



# Health Care

Human Resource Sector Council

## Continuing Care Assistant (CCA) Nova Scotia Supply and Demand Study

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Leadership  
*partnerships*  
Growth  
*collaboration*

# Leadership Growth

*partnerships*  
*collaboration*



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Health Care Human Resource Sector Council 2008  
Halifax NS

### **Acknowledgements:**

This report was a collaborative effort through the support of The Nova Scotia Department of Health, the Nova Scotia Department of Labour and Workforce Development and the Health Care Human Resource Sector Council

This initiative was funded by Service Canada's Local Labour Market Partnerships.

The authors recognize and thank the members of the CCA Supply & Demand Project Steering Committee for their assistance in implementing the project and for their review and contributions to the survey tools and the reports.

Thank you to all key informants and focus group participants for their input. Thank you to the employers who took time from their busy schedules to complete the surveys and provide the data. Their commitment of time and support is much appreciated.

Also thank you to Dr. Gail Tomblin Murphy and Mr. Adrian MacKenzie for their consultation on development of the Survey tools. To Heather McNamara, HCHRSC, for all the final edits and formatting.

June MacDonald

President

Price-MacDonald & Associates Consulting Inc.



Please Note: The opinions and interpretations in this publication are those of the author and project committee, and do not necessarily reflect those of the Government of Canada.

## Table of Contents

<b>Glossary of Terms/Acronyms.....</b>	<b>c</b>
<b>Charts &amp; Tables .....</b>	<b>d</b>
<b>Executive Summary.....</b>	<b>1</b>
<i>Strategic Directions: .....</i>	<i>4</i>
<i>Cooperative Efforts:.....</i>	<i>4</i>
<i>Marketing: .....</i>	<i>5</i>
<i>Recruitment:.....</i>	<i>5</i>
<i>Retention:.....</i>	<i>5</i>
<i>Engagement:.....</i>	<i>5</i>
<i>Evaluation Strategies: .....</i>	<i>6</i>
<b>Introduction.....</b>	<b>7</b>
<b>Mandate/Scope of Work .....</b>	<b>9</b>
<b>Deliverables .....</b>	<b>10</b>
<b>Approach .....</b>	<b>10</b>
<i>Stage 1: Research Plan and Design .....</i>	<i>10</i>
<i>Stage 2: Review of Literature .....</i>	<i>10</i>
<i>Stage 3: Data Collection and Analysis .....</i>	<i>11</i>
<i>Stage 4: Supply &amp; Demand Forecast .....</i>	<i>12</i>
<i>Stage 5: Dissemination of Findings.....</i>	<i>12</i>
<b>Limitations of the Study .....</b>	<b>12</b>
<b>Ethics.....</b>	<b>13</b>
<b>Background.....</b>	<b>13</b>
<b>Educational Preparation for CCAs in Nova Scotia .....</b>	<b>16</b>
<b>Education Surveys .....</b>	<b>18</b>
<b>Employer Survey Response .....</b>	<b>19</b>
<b>Response Rate by DHA.....</b>	<b>21</b>
<b>Findings.....</b>	<b>21</b>
<i>Demographics .....</i>	<i>21</i>
<i>Designation .....</i>	<i>22</i>
<i>Hires.....</i>	<i>24</i>
<i>Vacancies.....</i>	<i>25</i>
<i>Retirements.....</i>	<i>28</i>
<i>Resignations .....</i>	<i>29</i>
<i>Leaves.....</i>	<i>30</i>
<i>Service &amp; Staffing (Productivity) .....</i>	<i>32</i>

<i>Recruitment and Retention</i> .....	33
<b>Focus Groups</b> .....	<b>37</b>
<b>Key Informant Interviews</b> .....	<b>38</b>
<b>Supply &amp; Demand Projection</b> .....	<b>39</b>
<b>Recommendations</b> .....	<b>39</b>
<b>Conclusion</b> .....	<b>52</b>
<b>Bibliography</b> .....	<b>i</b>
<b>Appendix A: CCA Supply &amp; Demand Steering Committee</b> .....	<b>iii</b>
<b>Appendix B: Literature Review</b> .....	<b>iv</b>
Introduction:.....	iv
Supply and Demand: .....	v
Demography:.....	vi
Education: .....	x
Changing Health Care Delivery Models:.....	xiii
Policy Changes:.....	xv
Recruitment and Retention:.....	xix
Quality of Work-Life: .....	xxiv
Language of Service:.....	xxvii
Information Technology and Management: .....	xxix
Conclusion:.....	xxxi
Bibliography:.....	xxxiii
<b>Appendix C: Sample Screen from Searchable Annotated Bibliography</b> .....	<b>xxxvi</b>
<b>Appendix D: Survey Instruments</b> .....	<b>xxxvii</b>
<b>Appendix E: Focus Group Schedule and Questions Posed</b> .....	<b>xliv</b>
<b>Appendix F: Canadian Evaluation Society- Code of Ethics</b> .....	<b>xlvi</b>
<b>Appendix G: Education Survey</b> .....	<b>xlvi</b>
<b>Appendix H: Table of Contents and Tools, Nova Scotia Recruitment and Retention Toolkit</b> .....	<b>lii</b>
<b>Appendix I: Increasing Human Resource Capacity in the Continuing Care Sector - Logic Model for Evaluation</b> .....	<b>liii</b>
<b>Appendix J: Learning Organizations</b> .....	<b>liv</b>

## Glossary of Terms/Acronyms

CCA	Direct care/support service provider such as CCA, Personal Care Worker (PCW), Home Support Worker (HSW), and Home Health Provider (HHP) as defined by Department of Health regulations, as well as employees in this role with on-the-job training.
AC	Acute Care (facility)
DOE	Department of Education (Nova Scotia)
DoH	Department of Health (Nova Scotia)
DSH	Direct Service Hours
FTE	Full-time equivalent
HC/HS	Home Care/Home Support (agency)
HCHRSC	Health Care Human Resource Sector Council
HHR	Health Human Resources
HSNSA	Home Support Nova Scotia Association
HSW	See CCA
IFA	Intergovernmental Francophone Affairs
IT/IM	Information Technology/Information Management
IWK	Izaak Walton Killam Health Centre
NH/HFA	Nursing Home/Home for the Aged
NSAHO	Nova Scotia Association of Health Organizations
NSCC	Nova Scotia Community College
NSSS	Nova Scotia Seniors' Secretariat
PCW	See CCA
PHSOR	Provincial Health Services Occupational Review
PLAR/RPL	Prior Learning and Recognition/Recognition of Prior Learning
QWL	Quality of Work-Life
RSNE	Réseau Santé Nouvelle-Écosse
SDM	Supply and Demand Model
VON	Victoria Order of Nurses

## Charts & Tables

<b>Figure 1: CCAs by Work Setting in Nova Scotia .....</b>	<b>2</b>
<b>Figure 2: Nova Scotia Health Recruitment and Retention framework.....</b>	<b>3</b>
<b>Figure 3: Age Distribution of CCAs in Nova Scotia .....</b>	<b>8</b>
<b>Figure 4: Age Distribution of CCAs in Nova Scotia, Sept. 17, 2008.....</b>	<b>22</b>
<b>Figure 5: CCAs in Nova Scotia by Designation and Employment Setting .....</b>	<b>23</b>
<b>Figure 6: Data Table of reported and estimated numbers of CCAs in Nova Scotia.....</b>	<b>24</b>
<b>Figure 7: CCA Hires by Employment Setting 2003-2008 .....</b>	<b>25</b>
<b>Figure 8: Combined Vacancy Rate 2005-2007.....</b>	<b>26</b>
<b>Figure 9: Vacancy Rate NH/HFA 2005-2007.....</b>	<b>27</b>
<b>Figure 10: Vacancy Rate HC/HS 2005-2007 .....</b>	<b>27</b>
<b>Figure 11: Vacancy Rate AC 2005-2007 .....</b>	<b>28</b>
<b>Figure 12: CCAs Eligible for Retirement at 60 years as percent of Current CCAs. ....</b>	<b>29</b>
<b>Figure 13: Resignations by Employment Setting, Nova Scotia, Sept. 17, 2008 .....</b>	<b>30</b>
<b>Figure 14: Table of Leaves by Type, 2003-2008 .....</b>	<b>31</b>
<b>Figure 15: Leaves by Type and Employment Setting, 2003-2008 .....</b>	<b>31</b>
<b>Figure 16: Nova Scotia Health Recruitment &amp; Retention Framework.....</b>	<b>40</b>

## Executive Summary

This report builds upon previous research relating to health human resources in Nova Scotia, particularly research relating to the CCA<sup>1</sup> and others functioning in the role of direct care/support service provider. It incorporates current data provided through surveys, focus groups and key informant interviews satisfying the requirements of the Nova Scotia Department of Health (DoH) Health Human Resources (HHR) planning tool; thereby ensuring compatibility with existing databases and providing the appropriate data to facilitate a Supply & Demand forecast by the DoH HHR division. This study is both quantitative and qualitative in design. It explores the main factors impacting the supply and demand of CCAs in Nova Scotia, informs the DoH HHR planning tool, and provides a number of recommendations with respect to the recruitment and retention of CCAs for the Province.

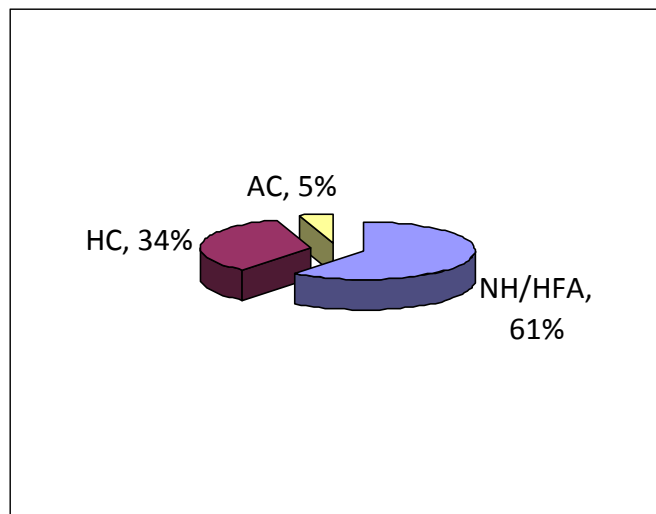
As with most complex problems, the HHR situation with CCAs is the result of numerous factors. An ageing workforce, a growing number of retirements and an increasing demand for continuing care services, combined with difficulty in recruiting students to educational programs, are some of the major contributing factors.

The study has drawn on information supplied by employers of CCAs, the Nova Scotia Department of Health, educators of CCAs and CCAs themselves to create a demographic profile of CCAs and to recommend on strategies for recruitment and retention of CCAs in the province. The estimate of the number of CCAs and persons working in the role of CCA, who comprise the present workforce, is 6655. Figure 1 illustrates the breakdown of CCAs by work setting.

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<sup>1</sup> For this study, CCA includes employees working in the role of direct care/support service such as CCA, Personal Care Worker (PCW), Home Support Worker (HSW), and Home Health Provider (HHP) as defined by Department of Health regulations, as well as employees in this role with on-the-job training.





**Figure 1: CCAs by Work Setting in Nova Scotia**

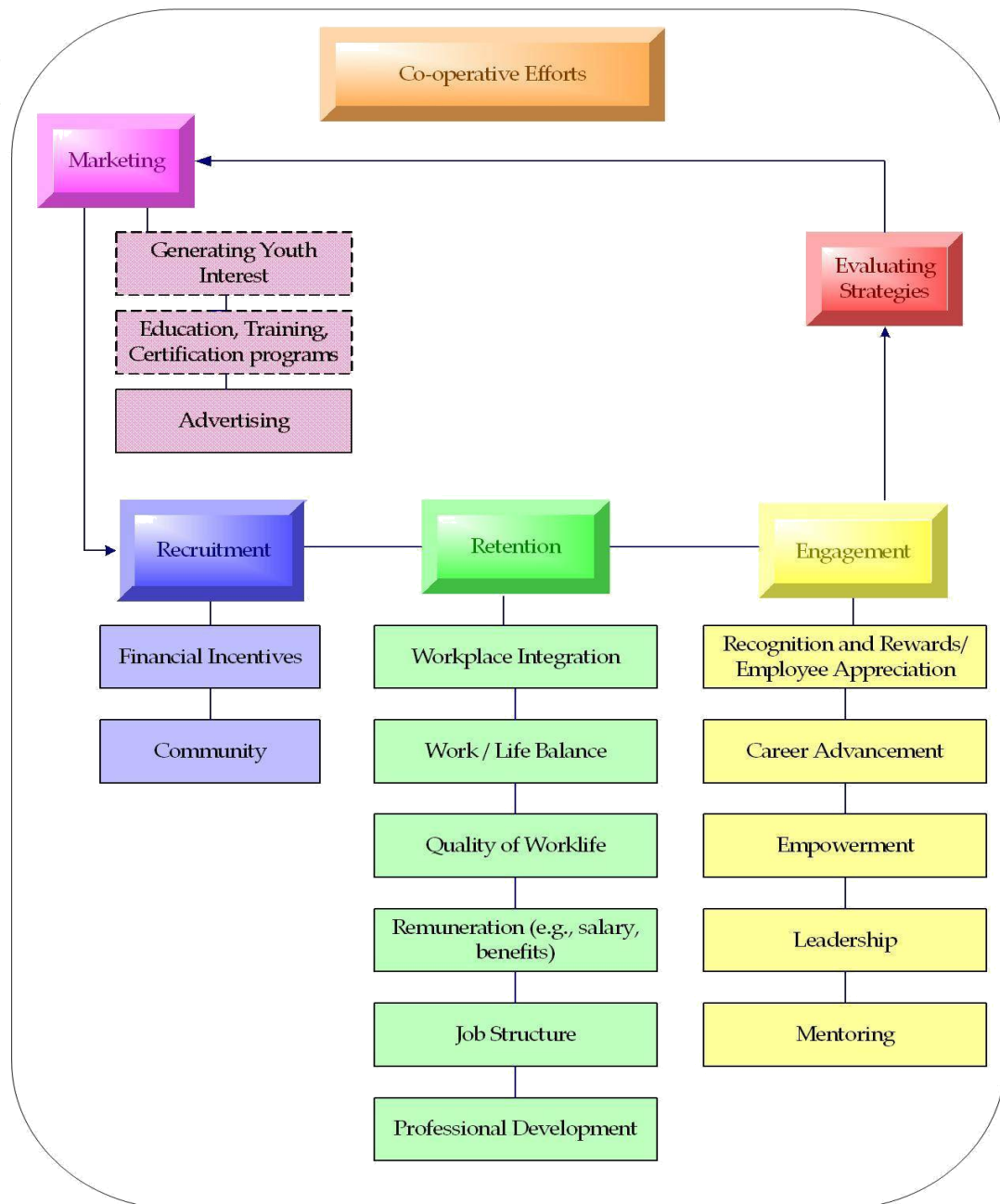
CCAs work in health care facilities and community based agencies where client acuity is advancing as the senior population ages. The demands for level of service and scope of practice are constantly evolving and wages and working conditions are often perceived as undesirable. In addition to these factors, increasing numbers of CCAs are dealing with injury and job-related physical and mental stress, which contributes to both work-life and personal problems. These issues increase sick time and workers compensation claims, creating greater staffing challenges and increasing the need for recruitment.

***Approx. 52% of all workplace leaves are WCB claims.***

One of the greatest challenges of the CCA Supply and Demand Study was the difficulty experienced by many employers with supplying HHR data, particularly historical data. This was reported to be associated with a lack of computerized systems for data collection and a lack of human resources to review paper files for the requested data. A need for support in this area across the sector is reflected in the recommendations of the report.

Recommendations of the report are aligned with the Nova Scotia Health Recruitment and Retention framework (2006), which has been developed by the Health Care Human

Resource Sector Council (HCHRSC). The framework illustrates five key areas in which cooperative and coordinated efforts are required to recruit and retain health care workers.



**Figure 2: Nova Scotia Health Recruitment and Retention framework**

This report presents three strategic directions and eleven recommendations that address CCA HHR issues. The recommendations section of the report contains suggested activities to implement the recommendations. Also included are notes identifying organizations with expertise and experience that are actively involved in some of the activities. In addition, new and continuing partners for the activities are suggested. Short and long-term benefits of implementing the recommendations are included.

***Strategic Directions:***

1. Develop an integrated HHR strategy for the CCA sector that utilizes the Nova Scotia Health Recruitment and Retention framework (HCHRSC,2006) that meets and builds on the DoH HHR objectives and that reflects the findings of the CCA Supply and Demand Study(HCHRSC, 2008).
2. Evaluate current and future CCA initiatives with respect to the objectives of the integrated HHR strategy for the CCA sector (above).
3. Create an occupational registry for CCAs in Nova Scotia in order to maintain a current and accurate provincial profile of CCAs for HHR planning.

***Cooperative Efforts:***

1. Promote collaborative Health Human Resources planning activities for CCAs.
  - 1.1. Continue to support and develop provincial level HHR planning groups.
  - 1.2. Support and facilitate HHR personnel and personnel development.
  - 1.3. Identify and implement best practices from within the Province and from other jurisdictions.
2. Develop an evaluation framework with clear indicators to measure success of Strategic initiatives.
  - 2.1. Design a logic model to guide and evaluate sector strategy.
3. Follow-up on recommendations from the Health Care Human Resource Sector Council's (2007) "Increasing Human Resource Capacity in the Continuing Care Sector through Information Technology".

- 3.1. Implement a standardized information technology and management system for the Continuing Care sector in Nova Scotia.
4. Develop models for shared human resources.
  - 4.1. Identify and share best practices within the sector.

***Marketing:***

5. Continue to support and develop provincial marketing campaigns.
  - 5.1. Review and evaluate present provincial marketing strategies.
6. Review the state of CCA education programs.
  - 6.1. Undertake a study of availability and uptake of education programs.

***Recruitment:***

7. Create an international recruitment strategy for CCAs.
  - 7.1. Prepare a position paper for discussion among stakeholders.
8. Develop programs targeting youth and men.
  - 8.1. Hold focus groups with youth and men to determine what attracts them to specific careers and what keeps them there.
  - 8.2. Continue to involve directly both the DoH and DOE to support marketing and recruitment strategies for colleges and private educators.

***Retention:***

9. Promote and support quality of work-life (QWL) policies and initiatives.
  - 9.1. Identify and evaluate efficacy and scope of current QWL programming in the context of the integrated HHR strategy.

***Engagement:***

10. Promote a career ladder for CCAs.
  - 10.1. Explore bridging opportunities to other health care professions.

**Evaluation Strategies:**

11. Develop a registry for employees working in the role of direct care/support service provider.

11.1. Require registration for CCAs.

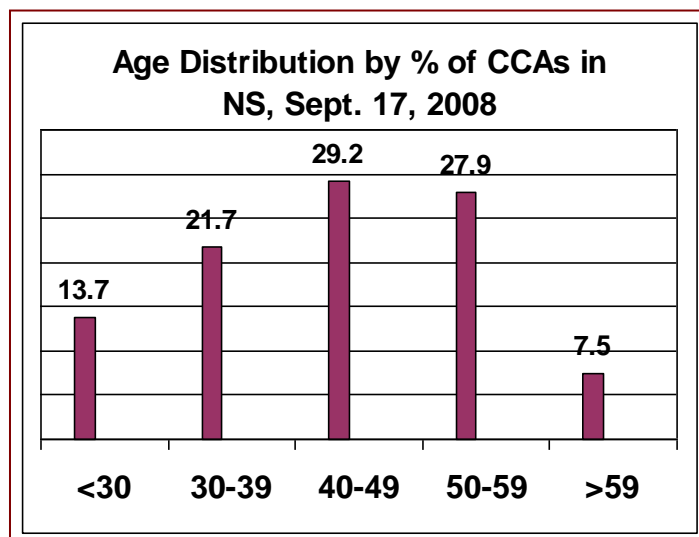
## Introduction

This report summarizes the activities and findings of the *Supply and Demand Study of Continuing Care Assistants (CCAs) in Nova Scotia*. The study took place from December 17<sup>th</sup>, 2007 to December 12<sup>th</sup>, 2008. This work builds upon previous research relating to health human resources in Nova Scotia, particularly research relating to the CCA<sup>2</sup> and others functioning in the role of direct care/support service provider. It incorporates current data collected from surveys, focus groups and key informant interviews satisfying the requirements of the Nova Scotia Department of Health (DoH) Health Human Resources (HHR) planning tool; thereby ensuring compatibility with existing databases and providing the appropriate data for a Supply & Demand forecast by the DoH HHR division.

Nova Scotia is impacted not only by an ageing population and an ageing workforce but also by the ageing of our health care workforce. If current trends continue such as HR drain from other sectors, an immigration rate too low to keep pace with the declining birth rate and expected mass retirements, the result will be fewer care providers to meet the present demand let alone the increased demand that attends an ageing population. Over the next decade, as the boomers move into retirement, labour shortages (in all sectors) will become more apparent. For the health care sector there are additional factors which affect service provision, including an unbalanced distribution of the workforce, changing work practices, increasing educational requirements, growing consumer/community expectations and demands for increased government funding for health care (Nova Scotia Department of Health [NSDoH], 2007, p. 3). As reported by the respondents to the CCA Supply & Demand survey (May to August, 2008) and illustrated by the bar graph below, the CCA population in Nova Scotia fits the norm for health care workforce ageing patterns. Approximately 65% of CCAs in Nova Scotia are over 39 years of age. Approximately 35% of the CCA population is over 49 years of age.

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<sup>2</sup> Employees working in the role of direct care/support service providers such as CCA, Personal Care Worker (PCW), Home Support Worker (HSW), and Home Health Provider (HHP) as defined by Department of Health regulations, as well as employees in this role with on-the-job training.



**Figure 3: Age Distribution of CCAs in Nova Scotia**

The ageing CCA workforce is supporting a health care sector where client acuity is advancing as the senior population both grows and lives longer, where demands for the level of service and the scope of practice are constantly evolving and where wages and working conditions are often perceived as undesirable. In addition to these factors, increasing numbers of CCAs are dealing with injury and job related physical and mental stress. Further concerns for the supply of CCAs in Nova Scotia include the following:

- a) It is estimated that there were nearly 1000 leaves of absence, on average, per year from the workplace for various reasons over the five-year period, 2003-2008. Of these leaves, employers report that approximately 52% are WCB claims, representing by far the most frequent reason for absence from the workplace.
- b) The average age of the female CCA is 43.7 years and that of the male CCA is 45.1 with a combined average age of 43.8.
- c) 94.5% of CCAs are female (this increases need for a balanced family/work life and maternity leave).
- d) If we consider 60 years to be the age of retirement then 6.1% of the present CCA population is currently eligible for retirement and 16.6% within the next five years. Within 10 years this percentage increases to 30%.

***Approx. 30% of  
CCA s will be  
eligible to retire  
within 10  
years.***

## **Mandate/Scope of Work**

Price-MacDonald & Associates Consulting Inc. was retained by the Health Care Human Resource Sector Council for the purpose of completing a Supply and Demand study for Continuing Care Assistants (CCAs) in Nova Scotia. The study was carried out under direction and with the support of a Steering Committee of industry stakeholders (Appendix A). The study began on December 17<sup>th</sup>, 2007 and the study was completed on December 12<sup>th</sup>, 2008. The broad project goal was to build on past research and work collaboratively with the Acute and Continuing Care sectors to:

- Create a demographic profile of Continuing Care Assistants (CCAs), including a demographic analysis (age, gender, pension eligibility, attrition rates, *etc.*) by region and employment setting.
- Provide an analysis of the labour market, including the availability of qualified CCAs, and information on Nova Scotia-based education programs.
- Conduct research employing both qualitative and quantitative methodologies and develop assumptions to be used in forecasting demands for CCAs.
- Forecast, based on available information, the demand for CCAs over the next five years, factoring in attrition rates, changes in demand based on independent demographic projections, increased skill expectations, and emerging trends and technologies.
- Identify potential shortages/surpluses over the next five years based on the aforementioned supply and demand information.
- Identify the specific challenges that will impact the retention of current CCAs and recruitment of new CCAs.
- Produce a CCA demographic profile, a CCA supply and demand projection and recommend a recruitment model for CCAs across the Continuing and Acute Care sectors.

When compiled the data was provided to the Nova Scotia Department of Health for the creation of a simulation model to forecast CCA HHR needs and to generate a five-year projection using their HHR Projection Tool.



## **Deliverables**

Deliverables of the project include:

- Literature Review / Preliminary Research
- Sector Input to validate Preliminary Research
- CCA Supply and Demand Forecast
- Dissemination of Findings

## **Approach**

The study was carried out in five stages:

### *Stage 1: Research Plan and Design*

In this stage, the consultants, in collaboration with the Health Care Human Resource Sector Council and the Steering Committee, identified challenges and limitations of the study and developed strategies for collection of priority information. A plan of action was drafted along with reporting schedules and Steering Committee meeting dates. A key informant list and tools for focus groups and interviews were generated. Because of the participation of the specific target groups in many recent studies and due to other HR challenges impacting the sector, the initial plan for the collection of information was to hold key informant interviews and focus groups, and mine data from various sources, so as to limit the time and energy demands on the sector. However, upon reflection, it was found that this approach was insufficient for gathering the specific information needed to inform the HHR Planning Tool; so the decision was made to draft and disseminate a survey directly to the CCA employers. The survey was accompanied with letters of support from the Nova Scotia Association of Health Organizations (NSAHO), the Home Support Nova Scotia Association (HSNSA) and the NSDoH.

### *Stage 2: Review of Literature*

To gain insight into the current situation of CCAs in Nova Scotia, and to identify the major trends and issues informing this picture, literature spanning the years 2001-2007 was reviewed. The documents chosen for review focus on how to best utilize available CCA resources and share a vision for Continuing Care in Nova Scotia. References

were compiled and documented in the style of an annotated bibliography that is formatted as a searchable Microsoft Excel spreadsheet. This tool can be expanded as research continues and renders the relevant literature easily accessible to future researchers and other interested parties (Appendix C).

### *Stage 3: Data Collection and Analysis*

Stage three spanned May 15 to August 31, 2008. Surveys were prepared and adjusted with feedback from the Steering Committee. Trial surveys were distributed to one small and one large CCA employer for their feedback and to determine time required to complete the survey.

On May 21, 2008, the final surveys (Appendix D) were distributed to 95 employers across the province. Letters of support from the NSAHO, HSNSA and DoH followed. Follow-up calls were placed after the letters of support had been circulated and offers to assist with the completion of the survey were tendered. In total, four rounds of follow-up calls were made between May and August 2008 to encourage participation and offer support. Two employers accepted an on-site visit for assistance.

Focus groups with CCAs and employers of CCAs were held across the province in June and July, 2008. The objective of these meetings was to gather insight into the recruitment and retention of CCAs. The focus group schedule and questions are included in Appendix E. A summary of the feedback from focus groups is found in the qualitative section of this report.

Key informant interviews were conducted with employers of CCAs who represent a cross-section of Long-Term Care, Home Care and Acute Care organizations in Nova Scotia. Key informants were drawn from large and small facilities/agencies and from urban and rural settings. The primary objective of the Key Informant interviews was to discuss recruitment and retention strategies, discover the elements of successful

recruitment and retention and to identify barriers to success. A discussion of common themes follows in the qualitative section of this report.

#### *Stage 4: Supply & Demand Forecast*

Data obtained from the surveys was compiled and provided to the NS DoH. A simulation model for CCAs is under development that will generate a five-year forecast for CCAs and provide policy direction for HHR planning.

#### *Stage 5: Dissemination of Findings*

Stage five encompasses the preparation of materials and dissemination of findings to stakeholders as identified by the Health Care Human Resource Sector Council and the project Steering Committee. The project was completed as contracted on December 12th, 2008.

### **Limitations of the Study**

In Nova Scotia, individuals with CCA and related education provide a multitude of services across the Continuing Care landscape. The authors recognize the contribution made by many categories of worker, such as the Residential Services Worker (RSW) in the Department of Community Services. However, the scope of this study is limited to the definition of Continuing Care Assistant as defined by the NSDoH, Continuing Care branch; that is, employees working in the role of direct care/support service such as CCA, Personal Care Worker (PCW), Home Support Worker (HSW), and Home Health Provider (HHP), as well as employees in this role with on-the-job training (DoH, 2007, p. 2). Therefore, surveys were distributed to Nursing Homes and Homes for the Aged, Home Care/Home Support Agencies and Acute Care Organizations from the ten DHAs and IWK.

The DoH is in the process of planning a three year transformation of the health care system. This will see the development of models of care that will enhance community based services. It is difficult to project precisely how these changes will impact the

supply of and demand for CCAs. It is anticipated that changes will most likely have far reaching effects for CCAs in both the Acute and Continuing Care settings.

Though surveys were available in both official languages, the study did not focus on the needs of the Francophone population, nor did it address care requirements for other cultural, ethnic and racial minorities.

Survey fatigue contributed to a laborious data collection process. In many cases a lack of resources, both human and IT, made reporting of historical HR data before 2007 nearly impossible.

Although the survey was thoroughly vetted by the Steering Committee prior to distribution to CCA employers, the inherent ambiguity in wording of such surveys contributed to inconsistent responses for some items.

## **Ethics**

As members of the Canadian Evaluation Society (CES), PMA consultants adhere to the CES Guidelines for Ethical Conduct (Appendix F). The field of evaluation as promoted by the CES includes the domains of: Program Evaluation, Action Research, Empirical Research, Qualitative Methods, Performance measurement and monitoring, Survey Research, Needs Assessment, Evaluability Assessment; Logic Models; Performance Audits; Implementation/ process evaluation, Economic Evaluation and Efficiency Assessment.

## **Background**

Supply and demand models (SDM) are simple abstract structures applicable to almost any domain, whether it is plants competing for sunlight, birds for worms, drivers for gasoline, or even fictitious consumers for fictitious widgets. So long as there is a finite quantity of resources (*supply*) and a definite (or indefinite) requirement for those resources (*demand*) a SDM can represent it. HHR is no exception: at any given time,

only so many health care workers are employed by the health care delivery system and available to service the health care needs of the population. The difference, if any, between the supply and the demand at a time represents either a surplus or a deficit of resources—or a ‘gap’. Analyzing the gap may suggest ways to improve the interaction between the supply and demand so as to bring about and maintain the ideal state of equilibrium. For instance, if there were fewer health care users (e.g., a healthier population), then the demand would decrease accordingly; thus the gap would be diminished.

Adding a dimension of time flow to a SDM creates a dynamic and more complex model by incorporating rates of change into the supply and demand equation. The advantage conferred by doing this is the ability to reliably predict future states of supply and demand from the present state. Moreover, these models enable one to entertain possible HR scenarios by variously adjusting the inputs, making clear the dynamics involved. Along with this better understanding comes clarity of vision that helps avoid policy pitfalls. For instance, any perceived benefit from increasing enrolment into CCA educational programs could easily be negated by not addressing issues in recruitment and retention or quality of work life. As more and more variables that affect the rates of change are considered, the more accurate the model’s predictions become.

Via the Atlantic Health Human Resource Study ([AHHRA] 2005), a health human resource planning tool – a rigorous SDM – was created (DoH HHR Planning Tool). It was adapted from the Canadian Institute for Health Information ([CIHI] 2005) document which identifies seven variables or ‘priority information needs’. These priority information needs are defined as “indicators and requisite data elements necessary to compile the measures and indicators for effective HHR management,” (p. 10), as follows:

1. Demographics: “the number and demographic characteristics of health personnel who are registered or licensed, or who are otherwise part of the available health workforce” (p. 13).

2. Education/Training: “the number and characteristics of applicants to, and graduates of, health education/training programs that may potentially enter the workforce. In addition: the number of institutions, the characteristics of each institution, [and] the programs within each institution” p. (14).
3. Geographical Distribution: “the number and characteristics of health personnel by geographical distribution” (p. 16).
4. Migration: “the number and characteristics of health personnel who immigrate from other countries and those who emigrate from [Nova Scotia] to other countries, as well as those who migrate between geographical locations within Canada [and Nova Scotia]” (p. 17).
5. Non Migration-Related Attrition: “the number and characteristics of health personnel leaving the health workforce for various reasons other than migration (retirement, change of profession, etc.)” (p. 18).
6. Employment/Practice Characteristics: “the number of and nature of health personnel engaged in employed activity” (p. 19).
7. Productivity: “the output of any health human resource (for example, clients/patients seen by health personnel) per unit of input (for example, earned compensation)” (p. 20).

Prior research has supplied much information with regard to CCAs in Nova Scotia but did not provide the detailed information required to inform the DoH HHR projection tool. To populate the tool a dedicated study into the present state and nature of the province’s CCA profile was necessary. The aim was to produce a reliable supply and demand projection and recommend a recruitment model for CCAs across the Continuing and Acute Care sectors. It is to this end that the present study is undertaken.

## **Educational Preparation for CCAs in Nova Scotia**

Individuals may become certified as a CCA in Nova Scotia in a number of ways (CCA Program, 2008). They include:

### *1. Completing the CCA Program:*

This learning opportunity is offered by the Nova Scotia Community College, private career colleges, licensed nursing homes/homes for the aged, home support agencies and Nova Scotia Work Activity Programs. Multiple delivery formats are available, including traditional classroom environments, full-time, on-demand and part-time, and distance options. The CCA Program consists of a minimum of 436 hours of class and lab time, 100 hours of home support field placement and 230 hours in a long-term care field placement. A directory of approved education providers and Information regarding CCA education program requirements is found on the CCA Program website.

### *2. Alternative Methods:*

2.1.Course Recognition: The course recognition process is designed for interprovincial formally educated direct care and support providers. The individual learning pathway is designed from the particular course and the learner must complete the required plan prior to writing the CCA Exam.

2.2.Equivalency with Nova Scotia recognized courses: The CCA Program Advisory Committee has designed prescribed pathways to CCA certification for individuals previously certified in Nova Scotia as HSWs, PCWs or NSCC educated HHPs. These pathways include workshops and courses from approved educational providers.

2.3.Prior Learning Assessment and Recognition (PLAR/RPL): The CCA PLAR process compares an individual's past experience and education (formal or on-the-job training) with the role of the CCA. Individuals may achieve credit toward their CCA Certification by gaining recognition for the skills and knowledge they have acquired on the job and through other formal and informal educational experience.

The CCA Program Advisory Committee has oversight for the implementation and ongoing assessment the CCA Program. The Committee acts in an advisory capacity to the Department of Health who is the ultimate authority of the program (CCA Program, 2008).

For the purpose of this report and the HHR projection only those entering the profession for the first time are considered. This includes graduates from basic educational programs and those entering the pool through course transfer from other jurisdictions.

Information on enrolments into traditional CCA programs is provided by Pam Shipley of NSAHO (see table below; NSAHO, personal communication, November 28, 2008). The 2007-2008 year is incomplete, 115 students are still enrolled in the program and should graduate before fiscal year end of March 2008. This and the fact that 2007 participants have two years in which to complete the program, slightly skews the overall attrition rate for the eight years. When the outliers are discarded the overall attrition rate becomes 15.26% for the traditional CCA programs. From one of the author's experience as an educator and manager of allied health programs, the attrition rate over the eight years of the program is consistent with attrition rates in other health care educational programs.

Enrolment in CCA programs has doubled from 315 in 2000/01 to 627 2007/08. Between 2000/01 and 2007/08 2885 CCA's graduated from both public and private institutions across the province from a total of 3565 who had enrolled. Efforts to recruit and retain CCAs to the programs have obviously been implemented and those that are shown to be cost-effective need to be continued.



Fiscal Year Calendar Year	Enrollments	Grads to match Enrollment	Incomplete	Attrition %	Failed Exam	Failure Rate %
2000/2001	315	267	37	11.7%	11	4.1%
2001/2002	355	303	47	13.2%	5	1.7%
2002/2003	332	285	39	11.7%	8	2.8%
2003/2004	480	407	70	14.6%	3	0.7%
2004/2005	470	407	62	13.2%	1	0.2%
2005/2006	493	398	87	17.6%	8	2.0%
2006/2007	493	393	88	17.8%	12	3.1%
2007/2008	627	425	202	32.2%	0	0.0%
<b>Total</b>	<b>3565</b>	<b>2885</b>	<b>632</b>	<b>16.50%</b>	<b>48</b>	<b>1.83%</b>

## Education Surveys

Ten (10) educational institutions were surveyed between May and June of 2008, by either telephone/paper survey as per the list of approved education providers (CCA Program, 2008). A copy of the interview/survey form is found in Appendix G. Five of ten institutions responded for a response rate of 50%.

As reported by the CCA education providers, deliveries of the basic CCA certification program ranges from 30 to 40 weeks (average = 33.8) with, in most cases, one to two admission periods per year (course delivery in hours must meet the minimum CCA standard of 766 hours, as defined above). The programs vary in cost from as low as \$300 (i.e., cost to student), where subsidized heavily, to as high as \$7400 at private career colleges. Of the providers surveyed, NSCC educates the most CCA's<sup>3</sup>. Of 491 total seats reported as available each year in the Province, NSCC accounts for 340 or roughly 70%. Most publicly funded programs report that they are operating at or near capacity and have been for the last five years. NSCC has grown in capacity over 50% since 2004. However, Université de Ste. Anne, appears to have trouble filling their seats and operates at just over 50% of their capacity.

<sup>3</sup> These numbers take into account traditional on-site delivery programs only.

The survey indicates that between 2003/2004 and 2007/2008, 1286 students have enrolled in the traditional CCA programs. Using the response rate of 50% this extrapolates to 1929 students enrolled. The 1082 that have graduated extrapolates to 1623 graduates over the four year period. NSAHO reports 1936 enrolled and 1610 graduated in this same four years. The overall rate of attrition is reported to be approximately 15.8 %. This is the same as that reported by NSAHO for the four years. The slight variations in survey numbers may reflect slightly different reporting cycles on the survey as staggered intakes and length of time in programs vary depending on the method of delivery, e.g. full-time, part-time, etc..

CCA students are predominately female. Males make up from 5-8% of student enrolment in any given year. Female students are on average 32.5 years old when they enrol, whereas males are considerably older at 38.8 years. A focus on attracting youth and males will be important for future targeted marketing campaigns.

## **Employer Survey Response**

Health care provision is a costly endeavour. Decisions regarding the most appropriate mix of the right providers with the right skill sets in the right locations and at the right time ought to be based on current and relevant data. Evidence-based decision-making offers the most effective and informed use of increasingly scarce human and fiscal resources. Comprehensive data gathering methodologies need to be employed in order to collect sufficient and reliable evidence and to ensure that as many relevant voices as possible will be heard. Within this context, the results of the primary research carried out for the CCA Supply & Demand Study are presented.

Interpreting the response rate for the CCA Supply and Demand Survey in Nova Scotia is not as straightforward as it might at first be expected. CCA's and their equivalents (e.g., PCW's, HSW's) are employed across the health care sector. They are predominantly found in the continuing care sector, working in Nursing Homes and Homes for the Aged (NH/HFA) and HC/HS agencies; however, they may also be employed in acute care

(AC) hospital settings. Surveys were distributed to employers of CCA's throughout Nova Scotia that targeted these work settings.

In total 95 surveys were distributed: nine went to each of the district health authorities, one to the IWK, 66 to NH/HFA and 19 to HC/HS agencies. A total of 59 surveys were completed (39 from NH/HFA, 15 from HC, 5 from AC). The surveys were returned in various states of completion and the individual questions were answered with varying degrees of fidelity. Verbal feedback from survey respondents indicate that lack of time, human resources and electronic filing and data systems made completion of the survey an onerous task in some instances. The overall survey response rate was 62.1%. Analyzed by health care facility type, there is a 50% response rate for the DHA AC organizations (including IWK), 59.1% for NH/HFA, and 78.9% for HC/HS agencies.

However, these percentages can be deceiving if not considered in the proper context. Not all NH/HFA are the same size, have the same carrying capacity, or employ the same number of employees; nor do they necessarily operate with the same employee-to-client ratios. The same holds true for HC/HS agencies and AC. They each encompass regions of different sizes with different population densities and demographics; and make different demands on the health care system. Hospitals, NH/HFA's and HC/HS agencies in and around Halifax are larger than others. Extrapolating from one region to the next requires that the above factors be taken into consideration.

Looking at the numbers again for NH/HFA, and considering the number of NH/HFA beds represented by those who responded, the actual province-wide response rate by beds represented is 61.6%. For the purposes of this study we use the number of nursing home beds as it tracks more closely the number of CCAs employed per DHA by NH/HFA than would the number of employers represented alone.

## Response Rate by DHA

Broken down by DHA<sup>4</sup> the contrast between response rate by facility and by beds is even more apparent. The following table demonstrates the response rate by employer and by percentage of total beds represented. One private employer operates six NH/HFA across three districts, which house 931 beds, 16% of the provincial total. While strictly speaking part of individual districts, this employer reported provincially and is included as 'Other'. Including these sites, the provincial survey response rate by number of NH/HFA beds represented is 61.6%.

DHA	Surveys Distributed to NA/HFA	Responses	% Response Rate by Employer per DHA	% of beds represented provincially	% Beds Represented Per DHA
A	6	5	83.3	9.1	80.1
B	5	5	100	4	100
C	8	6	75	8.7	88.8
D	7	5	71.4	6.1	41.7
E	7	3	42.9	7.7	33.9
F	14	8	57.1	25.9	59.1
G	4	1	25	7.6	10.4
H	12	4	33	12.8	31.1
I	2	1	50	2.4	36.2
Other	1	1	100	15.7	100
Total	66	39		100	

The response rate for HC/HS agencies was roughly 79%. One HC/HS employer, operating five sites across five health care districts reported provincially.

## Findings

### *Demographics*

The vast majority (94.5%) of CCA's are female, with an average age of 43 years. Males make up the remaining 5.5% with an average age of 45.1 years. The overall average

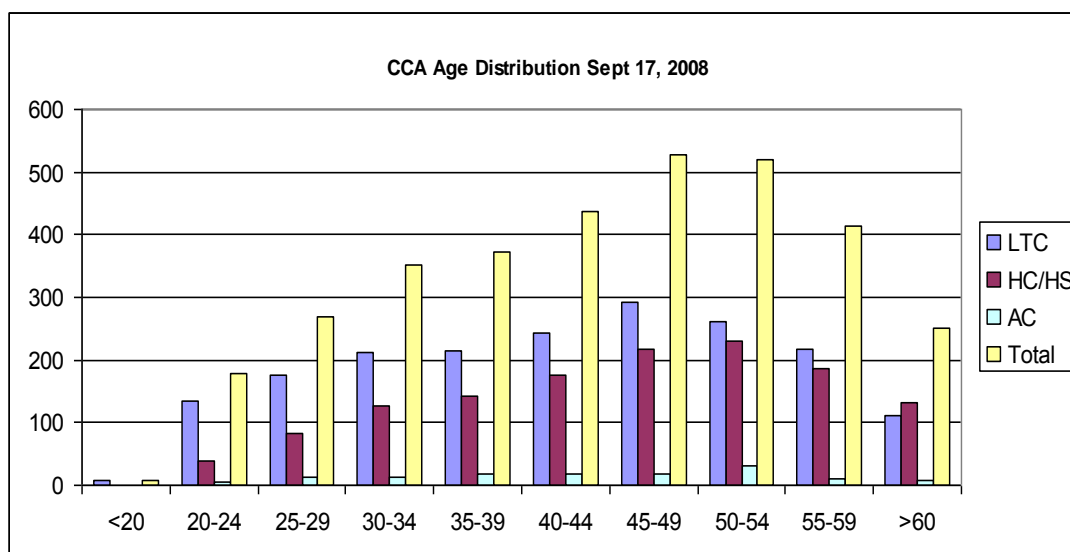
<sup>4</sup> The DHAs are given arbitrary labels and discussed in no particular order so as not to be readily identifiable.

age is 43.7 years. Across the DHA's the average ages range from 39.1 years to 45.8 years.

DHA-F reports 51.1% of the total male CCA population. While males account for only 3-4% of the CCAs in HC/HS and NH/HFA, they make up almost 40% of the AC CCA population.

By health care facility: NH/HFA reports an average age of 42.5 years, HC/HS reports 45.6 years, while AC reports an average age of 43.7.

Presently 7.5% of CCAs are in their 60s; 28% in their 50s; 29% 40s; 22% 30s; and 14% 20s or younger. Two thirds, then, are 40 years or older.

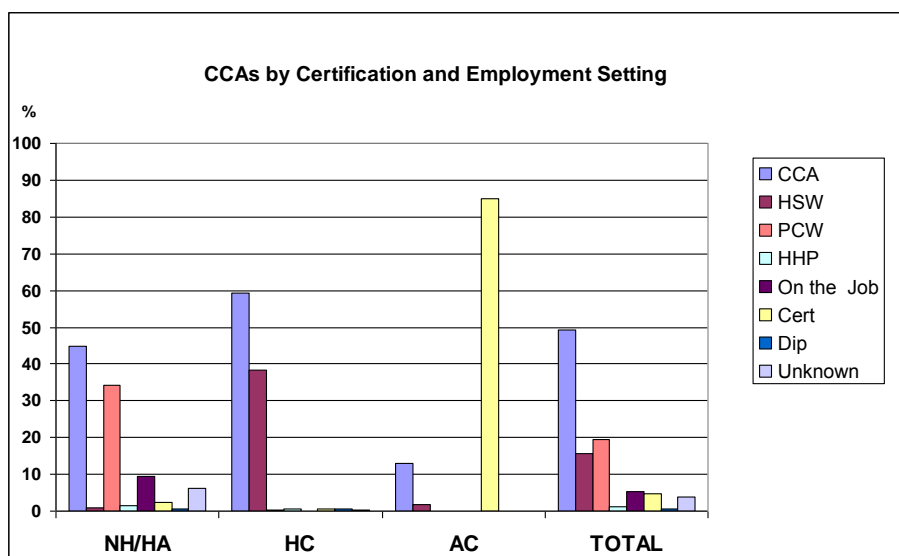


**Figure 4: Age Distribution of CCAs in Nova Scotia, Sept. 17, 2008**

### *Designation*

Almost half (49.6%) of the health care employees working in the role of CCAs are certified CCA's: NH/HFA nursing homes harbour 52% of them, HC/HS, 47% and AC the remaining 1%. Of the non-CCA certified 50.4%, who are functioning as CCA's: 15.7% are HSW's, 19.6% PCW's, and 1.1% Home Health Providers (HHP). Another 5.3% are

training ‘on-the-job’, while 4.6% possess some certificate (e.g., LPN, RN, RCW, PSW) and a mere fraction of a percentage have a diploma in an aligned discipline (e.g., human services); while 3.9% were reportedly of unknown designation. The overwhelming majority (96%) of HSW’s work for HC/HS agencies, while a similar majority (99%) of PCW’s are employed in NH/HFA. Of those functioning as a CCA in AC nearly 83% possess some certificate. Only NH/HFA facilities report that they provide ‘on the job’ training. As the certified CCA designation is a recent addition to the continuing care sector, it is clear that the CCA population is growing quickly and inevitably replacing HSW/PCW’s and other designations.



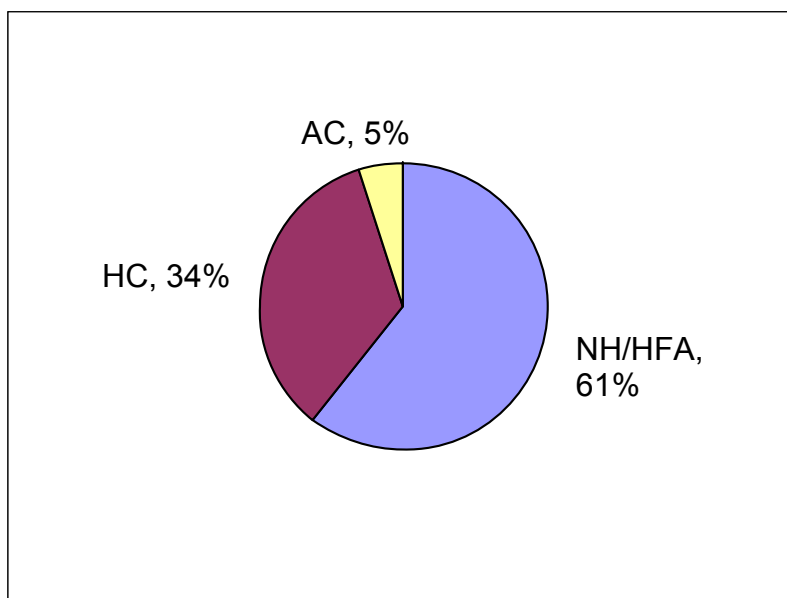
**Figure 5: CCAs in Nova Scotia by Designation and Employment Setting**

For the purposes of this study, all employees working in the capacity of a CCA are considered to be CCAs. Then, given the above numbers and the aforementioned survey response rate the total number of CCAs across the continuing care sector can be estimated. The survey responses account for 4415 CCA’s. By facility type that breaks down to 2523 in NH/HFA, 1739 in HC/HS and 153 in AC. As mentioned above the response rate for NH/HFA (calculated by beds represented) is 61.6%, for HC/HS (calculated by employer response) is 78.9% and for AC (also calculated by employer response) is 50%. However, since one AC facility reports no CCAs at all, they were

excluded from the calculations, rendering the AC response rate 44.4%. Extrapolating these numbers to 100% of the CCA population per DHA and then totalling them for the provincial count results in an estimated total of 3966 in NH/HFA, 2345 in HC/HS and 344 in AC; for a grand total of 6655 CCAs province-wide.

	NH/HFA	HC/HS	AC	TOTAL
<b>DATA</b>	2523	1739	153	4415
<b>ESTIMATE</b>	3966	2345	344	6655

**Figure 6: Data Table of reported and estimated numbers of CCAs in Nova Scotia**



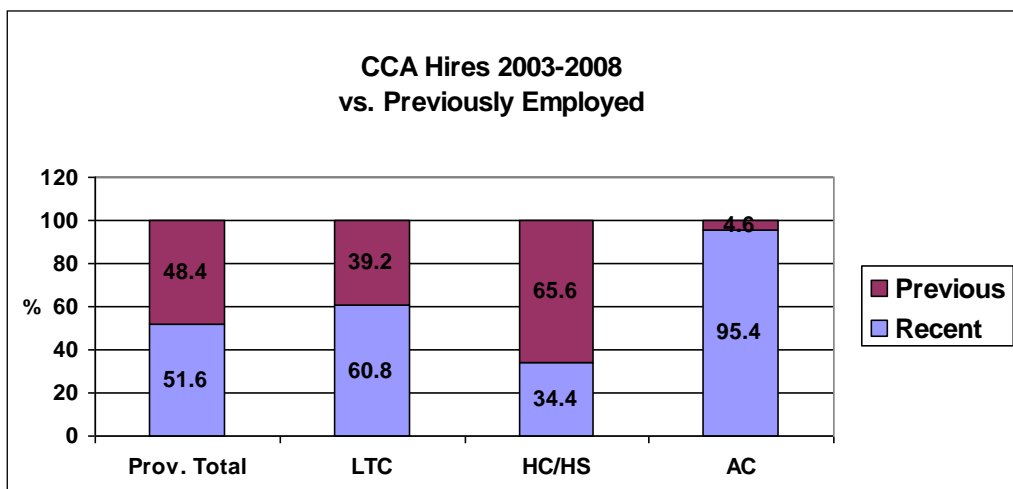
**Figure 1: CCAs by Work Setting in Nova Scotia, Sept. 1, 2008**

### *Hires*

More than half (51.6%) of the present CCA population was hired between April 1, 2003 and March 31, 2008<sup>5</sup>. By facility type we see that of the presently employed CCAs in NH/HFA well over half of them (60.8%) were hired recently, in HC/HS, 34.4% and nearly all (95.4%) of CCAs in AC. Of these recent hires 67.3% were hired into NH/HFA facilities, while 26.3% and 6.4% were hired by HC/HS agencies and AC facilities respectively. The trend seems to be that more and more CCAs are being hired in each

<sup>5</sup> Assuming that none of the recent hires have since retired, resigned, been terminated or are otherwise unavailable.

successive year, with an average yearly increase of about 12%. From 2003 to 2007 there was a 57% overall increase in hiring.



**Figure 7: CCA Hires by Employment Setting 2003-2008**

The respondents were also asked to indicate from where the new hires had been recruited. The majority (64.3%) of recent hires come from Nova Scotia. Those coming from 'elsewhere in the Atlantic Provinces', 'elsewhere in Canada' and 'elsewhere in the world' each account for less than 1% of new hires. A significant 34.7% are of unknown origin—clearly, tracking of such HHR information would be beneficial.

### *Vacancies*

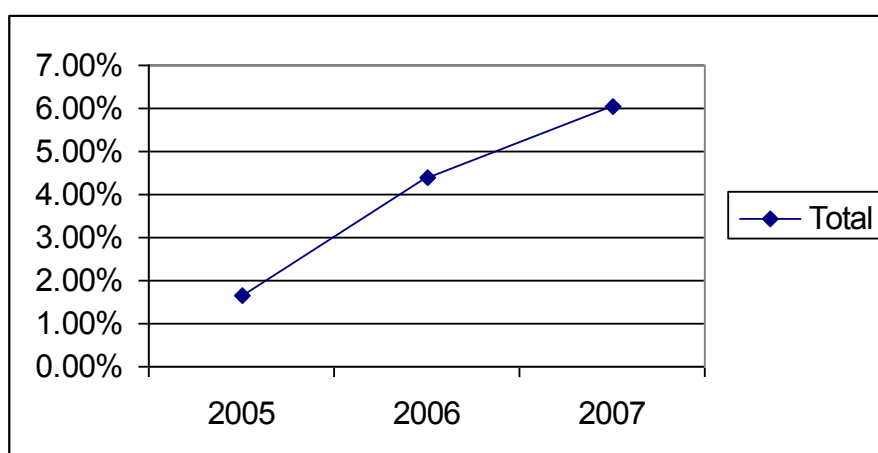
Employers were asked to report on vacancies between 2003 and 2008 by 'Employment Category (FT, PT, casual)' and 'Hours Vacant per Week'. This item created difficulties for respondents because of a lack of historical human resources data, inability to generate the necessary data<sup>6</sup>, or the question was found to be ambiguous. In particular, the duration of vacancies was not requested making the number of vacancies difficult to calculate. Moreover, very little data were available from 2003, 2004, and 2008 data was

<sup>6</sup> Some respondents reported that this data was time consuming to collect and that they lacked human resources to facilitate its collection.



for 6 months only. In order to present a meaningful picture the data from 2005-2007 were used to generate vacancy rates<sup>7</sup>.

Overall, the sector reports a 4.4 percentage point increase in the vacancy rate over 2005-2007, with full-time vacancies peaking at just over 3%, part-time vacancies at 2.5% and casual vacancies at approximately 0.5 % of the present workforce.

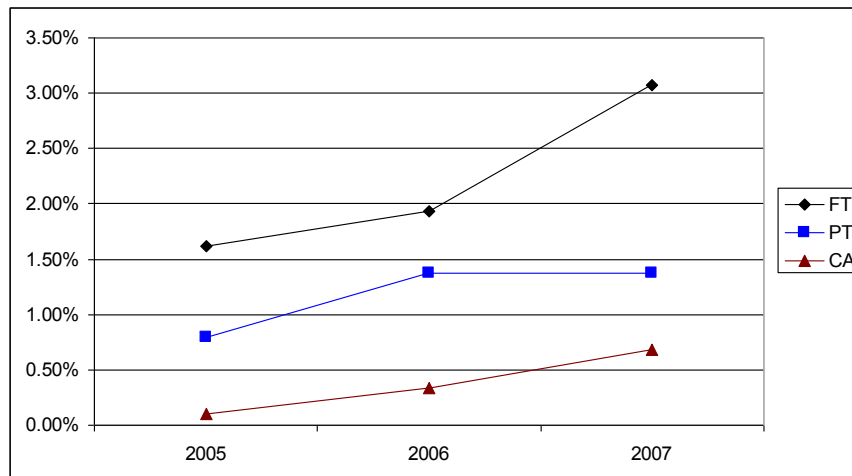


**Figure 8: Combined Vacancy Rate 2005-2007**

These vacancies may be the result of any number of factors, e.g. competition from other sectors for the same pool of employees, increased demand for services, or decreased interest in employment as a CCA. The duration of vacancies was not determined through this study but anecdotal feedback indicates that the duration of vacancies may also be increasing. The breakdown of vacancies by employment setting is as follows.

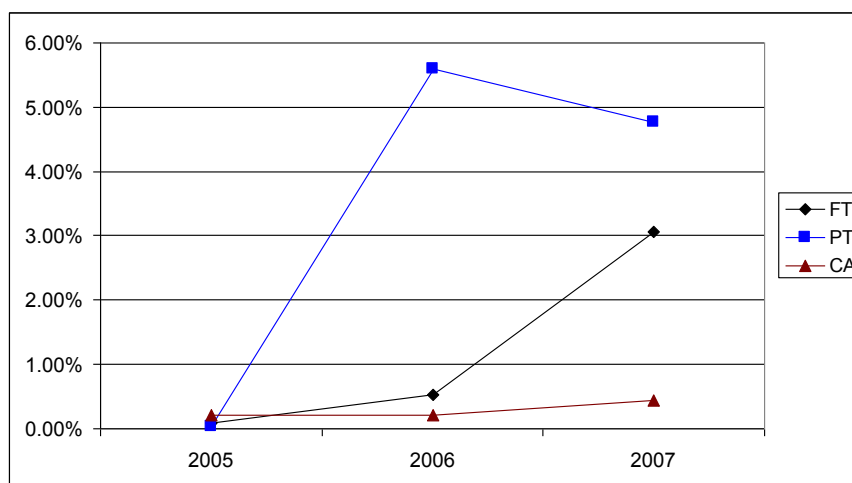
In the NH/HFA setting vacancy rates increase from 2005-2007 with full-time vacancies reaching just over 3% in 2007. Part-time vacancies increase from 2005 and levelled off at 1.5%. Casual vacancies also increased and in 2007 reached just over 0.5%. NH/HFA account for roughly 61% of the CCA workforce.

<sup>7</sup> Vacancy rates were calculated by dividing the number of vacancies by the number of employees reported for the 2008 year plus the vacancies.



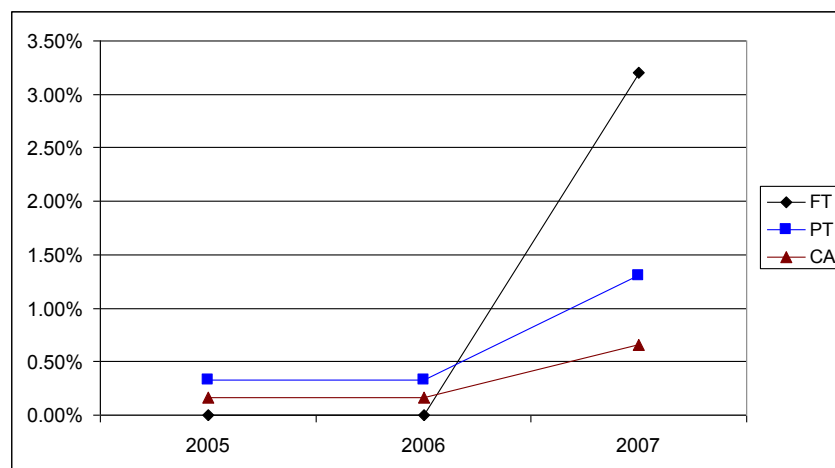
**Figure 9: Vacancy Rate NH/HFA 2005-2007**

In the HC/HS setting vacancy rates also increased from 2005-2007. Full-time vacancies increased from 2006-2007 and reach 3%. Part-time vacancies peaked at nearly 6% in 2006 and show a slight decrease in 2007. Casual vacancies show only a slight increase for the same period. HC/HS accounts for 34% of the CCA workforce.



**Figure 10: Vacancy Rate HC/HS 2005-2007**

Acute care recently began hiring CCAs to support the increasing numbers of long-term care clients occupying beds in that system. With this new demand, the vacancies increased from 2006-2007. Full-time vacancies reached over 3%, part-time just under 1.5%, and casual just over 0.5% in 2007. AC accounts for 5% of the CCA workforce.



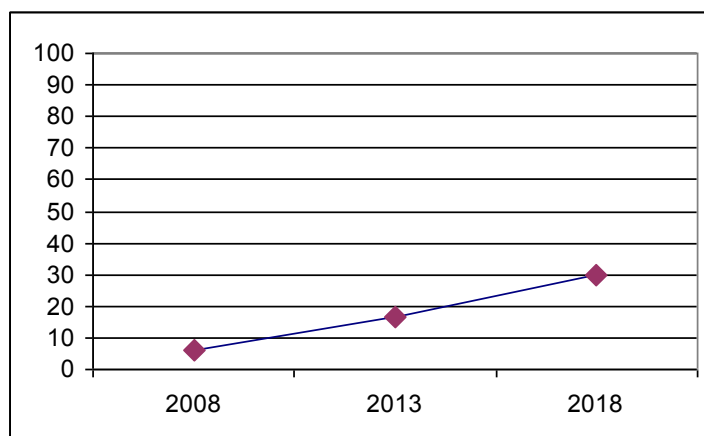
**Figure 11: Vacancy Rate AC 2005-2007**

In the absence of additional staff to fill these vacancies, services must be reduced or hours must be absorbed by the existing CCAs as overtime. This contributes to overwork, and employee stress and illness, not to mention the financial burden on the sector. A coordinated and global HHR plan for the sector is indicated.

### *Retirements*

Respondents were asked to report on retirements between April 1, 2003 and March 31, 2008 and expected retirements between April 1, 2008 and March 31, 2013. It is estimated that NH/HFAs saw 93 permanent CCA retirements between 2003 and 2008, whereas HC/HS saw 48 CCAs retire and AC zero. Assuming that CCAs will retire at age 60<sup>8</sup>, we can produce a simplistic 'worst case scenario' retirement forecast. There are an estimated 408 retirement eligible CCAs sector-wide: NH/HFA, 223; HC/HS, 167; AC, 18. In another five years, that number (408) will increase by an estimated 697: NH/HFA, 437; HC/HS, 237; AC, 23. As a worst case scenario, then, a total of 1105 CCAs are eligible for retirement by 2013, over 15% of the present CCA population. Ten years from now the number of retired CCAs will reach the equivalent of 30% of the present CCA population.

<sup>8</sup> CCAs may be eligible for retirement at 55, 60 or 65 years of age, depending on their pension plan. For the purposes of this report, 60 years is used because it is the mean age and also the age at which individuals are eligible for the Canada Pension Plan (CPP).



**Figure 12: CCAs Eligible for Retirement at 60 years as percent of Current CCAs.**

### *Resignations*

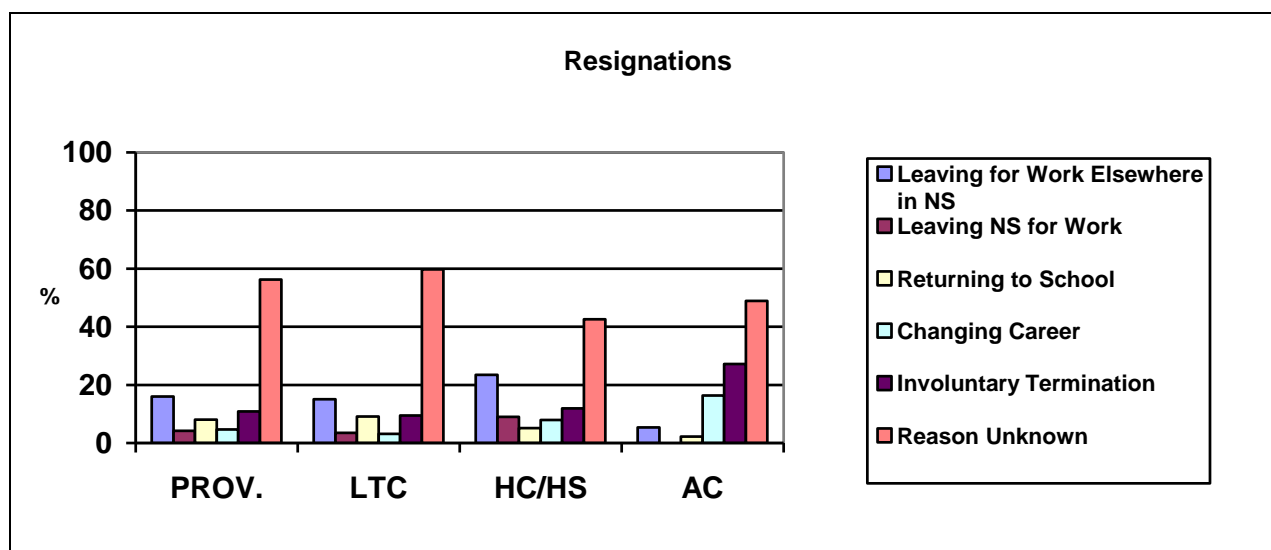
Over the five-year period, 2003 to 2008, NH/HFA facilities report on average 6 CCA resignations per year, HC/HS agencies report 3 per year and AC 5. This amounts to an annual rate of CCA resignations of roughly 498 sector-wide. Various reasons account for CCA resignations and the frequency of these reasons vary across healthcare settings.

The most frequently cited reason for resigning in NH/HFA is ‘leaving for work elsewhere in Nova Scotia’, followed by ‘involuntary termination’ and ‘returning to school for healthcare-related education’.

HC/HS also sees ‘leaving for work elsewhere in Nova Scotia’ as the most frequently cited reason for resigning. ‘Involuntary termination’ again comes in second; however, it is followed by ‘leaving Nova Scotia for work’ and ‘changing career to other than healthcare’.

AC, on the other hand, reports ‘leaving for work elsewhere in Nova Scotia’ as the third most frequently cited reason. ‘Involuntary termination’ is the most common reason, followed by ‘changing career to other than healthcare’.

It should be noted that the most common response to this question, regardless of healthcare setting, is 'reason unknown': NH/HFA, 59.8%; HC/HS, 42.6%; AC, 48.9% (overall, 56.2%). This indicates either the need for increased awareness of available HHR resources (such as the NSAHO and HCHRSC Recruitment & Retention Tools), in particular their exit interview tools, or the difficulty in implementing them.



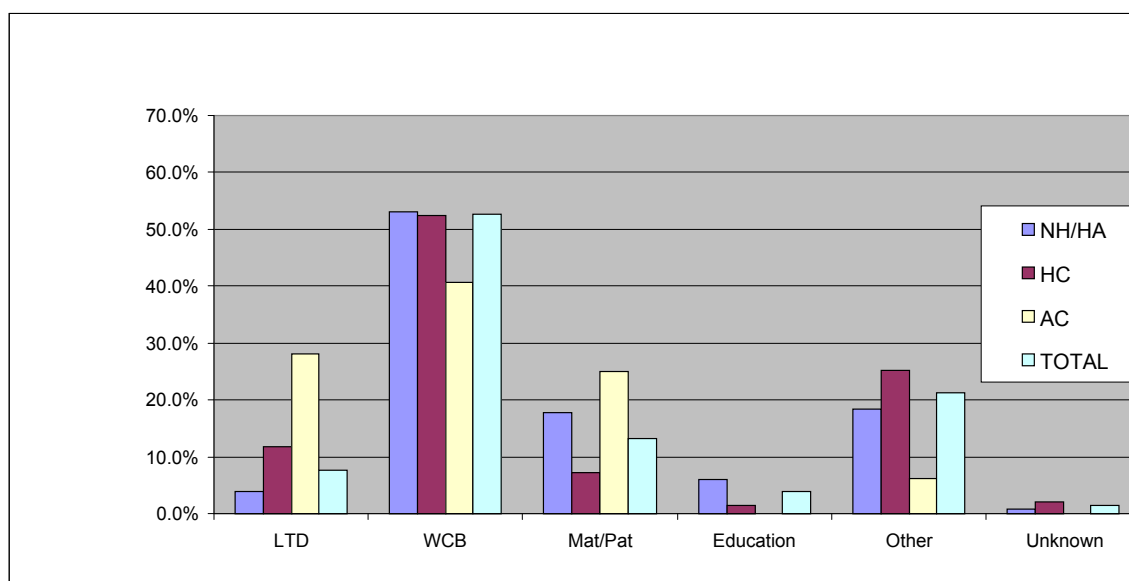
**Figure 13: Resignations by Employment Setting, Nova Scotia, Sept. 17, 2008**

### *Leaves*

The CCA supply and demand survey asked for employers to indicate the number of CCAs on leave over the past five years and the reasons for taking leave. There are various reasons why a CCA may take leave of their duties: long-term disability (LTD), workplace compensation board claim (WCB), maternity/paternity and education are the most common. Space was also provided on the survey for 'other' (a mixed bag of less frequent reasons, e.g., sick leaves, employment insurance claims and personal leaves of absence) and 'unknown' reasons for taking leave. This question was answered inconsistently making it difficult to discern general trends from year to year and among the DHAs.

	LTD	WCB	Mat/Pat	Education	Other	Unknown	TOTAL
NH/HFA	74	996	334	112	346	16	1878
HC	173	776	108	22	372	30	1481
AC	9	13	8	0	2	0	32
TOTAL	256	1785	450	134	720	46	3391

**Figure 14: Table of Leaves by Type, 2003-2008**



**Figure 15: Leaves by Type and % of Current Employee Pool, 2003-2008**

Between 2003 and 2008, NH/HFA facilities report on average 10 leaves of absence per year, while HC/HS and AC report 16 and 2, respectively. That amounts to an estimated 660 NH/HFA leaves, 304 HC/HS leaves and 18 AC leaves each year, for a sector-wide total of 982.

The reasons for leaves of absence vary across employment setting. However, the most frequently cited reason for absenteeism, consistent across employment settings, is Workplace Compensation Board claims, accounting for more than half of all leaves. Both NH/HFA and AC report significant percentages of absenteeism owing to maternity/paternity leaves; both HC/HS and AC see considerable percentages of time

lost due to long-term disability leaves; while both NH/HFA and HC/HS cite significant percentages of leaves for reasons other than the available survey options, the most common of which is 'sick leave' followed distantly by 'personal leave'. It is noteworthy that, unlike some previous questions, the 'unknown' response option accounts for a negligible proportion of reasons for absenteeism. A continued focus on quality of work life and employee health, safety and workplace wellness programs will be of benefit.

#### *Service & Staffing (Productivity)*

Item ten of the survey asked employers to indicate service/staffing requirements for their organization between April 1, 2003 and March 31, 2008. Item 11 asked for anticipated service/staffing requirements within their organizations between April 1, 2008 and March 31, 2013. These questions were aimed at assessing the productivity level of CCAs. Survey respondents were unable to provide consistent data for these items. Most indicated that a lack of readily available HR information and human resources to mine the data from paper records prevented them from participating. In addition, employers indicated that anticipated changes in models of care made it difficult to generate future service/staffing projections. For the purposes of the study and to inform the HHR projection tool, data for productivity has been compiled from secondary sources (DoH) and through follow-up with HC/HS agencies.

The ultimate problem here seems to be that a consistent workload measure for this industry has not yet been developed. A representative of the Canadian Institute for Health Information (CIHI)<sup>9</sup> Kate Miller indicated that "Revisions are currently being developed to include enhancements to Residential Facilities in the MIS Standards...The revisions will include clearer definitions for residential facilities and new functional centres, and the revisions have been discussed with the Provincial and Territorial MIS Coordinators. A separate workload measurement system for Residential Facilities and home Care is not planned for the current revisions" (personal communication, April 11, 2008).

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<sup>9</sup> CIHI webpage

### *Recruitment and Retention*

Analysis of survey respondents' comments to open-ended questions 3 and 12 to 20 reveals a number of thematic concerns and common experiences. Below is a brief discussion of themes and issues as they emerged from the responses to each question,

#### **3. Of those presently certified as other than CCA, what supports would be needed to encourage transition to a CCA certification?**

The development of an individually customizable training approach is mentioned by a number of respondents, as is the importance of support for more on-site and on-line training options and an increased use of PLAR/RPL. Financial support, particularly to reimburse wages lost during study period and to provide academic support and mentoring are also highlighted. Some respondents indicate that ensuring the success of current staff 'transition to CCA' programs requires both additional CCAs for replacement and funding for replacement staff.

#### **12. Have you experienced any reduction, suspension, or inability to provide requested service(s) due to lack of CCA staff?**

Nearly one-third (30%) of the organizations who responded indicate that shortages have made an impact on their ability to offer services. They cite changes to staff schedules, over-time costs and the need to use agency employees as backfill as factors negatively impacting resident care. When replacements can't be found it becomes necessary to work short-staffed—duties not affecting direct care are reduced. Examples of these reductions include getting clients out of bed, providing one-on-one care for difficult residents and providing tuck-ins at bedtime. Others report difficulty replacing absences for sick leave, vacations and holidays and not being able to schedule vacations as contributors to reductions in service. While some organizations indicate that the problem of wait-lists has improved, several facilities continue to have lengthy wait-lists because shifts can't be fully staffed. One facility notes that working conditions created by short-staffing contribute directly to loss of staff.



### **13. Do you actively recruit new staff?**

Eighty-seven percent of reporting facilities indicate that they are engaged in active recruitment. Their comments represent a wide range of advertising strategies with on-line and print media (e.g., newspaper) being the most common. Partnerships with NSCC and other educational institutions is also frequently mentioned as recruitment strategies. Several employers are also involved in outreach to local junior high and high schools. Attending Job fairs, internal recruiting, financial support in the form of bursaries, 'earn as you learn' programs and customized CCA training are less frequently mentioned strategies. There is no mention of out-of-region or international recruiting of CCA staff.

### **14. How could new staff best be recruited?**

Creating HR staff positions dedicated to recruitment and retention work is mentioned by most of the respondents. The need to offer CCA education/training in rural locations is also frequently mentioned. Building stronger partnerships with the Department of Education is suggested, as is the pressing need to actively address public perceptions of the CCA role. Offering full-time rather than casual starting positions and providing wage earning security are identified as the most important factors for recruitment by a number of respondents. One facility suggests appealing to women to re-enter the workforce, while another identifies the need for one-on-one consultation with students, in addition to class talks, presentations and mentoring of placement students. The development of youth-oriented strategies that reach students (e.g., using Facebook) and the placement of 'hip' ads in movie theatres and other youth venues are suggested as good ways to recruit new CCA students. Finally, exploring out-of-region and international recruitment is suggested.

### **15. What supports would improve the current or suggested recruitment methods within your organization?**

Funding for retaining current staff through various incentive programs, creating wage parity with acute care, engaging instructors and training more preceptors is mentioned frequently. Providing students with the option to study part-time and developing more

practicum learning models are also suggested. Funding for the development of recruitment plans and programs by dedicated HR staff is identified by a number of respondents. Several respondents suggest a need for more flexible bursary funding and an increase in the Department of Health bursary from the current 70%. Access to CCA education in rural/remote areas, a network for connecting CCAs and employers with the DoH recruitment planners and additional educational support programs are suggested as well. Finally, one facility suggests a mobile, shared, standardized recruitment tool to be made available to employers for visits to schools and job fairs.

**16. What would you see as the greatest challenge to recruitment of CCAs for your organization?**

Those facilities outside urban areas cite their location as the greatest challenge to recruiting CCAs. Rural settings face recruitment challenges due to limited opportunities for education, isolation and the relative absence of cultural and entertainment activities for young people. Other major challenges are the lack of full-time positions and full-time starting positions, the requirement to work split-shifts; the inability to guarantee hours and wages; the need to own a car or the cost of travel for HC staff; and too few people interested in becoming CCAs. Both rural and urban facilities report the need for more seats at NSCC. Too few opportunities for ongoing training and lack of resources to offer on-site training and ‘earn as you learn’ programs are identified by a number respondents as serious obstacles to recruitment. Intra-sector competition, particularly from Acute Care is currently a pressing problem for NH/HFA and HC/HS. Some facilities, particularly ageing facilities, report poor air quality, lack of technology, and lack of ergonomic equipment to support lift and transfer policies as serious recruitment issues.

**17. Is your organization involved in any retention strategies?**

Sixty percent of the organizations responded yes to being involved in active retention strategies. Bursaries and other forms of financial incentive programs such as service increments for senior staff are the most frequently mentioned strategies for increasing retention of staff. Successful use of IT-supported scheduling and innovative approaches

to scheduling are also cited by a number of respondents. Efforts to increase reliability of income and full-time hours are identified as challenging but not crucial for retention. Several facilities use return-for-service contracts for those who receive CCA bursaries and many have initiated staff recognition programs and are working at changing the work culture to promote and support healthy work-life balance. A number of facilities report having developed more collaborative relationships between employers and CCAs which also contributes to changing the work culture and improving retention.

**18. What CCA retention strategies would you recommend for your organization?**

Staff appreciation events and programs, years of service increments, money for training, improved benefits, better scheduling (e.g., regular shifts), less on-call hours, provision of permanent reliable full-time work, competitive wages with acute care, and access to employee and family (EFAP) referral programs are also cited.

**19. What supports would benefit the current or suggested retention strategies within your organization?**

Responses to this question echo those given to the questions above. Supports identified repeatedly and frequently can be summarized as follows: Provincial strategies and funding to address the need for more training opportunities; funding support for hiring dedicated HR staff to develop and run retention and recruitment activities; funding for the creation of more full-time positions and funding to create parity among CCAs sector-wide. Collaborating and creating formal methods for involving CCAs in decision-making are identified as further beneficial supports for increasing staff retention.

**20. What do you see as the greatest challenge to the retention of CCAs for your organization?**

The issues facing rural locations are identified as a major challenge. Among these challenges are: competition from urban areas where there are more job opportunities; the cost of travel; the requirement to work split-shifts and the inability to guarantee full-time hours for CCAs. Several respondents also note that ageing facilities in need of

upgrading pose a significant challenge. The demanding nature of working with NH/HFA clients is also identified by a number of facilities as a contributing factor to burn-out and employee attrition. For one facility, retention is considered to be less of a challenge than recruitment because they have an ageing staff, who are less inclined to migrate. Another respondent notes that young staff members in particular are highly mobile and looking for post-graduate training opportunities. Without the ability to offer such training, retention is a challenge. Finally, one facility indicates that shift-work and being on-call are problematic for many CCAs and they may leave for lower paying jobs in order to have a more regular workweek with weekends and holidays off.

## **Focus Groups**

Focus groups were held with employers and CCAs around the province in July of 2008. For a schedule of sites, see Appendix E. Participants were asked a series of open-ended questions (Appendix E) regarding recruitment and retention strategies, the outcomes of these strategies and the evaluation of the process.

Employer comments indicate that there are a variety of recruitment and retention strategies employed; however, the majority are informal with little formal evaluation or tracking of outcomes. This information supports a need for development of a comprehensive provincial recruitment/retention program with well-developed evaluation tools. There are a variety of successful practices (CBDHA and GASDHA) that should be shared across all DHAs to increased efficiency and reduce costs.

CCAs generally report that the time required for education and the subsequent low wages are the largest detractor to recruiting people into a career as a CCA. Lack of full-time jobs and committed hours of work for new graduates are seen as further detractors from HC/HS work. On the other hand, one CCA attributed the flexibility of HC/HS work as an attractor to those with young families and who want flexible work hours. Job satisfaction, recognition and immediate and daily client feedback are the foremost reasons given for staying in the CCA role.

***“The respect, consideration, and flexibility shown by our employer keeps me motivated to stay working”***

■ ***Focus group participant***

***“When your client tells you that you are the only reason that they are able to remain in their own home, it makes it all worth the effort.”***

■ ***Continuing Care Assistant***

## **Key Informant Interviews**

Key informant interviews represent individual opinions and were conducted one-on-one with employers and others, through face-to-face, telephone and sometimes a combination of telephone and e-mail conversations. This feedback, for the most part, reflects that of the qualitative survey and the employer focus groups. One novel and interesting aspect of these discussions centers on the employment of immigrants and an interest in international recruitment. Despite the interest, many report a lack of knowledge of available programs and feelings of trepidation with regard to the immigration processes. Anecdotal reports of failed, time-consuming attempts at securing temporary foreign workers as CCAs have discouraged many from exploring this avenue.

When considering off-shore recruitment of CCAs, employers agree that language and cultural barriers are significant considerations, as most clients are elderly, and many live with forms of dementia and other cognitive challenges that do not lend themselves well to the unfamiliar. It is also noted that because of the greater availability of immigrant services, urban settings may better support the integration of immigrants. Rural

employers argue, however, that their communities are closer knit and will provide more individual and personal support to new Canadians. This avenue of recruitment is one that bears some study and an international recruitment strategy for the sector would be helpful.

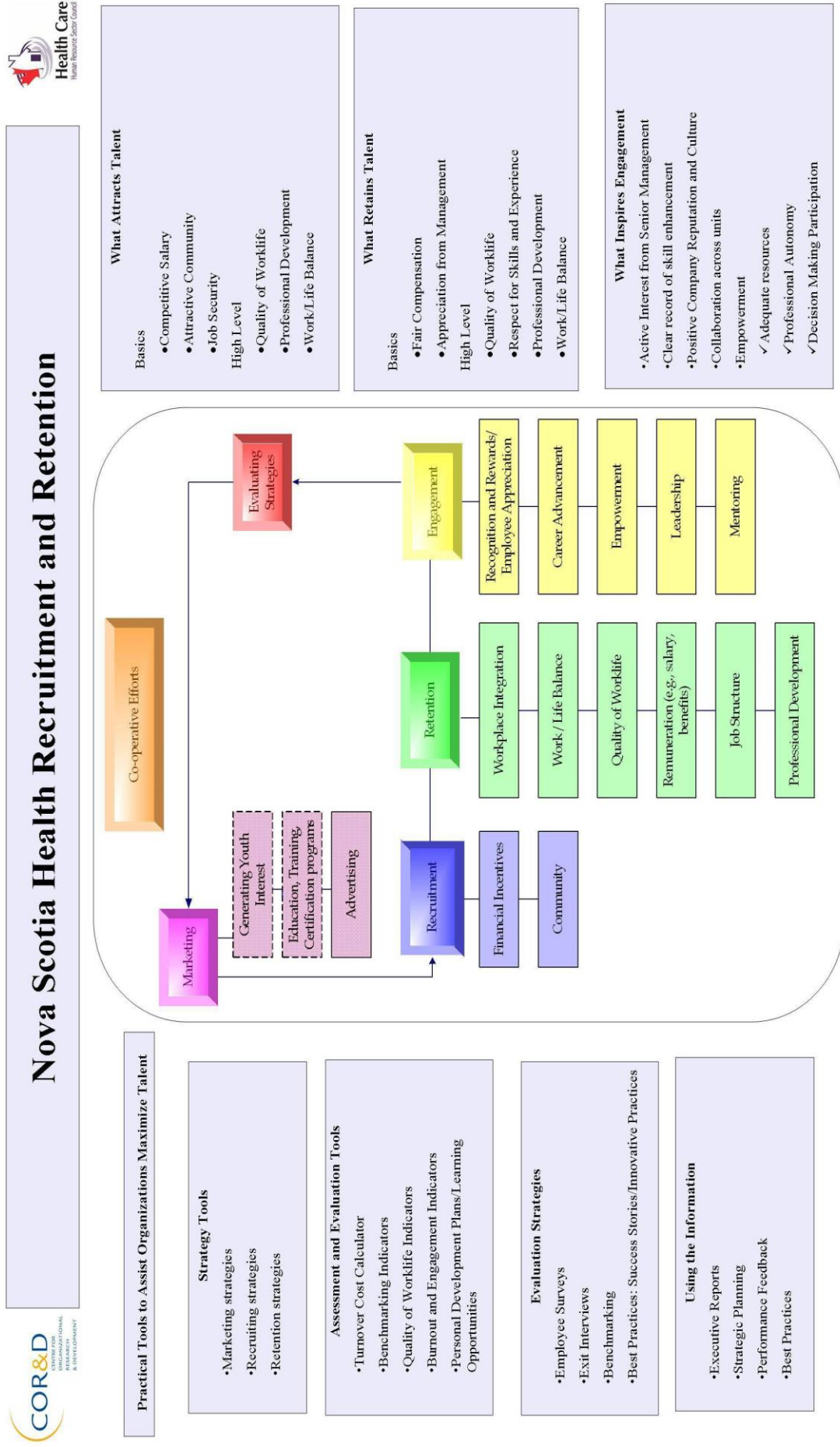
## **Supply & Demand Projection**

Data has been provided to the NS Department of Health to populate the HHR projection tool. Outcomes will be disseminated as an addendum to this report.

## **Recommendations**

Recruitment and retention issues among employers of CCAs in Nova Scotia mirror the issues of the broader health care sector, as documented by the HCHRSC (2006) study *The Nova Scotia Health Recruitment & Retention Study*; the NSAHO (2005) *CCA Recruitment and Retention Action Plan*; and the DoH (2006) *Continuing Care Strategy For Nova Scotia: Shaping the Future of Continuing Care*. The HCHRSC (2005) study produced the “Nova Scotia Health Recruitment and Retention Framework”. The framework informs the “development of recruitment and retention strategies that are appropriate and targeted toward ‘priority’ health occupations” (p. iv). This overarching framework applies to the CCA occupation and the recommendations of this report, in many instances, reflect those for the broader sector. For the sake of clarity and consistency and to build on the work of the HCHRSC and others, this study’s recommendations are grouped into categories congruent with the Nova Scotia Health Recruitment and Retention Framework, a copy of which follows.

**Figure 16: Nova Scotia Health Recruitment & Retention Framework**





The authors acknowledge that much cooperative work is already underway in various contexts addressing the categories identified in the above framework, such as:

- Cooperative Efforts: e.g., DoH NS: HHR Strategy: Recruitment, Retention & Development and the HSHRSC “Recruitment & Retention Toolkit”.
- Marketing: e.g., the NSAHO “Marketing Toolkit,” the Continuing Care Council’s “Continuing Care Public Image Committee” and the DoH’s “Continuing Care initiatives.”
- Recruitment & Retention: e.g., the HSHRSC “Recruitment & Retention Toolkit,” DoH’s “Continuing Care-HHR Strategy: Recruitment, Retention & Development” and “AWARE.NS, Health and Safety Association.”
- Engagement: e.g., HSNSA’s “Employee Recognition Program.” NSAHO’s “CCA Month”
- Evaluative Strategies: Many good initiatives employ and provide evaluation and assessment tools for employers addressing HHR, Marketing, Recruitment, Retention and other issues.; e.g., the NSHSA “Bringing It Home” campaign the CCA District Level Committees ; DoH Continuing Care Strategy Working Group, to name a few. There is a need, however, for a coordinated overall evaluation of these multiple efforts to identify their effectiveness, to discover and share best practices, and to provide for evidence-based decision-making and quality assurance.



### **Strategic Directions:**

1. Develop an integrated HHR strategy for the CCA sector that utilizes the Nova Scotia Health Recruitment and Retention framework(HCHRSC, 2006) that meets and builds on the DoH HHR objectives and that reflects the findings of the CCA Supply and Demand Study (HCHRSC, 2008).
2. Evaluate current and future initiatives with respect to the objectives of the integrated HHR strategy for the CCA sector (above).
3. Create an occupational registry for CCAs in Nova Scotia to maintain a current and accurate provincial profile of CCAs for HHR planning.

Recommendation	Action	Organizations Addressing Activity	Short Term	Benefits	Long Term
<b>Cooperative Efforts : Nova Scotia Health Recruitment and Retention Framework</b>					
<b>1 Promote collaborative cross-regional Health Human Resources planning activities for CCAs.</b>					
1.1 Continue to support and develop provincial level HHR planning groups.	Establish a multi-stakeholder group to review evaluate and monitor a coordinated provincial HHR strategy. Review CCA job descriptions to ensure that CCAs are working to full scope of practice in all settings.	Current: <b>HCHRSC:</b> <i>Recruitment &amp; Retention Toolkit.(Appendix H)</i> <b>NSAHO</b> <b>DoH NS:</b> <i>Continuing Care HHR Strategy: Recruitment, Retention &amp; Development.</i> <b>HSNSA</b>	Coordinated & Complementary recruitment & retention policies/ programs. Best deployment of skills.	Equitable distribution of CCA work force across the province. Efficiency and effectiveness.	

Recommendation	Action	Organizations Addressing Activity	Short Term	Benefits	Long Term
1.2 Support and facilitate HHR personnel and personnel development.	Appoint regional HHR personnel to assist and train employers with implementation of IT, R&R & QWL strategies.	Home Care Networking Group: <i>Recruitment Planning.</i>	Increased compliance with recording and reporting HHR data. Improved HHR planning at employer & DHA levels.	Improved provincial and inter-DHA policy development.	Enhanced Capacity for flexible and informed responses to ongoing change in HHR -CCA context.
		Suggested:			
		HCHRSC NS L&WFD NSAHO DoH DLC			
1.3 Identify and implement best practices from other jurisdiction.	Complete a national Environmental Scan with report to identify and recommend on current best practices.		knowledge of best-practices support for development of innovative HHR solutions.		
<b>2 Develop an evaluation framework with clear indicators to measure success of Strategic Initiatives</b>					
2.1 Design a logic model	Seek input from CCA	Current:	Collaboration and		Consistent evaluation and

Recommendation	Action	Organizations Addressing Activity	Short Term	Benefits	Long Term
to guide and evaluate sector strategy	sector to develop a shared model with measurable indicators	<b>HCHRSC</b>	Agreement.	measurement.	
<b>3 Follow-up on recommendations from the Health Care Human Resource Sector Council's (2007) report "Increasing Human Resource Capacity in the Continuing Care Sector through Information Technology"</b>					
3.1 Implement a standardized information technology and management solution for the Continuing Care sector in Nova Scotia	Utilized the 'Logic Model for Evaluation (Appendix I)' as the framework for implementation of all recommendations of the report.	<p>Current:</p> <p><b>NASHO. NS</b> Community Health Board Website.</p> <p><b>NSAHO, CCANS, NSCC &amp; NSNET:</b> Web page creation and on-line directory project.</p> <p><b>DoH:</b> HASP, CCRS, MDS 2.0, SEAscape. HC/HS Agencies Procura</p> <p><b>Yarmouth Argyle Home Support:</b> Microsoft Excel Spreadsheet</p>	<p>Ongoing and regular reporting of HHR data.</p> <p>Improved accuracy of data collected and record keeping.</p> <p>Improved accuracy of data collected and record keeping.</p>	Detailed accurate and reliable data to support evidence informed decisions making for CCA HHR.	
<b>4 Develop models for shared Human Resources</b>					
4.1 Identify best practices within the sector.	Evaluate the utility of IT systems, such as	Current:	Increased HHR capacity within the sector.	Maintain currency of skills Enriched work	

Recommendation	Action	Organizations Addressing Activity	Short Term	Benefits	Long Term
	PROCURA for meeting complex scheduling needs. Develop models to address equitable wage scales for CCAs across CCA employment sectors and regions.	Home Care/Home Support Agencies  Suggested: <b>CCA DLC</b> <b>DoH</b> Industry Associations	Capacity for provision of additional services. Increase practice of full skill set.	environment. Increased job satisfaction.	
<b>Marketing: Nova Scotia Health Recruitment and Retention Framework</b>					
<b>5 Continue to support &amp; develop provincially focused marketing campaigns.</b>					
5.1 Review and evaluate present provincial marketing strategies	Continue successful campaigns and develop new strategies and programs. Establish clear marketing outcomes that are tied to the provincial HHR recruitment plan and rigorously evaluate results. Develop niche	Current: <b>NSAHO: Continuing Care Marketing Toolkit</b> <b>NSAHO</b> - Continuing Care Council: CCA <i>Image Committee</i> <b>DoH</b> – <i>RecruitAd campaigns</i> <b>HSNSA: Bringing It Home campaign</b>  Suggested:	Determine success of present programs to inform planning. Continue to promote CCA as a viable career option. Determine on-going success of marketing programs & inform HHR planning.  Increase supply of potential CCAs.	Coordinated and Informed decision making for future. Increase attractiveness of CCA as a healthcare career. Early identification of changing trends & dynamic strategies that address changing environments.  Fill expanded educational Capacity.	

Recommendation	Action	Organizations Addressing Activity	Short Term	Benefits	Long Term
	marketing campaigns that target youth, men, persons transitioning from other healthcare roles, recent retirees and immigrants	District Level Advisory Committees, LTC, HS, DOE, educational Institutions, engaged Partners,			
<b>6 Review availability and uptake of present CCA training programs.</b>					
6.1 Implement educational study with report.	Review bursary program and identify alternative funding options for CCA participants. Support and promote PLAR/RPL program. Promote use of existing and expanded educational partnerships. Implement preceptor/mentor training program to prepare current CCAs to mentor students and new graduates.	Current: <b>NSAHO//CCA</b> Program Advisory Committee: <i>Alternative Methods for CCA certification: Equivalency, Course Recognition &amp; PLAR.</i>	Access to education/training whenever and wherever it is needed. Increased recruitment local and international. Strengthened DoH and DOE partnerships.	Equitable distribution of CCA educational programs. Proportionate distribution of CCA graduates. Optimize use of educational opportunities/capacity and inform HHR educational policy. Meet increasing need for CCAs.	
		Suggested:			

Recommendation	Action	Organizations Addressing Activity	Short Term	Benefits	Long Term
		DoH CCAPAC NASHO HSNSA Educators DOE Employers CCAs			
<b>Recruitment : Nova Scotia Health Recruitment and Retention Framework</b>					
<b>7 Create an international recruitment strategy for CCAs</b>					
7.1 Prepare a position paper for discussion among stakeholders.	Implement a targeted international recruitment pilot program.	Current:	Increase supply of potential CCAs.		Diversify and expand the recruitment pool for CCA.
		<b>DoH: International Workers in Continuing Care Working Group</b> <b>GEM</b> Healthcare <b>NSAHO: Recruitment and Retention Resource Guide</b>			
		Suggested:  District Level Committees , LTC, HS, CIC, NS Immigration, Educational Institutions, Engaged Partners.			

Recommendation	Action	Organizations Addressing Activity	Short Term	Benefits	Long Term
<b>8 Develop programs targeting youth and men</b>					
8.1 Focus Group with youth and men to determine what attracts youth and men to career options	Project images of CCA career that speak to youth and males. Employ tools that reflect current youth and male oriented strategies.				
8.2 Continue to involve directly both the DoH and DOE to supporting marketing and recruitment strategies for Colleges and private educators.					
<b>Retention : Nova Scotia Health Recruitment and Retention Framework</b>					
<b>9 Promote and support quality of work life (QWL) policies and initiatives.</b>					
9.1 Identify and evaluate efficacy and scope of current QWL programming in the context of consistent	Intensify workplace safety education, work -hardening programs and other supports to reintegrate injured	Current: <b>DoH: Continuing Care Strategy</b>	Reduce workers compensation claims and other sick leaves. Improved quality of work-life, better	Enhanced employer employee relationships. Reduce conflict between new and	



Recommendation	Action	Organizations Addressing Activity	Short Term	Benefits	Long Term
HHR policies.	workers. Appoint a Regional/ District Health & Wellness coordinator to include EFAP programs and to service all facility types. Review current employee recognition programs and implement a provincial employee recognition campaign. Complete a performance study to identify areas where modification of work-loads /practices may help improve work-life.	<b>HCHRSC:</b> <i>Recruitment &amp; Retention Toolkit:</i> <b>HCHRSC Strategic Framework for Supporting Learning Organizations (AppendixJ)</b> <b>HCHRSC:</b> QWL Assessment Toll <b>NSAHO</b> CCA Month <b>HSNSA:</b> Home Support Week <b>NSAHO &amp; DHAs:</b> National Quality Worklife Initiative <b>NSAHO:</b> Recruitment & Retention Resource Guide for Employers	recruitment & retention of CCAs.		senior workers. Support self-esteem and job identity of CCAs. Fully utilize available workforce.
		Suggested:			
		<b>AWARE.NS</b> WBC Prevention Services			
Engagement : Nova Scotia Health Recruitment and Retention Framework					



Recommendation	Action	Organizations Addressing Activity	Short Term	Benefits	Long Term
10 Promote a career ladder for CCAs					
10.1 Explore bridging opportunities to other health care professions.	Institute discussions with the NSCC and Dalhousie University to position CCA as an entry-level position that can transition to health care careers along the nursing spectrum.	Current:	Enhanced desirability of CCA as a career option. Increased job satisfaction. Contribution to Recruitment and Retention.	Increased recruitment. More professional opportunities. Increased retention	
		DoH: IEHP Atlantic Connection			
		Suggested:			
Evaluation Strategies: Nova Scotia Health Recruitment and Retention Framework					
11 Develop a registry for employees working in the role of direct care/support service provider.					
11.1 Require registration as an employment condition for employees working in the role of CCA.	Identify responsible partner for housing registry. Identify required supports for implementation.	Current	Constantly updated and Accurate profile of CCAs for planning	Improved evidence-based HHR planning and policy	
		NSAHO: CCA Program Advisory Committee's student/graduate registry HSNSA: Continuing Care Registry			
	Establish a standardized and	HCHRSC: Recruitment &			

Recommendation	Action	Organizations Addressing Activity	Benefits	
			Short Term	Long Term
	regular data collection processes, use to inform directly the budgeting process.	<i>Retention Toolkit</i>		
		Suggested:		
		HCHRSC NSAHO HSNSA DoH CCAPAC CCANS		
11.2 Assist CCAs to become regulated.	Identify appropriate organization to support regulation of CCAs.			
11.3 Explore apprenticeship opportunities for CCAs.				

## Conclusion

The recommendations offer a broad range of interrelated activities that together can form a strategic approach to collaborative HHR planning for CCAs in Nova Scotia. Many actions can be realized without additional funding; however, it is clear that full implementation will require some fiscal investment.

It is acknowledged that funding alone will not be the sole ‘make or break’ of the strategy. Successful implementation of these recommendations will depend on a high level of stakeholder commitment and involvement and is not limited to government alone. Employers, educators, providers, professional associations, unions, clients, and the public are all part of the solution. It is the people of Nova Scotia who must “do for themselves” and who will benefit in the end.

***“Adapting to our current realities is essential in ensuring that Nova Scotians continue to receive quality care”.***

■ ***Key Informant***

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## **Appendix A: CCA Supply & Demand Steering Committee**

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## **Appendix B: Literature Review**

### **Introduction:**

In conducting the “Supply and Demand Study of Continuing Care Assistants (CCA) in Nova Scotia” (2008) a review of the relevant recent literature (including both commissioned reports and electronic, grey literature) is necessary in order to establish the present knowledge-base of Health Human Resources (HHR) in the province as it pertains to the continuing care<sup>10</sup> sector and specifically to the CCA<sup>11</sup> population. At current estimates roughly 5900 CCA’s (including PCW and HSW) work in the health/continuing care sector, making them the largest group of health care worker in the province (ref). It is, therefore, especially important to construct an accurate provincial profile of CCA’s with respect to demography, regional distribution, employment setting (and status), and education, as well as the Nova Scotia-based education programs from which the vast majority issue, to mention but a few. Without an up-to-date occupational profile, given the aging population and its associated continuing care needs, province-wide HHR policy formation and administration is all but blind—unable to reliably predict HHR shortages and surpluses or effectively manage the existing stock—and is bound to rely on costly, reactionary stop-gap measures; thereby relegating planning strategies to the short-term only. In short, such a system is inefficient, wasteful and, crucially, unsustainable. After surveying the research on CCA’s to date it will be clear that there is a gap that must be filled if the government of Nova Scotia is to make empirically-informed decisions about the future of health care in general and thus provide for the growing demand for CCA’s in particular.

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<sup>10</sup> Continuing Care is “a system of delivery that includes both long-term care (residential and community) and home care (professional/paraprofessional)” (Hollander, M., as cited by HCHRSC, 2006c, p. 7). In Nova Scotia it is regulated by the Department of Community Services and the Department of Health.

<sup>11</sup> A Continuing Care Assistant “assists clients with personal care and support services, while promoting healthy and independent living in the client’s home or nursing home environment. In a home support environment, a CCA provides healthcare related services and support. They provide services to the elderly, the disabled and convalescent persons and their families. The purpose is to enable the clients to maintain their independence, or provide support during convalescence” (Health Care Human Resource Sector Council [HCHRSC], [www.hcsc.ca/careers.php](http://www.hcsc.ca/careers.php)).

## Supply and Demand:

Supply and demand models (SDM) are simple abstract structures applicable to almost any domain, whether it is plants competing for sunlight, birds for worms, drivers for gasoline, or even fictitious consumers for fictitious widgets. So long as there is a finite quantity of resources (*supply*) and a definite (or indefinite) requirement for those resources (*demand*) a SDM can represent it. HHR is no exception: at any given time only so many health care workers are employed by the health care delivery system and available to service the health care needs of the population. The difference, if any, between the supply and the demand at a time represents either a surplus or a deficit of resources—or a ‘gap’. Analyzing the gap may suggest ways to manage the interaction between the supply and demand so as to bring about and maintain the ideal state of equilibrium. For instance, assuming a dearth of HHR, if there were fewer health care users (e.g., a healthier population), then the demand would decrease accordingly; thus the gap would be lessened.

Adding a dimension of time flow to a SDM creates a dynamic and more complex model by incorporating rates of change into the supply and demand equation. The advantage conferred by doing this is the ability to reliably predict future states of supply and demand from the present state. Moreover, these models enable one to entertain possible HR scenarios by variously adjusting the inputs, making clear the dynamics involved. Along with this better understanding comes clarity of vision that helps avoid policy pitfalls such as screening-off or redundancies. For instance, any perceived benefit from increasing the enrollment into CCA educational programs could easily be negated (*i.e.*, screened-off) by not addressing issues in recruitment and retention or quality of work-life; or putting  $x$  resources (e.g., one computer) into information technology/management may result in a, say, two-fold increase in overall efficiency in the workplace; however, putting  $2x$  resources (e.g., two computers) into information technology/management may show no additional benefit.



As more and more variables that affect the rates of change are considered, the more accurate the model's predictions become. For instance, in addition to considerations of the present stock level, taking into account supply flow rates, influenced in a quantifiable way by, say, certain recruitment and retention strategies or educational policies, will confer the ability to better anticipate future stock levels. Therefore, a better understanding of the kinds of causal inputs and their interactions will permit a greater dexterity with which to manipulate the degree of gap between supply and demand. The following review will survey the significant factors identified in the existing literature that affect CCA supply and demand. However, it is clear that the research to date is insufficient to accurately predict future supply and demand levels. If the government of Nova Scotia is to have substantive CCA data for the purpose of filling-out the SDM and, ultimately, producing reliable HHR forecasts, then the present dedicated study into the present state and nature of the province's CCA profile is necessary.

## Demography:

While the Nova Scotia population is growing, up roughly 14,000 people to 913,465 in 2006 from 1991, it is also aging (Nova Scotia Community Counts [NSCC], [www.gov.ns.ca/finance/communitycounts](http://www.gov.ns.ca/finance/communitycounts)). However, while the population is expected to continue to grow into 2008 to 933,054, all else being equal, it is predicted to decline thereafter to 932,542 in 2011 to 928,402 in 2021 and to 900,441 in 2031 (NSCC). (See table One below)

	1991	2006	2008	2011	2021	2031
Population	972,465	913,465	933,054	932,542	928,402	900,441
Growth		+14,000	+19,589	-512	-4,140	-27,961

**Table 4: Population Trends in Nova Scotia**

Life expectancy is now at an all-time high: for those who reach 65, men will on average attain the age of 82, women 85 (Nova Scotia Seniors' Secretariat [NSSS], 2005, p. 14). The 65+ age group as of 2006 stood at 136,038 comprising nearly 15% of the provincial population.

In 2011, when the baby boomers (born between 1947 and 1966) begin turning 65 years old, the average age of the population will increase rapidly, owing also to a declining birth rate (well below replacement rate), a low immigration rate and the perennial out-migration of young Nova Scotians (NSSS, 2005, p. 14, 16; Health Care Human Resource Sector Council [HCHRSC], 2004a, p. 32).

As a result the 65+ age group is projected to increase to over 16% (151,569) of the provincial population by 2011, and upwards of 22% by 2021—a potentially dire situation for the health care system in Nova Scotia. Further on, without significant changes to the present demographic trends, specifically the aging population, the population will no longer be able to sustain itself and will begin to decline.

Year	2006	2011	2021
Senior Population 65+ as % of NS Population	15%	16%	22%

**Table 5: 65+ Age Group as Percentage of Total NS Population**

In 2001 nearly half of all health care expenditures (46.9%) were spent on the 65+ age group, which accounted for roughly 13% of the population. Where the average health care expenditure for the overall population was just under \$3,000, the 65+ age group required greater than three times that (>\$10,000) per capita (HCHRSC, 2003a, p. 35).

Presently a person 85 and older requires about \$23,500 per year to meet their health care needs (Department of Health [DoH], 2007a, p. 3). Although this number has been increasing steadily over recent years it is doing so at a slower relative pace than the growth of the 65+ age group: over the last 20 years the former increased roughly 22% whereas the latter showed a 33% increase (HCHRSC, 2003a, p. 36)—a testament to an increasingly healthier provincial population. Nonetheless, though life expectancy has increased countrywide, life expectancy without disability has not kept pace (HCHRSC, 2005a, p. 16). More than 20% of the population over 65 years of age can expect to live with some long-term disability or chronic condition (e.g., diabetes, arthritis, Alzheimer's, and other dementia) (HCHRSC, 2005a, p. 19).

Not only does an aging population put increased strain on the already stressed health care system, particularly its continuing care sector, it also has consequences for the health human resources, as Nova Scotians naturally constitute the health care workforce. A corollary of an aging population beset with a declining birth rate and disadvantageous migration patterns is an aging workforce. While an aging population increases the demand for health care resources, a corresponding aging workforce decreases the supply available to meet that demand. By 2010 it is expected that roughly 20% of the health care workforce will be eligible for retirement; by 2015, 44% (DoH, 2007a, p. 3).

A HCHRSC (2003a) study reports that there were about 50,000 health care workers in 2001, making the health care sector Nova Scotia's second largest industry (p. 43). Of those workers nearly 17,000 were employed in the continuing care sector with almost 13,000 split between long term care nursing homes (LTC: 9,600) and home care/home support (HC/HS: 3,200), comprising the scope of this present project. About 75% of these continuing care health human resources worked directly with clients as nurses, physicians, aides, etc. (where indirect employees function as maintenance staff, housekeeping, administration, etc.) (HCHRSC, 2003, p. 45). Roughly half of these direct health care providers were CCA's (including home support workers [HSW] and personal care workers [PCW]) working in either LTC or HC (HCHRSC, 2003a, p. 45, 54-56).

Other studies report estimates of 5,898 (Nova Scotia Association of Health Organizations [NSAHO], 2005) and 5,600 (HCHRSC, 2004b) CCA/PCW/HSW's split between nursing homes and home support agencies across the province, with NSAHO reporting that three quarters of them are employed in LTC nursing homes.

These numbers are the result of combining previous data collected by NSAHO and Home Support Nova Scotia Association (HSNSA) via surveys, supplemented with information from the DoH, then extrapolating them "across the broad continuing care

sector” wherever gaps required filling (NSAHO, 2005, p. 3). These gaps represent CCA’s working in other practice settings, such as private home support providers, retirement homes, assisted living and supportive housing arrangements, and acute care hospitals. As such the exact number of CCA’s in Nova Scotia providing direct and supportive care is uncertain.

Detailed information on occupational growth, supply changes, education levels, attrition rates, and migration patterns (both intra- and inter-provincially as well as intra- and inter-nationally), among other areas, is hard to come by and where available of dubious quality. Employing estimation techniques using data collected from multiple sources is a necessary evil at present. This is in part due to the fact that CCA’s are a non-regulated profession<sup>12</sup> (HCHRSC, 2003a, p. 38; NSAHO, 2005, p. 3). As such, the occupation is not legislated by a government Act nor is there a professional body that regulates a mandatory membership, quality assurance mechanisms, standards of practice and continuing competence requirements (HCHRSC, 2003a, p. 39). Though there is concern for the increased risk of harm to the public because of the lack of regulation, it may well be the case that the lack of gate-keeping and credentialism that also comes along with regulatory bodies is a boon to the profession by allowing for a freer scope of practice. Regardless, the greater issue as regards unregulated CCA’s is a general and systemic lack of reliable demographic data from a database of all CCA’s: number of workers, employment location (by district health authority [DHA]) and setting (LTC, HC, *etc.*), attrition rate, and education level, *etc.* (NSAHO, 2005, p. 3, 23; HCHRSC, 2007a, p. 53).

A few things, however, can be gleaned from the existing studies: of the estimated 5898 CCA (and equivalents) roughly three to four times as many work in the Cape Breton DHA as any other DHA save for the Capital DHA where there is nearly twice as many (NSAHO, 2005, p. 13); 20% of CCA/PCW in LTC and 24% of CCA/HSW in HS are over

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<sup>12</sup> “A non-regulated occupation is an occupation/trade for which there is no legal requirement or restriction on practice with regard to licenses, certificates, or registration” (Allen *et al.*, 2006, p. 58).

the age of 50, with an overall average age of 39.6 (HCHRSC, 2003a, p. 46); and 34% of HSW possess the CCA designation (NSAHO, 2005, p. 14).

## **Education:**

The aging population changes the health care needs of the province. For one, “health care needs will gradually shift from predominately acute and episodic care, towards a greater emphasis on care for individuals with chronic health conditions living within their community” (HCHRSC, 2003a, p. 66). Along with an aging population comes an aging workforce, which entails a much higher number of retirements in the coming years. Adapting to this changing landscape will necessitate a much larger number of CCA in the workforce, which in turn necessitates a much larger number of enrollments into CCA education programs, as well as an increased provincial educational capacity.

September 2000 in Nova Scotia saw the inception of the CCA education program. It replaced and absorbed the HSW/PCW and home health care worker education program (NSAHO, 2005, p. 9). Beginning in April 2006 the Department of Health introduced a CCA education entry-to-practice certification requirement hiring policy (HCHRSC, 2004a, p. 30; DoH, 2007d, p.39). While there is no professional organization that dictates CCA credentials or requires CCA’s to register with them, there is also no provincial or federal law that regulates the occupation. However, the entry-to-practice policy ensures that anyone entering the CCA occupation meets certain standard requirements. This policy does not affect those already employed as HSW/PSW/CCA prior to its implementation. The CCA Program Advisory Committee (CCAPAC), established by the Department of Health, also make provisions for the hiring of both unqualified and under-qualified employees via a ‘*conditional* offer of employment’<sup>13</sup> in such cases that properly qualified personnel are not available (NSAHO, 2006, p. 15; NSAHO, [www.nsaho.ns.ca](http://www.nsaho.ns.ca)).

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<sup>13</sup> That is, “conditionally on the candidate obtaining the required certification within the time frame provided in the DoH policy.”  
([www.novascotiacc.ca](http://www.novascotiacc.ca))

Five kinds of organizations offer the CCA program (HCHRSC, 2004a, p. 30-31; CCA Program [www.novascotiacc.ca](http://www.novascotiacc.ca)):

1. public colleges and one university, Nova Scotia Community College [NSCC] , Université Sainte Anne
2. private colleges (e.g., CompuCollege, Cape Breton Business College)
3. nursing homes/homes for the aged
4. home support agencies
5. Department of Community Services Work Activity Program Initiative

The CCA program is offered in a number of formats ranging from the traditional full-time classroom setting, to part-time work-study and online distance education, to self-study modules (for CCA equivalency) and agency delivered (NSAHO, 2006, p. 20) . This flexibility will increase the program's accessibility, especially to students living in remote areas and students who cannot afford the time and/or money to attend full-time studies. Although the structure of the program differs slightly depending on which education avenue one pursues, ultimately the successful CCA graduate will have completed a minimum of: 436 hours of class and lab time, 100 hours of home support field placement and 230 hours in a long term care field placement. The Continuing Care Assistant Advisory Committee/Department of Health has also developed a model for Prior Learning Assessment and Recognition (PLAR), a program that helps individuals with prior health care work experience and education become a certified CCA; essentially, easing the transition from uncertified skilled labour to certified. [www.novascotiacc.ca](http://www.novascotiacc.ca))

Since 2000, NSAHO has kept detailed records on educational deliveries in the Province. NSAHO records demonstrate that enrolment has doubled from 315 in 2000/01 to 627 2007/08. Between 2000/01 and 2007/08 2885 CCA's graduated from both public and private institutions across the province from a total of 3565 that had enrolled (NSAHO, 2008).

The best estimate of the number of CCA's working in continuing care was 5898 as of 2004/05, with 4372 in LTC and 1526 in HS. Given that the entry-to-practice policy is in place, it was calculated (though with unknown statistical validity) that the demand for new CCA graduates for the year 2005/06 was 377 in LTC alone (NSAHO, 2005, p. 38). This number was found by taking the number of CCA's needed to account for the 0.1 hour per resident increase in care (154) and adding the number of CCA's needed to replace CCA turnover, which is the institutional departure rate minus the rate of (re)hiring (223), for a total estimated demand for LTC CCA's in 2005/06 of 377 (NSAHO, 2005, p. 38). That same study found that between 2000/01 and 2004/05 1320 CCA's graduated from both public and private institutions across the province, most of them (47%) in the Cape Breton district and only 6% in the Capital district (NSAHO, 2005, p. 19). Distribution problems are apparent: 37% of CCA positions are found in the Capital district, whereas only 18% are in Cape Breton. This also suggests that there is potentially a problem with the distribution of CCA educational programs in the province, otherwise such problems shouldn't arise. The literature offers anecdotal evidence that the Capital district has difficulty attracting CCA's (both aspiring and certified) to LTC and HS owing to competition with the retail sector and call centres, where the pay is comparable, as well as intra-health care sector competition with acute care institutions (HCHRSC, 2003a). Although with the governments expressed commitment to a health care paradigm shift (see below), competition with acute care settings should soon become negligible.

At the very least, it looks as though recruitment strategies ought to be intensified, as filling all available seats is a simple and effective way to begin supplying the impending demand. However, with the out-migration patterns of young Nova Scotians (18-21yrs)—the traditional education stock—and competition from retail businesses and call centres offering comparable wages, this may prove challenging.

## **Changing Health Care Delivery Models:**

The health care system in Nova Scotia is in the midst of a paradigm shift. The old paradigm with its emphasis on hospital-based care by doctors and nurses is giving way to the new paradigm that focuses on a comprehensive, collaborative and integrated community-based primary health care approach involving the whole spectrum of health care providers (HCHRSC, 2003, p. 29). Roles are being re-defined; scopes of practice are broadening; private sector, government departments and community organizations are beginning to work together...and none too soon. Unfortunately, it is not happening fast enough. The Provincial Health Services Occupational Review [PHSOR] (DoH, 2007b), the most up-to-date and comprehensive review of the Nova Scotia health care system points out the simple yet profound fact that the system has reached a crisis:

There are serious and significant concerns that the Province cannot afford to continue to fund the healthcare system, given its growth at a rate that outstrips the increase in provincial revenues. When the consequences of an aging population are added into the mix, with the attendant increases in resource utilization and the accompanying need for a shift away from acute to chronic care and to diseases and conditions of the elderly, even massive infusions of money would not provide the services needed, were the status quo maintained. (ii)

This crisis is not unique to Nova Scotia. Canada on the whole faces the same problem.

The traditional solution of hiring more doctors and nurses will no longer suffice. The problem is systemic. The status quo is unsustainable and a complete transformation has become imperative. The solution the PHSOR (DoH, 2007b) offers is a matter of using efficiently health human resources: “it is a question of finding the appropriate range and mix of professional (and support) staff and giving them the scope to provide the healthcare services that the Province’s population will need” (ii). The PHSOR (DoH, 2007b) goes on to flesh out exactly what this solution entails, providing a laundry list of 103 recommendations covering every aspect of the health care system to be addressed over a three year period.



In broad strokes, the PHSOR (DoH, 2007b) recommendations amounts to this: hospitals ought to be reserved for acute care only and that all other forms of health care follow a community-based model, which entails a new focus on primary and continuing care (iii). This need is particularly apparent, for instance, when one considers that some DHA's reported up to 42% of hospital beds were occupied by patients requiring care other than acute (DoH, 2007b, p. 24). Not only does this cause a serious backlog in acute care, but more importantly it highlights a deficiency in the continuing care sector—clearly there are not enough beds. In response this insufficiency the Department of Health has committed to providing 832 new continuing care beds across the province no later than March 31<sup>st</sup>, 2010; with more than 1,300 new beds by 2015 (DoH, 2007b, p. 24; DoH, [www.gov.ns.ca/news/details.asp?id=20080331011](http://www.gov.ns.ca/news/details.asp?id=20080331011)). This, however, is only a start. Without a concerted effort to recruit new CCA's, retain the ones presently working and, more generally, commit to a health care revolution, new beds in and of themselves will be of little consequence; at worst serving only to further tax the already taxed health human resources. If the PHSOR (DoH, 2007b) recommendations are sound and they can be accomplished, then implementing them could go a long way to mitigating the looming CCA staffing shortfall.

The DoH accepted promptly all of the recommendations of the PHSOR (DoH, 2007b) and agreed to 'address' them immediately, stating that they "are committed to improving the health of Nova Scotians" (DoH, 2007a, p. 3, 4). They issue a three year implementation plan with the caveat that "anticipated time lines are contingent on budgetary planning" (p. 10), suggesting that concrete plans must await guaranteed funding. All 103 of the recommendations are subsumed by one of four broadly characterized commitments:

1. *helping people stay healthy*: a. improve access to primary health care; b. invest in primary health care; c. expand services closer to home; d. strengthen mental health and addictions services

2. *addressing the changing needs of seniors*: a. expand palliative care services; b. expand seniors' mental health initiatives; c. improve coordination of acute and continuing care services
3. *supporting health professionals*: a. create a better model of care; b. address a predicted shortage of laboratory professionals; c. support pharmacists to improve patient care
4. *investing for better results*: a. consolidate infrastructure and support services; b. approach efficiency in a new way; c. invest where it counts; d. improve information management; d. explore public-private partnerships (DoH, 2007a, p. 5-8).

While all this ('expanding,' 'creating,' 'addressing,' 'supporting,' 'improving') sounds good in broad strokes, without specific directions and substantive plans it is difficult to evaluate the strength of the overall plan. Nevertheless, the health care crisis had been explicitly recognized and the commitment is there whatever the details of the proposed solution may be.

## **Policy Changes:**

It should be pointed out that that there is a crisis is already well-documented in the literature covering the continuing care sector and its accompanying shortage of CCA's now and for the foreseeable future (DoH, 2006; NSAHO, 2005; Nova Scotia Seniors' Secretariat [NSSS], 2005; HCHRSC, 2004a; HCHRSC, 2003a; Manning, *et. al.*, 2002). In fact as early as 2002 Manning *et. al.* point out that one of the biggest needs in the continuing care sector is the need for information, which "is driven by demographic trends of population aging, policy shifts to promote care in the community, concerns about formal and informal caregivers, and an ever-increasing percentage of fiscal resources invested in the continuum of care" (p. 21). That the old model of health/continuing care is no longer applicable is clear given the sector growth (a rapidly aging population), its increasing complexity and diversity (more people living longer with disabilities and chronic diseases) and its perennially "underpaid, overworked, and

undervalued” caregivers (Manning, *et. al.*, 2002, p. 24). Added to these pressures is a decrease in federal funding and the concurrent increase of the province’s financial burden, often coming to rest on the shoulders of informal care givers (family members in particular) in lieu of taxpayers in general (Manning, *et. al.*, 2002, p. 23).

The imminent crisis prompted the DoH to devise the ‘Continuing Care Strategy for Nova Scotia: Shaping the Future of Continuing Care’ (2006), a ten year strategy with its stated vision “to have every Nova Scotian live well in a place they can call home” (DoH, 2006, p. 4). In conjunction with an April 2005 policy shift that saw resident care hours increase by 0.1 hour, adding to CCA demand, part of this new strategy is the aforementioned new long-term beds across the province, as well as the replacement of nine facilities (NSAHO, 2005; DoH, 2006). While neither a lengthy nor detailed booklet, the recognition of the need to change the *status quo* is there along with a commitment to do so. They estimate a cost of about \$122 million in just the first four years of implementing this strategy, a large burden to the tax payers of Nova Scotia no doubt, but a fraction of what they would pay if the health care system continued to founder in its present state (DoH, 2006, p. 11).

There are already clear signs that this new health care philosophy is taking hold. For instance, part of the continuing care strategy is new and innovative requirements for long term care facilities (DoH, 2007c). These facilities are designed in such a way as to promote tight-knit, community living. They literally embody the new continuing care philosophy: small group living environments (or ‘neighbourhoods,’ ‘resident houses’) with a small dedicated staff instil a feeling of community and foster close personal relationships among staff, residents and their families; residential features (e.g., private bedrooms with individual temperature control, bathrooms, central fireplace) make it feel like home; short hallways to living and dining areas (50 feet from bedroom entrances for 50% of residents and less than 75 feet for the rest) promote a greater sense of independence and self-reliance by making it safer and easier for residents to move around under their own power; to mention a few examples (DoH, 2007c, p. 9). In

moving away from an institutional atmosphere, the living environments are designed to fit residential scale and detail. In short, every effort is made to make the LTC feel like home, even—what at first blush seems ironic—provisions are made for a residents’ smoking room (DoH, 2007c, p. 32). What’s more, smaller unit sizes make it easier to contain infections and help to limit potentially catastrophic outbreaks in larger populations (DoH, 2007c, p. 1-2).

Not only are the facilities themselves designed with the residents’ health and wellness in mind, but so too are the ‘team-based resident-centred care’ administration policies and staffing models. Of particular interest for this review is the requirement that the LTC facilities declare one of two staffing models: either CCA Full Scope of Practice or Traditional CCA Direct Care (DoH, 2007d, p. 38). The former option means “a qualified employee who applies all of the required components of the CCA program curriculum skills within the household setting including: household management, personal care, mobility assistance, meal preparation, respite and emotional support” (DoH, 2007d, p. 40). Under this model the bulk of health care providers in a given LTC nursing home will be CCA’s. For example, in a nursing home with 36 beds, requiring roughly 41 FTE’s (full-time equivalents), be they nurses, ward clerks or directors, about 31 of those FTE’s will be CCA’s (DoH, 2007d, p. 40). The upshot is that the need for CCA’s will increase even more, though it will certainly be mitigated by the fact that they are now operating to the fullest extent of their scope of practice, resulting in a more efficient use of HHR. The latter option differs from the former insofar as both environmental services (*i.e.*, household cleaning) and dietary services (*i.e.*, food preparation) are excluded from funding and therefore from the CCA’s duties (DoH, 2007d, p. 42).

In preparation for the anticipated increase in scope of practice of CCA’s in the province the Continuing Care Assistant Program Advisory Committee/Department of Health has commissioned a review of the educational curriculum. It is expected that this review and the subsequent redesign of the educational curriculum may be completed around the same time as the present supply and demand study. Depending on the

recommended changes to the education requirements and/or up-grading of current health care providers, additional time may be necessary. While this may increase the time-lag for new CCA's entering the workforce, thereby exacerbating the current situation, should it be deemed necessary the result will be a better educated (*i.e.*, with a greater scope of practice and more occupational competencies) workforce in the long run. The authors will monitor this project for any information affecting the formulation of supply projections.

The Nova Scotia Seniors' Secretariat, a legislated cabinet committee under the aegis of the Department of Seniors, introduced the 'Strategy for Positive Aging' (2005). Along with emphasizing the reprehensible and endemic undervaluing of seniors in our society, they make a case for their—what should be self-evident—deserved respect and dignity and the importance of combating the unfortunate prevalence of ageism<sup>14</sup> in Nova Scotia, among other things. Left unaddressed these issues leave seniors isolated, both physically and mentally, within society and are contributing factors to both physical and mental deterioration. Crucially, the positive aging strategy both informs and complements the Continuing Care Strategy. For instance, in honouring seniors' intrinsic worthiness, it recognizes the great need for seniors to maintain their independence ('aging in place') for as long as possible, for the resulting empowerment of seniors has a positive influence on both their physical and mental health (NSSS, 2005, p. 40, 100). This, however, requires increased community-based and home support services and housing options, once more increasing the demand for health care providers (such as CCA's).

One way to alleviate this added strain on the health care system is to promote 'supportive communities', that is to say, encourage and support health care givers (volunteers), community agencies and not-for-profit local organizations through funding,

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<sup>14</sup> Ageism is defined as "a process of systematic stereotyping and discrimination against people because they are old (NSSS, 2005, p. 65)." It should be pointed out that this is a local definition, fit for the purpose at hand. However, any age group can in principle be the target of ageism.

education programs and access to any and all support they may require (NSSS, 2005, p. 57). It is estimated that unpaid care givers, usually an immediate family member, save the health care system about \$5 billion per year by volunteering their time, the equivalent of 276,000 full-time employees (NSSS, 2005, p. 89). Unfortunately, given the aging population and the high proportion of females (the traditional care giver at 78%) in the workforce today (over 80% of ages 24-54 compared with 52% in 1976), who are unable to provide the kind of volunteer hours that previous generations could, and the trend of declining birth-rates resulting in smaller families, has the potential to produce considerable volunteer shortages in the near future as well (NSSS, 2005, p. 88, 97). Because of this the strategy emphasizes that it is all the more important to support and nurture the care givers as much as the care providers, and not just financially but also by providing community support networks.

## **Recruitment and Retention:**

Recruitment and retention are perhaps the most important issues facing HHR in continuing care today. Many of the factors involved have been mentioned briefly above or otherwise merely alluded to. This section will flesh out the finer points contained in the relevant literature that has been culled from focus groups, key-informant interviews, sector surveys and data analysis.

The two components, recruitment and retention, are intimately tied together insofar as many of the areas that need to be addressed to retain the present employees (at least those not retiring due to their age) are the very same things that will lure new recruits into CCA educational programs and ultimately into the continuing care sector; such as, quality of work life issues, wages and benefits. Conversely, no matter how successful recruitment strategies may be, if employee retention is left unaddressed, the success is purely academic (HCHRSC, 2004b, p. 36).

The NSAHO (2005) report recognizes three main pressures affecting CCA recruitment and retention in the sector: societal barriers, competitive forces and quality of work-life

issues (all of which are echoed throughout the literature: HCHRSC, 2006a, b &c; NSSS, 2005; HCHRSC, 2004b; Manning *et al.*, 2002).

1. Societal Barriers:

- a. The continuing care sector has long suffered from a poor public image due in no small part to ageist attitudes prevalent in our society.
- b. The traditional CCA student target market, young females, has many more career options than just a generation ago, which is certainly a good thing in general; however, the continuing care sector still suffers because of it.
- c. The public knows little about the CCA occupation in general and consequently is unaware that it is a viable career path; to make matters worse for those who do know about the CCA program and are inclined to enroll many live in remote rural areas where the CCA program is either unavailable or difficult to access (NSAHO, 2005, p. 20).

2. Competitive Forces:

- a. Not only does the continuing care sector face competition for prospective CCA's from retail businesses, the largest employer of Nova Scotians, and call centres offering comparable wages, but it also must compete with other health care sectors (*i.e.*, acute care where CCA's are being hired as ward clerks and 'team aides' for better pay) as well as other employment settings within the continuing care sector (such as residential care facilities, assisted living and supportive housing where the workload can be considerably lighter) (NSAHO, 2005, p. 20-21, 30). It should also be recognized that the health care districts in Nova Scotia are, in a sense, competing with each other for the limited number of CCA's.

3. Quality of Work-Life Issues<sup>15</sup>:

- a. Monetary compensation, not surprisingly, may very well be the biggest obstacle<sup>16</sup>. Not only do other sectors (*e.g.*, call centres) offer comparable

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<sup>15</sup> Quality of Work-Life is broadly defined as "the promotion of a healthy work environment for workers (HCHRSC, 2004b, p. 9)." It will be discussed more fully in the subsequent section.

<sup>16</sup> HCHRSC (2004b) reports that wages and benefits are not as singularly important as they are often made out to be. Quality of work-life issues (*e.g.*, flexible schedules, work-life balance, career development, respect,



wages and do so without the added cost of tuition and its attendant time-lag to enter the workforce, but often they offer those wages with a lighter or lesser workload and steady, predictable work hours; whereas CCA's work is often physically demanding, even back-breaking, and their schedules irregular.

- b. The CCA position is a one-step career path with few to no opportunities for advancement (NSAHO, 2005, p. 21).

It should be noted that policy changes, as outlined above, have the potential to pull in both directions; that is, they can both aggravate existing pressures and assuage them. For instance, the introduction of the policy that saw an increase of 0.1 hour of care per resident increased significantly the workload in the continuing care sector whether or not there were any more CCA's available. On the other hand, with the government's commitment to health care transformation competition from acute care, which is presently significant, should lessen substantially in the coming years. What's more, the accompanying team-oriented health care philosophy and the move to a fuller scope of practice for CCA's should also create a more fulfilling and thus appealing employment setting, while allowing for a more efficient use of HHR, thereby increasing productivity and quality of work-life with it. The balance of recent policy changes is going a long way to alleviate these pressures.

As for recruitment strategies, they are left to the education providers themselves to implement. However, given their limited recruitment budgets, raising awareness of the CCA program is difficult and is often limited to brochures, newspaper advertisements, and newsletters, attendance at job fairs and the Human Resources and Skills Development (HRSD) job board (NSAHO, 2005, p. 22; HCHRSC, 2006a, p. 20). The

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recognition, teamwork, decision-making, etc.) if properly addressed can make up the difference and provide sufficient (and more cost-effective) compensation, thus increasing retention by reducing attrition. "Strategies should not be based on the assumption that wages are the number one issue in continuing care, although they are deemed an essential core component to consider" (3). A good quality of work-life also is an effective recruitment strategy insofar as the word of mouth that issues from a happy and fulfilled workforce goes. This report, however, suffers from an unfortunate statistically insignificant sample size. The evidence cited therein, therefore, is at best suggestive.



Continuing Care providers also actively recruit CCA's. The most successful strategies appear to be 'direct hiring from onsite practicum/internship sites for CCA education (NSAHO, 2005, p. 22)' and the pursuit of community avenues (e.g., local newspapers, newsletters and word of mouth), "because the largest source of CCA/PCW/HSW employees is the community" (HCHRSC, 2006a, p. 21, 25). A bursary program also exists for CCA education applicants.

The biggest problem at present seems to be the lack of an overarching agency responsible for a focused, province-wide, mass media recruitment strategy (NSAHO, 2005, p. 23). Indeed, the CCA Recruitment and Retention Action Plan steering committee recommends that a mandatory CCA registration be investigated for the goal of obtaining an accurate provincial CCA profile without which evidence-based workforce planning is blind (NSAHO, 2005, p. 28). In fact, this recommendation recurs throughout the literature. For instance, the HCHRSC (2004a) report states that a CCA regulatory body ought to be considered, for it could "...ensure that the work of CCAs is recognized and professionalized...that the hiring of individuals is done fairly and equitably, as well as be responsible for accreditation, education and ongoing skills and career development and negotiation of wages and benefits" (37). Other recommendations from the CCA Recruitment and Retention Action Plan steering committee include that: a CCA recruitment strategy is imperative (perhaps the HCHRSC could oversee it) (NSAHO, 2005, p. 28); the CCA bursary program needs to be enhanced (e.g., a flexible work-study bursaries) and the funding must be increased 'immediately' (p. 29); the wage/benefit 'playing field' must be levelled across the various health care sectors (p. 30); educational upgrade and career development opportunities are required for CCA's if it is to be seen as a viable career option; and quality of work-life must be improved (p. 30).

In a pointed attempt to understand the drivers of CCA retention, attrition/turn-over and absenteeism the HCHRSC (2004a) report, after the completion of a recruitment and retention exit tool survey (HCHRSC, 2003b), recognizes a number of reasons why

CCA's leave their jobs: provincial or district out-migration (i.e., moving); finding a new/better job; retiring; going back to school; taking maternity leave<sup>17</sup>; suffering injury/disability; physical demands of job are too taxing/overwork; insufficient wages/benefits; irregular hours are difficult to reconcile with life outside of work; insufficient hours/lack of job security (often only part-time or casual hours available); and illness in family/familial obligations (HCHRSC, 2004a, p.15; HCHRSC<sup>18</sup>, 2006a, p. 32). It is important to note that these reasons are neither necessarily mutually exclusive nor exhaustive.

Absenteeism and employee turnover has increasingly become a serious issue in continuing care. With about one quarter of CCA's now over the age of 50, "it has become more common for individuals to be actively working at a time when they are experiencing deteriorating health" (HCHRSC, 2004a, p. 33). Factor in overwork, which likely promotes poor work habits, and lack of proper equipment, the result is an increased incidence of injury, especially strains and sprains (HCHRSC, 2004a, p. 23, 34; HCHRSC, 2007b, p. 20). An aging and overworked workforce is also much more prone to sickness. Such absences are expensive. Not only are there costs of health care, rehabilitation and employment insurance benefits (for both short- and long-term disability), but there are the added costs of paying the wages of replacement workers, not to mention the costs associated with the learning-curve replacement workers inevitably experience. One study (HCHRSC, 2006ap.), for instance, calculates a total turnover cost of \$93,996 for four CCA's in one year (p. 9). If, however, no replacement workers are available, which is more and more the case province-wide and highly probable in remote areas, the existing staff must pick up the slack. This too is expensive. First, there is the cost of paying overtime hours. Second, there is the

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<sup>17</sup> Since women constitute 97% of CCA's, absenteeism owing to maternity leave is also a concern for the continuing care sector. However, this trend shows no sign of changing; as such there is little that can be done save increasing efforts to entice males into the CCA occupation.

<sup>18</sup> This study is a general look at Nova Scotia health care recruitment and retention, not particular to CCAs. Nonetheless its call for a provincial 'collaborative' and 'integrated' recruitment and retention strategy for the health care sector, if heeded, will have far-reaching effects, impacting individual organizations and the health care sector as a whole.

compound risk of employee dissatisfaction (from being forced to work extra hours) and employee injury (from overwork), both of which can result in further absenteeism or turnover (HCHRSC, 2004a, p. 33). In times of great demand and small supply of CCA's this vicious feedback cycle is almost a certainty.

### **Quality of Work-Life:**

One report (HCHRSC, 2007a) aptly states "if recruitment and retention of qualified workers are the primary issues for administrators, Quality of Work Life (QWL) is the focus for continuing care workers" (p. 17). Low wages and/or insufficient benefits, although significant, are clearly not the only deciding factor for people seeking employment or keeping the job they have. That is to say, while good wages/benefit packages are necessary conditions for retaining employees, they are not sufficient in and of themselves. More times than not the litmus test for worker loyalty is the quality of work-life. "Being undervalued in the work place is still an issue and that being treated with respect can make the difference between staying and quitting" (HCHRSC, 2004a, p. 33). Likewise, in a synthesis from focus groups, the HCHRSC study (2006a) reports that "managers need to cultivate an overall culture of respect and recognition to improve retention..." (p. 36). Issues such as strong leadership in the workplace, decision-making, job satisfaction, consistent hours of work, career advancement opportunities, teamwork, and a safe, healthy and supportive workplace are all important.

The development of supportive work environments recognizes that events which happen in personal lives influence productivity at work; therefore, by promoting a positive interaction between these multiple environments, employees [*sic*] are able to view the intermingling of work and personal life as a positive step to sustaining individuals providing direct care to clients in the workplace. (HCHRSC, 2004a, p. 36)

That is, accommodating as far as possible a reasonable work-life balance, employers can encourage worker loyalty and job satisfaction, thereby increasing retention (NSSS, 2005, p. 131). Of course, while this may sound simple enough in principle, it must be kept in mind that the logistics of thus accommodating employees' personal lives will

likely be difficult in practice. Crucially, however, far from the exorbitant spending that comes with increasing compensation, many of the quality of work-life issues can be addressed without added funds (HCHRSC, 2006a & b, p. 46).

The HCHRSC commissioned a study (to develop a) “Quality of Work-Life Strategy for Nova Scotia’s Continuing Care Sector” (HCHRSC, 2005b). This study outlines 21 factors or determinants subsumed by five domains (*i.e.*, quality of: physical work environment, organization’s own health practices, social environment, psychological environment and personal resources) (HCHRSC, 2005b, p. 9-12). A subset of those determinants found in the social and psychological domains are deemed particularly pertinent for ensuring a good quality of work-life: “relationships/group cohesion; communication; workload; empowerment; involvement in planning and decisions; role clarity; and rewards and recognition” (HCHRSC, 2005b, p. 4). If these areas alone can be addressed sufficiently, then both the health care provider’s and recipient’s ‘sense of well-being’ should increase significantly and, more importantly, their actual well-being along with it. This study (HCHRSC, 2005b) continually stresses the reciprocal nature of the interactions between workplace environment, employee and client ‘sense of well-being’ and quality of care provided/received (see ‘virtuous circle’, p. 8). In the end, this study issued an institution assessment tool that will help identify deficiencies in quality of work-life across the continuing care sector.

Following on the heels of the above report (HCHRSC, 2005b) is the HCHRSC (2007b) study “Increasing the Capacity for Quality of Work Life in the Continuing Care Sector—‘Next Steps,’” which takes as its explicit goal to “develop, deliver and analyze a survey tool that would measure both the uptake and depth of implementation of recommendations from the 2005 QWL report” (p. 10). The response rates to the surveys (one for employers and one for employees) are difficult to assess: of 249 organizations to receive the surveys 49 employers responded and 65 employees responded. It seems that the safest way to interpret the results, then, is to take them as suggestive rather than representative.

Interestingly, and without explanation, despite the aforementioned particular relevance of the social and psychological environments for promoting quality of work-life, this study (HCHRSC, 2007b) focused on the physical work environment (*i.e.*, “workplace safety, injury prevention, absence of violence and harassment, and shift-work related risk”) and the organization’s own health practices (*i.e.*, “availability of programs/services that heighten QWL awareness, formal structures/processes that enable staff input on QWL issues, supports that help with work-life balance, and comprehensive health benefits”) (p. 12). With that being said a few things can be gleaned from the report. And once again the familiar themes found throughout the literature appear: the need for a ‘central body’—in this case to “develop and deliver training specific to the Health sector to create and maintain high quality, healthy work places;” the lack of resources, both human and financial, and the attendant constraints on investing in anything above and beyond providing quality health care (*i.e.*, programs/training in support of organizational health, safety and quality of work-life initiatives in general) (HCHRSC, 2007b, p. 35). There does, however, seem to be a general receptiveness to the implementation of education programs and a ‘strong’<sup>19</sup> commitment to developing and maintaining a good quality of work-life and safe and health work environments (HCHRSC, 2007b, p. 6).

One novel way of promoting recruitment and retention in the continuing care sector is to address the lack of career development opportunities directly by developing and implementing learning organizations. A learning organization is an organization “...committed to on-going growth and development for all people who belong to the organization. Acquiring, sharing, and implementing knowledge becomes an inherent part of the workplace” (HCHRSC, 2006c, p. 9). As individuals within an organization learn and grow, so too does the organization as a whole develop and evolve. The result

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<sup>19</sup> One must be careful here not to read too much into this, however, since it is natural to suppose that those organizations with an actual ‘high degree of [QWL] commitment’ are much more likely to respond and to distribute the surveys to their employees than those with a correspondingly ‘low commitment’, thus potentially skewing the results.

is competent, skillful and empowered workforce offering a better quality of care. Once again the literature recognizes the need for an organization to take the lead. That is to say, what is required for this to work is “...a centralized body to take ownership and formalize a mechanism to implement Learning Organizations” (HCHRSC, 2006c, p. 49), which in turn requires a commitment from individual employees, the particular organizations and the sector itself. The recurring theme throughout the literature is apparent: the health care system in Nova Scotia can no longer afford to operate in the traditional siloed manner, rather a health care paradigm shift is imperative, where the stakeholders, the sector and the organizations within it operate as an integrated, collaborative whole to produce a high quality of health care in a sustainable way.

### **Language of Service:**

As of 2001 roughly 4% (over 37,000) of Nova Scotians were Acadian or french-speaking, that is, have French as their mother tongue (Intergovernmental Francophone Affairs [IFA], p. 1). Unfortunately, 50-55% of Francophones do not have access to French Health services (Réseau pour les services de santé en français – Nouvelle-Écosse [RSNÉ], 2006, p. 2). An inability to find health care offered in one’s first language can be detrimental to one’s health, at least insofar as it deters Francophones from availing themselves of front-line and preventative health care (RSNÉ, 2006, p. 4-5). Consequentially, they are “more likely to use emergency services,” which is the most expensive form of health care (RSNÉ, 2006, p. 5).

Francophones live throughout the province, where the most populous communities are to be found in the South West (Clare and Argyle), near Antigonish (Pomquet), parts of Cape Breton (Île-Madame and Chéticamp) including Sydney, as well as in Halifax/Dartmouth (RSNÉ, 2006, p. 7). At present, little community information on French health care services and access is available; nor is there much in the way of policies to provide French health care services. Efforts are being made, however. For instance, “A new policy has been implemented by the Cape Breton District Health Authority which stipulates that all direct patient care positions posted for the facility in

Chéticamp will include a French-language requirement” (IFA, [www.afi-ifa.ca/media\\_uploads/pdf/117.pdf](http://www.afi-ifa.ca/media_uploads/pdf/117.pdf), p. 2). A particular area of concern is long term care nursing homes: a mere three offer services in French, while eight others offer only some services in French (IFA, [www.afi-ifa.ca/media\\_uploads/pdf/117.pdf](http://www.afi-ifa.ca/media_uploads/pdf/117.pdf), p. 1).

In 2004 the RSNÉ in conjunction with the Department of Health sought to establish a directory of French speaking primary health care providers in Nova Scotia. To this end they developed a survey tool and distributed it to 6407 health care professionals (including CCA/HSW/PCW's) across six district health authorities (those with the highest concentration of French-speaking citizens: Cape Breton, Guysborough-Antigonish Strait, Capital, South Shore, South West, and the Annapolis Valley, as well as the IWK Health Centre) (RSNÉ, 2006, p. 3). Only 24% (*i.e.*, 1512 of 6407) of surveys sent were returned and 13.5% (204) of those returned indicated a willingness to feature in the Directory, 22 of which are CCA's (RSNÉ, 2006, p. 16-17). After phase I was completed, the Directory, containing names, professions and contact information, was made available, in both French and English, online at the Department of Health's website, [www.gov.ns.ca/health/frhc](http://www.gov.ns.ca/health/frhc).

Phase II of the Directory of French Speaking Primary Health Care Providers (RSNÉ, 2007) building on Phase I (RSNÉ, 2006), aimed “to promote the sustainability of the Directory by ensuring relevant and up-to-date information identifying French speaking primary health care providers in Nova Scotia (p. 4).” To this end they focused on developing and strengthening partnerships among the major stakeholders: professional associations, DHA's and primary health care providers. If the Directory becomes established as an ongoing, reliable demographic resource, then it will go a long way to informing aspects of the CCA supply and demand study, for it is important that the study incorporate the needs of the French speaking community when making staffing projections and recommendations.



## **Information Technology and Management<sup>20</sup>:**

In an effort to address many of the issues facing the continuing care sector, it has been recognized that an infusion of information technology (IT) and proper information management (IM) strategies could alleviate many of the pressures<sup>21</sup> impacting the continuing care sector today (HCHRSC, 2003c; HCHRSC, 2007a). An information technology needs assessment (HCHRSC, 2003c) of the continuing care sector found that “almost all organizations believe that their operations could improve with IT” and identified a province-wide need of computer hardware, software, technical support and training, and, crucially, funding. Moreover, it is generally believed that adopting new technologies, especially information technology (IT), will increase the public’s access to health care by increasing human resource capacity through the implementation of various IM strategies.

The ultimate goal is, or should be, to get all continuing care organizations to the point where they are full participants in:

1. integrated and collaborative reporting at both regional and provincial levels (e.g., Nova Scotia Health Administration Systems Project<sup>22</sup> (HASP)),
2. electronic health records and patient assessment tools (e.g., Procura<sup>23</sup>),
3. online resources for recruitment and retention,
4. online resources to support Quality of Work Life initiatives (e.g., real-time scheduling updates),
5. interaction with acute care data repositories,

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<sup>20</sup> Information technology (IT) is defined as “the software applications and computer hardware that supports information management,” which is “the procedure of collecting data and processing, presenting and communicating information” (HCHRSC, 2007a, p. 1).

<sup>21</sup> As discussed above: aging population, aging workforce, high levels of acuity, increased focus on community-based care, increased activity and complexity of care, and new training standard and entry requirements to practice certification (HCHRSC, 2007a, p. 8).

<sup>22</sup> A project to be completed in 2009 that will be a database of provincial health information (*i.e.*, financial, human resources, outcomes, waiting times, health status, electronic health records, *etc.*) collected from health care providers (HCHRSC, 2007a, p. 41).

<sup>23</sup> A data management tool that “purports to be a comprehensive point-of-care, clinical, and back office software system...” that can combine information from multiple sources (*i.e.*, health care facilities) (HCHRSC, 2007a, p. 43).



6. online public access to health care services (*i.e.*, kinds of patients served, available space, *etc.*),
7. professional development (*e.g.*, online education),
8. telemedicine (HCHRSC, 2007a, p. 48).

However, for these strategies to get off the ground, that is to say, “for the effective use of IT in the continuing care sector,” a few prerequisites must be in place (HCHRSC, 2007a, p. 48).

First, local IT needs analyses and the corresponding implementation plans must be conducted, since each organization, given their differing sizes and existing IT status, is bound to have different requirements. This way the continuing care sector will be guided by a ‘common vision’ and yet be flexible enough to accommodate the local, individual needs (HCHRSC, 2007a, p. 49). Second, there must be a sector-wide consensus on data term definitions and shared indicators. Otherwise, without a certain measure of standardization, it would be impossible to evaluate and compare data from one organization to the next. The data sets would be incommensurable—each organization’s data sets would, in a sense, be written in their own language. At the same time allowances must be made for ‘segmented definitions’ and ‘variance of measures’ across the different types of services offered in different settings (*e.g.*, rural/urban, residential/homecare/home support). Third, following on the heels of the individual needs assessments, the IT recommendations (*i.e.*, hardware/software) must be acquired and implemented, along with the necessary human resource development (*i.e.*, orientation, proper training and support, and workload adjustments<sup>24</sup>) (HCHRSC, 2007a, p. 49). Crucially, the front-line workers, such as CCA’s, must understand how and to what degree the introduction of IT will enhance the performance of their daily duties and, ultimately, the quality of care their clients receive. To this end, orientation sessions are of the utmost importance, at least until such time as the CCA certification

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<sup>24</sup> An initial negative learning curve is to be expected (*i.e.*, decreased productivity) when introducing such new technologies and tasks (*e.g.*, data entry and report writing). However, decreased productivity should be fleeting and short-lived provided proper training and support is in place (*i.e.*, until the new skills become familiar).

program includes modules relating to applied IT. Finally, and yet again, echoing the now familiar theme, “planning and collaboration at the organizational, regional, and provincial levels (HCHRSC, 2007a, p. 2)” is the key for a successful sector-wide application of IT/IM strategies.

It is often thought that older adults, who make up the bulk of the continuing care workforce, dislike technology and are in general unreceptive to its introduction in their places of work. However, this is not the case. In fact, the preponderance of evidence suggests that older adults are willing to learn and use technology, *provided* the proper training and support<sup>25</sup> is made available (HCHRSC, 2003c, p. 53; HCHRSC, 2007a, p. 23-24). A survey of 168 CCA’s, 73% of who are over the age of 40, indicates that about half of them are ‘familiar’ to ‘very familiar’ with computers, with only 21% reporting having never used a computer<sup>26</sup> (HCHRSC, 2007a, p. 20). Yet, over 60% do not use computers in their places of work (HCHRSC, 2007a, p. 21); while those who do report various uses: from filling out surveys/applications/forms to accessing professional resources and medical information to online training and telemedicine (HCHRSC, 2007a, p. 22). Interestingly, “in spite of limited current use, there is a high proportion of continuing care workers who are interested in using IT for a variety of job related functions, for collaboration, and for sharing their knowledge with stakeholders (HCHRSC, 2007a, p. 19). Provided IT/IM strategies can be implemented effectively and efficiently, and training and support is available, then this bodes well for increasing the human resource capacity in the continuing care sector.

## **Conclusion:**

If the Nova Scotia health care sector is to have substantive answers to the present health care crisis and its attendant burgeoning deficit of CCA’s in the continuing care sector, then those answers are going to have to be based on sound, empirically-

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<sup>25</sup> It is recommended that the Health Information Technology Service (HITS) already servicing the acute care sector should be extended to support the continuing care sector.

<sup>26</sup> It is important to point out that survey bias will likely significantly affect the actual percentages, as those facilities/agencies with some IT infrastructure already in place were, for the most part, those who chose to participate in the survey (HCHRSC, 2007a, p. 6).

informed policies and practices. At the moment one simple fact remains: clearly the available information on the number of CCA's, their whereabouts or any of the demographic characteristics and priority information needs (e.g., education/training characteristics, geographical distribution, migration, attrition, employment characteristics, productivity) integral for health human resource planning, policy formation and administration is either insufficient or unreliable. A review of the relevant literature on CCA's in the continuing care sector indicates that a significant gap between supply and demand has existed for a number of years. What's more, all signs point to a widening of this gap now and for the foreseeable future. Without an accurate understanding of the present health/continuing care situation and the dynamics driving it, it is all but impossible to gauge the effects of changing inputs. While funding is important, judiciously using it is all the more important, for money alone, even vast amounts of money, is ineffectual if doled out inefficiently. What is required is an infusion of the right amounts money in the right places in conjunction with evidence-based strategic planning, which in turn requires not only reliable sector-wide information but also an integrated and collaborative effort on the part of *all* the stakeholders; including the Departments of Health and Community Services, the DHA's, professional associations, educational institutions, individual organizations/agencies, unions and the public. Clearly, in order to understand the state of CCA affairs in Nova Scotia and thus to be able to plan accordingly, an accurate and reliable provincial CCA occupational profile is not only prudent but imperative. Processes, resources and supports for sustainable data collection and analysis of this workforce will also be required.

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## Appendix C: Sample Screen from Searchable Annotated Bibliography

Author	Date/pp	Title	Availability	Annotation
NSAHO & Nestman, Peter	2005/60	<i>CCA Recruitment &amp; Retention Action Plan</i>	Health Care Human Resource Sector Council	The authors concluded that in 2004 there were approximately 5898 CCAs working in both acute and home care in Nova Scotia. It was projected that policy shifts such as the .01-hour increase in resident care hours effective April 01, 2005 within the nursing home sector would increase the demand for the CCA/PCW/HSW by an estimated 154 positions. The study also includes a supply and demand forecast based on the then current and future pressures. It stated that the demand for CCAs would far outstrip the supply unless substantial action was taken. It was further concluded that a CCA Human Resource strategy should be established for both the short and long term for three different topics including recruitment, education, and workplace environment. The study includes 9 appendices including Appendix 2 - CCA/PCWs in NH/HFA; Appendix 3 - Home Support Workers; and Appendix 5 - Demand for CCAs Graduates in Long Term Care.



## **Appendix D: Survey Instruments**

### ***Continuing Care Assistant (CCA) Nova Scotia Supply and Demand Study***

The value of decision making around the education, recruitment, retention and support of Continuing Care Assistants (CCAs) in Nova Scotia is only as good as the data on which those decisions are made. With this in mind, the Health Care Human Resource Sector Council seeks your input to verify current labour market information.

The Health Care Human Resource Sector Council views your organization as a key stakeholder to ensuring that there is high quality and timely information on CCAs in Nova Scotia. Clearly there is a need for enhanced information in order to inform and improve both short term and long term planning.

This survey is in follow-up to the recommendations of the Nova Scotia Association of Health Organizations (NSAHO) CCA Recruitment and Retention Action Plan (2005). That report recommended that a “human resource strategy”<sup>27</sup> should be established for CCAs in Nova Scotia. This survey will help to inform that strategy.

Data gathered through this study will be used by the Department of Health to make projections for future human resource needs. It is hoped that this survey instrument will be formatted as an on-line response form and made available to you for regular updates, in order to keep data current and to avoid repetitive future surveys. The study results will be made available to all participating organizations.

***“Return of the completed survey will denote assent to be a participant in the Continuing Care Assistant (CCA) Nova Scotia Supply and Demand Study.”***

***Thank you in advance for your time and contribution to this important work.***

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<sup>27</sup> Nova Scotia Association of Health Organizations, CCA Recruitment and Retention Action Plan, Nestman, Peter 2005.



## CCA Supply & Demand Study Survey Form May 2008

Organization: |  
Address: |  
Contact Person: | Phone: |  
Email: |

Representing members/employees from: (Please check one)

- ☐ Home Care/Home Support  
☐ Long Term Care Facility  
☐ Acute Care  
☐ Other (Please specify)

The survey may be returned by:

1. fax: [1-\(506\)849-4419](tel:1-506-849-4419)
2. regular mail:

Attention: Colleen Curry, Research Associate  
PMA Consulting Inc.  
3 David Court  
Quispamsis NB E2E 1H8

Please submit your completed survey by [June 13<sup>th</sup>, 2008](#).

The Price-MacDonald & Associates (PMA) research team will be happy to assist in any way with questions, collection and tabulation of your data, etc. For assistance call [1-506-650-4471](tel:1-506-650-4471) or [902-423-1891](tel:902-423-1891). Information will be handled with confidence and no identifiers will appear in reports or materials for dissemination. Results of the study will be shared with participants.

***Note: For the purposes of the Supply & Demand Study of Continuing Care Assistants (CCAs) in Nova Scotia, CCA refers to all employees working in the role of direct care/support service providers such as CCA, Personal Care Worker (PCW), Home Support Worker (HSW), and Home Health Provider (HHP) as defined by Department of Health regulations, as well as employees in this role with on-the-job training.***

***TM, PMA Inc.***

***TM, PMA Inc., 2008***

xxxviii

**Please contact PMA Inc. 1-506-650-4471 for questions or assistance in collecting and compiling data.**

1. Please indicate the number and age of CCAs employed with your organization by completing either a or b:
  - a. A list of employees birthdays, by sex, with names removed
  - b. Complete the table below for year of birth and sex

CCAs by Year of Birth and Sex																	
Year	F	M	Year	F	M	Year	F	M	Year	F	M	Year	F	M	Year	F	M
1940 or Prior			1950			1960			1970			1980			1990		
1941			1951			1961			1971			1981			1991		
1942			1952			1962			1972			1982			1992		
1943			1953			1963			1973			1983			1993		
1944			1954			1964			1974			1984			1994		
1945			1955			1965			1975			1985			1995		
1946			1956			1966			1976			1986			1996		
1947			1957			1967			1977			1987			1997		
1948			1958			1968			1978			1988			1998		
1949			1959			1969			1979			1989			1999		

2. Please indicate the number of CCAs employed with your organization by designation:

Designation	Number	Type
Continuing Care Assistant		
Home Support Worker		
Personal Care Worker		
Home Health Provider		
On the Job Training		
Certificate - Other- Please indicate type		
Diploma - Please indicate type		
Unknown		

3. Of those presently certified as other than CCA, what supports would be needed to encourage transition to a CCA certification?

Please comment:


4. Please indicate number of CCAs hired between April 1, 2003 and March 31, 2008:

	Total Number of CCAs hired	CCAs Hired from						
		NS	NL	NB	PEI	Other Canadian Jurisdiction	International	Information Unknown
2003								
2004								
2005								
2006								
2007								
2008								

5. Of those hires educated internationally, please indicate the country of origin and previous certification, if known:

Year	Total Number of International Hires	No. of Temporary work Permit	Country of Origin	Previous Certification	First Language	Information Unknown
2003						
2004						
2005						
2006						
2007						
2008						

6. Please indicate the number of vacant CCA positions in your organization between April 1, 2003 and March 31, 2008, where information is available:

Job Classification	Average # Hours worked per week	Number Vacant					
		2003	2004	2005	2006	2007	2008
Full-time							
Part-time							
Casual							

Comments:

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7. Please indicate the number of permanent CCA retirements and anticipated retirements from your organization, by year, where information is available:

Retirements from CCA Employment April 1, 2003 March 31, 2008		Eligible for Retirement from CCA Employment April 1, 2008 March 31, 2013	
Year	Number	Year	Number
2003		2008	
2004		2009	
2005		2010	
2006		2011	
2007		2012	
2008		2013	

8. Please indicate the number of CCAs who left your organization between April 1, 2003 and March 31, 2008 and reason for resignation, if known:

Year	Number of Resignations	Number of Resignations					
		Leaving for Work Elsewhere in NS	Leaving NS for Work in another jurisdiction	Returning to School to further Health related education	Changing Career to other than health care	Involuntary Terminations	Reason Unknown
2003							
2004							
2005							
2006							
2007							
2008							

9. Please indicate the number of CCAs within your organization who were on leave, between April 1, 2003 and March 31, 2008 by type of leave:

Leaves by Type						
Year	LTD	WCB	Maternity/ Parental	Education	Other (Name leave)	Reason Unknown
2003						
2004						
2005						
2006						
2007						
2008						

10. Please indicate service/staffing requirements for your organization between April 1, 2003 and March 31, 2008:

Year	Beds / Clients served/day/month	Number of FTEs *	Number of CCAs Employed to fill FTEs *
2003			
2004			
2005			
2006			
2007			
2008			

\* FTE: full time equivalent, 35 hrs./week or more

11. Please indicate anticipated service/ staffing requirements within your organization between April 1, 2008 and March 31, 2013:

Year	Anticipated Increase in Beds / Clients served/day by Staffing Model			Anticipated Number of FTEs* Needed	Anticipated Number of CCAs needed to fill FTEs*
	Traditional	Full Scope	Other		
2008					
2009					
2010					
2011					
2012					
2013					

\* FTE: full time equivalent, 35 hrs./week or more

12. Have you experienced any reduction, suspension, or inability to provide requested service(s) due to lack of CCA staff?

No: ☐ ☐ (if "No" go to question 13)

Yes: ☐ ☐ (if 'Yes' – Please Explain)

Please explain:

---



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13. Do you actively recruit new staff?

No: ☐ ☐ (if “No” go to question 14)

Yes: ☐ ☐ (if ‘yes’) please indicate methods currently used

Methods currently used:

--	--	--

14. How would you suggest new staff could best be recruited?

Please comment:

--	--	--

15. What supports would improve the current and/or suggested CCA recruitment methods within your organization?

Please comment:

--	--	--

16. What would you see as the greatest challenge to the recruitment of CCAs for your organization?

Please comment:

--	--	--

17. Is your organization involved in any retention strategies for CCAs?

No: ☐ ☐ (if “No” go to question 18)

Yes: ☐ ☐ (if ‘Yes’) please indicate methods currently used

Please indicate methods currently used:

--	--	--

18. What CCA retention strategies would you recommend for your organization?

Please comment:

--	--	--

19. What supports would benefit the current and/or suggested retention strategies within your organization?

Please comment:

--	--	--

20. What would you see as the greatest challenge to the retention of CCAs for your organization?

Please comment:

--	--	--

***Thank you for your time and input, it is greatly appreciated!***

## Appendix E: Focus Group Schedule and Questions Posed



### *Invitation to Participate*

#### **Supply and Demand Study**

#### **Focus Group Session for Employers**

**Your input is valued!**

**Date:**

The session will be a Focus Group around the theme "Attraction, Integration and Retention of CCAs for Nova Scotia-Now and Into the Future" presented by PMA Consulting Inc., Project Researchers.

The objective of the Continuing Care Assistant (CCA) Nova Scotia Supply and Demand Study is to build on past research and work collaboratively within the Acute and Continuing Care sectors to incorporate quantitative and qualitative research design methods to create a Minimum Data Set (MDS) with a set of definitions and a process to support ongoing data collection. This data set will contribute to a supply and demand forecast for CCAs in Nova Scotia that can be integrated into a broad health human resource strategy for the Continuing Care Health Sector.

The Focus Group is primarily targeted to long-term care facilities and home care/home support agencies who employ CCAs and those working in the role of CCA but who may not have obtained the formal credential.

The session will be interactive and will last one hour. This is an opportunity to learn more about the current picture of CCA activity in the province, about the CCA Nova Scotia Supply & Demand Study, and to contribute to the outcomes of the research. Participants can expect a light, enjoyable yet educational session. Door prizes to be awarded!

# CCA FOCUS GROUP BOOKINGS, June - July 2008

Date	Meeting location	Attendees	Meeting Time	Consultant
June 4 <sup>th</sup>	<b>Digby</b> – The Pines Resort CCANS	Employers	4:00 -4:30	June
July 7 <sup>th</sup>	<b>Digby</b> Tideview Terrace 51 West St.	CCAs	2:00 – 3:30	Vicky
July 8 <sup>th</sup>	<b>Yarmouth</b> Yarmouth Argyle Home Support Services YAHSS	Employers CCAs CCAs	8:00-12:00 1:30-3:00 3:30-5:00	Vicky
July 8 <sup>th</sup>	<b>Sydney</b> Delta Hotel <b>Confirmed</b>	Employers CCAs CCAs	10:00-11:30 7:00-8:30 2:00-3:30	June
July 8 <sup>th</sup>	<b>Coldbrook</b> Wandlyn 7270 Hwy 1 <b>Confirmed</b>	Employers CCAs CCAs	10:00-11:30 1:00-2:30 3:30-5:00	Pat
July 9 <sup>th</sup>	<b>Bridgewater</b> Wandlyn Inn 50 North St	Employers CCAs CCAs	10:30-12:00 1:30- 3:00 3:30-5:00	Vicky



<b>Date</b>	<b>Meeting location</b>	<b>Attendees</b>	<b>Meeting Time</b>	<b>Consultant</b>
	<b>Confirmed</b>			
July 9th	<b>Antigonish</b> Greenway Claymore Inn <b>Confirmed</b>	Employers CCAs CCAs	1:00-2:30 3:00-4:30 7:00-8:30	June
July 9th	<b>Truro</b> Best Western Glengarry <b>Confirmed</b>	Employers CCAs CCAs	10:00-11:30 1:30-3:00 3:30-5:00	Pat
July 10th	<b>Halifax</b> Cambridge Suites 1583 Brunswick St <b>Confirmed</b>	Employers CCAs CCAs	1:00-2:30 3:00-4:30 7:00-8:30	Pat

## **Appendix F: Canadian Evaluation Society- Code of Ethics**

### **CES GUIDELINES FOR ETHICAL CONDUCT**

#### **COMPETENCE**

Evaluators should continuously strive to improve their methodological and practice skills.

1. Evaluators should apply systematic methods of inquiry appropriate to the evaluation.
2. Evaluators should possess or provide content knowledge appropriate for the evaluation.

Evaluators are to act with integrity in their relationships with all stakeholders.

1. Evaluators should accurately represent their level of skills and knowledge.
2. Evaluators should declare any conflict of interest to clients before embarking on an evaluation project and at any point where such conflict occurs. This includes conflict of interest on the part of either evaluator or stakeholder.
3. Evaluators should be sensitive to the cultural and social environment of all stakeholders and conduct themselves in a manner appropriate to this environment.
4. Evaluators should confer with the client on contractual decisions such as: confidentiality; privacy; communication; and, ownership of findings and reports.

#### **ACCOUNTABILITY**

Evaluators are to be accountable for their performance and their product.

1. Evaluators should be responsible for the provision of information to clients to facilitate their decision-making concerning the selection of appropriate evaluation strategies and methodologies. Such information should include the limitations of selected methodology.
2. Evaluators should be responsible for the clear, accurate, and fair, written and/or oral presentation of study findings and limitations, and recommendations.
3. Evaluators should be responsible in their fiscal decision-making so that expenditures are accounted for and clients receive good value for their dollars.
4. Evaluators should be responsible for the completion of the evaluation within a reasonable time as agreed to with the clients. Such agreements should acknowledge unprecedented delays resulting from factors beyond the evaluator's control.

## Appendix G: Education Survey

20/05/2008

### Re: Continuing Care Assistant (CCA) Nova Scotia Supply and Demand Study

Dear CCA Educator:

The Health Care Human Resource Sector Council (HCHRSC) is examining the supply and demand of Continuing Care Assistants (CCAs) in Nova Scotia.

Given anticipated changes in the practice of CCAs in continuing and acute care, coupled with the provincial governments' significant increase in the numbers of long term care beds, the current labour shortage of CCAs is expected to become a growing challenge.

The goals of this study are to:

- Work with the health care sector to create a profile of CCAs in Nova Scotia by region and employment setting;
- Forecast the demand for CCAs for the next five years; and
- Identify the specific challenges that will impact the retention and recruitment of CCAs.

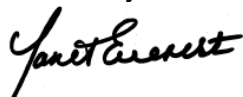
**An accurate profile of the current and emerging supply and demand for CCAs will be necessary to guide planning and to inform a human resource strategy. This will encompass graduates of CCA education programs.** Data gathered through this study will be used by the Department of Health to make projections for future health human resource needs. In future it is hoped that this survey instrument will be formatted as an on-line response form and made available to you for regular updates, in order to keep data current and to avoid repetitive future surveys.

The purpose of this letter is to invite your organization to contribute to this important study by providing information about your education programs and graduates. No personal or identifying information about an individual student is necessary. Information will be combined with data from other sources to create an accurate projection of CCAs available to the workforce.

Dr. Terry Murphy, Senior Research Associate, Price-MacDonald & Associates Inc. , will contact you soon to answer your questions and book a time for you to complete the survey by telephone.

Thank you in advance for your response to this request. The study results will be made available to all participating organizations.

Yours truly,



Janet Everest  
Executive Director  
Health Care Human Resource Sector Council

## CCA Educators Nova Scotia, April 2008

1. Cape Breton Business College
2. CompuCollege Mr. Jody LeBlanc
3. Futureworx
4. Highland Resources Career College
5. Island Career Academy Raymond George
6. Institute of Human Services Education
7. Nova Scotia Community College
8. Shannex Centre for Excellence
9. TEC College Janice Currie
10. Universite Sainte Anne

## Educational Profile of CCAs in Nova Scotia 2008

Program name: .....  
 Location: .....  
 Date of interview: .....  
 Interviewee name: .....  
 Interviewee title: .....  
 Interviewer: Dr. T. Murphy

### 1. Program Information (Please identify one preferred length of program)

year	length of program in semesters	length of program in weeks	length of program in hours	frequency of admissions	Total cost of program
2004					
2005					
2006					
2007					
2008					

Comments: .....  
 .....

### 2. Enrolment

year	capacity per program by calendar year	actual enrolment		number recommended for CCA certification testing		number of internationally educated health professionals transitioning to CCA	
		male	female	male	female	male	female
2004							
2005							
2006							
2007							
2008							

Comments: .....  
 .....  
 .....  
 .....

### 3. Student Demographics

year	On entry						CCA Certificates awarded	
	Average age		Number by gender		Average age		Number by gender	
	male	female	male	female	male	female	male	female
2004								
2005								
2006								
2007								
2008								

### 4. Does your institution / faculty carry out graduate follow up surveys?

no: ..... *if no, then go to question 5*  
yes: ..... *if yes, please share results for the period 2004 -2007:*

year	full-time work	part-time work	other
2004			
2005			
2006			
2007			
2008			

### 5. Growth Potential

a. Are there plans to increase capacity?

no: ..... *if no, then please comment*

yes: ..... *if yes, please continue*

Comment .....

b. What time frame would be required? .....

c. What constraints might impact the growth potential? .....

*Thank you for your valued input to this survey.*

## **Appendix H: Table of Contents and Tools, Nova Scotia Recruitment and Retention Toolkit**

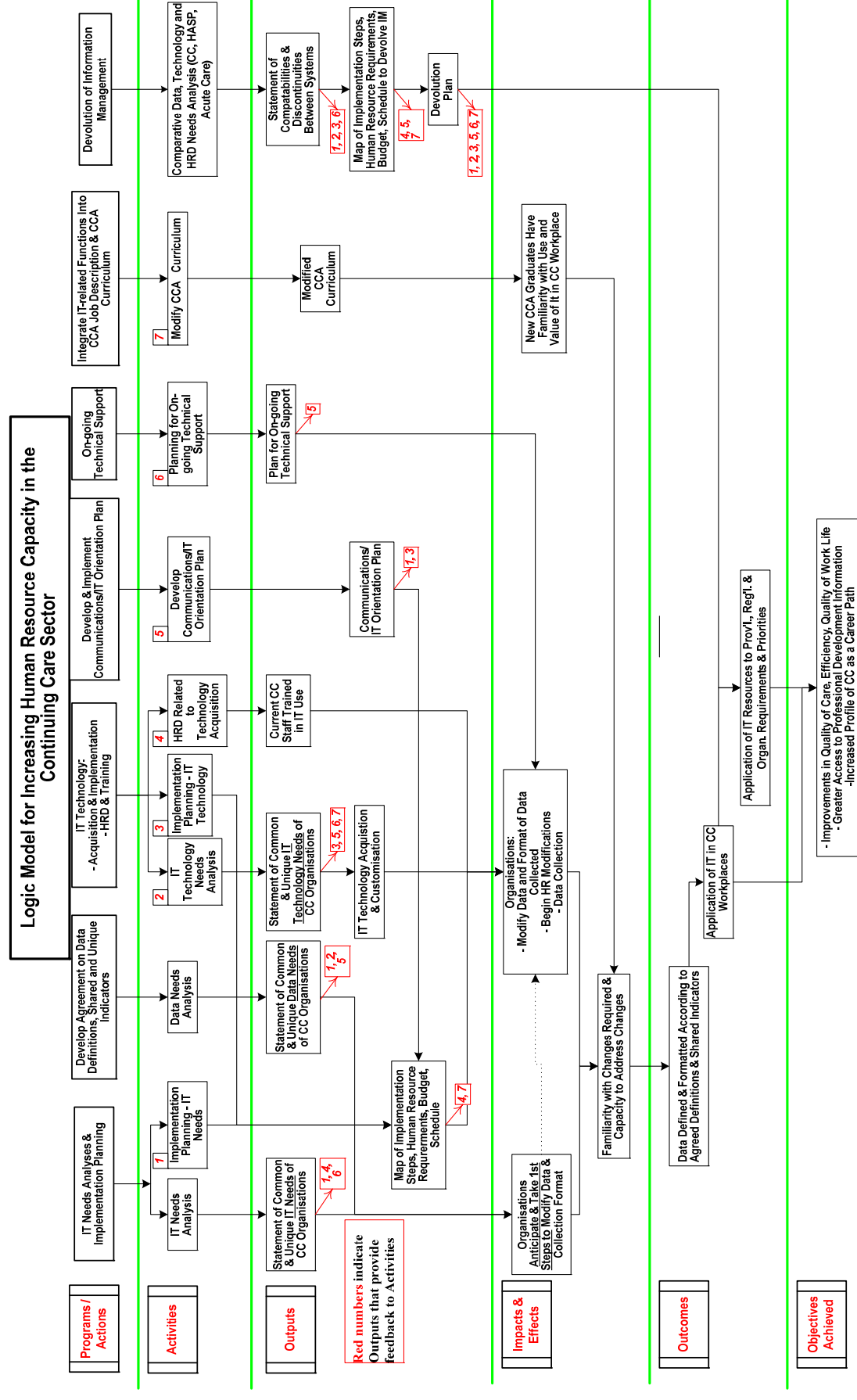
### **Recruitment and Retention Tool Kit Contents**

1. The Nova Scotia Recruitment and Retention Framework
2. Action Plans and Program Evaluation
3. SMART Tool
4. Employee Satisfaction Survey
5. Exit Interviews
6. Generations
7. Employee Development
8. Personal Development Plan (PDP)
9. Employee Recognition
10. Team Work
11. Benchmarking Indicators
12. Quality of Worklife Indicators
13. Stress and Burnout
14. Calculating Turnover Costs
15. Standard Terminology
16. Performance Management

**Nova Scotia Recruitment and Retention Toolkit**  
Health Care Human Resource Sector Council  
Centre for Organizational Research and Development (COR&D)

# Appendix I: Increasing Human Resource Capacity in the Continuing Care Sector

## - Logic Model for Evaluation





## Appendix J: Learning Organizations

<b>Leadership: Individual</b>			
<b>Start Up 1-2 years</b>	<b>Foundation 2-3 years</b>	<b>Implementation &amp; Transition 3-5 years</b>	<b>Sustainability 5-10 years</b>
<ul style="list-style-type: none"> <li>✓ Participate in Learning Organization Committees at the organizational level.</li> <li>✓ Participate in opportunities for program evaluation, reviews of strategic visions and mission statements.</li> <li>✓ Participate in opportunities for learning and sharing.</li> <li>✓ Communicate a shared vision.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Develop framework for individual educational and learning requirements.</li> <li>✓ Participate in internal program reviews.</li> <li>✓ Participate in cross training opportunities.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Participate in program evaluations.</li> <li>✓ Participate in Mentoring and Coaching Programs.</li> <li>✓ Participate in multi-disciplinary teams.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Sustain the momentum: enhanced Quality of Worklife.</li> <li>✓ Celebrate the growth and development of the sector.</li> <li>✓ Evaluate and continue planning, as necessary.</li> </ul>

<b>Leadership: Organizational</b>			
<b>Start Up 1-2 years</b>	<b>Foundation 2-3 years</b>	<b>Implementation &amp; Transition 3-5 years</b>	<b>Sustainability 5-10 years</b>
✓ Establish a Learning Organization Committee, at the organizational level.	✓ Implement internal review of program in collaboration with employees.	✓ Implement multi-disciplinary teams.	✓ Sustain the momentum: enhanced sector recruitment and retention.
✓ Establish an internal program review in collaboration with employees.	✓ Implement opportunities for cross training.	✓ Implement mentoring and coaching programs and resources.	✓ Celebrate the growth and development of the sector.
✓ Develop an action plan to review vision and mission statement, in collaboration with employees.	✓ Implement knowledge transfer guidelines.	✓ Implement communication plan and opportunities.	✓ Evaluate and continue planning, as necessary.
✓ Communicate the Learning Organization vision at all levels of the organization.	✓ Provide appropriate supervisory and management training to support organizational learning culture.	✓ Implement Learning and Development Plans.	
✓ Take advantage of existing and upcoming education programs.	✓ Set formal goals of education programs and standard requirements, including Professional Development Plan standards.	✓ Review and implement learning organization components.	

<b>Leadership: Sector</b>			
<b>Start Up 1-2 years</b>	<b>Foundation 2-3 years</b>	<b>Implementation &amp; Transition 3-5 years</b>	<b>Sustainability 5-10 years</b>
<ul style="list-style-type: none"> <li>✓ Establish Learning Organization Steering Committee at the sector/provincial level.</li> <li>✓ Develop Learning Organization Action Plan.</li> <li>✓ Articulate Learning Organization vision at all levels of care.</li> <li>✓ Obtain consensus among decision makers.</li> <li>✓ Develop a centralized management and supervisory training program for continuing care based on learning organization philosophy.</li> <li>✓ Address identified needs assessments as a sector-wide approach.</li> <li>✓ Implement a review of issues identified by the sector.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Investigate accreditation and licensing processes.</li> <li>✓ Develop plan for cross-opportunities for cross-training (secondments and exchanges).</li> <li>✓ Investigate the increased budget for replacement workers.</li> <li>✓ Investigate a minimum number of staff training days per year and indicate the commitment within the budget.</li> <li>✓ Establish a Best Practices Project to collect practices and establish a system for sharing information throughout the sector.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Establish mentoring programs guidelines and provide appropriate training and support programs.</li> <li>✓ Implement Cross Training programs.</li> <li>✓ Implement knowledge transfer guidelines for the sector.</li> </ul>	<ul style="list-style-type: none"> <li>✓ Sustain the momentum: enhanced sector recruitment and retention.</li> <li>✓ Celebrate the growth and development of the sector.</li> <li>✓ Evaluate and continue planning, as necessary.</li> </ul>