

BETTER HOME CARE IN CANADA

A National Action Plan



A collaborative partnership between:

Better Home Care in Canada Partners

The Canadian Home Care Association (CHCA) advances excellence in home care and continuing care through leadership, awareness, advocacy and knowledge.

The College of Family Physicians of Canada (CFPC) is the voice of family medicine in Canada and advocates on behalf of its members to ensure high quality in the delivery of care.

The Canadian Nurses Association (CNA) is the national professional voice of more than 139,000 registered nurses and nurse practitioners in Canada from coast to coast to coast.



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For more information on Better Home Care in Canada: A National Action Plan, visit <http://www.thehomecareplan.ca>

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BETTER HOME CARE IN CANADA

A National Action Plan

Home care is an array of health and support services provided in the home, retirement communities, group homes, and other community settings to people with acute, chronic, palliative, or rehabilitative health care needs. Services offered through publicly funded home care programs include assessments, education, therapeutic interventions (nursing and rehabilitation), personal assistance with daily living activities, help with instrumental activities of daily living*, and carer† respite and support.

Home care is a priority for all Canadians—for patients and their carers, for health care providers, and for governments. In recognition of this, the Canadian Home Care Association (CHCA), the Canadian Nurses Association (CNA), and the College of Family Physicians of Canada (CFPC) worked together to develop Better Home Care: A National Action Plan. The Action Plan aims to advance this priority by setting out recommended actions, measurable indicators, and specific considerations for the federal government in partnership with the provincial and territorial governments.

* The Canadian Institute for Health Information defines the activities of daily living as personal hygiene, toileting, locomotion, and eating and instrumental activities of daily living as meal preparation, housework, medication management, shopping, and transportation.

† Carers Canada defines a carer as a person who takes on an unpaid caring role for someone who needs help because of a physical or cognitive condition, an injury, or a chronic life-limiting illness.



Our Vision for Home Care

BETTER HOME CARE: A NATIONAL ACTION PLAN reflects the philosophy that home, not a hospital or long-term care facility, is the best place for an individual to recover from an illness or injury, manage long-term conditions, and live out their final days.

Home care is an essential part of an integrated health system that provides seamless patient- and family-centred care and supports for older adults living with frailty; those with complex, chronic disabling conditions; and individuals at the end-of-life. The achievement of this vision would result in:

- Patients accessing the health care and support services they need when they need them outside of the hospital.
- Patients and health care team members working together, and easily accessing and sharing relevant health information and care plans.
- Recognition of carers as partners in care, who know where and how to access resources and support.
- Individuals' health care wishes at the end-of-life being shared, understood, respected, and acted upon.

Meeting the Complex Chronic Needs of Older Adults Living with Frailty

The number one challenge identified by all provincial, territorial, and federal home care programs is the impact of our aging population on home care demand and service complexity. Older adults living with frailty are the group with the greatest demand for home care services, with one out of every six seniors (age 65 plus) receiving publicly funded home care services. In 2013, more than 1.8 million Canadians received publicly funded home care services; the majority of these services (70%) were provided to seniors age 65 and older.¹

Older adults living with frailty require care and support across a broad range of health care services for a number of health conditions. According to Statistics Canada, in 2012, almost 14% of the Canadian population aged 15 years or older—3.8 million individuals—reported having a disability that limited their daily activities. The prevalence of disability rose from 4% among 15- to 24-year-olds to 43% for persons aged 75 years or older. One in 10 people of working age (15 to 64 years) reported having a disability; among the senior population (65 years or older), the figure was 33%.¹¹

While health care is a provincial/territorial responsibility, transformational change in home care can be achieved only through effective government leadership and engaged home care providers. The federal government's commitment of \$3 billion for home care is a catalyst to achieving this goal. Addressing the needs of older adults living with frailty requires active participation from numerous federal departments, all of which have identified this priority in their ministerial mandates. The Action Plan includes both short-term (one-year), medium-term (three-year), and long-term (five-year) recommended actions. It captures the experience and expertise of policy planners, program managers, and health and social care providers involved in the development and delivery of home care across Canada.

The collaborative work undertaken by the CHCA, CNA, and CFPC from March to September 2016 included the following key components:

Identifying home care priorities and best practices

A framework detailing what Canadians want and need from home care and best practice elements required to meet those needs was developed based on resources and practices that were identified by the Better Home Care partner organizations and used to frame the consultation discussions.

Hosting stakeholder consultations

Four stakeholder consultations were held across Canada (Halifax, Ottawa, Whitehorse, and Calgary) with more than 160 participants representing all levels of government, health administration organizations, home care providers, home care recipients, doctors, nurses, and other allied health care providers.

Conducting a survey of the public and providers

An online survey was administered through our dedicated Better Home Care website (www.thehomecareplan.ca) to gather recommended actions and stories from more than 180 respondents, many of whom are home care recipients.

Harmonized Principles for Home Care

The foundation of the Action Plan, the Harmonized Principles for Home Care reflect the shared values of publicly funded home care programs across the country. Developed through extensive consultations with provincial and territorial governments, home care administrators, and home care providers, the principles articulate the fundamentals of home care without prescribing how services are funded, administered, or delivered. Broadly endorsed by governments and home care stakeholders, the principles reinforce quality and safety standards from both Accreditation Canada's Qmentum program and the Commission on Accreditation of Rehabilitation Facilities' Aging Services standards.

Organized under three themes—patient-centred accountable care, integrated care, and sustainable care—Better Home Care: A National Action Plan outlines a framework for action. The Action Plan is a road map for governments, health care providers, patients, and carers to achieve more and better home care. For each action, the plan indicates the specific area of the federal government that is best suited to take the lead.

Harmonized Principles for Home Care

PATIENT- AND FAMILY-CENTRED CARE

Patients and their carers are at the centre of the planning and delivery of care. This approach serves to:

- Foster autonomy and self-sufficiency
- Integrate safety practices into all patient care and service delivery
- Respect and address psycho-social, physical, and cultural needs
- Acknowledge patients' and carers' unique strengths and engage them as partners in care

ACCESSIBLE CARE

Patients and their carers have equitable and consistent access to appropriate care. This is designed to:

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

ACCOUNTABLE CARE

Patient, provider, and system outcomes are managed, met, and reported. This allows us to:

- Focus on increasing capacity and improving performance
- Ensure transparency through user-friendly reporting on service delivery information and outcomes
- Use performance metrics and outcomes to inform planning and delivery
- Foster adaptive leadership and governance to facilitate change and collaboration

EVIDENCE-INFORMED CARE

Patients receive care that is informed by clinical expertise, patient values, and best available research evidence. This involves efforts to:

- Collect and apply research evidence, provider expertise, and patient experience
- Use standardized tools and supports to strengthen the quality of services and programs
- Create a culture of innovation and ingenuity



INTEGRATED CARE

Patients' needs are met through coordinated clinical and service-level planning and delivery involving multiple health care providers and organizations. The goal is to:

- Build strong foundational partnerships between home care and primary care
- Optimize system resources and seamless navigation through care coordination
- Facilitate joint planning, decision-making, and open communication
- Engage health and social care sectors with a focus on continuity for the client

SUSTAINABLE CARE

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

- Use current and future population needs in strategic policy and system planning
- Modernize delivery through the exploration and testing of new funding and service models
- Plan and manage health human resources in anticipation of changing supply and future demand
- Develop strategic procurement approaches to evaluate and adopt innovations and new technology

Patient- and Family-Centred Accessible Care

Patients and their carers understand the support they can expect and have equitable and consistent access to appropriate care.

National Home Care Standards

WHAT MATTERS TO CANADIANS?* I want consistent, high-quality patient- and family-centred home care so that I can safely stay in my own home.

WHAT CAN THE FEDERAL GOVERNMENT DO? Establish standards and benchmarks to ensure Canadians have equitable access to high-quality home care, no matter where they live.

ACTIONS FOR THE FEDERAL GOVERNMENT

- ➔ (Health Canada and partners) Under the leadership of Health Canada, in collaboration with the Better Home Care partner organizations (CHCA, CNA, and CFPC), undertake an 18-month project[§] to develop **principle-based home care standards** through a consultative process that builds upon the existing Harmonized Principles for Home Care.
- ➔ (Health Canada and Health Quality Councils) Provide leadership to establish, monitor, and report on two to three **national indicators** for equitable access to quality home care.
- ➔ (Federal budget and the Canadian Institute for Health Information (CIHI)) Direct resources to CIHI to **enhance and expand the Home Care Reporting System**** and use of the Resident Assessment Instrument–Home Care (RAI–HC)[©] to capture and report on longitudinal demographic, clinical, functional, and resource utilization information on individuals in Canada receiving publicly funded home care services.

‡ "What matters to Canadians?" statements were developed based on research and reports from the three partner organizations (CHCA, CFPC, CNA).

§ Timeframe projection based on the National Care Standards – Care at Home, 2005 work by the Social Care and Social Work Improvement Scotland.

** The Home Care Reporting System (HCRS) was launched by CIHI in 2006–2007 as a pan-Canadian reporting system to support standardized reporting in publicly funded home care programs. HCRS has incorporated, with permission from inter-RAI, data element definitions of certain key demographic and administrative data elements from the Resident Assessment Instrument–Home Care (RAI–HC)[©] for all home care clients regardless of whether they receive a RAI–HC assessment.



INDICATORS OF SUCCESS

- By March 2018, jurisdictions will have shared values to guide the transformation of home care with the needs of patients and carers at the centre.
- The national home care standards will reference best practice tools and resources as part of an overall policy framework.
- By March 2019, all provinces and territories will provide data to the CIHI home care reporting system and users will have easy access to data.

CONSIDERATIONS

- The Harmonized Principles for Home Care (endorsed by home care and health care stakeholders, patients and carers) define a national home care program and provide a basis for the identification of common indicators, while respecting jurisdictional differences.
- National home care standards will be used to set benchmarks for accessible, equitable, quality services (both publicly and privately funded).
- Standards that support evidence-informed decision making and sharing of best practices will result in better patient care.
- As of 2016, Yukon, British Columbia, Alberta, Manitoba, Ontario, and Newfoundland and Labrador submitted home care data (partially or completely) to CIHI.

National principle-based home care standards enable the modernization of home care in Canada by:

- Providing clarity for patients and families
- Guiding the provision of high quality care
- Supporting integrated community-based models of care
- Framing core competencies and skills development
- Facilitating the sharing of best practices
- Influencing regulations and policies
- Informing funding and delivery strategies
- Set a framework for national indicators

Integrated Care

Patients' needs are met through coordinated clinical and service-level planning and delivery across multiple professionals and organizations.

Integrated Community-Based Care

WHAT MATTERS TO CANADIANS? My health care team works together to help me get the care and support I need outside the hospital.

WHAT CAN THE FEDERAL GOVERNMENT DO? Accelerate the identification, adoption, and adaption of integrated, community-based practices that address the needs of individuals with chronic complex needs, including end-of-life care.

ACTIONS FOR THE FEDERAL GOVERNMENT

- ➔ (Health Canada and partners) Accelerate the large-scale **spread and scale of best practices** by leveraging and enhancing current pan-Canadian resources that are building capacity and improving performance in the home care sector.

My mother-in-law received home care services for palliative care this year. It was a wonderful experience and the family was kept informed of what was going on. The service providers were responsive and had good communication with the palliative care consulting team.

–Family input, Better Home Care in Canada consultation

Screening for nutrition risk, with comprehensive assessment and interventions planned by a dietitian in the home care and primary care settings, could substantially decrease the rates of malnutrition on admission, and may decrease overall admission rates.

–Dietitians of Canada input, Better Home Care in Canada consultation



INDICATORS OF SUCCESS

- Ten jurisdictional home care programs will be actively supported and engaged in adopting and adapting integrated community-based models of care that demonstrate improvements in patient care, population health, and value-for-money.ⁱⁱⁱ
- The needs of patients with complex, chronic, disabling conditions (including end-of-life care) are met through integrated community-based care models as measured by increased patient satisfaction and positive provider experience.
- A reduction in unnecessary emergency room utilization and hospital admittance for complex older adults living with frailty.

I work on the Home First team in Saskatchewan. We work in all of the EDs in the three hospitals and at all acute care sites, to enable clients to leave the ED without needing to be admitted. They can go directly home with therapy services to assess their physical needs and their home environment; to install needed equipment; and to arrange with home care for supportive services.

–Health provider input, Better Home Care in Canada consultation

CONSIDERATIONS

- The benefits of integrated care for complex older adults living with frailty include: increased quality of life and satisfaction with care, enhanced service coordination, improved health outcomes, reduced duplication, and a more efficient health system.
- National resources such as the Home Care Knowledge Network^{††} and the Canadian Foundation for Healthcare Improvement identify promising practices and ways to build capacity in the home care sector.
- There are numerous best practices in integrated community-based care:
 - One Client, One Team™, a model that includes a patient-centred approach; an expanded role for home care in care coordination; strong partnerships between home care and primary care; and collaboration between health and social sectors.
 - Home First™, Home Again™, and Home is Best™ models in Ontario, Nova Scotia, and British Columbia, respectively.
 - The Way Forward Integrated Palliative Approach to Care.
 - The Patient's Medical Home.
- A key pillar of integrated community-based care is leadership from physicians, nurses, and other health care providers, working to their full scope of practice, within fully functioning teams.

^{††} The Home Care Knowledge Network is a practical way for policy, program, and frontline decision makers to access tools and resources, and share practices that will address home care challenges. <http://www.homecarekn.ca>

Information and Communication Technology

WHAT MATTERS TO CANADIANS? Everyone involved in my care (including myself and my carers) can easily access and share my relevant health information and plan of care.

WHAT CAN THE FEDERAL GOVERNMENT DO? Accelerate the adoption of technology in the home care sector and ensure that home care data are captured in electronic records.

ACTIONS FOR THE FEDERAL GOVERNMENT

- ➔ (Federal budget and Canada Health Infoway) Prioritize investment in **technology-enabled home care** (e.g., virtual care, tele-homecare, home care in the electronic record) and reflect this strategic direction in the mandate of Canada Health Infoway.
- ➔ Advance the **scale and expansion of proven tele-homecare solutions** to support patients, families, and their health care teams in effective management of complex health conditions.
- ➔ Support jurisdictions in **expanding existing electronic record** investment projects to include home care (and ensure new investments are contingent on connectivity and interoperability with home care and integrated community models).
- ➔ Provide leadership to help jurisdictions accelerate and deploy **technology to support operational functions** of home care, focusing on ensuring interoperability and access to relevant data.
- ➔ Increase funding and use of **technology-enabled home care** solutions for Indigenous populations.

As a home care case manager, my day-to-day work involves mostly computer work, but the computer program I use is very antiquated and slow, very work intensive. I think the computer programs must be redeveloped and made to be more efficient and user-friendly.

–Survey respondent, Better Home Care in Canada consultation



INDICATORS OF SUCCESS

- A majority of providers in home care have access to and use an electronic record (as reported through Canada Health Infoway annual progress reports).
- Home care clinical reports and care plans are included in the core electronic records for provinces and territories (the current six core systems are client and provider demographics, diagnostic images, profiles of dispensed drugs, laboratory test results, and clinical reports or immunizations).
- Start up, deployment, and/or evaluation projects are occurring for the application of tele-homecare in all jurisdictions across Canada.
- Virtual care is implemented and funded as a care modality for patients receiving home care in five jurisdictions.

CONSIDERATIONS

- Many home care programs are using paper-based documentation and tracking systems that present a major barrier to monitoring and improving patient care.
- Communication technology enables effective integrated community-based care; however, limited access to technology, restricted interoperability, and lack of connectivity impede success.
- Patients and health care providers are ready and eager to implement and use technology solutions.

From the experience that I have had, there seems to be a big black hole between the hospital discharge planners and home care providers. A lack of communication and not enough education prior to discharge results in complex patients being discharged home on a Friday afternoon with little or no planning or care coordination.

–Health provider input, Better Home Care in Canada consultation

Sustainable Care

Provision of care that improves the patient experience and achieves health and system outcomes in a cost-effective manner.

Dedicated Resources

WHAT MATTERS TO CANADIANS? I can access the health care services I need, when I need them, outside of the hospital.

WHAT CAN THE FEDERAL GOVERNMENT DO? Provide dedicated support and resources to accelerate capacity building in the home care sector and facilitate the shift of care delivery from facilities to the home and community.

ACTIONS FOR THE FEDERAL GOVERNMENT

- ➔ (Health Accord) In a new health accord, agreements could include reciprocal multi-year funding arrangements to reinforce commitment to, and financial investment in, home care.
- ➔ (Parliament of Canada) Propose the Standing Committee on Health includes a work priority to explore equitable incentives for Canadians to save and pay for home care privately (e.g., remove GST/HST from all privately paid home care services, tax-relief programs, long-term care savings plan).
- ➔ (Canadian Institutes of Health Research) Initiate a large-scale research project evaluating the long-term impact of shifting health care investments from facility-based care to home- and community-based care.
- ➔ (Federal budget) Support the Council of the Federation's Health Care Innovation Working Group to examine opportunities for pan-Canadian approaches to identifying, testing, and purchasing supplies and equipment for home care formularies.
- ➔ (Employment and Social Development Canada) Enhance and simplify the Canadian Mortgage and Housing Corporation's Accessible and Adaptable Homes program to provide easier access to more individuals.



INDICATORS OF SUCCESS

- A change in home care funding as a percentage of public health spending is reflected in provincial and territorial health care budgets (based on a target of 10% of total public health care spending).
- New models of home care funding are tested and evaluated.
- New options are available to Canadians to pay for necessary home care services that are affordable and best meet their needs.
- Provincial and territorial formularies for home care supplies and equipment streamline access and result in cost savings.

CONSIDERATIONS

- The health care system requires a redistribution of resources to support the increased need and demand for care in the home; home care currently accounts for only 4% of public health care dollars.^{iv}
- Access to therapy services (both the range of services and volume of hours) through home care programs varies widely across the country; this disparity is a concern, as therapists' interventions are effective at increasing independence and decreasing the risk of health deterioration and loss of function.
- Effective care in the home often requires housing adaptation and other considerations to support independent living.
- There is no oversight on pricing and quality for privately purchased equipment and supplies for home care even though many jurisdictions do not include these in their publicly funded services.

My mother was diagnosed with Alzheimer's at 65 and lived at home, cared for by family until she died at the age of 90. Whenever my mother needed medical attention, e.g., for a recurring urinary tract infection, the only solution was to call an ambulance and spend the day in emergency. It would have been so much more cost effective, and less strain on burdened resources, to have a home care nurse come to the house and take a catheter sample after which antibiotics could have been ordered.

–Family input, Better Home Care in Canada consultation

Support for Carers

A carer (also referred to as caregiver or family caregiver) is a person who takes on an unpaid caring role for someone who needs help because of a physical or cognitive condition, an injury, or a chronic life-limiting illness.

WHAT MATTERS TO CANADIANS? As a carer, I am a recognized member of the care team and I know where to get resources and supports for myself and my loved one.

WHAT CAN THE FEDERAL GOVERNMENT DO? Build awareness of the role and value of carers and alleviate the financial burden of being a carer.

ACTIONS FOR THE FEDERAL GOVERNMENT

- ➔ (Employment and Social Development Canada (ESDC)) Federal, Provincial, Territorial Ministers Responsible for Seniors should continue to promote carer readiness.
- ➔ Enhance, expand, and simplify compassionate care benefits^{##} and the family caregiver tax credit.^{\$\$}
- ➔ Support the creation of national standards for workplace inclusivity/participation of carers.
- ➔ (Office of the Prime Minister) Issue a proclamation recognizing the diversity, role, and value of carers on National Carer Day (first Tuesday in April).
- ➔ (Parliament of Canada) Propose the Standing Committee on Health study the policy issues and economic and social impact of self-managed/directed care models to support both patients and carers.
- ➔ (Health Canada) Study the impact that technology can have on supporting and enabling carers and ways to accelerate use of technology.

^{##} Compassionate care benefits are Employment Insurance (EI) benefits paid to people who have to be away from work temporarily to provide care or support to a family member who is gravely ill and who has a significant risk of death within 26 weeks (six months). A maximum of 26 weeks of compassionate care benefits may be paid to eligible people. http://www.esdc.gc.ca/en/reports/ei/compassionate_care.page#h2.1

^{\$\$} Family Caregiver Tax Credit is a non-refundable tax credit created by the federal government to help Canadians who take care of family members. It allows caregivers to claim an additional amount for dependants who have an impairment in physical or mental functions. Those dependants can be your spouse, common-law partner, child or another relative. <http://www.cra-arc.gc.ca/familycaregiver>



INDICATORS OF SUCCESS

- Broad awareness, recognition, and appreciation of the role and contribution of carers across Canada.
- Access to financial programs is simplified and available on an as needed basis.
- Increased understanding of self-managed/directed care and technology solutions by Canadians.
- Carers feel supported when looking after relatives at home, including deaths at home.

CONSIDERATIONS

- Home care depends on the active involvement of the more than eight million carers across Canada.
- Carers provide at least \$25 billion of unpaid care on an annual basis.^v
- With the increasing demand for home care, there is an increasing trend to rely on carers and volunteers. The supply of volunteers is decreasing. The ratio of volunteers of all kinds to home care consumers is projected to decrease by approximately 50% by 2046 (to 6.1 from 12:1 in 2003).^{vi}

I am a 70-year old and have recently retired. My mother is 93 years old, is quite frail and has advanced dementia. She is living in our home near Victoria, BC. I am her primary caregiver. We get 14 hours of home support services per week provided on the weekends. I am using my savings to pay for a qualified support person to be with her Monday to Friday. I am indeed happy that I can take care of my mother, but I am also getting somewhat worn out.

—Family input, Better Home Care in Canada consultation

Health Human Resources

WHAT MATTERS TO CANADIANS? I want to receive care from a health care provider who is qualified, skilled, and compassionate.

WHAT CAN THE FEDERAL GOVERNMENT DO? Fund the development and implementation of a continuing education program to support both unregulated and regulated health care providers.

ACTIONS FOR THE FEDERAL GOVERNMENT

- ➔ (Employment and Social Development Canada (ESDC)) Encourage and incent individuals to choose careers as unregulated home care workers through a federal training grants and awareness program.
- ➔ (Health Canada) Support the development of continuing education standards for unregulated workers and develop proficiency through education and practice standards.
- ➔ (Health Canada) Develop proficiency and leadership skills through the establishment and support of training, education, and practice standards for regulated health providers (e.g., physicians, nurses, therapists).
- ➔ (ESDC) Support community mentorship programs for regulated and unregulated providers (include financial incentives and professional development programs).
- ➔ (ESDC) Improve access to education and training for rural, remote, interprovincial, territorial, and Indigenous populations.

I worked for the Extra Mural Program for 16 years and it was one of the best nursing jobs I had. Working in an autonomous role and being able to use all my nursing skills was amazing.

–Health provider input, Better Home Care in Canada consultation

I am a clinical nurse educator. The demands on nursing far exceed our resources every day! We have many new grads with little experience and knowledge working autonomously and in isolation, often putting our clients at risk. I am the sole educator for a region that serves about 50,000 people.

—Health provider input, Better Home Care in Canada consultation



INDICATORS OF SUCCESS

- A national, recognized continuing education program is established for unregulated workers.
- Governments support the recruitment and retention of appropriate human resources to reflect population-based home care.
- Home care is a mandatory part of the education and practice standards for professional health providers.

CONSIDERATIONS

- Health human resources (availability, skills, and qualifications) are the number one challenge for government programs and private service providers.
- Unregulated workers provide the majority of home care services (70%–80%)^{viii}.
- Transformation change requires adaptive leadership; these skills are in their embryonic stage in the home care sector.
- Home care workers need and want opportunities to develop the skills to meet increasingly complex patient needs, and there is a need to provide interdisciplinary education programs and practicum opportunities at all levels: professional development across the home care sector through specialty training, continuing education, and supportive programs is necessary.
- Geographical issues in rural and remote areas exacerbate the challenges for home care as identified by stakeholders in Yukon, where distance and supply are key challenges.

I am a home care pharmacist and I see many patients admitted to LTC [long-term care] due to not having support with their medications.

—Health provider input, Better Home Care in Canada consultation

Advance Care Planning

WHAT MATTERS TO CANADIANS? My health care wishes at the end-of-life are shared, understood, respected, and acted upon.

WHAT CAN THE FEDERAL GOVERNMENT DO? Increase Canadians' understanding of their options for end-of-life care and the importance of appropriate advance care planning (ACP) and conversations with health care providers.

ACTIONS FOR THE FEDERAL GOVERNMENT

- ➔ (Federal budget) Launch a public awareness campaign to encourage Canadians to talk about and document their wishes for end-of-life care with their health care providers, significant others, and substitute decision makers.
- ➔ (Health Canada) Support health care providers' education and promising practices on end-of-life care that build on current ACP programs and tool kits (e.g., "Speak Up" ACP campaign, Alberta tool kit, Manitoba workbook).
- ➔ (Health Canada) Support mechanisms to ensure access to appropriate supports for grief and family counselling services (e.g., Virtual Hospice).

Too often, loved ones must come to the hospital for end-of-life care because their caregivers are burned out because there are not enough added dollars to hire health care professionals to assist with end-of-life care. Families find themselves faced with a moral dilemma because they had made a promise to have their loved one die at home.

–Health provider input, Better Home Care in Canada consultation



INDICATORS OF SUCCESS

- A federally sponsored awareness campaign is implemented that promotes the value and importance of ACP and options for end-of-life care, and includes measurements that show progress.
- Education and resources for end-of-life care and ACP are accessible to health care providers.
- An increased number of individuals are engaged in ACP with their formal and informal carers.
- Relevant ACP information is readily available to health care professionals across settings.

CONSIDERATIONS

- Home-based palliative care and ACP materials (tool kits, workbooks) are generally accessible to Canadians, but a challenge is that patients don't know what services are available and don't understand the benefits of choosing to die in their own homes.
- A 2013 survey found only 13% of Canadians have completed an ACP, and of those only 5% have discussed their wishes with their doctor; too often, health care providers are unaware of a patient's end-of-life wishes or these wishes are not translated into the planning and delivery of care.
- Moving toward mandatory ACP prior to elective surgery, and checking for its preparation on a regular basis, would assist in normalizing this important practice.

I watched both my mother-in-law and father-in-law have to be transferred to hospital to get sufficient care. Home care did not give enough support as they neared the end of their lives. Even with family support, it just wasn't enough.

–Family input, Better Home Care in Canada consultation

NEXT STEPS

MORE AND BETTER HOME CARE

Publicly funded home care enables individuals to recover from an illness or injury, manage long-term conditions, and live out their final days in their home setting. It lets them age in place surrounded by family, friends, and their community, to which they can continue to make a meaningful contribution. One of the least desirable outcomes for an older adult living with frailty is to be prematurely institutionalized—a potential outcome from the lack of home- and community-based care and support options.

WHERE DO WE WANT TO GO?

Better Home Care: A National Action Plan describes a new paradigm—one that shifts the emphasis of resources and planning from an episodic, acute care model to a supportive, integrated, chronic disease management model. We recognize that our health care system has already made advances in achieving this goal. Better Home Care will ensure that our vision of an integrated health system that provides accessible, responsive services will become a reality and enable people to safely stay in their homes with dignity, independence, and quality of life.

HOW WILL WE GET THERE?

Collaborative and intentional planning, targeted actions, appropriate resources, and strong and resolute leadership will make this happen. The Better Home Care partner organizations are committed to catalyzing change. For the next phase of this work, we recognize our success depends on the active engagement of many participants. Targeted actions to realize better home care include:

- **Federal government:** The partners will create detailed action plans for three priority recommendations within the Better Home Care plan that can be integrated in a new health accord and put into action over the



course of the current government's mandate, with the detailed plan to address:

- spreading and scaling up integrated community-based care delivery models;
 - building awareness and recognition of carers through the Prime Minister's proclamation; and
 - promoting the value and importance of ACPs and options for end-of-life care.
- **Provincial and territorial governments:** The partners will develop specific actions for better home care within the new health accord framework; these actions will relate to the health accord priority areas of mental health and access to prescription medication and address the cross-cutting imperatives to close the gaps in access to home care experienced by Indigenous communities, and highlight opportunities to improve the uptake of innovative solutions.
 - **Patient, provider, and non-governmental organizations:** The partners will host a series of online and face-to-face consultations to solicit direction for and encourage engagement in all recommended actions within the plan.

WHAT WILL WE ACHIEVE?

In five years:

- The federal government and all provinces and territories will provide home care services that reflect the Harmonized Home Care Principles.
- All jurisdictional home care programs will be actively supported and engaged in adopting and adapting integrated models of community-based care that demonstrate improvements in patient care, population health and value-for-money.^{viii}
- A proclamation from the Prime Minister will catalyze increased awareness, recognition, and appreciation of the role and contribution of carers across Canada.
- Forty per cent of Canadians will have completed an ACP, and of those 30% will have discussed their wishes with their primary care provider.

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- Accreditation Canada – The Qmentum accreditation program is designed to focus on quality and safety throughout all aspects of an organization’s services—from governance and leadership to direct care and infrastructure—to the benefit of patients, clients, residents, staff, and volunteers. (<https://accreditation.ca/qmentum>)
- CARF in an independent, non-profit organization that provides accreditation services worldwide. Standards include rehabilitation, home and community services, retirement living, and other health and human services. <http://www.carf.org/home>
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- The Way Forward – is a road map to an integrated palliative approach that supports earlier and more frequent conversations about the goals of care when patients and families are faced with a life-threatening illness. It includes a tool kit of resources and best practices. It offers suggestions for removing the barriers to integrated hospice palliative care, and encourages groups to build opportunities for their own communities. <http://www.hpcintegration.ca/about-us.aspx#sthash.Jsrkb5tg.dpuf>
- The Patient’s Medical Home is a vision where every family practice across Canada offers the medical care that Canadians want – seamless care that is centred on individual patients’ needs, within their community, throughout every stage of life, and integrated with other health services. <http://patientsmedicalhome.ca>
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BETTER HOME CARE PARTNERS



The Canadian Home Care Association (CHCA), incorporated in 1990, is a national not-for-profit membership association representing home care stakeholders from governments (federal, provincial and territorial), health authorities, publicly-funded home care programs, service providers, medical and technology companies, researchers and others with an interest in home care. The CHCA advances excellence in home care and continuing care through leadership, awareness, advocacy and knowledge. www.cdnhomecare.ca



The College of Family Physicians of Canada (CFPC) represents over 35,000 members. The College is the voice of family medicine in Canada and advocates on behalf of its members to ensure high quality in the delivery of care. Education is a key element of our mandate, and the CFPC establishes standards for the training, certification and ongoing education of family physicians; it is responsible for accrediting postgraduate family medicine training in Canada's 17 medical schools. www.cfpc.ca/



The Canadian Nurses Association (CNA) is the national professional voice of more than 139,000 registered nurses and nurse practitioners in Canada from coast to coast to coast. CNA's members include provincial and territorial nursing associations and colleges, the Canadian Nursing Students' Association, the Canadian Network of Nursing Specialties, retired nurses, as well as independent nurses and nurse practitioners from Ontario and Quebec. CNA broadly engages with registered nurses and nurse practitioners and promotes and enhances their role to strengthen nursing and the Canadian publicly-funded, not-for-profit health system. CNA aims to shape and advocate for healthy public policy provincially/territorially, nationally and internationally and advance nursing leadership for nursing and for health. www.cna-aiic.ca