Health Canada Santé Canada

FIRST NATIONS AND INUIT HOME AND COMMUNITY CARE PROGRAM

Summative Evaluation

Approved by

Senior Management Board
Finance, Evaluation and Accountability (SMB-FEA)
Health Canada

October 16, 2009

Canada

TABLE OF CONTENTS

Management Action Plan
First Nations and Inuit Home and Community Care (FNIHCC)
Summative Evaluation

Recommendations	Management Response	Key Activities	Responsibility	Time Frame
Funding				
1. It is strongly recommended that FNIHCC continue and be strengthened. Evaluation findings clearly confirm and endorse the continued rationale of FNIHCC, as assisting in addressing the health needs of First Nations and Inuit people, and of closing the health service delivery gap.	Management concurs.	Proceed with renewal of FNIHCC authority, as part of the cluster model approach.	Director, Primary Health Care Division (PHCD), Primary Health Care and Public Health Directorate (PHCPHD), First Nations and Inuit Health Branch (FNIHB), Health Canada	April 2012
8. It is recommended that the funding formula be updated. The formula should be re-designed so as to be more needs based, taking into account the increased burden of chronic illness and injuries. Provision for on-going training and capital requirements for FNIHCC should be included in the funding envelope. 9. The specific needs, challenges, and higher costs associated with FNIHCC in smaller, remote, isolated, communities should also be taken into account in the formula (several formulas have been proposed in earlier studies; these should be re-examined for feasibility). 10. Consideration should also be given to a funding formula based on diagnostic-related groupings due to the proportionately larger numbers of injuries and disabilities and the increasing population.	Current funding levels do not permit a change in the way that funding is distributed to communities.	Conduct analysis (see recommendations 11/21) to identify possible changes to funding model, should significant investments be made.	FNIHCC Program Manager, PHCD, PHCPHD, FNIHB, Health Canada	April 2011

Recommendations	Management Response	Key Activities	Responsibility	Time Frame
Gaps				
2. It is recommended that the highest priority be given to providing all essential components of FNIHCC in all communities. After establishing essential services elements, FNIHCC should consider the feasibility of addressing areas of unmet health needs and services gaps including mental health services, palliative/end of life care, rehabilitative care and respite care including the introduction of specialized training for service providers in this area.	FNIHCC essential service elements cannot be expanded to include mandatory provision of palliative care, acute care replacement or mental health in the home within current funding levels. Guidelines have been developed to assist communities and regions in providing FNIHCC, due to its Mandatory nature. Regions will continue to use the Risk Management Assessment Tool (RMAT) to maintain focus on the delivery of essential service elements. FNIHCC has undertaken a series of studies on unmet needs such as for palliative care, mental health, acute care replacement and children with special needs.	Review this research to keep it up-to-date for operational planning. Develop an options paper to consider innovative service delivery such as telehealth to support the delivery of essential service elements.	FNIHCC Program Manager, PHCD, PHCPHD, FNIHB, Health Canada FNIHCC Program Manager, PHCD, PHCPHD, FNIHB, Health Canada	April 2012 April 2011
Linkages				
3. It is recommended that closer linkages of FNIHCC with regional health authorities, other health care providers, medical services and health institutions be explored and encouraged, so as to provide more integrated and coordinated care to clients.	Management concurs. Linkages are a FNIHCC essential service element. Communities are required to include evidence of such linkages, and to plan their home care services within a wider system context.	Explore more formal linkages within FNIHB as part of authority renewal process.	Director, Primary Health Care Division, PHCPHD, FNIHB, Health Canada	April 2012
4. Policy makers should clearly establish the parameters and linkages among of the various health programs available (Home and Community Care, Primary Health Care, Public Health/Community Health Nursing, Addiction Services, to name a few) to determine where services, such as Mental Health	A number of AHTF projects are specific to home care, with their aim being to improve both internal and external linkages and demonstrate this for others to consider. The current tripartite initiative (BC and Saskatchewan) are expected to provide a focus on integration.			

Recommendations	Management Response	Key Activities	Responsibility	Time Frame
Services, should be located so that health service gaps are addressed.				
15. Although coordination and partnerships have been established, FNIHCC needs to continue to develop linkages, so as to promote more integrated and coordinated health care services for First Nations and Inuit patients.	More formal integration with Indian Affairs Services is being explored (see 16).			
Best practices/models of delivery				
12. It is recommended that the two piloted alternative service delivery models should be implemented. These include facilitating and expediting access to medical supplies, as well as providing web-based educational support for FNIHCC providers.	FNIHCC NIHB medical supplies project is now in implementation planning phase at the regional level. An evaluation of an expanded implementation of the @YourSide Colleague project in British Columbia, Saskatchewan and Manitoba communities is underway, intended to provide communities with information for implementation.	Prepare and finalize implementation plans. Review regional plans for implementation of the FNIHCC/NIHB process. Monitor progress on implementation of the NIHB process. Provide link to communities so that they can access evaluation report.	All Regional Directors, First Nations and Inuit Health, Regions and Programs Branch (RAPB), Health Canada Director General, Non-Insured Health Benefits Directorate, Director General, Primary Health Care and Public Health Directorate, FNIHB, HC FNIHCC Program Manager, PHCD, PHCPHD, FNIHB, Health Canada	April 2011 April 2011 August 2009
13 It is recommended that a more integrated, holistic and systematic framework for the delivery of all health services to First Nations and Inuit populations, including HCC, in rural, remote and isolated communities be developed. Efforts should be made to establish this framework and update it on a regular basis.	The scope of the recommendation is beyond the scope of a single program. However, community FNIHCC programs will continue to be encouraged to explore integration and linkages of their home care programs within a broader system approach.			

Recommendations	Management Response	Key Activities	Responsibility	Time Frame
	Current nursing innovation/collaboration project, will help to establish and demonstrate a more collaborative, holistic and innovative approach to service delivery involving home care and the broader health system. Some AHTF projects have also examined these issues.	Prepare a discussion document on possible approaches to disseminate information on project completion in 2013.	FNIHCC Program Manager, PHCD, PHCPHD, FNIHB, Health Canada	April 2010
14. It is recommended that primary prevention should remain in the PHC or Public Health component of health services to First Nations and Inuit communities. However, secondary and tertiary prevention should be strongly integrated as part of FNIHCC.	While primary prevention is not the principle focus of home care services generally, such primary prevention does occur opportunistically. It is especially critical for FNIHCC to be linked with primary prevention at the community level. In fact, in many communities, the home care program manager also has the lead on the implementation of primary prevention strategies. In many small communities, one nurse may play both primary and public health roles.	Share evaluation report with regional management and communities to encourage an integrated approach.	FNIHCC Program Manager, PHCD, PHCPHD, FNIHB, Health Canada	March 2010
16. In accordance with principles of client-centered service the implications of integrating the Assisted Living and FNIHCC programs should be considered by policy makers. This would allow for greater effectiveness, coordination and integration of continuing care service as well as economies of scale, and administrative/reporting streamlining.	Management concurs, and is exploring options to do so.	Continue work related to transfer of funding and authority for the in-home component of the Assisted Living program (Indian and Northern Affairs, INAC) to Health Canada. Decision regarding feasibility.	Director General, Primary Health Care and Public Health, FNIHB, working with INAC counterpart. Health Canada and Indian and Northern Affairs Canada, level to be determined	April 2011 To be determined.
18. Program managers should consider establishing FNIHCC performance benchmarks, service standards, and clinical outcome indicators, which would allow for more effective monitoring of quality of care and program efficiency.	FNIHCC has implemented service standards and policies, and developed a RMAT based on service delivery standards. Communities use standardized assessment tools many of which support benchmarking and clinical outcome indicators for use at the client planning level.	FNIHCC will continue to hold regular meetings with Accreditation program of Health Canada, FNIHB, Primary Health Care and Public Health, Primary Care Division, to encourage the uptake of accreditation among FNIHCC funded programs.	FNIHCC Program Manager, PHCD, PHCPHD, FNIHB, Health Canada	April 2011

Recommendations	Management Response	Key Activities	Responsibility	Time Frame
		Develop and disseminate a "quality handbook" that FNIHCC communities can use to apply continuous improvement activities to their program and services.	FNIHCC Program Manager, PHCD, PHCPHD, FNIHB, Health Canada	April 2011
Human Resources				
7. Efforts should continue to address human resource issues challenges associated with FNIHCC, including staff recruitment, retention, training and development, and compensation. In particular, efforts to recruit and train First Nations and Inuit care providers should be emphasized.	With a few exceptions, communities, and not Health Canada, are the employer. Like all health services, FNIHCC funded programs face shortages in the labour market for both professionals and para-professionals.	Collect data and provide access to it to help communities to monitor, manage and plan for ongoing HR recruitment and retention and to assist decision making at the community, regional and national level in turnover and vacancy rates (eHRTT).	FNIHCC Program Manager, PHCD, PHCPHD, FNIHB, Health Canada	April 2009
	FNIHCC requires that communities submit full-time equivalent staffing data for planning purposes, and starting in 2008-09, this data is now collected by eSDRT for all users. Over the past five years, Health Canada has provided additional new funding that could be used by communities to partially address wage parity issues. It is acknowledged that the real heart of the program is the dedicated women and men who provide services in communities, both paid and voluntary. FNIHCC recognizes the limitation of current funding that does not target funding specifically to training.	Review and revise FNIHCC program standards to reflect Quality of Work Life principles, with special attention granted to the roles and responsibilities and accountabilities of program leaders/ managers for all community health workers particularly in the area of position profiles, performance appraisals, program delivery handbooks, orientation material and the need to address client safety regularly.	FNIHCC Program Manager, PHCD, PHCPHD, FNIHB, Health Canada	April 2011

Recommendations	Management Response	Key Activities	Responsibility	Time Frame
Collection and use of data				
6. It is recommended that the RMAF and Performance Management System for FNIHCC be confirmed and made consistent so as to allow for effective FNIHCC program management, monitoring and evaluation. It is essential that regular, systematic reporting, with performance indicators based on a data collection strategy, be undertaken. Program outcomes need to be in line with resources expended for the program, and be realistic in terms of expected results.	FNIHCC was the first FNIHB program to require detailed service delivery data be provided. While we recognize that there have been challenges associated with the collection of this data and will continue to work on addressing these. FNIHCC, as all FNIHB funded services, are now included as a component in a cluster-funding model. Indicators for the clusters have been developed to streamline reporting.	Review and revise FNIHCC performance measurement strategy during the authority renewal process. Collect, monitor and report on the measures annually. Initiate corrective actions annually to redress/correct any data gaps or inconsistencies.	FNIHCC Program Manager, PHCD, PHCPHD, FNIHB, Health Canada	April 2012 April 2010 and ongoing annually. April 2010 and ongoing annually.
11. This evaluation revealed that patients' primary conditions appear to differ across regions and across community types, and the analysis found different costs per hour of services. These findings require analysis and investigation, with possible implications for the revised funding formula.	Management agrees that there do appear to be differences in service delivery across the country. Further analysis will help understand variation and could inform the consideration of possible funding models as noted earlier.	Undertake more detailed analysis of longitudinal eSDRT and Human resources data. Provide analysis to management for operational planning.	FNIHCC Program Manager, PHCD, PHCPHD, FNIHB, Health Canada	April 2011
21. The data analysis undertaken as part of this evaluation has shown regional differences in health conditions across the country (e.g. diabetes significantly higher in Western provinces), as well as different costs of providing FNIHCC services from region to region. Further research and analysis nees to be undertaken to understand if health care needs are different across the country, and if so, why, and why costs of services are different. If health care needs vary from region to region, this may need to be considered in the funding formula.				
17. Consideration should be given to the utilization of common assessment instruments (such as inter-RAI) to ensure optimal linkages between FNIHCC and provincial/territorial health care systems.	Management concurs. Communities have always been encouraged to use common standardized tools to support evidence-based practice and enable comparison with established benchmarks. (e.g. provincial assessment tools).	Develop a document to present possible options for implementation of interRAI and the Home Care Reporting System (HRCS) tools.	FNIHCC Program Manager, PHCD, PHCPHD, FNIHB, Health Canada	April 2010

Recommendations	Management Response	Key Activities	Responsibility	Time Frame
	FNIHCC has supported the development of a business case for possible adoption of interRAI tool, and shared this with all regions.			
19. It is recommended that the data which are collected, both mandatory and non-mandatory, should continue to be collected, and supplemented by additional fields, as recommended by the SDRT Study (Saint Elizabeth Health Care).	FNIHCC will continue to support eSDRT, with primarily focus on maintaining functionality. We will consider the addition of additional data fields, when feasible (one such field has already been included in eSDRT version 5, 2008).	Consider options for feasibility of including additional fields in the next version.	FNIHCC Program Manager, PHCD, PHCPHD, FNIHB, Health Canada	April 2010
20. Furthermore, the evaluation recommends:				
a. That client satisfaction information be collected on a regular, systematic, basis.	a. FNIHCC has no plans to collect client satisfaction on a national level. The current FNIHCC nursing handbook, provided to all communities, has examples of surveys that communities can use to collect such data. Some information on client satisfaction was collected by the Continuing Care research project, with the Synthesis report having been provided to all communities in 2008.	a. Review and update current tools to support communities to collect and use client satisfaction data as part of ongoing service delivery improvement.	FNIHCC Program Manager, PHCD, PHCPHD, FNIHB, Health Canada	April 2011
b. That more detailed health care provider information be collected, so as to allow for more effective management of FNIHCC resources.	b. HRTT tool has been developed to collect and report back human resources information in a more systematic way and allow better analysis of this data by users at all levels.			
c. That better health information on the population at large (First Nations and Inuit), be collected, so that more effective and targeted planning may be undertaken for the FNIHCC services.	c. FNIHCC will continue to work within the current FNIHB planning structure using established data sets.	c. Meet with Strategic Policy and Programs Directorate, FNIHB, Health Information, Research and Analysis Division to discuss access to and use of Regional First Nations Health Survey and Inuit Health Survey data and options for possible inclusion of additional questions in future cycles.	FNIHCC Program Manager, PHCD, PHCPHD, FNIHB, Health Canada	April 2011

Recommendations	Management Response	Key Activities	Responsibility	Time Frame
d. That outcome information on patient condition be collected so as to track condition, health status and measure effectiveness of services. e. That a set of FNIHCC benchmarks be established to allow for regional comparison on services.	d/e. Efforts to establish outcome measures/indicators/benchmarks will be directed towards the adoption of 'standardized, evidence-based' tools (e.g. interRAI and HRCS) vs. stand-alone FNIHCC tools. The use of standardized tools would allow comparison with existing evidence-based benchmarks (see recommendation 17).			
Culture				
5. Generally FNIHCC has been found to be culturally relevant in its approach, although efforts should be made to further align the program with holistic and traditional approaches.	FNIHCC recognizes that each community has its own unique traditions and ways of working and of incorporating these traditions into their work. Community programs will continue to be encouraged to work with their communities in connecting with local cultural and traditional approaches. Current resources have been reviewed for cultural appropriateness as they have been developed.	Review current resources for cultural appropriateness and update as necessa ry.	FNIHCC Program Manager, PHCD, PHCPHD, FNIHB, Health Canada	March 2011

Health Canada Santé Canada

First Nations and Inuit Home and Community Care Program

Summative Evaluation

March 31, 2009

Canada

Prepared by

North South Group, Inc.
5225 Tobin Street
Halifax, NS B3H 1S3

Donna Cona
130 Slater Street, Suite 1340
Ottawa, ON K1P 6E2

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The First Nations and Inuit Home and Community Care Program (FNIHCC) provides basic home and community care services to First Nations communities and Inuit settlements which are designed to be: comprehensive, culturally sensitive, accessible, effective and equitable to that of other Canadians, while still responding to the unique health and social needs of First Nations and Inuit. The program is a coordinated system of home and community based health related services, which enable people of all ages with disabilities, chronic or acute illnesses and the elderly to receive the care they need within their home communities.

The target population for the FNIHCC are First Nations and Inuit of any age who reside on a First Nations reserve (South of 60°), Inuit settlement (North/South of 60°), or First Nations community North of 60°. Eligible clients undergo a formal assessment process determining that they require access to the program's essential services.

This Summative Evaluation comprises the third examination of the performance of the FNIHCC, in compliance with Treasury Board accountability requirements. The first (evaluation) study, Study 1 "Implementation: Foundations for Success" was completed in 2004 and examined the need for home care in First Nations and Inuit communities. Study 2 examined how the program addressed the need for home care in First Nations and Inuit communities through surveys, and focus groups. The findings of this Evaluation are intended to enable policy makers and program managers to make future decisions on the continuation, funding levels and design and delivery of the FNIHCC, and to introduce changes, as required, to improve program quality which will make it more responsive and relevant to users.

The evaluation comprises multiple lines of evidence and the process was structured in a series of integrated and progressive components designed to build and complement each other. These lines of evidence included: a documentation review; Key Informant interviews; Key Representative interviews/survey; a study of accredited communities providing FNIHCC; and finally, an analysis of the electronic Service Delivery Reporting Template (eSDRT) and administrative data.

The following table describes the approach, methodology and lines of evidence utilized as part of this Summative Evaluation.

	Key Informant Interviews	Documentation Review	Key Respondent Interviews/ Survey	eSDRT and Administrative Data	Study of Accredited Programs
Scope	18 Key Informants contacted 14 interviews conducted	Academic and grey literature focusing on FNIHCC and home care delivered in an First Nations or Inuit setting Up to 100 studies and documents were reviewed (77 in the bibliography)	29 Key Representatives (including stakeholders) contacted 17 interviews/ surveys conducted	eSDRT data (2005/06, 2006/07 & 2007/08) Administrative data re level of funding, the population base, & HR re FTE allocation	Documents/websites reviewed 13 communities contacted 9 interviews conducted 3 surveyors contacted 2 surveyors interviewed
Tools Developed	Interview guide	Key word searches Environmental scan of targeted health & health care sites First Nations and Inuit health organisations Content analysis	Interview/survey guide	Validation and analysis framework Statistical and regression analysis; Validation with client authority	Environmental scan of targeted sites & respondents Documentation review/ content analysis Interview guide
Inclusion Criteria	FNIHB Regional & HQ program management representatives	Academic & grey literature focusing on FNIHCC and Aboriginal home care studies	Health Canada HQ & Regional FNIHCC program management Key external stakeholders	2005/06 2006/07 2007/08 data was available	First Nations and Inuit communities with accredited HCC programs Surveyors of First Nations and Inuit HCC programs
Exclusion Criteria	List & recommendations for interview provided by Contract Authority	General home care literature and studies	FNIHCC clients and providers	Other years not available	Only accredited HCC sites were included
Limitations/ Challenges	Availability of Key Informants within the required timeframe for interviews	Paucity of material on evaluation of Aboriginal home care Absence of recent studies on HCC	No first hand information from clients/users of FNIHCC nor service providers	Difficulty in obtaining and validating data 18 month delay Data not available to inform other lines of evidence Coding problems in matching two data sets Time constraints for analysis	Findings are not generalisable to all FNIHCC communities, but allow for examination of best practices, with potential for replicability
Mitigation of Challenges	Availability of team to interview on weekends & evenings	Supplementation of research through other lines of evidence	Discussed with Client Authority, & proposed other avenues for client-based information	Correction and validation of the data sets	Other lines of evidence pursued in this evaluation study

The major evaluation questions are posed, and the findings from all lines of enquiry are presented in the section below.

Relevance and Rationale

***Does the FNIHCC Program continue to reflect the Government and Health Canada priorities*?**

FNIHCC has been found to be highly consistent with the mandate and goals of the Government of Canada and Health Canada with respect to improving First Nations and Inuit health. Although improvements have been achieved, the health status of Aboriginal populations in Canada continues to lag behind that of other Canadians. Findings from all sources confirm the continuing need for FNIHCC in First Nations and Inuit communities.

The evaluation findings have identified significant gaps and further unmet needs for home and community care in First Nations and Inuit communities, as well as fragmentation in service delivery. Evaluation findings also identified the need to continue to ensure that FNIHCC is delivered with a culturally relevant approach to further align the program with traditional First Nations and Inuit approaches to health.

The following recommendations are presented in the Summative Evaluation Report:

That the FNIHCC program continue and be strengthened to close the health service delivery gap.

That the highest priority be given to providing all essential components of the FNIHCC program in all communities with consideration to addressing areas of unmet health needs and services gaps, including mental health services, palliative/end of life care, rehabilitative care and respite care, including the introduction of specialized training for service providers in this area.

That closer linkages of the FNIHCC program with regional health authorities, other health care providers, medical services and health institutions be explored and encouraged, so as to provide more integrated and coordinated care to clients.

Design and Delivery

How has the FNIHCC Program been implemented and delivered?

According to the Biannual Report produced in 2004, implementation of the FNIHCC Program was shown to be operating according to the plans, with most communities progressing along the pathway to service provision. Currently, FNIHCC Program is funded in 686 communities across all Regions in the country.

Evaluations findings have identified implementation challenges encountered by communities including: problems with the application of the funding formula for small, remote and isolated communities; health human resource issues (including recruitment, retention difficulties, and the need for additional training); coordination of care considerations; gaps in service provision and capacity issues related to administration and reporting.

A need for 24/7 care was identified across all lines of evidence. While 24/7 home care services in a home or community setting is preferable to having clients leaving the community when care can safely be provided in the home, the impact upon other elements of FNIHCC need to be carefully considered by program managers.

Alterations have been made to the FNIHCC Evaluation Framework, posing monitoring and evaluation difficulties.

It is recommended that the Results-based Management Accountability Framework (RMAF) and Performance Management System for FNIHCC be confirmed and made consistent so as to allow for effective FNIHCC program management, monitoring and evaluation. Program outcomes need to be in line with resources expended for the program, and be realistic in terms of expected results.

Efforts should continue to address human resource issues challenges associated with the FNIHCC program, including staff recruitment, retention, training and development, and compensation. In particular, efforts to recruit and train First Nations and Inuit care providers should be emphasized.

It is recommended that the funding formula be updated. The formula should be re-designed so as to be more needs-based, taking into account the increased burden of chronic illness and injuries as well as the higher costs associated with FNIHCC in smaller, remote or isolated communities. Consideration should also be given to a funding formula based on diagnostic-related groupings due to the proportionately larger numbers of injuries and disabilities and the increasing population. Provision for on-going training and capital requirements for the FNIHCC program should be included in the funding envelope.

It is recommended that the two piloted alternative service delivery models should be implemented. These include facilitating and expediting access to medical supplies, as well as providing web-based educational support for FNIHCC providers.

Outcomes

Is the FNIHCC Program achieving the outcomes expected (design and delivery outcomes, individual and community outcomes, policy outcomes)?

Respondents for this evaluation did not include users nor service providers. Respondents included program managers and key stakeholders. In general, the design and delivery of the FNIHCC was seen as having been successful in terms of meeting the original design intent of the

program by these respondents. The most highly rated impact on FNIHCC patient health outcomes cited were preventing or delaying health deterioration and reducing the onset of complications. Findings have identified facilitators for an effective FNIHCC Program, which include a commitment to professional development and training for staff, leadership support and coordination of services.

While benefits were noted, barriers to successful delivery of FNIHCC Programs were reported to be lack of funding, health human resource issues, workload and compensation of FNIHCC staff, service gaps and, administrative and reporting burdens.

Findings indicate that FNIHCC has contributed to the objective of building community capacity for the management and provision of home care services.

It is recommended that a more integrated, holistic and systematic framework for the delivery of all health services to First Nations and Inuit populations, including Home and Community Care (HCC), in rural, remote and isolated communities, be developed. Efforts should be made to establish this framework and update it on a regular basis.

It is recommended that primary prevention should remain in the Primary Health Care (PHC) or Public Health component of health services to First Nations and Inuit communities. However, secondary and tertiary prevention should be strongly integrated as part of the FNIHCC program.

Although coordination and partnerships have been established, FNIHCC needs to continue to develop linkages, so as to promote more integrated and coordinated health care services for First Nations and Inuit patients.

In accordance with principles of client-centered services, the implications of integrating the Assisted Living and FNIHCC programs should be considered by policy makers. This would allow for greater effectiveness, coordination and integration of continuing care services, as well as economies of scale, and administrative/reporting streamlining. Consideration should be given to the utilization of common assessment instruments (such as inter- Resident Assessment Instrument (RAI)) to ensure optimal linkages between FNIHCC and provincial/territorial health care systems.

Efficiency

How cost-effective is the FNIHCC Program?

Efficiency has been found to be difficult to assess due to lack of reliable health information and program information; however, the lines of enquiry pursued by this evaluation emphasize on-going problem areas, notably inadequacy of funding, human resources and compensation issues.

Findings from this evaluation demonstrate regional differences in health conditions across the country (e.g. diabetes significantly higher in Western provinces), as well as different costs of providing FNIHCC services from region to region. Further research and analysis needs to be

undertaken to understand if health care needs are different across the country, and if so, why, and why costs of services are different. If health care needs vary from region to region, this may need to be taken into consideration in any revisions of the funding formula.

It is recommended that the data which are collected, both mandatory and non-mandatory, should continue to be collected on a required basis, and supplemented by additional fields, as identified by the Service Delivery Reporting Template (SDRT) Study (Saint Elisabeth Health Care).

Furthermore, the evaluation recommends:

- That client satisfaction information be collected on a regular, systematic, basis;
- That more detailed health care provider information be collected, so as to allow for more effective management of FNIHCC resources;
- That better health information on the population at large (First Nations and Inuit), be collected, so that more effective and targeted planning may be undertaken for the FNIHCC services;
- That outcome information on patient condition be collected so as to track condition, health status and measure effectiveness of services;
- That a set of FNIHCC benchmarks be established to allow for regional comparison on services.

ACRONYMS

ACS	Acute Care Substitution
ADD/	Attention Deficit Disorder/
ADHD	Attention Deficit/Hyperactivity Disorder
ADI	Aboriginal Diabetes Initiative
AFN	Assembly of First Nations
ALS	Amyotrophic Lateral Sclerosis
ANAC	Aboriginal Nurses Association of Canada
CCHSA	Canadian Council on Health Services Accreditation
CHNAC	Canadian Health Nurses Association of Canada
CHCA	Canadian Home Care Association
CIHI	Canadian Institute for Health Information
COPD	Chronic Obstructive Pulmonary Disease
DDC	Drug Distribution Centre
eSDRT	Electronic Service Delivery Reporting Template
FASD	Fetal Alcohol Spectrum Disorder
FNI	First Nations and Inuit
FNIHB	First Nations and Inuit Health Branch
FNIHCC	First Nations and Inuit Home and Community Care Program
FNIHIS	First Nations and Inuit Health Information System
FNRHS	First Nations Regional Health Survey
FTE	Full-Time Equivalences
GoC	Government of Canada
HC	Health Canada
HCC	Home and Community Care Program
HHR	Health Human Resources
HQ	Headquarters
HR	Human Resources
HRDC	Human Resources Development Canada now HRSDC
HRSDC	Human Resources and Skills Development Canada previously HRDC
INAC	Indian and Northern Affairs Canada
ITK	Inuit Tapiriit Kanatami
LPN	Licensed Practical Nurse
NAHO	National Aboriginal Health Organization
NCR	National Capital Region

NIHB	Non-insured Health Benefits
NWT	Northwest Territories
OCAP	Ownership, Control, Access, and Possession
ONS	Office of Nursing Services
PHC	Primary Health Care
PEI	Prince Edward Island
P/T	Provincial/Territorial
RAI	Resident Assessment Instrument
RHA	Regional Health Authorities
RMAF	Results-based Management Accountability Framework
RN	Registered Nurse
SEHC	Saint Elizabeth Health Care
SDC	Service Delivery Center
SDRT	Service Delivery Reporting Template
@YSC	@ Your Side Colleague

1. INTRODUCTION

1.1 Background and Context

In response to studies which documented the urgent health needs of First Nations and Inuit communities, as well as significant health service gaps, the Federal Government established the First Nations and Inuit Home and Community Care Program (FNIHCC) in 1999 to provide basic home and community care services to this population. The FNIHCC was intended to address the negative health effects experienced by First Nations and Inuit resulting from high rates of chronic and acute diseases, injuries and disabilities, and the changing health delivery mechanisms associated with provincial/territorial health reform. It was also designed to provide a continuum of care; to prevent clients' further deterioration of health, and to maintain their independence in their home environment.

FNIHCC articulated a vision for home and community care services for First Nations and Inuit populations to respond to their specific health needs. Guiding principles for the program were developed as well as eligibility criteria. FNIHCC was intended to build on the existing home nursing services available under the federally-funded Building Healthy Communities, and the Indian and Northern Affairs Canada (INAC) Assisted Living Program.

This Report presents the findings of the Summative Evaluation of FNIHCC, as undertaken by Donna Cona/North South Group (DC/NSG). It is anticipated that the findings and recommendations included in the Report will be utilized to support decisions regarding the future of FNIHCC, as well as to initiate changes to strengthen the policy and management of the program.

1.2 Program Description

FNIHCC provides basic home and community care services that are designed to be: "comprehensive, culturally sensitive, accessible, effective and equitable to that of other Canadians while still responding to the unique health and social needs of First Nations and Inuit. The program is a coordinated system of home and community based health related services, which enable people of all ages with disabilities, chronic or acute illnesses and the elderly to receive the care they need within their home communities" (Health Canada, 1999).

Implementation of FNIHCC involved capacity building requirements from a capital, human resource and management infrastructure perspective; it entailed a process which required communities to undertake a local community home care needs assessment; develop an operational plan; and establish a service delivery plan. Community plans were assessed through a Regional peer-review process prior to approval and implementation.

It was intended that FNIHCC service delivery would occur at the community level through community governance structures, consistent with the principles of health transfer and self government. While First Nations and Inuit communities/settlements are responsible for the

delivery of FNIHCC and client service results, there is joint accountability with Health Canada, which is responsible for funding, for the access mechanism, implementation structure and ongoing second level support. As such, FNIHCC involves four levels of management and governance, namely; the community level (1); Tribal Council or grouping of communities level (2), regional (provincial/territorial) level (3) and national level (4).

1.2.1 Program Objectives and Activities

The overall objective of FNIHCC is to implement or enhance home and community care services under First Nations and Inuit control.

The Program objectives of FNIHCC are:

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

FNIHCC is comprised of essential service elements, delivered by trained and certified personal care and home health workers at the community level, supervised by registered nurses. The program is intended to coordinate with existing programs and services at the community and/or provincial/territorial levels, such as the Health Canada Building Healthy Communities Home Nursing program and INAC Adult Care Program (In-Home component).

Essential service elements include:

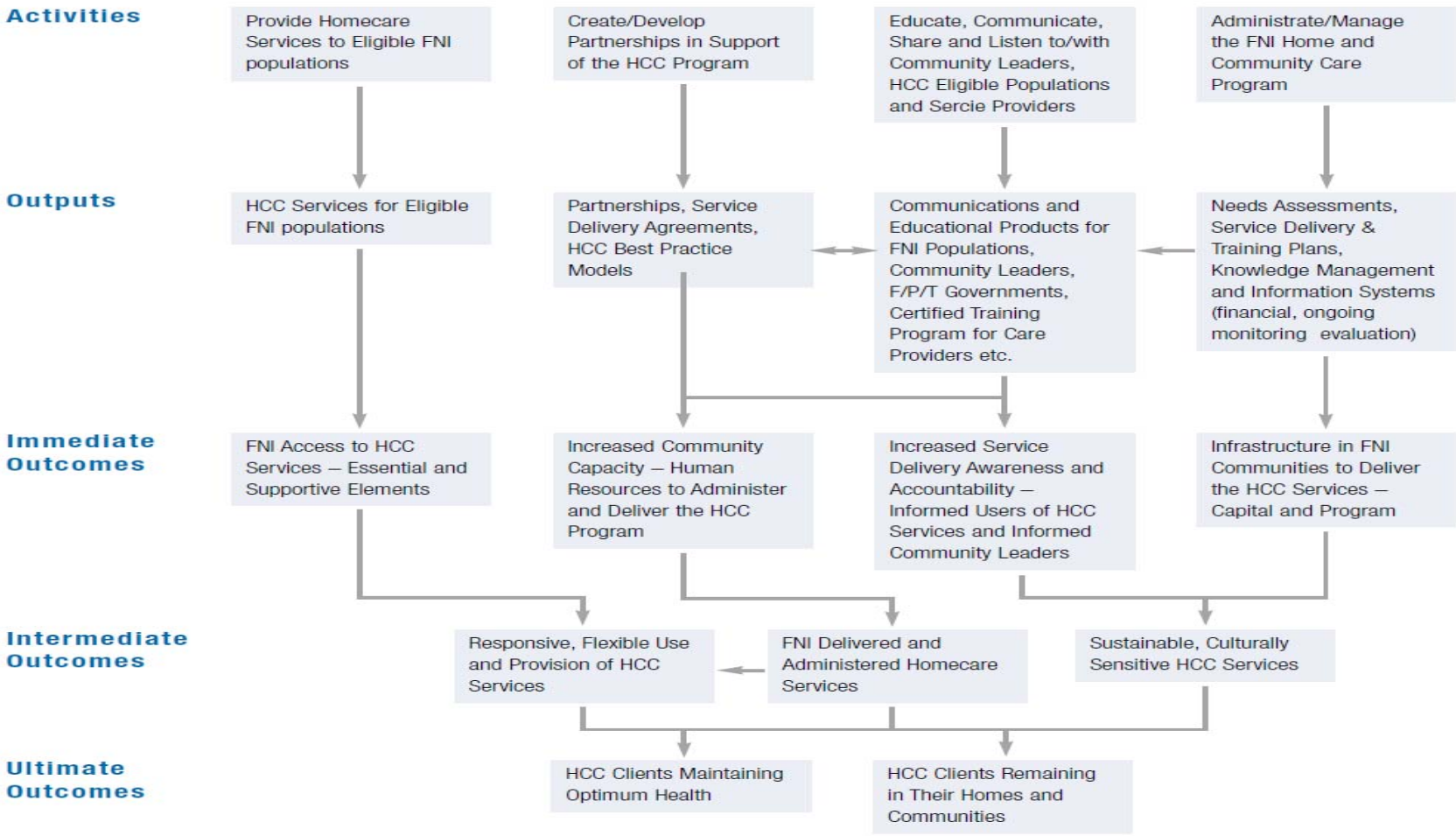
- A client assessment process that includes on-going reassessments and determines client needs and service allocation;
- A managed care process that incorporates case management, referrals and service linkages to existing services provided both on and off reserve/settlement;

- Home care nursing services that include direct service delivery as well as supervision and teaching of personnel providing personal care services;
- Delivery of home support personal care services;
- Provision of in-home respite care;
- Established linkages with other professional and social services;
- Provision of and access to specialized medical equipment, supplies and specialized pharmaceuticals;
- The capacity to manage the delivery of the home and community care program; and,
- A system of record keeping and data collection to carry out program monitoring, ongoing planning, reporting and evaluation activities.

1.2.2 Program Logic Model

The Logic Model, presented on the following page, presents an illustration of how the inputs, activities and outputs of FNIHCC were expected to lead to the achievement of the expected outcomes. It is the basis for ongoing performance measurement and evaluation of the program.

FIGURE 1
FNIHCC LOGIC MODEL



1.2.3 Program Target Population

The target population for FNIHCC are First Nations and Inuit of any age who reside on a First Nations reserve (South of 60°), Inuit settlement (North/South of 60°), or First Nations community North of 60°. Eligible clients will have undergone a formal assessment process of their continuing care service needs and will have been assessed to require one or more of the essential services. The program criteria further stipulates that services will be provided to eligible clients when these can be deployed with reasonable safety to the client and caregiver and within established standards, policies and regulations for service practice.

1.2.4 Program Funding

The Program was phased in over a three year period beginning in 1999. The focus in the first year ($17M budget) was on community development and awareness of the Program as well as planning and development of the delivery model. The second year ($45M budget) focused on establishing a management infrastructure, which included setting standards, policies and quality assurance guidelines. The third and final year ($90M budget) of this phased-in approach involved delivery of the full range of essential services to all communities identified for the Program. Ongoing funding has been $90M per year, with increases only realized since FY 2005/06 when there was a 13% Nursing top up followed by an across-the-board 3% increase per year for the following two years as per the following Table.

Table 1
FNIHCC Funding

Planned funding ($millions)						
	Vote 1, Operating	Vote 5, Contributions				Total Planned
		Program Planning	Program Service Delivery	Training	Capital	
1999-2000	2.74	12.65		1.62		17.00
2000-2001	3.37	8.35	14.38	5.40	13.50	45.00
2001-2002	3.98		66.02	5.50	14.50	90.00
2002-2003	3.08		86.92			90.00
2003-2004	3.08		86.92			90.00
2004-2005	3.08		86.92			90.00
2005-2006	3.08		86.92			90.00
2006-2007	3.08		86.92			90.00
2007-2008	3.08		86.92			90.00

Actual funding ($millions)						
	Vote 1, Operating	Vote 5, Contributions				Total Actual
		Program Planning	Program Service Delivery	Training	Capital	
1999-2000	0.28	4.73	0.18	0.40	1.79	7.38
2000-2001	2.27		31.06			33.34
2001-2002	2.56		67.23			69.79
2002-2003	3.79		81.43			85.21
2003-2004	3.93	9.43	76.05	0.83	0.22	90.45
2004-2005	3.82		90.60			94.42
2005-2006	3.48		89.52			93.01
2006-2007	5.01		91.77			96.78
2007-2008	4.23		93.30			97.53

As of 2007[1], 633 out of a possible 645 eligible First Nations communities and all 53 eligible Inuit communities received funding for FNIHCC. The program has been implemented in all seven Regions and three territories (through the Northern Region). Funding to the Regions and thereby to the communities is on a per capita and needs basis and in accordance with the original funding formula developed for this Program.

1.3 Evaluation Context

1.3.1 Purpose of the Evaluation

In accordance with Treasury Board accountability requirements, an evaluation strategy for FNIHCC was designed, as well as a Results-based Management Accountability Framework (RMAF) including a logic model, to govern the management, evaluation and reporting of the program. This RMAF was to ensure that the program was achieving its objectives; meeting the needs of the communities served, and was delivered in a cost-effective manner. Roles and responsibilities were delineated, as well as activities, which were linked to outputs and outcomes. Treasury Board requirements also entail the development of an evaluation strategy, along with specification of evaluation issues, identification of data sources, and proposed methods of data collection and analysis.

[1] Health Canada internal document - 2006/2007 Overview of FNIHCC Program Development Status, February, 2007

The first study, Study 1 "Implementation: Foundations for Success" was completed in 2004 and examined the need for home care in First Nations and Inuit communities. Study 2 examined how the program addressed the need for home care in First Nations and Inuit communities through surveys, and focus groups. This Summative Evaluation comprises the third examination of the performance of FNIHCC.

Drawing upon multiple research methods, the evaluation team sought to provide FNIHCC managers and funders key program information. The findings of this Evaluation will enable policy makers and program managers to make future decisions on the continuation, funding levels and design and delivery issues of FNIHCC, and to introduce changes, as required, to improve program quality which will make it more responsive and relevant to users. Audiences for this report include central agencies, senior managers, regional offices, key First Nations and Inuit stakeholders, as well as communities providing services under the program.

1.3.2 Evaluation Objectives and Scope

The objectives of this Evaluation are to determine whether the rationale for FNIHCC remains relevant; whether the intended impacts are being achieved; whether the program obtains value for money; and whether the program is being delivered in a cost effective manner.

The Evaluation's scope was national, entailing the examination of regional activities. In view of previous evaluations, the mandate called for very limited primary data collection, with a focus on using existing data sources, such as Electronic Service Delivery Reporting Template (eSDRT) and program administrative data.

1.3.3 Evaluation Issues and Questions

The main evaluation issues examined in the FNIHCC Summative Evaluation are: the program/ policy rationale and relevance; design and delivery; outcomes and success, and efficiency or cost effectiveness.

Relevance: Assessment of the need or continued need for FNIHCC, in terms of both needs in the community and gaps in service provision.

Rationale: Assessment of the appropriateness of FNIHCC tools chosen to fill the identified need.

Design: Assessment of the logic behind FNIHCC, the logistics, and the feasibility of meeting program objectives through the selected design model. Assessment of the appropriateness of the performance information collected and utilized for effective program management.

Delivery: Assessment of FNIHCC implementation and capability to reach target populations, including evaluation of the structure and organization of the program with respect to their potential ability to meet their stated goals and objectives and their capacity to reach target populations.

Outcomes/Success: *Design and Delivery Success* - assessment of the actual, not planned, delivery of FNIHCC program and its ability to reach target populations.

Individual Outcome Success - assessment of FNIHCC effectiveness from the perspective of participants and staff.

Policy Outcome Success – assessment of effectiveness of FNIHCC in terms of achieving broader policy objectives.

Efficiency: Assessment of the efficiencies realized through the implementation of FNIHCC.

Table 2
Evaluation Issues and Questions

Program Rationale and Relevance
Evaluation Question:
1. Does the FNIHCC Program continue to reflect the Government and Health Canada priorities?
Rationale
1.1 To what extent is the FNIHCC program and its components appropriate in terms of its ability to fill community needs and gaps in service provision? (program theory)
1.2 Is the FNIHCC program, it mandate, and its components culturally appropriate and aligned with First Nations and Inuit values?
Relevance
1.3 To what extent are FNIHCC services still relevant in terms of community needs for home care services?
1.4 To what extent are FNIHCC services still relevant in terms of gaps in community home care service provision? Do other programs delivery similar services?
1.5 To what extent are the six objectives and mandate of FNIHCC still relevant?
Design and Delivery
Evaluation Question:
2. Has the FNIHCC Program been implemented and delivered?
Design
2.1 Are the activities and outputs consistent with the mandate of the program?
2.2 Are the activities and outputs plausibly linked to objectives and intended outcomes? (program logic)
Delivery
2.3 Is the delivery of the program consistent with its planned roll-out and implementation?
2.4 Is the delivery of the program effective in meeting clients' needs

Success
Evaluation Question:
3. Is the FNIHCC Program achieving the outcomes expected (design and delivery outcomes, individual and community outcomes, policy outcomes)?
Design and Delivery Success
How is the FNIHCC program being implemented and delivered?
How is risk being managed? What are the outcomes?
Are FNIHCC administrators enabled to monitor and manage the program? What are the enablers and what are the obstacles?
Is the performance measurement system generating valid and reliable results?
3.5 Has awareness of FNIHCC service users and community leaders increased in terms of: • Types of services available • Community needs (based on assessments) • Match between community needs and services provided.
3.6 Has the capacity to administer and deliver FNIHCC increased in terms of: • Health human resources (number and qualifications of staff) • Recruitment and retention of staff • Service delivery models (types of staff, collaboration, care continuity, etc.) • Physical resources (facilities, equipment, technologies, etc.)
3.7 Has program delivery been consistent with First Nations and Inuit culture and values?
Individual and Community Outcomes Success
3.8 Has access to FNIHCC essential and support services increased for First Nations and Inuit clients? (e.g., number of admissions, separations, active cases per 1000, service hours per 1000, etc.)
3.9 Have there been any confounding factors affecting access? (e.g. cultural, health resource, care appropriateness, patient and provider safety, timeliness, understanding)
3.10 Have client health outcomes increased since the implementation of FNIHCC? * • Was health deterioration prevented or delayed? • Was onset of complications reduced? • Have clients been satisfied with services received?
3.11 Have health system outcome improved since the implementation of FNIHCC? ** • Have care workers been satisfied with care provided, and conditions of employment? • Have services provided substituted care that would otherwise need to be • provided in hospital or long term care settings? • Has the program maintained people safely in their home communities?
3.12 Have community ties been strengthened in their capacity to care for own clients?
3.13 Have there been any unintended positive or negative consequences?

Policy Outcomes Success

3.14 To what extent did the FNIHCC program contribute to the overall FNIHB mandate?

3.15 Did the FNIHCC promote linkages with other programs, or branches of FNIHB?

- Integration of home care services with primary and acute care provision,
- Number of partnerships and number of MoUs with other orders of government and health care authorities and providers.

3.16 What are the strengths of the FNIHCC program? What are its shortcomings?

3.17 In what manner, and to what extent, does the program complement, duplicate, overlap, or work at cross purposes with other programs?

Efficiency

Evaluation Question:

4. How cost-effective is the FNIHCC Program?

4.1 Could other programs delivery the same services at lower cost?

- What are the current costs of specific essential and support services delivered through FNIHCC?
- What would be the costs of these services if provided through hospitals or long term care facilities?

4.2 Could changes in the delivery system reduce costs of the FNIHCC program?

- Are all administrative steps necessary to effective delivery?
- What are the costs of staff, facilities, support services (e.g. technology) as the program is currently delivered?
- Could the delivery process be made more efficient by reducing processes, staff, or physical resources?

* While these questions were included in the evaluation team's original proposal, this information was not collected based on direction received from Health Canada – ideally clients and service providers and other community members should be surveyed to collect this data (see Study Limitations in following section).

** These should also be asked of service providers, who were not part of this survey (see Study Limitations).

1.3.4 Timeframe for the Evaluation Study

The original proposal for this evaluation was submitted by Donna Cona and North South Group on March 14, 2007 and included a supplemental component to survey providers and users of the Program. The evaluation team began work on the evaluation in July, 2007.

Problems in accessing the eSDRT data seriously affected the Project timeframe; these are detailed in the limitations section. These problems affected project timelines, and caused significant delays in the completion of the work.

The draft final report was submitted March 15, 2009.

1.4 Evaluation Design

The evaluation process was structured in a series of integrated and progressive components designed to build and complement each other.

An overview of the documentation provided by the client authority was conducted and key documents reviewed so as to provide the research team with an understanding of the goals, objectives, history and context of FNIHCC. As a result of this review, issues were identified and were used as a basis for the Key Informant interviews. Other important documents were also identified and provided to the research team for the detailed Documentation Review. The key and emergent issues obtained from this first round of interviews led to the design of Key Representative Interviews/Survey.

Several options were proposed to the client authority to collect user and provider data, as required by standard summative evaluation methods. After several discussions, it was decided that primary user and provider data collection would not be approved; however, a supplementary study which would examine client outcomes of the home care program through a review of accredited programs was agreed to by Client Authority.

As eSDRT and administrative program data became available to the research team, the final component of the evaluation involved the analysis of this data as part of the efficiency/cost-effectiveness component of the evaluation.

All findings were compiled, analysed, and a final report, including recommendations, prepared and submitted.

2. METHODOLOGY

2.1 Data Collection Methods

The evaluation team undertook a process which involved complementary research streams to access and analyze information on this program. Multiple lines of inquiry were used, concurrently, to provide for a variety of perspectives which will assist decision-makers to better understand the performance and achievements of FNIHCC[2].

The lines of inquiry designed and utilized by the research team were the following:

[2] Analysis of eSDRT and program data involved provisions for the protection of private patient and community identifying information as described in Section 2.1.4. Surveys were limited to program managers and key stakeholders and did not entail client nor service providers. Confidentiality protocols were established as described in the interview guides.

2.1.1 Telephone Interviews with Key Informants

A list of 10 key First Nations and Inuit Health Branch (FNIHB) Regional and HQ program management representatives was provided to the evaluation team. An interview guide was developed for the first session of consultations, with the assistance of the Client Authority. During the course of the interviews, additional potential key informants within the organization were identified. A total of 18 potential Key Informants were contacted with 14 interviews conducted. The Key Informants were interviewed in person in the National Capital Region (NCR), and via the telephone outside the NCR. Most interviews were on average 60 minutes in length, with one being 20 minutes (due to being in an acting position with limited experience with the program), some being 90 minutes in length, and one taking place over a two hour period.

Key themes emerged which assisted in the design of the Key Representative Interview/Survey (see 2.2.3).

The findings of this initial round of interviews were included as a data source for this evaluation.

2.1.2 Detailed Document and File Review

A thorough and critical examination of program documentation was conducted, to assess the extent to which specific evaluation questions had been addressed and answered to date. The types of documents that were reviewed included:

- Selected academic literature concerning provision of home care services to Aboriginal populations; literature on home care policy and programs in Canada;
- Program documentation 1 (policy documentation on FNIHCC);
- Program documentation 2 (program documents, funding, workplan, minutes, needs assessments, consultations with communities, implementation records, service information, monitoring records, evaluation records) ;
- Documentation from other sources obtained through targeted website searches or through contacting key organisations (stakeholders, other organizations);

This review examined over 100 documents/files and served as one of the major data sources for the evaluation. This review was designed to inform the evaluators as to the exact structure, design, logic, and delivery method of the program, along with its various dimensions and complexities.

2.1.3 Key Representative Interviews/Surveys

Based on information gathered during the Key Informant interviews (2.1.1 above) a semi-structured questionnaire (survey) was developed and approved by the Client Authority.

The two main respondent groups/audiences: Health Canada HQ and Regional FNIHCC program management, and key external stakeholders; hereafter referred to as Key Representatives. This group was contacted and provided with the questionnaire either in hard copy or electronic copy via e-mail, based on the choice of the respondent. In addition, the respondents were given the opportunity to provide the information via the telephone interview and/or via e-mail. Thus information collected in this phase of the evaluation was through three possible avenues:

1. Via an in-person or telephone interview, wherein the survey was completed during that time;
2. An in-person or telephone interview was conducted to obtain some of the responses to the survey questions, with the respondent completing the remaining survey questions online and returning to the evaluation team post interview; and,
3. A short introduction to the survey was given with the respondent choosing to complete the survey online and return to the evaluation team.

In person interviews were carried out in the National Capital Region. Telephone interviews were carried out for individuals outside the area (with the exceptions of the Atlantic and Quebec Regional FNIHCC representatives who were interviewed in person). The average time taken for conducting the survey interviews was 1.25 hours with each respondent. A total of 29 individuals were contacted, of which 17 (59%) were interviewed and/or completed the questionnaire. In the case where a survey was conducted on the telephone or in person, the responses were validated with the participant in real time.

2.1.4 Analysis of existing eSDRT and Administrative Data

Two data sets were obtained in order to examine both client level and community level statistics.

Information extracted from eSDRT databases for three fiscal years, 2005-2006, 2006-2007 and 2007-2008, was obtained. For each year, this data provided details on the type and length of services administered. The client anonymous data, was further rendered anonymous by removing all communities, organizational and tribal councils names from the data set, replacing them with distinct numerical values. This enabled analysis to be done at an aggregate level, in a manner similar to that used to produce standard eSDRT reports at a regional or national level. Thus, it was impossible to identify particular individuals and communities.

The second data set was administrative data containing information at the community level regarding the level of funding according to FNIHCC, the population on which the funding is based, as well as some human resources information regarding the number of full-time equivalences that are allocated to each community (according to the FNIHCC funding formula). This data set allowed for the computation of the total budget for that community in a given year, as well as get an estimate of the human resources allocated (and in some communities deployed) to dispense the services to the patients.

The two data sets were merged, (patient and services information, and budget and human resources information) in order to be able to derive estimates of services to patients (the first data set) in terms of budget and human resources (the second data set). The approach then involved analyzing how services in FNIHCC were provided through time and across provinces.

2.1.5 Study of FNIHCC Accredited Programs

There are approximately 23 First Nations and Inuit communities which have undergone the accreditation process for their health care programs with Accreditation Canada previously called Canadian Council on Health Services Accreditation (CCHSA). Of these, 13 have had their FNIHCC programs accredited. The Methodology for this component involved a documentation review (16 documents); consultation with the regional offices; interviews with the accredited communities (health directors and leaders), as well as interviews with the surveyors/accreditors of these programs.

Thirteen (13) communities were initially approached by the Client Authority, and then by the evaluation team. Of the 13 communities, 9 agreed to take part in the study. Interview guides were developed for the communities, and sent prior to the Interviews. Interviews were conducted, and the findings were sent to the respondents for verification and validation.

To supplement these findings, the research team also identified and interviewed CCHSA surveyors of First Nations and Inuit community health care programs. Three surveyors were approached and two agreed to be interviewed.

2.2 Data Analysis

The evaluation team compiled data from all lines of enquiry (Documentation Review; Key Informant and Key Representative Interviews/Survey; eSDRT and Administrative Data; and, Study of FNIHCC Accredited Programs).

Problems were encountered in the eSDRT and administrative data – namely, upon merging the two data sets, it was noted that some communities appear in one data set and not in the other. It would seem that the anonymous numerical coding of the communities was not done uniformly across the two data sets. The data was analysed and the evolution of the services through time and location for First Nations and Inuit communities was examined. The analysis, however, did not allow for comparing FNIHCC with a program aimed at a similar population among the non-aboriginal home care providers, due to time constraints in obtaining the data.

Findings from all lines of enquiry were organized on the basis of key or emergent themes, and under the major evaluation issues and presented in this Report.

2.3 Limitations/Challenges

This summative evaluation study was affected and constrained by several major methodological and work-related limitations, which are discussed below.

Mandate of summative evaluation/absence of user and provider data

A summative evaluation measures the outcomes, results and impact of a program on its intended clients or users. To accomplish this, researchers usually obtain primary data from program clients, and from service providers, in an attempt to understand and measure the effects of the program on the user audience. As stated above, this line of evidence was not approved by the client authority. While measures were taken to obtain information from some user groups, namely, accredited communities, this data cannot be considered representative nor generalisable to all communities, and cannot be used to assess program impact or outcomes. While findings of other studies and evaluations were utilized, some of the client or provider surveys were over five years old, and do not provide a current up-to-date picture of the program.

On-going changes to the evaluation plan

The foundational documents in an evaluation are those documents which establish the mandate, scope, objectives and budget of a public program. The conduct of evaluations and audits traditionally utilize those foundational documents, such as the Results Based Management and Audit Framework, as well as the established evaluation framework, to conduct these reviews. In the case of FNIHCC, there were several anomalies. The RMAF was created three years after the launch of the program, and the evaluation framework underwent a series of changes to the required data collection and evaluation studies. In addition, the established evaluation plan was not adhered to. These on-going changes are problematic for the conduct of a summative evaluation, as the program performance cannot be assessed against a set of established objectives, standards and indicators.

Unavailability/Reliability of eSDRT and Administrative Data

The team's inability to obtain the eSDRT data, a critical component of the evaluation, delayed the analysis, and ultimately, the completion of the Evaluation Report. Having begun its work in July 2007, the evaluation team was only able to obtain the eSDRT data in January 2009, a full 18 months after the initiation of the evaluation. The serious delays in obtaining this data, and the need for extensive work in correcting and validating the data sets, establishing compatibility between eSDRT and Administrative data had major implications for the conduct of the other evaluation components, including the inability to utilize findings from the data analysis to shape the design of the key informant and key respondent surveys and the triangulation of findings.

The Evaluation Team was advised that the data is not 100% valid and reliable due to possible different regional directions for entering the data[3].

[3] Information provided by Client Authority

Difficulty of establishing "net effects" of home care program

A summative evaluation examines outcomes and successes of a program through its "net effects", which is done by comparing groups of participants with non-participants, or comparing before and after information. In the case of FNIHCC, no before baseline data had been collected, no control or comparison groups were available, and no before and after interviews were possible.

Non-differentiation of Assisted Living and FNIHCC program

As noted in several of the surveys, respondents did not readily distinguish between the services provided through FNIHCC and Assisted Living, which made deriving conclusions about the FNIHCC program's outcomes difficult.

Lack of availability of identified interviewees

The lack of availability of certain key informants and stakeholders for interviews and surveys over the course of data gathering activities limited the completeness of the evaluation. Respondents were approached on several occasions by email and telephone, but project team were unable to obtain responses nor schedule interviews, due to absences, travel and schedule conflicts.

3. FINDINGS

The findings from the available data from all lines of investigation are presented in the sections below, and organized around the overarching evaluation issues of rationale, relevance, design, delivery, outcomes/success and efficiency and have been further grouped around emergent themes. The evaluation team encountered consistency in the findings across all lines of investigation - the documentation review, the interviews, the accreditation study, making the evaluation findings reliable. Limitations have been noted above.

3.1 Rationale and Relevance

All sources of information were examined with regard to the Rationale and Relevance of FNIHCC specifically to determine if, "….the Program continues to reflect the Government of and Health Canada's priorities". The findings presented below are grouped around the rationale for FNIHCC as well as its consistency with the Government of Canada's mandate to improve First Nations and Inuit health. The relevance of the Program is examined in terms of: community need for the program; current gaps that have been identified; and, the cultural relevance of the Program.

3.1.1 Rationale

Consistency of FNIHCC Program with the Government of Canada Mandate to Improve First Nations and Inuit health.

The evaluation has confirmed that the objectives of FNIHCC continue to be consistent with the mandate and objectives of the Government of Canada (GoC) and of Health Canada. Examples of this mandate can be found in the Reports on Plans and Priorities, which are published annually. For example, the 2006-2007 submission states that:

> The objectives of Health Canada's First Nations and Inuit health program activity are improving health outcomes, ensuring the availability of and access to quality health services, and supporting greater control of the health system by First Nations and Inuit (Health Canada, 2006).

A main objective of the First Nations and Inuit Home and Community Care Program is:

> To build the capacity within First Nations and Inuit to develop and deliver comprehensive, culturally sensitive, accessible and effective home care services at a pace acceptable to the community (Health Canada website, http://www.hc-sc.gc.ca/fniah-spnia/pubs/services/_home-domicile/prog_crit/index-eng.php).

In 2005, F/P/T First Ministers and Aboriginal Leaders developed a *Blueprint on Aboriginal Health: a Ten Year Transformative Plan*, which presented an action plan to improve health services for all Aboriginal Peoples and close the gap between the health status of Aboriginal Peoples and the Canadian public. The Blueprint's vision involves "improving access and quality of health services through comprehensive, holistic and coordinated service provision by all parties to the Blueprint, and through concerted efforts on determinants of health".

The Government of Canada has committed to enhancing the sustainability of federally-funded First Nations health-related programs by investing to enhance First Nations health programs and services, and to ensuring the long-term sustainability of the First Nations health program. It has further committed to providing multi-year funding mechanisms for health-related service delivery undertaken by First Nations communities[4].

Rationale for FNIHCC

The series of studies and reports analysed in the Documentation Review provided strong justification for the rationale for and relevance of FNIHCC; these included studies and reports on First Nations and Inuit health status; health care and health services utilization; as well as, access to services and needs. Gaps in service delivery and areas of "underfunding" to First Nations and Inuit populations were brought to light. The need for home care services among First Nations and Inuit populations was articulated in several major studies and reports.

---

[4] First Ministers, Leaders of National Aboriginal Organizations, 2005. Blueprint on Aboriginal Health. A 10-Year Transformative Plan

The *First Nations Regional Longitudinal Health Survey*, undertaken during 2002/03, documented the need for home care services in First Nations communities. The report provided a national statistical overview of the home care situation in First Nations communities (NAHO, 2006A).

Because of lower life expectancy and earlier onset of chronic conditions experienced by those living on-reserve, 55 was established as the cut-off age to be classed a senior. Seniors are more than twice as likely to report themselves to be in fair or poor health, compared to their younger counterparts (41% versus 16%), and three times more likely to have a disability. Seniors are nearly twice as likely to report one or more chronic health conditions and nearly three times as likely to report two or more conditions.

The most prevalent medical conditions reported in the survey were arthritis, high blood pressure, diabetes, hearing impairment, chronic back pain, allergies, cataracts and heart disease. Seniors were more likely to report complications resulting from diabetes.

In a *Presentation to the Senate Standing Committee on Aging (2006B)*, the National Aboriginal Health Organization (NAHO) outlined the need for home care in Aboriginal communities. It demonstrated how the health status of First Nations, Inuit (and Métis) remained substantially worse than the Canadian average, according to most indicators. On-going socio-economic difficulties contributed to poor health status among Aboriginal populations; these included: critical housing shortages; high rates of unemployment; lack of access to basic health services; and, low levels of educational attainment. These factors affect both life expectancy and quality of life for seniors. The presentation also drew attention to the shortage of long-term care facilities in First Nations and Inuit communities, which meant that seniors had to be transferred out of their communities to provincial and territorial facilities to receive care.

The Aboriginal senior population is expected to triple by 2026, and NAHO argued that steps needed to be taken to address their growing health care needs. The presentation argues for more resources to be invested in FNIHCC and INAC Assisted Living programs so as to meet a growing and wider range of health needs. It is emphasized that this care should be available at the community level both in the home and in long term care facilities (NAHO, 2006C).

Findings from the both Key Informant and Key Representative groups (n=27) interviewed and surveyed for this evaluation confirmed the rationale for and importance of FNIHCC.

3.1.2 Relevance

Relevance of FNIHCC Program

The relevance of FNIHCC clearly and consistently emerged from the evaluation research through all data sources: documentation review; key representative interviews; key informant interviews; analysis of the eSDRT and administrative data. The FNIHCC programs are available to all age groups. Interviews with representatives from programs which have been accredited noted that the majority of the clients tended to be older (age 55 and over) which chronic health concerns. One respondent noted that approximately 80% of their clients were in the home care

program as a result of diabetes complications. Other, older clients have disease related issues such as renal failure, cancer, Chronic Obstructive Pulmonary Disease (COPD), arthritis and Amyotrophic Lateral Sclerosis (ALS).

Community Need for FNIHCC

The second evaluation study, required by the evaluation plan of FNIHCC, was undertaken in 2005. (Training Task Group International, 2005A). It presents a very clear description of home care and needs; and also includes demographics and epidemiological information. The authors document increasing need and greater complexity of the needs presented, with more pressures on family caregivers. The authors emphasize that the First Nations and Inuit population, aged 65 and over, will increase at a much more rapid rate than the overall population, from 24,926 in 1996 to 81,928 in 2021, an increase of 228%, with annual growth rates increasing during the same period at about 5%. Life expectancy of First Nations males is expected to increase to about 72 years by 2010, and to 79 for females.

Many of the chronic conditions and illnesses which put First Nations members at risk of requiring a continuing care service begin to appear in the 45-64 year age group. Furthermore, the prevalence of chronic disease is greater, hospitalization rates are higher, and the nature and extent of disabilities in communities is relatively unknown, despite its health implications. The four leading causes of death among First Nations population are injury and poisoning, circulatory diseases, cancers and respiratory diseases. The Aboriginal population in Canada has a higher proportionate share of the burden of physical disease and mental illness. Age-standardized all-cause mortality rates for residents of reserves averaged for the years 1979-83 were 561 per 100,000 population among men and 334.6/1000,000 population for women, compared with 340.2/100,000 among all Canadian men and 173.4/100,000 among all Canadian women (ibid.)

Specific Aboriginal populations have an increased risk of death from alcoholism, homicide, suicide and pneumonia compared with the general Canadian population. Sub-groups of Aboriginal people are at greater risk of infectious diseases, injuries, respiratory diseases, nutritional problems, including obesity, and substance abuse. The prevalence of chronic diseases in Aboriginal communities is higher than for the general Canadian population. There is reference to a “transformation” in the disease profile of the Aboriginal population in Canada during the last several decades, with a shift away from a high prevalence of infectious diseases to increasing rates of chronic diseases, and often, co-morbidities (ibid.) These statistics emphasize and confirm the need for health services, specifically services offered through FNIHCC.

The need, with respect to disabilities and mental health, is also documented in the report, as is the growing need for palliative care services. The report’s analysis of the 1991 Aboriginal Peoples Survey demonstrates that geographic location and isolation has a large impact on disparities in health status and use of physician services. The capacity of the formal health care system to address these needs is not evident. Services for Inuit and First Nations people are fewer, and there are significant gaps and barriers faced (ibid).

The authors have found a very significant need for HCC, which continues and which is expected to increase over the years. Needs for home and community care are diverse and complex. The most common needs were identified as: personal care; medication management; specific progressive condition monitoring and education; diabetic care; arthritic care; home support services; friendly visits; post hospital care; foot care; preventive care; medical equipment and supplies; and, transportation (ibid).

In summary, the needs of communities are seen to be diverse and complex, and are of a physical, mental and emotional nature. There are also broader social and health related issues that are inter-connected. Many needs are being met which had hitherto not been met. However, needs are emerging and there exist still many gaps in service. Needs are also increasing due to awareness about the program, increased capacity of communities, and the overall policy commitment to improving health and well-being in the communities.

FNIHCC is seen to have considerable potential to improve health and quality of life in the communities.

In *An Assessment of Continuing Care Requirements in First Nations and Inuit Communities Review of Literature and National Health Data Sources* (Miller and Hollander, 2006A), the authors maintain that First Nations and Inuit have not, and currently, do not benefit from Canada's health care system to the same extent as non-Aboriginals, due to fragmentation of funding for health care; constitutional issues; inadequate access to health care services; poorer health outcomes; and, different cultural and political influences.

Furthermore, there is a higher health risk associated with the remoteness of many communities from full health and social service resources and the resulting loss of traditional family and community supports. In general, chronic conditions are likely to occur two to three times more frequently among First Nations and Inuit than among the general Canadian population (conditions include arthritis, high blood pressure, asthma, stomach problems or intestinal ulcers, diabetes and heart problems). It was also highlighted that culturally appropriate health services are of the utmost importance for Aboriginal Peoples, such as: having health services provided by First Nations and Inuit personnel, and in the individuals' own language; having access to traditional health approaches as well as western medicine; and, having the support of family and community members.

All Key Informants and Key Representatives (n=27) interviewed as part of this evaluation research also underlined the strong need for home care services, and the immense health care needs of First Nations and Inuit people.

Gaps Identified in FNIHCC

The majority (16 of 17=95%) of Key Representatives interviewed/surveyed for this evaluation emphasized the many gaps in the FNIHCC program, and areas of unmet needs which continue to make demands on the resources of the system. These include "after hours care" (evenings and weekends), palliative care, mental health services, disease prevention, and respite care. References to the underfunding and to "funding shortfalls" of FNIHCC were constantly reiterated, and attention drawn to the fact that the program was not meeting community needs. The majority of respondents referred to FNIHCC as providing the "base minimum" of services.

Nine of 17 (50%) of Key Representatives interviewed/surveyed emphasized the need to integrate home care within a comprehensive continuum of continuing care as a responsibility of the Federal Government, and merging FNIHCC with the INAC Assisted Living program was suggested.

A study – *Continuing Care in First Nations and Inuit communities: Evidence from the Research* (Health Canada, 2007C) – was undertaken to gain a better understanding of needs and existing home and facility-based continuing care services in First Nations and Inuit communities.

First Nations and Inuit continuing care clients were found to be younger than clients from the general Canadian population. At all age levels, both First Nations and Inuit appear more likely to be continuing care clients than do others in the general Canadian population. The study found that current continuing care services in First Nations and Inuit communities are often provided in a fragmented fashion.

Over 95% of clients interviewed for this study indicated that they would prefer to receive continuing care services preferably in their own homes, definitely in their own communities, and usually from family members. Housing was an issue for many clients with overcrowding, poor physical state, or in some cases, isolation of clients. Much care was provided by family members, on a voluntary basis. The potential for these caregivers to experience stress and burnout is high. Families and caregivers require better access to home and community care during evenings and weekends and to respite care.

It was found that continuing care services were required to address the higher care needs, including long-term and short-term facility-based care. Supportive housing was also seen to potentially fill some of the gaps at lower levels of care. Various funding issues needed to be addressed to meet the increased demand and higher level care needs and take into account case mix, community size and location and other factors such as culture and language requirements of the client, family and community.

A study was undertaken to examine the need for expansion of the FNIHCC program to include palliative care services (Lemchuk-Favel, 2003). Palliative care is not an essential element of the FNIHCC National Framework and not specifically funded under FNIHCC nor under the community health programs. The report analyzed issues and challenges with respect to palliative care in First Nations and Inuit communities. These include health human resource issues (shortages, training and education requirements); housing problems; jurisdictional issues and

linkages with the provincial health care systems; gaps in services for First Nations and Inuit populations; diseconomies of scale associated with remoteness or isolation; cultural issues; and scarcity of data Palliative care taxes regular nursing resources, often requiring 24/7 care, which is another issue for FNIHCC.

The findings of the Lemchuk-Favel study identified a strong need for palliative care in First Nations and Inuit communities. Linkages between communities and provincial/territorial systems, which offered palliative care to First Nations and Inuit patients, varied significantly from region to region. The need for integrated and coordinated services was emphasized.

The need for mental health and addiction services and home care in First Nations and Inuit communities was presented in another report – *Home Care Considerations in the First Nations and Inuit Mental Wellness Continuum (Draft)* (Lemchuk-Favel, 2005). The case is made for better quality of care and cost effectiveness, when mental health services are offered in the home and community. Studies have shown that home-based treatment is an effective alternative to admission for many clients, and integrating mental health professionals in primary care settings can enhance continuity of care, increase access to mental health services, and lead to more effective use of mental health resources. Clients may have concurrent physical and mental health needs and be in the home care system. Currently, FNIHCC nurses are not trained to specifically care for mental health patients.

Home based services are recognized as part of the mental health system in most P/T health strategies. The need for a holistic and comprehensive approach to health care services in First Nations and Inuit communities is presented, as the mental health continuum is linked to the broad determinants of health, and needs to be integrated with other programs and services. A survey of mental health home care services was undertaken in 2003 of FNIHCC coordinators. This survey showed that most mental health needs seen by home care workers are chronic. This study has shown that an integrated approach to health services includes a home-based mental health/addictions component, building on the strengths of the community and health and social system.

In the study regarding the accreditation of First Nations and Inuit FNIHCC programs, a respondent noted that in her experience, high addiction rates and high acquired brain injury rates (either drug or alcohol induced) have led to both acute and chronic mental health issues which remain unrecognized and untreated. Suicide intervention is urgently needed. The gaps in services are much greater that what the FNIHCC programs provide and mental health services pose one of the greatest challenges to effectively deliver within FNIHCC.

Another study examined the unmet needs of children and youth (0-19) and addressed how FNIHCC might include the needs of this client group (Lucarz Simpson, 2007). When FNIHCC was introduced in 1999, the client eligibility was not limited to any specific age group, although the majority of communities targeted the services for the frail elderly population, or persons with chronic disease or disabilities. According to eSDRT data for 2005/06, 54% of the program clients were patients classified as having "chronic disease", 17% with "acute illness". According to the 2005/06 data, a total of 1917 client occurrences of children were reported. Services included: palliative care; chronic disease management and support; nursing services; case management and parental support; provision and support with medical devices; and, physical therapies.

The study found that the absence or gaps in services has required the relocation of children to institutions outside of their communities, sometimes with extended stays. Many reasons were cited for these relocations: complex care needs; lack of access to therapies in the community; IV requirements; limited FNIHCC capacity and, Non-insured Health Benefits (NIHB) policies related to transportation and existing policy guidelines related to equipment procurement were cited as systemic reasons for these relocations.

Areas of unmet needs and barriers for pediatric clients were identified by respondents. These included: weekend in-home respite services; access to physiotherapy, occupational therapy and speech language pathology services; psychological counseling; nutritional counseling and assessment; dental care; trained personal care services with infant/child care knowledge; paid medical transportation to tertiary care centres for assessment/ reassessment/follow up; intensive care support on a short term high need basis; parental support and education for children with congenital birth issues or developmental problems; access to medical respite for children with complex medical needs; specialized services for children living with endocrine diseases and blindness; access to lab services; scope of practice issues for nursing (percutaneous intravenous catheterization); access to services for mental disabilities; support for accident-related injuries; renovations to provide access for those with disabilities; medical transportation services; timely provision of medical supplies and equipment; and many others.

The report documented promising practices obtained from several communities and recommended their incorporation into FNIHCC for pediatric care.

Cultural Relevance of FNIHCC Program

Findings regarding cultural appropriateness are mixed. Among the Key Representatives interviewed/surveyed, all Health Canada personnel (10 of the 17 respondents) found the FNIHCC program culturally appropriate and aligned with First Nations and Inuit values; however half of the others interviewed felt that the program overall was not entirely culturally appropriate. These stakeholders believed that funding should be set aside for traditional healers within FNIHCC, and a greater effort made on the part of service providers to understand cultural values and to provide services in First Nations and Inuit languages, especially when services were provided outside of the communities. One key stakeholder interviewed believed that cultural appropriateness was included more "as an afterthought", and that there had never been specific cultural policies and resources applied to the mandate at program inception.

According to Accreditation Canada documentation[5], Aboriginal health care organizations choose to work with Accreditation Canada as their accrediting body because of a holistic framework that is applied to existing standards, cultural relevance, and the use of Aboriginal surveyors. One criteria used in the First Nations and Inuit Health Service Standards is that "the (health care) team uses First Nations and Inuit cultural approaches, research evidence and best practice information to develop and improve its services" and that "the team work with others by collecting and sharing information about First Nations and Inuit approaches to health and wellness". Furthermore, the First Nations and Inuit Health Service Standards also require that, "the team always assess the clients strengths abilities and needs" by assessing the clients view of their wellness, quality of life, the clients health and wellness profile including behaviors, the clients physical status, lifestyle attitudes, mental health knowledge of their condition, and relationship roles/ social situation.

3.1.3 Conclusions and Recommendations

Evaluation Question

> *"Does the FNIHCC Program continue to refle.ct Government and Health Canada priorities?"*

FNIHCC has been found to be highly consistent with the mandate and goals of the Government of Canada (GoC); and Health Canada. Although improvements have been achieved, the health status of Aboriginal Peoples in Canada continues to lag behind that of other Canadians. Findings from all sources confirm the continuing need for FNIHCC in First Nations and Inuit communities.

Interviews and research findings strongly support the rationale for FNIHCC as a key component of the Government of Canada mandate with respect to improving First Nations and Inuit health. Health needs have been clearly documented in the research, and FNIHCC is designed to respond to these identified needs. However, findings identified significant gaps and further unmet needs for home and community care in First Nations and Inuit communities, as well as fragmentation in service delivery. Some respondents identified the need to continue to ensure that FNIHCC is culturally relevant and responds to the needs of the clients.

It is strongly recommended that FNIHCC continue and be strengthened. Evaluation findings clearly confirm and endorse the continued rationale of the FNIHCC program, as assisting in addressing the health needs of First Nations and Inuit people, and of closing the health service delivery gap.

[5] Accreditation Canada Telling Our Own Story (Video Clip) 2008 www.cchsa.ca

It is recommended that the highest priority be given to providing all essential components of FNIHCC in all communities. After establishing essential services elements, FNIHCC should consider the feasibility of addressing areas of unmet health needs and services gaps including mental health services, palliative/end of life care, rehabilitative care and respite care including the introduction of specialized training for service providers in this area.

It is recommended that closer linkages of FNIHCC with regional health authorities, other health care providers, medical services and health institutions be explored and encouraged, so as to provide more integrated and coordinated care to clients.

Policy makers should clearly establish the parameters and linkages among of the various health programs available (Home and Community Care, Primary Health Care, Public Health/Community Health Nursing, Addiction Services, to name a few) to determine where services, such as Mental Health Services, should be located so that health service gaps are addressed.

Generally FNIHCC has been found to be culturally relevant in its approach, although efforts should be made to further align the program with holistic and traditional approaches.

3.2 Design and Delivery

Design and delivery issues examine the roles and responsibilities for the administration of FNIHCC, its operations, and funding instruments to determine if "…the FNIHCC Program (has been) implemented and delivered". The findings from all lines of investigation and all data sources around design and delivery issues have been grouped around key thematic areas as follows:

- FNIHCC performance management system;
- FNIHCC funding formula and allocation process;
- Implementation process;
- Implementation challenges;
- Implementation issues;
- Alternative service delivery models;
- Second level support for home care; and
- Areas of need.

FNIHCC Performance Management System

The original FNIHCC commitments involved the development of a Performance Reporting Framework by March 31, 2000, a program wide performance indicator table, and FNIHCC modules for First Nations and Inuit Health Information System (FNIHIS), and Evaluation Framework by April 30, 2000, as well as an evaluation to be completed by March 31, 2005. As of April 1, 2001, the commitments to the Performance Reporting Framework, Performance

Indicator Table and Evaluation Framework had not been met. Timelines for the development of FNIHIS were delayed, and the FNIHCC modules for the information system could not be developed.

Critical evaluation issues emerged for this evaluation team in association with the review of these foundational documents, including the RMAF being developed three years after the program launch, as well as significant changes to the evaluation plan. In accordance with the RMAF, ongoing data collection was to include: annual reports and plans; eSDRT; biannual surveys of FNIHCC clients, care providers and administrators. However, changes to the RMAF reporting requirements were noted by the evaluation team. These involved: only one annual report was produced, in 2002/03; only one Biannual Report was produced, in 2000-02; and, Study 3, which was to examine if FNIHCC met the needs of First Nations and Inuit, was not undertaken as planned.

FNIHCC Funding Formula and Allocation Process

FNIHCC was phased in over a three year period. The original program commitment was to support planning and program development, as well as training and capital equipment/renovations in the first several years of the program and a phased in approach was adopted. The first year (1999/2000), or Phase I, focused on community development and awareness of the Program as well as planning and development of the delivery model with limited staffing and training activities. Planning was carried out at the national, regional and community level. The budget for Phase I was $17M.

The second year (2000/2001), or Phase II, focused on establishing a management infrastructure, which included setting standards, policies and quality assurance guidelines. Training programs were developed and initiated for professional and paraprofessional staff and the delivery of non-complex nursing and personal care services begun. Capital expenditures for renovations were also included in Phase II. The budget for Phase II was $45M.

The third and final year of this phased-in approach (Phase III, FY 2001/02) involved delivery of the full range of essential services to all communities identified for the Program. The bulk of the funding for Phase III was for program delivery, with continued training and capital expenditures, as needed. The budget for Phase III, and on-going years, was $90M.

The following table presents an overview of the budget allocation for the first three year start up stage for FNIHCC, as well as proposed allocations for ongoing implementation.

Table 3
FNIHCC Funding Distribution by Year, Total Budget Dollars and Program Component

Planned funding ($millions)						
	Vote 1, Operating	Vote 5, Contributions				Total Planned
		Program Planning	Program Service Delivery	Training	Capital	
1999-2000	2.74	12.65		1.62		17.00
2000-2001	3.37	8.35	14.38	5.40	13.50	45.00
2001-2002	3.98		66.02	5.50	14.50	90.00
2002-2003	3.08		86.92			90.00
2003-2004	3.08		86.92			90.00
2004-2005	3.08		86.92			90.00
2005-2006	3.08		86.92			90.00
2006-2007	3.08		86.92			90.00
2007-2008	3.08		86.92			90.00

Actual funding ($millions)						
	Vote 1, Operating	Vote 5, Contributions				Total Actual
		Program Planning	Program Service Delivery	Training	Capital	
1999-2000	0.28	4.73	0.18	0.40	1.79	7.38
2000-2001	2.27		31.06			33.34
2001-2002	2.56		67.23			69.79
2002-2003	3.79		81.43			85.21
2003-2004	3.93	9.43	76.05	0.83	0.22	90.45
2004-2005	3.82		90.60			94.42
2005-2006	3.48		89.52			93.01
2006-2007	5.01		91.77			96.78
2007-2008	4.23		93.30			97.53

All program planning and service delivery funding is allocated to the regions, which in turn, distribute funding through contribution agreements to communities or Tribal Councils.

Capital expenditures are managed regionally. One of the respondents interviewed with respect to the accreditation of FNIHCC programs indicated that the process of becoming accredited identified the need to put more resources into administration and reporting, as opposed to capital expenditures. Two respondents, however, indicated that becoming accredited had identified the need for more capital expenditures; e.g. clinic materials/consumables that had to be renewed.

Funding is based on a formula which calculates the projected workload for the delivery of services to each community. The initial formula was a combination of two other models, and was based on the principles of flexibility; sustainability; integration and linkages; accountability and accessibility. The formula calculates the cost of direct program service delivery for four levels of service providers based on the projected workload as well as for operating costs and an adjustment for remoteness for each Home and Community Care Program.

It was intended that the funding formula would be planned-based and needs-based without duplicating existing programs and services. Recognizing these principles, the factors or indicators used in the formula could then be adjusted after community needs assessments were completed and information on actual client care needs were made available. In actual fact, however, the projected workload or indicators in the funding formula, namely, the percentage of the population that would require the services, and the client hours required to deliver that service, were simply adopted or modified from available research data on demographics and morbidity for the entire First Nations and Inuit population (e.g., First Nations and Inuit Regional Health Survey and Saskatchewan utilization figures).

The funding formula that is used to calculate the amount allocated to each community is the sum of the total *Direct Program Service Costs; Operation Costs* calculated as a proportion of Direct Program Service Costs[6]; and, an *Adjustment for Remoteness* calculated as a proportion of Operation Costs.

An underlying assumption of the formula is that a viable comprehensive program requires a minimum population of 1000 (with an estimated caseload of 100). While the total resources available for the Region are calculated based on all communities, regardless of size, the original program commitment recognized that smaller communities would need to pool resources with other communities or other funding sources in order to provide comprehensive services to their population. Coordination of home and community care services with existing services is an expectation of the program, as stated in the program documentation.

Current Funding Situation and Participating Communities

This formula, as applied in the initial phasing in of the Program, is still being applied today. While the formula supports movement towards a needs-based approach, where actual care requirements can be used in the calculation, this has not been implemented to date. The

[6] Based on a modified formula used by 'Transfer'

allocation of funds to the regions and communities is still based on: a 1997 community population base; 1999 health survey statistics for the portion of the population requiring a service; and, an 'adjusted hours' per service set to be inline with the 1999 FNIHCC Program Documentation.

The only adjustments to the budget for the FNIHCC program have been a 13% top up for nursing granted in FY 2005/06, with an 11% increase being implemented in 2005/06 and the balance in 2006/07. This nursing top up was calculated based on the type of community, with the more remote communities (Types 1 and 2) receiving an additional $10,920 per FTE nurse as reported in the community in 2004, and Types 3 and 4 communities receiving an additional $9,230.

In FY2007/08 and again in FY2008/09, an overall 3% increase in Direct Service Costs was approved.

The following table provides an overview of the FNHCC program status as of February, 2007. The budget allocations per Region in the first year the program was in full operation (FY2001/02), as well as for the last fiscal year (FY2007/08), have been added for comparison.

Table 4
FNHCC Program Status (2007) [7]

Region	#First Nations Communities		# Inuit Settlements		Budget ($)	
	Eligible	Funded	Eligible	Funded	2001/02	2007/08
Pacific	204	200			12,073,958	13,329,336
Alberta	58	57			11,197,649	12,252,121
Saskatchewan	84	83			9,651,519	11,351,784
Manitoba	62	62			13,769,660	14,803,601
Ontario	124	119			14,894,903	16,422,451
Quebec	38	37	14	14	11,406,161	11,867,383
Atlantic	34	34	6	6	4,798,836	4,465,521
Northern Sec.						
Nunavut	0	0	27	27	4,816,151	5,049,259
NWT	27	27	6	6	4,741,498	3,531,454
Yukon	14	14			2,335,141	1,644,404
Total	645	633 (98%)	53	53 (100%)	89,685,496	94,717,316

[7] Health Canada Internal Document 2006/07 Overview of NFIHCC Program Development Status

Implementation Process

At the time of the release of Biannual Report for 2000-02, it was stated that: 667 of 697 communities were funded for program development activities; 87% had completed their program needs assessments; and, 80% had submitted service delivery plans. In general, 51% of eligible communities had access to services, reaching more than 63% of First Nations (282,000 individuals were receiving services in their communities). Among eligible Inuit communities, 34 of 54 had service delivery.

A National steering committee was set up in 2000/01 to approve the workplan developed by FNIHB, Assembly of First Nations (AFN) and Inuit Tapiriit Kanatami (ITK). Program phases were to include:

- Needs assessment;
- Service delivery plan;
- Policies and procedures/preparation to deliver; and,
- Full service delivery.

It was reported in the Biannual Report that the funding formula was modified because some communities were stalled in their needs assessment phase, so as to encourage them to reach service delivery phase[8]. Peer review processes, and training sessions were set up, for the purpose of building capacity in the communities at the second level.

Regional capital plans were developed, with specialists assigned to work with the regions and communities; a capital planning handbook produced, and regional presentations made. Resources were prepared for the FNIHCC communities: a Planning Resource Kit, as well as the following resources:

- Getting started;
- Needs assessment;
- Service delivery plan;
- Capital plan;
- Training plan;
- Preparation activities; and,
- Program services delivery.

[8] The evaluation team found no evidence to substantiate this statement.

Also, presentations were made regarding liability issues, FNIHCC standards, templates, and procedures. Program linkages were established, notably, with NIHB for access to medical supplies and equipment; allowing home care nurses to authorize purchase and payment of equipment and supplies. A relationship was also established with the Office of Nursing Services (ONS), and Human Resources and Skills Development Canada (HRSDC) previously called Human Resources Development Canada (HRDC) with respect to home care labour sector studies which were undertaken; and with INAC, concerning the Assisted Living Program. A continuing care framework was to be developed, in response to gaps which had been identified in several studies.

Palliative care/end of life care was examined by a Senate Committee, and a national action plan on palliative/end of life care was to be developed. Linkages with the FNIHCC were made and NAHO was mandated to develop a Palliative Care for Aboriginal Peoples discussion paper. This paper concluded that there was a serious lack of available data on needs of Aboriginal Peoples regarding palliative/end of life care.

St. Elizabeth Health Care, a private Not-For-Profit health organization in Ontario, was contracted to develop generic standards and policies for use by First Nations and Inuit communities.

The Biannual Report also states that relationships were also established with P/T Departments of Health.

A National Program Monitoring and Tracking Tool (2000/01 Tracking Tool) was set up in the form of a spreadsheet, and was intended to provide a standardized means of observing program results and measuring progress on a regional and national basis. In addition, a Service Delivery Reporting Template was rolled out to the regions and communities in 2002/03 which was designed to help them meet reporting requirements. Also, a Case Assessment and Management Tool was under development during that first year. Reference was made in the documentation reviewed as well as through Respondent interviews to the administrative burdens of reporting and utility of the data collection fields.

Addressing FNIHCC Implementation Challenges

The Delivery of the First Nations and Inuit Home and Community Care Program in Small and Remote Communities: A Review of Issues and Challenges (Adrian Gibbons and Associates, 2003) examined challenges to the FNIHCC program. At the time of the report, 60% of eligible communities were delivering FNIHCC. A challenge which emerged was the operation of viable and sustainable home and community care programs in small isolated First Nations and Inuit communities.

Communities across the country differed significantly in characteristics: size; location; accessibility; community infrastructure and capacity; jurisdictional arrangements; historical factors; and, in their potential for linkages and partnerships with neighbouring communities, tribal councils or second/third party First Nations service organisations, or with P/T governments. It was felt that standardized and universal policies were unable to take this

variation into account. In addition, some regions had a larger number of small and remote communities in their area, and, as such, required different resource algorithms.

The Gibbons and Associates (2003) report conducted an assessment and analysis related to service accessibility, delivery, quality and sustainability issues in these small and isolated communities. Major challenges identified by the study centered around health human resources issues: namely, recruitment and retention of FNIHCC personnel; the casualisation and marginalization of home support workers; lack of funding for training requirements; the limited funding based for small communities (below the critical resource threshold); the demands on human resources of planning, implementation, and reporting (including on-going issues with the reporting system); the lack of a small capital items replacement reserve fund; lack of funding for second-level services; and, higher transportation and shipping costs for remote communities. Multi-jurisdictional funding and lack of integration with the INAC Assisted Living program were also cited as a problem area at a systemic level.

The authors noted cost effective features used by some FNIHCC program managers, which included the integration of home care with other community services, such as: health and social services; providing strong pre-service training programs; and, pooling of resources to achieve economies of scale.

Recommendations which emerged from this study suggested ways of better addressing the needs of small communities. These involved: adjusting the funding base, to introduce a per community/per capita approach, with a provision for special needs and circumstances (a formula is provided in the report); integrating FNIHCC funding with transfer/integrated funding so as to increase program delivery flexibility; providing resources for professional development and on-going training (staff turnover was a problem); providing a small capital items replacement fund; and, providing more support to small communities with planning, implementation and operations. The continued used of tele-health and tele-medicine was identified as an innovative practice.

Larger, system-wide recommendations addressed the possible integration of FNIHCC with Health Transfer; INAC and Health Canada integration of funding; facilitating FNIHCC service networks (single source contact for information on services and supports; improving accessibility).

Support requested by small communities from FNIHB included: nursing consultation; adequate funding for operations, training and capital components; planning assistance; facilitating networking; and, facilitating bulk purchasing of supplies. The report also brought to light the importance of Aboriginal post-secondary training institutions to provide the Health Human Resources (HHR) for the health programs, including home care.

The importance of building capacity and service infrastructure is noted in the report: “Much of the success of First Nations and Inuit community health development over the past fifteen years has been due to the development of “foundational” health management and service infrastructure. This has provided First Nations and Inuit communities with the local authority and capacity to plan and operate community health services based on their own self-defined needs

and goals. [it has been noted] that the level of existing health and social service infrastructure and the participation of the community in health transfer were strongly associated with the successful planning and implementation of effective FNIHCC services".

The first of the three mandated evaluation studies was undertaken in 2004. *First Nations and Inuit Home and Community Care Program (FNIHCCP) Study 1, "Foundations for Success"* (Prairie Research Associates, 2004B), was a formative evaluation, which focused on the implementation process. The evaluation notes that FNIHCC had a unique, structured approach to program planning and development; and it took a collaborative approach to program implementation by involving all stakeholders in the design and planning process. A National Steering Committee was established, with representation from AFN, ITK, Health Canada and INAC. Tribal Councils and P/T organizations were also involved in planning and development.

The report relates how FNIHCC required all communities to complete a multi-stage program planning process (include community needs assessment, a service delivery plan, training plan and capital plan). With the exception of the Northern Region, for Nunavut and Northwest Territories (NWT), Health Canada (HC) regional offices were the primary point of contact and resource for communities during the planning stage. The report describes all of the program components and the three-phased roll-out of funding to the regions and communities.

HCC was managed through contribution agreements, and was founded on the principle of community-based planning and implementation. It also integrated the components of: needs assessment; service delivery and implementation plan; service delivery plan; training plan; capital plan and implementation schedule; regional review process; and, peer review process. Standards, policies, scope of practice, training were put into place to support the program. FNIHCC governance involved four levels of management: community; multi-community; regional/provincial/territorial; and, national. The National Steering Committee, the multi-partner oversight group, was in place for three years, and then disbanded.

Issues which emerged from the evaluation findings were: problems with planning and the implementation process, including community capacity issues, recruitment and retention of staff; training; difficulty with the planning process and timelines; and, missed opportunities to access funds for training and capital development. Communities reported that the availability of the planning resource kit for communities, the implementation schedule, and funding allocation process all took place over a very short time period. There were requests for more flexible approaches to funding. Communities also questioned why they were to conduct time-consuming needs analyses, if the funding formula was population based. The needs assessment created unrealistic expectations for some communities. Recruitment and retention of professionals were critical challenges cited by most respondents. Reference was also made to political challenges in the implementation process.

Communities generally valued the sense of community autonomy and management which FNIHCC afforded them. Larger communities, and transferred communities had more facility with planning, while small, remote and isolated communities were negatively impacted by the implementation process and funding formula.

The study provided data on implementation (by the end of Phase 3 - 2002/03), showing that 96% of eligible communities were funded, while 78% of eligible communities and 88% of eligible population had access to full service delivery. NWT, Prairie Provinces, Québec and Nunavut had achieved the most extensive coverage, while Ontario, British Columbia, the Atlantic region and the Yukon required additional time to fully implement the program. All communities in full service delivery had all essential service elements in place. However, the level of service varied significantly among communities.

The evaluation identified gaps in home care services to the communities; these were palliative care, rehabilitative care, respite care and mental health services.

The evaluation also identified problems with the data reporting system: it found that regional compliance was inconsistent with respect to the National Tracking Tool, as was reporting on the e-SRDT. The study refers to unreliability of reporting tools and frequent modifications made by Health Canada to the system.

In response to Study 1, FNIHCC national program managers developed measures to address the recommendations. *First Nations and Inuit Home and Community Care Program (FNIHCCP) Study 1, "Foundations for Success" Summary Report: Action Plan* (Prairie Research Associates, 2004E). These involved demonstration projects designed to address program implementation barriers, especially as these related to small communities. FNIHCC also assessed the training needs of community programs and committed to identify partnerships for ongoing training and capital development needs. It was also decided to undertake a survey of service providers to assess second and third level functions. FNIHCC undertook to provide reports for the communities, but this deliverable has not been completed, due to upgrades in the system.

These challenges to effective and universal implementation were also reiterated by Key Representatives and Key Informants, and supported the findings of the studies listed above.

On-going Implementation Issues

Half of Key Representatives (9 of 17) emphasized the significant differences which could be found among northern and/or remote communities, as compared with those in urban and/or southern locations. One respondent indicated that some communities in the south had First Nations and Inuit patient advocates for those needing hospitalization; however, that was not the case in the north. Implementation has rolled out differently, and at different paces in the various communities. Again, significant gaps in services were pointed out, and it was emphasized that the program should be expanded to include services such as palliative care, mental health, working with children with health challenges, such as Fetal Alcohol Spectrum Disorder (FASD), Attention Deficit Disorder/Attention Deficit/Hyperactivity Disorder (ADD/ADHD), and also, providing disease prevention programs. One of the stakeholder respondents indicated that his jurisdiction had expanded their FNIHCC program to provide services identified as secondary services, specifically, occupational therapy, physical therapy and palliative care. Two respondents (n=17) expressly stated that the program needed to move beyond essential services, with an associated increase in funding levels.

In-home respite care was identified by 85% (n=17) of the Key Representatives interviewed/surveyed as being in demand. However, this service is difficult to provide, due to funding and capacity (staffing) restrictions. The lack of respite and palliative care represented the most frequently cited gap in terms of FNIHCC program delivery.

In 2006, AFN commissioned a study to examine barriers and challenges preventing communities from accessing the FNIHCC service - *First Nations and Inuit Home and Community Care Project* (Boult, 2006). Communities experiencing difficulty tended to be small, remote, mostly in British Columbia and Ontario. Program documentation stated that FNIHCC was to be developed and established in all First Nations and Inuit communities with identified needs by FY 2002/03 and for communities which had established "mature programs", the program was transferable to community control after the successful completion of Phase 3.

By 2006, FNIHCC provided some home care assistance in almost all First Nations and Inuit communities. The vast majority of First Nations communities across Canada (684 out of 698 or 98%) had received funding for program development activities under FNIHCC. A total of 632 or 92 % of eligible communities, or 95% of eligible on-reserve population, has access to some FNIHCC services. However, challenges remained.

The author referred to previous evaluations and studies which had described challenges and barriers affecting both the establishment of the program and the achievement of FNIHCC across Canada. The most common challenges were human resource issues, including training and staffing, inadequate funding, planning and implementation challenges and issues related to supply and equipment purchases. The findings from the consultation process conducted for this evaluation revealed a significant convergence with previous findings.

All communities indicated that the primary barrier to accessing FNIHCC was the low level of funding; many respondents stressed that funding for such programs should not be on a per capita basis, as this effectively prevented many small communities from gaining sufficient funding to provide even the most basic services. Funding was considered to be insufficient by most respondents, who would need to access other sources, such as Tribal Councils. The funding formula did not adequately take into account the higher costs of working in the small and remote communities. Costs of recruiting health care staff, the need to compensate staff for driving long distances, higher cost of equipment purchases and higher training costs, all needed to be taken into account.

Human resource capacity was considered to be a critical component in communities not accessing the FNIHCC. Hiring and retention of nursing staff and home care staff were on-going concerns, as funding was insufficient to hire full time home care providers (part time position would result in high turnover of staff). It was suggested that many communities were not well versed in Human Resources (HR) legislation and labour practices.

Respondents also claimed that training programs needed to be targeted to literacy levels of potential personal care workers. Training needs and costs were stated to be greater for smaller communities, and additional costs included travel expenses of trainers coming into the community.

These administrative burdens of FNIHCC were deemed to be very demanding. Onerous amount of planning were required: Phase 1 required a detailed planning process including conducting a community needs assessment, developing service delivery, capital and training plans, activities for program delivery, and staffing training and infrastructure planning. The level of reporting and data collection required for the program were described as "heavy". The "one size fits all format" was seen to place unreasonable burden on smaller communities, which lacked sufficient capacity at the community level, to undertaken all of these requirements.

Linkages with other home care programs in the region were difficult due to higher costs associated with extending the service to smaller/more remote communities.

The study proposed options to effectively address barriers, such as adjustments to the funding formula to better reflect the needs and realities of small and remote First Nations communities. The authors proposed a base funding formula, with per capita top up, as a more viable model. Funding base levels should be sufficient to enable communities to cost share a FNIHCC coordinator with support from a Registered Nurse (RN). Furthermore, a specific budgetary allocation should allow regions to access funding for more focused assistance. Enhanced communications and support from regional FNIHB offices is called for, as is the consideration of increased on-line training.

In an effort to understand and address the human resources issues raised in the preceding studies and reports, an examination of labour market issues as related to FNIHCC was undertaken. This study, *Human Resources in Continuing Care in First Nations and Inuit Communities* (Health Canada, 2006A), also set out to examine how to address the mismatch between supply and demand. The study examined health human resource issues and challenges specific to First Nations and Inuit communities associated with the provision of continuing care services. Eight general issues emerged from this analysis, these concerned: wage disparity, skills and training, funding and jurisdictional issues, organisation/administration, recruitment, retention, labour market and culture and expanded services.

The study concluded that wage disparity was a critical issue, essential to the continuity of FNIHCC service delivery. Skills development and training were also seen to have a significant impact upon recruitment and retention. The study also urged that skills training and development be based on First Nations and Inuit models, culture and language so as to respond more specifically to the needs of client groups.

In the interviews regarding the accreditation of First Nations and Inuit FNIHCC programs, human resource issues were identified as being a limiting factor in the accreditation process. Trying to find the time and human resources needed to complete the various tasks required to becoming accredited was considered to be the biggest challenge to the process by all surveyed. One respondent noted that if you have to pull frontline staff off their regular tasks to work on accreditation processes, client services are not covered which led to the question, "how do you weigh the client services needs against quality improvements?" It was noted that Home Care has daily routines and needs that cannot wait for another day.

The key challenges to delivering FNIHCC identified were primarily staffing issues and funding. Several respondents noted that recruiting and retaining staff is a problem, which is compounded by the fact that the Province pays several dollars an hour more for the same work. While funding had been provided for training during the initial stages of setting up the program, many of these trained staff have left their positions and the funding is no longer available to train new staff. It was noted by one respondent that to build strong consistent programs, you need stable leadership. Another key challenge noted was the growing need for evening and weekend care which becomes a funding/financial issue due to overtime pay associated with these hours due to labour standards.

Nursing care was identified as the most challenging service to deliver in FNIHCC with the growing complexity of the procedures required of nursing care. One respondent noted that mental health services pose the greatest challenge to deliver effectively. Social/community problems such as drug and alcohol use in the family leads to safety concerns for staff going into the home and becomes a barrier to delivering needed nursing services.

Examining Alternative Service Delivery Models

Pilot projects were set up, with the objective of facilitating and expediting access to medical supplies for FNIHCC clients in two regions, Alberta and Atlantic. The established process in all communities with FNIHCC is that home care medical supplies (such as dressings, syringes, needles), not covered by a provincial health or other health care plan, are ordered through a physician prescription, and obtained through providers such as pharmacies. The cost is covered by the Non-Insured Health Benefits (NIHB) Program, and providers are reimbursed through First Canadian Health, with no direct charges to the client.

The major issues addressed by these pilot projects were nurses' time to contact and obtain prescriptions for supplies needed by clients, and if these were not locally available, to order these supplies from larger centres, also a time concern for patients requiring them. Cost was also an issue, in that mark-ups ranged from 40-66% of cost. The pilots were intended to address these issues, and further, to build nursing capacity as well. Pilot project activity took place from April 2003 to September 2004. These projects were evaluated in 2005 (Barron, 2005).

The role of NIHB Directorate is to cover medically necessary health goods and services not covered by other F/P/T/ parties, such as drugs, medical transport, dental care, vision care, medical supplies and equipment, crisis intervention, mental health, and other services. For this Pilot, FNIHCC and NIHB programs collaborated. FNIHCC nurses were assigned a prescriber number, so that they could order supplies needed from Drug Distribution Centres (DDC) through NIHB. This enabled centralized ordering and delivery for the pilot sites, as well as lower mark-ups on supplies.

The evaluation examined the pilot projects, along the following lines of investigation: determination of client outcomes (was access effective; was access timely; was care timely; were supplies appropriate; has access improved); effective use of health professionals (effect on workload; effect on case management); satisfactory process for users (client satisfaction; FNIHCC personnel satisfaction; management personnel satisfaction – NIHB/DDC/HQ);

effectiveness of process (effective use of medical supplies; success/problems in implementation; successes/problems in integration); cost-effectiveness of trial method (changes in costs, if any; are costs acceptable, sustainable).

Results of the survey were generally positive for clients and nurses. Clients were able to receive the care they needed, with the appropriate supplies, in the time that it was required. Nurses found the process flexible and user-friendly, and although the workload was higher at the beginning of the process, in order to learn how to use the new system, over time their workload evened out. Respondents at all levels were overwhelmingly in support of the process and expressed satisfaction with the process and the outcomes. Determining cost-effectiveness of the pilot project was not possible due to the changing nature of medical conditions of FNIHCC clients. However, the evaluation concluded that the unit cost of the supplies used during the pilot had decreased.

It was recommended that this system be rolled out to the other regions, that equipment also be included in this process and that an electronic ordering system be established.
Another demonstration project involved remote education and support for FNIHCC providers. Ensuring access for health care providers to affordable, on-going clinical support and education was especially challenging when facing barriers such as geography, climate, distances and Health Human Resource shortages. These challenges were particularly daunting for providers of health care services to patients in rural and remote First Nations communities. A demonstration project was conducted in Manitoba with health care providers, managers and administrators from First Nations communities through an interactive web-based e-learning application developed by Saint Elisabeth Health Care, called "@ Your Side Colleague" (@YSC). The project involved 35 First Nations communities.

With more First Nations communities establishing internet connectivity, web-based access to support and education were seen as viable alternative to traditional face to face access. The project included training materials, plans and manuals, as well as the development of an evaluation framework. Training sessions were conducted. Program components included: e-learning modules; virtual library resource centre; interactive exchange area for consultation, knowledge sharing; private messaging function; and, e-learning management systems. As such, the project provided remote access to a range of knowledge and resources at the clinical, program development, operational, management and evaluation levels.

An external evaluation was conducted in June 2004 - *Remote Education and Support of Health Care Providers: a Demonstration Project with First Nations of Manitoba* (Atack, 2004). The evaluation revealed that the majority of participants had a very satisfactory learning experience, and benefited from using @YSC. The main benefits which were highlighted included rapid 24/7 availability of information and resources for clinical and program management as well as, on-going convenient access to up to date information on best practices in health care. Participants were shown to have made significant knowledge gains in areas such as diabetes care, wound management, and quality and risk management. Providers and managers were highly satisfied with their e-learning experience. The @YSC was shown to be an effective means for providers and managers to gain access to current, evidence-based learning resources.

100% of respondents wished to continue using @YSC. Fast and reliable internet access was a key issue which needed to be addressed to allow this type of e-learning to continue. Continuing education for service providers was deemed essential, particularly in rural and remote areas.

Second Level Support for Home Care

FNIHCC is a national and complex system, which is delivered primarily by trained and certified personal care workers at the community level, supported and supervised by home care nurses. The continuously changing caseloads, the on-going needs and health status of clients, and evolving care plans, result in significant coordination and management resource requirements. As a result, the FNIHB commissioned a study examining second level service provision in home care across the country. The Canadian Home Care Association (CHSA), which represents home care providers across the country, undertook this study to provide FNIHB with information which would allow it to make management decisions about the program (Canadian Home Care Association, 2007B).

Second level support is defined by the FNIHCC Program Framework as the "range of activities that often lend themselves to maintaining quality assurance, service coordination, staff training and development, staff support, program review and report writing". Second level services may occur on site, close to the frontline delivery, or may be at the regional level.

The authors comment on the absence of a common terminology in home care across the provinces and territories, as well as variation in policy and operations issues across the country. Accordingly, ten sites were identified for survey and interviews as part of the study methodology. The ten home care organisations represented nursing, home support, therapy and case management services. The importance of second level support was confirmed by all respondents In the Canadian Home Care Association study as being vital to the safe and effective delivery of services.

There was a significant range in the resources allocated to second level support across organisations, but there was substantially more support required for nursing, than for the other functions, such as home support and case management. For economies of scale, respondents favoured having support services for program development, education, training and development at a regional or head office. Administrative support, such as the coordination of schedules and calls, were seen as services which should be available locally during the work day, and centralized for after-hours coverage. All respondents unanimously underlined the need for more investment in education.

Best practices, in terms of second level support which organisations provide as essential to quality home care, emerged from this study. These included supervisory presence in the community to support learning needs of personnel and to ensure quality control; 24 hours access and support for frontline staff; continuing education and skill training; "active listening" to the needs of staff and effective response; information sharing; peer mentoring and on-line education and resources.

Challenges identified were human resource supply and resources for on-going education and training. Technological support was also seen as essential to support front line workers, in the form of e-resources, education, case conferencing; peer dialogue, videoconferencing, e-charting.

Recommendations presented were to assess the feasibility of shared services to achieve economies of scale; exploring sharing second level support with provincial programs; use interRAI data to further refine second level support requirements; review the Community Health Nurses Association of Canada (CHNAC) practice standards to align the FNIHCC program with the CHNAC framework for developing competencies; consult with the Aboriginal Nurses Association of Canada (ANAC) to enhance opportunities for sharing information and practices related to home health care in these communities.

In the interviews regarding the accreditation of First Nations and Inuit FNIHCC program, almost half (4 of 9) of the respondents noted a high turnover rate at the regional level. It was noted that FNIHB used to have peer review committees where managers and FNIHB got together and provided support to one another but that this was no longer in place. Three respondents noted they had developed their own support network between communities/programs and meet regularly. Another respondent noted that high level regional linkages with provincial health authorities should be developed to ensure that FNIHCC programs keep up to date with their system. Other areas cited where FNIHB could improve support for Home and Community Care services included: providing feedback on the required workplans submitted to FNIHB; provide training in a timely manner; provide training resources; assist with the accreditation process; and, allow for flexibility to move money among program areas within the budget. One respondent noted that they "have a Memorandum of Understanding with the Province on coverage for programs needed off reserve but no provincial funding".

Continuing Areas of Need

A policy statement on the provision of 24/7 care underlines the stressors on the FNIHCC system. This document states that "the FNIHCCP is not funded and was not intended to provide 24/7 home care. This is consistent and equitable to that of other home care programs offered through provincial/territorial health care systems". *FNIHCC Policy Statement on the Provision of 24 hour home care by the FNIHCC* (Health Canada Internal Document, 2006).

It is further stated that the provision of 24/7 would compromise the delivery of the essential service elements and critically limit the ability of the program to respond to other client home care needs. The provision of 24/7 care would severely tax the financial and human resources of the program. The policy statement suggests that clients requiring this type of care work with FNIHCC to develop options to link with other health care delivery services.

The need for 24/7 was also reported by Key respondents in the interviews, although the cost of this service was identified as a financial consideration.

3.2.1 Conclusion and Recommendation

Evaluation Question

How has the FNIHCC Program been implemented and delivered?

According to the Biannual Report produced in 2004, implementation of FNIHCC was shown to be operating according to the plans, with most communities progressing along the pathway to service provision. Currently, FNIHCC is funded in 686 communities across all Regions in the country.

Studies and evaluations have identified implementation challenges encountered by communities. These have been also reiterated by Key Informants and Key Representatives. These challenges include: funding for small, remote and isolated communities; health human resource issues; coordination requirements; gaps in service provision and capacity issues related to administration and reporting. The need for additional training and capital resources has also been identified by communities.

A need for 24/7 care was consistently identified in the documentation and in the Key Informants and Key Representatives interviews. Continuing pressures and demands on the home care system include the demand for after hours coverage. While 24/7 home care services in a home or community setting is preferable to having clients leaving the community when care can safely be provided in the home, the impact upon other elements of FNIHCC need to be carefully considered by program managers.

There have been alterations to the FNIHCC Evaluation Framework. On-going problems have also been encountered with the collection and analysis of data obtained through the eSDRT and Tracking Tools, as well as the quality of the data collected.

Pilot projects have demonstrated a potential for alternative support pathways for service delivery which merit consideration for application.

It is recommended that the RMAF and Performance Management System for FNIHCC be confirmed and made consistent so as to allow for effective FNIHCC management, monitoring and evaluation. It is essential that regular, systematic reporting, with performance indicators based on a data collection strategy, be undertaken. Program outcomes need to be in line with resources expended for the program, and be realistic in terms of expected results.

Efforts should continue to address human resource issues challenges associated with FNIHCC, including staff recruitment, retention, training and development, and compensation. In particular, efforts to recruit and train First Nations and Inuit care providers should be emphasized.

It is recommended that the funding formula be updated. The formula should be re-designed so as to be more needs based, taking into account the increased burden of chronic illness and injuries. Provision for on-going training and capital requirements for FNIHCC should be included in the funding envelope.

The specific needs, challenges, and higher costs associated with FNIHCC in smaller, remote, isolated, communities should also be taken into account in the formula (several formulas have been proposed in earlier studies; these should be re-examined for feasibility).

Consideration should also be given to a funding formula based on diagnostic-related groupings due to the proportionately larger numbers of injuries and disabilities and the increasing population.

This evaluation revealed that patients' primary conditions appear to differ across regions and across community types, and the analysis found different costs per hour of services. These findings require analysis and investigation, with possible implications for the revised funding formula.

It is recommended that the two piloted alternative service delivery models should be implemented. These include facilitating and expediting access to medical supplies, as well as providing web-based educational support for FNIHCC providers.

3.3 Outcomes, Success and Effectiveness

Respondents from all sources interviewed for this evaluation were unanimous in extolling the need for and benefits of FNIHCC and address the question whether or not "..the FNIHCC Program is achieving the outcomes expected?"

There are 633 First Nations and 53 Inuit communities that receive funding for FNIHCC across all Regions, and 13 of these programs have been accredited by the CCHSA using the First Nations and Inuit Health Services Standards. The program is considered to be an important and vital component of the continuum of health care services offered to First Nations and Inuit communities.

The findings in this section are grouped around three thematic areas:

- Design and Delivery Success
  - Facilitators to successful implementation
  - Barriers and challenges to implementation
- Individual Outcomes Success and
- Policy Outcomes Success
  - Enhanced capacity in the communities for program management
  - A changing landscape for homecare
  - Linkages/collaboration

Outcomes relevant to the 2002 RMAF logic model are identified throughout section 3.3 in bold and the relevant indicators are included as block arrows.

3.3.1 Design and Delivery Success

Facilitators to Successful Implementation

Key representatives and stakeholders were asked to assess the success of the HCC program in meeting communities' needs, on a scale of 1 to 5. Nineteen percent indicated it was moderately successful (score of 3), while 79% felt it had a higher success rate (score of 4 or 5). One key stakeholder respondent indicated they had conducted qualitative surveys which indicated that their clients were pleased with the services they have been providing. However, there was also a stated recognition that "there is always room for improvement in any program", and that there are often variations between the success rate from one community to another. One respondent also indicated that, while the program is successful in terms of its original design, it is not meeting other needs such as "high risk clients, and only 9 – 5 service". The following were identified as major facilitators to the successful implementation of the FNIHCC program:

- Having trained staff and workers;
- Providing professional development for staff;
- Establishing standards, policies and procedures for the program;
- Having Inuit staff [for Inuit settlements];
- Having managerial staff with a commitment to HCC;
- Having required equipment available;
- Working with other communities and keeping them updated and informed;
- Working well as a team;
- Training nurses in specialized areas, such as foot care, geriatric issues, and chronic care.

The added benefits to those health care organizations as identified by those communities which have received accreditation include: community capacity building; increased autonomy; improved communication and collaboration; demonstrated credibility and accountability; as well as, knowledge transfer.[9] Furthermore, in 2007, the First Nations and Inuit Home and Community Care Quality Improvement Questionnaire was created which was designed to help identify quality improvement needs and practices in First Nations and Inuit programs.

In the interviews concerning the accreditation of First Nations and Inuit FNIHCC programs, respondents confirmed that there were mechanisms in place for client feed-back on FNIHCC; either an evaluation form; satisfaction reports or audit charts. In two of these three programs, they also have a formal complaint process with a form which can be filled in by the client or, if the complaint is phoned in, it is completed by an employee.

[9] Accreditation Canada Accreditation and Aboriginal Communities www.cchsa.ca

Barriers and Challenges to Successful Implementation

Barriers and challenges to the implementation process were also identified by Key Representatives. These included lack of, or insufficient, funding for staff training; recruitment and retention problems; overworked staff and increasing client expectations; staff departures causing loss of training knowledge and taking information and training materials with them; housing issues; lack of office and storage area for equipment; lack of case management; communities working in isolation, with no communication or linkages with other programs; lack of leadership support for, or understanding of, FNIHCC in the community.

Key Representatives believed that potential users and community leaders were somewhat aware of FNIHCC (median score of 3 on a scale of 1 to 5), and that increased knowledge would lead to greater pressures on the program resources. It was also reported that many individuals did not access the program because of "political differences with the leadership."

Immediate Outcomes: Infrastructure in FNI communities to deliver the HCC services — capital and program

Half of the Key Representatives interviewed/surveyed indicated that the capacity of communities to undertake a needs analyses for community programming has increased, and this was particularly true for larger, well-developed communities and Tribal Councils. **Communities' capacity to manage and administer FNIHCC had improved**, although 80% of respondents indicated that their ability to recruit and retain staff was an on-going problem area. Half of the respondents indicated that there had been an increase in the coordination with other FNIHB and non-FNIHB programs.

One Key Representative and one Key Informant interviewed noted that the program needed to focus more on cultural competency and needs in the communities. Further work was needed to show more respect for traditional cultural values, and that this objective sometimes took a secondary place "when staff are busy administering care to clients".

Study 2, the formative evaluation - *FNIHCC Program (Study 2) Draft, Home Care Needs in FN & I Communities. Final Report* (Training Task Group International, 2005A) assessed early program outcomes. Evaluation findings demonstrate, that in general, needs had been met, to some extent. The study emphasized that there was a very significant need for FNIHCC in First Nations and Inuit communities/settlements, which continued and which was expected to increase over the years. The program was seen as having considerable potential to improve health in these communities.

The authors note that in several respects, the program had been successful; in other respects, there had been considerable challenges in introducing this program over such a variegated contextual landscape, which made the program difficult to evaluate. Serious challenges to FNIHCC implementation were identified by the authors and included: financial; human resource; communications and support; data collection; and, program linkages. Specifically, the study drew attention to problems with the "roll out of funding"; to the disadvantage of smaller, remote communities. The underfunding of training and capital budgets was emphasized. The on-going health human resource problems are also highlighted: recruitment, retention, training and

continuity of FNIHCC personnel. The authors also point to issues with Non Insured Health Benefits, with respect to timely and efficient access to certain medical supplies and equipment. Finally, problems with eSDRT were documented.

Intermediate outcome: FNI delivered and administered homecare services

In terms of positive outcomes of the implementation process, the study notes the **positive engagement and commitment of First Nations and Inuit communities/settlements, and the community-based nature of FNIHCC**.

Another major evaluation issue identified in the study is the role played in continuing care by two federal government departments, INAC and FNIHB. Both are involved in the provision of "home care", with many communities integrating the management of the programs. Communities often use the same staff to deliver both health and social components of home care. Data is entered on the INAC-funded component of eSDRT – making it difficult for evaluators to "disentangle" the impact of the two programs.

Immediate outcome: Increased service delivery awareness and accountability—informed users of HCC services and informed community leaders

In summary, Study 2 concluded that the needs are diverse and complex, and that needs are being met which had hitherto not been met. However, needs are emerging and there still exist many gaps in service, such as mental health, rehabilitation therapy, palliative care and respite care. **Needs are increasing due to awareness about the program, increased capacity of communities, and commitment to improve health and well-being in the communities**.

A report for Health Canada (2006A) - *Health Human Resources in Continuing Care in First Nations and Inuit Communities Technical Repor*t - undertaken by the Aboriginal Research Institute, had as its principal objective providing information about labour market issues related to FNIHCC and how to address mismatch between supply and demand. It did, however, bring to light certain challenges and issues related to program operations. These dealt with difficulties in recruitment and retention of FNIHCC staff; wage disparity with provincial and private employers; skills and training needs; under- funding of the program, and jurisdictional challenges.

3.3.2 Individual Outcome Success

Immediate Outcome: FNI access to HCC services—essential and supportive elements

Program services are accessible at the community level, based on the feedback when respondents were asked to assess the access of FNIHCC services by communities, on a scale of 1 to 5. Thirteen percent indicated that the access was relatively low (score of 2), while 53% viewed the services to be moderately accessible by communities (score of 3). Thirty-four percent indicated they felt the access was high/good (score of 4 or 5). Two respondents indicated that many communities did not have full implementation of FNIHCC services, but

Intermediate outcome: Responsive and Flexible Use Provision of HCC service

for those who did they believed the access was "good". One stakeholder respondent indicated that qualitative surveys had been undertaken which indicated that their clients were pleased with the services which have been provided. However, it was also noted that there was room for improvement. Respondents also indicated that many elders lived in complete isolation, and that the only visits which they received were from FNIHCC program personnel. **Respondents also felt that there was a good match between the community needs and those services offered by HCC**. In particular, home support and personal care services were in high demand in smaller communities.

All stakeholders in the Key Representative interview/survey group indicated that cultural, safety, administrative, health human resources, and financial issues have affected access to services. In addition, confidentiality issues (small communities "know everything"), and preferred access ("leaders ensure that their relatives get the best service") were cited as negative factors affecting access to services.

Ultimate outcome: HCC clients maintaining optimum health

When asked to assess the impact of the HCC on patient health outcomes, 90% of respondents believed that **health deterioration was significantly prevented or delayed** (tallying a score of 4 or 5, when asked to assess the significance on a scale of 1 to 5), and the remaining 10% indicating this was moderately impacted (score of 3).

Ultimate Outcome: HCC clients remaining in their homes and communities

Three other patient health outcome indicators received identical assessments in terms of the impact of the FNIHCC on them, namely: **patient discharged early from hospital or another level of care, patient able to stay in his/her community, and entry to long-term care facility delayed**. When asked to assess the impact on a scale of 1 to 5, 6% percent of respondents indicated a relatively low impact of the FNIHCC on these three patient health outcome indicators (score of 2), while 44% indicated the program having a substantive impact (score of 3) and half (50%) indicated that the FNIHCC had a relatively high impact on these indicators (score of 4).

One respondent added that the FNIHCC "is a very good program but the resources are not there to meet increasing client needs [and that the] budget has not increased to meet the growing needs … [which may result in] a liability issue regarding the increased care required by clients."

Respondents were equally divided about whether they believed that, in general, clients were satisfied with the services which they received under FNIHCC. Respondents indicated a variety of means for assessing satisfaction, including "listening", as they received significant verbal feedback.

The quality of care provided under the program was well perceived, averaging a score of 4 out of 5 from respondents. All of the 5 individuals who responded to the question, indicated they believed that FNIHCC workers were satisfied with the care provided, with one individual stating "Yes, but they require more resources and staff." One respondent cited that the "staff that work these programs are very committed and hard working and try to meet the client needs as required." All key stakeholder respondents indicated they did not believe that program workers were satisfied with the conditions of employment with low wages and heavy workloads being cited as the main reasons for this.

Immediate Outcome:
FNI access to HCC services—essential and supportive elements

It should be noted that the comprehensiveness of the program itself received only a passing grade. When asked to rate the comprehensiveness of the program on a scale of 1 to 5, 12% rated it to be very incomprehensive (score of 1), while the majority (76% of respondents) stated it was moderately comprehensive (score of 3), and the remaining 12% rating it as being very comprehensive (score of 5).

Positive benefits of FNIHCC were listed as:

- Elders being able to stay in their homes and communities to receive care;
- Decreased number of amputations;
- Clients knowing how to monitor blood sugar and maintain results in the normal range;
- Fewer medical complications;
- Earlier diagnoses of cancer;
- Employment for local staff and spin-offs that from (written materials being available in First Nations language; different service providers becoming engaged with each other to address client needs).

It was reported by one respondent that the majority of chronic care clients assessed stayed on the home care list until they died, as their needs increased.

In 2004, research was undertaken to gain a better understanding of existing home and facility-based continuing care services in First Nations and Inuit communities/settlements *(Health Canada 2007C)*. Findings included the following: home care is used by clients at all levels of care, but it is used mostly by those assessed with lower care needs. Existing facility services are used by clients at all levels of care, but more frequently by those assessed with higher needs.

Current continuing care services in First Nations and Inuit communities/settlements were found to be often provided in a fragmented fashion. It was recommended that funding issues needed to be addressed to meet the increased demand and higher level care needs and take into account case mix, community size and location and other factors, such as culture and language requirements of the client, family and community.

3.3.3 Policy Outcome Success

Enhanced Capacity in the Communities for Program Management

Key Representatives interviewed/surveyed for this evaluation were clear in identifying the enhanced sense of community ownership of FNIHCC through their administration of the program, specifically with respect to self-governing First Nations communities. They also pointed to other accomplishments of FNIHCC: its strong community-base and community-grounding and understanding the specific needs and requirements of the various communities and their people.

Intermediate outcome: Sustainable, culturally sensitive HCC services

Findings regarding cultural appropriateness are mixed. Among the Key Representatives interviewed/surveyed, all Health Canada personnel (10 of the 17 respondents) found the FNIHCC program culturally appropriate and aligned with Aboriginal values; however **half of the others interviewed felt that the program overall was not entirely culturally appropriate**. These stakeholders believed that funding should be set aside for traditional healers within FNIHCC, and a greater effort made on the part of service providers to understand cultural values and to provide services in First Nations and Inuit languages, especially when services were provided outside of the communities.

Immediate outcome: Increased community capacity—Human resources to administer and deliver the HCC program

FNIHCC staff was assessed as very committed, hardworking and caring, and clients generally are pleased with and appreciate the services they receive. **The program is also beneficial in hiring local staff, who best know their communities and understand the context**. However, the need for more services was unanimously articulated by respondents.

A study by Adrian Gibbons and Associates (2003) - *The Delivery of the First Nations and Inuit Home and Community Care Program in Small and Remote Communities: A Review of Issues and Challenges* attributes the implementation process associated with the establishment of FNIHCC in communities as a significant factor in capacity development.

The implementation model provided by the FNIHCC program is credited with building a strong and effective management structure for sustainable programs. “Much of the success of First Nations and Inuit community health development over the past fifteen years has been due to the development of “foundational” health management and service infrastructure. This has provided First Nations and Inuit communities/settlements with the local authority and capacity to plan and operate community health services based on their own self-defined needs and goal...”[it has been noted] that the level of existing health and social service infrastructure and the participation of the community in health transfer were strongly associated with the successful planning and implementation of effective FNIHCC services”.

A Changing Landscape for Home Care

It was noted that FNIHCC was established, based on "the world of 1997". That world had changed: acuity was not taken into account; the need for palliative care has strongly emerged; there was a need for some weekend and evening visiting; the basket of services and the intensity of services had changed, and FNIHCC needed to be rethought in accordance with these changes. Changes in the management of provincial/territorial acute care facilities had also affected discharge policies. The program was initially designed to address chronic disease on reserve, but there was the need for acute services, as people were being discharged earlier and returning to their homes earlier.

Linkages/Collaboration

FNIHCC has promoted linkages with off-Reserve services, such as hospitals, regional health authorities, and care providers. Respondents indicated that there should be more coordination among the Health Canada programs, such as Building Healthy Communities, Aboriginal Diabetes Initiative (ADI) and Maternal and Child Health programs. One example of coordination was that ADI funds were being used to cover a Home Care Nurse to take diabetic foot care training. Key Informants, Key Representatives and documentation reviewed all made reference to the need for better coordination or integration with the INAC Assisted Living program.

One stakeholder respondent indicated that FNIHCC had been successful in building partnerships with other levels of government, health care authorities and providers. This is particularly important as, to a certain degree, some services must be accessed off-Reserve. However, it was noted that this collaboration was not universal. One recommendation provided by a respondent was to build a mobile team of specialists in each area to visit clients in communities: a "one stop bus with services" concept. Where the nurses had worked previously was seen to be a factor in building relationships with other institutions or District Health Authorities. One possible facilitator that would help communities to "speak the same language" with other home care providers or institutions would be the use of common assessment instruments.

Shortcomings of FNIHCC were identified both in the documentation reviewed and through interviews (Key Informant and Key Representative) as staff recruitment and retention issues; low wages for home care workers; lack of funding; lack of space; and increasing demand. Other respondents also noted problems with quality, safety, and standards of care.

Three Key Representatives pointed to the need for better monitoring of quality of care, and reference was made to the possibility of introducing accreditation for the home care program as a means of raising standards of care. While the issue of quality of care was mentioned by several respondents, there was not much reference to it in the literature or documentation reviewed.

3.3.4 Conclusions and Recommendations

Evaluation Question

> *Is the FNIHCC Program achieving the outcomes expected (design and delivery outcomes, individual and community outcomes, policy outcomes)?*

In general, the design and delivery of FNIHCC was seen as having been successful in terms of meeting the original design intent of the program. Where it has been implemented, the program addresses the immediate and intermediate outcomes, but there are challenges as have been noted. The program is seen as beginning to have an impact on the health of its clients and helps clients to remain in their own homes and communities, so there is an indication that the program will achieve its ultimate outcomes as well.

FNIHCC is meeting its objectives and responding to a need for home care services within communities. The most highly rated impact on FNIHCC patient health outcomes cited were preventing or delaying health deterioration and reducing the onset of complications.

Findings have identified facilitators for an effective FNIHCC, which include a commitment to professional development and training for staff, leadership support and coordination of services.

While benefits were noted, areas of need continued to be highlighted in the findings, across all lines of evidence. Changes in First Nations and Inuit health status and in the health care system require adjustments to the assumptions underlying FNIHCC. Barriers to successful delivery of FNIHCC Programs were reported to be lack of funding, health human resource issues, workload and compensation of FNIHCC staff, service gaps and, administrative and reporting burdens.

Findings indicate that FNIHCC has contributed to the objective of building community capacity for the management and provision of home care services.

It is recommended that a more integrated, holistic and systematic framework for the delivery of all health services to First Nations and Inuit populations, including HCC, in rural, remote and isolated communities be developed. Efforts should be made to establish this framework and update it on a regular basis.

It is recommended that primary prevention should remain in the PHC or Public Health component of health services to First Nations and Inuit communities. However, secondary and tertiary prevention should be strongly integrated as part of the FNIHCC program.

Although coordination and partnerships have been established, FNIHCC needs to continue to develop linkages, so as to promote more integrated and coordinated health care services for First Nations and Inuit patients.

In accordance with principles of client-centered services, the implications of integrating the Assisted Living and FNIHCC should be considered by policy makers. This would allow for greater effectiveness, coordination and integration of continuing care services, as well as economies of scale, and administrative/reporting streamlining.

Consideration should be given to the utilization of common assessment instruments (such as inter-RAI) to ensure optimal linkages between FNIHCC and provincial/territorial health care systems.

Program managers should consider establishing FNIHCC performance benchmarks, service standards, and clinical outcome indicators, which would allow for more effective monitoring of quality of care and program efficiency.

3.4 Efficiency

This section assesses the efficiencies realized through the implementation of FNIHCC and addresses the evaluation question, "How cost-effective is the FNIHCC Program?"

The findings from program documentation, service documentation, financial data, and interviews with program managers and stakeholders are grouped around key thematic areas as follows:

- The need for reliable program information;
- Previous assessments of efficiency;
- Study of FNIHCC accredited programs; and,
- Analysis of FNIHCC data, including proposed next steps for collection of FNIHCC data.

The Need for Reliable Program Information

A study by Miller and Hollander (2006A) - *An Assessment of Continuing Care Requirements in First Nations and Inuit Communities Review of Literature and National Health Data Sources* - pointed to the inadequacy of data collection systems with respect to costs of continuing care, comparative services across jurisdictions, or characteristics/needs of people receiving care. In particular, data is shown to be weak with respect to Aboriginal health; there is limited information as to how services are organized, what they cost, how effective they are, or what types of clients are served. Almost nothing is known about the effectiveness of different approaches to addressing language, cultural issues, or traditions in services. The study notes problems with Aboriginal services, finding little coordination with other services (physicians, hospitals), challenges with human resources, gaps in services, policy and funding stovepipes. This makes it difficult to coordinate and/or integrate services to meet the needs of those needing care. The concept of case management seems absent from aboriginal care systems. There are multiple funding sources, with their own rules and policies (many of which contradict each other), leading to blockages in continuity of care. They point to the lack of development of

measurement instruments relative to Aboriginal populations for program delivery, policy, planning or research purposes.

However, based on an examination of the literature, the authors find that, although results are mixed, that the majority of research studies seem to indicate positive and /or cost-effective outcomes for preventive home care initiatives. There are few Canadian studies on maintenance and preventive functions of home care. There are many studies of home care as a substitute for long term facility care which suggest that home care may be a cost-effective substitute for facility care (US and Canadian studies).

The authors emphasized that evidence does indicate that more integrated service delivery systems are more effective, using a single funding envelope, case management, a standard assessment instrument, and a standard classification system would lead to better care and reduced costs.

Multiple indicators of indigenous health exist in Canada, but the use of these indicators has not effectively contributed to improved health of First Nations, Inuit or Métis, according to the authors of the report - *First Nations, Métis and Inuit Health Indicators in Canada. A Background Paper for the project "Action Oriented Indicators of Health and Health Systems Development for Indigenous Peoples in Australia, Canada and New Zealand"* (Anderson et al., 2006). They claim that these indicators are not effectively utilized for health care monitoring, evaluation or surveillance systems. Furthermore, non status First Nations people and Métis (who represent approximately 40% of Canada's indigenous population), do not have access to services provided through FNIHB (FNIHCC or the non-insured program, e.g. drug coverage, allied health care services, dental care, medical equipment, and transportation for medical services). Increasing urbanization of indigenous Peoples is described as a trend.

Challenges in indigenous measurement systems are discussed, particularly for local and regional-level planning, and the additional complexity of multiple jurisdictions involved in the delivery of health care compound the problem.

The authors present the health data landscape. Multiple agencies, national and regional, collect health information on Aboriginal populations including: Statistics Canada; Canadian Institute for Health Information (CIHI); The Public Health Agency of Canada; Health Canada FNIHB; and, INAC; as well as non-governmental organisations, such as: NAHO; ITK; and, AFN. Problems with the data collection are discussed in the report. Data collected by FNIHB is largely project or program specific, and driven primarily by fiduciary accountability purposes, which "makes the available information difficult to use for public health monitoring or programming".

INAC collects indicators on registered First Nations and Inuit, although there is little Inuit specific information. Data includes information on life expectancy, infant mortality, disability, suicide, addiction, solvent abuse, as well as demographic data on housing, education, custody (children). However, once again, the primary purpose of this data is fiduciary accountability. Concerns about the accuracy of this data led to policy makers relying on the Census.

Aboriginal Peoples surveys (Statistics Canada) 1991 and 2001 included non--reserve Aboriginal people. These surveys included information on health status, and incorporated in their design an indigenous understanding of health.

NAHO comprises three centres, First Nations, Inuit and Métis. The First Nations Centre houses First Nations regional health surveys (released in the fall of 2005) which contain data for over 30 areas, including demographics, language, housing health status, culture and community development. The 1997 First Nations and Inuit Regional Health Survey included 11 Labrador Inuit communities, but the survey only included registered First Nations people living on reserve. First Nations Regional Health Survey (FNRHS) comprises longitudinal comparable data centered around First Nations' conceptualization of health, and is First Nations controlled and adheres to OCAP. NAHO has also conducted public opinion polls (self-reported health and health services). ITK is working on an Inuit-specific health information initiative to provide a longitudinal data set separate from First Nations or provincial/territorial data.

AFN has developed an Aboriginal Health Reporting Framework, using the medicine wheel as its graphic conceptualization, with the four sectors being individual health, health services, community health and health determinants. Its purpose is to enable First Nations communities to measure their health and use the information for community planning and identifying funding and program requirements.

Provincial/Territorial surveys generally do not have ethnic identifiers. However, Manitoba, British Columbia, Alberta and Saskatchewan do link provincial health data with a subset of the resident First Nations population through health care flags for First Nations people who are registered with bands or with INAC as having treaty status or, by performing linkages with INAC or other databases which identify First Nations persons with treaty status. These surveys are reported to vary in quality and exclude non status First Nations, Métis and Inuit.

At the regional level, Regional Health Authorities (RHAs) have data similar to that collected by provinces and territories, disaggregated to the provincial health regions level, but do not have Aboriginal specific data available. Some indigenous-operated health authorities, e.g. Prince Albert Grand Council Health, produce their own specific indicators report.

Having reviewed the various agencies and departments involved in data collection on Aboriginal Peoples, the authors present a list of barriers to effective use.

Indigenous health indicators barriers to effective use include:

- Data driven by accountability requirements;
- Poor quality of data;
- Availability is limited by lack of appropriate ethnic identification;
- Data quality affected by jurisdictional issues;
- Lack of data collection infrastructure at all levels;
- Human resources are inadequate;

- Little information is returned to the communities;
- Tensions between organizations which collect universal indicators and indigenous-owned processes;
- Mistrust of externally imposed processes;
- Need for culturally appropriate tools;
- Desire for population health focus; and
- Capacity development at community level is needed.

Conclusions of the report center around how current indigenous data, being so fragmented and having various purposes, do not translate into effective planning, programming and policies which can contribute to improved health.

Costing First Nations and Inuit Continuing Care, Acute Home Care Supplement, (Lemchuk-Favel, 2007) is a supplement to the continuing care cost report commissioned by the Joint Working Group on Continuing Care Policy Development for First Nations and Inuit. Together, these documents provide comprehensive cost estimates of continuing care clients (chronic and acute care) in First Nations and Inuit communities/settlements. The first report examined the costs of providing care to the chronically ill, while this report addressed short term or acute care needs for home care services for the FNIHCC program and INAC's Assisted Living Program.

Types of Acute Care Substitutions (ACS) were analysed in the report, comprising a wide range in clients and in services, and the factors concerning the FNIHCC program capacity to provide these services were examined (e.g. multiple visits per day, availability of evening and weekend coverage, etc.). With the ACS service model, clients have a shorter length of stay than chronic clients in home care, and they usually display a declining model of service provision. The service provision technical model is provided.

Nursing workload was examined, as were level/intensity of services, as well as personal care and home management requirements (workload/intensity of services). Using eSDRT data for 2005/06, ACS client prevalence was examined, in terms of number of client hours/levels of service. Based on this data, cost estimates were developed.

Rates were compared with Canadian ACS rates; research showed in a review of hospitalization and home care that an average of 25% of acute discharges from hospital required home care. It was noted that First Nations have generally higher hospitalization rate than the general population average; in Manitoba, this was found to be over twice the rate. Based on this 2.2 factor, an acute/active treatment separation rate of 19.6 per 100 population based on the 2006 Canadian rate was calculated. A comparison with provincial rates (using eSDRT data) would indicate an under resourcing of home care in First Nations communities. Cost estimates were provided, based on hourly costs for clients.

As reported by key representatives and informants interviewed as part of this study, HCC program data presents problems in terms of its completeness, accuracy and reliability. The evaluation team was also informed that the eSDRT and administrative data presented problems

in terms of accuracy/validity, due to different types of collection systems and differences in managing data entry processes and protocols. While the extent of these problems is difficult to assess, it is certainly clear that information, as it is currently collected, does not allow for robust program management or monitoring, nor precise evaluation. Caution should therefore be exercised in interpreting the different elements that may allow variation in the data and in the consequent analysis.

Previous Assessments of Efficiency

Study 2 - *FNIHCC Program (Study 2) Draft, Home Care Needs in FN & I communities. Final Report* (Training Task Group International, 2005A) – also examined efficiency and effectiveness in the FNIHCC program. The implementation of FNIHCC was described as in "a continual state of evolution", having developed at different rates in various communities. Some communities were said not to have been funded to offer the level of service which their plans required, especially the more remote communities. Other communities noted that health care demands were too huge on their existing health care workers. Matters were said to have improved since the initial implementation "growing pains", although the unevenness in service delivery among communities is said to have been a negative factor. The author also reports a disconnect between the services which are available and what the changing and increasing demands or needs are for services. This has put pressure on the home care workers and on budgets. In some communities, the administrative functions have stretched staff to their limits, which has affected productivity. Service utilization has changed since the implementation of the program and this needs to be taken into account in the service plans.

This study drew, as a conclusion, that the FNIHCC formula did not reflect funding requirements to meet home care needs of the communities. The study found that funding resources were insufficient for the need. Much variety was seen in service provision, in the capacity of communities, and in the roll-out of the program.

The study also highlighted staff recruitment and retention problems, noting the pay differential between FNIHCC and P/T counterparts. The report noted that in some regions, the skill and job standards/requirements for FNIHCC were lower than for provincial programs. The authors identified the need for system integration to realize greater efficiency and effectiveness. Tele-health was noted as having increased the potential for greater efficiency.
A study was commissioned by FNIHB - *Scan of Second Level Service Provision in the Provinces and Territories to Determine Minimal Requirements for FNIHCC* (Canadian Home Care Association, 2007B) - so as to acquire information on second level service provision of home care across the country, to acquire data which would allow FNIHCC program managers to benchmark their operations with other home care providers in the country. Second level support was described as activities which assist in maintaining quality assurance, service coordination, staff training and development, staff support, program review and reporting.

Respondents favoured a centralized/decentralized model of second level support, allowing for economies of scale, and leveraging of skills and knowledge from across a broader team of staff. For example, training and education, and program development support are provided at a regional level. Administrative support, such as coordination of client and staff schedule and

management of incoming calls, are examples where service is available locally during the day, and then centralized after hours. By centralizing the administrative function after hours, efficiencies and cost savings are realized.

Three levels of second level infrastructure were discussed. Most organisations provided administrative support for the service. One of the indicators of efficiencies was the use of clinical staff time to undertake clerical and administrative duties. All respondents provided supervision and clinical leadership to ensure quality of care, support for problem solving and staff development. This model provides for clinical expertise which is resourced centrally, and serves the entire region. Continuing education is another key component of the second level infrastructure and is comprised of orientation, certification, recertification of skills, and continuing education/external training. Most respondents drew on central resources to assist with program development and certification.

There was a strong commitment by organisations surveyed to providing educational opportunities for staff. Specific budgets are established to cover educational programs, which include mandatory programs required for second level support and regulatory or quality standard purposes. Respondents reported an increased reliance on intranet as an efficient way of supporting continuing education. All respondents emphasized the need for continued and increased investments in education.

Organisations were asked to quantify resources targeted for second level support for each services (nursing, home visits, therapy, etc), but found this exercise difficult. They provided information based on the total units of service delivery. Wide variation in organisations made comparability very difficult.

Organisations reported certain aspects of second level support as essential for quality home care services. These included:

- Presence of the supervision in the community to support learning needs;
- 24 hour access and support for frontline staff, where care is provided 24/7;
- continuing education and skill training as a retention and staff development strategy;
- active listening to the needs of staff;
- team meetings to bring staff together to learn;
- peer mentoring; and,
- on-line education and resources.

In terms of the future, organisations were unanimous in describing their priorities. These included education – through on-line learning; case conferencing and programming; increased budgets to support staff; mentoring programs; and, establishing learning centres. Technology was another priority area, through expansion of on-line resources; e-learning; videoconferencing; mobile e-charting; GPS; and, client monitoring tools. All respondents confirmed increased

investments in second level support personnel and technology. Recommendations were presented to FNIHB, and include greater sharing of resources among F/P/T levels, to achieve economies of scale, and moving toward common assessment and measurement tools.

First Nations and Inuit Home and Community Care Project. Final draft for Assembly of First Nations (Boult, 2006) brought to light challenges experienced by FNIHCC program providers and users, which included human resource issues, particularly training and staffing; perceived inadequate funding; planning and implementation challenges and issues related to supply and equipment purchases.

The communities surveyed indicated that the primary barrier to accessing the FNIHCC was the low level of funding (many respondents indicated that funding for such programs should not be on a per capita basis, as this effectively prevented small communities from gaining sufficient funding to provide even the most basic services).

Funding was considered insufficient, and sources of support, such as Tribal Councils, had to be accessed. It was felt that the funding formula did not adequately take into account the higher costs of working in the small and remote communities, which incurred additional costs of recruiting health care staff, of compensating staff for driving long distances, the higher cost of equipment purchases, and higher training costs.

The report concluded that the funding formula needed to be adjusted to better reflect needs and realities of small and remote FN communities.

Another study - *The Delivery of the FNIHCCP in Small and Remote Communities – A Review of Issues and Challenges* (Adrian Gibbons and Associates Ltd., 2003) - focused on small and remote communities. Major challenges identified by the study which relate to efficiency focused on health human resources problems: recruitment and retention; training; the casualisation and marginalization of home support workers; lack of funding for training requirements; the limited funding based for small communities (below the critical resource threshold); the demands on human resources of planning, implementation, and reporting (including on-going issues with the reporting system); the lack of a small capital items replacement reserve fund; lack of funding for second-level services; higher transportation and shipping costs for remote communities.

Multi-jurisdictional funding and lack of integration with the INAC Assisted Living program were cited as problem areas at a systemic level.

Recommendations entailed adjusting the funding base, to introduce a per community/per capita approach with a provision for special needs and circumstances; integrating FNIHCC funding with transfer/integrated funding so as to increase program delivery flexibility; providing resources for professional development and on-going training (staff turnover was a problem); providing a small capital items replacement reserve fund, and providing more support to small communities with planning, implementation and operations. The continued use of tele-health and tele-medicine was identified as an innovative practice which could assist with providing more support to FNIHCC program providers.

Larger system-wide recommendation addressed the possible integration of FNIHCC with Health Transfer; DIAND (now INAC) and Health Canada integration of funding; facilitating FNIHCC service networks (single source contact of information on services and supports; improving accessibility, etc).

Study of FNIHCC Accredited Programs

In the interviews regarding the accreditation of First Nations and Inuit FNIHCC programs, funding issues were identified as factors or changes that are needed to make current programs more effective and responsive to community needs. More funding for Human Resources – Personal Support Workers in one case, second level supervision in another and, Nursing by a third respondent – would make the current program more effective. It was noted that local hospitals are hiring more Personal Support Workers and paying them more than offered under FNIHCC. One respondent noted that there had been no increase in funding for seven years and that funding for training has been decreased from six months per person to six weeks per person. Two respondents noted that more palliative, end-of-life training was needed to build capacity in this area. Two respondents discussed the problems associated with the inflexibility in the current funding formula. Budgets and funding are prepared yearly and the needs of the community can change within the year. Money cannot be moved among budget lines nor between years and these restrictions can result in the loss of resources to the program.

Analysis of FNIHCC Data Sets

The eSDRT and administrative data were made available to the evaluation team at the conclusion of the study, and two months before the final report due date. Accordingly, the findings of the data analysis could not be utilized to shape the design of other lines of enquiry, nor to probe findings. Attempts were made, however, to link findings to other lines of evidence, as much as was possible, so as to draw some valid conclusions.

Two data sets were provided to the evaluation team. These two sets were merged for purposes of analysis. The first data set was extracted from eSDRT databases for three fiscal years, 2005-2006, 2006-2007 and 2007-2008. The second data set was FNIHCC program administrative data about the level of funding according to FNIHCC program, the population on which the funding is based, as well as human resources information regarding the number of full-time equivalences that are allocated to each community (according to the FNIHCC funding formula). The client anonymous data, was further rendered anonymous by removing all communities, organizational and tribal councils names from the data set, replacing them with distinct numerical values. This enabled analysis to be done at an aggregate level, in a manner similar to that used to produce standard eSDRT reports at a regional or national level. Thus, it was impossible to identify particular individuals and communities.

Patient Information

Findings show that when all Regions are grouped together, FNIHCC serves approximately 20,000 patients per year south of 60; in 2005-2006, the FNIHCC counted 11,666 female patients and 7957 male patients. Ontario had the highest proportion of patients at 4,273, followed by Saskatchewan (3,906), British Columbia (3,376), Alberta (3,157), and Québec (2,789).

By Client Type

The most prevalent type of eSDRT client is one with a chronic illness care, whether continuous (6,392 clients in 2005-2006) or intermittent (3,570 clients in 2005-2006). Chronic care clients are older (63 years) and a larger number of them have diabetes (25% to 29%, depending on the year).

This finding is consistent with the description of client groups, as provided through the interviews. FNIHCC clients were primarily described as chronic care patients, mostly older adults.

Services

By Primary Diagnosis

The incidence of diabetes, cardiovascular disease, skin condition and musculoskeletal condition (arthritis) is particularly high among the eSDRT clients. Furthermore, these conditions have increased over the three years in terms of numbers. It is noted that the average length of services for these conditions is around two hours. The number of frail elderly clients of average age of 78 years also increases through the years 2005 to 2007, and the average length of services is high (6 hours per service). Finally, it is noted that, with the exception of skin conditions and mental disorders, the average age of the patients tends to be in the sixties.

Once again, these findings from the eSDRT data base are consistent with the description of HCC clients provided through the interviews. Diabetes was described as a primary diagnosis of home care clients.

Overall: 2,500,699 services were provided, representing 6,192,491 hours of service (100 hours of services in average, with 40 services per patient)[10].

By Service Category

In terms of services provided, the data show that the largest services category is that labeled "Assisted Living,"[11] both in terms of the number of services and the total number of hours of services performed. The eSDRT is only measuring direct hours of service to the clients. It does

---

[10] Primary condition is not a mandatory field, and therefore was not reported by all communities

[11] This category consists of Home Making/Home Management, Meal Services, Transportation, Assistance, Water Delivery, Wood Cutting, Home Repairs and Maintenance, Adult Day Program and Other. Since the eSDRT has been designed to allow communities to capture those services funded by both INAC through its Assisted Living Program (called "Adult Care" at the time eSDRT was designed) and FNIHCC, it is not possible to determine how much of this category is in fact FNIHCC vs. INAC funded.

not capture, for instance, travel or administrative time. Of all these hours of direct services, the category of Assisted Living represents more than half of the total home care hours of services provided over the three years (4,778,109 of 7,772,540 hours), and about a third of the total number of services provided. In terms of the quantity of services, the second most heavily utilized category of services is Nursing Services, followed closely by the Case Management, although in terms of hours of services, Nursing Service hours are considerably greater than Case Management hours.

In terms of hours supplied, the second most heavily utilized category after Assisted Living is Personal Care services, followed by Nursing Services and then Case Management services. Overall, a progression of Nursing Services across the years can be noted, a leveling of Assisted Living and professional therapies, and an increase in Personal Care services.

Respite care has been identified as an area of unmet need, through several lines of evidence, discussed in previous sections. Yet, In-Home Respite services are not used frequently (their number is small), which is not consistent with the unmet need expressed. However, one notes that in the eSDRT data when these services are delivered, it appears that the number of hours is quite large. Thus, the small number of respite care services may be due to the unavailability of service workers to provide this service, as respite care services are intensive in terms of hours. The eSDRT data would then be consistent with the need expressed to augment the availability of In-Home Respite services. It is also possible that the small number of these services do not reflect an unmet need and is due to data entry issues. The problem is the eSDRT data provide information only on services which are rendered to clients, not on the additional services that clients (actual and potential ones) would require or demand. The triangulation of the eSDRT data with the information from respondents then does provide a possible indication of unmet needs. Additional information from a different data source (needs analysis) would be required to assess the level of services that would need to be supplied to meet that additional demand for In-Home respite services.

A similar comment can be made with regard to palliative care. There are relatively few palliative care patients (290 in 2005-2006, compared to 19,623 in total). It is unknown if the small number comes from the actual number of clients requiring palliative care in the community, or whether those who require palliative care obtain it from a different service provider in the community or externally. Given the need expressed through different lines of enquiry in this study, the latter seems more probable.

The data reveal that FNIHCC clients are principally diagnosed with diabetes, skin conditions, and musculoskeletal conditions. The data do not offer information on the health status of the clients, therefore the severity of the health conditions of the clients cannot be determined, nor whether the program contributes to an improvement of the health status of the clients. The data do reveal however that FNIHCC provides a substantial number of services per client, which would suggest that the clients' health conditions require a greater intensity of services. In terms of services to these clients, FNIHCC offers relatively more hours of services in the categories of Assisted Living and Personal Care, followed by Nursing Services and Case Management.

Thus, the information from the eSDRT data appears to be at least in some degree in accordance with the opinions expressed by respondents. Again, it could be that the data suffer from entry problems for some regions more than others, but overall, in terms of client conditions and services, the averages presented in the data do not seem utterly unreasonable.

By Region and Community type

The data show that, overall, the total number of supplied service hours per capita does not vary much across the three years, with an average of slightly more than nine hours of FNIHCC services supplied by capita. This average, however, hides some interesting provincial variations. Indeed, the Western provinces have a lower average of hours of services supplied per capita than the rest of the country (with the exception of Prince Edward Island (PEI), but there are only two communities in PEI). Furthermore, Atlantic provinces provide quite a large number of services per capita, particularly compared to Alberta.

This difference in hours supplied could be due to the fact that some provinces have different types of communities, which was tested. Non-isolated communities, in general, provide more hours per capita than isolated or remote communities. However, even when taking the type of community into consideration, it appears that the number of hours per capita is lower in the provinces of Alberta (for the four types) than for Saskatchewan (for remote-isolated, isolated and non-isolated).

It is not clear why the number of hours supplied is less in these provinces (or, equivalently, why it is higher in central and Atlantic Canada). The first possibility is that the difference in hours is due to a regional variation in data entry protocol that would persist across the three fiscal years. This variation could be due to differences in training, in definitions etc. While there are undoubtedly differences in data entry, it is not possible to determine fully whether this factor alone explains the variation across regions. Interviews with informants did not reveal a significant problem in reporting, however, further probing would be required so as to ascertain the extent of measurement error in explaining the regional variation in service hours.

Apart from measurement error, other possible factors in explaining the regional variation are elements related to either the health conditions of the patients or the organization and management of health services supplied. Unfortunately, these eSDRT data only examine patients and services offered represent the demand of health services from the population meeting the supply of services offered by FNIHCC. Unless additional information is provided, it is not possible to determine whether the relatively low number of hours per capita for Alberta is due to a lower demand for services due to, for example, to a hypothetically healthier population, or whether it is due to the fact that FNIHCC was unable to deploy more health workers to offer more services to a population that would hypothetically want more services but would not be able to have these services provided.

In general, the data show a difference in hours supplied across provinces, even when type of community is taken into consideration.

By Cost per Hours of Service

The term "efficiency" refers to how an organization uses the combination of health facilities and health workers to supply services to the clients. Efficiency refers to how the inputs (facilities, health workers and management) combine to provide an output (services to clients). Cost-effectiveness is a related concept which refers to an analysis of the costs of providing these services. In this context, terms such "less efficient" and more "cost-effective" should not be understood as carrying a subjective value. Aside from the possibility of data measurement problems, several factors may explain why some organizations deliver fewer services per worker or deliver a lower cost per hours of services; any comparative analysis of efficiency and cost effectiveness across regions and communities should be strictly understood as a potential means of comparison of two different places using the same yardstick (which may or may not be the correct one to use). If there are differences according to the same measure, it does not imply that one place is better or worse than the other. Rather, it will simply suggest that more information is required in order to assess why these differences appear and what can be learned from them.

It is thus with caution that comparisons across regions and communities can be made, and to the extent that the variation might be due to factors beyond data entry errors, implications of the variations should be further assessed. Due to data and time limitations, this evaluation will describe the comparison of the figures, rather than providing a definite analysis to explain why these differences might arise.

There are differences in hours supplied, but are there differences in the cost of supplying these services? One possible measure of cost-effectiveness is the cost of supplying one hour of service in a community. To calculate this measure, the annual sum of all services provided in the community was computed, and it was divided by the total annual FNIHCC budget allocation to that community.

The average cost per hour over the three years was $154.10, going from $111 in 2005-2006, $217 in 2006-2007 and back down to $133 in 2007-2008. Given that annual budgets do not change much, the difference appears to be due to variations in total hours of services supplied across the FNIHCC communities. It was also noted that, in the provinces where there were few hours supplied per capita, the cost of supplying this "hour of services" is higher. Indeed, Alberta, Manitoba and Saskatchewan (in 2006 only) show a much higher cost of delivering an hour of services than the other regions. Ontario stays in the $100 range, with Québec and the Atlantic Provinces exhibiting a lower cost range ($20 to $50).

The differences across provinces remained, even when testing for community type, removing outliers, as well as the Assisted Living services. Alberta communities have a higher cost of delivering an hour of service for non-isolated, semi-isolated and isolated communities. British Columbia communities that are categorized as isolated show an average of $1,016 per hour in 2006, Manitoba's isolated communities also show a higher average in 2005-2006 and 2006-2007. Interestingly, Saskatchewan's semi-isolated communities in 2006 show a cost of $2,309 per hour, though this could be due to some outliers. Again, this cost variation can mostly be attributed to a difference in hours supplied in these communities, compared to the rest of the communities, and in other provinces. Given this, the Western provinces show a relatively low number of hours supplied with a higher cost of supplying these hours, whereas, the Atlantic

Provinces and, to some extent Québec, are able to provide more hours of services for similar costs, with Ontario being in the middle range.

Two regression analyses were run of the cost per hour on categorical variables for the type of community and for given province to determine if certain dimensions were more significant than others. It emerged that semi-isolated and isolated communities tend to have a higher cost per hour than remote isolated, while non-isolated have a lower cost per hour than remote isolated communities. These differences, however, while large in terms of the coefficients (for instance, semi-isolated communities' cost is $224 more per hour than remote isolated) do not appear to be significantly different from zero. In terms of provinces, Alberta communities' cost per hour is $255 more expensive than Atlantic Provinces' communities, and Manitoba's cost is $183 more expensive. These differences are significant, and account for overall differences in community types. There does not appear to be significant differences between the Atlantic Provinces and the provinces of Québec and Ontario in terms of cost per hour of total services, even though the coefficients indicate a slightly higher cost.

Human Resources: Nurses and Nursing Services

The information on human resources is examined (the number of Full-Time Equivalences (FTE) allocated to each community in 2004) to assess the possible effects of the allocation. Two indicators were constructed, using the hours of nursing services from the eSDRT. The first one is to take the sum of hours of nursing services and divide them by the population in each community which comes from the FNIHCC administrative data. This indicator gives the number of nursing services in terms of the population in the community. The second indicator is the number of nursing services per FTE allocated in that community. The intent is to examine how productive each nursing FTE is in a community. This productivity is only potential: indeed, one is aware that the nursing FTE is allocated to a community. The data do not list how many nursing FTEs the community was in fact able to hire per year. The data only provide the allocated nursing FTE for 2004 and it does not change through the time period. Furthermore, the data set does not have the nursing FTE 2004 information consistently for all regions. Hence, the only change in the indicators will come from the change in the eSDRT reported nursing hours.

FNIHCC data do provide for some communities the number of nursing (RN and LPN) FTEs that were filled. Unfortunately, this number is self-reported and is not mandatory and cannot be used in the computation of the indicator for all the communities.

Since the allocated number of nursing FTE to a community is constant across the three fiscal years, it is not surprising to see almost no change, with the average nursing FTE per community being 0.60. The data showed that approximately three quarters of an hour of nursing services per capita are provided annually by the FNIHCC program. In addition, data show that each nursing FTE provides 800 hours per year (ranging from 794 in 2005-2006 to 842 in 2007-2008).

The number of allocated FTEs is roughly the same across community types, with the exception of isolated communities where the average FTE is smaller. Data also demonstrate that the isolated and non-isolated communities tend to have more productive nursing FTEs, with one FTE providing 800 or more nursing hours over the three years, compared to a nursing FTE in remote-isolated and semi-isolated communities. It is important to note that there are fewer nursing FTEs per capita in these communities, and they also provide less services.

When considering these variables by region, one sees that there is variation in allocated FTEs across the regions for which one has information. For instance, the allocated nursing FTE is highest in Alberta, followed by Saskatchewan, Québec, Ontario and then British Columbia. Ontario FTEs are less productive than the average, while Québec nursing FTEs are the most productive on average.

If information on the actual, rather than the allocated, human resources delivering the respective categories of services were available, the productivity analysis could then be extended to the type of human resources. It would then be possible to establish and make useful comparisons for the different health workers across regions and community types. The comparison would help to establish whether one worker in a given location is more efficient than another. Further, it would assist in understanding how work organization and community characteristics provide for different results, and whether there are lessons to be learned from one area or organization. Certainly, more could be done in the future to assess these differences. Finally, besides acquiring more information on the actual human resources used in a community, administrators must also make sure to supplement the eSDRT data base with data on the potential demand for health services. Human resources challenges were identified as a major problem through the respondent interviews. The variation in service hours point out that the problem differs according to the region, but the eSDRT data do not allow for the determination of the extent and the reasons of the problem. The evaluation team considers that a comparison of "standard service at a reasonable cost" cannot be undertaken, given the current data available.

In retrospect, the eSDRT data does allow for some interesting observations, but the data has significant limitations. For instance, respondents interviews found that "positive benefits of FNIHCC were: 1) Elders being able to stay in their homes and communities to receive care; 2) Decreased number of amputations; 3) Clients knowing how to monitor blood sugar and maintain results in the normal range; 4) Fewer medical complications; 5) Earlier diagnoses of cancer; 6) Employment for local staff and spin-offs that from (written materials being available in First Nations language; 7) different service providers becoming engaged with each other to address client needs)." Given the way the eSDRT data are collected, it is not possible to triangulate these claims with the data currently available. It is certainly possible that these claims are correct, however, the data do not allow for their confirmation. For instance, for claim 1), one would need to have additional information on transportation of individuals to health facilities either in the community or outside. For claim 2), information on the number of amputations before the program was established is needed, or in a similar community in the absence of the HCC program. For claims 3), 4) and 5), health outcome data on the patient are needed, which are not collected and from the hospital facilities where those clients would have gone, in the absence of the program. For claims 6) and 7), the current data do not yield this information. Of course, these claims may be all valid, but the eSDRT do not allow a proper verification.

Next Steps

The elements of a robust FNIHCC information would enable the collection of all of the necessary data elements required to undertake appropriate administrative, clinical and evaluative activities. This data system must also provide community level information that is of value to the community, so as to supports program management, program development and decision making based on the strong information. Having data that are meaningful and have utility at the community level greatly enhances the probability that the data will be collected and entered in a timely manner.

The data elements, both mandatory and non-mandatory, that are currently being collected within the FNIHB eSDRT system are required and should continue to be collected. Additional fields were recommended by a study undertaken by Saint Elizabeth Health Care (SEHC) Service Delivery Center (SDC) 2006, and should be implemented.

The study found that the current system was limited in its ability to track and monitor operational and clinical measurements and indicators, and recommends adding tracking elements for the dimensions of workload measurement, clinical outcomes measurement, quality and risk management, and allocation of resources.

For efficient financial management, information on costs to provide program services needs to be captured on a regular, ongoing basis. Planning for annual budget allocations, costing of new programs, and ongoing monitoring of all costs are critical pieces of information that all FNIHCC managers need. To be effective in optimizing the services while controlling program costs it will be essential to have this information readily available. Providing managers with financial information builds fiscal accountability into program management.

Outcome measures and benchmarks need to be developed in collaboration with communities and FNIHCC providers. Data elements must include ways of measuring the impact of a FNIHCC intervention. Indeed, there is a need to find out about the demographics and health characteristics of the community at large, and not only those who are patients. A survey of the community's individuals needs to be done as both a planning and tracking tool in order to plan and understand the effects of FNIHCC on the individuals as well as how the FNIHCC program affects the other parts of the health system. A more effective eSDRT combined with a comprehensive human resources tracking tool will allow a better evaluation of FNIHCC. The addition of a comprehensive survey of the health and demographics of individuals living in all the communities served by FNIHCC with data from other health facilities and providers would further strengthen tremendously not only the evaluation but also the planning and the management of FNIHCC.

3.4.1 Conclusions and Recommendations

Evaluation Question

How cost-effective is the FNIHCC Program?

Cost analyses of FNIHCC and comparisons are hampered by lack of reliable health information and studies

Efficiency has been found to be difficult to assess in view of uneven implementation and differences from community to community. Attention continues to be drawn to problem areas, notably funding, human resources and compensation issues in areas of program need.

A robust FNIHCC information system would enable the collection of all necessary data elements required to undertake effective program management, as well as provide clinical and evaluative activities. This data system should also provide community level information that is of value to the communities.

It is recommended that the data which are collected, both mandatory and non-mandatory, should continue to be collected, and supplemented by additional fields, as recommended by the SDRT Study (Saint Elisabeth Health Care).

Furthermore, the evaluation recommends:

- That client satisfaction information be collected on a regular, systematic, basis.
- That more detailed health care provider information be collected, so as to allow for more effective management of FNIHCC resources.
- That better health information on the population at large (First Nations and Inuit), be collected, so that more effective and targeted planning may be undertaken for the FNIHCC services.
- That outcome information on patient condition be collected so as to track condition, health status and measure effectiveness of services.
- That a set of FNIHCC benchmarks be established to allow for regional comparison on services.

The data analysis undertaken as part of this evaluation has shown regional differences in health conditions across the country (e.g. diabetes significantly higher in Western provinces), as well as different costs of providing FNIHCC services from region to region. Further research and analysis needs to be undertaken to understand if health care needs are different across the country, and if so, why, and why costs of services are different. If health care needs vary from region to region, this may need to be considered in the funding formula.

4. OVERALL RECOMMENDATIONS

Rationale and Relevance Recommendations

1. It is strongly recommended that FNIHCC continue and be strengthened. Evaluation findings clearly confirm and endorse the continued rationale of FNIHCC, as assisting in addressing the health needs of First Nations and Inuit people, and of closing the health service delivery gap.

2. It is recommended that the highest priority be given to providing all essential components of FNIHCC in all communities. After establishing essential services elements, FNIHCC should consider the feasibility of addressing areas of unmet health needs and services gaps including mental health services, palliative/end of life care, rehabilitative care and respite care including the introduction of specialized training for service providers in this area.

3. It is recommended that closer linkages of FNIHCC with regional health authorities, other health care providers, medical services and health institutions be explored and encouraged, so as to provide more integrated and coordinated care to clients.

4. Policy makers should clearly establish the parameters and linkages among of the various health programs available (Home and Community Care, Primary Health Care, Public Health/Community Health Nursing, Addiction Services, to name a few) to determine where services, such as Mental Health Services, should be located so that health service gaps are addressed.

5. Generally FNIHCC has been found to be culturally relevant in its approach, although efforts should be made to further align the program with holistic and traditional approaches.

Design and Delivery Recommendations

Program Management

6. It is recommended that the RMAF and Performance Management System for FNIHCC be confirmed and made consistent so as to allow for effective FNIHCC program management, monitoring and evaluation. It is essential that regular, systematic reporting, with performance indicators based on a data collection strategy, be undertaken. Program outcomes need to be in line with resources expended for the program, and be realistic in terms of expected results.

Human Resources

7. Efforts should continue to address human resource issues challenges associated with FNIHCC, including staff recruitment, retention, training and development, and compensation. In particular, efforts to recruit and train First Nations and Inuit care providers should be emphasized.

8. It is recommended that the funding formula be updated. The formula should be re-designed so as to be more needs based, taking into account the increased burden of chronic illness and injuries. Provision for on-going training and capital requirements for FNIHCC should be included in the funding envelope.

9. The specific needs, challenges, and higher costs associated with FNIHCC in smaller, remote, isolated, communities should also be taken into account in the formula (several formulas have been proposed in earlier studies; these should be re-examined for feasibility).

10. Consideration should also be given to a funding formula based on diagnostic-related groupings due to the proportionately larger numbers of injuries and disabilities and the increasing population.

11. This evaluation revealed that patients' primary conditions appear to differ across regions and across community types, and the analysis found different costs per hour of services. These findings require analysis and investigation, with possible implications for the revised funding formula.

Alternative Service Delivery Model

12. It is recommended that the two piloted alternative service delivery models should be implemented. These include facilitating and expediting access to medical supplies, as well as providing web-based educational support for FNIHCC providers.

Outcomes, Success and Effectiveness Recommendations

13. It is recommended that a more integrated, holistic and systematic framework for the delivery of all health services to First Nations and Inuit populations, including HCC, in rural, remote and isolated communities be developed. Efforts should be made to establish this framework and update it on a regular basis.

14. It is recommended that primary prevention should remain in the PHC or Public Health component of health services to First Nations and Inuit communities. However, secondary and tertiary prevention should be strongly integrated as part of FNIHCC.

15. Although coordination and partnerships have been established, FNIHCC needs to continue to develop linkages, so as to promote more integrated and coordinated health care services for First Nations and Inuit patients.

16. In accordance with principles of client-centered services, the implications of integrating the Assisted Living and FNIHCC programs should be considered by policy makers. This would allow for greater effectiveness, coordination and integration of continuing care services, as well as economies of scale, and administrative/reporting streamlining.

17. Consideration should be given to the utilization of common assessment instruments (such as inter-RAI) to ensure optimal linkages between FNIHCC and provincial/territorial health care systems.

18. Program managers should consider establishing FNIHCC performance benchmarks, service standards, and clinical outcome indicators, which would allow for more effective monitoring of quality of care and program efficiency.

Efficiency Recommendations

19. It is recommended that the data which are collected, both mandatory and non-mandatory, should continue to be collected, and supplemented by additional fields, as recommended by the SDRT Study (Saint Elisabeth Health Care).

20. Furthermore, the evaluation recommends:

    - That client satisfaction information be collected on a regular, systematic, basis.
    - That more detailed health care provider information be collected, so as to allow for more effective management of FNIHCC resources.
    - That better health information on the population at large (First Nations and Inuit), be collected, so that more effective and targeted planning may be undertaken for the FNIHCC services.
    - That outcome information on patient condition be collected so as to track condition, health status and measure effectiveness of services.
    - That a set of FNIHCC benchmarks be established to allow for regional comparison on services.

21. The data analysis undertaken as part of this evaluation has shown regional differences in health conditions across the country (e.g., diabetes significantly higher in Western provinces), as well as different costs of providing FNIHCC services from region to region. Further research and analysis needs to be undertaken to understand if health care needs are different across the country, and if so, why, and why costs of services are different. If health care needs vary from region to region, this may need to be considered in the funding formula.

5. BIBLIOGRAPHY

Accreditation Canada, 2008. Vision 2008; Accreditation Process; Telling Our Own Story (Video Clip); Accreditation and Aboriginal Communities; Qmentum Key Features. www.accreditation.ca

Adrian Gibbons and Associates Ltd. 2003. The Delivery of the First Nations and Inuit Home and Community Care Program in Small and Remote Communities: A Review of Issues and Challenges. Prepared for FHIHCCP, FHIHB, Health Canada. 55pp

Anderson, M., J. Smylie, I. Anderson, R. Sinclair and S. Crengle. 2006 First Nations, Métis, and Inuit Health Indicators in Canada. A Background Paper for the project "Action Oriented Indicators of Health and Health Systems Development for Indigenous Peoples in Australia, Canada and New Zealand. 38pp

Atack, Lynda. 2004. Remote Education and Support of Health Care Providers: A Demonstration Project with First Nations of Manitoba. Atack Associates, Inc.

Barron, Marcia. 2005. First Nations and Inuit Home and Community Care (FNIHCC) and Non-Insured Health Benefits (NIHB) Pilot Project on Medical Supplies Access. Evaluation Report. Barron Research Consulting, Dunda, ON 33pp

Boult, David, 2006. First Nations and Inuit Home and Community Care Project. Final Draft. For: Assembly of First Nations. The Consilium Consulting Group. 14pp

CIHI, 2007. Health Care in Canada. Public Sector Expenditures and Utilization of Home Care Serves in Canada: Exploring the Data.

Canadian Collaborating Centre – interRAI, Homewood Research Institute, 2004. Minimum Data Set for Home Care (MDS-HC). Resident Assessment Instrument – Health Informatics Project (RAI-HIP). A Comparison of First MDS-HC Assessments between Aboriginal Clients and All Others in Ontario. 46pp

Canadian Council on Health Services Accreditation, 2008 Strategic Directions Alignment: Strategic Directions & Strategic Initiatives 2006-2008. www.cchsa.ca

Canadian Council on Health Services Accreditation, 2007 Canadian Health Accreditation Report 2007. Raising the Bar for Health Quality.

Canadian Council for Health Services Accreditation. Application for CCHSA's Accreditation Program.

Canadian Council on Health Services Accreditation. CCHSA's Accreditation Program Community Health Services Standards. 53pp

Canadian Council on Health Services Accreditation. CCHSA's Accreditation Program Home Care Standards.

Canadian Council on Health Services Accreditation. First Nations and Inuit Health Service Standards.

Canadian Home Care Association, 2007A. First Nations and Inuit Home and Community Care Program in Small and Remote Communities: A Review of Issues and Challenges.

Canadian Home Care Association, 2007B. First Nations and Inuit Home and Community Care: Scan of Second Level Service Provision in the Provinces and Territories to Determine Minimal Requirements for FNIHCC. Final Report. 20pp

Canadian Home Care Association, 2006 Home Care for Children with Special Needs; Environmental Scan Across Canadian Provinces and Territories.

Chandler, M.J. and C. E. Lalond, 1998. Cultural Continuity and an Hedge Against Suicide in Canada's First Nations. Transcultural Psychiatry, 35(2): 193-211.

First Ministers, Leaders of National Aboriginal Organizations, 2005. Blueprint on Aboriginal Health. A 10-Year Transformative Plan.

First Nations and Inuit Health Information System (FNIHIS), 2007. eSDRT/HCC User Training Guide. Version 4.0x0. 62pp. www.fnihs.org

First Nations and Inuit Home and Community Care Program, 2004. Study 1 Implementation "Foundations for Success: Technical Report.

First Nations and Inuit Home and Community Care, 2007. Quality Improvement Questionnaire.

Government of Canada, Government of British Columbia, First Nations Leadership Council Representing the BC Assembly of First Nations, The First Nations Summit and the Union of BC Indian Chiefs, 2006. First Nations Health Plan Memorandum of Understanding.

Health Canada, 2006. Report on Plans and Priorities, 2006-2007.

Health Canada, 2002A. First Nations and Inuit Home and Community Care Program Evaluation Guide.

Health Canada, 2002B. First Nations and Inuit Health Branch Home and Community Care Program Results-Based Management and Accountability Framework.

Health Canada, 2004A. First Nations and Inuit Health Branch Home and Community Care Program Biannual Report 2000-2002.

Health Canada, 2004B. First Nations and Inuit Health Branch Home and Community Care Program Annual Report 2002-2003.

Health Canada, 2006A. Health Human Resources in Continuing Care in First Nations and Inuit Communities. Technical Report. 81pp

Health Canada, 2006B. Health Care Strategies and Policy Grant and Contribution Programs. Performance Measurement System Review as of: July 21, 2005. 40pp

Health Canada, 2007A. FNIHB Contribution Funding Framework: Overview.

Health Canada, 2007B. Canada Health Act Annual Report 2006-2007. Retrieved August 30, 2008. http://www.hc-sc.gc.ca/hcs-sss/pubs/cha-lcs/2006-cha-lcs-ar-ra/index-eng.php

Health Canada, 2007C. Continuing Care in First Nations and Inuit Communities: Evidence from the Research. Retrieved April 22, 2008. http://www.hc-sc.gc.ca/fniah-spnia/pubs/services/_home-domicile/2007_info_contin_care-soins/index-eng.php

National Council of Welfare. 2007 First Nations, Métis and Inuit Children and Youth: Time to Act. Volume #127. 138pp

Health Canada internal documents:

First Nations and Inuit Health Branch BEC, Audit, Evaluation and Review Sub-Committee, 2006. Agenda Item: Evaluation Function Status June 13, 2006.

First Nations and Inuit Home and Community Care Program Needs Based Funding Strategy, Draft 3 – May 15, 2000.

First Nations and Inuit Home and Community Care Program (FNIHCCP) Executive Summary, FINIHCC Evaluation Strategy, 2004.

First Nations and Inuit Home and Community Care Program (FNIHCCP) Policy Statement on 24 hour Home Care, 2006.

First Nations and Inuit Home and Community Care 2006/07 NWT Home Care Program Enhancement.

First Nations and Inuit Home and Community Care Program Long Term Care Construction and Operating, 2007.

Funding Framework and Formula for First Nations and Inuit Home and Community Care, 1999.

2006/2007 Overview of FNIHCC Program Development Status, February, 2007.

HCC Essential Service Elements Risk Management Appraisal Tool (Appendix to "Developing and Implementing a Health Plan: A guide for First Nations and Inuit"), 2008.

First Nations and Inuit Health Branch, Home and Community Care, Ongoing Program Funding 2007/2008, Feb 26, 2009.

First Nations and Inuit Home and Community Care Program Workplans, 2000-2001; 2001-2002; 2002-04; 2004-05; 2005-2006; 2006-2007; 2007-2008; 2008-2009.

First Nations and Inuit Home and Community Care. Policy Statement on the Provision of 24 Hour Home Care by the FNIHCC.

Compendium of Indigenous Health Indicators in Canada.

Hirdes, J.P., J. Ross, K. Reidel, and M. Jantzi. 2006. Resident Assessment Instrument for Home Care (RAI-HC). A Comparison of RAI-HC Assessments Completed in Ontario from 2003-2006 for Clients Who: Identify as Aboriginal in Origin and are Funded by First Nations and Inuit Health Branch (FNIHB), Identify as Aboriginal Origin and are Not Funded by FNIHB, and All Other Clients. Ideas for Health Research Group, University of Waterloo and Homewood Research Institute. 46pp

Hollander, Marcus, N.L. Chappell, M.J. Prince & E. Shapiro, 2007 Providing Care and Support for an Aging Population: Briefing Notes on Key Policy Issues. Healthcare Quarterly 10(3): 34-45.

Indian and Northern Affairs Canada, 2007. Assisted Living Program. (PowerPoint) Presented to the Associate Assistant Deputy Minister, Socio-Economic Policy and Regional Operations, Indian and Northern Affairs Canada. Draft October 26, 2007.

Indian and Northern Affairs Canada, 2003. Evaluation of Adult Care Services. Project 01/25. (Prepared by Departmental Audit and Evaluation Branch assisted by Prairie Research Associates, Inc.

Lafontaine, Carole, 2006. National Aboriginal Health Organization (Powerpoint) Presentation to the Senate Standing Committee on Aging. Monday, November 27, 2006.

Lemchuk-Favel, Laurel, 2003. First Nations and Inuit Integrated Palliative Care Program Framework. 62pp

Lemchuk-Favel, Laurel, 2005. Home Care Considerations in the First Nations and Inuit Mental Wellness Continuum (draft) 27pp.

Lemchuk-Favel, Laurel. 2006. Acute Care Substitutions Services in the First Nations and Inuit Continuing Care Acute Home Care Program. Technical Framework for a Costing Model. 29pp.

Lemchuk-Favel, Laurel. 2007. Costing First Nations and Inuit Continuing Care Acute Home Care Supplement. (draft) 15pp

Lucarz Simpson, Joanne (Health Matters – JLS Associates), 2007. First Nations and Inuit Home and Community Care Program Environmental Scan of the Unmet Home Care Needs of First Nations and Inuit Children and Youth. 87pp

Martin, K. Health Services in First Nations Communities in Ontario. An Overview – Powerpoint.

Miller, JoAnn & Marcus Hollander, 2006. An Assessment of Continuing Care Requirements in First Nations and Inuit Communities. An Examination of Continuing Care Requirements Across Canada and Findings from Interviews with Key Informants. For HC, FNIHB Hollander Analytical Services, Ltd., Victoria, BC. 153pp

Miller, JoAnn & Marcus Hollander, 2006A. An Assessment of Continuing Care Requirements in First Nations and Inuit Communities. Review of Literature and National Health Data Sources. For HC, FNIHB Hollander Analytical Services, Ltd., Victoria, BC. 163pp

Miller, JoAnn & Marcus Hollander, 2006B. An Assessment of Continuing Care Requirements in First Nations and Inuit Communities. Synthesis Report. For HC, FNIHB Hollander Analytical Services, Ltd., Victoria, BC. 239pp

NAHO, 2005. First Nations Regional Longitudinal Health Survey (RHS) 2002/03. Results for Adults, Youth and Children Living in First Nations Communities. 322pp.

NAHO, 2006A. First Nations Regional Longitudinal Health Survey (RHS) 2002/03. Report on First Nations' Homecare. 4pp.

NAHO, 2006B. Presentation to the Senate Standing Committee on Aging.

NAHO, 2007. Understanding Health Indicators, Information Resource on Indicators of Health and Well-Being for First Nations Communities.

Prairie Research Associates (in collaboration with FNIHCCP National Evaluation Advisory Group), 2004A. First Nations and Inuit Home and Community Care Program (FNIHCCP) Study 1, Implementation "Foundations for Success". Technical Report: Literature, Document and National Data Review. Health Canada Publication #3194. 59pp

Prairie Research Associates (in collaboration with FNIHCCP National Evaluation Advisory Group), 2004B. First Nations and Inuit Home and Community Care Program (FNIHCCP) Study 1, Implementation "Foundations for Success". Technical Report. Health Canada Publication #3194. 96pp

Prairie Research Associates (in collaboration with FNIHCCP National Evaluation Advisory Group), 2004C. First Nations and Inuit Home and Community Care Program (FNIHCCP) Study 1, Implementation "Foundations for Success". Summary Report: Executive Summary and Key Findings. Health Canada Publication #3196. 9pp

Prairie Research Associates (in collaboration with FNIHCCP National Evaluation Advisory Group), 2004D. First Nations and Inuit Home and Community Care Program (FNIHCCP) Study 1, Implementation "Foundations for Success". Technical Report: Action Plan. Health Canada Publication #3194. 4pp

Prairie Research Associates (in collaboration with FNIHCCP National Evaluation Advisory Group), 2004E. First Nations and Inuit Home and Community Care Program (FNIHCCP) Study 1, Implementation "Foundations for Success". Summary Report: Action Plan. Health Canada Publication #3196. 4pp

Richardson, B. 2000. Implementing Home Care in Canada: Four Critical Elements. Healthcare Papers, Fall; 1(4): 9-36.

Saint Elizabeth Health Care, 2006. FNIHB eSDRT Review and Recommendations. 12pp.

Training Task Group International. 2004. First Nations and Inuit Home and Community Care Program ' Home Care Needs in First Nations and Inuit Communities' Literature Review. Draft Report. 26pp

Training Task Group International. 2005A. First Nations and Inuit Home and Community Care Program (Study Two) DRAFT. Home Care Needs in First Nations and Inuit Communities. Final Report. 86pp

Training Task Group International. 2005B. Formative Evaluation of the First Nations and Inuit Home and Community Care Program. Home Care Needs in First Nations and Inuit Communities. Program, Epidemiological and Demographic Review. 47pp

Training Task Group International. 2006. First Nations and Inuit Home and Community Care Program (FNIHCCP) Study 2, Meeting the Need for Home and Community Care in First Nations and Inuit Communities. Summary Report. 14pp

Treasury Board Secretariat of Canada, 2004. Canada's Performance. Annual Report to Parliament. IV Aboriginal Peoples. Pp70-97. www.tbs-sct.gc.ca/report/govrev/o4/cp-rc-eng.asp

APPENDIX A
EVALUATION QUESTIONS AND SOURCES

This Summative Evaluation assignment involved the examination of four broad areas of investigation: the continued relevance, implementation and program success/effectiveness of FNIHCC, as well as its cost effectiveness. The following Evaluation Questions are organized around these areas of investigation and the data sources/instruments (as identified/numbered below) which addressed these questions are identified as well as the location in the Evaluation Report where these questions are addressed.

The **Data Sources** of information for this Evaluation were as follows:

1. Academic and grey literature;
2. Program documentation 1 (policy documentation on HCCP) ;
3. Program documentation 2 (programme documents, funding formula, evaluations and other studies);
4. Documentation from other sources (stakeholders, other organizations);
5. Service documentation (e- SDRT for three years, 2005/06, 2006/07 and 2007/08);
6. Interviews with program managers (FNIHB, national and regional);
7. Interviews with other stakeholders from First Nations and Inuit associations, as well as CCHSA accredited communities; and,
8. Financial data.

Data Source	1	2	3	4	5	6	7	8	Location in Document
Program Rationale and Relevance									
Evaluation Question: 1. Does the FNIHCC Program continue to reflect the Government and Health Canada priorities?									
Rationale 1.1 To what extent is the FNIHCC program and its components appropriate in terms of its ability to fill community needs and gaps in service provision? (program theory)	√	√	√	√		√	√		pp25-26
1.2 Is the FNIHCC program, it mandate, and its components culturally appropriate and aligned with First Nations and Inuit values?	√	√	√	√		√	√		pp25-26; 50-51
Relevance 1.3 To what extent are FNIHCC services still relevant in terms of community needs for home care services?	√	√	√	√	√	√	√		Pp27-31

Data Source	1	2	3	4	5	6	7	8	Location in Document
1.4 To what extent are FNIHCC services still relevant in terms of gaps in community home care service provision? Do other programs delivery similar services?	√	√	√	√		√	√		Pp27-31
1.5 To what extent are the six objectives and mandate of FNIHCC still relevant?	√	√	√	√		√	√		Pp27-31
Design and Delivery									
Evaluation Question: 2 Has the FNIHCC Program been implemented and delivered?									
Design 2.1 Are the activities and outputs consistent with the mandate of the program?		√	√		√	√	√		Pp32-33
2.2 Are the activities and outputs plausibly linked to objectives and intended outcomes? (program logic)		√	√			√	√		Pp32-33
Delivery 2.3 Is the delivery of the program consistent with its planned roll-out and implementation?		√	√	√		√	√		Pp32-33; 39-42
2.4 Is the delivery of the program effective in meeting clients' needs		√	√	√		√	√		Pp32-33; 39-42
Success									
Evaluation Question: Is the FNIHCC Program achieving the outcomes expected (design and delivery outcomes, individual and community outcomes, policy outcomes)?									
Design and Delivery Success 3.1 How is the FNIHCC program being implemented and delivered?			√	√		√	√		Pp41-44
3.2 How is risk being managed? What are the outcomes?									n/a
3.3 Are FNIHCC administrators enabled to monitor and manage the program? What are the enablers and what are the obstacles?			√			√	√		Pp48-49
3.4 Is the performance measurement system generating valid and reliable results?			√		√	√	√		Pp32-33
3.5 Has awareness of FNIHCC service users and community leaders increased in terms of: • Types of services available • Community needs (based on assessments) • Match between community needs and services provided.			√	√	√	√	√		Pp48-49

Data Source	1	2	3	4	5	6	7	8	Location in Document
3.6 Has the capacity to administer and deliver FNIHCC increased in terms of: • Health human resources (number and qualifications of staff) • Recruitment and retention of staff • Service delivery models (types of staff, collaboration, care continuity, etc.) • Physical resources (facilities, equipment, technologies, etc.)			√		√	√	√	√	Pp48-49
3.7 Has program delivery been consistent with First Nations and Inuit culture and values?			√	√		√	√		Pp51
Individual and Community Outcomes Success 3.8 Has access to FNIHCC essential and support services increased for First Nations and Inuit clients? (e.g. Number of admissions, separations, active cases per 1000, service hours per 1000, etc.)			√		√	√		√	Pp60-67
3.9 Have there been any confounding factors affecting access? (e.g. cultural, health resource, care appropriateness, patient and provider safety, timeliness, understanding)			√	√		√	√		Pp49-50
3.10 Have client health outcomes increased since the implementation of FNIHCC? * • Was health deterioration prevented or delayed? • Was onset of complications reduced? • Have clients been satisfied with services received?							√		n/a - not collected but referred to by some respondents Pp50
3.11 Have health system outcome improved since the implementation of FNIHCC? ** • Have care workers been satisfied with care provided, and conditions of employment? • Have services provided substituted care that would otherwise need to be provided in hospital or long term care settings? • Has the program maintained people safely in their home communities?						√	√		/a - not collected but referred to by some respondents Pp50
3.12 Have community ties been strengthened in their capacity to care for own clients?			√			√	√		Pp51-52
3.13 Have there been any unintended positive or negative consequences?			√			√	√		Pp51-52
Policy Outcomes Success 3.14 To what extent did the FNIHCC program contribute to the overall FNIHB mandate?		√				√			Pp51-52

Data Source	1	2	3	4	5	6	7	8	Location in Document
3.15 Did the FNIHCC promote linkages with other programs, or branches of FNIHB? • Integration of home care services with primary and acute care provision, • Number of partnerships and number of MoUs with other orders of government and health care authorities and providers.			√ √	√ √		√ √	√ √		Pp52 n/a
3.16 What are the strengths of the FNIHCC program? What are its shortcomings?			√	√		√	√		Pp47-52
3.17 In what manner, and to what extent, does the program complement, duplicate, overlap, or work at cross purposes with other programs?				√		√	√		Pp47-52
Efficiency									
Evaluation Question: 4 How cost-effective is the FNIHCC Program?									
4.1 Could other programs delivery the same services at lower cost? • What are the current costs of specific essential and support services delivered through FNIHCC? • What would be the costs of these services if provided through hospitals or long term care facilities?			√		√			√	Pp60-67
4.2 Could changes in the delivery system reduce costs of the FNIHCC program? • Are all administrative steps necessary to effective delivery? • What are the costs of staff, facilities, support services (e.g. technology) as the program is currently delivered? • Could the delivery process be made more efficient by reducing processes, staff, or physical resources?			√		√	√		√	Pp60-67

* While these questions were included in the evaluation team's original proposal, this information was not collected based on direction received from HC – ideally clients, service providers and other community members should be surveyed to collect this data

** These should also be asked of service providers, who were not part of this survey