About the Canadian Home Care Association

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

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

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

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

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

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

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

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

Together we can make this happen.

Nadine Henningsen
Executive Director
Canadian Home Care Association
HOME CARE IN CANADA
BY THE NUMBERS...

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<th>1.4 MILLION</th>
<th>$5.9 BILLION</th>
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<tr>
<td>Number of individuals receiving home care (2011) (provincial, territorial and federally funded programs)</td>
<td>Public expenditures on home care (2010) (provincial, territorial and federally funded programs)</td>
<td>Ratio of seniors (65 plus) receiving home care (2011) (average across Canada)</td>
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<tr>
<td>4.0%</td>
<td>5 Million</td>
<td>55%</td>
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<td>Percent of publicly funded health care budget spent on home care (2010) (provincial, territorial programs)</td>
<td>Number of family caregivers in Canada(^1)</td>
<td>Percentage increase in the number of home care clients (2008-2011)</td>
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\(^1\)Canadian Caregiver Coalition, 2008

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

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

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

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

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

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

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

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

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

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

- **Ontario**'s 14 Local Health Integration Networks plan and integrate local health services; fund a wide range of providers; and manage service agreements with hospitals, community care access centres, community support services, long-term care, mental health and addictions and community health centres. Community Care Access Centres are responsible for the administration and delivery (directly or contracted) of home and community care.

- **Quebec**'s 95 Local Health and Social Services Networks encompass all health stakeholders (including physicians) with a Health and Social Service Centre (CSSS) at the core of the network that is responsible for administration, management, delivery, monitoring and coordination of services (community services, home care, long-term care centres, hospitals).

- **New Brunswick** shares responsibility for home care between the Department of Health (Extra Mural Program) and the Department of Social Development (long-term home support services and residential care).
• The **Yukon** is not regionalized and the Department of Health and Social Services is responsible for administration and delivery of home care services.

• The **Northwest Territories’** eight Health and Social Services Authorities are also responsible for the planning and management of social services.

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

**LEGISLATION**

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

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

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

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

• **Accessible Care:** Canadians have equitable, appropriate, consistent access to home care, and are fully informed of the care and services options available to them.
• **Evidence-Based Care**: Knowledge that is grounded in evidence is used as the foundation for effective and efficient care provision, resource allocation and innovation.

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

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

**EVOLUTION**

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

- **1959**
  - Ontario funded six acute home care pilot projects.

- **1970**
  - Ontario formally established a home care program.
  - Home care services available for Canadian Forces personnel through the Department of National Defence.

- **1972**
  - Quebec’s home care program started.

- **1974**
  - Manitoba’s home care program was established through an Order-in-Council to provide services to all age groups.

- **1975**
  - Newfoundland & Labrador provided home care services on a limited basis.
  - Northwest Territories implemented a home care program in Yellowknife only.
  - Ontario phased in chronic home care services province-wide.

- **1978**
  - British Columbia introduced a province wide long-term care program.
  - Alberta’s home care programs provided professional services only for those 65 years of age or older.
  - Saskatchewan introduced a comprehensive program of home care.
  - Northwest Territories expanded home care services throughout the territory.
1979
- The New Brunswick Extra-Mural Hospital was founded with a broad mandate to provide an alternative to hospital and/or long-term care facilities.

1981
- Veterans Independence Program (VIP) launched as a pilot project to provide home care and community-based institutional care to aging WWII Veterans.

1985
- Newfoundland and Labrador provided home support services for seniors and persons with disabilities.
- Alberta expanded home care to include support services and palliative care.

1986
- PEI implemented a home care support program.

1988
- Quebec expanded the home care program across the entire province.
- Nova Scotia introduced a coordinated home care program for individuals over the age of 65 with limited income or long-term disabilities.
- Yukon implemented a Home Care Program.

1999
- FNHI received Cabinet approval for their Home Care Program.
- RCMP entered into Memorandum of Understanding with VAC to participate with a private health claims administrator.

2003
- Nunavut developed specific standards, policies and procedures for home care.
- Full service delivery of home care in 97 percent of FN communities and 100 percent of Inuit communities.

2003 - 2010
- Organizational restructuring and increased accountability mechanisms.
- Integration and enhanced access and service coordination.
- Policies and standards developed and revised.
- Strategies to increase access to home care (service maximums, expanded sites of care).
- Expansion of the range of home care services to include: palliative care, children with complex care needs, self-managed care, mental health, and telehealth applications.
- Aging in Place/Healthy Aging Strategies developed and implemented.
- Focus on integrated models of primary care and home care.

2011 - 2013
- Governments announce focus and direction to shift emphasis of care to home and community in nine jurisdictions (British Columbia, Alberta, Saskatchewan, Ontario, Quebec, New Brunswick, Prince Edward Island, Newfoundland & Labrador and Northwest Territories).
- Recognition of the vital role of the family caregiver in legislation, policy and practice.
Access, Funding & Service Delivery

ACCESS TO HOME CARE

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

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

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

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

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

- Alberta is accelerating discharge from the emergency department (for seniors and disabled adults) through the 'ED2Home' program that provides enhanced home care services to keep seniors safe, healthy and independent in their homes and to reduce the number of avoidable emergency department visits.
All jurisdictions use standardized assessment tools to determine client needs prior to the initiation of service. Seven locations use the Resident Assessment Instrument-Home Care (RAI-HC), a standardized, multi-dimensional assessment system used to assess frail elderly individuals or persons with disabilities to identify issues related to functioning and quality of life. The electronic assessments provide real-time data for frontline clinical decisions, as well as amalgamated data to support system management, quality improvement and policy-making.

ELIGIBILITY AND SERVICE GUIDELINES

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

SUPPLIES AND MEDICATIONS

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

CO-PAYMENTS AND INCOME TESTING

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

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


**SETTING OF CARE**

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

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

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

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

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

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

**FUNDING**

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

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

As a percentage of total provincial/territorial public health expenditures, home care spending in 2010/11 accounted for 4.1 percent, with variation across the country from 6.4 percent in New Brunswick and 5.8 percent in Manitoba to 2.4 percent in Alberta and 1.8 percent in the Northwest Territories.
Per capita spending on home care varies among provinces and territories ranging from $266.00 in Newfoundland to $150.00 in Ontario and $90.00 in PEI, with an average spending of $150.00. There are numerous causes for the variation in home care expenditures across the country including, service eligibility and limits, remuneration of home care workers, administration costs, delivery (balance between institutional versus community-based services), geography and travel costs, population density, population health needs and age.

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

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

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RANGE OF SERVICES

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

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

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

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

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

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

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

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

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

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

DATA COLLECTION AND REPORTING

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

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

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

ACCREDITATION

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

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

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

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

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

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

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

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

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

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

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

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

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

RESEARCH

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

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

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

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

**ELECTRONIC HEALTH RECORD**

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

**SYSTEM TECHNOLOGY**

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

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

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

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

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

- The **Veteran Independence Program** uses an electronic case record system that incorporates client assessment and case planning tools.
TECHNOLOGY TO SUPPORT DIRECT CLIENT CARE

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

Health Human Resources

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

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

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

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

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

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

- The Nova Scotia Department of Health and Wellness has developed a comprehensive human resource strategy with short and long term strategies to address continuing care staff shortages.
A broad range of health care professionals are involved in the delivery of home care services. Physicians play an active role in home care, particularly in chronic disease management, palliative care, acute care, rehabilitation, and complex care. Pharmacists provide community-based home care teams with information and tools to identify and resolve medication problems. Numerous health care professionals are directly involved in providing home care including nurses, physiotherapists, occupational therapists, dieticians, respiratory therapists, speech language pathologists, and social workers.

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

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

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

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

**FAMILY CAREGIVERS**

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

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

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

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

**INFORMATION & SUPPORT PROGRAMS**

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

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

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

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

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

**FINANCIAL MEASURES**

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

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

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

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

**HOME CARE EXPANSION & FUNDING STRATEGIES**

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

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

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

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

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

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

**SENIORS, AGING IN PLACE & HOME CARE**

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

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

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

- **Ontario**’s Aging at Home strategy supports seniors to remain independent in their communities through expanded alternative options for care, specialized assessments and intervention in long-term care homes, the Home at Last/Home First program, and the Assisted Living for High Risk Seniors Policy.
• **Quebec** released a multi-ministry policy ‘Vieillir et vivre ensemble, chez soi, dans sa communauté, au Québec,’ in 2012, to guide the development of services for the elderly, with home care as a cornerstone.

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

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

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

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

**CHRONIC DISEASE MANAGEMENT & HOME CARE**

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

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

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

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

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

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**Home care plays a vital role in chronic disease management.**

• Access to a wide range of community-based services.

• Support health promotion and illness prevention strategies.

• Partner in team based care with shared accountability.

*(National Home Care and Primary Health Care Partnership Project, Canadian Home Care Association, 2006)*
END-OF-LIFE CARE (PALLIATIVE CARE)

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

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

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

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

PRIMARY HEALTH CARE & HOME CARE

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

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

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

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

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

**AN AGING POPULATION & INCREASED DEMAND**

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

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

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

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

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

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

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

*(Revera Report on Ageism, November 2012)*
**CURRENT CAPACITY & LIMITED RESOURCES**

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

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

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

- Residents will have the majority of their health needs met by health quality community-based health care and support services (British Columbia)
- Recommendations to pursue policy opportunities in primary care, continuing care and mental health (Alberta)
- By 2017 seniors will have access to supports that will allow them to age within their own home and progress into other care options as their needs change (Saskatchewan)
- Strategies that will transform the health care system to one that is proactive and emphasizes care in the community (Ontario)
- Policy to allow seniors to remain in their homes and communities for as long as possible (Quebec)
- Recognition of home care as an essential component of the vision of One Island Health System (Prince Edward Island)
- Revitalize and strengthen community and long-term care services throughout the province (Newfoundland & Labrador)
- Ensuring people have the majority of their health and social needs met by high quality, community-based support and care (Northwest Territories)

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

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

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

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

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

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

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

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

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

Meeting the Technology Challenge

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

The first is **awareness and assessment of technology-based innovations**.
- How do decision makers learn about what is technologically possible?
- What technology works in their respective organizational, spatial and jurisdictional contexts?

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

Third is **sustainability**.
- What funds and resources will support the longer term roll-out of innovations across a system?

*(A Vision for Technology in Home Care, Canadian Home Care Association, 2013)*
An Opportunity to Realize a Vision

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

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

- Adoption of harmonized principles for home care that will reinforce a vision and set a foundation for the identification of common indicators and sharing of best practices.

- Introduction of fiscal policies and planning to ensure adequate resources.

- Integration of home care and primary health care.

- Application of new technologies and knowledge to support data collection, analysis and reporting that ensure accountability and evidence-based decision-making.

- Development of human resources strategies that recognize the vital role of family caregivers in the provision of home and health care.

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

_The strategic decisions we make, the legislation and policies we create, the targets and goals we strive for, and the people we nurture, will shape the future of our health care system and our country._
CLIENT AND FAMILY-CENTRED CARE
Clients and their family caregivers are at the centre of care provided in their home.

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

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

**Independence:** Foster autonomy and self-sufficiency.

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

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

**Safety:** Minimize and manage risk.

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

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

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

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

**Comprehensible:** Ensure understanding of services and options available.

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

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

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

**Quality:** Monitor performance indicators to support continuous improvement.

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

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

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

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

**Innovation:** Support a culture of innovation and ingenuity.

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

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

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

**Coordination:** Reduce disparities through care coordination.

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

**Prepared:** Enable timely access to information and resources.

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

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

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

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