Portraits of Home Care in Canada

2013

Canadian Home Care Association
canadienne de soins et services à domicile

The National Voice of Home Care

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About the Canadian Home Care Association

The Canadian Home Care Association is a national not-for-profit membership association dedicated to ensuring the availability of accessible, responsive home care and community supports to enable people to safely stay in their homes with dignity, independence, and quality of life. Members include governments, administration organizations, service providers, researchers, educators and others with an interest in home care. The Canadian Home Care Association, as the national voice of home care, promotes excellence through leadership, advocacy, awareness and knowledge.

For more information, visit our website at www.cdnhomecare.ca

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Home care is a critical component of an integrated, person-centred health care system. Portraits of Home Care in Canada 2013 is a reflection of this statement.

As the national voice of home care, the Canadian Home Care Association (CHCA) embarked on an extensive project to update our 2008 Portraits of Home Care in Canada report, with the intent of painting a picture of the progress, innovation, challenges and opportunities facing home care programs across the country. The 2013 Portraits of Home Care in Canada builds on the CHCA's two previous reports (2003 and 2008) and expands the picture of home care, with data collection and additional sections that reflect new service delivery models, quality and accountability processes, and the impact of technology on health and home care across Canada. All 17 jurisdictional home care programs (provincial, territorial and federally funded) are reflected through the following lens:

1. Governance & Organization
2. Access, Funding & Service Delivery
3. Quality & Accountability
4. Information Technology
5. Health Human Resources
6. Initiatives
7. Challenges
8. Opportunities

We understood, from the onset of this project, that some of the areas for gathering data would be challenging, as a number of the sections asked for information that may not be available or not collected and reported at a jurisdictional level. The opportunity that the absence of information affords us is twofold; the identification of critical metrics that are required to support quality and accountability, and an opportunity to gain insight into how other jurisdictions are addressing a common challenge. The CHCA cannot emphasize enough that this document is not a research paper. It is an amalgamation of information from key informants, reports, articles and consultations. Valid comparisons cannot be made because of the absence of data definitions and the variation of data collection methods and reporting across Canada. We suggest that this limitation serves as a strong reinforcement for common client assessment tools and comparable data reporting.

The CHCA is enormously grateful to the countless individuals who contributed their time to this project. Government representatives, professional association staff, and home care leaders all contributed to the gathering of information to illustrate home care across Canada. They sourced information, accessed databases, drew on experience, reviewed reports, read and reread the descriptions, and shared their invaluable time and knowledge to make this picture come to life.

The CHCA strongly encourages health care leaders to view these "snapshots" of home care to gain a greater understanding of the complexities of the home care sector and the vital role it can and will play in our health care system. For home care leaders, we hope this report will facilitate ongoing collaboration, stimulate new dialogue and help realize the CHCA's vision of home care as an integral part of an integrated, person-centred health care system.

Together we can make this happen.

Nadine Henningsen
Executive Director
Canadian Home Care Association

HOME CARE IN CANADA

BY THE NUMBERS...

1.4 MILLION Number of individuals receiving home care (2011) (provincial, territorial and federally funded programs)

$5.9 BILLION PUBLIC EXPENDITURES ON HOME CARE (2010) *(provincial, territorial and federally funded programs)*

1:6 Ratio of seniors (65 plus) receiving home care (2011) (average across Canada)

4.0% Percent of publicly funded health care budget spent on home care (2010) (provincial, territorial programs)

5 Million **NUMBER OF FAMILY CAREGIVERS IN CANADA**[1]

55% Percentage increase in the number of home care clients (2008-2011)

[1]*Canadian Caregiver Coalition, 2008*

The Canadian Home Care Association defines home care as an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for family caregivers.

This definition is used by most of the provincial and territorial home care programs with some slight modifications or variance in the range of publicly funded services. The definition reinforces the broad scope of the home care sector within an integrated health care system and the many functions that home programs can assume to support individuals to stay safely in their homes with dignity, independence and quality of life. Home care programs are designed to complement, not replace, the efforts of individuals to care for themselves, with the assistance of family, friends and community. Independence, self-care, community involvement, family caregivers, and well-being are all components of the provision of care in an individual's home environment or their community/work/school settings. These elements are reflected in the objectives and mandates of provincial, territorial and federally funded home care programs across the country that emphasize and reinforce the common goals of home care, which are to:

- Help people maintain health, well-being and personal independence in their homes and community.
- Prevent, delay or substitute for acute or long-term care alternatives.
- Facilitate appropriate use of community-based services including health and social services and residential care options.
- Recognize and supplement the care provided by family, friends and other community-based services.

Governance & Organization

The Ministry or Department of Health in each province and territory is responsible for:

- Health system planning and strategic directions and priorities.
- Legislation and regulations (eligibility, access, service allocation and client user fees for home care).
- Policy direction, standards and guidelines.
- Monitoring, accountability and compliance.
- Global funding of health care services.

In some ministries / departments, additional responsibilities can include benchmarking, research, human resource planning, information systems management and other items not included in this review of home care across Canada.

Provincial and territorial health systems have administrative bodies referred to as **Health Authorities / Health Integration Networks / Health and Social Services Agencies/Centres**, depending upon the jurisdiction. The administrative organizations range in number, from 25 (Nunavut) to 1 (PEI).

Provinces and territories vary in the types of health services, contractual arrangements and accountability agreements for which the administrative organizations are responsible. Regardless of the scope of health services designated to each health authority, they are generally responsible for:

- Planning and organizing health services and allocating resources (including funding).
- Administering and delivering (directly or contracted) a range of health services (this varies depending upon jurisdiction, but usually includes hospital care, **home and continuing care**, mental health, public health and ambulance services).
- Monitoring and reporting on the full continuum of services to ensure accountability.

The following jurisdictions have significant variations in the administration/service delivery structure:

- **Ontario's** 14 Local Health Integration Networks plan and integrate local health services; fund a wide range of providers; and manage service agreements with hospitals, community care access centres, community support services, long-term care, mental health and addictions and community health centres. Community Care Access Centres are responsible for the administration and delivery (directly or contracted) of home and community care.
- **Quebec's** 95 Local Health and Social Services Networks encompass all health stakeholders (including physicians) with a Health and Social Service Centre (CSSS) at the core of the network that is responsible for administration, management, delivery, monitoring and coordination of services (community services, home care, long-term care centres, hospitals).
- **New Brunswick** shares responsibility for home care between the Department of Health (Extra Mural Program) and the Department of Social Development (long-term home support services and residential care).

- The **Yukon** is not regionalized and the Department of Health and Social Services is responsible for administration and delivery of home care services. .
- The **Northwest Territories'** eight Health and Social Services Authorities are also responsible for the planning and management of social services.

The federally funded home care programs are structured differently from the provincial and territorial programs. Veteran Affairs Canada (Veterans Independence Program), Department of National Defence and the RCMP administer and provide services (either directly or contracted). The First Nations and Inuit Health Branch (Health Canada) is responsible for the funding and delivery of a range of health services, and, through the First Nations Inuit Home and Community Care program, funds and administers basic home and community services delivered by 633 First Nations and 53 Inuit communities. These services complement the social home care services (e.g. homemaking) provided by Aboriginal Affairs and Northern Development Canada (AANDC).

LEGISLATION

The Canada Health Act recognizes home care as an "extended health service" not an insured service to which the principles of the Act apply. Only four provinces (British Columbia, Ontario, Manitoba and Prince Edward Island) have legislation or an Order in Council that defines and governs the provision of home care services. Jurisdictions have other health and social legislation that directly impact home care including Acts that address health organizational structures and responsibilities, patient safety and rights, health information and privacy, accountability and appeals, and regulated health care professionals.

Because of the lack of a national legislated framework, there is a recognized need for a set of harmonized principles for home care that would guide policy and program development to achieve a level of consistency across the country, while respecting important jurisdictional differences. The Canadian Home Care Association undertook an extensive research and engagement process to gain consensus on a set of common principles. The resulting harmonized principles for home care align with and reinforce many of the principles identified by the jurisdictions, and provide a basis for the identification of common indicators.

- **Client and Family-Centred Care:** Clients and their family caregivers are at the centre of care provided in their home.

- **Integrated Care:** Home care facilitates the integration of care across the continuum of health care and with community and social services; care is complementary, coordinated and seamless with a focus on continuity for the client.

- **Accessible Care:** Canadians have equitable, appropriate, consistent access to home care, and are fully informed of the care and services options available to them.

- **Evidence-Based Care:** Knowledge that is grounded in evidence is used as the foundation for effective and efficient care provision, resource allocation and innovation.

- **Sustainable Care:** Home care contributes to the sustainability of an integrated health system by increasing efficiencies and delivering cost effective care.

- **Accountable Care:** Home care is accountable to clients, their caregivers, providers, and the health care system for the provision and ongoing improvement of quality care.

EVOLUTION

Formal home care programs in Canada are relatively young compared to the more established acute care sector and many were established in 1978 or later. The majority of programs were created through social services and provided care for seniors (aged 65 plus) or individuals with disabilities. Only Ontario began their evolution with a focus on acute care. Over the past ten years, home care has experienced a surge of activities that included increasing access to care, expanding the range of services, facilitating coordination and integration and recognizing the vital role of the family caregiver. Given the strong commitment to home and community-based care articulated by most governments it is reasonable to anticipate this momentum will continue.

1959

- Ontario funded six acute home care pilot projects.

1970

- Ontario formally established a home care program.
- Home care services available for Canadian Forces personnel through the Department of National Defence.

1972

- Quebec's home care program started.

1974

- Manitoba's home care program was established through an Order-in-Council to provide services to all age groups.

1975

- Newfoundland & Labrador provided home care services on a limited basis.
- Northwest Territories implemented a home care program in Yellowknife only.
- Ontario phased in chronic home care services province-wide.

1978

- British Columbia introduced a province wide long-term care program.
- Alberta's home care programs provided professional services only for those 65 years of age or older.
- Saskatchewan introduced a comprehensive program of home care.
- Northwest Territories expanded home care services throughout the territory.

1979

- The New Brunswick Extra-Mural Hospital was founded with a broad mandate to provide an alternative to hospital and/or long-term care facilities.

1981

- Veterans Independence Program (VIP) launched as a pilot project to provide home care and community- based institutional care to aging WWII Veterans.

1985

- Newfoundland and Labrador provided home support services for seniors and persons with disabilities.
- Alberta expanded home care to include support services and palliative care.

1986

- PEI implemented a home care support program.

1988

- Quebec expanded the home care program across the entire province.
- Nova Scotia introduced a coordinated home care program for individuals over the age of 65 with limited income or long-term disabilities.
- Yukon implemented a Home Care Program.

1999

- FNIHB received Cabinet approval for their Home Care Program.
- RCMP entered into Memorandum of Understanding with VAC to participate with a private health claims administrator.

2003

- Nunavut developed specific standards, policies and procedures for home care.
- Full service delivery of home care in 97 percent of FN communities and 100 percent of Inuit communities.

2003 -2010

- Organizational restructuring and increased accountability mechanisms.
- Integration and enhanced access and service coordination.
- Policies and standards developed and revised.
- Strategies to increase access to home care (service maximums, expanded sites of care).
- Expansion of the range of home care services to include: palliative care, children with complex care needs, self-managed care, mental health, and telehealth applications.
- Aging in Place/Healthy Aging Strategies developed and implemented.
- Focus on integrated models of primary care and home care.

2011 - 2013

- Governments announce focus and direction to shift emphasis of care to home and community in nine jurisdictions (British Columbia, Alberta, Saskatchewan, Ontario, Quebec, New Brunswick, Prince Edward Island, Newfoundland & Labrador and Northwest Territories).
- Recognition of the vital role of the family caregiver in legislation, policy and practice.

Access, Funding & Service Delivery

ACCESS TO HOME CARE

All programs have a single/coordinated entry point for referrals, which enables program administrators to make the most effective use of community and long-term care residential services. Service admission and provision is available 24/7, except in Prince Edward Island and Newfoundland and Labrador, and in the territories where geography and population density make it challenging to provide continuous access to service. For the federally funded programs, access is also limited to Monday to Friday and only physicians can refer to the RCMP and DND home care services.

An individual, family member, physician, long-term care facility, hospital, or community health partners can make referrals to home care. Hospitals provide the majority of referrals to home care. This pattern reinforces the critical role that home care plays in facilitating appropriate discharge, expanding alternatives to emergency room services, and addressing the alternate level of care (ALC) challenge. The term "alternate level of care" (ALC) is used in health care settings, including acute care, complex continuing care, mental health and rehabilitation, to describe persons who occupy a bed in a facility, but no longer need the intensity of resources and services provided in that setting. Managing ALC requires a systems approach and collaboration of providers across the health care continuum so that individuals receive the right care in the right location. A number of provinces are tracking ALC rates and using home and community care programs such as 'Home First' that provides flexible service options so that individuals receive the care they need to stay safely in their own homes.

All governments face the challenge of containing health costs and maximizing the utilization and management of hospital beds. This pressure has resulted in the implementation of integrated strategies between home care and acute care that are described in Portraits of Home Care 2013.

- The **Saskatchewan Surgical Initiative** is targeting improvements in surgical care and reductions in wait times and is using home care and rehabilitation therapy as strategies.

- In **Ontario**, the provision of timely home care services for patients who have hip and knee replacements improves system efficiency and reduces wait times, an important part of the government's strategy to transform health care.

- **Alberta** is accelerating discharge from the emergency department (for seniors and disabled adults) through the 'ED2Home' program that provides enhanced home care services to keep seniors safe, healthy and independent in their homes and to reduce the number of avoidable emergency department visits.

All jurisdictions use standardized assessment tools to determine client needs prior to the initiation of service. Seven locations use the Resident Assessment Instrument-Home Care (RAI-HC), a standardized, multi-dimensional assessment system used to assess frail elderly individuals or persons with disabilities to identify issues related to functioning and quality of life. The electronic assessments provide real-time data for frontline clinical decisions, as well as amalgamated data to support system management, quality improvement and policy- making.

ELIGIBILITY AND SERVICE GUIDELINES

Home care services are available to residents that hold a valid health card (or, in some cases, are in the process of obtaining a card) within each jurisdiction. Individuals of all ages are eligible to receive services, based on assessed need, in accordance with guidelines developed by each jurisdiction and enforced through the administration organization. Guidelines can include maximum limits of professional services (visits), or maximum hours of home support services or in some provinces (Saskatchewan, Manitoba, Quebec, New Brunswick EMP and Yukon) the equivalent cost of care in an institutional setting. Exemptions from service limits are for individuals waiting for long-term care placement or individuals requiring end-of-life (palliative) care. The federally funded programs also have guidelines and eligibility criteria in accordance with their mandates.

SUPPLIES AND MEDICATIONS

There is wide variation in the eligibility criteria to access publicly funded medications and supplies in the home setting. Provinces and territories have insured drug benefits plans and other financial assistance programs for seniors and low-income earners. Palliative care supplies and medications are covered by the public system, but the duration of coverage varies depending upon the jurisdiction's criteria for end-of-life. Supplies and medications for acute care services are paid for by the public system, although the duration of coverage varies from a minimum of two weeks, to as long as the care plan requires.

CO-PAYMENTS AND INCOME TESTING

Nine jurisdictions (Manitoba, Ontario, Nunavut, Northwest Territories, Yukon, FNIHB, DVA, DND and RCMP) have no co-payments or income testing for all home care services. In the other eight jurisdictions:

- Professional services (nursing, therapy, case management) have no co-payment or income testing.
- Personal care and home support services have co-payments and income testing, and may be capped at a maximum. Exceptions include personal care services for acute care (two weeks) and palliative care, which are provided at no charge and Quebec does not charge for personal support or homemaking if they are designated within the nursing care plan.

SETTING OF CARE

Home care services are provided in a variety of settings including an individual's home, retirement homes or supporting living environments, group homes, ambulatory clinics, an individual's place of work, schools , hospices, adult day programs and in shelters or on the street (for the homeless). In some cases, the types of services depend upon the location of care. Integrated models of care maximize community resources and increase the efficiency and effectiveness of care across multiple settings. Some examples of innovative models across Canada include:

- **British Columbia** uses a model of integrated primary and community care targeted to high needs patients, including frail seniors and patients with chronic disease and life-limiting illnesses.

- **Ontario's** Integrated Client Care Project (ICCP) is a new and evolving way for Community Care Access Centre case managers and contract service providers to work together using alternate reimbursement models based on outcomes and promoting innovation.

- **Quebec** is building a network of integrated services for seniors losing their autonomy (Réseau de services intégrés aux personnes âgées - RSIPA) to ensure continuity of care for clients with complex needs.

- **Nova Scotia** is creating a seamless, client-centred integrated community-based system of care that includes new approaches to minimizing service disruptions during setting transitions.

- **Prince Edward Island's** Collaborative Model of Care (CMoC) is a new approach to care that is designed to address staffing challenges while meeting the increasing demands for health care services.

FUNDING

Portraits of Home Care in Canada 2013, includes information on public expenditures for home care services by the provincial/territorial ministries in addition to the four federally funded home care programs (FNIHB, DVA, DNA and RCMP). Direct comparisons of home care expenditure data should not be made as there is not consistency in what is included in the 'home care' expenditures across jurisdictions (inclusion of administration, direct service, special funding, etc).

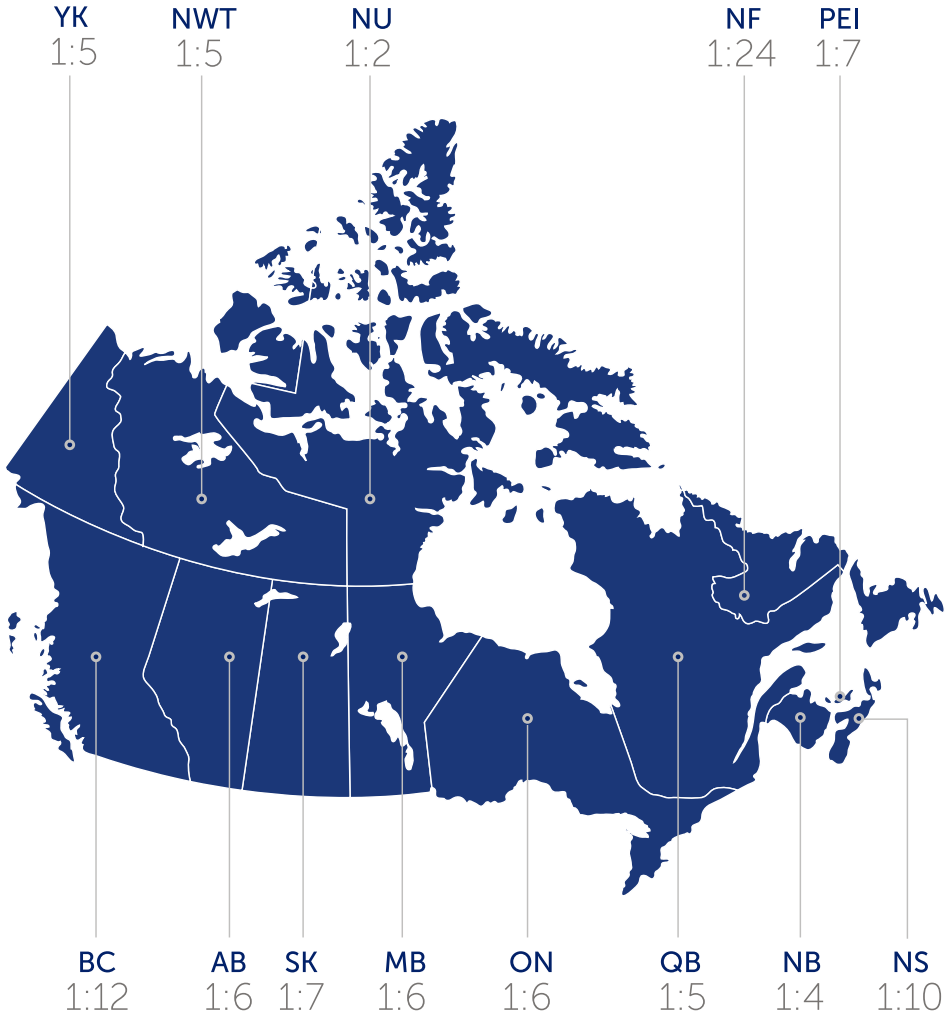
In 2010/11, $5.9 billion dollars was spent on home care services through the provincial, territorial and federally funded home care programs, with the provincial/territorial programs accounting for 92 percent of the funding. The $5.9 billion does not include monies paid privately on home care services (either through individuals payments, co-payments, or private insurance), which is not currently tracked by jurisdictions.

As a percentage of total provincial/territorial public health expenditures, home care spending in 2010/11 accounted for 4.1 percent, with variation across the country from 6.4 percent in New Brunswick and 5.8 percent in Manitoba to 2.4 percent in Alberta and 1.8 percent in the Northwest Territories.

Per capita spending on home care varies among provinces and territories ranging from $266.00 in Newfoundland to $150.00 in Ontario and $90.00 in PEI, with an average spending of $150.00. There are numerous causes for the variation in home care expenditures across the country including, service eligibility and limits, remuneration of home care workers, administration costs, delivery (balance between institutional versus community-based services), geography and travel costs, population density, population health needs and age.

The majority of home care services are provided to seniors. On average 61 percent of home care clients are aged 65 plus. In Nunavut and the Northwest Territories, the percentage of seniors receiving home care is much lower at 44 and 50 percent respectively. The ratio of seniors receiving home care and the differences among jurisdictions provide interesting statistics that require further exploration.

Ratio of Seniors Receiving Home Care by Province / Territory (2011)



RANGE OF SERVICES

All jurisdictions publicly administer home care services. Service delivery models vary across the country through public sector and/or contracts with the private sector providers. Most jurisdictions deliver professional services (nursing, therapy) through public sector employees and personal care/homemaking through contracts with private providers. The exception is Ontario who contracts a wide range of services (nursing, therapy, personal support and homemaking, supplies and equipment) to private providers.

All home care programs provide case management or care coordination through public sector employees. Case management is a collaborative, client-driven process for the provision of quality health and support services through the effective and efficient use of resources. Case management supports the client's achievement of safe, realistic, and reasonable goals within a complex health, social, and fiscal environment. Alberta and Nova Scotia have identified case management as a priority area and are working to enhance access, coordination and integration of services across the continuum of care.

All jurisdictions provide nursing and home support (personal care), but vary widely in the provision of therapy services. Some programs include all therapies (physiotherapy, occupational therapy, speech language pathology and respiratory therapy, dieticians, social workers), while others provide only select therapies, or on a limited/ per case basis or not at all. The disparity in access to therapy services in the home raises potential concerns. Therapists' interventions are effective at increasing independence, decreasing risk of health deterioration, improving health management, and decreasing loss of autonomy and function.

Housekeeping or homemaking services generally include tasks that are required to maintain a safe and supportive environment for a client, such as cleaning, laundry and meal preparation, and by exception, transportation, banking, or shopping. These tasks are essential to supporting older people's independence and defer the need for complex medical care. Home care programs across the country vary in the range of, and access to, these services.

- **Quebec** provides a wide range of support services including civic support activities (help with administering budgets and filling in forms), learning assistance, and other household supports.

- The **Veterans Independence Program** (VIP) covers a broad range of supportive services that include grounds-keeping, social transportation and home adaptations to facilitate access/mobility in the home.

- **British Columbia's** Choice in Supports for Independent Living (CSIL) is a self-managed model of care that provided direct funds for 846 clients in 2009/10 to purchase home support services.

- **Manitoba's** Self/Family Managed Care enables consumers/designated family members to maintain an independent, community living lifestyle by coordinating, managing, and directing their own home support/homemaking services.

- **Saskatchewan's** Individualized Funding (IF) program provides funding directly to a person (or their guardian) to arrange and manage their own support services.

Quality & Accountability

This section of Portraits of Home Care 2013 collected data on the status of accreditation and the use of quality measures that promote excellence in the provision of services and efficient use of resources. The information contained in this section is more expansive than in our last report on home care in 2008, a clear indication that jurisdictions across Canada are embracing quality improvement methods as a measure to provide better care and better outcomes at a better cost.

DATA COLLECTION AND REPORTING

Jurisdictions are implementing processes to measure, monitor and improve the quality of services, and are reporting on indicators that affect client care and systems efficiency. A challenge that many provinces and territories face is sharing information across the system, between direct providers, health authorities and the Ministry. There are currently many limitations in the availability of data and disparities in the capacity to collect and report on home care indicators across the country. The number of metrics reported by jurisdictions ranges from 11 in New Brunswick and 10 in Ontario to 3 in Northwest Territories and 2 in Newfoundland. Currently, jurisdictions track 3 common measurements:

- Amount of service delivered through home care (visits, hours, etc)
- Expenditures on home care
- Number of home care admissions

The need for data collection, analysis and reporting (locally, regionally and provincially) has challenged many jurisdictions to implement new infrastructures and develop new competencies. The Information Technology section of Portraits of Home Care 2013 includes some approaches taken by different regions to address this challenge.

ACCREDITATION

Organizations in Canada are accredited through Accreditation Canada, CARF, the Quebec Council of Accreditation (Quebec only) and/or registered with the International Standards Association (ISO). The majority of health authorities, and administrative organizations that administer and deliver home care are accredited or in the process of being accredited. Most jurisdictions state that accreditation is either mandatory or a clear expectation of operational requirements. Alberta, and Ontario have introduced mandatory accreditation, through a recognized accreditation body, for any provider of publicly funded home care services. In regards to the federally funded programs, 58 First Nations and Inuit communities have received accreditation through Accreditation Canada (as of January 2012), and the Canadian Armed Forces Health Services (Department of National Defence) is accredited.

QUALITY COUNCILS & SYSTEM APPROACHES TO QUALITY

New additions to the quality and accountability chapter in Portraits of Home Care 2013 include information on quality councils, patient safety, systems approaches to quality, and research.

British Columbia, Alberta, Sasktachewan, Ontario, New Brunswick, Nova Scotia, and PEI have established quality councils. The councils provide a provincial perspective on quality and safety issues and support the Ministry, health authorities and other stakeholders in planning, process improvement and capacity building. Details on each council are included in the specific chapters.

A number of jursidictions shared innovative practices about their system-wide approaches to continuous quality that included the home care sector as a critical component.

- The **BC Leadership Council** (comprised of health authority CEOs, the Deputy Minister of Health and Ministry of Health Executives) committed to using "Lean" methodology for continuous improvement. Throughout 2010/11 health authorities have completed more than 125 "Lean" events, many of which included home and continuing care.

- The **Saskatchewan** Ministry of Health committed to achieving system-wide performance improvement and a culture of quality through the adoption of "Lean" and other quality improvement methodologies. Specific strategies focus on making improvements to the health of the population, individual care and financial sustainability in the context of value. A fourth Aim will strengthen the health care workforce.

- **Ontario's** Excellent Care for All Act (2010) requires that health care organizations provide a copy of their annual quality improvement plan to Health Quality Ontario in order to allow a province-wide comparison of, and reporting on, a minimum set of quality indicators. The requirements, implemented in the acute care sector, will be expanded across all health care sectors including home care.

- **Northwest Territories** is publicly reporting on the health system priorities outlined in the 2009-12 'A Foundation for Change' through a balanced scorecard.

- **First Nations and Inuit Health Branch** introduced a Quality Resource Kit for FNIHCC programs, communities and health care organizations to enhance knowledge and skills in continuous quality improvement.

SAFETY

Ensuring a safe environment for the client, family caregiver and home care worker is a priority for all home care programs across the country. In most jurisdictions, safety is the responsibility of the health authority and service providers, so data is not amalgamated province wide. Even though most programs are local in nature, jurisdictions described a number of wide reaching approaches to patient safety currently underway.

- The **Manitoba** Institute for Patient Safety (MIPS), created in 2004, promotes, coordinates and facilitates activities that have a positive impact on patient safety throughout Manitoba.

- **Newfoundland** is implementing a comprehensive, electronic occurrence reporting system to support effective adverse event management, increase compliance and make occurrence reporting more efficient, and raise awareness of and commitment to a patient safety culture.

- The **Department of National Defence** program 'Creating a Patient Safety Culture in the Canadian Forces', continues to be successful in encouraging the reporting and follow up of patient safety incidents across the system.

RESEARCH

Knowledge, grounded in evidence, must form the basis of effective and efficient care provision, resource allocation, innovation and policy development. Jurisdictions clearly support this sentiment as nine provinces and one territory reported having access to institutions that conduct research on a variety of topics that influence home care including population-based health services, best practices in caring for seniors and healthy aging, dementia and frailty in the elderly, and caregiving issues.

The BC Home and Community Care Research Network was formed to create capacity for conducting health services research in the field of seniors and community care, and has three main objectives: capacity building, high quality research and knowledge translation.

The Ontario Home Care Research and Knowledge Exchange Chair, established by the Ministry in 2007, provides effective communication, coordination and evaluation to support the uptake of home care research.

Information Technology

Portraits of Home Care 2013 includes an expanded section on information technology, reflective of the importance of technology and innovation to the home care sector and health care in general. Jurisdictions provided information on their progress on implementing the electronic health record and their plans to integrate home care, their use of technology to systems efficiency and accountability, and the applications of technology to provide client care and support independence at home.

ELECTRONIC HEALTH RECORD

The majority of jurisdictions have not integrated home care into the electronic health record. The focus of activities is concentrated on acute care and development of an electronic health record for patient care related to admission to hospitals, diagnostic testing, pharmacy, with primary care a recent addition. British Columbia, Nova Scotia and PEI indicated that home care is planned for the next phase of integration.

SYSTEM TECHNOLOGY

The progress on implementing technology to support system efficiencies and accountability varies widely across the country. Some provinces have made system-wide strategic investments and approaches to technology; other jurisdictions are in the planning stages and using technology to support financial reporting only, and some are still using manual systems.

There has been progress from 2008, when technology was first introduced to the Portraits of Home Care reports, but there is still much work that needs to be done to leverage technology and realize systems efficiencies and quality gains. Only four of the seventeen jurisdictions identified significant investments in technology to support home care system efficiencies.

- Health authorities in **Saskatchewan** use the Home Care Administration System to facilitate information sharing across the continuum of care and support home care business functions. Future plans include electronic interface to other departmental systems, the Clinical Viewer system and the provincial home care assessments repository.

- **Ontario** has a province wide electronic home care record through the Client Health and Related Information System (CHRIS). This core client management system includes a web- based application that facilitates access from multiple locations, supports home care business functions and provides a single data repository.

- The electronic home care record in the **Yukon** is used to share referral and clinical information between front line staff and follows the client from home care, respite care and residential care.

- The **Veteran Independence Program** uses an electronic case record system that incorporates client assessment and case planning tools.

TECHNOLOGY TO SUPPORT DIRECT CLIENT CARE

All jurisdictions (except RCMP and DND) are using telehealth for education, communication and monitoring, especially in rural and remote locations where geography and distance pose barriers to home care. Telehealth is used for a wide range of services including palliative care, wound care, pre-and post-operative care, chronic care and rehabilitation. Alberta has funded the 'Continuing Care Technology Innovation (CCTI) Pilot Project', a two-year initiative that will assess the efficacy of technologies to assist people to remain at home.

Health Human Resources

Recognizing the health human resources challenge facing the home care sector, Portraits of Home Care 2013 included an enhanced section in each jurisdicational chapter describing the current status (if available), activities to support human resource planning, training and education, interdisciplinary teams, and strategies to support the vital role of the family caregiver.

Human resource management (tracking, planning, recruitment, retention, work-life issues and compensation) are the reponsibility of the service provider (often the health authority or other adminstrative body). When services are contracted to private providers these responsiblities are assumed by each organization. Comprehensive human resource planning that spans across the jurisdiction and includes other parts of the health care sector has been undertaken in British Columbia, Alberta, Sasktachwan, Ontario, Nova Scotia and Nunavut.

- In **British Columbia**, health partners are working with the Ministry of Health, Ministry of Advanced Education, and Ministry of Jobs Tourism and Innovation, to provide education and training opportunities for health care providers.

- **Alberta** has developed a province-wide, multi-sectoral group action plan that includes nineteen key initiatives and recommendations to address the health human resource challenge.

- **Saskatchewan's** vision and plan for health human resources, led by the Saskatchewan Cancer Agency in collaboration with educational institutes, and other health organizations, works to develop and maintain an optimum supply and mix of care providers.

- **HealthForceOntario** is the province's strategy to ensure that Ontarians have access to the right number and mix of qualified health care providers, now and in the future.

- The **Nova Scotia** Department of Health and Wellness has developed a comprehensive human resource strategy with short and long term strategies to address continuing care staff shortages.

A broad range of health care professionals are involved in the delivery of home care services. Physicians play an active role in home care, particularly in chronic disease management, palliative care, acute care, rehabilitation, and complex care. Pharmacists provide community-based home care teams with information and tools to identify and resolve medication problems. Numerous health care professionals are directly involved in providing home care including nurses, physiotherapists, occupational therapists, dieticians, respiratory therapists, speech language pathologists, and social workers.

The majority of personnel employed in the home care sector are personal support workers who provide approximately 70 percent of home care services (i.e. support for the activities of daily living). Across the country, the titles used for the personal support worker vary from health care assistant, health care aide, home care aide, continuing care assistant and home support worker. The personal support worker is not a regulated health care profession so jurisdictions set educational (content, length, duration) and certification standards for new entries into the field (these are described in more detail in each chapter). British Columbia, Ontario and Nova Scotia have provincial registries for personal support workers and Alberta is creating a provincial directory to assist in monitoring and tracking health care aides who meet standard requirements. Registries are a relatively new initiative for the provinces and have been implemented to meet a variety of needs.

- The **B.C. Care Aide and Community Health Worker Registry** became operational on January 29, 2010 with the intent to protect vulnerable clients, establish and improve standards of care and promote professional development.

- On June 1, 2012, the **Ontario** Government launched the personal support workers registry to recognize their work and help to better meet the needs of the people for whom they care.

- In 2010, **Nova Scotia** established a voluntary registry for continuing care assistants to identify staff, track education requirements, provide a venue for communicaton and gather input for future human resource planning.

FAMILY CAREGIVERS

Family caregivers provide care and assistance for spouses, children, parents and other extended family members and friends who are in need of support because of age, disabling medical conditions, chronic injury, long-term illness or disability. A family caregiver's effort, understanding and compassion enable care recipients to live with dignity and to participate more fully in society [Canadian Caregiver Coalition, 2008].

The Canadian Caregiver Coalition estimates that there are over 5 million family caregivers. For the family caregiver, home care is a vital service. Home care supplements, rather than replaces, the role of family and friends in the provision of care in the community and family caregivers are expected to provide as much support as is reasonable in their individual situations. The majority of home care programs recognize family caregivers in their policies and provide a variety of supports targeted to these indivdiuals. Currently, Manitoba is the only jurisdiction that has legslation specific to the family caregiver, **Bill 42 The Caregiver Recognition Act** (June 2011).

ASSESSMENT & RESPITE

Most jursidictions use a formal assessment tool to determine caregiver needs and identify the types of support they require. Assessment tools include the RAI-HC, the C.A.R.E. tool, and the caregiver strain questionnaire. The **Veteran Independence Program** is piloting the C.A.R.E. Tool and has recently modified their nursing assessment instrument to gather specific information about the capacity of caregivers to continue to assume that role, and to heighten awareness of the impact of caregiver issues.

All programs provide in-home respite services to give caregivers a break from their caring duties and a large portion of programs also provide facility-based respite and adult day programs to enable caregivers to take extended time away.

INFORMATION & SUPPORT PROGRAMS

Information for cargivers is also vital in supporting their role, and a number of provinces have invested in community-based programs to provide valuable education, coaching and networking for caregivers.

- **British Columbia** hosts a web resource through the Ministry of Health that provides caregiver self-assessment and a range of support tools, in addition to funding the BC Alzheimer Society's First Link Program.

- **Alberta** plans to increase and enhance education and support services for caregivers under their 'Community Initiatives Program'.

- In 2009, **Quebec** created a caregivers' support fund of $200M over ten years to build regional support structures and development of caregiver programs.

- **Newfoundland's** 2011-12 budget allotted $60,000 to develop and deliver caregiver education and training sessions across the province.

FINANCIAL MEASURES

Caregivers bear substantial costs — economic, social, physical and psychological. They are likely to incur out-of-pocket expenses and significant lifetime income losses. Of all the jurisdictions, only Nova Scotia and Manitoba provide additional financial supports for caregivers.

- **Manitoba** funds a Primary Caregiver Tax Credit (PCG-TC), a non-income tested and fully refundable tax credit for family caregivers based on assessed level of care of the home care client.

- **Nova Scotia** funds a Caregiver Benefit Program that provides $400 per month to a family member or friend to assist the caregiver in sustaining the support they provide to qualified care recipients residing in the community.

Initiatives

Provincial, territorial and federal home care programs are undertaking many transformational initiatives to meet the increasing need for community-based integrated health care. A detailed list of the initatives is included in each chapter and a sampling of some of the unique initiatives is described below.

HOME CARE EXPANSION & FUNDING STRATEGIES

- The Government of **Alberta** dedicated $25 million in the 2012 budget to enhance the provincial home care program and provide increased services to Alberta seniors and home care clients.

- **Ontario's** Action Plan for Health Care articulates a vision to provide a greater focus on home and community care to build a stronger continuum of care and shift the delivery focus from acute and residential care to home and community care.

- **Quebec** announced additional investments of $40 million for home care services and $5 million for PEFSAD.

- **First Nations and Inuit Health Branch** in collaboration with the Assembly of First Nations and Inuit Tamiriit Kanatami are developing a 10-year strategic plan for the First Nations and Inuit Home and Community Care program.

- As part of the departmental transformation agenda, **Veteran Affairs Canada** is undergoing a review of its health services to ensure continued relevance and efficacy.

- Modernization efforts of the **RCMP** health care services and programs are underway.

SENIORS, AGING IN PLACE & HOME CARE

- **British Columbia's** Seniors Action Plan includes facilitating access to home and community care, and building a modern and sustainable home and community care system as two key actions.

- In **Saskatchewan** supporting seniors to safely age at home and progress to other care options as their needs change is one of the priority target areas in the Saskatchewan Ministry of Health's plan.

- **Manitoba** is supporting seniors to remain independent in their homes through increased home support and rehabilitation services, in addition to a refresh of the Manitoba Long Term Care/Aging in Place Strategy.

- **Ontario's** Aging at Home strategy supports seniors to remain idependent in their communities through expanded alternative options for care, specialized assessments and intervention in long-term care homes, the Home at Last/Home First program, and the Assisted Living for High Risk Seniors Policy.

- **Quebec** released a multi-ministry policy 'Vieillir et vivre ensemble, chez soi, dans sa communauté, au Québec', in 2012, to guide the development of services for the elderly, with home care as a cornerstone.

- **New Brunswick** has introduced a revised Long-Term Care Generic Assessment tool to assist health professionals in determining the most appropriate care options for seniors in need.

- **Nova Scotia** is investing in 'positive personal health practices' to address frailty in an aging population and focus on community-based care.

- **Prince Edward Island** has launched a Healthy Aging Strategy that encompasses five areas of activity including enhancing access to palliative drugs in the home and greater investment in home care.

- **Newfoundland** is improving access to therapy services and assistive devices to support seniors' independent living, and supporting an increased understanding of Alzheimer's disease and other dementias through training and research.

CHRONIC DISEASE MANAGEMENT & HOME CARE

- **British Columbia** has developed a secure, web-based application that enables health care providers to access patient registries and a Chronic Disease Management (CDM) Toolkit.

- **Alberta** is developing and implementing a provincial chronic disease management strategy with the goal to improve self-management and decrease hospital admissions relating to diabetes and other chronic diseases.

- **Saskatchewan** continues to execute their Provincial Diabetes Plan to reduce barriers to optimal diabetes care and prevention, with ongoing funding (including home care) to support prevention, education, treatment and surveillance.

- **New Brunswick's** 2010 Chronic Disease Prevention and Management Framework leverages existing technologies to support patient self-management at home.

- **Prince Edward Island** is targeting chronic obstructive pulmonary disease (COPD) and exploring how home care can implement and support the pathway.

Home care plays a vital role in chronic disease management.

- Access to a wide range of community-based services.
- Support health promotion and illness prevention strategies.
- Partner in team based care with shared accountability.

(National Home Care and Primary Health Care Partnership Project, Canadian Home Care Association, 2006)

END-OF-LIFE CARE (PALLIATIVE CARE)

- **Ontario** is investing an additional $7 million for residential hospices to provide nursing and personal support services in support of the 'Declaration of Partnership and Commitment to Action', a shared vision and goal to achieve immediate and long term improvements in palliative care delivery.

- **New Brunswick** is developing a Provincial Palliative Care Strategy that will address the continuum of care setting - home, hospitals, residential and long-term care facilities.

- **Nova Scotia's** Department of Health and Wellness is developing a comprehensive provincial palliative care program that will include strategies for enhancing home care services, coordination across multiple care settings, access to medications and specialized resources.

- **Prince Edward Island's** Integrated Palliative Care Program continues to be a priority across the province to ensure access to palliative specialists, respite, and psychosocial support during and after the death of a loved one.

PRIMARY HEALTH CARE & HOME CARE

- In **British Columbia**, the Integrated Primary and Community Care, a foundation for their vision of health care delivery, integrates primary and community care and partners with patients and communities to improve health outcomes, increase satisfaction and achieve a sustainable health care system.

- **Saskatchewan** is responding to the 'Patient First Review' by transforming and strengthening primary health care services (including home care, end-of-life care, and therapy services) across the province.

- **Manitoba** is testing the "virtual ward" concept of linking service providers for a select group of high users of health care services.

- **Ontario** has created strong linkages between home care and primary health care as evidenced in the Ontario Diabetes Strategy (ODS) and Health Care Connect.

- The **Department of National Defence's** Primary Care Renewal Initiative 'Rx2000' resulted in a successful case management program.

Challenges

AN AGING POPULATION & INCREASED DEMAND

All jurisdictions across Canada identified the impact of our aging population as a major challenge to the home care sector, and the health care system. Seniors are the largest users of home care services in Canada. In 2011, one in every six seniors (aged 65 plus) received home care services.

Projections by Statistics Canada indicate that, in 2011, an estimated 5 million Canadians were 65 years of age or older (14 percent of the population), a number that is expected to double in the next 25 years to reach 10.4 million seniors by 2036 (23 percent of the population). Nova Scotia had the highest percentage of seniors (16.5 percent in 2011) and by 2036 it is expected that the four Atlantic Provinces will have the highest proportion of seniors. [Statistics Canada, 2011]

Frail older adults require continuing care across a broader range of health care services for a wider array of health conditions. According to Statistics Canada, 33 percent of Canadians aged 65 plus and 56 percent aged 75 plus, reported having a disability. The top three distresses resulting from their disability were lack of mobility, pain, and reduced agility. Statistics Canada has stated, "the need for home care services in Canada can be expected to increase in the coming years. As the number of elderly people in the population grows, so will the prevalence of age-related chronic conditions that may jeopardize an individual's ability to live independently in the community." [Statistics Canada, 2011]

Physical frailty is not the only challenge facing our aging population and the home care sector. According to the Alzheimer's Society of Canada, in their 2010 report 'Rising Tide: The Impact of Dementia on Canadian Society', by 2038 68 percent of Canadians 65 plus (approximately 500,000) with dementia will be living in their own homes – almost triple the current number.

These challenges will be faced by all jurisdictions and will have a major impact on home care programs over the next decade and more. Home care supports seniors to live safely and independently in their own homes and plays a key role in aging in place strategies, in reducing hospital readmissions and repeat emergency department visits, in reducing ALC days and ER wait times, in managing chronic diseases and in ensuring quality end-of-life care.

According to Canadians, the top three changes suggested to combat age discrimination are:

- Invest in technologies that can help older people live independently for longer.
- Raise awareness about ageism so that it is as socially unacceptable as other 'isms', like sexism and racism.
- Provide more government funding of healthcare solutions that address the specific needs of an aging population.

(Revera Report on Ageism, November 2012)

CURRENT CAPACITY & LIMITED RESOURCES

Ten of the seventeen jurisdictions identified balancing increased demand with limited capacity and resources as a critical challenge. Specific concerns included:

- Demand of care is out pacing resources and funding
- Escalating costs due to increased acuity of clients
- Increasing public expectations for home care services
- Ensuring equitable services across jurisdictions and geography
- Maintaining the supportive/preventive elements of home care within current cost-cutting environments

Governments have stated their commitment to shifting care to the home and community:

Residents will have the majority of their health needs met by health quality community-based health care and support services (British Columbia)

Recommendations to pursue policy opportunities in primary care, continuing care and mental health (Alberta)

By 2017 seniors will have access to supports that will allow them to age within their own home and progress into other care options as their needs change (Saskatchewan)

Strategies that will transform the health care system to one that is proactive and emphasizes care in the community (Ontario)

Policy to allow seniors to remain in their homes and communities for as long as possible (Quebec)

Recognition of home care as an essential component of the vision of One Island Health System (Prince Edward Island)

Revitalize and strengthen community and long-term care services throughout the province (Newfoundland & Labrador)

Ensuring people have the majority of their health and social needs met by high quality, community-based support and care (Northwest Territories)

Funding and resources must be available for the home care sector to meet these expectations and contribute to a sustainable health care system. Governments have made verbal commitments to the home care sector, but the percentage of total public health care spending on home care has not increased but remained static and, in some cases, decreased. The challenge of managing increased demands with decreased resources will continue to limit the potential of home care across the country and increase the gap of unmet needs for aging Canadians.

LIMITED SUPPLY OF HUMAN RESOURCES

The Final report of the 2003 Canadian Home Care Human Resources Study, a two-year study that explored the human resources issues related to home care, included ten recommendations and over 65 strategies to address this growing challenge. The recommendations ranged from building awareness of the home care sector, to organizational changes, funding, recruitment and retention, education, technology and supporting the vital role of the family caregiver and volunteer. Ten years, after the release of this report, human resources remains a number one challenge.

All provinces, territories and three of the federally funded programs expressed concerns about the availability and supply of human resources (both unregulated and regulated workers), the challenges of education and skills development to meet increasing client acuity, and the challenge of retention given an aging workforce. Geographical issues in rural and remote areas exacerbate these challenges, as identified by Saskatchewan, Manitoba and the territorial programs, whose northern regions have vast distances and a limited supply of adequately trained human resources.

Human resource planning in the home care sector must also consider the role of the family caregiver who provides the majority of support for clients in their homes. Identified by four jurisdictions as a distinct challenge, the availability of caregivers will continue to decrease as families today are smaller, more dispersed, and baby-boomer are working longer and delaying retirement. Addressing the complex challenges in health human resources is not a simple task (as seen in the numerous recommendations and strategies contained in the Canadian Home Care Human Resource Sector Study report). However, many jurisdictions have implemented innovative and promising practices, as outlined in the Human Resource section of each chapter in Portraits of Home Care 2013.

A Framework for Collaborative Pan-Canadian Health Human Resources Planning, an action plan with short, medium and long-term objectives in the following areas:

- Planning for the optimal number, mix and distribution of health care providers.
- Working closely with employers and the education system to develop a health workforce that has the skills and competencies to provide safe high quality care, work in innovative environments, and respond to changing health care system and population health needs.
- Achieving the appropriate mix of health care providers and deploy them in service delivery models that make full use of their skills.
- Building and maintaining a sustainable workforce in healthy safe work environments.

(A Framework for Collaborative Pan-Canadian Health Human Resources Planning, Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources September, 2005, Revised March 2007)

MANAGING NEW TECHNOLOGY & INNOVATION

Technological and innovation advancements have opened up new options for care delivery. Today's innovations enable the integration of monitoring and therapeutic systems, provide educational content, and facilitate communication and data flow between members of the health care team. Innovations in medication delivery systems and mobile, user-friendly applications have enabled care to be provided safely and effectively in the home. The introduction of new technologies and diagnostic and therapeutic procedures presents enormous opportunities for a transformative shift in the way we think about and deliver health care. Greater involvement and inclusion of individuals in self-care, reductions in hospitalizations and emergency room use, elimination of medical errors and creation of safe supportive environments will enable the right care in the right place by the right person.

A clear expectation of implementing technology and innovation is that the outcome will be more cost effective and care effective. In order to achieve this, technological and innovative changes must be integrated into operational processes without undue disruptive change or prohibitive cost. The challenge of achieving this was identified by six jurisdictions who voiced concerns about the cost and impact of technology on staff training, process redesign given limited time, and shrinking budgets. Provinces, territories and the federally funded home care programs are addressing many of these challenges and realizing the benefits and efficiencies that technology and innovation can create. Descriptions of promising practices in Ontario, Saskatchewan, Alberta, New Brunswick and First Nations and Inuit Home and Community Care are included in the specific chapters in Portraits of Home Care 2013.

Meeting the Technology Challenge

New and emerging technologies pose three major challenges for decision makers:

The first is **awareness and assessment of technology-based innovations**.

- How do decision makers learn about what is technologically possible?
- What technology works in their respective organizational, spatial and jurisdictional contexts?

The second is **scalability**.

- If a pilot initiative is successful, how will it be generalized beyond the pilot site(s)?
- What technologies should be adopted, knowing that there are and will be many products to choose from in the marketplace?

Third is **sustainability**.

- What funds and resources will support the longer term roll-out of innovations across a system?

(A Vision for Technology in Home Care, Canadian Home Care Association, 2013)

An Opportunity to Realize a Vision

Our approach to health and wellness has dramatically changed over the last decade and will continue to evolve as our population ages, new technology and innovations open up possibilities, and societal expectations are for both quality of life and longevity. The strategic decisions we make, the legislation and policies we create, the targets and goals we strive for, and the people we nurture, will shape the future of our health care system and our country.

Securing Canada's system of universal health care involves embracing a new paradigm. We must embrace and fund new approaches to health care delivery that shift care away from an episodic, acute care model and support long-term chronic care in the community through:

- Adoption of harmonized principles for home care that will reinforce a vision and set a foundation for the identification of common indicators and sharing of best practices.
- Introduction of fiscal policies and planning to ensure adequate resources.
- Integration of home care and primary health care.
- Application of new technologies and knowledge to support data collection, analysis and reporting that ensure accountability and evidence-based decision-making.
- Development of human resources strategies that recognize the vital role of family caregivers in the provision of home and health care.

The advances observed over the past ten years since the release of our first Portraits of Home Care in Canada, in 2003, have reinforced the realization that we can achieve our vision of an integrated health system that provides accessible, responsive services that enable people to safely stay in their homes with dignity, independence and quality of life. Provinces, territories and the federally funded programs are making great strides, but more must be done.

The strategic decisions we make, the legislation and policies we create, the targets and goals we strive for, and the people we nurture, will shape the future of our health care system and our country.

Harmonized Principles for Home Care

Guide policy and program development

Support consistency and equity across the country

Facilitate benchmarking and sharing of best practices

CLIENT AND FAMILY-CENTRED CARE

Clients and their family caregivers are at the centre of care provided in their home.

Dignity: Respect and value client and caregiver self-worth.

Holistic: Uphold all aspects of client and caregiver needs; psychosocial, physical and spiritual.

Independence: Foster autonomy and self-sufficiency.

Informed choice: Clear understanding of the facts, implications, and consequences of decisions and actions.

Positive partnership: Acknowledge unique strengths and engage client and family as partners in care.

Safety: Minimize and manage risk.

Self-Determination: Encourage, support and enable self-care.

ACCESSIBLE CARE

Canadians have equitable, appropriate, consistent access to home care, and are fully informed of the care and service options available to them.

Appropriate: Provide care that is needed and ensure the need for care.

Consistent: Reliable care among providers and across jurisdictions and geographies.

Comprehensible: Ensure understanding of services and options available.

Equitable: Create fair and unbiased access within and across jurisdictions and geographies.

ACCOUNTABLE CARE

Home care is accountable to clients and their caregivers, providers, and the health care system for the provision and ongoing improvement of quality care.

Transparency: Report on performance metrics and outcomes to inform the public on the quality of care.

Quality: Monitor performance indicators to support continuous improvement.

Value: Demonstrate value to clients and their caregivers, providers and the health system.

EVIDENCE-BASED CARE

Knowledge that is grounded in evidence is used as the foundation for effective and efficient care provision, resource allocation and innovation.

Evidence-Informed: Decision-making incorporates the best available evidence, expertise and experience.

Knowledge Transfer: Share ideas and information with clients, family caregivers, providers and planners.

Innovation: Support a culture of innovation and ingenuity.

Research: Promote awareness and application of research evidence to inform decisions.

INTEGRATED CARE

Home care facilitates the integration of care across the continuum of health care and with community and social services; care is complementary, coordinated and seamless with a focus on continuity for the client.

Continuity: Foster collaboration and communication to ensure seamless care transitions.

Coordination: Reduce disparities through care coordination.

Individualized: Customize care to the unique needs of clients and their families.

Prepared: Enable timely access to information and resources.

SUSTAINABLE CARE

Home care contributes to the sustainability of an integrated health system by increasing efficiencies and delivering cost effective care.

Health and Well-being: Focus on health promotion, disease prevention and management, and quality of life.

Needs Based Planning: Establish policies and programs on current and future needs and trends.

Optimum Effectiveness: Integrated resources planning across client populations and care settings.

BRITISH COLUMBIA

HOME CARE IN **BRITISH COLUMBIA**

Home Care in British Columbia is consistent with the Canadian Home Care Association definition.

Home care is an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the family caregiver.

Additionally, home care services are defined as "home health services" and include: case management, home support services, community nursing services, community rehabilitation services and adult day services. Home and Community Care services provide a range of health care and support services for eligible residents with a frailty or with acute, chronic, palliative or rehabilitative health care needs. These services are designed to complement and supplement, but not replace, the efforts of individuals to care for themselves with the assistance of family, friends and community.

BRITISH COLUMBIA

BY THE NUMBERS...

925,286 sq km **LAND AREA**	4,573,300[1] POPULATION (2011)	**85%**[3] Percent population in urban settings defined as an area with a population of at least 1,000 and with no fewer than 400 persons per square kilometre (2006)	
57.6[2] Dependency ratio (2009) Ratio of the population aged 0-19 and 65+ to the population aged 20-64	15.3%[1] **Population Seniors 65+ yrs** (2011)	81.4 years[1] **LIFE EXPECTANCY (AT BIRTH)**	**$3,886.60**[2] Public sector health care expenditure per capita (2011 Forecast)

[1]Statistics Canada | [2] Canadian Institute for Health Information (CIHI) | [3]Human Resources and Skills Development Canada

1. Governance & Organization

HEALTH CARE SYSTEM STRUCTURE

The **British Columbia Minister of Health**'s mandate is to guide and enhance the province's health services to ensure British Columbians are supported in their efforts to maintain and improve their health. The Ministry funds, monitors and evaluates the health system performance against clearly stated expectations. This oversight includes the funding, direction and evaluation of regional health authorities, in addition to the direct funding and operational responsibility for Pharmacare (prescription drug insurance), and Medical Services Plan (physician services).

The Government's strategic direction for British Columbia's health system embraces innovative ways to improve access to quality patient care while fostering the sustainability of the publicly funded health care system. It establishes the foundation for improved population and patient outcomes through enhanced quality and efficiency in prevention, primary, community and clinical services. The **'Innovation and Change Agenda'**, outlined in the Ministry's Health Service Plan 2010-11 supports the strategic direction through the articulation of Key Result Areas that are aimed at achieving these goals.

B.C.'s health governance structure consists of six health authorities: a Provincial Health Services Authority and five Regional Health Authorities (RHA). A Government Letter of Expectation (GLE) between the Ministry of Health and the health authorities sets out the accountabilities, roles, and responsibilities of both parties. Each GLE articulates high-level performance expectations and strategic priorities, and is the basis for health authority service planning and reporting to the Ministry.

Regional Health Authorities

- Interior Health Authority
- Fraser Health Authority
- Vancouver Coastal Health Authority
- Vancouver Island Health Authority
- Northern Health Authority

The GLE does not create any legal or binding obligations on the part of the Ministry or health authority, but rather is intended to define and promote a positive and co-operative working relationship.

The mandate of the **regional health authorities** is to plan, deliver, monitor, and report on a full continuum of health services, including hospital care, home and community care, mental health and substance use, and population and public health services. Regional health authorities are required to provide these services in a manner than meets the unique needs of their communities. Most of the regional health authorities have moved away from a focus on health service delivery areas – and use both a vertical and horizontal matrix of program leadership and operational coordination.

The **Provincial Health Services Authority** is responsible for working with the five health authorities to ensure British Columbians have access to a coordinated network of high quality, specialized health services, such as cancer care, transplant operations and specialized cardiac services. The Provincial Health Services Authority (PHSA)ensures that access and other service-related issues are equitably addressed, in addition to governing and managing the organizations that provide health services on a province-wide basis (e.g. B.C. Cancer Agency, Children's & Women's Health Centre of B.C. etc.). PHSA also oversees the operation of the BC Ambulance Service and Health Shared Services BC, which provide technical support and purchasing services province wide.

Regional health authorities are responsible for the planning and delivery of all home health services, either through direct service provision, or through contracted service providers. Services must be provided in a manner that complies with provincial priorities, legislation, policies, standards and guidelines.

The Ministry of Health addresses provincial policy issues including eligibility, access, service allocation and client user fees.

HEALTH CARE & HOME CARE LEGISLATION

There are a number of pieces of legislation that impact home and community care by virtue of its interrelationship with other parts of the health system. The following Acts that most directly apply to the provision of home and community care in the province of British Columbia include, but are not limited to:

Adult Guardianship and Planning Statutes Amendment Act (2007), including revisions to the **Health Care (Consent) Act and Care Facility (Admission) Act** and **Representation Agreement Act,** enforced on Sept 1, 2011 - encompasses legislation giving adults more options for making future personal planning decisions. New advance care planning options and forms are now in effect. Capable adults can appoint someone to make health care decisions on their behalf and/or make an Advance Directive to record their instructions for future health care in the event they become incapable of deciding for themselves.

Budget Transparency and Accountability Act (2000) - outlines the responsibility for tracking and reporting how well the health care system is doing in meeting its performance objectives.

Community Care and Assisted Living Act (2004) – regulates the licensing of community care and child-care facilities, and the registration of assisted living residences.

Continuing Care Act (1996) – defines home support, adult day services, meal programs (including meals on wheels), respite services, case management, residential care, short stay assessment and treatment centres, home oxygen program, and assisted living services as designated continuing care services.

The **Continuing Care Program Regulation** was amended to add community nursing and community rehabilitation services as designated continuing care services and to standardize the terminology for residential care.

Health and Social Services Delivery Improvement Act (2002) - enables health authorities to introduce new, cost-effective business arrangements to incorporate alternate service delivery methods and public/private partnerships in the provision of services.

Hospital Act (1996) – regulates the designation of acute, rehabilitation, and extended care hospitals and licensing of private hospitals.

Hospital Insurance Act (1996) – defines services to be provided as insured services in an acute, extended care or rehabilitation hospital.

Amendments were made to the **Continuing Care Act** and **Hospital Insurance Act** in 2009 to require health authorities to provide person specific information to the Ministry, and to provide Ministerial authority to set rates through the use of a formula rather than having fixed rates.

The **Continuing Care Fees Regulation** and the **Hospital Insurance Act Regulation** were amended in 2009 to incorporate the changes to the residential care fee structure, and to exclude the Registered Disability Savings Plan income from a client's after tax income, for the purpose of setting a client's rate

EVOLUTIONARY MILESTONES

1978
Long-Term Care Program introduced as a province wide program.

1980
The Community Physiotherapy Program and the Home Nursing Care Program transferred from Preventive Programs of the Ministry of Health. This expanded organization came to be known as the Home Care/Long-Term Care Program.

1983
The Home Care/Long-Term Care Program renamed the Continuing Care Division to emphasize the continuing nature of the care provided and to emphasize the continuum of supportive health care services, from community care to residential care.

1994
Introduction of the Choice in Supports for Independent Living (CSIL) program. CSIL clients receive funds directly from the health authority for the purchase of home support services, and assume full responsibility for the management, co-ordination and financial accountability of their services.

1997
Devolution to the health authorities for the delivery of services through the "Better Teamwork Better Care" initiative, a regionalization initiative that created 52 health authorities in the province.

1998-99
Ministry of Health Services launched a review of Continuing Care Services. *Community for Life - Review of Continuing Care Services in British Columbia* report provided a high-level view of the system, conditions, future expectations and a framework for change.

2000
Responding to the 1999 report, the Ministry of Health Services released its vision for continuing care renewal in December, *Strategic Directions for Continuing Care Renewal.*

2001
Health authorities reduced from 52 to five regional health authorities, and 16 health service delivery areas established to reflect natural referral patterns. Provincial Health Services Authority created to coordinate and deliver highly specialized services that cannot be offered in all established regions. Continuing Care program renamed Home and Community Care.

2002
Redesign of home and community care services to expand the range of care options, including the enhancement of home care and palliative services, development of community-based alternatives to acute care services, creation of new assisted living and seniors' supportive housing residences, and more appropriate utilization of residential care facilities.
Assisted living services introduced in the province. Assisted living residences provide housing and a range of supportive services, including personalized assistance, for seniors and people with disabilities who can live independently but require regular help with day-to-day activities.

2003
Fair PharmaCare program introduced to provide financial assistance to BC residents for eligible prescription drugs and designated medical supplies.

2004-05

Community Care and Assisted Living Act enacted to provide a regulatory framework for these services.

Regional health authorities Performance Agreements included an increase in the percentage of high-needs clients receiving services at home.

Ministry mandated implementation of the interRAI-HC, a standardized assessment system for all case managed home care clients.

2007

Ministry of Health Services re-stated its target for the construction of new units or beds to "partner with BC Housing and community affiliates to meet the target of 5,000 new residential care, assisted living and supportive housing with care spaces by December 2008."

2009

Revised Residential Care Regulation implemented and the use of the interRAI MDS assessment tool in all publicly subsidized residential care facilities mandated.

2010-11

Province-wide Innovation and Change Agenda included key result areas to support implementation of an integrated model of primary and community care, to more effectively meet the needs of frail seniors and patients with chronic and mental health and substance use conditions.

The Ministry of Health set a new goal whereby British Columbians will have the majority of their health needs met by high quality community-based health care and support services.

MANDATE, MISSION, PRINCIPLES & PRIORITIES

MANDATE

Health authorities are required to plan and deliver, either directly or through contracted service providers, a range of programs and services appropriate to the needs of individuals assessed as eligible for home and community care services. Although the specific mix of programs and services may vary from community to community, health authorities must ensure that clients have access in all areas of the province, where practicable. Health authorities must provide information to the public about home and community care services and how to access the services. While every attempt is made to accommodate exceptional and/or urgent circumstances, home and community care services are not emergency services.

PRINCIPLES OF HOME & COMMUNITY CARE

Health authorities are required to use the following values as the foundation for planning, monitoring, and managing health services:

- Citizen and patient focus which respects the needs and diversity of all British Columbians.
- Equity of access and in the quality of services delivered by government.
- Access for all to quality health services.
- Effectiveness of delivery and treatment, leading to appropriate outcomes.
- Efficiency; providing quality, effective, evidence-based services in a cost-effective way.
- Appropriateness; providing the right service at the right time in the right setting.
- Safety in the delivery of health services.
- Sustainability for the health system so it will meet British Columbians' needs now and in the future.

In addition to the principles and policies set out in the Health Services Management Policy, health authorities must adhere to the following requirements that are specific to front line service delivery:

- Deliver services in a manner that promotes the health, well-being, dignity and independence of clients and their families, up to and including the end of life.
- Provide services to supplement, rather than replace, the efforts of individuals and their caregivers to meet their health needs and make decisions about lifestyle and care.
- Plan services in collaboration with clients and family, clients' physicians and other health care professionals, balancing risk to both client and caregiver.
- Ensure services are evidence based and focused on achieving positive outcomes for the client.
- Ensure services are sustainable, demonstrating effective use of health resources to achieve positive outcomes for clients, caregivers and health care providers.
- Integrate services in a manner that meets needs and can respond in an urgent situation.
- Ensure that the client's behaviour and/or home environment does not jeopardize the safety of staff providing health services.

HOME & COMMUNITY CARE PROGRAM OBJECTIVES

The home care objectives are to:

- Support clients to remain independent and in their own homes for as long as possible.
- Provide services at home to clients who would otherwise require admission to hospital or would stay longer in hospital.
- Provide assisted living and residential care services to clients who can no longer be supported in their homes.
- Provide services that support people who are nearing the end of their life, and their families, at home, in assisted living, in residential care or in a hospice.

HEALTH SYSTEM PRIORITIES

The current health care priorities for the province of British Columbia are articulated in four goals.

Goal 1: Effective health promotion, prevention and self-management to improve the health and wellness of British Columbians.

Goal 2: British Columbians have the majority of their health needs met by high quality primary and community-based health care and support services.

Goal 3: British Columbians have access to high quality hospital services when needed.

Goal 4: Improved innovation, productivity and efficiency in the delivery of health services.

WITHIN THIS FRAMEWORK, KEY HOME & COMMUNITY CARE PRIORITIES INCLUDE:

- **Integration of Primary and Community Care:** to provide a system of community-based health care and support services built around attachment to a family physician and an extended health care team, with links to local community services.

- **Care Management Strategy:** to transform home and community care clinical practice from a reactive service eligibility-focused model to a proactive integrated model and direct clinical intervention, grounded in evidence-based standards, to better meet the needs of people with complex and chronic health conditions, disabilities and mental health and substance use issues, ensuring a cost effective sustainable service delivery model that produces improved client outcomes and client/caregiver experiences.

- **Increased Flexibility and Options within Housing and Care Models:** to expand flexibility in housing and care settings to meet unique needs, such as those of persons with dementia, couples with differing care needs, and other unique client groups. The goal of this initiative is to identify options to support increased flexibility and choice in providing supportive health services in a variety of housing and care settings.

Harmonized Principles for Home Care

The Canadian Home Care Association has developed a set of harmonized principles for home care which will define a national home care program without prescribing how services should be organized or delivered.

The principles will support the achievement of a level of consistency and provide a basis for the identification of common indicators, while respecting important jurisdictional differences.

As health care continues to shift to the community, these harmonized principles will serve as a unifying foundation for growth and expansion of home care programs across the country.

(Canadian Home Care Association - 2012)

2. Access, Funding & Service Delivery

ACCESS TO HOME CARE SERVICES

British Columbia has a single entry system for home and community care services and for the professional services of community home care nursing and community rehabilitation. In some areas, where population density and service demand make this practicable, community nursing, community rehabilitation and home support can be initiated 24/7 and accessed 24/7.

REFERRAL SOURCES

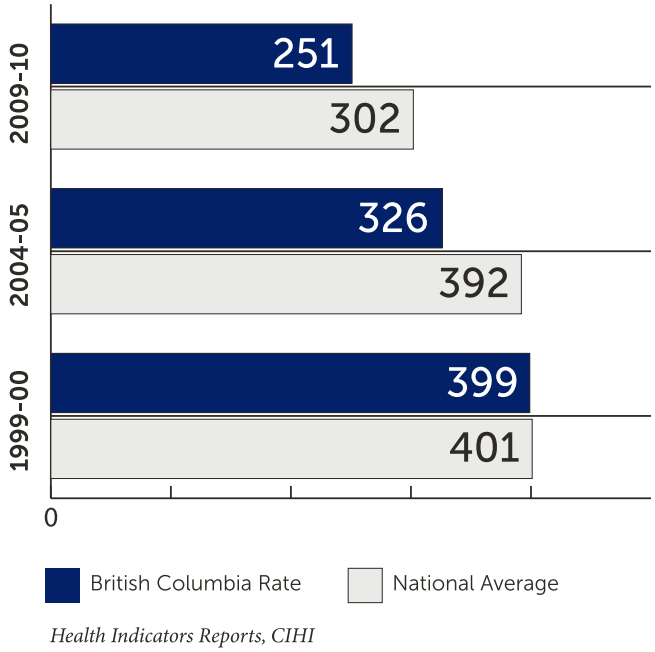
Anyone can refer an individual for assessment, including self-referral. A physician referral is not required for any home and community care service. Information on referral sources is not tracked provincially.

APPROPRIATE ACCESS TO HOME CARE & COMMUNITY-BASED CARE

Hospitalization rates for conditions that may be cared for in the community are one indicator of appropriate access to community-based care. These conditions include diabetes, asthma, alcohol and drug dependence and abuse, neuroses, depression and hypertensive disease. Preventive care, primary care and community-based management of these conditions may reduce the need for hospitalization.

Hospitalization Rates For Ambulatory Care Sensitive Conditions

Age Standardized Rate per 100,000 younger than 75



Health Indicators Reports, CIHI

Alternate Level of Care (ALC) is a measure used to reflect when a patient is occupying a bed in a hospital and no longer requires the intensity of resources / services provided in this care setting. The Acute ALC rate for 2010-11 for the Province of British Columbia is 13%. (Discharge Abstract Database; workload; ref. # 2011-268 ALC as a percent of total inpatient days)

ELIGIBILITY, COVERAGE & UTILIZATION

ELIGIBILITY

- Citizenship – an individual must provide documentation that establishes they: (a) are a citizen of Canada, or lawfully admitted to Canada for permanent residence; or (b) have applied for permanent resident status.
- Residency – an individual must have been a resident of BC for at least three months (90 days) – Health authorities may waive the three month residency requirement for an applicant, where appropriate.
- Individuals who have chronic health conditions that impair their ability to function independently; that require care following discharge from hospital or require care at home rather than hospitalization; or require end-of-life care for a life limiting condition.

AGE

No age restrictions for community nursing or community rehabilitation services

Must be 19 years of age or older for other home care services, such as home support and adult day services.

SUPPLIES, EQUIPMENT AND MEDICATION

The first two weeks of supplies are provided to clients receiving time-limited acute home health services, at no charge to the client.

Palliative specific pharmaceuticals and some medical supplies and equipment are available free of charge through the BC Palliative Care Benefits Program to eligible patients in the last six months of life, when deemed palliative by a physician.

LIMITS / GUIDELINES TO SERVICE PROVISION

There are no limitations on services outlined in provincial home and community care polices, but health authorities use guidelines to determine appropriate service levels.

An individual is not eligible to receive publicly subsidized home and community care services when an illness or injury is due to a third party for whom liability has been established.

DIRECT FEES AND INCOME TESTING

No charges for community nursing, community rehabilitation and case management services.

Home support clients must pay a daily client rate for home support services, except for the first two weeks while receiving time-limited acute home health services or if the client is eligible for the BC Palliative Care Benefits Program. The client rate for home support is based on household income less deductions for taxes, universal childcare benefit, registered disability savings plan, basic living expenses and, if applicable, earned income. The client rate is regulated by the Continuing Care Act - Continuing Care Fees Regulation. A client is not required to pay a daily charge for home support services if the client receives any of the following:

- The Guaranteed Income Supplement, the Spouse's Allowance or the Widowed Spouse's Allowance under the Old Age Security Act (Canada).
- A support and shelter allowance under the Employment and Assistance Act.
- A support and shelter allowance under the Employment and Assistance for Persons with Disabilities Act.
- A war veterans allowance under the War Veterans Allowance Act (Canada).

Approximately 71 percent of home support clients do not pay a daily client rate for services. Clients who believe paying the assessed client rate will cause serious financial hardship may apply to their health authority for a temporary reduction of their client rate. As of January 1, 2008, home support clients with earned income do not pay more than $300/month for their home support client rate.

Adult Day Services: a nominal daily client rate that cannot exceed $10.00 per day may be charged. The client rate may be waived if it would cause the client serious financial hardship and result in the client not being able to access the services.

LEARN MORE

Resident Assessment Instrument-Home Care (RAI-HC)

The Resident Assessment Instrument-Home Care (RAI-HC)© is a standardized, multi-dimensional assessment system for determining client needs. Assessments are captured electronically with real-time feedback to support care planning, in addition to providing data to support system management, quality improvement and policy-making.

The RAI-HC was developed through interRAI, a collaborative, non-profit, worldwide network of researchers that works to promote evidence-informed clinical practice and policy decision making across a variety of health and social services settings.

(RAI-HC© interRAI Corporation, 2001. http://www.interrai.org)

DETERMINING CLIENT NEED - ASSESSMENT TOOLS

Access to publicly-funded home and community care services is through an assessment process, conducted by a health care professional. Assessment activities include intake and screening, initial assessment, financial assessment of income, program planning, service authorization, monitoring, evaluation, follow-up and reassessment. All clients receiving home care services are assessed using the Minimum Data Set for Home Care (MDS-HC), a component of the Resident Assessment Instrument – Home Care (RAI-HC).

Based on information gathered during the assessment process, and in consultation with the client, the client's family, and other professionals, the health care professional (or case manager) determines goals of care, outlines a care plan for the client and identifies the most appropriate services to meet the client's needs. The family physician is informed of the care plan and services that have been approved for the client.

Health authorities must provide a copy of the client's care plan and health care assessment information to service providers and members of the client's health care team, including the client and family, the provider organization, visiting nurse, therapist and physician. A written summary of relevant findings is shared with the home support worker.

ADMISSIONS TO HOME CARE

Each health authority tracks admissions to home care for their jurisdiction. Access to home care is generally consistent between rural and urban settings. Under provincial policy, there are no provisions for wait-listing for home care services in B.C. However, staffing shortages, particularly therapy and home support, in rural settings may result in incidences of clients waiting for service. Additionally, there are capacity issues in some adult day programs.

SETTING OF CARE

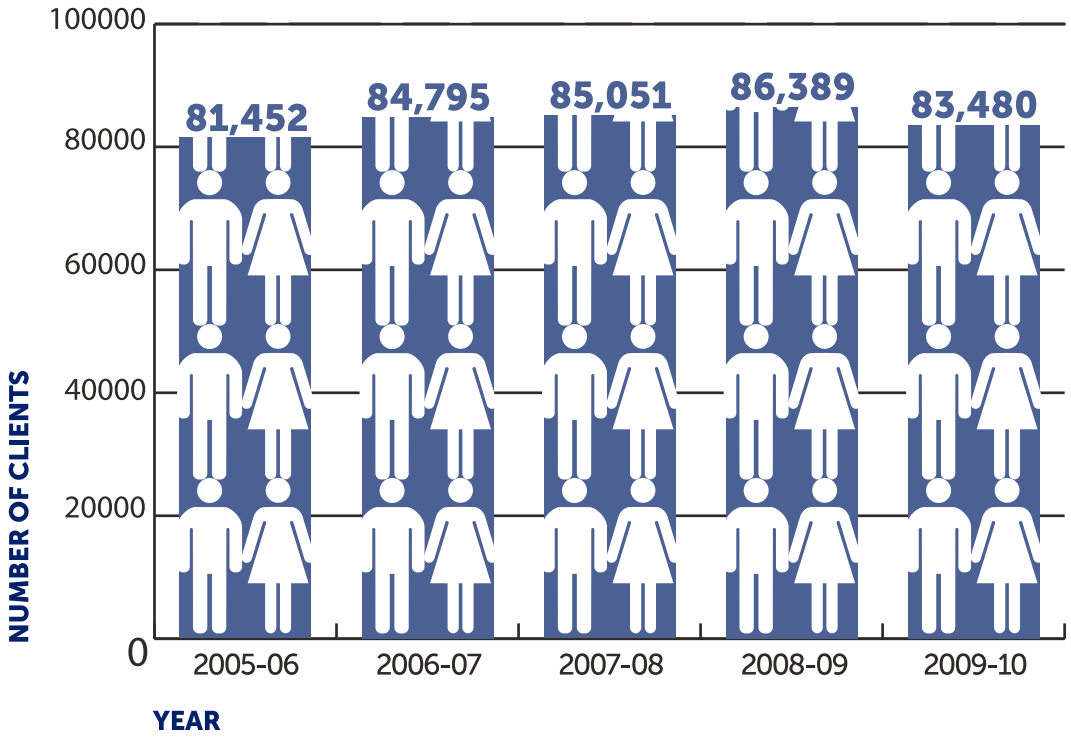
Home care services in B.C. are provided in the following settings:

- Clinic
- Group Home
- Home
- On Reserve
- Place of work
- Street - e.g. for homeless population
- Family Care Home
- Adult Day Program

INTEGRATED MODELS OF CARE

A model of integrated primary and community care was introduced by the Minister of Health in 2010. The objective is to provide all British Columbians with access to a family physician; and to establish collaboration between family physicians, through Divisions of Family Practice, regional health authorities, community organizations and other health-care professionals, including medical specialists, to provide better care. This integrated model targets high needs patients, including frail seniors and patients with chronic disease and life-limiting illnesses, with enhanced care planning and support through a coordinated health-care plan that links together various health professionals including the family physician, medical specialists, nurses, pharmacists and other allied health professionals. Home care staff are also directly linked to family doctors and the extended health care team to better coordinate care for home care recipients. By 2015, integrated primary and community care services will be available in more than 160 B.C. communities, covering the entire province.

Individuals Receiving Home Care



Continuing Care Data Warehouse Tables, Home Care Unique Client Counts by Age group, 2006/2007 to 2009/2010 (Project: 2011_0577) Health System Management Information Branch, Health Systems Planning Division, Ministry of Health, September 29, 2011.

Home and Community Care Minimum Reporting Requirements Data Warehouse Tables (version 2 specifications), September, 2011.

DISCHARGE FROM HOME CARE

Discharge disposition of individuals who have received home care service is increasingly important and instructive to the health care system as it is an indicator of effectiveness. The outcomes can guide system planning and the development of care algorithms for specific patient populations.

Provincial tracking of discharge status of home care clients is not yet available in British Columbia. After discharge from the home care program, individuals access medication, supplies and equipment on their own. The Fair PharmaCare program sets a maximum cost that it will recognize for eligible prescription drugs, medical supplies and for a dispensing fee. Any difference, in amounts or items not included in the formulary, is the full responsibility of the individual.

ALC Challenges and Solutions

The term "alternate level of care" (ALC) is used to describe persons who occupy a bed in a facility, but no longer require the intensity of resources and services provided in that setting.

7,500 or 14%, of acute care hospital beds are inappropriately used across Canada each day.

2.4 million days is the total use of acute hospital beds occupied by alternate level of care or ALC patients in a single year across Canada.

Home and community care programs play a key role in supporting the estimated 30-50 % of ALC patients across Canada who are candidates to return home.

Managing the ALC challenge takes a systems approach and requires collaboration of providers across the health care continuum so that individuals receive the right care in the right location.

(Canadian Institute for Health Information. (2009). Alternate level of care in Canada. (Analysis in Brief). Ottawa: Canadian Institute for Health Information.

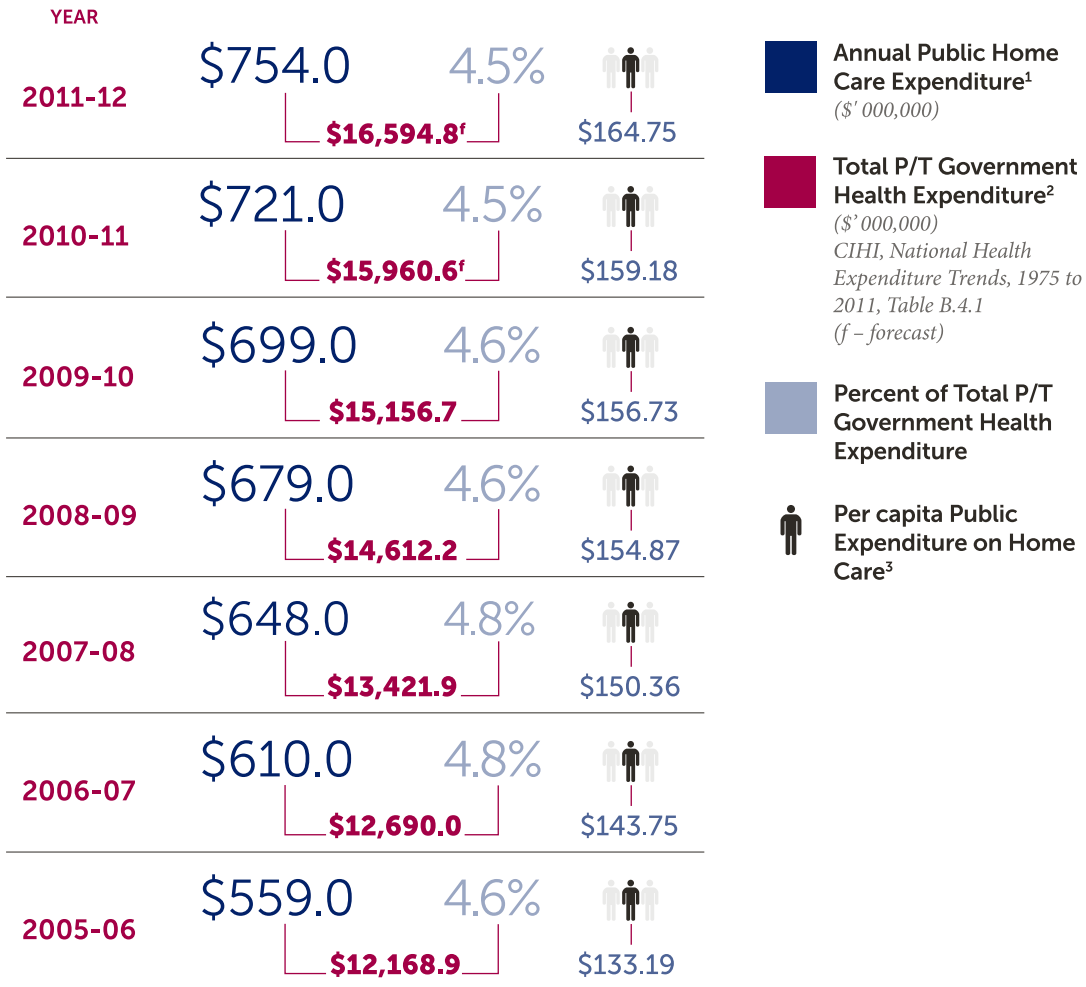
Canadian Health Services Research Foundation (2011). Exploring alternative level of care (ALC) and the role of funding policies: An evolving evidence base for Canada. CHSRF Series of Reports on Cost Drivers and Health System Efficiency: Paper 8.)

FUNDING

Base global funding is allocated to regional health authorities on a population needs based funding model. Health authorities receive new funding according to their population's relative health care needs. Each authority determines the appropriate allocation of funds to hospitals, home and community care, mental health and substance use, and population and public health services.

Publicly funded home care expenditures include assessment, care planning, case management, nursing, rehabilitative therapy assessment, health teaching, personal care, respite, home support, assessment and facilitation of long-term care placement, administration.

Public Expenditures on Home Care



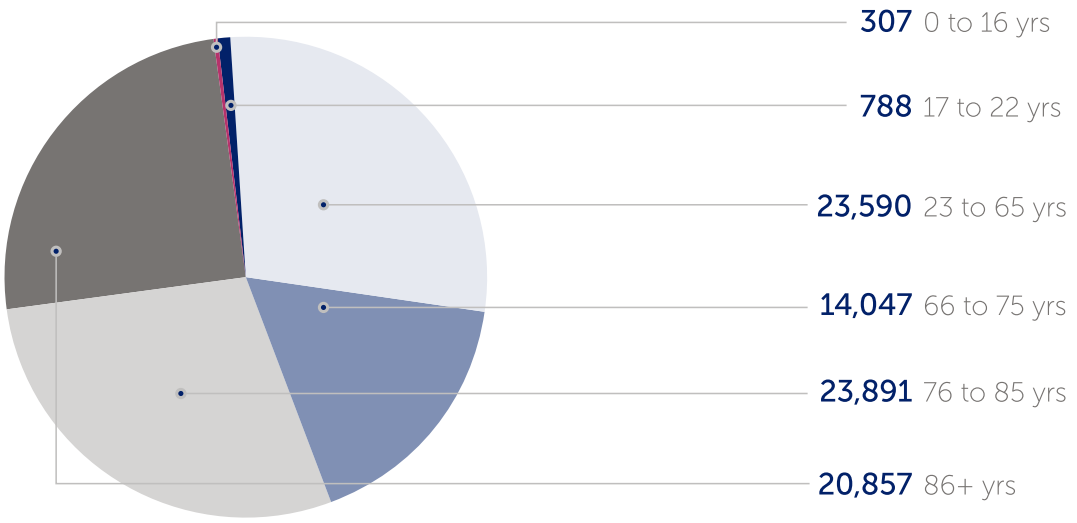
[1] *The total of home support and home care as reported by BC health authorities to the Ministry in May 2011.*

[2] *Figures include spending for health services reported by the provincial/territorial ministry responsible for health – does not include expenditures from municipal government or worker's compensation. [CIHI, National Health Expenditure Trends, 1975 to 2011, pg 92]*

[3] *Population data from Statistics Canada, Demography Division, Annual Estimates of Population for Canada, Provinces and Territories, from July 1, 1971 to July 1, 2012*

PROFILE OF CLIENTS RECEIVING HOME CARE

Number of Individuals Receiving Home Care By Age Category (2009-10)



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Home and Community Care Minimum Reporting Requirements Data Warehouse Tables (version 2 specifications), September, 2011.

SERVICE DELIVERY

MODEL OF SERVICE DELIVERY

British Columbia uses a mixture of public and private sector for service delivery. Professional services such as home care nursing and community rehabilitation are delivered through health authority employees. Home support services and personal care services are provided both through the health authority employees and through contracted provider organizations. Services can also be purchased privately by individuals through either insurance plans or direct payments.

RANGE OF HOME CARE SERVICES & PROGRAMS

Home Care Services currently funded through health authority home and community care services

Case Management	Case managers provide clinical assessment, care planning and coordinate home and community care services. They determine the nature, intensity and duration of services that would best meet client's needs, in collaboration with the client, family and other members of the care team, and arrange their services. The case manager will stay in touch with the client and make any adjustments necessary in the event their care needs change.
Community Nursing and Community Rehabilitation Services	Professional services, delivered to clients in the community by registered nurses and rehabilitation therapists. Nursing care is available on a non-emergency basis for British Columbians requiring acute, chronic, palliative or rehabilitative support. Rehabilitation therapists can also provide assessment and treatment to ensure a client's home is suitably arranged for their needs and safety.
Home Support Services	Provide accessible in-home services to seniors and other adults with disabilities who cannot live independently, due to health-related problems. Home support services help clients remain in their own homes, and provide personal assistance with the activities of daily living, such as bathing, dressing, grooming and, in some cases, light household tasks that help maintain a safe and supportive home.
Choice in Supports for Independent Living (CSIL)	A "self-managed model of care." Clients receive funds directly for the purchase of home support services. They assume full responsibility for the management, coordination and financial accountability of their services, including hiring, training, scheduling and supervising home support workers.
Respite Services	Respite care can provide non-professional caregivers, such as family members or friends, with temporary relief from the emotional and physical demands of caring for a friend or family member. Home support, adult day services, and residential care may be utilized for respite services.
Social Work	Services are available, but may be limited in some communities.
Dietetics	Services are limited to home bound clients only.
Adult Day Services	Adult day services provide supportive group programs and activities that assist with daily activities or give clients a chance to be more involved in their community. Activities vary with each centre. They may include: • Personal care services, such as bathing programs and administering medications. • Therapeutic recreation and social activities. • Caregiver respite, education and support. • In some centres, meals and transportation may also be provided or arranged. Clients may attend an adult day program in addition to receiving other services.

End-of-Life Care	Supportive and compassionate care that improves the quality of life of people in the end stages of a terminal illness or preparing for death. It is provided wherever the client is living, whether in their home, in hospital, hospice, an assisted living residence or a residential care facility. Community end-of-life services include palliative care co-ordination and consultation, professional nursing services, community rehabilitation services, home support and respite for the caregiver. Under the B.C. Palliative Care Benefits Program, eligible clients living at home receive free medications for pain and symptom relief as well as specified medical supplies and equipment.
Meals Program	A voluntary community service that provides and delivers hot nutritious meals to the homes of ill, elderly, or disabled persons who are unable to cook and/or shop for themselves. Congregate meal services, in which the recipients come together to eat meals in a communal setting, are also funded.

Ancillary support

Home Oxygen	Managed by RHAs.
Drugs	Diabetic certificate program allows access to supplies Palliative Care Benefits Program provides medication for pain and symptom relief, and medical supplies and equipment, at no charge Fair Pharmacare provides access to prescription drugs based on family net income. Those born in 1939 or earlier receive enhanced Fair Pharmacare coverage.
Supplies (dressings, stoma, etc)	The first two weeks of supplies are provided at no charge to post-acute home care clients. Palliative-specific pharmaceuticals and specified medical supplies and equipment are free of charge to clients receiving end-of-life services through the Palliative Care Benefits Program.
Equipment (wheel chairs, walkers, etc)	Home and community care staff may assist a client with assessment of needs and in accessing appropriate aids, however, the client is responsible for the purchase or rental of equipment.

SERVICES CURRENTLY NOT FUNDED THROUGH THE HOME AND COMMUNITY CARE PROGRAM

(provided through other programs and funding mechanisms)

- Nurse Practitioner
- Speech Language Pathology
- Physician Services
- Pharmacy Consultation

Home Care Clients Served

	2005-06	2006-07	2007-08	2008-09	2009-10
Community Rehabilitation	32,751	35,336	34,962	36,083	35,045
Community Nursing	38,824	39,325	39,659	41,412	41,860
Home Support (Excluding CSIL)	32,023	33,834	35,323	34,587	31,997
Choice In Supports For Independent Living (CSIL)	694	698	737	803	846
Adult Day Services	6,639	6,833	6,836	6,627	6,286
Assisted Living	2,321	3,768	4,708	5,285	5,470
Residential Care	34,582	36,448	37,026	37,729	38,411

Ministry of Health CERTS Data 2010-0486 HCC Age Std Rates.xlsx
BC is in the process of transitioning to a new provincial data system – and so there are delays in data for 2010/11 onward

CLINICAL (SPECIALTY) SKILLS

With the focus on discharging patients from hospital as promptly as possible, there has been an increase in the complexity of care provided at home. The challenge in much of Canada can be in having a critical mass of patients who require certain levels of expertise and, as a result, special skills only being available in urban centres. However, with the advent of remote access to support in the community, there is an opportunity for more complex care to be provided in less populated areas.

Home care nurses are able to:

- Administer narcotics.
- Provide enterostomal therapy, wound care, infusion therapy.
- Manage infusion pumps, central lines and peripherally inserted central catheters (PICC lines).
- Provide ventilator care and regular tracheostomy tube replacement.
- Manage home oxygen for individuals in their homes across the province.

Clinical services not currently provided in the home include:

- Administration of chemotherapy (except for some oral therapy).
- Administration of blood or blood products.

Peritoneal and hemodialysis are available to individuals at home through the BC Provincial Renal Agency (BCPRA). Founded in 1997, the BCPRA is a "virtual" agency with a network of health care professionals in the regional health authorities. In cooperation with the health authority renal programs, BCPRA coordinates service delivery to individuals requiring dialysis.

3. Quality & Accountability

HOME CARE INDICATORS

The home care indicators that are currently monitored at a provincial level include:

- Amount of service delivery.
- Expenditures.
- Home care admissions and wait times.
- Number of staff.

QUALITY & ACCREDITATION

EXTERNAL ACCREDITATION

Accreditation is an effective way for health services organizations to regularly and consistently examine and improve the quality of their services in order to ensure high standards of care. Organizations in Canada are accredited through Accreditation Canada, CARF, the Quebec Council of Accreditation (Quebec only) and/or registered with the International Standards Association (ISO).

Accreditation in British Columbia is not mandatory. Currently the Northern Health Authority, the Interior Health Authority, Vancouver Island Health Authority, Vancouver Coastal Health and the Provincial Health Authority are accredited with Accreditation Canada. Approximately 1200 organizations from a range of service sectors (e.g. Behavioural Health, Children & Youth Services, Employment and Community Services, Medical Rehabilitation) are accredited through CARF Canada.

High-quality care is evidence-based (appropriate), focused on the patient (or patient-centered), safe and timely (CIHI).

QUALITY COUNCIL

The British Columbia Patient Safety & Quality Council was established in 2008. The purpose of the Council is to provide advice and make recommendations to the Minister of Health Services on matters related to patient safety and quality of care, and to bring health system stakeholders together in a collaborative partnership to promote and inform a provincially coordinated, innovative, and patient-centred approach to patient safety and quality improvement in BC. The mandate of the Council is to:

- Bring a provincial perspective to patient safety and quality improvement activities.
- Facilitate the building of capacity and expertise for patient safety and quality improvement.
- Support health authorities and other service delivery partners (including home care) in their continuous effort to improve the safety and quality of care.
- Improve health system transparency and accountability to patients and the public for the safety and quality of care provided in British Columbia.

CLIENT / PATIENT ADVOCATE

A **Patient Quality Review Board** within each health authority reviews patient complaints related to the quality of care provided by a health authority. Patient Care Quality Review Boards are independent of the health authorities, and accountable to the Minister of Health. Recommendations by review boards, to health authorities, are issued from board to board and copied to the CEO and Patient Care Quality Office, as well as the Minister. Health authority boards are accountable to the Minister for the operation of the health authority, and therefore the organization's response to the review board recommendations.

The province is establishing an **Office of the Seniors' Advocate**. As of June 1, 2012 a provincial phone line will be operational to receive concerns about home and community care.

SYSTEM APPROACHES TO QUALITY IMPROVEMENT

In November 2010, the BC Leadership Council (comprised of health authority CEOs, the Deputy Minister of Health and Ministry of Health Executives) committed to use the Lean methodology within the health authorities as a process improvement tool. Lean is an approach to systematically eliminating waste in organizational processes in order to improve quality and productivity, and reduce costs. In health care, Lean involves mapping of a patient's journey through the system in order to identify steps that are of value to the patient, and those that add no value.

In 2010/11 the health authorities completed more than 125 Lean events. For example, an initiative in the Northern Health Authority addressed the referral process to home and community care so that clients would receive service in a timely manner. A second objective was to enter billing information into the electronic system correctly and promptly. The goals of timely service were achieved. Clients now receive services in 14 days following referral, rather than the 68 days it took previously. Overproduction and overprocessing have been virtually eliminated, and information is flowing to the right person at the right time. Billing mistakes have been greatly reduced, and data are entered into the system in a timely manner.

What is LEAN?

"**Lean**," is a type of quality improvement methodology which has been implemented in many industries. It is a production practice that considers the expenditure of resources for any goal other than the creation of value for the end customer to be wasteful, and thus a target for elimination.

In health care, Lean is patient-centred, as patients are the end consumers of care and thus, value must be defined from their perspective.

(Institute for Healthcare Improvement; 2005)

SAFETY

The **British Columbia Patient Safety & Quality Council** introduced the Global Trigger Tool (Institute for Healthcare Improvement) for Measuring Adverse Events to home and community care. Home care representatives also participated in a three-part Medical Reconciliation virtual learning series to help BC health care providers improve their efforts in preventing adverse drug events.

The BC Injury Research and Prevention Unit (BCIRPU) has been working for ten years to reduce the societal and economic burden of injury among all age groups in British Columbia through surveillance, research and knowledge development, knowledge synthesis, translation and education, and public information for the support of evidence-based, effective prevention measures. Falls prevention in the elderly has been a key focus for the group. BCIRPU has worked with a number of home care programs across the province and, in other jurisdictions, in a falls prevention program targeted at frail seniors receiving home support services.

HOME CARE RESEARCH

The **BC Home and Community Care Research Network (HCCRN)** represents the five health authorities, the Ministry of Health, the University of British Columbia and the University of Victoria. HCCRN was formed to create capacity for conducting health services research in the field of seniors and community care, and has three main objectives:

1. **Capacity Building:** Establish infrastructure to increase capacity for research and knowledge exchange within B.C.'s home and community sector, and enhance stakeholders' capacity to conduct health system research and use timely evidence-based information in creating health policy.
2. **Research:** Conduct high quality research to measure, at a population level, transitions in seniors' health and service provision, to evaluate the effects of such transitions on health outcomes, quality of life, service utilization, and service providers' quality of life, and to generate new knowledge through a program of research focusing on four key areas identified as priorities by Network members.
3. **Knowledge Translation & Exchange:** Develop and implement a strategy for multi-directional knowledge transfer and utilization.

The HCCRN research theme areas include:

- **Assisted Living** - to identify and develop a core set of valid and reliable indicators that will enable evaluation, comparison and benchmarking within this housing option, in a consistent and comprehensive manner.
- **Dementia** – to investigate models of care delivery, care pathways and care outcomes for those diagnosed with dementia, including Alzheimer's disease and other forms of dementia.
- **Indicators** - to identify and develop indicators to provide new insights into the effectiveness of specific interventions, and to develop benchmarking capability regionally, provincially, and nationally. The goal is to link these indicators to existing population health data (e.g., National Population Health Survey, BC linked databases and Canadian Census).
- **Seniors-at-Risk** – to look at social & geographic isolation related to home care support services in the North, and to identify issues related to Ethnic Minority Older Adults (EMOA) across the province.

The BC government also funds the **Michael Smith Foundation for Health Research (MSFHR)** to strengthen the BC health research enterprise through innovative, integrated services and programs that create and maintain a vibrant health research environment, mobilize stakeholders to identify priorities and address health and health system priorities, and build capacity for excellent health research. The Michael Smith Foundation for Health Research is currently partnered with the Ministry of Health and regional health authorities to design and implement a quality improvement information system, MELS (Monitoring, Evaluation and Learning System), as part of the commitment to integrated primary and community care.

4. Information Technology

ELECTRONIC HEALTH RECORD (EHR)

B.C.'s eHealth strategy is being implemented in phases to improve care by bringing lab results, diagnostic scans, medication histories and electronic prescriptions online to help patients anywhere health care is delivered in British Columbia. The **BC Health Sector IM/IT Strategy** (rev Jan 2011) identifies investment in electronic medical records and telehealth solutions to support the province's strategy for a province-wide system of integrated primary and community care. The implementation of Electronic Medical Records (EMRs) in physician offices is a foundational enabler, supporting integrated primary and community care, and is one of three components within the scope of BC's provincial eHealth initiative.

There is some electronic documentation of home care services; however, it varies across the health authorities. The home care record is not yet integrated into an overall regional or provincial electronic health record for the patient.

HEALTH DATA & THE HOME CARE REPORTING SYSTEM

The Ministry receives a detailed data report from each health authority that provides information on clients and services, as well as a select group of outcome summary measures from the health authorities on all clients assessed with the MDS-HC. This is used to support decision making at a provincial level. The MDS-HC data is used to help better understand client characteristics for individuals receiving various services, to monitor quality outcomes, to ensure accountability, and to support local and provincial planning and policy development

The Home Care Reporting System (HCRS), developed by the Canadian Institute for Health Information (CIHI), is a vehicle to collect and process information on publicly funded home care services in order to support jurisdictions in their analysis and decision making by providing data on:

- Access to home care services.
- Health and functional status measures.
- Clinical outcomes and wait times.
- Quality of care.
- Informal support.
- Service utilization by setting and provider type.

The HCRS captures standardized client-specific clinical, demographic, administrative and resource utilization information. A key component of the HCRS is the RAI-HC. It is expected that by the end of fiscal year 2011/12, all health authorities will be submitting MDS-HC data to the Canadian Institute for Health Information (CIHI), and that in turn, BC will be receiving aggregate provincial data through CIHI management reports, as well as detailed provincial data directly to its own RAI data warehouse.

Technology – Transforming Health

Technological advancements have the potential to fundamentally change our health care approach to support a more efficient and person-centred one regardless of the care setting.

Today's innovations enable the integration of monitoring and therapeutic systems, provide educational content, facilitate communication and data flow between members of the health care team and support systems management and quality improvement.

USE OF SYSTEM EFFICIENCY TECHNOLOGY

Since 1980, the Home and Community Care sector has relied on the Continuing Care Information Management System (CCIMS) as the provincial repository for data. The Ministry has now defined its information needs by developing, in consultation with the health authorities, Minimum Reporting Requirements (MMR) which encompass the type, level, quality and reporting expectations of the health authorities. MMR defines those data elements the health authorities must then report to the Ministry of Health to support the Ministry's current role of stewardship, and to ensure information is available to meet planning, monitoring, evaluation and research objectives. These data come from different sources. The RAI-HC assessment system is one source of information for a large proportion of Home and Community Care clients, supplying clinical and demographic information.

Each health authority has their own regional information systems, although three health authorities have implemented the Primary Access Regional Information System (PARIS) - an electronic health records system. PARIS is used by community health nurses, health care workers, occupational therapists, physicians, and social workers, as well as administrative staff, to manage the data needs of delivering and reporting on services across community programs.

USE OF TECHNOLOGY FOR CLIENT CARE

Telehealth applications have been introduced to varying degrees across the health authorities; and in home care for palliative, chronic, acute and rehabilitation care. As an example, a province-wide 'After Hours Palliative Nursing Service' has been implemented that provides access to a trained clinician by phone, during the hours when home health staff may not be available. In addition, a palliative specialist clinician is on call to respond to more complex issues, and to ensure linkage back to the home health team for follow up.

Telehome monitoring initiatives for monitoring of chronic conditions, conducting pre and post surgical follow up and managing complex wounds are in place across the province. Technology applications to support home care administration vary across the health authorities.

A Vision for Technology in Home Care

With the emergence of new technologies there are seemingly endless possibilities to support people in their homes. A variety of new technological innovations such as telemonitoring applications, mobile phone devices, personal digital assistants (PDAs) and smart homes are enabling the shift of care away from institutional and professional settings to individuals' homes.

Expanded technology-enabled home care offers a promising pathway to bend the cost curve for ever-growing health care expenditures. Independent of the economic benefit, the moral value of enabling older members of society to live in grace and dignity in their own homes, with a ripple effect on their caregivers, is arguably the most important – if unquantifiable – benefit of home care. [Kayyali et al, 2011].

(Canadian Home Care Association, A Vision for Technology in Home Care, 2013)

5. Health Human Resources

CLINICIANS PRACTICING IN HOME & COMMUNITY CARE

Health human resource data is tracked within the regional health authorities and provided to the Ministry of Health, but is not aggregated. The Ministry of Health, the Ministry of Advanced Education , the Ministry of Jobs, Tourism and Innovation and health system partners are working together to provide education and training opportunities for health care providers; and are investing in the continued recruitment, training and retention of nurses, allied health workers and other health professionals.

Community health workers administer bedside and personal care, such as aiding in ambulation, bathing and personal hygiene, to clients in their homes. They work under the general direction of a home care agency supervisor or nurse, with detailed instructions that explain when they are to visit clients and what services need to be performed. The scope of practice for community health workers is not defined provincially. Health care delivery organizations continue to review the skill mix needed to deliver health care services to British Columbians.

The **B.C. Care Aide and Community Health Worker Registry** became operational on January 29, 2010. It tracks all home support / personal support workers and is intended to:

- Protect vulnerable patients, residents and clients.
- Establish and improve standards of care in the care aide and community health worker occupations.
- Promote professional development for care aides and community health workers in identifying career opportunities.

Occupational/Physical Therapist Assistants (Rehab Assistants) are members of interdisciplinary teams and assist Occupational Therapists and Physical Therapists to promote, restore, maintain and/or enhance a client's level of functioning in the areas of mobility, self care, productivity, leisure and activities of daily living. Rehab Assistants are increasingly being deployed in home care.

EDUCATION & TRAINING

Community health workers, who provide publicly subsidized home and community care services for a provincial health authority or for a service provider contracted by a health authority, must have completed a recognized B.C. health care assistant training program of six to eight months duration, or an equivalent course.

In order for a community health worker or long-term care aide to be registered with the provincial Care Aide and Community Health Worker Registry, they must have completed the standardized content and curriculum hours outlined in the Health Care Assistant (HCA) Program Provincial Curriculum.

INTER-PROFESSIONAL COLLABORATION

The provincial Home and Community Care (HCC) care management strategy is intended to transform home and community care clinical practice from a reactive service eligibility-focused approach to a more proactive, interdisciplinary approach, based on national standards and best practice in case management.

FAMILY CAREGIVER

The importance of family caregivers is reflected in Ministry web resources where individuals can assess their personal balance in caring for a loved one, and source various forms of support. Additionally the Ministry has supported the development of specific initiatives to meet the needs of distinct client groups, such as persons with dementia. Funding from the Ministry has supported the BC Alzheimer Society to implement First Link across the province, which connects people with dementia and their caregivers to supportive community programs early in their journey.

Provincial policies also highlight the important role of both the client and caregiver as partners in their care, viewing them as part of the care team. The policy manual states that health authorities must:

- Deliver services in a manner that promotes the health, well-being, dignity and independence of clients and their families up to and including the end of life.
- Plan services in collaboration with clients and family, clients' physicians and other care professionals, balancing risk to both client and caregiver.

Short-term residential care service allows the client's principle caregiver a period of relief. Adult day service provides caregiver support, including respite, activities such as caregiver support groups, information and education programs. Home support services provide caregivers regular relief from the emotional and physical demands of caring for a family member.

Caregivers provide care and assistance for spouses, children, parents and other extended family members and friends who are in need of support because of age, disabling medical conditions, chronic injury, long-term illness or disability. A family caregiver's effort, understanding and compassion enable care recipients to live with dignity and to participate more fully in society.

5 million
is the estimated number of caregivers in Canada

80%
of care needed by individuals with a long-term condition is provided by family caregivers

60%
of caregivers provide care for more than three years

(Canadian Caregiver Coalition www.ccc-ccan.ca.)

6. Provincial Initiatives

INTEGRATED PRIMARY AND COMMUNITY CARE (IPCC)

This comprehensive undertaking is meant to fundamentally change the way health care is conceived and delivered in the province of British Columbia. The objective of IPCC is to integrate and target primary and community care to create a more sustainable health care system, and to partner with patients and communities in a manner that improves the health outcomes of people in the community, improves both patient and provider experience and increases the sustainability of the health care system.

CHRONIC DISEASE MANAGEMENT

Coordinated and integrated chronic disease management initiatives have been adopted. The Ministry has developed a secure, web-based clinical quality improvement application, supporting doctors and health care teams to use best practices in caring for their patients with chronic diseases. Health care providers can use the website to pick up personal chronic disease management patient registers, and use the Chronic Disease Management (CDM) Toolkit to help with management of their patients with chronic conditions.

SENIORS AND AGING

The province has committed to an age-friendly BC and is providing a grant and recognition program to help local governments create environments that allow seniors to enjoy good health and active participation in their community. The **Seniors Action Plan** is in response to the Office of the Ombudsperson's report on seniors' care in British Columbia (2012), which provides a comprehensive review of a number of services in the system of home and community care across the province. The Seniors Action Plan outlines six themes:

1. Concerns and complaints – a mechanism to report concerns and the establishment of an Office of the Seniors' Advocate.
2. Information – easy access to information in order to make informed choices about care.
3. Standards and Quality Management – initially focused on residential care facilities.
4. Protection – implementing strategies and measures to protect seniors from abuse and neglect.
5. Flexible services – in order to facilitate access to care at home and within the community.
6. Modernization – to ensure a sustainable home and community care system.

The actions identify changes that can be made across the system, resulting in sustainable and lasting improvements that will better serve seniors across the province. Other initiatives include:

- **Community Action for Seniors' Independence** (CASI) is a partnership project between the government and the United Way of the Lower Mainland. CASI is focused on developing and delivering non-medical home support programs to enable seniors age 65 and older to live independently in their homes as long as possible.
- A nationally and internationally recognized **fall prevention program.**
- **Seniors Hospital Care** - In collaboration with hospital and emergency department teams, work is underway to better respond to the needs of seniors in hospital settings, to improve their health outcomes and support them in remaining – or returning home successfully.

7. Challenges

The key challenge facing the health system is to deliver a high performing, sustainable health system (from prevention to end-of-life care) in the context of significant growth in demand. The most significant drivers of rising demand are:

- The aging population - by 2031 the proportion of individuals over the age of sixty-five is expected to increase to 24 percent - approximately 1.4 million.
- The increasing need to provide care to frail seniors.
- A rising burden of illness from chronic diseases, mental illness and cancer - Chronic diseases are more common in older populations and it is projected that the prevalence of chronic conditions could increase 58 percent over the next 25 years and be a significant driver of demand for health services.
- Advances in technology and pharmaceuticals driving new costly procedures and treatments.
- The supply of health human resources - attrition rates have recently decreased, however, looming retirements in the health workforce, combined with the rising demand for services, are still key challenges that will impact the Province's ability to maintain an adequate supply and mix of health professionals and workers.

8. Opportunities

A number of opportunities will contribute to realizing the goals of timely, client-centred home care in BC so that people can remain independent at home. These include pursuing:

- The Home and Community Care, Care Management Strategy, which is transforming practice to a proactive integrated model.
- The Seniors Action Plan that addresses recommendations from the Ombudsman's review.
- New Housing and Care Models that are identifying options to support increased flexibility and choice in providing supportive health services in a variety of housing and care settings.

The government of B.C. is committed to supporting a major shift in the focus of health care services, to ensure that British Columbians receive the majority of their health care services in the community, through integrated services that link physicians, health care providers, communities and patients as partners in care.

ACRONYMS / ABBREVIATIONS

ALC - Alternate Level of Care
BCIRPU - BC Injury Research and Prevention Unit
BCPRA - BC Provincial Renal Agency
CASI - Community Action for Seniors' Independence
CCIMS - Continuing Care Information Management System
CDM - Chronic Disease Management
CIHI - Canadian Institute for Health Information
CSIL - Choice in Supports for Independent Living
EHR - Electronic Health Record
EMOA - Ethnic Minority Older Adults
EMR - Electronic Medical Record
GLE - Government Letter of Expectation
HCA - Health Care Assistant
HCC - Home and Community Care
HCCRN - Home and Community Care Research Network
HCRS - Home Care Reporting System
IPCC - Integrated Primary and Community Care
ISO - International Standards Association
MELS - Monitoring, Evaluation and Learning System
MDS-HC - Minimum Data Set for Home Care
MMR - Minimum Reporting Requirements
MSFHR - Michael Smith Foundation for Health Research
PARIS - Primary Access Regional Information System
PHSA - Provincial Health Services Authority
RAI-HC - Resident Assessment Instrument – Home Care
RHA - Regional Health Authority

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Harmonized Principles for Home Care

Guide policy and program development

Support consistency and equity across the country

Facilitate benchmarking and sharing of best practices

CLIENT AND FAMILY-CENTRED CARE

Clients and their family caregivers are at the centre of care provided in their home.

Dignity:
Respect and value client and caregiver self-worth.

Holistic:
Uphold all aspects of client and caregiver needs; psychosocial, physical and spiritual.

Independence:
Foster autonomy and self-sufficiency.

Informed Choice:
Clear understanding of the facts, implications, and consequences of decisions and actions.

Positive Partnership:
Acknowledge unique strengths and engage client and family as partners in care.

Safety:
Minimize and manage risk.

Self-Determination:
Encourage, support and enable self-care.

ALBERTA

HOME CARE IN **ALBERTA**

In **Alberta**, the definition of home care is consistent with that of the Canadian Home Care Association.

> Home care is an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the family caregiver.

ALBERTA
BY THE NUMBERS...

642,317 sq km
LAND AREA

3,779,400[1]
POPULATION (2011)

82%[3]
Percent population in urban settings defined as an area with a population of at least 1,000 and with no fewer than 400 persons per square kilometre (2006).

55[2]
Dependency ratio (2009)
Ratio of the population aged 0-19 and 65+ to the population aged 20-64

10.8%[1]
Population Seniors 65+ yrs
(2011)

80.6 years[1]
LIFE EXPECTANCY (AT BIRTH)

$4,842.60[2]
Public sector health care expenditure per capita (2011 Forecast)

[1]Statistics Canada | [2]Canadian Institute for Health Information (CIHI) | [3]Human Resources and Skills Development Canada

1. Governance & Organization

HEALTH CARE SYSTEM STRUCTURE

Alberta's Ministry of Health (Alberta Health) provides global funding to Alberta Health Services (AHS) which allocates funding to the programs that it delivers and contracts, including home care. Alberta Health provides overall direction for home care through provincial legislation, directional policies and accommodation and health service standards.

Alberta Health Services (AHS) is the provincial health authority responsible for overseeing the planning and delivery of health supports and services to more than three and a half million people living in the province of Alberta. AHS was established on May 15, 2008, and became fully operational on April 1, 2009. AHS replaced the nine Regional Health Authorities (RHA) that managed and delivered services in Alberta between 2003 and 2009.

Geographic Service Delivery Zones in Alberta Health Services

- North Zone
- Edmonton Zone
- Central Zone
- Calgary Zone
- South Zone

The Alberta Health Services Board governs all health services in the province, working in partnership with the Ministry of Health to ensure all Albertans have equal access to health services across the province. The Board reports directly to the Minister of Health. The zones do not operate independently or autonomously. They exist to facilitate and provide flexibility for local decision making based on the unique challenges faced by the different regions of the province.

AHS is responsible for health service delivery, including hospitals, continuing care facilities, community health services [home care], and public health programs. Under the *Regional Health Authority Act,* AHS is required to perform the following tasks:

- Promote the health of the population and work to prevent disease and injury.
- Assess health needs on an ongoing basis.
- Determine priorities in providing health services and allocate resources accordingly.
- Ensure that reasonable access to quality health services is provided in and through the region.
- Promote health services in a way that responds to the needs of individuals and communities, and supports the integration of services and facilities.

HEALTH CARE & HOME CARE LEGISLATION

Alberta Health Act (2010) - moves the health system from an overemphasis on the needs of institutions and providers to one that better recognizes and responds to people and families needing health services. The Act requires the Minister of Health to establish: a health charter that sets out expectations and responsibilities within the health system, a health advocate to address citizen concerns with the health system as they relate to the health charter, and a process to provide for public input in the development of health regulations made under the Act. The Act is the result of consultation by the Minister's Advisory Committee on Health (MACH), beginning in the fall of 2009, with stakeholders and the public regarding Alberta's health legislation. The committee recommended that an Alberta Health Act be legislated to set the overall direction for Alberta's publicly funded health system. A second consultation took place in the summer of 2010 in order to gather input from Albertans on the MACH recommendations. This resulted in the *Putting People First: Recommendations for an Alberta Health Act* report which recommended pursuing policy opportunities in primary care, continuing care and mental health.

Health Information Act (2000) - establishes strong and effective mechanisms to protect the privacy of individuals' health information and to prescribe rules for the collection, use and disclosure of health information.

Health Professions Act (2000) - developed to regulate health professions using a model that allows for non-exclusive, overlapping scopes of practice. No single profession has exclusive ownership of a specific skill or health service and different professions may provide the same health services.

Health Quality Council of Alberta Act (2011) – required the Council to promote and improve patient safety and health service quality on a province-wide basis.

Provincial Health Authorities of Alberta Act (2000) – authorizes the Minister to establish one or more health regions in Alberta.

Public Health Act (2000) - regulates Alberta's public health policy practices. The Coordinated Home Care Program Regulation 296/ 2003 falls within the Public Health Act and is currently under review.

EVOLUTIONARY MILESTONES

1978

Establishment of home care programs through 27 Health Units providing professional services only for those 65 years of age or older.

1984

Program expanded to accommodate the increasing need for support services and palliative care.

1991

Persons under 65 years of age have access to support services regardless of their need for professional health services.

Waiting period for new residents of Alberta eliminated.

Elimination of the requirement for physician authorization for admission to the program.

1994

Seventeen Regional Health Authorities (RHAs) replaced over 200 boards and administrations, and assumed responsibility for hospitals, continuing care facilities and public health programs, including home care services.

1997

The Government of Alberta established the Long-Term Care Review Policy Advisory Committee to address home care, drug strategies, accommodation policies and health related support programs.

1999

Release of 'Healthy Aging: New Directions for Care', a report developed through extensive stakeholder consultations and input.

2000

Government responded with 'Strategic Directions and Future Actions: Healthy Aging and Continuing Care in Alberta', a strategy to develop an improved, sustainable and affordable continuing care system for Albertans.

2003

Restructured from 17 to 9 Regional Health Authorities and integrated mental health services into the regions.

2005

The 'Report of the Auditor General on Seniors Care and Programs' recommended that the 1995 standards for continuing care be updated, and that a process be implemented to regularly review and update the standards.

2006

New Continuing Care Health Service Standards released. These standards apply to long-term home care services (over 3 months).

2007

The $3000 per month, per client ceiling on long-term home care clients removed.

Updated Continuing Care Health Service Standards released.

2008

Nine Regional Health Authorities dissolved and the Alberta Health Services Board established to deliver health services for the province and be accountable to the Minister of Health and Wellness.

Updated Continuing Care Health Service Standards released.

2009

'Continuing Care Strategy – Aging in Place', recommends greater emphasis on care at home.

2010

Consultations with Albertans and release of report, 'Putting People First'.
Recommendations to increase home care were made.
Release of Alberta's '5-Year Health Action Plan'.
Alberta Health Act passed.

MANDATE, MISSION, PRINCIPLES & PRIORITIES

MANDATE

Alberta's home care program assists Albertans to achieve and maintain health, well-being and personal independence in the community.

PRINCIPLES OF HOME & COMMUNITY CARE

Alberta's home care program is governed by 'Continuing Care Health Service Standards' which are based on the principles of:

- **Client Centered Care** - care planning, coordination and delivery of services are centered on the client and their unique needs and preferences. The client participates in decisions regarding their care, and their decisions/choices are respected to the extent possible.

- **Integrated Care Teams** - all individuals who are providing care work together to develop and implement a care plan. Team members know their roles and responsibilities and work together and support one another in delivering the best possible care.

- **Client and Family Involvement** - clients/families are part of the integrated care team. They understand their roles/responsibilities and what is expected of them, and are supported in making informed decisions about their care.

- **Wellness and Safety** - clients are provided with services designed to address their assessed health needs and promote and maintain their well-being in a safe manner.

- **Quality Assurance** – ensuring a minimum quality of care is provided through compliance with the standards.

- **Quality Improvement** - improving the quality of care being provided through evidence-based best practices, supporting innovation and creativity, and creating a culture of quality. This should incorporate the six dimensions of quality of the Alberta Quality Matrix for Health developed by the Health Quality Council of Alberta.

HOME CARE PROGRAM OBJECTIVES

The home care specific objectives as outlined in the Program Policy Manual are to:

- Assist clients to live in the community as independently as possible, preserving the support provided by family and community.
- Work in partnership with other service providers to increase the effectiveness of community care, and to eliminate gaps and duplications in services.
- Manage services effectively and efficiently, demonstrating accountability for the use of public funds.

HEALTH SYSTEM PRIORITIES

Alberta's '5-Year Health Action Plan, 2010-2015' outlines five key strategies to drive health system improvements. These are:

1. Improve access and reduce wait times.
2. Provide more options for continuing care.
3. Strengthen primary health care.
4. Be healthy, stay healthy.
5. Build one health system.

The current home care priorities include:

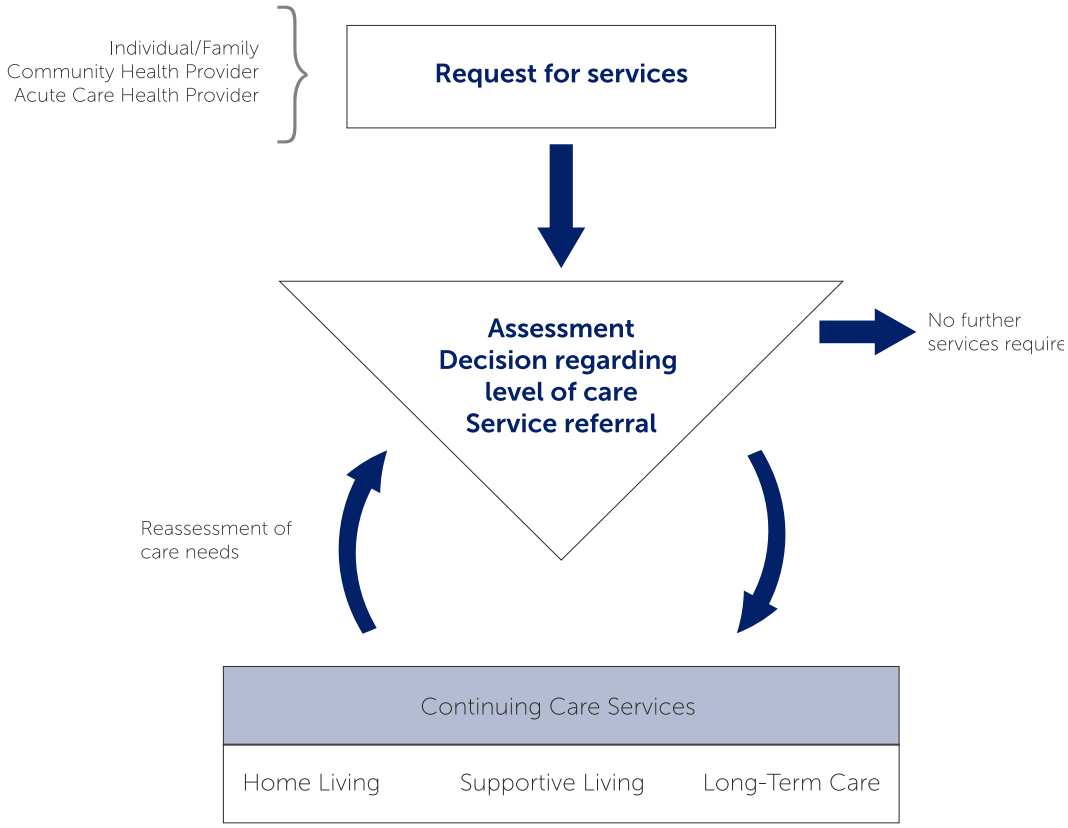
- Implementing coordinated access.
- Identifying core services.
- Implementing system-wide case management.
- Improving integration within the health care system.
- Improving consistency of service eligibility.
- Providing support for both clients and caregivers.
- Supporting the workforce through training and education.
- Developing a communication strategy.
- Building partnerships and collaboration.
- Expanding and adjusting home care so people can remain independent for as long as possible.
- Removing barriers and using technology to better support people at home.
- Increasing support to caregivers.
- Ensuring that people with special needs receive support, care and skilled attention from trained staff.
- Enhancing access, co-ordination and standards for continuing care.

2. Access, Funding & Service Delivery

ACCESS TO HOME CARE SERVICES

All Albertans have 24/7 access to health advice and health information from a registered nurse, via HEALTHLink Alberta. Through AHS' Coordinated Access process, individuals seeking home care, supportive living or long-term care facility services have a single point of entry, through which their needs can be assessed and matched to appropriate services as efficiently and effectively as possible. Only when a person cannot be supported in the community is a referral made for admission to a continuing care facility.

The following figure illustrates the process for accessing publicly funded continuing care health services.



REFERRAL SOURCES

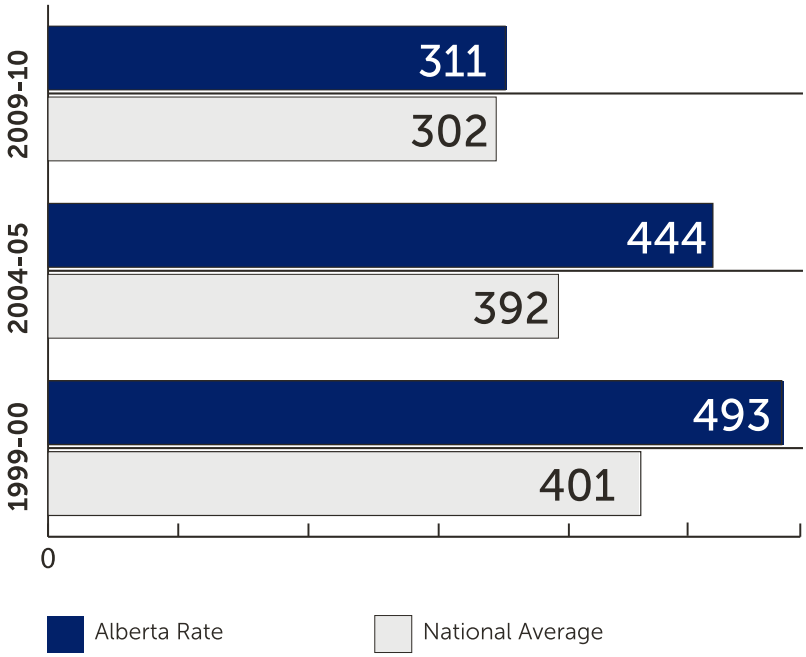
A request for service can be made by individuals, or by family members, friends, health care providers or community agencies acting on their behalf.

APPROPRIATE ACCESS TO HOME CARE & COMMUNITY-BASED CARE

Hospitalization rates for conditions that may be cared for in the community are one indicator of appropriate access to community-based care. These conditions include diabetes, asthma, alcohol and drug dependence and abuse, neuroses, depression and hypertensive disease. Preventive care, primary care and community-based management of these conditions may reduce the need for hospitalization.

Hospitalization Rates For Ambulatory Care Sensitive Conditions

Age Standardized Rate per 100,000 younger than 75



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Alternate Level of Care (ALC)

Alberta Health and AHS have recently developed standardized definitions and a process to track AHS Tier One measures. These measures include "the number of people waiting in acute care hospital beds for continuing care" which represents a subset of all ALC patients.

ALC Challenges and Solutions

"Alternate level of care" (ALC) describes persons who occupy a bed in a facility but no longer require the intensity of resources and services provided in that setting.

14%

of acute care hospital beds are inappropriately used across Canada each day.

30-50%

of ALC patients are candidates to return home.

(Canadian Health Services Research Foundation (2011). Exploring alternative level of care (ALC) and the role of funding policies: An evolving evidence base for Canada. CHSRF Series of Reports on Cost Drivers and Health System Efficiency: Paper 8.)

ELIGIBILITY, COVERAGE & UTILIZATION

ELIGIBILITY

All Alberta residents are eligible for services, subject to assessed need, with the following exceptions:

- Do not meet the eligibility criteria established in the Regulation.
- Require services that are not home care services or that home care is not authorized to provide.
- Require services that are the responsibility of another agency/ department.
- Require services that are the legal responsibility of the owner or operator of the individual's place of residence (e.g. provision of housekeeping in a lodge).
- Are Treaty Indians living on a reserve, unless a contract exists between Health Canada, the Band Council, and the Home Care Program in the area.

AGE

All ages

LIMITS / GUIDELINES TO SERVICE PROVISION

None

DIRECT FEES AND INCOME TESTING

Assessed professional case management, professional health, personal care, and caregiver support services are provided without charge.

A consistent provincial process and fee schedule is being established to determine client charges for the provision of home and community support services.

SUPPLIES, EQUIPMENT AND MEDICATION

Mixed public/private pay.

Albertans are responsible for the cost of prescription drugs provided to them outside hospitals, auxiliary hospitals and nursing homes. Alberta Health contracts with Alberta Blue Cross to offer three supplementary health plans for the following client groups:

- Non-Group Prescription Drug Coverage, available to Albertans under the age of 65 and their dependants.
- Coverage for Seniors, for all Albertans 65 and older and their dependants, and for recipients of the Alberta Widows' Pension and their dependants.
- Palliative Care Drug Coverage, for people diagnosed as being palliative (receiving medical care to relieve symptoms, provided for the terminally ill) and receiving their treatments at home.

The Alberta Aids to Daily Living (AADL) program helps those with a long-term disability, chronic illness or terminal illness to maintain their independence at home, in lodges or in group homes, by providing financial assistance to buy medical equipment and supplies. An assessment by a health care professional determines the equipment and supplies that an Albertan can receive through this program. Albertans pay 25 percent of the benefit cost to a maximum of $500 per individual or family per year. Low-income Albertans and those receiving income assistance do not pay the cost-share portion.

DETERMINING CLIENT NEED - ASSESSMENT TOOLS

Health care professionals from AHS use the RAI-Home Care Assessment and are implementing the RAI-Contact Assessment to identify client needs. The RAI Contact Assessment (RAI-CA) is a brief standardized clinical assessment designed to inform home care intake from community or hospital, and to screen vulnerable populations in hospital emergency departments.

Upon completion of the client assessment, AHS professional case managers discuss care options with the client and family to identify the required services and the most suitable continuing care setting. Home living, with some support, is often the recommended setting. The case manager will also provide a written summary describing the service options and any personal responsibilities, including fees or extra costs. The risks arising from the individual's choices are assessed and mitigated. Mitigation strategies to increase safety might include installing bathroom and kitchen safety aids, such as bath grab bars, or new technologies, such as those used to manage medications. The case manager then makes a referral for services.

All home care clients are assigned to a home care case manager, who is a liaison between the various services required for home care, the client and the client's family. Case managers provide a single point of contact to assist Albertans with matching their needs to the services provided by physicians, health care providers and volunteer-based organizations, such as the Multiple Sclerosis and Alzheimer societies. The case manager monitors progress to make sure the individual's needs are being met and regularly assessed. If needs change, the case manager will assist the individual and family to obtain the necessary services, either in the current setting or in a new continuing care setting.

ADMISSIONS TO HOME CARE

Work is underway to accurately track the number of admissions to home care per year. Issues of multiple admissions, clients seen by home care for assessment and referral to other programs and for movement within programs, are being addressed.

SETTING OF CARE

Home care requires a fixed address to deliver home care services. Where there is no address, staff will collaborate with social workers to establish an address so that services can be provided. Home care services in Alberta are provided in the following settings:

- Home.
- Supportive Living (housing with supports for daily living and health care).
- Nursing Home - Collaboration between LTC & home care, e.g. for teaching. Home care is not provided as direct care to LTC residents.
- Hospice.
- Community settings, e.g. ambulatory clinics and day programs.
- On reserve - Collaboration between reserve and home care, e.g. for teaching reserve health care staff best practice, etc. Do not typically provide direct care on reserve.
- Place of work - in very exceptional cases only – if client is well enough to go to work, they will go to a home care clinic for treatment or follow up.
- School - in collaboration with other partner organizations.

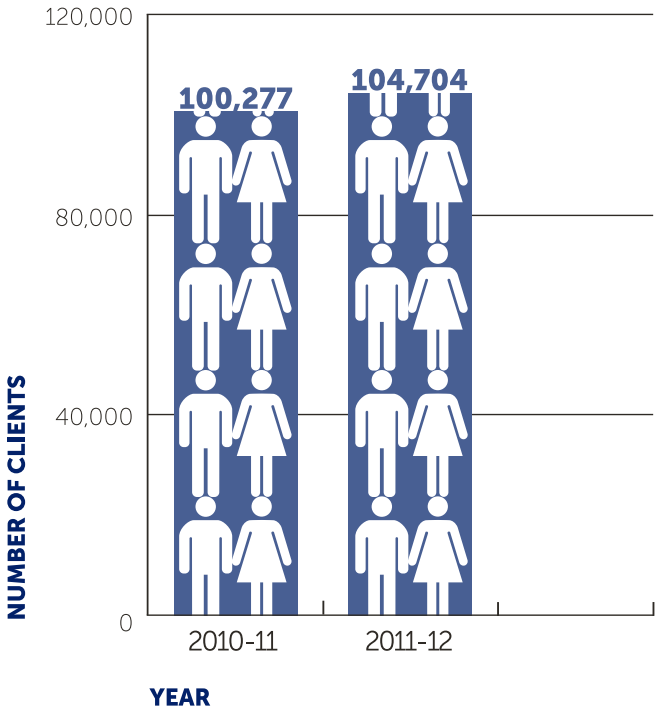
INTEGRATED MODELS OF CARE

Alberta has implemented a number of integrated models of care across the health care system. In order to keep individuals at home, emergency department support teams in 12 different locations throughout the province have been established. This model of care will be provinicialized to ensure clients who have visited emergency departments will be provided with necessary support when returning home. In these settings, the emergency department care co-ordinator (EDCC) is able to assess these highly complex clients and make necessary referrals to home and community support services, in order to avoid unnecessary hospital admission.

Partnership with emergency medical services (EMS) for the community health and pre-hospital support (CHAPS) program is another integrated model of care that provides health service options for seniors living in the community, who are identified to be at risk for loss of independence.

The Alberta government funds specific research programs supported through collaboration with the interdisciplinary team grants (ITG) program. The ITG program provides opportunities for high-quality, internationally recognized teams of investigators to address complex health issues of importance to Alberta.

Individuals Receiving Home Care



Includes clients living in their own home and in supportive living.

Public Expenditures on Home Care

YEAR			
2010-11	$402.4	2.4%	$108.06
	$16,570.3[f]		
2009-10	$383.2	2.6%	$104.34
	$14,574.1		
2008-09	$362.2	2.6%	$100.83
	$13,811.8		
2007-08	$308.4	2.5%	$87.79
	$12,377.8		
2006-07	$284.4	2.3%	$83.13
	$12,258.7		
2005-06	$268.7	2.6%	$80.88
	$10,197.5		

Annual Public Home Care Expenditure
($' 000,000)
Global funding to AHS, allocated to the home care program.

Total P/T Government Health Expenditure[1]
($' 000,000)
CIHI, National Health Expenditure Trends, 1975 to 2011, Table B.4.1
(f- forecast)

Percent of Total P/T Government Health Expenditure

Per capita Public Expenditure on Home Care[2]

[1] *Figures include spending for health services reported by the provincial/territorial ministry responsible for health – does not include expenditures from municipal government or worker's compensation. [CIHI, National Health Expenditure Trends, 1975 to 2011, pg 92]*

[2] *Population data from Statistics Canada, Demography Division, Annual Estimates of Population for Canada, Provinces and Territories, from July 1, 1971 to July 1, 2012*

PROFILE OF CLIENTS RECEIVING HOME CARE

Currently, there is no aggregated, provincial level data on age and diagnosis of individuals receiving home care. It is expected that this will be available once the data collected, using the interRAI-HC, has been successfully submitted to the Alberta Continuing Care Information System.

LEARN MORE

Resident Assessment Instrument-Home Care (RAI-HC)

The Resident Assessment Instrument-Home Care (RAI-HC)© and its next generation tool, the interRAI HC is a standardized, multi-dimensional assessment system for determining client needs. The assessment instruments are used to assess adults in home and community-based settings with chronic needs for care as well as those with post-acute care needs. The instrument is generally used with the frail elderly or persons with disabilities who are seeking or receiving formal health care and supportive services. Assessments are captured electronically and provide real-time feedback for clinicians to support care planning and monitoring in addition to providing organization and jurisdiction level data to support system management, quality improvement and policy-making.

The RAI-HC was developed through interRAI, a collaborative, not-for-profit network of researchers from around the world that works to promote evidence-informed clinical practice and policy decision making through the collection and interpretation of high quality data about the characteristics and outcomes of persons served across a variety of health and social services settings.

(http://www.interrai.org/
RAI-HC© interRAI Corporation, 2001.)

SERVICE DELIVERY

Community-based care programs, such as home care, personal and technical supports, community rehabilitation, assisted living, day programs and respite care, help people retain their independence for as long as possible.

MODEL OF SERVICE DELIVERY

The home care programs within each zone have the option to deliver home care services directly or through contract with outside private organizations. Service contracts are awarded through an open tendering process. Approximately 95 percent of nursing and therapy services are provided by staff directly employed by AHS. Home support services are primarily contracted out, with 80 to 95 percent of staff employed by private providers in the urban settings and approximately 60 percent in rural settings.

RANGE OF HOME CARE SERVICES & PROGRAMS

Services currently funded through home care in Alberta

Professional Case Management	Professional case management is provided by an Alberta Health Services health professional, e.g., a Registered Nurse, Social Worker, Occupational Therapist, or Physical Therapist, who has received additional case management competency training.
Professional Health Services	The Professional Health category includes, but is not limited to, services provided by a: • Registered Nurse (RN). • Nurse Practitioner (NP). • Licensed Practical Nurse (LPN). • Physiotherapist (PT). • Occupational Therapist (OT). • Speech Language Pathologist (SLP). • Respiratory Therapist (RT). • Social Worker (SW). • Registered Dietician (RD).
Personal Care	Personal care services, when required, are provided by Alberta Health Services or contracted providers to home care clients in their own homes, in supportive living or in a range of in community settings, e.g. day programs.
Home and Community Support	In a very limited number of cases, the program provides or arranges for services to be provided when there is no family/caregiver available or the family/caregiver is unable to provide the needed Instrumental Activities of Daily Living (IADL) assistance, community-based private or voluntary alternatives do not exist and there would be significant risk to the client if services were not provided.
Caregiver Support and Respite	Caregiver support and respite are available for primary caregivers who are identified as being in an "at risk" caregiving situation that would be expected to benefit from the provision of these services.
Nurse Practitioner	Availability varies.
Volunteer Coordination Services	

Ancillary support

Oxygen	Provided by Alberta Aids to Daily Living.
Drugs	Palliative drug coverage and non-group coverage for seniors is available through Blue Cross.
Supplies (dressings, stoma, etc)	May be partially provided by home care, client paid or funded by the Alberta Aids to Daily Living program.
Equipment (wheelchairs, walkers, etc)	Provided through Alberta Aids to Daily Living.

SERVICES TYPICALLY NOT FUNDED THROUGH HOME CARE IN ALBERTA

- Physician Services
- Pharmacy
- Clergy / Spiritual Advisor

CLINICAL (SPECIALTY) SKILLS

With the focus on discharging patients from hospital as promptly as possible, there has been an increase in the complexity of care provided at home. The challenge in much of Canada can be in having a critical mass of patients who require certain levels of expertise and, as a result, special skills only being available in urban centres. However, with the advent of remote access to support in the community, there is an opportunity for more complex care to be provided in less populated areas.

Home care nurses provide enterostomal therapy, although access to enterostomal therapists (ETs) can be very limited in rural and remote areas. Many rural sites in Alberta are working on advancing their telecommunications/video conferencing assessment capacity to expand access of ETs.

Home intravenous (IV) therapy is routine and well established in most urban areas and available in rural and remote areas, but not consistently across Alberta. A provincial home care redesign committee, established under Alberta Health Services, is addressing the inconsistencies in service provision in rural versus urban areas through standardization of best practice. For home infusion pumps, infusion therapy, central lines and PICC lines, it is very site specific. In these areas, IV therapy is provided out of the emergency department or hospital based ambulatory clinic.

Regular tracheostomy tube replacement and ventilator care is provided under very specific parameters, such as for children with complex needs.

The following clinical services are not provided in the home by home care staff in Alberta:

- Administration of chemotherapy, blood or blood products.
- Hemodialysis.
- Peritoneal dialysis.

3. Quality & Accountability

High-quality care is evidence-based (appropriate), focused on the patient (or patient-centered), safe and timely (CIHI).

HOME CARE INDICATORS

The home care indicators that are currently monitored at a provincial level through AHS include::

- Amount of service delivery.
- Expenditures.
- Home care admissions.
- Safety issues.
- Number of staff.

QUALITY & ACCREDITATION

EXTERNAL ACCREDITATION

Accreditation is one of the most effective ways for health services organizations to regularly and consistently examine and improve the quality of their services, in order to ensure high standards of care. Alberta Health Services (AHS) is required to be accredited by an organization(s) acceptable to the Minister. The requirement is contained in directive D5-2008 on Mandatory Accreditation, issued under the Regional Health Authorities Act. To date, the Minister recognizes three accrediting organizations for their areas of competence: Accreditation Canada, College of Physicians and Surgeons of Alberta (CPSA), and the Commission on Accreditation of Rehabilitation Facilities (CARF).

AHS received accreditation status award from Accreditation Canada in 2010. AHS continues its accreditation activities with Accreditation Canada each year as part of a continuous, rolling model of accreditation. This will ensure all programs and services provided by AHS are reviewed over the course of three years. The directive also requires that all AHS contracted service providers are accredited with the recognized accrediting bodies, in order to meet the national standards in home care.

QUALITY COUNCIL

The Health Quality Council of Alberta (HQCA) is a corporation created in 2006 by the *Health Quality Council of Alberta Regulation* under the *Regional Health Authorities Act*. The HQCA gathers and analyzes information, monitors the health care system, and collaborates with Alberta Health and Alberta Health Services, health professions, academia and other stakeholders to translate that knowledge into practical improvements to health service quality and patient safety in the health care system. The HQCA is responsible to:

- Measure, monitor and assess patient safety and health service quality.
- Identify effective practices and make recommendations for the improvement of patient safety and health service quality.
- Assist in the implementation and evaluation of strategies designed to improve patient safety and health service quality.
- Survey Albertans on their experience and satisfaction with patient safety and health service quality.
- On the request of the Minister, assess, inquire into, or study matters respecting patient safety and health service quality.

HQCA promotes patient safety and health service quality on a province wide basis, primarily through the lens of the *Alberta Quality Matrix for Health.*

CLIENT / PATIENT ADVOCATE

AHS is required (through the *Patient Concerns Resolution Process Regulation under the Regional Health Authorities Act*) to have a Patient Concerns Officer and patient concerns resolution process. If an individual is unsatisfied with the outcome of the patient concerns resolution process, he/she may file a concern with Alberta's Office of the Ombudsman – the Ombudsman can review the patient concerns resolution process for administrative fairness. The Ombudsman's authority comes from the Ombudsman Act.

The Alberta Health Act contains provisions for a Health Charter and a Health Advocate. The Act has not been proclaimed to date, as regulations are currently under development.

SYSTEM APPROACHES TO QUALITY IMPROVEMENT

The '**Alberta Quality Matrix for Health**' is a framework that provides a common language, understanding and approach to continuous quality improvement among health care organizations, professionals and other stakeholders. The quality matrix has two components: 1) Dimensions of Quality; and, 2) Areas of Need.

The six dimensions of quality focus on the patient/client experience, and are defined as: Quality that is experienced when a patient/client comes in contact with the health system and the system is seen as:

1. **Acceptable** - Health services are respectful and responsive to user needs, preferences and expectations
2. **Accessible** - Health services are obtained in the most suitable setting in a reasonable time and distance
3. **Appropriate** - Health services are relevant to user needs and are based on accepted or evidence-based practice.
4. **Effective** - Health services are provided based on scientific knowledge to achieve desired outcomes.
5. **Efficient** - Resources are optimally used in achieving desired outcomes.
6. **Safe** – Risks are mitigated to avoid unintended or harmful results.

SAFETY

The Health Quality Council of Alberta is responsible to assess and study patient safety and health service quality in the province. **The Patient Safety Framework for Albertans** is a foundational document developed by HQCA to guide, direct and support continuous and measurable improvement of patient safety in the province. The framework subscribes to the following principles:

- Patients are the primary focus of care.
- Organizations create a patient safety culture.
- Information about adverse events is shared in a transparent manner.
- A systems approach is required to understand and address the complexity of factors that contribute to error.
- A continuous improvement approach strengthens the ability to apply new knowledge to make informed patient safety improvements.

HOME CARE RESEARCH

Health research participation is a critical strategic priority for AHS. Alberta Health supports research conducted by the Health Quality Council of Alberta as previously described and by the following organizations and agencies:

Alberta Innovates – Health Solutions - This collaboration supports and enhances health research and research dissemination in order to enable and inform decision-making in health matters. It further links health sector stakeholders in a common enterprise of planning, conducting, synthesizing and applying health research, thereby supporting evidence-based decision-making.

Canadian Agency for Drugs and Technologies in Health (CADTH) - a national body that provides Canada's federal, provincial and territorial health care decision makers with credible, impartial advice and evidence-based information about the effectiveness and efficiency of drugs and other health technologies. CADTH provides information through three programs: Health Technology Assessment (HTA), the Common Drug Review (CDR) and the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS).

Institute of Health Economics - a unique partnership of the Government of Alberta, major academic centres in Alberta and the pharmaceutical industry. The Institute's research mandate is organized around six major programs: Health Economics, Health Technology Assessment, Knowledge Transfer and Dissemination, Special Evaluation Projects, Key Partnerships, and Capacity Building.

Better Health – Better Care – Better Cost

Triple AIM, a roadmap to achieving excellence, high performance and high value health care:

1. Enhance the individual (patient) experience of care (including quality, access, and reliability).
2. Improve the health of populations.
3. Reduce, or at least control, the per capita cost of care for populations.

The five components that support Triple Aim are:

1. Focus on individuals and families.
2. Partnerships of Primary Health Care – Home Care.
3. Population health management – Prevention and Health Promotion.
4. Cost control platform "receiving value for money".
5. System integration and execution.

Adapted from the Institute for Healthcare Improvement, Triple Aim Improvement Community. (Massachusetts: Institute for Healthcare Improvement, 2012)

4. Information Technology

Technology – Transforming Health

Technological advancements have the potential to fundamentally change our health care approach to support a more efficient and person-centred one regardless of the care setting.

Today's innovations enable the integration of monitoring and therapeutic systems, provide educational content, facilitate communication and data flow between members of the health care team and support systems management and quality improvement.

ELECTRONIC HEALTH RECORD (EHR)

Alberta Netcare has been developed by Alberta Health in cooperation and partnership with Alberta Health Services, and numerous partners including the health professional colleges and associations. Alberta Netcare links and coordinates the projects, processes, products, and services related to the Electronic Health Record. The Alberta Netcare EHR Portal improves care by providing data access to available information at the point of care.

Planning is underway to bring all home care programs across the province into a full electronic charting system. The most recent enhancement was the implementation of the Meditech RAI-HC in the Edmonton Zone.

USE OF SYSTEM EFFICIENCY TECHNOLOGY

There is some electronic communication and exchange of information between home care and the hospital, primarily for referrals in rural areas where both are using the Meditech system. The provincial portal (Netcare) enables exchange of information related to emergency department / hospital admissions, lab results, patient demographics, prescribed/dispensed drugs for those 65 years of age and older, diagnostic reports and information on allergies and immunization.

All of the provincial home care programs record the standardized assessment (RAI-HC) electronically. Most recently, the Edmonton Zone has implemented Meditech RAI-HC. With all home care programs in Alberta using the RAI-HC, analysis and benchmarking across the province will be facilitated. Currently, there is limited exchange between home care programs and AHS for submission of indicator data and for financial data exchange.

USE OF TECHNOLOGY FOR CLIENT CARE

Alberta has one of the largest and best integrated telehealth networks in North America. Telehealth in Alberta primarily uses videoconference technology (over 900 sites in the province) to connect Albertans to health care. Telehealth is widely used in home care for education, communication and monitoring. The technology enhances the support provided to those living in rural areas.

The **Continuing Care Technology Innovation (CCTI) Pilot Project** was a two-year initiative that was targeted toward home care clients to assess the efficacy of technologies to assist people to remain at home. The project was launched in 2010 in Medicine Hat and Grande Prairie, and evaluated assistive technologies designed to increase safety for seniors living alone in their homes. The CCTI project found that the technology used was able to provide caregiver support/respite.

Technology is used for scheduling of staff and for submission of indicator data and financial data to AHS. Home care staff is typically equipped with pager, cell phone and laptops/notebook computers. Some provider organizations are using GPS / mapping systems and other technology applications which are not quantified by AHS. The Edmonton Zone has invested in Pixalere, electronic wound care software that enables about 90 percent electronic documentation for wound care.

5. Health Human Resources

CLINICIANS PRACTICING IN HOME & COMMUNITY CARE

Alberta Health receives annual reporting on its health workforce from Alberta Health Services. Home care providers in Alberta, and the rest of Canada, are facing a number of challenges in delivering services due to changes in the services required by home care and community care clients, changing demographics and economic conditions. Alberta Health is working closely with Alberta Health Services and other stakeholders to improve staff recruitment and retention strategies and to develop initiatives to improve the delivery of home care services.

Provincially, a multi-sectoral group has been working on the health human resource issues. The **Health Workforce Action Plan 2007 – 2016**, with 19 key initiatives and recommendations, is a first step towards addressing these issues. Some of the strategies to address the province's health workforce issues over nine years include:

- Creating a health career and skills assessment network.
- Increasing clinical training capacity.
- Attracting health professionals working abroad.
- Reducing and avoiding injury.

HEALTH CARE PROFESSIONALS

Alberta regulates a number of health professions. The majority of these health professions are regulated by self governing colleges under the Health Professions Act (HPA). All regulated health professions will eventually come under the HPA.

UNREGULATED STAFF

Health care aides (HCA) are the unregulated staff deployed through home care. HCAs provide direct client service including personal care, support and basic health care services. HCAs practice under the direct or indirect supervision of a regulated nurse or other regulated health care professional. The '2001 Health Care Aide Competency Profile' defines the HCA scope of practice. Forty competencies are defined in key functional areas, namely:

- Function Effectively in Role.
- Function Effectively as a Member of a Health Team.
- Communicate Effectively.
- Safety.
- Documentation and Preparation of Reports.
- Client-Centered Focus.
- Dementia Care.
- Implement Care Plans.
- Assist Clients with Household Management Activities.
- Assist with Child Care.
- Assist with Palliative Care.

Alberta is creating a provincial directory to monitor and track the number of up-to-date HCAs in the province that meet standard education requirements.

Other unregulated staff used by some home care programs in the province includes the Physical Therapy Assistant and Occupational Therapy Aide.

Who are Family Caregivers?

Family caregivers provide care and assistance for spouses, children, parents and other extended family members and friends who are in need of support because of age, disabling medical conditions, chronic injury, long-term illness or disability. A family caregiver's effort, understanding and compassion enable care recipients to live with dignity and to participate more fully in society.

5 million
is the estimated number of caregivers in Canada

80%
of care needed by individuals with a long-term condition is provided by family caregivers

60%
of caregivers provide care for more than three years

(Canadian Caregiver Coalition www.ccc-ccan.ca.)

EDUCATION & TRAINING

HEALTH CARE PROFESSIONALS

The province intends to work on optimizing and expanding the scope of practice of key health professionals, so they can make full use of their education and skills. There will be increased opportunities for training and education and improved workplace health and safety through certification and mentoring programs.

To address the challenge of sufficient practitioners, the province will recruit at least 70 percent of registered nurses graduated in Alberta and will undertake to ensure the recruitment of the right mix of health professionals to appropriately address need.

UNREGULATED STAFF

The 'Health Care Aide Government of Alberta Provincial Curriculum' was first released in 2005. In 2010, the curriculum was updated and provided to public post-secondary and private institutions, and to employer organizations for use in health care aide education programs in the province.

The curriculum, consisting of 37 modules, is the tool by which HCAs are trained to the 40 competencies identified in the 2001 Health Care Aide Competency Profile.

INTER-PROFESSIONAL COLLABORATION

The province is committed, as part of its '**5-Year Health Action Plan**', to making changes to care processes to increase efficiency and ensure more integrated transitions between health care teams. For example, the **Calgary Rural Primary Care Network** has implemented a community-based model where physicians and Alberta Health Services work together to deliver primary care that addresses the needs of local populations. Patients, providers and the health care system are realizing early positive outcomes, and patients are receiving services locally that were previously unavailable or would have required travel to Calgary.

FAMILY CAREGIVER

Home care policies acknowledge the important contribution of the family caregiver. Assessment of caregiver need is captured through two questions in the RAI-HC. Some zones are using the Caregiver Risk Screen in RAI-HC, and some burden scales are also used. The Edmonton Zone conducted a demonstration project testing out the CARE Tool (a comprehensive psycho social assessment of caregivers). The '**Caregiver Support and Enhanced Respite Pilot Project**' involved an assessment of caregivers for individuals living in the community, with supports and interventions being provided based on the needs of both the individuals and their caregivers, including the flexible provision of respite care services. AHS is working to expand this initiative provincially.

Respite is available for caregivers, e.g. in home respite care hours that allow the caregiver a break from caregiving; however, the number of hours available per client is limited across the province due to budgets. Overnight respite in a facility bed is also available in most communities (pending bed availability) and is not typically funded by home care (client/family pays). The government is committed to increasing the support provided to family caregivers. Specifically, the plan is to increase and enhance education, care, respite, and support services and ensuring consistent access to respite care across the province. The "community initiatives" program that connects seniors, neighbours, and volunteers to support seniors aging in their homes, and was successfully piloted in Edmonton and Jasper.

6. Provincial Initiatives

Investments in home care are recognized as important to enabling successful aging in the community. Within the '5-Year Health Action Plan's' strategy to "provide more options for continuing care" is the goal to expand and adjust home care so people can remain independent for as long as possible. This will be achieved by:

- Expanding home care hours to allow at least 3,000 more people to receive home care services.
- Updating policies and services to ensure consistency in home care services across the province.
- Continuing to expand home care by adding more hours for those requiring short-term care, in order to prevent hospitalization or an emergency situation.

EXPANDING HOME CARE SERVICES

The Government of Alberta dedicated $25 million in Budget 2012 to these three key home care initiatives:

1. Adding new adult day programs for medical, rehabilitation, recreational, social, and related services for as many as 440 new home care clients.
2. Enhancing province-wide access to 24-hour on-call registered nurses for home care clients.
3. Introducing a new program called "Destination Home" to help individuals return home as quickly as possible after a hospital stay and avoid unnecessary hospital visits.

These initiatives will enhance Alberta's overall provincial home care program and provide increased services to Alberta seniors and home care clients.

CASE MANAGEMENT

In order to enhance access, co-ordination and standards for continuing care, a plan that describes the full continuum of care, from home care to long-term care, is being developed. The intent is to ensure that the province has a co-ordinated, flexible and sustainable continuing care system and that Albertans have more choices for services at home and in the community.

CHRONIC DISEASE MANAGEMENT

A chronic disease management strategy is being developed and implemented across the province. The goal is for improved self-management and fewer hospital admissions relating to diabetes and other chronic diseases. Alberta is pilot-testing home technology for monitoring chronic health conditions such as diabetes, emphysema and heart conditions, with the goal of reducing health risks and doctor visits.

SENIORS AND AGING

Home care services are being expanded in an effort to keep seniors safe, healthy and independent in their homes and to reduce the number of avoidable emergency department (ED) visits. An "**ED2Home**" program is being implemented in many jurisdictions to expedite the discharge of seniors and disabled adults from the emergency department to their homes with appropriate connections to community supports, thus reducing avoidable stays in a hospital bed.

The role of emergency medical technicians and paramedics is being expanded to treat patients on-site instead of taking them to an emergency department, as appropriate.

The establishment of a Dementia Coalition with community partners to improve support to caregivers, and the creation of a 24/7 help-line to support those with dementia, their families and caregivers are being explored.

END-OF-LIFE CARE

Expand palliative care beyond the hospital to provide more services in the community, such as day programs, hospices, and home care. A provincial end-of-life/palliative care policy is being explored.

ACUTE HOME CARE

The home care program is being expanded to provide more short-term services for those who are older, frail, or medically complex in order to prevent hospitalization or an emergency situation.

7. Challenges

The overall challenges facing Alberta's health care system include:

- An aging population - by 2030, one out of five Albertans will be more than 65 years old and the average age of Alberta's population will continue to increase.
- A lower 'health adjusted life expectancy' than the Canadian average.
- Decline in supply of human resources both unregulated staff and professionals
- Decline in informal caregiver support.

8. Opportunities

Having moved from nine health regions to one provincial health authority, the greatest need is now to standardize home care practice and ensure consistency of home care service delivery across the province. The opportunities are to:

- Expand and adjust home care so people can remain independent for as long as possible and to ensure people receive similar, consistent services no matter where they live in the province.
- Remove barriers to the use of technology and develop recommendations on province-wide implementation.
- Increase support to caregivers to ensure consistent access to respite care throughout the province.
- Ensure that people with special needs receive support, care and skilled attention from trained staff.
- Enhance access, co-ordination and standards for continuing care and publicly report on performance and compliance with standards.

Over the next five years, Alberta's home care program will be strengthened. More investment will also be made in home care for those living in their own home and those in supportive living.

The vision and role of home care in Alberta is one of a well positioned, integral component within the larger health care system.

ACRONYMS / ABBREVIATIONS

AADL -	Alberta Aids to Daily Living
AHS -	Alberta Health Services
ALC -	Alternate Level of Care
CADTH -	Canadian Agency for Drugs and Technologies in Health
CARF -	Commission on Accreditation of Rehabilitation Facilities.
CDR -	Common Drug Review
CCTI -	Continuing Care Technology Innovation
CHAPS -	Community Health and Pre-hospital Support
CIHI -	Canadian Institute for Health Information
COMPUS -	Canadian Optimal Medication Prescribing and Utilization Service
CPSA -	College of Physicians and Surgeons of Alberta
EDCC -	Emergency Department Care Co-ordinator
EHR -	Electronic Health Record
EMS -	Emergency Medical Service
HCA –	Health Care Aide
HCRS -	Home Care Reporting System
HTA -	Health Technology Assessment
HPA -	Health Professions Act
HQCA -	Health Quality Council of Alberta
ITG -	Interdisciplinary Team Grants
MACH-	Minister's Advisory Committee on Health ,
RAI-CA -	RAI Contact Assessment
RAI - HC -	Resident Assessment Instrument—Home Care
RHA -	Regional Health Authority

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SASKATCHEWAN

HOME CARE IN **SASKATCHEWAN**

In **Saskatchewan**, the definition of home care is consistent with that of the Canadian Home Care Association.

> Home care is an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the family caregiver.

SASKATCHEWAN

BY THE NUMBERS...

591,670 sq km **LAND AREA**	1,057,900[1] POPULATION (2011)	**65%**[3] Percent population in urban settings defined as an area with a population of at least 1,000 and with no fewer than 400 persons per square kilometre (2006)	
69.6[2] Dependency ratio (2009) Ratio of the population aged 0-19 and 65+ to the population aged 20-64	14.6%[1] **Population Seniors 65+ yrs** (2011)	79.5 years[1] **LIFE EXPECTANCY (AT BIRTH)**	**$4,864.94**[2] Public sector health care expenditure per capita (2011 Forecast)

[1]Statistics Canada | [2] Canadian Institute for Health Information (CIHI) / [3] Human Resources and Skills Development Canada

1. Governance & Organization

HEALTH CARE SYSTEM STRUCTURE

The **Saskatchewan Ministry of Health** establishes provincial strategy and policy direction, sets and monitors standards, and provides funding. The Ministry oversees a health care system that includes 12 Regional Health Authorities (RHAs), the Saskatchewan Cancer Agency (SCA), the Athabasca Health Authority, affiliated health care organizations and a diverse group of professionals. Home care services fall under the jurisdiction of the Ministry of Health.

The Ministry of Health is committed to providing high quality health care to the people of Saskatchewan through a responsive, efficient, and patient and family-centered health care system. The Ministry's priority is a health system that puts patients and families first and provides the best possible health care.

Regional Health Authorities (RHAs), which are the governing bodies of the health regions, receive global funding from the province. RHAs provide a comprehensive range of health services including ambulance, rehabilitation, community, mental health, long-term care and hospital services. Specific to home care, the board is responsible for the observance of, and compliance with, the Regional Health Services Act and Regulations and provincial policy pertaining to the delivery of home care.

Regional Health Authorities

- Cypress
- Five Hills
- Heartland
- Keewatin Yatthé
- Kelsey Trail
- Mamawetan Churchill River
- Prairie North
- Prince Albert Parkland
- Regina Qu'Appelle
- Saskatoon
- Sun Country
- Sunrise

The regional health authorities are accountable:

- Through the Ministry of Health to the Legislature for the proper expenditure of public funds to provide home care services.
- For planning, administrating and delivering home care services in the region.
- For adhering to program policies established by the Community Care Branch of Saskatchewan Health.

The exception to the above is the Athabasca Health Authority, which is not a regional health authority but an entity that annually enters into a funding agreement with Saskatchewan Health and the federal government to provide health services to those residing in the Athabasca Region.

HEALTH CARE & HOME CARE LEGISLATION

There is no legislation specifically for home care; however, there are many pieces of legislation that impact home care including, but not limited to:

Regional Health Services Act (2002) – An Act respecting the delivery of health services, establishing and governing health regions and regional health authorities, governing health care organizations, respecting standards related to health services and facilities and making consequential amendments to certain other Acts. This Act provides the authority for the delivery of home-based services by the regional health authorities.

The Department of Health Act (2003) - Provides the legal authority for the Minister of Health to make expenditures, undertake research, create committees, operate laboratories and conduct other activities for the benefit of the health system.

The Health Information Protection Act (2009) - Protects personal health information in the health system in Saskatchewan and establishes a common set of rules that emphasizes the protection of privacy, while ensuring that information is available to provide efficient health services.

The Health Quality Council Act (2002) - Governs the Health Quality Council, which is an independent, knowledgeable voice that provides objective, timely evidence-based information and advice for achieving the best possible health care using available resources within the province.

EVOLUTIONARY MILESTONES

1978
A comprehensive program of home care first introduced under the Department of Social Services.

1983
Home care became the responsibility of the Department of Health.

1984
All home care districts operational.
Services in the south of the province delivered by 45 non-profit incorporated home care boards.

1994
Amalgamation of home care boards and district health boards (32) in the mid and southern part of the province.

2002
Districts merged into 12 Regional Health Authorities (RHAs).
Children with Highly Complex Care Needs program formerly approved.
Individualized Funding commenced.

2005
Implementation of the Collective Funding Policy intended to simplify the managing, funding and accounting process for groups of people living together that are eligible for Individualized Funding through the home care program. This group of individuals is referred to as the collective group.

Implementation of Resident Assessment Instrument - Home Care Assessment (RAI-HC) in some RHAs leading to full implementation provincially.

2006
Health Accord/Agreement results in elimination of fees for personal care for short-term acute clients for up to 14 days.

Establishment of the mental health crisis line.

Enhancement of palliative care services through training and education for staff.

Saskatchewan Health worked with Regional Health Authorities to facilitate the development, implementation and delivery of acute community mental health home care. This includes acute community mental health home care, which includes case management, professional and home support, without fees, for up to 14 days.

2009
One-time funding $1.75M Regina Palliative Care Inc. (RPCI) for operations of the Greystone Bereavement Centre (GBC) in Regina.

Consultations with seniors and subsequent report, *"Focus on the Future: Long-Term Care Initiative"*.

Saskatchewan Surgical Initiative – included consultations with the RHA home care directors.
Implementation of Medication Reconciliation across all regions (in progress).

2010

Implementation of Medication and Compliance Packaging.

All RHAs have implemented Minimum Data Set for Home Care (RAI- HC) with the exception of Athabasca and Keewatin Yatthe Health Regions.

Completion of the telehomecare pilot project and evaluation in the Kelsey Trail Health Region (KTHR).

Home Care Policy Manual update. This manual provides direction and guidance to Regional Health Authorities.

2011

Saskatchewan Falls Collaborative, aimed at reducing the incidence of falls and injury from falls by 20% in participating home care and long-term care facilities, underway.

MANDATE, MISSION, PRINCIPLES & PRIORITIES

MANDATE

Home care helps people who need supportive, palliative and acute care to remain independent at home. Home care encourages and supports assistance provided by the family and/or community.

PRINCIPLES OF HOME CARE

- People can usually retain greater independence and control over their lives in their own homes.
- Most people prefer to remain at home and receive required services at home.
- Support provided by families and friends should be encouraged and preserved and, if necessary, supplemented.
- Service should assist individuals and families to retain maximum independence and avoid unnecessary dependencies.
- Home care should assist people to access needed health and social services.
- Home care should preserve and promote volunteer involvement.
- Service decisions in home care should be based on assessed client need and the risk to the client if service is not provided.
- Individuals and their supporters should help identify their needs, establish goals, and develop plans to meet goals.
- People with the greatest need for home care should receive priority for service.
- Individuals have the right to be treated with kindness, dignity and respect.
- A person's right to live at risk to one's self and to accept or refuse services is respected.
- Home care services should be provided respecting the client's cultural values and, whenever possible, by staff who are of the client's language and culture.
- RHAs should have significant responsibility for planning and delivering home care services.
- Home care involves the planning and coordinating of local health and social services.
- Home care does not usually provide services to allow caregivers to work at a long-term job.
- Home care is not normally provided to relieve parents from routine childcare.

HOME CARE PROGRAM OBJECTIVES

- To help people maintain independence and well-being at home by:
  - Determining needs and abilities, developing and coordinating plans of care.
  - Teaching self-care and coping skills.
  - Improving, maintaining or delaying loss of functional abilities.
  - Promoting and supporting family and community responsibility for care.
  - Supporting palliative, supportive and acute care provided by family, friends and neighbors.

- To facilitate appropriate use of health and social services by:
  - Preventing or delaying the need for admission to long-term care facilities and assisting on discharge.
  - Supporting people waiting for long-term care admission.
  - Preventing the need for hospital admission, making earlier discharge from hospital possible, and reducing the frequency of re-admission.
  - Helping individuals and families access needed services.
  - Promoting volunteer participation.
  - Educating the public about home care.
  - Participating in local service planning and coordination.

- To make the best use of home care resources by:
  - Serving people with the greatest need first.
  - Operating economically and efficiently.

- To meet client needs and optimize client independence within available home care financial resources while working cooperatively with other community agencies, organizations and individuals.

The **current home care priorities** are to support the Saskatchewan Surgical Initiative and achieve timely access to evidence-based and quality health services and supports.

Each RHA has developed and submitted a plan to the Ministry of Health to:

- Ensure targeted funds are allocated to home care and rehabilitation therapies.
- Implement the additional home care and rehabilitation therapies to support the surgical experience and report as required.

HEALTH SYSTEM PRIORITIES

The five year and strategic priorities for the health care system are to achieve "Better Health, Better Value, Better Care, Better Teams". Addressing care for seniors is a key priority and the outcome envisioned by the Ministry of Health is that by 2017 seniors will have access to supports that will allow them to age within their own home and progress into other care options as their needs change.

1. Better Care – Transform the patient experience through "Sooner, Safer, Smarter Surgical Care".
2. Better Health – Strengthen patient-centred primary health care by improving connectivity, access and chronic disease management.
3. Better Value – Deploy a continuous improvement system including training, infrastructure across the health system with the initial focus on the surgical value stream and 3P - Production, Preparation, Process methodology.
4. Better Care – Safety culture with focus on patient and staff safety.
5. Better Health – Identify and provide services collectively through a shared services organization.

2. Access, Funding & Service Delivery

ACCESS TO HOME CARE SERVICES

Saskatchewan has a single-entry system with 24 hr accessibility through each Regional Health Authority, which provides assessment and care coordination for clients. RHAs provide coordinated access to long-term care, respite, adult day programs and home care. The guidelines direct that coordinated access:

- To long-term care, home care, adult day programs and respite services ensures that clients are prioritized based on greatest need.
- Enables the Regional Health Authority to identify gaps in programming and the need for new initiatives, and to effectively use resources within the region.
- Includes a case management approach, avoids duplication of service and ensures that appropriate service is provided.

Each Regional Health Authority employs one or more case coordinators who are responsible for assessment, care planning and case management for home care clients. Home care is provided on the basis of assessed need and degree of risk for illness, injury and institutionalization. The coordinator monitors each client and alters the services if necessary. Service is based on functional need.

Accessing service after business hours for unpredicted needs is, at a minimum, through telephone contact with a person knowledgeable about the home care program. Appropriate action may include coordinating arrangements to meet the client's needs and a referral to a home care staff member, if required.

Access to home care is generally consistent between rural and urban settings. However, service delivery is more difficult in rural areas due to the large, sparsely populated geographic area.

REFERRAL SOURCES

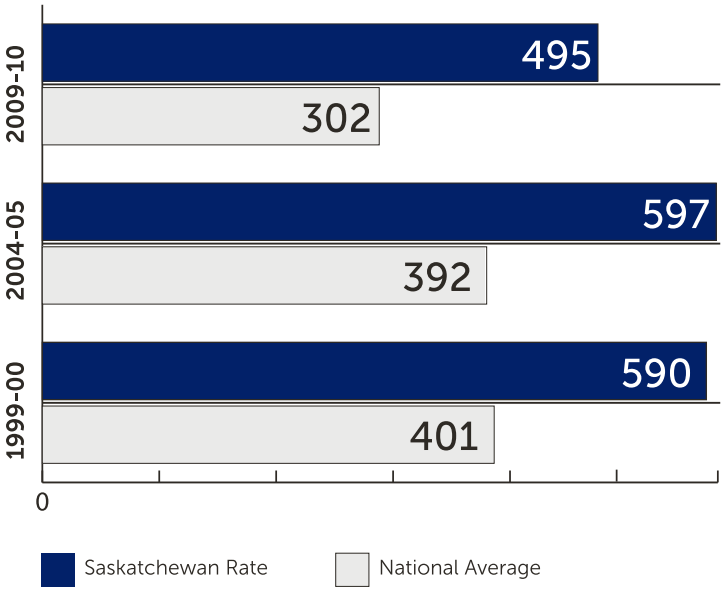
Anyone (i.e. self, physician and family member) can make a referral for home care services. In 2010-11, 41 percent of clients were referred from hospital directly to home care.

APPROPRIATE ACCESS TO HOME CARE & COMMUNITY-BASED CARE

Hospitalization rates for conditions which can be cared for in the community are one indicator of appropriate access to community-based care. These conditions include diabetes, asthma, alcohol and drug dependence and abuse, neuroses, depression, hypertensive disease and others. Preventive care, primary care and community-based management of these conditions may reduce the need for these hospitalizations.

Hospitalization Rates For Ambulatory Care Sensitive Conditions

Age Standardized Rate per 100,000 younger than 75



Health Indicators Reports, CIHI

Alternate Level of Care (ALC) is a measure used to reflect when a patient is occupying a bed in a hospital and does not require the intensity of resources / services provided in this care setting. Surveys of regional health authorities on March 31, 2012 indicate the percentage of acute care beds in the province occupied by clients waiting placement was 4.8 %.

LEARN MORE

ALC Challenges and Solutions

The term "alternate level of care" (ALC) is used to describe persons who occupy a bed in a facility but no longer require the intensity of resources and services provided in that setting.

- 7,500 or 14% of acute care hospital beds are inappropriately used across Canada each day.
- 2.4 million days is the total use of acute hospital beds occupied by alternate level of care or ALC patients in a single year across Canada.

Home and community care programs play a key role in supporting the estimated 30-50 % of ALC patients across Canada who are candidates to return home. Managing the ALC challenge takes a systems approach and requires collaboration of providers across the health care continuum so that individuals receive the right care in the right location.

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ELIGIBILITY, COVERAGE & UTILIZATION

ELIGIBILITY

Applicants for home care must meet one of the following criteria:

- Hold a valid Saskatchewan Health Services card.
- Be in the process of establishing permanent residence in Saskatchewan and have applied for a Saskatchewan Health Services card.
- Be a resident of Manitoba or Alberta in a border community where contractual arrangements have been approved by the Saskatchewan Ministry of Health.

Some Indian Bands have contractual service agreements with RHAs to request services for Registered Status Indians living on-reserve.

Non-residents who are not required to apply for a Saskatchewan Health Services card in order to access home care services include:

- Students (who are in the province for less than 12 consecutive months).
- Individuals who have employment contracts for a maximum of 12 months.
- Interim refugees who are covered by Health Canada.
- Refugees intending to remain in Saskatchewan who receive coverage upon application for a Saskatchewan Health Services card.

AGE OF CLIENTS

All ages

The *Children with Highly Complex Care Needs program* is for children and youth with complex, life-threatening conditions who meet the following criteria:

- Are younger than 22 years of age.
- Needs can be safely met at home.
- The family accepts the role as primary caregiver.
- The cost of the child's assessed direct care needs exceeds the average provincial monthly amount paid by the Ministry of Health for Institutional Supportive care.
- Require ongoing care for a period of time greater than three months.

DIRECT FEES AND INCOME TESTING

There is no fee for:

- Assessment and care coordination and services provided by a nurse, physical therapist, or occupational therapist.
- Services provided to palliative clients who are assessed as end stage or as requiring acute care management of palliative symptoms regardless of palliative stage.
- Personal care services for up to 14 calendar days for short-term acute clients, including clients with mental health issues.

For chargeable services (meals, homemaking and home maintenance), effective October 1, 2011 all clients pay $7.44 for each unit for the first ten units in a month. After ten units in a month, the client is charged a unit rate corresponding to the client's adjusted monthly income. A unit is an hour or a meal.

The maximum monthly charge is $74.40 for:

- Clients receiving Social Assistance Plan or Saskatchewan Employment Supplement.
- Clients receiving Saskatchewan Income Plan and not receiving a War Veteran's Allowance.
- Clients with an adjusted monthly income of $74.40 or less.

For all other clients, the maximum charge is the lesser of the rate corresponding to the client's adjusted monthly income, or $449 per month.

Home Care Fee adjustments occur annually in October.

For Canadian citizens staying temporarily in the province, the RHAs should charge for:

- All services, including assessment and care coordination, nursing and therapies.
- The direct cost of providing a unit of service, including all service costs, but not administration costs.
- Where the charge for services provided imposes a serious financial hardship for the non-resident, may charge less than the full cost of service, but not less than the amount a Saskatchewan resident with the same income would be charged for the same service.

Non-Canadian citizens staying temporarily in the province should be charged the full cost of service including administrative costs.

SUPPLIES, EQUIPMENT AND MEDICATION

RHAs fund:

- Home care nursing supplies if required, including, wound care supplies, urinary supplies, bowel supplies.
- Home parenteral medication program when prescribed as an acute care replacement measure. The Saskatchewan Prescription Drug Plan approves parenteral medications administered for maintenance therapy of life long or chronic conditions, except when the patient is a registered inpatient in an acute care facility. Drugs administered parenterally include subcutaneous or intramuscular injections as well as intravenous medications.
- Supply costs for specific medications in both the acute and chronic therapy categories. The supplies to be provided to the client without charge include but are not limited to, intravenous solutions, tubing, heparin locks and caps, pump cassettes, syringes and needles.

Eligibility of drugs for coverage will be subject to the Hospital Benefit Drug List, Saskatchewan Formulary, and/or Regional Health Authority protocols. These policies apply to residents of special care homes as well as community residents.

LIMITS / GUIDELINES TO SERVICE PROVISION

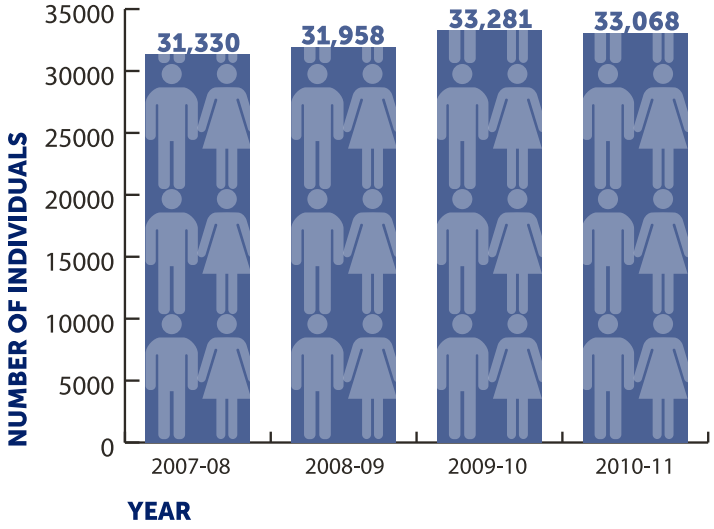
Home care services are provided to individuals based on assessed need. While there is no provincial policy that addresses limits to service, the regions often determine that when home care service reaches the level of the cost of care of a nursing home, home care clients should be reassessed and options provided.

DETERMINING CLIENT NEED - ASSESSMENT TOOLS

Resident Assessment Instrument – Home Care (RAI-HC) has been rolled out across the province to serve as the standard and automated assessment tool. This assessment is supported through technology and computer support software purchased by each Regional Health Authority from an interRAI approved vendor. All regions, with the exception of the Athabasca Health Region and Keewatin Yatthe Regional Health Authority are currently using MDS-HC (Minimum Data Set Home Care). For those regions that have not yet implemented MDS-HC, the Saskatchewan Client Information Profile (SCIP) is used for client assessments.

With the consent of the client the assessments are shared with the members of the health care team, including the client, family, power of attorney, personal care home staff, visiting nurse, home support staff, therapy staff and physician.

Home Care Admissions



Typically there are no wait lists for basic home care services, although some RHAs have reported wait lists for Individualized Funding (IF), a special program within the RHA home care program. The Individualized Funding Program, established in October 2002, is an option under the RHA home care program that provides funding directly to a person (or their guardian) to arrange and manage their own support services. (Professional health services such as registered nursing or therapies are not included in Individualized Funding.) Clients may still receive these professional services while receiving Individualized Funding.

SETTINGS OF CARE

Home care services in Saskatchewan are provided in the following settings:

- Clinic - typically professional services only.
- Group Home - typically professional services only.
- Home.
- Hospice - typically professional services only.
- Nursing Home – sometimes to provide IV Therapy.
- On-reserve - services can be provided by the RHA through contracts with the band
- Place of work – occasionally.
- Personal Care Home - typically professional services only.
- School – occasionally.
- Street - i.e. for homeless population – occasionally.

INTEGRATED MODELS OF CARE

Strengthening Primary Health Care in Saskatchewan is a framework designed to deliver high quality patient care. The model is patient-centred, community designed, and team delivered. Characteristics of the model include:

- Interdisciplinary, team-based care to provide integrated, holistic health services.
- Collaborative practice to facilitate more comprehensive and coordinated care.
- Professionals working to their full scope of practice while enjoying a better work-life balance.
- Teams working to develop greater integration between health services and improved collaboration and communication between health professionals.
- Extended hours of service and new technology to support enhanced access.
- Twenty-four hour health information through Healthline, a telephone service staffed by RNs, and Social Workers specially trained to help individuals make decisions about health care options.

LEARN MORE

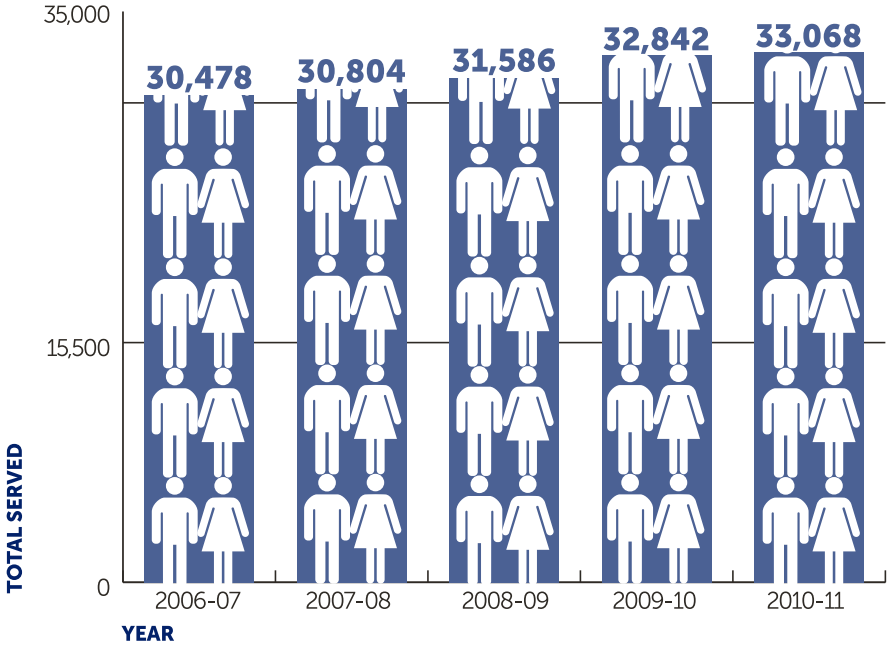
Resident Assessment Instrument-Home Care (RAI-HC)

The Resident Assessment Instrument-Home Care (RAI-HC)© and its next generation tool, the interRAI HC is a standardized, multi-dimensional assessment system for determining client needs. Assessments are captured electronically and provide real-time feedback for clinicians to support care planning and monitoring in addition to providing organization and jurisdiction level data to support system management, quality improvement and policy-making.

The RAI-HC was developed through interRAI, a collaborative, not-for-profit network of researchers from around the world that works to promote evidence-informed clinical practice and policy decision making through the collection and interpretation of high-quality data about the characteristics and outcomes of persons served across a variety of health and social services settings.

(RAI-HC© interRAI Corporation, 2001. http://www.interrai.org)

Individuals Receiving Home Care



DISCHARGE FROM HOME CARE

Discharge disposition from home care, of individuals who have received home care service, is increasingly important and instructive to the health care system as it is an indicator of effectiveness. The outcomes can guide system planning and the development of care algorithms for specific patient populations. The following chart includes all discharges – noting that a single client may have been discharged and admitted more than once in the fiscal year.

Discharge Destination

	2001-02	2005-06	2010-11
Acute In-Patient Facility	1.2%	1.2%	0.5%
Skilled Nursing Facility and Long-term Care Residence	11.4%	7.6%	7.0%
Other Care Home (Personal Care Home, Approved, Private, Group, etc.)	3.1%	3.9%	3.0%
Discharged to Self/Family Care	65.5%	68.0%	55.7%
Other	3.9%	4.7%	13.6%
Died	14.9%	14.6%	20.2%

Reason for Discharge

	2005-06	2009/10	2010/11
Functional Improvement or Recovery	62.0%	57.4%	52.7%
Deceased	14.6%	20.2%	20.2%
Care Needs Beyond Capacity of Home Care	9.8%	8.9%	9.0%
Other	4.6%	7.8%	12.1%
Support System Improved	4.0%	1.3%	1.4%
Moved Out of Region	2.7%	2.9%	2.8%
Client Refused Further Services	2.3%	1.5%	1.8%

In 2010/11 there were 858 admissions (2.5 percent) that occurred within 30 days of a previous discharge. Included in this figure were:

- Multiple discharge/re-admission combinations for the same client.
- Discharges in the last 30 days of the 2009/10 fiscal year if there was a corresponding admission in the 2010/11 fiscal year that occurred within 30 days.
- Clients with Out-of-Province Health Insurance Numbers.

Excluded from the figure were admissions and discharges occurring on the same day.

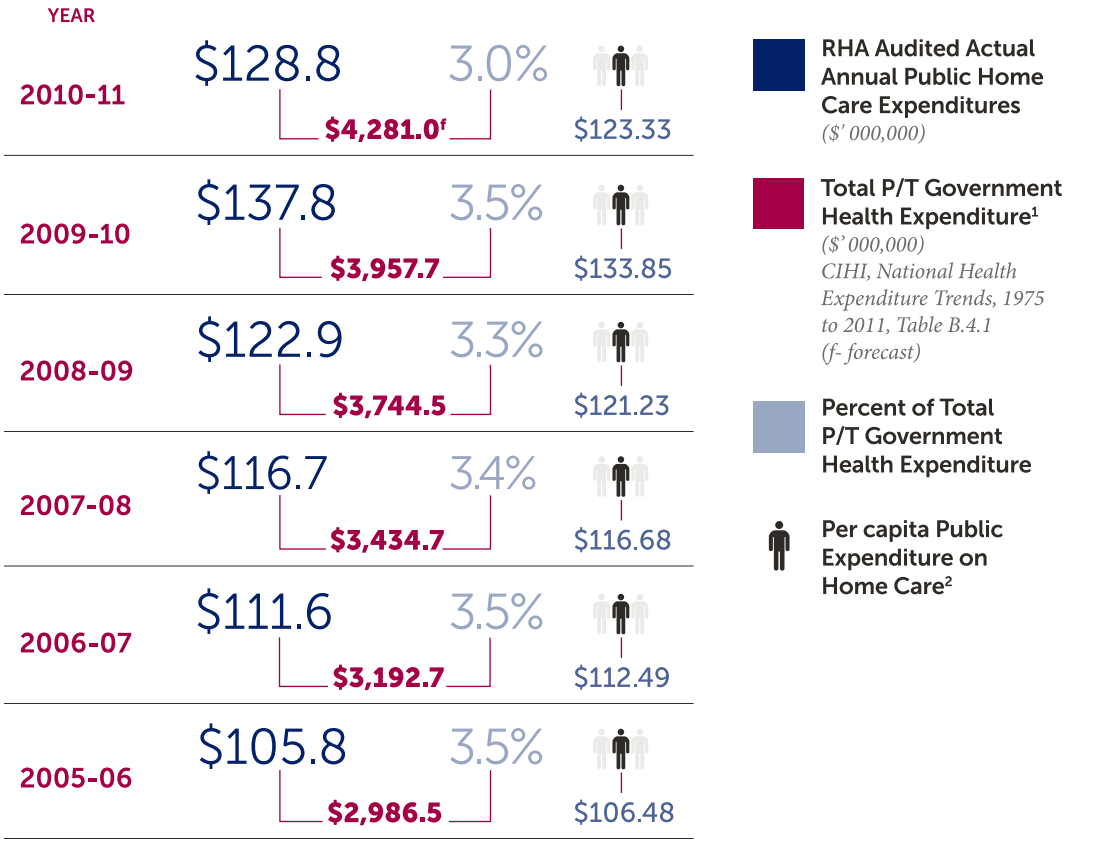
After discharge from home care, clients with valid Saskatchewan Health coverage may be eligible for drug plan benefits through the Saskatchewan Prescription Drug Plan. The cost of prescriptions varies depending on the type of benefits individuals receive.

The Saskatchewan Aids to Independent Living (SAIL) provides benefits that assist people with physical disabilities to achieve a more active and independent lifestyle and to assist people in the management of certain chronic health conditions. The SAIL program is comprised of: Orthopedic Services, Special Needs Equipment Program, Home Respiratory Services and Therapeutic Nutritional Products.

FUNDING

Saskatchewan Health allocates funds for home care, to Regional Health Authorities, on a global basis. The RHAs are responsible for service delivery and monitoring. Services covered under expenditures include: assessment, care planning, case management, nursing, rehabilitative therapy assessment, health teaching, personal care, respite, home support, assessment and facilitation of long-term care placement, administration.

Public Expenditures on Home Care

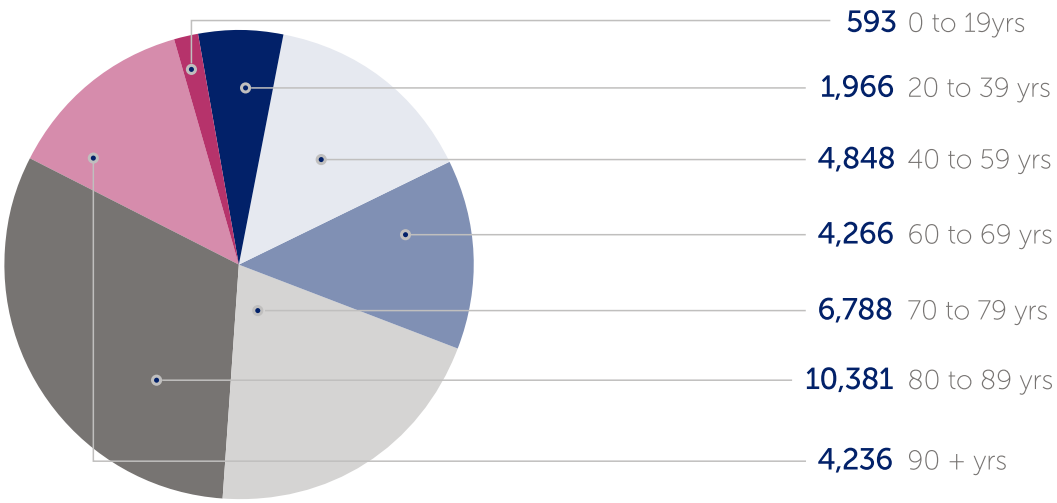


[1] *Figures include spending for health services reported by the provincial/territorial ministry responsible for health – does not include expenditures from municipal government or worker's compensation. [CIHI, National Health Expenditure Trends, 1975 to 2011, pg 92]*

[2] *Population data from Statistics Canada, Demography Division, Annual Estimates of Population for Canada, Provinces and Territories, from July 1, 1971 to July 1, 2012*

PROFILE OF CLIENTS RECEIVING HOME CARE

Number of Individuals Receiving Home Care By Age Category (2010-11)



CLIENT GROUPING

Saskatchewan uses a slightly modified version of the Canadian Institute for Health Information (CIHI) definitions, with 'maintenance' and 'rehabilitation' services reported under Long-Term Supportive Care and Acute Care Substitution categories, respectively.

LEARN MORE

Home Care Client Grouping

Developed in 2003, through the CIHI National Indicators and Reports for Home Care Project, five core home care program components were developed to enable comparisons between jurisdictions.

- **Maintenance** – maintain independence and, where possible, to enhance client's performance of ADLs and IADLs.
- **Rehabilitation** – improve functional status and facilitate social integration and independence.
- **Long-Term Supportive Care** – prevent or delay institutionalization.
- **Acute Care Substitution** – prevent an acute facility admission or re-admission and/or to reduce the length of stay in an acute care facility.
- **End-of-Life Care** – meet the needs of individuals whose health condition is not responsive to curative treatment and who are dying.

(Canadian Institute for Health Information. (2004). Development of National Indicators and Reports for Home Care—Phase 2 Final Project Report. Ottawa: Canadian Institute for Health Information.)

The number of clients served is summarized below. There has been a slight shift away from acute care substitution to long-term supportive care.

Numbers of Clients Served

	2006-07	2007-08	2008-09	2009-10	2010-11
Acute Care Substitution	9,912	9,484	8,723	8,840	8,425
End-of-Life Care (palliative)	1,230	1,197	1,463	1,513,	1,770
Long-Term Supportive Care	19,336	20,123	21,400	22,489	22,633
Unknown					240
Total	**30,478**	**30,804**	**31,586**	**32,842**	**33,068**

Units of Service Provided

	2005-06[1]	2006-07	2007-08	2008-09	2009-10	2010-11
Acute Care Substitution	158,105	123,546	120,673	110,892	121,923	107,930
End-of-Life Care (palliative)	47,460	40,826	41,386	53,950	55,737	61,157
Long-Term Supportive Care	1,519,073	1,503,434	1,455,152	1,440,434	1,502,807	1,518,029
Unknown	20,842					3,168
Total	**1,745,480**	**1,667,806**	**1,617,211**	**1,605,276**	**1,680,467**	**1,690,284**

[1]*Canadian Home Care Association, Portraits of Home Care 2008*

SERVICE DELIVERY

MODEL OF SERVICE DELIVERY

All home care services are provided directly by the Regional Health Authority home care programs. Every Regional Health Authority must offer the primary home care services which include:

- Assessment.
- Case management and care coordination.
- Nursing.
- Homemaking that includes personal care, respite and home management.
- Meal service.

RANGE OF HOME CARE SERVICES & PROGRAMS

Services Provided by Home Care

Case Coordination / Management	Includes assessment, planning, coordinating, implementing, monitoring and evaluating health-related services.
Nursing Services	• Teaching and supervising self-care to clients receiving personal care or nursing services. • Teaching personal care and nursing procedures to family members and other supporters. • Performing nursing assessments. • Performing nursing treatments and procedures as outlined in a home care nursing textbook approved by Community Care Branch. • Providing personal care when the assessment process specifies that it is warranted by the condition of the client. • Teaching and supervising home care aides/continuing care assistants, providing personal care and delegation of nursing tasks. • Initiating referrals to other health professionals and agencies.
Homemaking Services Personal Care	Personal care component may include: • Assisting with/or supervising activities of daily living, such as bathing, grooming, dressing, medication assists, feeding, toileting and transferring. • Teaching self care.
Homemaking Services Home Management	Home management may include: • General household cleaning. • Menu planning and meal preparation. • Laundry. • Changing linen. • Other aspects of operating a household as required.
Homemaking Services Respite	Any combination of services provided specifically for the purpose of giving relief to the family or other caregivers of a dependent person who lives at home.
Meal Service	Includes 'meals-on-wheels', in which meals are delivered from an institution, restaurant or private meal provider to clients at home; and/or, 'wheels-to-meals', in which meals are prepared and provided to clients at a central location where a meal is served. (e.g., Senior Citizens' Activity Centre).

Additional Home Care Services

The approval for proposed services beyond the primary services are reviewed on an individual basis considering traditional service patterns, assessed need and availability of resources and cost.

Home Maintenance	Includes: • Performing minor outdoor tasks essential for the safety of clients. • Performing minor home maintenance repairs essential for the safety of clients. • Installing and maintaining equipment aids for independent living. • Installing handrails and non-skid surfaces.
Volunteer Programs	Includes: • Surveillance. • Delivering meals. • Friendly visiting. • Attendant service. • Errands and shopping. • Transportation. • Home maintenance services.

Therapies	Includes: • Occupational therapy. • Physical therapy. • Respiratory therapy. • Dietetics. • Speech language pathology services.
Adult Day Programming	Typically provided through the special care home system, as opposed to the home care system.

Ancillary support

Oxygen	Covered by Saskatchewan Aids to Independent Living for individuals designated as "end stage" palliative through the RHA's assessment and case management process.
Drugs	Covered for individuals designated as palliative. Individuals in the later stages of their illness, for whom care consists primarily of managing symptoms such as pain, nausea and stress, may be eligible for full coverage of benefit drugs under the Saskatchewan Prescription Drug Plan.[1] Approved parenteral therapy medications are covered when they are prescribed as an acute care replacement measure for acute and chronic therapy in the home.
Supplies (dressings, etc)	Nursing supplies provided.
Equipment (wheel chairs, walkers, etc)	Saskatchewan Aids to Independent Living provides, without charge, a variety of equipment, appliances and supplies to persons with physical disabilities in the community that also includes 50 percent cost coverage for ostomy supplies.

[1]Drug Plan coverage does not depend on the Regional Health Authority's designation of the individual as "palliative," but rather on the physician's designation. As well, drug coverage is not restricted to the end stage of the palliative process.

SERVICES CURRENTLY NOT FUNDED THROUGH THE HOME & COMMUNITY CARE PROGRAM

- Nurse Practitioner
- Social Work
- Respiratory Therapy
- Physician Services
- Pharmacy
- Pastoral Care

Number of Individuals Served

	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
Home Support Service	11,243	11,217	10,632	10,823	10,884	10,756
Nursing – RN and LPN services	26,896	27,766	27,594	28,424	29,953	29,957

Amount of Service Provided

The amount of publicly funded service by service category[1] is expressed in units[2] in the following chart.

	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
Home Support Service	1,001,359	972,726	914,373	899,877	946,882	934,851
Nursing – RN and LPN services	348,680	357,878	397,859	354,134	375,678	388,037

[1] *An individual can receive more than one category of service*
[2] *One unit equals one hour of service.*

CLINICAL (SPECIALTY) SKILLS

With the focus on discharging patients from hospital as promptly as possible, there has been an increase in the complexity of care provided at home. The challenge in much of Canada can be in having a critical mass of patients who require certain levels of expertise and, as a result, special skills only being available in urban centres. However, with the advent of remote access to support in the community, there is an opportunity for more complex care to be provided in less populated areas.

Home care nurses are able to:

- Administer narcotics.
- Provide enterostomal therapy, wound care, peritoneal dialysis, infusion therapy.
- Manage infusion pumps, central lines and peripherally inserted central catheters (PICC lines).
- Provide ventilator care and regular tracheostomy tube replacement.
- Manage home oxygen for individuals in their homes across the province.

Clinical services not provided in the home by home care staff in Saskatchewan include:

- Administration of chemotherapy and blood or blood products.
- Provision of hemodialysis. (The Regina QuAppelle Health region has a home hemodialysis program managed through the region's renal program; home care does not currently provide support for this program).

3. Quality & Accountability

HOME CARE INDICATORS

The Ministry of Health works with the Regional Health Authorities to share information regarding home care measures that provide information about the provision of home care services.

Acceptability:

- Services provided to home care clients.
- Number of concerns – home care.

Accessibility:

- Home care clients and units of service by RHA.
- Home care clients by care type and RHA.
- Home care service ratios by care type.

Appropriateness:

- Distribution of home care services.
- Audited home based services expenditures.
- Home care expenditures by region.
- Home care units of service per client by age group.

QUALITY & ACCREDITATION

High-quality care is evidence-based (appropriate), focused on the patient (or patient-centered), safe and timely (CIHI).

EXTERNAL ACCREDITATION

Accreditation is an effective way for health services organizations to regularly and consistently examine and improve the quality of their services in order to ensure high standards of care. Organizations in Canada are accredited through Accreditation Canada, CARF, the Quebec Council of Accreditation (Quebec only) and/or registered with the International Standards Association (ISO).

Saskatchewan's home care programs are accredited through Accreditation Canada as part of the Regional Health Authority's process. All RHAs are accredited.

QUALITY COUNCIL

The Health Quality Council (HQC) is an independent agency that measures and reports on quality of care in Saskatchewan, promotes improvement, and engages its partners in building a better health system. The Council is led by an appointed panel of provincial, national, and international health leaders who provide advice to government, regional health authorities, and health care professionals on a wide range of issues related to health system quality and performance.

Quality Insight was developed by the Council to provide access to information about how the health system is performing. Measureable targets to improving the complex spectrum of surgical care (from

disease prevention and health promotion to improving access to physicians and specialists, reducing wait times for diagnostic tests, surgeries, and rehabilitation therapy, to ensuring the delivery of exceptionally safe care, and more) have been set and are being reported upon.

The data for the indicators come from a variety of health information sources, including analysis of administrative data from the Ministry of Health, the health regions, the Saskatchewan Acute Care Patient Experience Survey, as well as data from national sources such as the Canadian Institute for Health Information and the Canadian Community Health Survey.

Based on learnings, similar strategic whole-system engagement initiatives are also now underway to enable primary health care transformation, and coordinated, collaborative strategic planning and operations across all the health regions.

CLIENT / PATIENT ADVOCATE

Quality of Care Coordinators or Client Representatives, are available in each regional health authority to receive, investigate and monitor patient and/or public concerns in a confidential manner.

SYSTEM APPROACHES TO QUALITY IMPROVEMENT

In the 2011-12 Strategic and Operational Directions Report, the Ministry of Health committed to achieving system-wide performance improvement and a culture of quality through the adoption of Lean and other quality improvement methodologies. Each region engaged in the development of multi-year board-approved strategies focused on patient journeys, with targets, to spread Lean practices across the care continuum. A specific area for process improvements identified was discharge planning. This direction has been reinforced in the Ministry of Health's 2012-13 Health Plan, which was developed based on the Institute for Healthcare Improvement's Triple Aim initiative.

The strategies focus on making improvements to the health of the population, individual care and financial sustainability in the context of value. A fourth Aim will strengthen the health care workforce. Within this context, five areas for breakthrough improvements were identified:

1. The surgical patient experience.
2. Patient-centred primary health care.
3. The provincial continuous quality improvement system.
4. Patient and staff safety.
5. Service provision through a shared services organization.

What is LEAN?

"Lean," is a type of quality improvement methodology which has been implemented in many industries. It is a production practice that considers the expenditure of resources for any goal other than the creation of value for the end customer to be wasteful, and thus a target for elimination.

In health care, Lean is patient-centred, as patients are the end consumers of care and thus, value must be defined from their perspective.

(Institute for Healthcare Improvement; 2005)

SAFETY

Client safety in the home is monitored through systems internal to the RHAs. The province is currently undertaking a provincial Falls Prevention and Reduction initiative. RHAs are tracking the number of falls and have identified targets to reduce falls provincially.

In the Ministry of Health's 2012-13 Health Plan the focus on adverse events related to medication errors has been added. By 2015, medication reconciliation will be undertaken at all admissions and transfers/discharges in acute, long-term care and the community. By 2017 the goal is to have no adverse events related to medication errors.

HOME CARE RESEARCH

The **Saskatchewan Health Research Foundation** is the provincial agency that funds and facilitates health research in Saskatchewan, often in partnership with other organizations. The Foundation also supports research chairs in specific areas, such as causes of and cures for Alzheimer's disease, heart disease and stroke. In 2010-11 researchers were funded for an initiative called The Home Care: Emergency Department Interface - Transformations in Care Delivery.

The **Saskatchewan Population Health and Evaluation Research Unit (SPHERU)** engages researchers from the Universities of Regina and Saskatchewan conducting research into the social factors contributing to the well-being of various groups within the population. Research covers northern and Aboriginal health, children's health and development, socio-economic determinants of health in rural populations, evaluation, and health disparities.

There are a number of researchers studying home care and in the last three years there has been a focus on palliative care and telehomecare.

4. Information Technology

ELECTRONIC HEALTH RECORD (EHR)

eHealth Saskatchewan is the Saskatchewan Treasury Board Crown Corporation with the mandate to lead provincial EHR planning and strategy. The work of the organization is accomplished through strategic planning, procurement, implementation, ownership, operation and management of the Saskatchewan EHR and associated provincial components and infrastructure. eHealth's role is to lead Saskatchewan's efforts and investments toward building an electronic health record for each resident, and to coordinate, operate and maintain other selected IT systems on behalf of health care delivery organizations in the province.

The vision for the Saskatchewan EHR is getting the right information, to the right individual, at the right time, in the right place, in order to:

- Improve quality of patient care through informed decision making.
- Improve the patient experience through the coordination of service delivery.
- Improve overall efficiency and sustainability of the health sector.
- Inform management decision-making and provide the necessary information base.
- Support planning, outcome measurement, accountability and research.

Based on Saskatchewan's health sector priorities, current eHealth Saskatchewan project initiatives for the planning and implementation of new information systems and solutions fall into three main areas:

1. **Enabling the Provincial Electronic Health Record Strategy**
   Several foundation services for the EHR are already in progress or in place and a number of new initiatives will continue to enable the transformation of health care delivery.

2. **Enabling Province-wide Health Care Delivery**
   A number of hospital and community systems are already in place or in progress. Projects to implement new systems and make improvements to existing systems will continue to improve patient care, introduce efficiencies and provide for better decision making at the point of care.

3. **Integrated Clinical System**
   Since 2001, work has been undertaken with Regional Health Authorities to implement common, shared health care information systems through a program called the Integrated Clinical Systems (ICS). ICS includes a Clinical Viewer, Pharmacy, CPI/Registration, Lab, Transcription, and Home Care systems.

Technology – Transforming Health

Technological advancements have the potential to fundamentally change our health care approach to support a more efficient and person-centred one regardless of the care setting.

Today's innovations enable the integration of monitoring and therapeutic systems, provide educational content, facilitate communication and data flow between members of the health care team and support systems management and quality improvement.

HEALTH DATA & THE HOME CARE REPORTING SYSTEM

The Canadian Institute for Health Information (CIHI) developed the Home Care Reporting System (HCRS) as a means of integrating RAI-HC data to generate information using a common language across organizations, jurisdictions and care settings. The purpose is to collect and process information on publicly funded home care services in order to support jurisdictions in their analysis and decision making by providing data on:

- Access to home care services.
- Health and functional status measures.
- Clinical outcomes and waiting times.
- Quality of care
- Informal support
- Service utilization by setting and provider type.

Saskatchewan has begun to report its home care data to CIHI but has not yet been able to use the information to support decision making and policy development. The RHAs have reported using the data on client pain scores to change clinical practice.

High-Tech Home Care

Expanded technology-enabled home care offers a promising pathway to bend the cost curve for ever-growing health care expenditures.

Independent of the economic benefit, the moral value of enabling older members of society to live in grace and dignity in their own homes, with a ripple effect on their caregivers, is arguably the most important – if unquantifiable – benefit of home care.

(Kayyali et al, 2011)

USE OF SYSTEM EFFICIENCY TECHNOLOGY

Saskatchewan Home Care responded to the challenge of implementing common, shared home care information systems across the RHAs by providing:

- A standardized province-wide Comprehensive Home Care solution using Procura.
- A standardized assessment tool (RAI-HC) province-wide.

Within each Regional Health Authority the Home Care Administration System facilitates both the flow of information across the continuum of care and the execution of the business functions of home care programs. In the future, the Home Care Administration System will be able to transmit home care service event information using an electronic interface to other departmental systems, the Clinical Viewer system and the provincial home care assessments repository. Client demographic information will be provided using an electronic interface from the regional Client Patient Index/Registration System.

MDS Home Care (MDS-HC) or RAI-HC is the tool used to conduct in-home care functional assessments. Utilizing this tool will create a common assessment language for individuals receiving community-based services (across the continuum of care). MDS-HC has now been deployed in all health regions with the exception of two.

With the roll-out of Procura and RAI-HC across the province, a solid provincial picture of care with quality outcomes will enhance the ability to support home care clients to stay as healthy as possible in their own homes. Improved quality of care for clients has occurred using Procura's reports from the RAI-HC assessments. Specific examples of this can be seen through the measurement of outcome indicators such as pain or depression.

The achievement of the Saskatchewan Home Care Administration System is an integral piece of Saskatchewan Health's overarching strategy to implement commonly configured (common data definitions, tables, processes etc.) components of the EHR in each of the Regional Health Authorities. Eventually this will create Electronic Patient Records (EPRs) which will be inter-connected through an interoperation provincial EHR infrastructure. Currently, with the implementation of Procura, all Regional Health Authorities have progressed to a primarily Electronic Patient Record (EPR) (with the exception of the Athabasca Health Authority and the Keewatin Yatthe Regional Health Authority) that is accessible in rural areas and in hospital by discharge planners.

USE OF TECHNOLOGY FOR CLIENT CARE

Telehealth Saskatchewan is a Saskatchewan Health program endorsed by 'The Action Plan for Saskatchewan Health Care' as an effective approach to improve access to health services. In 2010 there were over 100 Telehealth sites currently operating in provincial, regional and northern hospitals in Saskatchewan.

The program uses communication and information technology to support the delivery of clinical care and professional education services. Using live, two-way videoconferencing, health care providers apply the latest tele-diagnostic instruments, including digital stethoscopes, patient examination cameras,

and digital imaging, to enable a remote patient to 'visit' an out-of-town health care provider from their home community rather than having to travel. Health care providers use Telehealth Saskatchewan for appropriate clinical appointments, consultations, follow-ups, meetings, and education sessions.

Currently, Telehealth Saskatchewan's Clinical Services provide patients with access to medical specialists in their home communities through two-way video communication. Additionally, Telehealth Saskatchewan provides services that deliver health education provincially such as medical/nursing education and diabetes clinics. Specialists and clinicians such as nutritionists, dieticians, and diabetes educators have used Telehealth to provide patient services within the RHAs.

Regional Health Authorities determine the communication technology that is supplied to home care staff. Typically, staff is equipped with cell phone, and/or laptop/notebook computers. Some RHAs have reported the use of iPads in home care and some are exploring the use of GPS systems.

5. Health Human Resources

The vision for health human resources is that by 2021:

- All health care providers in Saskatchewan understand patient and family-centred care (PFCC) and apply it consistently in their practices and professions.
- There has been significant progress in training health professionals to provide care for First Nations and Métis peoples.
- The health workforce is better prepared to provide care in rural, remote and northern communities.
- The health workforce supports self-management and aging in place, acknowledging a shift to greater service through home care.

Recruitment and retention of health care workers is a priority in Saskatchewan. A series of workforce retention grants has been offered as incentives. The Saskatchewan Cancer Agency, educational institutes, and other health organizations are working together to develop and maintain an optimum supply and mix of care providers.

In 2009-10, the health regions and Saskatchewan Cancer Agency employed 30,435 full-time equivalent (FTE) staff. This workforce was 87 percent female and the largest number of FTEs was in the 45-49 age group.

CLINICIANS PRACTICING IN HOME & COMMUNITY CARE

There were 5,651 FTEs in home care, represented by a total workforce of 8,685, from April 2009- March 2010. By 2020 it is projected that there will need to be 6,038 FTEs, and with retirements and other losses the province will need to recruit 2,520 staff over the next ten years.

HEALTH CARE PROFESSIONALS

Home care employs a variety of professionals to meet the service needs of clients, including:

- Assessors, case managers, care coordinators.
- Nurses – registered nurses, registered practical nurses, licensed practical nurses.
- Therapists - occupational therapists, physiotherapists.

UNREGULATED STAFF

Home care aides, also known as continuing care assistants, are the only unregulated staff employed by RHA home care programs and are used to provide supportive home care services to home care clients. There is no provincial registry for the home care aides/continuing care assistants.

EDUCATION & TRAINING

REGULATED PROFESSIONALS

The Saskatchewan Institute of Health Leadership (SIHL) is an initiative of the Centre for Continuing Education, University of Regina in partnership with:

- College of Physicians and Surgeons of Saskatchewan
- Registered Psychiatric Nurses Association of Saskatchewan
- Saskatchewan Association of Licensed Practical Nurses
- Saskatchewan College of Pharmacists
- Saskatchewan Registered Nurses' Association.

The aim of the Institute is to bring together professionals from all disciplines and all levels within the health care system to foster leadership potential, skills and the creation of a leadership community that works together to promote, support and sustain good health. SIHL supports the goals for health care in Saskatchewan by:

- Building upon leadership and professional development within an interdisciplinary context.
- Ensuring a new generation of skilled health care leaders.

The Saskatchewan Academic Health Sciences Network (SAHSN) works to develop interdisciplinary education, research and practice. SAHSN supports the Interprofessional Health Collaborative of Saskatchewan (IHCS) which supports and replicates innovative examples of inter-professional initiatives that support education of clinical placement in Saskatchewan

UNREGULATED PROFESSIONALS

There are standard educational requirements for home care aides/continuing care assistants and a training program approved by the Ministry of Health. Staff must complete the training program within two years of initial employment.

INTER-PROFESSIONAL COLLABORATION

Recently launched, the Saskatchewan eight primary care innovation sites will serve as models for team-based practices across the province. All teams will include or be connected to a family physician, but the membership of the rest of the team will be based on community needs. The framework puts a lot of emphasis on community involvement and a flexible funding approach "with decision-making located closest to the patient and community and Regional Health Authorities." One of the eight sites is the rural community of Meadow Lake which is already using the team-based model.

FAMILY CAREGIVER

RESPITE

Services for family caregivers typically include respite. The objectives of respite care are to:

- Relieve primary caregivers from the constant responsibility of providing care.
- Give primary caregivers the security of knowing that temporary relief is available if a personal crisis arises, and provide that relief if necessary.
- Support and strengthen families or other support systems to enable dependent persons to remain at home, and delay or prevent placement of dependent persons in long-term care facilities.

An assessment determines if respite is needed to relieve caregivers and a care plan is developed to meet that objective. In home care, respite may mean providing relief for time periods ranging from a few hours to a few days. Time periods depend on the needs of families and other caregivers in addition to regional resources and other options available for respite. It may be provided occasionally, or periodically on a regular basis, to allow primary caregivers time to perform everyday tasks. Respite does not usually include home care services for the purpose of allowing caregivers to work at a long-term job or to relieve parents from routine childcare. However, the region may make exceptions for complex care children when no other resources are available to the family.

Home care may provide crisis relief to allow the primary caregivers and their families the opportunity to deal with stressful events such as illness, hospitalization or a death in the family

ASSESSMENT

It is expected that the caregiver's needs, as well as the client's needs, will be reviewed in the RAI-HC assessment tool. This tool has a component that assesses the family caregiver and their ability to provide caring activities, their support network, and their level of distress. This decision support tool for home care professionals can be used to prioritize clients needing community or facility based services and to help plan allocation of resources. It is a powerful predictor of admission to residential care and may indicate caregiver distress.

The Vital Role of the Family Caregiver

Caregivers provide care and assistance for spouses, children, parents and other extended family members and friends who are in need of support because of age, disabling medical conditions, chronic injury, long-term illness or disability. A family caregiver's effort, understanding and compassion enable care recipients to live with dignity and to participate more fully in society.

5 million
is the estimated number of caregivers in Canada

80%
of care needed by individuals with a long-term condition is provided by family caregivers

60%
of caregivers provide care for more than three years

(Canadian Caregiver Coalition www.ccc-ccan.ca.)

Defining Caregiver Distress

Caregiver distress has been defined as "the overall impact of physical, psychological, social, and financial demands of caregiving."

The RAI-HC captures two items related to caregiver distress. A home care client is flagged as having a caregiver in distress when one or both of the following are present:

- A caregiver is unable to continue in caring activities—for example, a decline in the health of the caregiver makes it difficult to continue.
- The primary caregiver expresses feelings of distress, anger or depression.

(CIHI (2010), Supporting Informal Caregivers— The Heart of Home Care, www.cihi.ca)

FINANCIAL SUPPORTS

Tax Credits

As a component of the Income Testing Subsidy, basic exemption levels are established periodically for the applicant, spouse and dependent children. Effective October 1, 2011, the rates are: (a) $1,376 for the applicant; (b) $856 for the spouse; (c) $407 for each dependent child under 18 years of age; (d) $856 for the first dependent child under 18 years of age in a single parent family. A single parent may claim a spousal exemption for one child. This child cannot also be claimed as a dependent exemption. Effective January 1, 2011, the caregiver dollar amount, $8,563, was subjected to indexation.

Family Care Providers

Typically, RHAs do not compensate family care providers for assisting a member of his/her family, unless both of the following circumstances apply:

no practical alternative exists (e.g. a remote rural area with no resident home care providers in reasonable proximity), and

the care provider holds the qualifications and training required of a home care provider.

RHAs may choose to define guidelines that reflect the characteristics of the region and types of problems that need to be addressed. These guidelines assist staff with making practical decisions when assessing particular cases. For example, an RHA might specify that no exceptions will be made if the care provider:

Is a member of the nuclear family (the client's spouse, parents, children and siblings).

Lives with the client.

Has given care in the past without receiving payment.

Is not willing to serve other home care clients in addition to their family member.

6. Provincial Initiatives

The Saskatchewan Ministry of Health has been engaged in a number of initiatives including:

ADOPTING PATIENT AND FAMILY-CENTERED CARE

The Patient First Review (PFR), For Patients' Sake, released in October 2009, recommended that "the health system make patient- and family-centred care (PFCC) the foundation and principle aim of the Saskatchewan health system". Through effective and collaborative partnerships with patients and families, the health system is working toward the following goals:

- All patients and families are involved in their care at the level they choose.
- All patients are treated with respect and dignity.
- All patients' knowledge, values, preferences, beliefs and cultural backgrounds are honoured and incorporated into the delivery of their care.
- All patients and families receive timely, complete, accurate, unbiased information from health care providers regarding their diagnosis and treatment options, or have access to information to participate in their care and decision-making.

THE SASKATCHEWAN SURGICAL INITIATIVE (SKSI)

The SKSI is the first major project resulting from the 2009 Patient First Review that identified surgical wait times as one of the key concerns. The SKSI is striving to improve surgical care and reduce wait times. Supporting home care and rehabilitation therapy are key components of this strategy and, accordingly, a number of community based initiatives are included in the SKSI.

INDIVIDUALIZED FUNDING (IF)

In effect since October 2002, IF is an option within the Regional Health Authority (RHA) home care program that provides funding directly to a person (or their guardian) to arrange and manage their own support services. Professional health services such as registered nursing or therapies are not included in individualized funding. The program is designed to provide people with increased choices and flexibility in the way their needs are met through the home care program. Funding amounts are based on assessed need (up to a maximum) which is used for approved support services, such as personal care or home management, typically available from home care.

PROVINCIAL DIABETES PLAN

The Saskatchewan Ministry of Health and the RHAs remain committed to reducing barriers to optimal diabetes care and prevention. To support implementation of the Diabetes Plan (initiated in 2008), additional on-going funding is provided to RHAs to enhance the delivery of team based services related to the overall goals and objectives of the Provincial Diabetes Plan. These include:

- Primary prevention of type 2 diabetes.
- Optimum care for prevention of diabetes complications.
- Diabetes education for care providers, including home care staff in order to ensure consistency of care and messaging.
- Diabetes surveillance.

TELEHOMECARE

The Telehomecare pilot project began in January 2010 and was completed in January 2011 between the Ministry of Health, Kelsey Trail Regional Health Authority, HealthLine and SaskTel. This project allowed health care professionals and clients to monitor blood pressure and blood glucose levels from the home environment. It enabled caregivers to have up-to-date information on the patient's condition and generated alerts to HealthLine and caregivers if the blood pressure or glucose levels were outside predefined alert parameters. Additionally, Telehomecare offered an increased opportunity for client education and disease self-management. The Telehomecare pilot was named one of the finalists for an Information Technology Association of Canada (ITAC) Canadian IT Hero Award, a program developed in partnership with Industry Canada to celebrate and recognize the achievements of people across Canada using technology in innovative ways to help others.

An evaluation of the Telehomecare Pilot Project revealed that, overall, clients who participated in the project were satisfied with the project and experienced an improvement in the quality of their care. The Telehomecare Pilot Project evaluation also observed there was a reduction in the number of visits to physicians and to the emergency room (ER).

FALLS COLLABORATIVE

Over the course of two years, a Falls Collaborative was established between the Saskatchewan MoH, the Canadian Patient Safety Institute, Safer Healthcare Now! and the Saskatchewan Health Quality Council to assist Regional Health Authorities in reducing falls and in achieving the targets of the initiative. Nineteen LTC teams from eight RHAs (Athabasca, Cypress, Five Hills, RQ, Saskatoon, Sun Country, Sunrise and Prairie North) and seven home care teams participated in the collaborative.

MEDICATION AND COMPLIANCE PACKAGING

Individuals who live in their own residence in the community and who require medication assistance, as assessed by designated home care assessors or by health region outpatient mental health programs, are entitled to this program. The program includes a Medication Assessment and Compliance Packaging (form of packaging that reminds patients to take their medication) for clients referred by the aforementioned assessors.

The Medication Assessment Fee (MAF) remunerates pharmacies for assessing a patient's ability to administer their medications, appropriateness of the medication and dosing intervals, potential interactions, side effects, drug allergies, contraindications and includes communication with the physician and/or health care professional(s) to resolve discrepancies that exist, and potential or actual drug related problems identified.

MEDICATION RECONCILIATION

At varying stages, Saskatchewan health regions are implementing medication reconciliation on admission and for existing home care patients. MedRec prevents errors by ensuring that a patient's medication history is verified, medication and doses are appropriate, and any medication changes are documented throughout the patient's care experience.

PRIMARY HEALTH CARE

In response to the Patient First Review, the Ministry of Health is collaborating with patients and health and community leaders to redesign primary health care service delivery. This new initiative will help transform and strengthen primary health care services across the province. Presently, primary health care serves as the umbrella for many basic health programs and services, which include home care, end-of-life care, and therapy services. It encompasses preventive, promotive, curative, supportive, and rehabilitative services. High-risk individuals are identified so that services can be targeted to meet specific needs. Data collection and analysis has been started at several primary health service sites. As well, a framework has been developed to evaluate primary health services sites. This comprehensive evaluation will use both qualitative and quantitative methods in assessing the impact of the primary health services delivery model on specific populations served.

CHRONIC DISEASE MANAGEMENT

The Chronic Disease Management Collaborative facilitates quality improvements in diabetes, coronary artery disease, and access to primary care within a number of identified care facilities, practices and primary health care sites. Included in the improvement process is the Chronic Disease Management (CDM) Toolkit, used by physicians, authorized office staff and health care providers as a patient registry and decision support tool to assist in providing quality care for patients with chronic conditions.

SENIORS AND AGING

Seniors make up a substantial share of the province's population. The Ministry of Health values the contributions of older persons and recognizes that a significant portion of the province's population is over the age of 65, and plans to ensure that the health, dignity and well-being of all older persons in Saskatchewan are protected and promoted. As part of the Ministry of Health's plan for 2012-13, a number of priority targets for the health system have been identified over the next five years. One these targets identifies supports for seniors that will allow them to age within their own home and progress into other care options as their needs change.

A number of initiatives have been undertaken, including a plan to replace 13 long-term care facilities in seven regional health authorities and a pilot project regarding an innovative long-term care facility that supports aging-in-place, and supporting the Ministry of Social Services in the implementation of the recently announced Seniors Personal Care Home Benefit. Work will continue on priority initiatives that improve the overall health and well-being of Saskatchewan's seniors including our Falls Prevention and Reduction Strategy, the Home Security Program for low income seniors and seniors who have been the victim of home invasion, and the Medication Assessment and Compliance Packaging for eligible seniors.

MENTAL HEALTH

The overall goal of the Mental Health Services Program is to promote and support the mental health service needs of the population directly through the provision of care and services, and indirectly through support to the other service sectors involved with persons with mental health problems. The Mental Health Services Program is divided into four main service areas: Child and Youth Services; Adult Community Services; Psychiatric Rehabilitation Services; and Mental Health Inpatient Services. Additionally, health regions also devote a certain amount of resources to mental health promotion.

END-OF-LIFE CARE

In 2006 Saskatchewan MoH participated in the Canadian Institute for Health Information's "Western Canada End-of-Life Care Project" by contributing data and funding. The project examined system use at end-of-life in order to assist health care planners and policy makers as they develop approaches to meet the needs of their citizens. The report focuses on the use of hospital and pharmacy services because comparable data were available from all four provinces for these aspects of care.

Home Care & Primary Health Care

The nature of chronic conditions is that they are complex and associated with many co-morbid complications. Home care and primary care integration has been demonstrated to achieve improved client outcomes though more proactive comprehensive care for those with chronic conditions.

This integrated approach, enabled through linkages with home care, reduces fragmentation, increases coordination of complex care, and provides the necessary screening, monitoring and evaluation of patients using a holistic approach supported by the broader care community.

(Canadian Home Care Association (2006), National Home Care and Primary Health Care Partnership Project)

7. Challenges

The challenges facing home care in Saskatchewan include:

- Staffing and therefore access to home care in rural areas of the province.
- Heightening awareness about the capacity and potential of home care.
- Maintaining the supportive/preventive elements of home care.

8. Opportunities

The home care program will continue to support the Saskatchewan Surgical Initiative, develop stronger primary health care teams and home care services so that seniors are able to age at home or in the community and leverage technology in order to enhance the care at home. These opportunities align with the Ministry's strategic focus and priorities to allow aging in the home.

The vision for home care in Saskatchewan continues to be directed toward meeting client needs and optimizing independence within available home care financial resources. The goals are to:

- Help people maintain independence and well-being at home/in the community.
- Facilitate appropriate use of health and social services.
- Make the best use of home care resources by serving people with the greatest need first and operating economically and efficiently.

Continued efforts will also be focused on working collaboratively with other community agencies and organizations, as well as promoting and supporting family and community responsibility for care. In order to realize that vision the home care program continues to work toward providing greater access to home care especially in rural and remote areas.

ACRONYMS / ABBREVIATIONS

ALC -	Alternate Level of Care
CARF -	Commission on Accreditation of Rehabilitation Facilities
CDM -	Chronic Disease Management
CIHI -	Canadian Institute for Health Information
EPR -	Electronic Patient Record
FTE -	Full-time equivalent
GBC -	Greystone Bereavement Centre
HCRS -	Home Care Reporting System
HQC -	Health Quality Council
ICS -	Integrated Clinical Systems
IF -	Individualized Funding
IHCS -	Interprofessional Health Collaborative of Saskatchewan
ISO -	International Standards Association
ITAC -	Information Technology Association of Canada
KTHR -	Kelsey Trail Health Region
LTC –	Long-Term Care
MAF -	Medication Assessment Fee
MDS-HC -	Minimum Data Set Home Care
MOH –	Ministry of Health
PICC lines -	Peripherally inserted central catheters
PFCC -	Patient- and Family-Centred Care
PFR -	Patient First Review
RAI-HC -	Resident Assessment Instrument - Home Care Assessment
RHA -	Regional Health Authority
RPCA -	Regina Palliative Care Inc.
SAHSN -	Saskatchewan Academic Health Sciences Network
SAIL -	Saskatchewan Aids to Independent Living
SCA -	Saskatchewan Cancer Agency
SCIP -	Saskatchewan Client Information Profile
SIHL -	Saskatchewan Institute of Health Leadership
SKSI -	Saskatchewan Surgical Initiative
SPHERU -	Saskatchewan Population Health and Evaluation Research Unit

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Harmonized Principles for Home Care

Guide policy and program development

Support consistency and equity across the country

Facilitate benchmarking and sharing of best practices

ACCESSIBLE CARE

Canadians have equitable, appropriate, consistent access to home care, and are fully informed of the care and service options available to them.

Appropriate:
Provide care that is needed and ensure the need for care.

Consistent:
Reliable care among providers and across jurisdictions and geographies.

Comprehensible:
Ensure understanding of services and options available.

Equitable:
Create fair and unbiased access within and across jurisdictions and geographies.

MANITOBA

HOME CARE IN **MANITOBA**

In **Manitoba**, the definition of home care is consistent with that of the Canadian Home Care Association.

> Home care is an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the family caregiver.

Home care is further defined, in the province, as the coordinated delivery of a broad range of health and social services to meet the needs of the persons who require assistance or support in order to remain at home or whose functioning without home care is likely to deteriorate, making it impossible for the person to stay at home in the community.

Home care supplements, rather than replaces, the role of family and friends in the provision of care in the community. Family members are expected to provide as much support as is reasonable in their individual situations. Home care may provide services including respite and family relief to support the family in the provision of care.

MANITOBA

BY THE NUMBERS...

647,797 sq km **LAND AREA**	1,250,600[1] POPULATION (2011)	**71%**[3] Percent population in urban settings defined as an area with a population of at least 1,000 and with no fewer than 400 persons per square kilometre (2006)	
66.8[2] Dependency ratio (2009) Ratio of the population aged 0-19 and 65+ to the population aged 20-64	13.9%[1] **Population Seniors 65+ yrs** (2011)	79.5 years[1] **LIFE EXPECTANCY (AT BIRTH)**	**$4,828.27**[2] Public sector health care expenditure per capita (2011 Forecast)

[1]Statistics Canada | [2]Canadian Institute for Health Information (CIHI) | [3]Human Resources and Skills Development Canada

1. Governance & Organization

HEALTH CARE SYSTEM STRUCTURE

Manitoba Health oversees health care services available to Manitobans. Manitoba Health is responsible for:

- Strategic planning for priority populations.
- Home care policy development and interpretation.
- Monitoring and analysis of program activity at the provincial level and its impact on the target population and the health care delivery system.
- Development and monitoring of standards and provincial outcomes.
- Research on, and development of, program benchmarks and best practices.
- Management information system standards and development in conjunction with the Regional Health Authorities.
- Liaison with other components of the health system in Manitoba and Canada.

Regional Health Authorities (RHAs) are responsible, within the context of broad provincial policy direction, for assessing and prioritizing needs and health goals and developing and managing an integrated approach to their own health care system. They oversee the administration, delivery and operational management of home care services and are responsible for the service delivery standards.

Regional Health Authorities

- Northern RHA
- Western RHA
- Southern RHA
- Interlake-Eastern RHA
- Winnipeg RHA

Specifically, for home care, the RHAs are responsible for:

- Accepting referrals and determining eligibility for home care services, based on a multi-disciplinary assessment.
- Developing a plan of care which takes into account the needs of the individual and family as well as available community resources.
- Determining the amount and type of services to be provided by home care.
- Securing, scheduling and supervising the appropriate resources to meet home care service requirements.
- Developing and maintaining a "pool" of service providers and resources to ensure continuity in the availability of resources.
- Establishing quality assurance processes for ongoing care planning, monitoring and evaluation of services, including documentation of regional policies and procedures.
- Managing the personal care home placement process for individuals whose care can no longer be provided in the community.
- Developing and maintaining liaisons with other components of the health care system to ensure a collaborative and coordinated approach to the delivery of health services across the continuum of care.
- Establishing and maintaining a quality improvement process that perpetuates practices that contribute to and enhance quality in service delivery, and that identifies areas that require improvement.
- Collecting and analyzing data related to the delivery of home care services for the purposes of critiquing existing practice and planning for future home care service demand.

HEALTH CARE & HOME CARE LEGISLATION

The home care program was established through an Order-in-Council of provincial Cabinet.

The Regional Health Authorities Act (2007) - sets out the conditions under which the RHAs are incorporated, as well as defining duties and responsibilities of the RHAs and the Minister of Health. Both RHAs and the Department of Health are responsible for policy, assessment of health status and ensuring effective health planning and delivery.

Bill 18, The Regulated Health Professions Act (June 2011) - creates consistent regulation for all health professions and provides a process for unregulated health professions to apply for regulation.

Bill 32, The Personal Health Information Amendment Act (January 2011) - provides the right to access personal health information, and have personal health information kept private when that information is held by a health care provider, health care facility or public body (referred to in the Act as "trustees").

Bill 17, The Regional Health Authorities Amendment and Manitoba Evidence Act – enhances patient safety by providing a more secure environment for the investigation and frank discussion of critical incidents (CIs), while protecting the right of affected individuals to know what has happened and the consequences. Bill 17 amends The Regional Health Authorities Act and The Manitoba Evidence Act to require the disclosure, reporting and investigation of CIs.

Bill 42, The Caregiver Recognition Act (June 2011) - increases recognition and awareness of caregivers; acknowledges the valuable contribution they make to society; and helps guide the development of a framework for caregiver recognition and caregiver supports.

EVOLUTIONARY MILESTONES

1974

MHCP established through an Order-in-Council. The program was established to provide services to all age groups by providing alternatives to placement in a personal care home, facilitating hospital discharge, and providing assistance in the home to those individuals who would otherwise be at risk of having to leave their homes to access necessary health and supportive services.

1997-98

Responsibility for the delivery of core health care services was transferred to rural, northern and urban RHAs (Regional Health Authorities).

2002

Amalgamation of RHAs - South Westman and Marquette joined into the RHA of Assiniboine. The boundary through the Local Government District of Alonsa was changed, moving the border south. These changes have been reflected in the Manitoba Health data since April 2003.

2006

Introduction of province wide Aging in Place Strategy. This strategy increased the emphasis on providing seniors the opportunity to remain in the community for as long as possible. Home care is one of many types of services needed to achieve this goal.

2009

"Engagement of Family Members to Provide Non Professional Home Care Services" policy, administered under the home care program, was revised and approved to clarify the criteria under which families could receive funds to provide assessed home care services to family members. Guidelines and an indicator tool were developed for use in applying the Engagement of Family Members to Provide Non Professional Home Care Services policy.

2009

The Primary Caregiver Tax Credit (Income Tax Act, section 5.11) was introduced to provide recognition and financial support to individuals who serve as unpaid primary caregivers for more than three consecutive months. Criteria for eligibility include a minimal assessed care requirement of level 2. While an applicant does not have to be a client of the Manitoba Home Care Program, designated home care staff, in the Regional Health Authorities, approve applications for the tax credit.

2010-11

Manitoba's Long Term Care/Aging in Place (LTC/AIP) Strategy was refreshed with consolidation of the provincial framework with a focus on sustainability across the continuum of care in light of the anticipated system demands with the emerging demographic trends.

2011

Caregiver Recognition Act (Bill 42) was introduced to increase awareness and recognition of Manitoba's family caregivers, and acknowledge their valuable contribution to society.

2012

Announcement of the introduction of legislative amendments that would support reducing the number of regional health authorities to five from eleven.

MANDATE, MISSION, PRINCIPLES & PRIORITIES

The Manitoba Home Care Program (MHCP) was designed to help individuals live with dignity in their own home for as long as safely possible, since it was recognized that people needed ongoing health services or help with the activities of daily living not necessarily in a hospital or personal care home. This program goal has remained since home care was first developed in 1974.

MANDATE

Manitoba Health is a line department within the government structure, and operates under the provisions of statutes and responsibilities charged to the Minister of Health. The formal mandates contained in legislation, combined with mandates resulting from responses to emerging health and health care issues, establish a framework for the planning and delivery of services.

The mandate of the home care program is the provision of effective, reliable and responsive home health care services for Manitobans, to support independent living in the community, and the co-ordination of admission to facility care when living in the community is no longer a viable alternative.

PRINCIPLES OF HOME CARE

The principles that guide decision-making in home care are embedded in the vision and mission declared by Manitoba Health.

Vision: Healthy Manitobans through an appropriate balance of prevention and care.

Mission: Meet the health needs of individuals, families, and their communities by leading a sustainable, publicly administered health system that promotes well-being and provides the right care, in the right place, at the right time.

HOME CARE PROGRAM OBJECTIVES

Program objectives for home care are inherent to the Manitoba Health (MH) priorities and goals.

HEALTH SYSTEM PRIORITIES

Priority 1 – Capacity building

- Adopt a sustained planning and alignment process that advances role clarity, collaborative and innovative work practices, risk management, and effective use of resources.
- Apply innovative human resource policies and practices to help recruit and retain department staff.

Priority 2 – Health system innovation

- Improve health outcomes, contain costs, and support appropriate and effective services.

Priority 3 – Health system sustainability

- Direct the development and implementation of a long-term action plan that defines Manitoba's future health system and establishes clear roles for all stakeholders.
- Lead the development and implementation of a broad, health system human resource plan.
- Build sustainable, innovative and evidence-based service provider funding methods to ensure accountability, meet the health needs of Manitobans, and contain the rise in health costs.
- Enable information systems and technologies.

Priority 4 – Improved access to care

- Enhance and improve access to health services.
- Enhance the primary health care system to better meet needs through a greater emphasis on the patient.

Priority 5 – Improved service delivery

- Lead advances in health service delivery for First Nations, Métis, and Inuit Manitobans, through policy and programs with a focus on prevention, primary health care, public health, and education.
- Establish strategies, policy and partnerships that improve operational readiness to meet population needs in disaster situations.
- Realize customer service excellence.
- Guide effective and efficient department policies, processes, and service delivery methods to strengthen capacity, ensure roles are clear, accountabilities are met, and services are delivered in the best way possible.

Priority 6 - Improving health status and reducing health disparities among Manitobans

- Steer an innovative, evidence-based action plan to reduce health disparities and improve the health of Manitobans.
- Create an innovative, collaborative plan for public health to target major gaps in health status and improve the health of Manitobans.

Currently underway is a refresh/expansion of the Aging in Place/Long Term Care Strategy, the goal of which is to support Aging in Place. This strategy seeks to address the anticipated increase in demand on home care services in consideration of the emerging demographics.

Aging in Place is the central principle in the planning of all provincial government housing and long-term care initiatives.

The principle of Aging in Place addresses the need for affordable community housing with support options and services, such as home care, as alternatives to premature personal care home placement.

The strategy addresses the elements of care/service along the continuum from an individual living independently in his/her own home to moving to a personal care home.

2. Access, Funding & Service Delivery

ACCESS TO HOME CARE SERVICES

The point of access to home care is through the Regional Health Authorities (RHAs). Anyone (e.g. self, physician, or family member) can make a referral for home care services. Referrals are made through local RHA offices, intake phone lines and, in Winnipeg and some RHAs, there are home care referral and assessment staff located in hospitals.

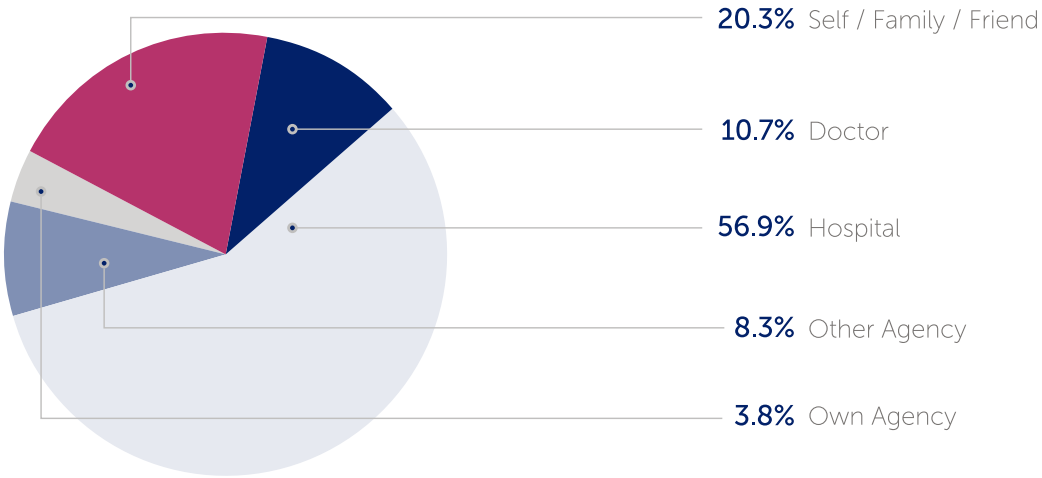
Home care case management includes the meeting of care needs, from the initial recognition of need for the individual living at home, through temporary absences from home (hospitalization), to placement into a care facility, if required. Home care case coordinators are responsible for assessment, determining eligibility, care planning and case management.

Referrals are assessed by regional home care program staff (the assessment often involves more than the case coordinator in order to engage the various skills of the team e.g. occupational therapist, physiotherapist) to determine:

- Eligibility.
- Services required from the home care program.
- How the family can best utilize the support(s) available to them through resources in the community.
- The best setting of care, based on assessed needs and available resources.

Once eligibility is determined, the home care program staff works with the individual and her/his family to design a care plan to meet the assessed needs. If the applicant wishes to manage their own care plan and arrange for services themselves, or have a family manager deliver the plan, the RHA's home care program staff may, based on assessment, make arrangements for the Self and Family Managed Care (SFMC) option.

Referrals to Home Care (2009-10)

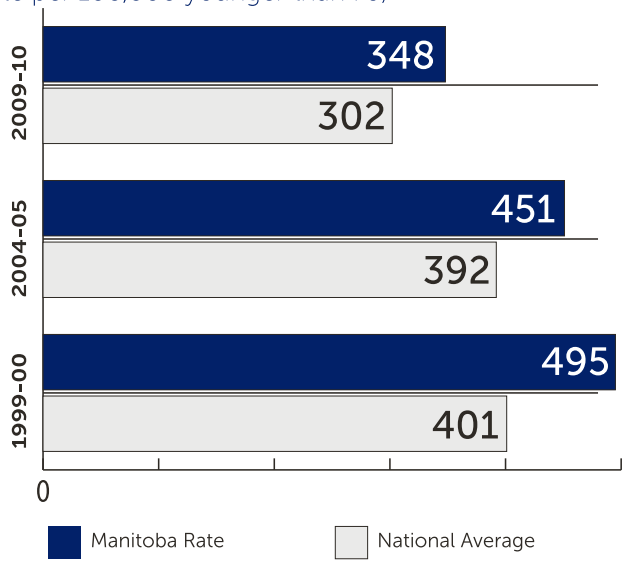


APPROPRIATE ACCESS TO HOME CARE & COMMUNITY-BASED CARE

Hospitalization rates for conditions that may be cared for in the community are one indicator of appropriate access to community-based care. These conditions include diabetes, asthma, alcohol and drug dependence and abuse, neuroses, depression and hypertensive disease. Preventive care, primary care and community-based management of these conditions may reduce the need for hospitalization.

Hospitalization Rates For Ambulatory Care Sensitive Conditions

(Age Standardized Rate per 100,000 younger than 75)



Health Indicators Reports, CIHI

Alternate Level of Care (ALC) is a measure used to reflect when a patient is occupying a bed in a hospital and does not require the intensity of resources / services provided in this care setting.

In March 2011 3.5 percent of all hospital cases were designated ALC with an average length of stay of 40 days (Annual Stats Report).

LEARN MORE

ALC Challenges and Solutions

The term "alternate level of care" (ALC) is used to describe persons who occupy a bed in a facility but no longer require the intensity of resources and services provided in that setting.

- 7,500 or 14% of acute care hospital beds are inappropriately used across Canada each day.
- 2.4 million days is the total use of acute hospital beds occupied by alternate level of care or ALC patients in a single year across Canada.

Home and community care programs play a key role in supporting the estimated 30-50 % of ALC patients across Canada who are candidates to return home.

Managing the ALC challenge takes a systems approach and requires collaboration of providers across the health care continuum so that individuals receive the right care in the right location.

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ELIGIBILITY, COVERAGE & UTILIZATION

ELIGIBILITY

Any Manitoba resident who has a Manitoba health card can be assessed to determine eligibility for home care supports. Individuals whose health care services are the responsibility of another jurisdiction are not eligible.

AGE

All ages

INCOME TESTING AND DIRECT FEES

No income testing is required.

No fees for home care services. However, some services accessed through the home care program have direct fees, e.g. adult day care, community meal programs, facility respite.

SUPPLIES, EQUIPMENT AND MEDICATION

The home care program funds some equipment and supplies as are necessary to support continued health and community living based on guidelines and standards. Clients must be dependent on the use of the supplies for the program to provide them.

Clients on the Self Managed Program pay for their supplies and equipment as part of the funding provided to them.

Medications are not covered by the home care program. The Manitoba Pharmacare Program is income-based and covers the cost of medication for eligible Manitobans who do not have coverage under other federal or provincial programs.

LIMITS / GUIDELINES TO SERVICE PROVISION

The established service limit is based on a formula for equivalent hours of non-professional care in an institution. Exceptions may be made for clients awaiting long-term placement, who have a short-term need, or have end-of-life care needs.

Specialty sub-components (such as home nutrition and home oxygen programs) may have additional criteria that define service provision.

DETERMINING CLIENT NEED - ASSESSMENT TOOLS

The Resident Assessment Instrument – Home Care (RAI-HC) is a standardized, multi-dimensional assessment system for determining client needs.

The RAI-HC is fully implemented and automated in Winnipeg, and serves as the tool used by staff for initial and ongoing client assessment. Assessment in other regions is based on the same criteria but is not automated.

Once a person has been referred, an assessment is done to determine the required areas of care/service to support the client in his/her home. Service allocation is unique to each client and takes into consideration the client's needs and the informal supports (family and friends) available to that client. The home care program staff assesses the client based on the following principles:

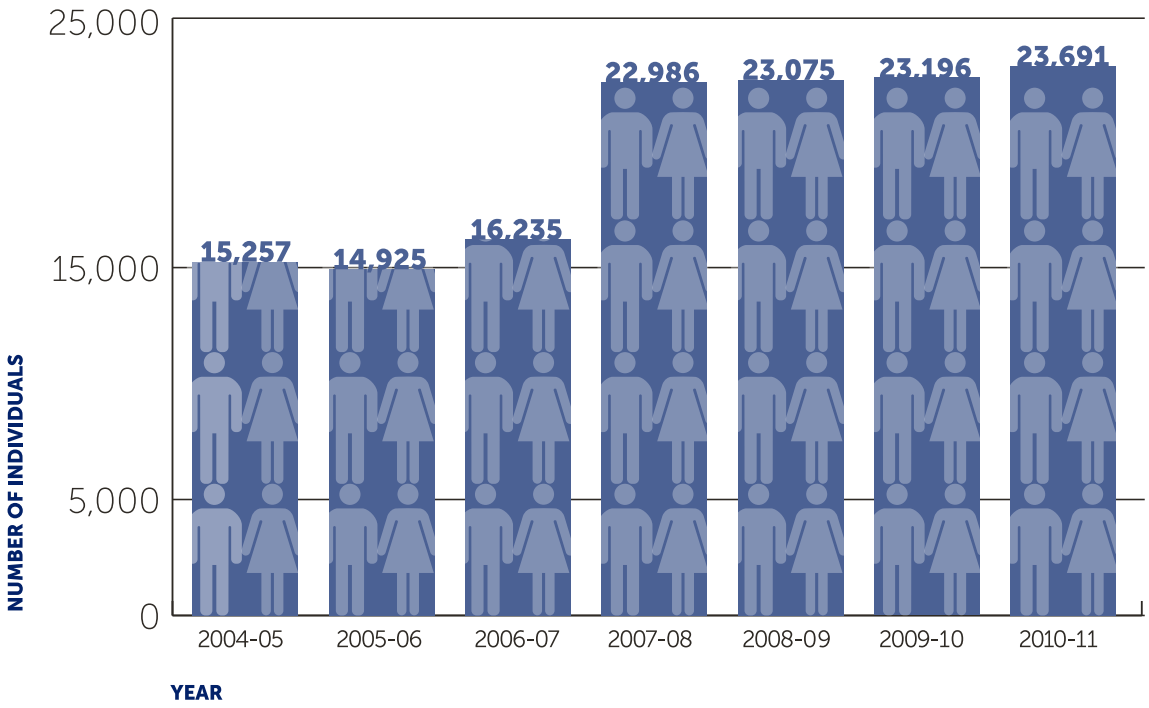
- Amount of service provided should support the client and their informal supports through the acute care/recovery period.
- Assessment should include the kind of teaching, monitoring and treatment modification that facilitate the provision of care for the client and family/friends in the home environment.
- Coordination of other service providers and funding sources for supplies and equipment is desirable.

In 2010/2011, there were 17,202 Manitoba residents assessed for admission. During this time period, 15,481 (89.9 percent) were admitted. The remainder were either ineligible (i.e. home care not required) or not admitted due to other reasons.

ADMISSIONS TO HOME CARE

Home care admissions increased significantly in 2007-08. Manitoba's Aging in Place/Long Term Care Strategy (released in 2006) promotes the delivery of health care to Manitobans in their homes or community-based settings. This shift in care delivery from a system perspective has contributed broadly to increased home care caseloads. Changing expectations of individuals have been evident. There is the desire for individuals to remain in their homes for as long as possible (as opposed to entering a long-term care facility). The emerging demographics and care requirements for those with chronic medical/psychiatric (e.g. dementia) conditions increase care needs in the community. There is increased public/community awareness of the home care program and available services.

Individuals Admitted to Home Care



SETTINGS OF CARE

Home care services in Manitoba may be provided in the following settings:

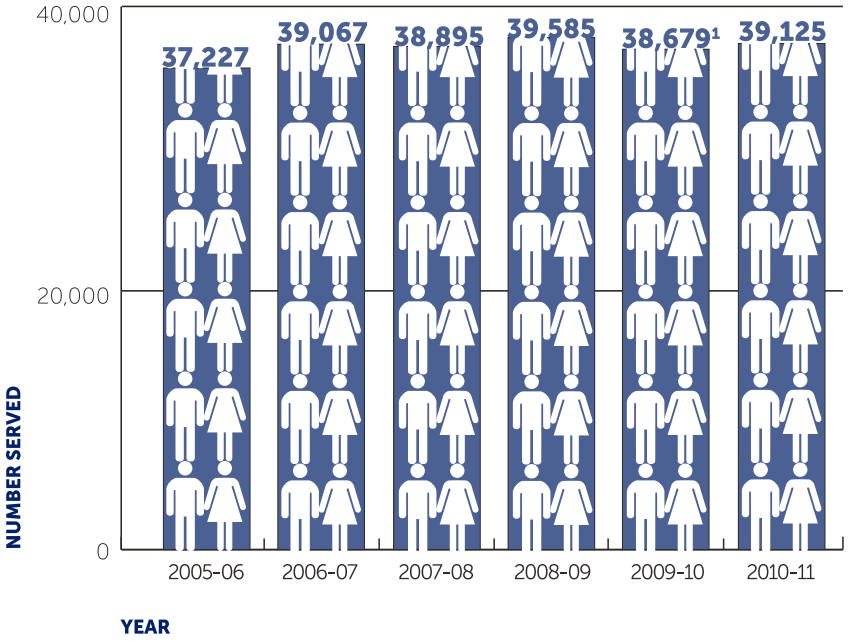
- Clinic
- Group Home
- Home (includes assisted living, seniors residence)
- Hospice
- Place of work
- School
- Adult Day Programs

INTEGRATED MODELS OF CARE

There are instances where an individual's care needs are complex and cross the service area of other departments/agencies. To facilitate a more streamlined service delivery for the client, the home care program collaborates with and coordinates service/care delivery as required with the involved departments/agencies (e.g. housing). This is increasingly a necessity because of the need to maximize resources; and the public expectation that people will be maintained at home.

The work to refresh the Aging In Place And Long Term Care Strategy is driving a smoother continuum.

Individuals Receiving Home Care



[1]*Retrieved from http://www.gov.mb.ca/health/homecare/index.html*

DISCHARGE FROM HOME CARE

Discharge disposition of individuals who have received home care service is increasingly important and instructive to the health care system as it is an indicator of effectiveness. The outcomes can guide system planning and the development of care algorithms for specific patient populations.

RHAs are responsible for tracking patient outcomes.

Provincial data shows that in 2010-11 there were a total of 14,710 discharges from home care. Of these, 40 percent were discharged to self care. After discharge from the home care program, the supplies that were covered by the home care program are no longer available and individuals must access any equipment or supplies that they need through local retail outlets. Medication is not part of the home care program and, accordingly, is a client responsibility; however, there may be exceptions made at the regional level to help individuals through a transition period.

Resident Assessment Instrument-Home Care (RAI-HC)

The Resident Assessment Instrument-Home Care (RAI-HC)© is a standardized, multi-dimensional assessment system for determining client needs. The information obtained from this assessment can be used for many purposes, including quality indicators, care planning, outcome measurement scales and a case mix system. The RAI-HC was developed through interRAI, a collaborative, not-for-profit network of researchers from around the world that works to promote evidence-informed clinical practice and policy decision making, through the collection and interpretation of high- quality data about the characteristics and outcomes of persons served across a variety of health and social services settings.

The RAI-HC and its next generation tool, the interRAI HC, can be used to assess adults in home and community-based settings with chronic needs for care as well as those with post-acute care needs. The instrument is generally used with the frail elderly or persons with disabilities who are seeking or receiving formal health care and supportive services. The interRAI HC is designed to highlight issues related to functioning and quality of life for community-residing individuals. Although the system can be used on admission to a home care program or at a hospital prior to discharge, its power is augmented by reassessment at a standard interval.

The assessments are captured electronically and provide real-time feedback for clinicians to support care planning and monitoring. They also provide organization- and jurisdiction-level data to support system management, quality improvement and policy-making.

(http://www.interrai.org/
RAI-HC© interRAI Corporation, 2001)

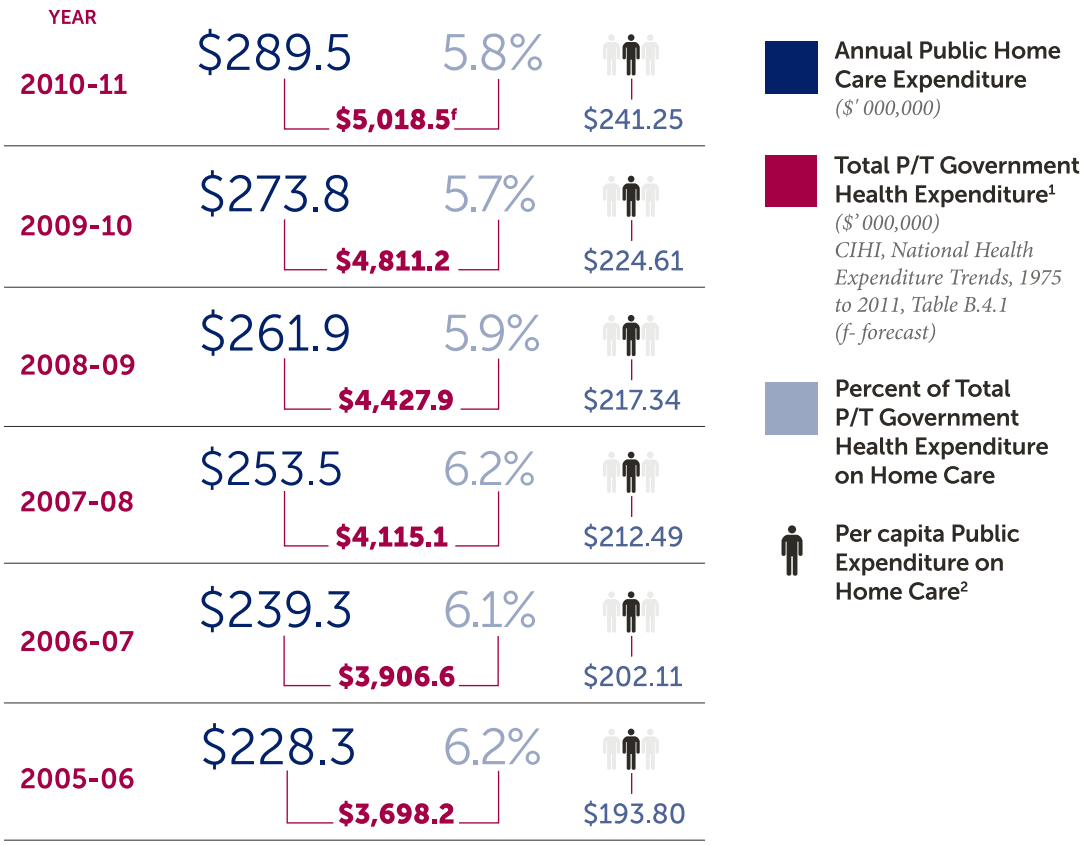
FUNDING

Manitoba Health funds the Manitoba Home Care Program. However, health services are delivered regionally and the RHAs have operational responsibility for home care, which includes planning, delivery and ongoing management of the services.

Each RHA prepares and submits a regional health plan, which includes objectives, priorities and financial components. Manitoba Health reviews all regional plans and, upon approval of provincial Estimates of Expenditure, RHAs are allocated funds for the fiscal year. RHAs determine the final annual home care budget for their respective region.

Services in the public expenditures include: assessment, care planning, case management, nursing, rehabilitative therapy assessment, health teaching, personal care, in home respite, home support, Adult Day Program, and Support Services to Seniors.

Public Expenditures on Home Care

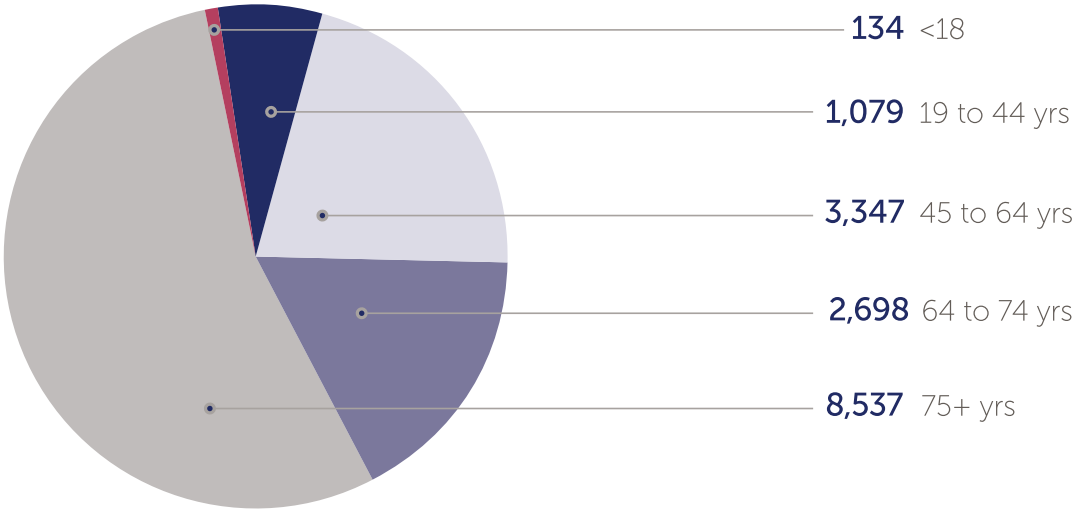


[1] *Figures include spending for health services reported by the provincial/territorial ministry responsible for health – does not include expenditures from municipal government or worker's compensation. [CIHI, National Health Expenditure Trends, 1975 to 2011, pg 92]*

[2] *Population data from Statistics Canada, Demography Division, Annual Estimates of Population for Canada, Provinces and Territories, from July 1, 1971 to July 1, 2012*

PROFILE OF CLIENTS RECEIVING HOME CARE

Client Age on Admission (2009-10)



DIAGNOSIS

The most common diagnoses for individuals receiving home care are not tracked provincially.

CLIENT GROUPING

Manitoba Health does not collect data according to the client grouping definitions (Acute Care Substitution, Maintenance, End-of-Life care (palliative), Rehabilitation, and Long Term Supportive Care) established by a federal / provincial / territorial working group on continuing care in 2001.

A phased-in provincial roll out of the Minimum Data Set (MDS) and Resident Assessment Instrument (RAI) has strong RHA and departmental support, but the implementation has been delayed.

SERVICE DELIVERY

MODEL OF SERVICE DELIVERY

Services of the MHCP are funded and provided through the publicly funded health care system. However, on a case-specific basis through the Self and Family Managed Care option, or when the required services cannot be provided by the existing regional home care staff, contracts may be arranged with private care/service providers. Funded services are based on program-assessed needs. In addition, individuals through either insurance plans or direct payments may contract with private service agencies for service, independent of the regional program.

RANGE OF HOME CARE SERVICES & PROGRAMS

The MHCP provides the following core direct services:

Units of Service Provided

The amount of publicly funded service by service category[1] is expressed in units[2] in the following chart.

	2006-07	2007-08	2008-09	2009-10	2010-11
Registered Nursing[3]	661,573	583,115	580,817	536,098	565,157
Licensed Practical Nursing	228,310	202,220	203,537	199,501	241,462
Rehabilitation Physiotherapy & Occupational Therapy[4]	29,131	79,686	79,009	82,871	74,449
Home Support (includes meal preparation, respite, cleaning and laundry)	641,189	569,274	525,916	501,433	447,208
Home Care Attendant (includes individuals in group shared care arrangements receiving attendant services / personal care)	5,357,401	4,630,571	4,857,501	4,568,222	5,275,960
Assessment and Care Coordination	Separate volumes not available				
Health Education	Separate volumes not available				
Access to Adult Day Programming	Separate volumes not available				

Ancillary Support

Oxygen	Home Oxygen is a distinct program within home care that provides oxygen via concentrator to clients. The average number of clients in 2010/11 was 1,023.
Drugs	Not a part of the MHCP
Supplies (dressings, stoma)	An approved range of supplies are provided to home care clients. Those clients who are on the Self and Managed Care option are excluded.
Equipment (wheelchairs, walkers)	Accessible through home care. An approved range of equipment is available on loan, as noted in section 2, "Eligibility, Coverage and Utilization".

[1] An individual can receive more than one category of service.
[2] One unit equals one hour of service. Reliable data prior to 2006-07 is not available.
[3] Registered nursing services in Winnipeg in 2001/02 were impacted by a shortage of RNs and by increased LPN service, following case reviews done to better target nursing services.
[4] Therapy includes physiotherapy and occupational therapy assessments.

SERVICES NOT FUNDED /PROVIDED THROUGH MANITOBA HOME CARE:

- Nurse Practitioner
- Speech Language Pathology
- Dietetics
- Physician
- Pharmacist
- Pastoral-Care

INDIVIDUALS SERVED

In 2010/2011, an average of 23,691 clients received home care services each month. A majority of clients received services from a home care attendant in any given month, while approximately one-third of clients received services from a registered nurse.

Average Monthly Number of Persons Receiving Select Services by Category [1]

Services	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
Home Support Service	6,087	6,017	5,975	5,739	5,745	5,645	5,240
Home Care Attendants[2]	12,692	12,981	13,617	13,762	12,965	11,292	14,248
Registered Nursing[3]	5,138	6,143	5,809	9,857	9,265	8,111	7,723
Licensed Practical Nursing	2,142	2,418	2,950	3,530	3,450	3,127	3,777
Therapy[4]	1,120	1,062	1,018	1,102	1,084	1,049	1,195

[1] An individual can receive more than one category of service
[2] Home Care Attendant also includes individuals in group shared care arrangements receiving attendant services
[3] Registered nursing services in Winnipeg in 2001/02 were impacted by a shortage of RNs and by increased LPN service, following case reviews done to better target nursing services.
[4] Therapy includes physiotherapy and occupational therapy assessments.

CLINICAL (SPECIALTY) SKILLS

With the focus on discharging patients from hospital as promptly as possible, there has been an increase in the complexity of care provided at home. The challenge in much of Canada can be in having a critical mass of patients who require certain levels of expertise and, as a result, special skills only being available in urban centres. However, with the advent of remote access to support in the community, there is an opportunity for more complex care to be provided in less populated areas.

In Manitoba, under the direction of a physician, the home care nurses are able to:

- Administer narcotics.
- Provide enterostomal therapy, wound care, infusion therapy (limited).
- Manage (to a limited extent) infusion pumps, central lines and peripherally inserted central catheters (PICC lines).
- Provide ventilator care (in Winnipeg) and regular tracheostomy tube replacement (in Winnipeg and Brandon).
- Manage home oxygen (delivered through a provincial contract).

Clinical services not currently provided in the home include:

- Administration of chemotherapy, blood or blood products.
- Hemodialysis (note - peritoneal dialysis is rarely provided).

3. Quality & Accountability

HOME CARE INDICATORS

The home care indicators that are currently monitored at a provincial level include:

- Amount of service delivery.
- Expenditures.
- Home care admissions.
- Referral source.
- Reason for non admit.
- Client disposition at discharge.

QUALITY & ACCREDITATION

High-quality care is evidence-based (appropriate), focused on the patient (or patient-centered), safe and timely (CIHI).

EXTERNAL ACCREDITATION

Accreditation is an effective way for health services organizations to regularly and consistently examine and improve the quality of their services in order to ensure high standards of care. Organizations in Canada are accredited through Accreditation Canada, CARF, the Quebec Council of Accreditation (Quebec only) and/or registered with the International Standards Association (ISO).

Accreditation of home care organizations in Manitoba is mandatory. The home care programs participate in accreditation as part of their RHA's activity. All current RHAs are accredited with Accreditation Canada.

QUALITY COUNCIL

The RHAs have operational responsibility for home care; quality is one component of program operations. The RHAs establish quality assurance processes for ongoing care planning, monitoring and evaluation of services to identify effective practices as well as those that require improvement. Quality functions include collecting and analyzing data related to the delivery of home care services for the purposes of critiquing existing practice and planning for future home care service demand.

CLIENT / PATIENT ADVOCATE

The Manitoba Health Appeal Board is a quasi-judicial body that hears appeals in home care after the regional complaint process has occurred, and if it is determined that an appeal is warranted. It also serves as an advisory body to the Minister on policy matters related to the MHCP. The Manitoba Appeal Board may be contacted when a client and or family are dissatisfied with the outcome of the regional complaint process. Appeals may be heard on the type of, level of, or eligibility for home care service.

SYSTEM APPROACHES TO QUALITY IMPROVEMENT

From the provincial system perspective, innovative approaches to home care delivery are being explored. In light of the current and anticipated program demands and available program resources, the need for a change in approach for delivery of home care has become necessary. The MHCP is likely to play a prominent role in the province's refresh of the Long Term Care/ Aging in Place Strategy that is currently underway. The recognition of the benefits of home/community-based services, for individuals and system alike, has raised home care's profile. Future program developments/initiatives are yet to be defined.

Better Health – Better Care – Better Cost

Triple AIM, a roadmap to achieving excellence, high performance and high value health care:

1. Enhance the individual (patient) experience of care (including quality, access, and reliability).
2. Improve the health of populations.
3. Reduce, or at least control, the per capita cost of care for populations.

The five components that support Triple Aim are:

1. Focus on individuals and families.
2. Partnerships of Primary Health Care – Home Care.
3. Population health management – Prevention and Health Promotion.
4. Cost control platform "receiving value for money".
5. System integration and execution.

(Adapted from the Institute for Healthcare Improvement, Triple Aim Improvement Community. (Massachusetts: Institute for Healthcare Improvement, 2012)

SAFETY

Client safety data is not collected provincially. Each RHA tracks safety issues through established occurrence reporting processes. Client safety within the home is monitored through ongoing assessments in the home. The home care coordinators perform assessments of the client's home environment and determine if any issues require resolution, both prior to initiating home care services and during the course of care. The direct service staff, additionally, report any concerns to the home care office. The client and family are responsible to ensure ongoing safety in the home. Options such as Life Line and bubble packs for medications help increase a client's safety. Safety concerns that have been identified include environmental issues, clinical care, and equipment. Critical incidents (CI) – for example, medication errors, falls - are reported to the Department by the RHAs. CIs are reported across all programs.

The **Manitoba Institute for Patient Safety** (MIPS) was created in 2004 to promote, coordinate and facilitate activities that have a positive impact on patient safety throughout Manitoba, while enhancing the quality of health care for Manitobans. MIPS is affiliated with the Canadian Patient Safety Institute. Campaigns such as "It's Safe to Ask" help to develop an informed and empowered health care consumer who can take an active role in his/her health care.

Issues of service provider safety are addressed by the RHAs through a number of routes such as the application of working alone guidelines, the development of safe visit plans, zero tolerance of abuse, and active workplace safety and health committees.

HOME CARE RESEARCH

Manitoba Health is actively working to identify/address the prevalent trends/challenges impacting the continuum of care. A 2011 report from the **Manitoba Centre for Health Policy** (MCHP), Population Aging and the Continuum of Older Adult Care in Manitoba, has helped to inform this process. The report details the challenges that Manitoba seniors face and the types of care that they require.

The MCHP is a research unit at the University of Manitoba. While partially funded by the Province of Manitoba, the MCHP is not a government agency. MCHP contracts with the Province of Manitoba (since 1991) to provide relevant research on health and social issues.

4. Information Technology

ELECTRONIC HEALTH RECORD (EHR)

An electronic health record has been implemented in Winnipeg and, to a limited extent, throughout the rest of the province. Within Winnipeg, clinical documentation at the point of care is electronic; however, the electronic home care health record is not incorporated into an overall regional or provincial electronic health record for the patient. Winnipeg and some of the other RHAs have established electronic communication between home care and hospitals; and between frontline staff for referral and sharing of clinical information.

HEALTH DATA & THE HOME CARE REPORTING SYSTEM

To meet the need for consistent, comparable home care information, the Canadian Institute for Health Information (CIHI) developed the Home Care Reporting System (HCRS). The purpose is to collect and process information on publicly funded home care services in order to support jurisdictions in their analysis and decision making by providing data on:

- Access to home care services.
- Health and functional status measures.
- Clinical outcomes and waiting times.
- Quality of care.
- Informal support.
- Service utilization by setting and provider type.

The HCRS captures standardized client-specific clinical, demographic, administrative and resource utilization information. A key component of the HCRS is the Resident Assessment Instrument—Home Care (RAI-HC). Home care data from the Winnipeg Regional Health Authority is submitted annually to CIHI.

USE OF TECHNOLOGY FOR CLIENT CARE

MBTelehealth utilizes information technology to connect people to health care services at a distance. A high-speed, secure, video link is used to connect clients to health care providers at different locations in Manitoba. It also provides professional education programs and administrative support to RHAs.

Access to MBTelehealth is available in all RHAs and not exclusive to home care. Using video-technology, MBTelehealth provides the opportunity for client follow-up at a distance, an important option in consideration of the sometimes remote location of home care clients. Exploration of expanded application within the province is underway. This would facilitate more effective and efficient follow-up for the clients and provide needed support for community care providers.

Technology is used in home care for scheduling of staff and for submission of indicator data and financial data within the RHAs and to Manitoba Health. The regions determine the communication technology that is supplied to home care staff.

5. Health Human Resources

CLINICIANS PRACTICING IN HOME & COMMUNITY CARE

HEALTH CARE PROFESSIONALS

Recruitment and retention of nurses, physicians and allied health professionals, from the provincial perspective, is a priority. The home care sector presents unique challenges to the practicing professional, such as the workplace setting, required travel, and working alone. The changing demographics and expectations for care in the home have increased the caseload volumes for home care staff, which brings an additional set of challenges to the program.

While work at the provincial level to address some of the challenges is ongoing, it is the RHAs that are specifically responsible for workforce planning and competency development of home care program staff. Data regarding the numbers of health care staff is tracked at a regional level through the RHAs and is not currently available on a provincial level. However, the Health Workforce Strategies (HWS) branch tracks nursing vacancies, enrollments, and education seats, and monitors data through information provided by the nursing regulatory colleges, Regional Health Authorities, and the Council on Post-Secondary Education (COPSE). As a result of continued aggressive recruitment and retention of nurses across the province in 2010, there was a net gain of 494 nurses from 2009, with a ten year net gain of 3,026 nurses.

UNREGULATED STAFF

Home care attendants (HCA) and home support workers (HSW) provide home care services. The specific scope of duties for HCAs and HSWs is part of the regional authority mandate. Typically HCAs deliver personal care – e.g. bathing, dressing, etc., while the HSW completes the support functions, e.g. laundry, housekeeping. Increasingly, RHAs are using HCAs, as their scope is broader.

There is no provincial registry for the unregulated home care staff.

EDUCATION & TRAINING

HEALTH CARE PROFESSIONALS

Regulation of education requirements is a part of professional licensing bodies. As one component of program operations, RHAs determine regional/job-specific training required for all home care staff. A network of home care program managers from each RHA meets regularly to review policy/practice to ensure consistency across the province in terms of service standards of practice.

UNREGULATED STAFF

RHAs define the education requirements of the unregulated staff as a part of their human resource policy. Typically, the RHAs require the HCAs to have completed the HCA certificate training. As the

training is unregulated, and the curriculums vary, the RHAs determine training programs and on-going task/competency-specific training. A network of home care program managers from each RHA meets regularly to review policy/practice to ensure consistency across the province in terms of service standards of practice.

INTER-PROFESSIONAL COLLABORATION

The MHCP delivers multi-disciplinary care/service to the program's clients. Case coordinators, in consultation with the involved health professionals, including but not limited to, occupational therapy and physiotherapy, identify clients' care/service needs and coordinate the delivery of the required services. Collaboration naturally occurs and information sharing is according to RHA policy and provincial legislation. This collaboration may also include other government agencies and community-based service providers.

FAMILY CAREGIVER

The role of the family is an important component of home care delivery and is defined by MHCP policy. Care/services provided by the MHCP are intended to supplement that which family/friends are able to reasonably provide with available community resources. Capacity to do so is part of the client assessment completed by the home care staff. Supports for the family caregiver include:

- **Respite** – The MHCP provides staff services in the home in order to give the family caregiver a brief time away. Respite may also take the form of inclusion of the home care client in day programs, or arrangements for the home care client to go to a personal care home for a designated longer period of time. The need for respite is recognized as an important caregiver support.

- **Financial support** - The Primary Caregiver Tax Credit (PCG-TC) is a non-income tested and fully refundable tax credit for informal (i.e. unpaid) care providers. The PCG-TC is based on the assessed level of care of the home care client. The assessment of care need is completed by the regional MHCP clinical staff, or a community care provider for non-home care clients. The RHAs process and approve all applications, although Manitoba Health does track overall program uptake. Caregivers may earn the credit for up to three care recipients at any given time. This means the maximum credit for a caregiver looking after three care recipients, throughout a full year (after a three-month qualifying period for each care recipient), is $3,825.

  To be eligible:

  - The primary caregiver must be a resident of Manitoba on December 31st of the claim year, identified by the person receiving care (or their parent if the person receiving care is under 18), and must not be paid to provide care to this person.
  - The care recipient must be assessed to have Level of Care Equivalency of 2 or higher, as determined by a licensed or registered health care professional.

Caregivers provide care and assistance for spouses, children, parents and other extended family members and friends who are in need of support because of age, disabling medical conditions, chronic injury, long-term illness or disability. A family caregiver's effort, understanding and compassion enable care recipients to live with dignity and to participate more fully in society.

5 million
is the estimated number of caregivers in Canada

80%
of care needed by individuals with a long-term condition is provided by family caregivers

60%
of caregivers provide care for more than three years

(Canadian Caregiver Coalition www.ccc-ccan.ca.)

Direct payment - Family may be the designated provider of non-professional care services through the Self and Family Managed Care Program (SFMC) of the MHCP. This permits payment to a family member who is the designated care provider (non-professional services) and is based on assessed care needs and subject to the established service limit policy. Because of the added client/family responsibilities for the SFMC option, participation requires specific assessment conducted by the regional home care program staff.

6. Provincial Initiatives

As home care is an integral service within the continuum of care, RHAs work to develop strategies to address region-specific challenges. Provincially, collaboration across care sectors is targeted toward increasing and improving available community resources and services.

PRIMARY HEALTH CARE

Manitoba's vision is to develop a coordinated primary care system within the province, where all partners, including family physician, mental health worker, home care staff and public health nurse, work together; where all primary care services are planned and coordinated based on the needs of a community; where primary care is accessible and of high-quality province-wide; and where these attributes of a well-functioning primary care system are continuously measured and demonstrated. Several pilot projects have addressed the goal of integration between primary/acute and home care sectors. The "virtual ward" concept, linking service providers for a select group of high users of health care services, is being explored. Review of results from pilot projects will help inform future steps.

CHRONIC DISEASE MANAGEMENT

In February 2011, Manitoba announced an innovative new rehabilitation program to help seniors regain and maintain their independence following surgery or injury, and also delay or prevent untimely or inappropriate placement in a personal care home.

SENIORS AND AGING

In February 2011, Manitoba announced more home care supports for those older adults that need support to help them live at home longer. There are increased efforts to maintain individuals in the community for as long as safely possible. A refresh of Manitoba's Long Term Care/Aging in Place Strategy is underway with the input of stakeholders across the province. A consolidation of provincial efforts and program sustainability are the long-term goals. It is expected that a multi-year action plan will be an outcome of the refresh.

7. Challenges

The top anticipated challenges for the MHCP are:

- **Meeting volume and diversity of service** - There is an increasing expectation that individuals remain in their homes/home community for as long as is safely possible. Both the aging population and increased prevalence of chronic disease are increasing service demands that often require resources beyond the capacity of the existing home care program.
- **Geographic Isolation and Human Resources** - Rural and northern RHAs are faced with challenges due to distance and the ability to attract and retain adequate human resources.
- **Lack of Coordinated Technology** - Technology to support complex care at home and the required specialized training. Lack of coordinated technology to support the care worker and the program, in terms of case reporting and coordination across care sectors, compromises the ability to maximize efficiency and quality.

Addressing these challenges will require innovative approaches to more effectively utilize existing resources, as well as additional resources that could support further service improvements. However, over the longer term, ongoing provision of those resources in the existing system, solely from the home care perspective, and in the absence of a system-wide perspective shift, is not likely to create the maximal system benefit. Ultimately, what is needed is a new look at home care in the broader context of other care programs, to create synergies that would address care delivery needs system-wide in a coordinated fashion.

8. Opportunities

Consistency and Accountability - Expansion of the Minimum Data Set - Resident Assessment Instrument (MDS-RAI) across the province is in the future. As the MDS is an acknowledged and reliable system of assessing and documenting care required / provided, it will provide consistency across RHAs and programs, which will support optimal care.

Home Care to Support Aging in Place - Enhancements to home care have been announced and implementation plans are under development. It is expected that further opportunities will be defined by the refresh of the Long Term Care /Aging in Place Strategy (LTC/AIP).

The mission of the MHCP is to provide effective, reliable, and responsive home care health services for Manitobans to support independent living in the community, and to coordinate admission to facility care when community living is no longer a viable alternative. As this is congruent with the goals of the LTC/AIP Strategy, it is not anticipated that it will change significantly.

ACRONYMS / ABBREVIATIONS

AIP - Aging in Place Strategy
ALC - Alternate Level of Care
CIHI - Canadian Institute for Health Information
CI - Critical Incident
COPSE - Council on Post-Secondary Education
EHR - Electronic Health Record
HCA - Home Care Attendant
HCRS - Home Care Reporting System)
HSW - Home Support Workers
HWS - Health Workforce Strategy
ISO - International Standards Association
LTC - Long Term Care
MCHP - Manitoba Centre for Health Policy
MH - Manitoba Health
MHCP - Manitoba Home Care Program
MIPS - Manitoba Institute for Patient Safety
MDS - Minimum Data Set
PCG-TC - Primary Caregiver Tax Credit
RAI-HC - Resident Assessment Instrument – Home Care
RHA - Regional Health Authority
SFMC - Self and Family Managed Care Program

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The chapter has been compiled from sources listed below, interviews with key informants and feedback to an electronic survey. Information replicated from provincial materials has been done so with the knowledge and permission of the key informant.

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ONTARIO

HOME CARE IN **ONTARIO**

Home Care in Ontario is consistent with the Canadian Home Care Association definition.

> Home care is an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the family caregiver.

It should be noted that the Canadian Home Care Association's definition is broader than publicly funded home care and could include such things as privately purchased home care services (outside of the jurisdiction of provincial authority).

ONTARIO
BY THE NUMBERS...

1,076,395 sq km **LAND AREA**	13,373,000[1] POPULATION (2011)	**85%**[3] Percent population in urban settings defined as an area with a population of at least 1,000 and with no fewer than 400 persons per square kilometre (2006).	
59.8[2] Dependency ratio (2009) Ratio of the population aged 0-19 and 65+ to the population aged 20-64	14.2%[1] **Population Seniors 65+ yrs** (2011)	81.3 years[1] **LIFE EXPECTANCY (AT BIRTH)**	**$3,912.71**[2] Public sector health care expenditure per capita (2011 Forecast)

[1]Statistics Canada | [2]Canadian Institute for Health Information (CIHI) | [3]Human Resources and Skills Development Canada

1. Governance & Organization

HEALTH CARE SYSTEM STRUCTURE

Home care in Ontario falls under the jurisdiction of the **Ministry of Health and Long-Term Care (MOHLTC),** which is responsible for Ontario's health care system including: health insurance, drug benefits, assistive devices, care for the mentally ill, community services, home care, community health, health promotion and disease prevention, hospitals and long-term care (LTC) homes.

The MOHLTC provides stewardship of Ontario's health system through legislation and regulations, policy, including funding policy, standards of care, and guidelines, as well as ensuring compliance with these requirements. The MOHLTC also provides support for provincial program development and implementation. The MOHLTC sets provincial priorities for improving the health care of all Ontarians and provides funding to **Local Health Integration Networks (LHINs)** who, in turn, plan, fund and integrate local health services, including home care.

Local Health Integration Networks (LHINs)

- Erie St. Clair
- South West
- Waterloo Wellington
- Hamilton Niagara Haldimand Brant
- Central West
- Mississauga Halton
- Toronto Central
- Central
- Central East
- South East
- Champlain
- North Simcoe Muskoka
- North East
- North West

The Excellent Care for All Act, 2010

The Excellent Care for All Act puts patients first by improving the quality and value of the patient experience through the application of evidence-based health care.

It will improve health care while ensuring that the system we rely on today is there for future generations.

(Ontario MOHLTC, Retrieved from http://www.health.gov.on.ca/en/common/legislation/ecfa/default.aspx)

In 2006, the management of local health services was devolved to fourteen LHINs. The LHINs are responsible for local health system planning and community engagement within specific geographic areas. They are responsible for funding a wide range of health service providers, in addition to managing service agreements with health organizations, including:

- Hospitals
- Community Care Access Centres
- Community Support Services
- Long-Term Care
- Mental Health and Addictions Services
- Community Health Centres

Aligned within the geographic boundaries of the LHINs are 14 **Community Care Access Centres (CCACs)** responsible for home and community care.

Together, all the system partners - government, LHINs, and providers – are accountable to the people of Ontario for quality and results.

HEALTH CARE & HOME CARE LEGISLATION

Community Care Access Corporations Act (CCAC Act) (2001) – governs the designation, objects, powers and duties of community care access corporations, and sets out the powers of the Minister of Health and Long-Term Care with respect to these corporations. On September 18, 2009, regulations came into force enabling an expanded role for CCACs relating to placement of persons into adult day programs, supportive housing programs and chronic care and rehabilitation beds in hospitals. Pursuant to section 6.1 of the legislation, a person has a right to communicate in French with, and to receive available services in French from a CCAC. The board of directors of a CCAC is required to take all reasonable measures and make all reasonable plans to ensure that persons can exercise this right to use French.

Home Care and Community Services Act (HCCSA) (1994) – governs the provision of community services, including professional, personal support, homemaking and community support services, to people in their own homes and other community settings. On September 18, 2009, regulations came into force to improve service maximums for nursing services, expand the professional services that CCACs can provide to include pharmacy services, respiratory therapy services, social service work services and diagnostic and laboratory services, and permit the provision of certain professional services in congregate or group settings. The HCCSA was formerly named the Long-Term Care Act, 1994 (the change in name occurred effective July 1, 2010).

Health Insurance Act (HIA) – Establishes a scheme for the payment of publicly funded physician, hospital and specified practitioner health care services (the Ontario Health Insurance Plan - "OHIP")

for all Ontario residents, in accordance with the requirements of the Canada Health Act. Also sets out a system for the review and recovery of payments made under the Act.

Ontario Drug Benefit Act – governs the administration of Ontario's publicly-funded drug plan, the Ontario Drug Benefit Program.

Long-Term Care Homes Act (LTCHA) (2007) – came into force on July 1, 2010 and replaces the former legislation governing long-term care homes (Nursing Homes Act, Charitable Institutions Act, and Homes for the Aged and Rest Homes Act). The LTCHA and its regulations govern residents' rights, care and services, admissions, operations, funding, licensing and compliance and enforcement. CCACs are the placement coordinators under this legislation that are responsible for admission to homes.

Excellent Care for All Act (2010) – requires health care organizations (defined as hospitals and other organizations that may be provided for in the regulations) to establish quality committees, develop a quality improvement plan, conduct surveys to collect information concerning satisfaction with the services they provide and have a patient relations process and a patient declaration of values. The legislation expands the mandate of Health Quality Ontario (formerly the Ontario Health Quality Council) to recommend standards of care in the health system, based on or respecting clinical practice guidelines.

Broader Public Sector Accountability Act (2010) – establishes rules and accountability standards for hospitals, LHINs and broader public sector organizations, including CCACs.

Local Health System Integration Act (LHSIA) (2006) – provides the LHINs with the authority to manage their local health systems and fund health service providers, including CCACs. The legislation places significant decision-making power at the community level and focuses the local health system on the community's needs.

French Language Services Act (1986) – guarantees an individual's right to communicate in French with, and receive available services in French from "government agencies". The FLSA defines "government agencies" to include all ministries and agencies of the Government of Ontario and various entities that have been designated as "public service agencies" by regulation under the FLSA. The preamble of the FLSA recognizes the contribution of the cultural heritage of the French-speaking population and the wish to preserve it for future generations.

Health Care Consent Act (1996) - sets out requirements for consent to treatment and establishes the legal criteria to determine whether a person has the mental capacity to make decisions about their own treatment, admission to a care facility (long-term care home) or personal assistance services (for a resident of a long-term care home). Where a person is not mentally capable of making these decisions, the Act provides a way to obtain substitute decisions from a formal decision-maker appointed through the legal procedures of the *Substitute Decisions Act, 1992* or, where there is no formal decision-maker, from certain family members.

Substitute Decisions Act (1992) – establishes the legal criteria to determine whether a person has the mental capacity to make decisions about their own personal care or property and describes how a formal decision-maker (an attorney or guardian) may be appointed to make these decisions for a mentally incapable person.

Personal Health Information Protection Act (PHIPA) (2004) – establishes rules governing the collection, use and disclosure of personal health information by health information custodians and certain other persons.

Ministry of Health Appeal and Review Boards Act (MHARBA) (1998) - establishes both the Health Professions Appeal and Review Board and the Health Services Appeal and Review Board, each of which hear matters under various MOHLTC statutes, including the HCCSA and the LTCHA.

EVOLUTIONARY MILESTONES

1959
Six acute home care pilot projects funded with federal health grants and assistance from the Ontario Hospital Services Commission.

1970
Home care formally established by the Government of Ontario.

1971
Three placement co-ordination pilots introduced.

1972
Acute home care services implemented province-wide as an insured benefit under the Ontario Health Insurance Plan (OHIP).

1975-84
Chronic home care services phased-in province-wide.

1978-84
Placement coordination services for admission to long-term care (LTC) phased-in province-wide.

1984
School services in publicly funded schools implemented to support provincial education reforms and enable universal access to public education for students with special needs.

1986-94
Integrated Homemaker Program phased-in province-wide to provide homemaking and personal care for adults who were living with a physical disability or were frail and elderly.

1993
Long-Term Care Statute Law Amendment Act, 1993 required that all admissions to LTC homes (nursing homes and homes for the aged) be authorized by placement coordination services. Policy direction was provided to CCACs in 1994.

1995

Long-Term Care Act, 1994 (LTCA) proclaimed into force.

Regulation made under the LTCA relating to the conveyance of assets of an approved agency.

1995

Amendments made to regulations under the *Health Insurance Act and the Homemakers and Nurses Services Act* to remove the requirement that a physician must authorize the provision of home care.

1995-96

Integration of acute, chronic, school health and homemaker programs into a single service-based model.

1996-98

Establishment across the province of 43 CCACs consolidating 38 home care programs and 36 placement coordination services under new community boards.

1999

Regulations made under the LTCA setting out eligibility criteria for persons receiving homemaking services and service maximums for homemaking, personal support and nursing services.

2000

Regulations made under the LTCA setting out eligibility and service maximums for school health professional services and school health personal support services to be provided to children attending private schools and home schools. (Regulation under the *Health Insurance Act* relating to these services was revoked). Policy direction was provided to CCACs in 2001.

2001

Community Care Access Corporations Act, 2001 proclaimed into force, making CCACs statutory corporations with Order in Council appointments for board members and executive directors.

Regulations under the LTCA amended to prohibit a CCAC from providing personal support services or homemaking services to a person unless the person is insured under the HIA.

2002

Forty-one of 43 CCACs designated as statutory corporations by regulation. Regulation also deemed CCACs to be approved agencies under the LTCA, and approved CCACs to provide all professional services and personal support services listed in the LTCA as well as all homemaking services, except for ironing and mending.

2003

Etobicoke and York CCACs merged bringing the total CCACs in Ontario to 42 (from 43).

2006

CCAC Act amended to allow for the reorganization and dissolution of CCACs in support of their alignment with LHINs.

Fourteen new CCACs established with boards of directors and executive directors appointed by Order in Council (OIC).

2007

Forty former CCACs were either amalgamated by regulation with the 14 new CCACs or had their assets and employees transferred to the 14 new CCACs, and were approved to provide services in the same geographic areas as the LHINs effective January 1, 2007.

2008

Strengthening Home Care Services Strategy - a multi-year and multifaceted strategy to strengthen the health care system by improving accountability for the provision of quality home care services; delivering improved health outcomes for Ontarians through integrated client care; enhancing fairness, transparency and communication in the selection of service providers for home care services; building on ministry-approved recommendations from "Choosing Quality, Rewarding Excellence"; and promoting flexibility and innovation in service provision.

Amendments to Regulation 386/99 under the *Home Care and Community Services Act, 1994*, to improve service allocations, permit new venues for CCAC funded service and authorize new specialized services – respiratory therapy, pharmacy, and social service work services.

2009

CCACs no longer statutory agencies of government and became non-profit organizations with independent community boards.

CCACs enabled by regulation under the CCAC Act to manage the placement of persons into adult day programs, supportive housing programs and chronic care and rehabilitation beds in public hospitals (in addition to their role for placement of persons into long-term care homes).

Regulations under the LTCA amended to improve service maximums for nursing services, expand the professional services that CCACs can provide to include pharmacy services, respiratory therapy services, social service work services and diagnostic and laboratory services, and permit the provision of certain professional services in congregate or group settings.

Review of school health professional services and school health personal support services undertaken by MOHLTC in partnership with the Ministry of Education and the Ministry of Children and Youth Services – evaluated services and identified opportunities for program improvement with a focus on three areas: access and equity, coordination, and quality.

2010

Excellent Care for All Act, 2010 came into force.

Long-Term Care Homes Act, 2007 (LTCHA) came into force on July 1, 2010. CCACs formally designated as the placement coordinators under the LTCHA and responsible for admission to LTC homes. LTCA renamed the HCCSA.

2011

Provincial review of the palliative care system launched in partnership with the LHINs.

2012

Ontario's Action Plan for Health Care announced strategies that will transform the health care system to one that is proactive and emphasizes care in the community.

MANDATE, MISSION, PRINCIPLES & PRIORITIES

MANDATE

The mandate of the fourteen Community Care Access Centres (CCACs) is to:

- Provide simplified access to home and community care.
- Make arrangements for the provision of home care services to people in their homes, schools and communities.
- Provide information and referral to the public relating to community-related services.
- Authorize admissions to long-term care (LTC) homes and manage the placement of persons into adult day programs, supportive housing programs and chronic care or rehabilitation beds in public hospitals.

PRINCIPLES OF HOME CARE

- Provide fair and equitable access to community-based services so that Ontarians are better able to remain in their home and/or desired community.
- Facilitate partnerships with health care and broader human services so that different parts of the system work together.
- Arrange cost-effective, well-managed services for eligible clients within available resources and in accordance with applicable legislation, regulations and ministry policy.

HOME CARE PROGRAM OBJECTIVES

CCAC services provided in the home or congregate settings on a visitation basis enable home care recipients to:

- Remain in their homes.
- Return home more quickly from hospital.
- Delay or prevent their need for admission to a hospital or LTC home.

CCAC services provided to children in schools enable them to attend school and participate in school routines. CCAC services provided to children who are home schooled enable these children to receive instruction.

HEALTH SYSTEM PRIORITIES

The MOHLTC is creating a patient-centred health care system that delivers quality, value and evidence-based care in Ontario. The priorities include:

- Improving access to care.
- Focusing on new, innovative programs and strategies to improve patient flow in the system.
- Ensuring patients receive the right care, at the right time and in the right setting.
- Enhancing home and community care capacity through integrated client care.

Ontario Action Plan for Health Care 2012

A patient-centred plan that makes sure Ontarians have:

1. Support to become healthier.
2. Faster access and a stronger link to family health care.
3. The right care, at the right time, in the right place.

(Ontario MOHLTC, 2012, Ontario Action Plan for Health Care, http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_healthychange.pdf)

The **current home care priorities** are:

- Supporting seniors to receive the care and support they need in the long-term.
- Strengthening community care through the use of integrated client care teams that focus on specific client clinical conditions to improve value in health care.
- Supporting the community sector's uptake of the Excellent Care for All Strategy; care is designed around client need, new funding incentives reward outcomes and quality of care is continuously supported by the best evidence and a continuous quality improvement approach.

2. Access, Funding & Service Delivery

ACCESS TO HOME CARE SERVICES

Individuals (or persons on their behalf) can contact the CCAC directly for home care services. In addition, CCAC case management staff are located in many hospitals to provide support to patients.

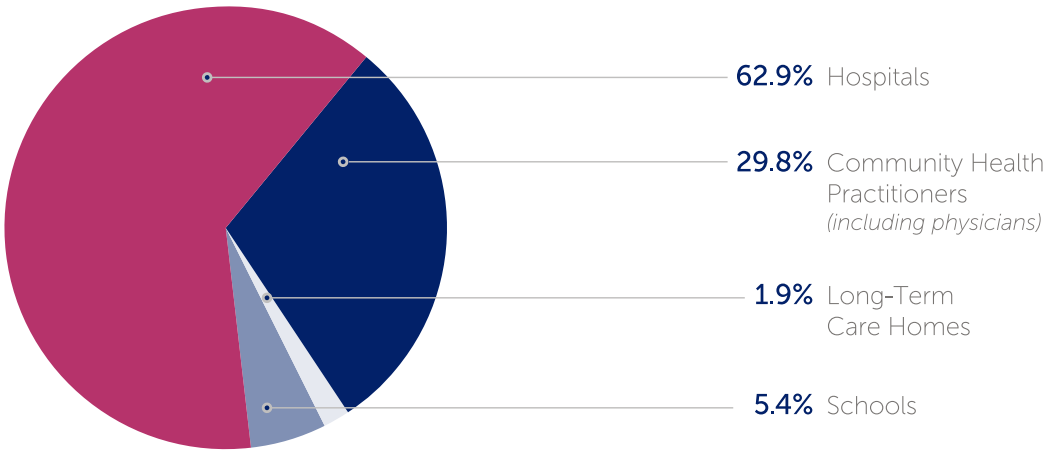
If an individual contacts a CCAC to request home care services, a CCAC case manager will assess the individual's requirements and determine his/her eligibility for home care. Once an individual is deemed eligible to receive services, the CCAC case manager will develop a plan of service to meet identified needs and co-ordinate the provision of these services.

REFERRAL SOURCES

Individuals can either be referred to a CCAC from a health care professional or institution, or may contact the CCAC directly for home care services.

Referrals to Home Care (2010-11)

Percentage of total referrals to home care

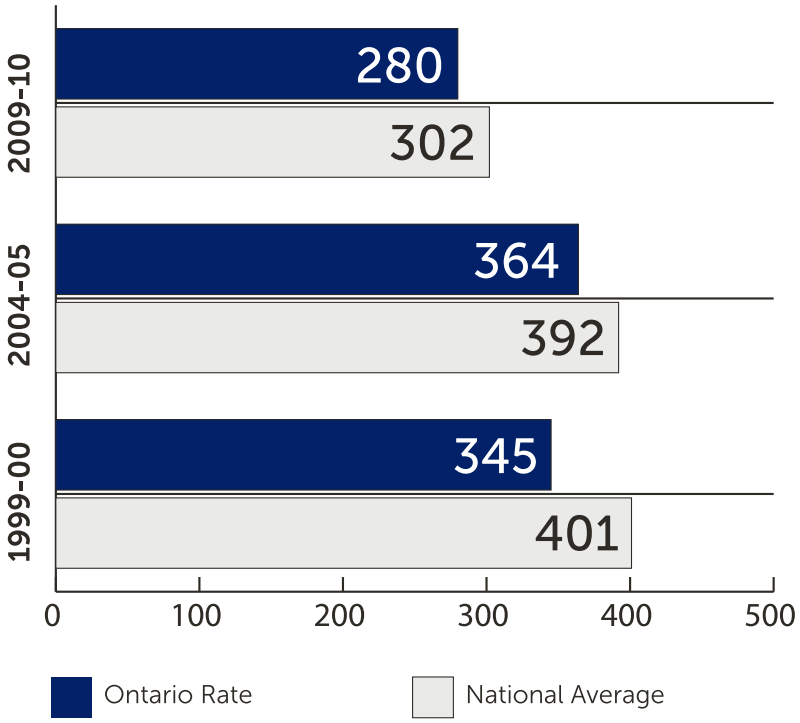


APPROPRIATE ACCESS TO HOME CARE

Hospitalization rates for conditions which can be cared for in the community are one indicator of appropriate access to community-based care. These conditions include diabetes, asthma, alcohol and drug dependence and abuse, neuroses, depression, and hypertensive disease. Preventive care, primary care and community based management of these conditions may reduce the need for these hospitalizations.

Hospitalization Rates for Ambulatory Care Sensitive Conditions

Age Standardized Rate per 100,000 younger than 75



Health Indicators Reports, CIHI

Alternate Level of Care (ALC) is a measure used to reflect when a patient is occupying a bed in a hospital and does not require the intensity of resource/services provided in this care setting.

The percentage of ALC days for Ontario Acute Care Hospitals from January-March 2011 was 16.6%.

ELIGIBILITY, COVERAGE & UTILIZATION

ELIGIBILITY

For professional services, personal support and homemaking: 1) the individual must be insured under the Ontario Health Insurance Act; 2) the home in which the service is to be provided must have the physical features necessary to enable the service to be provided; and 3) the risk of serious physical harm to the service provider must not be significant or reasonable steps can be taken to reduce the risk.

In addition:

- For **professional service**, the services must enable the person to remain in home or return home from a health care facility and the services (except for pharmacy) must be reasonably expected to result in progress to rehabilitation, maintenance of functional status or palliation.
- For **homemaking services**, the person: 1) must require personal support services along with the homemaking; 2) must receive personal support and homemaking services from a caregiver who requires assistance with the homemaking; or 3) must require constant supervision due to a cognitive impairment/ABI and the person's caregiver must require assistance with the homemaking services.

Professional services can be provided in a person's home or in a congregate or group setting (except for pharmacy services, which can only be provided in a person's home).

There are also additional service-specific eligibility criteria for some professional services (pharmacy services, physiotherapy, respiratory services and diagnostic/lab services).

AGE OF CLIENTS

All ages

DIRECT FEES AND INCOME TESTING

CCAC services are 100 percent funded by the province. There is no client co-payment or income testing.

LIMITS / GUIDELINES TO SERVICE PROVISION

Nursing services are provided by CCACs based on assessed need. Limits on service are expressed in terms of a monthly amount; for example, clients can receive up to 120 visits in a 30-day period from a registered nurse, a registered practical nurse or a registered nurse in the extended class. Limits are also expressed in terms of the number of hours which vary according to the type of nurse providing the service.

There are no regulated service maximums for the other professional health services provided by the CCAC.

Personal Support/Homemaking services are provided by CCACs based on assessed need. Limits on service are expressed in terms of the number of hours. A client can receive up to 120 hours in the first 30 days of service and up to 90 hours, in any subsequent 30-day period. Services can be provided in excess of the regulated limits for up to 90 days in extraordinary circumstances and for an indefinite period if the person is in the last stages of life, the person is awaiting admission to a long-term care home and has been placed on a waiting list, or for no more than 90 days in any 12-month period for any other person.

SUPPLIES, EQUIPMENT AND MEDICATION

Clients who are receiving professional services are eligible for coverage under the Ontario Drug Benefits Program for the period of time during which they receive these services.

CCACs can provide medical supplies, dressings and treatment equipment necessary to the provision of nursing services, occupational therapy services, physiotherapy services, speech-language pathology services or dietetics services.

Assistive Devices Program (ADP) – Ontario residents, with a valid OHIP number and a long-term disability, who have a physical disability of six months or longer are eligible to receive funding for personalized assistive devices. Specific eligibility criteria apply to each type of device. The program provides reimbursement for devices purchased from vendors registered with the Assistive Devices Program. In most cases, the client pays a share of the cost at time of purchase and the vendor bills ADP the balance.

The ADP pays up to 75 percent of the cost of equipment, such as artificial limbs, orthopaedic braces, wheelchairs and breathing aids. For others, such as hearing aids, the ADP contributes a fixed amount. For ostomy supplies, breast prostheses and needles and syringes for seniors, the client pays 100 percent of the cost to the vendor and the ADP pays a grant directly to the person.

An individual who has a chronic illness or dysfunction that requires long-term oxygen therapy may be eligible for home oxygen funding. The Home Oxygen Program pays 100 percent of the price for oxygen and related equipment for seniors 65 years of age or older and for individuals 64 years of age or younger who are on social assistance, residing in a long-term care home or who are receiving professional services through a CCAC. The program pays 75 percent of the price for all other persons.

LEARN MORE

ALC Challenges and Solutions

The term "alternate level of care" (ALC) is used to describe persons who occupy a bed in a facility but no longer require the intensity of resources and services provided in that setting.

7,500 or 14%, of acute care hospital beds are inappropriately used across Canada each day.

2.4 million days is the total use of acute hospital beds occupied by alternate level of care or ALC patients in a single year across Canada.

Home and community care programs play a key role in supporting the estimated 30-50 % of ALC patients across Canada who are candidates to return home.

Managing the ALC challenge takes a systems approach and requires collaboration of providers across the health care continuum so that individuals receive the right care in the right location.

(Canadian Institute for Health Information. (2009). Alternate level of care in Canada. (Analysis in Brief). Ottawa: Canadian Institute for Health Information.

Canadian Health Services Research Foundation (2011). Exploring alternative level of care (ALC) and the role of funding policies: An evolving evidence base for Canada. CHSRF Series of Reports on Cost Drivers and Health System Efficiency: Paper 8.)

DETERMINING CLIENT NEED - ASSESSMENT TOOLS

The Resident Assessment Instrument-Home Care (RAI-HC) is a standardized multi-dimensional assessment tool used to determine the needs of adult long-stay clients. This assessment is automated and integrated with the CCAC care management information system CHRIS (Client Health and Related Information System). Automated on-line and off-line versions of the assessment are available to facilitate assessments in the community.

The RAI-HC assessment tool is used by CCAC case managers to assess and reassess all adult long-stay clients for both CCAC services and for determining placement into long-term care homes. An adult long-stay client is defined as an adult who requires more than 60 uninterrupted days of service through a CCAC or requires admission to a long-term care home. These clients are assessed within 14 days of contacting the CCAC and are re-assessed every six months thereafter or upon a significant change in their health status. Individuals seeking admission to a long-term care home must be assessed within three months preceding the admission, or if there was a significant change within the three months, another assessment must be made. In 2012, the InterRAI-HC (the new generation tool) assessment will be implemented to replace and update the RAI-HC.

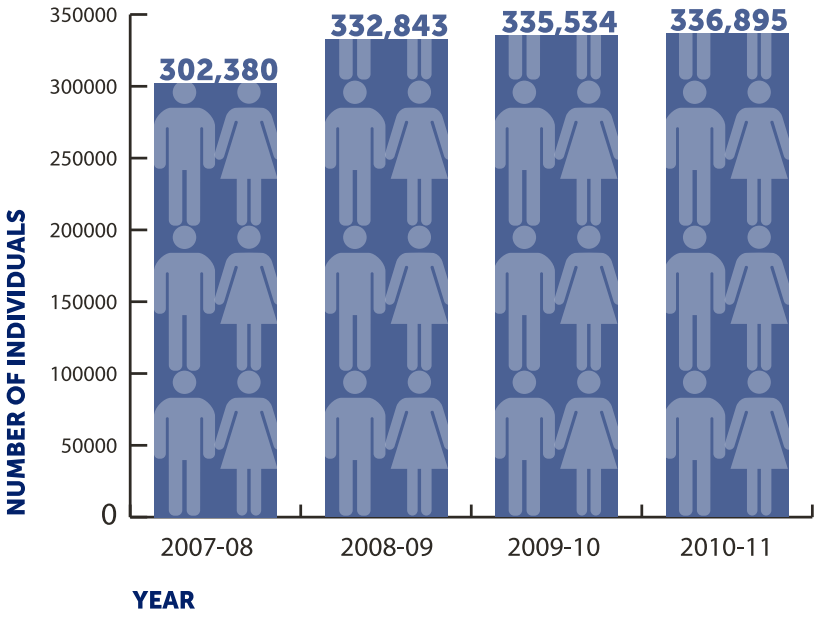
CCAC case managers use the RAI-HC assessment tool to conduct a standardized assessment using a laptop in the client's environment (e.g. home or hospital setting). During the client assessment, the case manager enters demographic, clinical and functional information directly into the software. If the CCAC case manager conducts the assessment "offline" (not connected to the network), the tool may be "uploaded" into a centralized database when the case manager re-connects to the network at a later time.

The automated tool uses client information to generate measures (e.g. CAPs - Client Assessment Protocols, MAPLe - Method of Assigning Priority Levels, CPS - Cognitive Performance Scale) that assist the case manager, in collaboration with the client/caregiver, to develop a plan of service that addresses the individual's identified needs.

The **RAI Contact Assessment (RAI CA)** is a brief standardized clinical assessment designed to inform home care intake from community or hospital, and screening of vulnerable populations in hospital emergency departments. CCACs have implemented this assessment tool for all adult clients.

Community Support Service (CSS) agencies (non-CCAC agencies that provide services that help people to live in the community independently and safely , such as adult day programs and meal services) are in the process of implementing the RAI-Community Health Assessment (CHA) and screener, including a shared assessment model. The RAI-Palliative Assessment will be fully implemented across the province electronically by fall 2012.

Home Care Admissions



Access to home care is consistent between urban and rural settings across the province.

There are individuals waiting for home care services (nursing, therapy and personal support). The longest waiting lists are for children who require occupational therapy and speech therapy in school, primarily for fine motor coordination and articulation problems. The problem is a shortage of therapy professionals and high client demand exceeding supply. All clients, including children in the school program, are assessed and prioritized for each service for which they are eligible. Clients with urgent service needs receive services immediately. Clients with non-urgent needs may wait for services.

There are also waiting lists for personal support services in some areas of the province. Clients with low to mild needs for assistance with personal care may be placed on a waiting list for CCAC personal support services. Information about or referral to service alternatives would be offered, such as community support services, acquired brain injury (ABI) services, assisted living services in supportive housing (ALSSH) for frail or cognitively impaired seniors, as well as supportive housing for people who have physical disabilities or HIV/AIDs.

SETTINGS OF CARE

Home care services are provided in the following range of settings; however, not all services are provided in all settings. Certain exceptions to the provision of services by CCACs are noted:

- Client's home.
- Congregate setting – except homemaking, personal support and pharmacy.
- Group Home – except where already provided by the group home.
- Hospice – CCACs only provide nursing and personal support.
- LTC Home – CCACs only provide nursing that is part of an outreach program as well as training to provide nursing, occupational therapy, physiotherapy, respiratory and speech-language pathology services.
- On reserve – except where already provided by First Nations on reserve.
- Retirement Home – no homemaking; other services except where already provided by the retirement home.
- School – CCACs provide dietetics, nursing, occupational therapy, physiotherapy, speech-language pathology and training of school personnel in publicly funded and private schools as well as to home schoolers. CCACs provide personal support services in private schools and to home schoolers.
- Shelter - i.e. for homeless population – all services provided as appropriate/feasible.

INTEGRATED MODELS OF CARE

The **Integrated Client Care Project (ICCP)** is an initiative that includes the development, implementation and on-going impact assessment of integrated client care teams focused on specific clinical conditions/ client care groupings to improve value in health care.

The project is developing and testing a new integrated care delivery model (including changes to delivery and funding methods) that includes:

- New and evolving ways for CCAC case managers and service providers to work together and alternate reimbursement model(s) for CCAC contracted providers based on outcomes and promoting innovation.
- Standardized care delivery incorporating coordinated and shared assessment, collaborative care planning, and best practice care pathways and care standards.
- System-wide care coordination appropriately aligned to client need.
- Integrated, population-based delivery teams working within and across different sectors in partnership with primary care.

The ICCP model, where care is organized around the client's condition over the full episode of care and delivered by an integrated team, will be implemented in the following four client groupings, through a phased approach:

- Wound care
- Palliative care
- Frail seniors (seniors 75+ years old with 2 or more medical conditions)
- Medically complex children

Individuals Receiving Home Care

LEARN MORE

Resident Assessment Instrument-Home Care (RAI-HC)

The Resident Assessment Instrument-Home Care (RAI-HC)© and its next generation tool, the interRAI HC is a standardized, multi-dimensional assessment system for determining client needs. Assessments are captured electronically and provide real-time feedback for clinicians to support care planning and monitoring in addition to providing organization and jurisdiction level data to support system management, quality improvement and policy-making.

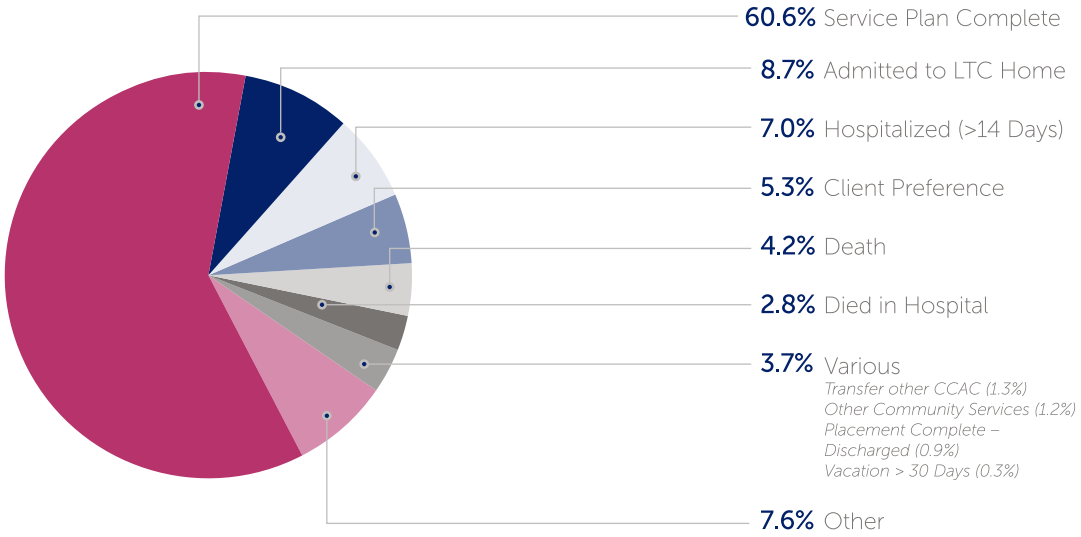
The RAI-HC was developed through interRAI, a collaborative, not-for-profit network of researchers from around the world that works to promote evidence-informed clinical practice and policy decision making through the collection and interpretation of high-quality data about the characteristics and outcomes of persons served across a variety of health and social services settings.

(RAI-HC© interRAI Corporation, 2001. http://www.interrai.org)

DISCHARGE FROM HOME CARE

Discharge disposition of individuals who have received home care service is increasingly important and instructive to the health care system as it is an indicator of effectiveness. The outcomes can guide system planning and the development of care algorithms for specific patient populations.

Clients Discharge Destination (2011-12)



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HOME CARE READMISSION RATES

The percentage of clients readmitted to home care within 30 days of discharge was 10.19 percent in 2005-06, and 6.3 percent in 2010 (CCAC Integrated Data Store HCD, June 2011). In 2010, 3.4 percent of those discharged were readmitted within 31 to 60 days and 2.5 percent within 61 to 90 days. (excludes discharges with concurrent referral still active; LTCH Placement Activity. Clients who are admitted to hospital, or are off of service for more than 10 days or more, are discharged and readmitted as a matter of policy.)

FUNDING

Public Expenditures on Home Care

YEAR				
2011-12	$2,112	**$47,155.9**	4.47%	$157.96
2010-11	$1,988	**$45,448.3**	4.37%	$150.48
2009-10	$1,882	**$43,525.7**	4.32%	$144.05
2008-09	$1,767	**$40,729.2**	4.33%	$136.63
2007-08	$1,670	**$38,004.9**	4.39%	$130.54
2006-07	$1,576	**$35,488.6**	4.55%	$124.26
2005-06	$1,445	**$33,024.5**	4.47%	$115.06

Annual Public Home Care Expenditure
($' 000,000)
Based on the Public Accounts. 2011/12 Annual Home Care Expenditure represents the interim Actual.

Total P/T Government Health Expenditure[1]
($' 000,000)
Includes operating and capital expenditures for the Ministry of Health and Long-Term Care.

Percent of Total P/T Government Health Expenditure on Home Care

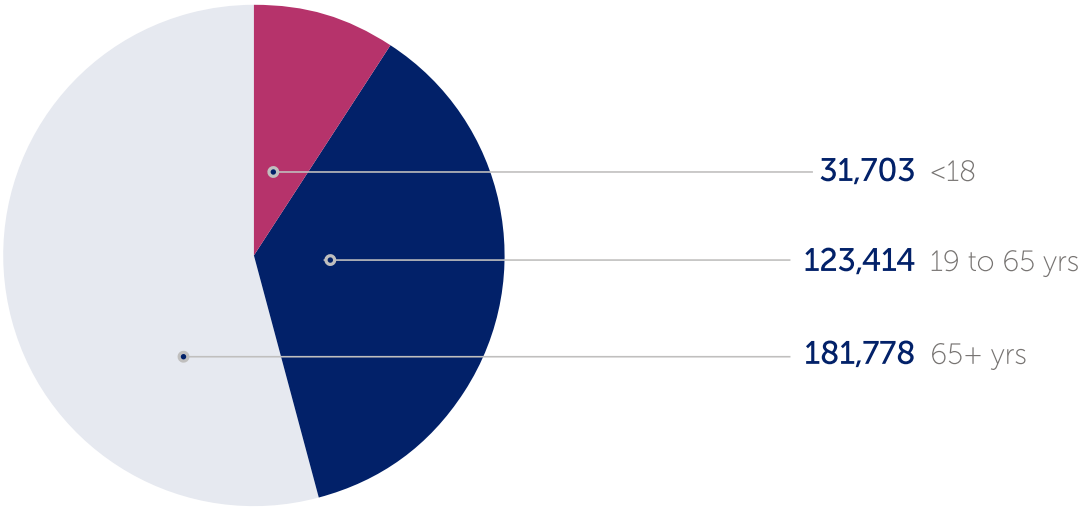
Per capita Public Expenditure on Home Care[2]

[1] *Total public sector health expenditures is based on Public Accounts of Ontario (http://www.fin.gov.on.ca/en/budget)*

[2] *Population data is based on the Statistics Canada estimates, as reported by the Ministry of Finance in the projected population for Ontario.*

PROFILE OF CLIENTS RECEIVING HOME CARE

Number of Individuals Receiving Home Care by Age Category (2010-11)



DIAGNOSIS

The most common diagnoses for individuals receiving home care in 2010/11:

- Specific delays in development (ICD9 Code: 315)
- Osteoarthritis and allied disorders (ICD9 Code: 715)
- Other cellulitis and abscess (ICD9 Code: 682)
- Encounter for other or unspecified procedure and aftercare (ICD9 Code: V58)
- Acute, but ill-defined, cerebral vascular disease (ICD9 Code: 436)

CLIENT GROUPING

Ontario categorizes its home care services according to the Canadian Institute for Health Information (CIHI) definitions.

Number of Individuals Served by Client Grouping

	2007-08	2008-09	2009-10	2010-11
Acute Care Substitution	120,903	122,907	130,532	127,875
Rehabilitation	145,656	138,390	142,143	137,508
Maintenance	234,045	154,577	170,132	178,001
Long-Term Supportive Care	64,669	50,051	51,073	50,637
End-of-life care	28,187	20,774	22,481	23,960
Not yet categorized	32,030	7,806	0	6
LTC Placement	94,406	87,810	93,975	92,117
Total	**719,896**	**582,315**	**610,336**	**610,104**

SERVICE DELIVERY

MODEL OF SERVICE DELIVERY

Publicly funded home care services are administered through 14 CCACs that are non-profit community agencies with community boards. CCACs contract with service providers selected by a competitive process to provide services to clients.

RANGE OF HOME CARE SERVICES & PROGRAMS

Home care includes professional services (nursing, occupational therapy, physiotherapy, speech-language pathology, pharmacy services, respiratory therapy services, social service work services, social work and training a person to provide a professional service e.g., nursing), personal support services, homemaking services and community support services, and each category has its own specific basket of services.

Professional Services

Nursing RN, RPN, NP	Includes both shift and visiting nursing. *Volume and Expenditures are available in following charts.*
Therapy	Includes physiotherapy services, occupational therapy services, speech-language pathology services, respiratory therapy services. *Volume and Expenditures are available in following charts.*
Social Work	*Volume and Expenditures are available in following charts.*
Dietetics	*Volume and Expenditures are available in following charts.*
Pharmacy **Diagnostic and Laboratory Services**	CCACs can arrange for pharmacy services, diagnostic and laboratory services.
Medical Supplies (dressings and treatment equipment)	Necessary to the provision of nursing services, occupational therapy services, physiotherapy services, speech-language pathology services or dietetics services provided by the CCAC. *Volume and Expenditures are available in following charts.*

Personal Support Services

Personal Hygiene Activities	Assisting a person with these activities of daily living and/or training a person to carry out or assist. *Volume and Expenditures are available in following charts.*
Routine Personal Activities Of Living	

Homemaking Services

Assistance or Training	Providing these services or training a person to carry out or assist with these services. • Housecleaning, laundry, ironing, mending, shopping, banking, paying bills, planning menus, preparing meals, caring for children.

Case Management

Case Management	CCAC case managers assess and review client requirements, determine eligibility, and develop and evaluate the plans of service for CCAC services. They authorize the expenditures of funds for services and authorize admission to LTC homes. *Volume and Expenditures are available in the following charts.*

Ancillary Services

Oxygen	The Home Oxygen Program through Assisted Devices Program. *Volume and Expenditures are available in the following charts.*
Drugs	Clients who are receiving professional services are eligible for coverage under the Ontario Drug Benefits Program for the period of time during which they receive these services. *Volume and Expenditures are available in the following charts.*

Community Support Services

Help clients to:

- live in the community independently and safely;
- reduce use of more expensive health care services (CCAC services and hospitals);
- reduce caregiver stress; and
- reduce admissions to long-term care homes.

Meal Services	Delivering nutritious meals to a person's home or providing them in other locations in the community.
Transportation Services	Providing transportation to persons who are unable to use existing transportation or assisting persons to obtain access to existing transportation.
Caregiver Support Services	Counselling, training, visiting and providing information, respite and other assistance to caregivers to support them in carrying out their caregiving responsibilities.
Adult Day Programs	Program of structured and supervised activities in a group setting, for adults with care or support requirements.
Client Intervention and Assistance Services	Providing support to persons to assist them to cope with activities of everyday living.
Emergency Response Services	Installing electronic devices in homes to connect persons with emergency response centres.
Home Help Referral Services	Referring a person who requires home help services to a person who provides such services.
Independence Training	Teaching the skills to improve independent functioning in the community, including the effective use of personal support services.
Psychogeriatric Consulting Services relating to Alzheimer disease and related dementias	Providing psychogeriatric consultation, training and support to staff of long-term care homes, CCACs and other approved agencies.

Services for Persons with Blindness or Visual Impairment	Providing rehabilitation, visual orientation, counselling, referrals and technology to persons with blindness or visual impairment.
Services for Persons with Deafness, Congenital Hearing Loss or Acquired Hearing Loss	Providing rehabilitation and communication training, counselling, technology and education to persons with deafness, congenital hearing loss or acquired hearing loss.
Other Community Support Services	Home maintenance and repair services. Friendly visiting services. Security checks or reassurance services. Social or recreational services. Aboriginal support services. Foot care services. Palliative care education and consultation services. Public education services relating to Alzheimer disease and related dementias.

SERVICES CURRENTLY NOT FUNDED THROUGH THE CCACS

- Physician Services - Some CCACs retain Medical Advisors.
- Pastoral Care - Provided through partnerships with faith-based and community organizations.

AMOUNT OF SERVICES

The amount of publicly funded services by service category[1] is expressed in units[2] in the following chart.

Publicly Funded Service : Units of Service

	2007-08	2008-09	2009-10	2010-11
Shift Nursing	1,389,872	1,482,230	1,553,950	1,617,410
Visiting Nursing	5,701,833	5,762,452	5,543,460	5,098,558
Personal Support/ Homemaking	17,058,085	18,777,246	20,229,107	20,809,682
Physiotherapy	527,990	520,168	483,163	426,449
Occupational Therapy	549,794	556,147	506,120	481,732
Speech Language Pathology	259,339	274,068	251,740	242,998
Social Work	81,699	79,278	70,196	52,371
Dietetics	58,683	58,584	52,877	45,382
Respiratory Services	109	154	145	548
Case Management	590,677	602,579	645,993	613,381

[1] An individual can receive more than one type of service
[2] Personal support services – the unit of service is one hour of service. For all professional services the unit is a visit.

EXPENDITURES

Public Expenditures: Costs of Service

	2007-08	2008-09	2009-10	2010-11
Shift Nursing	$69,013,873	$75,565,890	$83,212,126	$90,689,363
Visiting Nursing	$467,940,147	$496,452,006	$503,459,663	$487,134,775
Personal Support/ Homemaking	$507,668,720	$571,554,765	$644,306,865	$685,959,395
Physiotherapy	$56,801,128	$57,399,468	$54,822,947	$50,821,961
Occupational Therapy	$65,599,384	$67,835,905	$65,714,338	$65,467,889
Speech Language Pathology	$32,483,273	$34,077,952	$33,638,945	$33,209,704
Social Work	$11,747,092	$12,289,004	$11,681,150	$9,701,502
Dietetics	$7,122,294	$7,195,297	$6,716,508	$6,244,559
Respiratory Services	$30,799	$38,181	$47,002	$122,375
Case Management	$366,920,446	$401,017,980	$429,989,376	$467,672,081

Ancillary support

	2006-07	2007-08	2008-09	2009-10	2010-11
Oxygen	Funded through the Home Oxygen Program				
Drugs[1]	$134,289,734	$ 138,109,753	$146,316,820	$160,653,796	$162,140,965
Supplies (dressings, stoma, etc.)	$73,895,789	$86,391,745	$97,576,141	$101,502,036	$101,264,250
Equipment (wheelchairs, walkers, etc.)	$27,370,260	$30,010,398	$31,564,771	$31,654,983	$30,148,562
Other	$1,537,203	$1,207,214	$1,580,059	$2,381,918	$1,762,918

Note: These are expenditures in selected categories only. Employees' compensation, contracted out services, buildings and grounds and some other client expenses are not included.

[1] Ontario Drug Services Program Branch, Ontario Drug Programs Division, July 2012

CLINICAL (SPECIALTY) SKILLS

With the focus on discharging patients from hospital as promptly as possible, there has been an increase in the complexity of care provided at home. The challenge in much of Canada is having a critical mass of patients who require certain levels of expertise with the required special skills often only being available in urban centres. However, with the advent of increased technology there is an opportunity for more complex care to be provided in less populated areas.

In Ontario, home care nurses are able to:

- Administer chemotherapy and narcotics.
- Provide enterostomal therapy, wound care, hemo and peritoneal dialysis, and infusion therapy.
- Manage infusion pumps, central lines and peripherally inserted central catheters (PICC lines).
- Provide ventilator care and regular tracheostomy tube replacement.
- Manage home oxygen for individuals in their homes across the province.

Administration of blood or blood products is not conducted by home care staff.

3. Quality & Accountability

HOME CARE INDICATORS

The home care indicators that are currently monitored at a provincial level include:

- Amount of service delivery.
- Expenditures.
- Home care admissions.
- Referral source.
- Reason for non admit.
- Referrals to community support.
- Diagnoses.
- Client disposition at discharge.
- Safety issues.
- Number of staff.

QUALITY & ACCREDITATION

EXTERNAL ACCREDITATION

Accreditation is an effective way for health services organizations to regularly and consistently evaluate and improve the quality of their services. Organizations in Canada are accredited through Accreditation Canada, CARF, the Quebec Council of Accreditation (Quebec only) and/or registered with the International Standards Association (ISO).

Currently it is expected that CCACs will be accredited and in turn will require their service providers to be accredited. By 2013, any provider of publicly funded CCAC services will need to have a certificate of accreditation through Accreditation Canada, CARF Canada or the International Organization for Standardization (ISO).

QUALITY COUNCIL

Health Quality Ontario (HQO; formerly the Ontario Health Quality Council) reports publicly on a set of indicators that measures performance and supports quality improvement in the delivery of home care services to Ontarians. HQO publicly launched the home care website in 2010 (http://www.hqontario.ca/en/reporting/hc/) and reports indicators at the CCAC level. Indicators reflect each of HQO's quality attributes. They include:

Accessible

- Number of days to first service that 90 percent of people are waiting after discharge from hospital with referral for home care services.
- Number of days to first service that 90 percent of people are waiting in the community after referred to/applied for home care services.

Effective

- Percentage of clients whose bladder function has recently decreased or did not improve compared to previous assessment.
- Percentage of clients with new problem(s) communicating with or understanding others, or with an existing problem that did not improve over a period of time.
- Percentage of home clients who returned to hospital after discharge.

High-quality care is evidence-based (appropriate), focused on the patient (or patient-centered), safe and timely (CIHI).

Better Health – Better Care – Better Cost

Triple AIM, is a roadmap to achieving excellence, high performance and high value health care.

1. Enhance the individual (patient) experience of care (including quality, access, and reliability).
2. Improve the health of populations.
3. Reduce, or at least control, the per capita cost of care for populations.

Institute for Healthcare Improvement, Triple Aim Improvement Community.

(Massachusetts: Institute for Healthcare Improvement, 2012)

Safe

- Percentage of home care clients who say they have fallen in the last 90 days.
- Percentage of home care clients with a new or existing pressure ulcer that failed to improve.

Client-Centred

- Percentage of home care clients who were satisfied with service providers and with the handling of their care by case managers.

Efficient

- Emergency department visits for home care clients referred from acute care to CCAC after acute hospital discharge.
- Percentage of home care clients placed into a long-term care home who could have remained at home or elsewhere in the community *[http://www.ohqc.ca/en/hc_ccacs.php]*

Focused on Population Health

- Percentage of clients who did not receive an influenza vaccination in the last two years.

Most of the data is collected using the RAI-HC. Further measures will be developed over time, including service provider level indicators, which will be incorporated into the performance management framework used by CCACs to monitor performance and manage service contracts.

CLIENT / PATIENT ADVOCATE

Each CCAC has a formal complaints process that clients/family members can access regarding decisions related to eligibility for service, exclusion of service(s) from a plan of service, amount of service, termination of services, quality of service and violation of the Bill of Rights. If the client/family member is not satisfied with the response of the CCAC to the complaint, they can appeal decisions relating to eligibility, exclusion of service, amount of service and termination of service to the Health Services Appeal and Review Board.

The Long-Term Care Action Line, was expanded in 2007 to facilitate the intake and referral of home care complaints. Calls received by the Action Line are referred to the caller's CCAC or to an independent third party called an Independent Complaint Facilitator (ICF), as requested by the caller. The ICF's role is to work with the CCAC client/family member in order to address their concerns.

SYSTEM APPROACHES TO QUALITY IMPROVEMENT

The *Excellent Care for All Act (ECFAA)*, which came into law in June of 2010, puts Ontario patients first by strengthening the health care sector's organizational focus and accountability to deliver high quality patient care. The goal of the legislation is to blend quality and value in such a way that Ontarians will be able to count on the health care system for generations to come. The ECFAA includes requirements for:

- Quality committees that will report to health care organizations on quality-related issues.
- Annual quality improvement plans, which each health care organization will be required to develop and make public.

- Executive compensation which will be required to be linked to achieving improvement targets set out in the annual quality improvement plan.
- Patient/client/caregiver surveys to assess satisfaction with services.
- Staff surveys to assess satisfaction with employment experience and views about the quality of care provided by the health care organization.
- Declarations of values that will be developed, after public consultation, by health care organizations currently without one.
- Patient relations process to address patient experience issues and reflect its declaration of values.

The act also requires that health care organization in Ontario provide a copy of their annual quality improvement plan (QIP) to HQO in order to allow a province-wide comparison of, and reporting on, a minimum set of quality indicators. Ontario's vision for QIPs is based on the Model for Improvement framework for quality initiatives developed by thought leaders at the Institute for Healthcare Improvement (IHI). The requirements are first being implemented in the hospital sector, with the intent to expand across all health care organizations in the province.

SAFETY

Client safety data is not collected provincially. Each CCAC is responsible for monitoring and tracking safety issues within their jurisdiction.

Health Quality Ontario has initiated tracking of a number of home care metrics, including one related to falls - percentage of clients who say they have fallen during the last three months. The average provincial result for April 2009-March 2010 was 25.3 percent and for the subsequent year the result was 28 percent.

HOME CARE RESEARCH

The MOHLTC established a **Home Care Research and Knowledge Exchange Chair** in 2007 to ensure a permanent commitment to advancing home care research that will inform and improve the quality of home care services and inform home care policy in Ontario. The mandate of the Chair is to provide effective communication, coordination and evaluation to support the uptake of home care research by home care decision-makers and stakeholders, other health and social services-related institutions, the larger community and the MOHLTC. Dr. John Hirdes, Professor, University of Waterloo, is the current Chair.

The Chair establishes and maintains an infrastructure that supports knowledge exchange between key decision-making organizations (Home Care Chair's Steering Committee) and researchers in home and community care (Home Care Chair's Research Consortium). The Chair works closely with the Ministry's funded Seniors Health Research Transfer Network (SHRTN) to ensure that home care research is linked with long-term care research.

The **Institute of Clinical Evaluative Sciences** (ICES) is an independent, non-profit organization, with a mandate to conduct research that contributes to the effectiveness, quality, equity and efficiency of health care and health services in Ontario. ICES' key objectives are to:

- Carry out population-based health services research that is relevant to clinical practice and health policy development.
- Document province-wide patterns and trends in health care delivery.
- Develop and share evidence to inform decision-making by policy makers, managers, clinicians, planners and consumers.
- Promote linkages among health services researchers and decision-makers.
- Train researchers and promote a wider understanding of clinical epidemiology and health services research.

Based in the University of Toronto, department of Health Policy, Management and Evaluation (HPME), and funded by the Social Sciences and Humanities Research Council of Canada (SSHRC) and Ryerson University, the **Canadian Research Network for Care in the Community** (CRNCC), is a knowledge translation and exchange network that promotes community-driven research and knowledge translation in home and community care.

The **Change Foundation** is an independent health care think tank intent on changing the debate, the practice, and the health care experience in Ontario. They lead and leverage research, policy analysis, service redesign/quality improvement projects, and public engagement to achieve their strategic goal: to improve people's health care experience as they move in, out of, and across the health care system over time. Home and community care is one of their five policy areas.

Right Care, Right Time, Right Place

At the heart of our action plan is a commitment to ensure that patients receive timely access to the most appropriate care in the most appropriate place.

It's about getting the greatest value for patients from the system, allowing evidence to inform how our scarce health care dollars are best invested and ensuring seniors receive the care they need as close to home as possible.

(Except from Ontario MOHLTC, 2012, Ontario Action Plan for Health Care, http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_healthychange.pdf)

4. Information Technology

ELECTRONIC HEALTH RECORD (EHR)

eHealth Ontario is playing the lead role in harnessing information technology and innovation to improve patient care, safety and access, in support of the government's health strategy. The EHR's goal is to have a well-managed, sustainable, and cost-effective eHealth network that allows patient information to be safely and securely shared.

Integrating the home care record with the broader health system has not yet occurred and electronic linkages between providers are being tested. Work is underway on a provincial resource matching and referral system (RM&R) that will facilitate matching patients to health system resources with an initial focus on long-term care, rehabilitation beds, complex continuing care and home care.

A number of CCACs, in partnership with hospitals, have developed e-referral systems (ED Notification) that automatically notify CCACs when a home care client presents at a hospital emergency department.

The Integrated Assessment Record (IAR) is an electronic tool that allows authorized users to view a client/patient's previous assessment information and work in collaboration with other care providers to effectively plan and deliver services. IAR is designed to:

- Identify all providers within the client's circle of care and provide access to their most recent assessment.
- Provide data for health service planning to health care providers and LHINs.
- Support networks and learning opportunities across organizations.
- Identify service overlaps and gaps to improve the quality and reliability of care.

Selected LHINs are currently piloting IAR to test the use of shared assessment data by:

- Evaluating information management and planning benefits provided by a single source of assessment data.
- Facilitating increased collaboration between health care providers.
- Efficiently providing assessment data to health care providers, LHINs and the MOHLTC *[https://www.ccim.on.ca/IAR/default.aspx]*.

ELECTRONIC HOME CARE HEALTH RECORD

The electronic home care health record has been widely adopted across Ontario. Through the development and implementation of the **Client Health and Related Information System (CHRIS)**, a core client management system utilized by all CCACs, information related to case management and care planning is collected and shared across the province. A web based application that facilitates access from multiple locations over the internet, it provides key functions supporting intake and referral, assessment tracking, service monitoring and client data management, scheduling and automated task management and complex reporting based on a single data repository. Based on a client-centric architecture and approach, CHRIS is able to integrate with other CCAC business applications in the areas of client assessment, client placement and service provider integration (through Health Partner Gateway). Integration with other

provincial systems such as e-referral, LHIN and primary care based systems is also possible *[http://www.ccac-ont.ca/Upload/oaccac/General/CHRIS_Brochure.pdf]*.

A provincial CCAC eHealth Steering Committee provides guidance on ongoing enhancements to CHRIS and a provincial roadmap for the deployment of enhancements has been developed. CHRIS is not currently incorporated in an overall regional or provincial electronic patient record; however, enhancements to CHRIS will enable physicians and hospitals to access CHRIS information.

HEALTH DATA & THE HOME CARE REPORTING SYSTEM

The Canadian Institute for Health Information (CIHI) developed the Home Care Reporting System (HCRS) as a means of integrating RAI-HC data to generate information using a common language across organizations, jurisdictions and care settings. The purpose is to collect and process information on publicly funded home care services in order to support jurisdictions in their analysis and decision making by providing data on:

- Access to home care services
- Health and functional status measures
- Clinical outcomes and waiting times
- Quality of care
- Informal support
- Service utilization by setting and provider type

The HCRS captures standardized client-specific clinical, demographic, administrative and resource utilization information. Data is submitted to CIHI by the Ontario Association of Community Care Access Centres (OACCAC).

Aggregate RAI data is being used to inform the development, testing and implementation of a provincial Client Care Model, a population-based approach with consistent standards that will guide service and case management intensity, specialization and prioritization. In addition, Health Quality Ontario is using changes in RAI indicators, over time, to report to the public on the quality of home care services.

As part of the policy development, implementation and evaluation processes, the MOHLTC takes into consideration research, data and information from a variety of home care sources, including CIHI.
CIHI data, as well as other data from other sources such as Health Quality Ontario, RAI, ICES and the OACCAC, are used by LHINs, the home care sector and members of the public to support program planning, quality monitoring and information gathering.

USE OF SYSTEM EFFICIENCY TECHNOLOGY

There is some electronic communication and exchange of information between home care and the hospital, primarily for referrals. The e-Referrals and Access Tracking system provides the mechanism for the electronic exchange of referral information from one care provider organization to another care provider organization. The information contained in the message consists of client/patient demographics, the reason for the referral, and any other necessary information required by the receiving

organization. This may include medical treatment requirements, alerts, consents, behavior, and any environmental factors that the caregiver would need to know in order to perform the requested service. At present, the information is transferred directly to the receiving organization and only the initiator, receiver and status of the referral request are consumed by the e-Referrals & Access Tracking system.

There is also some exchange between CCACs and the Ministry for submission of indicator data and for financial data exchange.

A provincial portal has been developed to enable CCACs to share aggregate information on RAI-HC and RAI-CA indicators. RAI-indicators are also used for quality and performance reporting as part of the service accountability agreements between CCACs and Local Health Integration Networks.

USE OF TECHNOLOGY FOR CLIENT CARE

The Ministry is currently investigating the use of available technologies, including telehealth, to help enhance the care provided to home care clients. A provincial telehomecare expansion over the next three years is underway so that a greater proportion of eligible patients with chronic disease have access to this service.

Telehealth Ontario is a free, confidential telephone service Ontario residents can call to get health advice or general health information from a Registered Nurse. The Telehealth Ontario service is provided in English and French, with translation support for other languages and a direct TTY number for those with hearing and speech difficulties. Callers can also be connected to medication information and health information audio tapes. Access to experienced health advice is available 24 hours a day, seven days a week.

Ontario was involved with telehomecare as a pilot project spanning eight Family Health Teams from 2007 – 2009. The population focus was patients living with complex chronic diseases, including congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes and mental health disorders. This Patient-Centred Chronic Disease Management approach is enabled through software and patient home devices that support remote daily monitoring. It allows for effective sharing of information across the patient's care team, supporting excellence in clinical decision-making. An independent evaluation showed the effectiveness of Ontario Telemedicine Network (OTN) for patients and on health system utilization.

Some CCACs are using telehomecare to support individuals with chronic care needs, to provide rehabilitation, wound care and support for medically fragile children.

Technology is used for scheduling of staff, and for submission of indicator data and financial data to the MOHLTC. CCAC and frontline staff are equipped with cell phones, laptops/notebook computers and Blackberries. Many organizations are using GPS / mapping systems and CHRIS was recently enhanced with geo-coding capability. The technology applications deployed by service providers are not quantified by the Ministry.

Technology – Transforming Health

Technological advancements have the potential to fundamentally change our health care approach to support a more efficient and person-centred one regardless of the care setting.

Today's innovations enable the integration of monitoring and therapeutic systems, provide educational content, facilitate communication and data flow between members of the health care team and support systems management and quality improvement.

5. Health Human Resources

CLINICIANS PRACTICING IN HOME & COMMUNITY CARE

HealthForceOntario is the province's strategy to ensure that Ontarians have access to the right number and mix of qualified health care providers, now and in the future. There are many dimensions to the strategy, including:

- Education and training.
- Supporting evidence-based health human resources planning.
- Funding and incentives.
- Healthy Work Environments program - a strategic and comprehensive approach to providing the physical, cultural, social, and job-design conditions that maximize the health and well-being of health care providers.
- Interprofessional care - encompassing partnership, collaboration and a multi-disciplinary approach to enhancing care outcomes.
- Legislative and regulatory activities – as required to improve access to care.
- New roles in health care – such as physician assistants (PA). The PA assists a supervising physician to deliver medical services within patient care teams in various settings.
- Recruitment and retention programs that include the Nursing Graduate Guarantee and Health Professionals Recruitment Tour.
- Provincial nursing strategy initiatives such as the Late Career Initiative, Telementoring Project and Grow Your Own Nurse Practitioner.

HEALTH CARE PROFESSIONALS

In 2005/06, CCACs employed approximately 3,500 case managers and in 2011 employed 4,500. Case managers are responsible for intake, assessment, reassessment and discharge. This ensures the individual receives care and services according to their need and as outlined in their plan of service. Case management also enables the CCAC to maintain effective resource management and utilization.

To help ensure the right care at the right time in the right place, CCACs have developed and are implementing a model of care that will focus case manager skills, abilities and resources to meet the needs of defined client populations. This represents a common vision of how client services will be organized from a population-based perspective across CCACs. The Client Care Model is a framework that standardizes how CCACs define, work with, and are accountable for specific client populations. Each client receives specific case management and care coordination intensity, care planning and service that align with his/her care needs *[CCACs Client Care Model –Proof of Concept to Implementation." Ontario Hospital Association webcast. June 16, 2011].*

The MOHLTC does regulate the training requirements of regulated health professionals who are governed under the Regulated Health Professions Act, 1991 and their health profession Acts, and who are under contract with CCACs. The Colleges responsible for each health profession set out any necessary training requirements in regulations under their health profession Acts, and employers set out qualifications for

employment. CCACs in their service templates also set out expectations for service including, for example, that agencies and their staff must comply with relevant legislation, for example, the *Nursing Act, 1991*. Frontline home care professionals are employed by service provider organizations, not CCACs.

Amendments to the *Regulated Health Professions Act, 1991* and the health profession Acts were made recently to increase access to health services by better utilizing regulated health professionals and reducing barriers to practice for a number of professionals including nurse practitioners, pharmacists, physiotherapists and midwives.

UNREGULATED STAFF

The MOHLTC does not regulate the training requirements of Personal Support Workers (PSWs) under contract with CCACs. There are three different program approaches to PSW training in Ontario:

1. The certification program through the Colleges Association (CAAT) offered by the community colleges using curriculum approved by the Ministry of Training, Colleges and Universities (MTCU). This program requires 720 hours of training.
2. The curriculum developed and published by the Ontario Community Support Association (OCSA) for the Personal Support Worker program. This program requires 600 hours of training.
3. A curriculum set by the National Association of Career Colleges (NACC), which is a national program used by many private career colleges.

The "Personal Support Worker Program Standard" is the Program Standard for all Personal Support Worker programs of instruction leading to an Ontario College Certificate delivered by Ontario colleges of applied arts and technology.

The MOHLTC's PSW Training Fund is for direct service workers who provide personal support services in the community. It is used for the following:

- Training of direct service workers up to the PSW level.
- Specialized/enhanced training for direct service workers and PSWs in areas such as palliative care, acquired brain injury (ABI) and mental health.

Eligibility includes: direct service workers employed by agencies with CCAC contracts, long-term care supportive housing service providers, attendant outreach providers and adult day service providers funded by the MOHLTC directly or through a LHIN.

SCOPE OF PRACTICE

The *Regulated Health Professions Act, 1991* identifies certain "controlled acts", acts considered to pose a risk of harm if performed by unqualified persons. There is also a PSW Role Statement as provided by the Government of Ontario and the Ontario Community Support Association *[Role of Persons Trained as Personal Attendants or Personal Support Workers, http://www.psno.ca/pdf/PSW_Roles.pdf]*.

House Calls

For frail seniors, getting to their family care provider can be a challenge. Too often, those patients who need family health care the most cannot access that care and only enter the system once their condition becomes acute and they find themselves in an emergency room.

The MOHLTC is expanding access to house calls from health care professionals - doctors, nurses and occupational therapists, in addition to improving access to online and phone consultations.

(Ontario MOHLTC, 2012, Ontario Action Plan for Health Care)

PERSONAL SUPPORT WORKER REGISTRY

On June 1st, 2012, the Ontario Government, working with the Ontario Community Support Associations (OCSA), launched the Personal Support Workers (PSWs) registry. The registry will better recognize the work PSWs do for Ontarians, while helping to better meet the needs of the people they care for. PSWs will have the opportunity to sign up with the registry and provide key information such as: contact information, current employment, educational background and years of experience. Employers and the public could use the registry to verify this important information, and employers would be better informed to meet patient needs. (www.pswregistry.org)

Unregulated staff, or support personnel, may be employed to provide home care services that include physiotherapy assistants, occupational therapy aides and communications/speech language assistants. Qualifications and requirements are employer specific.

INTER-PROFESSIONAL COLLABORATION

The importance of interprofessional care in Ontario is documented in the May 2010 report, "*Implementing Interprofessional Care in Ontario - Final Report of the Interprofessional Care Strategic Implementation Committee.*" This committee of representatives, from academic institutions and professional associations as well as caregivers and regulators, was struck to work with the health care and education sectors to implement carefully thought out recommendations from an earlier report (Interprofessional Care: A Blueprint for Action in Ontario, July 2007) to help lay the foundation for a culture of collaborative, patient-focused care in Ontario at the system, organizational, educational, practice and policy levels. The report contains key information about interprofessional care and education-promoting best practices of relevant models and concepts as well as tools to help with implementation. The report defines "interprofessional care" as "the provision of comprehensive health services to patients by multiple health caregivers, who work collaboratively to deliver quality care within and across settings…[it is a] collaborative, team-based approach to providing optimal patient care. It benefits and empowers patients, and significantly improves health care provider satisfaction."

To advance interprofessional care in Ontario, the Committee recommended that LHIN interprofessional care champions focus their initial efforts on the provincial diabetes strategy. By aligning interprofessional care with diabetes, a pervasive chronic condition that involves multiple health caregivers, champions will be able to both implement and shape their role in moving the mandate forward, and build an understanding and capacity that can be transferred to team-based collaborative care delivery models.

The population focused integrated care delivery teams in the Integrated Client Care Project (ICCP) model will enable patients to flow better through the system and reduce the burden on hospitals. The existing model is organized by sector, specialty or discrete services. Having integrated population-based delivery within and across sectors is beneficial to both the patient and the system. Here, care is organized around a client's condition over the full episode of care and delivered by a team integrated with the broader health sector (primary care, community support services and chronic disease management).

FAMILY CAREGIVER

The role of the family is recognized as an important component of successful home care delivery. In 2008, the MOHLTC launched the **Caring-About-Caregivers** project to explore policy opportunities to assist caregivers and relieve some of the burdens imposed by this role. The purpose was to identify and address gaps and issues; identify strategies that support informal caregivers and are relevant; and identify areas for policy development.

Through Ontario's **Aging at Home Strategy,** a number of new programs have been developed which are helping to improve the lives of seniors and their caregivers. One example is First Link which, in addition to support for dementia care, provides support to reduce caregiver burnout and pre-mature long-term care placement *[http://www.alzheimergreybruce.com/first-link]*.

CAREGIVER ASSESSMENT

The needs of caregivers are assessed as part of the RAI–HC Minimum Data Set that includes two items on the extent and nature of informal care available, but not a detailed assessment of the role and/or capacity of the individual providing care. The Registered Nurses Association of Ontario has published a Clinical Best Practice Guideline, *Strengthening and Supporting Family through Expected and Unexpected Life Events* that recommends a number of family assessment tools, which may be used by home care providers or CCAC case managers.

SERVICES FOR FAMILY CAREGIVERS

Families can access in-home respite, adult day programs, and short-stay respite in a long-term care home. If an individual is eligible for services coordinated by the CCAC, in-home respite is paid for by MOHLTC. Otherwise, these services may be available from various providers for a consumer fee. Adult day programs provide social and other therapeutic activities at a location outside the home, usually for a consumer fee.

The short-stay respite care program in long-term care homes includes a co-payment fee which is different from the regular (i.e. long-stay) co-payment fee. The regulations under the *Long-Term Care Homes Act, 2007* have increased access to respite care short-stay beds by permitting applicants to be placed concurrently on the waiting lists of up to five selected long-term care homes.

FINANCIAL SUPPORT

The Ontario personal income tax system provides tax relief to caregivers of eligible relatives through the non-refundable caregiver credit and infirm dependant credit [Ministry of Finance, Communications Branch].

EMPLOYMENT BENEFITS

An employee (full-time, part-time, permanent or contract) can take Family Medical Leave of up to eight weeks to provide care or support to certain family members, and/or people who consider the employee to be like a family member, in respect of whom a qualified medical practitioner has issued a certificate indicating that the care recipient has a serious medical condition, with a significant risk of death occurring within a period of 26 weeks. Family Medical Leave is available whether or not federal Employment

The Vital Role of the Family Caregiver

Family caregivers provide care and assistance for spouses, children, parents and other extended family members and friends who are in need of support because of age, disabling medical conditions, chronic injury, long-term illness or disability. A family caregiver's effort, understanding and compassion enable care recipients to live with dignity and to participate more fully in society.

5 million
is the estimated number of caregivers in Canada

80%
of care needed by individuals with a long-term condition is provided by family caregivers

60%
of caregivers provide care for more than three years

(Canadian Caregiver Coalition www.ccc-ccan.ca.)

Insurance compassionate care benefits are accessed. Care or support includes: providing psychological or emotional support, arranging for care by a third party provider, or directly providing or participating in the care of the family member*[Ministry of Labour, http://www.labour.gov.on.ca/english/es/faqs/fml.php]*.

Personal Emergency Leave is available to employees who work for employers that regularly employ at least 50 staff. It provides the right to take up to 10 days of unpaid job-protected leave each calendar year due to illness, injury and certain other emergencies and urgent matters *[http://www.labour.gov.on.ca/english/es/pubs/guide/emergency.php]*.

6. Provincial Initiatives

Ontario has been actively engaged in strategies to transform the health system and shift care to the community. As an important element of the health care continuum, home care is involved and impacted by all initiatives to a varying extent.

ONTARIO'S ACTION PLAN FOR HEALTH CARE

This plan outlines improvements to the health care system that provide better access, quality and value. This vision will provide a greater focus on home and community care to build a stronger continuum of care and shift the delivery focus from acute and residential care to home and community care. The action plan has three priorities:

- Keeping Ontario Healthy.
- Faster Access to Stronger Family Health Care.
- Right Care, Right Time, Right Place.

ENSURING EFFECTIVE & EFFICIENT USE OF HEALTH CARE RESOURCES

This strategy puts individuals first by improving the quality and value of the patient experience through the application of evidence-based health care. This vision will move the health care system to a new patient-based payment model, which will shift Ontario hospital funding to a system that creates the right financial environment for providers to deliver high quality, evidence-based care. For home care, the alignment of client outcomes with payment incentives is expected to drive the uptake of best practices and result in significant improvement to client quality of care and improved use of health care resources as competition around client outcomes increases value for clients.

SUPPORTING PEOPLE TO LIVE AT HOME

This strategy ensures there are resources available for those who wish to live at home and receive care.

- The **Aging at Home strategy** expands community living options for seniors with a wider range of available home care and community support services. It also contributes to the priorities of reducing emergency room (ER) wait times and decreasing the number of alternate level of care (ALC) patients in hospitals. The strategy is expected to:
  - Increase the overall supply (both range and quantity) of services available to seniors.
  - Relieve pressures on hospitals and long-term care homes by helping to find more appropriate settings for patients and avoiding crisis through proactive wellness approaches.
  - Maintain and support seniors' right to dignity and independence.

Several initiatives were implemented to achieve strategy goals:

- **Increased Bed Capacity** - Increasing bed capacity in hospitals, long-term care (LTC) homes and alternative settings has been a strategy used by the LHINs to address these pressures.
- **Geriatric Emergency Management (GEM) Nurses** – GEM nurses decrease ER wait times by assessing patients promptly and efficiently and by linking with community-based providers; their role is to divert patients who could be cared for in the community.
- **Supportive Housing/Assisted Living Services** – LHINs have focused on increasing community services to seniors to allow them to remain in their homes and reduce potential ER visits and possible hospitalization.
- **Nurse-led Outreach Teams** – Teams consist of registered nurses and/or nurse practitioners who travel to LTC homes to provide appropriate care to residents who require more urgent or advanced interventions and assessments in order to prevent the need for transfers to local ERs or, in some cases, hospital admissions. These initiatives are directly linked to the ER Strategy goal of reducing ER demand.
- **Home at Last / Home First (discharge and multi-sector service coordination)** – This basket of service programs helps discharge patients return home from hospital and avoid readmission. There is some variation in services provided, including transportation from hospital to home, case coordination, meals and medication management.
- **Telehomecare** – Ontario Telemedicine Network (OTN) is one of the largest telemedicine networks in the world, helping to deliver clinical care and distance education among health care professionals and patients using live, two-way videoconferencing systems and related diagnostic equipment. The Telehomecare program employs sophisticated and easy-to-use equipment to link patients with health care professionals. The program empowers patients to self-manage their chronic illnesses thereby reducing hospital and emergency room visits. OTN recently completed a successful trial of the program involving more than 800 patients with one of two chronic diseases - congestive heart failure or chronic obstructive pulmonary disorder - with the following results: 65 percent reduction in the average number of hospital admissions; 72 percent reduction in the average number of Emergency Room visits; and 95 percent reduction in the average number of walk-in clinic visits.

Care as Close to Home as Possible

The most significant part of our plan focuses on ensuring patients are receiving care in the most appropriate setting, wherever possible at home instead of in hospital or long-term care.

It means structuring the system to meet the needs of today's population, with more focus on seniors and chronic disease management.

(Except from Ontario MOHLTC, 2012, Ontario Action Plan for Health Care, http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/rep_healthychange.pdf)

The new **Assisted Living for High Risk Seniors Policy** was developed to address the needs of high risk seniors who can reside at home, and require the availability of personal support and homemaking services on a 24-hour basis. This policy targets high risk seniors whose needs cannot be met through home and community care services provided solely on a scheduled visitation basis, but who do not require admission to a LTC home.

WAIT TIMES

Reducing wait times for key health services such as hip and knee replacements, is an important part of the Ontario government's strategy to transform health care. The provision of timely home care services supports patients who require services in the home post-surgery. Ontario is a national leader in reducing wait times for five priority health services, according to a report card issued by the Wait Time Alliance. For the fifth consecutive year, the alliance gave Ontario straight A's for meeting performance targets in reducing wait times in five areas – hip replacements, knee replacements, cataract surgery, radiation oncology and cardiac services.

NURSING INVESTMENTS

A number of strategies are being deployed to ensure that there are enough nurses to meet the growing demand in the community. Announced in May, 2012, Ontario is creating over 900 new nursing positions throughout the health care system to ensure Ontarians receive the right care, at the right time, in the right place. These nursing positions include: nurses for behavioural supports in LTC homes, nurse-led LTC home outreach teams, telemedicine nurses, nurses supporting mental health in schools, ambulance dedicated nurses, nurse practitioners in nurse practitioner-led clinics, registered nurse-surgical first assists, nurse practitioners for Aboriginal populations, nurses for early psychosis intervention teams, nurse practitioners for eating disorders, patient navigators in cancer care and discharge navigators. For home care, three new nursing programs are being funded to further strengthen the CCAC's role as care connectors for individuals with health needs that cross multiple health care sectors.

1. The **Rapid Response Nursing Program** provides in-home nursing visits for eligible individuals 24 hours post hospital discharge, 7 days a week, to reduce re-hospitalization / avoidable emergency department visits. The target population includes frail adults and seniors with complex needs and/or high risk characteristics.
2. The **Nurse Practitioner Integrated Palliative Home Care Program** enhances continuity and effectiveness of clinical care coordination.
3. The **Mental Health and Addiction Nurses in School Program** provides mental health and addiction supports and services, in an inter-disciplinary team, to children and youth in school.

INTEGRATED CLIENT CARE PROJECT (ICCP)

ICCP is a multi-year initiative that is expected to improve cost and service efficiency. ICCP has been the seminal deliverable for promoting better quality health outcomes in home care for Ontarians - areas of focus were chosen based on high cost and/or high volume, feasibility/infrastructure for change, availability of evidence, and current practice variation. Key design elements are integrated service delivery, alternative reimbursement (payment for outcomes) and system navigation. Enablers are clinical best practices, coordinated assessment and specialized case management. Integrated service delivery requires

a team that is as broad as needed to meet a client's needs, and that has clinical leadership provided by a lead service provider. There is a single chart and a shared care plan for the client, which is facilitated by a coordinated assessment. A CCAC specialized case manager becomes the point of contact to coordinate care across health and other support systems – with social determinants of health in mind - ensuring a seamless transition for clients at key transition points. Ontario is implementing integrated client care for clients with wounds and is planning implementation for clients who require palliative care.

ER/ALC STRATEGY

A multi-pronged, comprehensive ER/ALC strategy which includes:

- Expanding alternatives to ER services.
- Increasing capacity and improving processes within ERs.
- Addressing the Alternate Levels of Care (ALC) challenge.

Key initiatives include Virtual Ward and outcome-based payment. The Virtual Ward is an innovative service model that delivers high quality coordinated care to patients in the community, after they have been discharged from hospital. It is designed to provide for safe and seamless transition of patients between acute and primary care. Virtual wards are an appropriate form of post-discharge care for patients who are considered to be at high risk of readmission *[http://www.health.gov.on.ca/en/ms/ecfa/pro/picb/ward.aspx]*.

PRIMARY HEALTH CARE & CHRONIC DISEASE MANAGEMENT

Linkages with primary care are becoming increasingly important. CCACs have strengthened the collaboration with the family physician in an effort to better coordinate care, support clients with chronic conditions and support proactive interventions so that people can remain at home longer. For example, the Ontario Diabetes Strategy (ODS) helps people with diabetes and those who are at high risk of developing it. The strategy includes education, practice guidelines, health coordination and performance monitoring. In addition, **Health Care Connect** assists Ontarians without a family health care provider to find one in their community. The CCAC Care Connector works with local family health care providers to link individuals with a family physician.

MENTAL HEALTH & ADDICTIONS STRATEGY

The province is implementing a comprehensive Mental Health and Addictions Strategy, which in the first three years of the strategy focuses on children and youth in order to realize fast access to high-quality services, early identification and support, and helping vulnerable children and youth with unique needs. A key initiative is placing mental health workers and nurses with mental health and addictions expertise in schools and giving educators, social workers and other professionals the tools and training to identify mental health issues.

THE BEHAVIOURAL SUPPORTS ONTARIO PROGRAM (BSO PROGRAM)

The BSO program, targeted at seniors, was created to enhance services for Ontarians with behaviours associated with complex and challenging mental health, dementia or other neurological conditions

whether they live at home, in long-term care, or elsewhere; and to mitigate the strain on their families, health care professionals, and the health system. Behaviours such as aggression, wandering, physical resistance and agitation are a major source of distress for patients, their caregivers and the health system. Certain behaviours signal a need the patient can no longer communicate, making them potentially "responsive" to prompt and appropriate interventions.

PALLIATIVE/HOSPICE CARE

Ontario's 2006 End-of-Life Care Strategy to give those Ontarians with life-threatening illnesses the option of receiving care in their own homes, or in the home-like environment of a residential hospice, made Ontario a leader in end-of-life care.

New funding through the strategy expanded in-home end-of-life care services to 6,000 more Ontarians. In addition, Ontario committed nursing and personal support services for more than 30 residential hospices across the province.

In April 2011, the Ontario Minister of Health and Long-Term Care announced an additional $7M for residential hospices to provide nursing and personal support services, and committed to undertaking a provincial review of the palliative care system in partnership with the LHINs and sector stakeholders. As part of this review, the MOHLTC, LHINs and stakeholders launched a partnership engagement strategy in 2011 to advance high quality, high value palliative care delivery in Ontario.

The strategy produced a final report, the "Declaration of Partnership and Commitment to Action", which outlines the consensus achieved amongst engagement partners. It includes the shared vision and goals for the system, key measures of success to guide system transformation, and proposed action plans for partners to achieve immediate and long-term improvements in palliative care delivery. The report serves multiple functions, as proposed actions are directed to all participant groups. With a significant level of consensus achieved, the partners are moving forward to develop detailed plans to implement their commitments to action.

ACUTE HOME CARE

In 2004/05 through 2007/08, Ontario implemented a phased four-year plan, with an emphasis on acute home care, to address key health system issues such as:

- Improving system efficiency through hospital replacement and reduction of wait times.
- Reducing costs by addressing client needs in an efficient, timely way, preventing hospitalizations and unnecessary deterioration in health status.
- Utilizing scarce resources effectively.
- Enhancing existing short-term acute home care.
- Providing services that result in better client outcomes.
- Responding to clients' preference to receive care at home.

Access to Primary Health Care

Health Care Connects is designed to help Ontarians find a family health care provider.

- Individuals complete a health information questionnaire to determine their level of need for a family health care provider.
- Each individual is assigned a Care Connector who works with local family health care providers to determine who may be accepting new patients.

From February 12, 2009 - September 30, 2012...

226,371

patients registered with Health Care Connects.

74.1 %

of patients were connected with a family health care provider.

(http://www.health.gov.on.ca/en/ms/healthcareconnect/public/results.aspx)

CHILDREN & YOUTH

A review of CCAC school health services was undertaken by the MOHLTC, in partnership with the Ministries of Education and Children & Youth Services, to understand how well these services are being delivered, and to identify opportunities for program improvement. An outcome of the review is continued collaboration between the ministries partnering on an initiative to test different service delivery models for integrated speech and language services across the health, children's and education sectors.

7. Challenges

As part of an integrated approach to health care that focuses on better care, better health and better value, home care is faced with a number of key challenges.

- Reducing hospital readmissions and repeat emergency department visits as well as reducing ALC days and ER wait times to improve system flow.
    - An aging population with increased acuity will place greater demands on the health care system.

- Stratified care targeted at patients with the highest needs, as well as high users of health care services, can lead to health system quality improvements through improved coordination and continuity of care for these populations.

- Shortage of Health Human Resources
    - The growing acuity of seniors with multiple or complex conditions means that the availability of highly skilled nurses in the long-term care home, home care and community sectors will be of even greater importance.
    - As in many professions, there is a cohort of nurses who are aging and whose retirement will create even greater staffing demands.

- Escalating costs coupled with increasing demands for services will be exacerbated by emerging demographic shifts.
    - Users of high intensity care are placing greater demands on the health care system through elevated health care use over increasingly longer periods of time.
    - Frail older adults require continuing care across a broader range of health care services for a wider array of health conditions. Older people with high comorbidity report poorer health, take more prescription medications, and have the highest rate of health care visits among older adults with chronic conditions.
    - Currently, there are 181,000 Ontarians with dementia, with this number expected to rise by 50 percent in the next decade.

8. Opportunities

The opportunities in home care that Ontario is pursuing over the next five years include:

- Enhancing home and community care capacity with a focus on a Seniors Strategy.
- Addressing wait times related to ER/ALC and supporting the Seniors Strategy.
- Implementing the Excellent Care for All strategy.
- Implementing integrated models of care and strong linkages to primary care.

The following activities will improve home care services in Ontario:

- Shifting to outcome-based reimbursement of services.
- Standardized tracking of client/provider-level outcomes and transparent reporting of performance.
- Shifting delivery to flexible team-based integrated delivery structures.
- Sharing accountability for outcomes across providers and sectors.
- Driving value through quality, innovation and integration.

Ontario remains committed to the vision of home care:

- To provide Ontarians with fair and equitable access to community-based services so that Ontarians are better able to remain in their home and/or desired community.
- To facilitate partnerships with health care and broader human services so that different parts of the system work together.

ACRONYMS / ABBREVIATIONS

ADP -	Assistive Devices Program
BSO -	Behavioural Supports Ontario
CCAC -	Community Care Access Centre
CHRIS -	Client Health and Related Information System
CRNCC -	Canadian Research Network for Care in the Community
CSS -	Community Support Service
ECFAA -	Excellent Care for All Act
GEM -	Geriatric Emergency Management
HPME -	Health Policy, Management and Evaluation
HQO -	Health Quality Ontario
IAR -	Integrated Assessment Record
ICCP -	Integrated Client Care Project
ICES -	Institute of Clinical Evaluative Sciences
ICF -	Independent Complaint Facilitator
IHI –	Institute for Healthcare Improvement
LHIN -	Local Health Integration Network
LTC –	Long Term Care
MTCU –	Ministry of Training Colleges and Universities
MOHLTC -	Ministry of Health and Long-Term Care
NACC -	National Association of Career Colleges
OACCAC -	Ontario Association of Community Care Access Centre
OCSA -	Ontario Community Support Association
OHIP -	Ontario Health Insurance Plan
OTN -	Ontario Telemedicine Network
PA -	Physician Assistants
PSW -	Personal Support Worker
QIP –	Quality Improvement Plan
RM&R -	Resource Matching and Referral
SHRTN -	Seniors Health Research Transfer Network
SSHRC -	Social Sciences and Humanities Research Council of Canada

SOURCES

The chapter has been compiled from sources listed below, interviews with key informants and feedback to an electronic survey. Information replicated from provincial materials has been done so with the knowledge and permission of the key informant.

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Harmonized Principles for Home Care

Guide policy and program development

Support consistency and equity across the country

Facilitate benchmarking and sharing of best practices

CLIENT AND FAMILY-CENTRED CARE

Clients and their family caregivers are at the centre of care provided in their home.

Dignity: Respect and value client and caregiver self-worth.

Holistic: Uphold all aspects of client and caregiver needs; psychosocial, physical and spiritual.

Independence: Foster autonomy and self-sufficiency.

Informed choice: Clear understanding of the facts, implications, and consequences of decisions and actions.

Positive partnership: Acknowledge unique strengths and engage client and family as partners in care.

Safety: Minimize and manage risk.

Self-Determination: Encourage, support and enable self-care.

ACCESSIBLE CARE

Canadians have equitable, appropriate, consistent access to home care, and are fully informed of the care and service options available to them.

Appropriate: Provide care that is needed and ensure the need for care.

Consistent: Reliable care among providers and across jurisdictions and geographies.

Comprehensible: Ensure understanding of services and options available.

Equitable: Create fair and unbiased access within and across jurisdictions and geographies.

ACCOUNTABLE CARE

Home care is accountable to clients and their caregivers, providers, and the health care system for the provision and ongoing improvement of quality care.

Transparency: Report on performance metrics and outcomes to inform the public on the quality of care.

Quality: Monitor performance indicators to support continuous improvement.

Value: Demonstrate value to clients and their caregivers, providers and the health system.

EVIDENCE-BASED CARE

Knowledge that is grounded in evidence is used as the foundation for effective and efficient care provision, resource allocation and innovation.

Evidence-Informed: Decision-making incorporates the best available evidence, expertise and experience.

Knowledge Transfer: Share ideas and information with clients, family caregivers, providers and planners.

Innovation: Support a culture of innovation and ingenuity.

Research: Promote awareness and application of research evidence to inform decisions.

INTEGRATED CARE

Home care facilitates the integration of care across the continuum of health care and with community and social services; care is complementary, coordinated and seamless with a focus on continuity for the client.

Continuity: Foster collaboration and communication to ensure seamless care transitions.

Coordination: Reduce disparities through care coordination.

Individualized: Customize care to the unique needs of clients and their families.

Prepared: Enable timely access to information and resources.

SUSTAINABLE CARE

Home care contributes to the sustainability of an integrated health system by increasing efficiencies and delivering cost effective care.

Health and Well-being: Focus on health promotion, disease prevention and management, and quality of life.

Needs Based Planning: Establish policies and programs on current and future needs and trends.

Optimum Effectiveness: Integrated resources planning across client populations and care settings.

QUEBEC

HOME CARE IN **QUEBEC**

In the province of **Quebec**, home care refers to a series of basic and specialized health and social services provided to an individual at home.

QUEBEC

BY THE NUMBERS...

1,365,128 sq km **LAND AREA**	7,979,700[1] POPULATION (2011)	**80%**[3] Percent population in urban settings defined as an area with a population of at least 1,000 and with no fewer than 400 persons per square kilometre (2006)	
59.2[2] Dependency ratio (2009) Ratio of the population aged 0-19 and 65+ to the population aged 20-64	15.7%[1] **Population Seniors 65+ yrs** (2011)	81.4 years[1] **LIFE EXPECTANCY (AT BIRTH)**	**$3,708.56**[2] Public sector health care expenditure per capita (2011 Forecast)

[1]Statistics Canada | [2]Canadian Institute for Health Information (CIHI) | [3] Human Resources and Skills Development Canada

1. Governance & Organization

HEALTH CARE SYSTEM STRUCTURE

In Quebec, health and social services are integrated and managed within the same administration. This structure allows the Quebec health care system to address the health and well-being needs of the population.

Home support services fall under the responsibility of the **ministère de la Santé et des Services sociaux** (MSSS). The MSSS defines government policies and strategic directions on care and services, including home support services, in addition to identifying service targets, allocating resources, monitoring and accountability. The MSSS assumes the following responsibilities:

- Strategic planning.
- Development of policies, strategic directions and action plans.
- Resource allocation between the regions.
- Accountability.

At the regional level, health and social services agencies are responsible for the regional organization of services and the allocation of resources in their area.

Health and Social Services Agencies

1. Bas-Saint-Laurent
2. Saguenay – Lac-Saint-Jean
3. Capitale-Nationale
4. Mauricie et Centre-du-Québec
5. Estrie
6. Montreal
7. Outaouais
8. Abitibi-Témiscamingue
9. Côte-Nord
10. Nord-du-Québec
11. Gaspésie-Îles-de-la Madeleine
12. Chaudière-Appalaches
13. Laval
14. Lanaudière
15. Laurentides
16. Montérégie
17. Nunavik
18. Terres-Cries-de-la-Baie-James

Eighteen regional authorities including: fifteen **Health and Social Services Agencies,** the Centre régional de santé et des services sociaux de la Baie-James, the Nunavik Regional Board of Health and Social Services and the Cree Board of Health and Social Services of James Bay are responsible for the regional organization of services and resource allocation in their territory.

The health and social services agencies must provide regional planning, as well as the organization of home support services in their territory, so that they are aligned with government strategic directions. They ensure that services are coordinated in a way that allows equal access for all users (citizens) in their respective region. Their responsibilities include:

- Annual strategic planning.
- Coordination of regional and supra-regional services.
- Resource allocation.
- Accountability.

At the local level, the 95 local health and social services networks bring together all of the stakeholders, including general practitioners, in order to collectively share responsibility for a given territory's population. At the core of the local service network, the **health and social services centre (CSSS)** is the cornerstone of integrated service delivery and ensures the accessibility, management, monitoring and coordination of services to the public. The CSSSs resulted from a merger of the local community service centres (CLSCs), residential and long-term care centres (CHSLD), and, in most cases, a hospital centre (CH).

Two essential principles set the foundation of the planning and organization of services:

1. **Population-based responsibility** through which different stakeholders in a local territory collectively share responsibility for a target population by making all services accessible, and where management and support for people is provided by the network.
2. **Service tiers** to facilitate user navigation through referral mechanisms between service providers for first-line, second-line and third-line services.

The CSSS was created to bring services closer to the public and ensure the organization of accessible, coordinated and quality services for the entire population, including people who require home care services. The CSSSs have the following responsibilities for home care:

- Accepting referrals and evaluating the individual's needs.
- Developing an intervention or personalized service plan in collaboration with the individual, their family and those close to them.
- Coordinating services.
- Ensuring delivery of health and social services.
- Reviewing and evaluating the care plan at least once a year, or more often when required.
- Ensuring the quality of services, regardless of the type of service provided.

HEALTH CARE & HOME CARE LEGISLATION

There is no legislation specific to home care, however, the *Act to Amend the Act Respecting Health Services and Social Services* and other legal provisions, enacted in November 2005, provide details about the roles and responsibilities of those in charge of planning, organizing and delivering health and social services in Quebec. Section 80 assigns responsibility to the CSSS, under the CLSC mission, for organizing and coordinating services, particularly in terms of home care. The enactment of Bills 25, 30 and 83 ushered significant changes into the organization of health services and social services. The chapters addressing the responsibilities generally assigned to organizations or different governance levels were clarified.

EVOLUTIONARY MILESTONES

1972

Creation of the first CLSC.

1979

First report in Quebec on home care and services: *Les services à domicile.*

1988

Creation of the final CLSC extending the network across all of Quebec.

1994

Introduction of the concept of neutrality, i.e., clients are not required to pay for home care services – *Les services à domicile de première ligne – Cadre de référence.*

1997

Creation of the Financial Assistance Program for Domestic Help Services (*Programme d'exonération financière pour les services d'aide domestique* - PEFSAD) following the October 1996 Economy and Employment Summit.
The MSSS is the government authority responsible for this program, which is designed to:

- Organize the provision of domestic help services.
- Financially support the demand for service among the elderly losing their autonomy and living on low incomes.
- Prevent unreported employment.

2003

Third report on home care *La Politique de soutien à domicile Chez soi : le premier choix.*

2004

Release of *Précisions pour favoriser l'implantation de la Politique de soutien à domicile Chez soi: le premier choix , a report to* foster a shared understanding and enhance the harmonization of home care in all regions.
Creation of health and social services agencies under Bill 25.

2005

Enactment of Bill 83, which specified the roles and responsibilities of the CSSS and agencies.

2012

Launch of the policy: *Vieillir et vivre ensemble, chez soi, dans sa communauté au Québec*, developed under the shared leadership of the Minister Responsible for Seniors and the Minister for Social Services, to allow seniors to remain in their homes and communities for as long as possible. Recurrent financial commitments are $865.9 M for all departments and agencies, with initiatives included in the 2012-2017 Action Plan.

MANDATE, MISSION, PRINCIPLES & PRIORITIES

MANDATE

The home care policy *Chez soi: le premier* choix is intended for various clients that require home care services, regardless of the reasons or circumstances of their disability, their family or their significant others. These services allow them to remain in their home or to return home quickly after a health care episode. The type and nature of these services can vary in intensity and last for a limited time (short-term) or indefinitely (long-term).

The various individuals that may require home care services include: persons with disabilities (physical or mental disabilities or pervasive developmental disorders); persons losing their autonomy for age-related reasons; persons with a serious mental health disorder; persons with physical health problems (chronic illness, post-operative or post-hospitalization needs and palliative care); as well as families and significant others.

PRINCIPLES OF HOME & COMMUNITY CARE

Home care policy is based on the principles of solidarity, equity, free choice and neutrality. Fundamental to this is the recognition of a person's right to choose their living environment as long as it is appropriate, adapted to their situation and safe. The client must be involved in the decision-making process in order to identify their needs and develop their intervention plan or personalized service plan, and, depending on the case, the choice of required resources.

The principle of neutrality addresses the concept that services offered at home should not vary in the level of treatment provided. Thus, a person receiving services at home cannot draw any financial benefit from this service, for example, by being spared expenses that the individual would otherwise incur.

The home care policy also refers to the need to coordinate actions around the home. These are local services that will need intersectoral assistance, whether in terms of home adaptation, transportation, education, or monitoring services.

HOME CARE PROGRAM OBJECTIVES

The policy endeavours to meet several objectives categorized under three major orientations that form part of CSSS clinical project development.

Strategic Direction 1 – Adaptive Services and Personalized Support

- Improve **general access** to locally-available services and strengthen the *Guichet d'accès* access portal (CSSS).
- Offer a **comparable and equitable response** based on needs (for all clients).
- Ensure **service continuity and quality** from the client's perspective: referral pathways and appropriate means of communication based on quality standards, regardless of the service provider.

Strategic Direction 2 – Effective Management: A Clear Division of Responsibilities

- Follow-up on the strategic directions using **accountability mechanisms** agreed on among the provincial, regional and local levels (follow-up indicators, thresholds, and targets based on the programs).
- Ensure the continuous development of home care services as a lever for improving the health and social services system.

Strategic Direction 3 – Working Together: Towards a National Home Care Strategy

- Promote a societal vision of home care: intersectoral action to be strengthened or developed.

HEALTH SYSTEM PRIORITIES

The priorities for health and social services in Quebec, as defined in the 2010–2015 Strategic Plan, are to:

- Ensure the offering of long-term home care services to adapt to the increasing needs for all clients, including their families and caregivers.
- Ensure that people with disabilities have access to the services they require within established time frames.
- Foster self-management and rehabilitation of people with chronic disease through a continuum of treatment and care.
- Continue establishment of integrated service networks, for people with decreasing independence related to aging (RSIPA), in each local territory through implementation as defined in the MSSS guidelines.

Among the **home care priorities** of the Ministry is the commitment to adapting practices to contribute to the development of high-quality home support services to meet the needs of clients, families and caregivers. More specifically, home care aims to:

- Organize services in order to broaden access, maintain continuity and ensure continuous quality improvement.
- Offer members of the public the services they need to remain in their homes safely, for as long as possible, and avoid the undue use of hospital and residential services.
- Incorporate social support to help fragile and vulnerable persons remain in their community.

2. Access, Funding & Service Delivery

ACCESS TO HOME CARE SERVICES

The CSSS is the central access (*Guichet d'accès*) to home care services. Upon referral, an intervention worker (professional) from the CSSS performs a general assessment of the person's needs. If the situation is urgent, the response will be immediate. A more detailed assessment is conducted using the multi-client assessment tool (*Outil d'évaluation multiclientèle - OEMC*) that forms the basis of the intervention program, or a personalized service plan that is developed in order to facilitate service coordination. The intervention worker and other members of the multidisciplinary team will follow up and evaluate the services based on the evolution of a person's situation.

When the situation requires, home care services must be provided on a continuous basis (24/7). Measures are in place to ensure continuity of regular services and management of urgent requests so that an individual knows who to contact to obtain the services required during a situation that is urgent or judged to be so.

REFERRAL SOURCES

Individuals, family members, health and social services network professional (medical clinic, hospital centre, rehabilitation centre, etc.), or community or social service organizations can refer to home care.

ELIGIBILITY, COVERAGE & UTILIZATION

ELIGIBILITY

Any person with a temporary or chronic disability, whether physical, mental or psychosocial, is eligible to receive services if:

- The need for support is confirmed by a professional assessment based on the needs expressed by the person and their caregivers.
- The person and their caregivers agree to participate in the decision-making process, and to receive the services required.
- The person is home-bound given his or her condition, or it is more relevant clinically to offer services at home.
- It is more efficient to offer home support service instead of services in an institution or in an outpatient clinic.
- The home is deemed adequate and safe.

AGE

There are no age criteria.

DIRECT FEES AND INCOME TESTING

Professional services are offered free of charge to everyone, regardless of the location.

Domestic help and personal assistance services, specified in the response plan or personalized service plan, are offered at no cost:

- To persons with a temporary disability.
- To persons receiving palliative care.
- To persons with a significant and persisting disability.

Persons who are incapable of performing domestic activities only (and therefore require only domestic help) are referred to a social economy enterprise. Persons living on a low income receive the domestic help services specified in the response plan or personalized service plan free of charge. In other cases, the rules of the PEFSAD ((Programme d'exonération financière des services d'aide à domicile) apply. Persons who require domestic help services (rather than personal assistance services) may use the PEFSAD. The amount of financial assistance available depends on the personal income assessment (variable assistance ranging from $4 to $12.25 per hour). Two types of financial assistance are available:

1. Fixed rate: $4 for each hour of service.
2. Variable rate: Based on an income assessment (family income and marital status) to determine the allowable level of variable assistance (from $0.55 to $8.25 per hour of service). This amount is paid in addition to the fixed amount.

The maximum amount of financial assistance for persons living on low incomes is $12.25 (fixed plus variable amount). These individuals pay only the difference between the rate charged by the social economy domestic help enterprise and the financial assistance granted.

MEDICATION

In Quebec, the *Régime général d'assurance médicaments* (RGAM) was created to provide the entire population of Quebec with access to reasonably priced drug therapies dictated by their medical condition. It provides basic coverage of the cost of pharmaceutical services and drugs, and requires the person or families receiving the services to make a financial contribution based on their economic situation.

LIMITS / GUIDELINES TO SERVICE PROVISION

Home care services are generally the equivalent of what it would cost to provide accommodation to a person with the same needs profile, in a government institution.

DETERMINING CLIENT NEED - ASSESSMENT TOOLS

In 2003 the MSSS determined that the multi-client assessment tool (*outil d'évaluation multiclientèle* - OEMC) would be the standardized, valid and reliable tool used to assess the needs of anyone requiring home care services. The OEMC includes a number of components, from intake to response plan and/or personalized service plan development. Depending on a person's circumstances, complementary tools may also be used in order to organize appropriate services.

SETTINGS OF CARE

Home care service in Quebec may be provided to persons living in the following locations:

- A traditional home.
- A private residence for seniors, with or without services.
- Intermediate resources (through formal agreements between the institutions concerned to ensure integrated services suited to the needs of recipients).
- Family-type group homes.

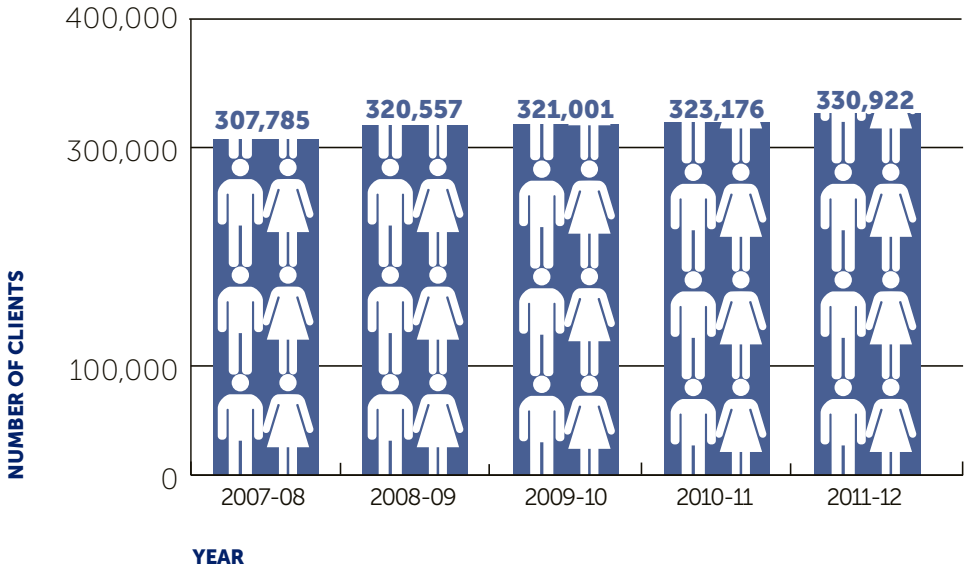
INTEGRATED MODELS OF CARE

The network of integrated services for seniors losing their autonomy *(Réseau de services intégrés aux personnes âgées* -RSIPA) is currently being established in Quebec to ensure the continuity and complementarity of care and services, as well as management and accompaniment for persons with more complex needs.

This integrated service model includes elements shared by all RSIPA partners:

- Administrative components, including collaborative mechanisms.
- Organizational components such as the *Guichet d'accès* (access portal), an integrated, multi-dimensional, expandable and computerized user needs assessment system.
- Clinical components, including: service planning, case management, involvement of the home care team and family physicians, and the availability of geriatric services.

Number of Individuals Receiving Home Care



FUNDING

The funding methodology used by the MSSS is a population-based approach that accounts for age, sex, material and social disadvantage indicators, income, education and social isolation. This method of resource allocation also accounts for regional characteristics within service and support programs. An overall funding envelope is thus calculated for each region, and then divided up among the institutions by the health and social services agencies.

Health and social service agencies allocate funds among the institutions in their area. Using the budgets allocated for all programs and services, the CSSS must organize home care services to meet the needs of the public in accordance with the priorities and targets set and agreed upon between the agencies and the MSSS. Within this framework, targeted investments have been made to improve the provision of home care services.

TOTAL PUBLIC EXPENDITURES ON HOME CARE

Public home care expenditures include all home care services provided by the CSSS such as nursing care, respiratory therapy, home care, psychosocial intervention, occupational therapy, physiotherapy and direct benefits. Certain other expenditures are also included for supplies and equipment, family support and other services under the institutions' responsibility.

Public Expenditures on Home Care

YEAR			
2010-11	$1,406.6 **$26,148.3 f**	5.4%	$177.94
2009-10	$1,358.1 **$25,155.6**	5.4%	$173.54
2008-09	$1,283.4 **$23,378.0**	5.5%	$165.59
2007-08	$1,155.6 **$21,830.0**	5.3%	$150.33
2006-07	$997.5 **$20,587.7**	4.8%	$130.71
2005-06	$903.1 **$19,421.9**	4.6%	$119.11

Annual Public Home Care Expenditure[1]
($' 000,000)

Total P/T Government Health Expenditure[2]
($' 000,000)
Data Source: CIHI, National Health Expenditure Trends, 1975 to 2011, Table B.4.1
f – forecast

Percent of Total P/T Government Health Expenditure

Per capita Public Expenditure on Home Care[3]

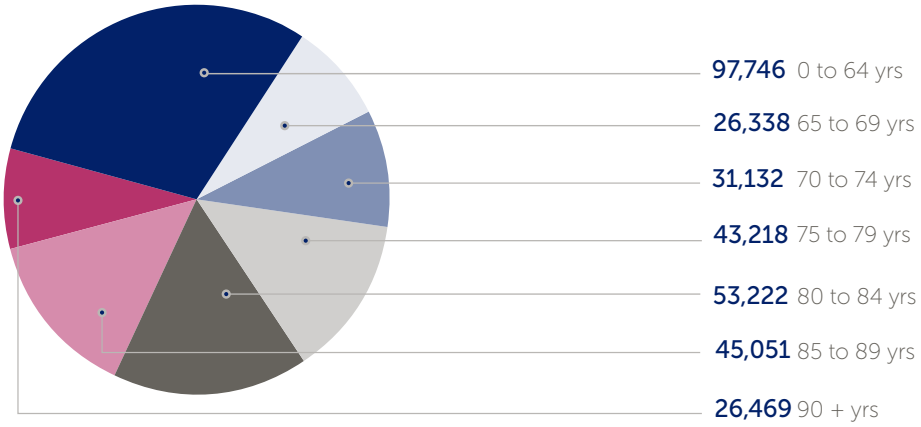
[1] *Includes Annual Public Expenditures by the Health and Social Services Home Care Network plus PEFSAD and Tax Credits (estimated expenditures).*

[2] *Figures include spending for health services reported by the provincial/territorial ministry responsible for health – does not include expenditures from municipal government or worker's compensation. [CIHI, National Health Expenditure Trends, 1975 to 2011, pg 92]*

[3] *Population data from Statistics Canada, Demography Division, Annual Estimates of Population for Canada, Provinces and Territories, from July 1, 1971 to July 1, 2012*

PROFILE OF CLIENTS RECEIVING HOME CARE

Number of Individuals Receiving Home Care By Age Category (2010-11)



DIAGNOSIS

Home care clients typically include persons losing their autonomy for age-related reasons, physical disability, intellectual disability, pervasive developmental disorders, palliative care, and short-term, post-hospitalization and post-surgical care.

SERVICE DELIVERY

MODEL OF SERVICE DELIVERY

The public network is responsible for organizing and delivering home care services. Community organizations and social economy domestic help enterprises are also partners of the public network. In this regard, the MSSS subsidizes services through the PEFSAD and direct allocation/employment-service cheques, as well as the community organization support program.

RANGE OF HOME CARE SERVICES & PROGRAMS

Home care services have evolved gradually and are organized differently in different regions; however, departmental policies establish a standardized range of recipient services:

- Professional care and services (medical services, nursing care, psychosocial services, nutrition, primary rehabilitation and respiratory therapy).
- Home care services (personal assistance, domestic help, civic support, accompaniment, etc.).

And **services for families and significant others:**

- Sitting and monitoring, respite care, back-up care, support in performing daily tasks and psychosocial services.

Home Care Services/Programs & Public Coverage

Professional Home Care And Services

Medical Services	Funded by the health and social services network.
Nursing Services	Funded by the health and social services network.
Nutrition Services	Funded by the health and social services network.
Occupational Therapy	Funded by the health and social services network.
Physiotherapy	Funded by the health and social services network.
Respiratory Therapy	Funded by the health and social services network.
Psychosocial Services	Funded by the health and social services network.
Community Intervention	Funded by the health and social services network.

Daily Living And Domestic Support Services[1]

Personal Assistance Services	Services include personal hygiene, meal assistance, transfers, etc. Funded by the health and social services network.
Domestic Help Services	Services include housekeeping, meal preparation, laundry, etc. Co-payment clients and PEFSAD.
Civic Support Activities	Services include assisting with budget management, completing forms, etc. Funded by the health and social services network or financial support paid to the agency.
Cooking, Accompaniment, Friendly Visits, etc.	Funded by the health and social services network or financial support paid to the organization.
Learning Support Services	Services include coaching and motivation activities related to personal and domestic activities, support during occupational activities, rehabilitation activities, etc Funded by the health and social services network.

Services For Informal Caregivers

Support for the Families of Persons with Disabilities (allowance)	Funded by the health and social services network.
Sitting	Funded by the health and social services network or financial support paid to the agency.
Respite	Funded by the health and social services network or financial support paid to the agency.
Back-up	Funded by the health and social services network or financial support paid to the agency.
Assistance with Daily Tasks	Services include various measures to relieve informal caregivers from their activities for a time. Funded by the health and social services network or financial support paid to the agency.

Ancillary Support[2]

Medical and Specialized Supplies	Administered by the CSSS and funded by fiduciary institutions, health and social services agencies and the CSSS.
Oxygen	Funded by health and social services agencies.
Technical Aids (walker, wheelchairs, etc.).	Equipment loans provided by various representatives.
Home Adaptations	Mandatory assessment by the CSSS occupational therapist. Two programs are available: Housing adapted to autonomous seniors and home adaptation. The *Société d'habitation du Québec* administers both programs. Adapted housing for independent seniors provides financial assistance to help with minor adjustments to the home or apartment. Home adaptation provides financial assistance irrespective of income to every person with a disability involving limitations that affect daily activities. The *Société d'habitation du Québec* and the Canada Mortgage and Housing Corporation share the costs of home adaptation.

[1]These home care services are provided by the CSSS, community organizations, volunteer groups and social economy domestic help enterprises under the PEFSAD.
[2]Ancillary support includes medical and specialized supplies, and the technical equipment and aids required to allow a person to remain at home or return home. Ancillary support is available under the 19 programs administered by the MSSS and its network, other departments or agencies and local organizations, provided the support in question is not already covered by a provincial or federal government benefit plan or a private insurance plan.

Expenditures per Year

	2006-07	2007-08	2008-09	2009-10	2010-11
Home Nursing Care	$197,886,154	$218,035,268	$235,478,257	$250,873,562	$257,051,502
Home Physiotherapy	$20,135,421	$23,179,956	$26,127,128	$28,451,002	$30,047,408
Home Occupational Therapy	$38,477,301	$42,406,260	$46,141,196	$47,118,730	$48,850,309
Home Psychosocial Services	$83,930,298	$92,967,316	$101,841,735	$109,332,984	$116,188,031
Home Respiratory Therapy	$13,253,184	$14,919,677	$15,509,052	$15,364,984	$16,463,547
Home Nutrition	$5,673,079	$5,955,545	$6,352,332	$6,997,045	$6,988,234
Home Care	$140,134,465	$158,770,580	$176,818,328	$182,122,419	$184,669,134
Community Response				$8,534,613	$8,382,314

HOME CARE SERVICE EXPENDITURES BY PROGRAM

Service Program Expenditures 2010-11

Program	Expenditures	Percentage
General Services	$97,685,072	9.21%
Physical Health	$128,505,410	12.12%
Mental Health	$7,051,811	0.67%
Public Health	$10,905,695	1.03%
Age-Related Loss of Autonomy	$550,443,542	51.92%
Intellectual Disability and Pervasive Developmental disorders	$53,131,598	5.01%
Physical Disability	$212,413,779	20.04%
Total	**$1,060,136,907**	**100%**

SERVICE VOLUME

Total Units[1] of Home Care Service

	2007-08	2008-09	2009-10	2010-11	2011-12
Amount of Service	7,551,549	8,061,016	8,319,010	8,234,683	9,272,727

[1]*Units represent home care visits*

Units (hours or visits)[1] per year

	2006-07	2007-08	2008-09	2009-10	2010-11
Home Nursing Care	2,485 651	2,550,699	2,634,883	2,689,489	2,515,203
Home Physiotherapy	207,153	221,717	244,387	260,123	271,893
Home Occupational Therapy	261,244	262,290	276,067	282,269	290,198
Home Psychosocial Services	754,808	782,382	842,668	887,383	937,549
Home Respiratory Therapy	120,432	126,616	131,140	133,718	115,682
Home Nutrition	39,785	43,050	49,280	53,063	51,749
Home Care (without SEC)	3,361,449	3,572,355	3,882,591	4,002,055	4,052,409

[1] *Also referred to as a 'response'. Based on the CLSC clientele and service information system (I-CLSC), a response is one or several actions on behalf of a user (individual, group or community) that require(s) significant documentation on file. Some activities, although necessary to a response, are not considered responses in themselves: reading a file, preparing material, etc.*

CLINICAL (SPECIALTY) SKILLS

With the focus on discharging patients from hospital as promptly as possible, there has been an increase in the complexity of care provided at home. The challenge in much of Canada can be in having a critical mass of patients who require certain levels of expertise, and as a result special skills only being available in urban centres. However, with the advent of remote access to support in the community, there is an opportunity for more complex care to be provided in less populated areas. Home care nurses are able to:

- Administer narcotics and chemotherapy.
- Provide enterostomal therapy, wound care, peritoneal dialysis, and infusion therapy.
- Manage infusion pumps, central lines and peripherally inserted central catheters (PICC lines).
- Provide ventilator care and regular tracheostomy tube replacement.
- Manage home oxygen for individuals in their homes across the province.

Clinical services not provided in the home by home care staff include the administration of blood and blood products.

3. Quality & Accountability

HOME CARE INDICATORS

The home care indicators that are currently monitored include:

- Number of hours of service.
- Number of clients served.
- Number of interventions / visits.
- Average number of interventions per client.
- Expenditures.

QUALITY & ACCREDITATION

Quality is a critical aspect of health and social services. According to the home care policy, it must be considered from three perspectives:

1. The user – are the services provided adequate (human contact, amount and waiting time)?
2. The service providers – is the service the most clinically effective?
3. The service system in general – is the service the most relevant, the most efficient and the best in terms of its cost-benefit ratio?

High-quality care is evidence-based (appropriate), focused on the patient (or patient-centered), safe and timely (CIHI).

EXTERNAL ACCREDITATION

Accreditation is mandatory for health and social service centres. Accredited institutions meet national standards of excellence in quality of care and service. Quebec has two Accreditation boards: the Conseil québécois d'agrément and Accreditation Canada.

CLIENT / PATIENT ADVOCATE

The Act respecting health services and social services requires all institutions to adopt a code of ethics. The code of ethics must establish rules of conduct toward clients, the clients' responsibilities and the various forms of recourse available to individuals to voice their dissatisfaction. The complaints procedure must be made available.

Each board of directors of health and social service institutions in Quebec passes a bylaw to establish a client complaints review procedure. The board of directors appoints and instructs a local complaints and service quality officer responsible to receive and process complaints for the institution. The local officer is also responsible for ensuring that individual rights, as set out in the code of ethics, are respected.

SAFETY

A priority of service organizations in Quebec is to provide high-quality, safe care and services to clients. Bill 113, enacted in December 2002, states that all clients are entitled to be informed as soon as possible of any incident that occurs while they are receiving care that could affect their health or well-being. It also provides that a person on duty in an institution is obliged to report any incident or accident as soon as possible after it comes to their attention.

Institutions must cultivate a culture of safety within their organization in order to reduce the number of undesirable health care and service-related incidents. A systemic outlook on errors and an integrated approach are the foundations of such a culture. Various programs are in operation to ensure that clients and employees have a safe work environment adapted to the nature of the activities in question.

CARE PROVIDER SAFETY

The Association *paritaire pour la santé et la sécurité du travail du secteur des affaires sociales* (ASSTSAS) works on injury prevention and training. One example is the safe user movement principles program (*Principes de déplacement sécuritaire des bénéficiaires* - PDSB).

4. Information Technology

HOME CARE CLINICAL SOFTWARE

At present, all institutions do not use the same software. The main objective of implementing the computerized clinical record (CCR) is to improve provider services by facilitating access to the information in client files.

HOME CARE MANAGEMENT

The CLSC client and service information system (I-CLSC) and its database provide relevant and comparable data on all services offered by the CSSS.

The management and accountability monitoring system (*système de suivi de gestion et de reddition de comptes* - GESTRED) makes it possible to periodically monitor management agreements. The data that is analyzed includes the cost of services produced and human resource information.

The computer solutions for the network of integrated services for the elderly (RSIPA) are consistent with the home care framework of services to the public in general and seniors in particular. Computerization of the RSIPA ensures the rapid and secure dissemination of the user needs assessment and better service planning.

TELECARE

Telecare pilot projects are currently in progress. These projects consist of reviewing the organization of work to maximize the clinical and operational objectives of managing more vulnerable clients at home.

5. Health Human Resources

CLINICIANS PRACTICING IN HOME & COMMUNITY CARE

Data on human health resources is monitored in each CSSS, and regionally by the health and social services agencies, for professionals and for personnel providing daily living and domestic support services. Improving the quality of client services depends primarily on the competency of human resources. Home care staff must receive training that covers the specific components of home care.

FAMILY CAREGIVER

The home care policy, published in 2003, recognizes informal caregivers and family members as partners, citizens and clients. As a result, they can rely on services organized by community partners, institutions within the health and social services network and community organizations. These services can include:

- Respite.
- Monitoring or sitting services.
- Day centres.
- Temporary accommodation, etc.
- Assistance in fulfilling parental or support roles.

These services may help them better cope with the added responsibilities of caring for a person with an illness or disability. As well, different departmental policies and orientations provide for the deployment or reinforcement of specific measures to improve the support provided to family members and significant others.

Support for families and significant others should not be construed as primarily the responsibility of the health and social services sector. It must form part of a multi-sectoral government approach that accounts for family, social and professional life in its entirety. Thus, apart from the measures provided in the home care policy, various other initiatives are provided to families responsible for dependent persons. These measures can be categorized as follows:

- **Financial measures** (tax credits, exemptions, financial benefits, etc.). Such measures allow people to purchase services or compensate to a degree for the additional expenses incurred due to such dependence.
- **Legislative measures** provide collective support to dependent persons and encourage employers to facilitate the role that significant others play in their lives. For example, An Act respecting Labour Standards provides for some leave from work for family responsibilities. The Quebec Parental Insurance Plan and the compassionate benefits adopted by the federal government in January 2004, are examples of such initiatives;

The Vital Role of the Family Caregiver

Family caregivers provide care and assistance for spouses, children, parents and other extended family members and friends who are in need of support because of age, disabling medical conditions, chronic injury, long-term illness or disability. A family caregiver's effort, understanding and compassion enable care recipients to live with dignity and to participate more fully in society.

5 million is the estimated number of caregivers in Canada.

80 % of care needed by individuals with a long-term condition is provided by family caregivers.

60% of caregivers provide care for more than three years.

Source: Canadian Caregiver Coalition www.ccc-ccan.ca.

- **The informal caregivers' support fund**, created in 2009, amounts to 200M over ten years. It financially assists regional support structures, and accompanies their development. In addition to rallying regional players around issues concerning informal caregivers and identifying solutions, regional initiatives can financially support various projects that encourage support for the caregivers of elderly persons, particularly those with Alzheimer's disease or cognitive impairments related to aging, or any form of physical or mental degeneration caused by aging.

6. Provincial Initiatives

Expansion of Home Support Program: Since 2003, public expenditures for the health and social services network for home support services (all clients combined) grew from $625.4 M in 2002-2003 to $1,033.5 M in 2009-2010, which represents a 65.3 percent increase over a seven-year period. In 2011 the MSSS announced annualized investments of $40 M to consolidate home care services and $5 M for the PEFSAD.

In the spring of 2012, Quebec Premier Jean Charest, the Minister Responsible for Seniors, Marguerite Blais and the Minister for Social Services, Dominique Vien, together with the Minister of Health and Social Services, Dr. Yves Bolduc, presented the public with the first government policy on aging, "Vieillir et vivre ensemble, chez soi, dans sa communauté, au Québec". The policy is the outcome of a joint effort by 18 government departments and agencies, and confirms the government's commitment to developing services for the elderly, with home care as a cornerstone. The policy addresses three priorities:

1. Stakeholder engagement
2. Maximizing health
3. Maintaining safety and security of seniors

It calls on stakeholders and organizations to work together to allow the elderly to remain in their homes and communities for as long as possible. The action plan commits to the monitoring of progress and investment in home care.

7. Challenges

The major challenges confronting home care in Quebec are:

Accelerated Aging of the Population; Between 2011 and 2031, the proportion of people 65 and older will increase by ten percent, from 16 to 26 percent of the total Quebec population. In 2031, thirteen percent of the population with be 75 and older.

Increased Number of People with Disabilities: twenty percent of individuals 65 and older live with disabilities that require support and assistance services.

Human resources for health and social services: It is estimated that the demand in health care related professions will significantly increase.

Integration of technology: The health and social services system must leverage information and communications technology in order to improve service access.

Family Support: Given the smaller and more dispersed family units, supporting caregivers is even more vital.

8. Opportunities

Within the next few years, the Health and Social Services Network will be faced with a labour shortage and a rise in the needs of its clients, especially among the aging population. The efforts of all health care stakeholders should lead to use of the right resource for the right person at the right time in the right place and at a better cost.

This overview clearly shows the importance of home care in organizing health and social services for the Quebec population. The human and financial investments made are an indication of the priority that the MSSS gives to keeping people at home for as long as possible and avoiding the undue use of hospital and residential services.

ACRONYMS/ABBREVIATIONS

ASSTSAS - association paritaire pour la santé et la sécurité du travail du secteur af faires sociales
CCR - Computerized Clinical Record
CH - centre hospitalier
CHSLD - centres d'hébergement et de soins de longue durée
CLSC - centres locaux de services communautaires
CSSS - centre de santé et de services sociaux
DCI - dossier clinique informatisé
GESTRED - système de suivi de gestion et de reddition de comptes
I-CLSC - service information system (I-CLSC)
MSS - ministère de la Santé et des Services sociaux
OEMC - Outil d'évaluation multiclientèle
PDSB - Principes de déplacement sécuritaire des bénéficiaires
PEFSAD - Programme d'exonération financière pour les services d'aide domestique
RGAM - Régime général d'assurance médicaments
RSIPA - Réseau de services intégrés aux personnes âgées

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NEW BRUNSWICK

HOME CARE IN **NEW BRUNSWICK**

The definition of home care in **New Brunswick** is consistent with that of the Canadian Home Care Association.

> Home care is an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the family caregiver.

In New Brunswick, health promotion is further clarified to reflect an emphasis on self management through education, at the individual and family levels. End-of-life care is referred to as palliative care.

NEW BRUNSWICK

BY THE NUMBERS...

72,908 sq km **LAND AREA**	755,000[1] POPULATION (2011)	**51%**[3] Percent population in urban settings defined as an area with a population of at least 1,000 and with no fewer than 400 persons per square kilometre (2006)	
59.2[2] Dependency ratio (2009) Ratio of the population aged 0-19 and 65+ to the population aged 20-64	16.2%[1] **Population Seniors 65+ yrs (2011)**	80.2 years[1] **LIFE EXPECTANCY (AT BIRTH)**	**$4,340.71**[2] Public sector health care expenditure per capita (2011 Forecast)

[1]Statistics Canada | [2] Canadian Institute for Health Information (CIHI) | [3] Human Resources and Skills Development Canada

1. Governance & Organization

HEALTH CARE SYSTEM STRUCTURE

The **New Brunswick Department of Health (DH)** and **Department of Social Development (SD)** work in partnership to deliver home care services with the DH responsible for health services and the SD for long-term home support services and residential care.

The **New Brunswick Department of Health** is responsible for the direction and funding of health services within the province, through the development of health care policy and oversight of health service delivery. The Planning, Sustainability, E-Health and Corporate Privacy Division within the department is primarily responsible for health system governance planning, including the research and development of innovative concepts/projects leading to the long-term sustainability of the health care system. The Division is also responsible for corporate strategic planning, policy development, legislative development, research and evaluation, federal/provincial relations, aboriginal health, statistical information and data gathering instruments, accountability tools, performance indicators and management of corporate and system wide E-health projects. The Department of Health works collaboratively with health systems partners to achieve five key goals/directions:

- Increase the number of years individual residents of New Brunswick live free of major illness, disability and handicap.
- Increase emphasis on promotion of well-being and prevention of social dysfunctioning.
- Assist individuals and families to achieve and maintain well-being.
- Promote the achievement and maintenance of a healthy physical and social environment.
- Provide equitable, affordable and appropriate health and wellness for the citizens of New Brunswick.

Two **Regional Health Authorities (RHAs)** are responsible for setting priorities for health services, in their respective regions, and managing and delivering acute care hospital services, extra-mural services, addictions services, public health and mental health services.

The RHAs report to the Department of Health and are required to:

- Develop and implement a three-year Regional Health and Business Plan (includes developing objectives, principles, and priorities).
- Ensure citizen input as to the needs and priorities of the region.
- Submit an annual report to the Minister.
- Provide advice through a Medical Advisory Committee and a Professional Advisory Committee.
- Ensure compliance with the Provincial Health Plan.

The New Brunswick Extra-Mural Program (known by many as the "hospital without walls") provides comprehensive home health care services to New Brunswickers in their homes and in community settings. The Extra-Mural Program (EMP) falls under the jurisdiction of the Department of Health, which in collaboration with the Regional Health Authorities (RHAs):

- Directs the development of the program.
- Fosters the maintenance of provincial forums to direct and to advise on issues relating to the program.
- Assures the availability of consistent home health care services throughout the province.
- Establishes provincial policy and standards.
- Funds and monitors the program.

Each RHA is responsible for the planning and management of Extra-Mural Program service delivery within its region, and for ensuring that home health care services are available and are delivered according to established policies.

Regional Health Authorities

Vitalité Health Network replaces RHA 1 Beauséjour (Moncton), RHA 4 (Edmundston), RHA 5 (Campbellton) and RHA 6 (Bathurst). Vitalité Health Network headquarters are based in Bathurst.

Horizon Health Network replaces RHA 1 South East (Moncton), RHA 2 (Saint John), RHA 3 (Fredericton), and RHA 7(Miramichi). Horizon Health Network headquarters are based in Miramichi.

The **Department of Social Development (SD)** administers long-term home support services and long-term residential care under the Long-Term Care Program, and the Disability Support Program. Social Development also provides services to children with disabilities and their families through the Children with Special Needs Program. 'Long-Term Care services' refer to a range of personal supports and/or physical, social and mental health services required by individuals who, because of long-term functional limitations, need assistance to function as independently as possible. In partnership with the Extra-Mural Program and Mental Health services, the Department of Social Development provides a single entry long-term care assessment program to determine the need for long-term assistance.

HEALTH CARE & HOME CARE LEGISLATION

There is no legislation specifically for home care; however, there are many pieces of legislation that impact home care including, but not limited to:

Family Services Act (1980) – addresses child custody, care and protection as well as adult protection services.

Hospital Services Act (1992, Amended 2003) - outlines the insured hospital and diagnostic services to which a person is entitled, the regulations without charge and the legal authority of the Department of Health and Regional Health Authorities.

Official Languages Act (first enacted in 1969) - states that every New Brunswicker has the right to receive health services from the Department of Health and Regional Health Authorities in the official language of their choice.

Personal Health Information Privacy and Access Act (PHIPAA) (2009) – provides directives regarding consent, collection, disclosure and documentation of personal health information.

Regional Health Authorities Act (2002) – establishes that regional health authorities have responsibility for delivering and administering health services in specified geographic areas and, when authorized, in other areas of the Province.

EVOLUTIONARY MILESTONES

1979
Extra-Mural Hospital founded with a broad mandate to provide an alternative to hospital and/or long-term care facilities.

1981
New Brunswick Extra-Mural Hospital accepted its first clients.

1989
Responsibility for long-term nursing care was transferred from Public Health to Extra-Mural.

1991
Extra-Mural partnered with Family and Community Services in a Single Entry Point Project (SEP) to provide health and social services to persons over 65 years of age.

1993
The Single Entry Project covered every region and area.

1996
Responsibility for the Extra-Mural Hospital was transferred to the Regional Hospital Corporations, and it became known as the Extra-Mural Program (EMP).

1997
SEP was replaced by the Long-Term Care (LTC) program, and services were expanded to include adults, with disabilities, not receiving income assistance.

All community rehabilitation services, including those provided to schools and nursing homes, were consolidated under EMP.

2000
Government restructuring led to the creation of the Department of Health and Wellness (now called Department of Health) and the Department of Family and Community Services.

2001
A new information system and a provincial data repository was implemented throughout the province to collect clinical and administrative information.

2002
Eight Regional Health Authorities established.

2005
Under the Standard Family Contribution Policy, the monthly cost ceiling for LTC clients was increased from $2,040 per month to $2,150 per month.

2006

Under LTC, the monthly cost ceiling replaced with a maximum of 215 hours of home support services per month.

The Standard Family Contribution Policy changed to reflect that assets were no longer considered in the financial assessment.

EMP implemented and evaluated the use of telehealth to provide remote monitoring to patients with chronic diseases such as congestive heart failure and chronic obstructive pulmonary disease.

Funding approved to enhance the delivery of acute and palliative home health care services, including the provision of short-term personal support services, and to provide for 15 rehabilitation specialists.

2007

The Department of Family and Community Services renamed the Department of Social Development.

2008

The eight Regional Health Authorities (RHA) merged to create two – Horizon Health Network and Vitalité Health Network.

The Quick Response Home Care introduced to prevent unnecessary admissions to hospital via emergency departments.

2009

FacilicorpNB, a public sector agency managing shared services for the health care system, constituted to assume responsibility for certain non-clinical services and programs through successive transitions beginning in 2009 and ending in 2013. This process will allow the RHAs to focus on providing high quality clinical care.

2010

The Disability Support Program made available throughout New Brunswick.

MANDATE, MISSION, PRINCIPLES & PRIORITIES

MANDATE

The Extra-Mural Program has a broad mandate to:

- Provide an alternative to hospital admissions.
- Facilitate early discharge from hospitals.
- Provide an alternative to, or postponement of, admission to nursing homes.
- Provide long-term care.
- Provide rehabilitation services.
- Provide palliative care.
- Facilitate the coordination and provision of support services.

The mission of the EMP is to provide a comprehensive range of coordinated health care services for individuals of all ages, for the purpose of promoting, maintaining or restoring health within the context of their daily lives, and to provide palliative services to support quality end-of-life care for individuals with progressive life-threatening illnesses.

PRINCIPLES OF HOME & COMMUNITY CARE

Social Development holds the belief that seniors and adults with disabilities, regardless of the nature of their needs, must have one place to go where their request for assistance will be dealt with directly, and from which they will have access to a continuum of services. The client care principles of Social Development are as follows:

- Services should enhance and not replace the natural support system.
- Service design should promote and foster independence and the importance of accepting personal responsibility for health and optimal functioning.
- The dignity and rights of individuals and families should be respected.
- People whose lives are affected by a decision should be part of the process of arriving at that decision.
- Services must be delivered in the client's language of choice.
- Services should be appropriate for identified needs.
- The primary determinant of need should be the functional limitations and capacities of individuals and their natural support systems.
- Utilization of services should be at a minimal level and the least expensive alternative required to maintain and/or improve the client's level of functioning in the community setting.
- Residential services should be considered only after all appropriate community options have been considered, or when the residential option is at the client's request.
- Ideally, service should include a prevention component.
- Delivery of services should promote continuity of care and formalize the linkages between services.
- For the Long-Term Care program, a generic assessment is used to identify needs, and to plan and initiate service.

The Extra-Mural Program (EMP) service delivery model has evolved over the years, and continues to be based on a client-centered approach and the following beliefs:

- All New Brunswickers have access to home health care services, when required, in the home and community environment, in order to progress towards and maintain an optimal level of health.
- Home health care is holistic in nature, and is delivered through the provision of coordinated services. In order to meet the identified needs of the client, service providers recognize the contribution of other providers, establish effective communication, and work together in partnership.
- Home health care service must be delivered in an environment that is safe for the client and the EMP service provider.
- The client's culture, experiences, knowledge and rights are central to, and carry authority within the client/service provider relationship. Services provided are responsive to the needs of the client.
- Home health care services are best provided through an interdisciplinary team with case coordination for each client and family.
- A continuous quality improvement approach is essential in the provision of home health care services that are responsive to the changing needs of clients and the community.
- Home health care services must support and incorporate the appropriate use of client self-care and service providers, both formal and informal.

- Relevant training and education of other health service providers, based on the needs of the client, are essential in the provision of quality home health care services.
- Development and maintenance of an ongoing learning environment are essential to recruit and maintain competent, innovative, effective and efficient service providers.

HOME CARE PROGRAM OBJECTIVES & PRIORITIES

The objective of home care in New Brunswick is to maintain individuals in their own homes, delaying or avoiding a residential placement for as long as possible. Social Development's aim is to provide the necessary supports to enable seniors to remain in their own homes. Flexible programming and services, some of which are home care, allow individuals to remain in their own homes, thus avoiding or delaying a residential placement.

The Disability Support program, now available throughout New Brunswick, provides personalized, flexible disability supports for persons with disabilities between the ages of 19 and 65. It allows for the provision of independent facilitation and the use of person-centered approaches to planning and designing disability supports.

Social Development's priorities for home care are to:

- Continue to improve recruitment and retention of home support workers.
- Continue to build on the effective partnerships with the Extra-Mural Program and Community Mental Health Services, to enhance home care options for clients to live independently.

HEALTH SYSTEM PRIORITIES

The health priorities for the province include:

- Achieving a better balance between promoting good health and providing health care for those who are ill.
- Enhancing access to health services when, where and how they are needed.
- Making quality count in the planning, implementation and delivery of all health care services.
- Harnessing innovation to improve safety, effectiveness, quality and efficiency.
- Building a stronger primary health care system/increasing access to primary care.
- Engaging partners in all aspects of health care delivery.
- Recruiting health care professionals.
- Improving the overall efficiency of the health care system.
- Ensuring sustainability.
- Implementing a Diabetes Strategy and a Chronic Disease Prevention and Management Strategy.
- Adopting the Mental Health Action Plan.
- Undertaking generic drug pricing initiatives.
- Reinstating the electoral process for some RHA board members.
- Planning stages of the 2013 Provincial Health Plan.

The current home care priorities include:

- Provision of quality home health care.
- Fostering a climate of learning and innovation.
- Strengthening integration and partnerships.
- Enhancing access to electronic point of care decision support and documentation tools.
- Enhancing accountability and responding to the population.

2. Access, Funding & Service Delivery

ACCESS TO HOME CARE SERVICES

New Brunswick is committed to a single, patient-focused, community-based, integrated health services system.

Clients are referred to the EMP (29 sites in the province) by a physician, with the exception of rehabilitation services, for which there is also direct access by the public. An EMP professional assesses the needs from the perspective of the client and makes recommendations for service delivery including intervention options. The EMP professional and client determine a mutually agreed upon care / discharge plan that includes client-centered goals, interventions, and the target date for goal achievement. Appropriate referrals are made to other members of the interdisciplinary team and/or other community partners or agencies, as needed. All clients, of the program, have 24 hour access to nursing services.

The delivery of acute, palliative, and long-term health care services in the home requires a comprehensive team working collaboratively with other stakeholders to meet the needs of the client and family in a holistic manner. The active participation of the patient, family and other informal supports in the delivery of care is an essential aspect in the provision of EMP services.

Changing demographics, rising acuity of patients in the home, supporting individuals to remain at home safely, early hospital discharge and a variety of other factors are significantly impacting the availability and ability of the informal support system to participate in the provision of personal care in meeting the needs of patients at home. Therefore, the EMP provides short term personal support services, based on assessed need and program parameters, to clients who require acute, palliative, and interim care in their home environment. The client must have an assessed need for home health care, meet the eligibility criteria for admission in the EMP, and require short term personal support services in order to remain in the home environment or to be discharged from hospital.

Any person requiring long-term in-home support services can access them through the Long-Term Care program, the Disability Support program or the Children with Special Needs program of Social Development. For the Long-Term Care program, Social Development partners with Mental Health and the Extra-Mural Program, creating a single entry system. Any of the three partners can complete an assessment for an individual who is seeking assistance with long-term care supports. On-going services are case managed and budgeted through Social Development.

In June 2011, Social Development introduced a new Long -Term Care Generic Assessment Tool for clients aged 65 years and older. Service profiles resulting from the new assessment tool will offer seniors the home support services they require to remain in their own homes, thus avoiding or delaying a placement for as long as possible.

For the Disability Support Program, Social Development partners with Mental Health and EMP. Professional staff from Social Development or Mental Health are able to facilitate individuals in their

application to the Disability Support program. Individuals also have the option of completing the application themselves, or with the help of an independent facilitator from a non-government agency. On-going services are case managed and budgeted through Social Development.

REFERRAL SOURCES

Referrals to the Extra-Mural Program are made by an attending physician or designate who has admitting privileges in the regional health authority. However, rehabilitation services can be accessed directly by the client/family or other sources including personnel in schools and nursing homes, hospitals, and public health organizations. Referrals can also be accepted for client assessment and coordination of long-term care services, as EMP is a full partner in this program, which is under the Department of Social Development. For all non-physician requests, the client's family physician is notified when the client is receiving EMP services. Access to home care is generally consistent between rural and urban settings.

Referrals Sources to Extra-Mural Program

	2006-07	2010-11
Hospitals	39.0%	32.4%
Community – providers, self, physicians	47.7%	56.6%
Long-Term Care	5.9%	5.8%
Other, includes schools	7.4%	5.2%

Referrals to Social Development can be initiated from any source. As with EMP, most referrals are from the community.

Referral Sources to Social Development (2011-12)

Hospitals	25%
Self referrals	14%
Community and other	61%

Access to Quality Care

In September 2004, First Ministers agreed to a 10 year plan (The Plan) to strengthen health care across Canada. The Plan recognized that in order to address issues of access to care and to reduce wait times, there was a need to invest in a number of key areas within health, including home and community-based services. Home care was identified as an "essential part of modern, integrated and patient-centered health care".

The experience of implementing The Plan has illustrated the extent to which the health system is interdependent. The targeted funding has not only increased the volume of home care services but has impacted the system as a whole.

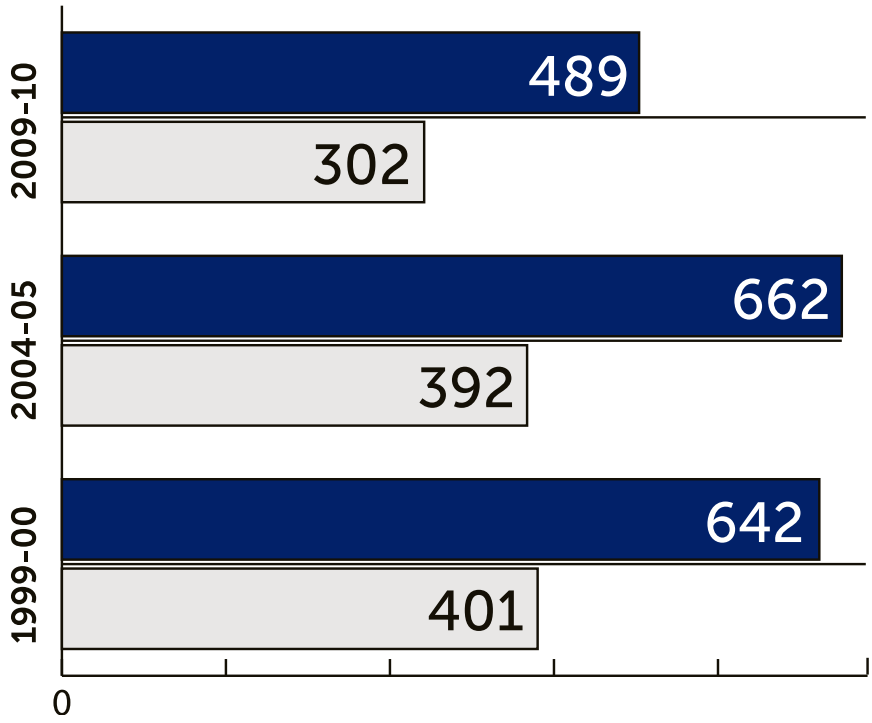
Canadian Home Care Association (2011), Home Care in Canada, Looking to the Future: Potential Opportunities and Outcomes, a Pan-Canadian Roundtable

APPROPRIATE ACCESS TO HOME CARE & COMMUNITY-BASED CARE

Hospitalization rates for conditions that may be cared for in the community are one indicator of appropriate access to community-based care. These conditions include diabetes, asthma, alcohol and drug dependence and abuse, neuroses, depression and hypertensive disease. Preventive care, primary care and community-based management of these conditions may reduce the need for hospitalization.

Hospitalization Rates For Ambulatory Care Sensitive Conditions

Age Standardized Rate per 100,000 younger than 75



Health Indicators Reports, CIHI

Alternate Level of Care (ALC) is a measure used to reflect when a patient is occupying a bed in a hospital and does not require the intensity of resource / services provided in this care setting.

The ALC rate for New Brunswick in 2010/2011 was 22.5 percent.

ELIGIBILITY, COVERAGE AND UTILIZATION

ELIGIBILITY

For **Extra-Mural Program:**

While all residents of New Brunswick are eligible for services, an individual needs to:

- Be a resident of New Brunswick with a valid NB Medicare card, or is in the process of receiving a card.
- Have an identifiable health care / functional need that can be addressed through the services provided by the program.
- Have a need that requires the provision of health care service in the individual's natural environment.
- Reside in an environment that is suitable for the care / service to be provided, both for the individual and the service provider.

For **Social Development:** To be eligible for home support services, the individual must reside in New Brunswick and have unmet functional needs, as determined through the LTC Assessment process or the Disability Support program.

For eligibility to the **Children with Special Needs program**, the child must have a severe developmental disability that is life-long and requires on-going daily assistance with personal care and everyday life activities.

AGE OF CLIENTS

All ages

LIMITS / GUIDELINES TO SERVICE PROVISION

Extra-Mural Program services are not to exceed the cost of health care service in a facility.

Home support services through SD cannot exceed 215 hours per month.

Exceptionally, case plans of up to 336 hours per month can be approved for individuals, in order to avoid unnecessary placement in a hospital or other facility.

DIRECT FEES AND INCOME TESTING

There are no charges for professional or short-term personal support services from the Extra-Mural Program.

Client contribution is required based on income testing for home support services through Social Development.

Long-term supportive and residential care is income tested according to net income.

Eligibility for the Children with Special Needs program is based on family income and family size.

SUPPLIES, EQUIPMENT AND MEDICATION

EMP clients are required to access third-party insurance for drugs where possible. If a client does not have insurance, an EMP drug card is issued to cover drugs directly related to the client's condition. Clients accepted for acute home care services receive medical supplies necessary to support the intervention, based on the reason for referral to the program. Equipment is provided when it is available in the EMP or it is accessed through various other agencies/loan banks. The need for medical supplies and equipment to support the client's plan of service is evaluated, and reviewed on a regular basis by the service provider.

Long-term care, Social Development clients may receive assistance with drugs, supplies and equipment via social assistance, or through the Prescription Drug Program for seniors.

DETERMINING CLIENT NEED - ASSESSMENT TOOLS

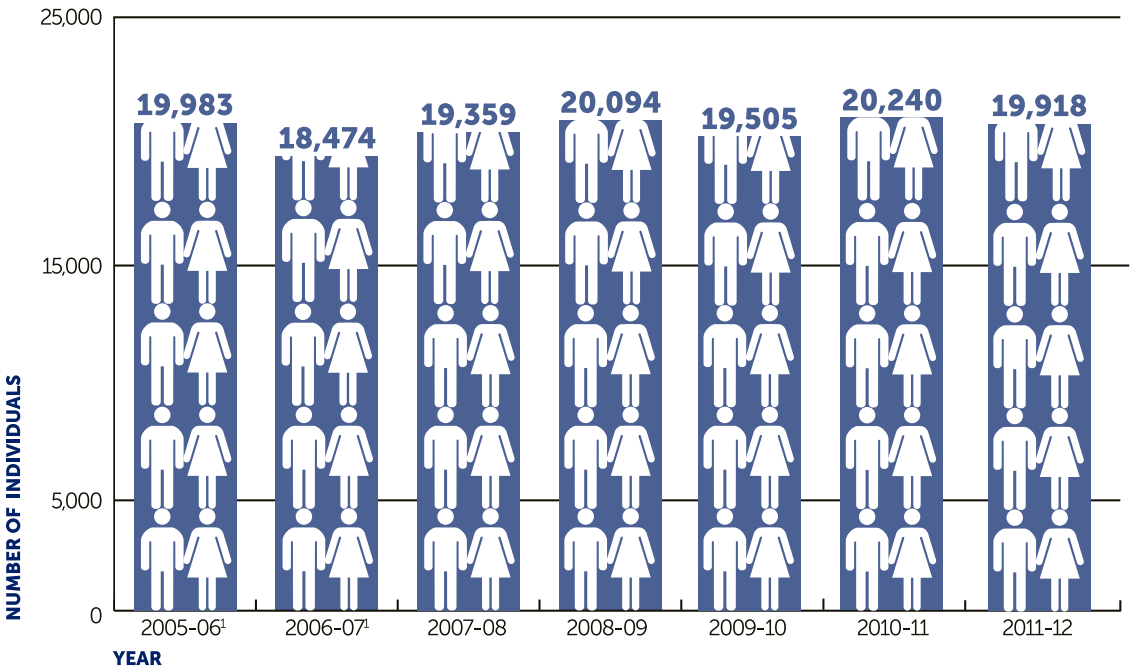
All of the three community partners (Extra-Mural Program, Social Development and Mental Health) use the same criteria and standardized long-term care generic or Disability Support program application process to determine the type of care needed by the client, for services outside of hospital services. They then refer or access the services available from all three partners as needed.

All professionals in EMP participate in care coordination and are identified as either the primary or secondary provider, depending on the client's needs and professional involvement required. EMP defines care coordination as the collaborative client-driven process of providing client care in a timely and responsive manner, utilizing the appropriate services at the right place and the right time. The intensity and level of care coordination is based on the client's characteristics and may change based on evolving client needs, involvement of other services, and the context of the client's environment.

ADMISSIONS TO HOME CARE

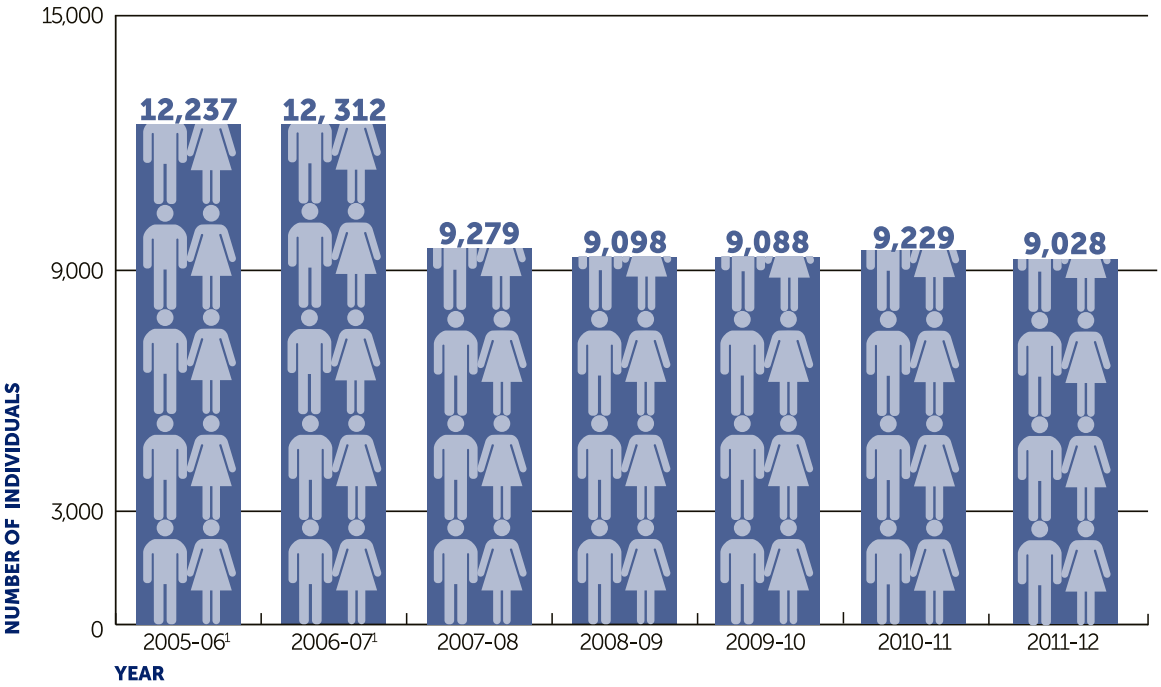
Clients can be admitted to home health care any time of the day or night. Services are initiated promptly as required. Requests for rehabilitation services are prioritized considering client centered practice, informed decision–making, client function, predicted outcome, and accountability.

Home Care Admissions – Extra Mural Program



[1] *From Portraits 2008*

Home Care Admissions – Social Development[2]



[1] *From Portraits 2008*
[2] *Clients in the Long-Term Care program, the Disability Support program and the Children with Special Needs program*

SETTINGS OF CARE

The Extra-Mural Program provides services to all New Brunswickers in the individual's natural environment. These home health care services include the following settings:

- Client's Home
- Residential facilities such as special care home, nursing home or group home
- On reserve
- Place of work
- Private retirement home
- School
- Clinic

Home support services in New Brunswick are provided by Social Development in the following settings:

- In-home.
- Alternate family living arrangements:
  - An in-home option for the provision of care and supervision services to long-term care clients or clients of the Disability Support program where applicable.
  - A voluntary living arrangement initiated by the client or the client's representative.
  - An arrangement which has the client participating as much as possible in regular family activities such as sharing meals, household chores, and leisure activities that are appropriate to their ability, as well as accessing community activities such as social/religious gatherings and recreational activities.
  - With an able individual(s) or family unit, unrelated to the client, who assumes the role and responsibility of care and supervision for the client.
  - Limited to no more than two clients per alternate family arrangement.
  - Based on a mutually supported agreement of expectations.
- Possibly to children in care (foster care).

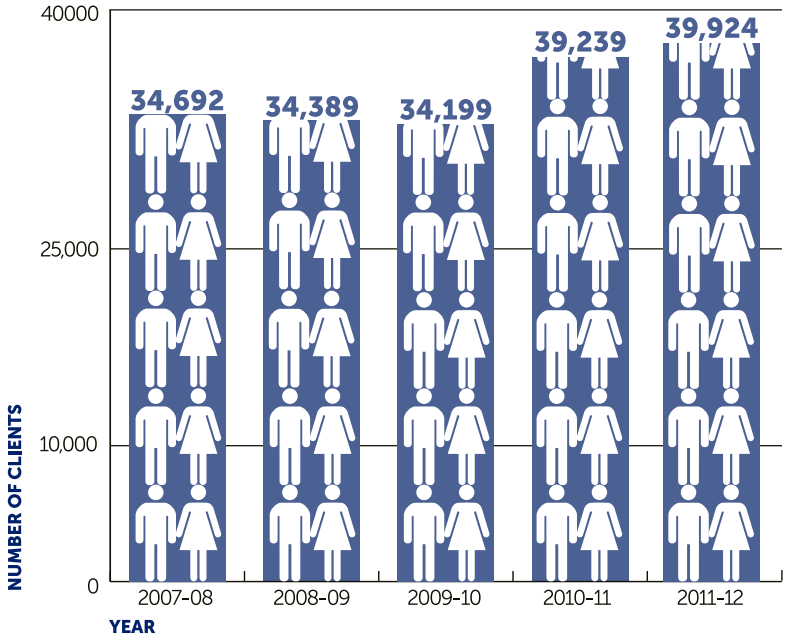
INTEGRATED MODELS OF CARE

The Extra-Mural Program (EMP) operates based on a client centered model of service delivery in which services are delivered according to the assessed needs of the client/family and a mutually agreed upon care and discharge plan. The EMP providers are specialists in the delivery of home health care services versus that of specialists in specific disease or program areas. This approach ensures the delivery of efficient and effective care and facilitates continuity of care.

All EMP non–physician professional service providers are employees of EMP and report to the management team of the service delivery unit. This structure facilitates close interdisciplinary team work and the ability to reduce the number of service providers involved with the client and family. One team member is responsible, as the primary care provider, for the coordination of care and service planning.

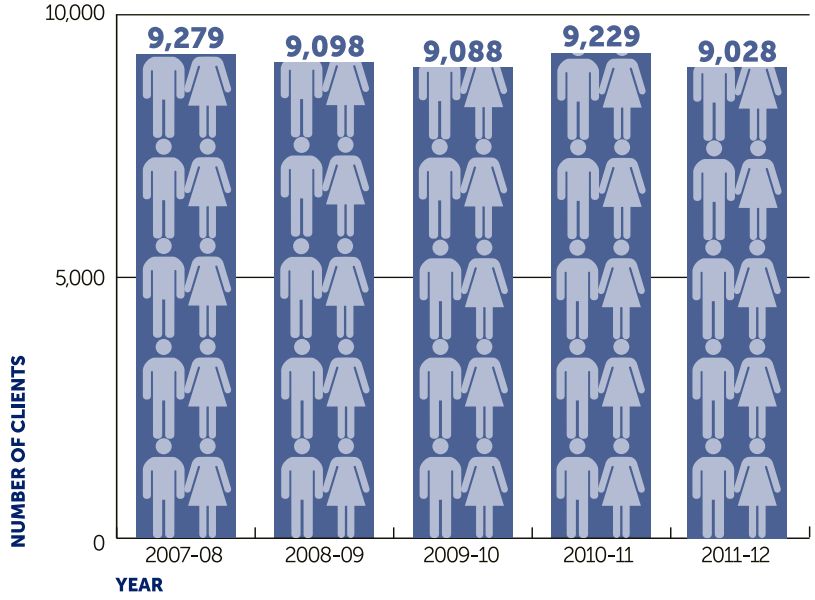
Physicians are integral members of the EMP home care team and, with the exception of salaried physicians, are remunerated on a fee for service basis for services provided to home care clients (visits, telephone, consultations, and admissions). Physician involvement is beneficial to the client's overall health and has been a critical factor in the overall success of EMP.

Individuals Receiving Home Care – Extra Mural Program[1]



[1] *Consultation and educational services to groups, the general public and facilities are not captured*
Note: some individuals receive services from both EMP and SD

Individuals Receiving Home Care – Social Development



Note: some individuals receive services from both EMP and SD

DISCHARGE FROM HOME CARE

Tracking of home care clients' discharge is currently done through a manual process of record reviews that does not support aggregation of data. Clients are discharged from the Extra-Mural Program when the:

- Goals of intervention have been met.
- Services are no longer appropriate.
- Client no longer meets the eligibility criteria of the program.
- Client has been admitted to hospital for a specific period of time.
- Client declines the services.
- Safety of service providers is threatened.

Social Development can offer up to 215 hours of service per month. Exceptionally, case plans of up to 336 hours per month can be approved under certain circumstances, for example, to avoid or delay placement in a hospital or residential facility. Many clients will receive services until discharged to special care homes or until they pass away.

Drugs for patients, after discharge from home care, are paid for by public drug plans (provincial and federal), private drug plans (usually employer sponsored) or the patients themselves, if they are uninsured. Most NB residents have some form of insurance to help cover drug costs either through private insurance; the government funded New Brunswick Prescription Drug Program (NBPDP), which includes low-income seniors who receive the Guaranteed Income Supplement, residents of nursing homes, clients of the Department of Social Development and others with certain medical conditions; through the Medavie Blue Cross Seniors Prescription Drug Program; or through Federal Government funded programs (First Nations, Veterans Affairs, RCMP, Correctional Services, National Defence and Citizenship and Immigration).

Social Development provides a grant to the Canadian Red Cross for an Equipment Loan Bank for seniors. The New Brunswick Prescription Drug Program provides drug coverage to eligible seniors residing in New Brunswick. Clients who have a Social Development health card can be funded for equipment and supplies.

FUNDING

The Extra-Mural Program is funded through a protected budget within the Regional Health Authorities global budget. Long-term care program funding is determined by the Social Development.

Public Expenditures on Home Care

YEAR			
2010-11	$187.2 SD-$113.2 / EMP-$74.4 **$2,940.3[f]**	6.4%	$248.64
2009-10	$179.0 SD-$105.9 / EMP–$73.1 **$2,782.1**	6.4%	$238.68
2008-09	$170.9 SD-$100.3 / EMP-$70.6 **$2,626.0**	6.5%	$228.80
2007-08	$156.8 SD-$92.7 / EMP-$64.1 **$2,463.4**	6.4%	$210.36
2006-07	$142.6 SD-$82.0 / EMP-$60.6 **$2,345.6**	6.1%	$191.24
2005-06	$132.3 SD-$77.7 / EMP-$54.6 **$2,131.6**	6.2%	$176.88

Annual Public Home Care Expenditure
SD[1] + EMP[2] ($' 000,000)

Total P/T Government Health Expenditure[3]
($' 000,000)
Data Source: CIHI, National Health Expenditure Trends, 1975 to 2011, Table B.4.1
f – forecast

Percent of Total P/T Government Health Expenditure

Per capita Public Expenditure on Home Care[4]

[1] *Does not include service delivery costs (SD employees involved in the Program), day activities service costs, services to children.*

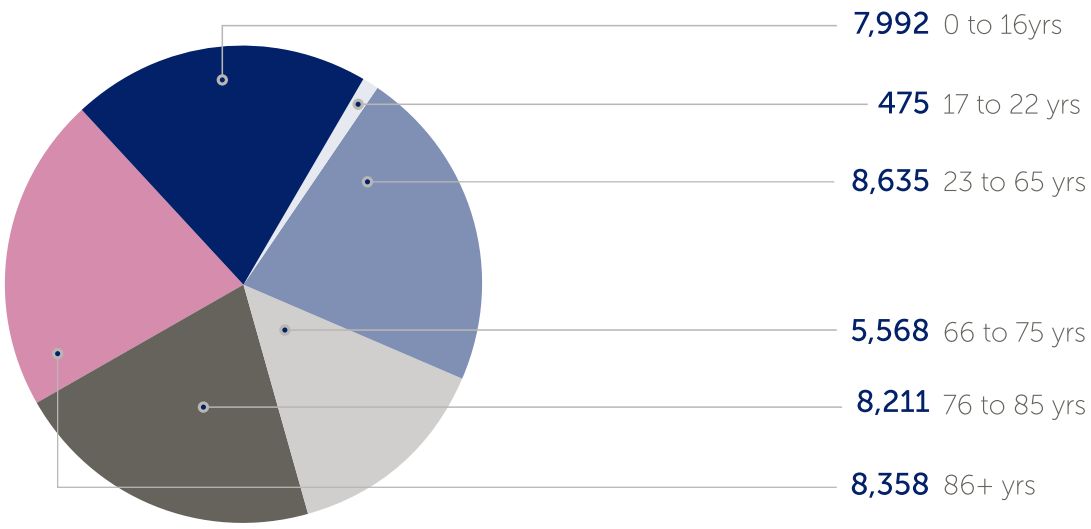
[2] *Total expenses include the following; salaries and benefits, drugs, oxygen, medical and other supplies, referred out services, equipment, fleet, sundry, buildings, leases and amortization and are according to CIHI MIS Reporting Guidelines.*

[3] *Figures include spending for health services reported by the provincial/territorial ministry responsible for health – does not include expenditures from municipal government or worker's compensation. [CIHI, National Health Expenditure Trends, 1975 to 2011, pg 92]*

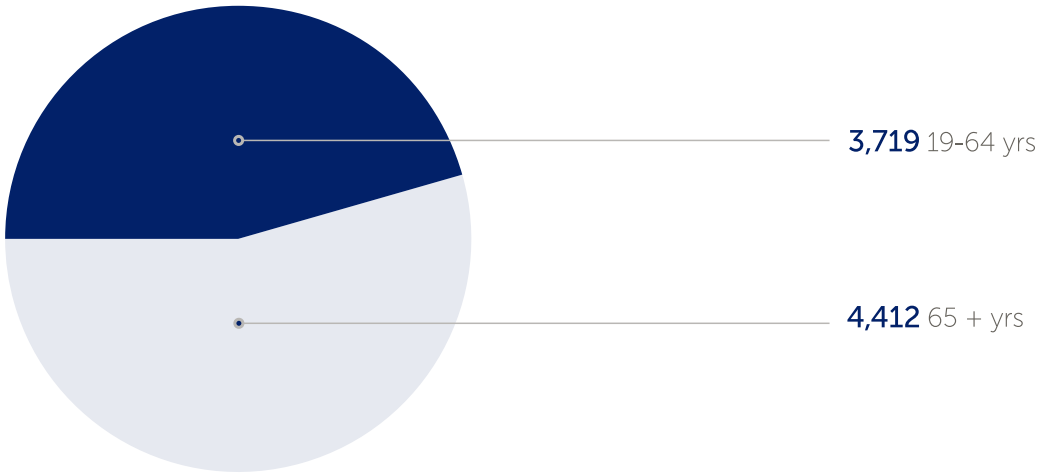
[4] *Population data from Statistics Canada, Demography Division, Annual Estimates of Population for Canada, Provinces and Territories, from July 1, 1971 to July 1, 2012*

PROFILE OF CLIENTS RECEIVING HOME CARE

Number of Individuals Receiving Home Care by Age Category (2010-11) (Extra-Mural Program ONLY)



Number of Individuals Receiving Social Development Long-Term Care in-home services[1] by Age Category (2010-12)



[1] *SD Long-Term Care Services are for individuals aged 19 and older. Services for those under 19 are under the Community-Based Services for Children with Special Needs program and are not included in these numbers.*

CLIENT GROUPING

The definitions used in New Brunswick's Extra-Mural Program (EMP)are:

Palliative/End-of-Life Care – "A home care client who has been assessed to receive home health services for a health condition that is not responsive to curative treatment, and for which the client and/or family have been informed by a physician that the client is expected to live less than six months." [MIS Standards-2011, 2010 Canadian Institute for Health Information] The goal of care is quality end-of-life care. Clients rating 50 percent or less on the Palliative Performance Scale are appropriate for this classification, along with any client where there has been a judgment that the service required is for end-of-life care (less than 6 months).

Acute – "A home care client who has been assessed to receive home health services for a health condition that is expected to respond to a time-limited, individualized care plan and discharge from home care services to independent management or recovery is expected within three months." [MIS Standards-2011, 2010 Canadian Institute for Health Information].

Chronic/Supportive Care-Maintenance -"A home care client who has been assessed to receive home health services and has ongoing unstable health conditions, living conditions, and personal resources that place the client at significant risk for institutionalization. The plan of care has no predicted discharge date." [MIS Standards-2011, 2010 Canadian Institute for Health Information]. The client's health condition(s) may be complex or multiple in nature. The primary focus of care is supportive, maintenance of health condition or prevention of deterioration.

Rehabilitation - "A home care client who has been assessed to receive home health services for a health condition that is expected to respond to a time limited, individualized rehabilitation plan that predicts improvements in the client's functional status and their discharge date." [MIS Standards-2011, 2010 Canadian Institute for Health Information]. The client has functional impairments (temporary or permanent), activity limitations and/or participation restrictions and has the potential and capacity for improvement in functional status. The primary focus of care is rehabilitative.

Long-Term Care Assessment- Individual requiring a long-term care assessment as part of the Long-Term Care program. This classification is only for clients for whom EMP is completing the LTC assessment.

The following table below shows the numbers of clients served according to the client grouping definitions (Acute Care Substitution, Maintenance, End-of-Life care (palliative), Rehabilitation, Long-Term Supportive care) established by a federal / provincial / territorial working group on continuing care in 2001.

Number of Individuals Served by Client Groups (EMP Only)

	2007-08	2008-09	2009-10	2010-11
Acute Care Substitution	11,687	11,972	11,778	14,040
End-of-life care (palliative)	1,334	1,301	1,394	1,865
Rehabilitation	10,277	10,484	11,071	14,248
Chronic[1]	9,668	9,118	8,583	10,063
LTC Assessment[2]	1,726	1,514	1,373	1,353
Total[3]	**34,692**	**34,389**	**34,199**	**41,569**

[1] Individuals with ongoing health condition(s) that may be complex or multiple in nature: The key feature is that the individual will have a continuing health condition which may be stable or unstable. The primary focus of care is supportive or maintenance of health condition or prevention of deterioration.
[2] Individual requiring a long-term care assessment as part of the Long-term Care program eligibility process. This classification is only for clients receiving the assessment component.
[3] Individuals may receive service through more than one program and therefore be counted more than once.

SERVICE DELIVERY

MODEL OF SERVICE DELIVERY

The delivery of acute, palliative, rehabilitative, and chronic health care services in the home requires a comprehensive team working collaboratively with other stakeholders to meet the needs of the client and family in a holistic manner. The active participation of the patient, family and other informal supports in the delivery of care is an essential aspect in the provision of EMP services.

Changing demographics, rising acuity of patients in the home, supporting individuals to remain at home safely, early hospital discharge and a variety of other factors are significantly impacting on the availability, and ability, of the informal support system to participate in the provision of personal care in meeting the needs of patients at home. Therefore, the EMP provides short-term and interim personal support services to clients in their home environment, based on assessed need and program parameters.

Home care support services are delivered through both the public sector and the private sector. Twenty-nine delivery sites in New Brunswick provide Extra-Mural Program (EMP) nursing services on a 24 hours-a-day, 365 days-a-year basis. This is accomplished through nursing shifts or, at a minimum, the on-call services of a nurse. EMP arranges for short-term personal support services for individuals with palliative care or acute needs. This service is used primarily to enhance and support the informal support network.

There are 58 approved agencies in the province that are contracted to provide home support and homemaking through Social Development (SD). Nursing and therapy services are provided by public employees through the Extra-Mural Program (EMP).

RANGE OF HOME CARE SERVICES & PROGRAMS

The **Extra-Mural Program** provides a broad range of services including acute care, palliative care, long-term care and rehabilitation service. It also provides a home oxygen program and participates as a partner in the Long-Term Care program.

Within EMP, the liaison nurse coordinates care between hospital, home and the community by:

- Engaging in cooperative discharge planning between the hospital and home.
- Reducing inappropriate admission by arranging for home and community services.
- Informing and educating hospital personnel of both the scope and the limitations of EMP.
- Providing information to the client and families.
- Arranging for necessary services and equipment, prior to discharge from a hospital facility.

EMP nurses with experience in home health care and community services work in Emergency Departments and use a combination of triage and screening to determine if seniors presenting there for care are able to return home and thereby avoid hospital admissions. This initiative, known as **Quick Response Home Care**, is provided in partnership with the Department of Social Development and allows seniors to return home safely, secure and supported.

The **Disability Support Program** was made available throughout New Brunswick in June 2010. This program provides individualized and flexible support to adults who have long-term disabilities, to address their physical, social or mental health needs.

Home care services required on a long-term basis are accessed through the Long-Term Care program, the Disability Support program and the Children with Special Needs program and are funded through eight regions of the SD. Fifty-eight government approved home support agencies provide home support services to clients of all ages. Clients also have the option to hire private home support workers.

Self Managed Care - In a number of cases, the client receives financial assistance from the government to purchase services directly from individuals or agencies. Clients may be eligible to receive up to 215 hours per month of home support services according to an assessment of their income and the level of assistance needed (Provincial Long-Term Care Program). Exceptionally, clients may receive up to 336 hours of service in order to avoid or delay placement in a hospital or residential facility.

Services Provided by Home Care (EMP and/or SD)

Nursing - RN & LPN	Provided through EMP
Home Support Worker / Personal Care Attendant	Provided through both EMP and SD
Physiotherapist	Provided through EMP
Occupational Therapy	Provided through EMP
Speech Language Pathologist	Provided through EMP
Social Work	Provided through both EMP and SD
Respiratory therapy	Provided through EMP
Pharmacy Services	Provided through EMP
Dietetics	Provided through EMP
Rehabilitation Assistant	Provided through EMP

Ancillary support

Oxygen	Provided through EMP for acute oxygen and long-term for individuals over 65 years. Provided by SD for individuals under 65 years.
Drugs	Individuals accepted for home care services receive the necessary drugs/supplies to support the intervention, based on need and reason for referral. EMP is the payer of last resort for all drugs. The majority of clients receive support from other payers.
Supplies	Provided by EMP to clients on service only, and includes medical supplies (e.g. dressings) necessary to support the intervention that is required. Provided by SD (supplies include dressing, stoma, etc).
Equipment	Provided by EMP for clients on service only to support the intervention that is required. Provided by SD including (wheelchairs, walkers, etc).

SERVICES CURRENTLY NOT FUNDED THROUGH EMP OR SD:

- Nurse Practitioner
- Pastoral Care
- Physician - integral members of the EMP home care team and, with the exception of salaried physicians, are remunerated on a fee for service basis for services provided to home care clients (visits, telephone, consultations, and admissions)

3. Quality & Accountability

HOME CARE INDICATORS

The Department of Health measures the quality dimensions of access, efficiency, appropriateness, safety, equity, and effectiveness. Home care indicators that are currently monitored at a provincial level through the Department of Health include:

- Amount of service delivery.
- Expenditures.
- Home care admissions and discharges.
- Referral source.
- Location of service.
- Long-Term Care Assessments.
- Client disposition at discharge.
- Safety issues.
- Number of staff.
- Hospital readmission rates for chronic obstructive pulmonary disease (COPD), (CMG 139) and congestive heart failure (CHF) (CMG 196).
- Impact of Quick Response Home Care Program on hospital admissions and emergency department visits (hospital admission rates, diversion rates, referral to community services, etc.).

QUALITY & ACCREDITATION

EXTERNAL ACCREDITATION

Accreditation is an effective way for health services organizations to regularly and consistently evaluate and improve the quality of their services. Organizations in Canada are accredited through Accreditation Canada, CARF, the Quebec Council of Accreditation (Quebec only) and/or registered with the International Standards Association (ISO).

Accreditation of home care organizations is not mandatory. All home support agencies that provide services to Social Development clients must meet the requirements as indicated in the Home Support Services Standards (2011) before they can be approved to deliver services. This is accomplished though the issuing of a Request for Proposal, whereby prospective agencies must indicate their compliance with requirements such as training and reporting of incidents.

As the Extra-Mural Program services are delivered by the RHA, they are included in RHA accreditation processes; both of which are accredited by Accreditation Canada. Six medical rehabilitation facilities are accredited with CARF.

High-quality care is evidence-based (appropriate), focused on the patient (or patient-centered), safe and timely (CIHI).

QUALITY COUNCIL

The **New Brunswick Health Council (NBHC)** is a public body created by the Government of New Brunswick to promote and improve health system performance. It has a two-part mandate. The first is to engage citizens in ongoing dialogue about important health system performance issues, in order to provide recommendations to the Minister of Health, and to bring the citizen/patient experience back to service providers and policy makers in a way that is objective, scientific and as useful as possible. The second involves measuring, monitoring and reporting on health system performance to both the public and the health system partners. Together, these two streams of activity contribute to greater accountability, improved health system performance, and promotion of a more citizen-centered health care system.

The home care specific indicators tracked by the New Brunswick Quality Council include:

- Extra-Mural Program – Clients served per 1000.
- Extra-Mural Program – Percent referred from community.
- Extra-Mural Program – Percent referred from hospital.
- New Brunswick Department of Social Development - Average number of days to complete long-term care generic assessment.

CLIENT / PATIENT ADVOCATE

Client Advocate Services was established to: inform patients of their rights when dealing with New Brunswick Medicare; provide help and guidance on matters of dispute or disagreement; ensure the *Medical Services Payment Act* is appropriately applied; and ensure the process of the different sections of the Act is respected. Examples of issues that can be brought to the attention of the Client Advocate Services include non-payment of services and eligibility issues.

The Regional Health Authorities have patient advocates to respond to patient and family concerns and questions regarding services and care. These advocates assist in resolving misunderstandings or problems within the RHA, which includes the Extra-Mural Program, between patients, families and staff. There is no patient advocate specific to home care.

SYSTEM APPROACHES TO QUALITY IMPROVEMENT

The **New Brunswick Health Council (NBHC)** promotes the improvement of health service quality in the province through the following six dimensions:

1. Accessibility
2. Appropriateness
3. Effectiveness
4. Efficiency
5. Equity
6. Safety

In addition to evaluating health service quality, the NBHC evaluates how the system is moving toward being more citizen-centered while targeting the needs and preferences of individuals and communities. The NBHC uses the quality dimensions through the continuum of care (primary health, acute care, supportive/specialty and palliative/end-of-life care) to further meet its objective. The Council conducted a survey to evaluate the quality of home care provided to New Brunswickers. Citizens who have recently received home care services, for which costs were entirely or partially covered by public funds, were contacted by phone and asked about their experiences. The survey looked at accessing and navigating services, meeting the needs of clients and their families, provider/client communication, safety, equity based on preferred language -of service and overall satisfaction with services. The final report is available at http://www.nbhc.ca/home_care_survey.cfm.

SAFETY

Client safety within the home is monitored through systems internal to the RHAs. Specific programs, such as the falls prevention program, target high risk populations such as seniors. Policies and procedures support staff to practice safely. Specific practices include:

- Dispatching two person teams in situations that are deemed unsafe.
- Ensuring staff have an understanding of their personal safety measures and recognize when to leave a home if they feel unsafe.
- Providing staff with regular education that includes safe driving tips and other safety information.

HOME CARE RESEARCH

The province, through the **NB Health Research Foundation**, sponsors a wide variety of investigator driven research, including studies which touch upon various aspects of home care. In 2011/12 three such projects, totaling approximately $75,000, were funded. These projects examined topics such as best practice guidelines in nursing homes, sustainable home support for seniors and the effects of health system organization on rural seniors.

High-Tech Home Care

Expanded technology-enabled home care offers a promising pathway to bend the cost curve for ever-growing health care expenditures.

Independent of the economic benefit, the moral value of enabling older members of society to live in grace and dignity in their own homes, with a ripple effect on their caregivers, is arguably the most important – if unquantifiable – benefit of home care. [Kayyali et al, 2011].

(Canadian Home Care Association, A Vision for Technology in Home Care, 2013)

4. Information Technology

ELECTRONIC HEALTH RECORD (EHR)

The provincial strategy includes the development and implementation of an electronic health record to allow information to flow between hospitals, doctors' offices, Extra-Mural Program, Public Health, Mental Health, pharmacies, laboratories and diagnostic imaging, and to allow access by authorized care providers anywhere in the health care system.

Currently, EMP home health records are manual, and therefore not fully incorporated into an overall regional or provincial electronic client health record. One unit in the province is using electronic clinical documentation at point-of-care. Attaining an information management system that supports point-of–care decision-making and documentation remains a priority for the program.

Social Development information is collected in the provincial administrative database (NBFamilies). A web enabled assessment tool is used for collection of data for the Long-Term Care program.

USE OF SYSTEM EFFICIENCY TECHNOLOGY

Sharing of information is done within the framework of the Personal Health Information Privacy and Access Act (PHIPAA), which directs consent, collection, disclosure and documentation of Personal Health Information. Electronic communication does not yet exist between home care and physicians, or between frontline home care staff. However, technology links home care and hospitals for referrals and exchange of clinical information. Technology applications are also used for submission of indicator data and for financial data exchange. In the discussion papers arising from the Premier's self-sufficiency initiative, it was noted that to deliver home care services, electronic delivery/e-health is essential.

USE OF TECHNOLOGY FOR CLIENT CARE

Telehealth has been introduced into home care for palliative care, acute care, chronic care and rehabilitation patients. EMPcare@home is a tele-home care project that demonstrated the effectiveness of tele-home care, timely staff intervention and an enhanced patient education program on client self-management of chronic disease. Vital sign data was sent over the telephone line and when retrieved, specialized software quickly alerted clinicians of parameter breaks, allowing for quick client prioritization for intervention which helped to break the cycle of emergency room visits and hospital readmissions.

The province's Strategic Telehealth Plan identifies home health care as a priority.

5. Health Human Resources

CLINICIANS PRACTICING IN HOME & COMMUNITY CARE

The Department of Health has begun to consider strategies that focus on improving the quality of work life in the health care system, as well as issues of professional roles, accountability, relationships and scopes of practice.

HEALTH CARE PROFESSIONALS

EMP Staff - Full Time Equivalents (Funded)

	2006-07	2010-11
Dietician	22	25.4
Occupational Therapist	62	62.2
Pharmacist	Contracted	1 (Demonstration project)
Physiotherapist	45	45.3
Registered Nurse	343	362.2
Registered Practical Nurse / Licensed Practical Nurse, Nursing Assistant		23
Respiratory Therapist	32	35.2
Social Worker	17	20.4
Speech Language Pathologist	52	53.9
Rehabilitation Support Personnel		13

Within the Extra-Mural Program each professional has the responsibility to provide case management as a component of the program's Care Coordination model. The EMP Primary Provider (the service provider who has the greatest ongoing involvement with and on behalf of the client) Care Coordination is the collaborative client-driven process of providing client care in a timely and responsive manner utilizing the appropriate services in the right place, at the right time and for the right client. The EMP recognizes the client as an equal participant in the identification of goals and organization of services.

UNREGULATED STAFF

Social Development has contracts with approximately 58 home support agencies that supply in-home services to eligible LTC clients. There is no registry for home support workers.

Other unregulated staff employed within the Extra-Mural Program (EMP) includes rehabilitation support personnel who work with physiotherapists, occupational therapists and speech language pathologists. Known collectively as 'rehab assistants', there are 13 within EMP as of 2010-11. These staff work under the clinical direction and clinical supervision of the regulated staff and under the management of the unit manager.

EDUCATION & TRAINING

HEALTH CARE PROFESSIONALS

Enhanced inter-professional approaches to education and care delivery are expected to improve access to timely, integrated care and make more effective use of scarce health human resources, while offering a more collegial, supportive and rewarding work life for health care providers.

The Extra-Mural Program operates on the philosophy of service that relevant training and education of health service providers (client, informal and formal), based on the needs of the client, is essential in the provision of quality home health care service. The program also believes the development and maintenance of an ongoing learning environment is essential to recruit and retain competent, innovative, effective and efficient service providers.

UNREGULATED STAFF

Home support workers must have completed either the Personal Support Worker (PSW) Training Program provided by the NB Community College or a similar program approved by the Social Development provincial consultant. In collaboration with Social Development and the Department of Post-Secondary Education Training and Labour, The New Brunswick Home Support Association is developing a standardized curriculum that is not only sensitive to the realities facing the home support sector, but will better prepare future workers with the knowledge and skills necessary to provide quality care and support to their clients.

INTER-PROFESSIONAL COLLABORATION

The Extra-Mural Program (EMP) team members practice with the belief that home health care services are best provided through an interdisciplinary team, with care coordination for each client / family. Through this interdisciplinary approach, the client benefits from many practitioners with specialized training and expertise sharing and coordinating care together with the client. Home health care is holistic in nature, and is delivered through the provision of coordinated services. In order to meet the identified needs of the client, EMP providers recognize the contribution of other providers, establish effective communications and work together in partnership.

FAMILY CAREGIVER

Home care policies acknowledge the important contribution of the family caregiver. A 'Caregiver Strain' questionnaire can be administered when the health care professional is completing the assessment for services. Respite services can be provided in the home or in residential settings.

Home health care services must incorporate the appropriate use of, and support for, client self – care, informal and formal service providers. Relevant training and education of health service providers, based on the needs of the client, are essential in the provision of quality home health care service. The Extra-Mural Program (EMP) has a policy regarding the delegation of tasks or activities by an EMP service provider to individuals, such as family members. Appropriate delegation is important in ensuring quality of client services.

6. Provincial Initiatives

PREFERRED PRACTICES MODEL

The Preferred Practices model for the health disciplines on the interdisciplinary EMP team is currently being updated and revised. The EMP Preferred Practice document defines the roles and responsibilities of each health discipline working within the EMP interdisciplinary team. This tool guides consistency in clinical practice such that services are coordinated, client-centered and integrated.

PRIMARY HEALTH CARE

A consultation on primary health care was conducted in 2011. Recommendations were directed at ensuring that all New Brunswickers have access to a family practice team that is able to provide them with personalized, comprehensive and coordinated primary health care services. Physician involvement is a critical factor in the overall success of EMP.

CHRONIC DISEASE MANAGEMENT

The **Chronic Disease Prevention and Management Framework for New Brunswick** provides a context for the shift toward health promotion and disease prevention at the core of health care service delivery. Evidence-based care processes, supported by automated clinical information and decision-support systems, will enable teams of health care providers to deliver proactive, integrated care across a variety of settings closer to where people live, work and learn. Expanded use of existing technologies, including telephone, internet, e-mail and remote monitoring, will also be used to support patient self-management as an integral part of a comprehensive approach to chronic disease management.

SENIORS AND AGING

The Long-Term Care Generic Assessment tool was revised and has been in use since June 2011. This new assessment tool makes it easier for professional health care staff to recommend the right type of service at the right time in a senior's life.

MENTAL HEALTH

Alignment of mental and public health services under the Regional Health Authorities was an important step toward building a more integrated health care system. The '**Action Plan for Mental Health in New Brunswick 2011-18'** is designed to improve the social determinants of health, provide individualized care to those in need, improve mental well-being in family, community and workplace settings, and address stigma in the community at large.

PALLIATIVE CARE (END-OF-LIFE CARE)

Significant enhancements have been made in the delivery of palliative care services, including enhanced human resources and personal support services funding. The EMP Palliative Care Guidelines enable consistent palliative care services in the home setting throughout the province. A provincial Palliative Care Strategy is under development. The strategy will be developed with the assistance of a multi-stakeholder advisory committee. It will cover the continuum of care locations, home, hospitals, residential and long-term care facilities.

7. Challenges

There are several key challenges facing home care in New Brunswick:

- An aging population with increasingly complex care needs and co-morbid chronic conditions.
- Changes in public expectations that include increasing demand for care at home and the use of innovative technologies.
- Recruitment and retention of qualified home support workers includes issues related to wages and transportation costs, as well as ongoing training and education.
- Escalating costs at a rate that is greater than the increase in government revenues.

8. Opportunities

Home care is included within the Provincial Health Plan that articulated over 100 initiatives to address the future challenges facing the health system. These initiatives are framed within six key pillars:

- Achieving a better balance between the need to promote good health and provide health care for those who are ill.
- Enhancing access to health services when, where and how they are needed.
- Improving the overall efficiency of the health care system.
- Harnessing innovation to improve safety, effectiveness, quality and efficiency.
- Making quality count in the planning, implementation and delivery of all health care services.
- Engaging partners in all aspects of health care delivery.

The EMP recognizes the contribution of other providers, establishes effective communication, and works in partnership to meet the identified needs of the client. The Department of Health and Regional Health Authorities are currently working with other partners and stakeholders to develop a four year strategic plan. Emerging themes include ensuring citizens receive quality home health care services by the right provider in a seamless and timely way, enhancing partnerships, integration, leadership and increasing the program's electronic information management capacity. The perspective of New Brunswickers is vital and will continue to be reflected in the planning and delivery of services.

Home care services are a crucial component in the effective delivery of services to seniors, persons with disabilities , and individuals with acute, palliative, and chronic care and supportive care needs across New Brunswick. Demand for these services will continue to increase with the growing senior population; therefore, decisions will need to be made to support an affordable and sustainable system for those requiring home care services, well into the future.

ACRONYMS / ABBREVIATIONS

ALC -	Alternate Level of Care
CHF -	Congestive heart failure
COPD -	Chronic obstructive pulmonary disease
CIHI -	Canadian Institute for Health Information
CMDB -	Canadian MIS Database submission
DH –	Department of Health
EHR -	Electronic Health Record
EMP -	Extra-Mural Program
HCRS -	Home Care Reporting System
LTC -	Long-Term Care
NBHC -	Brunswick Health Council
NBPDP -	New Brunswick Prescription Drug Program
PHIPAA -	Personal Health Information Privacy and Access Act
PSW –	Personal Support Worker
RAI-HC -	Resident Assessment Instrument—Home Care
RHA –	Regional Health Authority
SD –	Social Development
SEP -	Single Entry Point Project

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Harmonized Principles for Home Care

Guide policy and program development

Support consistency and equity across the country

Facilitate benchmarking and sharing of best practices

ACCOUNTABLE CARE

Home care is accountable to clients and their caregivers, providers, and the health care system for the provision and ongoing improvement of quality care.

Transparency:
Report on performance metrics and outcomes to inform the public on the quality of care.

Quality:
Monitor performance indicators to support continuous improvement.

Value:
Demonstrate value to clients and their caregivers, providers and the health system.

NOVA SCOTIA

HOME CARE IN **NOVA SCOTIA**

The Canadian Home Care Association definition of home care reflects **Nova Scotia's** vision for home care.

> Home care is an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the family caregiver.

However, in Nova Scotia the provision of health promotion and teaching, rehabilitation and social adaptation, and integration, although developing, is limited.

NOVA SCOTIA
BY THE NUMBERS...

55,284 sq km **LAND AREA**	921,727[1] POPULATION (2011)	**57%**[3] Percent population in urban settings defined as an area with a population of at least 1,000 and with no fewer than 400 persons per square kilometre (2006)	
46%[2] Dependency ratio (2009) Ratio of the population aged 0-19 and 65+ to the population aged 20-64	16.5%[1] **Population Seniors 65+ yrs (2011)**	80.1 years[1] **LIFE EXPECTANCY (AT BIRTH)**	**$4,315.55**[2] Public sector health care expenditure per capita (2011 Forecast)

[1]Statistics Canada | [2]Canadian Institute for Health Information (CIHI) | [3]Human Resources and Skills Development Canada

1. Governance & Organization

HEALTH CARE SYSTEM STRUCTURE

The Nova Scotia Department of Health merged with the Department of Health Promotion and Protection in 2011 to become the **Nova Scotia Department of Health and Wellness** (DHW). This was in recognition that health care is a continuum that requires a focus on both prevention and treatment. DHW is responsible for the strategic direction of the health care system, including the development, implementation and evaluation of provincial health policy. This department develops, or ensures development of, standards for delivery of health services, and monitors, measures and evaluates the quality, accessibility and comprehensiveness of health services. Additionally, DHW conducts financial and human resource planning, administers the allocation of available resources for provision of health services and establishes requirements for information systems used in the health care system.

Publicly funded home care services fall under the jurisdiction of DHW through its Continuing Care branch. DHW is responsible for auditing and compliance monitoring of home care providers according to the appropriate legislation, policies and standards. Responsibility for funding of annual budgets of the home care agencies remains with DHW and includes a reconciliation process at year-end based on the volume of service.

The nine **District Health Authorities (DHA)** plus IWK Health Centre are accountable for the day-to-day delivery of health programs and services, including hospitals, community health services, mental health services and public health programs in their districts. As a result of the recent integration of

District Health Authorities

1. South Shore Health Authority
2. South West Health Authority
3. Annapolis Valley Health Authority
4. Colchester East Hants Health Authority
5. Cumberland Health Authority
6. Pictou County Health Authority
7. Guysborough Antigonish Strait Health Authority
8. Cape Breton Health Authority
9. Capital District Health Authority
10. IWK Health Centre

Continuing Care Coordinators with the nine DHAs in 2009, the DHAs are now responsible for the assessment of clients and authorization of home care services, as well as the oversight of service delivery. Service Level Agreements are under development between the home care agencies and the DHAs, and are expected to be signed in 2012. Funding remains with DHW at this time.

The standards and policies for home care programs are established provincially by DHW. The DHAs are responsible for services and must provide a range and amount of service to help maintain client independence and well-being at home, and strive to ensure that appropriate care is provided to clients in their districts. DHAs must consider the needs of the entire district and operate within available resources.

The District Health Authority (DHA) is accountable:

- To the Nova Scotia House of Assembly, through the Minister of Health and Wellness, for proper expenditure of public funds to provide home care services.
- To govern, plan, manage, monitor, evaluate and deliver home care services in the district.
- To comply with provincial policies established in the Nova Scotia DHW Home Care Policy Manual.
- To report on home care services, as required by Nova Scotia DHW.

HEALTH CARE & HOME CARE LEGISLATION

Each DHA is vested with responsibility for the delivery of home care services. Though not limited to the following, the DHA is responsible for compliance with the:

Adult Protection Act (1989) – is relevant to those in the community. The purpose of this Act is to provide a means whereby adults who lack the ability to care and fend adequately for themselves can be protected from abuse and neglect by providing them with access to services which will enhance their ability to care and fend for themselves or which will protect them from abuse or neglect.

Health Authorities Act (2000) – sets out the general regulations for the District Health Authorities including the boundaries, governance, structure, oversight, duties, accountabilities, reporting structure and fiduciary responsibilities. The DHAs are responsible for the delivery of home care services. The Department of Health retains responsibility for funding, monitoring, measuring and evaluating the quality, accessibility and comprehensiveness of community-based health services.

Homes for Special Care Act (1989)* last revision 2010 – an Act to revise and consolidate the Boarding Homes Act, the Nursing Homes Act, and part of the Social Assistance Act.

Personal Directives Act (2008) – enables Nova Scotians to document their wishes regarding the personal care decisions that are made for them, and by whom, in the event that they are incapacitated and are unable to make these decisions themselves. The Act enables the appointment of a substitute decision

maker; the ability to set out instructions or general principles about what or how personal care decisions should be made when they are unable to make the decisions themselves; and, provides for a hierarchy of statutory substitute decision makers to make decisions regarding health care, placement in a continuing care home and home care where the individual has not prepared a personal directive in relation to those decisions. The Public Trustee is listed as the last substitute decision maker in the hierarchy.

Self-Managed Support Care Act (2005) – established a province-wide program that enables approved recipients to receive self-managed support services in their homes or other approved settings by hiring care providers directly. The recipient of self-managed support services is permitted to select the person that provides the support services and funding is provided either directly to the recipient or through a funding delivery agent designated by the Minister of Health.

EVOLUTIONARY MILESTONES

1988

Coordinated Home Care Program for individuals over the age of 65 with limited income or long-term disabilities. Home Care Coordinating Agency, overseen by the Department of Community Services, established to deliver program to seniors, disabled persons and families at risk.

1995

Responsibility for Home Care Nova Scotia program transferred to Department of Health. The key components included: centralized intake, policies for eligibility, entitlement and payment, assessment and case management. Care Coordinator positions established in communities and hospitals across the province.

1996

Funding for home oxygen service was added as an entitlement under Home Care Nova Scotia.

2000

Home Care Nova Scotia and long-term care services integrated under Continuing Care. Seniors' programs (Adult Protection, Residential Care Facilites and Community-Based Options, Long-Term Care Placement, In-home Support) previously administered under Department of Community Services were transferred to the Department of Health. This initiative was in response to the government's commitment to development of a Continuing Care system with a single-entry access point.

2001

Four Regional Health Boards (acute care) replaced by nine DHAs and the IWK Health Centre to enable health care decisions to be made at a local level, closer to the community level, aimed at improving accountability for health care decisions.

Rural Palliative Home Care Project initiated in northern region of Nova Scotia.

2002

One toll-free phone number established to provide a single-entry access point to vital services for seniors and others in need of continuing care across the province, enabling them to access an assessment for home care services, placement into nursing homes and other long-term care facilities and adult protection workers.

2004

Challenging Behaviour Program initiated in order to provide a comprehensive and integrated approach to the care of people who display difficult behaviours in long-term care or home care environments.

2005

Cost of Care initiative led to funding of health care services in long-term care facilities.

Self-Managed Care Program launched.

2006

Continuing Care Strategic Framework Plan developed.

2007

Increased access to monthly supply of home oxygen, including portable tanks, for clients in Home Oxygen Program and increased home care services for those in last three months of life.

2009

Continuing Care Services, including authorization and delivery of home care, devolved to DHAs, although funding remained with DHW.

2011

Home Care Policy Manual introduced to facilitate consistency in home care services and home care standards throughout the province.

2012

Emphasis in 2012-13 budget on increasing and adding to home care services, with goal of supporting people in their home and community when possible rather than admission to long-term care facilities.

MANDATE, MISSION, PRINCIPLES & PRIORITIES

MANDATE

Continuing Care is mandated to deliver an array of services to assist Nova Scotians of all ages, who have assessed unmet needs, in order that they can achieve and maintain their maximum independence while living in their own homes and communities. Home care helps people of all ages who need assistance to maintain their optimal well-being and independence at home. Home care serves clients with acute, chronic and palliative needs. Home care encourages and supports assistance provided by family and/or community.

PRINCIPLES OF HOME CARE

The provision of home care services is guided by the following principles:

- People can usually retain greater independence and control over their lives in their own homes.
- Most people prefer to remain at home and receive required services at home.
- Support provided by family and friends should be encouraged and preserved and, if necessary, supplemented.
- Services should be person-centred, assisting individuals to maintain their optimal independence and well-being and should avoid creating unnecessary dependencies on home care.
- Home care should assist people to access needed health and other community-based services.
- Service decisions in home care should be based on assessed client need and risk to the client if service is not provided.
- Clients and their supporters should help identify their needs, establish goals, and develop plans to meet goals.

- People with the greatest need for home care should receive priority for service.
- Individuals have the right to be treated with kindness, dignity and respect.
- An individual's autonomy is respected, which includes a person's right to knowingly live at risk to one's self and to accept or refuse services.
- Individuals are presumed to have capacity unless evidence demonstrates otherwise.
- Home care services should be provided in a manner that respects client's cultural values.
- District Health Authorities should have significant responsibility for planning and ensuring delivery of home care services.
- Home care should provide high quality, safe and effective services.
- Home care utilizes service providers to the full scope of their practice.
- Home care promotes continuity of care by providing the same service providers to clients where possible and appropriate.
- Home care recognizes that care in a facility is appropriate when the resources of the individual, family, community and home care program cannot adequately sustain the individual at home.

HOME CARE PROGRAM OBJECTIVES

The Nova Scotia Home Care Program objectives are to:

1. Help people maintain optimal well-being and independence at home by:
   - Determining needs and abilities, developing and coordinating plans of care.
   - Teaching self-care and coping skills.
   - Improving, maintaining or delaying loss of functional abilities.
   - Promoting and supporting family and community responsibility for care.
   - Supporting palliative, supportive and acute care provided by family, friends and others.

2. Facilitate appropriate use of health and other community-based services by:
   - Preventing or delaying the need for admission to long-term care facilities.
   - Supporting people waiting for long-term care admission.
   - Preventing the need for hospital admission, making earlier discharge from hospital possible, and reducing the frequency of re-admission.
   - Helping individuals and families access needed services.
   - Promoting volunteer participation.
   - Educating public and community agencies about home care.
   - Participating in local service planning and coordination.
   - Developing an awareness of, and integrating complementary services provided by, other organizations and agencies.

3. Make the best use of home care resources by:
   - Serving people with the greatest need first.
   - Operating economically and efficiently.
   - Communicating relevant information in a timely manner.

4. Meet client needs and optimize client well-being and independence within available home care resources, while working cooperatively with other community agencies, organizations and individuals.

The **current home care** priorities for the Department of Health and Wellness are to:

- Remove potential barriers to accessing home care.
- Increase utilization of existing and new programs (e.g. caregiver benefit, personal alert assistance, supportive care).
- Further expand home care services (type and amount of service).

HEALTH SYSTEM PRIORITIES

The Nova Scotia Department of Health and Wellness priority is "Better Care Sooner", which encompasses the following:

- Establish a plan to improve emergency care and enhance primary care in Nova Scotia.
- Reduce wait times - make improvements to surgery wait times with emphasis on knee and hip surgery. In addition, there will be research and analysis activities around utilization of key resources, such as operating rooms, and a costing analysis of national wait time targets.
- Focus on both prevention and treatment by establishing acute and chronic disease targets.
- Implement a Mental Health Strategy that includes Concurrent Disorders and ensures timely access to quality services and high levels of patient satisfaction.
- Enhance quality and patient safety through the establishment of a new Quality and Patient Safety Advisory Committee (QPSAC).
- Develop a physician resource plan in order to prepare for future needs in the province.
- Implement e-Health Technology Solutions – diagnostic imaging solution (DIS), National Ambulatory Care Reporting System (NACRS) and electronic health record (EHR).
- Invest in more Nurse Practitioners to work in community-based teams.
- Adopt the "Every Kid Counts" program that includes, among other initiatives, a childhood obesity prevention strategy, youth suicide prevention strategies and activities.
- Integrate Continuing Care into the DHAs/IWK in 2011-12.
- Improve life for seniors by giving seniors options to stay in their homes and communities longer; meeting their health needs in a more holistic way; ensuring they receive the care they need in the right place; and providing a drug plan to enable Nova Scotians to afford medications they need.
- Implement Provincial Workforce and Immigration Strategies with HHR planning and Physician Resource Plan.
- Adopt the Expenditure Management Initiative.

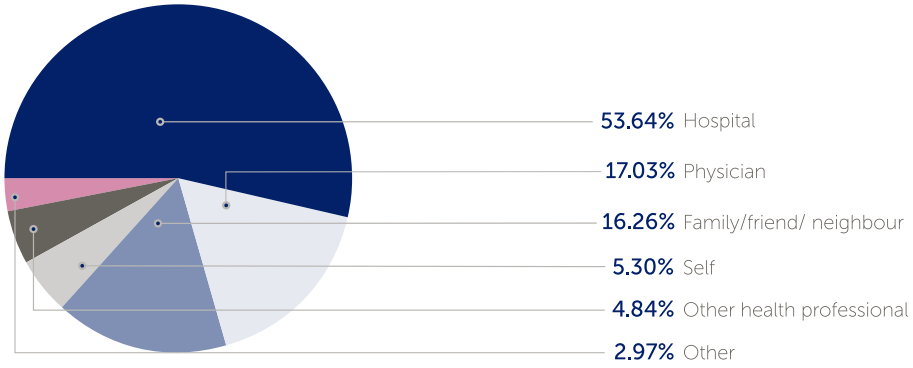
2. Access, Funding & Service Delivery

ACCESS TO HOME CARE SERVICES

Continuing care provides single entry access (SEA) to home care, long-term care and adult protection services through a province-wide, toll-free number. Care coordination staff of the DHAs are responsible for all case management functions including intake, assessment, service planning, resource allocation, authorization of service and referral to other community-based resources.

Anyone can refer an individual for assessment, including self, family, neighbour or health care provider.

Home Care/Long-Term Care Referrals 2011/12



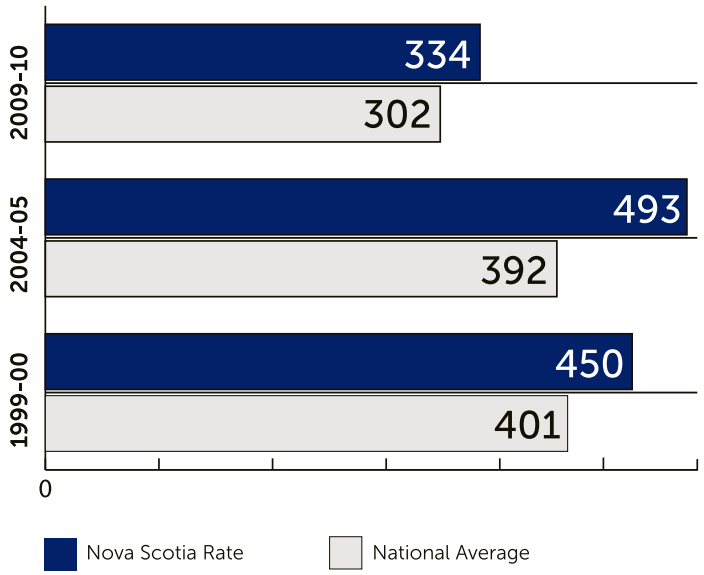
Access to home care is generally consistent between rural and urban settings. Capital District (DHA 9) has had a chronic wait list for home care, particularly for home support, and sporadically for nursing. There is also a wait list for the Bed Loan Program, most frequently in DHA 9. As the heaviest populated area, there is more demand and a shortage of home care staff, particularly continuing care assistants and home support workers. There appear to be some challenges with the process for referrals to home support agencies and efforts are now underway by all parties to rectify the causes for delays.

APPROPRIATE ACCESS TO HOME CARE & COMMUNITY CARE

Hospitalization rates for conditions that may be cared for in the community are one indicator of appropriate access to community-based care. These conditions include diabetes, asthma, alcohol and drug dependence and abuse, neuroses, depression and hypertensive disease. Preventive care, primary care and community-based management of these conditions may reduce the need for hospitalization.

Hospitalization Rates For Ambulatory Care Sensitive Conditions

Age Standardized Rate per 100,000 younger than 75



Health Indicators Reports, CIHI

Alternate Level of Care (ALC)

ALC is a measure used to reflect when a patient is occupying a bed in a hospital and does not require the intensity of resources / services provided in this care setting.

In 2010-11 there were 2,849 clients in ALC beds in Nova Scotia. This represented 3 percent of the hospital patients and 18 percent of the hospital bed days.

ELIGIBILITY, COVERAGE & UTILIZATION

ELIGIBILITY

Residents of Nova Scotia with unmet needs who have been assessed as requiring home care due to an illness or disability that can be cared for safely and effectively at home, and have or are in the process of applying for a Nova Scotia health card.

AGE OF CLIENTS

All ages.

DIRECT FEES AND INCOME TESTING

No fees for services are assessed to clients whose net income falls within or below the designated Nova Scotia Home Care client income category, or who are in receipt of income-tested government benefits (e.g. Guaranteed Income Supplement, Income Assistance, Family Benefits).

The maximum monthly client fee charge is determined by the Care Coordinator according to the client fee determination process. Clients in chronic home care may be charged an hourly fee for home support, personal care and family relief services provided by home support workers (ie. CCAs/ HSWs).

Clients receiving home oxygen services are assessed a monthly fee based upon net income and family size.

No fees are charged for nursing services or personal care services provided by Registered Nurses or Licensed Practical Nurses, or for physician services provided through Medical Services Insurance (MSI).

SUPPLIES, EQUIPMENT AND MEDICATION

Medical supplies used during the nursing visit are provided at no direct charge to the client. All medical supplies used between visits are the responsibility of the individual and/or family.

Clients are responsible for borrowing, renting or purchasing medical equipment required in the home, except equipment provided through home oxygen services. However, the HELP - Bed Loan Program provides temporary loans of hospital-type beds to eligible Nova Scotians. The program is funded by the Department of Health and managed by the Canadian Red Cross - Nova Scotia Region. Eligible individuals receive the bed at no charge and for as long as they need it.

Chronic home care clients and/or family are responsible to obtain, pay for, and transport all medications, and to have in place any medications to be administered during nursing visits.

LIMITS / GUIDELINES TO SERVICE PROVISION

The maximum home support per 28 day service plan is 100 hours.

The maximum number of nursing visits per 28 day service plan is 60. (Nursing home care is authorized and measured in "visits" rather than hours, as each visit can vary depending on the clients condition – e.g. as a wound heals, less time is needed for a visit, but this cannot usually be predetermined).

Monthly maximum service limits shall not apply when:

- The client meets the palliative home care criteria.
- The client is on a waitlist for placement in a long-term care facility funded by DHW and is being supported in the community because there is no suitable bed available within 100 km of the client's community of choice.

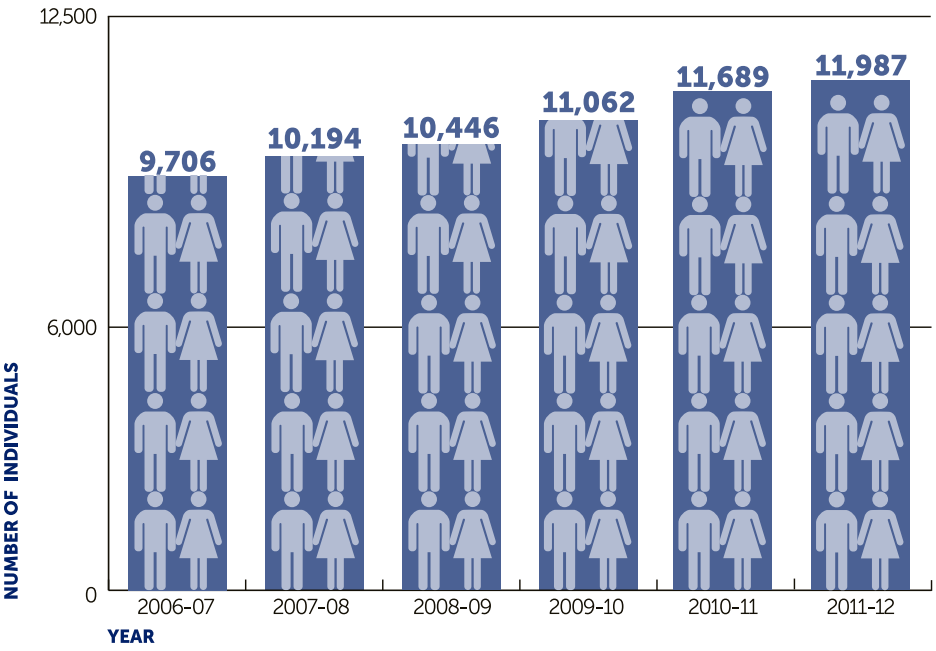
In "extraordinary circumstances", when clients only require home support services, the maximum amount of home support hours should not exceed 150.

DETERMINING CLIENT NEED - ASSESSMENT TOOLS

Care Coordinators use the RAI-Home Care assessment to identify client needs. The RAI-HC assessment is imbedded in the customized assessment software called SEAscape (**S**ingle **E**ntry **A**ccess **s**imultaneous **c**lient **a**ssessment, **p**lacement and **e**valuation) on laptop computers used by care coordinators. Upon completion of the assessment, the care coordinator reviews the Clinical Assessment Protocols (CAPs) that have been triggered and, using their professional judgment, determines a plan of care in consultation with the client and/or family. A verbal summary of the RAI assessment is provided to the client, family and where appropriate the adult protection workers. A complete copy of the assessment is provided to the home care provider organization who shares it with the nursing and home support staff assigned to the client, as appropriate. The assessment is also shared with the long-term care facility as required.

Care Coordination staff are located in communities throughout the province and assessment services are available in all general tertiary, regional and community hospitals in Nova Scotia. Intake and care coordination, including assessments for home care services, are only available eight hours per day, seven days per week. Service provision, nursing and home support are available to clients 24 hours per day, with some exceptions where there are staffing shortages.

Admissions to Home Care



In 2011-12 approximately 35 percent of persons waiting for long-term care were not receiving publicly funded home care, raising the question of how this group was managing to remain at home when their care needs were significantly high to require long-term care placement. A project has been initiated to determine why these individuals have not been admitted to the provincial home care program and to assess whether admission to long-term care could be delayed if home care services are provided.

SETTINGS OF CARE

Home care services in Nova Scotia are provided in the following settings:

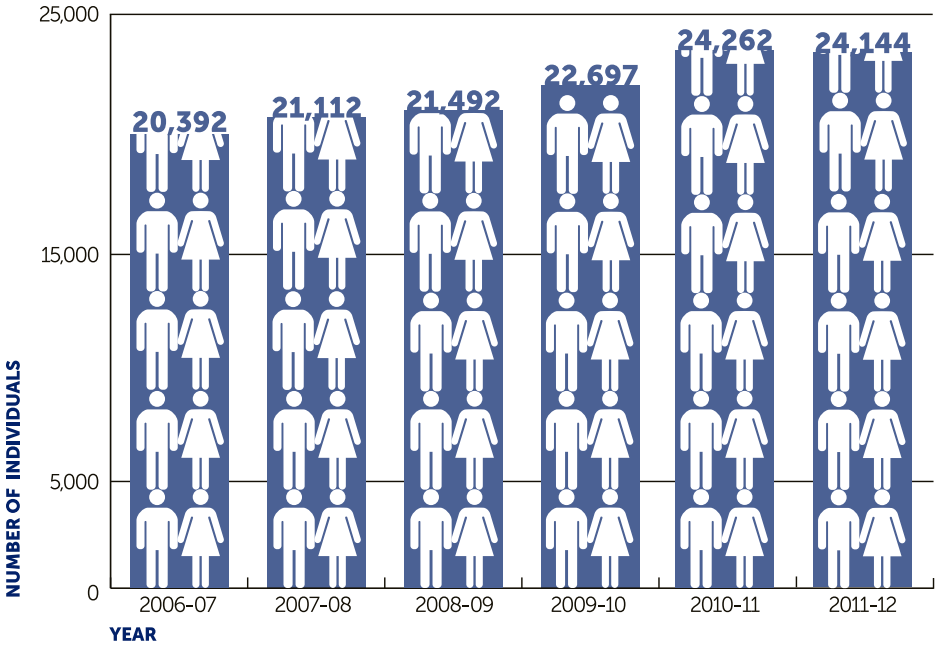
- Client's home
- Nursing home and DCS residential facilities for acute nursing and home oxygen
- On reserve
- Street for homeless population

INTEGRATED MODELS OF CARE

An initiative in 2008 developed a framework for integrating care, in order to better support Nova Scotians in their communities. The work laid out a 10 year plan for creating a seamless, client-centred integrated community-based system of care. For example, the concepts of "admission" and "discharge" from services are less important than the efforts to avoid service disruption during transitions.

The integrated system includes more than shared services, it represents all components working together to meet client needs and better manage client transitions. It is flexible and responsive. Supporting this approach has been a shift in administrative infrastructure to achieve linkages that span traditional boundaries between components of the health care system, including primary care, acute care, mental health, continuing care, and other services that support continuing care clients. For example, cross appointments of staff (between primary health care, mental health and acute care) allow for business planning and budgeting across the continuum. As of 2012 work continues to integrate community-based care with the Department of Community Services. Individuals with disabilities are joining the integrated system.

Number of Individuals Receiving Home Care Services[1]



[1]*Includes home care (nursing) home support, care giver allowances and personal alert assistance.*

FUNDING

Home care expenditures include: Care coordination, nursing and home support services, home oxygen, and palliative care. Total health care expenditures include: departmental administration, emergency health services, medical payments, Pharmacare program, other insured programs, other health initiatives/ other programs, home care (nursing and home support) and home oxygen.

Public Expenditures on Home Care

YEAR	Annual Public Home Care Expenditure ($' 000,000)	Total P/T Government Health Expenditure[1] ($' 000,000)	Percent of Total P/T Government Health Expenditure	Per capita Public Expenditure on Home Care[2]
2011-12	$194.2[b] (b - budget)	$3,746.1[f] (f- forecast)	5.2%	$203.89
2010-11	$196.1	$3,637.3[f]	5.4%	$207.48
2009-10	$182.9	$3,374.3	5.4%	$194.46
2008-09	$177.9	$3,299.3	5.4%	$189.76
2007-08	$165.9	$3,120.8	5.3%	$177.24
2006-07	$151.9	$2,898.5	5.2%	$161.94
2005-06	$131.5	$2,580.3	5.1 %	$140.20

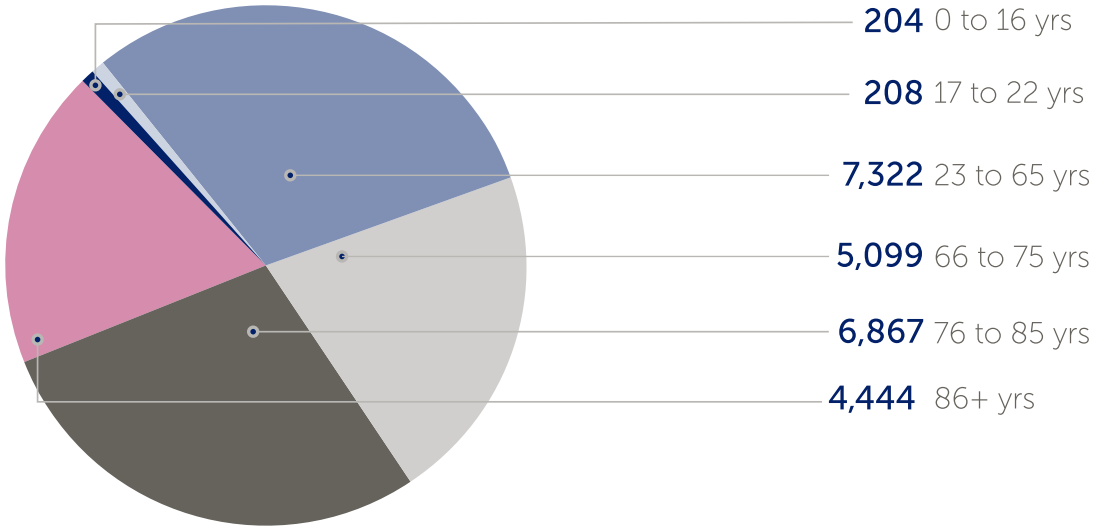
CIHI, National Health Expenditure Trends, 1975 to 2011, Table B.4.1

[1] *Figures include spending for health services reported by the provincial/territorial ministry responsible for health – does not include expenditures from municipal government or worker's compensation. [CIHI, National Health Expenditure Trends, 1975 to 2011, pg 92]*

[2] *Population data based on Statistics Canada, Demography Division, Annual Estimates of Population for Canada, Provinces and Territories, from July 1, 1971 to July 1, 2012.*

PROFILE OF CLIENTS RECEIVING HOME CARE

Number of Individuals Receiving Home Care by Age Category (2011-12)



DIAGNOSIS

The top three diagnoses for 2010-11 were hypertension, arthritis, and diabetes.

Distribution of Home Care Clients by Leading Health Conditions and Functional Limitations, Seniors Aged 65+ 2007-2009

Client Outcome Category	Active Diagnosis or Condition	Percent of Total Home Care Assessments
Leading Health Conditions	Arthritis	63.3
	Hypertension	62.5
	Coronary Disease	28.0
	Diabetes	27.1
	Dementia	26.2
Functional Limitations	IADL	97.2
	ADL	46.7

IADL= Instrumental activities of daily living (e.g., shopping, housekeeping, cooking)
ADL = Activities of daily living (e.g., bathing, dressing, toileting, feeding)

CLIENT GROUPING

Nova Scotia submits its RAI-HC data to CIHI, but until 2010 did not gather utilization data according to the client grouping definitions (Acute Care Substitution, Maintenance, End-of-Life Care (palliative), Rehabilitation, Long-Term Supportive Care) established by a federal / provincial / territorial working group on continuing care.

SERVICE DELIVERY

MODEL OF SERVICE DELIVERY

Home care services are funded and provided through the publicly funded health care system. However, services can also be purchased directly, by individuals, through either insurance plans or direct payments. The amount of privately purchased services is dependent upon the individual and is usually based on need and available funding. Home care services are provided through both the public sector and through contracts with the private sector organizations. The Red Cross, in addition to being one of the home support providers, is also contracted to provide a bed loan and special equipment service.

Continuing Care provides the following programs:

- **Acute services:** services to individuals requiring short-term care in order to delay, prevent or shorten hospital stays. Direct services can include nursing and home support. Clients are required to have an attending physician who accepts medical management of the case.
- **Chronic services:** services to individuals with ongoing needs who require support to remain living in their own homes. Direct services can include nursing and home support.
- **Self managed care:** launched in December 2005, the province provides funds directly to Nova Scotians for support services. This program allows clients with physical disabilities to oversee the care and supports they require for daily living. Supports may include personal care (personal hygiene, dressing, etc.) and home support activities (meal preparation, cleaning, laundry, etc.), however, the care plan may also be able to respond to unique situations and needs. There were 139 active clients as of March 31, 2012.
- **Palliative Care:** palliative care patients can access 200 hours of home care services per month, for a total of 600 hours in the last three months of life. These increased entitlements allow patients to access more concentrated home support services including nursing, personal care, home support, and respite support for families.
- **Challenging Behaviour Program:** a comprehensive and integrated approach to the care of people who display difficult behaviours in long-term care or home care environments. The program supports caregivers, health providers, and continuing care clients to assess and manage individual client behaviors.
- **Supportive Care Program:** provides cognitively impaired clients with funding of $500/month to purchase home support services (personal care, respite, meal preparation, and homemaking) that would otherwise be delivered through the provincial home care program. Under this program a person may also be eligible to receive reimbursement for snow removal services, up to a maximum of $495/year. There were 2 active clients as of March 31, 2012.

Services funded and provided through the Home Care Program

Assessment and Care Coordination	Includes assessment, service planning, care coordination and monitoring and evaluation of the effectiveness of the service plan.
Nursing (RN and RPN)	Includes: • Performing nursing assessments. • Performing nursing treatments and procedures. • Teaching self-care to and supervision of clients receiving personal care or nursing services. • Teaching personal care and nursing procedures to family members and other caregivers. • Providing service for personal care or respite when the assessment process identifies that the condition of the client warrants provision of these services by a nurse. • Teaching and supervising home support service providers who are providing personal care and performing delegated nursing tasks and initiation of referrals to other agencies and services as appropriate.
Home Support Services (Personal Care)	Includes assisting with, or supervising, activities of daily living in the areas of hygiene, toileting, dressing, feeding and mobility.
Home Support Services (Light Housekeeping)	Includes assisting with, and/or teaching, self-care techniques for instrumental activities of daily living in the areas of general household cleaning, laundry and changing linen.
Home Support Services (Meal Preparation)	Includes assisting with, and/or teaching, self-care techniques for instrumental activities of daily living in the areas of nutritional care, menu planning and meal preparation.
Home Support Services (Respite)	Any combination of services provided specifically for the purpose of giving relief to the family or other non-paid caregivers of a dependent person who lives at home. The objective of respite services through home care is to support the family environment by allowing primary caregivers time to attend to personal matters or to obtain needed rest and relief.
Therapies	Where feasible, a District Health Authority can choose to offer additional home care services which can include therapies when available (i.e. physiotherapy and occupational therapy).

Ancillary Support

Oxygen	Home oxygen is provided through a roster of approved vendors registered with Nova Scotia Continuing Care. Clients first access home oxygen services from other publicly funded programs, where these services are available. This includes, but is not limited to, services through the Department of Veterans Affairs, Workers Compensation Act, Motor Vehicles Accident Claims Act, and Health Canada's Medical Services Administration. Home oxygen services include the provision of oxygen concentrators and related supplies to individuals who meet medical eligibility and program criteria. In 2007 access to a monthly supply of portable oxygen was increased. Eligible home oxygen clients are provided with up to 10 portable oxygen tanks per month, each costing $18.00. The service includes an oxygen concentrator, along with regulator, nasal cannula, oxygen tubing and back up cylinder. Clients also receive funding for other needed equipment and supplies. The province pays part, or all, of the cost of the tanks of portable oxygen each month, depending on the client's needs, income and family size. Approved oxygen vendors deliver, set up and maintain the equipment. Respiratory therapist services are included in the total expenditure numbers. There were 1083 active clients as of March 31, 2012.
Equipment (wheelchairs, walkers, etc)	DHW does not provide this type of equipment to home care clients. However DHW has a bed loan program which makes beds available to continuing care clients in their own home.
Personal Alert Assistance Program	Initiated in January 2011, the program provides financial assistance of up to $480/year to low income seniors who live alone, receive publicly funded home care services, have experienced recent falls, and use a cane, walker or wheelchair in order to purchase an alert service. There were 102 active clients as of March 2012.

SERVICES CURRENTLY NOT FUNDED THROUGH CONTINUING CARE

- Nurse Practitioner - Recently introduced into community through Primary Care
- Social Work
- Dietetics
- Physician Services
- Pastoral Care
- Pharmacy

Units of Service

The amount of publicly funded service by service category[1] is expressed in units[2].

	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
Home Support Service	1,854,336	1,872,462	1,875,635	1,924,875	1,953,665	2,036,443
Registered Nursing	196,459	198,114	200,625	203,043	191,130	643,044
Licensed Practical Nursing	289,229	309,798	341,329	378,182	403,904	

[1] *An individual can receive more than one category of service*
[2] *One unit equals one hour of service for home support services and one visit for nursing services.*

Expenditures

	2006-07	2007-08	2008-09	2009-10	2010-11
Home Support Service	$55.1 M	$58.0 M	$61.7 M	$64.7 M	67.4 M
Registered Nursing	$12.9 M	$12.4 M	$13.4 M	$14.2 M	$14.7 M
Licensed Practical Nursing	$8.9 M	$10.0 M	$11.8 M	$14.3 M	$16.3 M
Therapies	N/A	N/A	$3.3 M	$3.3 M	$3.3 M
Oxygen	$2.2 M	$2.5 M	$2.7 M	$2.8 M	$2.9 M
Equipment (hospital beds, etc.)	$0.96 M	$1.7 M	$2.5 M	$2.5 M	$2.3 M
Medical Supplies	$3.4 M	$3.5 M	$4.4 M	$5.4 M	$5.2 M
Drugs	$0.49 M	$0.59 M	$0.55 M	$0.077 M	$0.079 M

CLINICAL (SPECIALTY) SKILLS

With the focus on discharging patients from hospital as promptly as possible, there has been an increase in the complexity of care provided at home. The challenge in much of Canada can be in having a critical mass of patients who require certain levels of expertise and, as a result, special skills only being available in urban centres. However, with the advent of remote access to support in the community, there is an opportunity for more complex care to be provided in less populated areas.

Home care nurses are able to:

- Administer narcotics
- Provide enterostomal therapy, wound care, infusion therapy, home based peritoneal dialysis.
- Manage infusion pumps, central lines and peripherally inserted central catheters (PICC lines).
- Administer blood and blood products.
- Provide ventilator care and regular tracheostomy tube replacement.
- Manage home oxygen.

Clinical services not currently provided in the home include:

- Administration of chemotherapy.
- Hemodialysis.

3. Quality & Accountability

HOME CARE INDICATORS

The home care indicators that are currently monitored at a provincial level include:

- Amount of service delivery.
- Expenditures.
- Home care admissions.
- Referral source.
- Reason for non admit.
- Referrals to community support.
- Diagnoses.
- Safety issues.

QUALITY & ACCREDITATION

EXTERNAL ACCREDITATION

Accreditation is an effective way for health services organizations to regularly and consistently examine and improve the quality of their services in order to ensure high standards of care. Organizations in Canada are accredited through Accreditation Canada, CARF, the Quebec Council of Accreditation (Quebec only) and/or registered with the International Standards Association (ISO).

All the District Health Authorities are accredited with Accreditation Canada. Eighteen medical rehabilitation facilities are accredited with CARF.

The Continuing Care Branch, DHW, is responsible for auditing all provincially funded home care providers on an annual basis. Accreditation by other organizations is not mandatory, however, a number of home care organizations within the province have achieved accreditation.

High-quality care is evidence-based (appropriate), focused on the patient (or patient-centred), safe, and timely (CIHI).

QUALITY COUNCIL

The provincial Quality and Patient Safety Advisory Committee (QPSAC) role is to:

- Be aware of quality issues facing the health system.
- Work with stakeholders to address quality issues at the system level.
- Make evidence-informed decisions for health care.
- Monitor, measure and evaluate the quality of health services.
- Provide reports to the public on the quality of the health system.
- Enhance regulatory and legislative mechanisms to support quality.

The DHW is working with the DHAs to advance key performance indicators and initiate an accountability framework. These include measures to determine access to care, effectiveness, efficiency, improved health status, outcomes and health promotion.

CLIENT / PATIENT ADVOCATE

There is no patient advocate specific to home care, however the Nova Scotia Office of the Ombudsman is responsible for investigating complaints under the Civil Service Disclosure of Wrongdoing Regulations.

SYSTEM APPROACHES TO QUALITY IMPROVEMENT

Between 2008 and 2010 the Home Care Standards for Quality Service developed by the Department of Health and Wellness were revised to reflect current practices. The standards are a tool used by the government in auditing the agencies providing home care service.

SAFETY

The Department of Health and Wellness is committed to quality and patient safety. As such, the department has established a forum of experts, the Quality and Patient Safety Advisory Committee (QPSAC), to provide advice to the Minister on issues of quality and patient safety and to create a provincial perspective spanning the continuum of care. QPSAC will bring health system stakeholders together in a collaborative partnership to promote and inform a provincially coordinated, innovative and patient-centered approach to quality and patient safety improvement in Nova Scotia.

HOME CARE RESEARCH

Nova Scotia is fortunate to have over a dozen universities and colleges, including many conducting research in health care and aging. In addition, DHW funds the **NS Health Research Foundation** whose role is to assist, collaborate with and fund individuals and organizations conducting health research in the province. The interest and activity, related to home care research, have increased in recent years and the Continuing Care Branch, DHW supports such research by providing in kind support and participation of research teams, both provincially and nationally.

In addition to the research carried out by the universities there is considerable research led by the Division of Geriatric Medicine, which provides services through its participation in the **Centre for Health Care of the Elderly (CHCE)** and the Faculty of Medicine at Dalhousie University. CHCE is a multi-service, interdisciplinary program based primarily in the Camp Hill Veterans' Memorial Building (CHVMB) of the Queen Elizabeth II Health Sciences Centre. Research within CHCE is primarily focused on two main areas, dementia and frailty in the elderly. All members of the division contribute to this endeavor. The Geriatric Medicine Research Unit, established by Dr. Kenneth Rockwood, has gained national and international stature.

Another resource for research on home care is the **Nova Scotia Centre on Aging (NSCA)**, which is affiliated with Mount Saint Vincent University's (MSVU), with the mandate of applied research, continuing education and community outreach/consultation in age-related issues. The NSCA works in partnerships with others - the academic community, governments, private sector, seniors, and voluntary/professional organizations - on research projects, continuing education initiatives, and community outreach activities

to address ways to promote and maintain autonomy and quality of life for the elderly population and their families. These initiatives are financially supported through external granting agencies and contracts, private foundations (e.g., Crabtree, Max Bell, Merck Frosst) and the F.R. MacKinnon Fund.

The NSCA's main areas of expertise are focused on issues related to family caregiving, continuing care and healthy aging. Project topics have included: age-friendly communities, human resource planning, caregiver support, seniors housing, prescription drug use, technology and older adults, and Alzheimer's disease and other dementias.

4. Information Technology

ELECTRONIC HEALTH RECORD (EHR)

Nova Scotia's electronic health record system, called SHARE (Secure Health Access Record), will provide health care professionals with secure access to patient information. SHARE is part of a national health information network, and is a foundational component of Nova Scotia's information management structure for health care. In the fall of 2010, SHARE was made available to specific groups of health care providers, beginning to put the technology in place to create a single electronic health record. A dedicated team will focus on roll-out and adoption in the community.

The home care records with the home care providers are in various stages of electronic implementation. However, all continuing care clients are assessed using the customized provincial electronic software system called SEAscape, which includes the international approved RAI-HC assessment. All information collected with this software, including important client, clinical and administrative data, is maintained electronically in a provincial database. Home care programs are working on an information management strategy in preparation for the implementation of an electronic system. This includes the identification of data requirements and information that should be shared.

Future E-health initiatives will involve integrating other point of service health systems with the Electronic Health Record including: Physician Office Electronic Medical Records, the Drug Information System, Public Health Systems and Continuing Care Systems. Other initiatives include:

- Enhancing patient care through greater adoption and use of telehealth/telepresence and home monitoring solutions.
- Investing in mobile health solutions and social networking.
- Getting information into the hands of the patients and family through Consumer Health Records and Consumer/Patient Portals.

Technology – Transforming Health

Technological advancements have the potential to fundamentally change our health care approach to support a more efficient and person-centred one regardless of the care setting.

Today's innovations enable the integration of monitoring and therapeutic systems, provide educational content, facilitate communication and data flow between members of the health care team and support systems management and quality improvement.

Resident Assessment Instrument-Home Care (RAI-HC)

The Resident Assessment Instrument-Home Care (RAI-HC)© is a standardized, multi-dimensional assessment system for determining client needs. Assessments are captured electronically with real-time feedback to support care planning, in addition to providing data to support system management, quality improvement and policy-making.

The RAI-HC was developed through interRAI, a collaborative, non-profit, worldwide network of researchers that work to promote evidence-informed clinical practice and policy decision making across a variety of health and social services settings.

(RAI-HC© interRAI Corporation, 2001. http://www.interrai.org)

HEALTH DATA & THE HOME CARE REPORTING SYSTEM

The Canadian Institute for Health Information (CIHI) developed the Home Care Reporting System (HCRS). The purpose is to collect and process information on publicly funded home care services in order to support jurisdictions in their analysis and decision making by providing data on:

- Access to home care services.
- Health and functional status measures.
- Clinical outcomes and waiting times.
- Quality of care.
- Informal support.
- Service utilization by setting and provider type.

THE HCRS captures standardized client-specific clinical, demographic, administrative and resource utilization information. A key component of the HCRS is the Resident Assessment Instrument—Home Care (RAI-HC).

In Nova Scotia, the data is used at the frontline, by care coordinators, to assist in determining the clients unmet needs and at the provincial level to support decision making. For example, the RAI data was used to develop the criteria for the Caregiver Benefit, to determine the eligibility criteria for a personal alert device program, and to determine where additional long-term care beds are required.

USE OF SYSTEM EFFICIENCY TECHNOLOGY

Electronic communication does not yet exist between home care and physicians or home care and hospitals. However, technology is applied between frontline staff to communicate referral and clinical information. Technology is also used to share information between home care programs and the Department of Health for submission of financial data.

About 80 percent of home care agencies funded by the province are using the same software program, which includes a case management and scheduling software. The extent to which this software is used by each of Nova Scotia's home care agencies varies.

USE OF TECHNOLOGY FOR CLIENT CARE

The Nova Scotia Telehealth Network (NSTHN) is a video conferencing communications network that connects 42 health care facilities throughout the province. Videoconferencing equipment is used to assist with providing patient care and education to individuals and families in Nova Scotia. Telehealth is used for clinical consults, educational sessions (for patients as well as health care professionals) and health care related administrative meetings within and across district health authorities. It is recognized as important to overcoming barriers in rural and remote settings. Telehealth is being considered for home care but is not yet an offered service, other than on limited trial basis.

Each Home Care Agency determines the communication technology that is supplied to their respective home care staff. Typically staff is equipped with a cell phone and/or pager.

5. Health Human Resources

CLINICIANS PRACTICING IN HOME & COMMUNITY CARE

The DHW has developed a comprehensive human resource plan with short and long-term strategies to address continuing care staff shortages. Strategies address the full range of human resource issues including workforce planning, replacement time, hiring freezes, use of casual staff and working conditions. A key area of focus is on the retention of new nurse graduates in the province.

HEALTH CARE PROFESSIONALS

It has been estimated that 44 percent of the 11,068 health care professionals in Nova Scotia will be eligible to retire from the acute care sector in 2015, which will put pressure on the entire system. Estimates for the numbers of staff in the community are not available.

PERSONAL CARE & SUPPORT PROVIDERS

The Continuing Care Assistant (CCA) provides personal care and support for activities of daily living (ADLs) and instrumental activities of daily living (IADLs) in home care. The scope of practice for CCAs outlines the accountabilities, roles and functions of the CCA, as well as outlines the limitations under which these services may be provided.

In Nova Scotia, CCAs are not regulated by legislation or governed by a regulatory body and, therefore, responsibility for issues related to public interest and governance rests largely with the employer. In the absence of a governing body, the DHW has supported and overseen the development of the CCA educational program and certification process. To assist with these activities, the DHW established the CCA Program Advisory Committee (PAC) with representation from key stakeholders. The role of the CCA PAC includes:

- Providing the basis for the development of practice standards and competencies.
- Guiding curriculum development.
- Assisting employers in developing job descriptions and performance reviews.
- Informing CCAs, other members of the health care team, and the general public about the accountabilities, roles, and functions that CCAs are educated for, and qualified to perform, as well as the limitations under which services may be provided.

A registry of CCAs has been established to identify staff, track education requirements, use information for future human resource planning, provide an avenue for contact with CCAs, and enable contact between CCAs.

Value of the Continuing Care Assistant Program

The Continuing Care Assistant (CCA) program offers graduates more employment options, ensures education and skills consistency across the continuum of care, while providing clients with reassurance that they are being cared for by a qualified individual that has met provincially-established standards.

When CCA students graduate, they are eligible to work in home care, long-term care facilities, hospitals and other continuing care settings.

The Continuing Care Assistant Program supports the Nova Scotia Department of Health and Wellness goal of "Better Care, Sooner", by providing an integrated approach to skills development and training.

(Health Association, Nova Scotia, http://www.healthassociation.ns.ca)

EDUCATION & TRAINING

HEALTH CARE PROFESSIONALS

DHW has committed to increasing investment in education and training for continuing care providers, and to work with educational institutions to expand or include continuing care in health program curricula and practicums.

PERSONAL CARE & SUPPORT PROVIDERS

To practice as a CCA, an individual must be a graduate of an approved CCA program and have successfully completed the Nova Scotia CCA Provincial Exam. The DHW supports and provides oversight for the CCA Program which is managed by Health Association Nova Scotia under contract with the DHW. The education program for CCAs combines theory and practice from the health professions, arts, sciences and the humanities. The CCA Program is offered through participating Nova Scotia Community Colleges, private career colleges, Nova Scotia Work Activity Programs and approved licensed nursing homes/homes for the aged and home support agencies. For individuals with experience, a Prior Learning Assessment and Recognition program can be taken in order to prepare for the provincial exam. This includes a Course Recognition process for those who have completed training in another province. Regardless of the method chosen to become a CCA, all applicants must write the NS Provincial CCA Examination. The DHW, in its oversight capacity, regularly assesses the CCA program to determine if graduates are appropriately prepared for work in facility and home care settings.

INTER-PROFESSIONAL COLLABORATION

The Health Professions Regulatory Network, established in 2006 as a forum for all the health professions' regulatory bodies in Nova Scotia to discuss and address common regulatory issues, agreed to a set of principles to guide inter-professional collaboration. It was acknowledged that through collaborative practice there would be increased public access to health care and improved health outcomes for individuals and their families.

The DHW is committed to a client-centred team approach that facilitates transition through the system, improves access to expertise and resources and advances integration. Continuing care is acknowledged as an integral part of the care team. A hospital in-reach approach that allows primary care teams to improve communication with clients, as well as follow them through the system, is being explored.

FAMILY CAREGIVER

Family caregivers are recognized in home care policy. Respite of up to 40 hours a month is available in the client's own home and up to 60 days per year is available in nursing homes.

A Caregiver Benefit Program provides $400 per month to a family member or friend to assist the caregiver in sustaining the support they provide to qualified care recipients residing in the community. To be eligible, the caregiver must be:

- A resident of Nova Scotia, with a valid Nova Scotia health card number.
- Nineteen years of age or older.
- Providing 20 or more hours of assistance with Activities of Daily Living and/or Instrumental Activities of Daily Living per week to a qualified care recipient.
- In a caregiving relationship, with a qualified care recipient, that is expected to extend beyond 90 days.
- Not receiving payment to provide assistance to the qualified care recipient.
- Determined by the Continuing Care Coordinator to meet the eligibility Criteria for the Caregiver Benefit Program.
- Willing to sign an agreement with continuing care defining any terms and conditions for receiving the caregiver benefit.

An individual is considered to be a **qualified care recipient**, for purposes of the Caregiver Benefit Program, when he or she is:

- A resident of Nova Scotia, with a valid Nova Scotia health card number.
- Aged 19 or older.
- Assessed by a Continuing Care Coordinator and demonstrates a very high level of functional impairment, as indicated by a score of 5 on the MAPLe© (method for assigning priority levels) decision support tool, or by a MAPLe© score of 4 combined with either a cognitive performance scale© (cps) score of 4 or higher and/or activities of daily living (ADL) self performance hierarchy scale © score of 3 or higher.
- In a caregiving relationship with an eligible caregiver that is ongoing, regular and is expected to extend beyond 90 days.
- In receipt of a net annual income of $22,033/single or $37,004/couple.

6. Provincial Initiatives

There are a number of initiatives to expand and enhance home care services in Nova Scotia.

HOME CARE SERVICES ON RESERVE

In 2007, First Nations organizations, the federal and provincial governments and District Health Authorities began working together to improve home care services on-Reserve in Nova Scotia. This collaborative effort was funded by Health Canada's Aboriginal Health Transition Fund (AHTF). A **Framework for Aboriginal Home Care in Nova Scotia** was released in 2010 outlining policy areas to be developed specific to the provision of home care services for First Nation individuals living on-Reserve. The work involved undertaking a comprehensive review of current federal and provincial home care policy, an assessment of service gaps and capacities in each First Nation community in the province, a comparison of First Nation and provincial home care program utilization data and a "cross Canada" policy review. All of this information and analysis resulted in 31 recommendations for change. The partners have had a number of successes already with policy changes being made to increase access for First Nation individuals living on-Reserve to Continuing Care Programs delivered through the district health authorities.

PRIMARY HEALTH CARE

Activities include improving access to primary health care services and ensuring that continuing care providers are regarded as important members of the team. Technology, such as telehealth, will improve access and continuity of care for continuing care clients.

CASE MANAGEMENT

The plan is to develop and implement an integrated provincial case management model that spans the health system. Partners are working to develop a common vision for case management across the health care and continuing care systems. Investments in education and skills development in the areas of case management, team building, and negotiation will be made.

SUPPORTIVE CARE

The Supportive Care Program supports eligible Nova Scotians with cognitive impairments (difficulty thinking, concentrating, remembering, etc.) by providing them with $500/month for home support services (personal care, respite, meal preparation and household chores). Under this program people may also be eligible to receive reimbursement for snow removal services up to $495/year. To receive funding for Supportive Care, you must: be 65 years or older, be a Nova Scotia resident with a valid Health Card, have significant memory loss and memory problems that affect daily functioning, be deemed by Continuing Care as needing a minimum of 25 hours/month of care support, and have a substitute decision maker (someone who will act on your behalf and has signed an agreement that defines terms and conditions for this program).

SENIORS AND AGING

In 2001, 13.4 percent of the Nova Scotia population was 65 years of age or over. It was predicted that by 2021 seniors will comprise 22 percent of the Nova Scotia population, but already in 2011 seniors comprise

16.5 percent of the population, the highest percentage in Canada. The distinction between frailty and age is being explored and strategies to reduce frailty by increasing opportunities for positive personal health practices are being adopted. Investments are being made in education, training, and supports, such as equipment, to help frail clients with complex needs in home and long-term care settings. Planning and policy development is recognizing frailty as a determinant.

A Seniors' Secretariat Strategy for Positive Aging has been recommended for Nova Scotia. The new entity will help to educate the business sector about seniors and their contributions; encourage seniors to volunteer and remain in the workplace; and, support seniors' health promotion and illness prevention activities.

MENTAL HEALTH

In spring 2012, DHW released Nova Scotia's first ever government-wide strategy for mental health and addictions care called **'Together We Can: The Plan to Improve Mental Health and Addictions Care for Nova Scotians'**. The five-year plan outlines 33 actions to provide "Better Care Sooner" for Nova Scotians living with mental illness and addictions and their families.

DHW is working to identify and analyse gaps in mental health services for continuing care clients and to increase the continuing care system's capacity to respond to the mental health care needs. Strategies will improve the availability of, and access to, mental health expertise in communities; there will be more mental health education for continuing care providers; and increased awareness of depression in seniors.

END-OF-LIFE CARE

DHW is developing a comprehensive provincial palliative care program available in multiple settings to all Nova Scotians of all ages. Specifically efforts are underway to:

- Extend home care authorization policies used in the Northern Region to the entire province.
- Prioritize long-term care placement and home support waitlists to support palliative care clients and their families.
- Revise policy to better support palliative clients remaining in their homes.
- Ensure that palliative care services include:
  - Case management and assistance with system navigation.
  - Standardized assessment, care planning, and charting.
  - Consult teams that include physicians, nurses, social workers, and pharmacists with specialized training in palliative care.
  - Training for primary health-care teams, volunteers, caregivers, and family members.
  - A bereavement program that expands end-of-life care.
- Provide access to palliative care medications and equipment that improves client comfort and safety.
- Expand home oxygen program entitlements for palliative care clients.
- Identify and address reimbursement issues for physicians providing palliative care.
- Continue to develop designated nursing expertise in palliative care.
- Provide access to palliative resources and expertise through a 24-hour hotline.

7. Challenges

Challenges facing home care in Nova Scotia include:

- Identifying and removing barriers to access home care services.
- Renewing the focus on person-centered care rather than relying on "prescribed options for care".
- Increasing utilization of home care so that individuals can remain in their homes longer and delay admission to long-term care facilities. It has been noted that increasing difficulties with IADLs are more often are the cause of an individual being admitted to a LTC facility than increasing difficulties with ADLs.
- The importance of caregiver support is also a priority as families are vital to supporting people to remain at home.

Strategies to address the challenges include:

- Building stronger linkages between Home Care and Primary Health Care and Acute Care.
- Continuing to work on implementation of the recommendations from the Aboriginal Home Care Framework Report, 2010.
- Expanding home care to reduce the need for institutional care.
- Providing more/better services to those with mental health and addictions and/or disabilities.
- Addressing the health human resource pressures that will continue to be an issue as the population continues to age and our percent of youth is less than that of seniors.

8. Opportunities

The vision for home care in Nova Scotia is to build a person-centered service with stronger linkages with primary health care and acute care. This will contribute to the province's goal of "Better Care Sooner" and will help people maintain optimal well-being and independence at home. The integration of the sectors will facilitate appropriate use of health resources and improve outcomes for Nova Scotians.

In Nova Scotia, like elsewhere, home care is now recognized for the value it provides and its potential to contribute to the health care of Nova Scotians. In this time of fiscal restraint, when many departments received no increase, or even experienced a decrease in their annual budget, home care was awarded $22 million to expand to find solutions to meeting the future needs of citizens so they can remain at home rather than relying on institutional care and hospitalization. There is also recognition that Nova Scotia needs to move to a person-centred approach, using a single-entry access for all, regardless of diagnosis or age. Nova Scotians are committed to providing support and care for family caregivers.

This is an exciting time to be involved in home care!

ACRONYMS / ABBREVIATIONS

ADL –	Activities of Daily Living
AHTF -	Aboriginal Health Transition Fund
ALC -	Alternate Level of Care
CAP -	Clinical Assessment Protocol
CCA –	Continuing Care Assistant
CHCE -	Centre for Health Care of the Elderly
CHVMB -	Camp Hill Veterans' Memorial Building
CPS –	Cognitive Performance Scale
IADL -	Instrumental activities of daily living
ISO -	International Standards Association
DHA -	District Health Authority
DHW -	Department of Health and Wellness
DIS -	Diagnostic imaging solution
EHR -	Electronic health record
HCRS -	Home Care Reporting System
MAPLe -	Method for Assigning Priority Levels
MSI -	Medical Services Insurance
NACRS -	National Ambulatory Care Reporting System
NSCA -	Nova Scotia Centre on Aging
MSVU -	Mount Saint Vincent University
NSTHN -	Nova Scotia Telehealth Network
PAC -	Program Advisory Committee
PICC lines -	Peripherally inserted central catheters
QPSAC -	Quality and Patient Safety Advisory Committee
RAI-HC -	Resident Assessment Instrument—Home Care
SEA -	Single Entry Access
SEAscape -	Single Entry Access simultaneous client assessment, placement and evaluation
SHARE -	Secure Health Access Record

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Harmonized Principles for Home Care

Guide policy and program development

Support consistency and equity across the country

Facilitate benchmarking and sharing of best practices

CLIENT AND FAMILY-CENTRED CARE

Clients and their family caregivers are at the centre of care provided in their home.

Dignity: Respect and value client and caregiver self-worth.

Holistic: Uphold all aspects of client and caregiver needs; psychosocial, physical and spiritual.

Independence: Foster autonomy and self-sufficiency.

Informed Choice: Clear understanding of the facts, implications, and consequences of decisions and actions.

Positive Partnership: Acknowledge unique strengths and engage client and family as partners in care.

Safety: Minimize and manage risk.

Self-Determination: Encourage, support and enable self-care.

ACCESSIBLE CARE

Canadians have equitable, appropriate, consistent access to home care, and are fully informed of the care and service options available to them.

Appropriate: Provide care that is needed and ensure the need for care.

Consistent: Reliable care among providers and across jurisdictions and geographies.

Comprehensible: Ensure understanding of services and options available.

Equitable: Create fair and unbiased access within and across jurisdictions and geographies.

ACCOUNTABLE CARE

Home care is accountable to clients and their caregivers, providers, and the health care system for the provision and ongoing improvement of quality care.

Transparency: Report on performance metrics and outcomes to inform the public on the quality of care.

Quality: Monitor performance indicators to support continuous improvement.

Value: Demonstrate value to clients and their caregivers, providers and the health system.

EVIDENCE-BASED CARE

Knowledge that is grounded in evidence is used as the foundation for effective and efficient care provision, resource allocation and innovation.

Evidence-Informed: Decision-making incorporates the best available evidence, expertise and experience.

Knowledge Transfer: Share ideas and information with clients, family caregivers, providers and planners.

Innovation: Support a culture of innovation and ingenuity.

Research: Promote awareness and application of research evidence to inform decisions.

INTEGRATED CARE

Home care facilitates the integration of care across the continuum of health care and with community and social services; care is complementary, coordinated and seamless with a focus on continuity for the client.

Continuity: Foster collaboration and communication to ensure seamless care transitions.

Coordination: Reduce disparities through care coordination.

Individualized: Customize care to the unique needs of clients and their families.

Prepared: Enable timely access to information and resources.

SUSTAINABLE CARE

Home care contributes to the sustainability of an integrated health system by increasing efficiencies and delivering cost effective care.

Health and Well-being: Focus on health promotion, disease prevention and management, and quality of life.

Needs Based Planning: Establish policies and programs on current and future needs and trends.

Optimum Effectiveness: Integrated resources planning across client populations and care settings.

PRINCE EDWARD ISLAND

HOME CARE IN **PRINCE EDWARD ISLAND**

In **Prince Edward Island**, the definition of home care is consistent with the Canadian Home Care Association definition.

> Home care is an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the family caregiver.

PRINCE EDWARD ISLAND

BY THE NUMBERS...

5,660 sq km **LAND AREA**	145,900[1] POPULATION (2011)	**47%**[3] Percent population in urban settings defined as an area with a population of at least 1,000 and with no fewer than 400 persons per square kilometre (2006)	
64.2[2] Dependency ratio (2009) Ratio of the population aged 0-19 and 65+ to the population aged 20-64	15.8%[1] **Population Seniors 65+ yrs (2011)**	80.2 years[1] **LIFE EXPECTANCY (AT BIRTH)**	**$4,487.90**[2] Public sector health care expenditure per capita (2011 Forecast)

[1]Statistics Canada | [2]Canadian Institute for Health Information (CIHI) | [3]Human Resources and Skills Development Canada

1. Governance & Organization

HEALTH CARE SYSTEM STRUCTURE

The home care program falls under the **Home-Based and Long-Term Care division of Health PEI**. This division provides supportive services to adults and seniors in need of home-based and long-term care. Within the division there are nine public nursing homes and five home care offices throughout Prince Edward Island. Administratively, the Executive Director, Home-Based and Long-Term Care is responsible for this division, and is a member of the executive leadership team.

The health system on Prince Edward Island is operated by a corporate entity called the PEI Health Services Corporation (the Corporation), which is external to government. Health PEI is a Crown Corporation responsible for the operation and delivery of publicly funded health services in Prince Edward Island, in accordance with the direction from the Minister of Health and Wellness.

Health PEI's organizational structure is arranged into the following divisions that deliver services to Islanders:

- Community Hospitals and Primary Health Care
- Home-Based and Long-Term Care
- Prince County Hospital
- Queen Elizabeth Hospital
- Provincial Clinical Services.

Home Care, an Essential Service

Home care was first available in Canada in the early 17th century, when nuns from religious orders arrived in Quebec to provide both direct care and disease prevention services [Community Health Nurses' Initiatives Group].

The first publicly funded home care program was established in 1970 and has continued to evolve and grow over time. Today, home care is an essential element of a is an integrated system that provides accessible, responsive services which enable people to safely stay in their homes with dignity and independence and quality of life.

(Canadian Home Care Association, http://www.cdnhomecare.ca/)

The divisions that support the health system are Corporate Development and Innovation, Financial Services, Health Information Management and Medical Affairs.

The Department of Health and Wellness is managed by a committee comprised of the Deputy Minister and five senior directors. This group is responsible for providing overall management direction to the department, and for overseeing long-term strategic planning. Specifically, the department provides:

- Leadership in maintaining and improving the health and well-being of citizens.
- Leadership in innovation and continuous improvement and high quality administration and regulatory services to the health system and Islanders.
- Policy, program and operational leadership respecting the Island health care system.
- Horizontal leadership and coordination in the implementation of Government's Healthy Living Strategy.

HEALTH CARE & HOME CARE LEGISLATION

The 1986 Home Care Support Program was implemented through an Order-in-Executive-Council. Currently, no act or legislation governs the program; however, legislation impacting home care includes, but is not limited to:

Health Services Act (R.S.P.E.I. 1988, Cap. H-1.6) - lays out the terms and conditions for the provision of health care in PEI. [Enacted in 2009; came into force 2010]

Consent to Treatment and Health Care Directives Act (R.S.P.E.I. 1988, Cap. C-17.2) – establishes the right of persons to consent or refuse treatment and make a health care directive, and provides the parameters where a person is incapable. The responsibilities of health care providers are described. [Enacted in 1996; came into force in 2000]

Community Care Facilities and Nursing Homes Act (R.S.P.E.I. 1988, Cap. C-13) – establishes a Board responsible to license, advise on standards and monitor the operation of facilities. [Enacted in 1985; came into force in 1988]

Adult Protection Act (R.S.P.E.I. 1988, Cap. A-5) – provides for provincial government assistance or intervention to protect an adult, who is unable to protect himself, against neglect or abuse that could otherwise cause serious harm to that adult. [Enacted and came into force in 1988]

Mental Health Act (R.S.P.E.I. 1988, Cap. M-6.1) - describes the responsibilities to care for those with mental health needs. [Enacted in 1994; came into force 1996]

EVOLUTIONARY MILESTONES

1986

Home Care Support Program (HCSP) implemented.

1991

A task force on health released **'Health Reform: A Vision for Change'**, calling for significant reform of the health care system.

1992

Establishment of a health transition team to develop a plan for implementation of the task force recommendations.

1993

The health transition team released its report, **'Partnerships for Better Health'**. The plan included a restructured health system comprised of five Regional Health Authorities, a Health and Community Services Agency, a Health Policy Council and the Department of Health and Social Services.

1993-94

Establishment of Regional Health Authorities (RHAs).

1996

Review of the home care support program.

1997

The Health and Community Services Agency and Health Policy Council disbanded and the functions transferred to the Department of Health and Social Services. The RHAs continue to operate.

1999

The RHAs moved from government appointed boards to combined elected and appointed boards, with the majority of board members being elected and representing electoral zones. Appointed members are members at large. The appointments are made by the Lieutenant Governor in Council, following the elections, to balance the complement of elected members, and to ensure diverse community representation on the boards.

2002

Restructuring to amalgamate two RHAs and establish a new Provincial Health Services Authority.

2005

Reorganization of the health and social service system resulting in the division of the Department of Health and Social Services into two separate entities - the Department of Health, and the Department of Social Services and Seniors. All Regional Health Authorities were disbanded.

2007

The co-pay requirement for home support services removed.

2008

Release of report **'An Integrated Health System Review in PEI: A Call to Action, A Plan for Change'** (Corpus Sanchez International).

2009

Launch of Home Care Renewal Strategic Initiative.
Establishment of PEI Health Governance Advisory Council to make recommendations regarding the development of a new health system governance structure.
Launch of PEI's Healthy Aging Strategy.

2010

Health PEI established as a Crown Corporation.

2012

Implementation of projects under the Home Care Renewal Strategic Initiative, including the Collaborative Model of Care (CMoC).

MANDATE, MISSION, PRINCIPLES & PRIORITIES

VISION FOR HOME CARE

As part of the One Island Health System, home care will offer a broad spectrum of high quality home based services that are accessible to all Islanders, and support their choice to remain at home as long as possible and to live with dignity and independence.

MANDATE

The PEI Home Care Program provides care and services to maintain or improve health, independence and quality of life for clients and their caregivers. Home care offers short-term care to clients recovering from surgery or acute medical conditions, long-term care and support to allow people living with chronic conditions to continue living in the community and palliative care to provide comfort and support to individuals living with a life-threatening illness.

Home care services supplement the care provided by a client's family, friends and other community-based services. Services are provided based on assessed need for a defined period of time. Home care offers a wide range of services, including:

- Assessment
- Care coordination
- Nursing
- Personal care and support
- Respite
- Occupational and physical therapies
- Social work
- Assessment for long-term care (nursing home) admission
- Community support services
- Transition support
- Adult Day Programs
- Adult Protection
- Integrated Palliative Care Program
- Provincial Renal Program (Renal Clinic, peritoneal and hemodialysis).

PRINCIPLES OF HOME CARE

The values and principles guiding the Home Care Program include:

Client & Family Centered - Clients and families have primary responsibility for their own health. Program staff will:

- Work in partnership with clients and families to respond to assessed needs and ensure client choice where possible.
- Always treat clients with respect and compassion ensuring their dignity is maintained.

- Recognize care at home often requires the support and input of family and friend caregivers; they will be valued and supported.
- Ensure all clients have a care plan that they have participated in creating.

Coordination - Clients benefit from support through transitions in care and transitions in life. All home care staff assist in coordinating care for clients, however, clients with more complex, high risk needs will benefit from a designated care coordinator. Program staff will:

- Process all referrals for service through a single point of entry.
- Assess all clients for their health status, functional status and available resources.

Accountability - Services will be monitored on the basis of how they improve quality of life and achieve client goals. The program will be monitored on the basis of how it achieves system goals. Program staff will:

- Strive to make services responsive to clients' needs.
- Develop care plans to the individual client's needs and resources, consequently no two care plans will be the same. However, there will be consistency in how/what the client receives no matter where they reside in the province.
- Evaluate care plans for appropriateness and/or potential for discharge on a predetermined basis and/or as needed.

Promotion of Wellness - Services to clients will emphasize the promotion of health, prevention of risk and quality of life.

Promotion of Self Care - Planning, care and support will promote self care, independence and preservation of function.

Partnerships - Formal, strong relationships will be developed along the continuum of care, and with community partners.

Staff are valued - All staff are recognized for their vital role as a part of the home care team; in supporting and caring for clients, they are valued and respected.

HOME CARE PROGRAM OBJECTIVES

Home care is an essential community service that supports individuals and families in achieving and/or maintaining health and independence through the delivery of appropriate, quality services based on assessed need.

The goals for the Home Care Program are:

- Maintaining Islanders in the community for as long as possible.
- Helping individuals get out of hospital as quickly as possible.
- Connecting Islanders to care and support.

Harmonized Principles for Home Care

The Canadian Home Care Association has developed a set of harmonized principles for home care which will define a national home care program without prescribing how services should be organized or delivered.

The principles will support the achievement of a level of consistency and provide a basis for the identification of common indicators, while respecting important jurisdictional differences.

As health care continues to shift to the community, these harmonized principles will serve as a unifying foundation for growth and expansion of home care programs across the country.

(Canadian Home Care Association, 2012)

The **current home care priorities** are to renew and enhance programs and services that support frail seniors to stay in their homes as long as it is safe to do so.

HEALTH SYSTEM PRIORITIES

Health PEI is working to realize the province's vision of One Island Community, One Island Health Care System: a sustainable, integrated health care system; one that shifts emphasis and culture toward wellness and primary health care, placing patients, clients, the community, and sustainability of the health care system above all other considerations

The health system values are:

- **Caring** – treating all people with compassion, respect and fairness.
- **Excellence** – working together in an environment of trust as team members and partners in care, and being dedicated to continuous improvement based on sound evidence.
- **Stewardship** – making decisions responsibly, acting with integrity and being accountable.

The health system goals are:

- **Quality** – ensuring the health system has the capacity to provide safe, dependable, quality care which promotes good health outcomes through:
  - ¤ Enhancing the quality of life of those served.
  - ¤ Maintaining or exceeding service satisfaction.
  - ¤ Reducing avoidable admissions to hospitals.
  - ¤ Ensuring that appropriate safety standards are met.

- **Equity** - providing fair allocation and access to services based on need, so that Islanders get the services they need, and need the services they get.
  - ¤ Ensuring appropriate wait times for key services in targeted areas.

- **Efficiency** - using health care resources as efficiently as possible, ensuring value for money, and making best use of workforce skills by:
  - ¤ Ensuring appropriate lengths of stay for bed based services.
  - ¤ Reducing the length of stay in hospital for patients who can appropriately receive care in a non acute setting.
  - ¤ Ensuring that health human resources are utilized efficiently and that hospital services provided are based on patient need.

- **Sustainability** – ensuring that the health system is stable and here to meet the needs of current and future generations by:
  - ¤ Ensuring the financial sustainability of the health system by maintaining operations within assigned resources and growth at a sustainable rate.
  - ¤ Ensuring a safe and healthy work environment.

HOME CARE RENEWAL

The Home Care Program has received increases in funding over the previous three fiscal years, in recognition of home care as an essential component of the vision of One Island Health System. The Home Care Renewal Strategic Initiative is focused on enhancing the existing Home Care Program and implementing new services to support Islanders, particularly frail seniors, in remaining home as long as possible.

First year (2009/10) investment resulted in the creation of additional full time equivalent positions that allowed an expansion of hours to seven days/week service at all sites, and supported several demonstration projects. These projects were aimed at delivering improved health outcomes and reducing pressure on acute and long-term care, including: expansion of the liaison role in acute care, a post-acute care supply initiative, a falls risk management program, a wound care initiative and the introduction of the LPN role to home care.

Second year (2010/11) investment supported the implementation of care coordination and the creation of new care coordinator positions across the province. Care coordination offers support, guidance and care to clients and their families to optimize resources and coordinate complex/chronic care. The number of clients requiring more than one home care service has increased by 11 percent since 2007/08.

Third year (2011/12) investment resulted in the Enhanced Home Care for Frail Seniors Pilot Program (currently in progress). This pilot is a partnership between Queens Home Care and the Queen Elizabeth Hospital that provides additional hours of service to frail seniors to allow them to return home from hospital sooner and remain safely at home longer.

The Enhanced Home Care for Frail Seniors pilot was launched in September 2011 with a planned one-year pilot phase. Early outcomes are positive, including great collaboration between acute care and home care, resulting in good client referrals coming from varied in-hospital sources, low cost of delivering the service relative to other care settings, and positive feedback from program clients. A full evaluation is planned for fall 2012.

2. Access, Funding & Service Delivery

ACCESS TO HOME CARE SERVICES

The Home Care Program serves as the single entry point for services at home and/or entry to a long-term care facility. A new central referral and intake process, introduced as part of the Collaborative Model of Care initiative, streamlines the process for home care clients.

REFERRAL SOURCES

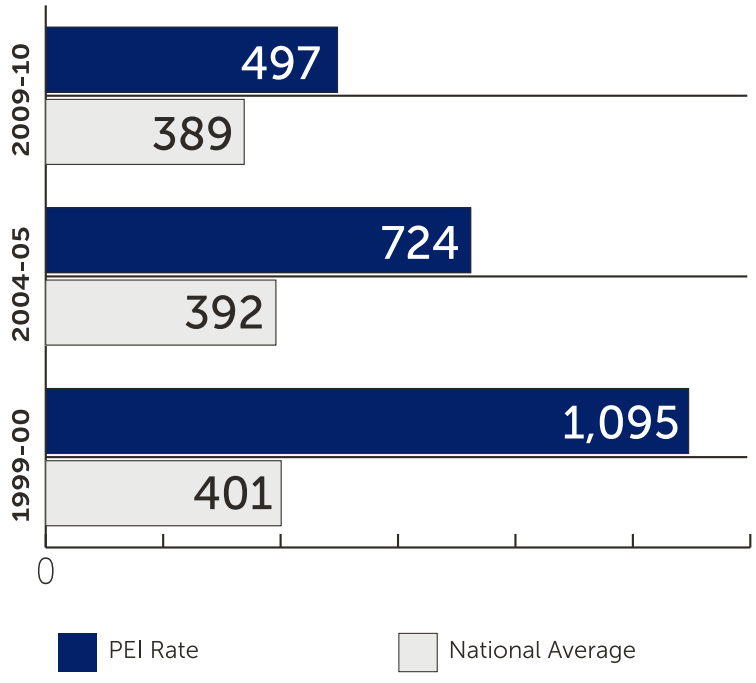
Referrals to the program are accepted from any source, including clients, family members, physicians and other health professionals. Information regarding sources of referrals will be available beginning in 2012-13.

APPROPRIATE ACCESS TO HOME CARE & COMMUNITY BASED CARE

Hospitalization rates for conditions that may be cared for in the community are one indicator of appropriate access to community-based care. These conditions include diabetes, asthma, alcohol and drug dependence and abuse, neuroses, depression and hypertensive disease. Preventive care, primary care and community-based management of these conditions may reduce the need for hospitalization.

Hospitalization Rates For Ambulatory Care Sensitive Conditions

Age Standardized Rate per 100,000 younger than 75



Health Indicators Reports, CIHI

Alternate Level of Care (ALC) is a measure used to reflect when a patient is occupying a bed in a hospital and does not require the intensity of resource / services provided in this care setting.

ALC data is not available. Hospital length of stay exceeding estimated length of stay (ELOS) data for home care clients is monitored and between 2008-09 and 2010-11 decreased by 1.54 days.

ELIGIBILITY, COVERAGE & UTILIZATION

ELIGIBILITY

Islanders, of all ages, are eligible to receive home care services if they meet the following criteria:

- Primary residence is on PEI, and has or is in the process of obtaining a PEI Health Care Number.
- They have an assessed need that can be most appropriately met by the home care program.
- The client is not able to provide the service/support themselves or is unable to access the service in an ambulatory setting.

AGE

All ages

DIRECT FEES AND INCOME TESTING

No fees for professional services.
No income testing is required.

SUPPLIES, EQUIPMENT AND MEDICATION

Clients must pay the cost of medications, supplies and equipment required for care, with the exception of supplies required after discharge from hospital that are eligible for coverage through the two-week Post-Acute Supply initiative.

Medications for clients at end-of-life are covered by the Palliative Home Care Drug Pilot Program.

LIMITS / GUIDELINES TO SERVICE PROVISION

Services are provided based on assessed need. All sites provide home support and nursing services seven days per week with evening service at the two largest sites. There is no access to 24 hour service.

The Enhanced Home Care for Frail Seniors pilot is testing an allocation of a maximum of 16 hours per week for frail seniors and there are plans to define service allocations for other population groups.

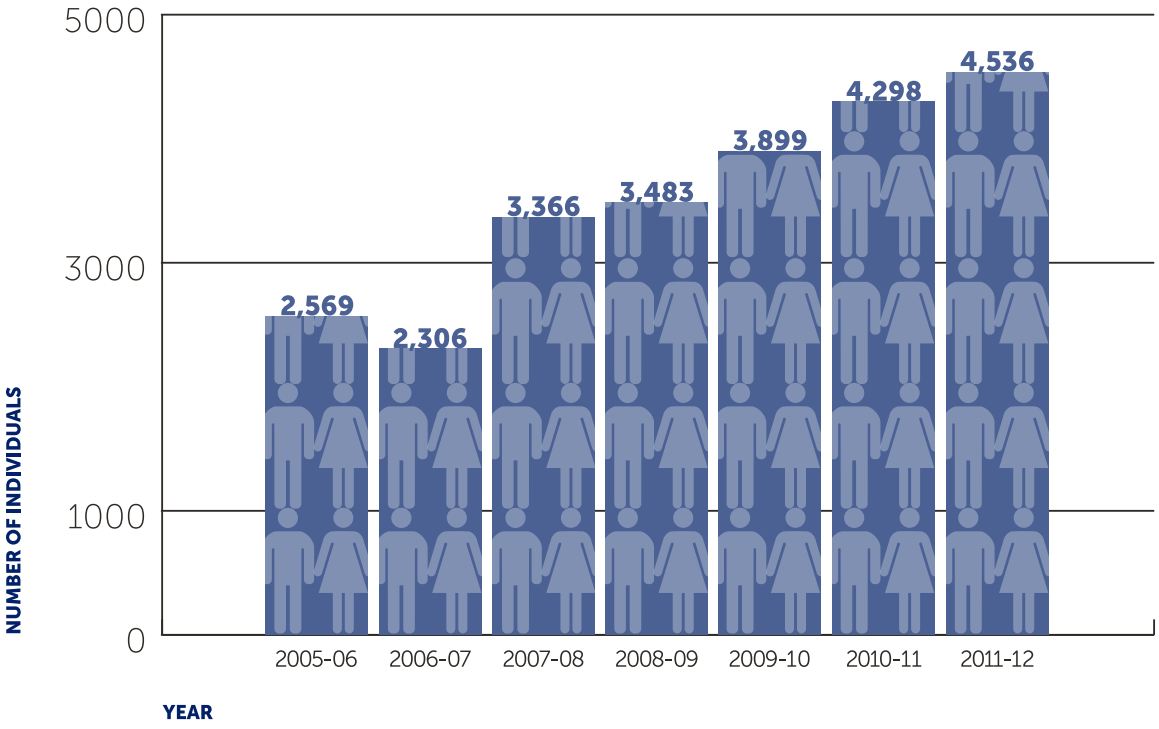
DETERMINING CLIENT NEED - ASSESSMENT TOOLS

Every client, at the point of intake, is assessed for intensity of coordination required and assigned a Primary Coordinator who serves as the primary contact for the client/family and other health services.

All clients are assessed as to need, the potential for risk of care breakdown or decline, the family or community support in place, and the additional services/supports required to safely maintain the individual at home or elsewhere. This is completed using an intake assessment tool that was created by the Home Care Program specifically for the intake process. The intake assessment is completed with the client to review the individual situation, health status, social support and needs. The assessment helps to determine the services required to best suit the individual's needs and goals, and to identify any risks and level of urgency.

Other assessment tools are used as appropriate to each client's situation to support needs assessment, care planning and evaluation. The standard tool, Seniors Assessment and Screening Tool (SAST), is used to determine needs for care and services and also eligibility for long-term and community care. The SAST is designed for use in the senior population and covers function, cognition, risks and caregiver support. A comprehensive palliative care assessment tool is used for palliative clients.

Home Care Admissions



SETTINGS OF CARE

Home care services in PEI may be provided in the following settings:

- Home, which includes long-term care, community care and assisted living
- Schools
- Adult day programs
- Place of work

INTEGRATED MODELS OF CARE

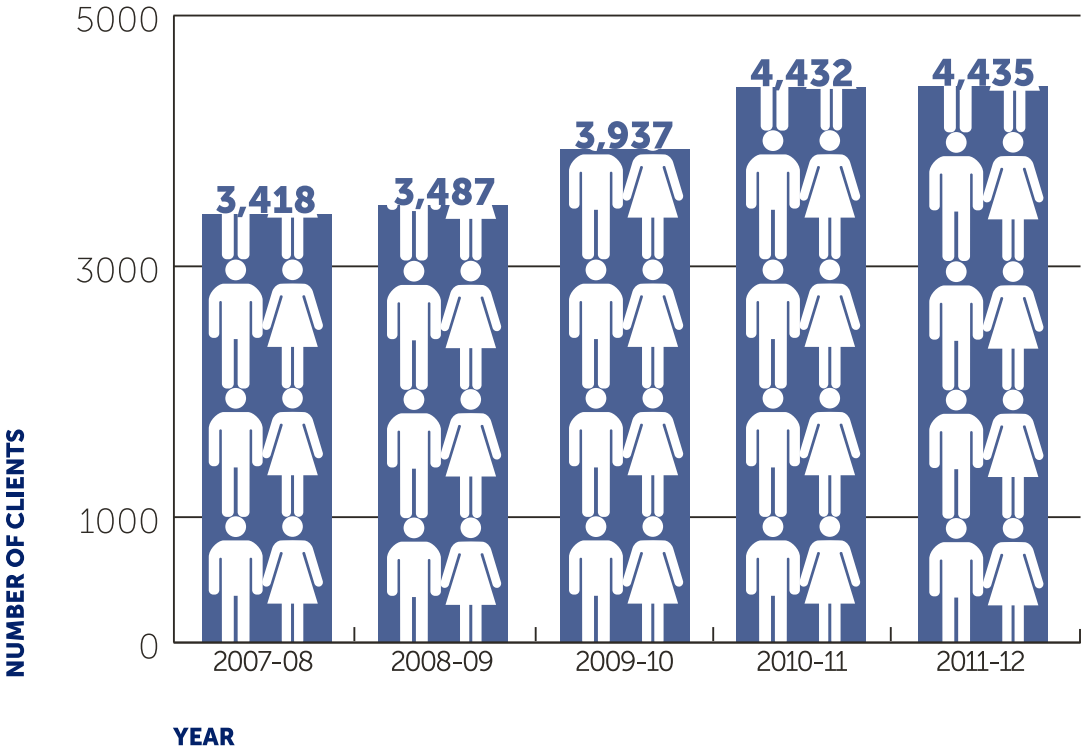
The Collaborative Model of Care (CMoC) is a new model of care for Health PEI that is designed to address staffing challenges and increasing demands for health care services. The provincial model is structured around care teams, processes, technology and communication.

Within the home care program, implementing the CMoC has meant introducing the role of licensed practical nurses (LPNs) to the home care team and implementing a new standardized business process featuring a central point of referral and intake. The focus of CMoC work in home care has been on integration, coordination and partnerships. Many of the projects under home care renewal align with and support the objectives of the CMoC initiative.

DISCHARGE FROM HOME CARE

Discharge disposition of individuals who have received home care service is increasingly important and instructive to the health care system as it is an indicator of effectiveness. The outcomes can guide system planning and the development of care algorithms for specific patient populations.

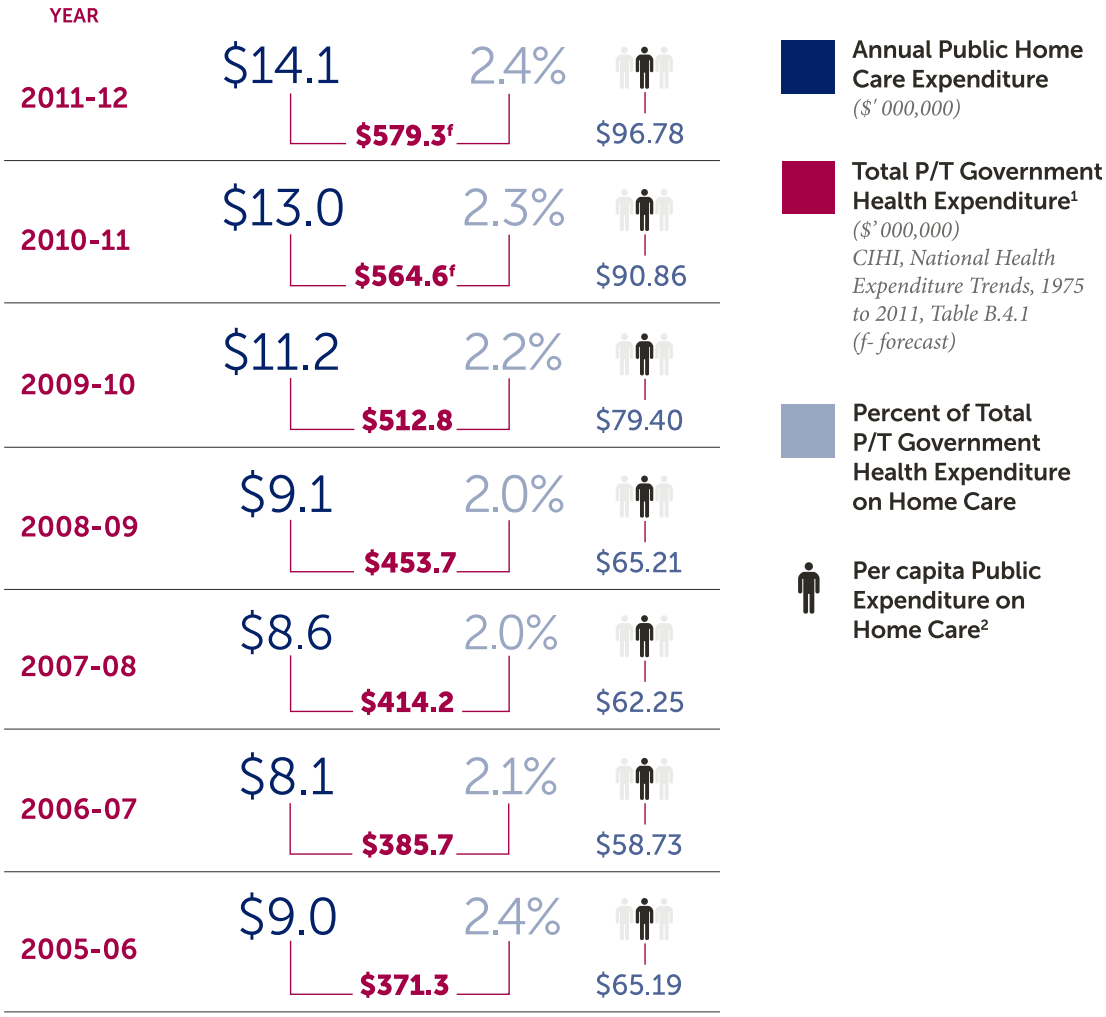
Home Care Discharges



FUNDING

Expenditures include administration, professional services and home support services.

Public Expenditures on Home Care

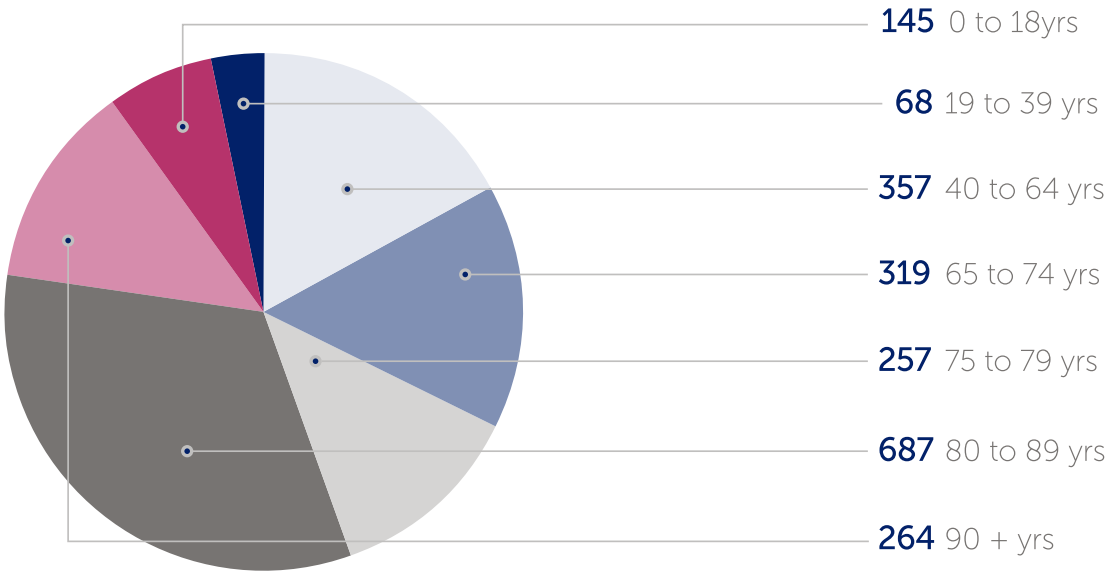


[1] *Figures include spending for health services reported by the provincial/territorial ministry responsible for health – does not include expenditures from municipal government or worker's compensation. [CIHI, National Health Expenditure Trends, 1975 to 2011, pg 92]*

[2] *Population data from Statistics Canada, Demography Division, Annual Estimates of Population for Canada, Provinces and Territories, from July 1, 1971 to July 1, 2012*

PROFILE OF CLIENTS RECEIVING HOME CARE

Number of Individuals Receiving Home Care by Age Category (March 2011)



CLIENT GROUPING

In 2010, PEI home care adopted the use of client groupings as a means to describe their clients from a population perspective, rather than by the service received. The groupings have been modified to five primary and one sub group.

1. **Palliative Care/End-of-Life:** In one's best clinical judgement, a client with any end-stage disease and a deteriorating clinical course. Client fits current criteria and is in agreement with receiving care and support from the Integrated Palliative Care Program (IPCP). The IPCP service focuses on individuals and families who are living with, or dying from, a progressive life-threatening illness.

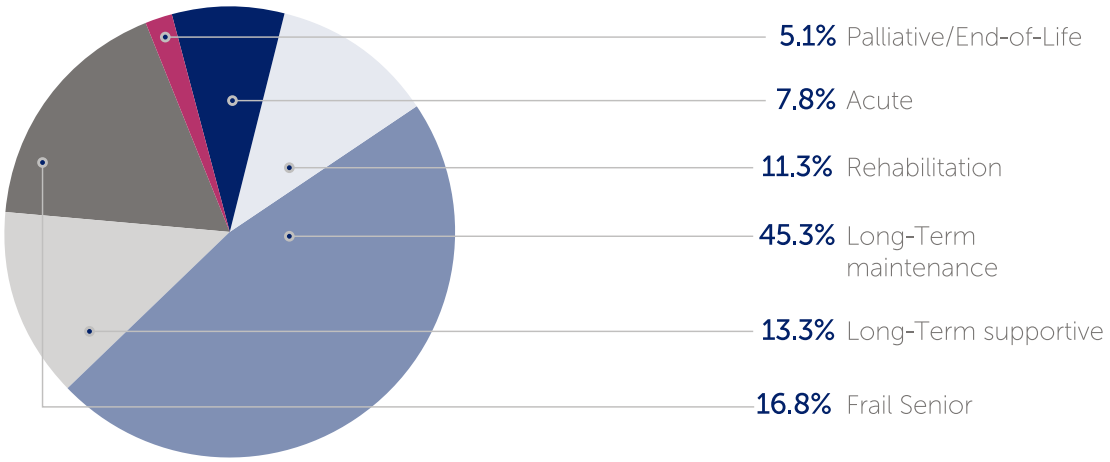
2. **Acute**: A client who needs immediate/urgent time-limited (up to three months) intervention to improve or stabilize a medical or post-surgical condition. The goal is to improve and/or stabilize the client's health issue(s).

3. **Rehabilitation**: A client with a stable health condition that is expected to improve with a time-limited focus on goal-orientated, functional rehabilitation. The rehabilitation plan specifies goals and expected duration of therapy (can be any length as long as improved function is still the goal).

4. **Long-Term Maintenance**: A client with stable, chronic health condition(s) or functional limitations, stable living conditions and personal resources, who requires ongoing support in order to remain living at home.

5. **Long-Term Supportive**: A client who is at significant risk of institutionalization due to unstable, chronic health conditions, and/or living condition(s) and/or personal resources.
    - **Frail Seniors**: A subgroup of Long-Term Supportive, therefore the previous description applies with the added criteria of 75 years of age or older who is assessed as level 3, 4, or 5 with the Seniors Assessment and Screening Tool (SAST).

Percent of Total Caseload in Each Client Grouping (snapshot - April 2011)



SERVICE DELIVERY

The Provincial Home Care Program provides services throughout PEI through three county programs with sites in Souris, Montague, Charlottetown, Summerside and O'Leary.

MODEL OF SERVICE DELIVERY

In most sites the regular hours of service are Monday to Friday 8:30am - 5:00pm, excluding statutory holidays. Home support and nursing services are available at all sites seven days per week, and at the larger sites during evening hours. All home services provided by the Home Care Program are delivered by employees of Health PEI.

RANGE OF HOME CARE SERVICES & PROGRAMS

Home Care Services Currently Funded through the Home Care Program

Assessment and Care Coordination	Care coordination is a frontline strategy that offers support, guidance and care to clients and their families to optimize resources and coordinate complex/ chronic care.
Nursing	Provides education and a wide variety of nursing procedures which can be safely provided in the home, including dressing changes, ostomy care, IV therapy and palliative care.
Home Support	Provides support with activities of daily living, including personal care and respite; intended to support clients and family/caregivers in delaying or preventing admission to an institution.
Physiotherapy	Services to maximize safe functional mobility (in some counties is a shared position between long-term care, hospital and home care).
Occupational Therapy	Services to train and teach clients how to manage routines of daily life (in some counties is a shared position between long-term care, hospital and home care).
Social Work	Provides a social context for assessing resources of the client and family and providing counseling to support coping.
Dietetics	Nutrition-related services including assessment, care planning, monitoring, counseling and education.
Adult Protection	Assessment and assistance to vulnerable adults who are unable to protect themselves from abuse or neglect. Services provided by Adult Protection Workers designated under the Adult Protection Act.
Community Support	Helps clients to find and access supports that assist them in remaining safely in the community.
Pharmacy	Provides support in managing medications, primarily for palliative clients (limited resources, not available at all sites).

Ancillary support

Oxygen	Access via PEI Home Oxygen Program.
Drugs	Clients must pay the cost of medications with the exception of medications for clients at end-of-life that are covered by the Palliative Home Care Drug Pilot Program.
Supplies (dressings, stoma, etc)	Clients must pay the cost of supplies required for care, with the exception of supplies required after discharge from hospital that are eligible for coverage through the two week Post-Acute Supply initiative.
Equipment (wheelchairs, walkers, etc)	Clients must pay the cost of equipment required for care.

SERVICES CURRENTLY NOT FUNDED THROUGH THE HOME CARE PROGRAM

- Nurse Practitioner
- Speech Language Pathology
- Respiratory Therapy
- Physician Services
- Clergy / Spiritual Advisor

3. Quality & Accountability

HOME CARE INDICATORS

The home care indicators that are currently monitored at a provincial level include:

- Expenditures.
- Home care admissions.
- Referral source (monitoring and reporting for these indicators will be available for fiscal year 2012/13 going forward).
- Reason for non admit (monitoring and reporting for these indicators will be available for fiscal year 2012/13 going forward).
- Client disposition at discharge (monitoring and reporting for these indicators will be available for fiscal year 2012/13 going forward).
- Safety issues.
- Number of staff.

QUALITY & ACCREDITATION

EXTERNAL ACCREDITATION

Accreditation is an effective way for health services organizations to regularly and consistently examine and improve the quality of their services in order to ensure high standards of care. Organizations in Canada are accredited through Accreditation Canada, CARF, the Quebec Council of Accreditation (Quebec only) and/or registered with the International Standards Association (ISO).

Health PEI, including the Home Care Program, received national accreditation by Accreditation Canada in 2010.

High-quality care is evidence-based (appropriate), focused on the patient (or patient-centered), safe and timely (CIHI).

CLIENT / PATIENT ADVOCATE

There is a layperson representative on the Quality and Safety Council. There is also an Ethical Framework for the PEI Health System, which includes a Provincial Clinical Ethics Committee, Provincial Research Ethics Committee, and Staff Decision Making Process. The Clinical Ethics Framework and the Decision Making Process link the values of the PEI Health System to the decisions made by the staff who work within the system.

SYSTEM APPROACHES TO QUALITY IMPROVEMENT

A key component of Health PEI's quality strategy lies in the work of 19 quality improvement teams who are responsible for prioritizing, implementing and monitoring quality improvement initiatives in each of their respective service areas.

The work of the quality improvement teams is overseen by a provincial Quality and Safety Council, which is a standing committee of the Executive Leadership Team (ELT). The Council's purpose is to support ELT in defining, planning, implementing and monitoring strategies, plans and policies related to the fulfillment of its quality and safety responsibilities.

SAFETY

A multi-disciplinary advisory committee, the Provincial Healthcare Safety Advisory Committee (PHSAC), is responsible to the Patient Safety Strategy for PEI. Their mission is "*to provide the safest possible healthcare environment for PEI*". The Committee engages stakeholders across the province to realize its goals:

- To have an organizational culture of safety in our health care system.
- To meet or exceed Safer Healthcare Now (SHN) and Accreditation standards.
- To collect, monitor, report and use evidence to improve patient safety.

Health PEI has implemented a number of provincial initiatives to improve quality and patient safety, including a formalized quality review process, a medication tracking list for patients, a provincial safety management system, as well as being involved in several national initiatives through the Canadian Patient Safety Institute. Areas of focus in home care include medication reconciliation, falls risk management program and infection control hand washing campaign.

HOME CARE RESEARCH

The **Prince Edward Island Health Research Institute (PEI HRI)**, at the University of Prince Edward Island, brings together health researchers and interested individuals from the University, community groups, government and the health care community on PEI to develop the Island's health research capacity.

The mission of the PEI HRI is to support, promote and enhance high quality research related to human health on PEI, thereby contributing to the health of Islanders and to the economy of Prince Edward Island. The Institute's initiatives and programs are designed to build research capacity, facilitate peer-reviewed funding success and encourage increased participation in health research.

PEI Quality and Patient Safety Council

The purpose of the Quality and Patient Safety Council is to provide leadership to the PEI health system in relation to the adoption and compliance with health care quality standards. The overall aim is to improve the quality of services Health PEI provides.

Its main responsibilities include the promotion of an organizational culture of continuous quality improvement, the support of quality improvement activities, the identification of barriers and strategies to improve quality, and the provision of oversight to the quality system.

(Health PEI Business Plan: April 1, 2011-March 31, 2012)

4. Information Technology

ELECTRONIC HEALTH RECORD (EHR)

The electronic health record, which integrates patient information into an electronic "chart" that follows them to any health care provider they choose, has been initiated in PEI. Health PEI is recognized as a national leader in implementing electronic health records provincially. Making this information more available to providers streamlines their work flow and increases the safety of every Islander who accesses the health system. The electronic home care record is called the ISM (Integrated Services Management System). This system is designed for and used by community services providers and is not yet incorporated into the provincial electronic health record.

HEALTH DATA & THE HOME CARE REPORTING SYSTEM

To meet the need for consistent, comparable home care information, the Canadian Institute for Health Information (CIHI) developed the Home Care Reporting System (HCRS). The purpose is to collect and process information on publicly funded home care services in order to support jurisdictions in their analysis and decision making by providing data on:

- Access to home care services.
- Health and functional status measures.
- Clinical outcomes and waiting times.
- Quality of care.
- Informal support.
- Service utilization by setting and provider type.

The HCRS captures standardized client-specific clinical, demographic, administrative and resource utilization information. A key component of the HCRS is the Resident Assessment Instrument—Home Care (RAI-HC). The PEI Home Care Program is currently working with CIHI to establish regular reporting from the home care electronic record (Integrated Services Management – ISM) to the HCRS. The target time line for commencing reporting is fiscal year 2012/13.

USE OF SYSTEM EFFICIENCY TECHNOLOGY

Electronic communication does not yet exist between home care and physicians, or home care and hospitals, with one exception. The Liaison Coordinator (home care staff assigned to the hospital) can access both the home care record (ISM) and hospital based Cerner system. The ISM system does not interface with the hospital system. Technology applications support communication between frontline home care staff to communicate referral and clinical information. Technology is also used to share information with the Department of Health for submission of indicator data.

Testing of the ISM on laptops with wireless connectivity, to enable point of care documentation, has been initiated. Further roll out of this technology is pending evaluation of the testing, but anticipated benefits are increased staff efficiency and reduced need for prep and charting time.

5. Health Human Resources

CLINICIANS PRACTICING IN HOME & COMMUNITY CARE

HEALTH CARE PROFESSIONALS

Health professions are regulated by self governing colleges under Acts specific to each profession, including the Registered Nurses Act, Physiotherapy Act, Occupational Therapists Act and Social Work Act. Most professions also have a professional association to guide and advocate for members. At this time, PEI does not have umbrella health professional regulation legislation.

Number of Staff – Full Time Equivalents

	2006-07	2011-12
Care Coordinator (Case Manager)	The case management function is integrated into the professional's practice and not a designated position	5
Palliative Care Coordinator		5.8
LTC Admission Coordinators		4.6
Dietician / Nutritionist	0.4	0.6
Occupational Therapist	5.7	7.3
Pharmacist	0.6	0.6
Physiotherapist	0.8	3
Registered Nurse	35.7	32.5
Licensed Practical Nurse	0	4.5
Social Worker/Adult Protection Worker	4.8	4.8
Provincial Director	1	1
Provincial Adult Protection Consultant	0.6	0.6

UNREGULATED STAFF

Home Support Workers (HSW) are unregulated health workers that provide personal care to home care clients on Prince Edward Island.

Number of Staff – Full Time Equivalents

	2006-07	2011-12
Home Support Worker	59.8	76.5

There is no provincial registry for the unregulated home care staff.

The Vital Role of the Family Caregiver

Family caregivers provide care and assistance for spouses, children, parents and other extended family members and friends who are in need of support because of age, disabling medical conditions, chronic injury, long-term illness or disability. A family caregiver's effort, understanding and compassion enable care recipients to live with dignity and to participate more fully in society.

5 million
is the estimated number of caregivers in Canada

80%
of care needed by individuals with a long-term condition is provided by family caregivers

60%
of caregivers provide care for more than three years

(Canadian Caregiver Coalition www.ccc-ccan.ca.)

EDUCATION & TRAINING

HEALTH CARE PROFESSIONALS

Regulation of education requirements is a part of professional licensing bodies.

UNREGULATED STAFF

The education requirements of the unregulated staff, in home care, are not defined by the province. As a result the curriculums vary and organizations determine recruitment criteria, training programs and on-going task/competency-specific training. Health PEI requires staff to have Resident Care Worker or equivalent training. The home care managers meet regularly to review policy/practice to ensure consistency across the province in terms of service standards of practice.

INTER-PROFESSIONAL COLLABORATION

Home care services are delivered by an interdisciplinary group of staff with a focus on collaboration and client-centered care. The Integration Model for Care Coordination in home care is a collaborative, front line strategy to support system integration and coordination across the continuum, at both the client and the system. The key elements include:

- Intake and engagement
- Referral, service request and communication
- Consultation, assessment
- Proactive care planning
- Partnerships
- Service delivery, intervention
- Service coordination
- Education, information sharing
- Evaluation, reassessment, client service
- Crisis management
- Person-centered care
- Discharge transition

FAMILY CAREGIVER

Home care staff work in partnership with families to provide services that complement the care provided to the family member/client by the caregiver. Some of the home care services that most directly support caregivers include respite, Adult Day Program and care coordination to help caregivers become aware of and access available resources.

The Home Care Program has been involved in the testing of the C.A.R.E. Tool - a psychosocial assessment tool to be used by home care practitioners with family caregivers to help understand Caregivers Aspirations, Realities, and Expectations (C.A.R.E). The C.A.R.E. Tool contains 10 sections: demographic information of the caregiver and care receiver, caregiving work, informal and formal support, living arrangements, other responsibilities, financial contribution, physical and emotional health, family relations, crisis and long-term planning, and service support needs. The final section summarizes the caregiving situation, allowing for the identification of areas of difficulty experienced by the caregiver and key areas of concern to be addressed in the future.

6. Provincial Initiatives

CHRONIC DISEASE MANAGEMENT

A new chronic obstructive pulmonary disease (COPD) pilot project was implemented in the spring of 2010. The goal of this project is to improve clinical outcomes and quality of life for patients by developing standard treatment approaches, working with a team of health professionals collaboratively and improving patient knowledge, skills and confidence for successful self-management of COPD. The COPD Care Pathway has been implemented in primary care and rollout is beginning in community hospitals. Health PEI is exploring how home care can implement and support the pathway Seniors and Aging

SENIORS AND AGING

A Healthy Aging Strategy, with five pillars of activity, has been launched. These include:

1. Manor Replacement – a staged approach to upgrading facilities in order to provide dementia care.
2. Palliative Home Care Drug Project – to provide the necessary drug coverage and care to enable palliative patients to remain at home.
3. Enhanced Home Care – greater investment in home care services.
4. Expanded and Improved Long-Term Care – investments in both facility and home based care.
5. Transitional Care – the establishment of a unit for patients awaiting alternate levels of care – the timeframe for this has not yet been determined.

END-OF-LIFE CARE

Access to the Integrated Palliative Care Program is available through home care offices in PEI. Care may include medical, nursing and other professional care for pain and symptom management, respite care, emotional support, spiritual support, counseling, and ongoing bereavement support after the death of a loved one.

POST ACUTE SUPPLIES

The two week Post-Acute Supplies Project was initiated in 2010 to provide necessary medical supplies to clients discharged from hospital who will be receiving home care nursing services. The purpose was to remove a potential barrier to discharging a patient from hospital and to ensure smooth transition home. On average 16 patients per month received the supplies.

WOUND CARE

The Enterostomal Therapy Nurse (Wound Care) Project in Kings County created a specialized nursing service and consultative support to health professionals. The ET nurse provides direct care to clients through advanced clinical knowledge and expertise, and also provides consultation, leadership and education to other health professionals who are caring for clients with challenging wound, ostomy and continence care needs. Wound care is an expensive service for health care organizations.

7. Challenges

The key challenges facing home care in PEI are:

- Aging population – projections are that those over the age of 75 will increase by 67 percent over the next twenty years.
- Chronic disease – an increasing prevalence as compared to the national average.
- Chronic shortage of health care professionals.
- Staff workload.
- Increasing costs to provide care.
- Increasing demands for service and increasing complexity of care required.

8. Opportunities

PEI has committed that care will be delivered through a single, integrated system of care, one grounded in evidence-based decision making and focused on improving health, enhancing access and refocusing the emphasis of the care delivery system on primary health care and services that can appropriately and safely be provided locally. The system will be more focused on meeting needs in the most appropriate setting, by the most appropriate provider and in the most cost effective manner. The PEI Home Care Program is pursuing a number of opportunities to strengthen health services provided to Islanders, specifically, continued integration of partners along the continuum of care and the implementation of a strategy to support frail seniors.

Through the collaborative efforts of all health system providers, significant improvements in patient care, access to services, and in the work place have been realized. A performance measurement framework has been established which will allow monitoring of the health system.

There is still much work to be done and home care will be an integral component of ensuring access to quality services at the right time and place.

Acronyms / Abbreviations

ALC –	Alternate Level of Care
CIHI -	Canadian Institute for Health Information
CMoC -	Collaborative Model of Care
COPD -	Chronic obstructive pulmonary disease
EHR –	Electronic Health Record
ELT -	Executive Leadership Team
HCRP –	Home Care Reporting System
HCSP -	Home Care Support Program
HSW -	Home Support Worker
IPCP -	Integrated Palliative Care Program
ISM -	Integrated Services Management System
ISO -	International Standards Association
PEI HRI -	Prince Edward Island Health Research Institute
PHSAC -	Provincial Healthcare Safety Advisory Committee
RHA – HC -	Resident Assessment Instrument—Home Care
RHA -	Regional Health Authorities
SAST -	Seniors Assessment and Screening Tool
SHN -	Safer Healthcare Now

SOURCES

The chapter has been compiled from sources listed below, interviews with key informants and feedback to an electronic survey. Information replicated from provincial materials has been done so with the knowledge and permission of the key informant.

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Harmonized Principles for Home Care

Guide policy and program development

Support consistency and equity across the country

Facilitate benchmarking and sharing of best practices

EVIDENCE-BASED CARE

Knowledge that is grounded in evidence is used as the foundation for effective and efficient care provision, resource allocation and innovation.

Evidence-Informed:
Decision-making incorporates the best available evidence, expertise and experience.

Knowledge Transfer:
Share ideas and information with clients, family caregivers, providers and planners.

Innovation:
Support a culture of innovation and ingenuity.

Research:
Promote awareness and application of research evidence to inform decisions.

NEWFOUNDLAND AND LABRADOR

HOME CARE IN **NEWFOUNDLAND & LABRADOR**

In **Newfoundland and Labrador** the definition of home care is consistent with that of the Canadian Home Care Association.

> Home care is an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the family caregiver.

Newfoundland & Labrador

BY THE NUMBERS...

373,872 sq km **LAND AREA**	510,600[1] POPULATION (2011)	15.8%[1] **Population Seniors 65+ yrs (2011)**	**58%**[3] Percent population in urban settings defined as an area with a population of at least 1,000 and with no fewer than 400 persons per square kilometre (2006)	
56.2%[2] Dependency ratio (2009) Ratio of the population aged 0-19 and 65+ to the population aged 20-64.		78.5 years[1] **LIFE EXPECTANCY (AT BIRTH)**	**$5,300.01**[2] Public sector health care expenditure per capita (2011 Forecast)	

[1]Statistics Canada | [2]CIHI | [3]HRSDC

1. Governance & Organization

HEALTH CARE SYSTEM STRUCTURE

The **Department of Health and Community Services** is responsible for policy direction, setting of standards and allocation of resources to the four regional health authorities (RHAs) and other mandated health and community service agencies. The Department is the lead for activities that include, but are not limited to, wellness, healthy aging, chronic disease management, mental health and addictions, long-term care and community support services, health human resource planning, and model of services co-ordination for children and youth. The Department is a participant in the multi-departmental initiatives such as violence prevention, persons with disabilities, immigration and poverty reduction.

The **regional health authorities** (RHAs) are responsible for delivering direct care to individuals in hospitals, long-term care facilities and community-based offices and clinics, as well as through public health and community support services. They have the flexibility to design the content of their programs to meet the unique needs of their region, within the parameters of provincial policy. The regions are responsible for decisions that impact access and consistency of service delivery, such as number of visits, duration of service, assignment of health care practitioners (which are guided by provincial home care service guidelines and policies) and decision making frameworks that reflect the experience to date. Home care services are funded by the Newfoundland and Labrador Department of Health and Community Services through block funding to four regional health authorities (RHAs).

Regional Health Authorities

- Eastern Health Authority
- Central Health Authority
- Western Health Authority
- Labrador-Grenfell Health Authority

HEALTH CARE & HOME CARE LEGISLATION

There are a number of components of legislation that impact home care and health care in Newfoundland and Labrador. They include, but are not limited to:

Adult Protection Act (2011)- replaces the *Neglected Adults Welfare Act*. Protects adults who are incapable of caring for themselves; refuse, or are unable, to make decisions for care on their own behalf; and, who are not currently receiving proper care and attention. Emphasis is placed on an individual making his/her own decisions where possible, and recognition that the best interests of the adult are of paramount consideration in an intervention to assist or protect a vulnerable adult.

Personal Health Information Act (2011) - governs the collection, use and disclosure of personal health information by individuals and organizations involved in the delivery of health care services. The law is intended to keep information confidential and secure, while allowing for the effective delivery of health care services in the province.

Regional Health Authority Act (2006) - outlines the requirements for the delivery and administration of health and community services in the province, by the health regions.

Transparency and Accountability Act (2004) - ensures greater government accountability to the people of the province. It covers strategic planning and annual reporting, financial forecasts, public entity borrowing, and performance-based contracts for senior officials. It requires public release of a wide variety of information so that it is accessible to the people of the province. This legislation applies to all government departments and public entities, with the exception of provincial courts.

Home Care, an Essential Service

Home care was first available in Canada in the early 17th century, when nuns from religious orders arrived in Quebec to provide both direct care and disease prevention services [Community Health Nurses' Initiatives Group]. The first publicly funded home care program was established in 1970 and has continued to evolve and grow over time.

Today, home care is an essential element of an integrated system that provides accessible, responsive services, which enable people to safely stay in their homes with dignity, independence and quality of life.

Canadian Home Care Association, http://www.cdnhomecare.ca/

EVOLUTIONARY MILESTONES

1975
Home care introduced on a limited basis.

1985
Home Support Program for seniors and persons with disabilities established in Department of Social Services.

1994
Regional Health Boards established.

1995
Home Support for seniors transferred to Department of Health and Community Services (DHCS).

1998
Home Support for persons with disabilities and Child, Youth and Family Services transferred to DHCS.

2002
A strategic health plan 'Healthier Together' released. The plan committed to the development of a long-term care and supportive services strategy, that includes home support.

2006
Bill 11, the *Regional Health Authorities Act*, provided for creation of four regional health authorities and the repeal of the Regional Health and Community Services Boards; and for the delivery of health and community services through regional health authorities.

Acute Home Care and End of Life Program developed.

2007
The 'Provincial Healthy Aging Policy Framework' included recommendations on personal care, long-term care, and home support.

2009
Financial eligibility criteria ceiling increased and income based testing introduced for the home support program.

Child, Youth and Family Services transferred from the Department of Health and Community Services to a new government department dedicated to focusing solely on the needs of children, youth and their families.

2012
Release of *Close to Home: A Strategy for Long-Term Care and Community Support Services* that will help revitalize and strengthen community and long term care services throughout the province.

MANDATE, MISSION, PRINCIPLES & PRIORITIES

VISION

The proposed vision for the Long-Term Care Community Support System is that individuals and families requiring long-term care and community support services will achieve optimal independence and quality of life in their homes and communities.

The current home care priorities are to increase access to home care services to prevent hospitalization, reduce length of stay and avoid premature long-term placement.

Specifically, the program continues to develop home/ community care and support services in the areas of end-of-life care, acute short term post discharge interventions, community chemotherapy, expanded wound therapy options and personal health achievement.

PRINCIPLES OF HOME & COMMUNITY CARE

Home care services are delivered under the values that govern all of the services provided by the Department of Health and Community Services:

- Professionalism - Each person is qualified and competent, and supported in their work through a culture that encourages continuing education and employee development.
- Excellence - Each person makes decisions based on the best evidence available and follows proven best practices to ensure individual and departmental performance is maintained at the highest possible standard.
- Collaboration - Each person engages others, both within and external to the department, in a positive manner, respectful of others and their different perspectives.
- Privacy - Each person manages and protects information related to persons / families / organizations / communities and the department appropriately.
- Transparency and Accountability - Each person takes their responsibilities to their clients seriously, and contributes to a culture of openness and transparency in decision-making and reporting.

HOME CARE PROGRAM OBJECTIVES

- Develop and implement processes to ensure clients and families requiring services are identified and referred in a timely manner.
- Ensure assessment, planning, implementation, evaluation and documentation are continuous components of the cycle of care.
- Participate in collaborative partnerships with community representatives, partner groups and other health care providers. These partnerships could include family physicians, pharmacists, allied health workers, aboriginal groups, Human Resources Labour and Employment, Veterans Affairs Canada, home support agencies and workers, spiritual advisors and volunteers.

HEALTH SYSTEM PRIORITIES

The strategic issues for the Department of Health and Community Services as outlined in the '2011-2014 Strategic Plan' include:

- **Quality and Safety** - a focus on support for training and licensing to improve health care resources, and improved monitoring to enhance system performance to meet current and future health care needs.
- **Improved Access and Increased Efficiency** - through improved assessment for services such as curative radiotherapy, cardiac bypass surgery, cataracts, hip replacement, hip fracture repair, breast and cervical screening, as well as a wait time management plan, expansion of telehealth and options for mental health and addiction services.
- **Population Health** - to enhance the focus on prevention of illness and injury, protect and promote health and well-being and improve the health status of the population.
- **Demographics and the Delivery of Health and Community Services** - align with changing demographics to ensure a responsive health and community services system.

2. Access, Funding & Service Delivery

ACCESS TO HOME CARE SERVICES

Home care services are accessed by referral to the regional health authorities (RHAs). A referral may be made by any individual or acute care facility. Referrals are accepted Monday to Friday during regular business hours. However, scheduled visits may include weekends or evenings.

There are wait lists for some home care services as a result of staffing shortages. These include home support, physiotherapy and occupational therapy in some areas. Additionally, response time for services may be longer in rural areas and not all communities are able to have home health visits on a daily basis.

REFERRAL SOURCES

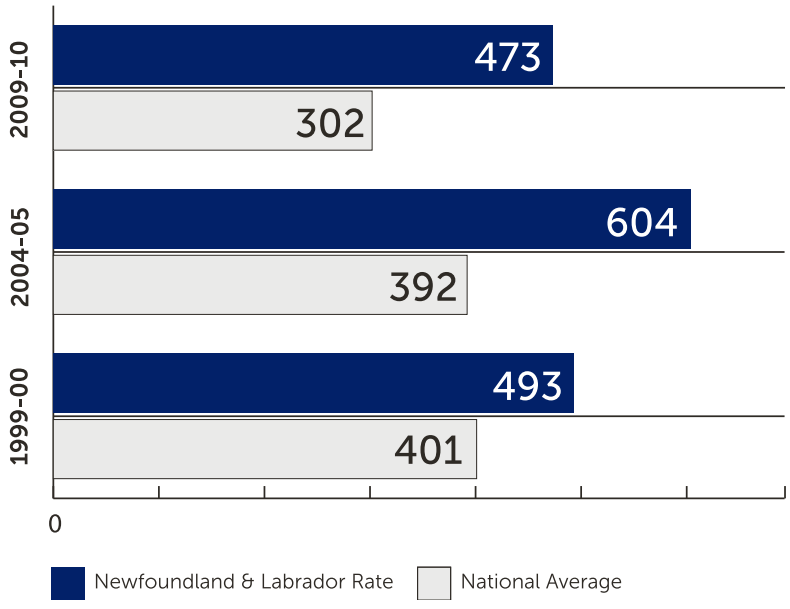
Anyone (e.g. self, physician, and family member) can make a referral for home care services. The source of referrals is tracked regionally.

APPROPRIATE ACCESS TO HOME CARE & COMMUNITY-BASED CARE

Hospitalization rates for conditions that may be cared for in the community are one indicator of appropriate access to community-based care. These conditions include diabetes, asthma, alcohol and drug dependence and abuse, neuroses, depression and hypertensive disease. Preventive care, primary care and community-based management of these conditions may reduce the need for hospitalization.

Hospitalization Rates For Ambulatory Care Sensitive Conditions

Age Standardized Rate per 100,000 younger than 75



Source: Health Indicators Reports, CIHI

ELIGIBILITY, COVERAGE & UTILIZATION

ELIGIBILITY

- Resident of Newfoundland, Labrador.
- Must have a demonstrated need.

AGE

All ages

Home support services are only offered to:

- Seniors (age 65+)
- Persons with disabilities
- Children, youth and their families.

SUPPLIES, EQUIPMENT AND MEDICATION

Eligibility for supplies and equipment is means tested unless the individual is on the acute care or end-of-life program, in which case a limited amount of health care supplies and equipment is provided.

The Newfoundland and Labrador Prescription Drug Program (NLPDP) provides financial assistance for the purchase of eligible prescription medications for those who reside in the province. The NLPDP is payer of last resort. A limited number of medications are provided, at the discretion of the region, for those on the acute home care program.

DIRECT FEES AND INCOME TESTING

There is no income testing for those requiring professional health services or short term care.

Home support services require a financial assessment to determine the client's ability to pay. Liquid assets are considered in determining eligibility for home support. The allowable liquid asset threshold is $10,000 for single persons under 65 years with a disability, and for single seniors. The threshold for couples is $20,000.

There may be a co-pay for home support services.

LIMITS / GUIDELINES TO SERVICE PROVISION

There are no specific service or dollar limits for professional services, and service level is based on assessed need and provided within available resources. However, these services cannot be accessed after hours and there is no emergency response mechanism.

The Acute Home Care Program provides services to individuals for a two week period to prevent hospitalization or facilitate early hospital discharge. Acute home care services are not available in all areas of the province.

Palliative care is provided as required and is non-means tested. End-of-life services are provided for up to a month when death is imminent.

Subsidized home support services are limited by a financial ceiling of $2,810/month for seniors and $4,035/month for adults with disabilities.

DETERMINING CLIENT NEED - ASSESSMENT TOOLS

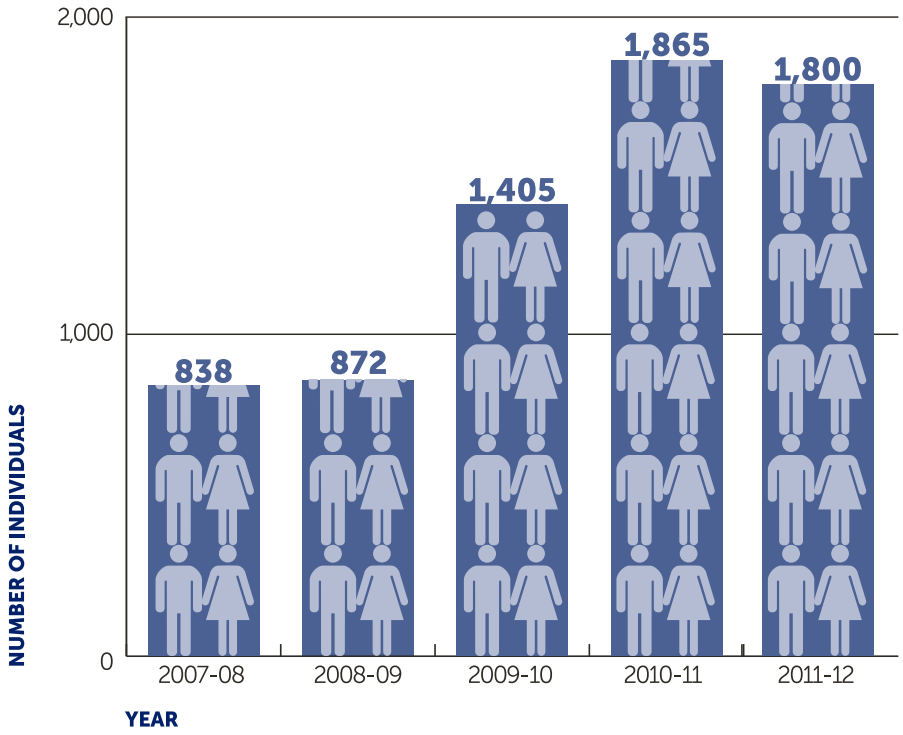
A standard provincial assessment tool, the **'Long Term Care and Community Support Program Adult Needs Assessment'**, is used to access a broad range of community and facility based services. The assessment is interdisciplinary and focuses on client need. The outcome of the assessment informs changes to the care plan. Home care service needs are usually assessed by a registered nurse and/or social worker, and a care plan is made based on assessed need and organizational policy. The client assessment, or relevant components, may be shared with any individual within the client's circle of care, as well as the individual/family. Sharing of the assessment is guided by the provisions of the Personal Health Information Act.

The province is planning to implement the RAI-HC in the near future, although there is no confirmed date of implementation.

ADMISSIONS TO HOME CARE

Access to home care is generally consistent between rural and urban settings, as the admission criteria are the same across the province. Data regarding home care admissions are not tracked provincially. However, the admission information for the home support component of the home care program is presented in the chart below.

Home Support Admissions



[1]*In 2009, financial eligibility criteria ceiling increased and income based testing was introduced for the home support program.*

[2]*Preliminary numbers*

Department of Health and Community Services, Newfoundland and Labrador

SETTINGS OF CARE

Home care services in Newfoundland and Labrador are provided in the following settings:

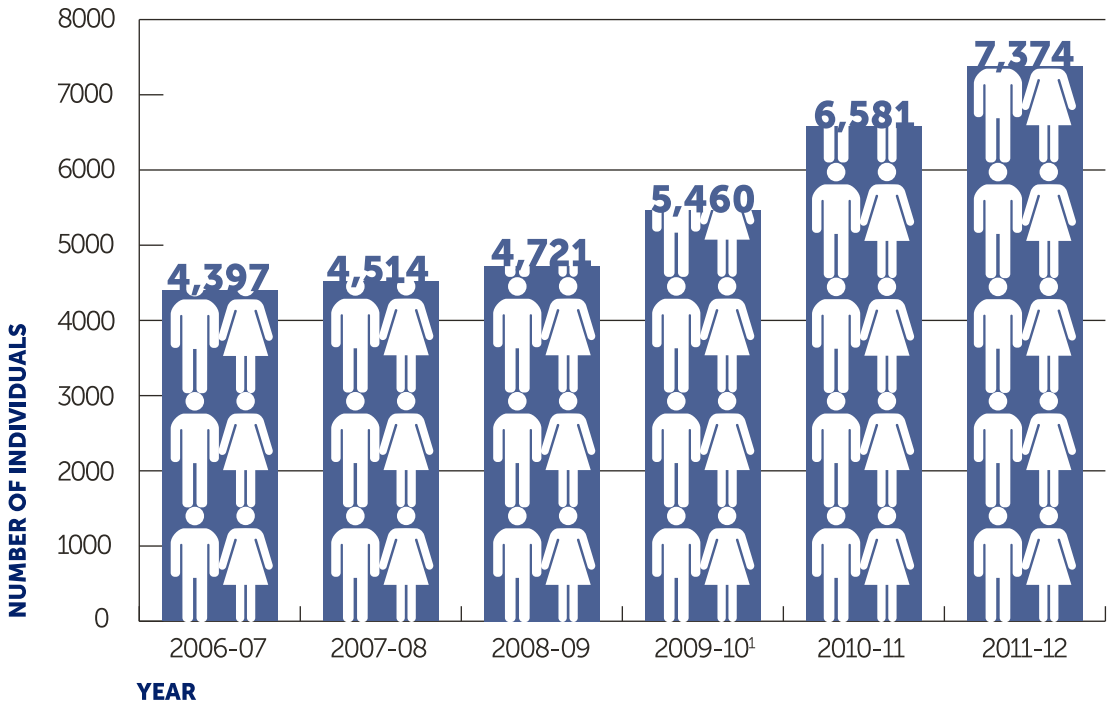
- Clinic - available in most areas of the province 5-7 days per week.
- Home - available throughout the province but may vary in frequency based on geography and staffing. Daily service is not available in all areas.
- Place of work.
- Retirement Home – known as Personal Care Home.
- School - provided for delegation of nursing interventions required by school age children. Public Health nursing is also provided to school age children in the school setting.
- Street – small demand for home care service for the homeless. The population would most often receive service in a prearranged location (e.g. Salvation Army-New Hope Clinic or community nursing clinic).

There are no residential hospices or groups homes in the province.

NUMBER OF INDIVIDUALS RECEIVING HOME CARE

The number of persons receiving home care services is not available. However, those receiving home support components of the home care program (adults 18 yrs+) are reflected in the chart below.

Individuals Receiving Home Support



[1]*Financial criteria changed during fiscal year that opened program eligibility to increased clients.*

DISCHARGE FROM HOME CARE

Discharge disposition of individuals who have received home care service is increasingly important and instructive to the health care system as it is an indicator of effectiveness. The outcomes can guide system planning and the development of care algorithms for specific patient populations.

Tracking of home care clients occurs at the regional level. After discharge from the home care program, clients must obtain their medications through private purchase, third party insurance or, if eligible and as payer of last resort, through the Newfoundland and Labrador Prescription Drug Program. Recent changes to the Provincial Drug Program have resulted in a greater number of people qualifying for the service. Eligible clients are maintained on the home care program for as long as they need approved equipment and supplies.

LEARN MORE

Resident Assessment Instrument-Home Care (RAI-HC)

The Resident Assessment Instrument-Home Care (RAI-HC)© and its next generation tool, the interRAI HC is a standardized, multi-dimensional assessment system for determining client needs. The assessment instruments are used to assess adults in home and community-based settings with chronic needs for care as well as those with post-acute care needs. The instrument is generally used with the frail elderly or persons with disabilities who are seeking or receiving formal health care and supportive services.

Assessments are captured electronically and provide real-time feedback for clinicians to support care planning and monitoring in addition to providing organization and jurisdiction level data to support system management, quality improvement and policy-making.

The RAI-HC was developed through interRAI, a collaborative, not-for-profit network of researchers from around the world that works to promote evidence-informed clinical practice and policy decision making through the collection and interpretation of high quality data about the characteristics and outcomes of persons served across a variety of health and social services settings.

Source: http://www.interrai.org/ RAI-HC© interRAI Corporation, 2001.

FUNDING

Expenditures reported below are for the **home support component for seniors and adults with disability only.** The expenditures for professional home care services cannot be extracted for the current data collected in Newfoundland and Labrador.

Public Expenditures on Home Support

(For Seniors and Adults with Disability Only)

YEAR	Annual Home Care Expenditure (Home Support for Seniors & Adults with Disabilities Only)[1]	Total P/T Government Health Expenditure[2] ($' 000,000)	Percent of Total P/T Government Health Expenditure on Home Support	Per capita Public Expenditure on Home Care[3]
2011-12	$155.0	$2,581.3 f	6.0%	$302.20
2010-11	$136.4	$2,430.1 f	5.6%	$266.47
2009-10	$107.1	$2,202.6	4.9%	$210.37
2008-09	$88.3	$1,988.9	4.4%	$174.38
2007-08	$79.2	$1,831.3	4.3%	$156.42
2006-07	$72.6	$1,690.2	4.3%	$142.27
2005-06	$68.1	$1,589.7	4.3%	$132.40

Data Source: CIHI, National Health Expenditure Trends, 1975 to 2011, Table B.4.1
f – forecast

[1] *Reported by Department of Health and Community Services, Financial Services*

[2] *Figures include spending for health services reported by the provincial/territorial ministry responsible for health – does not include expenditures from municipal government or worker's compensation. [CIHI, National Health Expenditure Trends, 1975 to 2011, pg 92]*

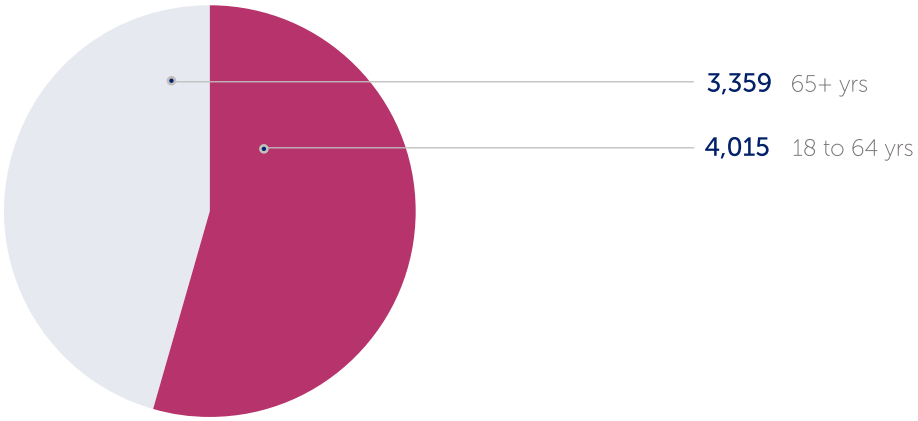
[3] *Population data from Statistics Canada, Demography Division, Annual Estimates of Population for Canada, Provinces and Territories, from July 1, 1971 to July 1, 2012*

PROFILE OF CLIENTS RECEIVING HOME CARE

AGE

Individuals are eligible for home care services across their life span. Data for ages of clients receiving home care is not available. A large proportion of the population in receipt of home care services is the adult population. Information for the home support component of home care is captured in two categories, seniors (over 65) and adults with disabilities (under 65).

Number of Individuals Receiving Home Support By Age Category



***Financial criteria changed during fiscal year that opened program eligibility to increased clients.*

CLIENT GROUPING

The Department of Health and Community Services is beginning to capture data in the Client and Referral Management System (CRMS). The client grouping definitions (Acute Care Substitution, Maintenance, End-of-Life Care (Palliative), Rehabilitation, Long-Term Supportive Care), established by a federal / provincial / territorial working group on continuing care in 2001, are being used and provincial data will be available in the future.

SERVICE DELIVERY

MODEL OF SERVICE DELIVERY

Services are delivered through the public and private sector. The public sector delivers professional services including nursing, social work and therapies, while the private sector delivers private pay nursing and home support / personal care services.

RANGE OF HOME CARE SERVICES & PROGRAMS

Services funded and provided through the Home Care Program

Case Management / Coordination	Case coordination and case management are provided within the multidisciplinary team that may include any number of professional home care services.
Professional Services	• Nursing, inclusive of nurse practitioners and licensed practical nurses. • Social work. • Therapies: physiotherapy, occupational therapy. • Speech language pathology (limited), respiratory therapy (in one region only). • Dietetics.
Home Support Services	An essential part of the continuum of health services, allowing people with health or functional deficits to live independently, and in many cases, prevents hospitalization and/or institutionalization. These services are delivered by non-professional staff that provide personal care, household management, behavioural management and respite services.

Ancillary support[1]

Eligibility for payment of medical supplies, equipment, orthotics and oxygen are financially assessed through the Special Assistance Program. Note: Drugs are not available through home care.

Annual Expenditures

	2007-08	2008-09	2009-10	2010–11	2011-12
Oxygen	$644,053	$957,495	$1,117,107	$1,130,305	$1,440,071
Supplies – (dressings, stoma, etc. wheelchairs, walkers, etc.)	$4,097,926	$4,460,051	$4,692,381	$5,532,087	$6,213,416

[1]*Reported by Department of Health and Community Services*

Services currently not funded through home care

- Physician
- Pharmacy
- Pastoral Care

CLINICAL (SPECIALTY) SKILLS

With the focus on discharging patients from hospital as promptly as possible, there has been an increase in the complexity of care provided at home. The challenge in much of Canada can be in having a critical mass of patients who require certain levels of expertise and, as a result, special skills only being available in urban centres. However, with the advent of remote access to support in the community, there is an opportunity for more complex care to be provided in less populated areas.

Home care nurses are able to:

- Administer chemotherapy and narcotics in select areas (rural service can be provided daily and urban settings can receive twice daily service).
- Provide enterostomal therapy, wound care, infusion therapy and peritoneal dialysis.
- Manage infusion pumps, central lines and peripherally inserted central catheters (PICC lines).
- Provide ventilator care and regular tracheostomy tube replacement.
- Manage home oxygen for individuals in their homes across the province.

Clinical services not currently provided in the home include:

- Administration of blood or blood products.
- Hemodialysis.

3. Quality & Accountability

HOME CARE INDICATORS

The home care indicators that are currently monitored at the provincial level include:

- Amount of service delivery.
- Expenditures.

QUALITY & ACCREDITATION

EXTERNAL ACCREDITATION

Accreditation is an effective way for health services organizations to regularly and consistently examine and improve the quality of their services in order to ensure high standards of care. Organizations in Canada are accredited through Accreditation Canada, CARF, the Quebec Council of Accreditation (Quebec only) and/or registered with the International Standards Association (ISO).

High-quality care is evidence-based (appropriate), focused on the patient (or patient-centred), safe and timely (CIHI).

Accreditation is not mandatory, however, each of the four regional health authorities that are responsible for the delivery of home care have achieved accreditation through Accreditation Canada.

Safety in the Home

According to a recent study that assessed the burden of safety problems among home care clients in Canada, 'many of the safety risk factors are modifiable but require client behaviour change, health provider behaviour change, and health system policy change' [Doran et al, 2009].

New fall and emergency room visits were among the most frequent adverse outcomes.

11%
of clients experienced a new fall

10%
experienced unintended weight loss

8.3%
presented to new emergency room visits

Doran, D. et al, (2009) The Nature and Burden of Safety Problems among Canadian Home Care Clients, Evidence from the RAI-HC Reporting System for Three Provinces and One Territory. Retrieved from http://www.patient-safetyinstitute.ca/English/research/commissionedResearch/SafetyinHomeCare/Pages/SafetyProblemsHomeCareClients.aspx

QUALITY COUNCIL

The **Centre for Health Information** (the Centre) provides quality information to health professionals, the public, researchers and health system decision-makers. Through collaboration with the health system, the Centre supports the development of data and technical standards, maintains key health databases, prepares and distributes health reports and supports and carries out applied health research and benefits evaluations. At this point in time the Centre does not report on home care.

Each RHA has a Quality Council. The Task Force on Adverse Health Events has provided advice on the potential establishment of a health quality council for the province.

CLIENT / PATIENT ADVOCATE

There is no patient advocate specific to home care, however, the **Office of the Citizen's Representative** deals with all complaints brought forward by individuals. The Office has dealt with issues related to eligibility and levels of home care service.

SYSTEM APPROACHES TO QUALITY IMPROVEMENT

The Department of Health and Community Services has a strong commitment to achieving a quality system where individuals receive timely access to appropriate care while cost-efficiencies are maintained. Cost efficiency is central to promoting the sustainability of the health care system. The approach is to establish an increased focus on performance measurement and monitoring.

SAFETY

Client and staff safety are monitored within the regional health authorities. Electronic reporting of client occurrences has been initiated in some of the health authorities while others are ramping up for this electronic documentation that will be standard across the province. Client safety is monitored by the professional case manager and care providers in the home. Medication management and falls prevention are areas where there is additional focus from a home care perspective. Concerns may be addressed through professional assessment, intervention, monitoring and teaching, by the professional staff.

The **Task Force on Adverse Health Events** was established in 2007 to examine and evaluate how the health system identifies, evaluates, responds and communicates regarding adverse events within the health system; to examine relevant best practices in other jurisdictions; to propose a mandate, structure and budget for the establishment of a health quality council in Newfoundland and Labrador; and, to make such recommendations as may be appropriate. As part of a report from the Task Force on Adverse Health Events, the province was advised to support the implementation of a provincial electronic occurrence reporting solution. The system, referred to as the Clinical Safety Reporting System (CSRS), is underway in the regional health authorities.

The plan is for the Department of Health and Community Services to conduct analysis of trends in occurrence reporting in order to identify system improvements.

HOME CARE RESEARCH

Research in Newfoundland and Labrador is through the **Patient Research Centre** at the Health Care Corporation of St. John's and the Centre for Health Information. The Patient Research Centre is responsible for:

- Liaising with industry to link research projects with appropriate investigators.
- Hiring and training research nurses.
- Contract negotiation and budgeting.
- Facilitation of ethics review.
- Access to community research networks.

The Centre for Health Information (the Centre) assists the Department of Health and Community Services, regional health authorities, researchers and others with their information and research needs by providing data extraction, data linkage, data management and information and analytical services. The Centre collaborates with Memorial University, the Patient Research Centre and other research organizations within the province.

4. Information Technology

ELECTRONIC HEALTH RECORD (EHR)

The Centre for Health Information (the Centre) is funded by the province to develop and implement a confidential and secure provincial EHR. Included in the mandate is facilitating the change management required to support adoption by end user clinicians. The Centre works with the Department of Health and Community Services and the RHAs regarding the planning and implementation of the various EHR components. At present, the focus is on areas outside of the home care sector.

There are two primary health information systems in the province:

- The provincial Client and Referral Management System (CRMS) used in the community setting.
- Meditech used in the institutional and long-term care settings.

Clinical documentation is captured electronically at the point of care when the service is provided in an ambulatory clinic environment in the community. Mobile access for clinical documentation is not available at this time.

USE OF SYSTEM EFFICIENCY TECHNOLOGY

Electronic communication does not yet exist between home care and physicians. However, home care and hospitals are linked for referral purposes, and technology is applied between frontline staff to communicate referral and clinical information. Technology is also used to share information between home care programs and the Department of Health and Community Services for financial data exchange.

USE OF TECHNOLOGY FOR CLIENT CARE

Telehealth officially transitioned from project status to a program in February 2010. There were over 8,500 patient encounters in 2010. The Centre continues to work with the RHAs and provincial partners to identify opportunities for Telehealth, such as improvements to chronic disease management, mental health counselling and support, and a tele-ophthalmology pilot project for the Burin Peninsula Health Centre with the Eastern Health Authority, to reduce patient waitlists related to screening for diabetic eye disease.

The province's Healthline Teletriage continues to serve as a means of supporting individuals and diverting unnecessary emergency room visits.

A scheduling application for scheduling of client visits is available through CRMS. There are regional variations as to the electronic equipment provided to frontline staff. Staff may be equipped with a cell phone, pager and/or laptop computer.

5. Health Human Resources

CLINICIANS PRACTICING IN HOME & COMMUNITY CARE

HEALTH CARE PROFESSIONALS

Data regarding the numbers of health care professionals within the home care program in Newfoundland and Labrador is not available. As many of the locations are rural in nature, one professional may have responsibilities across various programs. (i.e. one nurse may have program responsibilities in both home care and public health).

A Provider Registry is a foundational component of the provincial EHR. It uses a secure web-based system to hold information that identifies the estimated 740 licensed health professionals across all care settings, and will integrate with each component of the provincial EHR to identify providers before access, use, or disclosure of clinical information. The information in the Provider Registry is supplied by the five regulatory bodies/colleges of the province, and is an essential component of the current and future technologies of the Health Information Network being developed in the province.

UNREGULATED STAFF

Home support worker is the only category of unregulated staff within home care, with the exception of personal care attendant used in the Labrador Grenfell Health Authority. There is no provincial registry of home support workers.

EDUCATION & TRAINING

HEALTH CARE PROFESSIONALS

Health care professionals in the province are licensed through a professional association. Ongoing training is provided through programming in the regional health authorities and includes an orientation period for all new employees.

UNREGULATED STAFF

A provincial standardized education program is available, however, it is not a requirement for employment as a community home support worker. The hiring agency (or person in the case of self-managed care) sets the job description and qualifications.

INTER-PROFESSIONAL COLLABORATION

An individual's home care team may be comprised of nursing, social work, family and/or referring physician and/or allied health services, as required. In addition, opportunities for linkages exist with acute and long-term care sectors in the planning and provision of care.

FAMILY CAREGIVER

The caregiver is considered in the plan, for the provision of care, although there are no formal caregiver assessments. Family caregiver services may be available through the regional health authority or through non-profit agencies such as the Seniors Resource Center.

Respite support may be available to clients in their home or through facility based placements. Facility based respite is generally available up to a maximum of 30 days/year. Respite policies are managed within the health authorities.

The 2011-12 provincial budget allotted $60,000 to develop and deliver caregiver education and training sessions across the province.

6. Provincial Initiatives

FLEXIBILITY AND RESPONSIVENESS

Non-residential services in the province include, but are not limited to, home support services, family and non-family boarding arrangements, special assistance and programs for families with children with disabilities. The Department of Health and Community Services has been working to introduce more flexible and responsive service to provide individuals and families with increased choice in selecting the appropriate long-term care and community support services.

Who are Family Caregivers?

Family caregivers provide care and assistance for spouses, children, parents and other extended family members and friends who are in need of support because of age, disabling medical conditions, chronic injury, long-term illness or disability. A family caregiver's effort, understanding and compassion enable care recipients to live with dignity and to participate more fully in society.

5 million
is the estimated number of caregivers in Canada.

80%
of care needed by individuals with a long-term condition is provided by family caregivers.

60%
of caregivers provide care for more than three years.

Source: Canadian Caregiver Coalition, 2008

PRIMARY HEALTH CARE

Primary health care has been positioned as the central focus for delivery of health and community services in Newfoundland and Labrador, and the level at which the most significant health and community services occur. Professional home care staff work within the interdisciplinary team to improve access to comprehensive primary health care, emphasizing health promotion, and illness and injury prevention. The results are better health outcomes, better health status, sustainability and greater cost-effectiveness.

CHRONIC DISEASE MANAGEMENT

Professional home care staff provide assessment, teaching and monitoring for clients with chronic diseases. These clients may also be linked with a primary health care team. A provincial Chronic Disease Management Strategy targets areas such as self-management, standards of care, team-based care and stronger partnerships between the health care system and community agencies. The framework is based on an expanded Chronic Care Model and addresses:

- A greater emphasis on individuals being informed and more active in their own health with the support of health care providers and the community.
- A planned and integrated approach that includes health care providers and the community.
- The use of evidence and guidelines to provide quality care to better meet the needs of those with chronic diseases.
- A shift towards prevention - preventing disease, complications and increasing the awareness and assessment of the risk factors and signs of disease. Health promotion and prevention is integrated into all aspects of care and is age friendly.

SENIORS AND AGING

Seniors are supported through case management and may receive care in their home and community setting. Six priority directions provide the framework to support healthy aging:

- Recognition of older persons.
- Celebrating diversity.
- Supportive communities.
- Financial well-being.
- Health and well-being.
- Employment, education and research.

Some of the initiatives are to:

- Improve access to occupational therapy and physiotherapy in order to help people live independently.
- Improve access to equipment and assistive devices and review the Special Equipment Assistance Program and financial eligibility criteria.
- Enhance training for health care providers who treat people with Alzheimer's disease and other dementias.
- Research dementia care.

MENTAL HEALTH

Case managers with expertise in the care and treatment of persons with mental illness are assigned to the primary health care teams. Case managers provide assistance coordinating care; provide supportive counseling; home visits; linkages with family/client and primary health care team and other services; and client specific interventions such as coordinating home care, arranging transportation or administering medication. Home support services are provided for individuals of all ages with severe mental illness who require some supportive services at home in order to maintain functioning within the community.

END-OF-LIFE CARE

The Department is working with the health authorities to launch and monitor the **Short Term End-of-Life Home Care Program** (customized to the needs of each region), support access to palliative specialists and invest in skills development for palliative care staff and volunteers. The regional health authorities are developing models of care to enhance the coordination of end-of-life care across the acute, community and long-term care sectors. Continuing education in cancer care for all health care providers is a priority.

A Provincial Cancer Control Advisory Committee has been established to advise the Minister of Health and Community Services on priorities, progress and evaluation of cancer care in the province. The committee will liaise with other jurisdictions across the country.

7. Challenges

Challenges facing the home care sector in Newfoundland and Labrador include, but are not limited to:

- An aging population – by 2017 20 percent of the population will be 65 years of age or older. This will result in an increase in incidence of chronic disease and complex health care needs. Additionally, the shift in dependency ratio will mean fewer family caregivers.
- Responding to the expectations of the public regarding the amount and level of services.
- Human Health Resources (professional and non-professional service providers) to respond to client needs, today and in the future, as they reach retirement age.
- Home and community care response to clients with increased acuity, within fiscal realities.
- Integration of technology into the home care sector.

8. Opportunities

A number of opportunities will contribute to realizing the vision of a timely, client-centred home care program in Newfoundland and Labrador. These include

- Adoption of initiatives to support the upcoming Long-Term Care Community Support Services Strategy.
- Implementation of the RAI-HC to improve upon the assessment process and care planning for clients.
- Implementation of the home support services review that was announced in the 2011-12 provincial budget.
- Case management enhancement within the health care sectors to improve the care continuum for each client.
- Improvement of the home care data collection measures to support continued and enhanced quality service provision.

The Department of Health and Community Services is implementing the 'Healthy Aging Policy Framework' to specifically address the need for age-friendly strategies. Specific to home care, the Department is working to ensure that:

- Home care (home health and home support) services are age-friendly.
- The home support program is expanded to support independence.
- Changes to the home support financial criteria are considered.
- A home support program for seniors who require low levels of assistance to maintain independence is piloted.
- Current policy on hiring family members as home support workers through the provincial home support program is reviewed.

The implementation of the RAI-HC software will improve upon assessment for client access to services and care planning while, in tandem, providing a comprehensive data set for future program and policy guidance and decision making.

Home care is a component of the integrated continuum of health services available to the population of Newfoundland and Labrador. System pressures and fiscal realities will require innovative approaches and leading practices to ensure the viability of the health system. The home care sector will be a focus over the next decade to ensure that enhanced services and quality care are supported and that appropriate services are provided at the right time and in the right place.

ACRONYMS / ABBREVIATIONS

CRMS - Client and Referral Management System
CSRS - Clinical Safety Reporting System
DHCS - Department of Health and Community Services
EHR - Electronic Health Record
HCRS - Home Care Reporting System
ISO - International Standards Association
NLPDP - Newfoundland and Labrador Prescription Drug Program
PICC lines - Peripherally inserted central catheters
RAI-HC - Resident Assessment Instrument—Home Care
RHA - Regional Health Authority

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The Patient Research Centre at the Health Care Corporation of St. John's, Health Sciences website - http://www.med.mun.ca/prc/default.asp?nav=media

Harmonized Principles for Home Care

Guide policy and program development

Support consistency and equity across the country

Facilitate benchmarking and sharing of best practices

CLIENT AND FAMILY-CENTRED CARE

Clients and their family caregivers are at the centre of care provided in their home.

Dignity: Respect and value client and caregiver self-worth.

Holistic: Uphold all aspects of client and caregiver needs; psychosocial, physical and spiritual.

Independence: Foster autonomy and self-sufficiency.

Informed choice: Clear understanding of the facts, implications, and consequences of decisions and actions.

Positive partnership: Acknowledge unique strengths and engage client and family as partners in care.

Safety: Minimize and manage risk.

Self-Determination: Encourage, support and enable self-care.

ACCESSIBLE CARE

Canadians have equitable, appropriate, consistent access to home care, and are fully informed of the care and service options available to them.

Appropriate: Provide care that is needed and ensure the need for care.

Consistent: Reliable care among providers and across jurisdictions and geographies.

Comprehensible: Ensure understanding of services and options available.

Equitable: Create fair and unbiased access within and across jurisdictions and geographies.

ACCOUNTABLE CARE

Home care is accountable to clients and their caregivers, providers, and the health care system for the provision and ongoing improvement of quality care.

Transparency: Report on performance metrics and outcomes to inform the public on the quality of care.

Quality: Monitor performance indicators to support continuous improvement.

Value: Demonstrate value to clients and their caregivers, providers and the health system.

EVIDENCE-BASED CARE

Knowledge that is grounded in evidence is used as the foundation for effective and efficient care provision, resource allocation and innovation.

Evidence-Informed: Decision-making incorporates the best available evidence, expertise and experience.

Knowledge Transfer: Share ideas and information with clients, family caregivers, providers and planners.

Innovation: Support a culture of innovation and ingenuity.

Research: Promote awareness and application of research evidence to inform decisions.

INTEGRATED CARE

Home care facilitates the integration of care across the continuum of health care and with community and social services; care is complementary, coordinated and seamless with a focus on continuity for the client.

Continuity: Foster collaboration and communication to ensure seamless care transitions.

Coordination: Reduce disparities through care coordination.

Individualized: Customize care to the unique needs of clients and their families.

Prepared: Enable timely access to information and resources.

SUSTAINABLE CARE

Home care contributes to the sustainability of an integrated health system by increasing efficiencies and delivering cost effective care.

Health and Well-being: Focus on health promotion, disease prevention and management, and quality of life.

Needs Based Planning: Establish policies and programs on current and future needs and trends.

Optimum Effectiveness: Integrated resources planning across client populations and care settings.

NUNAVUT

HOME CARE IN **NUNAVUT**

In Nunavut, the definition of home care is consistent with that of the Canadian Home Care Association.

> Home care is an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the family caregiver.

NUNAVUT
BY THE NUMBERS...

1,936,113 sq km **LAND AREA**	33,330[1] POPULATION (2011)	**43%**[3] Percent population in urban settings defined as an area with a population of at least 1,000 and with no fewer than 400 persons per square kilometer (2006)	
82.5[2] Dependency Ratio (2009) Ratio of the population aged 0-19 and 65+ to the population aged 20-64	3.2%[1] **Population Seniors 65+ yrs** (2011)	75.2 years[1] **LIFE EXPECTANCY (AT BIRTH)**	**$11,113.19**[2] Public sector health care expenditure per capita (2011 Forecast)

[1]Statistics Canada | [2]Canadian Institute for Health Information (CIHI) | [3] Human Resources and Skills Development Canada

1. Governance & Organization

HEALTH CARE SYSTEM STRUCTURE

The **Department of Health and Social Services** (HSS) is responsible for health services and social programming in Nunavut. Staff at HSS work to improve the health and well-being of Nunavummiut by addressing the differing needs of each community through culturally appropriate programs and services.

The Home and Community Care Program (HCC) provides health care and support services, based on an assessment, in the comfort of an individual's home when he or she needs extra support due to illness, poor health, or disability. Home care is delivered through twenty-five centres, which report to the Nunavut Department of Health and Social Services. The centres operate according to policies and procedures that are continuously reviewed and updated in order to meet ongoing needs.

1. Arctic Bay Health Centre
2. Kimmirut Health Centre
3. Arviat Health Centre
4. Kugluktuk Health Centre
5. Baker Lake Health Centre
6. Pangnirtung Health Centre
7. Cambridge Bay Health Centre
8. St.Therese Kugaaruk Health Centre
9. Cape Dorset Health Centre
10. Pond Inlet Health Centre
11. Chesterfield Inlet Health Centre
12. Qikiqtarjuaq Health Centre
13. Clyde River Health Centre
14. Rankin Inlet Health Centre
15. Coral Harbour Health Centre
16. Repulse Bay Health Centre
17. Gjoa Haven - Kativik Health Centre
18. Resolute Health Centre
19. Grise Fiord Health Centre
20. Sanikiluaq Health Centre
21. Hall Beach Health Centre
22. Taloyoak - Judy Hill Memorial Health Centre
23. Igloolik Health Centre
24. Whale Cove Health Centre
25. Iqaluit Home Care

Geographical Challenges

The distances between communities and referral hospitals in Nunavut's health care system are the largest in Canada, perhaps the world. No other province or territory relies on as many extra-provincial hospitals in as many different provinces as Nunavut does.

Nunavut Tunngavik Inc. 2008, Nunavut's Health System, Annual Report on the State of Inuit Culture and Society, www.tunngavik.com

HEALTH CARE & HOME CARE LEGISLATION

There is no legislation specific to home care, however, staff are guided by a number of health related acts, including but not limited to:

Consolidation of **Licensed Practical Nurses Act** (2010) - addresses the professional licensing, registration, scope or practice and related matters of licensed practical nurses.

Consolidation of **Hospital Insurance and Health and Social Services Act** (1988) - articulates the eligibility and entitlement, governance and administration of insured health services.

Consolidation of **Medical Profession Act** (1988) – describes the registration process and legislative requirements for physicians.

Consolidation of **Mental Health Act** (1988) - describes the management of persons suffering from a mental disorder.

Consolidation of **Nursing Act** (1988) - defines the practice of nursing and the authority of the Registered Nurses Association.

Medical Care Act (1988) – defines insured health services.

EVOLUTIONARY MILESTONES

1999
NWT & Nunavut division.

2003
Nunavut specific standards, policies and procedures developed.

2011
Home and Continuing Care Worker Program developed with Nunavut Arctic College.

2012
External evaluation of the HCC program completed, showing home care is being delivered in a culturally sensitive way.

MANDATE, MISSION, PRINCIPLES & PRIORITIES

MANDATE

The Nunavut Home and Community Care Program offers health related services to Nunavummiut needing extra care because of illness, poor health or disability. The home care program aims to preserve and maximize an individual's ability to remain independent at home through care that is accessible, effective, equitable and responsive to individual needs and priorities within the community. The home care program also concentrates on supporting and strengthening family and community involvement in care delivery.

PRINCIPLES OF HOME & COMMUNITY CARE

- Services are provided to people based on their needs as identified through a client assessment.
- Home and community care (HCC) supports the belief that care should be provided to preserve and maximize an individual's ability to remain in their own home and allow them to be close to their loved ones as long as possible.
- Services should be provided in a holistic manner that looks at the person's physical, social, spiritual and emotional needs because each person is unique.
- The services support and improve the care provided by the family and community but should not replace it.

HOME CARE PROGRAM OBJECTIVES

- To develop a standardized home and community care training program to be delivered in the North.
- To continue to address HCC needs of Nunavummiut.
- To continue to advocate for required resources and programs.

HEALTH SYSTEM PRIORITIES

The Nunavut Department of Health and Social Services' current health priorities are:

- Healthy children, families and communities.
- Health protection.
- Treatment.
- Health insurance programs.
- Addiction reduction.

The current home care priorities are:

To offer health-related services to Nunavummiut requiring extra care due to illness, poor health or disability.

To preserve and maximize an individual's ability to remain independent at home by providing care that is accessible, effective, equitable, and responsive to individual needs and priorities within the community.

To support and strengthen family and community involvement in care delivery.

To increase the education and training opportunities available to home and community care staff.

To increase the use of technology in the delivery of home care services.

2. Access, Funding & Service Delivery

ACCESS TO HOME CARE SERVICES

The Nunavut Home Care Program provides and coordinates an assessment of the individual requiring care. The hours of operation vary across the communities depending on need, and fiscal and human resources.

When someone needs home care services, an assessor will determine the individual's needs by reviewing the client's situation, health status, supports available, health care and social care needs. The assessor, working with the client and/or significant others, will design a care plan outlining the services that best suit the individual's needs and health goals.

REFERRAL SOURCES

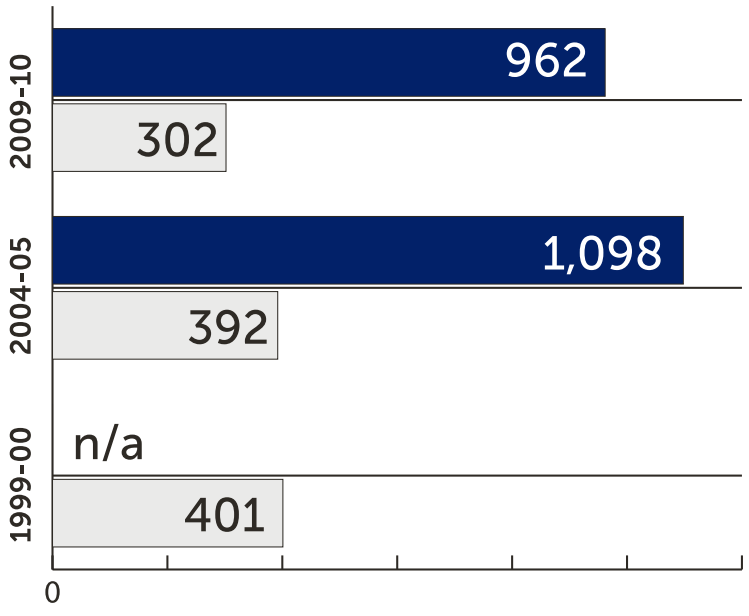
Referrals to the program are accepted from any source, including clients, family members, physicians and other health professionals. Nunavut is considered to be remote and access to home care services is generally consistent across the territory. There are no individuals known to be waiting for home care services in the territory.

APPROPRIATE ACCESS TO HOME CARE & COMMUNITY-BASED CARE

Hospitalization rates for conditions that may be cared for in the community are one indicator of appropriate access to community-based care. These conditions include diabetes, asthma, alcohol and drug dependence and abuse, neuroses, depression and hypertensive disease. Preventive care, primary care and community-based management of these conditions may reduce the need for hospitalization.

Hospitalization Rates For Ambulatory Care Sensitive Conditions

(Age Standardized Rate per 100,000 younger than 75)



Health Indicators Reports, CIHI

ELIGIBILITY, COVERAGE & UTILIZATION

ELIGIBILITY
- Residing in Nunavut

AGE
All ages

DIRECT FEES AND INCOME TESTING
There are no charges for home care services and no income testing requirements.

LIMITS / GUIDELINES TO SERVICE PROVISION
Services are covered according to the assessed need of the client. There are no minimums or maximums.

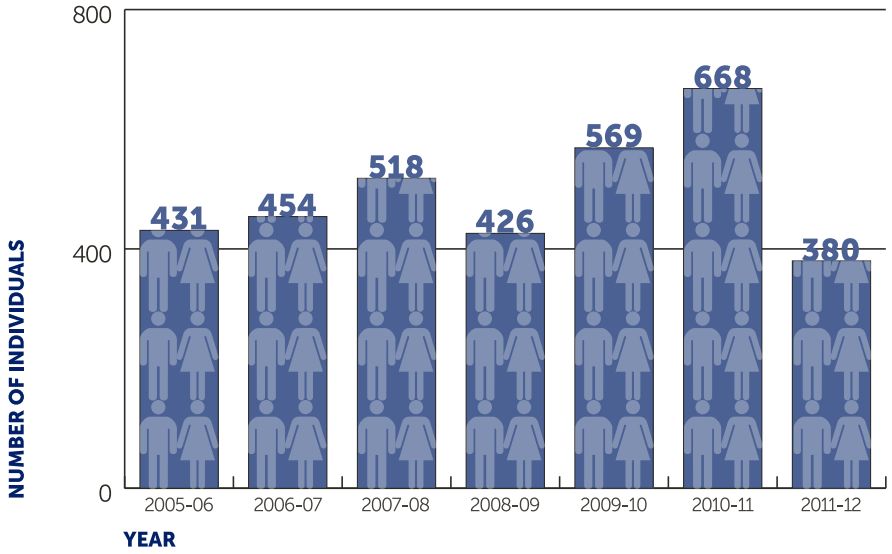
SUPPLIES, EQUIPMENT AND MEDICATION
Funded through Non-Insured Health Benefits (NIHB) for Inuit.
Otherwise, individuals may be eligible for Extended Health Benefits. In order to qualify, individuals must be enrolled with the Nunavut Health Care Plan and be:
- A non-beneficiary (non-Inuit and non-Status individuals) 65 years or older.
- A non-beneficiary Nunavut resident with a chronic disease or illness.
- A Nunavut resident who has used up or does not have other health care insurance options.

DETERMINING CLIENT NEED - ASSESSMENT TOOLS

Assessment and case coordination is a component of the home and community care program. Staff use the Nunavut Home & Community Care Assessment Tool. Given consent, the assessment is shared with the members of the home care team, including the client, family, home care provider organization, visiting nurse, home support worker, therapist and doctor.

The home and community care programs are managed by a home care nurse who may also function as a case manager, assessor and/or health professional within the program. The home care nurse is a member of a multidisciplinary, inter-agency team. In communities where the home care nurse position is not designated, the program is managed by a community health nurse.

Home Care Admissions



SETTING OF CARE

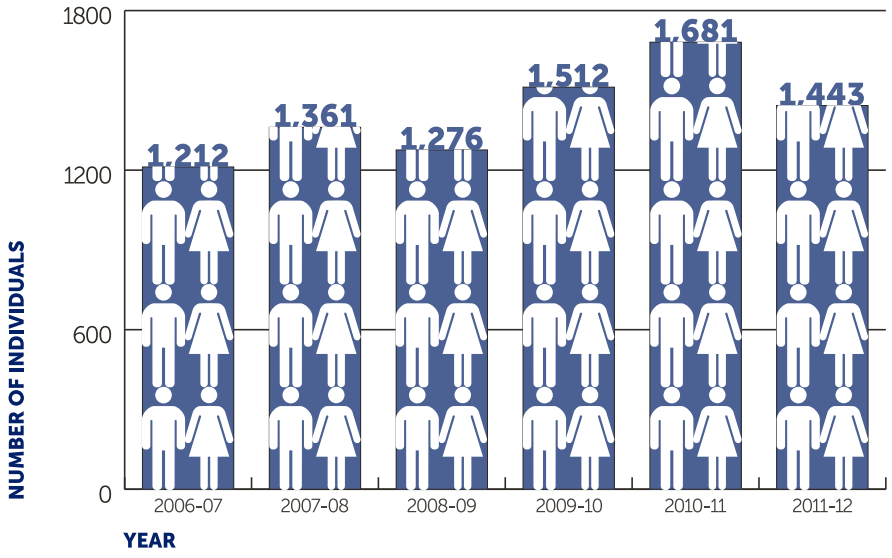
Home care services in Nunavut are provided in the following settings:

- Clinic
- Group Home
- Home
- Hospice
- Nursing Home

INTEGRATED MODELS OF CARE

An integrated model of primary health care is used in the north of which home care is an active and vital component.

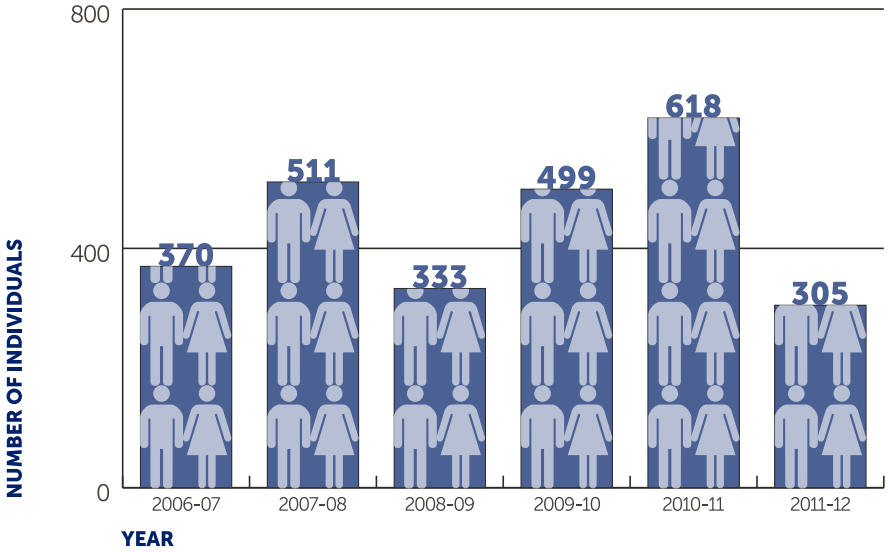
Individuals Receiving Home Care



DISCHARGE FROM HOME CARE

Discharge disposition of individuals who have received home care service is increasingly important and instructive to the health care system as it is an indicator of effectiveness. The outcomes can guide system planning and the development of care algorithms for specific patient populations.

Individuals Discharged from Home Care



Medication, equipment and supplies are available to individuals, regardless of age, after discharge through the Non-Insured Health Benefits (NIHB) for beneficiaries and the Extended Health Benefits (EHB) for non-beneficiaries. A physician prescription is required.

Successful Integrated Care Models

Integrated care is a process or strategy for improving the coordination of health services to better meet the needs of patients and providers. Successful integrated models include:

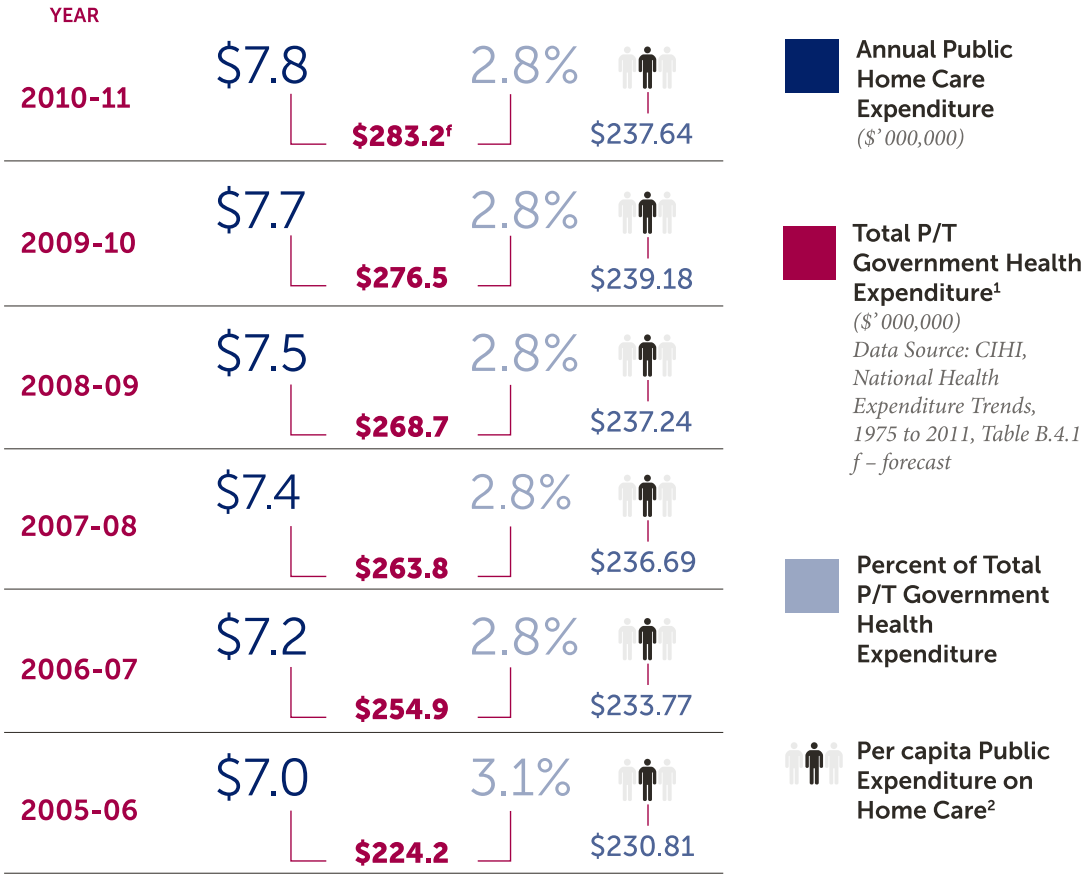
- Patient and family engagement
- Effective leadership
- Targeting a defined population
- Collaborative, multidisciplinary teams
- Shared accountability
- Alignment of financial incentives
- Shared accountability
- Evidence-based practice guidelines
- Enabling information technology

Canadian Home Care Association (2012), Integrated Models of Care, Synthesis Report, http://www.cdnhomecare.ca

FUNDING

Expenditures include administration, professional services and home support.

Public Expenditures on Home Care

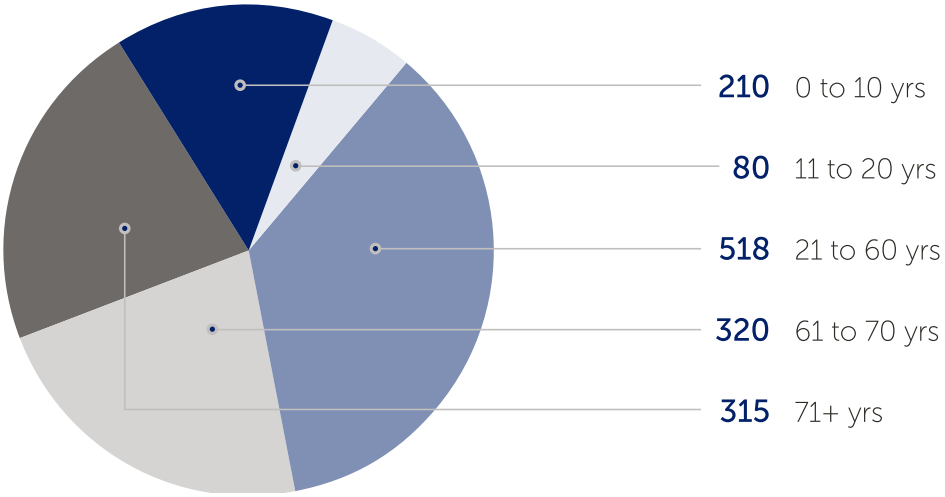


[1]*Figures include spending for health services reported by the provincial/territorial ministry responsible for health – does not include expenditures from municipal government or worker's compensation. [CIHI, National Health Expenditure Trends, 1975 to 2011, pg 92]*

[2]*Population data from Statistics Canada, Demography Division, Annual Estimates of Population for Canada, Provinces and Territories, from July 1, 1971 to July 1, 2012*

PROFILE OF CLIENTS RECEIVING HOME CARE

Number of Individuals Receiving Home Care By Age Category (2011-12)



DIAGNOSIS

The most common diagnoses for individuals receiving home care in 2011/12 were:

- Acute wound care (n=248)
- Respiratory condition (n=143)
- Cardiovascular disease (n=136)
- Arthritis (n=101)
- Cancer (n=97)

CLIENT GROUPING

The Nunavut Home Care Program tracks the numbers of individuals served according to the client grouping definitions (acute care substitution, maintenance, end-of-life care (palliative), rehabilitation, and long-term supportive care) established by a federal / provincial / territorial working group on continuing care, in 2001. Rehabilitation is not recorded separately, but is instead contained within the existing programs.

Number of Individuals Served by Client Grouping

	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
Acute Care Substitution	197	293	279	274	323	328
Chronic Disease Management	535	576	546	687	760	599
Long-Term Supportive Care	151	175	159	215	222	147
Other	82	80	91	93	115	115
End-of-life care (palliative)	35	33	45	61	65	63
Pre-Hospital Care	212	204	156	182	196	191
Total	**1,212**	**1,361**	**1,276**	**1,512**	**1,681**	**1,443**

Service Volumes

	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
Acute Care Substitution	3,550	4,370	3,939	3,861	3,658	3,337
Chronic Disease Management	32,067	32,875	28,068	31,621	34,766	33,730
Long-Term Supportive Care	8,082	9,156	7,696	6,726	5,479	4,638
Other	2,835	2,473	1,500	1,991	2,105	2,596
End-of-life care (palliative)	1,037	786	1,150	1,194	1,332	1,897
Pre Hospital Care	3,499	3,340	2,161	3,508	2,943	2,436
Total	**51,070**	**53,000**	**44,514**	**48,901**	**50,283**	**48,634**

Home Care Client Grouping

Developed in 2003, through the CIHI National Indicators and Reports for Home Care Project, five core home care program components were developed to enable comparisons between jurisdictions.

- Maintenance - maintain independence and, where possible, to enhance client's performance of ADLs and IADLs.
- Rehabilitation –improve functional status and facilitate social integration and independence.
- Long-Term Supportive Care – prevent or delay institutionalization.
- Acute Care Substitution – prevent an acute facility admission or re-admission and/or to reduce the length of stay in an acute care facility.
- End-of-Life Care – meet the needs of individuals whose health condition is not responsive to curative treatment and who are dying.

Canadian Institute for Health Information. (2004). Development of National Indicators and Reports for Home Care—Phase 2 Final Project Report. Ottawa: Canadian Institute for Health Information.

SERVICE DELIVERY

MODEL OF SERVICE DELIVERY

All home and community care services are delivered through the public sector and are available up to 24 hours per day, depending on the fiscal and/or human resources of the community. Home and community care services range from meals and housekeeping to personal hygiene and assistance with medication and post-operative dressing changes, foot care and other health care needs.

RANGE OF HOME CARE SERVICES & PROGRAMS

Units of Service Funded by the Home and Community Care Program

The amount of publicly funded service by service category[1] is expressed in units[2] in the following chart.

	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
Case Management	4,566	7,714	4,463	4,165	4,158	4,611
Home Support Service (Includes personal care, homemaking)	38,224	37,094	33,229	37,617	38,361	36,255
Nursing (Includes RN and RPN service)	6,747	7,596	5,720	6,291	5,864	5,748
Therapy (Includes physiotherapy, occupational therapy, social work and dietetics)	208	168	228	298	940	553

[1] *An individual can receive more than one category of service*
[2] *One unit equals one hour of service. Reliable data prior to 2006-07 is not available.*

Ancillary Support

Oxygen	Concentrators are provided through home care.
Drugs	Covered through Non-Insured Health Benefits (NIHB).
Supplies (dressings, stoma, etc)	Supplied by the Home and Community Care Program for individuals on the program. NIHB covers supplies for beneficiaries as per their program outlines.
Equipment (wheelchairs, walkers, etc)	The Home and Community Care Program loans equipment to persons on the home care program. NIHB supplies equipment for beneficiaries as per their program outlines.

SERVICES CURRENTLY NOT FUNDED BY THE HOME & COMMUNITY CARE PROGRAM

- Nurse practitioner
- Physician services
- Pharmacy
- Pastoral care
- Respiratory therapy

CLINICAL (SPECIALTY) SKILLS

With the focus on discharging patients from hospital as promptly as possible, there has been an increase in the complexity of care provided at home. The challenge in much of Canada can be in having a critical mass of patients who require certain levels of expertise and, as a result, special skills only being available in urban centres. However, with the advent of remote access to support in the community, there is an opportunity for more complex care to be provided in less populated areas.

Home care nurses are able to:

- Administer narcotics.
- Provide enterostomal therapy, wound care, peritoneal dialysis, infusion therapy.
- Manage infusion pumps, central lines and peripherally inserted central catheters (PICC lines).
- Manage home oxygen.

The following clinical services are not provided in the home by home care staff in Nunavut:

- Administration of chemotherapy, blood or blood products.
- Hemodialysis.
- Regular tracheostomy tube replacement.
- Ventilator care.

3. Quality & Accountability

High-quality care is evidence-based (appropriate), focused on the patient (or patient-centred), safe and timely (CIHI).

HOME CARE INDICATORS

The home care indicators that are currently monitored at a territorial level include:

- Amount of service delivery.
- Expenditures.
- Home care admissions.
- Referral source.
- Reason for non admit.
- Referrals to community support.
- Diagnoses.
- Number of staff.

QUALITY & ACCREDITATION

EXTERNAL ACCREDITATION

Accreditation is an effective way for health services organizations to regularly and consistently examine and improve the quality of their services, in order to ensure high standards of care. Organizations in Canada are accredited through Accreditation Canada, CARF, the Quebec Council of Accreditation (Quebec only) and/or registered with the International Standards Association (ISO).

Nunavut's Home and Community Care Program falls under the First Nations and Inuit Home and Community Care Program and, to date, accreditation is not a mandatory requirement.

CLIENT / PATIENT ADVOCATE

There is no patient advocate specific to home care. The government passed a motion to review the patient and client complaints procedure of the Health and Social Services Department.

SYSTEM APPROACHES TO QUALITY IMPROVEMENT

Quality improvement and risk management initiatives that support program changes, for improved quality of care and client outcomes, are in place and ongoing.

Inuit Healing & Research

Inuit healing reflects a holistic approach to health and a concern for balance between negative and positive approaches to health (disease versus wellness). Inuit are interested in research on concepts of wellness, and wellness indicators.

(Canadian Institutes of Health Research. 2002. Health Research Needs North of 60: Northern Town Hall Meetings, September 2001, pg. 12.)

SAFETY

Home care specific data on incidents or potential safety issues is not collected at the territorial level. Safety issues are addressed regionally. Client safety within the home is monitored by professional staff. Few concerns are reported; however, these would be investigated and addressed by the home care nurse and regional managers.

4. Information Technology

ELECTRONIC HEALTH RECORD (EHR)

Since 2008, the Health and Social Services Department has been working on migrating all health records to an electronic system. Meditech is being deployed across the twenty-five centres and will be in place by the end of 2012, thereby positioning Nunavut to have a truly jurisdiction-wide interoperable electronic health record (iEHR).

Some elements of home care documentation, such as case notes, are captured electronically but none at the point-of-care. Steps to expand the electronic documentation and to have it integrated across the health system have been initiated. The goal is to achieve full integration electronically by the end of 2012.

HEALTH DATA & THE HOME CARE REPORTING SYSTEM

To meet the need for consistent, comparable home care information, the Canadian Institute for Health Information (CIHI) developed the Home Care Reporting System (HCRS). The purpose is to collect and process information on publicly funded home care services, in order to support jurisdictions in their analysis and decision making by providing data on:

- Access to home care services.
- Health and functional status measures.
- Clinical outcomes and waiting times.
- Quality of care.
- Informal support.
- Service utilization by setting and provider type.

The HCRS captures standardized client-specific clinical, demographic, administrative and resource utilization information. A key component of the HCRS is the Resident Assessment Instrument—Home Care (RAI-HC). Nunavut does not submit home care data to CIHI at this time.

USE OF SYSTEM EFFICIENCY TECHNOLOGY

All health centres have access to internet as well as telehealth equipment. Technology is also used to share information between home care programs and the Department of Health and Social Services for submission of indicator data and for financial data exchange.

USE OF TECHNOLOGY FOR CLIENT CARE

In Nunavut, the Ikajuruti Inungnik Ungasiktumi (IIU) Network Nunavut Telehealth Project, which has been live and operational since 2003 through Canada Health Infoway support, connects 33 health care sites. Telehealth technology is used to provide case management services as well as, to a limited extent, for rehabilitation care, education and conferencing with members of the health care team. Home care scheduling is completed manually. Home care staff in Iqaluit have cell phones. Otherwise, staff members do not carry electronic devices.

High-Tech Home Care

Expanded technology-enabled home care offers a promising pathway to bend the cost curve for ever-growing health care expenditures.

Independent of the economic benefit, the moral value of enabling older members of society to live in grace and dignity in their own homes, with a ripple effect on their caregivers, is arguably the most important – if unquantifiable – benefit of home care. [Kayyali et al, 2011].

Canadian Home Care Association, A Vision for Technology in Home Care, 2013

5. Health Human Resources

CLINICIANS PRACTICING IN HOME & COMMUNITY CARE

There are very few physicians and a lack of nurses and nurse practitioners in Nunavut. The twenty-five centres responsible for delivering home care services in Nunavut are typically staffed with:

- Supervisor of Health Program.
- Community Health Nurses (CHN) - Assist clients in promotion, protection and restoration of health. The Community Health Nurse provides comprehensive community health services in collaboration with the health care team.
- Support staff.
- Home Care Nurses (referred to as supervisors of home and community care as of May 2010) - Available in many communities, these staff provide nursing and support services to elderly, chronically ill and disabled clients.
- Home and Community Care support staff - all communities.
- Registered Psychiatric Nurses - available in some communities.
- Social service employees.

HEALTH CARE PROFESSIONALS

Number of Staff - Full Time Equivalents (FTE)

The staffing complement with the Nunavut Home Care Program includes the following individuals.

	2006-07 FTE's	2010-11 FTE's[1]
Case Manager / Registered Nurse	18	23
Nurse Practitioner	0	23
Occupational Therapist	1	1
Physiotherapist	1	0

[1]*Refers to positions available – not all are filled*

Nurses are the backbone of Nunavut's health care system. They are the largest single group of professionals, and, as a group, they are on duty twenty-four hours a day, seven days a week. Recruitment and retention of staff, particularly registered nurses, is addressed through the "Nunavut Nursing Recruitment and Retention Strategy (2007-2012)". The strategy initiatives are designed to:

- Promote and support the recruitment of motivated and skilled nursing professionals for Nunavut's communities.
- Meet the Department's legal obligations under Article 23 of the *Nunavut Land Claims Agreement* by recruiting and training Inuit candidates for careers in nursing and other public health professions.
- Increase the retention of Nunavut's front-line nursing professionals.

The Vital Role of the Family Caregiver

Family caregivers provide care and assistance for spouses, children, parents and other extended family members and friends who are in need of support because of age, disabling medical conditions, chronic injury, long-term illness or disability. A family caregiver's effort, understanding and compassion enable care recipients to live with dignity and to participate more fully in society.

5 million
is the estimated number of caregivers in Canada

80%
of care needed by individuals with a long-term condition is provided by family caregivers

60%
of caregivers provide care for more than three years

(Canadian Caregiver Coalition www.ccc-ccan.ca.)

UNREGULATED STAFF

Home support workers / personal support workers are known as Home and Community Care Worker I and Home and Community Care Worker II respectively. They are referred to collectively as the Home and Community Care (HCC) representative. Within the Nunavut Home Care Program there are 78 home and community care representative full time equivalent positions. Responsibilities include providing emotional support, assistance with personal hygiene and other activities of daily living, upkeep of home, food preparation and childcare. There is no registry for tracking HCC representatives.

EDUCATION & TRAINING

HEALTH CARE PROFESSIONALS

As part of a retention strategy, nurses are supported to pursue continuing education. Relief nursing pools are established in regional centres in order to provide flexibility to nurses. Nunavut provides a nursing program in Rankin Inlet, Cambridge and Iqaluit. All nursing program graduates are guaranteed employment by the Department of Health and Social Services.

UNREGULATED STAFF

The scope of practice for the home and community care worker is defined through job descriptions, but there is no territorial standard. The educational requirements are for a certificate course that is provided through the Nunavut Arctic College.

In order to support the needs of the Home and Community Care Program, a training plan for the home and community care representatives has been established through Nunavut Arctic College. This program will be delivered over a five year period, offering several courses a year to the staff. Core courses are part of the health career ladder approach, and may be delivered with other programs to increase options for students who wish to further their education in other fields of health care. This multidisciplinary approach promotes readiness for employment in the community by developing the ability and willingness to function effectively within teams. The practical application of learning is basic to the program, and students will be learning and working in the community throughout the program.

INTER-PROFESSIONAL COLLABORATION

Typically the community health nurse leads an interdisciplinary team and is the first point of contact for patients. Members of the health care team collaborate to provide care, whether they are on-site, visiting or providing support remotely through telehealth, telephone or email.

FAMILY CAREGIVER

The important role of the family caregiver is recognized; however, there are no specific policies or assessments to address needs. Respite services are provided based on need as assessed by the home care nurse. The Government of Nunavut provides a Compassionate Care Leave of up to eight weeks of unpaid leave to provide care or support to a family member.

6. Territorial Initiatives

The Nunavut Home and Community Care Program continues to provide a complete range of home care services that take into account the many factors impacting health and home care service delivery.

HEALTH HUMAN RESOURCES

The Home and Continuing Care Worker Certificate program, which was developed in 2006-07, has recently been reviewed and updated. A five-year training plan has been established and will be delivered in conjunction with training for other health para-professionals. This will continue to build and strengthen the health care service delivery team in the community.

ELDERS/SENIORS AND AGING

The majority of home care services are provided to a more senior population based on their identified needs. Seniors and Elders are also supported through other programs with a focus on socialization, meal provision and various activities in many communities as they are respected members of Inuit culture and society. One of the main goals of the home care program is to provide support to Nunavummiut and their families to ensure that the client can remain at home, in their communities, for as long as possible.

MENTAL HEALTH

In collaboration with the community health centres, home care provides monitoring of medication compliance for clients with identified mental health needs.

ACUTE HOME CARE

Nunavut has one acute care hospital, the Qikiqtani General Hospital, located in the territory's capital, Iqaluit. The Iqaluit Home Care Program works with the hospital to provide post acute home care services, such as wound care and home parenteral therapy.

PEDIATRICS AND YOUTH

Home care services are provided to individuals of all ages including the pediatric and youth populations. In the past, parenting program initiatives have been delivered through the home care program and future planning is underway to revive this initiative.

7. Challenges

There are several challenges to delivering home care services in Nunavut.

- **Health human resource shortages** continue to be one of the main challenges in providing home care services in the community, particularly with respect to recruitment and retention of home care nurses.
- **Access to communities** also remains a challenge, as there is no means of transportation between most communities throughout the territory. The logistics related to the remoteness of the territory increases the cost of providing care. While all communities have access to telephone service, not all homes have a telephone and cellular phone service is currently still not available in all communities.

Staff recruitment is vital to addressing the home care challenges in Nunavut. It will be important to address health promotion and illness prevention in addition to providing care to meet the immediate health care needs so that Nunavummiut remain healthy and independent in their home and community for as long as possible. Advances in and access to technology across the territory will also play a very important role in improving home care services.

8. Opportunities

The Home and Community Care Program will also pursue expansion of the palliative / end-of-life aspect of the program to provide more services in people's homes.

Through the eHealth project currently underway in Nunavut, the Home and Community Care Program will update the assessment and data collection process to improve the statistical collection of information, in order to better reflect the needs of home care clients and the reality of Nunavut's home care needs.

Nunavut's Home and Community Care program will continue to provide culturally appropriate home care services that are holistic and meet the needs of Nunavummiut. Care will remain accessible, effective, equitable and responsive to individual needs and priorities within communities across the territory.

The Home and Community Care Worker program will continue to support the belief that care should be provided to preserve and maximize an individual's ability to be in their home and community for as long as possible. Services will continue to be delivered in a holistic manner, providing for a person's physical, social, emotional and spiritual needs, recognizing that each person is unique.

Nunavut's Home and Community Care Program will continue to build self-reliance by strengthening family involvement in care delivery, developing and training staff, and planning and allocating resources wisely.

ACRONYMS / ABBREVIATIONS
CHN - Community Health Nurse
EHB - Extended Health Benefit
FTE - Full Time Equivalents
HCC - Home and Community Care
HCRS - Home Care Reporting System
HSS - Health and Social Services
iEHR - interoperable Electronic Health Record
IIU - Ikajuruti Inungnik Ungasiktumi
ISO - International Standards Association
NIHB - Non-Insured Health Benefit
PICC lines - Peripherally inserted central catheters
RAI-HC - Resident Assessment Instrument—Home Care

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Harmonized Principles for Home Care

Guide policy and program development

Support consistency and equity across the country

Facilitate benchmarking and sharing of best practices

INTEGRATED CARE

Home care facilitates the integration of care across the continuum of health care and with community and social services; care is complementary, coordinated and seamless with a focus on continuity for the client.

Continuity: Foster collaboration and communication to ensure seamless care transitions.

Coordination: Reduce disparities through care coordination.

Individualized: Customize care to the unique needs of clients and their families.

Prepared: Enable timely access to information and resources.

NORTHWEST TERRITORIES

HOME CARE IN THE **NORTHWEST TERRITORIES**

Home care in the Northwest Territories (NWT) is consistent with the Canadian Home Care Association definition.

> Home care is an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the family caregiver.

In the NWT, home and community care and long-term care are part of a continuum of services generally referred to as continuing care services.

NORTHWEST TERRITORIES

BY THE NUMBERS...

1,183,085 sq km **LAND AREA**	43,700[1] POPULATION (2011)	**58%**[3] Percent population in urban settings defined as an area with a population of at least 1,000 and with no fewer than 400 persons per square kilometer (2006)	
55.5[2] Dependency ratio (2009) Ratio of the population aged 0-19 and 65+ to the population aged 20-64	5.6%[1] **Population Seniors 65+ yrs** (2011)	75.2 years[1] **LIFE EXPECTANCY (AT BIRTH)**	**$8,441.38**[2] Public sector health care expenditure per capita (2011 Forecast)

[1]Statistics Canada / [2] Canadian Institute for Health Information (CIHI) / [3] Human Resources and Skills Development Canada

1. Governance & Organization

HEALTH CARE SYSTEM STRUCTURE

Under the direction of the Minister, the **Department of Health and Social Services (DHSS)** is mandated to provide a broad range of health and social programs and services to the residents of the Northwest Territories (NWT). The major responsibilities of the DHSS include:

- Setting the system vision and strategic direction.
- Ensuring cost-effective service delivery.
- Aligning legislation, policy and standards.
- Monitoring, evaluating and ensuring accountabilities.
- Responding to emerging issues, challenges and opportunities.

The health and social services system is made up of the DHSS and eight **Health and Social Services Authorities (HSSAs)** which plan, manage and deliver a full spectrum of health and social services to 33 communities. The HSSAs are the operational arm of the system, and are responsible for the provision of timely access to appropriate health and social services that best meet the needs of those individuals they serve.

Health and Social Services Authorities (HSSAs)

1. Beaufort-Delta HSS Authority
2. Deh Cho HSS Authority
3. Fort Smith HSS Authority
4. Hay River HSS Authority
5. Sahtu Regional HSS Authority
6. Stanton Territorial Health Authority
7. Tlicho Community Services Agency
8. Yellowknife HSS Authority

There is no legislation governing the delivery of home care services in the NWT.

The Home Care Program operates within the parameters of the 'Health and Social Services Establishment Policy'.

Two forums facilitate ongoing consultation between the HSSAs and the DHSS:

1. **The Joint Leadership Council**, chaired by the Minister and comprised of the Chair of each HSSA and the Deputy Minister, has the mandate to set priorities and oversee the delivery of the health care system.
2. **The Joint Senior Management Committee**, chaired by the Assistant Deputy Minister and comprised of senior departmental management and the Chief Executive Officer of each HSSA, provides direction to the system at the operational level.

HEALTH CARE & HOME CARE LEGISLATION

Act to Amend the **Pharmacy Act** (2008) - provides for the regulation of the practice of pharmacy in the NWT. It sets out requirements for registration as a pharmacist, application procedures and scope of the practice.

Child and Family Services Act (1997, amended in 2010) - protects the best interests of the child, while ensuring the constitutional rights of parents and guardians are respected. The Act provides a framework for community involvement in child protection concerns through the implementation of Plan of Care Agreements.

Hospital Insurance and Health and Social Services Administration Act (1988) - articulates the eligibility and entitlement, governance and administration of insured health services.

Licensed Practical Nurses Act (1988) - addresses the professional licensing, registration, scope of practice and related matters of licensed practical nurses.

Medical Care Act (1988) – defines insured health services.

Medical Professions ACT (2010) - provides for an updated registration process for physicians that follows best practices, and modernizes the discipline and conduct provisions of the Act to make them consistent with other legislation in the NWT, and across the country.

Mental Health Act (1988) – describes the management of mental health services available for persons suffering from a mental disorder.

Nursing Profession Act (2003) – defines the practice of nursing and the authority of the Registered Nurses Association.

Public Health Act (2007) - came into force in 2009. The Act properly reflects the Charter of Rights and updates provisions addressing privacy, information management and the management of pandemics.

Social Work Profession Act (2010) – this act came into force in 2012. It provides for the registration and licensure of social workers in the NWT. The Act also includes modern discipline and conduct provisions.

A new *Health Information Act* is currently being drafted. This new Act will provide up-to-date, health-specific access and protection of privacy provisions that will apply to health providers, including private sector providers such as pharmacists. It will include standards for consent and notice, provisions for disclosure for research and system planning, as well as information systems management. Requirements for compliance and reporting will also be included. The development of a legislative proposal for a new *Mental Health Act* is underway. The development of umbrella *Health Professions Legislation*, which will apply to all other health professionals not referenced above, is underway.

EVOLUTIONARY MILESTONES

1975
Home Care Program implemented in Yellowknife.

1978
Home care is expanded to include communities throughout the territory.

1988
Regional Health and Social Services Boards established.

1996
Health and Social Services Authorities established.

2003
The Sahtu Regional Board created.

2005
Integrated Services Delivery Model implemented.

2006
NWT Health and Social Services Action Plan developed.

2009
'A Foundation for Change' released, articulating a vision for the future of health and social services in the NWT, including a three year action plan that forms the blueprint to advance towards the vision.

2011
New continuing care strategies developed.

'Building on Our Foundation' released: a five year strategic plan for the NWT health and social services system that builds on the 2009 report.

MANDATE, MISSION, PRINCIPLES & PRIORITIES

MANDATE

Continuing care in the NWT includes home care, supported living and long-term care, and refers to those services that maintain or improve the physical, social and psychological health of individuals who, for a variety of reasons, may not be able to fully care for themselves. The goal of continuing care is to improve independence and quality of life for these individuals and their families. The goal of home care is to provide an array of services that enables clients to live at home, often with the effect of preventing, delaying or substituting for acute or long-term care alternatives.

PRINCIPLES OF HOME & COMMUNITY CARE

The following principles guide health and social services:

- **Personal Responsibility** – Individuals, families and communities have a lead role in achieving their own overall health and well-being.
- **Collaboration** – Working together to ensure individuals, families and communities make well informed decisions about their health and wellness.
- **Core Need** – Publicly funded programs and services that support basic health and social needs.
- **Opportunities for Engagement** – Community provides input/advice on health and social service matters affecting their community.
- **Patient/Client Safety** – Health and social services are delivered within acceptable practice and clinical standards.
- **Transparency** – Outcomes are measured, assessed and publicly reported.

HOME CARE PROGRAM OBJECTIVES

The objectives of home care in the NWT are to:

- Enable any person with a medical or chronic care problem, or who is at risk of developing one, to be admitted to the home care program.
- Make available, to Northerners, a broad range of home and community care services including: respite care, palliative care, chronic care, foot care, medications management, wound care, home management, ambulation, post hospital/early discharge follow up, social support, meals on wheels, transportation assistance and equipment loan. In the larger centers other components may also include discharge planning, home IV therapy, and cardiac rehabilitation.
- Provide services by one or a combination of the following: physician, registered nurse, licensed practical nurse, physiotherapist, occupational therapist, speech language pathologist, community health representative, home support worker, personal care attendant, or medical social worker.

HEALTH SYSTEM PRIORITIES

The vision for the future of health and social services is "healthy people, healthy families, healthy communities". The 2011 strategic plan, 'Building on Our Foundation', includes the elements for a sustainable system that will provide Northerners with access to quality health and social services programs and services. The health system goals are:

- **Wellness** - Communities, families and individuals make healthy choices; children are raised in safe environments and are protected from injury and disease.
- **Access** - The right service at the right time by the right provider.
- **Sustainability** - Living within our means.
- **Accountability** - Reporting to the public and the Legislative Assembly.

The health system priorities to realize the vision include:

Priority 1: Enhance services for children and families – working with communities in establishing Child and Family Service Committees to ensure that plans for children reflect community values, and that every effort is made to keep children safe in their home communities.

Priority 2: Improve the health status of the population – working with communities, partners and individuals to provide integrated, culturally appropriate programming that builds on the existing capacities and resources in the communities.

Priority 3: Deliver core community health and social services through innovative service delivery – ensuring people have the majority of their health and social needs met by high quality, community-based support and care. This will be accomplished through the use of technology to maximize rural/remote access to limited specialized resources.

The Integrated Service Delivery Model (ISDM) recognizes that not every service can be available in every community; however, core or basic health and social services need to be accessible as close to where people live as possible. Primary community care is the first point of entry for individuals to the health care system.

Priority 4: Ensure one territorial integrated system with local delivery – improving the coordination of services territorially, while still providing for regional service delivery. Further, leadership will require the skills to manage risk, the flexibility to support system-wide change for best practices and function as one system.

Priority 5: Ensure patient/client safety and system quality – ensuring the quality of services and keeping patients and clients safe. The long-term outcomes associated with this priority are that NWT residents will have access to sustainable, safe, community-based health and social services.

Priority 6: Outcomes of health and social services are measured, assessed and publicly reported – developing and producing annual performance reporting for the public and the Legislative Assembly.

The current home care priorities are to:

Apply continuing quality improvement principles to ensure quality of care.
Enhance palliative care programs and supports to better reflect the cultural needs of the individual and their families.
Revise the continuing care standards for home care, supported living and long-term care.
Develop a standardized approach to allocating home care and home support hours to clients.
Ensure that staffing levels are adequate and consistent throughout the system.

2. Access, Funding & Service Delivery

ACCESS TO HOME CARE SERVICES

Any person with a medical or chronic care problem, or who is at risk for developing one, may be admitted to the home care program.

The NWT Home Care Program provides and coordinates an assessment of the individual requiring care. Referrals to the program are accepted from any source, including clients, family members, physicians and other health professionals. Upon referral to home care, an assessor determines the individual's needs by reviewing the client's situation, health status, supports available, health care and social care needs.

The hours of operation vary across the communities depending on need and resource (fiscal and human) availability. Service availability is dependent upon the size and capacity of the community, with many smaller communities only able to provide personal care, while the larger communities also deliver home support, specialized services and/or home nursing services.

REFERRAL SOURCES

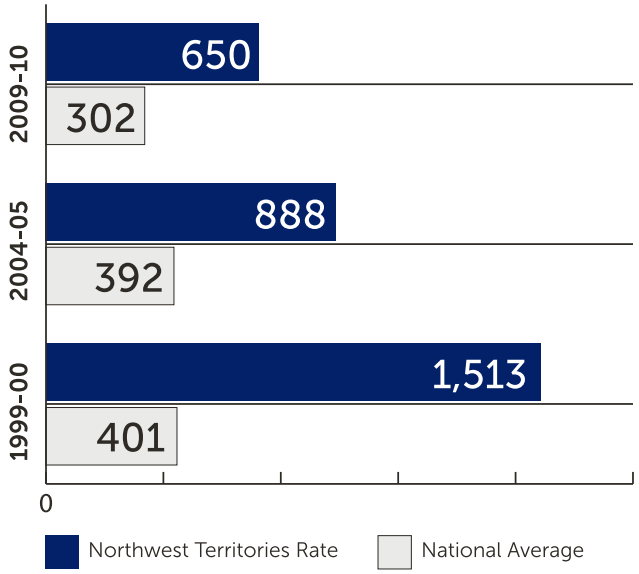
Anyone can refer an individual for a home care assessment, with the exception of palliative care, intravenous medication and foot care, all of which require a physician referral. Access to home care is generally consistent between larger and remote communities. There are no individuals known to be waiting for home care services in the territory.

APPROPRIATE ACCESS TO HOME CARE & COMMUNITY-BASED CARE

Hospitalization rates for conditions which can be cared for in the community are one indicator of appropriate access to community-based care. These conditions include diabetes, asthma, alcohol and drug dependence and abuse, neuroses, depression and hypertensive disease. Preventive care, primary care and community-based management of these conditions may reduce the need for hospitalization.

Hospitalization Rates For Ambulatory Care Sensitive Conditions

Age Standardized Rate per 100,000 younger than 75



Health Indicators Reports, CIHI

Alternate Level of Care (ALC) is a measure used to reflect when a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting.

The percentage of total bed days as ALC was 7.9% in 2009/10. The target is to reduce the number to 5% by 2013/14.

ELIGIBILITY, COVERAGE & UTILIZATION

ELIGIBILITY
Resident of the Northwest Territories with a valid NWT Health Care card.

AGE
All ages.

SUPPLIES, EQUIPMENT AND MEDICATION
May be funded through a variety of sources including user pay, Non-Insured Health Benefits , NWT Extended Benefits Program or private insurance.

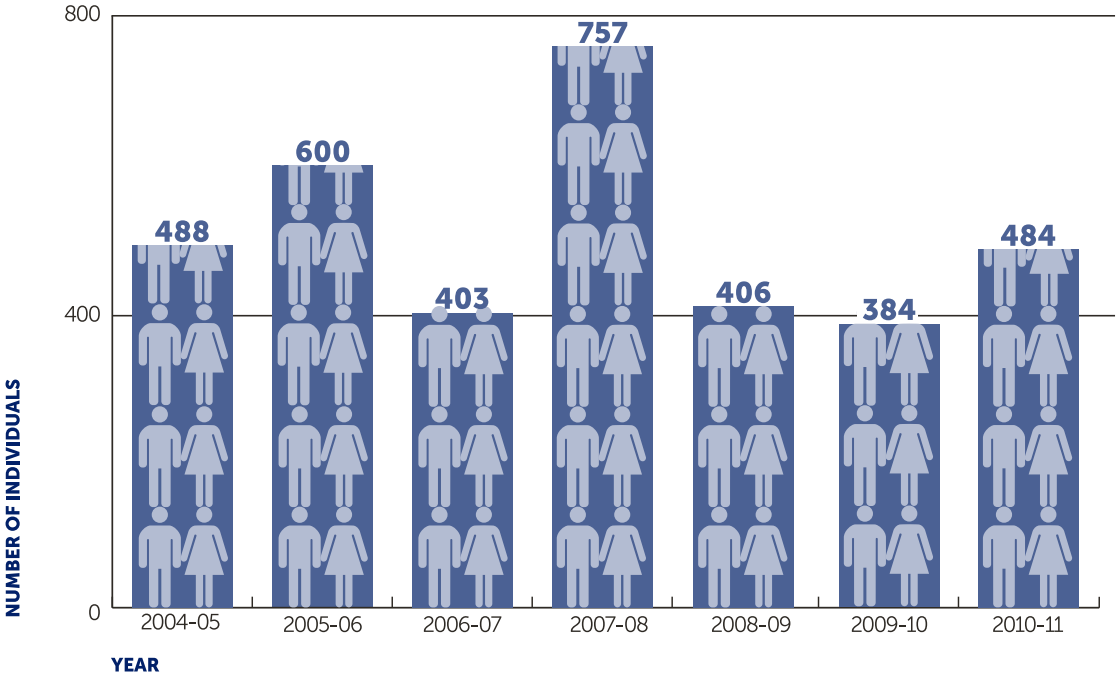
LIMITS / GUIDELINES TO SERVICE PROVISION
Services are covered according to the assessed needs of the client.

DIRECT FEES AND INCOME TESTING
No charges or income testing.

DETERMINING CLIENT NEED - ASSESSMENT TOOLS

The **Continuing Care Assessment Package** (CCAP), developed for the Northwest Territories, is used to determine client needs and to assign the most appropriate service at the most appropriate time in the most appropriate place. The CCAP supports access to all streams of continuing care - home care, supported living and long-term care. It also forms the basis of the client's chart across the system of care. The CCAP is not yet available in an electronic format. Client assessments are made available to all visiting health care providers, therapists and physicians, with client consent.

Home Care Admissions



The increase in admissions to home care in 2007-08 is related to admissions into the new Hay River Health and Social Services Diabetes Program.

SETTINGS OF CARE

Home care services in the NWT are provided in the following settings:

- Group Home
- Home
- Nursing Home (in smaller communities)
- On Reserve (Hay River Reserve)
- School
- Clinic – foot care clients are seen in Yellowknife at the Primary Community Care Clinic

INTEGRATED MODELS OF CARE

In 2004, the Department of Health and Social Services and the eight Health and Social Services Authorities (HSSAs) moved to an **Integrated Service Delivery Model (ISDM)**, a team-based, client-focused approach to providing health and social services. The ISDM was developed to ensure that people across the NWT received better and more equal access to services, and that HSSAs employed more consistent policies, procedures and standards. The ISDM combines 3 key elements:

1. Focusing on community-based services as a priority through a primary community care approach.
2. Connecting and collaborating with all caregivers and their organizations.
3. Identifying and strengthening core services.

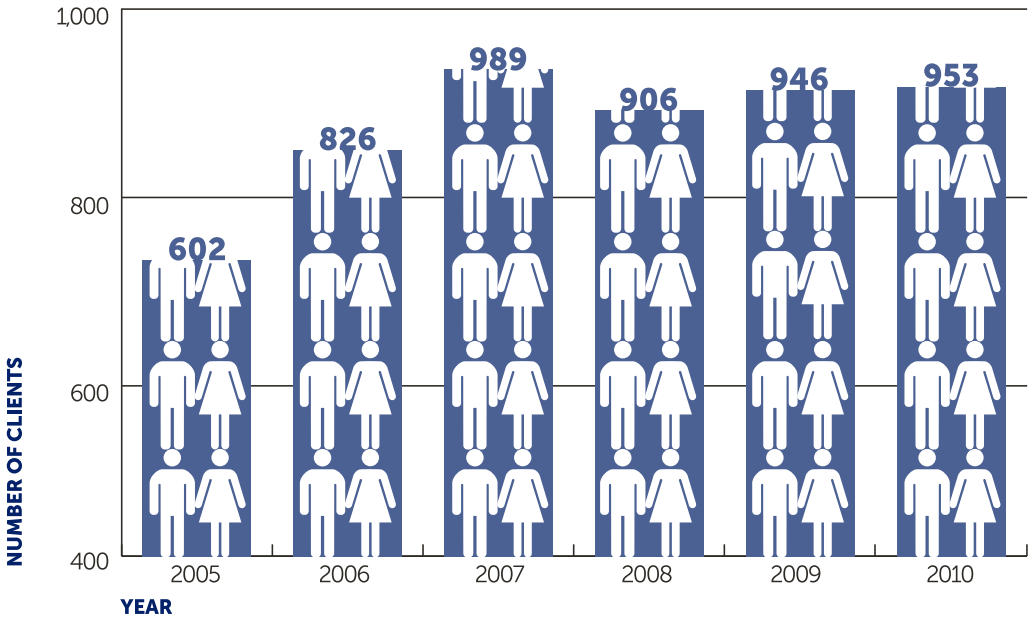
The goals of the ISDM are for the residents of the NWT to be able to:

- Get help from the most appropriate caregiver, at the right time, in the most supported way possible.
- Better understand the available services, the level of service that can be expected and how to access those services.
- Have more consistent access to services in all regions.
- Access more and better quality services, especially in areas of mental health and addictions, home care and rehabilitation.
- Receive care from an integrated team of caregivers, receive coordinated, seamless service including referrals and follow-up, and be certain caregivers protect confidential information.
- Have access to the 1-800 phone line for information and assistance.
- Benefit from increased health promotion and prevention, and be more responsible for their own care.

The ISMD supports clinicians to:

- Develop strong, supported working relationships among different disciplines, and to communicate effectively.
- Use the primary care approach and coordinate client care effectively and efficiently.
- Employ clear procedures and guidelines to refer clients, manage cases, and record and manage data.
- Enhance professional development through teamwork and the integrated system.
- Increase their overall job satisfaction.

Individuals Receiving Home Care



Information is reported on a calendar year

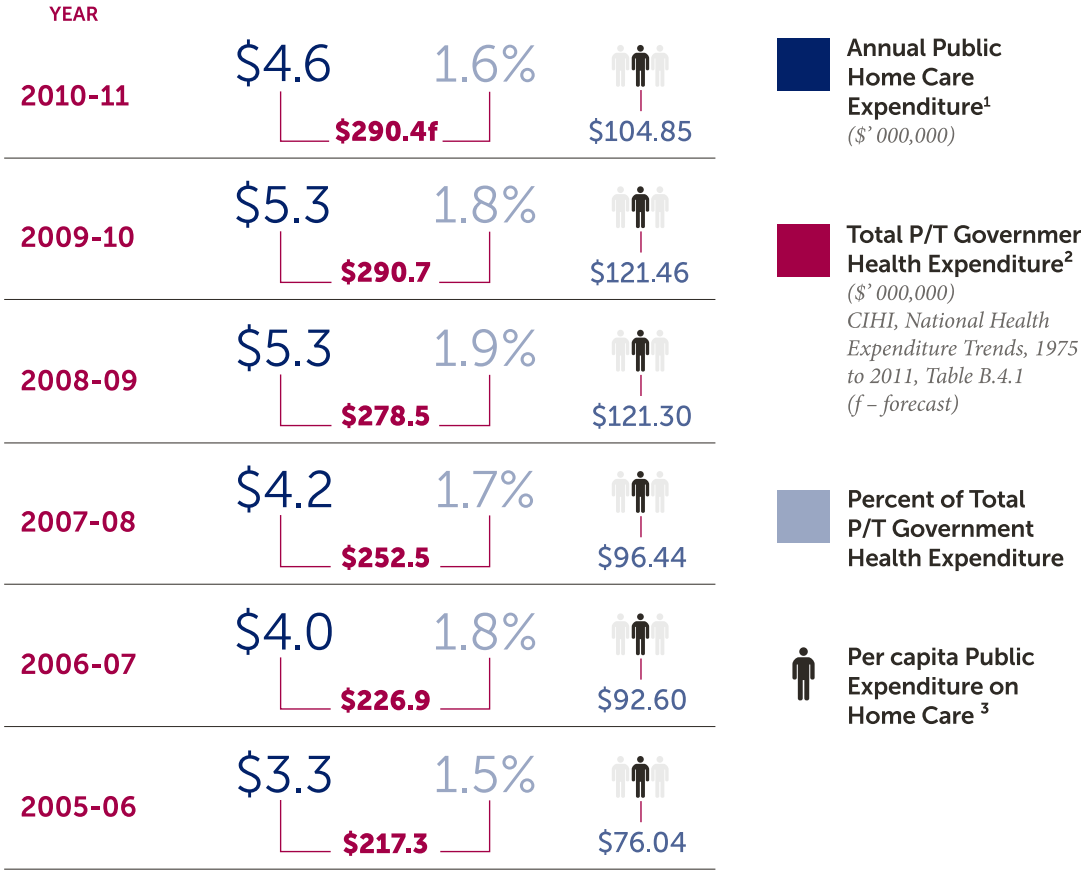
DISCHARGE FROM HOME CARE

After discharge from the home care program, individuals must access medication through retail pharmacies. They may have funding support through Non-Insured Health Benefit (NIHB); NWT Extended Health Benefits program for seniors, Métis, and specified diseases; or private insurance. Equipment or supplies that may be required by individuals are available through local retail outlets or regional rehabilitation programs. These can be funded through a variety of sources including user pay, NIHB, NWT Extended Health Benefits program, or private insurance.

FUNDING

The funding granted to the HSSAs is a mixture of block funding and specific program funding, which is based on historical levels. HSSAs have a large degree of latitude as to how the funding is allocated. Additional funds were provided in 2008/09 to HSSAs to increase the level of home care and support at the community level and increase accessibility to home care in the NWT.

Public Expenditures on Home Care



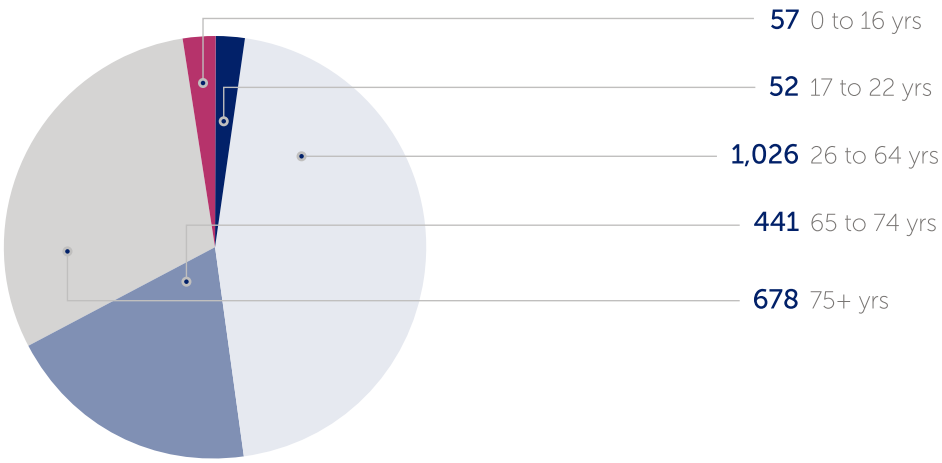
[1]*This does not include the additional funding from the Federal First Nations and Inuit Home and Community Care initiative to enhance existing home care programs in the NWT.*

[2]*Figures include spending for health services reported by the provincial/territorial ministry responsible for health – does not include expenditures from municipal government or worker's compensation. [CIHI, National Health Expenditure Trends, 1975 to 2011, pg 92]*

[3]*Population data from Statistics Canada, Demography Division, Annual Estimates of Population for Canada, Provinces and Territories, from July 1, 1971 to July 1, 2012*

PROFILE OF CLIENTS RECEIVING HOME CARE

Number of Individuals Receiving Home Care By Age Category (2010-11)



DIAGNOSIS

The current information system is not designed to collate diagnoses for trending and tracking. Health system data confirms an increase in chronic conditions as the NWT population ages. The most common chronic diseases are prolonged conditions such as diabetes, mental health, cancer, hypertension, congestive heart failure, chronic obstructive pulmonary disease, arthritis and asthma.

CLIENT GROUPING

The NWT classifies clients into the following groups, for data gathering purposes: acute chronic, acute mental health, acute post-hospital, chronic continuous, chronic time-limited, chronic mental health, disabled and palliative.

SERVICE DELIVERY

MODEL OF SERVICE DELIVERY

Home care services, including nursing, therapy and home support, are provided as per the Integrated Service Delivery Model (ISDM) and are exclusively provided by the public sector.

RANGE OF HOME CARE SERVICES & PROGRAMS

The home and community care program provides a broad range of services. These include: ambulation, post hospital/early discharge follow-up, social support and transportation assistance. There is some variation in services depending on the community and the availability of staff. In the larger centers, other components may also include discharge planning, home IV therapy and cardiac rehabilitation. Services are provided by one or a combination of the following: physician, registered nurse, licensed practical nurse, physiotherapist, occupational therapist, speech language pathologist, community health representative, home support worker, or medical social worker.

Services Accessed at the Community Level

Home Management	Home support workers (HSW) provide laundry, cleaning and meal preparation support.
Personal Care	Services performed by a home support worker.
Nursing Services	Services performed by registered nurses and/or licensed practical nurses. Specific tasks include wound care, medication management and blood pressure monitoring. One HSSA employs the services of a nurse practitioner shared between several programs including home care.
Respite Care	Support services are provided at scheduled times to assist family caregivers.
Nutrition Programs	Meals-on-Wheels.
General Home Upkeep	Handyperson work.
Palliative Care	Scheduled extended hours of care physician, nurse practitioner and/or nursing support are available in some larger communities.

Ancillary support

Oxygen	Home care nursing/private respiratory care service.
Equipment – (wheelchairs, walkers, etc)	Some communities have equipment available on loan.

REGIONAL SUPPORT SERVICES ARE ALSO PROVIDED TO HOME & COMMUNITY CARE CLIENTS.

- Assessment and Case Management (Nurses, LPNs, and/or medical social workers).
- Rehabilitation Services (Physiotherapy, occupational therapy, speech language pathology, social work and dietetics).
- Pharmacy.
- Training workers (through both DHSS and HSSA).
- Program Coordination (HSSA).

TERRITORIAL SUPPORT SERVICES (THROUGH THE DHSS) FOR HOME & COMMUNITY CARE CLIENTS INCLUDE:

- Public Awareness.
- Accountability and Data Collection.

SERVICES NOT PROVIDED THROUGH THE HOME CARE PROGRAM

- Self managed care.
- Respiratory Therapy.
- Drugs.
- Supplies (dressing, stoma, etc.).

CLINICAL (SPECIALTY) SKILLS

With the focus on discharging patients from hospital as promptly as possible, there has been an increase in the complexity of care provided at home. The challenge in much of Canada can be in having a critical mass of patients who require certain levels of expertise and, as a result, special skills only being available in urban centres. However, with the advent of remote access to support in the community, there is an opportunity for more complex care to be provided in less populated areas.

Home care nurses administer narcotics, provide enterostomal therapy, wound care and home oxygen (monitoring and support to the private contractor) across the territory. There is variation in services depending on the community and the availability of staff. Clients requiring infusion therapy, pumps, central lines and peripherally inserted central catheters (PICC lines) can be cared for in Yellowknife and other larger communities where there is expertise and support.

The following clinical specialties are not provided in the home:

- Administration of chemotherapy (with the exception of subcutaneous or intramuscular Methotrexate).
- Administration of blood or blood products.
- Peritoneal or hemodialysis.
- Regular tracheostomy tube replacement.
- Ventilator care.

3. Quality & Accountability

HOME CARE INDICATORS

The home care indicators that are currently monitored at a territorial level include:

- Expenditures.
- Home care admissions.
- Number of staff.

QUALITY & ACCREDITATION

High-quality care is evidence-based (appropriate), focused on the patient (or patient-centred), safe and timely (CIHI).

EXTERNAL ACCREDITATION

Accreditation is an effective way for health services organizations to regularly and consistently examine and improve the quality of their services in order to ensure high standards of care. Health care organizations in Canada are accredited through Accreditation Canada, CARF, the Quebec Council of Accreditation (Quebec only) and/or registered with the International Standards Association (ISO).

Although accreditation is not mandatory, the Health and Social Services Authorities (HSSAs) have obtained, or are working towards, accreditation as a priority.

SYSTEM APPROACHES TO QUALITY IMPROVEMENT

The Department of Health and Social Services (DHSS) has committed to providing quarterly public reports on the health system priorities outlined in the 2009-12 planning document, - 'A Foundation for Change'. The DHSS has received approval for a draft balanced scorecard and a preliminary list of performance indicators for the health and social services system. The performance indicators will be tied into the performance agreements, entered into with the HSSAs. Performance reporting will be internal until baselines and targets are established. An advisory committee has been established, made up of HSSA representatives, hospital representatives and DHSS advisors, in order to support capacity development for delivering the performance measurement and reporting system. Baseline and target measures are under development.

The performance measures related to community health and social services include:

- Incidence of community acquired methicillin-resistantStaphylococcus aureus (MRSA).
- Reduced hospitalizations due to injury.
- Number of standards reviewed and implemented.
- Percent of clients receiving home care in their community.
- Incidence of active tuberculosis.
- Number of clinical telehealth clients.

SAFETY

Home care specific data on incidents or potential safety issues is not collected at the territorial level. Safety issues are addressed regionally and at the community level. Client safety within the home is monitored by professional staff through ongoing assessment and provision of recommendations and support for clients.

HOME CARE RESEARCH

The NWT Home Care Program is not involved in any research at this time. Any research in the NWT must be approved by the **Aurora Research Institute (ARI)** that is responsible for:

- Licensing and coordinating research in accordance with the NWT Scientists Act.
- Promoting communication between researchers and the people of the communities in which they work.
- Promoting public awareness of the importance of science, technology and indigenous knowledge.
- Fostering a scientific community within the NWT that recognizes and uses the traditional knowledge of Northern Aboriginal peoples.
- Making scientific and traditional knowledge available to people of the NWT.
- Supporting or conducting research that contributes to the social, cultural and economic prosperity of the people of the NWT.

Besides the requirements common to other social sciences, health research in the NWT must have approval from the affected HSSA. This includes an additional review from the local HSSA's Ethics Review Committee (ERC) in the authorities where these committees are established (Stanton, Beaufort-Delta and Fort Smith HSSAs).

Better Health – Better Care – Better Cost

Triple AIM, is a roadmap to achieving excellence, high performance and high value health care:

1. Enhance the individual (patient) experience of care (including quality, access, and reliability).
2. Improve the health of populations.
3. Reduce, or at least control, the per capita cost of care for populations.

The five components that support Triple Aim are:

1. Focus on individuals and families.
2. Partnerships of Primary Health Care – Home Care.
3. Population health management – Prevention and Health Promotion.
4. Cost control platform "receiving value for money".
5. System integration and execution.

Adapted from the Institute for Healthcare Improvement, Triple Aim Improvement Community. (Massachusetts: Institute for Healthcare Improvement, 2012).

4. Information Technology

ELECTRONIC HEALTH RECORD (EHR)

The interoperable Electronic Health Record (iEHR) project began implementation in January 2009. The iEHR will provide a summary view of key records collected from specific systems, giving clinicians secure access to a comprehensive health history, and will support the provision of better patient care and safety. In 2010, the NWT HealthNet Viewer, a web-based integrated hospital information and health information exchange system, was implemented. The HealthNet Viewer is the first step in establishing a jurisdiction-wide iEHR, and provides health care professionals with remote view-only access to integrated demographic and medical information for all patients.

USE OF SYSTEM EFFICIENCY TECHNOLOGY

Electronic communication does not yet exist between home care and physicians, home care and hospitals, or between frontline staff. However, technology in the form of email is used for program management data between home care programs and the Department of Health and Social Services, and faxing is used for submission of indicator data and for financial data exchange. Human resource and financial data is tracked manually. Scheduling of staff is done manually and, at this point in time, there has been no application of electronic GPS / mapping systems in the Territory. Home care staff are provided with a cellular telephone; however, there is no cellular service in some of the smaller communities.

USE OF TECHNOLOGY FOR CLIENT CARE

In the NWT, telehealth services were initiated in 1998 with the WestNet Telehealth Pilot. Currently, all 33 communities have access to telehealth video conferencing technology, and it is used to provide regional or territorial services to the clients.

eHealth initiatives are critical to bringing health services closer to clients, improving costs and affording access to health care services in remote communities. Leveraging this technology, the NWT is creating virtual teams to expand the reach of specialists and allow the system to be more efficient. Initiatives include:

- Diagnostic Imaging/Picture Archiving and Communications Systems (DI/PACS).
- Tele-ophthalmology which captures images of a person's retina (living with diabetes) and transmits the "3-D" image to be reviewed by an Ophthalmologist and/or Retinal Specialist at a distant site (Alberta).

Specifically, for the delivery of home care services, telehealth technology is used in a limited manner to support services including acute care, chronic care, palliative care and rehabilitation. Telehealth units are available in most community health centres. The Chronic Disease Management Strategy will be working with the Home Care Program to examine working relationships and service expectations for these services within home care.

5. Health Human Resources

CLINICIANS PRACTICING IN HOME & COMMUNITY CARE

Health services in NWT are provided primarily in the public sector. Retention of health professionals continues to be a challenge across the NWT. Vacancies are occasionally filled with casual or contracted health professionals (primarily physicians and nurses). This is not an optimal situation, as temporary contract staff increases costs and impacts continuity of care for clients. To address this challenge, DHSS is actively recruiting, and offering training and education, in order to meet the growing demand for home and community care.

Current staffing levels for home and community care vary according to availability of staff and the health needs of specific communities. Generally, staffing mix at the community level consists of:

- Home support workers.
- Registered nurses specializing in home care.
- Community health nurse providing home nursing support

Staffing at the regional level also varies from one region to another and may consist of:

- A regional program coordinator.
- Specialized and support staff such as:
    - Registered nurses.
    - Social workers.
    - Nutritionists.
    - Rehabilitation specialists (e.g. Occupational Therapist, Physiotherapist, Recreational Therapist)
    - Clerk/interpreters.

Deliver core community health and social services through innovative service delivery

Integrate and modernize consistent standards, policies, best practices and decision making tools across the system. May include Community Health Nursing standards, management of chronic disease, renal dialysis, continuing and long-term care standards, and clinical standards.

Target:
Year 1, Gap analysis of existing standards and policies
Year 2, Identify resources required and develop a staged approach plan to complete the work
Year 3, Modernize and develop required standards and policies according to plan
Year 4, Implement standards and training - Develop and implement a compliance monitoring framework

Deliverable: Existence of updated standards, policies and tools

(Building on Our Foundation 2011- 2016, A Strategic Plan for the NWT Health and Social Services System)

Training and support to allow families to care for individuals and loved ones in their homes where appropriate. This includes home care that responds to higher acuity discharged patients as well as allowing seniors to age in place and palliative care

Target:
Year 1, Identify training needs and existing supports in the communities
Year 2, Implement training
Year 3, Ongoing training and evaluation

Deliverable:
Residents have access to care in their home

(Building on Our Foundation 2011- 2016, A Strategic Plan for the NWT Health and Social Services System)

EDUCATION & TRAINING

HEALTH CARE PROFESSIONALS

The Office of the Registrar, Professional Licensing is responsible for ensuring that the licensing of health professionals is carried out in accordance with legislation and best practices.

UNREGULATED STAFF

Home support workers provide a broad range of community care services including: social support, Meals on Wheels, management of medications, and follow up visits following hospital stays. There are no standard educational requirements across the NWT for home support/personal support workers. The HSSAs determine the requirements for these positions and define the scope of practice. Aurora College offers a course for home support/personal care workers and regular professional development opportunities are provided through HSSAs and the DHSS. There is no registry of support workers in the NWT.

INTER-PROFESSIONAL COLLABORATION

The Integrated Service Delivery Model (ISDM) is the framework that supports a team-based, client-focused approach to providing health and social services. Two forms of collaboration are supported within this model.

1. Multi-disciplinary collaboration, in which service providers at the community level, comprising a primary community care (PCC) team work together to meet client needs.
2. Care providers within each core service area establish vertical, intra-disciplinary linkages to ensure a continuum of services from community to regional to territorial levels.

FAMILY CAREGIVER

The needs of family caregivers are recognized and respite services are provided. There are no policies specifically for the family caregiver.

6. Territorial Initiatives

Most recently, territorial initiatives have been directed at improving the design and delivery of medical travel, improving the recruitment of human resources, and strengthening performance measurement and reporting. Coordinated referral and assessment is a priority area for the Home Care Program. DHSS continues to work with HSSA to implement standardized assessments across the continuing care service areas.

CONTINUING CARE STANDARDS

Draft Continuing Care Standards were completed March 31, 2011. The draft standards are currently being reviewed and used as a basis for standardized territorial policy development. These standards, and the policies that arise from them, will provide the basis for measuring standard levels of home care, fair distribution of home care resources and regional accountability for outcomes. They will provide the basis for continuing quality improvement initiatives.

CHRONIC DISEASE MANAGEMENT

The Home Care Program is engaged in the development and implementation of a Chronic Disease Management (CDM) model for the NWT. Currently, three pilot projects are in progress in the areas of mental health, renal care and diabetes. Lessons from the pilot projects will be used to inform a CDM strategy for the NWT. Funding was provided to support home support workers to attend regional diabetes workshops in 2010/11. The goal of the workshops was to increase home support workers' knowledge about diabetes, its prevention and management.

SENIORS AND AGING

Home care collaborates with the NWT Seniors Society (NWTSS) in the implementation of a Prevention of Elder Abuse Action Plan. The Plan, developed in 2004, has three objectives:

1. Empower the NWT elders to deal with abuse.
2. Identify and deal with elder abuse.
3. Deal with the addictions that contribute to abuse.

Home care helps to address elder abuse by advocating on behalf of the elder, and providing services and caregiver respite. In-servicing by the NWTSS to frontline home care staff and community members has been facilitated by the DHSS.

END-OF-LIFE CARE

Members of the Home Care Program and DHSS, in collaboration with the Dene Nation, have developed end-of-life care resources entitled **'Incorporation of Traditional Knowledge and Care with Palliative Home Care Programs and Services'**. These resources are available to all home care staff and have been accessed to guide the delivery of palliative care services across the NWT.

7. Challenges

The following are some of the factors that make the delivery of home health care in the NWT challenging.

Geographic size and population dispersion - NWT residents expect to receive the same level of primary health care services as those living in other larger and more densely populated regions of the country. However, the number of small communities, geographic barriers and large travel distances make this virtually impossible.

Aging population - It is estimated that the proportion of seniors aged 60 plus will increase from 9 percent in 2008 to 13 percent in 2017. Demand will increase, and the supply of health human resources will decline.

Recruitment of health professionals - Vacancy and turn-over rates for all levels of health care professionals in the NWT remain significant, and many health professionals are expected to retire over the next 10 years. The lack of health care professionals could compromise the delivery of health care services.

Second-highest per capita costs in Canada - These higher costs are generally attributed to the higher costs of providing services to a relatively small population living in a remote region of the country.

8. Opportunities

The Home Care Program will continue to work on:

- Expanding services for adults and elderly individuals requiring special services in home.
- Addressing gaps in service levels for the elderly.
- Conducting a needs analysis to determine the number of potential clients and program resources, and the resources required to meet those needs.
- Enhancing program standards and policies.

Over the next decade, home care in the Northwest Territories will be focused on working towards meeting the priorities identified in Building on Our Foundation (2011-2016):

- Apply continuing quality improvement principles to ensure quality of care.
- Enhance palliative care programs and supports that better reflect the cultural needs of the individual and their families.
- Revise the Continuing Care Standards for home care, supported living and long-term care.
- Develop a standardized approach to allocating home care and home support hours to clients.
- Ensure that staffing levels are adequate and consistent throughout the system.

ACRONYMS / ABBREVIATIONS

ALC -	Alternate Level of Care
ARI -	Aurora Research Institute
CCAP -	Continuing Care Assessment Package
CDM -	Chronic Disease Management
DHSS -	Department of Health and Social Services
DI/PACS -	Diagnostic Imaging/Picture Archiving and Communications Systems
ERC -	Ethics Review Committee
HSSA -	Health and Social Services Authority
HSW –	Home Support Worker
iEHR -	interoperable Electronic Health Record
ISDM -	Integrated Service Delivery Model
ISO -	International Standards Association
MRSA -	Methicillin-resistant Staphylococcus aureus
NIHB -	Non-Insured Health Benefit
NWTSS -	NWT Seniors Society
PCC –	Primary Community Care
PICC lines -	Peripherally inserted central catheters

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The chapter has been compiled from sources listed below, interviews with key informants and feedback to an electronic survey. Information replicated from provincial materials has been done so with the knowledge and permission of the key informant.

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Harmonized Principles for Home Care

Guide policy and program development

Support consistency and equity across the country

Facilitate benchmarking and sharing of best practices

SUSTAINABLE CARE

Home care contributes to the sustainability of an integrated health system by increasing efficiencies and delivering cost effective care.

Health and Well-being: Focus on health promotion, disease prevention and management, and quality of life.

Needs Based Planning: Establish policies and programs on current and future needs and trends.

Optimum Effectiveness: Integrated resources planning across client populations and care settings.

YUKON

HOME CARE IN **YUKON**

In the Yukon, the definition of home care is consistent with that of the Canadian Home Care Association.

"Home care is defined as an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the family caregiver."

In the Yukon the terms 'home care' and 'community care' are used interchangeably.

YUKON
BY THE NUMBERS...

474,391 sq km **LAND AREA**	34,700[1] POPULATION (2011)	**60%**[3] Percent population in urban settings defined as an area with a population of at least 1,000 and with no fewer than 400 persons per square kilometer (2006)	
47.5[2] Dependency Ratio (2009) Ratio of the population aged 0-19 and 65+ to the population aged 20-64	8.8%[1] **Population Seniors 65+ yrs (2011)**	75.2 years[1] **LIFE EXPECTANCY (AT BIRTH)**	**$7,101.88**[2] Public sector health care expenditure per capita (2011 Forecast)

[1]Statistics Canada | [2]Canadian Institute for Health Information (CIHI) | [3] Human Resources and Skills Development Canada

1. Governance & Organization

HEALTH CARE SYSTEM STRUCTURE

The **Department of Health and Social Services**, Continuing Care Branch of the Yukon Territorial Government administers the Yukon Home Care Program. The Continuing Care Branch is headed by an Assistant Deputy Minister (ADM). The Manager of Community Care reports to the Director of Care and Community, who in turn reports to the ADM. All professional staff report to the Manager, as does the Home Support Supervisor.

There is no regionalization in the Yukon and accordingly the home care program, as a Ministry program, has full responsibility for decision support, development of policy, program administration and direct service provision. Consistency of service (number of visits, time on the program, types of health care practitioners, etc) within home care is achieved through service guidelines and policies and decision making frameworks that reflect current experience to date.

The Program works closely with other departments, First Nation governments, medical facilities, and other community organizations.

The Yukon Home Care Program helps Yukoners who are not fully able to care for themselves at home. It is a community-based visiting service that encourages self-sufficiency, and supports family members and community involvement to assist individuals to remain independent in their own homes, for as long as possible.

HEALTH CARE & HOME CARE LEGISLATION

There is no legislation governing the delivery of home care services. However, legislative authority for the Home Care Program is included in many pieces of legislation including, but not limited to:

Financial Administration Act (2002) - directs the Commissioner in Executive Council to appoint the Internal Auditor. The Internal Auditor has the authority to audit the records of the Government in relation to all financial matters, including financial management, control and reporting. The Internal Auditor also has the authority to audit the organization, general management and operations of departments, and the extent of their compliance with legislation and directives of the Management Board.

Yukon Health Act (2002) - states that the "primary objective of Yukon's health and social services policy is to protect, promote, and restore the well-being of residents of the Yukon in harmony with the physical, social, economic and cultural environments in which they live and to facilitate equitable access to quality health and social programs and services."

Care Consent Act (2005) - addresses consent and substitute consent to health care, admission to care facilities and personal assistance services (e.g. home care). It sets out the requirements for a valid advance directive and establishes the Capability and Consent Board.

Adult Protection and Decision Making Act (2005) - provides a range of tools to assist adults (19 and older), who have some diminished ability, to make their own decisions. Tools include Supported Decision-Making Agreements, Representation Agreements, court-appointed guardianship and adult protection for adults who may be abused or neglected and unable to seek their own help.

Health Professions Act (2003) - governs designated health professions. This Act is anticipated to expand to include regulation of paraprofessionals in the territory.

EVOLUTIONARY MILESTONES

1988

Yukon Home Care Program created and implemented.
The growth of home care in the Yukon was fuelled primarily by demand from consumers (seniors' programs and their clients lobbied strongly for home care services).

2003

Program expansion - New categories of service introduced.

2007

Significant growth of the program with increasing services being offered in smaller communities.
Introduction of the Licensed Practical Nurse role.

2010

The Yukon Palliative Care team integrated with home care.

MANDATE, MISSION, PRINCIPLES & PRIORITIES

MANDATE

The Yukon Home Care Program provides client-focused health services in the home, improving quality of life and supporting Yukoners to live independently.

PRINCIPLES OF HOME & COMMUNITY CARE

The values and/or principles governing the Home Care Program are:

- Open, honest and effective communication.
- Self-determination.
- Excellence in care.
- Creative and positive work culture.
- Collaborative team approach.
- Respect and dignity.
- Client and community focused care.
- Commitment to whole health.

HOME CARE PROGRAM OBJECTIVES

The Program's objective is to support individuals so that they can live independently in their homes.

HEALTH SYSTEM PRIORITIES

The Department of Health and Social Services is committed to providing quality health and social services for Yukoners. This is achieved by helping individuals acquire the skills to live responsible, healthy and independent lives, and by providing a range of accessible, affordable services that assist individuals, families and communities to reach their full potential. Within the Continuing Care Branch, the priorities include:

- Enhancing the continuing care program and services.
- Supporting employees to reach their personal and professional potential.
- Service and program planning, supported by well-organized and meaningful information.
- Encouraging and supporting a quality and risk management culture that enables continuous improvement and sustainability of services and programs.

The current home care priorities are to:

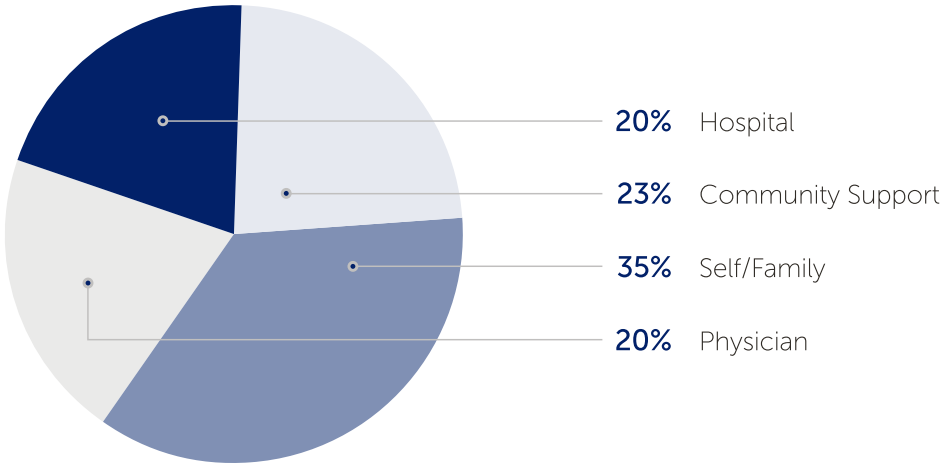
Ensure access to home and community care services to assist people to stay in their homes as long as possible.
Initiate and sustain promotion and prevention programs for clients.
Increase the use of data to inform care planning and program planning.
Implement innovative modes of service delivery to meet client need.

2. Access, Funding & Service Delivery

ACCESS TO HOME CARE SERVICES

Referrals to the Yukon Home Care Program are accepted from any source, including clients, family members, physicians and other health professionals. The Yukon Home Care Program provides and coordinates an assessment of the individual requiring care. Intake, assessment and referral activities are completed Monday to Friday between 8:30am - 5:00pm, excluding statutory holidays.

Referral Sources (2010-2011)

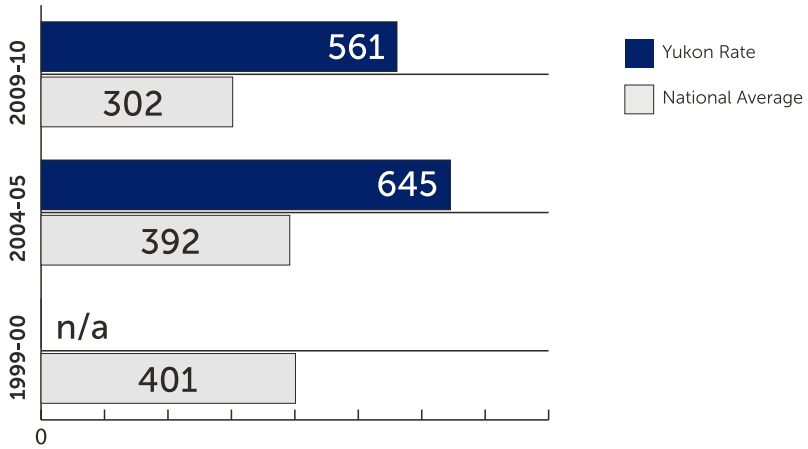


APPROPRIATE ACCESS TO HOME CARE

Hospitalization rates for conditions that may be cared for in the community are one indicator of appropriate access to community-based care. These conditions include diabetes, asthma, alcohol and drug dependence and abuse, neuroses, depression and hypertensive disease. Preventive care, primary care and community-based management of these conditions may reduce the need for these hospitalizations.

Hospitalization Rates For Ambulatory Care Sensitive Conditions

Age Standardized Rate per 100,000 younger than 75



Health Indicators Reports, CIHI

ELIGIBILITY, COVERAGE & UTILIZATION

ELIGIBILITY

Canadian citizen or landed immigrants claiming the Yukon as their place of permanent residence. All services are based on assessed client need and on the principle of utilizing existing family and community resources as part of the care plan. Criteria for admission to the Program:

- Physical and mental disabilities.
- Acute care needs.
- Frail elderly needing assistance in daily living.
- Terminal illness.

AGE

All ages

DIRECT FEES AND INCOME TESTING

There are no direct fees and no income testing.

LIMITS / GUIDELINES TO SERVICE PROVISION

Services are based on assessed need, within the following guidelines:

- The total cost of care cannot exceed cost of long-term care facility services.
- Acute care services are only provided for clients requiring less than 12 weeks of service.
- The maximum number of home support hours per client is 35 hours per week.
- Professional services are limited to twice daily visits.

SUPPLIES, EQUIPMENT AND MEDICATION

The Home Care Program provides 2 week coverage of supplies and equipment for short-term acute clients. There are several assistance programs for palliative care; persons over 65 years of age; and individuals registered in the Chronic Disease Program through Yukon Extended Care benefits. Some equipment and funding assistance can be requested from the Non-Insured Health Benefits for First Nations.

The Pharmacare Program provides prescription drug benefits to Yukon Health Care registrants who are at least 65 years of age and spouses aged 60 years or older. Those who have the cost of prescription drugs covered by another agency or private insurance must use that plan first.

The Chronic Disease Program provides prescription drug benefits to Yukon Health Care registrants who have a specific chronic disease or a serious functional disability, as provided under the Chronic Disease and Disability Benefits Regulations. Those who have the cost of prescription drugs covered by another private insurance must use that plan first. Clients must pay the first $250.00 per annum, per individual, to a maximum of $500.00 per family, effective on the 1st of April each year. Those residents eligible to receive benefits under the Chronic Disease Program may apply for a reduction or waiver of the deductible depending on income and family size. The application for reduction must be renewed each fiscal year based on the most current information, and be approved prior to benefits being received under the program.

Patients considered to be palliative will be fully covered under the Chronic Disease Program or Pharmacare Program and have their deductible waived. When making application for a patient, physicians will be required to specify life expectancy. Patients eligible for palliative coverage are those in late stages of terminal illness (life expectancy measured in months) for whom treatment aimed at cure or prolongation of life is no longer deemed appropriate, but for whom care is aimed at improving or maintaining the quality of remaining life (e.g. management of symptoms such as pain, nausea and stress). This coverage is not intended for cases where active treatment is being continued in the hope of remission or recovery.

DETERMINING CLIENT NEED - ASSESSMENT TOOLS

The Yukon Home Care assessment is administered at intake with all clients and used electronically. The Resident Assessment Instrument - Home Care Assessment (RAI-HC) is fully implemented and serves as the tool used by staff for client assessments of adult long-stay clients. The Yukon Home Care Program uses an electronic application of the RAI-HC tool.

Once a person has been referred, an assessment is done to determine the client's needs and types of services required to support independence. Service allotment is unique to each client and takes into consideration the client's needs and the informal supports (family and friends) available. The health professional completing the intake assesses the client based on the following principles:

- The amount of service provided should support the client and their informal supports through the acute care/recovery period.
- Assessment should include the kinds of teaching, monitoring and treatment modification that would make the care easier for the client and all the people involved in the home environment.
- Coordination of other service providers and funding sources for supplies and equipment is desirable.

The home care health professional, serving as coordinator, meets with the new client to clarify the request and to help identify the person's strengths and the ways in which family and friends can help. If necessary, home support and/or nursing care can start within 1-2 days to ensure the well-being of the client. This can be followed by a more thorough assessment by other team members. The assessments are shared, with client consent, to members of the family, the home care home support worker, the home care nursing and therapy staff and the physician.

LEARN MORE

Resident Assessment Instrument-Home Care (RAI-HC)

The Resident Assessment Instrument-Home Care (RAI-HC)© and its next generation tool, the interRAI-HC is a standardized, multi-dimensional assessment system for determining client needs. Assessments are captured electronically and provide real-time feedback for clinicians to support care planning and monitoring in addition to providing organization and jurisdiction level data to support system management, quality improvement and policy-making.

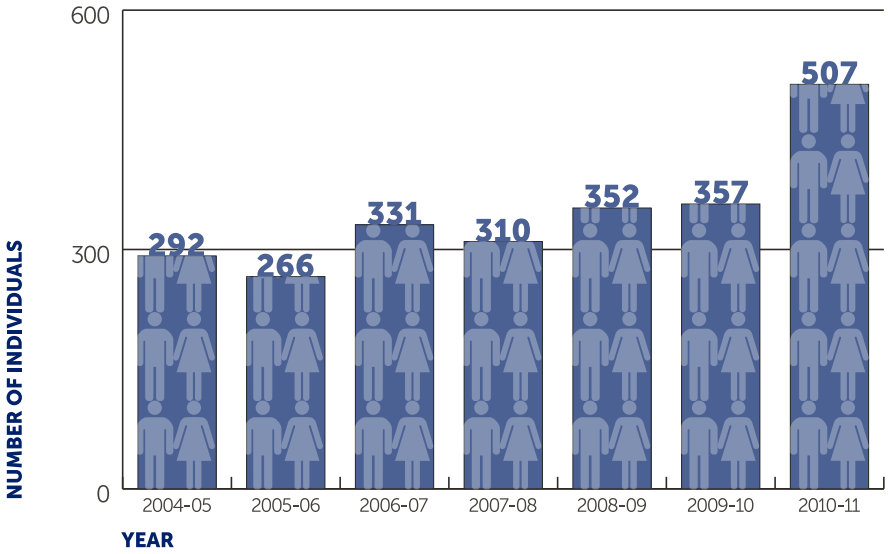
The RAI-HC was developed through interRAI, a collaborative, not-for-profit network of researchers from around the world that works to promote evidence-informed clinical practice and policy decision making through the collection and interpretation of high-quality data about the characteristics and outcomes of persons served across a variety of health and social services settings.

(RAI-HC© interRAI Corporation, 2001. http://www.interrai.org)

ADMISSIONS TO HOME CARE

As the chart below shows, home care admissions increased 42 percent in 2010-11. This reflects a growing population, aging demographic and inclusion of clients receiving regional therapy services which include occupational therapy and physiotherapy.

Home Care Admissions



Access to home care is generally consistent between rural and urban settings. There are no individuals known to be waiting for home care services in the territory.

SETTING OF CARE

Home care services in the Yukon are provided in the following settings:

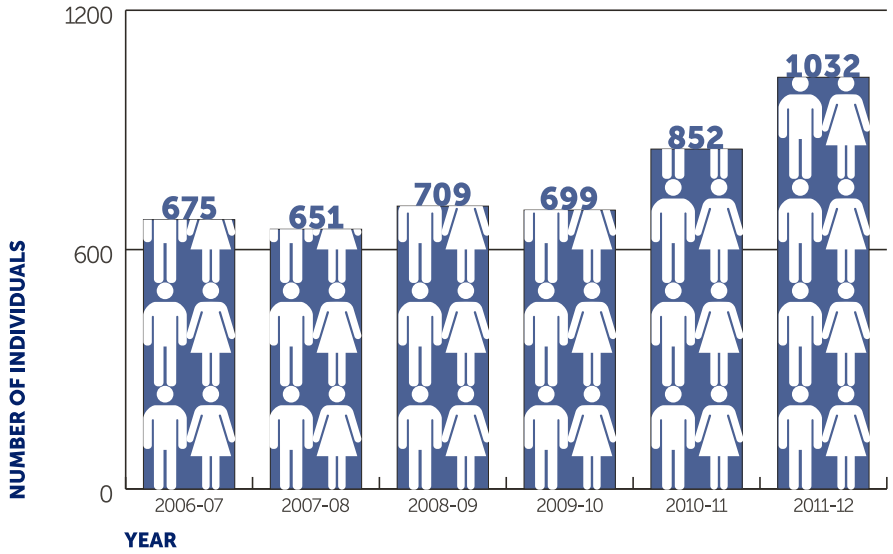
- Group Home
- Home
- Nursing Home

INTEGRATED MODELS OF CARE

Integration is acknowledged as optimizing the individual's access to the skills and competencies of a wide range of health professionals, and provides a broader focus on health that includes health promotion and the prevention of illness. Early stages of collaboration opportunities between home care and main territorial hospitals are being explored and barriers are being addressed. These include working with staff from the main hospital in Whitehorse to divert client admission and promote early discharge.

The Department of Health and Social Services, in partnership with the Salvation Army and the Kwanlin Dun First Nation (KDFN) Health Department, has opened a clinic at the Salvation Army that is readily accessible to the homeless in Whitehorse. The clinic will initially offer general nursing care, wound care, foot care, assistance with medications and case management support to access additional health and social services. The clinic operates for one half day a week and, since opening in August 2011, has provided over 400 nursing visits to 165 unique individuals.

Individuals Receiving Home Care

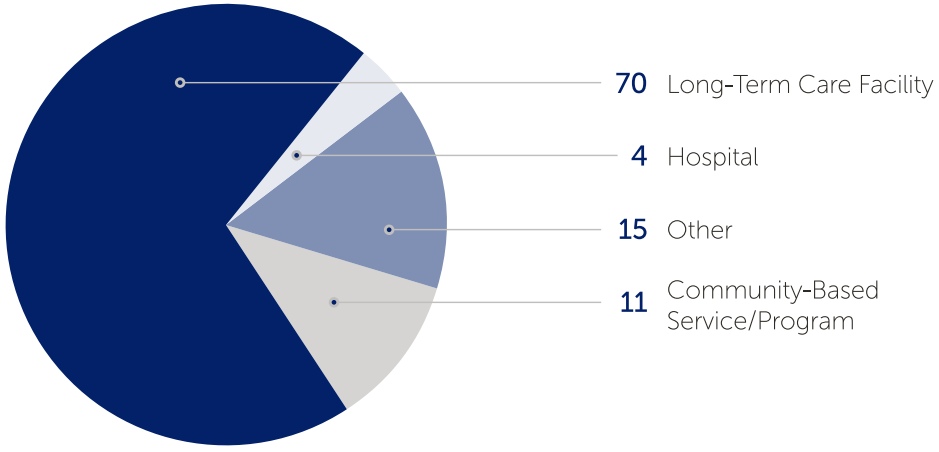


Note: From 2010 onward these numbers include clients receiving home care, occupational therapy and physiotherapy services in the communities outside of Whitehorse

DISCHARGE FROM HOME CARE

Discharge disposition for individuals who have received home care service is increasingly important and instructive to the health care system as it is an indicator of effectiveness. The outcomes can guide system planning and the development of care algorithms for specific patient populations. The Yukon Home Care Program tracks the outcomes of clients who have been on the program. In 2010-11, 60 percent of clients had their goals met on discharge and 16 percent died.

Discharge Destination (2010 - 2011)



After discharge from home care, clients must access and fund any requirements for medication, equipment and supplies through third party insurance or self pay. Seniors and individuals on the Chronic Disease Program can access benefits through the Yukon Extended Health Care Benefits program.

FUNDING

Expenditures include administration, professional services and home support. These numbers do not include social work and community nursing services in the communities outside of Whitehorse, nor do they include all home care services in Dawson City, which are administered by the intermediate care facility. The figures also do not include homemaking services for First Nation Citizens. Services such as Pharmacare, Adult Day programs and Meals on Wheels are funded through other programs, so again are not included in these numbers.

Public Expenditures on Home Care

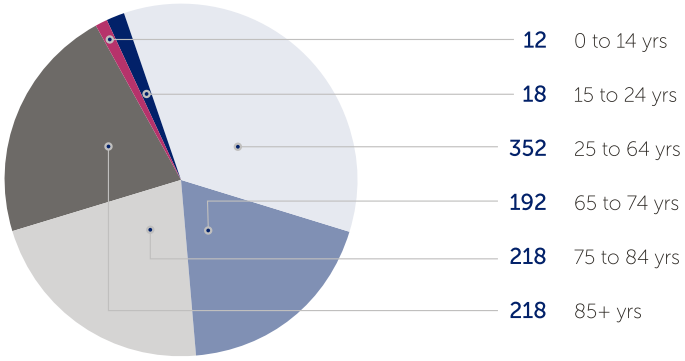
YEAR	Annual Public Home Care Expenditure ($' 000,000) (p – preliminary)	Total P/T Government Health Expenditure[1] ($' 000,000) Data Source: CIHI, National Health Expenditure Trends, 1975 to 2011, Table B.4.1 f – forecast	Percent of Total P/T Government Health Expenditure	Per capita Public Expenditure on Home Care[2]
2011-12	$5.4[P]	$206.5[f]	2.6%	$152.55
2010-11	$4.5	$201.2[f]	2.2%	$129.94
2009-10	$4.3	$184.3	2.3%	$127.41
2008-09	$3.8	$158.1	2.4%	$114.80
2007-08	$3.5	$145.3	2.4%	$107.49
2006-07	$3.7	$142.8	2.6%	$114.64
2005-06	$3.2	$125.0	2.6%	$100.30

[1]*Figures include spending for health services reported by the provincial/territorial ministry responsible for health – does not include expenditures from municipal government or worker's compensation. [CIHI, National Health Expenditure Trends, 1975 to 2011, pg 92]*

[2]*Population data from Statistics Canada, Demography Division, Annual Estimates of Population for Canada, Provinces and Territories, from July 1, 1971 to July 1, 2012*

PROFILE OF CLIENTS RECEIVING HOME CARE

Number of Individuals Receiving Home Care By Age Category (2011-12)



DIAGNOSIS

The most common diagnoses for individuals receiving home care are not tracked by the territory. Staff report the most common diagnoses to be hypertension, diabetes, emphysema, COPD, and asthma.

CLIENT GROUPING

The Yukon Home Care Program categorizes its programs according to the Canadian Institute for Health Information (CIHI) definitions.

LEARN MORE

Home Care Client Grouping

Developed in 2003, through the CIHI National Indicators and Reports for Home Care Project, five core home care program components were developed to enable comparisons between jurisdictions.

Maintenance - maintain independence and, where possible, to enhance client's performance of ADLs and IADLs.

Rehabilitation – improve functional status and facilitate social integration and independence.

Long-Term Supportive Care – prevent or delay institutionalization.

Acute Care Substitution – prevent an acute facility admission or re-admission and/or to reduce the length of stay in an acute care facility.

End-of-Life Care – meet the needs of individuals whose health condition is not responsive to curative treatment and who are dying.

Canadian Institute for Health Information. (2004). Development of National Indicators and Reports for Home Care—Phase 2 Final Project Report. Ottawa: Canadian Institute for Health Information.

SERVICE DELIVERY

MODEL OF SERVICE DELIVERY

Home care services are provided primarily through public sector employees. There is a minimal amount of private home care service available in the Yukon. Clients may receive home support and nursing service on weekends and evenings, but there are no overnight supports.

RANGE OF HOME CARE SERVICES & PROGRAMS

The Yukon Home Care Program provides and co-ordinates a continuum of care through assessment, instruction, and the provision of supportive, therapeutic and palliative services, in conjunction with an interdisciplinary team. The goal is to teach clients and family self-care techniques whenever possible, and suggest adaptations that may be helpful in their home environment.

The services provided in the Yukon vary from community to community. As of 2010, with an expansion of services in communities outside of Whitehorse, there is consistent care coordination for home care clients. This is provided through the home care nurse or through the home care Community Liaison Coordinator, who is typically a therapist.

Services Provided by the Home Care Program

Nursing	Outside of Whitehorse, nursing is provided by health centers that are under the jurisdiction of the Health Services Division Community Nursing Program. Case management is an integrated part of professional practice.
Home Support	Primary service coordinated by the care coordinator or, in communities outside of Whitehorse, by either the Community Liaison Coordinator or the home care nurse in that community.
Physiotherapy **Occupational Therapy** **Speech Language Pathology (limited)**	Outside of Whitehorse, the Regional Therapy Team provides regular visits to deliver physiotherapy, occupational therapy and speech language pathology services. Case management is an integrated part of professional practice.
Social Work	In 2010 services for social work were increased through support provided either through the social work team in Whitehorse, or indirectly through the home care nurse (7 communities) or the Community Liaison Coordinator (6 communities) Case management is an integrated part of professional practice.

Ancillary Support

Oxygen	Services are funded by a separate Pharmacare or Chronic Disease program, as well as Non-Insured Health Benefits (NIHB).
Drugs	
Supplies (dressings, stoma, etc)	Short-term supplies provided through home care
Equipment (wheelchairs, walkers, etc)	Short-term loans provided through home care

SERVICES CURRENTLY NOT FUNDED BY THE HOME & COMMUNITY CARE PROGRAM

- Nurse Practitioner
- Respiratory Therapy
- Dietitian
- Physician
- Pharmacist
- Clergy / Spiritual Care
- Self-Managed Care

CLINICAL (SPECIALTY) SKILLS

With the focus on discharging patients from hospital as promptly as possible, there has been an increase in the complexity of care provided at home. The challenge in much of Canada can be in having a critical mass of patients who require certain levels of expertise and, as a result, special skills only being available in urban centres. However, with the advent of remote access to support in the community, there is an opportunity for more complex care to be provided in less populated areas.

Home care nurses are able to support clients, and their families who have been trained by clinical specialists in the hospital, to manage central lines, infusion pumps (although rarely deployed to the community), peripherally inserted central catheters (PICC lines) and home peritoneal dialysis. Given the inherent risks, these services are only available to clients in the urban communities.

Subject to appropriate training and certification, home care nurses also provide wound care and enterostomal therapy, and are able to administer narcotics in the home care setting in special situations for clients at end-of-life.

The following clinical services are not provided in the home by home care staff in the Yukon:

- Home oxygen
- Administration of chemotherapy
- Blood or blood products
- Hemodialysis
- Regular tracheostomy tube replacement
- Ventilator care
- Infusion therapy

3. Quality & Accountability

HOME CARE INDICATORS

The home care indicators that are currently monitored at a territorial level include:

- Amount of service delivery
- Expenditures
- Home care admissions
- Referral source
- Reason for non admit
- Diagnosis
- Client disposition at discharge
- Safety issues
- Number of staff

High-quality care is evidence-based (appropriate), focused on the patient (or patient-centred), safe and timely (CIHI).

QUALITY & ACCREDITATION

EXTERNAL ACCREDITATION

Accreditation is an effective way for health services organizations to regularly and consistently examine and improve the quality of their services, in order to ensure high standards of care. Organizations in Canada are accredited through Accreditation Canada, CARF, the Quebec Council of Accreditation (Quebec only) and/or registered with the International Standards Association (ISO).

The Yukon Home Care Program is accredited by Accreditation Canada.

CLIENT / PATIENT ADVOCATE

There is no patient advocate specific to home care. However, there is a territorial ombudsman who serves to support patients who feel that decisions regarding their care need to be revisited.

SYSTEM APPROACHES TO QUALITY IMPROVEMENT

The Yukon Home Care Program, within the Continuing Care Branch, monitors and reports on its progress in ensuring quality care to clients. This program has established processes to minimize risks to clients, staff and the program as a whole. Quality and risk management facilitates the development of a systematic, comprehensive program with clear lines of accountability and authority.

The Continuing Care Director of Quality, Risk and Management is responsible for coordinating, monitoring and evaluating quality services in the Home Care Program.

SAFETY

Client and employee safety is monitored through documented incident reports. Aggregate data on the types and nature of incidents is not tracked. Currently, a medication reconciliation program is being implemented.

HOME CARE RESEARCH

The **Arctic Institute of Community-Based Research: For Northern Health and Well-Being** (AICBR) is involved in diabetes prevention and injury prevention. The focus of its work in the community goes beyond health specifically to include the broader determinants of health. The community-based research identifies eight principles:

- Recognizes community as a unit of identity.
- Builds on strength and resources within the community.
- Facilitates collaborative partnerships in all phases of the research.
- Integrates knowledge and action for mutual benefit of all partners.
- Promotes a co-learning and empowering process that attends to social inequalities.
- Involves a cyclical and iterative process.
- Addresses health from both positive and ecological perspectives.

4. Information Technology

ELECTRONIC HEALTH RECORD (EHR)

Currently the Yukon Government is developing privacy legislation that will relate to the electronic health care record. Once this legislation is in place the electronic health care record will be developed.

HEALTH DATA & THE HOME CARE REPORTING SYSTEM

The Canadian Institute for Health Information (CIHI) developed the Home Care Reporting System (HCRS) as a means of integrating RAI-HC data to generate information using a common language across organizations, jurisdictions and care settings. The purpose is to collect and process information on publicly funded home care services in order to support jurisdictions in their analysis and decision making by providing data on:

- Access to home care services.
- Health and functional status measures.
- Clinical outcomes and waiting times.
- Quality of care.
- Informal support.
- Service utilization by setting and provider type.

The HCRS captures standardized client-specific clinical, demographic, administrative and resource utilization information.

The Yukon Program submits its home care data to CIHI annually and has done so since 2006. The data analysis produced through CIHI is used for program planning; for example, training in chronic obstructive pulmonary disease (COPD) management was initiated when data showed a high percentage of clients with COPD. Another example is when the triggered Clinical Assessment Protocols (CAPS) are used to identify clients appropriate for the Fall Prevention program.

USE OF SYSTEM EFFICIENCY TECHNOLOGY

The home care record in the Yukon is electronic and increasing point of care capture is used. The home care record is not linked to the broader electronic health record, and electronic linkages between members of the health care team, beyond the home care team, are not yet in place.

Electronic communication does not yet exist between home care and physicians, or home care and hospitals. However, technology is applied between frontline staff to communicate referral and clinical information. An integrated health care record that follows the home care client into residential care, or is a shared record during respite, stays in the residential care facility.

Technology is also used to share information for submission of indicator data and for financial data exchange. Human resource data is computerized using PeopleSoft. An electronic scheduling system is used as of 2011-12.

USE OF TECHNOLOGY FOR CLIENT CARE

Telehealth is widely used in home care, for individuals on all programs – palliative, acute, chronic and rehabilitation. Fourteen communities have telehealth capability for medical care, continuing care, alcohol and drug counselling, and social and mental health services, as well as follow-up care via video conferencing. As the caseload of patients in remote areas requiring more home care has increased throughout the northern jurisdictions, so has access to electronic technology that facilities more locally-based patient care.

In Yukon, a project has been under way since 2009 to equip all home care staff with tablet computers that allow home care providers to quickly download patient information before or during the home visit, as well as immediately upload information at the close of a home care visit. Home care staff are currently provided with cell phones and laptop/notebook computers.

Technology – Transforming Health

Technological advancements have the potential to fundamentally change our health care approach to support a more efficient and person-centred one regardless of the care setting.

Today's innovations enable the integration of monitoring and therapeutic systems, provide educational content, facilitate communication and data flow between members of the health care team and support systems management and quality improvement.

5. Health Human Resources

CLINICIANS PRACTICING IN HOME & COMMUNITY CARE

Number of Staff – Full Time Equivalents

Home care services, including nursing, social work, therapy and home support, in the Yukon are exclusively provided by the public sector. The staff is unionized.

	2006-2007	2010
Case Manager	All health care professionals also act as case managers.	
Home Support Worker / Personal Care Attendant	13	14
Occupational Therapist	2.4	2.4
Physiotherapist	2	2
Registered Nurse	12	10
Registered Practical Nurse / Licensed Practical Nurse, Nursing Assistant		3
Social Worker	2.6	3.6
Home Support and Nursing Supervisor	1	2
Manager	1	1
Community Liaison Coordinator	1	2
Admin/Program Assistant	1	2

HEALTH CARE PROFESSIONALS

A human resource plan has been developed in order to strategically plan for the right number and mix of health care professionals needed to provide Yukon residents with health care, now and in the long term. Strategies include:

- Physician incentives to practice in Yukon – recent graduates, office start-up, accommodation for new physicians.
- Nurse Mentorship – intended to support both recruitment and retention.
- Medical residents – funding support for additional medical residents to train in Yukon, funds to support resident preceptors.
- Continuing nurse education funding.
- Ongoing Yukon Health Human Resource Strategy development.

UNREGULATED STAFF

Home support workers are the category of unregulated staff with the Yukon Home Care Program. They provide assistance to people needing help with activities of daily living, including personal care, homemaking and respite services.

The home care program defines the scope of practice for home support workers and requires that all staff have a certificate of completion from the Yukon College. The health care assistant (HCA) program is designed to provide students with opportunities to develop the knowledge, skills and attitudes necessary to function effectively as front-line caregivers and respected members of the health care team, in community and facility settings. Under the direction and supervision of a health professional, graduates provide person-centred care aimed at promoting and maintaining the physical, emotional, cognitive, social and spiritual well-being of clients/residents. Core courses are shared with other programs in the college to increase options for students who wish to further their education. This multidisciplinary approach promotes readiness for employment in the community by developing the student's ability to function effectively within inter-professional teams. There is no registry for unregulated staff in the Yukon.

INTER-PROFESSIONAL COLLABORATION

Inter-professional collaboration is a model designed as a way for the health care practitioners to work more closely as a team to address an individual's health needs with the sole objective of ensuring that the patient gets the best care approach resulting in improved health outcomes. The potential benefit of a collaborative care model includes: improved care quality, better access, increased continuity of care and best use of resources.

The collaborative care model is used in the Yukon on a limited basis. Specifically, nearly all physicians in most Yukon communities are using the model to manage diabetes. The feedback from clients and caregivers indicates that this model has worked well for managing this chronic disease, and has the potential of being used to manage other chronic diseases such as: congestive heart failure, chronic kidney disease, hypertension, chronic vascular disease, chronic obstructive pulmonary disease and depression.

Applied to the primary care setting, the model can help avoid inappropriate emergency room visits, improve patient access, and reduce physician workloads. Promoting inter-professional collaboration and encouraging improved communication and collaboration are priorities of the Yukon Department of Health and Social Services. The Yukon Home Care Program consists of a multi-disciplinary care team that includes all registered staff and home support workers. Collaboration, with service providers within the Department of Health and Social Services, hospitals, and the community, is a key component of the Home Care Mission and one of the core values.

FAMILY CAREGIVER

The family caregiver is recognized in home care policy. Caregiver support is provided through family involvement in the client care plan. Respite service is provided so that unpaid care providers can have time away from their caregiving responsibilities. Services are based on clients' assessed needs and subject to program guidelines.

Successful Integrated Care Models

Integrated care is a process or strategy for improving the coordination of health services to better meet the needs of patients and providers. Successful integrated models include:

- Patient and family engagement
- Effective leadership
- Targeting a defined population
- Collaborative, multidisciplinary teams
- Shared accountability
- Alignment of financial incentives
- Evidence-based practice guidelines
- Enabling information technology

(Canadian Home Care Association (2012), Integrated Models of Care, Synthesis Report, http://www.cdnhomecare.ca/media.php?mid=2965)

6. Territorial Initiatives

In 2008 and 2009 the Yukon government undertook an extensive review of its health care services. As a result of escalating health care costs, the Yukon Health Care Review was initiated to identify strategies to address this situation. A key recommendation was to expand services in continuing care and home care, to keep people in their communities.

PRIMARY HEALTH CARE

There is in an initiative to provide home care nursing services to marginalized individuals in a community based 'street level' clinic.

CHRONIC DISEASE MANAGEMENT

Home care provides staff education on Chronic Obstructive Pulmonary Disease (COPD), as well as collaborating with the territorial COPD rehabilitation program, which runs regular COPD management programs. COPD is the 4th leading cause of death in Canada. [Canadian Thoracic Society, Feb, 2010] in addition to being the leading cause of hospital admissions with a higher hospital readmission rate than other chronic illnesses. [CIHI, 2008]

SENIORS AND AGING

There has been a focus on a 'Fall Prevention' program, throughout the territory, for a number of years. As a consequence, a reference manual/guide was developed in conjunction with local First Nations targeting community level service providers and families. The home care program continues to provide fall prevention programs, in Whitehorse, to medium to high risk seniors with identified fall risk.

There are established partnerships with seniors and community health centres. The Care and Community Branch (which includes home care) funds contribution agreements with seniors' organizations in Haines Junction and Watson Lake to provide social support and some home maintenance, such as shoveling. The contribution agreement with Hospice Yukon Society is also managed through the Care and Community Branch of Continuing Care.

END-OF-LIFE CARE

The Yukon Home Care Program provides palliative care services in Whitehorse. Integration with the territorial palliative care team, who provide consultation and education, is underway. This integration will assist in providing more efficient and effective services for clients receiving palliative care in the home, across the territory.

7. Challenges

The population of the Yukon is small relative to its geographic size. While the majority of Yukoners live in Whitehorse, approximately 25 percent of the population lives in small, remote communities.

Issues affecting the sustainability of the health care system include:

- An aging population – the 50 plus age group is forecasted to represent 35.4 percent of the population by 2018.
- An increasing incidence of chronic diseases.
- Advances in technologies and pharmaceuticals.
- Human resource capacity challenges.
- Rising costs of service delivery.
- More expensive medications.

As a result of the systemic challenges, the Home Care Program in the Yukon is facing an increase in the number and acuity of clients. In order to address these challenges, service providers in the government and community are committed to working collaboratively to realize effectiveness and efficiencies of service.

8. Opportunities

Over the next five years, while continuing to provide high quality client care, the Home Care Program will undertake to better address the needs of caregivers, and enhance dementia care and services for marginalized clients.

By 2018, the Yukon Home Care Program will have an essential and unique role within an integrated health care system. The Program staff will provide a range of services that are easily accessible and enhance quality of life. The staff will create revolutionary paths, challenging the norms in order to provide best practice and innovative solutions that respond to the needs of our clients

ACRONYMS / ABBREVIATIONS

Assistant Deputy Minister (ADM).
AICBR - Arctic Institute for Community-Based Research: For Northern Health and Well-Being
ALC - Alternate Level of Care
CAP - Clinical Assessment Protocol
CIHI - Canadian Institute for Health Information
COPD - Chronic obstructive pulmonary disease
EHR - Electronic Health Record
HCA – Health Care Assistant
HCRS - Home Care Reporting System
ISO - International Standards Association.
KDFN - Kwanlin Dun First Nation
NIHB - Non-Insured Health Benefits
RAI-HC - Resident Assessment Instrument - Home Care Assessment

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The chapter has been compiled from sources listed below, interviews with key informants and feedback to an electronic survey. Information replicated from provincial materials has been done so with the knowledge and permission of the key informant.

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FIRST NATIONS AND INUIT HEALTH BRANCH

HOME CARE FOR **FIRST NATIONS AND INUIT**

Home care in the First Nations Inuit Health Branch is consistent with the Canadian Home Care Association definition.

> Home care is an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the family caregiver.

The distinction is that the services are described as 'basic' services for people of all ages.

FIRST NATIONS AND INUIT HEALTH BRANCH

BY THE NUMBERS...

50,480[1] INUIT POPULATION (2011)	**868,206**[2] Registered Indian population (On Reserve and On Crown Land, and Off Reserve - 2011)
NUMBER OF COMMUNITIES **633 First Nations reserves** **53 Inuit communities**	75.5 yrs (female) · 70 yrs (male) FIRST NATION LIFE EXPECTANCY (2000)

[1]Statistics Canada / [2]Aboriginal Affairs and Northern Development Canada

1. Governance & Organization

HEALTH CARE SYSTEM STRUCTURE

The **First Nations and Inuit Health Branch (FNIHB) of Health Canada** supports the delivery of public health and health promotion services on-reserve and in Inuit communities. It provides drug, dental and ancillary health services to First Nations and Inuit and primary care services on-reserve in remote and isolated areas, where there are no provincial services readily available.

FNIHB funds the **First Nations and Inuit Home and Community Care (FNIHCC)** program to provide basic home and community-based health related services to all First Nations people living on-reserve and in designated communities and to Inuit living in Inuit communities. There are 633 First Nations reserves/communities and 53 Inuit communities eligible to receive FNIHCC funding. These services complement the social home care services (e.g. homemaking) provided by **Aboriginal Affairs and Northern Development Canada (AANDC).** Within the FNIHCC program, the roles and responsibilities of the Federal Government include:

- Funding resources and negotiating appropriate financial arrangements with First Nations and Inuit to facilitate the implementation and maintenance of this program.
- Providing various technical, professional and capacity building supports which are negotiated and mutually agreed to by First Nations and Inuit.
- Working in partnership with First Nations and Inuit on the development and maintenance of appropriate First Nations and Inuit home and community care standards and practice.

The roles and responsibilities of First Nations and Inuit within the program are to:

- Plan and deliver home and community care services.
- Monitor and maintain the quality of services.
- Ensure training requirements are met.
- Maintain performance accountability to community members and the federal government.
- Maintain liability and malpractice insurance, delegation of responsibility.
- Negotiate with the federal government or other governments or service providers for various technical and professional supports that cannot be provided through the internal resources of the community.
- Work in partnership with the federal government on the development and maintenance of appropriate First Nations and Inuit home and community care standards of care and practice.

HEALTH CARE & HOME CARE LEGISLATION

The federal role in First Nations health is based on policy rather than legislation. The **Indian Health Policy** (1979) recognized that improved health must be built on community development, the traditional relationship of Indian people to the federal government and actively encouraging First Nations participation in the First Nations health system. The policy also recognizes the interdependency of a health system that encompasses roles at the federal, provincial and territorial government levels as well as that of the private secor and the communities themselves.

Traditional First Nations healing treats the whole person, body, mind, and spirit. According to traditional teachings, health can most simply be defined as "living your life in balance according to the natural laws of the Creator." First Nations believe that there are four aspects of man – Emotional, Mental (intellectual), Spiritual and Physical and they must be maintained in balance to be healthy. In First Nations belief, disease is a manifestation of a person's imbalance between these four aspects.

Inuit have a holistic view of health care, where mind, body, and spirit are intrinsically linked and a weakness in one will surface as a weakness in another aspect. Inuit medical knowledge does not only amount to mastering remedies and the necessary techniques to care for the sick body. Illness teaches us how to maintain life by developing a resistant body and a strong spirit, as the mind and body are complementary and are related to their environment, whether it be social, physical, or animal.

EVOLUTIONARY MILESTONES

1979

Indian Health Policy developed – provides guidance to the FNIHCC program.

1999

FNIHB received Cabinet approval for the program.

2003

97 percent of First Nation communities and 100 percent of Inuit communities in full service delivery.

2005

Aboriginal Transition Health Fund, a $200 million initiative, launched to support provincial projects on integration and improved health.

2008

Continuing care research recommended AANDC's (formerly INAC) in-home care services be integrated with Health Canada's Home and Community Care program.

2010

Funding for nurses training provided in Budget 2010 ($25M over 5 years).

2011

B.C. Tripartite Framework, First Nations Health Agreement, signed to support better health for B.C. First Nations.

2012

Quality Resource kit completed and disseminated.

Newly revised FNIHCC Program Standards completed and disseminated.

MANDATE, MISSION, PRINCIPLES & PRIORITIES

MANDATE

The First Nations and Inuit home and community care program provides a continuum of basic services that are comprehensive, culturally sensitive, accessible, effective and equitable to that of other Canadian citizens, and respond to the unique health and social needs of First Nations and Inuit.

PRINCIPLES OF THE FNIHCC PROGRAM

The guiding principles for the development and implementation of the First Nations and Inuit Home and Community Care Program are based on universally accepted home care precepts, with adaptations for First Nation and Inuit cultural values. They are:

- Respect for traditional and contemporary First Nation and Inuit approaches to healing and wellness.
- Planning that is community-based and community-paced.
- Programs available to individuals of all ages with an assessed need.
- Services are at least equitable, effective and equivalent to those received by the general population and supported by quality assurance measures.
- Programs are supportive to family and community involvement.

The **current home care priorities** within FNIHCC include:

- Ensuring the long-term sustainability of the FNIHCC program.
- Improving the quality of FNIHCC services through ongoing nurses training and quality improvement initiatives.
- Working with AANDC, First Nations and Inuit to improve access to a full continuum of continuing care services.
- Developing a 10-year Strategic Plan for the FNIHCC program, together with First Nations and Inuit.
- Improving strategies to promote health and prevent and manage chronic diseases.

HOME CARE PROGRAM OBJECTIVES

The objectives of the FNIHCC Program are:

- To build the capacity within First Nations and Inuit to develop and deliver comprehensive, culturally sensitive, accessible and effective home care services at a pace acceptable to the community.
- To assist First Nations and Inuit living with chronic and acute illness in maintaining optimum health, well-being and independence in their homes and communities.
- To facilitate the effective use of home care resources through a structured, culturally defined and sensitive assessment process to determine service needs of clients and the development of a care plan.
- To ensure that all clients with an assessed need for home care services have access to a comprehensive continuum of services within the community, where possible.
- To assist clients and their families in participating in the development and implementation of the client's care plan to the fullest extent, and to utilize available community support services where available and appropriate in the care of clients.
- To build the capacity within First Nations and Inuit to deliver home care services through training, evolving technology, information systems to monitor care and services, and to develop measurable objectives and indicators.

HEALTH SYSTEM PRIORITIES

As the provider of primary health care to First Nations and Inuit, the FNIHB of Health Canada continues to work with the provinces, territories, Aboriginal Health Organizations and other federal departments to help improve the overall health outcomes of First Nations and Inuit and help ensure the availability of and access to quality health care. Special focus over the next three years to strengthen First Nations and Inuit Health programming includes:

- Strengthening primary care and public health service delivery models, including implementing interdisciplinary teams to ensure access to a continuum of services.
- Advancing collaborative efforts with provinces/territories and First Nations and Inuit to ensure quality service delivery, and implement the British Columbia Tripartite Framework Agreement on First Nation Health Governance.
- Improving quality and availability of comprehensive mental health and addictions services, including defining service levels, standards and indicators.
- Emphasizing collaborative/horizontal work with AANDC and other key partners, and focus on strengthening data and information.
- Supporting effective delivery of Non-Insured Health Benefits to eligible First Nations and Inuit.

2. Access, Funding & Service Delivery

ACCESS TO HOME CARE SERVICES

The FNIHCC program is accessible to 98 percent of First Nations communities and 100 percent of Inuit communities. Any First Nations person living on a First Nation reserve and Inuit living in an Inuit community can request FNIHCC services through the local program. Referrals result in a home visit, a detailed client assessment to determine the care needs, development of a care plan and service delivery by the most appropriate program or agency to care for those needs.

Most FNIHCC programs provide basic health services from Monday to Friday, 9:00 a.m. to 5:00 p.m. Access to home care is generally consistent between rural and urban settings. Information on any waiting times for service is not gathered.

REFERRAL SOURCES

The request for service may come to the Home Care Nurse Coordinator from any number of sources, such as the person requesting the service, a family member, a community member, the doctor, community health or social service agencies or outside agencies. Referral source data is not mandatory in the FNIHCC program and it is, therefore, not available at a national level.

ELIGIBILITY, COVERAGE & UTILIZATION

ELIGIBILITY

- First Nations and Inuit of any age; and,
- who live in an Inuit community, First Nations reserve or First Nations Community North of 60; and,
- who have undergone a formal assessment of their continuing care service needs and have been assessed to require one or more of the essential services; and,
- who have access to services which can be provided with reasonable safety to the client and caregiver, within established standards, policies and regulations for service practice.

AGE

All ages.

INCOME TESTING AND DIRECT FEES

No income testing or direct fees.

SUPPLIES, EQUIPMENT AND MEDICATION

Provided free of charge.

LIMITS /GUIDELINES TO SERVICE PROVISION

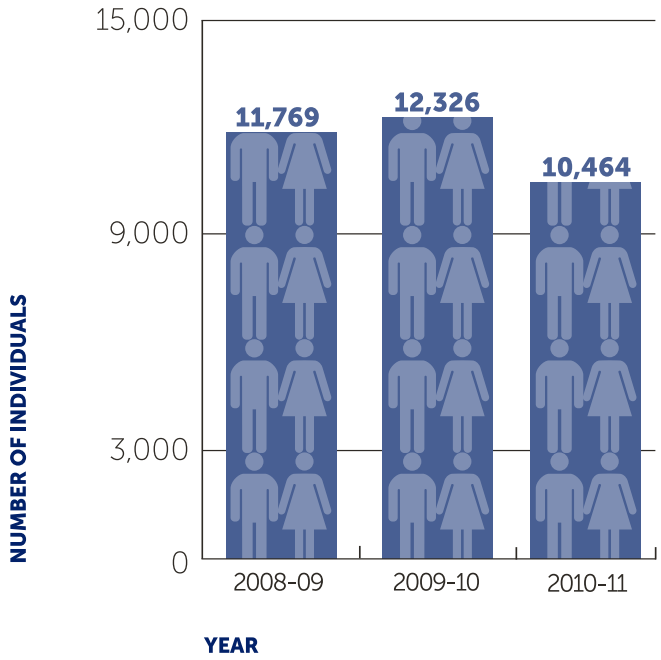
The FNIHCC program is limited in its home care service provision by the fact that it currently can only be available Monday through Friday.

DETERMINING CLIENT NEED - ASSESSMENT TOOLS

A key element of the FNIHCC program is a **structured client assessment process** (e.g. on-going reassessment to determine client needs, family supports and service allocation). A standardized assessment tool is a requirement for all FNIHCC funded programs and most programs have adopted the standardized assessment tool that is used by their province/territory. Additionally there is a Home Care Assessment tool provided by the FNIHCC national office which is used by some communities.

An innovative pilot project is currently underway in Alberta to gauge the feasibility of implementing the Home Care Reporting System (HCRS) in First Nations communities, with the intention of replacing the current e-SDRT application with the interRAI-MDS-Home Care Assessment among First Nation users, in the future.

Admissions to Home Care Program



Electronic Service Delivery Reporting Tool, Health Canada, 2012.

SETTINGS OF CARE

FNIHCC home care services are provided in the following settings within Inuit communities and on First Nations reserves:

- Community Health Centres
- Nursing Stations
- Home

INTEGRATED MODELS OF CARE

A number of integration initiatives have been launched with the support and funding of the Aboriginal Health Transition Fund (AHTF), a $200 million fund aimed at addressing the gap in health status between Aboriginal and non-Aboriginal Canadians by improving access to existing health services.

The AHTF supports:

- First Nations and Inuit communities in identifying and implementing projects that promote the integration of federally funded health services within First Nation and Inuit communities, with those funded by provincial and territorial governments.
- Provinces and territories in adapting their health services to better meet the needs of Aboriginal Canadians, including First Nations living on and off reserve, Inuit and Métis.
- Aboriginal peoples participation in the design, delivery and evaluation of health programs and services.

Since 2005, the AHTF has funded 311 projects across every province and territory. Projects piloted different approaches to integrate and adapt health services in areas such as mental health, child and youth health, palliative care, e-health, chronic disease management, substance abuse, hospital discharge planning, and health governance. One example involves working with the Nova Scotia Department of Health as it strives to integrate its home care program with the federally funded home care services offered on First Nations reserves. Additionally, in many communities, integration of social home-based services has been achieved, as well as linkages with primary care and acute care services.

FUNDING

Federal Expenditures on FNIHCC

YEAR	Annual FNIHCC Funding ($' 000,000)	Percent of Total FNIHB Health Expenditures	Total FNIHB Funding ($' 000,000)	Per capita Expenditure on Home Care
2011-12	$114.0	4%	$2,850.0	$209.00
2010-11	$110.0	4%	$2,750.0	$202.00
2009-10	$104.0	4%	$2,600.0	$191.00
2008-09	$101.0	4%	$2,525.0	$186.00

Reflects all moneys provided to fund the FNIHCC program

Based on 493,692 First Nation on-reserve population and 50,480 Inuit living in Inuit settlements (2010 Indian Registry projection)

Health Canada. First Nations and Inuit Home and Community Care Program, 2011

PROFILE OF CLIENTS RECEIVING HOME CARE

DIAGNOSIS

The most common diagnoses for individuals receiving home care in 2010-11;

- Diabetes (20%)
- Cardiovascular (10%)
- Musculoskeletal (14%)

CLIENT GROUPING

FNIHCC gathers utilization data according to the client grouping definitions (acute care substitution, maintenance, end-of-life care (palliative), rehabilitation, long-term supportive care) established by a federal / provincial / territorial working group on continuing care in 2001.

Home Care Client Grouping

- **Maintenance –** maintain independence and, where possible, to enhance client's performance of ADLs and IADLs.
- **Rehabilitation –** improve functional status and facilitate social integration and independence.
- **Long-Term Supportive Care –** prevent or delay institutionalization.
- **Acute Care Substitution –** prevent an acute facility admission or re-admission and/or reduce the length of stay in an acute care facility.
- **End-of-Life Care –** meet the needs of individuals whose health condition is not responsive to curative treatment and who are dying.

(Canadian Institute for Health Information. (2004). Development of National Indicators and Reports for Home Care—Phase 2 Final Project Report. Ottawa: Canadian Institute for Health Information.)

Percent of Service Volume by Client Grouping

	2008-09	2009-10	2010-11
Acute Care Substitution	6%	7%	6%
Maintenance	26%	26%	30%
End-of-Life Care	2%	1%	1%
Rehabilitation	2%	3%	3%
Long-Term Supportive Care	58%	57%	54%
Other categories	6%	6%	6%

Electronic Service Delivery Reporting Tool, Health Canada, 2012.

SERVICE DELIVERY

MODEL OF SERVICE DELIVERY

Home care services, including nursing and home support, are typically provided by staff hired directly by the local program. However, in some instances services may be contracted to service provider organizations.

The FNIHCC Program provides basic home and community care services that are comprehensive, culturally sensitive, accessible, effective and equitable to that of other Canadians and that respond to the unique health and social needs of First Nations and Inuit. The Program is a coordinated system of home and community based health related services which enables people with disabilities, chronic or acute illnesses and the elderly to receive the care they need in their home communities.

The home and community care program is comprised of essential service elements and may be expanded to include supportive service elements (such as palliative care and therapies) provided that the essential services are provided and contingent on the availability of resources and identified needs.

Most communities are not able to provide supportive service elements, due to the high assessed need for essential service elements (such as nursing and personal care).

In 2010/2011, 2.5 million hours of service were provided to more than 33,000 clients in over 633 First Nation and Inuit communities.

Aboriginal Affairs and Northern Development Canada (AANDC)'s Assisted Living Program is a residency-based program that provides funding to assist in non-medical, social support services to seniors, adults with chronic illness, and children and adults with disabilities (mental and physical) so that they can maintain functional independence and achieve greater self-reliance. The Assisted Living Program is available to all individuals residing on-reserve, or ordinarily resident on-reserve, who have been formally assessed by a health care professional (in a manner aligned with the relevant province or territory) as requiring services and who do not have the means to obtain such services themselves.

There are three major components to the program including in-home care, adult foster care and institutional care. The in-home care component of the program supports provision of homemaker and non-medical services (such as meal preparation, light housekeeping, and minor home maintenance); the institutional care component provides funding for non-medical support in an institutional setting; and, the adult foster care component supports supervision and care in a family setting.

RANGE OF HOME CARE SERVICES & PROGRAMS

Services Currently Funded by FNIHCC

Case Management	A managed care process that incorporates case management, referrals and service linkages to existing services provided both on and off reserve/ settlement. On-going reassessment and determination of client need and service allocation.
Nursing - RN, RPN, LPN	Includes direct service delivery as well as supervision and teaching of personnel providing personal care services.
Home Support Worker / Personal Care Attendant	Determined by the community needs assessment plan and that does not duplicate, but enhances existing AANDC adult care services. Home support services include light housekeeping, laundry and meal preparation. Personal care includes bathing, grooming and dressing.
In-home respite care	Includes support to families and other informal caregivers, with short-term relief from caring for dependent family members.

Ancillary support

Oxygen	Funded through the Non-Insured Health Benefits (NIHB) program.
Drugs	
Supplies (dressings, stoma, etc)	
Equipment (wheelchairs, walkers, etc)	

SERVICES CURRENTLY NOT FUNDED BY FNIHCC

The following services are not currently funded by FNIHCC but may be provided under existing authorities, based on community needs and priorities, the existing infrastructure and availability of resources:

- Physiotherapy
- Occupational Therapy
- Speech Therapy
- Nutrition Counseling
- Institutionalized Respite care (Funding is available for in-home respite only)
- Adult day care
- Meal programs
- Mental health home-based services for long-term psychiatric clients and clients experiencing mental or emotional illness; services might include traditional counseling and healing services
- Support services to maintain independent living, which may include assistance with special transportation needs, grocery shopping, accessing specialized services and interpretative services
- Home-based palliative care
- Social services directly related to continuing care issues, specialized health promotion, wellness and fitness.

Amount of Service (Units)

	2008-09	2009-10	2010-11
Nursing	271,216	235,442	217,832
Personal Care	409,869	422,968	421,858
Professional Therapies	27,941	30,788	29,009
Case Management	187,776	200,806	208,469
In-Home Respite	111,748	118,861	116,114
Home Support	1,639,965	1,675,230	1,549,938
Total	**2,648,515**	**2,684,095**	**2,543,220**

Electronic Service Delivery Reporting Tool, Health Canada, 2012.

FNIHCC hours of service may include a portion of the delivery of AANDC's Adult Care Program In-Home Services (e.g. home support or assisted living) if both the home care and adult care programs have been integrated at the community level.

Changes in hours of service may also be due to data quality, random fluctuations or issues having an impact on program delivery such as transportation, weather, the availability of health human resources (HHR), or extenuating circumstances that pull staff away from home care work (e.g., floods in Manitoba; fires in Alberta).

CLINICAL (SPECIALTY) SKILLS

With the focus on discharging patients from hospital as promptly as possible, there has been an increase in the complexity of care provided at home. The challenge in much of Canada can be in having a critical mass of patients who require certain levels of expertise and, as a result, special skills only being available in urban centres. However, with the advent of remote access to support in the community, there is an opportunity for more complex care to be provided in less populated areas.

Home care nurses are able to provide enterostomal therapy, although access to enterostomal therapists (ETs) can be very limited. Home intravenous (IV) therapy may be supported in some communities. The following clinical services **are not** typically provided in the home by home care staff in FNIHCC:

- Administration of chemotherapy, blood or blood products.
- Hemo and peritoneal dialysis.
- Regular tracheostomy tube replacement and ventilator care.

3. Quality & Accountability

HOME CARE INDICATORS

The home care indicators that are currently monitored at a national level include:

- Amount of service delivery
- Expenditures
- Home care admissions
- Diagnoses – on admission
- Number of staff

Indicators not tracked at the FNIHCC national level may be tracked at the community level.

QUALITY & ACCREDITATION

EXTERNAL ACCREDITATION

First Nations and Inuit communities that manage the home and community care program have the responsibility of ensuring quality care services are delivered safely. These communities must maintain performance accountability to their community members and the federal government. While the FNIHCC program does not require that programs achieve accreditation, FNIHB supports the process for those communities choosing to do so.

As of January 2012, 58 First Nations and Inuit community health delivery organizations are currently accredited through Accreditation Canada with more community health delivery organizations engaging in the accreditation process each year.

High-quality care is evidence-based (appropriate), focused on the patient (or patient-centered), safe and timely (CIHI).

Quality Resource Kit

The FNIHCC Quality Resource Kit (QRK) is a practical, relevant, and useful resource that improves the quality of care provided to home and community care clients and is comprised of 5 handbooks.

1. The concept of Quality and Quality Improvement
2. Theory and processes in Quality Improvement including the PDSA (Plan-Do-Study-Act) Cycle
3. Concepts and practices of Risk Management
4. References and templates for Quality Improvement and Risk Management
5. Definitions for the terminology used throughout the QRK

(First Nations and Inuit Health, http://www.hc-sc.gc.ca)

QUALITY COUNCIL

FNIHCC has established a Quality Network with representation from regional Home and Community Care (HCC) quality champions and includes First Nations and Inuit partners.

CLIENT / PATIENT ADVOCATE

As a community-based home care program, it is unknown whether communities have or have not identified a client advocate role for their community members.

SYSTEM APPROACHES TO QUALITY IMPROVEMENT

The Quality Resource Kit (QRK) has been developed, complete with Quality Improvement theory, tools and resources. The QRK is designed to be a practical, relevant and useful resource for all community-based health care workers. Not only are FNIHCC programs encouraged to use the QRK to develop Quality Improvement (QI) initiatives that will lead to better client health outcomes , better system performance and better professional development, but the QRK is also meant to support communities and health care organizations in making quality improvement and risk management processes part of the way they do business.

SAFETY

FNIHCC has newly revised program standards that reflect the current client safety and risk management practices to ensure the safe delivery of home care services. Quality and safety are inextricably linked and each of the HCC program standards have been aligned with all the activities that occur within the delivery of community-based HCC care and services

HOME CARE RESEARCH

FNIHCC is not directly involved in scientific research activities, however, the program may partner with academic institutions to carry out relevant research. The program conducts environmental scans for specific illnesses and health-related topics, such as dementia and chronic disease management, as well as collects information to track disease trends of First Nations people.

4. Information Technology

ELECTRONIC HEALTH RECORD (EHR)

FNIHCC includes a system of record keeping and data collection to carry out program monitoring, ongoing planning, reporting and evaluation activities. The majority of the health care record and clinical documentation is manual. A few communities have already adopted some EMR capacity, including EHR capacity for home care clients.

HEALTH DATA & THE HOME CARE REPORTING SYSTEM

To meet the need for consistent, comparable home care information, the Canadian Institute for Health Information (CIHI) developed the Home Care Reporting System (HCRS). The purpose is to collect and process information on publicly funded home care services in order to support jurisdictions in their analysis and decision making by providing data on:

- Access to home care services.
- Health and functional status measures.
- Clinical outcomes and wait times.
- Quality of care.
- Informal support.
- Service utilization by setting and provider type.

The HCRS captures standardized client-specific clinical, demographic, administrative and resource utilization information. A key component of the HCRS is the Resident Assessment Instrument—Home Care (RAI-HC).

First Nations Inuit Health (FNIH), Alberta Region has explored the feasibility of implementing the Home Care Reporting System (HCRS) in First Nations communities, with the intention of replacing the current e-SDRT application in the future. Based on the supportive results, FNIH has initiated a pilot HCRS implementation in three Alberta communities. The HCRS Pilot Project has been designed over a two year timeframe (April 1, 2010 –Sept 30, 2012), comprised of a full year pre-implementation strategy for planning and a full year implementation strategy for deployment. The pilot HCRS project will initiate the execution of pan-Canadian best practices within FNIH home care communities, which most provincial health care systems have already realized. This project further supports equitable and modernized health care service delivery, a strategic focal point of Health Canada.

Other FNIHCC data sources include:

- e-SDRT, which is an Excel-based tool that allows FNIHCC personnel to provide information on a range of activities, such as hours and numbers of visits and clients.
- e-HRTT, which is an Excel-based tool that allows FNIHCC personnel to provide information on the program's human resources, including number of staff, length of employment, and education.

High-Tech Home Care

Expanded technology-enabled home care offers a promising pathway to bend the cost curve for ever-growing health care expenditures.

Independent of the economic benefit, the moral value of enabling older members of society to live in grace and dignity in their own homes, with a ripple effect on their caregivers, is arguably the most important – if unquantifiable – benefit of home care. [Kayyali et al, 2011].

(Canadian Home Care Association, A Vision for Technology in Home Care, 2013)

USE OF SYSTEM EFFICIENCY TECHNOLOGY

Electronic communication does not yet exist between home care and physicians, home care and hospitals, or between home care staff. However, technology is used to submit indicator data. Home care staff are not specifically funded for equipment and as such each community determines the technology needs of their staff. Use of scheduling software systems and electronic GPS / mapping systems are not widely used within FNIHCC.

USE OF TECHNOLOGY FOR CLIENT CARE

Introduction of tele-health into home care has been initiated in some communities. For example, as a strategy to increase the capacity to serve its community the Keewaytinook Okimakanak Home and Community Care (KOHCC) Program has leveraged technology.

Since 2000, investments in information and communication technology infrastructure and distributed health services policy, human resources and partnership development have enabled what is believed to be Canada's largest and busiest First Nations telemedicine service – Keewaytinook Okimakanak Telemedicine (KOTM). KOTM, through its partnership with Ontario Telemedicine Network (OTN), facilitates access to specialists and health care services through video consultations. Beginning in 2003, KOHCC used telehomecare as a means of video and audio linkage to conduct team meetings, provide training and education and strengthen the linkage with staff. To date, KOTM has facilitated more than 10,000 interactions. Today, the Keewaytinook Okimakanak Home and Community Care Services have successfully integrated the use of information and communication technologies and distributed learning and clinical care methodologies into their existing programming. These material and service innovations have extended KOHCC's capacity to meet the community health needs of its home care clients, all of whom live in geographically isolated communities with uneven access to health service providers and support systems.

5. Health Human Resources

CLINICIANS PRACTICING IN HOME CARE

The total staffing complement serving First Nations and Inuit across Canada is approximately 1,623. Staff are employed directly by the communities who determine the mix of providers, within the program guidelines, required to meet their needs.

Two thousand three hundred and fifty-seven full-time equivalents (FTE) were allocated in 2010 to provide FNIHCC services across Canada. However, with 350 FTE vacancies, 2,007 FTEs were employed during this time. The number of vacancies is attributed to workload and availability of staff with the requisite scope of practice.

In 2010, the majority of FNIHCC staff were involved in providing personal care (39 percent) followed by home management support (22 percent). Registered nurses (RNs) and licensed practical nurses (LPNs) comprised 16 percent and 7 percent of FTEs, respectively. The remaining FTEs were in program support (9 percent), administration and clerical work (5 percent), or worked as allied professionals (2 percent).

Health Care Professionals
Number of Staff (Full Time Equivalents)

	2008-09	2009-10	2010-11
Registered Practical Nurse	151.87	318.09	352.48
Licensed Practical Nurse	41.67	138.41	164.1
Allied Professionals	31.87	32.05	35.51

Health Canada Human Resource Tracking Tool, 2011

Unregulated Staff
Number of Staff (Full Time Equivalents)

	2008-09	2009-10	2010-11
Personal Care Provider	402.55	792.4	861.22
Home Management Support	153.52	433.3	432.9
Program Support	75.83	185.78	208.93
Admin/Clerical Support	36.79	107.75	122.25

Health Canada Human Resource Tracking Tool, 2011

There is no registry for unregulated staff within FNIHCC, however, the eHRTT tracks information on staff certification, length of employment, number of staff, terminations and resignations.

EDUCATION & TRAINING

HEALTH CARE PROFESSIONALS

Home and community care (HCC) nursing services are critical for care, treatment and support, secondary and tertiary prevention of diabetes; and an important part of FNIHB's response to chronic disease management. To ensure the highest quality care possible, home and community care nurses require expanded training in clinical practice guidelines (CPG) and chronic disease management strategies to provide the increasingly complex care that is being delivered to diabetes clients in their homes and communities. The First Nations and Inuit Home and Community Care (FNIHCC) program data indicate that approximately 80 percent of the 25,000 clients have one or more chronic illnesses, and that diabetes is the primary reason for HCC services. Ongoing funding was provided to the FNIHCC program for nurses training in 2010.

UNREGULATED STAFF

The educational requirements and scope of practice is determined by each community that employs the staff and is generally aligned with the requirements within the province / territory. Staff are provided with continuing education as an expectation of the FNIHCC standards.

INTER-PROFESSIONAL COLLABORATION

FNIHCC promotes linkages with off-reserve services, such as hospitals, regional health authorities, and care providers (e.g. physicians, rehabilitation specialists and Long-Term Care facilities) as well as respite and therapeutic services. This is particularly important as, to a certain degree, some services must be accessed off-reserve. The program has linkages with community-based services such as health prevention and promotion, mental health and addiction programs and office of nursing services. Partnerships with provincial health authorities are essential to ensure the client care is continuous and effective post discharge.

FAMILY CAREGIVER

Home care policies acknowledge the important contribution of the family caregiver. Client assessments consider not only the needs of the client, but those of the caregiver, be it family or friend, and respite services can be provided based upon assessed need.

Who are Family Caregivers?

Family caregivers provide care and assistance for spouses, children, parents and other extended family members and friends who are in need of support because of age, disabling medical conditions, chronic injury, long-term illness or disability. A family caregiver's effort, understanding and compassion enable care recipients to live with dignity and to participate more fully in society.

- **5 million** is the estimated number of caregivers in Canada.
- **80 %** of care needed by individuals with a long-term condition is provided by family caregivers.
- **60%** of caregivers provide care for more than three years.

(Canadian Caregiver Coalition, 2008)

6. Initiatives

At the national level, FNIHCC is currently involved in a number of initiatives.

STRATEGIC PLANNING

The national program staff, along with FNIHB regions, the Assembly of First Nations, and Inuit Tamiriit Kanatami are developing a 10-year Strategic Plan for the FNIHCC program.

QUALITY IMPROVEMENT

The Quality Resource and Education Kit is currently being implemented through regional specific implementation plans. Quality champions have been identified and are working with communities to develop quality improvement initiatives. The FNIHCC program standards have been reviewed and revised and will be distributed to all regional coordinators and communities. The FNIHCC program handbook will be reviewed and revised to reflect current realities within First Nations and Inuit home care programs.

INTEGRATION & COLLABORATION

FNIHCC staff are involved in inter- and intra-departmental working groups on many health issues, including a system approach to chronic disease prevention and management and rural and remote health service delivery. The FNIHCC is a community-based and community-paced program serving clients closest to their home environment. At the community level, home care may or may not be involved in these issues, depending on the community.

CHRONIC DISEASE PREVENTION / MANAGEMENT

FNIHCC staff are working collaboratively to promote effective evidence-based approaches in the management of chronic diseases and prevention of complications.

7. Challenges

The key challenges for the FNIHCC program include:

- Recruiting and retaining qualified home care nurses and personal care workers.
- Meeting the needs of a population that is growing and aging.
- First Nations and Inuit experience more chronic illness and disability than the general Canadian population, often including higher rates of diabetes, high blood pressure, arthritis/rheumatism and lower life expectancy.
- Providing palliative care as it is not currently funded by the program. Palliative care is considered a supportive element and communities may provide this service if they have the capacity and resources or choose to access provincial resources to support clients' needs. Program officials are working with AANDC to identify options to extend the continuum of care which would build upon existing services and provide increased access to palliative and end-of-life care.

8. Opportunities

The Home and Community Care (HCC) program plays a vital role in improving First Nations and Inuit health and helps to prevent or delay health deterioration and complications. While the care needs of First Nations and Inuit are similar to the general population, Aboriginal peoples experience much higher levels of disease and disability in comparison to the rest of the Canadian population. For instance, chronic conditions are likely to occur two or three times more frequently among First Nations and Inuit than among the non-Aboriginal population.

Heart disease is slightly more prevalent overall among First Nation adults than in the general adult population (7.6 percent compared with 5.6 percent); prevalence of diabetes for First Nation people is three to five times that of the general population; and the rates of fetal alcohol syndrome/effects in some First Nations and Inuit communities are much higher than the national average. Many of these health problems start at a young age, and are chronic and more widespread than the non-Aboriginal population. The remote and isolated locations of many Aboriginal communities also have an impact on health status.

For First Nations and Inuit, particularly those living in remote and isolated communities, being able to access adequate health services can be very challenging because of geographic location, community size, the availability of health professionals, and the availability of services. For about 35 percent of First Nation communities, physician services are located more than 90 km away.

While First Nations and Inuit health has improved in some areas such as the prevention of infant deaths, gaps remain in the overall health status of First Nations and Inuit compared to other Canadians. Even for First Nations with higher levels of income, there remains a significant health gap between First Nations and other adults in Canada, with or without disabilities. Aboriginal health statistics and demographic trends indicate that the need for home care services will rapidly increase in the near future.

The First Nations and Inuit Home and Community Care (FNIHCC) Program's vision for their home care program is that it will provide basic home and community care services that are comprehensive, culturally sensitive, accessible, effective, equitable to that of other Canadians, and which respond to the unique health and social needs of First Nations and Inuit.

In order to realize their vision, the FNIHCC program is working with First Nations and Inuit partners to develop quality improvement strategies for safe delivery of home care services.

The FNIHCC program is also working collaboratively with its partners, including AANDC to develop approaches to improve access to a full range of continuing care services.

ACRONYMS / ABBREVIATIONS

AANDC - Aboriginal Affairs and Northern Development Canada
AHTF - Aboriginal Health Transition Fund
CPGs - Clinical practice guidelines
EHR - Electronic Health Record
ETs - Enterostomal therapists
FNIH - First Nations Inuit Health
FNIHB - First Nations and Inuit Health Branch
FNIHCC - First Nations and Inuit Home and Community Care
FTE - Full-time equivalents
HCC - Home and Community Care
HCRS - Home Care Reporting System
HHR - Health human resources
ISO - International Standards Association
KOHCC - Keewaytinook Okimakanak Home and Community Care
KOTM - Keewaytinook Okimakanak Telemedicine
LPN - Licensed Practical Nurses
NHIB - Non-Insured Health Benefits
OTN - Ontario Telemedicine Network
QI - Quality Improvement
QRK - Quality Resource Kit
RAI-HC- Resident Assessment Instrument—Home Care
RN – Registered Nurse

SOURCES

The chapter has been compiled from sources listed below, interviews with key informants and feedback to an electronic survey. Information replicated from provincial materials has been done so with the knowledge and permission of the key informant.

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Canadian Institute for Health Information (CIHI). Home Care Reporting System. http://www.cihi.ca/CIHI-ext-portal/internet/EN/document/types+of+care/community+care/home+care/services_hcrs

FNIHCC Planning Resource Kit, Book 5 "Program Service Delivery"

FNIHCC Program Description and Implementation Plan

Hazelwood, Tracey. (Key Informant) Senior Policy Analyst, First Nations and Inuit Home and Community Care Program, First Nations and Inuit Health Branch, tracey.hazelwood@hc-sc.gc.ca
Health Canada Web Site: www.hc-sc.gc.ca

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Harmonized Principles for Home Care

Guide policy and program development

Support consistency and equity across the country

Facilitate benchmarking and sharing of best practices

CLIENT AND FAMILY-CENTRED CARE

Clients and their family caregivers are at the centre of care provided in their home.

Dignity: Respect and value client and caregiver self-worth.

Holistic: Uphold all aspects of client and caregiver needs; psychosocial, physical and spiritual.

Independence: Foster autonomy and self-sufficiency.

Informed choice: Clear understanding of the facts, implications, and consequences of decisions and actions.

Positive partnership: Acknowledge unique strengths and engage client and family as partners in care.

Safety: Minimize and manage risk.

Self-Determination: Encourage, support and enable self-care.

ACCESSIBLE CARE

Canadians have equitable, appropriate, consistent access to home care, and are fully informed of the care and service options available to them.

Appropriate: Provide care that is needed and ensure the need for care.

Consistent: Reliable care among providers and across jurisdictions and geographies.

Comprehensible: Ensure understanding of services and options available.

Equitable: Create fair and unbiased access within and across jurisdictions and geographies.

ACCOUNTABLE CARE

Home care is accountable to clients and their caregivers, providers, and the health care system for the provision and ongoing improvement of quality care.

Transparency: Report on performance metrics and outcomes to inform the public on the quality of care.

Quality: Monitor performance indicators to support continuous improvement.

Value: Demonstrate value to clients and their caregivers, providers and the health system.

EVIDENCE-BASED CARE

Knowledge that is grounded in evidence is used as the foundation for effective and efficient care provision, resource allocation and innovation.

Evidence-Informed: Decision-making incorporates the best available evidence, expertise and experience.

Knowledge Transfer: Share ideas and information with clients, family caregivers, providers and planners.

Innovation: Support a culture of innovation and ingenuity.

Research: Promote awareness and application of research evidence to inform decisions.

INTEGRATED CARE

Home care facilitates the integration of care across the continuum of health care and with community and social services; care is complementary, coordinated and seamless with a focus on continuity for the client.

Continuity: Foster collaboration and communication to ensure seamless care transitions.

Coordination: Reduce disparities through care coordination.

Individualized: Customize care to the unique needs of clients and their families.

Prepared: Enable timely access to information and resources.

SUSTAINABLE CARE

Home care contributes to the sustainability of an integrated health system by increasing efficiencies and delivering cost effective care.

Health and Well-being: Focus on health promotion, disease prevention and management, and quality of life.

Needs Based Planning: Establish policies and programs on current and future needs and trends.

Optimum Effectiveness: Integrated resources planning across client populations and care settings.

VETERANS AFFAIRS CANADA

HOME CARE FOR **VETERANS**

The **Veterans Affairs Canada (VAC)** definition of home care is consistent with the Canadian Home Care Association definition.

> Home care is an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration and support for the family caregiver.

The VAC home care program, known as the **Veterans Independence Program (VIP)**, helps eligible Veterans, caregivers, survivors and certain civilians to remain healthy and independent in their own homes and communities

VETERANS AFFAIRS CANADA

BY THE NUMBERS...

107,600 **(average age 88)**
Estimated Veteran Population from Second World War (as of March 2012)

KOREAN WAR **10,600** **(average age 80)**
Estimated veteran population (as of March 2012)

CF Veterans *(Regular Forces and Primary Reserves)*
594,500 **(average age 55)**
Estimated Veteran Population (as of March 2012)

105,584
Individuals served by VIP program in 2011-12

Veterans Affairs Canada, retrieved from http://www.veterans.gc.ca/eng/department/press/gnstat

VETERANS INDEPENDENCE PROGRAM

1. Governance & Organization

HEALTH CARE SYSTEM STRUCTURE

The national home care program for veterans is funded through the Veterans Independence Program (VIP), and falls under the Service Delivery Branch of **Veterans Affairs Canada** (VAC).

The Service Delivery Branch Head Office in Charlottetown maintains functional and line authority over program operations within the health care, pensions and economic support areas, and is responsible for program delivery, development and management.

VAC's health care program provides veterans and other eligible clients with health care benefits, including treatment benefits and the VIP. The department also offers personalized health care services such as advice and information, needs assessment, assessment of health status, advocacy, and referrals. VIP does not replace other federal, provincial or municipal programs; rather, it complements these programs when necessary, to best meet the needs of clients.

HEALTH CARE & HOME CARE LEGISLATION

VIP - Veterans Health Care Regulations (1984) provides the authority for delivering services in the home.

Canadian Forces Members and Veterans Re-establishment and Compensation Act (2006) – referred to as the New Veterans Charter, the Act provides Canadian Forces Veterans, and their families, access to customized services and programs.

In the future, policy will continue to be reviewed and revised to accommodate the younger Veteran.

Home Care, an Essential Service

Home care was first available in Canada in the early 17th century, when nuns from religious orders arrived in Quebec to provide both direct care and disease prevention services [Community Health Nurses' Initiatives Group]. The first publicly funded home care program was established in 1970 and has continued to evolve and grow over time.

Today, home care is an essential element of a comprehensive health care system. Appropriately resourced home care programs play a critical role in managing wait lists, supporting health promotion and chronic disease management and enabling the frail elderly to live independently in their own homes.

Increasingly, home care has been recognized as a cost effective and care effective strategy within the broader health system.

(Canadian Home Care Association, http://www.cdnhomecare.ca/)

EVOLUTIONARY MILESTONES

1981
Veterans Independence Program (VIP) launched as a pilot project to provide home care and community-based institutional care to aging WWII Veterans.

1984
Development of the Veterans Health Care Regulations.
Extension of eligibility to War Veterans Allowance (WVA) recipients (low income) over age 75 and recipients of both a pension and WVA .
Addition of transportation service (social) for low income clients who were also in receipt of ambulatory or home care services.

1989
Eligibility extended to Canada Service Veterans.

1990
Authority for up to one year continuation, to the surviving spouse, those housekeeping and grounds maintenance services in place at the time of the Veteran's death.

2000
VAC approved the integration of the VIP payment processing into the Federal Health Claims Processing System (FHCPS).

2003
Lifetime VIP housekeeping and/or grounds maintenance benefits extended to qualified survivors or, if no survivors, qualified primary caregivers of Veterans who were receiving these services either at the time of death or admission to a health care facility, where the Veteran died within a year of admission.

2005
Approval for regulatory amendments to VIP housekeeping and/or grounds maintenance for primary caregivers (prior Treasury Board submissions extended eligibility to caregivers).

2006
New Veteran's Charter implemented to give Canadian Forces Veterans and their family access to customized services and programs and build on the services and benefits in place to help traditional war service Veterans live with dignity and independence.

2008
VIP housekeeping and grounds maintenance services extended to disabled or low income survivors of Veteran and civilian pensioners, and income-qualified Veterans and civilians who were not in receipt of VIP HK and/or GM at the time of death.

2010
VIP benefits extended to Allied Veterans who served during WWII or the Korean War, have resided in Canada for a minimum of 10 years post-war, and have a low income. Primary caregivers of Allied Veterans also acquired eligibility.

2012
The client payment mechanism for VIP Housekeeping and Grounds Maintenance services was changed from reimbursement to an upfront grant.

MANDATE, MISSION, PRINCIPLES & PRIORITIES

MANDATE

Veterans Affairs Canada achieves its mandate by providing services and benefits that respond to the needs of Veterans, other individuals, and their families.

VAC has three main roles:

1. **Provider of disability compensation and financial support** – VAC administers programs that recognize and compensate for the pain and suffering of service-related disabilities. The Department also provides financial support and assistance when career-ending or service related disabilities affect one's ability to earn income.

2. **Funder for health care and re-establishment services** - The Department works with other levels of government-federal, provincial and territorial-to provide access to health programs that enhance the well-being of Veterans and other eligible individuals, promote independence, and ensure continued care. The Department also provides support to Canadian Forces Veterans and their families to ease their transition to civilian life.

3. **Catalyst for national and international remembrance** - The Department keeps alive the achievements and sacrifices of those who served Canada in times of war, military conflict and peace, and promotes the importance of these efforts on Canadian life as we know it today.

PRINCIPLES OF HOME CARE (VIP)

The following guide VAC's approach to home care:

- Social and economic determinants of health figure prominently in demands for institutional admission. In effect, diminished capacity of the elderly to care for their surroundings and to maintain their dignity in the community was at least as influential a factor as diminished physical capacity.

- Alternatives to institutional care should be as comprehensive in scope as reasonably possible. To support delivery of care, the VIP benefits may be supplemented by access to the VAC treatment benefits program.

- Full interdisciplinary assessment of care requirements and the associated development of a care plan and follow-up monitoring are keys to a successful alternative.

- Compliance with the plan of care is critical to successful outcomes.

- Family care responsibilities should not be "taken over" by the alternative. The result of this finding was that the VIP did not normally pay a contribution toward family members providing care to the Veteran. The application of this principle has been controversial at times, and it has been modified over time.

- The VIP would be national in scope with the same level of benefit and the same access, depending on assessed need, no matter where the recipient resided in Canada.

- Wherever possible, Veterans' eligibility for like provincial benefits would be used first, with the VIP supplementation where needed. Currently, in many locales, the VIP and provincial programs work in concert to cost-share service delivery for the same client

HOME CARE (VIP) PROGRAM OBJECTIVES

The main objective of the VIP is to help individuals to remain healthy and independent in their homes and communities for as long as possible.

Some critical long-standing features of VIP are:

- Recognition of the critical role played by family caregivers.
- Self-management of home support services where feasible, which enables Veterans and their families to exercise a wide range of choice over service providers, within limits and according to assessed need.
- Integration with provincial and community services in a complex Canadian health care system.

HEALTH SYSTEM PRIORITIES

The New Veterans Charter's programs and services offer:

- One-on-one case management
- Rehabilitation
- Financial benefits
- Group health insurance
- Job placement assistance
- The lump sum Disability Award and other allowances
- Support to families

The **current home care priorities** within VAC include to:

- Provide a wide range of services, particularly home support services, to promote independent living at home.
- Provide early and easy access to services.
- Integrate effectively with provincial and community care systems.
- Promote consumer choice, family control and independence through self-managed care, when this is reasonable and possible.

2. Access, Funding & Service Delivery

ACCESS TO HOME CARE SERVICES

VIP Home care services are provided by local service providers and are arranged for by the veteran.

The VIP provides the veteran with a financial contribution towards eligible home care services. For housekeeping and grounds maintenance services, an upfront grant is paid. For other home care services, the veteran is reimbursed once services are rendered. The service provider may be paid directly, so the veteran is not out of pocket.

A Veteran can apply to the VIP Program by calling a central access number or visiting a local office, or printing an application from the Department's website. Individuals are assessed for eligibility for the Program through regular office hours (Monday to Friday 8:30 a.m. to 4:30 p.m.).

VIP is only available in Canada. It cannot be offered to clients who live outside of Canada.

REFERRAL SOURCES

Clients are referred by a family physician, self, VIP case management, and/or provincial home care program or other agencies. The number of referrals by source are not tracked.

DETERMINING CLIENT NEED - ASSESSMENT TOOLS

VAC references a wide range of assessment tools, including those used in other jurisdictions. VAC nurses and occupational therapists most often use departmental assessment forms and "optional tools" that are highly specialized. For example, there are tools for nursing, occupational therapy, medical, etc, such as FMMSE, GDS, HDS, FAST, Braden, Comfort Chart, CMAI, etc. These instruments are referenced by case managers and the interdisciplinary team for case planning as a component of case management and benefit delivery. The health status of Veterans is closely monitored, and there is frequent assessment and follow-up via screening, new assessments, and progress reports.

SETTINGS OF CARE

VIP services are intended to assist clients to live independently at home or in a retirement home (not long-term care facility) when it is considered the person's principle residence.

ELIGIBILITY, COVERAGE & UTILIZATION

REGULATIONS

ELIGIBILITY

Those eligible for the VIP may include:

- Disability client who needs VIP as a result of their disability entitlement
- Wartime (First World War, Second World War and Korean War) pensioner with a disability that is pensioned at 48 percent or higher.
- Disability client with a number of health conditions that, together with their disability entitlement, places the client at risk due to frailty.
- Wartime Veteran or overseas civilian who qualifies because of low income.
- Totally disabled former prisoner of war.
- Overseas service Veteran who is unable to access a Priority Access Bed.

Primary caregivers may qualify for VIP housekeeping and/or grounds maintenance services if they were the primary caregiver of a Veteran who was receiving these services at the time he/she passed away or was admitted to a long-term care facility. Most primary caregivers are spouses or common-law partners, but adult children or other individuals may also qualify.

To qualify for VIP as a primary caregiver, the client must need the services in order to remain independent in their home, but their health prevents them from doing these tasks. An individual qualifies as a primary caregiver if, at the time a Veteran passed away or was admitted to a long-term care facility, the caregiver :

- Was primarily responsible for making sure that care was provided to the Veteran.
- Did not receive a wage to provide this care.
- Lived in the principal residence of the Veteran and maintained the Veteran, or was maintained by the Veteran, for a continuous period of at least one year.
- Needed VIP services for health reasons to remain self sufficient in their home.
- Was a resident of Canada.
- Was not able to access services as an insured service under a provincial health care system or a private insurance policy.
- Had no other persons capable of providing the services .

VIP housekeeping and grounds maintenance services may be extended to low-income or disabled survivors of qualified veterans who were not in receipt of these services at the time of their death.

AGE

Adult

INCOME TESTING AND DIRECT FEES

Not applicable to VIP

SUPPLIES, EQUIPMENT AND MEDICATION

Clients who are eligible for VAC's Treatment Benefits would not normally have to pay for supplies, medication, or equipment for which they have been granted eligibility; however, clients must access provincial programming or existing private insurance first.

LIMITS /GUIDELINES TO SERVICE PROVISION

Clients may be provided with funds and allowed to self-manage care through selection of their own provider, providing that the provider meets certain criteria.

Clients are entitled to a maximum of:

- $9,991.00 for home care per calendar year, **including** up to the maximum amounts for grounds maintenance services ($1,394.09 per client per year) and personal care services (an amount not to exceed the cost of service for up to 59 days per calendar year)
- $1,161.75 per client per calendar year for ambulatory health care
- $1,394.09 per client per calendar year for transportation
- $8.06 per meal for nutrition
- $5,716.19 in home adaptations per principle residence
- $139.97 per client per day for intermediate care service

Individuals are provided services based on identified need. This is normally determined during an assessment process. Clients are expected to access provincial programs or existing private insurance first.

If the Veteran who was in receipt of services received both housekeeping and grounds maintenance services, then the caregiver will qualify for both. However, if the Veteran only received one of these services (such as grounds maintenance services) then this is the only service that will be available to the caregiver.

Once the primary caregiver qualifies for VIP, they will receive the services for as long as needed. Payments are not retroactive.

FUNDING

Expenditures - VIP Clients Receiving Home Care Services

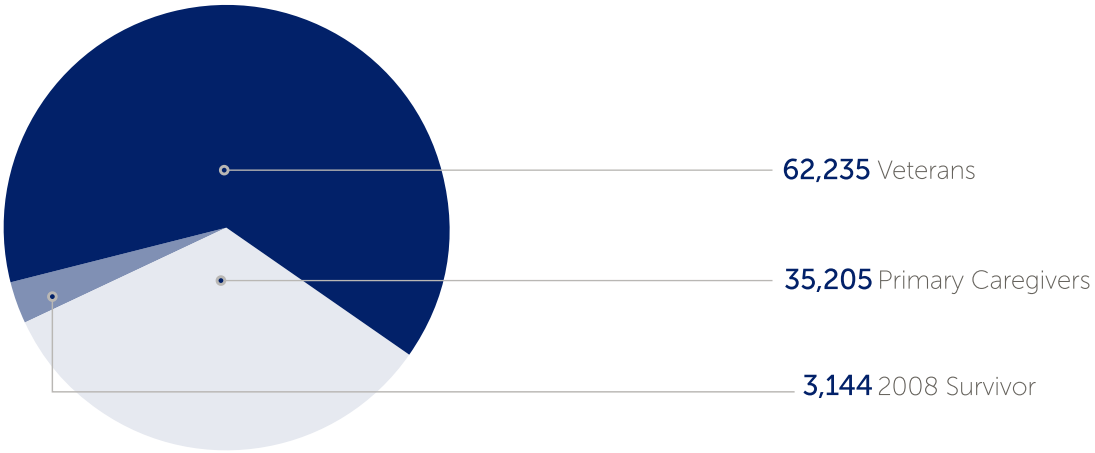
YEAR	Expenditures on Home Care Services[1] ($' 000,000)	Total VIP Expenditures ($' 000,000)	Percent of Home Care to Total VIP $	Average Expenditure per VIP Client[2]
2011-12	$339.9	$356.9	95%	$3,917.23
2010-11	$337.1	$354.4	95%	$3,240.97
2009-10	$321.7	$337.9	95%	$2,927.47
2008-09	$303.2	$320.0	95%	$3,096.54
2007-08	$287.4	$303.2	95%	$2,904.50
2006-07	$270.6	$286.7	94%	$2,788.63

[1] *Home care services expenditures exclude clients in intermediate care facilities (including their expenses for personal care, social transportation, ambulance services, nutritional services, etc.). The home care services expenditures column does include expenditures for housekeeping and/or grounds maintenance being received by the SP/PC of a Veteran, while the Veteran was residing in intermediate care. e.g: In 2011-2012, 5,429 VIP clients resided in intermediate care facilities. Of these clients, 1,930 had a spouse and/or primary caregiver receiving housekeeping and/or grounds maintenance at their primary residence. Therefore, these 1,930, as well as their expenditures on housekeeping and/or grounds maintenance, must be included in the home care services client counts and annual expenditures categories.*

[2] *Based on the number of clients with home care services translation (2006-07 – 97,037 / 2007-08 – 98,750 / 2008-09 – 102,040 / 2009-10 – 103,890 / 2010-11 – 104,012 / 2011-12 – 102,085)*

PROFILE OF CLIENTS RECEIVING VIP

Number of Individuals Receiving Home Care By Age Category (2011-12)



AGE

Recipients of VAC VIP are adults.

DIAGNOSIS

VAC funds home care services for clients with a large variety of medical conditions, including multiple co-morbid conditions. VAC does not fund provision of acute care interventions in the home. The home care related care needs of clients are changing somewhat, as the traditional client base of World War II Veterans continues to decline.

INTEGRATED MODELS OF CARE

VAC routinely collaborates with other jurisdictions, such as provincial home care, to develop comprehensive plans of care and to share in service delivery. An example of this would be in a situation where palliative care is required. The provincial ministry might provide a certain number of hours of personal care per week, with VAC funding provision of registered nursing services, or vice-versa.

DISCHARGE FROM HOME CARE

Once eligibility has been established, continuation of funding for medication is normally not affected by the client`s status within the home care program. Most clients in receipt of VIP services continue to retain these services over the long term, with adjustments based on need. VAC typically does not discharge, from home care services, the traditional client whose care requirements are not expected to diminish, unless they are placed in long-term care.

SERVICE DELIVERY

MODEL OF SERVICE DELIVERY

VAC's Health Care Programs offer an assessment-based, coordinated continuum of care that includes provision of supportive, therapeutic and palliative services. A case management model is applied, with support from an interdisciplinary team. Home care services, including personal care, and some professional services such as nursing, occupational therapy, rehabilitation, and mental health are provided through purchased services from approved providers. Services are not intended to duplicate or replace existing provincial/territorial or community services. When these services are not sufficient to meet client needs, VAC services may be approved to complement those offered.

Under VIP, a client may receive funds to help pay for grounds maintenance (such as grass-cutting or snow-shoveling), housekeeping, personal care, certain changes to one's home, care and support by health professionals, and some transportation. A client's ability to access VIP services depends on their health needs and whether these services are available to the client through another federal, provincial or municipal program.

RANGE OF HOME CARE SERVICES & PROGRAMS

For the purposes of this document, VIP home care consists of the following elements: housekeeping, grounds keeping, personal care, health and support services, access to nutrition, social transportation, ambulatory care and home adaptations. Intermediate care was not counted towards home care.

VIP home care expenditures were calculated separately from treatment benefits data.

Services Funded by the VAC VIP and Annual Expenditures

	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
Ambulatory Health Care Service (e.g. adult day care and travel costs	$836,078	$913,936	$923,162	$986,175	$1,119,299	$1,107,730
Nutrition (e.g. Meals-on-Wheels)	$6,737,755	$7,795,374	$8,285,628	$9,149,059	$9,488,929	$9,268,487
Direct Patient Care Health & Support Services (e.g. nurses, OTs)	$100,548	$90,281	$116,308	$164,585	$398,764	$340,959
Personal Care & Patient Support (e.g. bathing & dressing)	$18,583,146	$19,867,618	$20,513,989	$22,900,277	$24,427,841	$25,638,014
Housekeeping (e.g. laundry, vacuuming, meal prep)	$156,468,260	$170,307,280	$180,942,540	$196,406,022	$206,328,096	$210,799,301
Grounds-keeping (e.g. grass cutting, snow removal)	$42,084,260	$46,210,584	$49,576,374	$48,461,353	$52,006,382	$50,040,059
Social Transportation (e.g. to senior citizen centres, shopping, banking)	$2,902,265	$2,711,309	$2,510,292	$2,279,665	$2,106,750	$1,834,607
VIP Home Adaptations (facilitate access/mobility in the home)	$465,074	$437,234	$387,284	$547,863	$483,271	$690,135

VAC treatment benefits programs of choice support service delivery in the home environment and are complementary to VIP. The total health care dollar amount includes expenditures in the following programs of choice (POC):

Treatment Expenditures by POC for War Service and Canadian Forces

	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
POC 1 - Aids for Daily Living	$3,114,069	$3,054,782	$3,216,413	$3,232,476	$2,857,675	$2,741,832
POC 2 - Ambulance Service (Excludes HRT)	$2,541,206	$2,587,218	$2,765,732	$2,296,954	$2,537,458	$2,275,716
POC 3 - Audio Program	$38,275,859	$38,466,602	$41,854,477	$44,622,407	$41,492,327	$42,447,867
POC 4 - Dental Services	$18,468,405	$17,617,741	$19,643,118	$20,110,614	$19,096,619	$18,156,797
POC 5 - Hospital Services	$1,981,895	$1,820,603	$2,084,356	$1,828,740	$1,783,409	$3,025,553
POC 6 - Medical Services	$465,108	$392,353	$450,330	$499,548	$361,275	$671,828
POC 7 - Medical Supplies	$6,908,438	$6,730,529	$6,220,992	$6,264,958	$6,360,473	$6,434,199
POC 8 - Nursing Services	$7,990,840	$8,399,079	$8,643,563	$9,483,479	$10,730,111	$11,310,979
POC 9 - Oxygen Therapy	$3,736,196	$3,519,515	$3,188,192	$3,033,546	$2,607,418	$2,828,321
POC 10 - Prescription Drugs	$125,377,476	$122,872,145	$119,817,643	$117,065,034	$111,405,195	$102,656,273
POC 11 - Prosthetics & Orthotics	$2,811,896	$2,819,673	$2,599,165	$2,670,916	$2,580,242	$2,509,231
POC 12 - Related Health Services	$18,991,495	$19,885,982	$21,019,584	$23,042,510	$24,129,711	$28,500,196
POC 13 - Special Equipment	$30,795,510	$29,217,396	$30,682,699	$34,327,837	$32,384,625	$32,926,890
POC 14 - Vision Care	$5,539,061	$5,229,311	$5,526,729	$6,004,395	$6,547,024	$6,761,294
Total	**$266,997,454**	**$262,612,929**	**$267,712,993**	**$274,483,414**	**$264,873,562**	**$263,246,976**

Note: Includes Allied MC 2009 expenditures and excludes rehab only and health related travel expenditures.
Source: FHCPS transaction files

Falls Prevention Initiative

A community-based health promotion initiative established by Health Canada and Veterans Affairs Canada to help identify effective strategies to prevent falls in the community among veterans and seniors.

Collaborative fall prevention programs in British Columbia (BC), Ontario, and Atlantic Canada.

Greater awareness of the issue of falls

Creation of a permanent network of fall prevention leaders and champions

http://www.veterans.gc.ca/eng/health/fallsp

3. Quality & Accountability

HOME CARE INDICATORS

The home care indicators that may be currently monitored at a national level include:

- Utilization of programs and services
- Expenditures
- Intensity of service delivery
- Pensioned/awarded conditions
- Classification (intensity) of care requirements
- Number of service providers

QUALITY & ACCREDITATION

VAC regularly reviews programs and services and seeks way to improve efficiency and quality of service delivery.

CLIENT / PATIENT ADVOCATE

Announced on April 3, 2007, the Veterans Ombudsman is an impartial, arms-length, and independent officer with the responsibility to assist Veterans in pursuing their concerns and advancing their issues.

The Office of the Veterans Ombudsman works to ensure that Veterans, serving members of the Canadian Forces and the RCMP, and their families are treated respectfully, in accordance with the Veterans Bill of Rights, and receive the services and benefits that they require in a fair, timely, and efficient manner. The Office provides information and referrals, and addresses complaints, emerging, and systemic issues related to programs and services provided or administered by Veterans Affairs Canada. The Office also addresses systemic issues related to the Veterans Review and Appeal Board.

4. Information Technology

ELECTRONIC HEALTH RECORD

Each client has an electronic case record system that incorporates some health information. Client information is contained in the case manager's client assessment and case planning tools. These reports appear in their entirety in the electronic record file. Nursing and occupational therapy information is obtained via an assessment process, then transmitted via secure channel using web-enabled technology and included in the client's electronic file. Information contained in regular reports from service providers is included in the client record.

USE OF SYSTEM EFFICIENCY TECHNOLOGY

VAC is improving ways to augment electronic linkages with physicians, home care staff and programs. Some financial and service data may be submitted electronically.

USE OF TECHNOLOGY FOR CLIENT CARE

VAC has completed a pilot to introduce telehealth for certain types of client conditions, including mental health disorders. VAC has recently introduced the use of on-line technology via a secure channel medium, to request and receive reports from clinical care managers (CCM).

5. Health Human Resources

VAC staff complete assessments, however, they do not deliver therapeutic services (direct patient care). VAC employs community health nurses, physicians, case managers, contract occupational therapists, rehabilitation and mental health specialists, and others to comprise highly functioning inter-disciplinary teams to support case management. Under Programs of Choice and VIP, VAC funds service delivery by a wide range of health professionals as well as personal care workers.

EDUCATION & TRAINING

All Departmental and contract health professionals are regulated and currently registered with their respective regulatory bodies. VAC uses unregulated staff to provide home support and personal care. These providers must comply with provincial/territorial guidelines governing their work.

INTER-PROFESSIONAL COLLABORATION

VAC works in close collaboration with provincial/territorial counterparts in the development of individualized plans of care for clients in receipt of home care. Internally, service and benefit delivery involves input from interdisciplinary teams at district, regional, and head office levels, and includes the Treatment Authorization Centres, who are important partners in service delivery.

FAMILY CAREGIVER

The role of the family is an important component of home care delivery. VAC staff collect information about a caregiver's capacity to continue to provide care. VAC has piloted the C.A.R.E. Tool - a psychosocial assessment tool to be used by home care practitioners with family caregivers to help understand Caregivers Aspirations, Realities, and Expectations (C.A.R.E).

The C.A.R.E. Tool assists practitioners in gathering information related to caregivers' support needs and helps to identify key areas of concern. The C.A.R.E. Tool contains 10 sections: demographic information of the caregiver and care receiver, caregiving work, informal and formal support, living arrangements, other responsibilities, financial contribution, physical and emotional health, family relations, crisis and long-term planning, and service support needs. The final section summarizes the caregiving situation, allowing for the identification of areas of difficulty experienced by the caregiver and key areas of concern to be addressed in the future.

Recently VAC has modified the nursing assessment instrument to gather specific information about the capacity of caregivers to continue to assume that role, and to heighten awareness of the impact of caregiver issues. VAC staff routinely refers caregivers to external supports and resources, and VAC programming provides for respite for caregivers.

The Vital Role of the Family Caregiver

Family caregivers provide care and assistance for spouses, children, parents and other extended family members and friends who are in need of support because of age, disabling medical conditions, chronic injury, long-term illness or disability. A family caregiver's effort, understanding and compassion enable care recipients to live with dignity and to participate more fully in society.

5 million
is the estimated number of caregivers in Canada

80%
of care needed by individuals with a long-term condition is provided by family caregivers

60%
of caregivers provide care for more than three years

(Canadian Caregiver Coalition, 2008)

6. Initiatives

As part of the departmental transformation agenda, VAC is undergoing a review of its health services to ensure continued relevance and efficacy.

MENTAL HEALTH

The VAC suite of programs includes specialized programming and services with a focus on the client with a mental health condition, including access to mental health clinics and peer-support programs.

END-OF-LIFE CARE

VAC offers a comprehensive palliative care program to support those who wish to die at home. This program offers a 24 hour response time for review and decisions related to requests for funding.

PEDIATRICS AND YOUTH

VAC programs offer some services to support families of clients with mental health conditions.

7. Challenges

A key challenge facing VAC's home care program is the capacity to access, in some geographical areas, external service providers, including those with specialized skills, such as wound care nurses. This is usually related to the absence of these professionals in a given community.

8. Opportunities

The vision is reflected in the mandate and vision of the Veterans Independence Program (VIP). This national home care program helps qualified Veterans, caregivers, survivors, and certain civilians to remain healthy and independent in their own homes and communities. In order to realize the vision, VAC continuously reviews programs and services in order to ensure clients receive optimum care to meet their needs.

In keeping with VAC's transformation agenda, and the commitment to reducing red tape, VAC consistently reevaluates its programs and services and how these are administered. VAC continues to collaborate with its federal, provincial and territorial counterparts to improve programming and service delivery. The VIP will continue to evolve to respond to the diverse needs of a changing clientele.

ACRONYMS / ABBREVIATIONS

CCM -	Clinical Care Manager
FHCPS -	Federal Health Claims Processing System
POC -	Program of Choice
RCMP -	Royal Canadian Mounted Police
TAC -	Treatment Authorization Centres
VAC -	Veteran's Affairs Canada
VIP -	Veterans Independence Program

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DEPARTMENT OF NATIONAL DEFENCE

DEPARTMENT OF NATIONAL DEFENCE

HOME CARE FOR **CANADIAN FORCES**

The Canadian Forces defines home care as:

> The provision of health care, community and social support programs that enable entitled personnel (Canadian Forces members and foreign military members) to receive the care required to live at home as independently as possible.

DEPARTMENT OF NATIONAL DEFENCE

BY THE NUMBERS...

91,000	**POPULATION** 62,000 Regular Force members 25,000 Reserve Force members 4,000 Canadian Rangers	**35**	Number of Canadian Forces Bases / Detachments

1. Governance & Organization

HEALTH CARE SYSTEM STRUCTURE

The **Defence Portfolio** comprises the Department of National Defence (DND), the Canadian Forces (CF) and a number of related organizations, all of which are the collective responsibility of the Minister of National Defence.

Canadian Forces personnel belong to air, land, sea and special operations components. In the fall of 2012, the CF will launch the Canadian Joint Operations Command (CJOC), a new command and control structure that will be responsible for all operational force employment. CJOC will be established as an evolution of Canada Command, The Canadian Expeditionary Force Command and Canadian Operational Support Command. The Canadian Special Operations Forces Command will remain a separate entity reporting directly to the Chief of the Defence Staff due to its unique nature, capabilities and demands.

The **Canadian Forces Health Services** (CFHS) is the designated health care provider for Canada's military personnel, delivering medical and dental services at military installations across Canada and overseas. Overall corporate responsibility for CFHS is held by the Chief of Military Personnel (CMP) at DND. The CFHS, whose offices are headquartered in Ottawa, ON, is organized into two distinct areas of responsibility: patient care and support to military operations.

- The Director General Health Services is the senior CF health services officer responsible for health standards, doctrine, policies and the management of the military health system and its many programs in Canada and abroad.
- The Surgeon General is the senior physician responsible for all clinical issues.

HEALTH CARE & HOME CARE LEGISLATION

The CF is legally responsible for delivering health care under the National Defence Act, which stipulates that the Department of National Defence must provide appropriate care to Canada's military personnel. This responsibility is entrenched in the 1867 Constitution Act, which defined health care for Canada's military personnel as a federal responsibility. In addition, the 1984 Canada Health Act specifically excludes full-time CF members from its definition of insured persons for whom health services are provided under provincial health care insurance plans.

EVOLUTIONARY MILESTONES

1970

The home care program has been offered since the early 1970s.

2004

A consultant was retained to review the Canadian Forces Health Services (CFHS) Home Care Program as it compared to expectations within the 2003 and 2004 First Ministers' Accords on Health Care.

2005

Recommendation for the development of a National CFHS Home Care Program approved and the position of home care manager created.

2010

Manager of home care retained as a full-time position.

2011

Attendant Benefit and Caregiver Benefit policies introduced.

2012

A program review initiated. Restructuring of operational commands.

Home Care, an Essential Service

Home care was first available in Canada in the early 17th century, when nuns from religious orders arrived in Quebec to provide both direct care and disease prevention services [Community Health Nurses' Initiatives Group]. The first publicly funded home care program was established in 1970 and has continued to evolve and grow over time.

Increasingly, home care has been recognized as a cost effective and care effective strategy within the broader health system.

(Canadian Home Care Association, http://www.cdnhomecare.ca)

MANDATE, MISSION, PRINCIPLES & PRIORITIES

MANDATE

CFHS provides health care to Canada's 62,000 Regular Force and 25,000 Reserve Force personnel whenever and wherever required, and to the CF Rangers in special circumstances. The CFHS is an integral component of the CF. As well as serving the health needs of its patients while in Canada, the CFHS serves the needs of military members who are deployed.

PRINCIPLES OF HOME CARE

- **Caring** - empathy for patients, whose welfare is of foremost concern. Compassion is always evident with shared responsibility for their health.
- **Teamwork** - a multi-disciplinary team that works together, guided by the best interests of those served.
- **Communication** - listen to, understand and inform patients.
- **Accountability** - take responsibility for actions, decisions and behaviour.

HOME CARE PROGRAM OBJECTIVES

- Provide acute and chronic home care as well as palliative/end-of-life home care to regular and entitled Reserve and Foreign Service personnel.
- Offer 24 hours a day, 7 days a week availability.
- Ensure effective integration within the primary care clinic model.
- Ensure the most appropriate health care provider with the requisite training and expertise delivers care (e.g. nurses, physiotherapists, occupational therapists, nutritionists, social workers, case managers, speech therapists, personal support workers).
- Provide care based on client's assessed needs.
- Arrange for delivery of health care services by accredited public or private home care organizations.
- Deliver cost effective services.

HEALTH SYSTEM PRIORITIES

The priorities of the CHFS health care program are to:

- Maintain health and mental well-being.
- Prevent diseases.
- Diagnose or treat an injury, illness or disability.

The **current home care** priority within CFHS is to ensure all CF members receive timely access to quality home care services through publicly funded provincial health care organizations and/or third party home care provider organizations.

2. Access, Funding & Service Delivery

ACCESS TO HOME CARE SERVICES

CF members have access to the same standard of health care and publicly funded benefits and services that Canadians receive under provincial health care plans. The CF **'Spectrum of Care'** document describes these benefits and services, and sets one standard of health care for all CF members. The families of CF members access health care through provincial systems.

CF members access health care services through the nearest CF medical establishment. The CF member's attending physician at the clinic level certifies that the home care services are required and that the needs cannot be met on an out-patient basis. There are occasions when access to home care services (nursing and personal support worker services) is delayed for CF members who are posted to a base in a rural setting, due to local staff shortages.

REFERRAL SOURCES

Upon receipt of certification from the CF member's attending physician that home care services are required, the primary care nurse, within each care delivery unit at CF health services clinics across the country, initiates the referral to the local home care organization within the province/territory, for short-term acute home care that does not exceed three months. The CFHS case manager initiates the home care referral to home care organizations, for care, such as chronic (long-term) and/or palliative, that exceeds three months.

Access to Quality Care

In September 2004, First Ministers agreed to a 10 year plan (The Plan) to strengthen health care across Canada. The Plan recognized that in order to address issues of access to care and to reduce wait times, there was a need to invest in a number of key areas within health, including home and community-based services. Home care was identified as an "essential part of modern, integrated and patient-centered health care" and targeted funding for acute care home care, acute community mental health home care and end of life care was announced.

The experience of implementing The Plan has illustrated the extent to which the health system is interdependent. The targeted funding has not only increased the volume of home care services but has impacted the system as a whole.

(Canadian Home Care Association (2011), Home Care in Canada, Looking to the Future: Potential Opportunities and Outcomes, a Pan-Canadian Roundtable)

ELIGIBILITY, COVERAGE & UTILIZATION

ELIGIBILITY

Members of the Regular Force and members of the Reserve Force on Class C service, and Class B service who have served for over 180 consecutive days.

When the attending physician certifies that care is required and the needs cannot be met on an outpatient basis.

AGE

Adults 18 – 60 years

INCOME TESTING AND DIRECT FEES

No income testing and no fees for services charged to client or family.

SUPPLIES, EQUIPMENT AND MEDICATION

CFHS is responsible for all costs for medication, medical equipment and supplies that are medically necessary and are covered under the five principles of the 'Spectrum of Care', according to health benefit plan.

1. Necessary for the purpose of maintaining health and mental well-being, preventing disease, and diagnosing or treating an injury, illness or disability.
2. Necessary to sustain or restore a serving member to an operationally effective and deployable member of the CF.
3. In adherence with the scientific principle of evidence based medicine.
4. For purposes that are not purely experimental, research or cosmetic.
5. Funded by a single province or federal agency.

LIMITS / GUIDELINES TO SERVICE PROVISION

Homemaking (housekeeping) services are provided to CF members when the medical officer (physician) determines that the service is required as a result of the CF member's medical condition, and there are no other family members who can assist with the housekeeping activities.

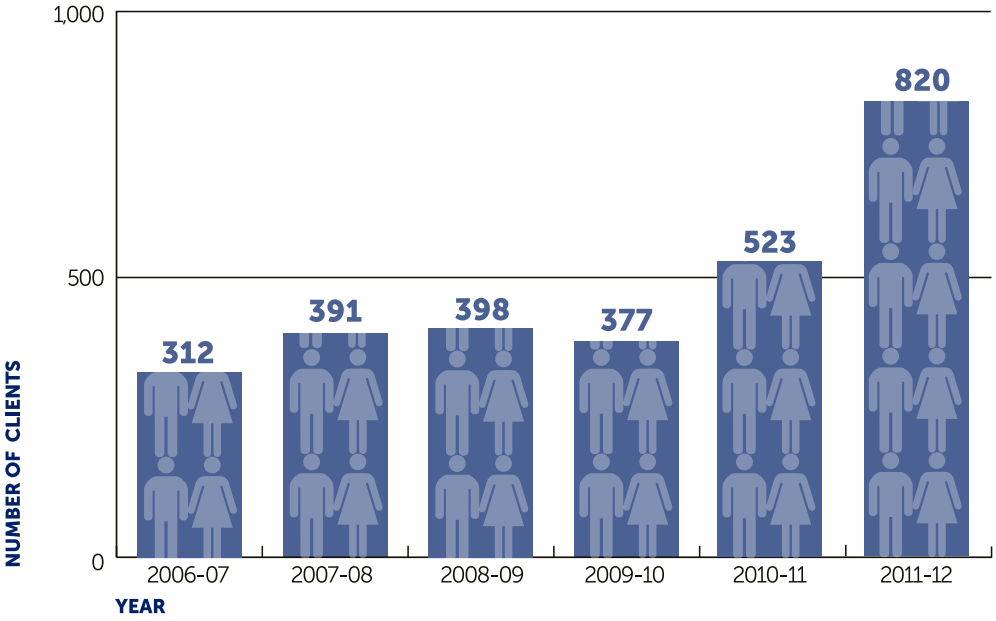
The Spectrum of Care provides coverage for housekeeping services for a maximum of six consecutive months.

Homemaking services are subject to a needs assessment.

DETERMINING CLIENT NEED - ASSESSMENT TOOLS

CFHS currently does not utilize a home care assessment tool. Home care assessments are completed by the public and private home care organizations/agencies that provide home care services to CF members. These organizations provide CFHS with a proposed plan of care and recommendation of services and duration. Based on the findings of the assessment, CF provides approval and authorizes services.

Home Care Admissions



SETTINGS OF CARE

CF home care services are provided in the following settings:

- Base Barracks
- Private Married Quarters (PMQ)
- Civilian house or apartment
- Hotel such as in situations when CF members are in receipt of tertiary care away from their home base and, on discharge, home care services must be provided in a temporary setting.

INTEGRATED MODELS OF CARE

In 2009, the CF established a network of eight **Integrated Personnel Support Centres (IPSCs)**, which are subordinate to the Joint Personnel Support Unit (JPSU) in Ottawa. The JPSU and its satellite IPSCs respond to requests for support and report patient concerns through the chain of command. They aim to improve the coordination of support services; to ensure that military personnel have access to consistent support across the country; and to reduce gaps, overlaps and confusion so no one falls through the cracks. CFHS case managers are key service partners with the IPSCs. The IPSC service manager, in consultation with the CFHS case manager, coordinates housekeeping services greater than six month duration, grounds keeping and home and vehicle modification services for CF members, and liaises directly with the ill or injured member ,or their representative, as the member's situation dictates.

DISCHARGE FROM HOME CARE

CFHS assumes responsibility for the costs of medication, medical equipment and supplies for CF members when discharged from home care services. These are provided by the CF member's local base clinic.

FUNDING

The annual home care expenditure is for health care provider services only (nursing, personal support workers, occupational therapists, social workers, case management, physiotherapy, speech therapist). The cost for medical equipment and supplies for home care is not included.

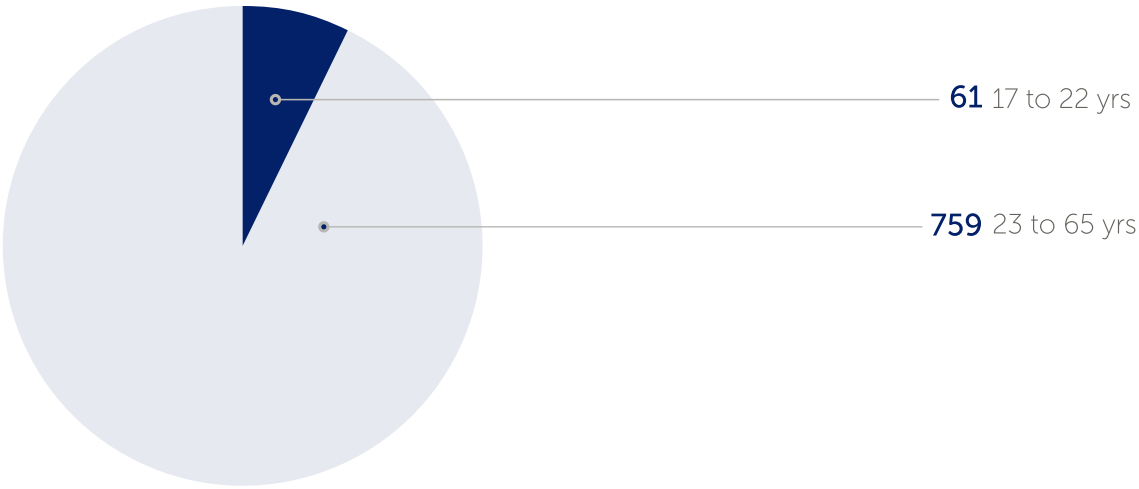
Public Expenditures on Home Care

YEAR	Annual Home Care Expenditure ($'000,000)	Total Health Expenditure ($'000,000)	Percent of Total Health Expenditure	Average Expenditure per CF Client [1]
2011-12	$0.80	**$410.48**	0.19%	$975.61
2010-11	$0.60	**$410. 21**	0.15%	$1,147.23
2009-10	$0.79	**$407.32**	0.19%	$1,984.92
2008-09	$0.60	**$366.74**	0.16%	$1,503.76
2007-08	$0.46	**$331.84**	0.14%	$1,176.47
2006-07	$0.37	**$306.93**	0.12%	$991.96

[1]Based on the number of clients with home care services translation (2006-07 – 373 / 2007-08 – 391 / 2008-09 – 399 / 2009-10 – 398 / 2010-11 – 523 / 2011-12 – 820)

PROFILE OF CLIENTS RECEIVING HOME CARE

Number of Individuals Receiving Home Care by Age Category (2011-12)



DIAGNOSIS

The home care data base does not capture the diagnoses for individuals receiving home care. However, there has been an increase in requirement for complex, long-term home care services for CF members with battle related injuries (e.g. improvised explosive device (IED)).

SERVICE DELIVERY

The CFHS provides health service to CF members in two distinct environments: in-garrison and on deployment. In Canada, in-garrison care is provided at every military base. Health services are provided overseas when and where CF personnel are deployed to promote Canada's interests and contribute to peace and international security. In-garrison and overseas health care services are closely linked - by ensuring that personnel are healthy, the CFHS can increase deployment readiness and reduce the risk of medical or dental emergencies on deployment.

MODEL OF SERVICE DELIVERY

At present the CFHS home care services are coordinated by the CFHS clinics and provided by the civilian home care sector. There are 35 clinics across all ten provinces and one territory (Northwest Territories). These medical units provide health care services similar to those found in community clinics, treating non-life threatening illnesses, performing minor surgical procedures and providing pharmacare. After hours, or for services not provided by the CFHS, CF members receive care at civilian hospitals or other health care facilities.

A health care coordinator acts as the senior medical person at every CF clinic, while military and civilian doctors, nurses, technicians and other health care professionals provide clinical care. Civilian staff are playing an increasingly important role in CF health provision, since military medical personnel are often called away to deploy or train.

RANGE OF HOME CARE SERVICES AND PROGRAMS

The CF 'Spectrum of Care' outlines the services to which CF members are entitled. To be included in the CF 'Spectrum of Care', a benefit (5 Guiding Principles) must be:

1. Necessary for the purpose of maintaining health and mental well-being, preventing disease, and diagnosing or treating an injury, illness or disability.
2. Necessary to sustain or restore a serving member to an operationally effective and deployable member of the CF.
3. In adherence with the scientific principle of evidence based medicine.
4. For purposes that are not purely experimental, research or cosmetic.
5. Funded by a single province or federal agency.

Feedback from the clinic level at this time has revealed that CF members are receiving the home care required; however, there are regional differences on the availability and types of services. There has been a recent increase in the demand for home care services due to the injuries CF members have received while engaged in military operations.

Achieving Health and Wellness

The achievement of "health and wellness" requires many inter-related services including health prevention, promotion and protection, diagnosis, treatment / cure, rehabilitation, support and maintenance, and social adaptation and integration [CIHI 2001].

Home care uniquely functions as a bridge between the various settings of care, including acute care hospitals, emergency rooms, supportive living, long-term care facilities, hospices, and the physician's office. These close linkages enable home care programs to meet client's needs in an individualized and comprehensive manner, and go beyond physical and mental health care to engage social supports as well.

(Canadian Home Care Association - 2011)

Services Funded & Expenditures

	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12
Professional Services						
Registered Nurse	$266,596	$313,652	$343,755	$395,663	$314,100	$305,376
Registered Practical Nurse / Licensed Practical Nurse, Nursing Assistant	$17,274	$33,434	$83,737	$127,938	$38,285	$12,005
Physiotherapist		$24,550	$27,739	$45,608	$21,131	$10,555
Occupational Therapist		$18,742	$62,970	$79,411	$81,784	$39,510
Speech Language Pathologist		$893	$3,680	$18,107	$8,688	$6,552
Social Worker ($348.00 expenditure in 2010/11)						
Case Manager – within home care programs / organizations ($43,110.00 expenditure in 2011/12)						
Nurse Practitioner ($834.00 expenditure in 2010/11)						
Other – Psychologist ($2,700.00 expenditure in 2009/10)						
Paraprofessional Services						
Home Support Worker / Personal Care Attendant	$87,633	$70,770	$82,007	$120,181	$134,506	$348,917
Ancillary Services						
Medical Supplies ($38,841.00 expenditure in 2011/12)						

SERVICES NOT FUNDED

- Clergy / Spiritual Advisor - Provided through CF chaplaincy division.

CLINICAL (SPECIALTY) SKILLS

With the focus on discharging patients from hospital as promptly as possible, there has been an increase in the complexity of care provided at home. The challenge in much of Canada can be in having a critical mass of patients who require certain levels of expertise and, as a result, special skills only being available in urban centres. However, with the advent of remote access to support in the community, there is an opportunity for more complex care to be provided in less populated areas.

Home care clinicians operate under the direction of the local home care program to provide a range of services to CF members. Typically home care nurses are able to:

- Administer narcotics.
- Provide enterostomal therapy, wound care, infusion therapy (limited).
- Manage (to a limited extent) infusion pumps, central lines and peripherally inserted central catheters (PICC lines).
- Provide ventilator care (in urban settings).
- Manage home oxygen.

Chemotherapy treatments are provided at urban civilian cancer treatment centres.

3. Quality & Accountability

HOME CARE INDICATORS

The home care indicators that are currently monitored at a national level include:

- Amount of service delivery.
- Expenditures.
- Home care admissions.
- Number of staff.

QUALITY & ACCREDITATION

EXTERNAL ACCREDITATION

Accreditation is one of the most effective ways for health services organizations to regularly and consistently examine and improve the quality of their services, in order to ensure high standards of care. Organizations in Canada are accredited through Accreditation Canada, CARF, the Quebec Council of Accreditation (Quebec only) and/or registered with the International Standards Association (ISO).

The Canadian Forces Health Services (CFHS) achieved Accreditation Status in February 2011 from Accreditation Canada.CFHS is the first and only federal pan-Canadian primary and ambulatory health care system to achieve this status. The next accreditation cycle is currently in process and CFHS will be evaluated once again in Spring 2013, using Accreditation Canada's Qmentum program. All CF clinics, as well as the entire CF health system, participate in accreditation surveys. In addition, a number of CF health care personnel have become surveyors, and the CFHS maintains a seat as a client member on Accreditation Canada's Board of Directors.

QUALITY COUNCIL

The membership of the **Quality Improvement Steering Committee** is comprised of the senior leadership of CFHS. This committee meets on a quarterly basis to review any system level quality improvement initiatives, performance measures, and patient safety incidents. Strategic direction over the Quality Improvement program is discussed and priorities determined. At the clinics, a similar structure exists that engages senior management at the clinics in quality improvement and patient safety.

High-quality care is evidence-based (appropriate), focused on the patient (or patient-centered), safe and timely (CIHI).

CLIENT / PATIENT ADVOCATE

Within each of the clinics, individuals who are identified as patient relations officers, provide administrative support to the patient and family members when they have concerns or complaints about the provision of care. Complaints are compiled by each clinic and reported to the National Quality Improvement office to track trends and identify issues that may need to be addressed, from a systems perspective.

SYSTEM APPROACHES TO QUALITY IMPROVEMENT

The Canadian Forces Health Services (CFHS) actively promotes continuous quality improvement in all aspects of the CF health care system. By taking a system-wide approach to the provision of health care, the CF has created a series of quality teams at both the local and national level. Monitoring the quality of health care delivery at the clinics is accomplished through standards assessment by the local leadership teams and through oversight by the National Headquarters. The Quality Improvement program is focused on six key core initiatives: patient safety, quality monitoring (including Accreditation), process improvement (focusing on lean methodologies), risk management, patient and staff relations, and decision support (including the development of a clinic performance measurement framework).

SAFETY

CFHS is committed to the safest possible delivery of health care. To this end, the health care team adopted patient safety as a priority in the strategic plan for the Quality Improvement and Risk Management Program. The Patient Safety Plan 2009–2012, "**Creating a Patient Safety Culture in the CF**," was launched during Canadian Patient Safety Week in November 2009. Although the Patient Safety program continues to be successful in encouraging the reporting and follow up of patient safety incidents across the system, there is opportunity to make this program a leading practice. With assistance from the successful Canadian Forces Flight Safety Program, CFHS is looking to integrate key successes and lessons learned, and to develop an electronic incident reporting database. Patient safety will remain a major priority for the organization.

4. Information Technology

ELECTRONIC HEALTH RECORD

CFHS is currently in the process of implementing a National Electronic Health Care Record called the **Canadian Forces Health Information System (CFHIS)**. The CFHIS is an electronic health record solution aimed at enhancing quality care by enabling CF care providers to securely share information, and coordinate care for regular and reserve force personnel, anytime, anywhere. The CFHIS will create a complete health record for every CF member by integrating a number of software applications that support a wide range of CF health services and functions. Four of the following software applications have been implemented:

- **Centralized Patient Registration and Scheduling:** Provides current patient demographic information, quick information retrieval, and the ability to schedule across services and providers. (completed)
- **Computerized Physician Order Entry and Clinical Notes:** Provides order entry capabilities, ability to review results in several formats, clinical notes and a cumulative patient profile.
- **Pharmacy Information System:** Provides prescription management, drug profiles, alerts, and an interface with the Department's drug plan administrator.
- **Laboratory Information System:** Provides order and results management for all lab functions. (completed)
- **Radiology Information System:** Provides order processing / examination tracking, results reporting and distribution. Also facilitates study management to the Picture Archiving and Communication System (PACS) and digital imaging modalities. (completed)
- **Dental Information System:** Provides treatment plans, charts and records. (completed)

The final functionality of the system will primarily allow care providers to sign off, compile and access clinical notes specific to patients, as well as capture orders electronically. The electronic records will become the official medical record and will result in a virtually paperless health care system. CFHIS is a bilingual electronic health record system functioning across Canada and in deployed operations. The system is unique in that it integrates medical, dental, and mental health into one system.

The CFHIS electronic health record solution enables CF care providers to securely share information and coordinate care for regular and reserve force personnel, anytime, anywhere. The system allows authorized providers within and across the Care Delivery Units (CDUs) to centrally schedule and coordinate services. It also allows them to securely access and share information in real time to support appropriate treatment decisions and to avoid duplication. For security reasons, the interface with the civilian sector is through paper only, which is scanned into the client's health record on CFHIS.

5. Health Human Resources

The CFHS is a team of more than 2,400 full-time Regular Force and 900 part-time Reserve Force health care professionals who provide a wide spectrum of health care services in Canada and overseas. This multidisciplinary team includes surgeons, general practitioners, dentists, pharmacists, nurses, medical assistants, biomedical electronics technicians, X-ray technicians, and health care administrators. Specialized military occupations, such as the multi-skilled preventative medicine technician, the medical assistant, and the physician assistant, provide a range of services that make them unique to the CF. The CFHS also employs civilian personnel through the Public Service, or via contracting arrangements, to provide health care and administrative support in Canada.

The home care manager is the only staff member dedicated solely to home care and, as such, works closely with the CF Health Services clinics across the country. Within the clinics, the primary care nurse (PCN) coordinates short term (three months or less) home care through local providers. The clinic case managers coordinate care for those with more complex and/or long-term care needs (greater than three months).

INTER-PROFESSIONAL COLLABORATION

The CFHS is patient-focused, and allows all members of the health care team to grow as professionals, and to apply their skills to their maximum extent. The heart of the health care delivery system is the Care Delivery Unit (CDU). All CF personnel are rostered to a CDU, where a multidisciplinary collaborative team provides focused, efficient and optimized care for both the individual patient and the relevant population.

A CDU core team consists of two uniformed medical officers, a civilian physician, a uniformed physician assistant, a civilian nurse practitioner, a primary care nurse (military or civilian), three military medical technicians and two civilian administrative support staff. The team works collaboratively with patients to assess their needs, and to provide and coordinate the care, in support of complete wellness. In-house physiotherapists, pharmacists and mental health professionals provide care either in collaboration with the team, or through direct intervention.

Along with the adoption and optimization of the clinic model, the CFHIS electronic health record is being rolled out to CF clinics. The electronic health record is more than a digital copy of traditional forms—it is critical to the success of the care delivery model. The CFHIS gives the team real-time access to documents and reports from any CF terminal so they can coordinate scheduling and tracking. It also allows the team members to discuss a patient's care electronically.

FAMILY CAREGIVER

A new policy for the Attendant Care Benefit was approved by Treasury Board in April 2011. The policy provides an attendant care benefit to a family member or attendant who provides the CF member with routine personal care and basic supervisory functions, on a full-time basis. A CF member is entitled to receive the Attendant Care Benefit if the member sustains, on operations in Afghanistan, a permanent catastrophic impairment, or a temporary catastrophic or non-catastrophic impairment, and is assessed as reasonably and necessarily needing attendant care. The Attendant Care Benefit is payable for a maximum of 365 cumulative days.

A second policy, the "Caregiver Benefit", was also approved by the Treasury Board in April 2011. The purpose of the Caregiver Benefit is to reimburse an ill or injured CF member for payments made for childcare or other caregiver expenses. A CF member is entitled to receive the Caregiver Benefit if a dependent physically resides with the member, and the member sustains, on operations in Afghanistan, a permanent catastrophic impairment, or a temporary catastrophic or non-catastrophic impairment, which is assessed as preventing the member from engaging in the care giving activities in which he or she engaged prior to those operations. The Caregiver Benefit can be used for expenses that include, but are not limited to: routine personal care, supervising daily activities, and household tasks.

Who are Family Caregivers?

Family caregivers provide care and assistance for spouses, children, parents and other extended family members and friends who are in need of support because of age, disabling medical conditions, chronic injury, long-term illness or disability.

A family caregiver's effort, understanding and compassion enable care recipients to live with dignity and to participate more fully in society.

5 million is the estimated number of caregivers in Canada.

80 % of care needed by individuals with a long-term condition is provided by family caregivers.

60 % of caregivers provide care for more than three years.

(Canadian Caregiver Coalition, 2008)

6. Initiatives

COLLABORATION WITH CIVILIAN HEALTH CARE AGENCIES

To fulfill its mandate of providing comprehensive health care to CF personnel, CFHS relies heavily on a wide variety of civilian health care agencies. Through strategic alliances, memoranda of understanding (MOUs), local arrangements, and a general spirit of cooperation and goodwill, CFHS has integrated itself into the mainstream of the Canadian health system.

COLLABORATION WITH GOVERNMENTS

As a pan-Canadian health system, with significant national and international responsibilities, CFHS maintains strategic links with a host of provincial and federal agencies to execute its assigned mission and tasks at home and abroad.

PRIMARY CARE RENEWAL & CASE MANAGEMENT PROGRAM

In 2010, Canadian Forces Health Services Group closed out the 10-year Primary Care Renewal Initiative (PCRI) called Rx2000, which transformed the way in which health care is delivered to CF members. One of the greatest successes of the Rx2000 reform of CF health services was one of its first initiatives, the Case Management Program. The introduction of this program addressed a significant complaint voiced by CF personnel— the lack of continuity of care. The Case Management Program is now a fully implemented and integral part of CF primary care. It provides a seamless, integrated mechanism for managing cases across the continuum of care. Because of its extensive and proven benefits, case management is the strategy for responding to the needs of CF personnel suffering from long-term and complex health issues. Improved processing of ill or injured CF personnel has enhanced overall operational capability. The program currently includes 58 case managers at 23 locations and satellite sites, and is overseen by two national coordinators and a national manager. It provides services to CF Regular Force personnel and Reservists with a temporary medical condition, those being medically released from service, and those requiring management of complex health issues. In 2009–2010, CF case managers maintained an active caseload of more than 3,000 personnel. Of these, approximately 1,200 were released from the CF on medical grounds.

7. Challenges

The greatest challenges facing delivery of home care services for the Canadian Forces Health Services are timely access to home care services in both rural and urban centers, and being able to provide equitable care while working with different provincial/territorial standards. Many CF members do not have access to family members to assist them with their home care needs, therefore, access to home care services in a timely manner is paramount.

8. Opportunities

The opportunities in home care for the CFHS include developing and strengthening linkages with national and local civilian home care organizations in order to enhance the planning, coordination and delivery of home care services for CF members. The CFHS has established formal relationships with six Community Care Access Centres in Ontario, for the coordination and delivery of home care services for CF members at CF bases within those jurisdictions. The national manager of home care has initiated communication with several Canadian national home care agencies to discuss the home care requirements of the CF, and to identify the types and availability of home services that these agencies can provide to members across the country. By the fall of 2012, the plan is for CF Health Services clinic managers to have fostered formal relationships with home care agencies in their local geographical area, and be establishing process mapping for accessing those home care services.

The Canadian Forces Health Services envisions ensuring that standardized, quality, safe and timely access to home care services is provided to CF members anytime and anywhere.

ACRONYMS / ABBREVIATIONS

CDU - Care Delivery Unit
CF - Canadian Forces
CFHIS - Canadian Forces Health Information System
CFHS - Canadian Forces Health Services
CJOC - Canadian Joint Operations Command
CMP - Chief of Military Personnel
DND – Department of National Defence
IED - Improvised explosive device
IPSC - Integrated Personnel Support Centre
ISO - International Standards Association
JPSU - Joint Personnel Support Unit
MOU - Memoranda of Understanding
PACS - Picture Archiving and Communication System
PCN - Primary Care Nurse
PCRI - Primary Care Renewal Initiative (RX2000)
PICC lines - Peripherally inserted central catheters
PMQ - Private Married Quarters

SOURCES

The chapter has been compiled from sources listed below, interviews with key informants and feedback to an electronic survey. Information replicated from provincial materials has been done so with the knowledge and permission of the key informant.

Canadian Forces Health Information System, http://www.forces.gc.ca/health/projects/CFHIS/pdf/engraph/CFHIS_brochure_e.pdf

Canadian Forces Health Services Group. (2010) Surgeon General's Report 2010 – Building our Strategy. http://www.forces.gc.ca/health-sante/pub/sgr-rmc-2010/default-eng.asp

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Langlais, Charlene CD, BScN, MPH. (Key Informant) Manager Home Care, HQ Accreditation Coordinator Health Services Delivery CFH Svc Gp HQ, LANGLAIS.CT@forces.gc.ca

National Defence website, http://www.forces.gc.ca/hr/engraph/health_e.asp

National Defence and the Canadian Forces website, http://www.forces.gc.ca/site/about/index_e.asp

ROYAL CANADIAN MOUNTED POLICE

HOME CARE FOR **RCMP**

The provision of nursing and home care services are allowed under the RCMP's three levels of care: basic, supplemental and occupational. The RCMP does not have a home care program. However, it does provide coverage for certain nursing and home care services, similar to those provided through provincial/territorial health care plans, workers' compensation and other employers' insurance plans.

The RCMP nursing and home care service provisions are based on the individual needs of the RCMP members, encompassing health promotion and teaching, curative intervention, end-of-life care and rehabilitation.

ROYAL CANADIAN MOUNTED POLICE

BY THE NUMBERS...

29,235

POPULATION 2011 Includes Regular/Special Constable/Civilian Members and Public Service Employees

The Royal Canadian Mounted Police (RCMP) is the Canadian national police service and an agency of the Ministry of Public Safety Canada.

Created by Parliament in 1919 – by merging the Royal North West Mounted Police and the Dominion Police – the RCMP has a mandate to enforce laws, prevent crime, and maintain peace, order and security. Through agreements between the federal government and other bodies, the RCMP provides national, provincial/territorial, Aboriginal and municipal police services across Canada. The RCMP provides a total federal policing service to all Canadians and policing services under contract to the three territories, eight provinces (except Ontario and Quebec), more than 190 municipalities, 184 Aboriginal communities and three international airports.

1. Governance & Organization

HEALTH CARE SYSTEM STRUCTURE

The **RCMP** is under the direction of the **Ministry of Public Safety Canada**. The Force is divided into divisions, including Headquarters (HQ) in Ottawa. At the local level there are more than 750 detachments.

The responsibility to maintain a national policy on RCMP health care programs falls under the **Occupational Health and Safety Branch**. The Branch provides policy directions and functional guidance to Occupational Health and Safety Services (OHSS) offices in 12 divisions across the country, located in nine of the largest provinces. Typically, a Health Services Officer (HSO) in each divisional office will report to the regional Officer in Charge (OIC) of Occupational Health and Safety Services.

HEALTH CARE & HOME CARE LEGISLATION

The **RCMP Regulations** 1988 (SOR/88-361) pursuant to the RCMP Act (R.S.C., 1985 c. R-10) provide the RCMP Commissioner with the authority to provide medical and dental treatment programs for RCMP members.

The **Pension Act** (R.S.C., 1985, c. P-6) is administered by Veterans Affairs Canada (VAC) and may provide a compensation award to RCMP serving members, or a compensation award and additional health services to retired members who have suffered a disability as a result of a duty related illness or injury.

EVOLUTIONARY MILESTONES

1989

Medavie Blue Cross was awarded a contract by Public Works and Government Services Canada (PWGSC) to provide health claims administration to Veterans Affairs Canada (VAC).

1999

RCMP entered a Memorandum of Understanding with VAC to participate as a partner in their contract with a private health claims administrator.

2012

Bill C-38, the Job, Growth and Long-Term Prosperity Act, which received Royal Assent June 29, 2012, amends the definition of an "insured person" within the Canada Health Act and now allows regular members of the RCMP to be included as insurable persons under provincial/territorial health care programs.

Home Care, an Essential Service

Home care was first available in Canada in the early 17th century, when nuns from religious orders arrived in Quebec to provide both direct care and disease prevention services [Community Health Nurses' Initiatives Group]. The first publicly funded home care program was established in 1970 and has continued to evolve and grow over time.

Today, home care is an essential element of a comprehensive health care system. Appropriately resourced home care programs play a critical role in managing wait lists, supporting health promotion and chronic disease management and enabling the frail elderly to live independently in their own homes.

Increasingly, home care has been recognized as a cost effective and care effective strategy within the broader health system.

(Canadian Home Care Association, http://www.cdnhomecare.ca/)

MANDATE, MISSION, PRINCIPLES & PRIORITIES

MANDATE

The RCMP funds coverage of home care services equivalent to services rendered to Canadian citizens through the basic health care program of provincial health care plans. This program will be changing as a result of recent inclusion of the RCMP under the *Canada Health Act*.

In addition, the RCMP, through the occupational health care program, provides coverage for home care services equivalent to services under the Provincial Workers' Compensation Board to employees who suffer work related injuries or illnesses. Coverage for nursing home care and other related nursing services are available through either the RCMP's supplemental or occupational health care programs.

PRINCIPLES OF HOME CARE

The guiding principles of the RCMP nursing and home care provisions are to:

- Provide coverage for nursing, home care and other related services to support members' recovery, return to work and fitness for duty.
- Promote members' health and safety.
- Promote the best possible quality of life by providing coverage for nursing and related / specialized services (e.g. end-of life-care at home).

HOME CARE PROGRAM OBJECTIVES

The RCMP nursing and home care service provisions are based on individual needs assessment and administered in accordance to the RCMP Health Care Entitlements and Benefits Programs Policy (AM XIV.1).

HEALTH SYSTEM PRIORITIES

The priorities of the RCMP's health care programs are:

- Basic Health Care – for eligible members to receive basic health care that is equivalent to most other Canadians.
- Supplemental Health Care - for eligible members to receive health care benefits similar to other employees through their health benefits insurance plans.
- Occupational Health Care – to minimize limitations and restrictions that affect a member's fitness for duty and to maximize employability.

The current home care priorities within the RCMP include:

Following the amendment of the Canada Health Act, the RCMP is pursuing modernization of its health care services and applicable policies.

2. Access, Funding & Service Delivery

ACCESS TO HOME CARE SERVICES

RCMP members can access community nursing and home care services 24 hours a day, 7 days a week. A RCMP Disability Case Manager reviews the referral and obtains appropriate authorization.

REFERRAL SOURCES

The source of referrals to home care organizations are not tracked on an individual basis although referrals must be provided by the treating physician, most often a community provider.

ELIGIBILITY, COVERAGE & UTILIZATION

ELIGIBILITY

An active regular /special constable member of the RCMP (includes civilian member with an occupational illness or injury), whether on leave with or without pay. However, treatment must be prescribed by the primary care physician and approved by the OHSS office in advance of service.

AGE

There are no age restrictions; as long as the member remains active he/she is entitled to coverage. There is no dependant coverage under this plan.

SUPPLIES AND EQUIPMENT

Provided according to the RCMP's health care policy, unless financial authority is obtained from the OIC Occupational Health and Safety Services for cases approved under occupational health care.

LIMITS / GUIDELINES TO SERVICE PROVISION

Specialized nursing and home care services are covered when prescribed by the primary care physician. Preauthorization generates a case review resulting in clarification of service limitations. Limitations are based on case-by-case analysis.

PRE-AUTHORIZATION

Pre-authorization by the HSO/OIC Occupational Health and Safety Services would include the verification of fees to ensure rates paid conform to limitations and conditions outlined in the RCMP Benefit Grid as per AM XIV.1. Health Care Entitlements and Benefits Programs policy.

DETERMINING CLIENT NEED - ASSESSMENT TOOLS

There is no standard assessment tool used. Any time an RCMP member is off work for more than four days, the appropriate OHSS office is advised. The Disability Case Manager monitors the individual case and facilitates the member's access to care.

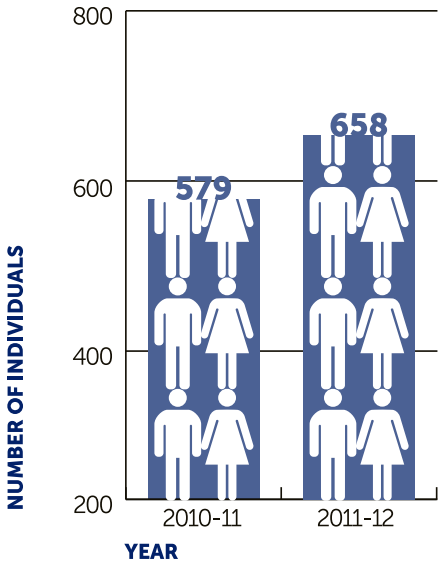
ADMISSIONS TO HOME CARE

Since the RCMP does not have a designated home care program, data pertaining to nursing and home care services received by RCMP eligible members is recorded on medical files and captured through the health claims administration.

SETTING OF CARE

Nursing and home care services are provided in a member's home.

Individuals Receiving Home Care*



**Members not necessarily receiving home care, but rather certain health care benefits that would pertain to either nursing or home care service provision.*

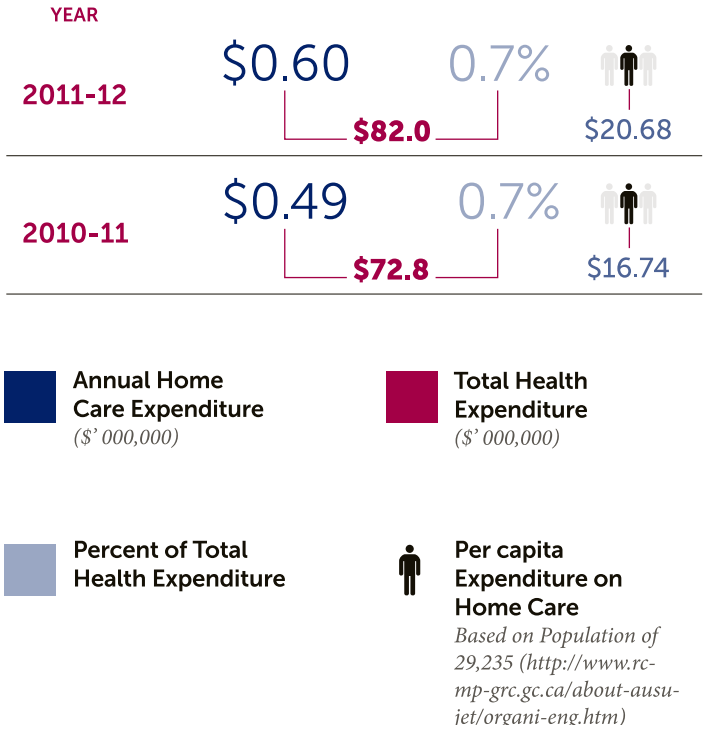
DISCHARGE FROM HOME CARE

The member's access to nursing and home care services and improvements in the member's condition are assessed by the Disability Case Manager. Discharge information is included in these assessments.

FUNDING

The annual home care expenditure is for services received from health care providers (e.g. nursing, personal support workers, occupational therapists, social workers, case management, physiotherapy, speech therapist). The cost for medical equipment and supplies for home care is not included.

Expenditures on Home Care



With the recent amendment of the definition of an "insured person" within the Canada Health Act, the RCMP members will, in future, receive health services from a provider of choice for their primary health care in the publicly funded provincial health care plans. Through the supplemental and occupational health care programs, the RCMP pays for nursing and home care service provisions, if authorized, as specified in the RCMP Benefit Grid AM XIV.1. Health Care Entitlements and Benefits Programs policy.

PROFILE OF CLIENTS RECEIVING HOME CARE

The RCMP pays nursing and home care service provisions to all active, eligible members. In 2011-2012, there were 658 members, all between the ages of 23-65 years, who received those services. This represented 3.4 percent of active membership.

SERVICE DELIVERY

MODEL OF SERVICE DELIVERY

Nursing and home care services are components of RCMP health care provisions and are designed in accordance with the provincial/territorial health care programs, workers' compensation and other employers' insurance plans. Once nursing and home care services are authorized by the RCMP, the use of community / private organizations is a decision made by the RCMP member and/or their delegate, with the assistance of the OHSS office if necessary.

RANGE OF HOME CARE SERVICES & PROGRAMS

The RCMP's health care program consists of three levels of care:	
Basic Health Care	Considered to be the equivalent to public health care services normally provided by a provincial or territorial government. This program is currently under review as a result of Bill C-38 and amendment of the Canada Health Act.
Supplemental Health Care	Equivalent to a group insurance plan such as is normally provided by any large employer, and includes components such as a drug program, dental program, and alternative treatment therapies such as chiropractic treatment, acupuncture, massage.
Occupational Health Care	Occupational Health Care has three components: • The goal of returning the member as close as possible to pre-injury status. The benefits in respect of injury or death on service for the RCMP members are covered under the legislation of the RCMP Superannuation Act and Pension Act. • Occupational health screening, such as periodic health assessments or special program assessments, for members working in areas considered to be at high risk for illness or personal injury, and • Disability Case Management and Return to Work programs, where care is designed to expedite healing in order to get the member back to work faster. These services are authorized by the OIC Health and Safety Services of the region based on the fiscal imperative to achieve a safe and timely 'return to work'.

The treatment under occupational health must be part of a treatment plan/comprehensive rehabilitation program that is prepared by the member's treating physician and submitted to the HSO for review and recommendation. Financial authority for approving occupational health care (OHC) levels of care falls to the OIC Health and Safety Services of the regional office.

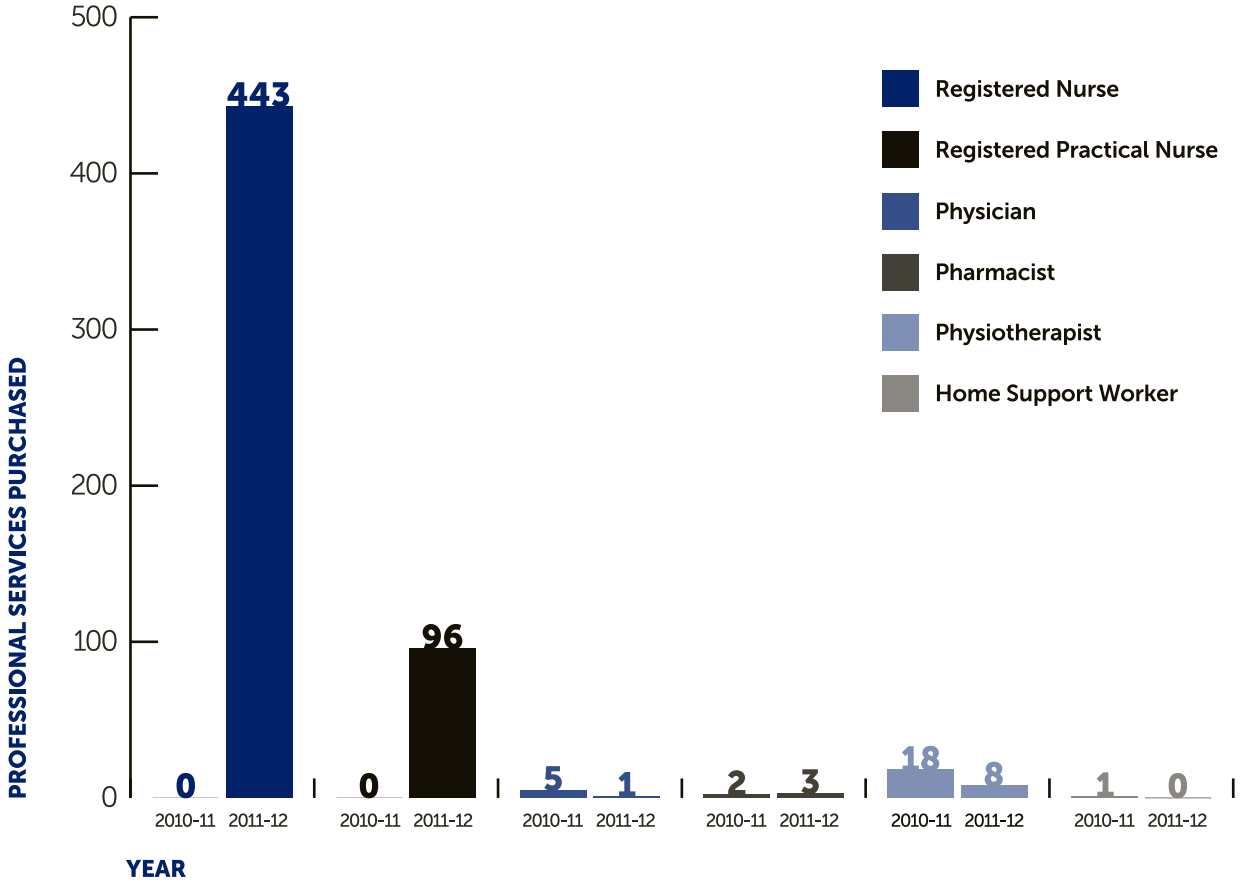
Nursing and home care services are contracted based on individual assessed needs.

In 2010, the RCMP revised its Health Care Entitlements and Benefits Programs Policy (AM XI.1). The graphs represent the number of claims (a claim may represent multiple units of service) paid by the provider type within nursing and home care provisions in the current policy.

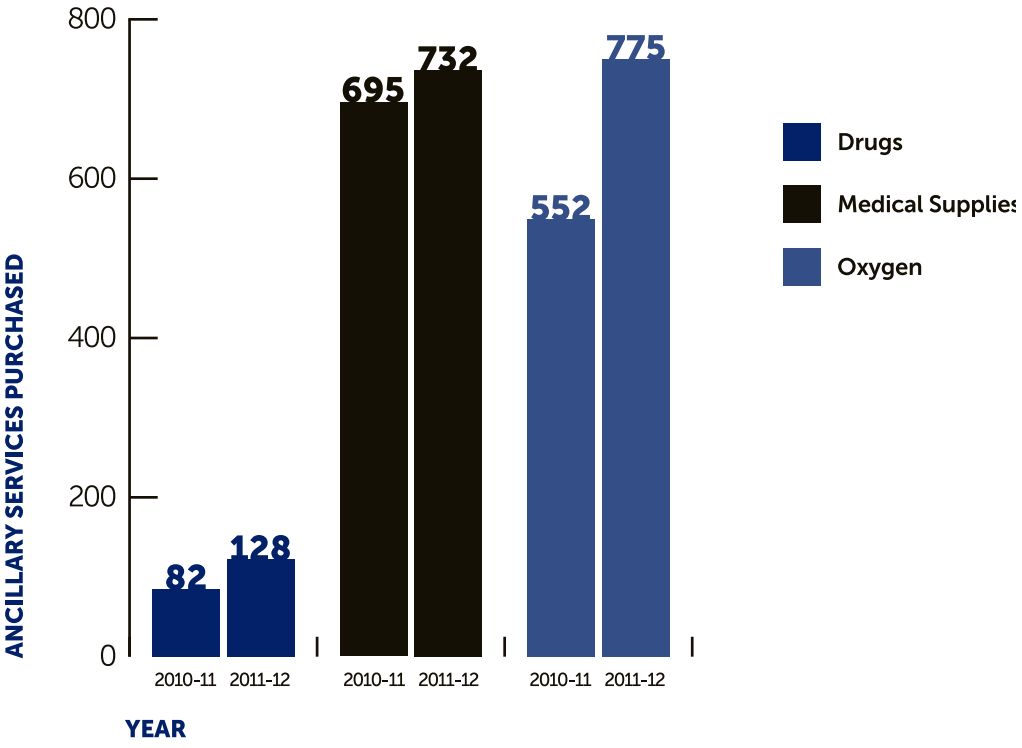
In 2011/12 the RCMP provided 533 outpatient visits by an RN/RNA, out of which 407 were for the purpose of home care treatment by a registered nurse, for a cost of $56,000. This represented an average of 0.6 visits per member receiving home care provisions.

For ancillary support services, the amount of public expenditures on home care products in 2010/11 was $486,012 and in 2011/12 was $546,491. The expenditure on breathing supplies, including oxygen, pressure breathing apparatus and sleep apnea machines represented the majority of the cost at $388,532. The expenditure on walkers, wheelchairs, and canes was $8087 in 2011/12.

Services Purchased – HHR



Services Purchased – Ancillary



3. Quality & Accountability

HOME CARE INDICATORS

The home care indicators that are currently monitored at a national level include:

- Amount of service delivery.
- Expenditures.
- Home care admissions (nursing).
- Referral source.
- Client disposition at discharge.

QUALITY & ACCREDITATION

The RCMP reports to the Canadian Institute for Health Information on annual health care expenditures for each province of business. The RCMP coordinates all the research and trend analysis of its health care benefits programs (this includes nursing and home care services) at the national policy centre – Occupational Health and Safety Branch. The RCMP also partners with other federal health care programs to strengthen research work and consultations with professional medical associations and institutions. Given the program's mandate, the RCMP does not have a Centre of Excellence or a research team dedicated to home care.

Better Health – Better Care – Better Cost

Triple AIM, is a roadmap to achieving excellence, high performance and high value health care:

1. Enhance the individual (patient) experience of care (including quality, access, and reliability).

2. Improve the health of populations.

3. Reduce, or at least control, the per capita cost of care for populations.

Institute for Healthcare Improvement, Triple Aim Improvement Community. (Massachusetts: Institute for Healthcare Improvement, 2012).

4. Information Technology

Electronic Health Record (EHR)

The RCMP does not have an electronic health record system; rather, members' medical files are maintained to document work related injuries, restrictions affecting members' fitness for duty and/or authorizations used to support additional health coverage.

5. Health Human Resources

CLINICIANS PRACTICING IN HOME CARE

For nursing and home care services to be covered at the RCMP expense, they must be received from qualified health care professionals who are legally practicing in their health discipline and are recognized by the RCMP. The RCMP health care professionals involved in disability case management provide an oversight of community health delivery. This is supported by multidisciplinary teams including: HSO (Health Services Officer- physician), a Psychotherapeutic Program Coordinator (psychologist), a Disability Case Manager (nurse), an Occupational Health Nurse for organizational assessments, an Occupational Safety Officer, and support staff.

FAMILY CAREGIVER

Respite coverage would be equivalent to what is available through provincial health care plans and the Workers' Compensation Board. Compassionate leave is available as per Administration Manual II-5. RCMP National Compensation Services is the policy centre responsible for this policy.

6. Initiatives

The RCMP Occupational Health and Safety Branch reviewed the RCMP Health Care Entitlements and Benefits Programs Policy (AM.XIV.1) in 2009/2010, followed by a comprehensive review of the Health Benefits Grid in 2010/2012. A number of initiatives are undergoing development to further modernize the RCMP health services and programs.

7. Challenges

Modernization efforts of the RCMP health care services and programs are underway. The RCMP continues to align with health care program standards being developed and delivered by provincial/territorial agencies.

8. Opportunities

The RCMP recognizes the need for nursing and home care services for members who are suffering the effects of an illness or injury. Because so many RCMP members are subjected to physical relocation to areas of Canada where they may not have the support of family or close friends, it is important that the RCMP health care programs facilitate appropriate and timely access to nursing and home care services.

The next five years will see continued enhancements and modernization of RCMP health services and programs that will focus on alignment and clarification of the program expectations and service delivery levels.

ACRONYMS / ABBREVIATIONS

OHC -	Occupational Health Care
OHSS -	Occupational Health and Safety Service
OIC -	Officer in Charge
HQ -	Headquarters
HSO -	Health Services Officer
PWGSC -	Public Works and Government Services Canada
RCMP -	Royal Canadian Mounted Police
VAC -	Veteran's Affairs Canada

SOURCES

The chapter has been compiled from sources listed below, interviews with key informants and feedback to an electronic survey. Information replicated from provincial materials has been done so with the knowledge and permission of the key informant.

Canadian Home Care Association. Portraits of Home Care in Canada 2012 Questionnaire. Issued May 2011.

RCMP website: http://www.rcmp-grc.gc.ca/

The RCMP. Occupational Health and Safety Branch, Health Benefits Program, OHSB_Health_Benefits_Program@rcmp-grc.gc.ca

Canadian Home Care Association
canadienne de soins et services à domicile

www.cdnhomecare.ca