HEALTH CANADA

FIRST NATIONS AND INUIT HEALTH BRANCH

HOME AND COMMUNITY CARE PROGRAM

Results-Based Management and Accountability Framework

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1.0 Purpose of the ***Results-Based*** Management and Accountability Framework

This Results-Based Management and Accountability Framework (RMAF) describes the integrated approach by which the First Nations and Inuit Home and Community Care (FNI HCC) Program will measure, manage, evaluate and report on results throughout its life cycle.

This document describes the roles and responsibilities of Health Canada, First Nations and Inuit Health Branch (FNIHB) and First Nations and Inuit communities in the implementation and delivery of the FNI HCC Program. It presents a clear and logical program design that links program resources to expected outcomes through a chain of activities, outputs, and expected outcomes. It lays out an appropriate performance management approach that includes ongoing performance measurement, an evaluation strategy, reporting on achievements and accountability for results.

This RMAF represents an understanding between all partners in program delivery as to what they aim to achieve, how they will work together to achieve it and how they will measure and report on outcomes. This RMAF is a tool for better program management and continuous learning.

2.0 ***Development*** of an RMAF for the FNI Home and Community Care Program

This RMAF fulfils or supersedes the commitments made in the original Treasury Board Submission as approved on April 25, 2000. The original submission committed to the development of a Performance Reporting Framework by March 31, 2000, a program wide performance indicator table, an FNI HCC module for FNI HIS, an Evaluation Framework by April 30, 2000 and an evaluation to be completed by March 31, 2005.

As of April 1, 2001 the commitments to the Performance Reporting Framework, performance indicator table and Evaluation Framework had not been met. Further, the development time lines for FNI HIS were delayed and as such the FNI HCC module for the information system could not be developed.

There were also policy changes from central agencies regarding transfer payment programs that had an impact on the performance and evaluation commitments

for FNI HCC. Specifically, the Treasury Board introduced a new Policy on Transfer Payments that came into effect on June 1, 2000. This new policy requires a Results Based Management and Accountability Framework for all programs with transfer payment components.

Discussions with the Treasury Board Secretariat regarding the unfulfilled performance and evaluation commitments for the FNI HCC program concluded that the development of an RMAF would meet the commitments made in the original Submission as well as be current with the performance measurement and management requirements of the new Policy on Transfer Payments.

3.0 ***Methodology*** for Development of the RMAF

This RMAF was developed using a participatory and inclusive process during fiscal period 2001/2002. The development of the RMAF relied heavily on the input of the First Nations and Inuit Home and Community Care Program Evaluation Working Group (FNI HCC EWG) which is composed of representatives from First Nations and Inuit, national and regional FNIHB-FNIHCC representatives and coordinators, FNI HCC program staff from the communities, the Assembly of First Nations (AFN) and the Inuit Tapiriit Kanatami (ITK). Please see Appendix A for a complete list of the members of the FNI HCC EWG.

The development of the RMAF also drew on existing and approved program documents including Memorandums to Cabinet, Treasury Board Submissions and program guidance documents developed with and for communities implementing the FNI HCC program.

The development process was facilitated jointly by an evaluation manager from the First Nations and Inuit Health Branch and the Departmental Program Evaluation Division in the Information, Analysis and Connectivity Branch.

The FNI HCC EWG working group met in person on three occasions (twice in Winnipeg and once in Calgary) as part of the development of the RMAF. During the first meeting the group worked through the initial brainstorming for logic model development. The second meeting was used to revise and validate the draft logic model that had been assembled by the Departmental Program Evaluation Division as well as review the first draft of the performance

measurement tables based on the logic model. Structured tools and work sheets were used to capture the input of the working group members. The third meeting was focussed on the review and validation of the full draft of the RMAF. In between these meetings consultation and information sharing was accomplished via electronic communication (e-mail).

It is felt that the participatory and inclusive approach used in the development of this RMAF will ensure a relevant and appropriate perspective on the national performance of the FNI HCC program for all stakeholders and balanced approach to reporting and accountability. The goal of this effort is the ensure a performance management approach that is seen as useful and credible by all stakeholders involved in the design, funding and delivery of the FNI HCC program.

4.0 The FNI HCC ***Program Profile***

4.1 Setting the Context

The need for home care services for First Nations and Inuit communities has been recognized as an issue for over 15 years. Some key demographic and health related indicators of this need are as follows:

Health Indicators:

- Disability rates are twice as high in Aboriginal communities as those of the general population;
- The First Nations and Inuit Regional Health Survey found that:
  - Some 50% of respondents 65 years of age or older had arthritis/ rheumatism and high blood pressure; and
  - Some 30% of Aboriginal seniors were also affected by diabetes and heart and lung conditions.
- Injury rates in Aboriginal communities are three times the national rate; and
- Some 37% of people 75 years of age or older need assistance with personal care and hygiene.

(Source: Annex D, First Nations and Inuit Home and Community Care Program Description and Implementation Plan, Submission to Treasury Board, April 25, 2000)

Demographic Indicators:

- The Aboriginal population will double over the next two decades;
- Statistics of on-reserve populations indicate that an increasing number of elderly First Nations people are returning to their home communities.

Due to the health status, demographic and health reform changes, a higher percentage of the overall First Nations and Inuit communities (Including Communities North of 60) are in need of home care. The situation is aggravated further on account of First Nations and Inuit not having the same type of access as other Canadians, such as re-investments in more complex and comprehensive home care services. The current programs available to First Nations and Inuit are not equipped to handle the increased demands placed on home care services.

In response to this need, a Joint Health Canada/DIAND/First Nations/Inuit working group was formed to develop a framework for a comprehensive home care program. This work initially guided the development of the FNI HCC Program.

Following the establishment of the program by Cabinet in June, 1999, a series of information and discussion sessions were held with First Nations and Inuit in all provinces and territories. These sessions focused on program design, delivery, funding, accountability principles, roles and responsibilities of the program in order to strategically address the health care needs of the First Nations and Inuit. Over 75% of the over 700 First Nations and Inuit Communities were represented at these sessions (Source: Annex D, First Nations and Inuit Home and Community Care Program Description and Implementation Plan, Submission to Treasury Board, April 25, 2000).

In addition, information sessions have been held with representatives from provincial and territorial health departments and DIAND Regions, to inform them of the new program, and to facilitate program linkages. Partnerships have been developed with territorial governments, as reflected in the Government to Government agreements. A number of national First Nations, Inuit and health professional organizations and associations have also been consulted in regards to the program design.

4.2 The Vision, Principles and Objectives of the FNI HCC Program

The overall vision of the FNI HCC Program is as follows:

The First Nations and Inuit Home and Community Care program will provide basic home and community care services that are 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. The program is a coordinated system of home and community based health related services which enable people with disabilities, chronic or acute illnesses and the elderly to receive the care they need in their home communities.

The guiding principles of the program are as follows:

- respect traditional and contemporary First Nation and Inuit approaches to healing and wellness;
- planning will be community-based and community-paced;
- programs will be available to individuals of all ages with an assessed need;
- services provided will be at least equitable, effective and equivalent to those received by the general population and supported by quality assurance measures; and
- supportive to family and community involvement.

The overall program objectives of the FNI HCC Program are as follows:

- 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 chronic 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 available First Nation and Inuit communities 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 while developing measurable objectives and indicators.

Program funding will be allocated from the National office to communities via the Regions, using a specially designed home and community care funding formula which is detailed in Annex "E" of the FNIHCCP Treasury Board Submission. This funding formula was designed to move towards a population based approach, and it supports the delivery of the essential program elements through current and future delivery patterns.

4.3 *Eligibility Criteria*

The following are eligible to receive home care services as part of the FNI HCC Program:

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

4.4 *The Program Model and the Services Provided*

The FNI HCC Program provides basic home and community care services - that are comprehensive, culturally sensitive, accessible, effective and equitable to that

of other Canadians while still responding to the unique health and social needs of First Nations and Inuit. The program is a coordinated system of home and community based health related services which enable people of all ages with disabilities, chronic or acute illnesses and the elderly to receive the care they need within their home communities. The program is delivered primarily by trained and certified personal care workers at the community level, supported and supervised by home care nurses.

The FNI HCC Program is comprised of essential service elements and may be expanded to include supportive service elements on condition that the essential services are established, and contingent upon the availability of resources and identified needs determined in the program planning phase.

In First Nation and Inuit communities that already possess some or all of the essential services through alternate sources, the program will not duplicate these services, but will allow communities to augment, utilizing the supportive service components, the current services and "Reach For The Top" levels of home and community care.

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

- a structured client assessment process that includes on-going reassessment and determines client needs and service allocation. Assessment is a structured dynamic process based upon continuous information gathering and knowledgeable judgements which 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 DIAND adult care services;
- provision of in-home respite care;

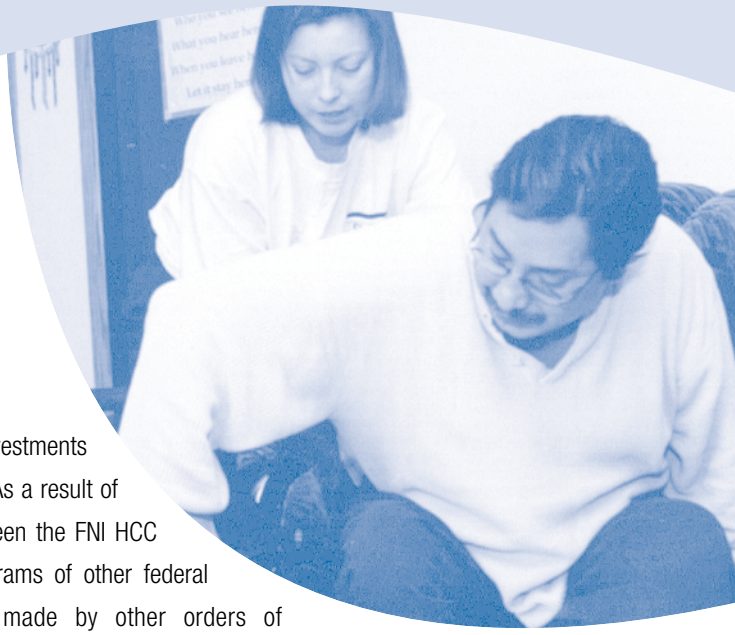
- established linkages with other professional and social services that may include coordinated assessment processes, referral protocols and service links with such providers as hospitals, physicians, respite and therapeutic services;
- provisions to provide home and community care;
- the capacity to manage the delivery of the FNIHCC Program that is delivered in a safe and effective manner, if existing community infrastructure is present; and
- a system of record keeping and data collection to carry out program monitoring, ongoing planning, reporting and evaluation activities.

Based on First Nation and Inuit community needs and priorities, the existing infrastructure and availability of resources, the FNIHCC Program may expand to include supportive service elements. The supportive elements that may be provided within an array 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 counseling and healing services, 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.

FNI HCC **will not:**

- fund the construction and/or delivery of long term care Institutional services; and
- will not duplicate funding for existing on reserve adult care services.



4.5 Linkages

The FNI HCC program builds on existing investments in health and community based services. As a result of this model, there are many linkages between the FNI HCC and other Health Canada programs, programs of other federal government departments, investments made by other orders of government as well as other government funded and non government organizations. Within the suite of Health Canada funded community based programs, some of the programs that FNI HCC has built linkages with include Aboriginal Diabetes Initiative, (which is part of the Canada Diabetes Strategy), Aboriginal Head Start (AHS), the Canada Prenatal Nutrition Program (CPNP). In addition, Home and Community Care and the Aboriginal Diabetes Initiative are working towards an eventual link to the First Nations and Inuit Health Information System (FNI HIS), which is a Government-On-Line funded initiative. FNI HIS will capture the necessary statistical information for users (clients, care providers, program co-ordinators, and program planners) to perform their day to day tasks, including case and program management.

Responsibility for the provision of community based programming for First Nation and Inuit populations is shared among a number of federal government departments. However, Health Canada and the Department of Indian Affairs and Northern Development (DIAND) are the key providers. As such, there are linkages between the FNI HCC program and other DIAND programs. The principle linkage is seen to be with the home making services funded by DIAND.

Some provinces and territories have also made investments in providing homecare services on reserves and in Inuit settlements, providing linkages among orders of governments.

Given the varying approaches taken to the implementation of these various initiatives and components across regions and communities and as such there is not a consistent approach to making links in terms of program delivery. However, the performance measurement and evaluation strategy will try to take a holistic and comprehensive approach to assessing program success.

4.6 Resources

The following table shows the resource profile for the FNI HCC Program as approved by the Treasury Board on April, 25, 2000.

Table 1 ***First Nations and Inuit Home and Community Care Detailed Financial Breakdown (in Thousands) (Revised April 25, 2000)***

Funding Item	1999-2000	2000-2001	2001-2002	2002-2003 (and future years)
OPERATING				
National	1,879.6	1,350	1,235	978
Regional Coordination and 3rd Level Program Support	640	1,600	1,600	2,000
Evaluation and Research	0	0	250	350
Corporate Services Branch	45.4	33.5	34	34
Communications	170	450	900	900
CONTRIBUTIONS				
Program Planning and Service Delivery	12,650	22,416	66,209	85,738
Training	1,615	5,650.5	5,272	0
Capital	0	13,500	14,500	0
TOTAL	**17,000**	**45,000**	**90,000**	**90,000**

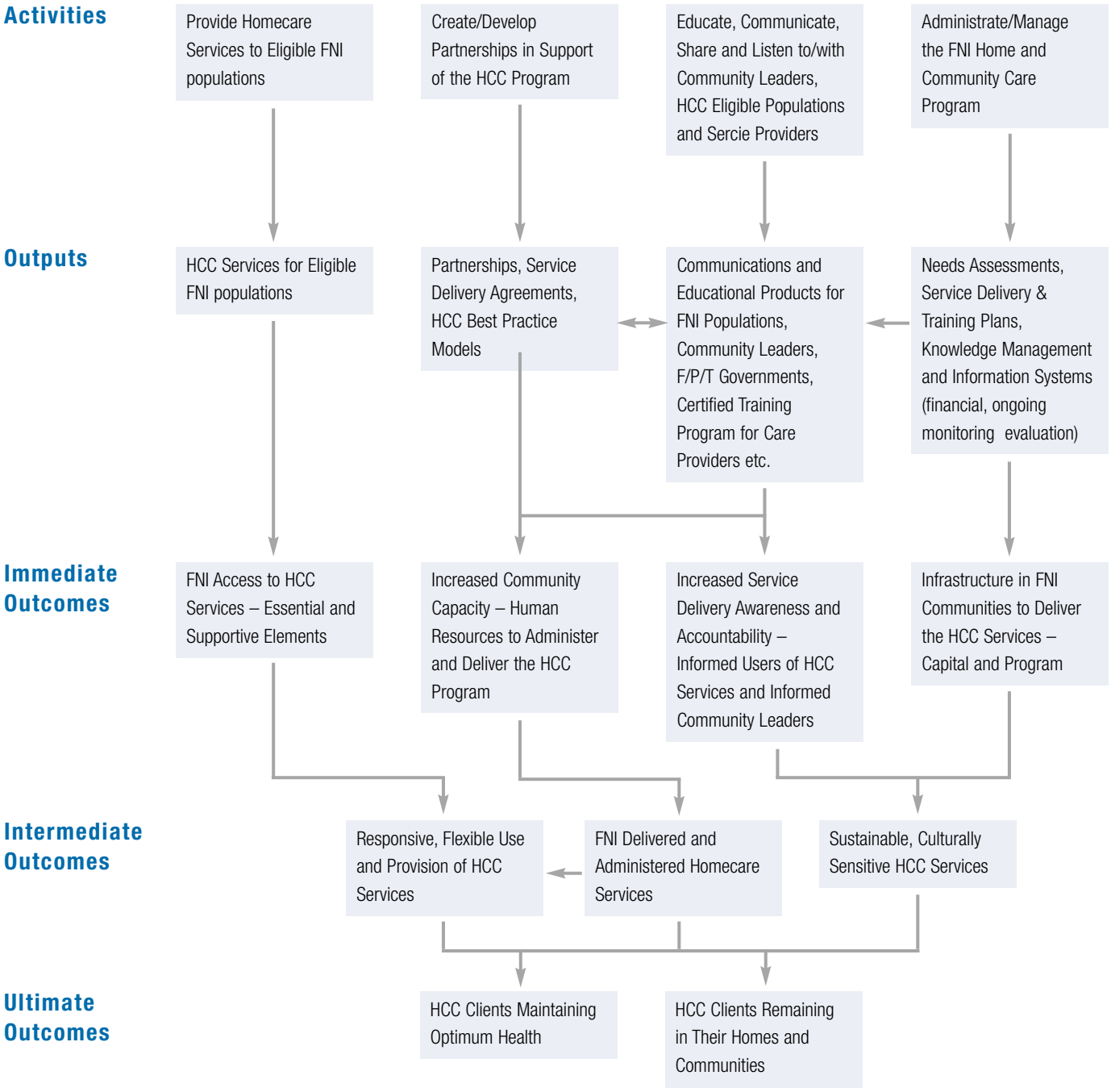
5.0 First Nations and Inuit Home and Community Care Program ***Logic Model***

A program logic model provides a simple means of describing and communicating the essence of a program design by displaying its key elements and the causal relationships among those elements. It is an illustration of how the inputs, activities and outputs of a program are expected to lead to the achievement of the expected outcomes.

The program logic model is a critical element of a RMAF as it is the basis for the selection of performance indicators and the foundation for ongoing performance measurement, evaluation and accountability. Through these three elements of performance management, it is possible to test the program design as displayed in the logic model to determine what is working, what is not and then apply the learning to improve program design which will enhance results achievement.

The following logic model presents the FNIHCC program, activities, outputs, outcomes and key causal links.

FNIHB - ***First Nations and Inuit Home and Community Care Program Logic Model***



6.0 ***Performance Management*** Strategy

Performance Management focuses program interventions on the demonstrated needs and expectations of stakeholders and target populations, enhancing responsiveness and accountability through:

- **Good Planning** - deciding on how to achieve the best performance and achieve outcomes with the resources available. This involves identifying and focussing on expected outcomes, selecting performance indicators, setting specific performance targets and examining alternative and/or complimentary means of achieving the expected outcomes.
- **Continuous Learning and Improvement** - measuring performance, assessing costs and using the information to improve the effectiveness of programs, policies and services.
- **Reporting** - reporting on performance to clients, partners, stakeholders, parliamentarians and Canadians in a balanced and objective way and engaging them in the process of planning, continuous learning and improvement of programs, policies and services.

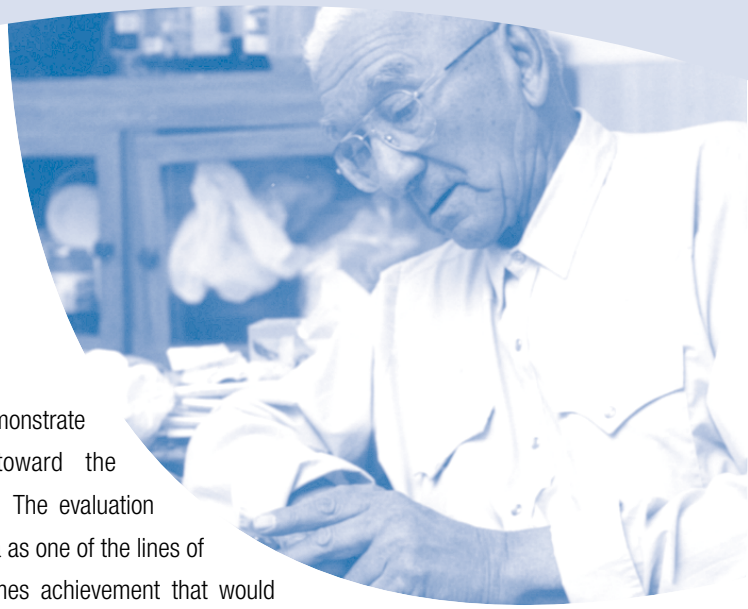
The performance management strategy for the FNI HCC consists of and integrates the following four key components:

- ongoing data collection;
- program evaluation;
- reporting on performance; and
- accountability for results.

6.1 Ongoing Data Collection Strategy

The ongoing data collection strategy will be based on the regular collection of FNI HCC information against the identified performance indicators for the activity, output and outcome components of the logic model. The collection of performance information is intended to be systematic and part of the service delivery and management practice for FNI HCC Program.

This ongoing approach is meant to support the First Nation and Inuit communities that are delivering FNI HCC services, as well as the program manager and staff of the First Nations and Inuit Heath Branch, Health Canada in the administration



of the program. The data collected will demonstrate how the program is progressing toward the achievement of the expected outcomes. The evaluation strategy will draw on the performance data as one of the lines of evidence in an in-depth study of outcomes achievement that would include testing of the causality displayed in the logic model and examining unintended outcomes within the program and on other programs.

The details of the ongoing data collection strategy are contained in the performance measurement tables in Appendix A. These tables contain the performance indicators that have been selected for the components of the logic model, data sources, the frequency of reporting and who will be responsible for collection. The selected performance indicators are consistent with those developed for home care by the Canadian Institute for Health Information (CIHI).

There are three key elements to the ongoing data collection strategy. The elements include:

- FNI HCC annual reports and plans produced by First Nations and Inuit communities;
- FNI HCC Program Service Delivery and Reporting Template (SDRT); and
- biennial survey of FNIHCC clients, care providers and administrators.

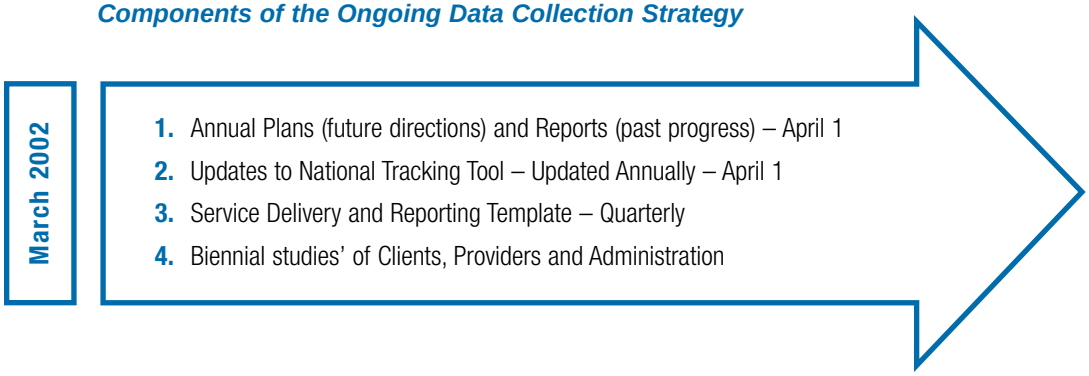
The annual plans and reports from the First Nation and Inuit communities will provide the overview and context for the data provided in the SDRT.

A significant proportion of the ongoing data collection will be collected through the SDRT. The content of these reports will be provided to the First Nations and Inuit Health Branch for storage in an electronic database. Ongoing Performance Measurement Strategy data requirements, to the greatest degree possible, have been harmonized with the requirements of the SDRT. To minimize data collection requirements at the community level, the data for the Ongoing Performance Measurement Strategy will be obtained through an extract from the SDRT database maintained by the program.

The SDRT will also provide important data on community and human resource profiles and updates on training and capacity building. The data collected through the National Tracking Tool will supplement the information in the SDRT, community level annual reports and the biennial survey.

The elements of the FNIHCC data collection strategy are summarized below.

Components of the Ongoing Data Collection Strategy



Ongoing data collection drawn from the described collection tools and will be supplemented through a survey of FNI HCC clients, a survey of FNI HCC administrators and care providers in the First Nations and Inuit communities and a survey of program staff in the federal government. The studies will be premised on the logic model and identified indicators and will be administered biennial by fax, mail-out or electronic means as appropriate. The quantitative data collected will be coded and entered into the ongoing data collection database.

Co-operation of First Nations and Inuit communities is essential to the success of the ongoing performance measurement strategy and the program. The FNIHB will work with the communities to minimize the incremental burden of data collection activities. To minimize the burden of the data collection strategy and to ensure that the data collection components are integrated, the FNI HCC program will undertake the following developmental activities:

1. Develop and maintain a database to store the information gathered from all the elements of the data collection strategy (consistent with FNIH Information System requirements);
2. Develop the FNI HCC client, provider and administrator survey; and
3. Develop and maintain the FNI HCC client, provider and administrator contact survey database (this will compliment the existing G&C's database).

As a program that provides services to individuals, privacy provisions must be considered. All data collected that is related to individuals will be aggregated and treated to remove identifying components to protect the privacy of persons receiving FNI HCC program services.

The ongoing performance measurement strategy is strongly linked to both the evaluation strategy and the reporting and accountability strategy. Program data will be one of the lines of evidence used to respond to the evaluation questions and will provide information on the level of attainment of expected outcomes and performance trends over time. However, evaluations are periodic events and programs are required to report on their progress more frequently. To this end, the data from the ongoing performance measurement strategy will support annual reporting as required by First Nation and Inuit communities, central agencies and parliamentarians.

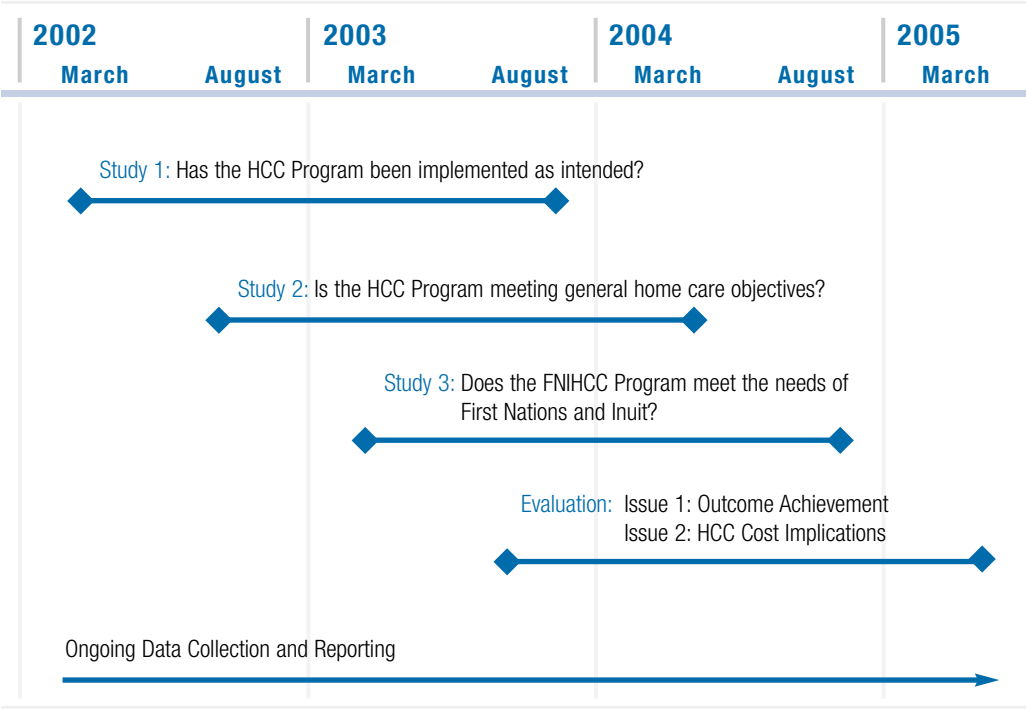
6.2 *Evaluation Strategy*

The evaluation strategy for the FNI HCC consists of two main components:

- focussed in-depth studies; and
- a comprehensive evaluation.

The elements of the FNI HCC evaluation strategy and schedule are summarized on the next page.

HCC *Evaluation Strategy*



Focussed In-depth Studies

Study 1: Has the FNI HCC program been implemented as intended?

The intent of this study is to focus on program delivery. This study will try to determine whether the program has been implemented as identified in the activity and output components of the logic model. In particular, the ability of the program to deliver planned activities consistently, using evidence-base decision-making while being responsive to changing program needs and identified priorities, will be addressed. Information from this study will provide program stakeholders and managers an opportunity to review and comment on program delivery issues and identify where immediate adjustments in the delivery of the program can be made.

This study will compare what was planned versus what has actually been done. The evaluators should attempt to test the following hypothesis: *The program has been implemented as designed*. Step one is to outline what the program was intended to do (activities) and what the program was intended to produce (outputs). Step two is to document what the program did (is doing) and what the program produced (is producing). Step three is to make a statement on the identified hypothesis. There should be a detailed document and file review (including existing annual reports) and interviews with current and past FNI HCC personnel.

Study 2: Is the FNI HCC program addressing the general purposes of home care programs?

According to the report *Development of National Indicators and Reports for Home Care*, by the Canadian Institute of Health Information, home care "services comprise health, social and support services provided in the home setting to meet the needs of service recipients, and their volunteer caregivers" (pg., 11). These services are generally provided to:

- substitute for services provided by acute and long-term facilities;
- allow clients to remain in their current environment rather than moving to a new and more costly venue; and
- to provide prevention efforts.

This study will examine if the continuum of care objectives of home care are being addressed. The evaluators will attempt to test following hypothesis: *The FNI HCC program is meeting the substitution, maintenance and prevention objectives of a home care program*. This study will use a post-treatment research design by examining a representative, randomly selected number of case studies. These case studies will be conducted in FNI HCC communities across Canada and will include a review of FNI HCC organization documents, interviews with clients, providers and administrators, as well as observational component. This study will also draw on existing case management data and biennial study results.

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

The intent of this study is to determine if the FNIHCC Program meets the Home and Community Care needs of First Nations and Inuit. This information will be used to assist First Nations and Inuit communities, program managers to identify potential future directions for the FNIHCC Program from a continuum of care perspective.

This study will review and report the significant health status indicators of the First Nations and Inuit with respect to the FNIHCC Program. A comparative methodology will be undertaken to demonstrate whether home and community care gaps in First Nations and Inuit communities have been addressed and resolved. The evaluators will attempt to test the following hypothesis: *There is a significant need for First Nations and Inuit home and community care.* The comparative approach would consider qualitative and quantitative data preceding the implementation of the FNIHCC versus present day data. It could also employ a comprehensive review of the literature (including an overview of other federal interventions), epidemiological data and interviews with First Nations and Inuit and informed health experts related to the FNIHCC Program. This study will also draw on the SDRT data and biennial study results.

Comprehensive Evaluation

The primary focus of the evaluation is to determine the degree to which the program has achieved its expected outcomes. The in-depth studies described above will have addressed the following issues:

- program design, implementation and delivery - study 1;
- success in meeting the objectives of substitution, maintenance and prevention - study 2; and
- overall efficacy of the FNIHCC Program to address and resolve home and community care gaps in First Nations and Inuit communities - study 3.

This comprehensive evaluation will consist of a synthesis of the information findings generated by the three studies in addition to a summative examination of the issues of outcomes achievement and cost effectiveness.

Issue 1: Achievement of Program Outcomes

The intent of this area of focus is to determine whether the FNIHCC Program has made progress toward the achievement of the outcomes identified.

Part one should test the following hypothesis: *Progress is being made on the achievement of program outcomes as expressed in the logic model.* To make a statement on program effectiveness, this research must be linked to the program implementation study.

The evaluation will use an analysis of pre-program and post/ongoing program measures/data to make comparisons. Ongoing monitoring of funded projects will have been undertaken. To determine whether or not the FNI HCC Program has impacted the immediate and intermediate outcomes a time series comparison must be undertaken. The evaluation of impact will focus on the immediate and intermediate outcomes. Part one will analyse the time series data from the SDRT, the national tracking tool and the biannual study of FNI HCC clients, providers and administrators. This analysis will focus on:

- access, awareness and use of FNI HCC services;
- community capacity and partnerships (administration and provision of FNI HCC services); and
- health and location of FNI HCC clients.

This will include a presentation of the current picture/situation for each outcome. This will draw on the inventory of data (information on the indicators we have identified) for the logic model outcomes.

FNI HCC documents, studies 1 and 2, and stakeholder interviews will compliment the data analysis.

Part two should test the following hypothesis: *As designed, the FNI HCC program will continue to have positive impacts in the future*. The evaluation will undertake a correlation analysis of the time series data. This approach will focus on the analysis of program effects (i.e., regression analysis to test impact of independent measures [counselling] against dependent measures [behaviour]). This will help develop some idea of the potential future impact of the program by statistically testing the programmatic theory (i.e., the logic model).

Issue 2: FNI HCC Benefits and Cost Implications

This issue will examine how First Nation and Inuit communities benefited from the FNIHCC Program. This issue will also examine if the program has been implemented in a cost effective manner.

This element of the evaluation has three main purposes. It will provide program personnel and managers with:

- a systematic inventory of the benefits and costs;
- an overall comparison of the program benefits relative to the cost; and
- assist in making funding decisions.

The first step will be to identify all relevant/significant program benefits and costs. Step two will be to associate a monetary value to all of the benefits and costs. Finally, the evaluation team will compare the benefits and costs to determine the overall net gain or loss incurred by First Nations and Inuit communities stemming from the FNI HCC Program.

As indicated in the Treasury Board Submission, the evaluation strategy will examine these issues at the community level and the tribal council, regional and national levels.

6.3 *Reporting and Accountability*

Health Canada, in partnership with First Nation and Inuit communities, will report on the performance of the FNI HCC program through the parliamentary reporting process using the Report on Plans and Priorities and the Departmental

Performance Report. The performance of the FNI HCC program forms part of the plans and results achieved for the First Nations and Inuit Health Business Line under Health Canada's Planning, Reporting and Accountability Structure.

The leadership of First nation and Inuit communities will report on progress to their members by means and with a frequency that they deem appropriate. The FNI HCC program could also develop special purpose reports speaking to progress achieved against the expected outcomes or learning from implementation experiences. The content of this type of report could include the following:

- updates on performance/administration of the program;
- sharing of key lessons learned and best practices arising from the implementation of the FNI HCC program in the various communities or from other jurisdictions; and
- identification of any gaps in expected performance and the strategy to address those gaps.

The First Nations and Inuit Home and Community Care Program is located in the Primary Health Care Directorate of the First Nations and Inuit Health Branch, Health Canada and is delivered to First Nations and Inuit populations through their community governance structures, consistent with the principles of health transfer and self government. This gives rise to joint accountability for results.

The persons accountable for the performance and results of the FNI HCC are:

- Director, Primary Health Care - for the administration of the program at the national level;
- Director General, Primary Health Care and Public Health - for overall program results; and
- Governments of the First Nations and Inuit communities - for the delivery of the program and client service results.

The vehicle for expressing these accountabilities for the Federal government's role in FNI HCC will be the Performance Management Program for executives of the Federal Government and the associated annual performance contracts that specify the results to be achieved and the measures by which the results will be demonstrated.

First Nations and Inuit populations will determine with their community leadership and the national organizations the manner by which accountability will be expressed.

This Results-Based Accountability Framework will be updated as the program evolves. The Director, Primary Health Care Division, will be responsible for making these revisions in collaboration with First Nation and Inuit communities.

7.0 Framework
Costing

	2002/2003	2003/2004	2004/2005	TOTAL
Ongoing Performance Measurement - including development of electronic data collection tools, database, survey development	1. FTE - 62K EBP - 12.5K PWGSC - 8.0K O&M - 75K	2. FTE - 62K EBP - 12.5K PWGSC - 8.0K O&M - 25K	3. FTE - 62K EBP - 12.5K PWGSC - 8.0K O&M - 25K	4. FTE - 189K EBP - 37.5K PWGSC - 24.0K O&M - 125.0K
Study 1	O&M - 95K	O&M - 25K	n/a	O&M - 120K
Study 2	O&M - 90K	O&M - 90K	n/a	O&M - 180K
Study 3	O&M - 25K	O&M - 55K	O&M - 30K	O&M - 110K
Evaluation		O&M - 125K	O&M - 150K	O&M - 275K
Totals	Salary - 82.5K O&M - 285K	Salary - 82.5K O&M - 320K	Salary - 82.5K O&M - 205K	Salary - 247.5K O&M - 810K

Total cost of RMAF implementation per the above table is 1052.5K. Program funding to March 31, 2005 totals 422 million. As such, RMAF implementation costs represent approximately 2.5% of program funding.

Appendix A - Performance Measurement *Tables*

TABLE 4.1 ***Outputs***

Performance Indicators	Data Source/ Collection	Frequency of Reporting	Responsibility
Outputs: *FNI HCC Services for Eligible First Nation and Inuit Populations*			
1. Number of First Nation and Inuit Home and Community Care Programs a) with essential elements b) with supportive elements	Service Delivery and Reporting Template	Updated Annually	• First Nation and Inuit Community • Region/Territory • Health Canada • Tribal/Band Council
Outputs: *Partnerships, Service Delivery Agreements, FNI HCC Best Practice Models*			
1. Integration of Home Care Services with Primary and Acute Care Provision	Service Delivery and Reporting Template Biennial Study	Quarterly Biennial	• First Nation and Inuit Community • FNI HCC Coordinator
2. Number of Partnerships and Number of Memoranda of Understanding with Other Orders of Government or Health Care Authorities and Providers	Service Delivery and Reporting Template	Updated Annually	• First Nation and Inuit Community • Region/Territory • Health Canada • Tribal/Band Council
Outputs: *Communications and Education Products for First Nation and Inuit , Community Leaders, Governments*			
1. Developed and Disseminated of Communications Documents to Target Audiences	Service Delivery and Reporting Template	Quarterly	• First Nation and Inuit Community • FNI HCC Coordinator
2. Development of Training Materials and Guidance Documents a) Participation at Certification Courses	Service Delivery and Reporting Template	Updated Annually	• First Nation and Inuit Community • Region/Territory • Health Canada • Tribal/Band Council
Outputs: *Needs Assessments, Service Delivery & Training Plans, Knowledge Management and Information Systems (financial perf. monitoring and evaluation)*			
1. Number and Coverage of First Nation and Inuit Community Health Plans	Organizational Plans and Reports	Annually	• First Nation and Inuit Community • FNIHCC Coordinator
2. Number and Coverage of First Nation and Inuit Community Health Reports and Timely Production of Financial Performance Reports	Organizational Plans and Reports	Annually	• First Nation and Inuit Community • FNIHCC Coordinator

TABLE 4.2 ***Immediate Outcomes***

Performance Indicators	Data Source/ Collection	Frequency of Reporting	Responsibility
Immediate Outcomes: *First Nation and Inuit Access to FNIHCC Services - Essential and Supportive Elements*			
1. Number of admissions per 1,000 (catchment area) CIHI	Service Delivery and Reporting Template	Quarterly Updated Annually	• First Nation and Inuit Community • FNI HCC Coordinator • First Nation and Inuit Community • Region/Territory • Health Canada • Tribal/Band Council
2. Number of separations (discharges and deaths) per 1,000 (catchment area) CIHI	Service Delivery and Reporting Template	Quarterly Updated Annually	• First Nation and Inuit Community • FNI HCC Coordinator • First Nation and Inuit Community • Region/Province • Health Canada • Tribal/Band Council
3. Number of active cases per 1,000 (catchment area) CIHI	Service Delivery and Reporting Template	Quarterly Updated Annually	• First Nation and Inuit Community • FNI HCC Coordinator • First Nation and Inuit Community • Region/Province • Health Canada • Tribal/Band Council
4. Number of service hours per 1,000 (catchment area) CIHI	Service Delivery and Reporting Template	Quarterly Updated Annually	• First Nation and Inuit Community • FNI HCC Coordinator • First Nation and Inuit Community • Region/Province • Health Canada • Tribal/Band Council
5. Average number of service hours, by type of service	Service Delivery and Reporting Template	Quarterly Updated Annually	• First Nation and Inuit Community • FNI HCC Coordinator • First Nation and Inuit Community • Region/Province • Health Canada • Tribal/Band Council

TABLE 4.2 ***Immediate Outcomes*** ***(continued)***

Performance Indicators	Data Source/ Collection	Frequency of Reporting	Responsibility
Immediate Outcomes: *Increased Community Capacity – Human Resources to Administer and Deliver the FNIHCC Program*			
1. Number of nurses providing service	Service Delivery and Reporting Template	Quarterly Updated Annually	• First Nation and Inuit Community • FNI HCC Coordinator • First Nation and Inuit Community • Region/Province • Health Canada • Tribal/Band Council
2. Number of support service providers	Service Delivery and Reporting Template	Quarterly Updated Annually	• First Nation and Inuit Community • FNI HCC Coordinator • First Nation and Inuit Community • Region/Province • Health Canada • Tribal/Band Council
3. Sufficient staff to administer and deliver FNI HCC	Biennial Study	Biennial	• FNI HCC Evaluation Manager
Immediate Outcomes: *Increased Service Delivery Awareness – Informed Users of FNIHCC Services and Informed Community Leaders*			
1. Level of Awareness of FNI HCC Service Offerings by Population Group	Biennial Study	Biennial	• FNI HCC Evaluation Manager
2. Awareness of First Nation and Inuit Community Leaders of Needs of Community and Role of Home Care	Biennial Study	Biennial	• FNI HCC Evaluation Manager
Immediate Outcomes: *Infrastructure in First Nation and Inuit Communities to Deliver the FNIHCC Services capital and program*			
1. Facilities for the Administration and Delivery of FNI HCC	Organizational Plans and Reports	Annually	• First Nation and Inuit Community • FNI HCC Coordinator

TABLE 4.3 ***Intermediate Outcomes***

Performance Indicators	Data Source/ Collection	Frequency of Reporting	Responsibility
Intermediate Outcomes: *Responsive, Flexible Use and Provision of FNIHCC Services*			
1. Client satisfaction with care	Service Delivery and Reporting Template Biennial Study	Quarterly Biennial	• First Nation and Inuit Community • FNI HCC Coordinator • FNI HCC Evaluation Manager
2. Distribution of service recipients by primary diagnosis/health characteristic CIHI	Service Delivery and Reporting Template	Quarterly Updated Annually	• First Nation and Inuit Community • FNI HCC Coordinator • FNI HCC Evaluation Manager
3. Distribution of service recipients by reason for discharge CIHI	Service Delivery and Reporting Template	Quarterly	• First Nation and Inuit Community • FNI HCC Coordinator
Intermediate Outcomes: *FNI Administered and Delivered HCC Services*			
1. Proportion of individuals who receive assistance from a First Nation and Inuit care provider CIHI	Service Delivery and Reporting Template Biennial Study	Quarterly Biennial	• First Nation and Inuit Community • FNI HCC Coordinator • FNI HCC Evaluation Manager
2. Distribution of the types of care received from First Nation and Inuit care provider CIHI	Service Delivery and Reporting Template Biennial Study	Quarterly Biennial	• First Nation and Inuit Community • FNI HCC Coordinator • FNI HCC Evaluation Manager
Intermediate Outcomes: *Sustainable, Culturally Sensitive FNIHCC Services*			
1. FNI HCC operating expense as a percent of total community expenditures CIHI	Organizational Plans and Reports	Annually	• First Nation and Inuit Community • FNI HCC Coordinator
2. Per capita community expenditures on FNI HCC services CIHI	Organizational Plans and Reports	Annually	• First Nation and Inuit Community • FNI HCC Coordinator
3. FNI HCC operating expenses by type of care service CIHI	Organizational Plans and Reports	Annually (Pending)	• First Nation and Inuit Community • FNI HCC Coordinator
4. Client satisfaction with care	Service Delivery and Reporting Template Biennial Study	Quarterly Biennial	• First Nation and Inuit Community • FNI HCC Coordinator • FNI HCC Evaluation Manager

TABLE 4.4 ***Ultimate Outcomes***

Performance Indicators	Data Source/ Collection	Frequency of Reporting	Responsibility
Ultimate Outcomes: *FNI HCC Clients Maintaining Optimum Health*			
1. Maintenance in Condition Specific Symptoms	Service Delivery and Reporting Template	Quarterly	• First Nation and Inuit Community • FNI HCC Coordinator
2. Level of functionality	Biennial Study	Biennial	• FNI HCC Evaluation Manager
3. Self-Assessed Health	Service Delivery and Reporting Template	Quarterly	• First Nation and Inuit Community • FNI HCC Coordinator
4. Quality of Life	Biennial Study Quality of Life Profile Survey	Biennial	• FNI HCC Evaluation Manager
Ultimate Outcomes: *FNI HCC Clients Remaining in Their Homes and Communities*			
1. Number of ill or disabled able to remain in communities	Service Delivery and Reporting Template Biennial Study	Quarterly Biennial	• First Nation and Inuit Community • FNI HCC Coordinator • FNI HCC Evaluation Manager
2. Number of clients who would have been admitted/required facility placement	Survey Service Delivery and Reporting Template		

Appendix B - Performance Measurement ***Glossary***

Accountability: The obligation to answer for a responsibility or authority that has been conferred.

Accountability Framework: Defines the scope and nature of the responsibilities or authorities conferred, the relevant performance expectations that have been established, and the manner in which the actual performance achieved is monitored and reported. (See also *Performance Framework and Management Framework)*

Activity: An operation or action that produces a good or service (output).

Aim: (See *Goal, Vision or Objective)*

Attribution: A measure of the extent to which a program, policy, or other initiative has produced results that would not have occurred without these initiatives. Also referred to as incrementality, causality, additionality or contribution.

Baseline: A description of the situation before a program, policy or other initiative was started, using qualitative and/or quantitative information. It serves as a point of reference against which the performance of a program is assessed over time.

Balanced Reporting: An approach to performance reporting that enhances a report's credibility by not only reporting good performance but also performance that has not met expectations.

Benchmark: A target, goal or standard against which performance is assessed.

Benchmarking: Setting standards of performance or identifying best practices by comparing similar organizations.

Business Line: A grouping of programs, policies and other initiatives that are aimed at achieving a common objective or result and are used as the structure for federal government business planning and performance reporting.

Business Plans - Departmental: A submission to the Treasury Board indicating the Minister's directions for the department for the next three years, the department's key priorities and how they support the government agenda, and strategies for delivering on those priorities.

Causal Model: (See *Logic Model)*

Citizen Engagement: The process of getting Canadians to participate in government decision making so that their evolving needs are met.

Citizens: Refers to the Canadian public in general. (See *also Stakeholder, Customer, and Client)*

Client: A direct consumer or user of government policies programs and services, typically in an inexpert-expert relationship with the government similar to that of a student and teacher. (See also *Citizen, Stakeholder*, and *Customer)*

Comptrollership: (See *Modern Comptrollership)*

Continuous Learning Culture: An organizational value system and climate that encourages employees to continually acquire, apply and transfer knowledge and skills in a concerted and deliberate manner that benefits them and improves the performance of their organization.

Contribution: (See *Attribution)*

Cost-Effectiveness: A measure or analysis of results achieved relative to the costs of achieving those results.

Customer: A buyer of government goods and services who typically understands what is being offered and exercises some choice in the transaction. (See also *Citizen, Stakeholder,* and *Client)*

Departmental Performance Report (DPR): The Departmental Performance Reports, tabled in the fall of each year by all federal departments, are part of the Estimates and Supply process. The reports explain what the government has accomplished with the resources and authorities provided by Parliament using the Report on Plans and Priorities as a point of reference. The performance information in the reports is intended to help parliamentarians advise the government on resource allocation in advance of the annual budget and supply process in the spring. (See *Report on Plans* and *Priorities)*

Estimates and Supply Process: The provision of information to Parliament under the Appropriation Act to support the government's request to spend public monies, and the associated Parliamentary review and approval process which enables the government to proceed with its spending plans. (See *Main Estimates* and *Supplementary Estimates)*

Expenditure Management System (EMS): An approach used to define the government's spending priorities within the framework and limits established by the Budget. It integrates departmental strategies; government fiscal and Budget decisions; and parliamentary scrutiny and approval.

Evaluation: A government review function which is expected to deliver timely, relevant and credible information on the continued relevance of government policies and programs; on the impacts they are producing; and on opportunities for using alternative and more cost-effective policy instruments or program delivery mechanisms to achieve their objectives.

Evidence: (See *Performance Evidence)*

Financial Information Strategy (FIS): A government-wide initiative to provide central agency and departmental decision makers with better financial information for improving the decision-making process, planning, program delivery and reporting.

Focus on Canadians: Views the benefits provided by government from the perspective of Canadians. This emphasizes the things that are important to Canadians as opposed to internal activities or services. (See also *Outside-in* and *Inside-out)*

Framework: A model or structure for organizing ideas, objectives, factors, players, activities, processes, criteria, etc., in a manner that helps show how they interrelate.

Goal: A broad statement of what an organization wants to achieve in fulfilling its mission and mandate. (Sometimes also referred to as an *Aim*, *Objective* or *Vision)*

Governance: The exercise of authority, direction and control over an organization through the definition of an organization's mission, values, policies, objectives, goals and accountability.

Government Priorities: Matters of critical importance identified in key government policy pronouncements such as the Speech from the Throne or the Budget that the government intends to address.

Health Determinant: Any physical, social, economic, educational, environmental, behavioural, biological, or genetic factor that affects the health of the population.

Horizontal Initiatives: Programs, policies or activities that affect multiple organizations, jurisdictions or areas.

Impacts and Effects: The consequences of a policy, program or other initiative, usually in terms of how they affect Canadians. (Terms used interchangeably - see also *Outcomes* and *Results)*

Improved Reporting to Parliament Project: Initiated in early 1995 as the second phase of the improvements to the government's Expenditure Management System (EMS). The reforms are intended to respond to both Parliament's expressed wish for accessible and effective performance information and the government's move to enhance the accountability of departments and agencies to Parliament.

Incrementality: (See *Attribution)*

Indicator: A particular value or characteristic (quantitative or qualitative) used to measure the state of being of something.

Inputs: The resources and authorities given to an organization to carry out activities, produce outputs and accomplish results. Resources include such items as tax dollars, user fees, human resources, capital and information.

Inside-out: A perspective that looks outward from an organization at the impact of its policies, programs or other activities on its external environment. This perspective is typically reflected in a review or evaluation function. (See *Outside-in)*

Instruments of Public Policy: The means available to governments to implement public policy. These could include taxation, regulation, subsidy, direct service delivery, third party/alternate service delivery and information and education programs.

Interdependence: The concept that the results achieved by one organization, policy, program or initiatives often affect, and are affected by, the results achieved by another organization policy, program or initiatives.

Internal Audit: A government review function which is expected to deliver timely, relevant and credible information on the cost-effectiveness of the systems, practices and controls adopted to manage program delivery activities and internal operations.

Internal Performance: Refers to the internal workings or operations of a department and describes how well a department manages its resources and implements changes to its policies, programs or activities in order to improve the benefits it provides to Canadians.

Key Results Commitments: The benefits that departments have committed to provide to Canadians. They relate to high level, enduring objectives of an organization and are used as a basis against which to set goals and report actual achievements to Parliament through the annual Report on Plans and Priorities and Departmental Performance Report. The term is also used in performance agreements under the Performance Management Program for executive compensation to define measurable goals against which the performance of executives will be assessed and pay-at-risk awarded. (See also *Performance Commitments)*

Knowledge Partners: Organizations and groups that contribute to the discussion and understanding of public policy issues. They can include other government organizations, business groups, research organizations, interest groups, and the academic community.

Logic Model: A tool to communicate how a government policy, program or service works. It describes a path or logical sequence of activities and events involved, usually by graphical means, in which inputs are transformed into outputs and the subsequent chain of impacts, effects or outcomes that occur as a result

of those outputs. Models may also describe who has been affected (See *Reach*) as well as indicate the other players or factors at work which influence the performance of the policy, program or service. (Also referred to as a *Causal Model)*

Main Estimates: Information prepared by the government in support of its request to Parliament for authority to spend public monies. The request is formalized through the tabling of appropriation bills in Parliament. The Estimates have traditionally been structured in three parts: Part I providing and overview of total government spending; Part II outlining spending by department and agency and directly supporting the *Appropriation Act*; and Part III documents providing detail on each department and its programs. More recently, Part III documents have been split into two distinct documents: a Report on Plans and Priorities tabled with the Estimates as Part III; and a Departmental Performance Report tabled in the fall. (See also *Supplementary Estimates)*

Management Framework: Defines the key principles and processes for managing an organization including planning, target setting, accountability arrangements, measuring and monitoring performance, reporting and feedback. (See also *Accountability Framework* and *Performance Framework)*

Managing for Results: (Also referred to as *Results-Based Management* or *Performance Management*, see also *Outcomes-Based Management)*

Mandate: Defines the nature and scope of an organization's responsibilities, authority or powers.

Mission: Defines an organization's purpose(s) or reason(s) for its existence.

Modern Comptrollership: A core management function that integrates, analyses and interprets financial and non-financial performance information to support informed management decision making and accountability processes.

Objective: A concise statement of the results that an organization wants to achieve in fulfilling its mission and mandate. (See also *Goal* and *Target)*

Organization Culture: A collective set of habits used by the members of an organization to get things done.

Organization Values: A set of core principles or beliefs that reflect what is important to the members of an organization and serve as a guide for appropriate behaviour.

Outcomes: The consequences of a policy, program or initiative that can be plausibly attributed to the program. Outcomes can be distinguished in many ways – intermediate or ultimate, short or long term, expected or unexpected, and intended or unintended. (Also referred to as *Impacts* and *Effects)*

Outcomes-Based Management: A process and value system that continually focuses on the needs and expectations of the people of Canada in order to be more responsive and accountable to them. It involves: *Good Planning* - identifying key results or outcomes, setting specific performance goals or targets, and examining alternative ways of achieving the desired outcomes; Continuous *Learning and Improvement* - measuring performance, assessing costs and using this information to improve the effectiveness of government programs, policies and other initiatives; and *Responsiveness and Accountability* – to clients, partners, staff, other stakeholders, parliamentarians and Canadians in general by reporting on actual performance and engaging them in the planning, continuous learning, and improvement of government policies programs and activities. (See *Managing for Results*, *Results-Based Management)*

Outputs: Goods or services produced or directly controlled by an organization, usually for outside use or distribution.

Outside-in: A perspective that looks at government policies, programs and services from the point of view, needs and expectation of citizens. This perspective is typically reflected in a policy analysis function. (See *Inside-out)*

Performance: How well an organization functions as determined by comparing its actual results achieved to defined goals, standards or criteria.

Performance Accomplishments: Actual results achieved in relation to previously stated performance expectations.

Performance Commitments/Expectations: A statement of results to be achieved within a specific time period in relation to defined goals, standards or criteria. (See also *Key Results Commitments)*

Performance Evidence: Information—indicators, measures, anecdotes or analyses—reported illustrating the actual results achieved by an organization.

Performance Framework: Defines the key performance expectations of an organization, and the performance measurement strategy and performance measures or indicators used to report actual accomplishments against those expectations. (See also *Accountability Framework* and *Management Framework)*

Performance Indicator: A particular value or characteristic (quantitative or qualitative) used to measure actual results achieved. (See *Indicator)*

Performance Measure: (See *Performance Indicator)*

Performance Management: (Also referred to as *Managing for Results* and *Results-Based Management*, see also *Outcomes-Based Management).*

Performance Target: A precise, usually quantified, statement of the results an organization plans to achieve, typically involving some increment of improvement over time.

Planning, Reporting and Accountability Structure (PRAS): The basis or framework for describing objectives, key results and financial information included in all expenditure management reports to the Treasury Board and to Parliament. Approved by the Treasury Board, the main objective of the PRAS is to ensure that there is consistent presentation of performance information from year to year.

Program Evaluation: (See *Evaluation)*

Quality Service: A management approach that stresses client satisfaction and employee involvement and innovation. In this approach, all employees contribute to the management and quality of their outputs and consequently to the success of their organization. (See also *Service Standards)*

Reach: Defines the extent of influence of a government policy, program or service in terms of the type and number of clients or other individuals and organizations affected by them.

Report on Plans and Priorities (RPP): As part of the Main Estimates, these reports provide information on departmental plans and expected performance over a three-year period. These reports are tabled in Parliament each spring, after resource allocation deliberations. They generally include information such as mission/mandate, objectives and strategies, as well as specific performance targets. (See *Departmental Performance Report)*

Result: An impact or effect of a government policy, program or initiative. This typically includes outcomes or outputs but can also involve changes to inputs such as resource reallocations or reductions. (See also *Key Results Commitments* and *Performance Commitments)*

Results-Based Management: An approach to management in government in which organizations are controlled and assessed by what they achieve. It focuses on the identification of results commitments and use of results information in planning; in continuous learning to improve programs, policies and services; and in being responsive and accountable to citizens, Parliament and partners. (Also referred to as *Managing for Results* and *Performance Management*, see also *Outcomes-Based Management)*

Review: An internal management function which is expected to deliver timely, relevant and credible information to support decision-making and to account for performance. It provides information on what is working in government and on the impact of government policies, programs and services. The function includes the disciplined ongoing performance monitoring and self- assessment activities of managers; internal audit and evaluation activities; as well as other professional and independent assessments of government policies, programs and services.

Risk Management: The systematic application of management policies, procedures and practices to the tasks of analysing, evaluating, controlling and communicating risk.

Service Standards: Include five essential elements: descriptions of service, service pledges, delivery targets, costs, and complaint redress mechanisms. They are more than service delivery targets such as waiting times or hours of operation. (See also *Quality Service)*

Societal Indicators: Measures describing the social and economic characteristics or well-being of citizens and society such as life expectancy, poverty levels, employment rates, crime rates, education attainment, disposable income, tolerance, volunteer rates, literacy rates, discrimination levels, etc.

Stakeholders: Anyone who can be, or perceives to be, affected by a government policy, program, service or decision. (See also *Citizen, Customer,* and *Client)*

Stewardship: The duties and obligations of the governing body of an organization for the safe custody and proper disposition of the assets of the organization.

Supplementary Estimates: Tabled in Parliament in the late fall and spring to obtain the authority of Parliament in an Appropriation Act to adjust spending levels approved in the Main Estimates for that fiscal year. (See also *Main Estimates)*

Value for Money: A general measure of the benefits provided by government programs or services relative to their costs. Represents an optimum trade-off between economy, effectiveness, efficiency, and quality.

Values: (See *Organization Values)*

Vision: A statement of a preferred future state or condition for an individual or organization. (Sometimes also referred to as an *Goal* or *Aim)*