Home and Community Care
The Frontline of Care

A Position Paper

January 23, 2025

ACCA Alberta Continuing Care Association

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Alberta Continuing Care Association

Executive Summary

Home and community care in Alberta has long operated in the shadows of the healthcare system, despite its proven ability to deliver cost-effective, patient-centered care. This position paper calls for a fundamental shift, advocating for home care to be recognized as a distinct and integral component of Alberta's health care strategy. By addressing historical underfunding, workforce challenges, and systemic inefficiencies, Alberta can unlock the full potential of home care to meet the needs of its aging population while alleviating pressures on acute and continuing care facilities.

This position paper emerges amidst Alberta's health system restructuring, policy reforms, significant demographic shifts, and a growing public demand for aging-in-place services. By 2031, one in five Albertans will be over the age of 65. Alberta's demand for continuing care services is projected to increase by 80% over the next 10 years as noted in the Canada-Alberta Aging with Dignity funding agreement for 2023-2028.

The MNP Facility-Based Continuing Care Review (FBCC) recommends increasing home-based care from 61% to 70% by 2030, reducing facility-based care to 30%. The shift is projected to save $452 million annually in operating costs (less daily expense for facility operations) and $1.7 billion in cumulative capital costs (fewer new facilities needed). This makes the system more sustainable while supporting Albertans' preferences to age at home.

By prioritizing home and community care, Alberta can create a compassionate, adaptable, and cost-efficient healthcare system that meets the needs of its aging population and those with chronic conditions or disabilities. This commitment is not only fiscally responsible but also deeply aligned with Albertans' values of dignity, independence, and community-centered care.

The position paper reflects the collective expertise and frontline experience of its contributors, Alberta Continuing Care Association (ACCA) members representing diverse perspectives from across the home and community care sector. This breadth of knowledge ensures that the recommendations are both comprehensive and deeply rooted in the realities of care delivery.

Alberta requires two streams of programming to support Albertans in remaining and aging at home and diverting hospitalization and rapid discharge post-acute care in both urban and rural communities across the province. Clients range in age from birth to end of life and increasing patient care complexity is the driver for change in Alberta's home care

system. A transformed home care system will be able to support each of the four pillars in Alberta's refocused health care system. A focus in rural Alberta is critically important as Alberta Health Services transitions to focus solely on acute care.

ACCA envisions oversight of these two programs under the Ministry of Health, and the Ministry of Community, Seniors and Social Services, respectively.

1. A home care program leveraging interdisciplinary team-based care to support clients with activities of daily living (ADL), which includes health care professionals such nursing and rehabilitation services under an existing provincial contract framework. Under this program it is essential for ongoing integration of evidence-based clinical practice using interdisciplinary, team-based care.

2. Government-funded client-directed home support programs that support clients with instrumental activities of daily living (IADL), which includes activities that clients cannot do themselves to safely maintain their independence. Under this program, it is essential to prioritize client autonomy and choice.

Call to Action

ACCA members envision a robust wrap-around home and community care system where Albertans can live with dignity, independence, and quality of life in the comfort of their homes and communities. This vision recognizes the essential role of home care as a foundation of Alberta's health system, reducing pressure on hospitals and continuing care facilities while improving outcomes and providing a cost-effective alternative to traditional care models. **Home care is not just a service but a solution to Alberta's most pressing healthcare challenges.**

ACCA is calling for a strategic, evidence-based approach to home and community care, supported by:

- Increased funding and fair compensation.
- Policy changes to redefine oversight and governance.
- Investments in technology, workforce development, and caregiver supports.
- Collaborative efforts to implement and scale innovative, patient-centered care models.

Summary of Recommendations

These 12 recommendations were collaboratively developed by ACCA members, including frontline care providers, caregiver advocates, and organizational leaders. They integrate

evidence, operational expertise, and real-world insights to present actionable solutions for addressing systemic challenges and driving transformative change.

1. **Define the Role of Home and Community Care in the Continuing Care System**
   Establishing home and community care as a distinct and integral pillar ensures its alignment with Alberta's health strategy, clarifies its purpose, and strengthens its ability to deliver sustainable, high-quality care.

2. **Develop a Comprehensive Home and Community Care Framework**
   A robust framework enhances collaboration, promotes independence, and ensures fair funding and compensation, positioning home and community care as a cornerstone for aging-in-place services and system sustainability.

3. **Reassess and Redefine the Role of Alberta Health Services (AHS) in Delivering Home and Community Care**
   Shifting oversight from AHS to an impartial entity addresses conflicts of interest, streamlines care coordination, and ensures timely access to services for clients and families.

4. **Establish a Patient and Caregiver-Centric Navigation System**
   A personalized navigation system empowers clients and caregivers, improves care transitions, and reduces delays, fostering better outcomes and informed decision-making across the care continuum.

5. **Adopt Standards for Home and Community Care Providers to Ensure Quality and Safety**
   Introducing safety and quality standards for providers enhances trust, consistency, and accountability, protecting vulnerable populations and ensuring excellence in service delivery.

6. **Implement Proactive and Preventative Care Programs for Better Health Outcomes**
   Proactive care models, such as chronic disease management and health coaching, reduce hospitalizations, enhance quality of life, and optimize resource use by addressing issues before they escalate.

7. **Enhance Provider Training and Resources to Meet the Increasing Acuity of Patients in Home and Community Care**
   Advanced training equips providers to manage complex physical and mental health needs, ensuring the safety of clients and caregivers while improving care outcomes.

8. **Support and Empower Caregivers with Structured Resources and Assistance**
   Structured caregiver supports, including training, financial aid, and flexible workplace policies, reduce burnout and ensure caregivers can provide effective and sustainable care.

9. **Integrate Advanced Information Management and Technology Solutions**
   Seamless technology integration enables real-time data sharing, enhances care coordination, and reduces inefficiencies, improving client experiences and provider capabilities.

10. **Provide Financial Incentives and Support to Sustain Home and Community Care Services**
    Targeted financial strategies, including rate adjustments and rural incentives, stabilize the workforce, ensure equitable access, and sustain critical care services across Alberta.

11. **Evaluate and Scale Proven Home and Community Care Programs**
    Systematically testing, refining, and scaling innovative care programs ensures resources are directed toward impactful solutions that enhance outcomes and reduce system pressures.

12. **Facilitate Knowledge Sharing and Translation Across the Care Sector**
    Creating platforms for collaboration and learning fosters innovation, creativity, and best practices, ultimately improving care quality and system-wide efficiency.

Conclusion

ACCA recognizes that achieving this vision requires partnership and collaboration. By working closely with government stakeholders, the ACCA and its members are ready to co-create a sustainable, equitable, and patient-centered home care system that meets the needs of Albertans. Together, we can build a healthcare model that respects dignity, empowers caregivers, and ensures long-term efficiency and sustainability.

Aging in Place: Opportunities and Challenges for Home and Community Care

People are living longer and healthier lives than in previous generations (National Seniors Council, 2024). By 2052, one-quarter (24.9%) of Canadians will be 65 years of age or older (Statistics Canada, 2022a). Among the fastest-growing age groups are those aged 85 and older, who experienced a 12% increase between 2016 and 2021 (Statistics Canada, 2022b).

Most older Canadians strongly prefer to age in their homes and communities. A 2020 survey found that 96% of Canadians aged 65 and older would do everything they could to avoid entering a long-term care facility (National Institute on Ageing, 2022). With appropriate support, older persons can remain in their homes and avoid transitioning to institutional living.

According to the Canadian Institute for Health Information (CIHI), 1 in 10 newly admitted long-term care residents could potentially have been cared for at home (CIHI, 2022). Despite this potential, unmet home care needs remain significant. In 2021, 475,000 people - 1.6% of the Canadian population - reported unmet home care needs, with the majority of these individuals aged 65 and older (Statistics Canada, 2023).

To meet this growing demand, while ensuring suitability and affordability of the system, a significant shift is required from facility-based continuing are to care delivered in the home and community. This shift is also consistent with recommended improvements related to quality of life, client choices and the ability to live at home/community longer and increasing the use of self-directed care.

Aging at home requires a comprehensive, multi-sectoral approach to ensure older persons, caregivers, community organizations, and governments have the resources needed to enable individuals to live safely, happily, and independently. This approach must include access to social support and essential services that promote physical, mental, and social well-being (National Seniors Council, 2024).

However, healthcare, social, and community services often remain fragmented, inaccessible, or unaffordable. Complex processes for accessing care, limited alternative care options, and insufficient age-friendly environments pose significant obstacles. These barriers prevent older persons from experiencing a seamless continuum of care that meets their needs across all dimensions of health (Deloitte Canada, 2020).

Family and friend caregivers are integral to supporting aging at home, but they face mounting pressures. Almost one-quarter of caregivers are over the age of 65 themselves, with many experiencing strain due to their caregiving responsibilities (Statistics Canada, 2020). The rise in one-person households further compounds this challenge, as older persons may increasingly lack family support (Statistics Canada, 2022c).

Finally, the COVID-19 pandemic amplified the pressures on Alberta's healthcare system, particularly in caring for seniors and the frail elderly. The COVID-19 pandemic further highlighted the vulnerabilities of the continuing care sector, exposing challenges such as aging infrastructure, higher operational costs, and increased infection risks. Meanwhile, patient preferences have increasingly shifted toward care options that are flexible, accessible, and closer to home.

This crisis also presents an opportunity to re-evaluate the role of home and community care within the newly envisioned Continuing Care organization as part of Alberta Health Transformation.

Alberta Continuing Care Association

Pathways to Transformation: Home and Community Care in Alberta

Alberta's Health System Transformation represents an ambitious effort to redesign the healthcare system for long-term sustainability, integration, and innovation. Optimizing home and community care is a key component to achieving seamless, patient-centered care across the continuum of mental health and addictions, acute care, primary care, and continuing care. The pathway to transformation is evolving with evidence-based recommendations, strategic investments and legislative advancements. and will require strengthened collaboration across healthcare and social services.

Evidence-Based Recommendations from the FBCC Report

Commissioned by Alberta Health, the 2021 **Facility-Based Continuing Care (FBCC) Report** developed by MNP provided guidance on transforming home and community care by:

- Highlighting the importance of **system navigation** to simplify access for clients and caregivers, ensuring seamless transitions between hospital, home, and community settings.
- Recommending strategies to improve **integration** of care across sectors, reducing fragmentation and delays.
- Encouraging the adoption of **innovative care models** that could inform improvements in home and community care settings, including personalized, client-centered support services.

The FBCC report underscores the opportunity to expand home-based care options as a sustainable, patient-focused solution that addresses care gaps and reduces system pressures.

In **Working Together to Improve Health Care for Canadians: Alberta Action Plan - Aging with Dignity,** the Province pledges that actions to implement the FBCC recommendations will continue for several years, particularly in the areas of:

- increasing community-based services and supports to ensure Albertans receive the care they need to age in place;
- enhancing workforce capacity and supports to meet client and resident needs;
- increasing choices for clients and residents;
- enhancing innovation amongst care providers and operators; and

- enhancing quality across the continuing care system.

Through the **Aging with Dignity** bilateral funding agreement, the Federal Government is investing **$627 million over five years (2023–24 to 2027–28)** as part of a 10-year collaborative plan. This funding accelerates Alberta's efforts to transform home and community care within its broader continuing care strategy. This includes $70 million annually dedicated to home and community care initiatives, such as palliative care, caregiver supports, and enhancements to home care infrastructure. Goals include:

- Improving **access to home and community care**, enabling more Albertans to remain at home with the support they need.
- Promoting **workforce stability** to ensure reliable and high-quality care.
- Supporting Albertans to **age well at home** through expanded non-medical supports, such as transportation and household assistance.
- Strengthening **caregiver supports** and resources to ease caregiver burden.
- Increasing home-based options for **palliative and end-of-life care**.
- Providing targeted financial and programmatic **support for home and community care clients** to meet both medical and non-medical needs.

Alberta's focus on home and community care is central to the vision of shifting care from hospitals to appropriate community-based settings, enabling more Albertans to receive care in their homes and avoid unnecessary institutionalization.

The **Continuing Care Act** (2024) represents a significant legislative milestone, creating a streamlined framework that prioritizes:

- Simplifying system navigation for clients and caregivers seeking home and community care services.
- Supporting innovative care models to enhance access, quality, and client outcomes in home and community settings.
- Integrating medical and non-medical services under a unified framework to better meet the diverse needs of Albertans.

The **Health System Refocusing initiative** operationalizes these goals by emphasizing integration and prioritizing home and community care as a central component of the broader healthcare system. This approach includes:

- Shifting governance to support streamlined transitions between hospital, home, and community-based care.

- Encouraging cross-sector collaboration to reduce silos and improve care coordination.
- Expanding options for **home and community care clients**, including medical and non-medical services tailored to individual needs.

Expanding the Role of Seniors, Community and Social Services (SCSS)

In October 2024, the Alberta government announced that responsibility for continuing care would shift from the Health Ministry to the Ministry of Seniors and Social Services. This transition reflects Alberta's recognition of the broader scope of home and community care, which spans beyond healthcare into areas such as:

- Housing
- Transportation
- Community-based social supports

While Alberta Health retains responsibility for clinical standards and funding, SCSS will focus on service delivery, navigation, and non-medical supports. This collaborative model aims to address the complex needs of clients in home and community care, enabling a more integrated, holistic system.

Investing in a Stable and Scalable Home and Community Care System

Alberta's health system transformation places home and community care at the forefront of its strategy, recognizing its vital role in reducing strain on acute care and providing high-quality, accessible, and sustainable care. By leveraging federal funding, adopting evidence-based recommendations, and fostering collaboration across ministries, Alberta is building a system that empowers individuals to live well at home while addressing the challenges of an aging population.

The Role of Home Care Providers in Driving Transformation

Home and community care providers in Alberta are at the forefront and frontline of transforming the continuing care system. The combined pressures of increased demand, regulatory changes, and the push for innovation and integration offer both challenges and opportunities. By adapting their operations, embracing flexibility, and prioritizing person-centered care, providers are positioning themselves as key enablers of Alberta's vision for a sustainable, responsive, and empowering continuing care system.

The position paper reflects the collective expertise and frontline experience of its contributors, ACCA members representing diverse perspectives from across the home and

community care sector. This breadth of knowledge ensures that the recommendations are both comprehensive and deeply rooted in the realities of care delivery.

Diverse Expertise: Contributors include representatives from leading home care organizations, caregiver advocacy groups, and service providers operating in urban, suburban, and rural settings. Their insights provide a well-rounded view of the challenges and opportunities facing the sector.

Practical Experience: The authors bring firsthand experience in managing home care operations, delivering personalized services, and navigating the complexities of Alberta's healthcare system. This operational perspective ensures that the paper's recommendations are realistic and actionable.

A Collaborative Approach: By involving multiple stakeholder perspectives, including caregivers and care recipients, the position paper embodies a holistic approach to home care reform. This collaboration strengthens its credibility and ensures that it reflects the needs of both providers and clients.

By prioritizing home and community care, Alberta can create a compassionate, adaptable, and cost-efficient healthcare system that meets the needs of its aging population and those with chronic conditions or disabilities. This commitment is not only fiscally responsible but also deeply aligned with Albertans' values of dignity, independence, and community-centered care.

Policymakers have an opportunity to drive meaningful change by seeing through the eyes of home and community care providers. Their perspective highlights critical areas for support and demonstrates the value of prioritizing home care in Alberta's continuing care system. By partnering with providers and addressing their challenges, the government can ensure a sustainable, integrated system that benefits all Albertans.

Vision for Home and Community Care in Alberta

ACCA home and community care members envision a robust wrap around home and community care system where Albertans can live with dignity, independence, and quality of life in the comfort of their homes and communities. This vision recognizes the essential role of home care as a foundation of Alberta's health system, reducing pressure on hospitals and continuing care facilities while improving outcomes and providing a cost-effective alternative to traditional care models.

Alberta requires two streams of programming to support Albertans to remain and age at home and divert hospitalization and rapid discharge post-acute care in both urban and rural communities across the province. Clients range in age from birth to end of life and increasing patient care complexity is the driver for change in Alberta's home care system. A transformed home care system will be able to support each of the four pillars in Alberta's refocused health care system. A focus in rural Alberta is critically important as Alberta Health Services transitions to focus solely on acute care.

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Key Components of the Vision:

1. **Person-Centered Care:**
    - Supporting Albertans to live at home and in their communities for as long as possible, connected to family, friends, and community resources.
    - Delivering compassionate, personalized care that meets the physical, mental, and social needs of each individual.
2. **Integrated Team-Based Care:**
    - Leveraging interdisciplinary teams, including health professionals like nurses and rehabilitation specialists, paraprofessionals, and community partners, to provide seamless, holistic support.
    - Fostering collaboration and coordination across healthcare, community, and social services to enhance continuity of care.
3. **Caregiver Empowerment and Support:**
    - Equipping caregivers with tools, education, and respite services to effectively support their loved ones.

   - Recognizing caregivers as essential members of the care team, ensuring their well-being is prioritized.
4. **A Foundation of the Health System:**
   - Highlighting the role of home care in reducing emergency visits, hospital stays, and reliance on long-term care facilities.
   - Positioning home and community care as an essential pillar of Alberta's healthcare strategy, enabling a sustainable and responsive system that meets the needs of all Albertans.
5. **Sustainable Investments:**
   - Establishing long-term, predictable funding that enables the home and community care sector to grow and innovate.
   - Focusing on workforce development, expanding access to underserved areas, and investing in technologies that enhance care delivery.
6. **Patient Choice**
   - It is crucial that we respect and consider the client's preference for their preferred homecare vendor.
   - This choice significantly impacts their comfort, satisfaction, and overall well-being, and our commitment to honouring their preferences can better ensure a safe and supportive care environment.
7. **Safety**
   - The safety and well-being of clients ultimately depend on the qualifications and skills of the individual caregivers assigned to them.
   - Every caregiver must possess the relevant competencies and experience necessary to provide safe and effective care in the home environment.

Strengthened Investment in Home and Community Care

ACCA applauds the Government of Alberta for its incremental investment in the home and community care sector in the most recent budget. However, with the growing demand for aging-in-place services and the critical scarcity of healthcare human resources, home and community care providers are increasingly concerned about the sector's ability to deliver sustainable services.

The current healthcare system restructuring presents a pivotal opportunity to position home and community care as a key mechanism to fulfill the expressed expectations of Albertans—to live in their homes and home communities for as long as possible. Expanding the range and variety of home and community care services will:

- Reduce hospitalizations and emergency room visits,
- Decrease reliance on paramedic, fire, and police services, and

- Improve health outcomes for Albertans while enhancing the efficiency of the overall healthcare system.

By prioritizing home and community care, Alberta can build a sustainable, patient-centered healthcare model that meets the evolving needs of its population and supports its long-term goals for system efficiency and resilience. This approach not only addresses current healthcare demands but also builds a resilient foundation for future challenges, promoting health equity, enhancing patient outcomes, and fostering a more efficient and compassionate system for all Albertans.

Evolving Alberta's Home and Community Care System

Alberta's home and community care system must urgently adapt to meet the growing demand for aging-in-place services. This evolution is essential to ensure that seniors, individuals with chronic conditions, and individuals with disabilities receive compassionate, high-quality care in their homes and communities. Key priorities for this transformation include:

1. **Fostering a Skilled and Well-Resourced Workforce:** Invest in training, recruitment, and retention to address workforce shortages and deliver consistent, quality care.

2. **Expanding Rural Access:** Bridge gaps in underserved areas to provide equitable care for Albertans in all regions.

3. **Integrating Technology:** Leverage innovative tools and solutions to improve care delivery, enhance communication, and streamline operations.

4. **Supporting Caregivers:** Offer education, resources, and respite services to empower family caregivers and alleviate their burdens.

5. **Strengthening Coordination:** Improve collaboration between home, community, and acute care systems to ensure seamless transitions and holistic care.

This vision places home and community care at the core of Alberta's healthcare strategy, creating a sustainable and adaptable system that reflects Albertans' values of dignity, independence, and community-centered care.

Scope of Home and Community Care

Home and community care includes a broad range of services delivered to individuals of all ages, either in private homes or congregate living settings. These services include:

Skilled Clinical and Medical Care

- **Nursing Care:** dressing changes and wound management, medication preparation, chemotherapy administration and chronic disease management etc.
- **Therapeutic Services:** Physiotherapy, occupational therapy, speech therapy, and nutritional counselling
- **Medical Equipment and Supplies:** Assistance with wheelchairs, pads for incontinence, ventilators, or oxygen equipment
- **Palliative and End-of-Life Care:** Supporting clients and families during advanced illness stages

Personal Support Services

- **Assistance with activities of daily living**: hygiene, dressing, toileting, incontinence management, mobilization, transferring, dining, oral care and other tasks
- **Household Support:** housekeeping, meal preparation, and access to Meals on Wheels etc.
- **Transportation Services:** facilitating access to medical appointments, community resources, or shopping etc.

Home and community care services may be:

- **Short-Term:** Supporting individuals recovering from surgery or an acute care episode
- **Long-Term:** Enabling individuals to live independently within their communities for as long as possible

Home and community care plays a critical role in keeping Albertans out of hospital, shorter hospitalizations when deemed appropriate, and remaining as long as possible in their homes and their community.

Types of Home and Community Care in Alberta

There are three types of home and community care recognized in the Continuing Care Act. They include different service models available through publicly funded home and community care in Alberta. Under the new legislation, a client may receive services from more than one type of home and community care provider.

Type 1. Regional Health Authority
Type 1 home and community care is typically used for case management and professional health services. It is also used for other home and community care services in communities without contracted home and community care providers.

Type 2. Contracted
Home and community care provided to a client by a home and community care provider who has an agreement with the regional health authority. Type 2 home and community care is typically used for personal care, caregiver respite, and home support services. The services are typically provided by health care aides and licensed practical nurses, particularly in urban and suburban settings.

Type 2 home and community care includes providers who hold an agreement to provide services within a specific geographic area, as well as providers who hold an agreement to provide services to people who live in a specific congregate living environment such as a continuing care home or other residential building.

Type 3. Client Directed Care
Home and community care provided through any service model where a client selects a home and community care provider of their choosing. This includes existing service models such as Self-Managed Care and Client Directed Home Care Invoicing. Type 3 home and community care has typically been used for clients with stable, ongoing needs for personal care, caregiver respite, and home support services.

Importance of Government Bill Rates for Home and Community Care

Government bill rates for Health Care Aides (HCAs) are a critical factor in sustaining the home and community care system for contracted providers who deliver services under agreements with Alberta Health Services. These rates directly impact the ability of providers to recruit and retain skilled workers, offer competitive compensation, and maintain high standards of care, all while managing operational and administrative costs.

Government bill rates vary by province and are influenced by factors such as regional cost of living, collective agreements, and specific contractual arrangements between provincial governments and care providers. The following table provides an overview of Health Care Aid Government Bill Rates across Canada to offer a comparative perspective:

Health Care Aid Government Bill Rates

Province	Health Care Aid Government Bill Rate
Alberta	$38.00
BC	$49.00
Saskatchewan	$36-38
Manitoba	$34.00
Ontario	$47.02 (recent 4% increase with an expectation that 3% must be spent on compensation)
Nova Scotia	$48.01

Why Alberta's Rate Needs Attention

At $38.00 per hour, Alberta's government bill rate for HCAs is lower than several other provinces, including British Columbia ($49.00), Ontario ($47.02), and Nova Scotia ($48.01). Even Saskatchewan, with a range of $36–$38, matches Alberta's rate at the upper end.

Workforce Competitiveness
Alberta's comparatively low bill rate makes it challenging for contracted providers to compete for HCAs, particularly with other provinces offering higher rates. This is concerning considering increasing demand for home and community care services and existing workforce shortages.

Operational Sustainability for Contracted Providers
Contracted providers in Alberta operate under significant financial constraints, with the bill rate needing to cover wages, benefits, training, and administrative costs. A lower rate limits their ability to offer competitive wages or invest in workforce development, potentially compromising care quality.

Client Impact and System Outcomes
Adequate bill rates are essential for ensuring timely and high-quality care for Albertans. Struggles to recruit and retain HCAs may lead to service delays and impact outcomes, reducing the effectiveness of home and community care as a vital part of Alberta's health system.

Alberta's government bill rate for HCAs must be re-evaluated to reflect the current labor market, cost of living, and operational needs of contracted providers. Aligning the rate with other provinces would not only enhance the competitiveness of Alberta's home and

community care sector but also reinforce its role as a cornerstone of the province's health system. A modest increase in the bill rate is a strategic investment in Alberta's health care workforce, contracted providers, and, most importantly, the well-being of Albertans relying on these essential services.

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What We Know about Alberta Home Care Clients

The Canadian Institute for Health Information (CIHI) collects data through its Home Care Reporting System (HCRS), providing standardized insights into publicly funded home care services across Canada. The data (April 1, 2022, to March 31, 2023) presented below offers a valuable snapshot of Alberta's home care system but does not represent the full scope of home care services in the province. Publicly funded home care data reported to CIHI comes from Alberta Health Services and includes:

- Care provided by AHS staff
- Contracted care services delivered by third-party providers
- Client-directed models, where individuals manage their own care arrangements using funding provided by AHS

Key Insights from Canadian Institute for Health Information Data

Key insights include the predominance of older adults in home care, the high prevalence of cardiovascular and neurological conditions, and the significant reliance on community health systems for referrals.

Alberta Demographics: Who Relies on Home Care?

Age Group	Percentage (%)	Description
85+ years	48.38	Largest group, reflecting significant reliance on home care for advanced ages
75–84 years	29.18	Second-largest group, indicating growing care needs in later years
65–74 years	13.8	Moderate utilization, representing early seniors requiring support
Under 65 years	8.65	Younger clients with chronic illnesses or disabilities needing long-term care

Prevalent Health Conditions among Alberta's Home Care Clients

Health Condition	Prevalence (%)	Implications for Home Care
Cardiovascular Diseases (heart disease, congestive heart failure, and	55.47%	Home care requires ongoing medical supervision, symptom management, and rehabilitative support, preventing hospitalizations, reducing complications, and improving overall health outcomes

coronary artery disease)		
Neurological Conditions	42.3%	Conditions like Parkinson's, multiple sclerosis, and cognitive impairments require multidisciplinary care, coordinated therapies, and caregiver education to maintain independence and quality of life
Stroke Recovery	14.08%	Comprehensive rehabilitative care, including physiotherapy, occupational therapy, and mobility supports are needed to promote better recovery, reduce recurrent strokes, and avoid transitions to facility-based care

The Importance of Non-Medical Home and Community Supports
Services such as housekeeping, meal assistance, transportation, social programs, system navigation, and case coordination, all enable individuals to remain at home and maintain independence. These services address daily needs, reduce isolation, and ensure access to essential care and resources, complementing medical services to support aging in place and improve overall quality of life.

Service Utilization: How Effective Is the System?

Community Health Systems as Gateways
With **37.67%** of referrals originating from community health systems, the data underscores the importance of strengthening partnerships between home care providers, community agencies, and primary care networks. This integration ensures clients are connected to services promptly and efficiently.

High Success Rates in Resolving Needs
The **64.93%** success rate in resolving client needs showcases the effectiveness of home care as a first-line intervention. This data validates the system's role in delivering short-term, outcome-driven care that alleviates the need for more costly or resource-intensive healthcare options.

Minimizing Transitions to Facility-Based Care
With only **2.16%** of clients transitioning to residential care facilities, the data highlights home care's pivotal role in supporting aging in place. This not only aligns with client preferences but also reduces pressure on Alberta's long-term care facilities, which are already facing capacity challenges.

Data Limitations

It is important to note that the CIHI dataset represents only a partial view of Alberta's home care landscape. It does not include data from privately funded care or informal caregivers, nor does it provide longitudinal tracking of clients or transitions between care settings. Additionally, jurisdictional variability in data collection and reporting methods limits comparability across provinces. The absence of data on informal caregivers, a cornerstone of home care support, leaves critical gaps in understanding and planning for their needs.

Alberta Seniors' Experiences as Home Care Clients

The Health Quality Council of Alberta (HQCA) conducts the Alberta Seniors Home Care Client Experience Survey in collaboration with Alberta Health Services and Alberta Health. The survey gathers feedback from seniors receiving long-term supportive and maintenance home care services under the administration of Alberta Health Services. This includes:

- AHS-Direct Home Care Services: provided by Alberta Health Services staff
- Contracted Home Care Providers: organizations contracted by AHS to deliver home care services

The 2024 survey results are anticipated to be released in the spring of 2025. In the interim, we draw upon the 2019 survey which evaluated home care services provided to seniors aged 65 and older with a focus on:

- Professional services, such as nursing, therapy, and health monitoring
- Personal care services, including hygiene, dressing, and mobility support
- Client experience with case management, care planning, and scheduling
- Drivers of overall client satisfaction, such as relational care, unmet needs, and communication

The survey results are useful to:

1. Inform quality improvement in home care delivery
2. Provide data for evidence-based policy and practice
3. Address the growing need for sustainable home care services in Alberta's aging population

Nearly 83,000 clients received home care services in Alberta during the 2018–2019 fiscal year, and 6,914 clients (59%) responded to the survey.

Key Findings from the Health Quality Council of Alberta

1. **Role of Home and Community Care**
    - **77% of clients reported that home care helped them remain at home**, highlighting its critical role in enabling aging in place and reducing reliance on institutional care. However, limitations in service hours and availability prevented some clients from receiving sufficient care to meet their needs.

These findings reinforce the need to establish home care as a core component of Alberta's healthcare system, emphasizing its preventative potential to alleviate pressures on acute care facilities and long-term care institutions.

2. **Addressing Case Management Challenges**
    - Case management for surveyed home care services was provided by Alberta Health Services staff. Respondents highlighted issues such as **fragmented communication, limited involvement of clients in care planning**, and variability in responsiveness, which led to delays and gaps in care.

A more integrated and responsive case management system is essential for delivering seamless, client-centered home care services.

3. **Supporting Caregivers**
    - Many caregivers, often family members, provide over 20 hours of care weekly, leading to **significant mental and physical strain**. Limited access to respite care and inadequate resources exacerbates caregiver burnout.

By alleviating caregiver burdens, the sustainability and effectiveness of home care services can be significantly improved.

4. **Improving Workforce Stability**
    - **Clients expressed concerns about continuity and consistency of care staff**, with only 42% reporting satisfaction with staff continuity. Gaps in training and communication among staff further affected service quality.

Workforce instability is a key barrier to high-quality care. Improved wages, professional development, and recruitment strategies may address these challenges, ensuring that home care workers can deliver consistent and skilled care.

5. **Leveraging Technology**
    - **Poor communication and coordination between providers and case managers were noted, partly due to outdated systems**. Clients and caregivers often had to repeat information, indicating the need for better integration of digital tools, such as electronic health records.

Investments in technology, including electronic health records and telehealth, are vital to improving service delivery, reducing administrative burdens, and ensuring seamless transitions between care settings.

The 2019 Alberta Seniors Home Care Client Experience Survey highlights the critical role of home care in helping seniors live independently and maintain their quality of life. While the system has significant strengths, opportunities exist to enhance case management, caregiver support, workforce stability, and technology integration. Targeted investments and improvements will ensure home care continues to grow as a sustainable, client-focused cornerstone of Alberta's healthcare system.

The Impact on Unpaid Informal Caregivers Who Support Seniors to Age in Place

In 2018, the Health Quality Council of Alberta published The Impact on Unpaid Informal Caregivers Who Support Their Loved Ones Aging in Place. The report is the first of its kind to be released in Alberta. The survey gathered feedback from unpaid caregivers who provided support to seniors receiving home care services under the administration of Alberta Health Services. These caregivers included family members, friends, and others providing unpaid care to loved ones.

The study focused on the experiences of caregivers supporting seniors who were cognitively unwell, specifically addressing:

- The types of care and support provided by caregivers, such as personal care, emotional support, and assistance with daily activities.
- The challenges faced by caregivers, including emotional, physical, and financial strain.
- The relationship between caregivers and the home care system, particularly in terms of coordination and communication.
- The unmet needs of caregivers, such as access to respite care, financial assistance, and mental health resources.

The study results serve to:

1. Highlight the contributions and challenges faced by informal caregivers in Alberta's home care system.
2. Provide actionable insights for improving caregiver supports and reducing caregiver burnout.
3. Inform strategies to ensure the sustainability of home care services by addressing systemic gaps.

Key Findings from the Health Quality Council of Alberta

1. **Role of Informal Caregivers**
    - Approximately 400,000 unpaid caregivers in Alberta provide over 200 million hours of care to seniors annually, fulfilling 70–75% of the care required by their loved ones.

- Many caregivers dedicate over 115 hours of care per week, highlighting their critical role in enabling seniors to age in place.

The sustainability of Alberta's home care system heavily depends on informal caregivers, who provide the majority of care. Without their support, the demand for professional services and institutional care would rise significantly, increasing costs for the healthcare system.

2. **Challenges of Caregiving**
    - **Physical and Emotional Strain**: The heavy caregiving workload often leads to burnout, social isolation, and poor mental and physical health for caregivers.
    - **Financial Strain**: Many caregivers reduce work hours or leave their jobs entirely to provide care, leading to significant economic hardship.
    - **Role Overload**: Balancing caregiving with other responsibilities, such as employment, household management, and self-care, is overwhelming for many caregivers.

Burned-out caregivers are at risk of becoming patients themselves, adding strain to the healthcare system. Effective respite care and financial supports are necessary to alleviate these pressures and ensure caregivers can continue in their roles.

3. **Caregiver Involvement in the Assessment Process**
    - Caregivers were often **partially involved** in the assessment process conducted by AHS case managers to determine the needs of the care recipient.
    - Many caregivers felt their **input was undervalued**, despite their intimate knowledge of the care recipient's daily needs and challenges.
    - **Limited Communication**: Caregivers were not always adequately informed about assessment criteria or how service allocation decisions were made.

Excluding caregivers from the assessment process can lead to care plans that fail to address critical unmet needs, further increasing caregiver burden. Including caregivers in assessments can ensure holistic care plans that support both the client and caregiver.

4. **Challenges with Navigation and Limited Information**

    - **Navigation Challenges**: Caregivers frequently reported difficulty understanding how to access and coordinate home care services. The

complexity of the system and inconsistent communication** from case managers and providers left many feeling unsupported.
   - **Limited Information**: Many caregivers lacked clear, accessible information about the services available to them and their loved ones. This gap in knowledge made it harder for caregivers to advocate for necessary care and resources.

These findings point to a broader system-level issue within Alberta's home care framework. **Improving how the system communicates and delivers information is essential to reducing caregiver stress and ensuring equitable access to care**. A more transparent and coordinated approach is needed to help caregivers understand and navigate the system effectively, enabling them to focus on caregiving rather than overcoming systemic barriers.

5. **Unmet Needs**
   - **Respite Care**: Caregivers identified a lack of adequate or flexible respite services as a critical gap in the system.
   - **Transportation**: Rural caregivers struggled with transportation access for medical appointments and other essential activities.
   - **Household Support**: Caregivers often had to manage additional tasks like cleaning, yard maintenance, and cooking, which are not covered by home care services.

Addressing unmet needs such as household support and transportation can reduce caregiver burden, especially for rural caregivers who face unique challenges. Flexible respite options can provide relief and improve caregiver well-being.

6. **Impact on Quality of Life**
   - Caregivers frequently experience a loss of independence, reduced social interactions, and a diminished sense of personal identity, feeling defined solely by their caregiving role.

Caregiving takes a significant toll on caregivers' mental health and personal lives. Programs that support caregivers' well-being, such as mental health services and social programs, can help them maintain their identity and independence.

The findings from the Impact on Unpaid Informal Caregivers report emphasize the crucial role caregivers play in Alberta's home care system. Their contributions are invaluable but come at a significant personal cost. The report highlights the urgent need for:

- Enhanced respite care options to alleviate caregiver strain.
- Improved financial and household support to ease economic and workload pressures.
- Better communication and coordination with home care services to support caregivers in their roles.

Addressing these issues is essential to sustaining Alberta's home care framework and ensuring caregivers can continue to support their loved ones aging in place. This study provides critical insights to inform policy and program development that prioritizes caregiver well-being alongside client outcomes.

Economic Case for Investing in Home Care and Caregivers

Shifting Towards Home-Based Care Results in System Level Savings

The MNP Facility-Based Continuing Care Review recommends increasing home-based care from 61% to 70% by 2030, reducing facility-based care to 30%. The shift is projected to save $452 million annually in operating costs (less daily expense for facility operations) and $1.7 billion in cumulative capital costs (fewer new facilities needed). This makes the system more sustainable while supporting Albertans' preferences to age at home.

Investments in home and community care have the potential to improve quality of life while generating substantial savings. Scenario-based analyses conducted in Quebec also found that government costs for long-term care services delivered through home care were less expensive than services provided in long-term care facilities (Clavet et al., 2021). Improved home care can also reduce the demand for new long-term care accommodations, as noted by the National Seniors Council (2024).

Supporting Caregivers Transforms Health and Generates Savings

Team Carepal partnered with HIMA Consulting to produce economic models designed to evaluate the costs, benefits, and health outcomes of caregiver support interventions over time. The model identifies four key interventions that address the challenges caregivers face and enhance their ability to provide care:

1. **Respite Care:** Professional caregiving services that temporarily relieve family caregivers, allowing them to rest and recover.
    - Caregiving without breaks leads to burnout, which reduces caregivers' ability to care for their loved ones effectively. Respite care prevents this, ensuring consistency and quality in care.

2. **Mental Health Support:** Counseling, peer groups, and stress management resources that help caregivers cope with the emotional demands of caregiving.
    - Many caregivers experience stress, anxiety, or depression. Emotional support helps them maintain resilience and continue caregiving.

3. **Care Coordination Tools:** Platforms or navigators that simplify access to healthcare resources and reduce the logistical burden on caregivers.
    - Managing appointments, medications, and care schedules is overwhelming for caregivers. Streamlined tools save time and ensure individuals receiving care have their needs met promptly.

4. **Financial Assistance:** Subsidies or tax credits to offset caregiving-related costs, such as reduced work hours or out-of-pocket expenses.
    - Financial stress exacerbates caregiver burnout, making it harder to balance work and caregiving responsibilities.

These interventions cost approximately $8,000–$11,250 per caregiver annually. For Alberta's 40,000 caregivers, the total investment over 5 years would range from $1.6 billion to $2.25 billion. While this may sound like a large sum, the results are remarkable:

- For every $1 invested, Alberta gains $11 in value through:
    - Reduced healthcare costs (fewer hospitalizations and LTC admissions).
    - Increased economic productivity (caregivers reclaiming work hours).
    - Improved quality of life for both caregivers and care recipients.

The model projects over $200 million in combined savings and value. Appendix Two contains in depth description of the model and associated outcomes.

Recommended Actions

Home and community care have been evolving over the past few years. The ACCA is supportive of the healthcare transformation the Government of Alberta (GoA) has undertaken and recommends the following considerations for a sustainable home and community care sector as a major part of that transformation. We do want choice to be critically important in this area of publicly funded home and community care. We recognize that independent, non contracted service providers play an important role. We also want to respect the role of the family caregiver who provide hours of ongoing care and need supports due to burnout and having their own families, careers and personal needs.

(1) Define the Role of Home and Community Care in the Continuing Care System
It is critical that Home and Community Care has a defined role and position as a prevention and service delivery strategy to achieve better and sustainable outcomes for Albertans and the health and social services systems. Home and community care should be its own division within the Continuing Care pillar and be connected to other pillars such as Alberta Health Services, (acute care), Primary Care Alberta and Recovery Alberta (mental health and addictions).

Ensure a clear and transparent communication with Albertans about the types of home health care services versus in home support services so they are informed in planning for the care and support they need. Patient and caregiver feedback should be systematically collected and integrated into service improvements.

(2) Develop a Comprehensive Home and Community Care Framework
Creating a comprehensive framework for home and community care is essential to addressing Alberta's growing demand for aging-in-place services and ensuring the sustainability of its healthcare system. By enhancing medical and support services, investing in innovative care models, and empowering both providers and clients, Alberta can build a robust, person-centered system that delivers high-quality care in homes and communities. This framework will strengthen collaboration, promote independence, and ensure fair compensation and funding, ultimately positioning home and community care as a cornerstone of the province's health strategy.

(a) Expand Home-Based Clinical (Medical) Services: Implementing home-based primary care, where RN's, nurse practitioners, or physician assistants regularly visit patients with chronic conditions or those recently discharged, can prevent complications and hospital readmissions.

(b) **Telehealth Integration:** Utilize telehealth for routine check-ups, monitoring, and consultations. Remote patient monitoring tools can track vital signs, glucose levels, and other health indicators, allowing for early intervention.

(c) **Skilled Nursing Care:** Provide access to skilled nursing services at home, where nurses can manage wound care, IV medications, oxygen, insulin, vital signs management and other clinical needs. These clinical services are also available via independent, fee for service providers.

(d) **Contracted Home and Community Care Service Providers Bill Rates:** Contracted Service Providers with AHS have been driving many of these transformative changes to enhance quality of care however funding continues to lag in comparison to facility-based care and other provinces. Contracted Service Providers are requesting a 5% increase in Healthcare Aide bill rates. This rate increase directly correlates to recognizing the demand for homecare, health system cost avoidances (EMS and Acute Care admission) and supports organizations to establish fair and sustainable compensation structures that will enhance retention and recruitment strategies. This in turn fosters a stable and skilled workforce to meet the evolving needs of clients and families. In addition, a bill code/rate should also be established for nursing, therapy and social services.

(e) **Client-Directed Management of Home Care Funding through Blue Cross:** Client Directed Home Care Invoicing (CDHCI) plays a critical role in Alberta's health system by empowering individuals to manage their own care and maintain independence. However, the program's intent has not always been fully supported under current administration by AHS. This program has gained significant momentum and merits a thorough review to evaluate its positive outcomes for Albertans.

To strengthen its impact, this should be a government-funded, client-directed home support program that enables individuals to access assistance with instrumental activities of daily living (IADLs). These include essential tasks that clients are unable to manage on their own, such as personal hygiene, ensuring their ability to live safely and independently.

Prioritizing client autonomy and choice is fundamental to the success of this program. To ensure its sustainability and effectiveness, the home and community

care sector is advocating for a 5% rate increase, at a minimum, to support the program's continued growth and responsiveness to client needs.

(3) Reassess and Redefine the Role of AHS in Delivering Home and Community Care

To ensure home and community care is delivered effectively, it is critical to reassess the role of Alberta Health Services (AHS) in the management and delivery of these services. AHS's current involvement creates challenges in objectivity, coordination, and efficiency, often resulting in fragmented case management and delays in care delivery. By transitioning responsibilities to more objective entities and redefining AHS's role, Alberta can create a more seamless, person-centered system.

a) **Contracts should be held by the Government of Alberta.** AHS should no longer hold the contracts for home and community care providers as they are in direct conflict with AHS's mandate. Additionally, AHS is a position to be biased towards a contracted vendor, which may and/or can lead to the inability to manage the contracted vendor.

b) **Case Management and Coordination and Integration of Care**

All Case Management is done by Alberta Health Services. Case Management is fragmented and not coordinated. Given the transitioning role of AHS, case management needs to be reviewed and led by an objective organization. Establish teams that coordinate care between the hospital, primary care, specialists, and home care services. This ensures a seamless transition from hospital to home and continuity of care.

i. **Recognize Family Caregivers as Partners in Case Management**: Involve family caregivers as essential members of case management teams. This ensures they have a clear understanding of the care plan, transitions, and any specific roles or tasks they can undertake, promoting a seamless flow of information from hospital to home.

ii. **Leverage Home Care Providers for Assessments**: Allow qualified home care providers to perform assessments and participate in case management to reduce delays and improve access to care. This proactive approach addresses current bottlenecks, such as waiting weeks for AHS assessments, and ensures timely support for clients with increasing acuity.

iii. Pre-Discharge Planning and Coordination: Introduce a dedicated pre-discharge planning process as a critical step in case management.

Discharge coordinators and transition services should collaborate to determine if a patient can safely return home and connect them with a home care provider prior to discharge. Addressing this step proactively reduces hospital stays, expedites discharges, and ensures home care services are in place immediately upon transition.

iv. **Establish Family Caregiver Liaisons**: Include a designated family caregiver liaison within case management teams. This role would support caregivers in navigating transitions, coordinating communication across hospital, primary care, specialists, and home care services, and ensuring continuity of care.

v. **Seamless Transition Planning with Family Caregiver Support**: For every hospital discharge, develop a structured transition plan that includes a family caregiver's involvement, ensuring they are informed, trained, and prepared to support the patient's recovery and health management at home. This would reduce readmissions and foster more effective, long-term care continuity.

c) **Post-Discharge Follow-Up**: Implement a structured follow-up system for recently discharged patients. This could include home visits or phone calls to ensure that they are adhering to care plans and not developing complications.

   a. **Regular Family Caregiver Check-Ins and Training**: Incorporate regular check-ins with family caregivers, ensuring they understand changes in care plans and any signs of health deterioration. Additionally, provide training on specific care tasks and identifying when to seek further medical support, empowering them to better assist in managing care transitions.

   b. **Streamlined Communication and Resource Access**: Implement a centralized system accessible to both case management teams and family caregivers, offering real-time updates on care plans, discharge instructions, and access to resources. This can help address the fragmentation in case management by ensuring all parties, especially family caregivers, are up-to-date and have the tools they need.

(4) Establish a Navigation System that is Patient and Caregiver Centric

Establishing a patient- and caregiver-centric navigation system will ensure Albertans receive personalized, supportive services that guide them through assessments, care options, and transitions.

(a) Currently, there is no navigation system for Continuing Care, leaving a significant gap in support for transitions from hospital to home or hospital to facility-based care. A patient-centered system is urgently needed to assist Albertans and their caregivers, starting with an assessment of the individual's needs, incorporating caregiver feedback, and guiding them through care transitions.

This system must go beyond bed capacity management to provide a personalized and supportive service that ensures individuals with complex needs, along with their caregivers, receive the information and assistance necessary to make informed decisions about their care. A well-designed navigation process will optimize patient and family outcomes, reduce the burden on the healthcare system, and ensure patients receive the right care, from the right provider, at the right time—improving efficiencies and lowering costs.

(b) **Promote Public Education on Available Home and Community Care Programs**
The Government of Alberta should develop messaging on the types and variety of home and community care programs available in Alberta to inform Albertans of their choices and options. Educational efforts must consider cultural diversity, language accessibility, terminology, and literacy levels to ensure that the information is inclusive and understandable for all individuals. Tailoring materials to meet the needs of different populations will maximize the reach and effectiveness of public education initiatives, giving choices and helping families and caregivers make informed decisions.

(5) Adopt Standards for Home and Community Care Providers to Ensure Quality and Safety

Establish standards and a pre-qualification process for the various levels of home care supports for Albertans to ensure safety, quality, and consistency in services, addressing any "buyer beware" concerns. This will help safeguard Alberta Blue Cross and other stakeholders from unintended consequences due to insufficient due diligence. Key components include:

(a) **Registration and Background Requirements**: Health Care Aides should be registered on the Alberta Health Care Directory, and all home care providers must undergo criminal record checks. For providers involved in clinical and personal care services, a Vulnerable Sector (VS) check is required to ensure the highest standard of safety and security for clients. This ensures a baseline of safe, quality care for Albertans receiving home support services and provides added protection for vulnerable populations.

(b) **Caregiver-Centered Care Education as a Standard**: Caregiver-Centered Care Education should be a provider policy to ensure they are equipped to support family caregivers in the care continuum. This training emphasizes effective communication, respect for caregiver roles, and understanding caregiver needs and limitations, creating a supportive and collaborative environment that enhances patient outcomes.

(c) **Involvement of Patients and Family Caregivers in Standard-Setting**: Actively involve patients and family caregivers in setting and reviewing home care standards, ensuring their perspectives are valued. This collaboration can help identify key needs and enhance the relevance and effectiveness of standards, fostering a more holistic approach to care.

(6) Implement Proactive and Preventative Care Programs for Better Health Outcomes

Develop innovative, integrated and proactive care programs for seniors to mitigate unnecessary use and misuse of the healthcare resources and increase quality of care for seniors and their families to age in place.

(a) **Chronic Disease Management Programs**: Develop programs that focus on managing chronic diseases like diabetes, COPD, or heart failure at home. This includes education, regular monitoring, and quick response to any signs of deterioration.

(b) **Health Coaching and Education**: Offer health coaching to educate patients and caregivers on managing conditions, medication adherence, and recognizing early signs of complications.

(c) **Vaccination and Preventive Services**: Provide vaccines, health screenings, and other preventive services at home to reduce the likelihood of serious illness.

(7) Enhance Provider Training and Resources to Meet the Increasing Acuity of Patients in Home and Community Care

Home and community care providers are finding increasing acuity of clients due to shorter hospitalizations, complex health and mental health conditions and the desire to stay in their homes longer. This requires Home Care providers to be educated on physical and mental health. Training and the use of technology are key ingredients for optimal health outcomes for Albertans and the safety and wellbeing of home care providers.

(a) **Community Health Workers**: Deploy Health Care Aides to provide basic care and support in the home, particularly in underserved areas.

(b) **Partnerships with Local Organization**s: Collaborate with local agencies, such as the Alzheimer Society, for specialized care, support, and resources.

(8) Support and Empower Caregivers with Structured Resources and Assistance

Caregivers play a critical role in the continuum of care, allowing Albertans to remain in their homes and communities for as long as possible. Building on existing successful programs, we propose an integrated model inspired by the Family Services Agreement through Persons with Developmental Disabilities (PDD). By adopting elements from the PDD program, this model provides caregivers with a more structured, supportive environment, ultimately reducing burnout and ensuring caregivers can continue to provide effective care. Key elements include:

a) **Integrated Care Coordination:** Caregivers would be formally recognized as core members of care teams, with structured support in care planning, communication, and access to resources. This approach mirrors PDD's collaborative care plans, ensuring caregivers' insights are valued in decision-making. Regular training for healthcare providers on caregiver-centered care would enhance provider-caregiver collaboration and understanding.

b) **Financial and Workplace Support:** Financial assistance, including caregiver allowances and targeted tax credits, would reduce financial strain. Employer-backed benefits like flexible work arrangements, job protection, and caregiver

assistance programs would further support work-life balance, reflecting PDD's approach to easing the burden on families.

c) **Enhanced Resource Accessibility:** A centralized caregiver resource platform would streamline access to support services, offering a user-friendly portal with direct links to community programs, financial aid, and respite care. By integrating technology and shared databases, caregivers can easily navigate resources without duplicating efforts across agencies.

d) **Radical Collaboration as a Core Principle:** This framework advocates for radical collaboration across organizations, mandating open data-sharing practices to ensure caregivers receive consistent, reliable support. This cooperative approach minimizes service fragmentation and strengthens continuity of care.

Through this comprehensive model, Alberta can create a more inclusive, effective caregiving framework, directly benefiting caregivers and their families. The integration of care coordination, financial and workplace flexibility, and enhanced resource access reduces caregiver burnout, promotes continuity of care, and strengthens caregivers' financial and personal well-being.

(9) Integrate Advanced Information Management and Technology Solutions

(a) **Patient Information Needs to Follow the Patient in the Home and Community Care System**: The Government of Alberta (GOA) should increase investment in the integration and performance of home and community care management technology among agencies. This ensures the efficient transition of patients from the hospital to the home, seamless communication of critical patient data across the continuum, and enhanced administrative efficiency in intake, billing, and reporting.

(b) **Interoperability**: Require health information systems, such as ConnectCare, NetCare, and other electronic health record platforms, to be interoperable, enabling seamless exchange of information across systems. This ensures real-time data sharing to enhance patient and staff safety.

(c) **Access for Home Care Providers**: Provide home and community care providers with at least **view-only access** to hospital records, such as pending investigations and care plans, to enable continuity of care. This access should ultimately evolve

into a **bidirectional information exchange**, allowing hospital staff to view updates from community care providers.

(d) **Impartial Oversight**: Consider removing AHS as the sole gatekeeper for systems like ConnectCare and establish impartial oversight to eliminate potential conflicts of interest.

(10) Provide Financial Incentives and Support to Sustain Home and Community Care Services

Sustaining home and community care services requires targeted financial strategies to ensure equitable access, fair compensation, and support for both care providers and family caregivers. By implementing innovative reimbursement models, subsidies, and rural incentives, Alberta can address systemic gaps and reduce barriers to care. Additionally, financial support for family caregivers and employer-backed benefits will enhance the sustainability of caregiving roles, improve patient outcomes, and promote a more resilient home care sector. These measures are essential for creating a care system that is accessible, efficient, and supportive for all stakeholders.

(a) **Reimbursement Models**: Establish reimbursement models that reflect the true value of home care services, recognizing their role in preventing costly hospitalizations and readmissions. This approach can include increased rates for services that actively involve and support family caregivers, enhancing patient outcomes and long-term savings.

(b) **Subsidies for Home Care Services**: Provide targeted financial support to patients in need of home care services who lack resources. Expand the Blue Cross Client Directed Home Care Invoicing program. Include family caregivers as eligible recipients of subsidies, offering them additional financial flexibility to meet caregiving needs or access supplementary care support when necessary.

(c) **Rural Incentives**: Cover travel and mileage costs for nursing and therapy services in rural areas to address access disparities. The current travel methodology outlined in the AHS contract falls significantly short of covering actual expenses. It also imposes administrative burdens due to challenges in aligning scheduling systems with the travel rules. Additionally, field staff do not typically travel from the nearest home care office; instead, they often commute from larger urban centers, further complicating travel logistics.

(d) **Financial Assistance for Family Caregivers**:

i. **Caregiver Allowances**: Establish a provincial caregiver allowance modeled after the PDD Family Services Agreement, designed to offset direct caregiving costs.

ii. **Tax Credits**: Offer targeted tax credits to reduce the financial burden on family caregivers, modeled after similar caregiver tax incentives, ensuring they can afford necessary care expenses.

iii. **Travel Support:** Include support for family caregivers in the form of stipends or allowances for travel to specialized services, helping them maintain continuity of care.

(e) **Employer-Backed Caregiver Benefits**: Promote workplace policies that support family caregivers, recognizing their need for flexibility and job security.

i. **Flexible Work Arrangements**: Encourage flexible schedules, remote work options, and part-time arrangements to help caregivers manage work and caregiving responsibilities without risking income stability.

ii. **Job Protection Policies**: Advocate for job protection for family caregivers, ensuring they can take caregiving leave without fearing job loss.

iii. **Caregiver Assistance Programs**: Partner with employers to establish assistance programs, such as paid time off for caregiving, resources for managing work-life balance, and support groups within workplaces.

(11) Evaluate and Scale Proven Home and Community Care Programs

Building a robust home and community care system requires a commitment to innovation, evidence-based decision-making, and continuous improvement. Evaluating the effectiveness of programs and scaling proven initiatives ensures that resources are directed toward impactful solutions. By revisiting innovative ideas from past proposals, piloting new approaches, and systematically refining programs, Alberta can address critical gaps in care, enhance patient outcomes, and reduce strain on the healthcare system.

(a) **Pilot Programs**: Start with pilot programs to test and refine approaches before scaling them up. Use data from these pilots to prove effectiveness and secure funding.

(b) **Continuous Improvement**: Regularly evaluate the impact of home and community care programs on hospital readmissions, patient satisfaction, and overall healthcare costs, and adjust as needed.

(c) **Revisit and Scale Innovations from the Alberta Health RFP Process**: During the RFP process for home care contracts, several innovative programs targeting areas such as palliative care, dementia, mental health, and addiction were proposed but largely overlooked or absorbed into general home care services. Revisiting these submissions presents an opportunity to:

- **Leverage Proven Ideas**: Many of these programs were designed to address gaps in care and could significantly enhance patient outcomes and reduce system pressures.
- **Pilot and Scale**: Select promising proposals from the RFP to pilot, evaluate, and scale based on effectiveness.
- **Support Transformation**: Encourage Alberta Health to provide targeted funding and infrastructure to pilot innovative programs, including facility-based respite and adult day programs.

By revisiting these innovative ideas and applying a structured pilot-and-scale approach, Alberta's home and community care system can better address the needs of its diverse populations while fostering system-wide transformation.

(12) Facilitate Knowledge Sharing and Translation Across the Care Sector

There are significant opportunities to enhance home and community care programs by fostering collaboration and sharing expertise. Creating a platform for providers to showcase their experiences and lessons learned can drive greater innovation and creativity across the sector, ultimately benefiting all Albertans.

One potential initiative could be a **Home and Community Care Conference** focused on best practices in client care, providing a space for professionals to exchange ideas, explore innovations, and advance the quality of care.

Shared Vision for Home and Community Care

The Alberta Continuing Care Association (ACCA) appreciates the Government of Alberta's (GOA) commitment to enhancing home and community care as a cornerstone of its Aging with Dignity strategy. Both ACCA and the GOA share a unified vision of ensuring that

Albertans have access to high-quality, person-centered care, enabling them to age in place, improve their quality of life, and reduce strain on the broader healthcare system.

As trusted partners in this mission, ACCA's home care providers offer valuable expertise and practical insights to complement the GOA's strategic priorities. Together, we can strengthen Alberta's home and community care system to meet the growing demand for aging-in-place services and foster a sustainable, integrated healthcare model for all Albertans.

Areas of Alignment and Opportunities for Collaboration

We commend the GOA's emphasis on increasing capacity and integration within Alberta's home and community care system, empowering and supporting caregivers and commitment to using technology to improve care delivery and coordination.

ACCA members are committed to working collaboratively with the Government of Alberta to strengthen home and community care for all Albertans. By aligning our collective expertise, resources, and priorities, we can create a sustainable, equitable, and person-centered care system that supports Albertans in aging with dignity. We look forward to furthering this partnership to achieve our shared vision.

Defining the Role of Home and Community Care

A clear definition of home and community care as a distinct entity within Alberta's Continuing Care system presents an opportunity for collaboration. ACCA members can support the GOA in establishing a comprehensive framework that integrates home care with primary and acute care systems, ensures transparency about service options, and incorporates patient and caregiver feedback into continuous improvement processes.

Establishing a Comprehensive Navigation System

There is an opportunity to co-develop a patient- and caregiver-centric navigation system that addresses gaps in transitioning between care settings. ACCA members can contribute practical insights to design a personalized navigation process, ensuring that clients and caregivers receive the guidance and support they need throughout the care continuum.

Enhancing Standards and Training

ACCA members are eager to collaborate with the GOA on establishing standards for home care providers, including registration, background checks, and caregiver-centered care education. This would ensure safety, quality, and consistency across services, safeguarding vulnerable populations and building trust in Alberta's home care system.

Sustaining the Workforce Through Fair Compensation

Addressing funding disparities between home and facility-based care represents a key area for collaboration. ACCA's recommendations for a modest rate increase for contracted providers and workforce incentives, particularly in rural areas, can support the GOA's goal of expanding capacity while ensuring stability and fairness in the sector.

Scaling Proven and Innovative Programs

By revisiting and scaling innovative programs proposed during the Alberta Health RFP process, the GOA and ACCA can jointly transform Alberta's home and community care system. Piloting these proven approaches—such as facility-based respite, dementia care, and adult day programs—can address critical gaps while fostering a culture of continuous improvement.

Conclusion

Alberta stands at a pivotal moment in transforming its home and community care system. By addressing key opportunities such as enhancing funding, building workforce capacity, and streamlining care coordination, the province can strengthen this vital sector and meet the evolving needs of its population. Empowering home and community care providers with equitable support, prioritizing caregiver well-being, and embracing innovative care solutions will ensure that Albertans can live with dignity, independence, and quality of life in their homes and communities. Achievable through collaborative action, this vision reflects Alberta's values and demonstrates a forward-thinking approach to creating a sustainable, person-centered care model that benefits individuals, families, and the broader health system.

Appendix One

Home and Community Care Working Group Membership Participants

The Alberta Continuing Care Association's (ACCA) **Home Care Position Paper** addresses the critical role of home care providers in Alberta's evolving healthcare system. This position paper reflects the shared perspectives of home care professionals, service provider organizations, caregiver advocates, and care recipients to provide actionable insights into how Alberta can strengthen home care services to meet growing demands.

About the Authors

Diverse Expertise

The authors come from a wide spectrum of organizations, including national providers, Alberta-based innovators, and local community service organizations. Their diverse expertise ensures the recommendations are practical, scalable, and relevant to Alberta's unique needs.

Grounded in Frontline Experience

The working group includes professionals who manage home and community care services daily. Their firsthand knowledge of operational challenges and opportunities lends credibility and depth to the paper.

Caregiver and Recipient Perspectives

By incorporating the views of caregivers and care recipients, the paper reflects a human-centered approach that balances systemic needs with individual and family-level impacts.

ACCA Leadership

The Alberta Continuing Care Association, led by Dr. Denise Milne and Tara Preston, brings a strong track record in policy advocacy, research, and strategic partnerships. Their leadership ensures the paper is aligned with both industry realities and government priorities.

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Appendix Two

Supporting Caregivers to Transform Health and Save Costs

Imagine a woman named Anna, a caregiver in Alberta. Like many others, she spends her days juggling a full-time job while caring for her aging mother, who has complex medical needs. From managing medications and attending doctor's appointments to helping her mother with daily tasks, Anna's responsibilities are endless. She is emotionally drained, financially strained, and often wonders how long she can keep this up.

Anna's story is not unique. Across Alberta, 40,000 caregivers—family members and friends—are silently holding up the healthcare system, providing unpaid support to loved ones and allowing them to remain at home rather than moving into long-term care (LTC). These caregivers are the backbone of Alberta's healthcare system - often at great personal cost, the toll on caregivers is heavy, leading to stress, burnout, and health challenges.

What if we supported caregivers like Anna?
Team CarePal partnered with HIMA Consulting to answer this question by employing a model designed to evaluate the costs, benefits, and health outcomes of caregiver support interventions over time.

The Interventions
The model identifies four key interventions that address the challenges caregivers face and enhance their ability to provide care:

5. Respite Care: Professional caregiving services that temporarily relieve family caregivers, allowing them to rest and recover.
   - Caregiving without breaks leads to burnout, which reduces caregivers' ability to care for their loved ones effectively. Respite care prevents this, ensuring consistency and quality in care.

6. Mental Health Support: Counseling, peer groups, and stress management resources that help caregivers cope with the emotional demands of caregiving.
   - Many caregivers experience stress, anxiety, or depression. Emotional support helps them maintain resilience and continue caregiving.

7. Care Coordination Tools: Platforms or navigators that simplify access to healthcare resources and reduce the logistical burden on caregivers.

- Managing appointments, medications, and care schedules is overwhelming for caregivers. Streamlined tools save time and ensure individuals receiving care have their needs met promptly.

8. Financial Assistance: Subsidies or tax credits to offset caregiving-related costs, such as reduced work hours or out-of-pocket expenses.
   - Financial stress exacerbates caregiver burnout, making it harder to balance work and caregiving responsibilities.

These interventions cost approximately $8,000–$11,250 per caregiver annually. For Alberta's 40,000 caregivers, the total investment over 5 years would range from $1.6 billion to $2.25 billion. While this may sound like a large sum, the results are remarkable:

- For every $1 invested, Alberta gains $11 in value through:
  - Reduced healthcare costs (fewer hospitalizations and LTC admissions).
  - Increased economic productivity (caregivers reclaiming work hours).
  - Improved quality of life for both caregivers and care recipients.

By applying these findings to Alberta's 40,000 caregivers, the model projects over $200 million in combined savings and value.

What the Numbers Tell Us: Tangible Benefits for Everyone
The model is based on predictions. It combines Canadian healthcare data with studies on caregiver interventions to estimate how much better things could be if caregivers received the right support. Think of it as running a simulation to see what would likely happen over 5 years if caregivers had access to programs like respite care, mental health support, and care coordination tools.

These outcomes are grounded in rigorous modeling techniques, including decision trees and Markov models, which are standard in healthcare economics. The model uses real-world data from trusted sources like The Canadian Institute for Health Information and Statistics Canada to ensure accuracy and reliability.

1. For Individuals Receiving Care: Better Health and Independence
When caregivers receive the support they need, the individuals they care for experience significant benefits, including better health outcomes and the ability to remain at home longer.

62 Fewer Hospitalizations

- Out of 1,000 care recipients, 62 would avoid going to the hospital over 5 years.
- Supported caregivers can manage health issues earlier—like ensuring medications are taken or symptoms are addressed—before they escalate into emergencies.
- Avoiding hospital stays improves the care recipient's quality of life and saves the healthcare system money. Each avoided hospital stay is worth $10,000, resulting in savings of $620,000.

12 Fewer LTC Admissions (or Delayed Placements)

- 12 out of 1,000 people receiving care can avoid or delay moving into long-term care (LTC) over 5 years.
- Supported caregivers are better equipped to care for loved ones at home, even as their needs increase.
- Aging in place improves mental and physical health for care recipients and reduces family and system costs. Delaying LTC admission saves $108,000 per person, adding up to $1.3 million in savings.

2. For Caregivers: Better Health and Financial Stability

Caregivers often experience stress, burnout, and health issues due to their responsibilities. Support programs help alleviate these burdens, enabling them to care for their loved ones without sacrificing their own well-being:

118 fewer caregivers (out of 1,000) would experience significant stress:

- Respite care, counseling, and peer support groups reduce the emotional strain of caregiving.
- Lower stress allows caregivers to provide sustained, effective care.

80 fewer caregivers face serious health declines:

- Chronic stress is alleviated through support programs, preventing conditions like depression, anxiety, and physical health problems.

11,431 work hours reclaimed, worth $658,685:

- Caregivers who are less stressed and healthier miss fewer days of work, while care coordination tools save time managing appointments.
- Maintaining employment prevents financial strain and ensures balance between work and caregiving.

3. For Alberta's Healthcare System: Significant Cost Savings

When caregivers are supported, their ability to care for loved ones reduces costs across the healthcare system:

- $2.1 million saved per 1,000 individuals over 5 years:

- Reduced hospitalizations and delayed LTC admissions lead to lower healthcare spending. Healthier caregivers also rely less on medical services themselves.

- Long-Term Impact and Return on Investment:
    - For every $1 invested in caregiver support, Alberta gains $11 in value. These returns come from healthcare savings, increased caregiver productivity, and improved quality of life.
    - By scaling this framework to Alberta's population of caregivers and their loved ones, the province can save millions while ensuring a stronger, more sustainable care system.

A Vision for the Future

Imagine an Alberta where caregivers are supported by a system that recognizes their vital role and empowers them to provide high-quality care without sacrificing their own well-being. Care recipients live longer and healthier lives at home, and the healthcare system avoids costly hospitalizations and long-term care placements.

This vision aligns with aging in place principles, which prioritize enabling individuals to remain in their homes and communities for as long as possible. Aging in place improves quality of life, fosters independence, and reduces the emotional and financial strain on families. These interventions would support caregivers in achieving this goal, ensuring that loved ones receive the care they need in the setting they prefer.

Outcomes of Supporting Caregivers

1. **Improved Health Outcomes for Care Recipients**: By providing family caregivers with the support they need, such as training, respite care, and financial assistance, the quality of care provided to care recipients is likely to improve. This could lead to better health outcomes, reduced hospitalizations, and an enhanced ability for individuals to age in place. For example, the Team CarePal model predicts a reduction of $332,767 in long-term care costs and a gain of $517,244 in Quality Adjusted Life Years (QALYs) when 1,000 caregivers are supported. This illustrates the potential for significant improvements in health outcomes and cost savings through enhanced caregiver support (Team CarePal Model).

2. **Reduction in Caregiver Burnout**: Providing adequate support to family caregivers can reduce the risk of burnout, allowing them to continue providing care for longer periods. This support could include access to counseling services, caregiver support groups, and respite care options that give caregivers a much-needed break.

The model demonstrates that, with effective support, 118 fewer caregivers out of 1,000 will experience significant stress, and 80 fewer will suffer health losses, underscoring the importance of caregiver well-being in sustaining long-term care (Team CarePal Model).

3. **Improved Navigation and Access to Resources**: Addressing the issue of healthcare system navigation and resource access can lead to more timely and efficient care. Developing centralized platforms or support systems that help caregivers find and access resources will reduce the stress and time burden on caregivers, ensuring that care recipients receive the appropriate services when needed. The Team CarePal model shows that caregivers gain back 43,965 hours of work that would have been missed due to caregiving, reflecting how improved resource access can directly translate into more balanced and manageable caregiving responsibilities (Team CarePal Model).

4. **Economic Benefits**: Supporting caregivers can have positive economic effects. When caregivers can balance their work and caregiving responsibilities, they are less likely to leave the workforce, which benefits the economy. Additionally, reducing caregiver stress and improving their health can decrease the demand for health services that caregivers themselves might require if their own health deteriorates. In the model, caregivers saved $2.5 million in work hours that would have been lost, highlighting the substantial economic benefit of supporting caregivers to maintain their dual roles (Team CarePal Model).

5. **Enhanced Quality of Life for Caregivers**: Addressing the needs of caregivers can improve their overall quality of life. This includes better mental health, reduced stress, and a greater sense of fulfillment in their caregiving role. Ensuring that caregivers have access to social support and resources can alleviate the isolation many experiences. The model shows that effective support can prevent health losses in 80 caregivers out of 1,000, emphasizing the potential for significant improvements in the quality of life for those who take on these crucial roles (Team CarePal Model).

6. **Sustainable Home and Community Care System**: By investing in the well-being of family caregivers, Alberta can create a more sustainable home and community care system. Caregivers play a vital role in allowing individuals to remain in their homes, reducing the strain on long-term care facilities and the healthcare system. The economic modeling indicates that, when applied broadly, such interventions can save the health system $29,435 in caregiver health costs alone, with additional

savings in reduced long-term care admissions and hospitalizations(Team CarePal Model).

7. **Outcome: Integrating Family Caregivers into the Care Team – A Saskatchewan Pilot as a Model for Alberta**: The ongoing Saskatchewan pilot program at Diamond House (Warman), under Golden Health Care (GHC), offers a promising model for integrating family caregivers into the care team during critical transitions from acute care to Alternate Level of Care (ALC) beds, and ultimately, to the home of choice. This approach emphasizes the positive impact of involving family caregivers in care planning and decision-making, leading to improved health outcomes and smoother transitions for older adults.

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