First Nation and Inuit Home and Community Care Program In Nunavut

Report to the Communities

History

In the fiscal year 1999-2000, Health Canada introduced the First Nation and Inuit Home and Community Care program to Nunavut. The program was to be implemented over a three-year period starting 1999/200 with full implementation by 2001/2002.

In the spring of 2000 Health Canada conducted a tour of all Nunavut communities to introduce the Home Community & Care Program. It was introduced as a community based and community paced program. Communities were to develop their own home care program based on their community's needs. They were told there would be a broad range of services and equipment that would be provided to them through this program.

Throughout 2000/01, many communities began the application process and struggled to comply with complex Home Care documentation and procedures. As well, there was confusion about who was going to administer the program in Nunavut. Was it the responsibility of the Government of Nunavut or Regional Inuit Associations or community governments of other community groups? What would everyone's role be ?

In the fall of 2000 the Government of Nunavut took the initiative to enter into contribution agreements with some communities that were ready to do Home & Community Care needs assessments, even though there was still not a clear understanding of the program and how it was to be administered in Nunavut. Some of the communities delivered services right away; other communities bought equipment; and some tried very hard to complete needs assessments. The program was still in jeopardy of not succeeding.

In January 2001, the Government of Nunavut realized that communities were continuing to struggle and that a significant amount of program money would lapse in the existing and upcoming fiscal year. A territorial Home & Community Care Coordinator was hired to get this program back on track. Issues and concerns that all of partners were experiencing were identified:

- Attempts during the first twenty months (1999/2000) to introduce the program created as much confusion as understanding. The net result was that the year and a half was lost in introducing the program to Nunavut.
- When working in Nunavut we have to work around the community's schedules
- In Nunavut there is a narrow window each year for ordering and shipping supplies
- Most communities had not completed the Home & Community Care needs assessments
- Some communities bypassed doing needs assessments and went right into service delivery
- Some communities spent needs assessment dollars on service delivery and capital costs
- The Home & Community Care program framework and criteria was developed and designed for the south (mostly reserves) and could not work the same way in the north.
- The Home & Community Care program dollar allocation for Nunavut was insufficient to meet Nunavut needs
- To change, modify, alter or even to receive direction for Home & Community Care and FNIHB programs was a time consuming process
- Heath Canada had almost impossible timelines for establishing service delivery in 2001

A strategy and implemented to bring all partners together to get this program back on track was developed to achieving Home and Community Care Service Delivery in 2001.

Relations With Health Canada

It was determined that Nunavut needed to deal with one body in Health Canada that has direct authority to sanction, modify, change or give direction for programs in Nunavut. Health Canada, Northern Secretariat assumed this responsibility. The Northern Secretariat is now working with the Department and Nunavut partners in a dynamic relationship where the needs of both Nunavut and Health Canada are being discussed and solutions put in place.

Taking Direction from the Communities in Nunavut

The Government of Nunavut, Health and Social Services, with funding from Health Canada, hosted a Home Care Conference in Rankin Inlet March 24 – 27, 2001. Home Care representatives from communities across Nunavut attended. Also present were representatives from Health Canada Northern Secretariat, Nunavut Social Development Council, Nunavut Regional Inuit Associations, Nunavut Arctic College and guests from the Yukon. The conference addressed the outstanding issues and challenges with Home Care in Nunavut.

At the end of the conference community representatives and Inuit organizations met separately with the Department and made the following decisions:

- Government of Nunavut Department of Health and Social Services would take the lead role in coordinating Home Care in Nunavut
- The Department would identify the needs in each community and work out the cost for capital requirements, training requirements and service delivery.
- The Department would be responsible for all service delivery of Home Care programs and services at least until individual communities achieved the capacity and indicated their intent to deliver the programs themselves.
- Service delivery of programs and services would be done through the community Health Centers
- The actual administration and work to be done would be coordinated from the Department for overall territorial application to Health Canada and at a Regional level with Regional Home and Community Care Coordinators. These coordinators would report to the Executive Directors in each Region
- The GN with Inuit partners and the Northern Secretariat would work together to get the budgets for Nunavut increased to meet the need. Initially, we would use the money we have to enhance our existing Home & Community Care Program, while we are working towards getting the proper funding to meet the needs in Nunavut.

Description of the Needs Assessment Process

Participation

Twenty-five out of twenty six Nunavut communities participated in the Needs Assessment Process. Community members and stakeholders in the community were interviewed either in focus groups or on a one-to-one basis to get information concerning existing services and expanded programs. The stakeholders included consumers of service, family members and professionals who work with current or potential clients. Results were cumulated, a report completed and in to Health Canada by the June 15, 2001 deadline.

Methodology and Process

The needs assessments were structured by Health Canada and carried out under the direction of the Territorial Home and Community Coordinator, with the involvement of some Regional Inuit Associations, where they were able to make staff available, Inuit community leaders, and the Nunavut Social Development Council. The methods used to carry out the needs assessment included home visits, focus groups, one-to-one interviews, survey questionnaires, and public meetings with community feasts.

Home Visits and Public Meetings

Radio broadcasts and public service announcements were utilized to emphasize the importance of the community assessment process and to publicize the public meeting. Information was gathered from consumers of home care services in the community by interviewing them at public meetings or directly in their homes utilizing the Community Members Survey Questionnaire. Individuals contacted included elders and people with illnesses or disabilities. Public meetings were organized in each community utilizing a workshop format. The Needs Assessments Survey Team facilitated the meeting and a representative from the Home Care Committee or community was present.

Key Knowledge Person Survey

The survey of persons with key knowledge was conducted by the distribution of the questionnaire as outlined in the guide handbook. This survey included personnel from the Department of Health and Social Services as well as key individuals from the community.

Technical Information and Data Collection

Technical information concerning demographics and existing services was collected utilizing the tools supplied in the resource guide and through one-to-one interviews with key informants from a wide variety of Nunavut and Federal Government departments.

Database

The Key Knowledge Person Survey and the Community Member Survey were entered into a Microsoft Access relational database. The number and frequency of the responses is statistically valid.

Tools Used

- *Review of Current Home and Community Care Services and Needs: Appendix C* - Personnel involved in the Iqaluit Home Care Program and the delivery of community based services took responsibility for collecting information as prescribed in *Table 1* of *Appendix C* of the *Community Needs Assessment Handbook.*
- *Key Knowledge Person Survey: Appendix D* - The survey questionnaire as found in Appendix D was distributed to key knowledge persons.
- *Survey Tool for Community Members: Appendix E* - This survey questionnaire was used for clients and community members. Using the translated version, one-to-one interviews were conducted in the local dialect.
- *Focus Group Questions: Appendix F* - A survey questionnaire was customized for the purpose of conducting interviews with focus groups.

Analysis and Conclusions

Training - During the needs assessment process, it became significantly evident that training was wanted and needed in all communities. Existing staff, community and family members all commented on the need for training to be provided within their respective communities. Many of the existing and potential supportive care staff requested an evaluation and upgrading of skills, i.e. upgrading to levels of certified Personal Support Workers (PSW) and possibly upgraded to a Licensed Practical Nurse (LPN) level.

Transportation - Almost all communities expressed the need for suitable transport of elderly and disabled. Without transport, people can't get to the Health Center, or the store, or to visit. Being shut in has a markedly negative effect on their physical and mental well-being. The largest need expressed was for adult day programs, which requires getting out of the house.

Personal and Respite Care - The next largest need was for in-home personal and respite care. Clients in many cases are in difficult living situations. There is a significant need for personal care and home making. As well, many families were tired and frustrated with having to provide 24-hour care without respite. Members could not go out on the land or participate in life outside of the home.

Equipment - One of the significant areas of need is that of medical equipment. Most of the homes where elderly or disabled reside are not wheel chair accessible. There are no handles in the washrooms or appliances installed to make life easier. As well, there is a significant requirement for oxygen concentrators in the home.

Enabling Service Delivery - Nunavut is the most remote area in Canada. It is expected that vehicles and equipment will be priority items for the Capital Budget. Without capital equipment, the effectiveness of service delivery will be diminished.

Completing the Capital Plans

The Department negotiated with Health Canada to determine the monies available for Capital. With short time frames and limited funding, longer-term renovation and facilities improvement were not achievable. The twenty-five Nunavut communities will access capital medical supplies available from Health Canada's National Depot and specific capital funds of $1.5m allocated to Nunavut for the fiscal year April 1, 2001 to March 31, 2002. The capital plan is based upon these resources.

The requisitions for equipment and supplies from the National Depot have been submitted. Additional capital requirements to meet service delivery capacity and deliver a sustainable Home and Community Care Program were clearly identified at the conference in Rankin by community representatives and from the extensive needs assessments conducted in each of the twenty-five Nunavut communities. With monies available this year, the priorities are vehicles to enable service delivery and medical equipment and supplies to provide personal care. Allocation of funding is prioritized as Vehicles 65% and Medical Equipment and Supplies 35%.

The department will apply $ 975,000.00 of capital funds available to purchase and deliver vehicles and $ 525,000.00 to purchase and deliver medical equipment and supplies. Vehicles will be delivered to the communities on the first available sealift in the summer of 2002. In a future full service mode, monies will be allocated to capital for maintenance, upgrading and replacement of equipment.

Training Plans

The first phase of training for Community Support Workers is completed with 85 certified graduates across Nunavut. It was a great success. The Department is now working with the regional Executive Directors and Nunavut Arctic College to develop and deliver Phase II training

Item	Prime	By Date
Negotiate phase II training	Territorial H&CC Coordinator Nunavut Arctic College	December 31
Regional & Community Home Care coordinators trained on using computers and data bases	Territorial H&CC Coordinator H&SS IT	March 2002

Service Delivery

Service delivery is about to start in all three regions. Significant work is underway to have in place the administrative structure, processes and procedures in place by that time. Following is a description of how service delivery will take place

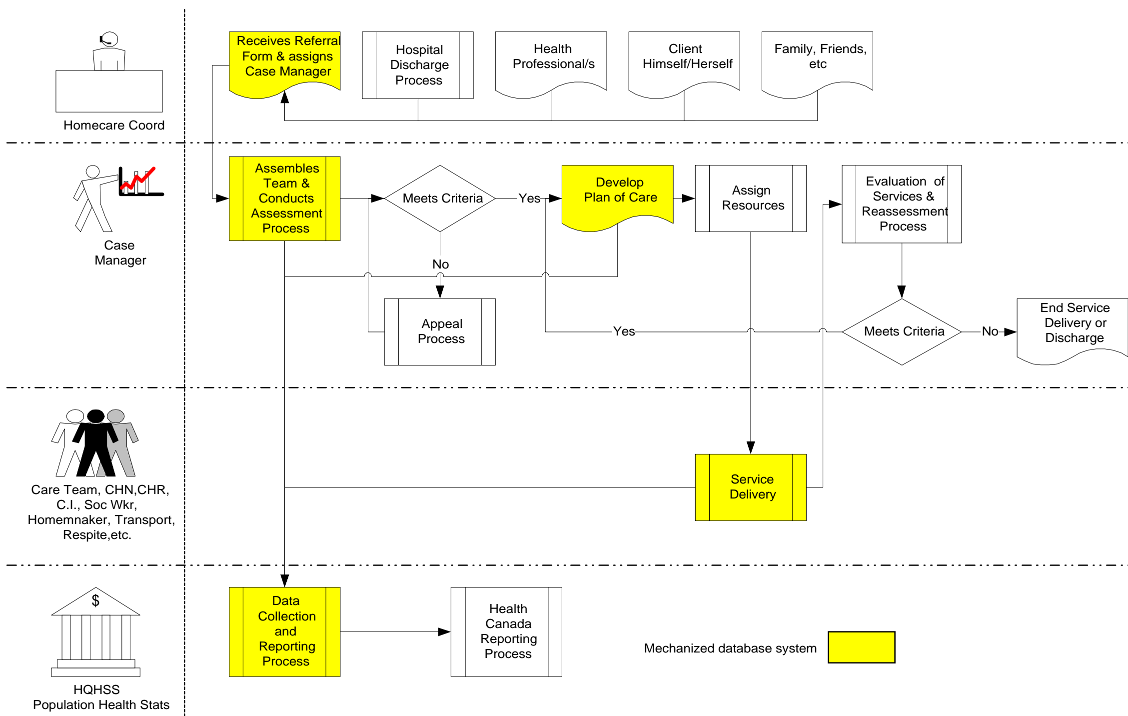
Program Vision

The Program will be integral to the health and social well being in each community. It will result in greater self-reliance of communities by supporting the needs of their members, promoting independence, enabling people to remain as close to home as possible, evolving to meet more of the existing and future needs and building support for the Program in each community.

Program Mission

The Nunavut Home and Community Care Program provides culturally appropriate home care services that are holistic, and meet the needs of Nunavummiat individuals, families and communities. Care is accessible effective, equitable and responsive to individual needs and priorities within the communities. The Program builds self-reliance by strengthening family involvement in care delivery, developing and training staff, and planning and allocating resources wisely.

Service Delivery Process Map



Service Delivery Processes

Processes	Description
Client Referral	The process by which the client or client advocate understands and accesses the services required to maintain the client within the community. Areas to be developed are: ▪ Education of partner facilities and their discharge process ▪ Education of Community regarding services ▪ Access to referral forms ▪ Expectation of processing duration
Assessment	The process by which the referral application is evaluated and admitted to a program or service. This process will identify: ▪ Participants ▪ Basic decision tree ▪ Communication process (what client can expect) ▪ Timeframes for processing
Appeal Process	A means by which an independent arbiter may re-evaluate an applicant's request. This process will identify: ▪ Accessibility ▪ Timeliness ▪ Criteria
Service Delivery	This process describes the assignment of resources (Human and Capital) and the ongoing maintenance of programs and services. Sub Processes Include: ▪ Delivery of Programs and Services ▪ Budgeting and Tracking ▪ Records ▪ Training (Skills & Competencies) ▪ Resource Acquisition (short & long term planning) ▪ Equipment and Inventory ▪ Quality Control
Service Design and Evaluation	Describes the ongoing development of services and programs relative to the needs of each community. Decisions are based on feedback from existing programs as well as the use of survey instruments to determine future requirements. Sub Processes Include: ▪ Performance management ▪ Economic Analysis ▪ Utilizing NPO's ▪ Reporting ▪ Advocacy
Health Statistics	Includes the mandatory reporting of health statistics and the Management Information System requirement for HQHSS and Regional Operations. Sub Processes Include: ▪ Reporting ▪ Data Analysis (integrity) ▪ MIS

Home and Community Care Essential Program Services

1. *Client Assessment*
   - Assessment to make sure that the health care provided is based on the unique needs of each person
   - A care plan put into place to guide the services provided

2. *Managed Care*
   - Discharge planning
   - Coordination with health and social service care providers

3. *Home Nursing*
   - Teaching to prevent secondary complications of existing disorders
   - Post hospital care
   - Wound management
   - Lifestyle counseling
   - Supervision of personal care
   - Palliative care
   - Medication management/ administration
   - Foot care

4. *Home Support*
   - Personal care (e.g. Bathing assistance, etc.)
   - Homemaking
   - In-home meal preparation

5. *Medical Supplies and Equipment*
   - Assistance to acquire equipment to assist with independent living

6. *Program Management and Supervision*

7. *Information and Data Collection*

Who can refer a community member for Home Care Services

- The person himself/herself
- Health and social work professionals
- Family members or friends – anybody

How ?

- The public should call or visit the Health and Social Services Centre and say that they want to make a home care referral. Health care professionals can do the same, but can also send or fax a written referral to the attention of the Home Care Coordinator at the Health & Social Services Centre

What happens next ?

- First, a health or social service professional does an assessment in the home. Without this, client needs may be missed, or unnecessary or unwanted service provided. A care plan is then *negotiated* with the client and their family / caregivers
- If resources are available, service delivery starts in the client's home
- The client will be re-assessed periodically in order to ensure an optimal level of care.

Work Underway

In addition to the work already described, there are a number of infrastructure and program initiatives underway. Listed below is some of the development work in progress:

- Continue with Critical Path with time lines and milestone deliverables
- Confirm standardization of Financial processes
- Capital Requirements for vehicles and medical equipment by community
- Develop procedures and options for control and usage of vehicles
- Develop the data collection model and standardize data collection process
- Develop measures, indicators efficiencies and evaluations
- Conduct Community meetings and provide community feedback/ update by region
- Continued negotiations with Health Canada
- Work at the national level with other regional and territorial Home Care coordinators

A Final Note

The Home and Community Care Program is an excellent example of how working in partnership can overcome seemingly insurmountable obstacles. A great deal has been accomplished in a short time. The goal of all of our efforts is to have service delivery in place for those who need it most.

The Home and Community Care Program will be in place in October with a delivery format that will meet immediate needs. The start-up was difficult, largely because Nunavut is so different from the rest of Canada. It took almost two years to get started. Without the co-operation and hard work of those involved, access to the program would have been lost.

But, we can't stop here. The planning process for the next fiscal year must start almost immediately. There are significant requirements for change that must be addressed in the areas of funding, program enhancement and expansion and capital.