Stepping up: enabling national strategies for home care

Expanding perceptions of primary care

To enact meaningful and sustainable change, a key first step is to expand prevailing perceptions of primary care from physicians as a central hub of care provision. Instead, we can envision a more holistic and connected ecosystem of care. Home care that is supported by technology that can link primary care to patients and their caregivers and back to acute care is a critical enabler. It can ensure the most appropriate points of care are delivered when and where they are needed based on individual patients’ needs and also remove the burden of being the sole care gatekeeper from the shoulders of primary care practitioners.

Many are indicating the need for more collaborative approaches, including the Canadian Medical Association. In its recently released platform for the new Health Accord, CMA President Dr. Granger Avery observes that “renewing our Canadian healthcare system requires a modern, collaborative approach that builds on existing silos of excellence.”

Today, most healthcare already occurs in the community through primary care clinicians as well as home and community care services. A broad range of services is largely in place, but each exists in relative isolation, impeding the integration necessary to make truly patient-centred home care an available and effective norm across the country.

What’s lacking are the basics: tools to empower, inform and engage patients and their caregivers, and technology platforms that will allow the many providers of care to connect, collaborate, and become better partners to the health system.
What might the future of home care look like?

Consider a fictitious example. Mary is a senior with Diabetes and Chronic Obstructive Pulmonary Disease (COPD). She has recently been discharged from hospital following treatment for a diabetic foot ulcer. Mary is receiving nursing care from an RN at home to assist with wound management, which entails multiple elements such as: wound care, infection prevention, possible referral to an occupational therapist, as well as client and family health teaching on related matters such as nutrition.

Mary is also receiving assistive care from a Personal Support Worker (PSW) a few times a week to help her with some activities of daily living. She continues to be at risk of re-admission and ER visits due to exacerbations of her COPD.

The care workers visiting Mary at home can coordinate their care. For instance, there may be an opportunity to delegate certain acts from the RN to the PSW. Furthermore, schedules need to be optimized to meet Mary’s needs as well of those of the care workers all while reducing travel time. In addition, the implementation of a Remote Patient Monitoring (RPM) and health coaching program can help Mary better proactively manage her chronic conditions at home, and avert acute events that would otherwise see her back in hospital.

The data from RPM can be analyzed in harmony with data recorded at the point of care by using a mobile app during the in-person interventions. With the assistance of data-driven decision support tools, in an ideal world, the timing and nature of the home care interactions would be designed as a function of how Mary is doing.

Mobilizing for right care, right place, right time

Delivering the appropriate care in the right place at the right time is only possible by coordinating and mobilizing a clinical and social service workforce that has patient data literally in-hand on a smartphone, tablet or other digital device.

AlayaCare considers the future of home care to be a combination of well orchestrated in-home visits, virtual visits and remote monitoring, and that insight based on the data collected through those interactions can help optimize the delivery of care.

Having the right digital underpinning is one piece of the puzzle. Equally, emphasis needs to be placed on integrating data, enabling workflows and supporting the provision of collaborative care across the primary and community care continuum with a range of solutions and infrastructure. Secure messaging, personal health records, electronic health records and electronic medical records are a few examples that can comprise an innovation backbone that links primary care, home and community care, patients and their caregivers and acute care.

Furthermore, alongside technological innovations, Canada also needs standards by which to ensure high performance and equity in the home care ecosystem.

In its October 2016 report, Bringing Home Care into Ontario’s Technology Strategy, Home Care Ontario makes several recommendations, two of which echo these needs:

- establishing two-way communication within electronic health records to enable frontline home care providers with timely access to relevant patient information across the continuum of care
- developing consistent data standards and definitions and applying analytics across the health care system so that appropriate benchmarking can be achieved and meaningful insights can be gained.
Standards for high-performing, equitable home care

The goal of ensuring a high quality of home care, combined with equity of access to this care can only be achieved through the implementation of standards.

Many Canadian health authorities have adopted the InterRAI assessment standards to establish this. Through a collaborative partnership, the Canadian Home Care Association, Canadian Nurses Association and College of Family Physicians of Canada offer recommendations for national home care standards in their National Action Plan, Better Home Care in Canada. In the US, the Medicare home health program has focused on a proprietary assessment standard referred to as OASIS.

When standardized assessment and care pathways are in place, health systems can begin the move to value-based reimbursement. There has been progress in this area. For example, in the area of wound care, the CCACs in Ontario offer outcome-based reimbursement. The same is true regarding hip and knee replacement, where an outcome is more easily measured.

As a software provider to both the Canadian and US home healthcare markets, AlayaCare has observed the shift in reimbursement models in the US catalyze a flurry of innovation in the private sector. In Canada we have a similar opportunity.

Strong political will

At both Federal and Provincial levels, there exists strong political will to better enable the delivery of home-based care and recognition that technology is an essential underpinning. In addition to offering patients and their families a more comfortable and convenient means of receiving care, home care also takes much of the burden away from costly acute and long-term care facilities. It is, in many ways, a panacea for achieving triple-aim objectives, i.e. to deliver better care for individuals, better health for populations and lower per capita costs.

There is a Federal commitment of $3 billion over the next four years to address home care and, in her address at the CMA’s Annual Council meeting earlier this year, Health Minister Jane Philpot cited Ontario as an example, noting that the province spends $55 a day to provide a person with care in their home; yet despite the cost efficiency only about five per cent of provincial health budgets go to fund home care.

More coverage, more public funding, more equitable access to care

According to CIHI, the proportion of public to private spending on total health care services has remained relatively stable in Canada over the past 20 years with public sector expenditure accounting for approximately 70% and private sector the remaining 30%. Yet the data suggests that for home care related services, this proportion does not hold true.

Due to chronic underfunding of the sector relative to other components of the health system, those in need of home and community services must disproportionately rely on private expenditures to fund the services they need. Compounding this is the lack of accessible private insurance for home care and other extended care services. The burden to ‘pick up the tab’ falls heavily on individual Canadians (the majority of whom are seniors, often with limited resources) to cover service gaps with out-of-pocket dollars. This reality creates serious equity and access to care challenges that cannot remain unaddressed. As current demographic trends continue to accelerate demand for home care services, the political will is mounting to make changes.

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Provinces emphasize connected services

In Ontario, the Province's "Patient's First" policy specifically calls for the need to connect services to deliver better, coordinated and integrated care in the community, closer to home.

British Columbia’s focus on providing access to home care may be unrivaled across the country. Earlier this year, BC announced an historic investment, reaching up to $52 million in a home health monitoring partnership with TELUS to advance access for British Columbians with complex care needs using technology to help manage their health conditions. Health Minister, Terry Lake noted that “patients have told us their home health monitoring has resulted in improved self-management and better health, as well as a noticeable decrease to their emergency room visits.” A smaller home health monitoring pilot is also underway in Yukon.

Nova Scotia’s One Person, One Record initiative, while not focused on home care per se, sets forth a visionary example of what is possible with a single, integrated clinical information system. This, in combination with the Province’s Personal Health Record (PHR) initiative delivered in partnership with McKesson’s RelayHealth, demonstrates the power of giving patients electronic access to their own health information and enabling patient-to-provider and provider-to-patient communication for appointment requests or routine care questions, and referrals.

While approaches differ, focused political will exists with an emphasis on better collaboration between family doctors and specialists and using digital technology to keep records and to share information that patients and providers alike throughout the care ecosystem can access.

Opportunity for Canada

According to the Canadian Home Care Association, the one million Canadians receiving publicly funded home care services annually is twice the number of individuals served over the past 15 years. And, it is estimated that another 500,000 individuals are accessing home care services not funded by government.

Canada stands to benefit from examples in other parts of the world, like the UK and Australia where less is spent per capita and as a percentage of GDP due to superior coordination, collaboration and integration of care. Better integrated home care results in fewer hospitalizations or ER visits, which translates directly into savings for the acute care system.

Denmark, more than any other EU country, has given explicit policy priority to community care over residential care to promote the elderly living in their own homes. In fact, no long-term care facilities have been built in Denmark since 1967. As a result, relatively few elderly are in long-term care institutions compared with other EU countries and instead, live in a varied range of dwellings adapted for their needs and are eligible to receive home nursing, home care and other practical help.

In the US, notions of the home health agency are not uncommon with some postulating that people’s homes may well become the center of the health care system in the future. Yet, for home health to fulfill its potential, policymakers will also have to step up, making it easier to activate Medicare’s home health benefit and providing more flexibility in what services it covers.

Similar observations apply in the Canadian context, presenting opportunities to:

- develop policies that make access to integrated home and community care services more affordable with more equitable for all
- harness Canadian innovations to deliver home-care infrastructure that mobilizes workforces and fully supports the health and community care ecosystem to enact government policy
- build on the powerful progress demonstrated in British Columbia and Ontario and elsewhere to scale pan-Canadian standards for home care
How TELUS is stepping up

In light of the Federal Government’s pledge of $3 billion over the next four years for additional home care, as a nation we must also commit to ensuring Canadians receive the very best value for this investment.

Performance measures and transparent reporting are critical in order to cycle key learnings back into the system. Equally important is the ability to integrate data, enable workflows, securely share information and equip the extended healthcare ecosystem to operate in concert for the benefit of individual patients and their caregivers.

Technology is a necessary pillar in meeting both of these requirements and TELUS Health offers several tangible commitments:

1. Delivering technology to enable care coordination and secure communication among providers, including a secure intra-provider messaging platform, mobile EMR, electronic health records (EHR) and personal health records (PHR).

2. Enabling patients to receive the care they need from the comfort of their home, with technologies such as home health monitoring and other smart home technologies powered by the Internet of Things and advanced analytics.

3. Investing in healthcare innovations, such as AlayaCare, that will enable home health care and community service providers to provide better and more integrated care. For example, through the TELUS partnership, AlayaCare can more readily scale their software platform so that citizens across Canada who are in need of home and community services can benefit from outcomes focused care. AlayaCare’s mobile first design, open API infrastructure and cloud delivery model means that care providers of all types can afford to have access to next generation tools that will drive better collaboration and better outcomes.

Overall, adopting a technology-based, ‘whole system’ approach to providing integrated, coordinated and collaborative services in the home is a key success factor to improving the patient experience of care, and by extension, improving the health of populations, and reducing the per capita cost of health care.

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