

# Project Charter

## Central East Priority Project Summary

Project Name: Supporting Caregiver Health and Well-being in the CE LHIN

Purpose of Board Review  For Information Only  
 For Approval  
 For Endorsement to Proceed with Further Planning/Refinement/Review

Project Charter Writing Sponsor(s) Durham East Collaborative

Project Sponsor CELHIN – Portfolio Lead

Health Service Provider Central East CCAC

Project Type  Service Enhancement  New Service / Program  Integration Activity  Demonstration Project  
 Single Phase Project  Multi-Phase Project

Funding Required \$ 394.60 [ ] [2008-09: \$ 140,062  
] 2009/2010 262,000

Funding Source Aging at Home Funding Year (s) , 2008-09, 2009-2010 beyond based on Strategic Plan Funding Type 2 Yr. Demonstration

Anticipated Project Owner (Accountability)  CE LHIN  Assigned CE LHIN Project Team  
 CE LHIN Health Service Provider

Project Deliverables / Goals

- Strategic Plan to guide investments to strengthen the caregiver support system in CE LHIN including a Best Practices review (agencies/literature) and design of an Evaluation process.
- Design and implement a pilot Caregiver Support Resolution Program to respond to and resolve complex and problematic caregiving situations.

Project Timelines Start: November 2007 Completion: Phased enhancements to caregiver support system

Project Reviewed By: Networks: CDPM and Seamless Care for Seniors Steering Committee received update on project goals; Members participate on project sponsor group  
Collaboratives: Durham East Collaborative lead Charter Development  
Task Groups: No  
CE LHIN Staff: Involved in Charter Development

### Strategic Directions

- The LHIN Board will lead the transformation of the health care system into a culture of interdependence.
- Healthcare will be person-centred in safe environments of quality care.
- Create an integrated system of care that is easily accessed, sustainable and achieves good

outcomes.

Resource investments in the Central East LHIN will be fiscally responsible and prudent.

<b>Priorities for Change</b>		<b>Enablers</b>	
<input checked="" type="checkbox"/> Seamless Care for Seniors		<input checked="" type="checkbox"/> Primary Care	
<input checked="" type="checkbox"/> Mental Health and Addictions		<input type="checkbox"/> E-health	
<input checked="" type="checkbox"/> CDPM		<input type="checkbox"/> Health Services Planning	
<input type="checkbox"/> Wait Times and Critical Care		<input type="checkbox"/> Health Human Resources	
		<input type="checkbox"/> Diversity	
		<input type="checkbox"/> Back Office Transformation	
		<input type="checkbox"/> Moving People Through The System	

**System Outcomes**

<input checked="" type="checkbox"/> Accessible	<input type="checkbox"/> Safe	<input checked="" type="checkbox"/> Appropriately Resourced
<input type="checkbox"/> Effective	<input checked="" type="checkbox"/> People Centred	<input checked="" type="checkbox"/> Equitable
<input type="checkbox"/> Efficient	<input type="checkbox"/> Integrated	<input type="checkbox"/> Focused on Population Health

Project Name <b>Supporting Caregiver Health and Well-being in the CE LHIN</b>		Project Acronym or No. <b>Caregiver Support</b>	
Workstream Lead/Project Sponsor(s) <ul style="list-style-type: none"> <li>Seamless Care for Seniors Steering Committee</li> <li>Mental Health &amp; Addictions Steering Committee</li> <li>Chronic Disease Prevention and Management Steering Committee</li> </ul>	Workstream Project Coordinator <b>Jeanne Thomas</b>	Target Project Completion Date <b>3 Year phased implementation to strengthen caregiver support system</b>	
Project Lead/Project Manager <b>Project Charter Development: Durham East Collaborative &amp; Other Planning Partner Representatives</b>		Version No. <b>0.7</b>	Version Date <b>2007/10/01</b>

**Project Background**

*Outline the context for the project by briefly explaining the current organizational environment. Provide necessary background to understand why the project was started. Under what circumstances was it initiated? Focus on relevant facts about the surrounding situation that are of importance to the project team, i.e.. Provide references to appropriate sections of the Business Case if one has been developed.*

This project focuses on “individuals who provide on-going care and assistance to family members and friends in need of support due to physical, cognitive, mental health or addiction conditions<sup>1</sup>” The term caregiver in this project refers to this network of family and friends.

The role of caregivers in the health care continuum

Health Canada’s 1995 report titled *Health Human Resources in Community-Based Health Care* report, noted that the traditional view of health human resources, which had tended to focus almost exclusively on formal caregivers (service providers), needed to be replaced by one that saw health human resources as a continuum, with those who care for relatives and friends forming part of the health care continuum. The report went on to note that without this caregiving network of family and friends “the formal health care system would collapse because it is unlikely to have enough resources to meet all health care needs and demands of all citizens” (p.3).

The important role that caregivers play within the health care continuum is well documented:

- “In North America today, the aging population, coupled with fundamental changes in the provision of health care services, is translating into an increased requirement for individuals to provide in-home care for family members in the home who have chronic health problems or disabilities” (Decima Research, 2002, p.1).
- “Caregivers care for individuals from all age groups, across all stages of life, and across the continuum of care” (VON Canada, 2005, p. 5 ).
- “There are approximately 4.2 million people with disabilities in this country” (Canadian Association for Community Living, 2002, p. 1) “The majority of people who need disability supports – children, youth, and adults – are supported entirely by their family members and friends” (Canadian Coalition for Family Supportive Policy, 2004,p2)
- “A shift away from institutionalizing has left the bulk of caregiving (for seniors) to family members and friends (Cranswick, 2003, p. 8). “Among all seniors in Ontario who received help because of a long-term problem, about three quarters received this help, in part or in total, from informal sources (a spouse, relative or friend)” (Turcotte M. & Schellenberg, 2007, 2007, p. 166). “In many cases, the presence and commitment of a close family member, a spouse or a neighbour can make an important difference in their quality of life, increasing the possibility that they can stay in their home”. (Turcotte M. & Schellenberg, 2007, p 161)
- Dupuis, Epp & Smale (2004) note that approximately half of the individuals with dementia in Canada live in the community and that almost all of these individuals (94%) are cared for by family or friends up until these caregivers are no longer able to maintain them at home.

<sup>1</sup> Wording based on Canadian Caregiver Coalition’s definition of caregiver (Canadian Caregiver Coalition, 2007)

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## Project Background

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- Family and friends often provide most of the care and support to people with mental illness. “Numerous studies have shown that involvement (of family and friends) in this role results in significant benefits for both the individual and the health care system.... (including) decreased rates of hospitalization and relapse, enhanced adherences to treatment choices, increased rates of recovery, decreased involvement with the criminal justice system, (and) savings to the mental health and addictions system”. (Family Mental Health Alliance, 2006, p 6).
- “It is estimated that caregivers provide 80% of the required care in the home” (Canadian Caregiver Coalition, 2003).

### Caregiver profile

- In many instances caregivers are a network of family and friends who provide assistance and care on a 24hour per day/ 7 day per week basis
- Whether or not particular family members regard themselves as part of the core “team” providing care to an individual, they intentionally or unintentionally, influence and are impacted by the environment of care.
- Family caregivers are predominantly female and typically older than the population-at-large. Seven in ten are 45 years of age or older. Consistent with these characteristics, family caregivers are most likely to be either retired or homemakers. Just over one in five are employed full time, while a similar proportion work either part time or are self-employed. (Decima Research, 2002)
- The composition of family caregivers largely mirrors the Canadian population in terms of language and ethnic background (Decima Research, 2002, p. 3).
- Most caregivers are looking after only one individual, but close to one in ten are looking after a second family member (in most cases the other parent). Most are receiving care because of physical disability; close to one in five have both physical and mental difficulties. One in six care receivers are children, many of whom have some form of mental disability. (Decima Research, 2002 )
- “We often think of seniors as the receiver of care, but older Canadians are also actively involved in caregiving”. (Cranswick, 2003, p.11). One quarter of family caregivers are at least 65 (Decima Research, 2002, p.3).
- “A new trend in caregiving is young caregivers, often teenagers or young adults caring for parents with chronic illnesses, such as MS or mental health problems” (Keating et al., 1999)
- Care can be categorized by personal care, household work, coordination of care, support and nursing care; caregiver who, live with the care receiver often provide more care and a wider variety of care tasks than other caregivers who do not live with the care receiver (VON, 2005)
- In many cases, formal or professional home care services are an essential or valuable support to caregivers looking after family members.... Survey results suggest that the use of formal care is more closely associated with care recipients requiring a lot of care, than as a means of caregivers minimizing their involvement (Decima, 2002, p. 23).
- ‘Homecare is an increasingly important component of the health care system in Canada. As family caregivers play a growing role in providing care, their need for respite, or time off, is also growing’ (Dunbrack, 2003. p. 1).

### Challenges faced by caregivers in their role as caregiver.

- “While caregiving includes immeasurable personal rewards, there are physical, psychological, social and financial risks assumed by family and friends providing care (Canadian Caregiver Coalition,2003, p 1)
  - Individuals providing care to a family member are most likely to feel stressed in terms of their emotional health, with close to 80% of individuals providing care to a family member reporting some emotional difficulties for themselves; 50% also report difficulties in terms of physical health (Decima Research, 2002. p 6).“
  - There are variations across the systems of care with regards to the types and level of support provided to caregivers, including variations in provider interpretation of what is needed and/or their obligation to provide information and services.
  - In it’s report titled *OUT OF THE SHADOWS AT LAST – Transforming Mental Health, Mental Illness and Addiction Services in Canada* (2006) The Standing Senate Committee on Social Affairs, Science and Technology (2006) noted that “...many caregivers have feel excluded, ignored by the mental health, mental illness and addictions system in Canada” (p. 18).
  - The J.W. McConnell Family Foundation (2007) notes that in spite of being the invisible back-up that allows the health care system to keep functioning despite limited public resources and a shift away from institutionalized care, the health system has been woefully inadequate in it’s support of family caregivers across Canada.
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## Project Background

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### Supporting caregiver health and well-being

- Caregivers' " needs, networks, resources, strengths and limitations vary from caregiver to caregiver". (VON, 2005, p. 3). "Caregivers of different ethnic groups may experience the caregiver role differently, due in part to different perceptions of family and family obligations as well as to differences in social supports and the personal coping capacities of the caregivers" (Dupuis, Epp & Smale, p. 33)
- When considering the supports required by caregivers it is essential to take a comprehensive whole person/holistic approach and consider the various influences and environmental factors that determine consumer and family health; consideration must also be given to the need for support at both the diagnosed and undiagnosed stages of caregiving.
- Enhanced knowledge, coping skills and resilience of caregivers promotes better health, improves quality of life and provides a supportive environment for the entire family.
- "When individuals and families have access to the right information, support and resources, they develop the knowledge and skills they need to play a more active role in managing their health and coping with a chronic disease (Ministry of Health and Long-Term Care, 2005, p. 18)
- "No single formal support program is effective in meeting all the needs of caregivers... Instead, caregivers need a range of integrated services that address both the emotional and mental stresses of caregiving and the challenges associated with the physical day-to-day tasks associated with the caregiving role" (Dupuis, Epp & Smale, 2004, p. 70).

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## Project Scope

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*Project scope describes the work that must be done to complete the project. Define the scope of this project by documenting the project's purpose, benefits, as well as specific goals, objectives and deliverables in sections below. The information provided here will serve as the basis for making future project decisions and for confirming or developing common understanding of project scope among the stakeholders. Provide further scope details and explain how changes to project scope will be managed in the Scope Management Plan.*

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## Project Purpose

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*Explain the purpose of this project by describing, at a high-level, what will be done. What is this project aiming to achieve? What is its vision? What need or opportunity will it address? What problem will it solve?*

In recognition that Caregivers are an essential part of the health care continuum, the project's purpose is to ensure that caregivers are provided the right support, at the right time in the right place. The project aim is to support caregivers more effectively and to build the capacity of individuals and families to be caregivers.

The project will acknowledge and validate issues and needs specific to caregivers, enhance and improve access to a variety of services, improve the consistency and coordination of existing supports and introduce new services as required.

Providing improved care and support to caregivers will ease demand on the health care system by enabling caregivers to provide support in a manner which prevents "caregiver burnout" and chronic illness due to stress and fatigue.

The project will identify best practices and opportunities for integration of caregiver supports through examination of what exists and what is not currently in place. The project will delineate the system of Caregiver support required for Central East LHIN. The LHIN will pursue consistent implementation and enhancements to the system of support by incorporating Caregiver Supports into Service Accountability Agreements with Health Service Provider Agencies.

In keeping with the Guiding Principles of the Chronic Disease Prevention and Management and the Seamless Care for Seniors Networks, the following Principles will guide the Caregiver Support project:

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## Project Purpose

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### Integrity

Health planning and delivery of services will empower and enable caregivers.

### Innovation

The CE LHIN, health and support service providers, consumers and caregivers are prepared to test new waters, are open to new ideas, methods or devices.

### Responsiveness and Respect

Planning, decision-making and service delivery will utilize a “relationship based approach” in which consumers, caregivers and service providers work collaboratively.

### Equity and Seamlessness

The continuum of care and supports should be comprehensive and equitable for caregivers across the CE LHIN.

### Accountability

There is shared accountability among caregivers and service providers in the Central East LHIN for the delivery and on-going evaluation of the system of caregiver supports.

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## Strategic Alignment

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*Provide an indication of the project's strategic importance by describing the linkages to government priorities or organizational strategies. Also, show how this initiative is supported.*

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This project impacts every aspect of the health care system. It has linkages with several health initiatives for the province; it has ties with several different ministries. It impacts all other LHIN initiatives and will directly impact local people and communities.

The Caregiver Support Project will:

- Identify resources currently invested by the province in caregiving services within the CE LHIN (e.g. MoHLTC funded Community Support Services that currently provide caregiver support).
  - Provide information during the development of new health initiatives effecting caregivers (e.g. Community Health Centres, Family Health Teams, private health/physician clinics).
  - Be relevant to multiple provincial ministries including the MoHLTC and the Ministry of Health Promotion (e.g. support and prevent decline of caregivers' physical or mental health and promote their well-being).
  - Support the growing and essential role of individuals in taking responsibility for their own health and for the well-being of family/friends. Growth in the responsibilities of caregivers is resulting from the complexity of care options, stretched public resources, the growing number of elderly and the recognition of the important goal of aging at home/in community.
  - As a component of the Aging at Home Strategy for CE LHIN this project will inform and be informed by activities in neighbouring LHINs and across the province.
  - Be relevant to caregivers who provide care and support to people with various healthcare needs (seniors, people with mental health/addictions needs and chronic conditions) by recognizing the variety of supports needed. For example, many consumer and family organizations in mental health and addictions (i.e. Family Mental Health Alliance) have identified meaningful daytime activities for consumers as not only important for consumers, but also a source of respite for caregivers.
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## Project Benefits

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## Project Benefits

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*Identify specific results-based benefits that can be expected as a result of completing this project. List specific metrics and targets to be achieved, if known.*

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Enhancing caregiver supports in CE LHIN will have qualitative and quantitative benefits for the caregiver, the consumer, individual health service providers and the healthcare system. In many instances, benefits attributed to individual caregivers and the individual(s) they are supporting will also directly benefit health service providers and the healthcare system.

### Benefits to the Caregiver:

- Individualized care and support acknowledging gender and cultural differences;
- Supports to assist caregivers to regain/maintain control of their lives;
- Provide real life tools and support-solutions (e.g. planning guide, respite opportunities);
- A clear avenue for problem-solving is in place to support caregivers in resolving difficult/challenging situations;
- Provide right information to caregivers in a timely manner;
- Improved Quality of Life for caregiver by providing strategies for maintaining caregiver health, supporting well-being and preventing illness;
- Public recognition of caregivers / public visibility of caregiver supports / ease of access
- Celebrating the role of caregivers through sharing of successes, sacrifices, accomplishments (i.e. the un-sung heroes supporting the healthcare system).

### Benefits to Individual the Caregiver is Supporting:

- Improved health outcomes, both physical and mental;
- Improved health maintenance;
- Increased rates of recovery;
- Increased likelihood to adhere to treatment choices;
- Reduced hospitalizations;
- Reduced or delayed admission to LTC Homes;
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### Benefits to Health Service Providers and the Healthcare System:

- Providing caregiver supports and “reaching caregivers before they are desperate/burnt-out” provides sustainable on-going health and non-medical supports to consumers and minimizes crisis;
  - Communities will be better positioned to support the growing number and needs of caregivers (e.g. projected growth in dementia rates will increase the number and demands caregivers of this client group);
  - Will inform and influence the model of care delivery to clients and caregivers in various healthcare settings;
  - Will support the realignment and reallocation of costs and responsibilities within the healthcare system by recognizing that the care provided by caregivers has an economic impact on the ability of programs to deliver effective and efficient services;
  - Strengthen the ability of caregivers to prevent crisis and the ability of the healthcare provider community to respond to client or caregiver crisis;
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Project Benefits

- Best use of existing and new caregiver resources – What is provided by healthcare system improves quality of life for caregiver and addresses what is most needed by leveraging local (Planning Zone) and LHIN-wide supports;
- Provides HSPs with consistent and coordinated information and tools to improve their ability to support caregivers.

Goals, Objectives & Performance Measures

*Provide the details of what this project aims to accomplish by listing its specific goals, objectives and deliverables. State the goals in terms of high-level outcomes to be achieved. Identify specific objectives and deliverables for each goal listed. Objectives are clear statements of specific activities/tasks that must be performed to achieve the goals. Identify both project product/service and people/organization change objectives. Deliverables are tangible, verifiable outcomes that signify completion of objectives. Performance measures are used to determine if objectives have been completed. They check if the expected results have been successfully achieved.*

Goals	Objectives/Deliverables	Performance Measures
<p><i>List all goals to be achieved by the project – ensure alignment with project purpose.</i></p>	<p><i>For each goal, list specific objectives and/or deliverables that will signify achievement of goal when finished.</i></p>	<p><i>For each objective/deliverable, list the measures that will be used to evaluate success of results achieved.</i></p>
<p>1. To coordinate and strengthen the system of care and support for caregivers.</p>	<p>The caregiver support system in CE LHIN includes:</p> <ul style="list-style-type: none"> <li>A. Structures and associated processes to plan, coordinate, strengthen and monitor the caregiver support system in CE LHIN. (e.g. a LHIN Caregiver Council, Zone-level Lead Agencies, etc.)</li> <li>B. Existing or newly developed mechanisms to support caregivers during times of transition between services and settings.</li> <li>C. Integration, partnership and coordination between generic and condition specific caregiver supports.</li> </ul>	<ul style="list-style-type: none"> <li>a) The preferred structure is designed, implemented and evaluated.</li> <li>b) HSPs implement mechanisms to support caregivers prior to, during and after transition.</li> <li>c) Mechanisms to link generic and condition specific caregiver supports are in place.</li> </ul>
<p>2. To provide caregivers with the tools, resources and skills needed to improve control over their health and quality of life.</p>	<p>The caregiver support system in CE LHIN includes:</p> <ul style="list-style-type: none"> <li>A. Innovative models and practices to ensure caregivers have easy access to specific “caregiver support locations” where caregivers are assisted</li> </ul>	<ul style="list-style-type: none"> <li>a) Models that improve ease of access to caregiver supports in all Planning Zones are implemented and evaluated.</li> <li>b) Individualized caregiver support</li> </ul>

<sup>2</sup> It is recognized that caregivers will not be identified as primary recipients of services by all HSPs. However, HSPs will be requested to consider how their Charter of Rights can appropriately reflect the role of caregivers.

Goals	Objectives/Deliverables	Performance Measures
	<p>in accessing the tools, resources and skills they need (e.g. information, peer supports)</p> <p>B. Individualized planning that recognizes the specific strengths and needs of the caregiver including cultural differences.</p> <p>C. Access to Self Management Training programs for caregivers. Caregivers become trained Peer Leaders in the Self-Management program.</p> <p>D. Development and dissemination of planning guideline(s) to assist caregivers in identifying the resources they need. Planning guideline(s) will build on resource material currently available.</p> <p>E. Inclusion of caregiver needs in the Charter of Client<sup>2</sup> Rights and Responsibilities of HSP.</p> <p>F. Design and implement (pilot) a Caregiver Support Resolution program to respond to and resolve complex and problematic care giving situations (i.e. enacting a community/ multi-agency response when current options are exhausted)</p> <p>G. Advice/Recommendations to the LHIN Board in determining their role in providing advice to provincial and federal bodies responsible for income tax relief for caregivers and employment supports (e.g. time off, compensation)</p>	<p>needs are identified and a plan to implement strategies is developed.</p> <p>c) Caregivers are enrolled in Self Management Training education sessions. Planning Guides are accessed by caregivers.</p> <p>d) HSPs measure and report on their performance against their Charter of Client and Caregiver rights</p> <p>e) Caregiver Support Resolution program is piloted and evaluated.</p> <p>f) Feedback is received from LHIN on next steps.</p>

Goals	Objectives/Deliverables	Performance Measures
<p>3. To improve availability and access to supports needed by caregivers through optimizing current investments and identifying the need for new investments.</p>	<p>The caregiver support system in CE LHIN includes:</p> <p>A. Identification of the range of supports required by caregivers and the availability and accessibility of these supports in the CE LHIN.</p> <p>Note:</p> <ul style="list-style-type: none"> <li>• This important baseline of information on CE LHIN caregiver services must include identification of caregiver support resources that currently exist; what is working well and where there are gaps/weaknesses [are]. Those caregiver programs/services which are delivered by HSPs but only partially funded by provincial MoHLTC resources should be included. Further bereavement support needs for caregivers after consumer has passed-away will also be identified. (i.e. a survey to agencies and caregivers and/or literature review).</li> <li>• Information compiled should be incorporated into an existing web accessible database and/or the CCAC Information and Referral system.</li> </ul> <p>B. An improved understanding of the benefits to the health system of investing in caregiver supports based upon existing research</p> <p>C. Building on the assessment of what exists and what the gaps are, identification of the priorities for new investments in caregiver supports across the CE LHIN. Which builds upon the assessment of what exists and where the gaps in are.</p> <p>Investments should improve equity of access to:</p> <p>a. A range of support service options including but not limited to: caregiver supports as outlined in Goal #2; professional counseling supports; peer support programs; day to day coping/life skills, and access to</p>	<p>a) A database of currently available caregiver support resources is compiled.</p> <ol style="list-style-type: none"> <li>i. Project Team provides input to design of survey and/or identifies questions to guide literature review.</li> <li>ii. The database is regularly maintained.</li> <li>iii. The database is incorporated into an existing database and/or CCAC Information and Referral system.</li> </ol> <p>b) A Strategic Plan to guide investments to strengthen the caregiver support system in CE LHIN is completed.</p> <ol style="list-style-type: none"> <li>i. Investments increase equity of access to C. a) – d)</li> <li>ii. Administrative processes are streamlined to improve access to relief (respite) options</li> </ol> <p>c) Evaluative processes designed and evaluation complete</p>

Goals	Objectives/Deliverables	Performance Measures
	<p>assistive devices.</p> <p>b. In-home and out of home caregiver relief (respite) which may include consumer accompaniment, meaningful daytime activities day/evening/overnight, camps, day programs, work options or drop-in programs.</p> <p>c. Short-stay/transitional residential options (e.g. LTC Home short-stay beds; partnerships with retirement homes or assisted living services )</p> <p>d. Supportive housing with 24/7 on-call access to personal care, nursing and other supports.</p> <p>D. streamlined administrative processes to improve access to respite options (i.e. reduce testing/paperwork for completion by LTC Homes for re-admission to short-stay beds).</p> <p>E. A qualitative and quantitative evaluative processes needed for continuous quality improvement and program sustainability.</p>	
<p>4. Best practices in supporting caregivers are known and applied by all health service providers in CE LHIN.</p> <p>Best practices support the following philosophy:</p> <p>The distinct needs of caregivers, and the knowledge base that they possess regarding the needs and abilities of their family member/friend, are understood, legitimized and supported, with caregivers recognized as core members of the health care and support team.</p>	<p>The caregiver support system in CE LHIN includes:</p> <p>A. The identification and recommendations for the delivery of best/promising practices in maintaining and enhancing the health of caregivers.</p> <p>B. Innovative caregiver support models. Learn from and provide education to front-line healthcare staff</p> <p>C. An education strategy on how to. Learn from and provide education to front-line healthcare staff based upon best practices(e.g. Caregiver Expert Advisory Coaching Teams to visit agencies, gathering and dissemination of</p>	<p>a) Best/promising practices are known and applied.</p> <p>b) Innovative models are in place.</p> <p>c) Best practices and learnings from the front-line healthcare staff are applied and knowledge transferred in an educational setting</p> <p>d) Caregiver support needs are assessed.</p> <p>e) Planning for the needs of Caregivers is included in the care planning process.</p>

Goals	Objectives/Deliverables	Performance Measures
	<p>real life experiences/case studies).</p> <p>D. Processes to ensure that Health Service Providers assess the needs of the caregiver independently/distinct from medical needs of consumer.</p> <p>E. A process to ensure that are planning includes identification and inclusion of the caregiver on the team providing care and support to client.</p>	

Project “IN” & “OUT” of Scope Items

“IN” Scope	“OUT” of Scope
<p><i>Describe specific items that WILL be included as part of the work performed by this project.</i></p>	<p><i>Describe specific items that WILL NOT be included as part of the work performed by this project.</i></p>
<ul style="list-style-type: none"> <li>Caregivers providing care and support to individuals who have or do not have a formal medical diagnosis.</li> <li>Caregiver support needs in a variety of care settings (i.e. home, community, institutional settings, from a distance)</li> <li>Strategies to restore relationships or create alternatives to traditional caregivers for those individuals who do not have a family/friend caregiver but who would benefit/accept support (i.e. 39% of people with mental health/addictions have no family/friend caregivers).</li> </ul>	<ul style="list-style-type: none"> <li>Although individuals who provide care as part of a health service provider organization (volunteer or paid) are not the primary target population for this project; it is recommended that the Project Team remain aware of the supportive role of agency volunteers and paid front-line providers (e.g. respite workers) and define opportunities to engage these individuals as the caregiver support project is implemented.</li> </ul>

Project Timelines

*Indicate when the project will take place. Provide a preliminary estimate for the duration of the project by documenting the target completion dates for high-level project milestones. Milestones are significant project events that usually signify completion of project phases or major deliverables. Use the milestones and target dates provided below as a starting point for the development of the Project Schedule.*

High-Level Milestones	Target Completion Dates
<p><i>List key milestones below. State milestones in past tense to signify achievement and completion. Include target dates for project kick-off and project end.</i></p>	<p><i>Provide preliminary estimates. Use ‘Month, Year’ format.</i></p>
<p>Secure Project Developer (proposed application of Aging at Home planning resources)</p>	<p>◆ November 2007</p>

High-Level Milestones	Target Completion Dates
Create Project Team to advise on development of Caregiver Strategic Plan (temporary)	♦ November/Dec 2007
STRATEGIC PLAN to guide enhancements/investments to strengthen [to] the Caregiver Support System in CE LHIN is developed.	♦ ♦ May 2009
Caregiver Supports and the components which make up a caregiver support system are Identified	♦ Nov 15, 2008
The on-going structure and processes to plan, coordinate, strengthen and monitor the caregiver support system are identified	♦ ♦ March 2009
Models that improve ease of access to caregiver supports in all Planning Zones are identified.	♦ ♦ Feb 2009
Identify the range of supports required by caregivers in the CE LHIN.	▪ Nov 15, 2008
Identify the availability and accessibility of current supports within the CELHIN	▪ April 2009
Identify the gaps in caregiver supports	▪ May 2009
<b>HSP ACTIVITIES:<sup>3</sup> Related to Strengthening the System of Caregiver Supports</b>	<b>2009/2010</b>
Guidelines for HSPs to implement processes to identify individualized caregiver support needs and develop strategies to address needs.	♦ ♦ May 2009
HSPs have identified current and proposed mechanisms to support caregivers prior to, during and after transition.	♦ ♦ July 2009
HSPs have identified current and proposed mechanisms to link generic and condition specific caregiver supports.	♦ ♦ July 2009
Recommendations and Development of a process for Inclusion of caregiver needs in the Charter of Client Rights and Responsibilities of every HSP	♦ Concurrent with Strategic Plan development
Development and dissemination of planning guideline(s) to assist caregivers in identifying the resources they need.	♦ ♦ Oct 2009
Identification and/or development of a caregiver needs assessment tool	♦ ♦ Dec 2009
HSPs identify or develop strategies to ensure care plans are developed in a collaborative manner.	♦
Other Activities:	
Caregivers begin to enroll in Self Management Training education sessions Caregivers are trained as Peer Leaders through the Self Management Program	. August 2008 (part of Self Management workplan)

<sup>3</sup> These actions could be communicated/requested of HSPs concurrent with Strategic Plan development

High-Level Milestones	Target Completion Dates
Processes are in place for Caregivers to be aware and access Self Management training programs	♦ March 2009
Design and implement (pilot) a Caregiver Support Resolution program to respond to and resolve complex and problematic care giving situations work with external consultant organization to design model and develop costing) –	♦ ♦ March 2010
LHIN Board has reviewed and determined their role in providing advice to provincial and federal bodies responsible for income tax relief , employment supports and advocacy for caregivers	♦ ♦ April 2009
Review of Literature and agency practices regarding staff training regarding needs of caregivers (local, provincial, national, international)	March 2009
Best/promising practices and learnings from the front-line healthcare staff are known and applied	♦ April 2009
Hold Education events and/or establish Best Practice Coaching teams	♦ Beginning January 2009 ongoing
Development of a project communication strategy	♦ November 2008 and ongoing
	♦

Project Costs

		Fiscal Yr: 08-09	Fiscal Yr: 07- 09-10	TOTAL
Category				
<i>Salaries and Wages</i>	Project Management Shared with Supportive Housing and CSS Review (Includes: Salaries/Wages, benefits, ODOE)	33020		33020
	Admin. Assistant – (Includes: Salaries/Wages, benefits, ODOE)		40000 Proposing for this year to have some support to implement some of the tangible items to the project charter.	40,000

Project Costs

		Fiscal Yr: 08-09	Fiscal Yr: 07- 09-10	TOTAL	
	Project Coordinator/Manager: On-going System Coordination (Includes: Salaries/Wages, benefits 18%, ODOE 5%)		82,600	87,600	182,600
Materials and Equipment/ Sponsor Costs			20,000	25,000	45000
Community Engagement	Consultation, day sessions, focus group		5,000	12000	17,000
Consulting Resources	<i>For activities related to Strategic Plan Development or other System Enhancements</i>				
	Project Developer: Initiation and Strategic Plan Development (07-08)				
Best Practice Identification and Dissemination	Best Practices review & report and identification literature and review of agency practices (local, provincial, national, international) – all three pop(n) Delivering caregiver education			5,000	5,000
Pilot Program	Design and Pilot a Caregiver Support Resolution Program			85,000	85,000
Investments to Caregiver Support System	<i>Specific resource requirements will be confirmed through Strategic Plan development</i>				
Tools, resources and skill-building	A range of supports as outlined in Goal #2 and including but not limited to, professional counseling supports; peer support programs; day to day coping/life skills, and access to assistive devices.		+\$	+\$	<i>Identify a target amt/ envelope from within Aging in place</i>

Project Costs

		Fiscal Yr: 08-09	Fiscal Yr: 07- 09-10	TOTAL
In-home and out of home caregiver relief (respite)	Examples: Consumer accompaniment (day, evening or overnight), meaningful daytime activities, day/week programs, work options or drop-in programs.	+\$	+\$	<i>Identify a target amt/ envelope from within Aging in place</i>
Short-stay/transitional residential options	LTC Home short-stay beds; partnerships with retirement homes or assisted living providers.	+\$	+\$	<i>Identify a target amt/ envelope from within Aging in place</i>
Education Events	e.g. Education events, Coaching Team development, etc.	+\$	+\$	<i>Identify a target amt/ envelope from within Aging in place</i>
Supportive Housing	Supportive housing with 24/7 on-call access to personal care, nursing and other supports.	<i>Resource needs to be identified through Supportive Housing project</i>		
<b>TOTALS</b>		140,062,	254,600	<b>394.6</b>

Funding Source

*Identify source of funding for this project (i.e. base, one-time, MB20 submission, etc.). Indicate whether project costs will be absorbed by an existing organization (i.e. covered by current Ministry or Division budget) or if separate source of funding is required.*

Aging at Home Strategy (Provincial MoHLTC Resources)

CE LHIN Priority Funding

CE LHIN Health Service Agencies

Health Canada

Partnerships with Insurance Companies

Project Team

Project Team

*Identify who is needed on the core project team to complete project deliverables and achieve its goals and objectives. What skills, knowledge and experiences are required? Consider the need for special expertise to deal with people and organization change challenges. Use table below to indicate who will be part of the core project team and who will be brought-in as required. Provide further details, identify source of resources and explain how they will be recruited, hired, trained, developed and managed in a separate Human Resource Management Plan.*

Team Member, Organization	Role on the Project	Required Involvement	
		Estimated Duration	Level of Effort
<i>Provide names and/or titles of core project team members.</i>	<i>Describe the role &amp; responsibility of each core project team member.</i>	<i>Indicate target dates or no. of weeks /months</i>	<i>Indicate F/T or days per week/month</i>
Project Team to advise on development of Caregiver Strategic Plan (Target 9-12) <ul style="list-style-type: none"> <li>• Caregivers with different perspectives</li> <li>• Physician/Primary Care Working Group representative</li> <li>• Front-line providers of in-home health care (paid and volunteer)</li> <li>• Durham East Collaborative rep(s)</li> <li>• CECCAC</li> <li>• LTC Home</li> <li>• Current agencies delivering significant caregiver support (e.g. Community support Services; Seniors Centres)</li> <li>• SCFS Steering Committee Rep</li> <li>• CDPM Steering Committee Rep</li> <li>• MHA Steering Committee Rep</li> </ul>	<ul style="list-style-type: none"> <li>• Advisory to Strategic Plan Development</li> <li>• Advisory to Program Developer on other Caregiver Support System project deliverables</li> <li>• Note: Goal #1 identifies the need to design and implement the most appropriate on-going structure to plan, coordinate, strengthen and monitor the caregiver support system in CE LHIN. (e.g. a LHIN Caregiver Council, Zone-level Lead Agencies, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Concurrently in the 2008/2009 year and 2009/2010 year</li> </ul>	<ul style="list-style-type: none"> <li>• 2-3 meetings (6 hours per month additional activity related tasks (3hours)</li> <li>2-3 meetings per month (6 hours)</li> <li>Prep work, activity tasks 3 hours</li> <li>Chair of working group will have an additional 1 hour per month.</li> <li>CECCAC – 2 additional hours per month</li> </ul>

Project Partners

**Project Partners**

*Is this project carried out in partnership with other groups/organizations? Indicate who else, in addition to those listed as project team members above, committed to contributing to this project. Partners are individuals, groups or organizations who work together towards joint interests to achieve common goals. Identify shared, mutually beneficial objectives below and the contributions of each partner. Provide details of each partnership in a separate document, such as a Memorandum of Understanding (MOU) or Service Level Agreement (SLA).*

Provincial:

Ministry of Health – branches TBD

Ministry of Health Promotion

Public Health Units

Seniors Secretariat – Ministry of Citizenship

Ministry of Community and Social Services – Special Services at Home (respite program)

Health Service Providers:

All

Family (GP/FP)

Specialist Physicians

LHIN Planning Partnerships:

Collaboratives (9)

CDPM Network

Seamless Care for Seniors Network

Mental Health and Addictions Network

Primary Care Working Group

Other:

Retirement Home Providers

Private and Not-for-profit visiting nursing and personal care agencies

SHRTN

MAREP

Partners	Common Interests & Priorities	Roles & Responsibilities
<i>Identify your partners. List names, groups or organizations.</i>	<i>State shared objectives and identify priorities for each partner listed.</i>	<i>List roles. What commitments have been made? Have MOUs or SLAs been signed?</i>
<ul style="list-style-type: none"> <li>See Appendix A</li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>	<ul style="list-style-type: none"> <li></li> </ul>

**Project Stakeholders**

*Stakeholders are individuals or organizations that have a vested interest in the initiative. They are either affected by, or can have an affect on, the project. Anyone whose interests may be positively or negatively impacted by the project, or anyone that may exert influence over the project or its results is considered a project stakeholder. All stakeholders*

**Project Stakeholders**

*must be identified and managed appropriately. Use the information provided below as a starting point to elaborate and provide further details explaining how project stakeholders will be managed in the Stakeholder Management Plan.*

Stakeholders	Interests & Needs	Management Strategies
<i>Identify your stakeholders. List names, groups or organizations.</i>	<i>Why are they stakeholders? How are they involved? List interests.</i>	<i>How will the project manage expectations &amp; meet their needs and requirements?</i>
<ul style="list-style-type: none"> <li>Caregivers</li> <li>Health Service Provider Agencies</li> <li>Individuals who receive care and support from caregivers</li> </ul>	<ul style="list-style-type: none"> <li>Target population</li> <li>Provide Services to Target Population</li> <li>Receive care and support from target population</li> </ul>	<ul style="list-style-type: none"> <li>Include in planning and deliberations; provide updates/communications.</li> </ul>

**Other Related Projects & Initiatives**

*Are there dependencies with other initiatives or projects? If you haven't described them in the Project Partners or Project Stakeholders sections above, identify below the known interdependencies with other projects or initiatives currently underway in your branch, division, ministry, cluster or across the OPS. Identify related multi-ministry projects, inter-jurisdictional initiatives and/or public-private partnerships as well.*

Project/Initiative	Interdependency & Impact
<i>List the project or initiative.</i>	<i>State the dependency and indicate how the dependency impacts your project.</i>
<ul style="list-style-type: none"> <li>Aging at Home Strategy</li> <li>LHIN Priority Projects: Supportive Housing, Self-Management Training, Community Support Service Review.</li> <li>Agency/community initiatives focused on caregiver support enhancements (to be identified)</li> </ul>	<ul style="list-style-type: none"> <li>Enhancements will need to be coordinated with objectives of the Aging at Home Strategy</li> <li>Will be influenced by outcomes of other LHIN projects</li> <li>Community projects/initiatives will have to be identified and linkages made to leverage/coordinate investments.</li> </ul>

**People & Organization Change Impacts**

*Identify the impacts this project will have on both the people and structures of the affected organizations. Who will be impacted (both positively and negatively) as a result of or during the execution of this project? Will there be changes to the current staffing levels, reporting structures or position classifications? What impact will this project have on current organization core values, standards, business processes, policies, procedures, technology and finances? Are there any security, legal or privacy implications that need to be considered? Will the project result in the creation of a new organization? Elaborate and provide further details in the People & Organization Change Plan.*

Description of Impact	Impact Management Strategies
<i>List the people and organization change impacts this project will have. Identify who/what will be impacted and provide a description of that impact.</i>	<i>List the strategies that will be adopted on this project to minimize the negative and maximize the positive change impacts of this project.</i>

Description of Impact	Impact Management Strategies
<p>All Health Service Providers – positive impact</p> <ul style="list-style-type: none"> <li>• LTC Homes</li> <li>• CCAC</li> <li>• Community Support Agencies</li> <li>• Hospitals</li> <li>• Physician/Primary Care</li> <li>• Mental Health and Addictions</li> <li>• Providing caregiver supports and “reaching caregivers before they are desperate/burnt-out” provides sustainable on-going health and non-medical supports to consumers and minimizes crisis;</li> <li>• Will inform and influence the model of care delivery to clients and caregivers in various healthcare settings;</li> <li>• Will support the realignment and reallocation of costs and responsibilities within the healthcare system by recognizing that the care provided by caregivers has an economic impact on the ability of programs to deliver effective and efficient services;</li> <li>• Strengthen the ability of caregivers to prevent crisis and the ability of the healthcare provider community to respond to client or caregiver crisis;</li> <li>• Best use of existing and new caregiver resources – What is provided by healthcare system improves quality of life for caregiver and addresses what is most needed by leveraging local (Planning Zone) and LHIN-wide supports;</li> <li>• Provides HSPs with consistent and coordinated information and tools to improve their ability to support caregivers</li> </ul> <p>Caregivers</p> <ul style="list-style-type: none"> <li>• Individualized care and support acknowledging gender and cultural differences;</li> <li>• Supports to assist caregivers to regain/maintain control of their lives;</li> <li>• Provide real life tools and support-solutions (e.g. planning guide, respite opportunities);</li> <li>• A clear avenue for problem-solving is in place to support caregivers in resolving difficult/challenging situations;</li> <li>• Provide right information to caregivers in a timely manner;</li> <li>• Improved Quality of Life for caregiver by providing strategies for maintaining caregiver health,</li> </ul>	<ul style="list-style-type: none"> <li>• Engagement in Strategic Plan development</li> <li>• Development of a communications strategy</li> <li>• Integration strategies</li> </ul>

Description of Impact	Impact Management Strategies
<p>supporting well-being and preventing illness;</p> <ul style="list-style-type: none"> <li>Public recognition of caregivers / public visibility of caregiver supports / ease of access Celebrating the role of caregivers through sharing of successes, sacrifices, accomplishments (i.e. the un-sung heroes supporting the healthcare system).</li> </ul> <p>Extended Family</p> <ul style="list-style-type: none"> <li>Improved health outcomes, both physical and mental;</li> <li>Improved health maintenance;</li> <li>Increased rates of recovery;</li> <li>Increased likelihood to adhere to treatment choices;</li> <li>Reduced hospitalizations;</li> <li>Reduced or delayed admission to LTC Homes;</li> <li>Reduced contact with criminal justice system</li> </ul>	

**Project Communications**

*Identify information needs of steering committee, project sponsor, project manager, team members, working groups, partners, stakeholders and others. List strategies for ensuring that right information is provided to right audience in most suitable and timely manner. Be sure to identify format and frequency of communication between the project manager and project sponsor regarding project status, performance, risks, issues, etc. Provide further details and describe how project information will be generated, collected, stored and communicated both internally within project team and externally with partners and stakeholders in the Communications Management Plan.*

Audience	Information Needs	Format & Timing	Responsible
<p><i>To Whom? List recipients of the information.</i></p> <ul style="list-style-type: none"> <li>Caregivers</li> <li>Health Service Providers</li> <li>General population</li> <li>Individuals receiving care and support from caregivers</li> </ul>	<p><i>What? State what information will be communicated.</i></p> <ul style="list-style-type: none"> <li>A project communication strategy will be developed</li> </ul>	<p><i>How? When? How often? Explain method &amp; frequency.</i></p> <ul style="list-style-type: none"> <li>As a component of Strategic Plan development</li> </ul>	<p><i>Who? Identify who will provide information.</i></p> <ul style="list-style-type: none"> <li>Developed in consultation with LHIN Communications team</li> </ul>

**Project Risks**

**Project Risks**

*Consider what if... Document high-level project risks apparent at this point that could either positively or negatively impact the achievement of project goals and objectives. Indicate initial likelihood and impact. Focus on risks that are likely to happen and have significant affect on project success. Be sure to consider risks associated with people & organization change, knowledge management and transition to operations. Provide further details and describe the approach that will be taken to identify, assess and respond to project risks in the Risk Management Plan.*

Risk	Likelihood	Impact	Risk Response
<i>List high-level risk events that pose threats or opportunities to the project.</i>	<i>Indicate Low/Moderate/High</i>	<i>Indicate Low/Moderate/High</i>	<i>Explain what will be done to avoid, transfer, mitigate or accept risks listed.</i>
<p><u>Opportunity and Threat:</u> Caregiver support is recognized as an area for enhancement by various priority populations/sectors (e.g. Seniors, People with Chronic Conditions, those with Mental Health and Addictions needs)</p> <p><u>Threat:</u> Resource requirements/demand for programming will increase given large number of caregivers who presently receive no/very limited support</p>	<ul style="list-style-type: none"> <li>High</li> <li>High</li> </ul>	<ul style="list-style-type: none"> <li>High</li> <li>Moderate</li> </ul>	<ul style="list-style-type: none"> <li>Awareness of activities and communication with other interested partners/stakeholders</li> <li>Although number of caregivers will increase the enhancements to system proposed will reduce demands on system and will provide needed supports.</li> </ul>

**Critical Success Factors**

*Define key factors that are critical to success of the project. These conditions must be satisfied to enable successful completion of project objectives and deliverables. Include significant events or decisions that need to take place. Whenever possible, ensure factors you list are measurable.*

- Caregiver participation and input
- Core resources
- Build on existing research
- Identify and address general and unique needs of caregivers to individuals with certain conditions (e.g. dementia, mental health and addictions)
- Project produces real improvements/tools – that can be immediately applied and benefit caregivers and HSPs
- Public recognition of caregivers / public visibility of caregiver supports / ease of access

**Assumptions & Constraints**

*Assumptions are external factors that, at the time of writing the charter, are considered true, real or certain for purposes of planning. Certain unverified or unknown aspects that are likely to happen must be assumed as facts to proceed. Constraints are factors that are outside the control of the project team, that restrict or regulate the project. They limit available options and affect performance of the project.*

Assumptions	Constraints
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Assumptions	Constraints
<i>List the assumptions made to date. What did you have to assume to be true to complete the charter?</i>	<i>List project constraints. Consider time, budget, scope, quality, availability/skills of resources, priorities, etc.</i>
<ul style="list-style-type: none"><li>• Aging at Home strategy will provide on-going resources for caregiver enhancements</li><li>• LHIN organization will support enhancements to caregivers services</li><li>• Health service providers will buy-in to need for caregiver system enhancements</li></ul>	<ul style="list-style-type: none"><li>•</li></ul>



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Sign-Off

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*Project charter must be approved & signed-off by project sponsor before Definition Phase can be completed. Project manager, partners and team members also sign-off the charter. Once completed & signed-off, the charter forms the basis for detailed planning and future decision-making. It cannot be modified. Any changes to information contained in the charter must be documented using a formal Project Change Request and the associated process.*

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Workstream Lead/Project Sponsor

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*Sign-off by sponsor signifies that there is clear commitment on behalf of the sponsor to provide guidance & support and contribute necessary resources to complete project goals & objectives as outlined in the charter. By approving the project charter, the sponsor has understood what will be delivered and is in agreement with performance measures and success factors identified.*

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Name & Organization	Signature	Date
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Project Lead

Project Manager

Project Coordinator

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*Sign-off by project manager/coordinator signifies a commitment on behalf of the manager to plan, execute, monitor, control and complete the project in accordance with goals, objectives, requirements, assumptions and constraints outlined in the charter. By signing the charter, project manager has understood what needs to be done, what resources will be available, and how success of the project will be measured.*

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Name & Organization	Signature	Date
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Project Charter Development: Durham East  
Collaborative Co-Chairs  
Joan Skelton and Lynn Park

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Project Partners (Health Service Provider)

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*List names of project partners or representatives of partner organizations. Obtain appropriate signatures. Sign-off by project partners signifies that they have understood their roles & responsibilities as outlined in the 'Project Partners' section and there is joint commitment and agreement to proceed.*

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Name(s) & Organization(s)	Signature(s)	Date(s)
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Project Team Members

List names of project team members. By signing the charter, team members confirm that they have understood their roles & responsibilities on this project and are committed to its successful completion.

Name(s) & Organization(s)	Signature(s)	Date(s)
Diane Bennett		
Tina Demmers		
Susan Haines		
Janet Irvine		
Jennifer Josephson		
Marie Kwok		
Laura McDermaid		
Cheryl McCarthy		
Milton Moonah		
Barb North		
Scott Pepin		
Anne Marie Yaraskavitch		
Colleen Zavrel		

## Charter Revision History

## Version Numbering:

- 0.x - internal draft - under development (*Working copy for Project Coordinators*)
- 1.x - document under review / internal draft (*Begin 1.0 numbering when sent to Workstream Lead for comment*)
- 2.x - document submitted for approval (*Begin 2.0 numbering when sent to Oversight for approval*)
- 3.x - document approved (*Renumber to 3.0 after Oversight Approval*)

Revision No.	Description	Modified By	Date
0.1	1 <sup>st</sup> Draft	Team	Aug 20, 2007
0.2	2 <sup>nd</sup> Draft	Team	Sept 4, 2007
0.3	3 <sup>rd</sup> Draft	Team	Sept 5, 2007
0.4	4 <sup>th</sup> Draft	Team	Sept 11, 2007
0.5	5 <sup>th</sup> Draft	Team	Sept 25, 2007
0.6	6 <sup>th</sup> Draft	Team	October 1 2007
0.7	7 <sup>th</sup> Draft	Team	October 2, 2007
0.8	8 <sup>th</sup> draft and Sign off	Team	Sept 30, 2008

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