**Appendix 2: Funding Agreements 2018- 2027**

**Federal/Provincial/Territorial Home and Community Care and Mental Health Services**

**N.B. Most funding for Mental Health and Addictions targets youth and adolescents**

| **Province/Territory**  **Date Signed**  **5-yr Funding**  **Special Pop. needs** | | **Current Home and Community Care and**  **Mental Health and Addictions Initiatives** | | | **Plans for Funding Allocation** | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Newfoundland and Labrador**  **Date Signed:**  **2018 - 01- 24**  **Funding;**  $67.7 million  **Unique circumstances:**   * rural and remote communities, rapidly aging, prevalence of chronic diseases and growing rates of mental health and addictions provide long term sustainability challenges * over reliance on facility-based care * mental health and addiction referrals steadily increasing   **Newfoundland and Labrador continued**   * alcohol most common addiction | | **Home and Community Care**  Have been developing/implementing Home First Initiative for those with complex needs   * includes palliative and end of life * integrates with regular programming   **Towards Recovery: The Mental Health and Addictions Action Plan** released June 2017   * set short, medium and long-term goals to implement 54 recommendations around 4 pillars:   + promotion, prevention and early intervention   + focus on person   + improve service access, collaboration and continuity of care   + include all people * implemented Opioid Action Plan including prescription monitoring, take home naloxone kit program, access to suboxone * a number of e-mental health solutions * 2 adult addiction treatment centres plus outpatient counselling | | | **The province will:**  **Home and Community Care**  1. Create Home First integrated network:   * fund clinical positions, programs and services for complex care needs in community including beyond traditional work hours * key areas: case management, home support, rehabilitation, nursing, physicians, pharmacy, counselling/spiritual supports, equipment   2. Integrate palliative approach across health care system:   * enhance clinical positions, implement professional development for clinicians, service provides and caregivers * fund public awareness campaign and develop tools to promote palliative care and advance care planning * support and create hospice beds in 2 regional health authorities   3. Enhance services for those with dementia:   * better respite services for caregivers * professional development for providers and caregivers * expand remote monitoring technology through provincial dementia care program including e-health consultation   **Mental Health and Addictions**  1. Integrate service delivery for children, youth, emerging adults with mental health/addictions: create specialist positions  2. Introduce e-mental health services and initiatives   * expand Strongest Families Institute (SFI) * hire new mental health position in each RHA * implement Therapy Assisted Online   3.Expand access to addiction services:   * enhance harm reduction initiatives * add naloxone take home kits   4. Invest in community-based services;   * single session walk-in clinics, day treatment hospitals, community crisis beds * increased access to psychological therapies; 4 positions to support Towards Recovery Action Plan | | | | |
| **Nova Scotia**  **Date Signed:**  **2018-08-30**  **Amount:**  **$141.9 million**  **Unique circumstances:**   * Population: 19.3% over 65, expect be 25.1% in 2026 * 18.8 % over 65 with disability   **Nova Scotia continued**   * 30,000 access home and community programs annually   **Nova Scotia continued** | | **Home and Community Care**  1. Home first approach, added hours, services and spaces in supportive care  2. Seniors Community Wheelchair and Bed Loan Programs  3. Caregiver benefit program, respite care  4. Funding for associations – Alzheimer’s, Caregivers NS  5. Extended Care Paramedic Program in long term care facilities  6. Special Patient Program to allow patients anticipating emergency care to communicate wishes  **Mental Health and Addictions**  Range of health promotion and prevention, and general and specialized treatment programs for mental health and addictions. These programs include ambulatory community-based programs, home or school-based interventions and in-patient services. | | | **The Province will:**  **Home and Community Care**  1. Enhance Continuing Care Services:   * increase flexibility of current programs * develop new programs- especially for complex needs * align with resources to support health outcomes, promote efficiencies, leverage community-based resources * enhance end of life care including 10 positions and staff training plus volunteer coordinator and training * target supports for remaining in community, expand bed loan, expand home adaption funds, short term intensive programs to transition from hospital to community, home lift program * support implementation of Acquired Brain Injury (ABI) Action Plan including pilot of intensive rehab day program and cluster of community-based rehab * enhance communication of programs and services   2. Support Caregivers:   * ensure awareness of and have access to services and supports that address their distinct needs * expand access to caregiver benefit program * introduce web-based booking, sources and coordination for respite care * increased funding for Alzheimer’s, Caregivers NS and funds for ABI * online/virtual/telephone support for caregivers, ongoing research   3. Support Integrated Care:   * Strengthen partnerships, systems and processes to enable a coordinated, holistic approach to care * expand Extended Care Paramedic and Special Patient programs to other parts of province * add additional paramedics, telenursing etc * enhance coordination between the Provincial Continuing Care Program, First Nations and Inuit Home and Community Care Program (FNIHCCP) needs assessment, intensive outreach team, ABI network   4. Enhance Sustainability, Accountability and System Performance:   * Ensure system design, services, and performance based on evidence, data, sector knowledge, and client experience * data submission portal for home care service providers * implement interRAI Long-Term Care Facilities Assessment Tool.   **Mental Health and Addictions**   1. Enhance integrated service delivery for children and youth with Mental Health/Addictions 2. Enhance Access to Community Based MHA Supports  * increase number of professionals in community, including First Nations * develop/implement standardized care model including staff and training * improve access to crisis service with staff, enhance crisis line and capacity for urgent follow-up * technology to support central intake for services plus additional staff and training and triage, enhance virtual care | | | | |
| **Prince Edward Island**  **Date Signed:**  **2018-02-23**  **Funding**  **$20.7 million/**  **(next 5 years $24.8 M)**  **Unique circumstances:**   * Surge in demand for services * 19.4% over 65 | | **Home and Community Care**  1.Enhanced investment in home and community care – nursing care, home support, palliative care, social work, dietician services, physio and occupational therapy, adult protection, long term care, adult day programs  2. Paramedics providing palliative care at home  **Mental Health and Addictions**  2016 10 year strategy for mental health and addictions (44 recommendations, identified barriers)   * added positions, mental health walk-in clinics, and enhanced existing programs | | | **The Province will;**  **Home and Community Care**   1. Mobile integrated initiative:  * rapid bridging of palliative, hospital, and emergency patients to home * paramedic check in program * establish delivery infrastructure and mechanisms * add staff resources; additional hours, emergency vehicle * facilitate transport from hospital to home * discharge with care plan * sensitive to first nations and francophone communities * provide interventions, follow-up assessments and in home support, including administer medications, case management * high priority clients for community support/scheduled visits  1. Home care IT infrastructure*:* pilot cloud based electronic medical record to support home care | | | | |
| **Province/Territory**  **Date Signed**  **5-yr Funding**  **Special Pop. needs** | | **Current Home and Community Care and**  **Mental Health and Addictions Initiatives** | | | | **Plans for Funding Allocation** | | | |
| **Prince Edward Island continued**   * Higher rates chronic diseases in over 50 * 80% of 911 calls by 65+ are non- emergency | | * 2 key initiatives identified: Student Well-Being (focus on school aged children and youth) and Mobile Mental Health Crisis (24/7) programs | | | 3. Implement Inter RAI (Resident Assessment Instrument)   * develop standardized tool for home and long-term care system to better inform decision-making   **Mental Health and Addictions**  Mobile Mental Health Crisis Program:   * additional staff for teams of mental health professionals supported by psychiatry connected to first points of contact * build on efforts to ensure cultural safety and awareness training for mental health and addictions staff. | | | | |
| **New Brunswick**  **Date signed:**  **2017-12-15**  **Funding:**  **$97.3 Million**  **Unique circumstances:**   * Seniors 19% of population * 61% emergency visits less/non-urgent | | **Home and Community Care**  1. NB Family Plan: Improve access to primary & acute care; wellness; support people with addictions & mental health challenges; support for seniors, foster healthy aging, advance women’s equality; reduce poverty; support people with disabilities  2. Establishing a network of primary care ser-vices: community health centres, health services centres, community mental health & addiction centres, public health centres, and extramural  3. Tele-Care: Universal 24/7/365 access  4. Family physicians – increasing availability  5. Patient Connect NB: connecting patient to family doctor | | | **The Province will:**  **Home and Community Care**   1. Integrate Community Care Services:  * Bring Extra-mural program, Ambulance NB, Tele-Care 811 under one management; * Extend time in community care; * Increase community care capacity; * Increase referrals and interactions between family physician and allied health professionals for patients residing in the community; * develop/implement clinical protocols  1. Implement a point-of-care electronic clinical informationsystem to support EMP: eHealth; complete and widely shareable client record; an electronic clinical information system. | | | | |
| **Province/Territory**  **Date Signed**  **5-yr Funding**  **Special Pop. needs** | | **Current Home and Community Care and**  **Mental Health and Addictions Initiatives** | | | | | **Plans for Funding Allocation** | | |
| **New Brunswick continued**   * 65% self-report 1 or more chronic conditions * Officially bilingual | | 6. Extra-Mural Program (EMP): home healthcare provides comprehensive in-home healthcare services  7. Palliative services in variety of settings with minimal access to team outside hospital  **Action Plan for Mental Health** exposed gaps   * services: prevention, withdrawal management, residential rehab. Opioid replacement, community treatment * 2 inpatient centres plus regional hospitals * school based for youth | | | | | 3. Shift toward more in-home and community palliative care   * provide more funding for out-of-hospital palliative care; * provide patients and families with more palliative care information and options; * support caregivers; * expand palliative care education for providers and public; * implement standardized assessment/monitoring tools; * develop monitoring/evaluation framework; * enhance hospice services; and * develop alternate residential services in rural communities. * implement senior care services in home.   **Mental Health and Addictions**   * programs/services need to be integrated/interdependent; * build community capacity, provide training for providers; * expand mobile services to include daytime hours; * establish e-mental health services; | | |
| **Quebec**  **Date Signed:**  **2018-09-17**  **Funding:**  **$1,645 Billion**  **Unique circumstances:**  Asymmetrical Implementation Agreement  **Quebec continued** | | **Home and Community Care:** Process to improve organization of home care and services underway  **Mental Health** Action Plan has 40 measures  **Addictions:** Interdepartmental Action Plan includes opioid strategy  Special Notes:   1. Will continue to do own reporting to population on use of funds 2. Will participate as observer in work of Canadian Institute for Health Information (CIHI) to develop common indicators for home care and mental health and addictions services | | | | | **The Province will:**  **Home and Community Care**  Consolidate home support services and provide a range of professional services in increased quality and quantity   * Make home assistance services more accessible * Promote adoption of best practices in home care across all establishments in health/social services networks * Implement clinical progress tools * Improve data quality   **Mental Health and Addictions**   1. Implement Cyber addiction services at integrated centers with addiction rehabilitation mission; 2. Deploy addiction professionals in all regions; 3. Set up psychotherapy access program; 4. Improve accommodation and community retention services; 5. Enhance community crisis services; 6. Consolidate assertive community treatment (ACT) and variable intensity support (VIS) services; and 7. Broaden the range of support services to establishments that provide mental health services from the Centre national d’excellence en santé mentale (CNESM). | | |
| **Ontario**  **Date Signed:**  **2019-01-23**  **Funding:**  **$1.8 billion for 2018 -2022**  **Unique circumstances:**   * 13 million receive health care; 2,132,000 (16.4%) of them are over 65 yrs. of age; * Spends $3B annually on home and community care clients.   **Ontario continued**   * Home care recipients have increased by 20% in the past 10 years. | | **Home and Community Care**   1. Shift to care in home and community settings led to 14 Local Health Integration Networks (LHINs). 2. Increased investment in Home Care by $250 Million annually since 2013. 3. 670,000 clients access home and community care, health therapy care, caregiver respite, and palliative and end-of-life care. 4. Home and community care provide nursing, personal health supports, and smooth transition from hospital, rehab or other settings. 5. Only 43.3% of dying clients receive palliative home care service. 6. 43.4% of caregivers experienced distress, anger or depression in 2017, up from 21% in 2012. 7. Caregivers in Canada currently provide $10 Billion worth of care annually. (The Province wants to enable them to keep doing that.)   **Mental Health and Addictions:**   1. One of the most serious health and social challenges facing Ontario’s youth; 2. Spend $4 B/year through 14 LHINs: supports 241 children and youth mental health organizations, 380 agencies, departments in 60 general hospitals and 4 stand-alone psychiatric hospitals. 3. Provides 17,000 supportive housing units for people living with mental health and addiction issues and for other vulnerable people. 4. Implementing policies, programs and services to address opioid addiction/overdose and expand access to withdrawal management. 5. Problems in mental health area:  * high wait times and limited service capacity; * barriers to access: * finding help and services; * poor coordination between primary care, hospitals, schools, and community-based services; * uneven service quality; * lack of data for citizens, service providers and system planners; * fragmented system – poor coordination across continuum of care. | | | | | **The province will:**  **Home and Community Care**   1. Build a dynamic home care system and enhance current community health services; 2. Invest in and transform home care to make it better coordinated and more convenient; 3. Partner, integrate home care with hospitals and primary care reducing pressure on hospitals and long-term care homes and avoiding unnecessary emergency department visits and hospital re-admissions. 4. Expand access to and improve delivery of home care.  * Provide additional nursing, therapy, personal support and care coordination; and enhance care for high need clients thus preventing or delaying re-admission into long term care facilities; * Dialogue/partner with Indigenous organizations to improve access to culturally appropriate home and community care for First Nations and Indigenous peoples;  1. Enhance support for palliative and end-of-life care by increasing hospice capacity, thus reducing the use of hospitals by people in the last years of their lives; 2. Encourage establishment of advance care plans. 3. Increase Support for Caregivers  * Establish a centralized place to access support, services and advice; * Provide training, education, and resources; * Invest in the provision of caregiver respite.  1. Adopt and utilize Info Technology (IT) in health care:  * For self -assessment, scheduling appointments, receiving test results, becoming partners in their own care plans; * To engage in telemedicine and remote monitoring devices at home; * To integrate care and data within care teams; * To improve the quality of care in rural and remote areas; * To spend $15 M on Health Care IT from 2019 – 2022.   **Mental Health and Addictions**   1. Match funding from the bilateral agreement for a total of $3.8 B over 10 years; 2. Improve client experience and outcome, improve access to quality mental care across the province, and focus on prevention, promotion of good health and early intervention; 3. Reduce wait times for community mental health services; 4. Enhance services, addressing opioids and addiction needs; 5. Create additional supportive housing; 6. Build capacity for child and youth mental health services;   7. Invest in services for Indigenous people.  Spend $773.17 M in federal funding (2017 -2022) | | |
| **Manitoba**  **Date signed**  **2019-03-28**  **Funding:**  **Home care: $12 M over the next 5 yrs**  **Mental Health & Addictions: $ 69.1 M over the next 5 years**  **Approximately $400 M over the next 10 yrs.**  **Unique circumstances:**   * Currently, seniors comprise 14.3 % of the population. Expected to double in number by 2038, with the greatest increase to be in the 75 to 84 age group. * 1974 province-wide, comprehensive universal home care service is the oldest in the country. | | **Home and Community Care:**  Demands for home care increasing.   * Priority Home” care project - moves patients from hospital to community via “Pathways to Home” in early stages of implementation. Aims to reduce/avoid expensive hospital/long term care time by providing intensive, person-centred collaborative home care service. Successful so far for 80% of clientele. Number of persons entering long term care facilities has been reduced by 88%. Wait lists reduced by 47%. * Province is expanding palliative care options. Manitoba has only 16 hospice beds for a population of 1,278,365 (all beds located in Winnipeg).   **Mental Health and Addiction Services:**   1. Compared with the national average (2012) Manitoba has the highest prevalence of major depressive disorder; the 2nd highest prevalence of alcohol use disorder; the 3rd highest prevalence of generalized anxiety disorder. 2. The use of crystal meth, alcohol, opioid use/misuse places great stress on health care system. 3. A recent study revealed that Manitoba’s children (age 6 –19) receive a mental disorder diagnosis at almost twice the national average, yet had the lowest hospitalization rates for mental disorders. | | | | **The province will:**  **Home and Community Care**   1. Transform health care by creating a provincial health organization, “Shared Health” to plan and integrate services, thus improving patient care. 2. Provide coordinated support to regional health authorities. 3. Work with the Federal Gov’t to improve health service to remote Indigenous communities; 4. Through transformation and innovation in care, reduce the number prematurely entering a personal care home; 5. Use a team approach to enhance availability and quality of integrated palliative care services, focusing on community/home care in rural areas; 6. Enhance access to psychosocial supports, health system navigation, pain management and respite care to facilitate home care; 7. Provide safe, seamless, individualized care on a continuum using a collaborative, team-based approach, increasing connections between patients and primary care givers; 8. Expand home care service delivery: increase nursing services, hours, home care attendant hours, home care dialysis (in 2018, home care service hours increased by 80,000).   **Mental Health and Addictions**   1. Increase opportunities for prescribers to enhance their competencies in addiction medicine; 2. Implement a peer support program through community-based agencies and implement transitional discharge models to reduce days spent in hospital; | | |
| **Province/Territory**  **Date Signed**  **5-yr Funding**  **Special Pop. needs** | | **Current Home and Community Care and**  **Mental Health and Addictions Initiatives** | | | | **Plans for Funding Allocation** | | |
| **Manitoba continued**   * Home care is provided free to all who qualify | | *Six Initiatives have been implemented over the last two years to address mental health and addictions challenges:* a third Program for Assertive Community Treatment; Proclamation of the Advocate for Children and Youth Act; Siloman Mission; Fountain Springs Housing; Hope North Recovery Centre for Youth in Thompson; and the Manitoba Opioid Support and Treatment Program | | | | 1. Use peer support in Crisis Response Centre/Emergency Departments to serve 5,000 clients in Year 1 and up to 15,000 in Year 2 and onward; 2. Redesign and enhance the Emergency Department Violence Intervention Program; 3. Implement a Pregnancy and Infant Loss Program.   (Other specific goals and expected outcomes are outlined in the detailed agreement.) | | |
| **Saskatchewan**  **Date signed:**  **2018-05-14**  **Funding:**  **$348.7M over the next ten years.**  **Unique circumstances:**   * Heavy reliance on costly hospital care and emergency dep’t * patient flow: 1/3 acute beds occupied inappropriately * vast geography difficult to serve * opioid crisis * by 2031 Indigenous peoples be 24% | | **Home and Community Care:**  Several initiatives to shift emphasis from emergency/hospital care to home/community:   1. Home First/Quick Response*:* sustain seniors in homes, provide transitional after-hospital care, prevent hospital re-admission. 2. Community Paramedicine: paramedicsprovide treatment/care in homes often after hours to stabilize patients/eliminate transfer to acute care facility. 3. Connecting to Care: interdisciplinary intensive case management services for clients with complex needs/require individualized approach 4. Primary Health Care networks*:* reorganize/ integrate primary health care services in communities to promote independent living, prevent disease, and promote self-management of existing health conditions. 5. Connected Care Strategy: safe, seamless transition through each level of appropriate care from home to palliative for every patient | | | | **The province will:**  **Home and Community Care**   1. Expand establishment of Community Health Centresto address “high needs” senior populations with high prevalence of complex chronic conditions and high rates of hospital utilization. Centres allow increased access to primary care, urgent chronic care, and home visits. Funds to hire inter-disciplinary health care teams co-located to deliver on-site and home-based outreach services and provide preventative and primary care; the Agreement funding will also support necessary infrastructure; ($65.5 M for 2018 -2022) 2. Enhance Palliative Care Services:Improve access at home or in other facilities, train medical personnel in end-of-life care, and provide/integrate care service teams in rural and remote areas;($17 M for 2018 – 2022) 3. Establish the Shared Care Plan: clinical care plan for every patient. All health care providers will have access to, and contribute electronically to one source of medical information for each individual, thus improving continuity of care empowering patients’ knowledge and participation in their personal health, improving communication among medical personnel, and enhancing efficiency of service;   ($12.6 M for 2019 – 2022 | | |
| aging population growing twice as fast as general population   * alcohol use/abuse 44% above national; * inadequate access to mental health and addiction services in rural, northern and remote areas | | | 1. Shared Care Plan:digital connectivity and smith flow of patients’ health information for shared decision-making and patient involvement. 2. Community Health Centres and Community Health Teams*.* These are currently being introduced in urban areas.   **Mental Health and Addiction Services:**  In 2014, the province adopted a ten-year mental health and addictions plan, *Working Together for Change,* which aims to improve response to individuals with mental health and addictions services and their families. | | | | | **Mental Health and Addictions**   1. Improve delivery of community mental health supports and addiction services especially for youth and young adults*:* 2. Improve access to community mental health supports, enhance delivery of evidence-based mental health services; 3. advance the 10-year Mental Health and Addictions Action Plan; 4. modernize and base delivery of addiction rehabilitation services in home communities; 5. expand access to internet-delivered, evidence-based cognitive behavioural therapy services..   ($63.4 M for 2017 – 2022) | |
| **Alberta**  **Date signed:**  **2018-05-07**  **Funding:**  **Home Care 2018 -2022: $327M**  **Mental Health and Addictions 2018 -2022:**  **$222M** | | | **Home and Community Care:**  Overall focus on stable, accountable, high quality, person-centred and sustainable health system emphasizes health and wellness; shifts towards community care and interdisciplinary, team-based home care; towards reducing the gap in health outcomes between Indigenous and non-Indigenous peoples.  **Home Care Program:**   * 2016/17 seniors 70% of the 119,000 receiving home care services. * Urban/metropolitan areas have better access than Indigenous or those in rural/remote areas. * Informal caregivers, often women, provide 80 -90% or more of the home care required in the province. (worth $25B annually to Canadians) | | | | | **Goals for Home and Community Care**   * increase home and community care services; * help maintain independence and avoid or delay the need for higher levels of care; * provide suitable care for all people, including Indigenous and non-Indigenous and those living in rural/remote areas;   reduce use of emergency department and hospital admissions and re-admissions.  **The province will:**   1. Make available standard basket of care services including basic home care and intensive restorative services to all 2. Increase access to specialized interdisciplinary services, avoiding hospitalization and emergency use 3. Expand Virtual Hospital and Integrated Care teams allowing for service within community settings 4. Maximize interdisciplinary team member skills and coordinate with primary and acute care providers | |
| **Alberta continued**  **Unique circumstances:**   * single health authority (AHS) responsible for the delivery of health services in the community. * Aging population: number of seniors estimated to double in the next 20 years to 12 million. | | | * Adult day program spaces and community rehab services increase client satisfaction and support informal caregivers. * Dementia Strategy and Plan recently implemented.   **Mental Health and Addiction Services:**   * Well-established core community addictions and mental health services including follow-up * Provides a range of emergency, crisis and outreach services to Albertans at risk/in crisis; * 2016-2017: Over $850M spent; increased $15M in 2017-18.   Valuing Mental Health Report 2016:   * Mental Health Capacity Building Program: 37 programs serve children & youth in 85 communities, 182 schools, 74 outreach programs; * 9,000 staff; 130,000 clients (2015-16) with 28,000 discharges; 930,000 consulted a physician for mental health challenges * Tele-mental health served 11,179 in 2016 * Mental Health Help Line received 18,500 calls * Addictions Help Line received 13,500 calls. * Opioid Dependence services offered in all Zones,   Growing demand for services has resulted in experiencing long wait times for services, not receiving services or receiving insufficient amount of service. | | | | | 1. Expand and increase palliative spaces and end of life services at home/in hospitals 2. Expand adult day programs, provide in home respite services to support informal care givers   **Mental Health and Addictions**   1. Coordinate and integrate mental health and addictions into community support services, and address gaps in services and wait times especially in rural and remote areas; 2. Through established Primary Care Network Committee (2017), provide governance, leadership, and strategic direction for mental health and addictions services. Underserved groups to be prioritized.; 3. Support AHS Addiction and Mental Health, leading to improved service delivery by building on current community-based services; spreading effective, innovative and evidence-based models of care; providing addiction and mental health supports in home care and supportive living environments, enhancing appropriate use of crisis and emergency services; reducing wait time for services; and promoting positive mental health in children and youth; 4. Increase centres of community-based mental health services for children and youth (examples: Rutherford Centre,) and access to services (example: North Zone Indigenous Travel Team) thus reducing the need for acute care admissions; and 5. Provide interventions for complex and high-risk populations seeking specialized mental health and addictions services | |
| **British Columbia**  **Date signed:**  **2018-09-21**  **Funding:**  **Home Care 2018 -2022: $394M**  **Mental Health and Addictions 2018 -2022:**  **$262M**  **$ 1.4B over ten years**  **Unique circumstances:**   * 18% population is 65+; many Canadians retire in BC, boosting the number of seniors * Expect seniors be 25% of population by 2036 * Nearly 20% of patients live with 2 or more chronic illnesses. * 1400+ died in 2017 due to opioid overdose * In any year, 1 in 5 experience mental health/addiction problem or disorder; about 1/3 able to access specialized treatment | | | Current Focus: integrated, person-centred, seamless, coordinated, easily navigable system emphasizing good quality of life for all, maintenance of good health, opportunity for good recovery from illness/surgery, and promotion of independence.  Shift care to community and away from hospital and care facility where possible.  Current initiative: implement “Patient Medical Homes” - networks of integrated team-based primary care delivery as a foundation for improved home and community care and mental health and addiction services.  **Home and Community Care:**   1. Range of services to help patients remain in homes/communities avoiding emergency visits and (re)hospitalization; HCC managed or contracted by health authorities. 2. Seniors Advocate’s Office surveys/reports on community care facilities, services and conditions. 3. Perceived gaps in home and community care planning, confusion/overlap regarding personnel roles; inadequately optimized professional skills; inconsistent linkages between formal health care system and community & home care; inadequate numbers of personnel and training; discrepancies in care access—rural, remote and reserve areas. 4. Ministry works, consults, plans, and monitors services with the First Nations Health Authority and the First Nations Health Council to provide | | | | | **The province will:**  **Home and Community Care**   1. Redesign/expand services into full suite of community-based services: each of 5 regional authorities to develop at least one Specialized Community Services Program and link it with Primary Care Networks to provide team-based, interdisciplinary, comprehensive and coordinated service delivery based on community needs. (a single program structure with care organized for clients by a single care manager; access to specialist medical care, home support, adult day programs, transitional residential care services, respite care services, palliative and end-of-life services.) 2. Increase services to occupants of residential care facilities and home-based clients: e.g. meals, bathing, foot care 3. Expand/improve home support access, services and hours; 4. Implement re-ablement programs to facilitate transitions between acute care and community post-acute care, preventing re-admission and decline; 5. Train, recruit, retain health care assistants for a vital workforce; 6. Integrate medical personnel into teams to optimize service in community/home-based services programs. 7. Create virtual care strategies to enable and increase service delivery and remote monitoring; 8. Support informal caregivers/reduce care giver burden by; increased access to health authority services, increased hours of operation devoted to supporting care givers, expanded adult day programs, & increased overnight and other respite opportunities for care givers; 9. Strengthen linkages between non -government organizations and health authorities to better support frail seniors living in the community (e.g. Better at Home) 10. Add 70 hospice beds by 2020 | |
| **British Columbia continued**   * 1n 2015 over 500 people died by suicide, the second leading cause of death among young people aged 15 -24. | | | culturally safer and relevant primary and trauma-informed services.   1. A leader in promoting integration of palliative and end-of life care (BC Centre for Palliative Care 2013, After Hours Palliative Nursing Service via telephone, addition of 56 new hospice beds since 2014.)   **Mental Health and Addictions:**   1. Mix of services: in long-stay facilities, psychiatric services in hospitals, primary and community mental health services, informal community services, and self-management services and supports. 2. Ministry to launch new strategy by spring 2019 of enabling citizens to ask once and get help fast. 3. Tiered model of mental health care enables individuals to access services and then be aligned to the intensity of services meeting current needs.   4.Transitions in care a problem: from youth to adult, GPs to specialist, across settings.   1. Inability to access timely service is a challenge.   5. 5. Indigenous populations experience disparities in mental health and wellbeing outcomes because of the effects of colonization and experiences of intergenerational trauma. | | | | | 1. Improve access, responsiveness, and quality of community-based palliative care. Integrate palliative care within “Patient Medical Home”; 2. Hire new clinical consultative palliative care resources; train more staff in palliative care giving   **Mental Health and Addiction**   1. Increase early intervention ability, respond to common disorders through prevention/early intervention and through increased capacity and referral 2. Provide evidence-based knowledge/resources to care givers to identity adverse childhood experiences, treat/plan care of youth and adult mental health problems, integrate services into the province’s new Primary Care Networks; 3. Evaluate feasibility of continuum of publicly funded psychotherapy; 4. Develop a robust and tiered clinical framework focused on the prevalent mental disorders among youth and adults. 5. Reduce disparities in access to mental health services by those in rural and remote and Indigenous communities 6. Evaluate potential, then implement lower-intensity, in-person cognitive behavioural therapy groups in 20 communities; 7. Establish an Indigenous-focused Mental Health and Addictions Strategy; 8. Expand culturally safer approach to suicide and crisis intervention and response through land-based healing opportunities, currently present in two Indigenous communities. 9. Build a virtual workforce to respond to problems through virtual clinic access. 10. Improve seamlessness access to crisis line network | |
| **British Columbia continued** | | |  | | | | | 1. Increase access for students by increasing the workforce capacity of mental health professionals in schools, and 2. Increase mental health/substance use literacy in schools. | |
| **Northwest**  **Territories**  **Date Signed:**  **2018-02-21**  **Funding:**  **$13.5 million over 10 years**  **Unique circumstances:**   * Large land mass,small population, communities without year -round access to larger centres * 35% under 25 * Suicide rate twice national * Self-injury hospitalization three times national * Alcohol hospitalizations five times national | | | **Home and Community Care and Mental Health and Addictions:**  1. Promotion and Prevention: annual community healthy living fairs, fund and work with aboriginal community governments to develop community wellness plans, community Talking About Mental Illness and Mental Health First Aid programs  2. Specialized Treatment: supported living for adults, specialized treatment resources to children and youth, out of territory placement program  3. 2017 Continuing Care Services Action Plan – focus on Home Care, Long Term Care and Palliative Care  4. Intervention: community counselling, 24/7 help line, On the Land Healing funds to communities, primary care community services, psychiatric assessment and treatment, short term inpatient care in Yellowknife, agreements with southern governments for facility care | | | | | **The territory will:**  **Home and Community Care**   1. Introduce a paid family/community care giving pilot (2017-21) – provide choice of self-managed care or those who work with Health/Community Services.   2. Create a Project team to implement an international  residential assessment tool across all continuing care programs – plan training/implementation 2019-20 – to facilitate evidence-based assessment and care planning  **Mental Health and Addiction**  Develop/implement Suicide Prevention and Crisis Support Network:   * *Prevention*: fund positions to work with communities ready to work on and participate in suicide prevention plans; * *Intervention*: integrate delivery approach, develop culturally-relevant suicide risk assessment tool, improve referral pathways, information sharing and discharge planning; * *Postvention:* Develop policies/protocols for coordinated, interdepartmental approach providing timely response immediately after crisis and in following days/weeks/ months; * establish clear roles and responsibilities focused on connecting with community to understand needs; * establish territorial team of community members and professionals with the competencies and skills to respond in a crisis and who are able to travel on short notice; and * implement Critical Incident Management training for staff and community members. | |
| **Nunavut**  **Date Signed:**  **2018-02-21**  **Funding:**  $11.2 million over 10 years  **Unique Circumstances:**   * Population: 38,000+, 50% under 25, 85% Inuit * Incorporate Inuit societal values in program/policy development and service design/delivery * Large land mass with 3 time zones and regions, 25 remote communities accessed by air * Poor social determinants of health: shortage of adequate housing, food insecurity, historical and intergenerational colon-ization, low educational attainment, socio- economic status * Anticipate triple number of seniors by 2030 (1360 in 2016 census) * Financial insecurity for community MHA programs | | | | **Home and Community Care**  Federal Northern Wellness Agreement supports front line program including training   * 3 continuing care and 3 Elders Home facilities * Can self refer, be referred and assessed to determine care level/services at home. Services include chronic disease management, palliative/compassionate care, short term post hospital home care, acute care replacement so return to pre-illness functioning, up to 6 weeks post-hospital care * Majority receiving over 65 (2016-17)   Territorial Health Investment Fund (THIF) supports training community-based Inuit outreach workers in Mental Health and Addictions  **Mental Health and Addictions**   * Working to support workforce with training – nurses, consultants, community outreach workers – on identification, intervention and treatment * Focus on community based, culturally relevant services/supports * Tele-link program * Mental Health and Addictions Outreach Worker Program (MHAOW)  1. delivers programs, education, fosters community partnerships and incorporates Inuit knowledge and values 2. priorizes hiring local Inuit 3. extensive orientation/training plan | | | | | **The territory will:**  **Home and Community Care**  Acquire and implement interRAI assessment tool to facilitate consistent evidence-based assessment/care plans, share data across providers, enable consistent data/tracking and assist in decisions   1. Work with system currently used to ensure seamless integration, focus first on regional centres then other communities 2. Training plan to implement and support 3. Develop/implement monitoring plan to measure progress, inform decisions and allocate resources   **Mental Health and Addictions**   * Designate Program Coordinator to support and scale up community driven projects for youth and develop model to recognize and share * Hire workers in each community * Provide professional development, resources and set up peer support networks * Develop website specific to child and youth mental health * Develop pilot project with nationwide partners beginning in 1 or 2 communities, then extending territorially |

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| **Province/Territory**  **Date Signed**  **5-yr Funding**  **Special Pop. needs** | **Current Home and Community Care and**  **Mental Health and Addictions Initiatives** | **Plans for Funding Allocation** |
| **Nunavut continued**   * 1999-2014: 7 times national suicide rate * Tight knit, resilient and strong communities support each other, strong commitment to the land and use natural resources to benefit family and community * Leaders/elders promote resiliency and cultural continuity | * Out of Territory Office provides residential placements * 2 in-territory residential facilities, 16 beds Iqaluit (85% occupancy), 10 beds Cambridge (95% occupancy) * Human resource issues (burnout, stress, etc) lead to reliance on transient professionals * High expenditures in emergency room visits, hospitalization for self-injury, medevac, out of territory services and secondary outcomes (assault, domestic violence, sexual abuse) * Several successful programs in each region (sewing, mentors, land camps developed entirely by community) |  |
| **Yukon**  **Date Signed:**  **2018-06-25**  **Funding:**  **Home & Community Care: 2018 -2022**  **$2.7 M**  **Mental Health and Addictions: 2018 -2022**  **$2 M**  **$11.4 million over 10 years** | Yukon supports a people-centred approach to wellness to help all citizens thrive in healthy, vibrant, sustainable communities.  **Home and Community Care**   1. Older adults require additional resources in the form of primary care, in hospital awaiting long term care, in home or community, in a long- term care facility. 2. In 2016-17, people living alone made up 61% of home care referrals resulting in demands on supports provided outside of the home as well as early referrals for long term care. 3. Palliative care and end-of-life care are provided only as part of the home care program. | Yukon will stablish a stronger philosophy of person and family-centred care, particularly in the care of older adults.  **The territory will:**  **Home and Community Care**   1. Enhance the Home First Program to support remain independence in homes and if hospitalized, to return home when 24-hour attention is no longer needed. 2. Enhance the Complex Clients Support program to meet the needs of patients to wound and IV therapy as well as home care, hospice, palliative and end-of-life care 3. Gather data to identify home care needs of rural and remote areas with the goal of setting up systems that improve access to care in those areas, 4. Plan and implement community programs based on identified ways of improving home care delivery in rural and remote areas |
| **Yukon continued**  **Unique circumstances:**   * Population 38,000; 30,000 living in Whitehorse, the rest in   rural and remote communities   * 23% of the population comprised of 14 First Nations, 8 language groups, * 11 First Nations groups have established land claims and self-gov’t agreements * Aging population, now 12% of the population, expected to double in the next 10 years. * Unique cultural groups | 4 Services for older adults tend to be provider- or institution-focused in the absence of age-friendly planning and design in mind  **Mental Health and Addiction Services:**   1. About 7500 Yukon people struggle with mental health or substance abuse challenges per year. 2. 1000 visits to emergency departments are related to drug or alcohol abuse. 3. Children and youth make an average of about 40 ED visits annually due to intentional self-injury 4. A recent emphasis has been on early interventions and prevention, strengthening partnerships to coordinate mental wellness, trauma and substance abuse and to provide coordinated, holistic and seamless care. (Mental Health Strategy and the Yukon Mental Wellness and Substance Use programs) 5. Collaborative, evidence-informed innovation and improving access to culturally safe services are emphasized. | 1. Implement technology support for home care: adding virtual visits and mobile chatting to in-person visits to promote social inclusion, avoid social isolation and manage symptoms, and to use in home care worker visit scheduling.   **Mental Health and Addictions**   1. Improve access to community-based mental wellness and substance abuse services and address local health needs by providing more access points in a greater number of community locations, close to where people live; 2. Provide earlier intervention and prevention activities on a continuum of mental wellness; 3. Promote education around safe substance use and self-management of mental health symptoms; 4. Add clinical counselling positions and implement mental health programs in youth centred locations; 5. Use culturally appropriate and integrated interventions; 6. Consult with First Nations to identify community priorities and to ensure the implementation of culturally appropriate interventions and mental health education; 7. Support collaborative care delivery through community hub-based health and social services model; Integrate mental health and substance use as part of the holistic health |

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