Veterans Affairs Canada / Anciens Combattants Canada

Expert Policy Papers in Support of the Veteran and Family Health Strategy

Principal Authors, Co-authors, and Abstracts

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1. Supporting Home Care Transformation: Strategies for Change

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Executive Summary

For the past decade, transformation of the health care system across Canada has focused on strategies to provide a wider range of services to a growing population with chronic health conditions and frailty - all while balancing the demands to contain costs.[2] Home care has emerged as a viable and cost effective solution to delivering a broad range of acute, chronic, rehabilitative, long-term, and palliative care services.

Technological advances have enabled the delivery of increasingly complex, specialized care in the home, with most Canadians preferring to receive care in the comfort and familiarity of this setting compared to institutional settings. Although formal care provision has shifted to the home, family caregivers continue to provide 80 to 90 percent of the care at home to Canadians receiving home care.

In response to the growing challenges in this sector, Veterans Affairs Canada appointed the Expert Group on Home and Community Care from the McMaster University's Aging, Community and Health Research Unit to identify: innovations, and potential strategies to address these issues and support home and community care transformation. The Expert Group reviewed 37 published and unpublished articles, reports and briefing documents related to home and community care; and conducted interviews with 12 experts in the field of home and community care.

Innovations to Support Home and Community Care System Transformation and Achieve Triple Aim Outcomes (improve patient access and experience, improve quality, and reduce cost)

- Numerous leading practices and innovative programs and services currently exist nationally

- Internationally there are examples of home care programs that effectively integrate delivery and funding models
- Technical innovations have increased access to home care services at a lower cost
- System-level quality indicators are in development for home and community care in Canada

The Challenges to Home and Community Care System Transformation

Although additional resources have been put into home care, home care resources are still inadequate in many regions to meet the demand for service. This has resulted in: limited attention to health promotion and prevention and the social determinants of health (e.g., income, housing); reductions in home care services by regulated providers (e.g., nursing, therapy services); lengthy wait-lists; increased use of privately-funded services; and increased reliance on family caregivers to provide care. Significant health human resource challenges also exist within the home care sector.

Our stakeholders told us that they want:

- Care that is patient and family-centred
- More information on what home care services are available
- National standards for home care and standardized accountability metrics
- Improved home and community care services for First Nations and Inuit communities
- Better coordination and integration of home care services across providers, organizations, and sectors, including a single point of contact for coordination of care and access to services
- Standardized data collection and information systems to enable cross-jurisdictional comparisons across Canada
- More efficient service delivery in home care to reduce duplication of services between home care, primary care, and the acute care sector
- More equitable and consistent access and funding of home care services across Canada
- Increased use of technology to improve communication within the circle of care, improve coordination of services, and reduce duplication
- More research in home care to inform policy and practice and support to scale-up effective models of care

Potential Strategies to Address These Challenges to Achieve Triple Aim Outcomes

- Provide patient and family-centred care that addresses the needs of patients and family caregivers as a dyad, ensuring that both are well supported
- Increase support for family caregivers
- Integrate home and community care fully into the broader Canadian health care system to promote an integrated service delivery/funding model that enhances quality care by providing:
    - Clarity about what publicly and privately paid services are available to support people in their homes

  - Consistent access to and funding of services across Canada
  - Timely and meaningful communication among home care providers, primary care providers, hospitals, and other members of the patient's circle of care
  - Seamlessly connected and coordinated care across settings that represent the full continuum of care, e.g., primary care and hospital care.
  - A single, coordinated basket of services for people whose needs cross multiple settings and sectors
  -

- Establish national standards for home and community care and efficiency, safety, and quality metrics that reflect these standards to enhance accountability for performance in the home and community care system. Indicators need to align with Triple Aim and reflect the interests and values of all stakeholders, e.g., patients, caregivers, providers, policy makers
- Expand use of technology to increase access to services, improve communication within the circle of care, improve coordination of services and reduce duplication
- Increase focus on prevention and health promotion with attention to the broader social determinants of health and mental health
- Enhance educational curriculum, training programs and practice supports to support a home care workforce prepared with the knowledge and skills required to meet the evolving needs of the population
- Support and invest in the spread of effective models of care, increase research capacity in the home care sector, and improve access to best practices

2. The Evolution of Palliative Care in Canada: Trends and Veterans' Specific Needs

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Executive Summary

In January 2017, Veterans Affairs Canada contracted Dr. Sandy Buchman and Sarina Isenberg to "conduct a review and prepare a report on emerging trends in Palliative Care." This report was intended to provide "an environmental scan of palliative services across Canada, and internationally," review best medical practices, and identify evidence-based trends.

To achieve these aims, the team engaged in the following activities:
Document review:
- Review of over 130 peer-reviewed articles, grey literature, and websites related to palliative care, and palliative care for veterans in particular

Consultations:
- Stephanie Wilsack, the Executive Director of McDermott House, Toronto, Ontario
- Dr. Karl Lorenz, Director of the Veterans Affairs Palliative Care Quality Improvement Resource Center based at the Veterans Affairs Palo Alto, California

The resulting report describes key concepts in palliative care and the current state of how palliative care is provided in Canada. The report then discusses the unique characteristics of palliative care for veterans.

The subsequent section of the report outlines promising practices for palliative care from within Canada, as well as international examples. The report also explores promising practices for veterans' palliative care, drawing on examples from the United States, United Kingdom, and Australia.

The report explores emerging trends in palliative care, which are continually evolving, focusing in upon the public health approach to palliative care, as well as improvements

and challenges in access, standards of care, and accountability. Medical Assistance in Dying (MAID) is also discussed as a new end-of-life option for Canadians.

The report concludes with a series of recommendations from the authors regarding palliative care in general, and more specifically, palliative care for veterans.

General Observations:
These general observations are organized according to the Ontario Palliative Care Networks (OPCN's) Provincial Clinical Standards categories.

System and Accountability

- There is a need to support and promote Bill C-277 to create a national policy along with other standards.
- Canada's regional programs require further development.

The Public

- There is a need to reduce the stigma associated with palliative care. This might be reduced with a national awareness campaign. For example, the Canadian Hospice and Palliative Care Association's Speak Up! Campaign is a successful model to emulate, expand, and scale up.
- Various populations and demographic groups do not have equitable and timely access to palliative care.

Clinicians

- Due to the shortage of providers trained in palliative care and increasing population demand for palliative care, there is a need for both improved professional development and education, as well as incentives and expansion of the palliative care-trained health professional workforce.

Tools to Improve Direct Care

- There is a lack of national or even regional standards of accountability for palliative care.

Direct Teams and Settings

- There are limited facilities providing pediatric palliative care.
- There is a need for more palliative care programs and resources tailored to First Nations Inuit Metis populations.
- There is a need for more palliative cared-trained primary care providers who can engage in goals of care discussions, advance care planning discussions, and provide referrals to specialized palliative care services, when necessary.
- There is a need for better supports for hospice palliative care teams.
- Further government investment is needed to expand residential hospices and palliative care units, inpatient programs, and outpatient services.

Veterans’-Specific Observations:

- Improved inter-ministerial collaboration, especially between Health Canada and Veterans Affairs Canada, can support and fund provinces to achieve these standards and support resources.
- Increased support of veterans’ specific research regarding palliative care needs in Canada would help to determine the extent to which veterans in Canada receive palliative care supports, where they die, who their personal supports are.
- Potential avenues for improving palliative care might involve scaling up successful models of palliative care for veterans in Canada (e.g., Sunnybrook Health Sciences Centre, Perley and Rideau Veterans Health Centre in Ottawa).
- Palliative care for veterans in Canada might also be improved by adapting successful programs in the US4 to Canada, for example:
- Honoring Veterans' Preferences Videos: advance care planning videos tailored to Veterans
- No Veteran Dies Alone (NVDA), which supports and provides companionship to dying Veterans
- Specialized trainings for providers who deliver palliative care to veterans

3. Systematic Review of Complementary and Alternative Treatments for Mental Health and Pain/Injury

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Executive Summary

Introduction: Complementary and alternative treatments (CATs) (generally described as therapies that are not part of the dominant health care system) are widely used in both military and civilian populations for a wide range of indications. At the request of Veterans Affairs Canada, this report focuses on a review of the efficacy of the following CATs: acupuncture, exercise (including Pilates, qi gong, tai chi and yoga), and mindfulness meditation for the management of mental health conditions (anxiety, addiction/abuse, depression, post-traumatic stress disorder), and pain or injury (including acute injuries such as traumatic brain injuries, and chronic pain).

CAT in Military Health Centres: There is limited publicly available information about the availability of CATs in Canadian military health centres. However, a 2014 US Department of Defense Report to Congress identified that 29% of all US military treatment facilities offered CAT programs, most commonly chiropractic and acupuncture. Other CATs such as meditation, and yoga were increasingly being provided to military personnel and their families. Despite the relatively widespread use of CATs in the military, evidence for the efficacy and cost effectiveness of most CATs is lacking. A number of research studies on the efficacy of CATs are ongoing in the US military including some notable partnerships with the Samueli Institute in the USA.

Evidence Review Methods: A systematic review was conducted to identify meta-analyses of the relevant CATs for each mental health and pain condition and eligible studies were assessed for overall quality of evidence in a manner informed by the Grading of Recommendations, Assessment, Development and Evaluations (GRADE). We followed GRADE in our focus on identifying clinical outcomes of importance to patients, analysing the methodological strengths and weaknesses of the available studies as well as the consistency of results across studies and identifying the strength of identified effects. In each review, we identified the specific outcomes on which we report and provided a summary of our assessment in tables. Finally, a colour-coded table was created to provide a quick reference summary of all the conclusions.

Results and Conclusions: Several CATs appear to be at least as effective as conventional treatments and/or may have added clinical benefit in addition to

conventional treatments: acupuncture for depression and chronic pain; exercise for depression; yoga for chronic pain and mindfulness meditation for depression. Additional research is needed to assess if these CATs are more effective than conventional therapies. Additional research is also needed to determine the cost effectiveness of implementing any of these CATs as part of the health care of military personnel and their families. Pilot studies designed as pragmatic trials are recommended to allow for the rigorous assessment of the effectiveness and cost effectiveness of CAT interventions, which will build the evidence base to inform future decisions about their use in a variety of health care settings.

4. Review of Chronic Care: Submitted by the Canadian Academy of Health Sciences

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ABSTRACT

This report presents current best practices and new and emerging trends in treating people with chronic physical health conditions both in Canada and internationally. Five key messages emerged: (1) There is a high prevalence of multiple chronic conditions in the general Canadian population. (2) Patient-centred primary care is required for the effective management of chronic health conditions to ensure comprehensiveness, coordination and continuity of care. (3) Critical elements of such patient-centred primary care models include an interdisciplinary team working with community and specialty resources to ensure needed services and support for patient self-management. (4) Clinicians require guidance and decision making tools that consider the overall burden of diseases to effectively manage care for people with multiple chronic conditions. (5) The patient-centred Chronic Care Model remains the most promising model of care for people with chronic health conditions, in spite of limited evidence.

5. Long Term Residential Care in Canada: Current Issues, Best Practices and Future Trends

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Stephanie Chamberlain, PhD Trainee, Translating Research in Elder Care Program, University of Alberta

Introduction

The landscape of facility-based long term care (LTC) in Canada varies widely. As an uninsured service, and therefore not part of the Canada Health Act, what is offered and how it is delivered differs amongst and even within provinces. Leading voices in LTC have called for increased attention to the role of facility-based LTC in Canada, in light of an aging population. In pushing for the inclusion of facility-based LTC on Canada's "health care policy agenda", the Canadian Healthcare Association argues that this care is essential, and that Canada must plan for, and anticipate, the expectations of Canada's future old. They note that key government reports (e.g, Romanow, Kirby) did not address facility based LTC. Given that projections of need for LTC beds in the future suggest a significant increase from the current availability, attention must be given to new and emerging trends in facility-based long term care, including best practices, to support those individuals who reside there.

Long term care is situated in the broader global policy concern of population aging; both the proportion and the absolute number of people aged 60 or older continue to increase worldwide. According to the World Health Organization, there are two main drivers of population aging: increased life expectancy and falling fertility rates. Due in part to the size of the baby boom cohort born after WWII, seniors are expected to make up a larger proportion of the Canadian population in the coming years, then ever before. Currently, most older adults in need of care due to aging, a chronic condition or disability are cared for at home by a family member or friend. The bulk of these caregivers are women; with more women in the workforce, fewer are available to provide informal care as was done in the past. That being said, nearly half of Canadians provide some informal care to a family member, friend or neighbor who is aged, chronically ill, or disabled; 10% of these informal caregivers provide 30 or more hours per week of care. The baby boomer cohort are currently the main providers of informal care to those older than themselves, yet as this cohort passes age 85, there will be fewer adult children available to provide care.

The type of care needed by seniors is increasingly complex and was never provided informally in the home in the past. Care needs may relate to frailty, which is often accompanied by accumulation of health deficits such as disability, chronic illness, and reduced mobility, or dementia, which is projected to affect 1.1. million Canadians by 2038, up from 564,000 at present. Furthermore, over half of seniors are affected by multi-morbidity of chronic illnesses or conditions. Multi-morbidity can cause poor quality of life, high health care costs, functional decline and disability. While evidence suggests older persons will experience more years of good health, the period of ill-health- though shorter- may be more acute.

In view of the growing attention to care for an aging population, Canadian researchers are bringing attention to long term care, an underrepresented area of health research. The Translating Research in Elder Care (TREC) program based at the University of Alberta, the Reimaging Long Term Care Project, the Seniors- Adding Life to Years (SALTY) project and the promotion and use of the Resident Assessment Instrument-Minimum Data Set 2.0 (RAI- MDS) are significant initiatives addressing the paucity of evidence. Together, these initiatives highlight the important work going on in LTC, as well as the areas where improvements can be made. TREC, led by Dr. Carole Estabrooks at the University of Alberta, is a research program that includes researchers and knowledge users from across Canada. Members of TREC are working on research projects and quality improvement initiatives under the vision of improving the quality of life of older adults in residential settings and the quality of work life for those who are employed in these settings. RAI-MDS, an assessment tool intended to provide high quality data on facility-based residents for the purposes of informing clinical practice and policy, is being used in LTC facilities in some Canadian provinces. Spearheading RAI in Canada has been Dr. John Hirdes, a Professor at the University of Waterloo and the chair of the interRAI Network of Canada (interRAI Canada, n.d.). The Reimaging Long Term Care project led by Dr Pat Armstrong at York University in Toronto focuses on attributes of long term care settings, while SALTY, led by Dr. Janice Keefe at Mount Saint Vincent University, focuses on adding quality of life in late life for persons receiving facility-based care, and will include attention to the family, friends and volunteers who support those in LTC. Still in its early stages, SALTY links research in four streams that will examine care practice, care relationships, innovative practice and the policy context of facility-based LTC. All of these initiatives aim to place the resident as the focus of their work.

Both the TREC and SALTY projects have utilized (or will utilize) RAI-MDS data to advance research on quality of life and/or quality of work life. We know that both of these issues are of central importance in LTC. As Baines and Armstrong describe, an important variable in quality care is staffing. When working conditions are lacking (for a variety of reasons), recruitment and retention of well-trained and qualified staff becomes a problem and this problem impacts the quality of care received by residents.

Additional issues of importance to the discussion of facility-based LTC include: the impact of Canada's changing demographics and the role of family/friend caregivers in supporting older adults; the complexity of care needs; the presence of challenging behaviours (e.g., as a symptom of dementia) and mental health issues amongst residents; and models of care. The interface between facility-based care and home care, and the role of home care in substituting for some of the functions of facility-based care, is also topical.

This report focuses on several leading initiatives/directions in residential long term care that aim to address key issues facing long term care providers. It draws on a search of existing literature (academic, grey), authors' insights/knowledge of the emerging issues and familiarity with best practices in long term care as well as insights from several key informants. We offer information on forecasting long term beds, best practices in the area of antipsychotic prescribing, access to primary care, person-centred care models, palliation care services, and knowledge sharing models. Section 5 provides information on initiatives that are contributing to the delaying/replacement of residential long term services.

We recognize the audience for this report is Veterans Affairs Canada and that the reader may benefit from understanding the report's content from a veterans' lens. As previously mentioned, current residents of long term care have complex care needs and the nature of illness/disability of veterans may be further complicated by the nature of their onset. For example, it is important that veterans have access to primary care providers who are aware of their specific needs. Common health conditions of veterans include musculoskeletal disorders and related chronic pain, as well as mild traumatic brain injury (MTBI). MTBI from blast exposure can cause cognitive or physical conditions. It is possible to have MTBI and no physical injury, so diagnosing can be difficult.

Health care providers need to understand something of military services culture and context in order to understand the symptoms that veterans may present with. There is interplay between service-related physical disability and resulting mental health issues, such as coping mechanisms and expressing need for help. Disability can arise from a veteran's impaired functional competence, and it can have psychological, social and environmental aspects.

Primary care providers need to know specific terms, such as operational stress injury which is persistent psychological difficulty arising from military service. They need to know how to identify PTSD symptoms and have the ability to arrange for therapy and treatment, and how to fill out medical forms to allow veterans to access programs and services once their symptoms identify them as eligible.

6. Taking the Pulse of New and Emerging Trends in Preventive Health: A Horizon Scan of Non---Pharmacological Developments

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Background

Health care decision---makers must deal with a complex and shifting landscape of emerging preventive health and medicine trends. Fresh evidence emerges daily: patient and societal needs change, and new lifestyle and behavior choices are adopted alongside the old. Trends in healthy and high---risk behaviours related to diet, physical activity, sex, substance abuse, addictions and others are early indicators of population health. Benefits and burdens of such trends inform the content of news media, research initiatives, and, ultimately, decision makers and policy.

Scientific evidence for prevention has been accumulating. As early as 1994, the Institute of Medicine (US) released its report on models of prevention for selected mental disorders. In 2011, Knapp and colleagues reported on potential economic returns for a range of mental illness and health promotion programs in the United Kingdom (UK), noting savings of up to 83 times the cost of the investment in some cases. On the other hand, a recent review of standalone “screen and treat” policies for prevention of type 2 diabetes found that, in isolation, these policies are unlikely to impact a worsening epidemic. It is therefore, critical for decision makers to distinguish between promising, effective, ineffective and inconclusive evidence behind new trends when possible.

Surveying current global government investment in preventive health, the UK has made notable investment in person---directed, non---pharmacological disease prevention and wellness initiatives, through NHS Choices. Launched in 2007, NHS Choices is the official website of the National Health Services (NHS) in Great Britain, the biggest ‘go---to’ health website in the UK, with over 48 million visits per month. The site’s ‘Live Well” page (second most popular page) is dedicated to disease prevention and health promotion, covering over 100 topics that address fitness, mental health, sexual health, tiredness, pain, smoking cessation, etc., with thousands of videos, personal health calculators, planners, and health check tools. In 2005, Canadian Ministers of Health (except Quebec) made a declaration of prevention and promotion, agreeing to an “Integrated Pan---Canadian Healthy Living Strategy”. Canada and the US have designated government agencies responsible for developing national guideline recommendations on preventive health since 1976 and 1984 respectively that inform decision makers. Additionally, the USA launched a National Prevention Strategy in 2011 as part of the ‘Affordable Care’ initiative. Similarly, Australia’s national preventive health task force, commissioned a National Preventive Health Strategy in 2009. Sweden’s National Board of Health and Welfare prepares national guidelines for decision makers and this government compensates employers with tax reductions for providing wellness benefits to employees.

Aligned with such initiatives, Veterans Affairs Canada (VAC) has commissioned a horizon scan of new and emerging trends in preventive health and medicine related to lifestyle choices, behavioural practices, and other non---pharmacological strategies for adults. These include health screening, health education, health technologies, and decision maker activities in Canada and other jurisdictions. This scan helps to develop the "big picture" behind such trends, informing other veteran specific health matters. The aim of this scan is to detect early signs of potentially important developments in preventive health and medicine, with an emphasis on new and unexpected directions, as well as identification of persistent problems, as well as issues at the margins of current thinking that may challenge past assumptions. This report will help decision---makers develop strategies for anticipating future Developments for Canadian Veterans and, thereby, gain lead---time for policy development, as well as for identifying trends for further monitoring and systematic examination.

7. Veterans and Their Families in MCT: What We Know and What We Don’t Know

Kelly Dean Schwartz, PhD

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Introduction:

The Life After Service Studies (LASS) program of research is designed to further understand the transition from military to civilian (MTC) life and ultimately improve the health of Veterans in Canada. LASS partners are Veterans Affairs Canada (VAC), the Department of National Defence/Canadian Armed Forces, and Statistics Canada. Building on the previous 2010 and 2013 surveys, the goal of LASS 2016 is to further understand the transition from military to civilian life, and ultimately improve the well-being of Veterans in Canada. The purpose of the present secondary data analysis of the LASS 2016 was to develop a demographic profile of Canadian Armed Forces (CAF) Veterans\' families, and to use this profile to identify themes and possible research questions that might be explored in future.

Methodology:

The LASS 2016 cross-sectional survey used a population frame of personnel with Regular Force service in the Canadian Armed Forces who released from service 01 January 1998 to 31 August 2015. The sample was designed to draw about half from those surveyed in 2013, and about half from Veterans released since LASS 2013. Survey data was collected over a 6-week period trained Statistics Canada interviewers using the Computer Assisted Telephone Interview. The response rate was 73%. The result was 3,033 cross-sectional respondents completing the questionnaire; of the responders, 2,789 (92%) agreed to share their data with VAC and DND. Respondents completed a module of questions in a wide range of areas:
Activities of daily living, adjustment to civilian life, chronic health and mental health conditions (including PTSD), social provisions, utilization of health and allied health professionals, and life satisfaction.

Results:

Preliminary results of the secondary analysis will be presented, with particular focus on the questions left unanswered related to the Veteran’s military-connected family.

Conclusion:

The secondary data analysis revealed that, although changes have been made to the 2016 LASS compared to previous versions, more focus on the role, impact on, strategies to support, and programs available for the Veteran\'s family is necessary. Themes and research questions related to Veteran’s families will be presented and discussed.

8. Spiritual Dimensions of Health and Moral Injury: A Review

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ABSTRACT TO FOLLOW