Final Report

Audit of the First Nations and Inuit Home and Community Care Program

October 2014

Table of Contents

Executive summary

The focus of the audit is the First Nations and Inuit Home and Community Care Program (the Program). In 1999, Health Canada launched a mandatory program that is a coordinated system of home and community-based health care services for 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. Health Canada provides funding through funding agreements for a continuum of basic essential services such as: client assessment and case management; home care nursing, personal care and home support, as well as in-home respite; and, linkages and referrals, as needed, to other health and social services. Care is delivered primarily by nurses, personal care workers and other community health and social development team members.

The objective of the audit was to assess the effectiveness of the management control framework (governance, risk management and internal controls) for the Program and to determine whether the transfer payments are in compliance with the Treasury Board *Policy on Transfer Payments*. The audit was conducted in accordance with the Treasury Board *Policy on Internal Audit* and the *International Standards for the Professional Practices of Internal Auditing*. Sufficient and appropriate procedures were performed and evidence gathered to support the audit conclusion.

Strategic direction for the Program is provided through a ten-year strategic plan (2013-2023), and oversight occurs through working groups. As well, a funding formula was developed at the outset of the Program for the distribution of the funds. Roles and responsibilities are clear and complementary between headquarters and the regions, especially as they relate to the management of funding agreements. The Program has a logic model and the performance measurement strategy that were developed in 2010. The ten-year strategic plan notes that the Program is dedicated to continuous quality improvement, based on high quality, consistent and standardized data collection and assessments, and notes short-term and medium-term actions to develop and revise the performance indicators.

In fiscal year 2014-15, the First Nations and Inuit Health Branch (FNIHB) implemented a new approach to the risk management process whereby risk management is integrated into the planning and reporting cycle. The Program also identified program-specific challenges/risks in its strategic plan, with corresponding actions over the short, medium and long term. Over the course of the implementation of this plan, the Program has an opportunity to monitor the risks identified to ensure that it continues to meet program objectives.

The Program has operational plans to manage its resources, policies and guidelines, and offers training and support to recipients in the delivery of home and community care. The program uses two electronic systems to capture data. One is related to the services delivered in each community and the second is a human resources system that captures data related to the professionals delivering the services. Over the years, it has become evident that there is a sustainability risk related to the server used to collect and store the data. Modifications to the database are proving to be time consuming and difficult. While the systems have provided much data, there is a need to examine them to ensure that they continue to meet the Program's needs. As well, not all communities provide consistent and standardized data, which impacts the comparability of data across regions.

The Program collects personal information via two of its key systems and would benefit from working with functional experts to review the collection and protection of personal information, as well as creating personal information banks.

The Program has been designed to support the capacity development of the communities, and has benefited from additional funding through the Aboriginal Diabetes Initiative to provide training for nurses. The guidance documentation, regional focus and training efforts have lent themselves well to supporting the capacity in the communities.

The Program was found to be compliant with the Treasury Board *Policy on Transfer Payments*. It was noted that there are processes in place towards the evaluation of recipient capacity, risk assessment and payment releases. However, the audit recommends that the process be enhanced to include the re-verification of liability coverage of recipient communities.

The audit report includes three recommendations to further aid in strengthening the management of the Home and Community Care Program. Management agrees with the recommendations and has provided a suitable management response and action plan to address each of the recommendations.

A - Introduction

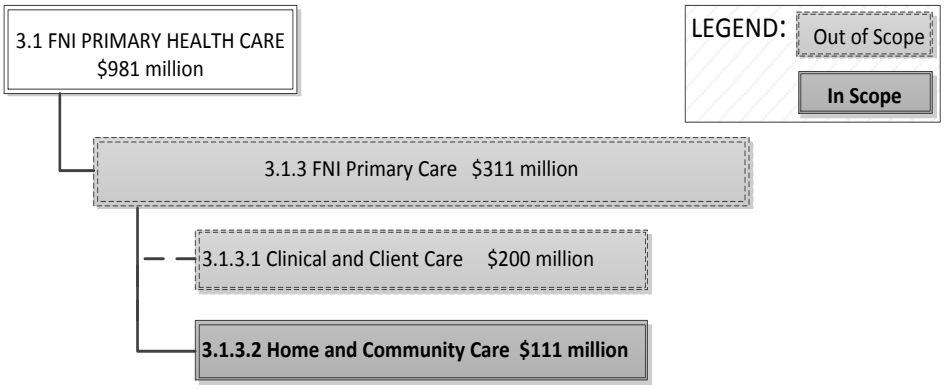
1. Background

Aboriginal health is a priority shared by the federal, provincial and territorial governments and First Nations and Inuit communities. The provinces and territories are responsible for the provision of health services to all residents, including First Nations and Inuit. Health Canada supplements and supports provincial and territorial health programs for First Nations and Inuit based on policy rather than legislation. The mandate of Health Canada with respect to First Nations and Inuit communities and individuals is to deliver health services and benefits that are responsive to their needs, in order to improve their health status.

The Department's role in First Nations and Inuit health is based on the *Indian Health Policy 1979*, as well as the general powers of the Minister under section 4 of the *Department of Health Act* to exercise functions and duties to preserve and protect the health and wellbeing of Canadians.

In order to meet its mandate, the Department provides or funds a continuum of health programs and services to First Nations and Inuit communities, and provides supplementary health benefits to eligible First Nations and Inuit individuals through a number of specific program components. Within the Primary Health Care component, the First Nations and Inuit Health Branch (FNIHB) delivers the First Nations and Inuit Home and Community Care Program (the Program), which was introduced in 1999 as a mandatory program. In 2013-14, the Program's expenditures amounted to $110.8 million. Ninety-six percent of the funding ($106.2 million) is in transfer payments to communities (see Appendices C and D). The remaining expenditures are for headquarters and regional program support expenses.

Figure 1: Federal funding for First Nations and Inuit Primary Health Care



Overall, 674 First Nations and Inuit communities (including 197 through the British Columbia Tripartite Agreement) receive funding from the Program. The Program is a coordinated system of home and community-based health care services that enable First Nations and Inuit people of

all ages with disabilities, chronic or acute illnesses, as well as and the elderly to receive the care they need in their homes and communities. To that end, FNIHB provides funding through funding agreements for a continuum of basic essential services such as: client assessment and case management; home care nursing, personal care and home support as well as in-home respite; and, linkages and referrals, as needed, to other health and social services. The Program has authority to provide but does not have direct funding for supportive services such as therapies, institutional respite care, meal programs, mental health home-based care, palliative care, specialized health promotion, wellness and fitness services. These services can only be provided once essential service elements are provided and if there are remaining funds.

Nine essential service elements:

1. Client assessment;
2. Case management;
3. Home care nursing services;
4. Home support services: personal care and home management;
5. In-home respite care;
6. Access to medical supplies and equipment;
7. Information and data collection;
8. Management and supervision;
9. Linkages with other professional and social services.

Service delivery is based on assessed need and follows a case management process. Care is delivered by nurses, personal care workers, and other community health and social development team members. These direct service providers are generally employed by the communities, with the exception of 13 health professionals in Alberta who are employed by Health Canada. There are two other program delivery exceptions: the Pacific and Northern Regions. Since October 2013, responsibility for the delivery of home and community care in British Columbia has been transferred to the First Nations Health Authority (FNHA), under the Tripartite Agreement. The Health Authority assumes the roles previously undertaken by the Pacific Regional office. In the Northern Region, home and community care is delivered through funding agreements with the governments of Nunavut and the Northwest Territories. In the two territories, the direct service staff are typically employees of the territorial government. In Yukon, delivery is through funding agreements between Health Canada and the First Nations communities.

2. Audit objective

The objective of the audit was to assess the effectiveness of the management control framework for the First Nations and Inuit Home and Community Care Program and determine whether the transfer payments are in compliance with Treasury Board *Policy on Transfer Payments*.

3. Audit scope

The audit focused on the management controls within the FNIHB related to governance, risk management and internal controls for the Program. It included financial and non-financial aspects of the funding agreements. The sample was selected from funding agreements that were active in 2013-14 and 2014-15. The Pacific Region was excluded due to the current transition to the tripartite model for service delivery. An audit of the British Columbia Tripartite Agreement is scheduled for 2016-17.

4. Audit approach

The audit was conducted in Health Canada's headquarters and through site visits to three regions. The principal audit procedures included:

- Review and analysis of FNIHB home and community care policy framework, national planning, program delivery and performance related documentation;
- Interviews (in-person and by telephone) with key program personnel at headquarters and in the regional offices;
- Site visits to Ontario, Quebec and Manitoba regional offices. The selection of regional offices for fieldwork was based on expenditure levels;
- Questionnaire on selected issues sent to regional offices that did not receive a site visit; and,
- Detailed examination of a sample of payments to transfer payment recipients for conformity with the *Financial Administration Act*, Treasury Board *Policy on Transfer Payments* and program eligibility.

5. Statement of conformance

In the professional judgment of the Chief Audit Executive, sufficient and appropriate procedures were performed and evidence gathered to support the accuracy of the audit conclusion. The audit findings and conclusion are based on a comparison of the conditions that existed as of the date of the audit, against established criteria that were agreed upon with management. Further, the evidence was gathered in accordance with the *Internal Auditing Standards for the Government of Canada* and the *International Standards for the Professional Practice of Internal Auditing.* The audit conforms to the *Internal Auditing Standards for the Government of Canada*, as supported by the results of the quality assurance and improvement program.

B - Findings, recommendations and management responses

1. Governance

1.1 Strategic direction

Audit criterion: *The First Nations and Inuit Health Branch plans for the strategic direction of the First Nations and Inuit Home and Community Care Program.*

The First Nations and Inuit Health Branch (FNIHB) communicate its objectives and priorities through the Branch Strategic Plan: A Shared Path to Improved Health. Feeding from the Strategic Plan is the Branch Operational Plan, which details FNIHB departmental priorities. The First Nations and Inuit Home and Community Care Program's (the Program) direction is defined in the program framework and the FNIHCC[1] 10-Year Plan 2013-2023. In this plan, the Program has committed to five goals with associated short-, medium-, and long-term actions to be achieved in accordance with the priorities of communities, Regions, and the national office. Review of both the program framework and the ten-year plan confirms that they are aligned with the goals found in the branch's Strategic Plan and the Operational Plan. The strategic direction is clear in both of these documents and is executed through a committee/working group structure.

Committees

The **FNIHB Senior Management Committee** is chaired by the Senior Assistant Deputy Minister, with membership including the Assistant Deputy Minister of Regional Operations, directors general and regional executives. It provides a forum for ongoing management of the Branch. At the January 2014 meeting, the FNIHCC 10-Year Plan 2013-2023 was tabled to the Senior Management Committee.

The Program has two working groups. The first one is the **FNIHCC Regional Coordinators.** Membership consists of representatives from both headquarters and the regions who meet face-to-face annually and hold monthly teleconferences. The objective of the working group is to identify policy gaps and discuss best practices and strategy directions. The second working group is the **FNIHCC Regional Coordinators and Partners**, whose membership comprises the regional coordinators, as well as First Nations regional partners. Similarly, this working group meets face-to-face annually and holds monthly teleconferences to offer the opportunity for a dialogue among partners.

The audit examined the terms of reference, agendas and minutes for both groups and noted an effective oversight activity; however, the terms of reference should be updated to reflect current membership and activities.

Funding allocations

The funding formula to distribute the $90M in funds was established 15 years ago. However, in 2006, the Program benefited from a 3% annual accelerator and in 2010, the program received $5M per year for five years from the Aboriginal Diabetes Initiative for training nurses on

[1] FNIHCC = First Nations and Inuit Home and Community Care, referred to in this report as the Program.

evidence-based clinical practice guidelines and chronic disease management strategies. In 2013-14, program funding amounted to $110.8M (see Appendices C and D), of which $106.2M (95.8%) is for funding agreements. The remaining 4.2 percent was allocated to fund national and regional activities: $4.1M (3.7%) for wages and salaries, and $591K (0.5%) for other operating expenses.

The formula is based on population, with four components: home nursing, personal care and program support; case management, coordination services and case assessment services; an amount for operating costs; and an adjustment for remoteness. Funding has increased over time to include additional allocations for nursing salary resources and annual operating increases.The funding formula for the Program was designed to allocate resources based on community needs and population size.

The Program notes potential financial pressure given the increased burden of chronic illness and injuries; training costs; higher costs associated with remoteness of communities; and increasing numbers of injuries and disabilities in an ever-increasing population. As the Program accumulates more reliable health services data, it may have to review the funding formula.

In conclusion, the Program's recently developed ten-year plan and early progress on some of the short-term actions, which are overseen by the two working groups, provides for good strategic direction and governance of the Program.

1.2 Roles and responsibilities

Audit criterion: *Roles and responsibilities for the delivery of the First Nations and Inuit Home and Community Care Program are documented and clear and are well- communicated.*

The FNIHB Accountability Framework (2012) and the Home and Community Care Implementation Plan (1999) define roles and responsibilities. The framework is designed for programs that are centrally managed but delivered regionally. The Implementation Plan exists since the launch of the Program and most sections remain relevant and accessible to recipients. In addition to the role played by the regional offices, there are three units at headquarters that support the management of the Program: the Interprofessional Advisory and Program Support Directorate; the Strategic Policy, Planning and Information Directorate; and, the Health Funding Arrangements Division.

The **Interprofessional Advisory and Program Support Directorate** is responsible for primary care programming, in partnership with First Nations and Inuit health authorities, although delivery of the Program is overseen by Health Canada's regional offices. Within the Directorate, the FNIHCC Unit in collaboration with Regions is responsible for program policy and for the coordination of the Program's committees, external and internal linkages, accountability, reporting, performance measurement, research and program enhancements.

The **Strategic Policy, Planning and Information Directorate** provides strategic policy and planning support to senior management and regional staff on key health related issues and initiatives. It is also involved in horizontal, cross-branch policy analysis, coordination and

integration; quantitative analysis; policy coordination; intergovernmental relations; performance measurement; audit liaison; operational planning and reporting; integrated risk management; and strategic planning. This directorate leads the processes to develop the FNIHB Strategic Plan, the FNIHB Operational Plan and the Branch Risk Assessment.

The **Health Funding Arrangements Division**'s role is to develop tools and processes, provide funding templates and develop accountability policies and practices, including leading the recipient audit process for the branch. This division plays a lead role for the branch in the harmonization of grants and contribution policies and processes related to Aboriginal recipients, with Aboriginal Affairs and Northern Development Canada (AANDC).

The **regional offices** are responsible for supporting the First Nations and Inuit communities in their delivery of the program and for managing all community-based funding agreements. Support for the Program is led by a coordinator, (commonly with a community health nurse), who oversees a team that may include nurse practice advisors, nurse educators and program administration staff. Each regional office has a funding agreement unit responsible for incorporating all programs into funding agreements, as well as overall liaison with each community. These units are generally staffed by community liaison officers. Since December 2011, the regional offices report to the Assistant Deputy Minister of Regional Operations.

The roles and responsibilities at headquarters and in the regional operations were documented and validated with program managers in the three sites visited; both headquarters and the regional staffs are aware of their respective roles as they relate to support for program delivery and transfer payment management. Interviews and documentation also indicate that information flows regularly between headquarters and the regional offices. The audit noted that while the roles remain unchanged, the responsibilities across the Program have evolved since 1999 and would benefit from being updated.

1.3 Performance management

Audit criterion: *There is a performance measurement strategy for the First Nations and Inuit Home and Community Care Program.*

Performance management is a framework for driving strategy into sustainable performance. The performance measurement strategy identifies the indicators required to monitor and gauge the performance of a program. Its purpose is to support program managers in continuously monitoring and assessing the results of programs and the efficiency of their management; making informed decisions and taking appropriate, timely action with respect to programs; providing effective and relevant departmental reporting on programs; and ensuring that the information gathered will effectively support an evaluation.

In 2010, the Program revised its logic model and supporting performance measurement strategy. The logic model has five themes with respective outputs and immediate, intermediate, and long-term outcomes. Table 1 shows the themes and outputs of the logic model.

Table 1: Abridged logic model for the First Nations and Inuit Home and Community Care Program

Objective	To provide home and community care assessment, treatment, rehabilitative, personal and supportive in-home respite and palliative/end of life services				
Target Group	First Nations and Inuit who live on a First Nations reserve, in a First Nations community north of 60 or in Inuit communities				
Theme	Service provision	Capacity building	Stakeholder engagement and collaboration	Data collection, research and surveillance	Policy development and knowledge sharing
Output	Home and community care services	Workforce education and training activities	Collaborative service delivery arrangements	Systematic service delivery information Research reports	Policies, standards and service delivery guidelines

As noted, the Program also developed a performance measurement strategy. The strategy contains six expected results and seventeen indicators. A sample of these indicators include measurements related to the percentage of the on-reserve population accessing home care and community (HCC) services; the total number of hours of HCC services provided; the percentage distribution of hours of HCC services provided by type of service; the ratio of nurses to personal care workers; the number and percentage of eligible communities that have achieved accreditation for HCC services. The Program provides annual reporting under the Departmental Program Activity Architecture – Performance Measurement Strategy and submits statistics for inclusion in the Departmental Performance Report.

Much of the data is drawn from the electronic Service Delivery Reporting Template, the Electronic Human Resource Tracking Tool database and the Community-Based Reporting Template. Communities are required to submit detailed service delivery information and staff information under the terms of the funding agreement.

As well, in its ten-year strategic plan, the Program commits to continuous quality improvement based on high quality, consistent and standardized data collection and assessments. In its short-term actions, the Program intends to develop analytical reports, present trends in home and community care delivery and service utilization and one-page snapshots or highlights of key indicators. Going forward, the Program intends to analyze collected data to identify service needs and service gaps. Over the medium term (4-7 years), the Program intends to develop service delivery home support standards with associated indicators.

The Program has established a logic model and a performance measurement strategy and is collecting data against a set of performance indicators.

2. Risk management

2.1 Risk management

Audit criterion: *External and internal risks associated with the First Nations and Inuit Home and Community Care Program are identified, assessed and managed.*

The Program continues to play a vital role in improving First Nations and Inuit health and to help prevent or delay health deterioration and complications. Community-based home care programs and services can relieve the pressures on provincial and territorial health systems by supporting individuals in their homes and communities rather than having to be admitted to hospital. Given the significance of the Program, it is important to manage the risks accordingly, in order to continue to meet program objectives.

In fiscal year 2014-15, the branch implemented a new approach to the risk management process whereby risk management is integrated in the planning and reporting cycle. This is a top-down approach. As a first step, the Branch Planning Steering Committee reviewed the previous year's risks, associated year-end performance data and other sources of evidence (audits and program evaluations). In January 2014, a revised set of risks was presented to the Senior Management Committee for final validation and approval. Finally, a crosswalk exercise was performed to link the relevant sections of the Department's Report on Plans and Priorities, and the Branch Operational Plan to the revised Branch Risk Registry.

The branch reports that by integrating the risk assessment into the planning, it is better positioned to tie objectives to the management of risk; to help managers to take risk management into account in the operational planning process; and to help link performance monitoring and reporting to risks. The Branch Risk Registry identifies ten branch risks. Of these risks, the audit notes six that are relevant to home and community care. The branch notes that because the risk management strategy is now integrated with FNIHB's operational planning process, the activities and initiatives contained within the operational plans are linked to applicable risks, and therefore serve as risk management responses and actions.

2013 Risks and Challenges:

- Increased demand due to rising rates of chronic diseases and the aging population;
- Existing and emerging service gaps;
- Changes to provincial health systems;
- Integration/partnerships with provincial services;
- Expectations of comparability with provincial services;
- Recruitment/training;
- Health technology to support delivery in remote areas;
- Support for family caregivers;
- Increased emphasis on prevention;
- Care needs met in a culturally relevant manner.

In December 2013, the FNIHCC 10-Year Plan was developed, which details several challenges, as listed in the accompanying text box. The actionable items (short, medium and long term) to address the challenges are outlined in the plan. As the ten-year plan is an evergreen document and will be regularly updated, the Program has an opportunity to monitor the risks identified so that it continues to meets its objectives. The Program notes that it is in the process of developing monitoring tools that can be used to monitor the risks and challenges identified.

3. Internal controls

3.1 Program management

Audit criterion: *FNIHB has operational plans and systems that demonstrate the use of its resources to support program delivery.*

Operational planning

An operational plan or work plan is an important tool for identifying tasks, aligning financial and human resources and setting deadlines. The Program develops an annual work plan for its operations. The 2014-15 headquarters work plan has six activities and 28 sub-activities for nine full-time equivalent employees. Each activity and sub-activity has an expected outcome. As well, each sub-activity aligns with a timeline and is assigned human and financial resources. When relevant, partnerships with other organizations such as AANDC, the Assembly of First Nations and Inuit Tapiriit Kanatami are incorporated within the work plan.

In early 2014, the regions began an integrated operational planning and reporting process whereby each region submitted a master regional work plan for 2014-15 to the Assistant Deputy Minister of Regional Operations for approval and budget release. It is expected that the regions will continue to be directly involved in the operational planning and reporting process in the years ahead.

For the regions to manage the Program, a detailed and program-focused work plan is developed every fiscal year and approved by the respective regional senior management. A review of these regional work plans showed that all regions except the Atlantic region, list their activities along with their outputs or expected outcomes and a completion date for the deliverables. The Atlantic region provided only a list of 13 potential deliverables, without outcomes and timelines. Also, none of the regions specifically assigned human or financial resources to their activity categories. This is understandable since the regional operations generally consist of a small staff of three or four people (see Appendix D). As the work plans are a regional effort, without a common template, each region presented the information differently. An opportunity exists for all regions to use a common template to present the Program information consistently and to report more effectively the expected outcomes and timeframe.

In conclusion, both headquarters and the regions demonstrate the use of resources to support delivery of the Program in the respective work plans.

Program systems

The Program requires high-quality consistent and standardized data collection and assessment to support program delivery and to identify existing and emerging home and community care service needs. In 2002, the Program developed an electronic service delivery database and a human resources database. The applications were developed to assist communities in submitting data related to all essential and support services. The service delivery application captures data on the type and frequency of service provided to the client, as described in the service delivery plan, and outlined in the care plan developed by the home care nurse.

Likewise, the electronic human resources system is a similar application that collects information on community staff professionals. The database allocates one line per professional to track staff per capita on-reserve, by type of provider, such as registered and licensed practical nurses and personal care workers, as well as the number of nurses and personal care workers, the vacancy rate and the number of professionals with full certification. The database is supported by the home and community care application, which was developed to accept monthly uploads.

The Program is able to use service data and human resource data to develop analytical reports presenting trends in home and community care delivery and service utilization rates. While the Program collects and analyzes the data, the audit found that there are inconsistencies in the data submitted. For example, the service delivery database was designed to gather complete data on the home care services provided to clients, as outlined in their care plans, regardless of which level of government (regional, provincial, federal) is funding the service. As well, the database is able to capture services provided by AANDC's Assisted Living In-home Care (such as house cleaning). However, some communities only include Health Canada services. Consequently, data is not comparable across regions or communities. One of the measures reported is the number of hours of nursing service as a percentage of total number of hours of service provided. This percentage fluctuates based on the accuracy and completeness of all the service hours reported. In 2012-13 the reported percentage of nursing hours by region ranged from as low as 5 percent to a high of 50 percent of total hours of service and the national average over a one-year period (2011-12 to 2012-13) increased from 10 percent to 17 percent.

To address this issue, the Program recently updated its user guide and training documents for the database system used by the regions and communities. The changes were to identify mandatory versus non-mandatory fields, in an attempt to achieve greater consistency. These changes were supported by refresher training sessions and the regions are in the process of making this available to all communities. This action should be helpful in achieving consistency in the collection of data to better inform health-related decision-making. However, the Program recognizes that further updates to the databases will be required and that any revisions will need to support the collection of data related to client outcomes, based on the performance measurement strategy.

Through interviews and document review, it was noted that there are concerns regarding the longevity of the server used to collect and store the data. Modifications to the database are proving time consuming and difficult. The Program recognizes this issue and officials are working collaboratively with the Clinical and Client Care Program to explore the development of a Primary Care Information System that could meet the data requirements of both programs.

Recommendation 1

It is recommended that the Assistant Deputy Ministers of the First Nations and Inuit Health Branch develop an interim solution to stabilize the system and develop an options analysis to identify a permanent solution.

Management response

Management agrees with the recommendation.

The First Nations and Inuit Home and Community Care Program's (the Program) e-SDRT and e-HRTT databases are updated regularly as communities and regions upload their program services and human resources data.

Technical issues (for example, data upload issues) are monitored and addressed by information technology staff.

Based on our pilot initiative undertaken in Alberta with First Nations and the Canadian Institutes for Health Information, FNIHB will explore the deployment of an application currently used in provincial health systems prior to considering the development of a new FNIHB-specific solution.

3.2 Capacity building

Audit criterion: *The First Nations and Inuit Home and Community Care Program has guidelines and offers training and support to recipients.*

The Program is primarily delivered at the community level through funding agreements. It supports these community services by providing resources to establish local program management and training to support nurses in providing care to patients with more complex and chronic needs. The Program's logic model identifies capacity building as a mechanism to increase the effectiveness and efficiency of the home care services.

Program support

At the inception of the Program, headquarters developed resource materials to support communities in planning and administering home and community care services. These resources included templates for policies and standards that the communities could customize and implement. More recently, the Program has developed quality improvement resources and a home care staff competencies guide.

The Program is implemented in the communities through a three-phase process, with funding increasing at each phase. In phase one, a needs assessment is produced by the community. The community initiates staffing and training activities, as well as other infrastructure and capacity development. In phase two, the community establishes a structured client needs assessment process and develops a management infrastructure that includes standards, policies, quality assurance and accreditation processes. The existence of a liability insurance policy is then verified by the region; however, it is never re-verified (see Section 3.7). Phase three is the final phase and involves the delivery of the full range of services. Most communities are in full delivery mode. In addition, the Program uses webinars and telehealth facilities to allow for widespread access to courses across most of the communities.

In addition to monitoring program delivery by communities, the regions work with communities

to strengthen the management of existing programs through service delivery plan reviews, formal and informal program reviews and support for staff recruitment activities. However, the regions have varying capacity levels in terms of nurse practice advisory staffing relative to the number of communities they support. For example, the 2013 evaluation developed a case study on regional support for communities. It found a strong correlation between the capacity of the regional office and the extent to which the communities were being supported in strengthening the programs. It was recommended that the Program develop options to strengthen the regional offices that have a lower capacity. As a result, an options document, including costing, has been developed in consultation with the regions.

Training

Offering relevant training supports quality of care to client populations and signals that staff are valued and supported as professionals. The ten-year plan identifies recruitment and training of home care workers as a continuing challenge as it relates to providing basic certification, as well as enhanced professional development training and supports to address the complexity of health issues.

Currently, the Program offers a range of clinical training and skills development courses to nurses, to support the health needs of clients and for managing home care services. Headquarters develops materials for training needs that apply across all regions. Training delivery is primarily a regional responsibility, including the decision on which training is needed; contracting with training suppliers or using Health Canada staff to deliver training; and running competitions for communities to receive contribution funds for training. Regions vary in the extent to which home and community care nurses training is integrated with training for Health Canada nurses at nursing stations. Communities are expected to provide some level of training within the funding provided for home and community care operations.

Funding from the Aboriginal Diabetes Initiative was used to establish a Nurse Training Fund of $5M per year for five years, from 2010 to 2015. The Program reports that between 2010 and 2014, a total of about 2,600 training sessions and events were organized in all regions. As of 2013-14, approximately 90 percent of home care nurses have been trained on clinical practice guidelines for diabetes and have participated in various other training activities (for example, wound care, foot care, etc.). However, the audit was unable to trace the training expenditures. In that regard, training is to be included in the performance measurement strategy and the Program intends to develop additional performance measurement standards for the collection of information on nurses training activities, including public opinion research surveys.

Overall, the Program provides support to develop capacity in the community through guidance, training and ongoing communication. The Program also provides training to the nurses in support of program delivery. Additional performance measures have been drafted in the updated performance measurement strategy which will further support the delivery of the Program.

3.3 Research and surveillance

Audit criterion: *FNIHB conducts research and surveillance to better inform management of the First Nations and Inuit Home and Community Care Program.*

Research

In 2007, FNIHB developed a Framework for Research and Research Related Activities. The branch notes that it participates in both internal and external research and research-related activities. The specific research activities support (either directly or indirectly) strengthening branch capacity to accurately define health risks, trends and emerging issues; support effective design and delivery of health programs and services; and support increased control by First Nations and Inuit. The activities are driven by specific information requirements for program and policy development and are both quantitative and qualitative in design.

One of the key roles outlined in the broad framework for research is to partner in order to influence and to facilitate external research that will have a positive impact on the health of First Nations and Inuit. As such, the Program relies on the Canadian Institutes for Health Research (a federal agency composed of 13 funded institutes) for relevant research activities. In July 2014, a Memorandum of Understanding was drawn up by three parties, namely FNIHB, the Public Health Agency of Canada (the Agency) and the Canadian Institutes for Health Research, to align research and intervention investments with the view to improving the health of Aboriginal Peoples. In particular, the Pathways Initiative aims to enhance understandings of how to implement multilevel and scalable interventions that will contribute to reducing health inequities facing Aboriginal Peoples, to understanding better how to reduce health inequities and how this new knowledge can be adapted and applied to other populations and in other contexts (reverse innovation, reciprocal learning); and to increasing research capacity in the area of implementation science related to the health of Aboriginal Peoples and other vulnerable populations. It will be important for the Program to leverage, where applicable, the results from these research activities to inform its programming.

In the last fiscal year, the research related activities included a literature review to inform the development of the Program's ten-year plan and the Program's annual report, the recent program evaluation and other reports that were developed through program funding agreements and contract funds, such as the regional capacity report and best practices reports.

The FNIHCC 10-year Plan identified research priorities. Recently, the Program developed a draft research plan which aligns to the priorities identified. The draft research plan highlights 16 research activities to address five priority areas over the next 10 years: HR capacity and Support; prevention; service gaps and alignment; impacts on health and innovation. The plan will be shared with regional staff and partners before being finalized.

Surveillance

The Program carries out the ongoing collection of health data through its electronic systems comprising the Service Delivery Reporting Template (eSDRT) and the Electronic Human Resource Tracking Tool (eHRTT). In 2012, the Program used the data to develop a program report that gives an overview and trend analysis of the home and community care data from

2008-09 to 2010-11. The report identified trends and emerging issues, and the evidence-based information was used to support decision-making.

The report also helped inform the development of the Program's ten-year plan. It contains multiple facts and figures on service delivery, with some regional details provided, and significant differences are often highlighted and discussed. Some of the data obtained from the eSDRT and analyzed in the report include the number of hours of service, the number of home visits and the primary reason for receipt of services. From the eHRTT, the key data analyzed was the number of full-time equivalents by category of workers, region, and allocated versus actual. The report was disseminated to the regions and other stakeholders. The regions used the report to inform their own decisions and undertake any necessary actions to mitigate gaps and the identified risks. While this larger surveillance exercise was performed in 2012, the Program plans to eventually produce the trend analysis report annually.

Regions and communities also extract the raw data directly from the systems for their own surveillance and monitoring purposes. Audit interviews noted that the regions use the data to help guide specific regional decisions.

Larger surveillance requirements are coordinated through FNIHB's Surveillance Health Information Policy and Coordination Unit.

3.4 Accreditation

Audit criterion: *FNIHB has a framework to enhance and support the accreditation of community health centres.*

First Nations and Inuit Health Branch has been involved in accreditation since 2004 as one approach to improve the quality, effectiveness and efficiency of health services, to increase First Nations management of health services and to integrate with provincial health services. Accreditation is granted to Community Health Centres through a recognized process that measures evidence-based standards against a health organization's practices to produce higher quality health services in a safer environment. It is also a way to recognize that a health organization has met national quality standards. This is usually done through self-assessments, on-site visits by peer surveyor/reviewers, interviews by the surveyors/reviewers and the careful study of administrative and clinical data and documentation. The process typically culminates in the provision of an accreditation report and notification regarding whether an organization is accredited.

In 2013-14 FNIHB received approval for a renewed investment of $22.62M over five years (2013-14 to 2017-18) for Community Health Centre accreditation. Community Health Centres undergoing accreditation can add more specific service standards for Home and Community Care. However, a Home and Community Care program that is delivered within a Community Health Centre would normally be included along with other programs and services under the accreditation four key assessment areas, namely leadership, governance, infection and prevention, and medication management. The funding agreement was supported with a performance measurement strategy with a specific indicator to increase the accreditation percentage of home and community care services.

Since the inception of the Home and Community Care program, service delivery standards have been in place to ensure program integrity and the safe delivery of services. In 2012, the Program reviewed and revised the service delivery standards. A workbook process was developed to assist communities in revising their standards. A quality resource kit with tools and resources was developed to build capacity, support communication and education activities and spread and sustain quality initiatives in regions and communities. The quality resource kit with tools and resources is designed to be a practical, relevant and useful resource for all community-based health care workers in small, medium or large communities. To further support and enhance service delivery, a Home and Community Care quality framework and a quality and safety tool were developed; the communities can use them to assess their preparedness in undertaking an accreditation process. In addition, each region identifies a quality champion who works with its respective partners to support roll-out and implementation activities. Each region is expected to develop short-, medium- and long-term goals and processes for the roll-out and implementation of the quality tools and resources that were developed. Face–to-face meetings were held to introduce new quality methods and processes and to continue to raise the bar on quality improvement for all communities. The Program reports that this work is a foundational piece for those communities considering accreditation. Recently the Program updated its performance measurement strategy to begin measuring the use of the quality improvement processes to respond to home and community care assessed needs. This measurement will provide the Program with a better indicator of those communities best positioned for accreditation.

3.5 Privacy

Audit criterion: *FNIHB has controls to ensure compliance with Government of Canada expectations for the protection of personal information.*

Under the terms of the funding agreements for home and community care, communities are required to collect and upload detailed service delivery information and human resources information. In some regions, the service delivery reporting may be done directly by Health Canada staff. Communities are also required to submit information about their staff using the eHRTT, which captures professional information such as staff education. Both databases are housed within Health Canada.

The personal information submitted through the eSDRT includes a client identifier, the birthdate or year of birth and the reason for service referral to the Program (diagnosis). The client identifier is intended to depersonalize the data but the combination of community, age, gender and medical condition could potentially identify the individual. While the reporting features of the eSDRT and eHRTT databases should only generate summary data rather than individual data, regional staff members note that they periodically receive raw data from communities to assist them with correcting errors or uploading data. Regional staff are aware that health information is sensitive but do not consider that personal information is collected because the individual's name is not included. However, according to the Access to Information and Privacy Division, such information should be considered confidential. Furthermore, it is worth noting that the data is collected and stored in a Health Canada database. The fact that personal information is collected, that in certain circumstances it is collected or viewed by Health Canada

staff, points to the need for a careful examination by the Program to confirm compliance with Government of Canada expectations for the protection of personal information.

Privacy impact assessment

Privacy impact assessments (PIA) are used to identify the potential privacy risks of new or redesigned federal government programs or services. Under the Treasury Board of Canada Secretariat's *Directive on Privacy Impact Assessment* (effective April 1, 2010), institutions must conduct a PIA in certain circumstances, and if a PIA is not required, the institution's Privacy Protocol must be followed.

To date, neither a privacy impact assessment nor a privacy review has been conducted. The Program has not confirmed its authority to collect the information or documented the justification for collecting the level of detail it currently holds. A privacy assessment and/or review will describe and document what personal information is collected, how it is collected, used, transmitted and stored, how it can be shared and how best to protect it from inappropriate disclosure.

Personal information banks

Personal information banks (PIB) are descriptions of personal information that are maintained by government institutions about individuals, in support of specific programs and activities. The *Privacy Act* requires that PIBs be documented for all personal information that is organized or intended to be retrieved by a person's name or by an identifying number, symbol or other particular identifier assigned only to that person. PIBs must also be documented for personal information that has been or is being used, or is available for use for an administrative purpose.

In July 2014, the Program informed the auditors that work had started to document PIBs for the information collected through the eSDRT and the eHRTT systems. The PIB being created may include name, contact information, biographical information, biometric information, date and place of birth and death, physical attributes, referrals to social and other services, supportive services information, medical and mental health information and identification numbers (for example, provincial health number, band number, etc.).

Recipient obligations

The audit conducted an analysis of the funding agreements (Section 3.6) and noted that they all contain the required confidentiality clause specifying that "the Parties shall comply with applicable laws pertaining to privacy and confidentiality in dealing with information and records related to the project." The majority of the personal information is collected by the communities, which are governed by provincial privacy legislation. Given that it is the responsibility of the Department to monitor the recipients' compliance with the terms and conditions of the agreements, including compliance to privacy requirements, it would be important to include the transfer payment mechanisms in a privacy review of the Program.

In conclusion, the Program is aware of the privacy matters but needs to work with the Access to Information and Privacy Division of the Corporate Services Branch to ensure that sufficient controls are in place to protect the personal information it collects and creates.

Recommendation 2

It is recommended that the Assistant Deputy Ministers, First Nations and Inuit Health Branch, work with the Access to Information and Privacy Division to ensure that controls over the protection of personal information are appropriate.

Management response

Management agrees with the recommendation.

The First Nations and Inuit Home and Community Care Program is committed to protecting the privacy of its clients. It has been working with the Access to Information and Privacy (ATIP) Division to create a personal information bank. Given the kind of information currently collected and the fact that no complaints have been received regarding the system, the Program will conduct a privacy review in collaboration with the ATIP Division.

3.6 Funding agreement process

Audit criterion: *Funding agreements comply with the Treasury Board* Policy on Transfer Payments.

Typically, FNIHB contributions combine all programs and services delivered by a community under the consolidated funding agreement. The *Directive on Transfer Payments* refers to three funding models for Aboriginal recipients: Set, Flexible and Block. The Set model allows for the least flexibility in transferring funding between health programs, while the Block model allows for the most flexibility.

The Regional Support and Coordination, Health Funding Arrangements and Infrastructure Division at headquarters has developed templates for Set, Flexible and Block agreements, which align with the Treasury Board *Policy on Transfer Payments*, and the supporting Directive. FNIHB staff uses the Grants and Contributions Standard Operating Procedures Manual (2011), which was developed as a collaborative effort between the Public Health Agency of Canada (PHAC), Health Canada's Centre of Expertise on Grants and Contributions, and the Health Canada branches that have a direct interest in the management and administration of transfer payments. It establishes a standard approach to managing and administering transfer payment programs in the Department and, wherever possible, across the Health Portfolio. The manual outlines the roles and responsibilities of departmental managers and program staff with responsibilities for managing funding agreements and provides administrative guidance that addresses the Department's control and accountability requirements and the government-wide initiative to reduce the administrative burden on recipients.

Each region or zone has a 'funding arrangement unit' that is responsible for preparing the funding agreement. There are several steps involved. First, the region assesses the level of autonomy or capacity readiness of the recipient for managing program activities. This helps determine the selection of the appropriate funding model (Set, Flexible or Block). Based on the selected funding model, the recipient prepares its Multi-Year Work (Flexible) or Health Plan (Block) which is reviewed and approved or rejected by Health Canada's FNIHB. A Program

Plan is provided for Set recipients. Once the Work or Health Plans and budgets are approved, following the steps in the Health Canada's Grants and Contributions Standard Operating Procedures Manual, staff prepares the agreement using the branch's templates.

Capacity assessment

The financial and program management assessments must be performed across all programs for communities that wish to move from the Set to the Flexible or Block funding model. The capacity assessment considers a recipient's past performance, as well as financial and program management capacities.

Based on the funding model selected, the recipient must complete either a Multi-Year Work Plan or a Health Plan for Health Canada's review and approval. The plan is reviewed by a multi-disciplinary team within the region and recommendations are made to the regional director. Audit tests on the sampled agreements confirmed that a plan existed in each case and was approved by Health Canada.

Agreement

The *Directive on Transfer Payments* identifies 23 elements that should be addressed in funding agreements. The terms and conditions also contain supplementary elements such as the dispute resolution and intellectual property clauses. The audit found that the funding agreement templates were compliant with the *Directive on Transfer Payments* and with the terms and conditions. The audit tested a sample of 28 agreements to determine that all agreements followed the template and the 2008 *Directive on Transfer Payments*.

Overall, the process of preparation of the funding agreements follows the Treasury Board *Policy on Transfer Payments* and the *Directive on Transfer Payments*.

3.7 Recipient monitoring

Audit criterion: *Risk-based recipient monitoring activities are conducted, including the review of recipient reporting and the receipt of deliverables, before the release of payments and recipient audits.*

The Treasury Board's *Policy on Transfer Payments* emphasizes the need for effective risk management in the administration of grants and contributions programs. To ensure that the recipients use funds properly and deliver the programs as intended, FNIHB uses monitoring controls, in particular recipient risk assessments, the Risk Management Appraisal Tool, the monitoring of liability coverage and recipient audits.

Recipient risk assessment

In 2012, Health Canada began harmonizing its management of transfer payments with AANDC. In 2014-15, FNIHB and AANDC conducted joint recipient risk assessments using the General Assessment tool and have been performing joint recipient audits whenever feasible. In 2015-16, FNIHB and the rest of Health Canada will adopt AANDC's Grants and Contribution Information Management System.

The General Assessment is an AANDC tool that replaces Health Canada's risk assessment tool (Enterprise Risk Management - Agreement/Recipient Risk Assessment Tool). Generally,

program managers prefer the new process to the previous one but voiced some concerns. Primarily, the overall General Assessment rating of a recipient is heavily weighted towards AANDC programs since AANDC's funding level is superior. The weighting may result in an overall General Assessment score that agrees with AANDC's rating but not with Health Canada's. Every region noted at least one recipient whose General Assessment score was the opposite of FNIHB's assessment. In such rare cases, FNIHB may choose to manage an agreement according to its own rating.

General Assessments were documented for all sampled agreements. Of the 20 sampled agreements in Quebec or Manitoba, some level of variation was noted among the ratings for risk criteria for each community and none was rated as risk-free. However, it was noted that, in the Ontario Region, nine out of the 10 agreements sampled were rated risk-free or very low risk, which raises concern that the various risk criteria were not considered in-depth.

Risk Management Appraisal Tool

The Risk Management Appraisal Tool (RMAT) is the Program's quality assurance instrument designed for the use of the regional offices and the communities. Its purpose is to assist communities to evaluate the quality and safety of care and services, and to create opportunities to improve program delivery. Also, the tool supports regional staff in assessing and monitoring program delivery and in offering assistance to communities as appropriate. By using the RMAT, communities are also able to determine their readiness to move into an alternative funding arrangement. This alternative funding arrangement allows a First Nations or Inuit community to manage and deliver home and community care and services with more flexibility.

The RMAT is organized around the nine essential service elements of the Program. These elements are: client assessment; case management; home care nursing services; home support services; personal care and home management; in-home respite care; access to medical supplies and equipment; information and data collection; management and supervision; and linkage with other services. The key objectives for this tool are to help communities move toward a more flexible funding arrangement (that is, Block). However, since the Program's funding model for most communities is 'Set', its use is sporadic. In the three regions visited, the RMAT was used by only four communities. There is an opportunity for the Program to use the RMAT for all its communities to assess the management and delivery of their programs.

Monitoring of liability coverage

Liability coverage offers protection against claims that the policyholder may be legally obligated to pay as a result of an error or omission in work. When setting up a home and community care program with a recipient for the first time, the recipient must provide proof of liability coverage for its health staff to the Program regional manager. For a program in a "block funding" arrangement, the RMAT requires that evidence of liability coverage be provided every five years. If the entire community agreement is in Block funding, the community must prepare a Health Plan. One of the requirements of the Health Plan is to include liability insurance with professional liability coverage. However, for those recipients not in a block arrangement there is no verification of the liability and it was noted that some of the initial agreements may date back as far as 15 years.

While the Ontario agreement authorities verify the existence of coverage for Block agreements only, Manitoba verifies for both Flexible and Block. The FNIHB Contribution Funding Framework User Manual states that such liability coverage should be funded by FNIHB, where required. However, in none of the regions visited will the program or the agreement authorities validate liability coverage for Set agreements.

Recipient audits

The *Policy on Transfer Payments* and the *Directive on Transfer Payments* outline broad elements for managing grants and contributions, including recipient auditing. At the departmental level, recipient auditing is one component of Health Canada's Transfer Payment Management Control Framework, to ensure due diligence in the establishment and administration of funding agreements. A recipient audit is an independent assessment provided by an independent auditor to give an assurance that a recipient's activities and use of public funds are in compliance with the terms and conditions of the funding agreement. Each region submits names of recipients, based on risk assessments, to the Health Funding Arrangements Division and Infrastructure, which reviews the list to make sure that the highest rated recipients are audited and coordinates the recipient audit process. In the past year, 31 audits were performed.

In 2011, the FNIHB Audit Guide was created, which was vetted for FNIHB by a private auditing firm to ensure it is compliant with Canadian Auditing Standards (CAS) and the Chartered Professional Accountant profession. This guide is provided to the audit firms selected to perform the recipient audits on behalf of FNIHB.

FNIHB supports the single recipient audit (joint audit) approach whereby an auditor representing one or more federal government funders conducts a single audit of a common recipient. For FNIHB, this other organization is AANDC. A joint contract is set up with the independent auditor for a joint audit, but with separate reports. In the past year, five of the 31 recipient audits were 'joint' with AANDC.

Other monitoring controls were reviewed during this audit. They include the presence of accountability documents such as financial statements, the withholding practices, the review of eligible expenses and payment support according to the *Financial Administration Act*. No significant findings were noted.

Overall, FNIHB has instruments to monitor transfer payments, however the Program would benefit from additional processes to ensure that all Program recipients have sufficient professional liability coverage.

Recommendation 3

It is recommended that the Assistant Deputy Ministers, First Nations and Inuit Health Branch, ensure consistency in the verification of liability coverage for all recipients.

Management response

Management agrees with the recommendation.

The First Nations and Inuit Home and Community Care Program will work with home and community care regional coordinators to update the Risk Management Appraisal Tool (RMAT). This update will include liability coverage verification.

The First Nations and Inuit Home and Community Care Program will work with regional staff to establish a plan, including timelines, for verification of liability coverage using the Risk Management Appraisal Tool.

Liability will be verified in accordance with this plan.

C - Conclusion

Health Canada 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 First Nations and Inuit Home and Community Care Program (the Program) is a mandatory program and is one of many health services delivered by the First Nations and Inuit Health Branch (FNIHB).

The Program's services are delivered primarily by communities or territorial governments that employ home care registered nurses, licensed practical nurses and trained and certified personal care workers. The Program is managed by the Interprofessional Advisory and Program Support Directorate but is decentralized; program delivery is overseen by Health Canada's regional offices.

The Program is well managed. The current governance framework for the Program provides for strategic direction and oversight. Roles and responsibilities are clear and balanced between headquarters and the regions. The Program has a recently updated performance management strategy and operational plans to manage its resources, has policies and guidelines and offers training and support to recipients in the delivery of the Program. There are processes in place for the evaluation of recipient capacity, risk assessment and payment releases. However, this audit makes three recommendations to further aid in strengthening the internal controls related to system upgrades, privacy and liability coverage.

Appendix A – Lines of enquiry and criteria

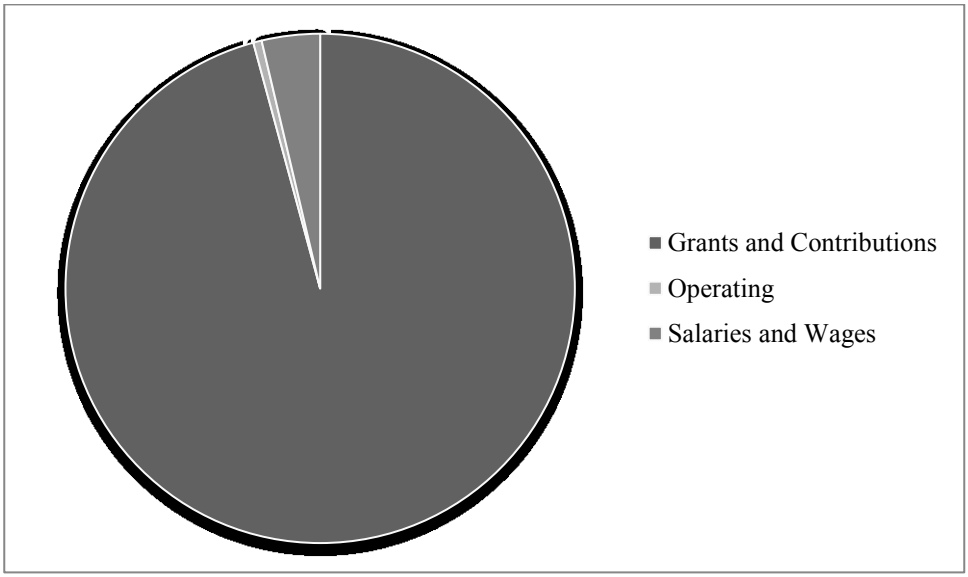
Lines of enquiry and criteria for the Audit of the First Nations and Inuit Home and Community Care Program		
Criteria Title		**Audit Criteria**
Line of Enquiry 1: Governance		
1.1	Strategic direction[2]	The First Nations and Inuit Health Branch plans for the strategic direction of the Home and Community Care Program.
1.2	Roles and responsibilities	Roles and responsibilities for the delivery of the First Nations and Inuit Home and Community Care Program are documented, clear and are well-communicated.
1.3	Performance management [5]	There is a performance measurement strategy for the First Nations and Inuit Home and Community Care Program.
Line of Enquiry 2: Risk management		
2.1	Risk management [5]	External and internal risks associated with the First Nations and Inuit Home and Community Care Program are identified, assessed and managed.
Line of Enquiry 3: Internal controls		
3.1	Program management [5]	FNIHB has operational plans and systems that demonstrate the use of its resources to support program delivery.
3.2	Capacity building	The First Nations and Inuit Home and Community Care Program has guidelines and offers training and support to recipients.
3.3	Research and surveillance [3]	FNIHB conducts research and surveillance to better inform the management of the First Nations and Inuit Home and Community Care Program.
3.4	Accreditation	FNIHB has a framework to enhance and support the accreditation of community health centres.
3.5	Privacy [4]	FNIHB has controls to ensure compliance with Government of Canada expectations for the protection of personal information.
3.6	Funding agreement process [5]	Funding agreements comply with the Treasury Board *Policy on Transfer Payments.*
3.7	Recipient monitoring	Risk-based recipient monitoring activities are conducted, including the review of recipient reporting and the receipt of deliverables, before the release of payments and recipient audits.

[2] Office of the Comptroller General – Core Controls
[3] Home and community Care logic model
[4] *Privacy Act*, *Policy on Privacy Protection*
[5] Treasury Board *Policy on Transfer Payments*

Appendix B – Scorecard

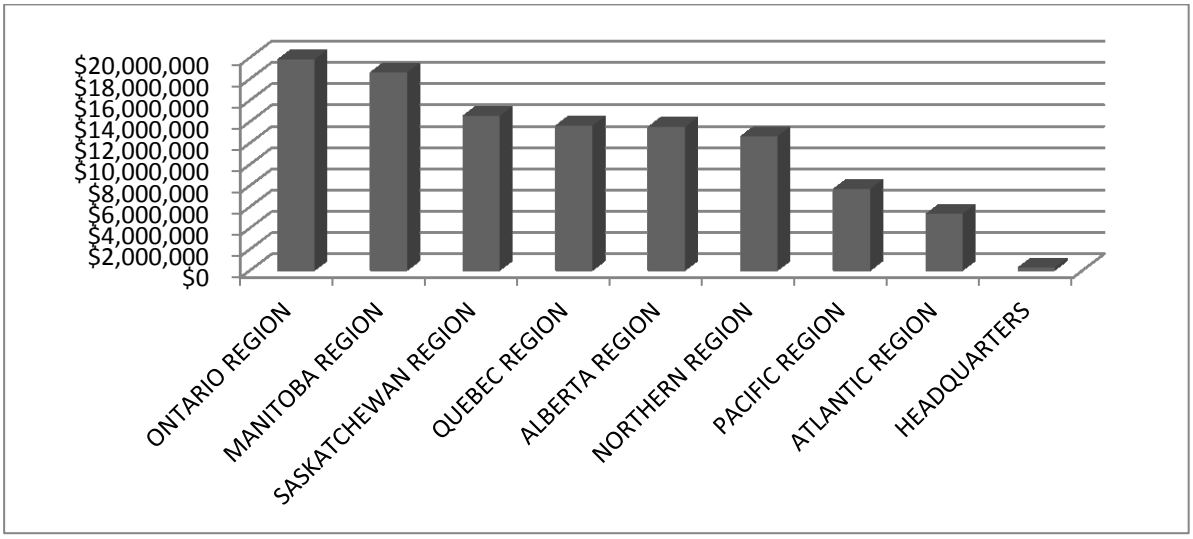
Scorecard - Audit of the First Nations and Inuit Home and Community Care Program			
Criterion	**Rating**	**Conclusion**	**Rec #**
Governance			
1.1 Strategic direction	**Needs minor improvement**	Program has a ten-year strategic plan and working group. However, the terms of reference should be updated.	
1.2 Roles and responsibilities	**Needs minor improvement**	Roles and responsibilities for the delivery are documented, clear and well communicated. The implementation plan should be updated to reflect newer responsibilities.	
1.3 Performance management	**Satisfactory**	The logic model and performance measurement strategy are aligned.	
Risk Management			
2.1 Risk management	**Satisfactory**	External and internal risks are identified and assessed at the branch level and the strategic plan identifies risk and challenges.	
Internal Controls			
3.1 Program management	**Satisfactory**	Both headquarters and the regions demonstrate the use of resources to support program delivery in respective work plans.	
	Needs moderate improvement	The Program will need to develop an interim solution for the sustainability of the electronic system and an options analysis aimed at finding a permanent solution.	1
3.2 Capacity building	**Needs minor improvement**	The Program has policies and guidelines and offers training and support to recipients in the delivery of the Home and Community Care Program. New indicators should track data on how Aboriginal Diabetes Initiative training funds are used.	
3.3 Research and surveillance	**Needs minor improvement**	A draft research and surveillance plan has been developed which aligns with the 10-year strategic plan. The plan is to be vetted with the regions prior to seeking approval.	
3.4 Accreditation	**Needs minor improvement**	The Program has a quality initiative program designed to support communities in developing standards towards supporting accreditation.	
3.5 Privacy	**Needs moderate improvement**	The Program will need to work with the functional privacy team to identify privacy requirements.	2
3.6 Funding agreement process	**Satisfactory**	The funding agreements are compliant with the *Policy on Transfer Payments.*	
3.7 Recipient monitoring	**Needs moderate improvement**	The Program needs to enhance processes to re-verify that recipients have maintained liability coverage.	3

Appendix C – Home and community care, by expenditure category



Expenditure category	FY2013-14
Grants and Contributions	$106,189,665
Operating	$591,091
Salaries and Wages	$4,097,320
Total HCC Expenditures	$110,878,076
G&C as a % of total	95.77%
Operating as a % of total	0.53%
Salaries as a % of total	3.70%

Appendix D – Grants and Contributions expenditure, by region



First Nations and Inuit Home and Community Care, by region					
FIRST NATIONS AND INUIT HEALTH BRANCH	**FTEs**	**Population 000's[6]**	**Communities**	**2013-14**	**Year-to-Year Change***
Ontario Region	3	92.6	111	$19,837,192	**1.39%**
Manitoba Region	4	90.2	62	$18,624,505	**1.31%**
Saskatchewan Region	4.2	71.1	83	$14,558,018	**4.02%**
Quebec Region	5	56.1	51	$13,635,632	**2.60%**
Alberta Region	8.5+13**	72.5	56	$13,527,717	**1.60%**
Northern Region	.2	54.7	74	$12,654,632	**-1.84%**
Pacific Region	6[7]	64.2	197	$7,700,334	**-51.98%**
Atlantic region	2.5	23.3	40	$5,365,434	**2.11%**
Headquarters	9	n/a	n/a	$286,201	**65.79%**
Grants and Contributions				$106,189,665	**-5.98%**
Grand Total (with Operating and Salaries)				$110,878,076	**-6.74%**
G&C as a percentage of grand total				95.62%	

*Source: SAP data; increase/decrease over fiscal year 2012-13.
** The number 13 represents the number of nurses delivering direct HCC services.

6 The eligible population comprises First Nations and Inuit of any age who reside on a First Nations reserve south of 60°, an Inuit settlement north or south of 60° or a First Nations community north of 60°. For the purposes of this table, the population has been estimated using NIHB and Program statistics.
7 Activities transferred to the First Nations Health Authority, under the British Columbia Tripartite Agreement.