

**HOME CARE PROGRAM LENS**

## Facilitating Collaboration and Integrated Care

### PROGRAM NAME:

**PROGRAM CONTEXT**

What is the objective of the program?

Who are the populations most likely to be affected by the program?

What are the expected outcomes of the program?

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| --- |
| OVERALL SATISFACTION WITH THE PROGRAM |

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| --- | --- | --- | --- | --- | --- |
|  | YES | NO | PARTIAL | DON’T  KNOW | N/A |

CLIENT-AND FAMILY-CENTRED CARE

INTEGRATED CARE

ACCESSIBLE CARE

EVIDENCE-INFORMED CARE

SUSTAINABLE CARE

ACCOUNTABLE CARE

Comments:

**PROGRAM NAME:**

**CLIENT – AND F AMILY -CENTR E D CAR E**

Patients and family caregivers are at the centre of care provided in their home and community.

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

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| --- | --- | --- | --- | --- | --- |
|  | YES | NO | PARTIAL | DON’T  KNOW | N/A |

PATIENT ENGAGEMENT:Is there a process to get patient and family caregiver input on the program?

Needs **Identification**: Does the program include methods to address patient and family caregiver needs (e.g. emotional, psycho-social, physical, spiritual, cultural, financial)?

**Dignity and Independence:** Does the program respect and encourage patient dignity and independence

**ETHICS**: Has the program considered ethical issues?

**SAFETY AND RISK:** Does the program include strategies to manage risk in the home and community setting?

**Adaptability**: Are there mechanisms to provide flexible services that reflect the patient’s changing health needs?

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### OVERALL LEVEL OF SATISFACTION WITH THE PROGRAM RE: CLIENT-AND FAMILY-CENTRED CARE

Extremely  Very  Somewhat  Slightly  Not at all

## ACTION on Client-and Family-Centred Care

Comment:

Resource considerations:

Action/next steps:

**PROGRAM NAME:**

**ACCESSIBLE CAR E**

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

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

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| --- | --- | --- | --- | --- | --- |
|  | YES | NO | PARTIAL | DON’T  KNOW | N/A |

**Access**: Are there mechanisms to ensure reliable and appropriate access to services?

**Equitability**: Is there a process to ensure fair and unbiased access to care?

**Technology:** Has the program considered the application of technology?

**Eligibility:** Does the program have eligibility requirements that are clear and transparent?

**UNMET NEEDS**: Is there a process to identify and communicate unmet needs?

**A** **Consistency:** Does the program include a mechanism to ensure consistency across providers and settings?

### OVERALL LEVEL OF SATISFACTION WITH THE PROGRAM RE: ACCESSIBLE CARE

Extremely  Very  Somewhat  Slightly  Not at all

## ACTION on Accessible Care

Comment:

Resource considerations:

Action/next steps:

**PROGRAM NAME:**

# A C C OUNTABLE 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.

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

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| --- | --- | --- | --- | --- | --- |
|  | YES | NO | PARTIAL | DON’T  KNOW | N/A |

**PERFORMANCE INDICATORS:** Are programs performance metrics used to track outcomes?

**TRANSPARENCY:**Does the program have a process to report on performance metrics?

**SHARED ACCOUNTABILITY:** Does the program define clear roles and responsibilities?

**CONTINUOUS IMPROVEMENT:** Does the program include a quality improvement process?

### OVERALL LEVEL OF SATISFACTION WITH THE PROGRAM RE: ACCOUNTABLE CARE

Extremely  Very  Somewhat  Slightly  Not at all

ACTION on Accountable Care

Comment:

Resource considerations:

Action/next steps:

**PROGRAM NAME:**

# EVIDENCE - INFORMED CAR E

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

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

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| --- | --- | --- | --- | --- | --- |
|  | YES | NO | PARTIAL | DON’T  KNOW | N/A |

**BEST AVAILABLE EVIDENCE:** Is there an understanding of where to find the best available evidence to develop or support the program?

Has best available evidence been applied to the program?

Is there a process to share experience and outcomes of the program?

**Innovation:** Does the program enable innovative service delivery models?

**Experience:** Is there a process to incorporate the experience of front-line health care providers and patients?

**Resources Allocation:** Is there a process to allocate financial and human resources to support the program?

Is there a process to evaluate the effective and efficient use of resources?

**Resource Determination:** Does the program recognize and support collaborative partnerships (private, public, voluntary sectors)?

**Emerging Technology:** Has the impact of technology been evaluated?

**Capacity Building:** Are health human resource staffing requirements included in the program?

Have the training, development needs of staff been considered in the program?

Does the program leverage the expertise and capacity of all partners?

**Change Management:** Does the program include a change management strategy to support adoption?

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

Extremely  Very  Somewhat  Slightly  Not at all

ACTION on Evidence-Informed Care

Comment:

Resource considerations:

Action/next steps:

**PROGRAM NAME:**

**INTEGRATED CARE**

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.

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

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

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| --- | --- | --- | --- | --- | --- |
|  | YES | NO | PARTIAL | DON’T  KNOW | N/A |

**STAKEHOLDERS:** Does the program have mechanisms to identify and engage the appropriate stakeholders?

**CONTINUITY OF CARE:** Are there processes to support the continuity of care across stakeholders?

**Setting of Care & Transitions:** Is there a mechanism to support the seamless transitions between care settings?

**COORDINATION AND COLLABORATION:** Is there a process to facilitate care coordination and collaboration among and between clients and their family caregivers and stakeholders (primary health care)?

**COMMUNICATION**: IIs there a process to facilitate effective communication between clients, family caregivers and stakeholders?

### OVERALL LEVEL OF SATISFACTION WITH THE PROGRAM RE: INTEGRATED CARE

Extremely  Very  Somewhat  Slightly  Not at all

## ACTION on Integrated Care

Comment:

Resource considerations:

Action/next steps:

**PROGRAM NAME:**

# SUSTAINABLE CARE

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

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

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| --- | --- | --- | --- | --- | --- |
|  | YES | NO | PARTIAL | DON’T  KNOW | N/A |

**Resources Allocation:** Is there a process to allocate financial and human resources to support the program?

Is there a process to evaluate the effective and efficient use of resources?

Resource Determination: Does the program recognize and support collaborative partnerships (private, public, voluntary sectors)?

**EMERGING TECHNOLOGY:** Has the impact of technology been evaluated?

**CAPACITY BUILDING:** Are health human resource staffing requirements included in the program?

Have the training, development needs of staff been considered in the program?

Does the program leverage the expertise and capacity of all partners?

**Change Management:** Does the program include a change management strategy to support adoption?

### OVERALL LEVEL OF SATISFACTION WITH THE PROGRAM RE: SUSTAINABLE CARE

Extremely  Very  Somewhat  Slightly  Not at all

ACTION on Sustainable Care

Comment:

Resource considerations:

Action/next steps:



The Canadian Home Care Association (CHCA) 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 CHCA, as the national voice of home care, advances excellence through leadership, advocacy, awareness and knowledge.

For more information: [www.cdnhomecare.ca](http://www.cdnhomecare.ca/) 905-567-7373

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