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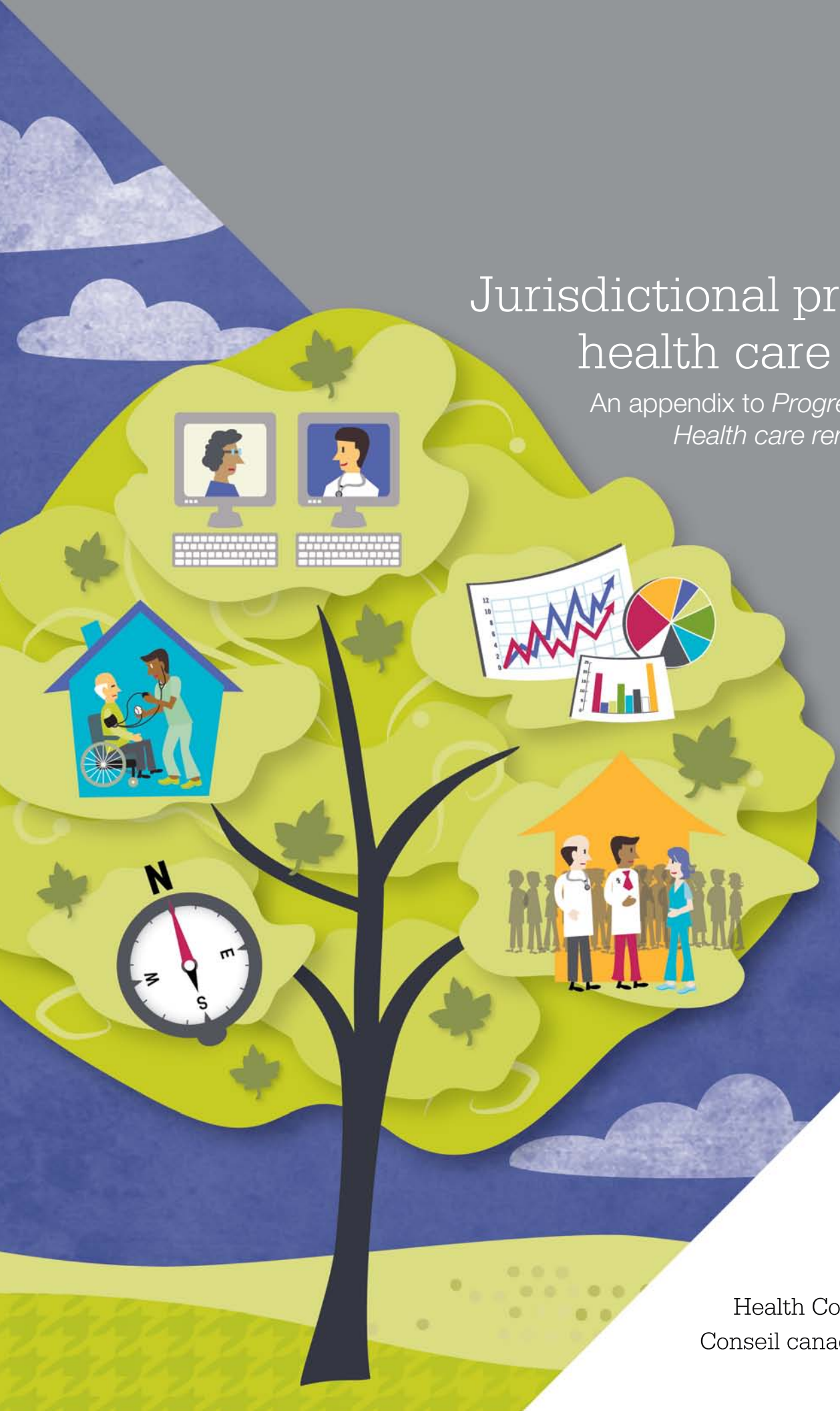
Jurisdictional profiles on health care renewal

An appendix to *Progress report 2012: Health care renewal in Canada*



Health Council of Canada
Conseil canadien de la santé

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About the Health Council of Canada

Created by the 2003 *First Ministers' Accord on Health Care Renewal*, the Health Council of Canada is an independent national agency that reports on the progress of health care renewal. The Council provides a system-wide perspective on health care reform in Canada, and disseminates information on leading practices and innovation across the country. The Councillors are appointed by the participating provincial and territorial governments and the Government of Canada.

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Progress report 2012

In *Progress report 2012: Health care renewal in Canada*, the Health Council of Canada reports on the progress made by jurisdictions in five priority areas of the health accords: home and community care, comparable health indicators, health human resources, telehealth, and access to care in the North. This document provides a more in-depth review of this progress by federal, provincial, and territorial governments.

Jurisdictional profiles on health care renewal

Provinces and territories have different health care needs and priorities and, as a result, each health care system is changing in different ways. In preparing these jurisdictional profiles on health care renewal, the Health Council examined health care priorities, targets, and performance reports; gathered information from government websites, annual reports, and news releases; consulted with government representatives, stakeholders and experts; and requested information directly from federal/provincial/territorial ministries/departments responsible for health. All profiles are current up to March 31, 2012.

British Columbia

Home and community care

With respect to short-term commitments, British Columbia has met the stated health accord commitments for home care. Specifically, British Columbia has provided post-acute home care with regard to nursing, personal care, and case management.[1] Further, the commitment to short-term mental health home care has been met and there are plans for additional long-term provisions and connections with primary care.[2] The province has also met the end-of-life home care commitments by developing a comprehensive end-of-life strategy.[3, 4] The province has stated its intention for the health care needs of British Columbians to be met by primary care teams and within the community as a way to promote integrated care.[5]

British Columbia supplemented the compassionate care benefit provided federally by enacting legislative amendments to the provincial *Employment Standards Act* in April 2006.[6] However, it's not apparent how well used the benefit is within the province.

British Columbia has implemented the Resident Assessment Instrument-Home Care (RAI-HC) across the province.[7] Health authorities in other regions are starting to report RAI-HC data to the Canadian Institute for Health Information (CIHI) through the Home Care Reporting System and the Continuing Care Reporting System. The ministry of Health and regional health authorities collect more home care data than are reported to CIHI. The ministry of Health uses this information for service planning and policy development.[8]

Comparable health indicators

British Columbia's ministry of Health reports on its spending on health programs and services through its Annual Service Plans.[9] These reports outline the province's achievement of specific performance goals in the previous year's service plan.[5] Further, each regional health authority is required to produce a similar plan, aligning with provincial goals.[10, 11] The ministry of Health has a strategic plan for health goals and sets benchmarks and targets.[12] There is no comprehensive public health system reporting as of yet; however, this is under development.[13]

The British Columbia Patient Safety & Quality Council (BCPSQC) was established in 2008 with a mandate to advise on improving transparency and accountability to the public for the safety and quality of health care provided in the province.[14] However, the BCPSQC's terms of reference do not include a requirement or plans for the council to produce regular reports on health system performance.[8, 15] While British Columbia published comparable indicators reports in 2002[16] and 2004,[17] the province has noted that these reports were of limited usefulness for health planning.[8] The earlier report contained results for 62 of the 67 indicators, and was consistent with all significant requirements for reporting on comparable health indicators, as agreed by the ministers of health. The latter report

adhered to the direction provided in the 2003 health accord where the provincial premiers and the prime minister agreed to further develop health indicators to focus on specific program and service areas that resulted in the preparation of a list of 18 featured indicators.[13]

British Columbia has no plans to produce a further comparable indicators report as it did in 2002[16] and 2004,[17] given the associated duplication of effort with CIHI and Statistics Canada, which they feel produce and maintain a wealth of comparable indicator data.[8, 18-20]

Health human resources (HHR)

Health human resources strategies for the province are captured in the British Columbia's ministry of Health's Annual Service Plans.[5, 9] While many of the deliverables will be developed at the systems level, British Columbia expects each regional health authority human resources strategic plan to support overall provincial HHR objectives.[8]

The Health Human Resources Strategy Council, which is made up of representation from the ministry of Health, health authorities, and the Health Employers Association of BC, provides quarterly progress reports on HHR to the ministry of Health and to the CEOs of all health authorities.[8] The 2011/12 to 2013/14 plan includes strategies to develop capacity for more effective HHR planning and forecasting and to redesign areas of care and service delivery.[5]

For example, the ministry and regional health authorities have put a focus on interprofessional care through its Care Delivery Model Redesign initiative,[8] and the BC Academic Health Council is developing strategies to advance interprofessional education opportunities.[8] The Interprofessional Rural Program of British Columbia (IRPBC), for students, is shifting from a focus on once-a-year student teams in select communities to having rural communities provide interprofessional experiences for all students through patient-centred collaborative learning environments.[21]

British Columbia is a member of the Western and Northern Health Human Resources Planning Forum,[22] which helps western provincial and territorial ministries of Health and Advanced Education to coordinate HHR planning.[23] With respect to undergraduate and postgraduate education for doctors and nurses, British Columbia has been involved in expanding residency positions for physicians, including family medicine, and training seats for medical and nursing programs.[8] As well, the Provincial Nominee Program, for example, allows foreign-trained doctors and nurses to gain permanent residence status more quickly.[24] The Skills Connect program bridges education programs and workplace integration for this group,[25] and it has made recruitment of foreign-trained health care professionals more successful.[8] Health Match BC supports health authorities with out-of-province recruitment both within Canada and internationally. The majority of recruitment activities were for communities outside the Lower Mainland. In the current calendar year (to June 30), more than 300 physicians were referred to positions throughout the province, with 126 matched so far. Additionally, more than 700 registered nurses and 50 hospital pharmacists have been recruited from outside BC. Recently, Health Match BC began targeting other allied health professionals, including physiotherapists, medical laboratory technologists, and radiation technologists.[26] Internationally educated health professionals are provided with assistance with licensing and immigration matters, including Provincial Nominee Program applications, to ensure speedy processing.[8]

Overall, from 2000 to 2010, there was a 22.2% increase in the number of physicians practising in British Columbia, and a 12.4% increase (versus 11.9% nationally) in the near term, from 2006 to 2010.[27] Also, between 2006 and 2010, the number of registered nurses in BC increased by 7.2% to 30,919 in 2010. In 2010, there were 129 nurse practitioners in BC, which was 5.2% of the national supply. Between 2006 and 2010, the number of licensed practical nurses (LPN) in BC increased by 52.2%, accounting for 10.1% of the overall supply of LPNs in Canada in 2010.[28] As of 2010, 95.6% of LPNs who graduated from BC also practise in the province, the third highest rate in Canada.[28]

Telehealth

In British Columbia, telehealth services are available in approximately 30 clinical program areas, including oncology, psychiatry, pharmacy, thoracic surgery, home care, and neurology.[13, 29] The capacity for video conferencing for clinical, administrative, and health-related educational encounters exists in more than 100 communities throughout the province.[13] There are approximately 230 telehealth facilities providing access to approximately 720 video conferencing end points. These services are delivered within each regional health authority and between regional health authorities.[13]

In November 2006, in support of the objectives contained within the Transformative Change Accord, British Columbia and the First Nations Leadership Council released a First Nations Health Plan outlining a range of program and service enhancements to address First Nations health status.[13, 30] British Columbia is working with the First Nations and Health Canada to plan and implement a fully integrated clinical telehealth network, which is essential to meeting the commitments in its Tripartite First Nations Health Plan.[13, 31]

In 2008, the Provincial Telehealth Office coordinated funding from Canada Health Infoway to help regions implement teleoncology, telethoracics, teleophthalmology, and telehomecare programs.[13, 32] Notable achievements include the Interior Health Authority and Vancouver Island Health Authority telehomecare projects, which demonstrated the benefits of utilizing technology to proactively treat congestive heart failure patients in the home while increasing patient self-management.[13] Both projects deployed remote devices into homes that transferred patient data through phone lines to central monitoring application software, monitored by clinicians. To date, using telehomecare technology, over 900 patients have been managed.[13]

In addition to initiatives funded by Canada Health Infoway, other successful telehealth programs are operating in British Columbia, such as Telestroke. Telestroke is part of the Province Stroke Strategy and a partnership between the Heart and Stroke Foundation and the ministry of Health.[13, 33] It is an emergency telemedicine application that enables timely access to a neurologist for consultation and potential delivery of a life-changing stroke treatment called tissue plasminogen activator.[13]

Access to care in the North

British Columbia does not receive federal funding under the Territorial Health System Sustainability Initiative since this program applies to the Northwest Territories, Yukon, and Nunavut.[34] However, about 300,000 people live in northern British Columbia, of whom almost one fifth are Aboriginal.[35] The strategic plan of the Northern Health Regional Health Authority emphasizes the need for an integrated health care system built on strong primary health care.[36] Northern Health intends to create “primary care homes” and to partner with Aboriginal communities to provide culturally relevant services.[36] Northern Health also offers the Connections program to help with medical travel.[37]

Several province-wide initiatives are being implemented in northern British Columbia. The Family Physicians for British Columbia (FPs4BC) initiative supports physicians to practise in communities of need. As of August 31, 2011, the Northern Health Authority has filled seven of its nine available spaces. The Divisions of Family Practice promote alignment of community-based services with family practice, quality improvement, shared care, practice coverage, and other initiatives. There are currently four divisions (two established and two under development) in the Northern Health Authority encompassing 12 communities. Also, Prince George is one of three prototype sites for the Attachment Initiative. This initiative provides funding that, among other aspects, provides continuity of care and access to family practices that focus on people with complex medical needs, pregnancies, patients with moderate to severe mental illnesses and/or substance use disorders, and the elderly.[8]

The British Columbia Travel Assistance Program (TAP BC) helps alleviate some of the transportation costs for eligible residents who must travel within province for non-emergency medical specialist services not available in their own community.[38] TAP BC is a corporate partnership between the ministry of Health and private transportation carriers who agree to waive or discount their regular fees.[8] In late 2010, British Columbia released *Healthy Minds, Healthy People: A 10-Year Plan to Address Mental Health and Substance Use in British Columbia*, which also references projects undertaken to improve telemental health.[39, 40]

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Alberta

Home and community care

Alberta has met the stated health accord short-term acute home care commitments for nursing, personal care, case management,[1] and access to intravenous medications related to discharge.[2] Further, the commitments to short-term acute community mental health services, specifically case management and crisis response services, have been met.[1] Specific policies are in place to ensure that residents receiving end-of-life care at home have 24/7 access to nursing and personal care services.[3]

Palliative-specific medications are funded through the Palliative Care Drug Coverage Program for all clients covered under the Alberta Health Care Insurance Plan.[2] Services are provided for up to 90 days at no cost to the patient, and in 2007 the funding limits on home care were removed.[1] Small fees for homemaking services are charged based on client income.[4] Alberta has developed *Continuing Care Strategy: Aging in the Right Place*[5] and *Becoming the Best: Alberta's 5-Year Health Action Plan*,[6] which set out strategies to increase available home care funding and services, and set new provincial wait time targets for home care and supportive living. The province has also initiated Aging in Place Community Demonstration Projects, which aim to develop sustainable community-based solutions to support seniors aging in their homes.[7]

With respect to compassionate care benefits, Alberta has not amended its *Employment Standards Code* to allow for the adoption of the federal compassionate care benefit.[8] Currently in Alberta, family caregivers accessing the federal compassionate care benefit do not have employment protection.[9]

Alberta is currently using the Resident Assessment Instrument-Home Care (RAI-HC) assessment tool,[3] and all continuing care service providers were mandated to implement RAI-HC assessment and planning tools.[10] A provincial reporting system has been built by Alberta Health and Wellness to capture RAI assessment and service detail data, which will be used to assess the quality of the data and ensure the data are available to Alberta Health and Wellness and Alberta Health Services.[10] The data will be used to create extracts for submission to the Canadian Institute for Health Information (CIHI), and it is anticipated that CIHI reporting functionality will be operational post-December 2012.[10]

Comparable health indicators

The *Alberta Health Services 2010–2015 Health Plan: Improving Health for Albertans* and the *Alberta Health Services 2011–2015 Health Plan* identify specific health system performance measures and outline detailed action plans for how Alberta Health Services will meet the goals set out in each plan.[11, 12] The plans also include baseline measures, to enable tracking progress compared to previous years.[11,12] The *Alberta Health Services 2011–2015 Health Plan* performance measures were built upon those outlined in the 2010–2015 Health Plan,[11, 12] and are aligned with strategic goals set out in *Becoming the Best: Alberta's 5-Year Health Action Plan 2010–2015*.[6] Alberta Health and Wellness' annual reports contain information on its health care spending and a summary of the performance measures for the fiscal year compared to outcomes from the previous year.[13] In addition, Alberta Health Services releases annual performance reports that provide performance measure updates, along with quarterly performance updates in performance dashboards.[14]

The Health Quality Council of Alberta (HQCA) was established in January 2002 as a result of the *Report of the Premier's Advisory Council on Health*.[15] The mandate of the HQCA is to promote patient safety and health service quality on a province-wide basis, primarily through the lens of the *Alberta Quality Matrix for Health*, which has six dimensions of quality: acceptability, accountability, appropriateness, effectiveness, efficiency, and safety.[16] The HQCA is mandated to measure, monitor, and assess patient safety and health service quality[16] and reports indicators at the provincial and regional levels. The HQCA has released two reports on health system performance: the 2009 and 2010 *Measuring and Monitoring for Success*.[17, 18] The 2009 report focused on system and clinical level indicators,[17] while the 2010 report focused on system and clinical level processes.[18] In addition, the HQCA reports on survey results in the following areas: urban and regional emergency department patient experience,[19] continuing care,[20] and satisfaction and experience with health care services.[21]

Health human resources (HHR)

Health human resources strategies for the province are captured in a Comprehensive Health Workplace Strategy that is comprised of a Health Workforce Action Plan, developed in 2007 and led by the Government of Alberta, and a Health Workforce Strategy led by health stakeholders.[22] The Health Workforce Action Plan contains five strategic policy directions and 19 proposed action areas to address labour shortages and workforce distribution.[22] The plan was developed in collaboration with two other government departments, Immigration and Industry and Alberta Advanced Education and Technology, that will support Alberta Health and Wellness in implementing government actions.[22] Progress on HHR performance measures is provided on an annual and quarterly basis by Alberta Health and Wellness.[13]

Alberta Health and Wellness also utilizes Human Resources Forecasting and Simulation Models (e.g., family physician and nursing models) to ensure the projected demand for health professionals reflects actual and future requirements.[13] The Board of Directors of Alberta Health Services has also formed a standing Human Resources Committee to consider, monitor, oversee, and make recommendations to the board related to Alberta Health Services' HHR issues.[23] While many of the HHR strategies are developed at the system level and led by Alberta Health and Wellness, the health authorities are responsible for planning, delivery, and management of health services within their province.[24] A provincial HHR planning guide was developed in 2008 by Alberta Health and Wellness to facilitate the health authorities' understanding of HHR planning at a provincial level and outline the roles of Alberta Health and Wellness and the health authorities in HHR planning.[24] Alberta is a member of the Western and Northern Health Human Resources Planning Forum.[25]

Alberta Health Services has developed an Employee Workforce Engagement Plan to increase job satisfaction in the health care sector. This plan identifies five organization-wide engagement strategies.[26] Every two years employee surveys are used to evaluate the effectiveness of engagement strategies and biannual reports (which include engagement metrics) that are presented by the CEO to the Alberta Health Services Workforce Engagement Working Group.[26] Physician recruitment and retention initiatives include funding to increase student clerkship in family medicine in rural Alberta; the Alberta Rural Remote Northern Program, which supports recruitment and retention by providing physicians with fee premiums on insured services when practising in rural, remote, and northern communities; and the International Medical Graduate Program, which improves the efficiency in placing foreign-trained physicians in alignment with identified provincial resource needs.[22, 27, 28]

Additional physician strategies include the Alberta Rural Physician Action Plan (RPAP), which was developed in 1991 and has multiple initiatives to improve rural medical education, recruitment, and retention.[29] The RPAP targets three groups: 1) rural high school students, medical students, and rural preceptors, 2) practising rural physicians and their families, and 3) Alberta Health Services and its partner rural communities.[29] Alberta Health and Wellness has also created Alternative Relationship Plans that have a clinical and academic component.[30] The aim of this program is to develop compensation strategies—other than fee-for-service—to remunerate physicians for providing defined program services and to encourage physician research and teaching.[30]

From 2000 to 2010, there was a 57% increase in the total number of physicians practising in Alberta, and a 19.1% increase (versus 11.9% nationally) in the near term, from 2006 to 2010.[31] Alberta relies heavily on internationally trained medical graduates: from 2006 to 2010, internationally trained physicians increased by 29.5% in Alberta, compared to national growth of 18%.[31] Between 2006 and 2010, the number of registered nurses (RN) in Alberta increased by 7.2%. to 28,681.[32] In 2010, Alberta accounted for 10.7% of the overall RN supply in Canada.[32] Between 2006 and 2010, the number of nurse practitioners (NP) increased by 68.6%, accounting for 10.6% of the overall supply of NPs in Canada in 2010.[32] Lastly, between 2006 and 2010, the number of licensed practical nurses (LPN) in Alberta increased by 30% to 7,301, accounting for 9.0% of the national supply of LPNs.[32]

Telehealth

Alberta's telehealth programs were governed by Alberta Health and Wellness until 2009, when responsibility was passed to Alberta Health Services.[33] Implementation is supported by partnerships throughout Alberta Health Services, and it extends clinical and scheduling services to the Northwest Territories, British Columbia, Saskatchewan, and the Yukon.[34] Over the years, the network has grown substantially, with a diversity of services provided across the province as a result of investments made by Alberta Health and Wellness, Canada Health Infoway, and an anonymous donation. Today, there are more than 900 video conferencing sites, making Alberta's network one of the largest and best integrated in North America.[33]

In 2003, the Alberta government introduced the Telehealth Clinical Services Grant Fund to support new telehealth programs that allow Albertans, regardless of location, to have access to needed medical professionals and specialists.[35] Projects enabled health service providers to provide better primary and specialist care in rural and underserviced areas.[36] Health Canada's First Nations and Inuit Health Branch (FNIHB) ensures that funds are extended to First Nations communities by contributing to grant funding and supporting implementation of services.[35] As part of the Clinical Telehealth Innovation Program, the Alberta government established Telehealth Change Management Capacity grants for the seven rural health regions to make training, education, and professional development more available to rural practitioners.[37] As well, the Telestroke program, which supports the Alberta Provincial Stroke Strategy, includes a focus on rural and remote areas.[38]

One of the strategies identified in *Becoming the Best: Alberta's 5-Year Health Action Plan 2010–2015* is to improve access and reduce wait times.[6] The strategy prioritizes increasing the use of telehealth for clinical interventions as a mid- to long-term action (by March 2015) with the goal of improving the linkages between primary health care providers and medical and surgical specialists. This builds on the original strategies and goals of the Alberta Telehealth Business Plan.[37] The *Alberta Addiction and Mental Health 2011–2016 Action Plan* includes telehealth

psychiatric services among the programs and services already underway, which supports the strategies in the overarching 5-year health action plan.[39] Vision 2020 is a recent initiative that identifies new directions for Alberta's health system, one of which includes enhancing access to high quality services in rural areas. Greater use of telehealth services is among the actions identified.[40]

Access to care in the North

Alberta does not receive federal funding under the Territorial Health System Sustainability Initiative since this program applies only to the Northwest Territories, the Yukon, and Nunavut.[41] However, approximately 435,000 people live in Alberta's North Zone, of whom 15.7% of the population are Aboriginal.[12] The 2011–2015 health plan for Alberta focuses on assessing the needs of each health region to determine priorities in the allocation of resources for health provision, and assuring that there is reasonable access to quality health services in each health region that are responsive to the unique needs of that region.[12] Alberta Health Services formed the Community and Rural Health Planning Framework to apply a standardized approach to planning community and rural health service across the province to build upon the unique strengths of each rural community.[42] The True North Health Advisory Council was established in June 2009 to work with Alberta Health Services on health services in Northern Alberta.[43]

To improve access to health care facilities in rural Alberta, the 3-Year Health Capital Plan allocated $2.5 billion to building health infrastructure projects and maintenance in medium-sized cities/towns and rural communities from 2010 to 2013.[13] Expanded access to local services in rural areas is delivered through mobile services, in-home services, telehealth technology, telephone services, satellite clinics, an Aboriginal Health Program, and outreach services in rural communities.[44, 45] The Government of Alberta also helps to provide transportations benefits to eligible residents with severe health problems who require access to ongoing medical treatment covered through the Medical Extraordinary Transportation Service.[46] The Rural Remote Northern Program is a component of the Clinical Stabilization initiative, which supports recruitment and retention of physicians in underserviced communities through incentive structures for service in eligible communities. The program has recruited and retained 3,010 physicians to date.[13]

To create interest in family medicine practices in rural communities, the Health Workforce Action Plan provides funding to medical students to complete a rotation in rural Alberta communities.[13] The Health Workforce Action Plan also provided approximately $300,000 to the Rural Physician Action Plan to run an 89-day locum program to attract United Kingdom–trained family physicians/general practitioners to rural practice in Alberta and increase interest in permanent medical practice in rural communities. This program was initiated in 2009 and has recruited four physicians.[47] Other professional programs include rural rotations as part of educational requirements, such as the registered dietitian program, which requires students to complete at least one of four placements in a rural location.[47] In addition to programs to increase access to physicians, new practice and reimbursement models for community pharmacists continue ongoing development to support pharmacists practising to their full scope, which will improve access to services in rural communities.[48, 49]

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Saskatchewan

Home and community care

Saskatchewan has implemented a number of short-term acute home care commitments for nursing, case management, personal care, and intravenous medication administration.[1, 2] In accordance with the 2004 health accord, Saskatchewan invested in a program of mental health home care aimed at supporting persons for the first 14 days after discharge from acute mental health wards of general hospitals. The programs also support a dedicated mental health aspect of the Saskatchewan Health Line.[3]

The end-of-life care services are included in the general home care program.[1] By December 2006, Saskatchewan had met all the commitments to short-term end-of-life home care including case management, nursing, personal care, and provision of palliative specific pharmaceuticals.[3]

Program expectations and guidelines based on best practices for home care have been recently updated in the *Provincial Home Care Policy Manual*. The manual has been posted to the ministry of Health website and is available to stakeholders and the general public.[4]

With respect to compassionate care, Saskatchewan amended its *Labour Standards Act* in 2004 to allow for adoption of the federal compassionate care benefit. The provincial amendment also increased caregiver leave up to 16 unpaid weeks.[5]

In 2006, a review was conducted on home care in the province.[6] Although implementation of these recommendations has not been publicly reported, Saskatchewan has reported that progress has been made on a number of these recommendations.[3] The ministry of Health, in collaboration with regional health authorities, continue to review the recommendations and ongoing work continues.

Although Saskatchewan does not send any home care data to the Canadian Institute for Health Information (CIHI), it is anticipated that Saskatchewan will send data to CIHI in 2012/13. The ministry of Health does not typically conduct evaluations on provincial regional health authority home care programs rather, provincial home care policy states every regional health authority must develop and implement a mechanism for evaluating their programs.[4]

Comparable health indicators

The ministry of Health produces annual plans that identify strategies and objectives for health care that align with the government's overall directions.[7, 8] These annual plans identify initiatives or plans that will be implemented to reach targets.[7] Specific measures are also identified, along with baseline measurements, in order to track performance[7, 8] in subsequent annual reports.[9] Saskatchewan's ministry of Health published reports using the comparable indicators in 2002[10] and 2004.[11] While these comparable indicator reports provided background for strategic planning, Saskatchewan also used other information sources and has noted that the approach towards health indicators has since evolved.[4]

The Saskatchewan Health Quality Council conducts extensive health system performance reporting. It was created in 2002, and among its objectives is to monitor and assess the quality of health services available in Saskatchewan.[12, 13] It reports most indicators at the health region level and some indicators at the facility or hospital level.[14] The Saskatchewan Health Quality Council has released two reports on health system performance: *Quality Insight 2008* and *Quality Insight 2010*, which are starting points toward a more comprehensive look at the quality of care in Saskatchewan.[13, 15]

Health human resources (HHR)

Saskatchewan developed a Physician Recruitment Strategy in 2010[16] and released its 10-year health human resources plan in December 2011.[17, 18] One of the 10-year HHR Plan's four goals captures the need for collaborative, inter-professional practice. It also considers what the province must do to ensure Saskatchewan has its required health professionals over the next 10 years to provide health services, but it is waiting for primary health care redesign to be advanced further before forecasting the numbers of doctors and nurses required.[17] Further, the government has a number of initiatives to help attract physicians to Saskatchewan, retain current supply of doctors, and ensure local medical school graduates establish practices in the province.[16] Saskatchewan's ministry of Health reports publicly on HHR progress in its annual report and the Physician Recruitment Agency of Saskatchewan also produces an annual report.[9, 19] The province uses HHR indicators and targets in its plans and reports.[9, 17]

Physician initiatives include the Provincial Physician Recruitment Agency, enhanced medical education to prepare for rural practice, improvement of the physician application and licensure process, and a Saskatchewan-based program to assess foreign-trained physicians.[16] In 2008, the province and the Saskatchewan Union of Nurses entered into a multi-year agreement to address nursing recruitment and retention issues, with initiatives such as assistance and training opportunities for specialized skills, recruiting expatriate nurses back to the province, and increasing the use of nurse practitioners.[20] As well, Saskatchewan's Northern Health Strategy assists and facilitates with HHR recruitment, retention, training and education in the North.[21] Saskatchewan is a member of the Western and Northern Health Human Resources Planning Forum.[22]

From 2000 to 2010, there was a 13.5% increase in the number of physicians practising in Saskatchewan, which was similar to the 13.2% increase (versus 11.9% nationally) in the near term, from 2006 to 2010. However, Saskatchewan is below the national average in terms of physicians per 100,000 people. Saskatchewan has a heavy reliance on international medical graduates: in 2010, 47% of its total workforce was international medical graduates; the highest percentage of all jurisdictions in Canada.[23] Between 2006 and 2010, the number of registered nurses (RN) in Saskatchewan increased by 12.5%. In 2010, Saskatchewan accounted for 3.6% of the overall RN supply in Canada.[24]

Between 2006 and 2010, the number of licensed practical nurses (LPN) in Saskatchewan increased by 22.4% to 2,723, accounting for 3.4% of the overall supply of LPNs in Canada in 2010. As of 2010, 89.5% of LPNs who graduated in Saskatchewan practise in Saskatchewan. Between 2006 and 2010, the number of nurse practitioners (NP) in Saskatchewan increased by 38.6%, accounting for 4.9% of the overall supply of NPs in Canada in 2009.[24]

Telehealth

The role of eHealth Saskatchewan, a Treasury Board Crown Corporation, is twofold: it will lead Saskatchewan's efforts and investments toward building an electronic health record for each resident; and, it will coordinate, operate, and maintain other selected clinical IT systems (e.g. telehealth) on behalf of health care delivery organizations in the province.[3]

Telehealth Saskatchewan is a Saskatchewan Health program endorsed by the 2001 Action Plan for Saskatchewan Health Care as an effective approach to improving access to health services; telehealth is an important part of the Northern Health Strategy.[25, 26] As part of the provincial e-health

program, eHealth Saskatchewan is well supported by a governance and organizational framework and extensive partnerships.[27, 28] In 2010 there were over 100 telehealth sites operating in provincial, regional, and northern hospitals; sites are located throughout every health region.[3, 29] Telehealth also links with other sites provincially, nationally, and internationally. If a patient needs to be referred to a specialist outside of Saskatchewan processes are in place to facilitate these arrangements.[3]

Notable achievements include the northern rural and remote strategy, integrating telehealth into provincial planning, specifically primary health care.[25] Saskatchewan reaches northern, rural and/or remote communities through initiatives signed between the ministry and Northern Inter-Tribal Health Authority (NITHA) and Health Canada's First Nations and Inuit Health-Saskatchewan Region (FNIH-SK Region).[3] In 2010, Telehealth Saskatchewan helped over 5,300 Saskatchewan residents see health care providers without travelling, and provided over 10,000 hours of education sessions.[3] As well, there are a wide variety of specialists and clinicians such as nutritionists, dietitians, and diabetes educators accessing telehealth to provide patient services within the health regions.[3]

Access to care in the North

Saskatchewan does not receive federal funding under the Territorial Health System Sustainability Initiative since this program applies to the territories only.[30] As in other provinces, health services in northern Saskatchewan are provided by various agencies. Recognizing the need for coordination, 13 agencies—including the provincial government, health regions and First Nations councils—developed a Northern Health strategy.[31] The Aboriginal Health Transition Fund (AHTF) helped support the planning and policy work done for the strategy.[31] Although funding from the AHTF ended in 2011, the work done in the Northern Health Strategy continues to support the work of those agencies addressing health issues in northern Saskatchewan.[32] The government works with the province's northern health regions, Keewatin Yatthé Regional Health Authority, Mamawetan Churchill River Regional Health Authority, and Athabasca Health Authority, on addiction.[31]

The Northern Medical Transportation Program was established in the 1980s to provide funding for emergent and non-emergent medical transportation in northern Saskatchewan. The program has two components: (a) emergency transportation provided by private air carriers, medical taxi, or road ambulance for all northern residents; and (b) non-emergency transportation to assist social assistance clients with access to medical treatment and appointments outside their community.[33]

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Manitoba

Home and community care

Manitoba has met the post-acute home care commitment to provide nursing, personal care, and case management.[1, 2] With regard to short-term acute mental health home care, the commitments for case management and crisis response were met.[3] In 2011, Manitoba announced a six pillar five-year mental health strategic plan called *Rising to the Challenge*. While this plan did not contain direct references to home care, community-based services were listed.[4]

Manitoba supplemented the federal compassionate care benefit with legislative amendments to its *Employment Standards Act* to provide up to eight weeks of unpaid compassionate care leave.[5] More recently, Manitoba demonstrated additional commitment to caregivers by implementing a Caregiver Tax Credit in 2009 and subsequently passing the *Caregiver Recognition Act* in 2011.[6, 7] In addition, in 2009 Manitoba Health enabled family members to receive funds to self-manage the care of their loved ones. In Manitoba's 2011 budget, the government committed to invest in long-term care, including home care.[8]

The Canadian Institute for Health Information (CIHI) holds home care data from the Winnipeg Regional Health Authority. However, no other regional health authority submits to CIHI at this time. Each regional health authority submits information monthly to the department of Health regarding their home care programs. This information is compiled annually and a summary is posted to the department's website.[9]

Comparable health indicators

Manitoba Health reports on its health care spending and programs in its annual report.[10] The report details the year's objectives, expected and actual results of specific programs, and a breakdown of each program's expenditures.[10] As well, Health Information Management publishes an annual statistics report, which provides a wide range of population-based indicators.[11, 12] Manitoba Health reports on wait times for diagnostic services, surgery, and cancer services beyond the wait time priorities reported on in the Health Council of Canada's *Progress Report 2011*.[13-16] The chief provincial public health officer is required to report every five years on population health.[17]

While Manitoba does not have a health quality council, the Manitoba Institute for Patient Safety aims to promote, coordinate, and facilitate patient safety and enhance quality of health care.[18] The institute provides information to patients and health care providers on improving patient safety in the health care system.[19] The Manitoba Centre for Health Policy produced an RHA Atlas in 2009 (edited in 2011) that reported on health and health system performance.[20] This report contains data at the provincial, health region, and district levels, as well as neighbourhood levels for Winnipeg.[20]

Manitoba Health published reports using the comparable indicators in 2002 and 2004,[21] but has discontinued this process.[9] Manitoba noted that to be useful from a health planning perspective there would need to be more detailed work completed.[9]

Health human resources (HHR)

Manitoba released a health human resource plan in 2006 that contained strategies and initiatives to address supply issues and other challenges.[22] HHR planning, strategies, and outcomes are reported as part of Manitoba Health annual reports,[10, 23] and reports such as the 2008 progress report on its nursing strategy[24] and an annual Manitoba Nursing Labour Market Report.[25] The government uses several health human resources forecasting models, involving scenario-based interpretations of the current situation versus the forecasted outcomes with various policy interventions.[9] While the annual report documents include detailed plans and results, there are no associated targets.[10]

Nursing education program seats have more than doubled since 1998 to 2010 (from 629 to 1,360 seats).[25] The province's nursing recruitment and retention fund also provides grants for nursing students and funding for ongoing education.[26] Interprovincial agreements are in place for certain health care professional training that is not offered within the province: a prosthetics and orthotics program at the BC Institute of Technology, and a nuclear medicine technology training program at the Southern Alberta Institute of Technology.[9] The province has increased the number of seats for ultrasound, medical radiologic technology, and medical laboratory technology training programs within Manitoba.[9]

Since 2005, a Physician Resource Coordination Office (PRCO) has collaborated with each of the regional health authorities to manage physician recruitment and retention for the province. The PRCO is working to increase accessibility to education, with measures such as the Physician Assistant Training Program.[23] Manitoba is the only jurisdiction with formal legislation supporting physician assistants as of 2011.[27] Physician incentives include a medical student/resident financial assistance program and a specialist recruitment fund. There has also been increased funding for residency positions in the Northern/Remote Family Medicine Stream with a return of service element to the grant.[9] Manitoba has a bridging program for internationally educated workers. The province also has an assessment and licensure program for conditional licensure of international medical graduates. The retention rate of international medical graduates who have completed the program is more than 80%. In 2008, a Manitoba recruitment mission to the Philippines resulted in the recruitment of 122 nurses.[23]

From 2000 to 2010, there was an 11% increase in the number of physicians practising in Manitoba, and a 8.8% increase (versus 11.9% nationally) in the near term, from 2006 to 2010. In 2010, Manitoba was below the national average in terms of the number of physicians per 100,000.[28] Between 2006 and 2010, the number of registered nurses (RN) in Manitoba increased by 6.7% to 11,630.[29] In 2010, Manitoba accounted for 4.3% of the overall RN supply in Canada. As of 2010, 76.1% of RNs who graduated in Manitoba also practise in Manitoba. Between 2006 and 2010, the number of licensed practical nurses (LPN) in Manitoba increased by 3% to 2,732, accounting for 3.4% of the overall supply of LPNs in Canada in 2010. As of 2010, 87.5% of LPNs who graduated in Manitoba practise in Manitoba.[29] The number of nurse practitioners (NP) increased from 32 in 2006 to 101 in 2010.

Telehealth

Manitoba has a well-developed governance and organizational structure to lead telehealth developments.[30] Manitoba eHealth is a single integrated organization, providing province-wide solutions. The vision and mission focus on expanding telehealth services to complement the need for health care reform and renewal, in particular, building an integrated primary care system and ensuring equitable access to telehealth for Manitobans without a phone.[31,23,32] Notably, MBTelehealth works to provide services to Ontario, Nunavut, and Saskatchewan. For instance, Manitoba provides training and support to

Nunavut on telehealth best practices.[33,34] Service provision to other jurisdictions is driven by relationships between the networks and referral relationships, although physician licensure requirements vary by jurisdiction and this can create challenges.[34]

MBTelehealth supports more than 200 specialists providing services in over 60 specialty areas, and one quarter of telehealth sites are in First Nations communities.[35] Successful collaboration among MBTelehealth, the First Nations and Inuit Health Branch (FNIH), and many other partners has led to improved access for First Nations communities across Manitoba.[36] MBTelehealth continues to update the approach to services in response to regular monitoring of program metrics, stakeholder consultation, and the *Benefits Evaluation Report*.[34] A number of initiatives are planned or are underway to improve access, including a review of program scheduling processes; updates to provider communication materials to increase adoption; enhanced connectivity to support equitable distribution of sites; and proof of concept demonstrations with applications such as store and forward telehealth and desktop video conferencing.[34]

MBTelehealth identified an interesting challenge related to telehealth expansion and use. For instance, longer-term consideration of incentives/disincentives to adoption with health service providers is required because the use of telehealth may shift costs and create impacts between programs that are not readily reflected in current funding models.[34]

Access to care in the North

Manitoba does not receive federal funding under the Territorial Health System Sustainability Initiative since this program applies to the territories only.[37] Northern Manitoba has over 81,000 residents, of whom 65% are Aboriginal.[38] The Northern Development Strategy, announced in September 2001, recognized the importance of health services in the quality of life for northern residents.[39, 40] Ongoing development plans include ensuring Manitobans have access to a family doctor by 2015, and expanding telehealth and electronic health records.[39] The Government of Manitoba offers a Northern Patient Transportation Program to subsidize travel expenses incurred by residents of a defined area whose costs are not covered by another insurer.[41] It also offers a Northern Healthy Foods initiative and a Provincial Youth Suicide Strategy for northern communities.[39, 42]

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Ontario

Home and community care

Ontario has met the two-week post-acute home care commitment with regard to nursing, personal care, and case management, and in some cases, short-term has been extended to 30 days until reassessment.[1] With regard to the mental health home care commitments, in 2005 a Mental Health Accountability Framework was developed that specifically addresses crisis response service and intensive case management standards.[2, 3] In addition, in December 2010, the Minister's Advisory Group on Ontario's 10-Year Mental Health And Addictions Strategy put forth recommendations to inform ministry of Health and Long-Term Care (MOHLTC) direction.[4] As well, as part of a strategy to reduce emergency department wait times, Ontario increased the amount of service clients could receive for personal support and homemaking hours and removed caps on these services for clients waiting for a long-term care home or receiving palliative care at home.[5]

Ontario also announced investments to its End-of-Life Care Strategy to help shift care of persons in the last stages of their life from hospitals to home or another appropriate setting of their choice, enhance interdisciplinary team approaches to care in the community, and work towards better coordination and integration of local services.[6] In 2011, a stakeholder engagement strategy to advance palliative care delivery resulted in the *Declaration of Partnership and Commitment to Action*, a consensus document on the vision for palliative care in Ontario.[7] In addition to acute home care and end-of-life care, the 2007 Aging at Home Strategy focused on community-based services to support seniors and their caregivers to stay healthy and live more independently in their homes. The ministry's Strengthening Home Care Strategy announced in 2008 and more recently the Integrated Client Care Project is testing a new service model that includes bundled reimbursement, client/provider level outcome tracking, and shared accountability across providers for population and system outcomes.[8-10]

With respect to the compassionate care benefit provided federally, Ontario supplemented the benefit with legislative amendments to the provincial *Employment Standards Act* in 2004. The amendments provide up to eight weeks of unpaid family medical leave.[11]

The Canadian Institute for Health Information (CIHI) holds Ontario's home care data from 2007 to 2011.[12] Data are submitted to CIHI by the Ontario Association of Community Care Assess Centres. The data are submitted as nonproduction, meaning not submitted through the standard web-based CIHI Home Care Reporting System submission process.[6] Health Quality Ontario (HQO) publishes annual home care updates as part of its *Quality Monitor*, which contains information on home care accessibility, effectiveness, safety, efficiency, resources, and integration.[13] HQO is developing and publicly reporting on a set of indicators that measure performance and support quality improvements; these indicators rely on Resident Assessment Instrument-Home Care (RAI-HC) data as well as data from various other home care sources.[14]

Comparable health indicators

Ontario's MOHLTC reports annually on health care spending and health programs and services delivered through its annual *Results-based Plan Briefing Book*. These plans contain a description of achievements in priority areas.[15] As well, HQO reports annually on overall health care system performance through its *Quality Monitor* reports.[16] HQO also reports on the quality of long-term care homes[17] and the quality of home care services.[14] Starting March 30, 2011, HQO became the provincial reporting repository for hospital quality improvement plans as part of the *Excellent Care for All Act.*[6, 18] It will publish its first performance results against these quality improvement plans in 2012.

Ontario's *Excellent Care for All Act* seeks to foster a culture of continuous quality improvement in the health care system. Under the legislation, quality improvement plans provide the means for hospitals to be held accountable and focused on creating a positive patient experience while delivering high quality health care.[6] However, although a results-based plan does exist,[15] clear targets and measurements on which to assess achievement do not. In addition to these reporting initiatives, the ministry reports on wait times for emergency departments,[19] patient safety,[20] and the five areas described in the Health Council of Canada's *Progress Report 2011*.[21] The MOHLTC published reports using comparable indicators in 2002[22] and 2004,[23] but no longer issues these reports.

Health human resources (HHR)

In 2005, Ontario appointed an assistant deputy minister for health human resources who reports to the MOHLTC and the ministry of Training Colleges and Universities.[24] Since that time, Ontario has taken on a number of initiatives under the HealthForceOntario strategy.[25] The strategy is to ensure that Ontarians have access to the right number and mix of qualified health care providers, now and in the future. As part of this strategy, Ontario has established new roles for health care professionals in high-need areas, including the introduction of physician assistants.[25] To develop the province's health care workforce, it has spearheaded initiatives such as a "9,000 Nurses" investment; created 1,200 new registered practical nurse (RPN) positions to long-term care homes; and funded education grants, student loan relief, and continuing education incentives for a variety of professionals.[6, 26] In addition to expanding education seats in undergraduate programs for medicine and nursing, creating additional residency positions, and enabling distributed medical education in non-traditional settings, there is a focus on primary health care expansion through such efforts as nurse practitioner–led clinics and plans to increase the number of family medicine residency positions by 160% (326 new positions) by 2013.[6]

Internationally educated health professionals are supported through programs such as the HealthForceOntario Marketing and Recruitment Agency's Access Centre,[27] the Internationally Educated Nurses Competency Assessment Program, and bridging programs such as CARE (Creating Access to Regulated Employment), which continues to evolve.[6] Other recruitment and retention initiatives include HealthForceOntario Marketing and Recruitment Agency, Health Professionals Recruitment Tour, Nursing Graduate Guarantee, and Late Career Nurse Initiative, which allows nurses over 55 to spend time doing less physically demanding work.[28]

Public reporting includes the HealthForceOntario Annual Report,[27] a section of the HQO annual report,[13] and a HealthForceOntario quarterly newsletter.[29] The province has also placed a focus on HHR research and data collection. The Health Professions Database (HPDB) was developed to collect data on over 20 regulated health professions,[6] and it produces an annual statistics book with demographic, geographic, employment, and educational data.[30] Some HHR initiatives noted by this province include the Nurse Practitioner Integrated Palliative Home Care Program, the de Souza Institute's oncology nurse training, demonstration projects in HHR planning, a population needs-based physicians simulation model, and an HHR research network.[6]

Collectively, these initiatives contributed to HHR supply increases in Ontario. There was a 13.1% increase in the number of practising physicians in Ontario between 2006 and 2010 (versus 11.9% nationally), with the growth from 2000 to 2010 being 18.3%. In 2010 specifically, Ontario was below the national average in terms of the number of physicians per 100,000.[31] A 2012 CIHI report indicates that between 2006 and 2010, the number of registered nurses (RN) in Ontario increased by 5.7% to 95,185. As of 2010, 91.9% of RNs who graduated in Ontario also practise in Ontario, the second highest retention rate in Canada. Between 2006 and 2010, the number of registered practical nurses (RPN) in Ontario increased by 21.3% to 30,423, accounting for 37.5% of the overall supply of RPNs in Canada in 2010.[32] Between 2006 and 2010, the number of nurse practitioners (NP) increased by 131.9%, accounting for 59.6% of the overall supply of NPs in Canada in 2010.[32]

Telehealth

Ontario has a centralized provincial program with a well-developed governance and organizational structure and extensive partnerships to support telehealth implementation.[5] There are more than 1,370 telemedicine sites—not only in hospitals, but also in primary and community care settings—involving more than 1,400 health care professionals providing services in over 200 clinical areas.[5] The use of telehealth has improved access in supporting primary care in rural and northern Ontario.[33] This is largely done through family health teams in the North who have used telehealth networks.[5] Ontario's telehealth programs are accredited.[33] Considerable progress has been made in the area of change management and related strategies to accelerate telehealth adoption among providers, as evidenced by the wide scope of organizations and providers involved in delivery.[34] For example, the introduction of software-based telehealth is expected to greatly reduce costs for telehealth equipment and thereby increase access and adoption.[35] A pilot of this new solution is being planned for 2012.[5] Telehealth also plays a critical role supporting access to primary care and specialty care in rural and northern Ontario.[35]

There are a small number of telehealth consultations happening between Ontario and other jurisdictions.[5] Yet, like many other jurisdictions, Ontario has identified barriers with telehealth.[5] For example, if Ontario physicians are providing care to patients outside the province via telehealth, then they must comply with the licensing requirements of the province/territory/country in which they are providing medical services.[5] That being said, there is room for expansion of telehealth services. According to a recent evaluation of Ontario's telehealth program by Praxia, the increase of telehealth use in rural communities has the potential to lead to a five-fold increase in the use of telehealth services, thereby realizing benefits for patients.[35]

Access to care in the North

Ontario does not receive federal funding under the Territorial Health System Sustainability Initiative since this program applies to the territories only.[36] The challenges of delivering health care in northern Ontario have been extensively addressed in a variety of reports. The Rural and Northern Health Care Panel released their report in March 2011, outlining recommendations to deliver accessible, effective, equitable, and integrated health care in rural, northern, and remote Ontario.[5, 37] In 2011, the government held consultations with citizens, both online and in rural and northern communities, to refine the recommendations and develop implementation options.[5]

Further to the health care capital projects undertaken since 2003, investments have also been made to improve access to primary and chronic care services in Northern Ontario.[6] There are 42 new family health teams in Northern communities (29 in small communities with a population of less than 10,000 people and 13 in communities with a population over 10,000).[6] The Northern Diabetes Health Network has also established two new northern sites to enhance prevention to intervention.[6]

With respect to Aboriginal health, Ontario has also established a Trilateral First Nations Health Senior Officials Committee, which includes representatives from the provincial government, the federal government, and the Chiefs of Ontario (representing First Nations).[6] The committee's working groups have been established in mental health and addictions (with a focus on prescription drug abuse), public health, diabetes, and data management.[6] The Sioux Lookout Meno Ya Win Health Centre provides acute care, continuing care, patient support, ambulatory care, and mental health and addictions services to patients from the Sioux Lookout region and 28 northern First Nations communities. It also provides traditional First Nations healing practices and culturally appropriate services, such as around-the-clock translation and a traditional healing, medicine, and food program.[6]

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New Brunswick

Home and community care

New Brunswick has met the two-week post-acute home care commitment with regard to nursing, personal care, case management, and administration of intravenous medications through the New Brunswick Extra-Mural Program (EMP).[1] Established in 1981, the EMP provides health care services to New Brunswickers in their home and/or community in partnership with other government departments and divisions, and health care institutions and agencies.[2, 3]

The goal of the program is to provide a comprehensive range of coordinated health care services for individuals of all ages for the purpose of promoting, maintaining, and/or restoring health within the context of their daily lives, and to provide palliative services to support quality of life for individuals with progressive life-threatening illnesses.[2]

New Brunswick monitors the success of the program through analysis of multiple data sources, including hospital utilization data. The EMP continues to evolve with ongoing initiatives such as enhancing integration of services with other components of the health and social systems. A recent example is the implementation of the quick response home care nurse role in targeted emergency departments.

Following a standardized screening and assessment process, nurses who are experienced in home health care and community services facilitate or arrange the appropriate health and social supports in the community, thereby enabling seniors to return home safely and thus preventing unnecessary hospital admissions.[1]

The commitment to short-term mental health home care has been met. New Brunswick developed a 10-year action plan for mental health for implementing an individualized patient-centred approach to mental health delivered in the community. The plan holds promise for integration with home care, primary care, and mental health services.[4]

New Brunswick supplemented the federal compassionate care benefit by enacting legislative amendments to the provincial *Employment Standards Act*.[5]

New Brunswick is not reporting home care data to the Canadian Institute for Health Information (CIHI) and currently has no plans to implement the Resident Assessment Instrument-Home Care (RAI-HC) within the province.[6] However, New Brunswick uses other tools to assess and measure outcomes. New Brunswick data are used to monitor funded programs and determine service delivery improvements. Within the EMP, New Brunswick uses the hospital data in measuring home health care service.[7]

Comparable health indicators

The department of Health reports annually on its health expenditures and programs in its annual report.[8] *Transforming New Brunswick's Health-Care System: The Provincial Health Plan 2008–2012* outlines a provincial health vision and strategic goals.[9] However, it is not clear whether specific targets and performance measures are attached to the goals or if there is tracking of performance against these goals. The department does, however, report on surgical and cancer services wait times beyond the wait time priority areas reported on in the Health Council of Canada's *Progress Report 2011*.[10, 11] The New Brunswick Health Council (NBHC) reports on different aspects of health system quality in the province.[12, 13] In 2010, NBHC produced its first *New Brunswick Health System Report Card.*[13] The department published reports using comparable indicators in 2002 and 2004;[14] however, like other jurisdictions, New Brunswick is no longer issuing them.

Health human resources (HHR)

The New Brunswick "Healthy Futures" Provincial Health Plan for 2004 to 2008 included building HHR capacity as one of its strategy priorities, with a commitment to an "adequate and appropriate supply and mix of health human resources."[15] Currently, the New Brunswick HHR strategy is integrated into its 2008–2012 multi-year Provincial Health Plan, which is focused on nursing, physicians, and allied health professions, with HHR strategies regarding recruitment and retention, education and training, and legislation and policy.[9, 16]

The Nursing Resources Advisory Committee priorities for 2011/12 include better integration of nurse practitioners into the health care system, building on the work of other jurisdictions to determine the best model of care for the province, and updating the nursing recruitment and retention strategy.[7, 17] There are plans to update the provincial physicians recruitment strategy;[18] in late 2011, the Physician Resource Management Committee provided advice to the minister of Health regarding physician resource supply, distribution, and management.[7] The province reports on the progress of its HHR initiatives in the department of Health's annual reports,[8, 16] and it releases demand and supply forecasting reports periodically.[19]

There are a variety of nursing initiatives, such as mentorship programs and tuition reimbursement for nursing refresher programs.[7] Physician incentives include grants for working in hard to recruit areas and bursaries for family medicine and specialty residents.[7] Distributed medical education programs are in place.[7] Since 2005, bursary programs have been in place for allied health occupations with high vacancy rates.[7] From 2008, there has been a provincial initiative to look at the right mix of pharmacists, pharmacy technicians, and pharmacy workers, to ensure resources are used appropriately in the hospital setting.[19]

Annual New Brunswick career days are held at six universities to showcase potential employment opportunities within the province's health system.[7] In collaboration with the other Atlantic provinces' HHR colleagues, New Brunswick has developed an Atlantic framework for the attraction, integration, and retention of internationally educated health care workers to Atlantic Canada.[7, 20] Additionally, each regional health authority has recruitment staff who oversee recruitment strategies for their region.[7] The province reports receiving federal funding in 2011 to explore interprofessional learning opportunities related to assessment of and bridging support for internationally educated midwives.[7]

From 2000 to 2010, there was a 34.1% increase in the number of physicians practising in New Brunswick, and a 16.7% increase (versus 11.9% nationally) in the near term, from 2006 to 2010. In 2010, New Brunswick was close to the national average in terms of the number of physicians per 100,000.[21] Between 2006 and 2010, the number of registered nurses (RN) in New Brunswick increased by 5.5% to 8,102.[22] In 2010, New Brunswick accounted for 3% of the overall RN supply in Canada. As of 2010, 79% of RNs who graduated in New Brunswick also practised in New Brunswick. Between 2006 and 2010, the number of licensed practical nurses (LPN) in New Brunswick increased by 5.9% to 2,802, accounting for 3.4% of the overall supply of LPNs in Canada in 2010. As of 2010, 92.9% of LPNs who graduated in New Brunswick practised in New Brunswick. Between 2006 and 2010, the number of nurse practitioners (NP) in New Brunswick increased by 187.5% to 69; and, in 2010 New Brunswick accounted for 2.8% of the overall supply of NPs in Canada.[22]

Telehealth

New Brunswick's Strategic Plan for Telehealth 2005–2010 aimed to integrate telehealth into the health system to fulfill the vision of "bridging distances by bringing quality health services and information to all New Brunswickers."[23] The strategic plan included recommendations for governance, funding, and evaluation. It identified five directions for telehealth, along with corresponding initiatives and goals that were aligned to the provincial health plan. The 2008–2012 provincial plan contained a commitment to improve telehealth and e-health clinical services for rural New Brunswickers.[24] Currently, telehealth in New Brunswick is decentralized and focused more on a disease class.[1, 25] The governance structure and integration of telehealth services are under review to further improve coordination between the regional health authorities and with the department of Health, as well as improve performance and allow for possible expansion and sustainability of services.[1]

Significantly, fee codes are in place for fee-for-service physicians who provide service through telehealth.[1] As well, a physician registry and regulations support physicians in the use of telemedicine.[1] New Brunswick has also developed streamlined processes for physicians from other provinces to provide services in the province.[1] As well, the department of Health met with professional associations (i.e. physicians, nurses, psychologists, physiotherapists) to address licensing restrictions in order to follow patient care and minimize travel to Halifax.[1] For instance, women, children, youth, and their families can receive primary and specialty care through the IWK Health Centre in Nova Scotia because they can be followed remotely by health care professionals in Halifax.[1]

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Nova Scotia

Home and community care

Nova Scotia has met the two-week post-acute home care commitment with regard to nursing, personal care, case management, and administration of intravenous medications.[1] End-of-life services are provided through the broader home care program. In 2007, Nova Scotia increased the number of accessible home support hours and nursing visits for the last three months of life.[1] In 2010, Nova Scotia removed the three-month restriction.[2] The Continuing Care Branch does not have a defined program for short-term acute mental health home care. There may be clients who have mental health issues who are eligible for home care services. Mental health supports are provided based on Resident Assessment Instrument-Home Care (RAI-HC) assessments of functional and cognitive decline, and on related depression and behavioural problems.[3]

Nova Scotia's home care program is administered and delivered by the district health authorities and funded by Nova Scotia's department of Health and Wellness. The province released an updated home care policy manual in June 2011.[1] For continuing care, Nova Scotia announced a 10-year continuing care strategy in 2006, which continues to be implemented. This strategy involves, among other aspects, the realignment of services, which was accomplished with investments and stakeholder involvement. However, since 2007 there have been no publicly available reports on progress or evaluation of this strategy.[4]

The Canadian Institute for Health Information (CIHI) holds Nova Scotia's home care data from 2007–2010. Regular reporting is expected to begin in 2012.[2]

Nova Scotia supplemented the federal compassionate care benefit early by enacting amendments to the *Labour Standards Code* in 2004. The amendments provide up to eight weeks of unpaid compassionate care leave.[5] Nova Scotia provides eligible caregivers who provide assistance to qualified care recipients residing in the community access to a Caregiver Benefit Program.[1] The caregiver benefit acknowledges caregivers' contributions in providing financial assistance to family caregivers, thus sustaining the support they provide.

Comparable health indicators

In January 2011, the department of Health and the department of Health Promotion and Protection merged to become the department of Health and Wellness.[6] Previously, these two departments reported publicly, though separately, on spending and programs in their respective annual accountability reports.[7, 8] The merged department combined the priorities of these two former departments.[9] The department of Health and Wellness accountability reports provide detailed information on performance measures. They include performance reporting against goals and priorities that are outlined in business plans or statements of mandate released each fiscal year.

Nova Scotia reports against national benchmarks for the five wait time priority areas, which were also reported in the Health Council of Canada's *Progress Report 2011*.[2] Further, the department of Health and Wellness reports wait times for health service areas, which include surgeries, diagnostic

imaging, oncologist referrals, radiation therapy, cardiac services, and addiction services.[2] Nova Scotia is also in the process of developing wait time indicators for mental health services, long-term care facilities, and emergency departments. The department's Healthcare Quality and Patient Safety Division has been advancing key indicators primarily for adverse events and health care–associated infections. To this end, the Healthcare Quality and Patient Safety Division has started developing an indicator framework.[2]

Nova Scotia does not have a provincial health council. However, Nova Scotia has undertaken reporting on health system performance indicators and health outcome indicators through its *Annual Statistical Reports.*[10] The most recent annual statistical report is for 2007/08,[11] since the format is being revised to reflect three-year reporting to capture trends. Nova Scotia anticipates that the 2009–2011 report will be released in summer 2012.[2] The department published reports using comparable indicators in 2002 and 2004, but no longer issues these reports.[12-16]

Health human resources (HHR)

Nova Scotia issued a *Health Human Resources Action Plan* in 2005.[17] The department indicates that current HHR efforts are related to workforce planning, innovation, and sustainable workforce.[18] A forthcoming provincial physician resource plan will project the number, mix, and distribution of family physicians and specialists for the province over the coming 10 years (2012 to 2021). Guiding principles include alignment with inter- and intra-professional delivery models of care that are designed in the context of the provincial health system plan.[3] Over the last five years, several annual performance documents—such as department of Health and Wellness statement of mandate[9, 19] and accountability reports[8]—have highlighted some HHR-related plans and progress within larger system priorities. For example, 2010/11 HHR-related activities to achieve a planned system target of 21% of the population having access to primary health care teams in that year included the introduction of family practice nurses and a new nurse practitioner recruitment and retention program.[19] As well, the department of Health and Wellness continues to implement the priorities of its 2007 nursing strategy (phase II),[20] including continuing education, orientation for new nurses, summer cooperative placements for nursing students, and bursaries.[3] In response to a recent nursing workforce analysis, adjustments to the nursing strategy may be forthcoming in 2012.[3]

The province has piloted and evaluated a model of care initiative, which is currently in its fourth phase of implementation.[3] This initiative is profiled in the *Progress Report 2012*. The province also provides funding support to the Registered Nurses Professional Development Centre to support continuing nursing education, as well as assessment services for internationally educated nurses.[3] Nova Scotia also participates in the Internationally Educated Health Professionals (IEHP) Atlantic Connection, under the oversight of a collaborative committee of the Atlantic Canadian departments of Health and Education. It was created in 2005 to address the important issue of IEHP supply and integration. The role of the Atlantic Advisory Committee on Health Human Resources (AACHHR) is to provide policy advice to the Atlantic deputy ministers of health and education and enhance intra-regional cooperation on issues relating to health human resources.[3]

From 2000 to 2010, there was a 12% increase in the number of physicians practising in Nova Scotia, and a 3.8% increase (versus 11.9% nationally) in the near term, from 2006 to 2010. In 2010, Nova Scotia was above the national average in terms of physicians per 100,000 people.[21] Between 2006 and 2010, the number of registered nurses (RN) in the province increased by 4.4% to 9,173.[22] In 2010, Nova Scotia accounted for 3.4% of the overall RN supply in Canada. As of 2010, 76% of RNs who graduated in Nova Scotia also practise in Nova Scotia. Between 2006 and 2010, the number of licensed practical nurses (LPN) in Nova Scotia increased by 11.2% to 3,530, accounting for 4.3% of the overall supply of LPNs in Canada. As of 2010, 89.6% of LPNs who graduated in Nova Scotia practise in Nova Scotia. Between 2006 and 2010, the number of nurse practitioners (NP) in Nova Scotia increased by 73.8%, accounting for 4.3% of the overall supply of NPs in Canada.[22]

Telehealth

The Nova Scotia Telehealth Network (NSTHN) is well established with demonstrated benefits for patients across the province in terms of improved care and reduced time, stress, and expense to receive care.[23] The NSTHN is a videoconferencing communications network that connects health care–focused facilities across Nova Scotia.[2] The NSTHN uses video conferencing technologies to improve access to health services for patients, families, and health care professionals.[2]

Patients from across Nova Scotia can meet face-to-face with health care professionals located anywhere on the network, without leaving their home communities.[2] This saves patients the time, stress, and expense associated with travel.[2] Barriers to health care access including travel costs or inclement weather are removed.[2]

The network works in collaboration with a number of partners, including the district health authorities and the IWK Health Centre in Halifax, to provide health services through telehealth.[2] Ninety-five percent of patients prefer to receive care in their home community and providers are interested in expanding the clinical consults they provide over the network; convenient portable video conferencing equipment is required to further support expansion.[2]

The 2011/12 statement of mandate for the department of Health and Wellness identified priorities, performance measures, and strategic actions to achieve targets, and identified the Better Care Sooner plan as a cornerstone for success.[9, 24] The plan focuses on two priorities: emergency care and primary health care.[24] Telehealth, specifically HealthLink 811, is an integral part of the Better Care Sooner plan.[2]

The IWK Health Centre in Halifax provides telehealth services to New Brunswick and Prince Edward Island.[2] As well, lung transplant consults are provided from Toronto to a variety of hospitals in Nova Scotia.[2] The prime enablers were staff who worked out the necessary processes.[2] Challenges have included equipment interoperability and physician issues including licensure requirements being different in each province. It is also important to note that education sessions, including medical rounds, are provided between Nova Scotia and other provinces.[3]

Notable achievements include the home telehealth project, which was initiated in 2004 for patients with congestive heart failure, which has helped reduce the need for emergency room visits and readmissions.[25] As well, Nova Scotia is working with provincial colleges of physicians and surgeons to remove barriers to providing care across jurisdictions in areas including licensure, liability, and reimbursement, and to work out specific clinical processes so there is consistency in the delivery and receipt of services across boundaries.[3]

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Prince Edward Island

Home and community care

Prince Edward Island (PEI) has met the home care commitments to nursing, personal care, case management, and administration of IV medications.[1] The community mental health program includes crisis response services and case management.[2] End-of-life services are provided through PEI's palliative care program.[3] A palliative home care drug pilot project was implemented in 2008, and by 2009 improvements in patient flow and decreases in net costs were reported.[4]

Furthermore, PEI's healthy aging strategy, released in 2009, mentions home care as a core service in the form of home nursing and other professional service, care coordination, home supports, caregiver supports, and end-of-life care.[4] PEI supplemented the federal compassionate care benefit early into the health accords by enacting legislative amendments to its *Employment Standards Act* in 2003. The changes provide up to eight weeks of unpaid compassionate care leave.[5]

PEI does not currently report home care data to the Canadian Institute for Health Information (CIHI), but is working with CIHI to map their data into CIHI's database. PEI expects to begin submitting its data next fiscal year. PEI reports annually on the home care key performance indicators that fall within Health PEI's Strategic Plan. Although a full evaluation of home care policies and programs has not been conducted, results of a bi-yearly client satisfaction survey and evaluation of programs and policies against accreditation standards are presented to inform the accreditation process.[6]

Comparable health indicators

The department of Health and Wellness (formerly the department of Health) last published an annual report on its website in 2007/08.[7] This report contained information on health spending and programs. Since that time, the health system underwent a significant reorganization, with the creation of Health PEI.[8] Health PEI is the provincial health care service provider that has released a strategic plan for the health system for 2009–2012, which details specific goals and objectives for the health system, with key performance indicators and targets.[9] In addition, Health PEI has released an annual report for 2010/11 that provides information on health system spending, programs, and indicator reporting.[10] As part of the province's commitment to improvement, the Health PEI quality council was developed to monitor the quality of health system performance, make recommendations, and communicate results of findings.

This indicator information is used to inform strategic performance, planning, and evaluation of programs and services.[6] The indicators are reported through the Health PEI public reports and publications.[6] The board also published a business plan for 2010/11 that builds on the strategic plan and details expenditures.[11] The province reported on health system performance, health outcomes, and health status in 2003, 2004,[12] and 2006.[13] The indicator framework has evolved over time.[6] Prince Edward Island now publishes its health trends, which was done in 2010 and 2012: *Prince Edward Island Health Trends 2010* and *Promote, Prevent, Protect: PEI Chief Public Health Officer's Report* and *Health Trends 2012*.[14, 15]

PEI's health indicator reports include a cross-section of indicators from the following dimensions: health status, non-medical determinants of health, health system performance, community, and health system characteristics and equity.[6] The indicator reports focus on health system performance and community and health system characteristics include Health PEI's performance indicators.[9, 10] These system indicators were defined in 2009 as part of Health PEI's strategic plan and are monitored at a provincial level for public reporting purposes and at an operational level for health system monitoring and accountability purposes.[6] Health PEI regularly reports progress on the Health PEI website on quality initiatives, including patient safety, efficiency projects, and patient-centred care.[6, 16, 17]

Health human resources (HHR)

PEI developed an HHR action plan in 2005[18] and a multi-year HHR strategy in 2008 that identified three strategic drivers: leadership capacity, workforce capacity, and the work environment.[19] As well, the PEI health system strategic plan 2009–2012 includes an HHR-related objective to improve efficient utilization of HHR.[20] Key themes in the 2008 HHR strategy include the need to align the HHR strategy to the health system's objectives, the importance of strengthening partnerships, implementing alternate service delivery models, the need to use workforce supply and population health-needs data in HHR planning, and the need to reduce barriers to internationally trained workers.[19] PEI department of Health and Wellness annual reports include some of the progress reporting on HHR; planning and strategies through annual reports from Health PEI and the department of Health and Wellness. The Recruitment and Retention Secretariat plays a role in HHR reporting and evaluation.[6] The department developed a physician recruitment, retention, and medical education strategy in 2006.[21] A report on physician HHR was completed by the Hay Group in 2010 to support physician resource planning.[22]

A Recruitment and Retention Secretariat was established in 2009 to support the recruitment of a variety of health care professions.[23, 24] Education opportunities for selected professions have been expanded over time, including a family medicine residency program in PEI through Dalhousie University in Nova Scotia,[7, 20] providing for radiation therapist training for PEI candidates at the Michener Institute in Ontario, and a medical laboratory technologist seat purchase program in New Brunswick.[23] There has been funding to increase the number of seats for RN education,[6] and a new accelerated nursing program was created at the University of Prince Edward Island (UPEI) in January 2009. A new master's of nursing program with thesis and nurse practitioner streams began in September 2011 at UPEI. Programs for licensed practical nurses (LPN) and resident care workers have been expanded across the province to meet the health system needs.[23] The nursing recruitment and retention strategy also includes the nursing sponsorship program, which provides undergraduate bursaries in exchange for a return of service commitment.[25] A nursing student summer employment program provides employment opportunities for nursing students.[24]

The PEI government is a partner in the Internationally Educated Health Professional Atlantic Connection, along with the three other Atlantic provinces.[6, 26] A recent PEI initiative is a pilot project to develop a retention tool kit and navigation resources with various health, education, and municipal partners and the PEI association of Newcomers to Canada.[11] A practice of note is the Collaborative Model of Care (redesign) initiative that will better meet the PEI population's needs while making effective use of health care resources.[27] It is being implemented in the acute care sector first, followed by home care and long-term care.[6, 28]

From 2000 to 2010, there was a 32.6% increase in the number of physicians practising in PEI. Since 2006, PEI experienced a 14% increase (versus 11.9% nationally). In 2010, PEI sat below the national average in terms of the number of physicians per 100,000 people, but the trend is upward.[29] Between 2006 and 2010, the number of registered nurses (RN) in PEI increased by 3.1% to 1,472.[30] In 2010, PEI had 0.4% of the Canadian population[31] and accounted for 0.5% of the overall RN supply in Canada.[30] In 2010, 71.1% of RNs who graduated in PEI also practise in PEI. Between 2006 and 2010, the number of LPNs in PEI decreased by 1.5%, accounting for 0.7% of the overall supply of LPNs in Canada in 2010.[6, 30]

Telehealth

There is limited use of telehealth to deliver health services in PEI and no Canada Health Infoway telehealth investment programs in the province.[23] As indicated by Nova Scotia, the IWK Health Centre in Halifax does provide some services to PEI residents.[23]

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Newfoundland and Labrador

Home and community care

Newfoundland and Labrador released its implementation report in 2005, which reported on the status of and plans for implementing the health accord commitments.[1] Newfoundland and Labrador has largely met the home care commitments to nursing, personal care, case management, and administration of IV medications, although services may be limited in some regions.[2] For example, IV meds are only available in specific communities, depending on location, staff availability, and pharmacy support.[3] Newfoundland and Labrador's mental health program provides for crisis response services, and case management and mental health services are provided at home to those with functional disabilities.[4]

Specific end-of-life programs were implemented into the home care program in 2008/09 that supported the provision of drugs, equipment, supplies, and home support to enhance palliative care in the community. The four regional health authorities are developing models of care to enhance the coordination of end-of-life care utilizing the interdisciplinary health care team across the acute, community, and long-term care sectors. Newfoundland and Labrador declared its intention to move toward a client-centred care model in which there is concentrated effort to maintain individuals in their homes.[3, 5]

Newfoundland and Labrador does not submit home care data to the Canadian Institute for Health Information (CIHI). However, the province is in the early stages of implementing the Resident Assessment Instrument-Home Care (RAI-HC) tool. With the availability of a software application available to support RAI-HC in the near future, home care data are expected to be reported to CIHI once the RAI-HC assessment tool has been implemented. The tool will be utilized for client assessment for specific home care populations in 2012.[3, 5] Through a pilot agreement in 2004, select mental health case managers in Newfoundland and Labrador began submitting InterRAI-Community Mental Health assessment data to the University of Waterloo, which was analyzed by CIHI in 2009. The province is in the process of renewing an agreement with InterRAI and CIHI to support the reintroduction of this tool and related data analysis.[5]

Newfoundland and Labrador supplemented the federal compassionate care benefit in the early stages of the health accords with legislative amendments to its *Employment Standards Act* in 2004. The amendments provided up to eight weeks of unpaid compassionate care leave.[6]

Comparable health indicators

Newfoundland and Labrador's department of Health and Community Services reports on expenditures and programs in its annual reports.[7-9] These documents report on performance toward achieving goals and targets aligned with government priorities laid out in its three-year strategic plan.[10, 11] The department reports on wait times for some of the priority surgical areas on its website.[12] In 2008, the department published *Health Reflections*, a report on health and health system performance in the province.[13] The Newfoundland and Labrador Centre for Health Information has some reports on health status indicators and select health system topics, but these are not reported on with regularity.[14]

The Government of Newfoundland and Labrador has a provincial performance-based planning and reporting system for all government departments, including Health and Community Services. Under the *Transparency and Accountability Act* (2006), the department of Health and Community Services and 11 other entities that report to the minister, including regional health authorities and advisory boards, produce a strategic plan once every three years. These plans include committed measurable actions and indicators to be undertaken. All report annually on performance and any variances in committed performance must be explained in the annual reports. These plans and reports are tabled in the House of Assembly.[5]

Newfoundland and Labrador published reports on comparable indicators in 2002[15] and 2004.[16] These documents were used as background information and references for general planning by the department.[3] Various entities within Newfoundland and Labrador report that the documents were used in their organizations; however, there are no plans to produce similar reports. Newfoundland and Labrador collects and analyzes its own comparative health indicators on a regular basis; they are the same as those reported in the Canadian Community Health Survey and provided by Statistics Canada and CIHI.[3]

Health human resources (HHR)

In 2003, the Newfoundland and Labrador Human Resources Planning Steering Committee issued a report with HHR recommendations and five goals: integrated planning, system leadership, appropriate supply, quality workplaces, and sufficient data; it served as an HHR action plan.[17] Currently, there is a new strategic health workforce plan under development, which is expected to be complete by March 31, 2012.[10] Newfoundland and Labrador's new education seats and training initiatives were developed and implemented based on its health care needs.[3] There are interprovincial collaborative efforts that include participation in the Atlantic Advisory Committee for HHR and the Atlantic Connection Working Committee, which oversees the regional Internationally Educated Health Professionals (IEHP) initiative, the Atlantic Connection.[3, 18] HHR information may be included in the department of Health and Community Services annual performance reports.[7, 8] The department issues a twice annual *Health Professional Vacant Position Report*.[3] It is also implementing a Health Human Resources Information System (HHRIS) in three of the four regional health authorities and upgrading the current HHRIS in the fourth regional health authority. It has also drafted a health workforce planning indicator scorecard with eight key workforce indicators.[3]

Newfoundland and Labrador has a recruitment website called PracticeNL (practicenl.ca), targeted towards physicians, nurses, and allied health professionals. The department has invested in 13 nursing-specific incentives and a signing bonus program for 24 health occupations.[3] Physician incentives include retention bonuses for physicians in rural areas; bursaries for medical students in family medicine, psychiatry, and specialist programs;[3] travelling fellowships for specialties not offered in the province; an enhanced clinical skills assessment and training program for international medical graduates (IMG); and the introduction of a five-year project to standardize assessment, preceptorship, orientation, and hospitality offered to IMGs.[19] In 2011, the province, with federal funding, is undertaking projects related to integrating and bridging internationally educated nurses and IMG retention.[3] There have been increased education opportunities, through additional provincial funding, such as the College of the North Atlantic programs in medical laboratory sciences and practical nursing.[3]

From 2000 to 2010, there was a 24.3% increase in the number of physicians practising in Newfoundland and Labrador, and a 14.8% increase (versus 11.9% nationally) in the near term from 2006 to 2010. In 2010 specifically, Newfoundland and Labrador was above the national average in terms of the number of physicians per 100,000 people; 40% of its physician workforce consisted of IMGs.[20] Between 2006 and 2010, the registered nurse (RN) workforce in Newfoundland and Labrador increased by 9% to 6,013. This was the third highest percentage change in the RN workforce in Canada. As of 2010, 73.2% of RNs who graduated in Newfoundland and Labrador were working in the province; either they did not move after graduation or eventually returned to this province to practise. Between 2006 and 2010, the number of licensed practical nurses (LPN) in Newfoundland and Labrador decreased by 5.5% to 2,495; the province was one of three provinces and territories that had a decline in supply. As of 2010, 87.4% of LPNs who graduated in Newfoundland and Labrador were working in this province. Between 2006 and 2010, the number of nurse practitioners (NP) in Newfoundland and Labrador increased by 7.9%.[21]

Telehealth

Telehealth is an integral part of the health care delivery system in Newfoundland and Labrador. The strategic framework for telehealth has five directions: self-care/telecare, chronic disease management (CDM), access to specialists, home care, and point of care learning.[3] These priorities fit within a larger vision that includes the integration of primary health care, EMR/EHR initiatives, governance, funding and evaluation frameworks, and operational supports.[22] Telehealth is a provincial program that has been operational since 2004.[5] Currently there are 59 certified sites in the province and 15 disciplines integrating telehealth into their current practice.[5]

Telehealth services are provided within and across the four regional health authorities with significant links to the tertiary care centre in St. John's.[3] Currently the Newfoundland and Labrador Centre for Health Information is tracking telehealth usage throughout the province.[3] Usage is increasing, and in fact has exceeded initially planned targets and expectations, but there is potential to increase usage on a greater level.[3] The advisory committee overseeing telehealth in Newfoundland and Labrador is discussing targets and evaluations; the committee supports increased marketing efforts.[3] A primary gap is with the marketing and use of telehealth by staff and physicians primarily due to lack of knowledge or use of the technology.[3] The province is partnering with the Centre for Health Information to market the program, and a new user's pamphlet highlighting the positive benefits of a telehealth system has been drafted for circulation.[3]

In 2010, an evaluation of the chronic disease management strategic objective of telehealth showed numerous benefits for patients, providers, and the health care system; it also identified challenges and opportunities for expansion (clinical specialities and geographic areas).[23] The evaluation found increases in the use and acceptance of telehealth over time, and that the chronic disease management component of the provincial program has expanded to other chronic disease areas as well as to diverse groups of health care professionals.[5, 23] The telehealth program was found to be associated with high levels of satisfaction for both patients and providers, with both survey and interview data suggesting telehealth can contribute to significant savings with respect to time, travel, and costs.[5, 23] Improved access to patient information, provider and management continuity, and an increase in frequency of patient follow-ups were also identified as benefits.[5, 23] Although there is room for improvement, the program has demonstrated tremendous benefits.[5, 23]

Access to care in the North

Newfoundland and Labrador does not receive federal funding under the Territorial Health System Sustainability Initiative, since this program applies to the territories only.[24] However, owing to the unique health care needs of northern communities in Labrador, a new division was created in the department of Health and Community Services to help develop a holistic and collaborative Aboriginal health policy framework.[3] In 2007, the government announced a Northern Strategic Plan for Labrador, a five-year plan to further economic and social development in Labrador.[25] A 2009 report noted progress that had been achieved to improve access to health care, including increasing reimbursement to patients under the Medical Transportation Assistance Program, hiring of additional health care professionals, and investments in telehealth and electronic health records.[26] Newfoundland and Labrador announced in its 2011/12 budget an enhancement of the Medical Transportation Assistance Program that allows patients to receive prepayment of half the costs of economy airfare and greater coverage of private vehicle expenses.[27]

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Yukon

Home and community care

The Yukon has met the commitment to provide two-week home care, specifically, in terms of nursing, case management and personal care, as well as providing some coverage of IV medications.[1, 2] Whether the two-week mental health home care commitment was met is unclear. Although community based mental health programs are available, connections with home care remain uncertain.[3] With regard to end-of-life home care, although investments and collaborative strategies have been announced, the degree of implementation remains unclear.[4]

The Yukon's amendment to its *Employment Standards Act* to provide eight weeks of unpaid compassionate care leave came into effect in 2004.[5] A broader definition of family members that included siblings, grandparents, grandchildren, step-parents, in-laws, and any relative permanently residing in the same household was adopted.[6] In the Yukon Health Care Review, recommendations were made to expand home and community care services to meet the growing demands of an aging population.[7] The Canadian Institute for Health Information (CIHI) holds Yukon's home care data from 2006–2011.[8] The Yukon was one of the first jurisdictions to provide data to CIHI, which it uses to support its planning.[9]

Comparable health indicators

Health expenditures by program and service are reported for the department of Health and Social Services in the territory's annual budget.[10] The government commissioned the Yukon Health Care Review in 2008.[11] One of the recommendations was for accountability through a strategic planning process with quantifiable performance measures to track performance against targets.[11] A review by the Office of the Auditor General of Canada released in February 2011 also recommended that the department establish key health indicators and benchmarks to measure performance.[12] The Medical Officer of Health for the Yukon has released health status reports (in 2003 and 2009), reporting on some health system performance measures in addition to health status.[13, 14]

The Yukon comparable indicators were published in 2002 and 2004.[15] However, Yukon noted that while these indicators provided some national context—both relative to other places and internally over time—many indicators were not possible to report on for the Yukon, either because of data numbers being too small or the lack of sufficient new data every two years to report on change.[9] In addition, some indicators did not work well in the Yukon context due to a different service delivery structure (e.g., access to primary care through community nurses rather than a family doctor).[9] That aside, relevant indicators have been built into the Yukon's health status reports, which it produces approximately every three years.[9]

Health human resources (HHR)

In 2007, the Yukon confirmed the next phase of its HHR strategy,[16] which continued to encourage young people to choose a health professional education program when making decisions about their future; helped students with the costs of their health profession education programs through bursary programs; supported graduates on entering the health care workforce; supported existing employees by providing educational and training opportunities; and improved the quality of the workplace to improve retention.[7, 11] The department of Health and Social Services is currently developing a new HHR plan that will include mentoring, succession planning, and recruitment and retention.[9] The Yukon has noted that in response to a February 2011 report from the Office of the Auditor General of Canada, it agrees that a comprehensive health information reporting system is required,[12] although, at present, Yukon reports that it lacks the resources to undertake such an endeavour.[9]

Work is underway with the Yukon Registered Nurses Association to update regulations for nurses working in the Yukon, including the identification of nurse practitioners as a specific new class of nurse in the Yukon.[9] This work has included examining issues pertaining to scope of practice and related matters.[9] Recruitment and retention incentives include office start-up support for new physicians,[17] bursary programs for medical residents, nurses, and other health professionals,[18] and funding to support professional development of hospital employees.[17] A practice of note is the use of YouTube videos for the recruitment of internationally educated nurses to the Yukon.[19] Another is a new staffing model for continuing care, which involves a greater use of licensed practical nurses (LPN), and a new training program at Yukon College.[11] The Yukon is a member of the Western and Northern Health Human Resources Planning Forum.[20]

From 2000 to 2010, the Yukon experienced the second highest growth in physician supply in Canada, with a 75.6% increase, which is in contrast to a 2.9% increase (versus 11.9% nationally) in the near term, from 2006 to 2010. In 2010, the number of physicians per 100,000 in the Yukon was above the national Canadian average; international medical graduates accounted for 42.9% of its physician workforce.[21] Between 2006 and 2010, the number of registered nurses (RN) in the Yukon increased by 10.2% to 357, the second highest growth rate in Canada. In 2010, the Yukon accounted for 0.1% of overall RN supply in Canada. Between 2006 and 2010, the number of LPNs in the Yukon increased by 5% to 63, accounting for 0.1% of the overall supply of LPNs in Canada in 2010. As of 2010, 69.8% of LPNs who graduated in the Yukon practised in Yukon, the second lowest retention rate across Canada. CIHI data do not report the supply of nurse practitioners in the Yukon.[23]

Telehealth

The Yukon Telehealth Network (YTN) began in 2002 with funding from Canada Health Infoway. Currently, the YTN is supported by the department of Health and Social Services and Canada Health Infoway.[24] All communities have and can use telehealth video conferencing equipment to improve access to services (there are now 59 sites in 14 communities, including a site in each Yukon First Nations office).[9, 24] In 2009, the Yukon Health Line 811 was launched (using BC's HealthLink as the service provider), enabling Yukon residents to access health information and advice over the phone with specially trained RNs.[24] As well, all Yukon's community health centres now have digital X-ray capacity, thus reducing wait times and the need to travel to Whitehorse.[24]

As a long-standing way of providing quality and effective health care to a small, widely dispersed population, the Yukon relies heavily on nurses, particularly in all its communities outside of the capital, Whitehorse.[24] Many of these nurses work with an expanded scope of practice.[9] Teleradiology has enabled the local community nurse to receive timely interpretations of diagnostic imaging.[9] Furthermore, telehealth video conferencing can provide access to medical advice and additional expertise to assist community nurses in providing patient care in their home community.[9]

The Yukon and British Columbia are working on sharing an e-health platform to provide appropriate access to personal health information by health service providers in both jurisdictions.[9] One challenge they have is figuring out how to work with the privacy requirements of both jurisdictions, with personal health information that crosses borders.[9] Other challenges, particularly for physicians, can involve the adjudication of problems in terms of whether they are resolved in the patient's or the provider's jurisdiction.[24]

Access to care in the North

Under the Territorial Health System Sustainability Initiative (THSSI), the Government of the Yukon receives an annual transfer from the federal government through targeted funding established until March 2014. The territorial government creates annual work plans outlining how the THSSI funding will be spent. These reports are forwarded to federal/territorial deputy ministers of health.[25] Under the medical travel fund, the Yukon government spends more than $10 million on medical travel per year.[26] The government is looking at improvements to the medical travel program, including an examination of referrals from rural areas to Whitehorse and developing their data collection capabilities.[9] A consultant has been hired to review the medical travel program and policies; the report was due to be completed by March 2012.[26] This includes funding from the Medical Travel Fund to offset or reduce medical travel costs and funding from the Territorial Health Access Fund.[27]

The Territorial Health Access Fund has supported government investments in a range of initiatives, including a social inclusion strategy, strategies on wellness and healthy aging, and enhanced mental health services.[9] THSSI was recently extended to the end of March 2014.[28] THSSI funding represented approximately 6% of Yukon's health system funding.[9] Yukon continuously looks for ways to provide services in-territory where it is medically feasible, financially feasible, and operationally possible to do so.[9]

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Northwest Territories

Home and community care

The Northwest Territories (NWT) has met the post-acute home care commitments of nursing, case management, personal care, and IV medication administration.[1] Mental health and addiction services are provided largely through primary community care teams, but connections to mental health home care are unclear.[2] The home care program includes end-of-life care.[1]

Amendments to the territorial *Labour Standards Act* have yet to be made to facilitate the adoption of the compassionate care benefit.[3] In 2009, a framework for health care improvement in the Northwest Territories identified the need to improve coordination, assessment, and accessibility, and to standardize service delivery in home care.[4] However, the 2011 auditor general's report suggests that standards for support and monitoring of home care should be updated to effectively deliver the program.[5] The Northwest Territories is unable to submit home and community care information to the Canadian Institute for Health Information (CIHI) at this time.[6] However, the Territorial Admissions Committee has reinforced the use of the Continuing Care Assessment and Placement (CCAP) tool, which ensures that a standardized assessment process is used to support clients' needs.[6]

Comparable health indicators

The health expenditures of the department of Health and Social Services are reported in the territory's annual budget.[7] The department has produced several action or strategic plans since 2002 that outline specific actions for health care reform in the territory.[4, 8-10] More recent strategic plans outline specific goals and actions with specific targets for deliverables.[4, 11] The department has also reported on performance towards achieving goals outlined in the strategic plans.[12] The 2011 report from the auditor general recommended that these plans be strengthened by establishing performance indicators.[5] With respect to progress on developing a set of system-wide indicators to report on health system performance as recommended in the auditor general's report of March 2011, the Northwest Territories has noted that it has drafted a balanced scorecard and a preliminary list of performance indicators.[6] As well, performance indicators will be tied into the performance agreements entered into with the authorities.[6] Reports using comparable indicators were published in 2002 and 2004.[13, 14] The Northwest Territories has since published health status reports in 2005 and 2010.[6, 15, 16]

Health human resources (HHR)

The Northwest Territories developed a comprehensive HHR strategy for 2004 to 2009 that has now expired.[5] "Maximize use of human resources" is currently identified as a high level action in the department's system action plan for 2009–2012,[4] but a 2011 Auditor General of Canada report recommends that the department continue to develop a comprehensive HR recruitment plan for the health care system and monitor progress on an ongoing basis. In particular, according to the auditor general, a plan is needed to address the territory's current dependence on temporary staff, particularly nurse practitioners (NP), registered nurses (RN), and physicians.[5] These needs are met by staff from a relief pool of nurses, particularly in remote regions, and by physician locums (physicians hired on a temporary basis). Both these approaches are costly.[5] There are several Northern Graduate program initiatives at Aurora College to encourage recruitment and retention, including a bachelor of science in nursing program, a social work diploma, and a primary health care nurse practitioner program, the latter offered in conjunction with Dalhousie University.[6]

As well, partnerships with universities—University of British Columbia, University of Calgary, and University of Manitoba—support medical clerkship and residency placements.[6] The government offers return of service bursaries to students studying medicine, nursing, social work, and allied health professions.[17] Of note is the government's identification of the need for workers to meet the growing demand for home and community care. The Northwest Territories has not yet moved forward on a key commitment outlined in its 2009 plan—managing physician services at a territorial level.[18] The department indicates that its Physician Bursaries Program is currently being evaluated, to determine if it provides sufficient value for money.[6] The Northwest Territories is a member of the Western and Northern Health Human Resources Planning Forum.[19]

From 2000 to 2010, the Northwest Territories was the only Canadian jurisdiction to experience a decrease, at 27.7%, in the number of physicians. There was a 29.2% decrease (versus an 11.9% increase nationally) in the near term, from 2006 to 2010. In 2010 specifically, the Northwest Territories had the second lowest number of physicians per 100,000 in Canada, and well below the national average (78 versus 203).[20] Between 2006 and 2010, the combined number of RNs in the Northwest Territories and Nunavut increased by 7.4%. In 2010, Nunavut and the Northwest Territories accounted for less than 1% of the overall RN supply in Canada.[21] As of 2010, 62.3% of RNs who graduated in the Northwest Territories also practised there, the lowest rate in Canada. Between 2006 and 2010, the number of licensed practical nurses (LPN) in the territory decreased by 6.5%; the Northwest Territories was one of three Canadian provinces/territories to see a decline in supply. As of 2010 the territory accounted for 0.1% of the overall supply of LPNs in Canada. As of 2010, 32.6% of LPNs who graduated in the Northwest Territories practised there, the second lowest rate in Canada. Between 2006 and 2010, the combined number of nurse practitioners (NP) in the Northwest Territories and Nunavut increased by 250%, the second largest growth rate in Canada. As of 2010, the two territories combined accounted for 2.3% of the overall supply of NPs in Canada.[22]

Telehealth

The Northwest Territories is a vast geographic area with many isolated communities, and telehealth helps eliminate distance barriers and improve access to services that otherwise would not be available.[6] As well, telehealth allows patients from remote communities to become more actively involved in their own health and well-being, as they are able to engage in self-management programs without leaving their home community.[6] The utilization of lay people in the provision of telehealth constitutes some innovative work in the territory to maximize resources in communities.[23]

The department of Health and Social Services action plan (2006–2010) identified a need to expand the use of telehealth and a deliverable was development of a three year strategic plan, with specific proposals to meet target outcomes.[12] A report on the strategic plan (2006–2010) identified phase 1 and 2 developments for the Diagnostic Imaging/Picture Archiving and Communications Systems (DI/PACS) along with TeleOpthamlology and TeleSpeech Language Pathology.[12] In the department of Health and Social Services, *A Foundation for Change (2009–2012)* identified actions and timelines for TeleSpeech Language Pathology.[4] This project is supported by Canada Health Infoway and phase 2, which is significant for enabling access to children at the site of learning, is in progress.[6,24] Under the Health and Social Services Integrated Service Delivery Model (ISDM), Health and Social Service authorities use telehealth for transmitting data, images, and other information.[23] Telehealth in the Northwest Territories currently consists of 58 units across 28 communities; 33 of those units are in schools.[6]

The use of telehealth is not without its challenges, including the ongoing need for staff training in the use of equipment largely because of staff turnover; the high use of locum staff places limitations on the ability to fully integrate telehealth into practice; and the availability of bandwidth in some remote communities limits access.[23] But overall, telehealth has contributed greatly to care in the territory; it has reduced medical and staff travel and increased the knowledge base among health professionals and the public, it encourages wider and more immediate participation in case management, and it enables primary care in remote communities to become more flexible and efficient, thereby reducing time and costs.[6] New projects will continue to be developed, with target setting and evaluation as outlined in the strategic plan.[6]

Access to care in the North

Under the Territorial Health System Sustainability Initiative (THSSI), the Northwest Territories receives $7.5 million in federal funding to help support health service innovation. This includes $3.2 million per year from the Medical Travel Fund to offset or reduce the costs of medical travel and $4.3 million per year from the Territorial Health Access Fund.[25] This transfer will be in place until March 2014.[26] Territorial governments create annual work plans outlining how this money will be spent and subsequent progress reports. These reports are forwarded to federal/territorial deputy ministers of health.[27]

The Territorial Health Access Fund has supported government investments in a range of initiatives, including investments in community nursing and expanding kidney dialysis and midwifery services, among other enhancements.[25] New community health nurse and nurse practitioner positions have been created.[25] An integrated chronic disease management model is being developed.[10] In collaboration with the Canadian Health Services Research Foundation, the Northwest Territories has brought together decision-makers to examine and improve service delivery for patients with chronic conditions.[28]

External consultants reviewed the medical travel program and submitted an extensive report in April 2009. The report concluded that the travel medical system is generally well-managed. It recognized growing cost pressures and made some recommendations for enhancing the cost-effectiveness of the program. These include increasing administrative staffing and targeted hiring of medical staff to provide more services in communities. The report also suggested operational changes, including potentially booking travel directly instead of through a travel agency.[29] Recently, the government committed to develop a territorial support network to assist health care providers in remote communities by providing access to shared expertise and guidance on patient care, with a view to possibly reduce the need for emergency medical evacuation.[10]

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Nunavut

Home and community care

Nunavut has met the home care commitment, specifically in terms of nursing, case management, personal care, and some coverage of IV medications.[1] In 2005, intentions were declared to provide a continuum of mental health services, including case management and crisis response services, but implementation status is unclear.[2] End-of-life home care is provided in some communities, where required.[3] A program evaluation is expected to be completed by March 2012.[4] Nunavut supplemented the federal compassionate care benefit by legislative amendments to its *Labour Standards Code* that came into effect in 2004. The amendments provide up to eight weeks of unpaid compassionate care leave.[5] There are no plans to implement the Canadian Institute for Health Information's (CIHI) Home Care Reporting System to collect home care data in Nunavut;[6] however, data are being collected in communities and stored centrally at the department of Health and Social Services headquarters.[7]

Comparable health indicators

The department of Health and Social Services expenditures are reported on in the territory's annual budget.[8] The department has published a business plan that outlines priorities and budget forecasts for 2011–2014.[9] Reports using the comparable indicators were published in 2002,[10] 2004,[11] and 2011.[12] While the 2004 and 2011 comparable indicator reports were produced, some indicators were excluded because Nunavut was not included in the applicable surveys.[4, 12] However, currently there are no public reports other than the comparable indicators report.[4]

Health human resources (HHR)

A Nunavut health human resources plan was developed in 2005.[13] A nursing recruitment and retention strategy was introduced in 2007.[14] The department of Health and Social Services human resources strategy is ongoing, with implementation planned for 2012–2014.[7,9] With respect to public reporting, there is some HHR-related information in the government's 2011–2014 business plan,[9] and limited information related to health human resources in the jurisdiction's 2007/08 *Public Service Annual Report.*[4, 15]

The department reports that its HHR nursing focus is on promoting recruitment of new personnel, retaining its active workforce through education and training, and supporting local Inuit nursing careers.[14] The goal of article 23 of the Nunavut Land Claims Agreement is to increase Inuit employment; human resources planning includes Inuit employment plans, and there are various education programs in place to promote health careers for Nunavut Land Claims beneficiaries, such as the foundation program

at Nunavut Arctic College, the bachelor of science program in nursing (Arctic Nursing) and a mental health program.[4] Nunavut's nursing recruitment and retention strategy has also included initiatives to create additional nursing positions; since 2008 there have been 91 new indeterminate nursing hires.[9]

Physician recruitment and retention efforts are now focused on increasing the number of family physicians.[9] The territory has signed a memorandum of understanding with Memorial University in Newfoundland and Labrador to host family practice residents for half of their training period.[4] As well, an internationally educated health professionals program has been established for 2009 to 2016 to recruit lab, ultrasound, and X-ray technicians, as well as family practitioners, physiotherapists, and others.[4] Nunavut is a member of the Western and Northern Health Human Resources Planning Forum.[16]

From 2000 to 2010, the number of physicians practising in Nunavut increased from seven to 13. In 2010 specifically, Nunavut had the lowest number of physicians per 100,000 in Canada, at 39, versus a national average of 203.[17] Between 2006 and 2010, the number of registered nurses (RN) in Nunavut/NWT combined increased by 7.4% from 1,033 to 1,109. In 2010, Nunavut/NWT accounted for 0.4% of the overall RN supply in Canada.[18] Data about the supply of licensed practice nurses are not reported by CIHI. Between 2006 and 2010, the number of nurse practitioners (NP) in Nunavut/NWT combined increased from 16 to 56. As of 2010, Nunavut/NWT combined accounted for 2.3% of the overall reported supply of NPs in Canada.[18]

Telehealth

The Ikajuruti Inungnik Ungasiktumi (IIU) Telehealth Network has existed in Nunavut since 1999. Supported largely by Health Canada's Canadian Health Infostructure Partnership Program (CHIPP), the project provides access to a wide range of programs and services.[19] Funding from the Primary Health Care Transition Fund (2003–2006) also contributed to the expansion of telehealth services.[7, 21] A 2005 Health Canada report showed positive effects, including increased access to primary health care, savings on travel, and building the capacity of health providers.[19] The program also involved clinical referral patterns with multiple southern jurisdictions (Alberta, Manitoba, and Ontario) and the Northwest Territories and Nunavut, illustrating successful cross-jurisdictional relationships.[19] Lessons learned and impact evaluation reports demonstrate telehealth's positive impacts on health at the community level.[7]

The Nunavut telehealth program has experienced rapid growth in the use and adoption of telehealth and has exceeded capacity in the past two years.[7] A collaborative initiative between Nunavut and Manitoba with MBTelehealth continues to allow for increased capacity and expanded services in Nunavut.[20] Changes to the program, including the Nunavut Manitoba Telehealth Expansion Project—a joint project between Canada Health Infoway, Manitoba Telehealth, and Nunavut—has increased the capacity to provide more advanced clinical services through the existing telehealth network.[7] The program continues to evolve and implement new initiatives that will provide care closer to home and help reduce the need for families to travel outside their home community.[7] For example, some new projects that just started recently are telepediatrics, telementalhealth, telepharmacy, and the expansion of teledietetics.[7] The telehealth expansion and knowledge management project is providing the telehealth team with knowledge that will enable them to provide increased clinical, administrative, and educational telehealth activity throughout Nunavut that is relevant and meets the needs of Nunavummiut.[7]

Nunavut notes that the challenges of geography, isolation of communities, and weather make it difficult to provide health care services to all of its remote communities.[7] Moreover, the cost of travel to send patients out of remote communities is exorbitant and one of the driving factors for using telehealth.[7] Telehealth is critical for the delivery of health care across three regions within the territory; it enables important connections for patients with health centres in Manitoba and Ontario for consultations with specialists and family visitations; and it reduces personal and professional isolation for providers and enhances education and training opportunities.[7]

However, Nunavut is further challenged by recruitment and retention problems, a tremendous workload burden for remaining staff, and multiple and competing priorities for government.[7] Issues such as a lack of physician fee codes outside of the territories and the adoption and use of telehealth by providers are challenges across the country, but are especially problematic for Nunavut with the heavy reliance on telehealth. Nevertheless, the program is experiencing rapid momentum and has made significant gains in the past year due to the commitment of the telehealth staff, management, local health care provider champions, physicians, Canada Health Infoway, and the Government of Nunavut.[7] The biggest limitation that currently inhibits the telehealth program is the reliance on a legacy satellite infrastructure that limits the amount of telehealth services that can be provided.[7]

Access to care in the North

Under the Territorial Health System Sustainability Initiative (THSSI), the government of Nunavut receives federal funding to help support innovation of their health system. This includes funding from the Medical Travel Fund to offset or reduce the costs of medical travel and funding for the Territorial Health Access Fund.[22] THSSI has been in place since 2005 and has been extended until March 2014.[23] Territorial governments create annual plans outlining how this funding will be spent. These reports are forwarded to federal/territorial deputy ministers of health.[24]

The Territorial Health Access Fund has supported government investments in a range of initiatives, including an expansion of midwifery services, training for health care professionals in areas such as mental health, and improving the management of the medical travel system.[7, 22] Nunavut is working on updating a mental health framework. Of the three territories, Nunavut receives the largest amount under the Medical Travel Fund due to the remoteness of its 26 communities.[22]

A memorandum of understanding has been created between the governments of Nunavut and Manitoba. The section on health relates to sharing best practices and identifying opportunities for greater use of selected health services in Churchill, Manitoba, by Nunavut residents.[25]

The government has planned a comprehensive review of the Client Travel Policy in 2011/12.[9] THSSI subsidizes Nunavut's medical travel costs. Travel costs have increased from original 2003/04 levels owing to population growth, fuel prices, increased levels of care, and increased contract rates, among other factors.[4] Nunavut manages these increases through policy reviews, statistical analysis, and electronic systems.[4]

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Federal Government

Home and community care

The federal government of Canada provides some home care services and funding for additional services for First Nations and Inuit communities, eligible veterans, Canadian Forces, and the Royal Canadian Mounted Police (RCMP). At present, the Canadian Forces delivers home care at the clinical level, where a health care coordinator acts as the senior medical person and military and civilian health care professionals provide the home care services. Availability and types of services vary by region. The current home care priorities within the RCMP include nursing home care services and the identification and provision of other services that may be needed to support recovery and a safe and timely return to work. Only active RCMP members are eligible for home care services, and accordingly, recipients all range from 23 to 65 years of age.[1]

Health Canada's First Nations and Inuit Home and Community Care (FNIHCC) program provides a coordinated system of home and community-based health care services to over 650 First Nations and Inuit communities. The FNIHCC program enables First Nations and Inuit seniors and people of all ages with disabilities, chronic illnesses, or acute illnesses to receive the care they need in their homes and communities. Services are provided primarily through contribution agreements with First Nations and Inuit communities and territorial governments, and strive to be equal to home and community care services offered to other Canadian residents in similar geographical areas. Services are delivered primarily by home care registered nurses (RN) and trained and certified personal care workers. Service delivery is based on assessed need and follows a case management process.[2, 3]

Established in 1981 by Veterans Affairs Canada, the Veterans Independence Program (VIP) is a national home care program that aims to help Canadian veterans remain healthy and independent in their own homes or communities by providing home care services to qualifying veterans, including health and support services, personal care, housekeeping, meals on wheels, grounds maintenance, transportation costs, and home adaptation services.[4] Beginning November 2010, the VIP expanded to provide housekeeping and/or grounds maintenance benefits to eligible primary caregivers, and low-income or disabled survivors of certain traditional war service veterans.[5]

Comparable health indicators

The federal government has published *Healthy Canadians* bi-annually since 2002.[6] The report provides comparable indicators, and it is the mechanism through which the federal government has met its reporting commitments under the 2004 health accord.[6] Health Canada last released *Healthy Canadians: A Federal Report on Comparable Health Indicators 2010* in the fall of 2011.[7] In addition to the work of Health Canada, Statistics Canada collects health information through health surveys.[6]

The federal government has invested in the Canadian Institute for Health Information (CIHI) so that additional health data can be made available. The federal government's 2007 budget committed $110 million in additional funding over five years.[6, 8] This funding positioned CIHI to continue its indicator work, as well as pursue work with provincial/territorial governments on data collection and reporting on health performance.[6] CIHI has produced a health indicators report each year to assess the health of Canadians and the health care system.[6, 9] CIHI provides data and analysis support on Canada's health care system, and works with federal/provincial/territorial governments on data development and reporting on health care system performance.[6]

Health human resources (HHR)

In response to the First Ministers' 2003 and 2004 health accord commitments to health human resources, the pan-Canadian Health Human Resources Strategy (HHRS) was launched in 2004/05.[10] A related initiative is the Internationally Educated Health Professionals Initiative (IEHPI). The federal government invests $20 million and $18 million annually into HHRS and IEHPI, respectively, to support Canada-wide activities and contributions to provinces and territories.[11] Health Canada has reported publicly against the HHRS and the IEHP initiatives through annual reports, the latest one for the period 2009/10.[12] Selected results related to the HHRS goals include:

- Supply: CIHI has reported increases overall in Canada in terms of the supply of health care professionals, such as physicians,[13] registered nurses,[14] pharmacists,[15] occupational therapists,[16] physiotherapists,[17] medical laboratory technologists,[18] and medical radiation technologists.[19] The federal government has also put a focus on northern communities, with investments to pilot collaborative health teams in remote and isolated First Nations communities and for more than 100 family medicine residents to receive training and provide medical services in remote and rural areas of Canada.[20]
- Planning and forecasting: The pan-Canadian health human resources planning framework (HHR planning framework), which has been used by all jurisdictions, captures a standardized approach for planning and implementing HHR initiatives. It has become an important reference point for provincial/territorial use of a needs-based approach.[6] However, the HHR planning framework does not contain indicators against which the jurisdictions can report progress.[21]
- Effective use of skills and sustainable work environments: The HHR planning framework has supported enhanced capacity among the provinces and territories, an example being an increased focus on new service delivery models (e.g., for interprofessional collaborative care). With respect to fostering a sustainable workforce and healthy work environments, jurisdictions report better integration of internationally educated providers, the existence of more programs to promote health careers, and healthier workplaces.[6] As well, HHRS funded initiatives, such as the Canadian Interprofessional Health Collaborative and the Quality Work Life—Quality Healthcare Collaborative support these goals.[12] Other partners in the area of interprofessional care include the Academic Health Council and Canadian universities involved in pre-licensure interdisciplinary education initiatives.[6]

In the health accords, the federal government made specific commitments related to:

- Internationally educated health providers: In addition to its original policy objectives, the IEHPI has now aligned its priorities with the pan-Canadian framework for the assessment and recognition of foreign qualifications (i.e. FQR framework). An evaluation of the IEHPI will be completed in 2012.[6]

- Aboriginal HHR: Since 2006, the Aboriginal HHR Initiative (AHHRI) has three key goals, one of which is to increase the number of Aboriginal people working in health careers in Canada.[11] An evaluation of the first few years of the strategy found that it has been successful in laying the foundation for future efforts.[22] In 2010, the AHHRI was renewed for a new multi-year mandate, with an additional element—to increase the training and certification of community-based health care workers. To this end, over 600 community-based health care workers received training in 2010/11.[6]
- Reduced financial burden on students training for health care professions: Federally funded initiatives include forgiving a portion of Canada Student Loans for new family physicians, nurses, and nurse practitioners who will practise in under-served rural or remote communities, including communities that provide health services to First Nations and Inuit populations.[6]
- Collaborative planning: The Advisory Committee on Health Delivery and Human Resources (ACHDHR) is an important collaboration among the federal, provincial, and territorial jurisdictions, and other key stakeholders. However, it has been critiqued for not being as inclusive as it might be.[21] Another key collaborative initiative is the recent creation of the Pan-Canadian Health Human Resource Network.[23] In the context of building public health HHR capacity, the Public Health Human Resources Task Group at the Public Health Agency of Canada (PHAC) is undertaking projects such as enumerating the public health workforce and quality graduate education. The Office of Public Health Practice at PHAC is also undertaking a pilot skills training effort geared towards training and skills enhancement of community health representatives in the far north, called the Northern Skills Strategy.[2]

Telehealth

Health Canada's First Nations and Inuit Health Branch (FNIHB) has a budget of approximately $2.2 billion (two thirds of the Health Canada budget).[24] With a staff of approximately 2,500 federal employees and 5,000 Band employees, FNIHB oversees 600 health facilities, many in fly-in remote communities, and serves a Registered Indian population of 845,783 (with 58% living on-reserve) and 50,485 Inuit (78% of whom live in Nunangat, which includes the four Inuit regions), comprising diverse cultural groups.[24]

FNIHB plays a lead role in enabling mainly First Nations communities in their adoption of telehealth consistent with their priorities and needs initiatives.[24] Working together in strategic collaborations with the Assembly of First Nations, regional First Nations organizations and communities, Canada Health Infoway, COACH, provincial governments, regional health authorities and health care providers, and professional associations, FNIHB is involved in the development of telehealth services in many ways to support improvements in access, quality, and productivity in health care services delivery.[2, 24] Its diverse roles include, for example, funding and guidance for clinical, educational, and administrative initiatives in telehealth services.[24] FNIHB also supports capacity building, and provides telehealth equipment, technical support, information, and training.[24]

FNIHB has undertaken substantial efforts over the past five years to deploy telehealth services to improve access to community-level health care and services in a fully integrated fashion, with provinces where possible.[24] As of December 2011, there are over 300 telehealth/video conferencing sites at the community level offering a wide range of services, including televisitation for family members, teleeducation for workers and community members, telediabetes, and telemental health, with future plans to introduce more clinical services in communities.[2]

FNIHB is committed to working in partnerships to achieve a fully integrated health service for First Nations community members that is sustained and continues to evolve to add more community-level services each year.[2] The longer-term vision is that First Nations and Inuit will have access to the same quality and availability of e-health services as the rest of the Canadian population and participate in the pan-Canadian vision of a fully interoperable electronic health record.[2]

Access to care in the North

The Territorial Health System Sustainability Initiative (THSSI) has enabled each territory to develop health promotion strategies and address gaps in service delivery in response to its changing needs.[25] It consists of $270 million in federal funds from 2005 until March 31, 2014.

THSSI funds are administered through agreements with the three territorial governments. The funds are composed of (a) the Medical Travel Fund to offset or help pay for medical transportation; (b) the Territorial Health Access Fund to reduce reliance over time on the health care system, strengthen community level services, and build territorial capacity to provide services; and (c) the Operational Secretariat Fund to support a federal/territorial assistant deputy minister working group, fund several pan-territorial projects, and provide resources to manage funding commitments.[25]

An evaluation of THSSI, which covered the Territorial Health Access Fund (THAF) and the Operational Secretariat Fund (OSF), was conducted in 2010.[6] This was both a formative and summative evaluation.This summative evaluation concluded that THSSI was successful.[25] Further, THSSI also has oversight mechanisms, including territorial work plans (which require the approval of territorial governments and Health Canada) and an annual report to territorial and federal deputy ministers of health outlining territorial/pan-territorial successes.[6]

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