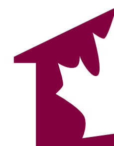
HOME CARE LENS
FOR POLICY AND SERVICES
Facilitating Collaboration and Integrated Care

USER GUIDE



Canadian Home Care Association
canadienne de soins et services à domicile

ABOUT THE CANADIAN HOME CARE ASSOCIATION

Working together to strengthen integrated home and community-based care

The Canadian Home Care Association (CHCA) is a national non-profit membership association dedicated to advancing excellence in home and community care. Through our diverse membership base, the CHCA represents public and private organizations who fund, manage and provide services and products in the home and community sector. Our vision is an integrated health and social care system that provides seamless patient- and family-centred care that is accessible, accountable, evidence-informed and sustainable.

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An aging population, changes within the hospital system and medical advances are transforming health care in Canada—the delivery and setting of care. Health care delivery has evolved to focus on being proactive, with greater emphasis on health promotion, chronic disease management and independence in an individuals' home and community. Determining the appropriate role and resources for the home and community-based care is often a challenge for policy planners and service providers, specifically in the acute care and primary health care sectors.

As our health system transforms to meet the needs of our aging population, policies and services must optimize the value of home and community-based care, and minimize any unintended negative consequences resulting from the shift from acute care to community. It is in this context that the Home Care Lens can play a vital role in the ongoing evolution of integrated health care.

What is a Lens?

A "lens" is a support tool designed to inform decision-making on the potential effects of new or modified policies and services. It guides users through a series of questions that will stimulate discussion and identify gaps and opportunities.

The Home Care Lens can effect positive change by:

- Guiding the development of new policies and programs
- Assisting reviews of existing policies and programs for potential gaps and/or unintended negative effects
- Supporting the evaluation of integrated policies and programs from a home and community care perspective
- Raising awareness about the role and function of home and community-based care within an integrated health system
- Supporting quality assurance programs, accreditation processes and program reviews in health care organizations

Home Care Lens Outcomes

Using the Home Care Lens tool, whether individually or as a team, provides a vehicle to review a policy or services from a vantage point that considers critical aspects of the home and community-based care environment (i.e., the core components and essential elements). The review will increase awareness and understanding of how effective home and community-based care can impact integrated care models, and may improve the user's own knowledge about home care. The Lens, if used in a group or team setting, will facilitate communication about the core elements of integrated community-based care.

The Home Care Lens is a catalyst for change and can be used:

- TO ASSIST IN THE DEVELOPMENT OF POLICIES AND SERVICES that optimize home and community-based care, and especially those being developed using an integrated model of care
- As the foundation for group discussions on policy and service development or modification
- To improve understanding and awareness of the strengthens and challenges of delivering care in the home and community

The lens can be used in a variety of ways:

- Provides a framework to evaluate community-based integrated policies and services through six fundamental principles
- Raises awareness about the role and function of home care within integrated care models
- Builds a greater understanding of the capacity and limitations of the home care
- Sets a baseline for reviewing existing policies and services for potential unintended negative effects and/or gaps
- Supports quality assurance programs, accreditation processes and service reviews

APPLYING THE HOME CARE LENS WILL RESULT IN:

- Increased awareness of home care as a key part of an integrated health system
- Increased understanding of the unique dynamics and context of providing care in the community through broad-based collaborative engagement
- Increased knowledge of the factors that potentially impact the effectiveness of home care within an integrated health system
- Identification of key issues and challenges impacting home care and integrated care models
- Understanding of the resource needs of new policies/programs as they impact home care

How the Home Care Lens (HCL) Works

The HCL tool is comprised of:

A Policy Lens that is focused on a policy and planning environment

and

A Services Lens that is targeted to operational and frontline decision-making.

For either lens, the logic model begins with three contextual questions to ensure a baseline understanding:

- What is the objective of the policy?
- What types of services are being offered?
- What segment of the population is most likely to be affected by the policy service?
- What are the expected outcomes of the policy service?

Core Components

Each lens guides the user(s) through these six core components that reflect Harmonized Principles for Home Care.1

The Home Care Lens evaluates six core components that frame the content:

- PERSON-AND FAMILY-CENTRED CARE
- ACCESSIBLE CARE
- ACCOUNTABLE CARE
- EVIDENCE-BASED CARE
- INTEGRATED CARE
- SUSTAINABLE CARE

PERSON-AND FAMILY-CENTRED CARE

Patients and their caregivers are at the centre of the planning and delivery of care.

ACCESSIBLE CARE

Patients and their caregivers have equitable and consistent access to appropriate care.

ACCOUNTABLE CARE

Patient, provider and system outcomes are managed, met and reported.

EVIDENCE-INFORMED CARE

Patients receive care that is informed by clinical expertise, personal values and best available research evidence.

INTEGRATED CARE

Patients' needs are met through coordinated clinical and service-level planning and delivery involving multiple health and social care providers and organizations.

SUSTAINABLE CARE

Patients whose needs can reasonably be met in the home will receive the services and support to do so.

For more information on the development and key dimensions of each Harmonized Principle, visit www.cdnhomecare.ca.

Evaluation Scale

A number of questions are posed for each component. These questions reflect a series of actions that are required to take the principle to practice and support the effective role of home care within an integrated model. Users are asked to evaluate the extent to which the policy or service satisfactorily addresses the specific element of the component.

Considerations for Action

Each Core Component section is followed by a series of action questions that provide an opportunity to summarily review your evaluation and discuss the implications for the policy or service.

Summary

After completing each of the six components, a final summary question helps you evaluate your overall satisfaction with the policy or service.

GENERAL CONSIDERATIONS / NOTATIONS

The sub-headings in the Harmonized Principles are not directly reflected in the Home Care Lens tool, rather the Lens tool delves into the concepts reflected in the Principles and translates them into practical policy and program elements.

The Target Populations for the lens tools are ones that are high users of home care. In the Issue framing the term "patient population" will be used. Include current data and mechanisms to determine needs.

SOCIAL DETERMINANTS OF HEALTH[3] INCLUDE:

1. Income and Income Distribution
2. Education
3. Unemployment and Job Security
4. Employment and Working Conditions
5. Early Childhood Development
6. Food Insecurity
7. Social Exclusion
8. Social Safety Network
9. Health Services
10. Aboriginal Status
11. Gender
12. Race
13. Disability

[3] Social Determinants of Health Social Determinants of Health: The Canadian Facts / Juha Mikkonen and Dennis Raphael: http://www.thecanadianfacts.org/The_Canadian_Facts.pdf

[1] For more information on Harmonized Principles of Home Care – visit: www.cdnhomecare.ca.

HOME CARE POLICY LENS

Facilitating Collaboration and Integrated Care

POLICY TITLE : ______________________________

POLICY CONTEXT

1. What is the objective of the policy?

2. Who are the populations most likely to be affected by the policy?

3. What are the expected outcomes of the policy?

OVERALL SATISFACTION WITH THE POLICY

	Extremely	Very	Somewhat	Slightly	Not at all
PERSON-AND FAMILY-CENTRED CARE					
ACCESSIBLE CARE					
ACCOUNTABLE CARE					
EVIDENCE-INFORMED CARE					
INTEGRATED CARE					
SUSTAINABLE CARE					

Overall Comments:

PERSON-AND FAMILY-CENTRED CARE

Patients and their caregivers are at the centre of the planning and delivery of care.
-Individuals' and caregivers' unique strengths and needs are understood, and they are engaged as partners in care.
-Care plans and delivery respect and address the emotional, physical, mental, environmental and cultural needs of individuals and their caregivers.

Note – Consider the patient population needs as they apply to home and community-based care.

	Yes	No	Partial	Don't know	N/A
PATIENT INPUT: Are consultations with target population representatives included in the development of the policy?					
NEEDS OF THE PATIENT/FAMILY: Does the policy include the identification of target population needs (e.g., emotional, psycho-social, physical, spiritual, cultural)?					
DIGNITY AND INDEPENDENCE: Has the impact of the social determinants of health been considered in the policy?					
ETHICS: Does the policy include ethical considerations associated with the target population?					
SAFETY AND RISK: Does the policy include recognition of the potential risks of providing services in an unpredictable home environment to the target population?					
ADAPTABILITY: Does the policy reflect the changing health needs of the target population?					
Does the policy consider health disparities[1] within the target population?					
HEALTH LITERACY: Does the policy include considerations for linguistic competency? [2]					

OVERALL LEVEL OF SATISFACTION WITH THE POLICY RE: PERSON-AND FAMILY-CENTRED CARE

Extremely Very Somewhat Slightly Not at all

ACTION on Person-and Family-Centred Care

Comment:

Resource considerations:

Action/next steps:

1 Health disparities refer to differences between groups of people. These differences can affect how frequently a disease affects a group, how many people get sick or how often the disease causes death. Many different populations are affected by disparities, Racial and ethnic minorities - residents of rural areas; women, children and the elderly; persons with disabilities (NIH: National Cancer Institute).

2 To communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate and individuals with disabilities.

POLICY TITLE : ____________________

ACCESSIBLE CARE

Patients and their caregivers have equitable and consistent access to appropriate care..
-Responsive and consistent care delivery among providers and across jurisdictions.
-Care meets the unique needs of patients and their caregivers

Note – Consider the patient population needs as they apply to home and community-based care.

	Yes	No	Partial	Don't know	N/A
BARRIERS: Have the barriers to access been identified and evaluated for their impact?					
Equitable: Does the policy include fair and unbiased access for vulnerable and at-risk populations?					
Eligibility: Does the policy objective align with the eligibility criteria?					
Technology: Does the policy consider the current and future impact of technology-enabled care?					
UNMET NEEDS: Is there a mechanism in the policy to identify unmet needs?					
Consistency: Does the policy account for the variability across jurisdictions and geographies?					

OVERALL LEVEL OF SATISFACTION WITH THE POLICY RE: ACCESSIBLE CARE

Extremely Very Somewhat Slightly Not at all

ACTION on Accessible Care

Comment:

Resource considerations:

Action/next steps:

POLICY TITLE : ______________________________

ACCOUNTABLE CARE

Patient, provider and system outcomes are managed, met and reported.
- Performance metrics and clinical outcomes are used to inform planning and delivery.
- Service delivery and outcome metrics in reported in a user-friendly way..

Note – Consider the patient population needs as they apply to home and community-based care.

	Yes	No	Partial	Don't know	N/A
PERFORMANCE INDICATORS: Does the policy include a strategy to identify performance metrics that support policy objectives?					
TRANSPARENCY: Does the policy include a method to inform the public and stakeholders on outcomes, impact and value?					
SHARED ACCOUNTABILITY: Does the policy include a governance model with decision-making authority, clear accountabilities and shared risk?					
EVALUATION: Does the policy include an evaluation component and feedback loop?					

OVERALL LEVEL OF SATISFACTION WITH THE POLICY RE: ACCOUNTABLE CARE

Extremely Very Somewhat Slightly Not at all

ACTION on Accountable Care

Comment:

Resource considerations:

Action/next steps:

POLICY TITLE : ______________________________

EVIDENCE-INFORMED CARE

Patients receive care that is informed by clinical expertise, personal values and best available research evidence.
- Collection and application of research evidence, provider expertise and individual experience.
- Standardized tools and methodology are used.

Note – Consider the patient population needs as they apply to home and community-based care.

	Yes	No	Partial	Don't know	N/A
BEST AVAILABLE EVIDENCE: Is the policy based on the best available evidence from relevant, valid sources?					
Is there alignment between the best available evidence and the policy objectives?					
INNOVATION: Does the policy foster innovation?					
KNOWLEDGE TRANSFER: Does the policy support collaborative patient, community and stakeholder engagement?					

OVERALL LEVEL OF SATISFACTION WITH THE POLICY RE: EVIDENCE-INFORMED CARE

Extremely Very Somewhat Slightly Not at all

ACTION on Evidence-Informed Care

Comment:

Resource considerations:

Action/next steps:

POLICY TITLE : ______________________________

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.
- Strong foundational partnerships between home care, primary care and acute care are in place.

Definition of Integration: The management and delivery of health services so individuals within a particular population group receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system [World Health Organization, 2008].

Note – Consider the patient population needs as they apply to home and community-based care.

	Yes	No	Partial	Don't know	N/A
CONTINUITY OF CARE: Is there a framework to identify and coordinate multi-sector (health, social services, housing, etc) engagement to address client population needs?					
Are there mechanisms to sustain multi-sector involvement?					
SETTINGS OF CARE & TRANSITIONS: Does the policy acknowledge various settings of care for the client population?					
Does the policy identify transitions of care across multiple settings?					
COORDINATION & COLLABORATION: Does the policy consider the need for structured agreements/partnerships to support integrated care across the health system (clinical and operational)?					
COMMUNICATION: Is there a strategy to promote ongoing communication among identified stakeholders to support implementation and evaluation?					
CROSS DEPARTMENTAL COLLABORATION: Does the policy reflect cross-departmental involvement (e.g. finance, regulatory, delivery)?					

OVERALL LEVEL OF SATISFACTION WITH THE POLICY RE: INTEGRATED CARE

Extremely	Very	Somewhat	Slightly	Not at all

ACTION on Integrated Care

Comment:

Resource considerations:

Action/next steps:

POLICY TITLE : ______________________________

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 are considered.
- Current and future population needs are used for both strategic policy and system planning.

Note – Consider the patient population needs as they apply to home and community-based care.

	Yes	No	Partial	Don't know	N/A
RESOURCES: Does the policy include a process to evaluate the balance between objectives, resources and outcomes?					
Does the policy include a reimbursement model to support an integrated system?					
PUBLICLY FUNDED RESOURCES: Has the policy considered the appropriate basket of services?					
Does the policy take into account the impact on the management support system(s)?					
BROADER NETWORK RESOURCES: Does the policy take into account resources from public, private and voluntary sectors?					
EMERGING TECHNOLOGY: Does the policy consider new technologies and strategies to apply them?					
INTEGRATED HUMAN RESOURCE PLANNING: Does the policy include a system approach to human resource planning?					

OVERALL LEVEL OF SATISFACTION WITH THE POLICY RE: SUSTAINABLE CARE

Extremely Very Somewhat Slightly Not at all

ACTION on Sustainable Care

Comment:

Resource considerations:

Action/next steps:

HOME CARE SERVICE LENS

Facilitating Collaboration and Integrated Care

PROGRAM NAME: ____________________

OVERVIEW OF SERVICES

1. What type of services?

2. Who are the populations most likely to be affected by these services?

3. What are the expected outcomes for the (a) system (b) population

OVERALL SATISFACTION WITH THE SERVICES

	Extremely	Very	Somewhat	Slightly	Not at all
PERSON-AND FAMILY-CENTRED CARE					
INTEGRATED CARE					
ACCESSIBLE CARE					
EVIDENCE-INFORMED CARE					
SUSTAINABLE CARE					
ACCOUNTABLE CARE					

Comments:

PROGRAM NAME: ______________________________

PERSON-AND FAMILY-CENTRED CARE

Patients and their caregivers are at the centre of the planning and delivery of care.
- Evidence-based assessment tools and protocols are used to determine the needs and strengths of patients and caregivers.
- Conversation strategies and tools effectively support patient and caregiver shared decision-making.

Note: Consider the client/patient and family caregiver needs as they apply to home and community-based care.

	Yes	No	Partial	Don't know	N/A
CLIENT INPUT: Is there a process to get client input on the services?					
NEEDS OF THE CLIENT/FAMILY: Is there an evidence-based assessment tools used to determine (a) client and (b) caregiver needs (e.g., emotional, psycho-social, physical, spiritual, cultural, financial)?					
DIGNITY AND AUTONOMY: Do the services encourage client dignity and autonomy?					
ETHICS: Have ethical issues been considered?					
SAFETY AND RISK: Is there a plan to ensure safety and to mitigate risk in an unpredictable home environment?					
FLEXIBILITY: Are there mechanisms to provide flexible services that reflect the client's changing health needs?					
HEALTH LITERACY: Are tools available to ensure informed decision-making and facilitate shared decision with both the patient and caregiver?					

OVERALL LEVEL OF SATISFACTION WITH THE SERVICES RE: PERSON-AND FAMILY-CENTRED CARE

Extremely Very Somewhat Slightly Not at all

ACTION on Person-and Family-Centred Care

Comment:

Resource considerations:

Action/next steps:

PROGRAM NAME: ______________________________

ACCESSIBLE CARE

Patients and their caregivers have equitable and consistent access to appropriate care.
- Models support effective home care delivery in urban and rural settings and for vulnerable populations.
Technology is available and effectively used to facilitate access to service in the home

Note: Consider the client/patient and family caregiver needs as they apply to home and community-based care.

	Yes	No	Partial	Don't know	N/A
AVAILABILITY: Are there mechanisms to ensure reliable and appropriate access to services?					
NON-DISCRIMINATORY: Is there a process to ensure fair and unbiased access to care?					
APPROPRIATE: Is information available and provided to ensure understanding of appropriate service options?					
WAIT TIMES: Is there a process to ensure access to services meets identified standards?					
UNMET NEEDS: Is there a process to identify and communicate unmet needs?					
TECHNOLOGY: Has the use and impact of technology been considered?					

OVERALL LEVEL OF SATISFACTION WITH THE SERVICES RE: ACCESSIBLE CARE

Extremely   Very   Somewhat   Slightly   Not at all

ACTION on Accessible Care

Comment:

Resource considerations:

Action/next steps:

PROGRAM NAME: ____________________

ACCOUNTABLE CARE

Patient, provider and system outcomes are managed, met and reported.
- Performance indicators for services are developed and used.
- Performance and outcomes are reported in a user-friendly way. .

Note: Consider the client/patient and family caregiver needs as they apply to home and community-based care.

	Yes	No	Partial	Don't know	N/A
PERFORMANCE INDICATORS: Are program performance metrics used to track processes and outcomes?					
TRANSPARENCY: Is there a process to to report on performance metrics?					
SHARED ACCOUNTABILITY: Are there clear roles and responsibilities for measuring, tracking and reporting on performance?					
CONTINUOUS IMPROVEMENT: Are the services continuously reviewed and improved upon?					

OVERALL LEVEL OF SATISFACTION WITH THE SERVICES RE: ACCOUNTABLE CARE

Extremely Very Somewhat Slightly Not at all

ACTION on Accountable Care

Comment:

Resource considerations:

Action/next steps:

PROGRAM NAME: ______________________________

EVIDENCE-INFORMED CARE

Patients receive care that is informed by clinical expertise, personal values and best available research evidence.
- Clinicians are supported to make evidence-informed decisions.
- Strategies are in place to measure the patient and caregiver experience.

Note: Consider the client/patient and family caregiver needs as they apply to home and community-based care.

	Yes	No	Partial	Don't know	N/A
BEST AVAILABLE EVIDENCE: Is there an understanding of where to find the best available evidence to develop or support the services?					
Do clinicians know how to use best available evidence to support their decisions?					
Has best available evidence been applied to the service?					
CLINICAL EXPERTISE: Is there a process to incorporate the expertise of front-line health care providers?					
INNOVATION: Is there a process to share experience and outcomes of the services?					
Are the services based on other leading practices?					
EXPERIENCE: Is there a process to incorporate patients' experiences?					

OVERALL LEVEL OF SATISFACTION WITH THE PROGRAM RE: EVIDENCE-INFORMED CARE

Extremely　Very　Somewhat　Slightly　Not at all

ACTION on Evidence-Informed Care

Comment:

Resource considerations:

Action/next steps:

PROGRAM NAME:

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.
- Integrated care models include home and community-based care, primary care and acute care.

Definition of integration: Services, providers and organizations from across the continuum working together so that services are complementary, coordinated, in a seamless unified system, with continuity for the client [Accreditation Canada].

Note: Consider the client/patient and family caregiver needs as they apply to home and community-based care.

	Yes	No	Partial	Don't know	N/A
STAKEHOLDERS: Are multiple stakeholder involved in the service delivery?					
CONTINUITY OF CARE: Are there processes to support the continuity of care across stakeholders?					
TRANSITIONS: Is there a mechanism to support seamless transitions between care settings?					
COORDINATION AND COLLABORATION: Is there a process to facilitate care coordination and collaboration among and between clients and their family caregivers and stakeholders (primary health care)?					
COMMUNICATION: Is there a process to facilitate effective communication between clients, caregivers and stakeholders?					

OVERALL LEVEL OF SATISFACTION WITH THE SERVICE RE: INTEGRATED CARE

Extremely Very Somewhat Slightly Not at all

ACTION on Integrated Care

Comment:

Resource considerations:

Action/next steps:

SERVICE NAME?

PROGRAM NAME:

SUSTAINABLE CARE

Patients whose needs can reasonably be met in the home will receive the services and support to do so.
- Health human resource planning includes recruitment, utilization and retention.
- Community resources are considered in service planning.
- Current and future population needs are used for service planning.

Note: Consider the client/patient and family caregiver needs as they apply to home and community-based care.

	Yes	No	Partial	Don't know	N/A
RESOURCES: Is there a process to allocate financial and human resources to support the service?					
Is there a process to evaluate the effective and efficient use of resources?					
CHANGE MANAGEMENT: Does the program include a change management strategy to support adoption?					
EMERGING TECHNOLOGY: Has technology been considered in resource planning?					
CAPACITY BUILDING: Have the human resource needs been considered?					
Do the service support collaborative partnerships?					
Have the training and development needs of the staff been considered					
SYSTEM SUPPORT: Has the expertise and capacity of partner organizations been considered?					

OVERALL LEVEL OF SATISFACTION WITH THE SERVICE RE: SUSTAINABLE CARE

Extremely | Very | Somewhat | Slightly | Not at all

ACTION on Sustainable Care

Comment:

Resource considerations:

Action/next steps: