

First Nations and Inuit Home and Community Care (FNIHCC) 10-Year Plan (2013–2023)



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EXECUTIVE SUMMARY

The First Nations and Inuit Home and Community Care (FNIHCC) Program's 10-year Plan was developed in collaboration with First Nation and Inuit partners, and Health Canada FNIHB both at the national and regional levels following the program's 10th anniversary. The plan identifies the priorities for home care over the next decade and is intended to be used as a resource guide for planning future home and community care workplan activities.

The plan will be updated yearly or as needed to ensure the goals and objectives, as presently identified, reflect the ongoing priorities of First Nations and Inuit. The activities throughout the 10-year time period will be undertaken according to the immediate health and social needs of home care clients and in accordance with acceptable home care practice and standards. Ultimately, the purpose of this plan is to provide a path forward towards collaboratively meeting the home care needs of First Nations and Inuit.

The vision for the FNIHCC Program is:

“a continuum of home and community care services that are comprehensive, culturally safe, accessible, effective, and equitable to that of other Canadians and which respond to the unique health and social needs of First Nations and Inuit”.

Consistent with this vision, the program has committed to five goals which are intended to be achieved in accordance with the priorities of communities, regions, and the national office over the next 10 years:

- A Home and Community Care Program that is based on a holistic wellness approach within a circle of care, offering high quality services and culturally safe care to clients through all phases of life.
- New and innovative partnerships (both formal and informal) and planning that aligns with and enhances existing programs and services to improve health outcomes for Home and Community Care clients.
- Promote sustainable and appropriate work environments in which Home and Community Care staff continue to be informed, competent, engaged and supported.
- A sustainable program that is supportive of the client, family and community, and is adaptable to changing needs and emerging trends, and is responsive to the Home Care needs of First Nation and Inuit clients.
- A program that is dedicated to quality improvement, based on high quality, consistent and standardized data collection and assessments.

The success of this plan is dependent upon stable funding, cooperative partnerships with provinces and territories and other federal departments, linkages with other First Nations and Inuit Health Branch (FNIHB) programs, regional health authorities, and the continued engagement of both Health Canada—FNIHB and First Nations and Inuit partners. Overall, this strategic plan forward reflects the collaborative home care vision for First Nations and Inuit as expressed by First Nation and Inuit partners, and Health Canada-FNIHB (national and regional level) throughout the development process.

INTRODUCTION

Health Canada-FNIHB national and regional home care staff, in partnership with First Nation and Inuit , health representatives of the Assembly of First Nations (AFN) and Inuit Tapiriit Kanatami (ITK), including regional representatives, collaboratively developed a 10-year strategic plan for the First Nations and Inuit Home and Community Care (FNIHCC) Program. This plan provides a 10-year roadmap for activities, supports and services, policy direction and program development.

The plan was developed with consulting assistance from Johnston Research Inc. Background research on the current operating context of home and community care, including a statistical overview of First Nations and Inuit home care health issues, and a scan of best practices in home care in Canada and internationally provided the foundation for stakeholder discussions. The profile of homecare and health trends in Canada, provided by the Canadian Home Care Association (CHCA), set the context for discussions. The following documents were developed by the consultant and the two national Aboriginal organizations to guide the development of this plan:

- Literature review
- Analytical report
- Meeting summary reports (2)
- Strategy development report
- AFN's FNIHCC Committee report
- ITK Strategy Report

The purpose of this plan is to assist program officials and home and community care professionals anticipate and respond to emerging health and demographic trends, complex and changing health needs, and other challenges in order to be responsive to the home care needs of First Nation and Inuit clients. The goals of this plan reflect the priorities of First Nations and Inuit and take into consideration the trends and projections of home care in Canada as part of the health care continuum. Each goal is client-focused—intended to support health providers in the provision of exemplary care that supports individuals, families and communities as they navigate through the experience of illness and loss; and rehabilitation to improve and maintain their health and wellness.

Within FNIHB, the FNIHCC Program plays an important role in supporting and protecting the health of First Nations and Inuit. FNIHCC is one of four mandatory programs in FNIHB. Operating within FNIHB's authorities, the goals of the FNIHCC Plan consistently align with the First Nations and Inuit Health Strategic Plan priorities—1) *Quality health services*; 2) *Collaborative planning and relationships*; 3) *Effective and efficient performance*; and 4) *Supportive environments in which employees excel*—and, as such, contribute to the overall FNIHB vision of healthy First Nations and Inuit individuals, families, and communities.

The activities identified in this plan take into consideration the findings and recommendations from the program's most recent evaluation: *Evaluation of the First Nations and Inuit Home and Community Care Program 2008–2009 to 2011–2012*. The CHCA's Harmonized Principles—client and family-centered care; accessible care; accountable care; evidence-based care; integrated care; sustainable care—are embedded in this plan's goals and actions, enabling FNIHCC to be more effective, integrated and comprehensive in providing home care services to First Nations and Inuit. Alignment with these principles of Home Care also enables the FNIHCC Program to align better with provincial and territorial home care programs.

PROGRAM DESCRIPTION

Background

Home care is not an insured service under the Canada Health Act. However, given the integral role home care plays within the health care system, all provinces and territories provide various levels of home care services, and generally do not provide services to First Nations and Inuit communities, noting that, in their view, this is a federal responsibility. To fill this gap, in 1999, Health Canada launched the First Nations and Inuit Home and Community Care Program to provide home and community care services to First Nations and Inuit. Home and community care services are provided to First Nations and Inuit as a matter of policy, not legislation.

The specific FNIHCC Program objectives are:

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

The FNIHCC Program is also guided by six principles that outline how the program is to be delivered. FNIHCC services will be:

- Respect both traditional and contemporary approaches to healing and wellness.
- Respect community priorities.
- Be available to those with assessed need.
- Deliver evidenced-informed, integrated quality care.
- Support the individual, family, and community.
- Strive to achieve sustainable funding and provide continuous care.

Home and community care is delivered primarily by provincially or industry registered home care nurses and trained and certified personal care workers. Service delivery is based on assessed need and follows a case management process. The program is delivered in 686 First Nations and Inuit communities. From 2008–2009 to 2012–2013, the number of First Nations and Inuit clients served through the program increased from 31,485 to 35,081. Over this period, an average of 900,693 home visits and 2.5 million hours of care were provided per fiscal year.

Eligibility

The FNIHCC program is available to all First Nations and Inuit of any age with disabilities, chronic or acute illnesses and the elderly

- who live in an Inuit community, First Nation reserve or community North of 60;
- has undergone a professional assessment of their continuing care service needs and has been assessed as requiring one or more of the essential services; and
- who has access to services which can be provided with reasonable safety to the client and caregiver, within established standards, policies and regulations for service practice.

Service Elements

FNIHCC supports the delivery of basic home care services which are typically offered between 9 a.m. and 5 p.m. Monday to Friday. These essential services include: a structured client assessment process; case management; home care nursing services; home support and personal care; in-home respite; established linkages with other professional and social services; access to specialized medical equipment, supplies and specialized pharmaceuticals; a system of record keeping and data collection; and program management and supervision.

The program also has the authority for supportive services, such as home-based palliative care, rehabilitation and other therapies, and adult day programs, which communities may offer, providing the essential program elements are in place and they are provided according to the community's priorities, existing infrastructure and availability of resources. The FNIHCC program is not funded for supportive service elements.

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. While 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.

Health Canada is responsible for funding arrangements and support for program implementation by communities. 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. In Inuit Nunangat (Inuit homeland), which includes all four Inuit regions: Inuvialuit Settlement Region, Nunavut, Nunavik, and Nunatsiavut, Health Canada's 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. With the exception of Nunatsiavut self-governing agreements in Labrador and funding provided by Quebec Region to Nunavik. 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.

The Yukon Government has their own Home Care Program which is accessible to all Yukon residents. The three Indian Bands without self-government agreements receive FNIHCC funds to fund basic home making services, shopping, cleaning, and chopping wood. No hands-on treatment services are provided as those functions are provided by the Yukon Government.

Since its origins, the FNIHCC Program has 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.

PLAN FORWARD

Since 1999, the FNIHCC Program has played 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. Home care also allows the early release from hospital, reducing the number of days in hospital, which can be costly and difficult for clients and their families.

While the program plays a vital role, it faces several challenges in the upcoming decade. These include:

- Increased demands for services as a result of rising rates of chronic diseases and an aging population.
- Gaps in services such as: second and third level support (e.g. nursing consultation); rehabilitation; and palliative care.
- Pressures from provincial/territorial health systems (early hospital discharge and alternative levels of care) to provide higher intensity complex care.
- Integration/partnerships with provincial services
- Expectations that the full continuum of care be available in communities.
- Existing and emerging service gaps that require attention if the program to provide is to provide service comparable to that provided to other Canadians, including: palliative care, after-hours care, service for the mental health needs of home care clients; complex care needs; a more strategic approach to chronic disease management; and the expansion of service to underserved areas.
- Recruitment, training and ongoing support of home care workers, who have expressed a desire for basic certification as well as enhanced professional development training and supports to address the complexity of health issues.
- Broader implementation of new and effective health technologies (e-Health) that would enable remote access to specialist patient care, allow greater program efficiency, and increase accessibility of home care services to clients in remote communities.
- Family caregiver burden.

- Increased emphasis on prevention (while recognizing that Home Care nurses cannot be expected to take on additional duties), in collaboration with other relevant programs and services. There is evidence that this constitutes promising practice, for example, in Denmark, mandatory preventative visits to the elderly over a number of years have significantly reduced hospital visits and admissions to long-term care facilities in its population.
- Pursuit of service alignments and integrated services for homecare clients that would see them aging in place and having a range of care needs met in a culturally relevant manner.

Population demographics, health status projections, and health determinants statistics indicate that there will be an increasing demand for home and community care services in the future. The current context indicates that strategic goals and actions which focus on partnerships and integration to increase efficiencies and maximize resources, innovations, and an understanding of lessons learned in other jurisdictions is critical if the program is to be sustainable and effective throughout the next decade.

Therefore, the goals of this plan will be advanced by building and maintaining effective relationships with First Nations and Inuit partners, Health Canada-FNIHB programs providing services to First Nations and Inuit communities, other relevant federal departments, such as Aboriginal Affairs and Northern Development Canada, provinces and territories, and various health organizations, such as the Canadian Home Care Association and the Canadian Hospice Palliative Care Association.

It is anticipated that this plan will enable the program to adequately respond to future challenges in a strategic and integrated fashion over the next ten years. The implementation of the activities identified to achieve the goals is expected to result in:

- Improved access to home and community care services.
- Increased capacity of the home and community care workforce.
- Increased collaboration with internal and external providers.
- Increased First Nations and Inuit awareness of home and community care services.
- Greater use of policies, standards, guidelines and best practices in service delivery.
- Increased use of evidence-based information to inform quality program delivery.

The plan sets out a path forward that enables program staff to build on their accomplishments over the past ten years while recognizing that everything cannot be done at once or in the same way in all places. As such, each jurisdiction (national, regional, community) will carry out their activities according to available resources, existing capacity, and in consideration of community/ AFN/ ITK/ Government of Canada priorities.



GOAL #1:

A Home and Community Care program that includes a Holistic Wellness approach within a circle of care, offering high quality services and culturally safe care to clients through all phases of life.

Aligns with FNIHB Strategic Plan Goal #1
Quality Health Services

Objectives for the Next 10 Years:

1. To collaboratively work to reach alignment between the model of care and the vision of First Nations and Inuit partners for high quality, culturally safe, holistic and family-focused care.
2. To ensure all home care professionals are clinically competent and provide culturally safe care to First Nations.
3. To recognize and support family caregivers as an important aspect of client care.
4. To promote and support a wellness and prevention focus that respects community-driven priorities.
5. To increasingly incorporate a primary care focus that respects the journey of illness and loss through healing.



Strategic Actions

SHORT TERM (Years 1–3)

- Collaboratively develop policies on an expanded model of wellness that includes the role of traditional healing, balance and wellness, and that honors the diversity and self-determination of First Nations and Inuit.
- Collaborate with relevant partners to promote the inclusion of standardized curriculum and training for First Nations and Inuit home care para professionals.
- Provide opportunities for training on cultural safety and sensitivity for non-Aboriginal staff.
- Carry out an environmental scan of tools and resources available for family caregivers.
- Explore family caregiver needs and current best practices (such as the Peer Support model used in B.C.).
- Carry out an environmental scan of the Home Care programs that are currently employing the model of preventative visits to the at-risk population over the age of 60.
- Collaborate with communities who utilize a model of preventative visits to prepare stories of best practices, trust building, prevention of hospitalization, and stories of increased quality of life through story-telling and other methods.

MEDIUM TERM (Years 4–7)

- Collaborate with relevant partners (e.g. Industry Associations; OGDs; First Nations and Inuit associations) to promote the inclusion of cultural competency education into nursing and personal care provider education curricula.
- Support communities to enhance skills of family caregivers.
- Use evidence from the preventive visits research to develop a pilot implementation model, including training of preventive visitors.
- Encourage and support service alignments that integrate home care with existing and emerging prevention activities for vulnerable and at-risk community members.
- As part of a horizontal initiative with OGDs (e.g. Public Health Agency of Canada (PHAC), AANDC, other FNIHB programs), implement a pilot study of the preventive visit approach in a small number of both First Nations and Inuit communities, using the pilot implementation model.
- Encourage and support the adoption, where feasible, of innovative healthcare technologies that can enhance the quality of care.

LONG TERM (Ongoing, and Years 7–10)

- Support and encourage alignment of services to maximize family caregiver support resources to reduce burden on family caregivers.
-



GOAL # 2:

New and innovative partnerships (both formal and informal) and planning that aligns with and enhances existing programs and services to improve health outcomes for Home and Community Care clients.

Aligns with FNIHB Strategic Plan Goal #2 Collaborative Planning and Relationships

Objectives for the Next 10 Years:

1. To establish and secure collaborative linkages and relationships with relevant external and internal stakeholders at all levels.
2. To increase accessibility of home care services through the use of supportive new health technologies and clearly defined partnerships.



Strategic Actions

SHORT TERM (Years 1–3)

- Maintain membership with non-government organizations (NGOs), such as the Canadian Home Care Association, and linkages with other health organizations.
- Conduct an environmental scan on best practices in cultural models of palliative and end of life care tools and resources to support linkages and partnerships.
- Create and maintain linkages with research initiatives such as those at Lakehead University, Northern Ontario School of Medicine, Western, and other research institutes.
- Increase access to palliative care and rehabilitation services through use of technologies and partnerships with provincial and territorial services.
- Review principles for the use of effective and appropriate health technologies to improve health, such as tele-health modalities, video-conferencing and diagnostics, using a cultural lens and availability of provincial services.
- Work to standardize professional assessments for community members and create linkages with provincial systems.
- Work with regional managers and First Nations and Inuit partners to develop a strategy to strengthen linkages with stakeholders at the national, regional and community levels.

MEDIUM TERM (Years 4–7)

- Collaboratively develop a framework for second level supports (such as nurse advisors, specialized therapies), including residual role clarifications for home care professionals.
- Ensure the collection of case management performance measurement data to support health and service delivery and improve client health outcomes.
- Implement a framework for aligning second level supports with service provision.

LONG TERM (Ongoing, and Years 7–10)

- Continue existing partnerships and discussions at the national, regional, and community levels.
 - Pursue new opportunities for effective partnerships with other key stakeholders at the national, regional and local levels.
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GOAL #3:

Promote sustainable and appropriate work environments in which Home and Community Care professionals and para professionals continue to be informed, competent, engaged and supported.

Aligns with FNIHB Strategic Plan Goal #4 Supportive Environment in which Employees Excel

Objectives

1. To build capacity within First Nations and Inuit leadership to deliver home care services through training and evolving technology and information systems to monitor care and services.
2. To support community-based home care programs in recruitment and retention of a full complement of qualified professional and para professional workers.
3. To support opportunities for appropriate training for professionals and para professionals, family/informal caregivers, and HC program staff.
4. Support the sustainable delivery of community-based services.
5. To support First Nations employers identify learning needs of their health care staff to ensure appropriate training and professional development, and processes to measure outcomes in terms of clinical home care competencies.



Strategic Actions

SHORT TERM (Years 1–3)

- Assess regional capacity, and demonstrate differences among regions, to deliver the Home and Community Care Program to communities, and work with regional offices to develop options to support and improve the delivery of the program in communities.
 - Collaboratively plan with communities and other federal, provincial, and territorial partners in supporting and encouraging First Nations and Inuit to choose home care as a profession.
 - Collaborate with First Nations leadership on being the employer of health care professionals, and ways to identify and improve home care nursing competencies and clinical competencies.
 - Clarify and improve communication processes that enable professional supports, networking and information exchange.
 - Promote and support innovative methods for staff to augment training and qualifications, such as bridging, laddering, innovative training technologies and supportive policies for those in continuing education
 - Collect performance measurement data to support future training requirements for nurses.
 - Support educational and training opportunities for staff to increase competencies.
 - Support First Nations employers in measuring of competencies, and assessing learning needs of their home care providers.
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MEDIUM TERM (Years 4–7)

- Continue efforts to support recruitment and retention of home care nurses, personal care workers, and other support professionals and para professionals.
 - Continue supporting communications that enable professional supports and networking.
 - Develop culturally relevant tools and resources for informal caregivers where they do not exist and provide linkages to external supports.
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LONG TERM (Ongoing, and Years 7–10)

- Adopt technology that will decrease isolation for home care providers, recipients of home and community care and families.
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GOAL # 4:

A sustainable program that is supportive of the client, family and community, and is adaptable to changing needs, emerging trends, and is responsive to the Home Care needs of First Nation and Inuit.

Aligns with FNIHB Strategic Plan Goal #3 Effective and Efficient Performance

Objectives

1. To ensure the program keeps pace with the home care needs of First Nations and Inuit.
2. To create horizontal linkages within FNIHB and with relevant federal partners to pursue an integrated and evidence-based approach that will reduce the impacts of social determinants of health on health outcomes for First Nation and Inuit.
3. To strengthen partnerships with other federal departments, regions, and First Nations and Inuit partners to improve service delivery and management of chronic diseases.



Strategic Actions

SHORT TERM (Years 1–3)

- Work collaboratively with other programs and services to develop First Nations and Inuit frameworks and implementation plans for chronic disease prevention and management relevant to the First Nations/Inuit context.
- Work with AANDC, provinces and territories to seek policy clarification of exceptional complex care clients and broaden our collaboration with public health.
- Work with other FNIHB programs and other federal departments to develop options for addressing social determinants of health, which are a contributing factor in the health status and outcomes of home care clients.
- Broaden collaboration with public health to affect the health status of home care clients.
- Develop a joint strategy to pursue negotiations with AANDC to achieve formal integration^{1*} of AANDC's Assisted Living In-Home Care component with the FNIHCC Program, in collaboration with First Nations and Inuit.
- Continue to discuss with communities the benefits of integration and sharing of best practices of integration of in-home services, and support communities' move to a more integrated approach to homecare delivery.

MEDIUM TERM (Years 4–7)

- Explore policy and funding options to stabilize access to services for clients with complex and specialized health needs.
- Seek additional funding to support evenings and weekend services under “exceptional circumstances”.
- Seek additional funding for the supportive elements (e.g. palliative care, mental health and therapies), as appropriate, and additional professionals (e.g. nurses) and para professionals (e.g. support workers for chronic care patients).
- Collaboratively develop a policy framework and funding options for response to exceptional homecare client needs in communities, including defining “exceptional clients”.
- Collaborate with appropriate FNIHB programs to explore the effects of social determinants of health (e.g. poverty, poor condition of housing, clean drinking water, limited access to healthy food, environmental contamination) on health status and outcomes of First Nations and Inuit.

LONG TERM (Ongoing, and Years 7–10)

- Collaborate with federal, provincial, territorial, regional and Aboriginal partners to define options for providing quality care that decreases the complications of the disease process within a framework that recognizes social determinants of health in First Nations and Inuit communities.
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GOAL #5:

A program that is dedicated to quality improvement, based on high quality, consistent and standardized data collection and assessments.

Aligns with FNIHB Strategic Plan Goal #3 Effective and Efficient Performance

Objectives

1. To support the program with the most timely and accurate data possible through improved performance measurement tools and the implementation of effective assessment instruments.
2. To improve the quality of program data to support program decisions, improve accountability, and protect the integrity of data.
3. To promote quality improvement within the home care environment through leadership, culture, best practices, innovation and change management.
4. To promote the spread and sustainability of quality improvement.
5. To promote capacity building in evaluation and performance measurement.



Strategic Actions

SHORT TERM (Years 1–3)

- Develop analytical reports presenting trends in home and community care delivery and service utilization and one-page snapshots/highlights presenting key indicators and selected statistics of interest.
 - Collaborate with appropriate partners and regions to revise the FNIHCC Logic Model, including the FNIHCC Performance Matrix, to ensure meaningful evaluation results; ensure that adequate program data are collected to facilitate evaluation of expected outcomes.
 - Work with regional coordinators to update the Risk Management Appraisal Tool (RMAT) and establish a plan (including timelines) to verify liability coverage.
 - Review service needs and identify the specific nature of service gaps, based on an analysis of collected data.
 - Conduct a special study to identify the number of clients whose needs could not be met through the HCC program.
 - Update the eSDRT and eHRTT databases and revise them to enable the collection of client outcomes based on the Performance Measurement Strategy, and develop a protocol to simplify the ongoing updating of the e-SDRT and e-HRTT data systems to ensure their sustainability.
 - Explore the development of the Inter-RAI² (Resident Assessment Instrument) used in provincial health systems (I-SMAF in Quebec) and piloted in Alberta with First Nations and the Canadian Institutes of Health Information.
 - Develop performance measurement standards for the collection of information (i.e. data) on nurses training activities, including Public Opinion Research surveys.
 - Work with the ATIP Division to conduct a Privacy Review of the existing FNIHCC data system, identify issues, and develop a plan to address gaps.
 - Work with regions to develop a best practices document for quality regional training activities on program standards and Quality Improvement.
 - Develop information materials to support and inform community programs about data and quality principles and practices.
 - Develop a culture of learning and innovation through knowledge transfer and exchange, educational opportunities, quality improvement, community case stories and network opportunities.
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MEDIUM TERM (Years 4–7)

- Develop FNIHCC service delivery home support standards with associated indicators.
- Create the most accurate picture possible of home and community care needs and population base, using all sources of data, including provincial data, eSDRT data, eHRTT, and health transfer evaluation data.
- Collaboratively plan with regions and program managers, how best to respond to service gaps.
- Initiate the necessary MOUs for data sharing at various levels.
- Assist in a formative evaluation of First Nations health and social service delivery.

LONG TERM (Ongoing, and Years 7–10)

- In 2021, conduct a service gap review based on current data.
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RESEARCH AND SURVEILLANCE PLAN

Introduction

The First Nations and Inuit Home and Community Care (FNIHCC; also referred to as Home and Community Care) Program is committed to continuous learning and development through the conduct of research and research-related activities. As identified in the FNIHCC Program Framework, an essential function of the program is to support and promote the program through awareness, knowledge gathering and knowledge sharing. Ongoing data collection and research contributes to the stability of the FNIHCC Program through ongoing assessment and improvement. It also contributes to the sustainability of the program over the long run by ensuring the program is able to anticipate and respond to emerging health and demographic trends, complex and changing health needs, and other challenges and is responsive to the home and community care needs of First Nations and Inuit.

This Research and Surveillance Plan was developed to support the FNIHCC 10-Year Plan and is consistent with the FNIHB *Framework for Research and Research-related Activities*, 2008. This plan serves to prioritize planned research activities over the next decade, based on anticipated community home care needs, program needs, and departmental requirements. The planned research activities identified throughout the 10-Year Plan complements the program's ongoing data collection and research activities which are described in the following section. It also shows how the planned research activities respond to the strategic priorities identified in collaboration with FNIHB Regions, First Nation regional partners, First Nation and Inuit National partners, and other relevant stakeholders.

PROGRAM PRIORITIES

During the development of the FNIHCC 10-Year Plan, several fulsome discussions and interactive workshops were held to identify areas on which the program would focus over the next decade. The discussions included factors that affect the program including program drivers and emerging trends; mainstream home care trends; population demographics; and complex and changing health needs of First Nations and Inuit. The outcome of these discussions resulted in several priority areas and bases for action which were first presented in the Strategy Development Report, March 2012, and were instrumental in informing the 10-Year Plan's goals and their associated strategic actions.³

Strategic Priorities and Bases for Action

1. Addressing regional and inter-community diversity
2. Social determinants of health approach
3. Program funding
4. Addressing service gaps
5. Addressing human resources issues
6. Program management and communication
7. Improving care through the use of supportive new health technologies
8. Addressing the needs of family caregivers
9. Actively pursue program and service integration
10. Addressing research and data needs

RESEARCH ACTIVITIES (2013-2023)

Sixteen research activities have been identified as priorities in the FNIHCC 10-Year Plan. These research topics can be categorized according to five themes. They are: Human Resources Capacity and Support; Prevention; Service Gaps and Alignment; Impacts on Health; and Innovation. Four of these five themes are linked to the strategic priorities listed above. For instance: Human Resources Capacity and Support (5; 8); Service Gaps and Alignment (4; 9); Impacts on Health (2); and Innovation (7). Prevention is the only theme that was not originally identified as a priority. However, prevention as a priority theme came up in later discussions involving the plan's development (after the Strategy Development Report, March 2012) and was therefore included as a research activity in the 10-Year Plan. Appendix A shows planned research activities according to their priority theme.

The other strategic priorities and basis for action will be addressed by activities other than research, such as policy and framework development; forming linkages and partnerships; and actions that support ongoing program activities, such as data collection and reporting and quality improvement. While policy and framework development may contain a research component, research is not expected to be a major aspect of the policy or framework development activity, and therefore, were not identified as research.

Any research activity that is expected to effectively respond to Branch/Departmental requirements will be conducted within an established (short-term) timeframe to meet such requirements. Other considerations for assessing an activity's priority includes available financial resources (i.e. budget), available staff (if done internally), and/or available (and interested) consultants who have the skills required to undertake the work.

ONGOING DATA COLLECTION & RESEARCH

Since 2002, the program has collected quantitative information through two databases to support the program. The first, the Electronic Service Delivery Reporting Template (e-SDRT), was created to assist communities in meeting program reporting requirements. It contains valuable information regarding client characteristics, client needs, client program access and program funding distribution. The program's second database, the Electronic Human Resources Tracking Tool (e-HRTT), contains information on full-time equivalents (FTEs) providing client services.

The collection of quantitative information satisfies three objectives: 1) to facilitate knowledge sharing—findings are made available to regions and communities, including those who provide direct client care and who perform data collection as well as First Nations and Inuit stakeholders and partners; 2) to support decision-makers to improve client care and client outcomes; and 3) to support audit and evaluation activities which satisfies Treasury Board requirements.

Although conducted less frequently, qualitative research provides vital information about the progress of the program, and helps Health Canada and its partners identify areas for improvements so that the program can be more responsive to the needs of its clients. The online Public Opinion Survey, conducted every two years, is a key instrument for collecting qualitative information to inform program assessment and direction.

The Home and Community Care Program has used research activities and findings to guide program activities and policy development by contributing to an underlying evidence base. For instance, First Nations driven research such as findings from the First Nations Regional Health Survey, published by the First Nations Information Governance Centre. The program conducts (internal) or commissions (external) ad hoc research studies to increase understanding of the home and community care needs of First Nations and Inuit, as well as the broader health issues relevant to these populations. Research activities are driven by specific information requirements for program and policy development and may be quantitative or qualitative in design. Since 2000, several research studies have been undertaken to contribute to the Program's development and capacity. These reports are identified in the FNIHCC Legacy document.

The topics of research that have been identified throughout the 10-Year Plan will contribute to this stock of knowledge by focusing on existing and emerging challenges and disease trends, and assist in the creation of new applications or approaches (e.g. models of care) to advance the Home and Community Care Program and to ultimately improve health outcomes for First Nations and Inuit.

SURVEILLANCE

The FNIHCC Plan will be aligned with the Program Performance Measurement Framework and Logic Model. Future program evaluations will also include in their review the extent to which the plan has been successfully implemented. Most indicators to be used for such evaluation will be the same indicators included in the current FNIHCC performance measurement strategy. However, new indicators might be developed to address key principles inherent in this plan such as those related to service integration, social determinants of health, and cultural competence.

Health statistics and surveillance data that is collected by other areas within FNIHB as well as other federal departments (e.g. Statistics Canada; Public Health Agency of Canada) and external organizations (e.g. Canadian Institutes of Health Information; First Nations Information Governance Centre; Assembly of First Nations; Inuit Tamiriit Kanatami) is useful for program planning purposes and priority setting. The HCC Program will collaborate with the Strategic Policy, Planning and Information Directorate, Health Canada, and other relevant research organizations to obtain First Nations and Inuit population health information and statistics.

REVIEWING & UPDATING THE 10-YEAR PLAN

A review of progress on this plan will be conducted at annual meetings of regional coordinators and partners, as well as monthly teleconferences where current issues are discussed and updates are provided. As such, the 10-Year Plan will be updated with any new research activity that is required to be undertaken, and these new activities will be prioritized in collaboration with regions and partners.

REPORTING ON ACTIVITIES

The status of each activity that has been identified in the 10-Year Plan will be reported on annually using the Reporting Template for the FNIHCC 10-Year Plan Activities (Appendix B).

APPENDIX A

Research Activities According to Priority Themes

PRIORITY THEME	RESEARCH ACTIVITY
HR Capacity & Support	Carry out an environmental scan of tools and resources available for family caregivers.
	Explore family caregiver needs and current best practices (such as the Peer Support model used in B.C.).
	Assess regional capacity, and demonstrate differences among regions, to deliver the Home and Community Care Program to communities.
	Clarify and improve communication processes that enable professional supports, networking and information exchange.
	Develop culturally relevant tools and resources for informal caregivers where they do not exist and provide linkages to external supports.
Prevention	Environmental scan of the home care programs that are employing the model of preventative visits to the at-risk population > age 60.
	Collaborate with communities that utilize a model of preventative visits to prepare stories of best practices, trust building, prevention of hospitalization, and stories of increased quality of life through story-telling and other methods.
	As part of a horizontal initiative with relevant partners (e.g. Public Health Agency of Canada (PHAC), AANDC, other FNIHB programs), implement a pilot study of the preventive visit approach in a small number of both First Nations and Inuit communities, using the pilot implementation model.
Service Gaps & Alignment	Conduct an environmental scan on best practices in cultural models of palliative and end of life care.
	Collect promising practices of integrating home care services at the community level.
	Review service needs and identify the specific nature of service gaps, based on an analysis of collected data.

PRIORITY THEME	RESEARCH ACTIVITY
Impacts on Health	Collaborate with appropriate FNIHB programs to explore the effects of social determinants of health (e.g. poverty, poor condition of housing, clean drinking water, limited access to healthy food, environmental contamination) on health status and outcomes of First Nations and Inuit.
	Work with other FNIHB programs and other federal departments to develop options for addressing social determinants of health, which are a contributing factor in the health status and outcomes of home care clients.
	Collaborate with federal, provincial, territorial, regional and Aboriginal partners to define options for providing quality care that decreases the complications of the disease process within a framework that recognizes social determinants of health in First Nations and Inuit communities.
Innovation	Review principles for the use of effective and appropriate health technologies to improve health, such as tele-health modalities, video-conferencing and diagnostics, using a cultural lens and availability of provincial services.
	Promote and support innovative methods for staff to augment training and qualifications, such as bridging, laddering, innovative training technologies and supportive policies for those in continuing education.

APPENDIX B

Reporting template for the FNIHCC 10-Year Plan Activities

GOALS AND ACTIVITIES	STATUS	COMPLETED BY/IN COLLABORATION WITH
<p>GOAL #1 A home and Community Care program that includes a Holistic Wellness approach within a circle of care, offering high quality services and culturally safe care to clients through all phases of life.</p>		

SHORT-TERM ACTIVITIES

<ul style="list-style-type: none"> Collaboratively develop policies on an expanded model of wellness that includes the role of traditional healing, balance and wellness, and that honors the diversity and self-determination of First Nations and Inuit. 		
<ul style="list-style-type: none"> Collaboratively with relevant partners promote the inclusion of standardized curriculum and training for First Nations and Inuit home care para professionals. 		
<ul style="list-style-type: none"> Provide opportunities for training on cultural safety and sensitivity for non-Aboriginal staff. 		
<ul style="list-style-type: none"> Carry out an environmental scan of tools and resources available for family caregivers. 		
<ul style="list-style-type: none"> Explore family caregiver needs and current best practices (such as the <i>Peer Support</i> model used in B.C.). 		
<ul style="list-style-type: none"> Carry out an environmental scan of the home care programs that are currently employing the model of preventative visits to the at-risk population over the age of 60. 		
<ul style="list-style-type: none"> Collaboratively with communities who utilize a model of preventative visits, prepare stories of best practices, trust building, prevention of hospitalization, and stories of increased quality of life through story-telling and other methods. 		

GOALS AND ACTIVITIES	STATUS	COMPLETED BY/IN COLLABORATION WITH
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MEDIUM-TERM ACTIVITIES

<ul style="list-style-type: none"> Collaborate with relevant partners (e.g. Industry Associations; OGDs; First Nations and Inuit associations) to promote the inclusion of cultural competency education into nursing and personal care provider education curricula. 		
<ul style="list-style-type: none"> Support communities to enhance skills of family caregivers. 		
<ul style="list-style-type: none"> Use evidence from the Preventive Visits research to develop a pilot implementation model, including training of preventive visitors. 		
<ul style="list-style-type: none"> Encourage and support service alignments that integrate home care with existing and emerging prevention activities for vulnerable and at-risk community members. 		
<ul style="list-style-type: none"> As part of a horizontal initiative with OGDs (e.g. Public Health Agency of Canada (PHAC), AANDC, other FNIHB programs), implement a pilot study of the preventive visit approach in a small number of both First Nations and Inuit communities, using the pilot implementation model. 		
<ul style="list-style-type: none"> Encourage and support the adoption, where feasible, of innovative healthcare technologies that can enhance the quality of care. 		

LONG-TERM ACTIVITIES

<ul style="list-style-type: none"> Support and encourage alignment of services to maximize Family Caregiver Support resources to reduce burden on family caregivers. 		
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GOALS AND ACTIVITIES	STATUS	COMPLETED BY/IN COLLABORATION WITH
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GOAL #2 New and innovative partnerships (both formal and informal) and planning that aligns and enhances existing programs and services to improve health outcomes for Home and Community Care clients.

SHORT-TERM ACTIVITIES

<ul style="list-style-type: none"> Maintain membership with non-government organizations (NGOs), such as the Canadian Home Care Association, and linkages with other health organizations. 		
<ul style="list-style-type: none"> Conduct an environmental scan on best practices in cultural models of palliative and end of life care. 		
<ul style="list-style-type: none"> Create and maintain linkages with research initiatives such as those at Lakehead University, Northern Ontario School of Medicine, Western, and other research institutes. 		
<ul style="list-style-type: none"> Increase access to palliative care and rehabilitation services through use of technologies and partnerships with provincial and territorial services. 		
<ul style="list-style-type: none"> Review principles for the use of effective and appropriate health technologies to improve health, such as tele-health modalities, video-conferencing and diagnostics, using a cultural lens and availability of provincial services. 		
<ul style="list-style-type: none"> Work to standardize professional assessments for community members and create linkages with provincial systems. 		

MEDIUM-TERM ACTIVITIES

<ul style="list-style-type: none"> Collaboratively develop a framework for second level supports (such as nurse advisors, specialized therapies), including residual role clarifications for home care professionals. 		
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GOALS AND ACTIVITIES	STATUS	COMPLETED BY/IN COLLABORATION WITH
<ul style="list-style-type: none"> Ensure the collection of case management performance measurement data to support health and service delivery and improve client health outcomes. 		
<ul style="list-style-type: none"> Implement a framework for aligning second level supports with service provision. 		

LONG-TERM ACTIVITIES

<ul style="list-style-type: none"> Continue existing partnerships and discussions at the national, regional, and community levels. 		
<ul style="list-style-type: none"> Pursue new opportunities for effective partnerships with other key stakeholders at the national, regional and local levels. 		

GOAL #3 Promote sustainable and appropriate work environments in which Home and Community Care professionals and para professionals continue to be informed, competent, engaged and supported.

SHORT-TERM ACTIVITIES

<ul style="list-style-type: none"> Assess regional capacity, and demonstrate differences among regions, to deliver the Home and Community Care Program to communities, and work with regional offices to develop options to support and improve the delivery of the program in communities. 		
<ul style="list-style-type: none"> Collaboratively plan with communities and other federal, provincial, and territorial partners in supporting and encouraging First Nations and Inuit to choose home care as a profession. 		
<ul style="list-style-type: none"> Collaborate with First Nations leadership on being the employer of health care professionals, and ways to identify home care nursing competencies and clinical competencies. 		

GOALS AND ACTIVITIES	STATUS	COMPLETED BY/IN COLLABORATION WITH
<ul style="list-style-type: none"> Clarify and improve communication processes that enable professional supports, networking and information exchange. 		
<ul style="list-style-type: none"> Promote and support innovative methods for staff to augment training and qualifications, such as bridging, laddering, innovative training technologies and supportive policies for those in continuing education. 		
<ul style="list-style-type: none"> Collect performance measurement data to support future training requirements for nurses. 		
<ul style="list-style-type: none"> Support educational and training opportunities for staff to increase competencies. 		
<ul style="list-style-type: none"> Support First Nations employers in measuring of competencies, and assessing learning needs of their home care providers. 		
MEDIUM-TERM ACTIVITIES		
<ul style="list-style-type: none"> Continue efforts to support recruitment and retention of home care nurses, personal care workers, and other support professionals and para professionals. 		
<ul style="list-style-type: none"> Continue supporting communications that enable professional supports and networking. 		
<ul style="list-style-type: none"> Develop culturally relevant tools and resources for informal caregivers where they do not exist and provide linkages to external supports. 		
LONG-TERM ACTIVITIES		
<ul style="list-style-type: none"> Adopt technology that will decrease isolation for home care providers, recipients of home and community care and families. 		

GOALS AND ACTIVITIES	STATUS	COMPLETED BY/IN COLLABORATION WITH
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GOAL #4 A sustainable program that is supportive of client, family and community, and is adaptable to emerging trends and changing needs in order to be responsive to the Home Care needs of First Nation and Inuit.

SHORT-TERM ACTIVITIES

<ul style="list-style-type: none"> Work collaboratively with other programs and services to develop a framework and implementation plan for chronic disease prevention and management relevant to the First Nations/Inuit context. 		
<ul style="list-style-type: none"> Work with AANDC, provinces and territories to seek policy clarification of exceptional complex care clients and broaden collaboration with public health. 		
<ul style="list-style-type: none"> Work with other FNIHB programs and other federal departments to develop options for addressing social determinants of health, which are a contributing factor in the health status and outcomes of home care clients. 		
<ul style="list-style-type: none"> Broaden collaboration with public health to affect the health status of home care clients. 		
<ul style="list-style-type: none"> Develop a strategy to pursue negotiations with AANDC to achieve formal integration of AANDC's Assisted Living In-Home Care component with the FNIHCC Program, in collaboration with First Nations and Inuit. 		
<ul style="list-style-type: none"> Continue to discuss with communities the benefits of integration and sharing of best practices of integration of in-home services, and support communities' move to a more integrated approach of homecare delivery. 		

GOALS AND ACTIVITIES	STATUS	COMPLETED BY/IN COLLABORATION WITH
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MEDIUM-TERM ACTIVITIES

<ul style="list-style-type: none"> Explore policy and funding options to stabilize access to services for clients with complex and specialized health needs. 		
<ul style="list-style-type: none"> Seek additional funding to support evenings and weekend services under “exceptional circumstances”. 		
<ul style="list-style-type: none"> Seek additional funding for the supportive elements (e.g. palliative care, mental health and therapies), as appropriate, and additional professionals (e.g. nurses) and para professionals (e.g. support workers for chronic care patients). 		
<ul style="list-style-type: none"> Collaboratively develop a policy framework and funding options for response to exceptional homecare client needs in communities, including defining “exceptional clients”. 		
<ul style="list-style-type: none"> Collaborate with appropriate FNIHB programs to explore the effects of social determinants of health (e.g. poverty, poor condition of housing, clean drinking water, limited access to healthy food, environmental contamination) on health status and outcomes of First Nations and Inuit. 		

LONG-TERM ACTIVITIES

<ul style="list-style-type: none"> Collaborate with federal, provincial, territorial, regional and Aboriginal partners to define options for providing quality care that decreases the complications of the disease process within a framework that recognizes social determinants of health in First Nations and Inuit communities. 		
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GOALS AND ACTIVITIES	STATUS	COMPLETED BY/IN COLLABORATION WITH
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GOAL #5 A program that is dedicated to quality improvement, based on high quality, consistent and standardized data collection and assessments.

SHORT-TERM ACTIVITIES

<ul style="list-style-type: none"> Develop analytical reports presenting trends in home and community care delivery and service utilization and one-page snapshots/highlights presenting key indicators and selected statistics of interest. 		
<ul style="list-style-type: none"> Collaborate with appropriate partners and regions to revise the FNIHCC Logic Model, including the FNIHCC Performance Matrix, to ensure meaningful evaluation results; ensure that adequate program data are collected to facilitate evaluation of expected outcomes. 		
<ul style="list-style-type: none"> Review service needs and identify the specific nature of service gaps, based on an analysis of collected data. 		
<ul style="list-style-type: none"> Update the eSDRT and eHRTT databases and revise them to enable the collection of client outcomes based on the Performance Measurement Strategy. 		
<ul style="list-style-type: none"> Develop performance measurement standards for the collection of information (i.e. data) on nurses training activities, including Public Opinion Research surveys. 		
<ul style="list-style-type: none"> Revise training and orientation materials to include a focus on standards and competencies. 		

GOALS AND ACTIVITIES	STATUS	COMPLETED BY/IN COLLABORATION WITH
<ul style="list-style-type: none"> Develop information materials to support and inform community programs about data and quality principles and practices. 		
<ul style="list-style-type: none"> Develop a culture of learning and innovation through knowledge transfer and exchange, educational opportunities, quality improvement, community case stories and network opportunities. 		
MEDIUM-TERM ACTIVITIES		
<ul style="list-style-type: none"> Develop FNIHCC service delivery home support standards with associated indicators. 		
<ul style="list-style-type: none"> Create the most accurate picture possible of home and community care needs and population base, using all sources of data, including provincial data, eSDRT data, eHRTT, and health transfer evaluation data. 		
<ul style="list-style-type: none"> Collaboratively plan with regions and program managers, how best to respond to service gaps. 		
<ul style="list-style-type: none"> Initiate the necessary MOUs for data sharing at various levels. 		
<ul style="list-style-type: none"> Assist in a formative evaluation of First Nations health and social service delivery. 		
LONG-TERM ACTIVITIES		
<ul style="list-style-type: none"> In 2021, conduct a service gap review based on current data. 		

(Footnotes)

- ¹ Integration refers to combining the funding, resources, and other program aspects of AANDC's In-Home Care component of the Assisted Living program with Health Canada's Home and Community Care program. Integration in this context is consistent with the World Health Organization's definition of integrated health services: "*the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money.*" Technical Brief No. 1, May 2008.
 - * It is recognized that 1) the AFN maintains that integration may be a viable option for a community, but it should not be a "top down" approach, and ultimately be each community's decision; and 2) Ontario has a unique situation with the 1965 Welfare Agreement.
- ² A provincial Home Care assessment tool to guide community-based care and service planning.
- ³ A more detailed description of each priority area and bases for action is provided in the Strategy Development Report (2012).