Canadian Home Care Association
canadienne de soins et services à domicile

Portraits of Home Care in Canada

2008

The National Voice of Home Care

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Government representatives, professional association staff, home care leaders and managers and providers all contributed to the gathering of information to describe home care as it is operationalised in their province, territory or program. They sourced information, reviewed reports and read and reread the descriptions and patiently provided feedback throughout the process. These individuals reviewed their databases, drew on their experiences and shared their knowledge of home care, thereby enabling this report to become a reality.

The undertaking was huge.... The results are impressive. Portraits of Home Care in Canada is the only comprehensive articulation of home care programs across Canada.

The Canadian Home Care Association Board of Directors provided invaluable guidance and direction throughout the project and extends a special thank you to Marg McAlister, MMC Consulting who led the project and provided expertise and diligence in the development of the project framework, the data collection, writing and review process.

It is our intention that this report will serve as a basis for discussion and further learning and advancement of home care across Canada.

Nadine Henningsen
Executive Director
Canadian Home Care Association
March 2008

About the Canadian Home Care Association

The Canadian Home Care Association (CHCA) is a not-for-profit membership association dedicated to ensuring the availability of accessible, responsive home care and community supports to enable people to stay in their homes with safety, dignity and quality of life. Members of the Association include organizations and individuals from publicly funded home care programs, not-for-profit and proprietary service agencies, consumers, researchers, educators and others with an interest in home care. Through the support of the Association members who share a commitment to excellence, knowledge transfer and continuous improvement, CHCA serves as the national voice of home care and the access point for information and knowledge for home care across Canada.

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

Executive Summary

1. INTRODUCTION

Governments and health care stakeholders across Canada recognize the integral role of home care within the health care system. This recognition stems from a number of events and subsequent reports that identified home and community based care as one of the key strategic areas that must be developed in order for our health care system to address the current and future needs of Canadians. Beginning in the late 1990's with the restructuring of hospitals and the movement to providing care "closer to home", to the Romanow Report in November 2002, that described home care as the next essential service and *"one of the fastest growing components of the health care system,"*[1] and the subsequent 10-Year Plan to Strengthen Health Care in September 2004, that stated *"home care is an essential part of modern, integrated and patient-centered health care"*[2] and identified standard services for acute, palliative and acute mental health home care; this sector has undergone enormous growth.

Over the past decade, home care has been a critical part of health care restructuring and has played a key role in primary health care, chronic disease management and aging at home strategies across Canada. Home care programs across Canada have experienced a 51 percent increase in the number of home care recipients to approximately 900,000. Not only are governments recognizing the importance of home care, Canadians have also identified the need for more home based health care services, as shown in the results of a recent survey[3] on health care where 78 percent of the participants supported developing more home and community care programs.

In the 2008 "Portraits of Home Care in Canada", the Canadian Home Care Association (CHCA) undertook an update of their 2003 "Portraits of Home Care in Canada" report with the intent to provide federal, provincial and territorial home care leaders the opportunity to have their voices heard through their descriptions of home care as it is known and understood within each of their respective jurisdictions, at the time their data was assimilated. This report reflects the incredible advancements that home care programs have undergone in the past 5 years, identifies the current challenges and documents the vision of home care in our future health care system.

Building on the CHCA's 2003 "Portraits of Home Care in Canada" report, this updated report provides more recent and relevant information on public home care programs and strategic directions in health care across Canada. Information was collected using the same framework as in the 2003 Portraits document. Additional sections describing strategic priorities, technology, safety, health human resources and decision support systems were added to reflect the expanded role and new influencers affecting health care and home care. The basic framework for data collection included:

1. Governance and Organization
2. Services
3. Quality and Accountability
4. Initiatives
5. Challenges
6. Vision of Home Care
7. Last Word

1. Commission, Building on Values: The Future of Health Care in Canada – Final Report, November 2002, 171.
2. http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index_e.html
3. 10th Annual Health Care in Canada Survey, November 2007

The CHCA's definition for home care - *"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 informal (family) caregiver"*; is reflected in most of the federal, provincial and territorial home care programs across Canada. It reflects the enhanced role of home care in our evolving health care system.

We understood from the onset of this project that gathering data for some of the areas of interest would be challenging, as the information might not be readily available or not collected / reported at a provincial level. The opportunity that the absence of data affords us is to define a clear vision of which information about home care delivery is vital to the monitoring and evaluation of home care programs and what is required for strategic planners and decision makers.

The 2008 Portraits of Home Care also includes federally funded and administered home care programs - the First Nations and Inuit Home and Community Care program, the Veterans Independence Program, the Royal Canadian Mounted Police Health Services Program and the Canadian Forces Health Services Program.

The CHCA cannot emphasize enough that this document is a qualitative collection of information that describes home care as it is commonly known or understood within each federal, provincial and territorial program. 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 to the document serves as a strong reinforcement for common client assessment tools and comparable data reporting. Provinces and territories have shown progress in the adoption of the interRAI-Home Care that incorporates rigorous internal standards for clinical assessment protocols and the outcome measures that inform decision-making at the "person" (client) level and provide quality indicators at the organizational level. Additionally progress on the CIHI Home Care Reporting System, is seen across Canada. This system with a minimum data set and standard home care client grouping will provide a source for standardized, longitudinal, comparable data and indicators to support: quality improvement, planning and accountability,

The CHCA strongly encourages policymakers and other decision-makers to consider these home care "snapshots", as a description at a point in time, and to recognize that work continues toward building stronger home and community care systems in their jurisdictions. Our approach to health and wellness in Canada will change dramatically over the next decade and the delivery of care will reflect where individuals have the greatest longitudinal interaction with the health system - in their communities through visits to their family doctors; and through self-management of their health conditions in their homes and communities. The health policies we develop, the people we recruit and train and the support systems we build now will shape the health care landscape tomorrow. Building upon the momentum and advancements in the home care community sector across Canada, we can ensure an accessible, high quality health care system for generations to come.

2. GOVERNANCE & ORGANIZATION

(A) STRUCTURE

While the overall governance structure that supports the planning, funding and delivery of home care services across Canada has not changed since the last publication of Portraits of Home Care in Canada in 2003, there are three significant changes that should be highlighted:

- Over the past three year, the Ontario government has introduced significant changes to the organizational structure that governs home care.
- Prince Edward Island has undergone a major reorganization of the health and social service system in 2005.
- A recent decision by government of Nova Scotia to transfer Continuing Care services, including Home Care, to the District Health Authorities by 2009.

In 12 of 13 provinces and territories, home care services fall under the jurisdiction of the respective Ministries of Health. The exception is New Brunswick (NB) where professional health care services or the 'Extra-Mural Program' falls under the jurisdiction of the NB Department of Health and Wellness and long-term home support services are administered by the NB Department of Social Development (formerly the Department of Family and Community Services).

The provincial / territorial ministries provide leadership and overall direction for home care through provincial legislation, policies, global funding decisions and health service standards and accountability frameworks. The ministries provide funding, administer legislation and regulations, set and ensure compliance with policies and guidelines for their health care system.

The organization responsible for the direct planning, management and delivery of home care services varies depending upon the jurisdiction.

- In British Columbia, Alberta, Saskatchewan, Manitoba, New Brunswick, Newfoundland, the Northwest Territories, and Nunavut, the **Regional Health Authorities** (or similar entities) , which are the governing bodies of the health regions, are provided with global funding from the province and are responsible for setting priorities for health services in the region and planning, managing and delivering home care services.
- In Ontario, the 14 **Local Health Integration Networks** (LHINs) who are responsible for the planning, integrating and funding of local health services, including home care services, work in partnership with the 14 **Community Care Access Centres** who are accountable for the planning, delivery and ongoing operational management of home care services.
- In Quebec, at a regional level, 18 **Regional Authorities** (*agences de la santé et des services sociaux*) have responsibility for strategic planning and organization for their respective jurisdictions and the allocation of resources between the institutions and communities in their region. In collaboration with their respective Regional Authority, 95 **Health and Social Services Centres** (CSSS) are responsible for the delivery and operational management of home care services.
- In Nova Scotia, Prince Edward Island (PEI) and the Yukon, home care services are delivered and managed through the provincial / territorial government (although services are in the process of being devolved in Nova Scotia). In PEI, home care services are managed, coordinated and delivered through the provincial program reporting to the health minister through the Director of Community Hospitals & Continuing Care. In the Yukon, the Department of Health and Social Service, Continuing Care Branch of the Yukon Territorial Government administers the home care program.

(B) LEGISLATION

One of the factors that distinguish home care programs across the country is the difference in, or lack of, specific legislation throughout the jurisdictions. The Canada Health Act recognizes home care as an element in the category of "extended health services", and, as such, it is not an insured health service to which the principles of the Act apply. Currently, eight (8) provinces and one (1) territory have legislation that impacts public home care through various Acts. Other provinces and territories have Orders- in-Council, guidelines or policies that direct the delivery of their home care services. This lack of a specific legislative framework for home care contributes to the wide variation in access and availability of services across Canada.

For the nationally funded and administered home care program the Veterans Independence Program, the health services for the Canadian Forces and RCMP have legislated Acts that impact home care. There is no legislation governing the First Nations Inuit Health Commuity Care (FNIHCC) program, however the program received Cabinet approval in 1999.

(C) EVOLUTION

Home care in Canada has emerged from the first program established in 1970, when Ontario first established a publicly funded home care program, to 1988 when all provinces and territories supported publicly funded programs for both acute or short-term care and chronic or long-term care needs. Through out the 1980's home care programs underwent restructuring and addition of services to meet public demand. The nationally funded and administered Veterans Independence Program was launched as an alternative care model for aging WWII Veterans to provide home care and community based institutional care as a pilot project.

The late 1990's saw an expansion of services and organizational changes into regional health authorities and other community based approaches to service planning, coordination and delivery. Nationally funded and administered programs for First Nations and Inuit and the Royal Canadian Mounted Police were developed in response to increase demand for home based care. The newly established home care program for Nunavut occurred in 1999.

Across Canada there was a notable increase in activities in the home care sector and expansion of home care services from 2002–2007 resulting from the increased recognition of home care and the September 2004 10-Year Plan to Strengthen Health Care which identified a core set of services for acute, palliative and acute mental health home care.

3. SERVICES

(A) MANDATE

Principles and Objectives

While individual provinces and territories vary in their mandate and principles for home care services there are consistent themes that transcend all programs across Canada. In general, home care programs across Canada 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. Home care services 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 services help people with a frailty or with acute, chronic, palliative or rehabilitative health care needs to **independently live in their community** and to ensure **co-ordination and management of admission to facility care** when living in the community is not a viable alternative.

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. Home care programs encourage and support the care provided by the family and/or community. Programs typically arrange for support and relief for family caregivers and provide individuals with information about, and make referrals to community-based services, long-term care homes, and other services. Home care programs across Canada embrace the principle of client-centredness and the concept of choice that is driven by the needs of the individual. Increasingly there is recognition that family caregivers must be considered as clients apt to require services of their own, as well as being partners able to provide services within their abilities.

While the objectives of home care across Canada are clearly stated, the reality of accessing necessary services is often impeded by available resources and funding limitations. Home care policies, services and their delivery vary greatly across the country, as each home care program evolved in response to the needs of their community and existing resources. An example of this variation is in the availability of supportive services for individuals with long-term chronic conditions which may include home support, homemaking and options for assisted living facilities.

Priorities

Home care is recognized as an essential component of an integrated, sustainable health care system and as such the home care programs priorities support the achievement of the overall health priorities in all jurisdictions. Home care plays a vital role in improving the health and wellness of individuals, providing high quality health care and optimizing the efficiency and effectiveness of health care delivery.

Key priorities specific to home care that are reflected across the country include:

- Adopting an "Aging in Place" or "Aging at Home" strategy by expanding the range of care options (home maintenance, housekeeping, nutrition, social interaction, respite, etc.) available to seniors and people with physical disabilities to ensure they receive appropriate care in the most appropriate setting, and to enable them to remain independent and in their own home or community for as long as possible.
- Planning for the future by implementing the common client assessment instruments (interRAI-HC) to effectively gather client data and support analysis of long-term future capacity requirements for home and community care services.
- Enhancing accountability by implementing and monitoring home and continuing care standards and revising policy and operating guidelines as necessary.
- Improving access to home care services by ensuring structured alignment and linkages with community partners and focusing on staff retention and recruitment.
- Fostering a climate of learning and innovation through the exploration and adoption of the information communication technology to support new service delivery models.

(B) ACCESS

All Home Care programs utilize coordinated access to provide individuals seeking home care, supportive living or long term care facility services with a single access point of contact through which their needs can be assessed and matched to appropriate services. In almost all jurisdictions, anyone can refer an individual for assessment, including self-referral.

While access to home care is generally consistent between rural and urban settings; access and service delivery and response time in some remote communities may be affected by an absence of service providers and human resource challenges. In the northern communities of Nunavut, Yukon and NWT access is generally inconsistent between larger and remote communities.

Waitlists for home care services have resulted mainly from limited human resources and increasing demand. While not all programs collect data on waitlists, there are some instances where individuals are on waiting lists for certain programs (Saskatchewan's Individualized Funding Program, Home Support in Nova Scotia, Therapies in Ontario, etc). PEI has indicated that they are in the process of developing a standard province wide definition and tracking system for wait lists.

It is generally acknowledged that waitlists for services could be a very near reality given the increased demand for services arising from an aging population, an increase in hospital referrals as hospitals work to contain their costs, and in some locations a shortage of health human resources. This future projection creates an impetus for governments to explore new and effective service delivery models to meet the increased client needs and demands of the future.

(C) ELIGIBILTY AND COVERAGE

Eligibility
Most provinces and territories have resident, landed immigrant or citizenship requirements as *basic eligibility* criteria. Federally funded and administered programs identify their employee groups (RCMP, DND, Veterans / Primary Caregivers of Veterans) or resident status (First Nations and Inuit of any age; and who live in an Inuit community, First Nations reserve or First Nations Community North of 60) as basic eligibility criteria. All home care services are provided based on assessment need. The suitability of the home environment for the provision of home care services was also identified by a number of provinces as a requirement of eligibility.

Age
All ages of clients are eligible for home care services across the jurisdictions with the exception of British Columbia, which has separate funding resources home support and adult day services which must be 19 years of age or older and Newfoundland which specifies eligibility for home support services to seniors (65+), persons with disabilities and/or families with children/youth with a disability.

For the federally funded programs the age criteria reflects the program with RCMP employees a minimum of age 19 and normally no older than age 65, and DND and VIP clients adult ages. FNIHB provides services for individuals of all ages.

Income testing
Seven (7) of the provinces and territories and all of the federally funded programs have no income testing for home care services. Of the remaining six (6) provinces with income testing the fees generally apply to long-term supports (i.e. home support) and/or residential care which are tested according to net income. It is important to note that the provinces vary in their approach to income testing as described below:

- British Columbia - home support is an income tested program, with the exception of two weeks post-acute home support or if the client is palliative. In 2005, the Ministry of Health increased the maximum allowable earned income deduction for home support clients aged 19 to 64 who have earned income, and capped home support fees for these clients at $300/month.

- Alberta – home support (not for assessed health care needs) is income tested according to the size of the family and the annual income.

- Saskatchewan - charges income tested fees to clients after their first ten units of service in a month which are $6.96 per unit/ hour, effective October 1, 2007. Subsequent to these first ten units of service, fees are charged based on the client's adjusted monthly income.

- New Brunswick - has income testing for long-term supportive and residential care services according to net income.

- Nova Scotia - has no fees for clients whose net income falls within or below the designated Home Care Nova Scotia client income category or who are in receipt of income-tested government benefits (e.g. Guaranteed Income Supplement, Income Assistance, Family Benefits).

- Newfoundland - has no income testing for those requiring professional health services or short term acute home support but applies a financial assessment for long-term home support services.

Direct fees
Only four (4) provinces (Ontario, Manitoba, Quebec and PEI – who just removed the co-pay requirement for home support services as of April 1, 2007) and the three (3) territories do not charge any direct fees for home care services. The federally funded programs also do not charge direct fees for home care services. Of the other seven (7) provinces, the fees are mainly charged for home support and homemaking services while professional services are provided with no charge. Other direct fees in some regions pertain to adult day care, meal delivery and respite. As a result of the 2004 September 10-Year Plan, many of the provinces have modified their direct fees schedules and included acute and palliative home

support as services that do not require additional fees. The fee schedules set by the provinces are generally based on a sliding scale and take into consideration the income testing and the ability of the client to pay for services. Reference the Eligibility Charts in each chapter to determine the specific fee schedules as set out by the provinces.

Supplies / equipment / medication

The funding of supplies, equipment and medication necessary for the provision of home care services is varied across Canada. While most provinces have implemented a mix of private / public payment for these items, some jurisdictions have modified their guidelines as a result of the 2004 September 10-Year Plan and their commitment to a standard basket of home care services for acute care home care and palliative care home care. The basic supplies, equipment and medications for these home care services are now covered by the provincial plans either through the home care program funding or provincial drug programs.

Limits / guidelines

While all home care services are provided based on assessed need, there is variation in the limits of home care services across Canada. In British Columbia, Nunavut, NWT and the FNIHB home care programs there are no maximum service limits set out in policy at this time. In Alberta the Regional Health Authorities set their own operational guidelines within provincial provisions. Saskatchewan, Manitoba, Quebec, New Brunswick Extra Mural Program, Nova Scotia Chronic Care Program and the Yukon set the upper limit costs based on a formula for equivalent level of institutional care, where costs for home care will not exceed the cost of health care service in a facility. Ontario, New Brunswick home support services through Social Development, and PEI set service limits for nursing and / or home support on a predefined amount of hours. Nova Scotia's acute home care program, Newfoundland and the federally funded VIP program for Veterans set limits for services based on specified dollar values.

Assessment Tools

Assessment and care coordination are considered core functions of all home care programs and often impact eligibility and service delivery. *Assessment tools* are employed across Canada to support case management services in the determination of the client needs and subsequent care plans. A variety of assessment tools are used regionally and include provincially specific assessment tools, as well as, the international data collection tools. One of the tools, which have been implemented by the majority of jurisdictions, is the Resident Assessment Instrument for Home Care (interRAI-HC) which was designed to identify client needs, using the Minimum Data Set for Home Care (MDS-HC). The clinical assessment protocols and the outcome measures that were developed within interRAI are used to inform decision-making at the "person" (client) level. Care planning protocols and outcome measures were created so that health professionals [case managers] can look at an individual client, decide what he or she needs, put together a service package, and then track how that client is doing over time. The quality indicators and organizational level measures are the direct result of the client level decisions. Eight (8) provinces and territories have currently implemented or are in the process of implementing the interRAI-HC assessment tool in an automated format.

The other provinces / territories are using assessment tools that have been designed for their unique needs, such as Quebec with their *Outil d'Évaluation Multi-Clientèle tool*, and in New Brunswick where all three community partners (EMP, FCS and Mental Health) use the same criteria and standardized assessment tool/process to determine the type of care needed by the client for services outside of hospital services. In addition the NWT has developed a Continuing Care Assessment Package. For the federally funded and administered programs, a variety of approaches to client assessments occur. A standardized assessment tool is a requirement for all FNIHCC services and most programs have adopted the standardized assessment tool that is used by their province/territory. VAC references a wide range of assessments, including provincial assessments, as well as Departmental assessments, and "optional tools" which are highly specialized.

(D) FUNDING & SERVICE DELIVERY AUTHORIZATION

Portraits of Home Care in Canada, 2008, contains information on public expenditures for home care services which is largely the responsibility of provincial and territorial governments, with some funding support from the federal government through transfer payments. For federally funded and administered programs, the funding is directly provided by the federal government. Direct comparisons of home care expenditure data should not be made as there are no consistent definitions of home care and no consistent financial criteria relative to expenditures. One can, however, assess the ranges of expenditures across the country and examine the system within each jurisdiction in order to gain some knowledge of the expenditures and trends for provincial, territorial and federal home care programs.

It is evident from multiyear total public expenditure information provided that the costs for home care have been increasing across all jurisdictions. Home care expenditures in the provinces and territories ranged from $82.00 / per capita to $198.00 / per capita in 2005 – 06. As a percentage of the total provincial or territorial health budget, home care expenditures ranged from 1.56% to 6.8%. In itself, this is not conclusive as there is no standard definition for capturing home care expenditures. The reader may instead be interested to examine trends within each jurisdiction.

(E) CLIENT PROFILE

Not surprisingly, the majority of clients receiving home care are seniors aged 65 and over. Home care is however, provided to clients of all ages. A variation to the trend is observed in the Nunavut home care program where 60% of home care clients are under 60 years of age; and with the First National and Inuit Home and Community Care Program where 49% (representing the largest age group) are adults aged 26 to 64 years.

There are approximately 900,000 individuals receiving home care services at any given time across Canada. The percentage of population served by home care services ranges from 1.3 % to 4.8 %. The majority of home care clients require long-term supportive care. Home care services are provided in a variety of settings including individuals' homes, nursing homes, retirement homes, clinics, schools, group homes, hospices, reserves, and on the street for homeless populations. There are variations amongst the provinces and territories as to the settings in which home care is provided.

(F) SERVICE DELIVERY

Service delivery models across the country are a mix of public sector and/ or contracts with the private sector.

Information was also collected on the range of services/specialty services and/or program categories offered through home care. In reviewing this information, it was evident that all jurisdictions provide services and/or programs that are generally designated as assessment and care coordination or case management, nursing and home support / personal care services.

Programs vary as to the extent to which they fund therapy services. Some therapies such as physiotherapy and occupation therapy are broadly funded, while speech language pathology and respiratory therapy are not typically funded or are funded only in a limited capacity.

Provision of homemaking also varies across jurisdictions. Quebec provides a wide range of support services including civic support activities (help with administering budgets and filling in forms), learning assistance, support in familial task and a range of services to support the family and other caregivers. VAC identifies a broad range of supportive services that are funded under the VIP program including, ground-keeping, social transportation and home adaptations to facilitate access / mobility in the home.

The New Brunswick Extra Mural Program reimburses physicians for services provided to EMP clients and Quebec funds physicians through RAMQ.

Only Newfoundland and Ontario indicate that they fund Nurse Practitioner services on a limited basis.

No jurisdictions report funding pharmacy consultations or pastoral care.

A majority of provinces and territories identified that they are collecting data by the CIHI Client Groups: Acute Care Substitution, Maintenance, End-of-life care, Rehabilitation and Long Term Supportive Care. The home care client groups were developed by CIHI in consultation with home care stakeholders to build a common foundation based on the needs that different clients have in the system. The client groups provide a common reference and basis regardless of whether individual programs use different terminology across the country. The Home Care Reporting System contains standard data elements for all the demographic data, administrative data and service utilization that apply to all of these client groups.[4]

4. QUALITY AND ACCOUNTABILITY

(A) ACCREDITATION & QUALITY

This section sought information on levels of accreditation and the use of quality measures that promote excellence in the provision of services and efficient use of resources. The past four years has seen a rise in accreditation of home care organizations and direct service providers. Today, accreditation of home care programs through Regional Health Authorities or on their own is a common occurrence across the country. Eight (8) of the 13 provinces / territories identify that they have achieved or are planning to achieve accreditation through the Canadian Council on Health Services Accreditation (CCHSA). Quebec, Manitoba, Newfoundland and NWT are the only jurisdictions where accreditation is mandatory. In Quebec the accrediting body is the Québec Council of Accreditation.

For the Canadian Forces Health Services, all CF clinics, as well as the entire CF health system, participate in Canadian Council on Health Services Accreditation (CCHSA) accreditation surveys. In addition, a number of CF health care personnel have become CCHSA surveyors, and the Canadian Forces Health Services has been given a seat as a client member on the CCHSA Board of Directors.

While the First Nations and Inuit Home and Community Care program does not require that programs achieve accreditation, FNIHB supports the process for those communities choosing to do so. Thirty-two First Nations and Inuit health delivery organizations are currently accredited (without conditions) through the Canadian Council on Health Services Accreditation (CCHSA).

(B) INFORMATION TRACKING & SYSTEMS

The tracking of home care data is often mixed between provincial and local levels. Some provinces are currently in a transition phase, either devolving the responsibility for information management to the Regional Health Authorities as in British Columbia or adopting new information tracking systems as in Alberta and Newfoundland.

Without exception, provincial and territorial governments collect home care data on expenditures and amount of service delivery. Indicators such as home care admissions and referrals sources are either tracked provincially or may be monitored at the regional health authority/local level and not reported to the province. Other indicators tracked by some provinces and territories include client diagnosis, safety issues, number of home care staff and referrals to community supports.

A common challenge among all home care programs is the ability to capture and utilize dates to inform current and future decisions. The interRAI-HC assessment tool is one source of information for a large proportion of home care clients, supplying clinical and demographic information. With the adoption of the interRAI assessment tool and the work done on minimum reporting requirements that include data elements to support national reporting requirements established by the CIHI through the Home Care Reporting System, the home care sector is advancing towards having the ability to

4. Nancy White, Manager, Home and Continuing Care, Canadian Institute for Health Information, excerpt from the 2008 CHCA Home Care Summit workshop "Data Trends and Accountability"

do comparative analysis of home care clients and services across Canada to identify trends in resource use and establishments of benchmarks for monitoring.

Documentation / Collaboration / Telehealth
This segment was intended to review the development of information communication technology and identify current applications to support service delivery approaches for clinical documentation, communication and collaboration with other health service providers and telehealth.

There currently is large variation in the extent and adoption of information technology to support home care clinical documentation across the country. The electronic home care health record is in early stages. Many provinces have begun introduction of electronic documentation for home care within specific regions, however none have achieved a province-wide approach. Four jurisdictions (Quebec, New Brunswick, Nunavut and NWT) are currently using manual systems for documentation of home care services. The Yukon has engaged in a project funded by Canada Health Infoway which will enhance electronic data capture and is anticipated to have point of care technology implemented within the next 1-2 years.

In a recent report on information communication technology in home care[5], the Canadian Home Care Association (CHCA) strongly recommended that "a comprehensive and effective electronic health record, accessible to health care practitioners across the country, will not be realized until the key elements of the home care sector contribution are embedded." Currently there is no progress towards this vision. All provinces and territories stated that at this point the electronic home care health record is not incorporated into an overall regional or provincial electronic health record for the patient. The CHCA feels this is a lost opportunity for effective and efficient care delivery. Canadians access and receive the majority of their health care services in the community, thus the home and primary care systems should be essential building blocks for any electronic health record. Periodic episodic visits to hospital may be interesting and the treatment approaches enlightening to subsequent care; but generally it is the health needs and care plans of the community which will inform practitioners' care in an emergency.

The application of information communication technology to support interdisciplinary communication and collaboration is somewhat limited in the home care sector and very diverse across the county. While most provinces/territories identified some electronic communications either in a planning or pilot stage, the majority of them did not have comprehensive approaches to enabling integration of home care with other health care sectors through information technology. New Brunswick states, in its discussion papers arising from the Premier's self-sufficiency initiative, that to deliver home care services, electronic delivery/e-health is essential.

Technology linkages between home care and hospitals exist, but few jurisdictions indicate any form of electronic communication between home care and physicians or between frontline home care staff.

Technology applications are being broadly used for submission of indicator data and for financial data exchange between home care programs and the ministry.

Information communication technology applications used in home care that directly impact clients include active monitoring devices, teletriage, tele-monitoring systems – telehealth, telemedicine or telehomecare. Telemedicine uses information and communications technology to transfer healthcare information for diagnosis, therapy and education. Today with the advances of technology, telemedicine applications involve advanced camera technology, videoconferencing technology, store-and-forward technology, and audio capabilities. The past few years have seen rapid advances in this technology application for home care clients across Canada.

- In British Columbia and Alberta and PEI telehealth applications have been introduced to varying degrees across the health authorities primarily to support chronic care. Examples include access to specialists by the physician and for access to enterostomal expertise for wound management.

5. Canadian Home Care Association, "Integration through Information Communication Technology for Home Care in Canada", March 2008

- Saskatchewan has introduced telehealth as an educational tool and is not currently used in the delivery of home care.
- Manitoba, Ontario and New Brunswick use telehealth as a clinical delivery tool for palliative, acute, chronic and rehabilitation patients.
- Quebec and Nova Scotia have implemented telehealth pilots involving home care.
- Newfoundland and Labrador has introduced telehealth into home care to support Healthline Teletriage and has developed a Telehealth Strategic Plan in which home care a priority.
- In the territories, telehealth is used to a limited extent to support case management services, rehabilitation care and chronic care. The Yukon primary uses telehealth to support discharge from hospital to community and is anticipating an expansion of this application resulting from project funding they received from Canada Health Infoway.

(C) HEALTH HUMAN RESOURCES

This section is new to the 2008 Portraits of Home Care as shortages of health and social care professionals have been identified as a major concern in every jurisdiction across the country. There is a perceived shortage of home care workers which is impacted by the general shortage of nurses in Canada and is particularly acute in rural and isolated areas. Human resource shortages exacerbate waiting lists for services, place additional burden on family caregivers and often compromise the quality of care since overburdened providers have insufficient time to visit or follow established treatment protocol.

The majority of personnel employed in the home care sector are para-professionals who provide a range of basic activities to support daily living for clients who have been assessed and found unable to do these activities for themselves. Titles for such personnel include home health aide, personal care worker, home health attendant, and home support worker. Other home care providers are described as professional workers and include nurses, case managers, physiotherapists, occupational therapists, dieticians, social workers, physicians, etc.

According to the Canadian Home Care Human Resources Sector Study, gender and average age of home care worker are particularly significant in defining the shortage of home care workers. Since female workers dominate the sector, the supply of potential workers is less than it would be if there were a tradition of both men and women working in the sector in fairly equal proportions. Informal caregivers are also predominantly female.[6] With the limited resource pool and the aging population, the biggest challenge to home care service delivery in the future is human resources.

Despite the magnitude of the human resource issue, most jurisdictions do not have easy access to the current number of paid individuals working in the home care sector and the number of informal caregivers and volunteers is not well defined. Some provinces indicate current work on province-wide strategies to look at recruitment and retention; and using providers to their maximum capacity.

Two key components of effective retention strategies for health human resources is providing decision support and ensuring a safe working environment. Portraits of Home Care 2008, looked at both these elements across Canada.

The work setting in the home care sector has both positive and negative consequences. Some workers see working in a home setting as an opportunity to have more independence, autonomy and challenge in their work. For others, working in private homes can be a source of stress, given the difficulties of working in often unsatisfactory conditions (e.g., unsanitary houses, conflict with family members) and without close professional supports.[7] Provinces report local approaches to ensuring both client safety and employee safety are priorities will all programs.

6. Cranswick, K. (2003). General Social Survey, Cycle 16: caring for an aging society. Statistics Canada
7. Canadian Home Care Human Resources Study. (2003) Synthesis Report, p8

5. INITIATIVES

Over the past five years, since the release of the 2003 Portraits of Home Care, the provincial and territorial home care programs have experienced huge transformations and major advancements to meet the increasing need and demand for home care. These initiatives have focused on enhancing partnerships and integration of care, linkages with primary health care, new approaches to chronic disease management, offering new and enhanced programs for populations with specific care needs, and made use of information technology to augment and improve service delivery. The following are examples of some of the recent initiatives demonstrating special projects and areas of excellence:

British Columbia: Seniors and Aging - In November, 2006 the Premier's Council on Aging and Seniors' Issues released a report entitled *"Aging Well in British Columbia"*[8] which provides recommendations for how society can support the independence, participation, and health and well-being of older people in B.C.

Alberta: Primary Health Care - A pilot project funded by Health Canada's Primary Health Care Transition Fund demonstrated the effectiveness of linkages between home care and primary care. Home care programs in all regions are now involved with the Primary Care Networks.

Saskatchewan: Provincial Diabetes Plan - A key priority for diabetes teams in Saskatchewan is a proactive team approach for the prevention and management of chronic conditions like diabetes. At the regional level, front line Primary Health Care teams and diabetes teams have been working in collaboration to improve the delivery of services and continuity of care for people living with diabetes. Funding has been provided to support the implementation of the *"Live Well with Chronic Conditions"*[9] program in all health regions over the next three years. The program is aimed at teaching individuals the skills needed to manage the day-to-day challenges of living with a chronic health condition.

Manitoba: Service Integration through Case Management - Case Coordinators are assuming more responsibility provincially and have expanded in functions beyond coordination. Winnipeg regional health authority has developed an *Integrated Service Coordination Practice Model* for clients who have cross-program/ complex needs.

Ontario: End of Life Care – A strategy which will help shift care of persons in the last stages of their life from hospitals to home or another appropriate setting of their choice; will enhance an interdisciplinary team approach to care in the community; and will work towards better coordination and integration of local services. Specifically, the Ministry of Health and Long-Term Care (MOHLTC) will: (a) fund CCACs to provide additional nursing and personal support services for people in their own homes (b) provide funding support for nursing and personal support services in residential hospices to over 30 communities by 2007-08 (c) support strengthening the role of hospice volunteers.

New Brunswick: Technology - A Provincial Telehealth Strategy was developed for the province. This Strategy contains actions relating to the EMP and the delivery of services closer to home. In addition to this, a demonstration project was carried out in one area of the province to test the utilization of home monitoring for home healthcare clients with chronic conditions. A comprehensive evaluation was conducted as well regarding the outcomes of this project and is available.

Nova Scotia: Systems Enhancement - In May 2006, the Department of Health reached a milestone with its release of the *Continuing Care Strategy for Nova Scotia: Shaping the Future of Continuing Care*.[10] The strategy launches work on a 10-year action plan to improve and expand the province's continuing care system.

Newfoundland: Healthy Aging - The government's *Healthy Aging Policy Framework*[11] released in 2007 outlines six policy directions to support its older population. They embrace such things as putting in place age friendly government policies, programs and services, and ensuring people, as they age, "have the best possible physical, emotional, social, mental and spiritual health and well-being."

8. http://www.cserv.gov.bc.ca/seniors/council/docs/Aging_Well_in_BC.pdf
9. http://www.saskatoonhealthregion.ca/about_us/strategic/transforming_live_well.htm
10. http://www.gov.ns.ca/health/ccs/ccs_strategy/default.htm
11. http://www.health.gov.nl.ca/health/hlthaging/healthy_aging_implementation_plan.pdf

PEI: Integrated Systems Management (ISM) - is fully implemented. ISM is an electronic data base used to collect information on all community based clients, including home care clients. The home care program is exploring the feasibility of expanding the ISM capacity for more detailed client information including care plans.

Nunavut: Seniors and Aging - Seniors are supported through elders group for socialization, activities and meals in many communities. Elders are a respected member of the community thus interventions to support that person are incorporated where ever possible. The program will support individuals and families to keep people in the home as long as possible.

Northwest Territories: Pediatrics and Youth – Regions employ the 'Great Kids, Inc.', home visiting and professional development model.

Yukon: Health Records - The Yukon Home Care Program has made substantive progress in the development of an integrated computerized health record and roll out of the RAI-HC assessment tool. Additionally the home care program has expanded in scope, number of clients and complexity of care.

Canadian Forces Health Services: Integration - Rx2000 employs a holistic approach to health care reform-bringing together health care resources under one command, developing a multidisciplinary approach to health care delivery, uniting the extended Canadian Forces health services family, and building partnerships with the civilian health care sector.

RCMP: System Renewal - The RCMP is undergoing a period of renewal, including policy revision and program enhancement that will support the development of templates and clarification of directives relative to needs assessments, decision making frameworks, alignment with federal agency service expectations, and governance/accountability for programs including home care.

Veteran Affairs Canada: Programming - VAC regularly reviews strategic direction vis-à-vis program service delivery.

First Nations and Inuit Home and Community Care: Collaboration - At the national level, FNIHCC staff are involved in a number of inter- and intra-departmental working groups on many health issues.

6. CHALLENGES

The number one challenge concerning home care that provinces face is **health human resources** - recruitment, ongoing education and retention of trained staff. Across Canada there are shortages of health care workers and the home care sector will be disproportionately impacted due to the aging population which typically develops long term chronic conditions and will require ongoing health services in their home and community. While the acute care experience is an important episodic event, Canadians have the greatest longitudinal interaction with the health system in their communities – through visits to their family doctors and management of their health conditions in their homes and communities. It is therefore not surprising that the ability to meet increased demands for community based services will be challenged by the limited health human resources. Not only are home care stakeholders faced with a lack of paid human resources, family caregiver who provides up to 80% of the care at home are also limited. As was articulated by the respondents from the Northwest Territories, "Care for the Caregiver support services need to be enhanced." The success and future sustainability of our health care system depends on the other supports that are in place for the patient, including caregiver and family support.

Compounding the human resource challenge is the **increased demand for home care as a result of our aging population**. A constant reality for home care stakeholders is the escalating costs of staff, technology and equipment coupled with increasing demand for services and limited funding and resources. As the demand for health care for an aging population with chronic disease shifts to the home and community sector, policy planners and health care stakeholders must explore new service delivery approaches and support a paradigm shift from acute institutional based investments, where there have been multi-generational solutions implemented to a focus on community where in fact the majority of the healthcare is delivered and experienced.

As home care continues to evolve, provinces and territories identify **increased client acuity and complexity of care** as a key consideration. This challenge has ramifications not only on the paid care provider but also the family caregiver who are often required to assist loved ones with complex care and coordinate multiple services in their homes.

Advances in technology are one of the most important trends which will impact how we provide home care services to the client, how direct service providers communication and interact and how the system tracks and plans for the future. The introduction of new technology and the expanding use of in-home medical technology will impact human resource requirements, training needs and the overall approach to the delivery of home care in the very near future.

7. VISION OF HOME CARE

Our approach to health and wellness has evolved over the past decade and will continue to change dramatically over the next decade. The health policies we develop, the people we recruit and train and the support systems we build now will shape the health care landscape and essential role of home care in an integrated health care system.

The vision of home care reflected by provinces, territories and federally funded home care programs is one of respect and client independence, accessible and flexible services, collaboration with health partners and communities, effective resource utilization and embracing innovation in order to continually challenge our approach to meeting the health care needs of Canadians.

8. LAST WORD

Provinces and territories know that home care programs are laying the foundation today for our health system of tomorrow. Through their initiatives, integration with primary health care and applications of new technologies, home care programs are evolving to realize their potential in within our health care system. The advances observed over the past five (5) years since the release of our last Portraits of Home Care in 2003, have reinforced the potential for realizing the CHCA vision for a comprehensive, responsive home care program accessible to all Canadians regardless of where they live.