Health Canada and the Public Health Agency of Canada
Santé Canada et l'Agence de la Santé publique du Canada

Evaluation of the First Nations and Inuit Home and Community Care Program 2008-2009 to 2011-2012

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List of Acronyms

AANDC	Aboriginal Affairs and Northern Development Canada
AL	Assisted Living
DPR	Departmental Performance Report
e-SDRT	Electronic Service Delivery Reporting Template
e-HRTT	Electronic Human Resource Tracking Tool
FNIHB	First Nations and Inuit Health Branch
FNIHCC	First Nations and Inuit Home and Community Care
HC	Health Canada
interRAI HC	Inter-Resident Assessment Instrument Home Care
LPN	Licensed Practical Nurse
NIHB	Non-Insured Health Benefits
PAA	Program Alignment Architecture
PHAC	Public Health Agency of Canada
P/T/RHA	Provincial/Territorial Government/Regional Health Authority
RN	Registered Nurse
RPP	Report on Plans and Priorities

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Executive Summary

This evaluation covered the First Nations and Inuit Home and Community Care (FNIHCC) program for the period from April 1, 2008 to March 31, 2012. The evaluation was undertaken in fulfillment of the requirements of the *Financial Administration Act* and the Treasury Board of Canada's *Policy on Evaluation (2009)*.

Evaluation Purpose, Scope and Design

The purpose of the evaluation was to assess the relevance and performance of the FNIHCC Program. The methodology used in the evaluation included input from 415 individuals from all provinces and territories through interviews, an online stakeholder survey and case studies of key issues. In addition, a review of documents, data, and literature was conducted. This was the second evaluation of the program, having been previously evaluated in 2009.

Program Description

The FNIHCC Program provides basic home and community care services that are comprehensive, culturally sensitive, accessible and responsive to the unique health and social needs of First Nations and Inuit. The program enables First Nations and Inuit people of all ages with disabilities, chronic or acute illnesses and the elderly to receive the care they need in their homes and communities. The program is primarily provided through contribution agreements with First Nation and Inuit communities and territorial governments and strives to be comparable to home and community care services offered to other Canadian residents in similar geographical areas. The FNIHCC Program average expenditures for the four-year period under evaluation were approximately $110 million annually. The Program is delivered in 657 First Nations and Inuit communities primarily by home care registered nurses, licensed practical nurses and trained and certified personal care workers. Essential service elements include client assessments, case management, nursing, personal and supportive care, and in-home respite.

Evaluation Conclusions and Recommendations

CONCLUSIONS - RELEVANCE

Continued Need for the Program

The FNIHCC Program continued to be relevant to First Nations and Inuit home and community care needs. The program design and funding were responsive to essential home care needs. The needs related to First Nation and Inuit home and community care are expected to increase and become increasingly more complex and, in response, a 10-Year Strategic Business Plan for the FNIHCC Program is being developed.

Alignment with Government Priorities

The FNIHCC Program is a mandatory program within the Primary Health Care Authority First Nations and Inuit Health Program and aligned with federal government and Health Canada priorities as identified in Budget 2008, Budget 2009 and various federal policies and initiatives.

Alignment with Federal Roles and Responsibilities

The FNIHCC Program aligned with the federal roles of the First Nations and Inuit Health Branch of Health Canada which has the responsibility to provide or fund the provision of First Nations and Inuit health programs consistent with the Indian Health Policy and subsequent Departmental mission or mandate statements. The FNIHCC Program clearly aligned with Health Canada's strategic outcomes.

CONCLUSIONS - PERFORMANCE

Achievement of Expected Outcomes (Effectiveness)

The FNIHCC Program was delivered as intended and is progressing towards its intended outcomes, including the long term outcome to be responsive to the needs of First Nations individuals and communities through the provision of home and community care services.

The program has been stable in terms of the services provided over the evaluation period and continues to provide access to essential home and community care services. While there have been initiatives to increase the capacity of the home and community care workforce, the evaluation found that lower capacity regional offices are challenged to deliver the HCC program in comparison with higher capacity regional offices. While there have been improvements in the collaboration of FNIHCC Program staff with other health care providers, linkages with social programs in communities are somewhat less effective. There have been regional and community efforts to improve the coordination with other programs in order to deliver seamless responses to home and community care needs (e.g., the integration of the program and the Aboriginal Affairs and Northern Development Canada Assisted Living Program - In-Home Care Component).

Initiatives have begun to increase the use of policies, standards, guidelines, best practices, and evidence-based information which are expected to have a positive future impact on program delivery at the community and regional levels. Although expected, it is not yet evident the degree to which national initiatives will increase the use of quality improvement processes.

Demonstration of Economy and Efficiency

The FNIHCC Program is considered to be efficiently managed and delivered. To maximize funds, the economy and efficiency of the program could be improved through increasing the capacity of lower capacity regional offices, clustering program delivery across communities, integrating programs, streamlining reporting requirements across programs, improving performance measurement and making greater use of technology.

RECOMMENDATIONS

Recommendation 1

Health Canada should develop options for increasing the capacity of regional offices that have lower capacity to support the efficient delivery of the FNIHCC Program in communities.

Recommendation 2

Health Canada should continue pursuing its negotiation with Aboriginal Affairs and Northern Development Canada (AANDC) to achieve formal integration of the FNIHCC Program with the AANDC Assisted Living Program - In-Home Component to improve efficiencies in the delivery of home care services.

Recommendation 3

Health Canada should strengthen linkages and partnerships between the program and other external social programs to increase collaboration.

Recommendation 4

Health Canada should continue its current initiatives to improve quality program delivery through the use of evidence-based information, program policies and standards, and quality improvement processes in a manner that is relevant and sustainable within current resource levels of regions and communities.

Recommendation 5

Health Canada should revise the logic model for the FNIHCC Program to ensure expected outcomes are reflective of the nature of this health program moving forward and ensure adequate program data are collected to facilitate decision-making and future evaluation.

Management Response and Action Plan 2012/2013

First Nations and Inuit Home and Community Care Evaluation

Recommendations	Management Response	Management Action Plan	Deliverables	Expected Completion Date	Responsibility/ Accountability
1. Health Canada should develop options for increasing the capacity of regional offices that have lower capacity to support the efficient delivery of the FNIHCC Program in communities.	Management agrees with the recommendation to develop options for increasing regional offices' capacity to support the delivery of the FNIHCC Program in communities.	FNIHCC will work with Regions to develop options to support and improve the delivery of the FNIHCC Program in communities.	Options Paper	March 2014	Executive Director, Primary Care Division, Interprofessional Advisory and Program Support Directorate
2. Health Canada should continue pursuing its negotiation with Aboriginal Affairs and Northern Development Canada (AANDC) to achieve formal integration of the FNIHCC Program with the AANDC Assisted Living Program - In-Home Component to improve efficiencies in the delivery of home care services.	Management agrees with the recommendation to continue to pursue negotiations with AANDC. HC will work with AANDC to achieve formal integration of the FNIHCC Program with the AANDC Assisted-Living Program In-Home Component.[1]	FNIHCC will develop a strategy to pursue negotiations with AANDC to achieve formal integration of FNIHCC with AANDC's Assisted Living In-Home Component.	Strategy Document	September 2015	Executive Director, Primary Care Division, Interprofessional Advisory and Program Support Directorate
		FNIHCC will continue its activities to inform communities of the benefits of integration and to encourage and support communities that have not integrated the delivery of the two programs to move to an integrated approach.	Key messages developed outlining the benefits of integration of the two programs	April 2014	

[1] Discussions between Health Canada and AANDC have been ongoing for several years regarding integration of these programs.

Recommendations	Management Response	Management Action Plan	Deliverables	Expected Completion Date	Responsibility/ Accountability
3. Health Canada should strengthen linkages and partnerships between the program and other external social programs to increase collaboration.	Management agrees with the recommendation to strengthen linkages with program and other external programs.	FNIHCC will work with First Nations Regional Managers and First Nations and Inuit Partners to develop a strategy to strengthen linkages with stakeholders both at a National, Regional and community level.	Strategy Report	September 2014	Executive Director, Primary Care Division, Interprofessional Advisory and Program Support Directorate
4. Health Canada should continue its current initiatives to improve quality program delivery through the use of evidence-based information, program policies and standards, and quality improvement processes in a manner that is relevant and sustainable within current resource levels of regions and communities.	Management agrees with the recommendation and will continue to improve the use of evidence-based information, program policies and standards, and quality improvement processes.	FNIHCC will work with Regions to identify best practices in the use of evidence-based information, program policies and standards and quality improvement processes and develop regional training activities on Program Standards and Quality Improvement processes.	Best Practices Document for Quality Regional Training Activities on Program Standards and Quality Improvement - Information sheet developed to promote uptake and roll-out of findings	April 2014	Executive Director, Primary Care Division, Interprofessional Advisory and Program Support Directorate
		FNIHCC will undertake an examination of the use of the evidence-based information, program policies and standards, and quality improvement processes.	- Report on Examination Findings	September 2014	Executive Director, Primary Care Division, Interprofessional Advisory and Program Support Directorate

Recommendations	Management Response	Management Action Plan	Deliverables	Expected Completion Date	Responsibility/ Accountability
5. Health Canada should revise the logic model for the FNIHCC Program to ensure expected outcomes are reflective of the nature of this health program moving forward and ensure adequate program data are collected to facilitate decision-making and future evaluation.	Management agrees with the recommendation for revision of the logic model and to continue to improve the collection of performance and monitoring data reflecting the FNIHCC Program activities, outputs and outcomes.	FNIHCC will work with Strategic Policy, Planning and Information, Performance Measurement Unit collaboratively to revise Logic Model including the HCC Performance Matrix.	Revised HCC Program Logic Model	December 2013	Executive Director, Primary Care Division, Interprofessional Advisory and Program Support Directorate Director, Strategic Policy, Planning and Information
		FNIHCC will work with Regions to seek input in the review of the Program Logic Model and the performance matrix.	Approved revised HCC Performance Matrix including a standard set of revised indicators	March 2014	
		FNIHCC will conduct awareness activities with Regions to ensure that adequate program data are collected to facilitate evaluation of expected outcomes.	Key Messages developed outlining roles and responsibilities regarding evaluation requirements on the collection of data	March 2014	
		FNIHCC will continue to improve the collection of performance monitoring data by developing a tool to standardize collection of data for improved data quality in collaboration with Regional offices.	Standardized collection tool	April 2015	Executive Director, Primary Care Division, Interprofessional Advisory and Program Support Directorate

1. Evaluation Purpose

The purpose of the evaluation was to assess the relevance and performance of the First Nations and Inuit Home and Community Care (FNIHCC) program for the period of April 1, 2008 to March 31, 2012.[2]

This was the second evaluation of the program which was previously evaluated in 2009. The evaluation was undertaken in fulfillment of the requirements of the *Financial Administration Act* and the Treasury Board of Canada's *Policy on Evaluation (2009)*.

2. Program Description

2.1 Program Context

The program was developed in response to home and community care needs for First Nations and Inuit. The FNIHCC Program provides basic home and community care services that are comprehensive, culturally sensitive, accessible and responsive to the unique health and social needs of First Nations and Inuit. Funding is provided primarily through contribution agreements with First Nation and Inuit communities and territorial governments and the program strives to be comparable to home and community care services offered to other Canadian residents in similar geographical areas. The FNIHCC Program enables First Nations and Inuit people of all ages with disabilities, chronic or acute illnesses and the elderly to receive the care they need in their homes and communities.[3] The program is delivered in 657 First Nations and Inuit communities.[4]

2.2 Program Profile

The objective of the FNIHCC Program is to provide First Nations and Inuit with basic home and community care services such as: client assessments, case management, nursing, personal and supportive care, and in-home respite.

The FNIHCC Program is delivered primarily by home care Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and trained and certified personal care workers. Service delivery is based on assessed need and follows a case management process. Essential service elements that all communities are required to deliver include: client assessment; home care nursing; case

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2 The original evaluation timeframe was from 2008-09 to 2011-12. However, since the start of the evaluation was delayed, the timeframe for the conduct of the evaluation was extended. Data collection ended in December 2012. Program expenditure information was provided up to the end of 2011-12.

3 Appendix 11, Consolidation of First Nations and Inuit Health Contribution Program Authorities, 2010.

4 *Ibid*.

management; home support (personal care and home management); in-home respite; linkages and referrals as needed to other health and social services; provision of and access to specialized medical equipment and supplies for care; and a system of client record keeping and data collection.

Additional supportive services may also be provided, depending on the needs of the communities and funding availability. Supportive services may include, but are not limited to: rehabilitation and other therapies; in-home palliative care; adult day care; meal programs; in-home mental health care; and specialized health promotion activities.

The federal government established the FNIHCC Program in the 1999 Budget to provide basic home and community care services for First Nations and Inuit.[5] The program was a response to the urgent needs of First Nations and Inuit for home care services identified in recent studies. These needs included the disproportionately high rates of disabilities and chronic or acute illnesses among the First Nations and Inuit population compared to the national average, the comparatively higher rate of population growth of First Nation and Inuit, and provincial/territorial health reforms which were resulting in a shift from hospital-based to community-based health care. These health status, demographic and health reform changes meant that a higher proportion of First Nations and Inuit of all ages were in need of home care services.[6]

The FNIHCC Program is not administered in the same manner for Inuit as it was for First Nations. First Nations communities receive funds through contribution agreements signed with the First Nations and Inuit Health Branch (FNIHB). According to these agreements, First Nations are required to provide annual information via the FNIHCC's e-SDRT (electronic service delivery reporting template). However, for Inuit living in Inuit communities (with the exception of those in Nunatsiavut, Labrador and Nunavik, Quebec), the program is managed directly by the Territorial governments. Although some reporting was done by the latter, it was not as detailed as the information available from the e-SDRT. As a result, when referring to the FNIHCC in this document, the information largely refers to First Nations and not Inuit, unless specifically mentioned. It is also worth noting here that the Aboriginal Affairs and Northern Development Canada (AANDC) Assisted Living: In-Home Services Program was not available in the Territories.

Governance

FNIHCC service delivery is intended to occur at the community level through community governance structures, consistent with the principles of health transfer and self-government. Although First Nations communities are responsible for the delivery of FNIHCC and client service results, the territorial governments of the Northwest Territories and Nunavut are responsible for FNIHCC service delivery for the First Nations and Inuit living in those territories. Within the FNIHCC Program, contribution funding is allocated from the FNIHB Regional Office to communities/tribal groups/First Nations and Inuit health authorities/territorial governments using the Modified Berger Formula developed in 1997.

5 First Nations and Inuit Home and Community Care Program Summative Evaluation, 2009.
6 Annex D, Funding for the First Nations and Inuit Home and Community Care Program, 2000.

In Inuit Nunangat (Inuit homeland), which includes all four Inuit regions: Inuvialuit Settlement Region, Nunavut, Nunavik, and Nunatsiavut, the home and community care program is administered in a slightly different manner. The Governments of Nunavut and the Northwest Territories deliver their home care programs to all residents regardless of ethnicity. Health Canada's Northern Region acts as a coordinating body between Health Canada and the territorial governments. The Nunavik Regional Board of Health and Social Services delivers the program to Inuit in Quebec only. The government of Nunatsiavut delivers the program directly to Inuit residing in that region. Nunavut's program is administrated through three regional coordination centres located in Cambridge Bay, Rankin Inlet, and Iqaluit with service delivery variations between the centres.

Since its origins, the FNIHCC Program has had partnership agreements with the national organizations representing the First Nations and Inuit served by the program: the Assembly of First Nations and the Inuit Tapiriit Kanatami.

2.3 Program Logic Model and Narrative

The FNIHCC Program Logic Model (see Appendix 1) outlines the linkages between activities (themes), outputs, and three levels of outcomes (immediate, intermediate and long-term). The five activity themes include: service provision; capacity building; stakeholder engagement and collaboration; data collection, research and surveillance; and policy development and knowledge sharing. Each of these activities produces numerous outputs which are then linked to specific immediate outcomes. The six immediate outcomes of the FNIHCC Program are:

- increasingly appropriate home and community care services based on assessed need;
- increasing capacity of home and community care workforce;
- increased collaboration with internal and external providers;
- increased First Nation and Inuit awareness of home and community care services;
- increased use of policies, standards, guidelines and best practices in service delivery; and
- increased use of evidence-based information to inform quality program delivery.

The immediate outcomes contribute to three intermediate outcomes[7]:

- improved access to home and community care services;
- improved coordinated and seamless responses to home and community care needs; and
- increased use of continuous quality improvement, including patient safety processes, to respond to home and community care needs.

Achievement of the intermediate outcomes contributes to the achievement of the long-term outcome, stated as: *home and community care services that are responsive to the needs of First Nations and Inuit individuals and communities.*

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[7] In the logic model there is a fourth intermediate outcome identified as "increased effectiveness of services". It is noted that effectiveness is generally interpreted as the extent to which a program is achieving *all* of the expected outcomes, and is assessed under program performance. As a result, effectiveness of services is being evaluated under the rubric of performance.

2.4 Program Alignment and Resources

The FNIHCC Program contributes to Health Canada's Strategic Outcome 3: First Nations communities and individuals receive health services and benefits that are responsive to their needs so as to improve their health status. The FNIHCC sub-sub activity is identified in the Department's Program Alignment Architecture (PAA) under Program Activity 3.1.3: First Nations and Inuit Primary Health Care.

At the program's inception in 1999, $90 million per year was allocated. Funding has increased over time to include additional allocations for nursing salary resources and annual operating increases. Table 1 details the data on FNIHCC Program expenditures over the 2008-09 to 2011-12 period. Almost all expenditures (95.4%) were for the contribution agreements which accounted for $423 million of the $443 million spent during this four-year period. During the evaluation period from April 1, 2008 to March 31, 2012 the FNIHCC Program expenditures increased from $104,704,675 million to $116,601,358 million representing an increase of approximately 11.3%.

Table 1: FNIHCC Program Expenditures 2008-09 to 2011-12[8]

Year	Contributions	Salaries/Wages	Other Operating and Minor Capital	Total
2008-09	$99,875,137	$3,442,920	$1,386,618	**$104,704,675**
2009-10	$103,524,172	$3,436,784	$1,205,451	**$108,166,407**
2010-11	$108,488,026	$3,689,026	$1,418,429	**$113,595,481**
2011-12	$111,139,939	$3,968,762	$1,492,657	**$116,601,358**
Total	**$423,027,274**	**$14,537,492**	**$5,503,155**	**$443,067,921**

The program occasionally received funding from other sources to supplement its existing work (these sources are not included in Table 1). Between 2009 and 2011, the program received approximately $612,000 from the time-limited National Nursing Innovation Strategy program to undertake activities that enhanced collaboration (e.g., within the communities and with other health providers) and also enhanced the wound-care knowledge and skills of FNIHCC nurses. Budget 2010 provided funds totalling $5.0 million per year for five years (with an option to seek renewal for a further five-year period) for the training of FNIHCC nurses on evidence-based clinical practice guidelines and chronic disease management strategies as part of the Aboriginal Diabetes Initiative.[9]

8 Source: Chief Financial Officer Branch. HCC-Evaluation-Actual Expenditures 2007-2012.pdf

9 Health Canada. (2012). First Nations and Inuit Home and Community Care: 2012 Report. Ottawa, ON.

3. Evaluation Description

3.1 Evaluation Scope and Issues

The scope of the evaluation covered the period from April 1, 2008, to March 31, 2012, and included all FNIHB HCC activities and services, as defined by the 2005 Authorities and renewed 2011 Authorities. The Primary Care Cluster funding under the 2005 Authorities included three components: Home and Community Care Program; Community Primary Care Program (now called Clinical and Client Care Program); and the Oral Health Care Program. Only the Home and Community Care Program is included in this evaluation. The evaluation included all of the activities carried out under the program (as defined by the renewed 2011 Authorities).

The evaluation issues were aligned with the Treasury Board of Canada's *Policy on Evaluation* (2009). The evaluation considered the five core issues under the two themes of relevance and performance, as shown in Table 2. Corresponding to each of the core issues, specific questions were developed based on program considerations and these guided the evaluation process.

Table 2: Core Issues and Questions

Core Issues	Evaluation Questions
Relevance	
Issue #1: Continued Need for Program	Is there a continued need for the program? • 1.1: Does the program continue to address a demonstrable need? • 1.2: Is the program responsive to the needs of First Nations and Inuit?
Issue #2: Alignment with Government Priorities	Does the program align with Government of Canada priorities? • 2.1: Does the program remain a priority of the federal government? • 2.2: Does the program align to departmental strategic priorities/outcomes?
Issue #3: Alignment with Federal Roles and Responsibilities	Is the program aligned with federal roles and responsibilities? • 3.1: Does the FNIHCC Program align with departmental strategic priorities/outcomes? • 3.2: Do the program's key stakeholders see the program's activities as relevant and aligned to its roles and responsibilities? • 3.3: Are the program's activities aligned/congruent with the department's jurisdictional and/or mandated role?
Performance (effectiveness, efficiency and economy)	
Issue #4: Achievement of Expected Outcomes (Effectiveness)	Is the program achieving the outcomes expected as outlined in the Logic Model? • 4.1: Has the program achieved its immediate outcomes? • 4.2: Has the program achieved its intermediate outcomes? • 4.3: Has the program achieved its long-term outcome?
Issue #5: Demonstration of Efficiency and Economy	Has the program been implemented efficiently and economically? • 5.1: How has the program optimized the overall quantity, quality, and blend of products and/or services to facilitate achievement of the program's expected outcomes? • 5.2: Are there alternative methods which ensure the same achievement of immediate expected results? • 5.3: Has the program minimized resources while optimizing outputs? • 5.4: Were the program's resources managed effectively to facilitate the achievement of relevant immediate outcomes?

3.2 Evaluation Approach and Design

The evaluation used an outcome-based approach to assess the progress made towards the achievement of immediate outcomes. The approach included collaboration with key internal and external stakeholders in the planning and conduct of the evaluation, review of technical data and in developing the evaluation report as well as the management response and action plan.

This evaluation used a non-experimental and retrospective design. The evaluation was non-experimental because evidence on the progress toward the achievement of expected outcomes was observational in nature. Furthermore, not only did the evaluation require a retrospective design because the data was based on past years of funding, but it also used a retrospective design because there was an absence of baseline data.

3.3 Data Collection and Analysis Methods

Information on the data collection and analysis methods are summarized below and provided in detail in Appendix 2. A total of 415 individuals from all provinces and territories provided input to the evaluation through interviews, an online stakeholder survey and case studies of key issues. These individuals included staff of Health Canada and the communities delivering the program, staff delivering other community programs, Band Chiefs and Council and their designates, national and regional Aboriginal organizations, non-governmental organizations, provincial/territorial governments and regional health authorities.

Literature, Document and Database Reviews

Literature was defined broadly as information from sources external to the FNIHCC Program, including both peer-reviewed and grey literature. A total of 40 documents were included in the literature review. A total of 47 internal FNIHCC Program documents (i.e., FNIHB and Health Canada documents) were also reviewed.

The database review focused on: review of a FNIHCC Program summary report completed in 2012, documents outlining processes and findings from program data quality reviews, and some additional summary tables provided by FNIHB that aligned data to the evaluation indicators. The main sources used were two FNIHCC tools: the Electronic Human Resource Tracking Tool (e-HRTT) and the Electronic Service Delivery Reporting Template (e-SDRT).

Key Informant Interviews

Using a purposive sampling approach, key informants were selected from population lists covering five groups at the national level and in the Health Canada Regions. These groups included:

1. Band Chief and Council or designates (i.e., Health Directors) – who served as a proxy group for FNIHCC clients;
2. Provincial/Territorial Governments and Regional Health Authorities representatives;

3. National and Regional Aboriginal Organizations and Non-governmental Organization (ABO/NGO) representatives;
4. Other federal government department representatives; and
5. Health Canada National and Regional Office representatives.

A total of 58 key informant interviews were conducted by telephone.

For qualitative key informant interviews, the following descriptive scale was used to indicate the approximate number of key informants that made the relevant statement, with “a few” being less than 20% of respondents, “some” being more than 20% to approximately 45%, “many” being more than 45% to approximately 60%, “most” being more than 60% to approximately 80%, and “almost all” being over 80%.

Online Stakeholder Survey

The online survey included the following stakeholder groups:

- First Nations Chiefs and Council and their designates (e.g., Health Directors) who served as proxy respondents for FNIHCC Program clients;
- FNIHCC Program community staff;
- Staff delivering other community health programs;
- Health Canada staff associated with the FNIHCC Program; and
- Other provincial/territorial/regional stakeholders such as Tribal Councils, Regional Aboriginal Organizations, provincial government representatives, and regional health authorities.

A total of 1,762 individuals were invited to participate of whom 332 completed the survey for a response rate of 18.8%.

Case Studies

Case studies were conducted of two cross-cutting issue “themes” that were thought to have an impact on the achievement of FNIHCC Program intended outcomes and which had the potential to address the evaluation questions. These themes were:

- regional capacity to deliver the FNHICC Program (both higher and lower capacity regions were selected considering criteria such as capacity to respond to community requests, use of data and reporting, staff turnover and unstaffed positions at the community and regional levels, development of pilot projects, sharing of best practices and community characteristics); and
- integration of the delivery at the community level of the FNIHCC Program and the Aboriginal Affairs and Northern Development Canada (AANDC) Assisted Living Program - In-Home Care Component.

Analysis

Evidence from all lines of inquiry was examined according to the key evaluation issues and questions. Data were analyzed by triangulating information gathered from the different sources and methods. Systematic compilation, review and summarization of the data were conducted to illustrate key findings.

3.4 Limitations and Mitigation Strategies

Most evaluations face constraints that may have implications on the validity and reliability of evaluation findings and conclusions. This section (Table 3) illustrates the limitations in the design and methods for this particular evaluation. Also noted are the mitigation strategies put in place to ensure that the evaluation findings can be used with confidence to guide program planning and decision making.

Table 3: Limitations and Mitigation Strategies

Limitation	Impact	Mitigation Strategy
Limited program data available to directly assess the outcomes and related indicators as stated in the Program Logic Model and challenges in determining incremental changes in outcomes without baseline measures.	For some outcomes, evidence is relatively indirect, highly variable or only includes examples of progress made, impacting the validity of the findings. Limited ability to assess increases or improvements in specific outcomes.	Other lines of evidence were used to gather opinions on outcomes to complement the evidence from the database and document reviews. Key informants were asked for a retrospective opinion on changes as well as their opinion on the current state of specific aspects of the program.
No input gathered directly from program clients (proxy group was used).	The proxy group has responsibility for the FNIHCC Program at the community level and may have a positive bias regarding the communities' delivery of the program and/or may not be able to fully representative the program client's perspectives.	Input was gathered through proxies (Chiefs and Council and health directors) to maintain anonymity of FNIHCC clients and the inherent sensitivity of information in small communities. The literature and document review attempted to identify and include any recent studies addressing the perspective of individuals living in First Nation and Inuit communities on the home and community care services to complement the perspectives of the proxy group but no related documents were found.

Limitation	Impact	Mitigation Strategy
Low response rate for Band Chiefs and their designates.	Under-representation of views from this important group, particularly given that this group was identified as the proxy group for FNIHCC Program clients.	In the case of the key informant interviews, three times the number of targeted key informants in this group were invited. Multiple follow-ups were conducted with this group by email and telephone for both the key informant interviews and survey. Due to low response rate, caution was used when interpreting the key informant findings. Key summary findings and conclusions were supported by other lines of evidence.
Reliance on a convenience sample.	Data and findings from the stakeholder survey may not be representative of the stakeholder groups invited to participate.	Caution was used when interpreting survey findings, particularly apparent differences between groups. Key summary findings and conclusions were supported by other lines of evidence.

4. Findings

4.1 Relevance: Issue #1 – Continued Need for the Program

The FNIHCC Program continues to address a demonstrable need for home care and community services among First Nations and Inuit. The program design and funding was responsive to essential home care needs. However, the needs related to First Nation and Inuit home and community care are expected to increase and become increasingly more complex. These needs include disproportionate disease burden experienced by First Nations and Inuit in comparison to the general Canadian population and changing demographics among the First Nations and Inuit population. As well, there has been a trend by provincial governments to offer community-based health services which has led to earlier hospital discharges and clients with more complex care needs in communities.

Demonstrable Need

The evidence from the literature and document reviews, key informant interviews and stakeholder survey indicated that there is a demonstrable need[10] for home and community care among First Nations and Inuit that is expected to increase in the future.

The literature and document reviews indicated that First Nations experience higher rates of various chronic conditions and diseases. For example, age-standardized rates show the prevalence of diabetes was 17.2% among First Nations individuals living on-reserve, 10.3%

[10] Note that the list of health issues are not exhaustive.

among First Nations individuals living off-reserve, and 7.3% among Métis, compared to 5.0% in the non-Aboriginal population.[11] Other conditions which were notably higher among First Nations adults included respiratory illness such as asthma (10.9% vs. 7.8%[12]), vascular diseases such as high blood pressure (21.8% vs. 14 %[13]) and ischemic heart disease with First Nations experiencing a significantly higher mortality rate (155 for males; 75 for females per 100,000) than that experienced by non-Aboriginals (123 for males; 49 for females).[14] First Nations adults also experienced higher rates of musculoskeletal conditions such as arthritis and rheumatism (20.7% vs. 13.9%).[15] As well, with respect to mental health issues, the suicide rate among First Nations was approximately double that experienced by the Canadian population in general (24 vs. 12 suicides per 100,000 population).[16]

The Inuit health profile found in the literature was different from that of First Nations with respect to chronic conditions and diseases. The greatest differences between the Inuit and the Canadian general population occurred in the areas of tuberculosis (114 vs. 5 cases per 100,000 population),[17] lung cancer (53-55 vs. 12-20 mortality rate per 100,000),[18] colorectal cancer (18 vs. 6-8 mortality rate per 100,000),[19] and suicide (135 vs. 12 per 100,000).[20] There was some indication that the chronic disease rates among Inuit are likely underestimated due to non-diagnosis.[21]

Rates of cancer have been calculated for people who live in Inuit Nunangat (the traditional Inuit Homeland in northern Canada), and compared to people who live in the rest of Canada. These rates showed that for males, the incidence of cancer overall was 14% lower in Inuit Nunangat than in the rest of Canada, while for females, the overall rate was 29% higher.[22] The incidence rates of certain types of cancer (e.g., cancer of the lung and bronchus and colorectal cancer) were higher among both male and female residents of Inuit Nunangat when compared to the rest of Canada.

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11 Population Health Agency Canada (2011). Diabetes in Canada: Facts and figures from a public health perspective. Retrieved February 4, 2012: http://www.phac-aspc.gc.ca/cd-mc/publications/diabetes-diabete/facts-figures-faits-chiffres-2011/highlights-saillants-eng.php#chp6.

12 Health Canada. (2009). A Statistical Profile on the Health of First Nations in Canada: Self- Rated Health and Selected Conditions, 2002 to 2005 (Report No. Health Canada Pub.: 3556). Ottawa, ON.

13 Health Canada. (2012). First Nations and Inuit Home and Community Care: 2012 Report. Ottawa, ON.

14 Health Canada. (2010). Healthy Canadians–A Federal Report on Comparable Health Indicators 2010 (Report No. Health Canada Pub.: 100353). Ottawa, ON.

15 Health Canada. (2012). First Nations and Inuit Home and Community Care: 2012 Report. Ottawa, ON.

16 Inuit Tapiriit Kanatami. (2008). Inuit Statistical Profile. Ottawa, ON.

17 Inuit Tapiriit Kanatami. (2008). Inuit Statistical Profile. Ottawa, ON.

18 Health Canada. (2010). Healthy Canadians–A Federal Report on Comparable Health Indicators 2010 (Report No. Health Canada Pub.: 100353). Ottawa, ON.

19 Health Canada. (2010). Healthy Canadians–A Federal Report on Comparable Health Indicators 2010 (Report No. Health Canada Pub.: 100353). Ottawa, ON.

20 Inuit Tapiriit Kanatami. (2008). Inuit Statistical Profile. Ottawa, ON.

21 Johnston Research Inc. (2012). First Nation and Inuit Home and Community Care Program Strategic Planning Meeting October 27-28, 2011: Meeting Report, DRAFT. Ottawa, ON: Health Canada.

22 Carriere, G.M., Tjepkema, M., Pennock, J., & Goedhuis, N. (2012). Cancer patterns in Inuit Nunangat: 1998-2007. International Journal of Circumpolar Health, 71.

The rate of mortality associated with malignant neoplasms (cancer) among residents of Inuit Nunangat was approximately two times higher as compared to Canada overall (which includes deaths occurring in Inuit Nunangat). This pattern was also noted for rates of colorectal and lung cancer, which were both significantly higher among residents of Inuit Nunangat as compared to Canada overall.[23]

In examining chronic disease rates as evidence of a demonstrable need for home and community care, it was also important to note that contributing to the level of need was the comorbidity of chronic disease, with significant rates of First Nations and Inuit reporting more than one chronic condition. For example, in the 2008-2010 period, over one-third of First Nations men (35.3%) and women (41.1%) living on-reserve reported that they had two or more chronic health conditions.[24] There was some indication of increased complexity of chronic conditions given that the prevalence of comorbidity as reported by First Nations adults on reserve with four or more chronic health conditions increased from 11.3% in 2002-03 to 16.0% in 2008-10.[25] Similarly, there was an anticipated increase in Alzheimer's and Dementia Related Diseases (ADRD) among First Nations and Inuit.[26]

There are a number of conditions in some First Nations and Inuit communities that may have impacted their health, as outlined in the evidence from the document and literature reviews. These conditions included: poverty, limited services, isolation, low levels of education, poor housing conditions, food insecurity, low levels of health literacy, high rates of smoking, high rates of alcohol and drug abuse, and high rates of obesity. [27,28,29,30,31,32,33,34] For example, one-

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23 Statistics Canada. (2010). CANSIM Table 102-0704 Mortality, by selected causes of death (ICD-10) and sex, five-year average, Canada and Inuit regions, every 5 years. Retrieved on May 24, 2013, from www5.statcan.gc.ca/cansim/a05?id=1020704 &stByVal=3&paSer=&lang=eng

24 Johnston Research Inc. (2011). 10-Year First Nations and Inuit Home and Community Care Strategy Literature Review Final Submission. Ottawa, ON: Health Canada.

25 Johnston Research Inc. (2011). 10-Year First Nations and Inuit Home and Community Care Strategy Literature Review Final Submission. Ottawa, ON: Health Canada.

26 Jacklin, K., & Walker, J. (2012). Trends in Alzheimer's disease and related dementias among First Nations and Inuit: Final Report (Contract No. 4500268919). Ottawa, ON: Health Canada.

27 Cohen, M., Hall, N., Murphy, J., & Priest, A. (2009). Innovations in community care: From Pilot Projects to System Change. Retrieved from http://www.policyalternatives.ca/sites/default /files/uploads/publications/BC_Office_Pubs/bc_2009/CCPA_bc_innovations_web.pdf

28 Johnston Research Inc. (2011). 10-Year First Nations and Inuit Home and Community Care Strategy Literature Review Final Submission. Ottawa, ON: Health Canada.

29 Health Canada. (2009). Statistical Profile on the Health of First Nations: Determinants of Health 1999-2003 (Report No. Health Canada Pub.: 3555). Ottawa, ON.

30 Johnston Research Inc. (2012). First Nation and Inuit Home and Community Care Program Strategic Planning Meeting October 27-28, 2011: Meeting Report, DRAFT. Ottawa, ON: Health Canada.

31 Scott, R. E., & Palacios, M. (2011). Background Paper on Telehomecare (Home e-Health) in Canada's First Nations and Inuit (FN/I) Communities. Where Are We – Where Can We Go?

32 The First Nations Information Governance Centre. (2011). RHS Phase 2 (2008/10) Preliminary Results: Adult, Youth, Child, Revised Edition. Ottawa, ON.

33 Government of Canada. Parliamentary Committee on Palliative and Compassionate Care. (2011). Not to be forgotten: Care of Vulnerable Canadians. Ottawa, ON.

34 BC Association of Community Response Networks. (2009). Promising Approaches for Addressing/Preventing Abuse of Older Adults in First Nations Communities: A Critical Analysis and Environmental Scan of Tools and Approaches. Retrieved from http://www.bccrns.ca/projects/docs/promising_ approaches_ addressing_preventing_abuse.pdf

third of First Nations adults living on-reserve (33%) indicated that they had a 2007 income of less than $10,000, with 17% living in a household with total 2007 income of less than $10,000. Approximately 40% of adults indicated that social assistance was a source of income.[35] Evidence of poor housing conditions were illustrated by the finding that over two-thirds (71%) of First Nations on-reserve indicated that their housing was in need of repairs in comparison to approximately one-quarter (26%) of Canadians.[36] Many of these conditions were exacerbated by the continued repercussions felt by communities from the history of the residential schooling system in Canada.[37,38]

Demographic trend evidence from the literature and document reviews suggested that the need for home and community care services is likely to continue to increase given the projected shifts among the First Nations and Inuit populations. Projections indicate significant on-reserve and Inuit population growth over the next 15 years. One study indicated that the First Nations populations living on-reserve aged 45 and over, which represents the majority of home and community care clients, will represent over 30% of the on-reserve population by 2026 compared to 21% in 2006.[39] At the other end of the age spectrum, it is anticipated that there will be increased need for home and community care services for post and perinatal care as the fertility rate for First Nations and Inuit is substantially higher than the Canadian rate of 1.61 births per woman. This, combined with lower infant mortality rates, may result in higher numbers of special needs children whose families will require home and community care services.[40,41,42]

The document review found evidence that the trend in many provinces and territories to release patients earlier from hospital settings and to provide more in-home care for the frail and elderly has resulted in an increasing need for home and community care services. The documents reviewed did not provide data on the extent of the increased demand for FNIHCC services due to this shift in service delivery.[43]

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[35] The First Nations Information Governance Centre. (2011). RHS Phase 2 (2008/10) Preliminary Results: Adult, Youth, Child, Revised Edition. Ottawa, ON.

[36] The First Nations Information Governance Centre. (2011). RHS Phase 2 (2008/10) Preliminary Results: Adult, Youth, Child, Revised Edition. Ottawa, ON.

[37] BC Association of Community Response Networks. (2009). Promising Approaches for Addressing/Preventing Abuse of Older Adults in First Nations Communities: A Critical Analysis and Environmental Scan of Tools and Approaches. Retrieved from http://www.bccrns.ca/projects/docs/promising_ approaches_ addressing_preventing_abuse.pdf

[38] Pauktuutit Inuit Women of Canada. (2011). National Strategy to Prevent Abuse in Inuit Communities: Environmental Scan of Inuit Elder Abuse Awareness. Retrieved from http://pauktuutit.ca/assets/04-Inuit-Elder-Abuse-Scan_EN.pdf

[39] Johnston Research Inc. (2012). First Nation and Inuit Home and Community Care Program Strategic Planning Meeting October 27-28, 2011: Meeting Report, DRAFT. Ottawa, ON: Health Canada.

[40] Health Canada. (2011). A Statistical Profile on the Health of First Nations in Canada: Vital Statistics for Atlantic & Western Canada, 2001/2002. (Report No. Health Canada Pub.: 3558). Ottawa, ON.

[41] Scott, R. E., & Palacios, M. (2011). Background Paper on Telehomecare (Home e-Health) in Canada‘s First Nations and Inuit (FN/I) Communities. Where Are We – Where Can We Go?

[42] Aarluk Consulting. (2012). Home and Community Care Program in Nunavut: Evaluation Report. Iqaluit, NU.

[43] Johnston Research Inc. (2012). First Nation and Inuit Home and Community Care Program Strategic Planning Meeting October 27-28, 2011: Meeting Report, DRAFT. Ottawa, ON: Health Canada.

Evidence from the literature and document reviews indicated that there is a demonstrable need for the provision of home and community care services that take into account cultural context and language needs. For example, one document cited that over 6 in 10 (65%) First Nations Elders and almost 7 in 10 (69%) Inuit Elders use their Aboriginal language as their primary language at home.[44] According to the documents reviewed, home and community care services that are delivered and managed by communities are more likely to appropriately reflect cultural aspects such as language, holistic nature of services, access to both mainstream and traditional care, and emphasis on traditional diet, lifestyle and relationship to the land.[45,46,47]

All key informants identified similar trends as noted above, related to the need for home and community care, including the increasing rates of chronic diseases among First Nations and Inuit, the shifts by provincial governments to more community-based services which has led to earlier hospital discharges and clients with more complex care needs, and an increasing need for palliative and rehabilitative care. Similarly, the stakeholder survey provided some indirect evidence that there was a demonstrable need for the FNIHCC Program. The majority of survey respondents (53%, n=147) perceived that the need for the FNIHCC Program has increased over the past five years due to increases in the population requiring services, increased complexity of cases, and faster hospital discharge times.

Responsiveness to the Needs of First Nations and Inuit

The evidence from the document and database reviews, key informant interviews and stakeholder survey indicated the FNIHCC Program is responsive to the essential home care needs of First Nations and Inuit that it was designed to address. However, the needs related to First Nation and Inuit home and community care are expected to increase and to become increasingly more complex. Program data indicated that over a three year period from 2008-09 to 2010-11, the FNIHCC Program was responsive by providing approximately 7.8 million hours of services.[48] Across the three year period, program funding was stable and the number of hours provided each year also remained relatively constant, averaging approximately 2.6 million hours per year.[49] Another indicator of program responsiveness relates to the amount of time services were not able to be provided. This happens when appointments are scheduled but do not take

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44 Johnston Research Inc. (2012). First Nation and Inuit Home and Community Care Program Strategic Planning Meeting October 27-28, 2011: Meeting Report, DRAFT. Ottawa, ON: Health Canada.

45 Johnston Research Inc. (2011). 10-Year First Nations and Inuit Home and Community Care Strategy Literature Review Final Submission. Ottawa, ON: Health Canada.

46 Cotter, R. P., Condon, J. R., Anderson, I. P. S., Smith, L. R., & Barnes, T. (2011). Indigenous aged care service use and need for assistance: How well is policy matching need? Australasian Journal of Ageing, 30 (Suppl 2), 38-44. doi: 10.1111/j.1741-6612.2011.00532.x.

47 Government of Nova Scotia. (2008). Cape Breton Home Care Discharge Planning Program: Evaluation Findings. Retrieved from: http://www.gov.ns.ca/health/ccs/aboriginal/documents/Cape-Breton-Home-Care-Discharge-Planning-Pilot-Evaluation.pdf

48 Hours of service are logged by nurses when they have scheduled home and community care appointments with clients. Service is deemed to have been provided if the appointment takes place. Service is deemed to not have been provided when the scheduled appointment does not take place.

49 Health Canada. (2012). First Nations and Inuit Home and Community Care – 2012 Report. *Note that these totals do not include Nunavut.*

place due to a range of issues such the environment of the scheduled appointment was deemed unsafe or the client refused the service. There were approximately 123,000 hours of service (only 1.5 %) not provided over the three year period.[50]

Key informants and survey respondents stated that the FNIHCC Program is responsive to the needs of First Nations and Inuit but that changes could be made to make it even more responsive. Essential services are being provided in most communities, according to almost all Band informants and most Health Canada key informants. The exception noted was for smaller communities that were not able to provide all the essential services due to their more limited program funding level.[51] It was noted by Health Canada informants that the program policy required communities to have a population of 500 or more to receive approval for funding in order to ensure an adequate staffing level for the program. This was resisted by some communities who preferred to deliver their own program and in some regions it was challenging to cluster small remote communities to deliver the program. Consequently, the policy allowed for some flexibility so that smaller communities could deliver the essential elements of the program in order to address the home care needs of community members. Data provided by FNIHB indicated that, currently, 151 communities with a population of less than 500 have their own funding agreement. This represents about one-quarter (23%) of the 657 communities being provided with FNIHCC services.

Most Band and Health Canada key informants indicated that the FNIHCC Program is providing these essential home care services to a large or very large extent, with the exception of smaller communities with less program funding. Similarly, the majority of survey respondents (53%, n=173) reported that the FNIHCC Program meets the essential home care needs to a large or very large extent. An additional sizeable proportion of respondents (38%, n=124) indicated that the program somewhat meets the needs.

None of the key informants indicated that the FNIHCC supportive services (rehabilitation and other therapies; in-home palliative care; adult day care; meal programs; in-home mental health; and specialized health promotion) are provided with FNIHCC funding. FNIHCC Program representatives indicated that the Government of Nunavut uses FNIHCC funds for these activities. Key informants observed that the communities that provide the FNIHCC supportive services do so primarily with funding from other federal programs or with funding/assistance from provinces via regional health authorities and/or internal community-based sources.

Key informants and survey respondents identified areas where the program could be improved to respond to these trends. A majority of key informants identified the following opportunities (in about equal proportion): make in-home palliative care an essential (and funded) service; provide more resources overall to meet the trend in increased needs; and continue funding for staff training to build on the recently increased training funds for FNIHCC nurses. A few key informants suggested extending the hours of care, continued improvements in policies and program tools, and integration with other programs.

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[50] Health Canada. (2012). First Nations and Inuit Home and Community Care Program – 2012 Report (tracked by e-SDRT).

[51] FNIHB acknowledges that smaller and remote communities are not able to provide all the services.

Survey respondents who indicated that the FNIHCC Program could be changed to make it more responsive were also asked to identify one main area for change. Some respondents identified an increase in funding to allow for the delivery of more services including offering other home and community care services including physiotherapy or speech therapy, mental health services and/or social work services, palliative care, and care during hours that extend into the weekends and evenings.

4.2 Relevance: Issue #2 – Alignment with Government Priorities

There was evidence that the FNIHCC Program, as a mandatory primary health care program, remained a priority for the federal government during the evaluation period. Reviews of Budget documents and various federal policies and initiatives provided statements of support and ongoing commitment to improving First Nations and Inuit health.

The document review provided evidence of statements of an ongoing federal commitment to improving First Nations and Inuit health. Budget 2008 identified First Nations and Inuit health as priorities with the commitment of funding to stabilize current First Nations and Inuit health programs and promote closer integration with provincial systems in order to achieve better health outcomes.[52] Budget 2009 included a funding commitment for practical partnership approaches with Aboriginal organizations and provincial and territorial governments on delivery of First Nations and Inuit Health programs.[53] Various federal policies and initiatives demonstrated that the FNHICC Program, as a key component in the provision of health services to First Nations and Inuit, remained a priority for the federal government. These included the longer ranging *Transfer of Health Services to Indian Control* and more recent initiatives and support for improving *Health Care Sustainability in the Territories*.[54]

The Terms and Conditions for the Primary Health Care Authority First Nations and Inuit Health Program identified the FNIHCC as one of the mandatory programs within the Primary Health Care Activity. Mandatory programs are those that have a direct impact on the health and safety of community members and the population. They have a strong public health and/or clinical component and require that health staff have certain credentials/certification/licensing and meet practice standards to ensure quality public health and client care services are provided.[55]

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52 Department of Finance Canada. (2008). The Budget in Brief 2008: Responsible Leadership. Ottawa, ON.
53 Department of Finance Canada. (2009). Canada’s Economic Action Plan, Budget 2009. Ottawa, ON.
54 Health Canada. (2011). Terms and Conditions for Primary Health Care Authority First Nations and Inuit Health Program. Ottawa, ON.
55 Health Canada. (2011). Terms and Conditions for Primary Health Care Authority First Nations and Inuit Health Program. Ottawa, ON.

4.3 Relevance: Issue #3 – Alignment with Federal Roles and Responsibilities

There were linkages between the anticipated outcomes of the FNIHCC Program and Health Canada's strategic priorities and outcomes. The FNIHCC Program aligned with Health Canada's mandated roles and key program activities as outlined in the Program Alignment Architecture.

FNIHCC services aligned with the provision of First Nations and Inuit health programs which are provided or funded by FNIHB in Health Canada consistent with the *Indian Health Policy* and subsequent departmental mission and mandate statements. Program documents indicated that the FNIHCC Program aligned with Health Canada's strategic priorities and outcomes. The strategic outcome in the FNIHB Strategic Plan[56] was stated as: "In the context of federal health programs under Health Canada, First Nations and Inuit communities and individuals receive health services and benefits that are responsive to their needs and that improve their health status" (p.8). Aligned with this strategic outcome was the FNIHCC Program's anticipated longer-term outcome of "home and community care services that are responsive to the needs of First Nation and Inuit individuals and communities."[57] The Terms and Conditions also outlined how the FNIHCC Program aligned with FNIHB objectives.[58] Health Canada's Departmental Performance Reports and Reports on Plans and Priorities for the years 2008-09 through to 2011-12 provided evidence of how health services for First Nations and Inuit continued to be a priority for Health Canada. For example, the 2010-2011 DPR highlighted the role that Health Canada plays in supporting the delivery of and access to health program and services for First Nations and Inuit, which helps to reduce the gap between health outcomes for First Nations and Inuit and those of other Canadians. The Health Canada PAA, a structured inventory of the programs undertaken by Health Canada, depicts programs in their logical relationship to each other and to the strategic outcome to which they contribute. The 2012 PAA[59] indicated that the FNIHCC Program, being a component of First Nations and Inuit Primary Care, aligned with departmental key program activities.

Documents also indicated that FNIHCC Program activities were congruent with Health Canada's mandated roles with respect to providing services to First Nations and Inuit. Health Canada's provision of health programs and services to First Nations and Inuit was consistent under the *Federal Indian Health Policy*.[60] According to the Terms and Conditions, improving the health of Aboriginal people is a shared responsibility between federal, provincial/territorial and Aboriginal partners. To this end, Health Canada works to develop partnerships between provincial governments and First Nations to integrate federal and provincial health systems, in addition to

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56 Health Canada. (2012). First Nations and Inuit Health Strategic Plan: A shared path to improved health. Ottawa, ON. Retrieved from www.hc-sc.gc.ca/fniah-spnia/pubs/strat-plan-2012/index-eng.php

57 FNIHCC Program Logic Model.

58 Health Canada. (2011). Terms and Conditions for Primary Health Care Authority First Nations and Inuit Health Program. Ottawa, ON.

59 Health Canada. (2011). Program Activity Architecture and the Performance Measurement Framework. Ottawa, ON.

60 Health Canada. (2011). Health Canada, 2010-11 Estimates, Part III - Report on Plans and Priorities. Ottawa, ON.

also supporting First Nations and Inuit communities to address their own unique health needs by increasing their control over health program design and delivery. [61] According to a recent RPP, Health Canada is responsible for providing home and community care in approximately 600 First Nations communities, which aligned with FNIHCC Program activities.[62]

Health Canada and other key informants (e.g., provincial/territorial/regional health authority representatives) were asked their opinions on the alignment of the FNIHCC Program with federal roles and responsibilities. All key informants indicated that the FNIHCC Program was aligned with federal roles and responsibilities. The reason most commonly cited was the federal government's responsibilities, fiduciary or treaty obligations to First Nations and Inuit to provide access to health care (mentioned by 75% of key informants). A few key informants noted the importance of the alignment of the FNIHCC services with provincial home care programs in order to ensure the program is relevant to First Nations and Inuit (i.e., to ensure clients have access to a continuum of coordinated care and safe discharge from hospitals, and to ensure home and community care services are aligned with those provided off-reserve).

4.4 Performance: Issue #4 - Achievement of Expected Outcomes (Effectiveness)

4.4.1 To what extent have the immediate outcomes been achieved?

Immediate Outcome #1: Increasingly Appropriate Home and Community Care Services Based on Assessed Need

The FNIHCC Program was delivered as intended to provide appropriate home and community care services based on assessed need. There was evidence that the services provided and needs addressed were relatively diverse and the patterns in service provision were consistent and unchanged over a three year period, except in Inuit communities where there was a shift to proportionately more acute care clients served.

The database review provided some information on outputs of hours of services delivered according to type of client and type of service, which was some indication of the diversity of services provided to all FNIHCC Program clients.[63] According to the 2012 FNIHCC Program summary report, in 2010-11, the hours of service were distributed to the following types of clients:

- approximately half the hours of service (53%) were provided to clients requiring long-term supportive care where clients have ongoing multiple and/or complex health conditions;

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[61] Health Canada. (2011). Terms and Conditions for Primary Health Care Authority First Nations and Inuit Health Program. Ottawa, ON.

[62] Health Canada. (2011). Health Canada, 2010-11 Estimates, Part III - Report on Plans and Priorities. Ottawa, ON.

[63] Not including Nunavut.

- one-third of services (30%) were provided to clients requiring maintenance care where clients have a stable chronic health condition or functional limitation; and
- the remaining 16% of service hours were delivered to clients requiring a number of specific services: acute care (6%), “other” care (6%), rehabilitation (3%) and end-of-life-care (1%).

Overall, the proportion of service hours according to client type remained relatively constant between 2008-09 and 2010-11.[64] However, from a separate study of Nunavut home and community care services, it was found that the types of clients served over a seven year period in this territory changed with proportionally more acute care clients served, and fewer chronic disease management and long-term care replacement clients served.[65],[66]

Similarly, while not directly addressing the outcome, there was an indication of diversity of services delivered by the FNIHCC Program to all clients according to the type of care provided. In 2010-11, the largest proportions of services were provided for home support (61%), personal care (17%), and nursing services (9%). Other services provided included case management (8%), in-home respite (5%) and professional therapies (1%). There was very little variation of this service pattern across the three years (2008-09 to 2010-11).[67]

Immediate Outcome #2: Increasing Capacity of Home and Community Care Workforce

There was some evidence of progress made towards increasing the capacity (knowledge, skills and abilities) of the home and community care workforce as a result of the increased clinical training for nurses.

The capacity of home and community care nurses has been augmented through other FNIHB initiatives that provided funding to FNIHCC to better serve home and community care clients. For example, the Aboriginal Diabetes Initiative provided funds for training to home care nurses (RNs and LPNs) on evidence-based clinical practice guidelines and chronic disease management strategies. A Health Canada key informant indicated that to date approximately 500 home care nurses had been trained as a result of this initiative. Based on FNIHCC Program data, this represented a large proportion (approximately 67%) of the home and community care nurses.[68]

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64 Health Canada. (2012). First Nations and Inuit Home and Community Care Program – 2012 Report (Analytical report developed by Performance Measurement Unit FNIHB).

65 Long-Term Care Replacement relates to services provided to home care clients with illness/disability to help them increase their level of functioning or self-care so that they can function without the support of home care services.

66 Aarluk Consulting. (2012). Home and Community Care Program in Nunavut: Evaluation Report. Iqaluit, NU.

67 Health Canada. (2012). First Nations and Inuit Home and Community Care Program – 2012 Report. *It should be noted that the data for Alberta is significantly different from that of the other regions, with a substantially smaller proportion of home support service hours (16%) and a larger proportion of nursing service hours (39%).*

68 This is based on the total number of Home and Community Care Nurses who are either Registered Nurses and Licenses Practical Nurses (n=745) identified in the most recent *First Nations and Inuit Home and Community Care Program: 2012 Report* (Health Canada, 2012).

Also, since 2009, through National Nursing Innovation Strategy Program funding to FNIHCC, some regions have been resourced to provide consulting services and training for FNIHCC community staff on current practices in wound continence and stomal care management in order to allow clients to recover quickly, use resources more effectively and allow the client to remain in their home community.[69] This new support was identified by a few Health Canada and Band key informants as needed and effective. A few Band informants and some Health Canada and provincial/territorial/regional key informants who commented on training stated that this incremental training has made a positive difference to the knowledge and skills of nurses. There has been no similar allocation for training of non-nursing staff (e.g., personal care workers) over the evaluation period. All key informants who commented on training mentioned that there is a continued training need for nurses as well as for personal care workers due to staff turnover and the need to keep up with emerging best practices. Some survey respondents (40%, n=122) reported that the training for front-line workers was adequate to a large or very large extent.

As an indicator of on-reserve home and community care capacity, data was available for a two-year period (2009-10 to 2010-11) on the ratio of health workers to on-reserve populations. Table 4 provides the figures for 2010-11. None of the rates for the various groups changed significantly over the two-year period covered by the data.[70]

Table 4: Number of Home and Community Care Workers per 100,000 First Nations Population On-Reserve

Number of home and community care workers (FTEs) per 100,000 First Nations population on-reserve (2010-11)	
Licensed practical nurses	35
Program support staff	71
Registered nurses	75
Home management support personnel	93
Personal care providers	184

Immediate Outcome #3: Increased Collaboration with Internal and External Providers

Progress was made towards increasing the engagement and collaboration of FNIHCC staff with other health care providers within and outside communities. Efforts to increase collaboration with social programs (e.g., social services, social workers, AANDC Assisted Living In-Home Care Component, and housing) were viewed as somewhat less effective overall. The linkages with social programs were considered stronger in communities where health and social programs were managed in one department or co-located.

Linkages and referrals to other health and social service providers were an essential element under the FNIHCC Program in order to ensure there was continuity of care provided to the clients of home and community care services.

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69 Health Canada. (2012). *First Nations Home and Community Care Project Information Sheets*. Ottawa, ON.
70 Health Canada. (2012). First Nations and Inuit Home and Community Care Program – 2012 Report.

Evidence of linkages included, for example, collaboration with external service providers. The key informant interviews and the stakeholder survey provided evidence that FNIHCC staff in a majority of sampled communities have established informal, and to a lesser extent, formal collaborative arrangements with external health care providers regarding coordination of care and access to provincial health services for community members. Most Band informants indicated they had informal collaborative arrangements while some had formal arrangements/agreements with external service providers (primarily regional health authorities) regarding health service delivery. Approximately three-quarters of survey respondents reported that their community had formal or informal collaborative delivery agreements for health service delivery with external providers. Most Health Canada regional informants indicated communities had predominately informal arrangements.

The key informant interviews indicated some increase in the level of collaboration over the evaluation period due to efforts at the community and regional levels. A few Health Canada informants cited formalized processes (e.g., provincial-level working groups or tripartite agreements in four regions) and pilot projects (e.g., electronic record, interRAI HC[71][Inter-Resident Assessment Instrument Home Care] tool, discharge planning kit) that were implemented over the evaluation period to improve collaboration with external providers. Similarly, some provincial/territorial/regional informants cited their initiatives to build linkages with Health Canada and community-level FNIHCC staff. Key informants who had higher satisfaction levels with their linkages to external service providers made more progress in developing collaborative arrangements. As well, some survey respondents reported that effective linkages were in place between FNIHCC Program community staff and external health care providers to a large or very large extent.

Further evidence of linkages included collaboration with internal health care providers. Evidence from documents and key informant interviews indicated that there were national and regional efforts under the period of evaluation to support integrated health program planning and joint staff training. This led to more collaboration of FNIHCC staff with other health staff in at least some communities. In 2008, implementation began of a Non-Insured Health Benefit NIHB)[72]/Home and Community Care Nurse Authorizer Ordering Process under which RNs were able to order medical supplies and equipment from a physician or nurse practitioner for eligible FNIHCC clients. This process was designed to improve client health outcomes by providing more timely access and a more efficient and streamlined process for ordering supplies. A Health Canada key informant indicated that Alberta Region fully implemented this process and other regions were currently rolling it out to communities.[73]

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71 interRAI is an international collaborative network of researchers committed to improving care for persons who are disabled or medically complex. The interRAI suite of comprehensive assessment instruments is designed to evaluate and respond to strengths, preferences and needs of persons from vulnerable populations with complex needs across the continuum of care.

72 Non-Insured Health Benefits Program provides coverage for a limited range of health care goods and services that are not insured elsewhere.

73 Health Canada. (2012). *First Nations Home and Community Care Project Information Sheets*. Ottawa, ON.

Most key informants were satisfied with the linkages of FNIHCC staff with other health programs within communities. Similarly, many survey respondents (56%, n=174) reported that effective linkages were in place between FNIHCC Program community staff and other health programs in the community to a large or very large extent.

Key informants were asked to comment on the linkages with social programs offered in communities. Most key informants referenced social programs in general when responding. Specific programs or services mentioned by some included the AANDC Assisted Living In-Home Care Component (an AANDC social program), social services/social assistance/social workers and housing. The case study of program integration indicated that integrated program delivery increased the level of collaboration of FNIHCC staff with staff of the In-Home Care Component of the Assisted Living Program.

The evidence indicated that less than half of all key informant groups were satisfied with the linkages of FNIHCC staff with social programs in the communities. Similarly, less than half of the survey respondents (40%, n=124) reported that there were effective linkages between FNIHCC Program community staff and other social programs to a large or very large extent. Key informants in general noted that the linkages were stronger in communities where health and social programs were managed within one department and/or co-located.

Immediate Outcome #4: Increased Use of Policies, Standards, Guidelines and Best Practices in Service Delivery

Overall, there was a high level of usage of policies, standards, guidelines and best practices by communities in the delivery of the FNIHCC Program. It is anticipated that national initiatives developed during the evaluation period will enhance use at the regional and local levels. Factors associated with increased use included higher levels of regional capacity to deliver the program and integrated delivery of programming.

FNIHCC standards and policies have been in place since the introduction of the program. In 2000, communities were provided with standards and policy templates as part of the Planning Resource Kit to assist them in developing standards and policies tailored to their community's FNIHCC service delivery plan. Communities funded to deliver the FNIHCC Program were required to develop, monitor and revise standards of care on an ongoing basis to ensure clients received appropriate services. FNIHB completed an update of the standards and templates in 2012 which is now in translation and scheduled for distribution in 2013. These will be disseminated to home and community care staff in communities along with the Quality Resource Kit (described in evidence for Intermediate Outcome 4) as a comprehensive tool to support quality program delivery.

Program documents indicated that the number of First Nations organizations with accredited home care programs under Accreditation Canada's home care or community health standards rose from 38 in 2008 to 58 in 2011. Assuming approximately 600 First Nations communities are delivering the FNIHCC Program, this represents an increase from 6% to 10% of communities with accredited home care programs over most of the evaluation period.

In regard to best practices, over the evaluation period, FNIHB funded the compilation of FNIHCC case studies from all eight regions and the publication of two reports aimed at promoting the sharing and adoption of effective practices at the community level. One was focused on home and community care services while the other focused on collaborative approaches in the delivery of mental health services and home and community care.[74,75] There was no evidence on the extent to which these have been used by FNIHCC staff in communities as there was no data on uptake.

Evidence from the key informant interviews and stakeholder survey indicated that various policy tools are in place and used in a majority of communities. Most Band informants indicated that they have and use FNIHCC Program policies, standards, guidelines, incident and occurrence reporting processes, and complaints processes. Similarly, most Health Canada informants who commented indicated that most Bands in their regions have policies in place and use these, have incident and occurrence processes in place (but that usage varies), and that complaints processes are in place and used regularly. A majority of survey respondents (65%, n=170) reported that policies, standards, guidelines, and best practices information are used in delivering FNIHCC services to a large or very large extent. Approximately one-half of the survey respondents (55%, n=139) indicated that processes for incident and occurrence reporting were in place to a large or very large extent (55%, n=139), as were processes to manage home and community care complaints and appeals (46%, n=115).

Most Band informants reported that there had been no change in the use of policies and best practices over the evaluation period, while half of the Health Canada informants reported that there is now more focus on this aspect of services by FNIHCC community staff, due to the greater focus within Health Canada on policies and quality improvement over the evaluation period.

Evidence from the case study on regional capacity suggested that higher levels of regional capacity positively influenced the use of policies in communities. All FNIHCC coordinators and community informants in the regions with higher capacity indicated that communities have improved in this aspect of the program over the evaluation period and that the support provided by regional FNIHCC staff was a positive influence. Most community informants in regions with lower capacity, and all the FNIHCC coordinators in those regions, indicated there has been no increase in the usage of policies, guidelines or best practices by communities over the evaluation period. The reasons given were that regional support in this area has been limited and many communities (particularly smaller ones with limited resources) have little capacity to do this work on their own (an issue which is exacerbated by turnover in community staff).

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[74] Canadian Home Care Association. (2010). Mind Body Spirit: Promising Practices in First Nations and Inuit Home and Community Care. Retrieved from http://www.cdnhomecare.ca/media.php?mid=2343

[75] Canadian Home Care Association. (2011). *Many Hands …One Spirit. Promising Practices in First Nations and Inuit Home and Community Care —Mental Health Services*. Mississauga, ON.

In the case study on program integration, all community informants reported that integration had increased the use of FNIHCC policies, standards and best practices in the delivery of integrated in-home care services through an extension of the FNIHCC policies and standards to staff that deliver the In-Home Care Component of the Assisted Living Program (who previously worked with few such policy tools).

Immediate Outcome #5: Increased Use of Evidence-based Information to Inform Quality Program Delivery

Less than one-half of program staff indicated using regularly collected program data to track, monitor or plan services. There was no indication that this pattern had changed substantially over a two-year period.

The document review found that, in the 2012 survey of FNIHCC Program staff (n=180), slightly over half (55%) of the respondents had used data from the e-SRDT template and less than three in ten (27%) had used data from the e-HRTT template. Of those who reported using the data, approximately two-thirds (n=124) indicated that it was useful for tracking, monitoring or planning.[76] The findings from the 2011 survey of FNIHCC Program staff (n=83) demonstrated similar patterns of usage with respect to e-SDRT and e-HRTT data.[77]

Immediate Outcome #6: Increased First Nation and Inuit Awareness of Home and Community Care Services

The evidence indicated that program staff was aware of the key program areas such as the types of essential services provided, how case management works, and staff's roles and responsibilities. The evidence also indicated that community members were, understandably, not as aware of these same key areas.

Band, Health Canada and Aboriginal organization/Non-government organization informants and survey respondents were asked to provide their opinion on the level of awareness of staff who deliver the FNIHCC Program in communities. Awareness related to various aspects of the program including the services that are provided, the case management process, their roles and responsibilities and culturally sensitive delivery. The key informants and survey respondents were also asked to provide an opinion on community members' level of awareness of similar aspects of the program including the services available, how to access services, the roles and responsibilities of home care staff and what they can expect in terms of culturally sensitive delivery.

The majority of survey respondents reported that program staff was aware of various aspects of the program. A majority of survey respondents (72% n=187) reported that staff were aware of the essential services provided by FNIHCC to either a large or very large extent, 61% (n=161) reported that staff were aware of how case management works including referrals into and out of

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[76] Health Canada, Public Opinion Research and Evaluation Unit. (2012). First Nations and Inuit Home and Community Care Program Report (Report No. HC POR: POR-11-NC24). Ottawa, ON.

[77] Health Canada, Public Opinion Research and Evaluation Unit. (2011). First Nations and Inuit Home and Community Care Program Report (Report No. HC POR: POR-10-NC29). Ottawa, ON.

the program to a large or very large extent, 75% (n=199) reported that FNIHCC Program community staff were aware of their roles and responsibilities to a large or a very large extent, and 75% (n=198) gave the same rating to staff's awareness of the need to deliver services in a way that is consistent with the culture and values of the community.

Similarly most key informants indicated that FNIHCC staff in communities was aware to a large or very large extent of various aspects of the program. Almost all of these key informants gave this rating to staff awareness of the services provided and of the need for culturally sensitive delivery. Most key informants reported staff in communities was aware to a large or very large extent of how referrals work and roles and responsibilities. Some Health Canada informants and a few Band informants reported that the recent increased training offerings for nurses (in particular case management training) had increased awareness among nursing staff of FNIHCC services and of their roles and responsibilities.

Survey respondents and key informants considered the community members awareness levels of the FNIHCC services to be lower than those of FNIHCC staff. These FNIHCC elements surveyed included essential services, how case management works, and the FNIHCC Program community staff's roles and responsibilities.

A majority of key informants indicated that community members were aware of various aspects of the program; however their ratings were comparably lower than those they gave to staff's awareness. Many key informants indicated that community members' were aware of the services available to a large or very large extent, most gave this rating to community members' awareness of how to access services, many to their awareness of the roles and responsibilities of FNIHCC staff, and almost all to community members' awareness of what they could expect in terms of culturally sensitive service delivery.

A few key informants observed that the program has been in place for nearly 15 years and that community members who need the home care services are aware of the program and how it works. Reasons given for the slightly lower positive ratings for community members included the varied capacity/resources of staff to communicate with community members about their role as home care workers (e.g., some communities have home care staff who wear uniforms to better communicate when they are 'at work'), community members confusing FNIHCC services with those of the Assisted Living In-Home Care Component services of AANDC, and a perception that those who need the services are likely more aware than the general community population.

4.4.2 To what extent have the intermediate outcomes been achieved?

Intermediate Outcome #1: Improved Access to Home and Community Care Services

The FNIHCC Program continued to provide access to essential home and community care services. However, the needs of First Nation and Inuit home and community care are expected to increase and to become increasingly more complex.

There was little evidence found from the document and database reviews that indicated improved access to home and community care services during the period under evaluation. Access remained high and constant over the period, with FNIHCC Program data suggesting that, between the periods of 2008-09 and 2010-11, the vast majority of eligible First Nations individuals had access to the FNIHCC Program (97-98%), while all of the eligible Inuit population had access to home and community care services (100%).[78]

As a less direct indication of access to home and community care services, the database review found that the provision of home and community care services had remained relatively constant over a three-year period with respect to the number of service hours delivered and the number of clients served. For example, the number of hours provided each year remained relatively constant,[79] averaging approximately 2.6M hours per year. Similarly, the number of clients served was relatively similar across the same period ranging from 11,769 admissions in 2008-09 compared with 10,464 admissions in 2010-11; and 22,511 continued service clients in 2008-09 compared with 23,972 clients in 2010-11.[80] It was challenging to compare this with data provided by Nunavut given the differences in time periods provided and the manner in which clients were counted.[81]

The evidence from the literature review and key informant interviews for Core Issue #1 (continuing need for the program) indicated the need for home and community care services in First Nations and Inuit communities is likely to increase within the next five to ten years due to demographic trends, conditions contributing to social determinants of health, and trends in primary care. This evidence, coupled with that above on the stable level of services provided, indicated that while the program was presently meeting essential needs with existing capacity (funding and staffing), the program will likely be unable to improve access and possibly meet needs in the future for the increasing numbers of clients requiring care.

Intermediate Outcome #2: Improved Coordinated Seamless Responses to Home and Community Care Needs

There were regional and community efforts to improve the coordination of FNIHCC services with other programs in order to deliver seamless responses to home and community care needs, but no evidence was found that significant improvements occurred over the evaluation period. The case studies suggested that the integration of the FNIHCC Program and the AANDC Assisted Living Program - In-Home Care Component contributed to improved coordination and seamless responses to home and community care needs.

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[78] Percentage of on-reserve population accessing HCC services (date, source unknown – provided by FNIHCC Program representatives).
[79] Not including Nunavut.
[80] Health Canada. (2012). First Nations and Inuit Home and Community Care Program – 2012 Report.
[81] The evaluation report for Nunavut Home Care covered the period from 2003-04 to 2010-11 and counted "clients" which did not distinguish if they were continued service clients or new clients.

The key informant interviews identified efforts to improve coordinated seamless responses to home and community care needs within the evaluation period. Efforts occurred at the national and regional levels to improve coordination with provincial health programs and with Health Canada's Non-Insured Health Benefits Program.[82] Efforts were made by FNIHB and AANDC to assist communities in aligning the services provided by the FNIHCC Program and the AANDC Assisted Living In-Home Component, including sharing best practices of communities that have integrated these two programs. There have also been community-led efforts to improve linkages with regional health authorities in a few communities. However, none of the key informants indicated that these efforts have actually led to significant coordinated and seamless responses at this point; rather, coordination was described as an ongoing work-in-progress.

The case study of program integration provided evidence that integration of FNIHCC and the In-Home Care Component of the Assisted Living Program has improved the coordination of services, which reinforced the relevance of the efforts noted above to assist other communities in considering integrated delivery of these two programs. Almost all integrated-community informants reported that integration had led to improved case management/assessments and most reported it led to a more tailored approach to service delivery. For example, one integrated-community informant stated that client monitoring by staff delivering the FNIHCC and the In-Home Care Component of the Assisted Living Program provides a better picture of how each client is faring and continuous reassessments result in the appropriate amount of service hours being provided to each client.

Intermediate Outcome #3: Increased Use of Continuous Quality Improvement, Including Patient Safety Processes, to Respond to Home and Community Care Needs

There have been national initiatives undertaken over the period under evaluation related to the increased use of quality improvement processes to respond to home and community care needs. Because some of these initiatives are currently being implemented, the extent to which these aspects of the program are in place in communities and whether there has been increased usage over the period under evaluation cannot be determined yet. However key informants suggested that recent national initiatives would have a positive future impact at the regional and community levels.

Most Band informants and almost all Health Canada informants indicated that FNIHCC staff incorporated continuous quality improvement as part of their service delivery. However, less than one-half of survey respondents (43%, n=96) indicated that there are specific approaches to continuous quality improvement being used in service delivery to a large or very large extent.

There were mixed views among key informants on whether there was an increase in the use of continuous quality improvement processes, including patient safety processes, over the evaluation period. Almost all Band informants who commented on the extent of change reported that there had been no change in these practices over the period under evaluation, while almost

[82] NIHB Program provides coverage for a limited range of health care goods and services that are not insured elsewhere.

all Health Canada informants reported there is now more focus on this aspect of services by FNIHCC community staff, citing a greater focus within Health Canada on this aspect of the program now that the program is established (23%). Some Health Canada and a few Band informants cited the accreditation process as creating more focus on continuous quality improvement processes. The difference in opinion on the extent of change in these processes may be due to timing. For example, a Quality Resource Kit was developed to assist communities delivering the FNIHCC Program in integrating various quality improvement concepts and practices into the design and provision of home and community care services to further optimize the overall quality of services. FNIHB developed this kit over the 2006-2012 period in collaboration with communities. This was distributed to regions in February 2012 and will be rolled out to communities as a multi-year initiative. A Health Canada informant indicated that this kit has been distributed to all Regions along with a complementary Quality Education Kit (designed to be supportive of this implementation process) and that regions are in the process of providing orientation and education to community FNIHCC staff on these resources.

The case study of regional capacity suggested that there have been limited structured efforts over the period under evaluation by most case study regions to increase the use of continuous quality improvement processes in program delivery. Almost all FNIHCC coordinators indicated that this has not been a focus of their work (three cited resource constraints as the reason), and most community informants confirmed there has been minimal regional support provided in this area and minimal impact on the quality improvement practices of staff in communities. The exception was one higher capacity region where the regional FNIHCC coordinator described a number of ongoing activities of the nurse advisors that support quality improvement including using the Risk Management Assessment Tool as an improvement tool, helping with chart quality audits, offering program review services to communities on request or as needed in response to issues, and assisting communities in improving data quality. All community informants in this region confirmed that the advice and training provided by the region had been helpful in their quality improvement practices. The case study of program integration suggested that this approach has led to an increased use of continuous quality improvement processes to respond to FNIHCC client needs due to the increased training of staff who deliver the In-Home Care Component of the Assisted Living Program and improved information sharing among staff regarding client conditions, according to established information sharing agreements between parties and/or via the circle of care.

4.4.3 To what extent has the long-term outcome been achieved?

Long-term Outcome: FNIHCC Services that are Responsive to the Needs of the First Nations and Inuit Individuals and Communities

FNIHCC services were found to be responsive to the essential home and community care needs they were designed to address; however, the evidence from key informants and the case studies indicated that the program may not be able to address the increasing demand for essential and supportive services.

A recent research study (Lavoie et al, 2011) estimated the impact of the FNIHCC Program on the rates of ambulatory care sensitive conditions[83] in Manitoba. Using program data from the 1989 to 2005 period, the study was able to show a decrease in rates of hospitalization for ambulatory care sensitive conditions after the implementation of the FNIHCC Program in a range of communities.[84]This indicates that the program has been responsive in addressing health conditions by providing home and community care services that reduced the need for ambulatory care and hospitalization.

Many Band and Health Canada informants and most provincial/ territorial/ regional informants reported that the program was meeting the essential home care needs of First Nations and Inuit to a large or very large extent, while most Aboriginal/Non-governmental organization informants reported that the program was somewhat meeting these needs. The exception was in small communities which had less program resources. However, key informants noted that the program was not able to be as responsive to the increasing demands for services and the increasingly complex nature of these demands. Informants most frequently mentioned the increasingly complex needs of clients (palliative care, rehabilitation services, increasing chronic disease) and the limited capacity of the program to respond to these needs as the key challenges to providing responsive services. Key informants described a few strategies used in the period under evaluation to address these challenges including prioritizing services to focus more on health care, a pilot project on collaboration in chronic disease management in two regions (funded under the National Nursing Innovation Strategy), collaborating with the regional health authority to access services, and more collaboration with other health services in communities.

On a broader level, FNIHB led a strategic planning process in collaboration with key stakeholders to set out a future path for the FNIHCC Program that will assist communities in responding to current and emerging service needs while managing within the current resource capacity of the program.[85] The planning process began in 2009 with a comprehensive review of the literature on home care, both national and international, and discussions with stakeholders on the perspectives of home care for First Nations and Inuit. The Strategic Business Plan is scheduled for completion in 2013 following a final meeting with stakeholders. As well, a strategic chronic disease prevention and management planning process is underway with key stakeholders to assess evidence-based and collaborative approaches to management.

The case study of regional capacity suggested that there has been some increase in the responsiveness of the essential FNIHCC services in communities in the regions with higher capacity to deliver the FNIHCC Program over the evaluation period, due to regional efforts to provide ongoing advice and training to community level staff. FNIHCC coordinators in both regions with higher capacity indicated that the supports provided by nurse advisors (and in one of these regions by tribal council nurse managers) and the expenditure of the additional training funds for nurses allocated through the FNIHCC Program over the past several years have been

[83] These conditions are defined as those diagnoses for which timely and effective outpatient care can help to reduce the risks of ambulatory care and hospitalization by either preventing the onset of an illness or conditions, controlling an acute episodic illness or conditions, or managing a chronic disease or condition. Billings et al., 1993.

[84] Lavoie, J. G., Forget, E. L., Dahl, M., Martens, P. J., & O'Neil, J. (2011). Is it Worthwhile to Invest in Home Care? Healthcare Policy, 6(4), 35-48.

[85] Health Canada. (2012). *First Nations Home and Community Care Project Information Sheets*. Ottawa, ON.

key to developing the capacity of community staff. All FNIHCC coordinators in regions with lower capacity indicated that there has been limited focus on developing the responsiveness of services and that there has been no change in community capacity to offer responsive services.

All community informants from the case study on integration thought that integration of the FNIHCC and In-Home Care Component of the Assisted Living Program increased responsiveness to the needs of First Nations and Inuit individuals and communities, particularly in regard to the services provided under the In-Home Care Component of the Assisted Living Program. These key informants cited improved case management/assessments (80%) and timeliness (40%) under the integrated model as examples of improved responsiveness.

4.5 Performance: Issue #5 - Assessment of Efficiency and Economy

The FNIHCC Program developed processes and strategies to optimize services within the allocated resources and was considered to be efficiently managed and delivered. Further efficiencies could potentially be achieved through integration/collaboration with other programs, supporting increased efficiencies in lower capacity regional offices, clustering smaller communities for service delivery, and streamlining reporting requirements across programs. Constraints in achieving program outcomes related to both community capacity to deliver the program and regional office capacity to support program delivery.

The Treasury Board of Canada's *Policy on Evaluation* (2009) and guidance regarding *Assessing Program Resource Utilization When Evaluating Federal Programs* (2013) defines the demonstration of economy and efficiency as an assessment of resource utilization in relation to the production of outputs and progress toward expected outcomes. This assessment is based on the assumption that departments have standardized performance measurement systems and that financial systems link information about program costs to specific inputs, activities, outputs and expected results.

The data structure of the detailed financial information provided for the program did not facilitate the assessment of whether program outputs were produced efficiently, or whether expected outcomes were produced economically. Specifically, the lack of output/outcome-specific costing data limited the ability to use cost-comparative approaches. In terms of assessing economy, challenges in tracking funding within the broader Home and Community Care program for the First Nations and Inuit envelope limited the assessment. Considering these issues, the evaluation provided observations on economy and efficiency based on findings from the key informant interviews and available relevant financial data.

In addition, the findings below provide observations on the adequacy of performance measurement information to support economical and efficient program delivery and evaluation.

Observations on Economy

This section provides a review of resource utilization (i.e., spending on salary, operating/ maintenance and contributions for funded projects) from fiscal year 2008-09 to 2011-12.

As noted in Table 2[86], FNIHCC average expenditures were approximately $110 million annually, with expenditures increasing by 3-5% annually over the period under evaluation. Health Canada informants stated that these increases were largely utilized to cover salary increases.

For the years included in the evaluation, Table 2 indicated that, on average, salaries represented approximately 3% of the amount of grants and contributions administered. Overall, operating expenditures (including salaries) were 5% of grants and contributions expenditures.

As mentioned previously, the program received additional funding from other sources to supplement its existing work including:

- $612,000 between 2009 and 2011from the time-limited National Nursing Innovation Strategy program to undertake activities that enhanced collaboration and the wound-care knowledge and skills of FNIHCC nurses; and
- $5.0 million per year for five years starting in 2010-11 for the training of FNIHCC nurses as part of the Aboriginal Diabetes Initiative. When feasible, some regions were able to include personal care workers in the nurses training forums to enhance worker knowledge and understanding.

The original Terms and Conditions for the FNIHCC Program indicated that the program was designed to provide basic home and community care services that were comprehensive, culturally sensitive, accessible, effective and equitable to that of other Canadians and which responded to the unique health and social needs of First Nations and Inuit. Communities were required to deliver the FNIHCC essential services and may have offered the FNIHCC supportive services if resources were available and the need for these services was identified. The design of the FNIHCC Program remained unchanged since inception and Health Canada and community key informants observed that the funding provided covered only essential services in most communities.

Observations on Efficiency

The evidence from key informant interviews indicated that the FNIHCC Program was considered to be efficiently managed and delivered by most Band and Health Canada informants. As evidence, key informants noted that there was a high volume and quality of services provided in communities with only limited resources. As well, the majority of survey respondents (61%, n=153) reported that the resources were used efficiently to a large or very large extent. Many Band informants and most Health Canada informants were satisfied with how well resources were managed to achieve intended outcomes to a large or very large extent, citing the positive impacts from helping clients remain in their homes and communities.

[86] Source: HCC-Evaluation-Actual Expenditures 2007-2012.pdf

Processes and Strategies to Optimize Services

Both the document review and key informant interviews provided evidence of processes and strategies carried out over the evaluation period to improve program efficiency:

- The document review identified a few strategies put in place by the FNIHCC Program to optimize certain areas or aspects of quality improvement processes (i.e., service timeliness, use of resources, data management, and risk management). A Risk Management Appraisal Tool was used to assist with quality assurance in determining the efficiency, quality and effectiveness of the FNIHCC services and supports at the community level. This tool was used by regions to review essential FNIHCC service delivery elements and develop actions to address gaps. It was also used prior to a shift in funding arrangements to allow a First Nation or Inuit community more flexibility in delivering home and community care and the tool was used by both regions and communities to review program status and delivery.[87] As noted earlier, the FNIHCC Quality Resource Kit being rolled out is designed to support integration of various quality improvement concepts and practices into the design and provision of home and community care services to further optimize the overall quality of services.[88] Also FNIHB carried out a detailed review of the two main program databases (e-SDRT and e-HHRT) which resulted in an optimization of the accuracy and reliability of the program data.[89,90,91]
- Key informant interviews indicated that the program included processes to optimize services within the allocated resources to meet essential home care needs in communities. Specifically, almost all Health Canada informants indicated that the FNIHCC Program funding model and community-led planning process worked well overall to ensure that the essential FNIHCC services were provided. Many Health Canada informants indicated that Regional Offices provided assistance to communities with service delivery planning.

However, Health Canada informants also identified a number of constraints to achieving program outcomes. Many indicated that regional assistance to communities is more efficient and effective in regions with nurse advisors on staff in addition to FNIHCC coordinators. A few key informants expressed concern with the general lack of capacity of regional offices to roll out national program initiatives that are intended to assist communities with capacity building. A few key informants indicated that smaller communities are challenged to offer all the FNIHCC essential services within the resources allocated and a few observed that the program management capacity of communities varied. A few key informants stated that the interRAI HC tool would be more efficient and effective than the e-SDRT to plan services and resource allocations and would improve coordination with provincial health service providers that are increasingly using this standardized assessment tool.

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87 Health Canada. (2008). Guide: Home and Community Care, Essential Service Elements Risk Management Appraisal Tool. Ottawa, ON: .

88 Health Canada. (2012). First Nations Home and Community Care Project Information Sheets. Ottawa, ON: Author.

89 Su, M. (2012). North Data Verification. Ottawa, ON: Health Canada.

90 Dubois, M. (2012). First Nations and Inuit Home and Community Care Program Data Verification. Ottawa, ON: Health Canada.

91 Dubois, M. (2012). HRTT Data Verification. Ottawa, ON: Health Canada.

Potential Alternative Methods

A number of alternative methods and approaches for the delivery of the FNIHCC Program emerged that could potentially enhance immediate results at similar or lower costs (however none of these were accompanied by a rigorous economic assessment). The most promising alternatives that could be further explored include: wider adoption of demonstrated collaborative approaches; increased integration of services and programming with other federal departments; and greater use of technology for both delivery of services and training.

Key informants were asked to identify alternative methods to achieve the same program results. Those considered to be most promising are included here. Promising options were those strategies or approaches that showed positive results and may be effective and transferable to other settings. However, there was insufficient evidence to conclude that they are applicable in all situations.

Suggestions made by key informants included the use of technology for telehealth, common electronic records across health service providers, staff training, use of the interRAI HC tool and accessing third-party or non-government organizational services. One example of the latter suggestion is a 'hybrid nurse model' in place in one region where a few Bands have entered into agreements with the regional health authority to provide funding for a nurse who then is assigned to work full-time for the Band. The strength of the model is that the nurse has ready access to all of the resources of the health authority. A few key informants suggested wider adoption of current models of delivery relating to clustering smaller communities for service delivery and integrating health programs within communities.

The case study on program integration suggested that an integrated approach improves the efficiency and effectiveness of service delivery. One positive impact was an improved use of funds through a common set of program criteria and coordinated service times. The other case study on regional capacity highlighted a few alternative methods to increase the regional capacity to deliver the FNIHCC Program within existing resources:

- The presence of strong partnership bodies with Aboriginal communities and organizations in the higher capacity regions was viewed by key informants as positively impacting the regional capacity to manage and develop the program. In one higher capacity region, a home care working group (with eight sub-committees) comprised of FNIHCC nurses was considered by key informants to be an efficient and effective way of prioritizing and acting on the priority needs of communities, including prioritizing the rolling out of new initiatives and providing community staff with access to training. The working group also shared the results of their work with other regions. Several other Health Canada informants indicated that this working group was considered to be an effective model. In the other higher capacity region, a Health Canada – First Nations co-management committee was in place for all FNIHB health programs. For this committee, the regional FNIHCC staff members played an important advisory and capacity building role carried out in collaboration with partners. In contrast, the two lower capacity regions did not have strong partnership bodies and the evidence indicated that they did not have sufficient regional office resources to work with partners and also provide the advisory support to communities needed.

- In terms of resourcing, one region with higher capacity developed a growth strategy to build sustainable regional staff capacity for the FNIHCC Program. The region reserved a modest portion of the annual incremental FNIHCC Program funds (with the knowledge of communities) to increase the number of regional nurse advisors. The regional key informant considered this strategy to be efficient by enabling the regional office to provide the program support needed by communities in a sustainable manner (i.e., with incremental resources that are sustainable year over year). This approach appears to be one that other regions could consider for exploration with communities that now receive the annual incremental funds.
- All FNIHCC coordinators in both high and low capacity regions used distance technology to varying extents to provide training to staff in communities. This helped in particular with access to shorter training offerings.

Integration with the Assisted Living Program - In-Home Care Component

Evidence from the case study on program integration suggested that the integration of FNIHCC and the AANDC In-Home Care Component of the Assisted Living Program improved the efficiency of service delivery for both programs. In the integrated communities included in the case study, the FNIHCC nurse supervised both programs. In some communities, the home care staff delivered both programs (i.e., all are certified to deliver personal care) or one of the two programs (i.e., only those delivering FNIHCC hold a personal care certification). All integrated-community informants who commented on efficiency thought that integration had improved the level of efficiency through improved coordination, improved assessments and case management, and more targeted funding to address needs and staff training. However, the need for separate reporting to Health Canada and AANDC was cited as a constraint to efficiency. One non-integrated-community informant thought that separate management resulted in inefficiencies due to the limited coordination of visits to homes by the staff of the two programs.

All integrated-community informants in the case study of program integration who commented on efficiency and effectiveness reported that integration had improved the services' ability to meet client needs. For example, one integrated-community informant referenced the ability of the FNIHCC to serve previously under-serviced populations, e.g., individuals with brain injuries and mental health issues.

Level of Regional Capacity

The evidence from the case study of regional capacity suggested that regions with higher capacity may be more efficient in the use of resources than those with lower capacity. Both higher capacity regions had formal partnership bodies in place. Neither of the two lower capacity regions included in the case study had collaborative models in place at the regional level. The evidence thus suggested that adopting an organized collaborative approach, tailored to the needs and context of the region, was an efficient practice.

The two higher capacity regions allocated resources to staff nurse advisor positions in addition to the FNIHCC coordinator and evidence suggested that this was an efficient way to provide the support needed by communities to deliver the program. For example, in one higher capacity region, the FNIHCC coordinator key informant observed that the e-SDRT data quality in communities had improved due to the efforts of nurse advisors that assisted communities in

developing their capacity to enter data in the e-SDRT and that this data was used by some communities in service planning. A study of the e-SDRT data in that region over the 2008-09 to 2011-12 period[92] found that community level data submissions had improved over time,[93] that some communities had near perfect submissions[94] and that this data allowed for community level analysis. One community informant in that region confirmed that the FNIHCC regional nurse advisor helped with a number of aspects of program management such as identifying trends in services and development of the service plan. The community key informant also noted that the respective roles were clear and appropriate in enabling the community to deliver the FNIIHCC Program (i.e., the community took the lead and the advisor provided the support or approval they needed).

As well, the case study on regional capacity suggested that regions with higher capacity provided more support to communities in the delivery of the FNIHCC Program than did regions with lower capacity and this contributed to the efficiency of the essential FNIHCC services provided. FNIHCC coordinators in the higher capacity regions indicated that they had a full work plan of advisory, monitoring and education activities. They also reported more successes than challenges in carrying out their roles. In both regions there was a focus on education in rolling out national program improvement initiatives and the provision of ongoing advice to communities. Community informants in these regions confirmed that the support provided had been timely and helpful in areas such as service planning (including e-SDRT data quality and analysis) and recruitment and retention of staff. All Aboriginal partner informants in these regions confirmed that the FNIHCC Program was providing timely services and expert advice to communities. All have partnered with the FNIHCC staff to coordinate the delivery of training or provide access to expertise on specific health care needs (e.g., diabetes) and all indicated that this had enhanced the services provided to communities. Regional management support was also identified as a factor contributing to efficiency, with key informants in higher capacity regions reporting more support from regional management for their staff resources and the promotion of a coordinated approach across Health Canada programs in supporting communities.

All FNIHCC coordinators in the lower capacity regions indicated that, because of their limited resources, they were unable to provide some services and as a consequence they had limited impact on increasing the efficiency of communities in delivering the FNIIHCC Program. FNIHCC coordinators in the lower capacity regions indicated they all developed modest work plans in keeping with their level of staff resources that focused on helping communities ensure the basic, essential elements of the program were in place. Their work plans also set out a staged approach to the rolling out of national program improvement initiatives so these were not overwhelming to communities that in many cases were still deficient in the essential program elements (e.g., small communities with limited resources to provide the essential services, poor quality of e-SDRT data due to limited staff capacity to work with the data tool and challenges with staff turnover). All community informants in these regions recognized that the regional staff capacity was limited but reported there were some self-sufficient communities that did not need a

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[92] Health Canada. (August 31, 2012). First Nations Home and Community Care Program Report. Assessment and Surveillance, First Nations and Inuit Health Branch – Alberta Region.

[93] The report noted that in 2008-09, 85% of the required data was submitted; in 2009-10, 88%; in 2010-11, 95%; and in 2011-12, 99%.

[94] No analysis was provided on variations across communities on the quality of submissions.

lot of support. They indicated that they were able to obtain the advice and support they needed from the regional office. Examples of inefficiencies cited in these lower capacity regions included the limited capacity to administer and spend all the contribution funds allocated in one region, a high backlog of requests for assistance from communities, and a limited number of effective partnerships with Aboriginal organizations to provide support to communities.

Key informants made a number of specific recommendations to improve efficiency such as: increasing resources/capacity (mentioned by 38%), integration of programs within communities (9%), and clustering of communities for service delivery (9%).

Observations on Adequacy of Performance Measurement Data

The lack of complete and standardized performance data to assess all outcomes over time hindered the provision of information to support the evaluation, in particular, data to support the achievement of all the expected outcomes outlined in the logic model.

The FNIHCC logic model included outcomes that were all worded in terms of increases or improvements to the outcome area which may not have been appropriate for all outcomes. In addition, limited baseline data were available for the outcomes at the beginning of the evaluation period (2008-09) to facilitate robust assessment. For some outcomes, the evidence collected was able to support findings on the extent to which a particular activity was contributing to the current program performance, but not to determine the extent to which the situation/outcome had increased over the time period. For example, while the evaluation found evidence that capacity building activities had taken place, it was not possible to determine the extent to which this represented increased capacity building.

5. Conclusions

5.1 Relevance Conclusions

Core Issue #1: Continued Need

The FNIHCC Program continued to be relevant to First Nations and Inuit home and community care needs.

The FNIHCC Program continued to address a demonstrable need for home care and community services among First Nations and Inuit. The program design and funding were responsive to essential home care needs.

The needs related to First Nation and Inuit home and community care are expected to increase and to become increasingly more complex. This includes a disproportionate disease burden experienced by First Nations and Inuit in comparison to the general Canadian population, demographic trends and trends by provincial governments to more community-based services which have led to earlier hospital discharges and clients with more complex care needs in the community. The FNIHCC Strategic Business Plan that is currently being developed with key stakeholders is intended to support home and community care staff to meet the increased demand for services while managing program pressures (i.e. operating within the current funding level).

Core Issue #2: Alignment with Government Priorities

The FNIHCC Program aligned with federal government and Health Canada priorities.

The FNIHCC Program is a mandatory program within the Terms and Conditions for the Primary Health Care Authority First Nations and Inuit Health Program and aligned with federal government and Health Canada priorities as identified in Budget 2008, Budget 2009 and various federal policies and initiatives that demonstrated the FNHICC Program was a key component in the provision of health services to First Nations and Inuit.

Core Issue #3: Alignment with Federal Roles and Responsibilities

The FNIHCC Program aligned with federal roles and responsibilities.

The FNIHCC Program aligned with federal roles of the First Nations and Inuit Health Branch of Health Canada which has the responsibility to provide or fund the provision of First Nations and Inuit health programs consistent with the Indian Health Policy and subsequent Departmental mission or mandate statements. The FNIHCC Program aligned with Health Canada's strategic outcomes as indicated in Health Canada's DPRs and RPPs for the years 2008-09 through to 2011-12. The 2012 PAA indicated that the FNIHCC Program, being a component of First Nations and Inuit Primary Care, aligns with departmental key program activities which are congruent with Health Canada's mandated roles.

5.2 Performance Conclusions

Core Issue #4: Achievement of Expected Outcomes (Effectiveness)

The FNIHCC Program was delivered as intended and is progressing towards its intended outcomes, including the long term outcome to be responsive to the needs of First Nations individuals and communities through the provision of home and community care services.

The program has been stable in terms of the services provided over the period under evaluation and has continued to provide access to essential home and community care services. There have been initiatives to increase the capacity of the home and community care workforce. As well, initiatives have increased the use of policies, standards, guidelines, best practices, and evidence-

based information which are expected to have a positive future impact on program delivery at the community and regional levels. FNIHCC program staff was aware of the key program areas such as the types of essential services provided, how case management works, and staff's roles and responsibilities, while community members were, understandably, not as aware of these same key areas.

There have also been improvements in the collaboration of FNIHCC Program staff with other health care providers; however, linkages with social programs in communities are somewhat less effective. There have been regional and community efforts to improve the coordination of FNIHCC services with other programs in order to deliver seamless responses to home and community care needs (e.g., the integration of the program and the AANDC Assisted Living Program - In-Home Care Component contributed to more coordinated responses to home and community care needs). Although expected, it is not yet evident the degree to which national initiatives will increase the use of quality improvement processes to respond to home and community care needs.

However, the program may not be able to address the increasing demand for essential and supportive services. In response, a 10-Year Strategic Business Plan for the FNIHCC Program is being developed to set out a path to assist communities in responding to the expected increase in chronic and complex needs over the coming years, within current program resources.

Core Issue #5: Economy and Efficiency

The FNIHCC Program was considered to be efficiently managed and delivered. The economy and efficiency of the program could be improved through increasing the capacity of lower capacity regional offices, clustering program delivery across communities, integrating programs, streamlining reporting requirements across programs, improving performance measurement and making greater use of technology.

The evaluation found that the FNIHCC Program has developed processes and strategies to optimize services within the allocated resources to meet essential home care needs in communities. The program was viewed by key informants as being efficiently managed and delivered. Further efficiencies could potentially be achieved through increasing the capacity of lower capacity regional offices (building on the lessons learned from regions with higher capacity), clustering smaller communities for service delivery, integration/collaboration with other programs, streamlining reporting requirements across programs and greater use of technology for service delivery and training. The ability to assess the efficiency and effectiveness of the program was impacted by the design of the logic model and the type of performance information collected against defined indicators.

6. Recommendations

Recommendation 1

Health Canada should develop options for increasing the capacity of regional offices that have lower capacity to support the efficient delivery of the FNIHCC Program in communities.

A more detailed needs analysis that identifies gaps and challenges of the lower capacity regional offices should be undertaken, building on the more general factors identified in this evaluation. To complement the needs analysis, further detailed examination of higher capacity regional offices should be undertaken to provide promising practices and lessons learned that could help increase the capacity of regional offices. The options for increasing regional offices' capacity to implement the FNIHCC Program will need to be tailored according to the particular challenges each region encounters.

Recommendation 2

Health Canada should continue pursuing its negotiation with Aboriginal Affairs and Northern Development Canada (AANDC) to achieve formal integration of the FNIHCC Program with the AANDC Assisted Living Program - In-Home Component to improve efficiencies in the delivery of home care services.

In the immediate future, Health Canada should continue pursuing its negotiation with AANDC, if it is a priority for both departments, to achieve formal integration of the FNIHCC Program with the AANDC Assisted Living Program - In-Home Component to improve efficiencies in the delivery of home care services. Health Canada should continue its activities to encourage and support communities that have not integrated the delivery of these two programs to move to an integrated approach. The information gathered in the case study for this evaluation should be used to inform communities of the benefits and considerations in undertaking integration. As well, FNIHCC staff in communities that have integrated the delivery could play a role as 'champions' in promoting this to other communities. Health Canada and AANDC should also examine ways to integrate the reporting for these two programs in communities where the programs are integrated to improve efficiencies. On a more strategic level, Health Canada and AANDC should pursue formal integration of the two programs.

Recommendation 3

Health Canada should strengthen linkages and partnerships between the program and other external social programs to increase collaboration.

In addition to the AANDC Assisted Living Program – In Home Care Component, Health Canada should work to assist communities in strengthening linkages and partnerships between the FNIHCC Program and other social programs. There have been improvements in the collaboration of home and community care staff with other health care providers but linkages

with social programs in communities are somewhat less effective. This would include the development of better linkages with community programming involving areas such as social services and housing. The evaluation found that the linkages between the FNIHCC Program with social programs were generally stronger in communities where health and social programs are managed in one department or co-located.

Recommendation 4

Health Canada should continue its current initiatives to improve quality program delivery through the use of evidence-based information, program policies and standards, and quality improvement processes in a manner that is relevant and sustainable within current resource levels of regions and communities.

Health Canada should build on the initiatives that were commenced during the evaluation period in the areas of increased use of evidence-based information, program policies and standards, and quality improvement processes which are expected to have a positive future impact on program delivery at the community and regional levels and which can inform quality program delivery. In furthering the development and implementation of these initiatives, it will be important to ensure that they are clearly linked to both the strategic planning process currently underway and the suggested revisions to the program logic model and data collection process (see recommendation #5). As well, it will be important to consider the potential challenges and capacity required at the regional and local levels to fully implement these initiatives.

Recommendation 5

Health Canada should revise the logic model for the FNIHCC Program to ensure expected outcomes are reflective of the nature of this health program moving forward and ensure adequate program data are collected to facilitate decision-making and future evaluation.

The logic model should accurately reflect the activities that are undertaken by the FNIHCC Program including the program development initiatives that have been recently undertaken and planned for the upcoming evaluation period. As well, the anticipated outcomes should take into account the context for the FNIHCC Program and focus on those contributions the program can realistically make to changes in the target populations. This recommendation should be implemented soon, as a revised logic model will be needed to assist with program planning, performance monitoring, initiative development and evaluation planning.

As well, the program should continue to work with regional offices and communities to ensure that data collection is of sufficient quality to be used for decision-making and future evaluation. These efforts should make use of technology and build on previous program work to build e-tools for data collection (e.g., interRAI HC pilot in Alberta and the computer assisted training tool on e-SDRT).

Appendix 1 - Logic Model

First Nations and Inuit Home and Community Care Logic Model

<table>
<tr><th>Objective</th><td colspan="5">To provide home and community care assessment, treatment, rehabilitative, personal and supportive, in-home respite and palliative/end of life services</td></tr>
<tr><th>Target Group</th><td colspan="5">First Nations and Inuit who live on a First Nations reserve, a First Nations community north of 60 or in Inuit Communities</td></tr>
<tr><th>Theme</th><td>Service Provision</td><td>Capacity Building</td><td>Stakeholder Engagement and Collaboration</td><td>Data Collection, Research and surveillance</td><td>Policy Development and Knowledge Sharing</td></tr>
<tr><th>Outputs</th><td>Home and community care services</td><td>Workforce education and training activities</td><td>Collaborative service delivery arrangements</td><td>Systematic service delivery information

Research reports</td><td>Policies, standards and service delivery guidelines</td></tr>
<tr><th>Immediate Outcomes</th><td>Increasingly appropriate home and community care services based on assessed need</td><td>Increasing capacity of home and community care workforce</td><td>Increased collaboration with internal and external providers

Increased First Nation and Inuit awareness of home and community care services</td><td colspan="2">Increased use of policies, standards, guidelines and best practices in service delivery

Increased use of evidence-based information to inform quality program delivery</td></tr>
<tr><th>Intermediate Outcomes</th><td>Improved access to home and community care services</td><td>Increased effectiveness[95] of services</td><td>Improved coordinated and seamless responses to home and community care needs</td><td colspan="2">Increased use of continuous quality improvement, including patient safety processes, to respond to home and community care needs</td></tr>
<tr><th>Longer Term Outcomes</th><td colspan="5">Home and community care services that are responsive to the needs of First Nations and Inuit individuals and communities</td></tr>
</table>

95 Effectiveness - is the extent to which a program is achieving all the expected outcomes (i.e., that are outlined in the FNIHCC logic model). The evaluation study will focus on the Performance (*effectiveness*, efficiency and economy) of the FNIHCC Program as part of the core evaluation issues listed, as per the GoC Policy on Evaluation (2009).

Appendix 2 - Details on Data Collection and Analysis Methods

The evaluation incorporated classic ex post-facto design aspects with primary data collection occurring post-intervention (key informant interviews, survey). This reliance on "post" data was mediated to some extent by analysing performance data that had been collected by the program during the period covered by the evaluation. The design did not include a formal comparison group. Given that the FNIHCC Program is a mandatory program delivered in the vast majority of First Nations and Inuit communities, it was not feasible to obtain a viable comparison group. A limited number of baseline comparisons and trend identifications were conducted where possible for comparison. Overall, the evaluation was designed to demonstrate the likely contributions of the FNIHCC Program to the expected outcomes, rather than demonstrate direct causal links.

Multiple lines of evidence were used to facilitate the triangulation of data to support evidence-based findings and conclusions. The lines of evidence are described below.

Literature Review

The strategy for the literature review consisted of searching citation indices for both academic peer-reviewed literature (Pubmed, HealthSTAR, Réseau-Santécom) and grey literature (Google, Google Scholar) using six main keyword groupings[96] following a sequential Boolean logic search process. Identification of potentially relevant literature was also supplemented with a "rolling reference" system, whereby potentially relevant literature referenced in one document, or identified via other evaluation methods such as key informant interviews or on-line consultation was considered for inclusion in the literature review. Potentially relevant literature was assessed for inclusion in the review according to the following criteria: 1) focused on services, programs, initiatives or policies within the 2008-2012 timeframe; 2) focused on programs/initiatives comparable to the FNIHCC Program with respect to target population, settings, and types of services provided; and 3) topics/themes covered related directly to at least one of the indicators outlined in the evaluation matrix for the literature review. In total, 67 potential documents were identified and assessed using the criteria. Forty (n=40) met the literature selection criteria and were included in the literature review. All retained literature was reviewed using a template specifically developed for the evaluation that aligned evidence retrieved from articles with specific indicators and interpretations for the evaluation. The template was pre-tested and calibrated with two project team reviewers reviewing three articles who attained a reasonable level of inter-rater reliability for coding of key pieces of extracted evidence (Kappa = 0.80).

Document Review

The search strategy for the document review was conducted initially by FNIHB representatives to identify internally produced documents and reports that could potentially be used to address the various evaluation questions. The external consultant then assessed each potential document for inclusion in the document review according to the following criteria: 1) the document makes

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[96] The six keyword groupings consisted of 1) Canada-First Nations-Inuit-Aboriginal; 2) remote-rural-isolated; 3) home- community-palliative care; 4) economy-efficiency-cost-alternatives-resources; 5) program-initiative - service; and, 6) quality-standards-delivery

reference to FNIHCC Program activities/outcomes within the time evaluation period (i.e., 2008-09 to 2011-12); 2) the document includes information that provides baseline/benchmark for FNIHCC Program activities during the evaluation period (such as previous evaluations, performance reports, etc.); and 3) the document provides information/evidence that directly links to a specific indicator and can be linked to at least one of the evaluation questions. Forty-five documents were identified by the FNIHB representatives, and 42 were assessed as relevant for inclusion in the document review. An additional 5 documents that met the inclusion criteria were identified through key informant interviews and included in the review. Therefore, 47 total documents (n=47) met the inclusion criteria and were reviewed in the document review. Similar to the literature review, a document review template specifically developed for the evaluation that aligned evidence retrieved from documents with specific indicators and interpretations for the evaluation. The template was pre-tested and calibrated with two project team reviewers reviewing three documents who attained a reasonable level of inter-rater reliability for coding of key pieces of extracted evidence according to indicators (Kappa = 0.82).

Database Review

For the database review, the project team reviewed a summary report along with some additional summary tables provided by the FNIHCC Program representatives who compiled tables to align with indicators outlined in the evaluation matrix. The main sources used to compile the summary data report and summary tables were the Electronic Human Resource Tracking Tool (e-HRTT) and the Electronic Service Delivery Reporting Template (e-SDRT). The e-HRTT is an Excel-based tool that allows FNIHCC personnel to provide information on the program's human resources. The e-SDRT is also an Excel-based tool that allows FNIHCC personnel to provide information on their activities. Similar to the other reviews, a database review template was developed that aligned evidence retrieved from the summary report and the summary tables with specific indicators and interpretations for the evaluation. The template was pre-tested and calibrated with two project team reviewers reviewing three tables who attained a reasonable level of inter-rater reliability for coding of key pieces of extracted evidence according to indicators (Kappa = 0.88).

Key Informant Interviews

Using a purposive sampling approach, key informants were selected from a population list of 1033 individuals developed by FNIHCC Program representatives covering five groups at the national level and in the seven Health Canada Regions. Sampling for the proxy group representing FNIHCC Program clients (i.e., Band Chief and Council or designates such as Health Directors) was carried out to select a representative sample of communities and regions based on taking into account total First Nations/ Inuit population in each region, population size of community, and community isolation/remoteness.

The table below sets out the total population by group in the lists developed by Health Canada national and regional offices, the planned interviews by group, the number of key informants invited and the number of interviews completed.

Key Informant Selection Process and Results

Key Informant Group	Population	Planned Interviews	Invitations	Completed Interviews	Completion Rate
Band Chief, Councillor or Designate (Band)[97]	935	40	134	20	50%
P/T/RHA	15	12	15	11	92%
ABO/NGO	45	7	10	8	114%
Federal [98]	2	2	2	1	50%
Health Canada National	6	5	5	5	100%
Health Canada Regional	30	14	15	13	93%
Total	1033	80	181	58	73%

Interviews were conducted by telephone using a semi-structured interview guide tailored for each informant group. The guide was pre-tested with a total of six individuals across all groups except other federal departments. The pretest resulted in minor changes to wording and positioning of questions. The guide consisted primarily of open-ended questions linked to the evaluation indicators, and a few closed-ended questions that used a five-point Likert-type scale to collect ratings. Interviews were conducted in respondents' preferred official language. The interviews were recorded with key informants' permission,[99] and the notes were sent to each informant for validation. A few key informants made changes to the notes, primarily to add or clarify information. Interviews were conducted between October 18 and November 30, 2012.

Stakeholder Survey

Target Groups

The target groups for the survey were identified in the evaluation framework and included: First Nations Chiefs and Councilors and their designates (e.g., Health Directors) who served as proxy respondents for FNIHCC Program clients, FNIHCC Program community staff, staff delivering other community health programs, Health Canada staff associated with the FNIHCC Program, and other provincial/territorial/regional stakeholders such as Tribal Councils, Regional Aboriginal Organizations, provincial government representatives, and regional health authorities. The sampling frame for each target group consisted of lists of potential respondents that were compiled by regional and national Health Canada representatives.

Survey Method

All respondents with valid email addresses were sent email invitations to participate in the survey, followed by one or two email reminders. The bilingual survey questionnaire was hosted online and could be accessed by visiting the website hyperlinked in the email invitation from November 1 to December 7, 2012.

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[97] Two were group interviews (one with three individuals and one with four individuals involved in FNIHCC delivery). Both these are recorded as one informant in the reporting.

[98] The responses asked of the federal informant were added to the P/T/RHA group and reported as P/T/RHA/Other

[99] Audio tapes will be deleted when the evaluation is complete.

Survey Instrument

Prior to launching the survey, the questionnaire was pre-tested with 12 respondents from three of the six stakeholder groups. The pretest resulted in minor changes to wording and positioning of items. The final version of the questionnaire consisted primarily of closed-ended questions which required the respondent to answer using a 5-point rating scale,[100] or to select from a list of response choices. All respondents were also asked several open-ended questions to provide them with the opportunity to further explain a rating or provide examples.

Analysis

At the analysis stage, closed-ended questions were analyzed using basic frequencies and cross-tabulations with a focus on comparing responses across region and stakeholder category. Verbatim responses captured in open-ended questions were initially reviewed to identify and develop themes/categories emerging from the data, and then coded according to these themes/categories.

Response Rates

As illustrated in the table below, the overall response rate achieved was 18.8% resulting in a sample of n=332.

Response Rate by Stakeholder Group and Region

Stakeholder Group	Invitations (n)	Completions (n)	Response Rate (%)
Chief and Councillors	187	16	8.6%
Health Directors	309	62	20.1%
FNIHCC Program Community Staff	724	168	23.2%
Other Community Health Staff	355	47	13.2%
Health Canada FNIHCC Program Staff	18	7	38.9%
P/T/Regional Stakeholders	169	30	17.8%
Region	**Invitations (n)**	**Completions (n)**	**Response Rate (%)**
Alberta	125	32	25.6%
Atlantic	131	31	23.7%
British Columbia	662	75	11.3%
Manitoba	95	43	45.3%
Nunavut	38	3	7.9%
North West Territories	18	4	22.2%
Ontario	392	61	15.6%
Quebec	88	33	37.5%
Saskatchewan	212	49	23.1%
Yukon	1	1	100.0%
TOTAL	**1762**	**332**	**18.8%**

[100] The rating scale used included the following categories: 1=not at all; 2=to a small extent; 3=somewhat; 4=to a large extent; and 5=to a very large extent.

Case Studies

Selection of Themes and Regions/Communities

Six potential issues were identified by FNIHCC Program managers and through the initial key informant interviews conducted for the evaluation. The external consultants rated these in regard to their potential to address the evaluation questions, the coverage of First Nations and Inuit communities, and the potential to implement the case studies within the timeframe of the evaluation. Two issue themes were selected from this process.

THEME 1: REGIONAL CAPACITY TO DELIVER THE FNHICC PROGRAM

Criteria were developed for the selection of regions that had high and low capacity to deliver the FNIHCC Program as follows:

- Capacity to respond to community requests for information, tools, support
- Use of data and reporting (e.g., RMAT) to inform decision-making
- Sharing best practices
- Development of pilot projects/trial changes in programming to meet region needs
- Staff turnover and unstaffed positions at regional office level
- Characteristics of FN/I communities that present challenges/opportunities at regional level (e.g., remoteness, number of communities, size of communities, political structures, etc.)

The FNIHB National Office applied these criteria to all seven regions, based on their knowledge of the regions. Based on this input, the consultants selected two regions that met the most criteria as high capacity regions and two regions that met the most criteria as low capacity regions. This sample of four of the seven regions was deemed to be sufficient to illustrate the different experiences and outcomes across regions using this case study method.

The external consultants then collaborated with the regional FNIHCC coordinator in each of these regions to identify key informants to interview for the case study: FNIHCC coordinators in two communities, the regional manager for the FNIHCC Program, a partner from within Health Canada and an external partner with whom the FNIHCC Program staff liaise in delivery of the program. All four FNIHCC regional coordinators provided their most recent work plans and any other documents they considered relevant to the case study.

THEME 2: PROGRAM INTEGRATION

Health Canada FNIHCC regional coordinators in the seven regions were asked to identify communities that had integrated the delivery of the FNIHCC Program and the In-Home Care Component of the Assisted Living Program and those that had not based on their knowledge of communities. Five of the seven regions identified communities that had integrated program delivery. The consultants selected an integrated community and a non-integrated community in each of these five regions, with a mix of small and large communities across the five regions, with the aim of including 10 communities overall for the case study. A total of eight communities agreed to participate within the timeframe established for this method which included five integrated communities and three non-integrated communities.

The table below sets out the total targeted and completed interviews for each case study, by key informant group. In categories where the targeted interviews were not completed, the reason was due to not being able to reach and arrange an interview with the key informants identified within the timeframe set for this evaluation method.

Case Study Key Informants

Case Study Theme 1	Targeted Interviews	Completed Interviews
Regional Management Representative	4	2
Regional FNIHCC Coordinators	5	5
FNIHCC – Health Canada Partners	4	3
FNIHCC External Partners	4	2
Communities – FNIHCC Coordinators	8	5
Total	***25***	***17***
Case Study Theme 2	**Targeted Interviews**	**Completed Interviews**
Integrated Communities – FNIHCC Coordinators	5	5
Non-integrated Communities - FNIHCC Coordinators	5	3
Total	***10***	***8***

Interviews were conducted by telephone using a semi-structured interview guide tailored for each informant group and linked to the evaluation questions. The guide was pre-tested with each group. The pretest resulted in minor changes to wording and positioning of questions. Interviews were conducted in respondents' preferred official language. The interviews were recorded with key informants' permission, and the notes were sent to each informant for validation. Interviews were conducted between November 14 and December 6, 2012.

Data Analysis Approach

In accordance with best practices in evaluation, multiple lines of evidence were used including primary and secondary, qualitative and quantitative data. The data collected was analyzed using the following procedures:

- Systematic review of data gathered through each line of evidence, using templates to gather and interpret the evidence from each source (e.g. document, key informant) for each indicator.
- Statistical analysis where counts and percentages were generated to analyze quantitative.
- Surveillance of data and preparation of charts to record the proportion of key informants expressing specific opinions.
- Thematic analysis of the key informant interviews and open-ended survey responses in relation to the evaluation indicators/questions.
- Triangulation of data gathered from the literature, document and database reviews.
- Reviews, key informant interviews, stakeholder survey, and case studies to identify the extent to which the lines of evidence corroborated findings.
- The inclusion of economy/efficiency assessment measures.

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