TABLE OF CONTENTS

ABOUT THE FIRST NATIONS AND INUIT HOME AND COMMUNITY CARE (FNIHCC) PROGRAM

Program Background

The First Nations and Inuit Home and Community Care (FNIHCC) Program provides basic Home and Community Care services designed to be comprehensive, culturally sensitive, accessible, effective and equitable to that of other Canadians and which respond to the unique health and social needs of First Nations and Inuit communities. The Program is a coordinated system of home and community based health-related services that enable people with disabilities, persistent or acute illnesses and the elderly to receive the care they need in their home communities.

In 1998, a Continuing Care Working Group was formed and included representation from Assembly of First Nations (AFN), Inuit Tapiriit Kanatami (ITK), Health Canada's First Nations and Inuit Health Branch (FNIHB), and the Department of Indian Affairs and Northern Development (DIAND). This group laid the foundation for the FNIHCC Program and the first phase the working group addressed was home care. The FNIHCC Program was announced in the federal budget of February 1999.

The planning and implementation of this initiative is carried out in partnership between the Federal Government (via FNIHB), AFN and ITK. The FNIHCC Program is intended to be built upon and/or enhance other existing federal programs such as Adult Care (In-home component) funded by Indian and Northern Affairs Canada (formerly DIAND) and the Home Nursing component of the Building Healthy Communities initiative.

Funding

A total of $152M was made available for the first three years of the program with an ongoing funding level of $90M per annum at the end of the three-year developmental period.

Program Year	Fiscal Year	Funding
1	1999/2000	$17M
2	2000/2001	$45M
3	2001/2002	$90M
4	**2002/03**	**$90M**

Funding for Years 2 and 3 included significant resources to begin to address capital and training requirements for the program. Year 4 did not include resources dedicated to training and capital although the funding for the program remained at $90 million for the year.

Program Objectives

The primary objectives of the FNIHCC Program are:

- to build the capacity within First Nations and Inuit to develop and deliver comprehensive, culturally sensitive, accessible and effective home care services;
- to assist First Nations and Inuit living with persistent and acute illness in maintaining optimum health, well-being and independence in their homes and communities;
- to facilitate the effective use of home care resources through a structured, culturally-defined and sensitive assessment process to determine service needs of clients and the development of a care plan;
- to ensure that all clients with an assessed need for home care services have access to a comprehensive array of services within the community, where possible;
- to assist clients and their families in participating in the development and implementation of the client's care plan to the fullest extent and to utilize community support services where available and appropriate in the care of clients; and
- to build the capacity within First Nations and Inuit to deliver home care services through training and evolving technology and information systems to monitor care and services and to develop measurable objectives and indicators.

Eligibility

The eligible recipients for this program are:

- First Nations and Inuit of any age;
- who live on an Inuit settlement, First Nations reserve or First Nation community North of 60;
- who have undergone a formal assessment of their continuing care service needs and have been assessed to require one or more of the essential services; and
- who have access to services that can be provided with reasonable safety to the client and caregiver, within established standards, policies and regulation for service practice.

Program Elements

Essential Service Elements

Essential service elements provide the foundation upon which future program enhancements can build. They include:

- a structured client assessment process that includes on-going reassessments and determines client needs and service allocation. Assessment is a structured dynamic process of continuous information gathering and knowledgeable judgements that attach meaning to the information being gathered. Assessment and reassessment processes can involve the client, family and other care givers and /or service providers;
- a managed care process that incorporates case management, referrals and service linkages to existing services provided both on and off reserve/settlement;
- home care nursing services that include direct service delivery as well as supervision and teaching of personnel providing personal care services;

- the delivery of home support personal care services that are determined by the community needs assessment plan and that do not duplicate, but enhance existing Department of Indian Affairs and Northern Development (DIAND) adult care services (e.g. bathing, grooming, dressing, transferring, care of bed-bound clients including turning, back rubs and routine skin care, etc.);
- provision of in-home respite care;
- established linkages with other professional and social services that may include coordinated assessment processes, referral protocols and service links with hospital service providers, physicians, nurse practitioners, advanced practice nurses, respite and therapeutic services;
- provision of and access to specialized medical equipment, supplies and specialized pharmaceuticals to provide home and community care;
- the capacity to manage the delivery of the home and community care program that is delivered in a safe and effective manner, if existing community infrastructure exists; and
- a system of record keeping and data collection to carry out program monitoring, ongoing planning, reporting and evaluation activities.

Supportive Service Elements

The essential service elements of the Home and Community Care Program are expected to be developed initially in each First Nation or Inuit community. The Program may expand to include supportive service elements based on community needs and priorities, existing infrastructure and availability of resources.

Supportive elements that may be provided within a continuum of home and community care might include, but are not limited, to:

- facilitation and linkages for rehabilitation and therapy services;
- respite care;
- adult day care;

- meal programs;
- mental health home-based services for long-term psychiatric clients and clients experiencing mental or emotional illness. These services might include traditional counselling and healing services, and medication monitoring;
- support services to maintain independent living, which may include assistance with special transportation needs, grocery shopping, accessing specialized services and interpretative services;
- home-based palliative care;
- social services directly related to continuing care issues; and
- specialized health promotion, wellness and fitness.

The FNIHCC Program:

- will not fund the construction and/or delivery of long term care institutional services nor duplicate funding for existing on-reserve adult care services.

NATIONAL OVERVIEW

Program Status

Based on program tracking data, following is a synopsis of the program status as of March 31, 2003. Figures are based on Program implementation and monitoring tracking data and supplementary figures provided by regional staff.

- 686 communities have been funded, up from 667 in 2001/02
- 95% of the communities have completed the home care needs assessments, up from 87% in the previous year
- Over 91% have submitted home care service delivery plans, up from 80% in 2001/02
- Almost 3 in 4 communities (72%) had access to service delivery at the end of 2002/03, up from 51% at the end of 2001/02. These communities represent more than 82% of the First Nations and Inuit population.

FNIHCC Program: Canada-wide Figures

Population	441,736
Average Population per Community	634
Number of Communities Eligible for Funding	698
Number of Communities Funded	686
% of Needs Assessments Completed	95%
% of Communities with Submitted Plans	91%
% of Communities in Planning Implementation	88%
% of Communities with Access to Service Delivery	72%

2002/03

National Workplan: 2002/03

For 2002/03, the National Team developed the National Workplan around three key goals:

1) to work collaboratively at the national/regional/territorial levels to identify and address developmental and implementation issues;
2) to enhance existing linkages and establishing additional linkages that are supportive to the delivery of home and community care services within a primary health care framework; and
3) to achieve accountability requirements and generate knowledge for future program planning and/or policy development inclusive of evaluation related activities.

Key Issues

Following are highlights relating to some of the key issues addressed by the National Team in 2002/03.

Continuing Care and Adult Care

Linkages between FNIHCC, Assembly of First Nations (AFN), Inuit Tapiriit Kanatami (ITK), and Indian and Northern Affairs Canada (INAC) continued during 2002/03 on continuing care issues, including joint strategic planning. FNIHCC Program representatives attended monthly liaison meetings with INAC social policy officials in continuing care.

Other examples of collaboration at the national level included:

- INAC formulated a joint working group to provide input into their adult care policy framework;
- integration between HCC and INAC adult care program was explored;
- a joint meeting with INAC, HCC and some community health programs was conducted in February 2003 to help promote integration of HCC and INAC adult care;
- a joint paper was initiated with emphasis on facility care and the gap in policy on the responsibility of providing institutional care. Neither Health Canada nor INAC has a mandate for institutional care;

- a background paper was created and a focus group was held with Health Canada, INAC, and a number of Aboriginal health programs to determine best practices and examples of successful integration at the community level;
- an option paper was researched and prepared, addressing Long Term Care on residency-issues, with particular emphasis on facility care in the context of Continuing Care; and
- program representatives participated in INAC meetings to discuss development of an evaluation of the adult care policy.

Medical Supplies and Equipment Access

Considerable work was accomplished through collaboration with the Non-Insured Health Benefits (NIHB) office of FNIHB. Efforts focused on exploring changes to policy that would improve access to certain NIHB medical supplies and equipment by allowing nursing authorization to those supplies and equipment. The goal was to make the process more efficient and provide more timely access to supplies and equipment, as an essential element of the FNIHCC Program is access to medical supplies and equipment. Planning focused on gearing up for pilot projects in one Nova Scotia and three Alberta First Nation communities to commence early in the 2003/04 fiscal year.

The collaboration through the pilot projects is intended to:

- test a new approach for the access to NIHB medical supplies and equipment for FNIHCC clients;
- identify a potential national process for ordering approved NIHB medical supplies and equipment through authorized Home and Community Nurse providers;
- test the use of wound management protocols in the selection of NIHB medical supplies and equipment benefits; and
- assess cost-effectiveness and appropriateness of supplies toward the health outcomes for the participating clients.

Palliative Care

Meetings were held with Health Canada's Palliative Care Secretariat to participate in the development of a national strategy and establish a model for funding allocation.

A contract for a Palliative Care Costing Model was awarded and Phase 1 on Home and Community Care was initiated. The first phase focused on HCC programs while Phase 2 focuses on community-based and institutional care. Health Canada collaborated with INAC and conducted surveys and focus groups, producing a paper on the issue.

Work also included engaging representation from First Nations communities, tribal councils and Inuit communities on task specific working groups in the area of Palliative Care, Human Resources development, and identification of small community issues. Five different working groups addressed areas and all had Aboriginal participation. In June 2002 Senator Carstairs, Minister with Special Responsibilities for Palliative Care, presented a strategy to Cabinet.

Nursing

The FNIHCC National Team collaborated with the FNIHB Nursing Working Group to publish a nursing handbook for First Nations and Inuit communities. The handbook was designed to be a resource for nurses and health directors alike. A draft manual was completed by the end of 2002/03 for final editing and publishing in 2003/04.

The Nursing Working Group also tackled issues surrounding HCC nursing, with the group having representation from the FNIHB Office of Nursing, HCC regional coordinators, First Nations and Inuit nursing partners, and national team staff.

The HCC planning resource kit had specific requirements for issues such as nursing supervision and the group revised appropriate sections and provided updates to communities.

A separate working group was exploring issues related to nursing recruitment and retention and the Nursing Working Group addressed relevant issues with this other group. As well, another group was working on ongoing second and third level support issues.

Representatives from the national team also participated as observers in national strategic work in FNIHB's Office of Nursing Leadership Committee.

Disabilities

The HCC national team coordinated FNIHB input into a Federal Disability Report, which was released in December 2002. The HCC team had initiated work on an environmental scan in fall 2002, including strategic initiatives and options in the area of disabilities. Human Resources Development Canada (HRDC) represents the federal lead on the issue of disabilities. Health Canada collaborated with HRDC in producing a terms of reference and HRDC produced the federal disability report.

Health System Renewal

Renewal activities included a joint committee with representatives from AFN, ITK, and FNIHB. The committee looked at the key issues with First Nations and Inuit health, the direction it is taking, and strategy development.

Risk Management

The issue of risk management has been a long-standing, complex issue within the FNIHCC Program. Discussions were held with the HCC regional coordinators to explore ways of addressing this issue, more specifically clinical practice in the home and quality care and risk management. Work was initiated on developing best practices on quality care and self-assessment in January 2003. The working group is also exploring legal opinions on the federal role in quality care.

Human Resources

Human Resources Development Canada (HRDC) was planning a research study on Health Human Resources in the Home Care Sector. There was preliminary consultation with FNIHB, AFN and ITK and on how to proceed with the study. However, funding for the First Nations and Inuit component of the study did not materialize and that portion of the study was discontinued.

As a result, the National Steering Committee directed that the Program HR/Training Working Group should address the home care human resource issues as part of the scope of activities undertaken. A request for proposals to carry out a small project to further clarify human resources and training issues for the FNIHCC was prepared. Only two proposals were obtained which were subsequently deemed unsuitable to research fully both First Nations and Inuit needs. The HRDC Labour Sector Study was completed and included several recommendations addressing the home care industry's labour sector needs.

Program Communications

Effective communication is an ongoing challenge for all individuals involved in programs such as the FNIHCC Program. The scope of the Program and the involvement of countless individuals, departments, and organizations across the country necessitate the need for timely and relevant communication.

The national team incorporated, where feasible, a variety of means of enhancing the flow of communications between the national, regional and community teams. These included meetings, workshops, conferences, teleconferences, and community visits.

Resource Materials

The following were part of the resources developed and/or distributed by the national team:

- Nursing Handbook
- Planning Resource Kit revisions
- FNIHCC Program Standards Manual revisions
- Workplan Template
- Website updates on publications and information
- Evaluation Guide and associated materials

Reporting Requirement Tools

Service Delivery Reporting Template

The Service Delivery Reporting Template (SDRT) was a key project rolled out to the Regions and communities during 2002/03. The SDRT was designed to assist communities in meeting program reporting requirements electronically.

Deploying the SDRT proved more challenging than anticipated. In addition to significant training and ongoing support requirements, the tool itself had system compatibility issues with over 600 communities. At the end of 2002/03, work was in progress to revise the tool for 2003/04. In the meantime, some communities and Regions have

explored other systems to meet reporting requirements, while others have combined a manual process with data transformation into the SDRT at the regional level.

Tracking Tool

The tracking tool, released by the national team in 2000/01, continued to be used by regions to assist in the data collection and reporting requirements for the program. Data collected at the regional level through the tool included the following:

- Number of communities eligible for funding
- Number of communities funded
- Population
- % of Needs Assessments completed
- % of Communities with Submitted Plans
- % of Communities in Planning Implementation
- % of Communities with Access to Service Delivery
- % of Population with Access to Service Delivery
- Overview of Program Affiliation/Delivery Model
- Overview of Training
- Human Resource Profile
- Linkages Developed between FNIHCC and other Programs

Performance Measurement and Program Evaluation

Setting the Context for the FNIHCC Program

Treasury Board regulations required that all programs apply for renewal of authorities. Part of this renewal process is to carry out an evaluation. First Nations and Inuit, INAC and FNIHB have worked together to jointly produce an evaluation strategy known as the RMAF. In addition to ongoing data collection and performance monitoring, three focused in-depth studies and a comprehensive national evaluation are part of the overall evaluation strategy.

The three studies respectively address:

1. Has the HCC Program been implemented as intended?
2. Is the HCC Program meeting general home care objectives?
3. Does the HCC Program meet the needs of First Nations and Inuit?

The evaluation will also address two key issues:

1. Outcomes achievement
2. HCC cost implications

Outputs

The following outputs are part of the Results-Based Management and Accountability Framework (RMAF) for the FNIHCC Program:

FNIHCC Services for First Nation and Inuit Populations

- Number of First Nation and Inuit Home and Community Care Programs with a) essential elements b) supportive elements (See section on “About the FNIHCC Program” for definitions of essential and supportive elements.)

Partnerships, Service Delivery Agreements, FNIHCC Best Practice Models

- Integration of Home Care Services with Primary and Acute Care Provision

- Number of Partnerships and Number of Memoranda of Understanding with Other Orders of Government and Health Care Authorities and Providers

Communications and Education Products for First Nation and Inuit, Community Leaders, Governments

- Development and Dissemination of Communications Documents to Target Audiences
- Development of Training Materials and Guidance Documents
- Participation of Certification Courses

Needs Assessments, Service Delivery and Training Plans, Knowledge Management and Information Systems (financial performance monitoring and evaluation)

- Number and Coverage of First Nation and Inuit Community Health Plans
- Number and Coverage of First Nation and Inuit community Health Reports and timely production of Financial Performance Reports

Immediate Outcomes

Immediate Outcomes to be assessed include the following:

First Nation and Inuit Access to FNIHCC Services – Essential and Supportive Elements

- Number of admissions per 1,000
- Number of separations (discharges and deaths) per 1,000
- Number of active cases per 1,000
- Number of service hours per 1,000
- Average number of service hours, by type of service

Increased Community Capacity – Human Resources to Administer and Deliver the FNIHCC Program

- Number of nurses providing service
- Number of support service providers
- Sufficient staff to administer and deliver FNIHCC

Increased Service Delivery Awareness – Informed Users of FNIHCC Services and Informed Community Leaders

- Level of Awareness of FNIHCC Service Offerings by Population Group
- Awareness of First Nation and Inuit Community Leaders of Needs of Community and Role of Home Care

Infrastructure in First Nation and Inuit Communities to Deliver the FNIHCC Services Capital and Program

- Facilities for the Administration and Delivery of FNIHCC

Evaluation Overview

Under the guidance of the HCC Evaluation Working Group, the National Evaluation Team continued to work with regional and national Program staff, Tribal Councils, and communities to implement the Results-Based Management and Accountability Framework (RMAF). Copies of the RMAF were distributed across the country and the National Evaluation Team conducted over 30 workshops nationwide to assist in the implementation of the RMAF.

A broad range of participants attended these workshops including service providers, regional program staff, administrators, HCC nurses, and other Program stakeholders. These workshops were designed to assist participants to understand not only evaluation and the RMAF as they pertained to the Program but also the role and merits of evaluation in federal government programs in general. As part of this, participants were encouraged to view evaluation as a management tool, something to help them as opposed to something "done to them".

Performance Measurement

Performance Measurement has two components:

1. Annual Report
2. Evaluation Studies

As part of the performance measurement strategy, templates were developed that linked directly with the program logic model in the RMAF. As part of the workshops held across the country, the National Evaluation Team assisted communities in developing workplans. Regional workplans were also based on this approach so that plans could be linked to tangible outcomes in the logic model.

Regions and communities typically carried out the workplan development process using one of three options:

1. Regions gave the template to communities and assisted them in completing;
2. Regions had communities fill out the workplan and then Health Canada put it together in a consistent format; or
3. The National Evaluation Team facilitated the process with regional and/or community representatives.

By the end of the fiscal year, many regions and communities were using the format.

Activities from the previous year's workplans were transcribed to new templates to determine where gaps existed. Regional workplans for each of the first four years of the Program were updated and revised so that each was consistent in format and led directly to the program logic model.

Annual Report

As part of the accountability and reporting requirements for the FNIHCC Program, a biennial report for 2000/01 and 2001/02 was initiated and is earmarked for completion in the first part of 2003/04. The report is based on tracking tool information, regional and national workplans, and from interviews with members of the regional and national coordinating teams.

Evaluation Studies

The FNIHCC Evaluation Advisory Committee (EAC) includes representation from the national team, AFN, ITK, a First Nations Elder, and two individuals from each region. The Health Canada Evaluation Division is also involved. The EAC established three key studies as part of the FNIHCC evaluation process. Terms of Reference were developed during 2002/03 for Study 1 and an evaluation consultant was selected for Studies 2 and 3.

Study 1: Has the FNIHCC Program been implemented as intended?

Study 2: Is the FNIHCC Program meeting general home care objectives?

Study 3: Does the FNIHCC Program meet the needs of First Nations and Inuit?

Key linkages were made with the evaluation of the Aboriginal Diabetes Initiative, due in part to the overlap of some personnel working on both Programs at the community, regional, and national levels.

A comprehensive, user-friendly evaluation guide was developed and distributed to communities, Program staff, and other stakeholders across the country. The aim was to assist program stakeholders on how to evaluate programs in general. Several articles were also written for various community and program newsletters across the country to create awareness of the evaluation process and goals.

Next Steps

The 2002/03 fiscal year focused on assisting communities in understanding the role of evaluation and in preparing communities for evaluating their respective programs, which for most communities would begin in 2003/04.

With a significant amount of work completed in education and training surrounding evaluation, the focus in 2003/04 will be on continuing work on the three key studies, and in assisting regions and communities in evaluating their respective programs.

THE REGIONS

The country is divided into eight regions for the FNIHCC Program. Each region has a team responsible for coordinating the Program, often in close conjunction with one or more First Nations and/or Inuit regional organizations. (source: 1997 CWIS Information)

Region	First Nations and Inuit Population	# of Communities	Average (Mean) Community Population
Pacific	63,416	204	311
Alberta	58,305	58	1,005
Saskatchewan	52,168	84	621
Manitoba	67,556	62	1,090
Ontario	77,879	124	628
Quebec	53,525	52	1,029
Atlantic	24,707	40	618
Territories	44,180	74	597
Total - Canada	**441,736**	**698**	**633**

In 2002/03, most regions shifted the focus from planning and implementation to full service delivery strategies. Each region continued to face a unique mix of factors in delivering home and community care services to clients in the respective communities.

Among the key factors were:

Existing capacity for service delivery

- This includes aspects such as the number and type of health care workers and capital infrastructure.

Access to training and training funding

- Training/funding for training relate to both existing workers and for training new workers. Prior to 2002/03, program funding allocated money specifically for training and capital. In 2002/03, all money was allocated directly to communities. However, budget variances in regions where not all communities were in service delivery were often used to fund training and capital projects.

Size and isolation of communities

- Virtually all regions have some small and/or isolated communities. However, in some regions, notably the North and British Columbia, this issue is even more acute.

Partnerships and linkages

- Partnerships and linkages were broad and were at both the regional and local level. They included other Health Canada or federal government programs, provincial programs and agencies, other First Nations organizations, educational institutions, and non-government organizations (NGOs), among others.

Dedicated Regional Resources for the Program

- Each region received $250,000 for regional coordination. Other sources of funding from other budgets were used in some regions to augment regional support. Regional resources also include program positions based out of other partner First Nations and Inuit organizations.

Following is a synopsis of each region for 2002/03.

Pacific

Fast Facts

Population	63,416
Average (Mean) Population per Community	311
Number of Communities Eligible for Funding	204
Number of Communities Funded	200
% of Needs Assessments Completed	91%
% of Communities with Submitted Plans	86%
% of Communities in Planning Implementation	81%
% of Communities with Access to Service Delivery	75%
% of Population with Access to Service Delivery	n/a

2002/03

The Region

The Pacific Region (British Columbia) is home to more communities than any other region. In fact, the region is home to approximately 30% of the total number of First Nations and Inuit communities in the country, yet represents fewer than 15% of the total population served. Communities correspondingly tend to be very small and geography dictates that many are isolated.

The basic structure for the Program in the Pacific Region for 2002/03 was the same as in the previous year. A partnership continued with the First Nations Chiefs= Health Committee (CHC). Staffing within Health Canada's office included the regional coordinator, an area home care nurse advisor and an administrative assistant. At the CHC, while the home care nurse position remained, the development advisor position was not fully staffed during the year due to the position becoming and remaining vacant for a significant portion of the year. Recruiting for an additional home care nurse advisor was underway but proved difficult to staff.

Overview: 2002/03

There was a marked increase in the number of communities reaching the pre-implementation phase and the full service delivery phase of the Program. Policy manuals for home care nurses, home support workers and an orientation manual for home care nurses and their supervisors were developed and distributed to communities. Monthly in-service conference calls for home care nurses commenced. The BC Home and Community Care Nursing team had regular conference calls with a contracted senior home care nurse.

A "train the trainer" project, detailed below, was successfully piloted to enable communities to train band members to become modified home support workers. While there were a greater number of communities in full service delivery, the Service Delivery Reporting Template (SDRT), which communities in full service delivery were required to complete, was very labour intensive and challenging to complete. Many communities had limited capacity to carry out the statistical tool and it proved very time consuming for staff.

Training

Following are some of the training activities conducted in the Region in 2002/03:

- ***"Closer to Home" Home Care Aide Train the Trainer Pilot***

  A key accomplishment within the Region was the development and implementation of the Home Care Aide "train the trainer" training program. The pilot project was designed for community learners unable to access traditional Home Support Worker training for a variety of reasons. "Trainers" were educated over three one-week sessions held in October, November, and January in Vancouver. Following each session, the trainers returned to their respective communities to teach the curriculum to learners in the community. This enabled several small, remote communities to enter into full service delivery as they had trained workers operating within a reduced scope of practice, thereby able to meet the essential service requirements. Seventy-five percent of funded BC First Nations communities were in full service delivery by year-end.

- ***Home Support Worker training***

- ***Home Care Nursing training***
- ***Service Delivery Reporting Template Training***

  This included training in-person on a one-on-one or in group environments, as well as via teleconference in some cases. Workshops held in five areas of British Columbia were targeted for communities in either phase two or three to provide training regarding the SDRT.

Partnerships and Linkages

Provincial Health/Regional Health Authorities

The province's interest in the FNIHCC Program increased and it was more interested in collaborating with First Nations. Each regional health authority has developed an Aboriginal Health Plan. In some communities, the regional health authorities provided home care nursing service and supervision.

INAC and Province

Partnerships with INAC and the Province were stronger, with increased collaboration to address high needs HCC clients unable to be supported at home with current funding levels.

St. John's Ambulance

A partnership with St. Johns Ambulance Family Home Care course was established.

Red Cross

The Red Cross took on a combined role, offering home care nursing and treatment services to one isolated community.

Veterans Affairs Canada and Non-Insured Health Benefits (NIHB)

Equipment depot partnerships were also developed through Veteran's Affairs Canada and Health Canada (NIHB).

Education

The Native Education Centre, a Vancouver school, collaborated with the region to develop and deliver the curriculum for the Train the Trainer pilot project.

First Nations

A strong partnership for the program continued with the First Nations Chiefs' Health Committee (CHC).

Resources Developed and/or Distributed

Three manuals were distributed to communities including:

- a policy manual for home care nurses;
- a policy manual for home support workers; and
- an orientation manual for home care nurses and their supervisors

A "Use of Volunteers" booklet was developed and distributed to communities to demonstrate practical ways of incorporating volunteers in the Home and Community Care program.

Alberta

Send draft to Heather Young and Lorene Mills.

Fast Facts

Population	58,305
Average Population per Community	1,005
Number of Communities Eligible for Funding	58
Number of Communities Funded	57
% of Needs Assessments Completed	100%
% of Communities with Submitted Plans	100%
% of Communities in Planning Implementation	100%
% of Communities with Access to Service Delivery	100%

2002/03

The Region

Alberta's 58 communities tend to be larger than in most other regions, with an average population of just over 1,000. Each of the province's three treaty areas (Treaty 6, Treaty 7, and Treaty 8) has two representatives on the HCC Sub-Committee for the Alberta Region. The committee also maintained representation from INAC and FNIHB.

At the regional level, in addition to the regional coordinator position, a home care practice consultant was hired in February 2003. This position's responsibilities include coordinating training and educational requirements, developing an orientation manual, and looking at practice issues among other activities. A home care manager intern was hired in March 2003 to learn the coordination role, as the current regional coordinator was scheduled to vacate the position in summer 2003.

There remained five zone nursing managers in the Alberta region (second level) and the HCC team continued to work closely with this group for consultation, advice and support for the program, its workers, and the health directors.

Overview: 2002/03

In 2002/03, there were 38 workplans representing 44 First Nations in the Province. As in the previous year, this represented 31 independent First Nations and 7 Tribal Councils. With almost all communities in service delivery by the end of the previous year, 2002/03 was a year for communities to build upon service delivery efforts and to learn from at least one full year of experience in running the program. All communities were in service delivery in 2002/03.

Despite challenges, smaller communities were able to run programs even with relatively small budgets and able to have an HCC nurse visit the community at least one day per week.

Training & Conferences

As 2002/03 was the first year in which funding was not specifically set aside for training and capital, the Alberta HCC Sub-Committee, which meets twice annually, recognized the need for ongoing training. As a result, it set aside $120,000 from the regional contribution agreements for regional training. Communities were still required to provide CPR, WHMIS, and other type of staff development and training.

Recruiting and Training

- RN and LPN recruitment was a significant challenge during the year, although some bands were able to hire HCC nurses and other staff with little support required from the region. Funding for training, capital and supportive services such as palliative and respite care also created challenges. Communities and Tribal Councils looked at alternate funding sources or investigated partnerships with other organizations to look at ways of overcoming these gaps.
- During the year, the number of home care workers increased to approximately 50 Home care nurses, 24 Licensed Practical Nurses, and 100 Personal Care Aides.

Professional Development Conferences

- The region hosted home care conferences for the professional development of RNs and LPNs in October and December 2002 respectively. A personal care aide conference was also held during the year.

Personal Care Aide Training

- Band members were encouraged to take personal care aide training. Many communities reported that participants were enthusiastic, making plans to further their training to become LPNs or RNs.

Other Training

- Across the province, health care workers received training in foot care, wound care, and case management.

Partnerships and Linkages

Some communities had success in working with palliative care clients, including collaborating with their respective regional health authority. Although financial support was minimal, communities worked with the health authorities and received advice and support from regional or zone nursing managers. Working with the families and educating them about the scope and limits of home care was a key role. As such, awareness and understanding correspondingly improved within the communities and among clients' families.

INAC

Collaboration between the FNIHCC Program and INAC continued and a representative from INAC remained on the HCC Sub-Committee in Alberta. Several communities continued to work to integrate the INAC Adult Care Program with FNIHCC.

Royal Alexander Hospital, Edmonton

A collaboration between the HCC and Aboriginal Diabetes Initiative cost shared personal care aides and home care nurses. The weeklong program was held in October 2002 with most communities sending at least one personal care aide and with most home care nurses for the Program attending.

Capital Health Authority

Discussions commenced to investigate linking with the Capital Health Authority Medication Management Program for personal care aides.

Medical Supply Working Group (NIHB)

This is the primary working group that remained active in the region for the Program. A pilot project was developed for early 2003/04. The project focuses on changes to policy that would improve access to certain NIHB medical supplies and equipment by allowing direct nursing authorization of those supplies and equipment. The goal is to make the process more efficient and provide more timely access to supplies and equipment, as an essential element of the FNIHCC Program is access to medical supplies and equipment. Planning focused on gearing up for pilot projects in three Alberta and one Nova Scotia community to commence early in the 2003/04 fiscal year.

Human Resources Development Canada (HRDC)

Communities accessed HRDC and social services for other sources of funding to compliment services provided through FNIHCC funding.

Resources Developed/Distributed

"Generic" Workplans

One of the most significant changes to the program in Alberta during 2002/03 involved instituting a "generic" Workplan. The region took the objectives from the National Home and Community Care framework, attached local objectives, and illustrated examples of activities that related to these objectives. Budget worksheet templates were also developed with detailed, standardized categories. These generic workplans and budget templates were provided to all communities, streamlining the planning and reporting process for communities and regional workers alike.

Meals on Wheels Manual

A Meals on Wheels Manual was developed and distributed to communities interested and able to provide this service or enhance an existing meals program.

Textbooks

Nursing textbooks were distributed as required. Medical equipment and supplies such as walkers were added to an existing "on loan pool" of equipment for short term usage of home care clients.

FNIHCC Program Manual

All communities and Tribal Councils are using the FNIHCC Manual and one Tribal Council has formally endorsed it. The manual assisted in cases where family members had previously been paid, to demonstrate that this was not the intent.

Saskatchewan

Fast Facts

Population	52,168
Average Population per Community	621
Number of Communities Eligible for Funding	84
Number of Communities Funded	83
% of Needs Assessments Completed	99%
% of Communities with Submitted Plans	99%
% of Communities in Planning Implementation	99%
% of Communities with Access to Service Delivery	98%
% of Population with Access to Service Delivery	97%

2002/03

The Region

For 2002/03, the Saskatchewan Region shifted from a developmental model to a service delivery model. While area program staff had focused more on the planning and community development aspects, the positions in 2002/03 concentrated more on home care nursing expertise and the associated support for service delivery. Staff included one full-time coordinator at the Federation of Saskatchewan Indian Nations (FSIN) and three full-time area coordinators, one each for the northern, central, and southern districts.

Except for the Regional Coordinator position through FNIHB, all of the other positions and personnel changed. While in 2001/02 there had been funding for six full-time positions including a clerical support position, this was reduced to three positions in 2002/03. The three home care nursing practice advisors were all part-time - one in the north, one in the central region, and one in the south. Although they were divided into the north, central and south, they focused on third level support.

Formed in the early 1990s, the Saskatchewan First Nations Home Care Working Group remained active. Created through FSIN, in 2002/03 the group was primarily comprised of home care staff throughout the province. The self-directed group continued to meet monthly with approximately 30 individuals in attendance at each meeting.

Overview: 2002/03

Programs were in full service delivery in Saskatchewan, along with increased service delivery in communities that had begun offering services in the previous year. Essentially, communities offering services in both 2001/02 and 2002/03 began to see programs become more fully entrenched over the course of the fiscal year.

Despite the reduction in the number of regional positions providing communities support for the Program, three quality nurses were recruited successfully to work on a part-time basis. At the community level, the program attracted more and well-qualified staff, which aided in serving more clients. In the south area, for example, 86 clients received care at the end of 2002/03, up from 18 during the same period one year earlier.

Clients were able to access services through a systematic system of referral, assessment and planned care, providing better accessibility for all people on reserve. Services expanded beyond basic care and in many cases included health promotion. Intra and interregional nursing groups continued to meet and address program issues in the different parts of the province.

However, some communities, particularly in the north, experienced a large turnover in staff.

Most communities across the province had dedicated home care nurses, although community health nurses continued to play a dual role in smaller communities. They often had to cover both community and home health nursing areas.

A key success during the year was being able to assure that all communities had direct nursing consultation and support at the second level (i.e. Tribal or 2nd level through FNIHB). By the end of 2002/03 all HCC nurses had some connection to professional support that they could call upon and support their practice. In the central and southern areas, there were some communities that were unable to provide nursing consultation and support for home care nurses. A system was developed whereby these communities could receive support for a fee that was included in the contribution agreements. For example, in Fort Qu'Appelle a nurse provided part-time practice advisor services but also offered hands on day-to-day contact with five communities.

Training & Conferences

As in all regions, this was the first year funding from National was not specifically allocated for training and capital projects. Some communities were unable to address ongoing training needs, particularly for training of new home health care aides and in the provision of ongoing training for workers.

SDRT Training

- Two Training sessions were held for the Service Delivery Reporting Template. The first was in June 2002 and over 80 community representatives attended. In March 2003, three sessions were held - one each in the north, central, and southern areas. Communities were again invited to send at least one representative.

Logic Model Workshop Training

- The National Evaluation Team provided training on logic model and other aspects of evaluation for approximately 30 community and regional program staff.

North

- Two conferences were held in the north, one for home care nursing and one for home health aides. Various training programs related to nursing education were facilitated through area post secondary institutions. The northern area continued to look at ways of offering ongoing training for home health aides.

Central

- Workshops on a variety of topics were provided to workers in the central area including Leadership Management Supervision, Policy Writing, IV Therapy, Assessment, TeleHealth (through Battleford Tribal Council and Dr. Tobe) and Wound Care (through Convatec).
- Home Health Aide training and a home health aide refresher program were provided, the latter through a partnership with the Saskatchewan Indian Institute of Technology.

South

- In the south, start-up training dollars from previous years resulted in the graduation of home health aides, with at least one certified home health aide being the result in each community. Charting, foot care, and back care training were also provided to home health aides.
- A diabetes education program was provided to health workers. Registered nurses received training in wound care, HIV, foot care, and fetal alcohol syndrome.
- Wellness clinics were held monthly and foot care workshops were provided for members of the public in several communities.

Partnerships and Linkages

INAC

Work included working towards joint reporting. A joint financial form was created while a data/statistics form is still in progress.

Home Care Working Group

The working group shared information and addressed regional on-reserve initiatives such as charts, policies, and procedures.

First Nations

Networking among First Nations representatives in the Saskatchewan Region continued as workers linked with other health care workers, communities, Tribal Councils, and organizations.

Community leaders, clients, and families became increasingly familiar with the Program and how it differed from the previous system. Communities were designing programs that met their own specific needs, involving members of the community and collaborating with other departments in the community such as education and other areas of health care, all with the support of band leaders.

Regional/Provincial Health Authorities

Linkages with service accessibility from health authorities were initiated and a partnership with the provincial home care program continued to augment some of the FNIHCC program goals. Communications with local physicians were reportedly enhanced for improved continuity of care for clients.

Diabetes Dream Project

The Battleford Tribal Council (BTC) in central Saskatchewan has been involved in diabetes research through a home care team in conjunction with a Toronto hospital.

Education

Partnerships continued with educational institutions such as the Saskatchewan Indian Institute of Technologies (SIIT) and the Saskatchewan Institute of Applied Science and Technology (SIAST) in providing culturally appropriate training programs. There were also linkages made with Continuing Nursing Education in the province.

eHealth Solutions Team

Toward the latter part of the fiscal year, linkages were made with eHealth both nationally and regionally, most notably for data collection support. Training was provided in March 2003 and hardware was provided where essential. eHealth set up the computers and the Service Delivery Reporting Template was pre-installed.

Non-Insured Health Benefits (NIHB)

Linkages in the region with NIHB included presentations and meetings.

Aboriginal Diabetes Initiative

The two programs investigated ways of ensuring continuity of diabetes education and care for clients.

Community Health

Collaboration and communication was built with community health nurses and community health representatives in several communities.

Resources Developed and/or Distributed

Chart Review Process

A significant undertaking in 2002/03 was a Chart Review Process, which included revising all basic chart forms and the development of a Charting Guidelines booklet. Because the charts had been developed years earlier, a significant update was overdue. The Home Care Working Group put together a volunteer committee to look at this and hired a consultant through regional resources. Copies were developed and distributed to all programs throughout the province.

Policy Manual

Work was undertaken on revising the FNIHCC policy manual. The second draft of the policy manual was distributed for review with the goal being to finalize during the 2003/04 fiscal year.

Nursing Procedure Textbook

An appropriate textbook was sourced and recommended.

Pamphlets

In the south, questionnaires and pamphlets developed locally about the program were distributed.

Manitoba

Fast Facts

Population	67,556
Average Population per Community	1,090
Number of Communities Eligible for Funding	62
Number of Communities Funded	62
% of Needs Assessments Completed	100%
% of Communities with Submitted Plans	98%
% of Communities in Planning Implementation	90%
% of Communities with Access to Service Delivery	68%
% of Population with Access to Service Delivery	79%

2002/03

The Region

Only the Province of Ontario has a greater on-reserve First Nations population than Manitoba. Communities in Manitoba tend to be large, with an almost equal number of communities with more than 1,000 residents as there are those with fewer than 1,000 people.

In 2002/03, a program support clerk position was added to the regional team, primarily to help with the administration workload, which was increasing due to data collection and eHealth requirements. In addition to the four members of the regional team, the seven HCC Coordinators at the Tribal Council level remained.

Quarterly meetings were held between the regional and Tribal Council coordinators. These meetings were held over a two-day period each quarter with agenda items including brainstorming, updates, strategic planning, and workshops and training. Working group participation included a working group for small and remote communities as well as participation on the National Evaluation Advisory Committee.

Overview: 2002/03

By the end of 2002/03, more than two-thirds of First Nations communities in Manitoba had reached the service delivery phase of the Program. Compared with the previous year, more of the work was geared toward planning implementation and service delivery compared with a greater emphasis on developing plans in 2001/02.

Quarterly briefing reports on the program were provided to the Assembly of Manitoba Chiefs and Program staff. Program staff at both the regional and Tribal Council levels spent a significant amount of time traveling to the 62 communities throughout the province.

A critical component of the program in the region remained the second level funding for the seven HCC Coordinators at the Tribal Council level. These positions were instrumental in planning and implementation, as well as in coordinating communications, training, capital projects, and facilitating workshops among other responsibilities.

The formal peer review process continued and worked well in developing strong community workplans, as well as in providing equitable, justifiable funding. The peer review committee met monthly during the year.

Client assessment and case management improved access dramatically in that it was increasingly based on need, as stipulated in service delivery plans.

The Service Delivery Reporting Template developed by the national team was not utilized in Manitoba. However, a regional reporting template tool that had been used successfully continued to be used in order to meet reporting requirements.

Recruiting and Retention

For staffing at the community level, while there was good success in recruiting home care nurses, retention was increasingly becoming an issue. The hiring of home care nurses, 52 in total, increased access to services tremendously across the province. In addition to the nurses, there were approximately 300 Health Care Aides.

Coordinators at the Tribal Council and regional level spent a significant amount of effort coordinating and supporting training for Licensed Practical Nurses (LPNs). First and second level services have provided the human resource requirements, particularly around nurses, to support

the program. They facilitated ongoing communications between Chief and Council, Programs and regions and provided leadership to the community, assisted communities in completing tasks and facilitated training and orientation.

Capital Projects

Capital projects continued using budget variance. Projects included building renovations to accommodate the program, construction of accommodations for health care professionals, and the purchase of some essential supplies and equipment.

Infrastructure development has been a major issue. Capital projects assisted in areas such as the creation of accommodations to house health care professionals.

Training & Conferences

National Partners Conference

- First Nations partners held their own independent national conference around Home and Community Care, spearheaded by the Assembly of First Nations (AFN). Regional Program staff from FNIHB attended the meetings as the conference was held in Winnipeg.

Licensed Practical Nurse Training

- Following the success of the previous year's Licensed Practical Nurse (LPN) training project in the north, regional LPN training commenced in the south with 31 students.

Implementation Plan Checklist and Workshop

- A Service Delivery Implementation Plan checklist was developed at the regional level for the Tribal Council coordinators. Two workshops were held in the north. The northern communities face unique challenges and workshops were designed to support them in development and implementation of their service delivery plans and strategies.

Data Collection Workshops

- Several workshops were conducted on data collection and reporting requirements for the program.

Other

- A number of skills training courses were provided for various service providers and Tribal Councils. These included such diverse areas as human resources, planning, policies and procedures, infection control, food handling for homemakers, client assessment, and case management among others.

Partnerships and Linkages

Education

The Assiniboine Community College is the provincially-mandated education authority for LPN training.

Provincial Health/ Regional Health Authorities

Partnerships were established with the Winnipeg Regional Health Authority in areas of Aboriginal health services. For example, there is a significant amount of jurisdictional coordination required when a patient from a reserve comes to Winnipeg for medial treatment. It includes a host of issues such as scheduling, medical transportation, discharge planning, accommodations, etc.

College of Licensed Practical Nurses

An opportunity to establish a partnership with the College developed when Winnipeg hosted the second annual LPN conference.

INAC

Only minimal communications with INAC took place in the form of a presentation to them during the year.

Other Health Canada Programs

During the fourth year of the Program, there were increased opportunities to look at ways of working with other Programs such as the Aboriginal Diabetes Initiative (ADI) and the First Nations and Inuit Health Information System. There was less participation at a regional level with the Non-

Insured Health Benefits program (NIHB) and with the Office of Nursing, although there were some presentations with the latter upon request.

Resources Developed and/or Distributed

Following are some of the resources developed and/or distributed in Manitoba during this period:

- Service Delivery Plan Implementation Checklist
- Regional HCC Program Administrative Procedures Manual (based on St. Elizabeth workshop information)
- CD Roms/diskettes with accompanying user guides for the Manitoba First Nations Data Collection Tool
- Generic service delivery plans were developed, primarily for those communities in developmental stage
- Generic objectives, activities and reporting requirements were developed and distributed so that program workers were informed about reporting requirements.

Ontario

Fast Facts

Population	77,879
Average Population per Community	628
Number of Communities Eligible for Funding	124
Number of Communities Funded	121
% of Needs Assessments Completed	94%
% of Communities with Submitted Plans	90%
% of Communities in Planning Implementation	86%
% of Communities with Access to Service Delivery	56%
% of Population with Access to Service Delivery	n/a

2002/03

The Region

The most populous province in Canada is also home to the greatest number of First Nations people on reserve. The Region is home to approximately 18% of both communities and First Nations/Inuit population served by the Program. More than two-thirds of communities in Ontario are small, with a mix of communities going through Tribal Councils or running programs independently.

In addition to the regional coordinator at FNIHB, three area coordinators remain with the program. A support person at FNIHB was added to the team, primarily to transpose data from the Service Delivery Reporting Template. There is also a nurse advisor who works with communities in the north-western part of the province.

FNIHB continued to work with the Chiefs of Ontario and the five PTOs, which include:

- Association of Iroquois and Allied Indians
- Grand Council Treaty #3
- Independent First Nations
- Nishnawbe-Aski Nation (NAN)
- Union of Ontario Indians

Overview: 2002/03

By the end of March 2003, sixty-eight (68) communities in Ontario were in full service delivery, with 30 more prepared to begin service delivery in early 2003/04. That compared to 13 in service delivery at the at the end of 2001/02. After four years of assessments, planning, and the early stages of service delivery, there was a stronger knowledge base and understanding of the Program reported among workers.

With the Program more fully entrenched, communities were better able to understand the different processes, stages and the corresponding requirements. Communication was improving as networking increased and Program staff from all levels looked at ways of addressing issues and challenges.

The Ontario Region conducted a program review for 12 First Nations that had been in full service delivery for over a year. The evaluation

addressed processes and outcomes (e.g. Were they delivering the essential service elements?). The review indicated that the overwhelming majority of communities were doing extremely well. While a couple of communities encountered issues with liability insurance, they were able to be put back on track. The review was conducted by a consultant who had experience in both home care and with First Nations. A final report is scheduled for 2003/04 and will be widely shared.

As communities moved further along and gained more and more experience with the Program, there was evidence of the momentum building, with more staff and better infrastructure in place to provide services and more people receiving care. At the same time, community leaders increasingly understood the Program and its benefits.

Training

Due to a relatively high budget variance for 2002/03, communities were invited to submit proposals to receive up to $10,000 for training initiatives. The application involved using a template from the Training Handbook. Many communities applied and received these funds for training that focused primarily on training of personal support workers. In total, over $900,000 from the budget variance was earmarked for training.

Training provided in 2002/03 included:

- First Nations Health Studies Program
- First Response
- Food Handlers Certificate
- Food Care for Caregivers
- Gerontology – Multidiscipline Post-Diploma
- Grief Recovery Certification Program
- Home and Community Care Orientation Protocol
- Health Science Leadership/Management
- Improving Health Care Management in Aboriginal Communities
- Senior Fitness Instructors Course
- Supporting Persons with Dual Diagnosis

- Total Quality Management/Quality Assurance
- Wise Use of Medications in the Home
- Workplace Hazardous Materials Information System
- Workplace Health Promotion/Bereavement Support
- Wound Care

Case Management

- Through the Chiefs of Ontario and McMaster University, a case management program was adapted to First Nations culture and two 6-day sessions were conducted in December 2002. In total, 137 people graduated and all communities had at least one individual attend.

Service Delivery Reporting Template

- Service Delivery Reporting Template training was provided to communities in service delivery. Additional training is anticipated as a requirement for other communities not in service delivery and for additional changes that might occur with the template if an overhaul is done on it.
- Training was conducted in Ottawa and a helpline was subsequently provided. The funding variance was used to purchase computers for all First Nations that did not have the appropriate hardware and/or software. Even with the training and equipment, a number of problems were encountered with the reporting template.

Capital Projects

While the majority of the variance was used for training, part of it was apportioned for capital projects for items such as office furniture, Hoyer lifts, and specialized beds. As with training, communities applied for this supplementary supplies and equipment funding.

Partnerships and Linkages

Partnerships and linkages improved during the year as awareness increased of the Program, its goals, and its scope. There was an increased realization that, when partnered effectively, everyone from staff to clients to communities benefited.

Chiefs of Ontario and PTOs

Ongoing discussions and planning continued with the Chiefs of Ontario and the five PTOs. The Peer Review Committee evolved into an advisory board capacity as the program moved from planning into service delivery.

Provincial Ministry/Community Care Access Centres

Memorandums of understanding were done at the local level with the provincial Ministry of Health/Community Care Access Centres (CCACs) on issues such as referrals and support. The province operates 43 CCACs across the province for all Ontario residents.

Work was undertaken to get the various funding organizations together for discussions. At the provincial level these included CCAC and the Ministry of Health and INAC and Health Canada at the federal level. One initiative was looking at coming up with one expenditure and one information report across all funders.

Educational Institutions

In addition to the case management course provided through McMaster University in Hamilton, partnerships were established with other educational institutions that provide personal support worker training.

Other Health Canada Programs

Collaboration and discussions occurred with some other Health Canada Programs on both a local and regional level such as the Aboriginal Diabetes Initiative, Office of Nursing, and the eHealth group. Discussions were also held with Community Health to investigate mentoring and support between HCC nurses and Community Health nurses, particularly in the area of personal support worker supervision.

Environment Health

One issue that came out of the program evaluation was the need for more education on issues related to environmental health through WHMIS and Sharpes disposal program. These included such issues as how to ensure that all dressings, soiled supplies and syringes were disposed of appropriately.

INAC

Linkages with INAC were minimal on both a regional and local level. A tripartite with Health Canada, INAC and First Nations is in place. The Ontario Ministry of Health administers homemaking services on reserve but INAC supplies the funding.

VON

Some communities in Ontario worked with the Victorian Order of Nurses (VON) in the provision of home care nursing services.

Resources Developed and Distributed

The following resources were developed and/or distributed to Ontario communities during the 2002/03 fiscal year:

- Palliative Care Manual
- Applicable Acts pertaining to Employment in Ontario
    - Employment Standards Act of Ontario (2000)
    - Health Care Consent Act (1996)
    - Homemakers and Nursing Services Act (1990)
    - Long-term Care Act (1994)
    - Power of Attorney Act (1990)
    - Substitute Decisions Act (1992)
    - Workplace Safety and Insurance Act (1997)
    - Regulated Health Professions Act (1991)
    - Labour Relations Act (1995)
- Compendium of Nursing Standards
- Ethics of Nursing in Ontario
- Computers and hard copies of SDRT training
- Case Management Manual (for McMaster training program)
- Ontario Community Support Association booklet on policies and procedures

Quebec

Fast Facts

Population	53,525
Average Population per Community	1,029
Number of Communities Eligible for Funding	52
Number of Communities Funded	51
% of Needs Assessments Completed	98%
% of Communities with Submitted Plans	98%
% of Communities in Planning Implementation	98%
% of Communities with Access to Service Delivery	98%
% of Population with Access to Service Delivery	99%

2002/03

In the Quebec Region, First Nations communities account for 85% of the Region's First Nations and Inuit population. The 38 First Nations communities represent 10 First Nations. The largest community is Kahnawake, near Montreal, which has a population of over 7,000 on the reserve itself.

Approximately 15% of the population served are Inuit in Inuit communities in the Nunavik Region. Within the fourteen Inuit communities, four have populations over 1,000 with the others as small as 125 people.

The Region

An integral part of the FNIHCC Program in Quebec is ongoing collaboration with the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) and Nunavik Regional Board of Health and Social Services (NRBHSS). These two organizations play vital roles in the planning, implementation, and monitoring of the program.

The Inuit communities are linked with each other through the NRBHSS. With the exception of the nine Cree communities, the other First Nations communities operate the program independently.

Committees were struck early in the process to establish funding distribution processes to communities. Approximately half of the communities in the province are considered small and isolated.

About Nunavik

The Region of Nunavik lies north of the 55th parallel in the province of Quebec. Nearly 8,000 Inuit call Nunavik home and live in 14 communities. Kuujjuaq is the Regional administrative centre with a population of approximately 1,500 residents.

With a lack of roads connecting the communities, the primary method of transportation between them and the south is via air and marine vessels.

Source: www.tapirisat.ca

About the FNQLHSSC

The FNQLHSSC is governed by a Board of Directors elected by the General Assembly. The Board of Directors is vested with all the responsibilities granted to in by the General Assembly of First Nations of Quebec and Labrador. The Board of Directors is accountable to the Chiefs of Assembly of First Nations of Quebec and Labrador and to the General Assembly.

The mission of the FNQLHSSC is to:
Improve the physical, mental, emotional, and spiritual wellbeing of First Nation and Inuit individuals, families and communities in respect of their local autonomy and culture. By helping the communities that with to initiate, develop and promote comprehensive health and social program and services as designed by First Nation and Inuit organizations recognized by our First Nations and Inuit.

Source: www.csssnpql.com

About the NRBHSS

The Nunavik Regional Board of Health and Social Services is responsible for the administration and delivery of health and social services to residents of the Nunavik Region.

Atlantic

Fast Facts

Population	24,707
Average Population per Community	618
Number of Communities Eligible for Funding	40
Number of Communities Funded	40
% of Needs Assessments Completed	100%
% of Communities with Submitted Plans	100%
% of Communities in Planning Implementation	100%
% of Communities with Access to Service Delivery	80%
% of Population with Access to Service Delivery	79%

2002/03

The Region

Spread across four provinces, communities in the Atlantic Region include First Nations, Inuit, and Innu populations. Communities tend to be relatively small, with approximately half with populations under 500.

Province	# of First Nations Communities	# of Inuit Communities	# of Innu Communities
Prince Edward Island	2	--	--
New Brunswick	17	--	--
Nova Scotia	13	--	--
Newfoundland and Labrador	1	5	2

In addition to a program manager (regional coordinator) staffed through the FNIHB Regional Office, there was also an administrative support position at FNIHB. Two area coordinators, employed by First Nations organizations, remained integral to the program in the region.

One area coordinator position is based in Nova Scotia and coordinates the program for the 21 communities in Nova Scotia and Newfoundland and Labrador. The total population served is approximately 15,000. The other position is based in New Brunswick and services the 17 communities in that province ands the two communities on Prince Edward Island, a combined population of approximately 10,000.

Overview: 2002/03

2002/03 was a highly successful year in the Atlantic Region, with approximately 80% of communities in service delivery by year-end. A corresponding increase in calls for referrals and increased awareness of the Program ensued. Despite the 40 communities spread across four provinces, the smaller number of communities enabled regional workers to conduct visits in person, develop working groups, and help in building capacity. As the Program matured, so did the confidence of workers in communities who began to feel less isolated and had a greater understanding of the Program.

Prior to the FNIHCC Program, there were very few home care services for people in the region. Since service delivery began, clients were receiving services based on assessment instead of having to be treated in a hospital. In fact, in some cases expectations were higher than the Program delivery capabilities in terms of type and scope of services.

Most communities now had the staff, including nurses and home support workers. They also had clients now assessed through established guidelines.

Pilot Projects

Several pilot projects were conducted in the region during 2002/03 including the following:

Palm Pilot "Pilot"

The national team contracted a company to test palm pilot usage at the community level in home care. Home care workers in one New Brunswick community and Registered Nurses and Licensed Practical Nurses in HCC in one Nova Scotia community participated. The pilot was completed in June 2002.

Hospital Discharge Pilot

Five Mi'kmaq bands on Cape Breton participated in this evidence-based evaluated pilot. The province of Nova Scotia was reluctant to participate initially and provide assistance from hospital staff, in part, due to the perceived increase in workload. Prior to the pilot there were gaps in service between discharge and people returning to the communities partially due to communication. The community coordinators in Cape Breton approached the province to see if home care staff would do an assessment on the First Nations clients and the coordinators developed a tool to collect information. Although there were a few issues, the province was very supportive and all involved are looking at rolling it out province wide in 2003/04.

The pilot also demonstrated the value of having the framework for the program in place, as it showed the provincial representatives the deliverables and outcomes desired of the program and the need for partnerships.

Working Groups

Working groups met each month, either in-person or via teleconference, and a primary benefit was sharing information among communities, offering support, and minimizing feelings of isolation. Guest speakers and specialized training was also provided to the community coordinators, most of whom had a nursing background. Most of the other community coordinators were health directors.

A Regional FNIHCC Steering Committee had representation from the following:

- each of the four political First Nations and Inuit organizations
- an Innu representative

- FNIHB representation
- a representative from the original FNIHCC pilot project conducted in a Nova Scotia community

Training

As in all regions, the funding formula changed in 2002/03 with all money earmarked to communities and no funding specifically earmarked for capital or training. This created a challenge to address these needs, particularly among smaller communities. All training in the region in 2002/03 was at the community level.

Home Support Worker Training

- Home Support Worker training was provided throughout the region, as funding would allow. In the fall of 2002 in the community of Escasoni, Nova Scotia, a community college trained 10 First Nations persons. Training was conducted within the community and was designed to be both convenient and culturally appropriate. Based on the success, plans are for the project to be replicated in 2003/04. In contrast, Davis Inlet in Labrador could not secure having someone come to the community so investigations began into distance learning options. In Prince Edward Island, workers took training of home support workers online, as these small communities could not afford the cost of sending workers to training off the island. Some small communities may not have any trained workers while larger communities could have ten personal support workers. These smaller communities would sometimes contract out the services of trained workers from other communities as needed.

Community Coordinator Training

- A successful training program was conducted for community trainers including a “train the trainer” approach on various aspects of home and community care.

Advanced Wound Care Training

- Advanced Wound Care Training for RNs and LPNs was provided in July 2002 through a partnership with Convatec, a Montreal-

based pharmaceutical corporation. The company contracted individuals to come to the region and teach advanced wound care so workers could be up on the latest techniques and best practices. Plans are for the training to be replicated in 2003/04. Convatec paid for consultants, meeting room and lunch/breaks. Communities paid for their workers' travel and accommodations. Over 75% of communities had at least one community person attend.

Case Management Training

- Case Management Training was offered through utilization of part of the regional budget variance. One person from each community was sent to the week-long case management course at McMaster University in Hamilton, Ontario.

Computer Training

- Basic training for computers was provided for community coordinators so they could learn to complete the Service Delivery Reporting Template. One central session was conducted with all coordinators through Health Canada's eHealth team.

Retention Issues

- Across the regions, a common issue was that people were being trained yet often they ultimately left for non-First Nations communities for a variety of reasons. The result was that the turnover of staff in all facets of the program, including RNs and personal support workers, was becoming an issue.

Partnerships and Linkages

Provincial

A significant accomplishment was the willingness of the Nova Scotia provincial home care program to partner with First Nations to help with assessments at hospitals. Through a tripartite organization that included First Nations, the province, and the federal government, the province began investigating ways of helping to build First Nation capacity.

International Social Worker Conference

Although this conference was held in Halifax in May 2003, a significant amount of planning occurred in the final quarter of 2002/03. In addition to the area coordinator for Nova Scotia and Newfoundland and Labrador, two other presenters included a community coordinator and the Provincial Director of Home Care in Cape Breton. Presentations focused on partnerships, successes and challenges. The conference was indicative of the program becoming better known and recognized outside of First Nations communities and organizations.

ADI

Linkages with ADI were conducted on both a regional and local level wherever feasible. This included collaborating at workshops, providing referrals, and developing programs benefiting both programs such as walking clubs. Presentations were also made at conferences and through training initiatives.

eHealth

Representatives from eHealth provided assistance in areas of training such as the Service Delivery Reporting Template training and support.

INAC

In several communities, HCC and INAC Adult Care funding were combined to avoid duplication of services and maximize efficiencies

Resources Developed and Distributed

Evaluation Guide

The Evaluation Guide developed by the National Evaluation Team was distributed in February 2002. The guide offers evaluation options for communities that may or may not have experience in evaluation. A New Brunswick community began developing a standard evaluation form using the booklet.

Newsletters

Area coordinators developed a newsletter for community staff, which was distributed semi-annually.

Fact Sheets

Several fact sheets were developed and distributed as part of the policy and procedures manuals and shared with communities. These sheets were used for a variety of program purposes such as conducting assessments, dealing with personnel, etc.

Textbooks

Textbooks were sourced and distributed to nurses.

The Territories (Northern Secretariat)

About the Northern Secretariat

The Northern Secretariat was created in the fall of 1998 to provide a coordinated, cohesive and equitable approach to First Nations and Inuit Health Branch (FNIHB) program delivery issues for First Nations and Inuit living in Yukon, the Northwest Territories (NWT) and Nunavut. The Northern Secretariat was also the departmental lead in assisting the Government of Nunavut establish their Department of Health & Social Services. In the fall of 2000, the Northern Secretariat was also charged with the additional responsibility of becoming the single focus for Health Canada's health promotion and illness prevention programs and other interactions with territorial governments and territorial stakeholders in a partnership relationship.

The main responsibilities of the Northern Secretariat are to:

- manage the implementation and delivery of Health Canada's community-based health promotion and illness prevention programs in the territories;
- integrate and streamline Health Canada's health promotion and illness prevention programs planning, management and implementation;
- manage the delivery of Non-Insured Health Benefits in all three territories;
- represent, advocate, advise on, and coordinate matters relating to Health Canada's involvement and role in the territories;

- participate in the negotiation and implementation of self-government agreements in the territories; and
- maintain and strengthen partnerships with territorial governments, First Nations, Inuit and other stakeholders in the territories.

The Northern Secretariat also provides additional support, which includes:

- assuming the lead in policy development regarding health programs development and implementation in the territories;
- participation on Inter/Intra departmental committees on issues which affect health programs and services in the territories;
- developing a strategically coordinated approach to the development, adaptation and implementation of health promotion and illness prevention programs and services in the territories; and
- a focal point for all of Health Canada's activities in the territories.

Fast Facts

	Nunavut	NWT	Yukon	TOTAL
Population	21,244	15,378	7,558	44,180
Average Population per Community	787	466	540	597
Number of Communities Eligible for Funding	27	33	14	74
Number of Communities Funded	25	33	14	72
% of Needs Assessments Completed	93%	100%	57%	89%
% of Communities with Submitted Plans	93%	100%	21%	82%
% of Communities in Planning Implementation	93%	100%	7%	80%
% of Communities with Access to Service Delivery	93%	100%	7%	80%
% of Population with Access to Service Delivery	99%	100%	9%	84%

2002/03

The Region

The Northern Secretariat of Health Canada administers the Program for the three territories.

Nunavut

The Nunavut region is vast, covering almost 2 million square kilometres. Within the boundaries lie 27 Inuit communities with a combined Inuit population of over 21,000.

Northwest Territories

The territory is home to 33 communities, which represent a mix of both First Nations and Inuit settlements. As in the other territories, the communities tend to be small and relatively isolated; however the average size is the smallest among the three territories.

Yukon

Approximately half of the 14 First Nations in the Yukon have a population under 500 and only one community, Kwanlin Dun, has a population over 1,000. At the end of 2001/02, five communities had completed needs assessments and by the end of 2002/03, three additional communities had completed needs assessments in the Yukon. As with the end of 2001/02, only one community was in service delivery at the end of 2002/03.

Linkages and Partnerships

- Service delivery plans submitted by the Regional Health and Social Service Authorities or First Nations/ Inuit Organizations were reviewed and approved as applicable.
- A partnership was developed with Aurora College for curriculum revisions for the Home and Community Care Program.
- Partnerships were also strengthened between the Health and Social Services Authorities, Department of Health and Social Services, Inuvialuit Regional Corporation and the Dene Nation.
- Conference calls and meetings were held with the Territorial/Regional Home Care Coordinators and Northern Secretariat.

Training and Recruitment

- Recruitment of nursing and other Home Care personnel was ongoing.
- Regional Home Care meetings/workshops were held.
- Work continued on strategies to increase interest in the Home and Community Care profession.

Resources Developed and Distributed

A key component of the regional workplan for 2002/03 was to "…educate, communicate, share and listen to/ with Community Leaders, HCC Eligible Populations and Service Providers by communicating with community groups and organizations about home care service and finding ways to support families in the provision of home care."

This was achieved, in part, through newsletters, home care fact sheets, pamphlets, posters, videos, and public service announcements.

CHALLENGES

As the focus in most Regions for 2002/03 continued the shift from planning and implementation to service delivery, approximately three in four communities across the country were providing home and community care services by the end of the year. While those involved in the Program from the community/Tribal Council, region, and national level were able to overcome a wide range of issues during the year, following are some common challenges experienced.

Reporting Requirements

As more communities moved into service delivery, the national team released the Service Delivery Reporting Template (SDRT). The SDRT was designed to assist communities in meeting the reporting requirements in an efficient, comprehensive manner. Unfortunately, it required significant training of regional and community staff and, ultimately, there were issues of system compatibility and the tool was perceived as onerous by many in the Program. In some regions, communities did the reporting requirements manually and then the region had the task of transposing the information online.

In a few regions, locally developed templates were used to collect data. While opinions appear mixed as to whether requirements themselves are becoming easier or more complex, the challenges of the SDRT have probably created a perception among some that they are more onerous. It also requires significant training and ongoing support. A few concerns have also been expressed that the SDRT does not capture all information required (e.g. trending data). There is significant interest in integrating INAC and FNIHB reporting requirements.

Nursing Consultation

In several regions, the provision of nursing consultation was a significant issue during the year. For example, in BC, the Home and Community Care nursing team was required to provide some home care nursing supervision and program review as some communities did not have an option to obtain this elsewhere. Another province cites issues relating to quality assurance, home care records, and associated supervision. Saskatchewan Region addressed the issue of nursing consultation for smaller communities by developing a system whereby smaller communities could use part of their respective funding to purchase this service as required.

While regions worked with workers to address the provision of nursing consultation, committees on both a regional and national level are looking at the issue.

Funding

As with most programs of this nature, there were a number of challenges reported surrounding funding. The rollout of the funding based on stages continued to receive mixed reviews with some program workers feeling that the "community-based, community-paced" philosophy contradicted the actual funding that was based on the stage the community was in.

Small, remote communities often are even more challenged as costs are higher, human resources more scarce, yet essentially the same type of work and levels of service are required.

Second and third level funding is reportedly an ongoing challenge within the regions. While some regions choose to augment the third level funding provided by the national office or to provide some funding for second level services via other budgets, there is a flat amount for third level funding for the program and no funding earmarked directly for second level support.

Different provinces have different levels of partnership, support and service for First Nations for home care, differences which are not taken into consideration with funding.

Recruitment and Retention

Nursing recruitment and retention issues varied in scope and magnitude both between regions and within regions. While recruitment is an ongoing issue even outside of First Nations and Inuit communities, some areas successfully attracted the requisite staff for the Program at the community level.

Retention became an increasing issue in some areas. Wage differentials between First Nations/Inuit communities and non-First Nations/Inuit communities were blamed as part of the reason. A lack of ongoing training support for workers was also cited as a reason workers were leaving.

At the regional and national level, turnover was also a challenge as changes affected momentum, communication, and continuity as new staff was recruited, hired, and trained.

Training and Capital Budgets

Without a specific budget for training and capital projects in 2002/03, regions and communities faced the challenge of providing ongoing training for current workers and for training new workers, specifically as home health care aides. Similarly, replacement of capital or provision of new capital projects proved challenging. Some regions were able to earmark budget variance to some training and/or capital projects but many regions, particularly those with most or all communities in service delivery, were not able to access alternate funding.

Communications & Support

Communications continued to present a challenge to all those involved at a local, regional, and national level. In addition to ad hoc written, verbal, and in-person communications, a number of other ongoing vehicles were devised to enhance the flow of information.

Regular meetings were held in some regions among community and regional workers, either in person or via telephone. Regional staff and First Nations and Inuit partners held regular conference calls and typically semi-annual meetings to learn, brainstorm challenges and opportunities, and provide support and guidance to one another. Despite ongoing efforts with communications, most involved felt that even more communications and information could only improve knowledge, support and services.

As many regions felt challenged and stretched in providing support to communities with relatively limited resources, despite many successes, the national team also experienced ongoing challenges in supporting regions and communities given the scope and nature of the Program. Many communities, in turn, were challenged to deliver a relatively complex program, particularly smaller and/or isolated communities. While support included working at the three levels, there is also a keen desire for support from other programs and offices (e.g. Office of Nursing, NIHB, INAC, etc.)

Despite the challenges faced in communications and support with this program, the achievements and successes at all levels across the country cannot be underestimated, as Program workers moved communities through planning, developing, launching and sustaining HCC Programs.

Linkages and Partnerships

While the level of linkage and partnerships between the Program and other government programs and non-government organizations varied significantly at the community, regional, and national level, some great successes were realized during the year as these collaborations developed or intensified.

Despite many successes, integration and linkages with other organizations and federal programs is challenging. Depending on the organization and issue, discussions and networking can be limited on a national, regional, and/or local level.

Non-Insured Health Benefits Issues

An exciting FNIHCC-NIHB pilot project was developed for early 2003/04 in three communities in Alberta and one in Nova Scotia. The project aims to improve timely and efficient access to certain medical supplies and equipment at the community level. However, the issue of consent and coverage for NIHB is viewed by some as a significant program issue and challenge for the future.

Partnerships: First Nations and Inuit Partners and Health Canada

The FNIHCC Program is premised on a partnership between the Federal Government (Health Canada) and First Nations and Inuit partners. First Nations and Inuit representatives were instrumental in providing input into the Treasury Board Submission for the Program. A National Steering Committee with equal representation from both government and First Nations and Inuit remained instrumental during the 2002/03 fiscal year. Within the regions, partnership and collaborative activities were also conducted. In each region and nationally, these partnerships operate differently, based, in part, on the organizations and individuals involved, their designated roles, and the history of past partnerships.

First Nations and Inuit Partners and government employees alike recognized the importance of collaboration to deliver the outcomes expected for the program. There is not always agreement on the way to achieve these objectives. It has been emphasized that it is important that First Nations and Inuit partners be involved from planning through to implementation, service delivery and evaluation. Challenges also go directly to the community level where it is sometimes difficult reconciling the roles and perspectives of the different bodies and individuals involved (i.e. disagreements between Government and First Nations and Inuit Partner representatives). When disputes do occur, it is difficult for either party to resolve formally issues with no formal dispute resolution system in place.

Despite these challenges, there were countless reports from a local, regional and national perspective where the partnerships between government, health care, and First Nations and Inuit partners worked well not only amongst themselves but also with other partners from other organizations and interest groups.

A LOOK AHEAD: 2003/04

Fiscal year 2003/04 will be the fifth year of the FNIHCC Program. During the first four years, almost three in four First Nations and Inuit communities across Canada have completed all stages of the program – from assessment, submission of plans through to planning implementation and ultimately full service delivery. The year ahead will see more communities move into service delivery, while those communities already in service delivery will benefit from learning obtained through more time and experience with the program.

Evaluation will become an increasingly critical component in 2003/04. Many communities will utilize the skills and ideas received through evaluation workshops and support and begin the process of evaluating the processes and outcomes of their own programs. This information will assist them in managing the program within their own unique environments.

On a national scale, three key studies will be conducted.

Study 1: Has the FNIHCC Program been implemented as intended?

Study 2: Is the FNIHCC Program meeting general home care objectives?

Study 3: Does the FNIHCC Program meet the needs of First Nations and Inuit?

The program will undoubtedly continue to see more and more HCC clients receive services in their respective communities across the country in 2003/04. While a number of challenges continue for workers and partners at all levels in building upon the work already accomplished, the foundation upon which the Program has been built during its first four years will undoubtedly assist all involved in delivering quality home and community care services to First Nations and Inuit people.

APPENDIX 1:
A HOME AND COMMUNITY CARE PRIMER

Basic Components

The following are basic components of Home and Community Care:

- provides services to people mainly in the home;
- provides services based on needs identified through a client assessment;
- designed to help people keep their independence in their own home and allow them to be close to their loved ones as long as possible;
- provides care in a holistic manner that looks at a person's physical, social, spiritual and emotional needs, recognizing that each person is different and unique; and
- supports and improves the care provided by the family and community but does not replace it.

Services

The services that make up Home and Community Care include:

Client Assessment

This is carried out through:

- speaking with the client and the client's family
- speaking with the client's doctor and other care providers
- review of client's health history
- physical check up

Case Management

This is the step after assessment to ensure that the plan for care is right and is provided by the right caregiver at the right time.

Home Care Nursing

- nursing care that is provided in a home or community setting
- includes teaching client and client's family about self care
- may include supervision of workers providing personal care services

Personal Care

- assistance with activities such as bathing, foot care, and dressing

Home Support

- help with light housekeeping, laundry, and meal preparation

In-Home Respite Services

- care for the client while the family, who usually cares for client, has a rest and it is not safe for the client to be left alone

Target Clients

Persons of any age who have an assessed need who:

- have been discharged from a hospital;
- have an illness or disease requiring follow up care;
- are unable to live alone while waiting for care in a long term care facility;
- have a disability requiring assistance to live on their own;
- need nursing care in the home; and/or
- choose to live at home instead of in a long-term care facility as long as it is safe, affordable and services are available.

Others who may benefit from Home and Community Care include family and friends who need support to continue to care for people in the home.

Referral Process

Clients may refer themselves or they may be referred by family members, friends, doctors, neighbours, or hospitals.

Service Providers

Home and Community Care services are provided mainly by registered nurses, licensed practical nurses and certified home health aides/personal care workers at the community level. Home health aides/personal care workers should be supported and supervised by registered nurses.