population?

- In a nursing home, a resident typically stays for an average of 2.6 years, a figure that has grown by 31 per cent, from 2.2 years in 2007–08 to 2.9 years in 2013–14.
- The percentage of individuals entering long-term care with high or very high needs averaged 78 per cent and remained unchanged over the strategy period. This data is contrary to the reported experience of long-term care service providers. Further study is required to understand client acuity in long-term care.
- Approximately 2,200 emergency department transfers occur annually between hospitals and long-term care facilities.
- Residents have reported a high level of satisfaction with services, as indicated on client satisfaction surveys.
- While some facilities use a standardized needs assessment (RAI-MDS) of residents in long-term care, such an assessment is not a provincial requirement. The absence of standardized assessment data is a significant barrier to evaluating health outcomes of long-term care residents, and to understanding the changing needs of long-term care clients.

Recommendations from the Strategy Evaluation specific to Long-Term Care

1. **Complete implementation of proposed revisions to Long-Term Care placement policies**

   The DHW, working with the Nova Scotia Health Authority (NSHA), should implement needs-based placement for clients on the wait list.

2. **Introduce standardized client assessments in long-term care**

   The DHW, working with the NSHA and long-term care facilities, should implement standardized assessment of residents in long-term care to promote quality improvement, client outcome measurement, and system planning.

3. **Evaluate the Home First Program**

   The DHW, working with the NSHA, should perform a formal evaluation of the Home First program to improve the program's contribution to reducing ALC days in hospital.

4. **Develop client profiles and future demand forecasts**

   The DHW, NSHA, and Long-term Care Service Providers should work together to develop client profiles to better understand the care needs of residents in long-term care, and forecast future demand.

5. **Implement an Accountability Framework**

   The DHW, working with the NSHA, should develop an Accountability Framework that establishes key performance indicators and associated performance targets for long-term care services.

6. **Improve the cost sustainability of long-term care**

   The DHW, working with the NSHA, should implement performance-based contracts for all long-term care service providers. The DHW should also consider transferring the budget for long-term care services to the NSHA to administer.

7. **Employ technology to improve health-system integration**

   The DHW, working with the NSHA, should enable better system integration between care coordinators and service providers by upgrading the Continuing Care Information Management System (SEAscape) to

   a. provide a bed-management solution to facilitate the placement process to long-term care

   b. facilitate standardized assessment of the ongoing care needs of long-term care residents

   c. provide a complete picture of the resources explored, prior to admission to long-term care

Home Care

How much have we invested?

- Investments in home care (home support and nursing) grew by 72 per cent from 2006–07. To enhance system capacity that enables Nova Scotians to stay in their own homes with the care and services they need, government has increased funding for home-care services and related services by $44 million over the last two fiscal years alone, bringing the annual budget for home support and nursing services to almost $200 million.
- Home-support services help the client with daily living tasks, such as dressing and undressing, bathing, toilet use, meal preparation, and mobilization. Home-support direct-service hours totaled 2.7 million in 2013–14, a 38 per cent increase from 2006–07.
- Home-care nursing provides a variety of nursing services in the client's home, such as nursing assessment, health teaching, health monitoring, and treatment. Direct nursing care in the home can include activities such as intravenous therapy, dressing changes, catheter care, and assistance with medication management. Nursing visits totaled 796,500 in 2013–14, a 64 per cent increase from 2006–07.
- Since 2006–07, over $33 million has been invested to support community care options, including Adult Day Programs, the Caregiver Benefit, and Direct Funding programs such as Self-Managed Care and Supportive Care. Respite availability in long-term care and at home has been enhanced as well.
- Annual funding of $3.3 million is provided to NSHA to increase the level of rehabilitation services (occupational therapy and physiotherapy) provided in the community.
- Annual funding of $1.5 million is provided to NSHA to support the Home First philosophy of enabling a safe return to home for clients with complex care needs, to prevent avoidable placement to long-term care, or to expedite a discharge from an acute-care facility.
- NSHA receives annual funding of $1.0 million to provide community resources to support Independent Activities of Daily Living. Examples of IADLs include shopping, meal preparation, and transportation.

What difference has this investment made to the health system?

- On any given day, approximately 12,000 clients are authorized to receive service (either home support, nursing, or both), with more than 22,000 individuals authorized to receive service annually. Home Care services enable these Nova Scotians to live at home longer by delaying or preventing long-term care placement or hospital admission.
- Over the duration of the strategy, the percentage of clients with very low and moderate health needs has declined, and the percentage of clients with very high health needs has doubled. The number of clients with very high needs increased 29 per cent from 2006–07 to 2013–14.

- For both home support and home nursing, the growth in the number of service hours and visits outpaced the growth in the number of clients, suggesting that home-care clients are on average receiving more hours of home support or more nursing visits than in the past.
- The average number of days between the initial referral and service for home support is about 56 days.
- In the past fiscal year, an average of 398 clients were waiting for home-support service each month. Wait lists and wait times for home support varied by health district, with the Annapolis Valley and Pictou County District Health Authorities having the highest.

How has the investment impacted the target population?

- The percentage of home-care clients who reported a fall has increased by about 12 per cent since 2006–07. While the percentages for falls have increased, the greatest percentage increase occurred in the three-or-more falls group, which doubled from 6.5 per cent to 13 per cent from 2006–07 to 2013–14. Despite the increase in falls, there have been no reported critical incidents leading to death in home care.
- Clients reported high satisfaction with home support and nursing services; in most years, over 90 per cent of clients reported that they were satisfied.
- The percentage of home-care clients reporting one or more visits to an emergency room since their last assessment has increased each year over the strategy period and was eight per cent higher in 2013–14 than in 2006–07.
- The percentage of ALC days spent in the hospital by clients waiting to be discharged home with home supports has averaged just under 10 per cent over the strategy period. The percentage was lowest in 2011–12 at seven per cent, but it has increased over the last two years, reaching a high of over 14 per cent in 2013–14.
- The percentage of home-care clients with high and very high needs who are waiting for long-term care placement has averaged 76 per cent and has remained essentially unchanged over the life of the strategy.

Recommendations from the Strategy Evaluation specific to Home Care

1. **Develop client profiles and future demand forecasts**

   The NSHA, working with the DHW, should develop client profiles for home-care services in order to better forecast future demand, starting with an evaluation of population-based models of home-care delivery used by other health jurisdictions. The 2008 Auditor General Report made a similar recommendation (see Recommendation 4.9 on page 57).

2. **Review Care Coordination Practices**

   The NSHA should conduct a review of care coordinator workloads and of the assessment and service authorization process. The review should ensure that service is provided in compliance with provincial policies. This recommendation corroborates a 2008 Auditor General Report recommendation that a quality assurance process be implemented to ensure that appropriate assessment decisions are made and that policies and procedures are followed and appropriately documented.

3. **Develop a human resources plan**

   The DHW should prioritize efforts to develop a human resources plan in collaboration with the home-care sector. Recruitment and retention strategies will need to be developed in partnership with service providers to ensure home care is appropriately resourced with care workers to meet future needs.

4. **Implement an Accountability Framework**

   The DHW, working with the NSHA, should develop an accountability framework for Continuing Care services that establishes key performance indicators and associated performance targets, to evaluate the performance of the Home Care program.

5. **Improve the cost effectiveness of home-care service delivery**

   The DHW, working with the NSHA, should move forward with implementing performance-based contracts to realize cost savings and service quality improvements in the Home Care program. The DHW should also consider transferring the budget for long-term care services to the NSHA to administer.

6. **Employ technology to improve health-system integration**

   The DHW, working with the NSHA, should enable better system integration between care coordinators and service providers by upgrading the Continuing Care Information Management System (SEAscape) to meet the operational needs of care coordinators and service providers.

7. **Develop standards for continuity of service**

   The DHW, working with the NSHA, should develop service standards for home care service providers to minimize the amount of care workers in the home, and enable home care clients to develop positive relationships with their paid caregivers.

8. **Better health system integration**

   The DHW should facilitate better system integration between acute care, home care, community supports, to ensure continuity of care for home care clients with complex care needs.

9. **Complete a jurisdictional review of home-care systems**

   The DHW should conduct a jurisdictional review of home-care systems to better inform future planning for Home Care services.

Self-Managed Care

The Self-Managed Care (SMC) program helps Nova Scotians aged 19 or older with physical disabilities to increase control over their lives. The program provides funding directly to clients so that they may employ others to provide home support and personal care. The client (or the care manager) assumes full responsibility for the coordination and management of the funded services. The goal of the SMC program is to provide clients with flexibility and choice, by enabling them to manage their care providers and schedules. Clients must be assessed by the NSHA Care Coordinator and meet program eligibility requirements to be eligible for SMC program funding.

How much have we invested?

- On March 31, 2014, there were 146 clients enrolled in the SMC program. On average, clients received approximately 157 hours of care per month through the SMC program.
- In 2013-14 fiscal year, total expenditure for the program was $5,331,756. The maximum funding available for each client was $46,270.68 per year or $3,855.89 per month, based on a rate of $18.73 an hour, and the average cost for each client was $36,518.88 per year or $3,043.24 per month.
- In fiscal year 2014–15, under the SMC program, clients could receive funding up to a maximum of $3,971.57 per month, based on a rate of $19.38 an hour.
- The DHW has developed a SMC Guide, which is provided to the client at or prior to the orientation. The guide informs the client that he or she is essentially acting as a small business, with all of the responsibilities that entails, such as the recruitment, the hiring, and possibly the termination of staff.
- In March 2013, the SMC policy was revised to allow clients to delegate a third party as care manager, to direct their care and possibly complete the administrative aspects of the program on behalf of the client.

What difference has this investment made to the health system?

- SMC is more cost effective than home support. Based on rates for fiscal year 2013–14, SMC clients could receive a maximum of $3,855.89 per month for approximately 205 hours of care, compared with home-support clients who could access a maximum of 150 hours of care per month at a cost of approximately $6,931.50. To provide 205 hours of care to home-support clients would cost approximately $9,473.05.

How has the investment impacted the target population?

- Eighty-four per cent of respondents stated that the program has improved their quality of life.
- Those on the program who are married have, in particular, reported improvements in quality of life, in part because the program allows their partners to continue or to resume work outside the home, obviating concerns about giving up a job in order to "look after" the care recipient.
- Care coordinators report that clients are very involved in care planning. In most instances, it is the client who initially develops the care plan, with the care coordinator providing assistance. In our evaluation survey, 80 per cent of SMC clients stated that the program is very flexible.

Recommendations from the Strategy Evaluation specific to SMC

1. NSHA should provide further education to care coordinators regarding client eligibility, the role of the care manager in supporting the client in the administration of the program, and the importance of helping clients to assume control of their own care.
2. DHW and NSHA should review, and potentially revise, the SMC Orientation and the SMC Guide to ensure that information is provided to clients in a way that is user-friendly and meaningful, and that supports clients in managing their own care.
3. DHW and NSHA should complete a review and revision of the financial reconciliation process to ensure it is streamlined and user-friendly for all parties, including clients, financial services officers (FSOs) and DHW Financial Services staff. DHW should work with the NSHA and Client Advisory Council to explore how to improve this process, examining types of information required from the client, how information should be collected, the potential for electronic submissions, and financial reconciliation options.
4. DHW should implement monitoring and reporting requirements related to the attainment of program outcomes and the appropriate use of funding.
5. NSHA should ensure that financial reconciliations meet DHW requirements

Occupational Therapy and Physiotherapy

The objectives of the community-based rehabilitation services are to improve or maintain independence of clients in the home and community through a primarily consultative and educational model. The types of clients seen include those at risk of admission to acute-care facilities, those seeking discharge from such facilities, those with medical or mobility issues who are unable to access public or private outpatient services, and those appropriately seen in the community to address their goals.

How much have we invested?

- Funding of $3.3 million has been provided to the former District Health Authorities (DHAs) to increase occupational therapy (OT) and physiotherapy (PT) provided in the community. Funding had been provided yearly as an interim measure, until July 2013, when Continuing Care moved this funding from interim to permanent status.

What difference has this investment made to the health system?

- Community OT and PT providers accept referrals from all access points of the health care system. In 2011–12, over 7,700 referrals and 20,510 community visits were conducted. Clients ranged between 60 to over 80 years of age, about 40 per cent of whom also receive other Continuing Care services, such as home support and nursing.
- Acute, primary, and continuing care staff who were surveyed strongly agreed that the introduction of community OT and PT services has resulted in improved integration, access to care, and transitions throughout the continuum.
- Community OT and PT workers are key care providers to clients in the Home Again Program.

How has the investment impacted the target population?

- Of the 400 client care plans examined, 322 (81 per cent) showed a statistically significant improvement in client performance and satisfaction for identified goals following intervention by OT and PT providers.
- Overall, 92 per cent of client care plans examined showed a statistically significant improvement in either performance, satisfaction, or both, following community OT or PT intervention on identified goals.

Recommendations from the Strategy Evaluation specific to OT and PT

1. The DHW should integrate OT and PT services into the bundle of services managed in its Home Care program, alongside Home Support and Nursing.
2. The DHW should develop a plan to address the growing need for OT and PT services through new investment and departmental human resource planning.
3. The NSHA should develop provincial standards for screening, assessment, and discharge to community-based OT and PT services.
4. The DHW and NSHA should explore options to further enable OT and PT providers to participate in shared care planning, including the expansion of the Continuing Care Information system (SEAscape).

Adult Day Programs

The 2006 Continuing Care Strategy included a commitment to develop a provincial Adult Day Program (ADP) to expand respite options in the community. The intent was to expand the range of supports available to functionally or cognitively impaired adults in the community and to increase available respite options for caregivers. ADPs offer meals; individual, small-, and large-group social events, recreation, and exercise; and medication support to their clients.

How much have we invested?

- In 2008, annual funding of approximately $1.7 million was allocated by the DHW to the DHAs to provide approximately 400 new Adult Day program spaces on an interim basis, to address current pressures in acute care, long-term care, and home care, until such time that a provincial ADP could be developed.

What difference has this investment made to the health system?

- After rapid initial growth, total attendance days by clients in the program stayed roughly the same over the last four years.
- Despite high reported levels of client satisfaction, participation in day programs remained relatively low, at an average of 45 per cent. Barriers to increased program participation include client fees, access to transportation, inflexibility in hours, facility space and amenities, types of programming and services offered, lack of awareness, and stigma.
- Program staff said that one of their primary purposes for a day program is to prevent clients from being prematurely institutionalized to long-term care. The percentage of clients participating in the program who were on the list for long-term care placement grew from 2 per cent in 2008–09, to 24 per cent in 2013–14.

How has the investment impacted the target population?

- Findings from client and caregiver focus groups revealed that clients enjoy interaction and socialization with other clients through activities, mealtimes, and outings. Not least, it provides relief from loneliness. However, Fancey, Hattie, and Keefe (2007) found that considerable variation in Adult Day models and lack of data make it difficult to draw the conclusion that the program enhances or maintains the functional status of care recipients.
- Unpaid caregivers reported that the program is very important to them because it provides them with much-needed respite. Before they had access to the program, they expressed feeling exhausted, and they feel that the program provides safe environments with competent staff who make their family member or friend feel useful and helpful. It also provides an opportunity for program participants to socialize with other people.
- Services specific to those with Alzheimer's or the late stages of dementia are underrepresented in the ADP. Most programs accept clients with dementia so long as their behaviour is not disruptive to the program and its other participants.

Recommendations from the Strategy Evaluation specific to ADPs

1. The NSHA should develop and recommend to the DHW a provincial model for ADPs that
   a. standardizes programming and client fees across all day programs to improve equity in day-program services available to Nova Scotians
   b. adopts a client-centred approach and engages clients, caregivers, and service providers to determine a standard set of services to be offered by all ADPs
   c. considers the unique service needs of those living with a chronic health condition, including dementia
2. The DHW should enable care coordinators to refer clients to ADP services through the Continuing Care Information Management System (SEAscape).
3. The DHW should consider including ADPs as part of the capped-fee program offered to home-care clients.
4. The DHW should consider transferring the budget for ADPs to the NSHA to administer.
5. The NSHA should encourage the use of IADL resources to cover transportation costs for ADP clients.

Supportive Care Program

The Supportive Care Program (SCP) is a directly funded program that supports seniors aged 65 and over who are authorized for at least 25 hours of care per month, have significant cognitive impairments that interfere with their daily functioning, and have a substitute decision maker (SDM) who is willing to act on their behalf.

The program enables the purchase of home-support services that would otherwise be delivered through the provincial Home Care program. Home-support services such as personal care, respite, meal preparation, and housekeeping may be purchased. Funding, in the amount of $500 per month, is deposited directly into the client's bank account, and the substitute decision maker assumes responsibility for managing the funds and making reports. Reimbursement of $495 per year is also available for snow removal for seniors with low income.

How much have we invested?

- In 2010, government allocated a $1.5 million annual budget for the SCP.
- When the program was implemented in 2011, clients had to be assessed as low income in order to qualify. This requirement was cancelled in 2013 to increase program accessibility.

What difference has this investment made to the health system?

- Approximately 52.5 per cent of Supportive Care clients also currently receive home-support services, at an average of 87 hours of home support per month. The evidence suggests that, although the SCP does offer an alternative to home support, many SCP clients have additional needs not currently being met through the SCP.
- A cost analysis was also completed as part of the DHW Business Case: An Examination of Direct Funding Models for Home Care Delivery (DRAFT, 2013), which concluded that, based on the financial information available, direct funding is more cost effective than indirect funding (which typically involves agencies). This is due to the high service delivery costs associated with agency-managed care. SCP clients receive $500 for a minimum of 25 hours of home support per month. By comparison, if a home-support client were receiving 25 hours of care per month, this would cost $1,155.25 (based on a home-support hourly rate of $46.21 in 2013–14).

How has the investment impacted the target population?

- Since the changes in program eligibility requirements were implemented in February 2013, the number of clients accessing the program has increased. As of October 2012, only seven clients had accessed the program since it began in 2011. By the end of 2013–14 there were 194 clients enrolled in the SCP.
- Many clients have been creative in terms of combining Supportive Care funding with that available in other programs, such as the Caregiver Benefit Program, in order to get the service they need.
- Care coordinators who were interviewed believe there is general lack of awareness, as well as confusion regarding the program's eligibility criteria. This is negatively affecting care coordinators' perceptions of the program and their decisions to offer Supportive Care as a care option to clients.
- A comparison of client assessment data (RAI–HC) conducted for this evaluation indicates higher reported caregiver distress for caregivers of Supportive Care clients compared to caregivers of Home Support clients. However, due to low program numbers for the first two years of the program, further analysis is required before a valid comparison can be made.

Recommendations from the Strategy Evaluation specific to the SCP

1. NSHA should provide further education to Care Coordinators regarding the SCP and client eligibility.
2. DHW should explore the option of allowing family members to act as paid care providers.
3. DHW and NSHA should complete a review and revision of the financial reconciliation process to ensure that the process is streamlined and user-friendly for all parties, including clients, FSOs, and DHW Financial Services staff.
4. DHW should implement monitoring and reporting requirements to provide DHW with information regarding the attainment of program outcomes and use of funding.
5. NSHA should ensure that financial reconciliations meet DHW requirements.
6. DHW should explore opportunities to obtain client feedback to better understand the extent to which the SCP is meeting program outcomes.

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