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A FRAMEWORK FOR NATIONAL PRINCIPLE-BASED HOME CARE STANDARDS

ALIGNMENT OF STANDARDS

PRINCIPLE-BASED STANDARDS

provide **high- level guidelines** for policy and program.

OPERATIONAL / SERVICE STANDARDS

establish **operating procedures** for quality, efficient care.

CLINICAL PRACTICE STANDARDS

set **clinical guidelines and pathways** for optimal patient care.

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ALIGNMENT OF STANDARDS

Example: Person- and Family -Centred Care

Principle-Based Standard	Operational Standard	Clinical Standard
Patients' and carers' needs are identified using an evidence-informed assessment tools	• The provider designs the assessment process with input from clients and families. • Any existing assessments or care plans for the clients are identified and related information is collected from the client, family and other service providers. • The care plan and assessments should be conducted by an appropriate member of the client's care team.	Evidence-informed assessment scales customized for clinical applications (e.g. stroke, pain, dementia)

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PRINCIPLE-BASED HOME CARE STANDARDS

ARE:	ARE NOT:
High-level guidelines that support implementation of core home care values	Rigid rules that are static and unchanging
Norms for home care policy and service delivery	Clinical practice guidelines and pathways
Evergreen and will improve over time in response to stakeholder expectations	Required organizational practices
Customizable and adaptive to unique populations and jurisdictional needs	Inflexible statements that assume ‘one-size fits all’

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FOUNDATION BASED ON
THE HARMONIZED PRINCIPLES FOR HOME CARE

6 core values for home care programs across Canada

PATIENT- AND FAMILY-CENTRED CARE
Patients and their carers are at the centre of the planning and delivery of care.
- Foster autonomy and self-sufficiency.
- Integrate safety practices into all patient care and service delivery.
- Respect and address psychosocial, physical and cultural needs.
- Acknowledge patients and carers' unique strengths and engage them as partners in care.

EVIDENCE-INFORMED CARE
Patients receive care that is informed by clinical expertise, patient values and best available research evidence.
- Collect and apply research evidence, provider expertise and patient experience.
- Use standardized tools and supports to strengthen the quality of services and programs delivered.
- Create a culture of innovation and ingenuity.

ACCESSIBLE CARE
Patients and their carers have equitable and consistent access to appropriate care.
- Provide care that is responsive and consistent among providers and across jurisdictions.
- Promote patients' and carers' understanding of care needs and options, and consequences of decisions and actions.
- Customize care to the unique needs of patients and their families to ensure appropriate care.

INTEGRATED CARE
Patients' needs are met through coordinated clinical and service-level planning and delivery across multiple professionals and organizations.
- Build strong foundational partnerships between home care and primary care.
- Optimize system resources and seamless navigation through care coordination.
- Facilitate joint planning, decision-making and open communication.
- Engage health and social care sectors with a focus on continuity for the client.

ACCOUNTABLE CARE
Patients, providers and system outcomes are managed, met and reported on.
- Focus on increasing capacity and improving performance.
- Ensure transparency through user-friendly reporting on service delivery information and outcome
- Use performance metrics and outcomes to inform planning and delivery.
- Foster adaptive leadership and governance to facilitate change and collaboration.

SUSTAINABLE CARE
Patients whose needs can be reasonably met in the home will receive the services and support to do so.
- Use current and future population needs in strategic policy and system planning.
- Modernize delivery through the exploration and testing of new funding and service models.
- Plan and manage health human resources in anticipation of changing supply and future demand.
- Develop strategic procurement approaches to evaluate and adopt innovation and new technology.

FOUNDATION BASED ON THE HARMONIZED PRINCIPLES FOR HOME CARE

Alignment with the Qmentum Accreditation – Quality Dimensions for Program Standards for home care and home support.

ACCREDITATION CANADA
Better Quality. Better Health.

HARMONIZED PRINCIPLES FOR HOME CARE	QMENTUM ACCREDITATION PROGRAM
Patient-and Family-Centred Care	Client-Centred Services
Provide safe care in partnership and consultation with the patient and family; respect patient's privacy, dignity and holistic needs; support autonomy and independence.	
Accessible Care	Accessibility
Provide care that is reliable, consistent, personal and available to all who need it.	
Accountable Care	Commitment to Quality Improvement
Monitor the quality of care; tell people about it; continually work to improve it.	
Evidence-Informed Care	Effectiveness
Provide care based on the best available research evidence, clinical expertise and patient values; share knowledge and innovative ideas.	
Integrated Care	Continuity of Services
Coordinate care with other health services; make information and resources available.	
Sustainable Care	Population Focus/Efficiency
Manage resources efficiently; use current and projected needs to develop strategic policy and system planning.	

WHY NATIONAL PRINCIPLE-BASED HOME CARE STANDARDS?

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IDENTIFICATION OF NEED

PRINCIPLE-BASED HOME CARE STANDARDS

CONFIRMING COLLECTIVE NEED:

Priority action identified through the Better Home Care Plan

OBJECTIVE:

Achieve a level of consistency in access and delivery of home care services across Canada, while respecting jurisdictional autonomy and distinctiveness

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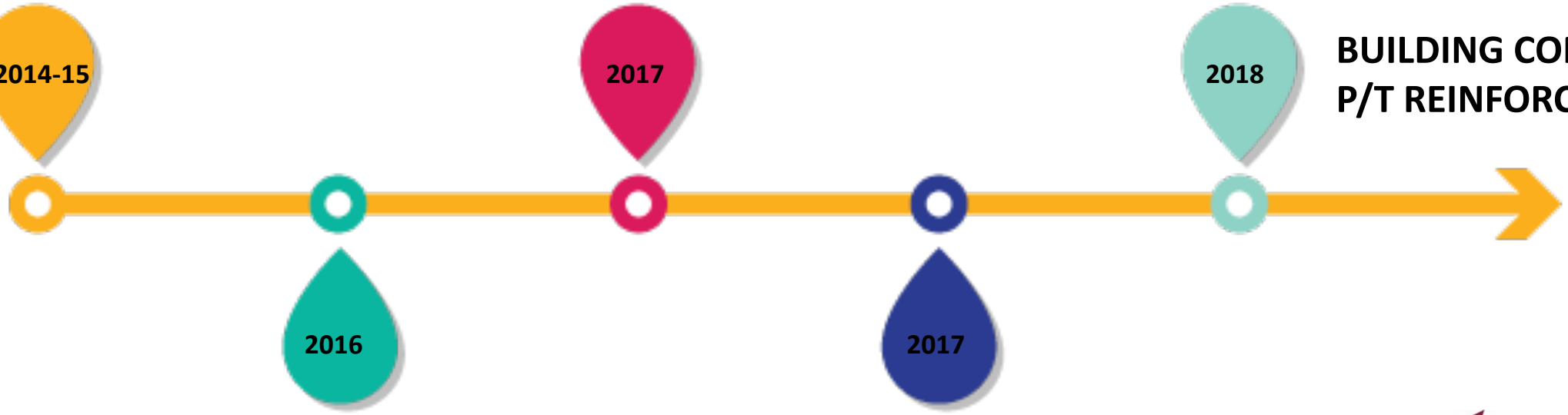
DEVELOPMENT PROCESS

PRINCIPLE-BASED HOME CARE STANDARDS

SETTING THE FOUNDATION

DEFINING THE FRAMEWORK

A consensus process to define the scope, application and development process of the standards. This work is guided by an **Expert Advisory Group**



CONFIRMING COLLECTIVE NEED

BUILDING MOMENTUM & AWARENESS

BUILDING CONDITION & P/T REINFORCEMENT

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STRATEGIC CONSULTATIONS (June to November 2017)

Purpose: Identify the scope, key elements and suggested development approach

- 2 rounds of online surveys (n= 144)
- 3 focus groups (n =75)
- Targeted interview format for Quebec stakeholders (n=25)

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GOALS

Set the benchmark for high-quality home care

Inform home care policies, programs and delivery

Facilitate the identification and sharing of promising practices

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OBJECTIVES

The principle-based home care standards will impact policies and programs that enable:

- Person- and family-centred care
- Accessible care
- Accountable care
- Evidence-informed care
- Integrated care
- Sustainable care

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OUTCOMES

The principle-based home care standards will result in:

Increased **accountability** in the home care sector

Greater consistency in the provision of high quality care across geography

Enhanced **person and family centred care**

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CORE ELEMENTS

Home Care Principle	Core Actions	Research Questions
PERSON- AND FAMILY-CENTRED CARE *Patients and their carers are at the centre of the planning and delivery of care.*	• Acknowledge individuals' and carers' unique strengths and engage them as partners in care. • Respect and address the emotional, physical, mental, environment and cultural needs of the individual and their carers.	• What home-based assessment tools and protocols are used to determine needs and strengths of (a) patients and (b) carers? • What conversation strategies and tools effectively support patient and carer shared decision-making?
ACCESSIBLE CARE *Patients and their carers have equitable and consistent access to appropriate care.*	• Care delivery is responsive and consistent among providers and across jurisdictions. • Care meets unique needs of individuals and their carers.	• What models support effective home care in urban vs. rural settings? • How does technology facilitate access to home care?
ACCOUNTABLE CARE *Patient, provider, and system outcomes are managed, met, and reported.*	• Performance metrics and clinical outcomes inform planning and delivery. • User-friendly reporting of service delivery and outcomes metrics.	• How are effective performance indicators for home care developed and used? • What elements need to be considered for effective reporting on home care performance and outcomes?

Home Care Principle	Core Actions	Research Questions
EVIDENCE-INFORMED CARE *Patients receive care that is informed by clinical expertise, person values, and best available research evidence.*	• Collect and apply research evidence, provider expertise and individual experience. • Use standardized tools and methodology.	• How are clinicians supported to make evidence-informed decisions? • What strategies are effective in measuring patient and carer experience?
INTEGRATED CARE *Patients' needs are met through coordinated clinical and service-level planning and delivery involving multiple health and social care providers and organizations.*	• Optimize system resources and seamless navigation through care coordination. • Build strong foundational partnerships between home care, primary care and acute care.	• What are the core elements needed for successful integrated care models that include home care, primary care and acute care?
SUSTAINABLE CARE *Patients whose needs can reasonably be met in the home will receive the services and support to do so.*	• Health human resource and social capacity planning. • Strategic policy and system planning.	• How are community resilience and human resource planning being used to predict future demand and optimization home care delivery?

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ALIGNMENT OF STANDARDS

Example: Person- and Family-Centred Care

Principle-Based Standard	Operational Standard	Clinical Standard
Communication strategy is in place to support patient and carer shared decision making	• Written and verbal communication and instructions are adapted to facilitate client and family understanding. • Translation and interpretation services are available for clients and families as needed • Verifies that the client and family understand information provided about their care	Practice standard for nursing documentation

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ALIGNMENT OF STANDARDS

Example: Accessible Care

Principle-Based Standard	Operational Standard	Clinical Standard
Information and telecommunication technologies are used where appropriate to facilitate access to home care	• Providers have policies and procedures in place, designed with input from clients and families, to govern the delivery of virtual services. • Providers have a process in place to address confidentiality and privacy as they relate to virtual health services and communication.	CNO's practice guideline for telepractice (help nurses to understand their accountabilities when providing care using information and telecommunication technologies)

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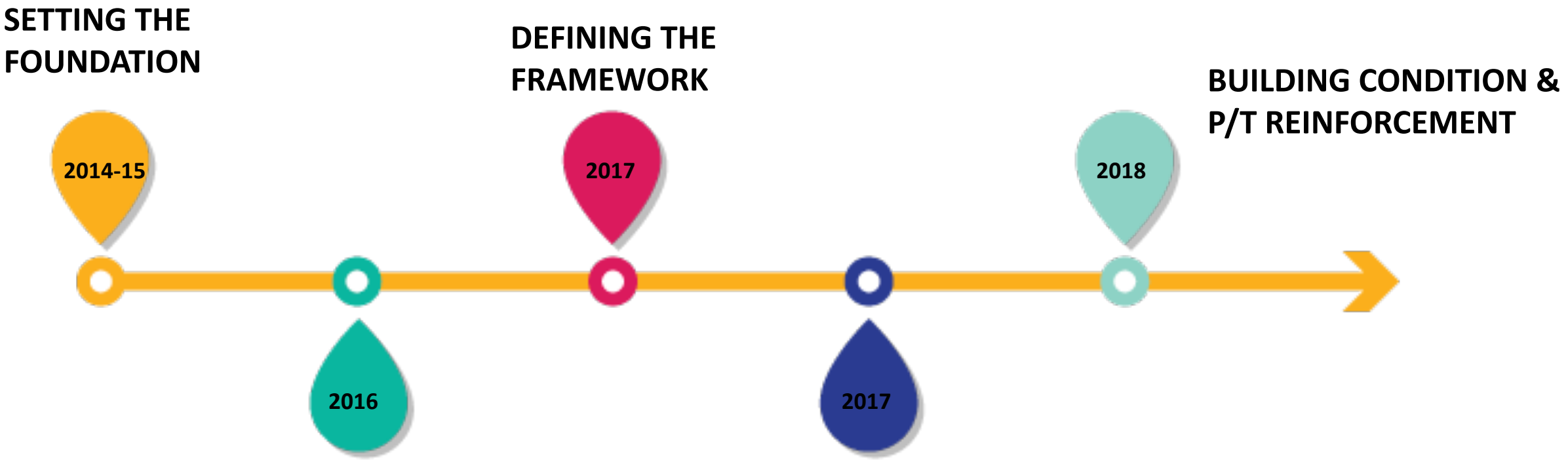
KEY CONSIDERATIONS

- Adaptability
- Engagement
- Knowledge translation and evaluation

WHAT'S NEXT?

PRINCIPLE-BASED HOME CARE STANDARDS



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NATIONAL PRINCIPLE-BASED HOME CARE STANDARDS

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